Lessons from the Field

Building the Capacity of Local Organizations in Reproductive Health: Nepal Case Study

This report describes the process World Neighbors used to partner with local non-governmental organizations in developing a reproductive health component in Terai, a rural area in the southeastern plains of Nepal. The Terai program was initiated in 2000 with support from the Bill and Melinda Gates Foundation. This document describes the setting, design, and unique aspects of the program, as well as its key accomplishments and lessons learned.

Preface and Acknowledgements

Preface

Reproductive health is a key aspect of World Neighbors integrated development program strategy. In 2000, with the support of the Bill and Melinda Gates Foundation, World Neighbors began a systematic effort to develop and document the lessons learned from its program experience in Terai, Nepal. The program in Nepal was one of six programs in which World Neighbors sought to strengthen and expand reproductive health and to develop a model that would have broader application.

This document describes the process of developing and implementing reproductive health activities in the rural, southeastern plains of Nepal, called the Terai[1] (see map on page 6). It includes the programmatic framework applied in these six World Neighbors program sites, which was developed and modified over the implementation period.

Acknowledgements

We would like to acknowledge the staff of our partners - local non-governmental organizations (NGOs) - and the community volunteers for their enthusiastic efforts to build the capacity of communities to meet their reproductive health needs. Not only have the local NGOs played an effective role in working with the communities, they have also maintained records and undertaken careful documentation, which has been critical to the success of the activities.

Our local NGO partners and the people in the communities deserve our sincere thanks for their support of our efforts to systematically document the success they achieved through the participatory integrated development programs, including the reproductive health component in the Terai districts of Dhanusha, Mahottari, Sarlahi and also in Sindhuli, part of the inner Terai. It is through this documentation process that we have been able to capture key lessons that have contributed to the develoment of a model applicable to World Neighbors programs globally.

Ms. Saraswati Gautam, the World Neighbors health coordinator, deserves special acknowledgement for her efforts to support the training of local NGO staff and community volunteers. She has closely and regularly monitored and supported the program work. The achievements described here are largely due to her commitment and dedication. In addition, World Neighbors South Asia's present and former staff – Subarna Hari Shrestha, Hari Bahaudr Thapa, Tanka Gurung, Shanta Jirel, Prem Moktan, Amrit Thapa, Purna Sinjali, Nanikaji Maharjan and Surya Bahadur Majhi, have contributed to the program's success.

Finally, the World Neighbors Nepal program team wishes to express their heartfelt appreciation to World Neighbors headquarters for supporting their efforts to adapt the approach developed in the hills of Nepal and apply it to the plains region of Nepal and Bihar, India with support from the Bill and Melinda Gates Foundation.

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[1] The Terai are the plains which run across the length of southern Nepal, along the border of India.

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Introduction

Nepal is among the poorest and least developed countries in the world, with 40% of its population living below the poverty line. Agriculture is the mainstay of the economy, providing a livelihood for over 80% of the population and accounting for 40% of the gross domestic product. In the United Nations' 2004 Human Development Report, Nepal's human development rating (HDI)[2] is 0.499, placing the country near the bottom of all countries ranked (143 of 177).

Eighty-two percent of Nepal's 24 million people live in rural areas lacking basic infrastructure and services, typically relying on subsistence farming for their livelihoods. Eighty-three percent live on less than two dollars a day[3].

Educational opportunities are limited. While current primary school enrollment is 70%, adult literacy is only 44%, with even lower literacy rates for women.

Overall life expectancy in Nepal is 59.6 years, and health indicators are poor. Infant and child mortality are 66/1,000 and 91/1000, respectively. Almost half (48%) of all Nepalese children under five are underweight for their age, and 21% of infants are born with low birth weight. The adjusted maternal mortality ratio is 540 deaths per 100,000 live births.

The total fertility rate of Nepal is 4.3. Population growth in Nepal has outstripped per capita food production, contributed to increased pressure on cultivable land and forest resources, and hampered the nation's ability to provide basic social services. This presents a serious challenge to the attainment of peoples' right to a better life.

The overall socio-economic and development indicators are worse in the rural areas compared to the urban and semi-urban areas, with the exception of selected slum areas. The situation in remote areas is further worsening as a result of ten years of the Maoist "people's war" which has claimed over 15,000 lives and rendered nearly half a million displaced. Most of this displacement is from rural areas. Restoring peace, democracy and human rights is the country's biggest challenge for which overcoming poverty is a prerequisite.

As a result of the combined effects over the several decades of feudalism, bad governance, political mismanagement, insurgency, corruption, opportunism of the elites, and the Maoist insurgency, Nepal is passing through a series of unprecedented political and constitutional crises.

Acronyms

ANM	auxiliary nurse midwife
BBP	Baudha Bahunipati Family Welfare Project
CBO	community-based organization
CMA	community medical assistant
FP	family planning
FPAN	Family Planning Association of Nepal
MOH	Ministry of Health
NGO	non-governmental organization
RH	reproductive health
RTI	reproductive tract infection
STI	sexually transmitted infection
TBA	traditional birth attendant
TSS	Tamakoshi Service Society
TTBA	trained traditional birth attendant
UTI	urinary tract infection
VDC	Village Development Committee
WN	World Neighbors

[2] Index score composed of health, education and income statistics.
[3] All statistics on this page are taken from the United Nations' 2004 Human Development Report.

The Setting, Terai

Program Context

World Neighbors has been implementing rural development programs in Nepal since 1973. Currently, World Neighbors partners with eight local Nepali non-governmental organizations (NGOs) to promote self-reliance in the areas of food security, reproductive health (RH) and women's empowerment. In keeping with World Neighbors philosophy and reflecting the complexity of rural community needs, programs integrate various livelihood, health and development activities.

World Neighbors strategy in Nepal has been focused on strengthening the ability of local community-based groups' to implement and manage integrated activities by working in partnership with the local NGOs. An early program was the expansion of the Boudha Bahunipati Project (BBP). BBP was initiated by the Family Planning Association of Nepal (FPAN) in 1973. With World Neighbors support, it expanded to Sindhupalchok and Kabhre districts in 1975. At that time, participatory needs assessments demonstrated community priorities to be the attainment of drinking water and adequate fodder for animals. These needs are largely felt by women, who often must travel long distances to obtain clean water and to gather fodder for feeding animals. World Neighbors initial efforts to respond to the community identified needs generated trust, thus laying the foundation for eventual results in family planning (FP) and community capacity building.

From early on, a key organizational element of BBP was the formation and strengthening of community-based groups. A variety of groups were formed including farmers, water supply, and women's savings and credit groups. Over time, the women's savings and credit groups were seen to have been the most effective and enduring of all these groups.

World Neighbors, in partnership with FPAN, tried different strategies to sustain the programs and to transition program ownership to local people. In 1984, World Neighbors introduced a participatory strategy to develop, plan, implement, and monitor the program. In 1988, leaders of the various groups were encouraged to establish and register as local NGOs to carry out the program. In the same year, in response to the communities' requests, the program began to obtain and sell medicines at reasonable prices. By 1992, eight NGOs were officially registered and carrying out these activities. In 1994, all BBP activities were handed over to the eight NGOs to continue implementation. The BBP staff played a role in networking, facilitating the exchange of ideas and experiences among the NGOs, and providing training and other important information. The NGOs were encouraged to develop collaborative relationships with government agencies, particularly with the district health office. These relationships enabled the NGOs to receive contraceptives and to provide specialized outreach services, training, and other basic commodities free of cost.

The joint World Neighbors and FPAN program, BBP, has served as a learning site for many governmental, local and international non-governmental development agencies regarding participatory integrated community development in partnership with local marginalized communities. In the 1980s and 1990s, BBP was able to draw the attention of international organizations like the International Planned Parenthood Association, the United Nations Population Fund, and the Ford Foundation. The Ford Foundation conducted various evaluations of BBP's strategies and impacts. The evaluations consistently confirmed the effectiveness of BBP's strategy to integrate reproductive health, agro-forestry and women's capacity building in achieving holistic development at the grassroots level.

World Neighbors has applied this successful model of integrated participatory development in other parts of Nepal. The first expansion was conducted with the Tamakoshi Service Society (TSS) in 1985, in the Ramechhap district in the eastern mid-hills of Nepal. The model continued to be adapted and refined in the Ramechhap program.

The second expansion, which is the topic of this case study, took place in 2000, with support from the Bill and Melinda Gates Foundation. At that time, World Neighbors expanded activities working in southeastern Nepal across the border into one of the neediest areas

of the world: Bihar, India. These areas were selected based on the following factors:

- The need for reproductive health (RH) services in the areas,
- The logistical feasibility of operating the program,
- The presence of established, interested and capable NGOs, and
- The cross-border similarities (geographical, cultural, and environmental) with the Madhubani area in Bihar, India.

A consulting firm was hired to study local NGOs working in the eight southeastern districts of Nepal and to recommend suitable partners to World Neighbors[4]. In order to do this, the following steps were followed:

1. The consultants provided a short list of the five best NGOs collected from other development agencies.
2. The NGOs were verified with district government authorities and different international and local NGOs.
3. The candidate NGO program sites were visited to observe the impact of activities.
4. Beneficiaries were interviewed and their views considered as to the NGO's effectiveness and commitment.

Through this process, seven local NGOs were identified as partners. Table 1 summarizes their key characteristics. While there have been some changes over time, the large majority of the local NGO partners remain those identified through the consulting process in 2000.

Table 1: Partners by district, number of Village Development Councils (VDCs) and activities prior to World Neighbors partnership

Local NGO Name	District	# of VDC	Existing Activities
CHETANA* (Awareness)	Sarlahi	2	Savings and credit, literacy, sustainable agriculture, livestock, non-timber forestry, skills development
Dhanusha Sewa Samiti (DSS)	Dhanusha	15	Savings and credit, water supply, irrigation, literacy, non-timber forestry, skills development, sustainable agriculture, livestock
Integrated Rural Development Society (IRDS)	Mahottari	5	Water supply, veterinary services, school construction, savings and credit, dental clinic, sustainable agriculture, livestock
Rural Community Development Service Council (RCDSC)	Mahottari	6	Water supply, veterinary services, school construction, savings and credit, sustainable agriculture, livestock and poverty elimination
Women's Cultural Development Centre (WCDC)	Mahottari	4	Literacy, legal rights, savings and credit, handicrafts, sustainable agriculture, poverty elimination, and livestock.
Rural Women's Uplift Association (RWUA)	Sarlahi	1	Rights awareness, skills development training for women, literacy, savings and credit, handicrafts, activities for the disabled, sustainable agriculture, and livestock.
Sindhuli Integrated Development Services (SIDS)	Sindhuli	3	Literacy, savings and credit, skills development, sustainable agriculture, livestock, poverty elimination

** partner added in 2001*

[4] Ram Krishna Neupane, Center for Development and Management Studies, NGO Assessment Study Report, January 2000.

Program Context

The four districts in which the NGOs work have a combined total population of over two million people. Table 2 summarizes the population by village development committee (VDC)[5] for the 38 VDCs in which the NGO partners are working.

Table 2: Number of VDCs and population by NGO partner

NGO	District	# of VDCs	Population		
			Males	Females	Total
CHETANA	Sarlahi	2	10,359	10,378	20,737
DSS	Dhanusha	11	38,459	36,126	74,585
IRDS	Mahottari	6	18,509	17,898	36,407
RCDSC	Mahottari	7	32,921	29,932	62,853
RWUA	Sarlahi	3	12,139	11,652	23,791
SIDS	Sindhuli	3	23,938	23,850	47,788
WCDC	Mahottari	6	27,019	25,351	52,370
Total		**38**	**163,344**	**155,187**	**318,531**

The overall program area is characterized by very low status of women and conservative social practices such as purdah,[6] dowry, and a caste system. Many women's lives are characterized by early age at marriage and early age at first birth. Preference for male children drives fertility in the area. The fundamental problems addressed by the program relate to RH, poverty, and the process of active marginalization of disadvantaged people. These problems are summarized by the following findings from a survey conducted with 960 women in the program area:

- Early age at marriage: 60% of women reported being married by the age of 17.
- Early age at first birth: 84% of the married women gave birth to their first child by age 20.
- Low modern contraceptive use and male sterilization: female sterilization 22%, pills 0.2%, Depo Provera 12%, condom use 1%, and male sterilization 0.5%.

[5] VCDs are a structure created by the Nepali government to coordinate local level development.

[6] Purdah is a practice related to women's use of veils to cover their faces and limiting their mobility outside the home.

Program Context

- Unmet FP need: 38% of women in the program area were using FP methods at the time of the survey. However, 30% of women said that they wanted to use contraceptives but that FP services were not easily accessible.
- Low use of prenatal care: 41% of pregnant women did not receive prenatal care.
- Low use of post-natal care: 73% of women did not receive post-natal care services 24-48 hours after the delivery.
- Few births assisted by skilled personnel: 70% of births were not attended by skilled personnel.
- Low rate of colostrum feeding after birth: only 46% of mothers fed colostrum to their babies within 1-12 hours of delivery. Another 6% fed colostrum to their babies within 24 hours of delivery.
- Reported gynecological problems: 29% of women experienced gynecological problems, including excessive vaginal discharge, lower abdominal pain, urinary tract infections (UTIs), reproductive track infections (RTIs), pelvic inflammatory disease, and uterine prolapse.
- High levels of illiteracy: 49% of men and 77% of women are illiterate.
- Gender-based violence: 18% (179) of women in the program area reported that their husbands had beaten them in the past year. Only 15% (27 women out of 179) of those battered women sought social or legal help.
- Women's access to money for health care: although 86% of women surveyed said they could use household money for health care, in fact only 19.5% ever had.

"The in-laws and husbands behaved in a cruel manner in the past since girls got married at the age of 12 or so. These innocent girls would not know how to do the household chores properly or please their husbands and in-laws and thus got beaten. Women these days are more aware and educated, and domestic violence has decreased significantly."
— Pachgachhiya women's group

Program Context

Identifying Needs

After selecting partner NGOs, World Neighbors worked with them to identify and prioritize community needs in their areas. A four day orientation training on how to conduct a needs assessment was carried out. The training included:

- Observation and exchange: Staff and volunteers were taken for observation to other program sites in order to get first hand practical knowledge of the integrated, participatory development approach developed in BBP.
- Community work: Discussion groups of community members were organized. Sixteen RH issue picture cards[7] were shown to stimulate discussion. In each picture, six questions were posed. These were: 1.What do we see in the picture? 2. What is happening? 3. Does it happen in our community, too? 4. Why does it happen? 5. Who would feel the effects of this issue more – men or women? 6. What can we do to reduce or eliminate this issue?
- Health service analysis: The accessibility of reproductive health services, including estimates of the monetary and time costs and the quality of services were analyzed with communities.

World Neighbors trained partner NGOs to use simple tools in conducting participatory needs assessments with the community. In particular, women were involved in leading the process of needs identification in the program areas. The felt needs were then classified and prioritized with the help of the community.[8]

Findings demonstrated that at the start of the Terai program RH services were felt to be needed and generally were not available. In response to women's desires to space and limit the number of children and the absence of RH services, the provision of health information and services were identified as priorities.

[7] Issue pictures included vaginal discharge, uterine prolapse, multiple pregnancies, delivery complications, girls education, violence against women, unsafe sexual behavior, women's roles and status, labor migration, alcohol abuse, infertility, infant and child mortality, HIV/AIDS, etc. For a full description of this exercise see, Caudill, D. Responding to Reproductive Needs, World Neighbors, 2001. p.12

[8] Caudill, D. Responding to Reproductive Health Needs: A Participatory Approach for Analysis and Action; revised edition edited by Linda Temple, Oklahoma City: World Neighbors 2001.

World Neighbors and DSS Clinic Staff, Dhanusha

Program Objectives

The central strategy of the program model is to support RH through women's empowerment. A key element is the provision of RH services through local NGO-run clinics and outreach services using female providers. The specific program objectives related to RH clinic and outreach services were:

- To increase contraceptive prevalence in response to unmet need,
- To reduce unwanted pregnancies,
- To improve the spacing of wanted children,
- To increase women's age at first pregnancy, and
- To increase prenatal, delivery and postnatal care by trained personnel.

In keeping with the holistic approach of the program other objectives included:

- To decrease borrowing from local money lenders by providing lower interest loans through self-help groups, and
- To increase group capacity to manage themselves.

In 2002, World Neighbors supported an additional set of activities aimed at increasing food security, fodder and fuel supply.

The following table describes how the program design addressed the key elements of the World Neighbors integrated development program approach for RH. Key elements used to guide all of World Neighbors reproductive health efforts include: integration linkages, information and counseling, quality reproductive health services, community and local capacity building, action learning, gender equity and efforts to address the needs of special populations.

Table 3: Implementing the World Neighbors RH key element framework

Key Elements	How elements are implemented in the program?
Integration: How is this accomplished and structured?	In the Terai, the RH activities were initiated with self-help groups that carried out small-scale income generating activities. These groups were initially composed exclusively of women and used their savings as the basis for rotating loans. These small scale loans were used most commonly for productive, agriculture-related activities, but also as means to pay school fees (particularly for girls) and to pay health service fees.
	Based on subsequent needs and feasibility assessments, a sustainable agriculture component was integrated in 2002. An objective related to fodder and fuel supply was incorporated.
RH information and counseling: How is information and counseling provided?	Both at the clinics and through outreach services, trained NGO paramedics like auxiliary nurse-midwives (ANM) and community medical assistants (CMAs) provide face-to-face information and counseling to the client or couple. Efforts are taken to ensure confidentiality and privacy, even in outreach settings.
	The 16 picture cards (described on page 8) are used to stimulate group discussions of specific issues and to evaluate progress.
	The elected leaders of the savings and credit groups receive additional training in RH and serve as a resource for the group at the community level.
	During gynecology camps, clinical staff provide information and couneling.
	Trained traditional birth attendants (TTBAs) provide community-based counseling and referral for maternal health services, family planning, reproductive tract infections and other concerns.

Program Objectives

Key Elements	How elements are implemented in the program?
Quality RH Services > Community > Outreach > Health facility levels How are services provided at these levels?	At the community level, trained TBAs provide some basic services such as pre-natal care, clean and safe delivery assistance, post-natal care, family planning and referrals.
	Partner NGOs are assisted to establish basic clinics run by paramedical staff. These clinics provide family planning services, treat common illnesses and provide maternal health and delivery care services to the communities linked with the self-help groups. They provide these services on a fee-for-service basis to ensure the sustainability of the clinics.
	NGO paramedical staff provide periodic outreach services to communities where the self-help groups are located. Usually these are monthly outreach services.
	Several of the NGOs organize annual "gynecology camps" where a team of four to five gynecologists provide necessary surgical services such as tubal ligations and repair of uterine prolapse.
Capacity Building How does this approach lead to capacity building in RH?	The main strategy for capacity building is to work with NGO staff and the community volunteers on a variety of levels: providing honest feedback, constructive criticism, and organizational self-assessment of the capacities needed for autonomy. This should bea transparent process from program planning to budgeting.
	Another important aspect of the approach was developing the capacity of the savings and credit groups. In most cases the group is transformed into a community-based organization, usually a savings and credit cooperative, which is self-reliant, self-improving and self- spreading financial and social institution in the community.
	Every six months all aspects of NGO performance are appraised by World Neighbors staff in a participatory manner. The key areas of in-depth analysis include: 1) NGO leadership/managerial effectiveness, 2) coordinator's effectiveness, 3) savings and credit groups' effectiveness, 4) savings and credit cooperative effectiveness, 5) RH program effectiveness, 6) sustainable agriculture effectiveness, 7) financial management, 8) clinic sustainability trend, 9) documentation and reporting and 10) utilization of other local, national, international resources. The NGOs rate themselves on these aspects and the World Neighbors team also assigns ratings. The ratings are then compared and discussed, and the areas that require strengthening are identified.
	A variety of participatory exercises and tools are used in organizational strengthening. These include: mini-survey, capacity assessment, clinical management protocol for clinic personnel, and a clinic quality-monitoring checklist. (Copies of these tools are provided in appendices 1-9.)

Program Objectives

<table>
<tr><th>Key Elements</th><th>How elements are implemented in the program?</th></tr>
<tr><td rowspan="2">Action learning

How is AL included in the program?</td><td>Participatory action learning activities based on the principle of structured self-assessment are conducted with both the NGOs and the self-help groups every six moths. These include participatory self- assessments with NGOs examining key capacity areas and clinic functioning, and mini-surveys with the self-help groups and the examination of changes and program impact.
A vital events register of births, deaths, migration, marriages, and other information about members can be used for comparison.</td></tr>
<tr><td>In addition, baseline and follow-up cross-sectional surveys were carried out with one NGO partner.</td></tr>
<tr><td>Gender-Related Aspects

How is gender taken into consideration in the program?</td><td>The approach encourages women to form self-help groups and conduct saving and credit activities. In addition to gaining experience in managing funds and decision making, the select leaders, who have had little opportunity for community leadership, gain experience. Many agro-forestry activities - establishing tree nurseries, plantations, fodder collection and use- have traditionally been considered women's jobs. An integrated RH and sustainable agriculture program addresses a wider range of women's needs. A number of communities have men's self-help groups in addition to women's. Many of the self-help groups are mixed and the men and women of the community work together to solve their common problems. Emphasis is placed on facilitating exchanges between men and women in the groups on a variety of topics including family planning, gender related violence, alcohol abuse, and family decision making.</td></tr>
<tr><td rowspan="2">Special Groups

Who are the special groups?

How are their needs met?</td><td>Adolescents: Information on RH including HIV/AIDS is provided to in-school and out-of-school adolescents. They also receive counseling and services through the NGOs. Some adolescents have formed self-help groups and initiated income generating activities. Some in-school adolescents have organized RH discussion sessions for out-of-school peer adolescents in their communities. All RH counseling and service activities related to adolescents are focused equally on boys and girls.</td></tr>
<tr><td>Dalits and indigenous groups: There are groups of dalits or socially excluded people and indigenous peoples who benefit through the groups and are brought into the program mainstream.</td></tr>
</table>

Sakunti is 19 years old with a new infant that is one month old. This is her third child, as she was married at 15. Her other children are three and two years old. Her husband works in India (right across the border) as a bicycle mechanic.

Sakunti didn't have any prenatal care for her prior pregnancies. With this pregnancy, she visited the RCDSC clinic for prenatal care. The ANM also assisted her during delivery, ensuring that she had a safe delivery kit (a basic kit with a clean razor blade, plastic sheet and bandages for cord care). She says she felt more confident with this last pregnancy because of the care she had.

Special Program Initiatives

Within this framework there are several unique aspects of the World Neighbors program in the Terai that merit special emphasis. These include: working with local NGOs that have little or no RH experience; establishing NGO-run self-reliant, rural clinics; providing outreach services linked with self-help groups; the development of formal savings and credit cooperatives (which, in turn, support the clinics); the supportive approach to monitoring and supervision, and addressing the practical needs of rural women. These aspects are described in more detail here.

a) Working with local NGOs with little or no RH experience

WN works in partnership with district based local NGOs. A local NGO is registered at the district level (as opposed to registering in Kathmandu, the capital city, and operating in many districts), and is owned and led by local people. The leaders and members live in the program communities and are well placed to understand the problems, their root causes and practical ways and means to address them.

The initial four-day long orientation described earlier is critical in order to build commitment to reproductive health and to help NGO staff develop confidence and skills in assessing needs, prioritizing and problem solving with their communities.

Initial misgivings about the program approach are addressed during the orientation period. For example, at first the NGOs found it difficult to charge for services and medicines. Their view was that people would not be able to pay for services or for medicines, so these things should be subsidized. Through a cross visit, they observed other World Neighbors partner NGOs charging and providing quality services. Through the fees they collected the other NGOs were able to ensure the sustainability of their services.

Initially the NGOs were also concerned that the self-help groups wouldn't be able to keep the necessary records (minutes, records of incomes and expenditures, and member's passbooks). They felt it would require too much staff effort and were also quite doubtful of the strategy itself. But when the leaders of the new NGO partners were taken to the successful older program areas like BBP and TSS for cross visits, they observed successful examples of grassroots capacity building and they were motivated to work with the groups to try out the approach. As they have worked through the process, they have gained confidence in supporting the groups.

b) Establishing NGO-managed, self-reliant, rural clinics:

The need for quality health care is very evident from the poor health statistics for Nepal described earlier. While government clinics are often described in planning documents along with well-defined catchment populations, the reality is that in many parts of rural Nepal there are few functioning health services. Even where government health services exist, shortages of personnel and drugs make for very poor quality services. Faced with this reality, World Neighbors approach evolved beyond simply ensuring access to information and the exploration of health needs to ensuring quality, convenient health services. Thus the rural NGO clinic emerged as a key aspect of the strategy.

The process of establishing rural clinics involves exposing partner NGO leaders to another NGO's functioning clinic that operates in program areas formerly supported by World Neighbors. Once the new partner NGO is able to assess the feasibility of and displays the commitment to starting clinical operations in its area, staff members are trained in basic management skills. The NGO clinics are intended to provide a basic level of health care. A description is provided in box 1.

Box 1: Description of Typical NGO Clinic

Staffing: Two paramedical staff (either ANMs and/or CMAs), one cleaner/ assistant

Medicine: A stock of basic medicine, valued between $1000-1200, and a three-month supply of contraceptives are maintained at the clinic.

Equipment: This includes very basic, but limited equipment such as a blood pressure cuff, stethoscope, and examining table.

Services provided: Basic clinical care, prenatal care, delivery care, post-partum care, family planning, pregnancy testing, ring pessaries, other RH services, and basic laboratory tests.

Hours of operation: Most clinics are open for a period of 7 hours (10 am to 5 pm). However, because the clinic staff lives on site, some services are available 24 hours.

Location: Usually two to three rooms rented in a building.

Another key aspect of the approach has been an emphasis on the sustainability of services and making the clinics self-reliant. Over the years, a great deal of progress has been made in the area of cost-recovery through registration fees and the sale of medicine. These strategies have reduced the recurrent costs to about $1,000 a year or about the salary of the ANM. The challenge has been to identify local sources of support to provide for these costs.

The clinic service charges are subsidized for group members. NGOs involve the group members in determining the prices of medicines and the service charges for clinics and outreach services. Normally the medicines are sold at the company-recommended maximum retail price. The NGOs purchase medicines from the manufacturers, avoiding the middle person, receiving a discount for bulk purchases. They also receive other promotional benefits. These activities enable the NGOs to make about a 20% gross profit on the sale of medicines.

While World Neighbors has greatly valued its partnership with local NGOs, unless they have a permanent source of income from investments or endowments, any external project funding would eventually come to an end and the activities would stop. Experience demonstrated that self-help savings and credit groups were more self-reliant than NGOs. Thus, working with the local NGOs, World Neighbors assisted the self-help savings and credit groups to build their capacity, to expand and to develop into multi-purpose cooperatives. This was a long but ultimately rewarding process. The savings and credit cooperatives were created by the NGOs in the same communities where the clinics existed. Therefore, because the self-help groups had worked with the clinics and had benefited from the services, the sense of ownership was already present. The cooperatives began using some of the earnings from savings and credit activities to support the clinics. The most outstanding example is the case of TSS in Ramehchhap. In 2002, the local cooperative provided $10,000 to run the 10-bed hospital. The hospital was initiated in 1985 with World Neighbors support as a small clinic with only one paramedical staff.

WCDC Clinic

Special Program Initiatives

The Terai program provides the most recent example of NGOs mobilizing the local savings and credit cooperatives to support clinics. The evolution from a self-help group to a cooperative takes place when the group membership increases to more than 25 people and savings has surpassed $1,000. By registering with the government as a cooperative, the group can increase its savings and can charge interest. They also open their membership to the wider community and include members from other villages. The cooperatives have the objective of focusing on the welfare of the members and the communities. Currently, fourteen cooperatives have been established in the Terai, although only 10 have officially been registered. About three fourths of the cooperatives and their boards are female.

The following table describes how various sources of income will be applied to the operating costs of the clinics over the next five years. Support from the cooperatives increases over time, as does income from registration fees and service charges. The profit is accumulated in savings accounts where it also collects interest.

Table 5 below provides an example of the careful monitoring of clinic expenses and revenue. It provides a comparison between the planned one-year income and the actual income for a six-month period for the clinic run by IRDS in Mahottari. From this table, it appears that the clinic will meet its goal of becoming self-reliant in the next two years.

Table 4: Sustainability plan for seven NGO clinics in Terai, Nepal in US dollars

Sources of Income	***04-05***	***05-06***	***06-07***	***07-08***
Profit margin from the sale of medicine	6,786	8,671	10,771	11,343
Registration fees	1,729	2,100	2,586	2,871
Service charges	3,471	4,500	5,486	5,914
Interest from deposit in co-operative	1,907	3,621	5,400	7,186
Other income	1,543	2,100	2,857	3,414
Support from cooperative	1,786	3,457	6,429	8,071
Grant from World Neighbors	28,598	29,810	31,164	0
Total Income	**45,820**	**54,259**	**64,693**	**38,799**
Expenditures	***04-05***	***05-06***	***06-07***	***07-08***
Salary of ANMs/CMAs	21,255	22,872	24,657	24,272
Salary others staff	3,541	3,739	4,079	4,108
Clinic rent	3,393	3,256	3,370	2,070
Clinic miscellaneous expenses	2,929	3,103	3,293	3,436
Total Expenditure	**31,118**	**32,970**	**35,399**	**33,886**
Profit	***14,702***	***21,289***	***29,294***	***4,913***

Table 5: Comparison between 12 month planned and 6-month incomes for IRDS clinic in from July 2004-June 2005

Sources of Income	**Planned (one year) US$**	**Actual (6 months) US$**	**Difference US$**
Margin from Medicines	1,000	476	(524)
Registration Fee	357	258	(99)
Service Charges	1,071	777	(294)
Interest	286	0	(286)
Other Income	86	36	(50)
Support from Cooperative	214	0	(214)
Grant from World Neighbors	4,943	2,662	(2,281)
Total	**7,957**	**4,209**	**(3,748)**

c) Outreach services linked with self-help groups

Service delivery is critical because in the remote, rural areas where World Neighbors programs operate, essential RH services often are not available. It is widely known that services do not exist in the rural areas and the available, urban-based services are accessible only to the few who can afford the luxury of traveling to them in the nearby towns. So, in addition to locating NGO clinics in rural locations, the strategy also includes making outreach services accessible in the program areas at affordable costs. Counseling and service delivery are carried out in the villages adjacent to the clinics by the NGO paramedical staff. Every month, the NGO clinic paramedics spend several days trekking to the adjacent villages where the self-help groups are located.

Generally traveling in groups of two, the paramedical staff provides basic preventative and curative services, including family planning, at a designated health station in each village. The outreach session is organized by self-help group members but is open to any community member. Generally, about one third of clients in outreach sessions are from non-member families. A small fee is charged for the services.

One limitation is that not all services can be provided. Some of the necessary equipment, medicines and contraceptives cannot be transported on foot. However, the basic services provided ensure minimal levels of care and provide opportunities for health education, counseling, follow-up and referral to clinics. The dates for the monthly visits are finalized in participation with the groups.

d) Self-help savings and credit groups

The creation of self-help savings and credit groups helps reverse the marginalization process by reducing and eliminating borrowing from local moneylenders and by supporting the development of local leadership and collective organization. Poor people traditionally borrow money from local moneylenders at very high interest rates. This often is the beginning of a downward spiral into further debt and poverty. Annual interest rates on these debts range from 36% to over 100%. The debts are passed from generation to generation. Despite in-kind labor and repayments on the original loan, the interest on the principal continues to increase. In time, the borrower's family may be turned into bonded labor, tied to the moneylender for generations.

In order to reverse this impoverishing practice, the program worked with small groups, encouraging them to save their own funds. In this way, group members could borrow from this fund at lower interest rates that they determined themselves. Again, there was a lot of initial skepticism on the part of NGO partners and community members as to the effectiveness of this approach. Cross-visits to successful groups were an important activity in building enthusiasm for the activity. These self-help groups are a fundamental part of World Neighbors approach in Nepal, and their success has been demonstrated repeatedly in a variety of program settings.

One of the problems identified by women was inaccessibility of funds to use for RH services. Thus, when the women's groups were able to save funds and to make loans for income generating activities, they also had some funds at their disposal for basic RH needs. In addition, they also used the loans for related issues, such as supporting the education of their daughters.

The self-help savings and credit groups are central to the program approach. All programs are implemented through group members, for group members and by group members. Groups have a stronger potential to becoming self-sustaining using local resources, whereas NGO activities are dependent on the participation of the groups and outside funding.

e) Transition to a savings and credit cooperative

As discussed earlier, the formal registration of the self-help groups as savings and credit cooperatives contributes to the sustainability of both the clinics and the savings and credit activities. This transition occurs when group membership exceeds 20 people and the group accumulates more than $1,000 in savings. When the groups have grown sufficiently in terms of funds and managerial capacity, the partner NGOs assist them in this registration. To date, there have been 14 savings and credit cooperatives established, and 10 have been registered and recognized officially. In World Neighbors experience, the bringing together of groups into a cooperative enhances sustainability at a higher level of empowerment and performance.

When a group grows in terms of funds and capacities, it needs to operate as a bank for its members. While the savings and credit group is an informal arrangement, a savings and credit cooperative is a formal institution with legal rights that enables it to protect the investments of its members.

Moreover, savings and credit cooperatives can be active in civil society and community development, and they can donate profits to a cause acceptable to their members. In numerous cases, cooperatives have taken wider social responsibility such as supporting the local clinics with their own resources. In the Terai, these cooperatives have decided to contribute US $1,786 in the coming year to support the running of the NGO clinics. This fact also speaks to the acute need in rural areas for quality health services.

f) WN support supervision and follow-up

NGO field workers visit the self-help groups at least once a month and report to the NGO coordinator. The NGO coordinator is responsible for all World Neighbors-supported activities. Thus, if there are any problems to be addressed in the field, the coordinators are immediately informed by staff and/or community members. The coordinators are responsible for reporting and monitoring clinic operations on a daily basis and for visiting the surrounding villages frequently. (See Appendices 4-7 for the monitoring tools and reports used by NGO coordinators).

In addition, World Neighbors team members visit all NGO partners and their programs at least once a year. In practice, the World Neighbors team often visits clinics more than three times per year. During these visits, World Neighbors team members use clinical checklists as reporting tools for monitoring partners' clinics, and they also verify the completion of other reports (see appendices 8 and 9).

g) Addressing the needs of rural women

The needs of rural, marginalized women are multi-faceted and include the need for economic empowerment as well as the means to ensure good health. World Neighbors experience indicates that assisting marginalized women to form self-help groups and enabling them to respond to their priority needs has had a transformative effect on then and on their communities. The success of the savings and credit groups and the increased demand for reproductive health services are testament to this transformation.

A critical aspect of holistically addressing the needs of rural women has been strengthening the capacity of the groups. This work is done through the NGO staff and the group leaders, and it includes support for needs assessment, problem identification, priority setting, planning, implementation and self-assessment. Using this process, the groups develop skills in identifying and addressing issues of importance to them.

Initially, the approach included reproductive health, income generation and agro-forestry activities. Integration of other activities such as sustainable agriculture, functional literacy, drinking water, and development of local credit unions has enabled the participants to meet their basic needs and to improve their quality of life. In each of these activities, NGO field staff raises awareness about gender-related issues, leading to improved couple communication and action to address gender inequity.

Special Program Initiatives

Several aspects of the approach have been important in effectively reaching marginalized women. These include:

- Carrying out a participatory needs assessment using the tools described earlier, which allows participants to overcome cultural barriers and inhibitions.
- The hands-on approach to prioritizing problems and identifying feasible solutions at the grassroots level, such as creating a cash fund by pooling small amounts of savings together.
- The effective capacity building of the savings and credit groups including the judicious mobilization of funds, conducting monthly meetings, and keeping minutes and financial records, all of which reinforce the camaraderie among the women group members.
- The almost immediate results produced by the savings and credit group and its activities.
- The realization that the rural women involved are serious, honest, straightforward, hardworking, and capable of managing their own affairs.

"When women are united, men cannot dominate us. Women's group makes rules to stop drinking alcohol and gambling so that there is less violence against women." —
Pachgachhiya women's group

Key Accomplishments

The major accomplishments of the program are presented using six sources of information. These are: 1) the evaluation findings from a December 2002 survey of 864 women of reproductive age, 2) service statistics for the seven clinics supported by the program, 3) clinic sustainability indicators, including cost recovery through sales of medicine and fees for service use, 4) rural livelihood indicators for the self-help groups, 5) key aspects of social change, and 6) self-assessment capacity indicators for NGO partners.

1. EVALUATION FINDINGS

An evaluation survey was conducted with 864 women of reproductive age.[9] An external consulting group conducted the cross-sectional survey and compared the findings to an earlier baseline survey of 960 women. It should be noted that the implementation period between the two surveys was only 18 months, as the baseline data was collected in January 2001[9] and the evaluation was conducted in July 2002. Nonetheless, changes in reported service use and other practices were noted. Findings are presented by topic.

a) *Maternal health care*

During this short implementation period, there were increases in key maternal care indicators. These included increases in prenatal care use, iron folate supplementation and trained delivery assistance. Table 6 summarizes findings for maternal health care.

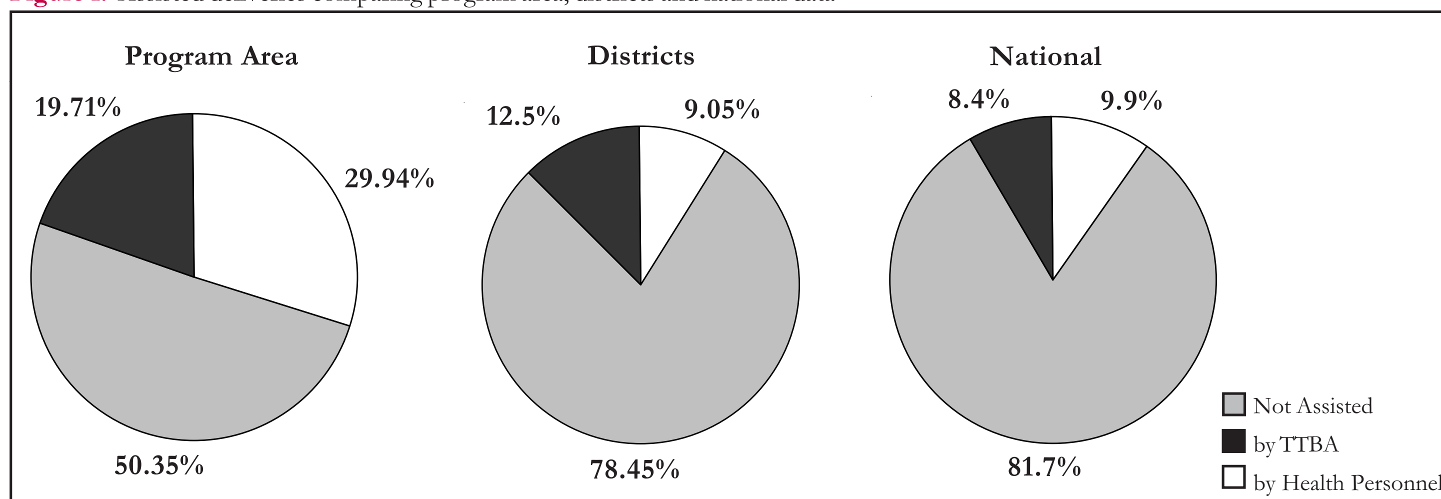
Because the services are available to the entire community, not just the group members, the program sought to verify if non-group members living in the program villages also had improved RH indicators. Thus the survey compared savings and credit group members to non-members using key variables. For prenatal care, 69% of members reported using prenatal care during their most recent pregnancy, versus 65% of non-group members. These rates compared very favorably to the district average of 17% at the time of the survey as reported by the Ministry of Health.

Table 6: Comparison of maternal health care findings between baseline and evaluation in Mahottari district, Nepal

Maternal health variables	Key Findings		
	January 2001 %	July 2002 %	Absolute change %
Prenatal care during last pregnancy	58.8	66.3	7.5
Average prenatal care visits	2.7	2.9	0.2
Tetanus toxoid immunization during last pregnancy	96	97	1
Iron folate during last pregnancy	22	29	7
Delivery at health facility	3.5	4.4	0.9
TTBA assisted delivery at home	13	27	14
Use of clean delivery kit at home	19.8	27.8	8
Delivery at home attended by skilled personnel (ANM/CMA)	2.8	5.0	2.2
Average post-natal care visits (mean number)	3.1	3.2	0.1

[9] Valley Research Group,
Evaluation Study on Reproductive Health Awareness, Attitudes and Practice of Women in the WN Support Project Areas of Mahottari District. December 2002.
[10] Valley Research Group, Baseline Survey on Reproductive Health Awareness, Attitudes and Practice of Women in the WN Supported Project Areas of Mahottari District, April 2001.

Figure 1: Assisted deliveries comparing program area, districts and national data



The most significant finding has been the increase in use of trained assistants at delivery. This trend has continued as evidenced through comparing district level data from the Ministry of Health[11] to service data in the program area. Figure 1 presents the findings based on the averages from all seven of the partner NGOs.

Table 7: Comparison of family planning findings between baseline and evaluation surveys in Mahottari district, Nepal

Family planning variables	Findings		
	January 2001 %	July 2002 %	Absolute Change %
Use of any modern method	36.6	39	2.4
Intention to use a family planning method	59.0	67.5	8.5
Unmet need for family planning	30.0	27.3	-2.7

b) Family planning

As indicated in table 7, there was an increase in family planning use and in the intention to use family planning between January 2001 and July 2002. Also, the unmet need for family planning decreased somewhat. Table 7 summarizes the survey findings for family planning.

After disaggregating the survey data by group and non-group members, it was evident that group members had a higher family planning use rate (52%) in comparison to the non-group members (33%). At that time, the rate of family planning use in non-group members was very comparable to the average district rate as calculated by the Ministry of Health (31%).

More recent data demonstrates different patterns for the other three districts. Figure 2 indicates that both savings and credit group members and non-group members within the same communities demonstrate higher rates of contraceptive use than the averages for Dhanusha, Sarlahi and Sindhuli districts.

c) Use of Household Money for RH Needs

A key element of the program approach is the support for women's self-help savings and credit groups. The changes with regard to the use of household money for RH purposes are notable and speak to the need for women to be able to access funds to meet their RH needs. Table 8 presents the survey findings.

[11] Department of Health Services, Annual Report, 2003/2004

Figure 2: Contraceptive prevalence rates (CPR) for the districts, non-group members and group members in December 2004

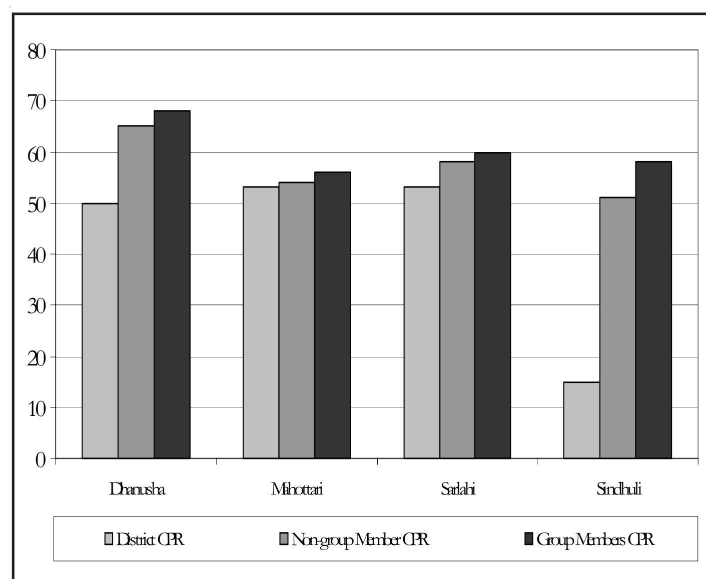


Table 8: Comparison of use of household resource findings between baseline and evaluation surveys in Mahottari district, Nepal

Household money use variables	Key Findings		
	January 2001 %	July 2002 %	Absolute Change %
Women using household money during last pregnancy (among those who had ever used)	52.4	76.0	23.6
Ever used household money for RH needs	19.5	50.2	30.7

Small but regular savings over time have been very helpful to these underserved communities. This has been particularly true for women, as they can use their own savings when they need money. Group members are encouraged to use the loans to increase their income, but funds can also be used for non-productive purposes, such as girls' education or health care.

By having their own funds, the group members are not dependent on local moneylenders for small loans. Thus, they are able to escape from the vicious cycle of debt and deepening poverty. Moneylenders commonly charge high interest rates. Poor people who are unable to repay the loan find themselves in a situation where

"Now that we have women's group we can easily get loans at very low interest from our group. We do not need to go to moneylenders. We meet once a month and talk about various women-related issues like RH, kitchen gardening, goat raising, poultry-raising and so on." —— women's group in Pachgachhiya

they have to work without remuneration to pay the interest, with no hope of paying the loan back. Through their membership in savings and credit groups, women are able to access and pay back small amounts of funds at interest rates set by the group. Additionally, qualitative information indicates that women are more valued in household and community decision making process because they have their own income.

2. SERVICES PROVIDED BY THE NGO CLINICS

Table 9 summarizes by year the services provided by the seven clinics. While the largest increase for most services appears to be from the first year to the second, family planning services increased dramatically between years two and three. Prior to program activities, treatment for uterine prolapse, UTIs and RTIs were not available in the area. Similarly, there were no safe delivery services or maternal health care services available.

The partners also analyze their service data by average age and average number of children in order to examine trends in service use. Tables 10 and 11 present the new acceptors of family planning by age and number of children for the RCDSC clinic.

The two tables present trends in key characteristics of new family planning clients at the clinic. Although the samples are small, they do show a trend in new users being younger women with fewer children. The collection and analysis of this information is important as it provides information with regard to progress toward the objectives. The fact that the clinic seems to be serving a steady number of new and younger users would seem to indicate that progress is being made toward addressing unmet needs.

Key Accomplishments

Table 9: Client visits for the seven NGO clinics by year and by service

S. No.	Services				
RH-related services		**Year 1**	**Year 2**	**Year 3**	**Year 4**
1	Delivery assisted by paramedical staff	136	325	508	436
2	Prenatal care visits	1,408	3,420	4,403	4,158
3	Post-natal visits	192	921	818	877
4	Uterine prolapse	248	283	240	225
5	Ring Pessuries inserted	157	151	173	128
6	Ring Pessuries changed	168	243	386	399
7	RTIs/STIs	856	1,128	859	767
8	UTIs	299	518	594	444
9	Pelvic/vaginal bleeding	135	338	460	471
10	Consultations	247	331	485	704
11	Breast abscess	68	168	151	159
12	Infertility	42	43	32	50
13	Other RH cases	118	459	209	370
Total RH services		**4,074**	**8,328**	**9,318**	**9,188**
1	Referrals	298	321	601	392
2	General health service	7,946	18,924	24,991	19,153
3	Total FP service	940	3,347	6,763	7,578
4	Total laboratory service	166	818	700	804
Total		**13,424**	**31,738**	**42,373**	**37,115**

Table 10: New family planning clients by year and number or children

Year	Clients	No. of Children		
		Lowest	Highest	Average
Year 1	145	1	9	4.29
Year 2	144	1	7	3.65
Year 3	132	0	6	3.29
Year 4	136	0	7	3.27
Year 5	142	1	7	3.18

Table 11: New family planning clients by year and age

Year	Clients	Youngest	Oldest	Average
Year 1	145	17	45	34.00
Year 2	144	17	40	29.10
Year 3	132	17	39	28.47
Year 4	136	17	41	25.72
Year 5	142	18	40	20.47

3. CLINIC SUSTAINABILITY

An important aspect of the program has been the emphasis on clinic sustainability. For the program, sustainability means that services currently being provided by the clinics will be continued into the future without any reduction in quality. In order to achieve this, the NGO-run clinics need to be financially sound and have managerial capacity. Clinics aim to recover as much of their costs as possible. Cost recovery is done in two key ways; 1) through the funds generated from the sale of medicines, and 2) through fees for registration and services.

Clinic registration fees are set by the NGO in collaboration with local groups and communities. The fees differ among the NGOs, as do the payment schedules. Two of the NGOs collect registration fees yearly, and others collect fees every four months. Service charges are also set in the same way and vary from clinic to clinic.

Figures 3 and 4 describe the evolution of income from registration fees and service charges over the four-year period. These trends are positive. It is notable that income from service fees is continuing to increase, while registration fees appear to have leveled out.

Table 12 provides details of the revolving fund for medicine. Both the sales and purchases have grown over the four-year period, and have shown a positive margin.

"Before RWUA health personnel started providing health care services to our village, women did not know that they should go for prenatal or postnatal care. In the future we hope that mothers-in-law will help their daughters-in-law to go for regular check-ups." ——Pachgachhiya women's group

Figure 3: Registration fees for seven clinics over a four-year period

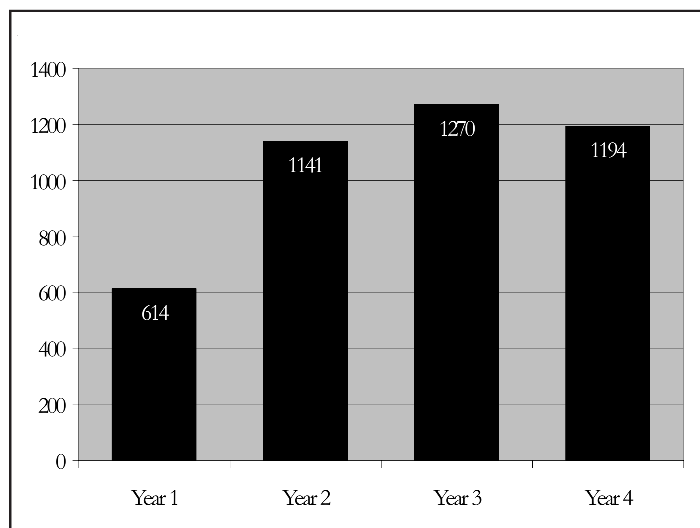


Figure 4: Service charges for seven clinics over a four-year period

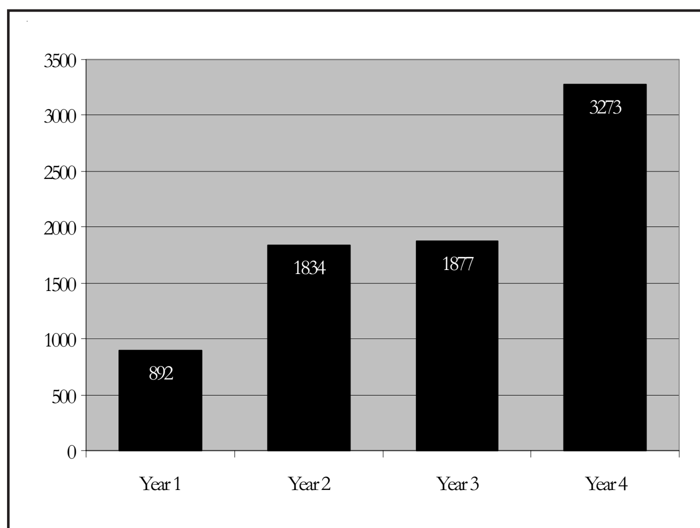


Table 12: Revolving funds for medicines

Particulars	Year 1	Year 2	Year 3	Year 4
Medicines sold	7,594	17,188	20,326	22,872
Closing stock	4,878	8,146	8,077	9,955
Medicines purchased	8,456	16,230	16,018	18,722
Opening stock	1,615	4,878	8,146	8,077
Margin*	2,401	4,226	4,239	6,028

* The margin is calculated by adding the medicine sold plus the medicine closing stock and then subtracting the medicine purchased and the medicine opening stock.

4. IMPROVING RURAL LIVELIHOODS THROUGH LOCAL ASSET BUILDING

Another important aspect of the program has been the savings and credit groups. Over the four years, the number of groups has almost doubled, as has total membership, as shown in table 13.

Table 13: Number of groups and members over the four-year period for 7 NGOs

Particulars	Year 1	Year 2	Year 3	Year 4
No. of Groups	219	366	372	406
No. of Members	3,705	6,379	6,964	7,726

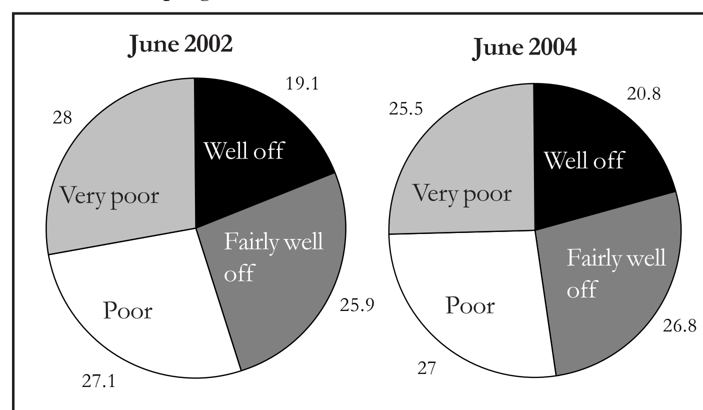
Table 14: Accumulation of assets, interest and loans mobilized

Particulars	Year 1	Year 2	Year 3	Year 4
Groups' Assets	$19,586	$41,830	$67,582	$105,751
Interest Earned	NA	$765	$2,168	$8,762
Loans Mobilized	$30,533	$89,675	$95,150	$200,306

Another area of impact has been the accumulation of group assets and interest earnings. As the groups have grown, so have their assets and the number of loans mobilized. The significance of the information on table 14 is that women are increasing their savings. It does not simply indicate that they have increased assets, but it also shows that the members have increased their capacity to accumulate savings over time. This increases their capacity to mobilize loans, which will help them plan, implement, monitor effectively, and have greater impact on improving the well-being and livelihoods of members. It also demonstrates increased capacity in maintaining simple accounts.

A tool that World Neighbors uses to estimate trends over time is a well-being analysis whereby each household is ranked in terms of local criteria for well-being[12]. This exercise provides an estimate of program impact. Figure 5 below demonstrates changes in household well-being ranking in the SIDS program area.

Figure 5: Household well-being ranking for June 2002 and June 2004 for SIDS program area



5. SELECTED ASPECTS OF SOCIAL CHANGE

Assessments using participatory methods were conducted to examine program effects over time on social interactions. Table 15 presents findings from a trend analysis exercise conducted in two villages with RWUA. The 12 group members examined the status of communication with their spouses on specific topics during a three-year program period. According to the findings, couple communication has increased over time for all the topics examined. While RWUA was frequently cited as the most important influence, other groups also played a role in the change. In particular for post-partum care, the program of another agency was cited as effective. As a cross-reference, the results

[12] For a full description of well-being ranking, see Gubbels, P. and C. Koss, 2000, From the Roots Up: Strengthening Organizational Capacity through Guided Self Assessment. World Neighbors. Oklahoma City, Oklahoma. Pp 114-115.

Table 15: Trends in couple communication on selected RH and social issues as compared to 2001 (pre-program) as reported by program participants

RH Issues	Change	Factors/Sources of Change	Comparison between Pachgachhiya & Kachhadiya
Pre-natal care	Increased	RWUA, TBAs, TV, Radio, Posters, Group Members, Demonstration Effect, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Family planning acceptance	Increased	RWUA, TBAs, TV, Radio, Posters, Health Post, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Nutrition pregnant/lactatin-g women	Increased	RWUA, TBAs, TV, Radio, Posters, Health Post, Child Nutrition Program etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Workload during pregnancy	Increased	RWUA, TBAs, TV, Radio, Posters, Health Post, Child Nutrition Program etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Post-natal care	Increased	RWUA, TBAs, Child Nutrition Program, Group Members, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Number of children	Increased	RWUA, TBAs, Group Members, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Girls' education	Increased	RWUA, Education Department, Media, School, Demonstration Effect, etc.	In both villages, there were increased numbers of girls attending school.
Marriageable age	Increased	RWUA, Media, Group Members, Demonstration Effect, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Spacing of children	Increased	RWUA, Media, Health Post, Group Members, Demonstration Effect, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Dowry	Increased	RWUA, Media, Group Members, Demonstration Effect, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation
Assistance during delivery	Increased	RWUA, Media, Health Post, Group Members, Demonstration Effect, etc.	More improved in Pachgachhiya than Kachhadiya, verified through field observation

in the village (Pachgachhiya) were compared with a neighboring area (Kachgachhiya). A similar exercise was also completed for decision-making, which also demonstrated positive trends.

6. NGO PARTNERS CAPACITY ASSESSMENT

Tables 16 and 17 present summaries of capacity assessments carried out with the partners over a three-year period. The scores are established through a process of NGO self-ranking and discussion with the World Neighbors team. Table 16 describes an initial capacity assessment in October 2002 and table 17 represents a February 2005 assessment. Although criteria change over the period, there is a relatively small gap of nine points between the highest rated NGOs and the lowest.

Table 16: Terai NGO partners' assessment by capacity, October 2002

	CRITERIA	SIDS	DSS	RWUA	CHETAN-A	IRDS	WCDC	RCDSC
1	Leadership's effectiveness	80	80	80	80	65	70	70
2	Field coordinator effectiveness	80	50	80	65	80	70	50
3	Staff commitment	80	70	70	80	65	55	60
4	Stakeholder satisfaction	75	70	70	75	50	50	50
5	Clinic sustainability level	45	60	45	30	55	50	55
6	External resource mobilization	70	80	70	70	70	70	75
7	Quality of clinic management	70	80	70	70	80	75	65
8	Overall financial management and transparency	80	80	80	80	80	70	70
9	Overall program effectiveness	80	80	80	80	80	80	80
10	Image	80	80	80	80	80	80	80
Average		**74**	**73**	**72.5**	**71**	**70.5**	**67**	**65.5**
RANK		**1**	**2**	**3**	**4**	**5**	**6**	**7**

Table 17: Terai NGO partners' assessment by capacity, February 2005

	CRITERIA	SIDS	DSS	RWUA	CHETANA	IRDS	WCDC	RCDSC
1	Volunteer leadership/management effectivenes	87	84	81	80	83	82	80
2	Field coordinator effectiveness	90	85	87	60	84	89	81
3	Savings and credit groups	90	90	88	87	88	89	88
4	Savings and credit cooperative	89	87	85	59	87	90	84
5	Reproductive health activities	90	89	83	85	94	85	86
6	Sustainable agriculture activities	90	86	80	69	80	75	69
7	Financial management	91	90	90	90	90	90	90
8	Clinic sustainability trend	82	78	62	90	92	80	75
9	Reporting and documentation	90	90	86	91	86	89	85
10	Use of other local, national, international resources	81	88	84	77	84	84	88
Average		**88**	**86.7**	**82.6**	**78.8**	**86.8**	**85.3**	**82.6**
RANK		**1**	**3**	**5**	**7**	**2**	**4**	**5**

Lessons Learned

There is demand in these rural areas for quality RH services if they can be provided at a reasonable cost and within a reasonable distance. The increases in RH service use observed by this program indicate that the program model meets an unmet need in rural areas. It further confirms the important linkage between supply and demand as this model works effectively on both aspects.

Local NGOs can provide quality RH services, and the services can be sustainable. The NGOs continue to make progress toward ensuring sustainability as demonstrated by their efforts at cost recovery. These are all local NGOs with no prior experience in providing clinical services. As a result of their partnership with World Neighbors, clinics and outreach services have become an important part of their development work.

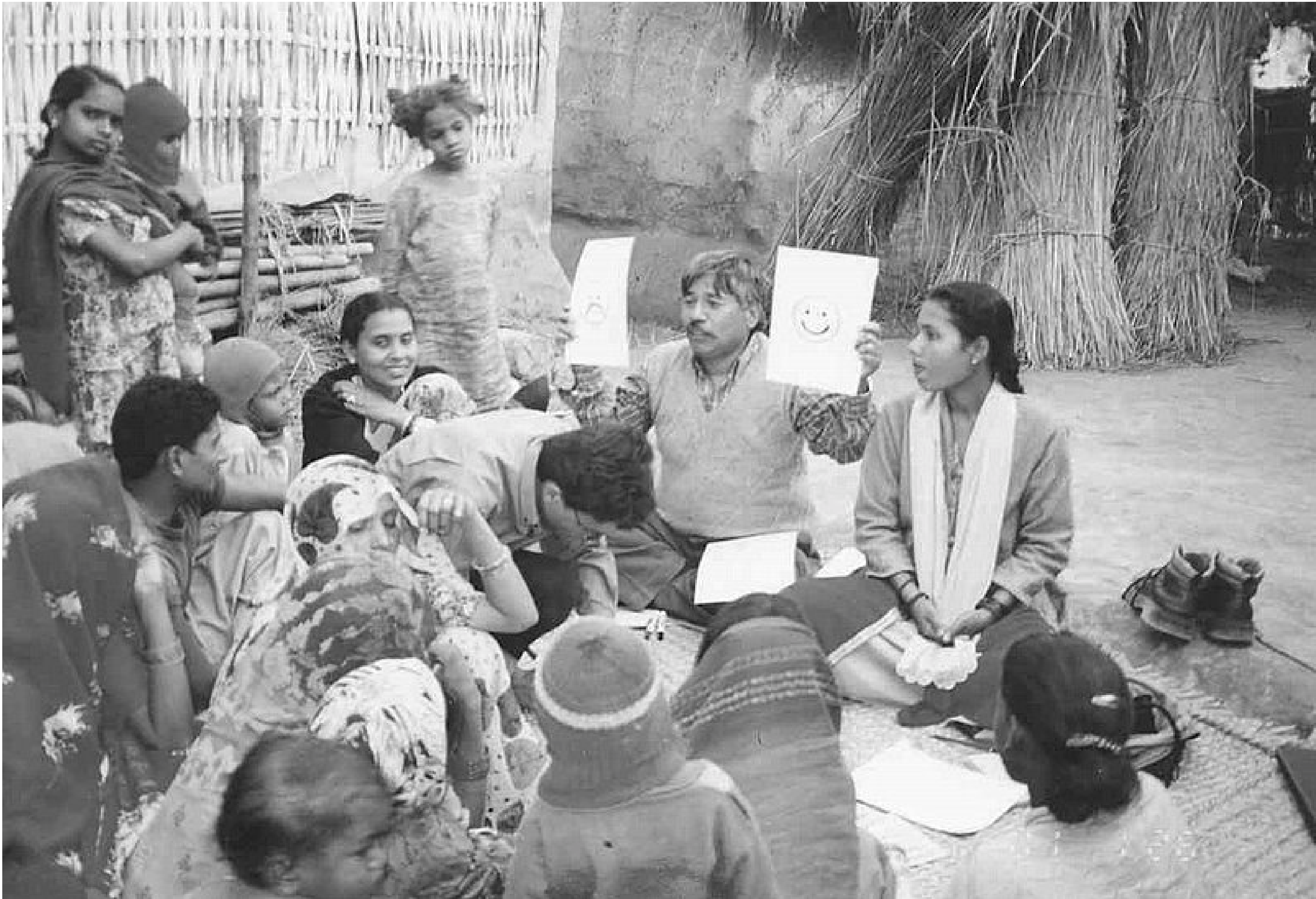
Despite much effort to raise awareness and advocate for rights, the government's service delivery system remains only theoretically operational in many areas. The NGOs offer an alternative means of providing sustainable, quality health services. With the support of the local cooperatives, these services have the potential to be completely sustainable.

Early cross-visits to successful programs facilitate learning and overcoming obstacles. The cross-visits to successful programs have been a key factor in building the capacity of local NGOs. These visits enable NGO leaders to observe and discuss program approaches with others. This kind of exposure to other operational programs helps them to envision how the approach would work in their own settings.

Female providers are important in service use by rural women. The program found that service provision using female providers makes the service more culturally acceptable in Nepal generally, but particularly in the Terai. Traditionally, in this region, women are not supposed to talk openly with men about sexual or reproductive health issues. The program approach demonstrated that it is feasible to hire female paramedics to provide services in a cost-effective way.

Linking savings and credit with reproductive health. One of the main objectives of the savings and credit groups is to facilitate access to RH services. The local NGOs have established clinics that provide quality services with reasonable charges. NGO staff also provides RH outreach services carried out in collaboration with the self-help groups.

The savings and credit groups provide a means by which women can access money for RH services. Women may not have money for RH services for a number of reasons. The funds may not be available within the household, or the head of the household may not see RH needs as a priority. The savings and credit groups have helped to reduce, if not totally eliminate the problem of accessing necessary funds. Because of their participation in the savings and credit groups, in the case of an emergency or other pressing need, they can borrow funds based on their own request.



World Neighbors and NGO staff, Terai

Conclusions

One of the key aspects of the program is the demonstrated viability of the BBP model and its applicability to other settings. This model provides a needed alternative to public sector services, and, in contrast to other private-sector models, it focuses on meeting the needs of the poor. The linkage with self-help groups and the careful monitoring of program activities helps to ensure that even the poorest women have access.

Another important aspect of the approach is the social change that has resulted through the program efforts. The design supports initiatives related to women's autonomy, such as increased couple communication, use of household money, and participation in groups. Indicators for these variables have changed substantially in favor of enhanced women's status and well-being.

In remote areas, just creating awareness without increasing the accessibility of services is not enough, particularly with regard to reproductive health. Many obstacles, including financial and cultural issues, prevent women from using services. Although information on reproductive health topics may be well disseminated, unless services are also made available in underserved communities, women and their families will not be able to benefit.

Finally, the approach of supporting the capacity building of women's groups at the grassroots level has been successful in helping them become self reliant. Additionally, building the capacity of the community organizations has bolstered the sustainability of the financial and health services they provide to their members and the wider community. World Neighbors and the partner NGOs have played a catalytic role in this process. It is worth noting that the approach is not only in demand in the communities in Nepal, but has also been successfully applied in Madhubani District in neighboring Bihar.

"We have chosen group formation as our most important activity. As the impact flow chart shows, from the group we were able to access services such as medical treatment, family planning, low interest loans, training, literacy and opportunity for cross-visits. The group is an important medium to get opportunities to learn many things. Because of our group work, women from neighboring villages are also eager to form such a group. It is always good to work together." — Pachgachhiya Women's group

Appendices

Appendix 1: Individual Member Information Card

These forms are used to organize information on individual group members. These cards provide a composite view of group members.

<table>
<tr><td rowspan="2">House no. from list</td><td colspan="6">Name of household head:</td><td colspan="2" rowspan="2">Membership number</td></tr>
<tr><td colspan="6">Name of woman:</td></tr>
<tr><td rowspan="2">House wealth ranking</td><td colspan="2" rowspan="2">Education</td><td colspan="4" rowspan="2">Change in livelihood</td><td colspan="2">Member in women's group</td></tr>
<tr><td>Yes</td><td>No</td></tr>
<tr><td rowspan="2">Reproductive age</td><td colspan="4">Marital status</td><td colspan="2">Pregnant</td><td colspan="2">Acceptor of FP method</td></tr>
<tr><td>A</td><td>B</td><td>C</td><td>D</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="4">Number of children born:</td><td colspan="5">Number of children alive:</td></tr>
<tr><td colspan="2">Son</td><td colspan="2">Daughter</td><td colspan="3">Son</td><td colspan="2">Daughter</td></tr>
<tr><td colspan="9">Last delivery</td></tr>
<tr><td colspan="4">Where:</td><td colspan="5">Assisted by:</td></tr>
<tr><td rowspan="2">Loan taken</td><td colspan="3">How much:</td><td colspan="5">Purpose:</td></tr>
<tr><td colspan="3">How much:</td><td colspan="5">Purpose:</td></tr>
<tr><td colspan="9">Other RH description:</td></tr>
<tr><td colspan="9">Other important information:</td></tr>
</table>

A = Unmarried Girl, B = Married, C = Widow, D = Divorced

Household Card

<table>
<tr><td>House number from list</td><td>Name of household head</td></tr>
<tr><td>House wealth ranking</td><td>Group membership number</td></tr>
<tr><td colspan="2">Program activity involvement:</td></tr>
</table>

The Household Cards were half the size of Individual Member Info Cards. The color of these cards differed from one village to another, which facilitated quick recognition and would avoid mixing of the cards with one another.

Appendices

Appendix 2: Mini-Survey

The mini-survey is a simple participatory technique. The NGO coordinator and WN teams work with key informants in the community to complete a matrix regarding key events for each household in the community (see below). These mini-surveys are conducted once every six months in communities comparing group and non-group member households. In this way, the program collects information on births, deaths, migration, contraceptive use, etc. It also provides information for comparison between group and non-group members.

Group member mini-survey, RCDSC Mahottari

Mini-Survey Matrix

Name of the Group:
Address of the Group:
Date:
Group Id. #:

S#	Household Head	Group Member		0-4		5-14		15-44		45+		Total			Birth		Death		Migration		Eligible Couple	FP Acct.	Remarks
		Y	N	B	G	M	F	M	F	M	F	M	F	Sum	B	G	M	F	In	Out			

Y = Yes, N = No, B = Boy, G = Girl, M = Male, F = Female

Appendix 3: Trend Analysis- related issues

This exercise requires 8 to 10 participants.

1) Along with cards and markers, the facilitator should also have the pictures of a happy face, a sad face and a plain face. After the participants recognize the happy, sad and plain faces explain to them that they mean 'progress', 'no progress' and 'no change' respectively.

2) Ask the women to come up with issues related to them such as education, childbirth, fodder and household work – place them in order of importance.

3) For each issue ask the participants if they think the situation has improved, gotten worse or remained the same compared to the past and place the appropriate picture next to it.

4) Ask them the reasons for the changes in each issue including the role of the group members and the people of the community in bringing about such changes.

The results from the village Sakhuwa were as follows:

Present Situation	Issues	Notes
Getting Better	***Age at marriage***	Due to education and awareness among people, the marriageable age is now 18 for girls and 22 for boys.
	Giving birth to babies	These days health clinics and drugs are available everywhere. TBAs and health staff provide us services. RWUA provides door-to-door services and pregnant women get check-ups every month to ensure that the baby and the mother are healthy and safe. We go to clinics for delivery for both normal and complicated cases. Women these days also give birth to fewer children compared to the past.
	Taking care of children	Due to awareness and education, people now know about family planning methods. These days couples think that the ideal number of children is 2 to 3 - this way a child can be provided with good education, clothes and care.
	Grinding Mill	In the past, we did not have mills - we used Jato (grinding stone). Mills have made it faster, easier and more convenient to grind grains.
	Education	In the past, there were only a few schools and they were far from this village and people did not know the value of education. Now there are government and private schools in neighboring villages - there is no problem for our children to go to school.
	Volunteer health service	In the past, nobody understood the importance of voluntary work - they were only engaged in their personal work. Now some people are providing voluntary service in health and other fields.

Present Situation	Issues	Notes
Getting Better	***Purchasing goods***	If you have money everything is at your doorstep and you don't need to walk miles to get your commodities. But people have to go to cities to buy food, clothes and grains. These days different types of seasonal fruits and vegetables are also available near our village.
	Fodder	In the past, we depended only on the forest to feed our animals. We even bought hay to feed our buffaloes. Now we have planted different species of fodder seedlings in our lands and we have relatively easy access to fodder.
	Access to food items	In the past we had to borrow rice from our neighbors. Now dry lands have become wet because of irrigation and everyone grows rice. We can also go to the market to buy any kind of food, even meat.
	Agriculture	In the past, either people dug their field themselves or used ploughs. These days we use tractors and harvest more grain than in the past. We now have better irrigation systems and use chemical fertilizers, pesticides and good seeds for better farming.
Same	***Domestic violence***	Everything is improving in this village except domestic violence. Men still drink alcohol and beat their wives. We have not been able to reduce violence against women in this village.
Getting Worse	***Household chores for women***	The load of household chores has increased - women now spend more time in the kitchen than in the past. We have to prepare tea many times a day for guests as well as family members. We even prepare more food items than in the past. We give more time for our personal hygiene - houses are kept cleaner. We have to wash children's school dresses and prepare food for them. Despite all the awareness and needs, women's work has increased. Men do not share the domestic chore with women.

Appendix 4: Savings and Credit Group Progress Report – completed by NGOs

Name of Partner NGO: ____________________

Period covered by this report: **From:** ____________ **To:** ____________

Particulars	Women's Group	Men's Group	Mixed Group	Total
No. of SCGs				
No. of Members				
Self Reliance SCGs				
No. of SCGs dropped (sustained)				
No. of new SCGs formed				
No. of Account literate SCGs				
SCG's accumulated Fund (Without interest)				
SCGs' income from interest and other sources				
Total assets of SCGs				

Loans used	Reproductive Health		Income Generation		Others		Total	
	Time	Amount	Time	Amount	Time	Amount	Time	Amount

SCG = Savings and Credit Group

Appendices

Appendix 5: Savings and Credit Cooperative Progress Report

Name of the SC Cooperative:

Address:

Name of Supporting Organization:

Reporting Period: **From:** **To:**

Particulars		Earlier Report	This Report	Total
1) Shareholders	Male			
	Female			
	Total			
2) Capital & Funds	Paid-up Capital			
	Reserved Fund			
3) Savings Collection	Regular Savings			
	No. of Savers			
	Periodical Saving			
	No. of Savers			
	Other Savers			
	No. of Savers			
4) Savings Returned	Regular Savings			
	Periodical Savings			
	Other Savings			
	Regular Savings			
	No. of Savers			
5) Balance of Savings to be Returned	Periodical Savings			
	No. of Savers			
	Other Savings			
	No. of Savers			
6) Borrowed by Organization				
7) Returned against Borrowed by Organization				

Appendices

Particulars		Earlier Report	This Report	Total
8) Balance of Borrowed by Organization	Loans within time			
	Within 6 months over			
	Within 1 year over			
	Over 1 year time			
9) Loans to Depositors	For Agriculture			
	No. of Borrowers			
	For Business			
	No. of Borrowers			
	For Hire Purchase			
	No. of Borrowers			
	For Service Business			
	No. of Borrowers			
	For Housing			
	No. of Borrowers			
	For Education			
	No. of Borrowers			
10) Loans Repaid	Against Agriculture			
	No. of Persons Repaid			
	Against Business			
	No. of Persons Repaid			
	Against Hire Purchase			
	No. of Persons Repaid			
	Against Service Purchase			
	No. of Persons Repaid			
	Against Housing			
	No. of Persons Repaid			
	Against Education			
	No. of Persons Repaid			

Particulars		Earlier Report	This Report	Total
11) Liquidity	Cash			
	Bank			
	Bonds			
12) Remained Loans	Loans within time			
	Within 6 months over			
	Within 1 year over			
	Over 1 year time			
13) Income	Interest Earned from Bank			
	Interest from Loans			
	Service Charges			
	Entrance Charges			
14) Expenditure	Interest Paid on Loans			
	Dividend			
15) Compulsory Funds	Secured Fund			
	Staff Bonus Fund			
	Lost Covering Fund			
	Member Education Fund			
	Doubtful Debt Fund			
	Organization Dev. Fund			
	Social Welfare Fund			
16) Provision of Risk	1% for on time Loans			
	10% for 6 months			
	50% for 1 year			
	100% for over 1 year			

Provide other essential information:

Note: Trial Balance, Income & Expenditure Statement and Balance Sheet should be enclosed along with this report.

Prepared By: Name: Designation: Date:
Approved By: Name: Designation: Date:
Official Stamp

Appendix 6: Clinic Self-Reliance Progress Report

Name of Partner NGO: ________________________________

Period covered by this report: **From:** ______________ **To:** ______________

Income and Expenditure Statement

Income		Expenditures	
Particulars	**Amount**	**Particulars**	**Amount**
Present medicine stock		Medicine purchase	
Amount of medicines contributed/donated (calculate at prevailing price of medicine)		Closing stock of the last year	
Medicine sales			
Other income on medicines		Other expenses on medicines	
Total Income		**Total Expenditure**	
Income from medicines (Total income - Total expenditure)			
Other Incomes: Registration fees			
Service charges (Reproductive/general health, FP, lab, etc. services)			
Organization's other incomes (membership renewal fee, bank interest, donations, etc.)			
Total Income			

Appendix 7: RH/CH Service Report

Name of Partner NGO: ____________________

Period covered by this report: **From:** __________ **To:** __________

1. Reproductive Health and General Health Services

Services	Achievements		
	Clinic	**Field (Outreach Clinic)**	**Total**
a) Reproductive Health Services			
Delivery by ANMs			
Delivery by Trained TBAs			
ANC			
PNC			
Uterus Prolapsed			
Ring Pessary Inserted			
Ring Pessary Changed			
Reproductive Tract Infection			
Urinary Tract Infection			
PV Bleeding			
Breast Abscess/Problems			
Infertility			
Other RH Services			
Total			

Services	Achievements		
	Clinic	Field (Outreach Clinic)	Total
b) Referrals			
Delivery			
ANC			
Uterus Prolapsed			
PV Bleeding			
Breast Abscess/Problems			
Infertility			
Female Sterilization			
Male Sterilization			
Other RH Services			
General Health Referrals			
Total			
c) Total General Health Services			
d) Total FP Services			
e) Total Lab Services			
Total from a-e			
Condom Distribution in Units			

2. Laboratory Services

Name of Test	No. of Test	Name of Test	No. of Test	Name of Test	No. of Test
1. TC, DC		4. Sputum		7. Stool	
2. ESR		5. Pregnancy		8. Urine	
3. HB		6. Semen		9. Others	
Total persons benefitted			**Total tests done**		

Note: If more than the above mentioned tests have been performed, please write them on a separate page and attach.

3. Pregnant Women, ANC/PNC and Ring Pessuries Change

Particulars	Inside Group		Outside Group		Total			
No. of pregnant women	Once		Twice		Thrice		4th time or more	
	Inside Group	Outside Group	Inside Group	Outside Group	Inside Group	Outside Group	Inside Group	Outside Group
ANC taken								
PNC taken								
Ring pessaries changed								
Total								

4. Family Planning

Family Planning Method	New		Old		Continue	
	Inside Group	Outside Group	Inside Group	Outside Group	Inside Group	Outside Group
Depo-Provera						
Condom						
Pills						
IUD						
Norplant						
Female Sterilization						
Male Sterilization						
Other FP method						
Total						
No. of fertile women in the group: Members						
No. of group members accepting family planning: … Persons						

5. Reproductive Health Education for In-School Youths

S.N.	Name of School	No. of Participants		Average marks obtained in pre-test	Average marks obtained in post-test
		Boys	Girls		
	Total				

Appendix 8: Clinical Checklist

Name of Partner NGO:

S.N.	Particulars (Questions)	Answer		Plan for improvement, if the answer is NO	
		Yes	No	By what time	By whom
I. Sanitation:					
1.	Smoke free office premises				
2.	Clean toilet				
3.	Cleanliness around the clinic				
4.	Process adopted for disposing used things				
5.	Cleanliness in office rooms/training hall/store/kitchen				
6.	Proper maintenance of equipment				
7.	Hand washing facilities				
II. Clinical Services:					
1.	Good skill to examine general patients				
2.	Use of appropriate medical equipment/tools				
3.	Good behavior with patients				
4.	Welcoming atmosphere and confidential counseling				
5.	Practical use of skill learnt from training				
6.	Follow-up of ring pessary cases				
7.	Delivery of RH services as per protocol				
8.	Proper dressing				
9.	Use of necessary medicines with correct doses				
10.	Proper arrangement of delivery room				
11.	Proper management of clinical equipment and materials				
12.	Proper referral and follow-up system				
13.	Proper referral and follow-up system (FP)				
III. Medicines:					
1.	Administration of medicines in a correct way and proper counseling on possible side-effects from drugs				
2.	Systematic storage of medicines				
3.	Timely return of medicines with less than 4 months' expiry date				
4.	Contraceptive supplies adequate for 3 months				

S.N.	Particulars (Questions)	Answer		Plan for improvement, if the answer is NO	
		Yes	No	By what time	By whom
IV. Organization's Image:					
1.	Good comments from beneficiaries				
2.	Good behavior of staff				
3.	Good behavior of volunteers				
4.	Good result from the program				
V. Recording/reporting:					
1.	Timely recording in prescribed forms and formats				
2.	Timely reporting to the concerned authority				
VI. I.E.C.					
1.	Proper placing of health related posters and pamphlets in the waiting room				
2.	Health education to clients/patients				
VII. Others, if any					
1.	***Antenatal care***				
	Iron folate distributed to every client every month				
	Tetanus toxoid				
2.	***Postnatal care***				
	Immediate breast-feeding (Bigauti duth)				
	Physical examination				
	Immunization				
	Distribution of iron folate for 1 month				
	Administration of a dose of Vitamin 'A'				
	Family planning counseling				
3.	***Neonatal care***				
	Resuscitation skill				
	Cord care				

Monitored by: Signature: Date:

Note: After completing the form, a meeting is held with the concerned members of the organization to review comments, solicit their response and document meeting outcomes.

Appendix 9: Check List for Partner Clinic Quality Monitoring

Name of Partner NGO:
Address:
Date of clinic initiation:

S. No.	Particulars	Excellent	Very Good	Good	Satisfactory	Poor	Remarks
I.	**Service provided by clinic**						
	1. Delivery						
	2. STD						
	3. RTI						
	4. Ring pessaries inserted						
	5. Ring pessaries changed						
	6. ANC						
	7. PNC						
	8. FP (use another sheet)						
	9. Breast problems						
	10. UTI						
	11. Bleeding						
	12. Irregular menstruation						
	13. Pregnancy test						
	14. Other RH						
	15. Other treatment						
II	**Services Provided from field**						
	1. Delivery						
	2. ANC						
	3. PNC						
	4. FP (use another sheet)						
	5.Other RH						
	6. Other RH						

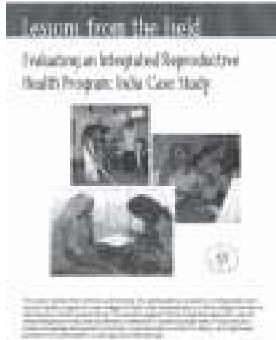
S. No.	Particulars	Excellent	Very Good	Good	Satisfactory	Poor	Remarks
III.	**Referral Services**						
	1. Delivery						
	2. Infertility						
	3. FP (use another sheet)						
	4. Other RH						
	5. Other conditions						
Remarks of the monitoring person:							

Date: Signature:

Note: After completing the form, a meeting is held with the concerned members of the organization to review comments, solicit their response and document meeting outcomes.

More Integration Resources from World Neighbors

Evaluating an Integrated Reproductive Health Program: India Case Study



This report details the methods and findings of a participatory evaluation of integrated reproductive health programs in two villages in India, with comparisons to a third village that had no reproductive health programming. The results suggest that the integrated approach used by World Neighbors - India and its partners is effective in achieving high rates of reproductive health knowledge and positive practice, improvements in women's status, and significant benefits from participation in savings and credit programs.
60 pp, available in English. $10.00 plus shipping.

Integration of Population & Environment

This collection of articles explores the creative ways in which World Neighbors and other organizations are addressing population and environmental issues at the community level. Articles include case studies of integrated programs and discussions on organizational needs and funding trends. These papers were originally presented at the American Public Health Association's 125th Annual Meeting in 1997. The authors represent a range of organizations involved in efforts to link population and environment, including Population Action International, The Summit Foundation, The University of Michigan Population-Environment Dynamics Project, World Neighbors, and World Wildlife Fund.
69 pages, available in English. $5.00 plus shipping.

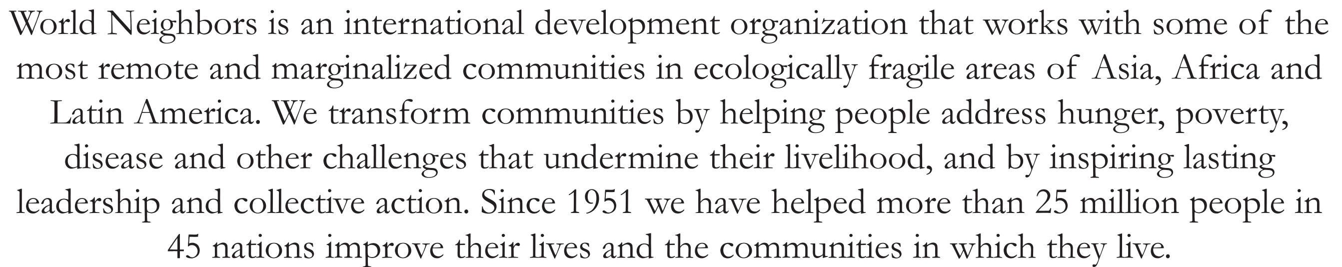
Integration of Population & Environment II: Ecuador Case Study

This report presents the findings of a three-year Operations Research Project carried out in partnership by World Neighbors and the Ecuadorian family planning organization CEMOPLAF. The results support a compelling argument for implementing an integrated approach which combines reproductive health and agricultural/natural resource management programming to address population and environmental issues at the community level. Published with the University of Michigan Population-Environment Fellows Program.
26 pp; English.

World Neighbors In Action: Understanding NRM & RH in the Philippines

This issue of World Neighbors In Action presents key aspects of design organization and findings of a workshop held in the Philippines for NGOs to share experiences in integrating reproductive health and natural resources management.

Workshop participants explored common issues for integrated RH/NRM, common assumptions and next steps for working together on priority issues identified.
8 pp; English/French/Spanish; $2.00 plus shipping; 2003.



World Neighbors is an international development organization that works with some of the most remote and marginalized communities in ecologically fragile areas of Asia, Africa and Latin America. We transform communities by helping people address hunger, poverty, disease and other challenges that undermine their livelihood, and by inspiring lasting leadership and collective action. Since 1951 we have helped more than 25 million people in 45 nations improve their lives and the communities in which they live.

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World Neighbors inspires people and strengthens communities to find lasting solutions to hunger, poverty and disease and to promote a healthy environment.

For more information about World Neighbors, please visit our website at www.wn.org