Strategy Karuna Foundation 2011-2013

On the basis of the experiences over the past 3 years, of the lessons in India and the discussions from 16-18 January 2011 (Rene aan de Stegge, Toon Kasdorp, Deepak Raj Sapkota, Yogendra Giri and Betteke de Gaay Fortman) we developed a new long-term strategy in summary for Karuna for the coming years. This strategy has also been discussed among the Nepalese team and agreed by all staff members.

We decided to work with 2 different scenarios in the coming years:

- Consumers/complementary approach under Share&Care, and the
- Prevention/rehabilitation strategy (VDRC/ToP) without Share&Care.

For more details on costs, sustainability, outcome, please refer to the Excell file (Final Overview Strategies.xls).

Following are in summary and headlines the most important strategy issues to be addressed and implemented.

1) We will continue **Share&Care** in the existing 6 Village Development Committee (VDCs)s with an improved structure **(Consumers Committee/Complementary approach):**

    a. A consumer committee (Share & Care Consumers Committee) will be formed to organize the people. One program coordinator will be appointed among them to lead the process, and take responsibility for membership, prevention, rehabilitation and other components of Share&Care. The leader/S&C Committee has no direct control on the governmental health services, but as clients/users they can strongly influence and put pressure to the health service delivery. This consumers group will feel responsible and accountable for the health service delivery. They will decide whatever they think necessary to improve the provision of health services.

    b. As a matter of principle, one person can't be member of both the Health Facility Management Committee (HFOMC) and the Share&Care Committee at the same time.

    c. User groups, especially women (on ward and cluster level) will be formed under the umbrella of the consumer committee; it will be possible to reach the whole community by building up this grass root structure (awareness raising regarding prevention; membership making, control of rehabilitation work, influencing and pressuring quality of the health services, etc). This user groups could introduce some microfinance activities.

    d. This structure will be used in this transitional period of 1 year. The advancement will be evaluated after a year and then it will be decided whether this

Consumers Committee can take the lead of implementing SC (apart from delivery of the health services which still goes under the mandatory of the government of Nepal) in the villages at the desired level.

e. Our highest priority is rehabilitation and prevention in a sustainable model. Replication of course would be nice, but is not our highest priority.

f. To achieve sustainability, financial support shouldn't be more then 2 years. For building up a sustainable system, 2 more years of technical support is needed. Our principle is to stick to 2 years financial support.

g. As an exception, if the sustainable health system is nearly established after 2 years, but merely needs a small additional contribution, Karuna Foundation can decide to support financially to overcome the gap, for a maximum amount of 3000 euro per village per year in the third and fourth year. However, as it is an exception, approval of the Board is needed for this decision.

2) In 2011 2 new villages in Sunsari will start **Share&Care** under the **Consumers Committee/Complementary approach**.

Principles:

a. There will be a separate structure of providers and users of health care:
   - The governmental Sub / Health Post under the mandate of the District Health Office
   - Share&Care Committee with a leader and women groups (members) organized cluster and ward-wise (see structure)
b. When entering a village, we will still first start to have an agreement with the Health Facility Operation and Management Committee and make very clear what are the responsibilities of the Health Facility Operation and Management Committee and what are the responsibilities of the Share & Care consumers committee to be formed as soon as members are there. A separate protocol and structure are developed. We have to be very keen, innovative and flexible during implementation of this new structure. Most importantly health delivery and prevention will go under the Health Facility Operation and Management Committee; community based rehabilitation, community based health insurance (membership, mobilization, etc) and community based entrepreneurship will go under the Share&Care Consumers Committee.
c. After achieving the targeted membership, the Share&Care consumers committee will be formed under the leadership of a local program coordinator/Administrator.
d. Some initial investments from Karuna's side will be made on capacity building, on basic health care needs, etc to convince the people about the program.

e. Karuna's financial contribution will only start after having membership enrolment (at least 30% of the total population in the first enrolment phase) and the promise of the local authorities (VCD) that the amount budgeted on health from the government's grant, as per the guidelines of Ministry of Local Development, will be released for the Share&Care program.
f. To achieve sustainability, financial support shouldn't be more then 2 years. For building up a sustainable system, 2 more years of technical support is needed. The project period is 4 years: 2 years financial and technical support and 2 more years technical support.
g. The rehabilitation work and the social mobilization (membership collection, income generation, etc.) will be the responsibility of the Share&Care Consumers Committee. From the beginning the Share&Care Consumers Committee is responsible and accountable for membership collection.
h. In all the S&C villages, a Village Development Rehabilitation Committee (VDRC) is formed or will be formed to guarantee a good and sustainable rehabilitation program. We have to think further how this VDRC committee is related to the consumers committee and what are the different tasks and responsibilities. [action/protocol to be taken/developed by Deepak].

3) We have developed a new **prevention and rehabilitation strategy (VDRC-ToP)** to be implemented in 10 villages in the coming years. This gives us the opportunity to focus 100% on our mission and achieve a sustainable prevention/rehabilitation model with a less complicated structure . This new strategy will be based on a Village Disability Rehabilitation Committee under the policy of government of Nepal. Social sustainability (long-lasting impact on children with a disability, change of attitude towards them etc) will be achieved after 3 years. Financial sustainability will only be guaranteed if government takes their responsibility after few years. As we strongly believe this system and structure is simple, good and easy to implement without strong presence and push from Karuna's side, we believe the chance of sustainable success is high. As a catalyst external organization we show the government reliable and doable examples by helping to build the structure and organize the people. After that our role is over. The impact the program has created has to be and definitely can be the inspiration to go further without any external financial support. However, we have to accept that not every social issue (especially rehabilitation of disabled children) can become fully economic viable without financial support by governments. But we as an organization and a team are committed to make it happen. As a part of sustainability and as a contribution to the costs of the medical treatment of their child, it is very important that the families of children with a disability participate financially at least equivalent of 5 euro per child per year to the program so that they feel the value and also feel proud. Prevention (institutional delivery and direct contribution to achieve the improvement on mother-child Health

aiming reducing 30% prevalence of disability) and Rehabilitation of Children With Disability (CBR).

4) **Income generating activities** among women groups and below poverty families will take place under limited conditions; a. no individual loans will be given; b. families with a child with a disability have priority; c. people who take a loan, have to save money (mandatory) to be able to become a member of Share&Care. Karuna Foundation will give seed capital for these saving and credit groups for a maximum amount of 4000 euro per village.

5) **Training Department** of Karuna Foundation will be full swing the coming 3 years to increase the capacity and the leadership in the villages in order to have a sustainable model in place after Karuna exits.

6) At the end of 2010 nearly all the prevention projects of the **Training of Professionals program** were handed over to the District Health Offices of Sunsari and Kavre district. In 2011 the program of Training of Professionals (ToP) will have its last year in Kavre. After having the final results of the program at the end of 2011, and after having 1 year experience with the District Health Offices of Sunsari and Kavre as supervisors of the prevention projects, we can decide to expand the program in other districts in the following years. In order to have evidence-based results of this prevention/training program , we will put effort in 2011 to cooperate and have an agreement with the Free University of Amsterdam (Wim van Brakel/Joske Bunders) and with a university in Kathmandu.

7) To control and increase the quality of the CBR work, a separate **CBR department** within Karuna is in place. For Share&Care we have a focal person who follows the process, and compiles the facts and figures very closely so that we have evidence-based experiences to be able to develop a proved model ready for replication.

8) **The CBR work in Rasuwa district**, will be included in the prevention/rehabilitation plan (see under point 3), despite the difficult situation in which RCRD left the project. The sooner we can start our CBR work there, the better.

9) In **Hansposa** we will start the **CBR project** on the 1st of May 2011 (after the formal Share&Care program finished legally.