**IMPACT EVALUATION**

**CDP and HIV/AIDS Programmes in Nepal**

**Funded by Norwegian Red Cross**

**



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**Executive Summary**

This report is an impact evaluation of the partnership between Nepal Red Cross Society (NRCS) and Norwegian Red Cross (NRC) and the associated Community Development Programme (CDP) and the Enabling Youth to combat HIV, Human Trafficking and Social Discrimination project (hereinafter ‘HIV/AIDS project’).

NRCS and NRC have been in a partnership since 1988, when support to the implementation of CDP was initiated, while support to HIV/AIDS programming started in 1995. In addition, NRC has supported different projects at NRCS headquarters, co-funded the construction of NRCS’ national Training Centre and supported a Youth Delegate exchange programme since 2006.[[1]](#footnote-1) In relation to the CDP, the partnership is now in its fourth phase (2009-2010/2012), and currently targets the three districts of Baglung, Manang and Mustang. In relation to the HIV/AIDS project, the partnership is likewise in its fourth phase, and currently targets the five districts of Lamjung, Makwanpur, Myagdi, Palpa and Sarlahi.

The objective of this evaluation was to verify the overall efficiency and sustainability of the long-term partnership between the NRCS and NRC and the associated programmes, which would also form the basis to determine the next stage of the partnership.

The evaluation involved field visits to one current target district and one phased-out district of each of the programmes/projects, namely Baglung (current) and Kanchanpur (phased-out) district of the CDP and Lamjung (current) and Nuwakot (phased-out) district of the HIV/AIDS project. Multiple informants and stakeholders were interviewed and consulted for the evaluation and a series of findings and recommendations are contained in this document. The key findings are extensively reported on, and relate specifically to the:

* Objectives and activities with a predominant focus on the current phases of the programmes as to their relevance, effectiveness, efficiency, impact and sustainability in addressing the complex issues of community development and HIV/AIDS.
* NRCS/NRC partnership including the relationship involved in the management and implementation of the programme support and associated strengths and weaknesses.

The programme objectives of the current CDP are:

1. The basic health and economic status of the most vulnerable communities are improved.
2. The capacity of community organisations and NRCS at all levels is strengthened and quality services expanded.

The programme objectives of the current HIV/AIDS project are:

1. Reduce vulnerability to HIV and its impact among youth
2. Reduce human trafficking especially on women and children
3. Reduce the social discrimination and intolerance in the project communities.
4. Strengthen the management capacity of NRCS to deliver sustainable response to HIV prevention, trafficking and social discrimination.

The evaluation concluded that the NRCS/NRC partnership is relevant to the strategies and priorities of NRCS and NRC, contributes towards overall national development objectives and is responsive to the needs of vulnerable communities, but that it should be considered to work more directly with the out-of-school youth in the HIV/AIDS project, and to also consider the issue of migration in the CDP.

In relation to effectiveness it was found that both interventions have/are largely contributing to the expected results being met, but that the CDP health component is performing much stronger compared to its livelihood/economic empowerment component, while the HIV/AIDS project should consider to build more capacity in relation to care and support of PLHIV and to develop a more sophisticated peer education model vis-à-vis out-of-school youth.

In terms of efficiency, it was found that especially the CDP has a very expensive set-up especially considering the relatively small number of beneficiaries, and it is advised to consider ways to channel more of the total budget into actual activities directly benefitting communities. For the CDP this should involve strengthening the programme’s volunteer model.

In relation to impact, understood as positive changes experienced by communities as a result of the programme interventions, it was found that both the CDP and the HIV/AIDS project have significant impact as measured in terms of e.g. increased awareness, changed practices, reduced morbidity, empowerment of youth, women, low caste etc. Both interventions have taken many positive steps to include the most vulnerable, but it is still recommended to explore additional ways and means to further promote social inclusion also in relation to the programme/project management structures.

In terms of sustainability many sound measures have been taken, and field visits to phased-out districts demonstrated that changed practices are generally sustained and that the majority of initiatives such as women groups and water user committees have continued after phase-out.

In relation to the NRCS/NRC partnership, this generally appears to be very consolidated and healthy in terms of key dimensions of the RC/RC “Code of good partnership” such as equality and respect, integrity, transparency and ownership, and provides a good foundation for a continuation of the collaboration. However, it is recommended that NRC scales up its engagement in current discussions related to e.g. the CDP Operational Alliance and the future sixth NRCS development plan.

Based on the above factors it was recommended to continue the partnership beyond the current phase, but with modifications as per the recommendations presented in summary form below, some of which can already be implemented in the next funding cycle (2011-2012).

***CDP Specific Recommendations***

1. Replicate some of the HIV/AIDS project’s mobility/migration strategies, especially those involving women groups, as women self-help groups also form a cornerstone of the CDP.
2. Take steps to embed the CDP within a more solid volunteer model in the future.
3. Disaggregate beneficiary data (according to wealth ranking, caste, ethnicity etc.) in relation to the CDP’s hardware component as well as in addition to women group members.
4. If funding allows, strengthen the saving/credit schemes of the women groups, e.g. pilot a bigger cash infusion from the project budget – with accompanying regulations, restrictions and technical advice - to a few women groups to test if this could generate more genuine empowerment and livelihood opportunities.
5. Carefully analyze whether NRCS has the capacity, competency and comparative advantage to deliver in relation to a possible future agricultural/livestock based CDP component before embarking in this area.
6. In future programme phases, it should be attempted to select project areas from some of the more vulnerable parts of Nepal as measured by e.g. the socio-economic terms/district ranking of the National Planning Commission and VDCs with high needs in relation to access to water and sanitation.

***HIV/AIDS Project Specific Recommendations***

1. Attempt to more specifically target out-of-school youth in the project by also training out-of-school youth (age 10-24 years) as peer educators.
2. Strengthen the training curriculum/training/supportive materials for peer educators especially in relation to the human trafficking and social discrimination components.
3. If the budget allows, develop a more systematic and comprehensive approach to care and support to PLHIV.
4. Promote a continuous enrollment of new peer educators in the targeted schools to ensure a continuation of the initiative.

***Crosscutting recommendations:***

1. Explore additional ways and means to further promote social inclusion also in relation to the programme/project management structures.
2. Provide RC volunteers with uniform (e.g. t-shirt) to promote RC visibility and image as well as RC spirit among volunteers.
3. Ensure consistency between various programme log frames, improve formulation of expected results, indicators etc. where required and improve the methodology regarding measurement of certain aspects of implementation, especially in relation to water and sanitation (for CDP) and human trafficking and social discrimination (for HIV/AIDS project).
4. Increase coordination with the NRCS Health Department to ensure greater synergy and avoid duplication.
5. In the future, when programmes/projects are being designed, make sure that no commitment is made to chapters/sub-chapters and communities until the actual funding is secured and confirmed.

**Acronyms**

AIDS: Acquired immunodeficiency syndrome

ART: Anti-retroviral therapy

CBFA: Community based first aid

CBHFA: Community based health and first aid

CDP: Community Development Programme

DC: District Chapter

FA: First Aid

FGD: Focused Group Discussion

GA: Global Alliance

HIV: Human immunodeficiency virus

IFRC: International Federation of Red Cross and Red Crescent Societies

IHL: International humanitarian law

MDG: Millennium Development Goal

NORAD: Norwegian Agency for Development Cooperation

NRC: Norwegian Red Cross

NRCS: Nepal Red Cross Society

NS: National Society

OA: Operational Alliance

PHAST: Participatory Hygiene and Sanitation Transformation

PLHIV: People living with HIV

PNS: Partner National Society

SC: Sub Chapter

VDC: Village Development Committee

VCDC: Village Community Development Committee

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NRC and the NRCS commented upon a draft version of this report. This version is the final one; the responsibility for the content belongs with the consultants who wrote it. The views expressed in this report may not always coincide with the opinion of NRCS, NRC, resource persons or stakeholders.

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*Photos on cover page by Consultant. Clockwise from upper left corner:*

1. *CDP improving access to water in Baglung district*
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# 1. Introduction

This report presents the findings and recommendations of an external consultant to the Norwegian Red Cross (NRC) tasked to undertake an impact evaluation of the long-term partnership between NRC and the Nepal Red Cross Society (NRCS).

NRCS and NRC have been in a partnership since 1988, when the NRC support to the implementation of a Community Development Programme (CDP) began, which has so far been implemented in seven districts through NRC support. In 1995 an HIV/AIDS prevention project was added to the partnership, which has so far been implemented in 24 districts through NRC support. In addition to these programmes, NRC has supported different projects at NRCS HQ, co-funded the construction of the National Training Centre and funded a Youth Delegate exchange programme since 2006. However, only the CDP and the HIV/AIDS project fall within the scope of this evaluation. In relation to CDP, the partnership is now in its fourth phase (2009-2010/2012), and targets all 45 wards of 5 VDCs in the three districts of Baglung, Manang and Mustang in the Western Development Region of Nepal. In relation to the HIV/AIDS project, the partnership is also in its fourth phase, and targets a combined 86 schools and 12 VDCs in the five districts of Lamjung, Makwanpur, Myagdi, Palpa and Sarlahi located in the mid and western region of Nepal. Maps indicating programme/project areas are attached in **Annex 1A and 1B**.

The evaluation was undertaken by an independent, external consultant. A participatory evaluation approach was applied throughout the evaluation exercise and the consultant was thus working closely with NRCS Community Development Department and Youth Department as well as district-based programme staff. The evaluation was carried out in Nepal in the period 26 September – 11 October 2010 and involved consultations in Kathmandu as well as field visits to four districts, namely: Baglung (current) and Kanchanpur (phased-out) district of the CDP and Lamjung (current) and Nuwakot (phased-out) district of the HIV/AIDS project. The full Terms of Reference and the programme of the mission are detailed in **Annex 2** and **Annex 3**.

# 2. Background

***Country Context***

Nepal, officially the Federal Democratic Republic of Nepal, is a landlocked country in South Asia bordering China and India. It covers an area of approximately 147,000 square km, and has an estimated population of approximately 30 million people. The country is divided into 5 development regions, 14 zones and 75 districts, which again are divided into 3,915 Village Development Committees (VDCs), which form the lowest administrative unit of government. Nepal can be divided into three physiographic belts running from east to west: 1) The mountainous belt in the north including the high Himalaya, which makes up 35% of Nepal’s area, but accommodates only 7.3% of the population; 2) The middle hills taking up 42% of the area and accommodating 44.3% of the population, and 3) The Terai in the south, which comprises only 23% of the total area, but which is home to 48.4% of the population. Nepal is considered one of the world’s most vulnerable countries to earthquake damage due to its geology, haphazard urban development and poor construction standards.[[2]](#footnote-2) In addition, floods and landslides disrupt the lives and livelihoods of thousands of people each monsoon season and cause big financial losses to individuals as well as society as a whole.[[3]](#footnote-3)

Nepal is a multiethnic, multilingual and culturally diverse country. The country has 103 caste and ethnic groups speaking 92 different languages and dialects. The official language is Nepali, which is spoken by approximately 49% of the population as mother tongue. 81% of the population follows Hinduism, while almost 10.7% are Buddhists and 4.2% are Muslims.[[4]](#footnote-4) As other diverse countries, Nepal struggles with issues related to discrimination and exclusion. The reasons for this are multifaceted and differ for all the disadvantaged groups despite their political, economic, social and cultural parallels.[[5]](#footnote-5)

The country has undergone big political change in the past decades, and is still in the process of defining its political and administrative future. In 1996, the Communist Party of Nepal (Maoist) started a civil war in a bid to replace the royal parliamentary system with a people’s socialist republic, which over the years resulted in more than 12,000 deaths, a lot of material destruction as well as major disruption of public services in areas like health and education. In 2006, the government and Maoists signed a Comprehensive Peace Accord, which declared a formal end to the 10-year rebel insurgency, and transformed the Nepali state. In 2008, the country voted in a Constituent Assembly, abolished the monarchy, formed a coalition government and started writing a new constitution. It is expected that the new Nepal that is to emerge will take on a more Federal character with changed administrative and decision-making characteristics, but in relation to drafting the new Constitution critical issues are yet undecided. In addition, the country has since June 2010, when the Prime Minister resigned, been in a political deadlock, as continuous rounds of voting in parliament have yet to result in a majority for new Prime Minister. This situation is considered a threat to the country’s peace process and could lead to a financial crisis.

Nepal is the poorest country in South Asia with a GDP per capita of approximately USD 470. Life expectancy at birth has increased, but at 63 years, it is still lower than its neighboring South Asian countries. The infant mortality rate is among the highest in the region and due to high maternal mortality, life expectancy for women is lower than for men. Gender disparities are also common when it comes to literacy, and only 26% of Nepal's women are literate, compared to 62% of men. Nepal has made considerable progress toward reducing poverty, with the headcount poverty rate falling from 42% to 31% between 1995/96 and 2003/04, but the decrease in poverty has been very unequal in relation to ethnicity, caste and gender as well as geographical location. Poverty incidence is much higher among Dalits, Muslims and Hill Janajatis compared to Newar and Brahman/ Chhetri. As another illustrative example, in relation to education, Terai Brahmins/Chhetris attend school for five times as long as Terai Dalits.[[6]](#footnote-6)

Linked to poverty, Nepal is a country characterized by high levels of internal as well as external migration. Approximately 4 million Nepalese are believed to reside in India, 29% of households have at least one member living abroad, and 30% of households receive remittances. In addition, an estimated 150,000 girls and women are believed to be trafficked into sex work each year across South Asia, with India being the primary recipient in the region. The return of sex trafficking victims to Nepal is a critical factor in the increase in new HIV infections in the country, e.g. a 2007 study found that 38% of repatriated Nepalese sex‐trafficked girls were HIV positive. The partners of male migrants are likewise very vulnerable to HIV infection as documented by a recent survey that identified HIV prevalence rates of up to 4.5% among the wives of migrant laborers. The overall HIV prevalence rate is estimated at 0.5%, but over the last few years, Nepal has moved from being a low prevalence country to one with a concentrated epidemic within sub‐groups of the population, including migrant workers, sex workers and injecting drug users.[[7]](#footnote-7)

***Organisational Context***

NRCS was established in 1963, and today constitutes one of the biggest humanitarian organisations in Nepal with district chapter (DC) in all 75 districts, 1,225 sub-chapters (SC) and almost 5,000 Junior/Youth Red Cross Circles. NRCS’ vision is an efficient, self-sustainable and independent humanitarian organisation committed to provide immediate relief to human suffering and reducing vulnerability. The current NRCS Development Plan (2008-2010) divides the work of NRCS into the following four core areas: 1) Promotion of humanitarian values; 2) Disaster Management; 3) Health and Care in the community, and 4) Organisational Development. Both the CDP and the HIV/AIDS project are part of the NRCS overall Health and Care programme, and both also contain a significant organisational development component.

NRCS has numerous RC movement partners, namely IFRC, ICRC, and several partner national societies (PNSs) including Austrian, Belgium, British, Danish, Finnish and Norwegian RC. NRCS also has several non-RC movement partners including UN agencies and international NGOs, who sometimes work through the NRCS HQs and sometimes partner directly with a NRCS DC.

The office bearers of the NRCS governance are all elected through a democratic process taking place every four years starting at the SC level and culminating in the election of a Central Executive Committee (CEC) at the Central Assembly. The CEC has furthermore constituted 10 central level committees, including a Community Development Committee, Health Service Committee, Organisation Development Committee, Junior/Youth RC Committee and Women Development Committee, mandated to provide policy support and recommendations to the CEC and supervise relevant NRCS departments. Administratively, these committees are matched by 10 different HQ Departments, including the Community Development Department, which the CDP falls under, and the Junior/Youth Red Cross Department, which the HIV/AIDS project belongs to.

NRCS is known to be a strong national society, and often receives delegations from other RC national societies, which come to learn from its successes. Various informants consulted during this evaluation exercise, however, pointed towards NRCS facing a number of internal organisational challenges. The various central level committees, consisting of elected members, are perhaps sometimes too involved at activity level, and in some instances coordination between different departments of the organisation could be improved. In some ways the organisation also suffers from being “too democratic” as huge amounts of time, resources and attention are involved in the election process, which is carried out every four years.

***The Norwegian Red Cross Support / the Projects***

As already mentioned, NRC provides financial and technical support to NRCS in several areas, but this evaluation is concerned with the support to the CDP and the HIV/AIDS project.

***Support to the CDP***

NRCS has supported the CDP since 1988[[8]](#footnote-8), and the NRC/NRCS CDP partnership is now in its fourth phase (2009-2010/2012), and has covered a cumulative seven districts including the current three target districts of Baglung, Manang and Mustang. See **Annex 6A** for more details about the different CDP phases. The CDP is one of the biggest programmes of NRCS, and presently targets a total of 13 districts through combined Austrian, Belgium, Danish, Finnish and Norwegian RC support, and has since 2009 been managed and implemented through an Operational Alliance (OA) aiming at promoting an integrated and standardized approach to programming and improving in-country coordination e.g. through standardized log frames, budget formats, policies and procedures and consolidated annual review meetings. From 2011, Danish Red Cross and possibly others will withdraw support to the CDP, and instead implement similar and related initiatives through the NRCS Health Department. This could significantly impact on the level of human resources and technical capacity in the Community Development Department. As per the OA framework, the standard CDP programme cycle is five years, while the current NRC/NRCS programme phase is only four years.

The programme objectives of the current CDP are:

1. The basic health and economic status of the most vulnerable communities are improved.
2. The capacity of community organisations and NRCS at all levels is strengthened and quality services expanded.

The CDP targets all wards of a total of five VDC in the three districts. The target population is 7,201 persons from 1,364 households out of which 764 persons, approximately 10.6%, are Dalits, while the rest are Bhrahman, Chettri and ethnic groups including Magars, Gurung and Thakali. Some of the programme activities target sub-sets of the population most particularly women, while other activities, especially those related to the construction of water and sanitation hardware, target the population as a whole. The combined 2009 and 2010 budget is 18,758,185 NPR, which is equal to approximately 260,000 USD using the current exchange rate.

The CDP is a multi-sectoral community-based programme, which has components related to drinking water and sanitation; health awareness and promotion including hygiene promotion, safe motherhood and nutrition; women empowerment through self-help; livelihood focusing on women and marginalised groups, and organisational development of NRCS HQs, chapters/sub-chapters as well as community organisations. Compared to earlier phases, the CDP has increased the focus on reducing social discrimination and targeting the marginalised and has reduced the focus on non-formal education, which according to NRCS has to do with the government increasingly filling this need. The CDP is mainly ‘software’ oriented and is predominantly focusing on building local capacity, changing awareness and practices, but the programme also has a limited “hardware” focus in the form of support to the construction of water schemes, sanitary installations, establishment of kitchen gardens, and support to NRCS chapter buildings.

The programme’s target districts have largely been selected by the NRCS Central Community Development Committee, taking requests from NRC in relation to accessibility of the programme areas into consideration, while the relevant DCs and district-level stakeholders were involved in the selection of VDC/s.

***Support to the HIV/AIDS project***

NRC has supported NRCS HIV/AIDS programming since 1995, and the partnership related to the NRC supported HIV/AIDS project is likewise in its fourth phase (2009-2010/12), and has through NRC support covered a cumulative 24 districts including the current five target districts of Palpa, Myagdi, Lamjung, Sarlahi, and Makwanpur. The overall HIV programme of the NRCS Junior/Youth RC Department has previously enjoyed support from several partners including the Global Fund, UNDP and the Swiss Development Agency, but presently NRC is the only funding partner. According to NRCS this can be attributed to several factors including some non RC partners preferring to provide support directly to NRCS chapters, and NRCS opting out of some partnerships, where the partners have been too demanding to work with, while only channelling modest amount of funds through NRCS. Furthermore, the NRCS Health Department has expanded its portfolio to include HIV programming, and e.g. Swedish RC through IFRC is currently channelling support to HIV activities through the Health Department.[[9]](#footnote-9)

NRCS is a partner to the RC HIV Global Alliance (GA), however there is very little involvement of the Junior/Youth RC Department in relation to this initiative despite the vast HIV programming experience and significant programming of this latter department.

Modifications have been made to the HIV/AIDS project across the different phases.[[10]](#footnote-10) E.g. in the first three phases of the project, there was a more significant focus on reproductive health; the third phase (2004-08) piloted a component on human trafficking in one VDC in one of the target districts, which has been mainstreamed to all project areas in the current phase; the fourth/current phase has introduced a male component, just as the focus on positive prevention and care and support has increased.

The project objectives of the current project phase are:

1. Reduce vulnerability to HIV and its impact among youth
2. Reduce human trafficking especially on women and children
3. Reduce the social discrimination, intolerance in the project communities.
4. Strengthen the management capacity of NRCS to deliver sustainable response to HIV prevention, trafficking and social discrimination.

The target group consists of school and out-of-school youths (defined as 10-39 years), the latter including members of women and male groups in the communities. The project is targeting 85 schools, 99 women groups and 11 male groups (approximately 20 members in each women/male group) in 11 VDCs in the five districts. The combined 2009 and 2010 budget is 18,755,622 NPR, which is equal to approximately 260,000 USD using the current exchange rate.

The main project implementation strategies are based on peer education and community mobilisation. Peer educators (PEs) are selected among in-school youth, who are trained by Teacher Sponsors using a training of trainers and life-skills based approach. The peer educators are expected to engage and share their knowledge with youth from their schools and with out-of-school youth from their communities. The project furthermore supports the establishment of women and male groups (age 16-39), from which some HIV peer educators are also trained. These groups also play a key role in relation to providing support for people living with HIV (PLHIV) and spreading awareness in communities on trafficking and the potential dangers of migration. Both the school-based peer educators and the women groups are furthermore used as vehicles in relation to the project’s social discrimination component. In addition, the project funds Community Mobilisers/Motivators in each VDC tasked with creating community awareness and helping to facilitate various advocacy events. Like the CDP, the HIV/AIDS project has an organisational development component, but has a more limited budget for support to SCs. In addition to capacity building of DCs and SCs, the project also aims at strengthening the Junior/Youth Red Cross circles.

NRC has no programme office in Nepal, but communicates and provides support to NRCS from its headquarters office in Oslo. The NRC Programme Coordinator for Asia visits Nepal approximately once per year, and is in frequent email/telephone contact with relevant NRCS staff to discuss the cooperation, monitor progress and provide technical support where and when needed.

# 3. Purpose of the Evaluation

This impact evaluation will be conducted to verify the overall efficiency and sustainability of the long-term partnership between the NRCS and NRC. This will likewise form the basis to determine the next stage of the partnership. This involves:

* To evaluate the relevance, efficiency, effectiveness, impact and sustainability of the partnership between the NRCS and NRC in general and the programmes/projects in particular.
* To evaluate the justification for continuation of the existing projects beyond the current time frame (2009-2012) and recommend revising the programme activities and indicators to further ensure relevance, quality assurance and sustainability.
* Should the recommendation be not to continue beyond the current time frame, to recommend modifications in modus operandi of the programme for the remaining time frame (2011-12) in order to secure sustainability in the programmes.

The complete Terms of Reference are attached as **Annex 2.**

# 4. Evaluation Methodology

The evaluation team used the following methods for the evaluation:

* Review of relevant documents. The list of documents reviewed is attached as **Annex 5**.
* Consultation with NRC Programme Coordinator through telephone and email.
* Interviews with NRCS headquarters (Secretary General, Community Development Department Director, advisor and programme coordinators; NRCS Junior/Youth Department Director, advisor, and programme coordinators) and NRCS staff at chapter/sub-chapter level according to semi-structured interview guides.
* Meeting with IFRC Representative in Nepal and PNS representatives of Danish, Finnish and Belgium Red Cross.
* Meetings with local government and other stakeholders at district level.
* Focused group discussions (FGDs) with RC volunteers according to semi-structured interview guides.
* Four FGDs with representatives of female groups (one in each district visited); one FGD with members of male group (in Lamjung district), and two FGDs with peer educators (in Lamjung and Nuwakot district).
* Small knowledge/attitudes survey involving peer educators and members of women groups/male group of the HIV/AIDS project.
* Interviews and house visits to beneficiaries of CDP support.
* Observation of selected RC activities (water schemes, toilet construction, vegetable gardens, improved cooking stoves, role plays, songs etc.).

The complete list of persons and stakeholders consulted is attached as **Annex 4**. The consultant visited four districts, namely one current and one phased-out district of each of the interventions, which had been pre-selected by NRCS and NRC largely based on access and time/logistical considerations.[[11]](#footnote-11)

Due to time and budget constraints unfortunately very limited quantitative data gathering could take place, but in relation to the HIV/AIDS project a small survey was conducted to test the HIV knowledge and attitudes towards marginalised people (PLHIV and Dalits) of peer educators and members of women and male groups. The survey also involved one question related to awareness of human trafficking.

The guidelines for semi-structured interviews, FGDs and the survey questions are attached in **Annex 9**, and the results of the survey are attached in **Annex 10**.

Based on the above, it needs to be stressed that the findings from the field are not necessarily representative of all the programme/project areas, and generalising from the small ‘sample’ and the extensive use of qualitative methods is not without risks. E.g. the survey only included one of the currently targeted 86 schools. However, despite the limitations and constraints the fieldwork in conjunction with the desk review has generated important information that highlight some of the current strengths and weakness of the programme/project, as well as areas where more information is needed.

The external consultant did not speak Nepali, and was therefore dependent on translation to conduct the interviews and FGDs. Translation was done by NRCS HQ staff involved in the management of the programmes. This arrangement presented some benefits, in particular intimate knowledge of all aspects of the programmes and familiarity with programme terminology, but also some potential disadvantages, including possible bias as a result of being too involved in the object of the evaluation.

# 5. An Assessment of the relevance, efficiency, effectiveness, impact and sustainability of the NRCS/NRC partnership and the associated projects

This section of the report considers how the partnership and associated programmes have addressed the issues of community development, HIV/AIDS, social discrimination and human trafficking in relation to relevance, effectiveness, efficiency, impact and sustainability. As separate programme/project evaluations have already been carried out of earlier phases of the CDP and the HIV/AIDS project, the analysis below will predominantly focus on the current phases.

## 5.1 Relevance

*“Before we used to deliver our babies in the cow shed. We did not believe in health staff and thought God would punish you if you touched a woman who had just delivered”* (Member of women’s group in Chadani VDC, Kanchanpur district).

*“My brother died from AIDS before I became a peer educator. My parents and I did not know much about HIV/AIDS and did not support my brother, as we were afraid to get infected. Through the HIV/AIDS project, I learned how to behave with PLHIV. I took my sister-in-law and her children to VCT, but luckily they were negative. If I had been trained earlier I could perhaps have assisted my brother to get a longer life” (*Female peer educator from school in Nuwakot district).

* Relevance is understood as the degree to which the partnership/programme objectives are in line with the NRCS and NRC organisational priorities and the relevant national development objectives. Furthermore it considers whether the current NRC funded programmes are based on an adequate analysis of needs.

***Relevance in relation to NRCS and NRC organisational priorities and national development objectives***

From the perspective of the NRCS, the partnership fits very well with three of the four general objectives of the NRCS Fifth Development Plan (2008-2010), namely:

Objective 1: Promote respect for diversity and human dignity, and reduced intolerance, discrimination and social exclusion.

Objective 3: Improve health status of the vulnerable people.

Objective 4: Further develop and strengthen organizational and management capacity of NRCS as a well-functioning national society.

The next NRCS Development Plan is currently under formulation, and according to key people involved in the process, it is expected to be aligned to Strategy 2020, and to include a stronger focus on livelihood, crisis and disaster, mobility/migration and climate change.

In relation to NRCS’ more programme specific plans and strategies, it should be highlighted that the CDP largely follows the overall CDP Operational Alliance, while the HIV/AIDS project is in line with the NRCS Five Year HIV/AIDS Operational Plan (2006-2010) in particular its priorities of:

* Targeted prevention (young people aged 10-29), migrant people and their spouses.
* Care and Support.
* Management and institutional capacity building.

NRCS has largely been in the driver’s seat in relation to designing the NRC funded interventions and the associated program documents, which indicates a high degree of NRCS ownership. The only deviation in relation to the above is the revision of indicators and reformulation of some of the expected results, which was initiated by NRC in response to feedback from the back donor, NORAD, which has led to multiple and not completely aligned reporting formats. NRCS still plans, budgets and produces internal reports according to the original log frames, but now also has to prepare reports according to a different NRC/NRCS reporting format, which has somehow merged the two log frames into one and developed some new indicators, but extensively based on the structure and content of the CDP log frame.

The partnership is also in conformity with the NRC international strategy, in particular the main objectives of providing “effective support to all its partners in the field of community-based health education and disease prevention”. Furthermore, the increasing focus of both the CDP and the HIV/AIDS project on fighting social discrimination can also be considered very relevant to the main objective of the NRC international strategy of contributing “towards increased access to victims”. The strategy makes little independent mentioning of livelihood and economic empowerment, which as mentioned above form key components of the CDP.

From a national perspective, the CDP and HIV/AIDS project are similarly assessed as being very relevant to the Nepal’s Three-year Interim Plan (2008-2010), which is closely tied to the Millennium Development Goals (MDGs). In particular, they both contribute towards MDG 1 (eradicate extreme poverty), 3 (promote gender equality and empower women), 4 (reduce child mortality), 5 (improve maternal health), 6 (combat malaria, HIV/AIDS and other diseases).

***Relevance in relation to needs***

Both interventions generally appear to be very relevant to the needs of the local communities consulted. However, regarding the HIV/AIDS project it could be discussed whether it is relevant to base the PE approach so solidly on the in-school youth, as opposed to the out-of-school youth. It is advised to more specifically target out-of-school youth, as it is probably safe to assume that this group has lower health and HIV awareness levels and is also more vulnerable to risk behaviour, migration and trafficking. This forms a key recommendation.

Mobility /migration also appear to be a significant issue in some of the CDP areas, but this is not addressed. It could be considered to replicate some of the strategies of the HIV/AIDS project in this regard, especially those involving women groups, as women self-help groups also form a cornerstone of the CDP. This forms a key recommendation. The CDP livelihood activities mostly target women, but it could be considered relevant to also involve men more in this regard, as livelihood options or lack of the same are intimately linked with migration, and ultimately the economic status of men will also have a big impact on the vulnerability of women. Should it be decided to further prioritize the livelihood component of the CDP in the future, it is therefore recommended to increasingly consider how men could also benefit from such activities.

## 5.2 Effectiveness

*“Before the CDP, the local sub-health post was also trying to create health awareness, but no one took us seriously. Now the people of this VDC have improved their health seeking behaviour dramatically and we can already see a reduction in common disease” (Assistant Health Worker of Sub-health post, Bhakunde VDC, Baglung district).*

* Effectiveness is understood as the degree to which the outputs are achieved or, in other words, whether the interventions achieved what they set out to do and whether it was done in the right way. Effectiveness thus relates to how well the *design, implementation and monitoring processes* of the interventions have contributed to the expected results being met. Answering this question will involve assessing the quality of the project activities and the effectiveness of the implementation methodologies and approaches, including the relevance and application of the training courses provided to the staff and volunteers.

In relation to the current programme phases, it should be kept in mind that the interventions are not yet half way through the current implementation cycle. Additionally, the first transfer to target districts was only initiated in May 2009, due to delays in signing the NRC/NRCS cooperation agreement. In the following, the analysis will be conducted programme/project wise, and structured around the expected results, starting with the CDP. This will be followed by some observations regarding the log frames and data collection related to both interventions. Furthermore, **Annex 7A and 7B** provide an overview of achievements in terms of activities conducted and spending against plans and budgets of the current implementation phase.

**Effectiveness of CDP**

***Output 1.1: Level of health and nutrition knowledge in community people increased***

The Motivators[[12]](#footnote-12) and trained volunteers (FA volunteers trained for four days; Health and Sanitation Volunteers trained for six days, and Safe Motherhood volunteers[[13]](#footnote-13) trained for three days) have provided health education, personal hygiene and safe water handling sensitization to community members through women groups and door-to-door visits. Information from all the stakeholders consulted indicates that these efforts have been effective in increasing community members’ health knowledge. Women group members gave various examples of the elimination of previous misconceptions and lack of health knowledge prior to the CDP.[[14]](#footnote-14)

As opposed to earlier, the CDP has stopped training Traditional Birth Attendants (TBAs) on technical delivery issues, and instead concentrates efforts on facilitating TBA referral to the formal health system through training on safer motherhood. This is in line with what is currently considered good practice by WHO, and is an illustration of how the CDP has kept updated with developments in public health thinking.

The training of volunteers appears too short (especially for Health & Sanitation and Safe Motherhood volunteers), and it takes too long before refresher trainings are conducted. Trainings are provided in one consecutive sequence, while it is generally considered more effective to spread training out in smaller sequences. The supportive materials provided to volunteers are strongest in relation to hygiene promotion. It is also recommended to concentrate the trainings on fewer volunteers, instead of training one group in FA, another in safe motherhood etc., to really focus on creating some core capacities at community level. This forms a key recommendation. It is believed that focusing on quality as opposed to quantity will ultimately result in higher and more effective community capacity.

***Output 1.2: The hygiene and sanitation situation of targeted community improved***

The first year of programme implementation largely focused on the software aspects, and as of June 2010, 92 toilets had been constructed. Most are double pit water sealed toilets, which means that the beneficiaries generally do not have to worry about emptying the pits, which makes it much more likely that they will sustain the new sanitation practices. In line with good practice an informed choice method has been used, and toilet construction takes place with the technical support of NRCS HQ/DC staff and local community members trained in plumbing / toilet construction (10 day / 6 day training respectively). In Mustang district, an external partner has supported toilet construction, and more such partnerships will be required to ensure 100 % access to improved sanitary facilities. All beneficiaries consulted were very satisfied with their toilets, and claim that smaller children of the household are also using them. In the phased-out district visited, the SC highlighted the construction of toilets as the most effective and appreciated type of activity, but also acknowledged that the toilets did not reach the poorest as these could not satisfy the financial self-contribution requirements.

In the phased out district/VDC visited, there has been a continued increased demand for sanitation, which indicates the effectiveness of the project approach. 60 toilets have thus been constructed through the SC after the CDP phase-out.

The CDP also appears successful in terms of promoting environmental sanitation. E.g. the target VDC of Baglung district has been declared a plastic-free zone, and will soon also be declared an open defecation prohibition zone, which can very much be attributed to the programme’s combined software/hardware focus.

***Output 1.3: Access to drinking water of targeted community increased.***

Access to safe/improved water facilities has increased as a result of the programme, but still at a relatively modest scale. Until June 2010, additional 66 households had been provided with access to safe water as a result of the establishment/rehabilitation of water systems. Water prospecting and water system construction is taking place with the technical support of NRCS HQ/DC staff and also involves local water user committee members, who are trained and supported for registration through the programme.

Local community participation and contribution takes place in line with good practice. Maintenance funds have been created, which are managed by the SC (for toilets) and Water User Groups respectively. The user groups are provided with one set of tools each, and HDPE pipes are stored for future maintenance. As opposed to earlier, the water quality is now being systematically tested for E.coli, fluoride, iron and pH value, and in the event it does not live up to required standards, community members are instructed to carry out point of use intervention. According to NRCS, arsenic is not a problem in the current programme areas.

In some wards/settlements of the target VDC of Baglung district, the only option in terms of securing access to safe water is through rainwater harvesting systems, which cannot be accommodated through the current budget, but NRCS DC with the support of the NRCS HQs are in current consultations with the District Drinking Water and Sanitation Department regarding the construction of rain water harvesting tanks funded through public budgets.

Due to budget limitations, PHAST (Participatory Hygiene and Sanitation Transformation) has not yet been introduced in NRC funded target areas, unlike in other CDP areas. In addition, CDP HQs staffs are in the process of customizing PHAST materials to the Nepali context, and as soon as that has been done, it is advised to also implement PHAST in the three NRC funded districts.

Unfortunately the programme budget is insufficient to ensure 100% access to safe/improved water (this also goes for sanitation). There is a risk that the current approach does not favour the most vulnerable due to the financial self-contribution requirement and the decision-making procedures. It would be useful if future progress reports could indicate the wealth ranking of beneficiaries to verify whether the most vulnerable are prioritised in terms of receiving such support. If that is not the case, it should be considered to deviate from the financial self-contribution requirement in relation to the poorest households, and only to request for contributions in terms of labour. This forms a key recommendation.

***Output 2.1: Social discrimination and domestic violence in targeted communities reduced.***

The activities designed to contribute to this output are mainly related to advocacy and orientation in addition to some trainings on the topics. In addition, the programme has generally made many efforts of promoting a gender approach. Many activities focus exclusively on women, and all Motivators are female. Generally, women are very well represented in numbers, but sometimes appear less influential in actual decision-making, especially in related to the decision-making structures associated with the programme. Indicative of this, all the 12 SC and VCDC representatives consulted in the current project VDC/district were male.

The Dalit representatives consulted informed that the CDP has resulted in big changes, e.g. according to one member of a women group: “*Before joining the women group, I could not show my face in public and even less speak up in public*”. However, despite the good efforts, there also still appear to be challenges in terms of involving marginalised groups, especially Dalits, both in relation to numbers and genuine involvement. E.g. no DC/SC board members or project staffs are Dalits, and in relation to the VCDCs, which constitute the lowest level of the CDP project structure, and consist of seven members per ward, only five of the total 63 VCDC members in the current project district visited are Dalits despite 24.4% of households in that area being Dalits.[[15]](#footnote-15) The VCDCs play a key function in relation to communicating the needs and requests of their respective communities. In addition, the general observation from the field visit was that the Dalits represented in the various project activities are not very influential or powerful. This challenge is by no means unique to the CDP, but something all development agencies struggle with in Nepal as also indicated by the latest UNDP Nepal Human Development Report from 2009, which has a whole chapter on “*unequal* human development”, focusing on issues related to discrimination and exclusion.[[16]](#footnote-16) Based on these findings it is advised that additional strategies should be explored to further insure social inclusion. E.g. it might be useful if the activities related to “humanitarian value promotion” and “social inclusion advocacy campaigns” could take place prior to forming the VCDCs, and likewise it should be considered to make a greater effort to include Dalits among the Motivators[[17]](#footnote-17). This forms a key recommendation.

In relation to socio-economic vulnerability, it is recommended to disaggregate monitoring data to e.g. find out how many of the women group members belong to the different wealth rankings (A, B and C) with a view to establish to which extent the programme targets the economically most deprived. This is similar to the recommendation raised in relation to the CDP’s hardware components above.

***Output 2.2 Sustainable livelihood activities established focusing on women and marginalized groups***

Currently, the CDP supports 34 women groups with a total of 1,056 members. In both CDP districts visited, the majority of groups existed prior to the CDP, but they have been strengthened through trainings of selected members in group management and accounting. Some of the group members have also been trained as volunteers (FA, safe motherhood, health and sanitation). A few new women groups have also been formed in wards with gaps, and in one ward in Baglung the CDP has facilitated the establishment of a new women group with Dalits as members only. The same goes for cooperatives, which were also all largely in existence prior to the commencement of the CDP, but one of the achievements of the CDP is that it has facilitated a greater participation of women/women group members into the cooperatives. The vast majority or all the women groups are involved in saving and credit schemes. The schemes involve rather modest amounts, and there are only few examples of the schemes leading to new employment or livelihood opportunities for the women involved.[[18]](#footnote-18) As livelihood, job creation and income-generation are main priorities of most of the people consulted in the field, it could be considered to pilot a larger cash infusion from the programme budget, while at the same time avoid repeating past failures in this area. Should the scheme develop into a more genuine micro-finance oriented scheme, it would obviously be necessary to develop very strict regulations and supervision mechanisms to avoid mismanagement. This forms a key recommendation.

The CDP’s experience with skills development and income generation is somehow disappointing. There are plans to strengthen the focus on livelihood in the next NRCS overall development plan likely with an explicit focus on agriculture and livestock activities. It is however advised to carefully consider whether NRCS has the capacity, technical competency and comparative advantages to deliver in these areas. A decision to embark upon activities in a sector like agriculture where NRCS has limited capacity carries a high risk of failure, and even doing harm to local communities. If it is decided to pursue such activities, the feasibility of these should be established and partners co-opted with a proven track record in this area. This forms a key recommendation.

***Output 2.3: Capacity of NRCS and community organisations to implement and sustain a participatory, inclusive and transparent community based project enhanced.***

The CDP has provided material and capacity building support to DCs and SCs, and the targeted chapter/sub-chapters are generally much stronger compared to the situation prior to the CDP as reflected in e.g. increase in number of members, diversification and increase in income generation, increase in types and scope of regular DC/SC activities etc. A common comment was that people were not aware and/or interested in the Red Cross prior to the CDP intervention, but that this has changed. Compared to the investment, the CDP support appears to have resulted in modest results in terms of income-generation, but the support has definitely improved the image of the NRCS locally and also resulted in a more active and dedicated chapter leadership.[[19]](#footnote-19)

Despite the infusion of many programme staff, the CDP is solidly integrated within the existing NRCS structures (DCs and SCs), which is a very good achievement and also positive from a sustainability angle. As stated by the Kanchanpur DC: “*We were fully in control as DC on project management”.* However, it does appear to be a challenge to build a sufficiently strong volunteer base of SCs, and to really embed the CDP within a volunteer-based model. E.g. in the phased out CDP district visited (Kanchanpur), the DC/SC were not aware of to which extent trained volunteers were still active. A more comprehensive and systematic use of volunteers can also be expected to make it easier for the DCs to replicate more components of the CDP to additional VDCs, which unfortunately also appears to be a challenge at the moment. It should be attempted to build more of a volunteering spirit among the selected volunteers, and also providing clear and tangible expectations to volunteers before they are trained. It is furthermore suggested to improve the sub-chaters’ volunteer management capacity including setting up some structures and supporting mechanisms between sub-chapters and volunteers that can be sustained when there are no longer any paid project staff assigned to the sub-chapter. This forms a key recommendation.

**Effectiveness of HIV/AIDS Project**

***Output 1.1: Prevented further infection of HIV among youth of project communities by promoting life skills.***

In the current project, 1,600 peer educators have been trained, who have so far conducted1,000 interactive sessions in schools and 1,354 sessions in communities with their peers. The interviewed peer educators, women and male group members confirmed that previous misconceptions, in particular that HIV can be transmitted through social interaction and mosquito bites, have been eliminated, and that knowledge had increased as a result of the project. One member of the consulted women group in Nuwakot, explained: “*Before the project, I knew almost nothing about HIV, and always got so scared when there were HIV messages on the radio”.* A mini survey confirmed that knowledge of HIV has improved compared to the baseline information. E.g. the vast majority of the sample’s student peer educators could list three or four modes of HIV transmission. However, there is still work to be done in this area, as documented by e.g. the high proportion of survey respondents believing that it was not possible to get HIV the first time having sex. See **Annex 10** for more details.

The project’s approach in this key activity area is solidly embedded within the school system in the sense that all trained peer educators are in-school youth, who are attached to a teacher sponsor. There is reason to doubt the efficacy of this approach in relation to out-of-school youth, and even to question whether it is correct to call it peer education, when a trained in-school youth communicate with an out-of-school youth. In any case, it can be expected that the intervention is less effective, when peers communicate outside their group for reasons relating to sharing common characteristics, which again have implications for respect, acknowledgement, trust and language.[[20]](#footnote-20) On a positive note, it can be stressed that the teacher sponsors consulted were very enthusiastic and supportive of the programme, and embedding the activities in schools certainly provides benefits in relation to making the programme more easily acceptable to in-school parents. However, for reasons related to vulnerability of HIV infection, and human trafficking it is advised to also train out-of-school youth (age 10-24 years) as peer educators in the future. It should be considered to also utilize Teacher Sponsors for this, as they could make such an intervention more acceptable to parents of out-of-school youth. In addition, using the teacher sponsors would also help to keep the costs down. This forms a key recommendation.

Peer educators are provided with limited supportive materials to assist them in peer education in school and in their communities. The newsletter ‘Yuba Chautari’ is very popular, and is a very innovative and interesting publication, but it would be useful if peer educators could be provided with additional materials including pamphlets, which they could share especially with the out-of-school youth. This also applies in relation to sharing knowledge on human trafficking and social discrimination.

It is not always clear to which extent women and male group members represent youth.[[21]](#footnote-21) This does not mean that the project activities are not effective. As a matter of fact, the women and male group members are most likely at much more immediate risk of HIV, human trafficking etc. E.g. there were high numbers of previous migrants among the male group consulted in Lamjung, and the majority of members of the women groups consulted in Lamjung and Nuwakot had spouses working abroad[[22]](#footnote-22), but the title of the project could be considered a misnomer in relation to these activities considering the WHO definition of youth using the age range of 10-24 years

***Output 1.2: Extended support by communities to people living with HIV and AIDS.***

The project’s positive awareness activities appear effective and in line with the MIPA (Meaningful involvement of people living with HIV) principles. In the current project phase, the support to the establishment of PLHIV (people living with HIV) positive network at district level has been cancelled due to budget constraints, but the project has been very successful with this approach in previous phases as Nuwakot is one example of.[[23]](#footnote-23)

Compared to the project’s prevention component, the support to PLHIV appears much less systematic, which also has to do with the much smaller budget allocation to activities related to this output. As demonstrated by the field visit to Nuwakot, i.e. a phased-out district, there are good examples of local communities/women groups providing valuable support to PLHIV and their relatives[[24]](#footnote-24), but as more people are finding out about their HIV status it should be considered to develop a more systematic approach to care and support including training volunteers in counselling and home-based care. Currently the type of support provided to PLHIV very much depends on the women groups’ own initiative and their existing capacity and interest. If possible, an increased focus on care and support should be guided by the HIV GA and done in coordination with the HIV/AIDS programme of the NRCS Health Department to ensure a more programmatic approach within NRCS to care and support. This forms a key recommendation.

***Output 2.1: Mobilized women to spread awareness against trafficking on women and children***

As described above, human trafficking was piloted in the previous project cycle, and has now become a mainstream component of the project. The various target groups consulted indicated that they had become more informed about the dangers of human trafficking and in particular the risk of becoming a victim of trafficking when seeking employment abroad. Female/male groups also informed that local communities have become more alert in relation to outsiders visiting their villages. Women and male groups use many creative approaches to spread awareness including songs, competitions and drama, but unfortunately several activities have been cancelled due to budget constraints. Motivators also conduct household visits to inform about human trafficking. It is felt that IEC and training materials on human trafficking could be improved, and it would be useful if IEC materials for household use could be developed.

***Output 3.1: Reduced the incident of caste, gender, ethnicity and religion based violence***

Both students and women/male group members informed that they had become more aware of issues related to social discrimination, and that they now exhibited higher levels of tolerance across gender, ethnicity/caste. A “Mini survey” revealed differences in tolerance levels between groups of the phased out district (where this issues was not addressed) and groups of the current district. See **Annex 10**. In particular, staff and women group members highlighted the non-discriminatory camps, where people from different castes and ethnic groups eat together, as effective. One Dalit member of the women group consulted in Lamjung district explained: “*Before we were not accepted, but now we are part of the same group as sisters*.”

In relation to gender it appears that the women groups have been effective in empowering its members, and they are actually now so popular that they cannot accommodate the many women wanting to join. Members explained that they used to be confined to kitchen work, and did not take part in community initiatives. Through the group they felt much stronger, and also increasingly able to speak up against their husbands, as explained by one member of the women group in Lamjung district: “*My husband came back after having worked six years abroad. I went to Kathmandu to receive him, but refused to be involved in any intimate action until he had taken a HIV test. Luckily he was HIV negative*”.

As it is the case with the human trafficking output, several activities related to this output have been cancelled due to budget constraint, and it is also believed that IEC and training materials on social discrimination could be improved.

***Output 4.1: Improved project management capacity of NRCS units at all levels***

The HIV/AIDS project has a much broader geographical scope than the CDP (12 VDCs compared to five), and consequently involves more sub-chapters than the CDP. However, at the same time the capacity building “package” is much smaller in terms of trainings and material support compared to the CDP (e.g. the HIV/AIDS project only provides material support to the DC level, and provides no support for buildings), but the DCs still appear to have become stronger as a result of the project, and have also taken good ownership of the project. In some places, e.g. Lamjung, the project has also facilitated the establishment of new sub-chapters and more members in existing chapters. Similarly the Junior/Youth RC circles have become stronger as a result of the project, and now have more members and engage in more activities.[[25]](#footnote-25)

It should also be stressed that the NRC support has been very crucial in relation to capacity building of the NRCS Youth Department. Until 2009, an amount of 300,000 NPR per year was allocated annually to capacity building initiatives, which according to NRCS HQs staff has been crucial in relation to NRCS now being recognised as a national player in the area of HIV and nurturing NRCS leaders.[[26]](#footnote-26) From 2010, this budget was totally eliminated due to budget constraints as a result of NORAD allocating less money than originally applied for.

**Log frame design and data collection:**

The design of both the CDP and the HIV/AIDS project in terms of its ‘logical’ approach to achieving its ‘objectives’ is generally well thought through. The log frame of each programme/project illustrates how outcomes will be achieved via outputs and inputs, with corresponding performance indicators.

In 2009 revised expected outputs and corresponding indicators were developed for the back donor, NORAD in a format, which merges elements of the CDP and HIV/AIDS log frame, but mostly adopting the structure and content of the CDP log frame. However, NRCS has continued to plan and budget according to the original log frames, but report annually according to the “NRC/NORAD log frame”. It would be useful with a higher degree of consistency, and also be time saving for NRCS programme staff. It can also be noted that several of the indicators of the NORAD “log frame” have no targets and no baseline data. Refer to Annex 8 for more detail.

Some expected results of the more detailed programme/project specific log frames are considered too ambitious, and more suitable for an immediate project objective, e.g. expected result 1.1 of the HIV/AIDS project, “Prevented further infection of HIV among youth of project communities by promoting life skills***”.*** A better formulationof this expected result would be: “Knowledge about HIV among youth of project communities improved”.

Some indicators need improvement. E.g. several of the HIV/AIDS project goal and specific objective indicators merely measures how many have been reached through the intervention. In the CDP, the specific objective indicator of “Infant/child and maternal mortality rates reduced” is too ambitious and cannot be measured reliably considering the small size of the target population. It should also be considered to reduce the number of indicators and aim at a few, very good indicators guided by the principle of “what we need to know” versus “what it is nice to know”. It could be said that the NORAD “log frame” is a step in that direction, but it is important that the M&E systems of the two interventions also genuinely agree on and adopt the NORAD indicators instead of operating with two parallel sets of indicators.

In relation to data collection and methods of measurement there are also a few issues that should be addressed. In relation to the CDP, it appears that inconsistent methodologies are used regarding measuring access to water, which might impact on the reliability of the collected data. In the baseline survey the surveyors were using the term access to “safe water”, and apparently just asking sample households whether they were having access to a safe water source without making an independent assessment. In the periodic progress reporting to NRC, NRCS refers to access to “potable water”, but it is not clear if independent assessment takes place by evaluators/enumerators in relation to gathering this information. It is recommended that NRCS improves the survey design related water and sanitation, and in this regard they could get inspiration from the UNICEF/WHO publication “Core Questions on Drinking Water and Sanitation for Household Surveys”, 2006, which has already been shared with CDP staff by the consultant. This forms a key recommendation. In relation to the expected result on social discrimination of the HIV/AIDS project, a more sophisticated method of measurement should be developed, which considers both attitudinal and behavioural indicators of discrimination and which involves different questions to the “marginalised”, on the one hand, and other local community members on the other.[[27]](#footnote-27) This also forms a key recommendation,

Generally, it also advised to improve quality control around various surveys conducted, e.g. in connection with baselines and end of phase evaluations, and to be more explicit about what population/sub-population the data represents and how it has been generated. E.g. it is important to know whether a given figure represents all women or only the member of the women groups. In connection with the visit to the phased-out CDP district, Kanchanpur, a previous Motivator, who had been involved in the end of phase evaluation cautioned on the reliability of the end-of-phase evaluation survey data as she explained that many of the respondents in the household survey had been the oldest people of the household, due to the time of the day the survey was carried out, and she was of the belief that many had provided incorrect information e.g. in relation to morbidity within the family and that their knowledge levels could not be taken as representative for the household as a whole.

## 5.3 Efficiency

* Efficiency is understood as to what degree resources/inputs have been converted into results/outputs, and also involves a consideration of the coordination process between NRCS HQs and chapters/sub-chapters.

***Conversion of resources/inputs to outputs***

As NRC does not have an in-country presence, the vast majority of the budgets goes directly to NRCS. When that is said, the CDP appears to involve a very expensive structure at HQs as well as DC level with high administration/overhead costs compared to the rather low number of 7,201 beneficiaries benefitting directly from the programme. The NRC funded CDP pays for 4 staff at HQs level, 3-4 staff members in each of the target districts in addition to a total of 14 Motivators. To illustrate, at NRCS HQ level the 2010 budget for salaries, administrative and logistic support (which does not cover monitoring costs) is 1,698,260 NPR, which is equivalent to 62.8% of the total NRC funded CDP HQs budget, while in Mustang district, the 2010 budget for salaries, remuneration of Motivators, administrative and logistic support is 1,470,862 NPR, equivalent to 55% of the total Mustang district CDP budget.

The HIV/AIDS project has significantly smaller overhead costs. The 2010 budget for salaries & benefits as well as project support and management support costs is 4,456,342 NPR, equivalent to 45.3% of the total budget. However, the HIV/AIDS project also involves less sectors, hardware and technical solutions.

One of the contributing reasons for the rather high overhead costs compared to the overall programme/project turnover, is the fact that both interventions were designed according to a total budget figure of 848,746 USD for the CDP and 783,500 USD for the HIV/AIDS project. However, NORAD approved significantly smaller budgets, namely approximately 750,000 NRK for 2009 per programme/project, and 800,000 NRK for 2010. In this vein the revised HIV/AIDS budget for 2010 is only approximately ¾ of the original 2010 budget. When NRCS was informed of the reduced budgets, it was felt to be too late to reduce the number of target areas as commitments had already been made. A preliminary analysis of activity plans and budgets indicate that it is predominantly (but not exclusively) spending on activities that have been reduced in efforts to match the new budget. Several activities have been cancelled or reduced in scope, which at first resulted in some confusion and frustration among beneficiaries. E.g. PHAST exercise, training of FA volunteers, distribution of FA kits to trained FA volunteers, volunteer “uniforms” (e.g. t-shirts or hats) and dissemination of health messages on local FM radio have been affected. With at least one PNS stopping its support to the CDP with effect from next year, it is probably unrealistic to expect that NRC can reduce its salary support to the NRCS Community Development Department. Should more funding become available, it is believed that both the CDP and HIV/AIDS project could meaningfully increase the ‘turnover’ within current target areas by allocating more to actual activity costs. This would also ensure a more efficient use of already deployed human resources.

However it is recommended to consider ways to reduce overhead costs. E.g. the CDP relies significantly on door-to-door visits by Motivators as a vehicle of implementation, which is a very time-consuming and thus inefficient approach, and it should be considered to “outsource” this type of activity more exclusively to volunteers.

***Coordination Process***

The planning, budgeting and coordination process has been increasingly decentralised over time for both the CDP and the HIV/AIDS project, and wards now have a more formal role in the planning and budgeting process. The DCs still play a key role in relation to project implementation and e.g. approves all expenses through a district level project steering committee. For SCs at a more advanced stage of development, it could be considered to provide SCs with a more formal role in relation to the project management, which might also reduce some of the overhead costs.

Furthermore, it was noted that the CDP and HIV/AIDS project had very good coordination with local authorities as well as other stakeholders including NGOs and local CBOs, who are consulted and involved throughout the implementation cycle e.g. in relation to the identification of target VDCs/schools, providing support to various training initiatives and providing other technical input where needed. E.g. the CDP exhibited a very close relationship to the District Water and Sanitation Sub-Division Office, while the HIV/AIDS project closely coordinated with the District Education Office and the District AIDS Coordination Committee (DACC). This is also considered promising from a sustainability perspective.

At NRCS HQ level it is recommended to increase coordination between departments, in particular with the NRCS Health Department to ensure greater synergy and avoid duplication both in relation to the CDP and the HIV/AIDS project. The consultant unfortunately was not able to meet with the NRCS Health Department during the time of the evaluation mission, but it is believed that this coordination responsibility goes both ways, and that the Health Department should also to a larger degree involve other Departments, e.g. in relation to the HIV Global Alliance and trainings facilitated by resource persons from the IFRC regional and zone office. This forms a key recommendation.

## 5.4 Impact

*“Before, the women living here used to spend 2-3 hours every day just to fetch water, and the people here, especially children suffered from diarrhoea, jaundice and other water borne diseases all the time. After the RC support for construction of drinking water scheme, we just go outside the house to collect the water we need, we don’t get sick any more, and we have a lot more time that we can spend on keeping the houses and the community clean, holding meetings, growing vegetable gardens etc. The water scheme has really changed life for everyone”. (Female beneficiary and member of water user committee in Bhakunde VDC, Baglung district).*

*“A women in our community, who is now 35 years old, has been through a bad experience, which is almost like a bad film. When she was 22 years old she was trafficked to India through her aunt, where she worked in a brothel. She met a man from this VDC while in India and they got married. After returning here she became very sick and developed symptoms of HIV/AIDS. Her husband’s family kicked her out of the house. One of our group members took her to Kathmandu for VCT, and she is now on ART, and much better. She can take care of buffaloes and is now earning money for herself. She has one son, who has been tested three times, but luckily he is negative” (Member of women group in Taruka VDC, Nuwakot district).*

* In this evaluation, impact is understood as positive changes experienced by communities brought about by the programmes. Specifically, those changes that enable target communities to better deal with and proactively combat health including HIV threats, socio-economic difficulties, social discrimination etc.

Before moving into the analysis, a few precautionary comment. Firstly, the interventions are net yet half way through the current cycle, and there is therefore a limit to what can be expected in terms of impact at this stage. Secondly, and as already explained in section 4 above, this evaluation has not involved comprehensive surveys and collection of quantitative data for the indicators of the programme/project objectives. When that has been said, there are several indications that impact is/will be achieved. The NRCS internal M&E systems as well as information received from beneficiaries, members of the district project team, sub-health posts and other stakeholders in the field strongly indicate significant impact in the form of e.g. behaviour change, improved health practices and reduction in morbidity and social discrimination, improved life skills of youth as well as higher degrees of tolerance among community members.

Examples of positive changes in relation to CDP include: Improved hand washing practices; improved personal and environmental sanitation, higher child immunisation rates, increase in numbers of women going for ante-natal and post-natal care visits and delivering with support from a skilled birth attendant[[28]](#footnote-28), increase in number of people seeking diagnosis/treatment at official health institutions as opposed to consulting traditional healers, reduction in morbidity including diarrhoea rates, waterborne and communicable disease more broadly etc. However, the CDP appears to have had less impact in relation to changing the economic status of vulnerable communities, and there is currently little evidence to suggest systematic improvement of the economic status of vulnerable individuals and communities.

Example of positive changes in relation to the HIV/AIDS project include: More people have accessed voluntary counselling and testing and consequently know their HIV status; women are increasingly aware of their vulnerability to HIV and have improved their condom negotiation skills vis-à-vis their husbands when relevant; discrimination of PLHIV has reduced; more PLHIV are living openly with HIV; indications of improved life skills and improved academic performance of PEs. In relation to the HIV/AIDS project, it is difficult to measure the extent to which vulnerability to human trafficking has been reduced. This is a challenge most agencies involved in human trafficking struggle with, as it is even difficult to establish a reliable baseline. The best that can be measured is probably whether the target population’s awareness of human trafficking has increased, but it is found that the baseline questions attempting to measure this are not very good and should be improved, and it is suggested to request advice from agencies with more human trafficking experience in this regard.

Though all parts of Nepal can be claimed to be somehow in need of support, it appears that some of the current CDP project areas (Mustang and Manang) are not among the most vulnerable according to the District ranking of the National Planning Commission. According to UNDP, Nepal is among the five countries of the world with the highest severe malnutrition rate among children. However, in the visited CDP areas, child malnutrition was not a serious issue according to sub-health posts. Similarly, according to the NRCS CDP 2009 progress report to NRC, 90% of households had access to safe water prior to the commencement of implementation, which could lead to questions about needs of the current programme areas.

Furthermore, within the target districts, it is not always clear to which extent the most vulnerable communities are reached, and the current decision-making procedures in relation to nomination of members of various groups, people to be trained including peer educators, beneficiaries of support etc. appear not always to favour the most marginalised (in terms of socio-economic status, gender, ethnicity, caste etc.). It is acknowledged that this is an extremely difficult and complex area, but it is still recommended to look into it. E.g. according to the CDP baseline survey of Baglung district, 24.44% of households are Dalits, and 52.55% Janajati, and compared to these figures, especially Dalits seem to be underrepresented in the CDP structures, which could be expected to have an impact on the extent to which they will ultimately benefit from the programme.

## 5.5 Sustainability

* Sustainability relates to the likelihood of the programme activities in some form continuing after technical and financial assistance has been withdrawn as well as improved health practices being sustained.

***Replication of the programme to new areas and sustaining activities in the target areas***

Both interventions have taken important measures in support of sustainability. As examples can be mentioned: The decision not to introduce financial incentives in the form of e.g. per diems to volunteers that cannot be sustained when funding ends; the creation of maintenance funds and involvement of beneficiaries in their own development; beneficiary contribution to e.g. toilet construction, water systems, washing platforms and ICS (this is however as discussed in section 5.2 not always positive from a vulnerability perspective). Some of the trained persons of the CDP, e.g. Plumbers and Toilet Constructors, receive a daily allowance, but as demonstrated in the phased-out district visited this is not necessarily a negative thing from a sustainability angle as it provides a financial incentive for the persons to continue their work.

The CDP, and to a lesser extent the HIV/AIDS project, rely significantly on Motivators, who receive compensation equal to approximately 40 USD per month. There is no systematic information regarding how many of these continue with RC activities after funding ceases, but it does not appear to be very many. Again, it is believed that a greater and more systematic utilisation of volunteers in awareness raising efforts would further contribute to sustainability.

The field visit to phased out districts revealed that the women groups continue to meet, which is very satisfying, and other structures, such as VCDCs and Water User Committees are also still functioning.

In the HIV/AIDS project, the visited school of the phased out district had not taken systematic provision to enrol new peer educators to replace old peer educators graduating/leaving the school. To sustain the momentum and ensure a critical mass of peer educators, who can also assist in passing on the learning to new members of the peer educator network, it is recommended to find out if this school is representative of all phased-out schools, and if this is affirmative, to address this issue.

***Sustainability of programme operations through internal funding mechanisms***

Helping chapters and sub-chapters to diversify their funding sources and to increase income generation is an important strategy of the programmes, and this has been done with some success allowing higher chapter activity levels especially in relation to emergency responses. Furthermore, the visited chapters/sub-chapters from the phased out areas exhibited a lot of motivation and energy. Their main frustration is that they want to do so many things, but lack the means, as explained by the chairperson of Chadani VDC of Kanchanpur: “*We want to do many things, but lack the money. If we could only provide tea and snacks we could do a lot more*”. It also appears that the chapters have not been overwhelmingly successful in replicating the activities in VDCs and schools outside of the programme target areas /schools, which is largely due to financial constraints.

# 6. An assessment of the justification for continuation of the partnership/existing projects beyond the current time frame (2009-2012) and recommend revising the programme activities and indicators to further ensure relevance, quality assurance and sustainability.

The analysis conducted in section 5, provides the main basis for assessing the justification for continuation of the existing project beyond the current timeframe including recommendations regarding any revisions. In addition the following section will reflect on the more general state and nature of the NRCS/NRC partnership primarily seen from the perspective of NRCS.

The partnership appears to be in a good state in terms of all the dimensions covered by the “RC/RC Code of Good Partnership” and the tool developed for assessing the partnership re RC/RC 8 NS Africa Initiative which in turn is based on the RC/RC Code of Good Partnership (Refer also to the VicHealth ‘Partnership Analysis Tool’). In the following a very brief analysis of the partnership will be conducted in relation to the themes of 1) equality and respect; 2) integrity; 3) transparency; 4) ownership, and 5) harmonization.

**Equality and respect** is about feeling being *equal* partners and honouring each other’s right or decision to act in certain ways and respecting the choices made. For example, do NRCS and NRC treat each other in the same way using the same standards, or do they have different standards that they apply to each other.

The partnership appears to be based on equality and respect. E.g. NRCS praised NRC for steering away from micro management, and generally having faith in NRCS’ suggestions and recommendations.

**Integrity** means both partners do what they say they will do and that they work in open, transparent and accountable ways.

The NRCS senior management praised NRC for being a “convenient” and listening partner, who is willing to think out of the box, and has enough flexibility to fund new types of activities. It was also stressed that this has sometimes led to new approaches being adopted on a much wider scale. E.g. the peer education approach in relation to HIV awareness largely came about through NRC support. Likewise, NRC has been pioneering NRCS efforts within human trafficking. Another example mentioned, was NRC’s support to the NRCS training center.

**Transparency** is about openly sharing information that is important for effective work. For example, sharing budgets, financial statements, records, and other plans that affect the partnership (e.g. other PNS plans for working in Nepal *or* NRC plans for increasing/reducing funding).

NRCS is aware that the funding support is beyond NRC’s control, but the uncertainty about future budgets makes it difficult for NRCS to plan effectively. E.g. at the time the evaluation mission took place, NRCS had still not been informed of the 2011 budget. However, NRCS also appreciated NRC for taking responsibility and personally assisting in explaining to target areas and beneficiaries about the reduced budgets described in more detail above.

**Ownership** is concerned with how much partners invest in and care about the work they do together. For example, fully participating in the planning, design and implementation of a new programme would suggest *high* ownership. Whereas, just being given a project to do without consultation would suggest *low* ownership.

NRCS feels that they are given ownership of the NRC funded interventions. NRC has no delegation in Nepal, which could be viewed as a reflection that NRC trusts the NRCS capacity to manage and implement activities. However, interestingly, NRCS requested for more communication and dialogue with NRC. E.g. it would be useful if NRC provided more input to the current discussions regarding the future of the CDP OA and the formulation of the sixth NRCS Development Plan.

**Harmonisation** is the shared acceptance of a common framework of operation objectives and indicators, standards, formats, systems, and procedures.

In relation to this it can be mentioned that NRC has generally not imposed any parallel structures or standards and that NRCS’s standards are leading, e.g. in relation to use of cost norms, salaries, per diems etc. As described above, the reporting is currently done according to parallel formats, due to the NORAD feedback regarding the CDP and HIV/AIDS project indicators. It would be useful if this parallel system could be eliminated or at least aligned better, so that common indicators are used.

Based on this generally healthy state of the partnership as well as the positive results of the CDP and HIV/AIDS project, it is recommended that NRC continues the partnership with NRCS beyond the current time frame (2009-2012). However, to promote increased performance, in particular in relation to effectiveness, efficiency and impact, it is advised to implement the recommendations arising from the analysis in section 5 in a continuation of the partnership (these include recommendation 1- 15 below). It is furthermore believed that some of the recommendations could already be addressed in connection with the next funding period (2011-2012) of the current timeframe (2009-2012).

# 7. Recommendations

This section identifies the recommendations that arise from the findings and lessons learned during the evaluation. They are generally presented in the order identified in the report narrative, and are presented according to whether they apply to the CDP, the HIV/AIDS project or are crosscutting.

***CDP Specific Recommendations***

1. Replicate some of the HIV/AIDS project’s mobility/migration strategies, especially those involving women groups, as women self-help groups also form a cornerstone of the CDP. Most areas of Nepal appear to be characterized by high levels of migration, which is closely linked to vulnerability both as cause and effect.
2. Take steps to embed the CDP within a more solid volunteer model in the future. This would involve concentrating the volunteer training effort on fewer people. At the moment the training approach appears slightly fragmented in the sense that many different people are trained in many different areas. It is believed to be more effective, if the same people would be trained in e.g. FA, health and sanitation and safe motherhood. It would furthermore be useful to spread the training into more, but smaller periods and provide refresher trainings at shorter intervals, and to provide volunteers with supportive materials and systematic guidance on how to share heir knowledge with other community members, e.g. something like the CBHFA volunteer manual. In addition it would involve building more of a volunteering spirit among the selected volunteers and improving the sub-chapters’ volunteer management capacity including setting up some structures and supporting mechanisms between sub-chapters and volunteers that can be sustained when there are no longer any paid staff assigned to the sub-chapter.

1. Disaggregate beneficiary data (according to wealth ranking, caste, ethnicity etc.) in relation to the CDP’s hardware component as well as in addition to women group members to further ensure the most vulnerable are being reached and sufficiently prioritized. Should there be indications that the poorest households are not sufficiently benefitting from this support, it should be considered to deviate from the financial self-contribution requirement in relation to this group and only request for contribution in terms of labour.
2. If funding allows, take steps to strengthen the saving/credit schemes of the women groups, e.g. try to pilot a bigger cash infusion from the project budget – with accompanying regulations, restrictions and technical advice - to a few women groups to test if this could generate more genuine empowerment and livelihood opportunities. As described above, the CDP is currently performing much stronger in relation to the programme’s health component compared to the results in relation to implementing sustainable livelihood activities, which are somehow disappointing.
3. Carefully analyze whether NRCS has the capacity, competency and comparative advantages to deliver in relation to a possible future agricultural/livestock based CDP component. The livelihood component is what really separates the CDP from ‘just’ being a health programme, but at the moment the NRCS HQs does not appear to have the technical capacity to systematically deliver in relation to agriculture and livestock-based livelihood development.
4. In future programme phases, it should be attempted to select project areas from some of the more vulnerable parts of Nepal as measured in e.g. socio-economic terms/district ranking of the National Planning Commission and VDCs with high needs in relation to access to water and sanitation. E.g. Manang and Mustang districts are performing rather well economically compared to other parts of the country.

***HIV/AIDS Project Specific Recommendations***

1. Attempt to more specifically target out-of-school youth in the project by also training out-of-school youth (age 10-24 years) as peer educators. If feasible it should be considered to also utilize Teacher Sponsors for this. Obviously training the out-of-school youth will be a lot more challenging, and the project will have to think carefully about the design, but it will make a lot of sense from a vulnerability and HIV/human trafficking risk perspective.
2. Strengthen the training curriculum/training materials for peer educators especially in relation to the human trafficking and social discrimination components and also provide peer educators with better supportive materials to assist them in conducting peer education in schools and in their respective local communities.
3. If the budget allows, develop a more systematic and comprehensive approach to care and support to PLHIV if possible in coordination with the HIV/AIDS programme of the NRCS Health Department and informed by the NRCS Global Alliance on HIV. This could involve training volunteers and/or women group member in home-based care, counseling and/or providing support to PLHIV on or about to start anti-retroviral therapy in relation to treatment literacy.
4. Promote continuous enrollment of new peer educators in the targeted schools to ensure that the initiative will not die out when the current batch of peer educators have left school.

***Crosscutting recommendations:***

1. Explore additional ways and means to further promote social inclusion also in relation to the programme/project management structures. E.g. it might be useful to conduct more community sensitization and advocacy on issues related to social discrimination before various project groups and volunteers are formed/selected to ensure better and more genuine inclusion and participation of marginalized. Likewise it should be considered to make a greater effort to include Dalits among the Motivators and peer educators, and if required deviate from the current selection criteria in relation to this group.
2. Provide RC volunteers with uniform (e.g. t-shirt) to promote RC visibility and image as well as RC spirit among volunteers.
3. Ensure consistency between various programme log frames, improve formulation of expected results, indicators etc. where required and improve the methodology regarding measurement of certain aspects of implementation in line with comment in section 5.2 above. E.g. for the CDP it is recommended to establish a more consistent M&E framework in relation to access to water, and a more systematic and transparent data collection methodology in relation to measuring community access to safe/improved water and sanitation. For the HIV project, it is recommended to improve the methodology regarding measurement of human trafficking as well as social discrimination capturing attitudinal as well as behavioural aspects of social discrimination.
4. Increase inter-departmental coordination at NRCS headquarter level in particular with the NRCS Health Department to ensure greater synergy and avoid duplication. Of course, coordination is a two-way process, and it is thus ultimately “everyone’s” responsibility that it will take place, but it would be useful if the NRCS senior management could provide more direction in this regard to ensure a better use of resources and reduced duplication.
5. In the future, when programmes/projects are being designed, make sure that no commitment is made to chapters/sub-chapters and communities until the actual funding is secured and confirmed to avoid disappointment among beneficiaries and RC chapters and to ensure that the funding is not overstretched on too many target areas.

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# 8. Conclusions

In conclusion the NRCS/NRC partnership is found to be relevant to the strategies and priorities of NRCS and NRCS, to be contributing towards overall national development objectives and to be responsive to the needs of vulnerable local communities. To further direct the response of the HIV/AIDS project it is suggested to work more directly with the out-of-school youth, and additionally it is recommended to also consider the issue of migration in the CDP.

In relation to effectiveness it is found that both the CDP and the HIV/AIDS project are largely contributing to the expected results being met. Both interventions have a very strong community-based approach, which promotes involvement of beneficiaries in their own development, and which appears to be paying off. However, in relation to the CDP the health component is performing much stronger compared to the activities related to livelihood and economic empowerment, while in relation to the HIV/AIDS project, more capacity could be built in relation to care and support of PLHIV and to develop a more sophisticated peer education model vis-à-vis out-of-school youth.

In terms of efficiency, especially the CDP has a very expensive set-up especially considering the relatively modest number of beneficiaries. As described in the report, the budget reduction has contributed to overhead/administration costs taking up a large proportion of the entire budget, but it is still advised to consider ways to channel more of the total budget into actual activities directly benefitting communities. For the CDP this should involve strengthening the programme’s volunteer model.

In relation to impact, understood as positive changes experienced by communities as a result of the programme interventions, both interventions demonstrate significant impact as measured in terms of e.g. increased awareness, changed practices, reduced morbidity, empowerment of youth, women, low caste etc. Related to the comment under effectiveness, the least impact appears to be made in relation to improving the economic status of vulnerable communities. Both the CDP and the HIV/AIDS project have taken many deliberate steps to include the most vulnerable, but it is still recommended to explore additional ways and means to further promote social inclusion also in relation to the programme/project management structures.

In terms of sustainability many sounds measures have been taken, and field visits to phased-out districts demonstrated that changed practices are generally sustained just as the majority of initiatives such as women groups and water user committees have continued after phase-out.

In relation to the NRCS/NRC partnership this generally appears to be very consolidated and healthy in terms of key dimensions of the RC/RC “Code of good partnership” such as equality and respect, integrity, transparency and ownership, and provides a good foundation for a continuation of the collaboration. However, it is recommended that NRC scales up its engagement in current discussions related to e.g. the CDP OA and the future NRCS development plan.

Based on the above factors it is recommended to continue the partnership beyond the current phase, but with modifications as per the recommendations above some of which can already be implemented in the next funding cycle (2011-2012).

# Annex 1A: Map of the CDP target areas

# Annex 1B: Map of the HIV/AIDS target areas

# Annex 2: Terms of Reference

**IMPACT EVALUATION**

**CDP AND HIV/AIDS PROGRAMMES IN NEPAL**

**FUNDED BY THE NORWEGIAN RED CROSS**

**• Background (Country specific background information)**

The Norwegian Red Cross (NorCross) has since 1988 been a partner to Nepal Red Cross Society (NRCS) in supporting the implementation of Community Development programme (CDP) in selected districts. Since 1995 an HIV/AIDS prevention programme has been added to the partnership and this programme has so far been implemented in 24 districts. In addition to these programmes, NorCross has supported different projects at NRCS HQ, co-funded the construction of the National Training Centre and a Youth Delegate exchange programme since 2006.

CDP

Nepal Red Cross (NRCS) has, since its inception in 1963, been involved in various community development activities in the area of Primary Health Care, drinking water, sanitation and youth activities. The Community Development Programme (CDP) was initiated in 1983 to uplift the quality of life for the target population in remote villages. Approaches and strategies of the programme and its implementation have been changed from 1996 based on the studies and evaluations carried out in between 1992 and 1995. A new system was hereafter introduced to conduct situation analysis and baseline survey before project implementation, focusing on participatory planning, implementation and monitoring and with in-built component of mid term and final evaluation. Project activities were implemented intensively within 2 to 5 wards of one Village Development Committee (VDC) with minimum external input with a view to replicating them locally. However, after the comprehensive assessment of community development programme model study in 2002, it was decided to implement the project activities in entire wards of one VDC or two considering the population size and geographical set up to further ensure local level coordination and partnership with line agencies like VDC, NGOs and local health posts etc.

HIV/AIDS

Since the first AIDS case was reported in 1988, the HIV epidemic in Nepal has evolved from a “low prevalence” to a “concentrated epidemic”. The majority of Nepal’s reported HIV infections were among the most productive part of society, i.e. from 25 to 39 age groups. Nepal has a large number of seasonal migrant workers who cross the border to India and this group was one of the most vulnerable groups. Accordingly the NorCross supported HIV/AIDS prevention project targeted the districts which were the main source of migrant workers.

TRAFFICKING

Trafficking was the second source of HIV/AIDS spreading in Nepal. Trafficking of women and children is a century long historical phenomenon in Nepal. Often it remained as a hidden crisis in the public eyes. The problem of trafficking has been brought to public attention because of the increasing number of young girls trafficked to India and other countries. Some reports claim that around two million Nepalese girls serve in the Indian sex industry, and many of them return back to Nepal being HIV infected. In 2006, the HIV/AIDS prevention programme also included an anti-trafficking component.

SOCIAL STIGMA AND DISCRIMAINATION

Social stigma and discrimination is wide spread throughout Nepal. People are discriminated based on caste, gender, religion, and diseases. Women, lower caste and the ethnic groups are underprivileged. Discrimination due to lack of knowledge is high in rural areas because of patterned social structure. Since the country was in the process of drafting a new constitution in 2009, ensuring rights of all groups, the HIV/AIDS programme included anti social stigma and discrimination component to empower the people so they can put their views/demands on wider social and political spectrum.

**• Objective**

This impact evaluation will be conducted to verify the overall efficacy and sustainability of the long term partnership between the Nepal Red Cross and Norwegian Red Cross. This will likewise form the basis to determine the next stage of the partnership.

The objectives for this impact evaluation are:

• To evaluate the relevance, efficiency, effectiveness, impact and sustainability of the partnership between the Norwegian Red Cross and Nepal Red Cross in general and the two projects in particular.

• To evaluate the justification for continuation of the existing projects beyond the current time frame (2009 - 2012) and recommend revising the programme activities and indicators to further ensure relevance and quality assurance.

• To evaluate justification for phasing out the existing projects and recommend modifications in modus operandi of the programme for the remaining time frame (two years, 2011 - 2012).

**• Scope of Work**

The impact evaluation will be conducted as a practical and pragmatic exercise, specifically looking at adaptability of approaches, process, methods and tools applied by the project(s). The evaluation shall examine the following key areas in the programme implementation:

• Review to what degree the resources/inputs (funds, expertise, time etc.) are converted to results/outputs?

• Assess the training courses provided to the staff and volunteers in terms of relevance and application in NRCS

• To review to which degree the NRCS District Chapter /Sub Chapter has been able / has capacity to replicate the programme to new areas and to sustain the activities in the target area.

• Review whether programme implementation methodologies have contributed to enhanced participation, accountability, non-discrimination and empowerment of different ethnic groups in the target area.

• Assess opportunities to ensure the sustainability of programme operations, which should focus on internal funding mechanisms.

• Review the coordination process between NorCross, NRCS HQ and District Chapters.

• Identify good practice or lack of the same in the partnership of NorCross and NRCS in the implementation of the programme.

**• Method of Work / Methodology**

Prior to the evaluation, the consultant(s) will study relevant materials of the programme.

A practical and participatory approach shall be applied throughout the exercise. During the field-visit, interaction and interview with the beneficiaries should be an important source of collecting information.

The following (though not limited to), key resource persons will meet with the evaluation team to look at organizational development issues and programme implementation as a whole:

NRCS Secretary General

NRCS Executive Director

NRCS CDP department Director, advisor and programme coordinators

NRCS Youth department Director, advisor, and programme coordinators

NRCS DC / SC Board members

NorCross programme Coordinator

Field visit will be made to:

• Banglung- existing CDP project, started in 2009,

• Kanchanpur - phased out CDP project (2005 – 2008),

• Lamjung- existing HIVAIDS project, started in 2009 and

• Nuwakot- phased out HIV AIDS 2005 – 2008).

**• Time Frame**

• The in-country mission will be a total of (13) days and will take place from 19.july 2010 till 5 August 2010, a total 19 days including domestic travel, preparation and reporting.

• The final report will be submitted to the NorCross and NRCS not later than 1 September 2010.

**• Output/Reporting**

The report (15 pages + annexes) will consist of three sections - executive summary, main report and annexes (if applicable).

Comments from NRCS and NorCross will be presented in a separate document and attached to the report.

**• Team Composition**

International consultant (team leader) working in collaboration with staff of the NRCS Community Development Department and Youth Department.

**• Documents available**

All NORAD annual applications and reports.

Annual plan of action as well as annual reports from Nepal Red Cross

All mid-term and final reports of the projects

Mission reports by programme coordinator from NorCross.

# Annex 3: Programme of the evaluation mission

**The Proposed Districts:**

1. HIV AIDS Programme: Lamjung (current) and Nuwakot(phased out)
2. CDP: Baglung(current) and Kanchanpur(phased out)

|  |  |  |
| --- | --- | --- |
| **Day/Date** | **Description** | **Estimated time** |
| **26 September** | Arrival to Kathmandu, Pickup by a RC Car at Airport (TIA) | **Not confirmed** |
| **Day 1**  27 Sep, 2010 | Meeting with CDP  Courtesy meeting with Secretary General and Executive Director of NRCS  Meeting with HIV AIDS Programme | 3 Hours  1.30 Hours  3 Hours |
| **Day 2**  28 Sep, 2010 | **Travel KTM to Baglung by Red Cross Car** | **8 hours drive** |
| Stay in a hotel at Baglung Bazar |  |
| **Day 3**  29 Sep, 2010 | Meeting with District chapter and stakeholders organizations | 2 hours |
| Travel to project area (Bhakunde VDC) and discussion/observation of project activities | Whole day |
| Night stay in the project area |  |
| **Day 4**  30 Sep, 2010 | Continue meeting and discussions in Morning in CDP Project area | 2 hours |
| Travel from Baglung to Lamjung district | 6 hours |
| Stay at Beshisahar: district headquarter |  |
| **Day 5**  1 Oct, 2010 | Meeting With Lamjung District chapter and stakeholders | 2 hours |
| Travel to Bhulbhule VDC by Red Cross Car | 1. hours |
| Meeting with Women group in Bhulbhule | 2 hours |
| Back to Lamjung Beshisahar and night stay in Beshisahar | 1 hour |
| **Day 6**  2 Oct, 2010 | Meeting with Male Group in Bharate at Dhoke | 2.30 hours |
| Saturday Second half off and night stay in Beshisahar | - |
| **Day 7**  3 Oct, 2010 | Meeting with PEs in a school at Kalimati | 2.30 hours |
| Travel Back to Kathmandu and Stay in Kathmandu | 5 hours |
| **Day 8**  4 Oct, 2010 | **Travel from Kathmandu to Nuwakot project community: Taruka** | **3 hours** |
| Meeting with Women Group in Taruka | 2 .30 hours |
| Stay at Bidur: district headquarter of Nuwakot |  |
| **Day 9**  5 Oct, 2010 | Meeting with District Chapter | 1.30 hour |
| Meeting and discussion in School | 2.30 hours |
| Travel Back to Kathmandu | 3 hours |
| **Day** **10**  6 Oct, 2010 | **Travel from Kathmandu to Kanchanpur, Mahendranagar KTM-Dhangadi - 1.25 hrs flight**  **Dhangadi to Mahendranagar 1hours drive** |  |
| Meeting with Kanchanpur District Chapter and stakeholders organizations and overnight stay at local hotel in Mahendranagar | 2 hour |
| **Day** **11**  7 Oct, 2010 | **Travel to CDP project area (Chadani VDC), field study, observations and discussions** | Whole day |
| Travel Back to Mahendra Nagar and Night Stay at local hotel in Mahendranagar |  |
| **Day** **12**  8 Oct, 2010 | Travel back from Mahendranagar to Kathmandu |  |
| **Day 13**  9 Oct, 2010 | Day off in Kathmandu (Saturday) |  |
| **Day 14**  10 Oct, 2010 | Debriefing meeting with concerned programme personals and NRCS management team |  |
| Farewell dinner (hosted by NRCS) |  |
| **Day 15**  11 Oct, 2010 | Travel back to Norway | Not confirmed |

# Annex 4: List of people consulted by the evaluation team.

*Nepal Red Cross Society*

* Mr. Dev Ratna Dhakhwa, Secretary General, NRCS.
* Mr. Pushpa Raj Paudel, Director, Community Development Department, NRCS.
* Mr. Bishnu Hari Devkota, Director, Junior and Youth Red Cross Department, NRCS.
* Mr. Indra Prasad Adhikari, Director, Communication and Humanitarian Values Department, NRCS.
* Mr. Saroj Shreshta, Manager, Community Development Programme, NRCS.
* Mr. Ramesh Kumar Paudel, Senior Officer, Community Development Programme, NRCS.
* Mr. Bipul Neupane, Programme Manager of HIV Prevention, Human Trafficking and Social Discrimination Programme, Junior and Youth Red Cross Department, NRCS.

*Norwegian Red Cross*

* Mr. Gideon Tesfai, Programme Coordinator for Asia, NRC headquarters.

*IFRC & PNS*

* Ms. Victoria Bannon, Federation Representative in Nepal
* Mr. Dries Goeminne, Representative, Belgium Red Cross
* Mr. Jørgen Kristensen, Representative, Danish Red Cross
* Mr. Marko Korhonen, Representative, Finnish RC

**CDP DISTRICTS**

**1. Baglung District:**

*DC Level*

* Mr. Ananta Khadka, Vice-chairperson of DC and other DC members.
* Mr. Ganga Bdr Shreesh, CDP Project Officer.
* Ms. Muna Maharjan, CDP Accountant.
* Ms. Manjari Khadka, CDP Field Supervisor.
* Ms. Ranmaya Adhikari, CDP Women Health Worker.
* Various stakeholders including VDC Secretary, District Water and Sanitation Sub-Division Office, District Women Development Office, District Education Office and local NGOs/CBOs.

*Bhakunde VDC*

* 4 SC Executive Committee members (4 male)
* 5 VCDC members (5 male)
* 6 CDP Motivators (6 female)
* Assistant Health Worker of sub-health post (female)
* 5 FA volunteers ((3 male/2 female)
* 9 Health and sanitation volunteers (2 male/7 female)
* 17 safer motherhood volunteers (17 female)
* 5 members of Water user committees (3 male/2 female representing 2 different committees)
* 7 representatives of women’s groups (7 female representing 6 different groups).
* 4 representatives of Cooperatives (4 different cooperatives represented)

**2. Kanchanpur District**

*DC Level*

* Mr. Keshab Dutta Panta, President of DC
* Mr. Tek Raj Uprety, Secretary of DC
* 7 other DC EC Members and staff (5 male/2 female)

*Chadani VDC*

* Mr. Ram Sing Makatara, President of SC
* 6 other SC EC members (4 male/2 female)
* Mr. Anand Prasad Bhatta, Secretary of VDC
* Assistant Health Worker of sub-health post (male)
* 13 representative of women groups (3 different groups represented)
* 1 previous CDP Motivator (female)
* 4 kitchen gardening promoters (3 male/1 female)
* 2 persons trained in ICS (male)

**HIV/AIDS PROGRAMME DISTRICTS**

**1. Lamjung District**

* Mr. Arjun Parajuli, Chairperson of DC and other DC members.
* Ms. Chandrakala Khadka HIV/AIDS Project Field Officer
* Ms. Bimala Paudel, HIV/AIDS Project Field Assistant
* Members of project steering committee.
* Various stakeholders including District Education Office, Senior Public Health Officer of Lamjung Hospital, District AIDS Committee, representative of positive network, District Women Development Office.
* 2 Motivators (female)
* 20 members of women’s group, Bhulbhule VDC
* Representatives of Bhulbhule SC Executive Committee
* 16 members of male group, Bharat VDC
* 21 peer educators from Bir Bhakti Higher Secondary School, Tarkhugay in Klimati VDC (9 male/12 female), Teacher sponser (male) and representatives of school management
* Representatives of Kalimati SC Executive Committee

**2. NUWAKOT DISTRICT**

* Mr. Ganesh K. Nepal, President of DC
* Mr. Shankar Amatya, Treasurer of DC
* Mr. Bharat Subedi, Secretary of DC
* Mr. Bishnu Nepal, Immediate passed President
* Dr. Ramesh Bikram Singh, Chief District Health Officer and DAC Focal person (male).
* Mr. Sadhuram Sapkosa, Trishuli Plus Hope Center.
* 15 members of women group in Taruka VDC
* 19 peer educators of Shree Bhairabi Higher Secondary School (7 male / 12 female)
* Mr. Shyam Sundar Shrestha, School Principal

# Annex 5: List of documents reviewed

*NRCS documents*

* NRCS Fifth Development Plan 2008-2010.
* NRCS Five Year HIV/AIDS Operational Plan, 2006-2010.
* NRCS Annual Report, August 2008-July 2009.
* NRCS CDP Annual Report (consolidated), 2009.
* CDP Operational Alliance Manual, September 2009.
* CDP Policy and Procedure Directive, including first amendment.
* CDP Joint Annual Review, Lessons Learnt and Planning Workshop – 2009, 9-11 November 2009.

*NRC documents*

* NRC International Strategy 2009-2014.
* NRC Framework for Asia 2010-2012.
* NRC Applications to NORAD for periods 2003-2005 and 2009-2012.
* NRC Revised indicator list to NORAD, 2010.
* NRC reports to NORAD for 2004, 2003-2005, 2006-2008, and 2009.
* NRC mission report for mission conducted 22.11-2.12.2008.
* “The Red Cross Transforming Local Communities in Nepal” (web story).
* “Youth Delegates Initiate Anti-Trafficking Program for Youth” (web story).

*Programme documentation*

* Cooperation Agreements between NRC and NRCS.
* Combined CDP and HIV&/AIDS Programme document for 2009-2012.
* External Evaluation of CDP, Kanchanpur District November/December 2008.
* Baseline Survey and Situation Analysis of Community Developmet Programme in Baglung District, 22 March 2009.
* CDP Progress Reports: 2009 Annual Progress Report, 2nd Quarter 2010 Progress Report.
* CDP 2009 and quarter 1 2010 financial statement.
* Final Evaluation of HIV/AIDS and Reproductive Health Programme, November 2004.
* Mid-term Evaluation of HIV Prevention and RH Programme and Anti-trafficking Initiatives, November 2007.
* Review and Need Analysis: Combating Trafficking in Women and Children, September 2006.
* Baseline Survey of 2009-2012 Enabling Youth to Combat HIV, Trafficking and Social Discrimination Project, January 2009 (covering all five target districts).
* 2010 Yearly Plan of Operation, Enabling Youth to Combat HIV, Trafficking and Social Discrimination Project.
* 2009 Estimation Budget and 2010 revised budget for Enabling youth to Combat HIV, Trafficking and Social Discrimination Project.
* 2009 audit report for Youth Delegate Programme and Enabling Youth to Combat HIV, Trafficking and Social Discrimination Project,

*IFRC documents*

* Strategy 2020.
* Characteristics of a Well-functioning National Society, 1995.
* A Common Approach to National Society Development, 2005.
* Code for Good Partnership, 2009.
* Standard for HIV Peer Education Programmes, 2009.

*Other documents*

* Timothy Powell-Jackson & Kara Hanson: Financial Incentives for Maternal Health: Impact Evaluation of a National Programme in Nepal, London School of Hygiene and Tropical Medicine, March 2010.
* HIV & AIDS datahub for Asia Pacific: HIV and Migration, Country Profile 2009: Nepal, [www.aidsdatahub.com](http://www.aidsdatahub.com).
* UNDP Nepal: Annual Report 2009.
* UNDP: Nepal Human Development Report: State Transformation and Human Development”, 2009.
* UNICEF/WHO publication “Core Questions on Drinking Water and Sanitation for Household Surveys”, 2006.

# Annex 6A: Summary of different CDP phases funded by NRC[[29]](#footnote-29)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **1st Phase** | **2nd Phase** | **3rd Phase** | **4th Phase** |
| **Name of programme** | Community Development Programme | Community Development Programme | Community Development Programme | Community Development Programme |
| **Time frame** | 1988-1995 | 1999-2003 | 2004-2008 | 2009-2010 with possibility of extending up to 2012 |
| **Budget (NPR)** | Not available | 26,156,991 | 42,800,761 | 18,758,185[[30]](#footnote-30) |
| **Actual spending (NPR)**  *Total in-country spending* | Not available | 24,113,370 | 42,631,088 | 18,758,185[[31]](#footnote-31) |
| **Target areas**  *Name of districts*  *Number of VDCs*  *Number of wards* | Morang  8 VDCs  72 wards | Myagdi  1 VDC  5 wards | Khotang and Kanchanpur  2 VDCs (1/district) | Banglung, Mustang and Manang  5 VDCs (1 in Banglung, 2 in Mustang and 2 in Manang)  45 wards (all wards of targeted VDCs) |
| **Target Group**  *Type and number* | Ethnic group and Bhrahman, Chettri and Dalits | Magar (ethnic group): 2,587 persons from 520 households  Dalits: 324 persons from 65 households | 22,717 persons from 3,820 households  Including: 3,250 Dalits from 532 households.  Rest: Bhrahman, Chettri and other ethnic groups | 7,201 persons from 1,364 households  Including: 764 Dalits from 145 households.  Rest: Bhrahman, Chettri and ethnic groups (especially Magars, Gurung and Thakali) |
| **Cost (NPR)/beneficiary** |  | NPR 8,284 per person | NPR 1,877 per person | NPR 2,605 per person |
| **Development objective/programme goal** | To fulfil the basic need of the targeted community | To develop the capacity of communities who constantly live in the situation where their socio- economic security and dignity are threatened and to achieve the reduction of their vulnerability primarily through improvement in health status and capacity building | To develop the capacity of communities who constantly live in the situation where their socio- economic security and dignity are threatened and to achieve the reduction of their vulnerability primarily through improvement in health status and capacity building | The basic health and economic condition of the most vulnerable communities in the target area are raised |
| **Specific project objectives** | Not available | 1. To increase the level of awareness and to improve the health condition of the most vulnerable people of the project area  2. To promote and built up the capacity of community organizations and NRCS institutions at all levels and make them self reliant | 1. To increase the level of awareness and to improve the health condition of the most vulnerable people of the project area  2. To promote and built up the capacity of community organizations and NRCS institutions at all levels and make them self reliant | 1. Preventive health practices of people of targeted area improved  2. Community people, especially women and marginalized groups, are economically and socially empowered |
| **Key characteristics of project implementation strategy** |  | - Only targeting selected wards of target VDC.  - Focus on women and children. | - Started including all wards within target VDCs.  - Focus on women and children. | - CDP Operational Alliance in place.  - Increased focus on “marginalised in addition to women.  - Sustainability measures from beginning  - Increased coordination and collaboration with related stakeholders organizations  - Higher focus on software activities |
| **Other funding partners of overall CDP during this period** |  | Swedish Red Cross through Federation, Belgium Red Cross, Danish Red Cross, Finnish Red Cross, One district chapter of Swedish Red Cross under twinning cooperation programme | Swedish Red Cross through Federation, Belgium Red Cross, Danish Red Cross, Finnish Red Cross, one district chapter of Swedish Red Cross under twinning cooperation programme | Belgium Red Cross, Danish Red Cross, Finnish Red Cross, Austrian Red Cross |

# Annex 6B: Summary of different HIV/AIDS project phases funded by NRC[[32]](#footnote-32)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **1st Phase** | **2nd Phase** | **3rd Phase** | **4th Phase** |
| **Name of project** | HIV Prevention and Reproductive Health | HIV Prevention and Reproductive Health | HIV Prevention and Reproductive Health | Enabling Youth to combat HIV, Human Trafficking and Social Discrimination |
| **Time frame** | 1995-1998 | 2000-2004 | 2004-2008 | 2009-2012 |
| **Budget (NPR)** | Not available | 30,502,305 | 40,333,753 | 18,755,621[[33]](#footnote-33) |
| **Actual spending (NPR)**  *Total in-country spending* | Not available | 28,595,176 | 40,341,806 | 13,367,877[[34]](#footnote-34) |
| **Target areas**  *Name of districts*  *Number of VDCs*  *Number of wards*  *Number of schools*  *Number of female/male groups* | Nawalparasi  Dang  Achcham  Dhading  Morang  Sunsari  Jhapa  (No. of schools unknown) | Bara  Rautahat  Surkhet  Dailekha  Gulmi  Arghakhachi  Rasuwa  (No. of schools unknown) | Taplejung  Bhojpur  Parsa  Dhading  Nuwakot  Bajhang  (240 schools, 20 VDCs, 78 groups) | Palpa  Myagdi  Lamjung  Sarlahi  Makwanpur  (85 schools, 11 VDCs, 99 female groups and 11 male groups.) |
| **Target Group**  *Type and number* | School youths | 150,000 school youths between12-24 years | 250,000 school and community youths between 10-39 years | 200,000 school and community youths between 10-39 years |
| **Actual beneficiaries**  *Type and number* | 250,000 school youths | 200,000 school youths | 230,000 school and community youth and community women | 46,000 (in 2009) |
| **Cost (NPR)/beneficiary** | Not available | 143/beneficiary | 175/beneficiary | 194 /beneficiary |
| **Development objective/programme goal** | To create supportive environment to keep young people safe from HIV/AIDS and improve their RH situation through promotion of self-esteems of adolescents/youths and strengthening institutional capability of the Junior/Youth Red Cross. | To improve HIV/AIDS and reproductive health situation and promote self-esteems of adolescents/youth through promotion of life skills, and strengthen institutional capacity of Junior/ Youth Red Cross | To improve HIV/AIDS and reproductive health situation and promote self-esteems of adolescent /youth and strengthen institutional development of Junior/Youth Red Cross | Young people are less vulnerable to HIV transmission, trafficking and social discrimination |
| **Specific project objectives** | Not available | Not available | 1. To promote adolescent/youth, and community women's access to information about HIV/AIDS, and reproductive health,  2. To promote communication skills among adolescent/youth, and women groups to empower them to play active role in social decision,  3. To build up institutional capacity of the Junior /Youth Red Cross and sub chapter though training and professional development activities.  4. To practice planning, monitoring, evaluation and transfer in to action. | 1. Reduce vulnerability to HIV and its impact among youth  2. Reduce human trafficking especially on women and children  3. Reduce the social discrimination, intolerance in the project communities  4. Strengthen the management capacity of NRCS to deliver sustainable response to HIV prevention, trafficking and social discrimination |
| **Key characteristics of project implementation strategy** | Peer Education  Junior/youth mobilization at school  Ensure sustainability  Coordination with stakeholders | Peer Education  Junior/youth mobilization at school  Ensure sustainability  Coordination with stakeholders | Peer Education  Community mobilization  Junior/youth mobilization at school  Ensure sustainability  Coordination with stakeholders; Anti-stigma campaign, human trafficking piloted in Samundratar VDC of Nuwakot.  High priority to women  Provision of positive awareness | Peer Education  Community mobilization  Junior/youth mobilization in school and community  Ensure sustainability  Coordination with stakeholders;  Anti-trafficking scaled up as a major component of project  Social discrimination included as a new component to address current social need  High priority to women, Dalits and ethnic groups  Provision of community based support to PLHIV-limited  Provision of positive awareness |
| **Other funding partners of overall HIV/AIDS programme during this period** | Swiss Red Cross, Centre for Economic Development and Population Activities (CEDPA) /Nepal, IFRC | Swiss Red Cross, Swiss Development Agency, CEDPA /Nepal, OPEC, GTZ | Swiss Development Agency, UNDP  British Red Cross, Global Fund | UNDP, Norwegian Youth Red Cross for human trafficking project |

# Annex 7A: Summary of Achievements for CDP current phase[[35]](#footnote-35)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity code** | **Activity related to output** | **Planned**  **2009-2012[[36]](#footnote-36)** | **Accomplished**  **2009 – June 2010** | **Budget**  **2009-2012 (NPR)** | **Spending**  **2009 – June 2010 (NPR)** | **Comments** |
| 1.1 | **Level of health & nutrition knowledge in community people increased** |  |  |  | 3308718.10 |  |
| 1.1.1 | Select and train 72 first aid Volunteers | 72 trained and retrained | 46 people (35 female and 11 male) trained for 4 days in basic first aid. Have delivered FA services to 124 injured persons. | 250,000 | 132,000 |  |
|  | Select and train health and sanitation volunteers | XX trained | 46 people (5 male and 41 female) trained. | 330,000 | 188,000 |  |
|  | Select and train 24 safer motherhood volunteers | 24 trained and retrained | Planned for third quarter 2010 | 50,000 | 0 |  |
| 1.1.2 | Train beneficiaries on promotion of kitchen garden and establish kitchen garden | 150 people trained and 1,000 kitchen gardens established | 61 people (58 female and 3 male) trained.  700 HHs have established kitchen gardens. | 150,000 | 55,870 |  |
| 1.1.3 | Conduct health education classes to local community by women health worker | 300 health education classes | 75 health education classes conducted to 931 women. | 75,000 | 66,000 |  |
| 1.1.4 | Conduct home visits including the printing and publication of home visit manual | At least 10 times/HH.  Design, print and publish hove visit manual. | 15 women motivators conducted 3,332 home visits (same house has been repeated multiple times). HQs produced a home visit manual. | 89,000 | 89,000 |  |
| 1.1.5 | Organize health volunteer meetings | 48 meetings | 15 meetings organised. | 132,000 | 88,000 |  |
| 1.1.6 | Collect /procure/print, publish/produce, and distribute appropriate IEC materials | Collect, procure, print, produce and distribute appropriate IEC and visibility materials in the community as well as in the district. | 800 calendars with different health, sanitation and hygiene massages distributed to HHs and 100 bag packs with RC Logo /150 t-shirts distributed to health volunteers and staff | 1,200,000 | 626,000 | Due to budget constraints, insufficient IEC materials are produced |
| 1.1.7 | Celebrate days/events at DC and community level | Celebrate FA, condom, AIDS day at community as well as at district level. | Total of 15 commemorations in all 3 districts, | 120,000 | 53,788 |  |
| 1.1.8 | Recruit, train and mobilize motivators | 15 female motivators (6 in Baglung, 5 in Manang and 4 in Mustang) | 15 female motivators recruited, trained and mobilised as per their job description. | 2,340,000 | 877,500 |  |
| 1.1.9 | Recruit, train and mobilize 3 women health workers (WHW) | Recruit, train and mobilize 3 WHWs | 3 already trained WHWs deployed and mobilized as per their job description | 3,100,000 | 1,132,560 |  |
| 1.1.10 | Creation of database of pregnant women | Create database of all pregnant women of project area and motivate them to visit health institutions at least four times for pregnancy check-up. | Database has currently identified 142 pregnant women.  98% have visited health institutions for regular check up as per the schedule. | 0 | 0 |  |
| 1.1.11 | Creation of database of children below two years | Create database of children below two years for monitoring the status of vaccination to them | 692 children below two years identified (356 girls and 336 boys) of which 623 children (312 girls and 311 boys) have been taking all doze of vaccinations on regular basis. | 0 | 0 |  |
| 1.2 | **The hygiene and sanitation situation of targeted community improved.** |  |  |  | 876,040.87 |  |
| 1.2.1 | Organize sanitation campaigns | Organize sanitation campaigns at community level on regular basis | 140 sanitation campaigns organised in separate clusters covering the entire project area.  2,400 female and 1,500 male participated actively. | 30,000 | 12,000 |  |
| 1.2.2 | Select and train persons for toilet and washing platform technician training | 9 persons trained | 9 persons (1 female and 8 male) trained and mobilized in the community | 150,000 | 61,876 |  |
| 1.2.3 | Install family toilets | Install 300 family toilets in all 3 project areas | 92 family toilets installed (including 13 through financial support of ACAP). | 1,500,000 | 415,389 | Due to budget constraints, project focuses more on partnership with other line agencies for resources sharing |
| 1.2.4 | Install washing platforms (including utensils drying stands, clothes drying strings) | Install 300 washing platforms including drying stand and cloth drying strings | 126 washing platforms installed (in partial support of CD project). | 400,000 | 112,675 | Same as for 1.2.3 |
| 1.2.5 | Collect NPR for sanitary units construction from beneficiaries | Collect NPR 150,000 from beneficiaries | NPR 30,446 collected by SCs and deposited in separate account. | 0 | 0 |  |
| 1.2.6 | Install metallic Improved Cooking Stoves | Install 150 metallic improved cooking stoves in partnership with relevant line agencies | 81 metallic improved cooking stoves installed in partnership with ACAP, DDC, VDC, and beneficiaries. | 450,000 | 242,600 | Due to budget constraints, project focuses fore on partnership with other line agencies |
| 1.2.7 | Train FS and WHW in community led total sanitation (CLTS) training | Train 1 FS and 3 WHWs in community led total sanitation approach | 1 project officer, 2 WHWs and 1 field supervisor trained (organized by CDP, HQs in Udaypur district). | 31,500 | 31,500 |  |
| 1.3 | **Access to drinking water of targeted community increased.** |  |  |  | 1,235405.18 |  |
| 1.3.1 | Identify and survey of feasible water sources | Identify all possible water sources to tap in the project area and | 12 water sources identified for the supply of which detailed survey was conducted to tap 10 number of water sources in the community | 0 | 0 |  |
| 1.3.2 | Form functional DWUCs |  | 10 DWUCs formed with 70 members (30 male and 40 female). | 0 | 0 |  |
| 1.3.3 | Conduct pre and post construction DWUC workshop | Conduct pre and post construction DWUC workshop for all members of DWUC prior to start construct of any drinking water schemes and after completion of schemes | Pre-construction DWUC workshop held with 48 participants. | 60,000 | 10,000 |  |
| 1.3.4 | Collect minimum 5% of maintenance fund form the water beneficiaries. | Collect minimum 5% of the total project cost of drinking water schemes from among the water beneficiaries. | NPR 15,000 collected and deposited in bank for future maintenance | 0 | 0 |  |
| 1.3.5 | Construct gravity fed drinking water schemes | Construct 5 gravity fed drinking water schemes to improve access to safe water facility for 150 HHs | 4 DW schemes (two in Baglung, one in Manang and one in Mustang) benefitting 66 HHs. | 2,000,000 | 899,991 |  |
| 1.3.6 | Collect water tariff regularly | Collect water tariff from water beneficiaries for the payment to water care takers on monthly basis | NPR 39,500 collected. | 0 | 0 |  |
| 1.3.6 | Train and recruit water technicians, water care takers field supervisor at district level | Train at least 10 persons as the water technicians per district and one person per one drinking water scheme | 10 water technicians trained in Baglung district and one female field supervisor recruited to look after all hardware activities of the project. | 900,000 | 325,414 |  |
| 2.1 | **Social discrimination and domestic violence in targeted community reduced.** |  |  |  | 41,016.00 |  |
| 2.1.1 | Conduct humanitarian value promotion orientation to reduce the discrimination based on cast, gender and ethnicity | Target at least 200 local people | 3 humanitarian value promotion trainings organised for 90 people. | 50,000 | 36,001 |  |
| 2.1.2 | Conduct women legal literacy orientations for persons. | Conduct women legal literacy orientations on regular basis. | 3 women legal literacy orientations to 72 women conducted. | 50,000 | 13,015 |  |
| 2.1.3 | Train 3 project officers on women and marginalized group empowerment on legal aspects training. | All 3 three project officers trained | 3 project officers participated in a 4-day training on women and marginalized group empowerment on legal aspects organized by CDP, HQs. | 31,600 | 0 |  |
| 2.2 | **Sustainable livelihood activities established focusing on women and marginalized groups.** |  |  |  | 236,341.00 |  |
| 2.2.1 | Conduct self-help group orientations for persons and form new self-help groups. | Conduct self-help group orientations to all self-help group members | 2 self-help group orientations to 71 group members conducted in Manang and Mustang districts. | 50,000 | 20,000 |  |
|  | Conduct meeting, sharing workshops and interaction sessions with active line agencies for linkage building, partnership and further collaboration. | Conduct a series of meeting, interaction sessions, and sharing workshops with active line agencies for linkage building, partnership and further collaboration. | 10 formal meetings, 3 sharing workshops and informal series of interaction sessions conducted. | 300,000 | 205,656 |  |
|  | Conduct saving and credit cooperative management training for group members. | Conduct saving and credit cooperative management training for all self-help group members. | 1 saving and credit cooperative management training organised in Baglung attended by 26 people (22 female and 4 marginalized). | 40,000 | 10,685 |  |
|  | Train self-help group member in life skill development trainings (Poultry, goat, pig, etc). | Train at least 25% of self help group members in life skill development trainining. | In the process of conducting different trainings in partnership with other concerned line agencies. | 100,000 | 0 |  |
| 2.3 | **Capacity of NRCS (subchapter, district chapter and national headquarters) and community organizations to implement and sustain a participatory, inclusive and transparent community based project enhanced.** |  |  |  | 5,237,091.95 |  |
| 2.3.1 | Form, orient and mobilize village community development committees in managing and implementing community development activities. | Form and orient 24 committees. | 24 community development committees formed (9 in Baglung, 10 in Mustang and 5 in Manang) with 216 members. | 41,406 | 41,406 |  |
| 2.3.2 | 3 project officers trained in planning, Implementation, Monitoring and Evaluation System (PIMES) training focus on indicators | 3 project officers participate in PIMES training focusing on indicators of all levels of objectives. | Planned for third quarter of 2010. | 27,500 | 0 |  |
| 2.3.3 | Conduct coordination meeting/workshop with active line agencies at community level. | Conduct at least 2 coordination meetings/workshops. | 9 formal coordination meetings conducted. | 200,000 | 80,353 |  |
| 2.3.4 | Conduct coordination meeting /workshop with active line agencies at district level | Conduct at least 2 coordination meetings in each district. | 12 coordination meetings conducted. | 200,000 | 80,353 |  |
| 2.3.5 | Purchase 3 mobile sets to three project officers | Purchase 3 mobile sets. | 3 mobile sets purchased | 30,000 | 29,000 |  |
| 2.3.6 | Purchase furniture, furnishing and office equipments for DC, SC and HQs level. | Purchase minimum furniture, furnishing and office equipments for 3 DCs, 5 SCs and HQs. | Minimum furniture, furnishing and office equipments purchased | 1,000,000 | 858,963 |  |
| 2.3.7 | Provide token support for the income generation activities of DC and SC | Provide token support to three district chapters and five sub chapters for the regular income generation activities | Token support provided to Baglung DC to start income generation building at district headquarters | 3,900,000 | 99,981 | Other DCs and SCs are in process of searching other funding partners to initiate this process. |
| 2.3.8 | Recruit and mobilize 3 project officers in 3 districts, 1 programme manager, 1 programme coordinator, 1 technical coordinator, and 1 driver at HQs level as per their job description. | Recruit and mobilize 3 project officers in 3 districts, 1 programme manager, 1 programme coordinator, 1 technical coordinator, and 1 driver at HQs level as per their job description. | NRCS CDP, HQs transferred 3, already trained, project officers (1 per district), 1 programme manager, 1 programme coordinator, 1 technical coordinator and 1 driver at HQs level. | 6,000,000 | 2,249,052 |  |
|  |  | Recruit, train and mobilize 3 accountants (1 in each district) as per their job description. | 3, already trained, accountants transferred. | 3,200,000 | 1,156,140 |  |
| 2.3.9 | Provide 50% basic salary to three messengers in three districts | Recruit or place 3 messengers (one in each district) | 3 messengers recruited. Project supports 50% of their basic salary. | 600,000 | 189,000 |  |
| 2.3.10 | Celebrate Nepal Red Cross and International Red Cross day | Celebrate Nepal Red Cross and international Red Cross Day by DC and SC every year separately. | All 3 DCs and 5 SCs have been celebrating Nepal Red Cross and International Red Cross Day. | 80,000 | 16,800 |  |
| 2.3.11 | Organize planning meeting at community level | Organize planning meetings at community level to prepare annual plan, activities and budget of each year. | Total of 45 planning meetings organised at ward level. | 150,000 | 68,009 |  |
| 2.3.12 | Organize quarterly review and planning workshop at DC/SC level | Organize at least 4 quarterly review meetings per district per year. | Total of 9 quarterly review meetings organised to date. | 600,000 | 330,000 |  |
| 2.3.13 | Organize annual review and planning work shop at DC/SC level | Organize 1 annual review and planning workshop per year per district at DC/SC level | Annual review and planning workshop held in each district | 750,000 | 26,000 |  |
|  | Participate in an annual review, lessons learnt and planning workshop at HQs level | Project officer, DC coordinator, sub chapter coordinators attend annual review, lesson learnt and planning workshop organized by CDP, HQs once a year | 3 project officers, 5 SC coordinators, 3 DC coordinators participated in workshop organized by CDP, HQs in 2009. | 180,000 | 0 |  |
| 2.3.14 | Organize district community development committee meetings with proper minutes. | Organize at least 6 community development committee meetings per year per district | Total of 17 meetings with proper minutes organised. | 90,000 | 12,035 |  |
| 2.3.15 | Form sub chapters | Form at least 12 new sub chapters in all 3 districts | 10 new SCs formed (3 in Mustang and 7 in Manang). | 0 | 0 |  |
| **2.4** | **Support provided to ensure the quality of programme** |  |  |  | **3087182.50** |  |
| 2.4.1 | Conduct internal annual evaluation | Conduct internal annual evaluations in all 3 districts separately to track the progress of all indicators of expected results and specific objectives and expected results. | CDP, HQs conducted internal annual evaluations through a survey in all three districts. | 120,000 | 20,000 |  |
| 2.4.1 | Conduct impact evaluation of Myagdi community development project (Phased out project) | Conduct impact evaluation of Myagdi community development project (Phased out in 2004) | Impact evaluation of three phased out community development projects including Myagdi CDP phased out in 2004 conducted (using external consultant). | 0 | 0 | The cost of impact evaluation was charged to other CDP partners |
| 2.4.2 | Conduct periodic audits | Conduct external common audit on annual basis | The project conducted external audit (Donor audit) recruiting an audit firm in consultation with all CDP partners | 200,000 | 88,352 |  |
| 2.4.3 | Conduct monitoring and follow up visits to project area | Conduct at least 4 monitoring visits by CDP, HQs to all 3 target districts and 6 visits by district team to project area | CDP, HQs visited all three project areas 12 times whereas the concerned district chapters visited their respective project areas 39 times in this one and half years period. | 1,200,000 | 574,432 |  |
| 2.4.4 | Administrative and logistic support | Provide necessary administrative as well as logistic support to all three district projects for the effective implementation of the planned project activities | Necessary administrative and logistical support provided. | 3,800,000 | 1,971,098 |  |
| 2.4.5 | Provide 5% management support cost to NRCS | Provide 5% of the total transferred fund from NRC to NRCS as the management support cost. | In 2009, NRCS collected NPR 432,800 as the management support cost from total of NPR  9,089,616 transferred from NRC to CDP, NRCS. | 3,000,000.00 | 432,800 |  |

# Annex 7B: Summary of Achievements for HIV/AIDS project current phase[[37]](#footnote-37)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity code** | **Activity related to output** | **Planned**  **2009-2012[[38]](#footnote-38)** | **Accomplished**  **2009 – June 2010** | **Budget**  **2009-2010** | **Spending**  **2009 – June 2010** | **Comments** |
|  | **1.1 Prevented further infection of HIV among youth of project communities by promoting life skills** |  |  |  |  |  |
| 1.1.1 | Interaction sessions in schools and communities | Organize 12,445 sessions in schools and 2,805 sessions in communities | 1,000 sessions in schools and 1,354 sessions in communities organized | 102,000 | 60,200 | Target is ambitious because project area has been reduced due to budget limitation; will revise target in review meeting 2010 |
| 1.1.2 | Letter writing to migrant workers | Reach 5,000 migrants by information package | 700 migrants reached by information package | 18,730 | 10,640 | Target is revised to 2,500 due to budget limitation |
| 1.1.3 | Marking events | Celebrate World AIDS Day, Condom Day, Candle Light Day, Junior Youth Red Cross Days - 80 events | 25 events celebrated | 115,000 | 78,304 |  |
| 1.1.4 | Organize competitions | 20 essay writing and 20 drawing competitions | 5 essay writing and 5 drawing competitions | 106,077 | 44,565 |  |
| 1.1.5 | Interaction with Journalists in Schools and Communities | 11 visits, once in a VDC | 2 visits conducted | 15,000 | - | Target revised to only 5 visits due to budget limitation |
| 1.1.6 | Organize life skills based HIV ToT to teacher sponsors | 5 trainings to train 100 teachers | 5 trainings conducted and 93 trainers trained | 336,062.5 | 335,704.5 |  |
| 1.1.7 | Organize refresher on life skills based HIV ToT to teacher sponsors | 5 trainings to refresh 100 trainers | 5 refresher trainings conducted for 93 trainers | 259,550 | 262,711 |  |
| 1.1.8 | Organize life skills based peer education training to youth in schools and communities | 130 trainings to train 2000 peer educators in schools and 600 peer educators in community | 85 peer education trainings conducted, 1600 peers trained | 863,586 | 854,867 |  |
| 1.1.9 | Organize refresher on Life skills based peer education training to youth in schools and communities | 130 refresher training to refresh 2,000 peer educators in schools and 600 peer educators in community | 84 refresher trainings out of 107, conducted and 1,600 peer educators in school and 220 PEs in community refreshed | 855,572 | 479,760 |  |
| 1.1.10 | Organize life skills based peer education training to women group members | 2 training in each VDC, 60 training organized and train 1,200 women members on PE | 11 trainings were conducted in 11 VDCs and 220 women group members were trained on PE | 145,328 | 146,728 |  |
| 1.1.11 | Organize refresher training on Life skills based peer education to women group members | 2 training in each VDC, organize 60 PE training for selected 1,200 women members | 8 trainings were conducted and 160 women group members received refresher training on PE | 151,867 | 112,267 |  |
| 1.1.12 | Organize condom demonstration sessions | Community women group members organize 10,000 condom demonstration sessions | 1,500 demonstrations organized | Budget not allocated |  | Needs to strengthen recording. May be this event is under reported because it is combined with information sharing |
| 1.1.13 | Information, Education and Communication Materials’ development, purchase, adaptation | **Developed:**  160,000 copies of Yuba Chautari, 5,000 copies of PE manual, 2,100 PE bags, 5000 badges, 15,000 PE diary, 5,000 letters to migrant workers, 1,500 pieces of penis model, 10, 000 copies of life skills manual; **Adopted:**  20,000 posters of two types and 600 flip-charts, **Purchased:**  500 manuals on anti-trafficking, 500 manuals on gender and 500 manuals on social inclusion) | 60,000 copies of Yuba Chautari, 2000 copies of PE manual, 9,800 copies of PE diary, 5000 letters to migrant workers, 500 pieces of penis model, 2,500 copies of pass book for women group members  Adopted: 5,000 posters (HIV and human trafficking)  Purchased: 25 manuals on anti trafficking | 1,182,000 | 868,660 | This budget line reduced with NPR 200,000 in 2010 to meet budget revision |
|  | **1.2 Extended support by communities to people living with HIV and AIDS** |  |  |  |  |  |
| 1.2.1 | Conduct positive awareness | Involve 25 HIV positive people for awareness raising in schools and communities | 10 PLHIV involved for awareness raising in school and communities | 85,000 | 13,000 |  |
| 1.2.2 | Develop/support for PLHIV network | One PLHIV network in each district | - |  |  | Not conducted due to budget limitation |
| 1.2.3 | Support to HIV positive and their families | 70 HIV positive people and their families | 5 Networks, 10 PLHIV and their family members supported from community groups and project | 85,000 | 13,000 |  |
|  | **2.1 Mobilized women to spread awareness against trafficking on women and children** |  |  |  |  |  |
| 2.1.1 | Mobilization of community women group | 120 women groups organize 2880 meetings in the project communities | 99 women groups organize 990 meetings in the project communities | Budget not applicable |  |  |
| 2.1.2 | Support to community women groups | 120 women groups received seed money for the group | 99 women groups received seed money for the group | 628,200 | 312,550 |  |
| 2.1.3 | Support to community male group | 30 male groups received seed money for the group | 11 male groups received seed money support | 39,600 | 2,000 |  |
| 2.1.4 | Organize street drama training to youth | 5 trainings to train 100 street drama performers | - |  |  | Not conducted due to budget limitation |
| 2.1.5 | Organize street drama refresher training | 5 refresher training to refresh 100 street drama performers | - |  |  | Not conducted due to budget limitation |
| 2.1.6 | Organize street drama shows | 400 street drama shows | 23 street drama shows organized | 94,500 | 45,000 | Target was revised due to budget limitation |
| 2.1.7 | Organize folk song competitions | 20 folk song competitions | 2 folk song competitions were organized | 10,385 | 3,385 | Target was revised due to budget limitation |
| 2.1.8 | Income generation initiatives | Based on need of most vulnerable communities | - |  |  | Not conducted due to budget limitation |
| 2.1.9 | Training to women group on legal provisions on trafficking | 5 trainings for selected 100 women group members | - |  |  | Not conducted due to budget limitation |
| 2.1.10 | Celebration of anti-trafficking day | 120 events in the project communities | 20 events in the project communities | 33,050 | 18,050 | Financial report yet to be received from districts |
| 2.1.11 | Door to door visit to aware households on anti-trafficking | 9,000 household visits |  | budget not applicable |  |  |
| 2.1.12 | Dissemination through NRCS radio program | 16 episodes | 4 episodes | 32,000 | 29,154 |  |
| 2.1.13 | Account keeping and group management training | 11 trainings for the group members | 9 trainings conducted 162 people trained | 151,631 | 92,454 | Activity was added in the plan after feedback from beneficiaries |
| 2.1.14 | Motivational materials (Identity) for group members | 1900 women group members | - | 396,000 | have to revised due to budget limitations | Activity was added in the plan after feedback from beneficiaries |
| 2.1.15 | Advocacy at local level | 25 advocacy sessions, five sessions in each districts | 11 advocacy sessions in communities | 11,000 | - | in 2010 only (target revised due to budget constraints) |
|  | 3.1 Reduced the incident of caste, gender, ethnicity and religion based violence |  |  |  |  |  |
| 3.1.1 | Orientation to school teachers and staff | 100 sessions | 34 orientation sessions in school for teachers and staff conducted | 69,964 | 69,964 |  |
| 3.1.2 | Advocacy at local level | 120 advocacy sessions at VDC level | 20 advocacy sessions at local level conducted | 23,000 | 20,000 |  |
| 3.1.3 | Organize non discriminatory camps | 120 camps | 11 non discriminatory camps were organized | 186,610 | 86,674 |  |
| 3.1.4 | Training on gender role and responsibility | 30 trainings | - | - |  | Not conducted due to budget limitation |
| 3.1.5 | Celebration of women’s day | 120 events at VDC level | 20 events were organized | 27,000 | 21,000 |  |
| 3.1.6 | Recruit Community Mobilizers to create awareness on HIV, trafficking and social discrimination | 1 Community Mobilizer in each project VDC | 11 community motivators were recruited and mobilized (1 community motivator in each project VDC) | 762,226 | 504,311 |  |
| 3.1.7 | Conduct door to door visit by Mobilizers to create awareness about caste, gender and social discrimination | 9,000 household visits | 2,600 person were visited during household visits | budget not applicable |  |  |
| 3.1.8 | Organize leadership training to women group members | 5 trainings to selected 100 women group members) | 3 trainings including 60 women group members | 100,800 | 43,200 | Target was revised from 5 trainings to 3 trainings due to budget limitation |
| 3.1.9 | Establish and operate community resource/information centres on HIV, Gender and social inclusion | 5 resource centers in centre point of project VDCs in each of the 5 project districts |  |  |  | Not conducted due to budget limitation |
| 3.1.10 | Dissemination through local FM radio |  | 50,000 |  |  | Activity was added in the plan after feedback from beneficiaries |
|  | 4.1 Improved project management capacity of NRCS units at all levels |  |  |  |  |  |
| 4.1.1 | Organize district chapter orientation | 20 orientation sessions | 10 orientation sessions conducted | 18,100 | 18,100 |  |
| 4.1.2 | Organize sub chapter orientation | 20 orientation sessions | 11 orientation session conducted | 16,290 | 16,290 |  |
| 4.1.3 | Workshop for coordination | 20 coordination meetings | 10 coordination workshop conducted | 47,417 | 46,457 |  |
| 4.1.4 | Annual review and planning and half yearly project staff meetings | 8 meetings | 4 meetings(2 annual and 2 half yearly) conducted | 490,415 | 418,735 |  |
| 4.1.5 | District Level Review Meeting (Schools) | 5 reviews | Planned for Dec. ‘10 | 72,000 |  | Added in 2010 |
| 4.1.6 | District Level Review Meeting (Communities) | 5 reviews | Planned for Dec. ‘10 | 63,750 |  | Added in 2010 |
| 4.1.7 | Support for District JYRC seminar | 20 district JYRC seminars | 5 JYRC seminar supported | 20,000 | 5,000 |  |
| 4.1.8 | Physical and equipment support to districts and HQs | 5 desk top computers, 1 laptop, 5 fax machines, 5 printers and connection charge of internet and email | 5 desk top computers, 1 laptop, 5 fax machines, 5 printers and connection charge of internet and email | 425,242 | 356,707 |  |
| 4.1.9 | Capacity building of staffs and volunteers | Participation in need based trainings, conferences and exposure visits | Community mobilization training for community mobilizers and field assistants | 369,000 | 368,876 |  |
| 4.1.10 | Consultant | Purchase consultant service based on need | Consultant not hired yet | - |  |  |
| 4.1.11 | Headmasters’ workshop | 20 workshops | 10 workshops conducted | 108,730 | 108,432 |  |
| 4.1.12 | Sustainability plan development workshop | 5 workshops |  |  |  | Will be conducted in fourth year |
| 4.1.13 | Incentive for Field Assistant | 5 Field Assistants recruited and mobilized | 5 Field Assistants recruited and mobilized | 531,355 | 437,355 |  |
| 4.1.14 | Salary and Benefits | 5 Field Officers at district and 6 staff at NHQs (Programme Manager, M&E, Training and IEC officer and Admin assistant and Account officer with 50% salary) | |  | | --- | | 5 Field Officers at district and 6 staff at NHQs (Programme Manager, M&E Officer, Training Officer, IEC Officer, Admin assistant and an Account officer with 50% salary) | | 7,216,292 | 5,325,162.96 |  |
| 4.1.15 | Project Support cost (stationery, communication, maintenance, hospitality etc.) |  |  | 1,073,365.40 | 839,212.36 |  |
| 4.1.16 | Management Support Cost |  |  | 1,011,204.90 | 420,676.94 |  |
|  | 5. Baseline, planning, monitoring and evaluations of project |  |  |  |  |  |
| 5.1 | Baseline survey | 1 baseline survey report | 1 baseline survey report | - |  | Was conducted from the budget of 2008 |
| 5.2 | Mid-term evaluation | 1 mid-term evaluation hiring external consultant after 18th month of implementation | Not planned in 2010 | 60,000 |  | Budget allocated for Impact Evaluation |
| 5.3 | Final evaluation | 1 final evaluation in the last quarter of implementation | - |  |  |  |
| 5.4 | Monitoring and supervision visits | 80 visits from Headquarters to districts and 80 visits from districts to communities | 20 visits from HQs to districts and 30 visits from districts to communities | 611,330 | 478,724 |  |
| 5.5 | Submit Progress  and Financial Reports | 16 quarterly and 4 annual progress reports + monthly financial updates and quarterly financial reports from project districts to NRCS HQs  16 quarterly and 4 annual consolidated progress + financial reports from NRCS HQs to NorCross | 6 quarterly and one annual progress report +18 monthly financial updates from project districts to NRCS HQs  6 quarterly and one annual progress reports + 6 quarterly financial reports from NRCS HQs to Norcross | - |  |  |

# Annex 8: Performance According to NORAD Indicators[[39]](#footnote-39)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Goal** | **Indicators** | **Target** | **Baseline** | | **Status as of 30 June 2010** | |
| **CDP** | **HIV/AIDS** | **CDP** | **HIV/AIDS** |
| The basic health and economic condition of the most vulnerable communities in the target area are raised | 1. Diarrhoea incidence rate among children (both boys and girls) under 5 in the target areas is reduced | Reduced by 10% | Not available |  | Not available |  |
|  | 2. Income of women in the target areas is increased | No target | Not available | Not available | Not available | Not available |
|  | 3. The marginalised groups’ (HIV+ and socially marginalised groups) awareness of their social rights in the target area (M/F) is increased | No target | Not available | Not available | Not available | Not available |
| **Expected Results** | **Indicator** | **Target** | **Baseline** | | **Status as of 30 June 2010** | |
| **CDP** | **HIV/AIDS** | **CDP** | **HIV/AIDS** |
| **1.** Access to water and sanitation services in the target area increased | **1.1** Access to safe drinking water facilities increased in the target areas | Access rate increased to 95% of the HHs | Not available |  | Not available |  |
|  | **1.2** % of HHs that have installed basic sanitary units (toilet platform, washing platforms and drying stands, garbage disposal pits etc.) | 95% of households | Not available |  | Not available |  |
|  | **1.3** % of the people in the target area that have attended health education , personal hygiene and safe water handling training | 75 % of the people | Not available |  | Not available |  |
| **2.** Awareness and practice on child nutrition and immunization in target area increased | **2.1** % of children (both boys and girls under 5 years) immunized in the project areas | 95 % of children under 5 | Not available |  | Not available |  |
|  | **2.2** Number of HHs having all season kitchen gardening increased | No target | Not available |  | Not available |  |
|  | **2.3** % of breastfeeding mothers for children under 2 years of age | 95 % | Not available |  | Not available |  |
|  | **2.4** % of mothers who have visited ANC centre at least 4 times during pregnancy increased | Increased by 75% | Not available |  | Not available |  |
| **3.** Women self-help groups developed | **3.1** % of women in the target area are trained in self-help strategies | 90% of women | Not available | Not available | Not available | 100% women group members are involved in saving activity. Out of 1900 group members 180 were received Account and group management training. |
|  | **3.2** % of self help groups members engaged in income generating activities | 70% of members | Not available | Not available | Not available | 20% of women group members are engaged on income generation taking loan from group fund. |
| **4.** RC district staff is trained in planning, implementation and monitoring of activities | **4.1** The district and sub-district RC have prepared an annual plan | No target | Not available | Not available | Not available | All Red Cross district chapter and sub chapter, Junior Red Cross Circles even group facilitated by the project developed their work plan. |
|  | **4.2** Number of female membership and representation in the board increased | No target | Not available | Not available | Not available | 100 women received membership of Red Cross (ordinary + life) throughout the project districts and engaged in RC services |
|  | **4.3** Number of RC volunteers trained each year on combating social discrimination, human trafficking and FA | 100 per year | Not available | Not available | Not available | 109 RC volunteers trained on combating HIV, social discrimination and human trafficking |
|  | **4.4** RC district branch and sub branch have secured funding for their activities through income generating activities | No target | Not available |  | Not available |  |
| **5.** Knowledge of HIV mode of transmission, consequence of human trafficking and social discrimination in the target area increased | **5.1** % of young people (boys and girls) who know the four modes of HIV transmission increased[[40]](#footnote-40) | No target |  | 13% |  | 29% (as of December 2009) |
|  | **5.2** Number of women who have been reached with information on human trafficking and its consequences is increased[[41]](#footnote-41) | No target |  | 22% |  | 40% (as of December 2009) |

# Annex 9: Guidelines for interviews, FGDs and survey

**1. Question guide to NRCS HQ staff and governance**

**Introduction**

Introduce the evaluation process, and explain the input from NRCS HQ is very important in relation to shaping the future support from NRC to NRCS

**Background information of person interviewed**

1. Position?
2. How long have you been in your current position?

**Partnership**

1. How would you describe the partnership between NRCS and NRC?
2. What are its strengths?
3. What are its limitations?
4. How is the NRC support valuable to NRCS? Can you name the most important changes as a result of the NRC support?
5. Does NRC work differently from other PNS partners? How?
6. Do you see a continued need for NRC support? Same/new focus (geographically, sector wise etc.)?
7. How would you like the partnership to evolve beyond the current programme cycle (2009-2012)?
8. From your perspective what is the added value of NRC as a partner?

**General project/management set-up**

1. Please describe the organisational and management structure of the NRC funded projects. Does it differ from your partnership with other PNS / partners?
2. From your perspective, have their been any changes in the NRC modus operandi in Nepal over time?
3. How have the NRC funded projects evolved over time? E.g. any changes in strategy or methodology, management set-up or focus?
4. How were the project target areas selected?

**NRCS Strategy/Policy:**

1. Will there be any change in the strategic focus of NRCS in the next development plan?
2. Do you have any vision in relation to working with vulnerable populations in urban settings?
3. What are the biggest challenges faced by NRCS?
4. What do you consider the biggest risk factors?

**2. Question guide to NRCS CD/SC staff/governance involved in current CDP / HIV/AIDS projects**

**Introduction**

Introduce the evaluation process, and explain the input from chapter staff is very important in relation to shaping the future support from NRC to NRCS.

**Background information**

1. Position?
2. How long have you been in your current position?
3. Funding support from other partners in this district/VDC?

**General project/management set-up**

1. What is the link between NRCS HQ and the DC/SC in relation to the CDP / HIV/AIDS projects?
2. Have you been involved in the project design? How?
3. How is the project delivered?
4. Describe the chapter level M&E system?
5. Would you like to suggest any changes in how the project is managed?
6. How are women represented in this chapter? (in chapter/sub-chapter EC, Project Committee, among staff, volunteers etc.)
7. How are ethnic minorities and marginalised groups represented in this chapter?

**The Work of the Programme**

1. How relevant is the work of the Program in Nepal today?
2. Are the activities relevant to the needs of communities (i.e. what is the empirical evidence that justifies the activities being undertaken)?
3. How is that evidence gathered? Is it reliable?

**Project activities**

1. What do you do to meet each of the project objectives (2 for CDP project and 4 for HIV/AIDS project)?
2. What challenges do you face in your work?
3. What challenges do you face working with each ‘group’ (e.g. youth/out-of-school youth, women, marginalised, PLHIV)?
4. How do you know you have increased the knowledge and response abilities of target groups?
5. What changes have occurred as a result of the project?
6. What still remains to be achieved?
7. *For CDP:* How do you test the water quality? Do you have any problems with arsenic? If yes, how are you addressing this?
8. What recommendations do you have for improving project activities in future?

**Capacity Building:**

1. What capacity-building support have you received?
2. What challenges do you face in doing this work?
3. What TA do you receive to help you in your work?
4. How is the work of RC volunteers organised and managed?
5. For *HIV/AIDS Project:* How are peer educators / teacher sponsor selected?
6. Do you have any problem with retention of volunteers? If yes, what could be done to change this?
7. Has your chapter/sub-chapter improved in relation to income generation? How much of your income generation is allocated to activities? How much is used on administration?

**Support/Services to local communities:**

32. How are members of various groups selected (E.g.. women’s groups, water user groups)?

33. For CDP: How are beneficiaries of support (e.g. water system, sanitation facilities etc.) selected?

34. Do you disaggregate beneficiary data according to caste/ethnic/socio-economic status?

1. What project activities do you find most useful to local communities?
2. Have there been any project activities that you have found not very useful?
3. Do you have any stories about how RC has improved the life of people at grassroots level?

**Future sustainability**

1. Could you summarize what you consider to be the impact of the NRC support to NRCS from the perspective of your Chapter?
2. What do you think will happen to this DC/SC when the NRC funding ends?

**3. Question guide to NRCS chapter/sub-chapter governance/staff from phased out CDP/ HIV/AIDS programme areas**

**Background information:**

1. Position?
2. How long have you been in your current position?
3. Funding support from other partners in this district? Since when?

**General management set-up:**

1. Has your relationship to NRCS HQ/chapter changed after the project ended?
2. Have you continued with an M&E system after the project ended? Describe.
3. Would you like to make any recommendations in relation to how the project was managed?
4. How are women represented in this district chapter? (in chapter/sub-chapter EC, Project Committee, among staff, volunteers etc.)
5. How are ethnic minority and marginalised groups represented in this district chapter? (in chapter/sub-chapter EC, PC, among staff, volunteers, women’s groups, water user groups etc.).

**Project activities/Impact:**

1. Which of the project activities have been most effective?
2. Which of the project activities have been least effective?
3. What changes have occurred as a result of the project?
4. What still remains to be achieved?
5. Replication of activities to other VDCs?

**Capacity building:**

1. What capacity-building support did you receive?
2. What TA did you receive to help you in your work?
3. Was it adequate?

**Sustainability**

1. Can you summarize the situation in this chapter / sub-chapter after phase out of the CDP / HIV/AIDS project?
2. Which activities have you managed to continue?
3. Which activities have you not managed to continue?
4. How many of the Drinking Water User’s Committees / women SHGs / PE activities created through the CDP / HIV/AIDS project are still functional?
5. What is the status of the maintenance fund/how is it used?
6. Do you have the same number of volunteers as before? (Safe motherhood, health & sanitation, TBA, FA, toilet construction masons)
7. Have you managed to sustain the positive results (e.g. in relation to health, access to water and sanitation, changed practices, reduction of social discrimination, reduction of trafficking etc.)?

**4. Question Guide for group discussion with beneficiaries (men/women group etc.)**

**Introduction**

Introduce the evaluation process, and explain the input from the communities where we work is crucial for the NRCS to be able to make the work we do in the future stronger. Also stress that it is voluntary to participate and that information provided in the session will not be traced back to individuals.

**General**

1. What do you know about the CDP / HIV/AIDS project?
2. Who gets involved in RC activities in the community? Who doesn’t? (men/women/dalit etc.)

**Impact**

1. Describe the situation in your community before the CDP / HIV/AIDS project started.
2. Has the program helped improve your life in any way? If so how?
3. What difference has it made to the way you behave? Please explain.
4. What recommendations do you have to further improve the situation of the vulnerable / ‘at risk’ groups in your community?

**Sustainability**

1. Do you think that the programme activities will continue without NRCS funding support?
2. What are your plans for maintaining the water supply in the future?

**5. Question Guide for group discussion with Red Cross Volunteers & Group Members (VCDC members; FA volunteers, Safer Motherhood volunteers; Health and Sanitation volunteers; Water User Committee members; Toilet Constructors; Drinking Water Technician/caretakers; kitchen gardening promoters)/women group members/male group members/peer educators.**

**Introduction**

Introduce the evaluation process, and explain that input from RC volunteers is crucial for the NRCS to be able to make the work that we do in the future stronger.

1. Why and when did you become a volunteer/member of group/peer educator?
2. How much time do you spent on RC activities? (days per month or year).
3. What type of training have you received?
4. How do you work (e.g. alone or in team)? For Male / Women group members /PEs: How often do you meet, and how do you operate?
5. Characteristics of groups/PEs/volunteers in relation to age, gender, ethnicity, cast etc.
6. How are you supported by the RC chapter/sub-chapter? Would you continue without this support?
7. Is there any other support you would like from the chapter/sub-chapter or the RC project team?
8. How do you know if the community is happy with the work you are doing?
9. Being a RC volunteer, what are the good things and what are the challenges?
10. Tell a story about how you have improved the life of people in the community?
11. Do you see any unmet needs in your community that you think NRCS should address?
12. Do you have any suggestions for how NRCS can support you in the future?

**7. Peer Educator /Women group/Male Group (only HIV/AIDS project) Survey**

Please tick the answer you think is correct –– yes, no, or don’t know:

YES NO DON’T KNOW

1. Can a woman get HIV by having sex with a man?
2. Can a man get HIV by having sex with a woman?
3. Can a man get HIV by having sex with another man?
4. Can you get HIV the first time you have sex?
5. Can a person get HIV through mosquito bites?
6. Can a person get HIV by sharing needles?
7. Can a healthy looking person be HIV positive?
8. If a woman with HIV is pregnant, could her baby

become infected with HIV?

1. Is there a cure for HIV/AIDS?
2. Can you get infected by sharing food with someone with HIV?
3. Can you get HIV by sharing the same toilet as someone with HIV?
4. Do you think a teacher, who is HIV positive, but not sick,

should be allowed to continue teaching in school?

1. Would you buy food from a vendor, whom you knew were HIV positive?
2. If you got infected with HIV would you be willing to tell others?
3. Is there anything that a person can do to avoid getting HIV?
4. Does using condoms during sex prevent HIV transmission?

*For Peer Educators only*:

1. Please name all the modes of HIV transmission you know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Annex 10: Results of survey

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Women’s Group, Lamjung (N=24) | | | Male Group, Lamjung (N=15) | | | Peer Educators in Lamjung (N=20) | | | Women’s Group, Nuwakot [[42]](#footnote-42)(N=15) | | | Peer Educators in Nuwakot (N=19) | | |
|  | Correct / tolerant  answer | Incorrect / intolerant  answer | Don’t Know/No answer | Correct/ tolerant | Incorrect /intolerant | Don’t Know | Correct/ tolerant | Incorrect /intolerant | Don’t know | Correct/ tolerant | Incorrect/ intolerant | Don’t know | Correct / tolerant | Incorrect /intolerant | Don’t know |
| Can you get HIV the first time you have sex? | 46% | 50% | 4% | 40% | 60% | 0% | 100% | 0 % | 0% | 40% | 40% | 20% | 26% | 68% | 5% |
| Can a person get HIV through mosquito bites? | 83% | 13% | 4% | 100% | 0% | 0% | 5 % | 95% | 0% | 73% | 7% | 20% | 63% | 37% | 0% |
| Can a person get HIV by sharing needles? | 88% | 4% | 8% | 93% | 7% | 0% | 100% | 0% | 0% |  |  |  | 100% | 0% | 0% |
| Can a healthy looking person be HIV positive? | 92% | 4% | 4% | 100% | 0% | 0% | 100% | 0% | 0% | 80% | 7% | 13% | 84% | 16% | 0% |
| Can you get infected by sharing food with someone with HIV? | 71% | 21% | 8% | 100% | 0% | 0% | 95% | 0% | 0% |  |  |  | 0% | 100% | 0% |
| Can a HIV positive mother pass on HIV to her baby? |  |  |  |  |  |  |  |  |  | 54% | 13% | 33% |  |  |  |
| Is there a cure for HIV/AIDS? |  |  |  |  |  |  |  |  |  | 86% | 7% | 7% |  |  |  |
| Would you buy food/vegetables from a vendor, whom you knew was HIV positive? | 96% | 4% | 0% | 100% | 0% | 0% | 100% | 0% | 0% | 80% | 13% | 7% | 84% | 5% | 11% |
| Would you eat with together with a PLHIV? |  |  |  |  |  |  |  |  |  | 73% | 20% | 7% |  |  |  |
| Does using condoms during sex prevent HIV transmission? | 92% | 4% | 4% | 100% | 0% | 0% | 100% | 0% | 0% |  |  |  | 89% | 11% | 0% |
| If you got infected with HIV would you be willing to tell others? |  |  |  | 86% | 7% | 7% | 100% | 0% | 0% | 73% | 13% | 13% | 95% | 5% | 0% |
| Have you ever invited a Dalit inside your home? | 58% | 42% | 0% | 100% | 0% | 0% | 100% | 0% | 0% | 7% | 80% | 13% | 84% | 11% | 5% |
| Is a woman taking a job in another country in risk of trafficking? | 71% | 4% | 25% | 100% | 0% | 0% | 100% | 0% | 0% | 73% | 0% | 27% | 100% | 0% | 0% |
| Please name all the modes of HIV transmission you know:[[43]](#footnote-43) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| - 4 correct |  |  |  |  |  |  | 90% |  |  |  |  |  | 52% |  |  |
| - 3 correct |  |  |  |  |  |  | 5% |  |  |  |  |  | 32% |  |  |
| - 2 correct |  |  |  |  |  |  | 5% |  |  |  |  |  | 11% |  |  |
| - 1 correct |  |  |  |  |  |  | 0 |  |  |  |  |  | 5% |  |  |

1. Only the CDP and the HIV/AIDS project are within the scope of this evaluation. [↑](#footnote-ref-1)
2. UNDP 2009 Annual Report, p. 52. [↑](#footnote-ref-2)
3. E.g. in August 2008, the Koshi river breached its embankment flooding large areas of Sunsari district displacing 42,800 people. [↑](#footnote-ref-3)
4. [www.wikipedia.com](http://www.wikipedia.com) & UNDP, Nepal Human Development Report 2009. [↑](#footnote-ref-4)
5. As stated in the 2009 UNDP Nepal Human Development Report on the reasons for discrimination and exclusion: “*For women the chief obstacle to human development is patriarchal society; for Dalits, it is the hierarchal caste-based system; for the Janajati, it is identify, culture and resources; for Madhesi it is language and regional autonomy; while for people of the Mid-West, it is paucity of resources closely bound up with their deprivation of physical connectivity to better-developed areas*”, p. 21. [↑](#footnote-ref-5)
6. The data in this paragraph is from The World Bank, Nepal Country Overview 2010 & UNDP, Nepal Human Development Report 2009, Table 2.5 and Table 4.5. [↑](#footnote-ref-6)
7. HIV & Migration, Country report: Nepal 2009, www.aidsdatahub.org. [↑](#footnote-ref-7)
8. NRCS initiated the CDP in 1983 through Swedish RC support. [↑](#footnote-ref-8)
9. According to the IFRC representative in Nepal this support from Swedish RC will however phase out at the end of 2010. [↑](#footnote-ref-9)
10. Annex 6B provides more information regarding the different phases. [↑](#footnote-ref-10)
11. Originally the evaluation was planned for July 2010, i.e. in the middle of the monsoon season. [↑](#footnote-ref-11)
12. There are 5 Motivators per district, who are paid a daily allowance, and somehow fall in between volunteers and professional staff. [↑](#footnote-ref-12)
13. Regarding the training in safe motherhood, the CDP is largely training the government nominated Female Community Health Workers, who gets 3,000 NPR from the government/year. This approach avoids duplication and adds to already existing capacity. [↑](#footnote-ref-13)
14. E.g. not being aware of the importance of hand washing for good health, believing the first breast milk (colostrum) is bad for the baby and believing that wounds should be treated with soil. [↑](#footnote-ref-14)
15. The number of Dalit households in Baglung district has been taken from the baseline report. [↑](#footnote-ref-15)
16. UNDP: “Nepal Human Development Report: State Transformation and Human Development”, 2009. [↑](#footnote-ref-16)
17. It should be considered to deviate from the current educational requirement in relation to Dalits, if this requirement constitutes a barrier for the recruitment of Dalit Motivators. [↑](#footnote-ref-17)
18. E.g. the three women groups consulted in the phased-out VDC/district had only managed to raise 35,000 – 42,000 NPR each. [↑](#footnote-ref-18)
19. E.g. in Kanchanpur DC, the CDP contributed 900,000 for the construction of a building, which is currently generating 7,500 NPR/month in rent, i.e. it will take 10 years not considering maintenance costs before the income equals the CDP contribution. The income is spent on humanitarian relief and health campaigns. [↑](#footnote-ref-19)
20. According to the IFRC HIV Peer Education Guidelines of 2009, a peer can be defined as: “a member of a group of people sharing the same characteristics. For example, people of the same age and background, or who do the same kind of work, have the same or similar lifestyle, experience or beliefs. The more a peer has in common with the person they interact with, the more likely that person is to receive the messages and be influenced”. [↑](#footnote-ref-20)
21. E.g. in the women group consulted in Lamjung, no members were below 20 years, only five of the 20 members were between 21- 25 years, eight were between 26 and 35 years, while seven were above 35 years. [↑](#footnote-ref-21)
22. 11 of the 20 male group members were previous migrants, while 14 of 20 members of the women group in Lamjung and 10 of 18 members of the women group in Nuwakot had migrating spouses. [↑](#footnote-ref-22)
23. The last column of Annex 7B, provided an overview of the activities that have been reduced or cancelled due to budget limitations. [↑](#footnote-ref-23)
24. The women group consulted has thus assisted 7 PLHIV to get ART, and the savings scheme of the group contributes towards transport of PLHIV to travel to Kathmandu for ART. The group also support an orphan girl living with HIV in relation to food, stationary and psycho-social support. [↑](#footnote-ref-24)
25. E.g. in the school visited in Lamjung the Junior/Youth RC circles had been almost revitalised as a result of the HIV/AIDS project, and had also started sanitation activities. [↑](#footnote-ref-25)
26. E.g. two of the current NRCS department heads started their careers in the Youth Department. [↑](#footnote-ref-26)
27. Possible questions to marginalised sample: In the last X months, have you [fill in from list below] because of your gender/caste/ethnic status? A) Been excluded from a social gathering; B) Been verbally abused or teased; C) Been physically assaulted; D) Had property taken away; E) Been denied any government services; F) Been invited into someone’s home from a different caste/ethnic group. [↑](#footnote-ref-27)
28. Most probably the government’s Safe Delivery Incentive Programme (SDIP) initiated in 2005, which provides cash incentives to women conditional on them giving birth in a government health facility and financial incentives to health workers attending the deliveries at the facility or at home, has also contributed to this development. [↑](#footnote-ref-28)
29. The information in this table has been inserted by NRCS, and not all the information has been independently verified by the consultant. [↑](#footnote-ref-29)
30. 2009-2010 budget [↑](#footnote-ref-30)
31. Expected spending for 2009-2010 [↑](#footnote-ref-31)
32. The information in this table has been inserted by NRCS, and not all the information has been independently verified by the consultant. [↑](#footnote-ref-32)
33. For period 2009-2010. [↑](#footnote-ref-33)
34. For the period January 2009-June 2010. [↑](#footnote-ref-34)
35. The information in this table has been generated from the internal M&E system of the programme. [↑](#footnote-ref-35)
36. The information reg. planned activities and budget are as per revised total activity plan and budget after NRC communication of actual NORAD grant, which was only approximately 75% of the amount applied for. [↑](#footnote-ref-36)
37. The information in this table has been generated from the internal M&E system of the project. [↑](#footnote-ref-37)
38. The information reg. planned activities and budget are as per revised total activity plan and budget after NRC communication of actual NORAD grant, which was only approximately 75% of the amount applied for. [↑](#footnote-ref-38)
39. The information in the table has been generated from the M&E systems of the programme/project. [↑](#footnote-ref-39)
40. The data for indicator 5.1 and 5.2 has been generated from a survey involving 5 schools and 5 women groups in each target district carried out by project staff. [↑](#footnote-ref-40)
41. The baseline/status figures refers only to women who are part of the women groups, and not women as a whole. [↑](#footnote-ref-41)
42. The consultant had forgot to bring the questionnaire to the women group in Nuwakot, and the members of this group were therefore asked a slightly different set of questions. [↑](#footnote-ref-42)
43. The following misconceptions were expressed in survey: HIV can transmit through mosquito bites (1 person) and through masturbation (1 person) [↑](#footnote-ref-43)