Hospital and
Rehabilitation Centre
for Disabled Children

Annual Report 2009

Hospital and Rehabilitation Centre for Disabled Children
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A Program of The Friends of the Disabled (FOD)

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Message from the Chair

Dear Friends

The year 2010 denotes the 25th anniversary of the establishment of our services to needy children with physical disabilities in Nepal. A variety of activities, both symbolic and promotional, will be held throughout the year to mark this momentous milestone.

The challenges to provide quality care on a long term basis, to a diverse group of patients scattered throughout the country, are enormous. Illiteracy, inadequate transport facilities and communication links, coupled with ignorance and poverty, compound the challenges faced by HRDC. In our effort to achieve our targets, the support we receive from our friends, both institutional and individual, takes us far. But the worldwide economic slump and the escalating inflation have made our tasks most daunting. We are constantly seeking cost effective alternatives to continue to provide the best care for our children.

The smiling faces of children and the ever increasing demand for our services spur us all on; to do more and do better. Please continue to help HRDC.

Many thanks and our best wishes for a most successful New Year to all our friends and well wishers, from all of us at HRDC.

Sincerely,

Dr. Ashok Kumar Banskota
Chairman
Friends of the Disabled (FOD)

Background Information

Prevailing Disability and Intervention: Children with physical disabilities in Nepal not only suffer from a lack of comprehensive care and rehabilitation options, they are also socially stigmatized by their disability, pushing them further to the margins of society.

The majority of Nepalese people are still dependent on their own agricultural products as a source of food and income. In most instances, they do not produce enough to support the household throughout the year. Therefore many are compelled to seek employment in urban areas or in India or other neighbouring countries. When a family is struggling to simply exist and demanding every member's productive contribution, people with disabilities are left out. In addition, the traditional Nepalese community has neither the awareness of, nor the resources to implement non-traditional economic activities to offer the person with disability productive work.

In order to survive, many families need their children to work. A child marginalised by disability is often the first to be taken from school and put to, usually underpaid, menial work. A lack of education has a serious impact in the quality of life of the child and repercussions last well into their future. Lacking academic and social skills, an education would have provided, affects their self-esteem, opportunities for marriage and integration into their community as adults.

The prevalence of disabilities in Nepal is closely linked to poverty. Malnutrition, poor hygiene and sanitation facilities, and inadequate and poor quality health information and services all cause or aggravate disabilities. Medical professionals are still in low numbers in Nepal and usually prefer to work in urban areas. Health posts and medical centers in rural areas are often understaffed and do not have sufficient medications available. The commitment of the government to provide free medication through local health institutions has faced a number of problems in its implementation.

In addition to HRDC, there are several other hospitals in the country providing orthopaedic services. However most are limited in what they can offer, so often refer patients to HRDC for more specialised orthopaedic interventions. HRDC is the only institution with the capacity and range of comprehensive services catering to children. Often patients come to HRDC with very little or no resources at hand – having already fruitlessly spent money on treatment in other medical facilities.

HRDC – A BRIEF INTRODUCTION

In 1985, Terres des Hommes (TdH), a Swiss non-governmental organization, established the Hospital and Rehabilitation Program. In 1992, the program with its new name, Hospital and rehabilitation Centre for Disabiled Children (HRDC) came under control of the Nepalese NGO, Friends of the Disabled. At that time services were offered in a small clinic in Lalitpur, a district in the Kathmandu Valley. Five years later, in October 1997, HRDC moved to its current location in Adhikari Gaon, in the Village Development Committee of Ugratara, Kavre District, 25 kilometres east of Kathmandu.

The complex is built on a small promontory, south of the Arniko Highway, overlooking a lush green valley to the south and the busy Banepa Valley to the northeast. It is connected to the highway by a pitched road of approximately 1.2 kilometres. HRDC comprises of wards with 72 beds and medical, surgical and rehabilitation services, built around two court yards.

HRDC is FOD's only program and provides a nationwide network of family based follow-up and aftercare, reaching out to children with physical disabilities through the popularly accepted approach of community-based rehabilitation (CBR).

OBJECTIVES and STRATEGIES FOR 2009

Targets, in line with a logical framework established by the hospital, were to assess 1,500 new and 6000 follow up patients during the year, collectively set rehabilitation goals for every patient; and develop and execute the following activities relevant to achieve the objective:

1. Prepare, execute surgery and provide post surgical care for 1,145 patients requiring major surgical interventions,.
2. Take measurements to fabricate, distribute and evaluate usefulness of more than 2,600 orthopaedic assistive devices for more than 1,800 children.
3. Thoroughly assess 2,050 patients, set goals for their functional mobility, organize and implement activities to achieve the goals, and evaluate the impact of such activities.
4. Through the CBR Department,
   a. Monitor rehabilitation of 5,000 patients through home visits and 3,000 through outreach mobile camps. Assist the clients in achieving optimal functional independence in daily living through various activities and enable them to participate in social events to their full potential.
   b. Screen a total of 6,000 students in different schools for spine problems and refractive errors.
   c. Establish and regularize local partnerships for paediatric disability management.
5. Plan and execute education and training activities for clients and staff on how to enable the clients to reach a functional physical independence.
6. Mobilize resources so that adequate funds are made available to meet HRDC's objectives.
7. Implement administrative and managerial policies approved by the Executive Board of the Friends of the Disabled.

HRDC's Vision:

To creating a society in which individuals (especially, children) with disabilities and their guardians live as equal citizens with an optimum quality of life, independence and participation.

HRDC's Mission:

Provide comprehensive, quality medical care and rehabilitation services to children with participation restriction due to physical challenges, and assist them with integration into society.

Goals:

The core goal of HRDC is the treatment and comprehensive rehabilitation of children with physical disabilities. To achieve this, HRDC has been efficiently introducing itself in the roles of educator, researcher and advocate for physically challenged children, to protect their rights and rehabilitate them with the following strategic goals:

Continue to maintain HRDC as the leading resource and referral centre in disability management by:

- Increasing access by further decentralization of treatment and rehabilitation services to different strategic locations in the country
- Increasing participation of children with disabilities in community activities
- Strengthening HRDC as a training and resource centre in rehabilitation therapy
- Mobilizing resources for HRDC activities

We intend to improve the current status of treatment and rehabilitation for children with disabilities so they can demonstrate functional independence at least in daily activities.

Strategic Plan:

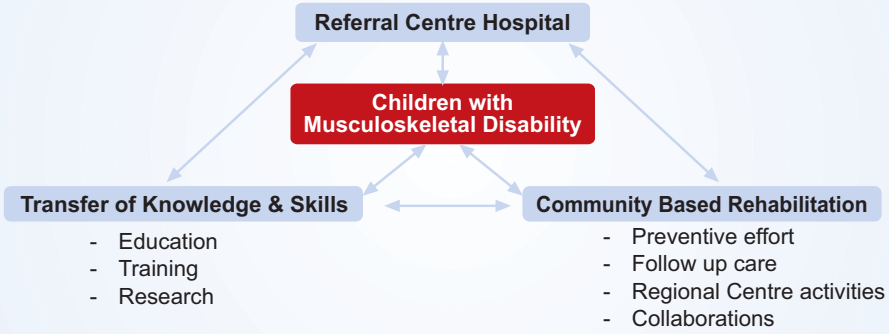


Photo Feature

Students Celebrating Teacher's Day at Dr. Banskota's Residence

Eileen Moncoeur (AHF) at HRDC

Dr. Banskota with AHF Officials Ms. Erica and Mr. Richard

Dr. Banskota, Dr. Mallya (External Examiner), Dr. Rajbhandari (External Examiner) and Dr. Pandey at the final examinations with the graduating residents.

Dr. AKB with HRDC's first physiotherapy (1985-87) Dawny Lagriet.

A young boy from Bhutan who had no limbs

This is the story of a 12 year old boy, Master Suk Raj, who comes all the way from Geserling Gewok, a small village in Dagana district of southwest Bhutan.

He was born with severe Amelia, a congenital condition in which only vestiges of the limbs are present. Abandoned by his parents, he was later adopted by a kind family running a small shop.

His (foster) parents come from a low socio-economic background and rely completely on the income of the shop for survival. As his condition is a very rare occurrence, his father says there is so much curiosity regarding him, it is almost a national issue!

For years, Suk Raj's fate was deemed to be doomed until one year a Dutch engineer happened to visit Bhutan on a project. She was heartfelt by the enthusiastic boy who was short for his age, and had no limbs ,but still managed to go to school together with his siblings. Deciding to help him, she made a documentary film and sent the video our way, inquiring if we could help him.

Unfortunately, Suk Raj's condition has no radical surgical cure. The only thing we could do for him was to provide prosthesis. However, as all of his four limbs were affected, it was a challenge for us to make him walk using the prosthesis. He underwent minor surgery for stump revision before the prosthesis could be fitted and our prosthetic team designed and produced custom prostheses for him. Given the experience and expertise of the HRDC prosthetic team, the hardest part was not making the prostheses; it was to rehabilitate and train him to walk using them!

The first few days were a real hardship for Suk Raj; he had been ambulating in his own way with his remnant limbs and now was being trained to walk upright. The ever-determined Suk Raj amazed us by, within a few weeks, walking upright holding a crutch with a small upper limb stump. We could see the joy in his face when he finally could talk to his friend face-to-face, walking side by side.

His father now helps other needy children to show the way to HRDC. Little wonder we feel delighted when he rings us at HRDC sometimes just to say hello.

Achievements of the year 2009

A total of 12,990 cases with various musculoskeletal problems were treated in 2009. There were 3,360 new registrations with the remainder being follow-up cases. This year, 2,655 children completed treatment and rehabilitation, and their files were closed.

The out-patient clinics are run three days a week on Monday, Thursday and Friday, with Tuesday and Wednesday being operating theatre days.

A total of 1,122 children were admitted to the hospital for surgical or rehabilitative purposes. There were 1,392 surgical interventions performed during the year, of which 809 were major and 583 minor. The average bed occupancy was 85%.

The physiotherapy department is one of the busiest at HRDC, providing services seven days a week with a limited number of staff. They not only provide services in the hospital, but also at the community level during field camps. Of a total of 5,129 children treated at the department, 1,911 were new registration. These children received a total of 41,635 sessions, meaning on average each child required eight physiotherapy sessions.

Clubfoot deformity is one of the most common congenital problems presented at HRDC. In 2009, there were 1,163 children with this deformity, all under one year of age. There were 317 new registrations of clubfoot patients. In total they received 15,580 physiotherapy sessions / therapy treatment cycles.

The orthotic and prosthetic workshop, staffed by our owned trained employees, fabricates cost effective assistive devices from locally available materials. In 2009, a total of 2,970 devices were manufactured for 1,787 children. These devices included long and short leg callipers, protective and functional splints for upper and lower limbs, spinal orthotic and lower limb prosthesis. The department is capable of producing quality product on par with any available commercially. From 2009, the department has been actively participating in fundraising by availing some ot its products against contribution of full cost.

CBR services:

a. In 11 rounds of mobile camps, 1,835 children (of which 864 were girls) were assessed identifying of 994 children with physical disabilities (406 girls).

b. 5,879 cases (2209 girls) were served through home visits. This included a first home visit to 4,068 children (1,531 girls).

c. Awareness activities included 7,521 people (3,761 females) from groups such as teachers, students, representatives of community organizations and other stakeholders.

d. In addition to surgery done at the Hospiital in Banepa, a total of 54 children with physical disabilities received successful corrective surgery through two surgical camps.

e. When the Ponseti technique of clubfoot management was taught to 2 persons one each for the east and mid-west regional office, they successfully applied the technique to a total of additional 48 children with clubfoot.

Impact Trends of clients through HRDC / FOD 2008-2010:

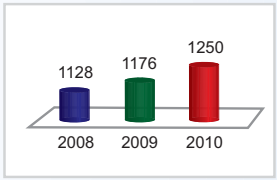
The main result expected was the improvement of the current status of treatment and rehabilitation of children with disabilities by effective mobilization of resources:

Objective 1:

To increase access by further decentralization of treatment and rehabilitation services to different strategic locations in the country.

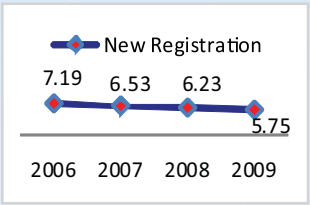
Result 1: Increased number of hospital admissions

Admissions of patients increased by 5.45% in 2009 compared to 2008, as the bar diagram at the right illustrates. Admission of 1,250 children with physical disabilties is the target set for 2010, a 6.3 % increase over 2009.



Result 2: Increased early identification of CWDs

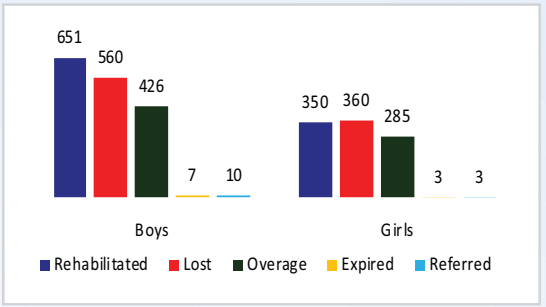
· These days children with physical disabilities are being identified earlier than in the past. The progressive decrease in average age at registration from 2006 to 2009 is visible in the diagram at the right.



Result 3: Improved mobility with correction of deformities

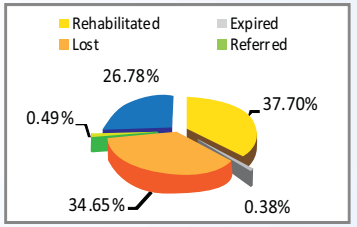
· A total of 2,655 cases were closed in 2009. Some of the reasons and their distribution are as displayed in the bar diagram at the right and the pie chart below:

· A total of 1,001 (37.7% of the total patients whose files were closed) became ADL independent



Result 4: CWDs are successfully rehabilitated in their respective family and society:

· 738 patients among 1,001 patients who improved mobility have been rehabilitated.



Result 5: Availability of treatment and rehabilitation services at the local level

- Two surgical camps were organized using, in part, professionals from the local level. A total of 54 children were operated on successfully in the camps.
- An International Ponseti conference was conducted at HRDC in January 2009 enabling additional medical professionals to use the technique on children, younger than three years of age, with clubfoot deformities and disabilities. A series of Ponseti trainings were organized in 2009, utilizing local expertise from BPKIHS, Dharan; Neuro Hospital, Biratnagar and Western Regional Orthopedic Hospital, Nepalganj for corrective surgery and follow-up.

Objective 2:

Increase in participation of CWDs in community activities

- Data on CWDs' involvement in child clubs is not available
- Among 2,655 patients who completed treatment and rehabilitation:
  - School attendance among school age children is 81.69%.
  - 6 patients of age 16 – 18 years are receiving different vocational training (sewing, knitting and computer sjills) with links established by our field staff

Result 1: Pro-CWD policies are made at local institutions

- HRDC's Executive Director was involved in the formulation of district plan and policies of persons with disabilities in the coordination of National Federation of Disabled - Nepal.
- In HRDC covered districts, CBR staff have been representing in local networks or coordination groups involved in disability management and have been advocating for appropriate local policies.
- Executive Director of HRDC / FOD was part of the lobbing group for ratification of Convention on the Rights of the Persons with Disabilities by the country and this was done in December 27, 2009.

Objective 3:

Strengthen HRDC as a training and resource centre in rehabilitation therapy

- Twenty four trainees successfully completed Primary Rehabilitation Therapy training conducted by HRDC in 2009. Also eight people from previous batches of PRT completed refresher training.
- Four people in the leather business were trained in the repair and maintenance of Ortho-shoes
- A diploma course on CBR for staff was not initiated yet due to a shortage of funds
- Physiotherapy staff attended the conference on clubfoot management

Result 1: Quality resources are available

- Forty eight volunteers from different countries came to HRDC either for pre-career exposure or for elective study.
- Five groups of students from nursing colleges visited HRDC to observe its systems
- Forty eight medical professionals from Nepal as well as India received training in the Ponseti method

Objective 4:

Mobilize resources for HRDC activities

- In 2009, the total income was NPR 68.15 million (unaudited) compared to NPR 50.44 million (with 8.6 million Rs booked in 2007 for 2008) in 2008. Two years' total was 118.69 million rupees. Projected income in 2010 is NPR.61,498,425.00. We may be close to the target of mobilizing 200 million rupees for a period of three years.
- Need to focus on further resource mobilization.

Result 1: HRDC's core activities are smoothly running

- In "Out of the Hospital" category, 32% was allocated in projected expenditure but 27.77% was spent. (Out of Hospital Category includes CBR, Regional Offices, Training and 30% of Administrative and Finance departments of total Expenditure)

Result 2: Resources shared with the partners

- Piloting of the first lot of organized partnerships with three local DPOs was completed in 2008. The partnerships requiring monetary support were dropped for lack of funds. We are still in contact and collaboration with 316 NGOs, DPOs, CBOs and other stakeholders in the country.
- Students from more than six nursing colleges and several schools visited HRDC for observing service delivery and management.
- HRDC is the second largest clubfoot management centre in the World. The International Ponseti Organization has recognized HRDC as a training centre for the Ponseti method. In 2009, medical professionals, physiotherapists and other stakeholders were trained in the Ponseti technique of clubfoot management and such trainings are run every year on an on-going basis
- Ortho shoe making training is regularly given to local leather entrepreneurs so that services are available at the local level. In 2009, four locals were trained.
- Primary rehabilitation therapy for 24 new participants and refresher training for eight participants from previous batches were completed in 2009.

Summary of targets, quantitative indicators & achievement

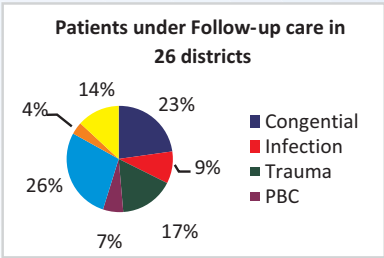
	Projected Data / Targets	2009	
SN	Headings	Target	Achievement
1	**Medical Consultation**		
	New Patients at the Hospital	1500	1651
	Follow up at the Hospital	6000	6239
	Sub-total: Medical Consultation	7500	7890
2	**In-Patients Services**		
	Admission	1145	1122
	Major Surgery	930	804
	Minor Surgery	840	590
	Sub-total: Surgery	1770	1394
3	**Community Based Rehabilitation**		
	Social Consultation / Follow-up (Home Visit)	5000	4068
	General / Orthopaedic Camp	3000	1835
	New Patients	800	994
	Follow up	2200	841
	Counselling at the Hospital	3000	1852
	Assessment in Early Identification Camp	6000	1579
	Disability Orientation	6000	7521
4	**Fabrication of Orthoses – Prostheses**	**2600**	**2970**
	Beneficiaries	1800	1787
5	**Physiotherapy Assessment**	**2100**	**1911**
	Clubfoot Management through the Ponseti method	450	1113
6	**Treatment Complete / ADL Independent**	**500**	**2655**
7	**Training and Education**		
	MS Orthopaedic Surgery / KUTH	3	3
	Primary Rehabilitation Therapy Training	24	24

Summary:

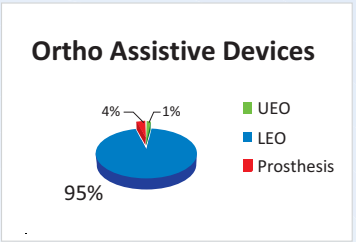
	New Patients			Follow Up			Total	Total	Grand
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Mobile Camp	588	406	994	531	310	841	1119	716	1835
Regional Office	420	295	715	1133	1417	2550	1553	1712	3265
Hospital	990	661	1651	3743	2496	6239	4733	3157	7890
Total	1998	1362	3360	5407	4223	9630	7405	5585	12990

Discussion on Quantitative Analysis

- A total of 12,990 cases (including 5,585 girls) were provided with services from the hospital's OPD, regional offices, communication and rehabilitation centres, mobile camps and home visits.
- Total new patients were 3,360 and the rest were follow-up.
- Follow-ups at the hospital without appointments were higher (3,178 with 1,286 girls) than with appointment (3,114 with 1,206 girls) by 2%. This trend was seen in girls and not in boys. Of the total, the drop-out rate for girls was higher by 0.2%. Though the number may seem insignificant, it is still important as girls' inflow for treatment is lower (38.8% of the total) compared to boys.
- The higher percentage of inflow (51.37% of total 6,403 with appointments) in follow-up without appointment shows that we, the services providers, should remain flexible and the services cannot be very structured. This may have to do with a larger pool of clients still under follow-up care in the country.
- As of December 2009, 765 clients (334 girls) are lined up already for admission in 2010
- In 2009, there were 6,826 patients in 26 districts (CBR districts) under regular follow-up care. Categories of problems and clients' distribution is as shown in the pie chart at the right. (PBC=Post Burn Contracture)



- A total of 2,655 files of patients (1,002 girls) were closed on grounds of completion of rehabilitation, overage, no-show for five years, some deaths and referrals.
- Mean age of clients at registration and admission was 5.75 years and 8.01 respectively. Mean age has gone down showing and increase in early registration and intervention.
- A total of 1,392 surgical procedures were successfully carried out in 102 operation theatre days. There were 809 major cases. The rest were minor.
- Bed occupancy remained at 86%, and 90% of the children's guardians stayed with them during hospitalization. This opened up opportunities for teaching them so that some rehabilitation activities could be continued at their home.
- The Physiotherapy Department assessed 5,129 cases of which 1,912 (705 girls) were new. A total of 41,635 physiotherapy treatment cycles were performed. A total of 317 new clubfoot children (80 girls) under one year of age received conservative intervention. (The data is already included in the total above)
- A total of 2,970 orthopaedic assistive devices were fabricated of which 2,767 were given to 1,787 needy children with physical disabilities. There was a repair flow of 417 in 2009. Other mobility devices distributed were 217 crutches, 36 walkers and 261 splints. The diagram at the right shows types of appliances: UEO stands for Upper Extremeity Orthoses and LEO lower Extremeity Orthoses.



Departments

1. Medical Services:

a. Medical Support Services (MSS): This department is responsible for assessment and diagnostic services at the centre and in the field, which help to develop short and long term intervention goals in consultation with the patients themselves and their guardians. The department is also responsible for executing the treatment and rehabilitation plans. MSS is made up of the following sections:

i. Out-Patient Department (OPD): The OPD consists of one full-time medical in-charge, one full time orthopaedic surgeon, two full-time house-officers, two part-time orthopaedic surgeons and several visiting orthopaedic consultants. The department is involved in screening of children with physical disabilities and co-ordinates with other departments for rehabilitation interventions. Additionally the department provides consultation and counselling to clientele and on an out-patient basis, so that the clientele can make decisions on further interventions.

ii. X-ray: This section is responsible for radiographic services assisting medical team in diagnosing patients' problems. The department consists of two personnel. In 2009, 5,660 x-ray plates of different sizes were used for 3,597 children (of which 1,460 were girls) to assist in diagnosis and intervention. Among these 637 were inpatients (113 new and 47 girls) and 2,960 outpatients (1,210 new with 467 being girls).

iii. Laboratory: This section is responsible for laboratory examinations assisting medical teams to diagnose patients' problems. The department consists of two personnel. In 2009, 3,210 children received laboratory services in which 196 children were identified with worms / bacteria / cysts, etc. Of the tests, the three highest were routine blood, urine and stool. Blood cross match was performed for 363 children.

b. In-Patient Department (IPD): The IPD service is responsible for total care of those who are admitted to the centre; preparing them for surgery, and follow-through all post operative and rehabilitation procedures. The department includes two major sections; ward/nursing and surgical service and consists of twenty-nine personnel having different responsibilities from admission, preparation for surgeries, and providing compassionate care.

2. Physiotherapy:

Physiotherapy plays a vital role for pre and post operative intervention and for rehabilitation in general. Though the situation is slowly improving, trained physiotherapists are still very scarce in the country. Another problem is that physiotherapy services are not provided in the district hospital system. Government certified physiotherapy training was terminated several years ago, but was reinstated by Dhulikhel Medical which has been stopped now for upgrading it to bachelor level. It will take years for the institution to train enough workforce to address the demand. Due to resource shortage, local NGOs working in the rehabilitation of people with physical challenges have not been able to hire qualified physiotherapists. Additionally there is heavy talent drain out of the country as the scarcity is global.

For the past several years, HRDC has been running three month long training programs to provide basic level staff who can assist physiotherapists to carry out simple primary rehabilitation therapies in a rural environment. To some extent, and in a cost-effective manner, this has helped address the need.

3. Orthopaedic Assistive Devices:

There are several workshops for the production and fabrication of orthopaedic appliances in the country but the prosthetics and orthotics workshop at HRDC fabricates and provides the largest range of appliances custom made for children with physical disabilities. The department provided training to local organizations and individuals (local cobblers included) to transfer skills of production and repair of assistive devices.

Access to rehabilitation services in the country is still very restricted, particularly for children outside the catchment areas of organisations. Therefore HRDC has expanded its activities to three regional offices and to as many districts as possible outside the area covered by CBR and the regional offices.

4. CBR Department:

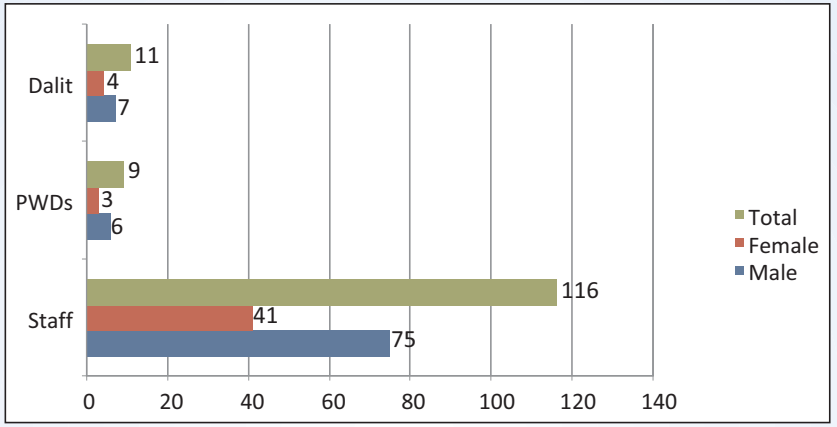
The community based rehabilitation (CBR) department plays an important role in achieving HRDC and FOD's goals and objectives. The CBR department performs a systematic follow-up of children with disabilities after their initial treatment to the completion of their rehabilitation. The CBR department disseminates information and conducts disability prevention and education activities to raise awareness in the community to support rehabilitation and the inclusion and rights of people with disabilities. It organizes screening and surgical mobile camps in partnership and collaboration with government and non-government organizations. It also involves families of children with disabilities and DPOs, for networking and coordination, so that duplication can be reduced. In a CBR approach particularly, it is said, rehabilitation is less effective without involvement of the family and the community, so partnership collaboration and networking are important for successful rehabilitation.

Regional offices: Under close support and monitoring of the CBR department three regional offices in Itahari, Baglung and Nepalgunj conduct activities to extend access of HRDC services for people with disabilities from disadvantaged and marginalized communities.

5. General Administration

The function of general administration is to ensure quality service for clients through all departments of HRDC. Administration includes: 1. Personnel Administration and Security, 2. Maintenance and Transport Management, 3. Smooth delivery of domestic services including cleanliness of the premises and catering and 4. A Medical Record Section which maintains data of the clientele.

One hundred and thirty six staff were working at HRDC as of the 31st of December with 88 males including six PWDs and seven Dalits, and 48 females including three PWDs and four dalits. The bar diagram below represents the figures presented above.

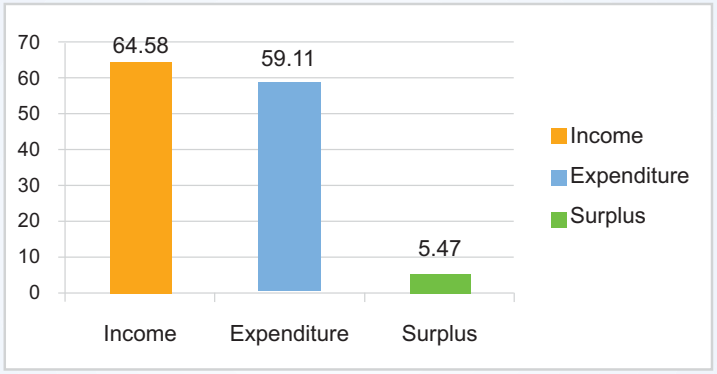


Resource Mobilization: Finances and Marketing

This department receives revenues, records expenditures in standard and acceptable accounting principles. The department consists of procurement management, stock and store management and accounting and book keeping.

With the support of the major donors complimented by other support groups (individuals and institutions), HRDC has been able to muster the funds required to run its program at the centre and in the periphery. The peripheral outreach program generates a new backlog of work which requires additional funds. The departments of finances and marketing are at work continuously to find additional revenues and new collaborations.

The chart below is the diagrammatic presentation of the income and expenditure of 2009 expressed in million rupees:



Resource Mobilization Strategy:

With a few years of experience in marketing for non-profit under the guidance of a professional marketing company, HRDC/FOD has shifted its approach from a key staff initiation to group mobilization for raising funds and the mobilization of resources:

1. Marketing for non-profit organization like FOD/HRDC is a collective effort among the key duty bearers and stakeholders. A team has been formed to constantly pursue resource mobilization. The marketable strengths of HRDC/FOD shall be identified and exploited where and when feasible.
2. A cost recovery system was introduced in April 1998. As the rates of participation in cost issues for different rehabilitation activities on behalf of the clientele was 12 years old, new rates of participation were introduced in 2009, coming into full effect from 2010. We would like to communicate to the reader of this Annual Report that FOD/HRDC are still charitable organizations and seeking increased participation in rehabilitation costs from the clientele is intended to remind the stakeholders (beneficiaries) of their own the investment towards the rehabilitation of their child.
3. For every rehabilitation activity of the field we shall make an effort to mobilize as much local resource as possible.
4. Any new or expansion in the program shall be accepted only with a guarantee of full comprehensive cost coverage associated with the change.
5. The sentiment expressed through “A penny saved is a penny earned!” shall be strictly adhered to in the approach of a sustainable future but thinking beyond this is equally important as a “non-profit” normally liquidates its earnings with investment in services for needy clientele. So for HRDC/FOD an appropriate approach in resource mobilization is taking direction with a sensitive balance between these concepts.

How you can help

			Equivalent US $
1	Cost of an early identification (for scoliosis for example) screening camp for 800-1000 students in a nearby school	Rs. 10,000.00	$138.88
2	Fabrication and fitting of ten low cost orthoses for ten children	Rs. 21,250.00	$295.14
3	Comprehensive physiotherapy for ten children for a week at HRDC	Rs. 22,000.00	$305.55
4	Fabrication and fitting of ten low cost prostheses for ten children	Rs. 34,450.00	$478.47
5	Cost of one patient's rehabilitation for the whole year including follow-up	Rs. 55,000.00	$763.88
6	Management of ten clubfoot children below 4 years of age, through the Ponseti technique	Rs. 220,000.00	$3,055.55
7	Cost of one health and rehabilitation camp of a one week duration in a remote district of Nepal	Rs. 350,000.00	$4,861.11
8	Cost of one surgical camp (with reconstructive surgery of 16 children) in a region	Rs. 480,000.00	$6,666.66

A small boy with a rare tumour

Pre Operative X-ray

3 month Post Operative X-ray

Each child deserves to have his or her share of joyful experiences in childhood. Why should they be deprived of this right simply because of a physical disability? Should we not consider helping such children to make their lives more pleasant and worthwhile with whatever means that lie within our capacity? We at HRDC share this sentiment and constantly endeavour to remind ourselves why we do what we do.

Dimple lives with his parents in Pokhara. His father struggles to earn any little amount of money that he can to provide for his family. His mother is a housewife. Since a young boy of four, Dimple suffered from constant pain in his right leg. After visiting several local healers and hospitals, he arrived at HRDC for evaluation. After arriving at HRDC, Dimple's parents finally felt at ease with the understanding they had found a hospital where they could have their son treated without impassable financial hurdles.

After evaluation by our experts, Dimple was found to have an affliction of his right hip - a rare condition called 'dysplasia epiphysealis hemimelica' which is a bony outgrowth affecting the growth centers of children. Even rarer was the fact that this had lead to dislocation of his right hip which significantly hampered his ambulation. Left untreated this would lead to considerable morbidity and disability as he grew into an adult and the family was counselled for surgical treatment along these lines. With an intensive surgical treatment, the tumour was successfully removed and the affected side of the hip was relocated back to its normal position. After a period of immobilization in a special plaster cast (a hip spica), Dimple is now able to walk on the affected leg without any pain, and soon hopes to join his peers in the outdoor activities that he could only sit and watch before.

Challenges Positively Resolved in 2009

1. For quite some time, the line management system was disturbed due to inadequate number of members in the Executive Management Team. Because of this, supportive supervision and communication were not adequately taking place. The Team was completed only towards the middle of 2009.

   How it was handled:

   a. Informal consultation among senior staff members and Chairman, Dr. Banskota for serious issues helped to take operating decisions.
   b. Dr. Banskota created a flow chart with the Medical Registrar taking the role of the EMT member which did not function as expected.
   c. Frequent meeting of heads of departments also helped to take operating timely decisions.

2. Amidst political chaos prevalent in the country and bandhas (strikes) affecting the movement of clientele and their ability to reach services, maintaining costs was next to impossible as patients' influx fluctuated forcing us to accommodate them for longer periods at the hospital thereby spending additional resources.

   How it was handled:

   a. A flexible approach was taken, giving priority to safety of the clientele
   b. Compulsive utilization of the contingency fund

3. Deficit Management: Triggered by a huge deficit in 2008 and a projected deficit in 2009 due to inflation, HRDC and FOD management were under a lot of pressure due to concerns over the ability to continue to provide, in the long term, the treatment and rehabilitation services of HRDC. We were therefore compelled to compromise and take measures to turn the situation around.

   How it was handled:

   a. Not filling certain vacant positions including Training Coordinator, Marketing Manager, Physiotherapy Technician, CBR Facilitator, Inpatient Coordinator.
   b. The revision of cost recovery with appeal of more participation from the stakeholders who could afford to contribute.
   c. Utilization of the reserve to earn more as project for services sustainability
   d. Releasing certain orthopedic products in the local market with full contribution against cost price.

4. Water Problems: There was a survey done during construction planning by water engineers on the flow of water from a spring source in the forest above the HRDC Complex. The survey finding mentioned that the water available from the source would address HRDC needs plus population growth for the following 10 years. This is what exactly happened. We are in the 13th year at the current location and for the last two to three years, we have had difficulty to meeting HRDC's water requirements and the problem has been aggravated by the long draught and unusual patterns and a decrease in volume of the monsoon rains.

   How it was handled:

   a. Decision was made to purchase water to suppliment the current need and availability. Then arrangements were made with water suppliers to provide water at a competitive price.

   b. Since the duration of us buying water is getting longer every year and the cost of water supply is increasing, rationing water use and seeking a permanent solution is inevitable.

   c. A team consisting of Er. Board Executive, Maintenance and Transport Coordinator and HRDC Administrator has been formed to look into feasible solutions.

5. Early identification of Scoliosis: Not enough cases were identified by early identification camps. We did not find it justifiable in light of the investment.

   How it was handled:

   a. For cost reasons, school screening program targeted to scoliosis identification was merged into general field work from since 2009.

   b. Given the fact there is global economic down turn and donors partners are on the verge of saturation, and finding money for expensive surgery has been difficult, we have compromised by catering to a less number of scoliosis cases. Also efforts has been made for a higher participation from those families who can afford it.

6. The Refractive Error Correcting Unit, established two years ago as a pilot project to address identification of refractive error from school screenings and the early identification program for scoliosis identification was dropped.

How it was handled:

a. There was a resource constraint in handling programs not central to our core approach of functional independence for children with physical disabilities, so we dropped the unit.

b. As there was change in approach for identification of scoliosis cases by merging it with general camps, we thought it would be simpler to stop the Unit from 2009 and refer the identified cases to other organizations handling the rehabilitation of low vision problems or refractive cases.

7. Sustainability and Long term Plans: We appreciate the contribution from our current partners and for their unflinching support to HRDC and FOD. Without this support, HRDC would not be at this level today. However increasing resource demand created due to general price increases, prices on everyday commodity items being used at HRDC, decreased purchasing power of clients due to general poverty, and increasing disparity in affordability among clients, have raised a question on long term planning of services to clients. Almost all partners would like to have a yearly review of the resource availability and support accordingly. It is quite natural for anybody to look into own pocket before jumping into a commitment and offer support accordingly. This has compelled us to think in short term and HRDC's business planning beyond one year has almost become only a long shot.

   How it was handled:

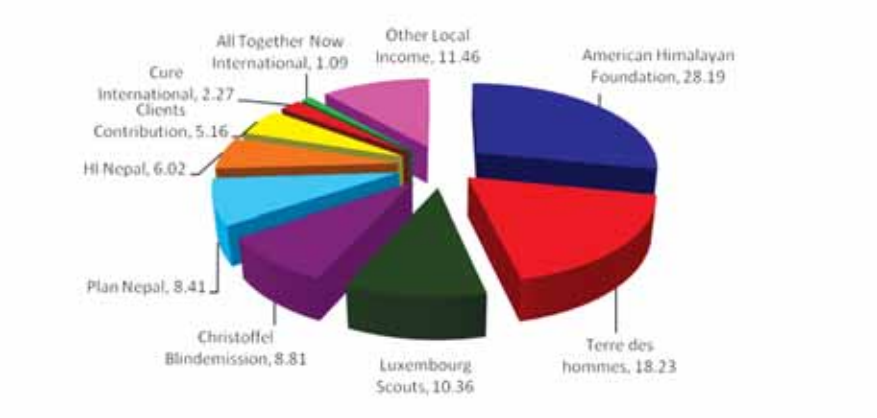
   a. Adapt a flexible approach to planning

   b. Deal with situations as they come

Contribution from different partners and income from various sources in 2009:

HRDC / FOD are very thankful to all partners for their invaluable contribution which has taken HRDC to the height it is now. Friends! A humble salute to all of you!

Financial transactions in 2009 were favorable with a total collection of 68.15 million Rupees and a saving of 6.4 millions as per to the accounts. The contribution is presented below as a percentage:



Donation of Land:

Regional Office East (ROE) In-Charge, Hari Tamang, was able to convince the property dealers Mr. Uddhav Kumar Rai and Mr. Man Bahadur Rasaili to donate 8 kathas and 3 dhurs of land to HRDC / FOD at Akamba V.D.C., Sunsari, on the 13th of May 2009 for construction of rehabilitation centre. The HRDC / FOD Management is very thankful to Mr. Rai and Mr Rasaili for being part of the mission to create positive impact in quality of lives of children with physical disabilities.

In the picture at the right are Mr. Rai (the 3rd from left – standing) and Mr. Rasaili (the 5th from the left – standing) just before the official and legal paper work for donating land to HRDC / FOD. Others in the picture include local active women and other groups, SOS Director, ROE In-Charge Hari Tamang and HRDC Team members: Nitra Deuja, CBR Coordinator and Krishna P. Bhattarai, Executive Director. The land is 2-3 Km west from the rapidly growing town of Itahari and 2 Km south of the East-West Highway. The group is posing for picture at the entry point to the Land.

Other Donors of 2009

Mr. Uddhab Kumar Rai & Man Bdr. B.K (see below)	M/S S & P Intdustries
M/S B&B Hospital for Data Management	M/S Manandhar Eletrical
M/S G.R. Drinks	Dr. Steven Eisen, USA
M/S Dhulikhel Lodge Resort	Mr.& Mrs. Ranzo Bertolini
Devotees, Paramahansa Yogananda Sadhana Bhawan, Kupondol	Mr. Niraj Hamal
M/S Zen Travel & Tour Pvt. Ltd	Ms. Mayaki
Mr. Suk Raj Sherpa C/O T. B. Gurung	M/S United Nation Human Rights staffs
Mr. Hari Kumar Tamang	Mr. Ali Hussain
M/S Kisan Printing Press	M/S Capital Enterprises
Ms. Rajani Joshi, USA	M/S Bank of Kathmandu
Mr. Dinesh Khanal	M/S Rotary Clubs of Dhulikhel and Banepa

THE STORY OF ORGANIZING A MOBILE CAMP IN DOLPA

Dolpa, the Karnalu Zone in northwest Nepal is one of the most remote districts in the country. Dolpa has neither easy road access nor good airline services and has neither fertile land nor cultivable valleys. A total of 23 Village Development Committees with 29,545 marginalized populations dwell in such a very difficult location (Census, 2001).

The camp team at the airport

The Population Census 2001 has under reported the prevalence of disability in the region. Until 2008, only eight children with a physical disability from Dolpa received services through HRDC. This number has now gone up to 72.

Because of Dolpa's remoteness, there was very little information easily available regarding the situation of people with disabilities in the district. HRDC's regional office in Nepalganj, learnt of a disabled persons' organization operating in Dolpa; Mukuteswor Apanga Sewa Samiti (MASS) and established contact with it. In mid 2008 , the Chairman, Mr. Chandra Bahadur Rokaya, visited HRDC and was briefed on the services and facilities, and agreed to expand treatment and rehabilitation services in Dolpa through the staging of a medical camp. Without the resources of MASS, such a camp would not have been possible and with their help a mobile camp was scheduled for April 2009.

Our next step was to raise awareness of the responsibilities in disability management, of DPOs and other community stakeholders. MASS conducted several meetings with local stakeholders and was able to mobilize some resources. The local government and other organizations allocated funds with the technical support of HRDC.

The regional office in Nepalganj and the center at Banepa began preparing for the mobile camp. Logistics were set up, medicine and medical materials were assembled, old case files were studied and transport was arranged. At the same time, HRDC conducted meetings with MASS and the other organizations and information about the date, time, venue and nature of the camp was disseminated through letters and over the local radio station.

On March 20, 2009, the camp team consisting of doctors, a physiotherapist, an orthotic prosthetic technician, a CBR coordinator, the Nepalganj officer-in-charge and the President of the National Federation of the Disabled Nepal (NFDN), headed for Dolpa via Nepalganj. The team was delayed in Nepalganj for two days due to unavailability of seats on the aircraft flying to Dolpa. To utilize the downtime in Nepalganj, the team took the initiative to organize a two day workshop with the local disability coordination committee from Banke and the NFDN President. The workshop on the "District Disability Policy and Plan of Action' began on March 31.

On April 2, the team flew to Johpal in Dolpa where local representatives from the camp management and support team were waiting for us. We then walked for three hours to the district headquarters, Dunai with the camp materials carried by porters.

The first day of the camp was held at
assessed and counselled the clientele w
participated in a workshop on district le
the team gave a presentation on HRD
information among the 200 participants

Forty-six children with physical disabi
treatment and rehabilitation services. Th
Secondary School and another 12 child
of 58 children from 18 VDCs were exami
physiotherapy assessment, measuring o
and their guardians.

As in any mobile camp, the identification of children with disabilities is only the first step. Subsequent challenges include organizing for the children to get to HRDC for medical interventions on a given date; unavailability of funds to cover travel and treatment costs and follow up sessions in future camps until the rehabilitation is complete and the children become ADL independent. Many challenges take time to resolve and even then, all the issues cannot always be fully addressed. Dolpa was no different.

In our analysis of these challenges we discussed the need for a follow up camp at the District Administrative Office on April 3. The Chief District Officer, Local Development Office, District Education Officer, staff from MASS and the HRDC team were present. One of the decisions made at the meeting was that one local should undergo Primary Rehabilitation Therapy training at HRDC. The person would then be able to conduct follow up treatment with the children regularly.

This training was undertaken at HRDC from June 15 to September 7, 2009 and the trainee has been providing services to the children and also referring newly identified cases to HRDC. After the camp, 14 children underwent interventions at HRDC, have already returned to their families and are under follow up care in their own communities.

Laphu Kathayat, who received treatment at HRDC is one example. She has been spreading around her good impressions of HRDC's services to locals and other CWDs in Dolpa. Seeing the positive changes in the lives of Laphu and other children enabled by HRDC's services, people of Dolpa have a new appreciation for what we do and HRDC is the most preferred orthopaedic hospital in the district.

A camp in a remote area like Dolpa is costly but helps strengthen the reputation of HRDC abilities to address the needs of clients seeking our services. This camp was able to do just that for a small number of marginalized children living in the remotes part of our country.

People at the community level appreciated our work and many times thanked us for our benevolence and services. MASS and HRDC are still in close contact and are currently planning another camp for Dolpa in the future.

Many of the clientele did not have money for travel costs from Dolpa to HRDC and resources needed for treatment and rehabilitations are big issues for CWDs, MASS, HRDC and other stakeholders.

Though this camp was a single event, we had multiple objectives such as the building and strengthening of our reputation and relationships with other stakeholders; support on technical matters, post-camp planning and follow up care, networking, empowerment through sensitization, sharing knowledge and local resource mobilization to ensure sustainability of services.

All these are also needed for the future, as we have limited resources and we are not able to do all the activities at the same time. Organizing the camp in Dolpa was a difficult job which the HRDC team successfully handled in close cooperation with the local people.

Lastly, HRDC is very thankful to all stakeholders including donors, partners, local government representatives, technical members of the camp, local organizations, volunteers, the clientele and other who provided invaluable support.

The team returned to Nepalgunj via Surket on April 7, 2009 and participated in additional mobile camps in Banke and Bardiya districts.

Projects in the pipeline and an appeal for support!

HRDC / FOD are working on the following projects for 2010. Where we have received full support for some items, we appeal for support for the rest:

1. Establishment of an ICU: The Rotarhy club of Okotok, Germany.
2. Donation of a X-ray Machine: The Rotary club of Seatle, USA asssisted by Rotary Clubs of Dhulikhel and Benepa.
3. Construction expansion of HRDC's bed capacity: Philip Green Memorial Trust has agreed to support with some cost, but need support for the rest.
4. Alternative energy: Photovoltaic project: FNEL-ONGD, Luxembourg Scouts . This will be meet part of the total energy requirement of HRDC. We need further support for the meeting remaining huge requirement.
5. Water Shortage:The shortage of water is very critical and of course, comes under basic requirement for a hospital
6. Construction of HRDC's Rehabilitation Centres in Itahari, Sunsari District for the eastern region and in Banke District (Nepalgunj-Kohalpur area) for mid - & far-western regions.

Training and Education

This department coordinates and plans internal and external training programs, provides health education and actively pursues efforts to improve educational services at the Centre.

Departmental Objectives:

- Conduct primary rehabilitation therapy (PRT) training for community workers and CBR facilitators who are working at the grass-root level and produce at least 40 PRT technicians in 3 years who will meet needs of different communities.
- Conduct PRT refresher training for participants of previous PRT trainings.
- Conduct orientation and health education sessions for patients and their guardians.
- Provide support in educational and vocational activities to the children and their guardians in the hospital.

Academic

HRDC is one of the training venues for the masters degree program in Orthopaedic surgery affiliated to Kathmandu University. The program was started in the 1999 with enrollment of two students. Now it is accepting 3 students every year in this 3 year residency program. Untill now 17 skilled orthopaedic surgeons have been produced and they are providing expert orthopaedic surgery services in different hospitals in the country.

In addition to the masters program, the Hospital is in the process of starting a fellowship program in paediatric orthopaedic surgery. Two students are currently involved in the program.

Organization of, and participation in academic activities has been a major part of the department's responsibilities. Paper publication and presentation in scientific sessions strengthen the department.

Awards and Publications

1. Epidemiology of Surgical Admissions to a Children's Disability Hospital in Nepal in World Journal of Surgery.
2. The First Oration of the Nepal Orthopaedic Association Challenges of an Orthopaedic Surgeon in Nepal: Journal of Orthopaedic Association
3. Charcot's Neuroarthropathy of the Foot and Ankle: Journal of Orthopaedic Association
4. Hip Arthrodesis in Children: A review of 28 patients: Indian Journal of Orthopaedics

Papers presented

International (IOACON- India)

1. Semitendinosus Tenodesis for the Treatment of Recurrent dislocation of the Patella in Children
2. Review of Leg-Calve-Perthes Disease at Hospital and Rehabilitation Centre for Disabled Children (HRDC)
3. Functional Outcome of the Quadrupled Semitendinosus and Gracilis Graft used in the Treatment of the Complete Anterior Cruciate Ligament.
4. Role of Serum Lactate in Evaluation and Treatment Plan of the Patient with Long Bone Fracture.
5. Results of Simultaneous Open Reduction and Salter Innominate Osteotomy for Developmental Dysplasia of the Hip: A decade long HRDC Experience

National

1. Correction of Post Tubercular Kyphotic Deformity in Paediatric Population.
2. Evolution of Spine Surgery in HRDC.
3. Rehabilitation of Paraplegic Patients.
4. Chiary Osteotomy for Developmnetal Dysplasia of the Hip.
5. Thoraco-Lumbar Burst Fracture - Our Experience.

Participation in conferences:

1. Orthopaedic Conference (Orthocon): National Orthopaedic Conference organized by Nepal orthopaedic Association which was held at Manipal Hospital, Pokhara.
2. Asian Spinal Injury Conference (ASCoN), 2009: International spinal injury conference held at Kathmandu.
3. Indian Orthopaedic Association Conference (IOACoN) 2009, Bhubaneshor: An international orthopaedic conference where our three residents along with one orthopaedic surgeon attended the meeting under our annual academic schedule.

Complications from a neglected trauma

A simple fall from a tree can become a desperate situation for many children living in the distant rural locations of Nepal. They do not have enough money to get a fracture checked out at a hospital and often the nearest hospital is days away. A fracture that is initially neglected can get infected due to lack of even the most basic treatment and lead to additional problems such as severe deformity or a short leg. Here at HRDC, such presentations of a totally preventable complications are not at all uncommon and often require massive resources from our limited coffers which would otherwise be unnecessary in a scenario where primary care and proper referral mechanisms for musculoskeletal problems were established.

Basudev Poudel is one such unfortunate sixteen-year-old boy from Pyuthan district in the mid-west part of Nepal. Basudev completed his tenth grade but could not continue his education further due to limitations imposed by his physical disability. Like many families in Nepal, the Poudel family derives their source of income through farming. Nine years ago, Basudev fell from a tree and broke his left thigh bone. At that time there were no major visible complications. His fracture was treated at home. Three years after the fall, Basudev started to have acute pain in the affected leg. He gradually started to limp while walking. After it reached a point when he was unable to sit crossed-legged, his family decided to have him checked out at a hospital. They went from one hospital to another, but to their dismay, none were affordable. A year ago, on their way back from another disappointing hospital visit, the Poudel family came across our community based rehabilitation (CBR) team who suggested that Basudev receive treatment at HRDC.

Basudev was diagnosed as having post traumatic varus (angular) deformity and shortening of his left leg. After going through a surgical procedure using an Illizarov ring fixator on

his left leg, Basudev is slowly recovering. This specialized treatment modality which is performed regularly by the surgical team at HRDC allows the deformity to be corrected as well as the leg length to be restored gradually by a phenomenon called 'distraction osteogenesis'. His deformity is already corrected and half of his leg shortening has also been addressed. Though such a treatment entails a long duration of time, the results are visible and he feels happy and optimistic about his progress at HRDC. Once the treatment is complete, Basudev wishes to continue his education and get a job so he can help his family and we will be glad to have put another intelligent youth back on his feet and a smile back on his family's faces.

Basudev Poudel with an Illizarov ring fixator.

His thigh deformity is already corrected and he is halfway through achieving the normal length of his leg which was short by 11 cms at presentation.

Photo Feature

Patients with their escorts taking interest in cleaning the Hospital

Family members of patients contributing some funds with heartfelt gratitude.

Instructor, Mr. Bharat Negi conducting an awareness lecture to patients and familes.

Clubfoot clinic attendees at HRDC

Occupational therapy focused on activities for daily living.

Activity of training and team planning at HRDC.

In Hospital Education for patients.

Treatment at HRDC coupled with fun and play

Happy Patients

News In pictures

HRDC Activities of 2009:

HRDC / FOD celebrates the International Day of Persons with Disability every year with clientele and other stakeholders. Some photographs taken during the occasion are presented below:

TdH Head of Mission Nepal, Mr. Joseph Aguettant providing fruit to children in HRDC Wards.

Mr. Aguettant receiving a badge from the able PWD, Miss Rewati, HRDC's tailor.

HRDC's Executive Director Mr. Krishna P. Bhattarai speaking during the ceremony.

Children doing group exercises in HRDC's phsyiotherapy department

News In pictures

HRDC makes a serious effort to involve local officials, members of the community and other stakeholders in its events. One such event was organized to sensitize them to HRDC's needs and sought options for the mobilization of resources.

Medical In-Charge Dr. Binod Bijukachhe presenting an introduction to HRDC, to local Constituent Assembly members from different parties, and local government officials during an interaction organized at HRDC for raising awareness and potential resource mobilization in support of treatement and rehabilitation for children with physical disabilities.

Third year residents with Dr. Om P. Shrestha, orthopaedic surgeon (second from the left), at the Indian Orthopedic Association International Orthopedic Conference (IOACON).

WHO CBR expert Mr. Chappal Khasnabis visited HRDC in June 2009 with the Mobility India team for impact study of their prosthetic orthotic training.The event was facilitated by Handicap International Nepal.

News In pictures

This is for your information that Plan Nepal has been supporting HRDC since the last 4 - 5 year in the empowerment of children with physical disabilties in six district of Nepal under Inclusion Project. The picture shows 2 members of the Norwagian Support Team with Mr. Hem Paudel of Plan Nepal in a meeting organized to brief the Inclusion Project and its development where HRDC team presented the progress in presence of all other proj

Ponseti Technic of Clubfoot Management

The Ponseti technique of Clubfoot management, devised by the late Dr. Ponseti, specially for babies under two years of age has become very popular for two reasons: It is a very efficient and cost effective technique, and there is no need for a highly skilled person to execute it.

HRDC / FOD has pioneered the introduction of this technique through our honorary Consultant Dr. David Spiegel a practicing pediatric rehabilitation expert from the Children's Hospital of Philadelphia (CHOP), USA. Since the technique's introduction, HRDC / FOD has organized several events and local and international training workshops. Below is a photograph of once workshop organized for doctors and physiotherapist in April 2009:

Prof. (Dr.) Banskota giving a talk on Ponseti Management

Primary Rehabilitation Training:

One of the most sought after events at HRDC is the 3 month long Primary Rehabilitation Training (PRT). HRDC runs the course at least once a year to meet the needs of low level community based rehabilitation workforce.

The PRT prepares partcipants as community social activitists who provide basic stretching exercises, sensitize and motivate PWDs and CWDs to the importance of early intervention, provide follow-up rehab care and refer clients for expert intervention. So far 211 people have received primary rehab training since its inception in 1997. One of the reasons that PRT has become so popular is that physiotherapists are scarce and services are expensive. One such Training was run from June to September 2009 for 24 participants from various organizations.

Partcipants from the 13th PRT batch, with instructors from different departments of HRDC.

The next batch of PRT is tentatively planned for June 2010.

Silver Jubilee Celebration and the 2009 Annual General Meeting:

The treatment and rehabilitation program initiated by Terre des Hommes in 1985 and fully undertaken by the Friends of the Disabled in 1992 has now completed 25 successful years. Therefore HRDC / FOD management has decided to celebrate the Silver Jubilee throughout 2010 (SJC 2010). The Annual General Gathering held in Jannuary 2010 was the first silver jubilee event.

Children singing and dancing during the 2009 annual general gathering - the first jubilee event.

Prof. (Dr.) Banskota Chairman of FOD was felicitated by HRDC personnel on the occasion, for his relentless and quality guidance and direction

Reaching the Unreached

Some of the HRDC's rehabilition work has been decentralized to 3 regional offices: Nepalganj in the mid-west since the last a few years, Baglung in the west and Itahari in the east. The work inlcudes field follow-up, management of clinics in each of the office's areas, conducting health, surgical and rehabilition camps, awareness activities in the community, local resource mobilization, etc. Accessibility to rehabilition services has been increased by these regional offices. Also it has also been easier for the children from far flung areas unreached ultil now.

Social Mobilizer and office assistant fitting a cast on a baby at the Nepalganj office.

PRT Instructor Madhu from the itahari office conducting awareness raising activities.

Core committee members of newly formed Network, Myagdi District with HRDC's Executive Director and Regional In-Charge Mr. Laxaman Thapa (back row - 4th from left).

Plan Nepal is supporting HRDC in the implementation of the Inclusion Project in five districts in Nepal: Morang and Sunsari in the east and Parbat, Baglung and Myagdi in the west. The HRDC Inclusion Project pushes local organizations such as DPOs, CBOs, and other stakeholders, to network in order to play supplimentary and complimentary roles in accessing rehabilitaion services. One such workshop was organized in Myagdi district and a network was formed.

In appreciation...

Mr. Uddhav Kumar Rai and Mr. Man Bahadur Rasaili generously donated eight plus kathas of land in the Sunsari district. HRDC / FOD is thankfull to both of them for their support to HRDC:

HRDC Exectuive Director (at the right) receiveing the deeds to the land from the donors.

Surgical Project

HRDC's Executive Director (back row, third from the left) is with the new Director of HI Nepal Mr. Florent Milesi (back row, sixth from left), HI Nepal Officials and partner representatives

Handicap International Nepal and HRDC / FOD agreed to work together for the rehabilitation of children with physical disabilities for the past year. In 2009 HI Nepal, through their partners and screening centre, referred a total of 229 children in need of corrective surgery which HRDC successfully treated. At the end of the project, there was an experience sharing workshop for all the partners, organized by HRDC. HRDC's Executive Director also participated and shared HRDC's experience, particularly in management of corrective surgery.

Networks and Networking

There is a network of NGOs supported by individuals and Nippon NGOs Network for Nepal (4N). HRDC's Executive Director and Rehab Manager participated in the fifth 4N Conference. HRDC's Executive Director was National Coorinator of the Nepal Japan NGOs Network for almost two years.

HRDC Exectuive Director (first row - second from the right) and Rehab Manager (back row - 7th from left) with the 4N Chairperson and other Nepalese and Janapese participants.

Group of personnel from UN Office of High Commission of the Human Rights visited HRDC to celebrate International Disability Day with CWDs at HRDC. They aslo brought some donation in-kind to HRDC and the children. Thanks to the Human Rights Team for the visit and the donation!

Dr. Banskota receiving a donation in-kind from the Human Rights representative for Nepal.

Please note that CBM Germany through CBM South Asian Regional Office (North) has been HRDC's partner since more than a decade supporting us in the Rehabilitation of children with physical disabilties. In the picture, the Program Officer Mr. Dinesh Rana (front row left) from CBM is talking to children during his visit to the children intervened by HRDC. CBR facilitator Mr. Sapkota is with him.

Words from the Executive Director

Dear Friends and Well-Wishers!

Belated Happy New Year 2067!

In 2009, we served a total of 12,990 cases with almost 50% (5,585) being girls through all HRDC's service outlets. This is the highest track record in HRDC history! This was possible only due to the confidence of clientele who reached to HRDC's services despite all political odds and road blocks / bandhas (strikes) which prevailed in the country. Thank to all our clientele for giving us opportunity to serve you!

2009 proved one of the many remarkably successful years especially in "Management Strengthening", as the Executive Board of the Friends of the Disabled was extended and the Executive Management Team of HRDC was reinstated enabling HRDC to function better. Reinstating, and extending the Executive Management Team has opened up opportunities for better line management systems which will facilitate to monitor quality of services and offer supporting supervision to the front runners providing the services. This will then help us in reaching new heights of quality at all levels of management. Positive results were visible in the second half of 2009 with its reverberation in resource mobilization, quality of care to clients and sustaining HRDC as a "The Centre of Excellence" in the true sense.

Also we are about to launch a software in the "Management Information System of HRDC" developed in 2009 which will avail us clean data, enabling us to do more research and make effective and efficient decisions in the coming days.

HRDC / FOD is very grateful to American Himalayan Foundation, Terre des Hommes, Plan Nepal, Christoffel Blindenmission, Germany, FNEL - Luxembourg Scouts, All Together Now International, Handicap International Nepal, different levels of Nepal Government and all other local as well as international organizations and individual supporters for earnestly being instrumental to take HRDC to this height through your continued and unconditional support.

While we have started celebrating 2010 as our Silver Jubilee Year, be assured that we will do our best to continuously provide the best quality services and retain your trust in the future.

Thank you very much!

Krishna P. Bhattarai
Executive Director
HRDC