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## BODHI Project Proposal

**Green Tara Trust, December 2009**

### What effect does a participatory health promotion programme have on perinatal health behaviour in a rural, post civil war Nepal?

**Project Site (including name of village):**

Chhaimale and Dachhinkale VDCs (population 10,000), Kathmandu Valley, Nepal

**Project Title:**

What effect does a participatory health promotion programme have on perinatal health behaviour in a rural, post civil war Nepal?

**Description of the Project and people involved:**

**Need**

Nepal has some of the worst figures in the world for women and children dying in childbirth, lack of contraceptive use and specific vitamin related malnutrition. Maternal and infant mortality are linked to young pregnancies, lack of antenatal care, no trained assistant at delivery and poor post natal follow up. HIV and other sexually transmitted infections are increasing rapidly. 85% of Nepal is rural and these areas have much worse health indicators than urban areas. This is due to poverty and poor access to health facilities:

INDICATOR	RURAL	URBAN	USA
Total fertility rate	4.4	2.1	2.0
Infant Mortal. Rate	79.3	50.1	6.9
Adolesc. with kids (%)	22.5	12.6	None avail
Deliveries with skilled attendant (%)	10.1	51.1	>99
Contraceptive use (%)	33.2	56.3	73

The health system has little money. There are only 5 doctors for 100,000 people (vs 549 in USA). Many health staff in rural areas do not come to work and have no refresher training. Health indicators and sexual violence have been getting worse since the start of the civil war. The only hope for change is a community-led participatory approach to health through Health Promotion. By the time someone is ill there is little or no facility for treatment. The government and community requested this work from us. We hope to show that working in this way can improve the above health indicators. It is a pilot programme which we hope to roll out to other areas in Nepal. Our experience will be use to re-write the government based health curriculum for staff to include a Health Promotion approach. We will do this in conjunction with the Ministry of Health. In this way the whole of Nepal will eventually benefit from our experience.

GTT is now 2 years into this 5 year programme. The baseline survey was completed in Jan 08; 420 questionnaires were completed, covering 98% of all women with children under 2 in both the project and control areas.

## Baseline survey findings

**Antenatal care:** 80% of women had had some form of antenatal check up prior to delivery, and distance to the health facility was a major barrier. In more than 60% of cases, the decision about whether or not to seek antenatal care was made a family member, not the mother.

**Delivery care:** Approximately 40% of women delivered at home, and most were assisted by the mother in law or an untrained local woman. In more remote areas only 10% had a trained assistant at delivery. Long labour, infection and a retained placenta were the main problems women experienced after a home delivery.

**Post natal care:** There was no perceived need by the women for a post natal check unless they suffered a complication, by which time they were very sick and needed emergency care. If they did need to go to hospital, lack of money and family support were the main barriers. Over 90% of women did not use a sterile blade to cut the baby's cord and a quarter put oil on the stump; both these practices can lead to infection of the baby. Sickles, vegetable knives and unsterilized shaving blades were mainly used. Only 20% of women got their baby checked in the first month of life. Infection, fever and acute respiratory illness were the main illnesses experienced by babies.

**Contraception:** 25-30 % of the pregnancies were unplanned and half were ineffectively using contraceptive methods prior to conception.

**HIV:** Knowledge around HIV was poor; it was commonly believed HIV could be spread through mosquitoes or sharing food, and most women did not know where to go to get an HIV test.

**Women's empowerment:** Only 23% of women were members of a voluntary organisation and none held elected posts in the local community. 60% said their health care was decided by their husband, mother in law or other family members.

**Disability:** Approximately 8% felt they had a disability and 10% reported having a disabled family member. Interestingly, all only saw disability as a physical condition (eg having a missing leg); none saw illnesses such as HIV, diabetes, learning difficulties or psychiatric complaints as a disability. 33 % believed disabled people should not be allowed to marry but 80% thought they should be able to sit on committees and go to school.

The programme was thus able to identify by village area:

- The poorest people
- The people with the poorest maternal health and child health under 2
- The people who do not access health facilities
- Disabled people (who are less likely to be able to access health care and more likely to be poor)

## Activities

The project educates mothers, mother in laws and husbands about maternal and child health through group training, a mentoring system, and through providing clean delivery kits and post-natal checks. The project trains local health staff and local volunteers. It guides and supports the community in advocacy, particularly around domestic violence, alcoholism and family mediation. The project also works with government officials and local NGOs to improve health services and re-write the national health education curriculum.

The basis for delivering the programme is through groups; the programme now has over 500 people in 40 groups. Those who cannot/ do not want to access groups get health promotion delivered to them through home visits, antenatal gatherings and mass events.

## Objectives of the Project:

At a local (field) level, 5 outcomes were selected that the community and the Green Tara Trust (GTT) felt were achievable and necessary to improve health and community priorities:

1. All mothers to have improved antenatal care: this consists of 4 antenatal appointments, access to nutritious food, and access to contraception counselling.

2. To increase girls' and women's control over their sexual and reproductive health practices.
3. All new mothers and babies to have a health check up by a qualified health professional within 48 hrs of delivery.
4. To improve breastfeeding practices: to increase the feeding of colostrum (first breast milk) and increase percentage of women exclusively breastfeeding to 4 months.
5. To reduce the rate of diarrhoeal disease and acute respiratory distress in under 1s (the main causes of neonatal and infant mortality).

**Number of people the project will help:**

Direct help through groups, mass events etc approx 10,000 people

Overspill into surrounding community approx 2,000 people

Long term, through national level changes to curriculae and curricular training at a national level (which has already started); cannot estimate, but changes being made to the curriculae now will affect the whole health system.

**How Bodhi money will be used?**

**1. Mass event**

GTT runs 2 mass events per year in the programme area. The aim of this is to deliver health promotion messages through another medium apart from groups, and to attract people who may not otherwise be hearing perinatal health messages. This year GTT held a mass event in antenatal care in which approx 700-1000 people attended. It was held in the most conservative and patriarchal area of the programme and, for the first time, women came out and to attend without the permission of their families. The women from the groups performed songs, plays and gave personal stories of their experiences of antenatal care in their families, within health services, and publicised our programme. It was a turning point for the programme and community around women's rights and confidence to hold their own

**2. Refresher training for Traditional Healers.**

Most women in the field area call on traditional healers prior to medical staff if they have problems in pregnancy and delivery. This is because they are cheap, they are locally available, their mother-in-laws prefer using them to the western approach and they are trusted. However, consulting a traditional healer can cause a delay in accessing timely medical intervention, particularly during delivery and post natal care.

We delivered this training programme for the first time last year with some success. The traditional healers felt proud to be included in the programme, and appreciated being treated as a health worker with their own knowledge. It has been made clear we do not want to take their work away, but they now know how to recognise signs of a problematic delivery, know the referral pathways and have access to a mobile phone (via their local GTT women's group) to call an ambulance. They have been issued with referral forms for them to complete to hand over to the ambulance/ medical staff.

The government produced a good Traditional Healer programme with Save the Children a few years ago, and we have adapted that programme to include perinatal care and the three delays. Since last year's training, THs have started referring people to health workers, GTT staff and hospital. They have become keen advocates and spokespeople of the programme.

**Duration of project:**

**5 years**

**Any other information you consider to be relevant:**

Midterm review coming up in March- April; will be able to give clear indication of programme progress once this is completed.

**How will the project be?**

1. Baseline, midterm and final evaluations
2. Community and GTT monitoring (constant)

**Budget:**

<b>Particulars</b>	<b>Funds requested from BODHI</b>	<b>Other contributions, if applicable</b>	<b>Total, pounds sterling</b>
<b>Mass event</b>	<b>450</b>		<b>450</b>
Tent hire	115		
Costume hire	60		
Music system	60		
Generator hire	30		
Publicity	40		
Refreshments	80		
Prizes	25		
Camera person hire, film editing	40		
<b>Traditional Healer Refresher Training (14 people, 4 days)</b>	<b>350</b>		<b>565</b>
Proportion staff salary	30		
Proportion international staff expenses (travel, food, accommodation)	300	215 Green Tara Trust	
Local travel and van hire	120		
Training materials	50		
Refreshments	30		
Room hire	35		
<b>Total</b>	<b>800</b>	<b>215</b>	<b>1015</b>