
Index:

I: Interviewer

P: Participant

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I: Let's start now. It is going to be recorded now. The WHO has recently recommended stimulation and nutrition interventions. This programme improves in the growth and development for kids. Discussions have been going on for a long time to integrate these programmes A formal documentation was published last year from the WHO. We will be discussing on this topic today. I am going to ask questions related to this only. Let us discuss on the topic of ECD. Would you like to share about the strategies, rules and regulations related to early childhood development for kids under 3 years old in Nepal?

P: Early childhood development programme was initiated in our country, through the leading agency, Ministry of Education. But there are multiple stakeholders Ministry of Education, Ministry of Health ... Ministry of women, child and elderly people is also a part of it. The chairperson of this committee is the chairperson of NPC (National Planning Commission) ... they oversee this work Early childhood development has been initially established via Ministry of Education as a preprimary child educational programme. In health, for child up to 5 years or newly born babies ... Nepal Government has programmes Early childhood development is considered from conception to up to 8 years... Currently in our country, especially if we see in Health programme, for children up to 5 years there is specific programme ... then there is programme for adolescent... so, there is gap in between... The introduction of ECD in health programme for children up to 5 years hasn't been very long. We need to try to understand this. We have programmes related to early childhood development and it is in operation as well ... but Ministry of Health knew about this later only that there is programme is related to ECD and is

launched to address issues related to children development ... when Nepal government started to develop strategies related to early childhood development which was recently approved in 2020. While this was communicated to multiple stakeholders, multiple ministries, we lead this from child health division, Ministry of Health. We have realised that we have been using ECD for a long time before, just that we were not using the terminology. Talking about our health programmes that address ECD ... mainly from to begin with the stage of conception ... we have maternal reproductive health programme... there are antenatal care programme... We have minimum 4 times antenatal visit from the period of conception to pregnancy. We see birth defect and mother's health condition examination and tests. We provide iron folic acid to the pregnant mothers for 180 days for 6 months and thereafter continued for 45 days. Similarly, we provide them vitamin A, tetanus, and STD vaccines as well. We provide these services to the mothers from conception to before delivery, which fall under ECD. To promote institutional delivery, we are expanding birthing centers and increasing skilled birthing attendants through training. After the delivery of a baby, we provide post-natal care (PNC) to the mother and newly born baby for 3 times as per national guidelines. We have made decisions to expand antenatal care (ANC) to 8 times but currently it's not in practice. It's still 4 times ANC and 3 times PNC For children, we begin with BCG vaccination programme and provide vaccination from birth to 15 months. It includes vaccination that includes 11 antigen which can resist 11 types of diseases. This is one of the interventions that exist.

From nutritional programme point of view, we have growth monitoring programme from birth to up to 2 years ... We also talk about exclusive breastfeeding and, we are promoting talk about breastfeeding within one hour through health department. We have been promoting exclusive breastfeeding for 6 months ... We also talk about supplementary feeding and extended breastfeeding for up to 2 years. We are promoting three stages of breastfeeding early, exclusive, and extended breastfeeding. Along with this we are also promoting nutritional diet for children from nutritional point of view. We have talked about the immunization interventions for babies we do. To prevent children from contracting disease ... main reasons for child mortality are due to diseases like

diarrhea, pneumonia ... (00:6:33) we have high child mortality ... we have CBIMNCI (Community-based integrated management of neo-natal and childhood Illness) in place to overcome child mortality in our country. This programme is in action and in this programme, we counter the problem with integrated approach ... whenever a child is brought in health post due to any illness ... as a collective way we call it 5 killer diseases and we treat for this disease based on the assessment. Due to this, disease doesn't become severe, it's detected early, and treatment is provided ... This programme has resulted into less morbidity and reduced mortality. If we look at the data from 1990 to 2016, we have found high reduction in child mortality rate.

Similarly, we have been focusing on neo-natal health for babies under 28 days old in under 5 programmes, ... If any newborn under 28 days is admitted to any governmental health posts or hospitals due to illness, they receive free treatment all over the nation. We have free newborn care programme in our country. This includes any newly born baby who is admitted to any health posts/hospitals ... if it is indoor, because of illness, then entire treatment, tests, medicines are completely free of cost. The hospitals get refund from the government. Parents and caretakers do not need to spend anything out of their pocket. This is completely free. We have these services. To increase institutional delivery, we are providing incentives from safe motherhood programme. We have allocated price for transportation cost in HIMAL, PAHAD and TERAJ such as rs.1000, rs.2000, rs.3000 respectively. We also provide rs.800 as incentive for four ANC. We have all the above-mentioned health related interventions which are related to early childhood development programme. (00:09:02)

I: Sir, you have talked about programmes related to every level ... Let's focus on Nutrition only for now. These all programmes you said earlier, lies under IYCF programme, right? ... there are stimulation related activities targeting ECD where parents and kids play together, increase their interaction, teach them communication, and teach them responsive feeding. These all lies in types of stimulation interventions. According to you, how can this stimulation programme combined with nutritional programme can be launched in the community?

94 P: In nutrition, we have IYCF programme, which is now called MIYCN (Maternal, Infant
 95 and Young Child Nutrition). We used to call it IYCF and now we have added maternal
 96 nutrition as well and is called MIYCN. We have stimulation as a part of an intervention
 97 within MIYCN training package. We talk and promote about active feeding babies by
 98 mothers.
 99

100 I: Is this still going on? Active feeding promotion?

101 P: Yes. We have active feeding in our training package and have been training it to all the
 102 health workers and female community health volunteers (FCHV) as well. FCHV's are
 103 discussing it in group discussion with the mother's group as well, where female health
 104 volunteers give training about active feeding as a major component. We also provide
 105 awareness related to children's milestone which occurs respective to their age. It is also
 106 integrated in the training package as well.
 107

108 I: What are the things that have been included in the milestone?

109 P: In milestone, we have included ... when does the child start of grasping? ... when they
 110 start to walk... before that when they have head movements or hold their head straight.
 111 These are the physical milestones under developmental milestone... We have been
 112 training using cascade principle, which includes T.O.T and M.T.O.T training to FCHV
 113 level and then it goes to the community level. We basically grasp or target mother's
 114 groups at two stages. Firstly, we have been promoting these interventions in mother's
 115 group meeting. Secondly, if any mother brings their child under 5 years of age to the
 116 health post, either due to child illness or for vaccination, we teach these things to mothers
 117 as a part of counselling ... we have been teaching these things ... If we look at the
 118 stimulation, there are large number of components not just one small part. Currently, only
 119 small part has been included in this stimulation programme ... we mostly talk about their
 120 physical development but there is other component like social development, mental
 121 development, and other new interventions on stimulation.... We have not been able to
 122 include everything in this stimulation programme. In response to your question on how
 123 we can take this programme in the community; there is already a modality in practice in
 124 Nepal; if we can run new interventions in conjunction with these existing modalities then

it would be more effective. If we could take this to the community via FCHV or Health workers and target mothers ... if we can reach them, we can integrate stimulation with nutritional programme. There are some aspects of stimulation in the current nutritional programme, and if we can take this to advance level then it will be easier. (00:13:45)

I: Sir, you have been running small portions of simulation programme. We have not been able to integrate the rest of it. You have been mentioning different domains for the community development programme. Why do you think we have not been able to run this?

P: The main reason is that preliminary school for early child development has been focusing on stimulation ... but for children within 3 years of age ... our health system has never done such a thing like ECD before. We have been using this ECD in our health system for 2 years only now. We are still learning about ECD and what it includes. Before we only included what we knew in the nutrition package. We can now analyse and comment things from ECD's perspective and we can identify what we are lacking. We just found out about this and that national ECD strategy was recently approved Since its approval, we have taken the stimulation component and in this fiscal year i.e., till Asaad (third month in Nepali Calendar), we are looking at how we can take this further in the community ... so we are in the planning phase ... we are in the planning phase, and it is being delayed because of COVID. We have also identified gaps. We have planned to merge and update this in our currently established interventions. We have been doing ECD for 2 years. One year was wasted because of COVID. We are talking about the frameworks in this ECD programme now. We had been taking nutritional programme as just a nutritional programme. We are planning to update framework, ECD in this nutritional programme. We are in planning phase and within next year we will surely update this... (16:00)

I: Sir, you have been planning these interventions ... How can we manage this and take this in community level? How should we do the planning?

P: Among all our current programmes, if we consider child health programme, we have established a chain or protocol for that. When we get new programme, we use those

established method for launching a new programme which will reach to the community level. For example, when we get new component, we firstly update the current package and sometimes we just develop new package ... for example Kangaroo mother care (KMC) ... a small part of KMC component was already there in action but when we received more small and sick children, we started making new package. So, we took two approaches. First, we updated the ongoing package, and next we develop a new package. Once we update packages, we need to update and orient every health worker in Nepal. We do a master T.O.T at central/Federal level for this and call health workers from all 7 provinces. These health workers from province level now train those health workers of their respective districts. After this, these health workers will now train and give orientation to every health worker in their district in different batches based on the packages. After this, these trained health workers of health post or PHC now will give training to the female community health volunteers. They will then provide this information to their respective mother's group. We are following this step wise cascade system and are reaching to the community level. We have been adopting this approach in every intervention. We update community people twice, every time whenever they come in the health post and second via female community health volunteers when they reach in the community level.

I: Sir, according to you, we need to go via FCHV in the community level, right? Every programme comes with updated and added activities to it. How can this affect their existing work and programme? How would they take it?

P: There has been a great reduction of work than before in FCHV's work. They used to do a lot of work before. When FCHV was established... the main concept was... they were hired with a perspective of health education ... 10-15 years ago in Nepal, in community level, in remote areas ... or those community with disadvantaged groups ... people did not have access to health post and facilities ... due to this we started health care services via FCHVs ... For instance, distributing iron tablets, ORS (*Jeevanjal*), protein tablets (*chakki*) for pneumonia etc. were carried out by the FCHVs. What we have seen in recent time, there has been reduction in work of clinical part for FCHV. When there is new programme, there always arises a question. Your question is very eligible to us (as a

programme manager). We must think about this a lot. We must think about whether there is increased workload. Workload will obviously increase when there is formation of new package. For instance, if there is already a nutrition package and they know what to teach, so if we update that package then their workload is not much... but if we introduce new package, they will be more excited at first when their work is increased... what we have seen is when we introduce a new package, they are more excited and promote new programme more and forget about existing or old programmes. If there is no refresher training, no continuation of programmes or updated or followed up, those old programmes keep falling behind. We take help from FCHV in programmes like malaria, TB, and many other programmes. Recently, they are giving more priority to ANC, institutional delivery, child health part and PNC programmes ... if the programme is running, then they would work, otherwise these programmes will disappear. They have been recognized for providing Vitamin A and B12 tablets twice a year. This programme is currently in action on *Baisakh* 6 and 7, 2078 and once in month of *KARTIK* 2078 ... as this programme gives them a different recognition in the country. If new packages are launched, then they are happy ... We have not seen any overload of work for them ... in the past, our studies have not shown any work overload in FCHVs... There has been reduction in their role in clinical part for sure. There is nothing to worry about. (00:22:00)

I: Sir, we talked with similar group recently and found a couple of things. Talking about workload, FCHVs replied to the same way as you did. They don't have a workload. They would work like five days instead of four days which they are supposed to work. They want the work classified according to the incentive. They wish that additional facilities should be provided to them. What is your point of view on this?

P: See the thing is, we cannot compare the work they have contributed for Nepal's health care system and maternal health care programme. Because of them maternal and child mortality rates have been declining a lot due to their role. We have been upgrading as well. They have not been provided with enough incentives according to their work. Technically, we policymaker are sheathing in the name of "*volunteer*". We cannot give them anything monthly because of this term "*volunteer*". We are providing them allowance in every meeting they attend. We are also providing them *posak vatta*

(Costume allowance) yearly. If not nationally but in some *Palika* (Municipality) has been providing FCHVs monthly salaries like NPR 5000, NPR10,000 according to their policies. In recent trend, whenever we launch new programme, they have been receiving incentives/allowance in every training, group discussion, orientation, and meeting... we have been providing incentives to them whenever they run any group discussions and training as well. But it does not continue for a long time. Suppose one programme is launched, after one year this discontinues ... It will go under a regular programme. For example, they were getting incentives for Vitamin A programmes They have not been getting monthly. We have been raising our voice and their union is also raising the same voice about this. There is a problem in the name of "Volunteer". Since, in our country there are more ANM than FCHVs, we have been focusing on community based ANM concepts too. We have made a motherhood road map documentation till 2030. This is a 10-year plan till 2030. We have introduced community based ANM in this. There is a new concept for school health nurse for prioritizing health. To improve the quality of services provided by health facilities, we need to add ANM in health posts as well instead of just FCHVs. We are updating that too. In the coming days, we will be using FCHV as volunteers and ANM will be used to deliver the current health services and education. We need to provide incentives as well in new programme. We have been providing that also ... It is not going to continue after this new programme becomes old and is implemented as a regular programme. (00:26:15)

I: Sir, by doing this will affect in the continuity of the programme ... what do you think?

P: The thing is, we have been bearing the expenses that takes place during meeting in a mother's group. We have made a separate package for FCHV when they attend meetings in mother's group. Since the new programme must go with an intensive load, there will be extra workload ... so we provide incentives at that time. Once this programme has passed the intensive level and this mother's group meeting becomes a regular meeting, that's when they have to inform ... which they are already doing so in the existing mothers group ... For extra work that they have to inform we add that to their existing package, and we upgrade their package. When they deliver the same package as a regular

work, we don't give additional incentives... Because when we have started all over and to cover everything, we give additional. (00:27:14)

I: Sir, if there is a possibility of introducing new category, what are the chances of conflict in roles of existing FCHVs? How can we overcome this and how can they work together in a community?

P: We have not said anything about FCHV's alternative. To improve the quality services given by FCHV in the community, health education is not sufficient. For this we are considering ANM. The main vision is that "If any health-related projects is run via ANM in every ward, then the sole role of FCHV will be volunteering only. Then their roles will be purely obsolete functioning only". Like *MASIKA* (Maternal child health worker) and *GRASWOKA* (Village Health workers), they were replaced by *AHEBA* (Auxiliary health worker (AHW)) and *ANAMI* (Auxiliary nurse midwife (ANM)), respectively due to the increase of education level. AHW and ANM is slowly now being replaced by HA (Health assistant) and staff nurse ... In Nepal they are shutting down colleges. Nepal government has made this decision two to three times already to stop conducting diploma level and only conduct PCL level. Gradually our educational level is also increasing as well as minimum of criteria level is also increasing... in future... it is not going to be confirmed yet... FCHVs have been doing their part of work. ANM will be delivering health services in community level now. In future, once ANM is rolled out, FCHV will eventually be obsolete. In major work their roles might still exists ... But for new programmes just like when we talk about work overload or that we must go via FCHV in mother group meetings and for health education that will definitely go through ANM and not FCHV.

I: Sir, how it is going to effect on the resource's availability after the addition of new category?

P: For that like I said, it has been included in road map. Because of this in some district in the western part of the country, we have been piloting. If this is successful, then slowly we can expand ... currently Federalism has brought a nice thing in Nepal. Just like school health nurse has been a concept for past 5-7 years, but we have not been able to put it in as there were problem in resources in all over the country. It would look like a bulk

279 money to distribute all over Nepal. So Bagmati province started school health nurse at
280 first. After that it started in different provinces. National level government needs to make
281 policy and it must be applied to the federal level ... local level needs to grasp this ... we
282 do have sufficient resources. Advocacy is done by the federal body in province level. We
283 will do advocacy in municipality level as well. They are also managing the resources
284 level. We have been doing piloting from the federal level. (00:30:44)

285

286 I: So, there might not be any financial level restrictions situation in resources even if we
287 add categories, right?

288 P: Yes, we don't have anything like that ... The current health workers have been appointed
289 based on the workload from past 30 years ago ... now we cannot operate if we don't
290 appoint new health workers. It seems like we need double the number that we have now.
291 For this, the provincial government and local government has hired staff on a temporary
292 basis. Because decision is made in 3 levels of government, there is certain benefits of
293 that. It seems more costly if federal government hires 785 staffs. It is not a big amount or
294 not a lot of resources, when the municipality hires one staff in each municipality. They
295 have been hiring 4-5 staffs recently. (00:32:00)

296

297 I: Sir, you said that we need to target mothers in the community for stimulation-related
298 activities, right? Whom can we target besides mothers in the community?

299 P: We have been talking about mother's groups, so we have targeted mothers only through
300 FCHV. We have been moving forward in couple of ways in BCCI (Behavior and trend
301 communication activities) and child health programme. We have targeted mothers in
302 mother's group. Similarly, we have PWG (Pregnant women group), we have been
303 teaching pregnant groups about stimulation and nurturing care. We have been teaching
304 them about those components which are currently available in the intervention. These
305 things are taught before delivery, during pregnancy period. In community level, mother-
306 in-law and father-in-law are guardian/caretaker/decision-makers in their household in our
307 country. So, there is also a component called orientation or activities programme for
308 mother-in-law and father-in-law and conduct meetings with them and conduct meetings.

309 These information to them is being transferred by FCHVs and health workers. Husband
310 and wife are another decision-maker/caretaker in the family. We have 4 categories now.

311

312 I: Is this upcoming or currently running?

313 P: ... it is ongoing. Pregnant group, mother's group, mother-in-law and father-in-law and
314 husband, and wife. These are the 4 categories. The thing is these are not functional in
315 every place. This is the problem. It is not in operation in every place. For instance, in
316 programme like CBIMNCI for children, we talk about vaccination and treatment when
317 children visit nutrition programme. If they go for vaccine, then they will also receive
318 nutrition counselling ... and if they come for treatment of any disease then they are
319 counselled about nutrition and immunization... in this way all programmes are delivered
320 in integrated manner... So in MIYCN, meetings in these four categories are through
321 FCHVs. ... Safe motherhood has been targeting pregnant woman group programme...
322 messages are delivered in integrated manner. Every programme target mother's groups
323 and gives integrated message. Similarly, MIYCN targets mother-in-law and fathers-in-
324 law. Family planning targets husband and wife group more. Wherever they go, they
325 provide integrated message on child health, maternal health, and reproductive health in
326 all these four groups. We have been focusing on these 4 groups. (00:35:07)

327

328 I: FCHV's run this groups?

329 P: Yes.

330

331 I: Sir, you said that it is not functioning, why do you think so? What might be the reasons
332 for it? I am not trying to generalize it as I have been to 2 places only. I have not heard any
333 groups like father-in-law and mother-in-law groups as well as husband and wife group. I
334 want to know about this ...

335 P: We have done special budgeting for all these groups only in MIYCN programme and it is
336 in operation as well. The programme keeps on operating until they receive budget. If the
337 budget stops, then the meeting in that group also stops. They expect snack, allowance in
338 every programme related to INGO/NGO. They don't get allowance, but snacks in any
339 governmental programme. In MIYCN we have been sending the budget for the mother's

340 group and mother-in-law and father-in-law group, so the group are being regulated...
341 Through, family planning programme, husband and wife are getting allowances, but the
342 budget hasn't reached every municipality. So, this may not be regulating in all places...
343 Initially, all ward received budget, so it was functional everywhere. But now programme
344 is operational in those places which receives budget, otherwise they are not functional.
345 We have these 4 groups in the policy level whenever a new intervention launches, we can
346 take it through these 4 groups. (00:37: 00)

347
348 I: Why is there a budget problem in some places and why not in the rest of the others?

349 P: We do a budget analysis with the finance ministry at the beginning of any new
350 programme. It becomes easy when we do budget analysis based on the difference. After
351 running the programme for 2-3 years, they don't approve to continue the budget. They
352 say that this is community level work, and we don't need to spend money on allowance
353 and food. Their approach is that volunteers should run this programme free of cost. It is
354 not easy to run programme like this in community. They start cutting the budget like 10%
355 & 20% and we are forced to stop the programme in certain district. The places which
356 don't have any more budget the programme discontinues. This is all because of the
357 budget that is cut off from the finance ministry. We demand every year about the budget.
358 This whole thing depends on the budget that we have been allocated. (00:38:05)

359
360 I: Sir, you talked about INGO/NGO. How do you think an INGO/NGO could help in any
361 programme that have been in operation from the government?

362 P: (Audio cut ...)

363
364 I: We were talking about NGO and their roles.

365 P: In community level activities, support received from NGO staffs by participating in the
366 classes and orientations conducted by FCHV in community level ... have made it easier
367 for us. Their support is needed more in the community level activities rather than in
368 district level ... in reality, we provide training to FCHVs for 2 days to orient them. They
369 learn and go to the field. They can get confused in the field as more than 20-25 people
370 had participated in that training. Everyone has different rate of understanding in those

two days training.... Since we have few health officers, we cannot attend in every mother's group meeting. Where NGO/INGO staff are present, if they could be supportive to those health volunteers who are running the classes or while interacting with the group in any new interventions or programme ... and provide guidance and supervision to FCHVs and help them ... sometimes if wrong messages are being delivered than that gets corrected... This makes it easier and is seen as a good thing. NGO/INGO ... I have not seen any resource problem in any governmental programme till today. The government only asks for evidence of the success rate of any new programme that is going to be introduced. NGO's roles are needed when introducing new programme. Their presence is needed in the local level during the implementation phase where the federal level approach and supervision is less. Its better if they are greatly involved and provide help at the community level. If I must take an example, there is a programme named SUA AHARA project, in which they have an effective presence in the community level as they have supported in community-level activities ... This provides good quality assurance. I have seen due to their good presence in the community level activities in SUA AHARA, we are receiving good support ... (00:41:44)

I: What we found in the community level after asking them is that they prefer this programme to be launched via NGO and INGO as well. If any programme is launched from the existing health system, it might run for long period of time and is sustainable as well ... But people prefer it more if outside people come and runs this programme. According to their perception, outside people know it better. What do you think about that?

P: That is the reality, and we need to see from both sides. First thing, wherever NGO is situated, they have their own staff. We also include them in orientation in the district level. NGOs recruit staff with minimum education level SLC/+2 graduated. Generally, if we look at their staff, they are SLC/+2 graduates. If they work in health, they recruit people with health backgrounds. We also provide them with trainings given by the governmental level, and we seek their support in the community level. Where there is no qualification to be FCHV, they are guided by a more educated person. These people are in our system as well as in health system. In health posts there are 4 people, but the thing

is whether they focus on health posts more or in community-level health activities. Government has given both roles to them but practically it is not possible. All these people (FCHVs) are seeking supervision from them (health workers). If higher level person is there, then they think they will get extra support from them. Since governmental staffs are not there to help them, and they have only seen more presence of NGO's staff hence in their perspective presence of NGO/INGO staff will be a support for them. As per our understanding, the main reason is that FCHV is always seeking supervision from the higher-level people than them and their confidence level will be boosted. As I have said in the sustainability part, I said it earlier when there is a normally running programme and when introducing new programme female health workers to provide them guidance at the beginning some orientation programme is needed...

I: Sir, your voice has been cut off ... What happened? Your voice is cut off ...

P: Sorry, due to weak internet connection, my voice had been cut off.

I: It's fine sir ... 00:45:07

P: As I was saying earlier, where one programme is already running in the community level and when a new programme starts and if the NGO/INGO (INGO should not intervene directly though) provides technical support in the beginning then it can help maintain its's quality. But it's impossible for NGO/INGO to stay there forever in reality... Government of Nepal or any government requires seeing the effectiveness of the new interventions/programme before allocating the budget. We need help from supporting agencies for piloting new programme. If everything seems successful once they have been implemented, then only government will continue. NGO/INGO also has specific roles in specific sectors not just the government. We need their presence and support. It won't be good if we go parallel with regular programmes as well. But if we consider then we do need NGO/INGO and they have roles too ... after they have supported for certain time ... the best way is to hand over the programme to the government and bring it under routine programme. (00:46:44)

I: Sir, we have seen one conflicting idea as well. Previously, people were excited when we went there and taught things. But today, they expect something from the learning as well.

They ask us what they would get. This is a major concern. Different organization has been launching different programmes and they have been providing facilities/incentives according to their policies. We don't have anything for the participants from the government side. It is not possible as well. We see a gap in between these projects. How can we minimize this?

P: It is a challenging factor for the government programme and staff like us who works for the government most of the time. We need to do piloting thinking that one day it will be owned by the government. If we go accordingly then we can measure whether the piloting is successful or not. What we do here is that ... to do piloting, we take up more resources than we need for small intervention in few places. This will make it look like successful. Once it reaches to the government, we need to follow the rules, regulations, and norms of the government. When we start following that, available resources will get depleted due to this ... our norms and donor's norms do not match up. Similarly, UNICEF, GIZ, USAID and WHO norms does not match with ours either. Everyone has different norms. In this situation it gets challenging for us because when successful piloted programme is owned by the government and continues this arises problem in its survival. The problem is due to nothing else but the allowance. Simply to describe this ... WHO provides field allowance of 2500 rupees to a person while Nepal government gives 1600 rupees only which is DSA. Hence, they prioritize project activities more than that of governmental activities to receive more money.

According to the governmental norms in FCHVs used to get 400 before for running a group meeting and recently it has gone up to 800 since this fiscal year. They get it as travel allowance...It was NRS 400 but when one NGO goes, they provide NRS 1000. They get 1000 of the same amounts of work from NGO but only get NRS 400 from the government. That is why they prefer INGO/NGO either for technical support or for monetary (financial) value. It has been challenging to us, but we have been slowly bringing things in track ... whenever any projects bring new programmes, if it is for piloting or if they want it to be owned by the government then we suggest them to align with the government norms from the beginning. For example, this has led UNICEF to start providing allowance as per governmental norms. USAID totally provides allowance

as per governmental rules. Where we saw problem is government could not take over projects made successful by UNICEF and when government was able to take over the project there was no acceptance due to financial norms. It wouldn't be a big deal if they provide 400-800 as allowance from the beginning. If NGO pay rs.400 same as government then it doesn't make any difference to FCHVs. They will work with motivation, but it is difficult when they receive rs.1000 instead of 400 for the same work. This is challenging and we are facing this internally in our system as well. This has affected the programmes It effects mostly in the transition phase. Recently overtaken projects by the government could face problems for few days. But in reality, all the health workers know that this is the norms of the government, this is the norms of Ministry of finance, and they won't get any more amount than this from governmental projects. For other 10 programmes they received rs.400, and now they get rs.800. They are mentally prepared that before they received rs1000 for projects which is finished and gone and now they will only receive what government provides. But in transition phase for up to 6-8 months, these things will arise in every programme. (00:51:05)

I: Sir, one solution we found is, certain organization has been adopting governmental norms. So, what else? How can we tackle this challenge? This is not from the health worker's perspective. This is from the people's point of view as well. We need to bribe to the people now to make them understand things in meetings. For an example, let me give one sentence from the community which I received. They said, "If you don't give me anything from the meeting that you want me to learn, why should I even come to learn then." It was said by the community people.

P: Yes, we share this in the meeting, and we repeatedly say these reflections to all our donors and partners as well. When they do any programme, invite people from the community or whenever you say they are doing health education programme, they invest more in allowance and food rather than in education. But after they leave, whatever they write in their sustainability plan that programme does not retain its sustainability because government norms cannot provide those. Programme can never go forward like this. If you call them by providing money, government cannot provide that money. We have said this repeatedly that this brings problem ... Just like I said, some organisation has already

come with us, for instance since USAID has adopted this policy, our existing
SUAHAARA project has also started following governmental norms which have also
made it easier. We have big SUAHAARA project in 42 districts. SUAHAARA is a
major nutrition programme. They have been following governmental norms in the
community level. It has become easier. It is a human nature that they expect NGO/INGO
to bring programme which gives high allowance. Most of the time when we send letter
for the programmes, they call us via phone to ask if the programme is associated with
allowance or not... Since things have been damaged from the beginning the number of
participations is also influenced by whether there is an allowance or not. We are on the
path of improving this via dialogue with our partners, we have improved in some places
and its ongoing. But it is still difficult in some places where the government norms
haven't reached. In some places government norms are so less that we also feel that it is
very less. Let me give you a simple example, we run this comprehensive newborn baby
level 2 care training for SNU level. We need to call pediatricians for that who are
government workers. The training is of 6 days. According to governmental norms, we
need to provide 1600 per day. We can add 1000 rupees more for taking classes. So, they
must manage food and lodge from that 2600 rupees. According to pediatricians, they say
they were earning a minimum 10000 in 6 days from their clinics, and they have left
behind daily earning of 60,000 ... They say there isn't any necessity for them to go to
government training. They say instead they won't even take T.O.T. If they take T.O.T
(Training of trainers), they need to go for the training. They will get a total of 2600 per
day from that, and an NGO provides 8000 per day, which is okay for them. They even
say it is fine ... They will go to the trainings as well They would do the trainings.
They are governmental worker, and they will work. But the government should also
consider their financial aspects and see their loss from going one place to another. In
some instances, we have felt that too when using specialized level service ... A 7th level
officer and pediatrician both are getting the same payment. We need to give payments
based on service, but our system pays according to the position of the job. There is no
value of specialization in service from finance point of view in our allowance system. We
have been saying this from the Ministry of Health, but this decision must be made from
the Ministry of Finance, we have not got any support from that. (00:57.23)

526

527 I: So, this is also going to create a barrier in financial point of view.

528 P: Yes, because of this is our obligation when running programme instead of running
529 through governmental norm we have to request donor to run this programme and say
530 them that we don't have trainers and difficulty finding them to conduct the trainings as
531 per our norms. Personally, we understand that when we invite specialist for specialized
532 services, we need to pay according to their specialization in service, but our Nepal
533 governmental system does not allow that. We have been facing these challenges as well
534 and we are trying to address this as per our capacity. Yes, there are gaps which we see it
535 will require addressing in future too. If not sooner but slowly we will ...

536 I: Sir, we are at the end of our interview. Now let me ask you about barriers and facilitators
537 as well. This programme has not been launched yet. We are still thinking about its
538 possibilities only in future. You also said that you are also planning to launch it in
539 addition to a programme. We also talked about bringing new category of health workers.
540 Local governments under federal system, has resources and they can also mobilize it.
541 What could be the barriers for this programme to be successful?

542 P: Okay, there are so many opportunities with us, right? You are trying to either you are
543 bringing programme or let's say ... I am just seeking clarification whether you wanted to
544 know the barriers brought by the government or the barrier brought by the external other
545 than the government, or ...?

546 I: Government's barrier when they bring this programme.

547 P: Government ...

548 I: Sir your voice has been muted ...

549 P: Okay... Budget allocation is the major barrier when launching any new projects. We
550 have no problem in adding new contents in existing programme. But if we make new
551 package, it needs a lot of money because we have to take this from the central to local
552 body. For this ... it is not difficult, but we need a well justified document. This will help
553 us deal with Ministry of Health and Ministry of finance for budget allocation ... we will
554 be able to deal with them ... we will be able to explain them and then the budget will be
555 allocated.... This is the first part. Preparation of the Documentation is the second part,
556 and third part is we need to develop master trainers. The main barrier is "continuity" in

the community level. Like I said, from the beginning we provide incentives from the government and later when there is lack of incentive, we have seen its impact in mother's group meeting as well. Discontinuation of services is one of the major challenges here. We have suffered in many services in absence of monetary/budgeting value is still the major challenge. If I must rank, the challenges faced in the community level is in higher position than higher level services. Continuation of health education programme and community mobilization programme are the most challenging programmes We need to allocate resources before deciding the project. We cannot go beyond norms even if we have more resources, in governmental projects. We cannot go beyond rules and regulations. This leads to the shortage of budget. Now it takes more time when it is supposed to be completed in a year time. We start in first year and reinforce in the next year and goes on ...It takes time to speed up... that programme could be taken much forward with allocation of high resources ... It may take time to establish in the community by going through government norms. This is the major challenge. (1:02:34)

I: Sir, could you elaborate about master training as well? You said that we need to master training, right?

P: We have classified trainings into 3 levels. The training we do in federal level is called master training (MTOT- Master training of trainers) and we make master trainer. There is no big difference in the packages, there is only a day difference. Learning Teaching methodology is different. Like when we are developing master trainer, we teach them how to train trainers and how to take classes. There are contents as well but for one day we focus more on teaching learning methodology for the master trainers. For example, when developing master level in central, from 7 province we can invite group of 3 people from each province, total up to 21 people. Those 21 people are now mater trainer. . . Now in provincial level they can run T. O. T... There are 3 master trainers in a province, and they can invite 2 to 3 people from all the districts and run training ... So now there are trainers in district level. When they give trainings to the health workers in their districts, they get trained, but they do not become a trainer ... This is the level of our approach, and we call them master trainers, trainers and health worker who took the training. (1:04:09)

588 I: How is this a challenging factor then?

589 P: Whenever we start new component, we find it challenging to find trainer who is the right
590 person and responsible. Next challenge is to mobilize the trained trainer once we have
591 provided training. Suppose there are 21 people who completed master trainers only 10-11
592 trainers are left for mobilization. Some gets transferred, some gets out of the system,
593 sometimes the hospital sends them for training and sometimes hospital does not approve
594 the leave of these trainers. They don't allow their movement at all. In this situation we
595 find it challenging. We expect 50% of these trainers to be available and ready out of all
596 we have trained. That is why we develop double the number of the trainers in general
597 practice, then our basic criteria.... If we need 10 people, then we need to train minimum
598 20 people. So that I would have at least 10 people to conduct the trainings. This is the
599 challenge. Suppose I have given training to some people this year and next year they
600 might have been transferred or they might have gone out of the system ... or if they are
601 MBBS they could be gone to study MD after this. They could have taken study leave.
602 Those challenges are in our system. But even if they are in the system, sometimes their
603 organization does not allow their leave for training upon our request. They won't be
604 available for the training. So, the challenges are they could trainer but may not be
605 available for the training when required. (1:06:01)

606

607 I: Sir, you talked about 3 major challenges. Budget allocation, trainers, and continuation of
608 the projects. What can be done to tackle these problems? You said that we lose master
609 trainers, and it is hard to find master trainers. For a solution, you have been training
610 double the number than needed but there is a gap in that too. What can be done to tackle
611 situation like this?

612 P: Sorry, I could not get the question.

613 I: What can be done to tackle problems like budget allocation, trainers, and continuation of
614 projects? For a solution, you have been training double the number than needed but there
615 is a gap in that too. What can be done to tackle situation like this? (1:07:24)

616 P: Budget allocation in central level we need to have well documentation evidence stating
617 this works ... this intervention works ... We need to have this for budget allocation and
618 the process will be easy. Without documentation, budget allocation is going to be

difficult ... If we want to implement some new interventions or new programme, we must have evidence or we must have result report of the piloting programme ... any piloting programme of small districts We need to do piloting first then document and provide first evidence or recent evidence-based documents... Secondly for trainer's part, we calculate the minimum numbers and general numbers of trainer required and provide training to double the minimum numbers in average so that we never have to face the shortage of trainer. If it goes to lower level, we hope that this will not disturb the programme. For community level continuation, we need some reinforcement activities. We need to do some counselling also for the training. We have recently started that. Before this we, when we trained FCHVs or health workers we used to talk only about clinical part/content ... now we have added "why do we need this and what would happen if we discontinued this?" what is your role in this?" Why it is important to continue this service? What is the impact of the discontinuation this project? We do have the content about the importance of this. For example, we have content in Malaria programme. We teach them what's happens in malaria, what they need to do, what do to need to see, learn... We are also teaching them about why this is important and what happens if they don't do this, in national level and how it will impact on community level. We are implementing counselling as a part of this. They will understand the seriousness of the programme after that. We have been developing our packages in a way so that it won't hamper the financial aspect ...

I: Sir, these are the barriers. Now talking about the opportunities, we do have established programmes for nutrition. There are stimulation related programmes, and we can launch in combination with them as well. We also talked about financial resources as well. We have existing FCHV, through which we can reach in the community level as well. We also talked about the governmental aspects and its structures. Can you add anything in opportunities? How can this programme go smoothly to the community level?

P: In my view, in terms of resources or creating any model, we have major opportunities that local government are willing to launch new programmes They already have a lot of budgets, but they have no idea where to allocate it. Municipality's mayor, sub mayor and ward president often they say that we are the people's representatives we don't have

technical knowledge. We know where to construct bridge and roads, electricity ... They have no idea related to education and health ... Building hospital is there but someone should educate us about what kind of programmes is required and where is it required. We get these kinds of demands from many places.... whenever we reach out to them about any programmes and give them directions, they say that we need to teach them first, they say “we are new on this” ... The gap that they have identified in terms of capacity building, and they tell us... due to this reason ... we have one opportunity that... if we are able to convince them, build their capacity then they could help us in reinforcement of our programmes ... because they have the full authority for supervision and implementation. If municipality’s mayor, sub mayor and ward president are convinced then no programme will phase out from the community. This is a big opportunity. We used to have local health officers in community level. Now there is local government too in the local community. If we can convince them, teach them about the importance of this programme and build their capacity, then any programme which has the high chances of discontinuation or disappearing that problem will go away. Local municipality will also allocate sufficient budget for programmes in terms of resources. There will be no problems in resources as well. local government can go beyond the central level government norms and provide financial support and it is legally approved ... Hence, due to the availability of facility and authority for local government to support any programmes by going beyond the norms of the central government ... if our programme is suffering due to financial limitation then there are less chances of this happening...

I: Sir, I wanted to know if any initiatives have been launched from the ministry regarding these opportunities.

P: Every programme has different divisions whichever programme we are responsible for, for example child health programme.... we allocate orientation regarding child health to municipality every year. We are performing orientation to municipality. Since this government is newly formed ...but when we do orientation, we inform municipality about what is child health programme? why is this required? what are the things central government is doing? what is the gap? And what can the local government do to

minimize this? ... Because of this there is additional allocation of budget in various places at local level. For instance, we give 800 as an incentive to FCHVs and in some places they are providing 10,000 to them as monthly salary. They have allocated 5,000 monthly in some places. Like when going for ANC visit, in some places where ... before projects used to do this ... now local municipality as per the availability of resources and affordability they provide essential things like salt (Iodine), eggs, oils, and many more in ANC visits. They provide them after delivery. For children under 5 years old, Government has allocated 400 rupees, some places its allocated and provided NRS 1000. Central government has fixed the minimum allowance rate, but local government can add to that and provide as they per their policy ... that's why when we do orientation or capacity building and advocate for health programme with local government, we have been seeing these things being reflected in their budget planning. All the divisions within Ministry of health ... we have designed our programme and have prepared orientations for municipality level, and this is running currently. (1:15:54)

I: Sir, what we have found from the health directors, health workers, community people are, they are saying that ministry should provide them guidelines. They have been expecting from the ministries. They are saying that because of insufficient knowledge, they could not have been performing well. Do you want to say anything regarding this topic?

P: The thing is, due to the existence of three level of government, as per them they have been focusing more on the budget part than guideline. They are indirectly trying to say that if they receive budget from the provincial level for municipality's orientation, they will do the work. We already have guidelines about every programme, how we are going to run it, its purpose. Every directorate knows how our programme is running, what orientation is there... In provincial level orientation, the health directorate calls people from training center, social development ministry, and everyone from the stakeholder and gives orientation about the national programme. They give orientation regarding child health when there is a child health programme; if vaccination programme is starting, they orientate about vaccination, family planning, and many more. There is different orientation for a different programme. Municipality gets the budget from the municipality level or district health office. If the budget goes to district health office, then the district

health office will run that programme that's why there is the question of nobody informing them at the municipality level and they are unaware. These are the orientation that has been run via district health office or from the municipality level. Municipalities have been doing have been doing provincial level programmes only and various divisions have been doing this... (1:17:59)

I: Okay sir, thank you. We talked about how to launch this programme, what are the opportunities and barriers related to this programme. How can we run this programme more efficiently and how can we involve NGO/INGO to this? What are the new planning methods from the governmental side? You have shared this. Do you have to ask anything to me related to this? Do you want to add anything you feel is left out?

P: I don't think so. We have discussed a lot. We have talked about this in a holistic approach. We do have challenges and opportunities in this in our new system. If we could forget COVID, we were moving forward in health sector too. New interventions have been accepted. We are lagging. So, let's hope this ends soon. We are setting target now, even if we could not launch new programmes, we should not discontinue the old programmes that have been running and is in operation. We want it to hold and give continuity. We have been working on that. Your research will bring a new thing for sure. It will also guide us at policy level. We see thing from our perspective as well. It will show holistic approach from your side. It will guide us too. We wish you all the best.

I: Thank you so much sir. I am going to stop this recording.

End of the Interview
