Karuna_foundation_

Results and Output in 2012

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1. Summary

2012 was the last year of our pilot phase and it was full of rewards. 14 communities have continued to improve the lives of around 500 children with a disability and their families. Health workers and female community health volunteers in these communities have reduced the risks of new-borns and children becoming disabled. Basic health care services in these villages have definitely improved given the fact that patient flow in the Sub Health Posts increased remarkably. The Share & Care program has proven to be financially sustainable. In the year 2012 the first 7 Prevention and Rehabilitation program villages completed their first year in a very successful way. The program has proven to rapidly boost development in prevention and rehabilitation.
Also the replication proposal (2013-2017) has been finalized and submitted to the Ministry of Health.

Positive results have been made in the coordination with the Ministry of Health and development stakeholders (World bank, GiZ, KOICA, Karuna) regarding the National Health Insurance Pilot. Karuna is seen as a strong grass-root level experienced partner and will carry out the Share&Care program in one of the five selected districts for the National Health Insurance Pilot.

Our organization in Nepal is still going strong and continuously learns from the work in the field, in exchanging, reflecting, modifying and innovating our activities and strategies. For the new phase we are strengthening the existing team by adding new professional staff (health economists, monitoring & evaluation etc) and trainings (such as Social Return on Investment).

In 2012 the cooperation/partnership the Dutch FEMI Foundation continued after the feasibility study in 2011. Betteke and Rene were invited to visit the program in Tanzania November 2012. FEMI is also interested in working together with karuna in Sunsari district (Nepal) to implement an integrated approach to development.

Karuna Nepal cooperates with many different stakeholders in Nepal and has built a good network within the sector, Ministry, private sector, health care etc. On the International disability day an inspiring and innovative Career Event for persons with disabilities was organized together with the Association of INGOs Nepal (AIN), Employer organisations and Disabled People Organisations which was visited by 1500 people. The event was highlighted in all newspapers of Nepal.

Both in Nepal and in the Netherlands Karuna became more visible by sharing its successes and lessons learnt in different ways. Karuna Nepal has built a large network within the development, public and private sector. As a support and confirmation of the success, Karuna received the Jobena award, placed 9 in the Top 50 good causes in the newspaper Trouw, and Karuna Nepal received direct support from GiZ, the German development organisation.

The new phase
Karuna is ready for the new phase in which we will scale up the existing programs of Share&Care within the National Health insurance Pilot and the Prevention & rehabilitation Program in Rasuwa district. We have consulted many stakeholders during the process of developing a realistic, decentralized feasible model and we will put all our efforts and hearts in making it a success. We can only continue this mission with the trust, support and efforts of our donors and partners to which we are very thankful.

2. Share & Care

2.1. Progress in the villages

We will continue Share&Care in the existing 5 Village Development Committee (VDCs)s with an improved structure (Consumers Committee/Complementary approach). And in 2011 two new villages in Sunsari will have started Share&Care under the Consumers Committee/Complementary approach.

Initially at the end of 2011 we planned on changing the implementation structure of Share&Care by introducing consumer committees and handing over the responsibility from the health management committees (HFOMC) to the consumer committees. Because of recent developments in Nepal concerning National Health Insurance Pilot and the officially acknowledged status of the Health Management Committees we have decided to stick with the original structure Karuna had designed where the HFOMC has responsibility in a fully decentralized health care system. However, because of the positive added value of forming strong consumer groups we will continue with this process and make sure consumer groups are formed in the different wards of a village. From each ward a representative of a consumer group is chosen to take place in the HFOMC.

There were some delays (2-3 months) in signing the new agreements with some of the villages as the Ministry of Health had ordered their District Health Offices to halt cooperation with all INGOs, a mainly bureaucratic process, but also political move. Because of this new membership campaigns were delayed, health care services continued.

Rasuwa

- Syafru Bensi (Rasuwa district), started in 2009 and currently in its 4th year.

The health-post in charge is proactive in doing all the activities regarding the program. His pro-activeness in the overall loan instalment collection and membership collection of 4th year was something very remarkable. Though we cannot deny the fact that the HFOMC could not be mobilized in these works and others as well but his personal contribution towards the program as a whole is noteworthy especially seeing the attitude in the beginning of the program.

The SC program in Syafru is led by the HP in charge. All the management of the program including service providing, record keeping, and arranging meetings is done by him with the help of other health post staffs, ANM and Lab assistant. The leadership of HFOMC in leading the program is seen nowhere at the present context. Ownership of the program by the HFOMC is minimal, the interest is there but it still needs encouragement from Karuna's side. Membership levels have decreased slightly over the years, the fourth is also challenging, but Karuna is positive it will increase again. The membership collection is currently going on (spring 2013).

Kavre

Karuna will phase out of Kavre overall in 2013.

- Chapakhori, started in 2009 and currently in its 4th year.

The dependency of Share&Care in Chapakhori on Karuna is still too high, both financially as well as technically. There are limited local resources and the membership is low. It is currently a very small scale insurance scheme which can be sustainable, a bit similar to Mechhe and we expect it will continue in this manner after exit.

- Mechhhe, started in 2008, currently in its 4th year.

The only person who is fully reliable and motivated is the health worker In-charge, Mr Kafle. He was also one of the people to receive the small 'Jobena award' . He continues the micro-insurance with passion and commitment with a membership fee of 500 Nepalese Rupees. It is a small scale scheme with 200 members paying for the costs of extra medicine and some small medical supplies. Karuna is very minimally involved and there is no need for further financial support.

Sunsari

- Madesha (Sunsari district), started in 2010 and currently in its 3rd year.

In this village people are quite empowered, also the Health Management Committee. However, the obstacle is the cooperation with the Health-in-Charge. He can still improve in leadership, service and reliability. The Community Based Rehabilitation Work is successful, as well as livelihood activities for the poorest families in the village. Membership has been good over the years, with a small drop in the 2nd year and an increase in the 3rd. Local resources are mobilized up to a good level in Madhesha and they have been getting regular support from VDC council.

- Bhokraha, started in 2009 and currently in its 4th year

This village remains to be one of the most committed villages in terms of leadership and responsibility. In terms of ownership, quality of health services, safe deliveries, CBR work and social cohesion Bhokraha is a great success and example. The Health worker in charge is doing very motivated and positive, including his health staff. Together they play a crucial role in membership collection and of course in providing adequate health service to the people. The HFOMC members meet regularly and the participation is high. They do still need more capacity building and strengthening to trust in their own capabilities and the community. The membership has increased from the first to the second year, and also to the third year. However in this extreme poor village the membership balances around 20% of the population. More trust, awareness and knowledge needs to be generated among the extreme poor community people. Local resources have been mobilized at optimum level in Bhokraha. They have been getting regular support from VDC council. In addition to that they are generating money from ambulance, lab etc.

- Aurabani, started 2011, currently in 2nd year

The advisory committee of the VDC is very much proactive here and has taken the ownership of the program, especially one member of the advisory committee; he is committed, motivated and responsible to make the program sustainable. They are collecting members, generating resources, mobilizing health staffs. Meeting of HFOMC has been regularly but few members are present in the meeting. The Health Incharge changed recently. The new one is much better in delivering quality health services. Karuna hopes the new health Incharge will be able to motivate the other staffs in the health post who so far were not very committed.

- Bhaluwa, started 2011, currently in 2nd year

Most of the HFOMC members are motivated and proactive. Though one HFOMC member, Admin staff, ANM and Health incharge are taking the leadership of the program. The leadership of the HFMOC in total has room for improvement. Meeting of HFOMC and other bodies are being regularly. Health workers are positive and motivated. They are playing crucial role in membership collection and to provide the service to the people.

2.2. Membership

A. *General*

- At least 6000 households with 35.000 people have access to improved primary health care services.
- In 2012, 2294 households (13.000 people) are member of the health Insurance scheme and are financially protected against health costs in improved primary care and referral to secondary care.

B. *Membership level on average 25% of the total population in the community*

The average membership level in the villages is 25% of the total population and 39% of the target population within the reach of the health post.
The membership dropped in the second year in most of the 'second generation' villages, except for Bhokraha. A drop in membership after the first year is a universal phenomenon in Health Insurance. Overall the membership increases again in the third year. However, in Karuna's 'third generation villages' Aurabani and Bhaluwa we see that the membership remains the same or even increases slightly in the second year, which is promising for the future. On average the renewal rates are 57% in the second year and 71% in the third year.

Overview membership per year in the S&C villages

		Total population		Total population within reach of SHP		Membership per village per S&C year (new and renewal)																	Total HH in last completed S&C year			
						Year 1		Year 2					Year 3					Year 4								
	Completed years S&C	Total no of HH	*Total population*	HH within reach of SHP	*Population within reach of SHP*	new	% of total	new	renew	**total**	% of total HH	% of members in year before	new	renew	**total**	% of total HH	% of members in year before	new	renew	**total**	% of total HH	% of members in year before	**Insured HH**	*Insured population*	% insured HH of total HH within village	% insured HH of HH within reach of SHP
Syafru (2009)	3 yrs	485	*2.535*	315	*1.646*	**188**	*39%*	97	67 36%	**164**	*34%*	*87%*	48	70 43%	**118**	*24%*	*72%*						**118**	*617*	*24%*	*37%*
Mechhhe (2008)	4 yrs	1218	*9.214*	700	*5.295*	**468**	*38%*	25	270 58%	**295**	*24%*	*63%*	0	220 75%	**220**	*18%*	*75%*	71	120 55%	**191**	*16%*	*87%*	**191**	*1.445*	*16%*	*27%*
Chapakhori (2009)	3 yrs	555	*4.011*	361	*2.609*	**230**	*41%*	22	132 57%	**154**	*28%*	*67%*	37	154 100%	**191**	*34%*	*124%*						**191**	*1.380*	*34%*	*53%*
Bhokraha (2009)	3yrs	3.200	*19.368*	2.080	*12.589*	**165**	*5%*	361	90 55%	**451**	*14%*	*273%*	406	158 35%	**564**	*18%*	*125%*						**564**	*3.414*	*18%*	*27%*
Madesha (2010)	2 yr	1.290	*7.023*	839	*4.568*	**551**	*43%*	104	317 58%	**421**	*33%*	*76%*	99	378 90%	**477**	*37%*	*113%*						**421**	*2.292*	*33%*	*50%*
Aurabani (2011)	1 yr	1.567	*9.200*	1018	*5.977*	**394**	*25%*	206	217 55%	**423**	*27%*	*107%*											**394**	*2.313*	*25%*	*39%*
Bhaluwa (2011)	1 yr	975	*3.604*	634	*2.344*	**415**	*43%*	138	281 68%	**419**	*43%*	*101%*											**415**	*1.549*	*43%*	*65%*
TOTAL		**9.290**	***54.955***	**5.947**	***35.028***	**2.411**	*26%*	953	1.374 57%	**2.327**	*25%*	***97%***	590	980 71%	**1.570**	23%	***106%***						**2.294**	**13.010**	***25%***	***39%***

2.3. Financial data

For details on financial data in the villages please look at the three tables below.
The costs (income and expenses) shown in the table below only represent the costs directly involved in and managed by the community. The costs that Karuna invests in training, capacity building, monitoring, overhead etc. is not included here, neither is the regular budget from the District Health Office for the sub health post. For further analysis of the financial information please look at the explanation under point D.

C. Balanced income and expenses per village

Yes there is a balanced income and expenses in the schemes. After the second year there is a minimal bank balance of 10% left. In the third year Karuna provides minimal financial support to the scheme in the 3rd year. Currently only our first pilot Mechhhe as completed the 4th year, but unfortunately isn't a good representation of the other villages and we therefore do not present it here.

Financial details of Income and Expenses of Share& Care at village level for year 1 (red table), year 2 (yellow table) and year 3 (blue table)

YEAR 1	Income year 1						Expenses year 1											
	Total income	Karuna Foundation	Local contributions	*Community through premium*	*govern-ment*	*other*	Total expenses	Org. dev.	CBHI	Investment - health facility	Running costs - health facility	Prevention	CBR	Livelihood	PSC	Advances	Bank balance	Total expenses + left balance
Syafru (2009, 3yrs completed)	**€ 16.862**	€ 13.402	€ 3.460 *21%*	*€ 1.500*	*€ 1.560*	*€ 400*	**€ 16.315**	2%	5%	37%		9%	22%	16%	9%	0%	€ 552	€ 16.867
Mechhhe (2008, 4yrs complete)	**€ 33.436**	€ 20.366	€ 13.070 *39%*	*€ 3.910*	*€ 8.382*	*€ 778*	**€ 13.743**		49%	26%				25%			€ 19.692	€ 33.435
Chapakhori (2009, 3yrs completed)	**€ 14.528**	€ 10.954	€ 3.574 *25%*	*€ 1.765*	*€ 282*	*€ 1.527*	**€ 14.290**	4%	8%	47%		9%	16%	7%	9%	0%	€ 299	€ 14.589
Bhokraha (2009, 3yrs completed)	**€ 20.608**	€ 12.922	€ 7.686 *37%*	*€ 2.598*	*€ 3.880*	*€ 1.208*	**€ 19.661**	4%	15%	63%		2%	8%	0%	8%	1%	€ 987	€ 20.648
Madesha (2010, 2 yrs completed)	**€ 28.719**	€ 16.388	€ 12.331 *43%*	*€ 6.524*	*€ 3.152*	*€ 2.655*	**€ 21.586**	1%	13%	42%		5%	4%	28%	7%	0%	€ 7.132	€ 28.718
Aurabani (2011, 1 yr completed)	**€ 26.030**	€ 14.517	€ 11.513 *44%*	*€ 3.793*	*€ 2.810*	*€ 4.910*	**€ 25.098**	6%	13%	42%	12%	4%	10%	7%	6%	0%	€ 833	€ 25.931
Bhaluwa (2011, 1 yr completed)	**€ 24.377**	€ 15.557	€ 8.820 *36%*	*€ 4.844*	*€ 3.463*	*€ 513*	**€ 22.094**	11%	14%	27%	14%	5%	10%	12%	8%	0%	€ 2.282	€ 24.376
Totaal	**€ 164.560**	**€ 104.106**	**€ 60.454** 37%	*€ 24.934*	*€ 23.529*	*€ 11.991*	**€ 132.787**	5%	17%	40%		8%	12%	12%	8%	0%	**€ 31.777**	**€ 164.564**
Average	**€ 23.509**	**€ 14.872**	**€ 8.636**	*€ 3.562*	*€ 3.361*	*€ 1.713*	**€ 18.970**										**€ 4.540**	**€ 23.509**

YEAR 3	Income year 3									Expenses year 3												
	Total income	Karuna Foundation	Local contributions		Community through premium	govern-ment	other	Bank Balance	Total fund (income+balance)	Total expenses	Org. dev.	CBHI	Investment - health facility	Running costs - health facility	Prevention	CBR	Livelihood	PSC	Advances	Ambulance	Bank balance	Total fund (Expenses+balance)
Syafru (2009, 3yrs completed)	€ 5.107	€ 2.332	€ 2.775	54%	€ 964	€ 1.746	€ 65	€ 1.602	€ 6.709	€ 4.853	0%	14%	38%		36%	0%	0%	11%	0%		€ 892	€ 5.745
Mechhe (2008, 4yrs complete)	€ 3.486	€ 1.000	€ 2.485	71%	€ 1.190	€ 1.122	€ 173	€ 16.113	€ 19.599	€ 5.458	10%	57%	10%	5%		6%		12%			€ 14.141	€ 19.599
Chapakhori (2009, 3yrs completed)	€ 5.774	€ 2.810	€ 2.964	51%	€ 640	€ 2.306	€ 18	€ 4.267	€ 10.041	€ 9.446	17%	29%	20%		3%	6%	0%	24%	0%		€ 592	€ 10.038
Bhokraha (2009, 3yrs completed)	€ 21.896	€ 5.940	€ 15.956	73%	€ 2.522	€ 2.571	€ 10.863	€ 6.244	€ 28.140	€ 20.779	3%	12%	8%	19%	6%	4%	11%	11%	0%	26%	€ 7.361	€ 28.140
Madesha (2010, 2 yrs completed)	€ 13.209	€ 3.636	€ 9.573	72%	€ 5.455	€ 2.982	€ 1.136	€ 1.554	€ 14.763	Ongoing												
Total	€ 49.472	€ 15.718	€ 33.753	68%	€ 10.771	€ 10.727	€ 12.255	€ 29.780	€ 79.252	€ 40.536	8%	28%	19%		15%	4%	4%	15%	0%		€ 22.986	€ 63.522
Average	€ 9.894	€ 3.144	€ 6.751		€ 2.154	€ 2.145	€ 2.451	€ 5.956	€ 15.850	€ 10.134											€ 5.747	€ 15.881

YEAR 2	Income Year 2									Expenses year 2												
	Total Income	Karuna Foundation	local contributions		community through premium	Govern-ment	Other	Bank balance	Total fund available	Total expenses	Org. dev.	CBHI	Investment - Health facility	Running costs - health facility	Prevention	CBR	Livelihood	PSC	Advances	Ambulance	Bank balance	Total Fund (expenses +left balance)
Syafru (2009)	€ 8.404	€ 2.110	€ 6.294	75%	€ 1.632	€ 2.796	€ 1.866	€ 552	€ 8.956	€ 8.087	14%	15%	47%		2%	6%	3%	5%	0%	0%	€ 869	€ 8.956
Mechhe (2008)	€ 11.414	€ 8.601	€ 2.812	25%	€ 2.060	€ 372	€ 380	€ 19.692	€ 31.106	€ 14.993	10%	25%	42%	4%	3%	4%		11%			€ 16.113	€ 31.106
Chapakhori (2009)	€ 22.219	€ 16.975	€ 5.244	24%	€ 639	€ 2.732	€ 1.873	€ 299	€ 22.518	€ 18.250	8%	5%	39%		4%	8%	4%	5%	8%	0%	€ 4.267	€ 22.517
Bhokraha (2010)	€ 35.491	€ 18.685	€ 16.806	47%	€ 3.462	€ 3.800	€ 9.544	€ 987	€ 36.478	€ 30.594	4%	9%	37%		7%	2%	11%	2%	0%	12%	€ 5.883	€ 36.477
Madesha (2010)	€ 23.668	€ 10.203	€ 13.465	57%	€ 5.073	€ 2.700	€ 5.692	€ 7.132	€ 30.800	€ 29.341	2%	34%	17%	19%	5%	6%	10%	8%	0%	0%	€ 1.710	€ 31.051
Total	€ 101.196	€ 56.574	€ 44.621	44%	€ 12.866	€ 12.400	€ 19.355	€ 28.662	€ 129.858	€ 101.265	8%	18%	36%		4%	5%	7%	6%	2%	3%	€ 28.842	€ 130.107
Average	€ 20.239	€ 11.315	€ 8.924		€ 2.573	€ 2.480	€ 3.871	€ 5.732	€ 25.972	€ 20.253											€ 5.768	€ 26.021

D. *Minimum of 30% contributions from community and government in 1st year, 60% in the 2nd year, 75% in the 3rd year and full 100% of the costs in the 4th year.*
   - Year 1 → average of 37% local contributions (range 21-44% from 7 villages) of the total average budget of € 23.509
   - Year 2 → average of 60% local contributions (range 23%-75% from 7 villages) on a total average budget of € 20.239
   - Year 3 → average of 68% local contributions (range 44% to 73% from 5 villages) on a total average budget of €9.894

In the third year the target of 75% is not completely achieved which is due to the fact that the presented villages are first and second generation villages where Karuna's investment have been distributed more over the years (as opposed to only in the first two years). We do however expect the new third generation villages of Aurabani and Bhaluwa to do better in this regard. Our expectation is that in the 4th year all villages will be able to manage their income completely from local resources. For creating a sense of trust and motivation Karuna might consider allocating a minimal budget of 200 Euros for some special events in the fourth year.

The percentage of local contributions to the budget of Share&Care increased every year mainly because of Karuna's contribution decreasing as planned, but not so much because of local contributions increasing in absolute terms.

Averages of income per resource per year extracted from detailed financial tables	Year 1	Year 2	*% compared to yr 1*	year 3	*% compared to yr 2*
Average income from **Membership collection**	€ 3,259	€ 2,573	*79%*	€ 2,154	*84%*
Average income from **Government**	€ 3,451	€ 2,480	*72%*	€ 2,145	*87%*
Average income from **Other resources***	€ 1,314	€3,871	*295%*	€ 2,451	*63%*
Average income from **Karuna investment**	€ 14,806	€ 11,315	*76%*	€ 3,144	*28%*

*Income from Other expenses mainly come from health care services, laboratory services, medicine sales and ambulance service to non members. On top of this villages collects the instalments/loans from the microcredit program in which Karuna made a small capital investment. It now functions like a revolving fund.

When looking at the average income per year from different sources in the small table above (extracted from the larger previous tables) you can see that the income from membership decreases over the years, this is partly due to the fact that premium amount has gone down in some villages, e.g. in Bhokraha from €15 in year, to €7,5 in year 2 and to €5 in year 3. So even if membership increases, which is does in year 3, the absolute amount in income from membership might not increase with the same rate.
Also government contributions somewhat declined. But because of the current progress within the National Health Insurance pilot and the commitment from the Nepalese government in this we expect these contributions to rise again and remain steady.
Income from other sources, such as services to non-members, ambulance have increased and provide a reliable income for villages. This is also one of the reasons some villages decided to decrease the premium amount.

The averages are mainly based on first and second generation villages. Karuna and partners in Nepal have fully recognized these aspects need full attention, and all efforts will go into changing the trend for the third and fourth years. We fully realize that this needs more effort, trust, capacity to make sure that the first and second generation VDCs will improve in this regard. We expect that the trend in the third generation (aurabani and bhaluwa) villages will be much better in this regard.

2.4. Health care & prevention

E. Patient flow is 2x as high in the first two years of S&C and remains steady in the 3rd and 4th year.

Patient flow has improved over from in the 1st year compared to before the Share&Care program, with on average 3x times as many patients visiting the health post (on average from 7 patients per day to 23 patients in a sub health post). In the second year it is 4x as high as before the program. In the third year the patient flow stabilizes and is roughly the same as in the second year.
Almost in all villages non-member patient flow is higher than member patient flow(60/40). This still means there is a large group using services but not protected against expenses and thus a potential member for health insurance.

F. Maternal child health indicators ((HMIS) have improved on average with 5%

One of the major lessons over the last 5 years is that we need to emphasize more on improving the health management information systems of the government within the Share&Care program. Especially for the scaling up phase this is crucial. We need to learn more from our ToP program in this regard since it has been successful in this regard. We don't want to set up parallel systems so capacity building of the people (health workers) in charge of managing HMIS data is important in 2013 and beyond.

In 2012 a student of the VU university in Amsterdam did a research on the impact of Share&Care on maternal and child health. Because of lack of data of the government system a good quantitative analysis wasn't possible. However by linking the existing HMIS data to outcomes of focus group discussions she gave some conclusions:

- *The CBHI Share & Care program seems to have a positive influence on the prevention of disabilities and the improvement of mother and child health according to women and health workers, the HMIS shows positive changes in Sunsari and no positive changes in Kavre.*
- *The size of the influence of the Share & Care program on the prevention of disabilities and the improvement of mother and child health is not clear.*
- *Social inclusion of community members in health programs is more present in S&C villages then in control villages. In both S&C and control villages, empowerment in terms of health care seeking behaviour has been increased the past years, this is due to changes in Nepal, the media and S&C.*
- *In Nepal a lot has changed and improved in mother and child health the last couple of years. This most likely has also positive influenced the improvements in the Share & Care villages and therefore the prevention of disabilities.*

HIV/AIDS

Karuna has incorporated awareness raising activities on HIV/AIDs in the counselling to newly married couples, prevention campaigns, check-ups of pregnant women. Today in Nepal the prevalence of Hiv/Aids is mainly prevalent among high risk groups. However STI infections are quite prevalent, especially among women. This also leads to risks for the foetus in case of pregnancy.
Key Findings on HIV/AIDS from the Demographic health survey Nepal (2011)

- Eighty-six percent of women and 97 percent of men age 15-49 have heard of AIDS.

- Comprehensive knowledge of AIDS is not widespread among either women (21 percent) or men (30 percent).
- Only about one in four women (27 percent) and men (29 percent) know of ways to prevent mother-to-child transmission of HIV.
- Overall, half of women and men age 15-49 express accepting attitudes toward people living with AIDS.
- Thirteen percent of sexually active women and 3 percent of sexually active men age 15-49 reported having had a sexually transmitted infection (STI) and/or STI symptoms in the 12 months prior to the survey.
- One-quarter of female and one-third of male youths age 15-24 have comprehensive knowledge of AIDS.

Preventive practices are insufficiently known and followed by men and women, which poses higher risks of transmission. Therefore early action should be taken to prevent the HIV/Aids transmissions and sexually transmitted infections in Nepal. Karuna will continue focussing on this in the prevention activities and also encourage local partners to include the topic in preventive activities.

2.5. Rehabilitation

G. 30% of the 308 children with a disability have improved quality of life at the end of 2012.

In the 7 Share&Care villages there were 334 children with a disability which were all included in the local rehabilitation programs. Of these children 65 (20%) children recovered completely from the impairment they had and no longer needed any other support to take part in daily life and society. 27 children migrated out of the village since the start of the programs. Many of these children moved away for further study and some for marriage. Others migrated with their family for other reasons. Very unfortunately there were also some sad situations where children with a disability died, in total 6 children:2 bhaluwa, 2 aurabani, 2 bhokraha. Some of these were unavoidable, such as the child with a severe braintumour. However some children who suffered from diseases might have been saved if with the right knowledge and attitude earlier action had been taken either by parents or from local health and social workers. Most of the children who died had cerebral palsy, which is a disability that often requires special, such as adjusted feeding practices to avoid malnutrition. In many cases these children are malnourished, and therefore suffer more quickly from diseases because of weaker immune systems. The loss of these children has given Karuna even more motivation to work hard and push more on prevention, early detection and intervention immediately from the start of Share&Care. This very much accords with prevention and timely health care seeking behaviour for all young children in case of diarrhoea, fever, and pneumonia.

In 2012 there were in total 271 children who are all reached by the community based rehabilitation program.

The development of the children and their improvement is very different, depending on de type of disability, the attitude of the parents and the duration of the program. However we are confident to state that **more than 50% of children experience major improvements in their health condition, mobility, education, opportunity to participate in society, increased access, and acceptance by family and society.** There are also some of children with complicated disabilities with whom

improving the quality of life proceeds in extreme small steps. Awareness raising, orientation, and street drama on disability issues have been playing an important role to minimize social stigma, discrimination and change negative feelings, attitude and behaviour of family members and community people.

Summary external evaluation by Huib Cornielje. (full report can be find on the Karuna website)
The CBR programme has resulted in increased awareness of the needs and challenges of children with disability among the community at large. CBR field workers or facilitators play a major role in the actual services and activities of the programme. They focus on identification and referral of children with disability and are capable, though to a limited extent, to provide also basic therapeutic /rehabilitative services to these children. They struggle mostly with the more complex type of disabilities. It is advisable to strengthen the capacity of field staff by means of focused training in handling techniques of children with cerebral palsy and intellectual and behavioural disability.
The community structures, which are in charge of the CBR programme are enthusiastic supporters of the programme and recognize the importance of continuing this programme even after the withdrawal of the Karuna Foundation.

Summary conclusion from the study on quality of life of children with a disability by a student from the VU university (report will be published on Karuna's website)
This study has shown the impact of CBR on the individual level of children with a disability and their families. For a majority of the children CBR caused positive changes in their lives. Those changes were not similar to the impact children experienced from CBR. The major changes occurred on physical health. The impact is mainly experienced on a social level, empowerment and level of independence. Children have more friends and experience less stigma, they go more often to school and therefore they feel more independent and more positive about the future. Due to this impact children and families feel happier and more confident about themselves. However there is also room for improvement both in the quality of CBR work, especially towards a broader focus than medical care, as well as in the baseline measuring of quality of life.

H. Working document of Replicable Model of Share & Care finalized at the end of 2012

The proposal for the Ministry of Health has been finalized and presented in March. The proposal is send together with this report.

3. Training of Professionals

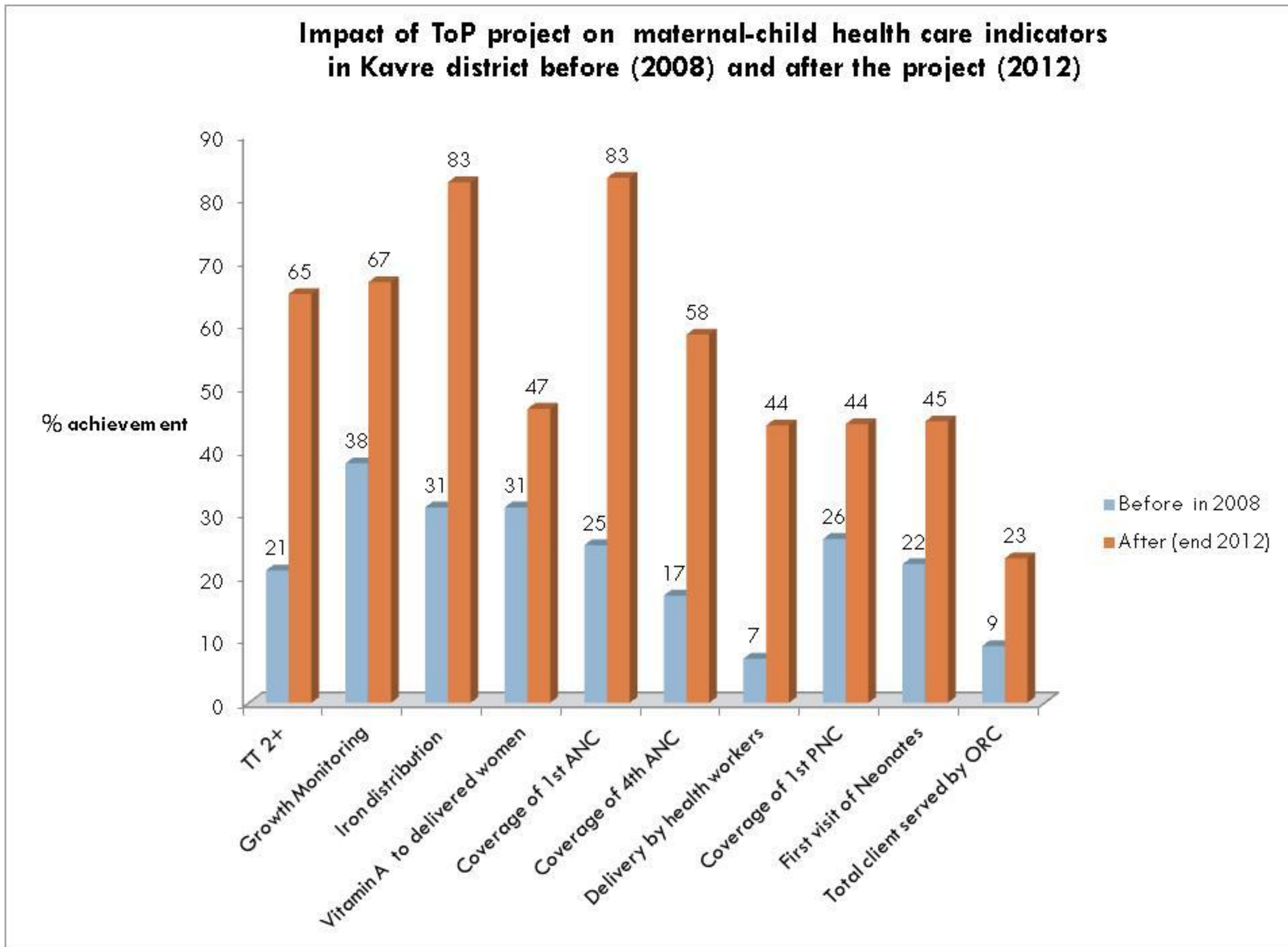
The training of professionals program has silently proven to be a very successful program which is easy to replicate and can be carried out by government, optionally with technical support from Karuna Foundation. It is also important that the current villages keep up the good work and stay motivated. This still needs further follow up.

- Total prevention projects till date : 154
- Review meeting of the prevention projects Kavre with the District health office
- Awards for excellent prevention projects

3.1. Health indicators outcome and impact

A. *Improvement of maternal child health indicators with 7,5 % (presented in graph)*

As an example of the impact on health care indicators the data from Kavre have been presented in the graph below. It shows the health care indicators for women and children before the ToP program in 75 villages in Kavre in 2008 and after some years in 2012. A strong improvement can be seen in all of the indicators with an average increase of 33%.



B. *150 babies are healthy born babies who would have otherwise without the intervention of ToP developed a disability.*

Based on the latest data on the health care indicators in Kavre major improvements have been made. Using the same calculation rationale as in 2009 we can now carefully say that the Karuna ToP program has contributed to 773 new-borns having a higher chance of being born healthy through improved prenatal care, assisted deliveries and infancy care in the last 5 years.

4. Prevention and rehabilitation program

New project focused specifically on prevention and rehabilitation in 7-10 new villages in Rasuwa (among which the previous CBR villages) and Sunsari.

It has been over one year since Karuna foundation has started the Prevention and Rehabilitation Program in 4 villages of Rasuwa and 3 villages in Sunsari.

4.1. Rehabilitation & prevention

A. 200 children with a disability are identified and have an individual treatment plan at the end of 2011 and all children will be involved in the CBR program in 2012

In total there were 258 children with a disability in the P&R villages. All children were identified and have an individual rehabilitation plan. Unfortunately the first year is always challenging to reach all the children effectively because of lack of care, belief, and trust of parents and community.

B. 30% of these children will be on their way to an improved quality life at the end of 2012.

The first year was mainly a focus on attending the first needs such as medical treatment of impairments, getting identity cards, educational support in Rasuwa. In Sunsari there were many medical treatments, also physiotherapy and home visits, nutrition counselling, educational support, formation of self-help groups and child clubs.
6 children completely recovered from the (minor) impairments they had and no longer need support in health, education, social participation etc.
Just around the start of the programmes very sadly four children died (3 children Dumraha in Sunsari, 1 child from Dhaibung in Rasuwa). Most of these children had cerebral palsy which needs more special care practices which the parents and community often don't know yet. 10 children completely recovered from the (minor) impairments they had and they no longer need medical, social, educational support.
Actions have also been taken in building disabled friendly environments, in terms of social acceptance and physical adjustment in infrastructure such as ramps in schools.
Inclusive child clubs have been formed with games, singing and dancing, quiz competition, painting etc. Also self-help groups, including the livelihood families were formed. 40 families have been selected for the livelihood program and trained in general entrepreneurship, but also specific skill training in selected areas of entrepreneurship.
So far educational support has been support for stationeries and facilitation for scholarship to a few students. More needs to be done regarding supporting further study, supporting environment in the school, support in education from the family members, training teachers etc.

C. Comprehensive structure for information flow and monitoring to create awareness, behaviour change and follow up.

Various prevention related activities like school health education (intro disability, prevention, disability rights, inclusion in society), ward level health education (maternal health, prevention of disability), orientation to newly married couples (sexual health, family planning, maternal health, prevention of disabilities), and wall paintings have been carried. Health workers and female community health volunteers (in total 140) have received awareness and orientation training on CBR

and prevention. And many women and children have been reached through the community prevention program.

D. Maternal – child health indicators have improved with 5-10%.

The prevention activities have only started last year, so therefore it is too early to measure any concrete impact on the health indicators.

4.2. Implementation, leadership and finances

E. Embedding and/or strengthening of prevention and rehabilitation strategies in the local government structure.

The local Village Disability and Rehabilitation Committees (VDRC) are responsible and develop their leadership skills. Ownership and leadership of the programme has been taken up by most of the VDRCs. In Madhuvan the members are less pro-active, we expect this to change in the second and third year. The Chairman of the VDC (village) is automatically also the chairman of the VDRC (this is government policy) which often provides a challenge in the time he has available to take lead of the program. In all villages the health workers are positive and they have been supportive to the CBR facilitator. CBR workers in almost all villages are competent and have taken up their responsibility actively. However in Dumraha strong encouragement and motivation towards the CBR workers is necessary.

The coordination with CBR-DCC (the official district body for coordinating VDRCs) is currently done by Karuna because coordination from VDRC to CBR-DCC and vice versa is not strong enough yet. Supervision from CBR-DCC to the program VDC's has only started recently. Recently, the first ID- card (identity) camps have been organized in support of CBR-DCC as a first start of the collaboration. Karuna will do more on capacity building and relationship building between VDRC and CBR-DDC.

F. The contribution of local community & government is 20% in the 1st year, 40% in 2nd year, 75% in 3rd year, 100% in 4th year.

In the two tables on the following pages the income and expenses per district and village for year 1 are given. Expenses are split in the different headings of prevention, rehabilitation, capacity building & training, programme implementation.

So far the main income sources for Prevention & Rehabilitation come from Karuna (75%). The other 25% comes from the VDCs (municipality). It is expected that in the second year district government will commit financially to the programme, paving the way to a sustainable programme. In Rasuwa the local development office (LDO) has committed to contribute €1000 for every village in the 2nd year.

After 2 years of the program the plan is that the local committees also ask the parents to contribute to the services.

Rasuwa

Income 1st year

	Bhorle				Ramche				Lahare Pauwa				Dhaibung			
Source of income	**NRs**	**Euro**			**NRs**	**Euro**			**NRs**	**Euro**			**NRs**	**Euro**		
Karuna Foundation Nepal	229460	€	2,185	*81%*	229711	€	2,188	*99%*	193711	€	1,845	*97%*	169461	€	1,614	*77%*
Villag Development Committee Contribution	52000	€	495	*18%*	2000	€	19	*1%*	2000	€	19	*1%*	52000	€	495	*23%*
other	1679	€	16	*1%*	560	€	5	*0%*	3319	€	32	*2%*		€	-	*0%*
TOTAL INCOME	283139	**€**	**2,697**		232271	**€**	**2,212**		199030	**€**	**1,896**		221461	**€**	**2,109**	

Expenses 1st Year

Activities	**Bhorle**				**Ramche**				**Lahare Pauwa**				**Dhaibung**			
	NRs	**Euro**			**NRs**	**Euro**			**NRs**	**Euro**			**NRs**	**Euro**		
Preparation & Capacity building	31,670	€	302	*16%*	**30,950**	€	295	*15%*	**32,010**	€	305	*17%*	32249	€	307	*18%*
Health promotion & Disability prevention	39,350	€	375	*20%*	**65,500**	€	624	*32%*	**46,693**	€	445	*25%*	38854	€	370	*22%*
CBR	121,605	€	1,158	*61%*	**104,280**	€	993	*51%*	**96,921**	€	923	*52%*	100970	€	962	*56%*
Program implementation costs	7,807	€	74	*4%*	**4,691**	€	45	*2%*	**11,828**	€	113	*6%*	8070	€	77	*4%*
Total expenses	200,432	**€**	**1,909**		205,421	**€**	**1,956**		187,452	**€**	**1,785**		180,143	**€**	**1,716**	
advances	4,697	€	45		**19,110**	€	182		**9,578**	€	91		7978	€	76	
balance	78,010	€	743		**7,740**	€	74		**2,000**	€	19		33340	€	318	
Total including balance	283,139	**€**	**2,697**		232,271	**€**	**2,212**		199,030	**€**	**1,896**		221,461	**€**	**2,109**	

SUNSARI

	Income 1st year	Baklauri				Madhuvan				Dumraha			
	Source of income	NRs	Euro			NRs	Euro			NRs	Euro		
1	Karuna Foundation Nepal	407835	€	3,884	78%	419411	€	3,994	79%	375342	€	3,575	75%
2	Villag Development Committee Contribution	100000	€	952	19%	100000	€	952	19%	116112	€	1,106	23%
3	Women Development Office Contribution	12000	€	114	2%	11000	€	105	2%	12000	€	114	2%
	TOTAL INCOME	**519835**	**€**	**4,951**		**530411**	**€**	**5,052**		**503454**	**€**	**4,795**	

	Expenses 1st Year	Baklauri				Madhuban				Dumraha			
	Activities	NRs	Euro			NRs	Euro			NRs	Euro		
1	**Preparation**	**480**	**€**	**5**	0%	**1425**	**€**	**14**	0%	**1080**	**€**	**10**	0%
2	**Health Promotion and Disability Prevention**	**131,694**	**€**	**1,254**	28%	**89,396**	**€**	**851**	22%	**49,308**	**€**	**470**	12%
3	**Community Based Rehabiliattion**	**312,242**	**€**	**2,971**	67%	**285,542**	**€**	**2,719**	70%	**319,293**	**€**	**3,041**	79%
3.1	*Management (salary CBR worker)*	*149,582*	*€*	*1,425*		*152,563*	*€*	*1,453*		*139,451*	*€*	*1,328*	
3.2	*Health*	*27,250*	*€*	*256*		*7,545*	*€*	*72*		*11,947*	*€*	*114*	
3.3	*Education*	*25,455*	*€*	*242*		*14,504*	*€*	*138*		*21,351*	*€*	*203*	
3.4	*Livelihood*	*100,000*	*€*	*952*		*100,000*	*€*	*952*		*113,395*	*€*	*1,080*	
3.5	*Social*	*-*	*€*	*-*		*8,270*	*€*	*79*		*28,170*	*€*	*268*	
3.6	*Empowerment*	*9,955*	*€*	*95*		*2,660*	*€*	*25*		*4,979*	*€*	*47*	
4	**Program Implementation**	**2,640**	**€**	**25**	1%	**600**	**€**	**6**	0%	**1,525**	**€**	**15**	0%
5	**Others**	**21,780**	**€**	**198**	4%	**31,900**	**€**	**290**	7%	**31,700**	**€**	**288**	8%
	TOTAL EXPENSES	**468836**	**€**	**4,465**		**408863**	**€**	**3,894**		**402906**	**€**	**3,837**	
	Advances	43286	€	412		1390	€	13		3771	€	36	
	Bank balance	8713	€	83		120158	€	1,144		96777	€	922	
	TOTAL including balance	**520835**	**€**	**4,960**		**530411**	**€**	**5,052**		**503454**	**€**	**4,795**	

5. Lobby & advocacy

Policy, Advocacy and Networking are effective tools that helped Karuna to achieve the position where we are today and create synergy in the work we do with others. Planning an effective policy, sharp advocacy on your work and networking with right stakeholders creates a positive environment for better functioning.

- Because of our pro-activeness Karuna has been identified and recognized as one of the important organizations in the field of disability and health.
- Establishing strategic partnership (formal and informal) with key stakeholders including Ministry of Health and Population and Ministry of Women, Children, and Social Welfare, National Planning Commission, National Federation of Disabled Nepal, Association of INGOs in Nepal led to:
    - Events, like Career Expo for Persons with Disabilities, are one of the key strategic moves of Karuna to generate support and synergy in its work.
    - Working with Ministry of Women Children and Social Welfare to publish 'Disability Resource Book', to finalize the 'National CBR Guideline' and 'Accessibility Guideline'.
    - Being one of the members of task force to draft the National Health Insurance Policy of Government of Nepal
    - Being elected as a member of Steering committee of Association of INGOs in Nepal.

6. The organization

6.1. Nepal

- *Extensive training and capacity building within Karuna Nepal is carried out, especially focussed on their role as coach, facilitator and trainer in the VDCs.*
  In 2012 no new trainings were carried out, the most important ones were already done in 2011. It was a year of consolidating and preparing for the next phase.

- *A well organized, professional, transparent organization with a competent, balanced and inspiring team both in Nepal and the Netherland.*

  Strengths
  1) Learning by doing
  2) Open and transparent
  3) Commitment
  4) Team Work
  5) (Self)Critical
  6) Leading organization in health insurance and community based rehabilitation in Nepal
  7) Thinking out of Box
  8) Technical Knowledge on health insurance has grown rapidly in 2012

  Weaknesses
  1) Data compilation and Documentation
  2) Data Analysis (good evidence based facts and figures)

- *Several PR activities have been carried such as organisation of events, publishing (joint) reports etc.*
  A very successful career event for persons with disabilities was carried out for the International Disability Day (dec 3rd 2012). This event was organized by Ministry of Nepal, National Federation of Disabled Nepal, Association of International NGOs Nepal and Federation of Nepalese Chambers of Commerce and Industries together with Employer organisation MeroJob and the Federation of journalists. More than 1500 persons with disabilities attended the event and over 600 registered with MeroJob and posted their CV's online. 12 persons with disabilities managed to get a job on the same day as the event. It was a good event to create awareness on capacities and capabilities of persons with disabilities and stress equal rights to employment.

  Karuna Foundation received the Dutch Jobena award which came with a prize of 10.000 euros. We decided to make small Jobena awards to leading and accountable community people (health workers, CBR workers, HFOMC committees, etc) in the program areas. In total Karuna awarded 10 Jobena prizes as a matter of recognition and motivation for the person receiving it, and for others as an encouragement to work hard and receive the award in the next year.
  It gave an enormous boost and motivation to the communities and we will continue this tradition.

- *Karuna Foundation Nepal coordinates and partners with different stakeholders in the field of health, disability and development*
  Karuna has set up a strong network of partnerships in Nepal. Where ever possibilities and opportunities rise in cooperating together with others we do. Some examples: CBR Biratnagar, Hospital for Rehabilitation of Disabled Children (HRDC), SIRC (Spinal injury), Madat Nepal, Women for Women, KOICA (Korean development agency), SHIA, PLAN Nepal, Phect Nepal, GiZ, District authorities, National authorities, different INGOs within the association of INGOs in Nepal.

- *At the end of 2012 final evaluation of 5 year program by the Social Welfare Council of Nepal*
  This evaluation was carried out in the beginning of March 2013 and we are expecting the results end of March 2013.

6.2. Netherlands

- *Inspire other organisations and entrepreneurs with the entrepreneurial development approach of Karuna (through presentations, partnerships, meetings)*
  - Participation in different coalitions and platforms (DCDD, Health Insurance Platform of the Poor, Partos, etc)
  - Karuna gave an extensive presentation on the Share&Care program at the HIP platform meeting May 2012. Other presenters during this meeting were PharmAccess and HealthnetTPO.
  - Betteke and Rene attended the FIN meeting with the theme 'evaluation' in autumn 2012 and presented cases from Karuna.

- The partnership with FEMI continued and November 2012 Betteke and Rene visited the projects in Tanzania with the board of FEMI.
- FEMI is also interested in working together in Nepal.

- *Promote inclusion of disability and prevention in mainstream development organisations and initiatives.*
  Karuna Foundation is an institutional member of Dutch Coalition of Disability and Development (DCDD) and Karuna's director is also a board member. We also have worked to inspire other organisations and partners we work with to mainstream disability and prevention in their projects.

- *Several PR activities have been carried out such as a folder and articles.*
  - The Dutch year report was published, and send to all partners and relations.
  - The year report 2011 was also submitted to PriceWaterhouseCooper for the Transparency prize for small organisations. It was our first submission, we placed in lower segment, but we received very constructive and positive feedback for the next year report.
  - Betteke de Gaay Fortman wrote an article on leadership in the development sector with examples from Karuna Foundation in Vice Versa.

- *Continued participation of other (entrepreneurial & INGO) donors.*
  - In 2012 Giesbers Groep, Rene aan de Stegge, Achmea Foundation, Dura Charity Foundation, Johanna Grote Donk Stichting financially supported Karuna Foundation.

- *Work towards replication of the Share&Care model.*
  Share&Care is ready to be scaled up starting in 2013 and the proposal to the Ministry of Health has been submitted in March 2013. Also a new general agreement (for INGOs) has been signed with the Social Welfare Council for a new 5 year project period including scaling up S&C and continuation of Prevention & Rehabilitation.

- *Work towards evidence-based results, eventually in partnership with a Dutch or Nepalese University.*
  The research by the two students of the VU University has been completed. It has provided indications of the impact of Karuna's projects, but strong conclusions can't be drawn. For the new phase we are still looking for possibilities of working together with a university. However a great deal of the evidence based practices/knowledge that we wanted to get out of this partnership also was established through knowledge and research networks such as the HIP-Platform.

7. Lessons

- Replication/scaling up S&C is only possible within the government structure with a decentralized structure.
- S&C is financially sustainable in 2-3 years, but technical and moral support to the villages is still necessary for some more years to guarantee a sustainable development.

- Success factors which we identified and which are also validated by the Dutch Erasmus University are:
  - Good coordination and cooperation with local authorities and like-minded organisations based on trust and respect
  - Direct implementation and active participation of the target group
  - A well thought out concept and vision combined with 'learning by doing' and prompt action
  - Taking risks and accepting possible failures
- In the Prevention and Rehabilitation villages, visible and tangible results are necessary first before the district and community are ready to contribute financially to specific topics of prevention and rehabilitation.
- For strong and ongoing improvement in CBR and prevention more exchange and commitment among clusters of villages is necessary. Work in isolation doesn't provide the very much needed motivation and change enough, working together and in a broader perspective will.