Inspire2Care: A Disability Prevention and Rehabilitation Programme

A system change in healthcare in Nepal
2019-2025

Karunafoundation

Contents

Acronyms

ADED	Appui au Developpement de l'Enfant en Detresse
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
CBR	Community Based Rehabilitation
CBRF	Community Based Rehabilitation Facilitator
CEONC	Comprehensive Emergency Obstetric and New-born Care
DALY	Disability Adjusted Life Years
DPO	Disabled People's Organisation
DPRP	Disability Prevention and Rehabilitation Program
ECD	Early Childhood Development
EVPA	European Venture Philanthropy Association
FCHVs	Female Community Health Volunteers
FY	Fiscal Year
HFOMC	Health Facility Operation and Management Committee
M-Health	Mobile Health
MIS	Management Information System
MoSD	Ministry of Social Development
NFDN	National Federation of the Disabled - Nepal
NGO	Non-Governmental Organisation
PNC	Post Natal Care
(R) M	Rural Municipality
SBA	Skilled Birth Attendant
STI	Sexually Transmitted Infection
TD	Tetanus Diptheria
ToT	Training of Trainers
UBS	United Bank of Switzerland
USG	Ultrasound/Sonography
WHO	World Health Organisation

Summary

On June 16th, 2019, the provincial government of Province 1 in Nepal has decided to adopt the Inspire2Care programme, a community based healthcare and rehabilitation programme, as developed by the Karuna Foundation in the past 12 years. They renamed it into the Disability Prevention and Rehabilitation Program (DPRP) and changed its policy by endorsing DPR Implementation Directives. The Ministry of Social Development mandated for the Health, Education, Sports, and Social Development agendas has been given the responsibility to unroll the program in all municipalities (Palikas) of Province 1, where the implementation responsibility is given to Palikas themselves. The Provincial Cabinet has allocated budget, approved of new cost-sharing modalities and committed to being the first province to implement prevention and rehabilitation as an example. We see this as a great encouragement that we are on the right track in changing not only the mindset but also presenting a feasible solution to prevent disabilities and rehabilitate people with a disability, with the following goals:

- **To strengthen the existing healthcare system, particularly maternal and child care, in order to prevent birth defects and (childhood) disabilities.**

- **To develop disability-inclusive societies, in order to improve the access to healthcare, education, livelihood opportunities and participation in social life for people with a disability by strengthening local systems.**

In this replication phase, the Karuna Foundation will support the government by providing training, advices, co-funding and support in the implementation to make sure the provincial government and municipalities involved can continue the programme at their own accounts in each municipality after three years. In addition, Karuna expects to inspire other provinces and the federal government in Nepal to adopt the programme. A first indication this is starting to happen was a call from the minister of Province 5 to ask for support in implementing DPRP in his province.

This proposal
This document starts with a brief introduction to the history of the organisation and the programme. Subsequently it explains why we started the programme and how the programme is being implemented, describing the mission, the implementing partner organisations and the step-by-step approach in the field. Also, we describe in more detail what the different interventions encompass in the prevention and rehabilitation programme. In the second part of this document we illustrate our strategy for the replication and scaling in the coming 5 years. We share the expected impact of the programme at output and outcome level and present the budget, the funding of phase1 and the proposed funding opportunity for phase2.

NB Some provinces are in the process of finalising their names by the Provincial Assembly, whilst four out of seven already have their names.

History of the programme

The Karuna Foundation was established in 2007 with the goal to improve the lives of children with a disability in developing countries. Nepal was identified as a country with a high need in this respect, lack of good care and potential for development. The social entrepreneurs and development specialists Deepak Raj Sapkota and Yogendra Giri started the Karuna Foundation in Kathmandu, Nepal to develop disability-inclusive societies in Nepal under the adagio of 'saving children from disability, one by one'. Karuna Nepal grew out to be a full-fledged organisation with over sixty Nepalese professionals.

With private money, shared ambitions for innovative system change, and willingness to continuously learn and adjust, they developed and piloted the Inspire2Care program in close cooperation with the local Governments. Pilot programmes were implemented, tested and evaluated in fifteen villages in the districts of Kavre, Sunsari and Rasuwa – between 2008 and 2015. After they learnt what could be achieved with their approach and interventions, it was decided to scale up Inspire2Care. In the district of Ilam, in the hilly far-east of the country, the programme was replicated in all ten municipalities (former 46 villages and three municipalities) from 2015 onwards. Also, a cooperation with the Netherlands Leprosy Relief (NLR) resulted in the adoption of Inspire2Care in their approach in three villages-in the district of Jhapa.

The Karuna foundation has always worked closely together with the government in the belief that they are responsible for all agendas related to their people. This includes sustainable healthcare and disability policy. Therefore, it has from the start aimed at adoption and scaling of the programme by the government of Nepal.

With the promising results from Ilam and ownership by the local government, the Karuna Foundation decided in 2019 to approach the provincial government for replication of the programme in the whole of Province 1 in collaboration with local governments. The government accepted the concept as an innovative programme that could strengthen the current healthcare system.

Why this programme?

Nepal has achieved significant reductions in maternal and infant deaths over the past decade. Nevertheless, the country still faces a challenge in reducing the neonatal mortality rate and birth defects. Currently, 21 neonates per thousand live births die before 28 days of life, as reported by the National Demography and Health Survey in 2016. Congenital anomalies or birth defects cause more than one-third of neonatal deaths in Nepal. The baseline survey conducted in 2015 by Karuna Foundation Nepal in the Ilam district revealed that 50 percent of the 1.029 persons with disabilities surveyed reported disabilities by birth. Children also develop disabilities every year due to lack of treatment or conditions such as malnutrition, infection and other diseases. Access to basic healthcare services is limited and the quality of healthcare and nutrition services is still insufficient. Other UN agencies including UNICEF and

some INGOs have maternal and childcare programs, but their focus is in other provinces i.e. Province 2 (southern plain of Nepal) and Karnali Province (Mid-West).

One of the problems is the low rate of institutional deliveries, as birthing centres lack minimum standard facilities, including ultrasound screening services. Although ultrasound screening is extremely important for early detection of pregnancy complications, they are not available at the majority of the birthing centres in Nepal. On average, in a district with 20-25 birthing centres, only one has been found with an ultrasound machine. This results in a situation where pregnant women living in remote areas have to travel to the district headquarters or even beyond to get a simple scan, or worse, they do not utilise the service at all. Although the government aims at ensuring access for pregnant women to this service, their effort only extends to zonal and tertiary hospitals due to constraints in resources. The government's pilot of the 'Rural Ultrasound Programme' has been able to reach just 12 out of 77 districts of Nepal. Moreover, none of the pilot districts fall in Province 1.

People with a disability in Nepal have even less access to healthcare, education, social participation and decision making and other basic facilities and services. Furthermore, they often face discrimination and stigma, are excluded from social life and their capabilities are not seen. Although there are strong legal and policy frameworks in the area of disability, unfortunately, there is no focused inclusive disability programme simply because there were no proper structures to deal with disability in Nepal. The persons with disabilities and their families are often unaware or not in position to claim services despite of the entitlements. Here, we can clearly see the double poverty of persons with disabilities and their families! Whilst the provision of 'disability identity cards' has assured the right to services such as healthcare and social security allowances, an estimated 60% of persons with a disability do not possess this card and are deprived of benefits entitled to them. This can be due to unawareness of the existence of such cards or lack of support in applying for one. (NB Depending on the severity of the disability, different coloured cards are provided each with its own allowances/services). The government has started inclusive education via 'resource classes' related to primary schools, however the number of these classes is limited.

How do we work?

Our mission and principles

We believe that the problems mentioned above – birth-defects and disabilities and the exclusion of people with a disability – can only be solved in a sustainable manner if the *system* is changed. Our twofold mission is therefore to:

- **Strengthen the existing healthcare system, particularly maternal and childcare, in order to prevent birth defects and (childhood) disabilities.**

- **Develop disability-inclusive societies, in order to improve the access to healthcare, education, livelihood opportunities and participation in social life for people with a disability by strengthening local systems.**

We embrace the principles of local ownership, cost-sharing, and the exit of Karuna already from the start of the implementation, in order to enable local governments to continue the programme on their own accounts and with own funding. Karuna's principles have always been at the heart of our programmes and simultaneously could be identified as part of our success factors. These success factors are derived from evaluation studies, internal reflections by the team and by recognition of other organisations (also see 'track record' further below).

1. **Local accountability**: we involve the target groups and give them responsibilities for the implementation of the programme;
2. **Readiness of local leaders**: we only start in a village when local leaders show their commitment in terms of ownership and funding;
3. **We treat the children as if they are our own and leave no one behind;**
4. **We dare to stop** (in case of underperformance by one of the partners);
5. **We stay temporarily**: we will exit after 3 years of implementation in each municipality and we will stop in 2025 when the whole province is covered;
6. **Cost-effectivity** of the programme;
7. **Ownership by the (local) government**, making them responsible for success and continuation after the exit of Karuna;
8. **Establishing a network of supporting care organisations** in Nepal and linking them to those who need care;
9. **Cost sharing** with the government and **strengthening of current health institutions** and local finances.

The implementing partners

Governmental partners: Province 1 and municipalities

Provincial Government

As Karuna has been working in a number of municipalities of Province 1 in the past years, it was decided to focus the replication in this province. Nepal has 7 provinces and Province 1 is located in the far east (see annex 1). The province has the second largest population (5 million approximately) and its topography ranges from the plains and hills to mountainous areas (with the 7 world's highest mountains out of 10, including Mount Everest). In Province 1 live an estimated 100.000 persons with a disability, of which approximately 25.000 children (estimation based on the latest Nepalese census of 2011 and field research by Karuna). Most villages in the hills and mountains are poorly accessible and particularly persons with a physical disability have an extremely poor mobility.

In 2015, after many and long battles to restore democracy, Nepal got its Constitution drafted and endorsed by the elected members of the constituent Assembly. The Constitution restructured Nepal into a federal republic with three tiers, Federal Government, Provincial Level and Local Level. It divided the nation into seven provinces. It completed the transition of Nepal from constitutional monarchy to republicanism and from a unitary system to federalism. The guiding principles of the 'Holding Together' type of the Nepalese federal system is based on Co-existence, Co-operation and Co-ordination (the 3 C's).

Each province has its own elected Provincial Assembly, cabinet, plans and budget. In the provincial government, the Ministry of Social Development is responsible for healthcare, education, disability and senior's citizen related issues, sports and social development. The provincial cabinet has endorsed our programme in 2019 and developed the 'Disability Prevention and Rehabilitation (Implementation) Directives 2019. This directive clearly explains the funding modality and implementation strategies. A Steering Committee, chaired by Minister of Social Development, has been formed with all relevant senior government officials, Karuna, and the National Federation of the Disabled. The provincial headquarters is in Biratnagar.

Municipalities

The programme will be implemented in 117 municipalities (Palikas) under their own responsibility. The restructuring in 2015 also strengthened the local governance. Four to five villages were grouped into municipalities, enlarging scale, budget and local authority. Also, the introduction of elected mayors and ward members has strengthened the local governance and accountability. Each mayor and his/her team of elected ward members, is eager to show good results in his/her municipality and has ambitious plans for development. So far, the first 27 mayors in Batch I (year1) of the replication have all embraced the DPRP and developed their own DPRP plans and budgets with the involvement of all local village leaders, officials, beneficiaries and other stakeholders. Local DPRP management committees are formed to steer progress and results. All these municipalities are sub-divided in wards (villages) ranging from 7 to 19 per municipality.

Karuna Foundation in the new phase

With the scaling of the programme, the Karuna Foundation is formed by two organisations each with their own roles:

Karuna Foundation Nepal is a local NGO in Nepal. Karuna Nepal is headed by Deepak Raj Sapkota and Yogendra Giri, who manage and lead an enthusiastic and highly motivated team of over sixty professionals in Nepal. The management of Karuna Nepal is responsible for the strategy and implementation of the programme. As the government has adopted the programme and is responsible for the implementation, Karuna has a new role to cooperate, support and train government staff and local leaders and co-create the DPRP in the coming 5 years. The team is divided over three offices: central, province and districts offices. Karuna Nepal has its own board consisting of seven Board Members and five "General Members" in a

more policy formation and advisory role. They all are Nepalese Citizens with high integrity and recognition in the country.

KarunaNL remains a small organisation with one employee in the Netherlands, the current Director dr. ir. Annet van den Hoek. It supports the scaling and replication of the DPRP programme via fundraising, coordination of communication to various funding partners and foundations, the representation of Karuna at different international fora and shared reporting. The board of KarunaNL consists of René aan de Stegge (entrepreneur and investor), dr. ir. Charles Nijman (expert in the field of development cooperation) and prof. dr. Geert Blijham (former managing director of the Academic Hospital of Utrecht in the Netherlands).

The DPRP approach

The Karuna Foundation adopted evidence-based interventions in the DPRP and aims at strengthening existing healthcare institutions to implement these interventions carefully.

The current healthcare system at local level is formed by health clinics and 'Female Community Health Volunteers' (FCHVs), who are generally addressing preventive, curative and promotive healthcare needs of mothers and children in their villages and provide information on events of the health clinics. The Nepal Health Infrastructure Development Standard has mandated one health clinic (of any level) at each ward of the municipality. In some situations we see a clinic covers 1-3 wards. Some health posts are staffed with medical doctors, while other health units are staffed with paramedics.

FCHVs are women of the local community selected by the Mother's Groups in the community to serve as unpaid volunteers for health. They may not have a specific educational background but following their selection, they receive an 18-day basic training on family planning, maternal, newborn, child health and nutrition issues which prepares them for their role as health volunteers. Their role has been indispensable in primary healthcare in Nepal. As the prevalence of diseases changes, the Ministry of Health and Population is in process to upgrade the level of FCHVs. In the DPRP, they therefore play an important role in the prevention programme, as will be explained below.

The quality of life of people with a disability can be improved significantly with the introduction of 'community-based rehabilitation' (CBR), the integral approach of the World Health Organisation (WHO). The program introduced the new position of a Community Based Rehabilitation Facilitator (CBRF) in the existing local healthcare and rehabilitation system and incorporated the five components of CBR.

On the following page we illustrate our approach in each municipality, step by step:

Step 1: The Start
Via a start meeting and call for proposal from the Ministry of Social Development (MoSD) in the Province (in different phases), Palikas are invited to submit a proposal for the DPRP. Plans are developed together with all local stakeholders with support of Karuna staff. All are assessed by the DPRP Directive Committee in the MoSD, on their interest, willingness towards the programme and necessary budget allocation in the Palika, as described in the guidelines. Subsequently, agreements are signed between Karuna Foundation Nepal and the Palika – as endorsed by the Provincial Government – for their 3-year cooperation: the first two years Karuna provides financial and technical support and the third year only technical support. Local DPRP Management Committees are formed per village (ward). Karuna provides training to local leaders and health officials on the DPRP principles and approach.

Step 2: Preparations
The Palika will select and appoint the Community Based Rehabilitation Facilitator (CBRF). This CBRF, who has a background as midwife or an auxiliary health worker, is an inhabitant of the village (if possible). It is a new post and salaries are paid by the Palika (as part of DPRP budget). These CBRFs are trained by Karuna (three months programme with accredited course). They go from door-to-door, identify all persons with a disability, make sure they receive an ID-card and develop an individual care plan together with their family members and a multi-disciplinary team including medical professionals and therapists. In the Prevention Programme, Karuna gives training to local health workers and the *'Female Community Health Volunteers'* (FCHV) on causes of birth defects, stunted growth, disabilities and how these can be prevented with a set of evidence-based interventions. They are also trained in the M-Health programme: a messaging service for ante and post-natal check-ups, which is part of the prevention programme of the DPRP. At least one birthing centre and one physio centre per Palika are equipped with instruments and health workers are trained.

Step 3: Implementation
The prevention programme.
Health workers give extended service to (pregnant) women and young mothers. Just married women (couples) receive folic acid. Via M-Health, all women are registered, and messages are sent to attend the four ante and three post-natal check-ups. Also, FCHV's make sure the women will get professional support via institutional delivery in the newly upgraded birthing centres. The health workers and FCHVs, equally, reach Married Women of Reproductive Age with information on reproductive health directed towards disability prevention.

The CBR programme
The CBR Facilitator, together with parents or caretakers develop rehabilitation goals for each person with a disability, supported by experts of the Karuna team. In line with the goal, the CBRF and family together organise care and medical treatment (see below). The CBR will help children to get ready for school (those who can go), try to find alternatives i.e. home-based education for those who can't and organises inclusive child clubs. Together with DPOs, self-help groups (with capital out of the DPRP budget as a part of programme and occasionally provisions by others) are started for persons with a disability or their family members to generate a source of income and give them access to social life. Skill development and/or vocational training are also part of the DPRP programme. Cooperation with other NGOs, hospitals and schools is initiated to strengthen the care.

Step 4: the exit and continuation

After two years Karuna stops the funding in a municipality. The programme will be continued under the responsibility of the municipalities with funding of Municipalities and Provincial Government (50-50 cost sharing). The budget per municipality differs, as their plans differ (see details under 'funding'). Karuna offers one more year of technical assistance. During the 3-year presence, Karuna will constantly organise support and refresher training programmes for CBRF's, local health workers, schoolteachers and local leaders to make sure all are well equipped and motivated to continue the programme after Karuna leaves in 3 years. The Training and Resource centre will continue to train new staff and provide technical support, capacity building and lobbying.

These women are the Community Female Health Volunteers, who since decades provide health care to fellow villagers throughout Nepal. In the DPRP, they are trained to implement the prevention program. With the Medic Mobile Health programme, they register all pregnant women and send them messages for the Ante and Post Natal Care to make sure they attend the essential check-ups.

What are the interventions?

The prevention programme

The prevention-programme largely consists of the Best Wishes Component (best wishes cards, an M-Health system for pregnancy registration), creating awareness and organizing health screenings in improved birthing centres.

Best Wishes
Best Wishes are conveyed to newly married couples and pregnant women respectively. Two different cards designed for both groups are issued by the Female Community Health Volunteers (FCHV) and/or mid-wives. These cards provide Best Wishes and useful information relating to family planning, nutrition including peri-conceptional folic acid, STIs, etc. and their relation to the prevention of birth defects. All information is shared via pictures and graphs to make it understandable for all. The Best Wishes card also encompasses messages on care during pregnancy, danger signs, and services by the government for pregnant and women who recently delivered. The card provides space to track the services taken by each pregnant woman (verified by FCHV and ANM) which is also validated by the M-health system.

The M-Health system
Each FCHV gets a mobile phone and they register pregnant women, sending mobile message to the system. After the registration, the system sends reminder messages to the FCHV to send pregnant women for ANC visit, iron, folic acid and calcium tablet consumption, TD vaccine, institutional delivery and PNC of that pregnant women. After each reminder message, FCHV meets the pregnant woman and sends her to the health facility for check-ups. Karuna cooperates with the organisation Medic Mobile Nepal, who develops software for the messaging and data management system, provides training to Karuna staff and health workers and helps to cover the gateway phone costs and necessary materials. Medic Mobile is a non-profit organisation whose mission is to improve health in the hardest-to-reach communities. They are known for building open-source software that supports health workers in delivering equitable care through tools and apps that help health workers ensure safe deliveries, track outbreaks faster, treat illnesses door-to-door, keep stock of essential medicines, communicate about emergencies, and more. They are currently working in 15 districts of Nepal and 14 countries across Asia and Africa.

Awareness and health screenings
Also, as part of the prevention programme, local health workers orient the 'Golden 1000 Days' mothers on the importance of nutritious food. The period of 1000 days between a woman's pregnancy and her child's second birthday is a critical window for the development of a child. Good health and nutrition can mitigate the risks of poor physical and cognitive development, that can create disabilities. Hence, as a major part of the prevention programme, this golden 1000 days screening reaches hundred-thousands of women even in the most marginalised communities.

Moreover, a school health screening programme is organised via screening camps at the primary schools and cover children of 4-10 years. In addition, CBRF's ensure that children

below four years also visit the camp and/or the local health facility. The screening is conducted by the local health workers with a focus on untreated eye problems, ear problems and malnutrition An orientation and screening protocols have been developed for this purpose. Children with identified problems are referred to health centres for early interventions and follow-up.

Birthing centres

In order to improve the options for institutional delivery in each municipality, Karuna will support the establishment of one well equipped birthing centre per Palika with an ultrasound machine and organise training. Ultrasound services will help to:

- Provide good quality maternal services;
- Attract more women to birthing centres, which can result in increased utilisation of other health services as well;
- Reduce time and resource of pregnant women and their families, as ultrasound services will be available nearby;
- Increase trust by pregnant women towards maternal health services (research has shown that women perceive ultrasound to be of significant value for reassuring the health and progress of the baby).

The 27 (rural) municipalities of Province 1 that we plan to reach in the first year of implementation have over 80 birthing centres and the need for ultrasound machines in at least one improved birthing centre per rural municipality is considered a bare minimum. The birthing centres have sufficient personnel as sanctioned by the Government of Nepal, the minimum number of positions for a birthing centre being 5. At least 2 of these are for nursing staff. The programme plans to train at least one midwife on Skilled Birth Attendant (SBA).

The government of Nepal has prepared a 21-day training package on rural ultrasound. The nurses from the selected birthing centres will receive this training. These centres fall under the jurisdiction of local governments and will be managed by the local governments themselves. Once the ultrasound machines are handed over to the municipalities, the maintenance and repair of the USGs will be the responsibility of the local governments. A protocol will be developed on the use of ultrasound machines and referral mechanisms following diagnosis. Other legal aspects will also be covered such as prohibition of its use for sex determination of the foetus to prevent female feticide. There is a pre-existing mechanism of the government to refer complicated pregnancies to higher centres/hospitals that have Basic or Comprehensive Emergency Obstetric and New-born Care (CEONC). The emergency obstetric care services include assisted delivery, antibiotics for maternal infection, drugs to prevent haemorrhage, removal of retained placenta, caesarean section and blood transfusion.

The Right to Safe Motherhood and Reproductive Health Right (2018) defines pre-birth disability as one of the conditions in which a woman can legally terminate her pregnancy if it is up to 28 weeks of gestation. Terminations after that are illegal.

The CBR programme

Community Based Rehabilitation includes five focus areas, as depicted by the WHO: access to good healthcare, education, livelihood, social participation and empowerment. The idea of the WHO is that CBR is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services.

In the DPRP, CBR Facilitators (CBRF) play a pivotal role. They provide counselling, basic care and help parents/caretakers to accept and treat their children with a disability in a good manner. In case a person needs specialised care, the CBRF will ask for support by the physiotherapists or psychologist of the provincial team and/or other service providers to organise treatment in local hospitals or medical camps. Karuna will also help to organise specialised care and supply of assistive devices via other active NGOs in the region. Karuna will map all relevant NGOs and will develop agreements with these NGOs, like the CP Centre, Autism Care Society Nepal, Down Syndrome Society Nepal and NGOs specialised in vision/hearing. For medical treatment and minor surgeries, the designated budget under the DPRP (medical treatment) is utilised. In most of the cases, the family does also participate in the cost.

The programme also organises home-based education for those unable to attend school due to the severity of their disability and link others to school. Most of these children have been lying in bed for years and with the support of CBRFs, treatment and/or assistive devices, many of them are ready to go to school and/or take part in social life. The CBRF will approach the local teachers to discuss how this child can enter school in the best manner and organise home-based education to get the child ready. Besides organising care and education, CBRFs will also form self-help groups together with Disabled People Organisations (DPOs) and support them in starting income generation activities and transform them into legal cooperatives. Karuna will provide vocational training programmes and works closely together with the National Federation of Disabled People Nepal to train and empower the DPOs.

To support the work and services of the CBRFs, the program plans to support health centres with the equipment of one physio room per Municipality. CBR staff from Karuna (physiotherapists) will train the health workers on physiotherapy.

The number of CBRFs in a Palika is determined by topography: 1 CBRF per 300 persons with disabilities in the plain regions (Terai), 1 CBRF per 150 persons with disabilities in the hilly regions and 1 CBRF per 100 persons with disabilities in the Himalayan regions.

Like other activities, the costs of both physio and birthing centres will be shared by the Provincial Government, the Municipality and Karuna. Both are expected to help improve the quality of care and are incorporated in the programme on urgent requests of mayors, local leaders and provincial health officers.

The replication strategy for 2019-2025

Background

The signing of an agreement between Karuna Foundation and the government of Province 1 was a milestone and crucial step in the realisation of our ambition to replicate the programme.

Changing the system of the government is not easily done. In the past months, the provincial government, supported by Karuna, developed implementation directives for the implementation, indicating responsibilities, funding and reporting procedures and cost-sharing mechanisms. In preparation of a good start, a workshop was organised in July 2019 with all stakeholders involved (including the Minister himself) to share the content of the programme, the directives, and to create a sense of ownership amongst all. It became clear what was needed to fully integrate the programme in the current system and which adjustments need to be made. At provincial level, a Directive Committee is formed to properly manage the replication in the coming years.

In autumn 2019, new staff was recruited by Karuna Foundation and a provincial office was set up. All were extensively trained in the values, principles and approach. The Karuna team worked closely together with the provincial government to develop guidelines for implementation, a format for agreements with municipalities and funding arrangements. In December 2019 all municipalities signed the agreement with Karuna in which Karuna and Province 1 committed their support for three years and the terms for cooperation (see box below).

In January 2020, all 27 municipalities of Batch I started with the recruitment of their CBRFs and a start will be made with the prevention programme. All CBRFs will be trained in an officially accredited programme for 3 months by Karuna.

Preparations have also started for the implementation of Batch II of the DPRP. Karuna selected 14 new staff members for the support in the new districts, who will join Karuna Nepal on February 13, 2020. As part of the preparations and rapport building, all municipalities of Batch II of the Sankhuwasabha and Bhojpur districts have been visited by Karuna staff and the mayors and chairpersons of the wards have been informed about the programme. They responded enthusiastically. The elected representatives, officials and stakeholders of the new municipalities shall be informed in the week of February 18, 2020.

Planning

The proposed planning of the replication is illustrated in the table below:

Variables	# Palikas	Jan-Mid July 2019	Mid July 2019-Mid July 2020	Mid July 2020-Mid July 2021	Mid July 2021-Mid July 2022	Mid July 2022-Mid July 2023	Mid July 2023-Mid July 2024	Mid July 2024-Mid July 2025	Mid July-December 2025
		FY 2075-76	FY 2076-77	FY 2077-78	FY 2078-79	FY 2079-80	FY 2080-81	FY 2081-82	FY 2082-83
Batch I	27	Overall Preparation	Prep-I & 1st Half of Year 1	2nd Half of Year 1 and 1st Half of Year 2	2nd Half of Year 2 and 1st Half of Year 3	2nd Half of Year 3			
Batch II	31		Prep-II	Year 1	Year 2	Year 3			
Batch III	33			Prep-III	Year 1	Year 2	Year 3		
Batch IV	26				Prep-IV	Year 1	Year 2	Year 3	Closing
Name of Districts			Dhankuta, Pancthar, Morang, Sunsari, Bhojpur, Sankhuwasabha	Dhankuta, Panchthar, Morang, Sunsari, Bhojpur, Sankhuwasabha, Khotang, Okhaldhunga, Solukhumbu, Udayapur	Dhankuta, Panchthar, Morang, Sunsari, Bhojpur, Sankhuwasabha, Khotang, Okhaldhunga, Solukhumbu, Udayapur, Jhapa, Tehrathum, Taplejung	Dhankuta, Panchthar, Morang, Sunsari, Bhojpur, Sankhuwasabha, Khotang, Okhaldhunga, Solukhumbu, Udayapur, Jhapa, Tehrathum, Taplejung	Khotang, Okhaldhunga, Solukhumbu, Udayapur, Jhapa, Tehrathum, Taplejung	Jhapa, Tehrathum, Taplejung	
Palikas to begin with Programme Ground Implementation *		0	27	31	33	26	0	0	
Number of Palikas with Programme in the year **		0	27	58	91	117	59	26	

** This number indicates in how many Palikas the program will start per year (with an agreement between the respective Palika and Karuna Foundation Nepal).*

*** This represents the total number of Palikas where the programme is being implemented in the given year.*

NB Considering the next expected elections in 2023, Karuna may decide to prepone the start of implementation of Batch IV and Batch III, if Karuna feels they can manage it well.

We focus on the implementation of 117 Palika's (municipalities), whilst the Netherlands Leprosy Relief Foundation will implement their DPRP programme in 9 Palikas, and the pilot of Karuna in Ilam and Sunsari district covers another 11 Palikas.

In the description of our approach we explained the role of the different organisations. Below we will give a summary of their roles in the replication.

Who will do what in the replication?

The provincial government. The Directive Committee has selected the municipalities for each batch of implementation in the coming 5 years. She will mobilise a team of government employees to manage the implementation of the programme, recommends the Ministry of Economic Affairs and Planning to allocate budgets and makes sure the funds are transferred in time to the municipalities, and informs and mobilises local leaders and health institutions to cooperate well. The Policy, Planning and Health Division, Social Development Division and Education Division are the key divisors to lead the process. The government will also play a key role in monitoring the programme activities. Together with Karuna Foundation, she will take care of reports on finance, progress and performance. The provincial government will invite colleagues from other provinces and from the federal Ministry of Health to share their experiences and results and inspire them to adopt the programme in the future. The Directive committee of the DPRP will organise an annual evaluation session to draw lessons learnt and adapt the programme and strategy, if needed.

Municipalities are responsible for implementation and the elected mayors and ward members become accountable for success. Municipalities control the quality of care and direct the CBR Facilitators. Municipalities mobilise their health and education institutions and disability management structures to realise the objectives of the programme. The municipality nominates a program coordinator from the health or social development section, who will be responsible for day to day management and implementation of the programme. Exposure visits will be organised for all mayors to share experiences and lessons learnt.

Karuna Foundation Nepal will support the Provincial Government in the planning and organisation of the replication. Also, they will support the municipalities in the implementation and training of all CBRFs, health workers and local leaders. Annex 4 provides an organogram of their organisation. Per district 5-7 Karuna field staff will be active to visit the municipalities on a daily basis and provide guidance and support. All are supported by the team at the Provincial Office.

Karuna Foundation Nepal has started a (virtual) Training and Resource Centre. They will recruit a manager, rent a place, hire resource persons (trainers) and implement the different training programmes in the provincial capital of Biratnagar. Their 3 months training for CBRFs has an accredited curriculum. They will build a DPRP 'portal' providing:

- Information on all types of disabilities and possible care/treatment;
- Information and location of specialised care providers;
- All training modules and online courses and lectures;
- Information for teachers on inclusive education;
- Forum for online communities to exchange information;
- Site for CBRFs to exchange experience and information;
- Help desk.

A pilot is foreseen in the second half of 2020 with MyHandicap (a Swiss NGO) to develop this portal.

The training programme in the period starting 2020 until 2021 includes:

- CBRF training to newly recruited persons;
- Refresher courses to all current CBRFs in the Ilam district;
- Training for new staff of Karuna Nepal;
- Training to local leaders of all municipalities;
- Modules for training that are directly conducted at Palika level including training on for example birth defects identification, physiotherapy training and orientation on DPRP for local government officials.

The management team in Nepal will use the experience with this virtual centre in the coming year to develop a further strategy and plan for the centre in 2021.

Expected impact and changes

Impact in the past years

Different independent studies on the impact of the predecessor of the DPRP (the Inspire2Care programme) in the pilot district of Sunsari, Rasuwa and Ilam – by an independent Nepalese researcher in 2018, Kaarak Enterprise Development Service India in 2017 and by Health Economist Kelsey Vaughan in 2018 – showed the following results:

- 62% reduction in birth defects in Inspire2Care communities;
- 61% increase of birth deliveries in a clinic;
- 70% of children with a disability indicated moderate to significant improvement in the quality of their lives;
- Access to government services via ID cards increased from 24% to 89%;
- Visibility, recognition and acceptance and care for people with disability has been increased;
- 80% of all villages continue the Inspire2Care programme after the exit of Karuna at their own costs.

  NB These developments cannot be solely *attributed to Karuna as also the government has improved its care programmes significantly in the past decade.*

UBS Optimus Foundation, who supported part of the scaling in Ilam, funded an evaluation study by an independent research institute. The cost per DALY (*Disability Adjusted Life Year*) appeared to be €262, which shows according to WHO standards an effective and efficient CBR programme.

According to WHO standards, an intervention that, per disability-adjusted life-year (DALY) avoided, costs less than three times the national annual GDP per capita is considered cost–effective, whereas one that costs less than once the national annual GDP per capita is considered highly cost–effective. At the time the study was conducted, the annual GDP per capita of Nepal was € 549. Hence the cost per DALY averted was half the annual GDP per capita, making it a cost effective program.

Other organisations were inspired by the approach after visiting the pilot area in Ilam and replicated elements in their own care models. Examples are: Assist India, PachaMama in Peru, the Netherland Leprosy Relief in Nepal, and ADED in Congo. Also, recognition for the good work was shown in awards from the Zero Project and the Ashoka foundation for one of the most innovative and scalable models for inclusive development. These proven signs of impact, plus the enthusiastic mayors in Ilam, helped to convince the government of Province 1 to mainstream healthcare and social development (disability management) policy and programmes.

Based on our lessons learnt, evaluations and recognition we adjusted the programme to the current DPRP and formulated our success factors. Below we present a summary of relevant publications and recognition.

Track record

2018 Inspire2Care is in the top 10 'most scalable solutions' of the Zero Project Impact Transfer programme, a collaboration between Essl Foundation and Ashoka.

2018 Inspire2Care was selected as Innovative Practice on Accessibility during the Zero Project Conference 2018 in Vienna. See this Zero Project video on Karuna at the awards.

2017 Inspire2Care is 'effective, efficient and strategic, with significant impact', shows independent research in the Ilam district, commissioned by UBS Optimus Foundation.

2017 Inspire2Care was selected as EVPA success story. The European Venture Philanthropy Association developed a webpage with 'Little funding stories, big social impact'.

2017 Best Wishes is one of eleven good practices in the book 'Everybody Matters' about inclusion of people with disabilities in sexual and reproductive health and rights programmes. Best Wishes is part of Inspire2Care.

2017 An extensive impact evaluation in the 6 pilot communities in Nepal by Kaarak Enterprise Development Service India has shown the positive impact of Inspire2Care and Share&Care after the exit of Karuna from the community.

2017 Inspire2Care was selected as Innovative Practice 2017 on Employment, Work and Vocational Education during the Zero Project Conference 2017 in Vienna.

2016 Inspire2Care was selected as a 'good example of a sustainable and innovative method' during the World Congress on Community Based Rehabilitation in Kuala Lumpur.

2015 Inspire2Care is one of the five best practices in integrating people with disabilities in their own communities, according to the Asian Pacific Centre for Development and Disability in an investigation among 53 Asian countries. In 2015, Karuna presented her results during an international congress in Tokyo by the World Health Organisation.

2014 Inspire2Care is scientifically proved 'very cost-effective' according to independent research of the Dutch Royal Tropical Institute. The study was executed by Health Economist Kelsey Vaughan.

2012 Share&Care wins the Jobena Prize 2012 for the project with the most appealing practice for self-development as a method and goal. The Jobena Foundation supports cultural and development projects.

2011 Brilliant Failure award for the best learning moment 'Quitting is an option'. Karuna won the public's award in the category of development cooperation. Karuna believes in the power to STOP if things do not go as per the planning and agreement and hence help to deconstruct the myth in Nepal that development agencies remain supportive whether programmes go as planned or not.

Expected impact in the coming years

KarunaNL and UBS-Optimus Foundation have assigned an impact study to the KIT (Royal Tropical Institute) Amsterdam at the start of the replication. By following evidence-based interventions within the programme, this impact study aims to document evidence of impact at outcome and output levels of the programme throughout the first two phases of the replication. Therefore, baseline data collection will commence in Q1 of 2020 and the final report with study findings will be produced after endline data collection in 2025.

To evaluate the outputs of evidence-based components of the programme, the study's methodology follows a quasi-experimental mixed methods approach which allows for triangulation between its three key components: a quantitative epidemiological study, a qualitative study and a costing study. The objectives of the quantitative epidemiological study are to analyse trends of existing key programme indicators through a household survey on key Maternal, Neonatal and Child Health and Disability issues in a number of randomly sampled implementation and control districts (based on socio-demographics and government decision regarding replication districts and Palikas) at baseline and endline with an optional midline. The qualitative study aims to give insight into the barriers and drivers for sustainable implementation in existing Government, local health institutional and community structures as well as unexpected impact of the programme at base- mid- and endline and the cost and cost-effectiveness study aims to understand the important cost drivers of the programme and its efficiency in terms of cost per DALYs averted.

Our Theory of Change shows the expected outcome and output of the DPRP (Annex 2, see also separate document). Expected outcomes for the prevention component of the programme are increased institutional delivery, increased antenatal care uptake and increased folic acid supplementation prior to delivery compared to control Palikas. With this outcome we expect to reach the reduction of birth defects, but the latter is impossible to measure properly in this study. Expected findings for community-based rehabilitation are increased allocation of provincial financial resources to persons with disabilities and increased uptake of education, vocational training, assistive devices and microloans by persons with a

disability. Findings from the impact study will inform recommendations to further maximise impact of the programme for its implementers and beneficiaries.

As stated earlier we have to be realistic and document evidence of impact at outcome and output levels of the programme. Below we summarise the expected outcomes of the programme in the replication programme in 117 municipalities (out of the total 137 municipalities, as 20 Palika's are covered in pilot district of Ilam and by the Dutch Lepra Foundation.

70% of the 16.000 children with disabilities experienced an improvement in their quality of life (scores measured by WHO Quality of Life Tool);

20% of the 62.000 adults with disabilities experience this improvement in quality of life

80% of the expected 108.000 deliveries/year are professionally guided in a clinic (compared to 62% in 2016);

Maternal mortality is reduced by **40%** and child mortality by **38%**.

From 2016-2015, amongst **786.000 children below 10** years old:

- Decrease in stunting from 33 to **20%**;
- Decrease in wasting from 12 to **5%**;
- Decrease in underweight from 24 to **16%**.

108.000 pregnant women per year receive 4 prenatal and 2 postnatal check-ups. This is increased to **80%**; The current percentage is 59%.

50% of expected pregnant mothers taking folic acid prior to conception.

And moreover:

- Death of just born babies will reduce from 21 to 14 per 1000 live births just born;
- 33% of all people with a disability improve their social and economic participation;
- 100% of school-going aged children with a disability (excluding those with complete, severe disabilities) continually go to school;
- 80% of all municipalities continue the programme after Karuna exits (with the provincial government);
- 10% of members of Government services and organisations involved are persons with a disability. The same is expected for cooperatives, child clubs, forest consumers groups.

The targets are close to the following mentioned SDG 3 targets for Nepal for 2030: to reduce maternal mortality ratio (MMR) to less than 70 per 100,000 live births, to reduce preventable deaths to less than 1 percent of new-borns and children and raising the proportion of births attended by skilled birth attendants (SBA) to 90 percent.

The organisation will make use of an online Management Information System. Karuna will also implement continuous monitoring and provide feedback and support to the programme. The Monitoring and Evaluation team will track the programme progress based

on Key Performance Indicators. Documentation will include impact stories via videos, infographics and case stories, making use of learnings to ensure quality and framing of the program for future sustainability. Programme marketing documents such as a yearbook, including monthly and annual reports, will also be published regularly. Karuna is expected to learn a lot from the impact study implemented by the KIT Amsterdam and improve their knowledge and skills on developing a useful MIS.

Risks and mitigating measures

We realise that the replication and scaling of the programme is a challenging journey. By example it requires cooperation between different partners and stakeholders in a form of public-private partnership, which is not easy in a developing country. Besides the provincial and local government, we also have to come across other stakeholders like the National Federation of the Disabled, Nepal (NFDN), other NGOs active in the field of healthcare and livelihood programmes and the federal Ministry of Health.

Among others we foresee the following potential risks and have identified a number of mitigating measures:

Potential risks:	**Mitigating measures:**
Political changes (next election) or replacement of key persons (politicians, bureaucrats) at the Ministries and municipalities. Political issues and conflict of interests with partners	Institutionalisation of the programme (policy act, guidelines, funding modalities, directive committee, three-year agreements with municipalities). Annual evaluation with all stakeholders and possibility to adjust the plan and funding. Maintain strong network of Karuna Nepal Collaboration with NFDN and DPO's and giving them a role in the programme
Delay in funding by partners	Signed funding agreements and establish financial management & control system for all three parties.
Shortage in funding	Execute the fund-raising strategy by KarunaNL.
Delay in implementation	A strategy for catching up in January 2020 (see new replication planning).
Insufficient support capacity available for specialised care by cooperating partners	Inventory of capacity of different NGOs MOU signed by Karuna Nepal with all cooperation organisations. Plan for increasing the capacity by the Government.

Guidelines for implementation, signed by Municipalities and Karuna, as endorsed by the Provincial Government, provide the following control mechanism and will further minimise risks:

"Karuna shall disburse funds on a tri-annual basis into the reserved fund of the municipalities on the basis of programme progress and expenses.
The municipalities shall continue the programme in coordination with Min. of Soc. Development and Province no 1 after the completion of programme

The accumulated budget that has been collected from all 3 parties shall be mobilised and account auditing shall be conducted according to the Nepal government law by first party. The copy of audit report shall be provided to Social Development Ministry and to the Karuna Foundation.

For the proper documentation of income and expenses and report preparation, Karuna Foundation will provide separate Excel format and training regarding the format to the municipalities.

Municipalities shall organise municipal level annual review meeting with Ministry of Social Development, Karuna Foundation, DPO and other stakeholders where programme achievements, challenges and opportunities shall be reviewed.

In the case that expected outcome is not achieved till the mid-term review, the decision of directorate committee regarding continuation of programme will be acceptable for both municipalities and Karuna Foundation."

With Community Based Rehabilitation, children, youngsters and adults with a disability can fully participate in social life. This tremendously increases the self-esteem of people with a disability, like with the two youngsters here. And: seeing is believing: a positive self-image makes it possible that people with a disability become role models in their community and for future generations.

The budget and funding

Budget

The budget of the Replication Plan is € 23.016.563 of which the Provincial and Local Government will pay € 9.242.761. Hence, the budget for Karuna NL will be € 13.773.802 Below, we present a summary of the total budget. Please find the extensive budget in the Excel file that is sent alongside this document.

Disability Prevention and Rehabilitation Programme SUMMARY BUDGET January 2019 to December 2025	
Category	**Total**
Implementation costs program	€ 17.629.591
Monitoring and evaluation	€ 354.628
Communication and documentation	€ 50.325
Policy and advocacy	€ 105.587
Salaries and administration costs	€ 2.482.596
Human Resource, training and development of Karuna staff	€ 174.277
Training and Resource Centre	€ 359.280
Costs management Karuna NL	€ 1.050.000
Contingency exchange rate difference	€ 250.000
Unforeseen costs (5%)	€ 560.279
Total	**€ 23.016.563**
Contribution municipalities	€ 4.642.002
Contribution province 1	€ 4.600.760
Contribution phase 1 (batch I + II)	€ 6.886.901
Funding opportunity phase 2 (batch III + IV)	**€ 6.886.901**
Total contribution Karuna NL	**€ 13.773.802**

Below we illustrate the division of the implementation costs for the first three years. The total budget Per Palika for 3.5 years is € 116.048 on average. Year 3 is fully paid by the Province and Municipality.

Particulars	Preparation period	Year I	Year II	Year III	Total
117 Palikas (Nepalese Rupees, NPR)	₹ 150.262.006	₹ 801.844.500	₹ 427.789.955	₹ 358.038.185	₹ 1.737.934.646
Per Palika (NPR)	₹ 1.284.291	₹ 6.853.372	₹ 3.656.324	₹ 3.060.155	₹ 14.854.142
Per Palika (euro)	**€ 10.034**	**€ 53.542**	**€ 28.565**	**€ 23.907**	**€ 116.048**
Karuna Foundation Nepal Contribution (euro)	€ 10.034	€ 17.847	€ 9.522	€ -	€ 37,403
Province Contribution (euro)	€ -	€ 17.847	€ 9.522	€ 11.954	€ 39,323
Palika Contribution (euro)	€ -	€ 17.847	€ 9.522	€ 11.954	€ 39,323

What is funded already by whom?

Three Dutch foundations (Ineke Feitz Stichting, Stichting Weeshuis der Doopsgezinden and Stichting Perspectief) and UBS Optimus Foundation have committed themselves in March 2019 to the replication of DPRP in the first two batches in Province 1, which is 50% of the total funding needed for this programme in the coming five years. This commitment served as leverage for the allocation of funds by the Nepalese Government for a total of €9.2 million. A fourth Dutch funding partner, the Hofstee stichting, has joined us in December 2019. In addition we have a group of smaller funders whom we call "incidental funders".

By January 2020 the provincial government has already transferred their first instalment of year 1 to the municipalities of €120.703.

We propose the current funder s to fund Phase 1. We expect a decision by March from their boards on their funding of €6.886.901 for phase 1.

In addition, UBS-Optimus Foundation has committed the funding of €350.000 for the implementation of the impact study, assigned to the KIT Amsterdam. UBS and KIT signed a contract on this matter.

This leaves us with a funding need for phase 2 of **€ 6.886.901**.

Can you help to make a difference in Nepal?

With your contribution to the funding of phase 2, you can help to make this change in healthcare and CBR in Nepal possible. It will be a crucial signal of support to the government of Province 1 and pivotal for their funding and sustainable adoption of the programme.

Together, we hope to inspire the federal government and other provinces to adopt the programme and hence reach 7-fold of our target group in Nepal for years to come.

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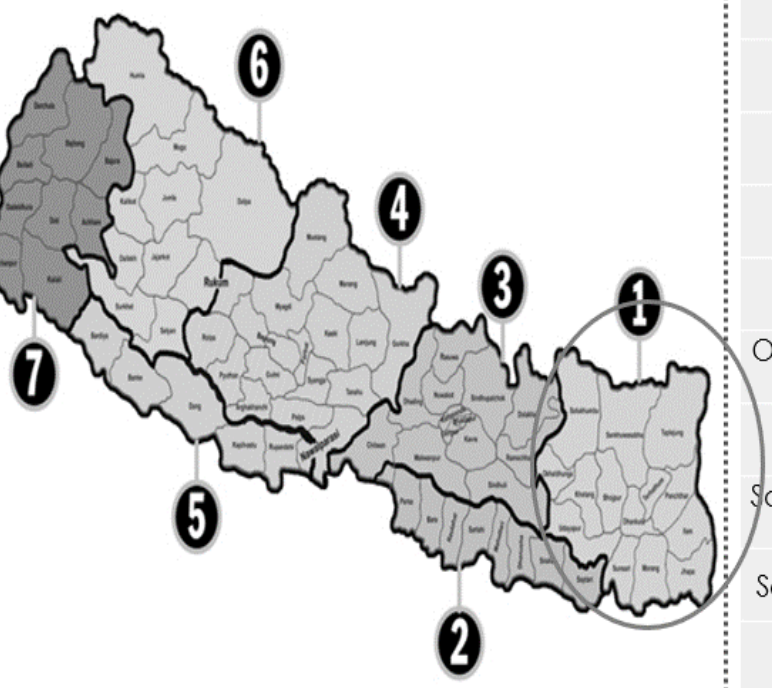
Karunafoundation

In the hilly eastern part of Nepal, it is not always easy to move around in a wheelchair. With the care of a dedicated neighbour life becomes more bearable.

Seven Provinces of Nepal



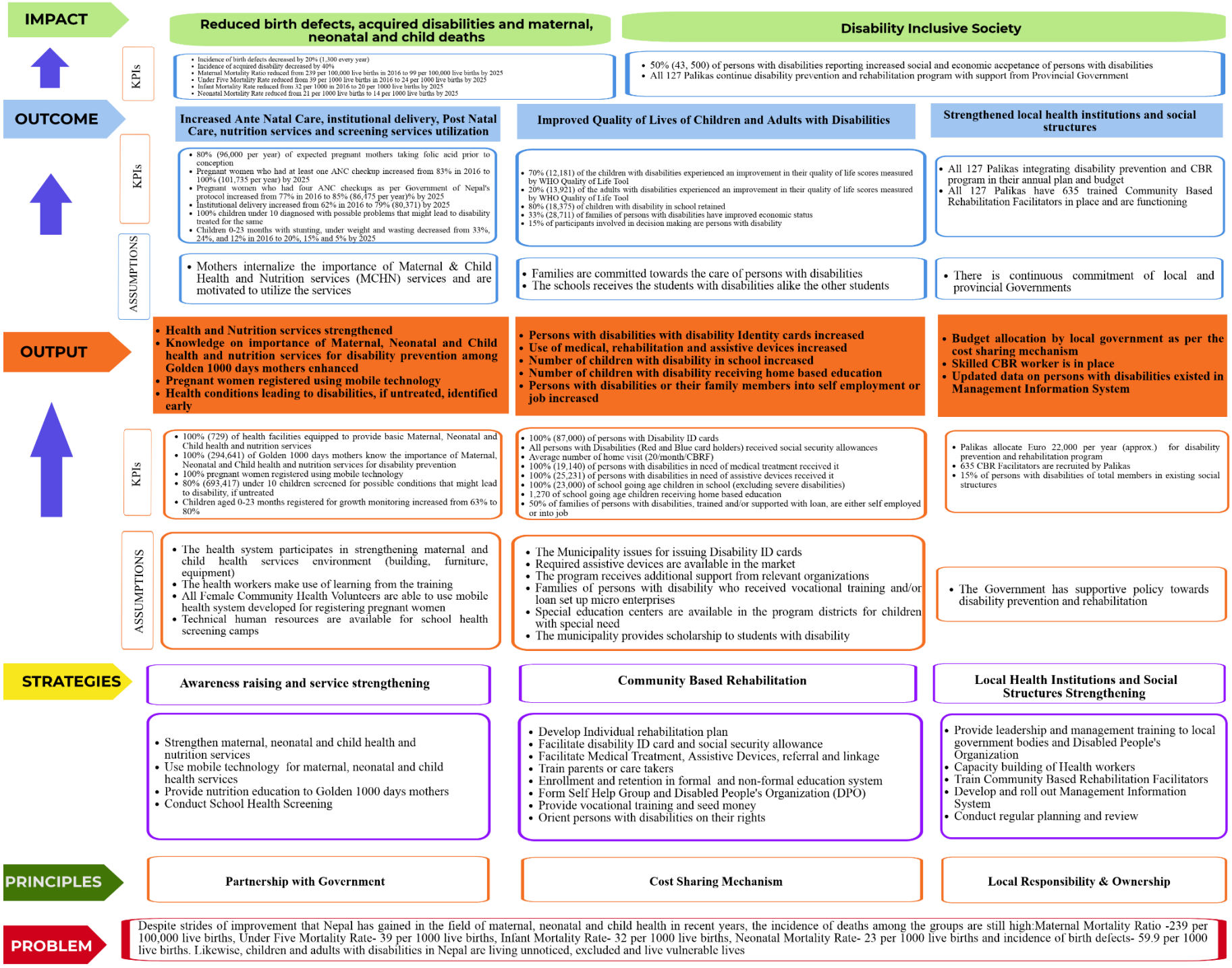
Metro : Metropolitan City
Sub-Metro : Sub Metropolitan City

14 Districts of Province 1

Districts	Metro	Sub Metro	Muni	Rural Muni	Wards	Population
Bhojpur			2	7	81	160,301
Dhankuta			3	4	60	170,068
Ilam			4	6	81	308,668
Jhapa			8	7	131	908,109
Khotang			2	8	79	179,386
Morang	1		8	8	159	1,073,307
Okhaldhunga			1	7	75	151,153
Panchthar			1	7	60	196,466
Sankhuwasabha			5	5	76	156,583
Solukhumbu			1	7	52	103,060
Sunsari		2	4	6	124	888,730
Taplejung			1	8	61	130,395
Terhathum			2	4	43	101,035
Udayapur			4	4	75	350,166
Grand Total	**1**	**2**	**46**	**88**	**1,157**	**4,877,427**

Annex 2: Theory of Change

Strengthening local health institutions and social structures for Maternal, Neonatal and Child Health to prevent disability and rehabilitation of Persons with Disabilities



Annex 3: DPRP interventions

In our Theory of Change (Annex 2 and attachment) we have described our expected outcome, output and activities. Below we provide an overview of the activities in the DPRP programme that are expected to generate these outcomes:

Intervention 1: The Prevention Programme (Ante Natal and Post Natal Care):

- Orientation on Best Wishes Programme to Health Facility Staff.
- Provision of mobile phones for:
  - All Female Community Health Volunteers.
  - Health Facility and Gateway;
- Marriage registration (information card);
- Pregnancy tracking and registration by FCHVs.
- Introduction of best wishes programme at (R)M and register.
- Folic Acid Supplementation to newly married women.
- Orientation of local health workers on Folic Acid Supplementation to newly married women.
- Community Based Birth Defects Surveillance of Birth Defects.
- Strengthening and supporting establishment of birthing centre (including 1 ultrasound machine/Palika).

Intervention 2: The Prevention Programme (Improved use of child health service and nutrition)

- ToT to health workers on school health screening camp to identify malnourishment and disability.
- School health screening camp to identify children with possible conditions of developmental disability.
- Referral of Children to specialised service centre.
- Nutrition education to mothers of 1000 Golden Days.
- Health Education to adolescents on Sexual and Reproductive rights and disability prevention.

Intervention 3: Improved Quality of Life of Person with Disability through Community Based Rehabilitation

Output 1: Updated Information Management of Person with Disabilities

- Identification of person with disability- By CBRF.
- Disability Assessment Camp (by multidisciplinary team; doctors, physiotherapist, orthopaedics etc.).
- Rehabilitation Plan, Profile development and update.

Output 2.: Improved Health Status of Person with Disabilities

- Home visits;
- Home based primary rehabilitation therapy.
- Medical treatment support and follow up.
- Support with assistive or protective devices.
- Nutrition support;
- Training and transfer of skills to parents and care takers.
- Support to self-help groups led by persons with a disability.

Output 3: Increased Access to Education

- School enrolment support;

- Training to teachers and ECD facilitators on inclusive education.
- Home based education services (formal and non-formal).

Output 4: Increased Economic Status/Livelihood of Person with Disabilities
- Vocational and Skill Development Training.
- Seed Capital for self-help group.
- Support Passbook and Register to SHG.
- Support for access to identity card.
- Formation of cooperatives for Persons with Disability.

Output 5 : Increased Access to Social Activities
- Orientation on Disability and CBR to community groups.
- Celebration of International Disability Day.
- Formation of inclusive Child Club.
- Meeting of Child Club;
- Peer Education Training;
- Extra-curricular activities in Child Club.

Output 6 : Empowered Family and Person with Disability
- Formation and meetings of Milijuli groups (self-help groups).
- Formation and meetings of DPO.
- Leadership Development and Saving and Credit Mobilisation training to Milijuli group.
- Leadership Training to Child Club.

Intervention 5: Strengthened Community Healthcare System and social organisations

Output 1: Strengthened local government system
- Orientation to Chairperson/Mayor about the programme at Provincial level including EO.
- Training to elected bodies about Inspire2Care programme including health facility staffs at Village level.
- Annual Planning Workshop and Agreement with Palika.
- Review meetings at Palika level.
- Furniture and equipment support to CBRF office.
- Administrative cost for HFOMC and CBRF.

Output 2: Improved Administration and Management
- Recruitment and training of CBR Facilitators.
- Monthly meeting of Health Facility charge and CBRFs.
- Salary of CBR Facilitator and incentive for accounting staff at (Rural) Municipality.
- Programme Focal Person;
- Capacity building (incl. financial management) in Palika's.

Annex 4: Budget DPRP in 1 district *after exit*

Code	Activities - *Bhojpur district taken as sample here*	Unit	Budget (Nepalese Rupees)	Budget (EUR)
1	**Outcome 1: Improved health status of mothers and children by increased utilization of MCH services**			
1,1	**Increased use of ANC/institutional Delivery and PNC services**			
1.1.5	Ensure marriage registration (information card)	Pieces	112.500	879
1.1.6	Pregnancy tracking and registration by FCHVs	Person	419.200	3.275
1.1.7	Review of best wishes program at (R)M	Event	462.900	3.616
1.1.8	Best Wishes Card and Register printing	Pieces	125.760	983
1.1.9	Purchase of Folic Acid Supplementation to newly married women	Couples	1.697.760	13.264
1.1.11	Community Based Birth Defects Surveillance of Birth Defects	Person	711.000	5.555
1,2	**Improved use of child health service and nutrition**			
1.2.2	School health screening camp to identify children with possible conditions of developmental disability	Event	585.200	4.572
1.2.3	Referral of Children to specialized service centre	Person	162.000	1.266
1.2.4	Nutrition education to mothers of 1000 Golden Days and orientation on organic farming	Event	1.836.000	14.344
1.2.5	Health Education to adolescents on Adolescent Sexual and Reproductive and disability prevention	Event	74.000	578
2	**Outcome 2: Improved Quality of Life of Person with Disability through Community Based Rehabilitation**			
2,1	**Output 2.1: Updated Information Management of Person with Disabilities**			
2.1.3	Rehabilitation Plan, Profile development and update	Person	27.600	216
2,2	**Output 2.2 : Improved Health Status of Person with Disabilities**			
2.2.3	Medical Treatment Support and follow up	Person	1.856.000	14.500
2.2.4	Assistive or protective Device Support	Person	1.148.000	8.969
2.2.5	Nutrition Support	Person	324.000	2.531
2,3	**Output 2.3: Increased Access to Education**			
2.3.1	School Enrollment Support	Person	162.000	1.266
2.3.3	Home Based Education services (Formal/Non formal education)	Person	324.000	2.531
2,4	**Output 2.4: Increased Economic Status/Livelihood of Person with Disabilities**			
2.4.4	Support for access to identity card	Lumpsum	56.700	443
2.4.5	Establishment of cooperative led by Persons with Disabilities	Palika	270.000	2.109
2,5	**Output 2.5 : Increased Access to Social Activities**			
2.5.2	Celebration of International Disability Day	Event	324.000	2.531
2.5.4	Meeting of Child Club	Times	182.250	1.424
2.5.5	Peer Education Training	Event	187.200	1.463
2.5.6	Extra-curricular activities in Child Club	Event	405.000	3.164
2,6	**Output 2.6 : Empowered Family and Person with Disability**			
2.6.2	Meeting of Milijuli group	Times	631.800	4.936
2.6.4	Meeting of DPO	Times	202.500	1.582
	Outcome 3: Strengthened Community Support System			
3,1	**Output 3.1: Strengthened local government system**			
3.1.3	Annual Planning Workshop and Agreement with Palika	Event	327.150	2.556
3.1.4	Review meeting at Palika level	Event	267.300	2.088
3.1.6	Administrative cost	Month	864.000	6.750
3.1.7	Internet cost for CBRF	Month	216.000	1.688
3,2	**Output 3.2: Improved Administration and Management**			
3.2.3	Monthly meeting of HF in charge and CBRFs	Month	923.400	7.214
3.2.4	Forms and Format Printing	Lumpsum	550.200	4.298
3.2.5	Salary of CBR Facilitator	Month	7.956.000	62.156
3.2.6	Incentive for accounting staff at (Rural) Municipality	Month	324.000	2.531
3.2.7	Program Focal Person	Month	540.000	4.219
	District Total		**24.255.420**	**189.495**
	Palika contribution		**12.127.710**	**94.748**
	Province contribution		**12.127.710**	**94.748**
	KFN contribution		-	-
	Total of 9 Palikas in Bhojpur (euro)		**€ 189.495**	**€ 189.495**
	Cost per Palika		**€ 21.055**	**€ 21.055**

Annex 5: Organogram of Karuna Foundation Nepal (confined to DPPR only)