Children Improved Nutrition Through Integrated Approach (CINIA) Project

ChildFund Laos

Final Evaluation Report

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While hopefully this report presents an accurate picture of the situation in Nonghet and Khoun Districst and the sample villages which comprised this study, any errors contained in this report are solely the responsibility of the authors.

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In line with ChildFund's Child Protection Policy, the photographs included in this report were taken by the consultants and evaluation team members with the permission of the subjects on the understanding that they would be used exclusively in this report and not for other purposes.

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List of Acronyms

ANC	Ante-Natal Care
CINIA	Children Improved Nutrition through an Integrated Approach
CWD	Children with Disabilities
DHO	District Health Office
DICT	Department of Information, Culture and Tourism
FGD	Focus Group Discussion
IEC	Information, Education, Communication
IYCF	Infant and Young Child Feeding
KAP	Knowledge Attitudes and Practices survey
KII	Key Informant Interview
MCH	Maternal Child Health
MEL	Monitoring, Evaluation and Learning
MoPH	Ministry of Public Health
MUAC	Mid Upper Arm Circumference (A method for measuring infant growth)
PHO	Provincial Health Office
PNC	Post-Natal Care (or Peri-Natal Care)
PWT	Project Working Team
TOR	Terms of Reference
ToT	Training of Trainers
VHV	Village Health Volunteer

Executive Summary

Introduction: This report includes the findings, lessons learned and recommendations of a final evaluation of the Children Improved Nutrition through an Integrated Approach (CINIA) Project conducted in May – June 2020 in two target districts, Nonghet and Khoun, in Xieng Khouang Province. The CINIA Project, which aimed to increase knowledge and change behaviours related to maternal child nutrition as well as increase access to MCH services at community level, was implemented between 2017 and mid-2020.

Scope and methodology: In addition to gathering data at national, provincial and Nonghet and Khoun District levels, eight sample villages (36% of the 22 target villages) were visited together with sevenHealth Centers for more in-depth community level assessments. As specified in the ToR, the methodology used was largely qualitative, involving interviews, focus group discussions, and observation, and involved mothers, fathers, village committee members, and young people, as well as relevant Government staff at District level. Substantial quantitative data was also gathered from existing sources - mainly relevant health data from Health Centers. A planned household level end-line survey was not done due to Covid-19 limitations and risks. Village visits were led by the national consultant, supported by one or two Government and/or CFL staff, depending on availability.

Challenges: Challenges included limitations on fieldwork due to the Covid-19 pandemic (all respondents, were required to wear masks and maintain social distancing), limited availability of local Government staff (which also meant frequent changes in staff to assist the evaluation), and limited time available by CFL staff due to preparations for program closure.

Findings: The findings are organised primarily under each of the two main objectives - (1) improved knowledge and practices related to maternal-child nutrition, and (2) increased access to MCH services, as well as enhanced capacity of health staff. In relation to each objective, aspects of *process* and *impact* were reviewed and assessed[1]. Management of the project as well as overall sustainability, were also evaluated.

Objective 1. To increase knowledge about the importance of, and access to nutritious food and health for the community, especially mothers, children and pregnant women

Process

Output 1.1: *Training and follow-up support by Project Working Team (PWT) for Health Center staff and Village Health Volunteers (VHVs) in improving the nutritional status of undernourished children 0-5 years*

A total of 65 VHVs were involved in the CINIA Project, with 23 in Nonghet and 42 in Khoun (57% female). Training of trainers (ToT) for VHVs in how to provide training at village level for pregnant women and mothers of infants was provided five times in each target district by staff from the District Health Office and Health Centers. Modules included infant nutrition, hygiene and infection, growth monitoring, and ANC/PNC. VHVs reported that the content of the modules was easy to understand and appropriate for the target audience, though some topics were said to be repetitive.

Overall, while the training content of the modules was felt to be relevant and appropriate for village level training, specific aspects could have been adapted more to local conditions, including more attention given to locally available foods and cultural food taboos, separation of growth monitoring from training sessions, and dropping of pre- and post-tests from village level training.

[1] ***Process*** includes the relevance and quality of activity implementation, the challenges faced (and how they were managed), external influences, and, where relevant, efforts to include more marginalised groups such as people with disabilities and the poorest. ***Impact*** covers evidence of learning and change as a result of activities, the sustainability of these changes, as well as any unintended outcomes.

Output 1.2: *IEC materials produced and distributed to support training*

The CINIA project produced a range of materials to support relevant maternal-child health (MCH) messages being delivered by the project. These included posters, booklets, flipcharts and T-shirts/jackets (with appropriate MCH messages) and totalled more than 4,000 items. VHVs said they found the posters and flipcharts to be useful when delivering village level training and villagers reported seeing the posters displayed at the Health Centers and in villages, and that they were easy to understand.

Output 1.3: *VHVs lead campaigns re peri-natal nutrition, Infant and Young Child Feeding (IYCF), and hygiene/infection for mothers and children 0-5*

This activity was one of the two main areas of focus of the CINIA Project and involved training being provided to villagers, with the main target group being pregnant women and mothers of small children. Training was provided five times in each target village during the project period. Topics presented in the five sessions included two sessions on hygiene and infection, two sessions on ANC and PNC, and one session on infant and young child feeding (IYCF). Participants were invited to attend by announcement, rather than by selection. This was reflected in the fluctuating number of participants at each session, which in some villages ranged between 9 and 32. No records were kept of individual participants, and consequently there was no follow-up. While VHVs led training delivery (and usually shared topics among themselves), they were often supported by Health Center and CFL staff. Most participants were women – pregnant women, mothers of small children and some elderly women, though a few men also joined in some villages. A monitoring checklist was used (See *Annex 3. Village Training Monitoring Checklist*), by a CFL or local Government staff member, but based on feedback as to how these forms were used, the reliability of the data on these forms is questionable. There was no follow-up of individual participants after each training session which could have contributed to better quality implementation and positive impact (see *Recommendation 6.1*).

Output 1.4 *Radio programs produced and broadcast*

In both districts, the Department of Information, Culture and Tourism (DICT) worked with DoH and CFL staff to produce radio spots to support MCH messages from the CINIA Project in three languages – Lao, Hmong and Khmu - which were broadcast on community radio stations and provided to target villages that had loudspeaker systems. There were differences between the spots in Nonghet and Khoun Districts, with messages in Khoun being mixed with different music with messages not so clearly identifiable, while in Nonghet District each spot started with the same music and an introduction to the topic. There were reportedly issues regarding coordination between DHO and the DICT offices over development of the spots, and staff in both districts felt they needed more training and support to produce these. Recordings of the spots were also just sent out to each target village without any guidance or training in how to broadcast them in a way that ensured maximum effectiveness.

Impact

VHVs*:* Health Center staff, villagers and VHVs themselves all reported that the work of VHVs in target villages had mostly improved as a result of involvement in the CINIA Project. VHVs interviewed said that their involvement, including training, the provision of per diems, receiving basic infant measuring equipment and T-shirts and caps, had helped to motivate them. Health Center staff in all sample centers visited reported that VHVs involved in the CINIA Project understood their roles better and that the quality of data collection and coordination with the Health Centers had improved.

Nonetheless, villagers in some communities complained that the VHVs lacked basic health knowledge, even after receiving training. As a result, they could not provide quality training to villagers. In some villages visited in Khoun District, where there were more than two VHVs in the village, respondents reported that

only one or two VHVs were functioning. This suggested that while in theory, having more VHVs should reduce the workload, in reality, it seems this was not the case, and that having only two motivated VHVs would be more effective.

Pregnant Women and Mothers*:* A number of changes were reported by women who had participated in the training, including a longer period of exclusive breastfeeding than before and mothers giving more attention to preparing food for their infants. Most young mothers with new born babies, reportedly changed their dietary habits and now eat a greater variety of food, including food that was previously prohibited due to cultural taboos. Hygiene, particularly more frequent hand washing, was also reported. Several respondents also said that the village level training had encouraged more women to access ANC and PNC services at the Health Center or District hospital, as well as encouraging immunisation of their children.

Children*:* Due to the lack of reliable quantitative data, it is difficult to assess the impact of the training provided on children's health. Accordingly, perhaps the only conclusion from the limited quantitative data available is that the number of children reached through growth monitoring has increased substantially. Apart from this statistical data, several respondents also reported a reduction in the numbers of malnourished children as a result of increased knowledge and change of behaviour of mothers in terms of health and nutrition.

Thus while the data available was largely qualitative and subjective, it does appear that activities under the first objective of the CINIA Project have had some positive impact in terms of:

- Improved diet of both mothers and children;
- Extended periods of exclusive breastfeeding among some mothers;
- Increased growth monitoring of infants by health staff;
- Increased use of health services by parents of children under five;
- Increased immunisation of children under five years;
- More effective functioning of VHVs.

Objective 2. To increase accessibility to MCH services (including peri-natal care) for pregnant women and to improve the capacity of VHV, village authorities and District level to provide nutrition instruction to pregnant women.

Process

Output 2.1: *Training for Health Centre and District Health Staff on clinical skills for MCH*

The content of training in MCH clinical skills for District Health Office (DHO) and Health Centre staff was reportedly based on needs identified at the start of the CINIA Project, but as there was limited documentation available at the time of the evaluation, it was not possible to confirm this. Both DHO and Health Centre staff found the training to be very relevant to their needs and applicable in their work. However, due to changes in training staff from the Provincial Health Office (PHO), participants found that often they had more experience than the PHO trainers. After training, there was a follow up activity done once a year in each district but the participants felt that it would have been better to have this done on a quarterly basis as well as being done more systematically, through checking and providing them with feedback and areas for improvement.

Output 2.2: *Equipment provided to VHV's, Health Center and ChildFund Laos Project staff to measure, weigh, identify malnourished children 0-5 yrs*

As with the training, the provision of equipment for Health Centers and VHVs was reportedly based on the needs assessment conducted at an early stage of the CINIA Project. Most of the requested equipment related to infant growth monitoring (e.g. scales, height measuring equipment) and ANC and PNC (e.g. ultrasound) was provided, and was reportedly being used on a regular basis. However, there was some concern at the quality of maintenance of some of the equipment (e.g. forceps, scissors etc.) and their sustained use longer term.

Output 2.3: *KAP baseline and end line surveys, mid-term and end of project independent evaluation conducted*

While a comprehensive knowledge, attitudes and practices (KAP) survey was conducted at the start of the CINIA project to establish a baseline in terms of quantitative data, it was unfortunately not possible to repeat this survey at the end of the project due to Covid-19 pandemic restrictions. Accordingly, it was not possible to measure changes in key areas quantitively, apart from numbers of ANC visits. An internal mid-term review was conducted in July 2019, and the findings were used to inform this final evaluation.

Impact

Overall, the data indicates a significant increase in the numbers of women having ANC checks at Health Centers in Nonghet District between 2017 and 2019, with an over 30% increase in women making one visit and over a 50% increase in women making four visits. While this data may not be totally reliable, it does show a trend of a significantly increased number of ANC visits in most target Health Centers.

Evidence from the interviews of VHVs and Health Center staff indicated that most pregnant women in the villages visited were advised to use health facilities either at Health Centers or at the District hospital. While not possible to assess quantitatively, all pregnant women and mothers interviewed who had accessed services at their Health Centers were able to give an indication of what they had learned as a result of ANC and PNC visits, and all Health Center staff interviewed said that they provided consultation/advice to mothers when using ANC and PNC services. This may also be partially reflected in a decline in infant mortality rates in both Districts.

Management: Although the original proposal envisaged that a Project Working Team (PWT) would be established in each district, comprised of a CFL Health Project Officer, DHO, LWU and DAFO staff, this was never activated. In practice, the project was managed by the CFL Health Project Officer working closely with a DHO Coordinator, with higher level management organised in line with other CFL supported projects under their MoU. CFL Health Officers reported to the CFL Provincial Area Manager (PAM) who submitted formal progress reports to District and Provincial Government twice per year. While a monitoring checklist was developed for village level training, the accuracy of the information is questionable, as it was reported that often these checklists were filled in after the training, or were not completed at all, but data just made up to meet the reporting requirement.[2] In terms of overall project documentation, it appears that based on what was available, documenting planning and implementation of the CINIA project was not given sufficient attention by CFL staff nor by Government counterparts.

Sustainability: The final evaluation found that the CINIA Project had largely met most of the key sustainability related areas stated in the original CINIA Project document[3]. Project activities were largely aligned with and supported the Lao Government's National Nutrition Strategy to 2025 and Plan of Action 2016-2020. The CINIA Project also worked with and through existing health care systems and staff, with implementation done through the DHO, Health Centers, and VHV networks at village level. Training of

[2] It was reported that the data recorded on the village training checklist was only 30%-50% accurate.

[3] See: *CINIA Project Proposal*, Approved 8 November 2017.

health staff at village and Health Center levels indicated a high degree of integration into existing capacity development within the Ministry of Public Health. In terms of the Project being based on identified local health issues and culturally related issues, while it did focus on addressing issues related to maternal-child nutrition, such as under-nutrition and stunting, the extent to which it took local context and culturally related matters into account was limited.

Overall, the CINIA Project has contributed, together with other influences, to longer term change in terms of community knowledge and behaviour regarding maternal-child nutrition, as well as improved hygiene practices. The Project has also helped to strengthen the health care system at village and Health Center level through supporting provision of training and equipment for health staff, and this in turn has contributed to increased confidence in, and use of these health services.

Cross-Cutting Program Areas: Cross-cutting areas include gender equity, reaching people with disabilities, and reaching the most vulnerable groups. In terms of gender equity, the Project did not really address the issue of limited involvement by fathers in MCH. Although this was raised in the mid-term review (MTR) report as an issue of concern, very few fathers attended the village level training, perhaps due to cultural perceptions of male and female roles. However, the Project did ensure a reasonable balance of female to male VHVs. Six monthly reports indicate that there were efforts to encourage disabled mothers and children to attend training, though with limited success, as well as disaggregating participants in village training in terms of disability. The final evaluation found that neither VHVs nor Health Centers had any record of PWDs in their communities. However, another CFL supported project, Wheelchairs for Kids, did provide 13 children with disabilities from the same target villages with wheelchairs. A significant number of target communities were comprised of ethnic groups (Hmong and Khmu) who are relatively poor, so the project can be said to have reached at least some of these more marginalized groups. However, within each community, it seems there was no specific attempt to reach the poorest women and ensure their participation in training and other support activities.

Possible Learning Points: Evaluation of the CINIA Project raises a number of points which could be considered in the design and implementation of similar projects in future. These include:

- Sustainability of the VHV system needs to be a priority.
- Systematic follow-up after training is key.
- Training modules would benefit from adjustment to local context.
- Pre- and post-tests are not useful for village level training.
- MUAC is best done separately from village MCH and nutrition training sessions.
- IEC materials and radio spots played a useful role.
- Clear identification of, and support for the target groups may have strengthened the impact.
- Ensuring scheduling of training sessions fits with villagers availability.
- Comprehensive and accurate documentation and data are essential to effective monitoring and evaluation.

Key Successes: The evaluation also identified several good practices or key successes which may have relevance for ChildFund's future project design in other districts:

- Bringing international ‘good practice’ in maternal-child nutrition to semi-remote communities.
- Combining capacity development together with provision of hardware.
- Using community radio and village loudspeaker systems enhanced the dissemination of health messaging.
- Strengthening the VHV system is essential.

Recommendations

As the CINIA Project will not continue to another phase in the two target districts, the recommendations below are suggestions for the design and implementation of similar projects elsewhere in the future.

- Consider more focused targeting of pregnant women and mothers in future village level training.
- Directly target fathers in training.
- Review and revise village level training curriculum to ensure it is more appropriate for the local context.
- Motivate and retain VHVs.
- Improve health data collection and data availability.
- Radio spots and how these are produced and delivered needs improvement.
- CFL could engage more in MCH at national level.

Conclusion: Overall, the CINIA Project has achieved its intended outcomes to quite a large extent in the 22 target communities. It has ensured relevance through targeting disadvantaged ethnic communities, in line with MoPH policy, and working within the framework of existing MCH systems. The project has also strengthened health care systems at local level through training for staff as well as provision of equipment to support improved ANC and PNC services, and growth monitoring of infants at village level. These positive impacts have been reflected in quantitative data related to numbers of women accessing services at Health Centers, as well as numbers of infants and small children having their growth monitored, as well as being immunised. While these positive impacts cannot be solely attributed to the CINIA Project, as at the same time there have been Lao Government initiatives, such as free maternal-child health care at health facilities, as well as free immunisations, the Project has been a major contributing factor. At the same time, the CINIA Project has faced some challenges, which provide learning opportunities for future projects, including the need for better targeting of participants and ensuring their ongoing participation in village level training and follow-up. Specific targeting of fathers for training also has the potential to enhance the impact of the project. While the training curriculum used reflects good practice, it could also benefit from adjustment to better fit with the local context. At the health systems level, improved data collection and data availability could contribute to improved planning and reporting. CFL's own monitoring system, particularly for village level training, could also be improved. However, despite some areas for improvement, the CINIA Project has contributed to longer term sustainability through helping to bring about changes in target communities, in the form of behaviour and practices related to maternal-child nutrition and hygiene.

1. Introduction

ChildFund Laos (CFL), with support from the Australian Department of Foreign Affairs and Trade ANCP program and ChildFund Australia, has been implementing Phase 2 of the Children Improved Nutrition through an Integrated Approach (CINIA) project in Nonghet District since 2017 and Khoun District since 2018, with an end date of June 2020, marking the end of CFL's involvement in these two districts. Designed to address several issues in these target areas, including under-nutrition among children under five years, as well as maternal nutrition and hygiene and limited access to maternal-child health services, the CINIA Project had two overall objectives[4]:

- To increase knowledge about the importance of, and access to nutritious food and health for the community, especially mothers, children and pregnant women.
- To increase accessibility to MCH services (including peri-natal care) for pregnant women and to improve the capacity of VHV, village authorities and District level to provide nutrition instruction to pregnant women.

The evaluation examined the implementation and impact of the CINIA Phase 2 Project from November 2017 to June 2020 in Nonghet and Khoun Districts. As well as identifying changes brought about by the project and the factors that have contributed to this change, the evaluation also looked at how these initiatives were implemented and managed – i.e. *process* – as well as changes, or *impact*, and the sustainability of these changes. There was a particular focus on what could be learned from this project in Nonghet and Khoun Districts that may be applicable to both ChildFund's maternal-child and MCH work in other districts in the Lao PDR in future, as well as for District Health Offices (DHOs) in the target Districts themselves as they continue without support from CFL.

Although the final evaluation took place in the midst of Covid-19 restrictions (see *2.4 Challenges* below), it was felt necessary to proceed with this, as CFL was ending its support to both districts and there was a need for the findings to inform both the future related work of the District Health Offices in each district, as well as future maternal child nutrition related projects supported by CFL in other districts in the future. Accordingly, preliminary findings from the evaluation were presented at CFL closeout meetings with local Government stakeholders in each of the two target Districts in early June 2020.

2. Methodology

2.1 Scope

Geographical Scope:

In addition to gathering data at national, provincial and particularly Nonghet and Khoun District levels, a number of sample villages were selected for more in-depth community level assessments. Of the 22 villages that were targets for the CINIA Project, a sample of eight villages were selected, comprising approximately 36% of target villages. These were selected based on the following criteria:

- Target villages from Phase I in Nonghet District (one near the road, the other more remote; different population sizes, ethnic composition, and numbers of children under the age of 5);
- Target villages from Phase II in both Nonghet and Khoun Districts (near the road, other more remote; different in population, size, ethnic composition, numbers of children under the age of 5);
- Balance of villages across the two districts (four in each district);

[4] Initially the Project had three objectives but the design was revised and streamlined in 2018 to two objectives. This revised design has been used for this final evaluation.

- Cross-cutting – a range of village size and ethnic composition, remote/semi-remote as well as on the road, and villages with or without support from other projects.

Based on these criteria, the following villages were selected for the CINIA evaluation:

Nonghet District

1. **Phamao** – a target village since Phase I, a smaller village with many children under 5 which has some mothers/children with disabilities (PWD/CWD), but has no health centre; located in the Phakkhae Cluster, 100% ethnically Hmong, and semi-remote.
2. **Nammen** - a target village since Phase I, a smaller village with fewer children under 5, and has no health centre; also in the Phakkhae Cluster, 100% Khmu, and located on the main road.
3. **Pha-En** – a target village of Phase II, a larger village with many children under 5 with some PWD/CWDs, and has a health centre; in the Pha-En Cluster, 100% Hmong, and remote.
4. **Phaclak** – a target village of Phase II, a smaller village with many children under 5 with some PWDs/CWDs, but has no health centre; in the Tepsaban Mueang Cluster, 100% Hmong, and located on the main road.

Khoun District

1. **Nathong – a** target village of Phase II, a smaller village with many children under 5 and some PWDs/CWDs, and a health centre; in the Nam Oun Cluster, 100% Lao Tai, and located on the road.
2. **Nam Phanh – a** target village of Phase II, a larger village with many children under 5 and some PWDs/CWDs; it has a health centre, is located in the Nam Phanh Cluster, is comprised of mixed ethnic groups, and is semi-remote/remote.
3. **Thenthong – a** target village of Phase II, a smaller village with fewer children under 5 and some PWDs/CWDs and no health centre. Located in the Longsan Cluster, it is comprised of mixed ethnic groups, and is semi-remote/remote.
4. **Nasom –** a target village of Phase II, a smaller village with many children under 5, has no PWDs/CWDs and no health centre; it is located in the Samphanxay Cluster, with an ethnic composition of 70% Phuane and 30% Hmong, and is semi-remote/remote.

In addition to these sample villages, seven Health Centers that had received support from ChildFund were also visited (two very briefly) as part of the evaluation (see *Annex 2. Health Centers*).

Respondents:

A wide range of respondents were interviewed for the evaluation, and included the following:

Table 1. Number of Participants

Participants	Total	Male	Female
Village committee	9	9	0
Village Health Volunteers	12	2	10
Health Clinic Staff (souksala)	9	4	5
Pregnant women	7	0	7
Mothers with children under 5	7	0	7
Fathers	9	9	0
Youth	1	0	1
District staff	13	6	7
ChildFund Laos staff	3	2	1
Total	**70**	**32 (46%)**	**38 (54%)**

2.2 Methodology

As specified in the ToR, the methodology used was largely qualitative, involving key informant interviews (KIIs), focus group discussions (FGDs), and observation, including with mothers, fathers, village committee members, and young people, as well as relevant Government staff at District level. Substantial quantitative data was also gathered from existing sources - mainly relevant health data from Health Centers (*Souksala*) and particularly from the District Health Office, as well as relevant data from CFL and other sources. A household level end-line survey was not done due to Covid-19 limitations and risks.

2.3 Evaluation Team

Due to the limited availability of Government and CFL staff and constraints imposed by the pandemic, it was not possible to have a full team to assist with the evaluation, as would normally be the case for a project evaluation. However, the CFL Health Officers and a small number of local Government staff did assist with arrangements and some of the interviews, depending on their availability (see *2.4 Challenges below*), and were involved later in some of the initial village level data consolidation and analysis. As much as possible, the evaluation tried to ensure a gender balance among the team – having two government staff from Nonghet District (one male and one female) to work with the team from start to finish, and four from Khoun District (two males and two females). There were more team members in Khoun District as each of them had limited availability and thus the team arranged at least one or two staff to join the consultant on each village visit.

2.4 Challenges

Challenges included limitations on fieldwork due to the Covid-19 pandemic, limited availability of local Government staff as a result (which also meant frequent changes in staff to assist the evaluation), and limited time to assist by CFL staff due to preparation for program closure. Those who did join the evaluation had very limited evaluation experience, which meant that most of the data collection and consolidation was done by the consultant.

The main challenge faced was due to restrictions on travel and data collection due to the Covid-19 pandemic, which limited the availability of respondents, particularly local Government staff who were busy with pandemic-related work, as well as limiting time spent in sample villages. It was also not possible to repeat a quantitative (KAP) survey which had provided baseline data against which changes brought about by the CINIA Project could be measured, as this would have required a larger evaluation team as well as a preparation workshop and more time spent in sample villages than was possible under the current circumstances.

As the interviews had to strictly follow Covid-19 protocols, with everyone wearing face masks and sitting at least 2 meters from each other, this created a feeling of 'unease' for the participants, and limited full expression of their views. In addition, due to the fact that the evaluation was being done at the start of the rice and cash-crop planting season, most villagers were unavailable for interviews. Other challenges were related to local language use, particularly in interviewing mothers from Hmong communities, many of whom do not speak Lao fluently and thus an interpreter was needed, as well as difficulty getting secondary data from relevant government offices at the district level, and from Health Centers.

While every effort was made to gather as much relevant data as possible, the above constraints did limit the extent of the findings and may have had an effect on the comprehensiveness of this evaluation report.

3. Findings

The findings below are organised primarily under each of the two main objectives and then within each, aspects of process and impact are examined. ***Process*** includes the relevance and quality of activity implementation, the challenges faced (and how they were managed), external influences, and, where relevant, efforts to include more marginalised groups such as people with disabilities and the poorest. ***Impact*** covers evidence of learning and change as a result of activities, the sustainability of these changes, as well as any unintended outcomes. Findings related to management of the project, including monitoring and reporting, as well as overall sustainability, are covered separately at the end of this section.

3.1 Objective 1 – Maternal-child Nutrition

> ***Objective 1.*** *To increase knowledge about the importance of, and access to nutritious food and health for the community, especially mothers, children and pregnant women*

***Findings - Process*:**

Activities: Activities supported by the CINIA Project under this first objective primarily involved a cascade training model related to maternal-child nutrition, with additional activities related to production of relevant IEC visual materials (posters, etc.) and radio programs in the three languages spoken by the target groups. In the project proposal, the cascade model involved the Project Working Team (PWT) receiving training in three integrated nutrition modules (including growth monitoring and MUAC) and then the PWT providing training to Village Health Volunteers (VHV). However, as a PWT (as envisioned in the original project proposal[5]) was not established, training in the three nutrition related modules was reportedly provided directly to DHO and Health Center *(Souksala*) staff who then trained VHVs. These VHVs then went on to provide training in their communities, primarily targeting pregnant women and mothers at village level. At the same time, visual (IEC) materials, particularly posters, with related maternal-child health messages, were produced, as well as radio programs in Hmong, Khmu and Lao languages. The radio programs were broadcast on local community radio as well as on village loudspeaker systems.

Output 1.1: ***Training and follow-up support by PWT for Health Center staff and VHVs in improving the nutritional status of undernourished children 0-5 years***[6] *(NOTE: This output includes VHV selection and support)*.

A total of 65 VHVs supported the CINIA Project, with 23 in Nonghet and 42 in Khoun (see *Table 2* below). In terms of gender balance, 57% of the VHVs were female, though not all communities had a balance of female and male volunteers (Three villages, all in Nonghet District, had only male volunteers, while six villages had only female volunteers). Most of the VHVs were already part of the village level PHC system prior to the implementation of this phase of the CINIA project, though a few additional VHVs were recruited to provide support specifically for the project.

[5] '***Section 10 - Project Management*** *The Health Officer will work with the District Health Officers and other relevant District officers (Agriculture, Women's Union) to form the Project Working Team*.' Pg. 19.

[6] NOTE: The wording of this output has changed over time, from "*Parents and caregivers in XX villages provided training and follow-up support for improving the nutritional status of undernourished children 0-5 years*" in the original proposal in 2017 and the proposal variation in 2019, though reference to follow-up support was reworded in a revised version in 2018 to only refer to training for DHO and Health Center staff. Whatever the wording, follow-up after training does not appear to be mentioned as a specific activity.

Table 2. Village Health Volunteers (by Gender, Village and District)

No.	Village	Supervision – Health Center/DHO	Cluster	District	Total	M	F	% Female
1	Pha Mao	Phakkheak	Phakkheak	Nonghet	2		2	100%
2	Nyorkho	Phakkheak	Phakkheak	Nonghet	2	1	1	50%
3	Nam Kouanyua	Nammen	Phakkheak	Nonghet	2	2		0%
4	Nammem	Nammen	Phakkheak	Nonghet	2	1	1	50%
5	Pha En	Pha En	Pha En	Nonghet	2		2	100%
6	Khobmou	Pha En	Pha En	Nonghet	1	1		0%
7	Phounong	Pha En	Pha En	Nonghet	1	1		0%
8	Nonghet Tai	DHO - Nonghet	Nonghet Tai	Nonghet	2		2	100%
9	Paka	DHO - Nonghet	Nonghet Tai	Nonghet	3	1	2	67%
10	Houykeeling	DHO - Nonghet	Nonghet Tai	Nonghet	2		2	100%
11	Phaclak	DHO - Nonghet	Mueang	Nonghet	2	1	1	50%
12	Nonghet Nuea	DHO - Nonghet	Mueang	Nonghet	2		2	100%
					23	**8**	**15**	**65%**
13	Phoumoumueng	Nam Oun	Nam Oun	Khoun	3	2	1	33%
14	Nalam	Nam Oun	Nam Oun	Khoun	4	2	2	50%
15	Nathong	Nam Oun	Nam Oun	Khoun	5		5	100%
16	Xumnyoun	Nam Oun	Nam Oun	Khoun	5	3	2	40%
17	Nam Phanh	Nam Phanh	Nam Phanh	Khoun	5	3	2	40%
18	Phuckhing	Kewsead	Kewsead	Khoun	3	2	1	33%
19	Samlouang	Sanlouang	Sanlouang	Khoun	4	2	2	50%
20	Thenthong	Longsan	Longsan	Khoun	4	2	2	50%
21	Houyloun	Longsan	Longsan	Khoun	4	2	2	50%
22	Nasom	Samphanxay	Samphanxay	Khoun	5	2	3	60%
					42	**20**	**22**	**52%**
Total					**65**	**28**	**37**	**57%**

Training of trainers (ToT) for VHVs in how to provide training at village level for pregnant women and mothers of infants and toddlers was provided five times per year in each target district. Trainers were staff from the District Health Office and Health Centers. Modules included infant nutrition, hygiene and infection, growth monitoring, and ANC/PNC[7]. VHVs reported that the content of the modules was easy to understand and appropriate for the target audience, though some topics were said to be repetitive, while others were more difficult to understand, perhaps due to the Lao terms used. For example, VHVs in Thenthong village found it difficult to understand the topic of peri-natal care, particularly taking care of mothers after giving birth when they have loss of blood, and how to ensure the mother's safety.

VHVs interviewed said that there was follow-up by the trainers after the initial training at District level. This seems to have largely involved completing a checklist and observation guide that was supposed to be done while VHVs were giving training to villagers. However, based on responses as well as completed checklists, it appears that there was little if any provision of feedback or guidance to VHVs on how to better conduct the

[7] Although family planning was also mentioned in the original proposal as a topic for this training, it appears from the module documents that this was not included.

training – e.g. reviewing their training plan developed during the TOT, preparation and use of training materials including IEC materials, training delivery, use of training assessment tools, etc.

Overall, the training content of the modules was felt to be relevant and appropriate for village level training. A review of the three training modules[8] – ANC and PNC, IYCF and hygiene and infection management – found that overall, they were comprehensive and well structured, presenting relevant information in an easy to understand format. Some specific aspects which could have been improved on or adjusted included:

- *Food pyramid:* In presenting this topic, the availability of relevant foods within the village as well as cultural taboos on eating some of these foods could also have been given more attention.
- *MUAC of children as part of each training session*: To combine this with a village level training, which may have involved more than 20 mothers, would seem to have unnecessarily complicated the training process. This was confirmed in the later training records from village level where this activity was largely dropped, occurring in only about 20% of the village training sessions (see Output 1.3 below), although it had originally been suggested that it took place at each session[9].
- *Pre-test/Post-test:* Given the informal nature of the village sessions and the benefit of hindsight, conducting these and recording the results as a way of measuring any increase in knowledge among participants was not feasible, and in fact these were not done in the majority of village level trainings conducted (see *Output 1.3* below).
- *Responsibilities of VHVs:* These were to be part of the introduction for each village level training and provided the ideal, rather than the reality, and specified household visits by VHVs. Interviews with VHVs suggested that household visits were never done in any systematic way, but only on an *ad hoc* basis if at all.

Output 1.2*: IEC materials produced and distributed to support training*

The CINIA project produced a range of materials to support relevant MCH messages being delivered by the project. These included posters, booklets, flipcharts and T-shirts/jackets (with appropriate MCH messages) and totalled more than 4,000 items (see *Table 3* below).

Table 3. IEC materials produced and distributed

IEC Materials	2019	2020	Total
Posters - copies	76	3000	3076
Flipcharts	336	0	336
T-shirts & jackets	0	650	650
Total	412	3650	4062

VHVs said they found the posters and flipcharts to be useful when delivering village level training in order to illustrate the points being presented. Villagers, both mothers and fathers and village heads reported seeing the posters displayed at the Health Centers and in villages, and that they were easy to understand, with the exception of some more technical terms such as calories and carbohydrates. While non-literate women

[8] Only the original English language versions of the modules were reviewed. Whether the content was adjusted when translated into Lao and/or when presented in training, is unknown.

[9] The use of MUAC was reportedly dropped because the health authorities did not agree with its use as it was not a formal health system indicator. Instead CFL provided MUAC bands to mothers with instruction on how to use them.

could not read the text on these posters, in some cases they asked women who could read them to say the messages aloud so that they could understand[10].

Output 1.3: ***VHVs lead campaigns re peri-natal nutrition, Infant and Young Child Feeding (IYCF), and hygiene/infection for mothers and children 0-5***

This activity was one of the two main areas of focus of the CINIA Project and involved training being provided to villagers, with the main target group pregnant women and mothers of small children. Training was provided five times in each target village during the period of the project. Topics presented in the five sessions included two sessions on hygiene and infection, two sessions on ANC and PNC[11], and one session on infant and young child feeding (IYCF). In terms of selection/invitation of participants, delivery of training, and follow-up after training, the findings were as follows:

***Invitation/Selection of Participants*:** Where villages had a functioning loudspeaker system, it appears that the village training was announced by the Village Head and then those who were interested and had time, attended the sessions, whereas in other villages without such a system, VHVs would go to each house and inform them of the training. It seems there was little individual targeting of invitations, judging by the fluctuating numbers who attended each session (for example, the number of participants varied each time from 9 – 32 in Phamao Village in Nonghet District, and between 20 and 51 in Houayloun Village in Khoun District)[12]. Also, there were apparently no records kept of who the participants were – who had attended each training or attended only one or two sessions. Having this system in place could have helped VHVs, Health Center, or DHO and CFL staff better monitor individual attendance. This could also have helped VHVs to get a better understanding of who may have needed additional support.

Training Delivery: While VHVs led training delivery (and usually shared topics among themselves), they were often supported by Health Center and CFL staff. This included helping VHVs to explain topics that had not been well elaborated or that VHVs found difficult to explain, and monitoring sessions using the checklist tool. In some cases, in Namphane Village, for example, Health Center staff reported that they led on some training topics due to limited knowledge and capacity of VHVs.

Most participants were women – pregnant women, mothers of small children and some elderly women, though a few men also joined in some villages. In some villages, it was reported that several of the target group chose not to attend, either because they were not interested (They reportedly felt that either topics were not new for them or because there were no incentives being offered for attendance) or were busy with other work.

As was mentioned above, a monitoring checklist was used (See *Annex 3. Village Training Monitoring Checklist*), presumably by a CFL or local Government staff member, but based on feedback as to how these forms were used, the reliability of the data on these forms is questionable (The usefulness of this monitoring form is covered in more detail *in Section 3.3 Project Management*). However, several of the checklist categories relate to the quality of training delivery by VHVs, including use of posters and visual aids, clarity of presentation, coverage of activities for the topic, and summary of key points. Apart from coverage of

[10] This suggests that draft IEC materials should be reviewed in terms of level of understanding by non-literate target groups.

[11] Where there were two sessions held on the same topic, the second was a refresher training.

[12] There were significant differences between numbers of participants attending based on respondent accounts compared to the number documented in CFL training records. (e.g. Namphane Village: VHVs reported approximately 10 participants attending each of the trainings, while the CFL training records showed number of participants ranging between 25 and 54.

activities for the topic, which was left blank on the forms[13], the other categories related to quality of delivery were all positive. However, this was not always supported by responses from villagers and from some VHVs themselves, who said that while several of the topics were clearly explained, VHVs struggled with some of the topics due to their limited knowledge and at times, inability to translate Lao terms into local language.

Follow-up Post Training: As mentioned earlier, while the wording of Output 1.1 in both the original (2017) and final variation (2019) proposals suggests that pregnant women and mothers of small children would receive follow-up support after training, this appears to have been changed in a 2018 version, where follow-up being mentioned in Output 1.1 only in relation to the higher level ToT training provided – i.e. follow-up for VHVs and Health Center staff who had received training. As follow-up, particularly of pregnant women and mothers who had participated in the training was not specifically mentioned as part of any activities, it was reported that that this was not done in target villages. As it was not part of the actual implementation, it is just flagged here as an activity that may have contributed to better quality implementation and positive impact[14]. This issue is discussed further under *Recommendation 61* later in this report.

Output 1.4 ***Radio programs produced and broadcast***

In both districts, the Department of Information, Culture and Tourism (DICT) worked with DoH and CFL staff to produce radio spots to support health messages from the CINIA Project in three languages – Lao, Hmong and Khmu. These were then broadcast on community radio stations as well as being provided to target villages that had loudspeaker systems. A total of 178 spots were developed and broadcast from 2019 - 2020 in Nonghet District and 260 spots in Khoun District, making 438 spots in total (See *Table 4.* below). The content of the spots related to the content of the village level training and included spots on maternal-child nutrition, ANC services, hygiene (including hand washing practices), and reproductive health.

Table 4. Number of Radio Spots Developed

Location/Languages	2019	2020	Total
Nonghet District	65	113	178
Lao	23	41	64
Hmong	12	32	44
Khmu	30	40	70
Khoun District	204	56	260
Lao	68	24	92
Hmong	68	24	92
Khmu	68	8	76
Total spots developed	269	169	438
Lao	91	65	156
Hmong	80	56	136
Khmu	98	48	146

The spots were distributed to those target villages that had loudspeaker systems, though it appears there was no guidance given on how they should be broadcast. Most respondents at village level had heard the spots broadcast and considered them useful and easy to understand.

[13] Some of the key activities were reportedly not done due to late printing of supporting IEC materials and these not being covered adequately in the initial training for VHVs.

[14] VHV house visits were reportedly dropped from the activities due to limited capacity re health promotion and counselling on the part of VHVs.

However, while these spots were very helpful in ensuring the key messages related to maternal-child health and nutrition were put out into the communities, thus reinforcing the key messages in the village level training, there were some issues related to these that were identified in the evaluation. These included:

- Development of the spots in Khoun District was not closely monitored by CFL or DHO staff, resulting in messages that were mixed with more music and as a result, the health messages were not so clear (See *Table 5. Breakdown of Radio Spots* below).

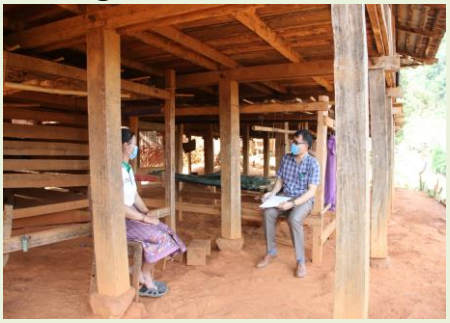
Table 5. Breakdown of Radio Spots

District	Language	Date	Topics	Words/ Key messages	Music
Khoun	Khmu	Nov-18	MCH & Nutrition	35%	65%
Khoun	Khmu	Dec-18	MCH & Nutrition - Practices during ANC & PNC	37%	63%
Khoun	Khmu	Apr-19	MCH & Nutrition - Five reasons for not giving food to CU 6 months	30%	70%
Khoun	Lao	Nov-18	MCH & Nutrition - Practices during pregnancy	36%	64%
Khoun	Lao	May-19	MCH & Nutrition - Basic knowledge of vitamin B2	24%	76%
Average - Khoun District				**33%**	**67%**
Nonghet	Khmu	Jul-19	MCH & Nutrition	58%	42%
Nonghet	Khmu	Dec-19	MCH & Nutrition	55%	45%
Nonghet	Khmu	Apr-20	MCH & Nutrition	51%	49%
Nonghet	Lao	Nov-19	MCH & Nutrition	55%	45%
Nonghet	Lao	May-20	MCH & Nutrition	66%	34%
Average - Nonghet District				**57%**	**43%**

- There seems to have been an issue regarding internal coordination between DHO and DICT district offices involved in the development of the radio spots. It was reported that DHO were to provide health-related data to DICT to help them create the content based on an agreed schedule, but sometimes DHO staff could not provide the information as scheduled, resulting in delays to radio program production. In Nonghet, most of the radio programs were developed by DICT but were not checked by DHO to ensure that the health-related contents were appropriate;
- Both in Nonghet and Khoun Districts, staff involved in the radio spot production felt that they needed more training on how to write effective radio scripts and more funding support to conduct pre-production (to assess community needs) and post-broadcasting (to understand what had gone over well and what had not), in order to improve quality and relevance;
- In addition to ensuring quality control on content production, there is also a need to agree on a broadcasting schedule both at the district and village levels so that the messages are effectively conveyed and coordinated with village level training;
- Recordings of the spots were just sent out to each target village without any guidance or training in how to broadcast them in a way that ensured maximum effectiveness. For example, messages were not broadcast in a logical order, and spots in different languages were broadcast randomly.

Loudspeaker systems in several villages were either not fully functioning or not functioning at all. While CFL addressed this issue by ensuring broken systems were repaired, there is a longer term issue regarding sustainability when villages have to rely on a project to get their loudspeaker systems repaired.

Case study – VHV in Nasom Village, Khoun District



Nasom is a relatively remote village located about 45 km.s from the District town of Khoun and is comprised of 70% from the Phuan ethnic group and 30% Hmong. There is no Health Center in Nasom, but there are 5 VHVs and basic medicines are available. Keochai[1] is one of them, and she followed in her mothers footsteps, becoming a VHV at the age of 14 after her mother passed away. Now 29 and mother of three children, Keochai has been a VHV for 15 years, but until the CINIA Project came to work in her village in 2017, had never received any training.

Keochai said that she has learned many new things from the training provided by the Project, including how to train villagers in nutrition and hygiene practices, use of a thermometer, testing blood pressure, measuring weight and height, and basic knowledge of diagnostics and giving medical prescriptions. "The training has enhanced my confidence, and my commitment to help people in our village, as well as engage more with village elders.

Since receiving training as a trainer, Keochai has provided sessions for pregnant women and mothers of small children that were also attended by some elderly members of her community. Together with other VHVs in the village, and with the support of DHO staff, she conducted training at the house of the Village Head, usually in the evenings when women had time to attend. As well as providing training, Keochai also helps Health Center staff from to collect MCH related data (including number of new born babies, pregnant women, children under 5 years old) and report to them monthly. She also makes referrals to the Saphanxay Health Center, or if only a minor illness, provides medicine from the village medicine cabinet. She also helps Health Center staff when they come to immunize small children, and takes a lead role in hygiene promotion in her village, including cleaning the village and burying rubbish.

She said she will continue working as a VHV after the CINIA Project has ended, even though there may be no further training for a long time and even though she receives no support for the expenses she incurs as a VHV, such as mobile phone usage and fuel for her motorbike. She said is proud to be part of the volunteer team creating positive change in her community. While not all VHVs are as motivated as Keochai, it was clear during the final evaluation that if the DHO, perhaps through the Health Center, can provide periodic training and some small incentives for VHVs like her, this would certainly contribute to strengthening the primary health care system at community level and help embed the gains made by projects such as CINIA.

Findings - Impact:

Indicators (Objective 1):

- *At least 70% of parents and caregivers will have improved knowledge of nutritional diets and associated health-care for children 0-5 years and pregnant women.*
- *25% increase in children under 2 with a minimum acceptable diet (i.e. They have met both minimum dietary diversity score and minimum meal frequency)*
- *50% Households with children <5 have improved average dietary diversity score*

In terms of the three impact indicators, it was only possible, given the limitations already mentioned, to partly assess or measure change against the quantitative data from the baseline KAP survey. The final evaluation involved interviews and FGDs with a limited number of parents with small children, VHVs and village committee members, and thus it was only possible to get more general feedback on changes in parents knowledge regarding nutritional diets and healthcare for children under five and pregnant women which could be attributed at least in part to the training provided. Relevant data from growth monitoring was only available from three Health Centers in Nonghet District and this data was in the form of numbers of women and children, rather than percentages (i.e. against the total population of a specific sub-section of the community).

Impact – VHVs: Information from Health Center staff, villagers and VHVs themselves was consistent in that the work of VHVs in target villages had mostly improved as a result of involvement in the CINIA Project. VHVs themselves reported that involvement in the CINIA Project, including training, the provision of per diems, basic measuring equipment and T-shirts and caps, had helped to motivate them. Health Center staff in all sample centers visited reported that VHVs involved in the CINIA Project understood their roles better and that the quality of data collection and coordination with the health enter had improved. Staff at Longsan Health Center in Khoun District said they could see a difference between the work of VHVs in CINIA Project target villages compared to those VHVs in non-target villages. They were regarded as more responsible, accountable and confident with the work they do. Their capacity has also been increased, for example, they can now do child growth monitoring including weight and height measuring. The community was more cooperative and more easily accessed by Health Center staff due to the work of the VHVs.

Nonetheless, villagers in some communities were less positive about the work of VHVs. For example, in Namphane Village in Khoun District, as well as in Phaclack Village in Nonghet District, some complained that the VHVs lacked basic health knowledge, even after receiving training. As a result, they could not provide quality training to villagers. Also, that they were not able to provide medicine, and youth reported that they did not receive support or advice from VHVs either on reproductive health related issues or advice on early marriage and preparedness for 'to-be' mothers. In some villages visited in Khoun District, where there were more than two VHVs in the village, respondents reported that only one or two VHVs were functioning. This suggested that while, ideally, having more VHVs would reduce the workload, in reality, it seems this was not the case, and that having only two motivated VHVs would be more effective.

Impact – Pregnant Women and Mothers: A number of changes were reported by women who had participated in the training, confirmed by the few husbands interviewed who had not participated, but observed changes in their and other families[15]. Changes included a longer period of exclusive breastfeeding than before (e.g. in Nammen, Pha-En, Nasom and Nathong villages, from 3-4 months only to 6 months), and mothers giving more attention to preparing food for their small children - before they used to give their children food the mother had chewed first but now they prepared food specifically for their children, such as rice porridge with egg and vegetables. Hygiene, particularly more frequent hand washing, was also reported. Several respondents also said that the village level training had encouraged more women to access ANC and PNC services at the Health Center or district hospital, as well as encouraging immunisation of their children.

What was considered to be completely new knowledge gained among most, if not all, mothers was the 1000 days of child care and nutrition. This was not only associated with the change in eating a greater variety of food types, but also the frequency of giving birth. For instance, in Namphane Village, most mothers have

[15] Because of the small sample size (for the reasons already mentioned) and qualitative nature of data collection, it is not possible to rank these in order of importance.

another baby less than one year after the birth of the previous one, but now they are more aware that waiting to have the next child after the previous one reaches two years of age will help ensure that the new child and mother will be stronger and healthier. It was also reported that most young mothers with the new born babies (especially during the first month), have changed their dietary habits and now eat a greater variety of food, including food that was previously prohibited due to cultural taboos. In the past, new mothers were only permitted to eat rice with salt and chicken or only fish and vegetables, but now they eat meat, vegetables and fruit. Mothers in Nasom Village reported that these fewer restrictions on food had helped mothers to produce more milk for their children.

Impact – Children: Due to the lack of reliable quantitative data (such as from a KAP survey), it is difficult to assess the impact of the CINIA project on children's health. Data that was available only shows total numbers, rather than percentages against specific cohorts within communities. As *Table 5* below indicates, data from three Health Centers in Nonghet District – Pha-En, Phakkae and Nammen – mostly shows an increase in the number of infants classified as 'normal' (or 'green') between 2016 and 2019, although there are fluctuations, particularly in 2018[16]. However, the number of infants classified as 'stunted' (or 'red') only appears to have declined at Phakkae Health Center. On the other hand, the data does show a significant increase in the number of parents of children under five years who consulted with health staff, as well as numbers of children undergoing growth monitoring. Accordingly, perhaps the main (and only) conclusion from this data is that the number of children reached through growth monitoring has increased substantially, probably due in large part to support provided by the CINIA Project in terms of training and equipment.

Table 6. Sample - Growth Monitoring Indicators – Three Nonghet District Health Centers

Item	Classification	2016	2017	2018	2019
Pha-En					
Height and weight -Normal	Green	15	152	73	241
Height and weight – At risk	Yellow	3	10	25	52
Height and weight - Stunted	Red		3	3	9
Number of children under 5 whose growth was monitored by doctor	N/A	N/A	128	101	319
Number of parents of children under 5 who consulted with doctor	N/A	N/A	84	101	319
Phakkhae					
Height and weight -Normal	Green	538	468	129	432
Height and weight – At risk	Yellow	50	205	16	70
Height and weight - Stunted	Red	10	14	4	1
Number of children under 5's growth monitored by doctor	N/A	354	408	149	503
Number of parents of children under 5 who consulted with doctor	N/A	321	272	153	503
Nammen					
Height and weight -Normal	Green	139	183	114	172
Height and weight – At risk	Yellow	17	58	26	36
Height and weight - Stunted	Red	3	15	3	12
Number of children under 5's growth monitored by doctor	N/A	131	257	143	223

[16] There appears to be a sharp drop in the number classified as 'normal' in 2018, together with other numbers, which may be partly due to a drop in measuring due to reasons unknown.

Item	Classification	2016	2017	2018	2019
Number of parents of children under 5 who consulted with doctor	N/A	131	65	143	209

Apart from this statistical data, several respondents also reported a reduction in the numbers of malnourished children as a result of increased knowledge and change of behaviour of mothers in terms of health and nutrition. For example, in Phacklak Village, it was reported that as mothers were more aware of the importance of child nutrition, there were no malnourished children reported in the past three years. In Pha-En Village, mothers understood that giving food to their children more frequently can prevent children from being underweight and stunted. Respondents in almost all villages visited, except Namphane Village, reported that at least 90% of children under five years old were vaccinated[17]. Growth of children was also monitored, though not regularly, due to the lack of availability of equipment at the village level.

Thus while the data available was largely qualitative and subjective, it does appear that the CINIA Project has had some positive impact in terms of:

- Improved diet of both mothers and children;
- Extended periods of exclusive breastfeeding among some mothers;
- Increased growth monitoring of infants by health staff;
- Increased use of health services by parents of children under five;
- Increased immunisation of children under five years;
- More effective functioning of VHVs.

3.2 Objective 2 – MCH Services

> ***Objective 2.*** *To increase accessibility to MCH services (including peri-natal care) for pregnant women and to improve the capacity of VHV, village authorities and District level to provide nutrition instruction to pregnant women.*

Activities supported by the CINIA Project under this objective include provision of training and equipment for District Hospitals and Health Centers (*Souksala*), as well as provision of basic infant measuring equipment for VHVs. Training for MCH and Health Center staff in MCH clinical skills were based on national training curricula as much as possible, related to peri-natal care – i.e. safe motherhood and newborn care and nutrition, as well as management, and included a study visit to observe MCH health systems in Luang Prabang (2019). Equipment provision was based on an initial needs assessment at DHO and Health Center levels, as well as provision of infant measuring equipment for VHVs (to assist nutrition survey data collection and measurement).

Findings - Process:

Output 2.1: ***Training for Health Centre and District Health Staff on clinical skills for MCH***

The content of training in MCH clinical skills for DHO and Health Centre staff was reportedly based on needs expressed by DHO and Health Center staff at the start of the CINIA Project, and consistent with Ministry of Public Health guidelines, but as there was limited documentation available at the time of the evaluation, it was not possible to assess the relevance of the training content. The training was provided by trainers from

[17] Unfortunately, it was not possible to confirm this from Health Center data, as they tend to record the number of children vaccinated only, without comparison with the total number of children in each village in order to produce percentage of coverage.

the Provincial Health Office (PHO) as well as from the Ministry of Public Health and external consultants recruited by ChildFund Laos and was usually conducted in the Provincial capital, Phonsavanh. Both DHO and Health Centre staff, particularly the latter, found the training to be very relevant to their needs and applicable in their work. However, due to changes in training staff from the PHO, participants found that often they had more experience than the PHO trainers. After training, there was a follow up activity done once a year in each district but the participants felt that it would have been better to have this done on a quarterly basis as well as being done more systematically, through checking and providing them with feedback and areas for improvement. An increase in the frequency of follow up of trainees was also suggested by CFL staff.

Output 2.2: ***Equipment provided to VHV's, Health Center and ChildFund Laos Project staff to measure, weigh, identify malnourished children 0-5 yrs***

As with the training, the provision of equipment for Health Centers and VHVs was reportedly based on the needs assessment conducted at an early stage of the CINIA Project. While not all equipment requested was approved by CFL, most of the requested equipment related to infant growth monitoring (e.g. scales, height measuring equipment) and ANC and PNC (e.g. ultrasound) was provided and was reportedly being used on a regular basis. However, while Health Center staff said all the equipment was being well maintained, CFL staff expressed concern at the quality of maintenance of some of the equipment (e.g. forceps, scissors etc.) and its sustained use longer term. Of particular concern was care of the basic growth monitoring equipment provided to VHVs as this was not being monitored or checked on a regular basis.

Output 2.3: ***KAP baseline and end line surveys, mid-term and end of project independent evaluation conducted***

While a comprehensive KAP survey was conducted at the start of the CINIA project to establish a baseline in terms of quantitative data related to MCH, infection prevention and treatment, nutrition and home gardens, and ANC visits by pregnant women, it was unfortunately not possible to repeat this survey at the end of the project due to Covid-19 pandemic restrictions. Accordingly, it was not possible to measure changes in key areas quantitively, apart from numbers of ANC visits (see *Table 6*. below). However, more general qualitative data was sought from the limited number of pregnant women, mothers and fathers who were interviewed, regarding the main areas covered by the KAP survey. An internal mid-term review was also conducted in July 2019, and the findings were used to inform this final evaluation.

Case study – Improved Access to Health Services, Phaomao Village, Nonghet District

Phamao village is located about 33 Km.s from the district town of Nonghet, and approximately 5 km.s from the main road. It takes around an hour's drive to reach the village, which can be accessed all year round. Phamao is a Hmong village with a total population of 550 people. Livelihood activities include growing corn and vegetables, and raising some domestic animals for family consumption and sale. Due to soil degradation and use of pesticide, villagers did not grow rice but bought it from the district market or relatives in other villages, using their income from selling corn and other agricultural products.

Several villagers said that most vexperienced food insufficiency, especially meat and fruit. There was only drilled well water (*Nam Bo*) available but water was not clean or sufficient, especially during the dry season. It was also reported that 1/3 of small children in the village were malnourished and the incidence of diseases was high, as a result of food shortages and unclean water, as well as poor parental care due to parents being busy with farm activities, leaving children in the care of grandparents or siblings. It was also reported that pregnant women and mothers in this village carried their babies when using pesticides on their corn.

Despite the challenges faced, the Phamao village head reported that access to health care, especially among mothers and children, had significantly improved in the past few years, estimating that 90% of pregnant women used ANC services and 80% used PNC services at the Health Center located around 6 km.s from the village. Parents are now taking care of their children better than before, MCH and nutrition have been improved, and 100% of children were vaccinated. Statistics from the Health Center seems to support this argument with the numbers of mothers accessing ANC services increasing - those making one visit increased from 77 to 95 from 2017 – 2019, while those making four ANC visits increased from 50 to 71 during the same period. The number of mothers taking iron tablets also increased, as did the number of women giving birth at the Health Center compared to home.

This increased use of services was confirmed by Health Center staff and has resulted in the Health Center recently being upgraded to become a 'small hospital – category A' (*Hong Mor Noi Kor*). This increase in the number of users at the Health Center can be attributed in part to the support of CFL under the CINIA Project coupled with government intervention (e.g. free medical care for the poor). Apart from the provision of equipment and training for Health Center staff, a key factor also seems to be the village-level training with strong and motivated VHVs. A young female VHV recruited in 2017 to work as part of the CINIA project reported that five years ago, most, if not all mothers did not want to use services available at the Health Center because they were shy, especially as most of the doctors were male. However, as a result of the CINIA supported training, which was done two or three times per year and attended by 20 – 30 people, mostly women, as well as provision of more female doctors at the Health Center, pregnant women and mothers now like to use the health care services provided.

Findings - Impact:

Indicators (Objective 2):

- 50% of referrals by HC/VHV on prenatal check of pregnant women increased from baseline.
- At least 50% of mothers and pregnant women who received services from community Health Center/VHV have improved their knowledge and practice on health care and nutrition for their children 0-5 years and themselves.

While the first indicator is somewhat unclear, it appears to suggest a 50% increase in pre-natal checks of pregnant women from target villages compared to the baseline. *Table 6.* below shows the number of ANC visits at each Health Center from the time of the baseline in 2017[18] to the figures provided for 2019.

Table 7. Pre-natal Checks of Pregnant Women

No.	Health Centre	2017		2019	
		At least 1 visit	At least 4 visits	At least 1 visit	At least 4 visits
Nonghet District					
1	Nammen HC	45	22	50	37
2	Pha En HC	27	13	47	21
3	Phakhaek HC	75(77)	50	95	71
Total – 3 HCs		**147**	**85**	**192**	**129**
Khoun District					
1	Nathong HC	125(126)	84	132	79
2	Samphanxay HC	78(79)	52	73	55
3	Keosaed HC	125(101)	31(53)	96	70
4	Sanlouang HC	70	44(41)	51	30
5	Namphan HC	67(64)	45(39)	71	31
6	Longxan HC	101(107)	65(63)	131	119
Total – 6 HCs		**566**	**321**	**554**	**384**

Overall, the data indicates a significant increase in the numbers of women having ANC checks at Health Centers in Nonghet District with an over 30% increase in women making one visit and over a 50% increase in women making four visits. The figures for Khoun District would appear to show a slight decline in the number of women making a single visit[19] but a significant increase (approximately 20%) in women making four visits to a Health Center. While this data may not be totally reliable, it does show a trend of a significantly increased number of ANC visits in most target Health Centers. While this cannot be attributed solely to the CINIA Project – for example, the Lao Government policy of free MCH services[20] and perhaps improved road access may also be factors – it can be concluded that the training and equipment provided to Health Centers and their staff by the CINIA Project has played a significant contributory role in the increased uptake of ANC and PNC services.

[18] Note that there were discrepancies between the data provided by the Health Centers during the final evaluation and the data that was recorded for 2017 at the time of the baseline survey. The baseline figures are recorded in parentheses in the table.

[19] This appears to be attributable to the decline in numbers of women accessing ANC services on a single visit at the Keosaed and Sanlouang Health Centers, though the reasons for this decline are unknown.

[20] Introduced in 2012 and then expanded in 2016, this policy enables women to obtain free ANC and PNC services at their local Health Center or district hospital.

The overall numbers of women making either one or four ANC visits to a health facility, either a Health Center or a district hospital, has increased significantly in both districts between 2017 and 2019. Figures 1 and 2 below show that in each district, more than one thousand women are now accessing ANC services at least once, while between 600 – 800 women are accessing these services at least four times.

Figure 1. Number of ANC users - Nonghet District

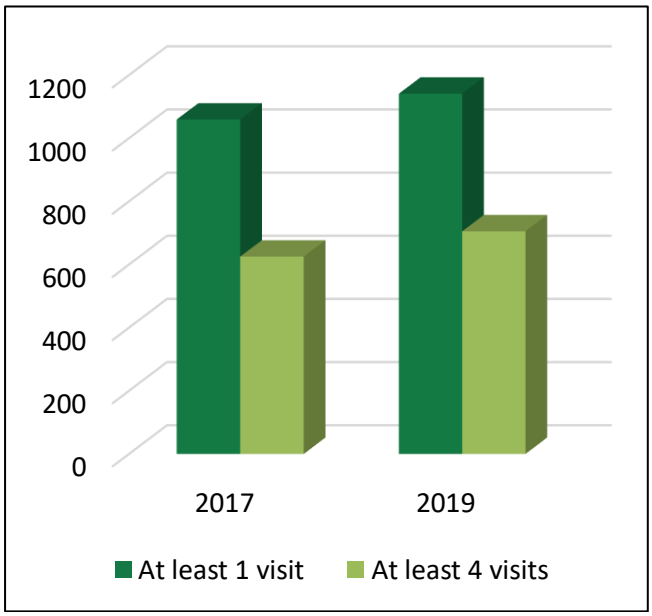


Figure 2. Number of ANC users - Khoun District

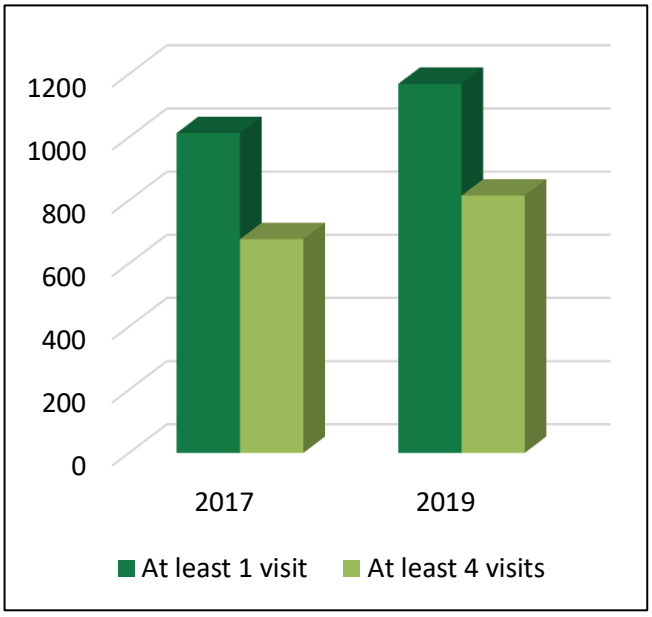
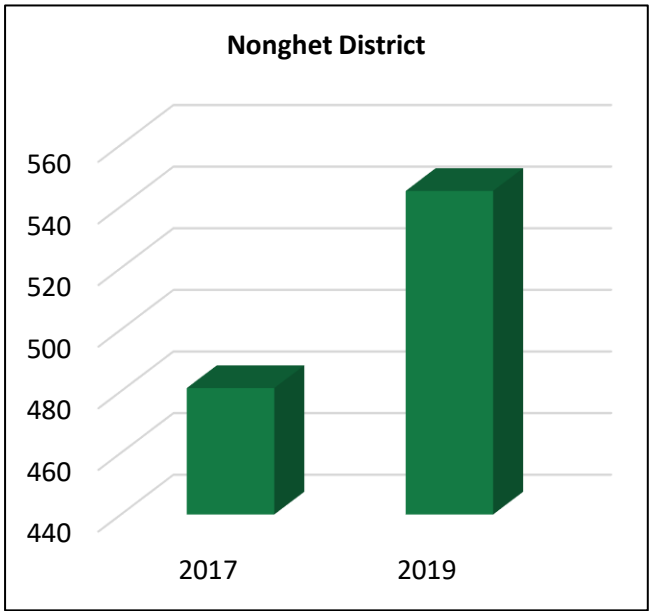
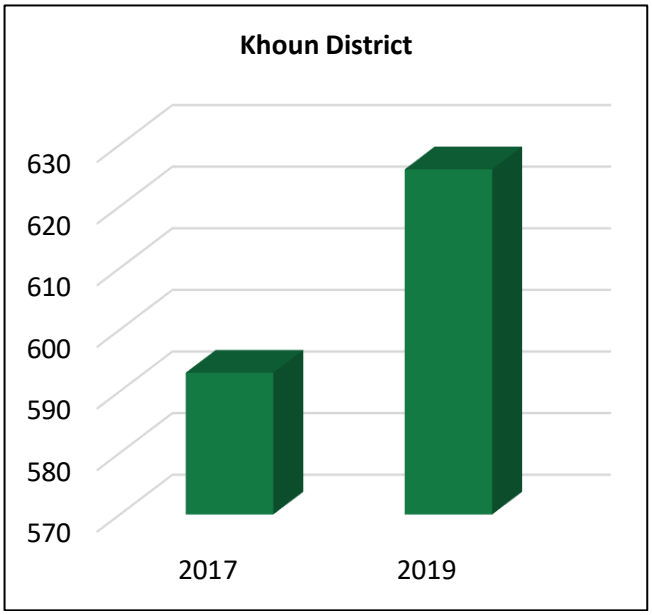


Figure 3. Number of deliveries at health facilities in Nonghet and Khoun Districts





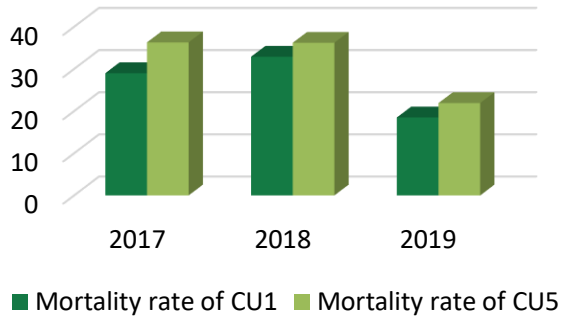
Data from the DHOs in each District (see Figure 3. above) indicate a significant increase in mothers giving birth at health facilities, rather than at home. While this also is due to a number of factors, including improved road access, expansion of the electricity network, provision of fee free services, etc., training for Health Center and DHO staff, provision of equipment, such as ultrasound, and health promotion messaging in communities has also been a contributory factor.

Evidence from the interviews of VHVs and Health Center staff indicated that most pregnant women in the villages visited were advised to use health facilities either at Health Centers or at the district hospital. However, it was noted that the advice seems to be followed mostly by women or villagers living near by the road where access was easier, rather than those living in remote villages who may find access more difficult. At the Namphane Health Center, for example, staff reported that they have to visit the remote villages in order to provide ANC and PNC services.

The second indicator, which related to a 50% increase in knowledge among pregnant women and mothers accessing ANC and PNC, was not possible to assess quantitatively. However, all pregnant women and mothers interviewed who had accessed services at their Health Centers were able to give an indication of what they had learned as a result of these visits, and all Health Center staff interviewed said that they provided consultation/advice to mothers when using ANC and PNC services; thus it is assumed that this indicator was fully met.

In terms of overall impact related to both indicators, an increase in access to ANC and PNC services and knowledge among pregnant women and mothers on health care and nutrition for their children 0-5 years and themselves as a result of the CINIA Project, may also be reflected to some (unquantifiable) extent in the decline in infant mortality rates. While data is only available for Nonghet District, this shows a significant decline in infant mortality between 2017 and 2019 (See *Figure 4.*), although with little change in 2018.

Figure 4. Infant Mortality Rates, Nonghet District



3.3 Management

In the original proposal, it was envisaged that a Project Working Team (PWT) would be established in each district, comprised of a CFL Health Project Officer, DHO, LWU and DAFO staff. However, it appears that this structure was never activated, with the kitchen garden activities being dropped in 2018 (which meant there was no further need to work closely with Department of Agriculture technical staff) and Lao Women's Union involvement minimal[21]. In practice, the project was managed by the CFL Health Project Officer[22] working closely with a DHO Coordinator, with higher level management organised in line with other CFL supported projects under their MoU, with the District Agriculture and Forestry Office playing the main coordination role. CFL Health Officers reported to the CFL Provincial Area Manager (PAM) who submitted formal progress reports to District and Provincial Government twice per year.

CFL Health Project Officers played the main role in managing and monitoring the project, including managing the finances for the project. Expenditures were managed directly by CFL due to concerns regarding potential corruption on the part of partners. A monitoring checklist was developed for village level training, and this was either filled in by CFL staff or by Government counterparts, depending on who was observing the village training, with the data later consolidated on a spreadsheet (see *Annex 3. Village Level Training*). While the checklist includes topics covered, number of participants (disaggregated by sex and disability), performance of the VHV trainers, and other aspects, the accuracy of the information is questionable, as it was reported that often these checklists were filled in after the training, or were not completed at all, but data just made

[21] The LWU reportedly worked with CFL on the Ready for Life Project rather than the CINIA Project.
[22] Although at the start of the project, the CFL PAM reportedly played a more direct role in management.

up to meet the reporting requirement.[23] In terms of overall project documentation, it appears that based on the documentation available, documenting planning and implementation of the CINIA project was not given sufficient attention by CFL staff or the Government counterparts.

Support from local government at the district and village levels appeared to play a significant role in ensuring effective project implementation and success. According to CFL field-based staff, they felt that they received greater support from local government in Khoun District than that in Nonghet District. While there may be several reasons for this, gender and age biases may have been one of the factors involved[24], suggesting that more needs to be done to change attitudes among local Government partners.

3.4 Sustainability

The original CINIA project document regarded sustainability of changes would be brought about as a result of implementation due to:

- Alignment with national and district level policy;
- Working in partnership with local health systems and staff;
- Responding to health issues identified by indigenous Hmong and Khmu communities, including responding to culturally related breastfeeding, sanitation and food issues;
- Identification of key areas that need further support and development by local Government partners through a mid-term review and final evaluation.

The final evaluation found that the CINIA Project had largely addressed most of these key areas from the original CINIA Project document that had been identified as contributing to sustainability. Project activities were largely aligned with and supported the Lao Government's National Nutrition Strategy to 2025 and Plan of Action 2016-2020, addressing underlying causes (Strategic Direction 2 and Strategic Objectives 5 – improving mother and child care practices – and Objective 7 – improve access to health services), as well as basic causes (Strategic Direction 3 – Strategic Objective 9 – improving human capacities). It was also consistent with the Global SUN Initiative of which the Lao Government is a partner. This alignment increased the likelihood of the relevant activities being continued in future without CFL input.

The CINIA Project also worked with and through existing health care systems and staff. While the main target groups were pregnant women, mothers, and children under five years, implementation was done through the DHO, Health Centers, and VHV networks at village level. Training of health staff at village and Health Center levels was mostly provided by Ministry of Public Health, provincial and district health trainers, indicating a high degree of integration into the existing capacity development within the Ministry.

Regarding the extent to which the project was based on identified local health issues and culturally related issues, this was an area where changes could have contributed to more effective MCH outcomes. While the project did focus on addressing issues related to maternal-child nutrition, such as under-nutrition and stunting, the extent to which it took culturally related matters into account was limited[25]. The training

[23] It was reported that the data recorded on the village training checklist was only 30%-50% accurate.

[24] Given that the CFL District health Officer in Nonghet was a young woman.

[25] While there appear to have been no studies of food taboos among ethnic groups in Nonghet and Khoun Districts, a study among Khmu and other ethnic groups in northern Laos, for example, found that certain foods were avoided for 1-5 months during pregnancy – including beef, white buffalo, deer, female pig, wild pig, dog, and white and red chicken, as well as certain fish, fermented foods and pumpkin tops. (See: *Influences on maternal and child nutrition in the highlands of the northern Lao PDR*, Asia-Pacific Journal on Clinical Nutrition 2007. Pg. 539.)

provided, while representing international 'good practice', did not fully take into account food availability[26] and relevant cultural beliefs, particularly those around food taboos. Rather, it presented a package of information drawn from international good practice without adjusting this to fit more with the local context.

Overall, the CINIA Project has contributed, together with other influences, to longer term change in terms of community knowledge and behaviour regarding maternal-child nutrition, as well as improved hygiene practices. The Project has also helped to strengthen the health care system at village and Health Center level through supporting provision of training and equipment for health staff, and this in turn has contributed to increased confidence in, and use of these health services. At the same time, other external factors have also played a part, including the provision of free maternal-child health care by the Lao Government, as well as support from other health organisations such as WHO and GAVI.

3.5 Cross-Cutting Program Areas

Cross-cutting areas include gender equity, reaching people with disabilities, and reaching the most vulnerable groups. Each of these is examined in more detail below, both in terms of what was done as well as possible change or impact.

Gender Equity: The CINIA project did not set out to be gender transformative, particularly regarding the roles of mothers and fathers in maternal-child nutrition and hygiene. However, the proposal referred to three specific barriers that would be addressed, including:

- The role of men in MCH and maternal-child nutrition was highlighted, and evidence-based research was cited showing that the more men were involved in MCH/nutrition approaches, the more effective these were likely to be in bringing positive change[27]. The Mid-term Review found that very few fathers attended the training – according to training records, approximately 25% of participants in the training were male, but it is not known how many of these were fathers of small children – but did not make any specific recommendations on how to change this. It was reported during the final evaluation, that in the cases of the few fathers who did attend, this was due to mothers being busy with other work, and the men attended on their behalf. The very limited involvement of fathers in the training was most likely due to the perceived relevance of training topics. MCH responsibilities are culturally perceived, particularly in Hmong communities, as being related to women's roles, which supports the argument for training specifically designed for fathers (see *Recommendation 6.2*).
- Developing an action plan to ensure men's participation in the project was also mentioned in the proposal, in particular through working closely with the Lao Women's Union. It appears that this was not done and thus men's involvement in childcare was not actively encouraged.
- Ensure there are both female as well as male VHVs in each target village. This was achieved to some extent, with four out of 12 villages having both female and male VHVs, five villages with only female VHVs, and three villages with only male VHVs. In Khoun District, nine out of ten villages have both female and male VHVs, and eight out of ten villages have at least two female VHVs. While in Khoun was almost gender balanced (52% female), in Nonghet female VHVs were predominant (65% female). Ensuring gender balance of VHVs seem to be challenging, in particular where gender norm exists.

[26] Apart from using the Lao MoPH food pyramid, which takes into account locally available foods, including local vegetables, frogs and rodents.

[27] *The involvement of men in maternal health care: Cross Sectoral Pilot Case Studies from Uganda*, US National Library of Medicine, 2014.

Overall, it appears that the CINIA project did not really address the issue of minimal male involvement in maternal-child nutrition training. While data was disaggregated by sex, and there was an effort to get more female VHVs involved in the project, for example, with only two villages in Nonghet District at least with only male volunteers, the CINIA Project was more gender accommodating rather than gender transformative.

People with Disabilities: The proposal referred to three planned nutritional surveys during the CINIA Project period with a specific target to identify any disabled mothers and children, but these were removed during the project variation in 2018, though the reasons for this are unknown. In addition, reports make no mention of training for health staff in how to support disabled mothers in accessing services, and it appears these were not implemented. However, six monthly reports indicate that there were efforts to encourage disabled mothers and children to attend training, though with limited success, as well as disaggregating participants in village training in terms of disability. The final evaluation found that neither VHVs nor Health Centers had any record of PWDs in their communities. While there does not appear to have been any specific targeting of people with disabilities as part of the CINIA Project, another CFL supported project, Wheelchairs for Kids, did provide 13 children with disabilities from the same target villages with wheelchairs.

Ethnic, Excluded and Other Vulnerable Groups: A significant number of target communities were comprised of ethnic groups (Hmong and Khmu) who are relatively poor, so the project can be said to have reached at least some of these more marginalized groups. However, within each community, it seems there was no specific attempt to reach the poorest women and ensure their participation in training and other support activities.

4. Possible Learning Points

Evaluation of the CINIA Project raises a number of points which could be considered in the design and implementation of similar projects in future. Some of these points are further developed as recommendations in Section 6 below.

***Sustainability of the VHV system needs to be a priority*:** The majority of the VHVs who worked on the CINIA project were previously VHVs in the target villages with only a few additional VHVs being recruited to assist the project. However, apart from training (knowledge and materials) and some growth monitoring equipment, as well as per diems, branded clothing items and other small incentives when attending training, there was little else provided to motivate them to continue their roles, particularly after the CINIA Project has ended. This was mentioned by most of the VHVs and Village Heads interviewed as a disincentive in their work. While allowances would not be possible, sustainable, nor advisable, other low cost ways need to be found to support them. For example, VHVs are expected by the DHO to report to their local Health Centers on a regular basis, and yet have to use their own mobiles and phone credit or motorbikes in case of travelling to Health Centers. Providing limited monthly phone credits or fuel could help them to feel more supported.

Systematic follow-up after training is key: While VHVs reported being visited by trainers after each TOT session when they were giving training in their communities, there was no evidence that follow-up was done in a systematic way, with guidelines and a simple form. The training monitoring form did contain several points related to training delivery, but this appears to have been completed by CFL staff and not always done systematically, nor discussed with VHV trainers after each session.

Training modules would benefit from adjustment to local context: While the modules represented 'best practice', they do not appear to have significantly taken into account availability of relevant foods locally, nor local beliefs and practices related to maternal-child nutrition, although they did use the Lao Ministry of

Public Health food pyramid poster which included locally available foods. Effective training in the use of these modules was also constrained by limited training capacity on the part of the master trainers. With improved training capacity, adjusting sessions to take locally available foods and traditional beliefs and taboos into account could have made delivery more interactive and a better fit with local conditions. It is also suggested that the similar modules could be combined to make it more appropriate to the time and availability of the villagers, and the refresher training period could be longer (once in every 1.5 – 2 years for example).

Pre- and post-tests are not useful for village level training: These are generally used to assess an increase in knowledge on the part of trainees in a more formal training setting and thus were not of much if any value in village level training. While they might have been used to stimulate discussion around what was known on specific topics, this was already a part of the module.

MUAC is best done separately from village MCH and nutrition training sessions: As mentioned earlier, combining these with the training perhaps unnecessarily complicated the training session, and were dropped anyway in many/most training sessions due to lack of official approval, as previously mentioned.

IEC materials and radio spots played a useful role: These played an important role, together with the radio spots, in reinforcing the key messages of the training. Regarding the radio spots, as mentioned above, ensuring more guidance for broadcasting on village loudspeakers and ensuring these systems are working and can be sustained, would have been an improvement.

Clear identification of, and commitment from the target groups may have strengthened the impact: It appears that the community training sessions were announced and then those who might have interest and/or time attended. This resulted in significant fluctuations in the numbers of attendees. Identifying a clear target group in each village beforehand and then ensuring that most of them attended regularly (and ideally received either individual or small group follow-up support afterwards), may have enhanced the impact of the project in terms of both knowledge and practice. As this would be an additional role for VHVs, putting this in place is also linked to the need for a greater investment in VHVs in terms of training and other support.

Ensuring scheduling of training sessions fits with villagers availability. In collaboration with district staff, especially from the DHO, village level training was often done in the evening or a time when community members were available. This is considered by the DHO head of Khoun to be an effective way of working and good practice that CFL could or should continue doing in their future programming. However, it was not suggested that CFL should do this in all target villages they work with, but rather to consult with the community in order to find the best time to conduct training in order to ensure increased reach and effectiveness.

Comprehensive and accurate documentation and data are essential to effective monitoring and evaluation. The evaluation found that there was limited documentation and a lack of reliable data on the part of the health system as well as from project monitoring. This made evaluation of both project implementation and impact particularly challenging.

5. Key Successes

The evaluation has also identified several good practices or key successes which may have relevance for ChildFund's future project design in other districts. These include:

5.1 Bringing international 'good practice' in maternal-child nutrition to semi-remote communities

The content of the training curriculum is consistent with WHO and other international standards for maternal-child nutrition and the first 1,000 days. It provides a structured way for this information to be disseminated in disadvantaged communities by those with limited or no training experience (even though this evaluation does suggest some adjustment to make the curriculum more relevant to the local context).

5.2 Combining capacity development together with provision of hardware

The CINIA Project provided appropriate training and equipment for the health system which contributed towards increased usage of health services at the local level as well as better quality services. Training for DHO and Health Center staff, as well as the provision of equipment needed for growth monitoring and ANC and PNC services was based on an initial needs assessment which helped ensure that the training and equipment provided was appropriate to their needs.

5.3 Using community radio and village loudspeaker systems enhanced the dissemination of health messaging

The use of radio spots with health messages in local languages to be played on both community radio stations as well as village loudspeaker systems was an excellent way to get relevant information out to target audiences. There are also lessons to be learned from this experience (see *Recommendation 7.6* below) in terms of radio spot production, guidance on use of the spots, as well as maintenance of village loudspeaker systems, but if these issues are addressed, production and dissemination of these radio spots should be a standard component of maternal-child nutrition related projects in future.

5.4 Strengthening the VHV system is essential

Many, perhaps most, of the VHVs involved in the CINIA Project had not received any significant training before, and the capacity development activities the project provided played a major part in helping them to better understand their roles in the community as well as increasing their knowledge and skills related to maternal-child health and nutrition. Health Center staff are usually responsible for more than six or seven villages and thus face limits on the extent to which they can be involved in these communities. The VHVs have a vitally important role to play in the primary health care system and it is essential that those who are motivated to continue their work are supported and that this support continues beyond the life of a project.

6. Recommendations

As the CINIA Project will not continue to another phase in the two target districts, the recommendations below are suggestions for the design and implementation of similar projects elsewhere in the future.

6.1. Consider more focused targeting of pregnant women and mothers in future village level training.

Training at village level adopted what could be called a 'shotgun approach' when targeting pregnant women and mothers, in that training sessions were announced and then those who were interested and available came to join the sessions. However, the significant fluctuation in numbers attending each session indicated a lack of continuity in terms of participation. Identification of a specific target group beforehand followed by individual encouragement to attend may have resulted in more sustained impact in terms of knowledge and behaviour change. This would also have enabled more specific targeting of women from the poorest families, as well as those with disabilities. Working with a consistent group of women in each community would also enable individual or small group follow-up after training, in order to check understanding and provide support for practicing what had been learned from the training. This will also require a greater investment in VHVs through training and other support, as they would need to play a key role here in helping to ensure participant identification and then continuity of attendance (See *Recommendation 6.4* below).

6.2 Directly target fathers in training.

Although the original proposal indicated that special attention would be given to ensuring fathers also benefitted from training, it appears no special effort was made to encourage their participation and few actually attended. Given that many of them probably regarded the content as aimed at mothers and mothers to be (which in fact it was), consideration could be given to having additional shorter sessions targeting fathers/fathers to be, delivered in the evenings when they are available. The content could be more culturally geared towards their roles in supporting their wives and children in terms of nutrition, hygiene and child care and could also include more gender transformative content.

6.3 Review and revise village level training curriculum to ensure it is more appropriate for the local context.

While the curriculum covers what is considered internationally as good practice in maternal-child nutrition and hygiene, reviewing and revising it together with local health staff could help to make it more relevant to local conditions. For example, it could be made more interactive in terms of taking into account availability of local foods as well as encouraging more discussion related to local customs regarding maternal-child nutrition. Also, there were suggestions from both CFL and health staff that there was too much repetition in terms of topics[28], so a review could enable other adjustments to be made.

6.4 Motivate and retain VHVs.

To ensure sustainability and retain VHVs already trained longer term, there is a need to ensure ongoing motivation of VHVs through provision of incentives – e.g. phone cards, ongoing training – with a small budget for administration - and enhanced integration of VHVs into the PHC management system at DHO and Health Center levels (as appropriate). An up to date record is needed of VHVs which shows any changes. Also, VHV selection needs to ensure as much as possible a balance of male/female in each village.

6.5 Improve health data collection and data availability.

While useful health information data is apparently being gathered by Health Center and DHO staff, it was difficult to find useful and meaningful data, other than numbers of people accessing health services. Health Center staff said they don't keep copies or systematically store this data – just send the data upwards when requested. As a result, the Health Centers do not retain village level data to support planning and implementation of their work. While staff received training in data collection from CINIA, the database needs to be updated to ensure data is always available; VHVs can play a vital role in data collection at village level and thus also need more training in addition to further training for Health Center and DHO staff.

In terms of data related to project implementation, particularly monitoring of training, this also needs to be reviewed and revised to ensure that data is easy to gather and store, and that it is used to feedback into the project to improve the quality of planning and implementation.

6.6 Radio spots and how these are produced and delivered needs improvement.

Radio production and broadcasting were done primarily by government district staff from DHO and DICT with minimal involvement of CFL staff. As a result, it was reported that radio spots especially in Khoun were more of music/entertainment rather than content. More involvement of CFL project staff on the radio spot production, as well as planning on broadcasting schedule could help ensure target audience receive proper

[28] This was apparently due to different viewpoints between District health staff and ChildFund technical staff. The former wanted more technical trainings, while the project had aimed to build their health communication and community engagement skills using very simple and repetitive health and nutrition messages. This reportedly may have had some impact on the training that was provided.

message in appropriate time, though this may be seen as 'sensitive' in some districts[29], though informal involvement by CFL staff seemed to work in Nonghet District. Consideration could also be given to providing low cost training for Government staff involved in producing these spots, possibly by trainers from the Ministry of Information, Culture and Tourism in Vientiane.

Broadcasting these through village loudspeaker systems can be made more effective with basic guidance/training for those responsible (i.e. not just giving them the recordings to play). It is suggested that a suitable repair shop be found, either locally or within the Province, so that District authorities can facilitate the repairs as needed. Staff from Information, Culture and Tourism should lead in monitoring and helping to repair these systems.

6.7 CFL could engage more in MCH at national level.

While the level of engagement by CFL with the MoPH and relevant networks, such as SUN, at the national level was not explored as part of the final evaluation, this is an area that CFL could review internally. An internal, informal review could assess the extent to which CFL is engaged with relevant sections within MoPH and national and international networks, particularly in terms of links with MCH related projects they are supporting at district level, to see if any improvements are needed. Engagement in these national level discussions would provide benefit in terms of a two way flow of information (i.e. from project to central level and vice versa) as well as enabling CFL to potentially influence the MoPH on prioritization of training and improving MCH services.

7. Conclusion

Overall, the CINIA Project has achieved its intended outcomes to quite a large extent in the 22 target communities. It has ensured relevance through targeting disadvantaged ethnic communities, in line with MoPH policy, and working within the framework of existing MCH systems. Many women, the majority of whom are from ethnic groups that have typically been difficult to reach due to remoteness, language and other barriers, have had access to health information related to maternal-child nutrition and hygiene and have started to change their practices as a result. At the same time, health services at local level, particularly those provided through Health Centers and VHVs, have been strengthened through training for staff as well as provision of equipment to support improved ANC and PNC services, as well as growth monitoring of infants at village level. In addition, the project has used resources effectively through basing interventions on identified needs, both in terms of training and equipment. These positive impacts have been reflected in quantitative data related to numbers of women accessing services at Health Centers, as well as numbers of infants and small children having their growth monitored, as well as being immunised. While these positive impacts cannot be solely attributed to the CINIA Project, as at the same time there have been Lao Government initiatives, such as free maternal-child health care at health facilities, as well as free immunisations, the Project has been a major contributing factor, at least in target communities, and in some cases, in other communities as well.

At the same time, the CINIA Project has faced some challenges, learning from which has the potential to provide useful lessons for the design and implementation of similar projects in future. Better targeting of participants and ensuring their ongoing participation in village level training and follow-up could potentially achieve a better impact in terms of positive change, as well as help ensure a higher level of inclusion, particularly of more marginalised women such as the poorest and disabled, in those communities. Specific

[29] Due presumably to the involvement of outsiders in what has been traditionally seen as the propaganda arm of the Government and Party.

targeting of fathers for training also has the potential to enhance the impact of the project. While the training curriculum used reflects good practice, it could also benefit from adjustment to better fit with the local context. At the health systems level, improved data collection and data availability could contribute to improved planning and reporting. CFL's own monitoring system, particularly for village level training, could also be improved.

However, despite some areas for improvement, the CINIA project has contributed to longer term sustainability through helping to bring about changes in target communities, in the form of behaviour and practices related to maternal-child nutrition and hygiene among those women who participated in the project. Most importantly, it has contributed to strengthening the health system at local level.