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Strategic Program Document on Remote Area Initiative
(RAI) of Nepal CRS Company, May 2014

FHI 360

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
CRS	Nepal CRS Company
FHI 360	Family Health International
FP	Family planning
GIS	Geographic information system
GON	Government of Nepal
HIV	Human Immunodeficiency Virus
IUD	Intrauterine device
KAP	Knowledge, attitudes, and practices
MCH	Maternal and child health
MOV	Means of verification
NTO	Non-traditional outlets
OCP	Oral contraceptive pills
ORS	Oral rehydration salts
RH	Reproductive health
RAI	Rural Access Initiatives
SBCC	Social and behavior change communication
STI	Sexually transmitted infection
WRA	Women of reproductive age

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Background

CRS started in 1978 as the Nepal Contraceptive Retail Sales Project, a joint collaboration between the Government of Nepal, USAID, and Westinghouse America. In 1983, this project was converted into a non-profit company called CRS Company Pvt. Ltd.

CRS has grown steadily since 1978 and contributes more significantly each year to national family planning and public health efforts. The company has pioneered social marketing approaches and established itself as a leading public health organization in Nepal.

CRS has become synonymous with family planning and its condom brand, Dhaal Deluxe, synonymous with condoms. The organization has created strong brand equity among various stakeholders and the public at-large. It now markets a portfolio of 13 products, and its sales network reaches into all 75 districts of the country. The 2011 Nepal Demographic Health Survey reported that one in four Nepalese using a reversible form of birth control and 66% of those using oral contraceptives were using CRS products.

The vision of CRS is to build a healthy future for the people of the Nepal, operating as an efficiently run social marketing enterprise implementing marketing and communication programs in collaboration with the Government of Nepal, international non-governmental organizations, national non-governmental organizations, and donors.

The CRS Mission is to enable the poor and underprivileged to build a healthier future for themselves by making family planning, HIV/STI prevention, and maternal and child health products and services more accessible and conducting behavior change communication programs to create awareness and increased use of these products and services.

Considering the earlier intervention of Behavior Change Communication (BCC) program experience in 2001 as a pilot initiative on family planning and health products in five districts of the country - Jhapa, Morang, Sunsari, Chitwan, and Banke which was expanded to 4 additional districts, covering 9 districts by August 2003 and again implemented (2006-2007) Sangini Didi Neighborhood Program (SDNP) to inform, educate, and communicate messages to women groups on family planning/reproductive health and safe motherhood with support from AED/N-MARC.

The current endeavor of CRS is to develop a Program (2014-2016) by identifying strategic measures that would contribute to the realization of Nepal's National Health Sector Program – Implementation Plan (NHSP-IP) outputs. These include *inter alia*, universal access to Essential Health Care Services (EHCS), especially safe motherhood care; strengthening the decentralization process; promoting the role of private sector, with focus on vulnerable groups, women of hard to reach and remote areas.

CRS has the following strengths and comparative advantages:

- A well spread and established distribution network spanning all 75 districts
- Effective market coverage through a field force in all five regions
- Sizeable social product portfolio consisting of family planning/reproductive health, HIV/STI

prevention and maternal and child health products

- CRS consistently maintains a leadership position in contraceptive market
- CRS maintains a good relationship with GON and they acknowledge the importance of social marketing.
- Has adopted modern management methods, improved its information systems and delegation of responsibility that empowers employees at mid- and lower levels to make decisions
- Has significant contribution to National Family Planning program. It is contributing around 25% of the total national FP achievement of non-surgical reversible methods.

Reproductive Health Sector of Nepal

The government is committed to improving the maternal health outcomes, reducing the reproductive morbidity and mortality in all its policy initiatives, as evidenced by the high priority given to the National Safe Motherhood Program within the Nepal Health Sector Program- Implementation Plan.

The government is committed to achieving the national millennium development goals (MDGs) by reducing the infant mortality rate (IMR) to 30/1,000 live births, maternal mortality rate to 134 /100,000 live births, halt and reverse the spread of HIV-AIDS, and ensure 60% of all deliveries are conducted by the skilled birth attendants (SBAs) and emergency obstetric care (EOC) by 2015.

The Nepal Health Sector Program -II 2010-2015 which follows on Health Sector Strategy-Agenda for Reform and Nepal Health Sector Program Implementation Plan provides guidance for “more focus on a community-based programs and strengthening of referral sites, integrating newborn interventions with child health and maternal health programs; strengthening the district management capacity effective implementation of packages and engaging the private sector for more holistic programming”,

Similarly The National Safe Motherhood and Neonatal Long Term Plan 2006-2017 plans to strengthen and expand delivery by skilled birth attendant, basic and comprehensive obstetric care services (including family planning) at all levels through development of infrastructure, protocols, strengthening human resource capacity and referral management system from communities to district hospitals for obstetric emergencies and high risk pregnancies

Nepal has made significant progress with its family planning Program over the last thirty years. The Total fertility rate (TFR) has decreased from 6.3 in 1976 to 2.6 in 2011(NDHS, 2011), and the contraceptive prevalence rate (CPR) has increased from 2.9% to 43% within the same timeframe. Large reductions in the maternal mortality ratio in recent years have been partly attributed to improved family planning. The government has increased investment in family planning and developed a strong policy framework to meet the targets of a CPR of 67% by 2015 and a further slight reduction in the TFR to 2.5 by 2017. In addition, large disparities exist in rates of contraceptive use, and levels of unmet need vary substantially by place of residence. Unmet need is highest among younger women (38% among 15-19 year olds and 33% among 20-24 year olds), mountain dwellers (30%), and women from the hills (28%), rural women (25.5%) and women from the two lowest wealth quintiles.

The unmet need for urban women is 19.8%. Among different social groups, Muslims have the highest unmet need at 37% followed by Hill Dalits at 34%.v In contrast, the total level of demand for

contraception, which encompasses both current use and unmet need, varies little by women's background characteristics.

However, despite government's commitment to improve the maternal and reproductive health reflected in its policy and strategy documents on reproductive health and safe motherhood, large gaps continue to exist between the policy and its implementation, which is reflected in the high maternal mortality rate (539 per 100,000 live births), neonatal (39 per 1000 live births) and infant mortality rates (64 per 1000 live births), low ante-natal and post-natal coverage, low skilled birth attendance, high incidence of maternal morbidity especially uterine prolapse.

The contraceptive prevalence rate (CPR) for modern family planning method is 43% the same rate reported by the Nepal Demographic Health Survey, 2011 (NDHS). The Central Development Region reported the highest CPR (49%) and the western region reported the lowest (32%). Achieving the NHSP-2 goal of 67% by 2015 thus remains a large challenge. However, there has been a decline in the total fertility rate (TFR) from 3.1 per women of child bearing age in 2006 to 2.6 in 2011 (NDHS 2011) and it is expected that the NHSP-2 target of 2.5 will be met by 2015. In 2068/69, only 18% of the CPR comprised birth spacing methods, much lower than the NDHS 2011 estimate of 47%.

Unmet Need for Family Planning

According to NDHS 2006 the CPR (all methods) was 48 percent with an unmet need of 25 percent of which 10 percent is for spacing and 15 percent is for limiting. While NDHS 2011 showed that the CPR increased to 49.7 percent and unmet need for family planning increased further to 27 percent including 10 percent for spacing and 17 percent for limiting

Safe Motherhood

While 83% of all mothers received antenatal care services, less than three fifths had four antenatal care check-ups indicating that more than two fifths of mothers did not complete the recommended

Executive Summary
DoHS, Annual Report 20668/69 (2011/2012) four check-ups. There was a large increase in skilled birth attendance at deliveries from 32% in 2066/67 to 44% in 2068/69. There was also a large increase in institutional deliveries from 31% of all deliveries in 2066/67 to 44% in 2068/69. Postnatal care check-ups remained almost the same as in the previous fiscal year. More than two-fifths of pregnant women (43.3%) benefited from free institutional delivery care under the Aama Program and 43% received its transport incentive in 2068/69. There was a substantial increase in the budget allocation. FCHVs also contribute significantly to counselling and referring mothers and children to health facilities for service utilization.

Fertility Status (NDHS, 2011):

- The total fertility rate for the three years preceding the survey is 2.6 births per woman, with rural women having about one child more than urban women.
- Fertility has decreased from 4.6 births per woman in 1996 to 2.6 births per woman in 2011, a two-child decline in the past 15 years.

- Childbearing begins early in Nepal, with almost one quarter of women giving birth by age 18 and nearly half by age 20.
- Seventeen percent of adolescent women age 15-19 are already mothers or pregnant with their first child. In the last five years, teenage pregnancy has fallen by 10 percent.
- Half of births occur within three years of a previous birth, with 21 percent occurring within 24 months.

FP Status (NDHS, 2011):

- Knowledge of contraception is universal in Nepal.
- One in two currently married women is using a method of contraception, with most women using a modern method (43 percent).
- The three most popular modern methods used by married women are female sterilization (15 percent), injectable (9 percent), and male sterilization (8 percent).
- Use of modern methods has increased by 66 percent in the past 15 years. However, there has been little change in the last five years.
- The government sector remains the major provider of contraceptive methods, catering to more than two in three users (69 percent).
- Overall, 51 percent of contraceptive users discontinued using a method within 12 months of starting its use. Twenty-six percent of episodes of discontinuation occurred because the woman's husband was away.
- Twenty-seven percent of currently married women have an unmet need for family planning services, with 10 percent having an unmet need for spacing and 17 percent having an unmet need for limiting.

Maternal Care		
Indicator	Achievement (2013)	Target (2015)
Institutional delivery	38% (45%-FHD)	40%
ANC 1st visit	88%	-
ANC 4th visit	50%	80%
CPR	45.3%	67%

Some of the reasons for the gaps in the FP services include: limited availability and access to contraceptives, concerns regarding the quality of family planning services, uncertain RH commodity security. The underlying problems also poor involvement of men in FP, poor participation by socially excluded population, particularly Dalits and Muslims, prevailing myths and misconceptions and lack of awareness about safe sexual behavior.

RAI Districts Context on FP and MCH

Bajhang

The contraceptive prevalence rate in Bajhang was 27% (2011), much lower than the national (44%) and regional (36%) averages. Of expected pregnancies, one in five deliveries were assisted by a skilled birth attendant and 423 female community health volunteers extend maternal health care services beyond health facilities. However, still a third of women aged 15-49 who gave birth in the preceding two years reported receiving no ante-natal care at all

As per the annual report 2011/12 of DoHS, 44.48% expected pregnancies sought ANC 4 visits. There were 53.16% of women who accepted family planning after abortion care. The Contraceptive Prevalence Rate was noted 52.48 in 2011.

Thirty five percent (35%) of childbearing women aged 15-49 who report receiving no ante-natal care.

Jumla

For pregnant women in Jumla, the practice of delivering at home is deeply rooted. The total number of health workers trained as Skilled Birth Attendants is 24; working in 13 Birthing Centers at existing health facilities. While women are well aware of the possibilities for institutional delivery and antenatal care, there are many factors that prevent them from using these services. It is often in-laws who are empowered to make the decision, and they may think that giving birth in a faraway facility will expose the infant to evil spirits and other harms. In addition, some rural settlements are several hours away on foot from the facilities. The CPR of Jumla was 41% in 2011, 22.45% deliveries were conducted by Skilled Birth Attendant in 2011.

Bardiya

Moreover, from the discussion on the RH Sector above, it is clear that Nepal has a long and arduous road ahead before it can achieve the millennium development goals relating to this sector. The public health institutions, in their current situation, are unlikely to deliver the services that would enable the country achieve all its development goals. Further, distortions continue to exist on the demand side as well since women, socially excluded communities, those living in the remote and inaccessible areas, and the impoverished and the illiterate population are either unaware or are incapable of accessing the health services unless sustained support is extended to help these groups overcome the barriers.

Several factors contribute to the unacceptably high rates of MMR, IMR and other critical indicators, some of which include: by lack of access, inadequate infrastructure, shortage of trained human resources, weak management systems, and ineffective referral systems; high incidence of poverty, social inequities, political instability, poor participation of the community in determining their priorities, lack of accountability and transparency, frequent transfer of managers, and above lack of consistent policy direction and continuity of management at senior levels of the government.

This program is designed with due consideration to the plethora of challenges that lie ahead, with due regard to the dynamic situation that is constantly evolving. The program, therefore, will remain highly flexible, however with unwavering focus and commitment to the national development goals and

objectives.

Rationale

- Government's policies support the CBD of family planning services
- Existing community-based program that might benefit from the addition of FP and maternal health services
- Prior experience of CRS in conducting CBD projects
- CRS strength and comparative advantages in socially marketing health products across the country
- change of strategic focus from products to services following a development of CRS Business Plan (January 2014 – November 2016) and its approval by USAID/Nepal
- Availability of funds to CRS to expand its product portfolio and services to support FP and MCH national objectives through creating demand for and access to CRS's product and services in hard to reach areas
- Community needs

Goal

The goal of the project is to improve the quality, demand, access and delivery of family planning and maternal health services.

Objectives of the Program

- Improve family planning knowledge, attitude and practice among Married Women of Reproductive Age Group (15-49) in hard to reach geographical areas.
- Create demand for FP/MCH products and services through BCC programs
- Increase accessibility and availability of contraceptives through social marketing
- Increase modern methods of contraception use among marginalized and vulnerable groups.
- Increase Institutional Delivery
- Increase ANC attendance
- Increase awareness about Uterine Prolapse and service seeking behavior

Specific Objectives

1. Specify expected increase in CPR(after result of Baseline survey)
2. Specify % of deliveries by trained personnel (after result of Baseline survey)

Key Indicators

Monitoring indicators

1. Number of group meetings organized to create demand for FP/MCH services/products
2. Number of clients referred to Sangini centers for OCP and injectable by Community Change Agents/Cos

3. Number of clients referred to public health facilities for long-term reversible contraceptives by Community Change Agents/Cos
4. Number of cases of ANC visits, Institutional delivery, uterine prolapse cases referred to public health facilities by Community Change Agents
5. Number of depot/NTOs opened to supply condom and MCH products

Evaluation indicators

Project Strategies

This project utilizes community-based approach to promote family planning and maternal & child health (MCH) services in the community. Main emphasis of the project is to increase the use of modern spacing methods among young and low parity couples. The change agent will organize meeting with women and male groups and encourage couples to adopt family planning methods as per their choice and provide them assistance for availing MCH services.

General Strategies

Work with local Community Organizations (CO) to create demand of FP/MCH products

Engagement of local organizations/NGOs/CBOs community groups will encourage and increase the level of local participation. Conducting meeting and discussion with local NGOs/CBOs and groups will help to bridge link between the local community and stakeholders providing FP and MCH services.

Orient community groups (micro credit, women forest users groups)

In partnership with local level community groups, the members of mother groups will be provided orientation on FP and MCH during community meetings *where* women will be encouraged to discuss their reproductive health questions, concerns and needs in an intimate, confidential environment. The counseling provided at these venues increases the comfort level of potential clients as well as the value of information they receive. Some community meetings will also be arranged for male participants.

Further, the community level program is linked with local media channels like local FM stations and newspapers. The success stories of mother groups are shared to community people through radio programs. This will motivate community groups within and outside the locality to establish linkage and follow their path.

- Establish linkage with Sangini center for OCP, injectable and long-term contraceptives
- Establish linkage with public health facilities for FP/MCH for free supply
- Open NTOs for the distribution of condom, and MCH products (ORS, Piyush, and CDK)
- Promote health-seeking behavior of beneficiaries (e.g. counseling for ANC visits, institutional delivery, and establish referral linkages to health institution for prevention and treatment of uterine prolapse etc.)

Project Specific Strategy

Networking with District Health Facilities

Monthly Coordination Meetings: To strengthen coordination and liaisoning with GON health staff, it is envisaged that PC will attend monthly meeting with health staff at the PHC and District Hospital and Community Mobilizer and CCA will attend meetings with service providers at SHP and HP level. All issues pertaining to coordination and service delivery, follow-up and logistics are to be resolved in the monthly coordination meetings. These meetings will also be used for joint planning of various family planning & RH related Programs in the project area.

Networking with District Level Functionaries: PC will also maintain regular contact with the LDO/VDC/School teachers/CBOs authority, Health Facilities Management Committees (HFMC) to seek their support for the project activities.

Sustainability strategies

Community Ownership and Management

During this project supervisors (Project Coordinator and Community Mobilizer) together with CCA would encourage and actively participate in Health Facility Management Committees (HFoMC), who would on a regular basis plan, and review progress.

Service Delivery Approach

To meet the above objectives of the project, it is essential to have village-based access to proper counselling and appropriate services through community change agents. The CCAs will provide counselling and explain the benefits of healthy family, dispel myths, misconception, inform them about the ANC, and create demand for family planning services. They would also deliver the services as per the need of the people. CCA will record pregnant women, deliveries, refer uterus prolapsed cases to the Government health facilities. The CCA will make use of IEC materials and activities such as group meetings, Hat – Bazar, Sadak nataks, posters, flip book, cards, folk songs etc. to spread messages.

The service package through RAI will include the following services:

1. Counselling of clients
 2. Awareness generation through group meetings and other IEC/BCC activities
 3. Linkages with Government Health Facilities for Referrals for Long Acting Contraceptive methods
 4. Health Care Waste management
 5. Follow-up care
1. **Counselling** is an integral part of the RAI project. Counselling would emphasis on providing complete information to the people on the advantage and disadvantages of a particular family planning method including the side effects. For effective counselling, CCA/Mobilizer will identify influential mother's group/PAF groups/forestry group persons or village level volunteers such as FCHVs Health

Facilities Management Committee members, school teachers, CBOs, youth club members and others. Support from them would be sought in providing counselling to the clients as and when required.

2. **Awareness Generation** is essential for the success of the project and for making the efforts sustainable. This will include folk media, street dramas. Culturally acceptable and district specific BCC materials will be made available by CRS. Project team will make use of BCC materials to educate the community. The community will be educated through inter-personal counselling, door to door visits, group discussions, awareness generation. Involvement of other grass-root institutions & CBOs will be crucial in effective implementation of the project.
3. **Group Meetings:** For awareness building more focus will be on group meetings. CCA will hold group meetings regularly. In each ward minimum one meeting will be conducted by the CCA every month. Focus in these meetings will be on specific topics i.e. during the first month topic of discussion may be family planning and management of side effects. In the second month topic may be ANC checkup, its importance, schedule for checkups, Institutional delivery, Three delays ; During the third meeting, focus may be shifted to ORS +Zinc , Health Care Waste Management. CCA may also attend the regular meetings of the CBOs/projects in their area which will be an effective platform for dissemination of the information.
4. **Wall Writing:** Wall writings will be done as a part of message dissemination. These writings will focus more on concrete information regarding service availability and various schedules of MCH services. Apart from above messages, CCA will have to coordinate with the folk performances being organized by other agencies from time to time.
5. **Distribution of OCP & Condoms – Free Supply or CRS Brands:** Each CCA will be provided the contraceptives as per the requirement in her area for further distribution. To provide contraceptive choice to people, different brands of contraceptives would be made available to people in the project area. This would be introduced in the project area from the very beginning. The CCA would provide expanded choice of contraceptives.
6. **Linkages with Government Health Facilities for Referrals:** For provision of clinical services, clients would be referred to the health facilities to seek such services. Sterilization services under the project would be provided by the existing government health structure in the project area. Clients for tubectomy & vasectomy will be referred to government district hospital/sterilization camps Women will be also referred to the HP/PHC/DH for IUCD/Jadalle insertion, ANC and others. High-risk pregnancy cases also will be referred for safe delivery.
7. **Distribution of ORS packets + Zinc Tablets:** The community mobilizers will ensure that ORS and Zinc are available at retail level.
8. **Screening & Follow-up Care:** To maintain the chain of service delivery and minimize the dropout rate, regular services and follow up of clients would be done by the project staff in the project area. Emphasis would be laid on quality contact with the community. The follow up of clients will be done in the following ways:

- IUD clients will receive a follow up visit within the first week after insertion, as IUD clients need a lot of assurance. The CCA will ensure that IUD clients visit the staff Nurse for an examination after the first six weeks and conduct follow up visits once every six months as long as the client remains a user. In case of any complications, clients will be referred to the PHC/district hospital.
- Besides this, all the FP & MCH clients will also be encouraged/ motivated to visit the Gaown Ghar Clinic held nearest to their homes and gets the check-up / follow up done by the visiting lady doctor.

Project Implementation

The Rural Area Initiative (RAI) project will be implemented in three districts – Bardiya (Thakurdwara, Shivapur, Suryapatwa); Bajhang (Chainpur, Luyanta, Rithapata and Jumla (Haku, Dillichowor, Patmara) Initially the project activity will be implemented in 3 VDCs each and gradually expanded through learning process and further scaling of the project activities covering all VDCs of 3 districts by the end of 1 year implementation.

Under the oversight of Central authority of CRS and Field Operations Department, Area Manager for Mid and Far Western Development Region will be responsible for overall operationalization of the RAI project.

At the District level two paid staff will be recruited. Generally one CCA (volunteer) will be identified in 1 VDC and responsible to organize the group meetings according to the existing groups (Mothers group in Bajhang; Forestry groups in Bardiya and PAF groups in Jumla) The reason for going through these groups are based on the information from the field that these groups are organized and regular meetings are being held through other projects working in these districts for some other purposes- such as PAF activities are being undertaken in Jumla district while in Bajhang Suaahara project is working through for groups for nutrition related activities and Forestry groups in Bardiya. Rather than re-inventing the wheel and establish a parallel system the project will be building on the existing structure in place and will bring the synergy and coordination within the other services being offered in the districts

Human Resources /Project Team

To meet the objectives of the project, the following **team of persons** will carry out the activities as described in the job description under the overall guidance and oversight of the CRS national/central team (**Annexure – 1**):

1. Area Manager
2. Project Coordinator
3. Mobilizer
4. Community Change Agents (CCA)

The **CCA** would be identified for a population of 2000-4000 population. There would be one **Mobilizer** for 3 -5 CCAs. The Mobilizer would provide supportive supervision to CCA and report to Project Coordinator.

Training

Before actual implementation of the project PCs and mobilizers will be provided induction training. The training will be provided by CRS HQ/Regional staff to orient the project staff in managing the project as well as providing the services. In addition, they will also receive intensive training in project management. This comprehensive training will be provided by the Area Manager with the help from concerned training departments of CRS HQ through a training modules comprising financial & administrative management, MIS, contraceptive logistics, counselling, supervision & monitoring.

Community Change Agents (CCA) would undergo intensive training in counselling, service delivery and record keeping. The training components would include reproductive health and safe motherhood issues including uterine prolapse, counselling, motivation, family planning education, service delivery, referral & follow ups, ORS+Zinc, client record keeping.

Monitoring

Monitoring will be essential component of the project. Technical support and monitoring will be the main responsibility of the mobilizer under the guidance of the PC at the district HQ.

A management information system will be developed for the project and flow of information so that decisions for the strengthening of the project and expansion are based on the evidence

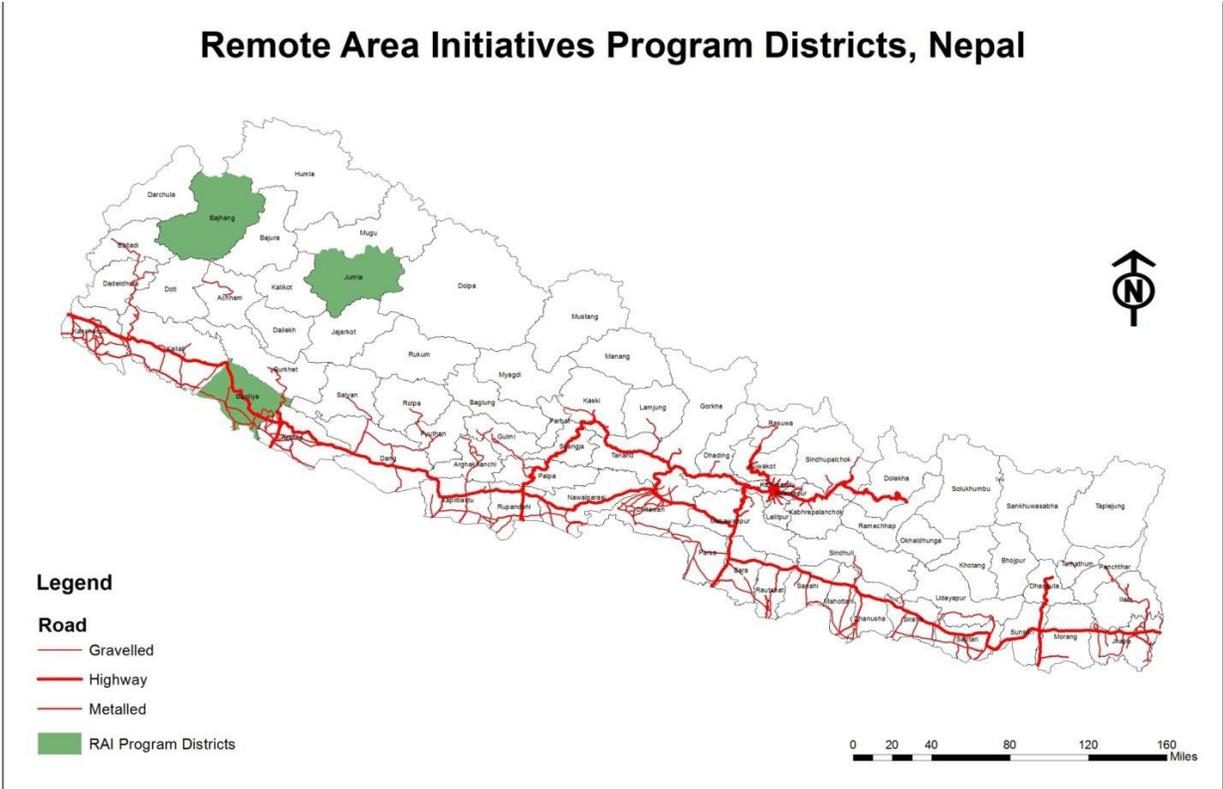
An annual evaluation will be carried out to assess the relevancy effectiveness and efficiency of the over one year period and revise and update the plan based on the recommendations.

Project review will be carried out on a three monthly basis to know the status of the project including through community stakeholders to guide the program to take corrective and forward looking measures while expanding the program VDCs.

The following Record/Registers are to be seen by Monitoring Officers (Area Manager/PC).

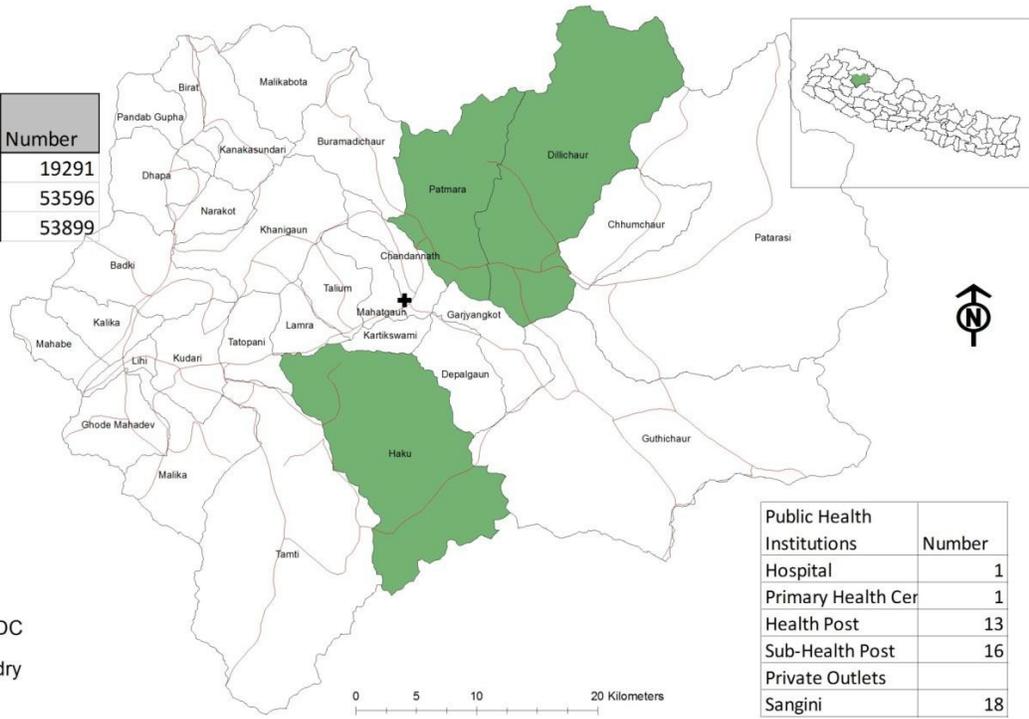
1. Monthly Work plan of each category of staff;
2. CCA Daily Dairy, Referral Card;
3. Monthly reports of CCA /Mobilizer/PC.
4. All the Quarterly Progress Reports (QPR)
5. Contraceptive Logistic Register at project as well as VDC/ward level.
6. CSM Register
7. Referral Register at project level.
8. IEC Activity Register
9. Co-ordination register (Correspondence with Health facilities)

Annex I: RAI Program Area Map



RAI Program VDC, Jumla, 2014

Household and Population (2011)	Number
Total Household	19291
Male	53596
Female	53899



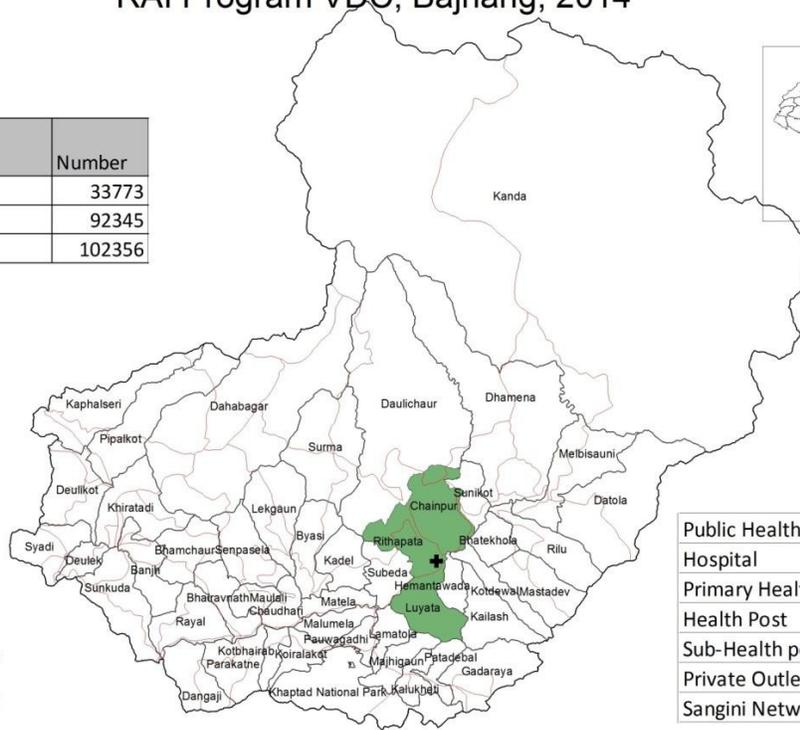
Legend

- Road
- Program VDC
- VDC Boundry
- ⊕ District HQ

Public Health Institutions	Number
Hospital	1
Primary Health Cer	1
Health Post	13
Sub-Health Post	16
Private Outlets	
Sangini	18

RAI Program VDC, Bajhang, 2014

Household and Population (2011)	Number
Total Household	33773
Male	92345
Female	102356

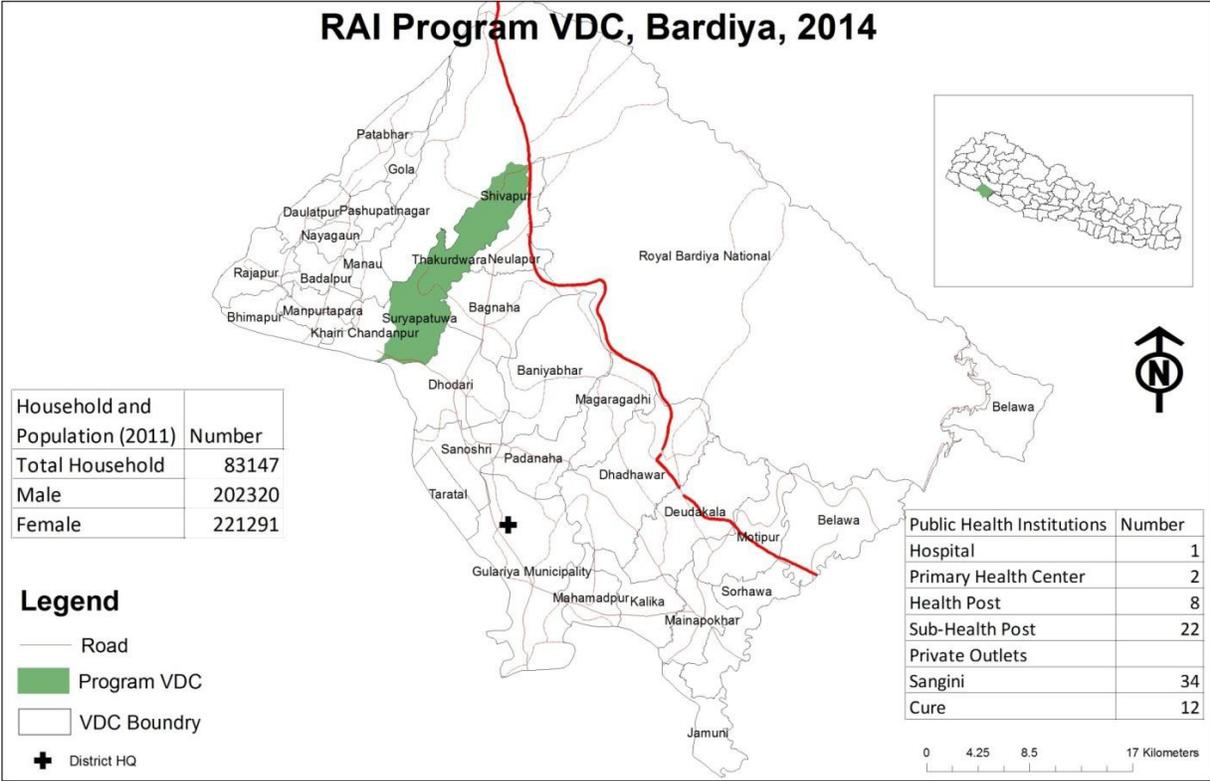


- Legend**
- Road
 - Program VDC
 - VDC Boundry
 - ⊕ District HQ

Public Health Institutions	Number
Hospital	1
Primary Health Center	2
Health Post	15
Sub-Health post	41
Private Outlets	
Sangini Network Outlets	4



RAI Program VDC, Bardiya, 2014



Annex II : Job Descriptions

1. RAI District Program Coordinator

Job Title	RAI District Program Coordinator		
Job Summary	<p>The District RAI Program Coordinator will be responsible for the implementation and monitoring of remote areas initiative program in district. S/he will also be responsible for coordinating with districts stakeholders including government line agencies, like-minded NGOs and other partners of the project. The Program Coordinator will make necessary arrangements for implementing the program, continually assess, and involve in a wide range of programmatic issues including activity and financial planning, organizing events, recording, monitoring and managing internal and external program relations.</p> <p>S/he will be responsible to establish and maintain relation with Government, CBOs and other stakeholders and continually communicate and reach out to them for guidance and support to create enabling environment for implementing RAI activities</p>		
Department	Field Operations		
Location	Jumla/Bajhang/Bardiya	Reports to	Area Manager
Level/Grade	On Contract	Reported by	Community Mobilizers
Key Responsibilities			
Strategy Development, Planning & Reporting	<ul style="list-style-type: none"> • Prepare annual operating plans with budget that support strategic direction set by CRS • Interface with key stakeholders in the district and communicate RAI program goals and seek support • Periodically assess the program activities and report to supervisor 		
Planning / implementing	<ul style="list-style-type: none"> • Ensure planning and implementation of initiatives / programs as planned and approved within the stipulated timeframe • Provide sound leadership and technical guidance to community Mobilizer • Prepare monthly/quarterly/semi-annual and annual reports and carefully review them before disseminating • Frequently travel to places of activities and provide input as appropriate 		
Operations Management	<ul style="list-style-type: none"> • Constantly review activities and financial management to determine progress and status in attaining objectives, and suggest any revisions in accordance with current conditions • Ensure implementation of corrective actions for performance deviations • Attend meetings as delegated • Represent CRS with partner and stakeholders as needed 		
Community Relationships, networking & representation	<ul style="list-style-type: none"> • Collaborate with area managers and other staff in HQ in engaging the external community in the district by representing CRS at various events and meetings of prominence to ensure visibility and promote and highlight the organization, crucial in building essential relationships that benefits the organization • Ensure CRS's mission, programs, and services are consistently presented in a strong, positive image to relevant stakeholders 		

	<ul style="list-style-type: none"> • Network and develop relationships with key staff in the district within donors, and other key stakeholders to gain an understanding of their priorities, to represent CRS advocacy and influencing.
Key People Responsibilities	
	<ul style="list-style-type: none"> • Work closely with each direct reporting supervisee to ensure timely delivery of all planned outputs • Ensure that good quality reports are submitted on time • Allocate, monitor and evaluate the performance of the supervisees • Ensure adequate resources are in place to conduct the planned activities • Ensure cost-effectiveness in implementing programs
Key Performance Indicators	
1	Overall performance of RAI program in terms of carrying out activities on time and achievement of results as per plan
2	Quality and timeliness of reports sent
3	Number of community based interactions attended
4	Number of meetings attended with district level stakeholders
5	Number of meeting organized with district level stakeholders
Primary Interface- External	
Source	Purpose
Industry Experts and National and International Agencies	Coordinating with supervisor to represent CRS and speak in forums about the company in conferences and/or any other such opportunities. The objective can be to spread awareness and build a positive reputation of the company
Donor Agencies	Updating on the performance of the company and providing details on all the aspects asked for
Trade Partners	Build and maintain relationship with business partners of CRS in the district
Primary Interface- Internal	
Source	Purpose
Area Managers	Updating area Managers on overall operational status of RAI program in the district. Reporting and seeking direction whenever necessary in solving problems and/or formulating operational strategy.
All CRS Employees	Act as the overall member of CRS staff and communicate for sharing and seeking help in matters related to the implementation of RAI program in the district.

2. Community Mobilizers

Job Title	Community Mobilizer		
Job Summary	<p>The Community Mobilizer is responsible for community mobilization in RAI districts for implementation of project activities in coordination with partner agencies and or community organization.</p> <p>The specific duties and responsibilities of Community Mobilizers include:</p> <ul style="list-style-type: none"> • Conduct program awareness community meetings at the beginning of the project in targeted communities; • Organize community meetings and facilitate the selection of the Community Change Agent (CCA) and support them in fulfilling their duties; • Conduct regular community meetings in the project targeted communities; • Conduct monitoring activities, data collection and reporting; develop weekly updates and monthly reports on community mobilization activities; 		
Department	Field Operations		
Location	Jumla/Bajhang/Bardiya	Reports to	Project Coordinator
Level/Grade	On Contract	Reported By	Community Change Agents
Key Responsibilities			
Community mobilization and sensitization	<ul style="list-style-type: none"> • Receive training on the project concept and approach to the community mobilization. • Contact communities to establish early rapport and to provide overall orientation of the project. • With the support of CCA, interact and dialogue with beneficiary for the organization of community meeting. • Provide orientation training to the members of community to raise awareness about the project. • Facilitate community meetings to encourage discussions on family planning, MCH and RH. • Facilitate the process of “Community Action Plan (CAP)” preparation in each district of the project. • Facilitate the process of identification of Community Change Agent community level. • Facilitate resolution of dispute, conflicts between individuals and among members of community 		
Planning / implementing	<ul style="list-style-type: none"> • Ensure implementation of initiatives / programs as planned and approved within the stipulated timeframe • Frequently travel to places of activities and provide input as appropriate 		
Conduct Monitoring and data collection	<ul style="list-style-type: none"> • Obtain community data necessary for preparing community profiles 		

	<ul style="list-style-type: none"> • Provide necessary reporting inputs to the monitoring and evaluation officer • Constantly review activities to determine progress and status in attaining objectives, and suggest any revisions in accordance with current conditions • Ensure implementation of corrective actions for performance deviations
Reporting	<ul style="list-style-type: none"> • Assist District Program Coordinator in development of a clear work plan for the community mobilization activities of the projects with the aim to complete the activities within the time frame of the project. • Capture success stories and lessons learned in each phase of program implementation. • Prepare monthly and quarterly report
Key People Responsibilities	
<ul style="list-style-type: none"> • Work closely with each direct reporting supervisee to ensure timely delivery of all planned outputs • Ensure that good quality reports are submitted on time • Ensure adequate resources are in place to conduct the planned activities • Ensure cost-effectiveness in implementing programs 	
Key Performance Indicators	
1	Number of community based interactions organized
2	Number of meetings attended with community level stakeholders
Primary Interface	
Source	Purpose
District Program Coordinator	Updating District Program Coordinator on status of activities program in the district. Reporting and seeking direction whenever necessary in solving problems and/or formulating operational strategy.
All CRS employees	Act as the overall member of CRS staff and communicate for sharing and seeking help in matters related to the implementation of RAI program in the district.

3. Roles of Community Change Agents

1. Prepare and maintain target couple registers.
2. Maintain records of pregnant women, 0-1 years and 1-5 years.
3. Maintain records of high risk pregnancies, deliveries, and distribution of delivery kits to pregnant women and ORS packets +Z inc.
4. Maintain the records of new acceptors.
5. To identify and accompany referral cases to health centers in her area (SHP/HP/PHC/District hospital or NGO/CBOs running clinics in assigned areas).
6. To give regular and uninterrupted FP supplies to clients.

7. To persuade the clients to avail the family planning services and delivery services in Government health facilities and other health facilities, Gaown Ghar Clinic and Camps organized for Sterilization Uterine prolapse and others.
8. To generate awareness, educate and motivate eligible couples.
9. To provide family planning, mother and child health education and services to the assigned groups and community people through door-to-door visits and informal meetings.
10. Educate couple on spacing methods along with sterilization.
11. Identify and refer IUD and voluntary sterilization acceptors.
12. Do the follow-up of all family planning clients.
13. Attend training and monthly meetings.
14. Prepare and submit monthly reports to Mobilizer.

Criteria's for Identification/Selection of CCA

- Young , energetic preferably female and literate and who have good trust and reputation in the groups/communities
- Family planning users and to do something to improve their social status.
- Identified by and among the group members
- Preferably representing the groups for example if the group members are mostly Dalits, CCA should be from that community