# Introduction

## A. Program Background

Building on the past experience of Nepal's Community Health Leaders Program, the National Female Community Health Volunteer (FCHV) Program was established in 1988 under the Public Health Division of the Ministry of Health, His Majesty's Government of Nepal (MOH, HMG/N). The National FCHV Program (FCHV/P) was designed to enhance Nepal's primary health care network through community participation and expanded outreach by local women working voluntarily. Across Nepal's 75 districts, there are now 48,549[1] FCHVs currently assisting with primary health care activities and acting as a bridge between government health services and the community.

Since the inception of the program, FCHVs have served as frontline local health resources persons who provide community-based health education and services in rural areas, with special focus on maternal and child health and family planning issues. After their selection by local mothers' groups (MGs), FCHVs receive basic training during which they are provided with a reference manual, program materials and other supportive behavior change communication (BCC) resources. To enable FCHVs to provide vital community-based outreach, FCHVs are provided with a set of essential commodities and first aid supplies, which are to be replenished locally on a regular basis.

Through their voluntary service, FCHVs contribute extensively to the health and well being of their communities. FCHVs have played a significant role in the semi-annual distribution of vitamin A capsules and National Immunization Days, and in providing community-based treatment of acute respiratory infection (ARI) cases and referral to health facilities (HFs) in program districts. With their unique and close proximity to the community, FCHVs form the grassroots foundation of Nepal's community-based primary health care system and are the key referral link between health services and community members. Additionally FCHVs have made significant contributions to women's leadership and empowerment at the VDC level, and several active FCHVs were elected as VDC members in the last local elections.

The foundation of the original program strategy was based on the organizational design of the Nepal Women's Organization (NWO). Key features of the original strategy included: the pivotal role of Nepal Women's Primary Committees in planning and implementing the FCHV/P; modular basic training for FCHVs which included three segments totaling 24 days (12 days + 6 days + 6 days); FCHVs' monthly allowance of Rs. 100; and a deduction of Rs. 250 from FCHVs' training allowance for use as seed money to replenish FCHVs' medical supplies. One FCHV per ward was selected for training. The program was first initiated in 19 Central Region districts and 8 Mid-Western Region districts.

In September 1990, the original strategy was revised in response to the establishment of a multi-party, parliamentary democracy. The responsibilities for MG formation and FCHV selection were shifted from the NWO to local women. At this time, FCHVs' basic training was reduced from 24 days to 20 days and divided into two modules (10 days + 10 days), and the provision for FCHVs' monthly allowance was withdrawn. By the end of 1990, the FCHV/P was expanded in a phase-wise manner into an additional 29 districts across the

[1] FCHV Section/FHD Report/FHD, MOH, HMG/N, 2002.

Eastern, Western and Far-Western Regions; and by 1995, the program reached the remaining 19 Western and Mid-Western districts, thereby ensuring that one FCHV per ward in all 75 districts had been selected and trained.

Following the introduction of a new health policy in 1991 and an evolving political landscape, the FCHV/P strategy was again revised in1994/95. In the second revised strategy, several new concepts were introduced including the population-based approach to MG formation and FCHV selection, and the position of Village Development Committee (VDC) level FCHV Coordinator. The duration of basic training was reduced from 20 days to 15 days into one module, and the policy of deducting Rs. 250 from FCHVs' training allowance for supply replenishment was withdrawn.

Between 1995 and 1998, the population-based approach expanded the FCHV/P in 28 of Nepal's more populous districts, which were originally established as ward-based districts. Simultaneously, the VDC level FCHV Coordinator approach was initiated in 14 districts. Due to funding limitations, neither the population-based nor VDC level FCHV strategy was further implemented.

Since the implementation of the FCHV/P in 1988, the context in which FCHVs have been involved in community health improvement has witnessed some significant change. During the past fifteen years, the roles and responsibilities of FCHVs have continually evolved and the variety of different health programs utilizing community-based approaches has increased. Simultaneously, the dual processes of health sector reform and the Local Self-Governance Act (LSGA), through which VDCs have begun to take local responsibility for the management of sub health posts, have been initiated. Each of these changes prompted the need to again review the existing program strategy, last revised in 1994 during 2003.

This newly revised national FCHV/P strategy will guide the government and its many collaborating agencies working together to support the FCHV/P. This document provides strategic directions and critical approaches to ensure a strengthened national program and consistent, continuous support of each and every FCHV.

## B. Program Goal and Objectives

**Goal**

The National FCHV Program, focused on family planning, maternal/neonatal and child health, including the semi-annual Vitamin A supplementation program, will contribute to Nepal's goal of reducing the total fertility rate and the under 5 mortality and maternal mortality rates.

**Objectives**

- To develop in every ward with at least one FCHV, knowledgeable, trained and well-supported health resource person through capacity building, distance education and supportive monitoring activities, which will reinforce each FCHV's ability to fulfill her role as health educator, referral agent, community mobilizer and community-based service provider.

- To provide FCHVs with necessary skills and support to empower rural women with basic health knowledge and skills in order to increase utilization of available primary health care (PHC) services and participation in community health development.

- To increase community awareness about the importance of the joint roles and responsibilities of FCHVs and MGs through advocacy and health communication activities; and

- To strengthen community level ownership, management and long-term sustainability of the FCHV/P, in conjunction with the LGSA, through the establishment of local funds by local VDC and District Development Committee (DDC) authorities, and through active support and commitment from all levels of implementation, including health facilities (HFs)[2], health facility management committees (HFMCs) and District Health Offices/District Public Health Offices (DHO/DPHOs).

[2] Throughout this document, the term health facility (HF) represents the combination of Primary Health Care Centers (PHCC), Health Posts (HP) and Sub Health Posts (SHP).

# Key Elements of Program Strategy

## A. Summary

The strategy for the implementation of the FCHV/P was originally formulated in 1988 and was then revised in both 1990 and 1994 with some modifications required after political changes in the country. During 2003, the program strategy was further revised to ensure strengthened and effective implementation of the program (See Annex 2 for strategy implementation plan.)

1. ***Orientation activities:*** Community orientation activities will be conducted at the DDC, VDC, HFMC and ward levels to reorient community members to the FCHV/P, to clarify the important roles and responsibilities of MGs and FCHVs, and to emphasize the importance of reaching disadvantaged and underserved groups within the community in MG formation and FCHV selection activities. Orientation activities will also be conducted at DDC and VDC levels following new elections

2. ***Mothers' group reorganization or formation:*** The need for MG reorganization or formation will be assessed and facilitated in wards where MGs have become inactive and require reorganization, or where FCHVs are currently working without the support of an active MG. This activity will be facilitated by the Health Facility In-Charge (HFIC), Village Health Worker (VHW) and Maternal Child Health Worker (MCHW), with support from the HFMC, VDC Committee and active local women. General MG membership will be extended to all women of reproductive age in a ward. A group of approximately 10 mothers with an elected chairwoman will be established as the MG 'executive committee.' In wards with large populations, widely separated villages or large geographical areas, more than one MG may be formed.

3. ***FCHV selection:*** MGs will then select new FCHVs based on specific criteria. At a minimum, at least one FCHV per ward will be selected. To ensure overall program sustainability and consistent, responsive support to all current FCHVs, the ward-based approach will be strengthened nationally and be implemented as the primary approach of the FCHV/P. Emphasis will be given to strengthening support to all current FCHVs. In specific cases where DDCs, VDCs or municipalities demand program expansion or request an increased number of FCHVs, the population-based approach may be expanded cautiously and implemented on the basis of clearly defined criteria.

4. ***Municipality-based FCHV/P activities:*** Existing models of municipality-based FCHV/P activities will be reviewed and recommended for appropriate expansion to other municipalities.

5. ***Basic training:*** Newly selected FCHVs will receive 18 days of basic training conducted by HFICs (representing PHCC/HP/SHP). The basic training will be divided into two modules of 9 days and conducted at 2-month intervals covering content as per the revised curriculum. Training allowance will be provided to FCHVs for all training days attended.

6. ***Essential materials and commodities:*** Each FCHV will be provided with a full set of FCHV/P materials, medicine kit with essential commodities and simple first aid supplies free of cost at the end of her basic training. The regular replenishment of essential commodities and other supplies will be the responsibility of the HFMC in

coordination with HF staff and DHO/DPHO. FCHVs are responsible to monitor their stocks of commodities and request resupply on a timely basis. FCHV/P materials will be replaced as needed during refresher training activities.

7. ***District training of trainers:*** All health workers involved in implementing FCHV/P activities will be reoriented to planning, implementation and evaluation of activities. Select DHO/DPHO staff and PHCC/HP/SHP-ICs [including both Health Assistant (HA) and Auxiliary Health Worker (AHW) cadres] will participate in a one-week district training of trainers' (DTOT) course to refresh and reinforce their skills in conducting FCHV basic and refresher training activities. The DTOT will also focus on program management, supervision and monitoring skills, interpersonal communication and social mobilization skills and other new content areas in order to provide stronger support to FCHVs. The number of health workers involved in DTOT will be determined based on the number of total FCHVs per district.

8. ***Health worker refresher training:*** AHWs, VHWs and MCHWs will be provided with refresher training to strengthen their ability to support FCHVs. The refresher training will focus on monitoring, supervision, community mobilization, facilitation and interpersonal communication skills and other new content areas in order to provide stronger support to FCHVs. Both VHWs and MCHWs will serve as FCHVs' immediate supervisors, as assigned by the HFICs.

9. ***Key FCHV/P personnel***: Required personnel will be in place at all levels to support the implementation of the new strategy. The responsibilities related to coordination, program management, and supervision and monitoring will be established from the central level through the VDC and SHP (See Annex 3 for details).

10. ***FCHV refresher training:*** At the ilaka or HP level, a five-day refresher training will be conducted for all FCHVs every five years. The refresher training will be conducted by HFICs who have participated in refresher DTOT, and will be planned according to established training methodologies and content as per the revised curriculum.

11. ***FCHV review meetings:*** At the SHP level, a one to two-day review meeting will be held every four months for reviewing and planning of FCHV/P activities. All FCHVs, MCHWs and VHWs will participate in the meeting, which will be facilitated by the HFIC. Review activities will include FCHVs' progress updates and forward plans, problem solving, data collection and review of FCHV registers, provision of supportive feedback to FCHVs and resupply of essential commodities. The first meeting of the year will be two days in duration at which HFICs will facilitate a planning discussion. The second and third meetings of the year will each be one day in duration. The HFIC will facilitate an annual performance review during the third meeting. Review meetings will be scheduled around primary agricultural activities as per the local situation.

12. ***Community involvement in FCHV review meetings:*** Every possible effort will be made to achieve and maintain full community participation and integration in the review and planning of FCHV/P activities. Select VDC members and female ward members will be invited to participate in the FCHVs' review meeting. At the trimesterly district level review meeting conducted by the DHO/DPHO, select DDC members will be invited to participate in order to review and plan the FCHV/P

activities. Other district review meeting participants will include HFICs (from PHCC/HP/SHP levels), the district FCHV Subcommittee and other relevant district staff.

13. ***Integrated health review meetings:*** With the implementation of the LSGA, it is foreseen that an integrated review of all health program activities, including FCHV/P activities, will be planned once every four months at the ilaka and district levels. This forum will also be used for reviewing and planning FCHV/P activities. Regional and national level review and planning will also be integrated into the trimesterly review meeting cycle. Regional meetings will include DHO/DPHOs, Regional Health Directorate (RHD) officers and relevant Department of Health Services (DHS) officials.

14. ***Support mechanisms and advocacy activities:*** To more fully recognize, reward and encourage FCHVs' valuable contributions to community health, a variety of support mechanisms and advocacy activities will be implemented and advocated by supporting partners.

15. ***Decentralization:*** Local participation and ownership in the FCHV/P, and shared responsibility for supporting FCHV activities among DHO/DPHO and DDC at the district level, and among VDC, HFMC and health facility staff at the community level, will be developed and linked with the ongoing processes of decentralization and handover of local health facilities to VDCs.

16. ***FCHV Subcommittee:*** A FCHV Subcommittee will be established by the FHD under the RHCC, which will function as a program support mechanism to the FCHV Section/FHD. It will be a voluntary forum of members working together to create a collaborative, cooperative and better coordinated working relationship among all FCHV/P partners. Regular meetings will be held monthly during the initial implementation phase of the revised strategy, then on a trimesterly basis. The subcommittee will have adequate representation of government, donors, international/ non-governmental organizations (I/NGOs) and other appropriate partners from the national to the community level (see Annex 3 for details).

17. ***Coordination:*** All partners working with FCHVs – including governmental programs, donors and I/NGOs – will report on their progress to and coordinate with the FCHV Section/FHD and the FCHV Subcommittee. The FCHV Section/FHD and FCHV Subcommittee will also coordinate the regular review of the FCHV/P strategy every five years.

    Senior level donor and I/NGO partners, as well as relevant DHS Division/Center directors, will meet trimesterly with the Director General to discuss policy level matters and address issues raised by the FCHV Subcommittee.

## B. Ward-based and Population-based Approaches

To ensure overall program sustainability and consistent, responsive support to all FCHVs, the ward-based approach will be strengthened nationally and implemented as the primary approach of the FCHV/P. Emphasis will be given to strengthening support to the all FCHVs.

However, in specific cases where DDCs, VDCs or municipalities demand program expansion or request an increased number of FCHVs, the population-based approach may be expanded cautiously and implemented on the basis of the following criteria:

***Criteria for Population-based Expansion***

1) The VDC or municipality is able to bear all costs and can provide financial, human and material resources for the following requisite program activities:

    - Community Mapping of the VDC or municipality
    - Orientation Meetings
    - Basic Training
    - Refresher Training
    - Review Meetings

    Support for the above activities may be provided by EDPs, I/NGOs or community-based organizations (CBOs) where they are supporting core or add-on activities.

2) The VDC or municipality will make a formal commitment to providing this support, in writing, before the process begins. A standard memorandum of understanding (MOU) will be established between the VDC or municipality, the DDC, DHO/DPHO and FHD/DHS.

3) The FCHV Section/FHD, with support from the FCHV Subcommittee, will develop criteria detailing how more under-served and disadvantaged families in the community will be targeted for priority involvement in the FCHV/P through orientation, MG formation or reorganization and FCHV selection activities.

4) MGs will be representative of the whole population of a ward, and will select their FCHV according to the selection criteria. Outreach to under-served and disadvantaged mothers will be addressed during ward and MG orientation meetings, and the VDC committee and assembly will play a consultative role in this process. Local NGOs and CBOs working with under-served families will also be consulted and involved.

5) Cluster-based sampling will be implemented to avoid the selection of more than one FCHV from the same cluster of households or geographic area. Clusters will be determined through community mapping exercises facilitated by the HFIC and VDC, with assistance from VHW and MCHW and other partners as applicable.

6) The population ratio for an expanded population-based program will be as follows:
   - Terai: 1 FCHV per 1000 population
   - Hills: 1 FCHV per 350 population
   - High Mountains: 1 FCHV per 200 population

Existing models of municipality-based FCHV/P activities will be reviewed and recommended for expansion to other municipalities by the FCHV Section/FHD and FCHV Subcommittee.

## C. Community Mobilization Activities

An important component of the FCHV/P has been to create awareness among community members and to help them recognize their critical role in motivating FCHVs and other health workers. It is critical that community members understand that their active support of FCHVs is essential to the success of the program.

To mobilize people for increased community involvement in the FCHV/P, a new round of orientation meetings will be conducted at the VDC, ward and MG and other community group levels. The content of the orientation meetings will have specific emphasis on new elements in the revised program strategy, how each level can support the FCHV/P, how ownership of the program can be decentralized and how community ownership can be fostered.

At the VDC level orientation, VDC chairperson, ward members and FCHVs will all participate in the meeting facilitated by HFIC with support from the HFMC. At both the VDC and ward levels, a broad foundation of community awareness and involvement in the FCHV/P will be reinforced by involving teachers, nonformal leaders and existing groups (including savings and credit groups, income generation groups, forest and water users groups, youth clubs and general MG members) in orientation activities. Partner organizations including External Development Partners (EDPs), I/NGOs and CBOs are expected to play a significant role in mobilizing grassroots support for the FCHV/P and outreach to under-served families for their inclusion as MG members and FCHVs.

At the regional and district level orientation meetings, the revised program strategy will also be disseminated and discussed. (See Annex 3 for description of implementation activities.)

## D. Role and Revitalization of Mothers' Groups

Active mothers' groups (MGs) are a key component to ensure a successful and sustainable FCHV/P. The network of MGs will be mobilized as a platform for community participation in health improvement. MG members are not just passive recipients of FCHVs' health messages and activities; rather MG members have an active role to play in mobilizing community members for their involvement in community health improvement, and reaching out to mothers who are not participating in MG meetings. Building on lessons learned, HF staff, HFMC and the VDC committee will work together to address problems that have caused MGs to become inactive and to strengthen the network of women who participate in MG activities.

Several strategies for revitalizing MGs have been identified:[3]

1) Strengthen the orientation process at VDC and ward levels to clarify the roles and responsibilities of MGs, and to ensure community members are well oriented to the FCHV/P. Assess whether MGs have become inactive and determine where MG reorganization is needed. HFICs, with support from HF staff, HFMC and VDC members, will facilitate ward and MG orientation meetings as well as MG formation or reorganization activities as needed.

2) Ensure balanced representation of all community members with proactive effort to include disadvantaged and under-served groups (including ethnic minorities and dalits) in the formation of new MGs. HFIC, with support from HF staff, HFMC and VDC, will facilitate community mapping exercises to identify under-served families for inclusion in MG activities.

3) Build upon the existing network of community and women's groups (such as income generation, savings and credit, forest users and literacy groups) where MGs are not active. Coordinate with the relevant line agencies, local NGOs and CBOs that support these groups. Reinforce this network by providing these groups (both male and female members) with orientation on the FCHV/P and the important role of MGs, thereby fostering their support.

4) Provide additional incentives to existing MGs by linking them with line agencies, local NGOs and CBOs that support community development activities (such as income generation, savings and credit, forest users, literacy and other groups). Support MGs to develop and manage emergency health funds for use by the general MG membership and community.

5) EDPs, I/NGOs and CBOs are requested, to every extent possible, to coordinate any new activities through the existing MG structure, including the general membership and executive committee of the MG, thereby strengthening and integrating overall community health and development efforts.

[3] Packages to support MGs as a platform for mobilizing community participation in health are available from partner organizations including GTZ-HSSP, SDC, SC-US and CARE.

The criteria for MG formation or reorganization will be consistently implemented in all wards:

***Criteria for Mothers' Group Formation or Reorganization***

- MG membership is extended to all women of reproductive age in the ward, with priority given to mothers with children under five, pregnant women and newly married women.
- Representation shall reflect the ethnic, social and economic composition of each ward or tole, and include members from minority and dalit families.
- A subset of the full MG membership will be called the MG Executive Committee and will consist of approximately 11 MG members. The MG executive committee will be formed based on mothers' interest and motivation to be active MG participants.

In addition to MG members, many other people play an important role in strengthening the system and participation of MGs in community health improvement. HF and VDC staff will work to ensure that each person fulfills his or her respective role:

***Support of Mothers' Group Activities***

***Role of Executive MG Members***

- Each MG executive committee will elect a chairwoman, who is responsible for organizing and conducting MG executive committee meetings monthly or more frequently as needed.
- Executive MG members are responsible for reaching out to all mothers in the general MG membership and actively supporting FCHVs in their health education and promotion activities to improve the well being of the whole community and increase utilization of health services.
- Executive MG members will annually review the performance of their FCHV, with support from the HF staff, according to performance review guidelines.
- Executive MG members, in consultation with the HFIC, VHW and MCHW, have the authority to replace their FCHVs and also have the authority to reorganize the MG executive committee.
- MG members listen to Radio Drama Serial and encourage members of the community to listen.

***Role of FCHVs***

- Support executive MG chairwoman to organize and conduct regular monthly MG executive committee meetings, and jointly prepare the meeting agenda as per the need and interest of MG members.
- Attend MG executive committee meetings and serve as MG secretary.
- Involve executive MG members in health education and promotion activities through coaching and practice in delivering health messages of priority national health programs and demonstration of appropriate health practices. Executive MG members will then share these messages with MG general members, all mothers in the ward.
- Discuss and plan with executive MG members how to reach inactive and/or disadvantaged mothers with health communication activities.

***Role of VHWs and MCHWs***

- Conduct with HFICs ward orientation and MG orientation meetings on FCHV/P and the important role of MGs
- Attend monthly MG executive committee meetings and support FCHVs and MG members in their health education and promotion activities
- Support HFIC and VDC members with community mapping exercises as needed

***Role of HFICs***

- Conduct ward orientation and MG orientation meetings on FCHV/P and the important role of MGs
- Identify and/or help reorganize MGs as needed, and ensure inclusion and participation of ethnic minorities in MGs and FCHV selection
- Ensure FCHVs receive health education materials available from DHO/DPHO supplies at review meetings
- Conduct regular monitoring visits to MGs and FCHVs
- Support resupply of essential commodities to FCHVs
- Encourage active MGs to work together and support the activities of each other and multiple FCHVs

***Role of VDC and Municipality***

- Support HFIC and VDC members with community mapping exercises as needed
- Integrate FCHV/P into annual and long-term planning exercises
- Review the status and performance of FCHVs and MGs.
- Coordinate with the HFMCs to support FCHVs and MGs
- Provide recognition for active FCHVs and MGs
- Encourage and ensure female ward member participation in MG meetings

***Role of DDC***

- Review the status and performance of FCHVs and MGs
- Coordinate with the DHO/DPHO and VDCs to support FCHVs and MGs
- Provide recognition for active FCHVs and MGs

***Role of DHO/DPHO***

- Review the status and performance of FCHVs and MGs
- Coordinate with the DDC and HFMCs to support FCHVs and MGs
- Provide recognition for active FCHVs and MGs

***Role of EDPs, INGOs, NGOs and CBOs***

- Collaborate with and support MGs and FCHVs in effective implementation of community health promotion activities
- Support HFIC, HF staff and VDC members to conduct community mapping activities to give priority to participation of under-served families in MG activities.

## E. FCHV Selection and Replacement

The entire membership of the MG members will nominate and select their FCHV based on the following criteria:

***FCHV Selection Criteria***

- Willing and able to volunteer at least one 10-year term of service
- Local resident of ward
- Between 20 and 44 years old, upon start of service
- Family support of her involvement in the FCHV/P
- Priority will be given to under represented and disadvantaged families (ethnic minorities and dalit)
- Preference will be given to those already involved in social and health activities, including trained and traditional birth attendants
- Preference will be given to women who are literate and have completed primary education; however, illiterate women may also be selected and will be given priority for participation in literacy activities

1) FCHVs will be selected to serve a minimum term of 10 years. FCHVs may continue to serve as long as they are active, interested to continue and have the support of their MG and HFIC. Annual performance evaluations by HFIC, VHW, MCHW and executive MG members will aid in assessing FCHVs' effectiveness and level of activity.

2) At the 10-year mark, three courses of action may be taken:
    - She may choose to continue for additional 5-year terms based on her continued interest and level of activity.
    - She may voluntarily retire, and will receive a certification of appreciation (*abhinandan*) for her contribution after 10 years of service or more from the VDC and HFMC and from the DHO/DPHO.
    - She may be asked to retire, based on joint decision by the HFIC and the executive MG committee with consensus of HF staff (MCHW and VHW) because of her inactivity or otherwise unsatisfactory performance.

3) It will be the responsibility of the MG executive committee, in consultation with the HFIC, to replace an inactive FCHV. Executive MG members and HFIC will request compulsory retirements for FCHVs who are:
    - Physically unfit (not able to see, hear, or are unwell)
    - Inactive for two years (that is, does not help organize or participate in MG meetings, completes less than 50% of expected activities, does not maintain records)

4) In addition to cases of voluntary or compulsory retirement, the MG executive committee will also select a new FCHV in the cases of drop out, death or migration.

## F. Roles of FCHVs

### 1) Core Activities

FCHVs are understood to play a supportive role in linking the community with available PHC services and will continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level. FCHVs will continue to promote the utilization of available health services and the adoption of preventive health practices among community members. In all 75 districts in Nepal, it is recognized that FCHVs act voluntarily as health educators and promoters, community mobilizers, referral agents and community-based service providers in each of the health areas they are trained. FCHVs will be enabled to fulfill these roles through the provision of continuous capacity building, monitoring and supervision, community support and other necessary FCHV/P activities (See Annex 1 for a detailed description of FCHV core activities).

### 2) Add-on Activities

Whereas core activities are those in which FCHVs in all 75 districts are participating, FCHV "add-on" activities are those undertaken in one or more VDCs, districts or regions, but have not yet been introduced on a national scale. Add-on activities are fully consistent with FCHV/P goals and objectives and are supported by governmental programs, EDPs or I/NGOs. These partner organizations provide support to FCHVs in capacity building, monitoring and supervision, commodities resupply, community support and mobilization and other necessary FCHV/P activities (See Annex 1 for a detailed description of current and potential FCHV add-on activities).

## G. Capacity Building Activities

Several capacity building initiatives are required to maintain a supportive environment in which FCHVs can serve their communities. These activities include training of FCHV trainers, basic and refresher training, review meetings and distance education. All activities will be scheduled around agricultural activities as per the local situation.

### 1) Training of Trainers

The training of trainers (TOT) standard package will be skills-oriented and applied in a needs-based manner. TOT activities will be conducted at three levels:

- TOT at regional level, involving RHTC, RHD and DHS
- District TOT (DTOT), including selected HFICs from PHCC/HP/SHP levels will conduct basic and refresher training for FCHVs
- Refresher training for all AHWs, VHWs and MCHWs in supporting FCHVs though strengthened skills in social mobilization techniques, group facilitation, interpersonal communication, monitoring and supervision, and adult learning skills and participatory training approaches

### 2) Basic Training

Basic training will be conducted for all newly recruited FCHVs. The duration of basic training will be increased to 18 days total and will be divided into two 9-day modules to be conducted at 2-month intervals. Basic training materials have been integrated with the revised strategy and the clarification and expansion of FCHVs' expected roles.

The FCHV Section/FHD, in conjunction with DHO/DPHOs, will plan basic training sites within one district, several districts or one region. Recipients of DTOT for FCHVs will conduct basic training for a minimum of 15 new FCHVs per session, every three years or as needed. Convenient residential training sites will be identified in central areas based on FCHVs' location and travel distance.

Upon completion of basic training, all FCHVs will be provided with the following supplies:

- Training certificate
- Reference manual, a set of BCC materials and a shoulder bag
- Ward register record book and other recording and reporting forms
- Photo identification card
- FCHV signboard
- Essential commodities, which include the following items and quantities:

| Commodity | Quantity |
|---|---|
| Condoms | 100 pieces |
| Pills | 5-10 cycles |
| ORS | 10 packets |
| Vitamin A capsules | Per current policy in each district |
| Iron/folate tablets | Per current policy in each district |
| Cetamol | 100 tablets |
| Iodine | 100 ml bottle |

| | |
|---|---|
| Gentian Violet | 5 grams |
| Cotton | 1 roll |
| Bandages | 10 pieces |
| Scissors | 1 piece |
| Other supplies | Depending upon availability |

To ensure that the prior commodities are regularly replenished for FCHVs, the following activities will be implemented:

- HFMC is responsible to ensure commodities are regularly replenished from the DHO/DPHO to the HF and will coordinate with the Community Drug Program per current policy in each district.
- Distribute commodities to FCHVs at trimesterly review meetings and to their homes on monthly basis (during VHW supervision visits).
- HF staff will make commodities available to FCHVs on demand with provision of FCHV treatment and distribution records.

The basic set of FCHV/P materials (such as bag, signboard, BCC materials and manual), will be replaced as needed at the time of refresher training.

### 3) Refresher Training

At the HP/ilaka level, a five-day refresher training will be conducted for all FCHVs every five years. The refresher training will be conducted PHCC/HP/SHP-ICs who have participated in refresher DTOT, and will be planned according to established training methodologies and content as per the revised curriculum.

### 4) Review Meetings

At the SHP level, a review meeting will be held every four months (trimesterly) for reviewing and planning of FCHV/P activities. Review meetings will be conducted by the HFIC with participation by all FCHVs and the VHW and MCHW. Review meetings will be scheduled around primary agricultural activities as per the local situation

Review activities will include FCHVs' progress updates and forward plans, problem solving, data collection and review of FCHVs registers, provision of supportive feedback to FCHVs and on the spot resupply of essential commodities. The first meeting of the year will be two days in duration at which HFICs will facilitate a planning discussion. The second and third meetings of the year will each be one day in duration. The HFIC will facilitate an annual performance review during the third meeting.

### 5) Cycle of FCHV Program Review Meetings

The primary objectives of review meetings are to strengthen coordination, planning and monitoring at all levels; to institutionalize the process of record review; and to provide a forum for problem solving approaches and discussion of best practices. This cycle of meetings will be further strengthened through the joint development of review meeting

guidelines by the Ministry of Local Development (MOLD) and MOH, which provide instructions for agenda preparation and which mandate the regional and district levels to include FCHV/P activities in all integrated review meetings. FCHVs' participation will be included in all levels.

To strengthen the overall FCHV/P review meeting cycle, one-day meetings will be conducted in the following sequence:

- Planning meeting for upcoming review activities between HFICs and DHO/DPHOs annually
- Review meetings for FCHVs at HF every four months
- Integrated review meeting of HFICs (SHP, HP, PHCC) at district or ilaka level every four months
- Integrated review meeting of DHO/DPHOs at RHD every four months
- Integrated review meeting of RHDs at DHS every four months

### 6) Radio Distance Education

The capacity building initiative will also include the Radio Health Program with Distance Education (DE) component for FCHVs broadcast nationally. The distance education will be focused on reinforcing the knowledge and skills of FCHVs, thereby enabling them to carry out their expected roles effectively. The overall purpose of the DE will be to update the technical knowledge of FCHVs on different aspects of family health such as family planning, maternal and neonatal health, child health, HIV/AIDS/sexually transmitted infections (STIs) and infectious diseases. It will also improve FCHVs' interpersonal communication skills and motivate them to perform their job more effectively. The DE messages are integrated with the revised FCHV reference manual.

In conjunction with the broadcast of radio distance education, support activities for radio listeners' groups, facilitated by FCHVs, will be implemented in 17 CPD districts. In order to reinforce the messages given through the DE, supplementary materials (flip chart, resource book, posters and flyers) will also be provided to FCHVs.

### 7) Revised Training Materials

Three processes have been integrated to contribute to strengthened and expanded FCHV training materials content: the FCHV/P strategy review, FCHV training materials revision, and design document of the FCHV radio DE program. Each has been an ongoing consultative process during 2002-03 with key stakeholders and partners.

To enable FCHVs to fulfill their core roles and responsibilities, additional training support in several areas will be needed. During the revision of FCHV training materials, new and expanded modules covering these topic areas were incorporated into the basic and refresher training curricula and linked to lesson plans developed for the distance education radio program (see Annex 1 for detailed content areas). These new topic areas included:

- Increased interpersonal communication, social mobilization techniques, community-based counseling, group facilitation and MG meeting conduction skills to develop ability and confidence to communicate effectively

- Family planning (with specific focus on informed choice, options, advantages, disadvantages, side effects and where methods are available)
- Maternal and neonatal health (with specific focus on antenatal care, delivery care, postpartum care, newborn care and, danger signs during pregnancy, delivery, postnatal and neonatal periods)
- Child health (with specific focus on home-based care and indications for referral of diarrheal dehydration and ARI and conditions requiring treatment with vitamin A high-dose)
- Infectious diseases (with specific focus on prevention of STIs/HIV and treatment of STIs)
- Adolescent reproductive health (with specific focus on of puberty, physical and emotional changes, conception and contraception needs )

# H. Program Management and Coordination

### 1) Roles and Responsibilities

To ensure that the FCHV/P will function effectively, roles and responsibilities related to coordination, program management, supervision and monitoring will be clearly established at all levels of the public health system (see Annex 3 for additional details).

The following roles and responsibilities are listed in addition to those that relate specifically to support of MG activities. Proposed roles for MOLD institutions -- DDC, VDC and municipalities – are outlined separately.

**a) All Levels**

All DHS divisions and centers, other governmental programs, donor and I/NGO partners that currently support or propose to work with FCHVs in the future will consult and coordinate with the FCHV Section/FHD.

**b) Central Level**

***FCHV Section, Family Health Division, Department of Health Services***

- Act as the central level focal body for National FCHV/P
- Plan, monitor and evaluate the program with partners at central level
- Assist in program implementation according to revised strategy
- Coordinate with relevant governmental divisions and partners at central level
- Determine national level focal persons at the RHD and DHO/DPHO
- Assist RHD in conducting regional level planning and programming workshops

***FCHV Subcommittee*** (See Annex 3 for background, composition and functions)

- Provide regular support to the National FCHV/P and FCHV Section/FHD
- Strengthen coordination and collaboration among all stakeholders and partners supporting and working with FCHVs
- Represent major program stakeholders (including relevant government divisions, donor and I/NGO partners) at central level and involve others partners as needed
- Assist and guide program implementation according to revised strategy, develop necessary guidelines and review partners' progress on trimesterly basis
- Coordinate development of annual workplan among major stakeholders
- Develop guidelines for implementation of partner-supported add-on activities, and technical review of add-on training materials

***National Health Training Center***

- Act as the primary training service provider to the FCHV/P using adult education, competency-based and needs-based training methodologies
- Plan, implement and monitor training activities, including TOT, FCHV basic and refresher training, and AHW/MCHW/VHW refresher training activities, through RHTCs and DHO/DPHOs.

**c) Regional Level**

***Regional Health Directorate***

- Plan, supervise and monitor the program with partners at regional level
- Assist DHO/DPHOs in program implementation at district level

***Regional Health Training Center***

- Organize and conduct training of trainers for DHO/DPHO and HFICs and refresher training for AHW/VHW/MCHW
- Assist DHO/DPHOs to plan, implement and monitor orientation, training and review meetings at district and HF levels

**d) District Level**

***District Health Office / District Public Health Office***

- Plan, supervise and monitor the program at the district level
- Orient district partners (including DDC, Municipality, I/NGOs, CBOs) to the FCHV/P and coordinate with them for effective implementation through the district FCHV subcommittee
- Guide and support VDCs in program implementation in consultation with DDC
- Organize the FCHV/P DTOT for HFICs and DHO/DPHO staff and assist with training, orientation and other program related activities
- Manage the district-wide distribution and resupply of FCHV commodities
- Manage district budget for the FCHV/P including review meeting budget
- Analyze reports received from HP/PHCCs and use data to monitor activities
- Prepare district progress report on program activities and submit to the FCHV Section/FHD regularly
- Recognize and award HFICs, VHWs, MCHWs for active support of FCHV activities

***District FCHV Subcommittee, under the District Reproductive Health Coordinating Committee (RHCC)***

- Coordinate with DDC, municipality, VDC and other relevant district level organizations for effective FCHV/P planning, implementation and monitoring activities.

**e) VDC Level**

***Health Facility Management Committee (HFMC[4])***

- Strengthen HFMC and orient members about FCHV activities (core and add-on)
- Coordinate through the HFMC and VDC plans for program sustainability and community support for FCHVs' activities (core and add-on), and obtain endorsement for add-on activities
- Ensure replenishment of FCHVs' supplies with HFIC support
- Disseminate information about add-on activities throughout VDC by VDC members, HFMC members and local leaders.
- Monitor, encourage, support, reward and recognize FCHVs activities and achievements.

***Health Facility – In Charge (PHCC, HP, SHP)***

- Supervise and monitor all FCHV related activities at HF level, and provide necessary support to VHWs, MCHWs and FCHVs on a regular basis
- Coordinate with VDC and HFMC for effective FCHV/P implementation
- Conduct orientation sessions for VDC, ward and MGs

[4] Packages to support the establishment and management of HFMCs are available from partner organizations including CEDPA, SDC and NFHP.

- Organize and conduct FCHV refresher training and review meetings
- Implement national level guidelines for annual performance evaluation in coordination with FCHVs, executive MG members, VHW and MCHW at review meeting
- Discuss issues collected at FCHV review meetings at subsequent ilaka and district level review meetings
- Manage with the HFMC the resupply of FCHV commodities
- Conduct regular PHC outreach services so that FCHVs' referral cases can be treated at the village level
- Collect monthly reports from VHWs/MCHWs; analyze, compile and prepare PHCC/HP/SHP reports; use data for monitoring FCHV/P activities; and regularly submit them to DHO/DPHO.
- Encourage VDC and DDC to provide awards for the best performers in the FCHV/P among HFICs, AHWs, MCHWs and VHWs

***Community Health Workers (VHW and MCHW)***

HFICs will allocate supervision responsibilities between VHWs and MCHWs equitably; each will supervise a minimum of 4-5 FCHVs per month.

Both VHWs and MCHWs are responsible to:

- Support the HFIC to conduct orientation sessions for VDC, ward and MGs and to form or reorganize MGs
- Assist the MGs in selecting FCHVs, and support FCHVs by participating in MG meetings
- Act as FCHVs' immediate supervisors as per assignment by HFIC
- Visit the FCHVs monthly to provide feedback, collect FCHV report and resupply commodities
- Report monthly to HFIC on FCHV activities
- Provide supportive feedback and supervision to FCHVs, and provide on-the-spot training in key knowledge and skills areas
- Support HFIC to conduct FCHV review meetings and performance review

**f) MOLD Institutions**

***DDC, VDC and Municipality***

- Establish and support FCHV endowment funds, and other sources of local resources for the FCHV/P
- Implement population-based expansion as per established criteria
- Integrate FCHV/P into annual and long-term planning exercises
- Participate in review meetings at the appropriate level

**g) Other Partners**

***EDPs, I/NGOs and CBOs***

- Mobilize grassroots support for the FCHV/P and assist with outreach to under-served families for participation as MG members and FCHVs

- Coordinate through the HFMC and VDC plans for program sustainability and community support for FCHVs' activities (core and add-on), and obtain endorsement for add-on activities

### 2) Reporting and Monitoring Activities

a) To ensure responsive and supportive monitoring and supervision of FCHVs, the following activities will be implemented by HF and DHO/DHPO staff:

- Refresher training updating HFIC, AHW, VHW and MCHW skills on supportive supervision and monitoring of FCHV activities, including facilitation of strengthened review meetings, interpersonal communication and community mobilization skills (3 day package to be developed by NHTC)
- Monthly supervision visits to FCHVs conducted by VHWs and MCHWs in order to check registers, collect record of activities, provide feedback, address problems identified and resupply commodities
- Supervision visits from HFIC (SHP) to 100% of FCHVs annually
- Supervision visits from HFIC (PHCC and HP) to 50% of FCHVs annually
- Supervision visits from District to 10% FCHVs annually
- Provision of reward for HFICs, VHWs and MCHWs who actively mobilize FCHVs and regularly submit FCHV activity reports

All supervision visits will be scheduled according to times convenient to FCHVs, which may be outside of HF office hours.

b) To ensure that FCHVs' services are accurately and regularly recorded, the VHW and MCHW will routinely check FCHVs' ward registers to make sure they are well maintained. A number of new indicators will be added to the FCHV register and corresponding HMIS forms (please see Annex 2 for indicators recommended for inclusion in the HMIS).

c) To ensure a common participatory mechanism for program follow up and supervision at the district and VDC levels, all partners will:

- Meet at trimesterly District FCHV Subcommittee meetings
- Use a standardized monitoring checklist

d) To ensure consistent and regular collection of FCHV/P data, a standardized monitoring checklist will be developed for use by all implementing partners. The FCHV Section/FHD and key partners will jointly develop the monitoring checklist and share the responsibility of checklist utilization by all partners.

The monitoring checklist will cover four levels of program implementation – FCHV, HF, DHO/DPHO and Central – and will include data on relevant sources and indicators (see Annex 3 for description of implementation activities).

e) For data collection and analysis, the FCHV Section/FHD, HMIS, DHO/DPHOs and HFs have shared responsibility. For national level analysis, reporting and dissemination to concerned partners, the FCHV Section/FHD is responsible, with support from HMIS, is responsible.

f) A central level electronic database will be developed to include every FCHV's profile and contact information. The database will be prepared, printed and distributed to all districts, with yearly updates. It will include district level and ward level data from the national census. The DHO/DPHO will provide this information to the VDC level for FCHVs' and community groups' use.

# I. Management of Add-on Activities

FCHV "add-on" activities are those activities, which are fully consistent with FCHV/P goals and objectives, and are supported by HMG/N, EDPs and I/NGOs in one or more VDCs, districts or regions. These activities are complementary to FCHV core roles and responsibilities but require significant levels of partner support and are not conducted on a national scale. Future proposals may involve new add-on activities or the expansion of some add-on activities to cover larger populations or geographic areas. The FCHV Section/FHD and the relevant partner organizations will coordinate and monitor such initiatives.

### 1) Program Coordination

The FCHV Section/FHD, with support from the FCHV Subcommittee, is responsible for developing and disseminating guidelines to promote effective coordination of add-on activities and to ensure that sufficient partner support is provided.

To initiate any new FCHV add-on activities, partner organizations, including other government programs, will share their proposed activities with and get approval from the FCHV Section/FHD and the FCHV Subcommittee. Proposals will be discussed and decisions communicated to the appropriate authority.

Implementing partners are expected to submit progress reports including quantitative data, and feedback for all ongoing and future add-on activities to the FCHV Section/FHD during trimesterly FCHV Subcommittee meetings.

### 2) Training, Orientation and Review Activities

In areas where partner organizations are supporting FCHVs in add-on activities, partners and HMG will share the responsibility for basic and refresher trainings, as well as for orientation meetings. Training and orientation components related to add-on activities will be developed by partner organizations and coordinated through the FCHV Section/FHD and FCHV Subcommittee at the central level.

Partner organizations will develop specific training materials, which will be presented to the FCHV Section/FHD and FCHV Subcommittee. These materials will be considered as a supplement to the basic training materials. To ensure consistent messages, a technical review board will be formed of key resource persons, acting in conjunction with the FCHV Subcommittee. Partners will introduce their specialized training materials during trimesterly review meetings and specialized training activities.

### 3) Monitoring and Supportive Supervision

Partner organizations are responsible to provide FCHVs involved in add-on activities with:

- Consistent, frequent monitoring and supportive supervision visits
- Trimesterly FCHV review meetings
- Opportunities for skill-based refresher training
- Training allowance
- BCC materials
- Assistance in maintaining regular resupply of commodities

### 4) Support Mechanisms

To promote local ownership and future sustainability of the FCHV/P, partner organizations will be involved in the following where a favorable environment exists:

- Governmental organizations, EDPs and I/NGOs that support FCHVs in ongoing add-on activities will assist VDCs or municipalities to establish Endowment Funds (EF) with VDC or municipality resources.
- Governmental organizations, EDPs and I/NGOs initiating new add-on activities will assist VDCs or municipalities to establish EF with VDC or municipality resources, and will contribute additional resources to the EF.

## J. Program Support and Advocacy

For the FCHV/P to remain successful and sustainable, FCHVs must be recognized for the very important role they play in improving and maintaining the health of Nepalese families and communities. FCHVs require strong support from all levels, beginning with their families and communities up through the district and central levels. Communities can play an increased role in the future success and ownership of the program, as well as in generation of support for FCHVs. To more fully recognize, reward and encourage FCHVs' valuable contributions to community health, the following support mechanisms and advocacy activities are outlined:

### 1) Support Mechanisms

a) Advocate with Ministry of Education, Regional and District Education Offices, and other partner organizations working in nonformal education and literacy to gain priority for FCHVs' participation in literacy classes (FHD/DHS is responsible to initiate).

b) Advocate with Ministry of Water and Sanitation, Regional and District Water and Sanitation Offices and other partner organizations working in this sector to gain priority support to FCHVs for latrine construction, technical assistance and funds. (FHD/DHS is responsible to initiate).

c) Develop provision for health care insurance to all current FCHVs:
- Develop guidelines for FCHV health care insurance, which would include free services to FCHV at district level until retirement (this includes free x-ray, lab test registration fees, etc. but excludes free medication). (FCHV Subcommittee is responsible to develop guidelines.)
- Ensure smooth implementation of health insurance provisions for FCHVs by government and partners upon approval of guidelines (FHD/DHS is responsible to obtain approval of guidelines and initiate implementation).

d) Advocate with DDC and VDC to generate and further develop local support resources (financial, human and material) for increased local ownership and sustainability of the FCHV/P. One such example of local support resources is the Endowment Fund (EF).

e) Establish FCHV EFs in all VDCs and municipalities as a standardized base of local resources for support of FCHV activities:
- Implement guidelines developed in coordination with DHS/MOH and MOLD in expanded manner.
- Mobilize VDC, municipalities and select DDCs to establish EFs.
- Implement policy guidelines to establish district level EF. Balance of district level funds remaining from past FCHV/P activities will be utilized by the DHO/DPHO in conjunction with the DDC to establish EFs wherever such funds are available. These funds will be used for district-wide activities that benefit FCHVs.
- Responsible partners for the implementation of EF include the DDC or municipal office and DHO/DPHO at district and municipal levels, and the VDC and HFMC at VDC level.

- Motivate district partners, VDCs and municipalities to generate funds to provide incentives for FCHVs.
- Coordinate with implementing partners (EDPs, I/NGOs and CBOs) to contribute resources for EF and establish a basket fund for FCHVs in add-on activity areas.
- Develop EF monitoring system (FCHV Section/FHD and FCHV Subcommittee will be responsible).

f) Provide rewards and incentives to FCHVs regularly at VDC, municipality and district levels with local resources generated from FCHV EFs. This may include providing all FCHVs in VDC with uniforms of their choosing or meeting other needs they have identified.

g) Issue all new FCHVs with photo identification cards upon completion of basic training; all current FCHVs will be issued a photo ID card upon completion of refresher training by the DHO/DPHO.

h) Provide a basic minimum daily allowance as per HMG/N rules and regulations to FCHVs for their attendance at basic and refresher trainings and review meetings. VDCs or municipalities may decide to utilize or increase the basic minimum allowance for FCHVs' participation in health campaigns or other community activities. As per HMG/N rules and regulations, an additional rate based on geographic area (mountain, hill or terai) will be added to the FCHV training allowance.

i) Adjust FCHVs' training allowance regularly, as necessary to meet inflation and cost of living increases, by the FCHV Section/FHD in conjunction with FCHV Subcommittee.

j) Provide FCHVs with the opportunity to observe and network with FCHVs in other districts through exchange visits. FCHV Section/FHD in consultation with RHDs, DPHOs, and partners will organize these activities.

k) Generate support for FCHV DE radio listeners' group activities, facilitated by capable FCHVs. Use community-based media (street theatre) to raise community awareness on health and the important role that FCHVs play in their communities.

**2) Advocacy Activities**

a) Increase awareness and promote wider support for the FCHV/P by orienting parliamentarians and newly elected members of DDCs, municipalities and VDCs:
   - Director General, DHS to introduce FCHV/P to parliamentarians
   - DHO/DPHO to orient DDCs and municipalities; HFICs to orient VDCs:
     - Conduct at district level the orientation for newly elected members from DDC, Municipality and VDC levels (following new elections)
     - Include orientation meetings in DHO/DPHO and HF work plans
     - Allocate budget for orientation meetings

– Ensure members from District Health Coordination Committee are present during the orientation meetings

b) Mobilize DDCs, VDCs and municipalities to celebrate and highlight FCHVs' contributions through two national level events:
   - Create National FCHV day to recognize FCHVs' achievements at all levels
   - Utilize International Women's Day as a forum to recognize and advocate for FCHVs

c) Generate and maximize support for FCHVs through media (radio, television, print and street theater) by informing the general public of their service to communities. Motivate communities, health workers and FCHVs to support and participate in the Radio Health Program's drama serial for FCHVs and the general public.

d) Increase opportunities for raising awareness of FCHV/P progress by including FCHV/P progress reports in:
   - Central level meetings
   - Regional level review meetings
   - District Council and RHCC meetings
   - VDC Council and VDC meetings

# Annex 1: FCHV Roles - Core and Add-on Activities

FCHVs play a supportive role in linking the community with available PHC services and will continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level. In all 75 districts in Nepal, it is recognized that FCHVs act voluntarily as health educators and promoters, community mobilizers, referral agents and community-based service providers in each of the health areas for which have been trained. FCHVs will continue to be encouraged and supported to promote the utilization of available health services and the adoption of preventive health practices in the following core activities.

## Core Activities

| Program Issues | Core Activities |
|---|---|
| **Family Planning** | |
| | – Educate couples about the importance of FP and birth spacing<br>– Provide FP community-based counseling including information on alternative methods, side effects, advantages, disadvantages, where to go for services<br>– Inform potential clients about VSC static and mobile sites and refer those who desire services<br>– Refer clients interested in other contraceptive methods to the appropriate health facilities<br>– Refer complications and infertility concerns to health facilities<br>– Distribute condoms<br>– Resupply pill acceptors |
| **Maternal/Neonatal Health** | |
| ***General*** | – Educate the community on benefits of delayed first sex, marriage and childbearing, and the importance of safe sex<br>– Promote balanced nutrition and tetanus toxoid (TT) immunizations for adolescent girls (aged 10-19) |
| ***Antenatal Care*** | – Educate and motivate women about antenatal care, conveying the following messages:<br>o Attend at least 4 antenatal checkups and receive 2 TT immunizations<br>o Eat a healthy and varied diet<br>o Take iron/folate supplements<br>o Get treatment of night blind pregnant women with low does of vitamin A capsule after 1st trimester<br>o Reduce workload and get more rest<br>o Identify pregnancy-related danger signs<br>o Take appropriate action upon observing danger signs<br>– Refer high risk clients to health facilities |

| Program Issues | Core Activities |
|---|---|
| **Maternal/Neonatal Health** (continued) | |
| ***Delivery Care*** | – Educate and motivate women about safe delivery care, conveying the following messages:<br>o Plan for a safe and clean home delivery with skilled attendance<br>o Identify delivery-related complications<br>o Take appropriate action upon observing complications<br>– Refer women to health facilities and skilled birth attendants for home delivery |
| ***Postnatal Care*** | – Educate and motivate women about postnatal care conveying the following messages:<br>o Take Vitamin A supplement within 6 weeks postpartum<br>o Continue iron/folate supplementation for 6 weeks postpartum<br>o Attend 3 postnatal visits<br>o Eat a healthy and varied diet<br>o Reduce workload and get more rest<br>o Plan to use FP methods for birth spacing<br>o Identify postpartum danger signs<br>o Take appropriate action upon observing danger signs<br>– Refer women exhibiting danger signs to health facilities |
| ***Newborn Care*** | – Promote normal newborn care and educate women about the following messages:<br>o Immediate wiping and drying<br>o Wrapping and keeping warm<br>o Immediate breast feeding including colostrums<br>o Delay bathing for at least 24 hours<br>o Apply nothing on stump<br>o Identify newborn danger signs<br>o Take appropriate action upon observing danger signs<br>– Educate mothers about the importance of preventing harmful newborn practices<br>– Refer infants with danger signs to health facilities |
| **Child Health** | |
| ***Diarrhea*** | – Educate mothers how to prevent diarrhea through improved hygiene and sanitation<br>– Promote three rules on home-based care and treatment of diarrheal dehydration<br>– Teach mothers about Oral Rehydration Solution (ORS) preparation<br>– Educate mothers about the signs of dehydration and action to take upon observing signs<br>– Refer severe cases of diarrheal dehydration to health facilities<br>– Distribute ORS packets |

| Program Issues | Core Activities |
|---|---|
| **Child Health** (continued) | |
| ***Acute respiratory infection (ARI)*** | – Promote home-based care and treatment of cold, cough and pneumonia<br>– Educate mothers about ARI danger signs and action to take upon observing danger signs<br>– Refer severe cases to appropriate health facilities |
| ***Nutrition*** | – Teach mothers about the importance of exclusive breastfeeding for first six months (and no prelacteal feeding) and continued breastfeeding for at least two years<br>– Promote timely, proper introduction and types of locally available weaning foods after child reaches five months of age<br>– Promote use of iodized salt<br>– Identify malnourished children and refer to health facilities<br>– Distribute semi-annual Vitamin A supplements for all children from six months to five years of age and deworming medication for children from 2 to 5 years of age<br>– Educate women about what conditions should be treated with high-dose Vitamin A:<br>o Measles<br>o Persistent diarrhea<br>o Night blindness<br>o Severe malnutrition<br>o Post partum (within 6 weeks of delivery)<br>– Refer night blind children and pregnant women, and other cases requiring high-dose Vitamin A treatment to health facilities |
| ***Immunization*** | – Inform mothers about the importance of routine immunization (BCG, DPT, Measles, Polio, TT) and the dates and locations of immunization clinics<br>– Identify children and women who need immunizations and encourage their attendance at immunization clinics |

| | |
|---|---|
| **Infectious Diseases** | |
| ***STIs and HIV/AIDS*** | – Provide information and education on STIs and HIV/AIDS<br>– Refer suspected STI cases to health facilities for diagnosis and treatment |
| ***Tuberculosis, Leprosy, Malaria, Kala-azar and Japanese Encephalitis*** | – Provide information and education on the infectious diseases affecting their locality<br>– Educate community about transmission, prevention and available treatment<br>– Refer suspected cases to health facilities |
| **Other Activities** | |
| | – Provide limited first aid services and refer severe cases to health facilities<br>– Maintain completed ward register report and submit to supervisor on monthly basis (reports will be collected during monthly supervision visits)<br>– (Re)activate mother's group, serve as MG secretary and actively participate in regular monthly meetings |

## Add-on Activities

Whereas core activities are those in which FCHVs in all 75 districts are participating, FCHV "add-on" activities are those undertaken in one or more VDCs, districts or regions, but have not yet been introduced on a national scale. Some FCHV activities, which began as add-on activities -- such as semi-annual vitamin A supplementation – are now core activities. Add-on activities are fully consistent with FCHV/P goals and objectives and are supported by governmental programs, EDPs or I/NGOs. These partner organizations provide support to FCHVs in capacity building, monitoring and supervision, commodities resupply, community support and mobilization and other necessary FCHV/P activities.

This section describes the FCHV add-on activities that are ongoing and being implemented through support from partner organizations, as well as new categories of add-on activities proposed for FCHV involvement, *where sufficient partner support is provided and ensured.*

| Program Issues | Add-on Activities |
|---|---|
| **Maternal/Neonatal Health** | |
| ***General*** | – Refer cases of night blind women to health facilities |
| ***Antenatal Care*** | – Distribute iron/folate tablets to pregnant and lactating women |
| ***Birth Planning/ Delivery Care*** | – Implement birth preparedness package (BPP) and activities[5]<br>– Promote planning and preparation for delivery including funds, food, transport |
| ***Postnatal Care*** | – Counsel on birth spacing and FP methods availability |
| **Child Health** | |
| ***Diarrhea*** | – Distribute blue plastic cups |
| ***Community-Based Pneumonia Treatment*** | – Identify pneumonia cases<br>– Treat pneumonia cases in children between 2 months and 5 years of age<br>– Refer children <2 months with high respiratory rate or other ARI danger signs to health facilities<br>– Refer all severe pneumonia cases in children under 5 years to health facilities |

[5] Gradual expansion of BPP activities will be linked to priority districts where the Basic Essential Obstetric Care (BEOC) package is being implemented. The implementation of the BPP covers the period from 6 weeks of pregnancy to 6 weeks post partum.

| Program Issues | Add-on Activities |
|---|---|
| **Child Health** (continued) | |
| ***Immunization*** | – Mobilize community during polio eradication campaign activities (including National Immunization Days (NID), Sub-NIDs, Mop Up and/or Responsive Mop-up rounds)<br>– Assist health staff health staff and community members to promote Maternal Neonatal Tetanus Elimination campaign and Hepatitis B immunizations<br>– Assist health staff and community members in controlling measles outbreak |
| **Reproductive Health** | |
| ***General*** | – Provide information and education about prolapsed uterus, menstruation and abortion |
| ***Adolescent Reproductive Health*** | – Provide information and education on adolescent reproductive health through MGs (including topics of puberty, physical and emotional changes, conception and methods of contraception) |
| **Infectious Diseases** | |
| ***Tuberculosis*** | – Support staff of local health facility with Directly Observed Therapy Short Course (DOTS) activities<br>– Motivate clients to comply with treatment<br>– Refer suspected cases to health facility |
| ***Malaria, Kala-azar and Japanese Encephalitis*** | – Promote the use of insecticide-treated bednets<br>– Support health staff with slide collection and presumptive treatment in selected areas<br>– Refer suspected infectious disease cases to health facilities for diagnosis and treatment |
| ***Rational Use of Drugs*** | – Educate community about:<br>o Harmful effects of unnecessary medication<br>o Treatment compliance<br>o Appropriate dose, timing and duration. |

# Annex 2: Revised Strategy Implementation Plan

| No. | Activity | 2003/04 Year 1 | 2004/05 Year 2 | 2005/06 Year 3 | 2006/07 Year 4 | 2007/08 Year 5 |
|---|---|---|---|---|---|---|
| **1.** | **Dissemination of Revised FCHV Strategy and Orientation Meetings** | | | | | |
| 1. | Translate and disseminate FCHV/P Revised Strategy | X | | | | |
| 2. | Conduct orientation meeting for RHD/RHTC staff | X | | | | |
| 3. | Conduct orientation meeting for DHO/DPHO/DDC members | X | | | | |
| **2.** | **Training of Trainers in revised FCHV curriculum** | | | | | |
| 4. | Train RHTC staff at regional level | | X | | | |
| 5. | Train DHO/DPHO staff at district level | | X | | | |
| 6. | Train HFICs (SHP, HP and PHCC) at district level | | X | | | |
| 7. | Provide refresher training to insure that AHWs, VHWs and MCHWs have the necessary skills to provide supportive supervision to FCHVs | | X | | | |
| **3.** | **Community Mobilization Activities** | | | | | |
| 8. | Conduct orientation meeting for VDCs | | X | | | |
| 9. | Conduct orientation meeting for ward members | | X | | | |
| 10. | Conduct orientation meeting for MGs | | X | | | |
| 11. | Form or reorganize MGs as needed | | X | | | |
| 12. | Select new FCHVs as needed (by MGs) | | X | X | X | X |
| **4.** | **FCHV Training Activities** | | | | | |
| 13. | Conduct basic training for newly selected FCHVs as needed (two modules of 9 days each, with 2 month interval) | | X | X | X | X |
| 14. | Conduct refresher training for all current FCHVs in phase-wise manner (five days, every five years) | | X | X | X | X |
| 15. | Conduct review meeting for all current FCHVs (every four months, 2 days +1 day +1 day) | X | X | X | X | X |
| **5.** | **Monitoring Activities** | | | | | |
| 16. | VHWs/MCHWs conduct monthly supervision visits to all FCHVs to collect FCHV services records, provide feedback and technical information, and re-supply essential commodities | X | X | X | X | X |
| 17. | HFICs (SHP) conduct supervision visits to 100% FCHVs per year | | X | X | X | X |
| 18. | HFICs conduct supervision visits to 50% FCHVs per year | | X | X | X | X |
| 19. | District Supervisors conduct supervision visits to 10% FCHVs per year | | X | X | X | X |
| **6.** | **Program Review and Coordination Activities** | | | | | |
| 20. | Conduct planning meeting for upcoming review activities between HFICs and DHO/DPHOs annually | X | X | X | X | X |
| 21. | Conduct integrated review meeting of HFICs (PHCC/HP/SHP) every four months | X | X | X | X | X |

| No. | Activity | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|---|---|
| | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| 22. | Conduct integrated review meeting of DHO/DPHOs at RHD every four months | X | X | X | X | X |
| 23. | Conduct integrated review meeting of RHDs at DHS every four months | X | X | X | X | X |
| 24. | Conduct central level FCHV/P review meetings with FCHV Subcommittee every four months, including progress reports on add-on activities from partners | X | X | X | X | X |
| **7.** | **Program Support and Advocacy Activities** | | | | | |
| 25. | Establish Endowment Funds at the VDC level (EF orientation will be integrated into general FCHV orientation meetings at all levels: district, VDC, ward, MG) | X | X | X | X | X |
| 26. | Provide FCHVs with rewards and incentives regularly with local resources as per their identified needs | X | X | X | X | X |
| 27. | Broadcast radio health program (distance education and drama serial activities) to build FCHVs' capacity and to increase community support for FCHVs | X | X | X | X | X |
| 28. | Advocate with line agencies and partners working in education and water and sanitation to gain priority for FCHVs' participation | X | X | X | X | X |
| 29. | Organize exchange visits for FCHVs to network with each other | X | X | X | X | X |
| 30. | Orient newly elected members of Parliament, DDCs, municipalities and VDCs to the FCHV/P | X | X | X | X | X |
| 31. | Conduct National FCHV Day to recognize FCHVs' achievements | X | X | X | X | X |

# Annex 3: Detailed Implementation Activities

This annex provides detailed, supplemental information on implementation activities related to issues discussed in the main strategy document.

## 1. Program Management and Coordination

### a) Required Personnel for FCHV Program Implementation

- A strong FCHV Section located in the Family Health Division, Department of Health Services, with necessary personnel including the Section Chief, FCHV Coordinator and additional secretarial support. FCHV Section Chief will be the focal person for the FCHV Subcommittee

- In each RHD, one focal person and a unit with appropriate personnel to oversee FCHV/P activities at the regional level.

- The DHO/DPHO is responsible to supervise and monitor the FCHV/P activities at HF and field levels. The DHO/DPHO will delegate FCHV/P responsibilities to a centrally mandated district level focal person.

- Each HF (PHCC, HP and SHP) must have adequate staff to carry out FCHV training, monitoring and supervision activities.

- VHW and MCHW must be available and working in each VDC of the program area, and trained to provide support and supervision to FCHVs.

### b) FCHV Subcommittee

***Background***

A FCHV Subcommittee will be established by the FHD under the RHCC. It will be a voluntary forum of members working together to create a collaborative, cooperative and better coordinated working relationship among all FCHV/P partners. Regular meetings will be held monthly during the initial implementation phase of the revised strategy, then on a trimesterly basis. The subcommittee will have adequate representation of government, donors, I/NGOs and other appropriate partners.

***Purpose and Functions***

Purpose: To enhance central level coordination of the National FCHV Program by supporting the FCHV Section/FHD through increased communication and collaboration among all stakeholders and partners supporting FCHVs.

Functions:

- To provide a forum which reviews and addresses issues that require government attention and policy level intervention;
- To provide a forum for presentation of partners' progress reports, information dissemination, and sharing of best practices and lessons learned;

- To mobilize increased resources, commitment and involvement in the FCHV/P at the national, district and community levels; and

- To serve as an implementation-level roundtable, which guides and coordinates the implementation of the FCHV/P revised strategy.

- To feedback to the senior level group involving major donors and partners, and concerned Division/Center directors that meets trimesterly with the Director General to discuss policy level issues and issues raised by the FCHV subcommittee.

***Composition***

The membership of the FCHV subcommittee will reflect the public-private mix of concerned stakeholders and partners currently supporting the FCHV/P. It will require adequate representation of partners from government including key DHS Divisions/Centers: FHD, CHD, LMD, NHTC, NHEICC; as well as MOLD and MOWSW. Representatives of EDPs including UNICEF and UNFPA; and implementing partners including NFHP, NTAG and other I/NGOs will be selected. Participation by other donors (including GTZ, NSMP/DFID, JICA and AusAID) will also be encouraged as required.

The FCHV Coordinator position (location TBD) will serve as the FCHV subcommittee's secretariat and will provide administrative and organizational support to the FCHV Section/FHD to facilitate coordination among FCHV/P partners. This position will have the capacity to organize meetings, document meetings and disseminate materials.

**2. Monitoring FCHV Program Activities: Reporting and Data Collection Issues**

a) To ensure consistent and regular collection of FCHV/P data, a standardized monitoring checklist for use by all implementing partners will be developed. The monitoring checklist will cover four levels of program implementation (FCHV, HF, DHO/DPHO and Central) and will include data on the relevant sources and indicators:

***FCHV***

- Check on stocks of commodities
- Review FCHV ward registers for:
  - Service coverage and referral activities
  - Frequency of MG meetings
  - Frequency of VHW/MCHW supervision visits

***HF***

- Review meetings conducted, number of participants and month when conducted
- Frequency and quality of VHW/MCHW reports on FCHV activities and services provided
- Number of replacement FCHVs needing basic training
- FCHV records included in HMIS forms
- Quantity of commodities distributed to each FCHV during past quarter
- HF supervision plan for FCHV activities

***VDC***

- Endowment fund established
- Endowment fund balance

***DHO/DPHO***

- Review meetings conducted, number of participants and month when conducted
- Frequency and quality of HF reports on FCHV activities
- Number of replacement FCHVs needing basic training
- District supervision plan for FCHV activities
- FCHV records included in HMIS forms
- Stock levels of commodities
- Budget for FCHV activities

***Central Level***

- Review meetings conducted, number of participants and month when conducted
- Number of dropouts and replacement FCHVs requiring Basic Training
- Information on add-on activities (current or proposed) from all partners

b) To ensure that FCHVs' services are accurately and regularly recorded, the VHW and MCHW will ensure that FCHVs ward registers are well maintained during monthly supervision visits.

c) The FCHV services currently in HMIS will be well maintained, and the required indicators will be added to the FCHV record and corresponding HMIS forms:

- Iron/folate tablets and Vitamin A capsules distributed
- Cases of dehydration and diarrhea treated and referred
- Condoms and oral contraceptive pill packets distributed
- Pneumonia cases among children treated by pediatric cotrimoxazole (in program districts)
- Treated pneumonia cases among children followed up on third day
- Referrals of all types documented (FCHV ward register requires a supplemental simple pictorial checklist for referral of child health, pregnancy, delivery and family planning cases).

## 3. Support Mechanisms: Endowment Fund Guidelines

### *Background*

The Endowment Fund (EF) concept was created to address the need for a sustainable community-based health workforce throughout Nepal.[6] The FCHV EF is an authorized capital amount that is deposited in a fixed government bank account and earns interest although the principal cannot be used. Additional funds can be added to the principal but the principal cannot be withdrawn. A principal amount of at least NRs. 50,000 per VDC or municipality is necessary to generate sufficient interest to financially support the FCHV/P.

Following the successful establishment of a pilot fund, the MOH and MOLD, in conjunction with the National Planning Commission, formalized guidelines for the FCHV EF. The capital (principle) for the EF can come from a variety of sources. The majority of the principal should come from the VDC or municipality, with additional funds provided by partner organizations where possible.

### *Composition and Functions of Executive Committee*

a) To manage the EF and the accrued interest, an Executive Committee, including representatives of all stakeholders, will be established.

b) The Executive Committee will be comprised of the following seven members:
   - 1 VDC Chairperson or Mayor of municipality — Chairperson
   - 1 elected female ward member — Member
   - 3 FCHV representatives, chosen by FCHVs — Member
   - 1 representative chosen by VDC Chairperson or Mayor — Member
   - 1 PHCC/HP/SHP-In Charge — Member-Secretary

c) Meeting Schedule: The Executive Committee will meet at least once every four months to follow up on the status of the interest accrued and to discuss the activities and program it will support. The Member-Secretary, in consultation with the Chairperson, will summon the Executive Committee meeting. In the case of municipalities without a health facility, the Social Welfare Officer of the Community Development Section will act as the Member-Secretary.

d) Account Operation: The FCHV EF and its savings account will be operated under the joint signature of the VDC Chairperson or Mayor and the PHCC/HP/SHP-IC. In the case of municipalities without a health facility, the account will be operated under the joint signature of the Mayor and the Social Welfare Officer of the Community Development Section who is responsible for health programs.

e) Prior to withdrawing the interest amount from the FCHV EF savings account, it is necessary to obtain approval from the Executive Committee in which the representatives chosen from the FCHVs must be present.

f) Expenditure of Interest Amount: The interest generated from the FCHV EF will be used for the benefit and encouragement of FCHVs. The FCHV representatives will facilitate a discussion with the other FCHVs in their VDC or municipality about how

[6] Adapted and quoted from Nepal Technical Assistance Group (NTAG), FCHV Endowment Fund Report (draft), October 2002; and the DHS/MOH and MOLD FCHV Endowment Fund Guidelines.

the interest amount should be spent; the FCHV representatives will then submit their recommendations to the Executive Committee for final decision. Upon approval, the amount will be spent according to the approved decision.

g) It is prohibited to use the interest amount for monthly remuneration and contingencies.

h) Auditing Procedures: The Member-Secretary will be responsible to maintain the EF account. He/she will be required to submit details of income and expenditure at every EC meeting. The FCHV EF must also be audited when the VDC or municipality accounts are also audited.

# Annex 4: FCHV Program Districts and Approaches[7]

| Districts | | HMG/N FCHV Program Approaches | | |
|---|---|---|---|---|
| | | VDC level FCHV Coordinator | Population-based[8] | Ward-based |
| **Eastern Development Region** | | | | **10,485 FCHVs** |
| 1 | Bhojpur | | | ✓ |
| 2 | Dhankuta | | | ✓ |
| 3 | Ilam | | ✓ | |
| 4 | Jhapa | | | ✓ |
| 5 | Khotang | | ✓ | |
| 6 | Morang | ✓ | | ✓ |
| 7 | Okhaldungha | ✓ | ✓ | |
| 8 | Panchthar | | | ✓ |
| 9 | Sankhuwasabha | | | ✓ |
| 10 | Saptari | | | ✓ |
| 11 | Siraha | | | ✓ |
| 12 | Solumkhumbu | | | ✓ |
| 13 | Sunsari | ✓ | ✓ | |
| 14 | Taplejung | | ✓ | |
| 15 | Terathum | | ✓ | |
| 16 | Udaipur | | | ✓ |
| **Central Development Region** | | | | **13,830 FCHVs** |
| 17 | Bara | | | ✓ |
| 18 | Bhaktapur | | | ✓ |
| 19 | Chitwan | | | ✓ |
| 20 | Dhading | | | ✓ |
| 21 | Dhanusha | ✓ | | |
| 22 | Dolakha | | | ✓ |
| 23 | Kathmandu | | ✓ | |
| 24 | Kavre | | | ✓ |
| 25 | Lalitpur | | | ✓ |
| 26 | Mahottari | | | ✓ |
| 27 | Makwanpur | | | ✓ |
| 28 | Nuwakot | ✓ | ✓ | |
| 29 | Parsa | ✓ | | |
| 30 | Ramechhap | | ✓ | |
| 31 | Rasuwa | | ✓ | |
| 32 | Rautahat | | | ✓ |
| 33 | Sarlahi | | ✓ | |
| 34 | Sindhuli | | ✓ | |
| 35 | Sindhupalchowk | | | ✓ |
| **Western Development Region** | | | | **10,828 FCHVs** |
| 36 | Arghakhanchi | | ✓ | |
| 37 | Baglung | ✓ | ✓ | |
| 38 | Gorkha | | | ✓ |
| 39 | Gulmi | | ✓ | |
| 40 | Kapilvastu | | | ✓ |

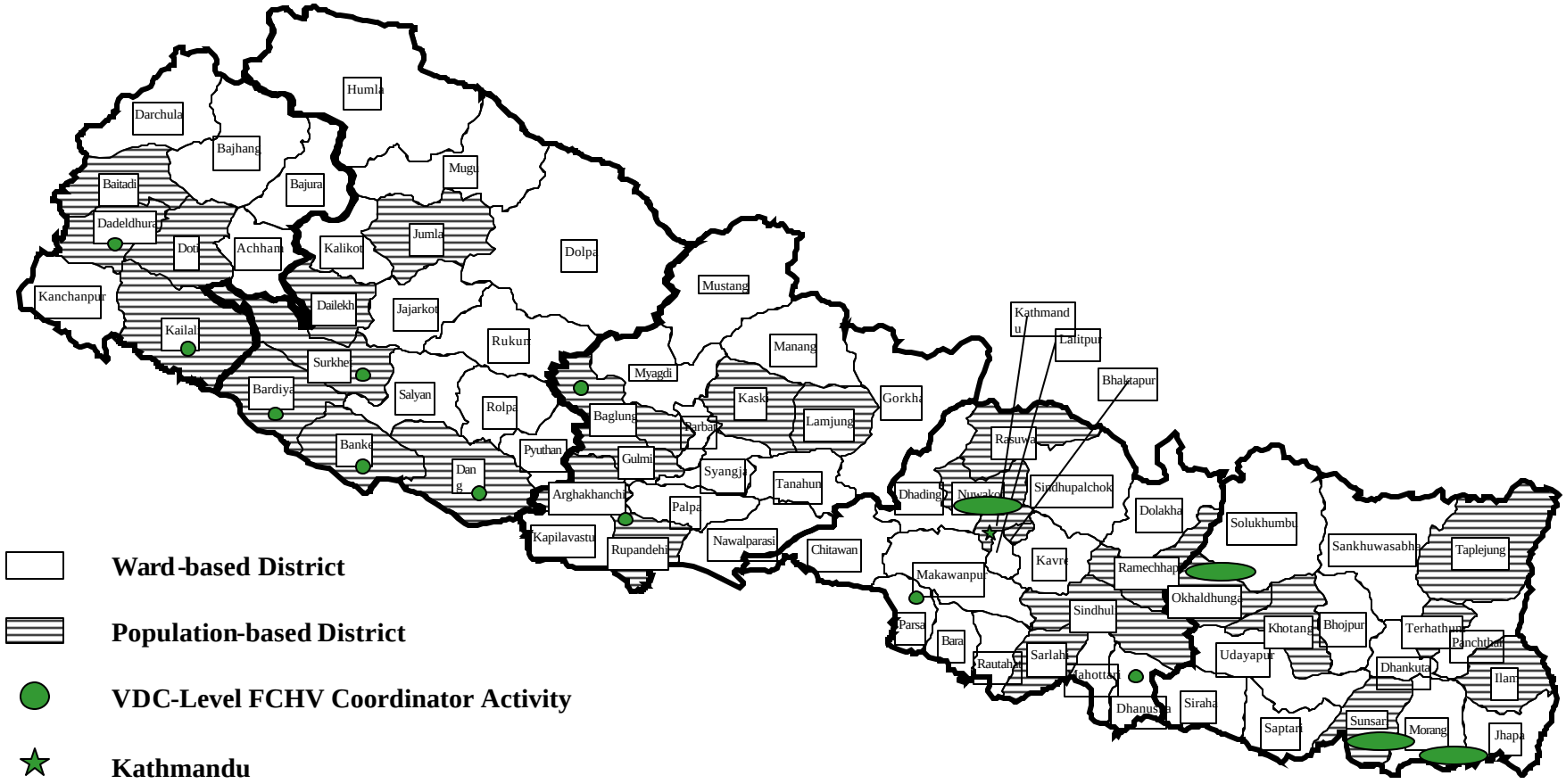
[7] Data excerpted from FCHV Section/FHD Summary Report, 2002.

[8] In an additional seven districts (Nawalparasi, Manang, Kapilvastu, Dhanusha, Bajhang, Bajura and Kanchanpur), partner organizations or municipalities have supported the expansion of FCHVs based on project needs.

| Districts | | HMG/N FCHV Program Approaches | | |
|---|---|---|---|---|
| | | **VDC level FCHV Coordinator** | **Population-based**[9] | **Ward-based** |
| 41 | Kaski | | ✓ | |
| 42 | Lamjung | | ✓ | |
| 43 | Manang | | | ✓ |
| 44 | Mustang | | | ✓ |
| 45 | Myagdi | | | ✓ |
| 46 | Nawalparasi | | | ✓ |
| 47 | Palpa | | | ✓ |
| 48 | Parbat | | | ✓ |
| 49 | Rupendehi | ✓ | ✓ | |
| 50 | Syangja | | | ✓ |
| 51 | Tanahu | | | ✓ |
| **Mid-Western Development Region** | | | | **9,825 FCHVs** |
| 52 | Banke | ✓ | ✓ | |
| 53 | Bardiya | ✓ | ✓ | |
| 54 | Dailekh | | ✓ | |
| 55 | Dang | ✓ | ✓ | |
| 56 | Dolpa | | | ✓ |
| 57 | Humla | | | ✓ |
| 58 | Jajarkot | | | ✓ |
| 59 | Jumla | | ✓ | |
| 60 | Kalikot | | | ✓ |
| 61 | Mugu | | | ✓ |
| 62 | Pyuthan | | | ✓ |
| 63 | Rolpa | | | ✓ |
| 64 | Rukum | | | ✓ |
| 65 | Salyan | | | ✓ |
| 66 | Surkhet | ✓ | ✓ | |
| **Far-Western Development Region** | | | | **5,581 FCHVs** |
| 67 | Achham | | | ✓ |
| 68 | Baitadi | | ✓ | |
| 69 | Bajhang | | | ✓ |
| 70 | Bajura | | | ✓ |
| 71 | Dadeldhura | ✓ | ✓ | |
| 72 | Darchula | | | ✓ |
| 73 | Doti | | ✓ | |
| 74 | Kailali | ✓ | ✓ | |
| 75 | Kanchanpur | | | ✓ |
| ***Total HMG/N FCHV Program Districts*** | | **14** VDC level FCHV Coordinator Districts | **28** Population-based Districts | **47** Ward-based Districts |
| | | | **75 Total Districts** | |
| ***Total No. of FCHVs*** | | **4,000** VDC level FCHV Coordinators | **11,548** HMG/N Expansion<br>**1,001** Partner-Supported Expansion | **36,000** |
| | | | **48,549 Total FCHVs** | |

[9] In an additional seven districts (Nawalparasi, Manang, Kapilvastu, Dhanusha, Bajhang, Bajura and Kanchanpur), partner organizations or municipalities have supported the expansion of FCHVs based on project needs.

# Annex 5: Map of Nepal's National FCHV Program




**Ward-based District**

**Population-based District**

**VDC-Level FCHV Coordinator Activity**

**Kathmandu**

# Annex : 6 FCHV Program Strategy Review Workshop

## January 29-31, 2003

## LIST OF PARTICIPANTS

(Actual participation)

*Venue: Park Village Resort, Budhanilkantha, Kathmandu, Nepal*

| S/N | Gender | Name | Designation | Organization |
|---|---|---|---|---|
| 1 | M | Dr. L. R. Pathak | Director General | DoH |
| 2 | M | Mr. Tek Bahadur Dangi | Senior Public Health Administrator | FHD |
| 3 | M | Mr. Ashok Sherstha | DCoP - Program | NFHP |
| 4 | F | Ms. Neena Khadka | NSL Manager | SNL/SC-US |
| 5 | M | Mr. S. B. Chaudhary | RFO coordinator | UNFPA |
| 6 | F | Ms. Harriet Hoffman | Junior Program Officer | UNFPA |
| 7 | M | Mr. Hari Sharma | D.Project coordinator | GTZ/HSSP |
| 8 | M | Mr. Parashu Ram Shrestha | Sr. Public Health Officer | CHD |
| 9 | M | Mr. Pranay Upadhyay | Sr. Public Health Officer | ECDC |
| 10 | M | Mr. Sanjay Dahal | Public Health Inspector | NHTC |
| 11 | M | Mr. Madhusudan Koirala | Sr. Public Health Officer | NCASC |
| 12 | M | Mr. Hari Saran Karki | Programmer | NHEICC |
| 13 | M | Mr. Rishi Pd. Lamichhane | Sr. Public Health Officer | DPHO, Lalitpur |
| 14 | F | Ms. Mangala Manandhar | Sr. Public Health Officer | FHD |
| 15 | F | Ms. Sharada Pandey | Chief, IVUT Section | CHD |
| 16 | F | Ms. Savita Acharya | Senior Program Officer | NFHP |
| 17 | M | Mr. Kumar Lamichhane | Team Leader, FCT | NFHP |
| 18 | M | Mr. Madan R. Thapa | Senior Program Officer | NFHP |
| 19 | M | Mr. Heera Tiwari | FHFO | NFHP, Biratnagar |
| 20 | M | Mr. Shree Hari Sharma | Family Health Field Officer | NFHP, Pokhara |
| 21 | M | Mr. Heem Shakya | Program Officer | NFHP |
| 22 | M | Mr. Sushil Karki | Program Officer | NFHP |
| 23 | M | Mr. Binoy Dil Lama | Program Officer, FCT | NFHP |

| S/N | Gender | Name | Designation | Organization |
|---|---|---|---|---|
| 24 | M | Mr. Ram Bhandari | Program Officer | NFHP |
| 25 | M | Mr. Prem Adhikari | Program Assistant | NFHP |
| 26 | M | Mr. Dharma Bajracharya | Program Assistant | NFHP |
| 27 | M | Mr. Rajendra Karki | Consultant | UNICEF |
| 28 | M | Mr. Hari Koirala | Program Specialist | USAID |
| 29 | M | Mr. Bala Ram Ghimire | Consultant | World Education |
| 30 | M | Mr. Sita Ram Devkota | Community Health Specialist | CARE Nepal |
| 31 | M | Mr. Dharmapal Raman | Program Specialist | USAID |
| 32 | M | Mr. Muneswor Mool | Sr. Admn. H. I. | HMIS |
| 33 | F | Ms. Surya Bandana Pandit | Section Officer | MoLD |
| 34 | F | Ms. Indira Joshi | Health Program Officer | WWD |
| 35 | F | Ms. Gyanu Basnet | Sr. Nsg. Officer | HIMDD |
| 36 | M | Mr. Dillip Chandra Poudel | Team Leader, Child Health Team | NFHP |
| 37 | M | Mr. Ram Kumar Shrestha | Director | NTAG |
| 38 | M | Mr. K. P. Acharya | Technical Manager | NTAG |
| 39 | F | Ms. Maya Shrestha | Consultant | NTAG |
| 40 | F | Ms. Sanju Bhattarai | Program Associate | CEDPA |
| 41 | F | Ms. Asha asnet | Associate Director | FHI |
| 42 | F | Dr. Penny Dawson | Chief of Party | NFHP |
| 43 | F | Ms. Anita Gibson | Training Specialist | NFHP |
| 44 | M | Mr. Shyam Shrestha | Project Coordinator | WE |
| 45 | F | Ms. Archana Singh | Int. Support Specialist | EHP |