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# TWENTY-FIVE YEAR REVIEW OF ASSISTANCE TO NEPAL'S HEALTH SECTOR

**May 2016**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Judith Justice, Sudip Pokhrel, Jeevan Raj Sharma, Mahesh Sharma, Ashoke Shrestha, Sanjaya Singh Thapa, Ghanshyam Gautam, Heem Shakya and Devendra Shrestha.

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**Global Health Performance Cycle Improvement Project**

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20006

Phone: (202) 625-9444

Fax: (202) 517-9181

[www.ghpro.dexisonline.com](http://www.ghpro.dexisonline.com)

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# ACRONYMS

AIDSCAP	AIDS Control and Prevention Project
ART	Antiretroviral therapy
ASHA	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS
AusAID	Australian Agency for International Development
CB-IMCI	Community-based Integrated Management of Childhood Illnesses
CB-MNC	Community-based maternal and newborn care
CB-NCP	Community-based neonatal care package
CHL	Community Health Leaders
CPR	Contraceptive prevalence rate
CRS	Contraceptive Retail Sales
DFID	Department for International Development, UK
DHS	Demographic and Health Survey
EDP	External development partner
FCHV	Female Community Health Volunteers
FHD	Family Health Division
FHI	Family Health International (now FHI 360)
FPAN	Family Planning Association of Nepal
FSN	Foreign Service National
GDP	Gross Domestic Product
GHI	Global Health Initiative
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GON	Government of Nepal
GTZ	German Technical Cooperation Agency (Gesellschaft für Technische Zusammenarbeit)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HKI	Helen Keller International
HMIS	Health management information system
IBBS	Integrated Bio-Behavioral Survey
IHP	International Health Partnership
IMPACT	Implementation AIDS Prevention and Care
INGO	International non-governmental organization
Jhpiego	Originally Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	John Snow, Inc.
KfW	Kreditanstalt für Wiederaufbau (German Government Development Bank)
KISAN	Knowledge-based Integrated Sustainable Agriculture and Nutrition
LMD	Logistics Management Division

LMIS	Logistics management information system
MCH	Maternal and child health
MDG	Millennium Development Goal
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MSNP	Multi-Sectoral Nutrition Plan
NAGA	Nutrition Assessment and Gap Analysis
NCASC	National Centre for AIDS and STD Control
NFHP	Nepal Family Health Program
NHTC	National Health Training Center
NGO	Non-governmental organization
NHSP	Nepal Health Sector Programme
NPR	Nepalese Rupees
NTAG	Nepal Technical Assistance Group
NVAP	Nepal Vitamin A Program
OMNI	Opportunities for Nutrition Interventions Program
PMTCT	Prevention of mother-to-child transmission
RFA	Request for Application
RFP	Request for Proposal
RTI	Research Triangle Institute
SO	Strategic objective
SOW	Scope of work
STD	Sexually transmitted disease
SUN	Scaling up Nutrition
SWAp	Sector-wide Approach
TARF	Technical Assistance Resource Fund
TB	Tuberculosis
TFR	Total fertility rate
TWG	Training Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
VITAL	Vitamin A Field Support Program
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

# EXECUTIVE SUMMARY

This report was prepared in response to USAID's request for a review of its investments and approach to providing technical assistance to Nepal's Ministry of Health (MOH) over a 25-year period (from 1990 to 2015). The review was also designed to examine USAID's contributions in the context of the larger donor effort to improve health services, systems and outcomes in Nepal, by providing an overview of its partnership with the MOH and its role in the donor community to strengthen aid effectiveness and improve health outcomes and systems. Although the review was not designed to establish causal links between USAID's efforts and health outcomes, it does look at key technical and programmatic investments developed to influence and contribute to positive change in Nepal's health sector. The perceptions and assessment of USAID's contribution were obtained through 62 interviews with a broad range of Government of Nepal (GON) officials, external development partners (EDP) and U.S.-funded partner organizations, in addition to review of documents.

**Limitations and challenges:** The terms of reference specified a review of the health sector, with a special focus on USAID's contribution and approaches to providing support. Therefore, this is not an evaluation, but a review of developments during the 25-year time frame, and it did not involve project assessment, site visits or interviews with beneficiaries. Many challenges were encountered during the review period, including identifying and contacting people who were involved over the 25-year period and were able to reflect upon and discuss the situation during the different periods of time. Obtaining specific details over a 25-year period and reconstructing a social history of USAID's assistance—encompassing the diverse sources of funding, various interventions, engagement of multiple partners and wide range of projects and activities supported—was challenging. Many documents were not available, especially for the years 1990–2000. In addition, statistics varied greatly, depending on the consulted report, data collection method and population (e.g., ethnic group, geographic location). During the review period (August 2015 to January 2016), Nepal experienced a number of challenges, including political protests, political transitions in the GON and closure of the India-Nepal border, causing extreme shortages of essential commodities and making transportation and daily life difficult in Nepal. Also, the review commenced after a major earthquake in Nepal (April 2015).

**National context:** This report presents a brief description of Nepal's political history and socioeconomic situation between 1990 and 2015 to help provide a context for understanding the health sector and the roles of the GON and EDPs. The major political influences during this time period include: the 1990 political uprising, which ended Nepal's single-party Panchayat system and restored multiparty democracy, raising people's expectations for reforming government sectors including health; a more market-oriented and liberal economic policy, opening up the participation of the private sector and non-governmental organizations (NGOs); and expedited decentralization and increased authority of local governments. The opening of the private sector and thrust for decentralization had major implications for the health sector, including an increase in the number of health training institutions, health facilities and services. However, the multiparty political system was marred by continuous political disagreements between and within political parties and frequent changes in government. In 1996, the Maoists began an armed insurgency, which lasted 10 years, had major implications for the country and hindered the delivery of health care services. The conflict did encourage the EDPs supporting the health sector to collaborate, beginning with informal meetings, which have evolved into an EDP Forum that still meets regularly. Following the Peace Accord between the GON and Maoists in 2006, the constitutional monarchy was abolished and Nepal was declared a "Federal Democratic Republic State." It has taken the Constituent Assembly many years to draft and obtain majority support for a constitution, which was approved in September 2015, although the proposed federal form of

government has not yet been accepted by all political parties, with the result that unrest continues. However, the Constitution of Nepal (2015) does preserve health as a fundamental right.

In spite of the many political upheavals and governance challenges, Nepal has made steady progress in improving health and population outcomes. In fact, its achievements in family planning, reducing child mortality and improving maternal health are seen as exemplary successes and often lauded internationally, as they are part of the Millennium Development Goals (MDG) 4 and 5. For example, between 1990 and 2014, Nepal reduced under-5 mortality by 73 percent, infant mortality by 67 percent and neonatal mortality by 57 percent. Although current data on maternal mortality remain contentious, using the estimate of the UN agencies, it has declined by 76 percent, from 790 to 190 (per 100,000). Improving maternal and child nutrition continues to be a challenge for Nepal, but some progress has been made. New HIV infections have declined from 8,329 in 2002 to 1,408 in 2013. Until recently, population growth was around 2-2.5 percent but has recently declined to 1.35 percent, which is attributed to a reduction in the fertility rate (from five births per woman in 1990 to 2.3 in 2014) and the growing trend of out-migration among young people.

Despite the overall progress made during recent years, equity gaps persist, and marginalized and vulnerable communities continue to face several barriers in accessing health care services. One of the major challenges facing the health sector today is ensuring quality of services. Many deficits in Nepal's health care system limit efforts to improve quality, including the need for major improvements in management of human resources, procurement and finances, and in government regulatory functions. In addition to communicable diseases, Nepal also faces the burden of non-communicable diseases and increasing threats to human health from natural disaster (e.g., the 2015 earthquake), climate change, violence, injuries and traffic accidents (Nepal has one of the world's highest rates of road traffic accidents and fatalities). There are major developments in the private sector and some examples of public-private partnerships, but there appears to be no momentum within the GON to take a joint agreement forward. Recently there has been discussion about the fact that health is not solely the business of the MOH or health sector, but that other sectors also contribute significantly. Despite the development of multisectoral plans in areas such as nutrition, water, sanitation and hygiene (WASH), and road-traffic accidents, in practice, it is difficult to bring different sectors together.

**International assistance in the health sector:** Global development assistance in health increased substantially since 1990. Approximately USD 7 billion was disbursed globally as health aid to low- and middle-income countries in 1990; by 2014, the total disbursement had reached USD 35.9 billion. In Nepal, the contribution of the EDPs to the health sector since 2005 has remained almost one third of the total MOH expenditure. The United States, together with Japan and the United Kingdom, are among the largest bilateral health donors to Nepal, while the Asian Development Bank and the World Bank are the major donors among multilateral institutions. Support from the EDPs to the GON is channeled through various mechanisms. These include "Pool Fund Budgetary Support," which is reflected in the annual work plan and budget of the GON and channels funds through the GON Treasury. (The U.S. Government does not contribute to pooled funding mechanisms, but in Nepal it has been creative in finding a way to participate in the Sector-wide Approach, or SWAp, with other EDPs.) "Non-pool Budgetary Support" is also reflected in the GON's annual work plan and budget, but the funds are managed either by the supporting agency or partially provided to the government's spending units. "Non-budgetary Technical Support" is not reflected in the GON's annual work plan and budget, and funds are directly managed by the supporting donor or the agency providing technical assistance.

**USAID's approaches to providing assistance to the health sector:** The United States is one of the earliest bilateral donors to Nepal and is also one of the major bilateral donors in terms of the volume of its contribution. During the 25-year period from 1991 to 2015, USAID's total obligation has been USD 1.34 billion, in the form of economic assistance (1.3 billion) and military assistance (40 million). The health sector is the prime recipient of USAID's support for Nepal, followed by economic

growth and governance sectors. From 2007 to 2014, the health sector received approximately 50 percent of USAID's total contribution for Nepal.

USAID/Nepal's goals, objectives and strategies over the last 25 years, as well as the position of health under the overall USAID strategic documents and the framing of specific objectives, have been influenced by factors such as USAID global policies, priorities and directions reflecting U.S. Government administrations, USAID funding levels, its regional bureau priorities and emerging global and country-specific health issues. These factors must be considered in the context of significant improvements in health status and the changing political and socioeconomic environment in Nepal. Family planning and maternal and child health (MCH) have been the dominant components, although from 2006–2008, HIV/AIDS received the most funding, and recently nutrition has received increased budgetary support.

USAID's approaches and policies in the health sector have remained largely the same during the 25-year period and have included developing an approach to work with the GON and other EDPs. The following financing mechanisms are used by USAID to provide financial and technical support to the health sector in Nepal:

1. Bilateral projects, which are commissioned through cooperative (Request for Applications) or contractual (Request for Proposals) agreements, such as the Suaahara Project (cooperative) and Health for Life Project (contractual);
2. Funding that is extended through central or field support projects, such as support for conducting the Demographic and Health Survey (DHS);
3. Grants to public international organizations, such as the World Health Organization, to accomplish the defined objectives;
4. Direct funding for GON activities, following the Government-to-Government channel, under which supported activities are directly reflected in the annual work plan and budget (Red Book) of the government.

**USAID support to health programs:** Between 1990 and 2015, USAID supported the GON's health sector through a broad range of innovations and technical interventions. The areas most often associated with USAID were: family planning and reproductive health, MCH, HIV/AIDS and health logistics. Although USAID/Nepal includes nutrition as a key technical component, interviewees only recently associate USAID with nutrition, except for vitamin A, which was closely identified with USAID support. USAID was credited with early and long-term support for the crosscutting Female Community Health Volunteer (FCHV) program. USAID was not directly associated with health system strengthening, except for logistics management and evidence-based (i.e., research, pilot projects and DHS) policy and program development. USAID also lists environmental health as a major technical component, but interviewees did not identify this as an area of major contribution, except for a few who said that USAID should be encouraged to continue supporting WASH. Support for social marketing was primarily associated with Contraceptive Retail Sales (CRS). Because it is not possible to describe all areas supported by USAID, a brief description of the most frequently identified interventions and innovations are given in the report. The discussion of these programs and projects confirm that USAID support is viewed as making a major contribution, especially to these key interventions. However, as with all health-related issues, there are also inconsistencies, complications and ongoing challenges that require attention and action.

**Findings:** Analysis of the data from the 62 interviews provided a rich source of information from several perspectives. These data reflect the experiences, views and perceptions of government (especially the MOH, Ministry of Finance and Planning Commission), other EDPs, consultants, USAID partner organizations (e.g., NGOs, international NGOs (INGOs) and U.S.-based contracting groups) and USAID staff. In all categories, the interviewees represented people currently or formerly involved

throughout the 25-year time frame. Therefore, interviews drew on a broad range of professional positions and personal experiences. Comments were made in response to questions from the interview guide and not as criticisms, but rather as observations and views about USAID's structure, policies, procedures and relationships, and, of course, all were related to its approaches to development assistance to the health sector.

Key findings from the interviews follow:

- Most interviewees were consistent in identifying USAID's contribution to the health sector as including family planning and reproductive health, vitamin A, community health (FCHVs), MCH, HIV/AIDS, logistics and the DHS.
- USAID's support for evidence generation, research, innovative pilot projects and scaling up was viewed as a very positive contribution, including support for vitamin A, acute respiratory infection/community-based Integrated Management of Childhood Illness (CB-IMCI), chlorhexidine and misoprostol.
- USAID's long-term support for logistics was widely appreciated. However, it was noted that recently there has been a reverse in the curve, which may be associated with a decrease in USAID support for logistics.
- USAID and other donor-supported investments are viewed as increasing access to health care, although many people interviewed noted the need for an increased focus on the quality of care.
- Wide recognition was given to Nepal's overall achievements in health outcomes, including international recognition for meeting MDG targets (e.g., total fertility rate; maternal, neonatal, infant and under-5 mortality; etc.). Although many interviewees noted the increases in private sector and government facilities and the number of trained health professionals and paramedical staff, they also attributed the achievements to broader changes and overall developments in Nepal, such as increased roads contributing to improved access, education for girls and improved economy, including out-migration and the availability of cash income from remittances.
- Several interviews noted that the focus on achievements masked internal issues related to disparities and equity.
- USAID-supported projects and activities are viewed as being target and results-oriented.
- USAID is viewed as being the donor that is most risk-adverse.
- USAID, in general, is not viewed as being responsive to GON requests, compared to some other EDPs, but was described as being more responsive only when GON requests were within the sphere of work of USAID-supported projects.
- USAID is viewed as being guided by global rather than country priorities. When global and local priorities align, then USAID was described as being a strong partner.
- USAID was described as having a preference to work with the private sector, INGOs and NGOs.
- Many interviewees, especially GON officials, commented on USAID funding modalities and the limited budget support put through the Red Book, in comparison to project-related assistance through U.S.-based organizations.
- USAID was perceived as having stronger partnerships and influence with the GON in earlier years. Changes in technical background, negotiation skills and the experience of USAID staff (globally and at country/mission level) have resulted in USAID having less influence with the GON. Unlike other donors, such as the Department for International Development/UK (DFID)

and the World Bank, USAID was viewed as having less interaction and influence with the government.

- There was a widespread observation among people interviewed that at the global and country levels, USAID's contracting office currently has a greater influence in decision-making and type of funding mechanisms, as well as internal USAID relationships during project implementation. These factors have affected relationships with the GON and partner organizations. This has also meant that technical aspects of projects may receive less priority than compliance.
- USAID was seen as shifting from more flexible to tighter funding mechanisms and managerial oversight, which was viewed by partners as USAID being less flexible, with more control and micromanagement of projects.
- Many (in all categories of interviewees) noted changes in the relationship between USAID and partner organizations, e.g., less appreciation for the technical skills of partners, more formal relationships between partners and USAID staff, more oversight and increased micromanagement.
- The location of USAID within the U.S. Embassy was viewed as a barrier to communication and collaboration with the GON and stakeholders. This move was also perceived as resulting in USAID being more closely aligned with U.S. political priorities and less oriented to the local country situation.
- USAID is viewed as not paying competitive salaries for Foreign Service National (FSN) staff and as having a difficult contracting process for consultants, which was described by many as discouraging well-qualified people from working with USAID.
- USAID's RFP/RFA process for projects was described as being so minutely defined that the process provides limited scope for GON and stakeholder inputs during project planning. Several examples were given, describing observations of USAID's limited consultation with the GON and others (e.g., EDPs) regarding development of new policies and project planning.
- USAID's recent increase in support for nutrition is appreciated, but many viewed the projects as having some problems, including lack of alignment with the Multi-Sectoral Nutrition Plan (MSNP), problems with multisectoral collaboration at the central level and post-project continuity, among other issues.
- Although interviewees did not associate environmental health as an area of major contribution, USAID's support for WASH was recognized and encouraged to continue.
- USAID's assistance to the private sector was associated primarily with its long-term support for CRS.
- Although the review attempted to identify USAID's support for capacity building, this was difficult to assess, because there did not appear to be a common understanding of the meaning, approach and implementation modality. One of USAID's important contributions has been in supporting the GON staff to deliver a range of health services in family planning, maternal, neonatal and child health and HIV through training and mentoring. Outside government, it has supported various institutions such as CRS, the Family Planning Association of Nepal (FPAN) and New ERA, and many individual professionals, who are used to provide short-term technical inputs in different programs.
- USAID's earlier support for scholarships and fellowships (e.g., for Master's in Public Health) was viewed by many as building capacity and relationships, but it has been discontinued.

- Donors were described as having focused on developing the GON's capacity for service provision, rather than on stewardship and regulatory capacity.
- Although USAID Forward was a major initiative under the Shah administration, it did not appear to have much visibility in Nepal and was not mentioned by interviewees. In general, USAID was not viewed as supporting local organizations, except for those few mentioned above (New ERA, FPAN, CRS), but rather building the capacity of INGOs (e.g., Save the Children, CARE, Helen Keller International (HKI)) and large U.S.-based contracting groups such as Family Health International (FHI, now FHI 360), John Snow, Inc. (JSI), and Jhpiego, among others.
- During Nepal's armed conflict, USAID and other donors began closer collaboration, which evolved into the formal EDP Health Forum, which still meets every two weeks.
- Despite U.S. Government regulations, both donors and the GON expressed appreciation for the efforts of USAID's country office to find a way to participate in the aid effectiveness agenda by signing joint agreements and participating in other joint mechanisms, such as the Joint Annual Review.
- Although USAID is seen as an active participant in the EDP Forum and other collaborative mechanisms, it is also frequently viewed as doing things in its own way, despite feedback from other donor partners.
- Some GON officials observed that the EDP Forum is not adding value to the GON, because as a group they are not able to go beyond their individual bilateral agreements with the GON.

**Moving Forward:** Based on the findings of the review, including interviews and review of documents, the following recommendations are made for moving forward.

- Because of USAID's strong results orientation and long experience in the delivery of technical interventions, its comparative advantage is viewed as technical and managerial assistance in the actual implementation of programs at the level of service delivery, rather than at the national health system and policy level. Some interviewees viewed USAID's project support as also strengthening the health system at district and local levels.
- Many observed that USAID's consultation with the GON (and other donors) during planning of projects could be increased. Lack of consultation and engagement with GON officials appeared to fuel the perception that "USAID does its own thing."
- In order to address the widespread critical view of current recruitment and contractual policies and procedures, in addition to its low salary structure compared to other donors, USAID will need to develop a long-term strategy to attract and retain qualified and experienced staff and consultants to support its programs.
- A frequent theme during interviews was that EDPs expect the GON to provide detailed information, but that USAID and other EDPs are not forthcoming or transparent with the GON. A more equal exchange of information could help improve the relationship between USAID and the GON.
- USAID should reconsider comprehensive support for logistics to ensure commodity security, building upon its past experience and investment. Sustainability of earlier achievements has been especially challenging given Nepal's recent history of armed conflict and ongoing political instability. However, a well-functioning health logistics system is essential for the successful implementation of current and future health interventions and the country's proposed universal health coverage.

- USAID should consider supporting construction and renovation of the health infrastructure and equipment. The poor infrastructure base has an impact on the quality of services. Support for infrastructure, power supply and equipment should be provided together with technical and advisory support.
- USAID and other donors have invested in improving access to care, and now there is a greater need to support improving the quality of care. While there has been expansion in reach over the years because of the focus on targets, there are consistent concerns about quality.
- Because of the shifting burden of disease, Nepal needs to focus beyond communicable diseases to address emerging non-communicable diseases and conditions (e.g., mental health, diabetes, cancer, road traffic accidents) and public health threats from natural disasters and climate change.
- USAID and other donors, jointly with the GON, should undertake a sector-wide capacity assessment of the GON to develop a capacity-development plan and mutually implement it. In addition to the current focus on measurable results in specific health outcomes, USAID's assistance in the health sector should also be judged by its impact in building the organizational and institutional capacity of the GON, NGOs and the private sector.
- As noted above, a major change in Nepal's health sector is the development of private health facilities and services, which are widely used by the public throughout the country, both in urban and rural areas. However, there have been very limited efforts to document the comparative use of government (public) and private health services, which are basically unregulated. In addition, there has been a rapid increase in the number of private medical colleges, nursing schools and paramedical training institutions, also unregulated. USAID and other EDPs could work with the MOH and Ministry of Education to review this situation and support the development of a system of oversight and regulation, including curriculum development and quality of education and training.
- Although interviews were positive about USAID's long-term support for FCHVs, it was noted that their increasing use in the delivery of health programs should be balanced with the supervision, support and mentoring needed from GON health workers. USAID and other donors need to follow up on this and other ongoing challenges, documented by the many USAID-supported reviews of the FCHV program, which confirm the need for more regular supply of commodities, supervision and support, and addressing the unresolved issue related to incentives, plus future roles related to the MOH's proposal to place trained auxiliary nurse midwives at the community level.
- USAID and other donors should be more committed to addressing the inequalities in health outcomes, including the needs of marginalized and hard-to-reach populations. Unequal health outcomes, embedded in gender and caste relations, remain a major challenge in Nepal. Conducting a political and economic analysis through an equity lens is very important prior to undertaking any technical interventions.
- Resource mapping (following the money and the institutions) would be important as a way to better understand the relationships between different organizations and institutions working in the health sector. At present, it is difficult to map USAID and other donor-funded projects and programs in Nepal. The GON's attempt to map external assistance through the Aid Management Platform is incomplete and does not capture all of the assistance.
- Although USAID has helped to build the technical and managerial capacity of individual professionals to support the health sector, support for institutional capacity has been limited. USAID is encouraged to explore initiatives designed to build more sustainable capacity. Despite

USAID Forward, local organizations are often excluded as prime recipients of USAID funding and must work as subcontractors. Direct funding of local organizations would not only help reduce transactional costs, but would also result in making USAID's assistance more accountable, sustainable and closer to the beneficiaries.

- USAID's long-term partnership with international organizations such as FHI, JSI and Jhpiego has made an important contribution to supporting the health system and service delivery in Nepal. Many of these organizations have had a long tenure in Nepal, and USAID should now work with them to start transferring more administrative, managerial and technical skills to local partners.
- USAID will need to ensure that its assistance is accountable not just to the U.S. Congress, but also to the GON and the actual beneficiaries. It was also noted that USAID-supported health-related activities need to be more closely aligned with GON strategies, goals and objectives, including for projects noted in interviews, e.g., Suaahara and Health for Life.
- USAID is strongly encouraged to continue its support for research/operational research, piloting projects and other forms of generating evidence, which has made a major contribution to Nepal's health sector, including in policy development, planning and implementation of health interventions. The focus on evidence has helped assert USAID's important contribution to the health sector in Nepal.
- In planning future programs, USAID, together with other donors, needs to consider the new constitution and its forthcoming federal structure. As warranted by the constitution, the GON is currently in the process of reorganizing functions and structures of the various sectors, including health, for transitioning to a federal form of governance. The current discourse within the government has not yet produced concrete plans on some significant issues, such as the formation of local governance units and setting up fiscal decentralization mechanisms under federalism, which may have important bearing for future USAID investments in Nepal. USAID and other EDPs will need to keep informed about such changes, as they could greatly affect the way donors and the government work together in the future.

# I. INTRODUCTION

## I.1 BACKGROUND AND SCOPE OF WORK

USAID requested an overview of its investments and approach to providing technical assistance to Nepal's Ministry of Health (MOH, previously known as the Ministry of Health and Population, or MOHP) over a 25-year period (from 1990 to 2015). Although USAID has had earlier publications describing its overall assistance to development in Nepal (*A Quarter Century of American Assistance to the Development of Nepal*, U.S. Information Service, 1976) and the diplomatic relationship between Nepal and the U.S. (*50 Years of Success: 1947–1997*, U.S. Information Service, 1997), in addition to a report on its contributions to global health (*50 Years of Global Health: Saving Lives and Building Futures*, Tonya Himelfarb, 2013), this current review was designed to trace USAID's investments in the health sector during the past 25 years in Nepal, including important technical contributions, interventions and innovations, in addition to how USAID's strategies, leadership, production of evidence and partnership with the MOH have contributed to Nepal's health policies and programs over time.

The review was also designed to examine USAID's contributions in the context of the larger donor effort to improve health outcomes, services and systems in Nepal, by providing an overview of its partnership with the MOH and its role in the donor community to strengthen aid effectiveness and improve health outcomes and systems. Although the review is not designed to establish causal links between USAID's efforts and health outcomes, it does look at key technical and programmatic investments designed to contribute to and influence positive change in Nepal's health sector. The perceptions and assessments of USAID's contribution were obtained through interviews with a broad range of Government of Nepal (GON) officials, external development partners (EDPs), USAID former and current staff, and USAID-funded partner organizations, in addition to review of documents. (See section 1.2.1 Methods for details.)

It is hoped that the review will provide a useful health resource for USAID/Nepal and USAID/Washington, the MOH and the greater donor community in understanding the approaches to providing technical assistance, which were designed to achieve better health outcomes and strengthen the health system. In addition, it is hoped that this 25-year review will also provide the mission with insights into how USAID's contribution to date has been viewed and how it could contribute to the health program in Nepal in the future and as part of the larger donor community.

### I.2.1 Data Collection Methods

Reviewing support to the health sector over a 25-year period, as specified in the terms of reference, presented a special challenge, especially because of the long time frame, diverse range of interventions, projects and activities, and several types of funding channels. Therefore, the following methods of review were used:

Document review: Documents were obtained from USAID, the GON, other EDPs, and USAID partner organizations. However, many documents from the early years were difficult to obtain or not available. A complete list of documents consulted is listed in Annex 3.

Identification and review of existing data from secondary sources, including statistical data on key health outcomes, as well as health financing: Information was often difficult to obtain from USAID, the GON and other EDPs, especially from earlier years.

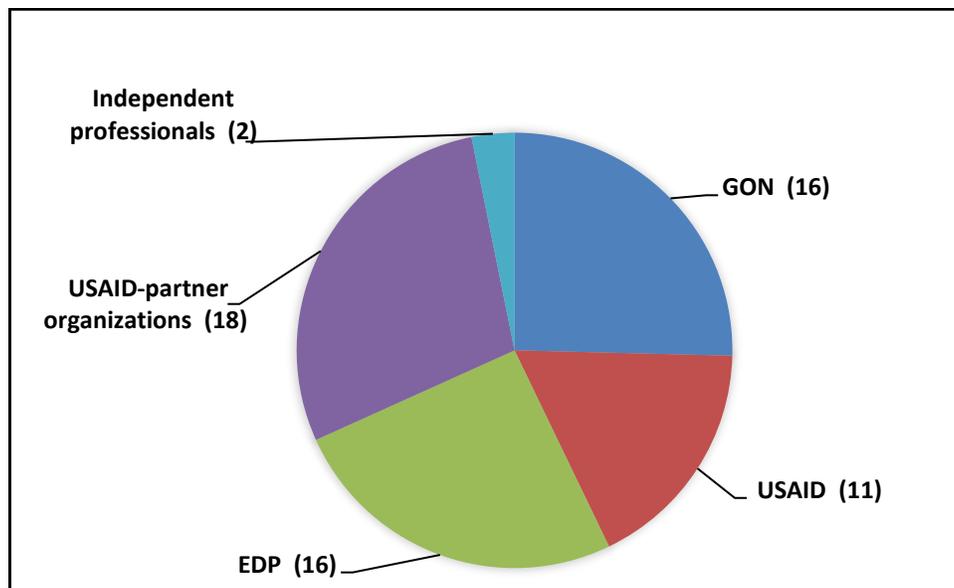
Interviews: Based on the terms of reference and questions elicited from the document review and USAID, the review team developed a comprehensive set of review questions. From this list, interview guides were further developed and piloted. (A sample interview guide is included in Annex 4.)

Key groups of people to be interviewed were selected, beginning with an initial list based on long-term experience and existing networks of the review team, in addition to recommendations from former and current USAID staff and many others. Some names were added as the review progressed. The final selection was based on interviewees' availability, as discussed below. Categories of interviewees are listed below:

- Government, including current and former officials with the MOH, Ministry of Finance and National Planning Commission
- USAID current and former staff
- EDPs, including DFID, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Swiss Agency for Development and Cooperation, the World Health Organization (WHO), UNICEF and the World Bank
- USAID-funded partner organizations, including private organizations, INGOs and NGOs
- Independent professionals

Over the four-month review period, 62 semi-structured interviews were conducted in person and by phone (for a duration of one to two hours). Those interviewed included: GON (16), USAID (11), EDP (16), USAID-partner organizations (18), and independent professionals (2). (See Figure 1.)

**Figure 1. Categories of persons interviewed**



The review team consisted of five consultants with relevant background and experience in Nepal's health sector. In addition, three specialists were contracted to assist with identifying and analyzing information on health economics/financing, statistics and logistics. (See Annex 2. Consultant Biographies.)

### **1.2.2. Limitations and challenges of the assignment**

The terms of reference specified a review of the health sector, with a special focus on USAID's contribution and approaches to providing support. Therefore, this is not an evaluation, but a review of developments during the 25-year time frame, and it did not involve project assessment, site visits or interviews with beneficiaries.

Many challenges were encountered during the review, including identifying and contacting people who were involved over the 25 years and were able to discuss the situation during various periods. Many key people were not available or difficult to reach or to schedule appointments with; in addition, there were a few refusals and frequent cancellations. Related to data analysis, many interviewees were asked retrospective questions, and thus some information was based on recall, which has its limitations. Interviews provided perceptions of certain interventions and approaches, based on the interviewee's reflection or memory. Therefore, it was challenging to obtain specific details over the 25-year period and reconstruct a social history of USAID's assistance, as well as to cover the diverse funding channels, various interventions, engagement of multiple partners and wide range of projects and activities supported. Although the review team made every attempt to address the terms of reference, some information and many documents were not available, especially for the years 1990–2000. In addition, there were inconsistencies in the reported statistics, depending on the source, data collection methods used by the original survey, and within Nepal's diverse population (e.g., ethnic group and geographic location).

At the time of the review (August 2015 to January 2016), Nepal experienced a number of challenges, including political protests, political transitions in the GON, and the closure of the India-Nepal border, causing extreme shortages of essential commodities such as fuel and cooking gas, and making transportation and daily life difficult for Nepalese at large and for the consultant team. The review commenced after a major earthquake in Nepal (April 2015), which also meant that USAID staff and interviewees were exceptionally busy with recovery activities, making the scheduling of interviews more difficult.

### **I.2.3. Analytical Approach**

Team members took detailed notes during interviews. The information/data from document review and interviews were aggregated according to the questions in the terms of reference to ensure that the review team's conclusions would be based on the quantitative and qualitative data derived from several sources. In some cases, the team returned to USAID, the GON and others for further information and/or clarification. Preliminary findings and recommendations were presented to USAID. The comments and further information generated from the debriefing discussions have been incorporated into the writing of this report.



## 2. NATIONAL CONTEXT

A brief description of Nepal's political history and socioeconomic situation between 1990 and 2015 helps provide a context for understanding the health sector and the roles of the GON and EDPs.

Nepal is a landlocked country located in the central Himalayas between India and China, with an area of 56,827 square miles and an estimated population of over 29 million. For a country that is only 500 miles long and 110 miles wide, Nepal has varied geographic terrain, ranging from high mountains in the north to subtropical lowlands to the south. Nepal also has broad ethnic diversity, with 125 caste and ethnic groups speaking 123 languages.<sup>1</sup> Such topographic and ethnic diversity, in addition to ongoing political instability, makes socioeconomic development particularly challenging for the GON and its development partners.

### 2.1. POLITICAL CONTEXT

The political uprising of 1990 ended Nepal's single-party *Panchayat* system and restored multiparty democracy. During the 30 years of the *Panchayat* system, there had not been enough socioeconomic progress to contribute to meaningful change in people's lives. The inequality in wealth had not declined, and social inequities persisted in almost every sector from health, to education, to agriculture. Therefore, the end of the *Panchayat* era was met with much enthusiasm, and people had high expectations from the reemergence of multiparty democracy.

The promulgation of the new constitution in 1990 was followed by a drive to reform various government sectors, including health. Nepal's economic outlook became more market-oriented, and the liberal economic policy opened up the participation of the private sector and NGOs, which had been heavily curtailed during the *Panchayat* era. In the 1990s, the GON expedited decentralization and started to devolve authorities to local governments. The Local Self-governance Act, enacted in 1999, provided the legal basis to constitute local government bodies and stipulated functions for central and local governments.

The opening up of the private sector and the thrust for decentralization had major implications for the health sector. The National Health Policy of 1991 and the subsequent eighth and ninth GON five-year plans provided space for private sector (including NGO) participation in the health sector. This resulted in the mushrooming of private hospitals, medical colleges, diagnostic clinics and pharmaceutical companies in urban areas and escalated the involvement of NGOs in providing health care services to rural communities. In 1990, there were only 16 private hospitals in Nepal; by 2006, the number had risen to 190, and as of 2014, there were 301 registered private hospitals.<sup>2</sup> Similarly, the number of NGOs working in health also grew exponentially, from 110 NGOs working in health in 1995 to as high as 20,000 NGOs having some form of health-related activities in 2008, according to one estimate.<sup>3</sup>

The push for decentralization and the drive to expand public services led to the creation of 4,000 additional health facilities, in the form of sub-health posts, one in each Village Development Committee. Similarly, one primary health care center was established in each electoral constituency. During this period, the MOH began delegating administrative and financial authority to its subordinate institutions, i.e., the departments, regional directorates, district health offices and hospitals. The Local Self-

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<sup>1</sup> Central Bureau of Statistics. 2012. *National Population and Housing Census 2011*. Kathmandu.

<sup>2</sup> Central Bureau of Statistics. 2013. *A Report on Census of Private Hospitals in Nepal 2013*. Kathmandu: National Planning Commission.

<sup>3</sup> RTI International. 2012. *Overview of Public-Private Mix in Health Care Service Delivery in Nepal*. NC: Research Triangle Park.

governance Act recognized the delivery of primary health care at the district level and below as one of the core functions of local government bodies, i.e. municipalities, District Development Committees and Village Development Committees. Subsequently, the MOH handed over 1,433 health facilities in 28 districts to these local government bodies.<sup>4</sup>

However, the multiparty political system did not meet people's expectations, as it was marred by continuous political disagreements between and within political parties and frequent changes in government. This meant that, despite the many reforms during the 1990s, the country never enjoyed a credible and predictable leadership that would drive socioeconomic development. On the other hand, the role of civil society and NGOs, suppressed during the Panchayat era, blossomed, bringing about awareness among the general populace of social, economic, political and legal issues. Ordinary citizens, who had been largely excluded from social, economic and political happenings, were now flooded with new knowledge. The flagging political system juxtaposed with a newly found sociopolitical conscience of ordinary citizens, creating a conducive atmosphere for further political conflict.

In 1996, amid this volatile atmosphere, the Maoists publicly announced the beginning of an armed insurgency in Nepal. A decade-long conflict left more than 13,000 killed and many more displaced internally.<sup>5</sup> The economic ramifications of the armed conflict were immense: It destroyed much of the country's infrastructure, the already weak industrial sector was brought to a virtual stand-still, the tourism sector declined, and it set off a widespread trend of migrant workers leaving home to work abroad.

Even though the health sector was not targeted directly, the destruction of the supporting infrastructure—transportation, energy, communications, etc.—hindered the delivery of health care services. Deteriorating governance and the worsening security situation also had a negative impact on the country's health systems. For example, the GON's decision to dissolve local government under the pretext of armed conflict indefinitely halted the earlier progress made on decentralizing health care. Mobilizing health workers and resources was particularly difficult due to frequent transportation blockades, threats of abduction and forced levy demands. The "forced" use of public health logistics (drugs, supplies, vehicles, etc.) by the warring factions also hampered activities on the ground.<sup>6</sup>

To minimize the effect of armed conflict in health service delivery, many development partners, including USAID and INGOs, adopted conflict-sensitive approaches, such as Safe and Effective Development in Conflict and "Do No Harm" policies.<sup>7 8</sup> The conflict also compelled the development partners to better collaborate with each other.

Although there were a few intermittent cease-fires, the armed conflict did not end until 2006, following the people's uprising (*Jana Andolan II*) to end the direct rule of the king and the signing of the Comprehensive Peace Accord between the government and the Maoist rebels. The interim constitution drafted in 2007 abolished the constitutional monarchy and declared Nepal a "Federal Democratic Republic State." A Constituent Assembly was formed in 2008 through national elections, with its foremost responsibility to draft a new federal constitution. However, it failed to write and pass the new constitution amid continuous political disagreements and increased protests and violence by splintered

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<sup>4</sup> Government of Nepal. 2013. *Collaborative Framework Signed between Ministry of Health and Population and Ministry of Federal Affairs and Local Development for Strengthening Local Health Governance in Nepal*. Kathmandu.

<sup>5</sup> United Nations Office of the High Commissioner for Human Rights. 2012. *Nepal Conflict Report*. Geneva.

<sup>6</sup> Pokhrel, Sudip, K.K. Singh, and Friedegar Stierle. 2008. *GTZ's Modes of Delivery in the Joint Cooperation Project Health Sector Support Programme (HSSP) During the Armed Conflict in Nepal*. Kathmandu: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

<sup>7</sup> Ibid.

<sup>8</sup> Bauman, Peter and Winifred Fitzgerald. 2006. *Do No Harm in Nepal*. Kathmandu: Collaborative Development Alternatives.

political groups, which remained outside of mainstream politics and harbored a different political agenda. Because of the failure of the first Constituent Assembly to produce the constitution within the mandated period, a second was formed through fresh national elections in 2013. The Assembly finally promulgated the Constitution of Nepal in September 2015, which was endorsed by 90 percent of its members. Despite a two-thirds majority accepting the constitution, political parties representing certain ethnic groups, especially the Madhesi community in the Terai region, have rejected it on the grounds that it is discriminatory; issues with citizenship provisions and existing demarcation of provincial boundaries are some of the main contentious issues. The ensuing protests in the Terai region have led to border closures affecting imports from India, which have created serious scarcity of daily supplies and commodities in Nepal's markets, and thus far caused nearly USD 1 billion of economic loss.<sup>9</sup>

Despite the ongoing political instability, the promulgation of the new constitution does present a few opportunities for the health sector. The Interim Constitution of 2007 had, for the first time in the history of Nepal, declared health as a fundamental right of every citizen. The 2015 Constitution of Nepal continues to preserve health as a fundamental right. This and other constitutional provisions in health provide a basis for the GON to adopt and roll out social health protection measures to safeguard the health of the citizens incurring catastrophic expenditure in health care. The forthcoming federal form of governance also presents an opportunity for the health sector to restructure its institutions and reorganize existing functions to make them more conducive to sustaining existing achievements and to tackle emerging health challenges. For the health sector, federalism is also an opportunity to effectively devolve and decentralize the health system and health care service delivery.

## 2.2. PROGRESS WITHIN THE LEVEL OF DEVELOPMENT

With a human development index of 0.54, Nepal ranks 145th out of 187 countries. As of 2010/11, 25.16 percent of its population was living below the poverty line, compared to nearly 50 percent in the 1990s.<sup>10 11</sup> The current life expectancy of Nepalese at birth is 66.6 years. “The life expectancy of females has overtaken males in the last 30 years. Life expectancy at birth for females has increased from 48.1 years in 1981 to 67.9 years in 2011.”<sup>12</sup> In 1990, 39 percent of Nepalese were literate; by 2010, the literacy rate had increased to 66 percent. Among females, literacy increased from 12 percent in 1990 to 30 percent in 2010. Among the literate population, only 5 percent had completed high school (10 years of schooling) in 1991, which had doubled to 10 percent by 2010.<sup>13</sup>

Nepal's economy (Gross Domestic Product, GDP) grew from less than USD 5 billion in 1991 to nearly 20 billion in 2014.<sup>14</sup> The average GDP growth for the last five years (2010–2014) was 4.3 percent, but in the aftermath of the devastating earthquake, it is expected to drop to 3 percent.<sup>15</sup> Currently 60 percent of the employed population is engaged in the agriculture sector; however, “The contribution of the agriculture sector to the GDP has declined from 61% in 1981 to 31% in 2011, and the contribution of the service sector has increased from 27% to 48% during this period.”<sup>16</sup> The population census of 2011

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<sup>9</sup> *Republica Daily*. 2015. Country has suffered Rs 105b in economic losses due to blockade, says NCC. December 01.

<sup>10</sup> Gautam, Dilli Raj. 1997. Contemporary issues on population poverty and environmental crisis in Nepal. *Tribhuvan University Journal* 19.

<sup>11</sup> Central Bureau of Statistics. 2014. *Population Monograph of Nepal*. Kathmandu: National Planning Commission.

<sup>12</sup> *Ibid.*

<sup>13</sup> National Planning Commission. 1991. *National Population and Housing Census 1991*. Kathmandu; National Planning Commission. 2012. *National Population and Housing Census 2011*. Kathmandu.

<sup>14</sup> Trading Economics. Nepal GDP. <http://www.tradingeconomics.com/nepal/gdp>.

<sup>15</sup> Ministry of Finance. 2014. *Economic Survey Fiscal Year 2013/14*. Kathmandu: Government of Nepal; National Planning Commission. 2015. *Final Report on Post Disaster Needs Assessment and Recovery Plan of Health and Population Sector*. Kathmandu.

<sup>16</sup> Government of Nepal. National Planning Commission. Central Bureau of Statistics. 2014. *Population Monograph of Nepal*.

shows that 65 percent of households have access to mobile phones. It is interesting to note that more people have access to mobile phones than toilets (only 62 percent) in their households.

### 2.3. HEALTH AND POPULATION OUTCOMES

Despite many political upheavals and governance challenges, Nepal has made steady progress in improving health and population outcomes. In particular, Nepal's achievements in family planning, reducing child mortality and improving maternal health are seen as exemplary successes and often lauded internationally, as they are part of the Millennium Development Goals (MDG) 4 and 5. Between 1990 and 2014, Nepal has reduced under-5 mortality by a remarkable 73 percent, from 142 deaths per 1,000 live births in 1990 to 38 in 2014. This period also saw an impressive 67 percent decline in infant mortality, from 99 per 1,000 live births to 33. During this period, neonatal mortality was only reduced by 57 percent, from 53 per 1,000 live births to 23, which is why currently it accounts for more than 50 percent of all under-5 mortality in Nepal.<sup>17 18</sup> The current data on maternal mortality remain contentious, but using the estimate of the UN agencies, it has declined by 76 percent (from 790 per 100,000 live births to 190) between 1996 and 2013.<sup>19</sup> (See Annex 6. Trends in Key Health Indicators in Nepal, 1991–2014.)

The achievements in the MDGs were made through the joint efforts of the GON and development partners. Strong support from USAID and other development partners to the GON in setting up and nurturing community-based approaches and interventions contributed significantly to improving child survival and maternal health in Nepal. Female Community Health Volunteers (FCHVs), community-based Integrated Management of Childhood Illnesses (CB-IMCI), numerous community-based clinical trials and research are examples of support provided by USAID and other development partners. Furthermore, the strong partnership formed between the GON and EDPs with the advent of the Sector-wide Approach (SWAp) has resulted in a rapid, nationwide scale-up of proven initiatives, such as the safe delivery incentive scheme (Aama Program).<sup>20</sup> (See Annex 5 for a more detailed discussion of MDGs.)

Outstanding progress was made in immunization over the last 25 years. Vaccine coverage has nearly tripled from 28.8 percent in 1991<sup>21</sup> to 84.5 percent<sup>22</sup> in 2014. The GON plans to achieve full immunization coverage by 2017, and it has already achieved polio-free status, maternal and neonatal tetanus elimination status, the measles mortality reduction goal and control of Japanese encephalitis. The introduction of community-based programs has paid dividends. The case fatality rate of acute respiratory infections among children under 5 has decreased from 0.24 in 1994 to 0.06 in 2014. The case fatality rate of diarrhea among children under 5 also declined from 0.29 in 1994 to 0.02 in 2014.<sup>23</sup>

Improving maternal and child nutrition continues to be a challenge for Nepal, but some progress has been made. In 1996, 48 percent of children under 3 were stunted, and 47 percent were underweight. For children under 5, the prevalence of stunting in 2001 was 57 percent, and 43 percent were underweight. By 2014, the prevalence of stunting and underweight among children under 5 decreased to 37 percent and 30 percent, respectively. Despite this declining trend, Nepal is still above the WHO threshold. Wasting is another area where Nepal needs to make major improvements; currently 11

<sup>17</sup> UN Inter-agency Group for Child Mortality Estimation. 2014. *Levels & Trends in Child Mortality*. New York.

<sup>18</sup> Central Bureau of Statistics. 2014. *Nepal Multiple Indicator Cluster Survey 2014 Key Findings*. Kathmandu.

<sup>19</sup> WHO et al. 2014. *Trends in Maternal Mortality: 1990 to 2013*. Geneva.

<sup>20</sup> Vaillancourt, Denise and Sudip Pokhrel. 2012. *Aid Effectiveness in Nepal's Health Sector: Accomplishments to Date and Measurement Challenges*. Kathmandu: International Health Partnership (IHP+).

<sup>21</sup> Ministry of Health. 1993. *Nepal Fertility, Family Planning and Health Survey 1991*. Kathmandu.

<sup>22</sup> Central Bureau of Statistics. *Nepal Multiple Indicator Cluster Survey 2014 Key Findings*.

<sup>23</sup> Department of Health Services. 2015. *Annual Report 2070/71*; Department of Health Services. 1995. *Annual Report 2051/2052*.

percent of children are wasted and 3 percent are severely wasted.<sup>24</sup> Nepal's community-based micronutrient supplementation programs, such as vitamin A supplementation and antenatal iron and folic acid supplementation are often recognized at international conferences. A study conducted in 2005 showed that vitamin A supplementation reduced "the odds of dying at age 12-59 months by slightly more than half";<sup>25</sup> similarly, a 2015 study on antenatal iron and folic acid supplementation showed significant contribution in reducing the risk of neonatal and under-5 mortality in Nepal.<sup>26</sup> Despite these successes, further challenges remain. Micronutrient deficiencies continue to prevail in communities, with high anemia rates of 46 percent among children under 5 and 35 percent among women of reproductive age. Anemia prevalence is even higher for pregnant women (48 percent). Even though acute undernutrition among women is declining, 18 percent still have a Body Mass Index of under 18.5. It is important to note the recent rise in obesity among Nepalese women: As of 2014, 14 percent were obese, as compared to 9 percent in 2006.<sup>27</sup>

New HIV infections have declined from 8,329 in 2002 to 1,408 in 2013 and are expected to decrease to 720 in 2020. Although antiretroviral treatment (ART) coverage has improved, with more than 10,000 treatments, there is still a need to provide treatment to all of the almost 23,000 reported cases. The current 21 percent coverage of prevention of mother-to-child transmission (PMTCT) also needs major improvement.<sup>28</sup> The government plans to eliminate malaria by 2026, as the parasite incidence for malaria is declining.<sup>29</sup> The tuberculosis (TB) case detection and success rates have improved, but the increase of drug-resistant TB needs attention.<sup>30</sup> Nepal has already achieved elimination status for leprosy and kala-azar (visceral leishmaniasis) and plans to reach elimination status for trachoma and lymphatic filariasis by 2017 and 2020, respectively.<sup>31</sup>

For the last three decades, the population growth in Nepal hovered around 2-2.5 percent, but now it has declined to 1.35 percent.<sup>32</sup> This decline is often attributed to the reduction in the fertility rate in recent years and growing trend of youth migration.<sup>33</sup> The total fertility rate (TFR) declined significantly from 5 births per woman in 1990 to 2.3 in 2014.<sup>34</sup> The contraceptive prevalence rate (CPR) increased steadily by 2 percent per year between 1996 and 2006<sup>35</sup> but has stagnated in the last decade. Experts have attributed this stagnation to five factors: high spousal separation due to the growing trend in migration, increase in traditional family planning methods, easier access to abortion services, increase in

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<sup>24</sup> Central Bureau of Statistics. *Nepal Multiple Indicator Cluster Survey 2014 Key Findings*.

<sup>25</sup> Thapa, Shyam, Minja Kim Choe, and Robert D. Retherford. 2005. Effects of vitamin A supplementation on child mortality: Evidence from Nepal's 2001 Demographic and Health Survey. *Tropical Medicine and International Health* 10, no. 8.

<sup>26</sup> Yasir Bin Nisar et al. 2015. Antenatal iron-folic acid supplementation reduces neonatal and under-5 mortality in Nepal. *The Journal of Nutrition* 145, no 8.

<sup>27</sup> Ministry of Health and Population; New ERA; and ICF International, Inc. 2012. *Nepal Demographic and Health Survey 2011*. Kathmandu.

<sup>28</sup> National Centre for AIDS and STD Control. 2014. *Country Progress Report on HIV/AIDS Response Nepal*.

<sup>29</sup> Epidemiology and Disease Control Division. 2011. *Nepal Malaria Strategic Plan 2011–2016*. Kathmandu.

<sup>30</sup> Shrestha, Lochana, Kashi Kanta Jha, and Pushpa Malla. 2010. Changing Tuberculosis Trends in Nepal in the Period 2001–2008. *Nepal Medical College Journal* 12, no. 3.

<sup>31</sup> USAID. Nepal's NTD Program. USAID, <http://www.neglecteddiseases.gov/countries/nepal.html>

<sup>32</sup> Central Bureau of Statistics. *National Population and Housing Census 2011*.

<sup>33</sup> *Population Monograph of Nepal*.

<sup>34</sup> *Nepal Multiple Indicator Cluster Survey 2014 Key Findings*. Central Bureau of Statistics (GON) and UNICEF Nepal.

<sup>35</sup> Ministry of Health and Population, New ERA, and Macro International Inc. 2007. *Nepal Demographic and Health Survey 2006*. Kathmandu.

use of emergency contraceptives, and unmet family planning needs among certain groups.<sup>36</sup> Improving the CPR and addressing unmet need remain the foremost challenges in family planning. The GON has made an international commitment to address these issues by 2020, including meeting the CPR target of 52.<sup>37</sup>

In 1991, nearly 6 million young people aged 10-14 lived in Nepal; by 2011, this number increased to 9 million, one third of the population. The average age of first marriage among men is 21.6 years, while for women, it is 17.5 years.<sup>38</sup> Despite more attention in recent years within the health sector, Nepal is still struggling with providing youth- and adolescent-focused health services. The Mid-term Review of the Nepal Health Sector Programme 2010–2015 (NHSP II) notes that while there has been a remarkable increase in the number of health facilities providing adolescent-friendly health services (from 78 in 2011 to 500 in 2013), existing challenges include quality of care, availability of human resources, and physical infrastructure, which all hamper effective health care services to young people.<sup>39</sup>

Migration is a rapidly growing trend in Nepal. The percentage of the population living outside of Nepal has doubled from 3.5 percent in 1990 to 7.2 percent in 2011. In terms of numbers, 658,290 people were living abroad in 1990; by 2000 this increased to 762,181, and as of 2011, 1,921,494 Nepalese were living out of the country.<sup>40</sup> The main reason for migration is foreign employment, which has become a major source of income for many Nepalese households. In 2013, remittances from abroad were more than USD 5 billion, which is 25 percent of the national GDP. Currently a majority of migrant laborers are men. In 2013, 95 percent of labor permits were issued to men; however, if those going abroad through informal channels are counted, female migration might be as high as 12 percent of the total workforce abroad.<sup>41</sup> In addition to outbound migration, internal migration is also increasing. In 2011, 2.6 million inter-district migrants were reported to be lifetime migrants, as compared to 1.5 million in 1981. Primarily because of the increase in male migration, female-headed households have doubled since 1990, from 13 percent to 26 percent.<sup>42</sup> The vulnerability of migrants to certain health risks is a growing challenge. For example, “The highest percentage of total cases of HIV in Nepal (46%) is contributed by seasonal labor migrant workers.”<sup>43</sup>

Nepal is urbanizing rapidly. Since 1990, the urban population has nearly doubled. The population census of 2011 shows that the urban population, residing in 58 municipalities, constitutes 17 percent of the total population. However, if the 72 municipalities that were declared after 2010 are included, (130 municipalities in total), the urban population constitutes 27 percent of the total population. This growth in urban population has also increased urban poverty and health inequities. For example, children from the poorest wealth quintile in urban areas are 4.5 times more likely to die before the age of 5 than those of the wealthiest urban quintile. Similarly, only 45 percent of women in the poorest urban wealth

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<sup>36</sup> Shrestha, D.R., A. Shrestha, and J. Ghimire. 2012. Emerging challenges in family planning programme in Nepal. *Journal of Nepal Health Research Council* 10, no. 21.

<sup>37</sup> *Family Planning 2020: Commitment Form for Countries*, (16 March, 2015).

<sup>38</sup> Ministry of Health and Population, New ERA and ICF International Inc. *Nepal Demographic and Health Survey 2011*.

<sup>39</sup> David Daniels et al. 2013. *Nepal Health Sector Programme II Mid-Term Review*.

<sup>40</sup> Central Bureau of Statistics. *National Population and Housing Census 1991; National Population and Housing Census 2011*.

<sup>41</sup> International Labour Organization. *Labour Migration in Nepal*. <http://www.ilo.org/kathmandu/areasofwork/labour-migration/lang--en/index.htm>.

<sup>42</sup> Central Bureau of Statistics. *Population Monograph of Nepal*.

<sup>43</sup> Aryal, Arjun, Y.N. Yogi, and H. Ghimire. 2013. Vulnerability to unsafe sex and HIV infection among wives of migrant workers in far western Nepal. *Journal of Chitwan Medical College* 3, no. 3.

quintile have access to skilled birth attendants, compared to 85 percent of women in the wealthiest urban quintile.<sup>44</sup>

## 2.4. EQUITY AND QUALITY

Despite overall progress made during recent years, equity gaps persist, and marginalized and vulnerable communities continue to face several barriers in accessing health care services. The Gender Equality and Social Inclusion strategy of the MOH specifically mentions financial, sociocultural, geographical and institutional barriers that impede marginalized communities' access to services.<sup>45</sup> These barriers have resulted in health outcome disparities among different population groups. For example, under-5 mortality in the poorest income quintile is more than double (75) than in the wealthiest quintile (36). Similarly, despite Nepal enjoying high immunization coverage, certain groups continue to be excluded, as documented by the Nepal DHS 2011; 10 percent of children did not receive full immunization, and 3 percent did not receive any vaccinations.<sup>46</sup> Such patterns of internal disparities are visible across a wide range of health services, e.g., family planning, nutrition, safer motherhood and the treatment and control of communicable diseases.

Although the narrowing of these equity gaps continues to be a challenge for the sector, a few recent initiatives have contributed to some positive changes. The safer-delivery incentive scheme, the *Aama* program, has increased delivery at health institutions, not only among the general population and in wealthier communities, but also for the disadvantaged and marginalized. In fact, a 2013 assessment of *Aama* showed that the highest proportion of mothers delivering under this scheme belonged to *Dalit* caste groups and religious minorities.<sup>47</sup> Even though it may be difficult to attribute directly, one survey has shown that since the introduction of the free health care policy in 2008, "Households from the poorest quintile were most likely to have received services free of charge..."<sup>48</sup> The GON is also planning to pilot a social health insurance scheme in three districts. Among other things, the pilot is expected to generate evidence of the feasibility of using social health insurance as a vehicle to protect the poor and marginalized populations from incurring catastrophic expenditure in seeking health care. The health management information system (HMIS) has also started to record and will eventually report service statistics disaggregated by caste, ethnicity and gender. As part of the National Action Plan in the Prevention of Gender-based Violence, the MOH has also started One-Stop Crisis Management Centers to treat and counsel the victims of gender-based violence.

The foremost challenge facing the health sector today is ensuring quality of health care services. There have been some sporadic efforts earlier, but no concrete headway has been made to improve the quality of care. In many instances, such as establishing birthing centers, the focus has been on promoting access to care rather than quality. Improving quality at the point of service delivery is an area needing urgent attention and significant investments from both the GON and development partners. They have made some joint attempts to develop a district quality management system and a performance-based

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<sup>44</sup> Health Research and Social Development Forum and COMDIS-HSD. 2014. *Urban Health Technical Brief*. Kathmandu.

<sup>45</sup> Ministry of Health and Population. 2013. *Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector*. Kathmandu: Government of Nepal.

<sup>46</sup> Ministry of Health and Population, New ERA, and ICF International Inc. *Nepal Demographic and Health Survey 2011*.

<sup>47</sup> Upreti, Senendra Raj, et al. 2013. *Rapid Assessment of the Demand Side Financing Schemes: Aama and 4ANC Programmes*. Kathmandu: Ministry of Health and Population.

<sup>48</sup> RTI International. 2010. *Pro-Poor Health Care Policy Monitoring: Household Survey Report from 13 Districts*. Kathmandu, Research Triangle Park, NC.

management system, and in 2009 the GON even developed the Quality Assurance Policy; however, commensurate resources to implement these instruments were never secured.<sup>49</sup>

Perhaps the reason for limited success in improving the quality of care is because quality is often a resultant effect achieved by making cumulative improvements in the overall health system, and there are still many deficits in components of Nepal's health systems. For example, to make a positive change in the quality of care, major improvements are needed in the management of human resources, procurement and finances, and in government regulatory functions. The National Health Sector Strategy 2015–2020 recognizes this and has also identified concrete measures, such as defining standards to measure quality of care at health facilities and setting up a semi-autonomous accreditation body for quality assurance.

## 2.5. TRIPLE BURDEN OF PUBLIC HEALTH PROBLEMS

In addition to communicable diseases, Nepal also faces the burden of non-communicable diseases and increasing threats to human health from natural disasters, climate change, road traffic accidents, violence and injuries. There are estimates that in Nepal, non-communicable diseases account for more than 44 percent of deaths, 80 percent of outpatient contacts, and 39 percent of disability-adjusted life years lost.<sup>50</sup> The devastating earthquake of April 2015, which resulted in nearly 9,000 deaths and more than 22,000 injuries,<sup>51</sup> exposed the limited capacity of the health sector in the area of disaster preparedness and response. Similarly, there is very little knowledge within the health sector on the consequences of climate change for human health.<sup>52</sup> In the last decade, 9,000 Nepalese have lost their lives in road traffic accidents;<sup>53</sup> Nepal's fatality rate of 17 per 10,000 registered vehicles in 2009/10 is one of the highest in the world.<sup>54</sup>

## 2.6. HEALTH SYSTEMS AND GOVERNANCE

As discussed above, Nepal's health system has several shortfalls. In particular, human resource management continues to be an Achilles' heel for the GON. All aspects of human resources—production, recruitment, deployment and retention—suffer from many deficits.<sup>55</sup> This has resulted in unplanned recruitment, ad hoc deployment, frequent transfer of staff and high absenteeism of health facility workers. It is interesting to note that all these issues are well known to the GON and development partners, but solutions are not forthcoming. This could be because of undue political influence within the bureaucracy and the current structure of the civil service, which may want to preserve the status quo. Therefore, many in the sector believe that human resource issues can only be solved by overhauling the entire civil service and restructuring the health sector. The National Health Sector Strategy NHSS 2015–2020 has emphasized revisiting the current structure and restructuring the

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<sup>49</sup> Daniels, David, Kapil Ghimire, Poonam Thapa, Marc Réveillon, Deb Raj Pathak, Kedar Baral, Narmeen Hamid, et al. 2013. *Nepal Health Sector Programme II Mid-Term Review*.

<sup>50</sup> Ibid.

<sup>51</sup> National Planning Commission. *Final Report on Post Disaster Needs Assessment and Recovery Plan of Health and Population Sector*.

<sup>52</sup> Sharad Onta. 2007. Climate change and health: An overview. Paper presented at the National Workshop on Climate Change and Human Health: Potential Impact, Vulnerability and Adaptation in Kathmandu, Nepal.

<sup>53</sup> Thapa, Arjun Jung. 2013. Status paper on road safety in Nepal. Europe-Asia Road Safety Forum and the 67th Session of the Working Party I of UNECE. New Delhi: Department of Roads.

<sup>54</sup> Ministry of Physical Planning and Transport Management. 2013. *Nepal Road Safety Action Plan (2013–2020)*. Kathmandu: Government of Nepal.

<sup>55</sup> Ministry of Health and Population. 2012. *Human Resources for Health Strategic Plan 2011–2015*. Kathmandu: Government of Nepal.

MOH within the next five years, but this is only possible if there is a firm high-level political commitment and follow-through at the ministry level.

The health sector procurement system and supply chain management are weak, resulting in resource inefficiencies and frequent stock-outs of drugs and commodities at health facilities. Public financial management capacity is also weak, with the budget absorption rate hovering around 75-80 percent in recent years.<sup>56</sup> There are persistent delays in authorization of expenditures and poor reporting of expenditures. The recently developed Transaction and Budget Control System is expected to improve expenditure reporting. There is also a need to revise the current resource allocation practice and develop a need-based formula.

Monitoring and evaluation, information management and reviews have shown some improvement,<sup>57</sup> but much remains to be done. Different information systems operate without functional linkages between them. In recent years, the performance of the HMIS has also decreased. The GON has started to draft an e-Health strategy to further improve information management functions, overall health governance and use of data for planning, as well as to ensure data protection and confidentiality.

There are some examples of public-private partnerships in the health sector. The GON has partnered with the non-state sector in areas such as treatment of uterine prolapse, family planning and eye care, but strategic thinking on systematically leveraging the private sector is still needed. The State and Non-State Partnership Policy drafted in 2012 is yet to be endorsed, as there is no momentum within the GON to take it forward.<sup>58</sup> The government plays the role of service provider rather than service guarantor, and in many instances is “competing” with the private sector. As compared to the service provision function, the regulatory function of the government is extremely weak. Also, the development partners have not shown much enthusiasm for developing government regulatory capacity. Since 1990, the involvement of the private sector in health has grown exponentially. A survey conducted in 2013 showed that the number of beds in the private sector (19,580) is much higher than what is available in the public sector (5,644).<sup>59</sup> This fact alone warrants strong partnership with and regulation of the private sector; unfortunately, both of these aspects remain weak.

In recent years, much thought has been given to the fact that health is not solely the business of the MOH or health sector at large, but that other sectors also contribute significantly. The government has developed multisectoral plans in areas such as nutrition, water, sanitation and hygiene (WASH) and road-traffic accidents. However, in practice, it is difficult to bring different sectors together. Therefore, while multisectoral collaboration is very much needed in the health sector, renewed thinking is required on the practicalities of harnessing multisectoral partnerships and the often elusive realities that such partnerships entail, plus the challenges of implementing such a strategy.

Despite the rhetoric on decentralization, planning and budgeting primarily remain top-down, with very limited delegation of financial authority at lower levels. The MOH and Ministry of Federal Affairs and Local Development signed a collaborative framework in 2014 to jointly promote health sector decentralization and local health governance, but very little has been achieved to date. At the subnational level, the districts do develop health plans, but these are rarely honored by the central level, with budget flowing at the discretion of the central level rather than according to districts’ needs.

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<sup>56</sup> Daniels et al. *Nepal Health Sector Programme II Mid-Term Review*.

<sup>57</sup> Ibid.

<sup>58</sup> Ministry of Health and Population. 2014. *Progress Report on Partnership, Alignment and Harmonisation in the Health Sector*. Kathmandu: Government of Nepal.

<sup>59</sup> Central Bureau of Statistics. 2013. *A Report on Census of Private Hospitals in Nepal*.

Without the devolution of authority for both personnel and budgets, true decentralization remains unattainable.

## 3. INTERNATIONAL ASSISTANCE TO THE HEALTH SECTOR

### 3.1. DEVELOPMENT COOPERATION TO THE HEALTH SECTOR

Global development assistance in health has substantially increased since 1990. Approximately USD 7 billion was disbursed globally as health aid to low- and middle-income countries in 1990; by 2014, the total disbursement had reached USD 35.9 billion. The surge in health aid was substantial between 2000 and 2010, perhaps fueled by the launch of the MDGs, with an annual increase of 11.3 percent. However, during 2010–2014, global health aid stagnated, with the total disbursement hovering around USD 35 billion. If the annual growth rate of 11.3 percent had continued, an additional USD 38.4 billion would have been available for global health during these four years. The United States continued to be the largest source of global health aid, disbursing USD 12.4 billion in 2014, followed by the United Kingdom, which disbursed USD 3.8 billion. Since 2000, the growth in global health aid was substantial for HIV/AIDS: 15.8 percent annual growth, as compared to a modest annual growth of 6.2 percent for maternal, neonatal and child health (MNCH). Furthermore, the growth for child health was 8.3 percent per year, as compared to only 3 percent for maternal health.<sup>60</sup>

Government health expenditure in low and middle-income countries continues to grow, and by 2012, it had reached USD 711.1 billion globally, 9.7 percent more than in 2011. This means that government health expenditure was considerably higher than development assistance in health, with USD 19.8 in government expenditure for each dollar coming from health aid.<sup>61</sup>

In Nepal, the contribution of the EDPs to the health sector since 2005 has remained almost one third of the total MOH expenditure. In 2009, the EDP contribution reached its highest level at 42 percent, and in 2013 it was the lowest (25 percent).<sup>62</sup> Donors' health contribution may decrease further in light of Nepal's plan to graduate to the status of a Lower-Middle Income Country by 2022.<sup>63</sup>

Both India and China continue to be major donors to the health sector in Nepal. Despite being signatories to the Paris Declaration on Aid Effectiveness, these two countries primarily operate independently, without maintaining any linkages or coordinating with other development partners.<sup>64</sup> One study estimated that between 1990 and 2013, India invested approximately USD 85 million in Nepal's health sector, and China invested approximately USD 50 million. However, this unofficial estimate is conservative and does not capture all the investments, e.g., 342 ambulances provided by India from 1994 to 2012. Therefore, the actual investments made by India and China could be much higher.<sup>65</sup>

Many view the endorsement of the Health Sector Reform Strategy and subsequent advent of the SWAp in 2004 as a beginning to an improved partnership between the GON and the EDPs. Nepal's health

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<sup>60</sup> Institute for Health Metrics and Evaluation. 2015. *Financing Global Health 2014: Shifts in Funding as the MDG Era Closes*. Seattle, WA: IHME.

<sup>61</sup> Ibid.

<sup>62</sup> Ministry of Finance. *Red Book 2009–2014*. Kathmandu: Government of Nepal.

<sup>63</sup> Central Bureau of Statistics. 2011. *Nepal Living Standards Survey 2010/11*.

<sup>64</sup> Alice Schmidt. 2009. *Health Aid Effectiveness in Nepal: Paris, Accra, civil society and the poor*. Action for Global Health.

<sup>65</sup> Haomin Yang et al. 2014. Development assistance for health given to Nepal by China and India: A comparative study. *Globalization and Health* 10, no. 1.

sector SWAp is also seen as mature.<sup>66</sup> Since 2005, under the SWAp framework, there has been progress in the formulation and implementation of results-oriented strategies in the health sector. The five-year health strategic plans for the periods 2005–2010, 2010–2015 and 2015–2020 were developed with the joint participation of the GON, EDPs and other state and non-state stakeholders. The SWAp has also provided a better environment to practice the use of a single monitoring and evaluation framework for the health sector. At the implementation level, there is also a growing culture of working through technical working groups, comprised of representatives from the government and its partners. Since the beginning of the SWAp, the EDPs have met fortnightly as a semiformal group, with the chair and co-chair positions rotating annually. Many see this forum as having contributed to improved harmonization among the EDPs.<sup>67</sup> One of the important instruments of the SWAp is the Joint Annual Review, in which the MOH, EDPs and an increasing number of non-state actors, such as INGOs and civil society, discuss and review national strategies and programs. Based on the results of these mechanisms, a mutually agreed-upon aide-mémoire is developed for the period of one year. The Joint Financial Arrangement for NHSP II, signed between MOH and eight EDPs in 2010, set out harmonized procedures for performance reviews, financial management and coordination of planning, monitoring and review exercises.

Many in the sector feel that the SWAp approach and partnership mechanisms within it need some adjustments to engage the EDPs and the GON in meaningful policy dialogue. For example, the wide perception within the government is that forums such as the Joint Annual Review only instigate a one-way conversation, with EDPs questioning and government responding, rather than facilitating a mutual dialogue to address issues and challenges. Joint Annual Reviews also need to be more effective as a platform to assess EDPs' performance on their aid commitments.<sup>68</sup> Two large donors in the health sector, India and China, are yet to be integrated fully within the SWAp framework. The same also applies to INGOs, which are not officially mandated to report to the MOH on their activities. This has proved difficult for the MOH, and to some extent also for the EDPs, to map all the support provided by INGOs to the sector. Both the EDPs and INGOs working in the health sector have their own respective forums to coordinate among themselves, but these almost never meet together, leaving a disconnect between two important sets of health sector partners. An important objective of the SWAp is to reduce the transaction cost, especially for the government. However, transaction costs to the government and EDPs under SWAp have not been fully assessed, and there is mixed evidence on whether they have increased or decreased. While the culture of working through technical working groups is firmly established in the sector, often these groups enjoy strong EDP participation but suffer from low GON participation and ownership.<sup>69</sup> There are perceptions within the senior leadership of the MOH that the EDP forum may be effective in harmonizing among the donors, but that it does not add much value for the government. This feeling stems primarily from the fact that the GON sees the EDP forum as not being able to go beyond their individual bilateral agreements with the GON to provide support to meet their emerging or unanticipated needs. The engagement of civil society in important events, such as Joint Annual Reviews, has improved over the years; however, they are not systematically involved in policy dialogues and sector meetings, and there is often a practice of selectively engaging only a few organizations, which may not necessarily represent the people on the ground. The limited and selective engagement of civil society could also be due to the fact that health is not a priority for many

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<sup>66</sup> Daniels et al. *Nepal Health Sector Programme II Mid-Term Review*.

<sup>67</sup> Vaillancourt, Denise and Sudip Pokhrel. 2012. *Aid Effectiveness in Nepal's Health Sector: Accomplishments to date and measurement challenges*. Kathmandu: International Health Partnership (IHP+).

<sup>68</sup> Ibid.

<sup>69</sup> Ibid.

civil society organizations in Nepal, and they do not coordinate well among themselves at the national level.<sup>70</sup>

Effectively coordinating and managing technical assistance remains a challenge in the health sector. Earlier efforts made by the EDPs and the GON, such as the Joint Technical Assistance Agreement and Technical Assistance Matrix, have not produced results. Despite a few initial discussions, the Joint Technical Assistance Agreement failed to materialize, and the publication and use of the Technical Assistance Matrix<sup>71</sup> has been intermittent at best. In 2013, a Technical Assistance Coordination Committee was formed but remains inactive. Also in 2013, at the request of the MOH, DFID agreed to put in place the Technical Assistance Resource Fund (TARF), a flexible fund designed to support the government's unanticipated technical needs. The fund is governed by a Fund Management Team, chaired by the chief of the Policy, Planning and International Cooperation Division of the MOH. The fund is set up so that MOH divisions and centers can apply to meet their immediate and unanticipated technical needs. The TARF mechanism is generally appreciated by MOH officials, but it was not widely advertised, and therefore many government officials do not know about it. Some officials are interested in expanding TARF beyond DFID's support and setting up a multi-donor technical assistance fund, but to date no concrete discussion has taken place between the GON and donors.

In 2007, Nepal became one of the first countries to sign the International Health Partnership (IHP+), which aims to strengthen health aid effectiveness and the partnership agenda at both global and country levels. The IHP+ Country Compact, locally dubbed as the Nepal Health Development Partnership, was signed in 2009 between the EDPs and the GON. The Compact was seen as a useful resource to reinforce earlier commitments to partnerships and aid effectiveness,<sup>72</sup> rather than introducing "anything new from a coordination perspective."<sup>73</sup> With the coordination support of IHP+, a Joint Assessment of National Strategies exercise was undertaken in early 2010. Involving both the GON and the EDPs, this exercise facilitated a coordinated, joint review of Nepal's draft NHSP II and subsequently contributed to the development of the Joint Financial Arrangement.

### 3.2. FINANCIAL INVESTMENT

The United States, together with Japan and the United Kingdom, are among the largest bilateral donors for Nepal, while the Asian Development Bank and the World Bank are the major donors among multilateral institutions.<sup>74</sup> EDP support is channeled through various mechanisms. Broadly, these include "Pool Fund Budgetary Support," which is reflected in the GON's annual work plan and budget and channels funds through the government Treasury; "Non-pool Budgetary Support," also reflected in the annual work plan and budget, but either managed by the supporting agency or partially provided to government spending units; and "Non-budgetary Technical Support," not reflected in the annual work plan and budget, with funds directly managed by the supporting partner providing technical assistance.

The financing trend for MOH expenditure is presented in Figure 2.<sup>75</sup> As reflected in this figure, the EDPs' share of total MOH expenditures increased alongside SWAp adoption in 2004/05, reaching 45 percent in 2008/09, up from 32 percent in 2004/05. However, since then, EDP contribution has reversed, declining to approximately 27 percent of total MOH expenditure by fiscal year 2014/15. However, this trend should be interpreted cautiously, as it captures only the expenditure that is

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<sup>70</sup> Schmidt. *Health Aid Effectiveness in Nepal: Paris, Accra, civil society and the poor.*

<sup>71</sup> Technical Assistance Matrix is a compilation of EDP support aligned with the goals of the GON's five-year health sector strategic plans.

<sup>72</sup> International Health Partnership. 2010. *IHP+ Results 2010 Performance Report.*

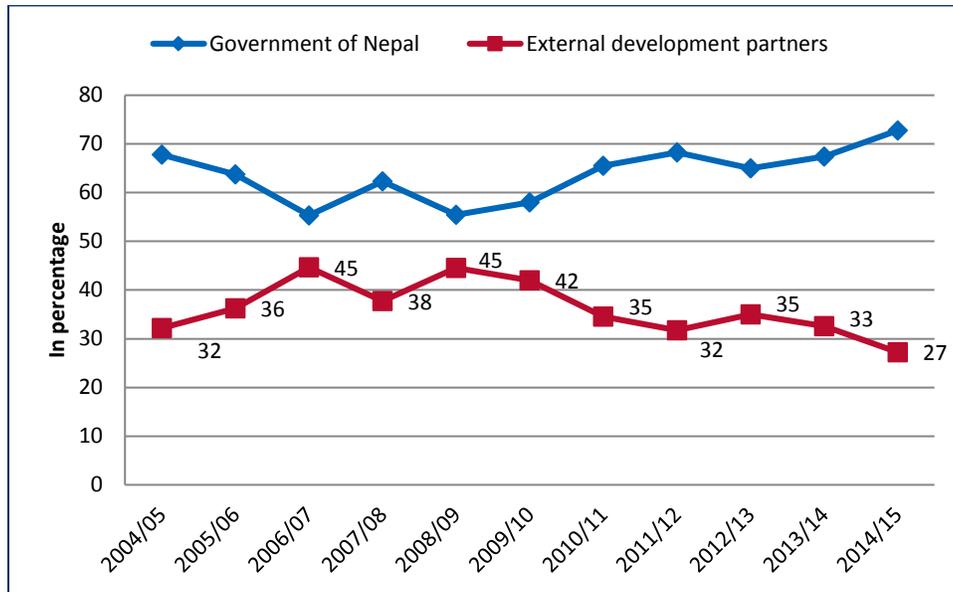
<sup>73</sup> Schmidt. *Health Aid Effectiveness in Nepal: Paris, Accra, civil society and the poor.*

<sup>74</sup> Country Strategy 2009–2013

<sup>75</sup> Source: Ministry of Finance. *Estimates of Expenditure "Red Book."* Various fiscal years.

reflected in the annual work plan and budget of the MOH, hence leaving out a substantial share of EDP funding in the form of non-budgetary technical support.

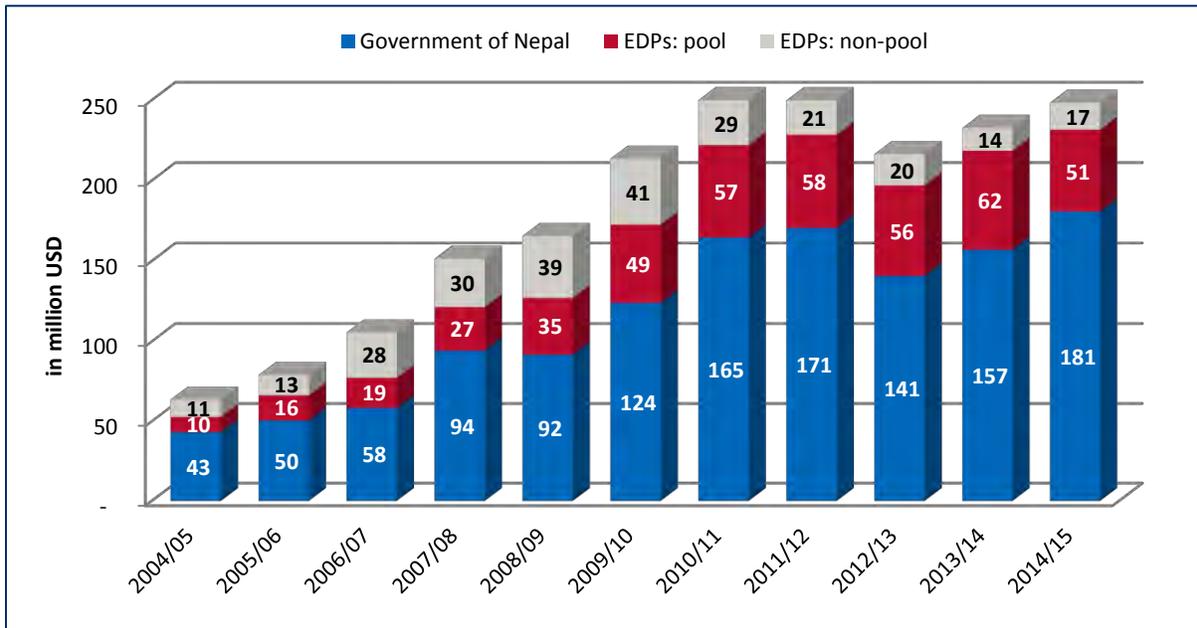
**Figure 2. Share of government and EDPs in total MOH expenditure**



The trend in MOH expenditure, which includes every source of financing, is presented in Figure 3, below.<sup>76</sup> Total MOH expenditure increased more than fivefold during the 10-year period, from 4.6 billion NPR in 2004/05 to 24.5 billion NPR in 2014/15. However, measured in U.S. dollars, expenditure only increased by 3.9 times during the same period, with the exception of a fall in expenditure in fiscal year 2012/13.

<sup>76</sup> Ibid.

**Figure 3. Trend in MOH expenditure by source of financing**





## 4. USAID’S APPROACHES TO PROVIDING HEALTH SECTOR ASSISTANCE

### 4.1. USAID’S GOALS, OBJECTIVES AND STRATEGIES DURING THE 25-YEAR TIMEFRAME

USAID/Nepal’s goals, objectives and strategies over the last 25 years, as well as positioning of health under the overall USAID strategic documents and the framing of specific objectives, have been influenced by USAID global policies, priorities and directions reflecting U.S. Government administrations, USAID funding levels and regional bureau priorities and emerging global and country-specific health issues. These factors have to be considered in the context of significant improvements in health status and the changing political and socioeconomic environment in Nepal.

**Table 1. U.S. Government administrations**<sup>77</sup>

President	USAID Administrator	Dates
1981–1989 Ronald Reagan	Peter McPherson	1981–1987
	Alan Woods	1987–1989
1989–1993 George H. W. Bush	Ronald Roskins	1990–1992
1993–2001 Bill Clinton	Brian Atwood	1993–1999
	J. Brady Anderson	1999–2001
2001–2009 George W. Bush	Andrew Natsios	2001–2006
	Randall L. Tobias	2007–2007
	Henrietta Fore	2007–2009
2009–2017 Barack Obama	Rajiv Shah	2009–2015
	Gayle Smith	2015–present

USAID/Nepal’s planning, strategic documents and agreements expressing its objectives and strategies have varied over time, in line with the above influences. Since 2000, USAID country strategy documents for Nepal have usually been applied to five-year periods, except from 2007 to 2009.

#### Late 20th century–1990s

In the early 1990s, in line with the U.S. Congress’s focus on child survival and Nepal’s high under-5 mortality rate, USAID/Washington designated Nepal as one of 22 “Child Survival Priority Countries.”<sup>78</sup> This provided the opportunity for several INGOs to bid for and implement small child survival projects in Nepal,<sup>79</sup> which were designed and implemented mostly in a single district.

Based on lessons learned from these activities, the national Child Survival/Family Planning Services bilateral project was awarded in the first half of the 1990s, reflecting USAID’s and the MOH’s emphasis on five basic themes:

- I. **Services by and for women:** The best way to get services to women—the MOH’s principal clients—is to provide them through other women. The FCHV program is a significant move in this direction.

<sup>77</sup> Devex. 2016. USAID: A history of US foreign aid. <https://pages.devex.com/USAID-history.html>

<sup>78</sup> Isaacson, Joel M. Christa A. Skerry, Kerry Moran, and Kay M. Kalavan. 2001. *Half-a-Century of Development—The History of U.S. Assistance to Nepal 1951–2001*. USAID/Nepal.

<sup>79</sup> CARE Nepal. *Child Survival in Nepal, Annual Report 2004-05*; Adventist Development and Relief Agency Nepal. 1997. *Child Survival IX*; Save. 1995. *Child Survival Final Evaluation Report*.

2. **Beyond the health post:** To address the low client flow at fixed facilities, the mission emphasizes the need for village-level health services.
3. **Full-service family planning and maternal and child health (MCH) services:** USAID emphasizes balanced motivation for and provision of temporary and permanent contraceptive methods, along with other priority MCH services.
4. **Decentralization and regionalization:** USAID support concentrated on the Central Development Region to identify issues and resource requirements needed for the development of regional and district management systems.
5. **“Don’t forget malaria”:** USAID continued support for improved training capability; decentralized case detection and treatment; service expansion to include other vector-borne diseases (e.g., Japanese encephalitis), transmission and sustained management; and political attention to ensure maintenance of a national malaria control capacity.

The contract’s original scope of work was later modified to reflect changing USAID priorities; the final scope included logistics, child survival, work plan development and procurement.<sup>80</sup> Reflecting the Clinton administration’s increased interest in population, technical support to Nepal’s family planning program was provided through USAID field support mechanisms by the Association for Voluntary Surgical Contraception/EngenderHealth (service delivery), Jhpiego (training) and the Johns Hopkins Center for Communication Programs (information, education and communication and behavior change).

During this period, an important research activity was the USAID-funded Nepal Nutrition Intervention Project in Sarlahi (1988–1991), implemented by Johns Hopkins University, which documented a 30 percent reduction in infant mortality among children 6-72 months who received high-dose vitamin A capsules. Another USAID-funded vitamin A trial, conducted in Jumla in 1989, demonstrated that the risk of death for children aged 1-59 months was 26 percent lower among those who received high-dose capsules of vitamin A than among those who did not. These findings convinced USAID and MOH senior officials of the potential of vitamin A and resulted in the continuum of action from research to pilot, policy changes and successful scale-up of the vitamin A program. The biannual supplementation program not only demonstrated that high coverage was possible and effective, but also realized the full potential of the FCHVs in community-based health programs.

This modality, used by USAID/Nepal, of basic research to establish the potential of an effective intervention, operational research to establish the feasibility of implementation, policy changes to permit the application, large-scale implementation with close monitoring and then widespread dissemination of results to influence global public health practices has been used in Nepal for a number of important health interventions, such as oral rehydration therapy for diarrheal disease, community-based diagnosis and treatment of acute respiratory illness and community-based use of chlorhexidine to reduce neonatal mortality due to sepsis.

In the mid-1990s under the Clinton administration, USAID faced a threat by the Republican Congress to eliminate USAID, and many USAID missions were closed. The USAID/Nepal budget was greatly reduced, and only the health budget was protected. In 1996, under the USAID Administrator Brian Atwood, USAID introduced strategic objectives as a means of guiding USAID programs worldwide in order to make them more understandable and defensible to Congress. USAID/Nepal selected “to reduce the fertility and protect the health of Nepalese families” as its Health Strategic Objective 2 (SO2) which remained in effect until 2007. In 2000, USAID also faced shifting priorities to address the regional crisis in Southeast Asia, and at the same time, Nepal faced an escalating conflict with the Maoist insurgency, which also led USAID/Nepal to concentrate most of its resources on health programs.<sup>81</sup>

<sup>80</sup> JSI. *Final Report, Child Survival and Family Planning Services Project, 1990–1997*.

<sup>81</sup> USAID/Nepal. *Strategic Objective 2 (SO 2) Close Out Report*.

This strategy was (and is) the basis for the Strategic Objective Grant Agreements that USAID signs with the GON Ministry of Finance, which provide the legal structure for USAID's work in Nepal.

### **Early 21st century–2001 to 2015**

The strategic objective framework straddled the 20th and 21st centuries (1996–2007) and overlapped with USAID/Nepal's Country Strategic Plan for 2001–2005. This strategy reflects USAID/Nepal's vision for responding to the changing development context in Nepal, as well as changing USAID priorities and resources. Budget constraints forced USAID/Nepal to reevaluate priorities, create greater efficiencies within the program and restructure management and technical expertise to take full advantage of the available resources.<sup>82</sup>

The new strategy comprised only three strategic objectives:

- SO2: Reduced fertility and protected health of Nepalese families
- SO4: Increased private sector participation in environmentally and socially sustainable hydropower development
- SO5: Strengthened governance of natural resources and selected institutions

Others, including agriculture and education, were completely abandoned.

Under the George W. Bush administration and USAID Administrator Andrew Natsios's management, USAID switched to a standardized set of strategic objectives. In 2005, in response to the U.S. Government's classification of Nepal as a "fragile state" because of the political crisis, USAID/Nepal prepared a new Fragile States Strategy, which was approved in 2006.<sup>83</sup> The overarching goal of this strategy was "A peaceful, prosperous and democratic Nepal." Because the course of the Maoist insurgency was difficult to predict, USAID decided to try to address major political, social and economic issues causing instability and insecurity. Thus, the strategic objectives were framed differently from those in the past, and although this strategic statement did not have a specific end date, each objective was programmed for three years instead of the usual five:

- SO 9: Enhance stability and security
- SO 10: Strengthen governance and protect human rights
- SO 11: Build capacity of critical institutions

HIV/AIDS activities were placed under SO 9, while family planning, MCH and other public health activities were placed under SO 11. The basic rationale was that improved capacity to deliver basic services to its citizens would greatly enhance the GON's status as a legitimate and effective power worthy of popular trust. The strategy permits a continued focus on quality of and access to health services.

In 2009, a few years after the comprehensive peace agreement with the Maoists, with the advent of the Obama administration with USAID Administrator Rajiv Shah, USAID entered into another five-year agreement with the GON<sup>84</sup> to build and sustain a democratic, well-governed state that responds to the needs of its people and reduces widespread poverty. The six objectives agreed under this agreement were:

1. Peace and security
2. Governing justly and democratically
3. Investing in people

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<sup>82</sup> USAID Nepal Country Strategy 2001–2005.

<sup>83</sup> USAID Nepal Country Strategy 2007–2009.

<sup>84</sup> Assistance Agreement between GON and USAID Foreign Assistance Program; Sept 01, 2009 to Sept 30, 2013.

4. Economic growth
5. Humanitarian assistance
6. Program development and program administration costs

The third objective, “investing in people,” was to assist the GON to provide sustainable, accessible and quality basic health services to its people, particularly the poor, and to strengthen its delivery system to ensure achievement of the MDGs. It is worth noting that this agreement states that the “US Foreign Assistance program will coordinate closely with the Ministry of Health and Population and other health sector donors to achieve maximum impact through the development of a unified Health Sector Implementation Plan, Phase II, 2010–2015.”<sup>85</sup> This agreement also mentions for the first time that USAID, in coordination with other stakeholders and the GON, plans to design and implement a comprehensive nutrition activity to address the malnutrition of women and children.

The latest and current country strategy is for the period 2014–2018.<sup>86</sup> In this country strategy, USAID/Nepal, as in the recent past, sets the overarching goal of fostering “a more democratic, prosperous, and resilient Nepal” over the next five years. In consonance with USAID’s strategy to address broader country development goals, the framing of objectives has also been changed, naming them “development objectives” rather than “strategic objectives,” in line with USAID/Washington directives:

- Development objective 1: More inclusive and effective governance
- Development objective 2: Inclusive and sustainable economic growth to reduce extreme poverty
- Development objective 3: Increased human capital

Development objective 3 is a continuation of SO3 “investing in people” from the previous country strategy. As in the past, USAID’s health sector support comes under this objective.

In summary, since 2000, USAID/Nepal has moved toward regular five-year strategic documents, guided in major part by new Washington administrations. The framing of the country objectives has shifted from health-specific to a broader development objective, with health seen as a means to a development objective rather than an end by itself.

Although USAID rules do not permit being a “pool partner,” USAID/Nepal has consistently made a commitment in the national strategic documents to be a partner in the unified Health Sector Plan. Despite changes in funding levels and framing of country objectives, USAID/Nepal has maintained a steady support to the health sector.

## **4.2. MODALITIES OF USAID’S ASSISTANCE TO THE HEALTH SECTOR**

USAID’s health sector approaches and policies have remained largely the same during the 25-year period, including developing an approach to work with the GON and other EDPs. Although USAID does not contribute to the pooling of funds, it has been able to find mechanisms that enable collaboration with other EDPs in the health SWAp. Interviews described USAID as focusing more on practice (rather than policy) and the implementation of projects as a way to achieve results. In addition, USAID was described as being concerned with the visible impact of its support and therefore focusing on measurable/quantifiable indicators as a way to achieve results and ensure value for money.

### **Financing modalities**

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<sup>85</sup> Ibid.

<sup>86</sup> USAID Country Development Cooperation Strategy, FY 2014 to FY 2018.

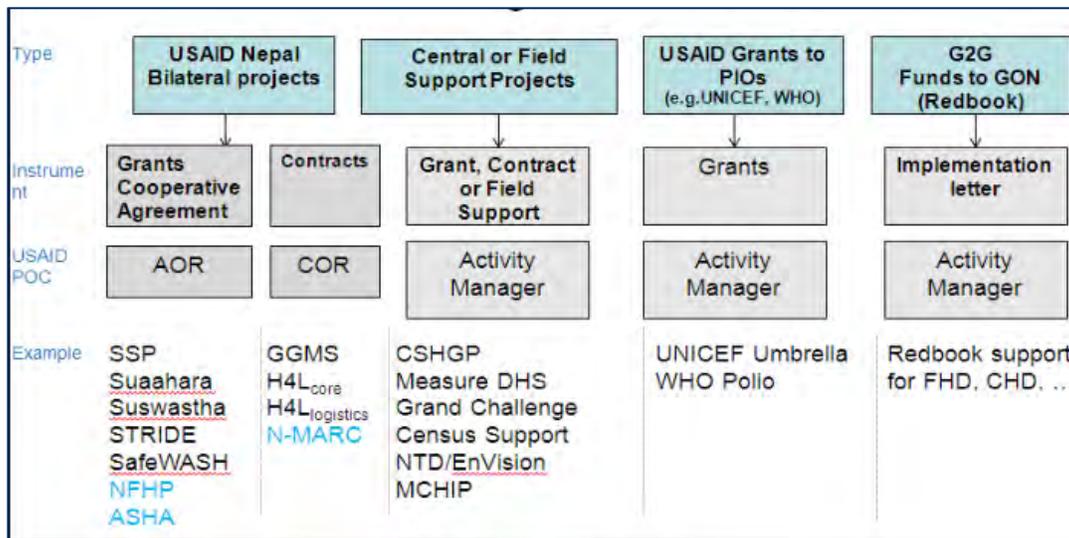
USAID puts only limited funding through the GON budget system (Treasury) because of concerns about governance and accountability. This modality of financing has continued from the early 1990s to 2015 and is discussed further below under “Direct funding for government activities following the G2G [Government to Government] channel.”

During interviews, USAID’s approaches to assisting the health sector were frequently discussed, especially by government officials and other EDPs. The GON defines its financing modalities as:

- **Budget–on treasury:** In this modality, donor funding is reflected in the Red Book (including work plans), and funds are channeled through the government treasury system.
- **Budget–off treasury:** Donor funding is reflected in the Red Book (including work plans) but not channeled through the government treasury. Interviewees viewed USAID’s motivation for using this modality to support project implementation as a mechanism for “overcoming” the government system, which is often described as being slow, bureaucratic and not compatible with the donors’ budgeting systems and financial reporting requirements. Therefore, USAID was described as channeling money through NGOs and private sector organizations to enable better oversight of the funds and to ensure results.

The following are the financing mechanisms USAID uses to provide financial and technical support to the health sector in Nepal, as illustrated in Figure 4, below:

**Figure 4. USAID funding channels**



**Bilateral projects** are commissioned through cooperative or contractual agreements, such as the Suaahara Project (cooperative) and Health for Life Project (contractual).

There is a widespread perception that USAID has shifted from cooperative agreements to more contracting, which is viewed by partners as USAID being less flexible, with more control and oversight. This was described as making it very difficult for USAID to work with the government and other partners because of the rigidity imposed on the implementing partners. However, in reality, during the 25-year period, more than 60 percent of the funding has been channeled through cooperative agreements.

Both government officials and implementing partners expressed the view that USAID works under an umbrella agreement signed with the Ministry of Finance, but line agencies are not aware of this, and details are not shared with the line agencies that are the actual implementing agencies. At times, this has created problems and delays in project implementation.

During the design phase of USAID bilateral projects, interviewees viewed consultations with the MOH to be minimal. Similarly, once USAID receives proposals for the implementation of bilateral projects, the involvement of MOH officials in the selection process is viewed as being limited to a few high-level officials, and at times is viewed as even excluding important technical people. Furthermore, the proposed activities are specially designed to respond to USAID's design of the bilateral project, and minimal leeway is provided for any subsequent changes or modifications. Lastly, once the bilateral project has been awarded, the implementing partner must do most of the legwork, and communications and interactions with USAID officials are reported to be minimal.

Some government officials suggested that although the National Planning Commission does not accept the "off treasury" mechanism, some MOH officials like it because of its flexibility and faster performance. When government absorptive capacity is low, the "off budget" approach is viewed as being better and less controversial.

1. **Funding that is extended through central or field support projects**,<sup>87</sup> such as support for conducting the Demographic and Health Survey
2. **Grants to public international organizations**, such as the World Health Organization, to accomplish defined objectives
3. **Direct funding for government activities following the G2G channel**, under which supported activities are directly reflected in the annual work plan and budget (Red Book) of the government. Under this category, USAID reimburses the GON against its expenditures. However, expenditure norms of USAID do not necessarily match with those of the GON, and hence USAID may not reimburse the entire amount spent by the entities of the MOH, which complicates the government's financial management. In fact, one interviewee expressed the view that given all the problems related to accounting for USAID support through the Red Book, including strict auditing requirements, it was easier for the MOH not to receive direct funding.

On the other hand, concerns were expressed that Red Book support is not increasing, as it remained constant at around USD 1 million during 2001 to 2014, and, therefore, USAID's intention of increasing G2G support was viewed as being compromised. However, in 2015, USAID increased this amount to USD 2 million and intends to increase it even further in future years. Because of the low absorption capacity (low budget burn rate), USAID is constrained in channeling more funding through the Red Book. To improve the overall working relationship, engagement of government and ownership of USAID-supported programs, G2G support is crucial.

### **Approaches to influencing policy**

USAID's modality has always prioritized the generation of evidence for replicable interventions and scaling these up as a way to increase results and achieve targets in health outcomes. USAID draws on

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<sup>87</sup> Central support refers to funding that is originally given to the Mission, but which is sent back to Washington for projects that are managed by HQ, such as the DHS, to fund activities for the country. Field Support is funding that comes from the Country Mission to Washington-managed projects for activities that benefit the country.

global health innovations through its global work and its partnership with researchers, scientists and universities (research-practice-research linkages).

USAID prioritizes implementation of programs, in partnership with the Department of Health Services and its various divisions and other offices, over changing national policies. As part of implementing projects, it works to strengthen the health system through training, mentoring, supervision, documentation of best practices and provision of technical support to improve guidelines and strategies at the level of implementation, rather than “abstract” national policies. With Health for Life, USAID has attempted to work more explicitly at the policy level.

In the last 25 years of assistance to the health sector, USAID has focused more on service delivery than on health systems at the central level, despite USAID-funded projects being designed after first conducting an analysis of the national health sector, policies and strategies such as NHSP I and II and other sectoral strategies. The inputs in areas such as training and human resource development, logistics management/logistics management information system (LMIS), equipment and small-scale infrastructure (e.g., renovation of warehouses) are all primarily designed around service delivery of USAID-financed projects.

*Evidence-based policy development:* Working directly in service delivery and piloting innovation at the field level allowed USAID to contribute in the policy development process. It appears that USAID’s theory of change to bring about improvements in the health sector is based on adoption of replicable interventions through the generation of evidence and then scaling up, which does have an influence on policy.

Rather than large changes in overall health policy science, USAID’s focus is on implementation science and introduction of specific activities and guidelines, such as family planning and MCH, including misoprostol, vitamin A, etc. Such innovations have contributed to achieving the MOH’s policy and strategic objective in MCH, in addition to developing sector-specific policies and strategies (e.g., FCHV, family planning, communication, etc.). Some interviewees, however, argued that USAID’s work at the policy level has often been overshadowed by heavy involvement in project activities at the district and community levels. In addition, some major policy initiatives where USAID has had no direct inputs, such as incentives for institutional delivery, the pro-poor scheme for medical services and free essential health care, including free drugs, also have contributed to improvements in health status and in addressing inequity.

### **Partnership with non-government partners**

In general, USAID-funded projects (contractual/co-operative agreements/grant-based partnership agreements) are implemented in partnership with U.S.-based private sector organizations, INGOs and universities. During the 25-year period, the scale and the complexity of the projects have meant that often USAID works with a consortium of international and national organizations to implement projects.

Recently, more international agencies have been brought into program implementation as the prime or lead agency. Earlier national institutions, such as New ERA, CRS and the Nepal Fertility Care Center, all enjoyed direct contact with USAID. This approach allowed these institutions to have a better working and policy-influencing position vis-à-vis government and other national partners. The nature of partnership with national institutions was viewed as changing in such a way that sub-recipients are limited to a specific activity in the implementing role. As stated in several interviews, the role of national institutions is “downgraded,” and the long-term institutional development of national organizations is compromised. An observation was made that the Academy for Educational Development (a U.S.-based organization) was brought in to provide technical advice to CRS (a Nepali company established with U.S. support) and paid consultants to tell Nepali organizations what to do and how to do it. This was not viewed positively, but was described as being “what USAID does.”

Another major approach has been USAID's long-term partnership with agencies such as Family Health international (FHI, now FHI 360) in HIV, and John Snow Inc. (JSI), Jhpiego and Johns Hopkins University in MNCH. These organizations play an important role in providing technical assistance in translating global health innovations (such as misoprostol, vitamin A, and others) and to contextualize these innovations in Nepal. The role of USAID's long-term global health partners remains important in sharing and exchanging lessons as a way to support the health system and service delivery in Nepal. It was noted that a number of these organizations have had a long tenure in Nepal and should start transferring more administrative, managerial and technical skills to local partners.

Some views were expressed that USAID currently demands that local organizations such as CRS should be more sustainable, and therefore funding should be curtailed. Contrary to its stated commitment to sustainability, USAID continues to fund international organizations, e.g., FHI 360 and Research Triangle Institute (RTI), without requiring such international groups to be sustainable. Interviewees expressed the view that this approach needs to change and that USAID should continue to support local organizations in the future.

### **Partnership with government**

The partnership arrangement with the MOH has remained the same during the review period, and there has been no major shift in USAID's official position. USAID, however, has continued to make adjustments in program implementation and contextualizing its inputs, demonstrating its flexibility. USAID is seen as being guided by global rather than host country priorities. When these priorities align, USAID is seen as a strong partner. It was suggested that USAID needs to focus more on country-level priorities. Despite the perceived rigidity in U.S. Government policy, the USAID country team made efforts to find ways to participate in the aid effectiveness agenda: USAID signed the letter of intent (the founding document signed by EDPs and the MOH to establish a formal working partnership to develop a common framework for joint planning and programming in support of Nepal's health development goals) in 2004, the IHP+ international compact in 2010 (although USAID did not sign the National Compact in 2009), and the Joint Financing Arrangement as a non-pool partner in 2009, playing an active role in the SWAp as a non-pooling partner.

In general, the difference between USAID and WHO, DFID and the World Bank is that the latter are more systems-oriented, and USAID works more on the ground and is more oriented toward service delivery. USAID focuses on immediate results to make sure the projects are implemented and to ensure results. However, some interviewees viewed USAID's project support as contributing to systems development at district and local levels. (Projects were defined as focused and time-limited, in contrast to programs.)

It was often reported that USAID assistance is "too projectized," and many such projects rely on government networks (e.g., health facilities, health workers, FCHVs) and systems for facilitation and clearance. It was reported to be overwhelming for the government to cater to the needs of and attention required by these projects.

Over the 25-year period, the working relationship and USAID's influencing and coordinating role have been reported to vary depending on leadership and personnel at USAID. USAID was viewed as having stronger influence with government in earlier years. Changes in seniority and experience of FSNs and USAID staff (globally and at the country/mission level) were described as resulting in staff that were less technical and had less country experience. This has resulted in the view that USAID currently has less influence at the MOH. The changes in the staffing structure, with reportedly less experienced staff in the USAID country team, has affected the relationship and partnership with government. This dynamic further rests on the fact that government officials are now more capable of collecting, analyzing and presenting the information more succinctly and convincingly in national and international forums and donor negotiation.

## **Discussion and summary**

The mission was described as being aware of Nepal's different funding mechanisms, other EDPs' interest and practices, and government's preferred funding modality. However, it was viewed as often choosing the channel that made it easier to move funds more quickly and maintain closer control over implementation. Changes in Washington have led to increased oversight and micromanagement of projects. Earlier, there was a yearly review and budget discussion with Washington; after agreement on the budget and plan, the mission had greater flexibility in managing project implementation. Washington was described as currently wanting input and interaction all the time, and staff are spending more time on conference calls at all times of day and night.

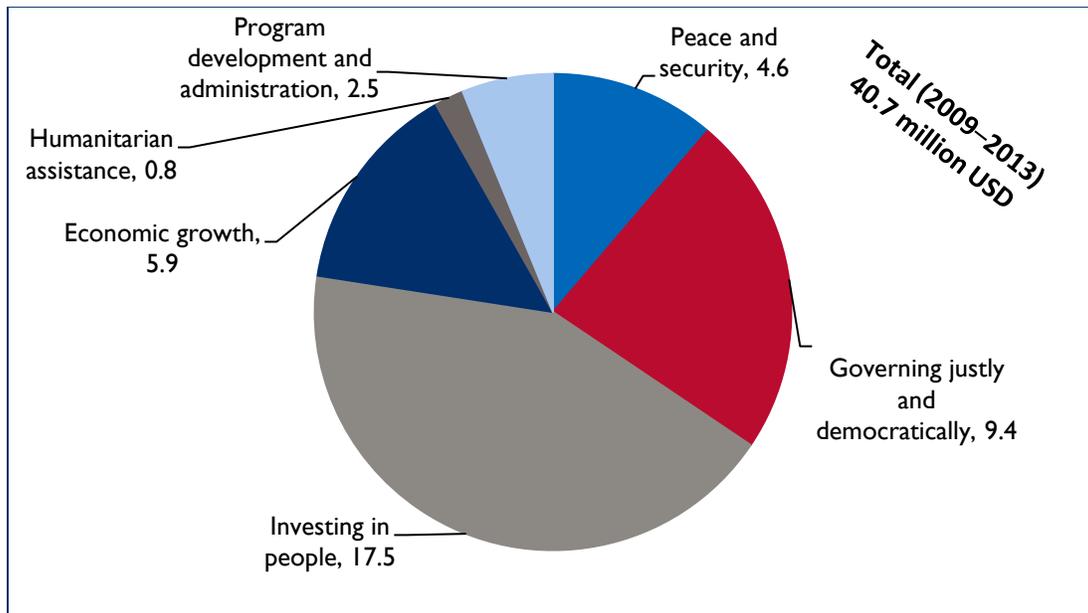
Government perceptions about funding and technical assistance approaches varied. There was a general tendency among government interviewees for increasing G2G support to give government better accountability for donor assistance. Supplementary budget (reflected in Red Book but managed by the implementing partner) was appreciated, as it directly assisted in implementation of project activities through government structure. The vertical nature of USAID's technical assistance approach outside the pool fund arrangement was interpreted as providing a safety net by not putting all the money in the government basket, as government-channeled implementation is often marred by a number of obstacles and bureaucratic red tape. However, the major disadvantages of this approach as an ongoing problem for the MOH are never addressed. In other words, the opportunity for the MOH to develop its capacity in managing projects and improving its fiduciary system is lost. A two-pronged approach was viewed as being better, i.e., helping develop government as a strong regulator while at the same time providing service to the people. While USAID's direct implementation approach may yield better and immediate results, it is not utilizing government systems and mechanisms, which will hamper the results in the long term, because USAID will not be supporting and implementing the health programs forever. Many noted that despite USAID's direct implementation approach, because of its political influence and funding size, it continues to be an influential actor in the donor community.

## **4.3. USAID FUNDING TO THE HEALTH SECTOR**

### **Overall USAID contribution**

The composition of USAID's contribution by objectives is only available for recent years (2009–2013), as presented in Figure 5, below. Of the USD 40.7 million in grant agreements for the period of 2009–2013, two thirds of the funding was provided for two objectives: investing in people and governing justly and democratically. The rest was provided for the remaining four objectives, including program development and administration cost.

**Figure 5. Composition of grant by objectives (2009–2013)**



Source: USAID Country Office, Nepal. Grant agreement documents.

Strategic objectives were reduced to three in the 2014 grant agreement, with a financial obligation of USD 64.4 million from 2014 to 2018. The highest budget share was assigned for increased human capital (55 percent), followed by inclusive and sustainable economic growth (31 percent) and more inclusive and effective governance (14 percent).

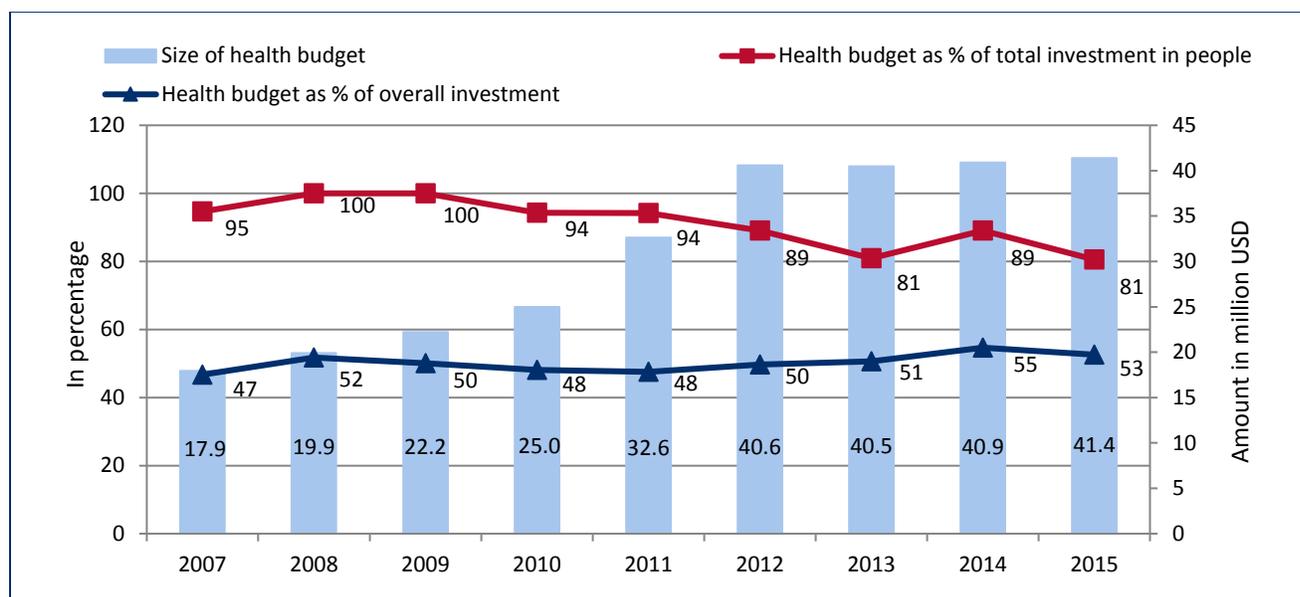
During this seven-year period, USAID’s total development budget to Nepal almost doubled to USD 74.8 million in 2014 from USD 38.4 million in 2007.<sup>88</sup> Budget allocated to the health sector has hovered around 50 percent of USAID’s total contribution for Nepal during the period 2007–2014.

### **Contribution in the health sector**

USAID’s contribution to Nepal’s health sector is presented in Figure 6. Although the size of the health budget has increased over the years, the health budget as a percentage of overall USAID support to Nepal has remained stable at approximately 50 percent of the total financial contribution. Health, education and humanitarian assistance are three sectors that are considered as investment in people. Contribution to the health sector out of the total investment in people has declined slightly over the years to 81 percent in 2015.

<sup>88</sup> This is as per the USAID budget data, which slightly differ from the disbursement data presented in the graph above.

**Figure 6. Contribution of USAID to Nepal’s health sector**



Source: USAID Country Office, Nepal

USAID’s contribution to Nepal’s health sector has ranged between 11.7 percent and 18.7 percent of total MOH expenditure from 2007 to 2015, showing an erratic pattern. However, in per capita terms, USAID’s health sector contribution has doubled from USD 0.7 in 2007 to USD 1.5 in 2015.

**Table 2. USAID Health budget compared to MOH expenditure**

Description		2007	2008	2009	2010	2011	2012	2013	2014	2015
USAID contribution in health sector	million USD	17.9	19.9	22.2	25.0	32.6	40.6	40.5	40.9	41.4
	USD per capita	0.7	0.8	0.9	1.0	1.2	1.5	1.5	1.5	1.5
MOH expenditure (million USD)		105.5	151.5	165.1	213.6	251.4	249.9	216.5	232.7	248.4
USAID health contribution as percentage of MOH expenditure		17.0	13.1	13.4	11.7	13.0	16.2	18.7	17.6	16.7

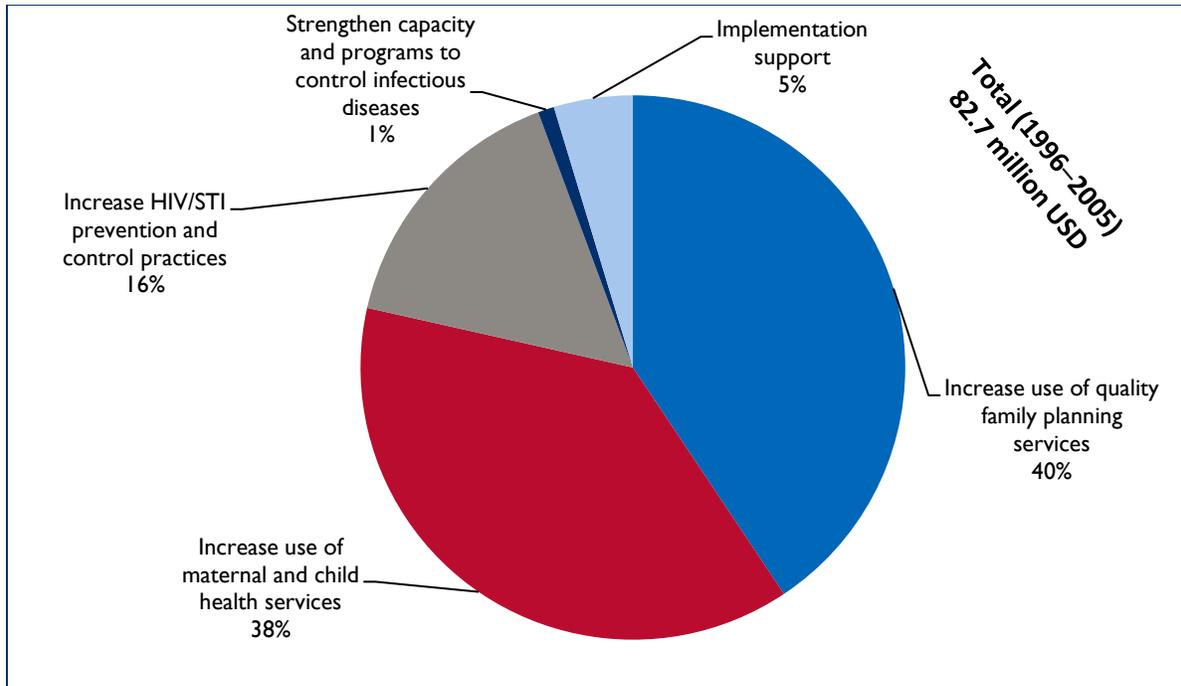
Source: USAID Country Office, Nepal

### Composition of Health Sector Contribution

The Child Survival/Family Health Services Project was USAID’s umbrella program in the first half of the 1990s, later extended until 1998. Basic needs, child survival and population management were emphasized in the project (funded for USD 43 million), designed to reduce child mortality and encourage family planning by improving the quality and coverage of services.<sup>89</sup> The composition of USAID’s obligation for Nepal’s health sector is presented in Figures 7 and 8 for 1996–2005 and 2006–2008, respectively. During 1996–2005, family planning services and MCH services remained the dominant components, respectively sharing 40 percent and 38 percent of the total USAID contribution in Nepal’s health sector.

<sup>89</sup> Isaacson et al, 2001

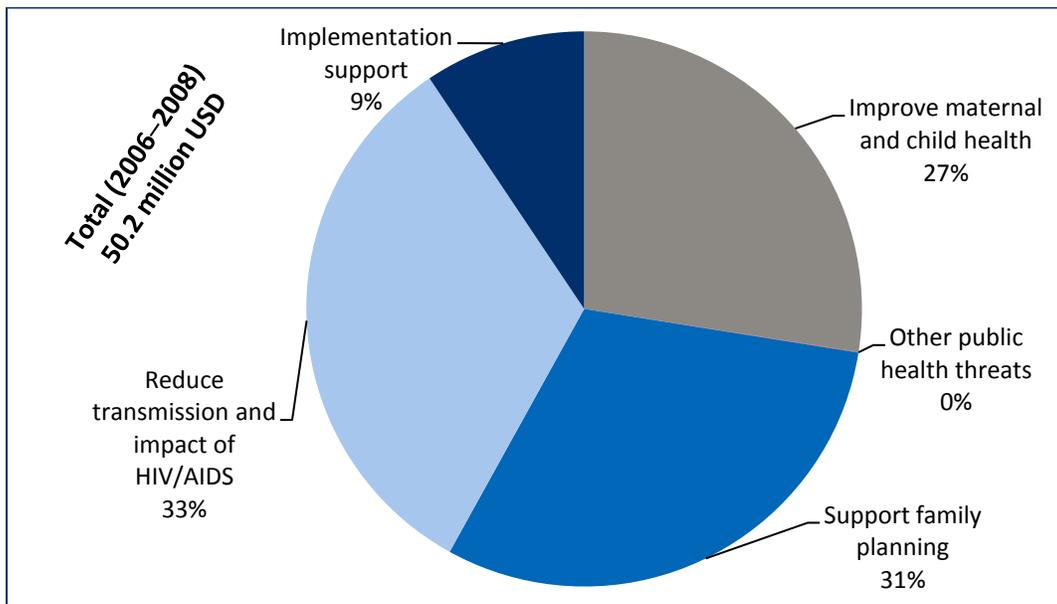
**Figure 7. USAID health sector obligation for Nepal by strategic objective (1996–2005)**



Source: USAID Country Office, Nepal. Grant agreement documents.

However, HIV/AIDS was the major subsector from 2006–2008, capturing one third of USAID’s USD 50.2 million obligation. The other two subsectors, family planning and MCH, received 31 percent and 27 percent of the obligation, respectively, and the remaining 9 percent was for implementation support. (See Figure 8.)

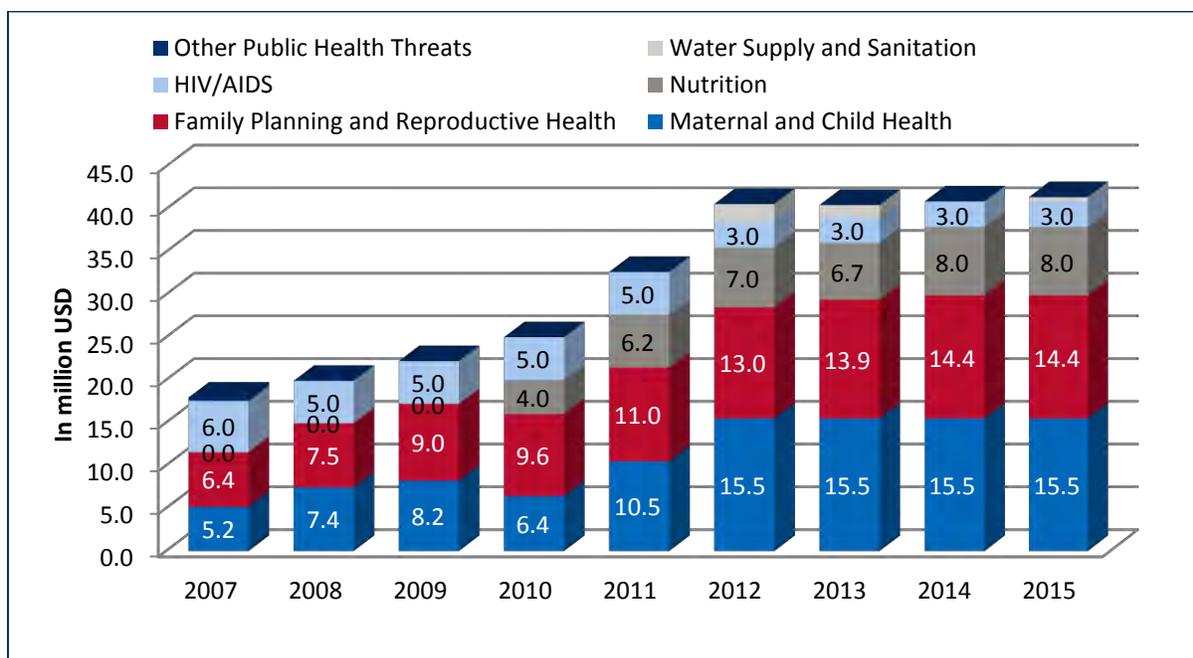
**Figure 8. USAID health sector obligation for Nepal by strategic objective (2006–2008)**



Source: USAID Country Office, Nepal. Grant agreement documents.

The composition of USAID’s health budget for Nepal is presented in Figure 9, which shows that MCH and family planning and reproductive health are two major thematic areas, each consistently receiving approximately one third of the total health sector budget during the entire period from 2007 to 2015. Nutrition, which had no budgetary provision during 2007–2009, has received 10–20 percent of the health sector budget in successive years. However, the budget share of HIV/AIDS has declined from one third in 2007 to 7 percent in 2015. The most recent budget pattern shows that USAID has maintained almost the same level of priority on MCH and family planning services, and the focus on HIV/AIDS is gradually shifting to nutrition.

**Figure 9. Composition of USAID health sector budget by thematic areas**

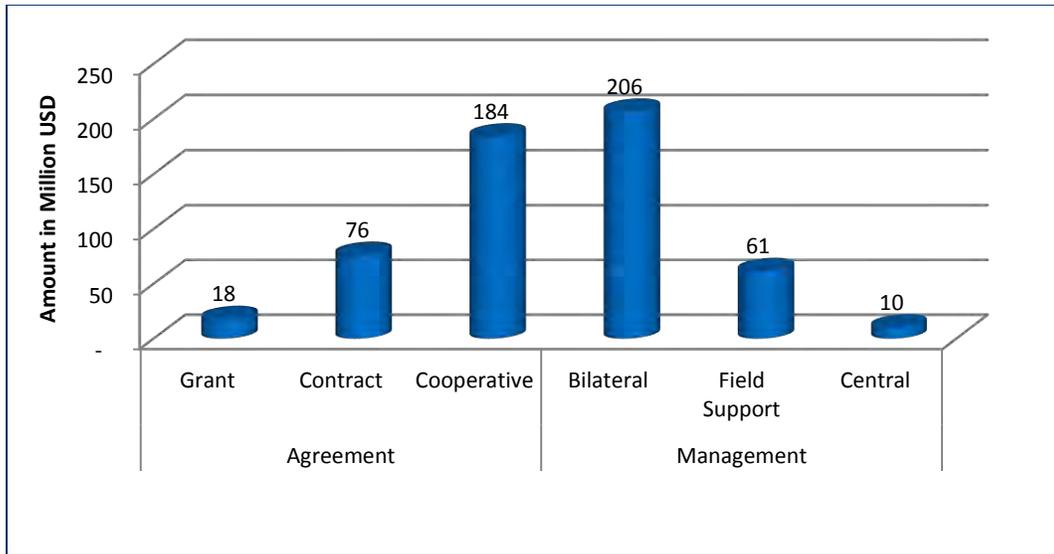


Source: USAID Country Office, Nepal

### Contribution by Funding Channel and Management

Data disaggregated by funding channel and management type were available only for 2007–2015 and not for 1990–2006. Based on the available data for 39 projects, two thirds of the funding has been channeled through cooperative agreements, and only approximately 27 percent was in the form of contractual agreements, with the remainder being for grants. Similarly, almost three quarters of USAID’s contribution has been mobilized through bilateral projects, while 22 percent is in the form of field support, as summarized in Figure 10.

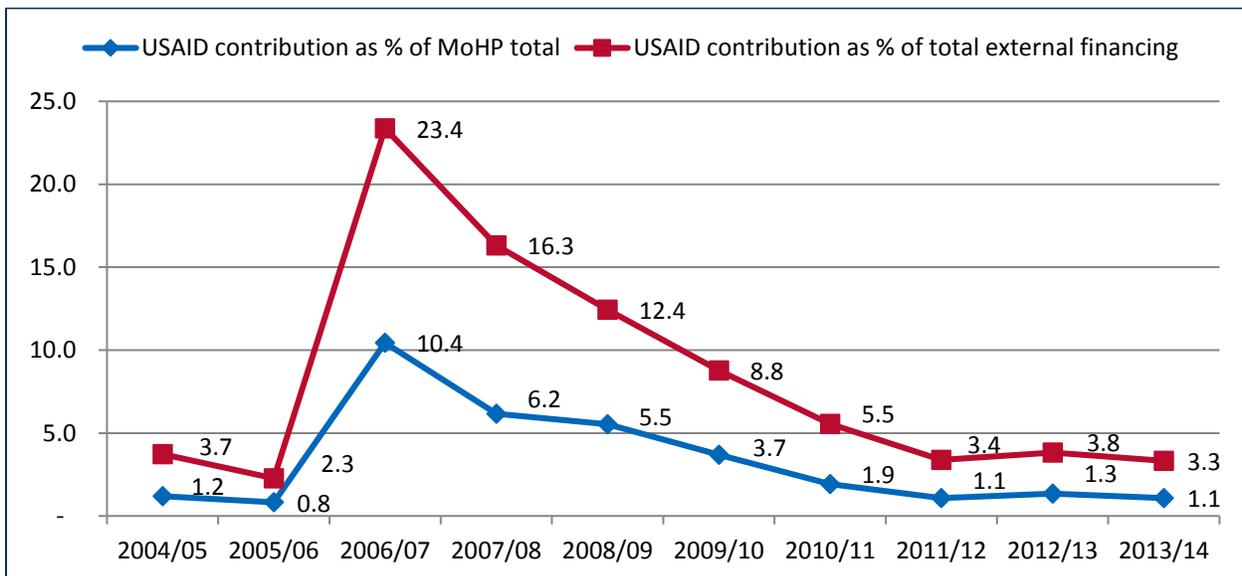
**Figure 10. Contribution of USAID channeled through type of agreement and management**



Source: USAID Country Office, Nepal

Only a small fraction of USAID’s contribution in the health sector is reflected in the annual work plan and budget of the MOH. During the period from 2004/05 to 2013/14, USAID’s contribution ranged from 1-10 percent of total MOH expenditure. With respect to other EDPs, USAID’s share in MOH’s total expenditure remained between 2 percent and 23 percent of the total EDP contribution, as presented in Figure 11. USAID’s share in the total MOH expenditure was high in 2006/07, which was mainly for non-tropical disease control, particularly trachoma.

**Figure 11. Trend of on-budget USAID support to the MOH**



Source: Ministry of Finance. Estimates of Expenditure “Red Book.” Various years.

There is an inherent issue related to USAID’s support channeled through the GON budget, which interviewees suggested needs to be resolved. The problem originates from the spending norms that have been agreed upon between USAID and the GON, but which do not match the GON’s financial rules. This means that USAID may not reimburse all of the allocated amount if the MOH’s spending is

not according to the USAID agreement, irrespective of whether it is in accordance with general GON rules or not.

Although USAID is one of the key donors supporting Nepal's health sector, a comparative analysis of donor support is challenging because of the unavailability of comprehensive data. The Organisation for Economic Co-operation and Development database on the creditor reporting system is considered to be the most reliable source of aid data,<sup>90</sup> providing a comprehensive database of official development assistance. However, there is an inconsistency between that system and country-level reporting of the aid inflow. As per the creditor reporting system, the share of USAID's aid inflow for the health sector ranges from 1 percent to 24 percent of the total aid inflow to Nepal's health sector during the period 2002–2013 (Annex 4).

### **Discussion and Summary**

The United States is one of the earliest bilateral donors to Nepal, and also one of the major bilateral donors in terms of the volume of its contribution. During the 25-year period from 1991 to 2015, USAID's total obligation has been USD 1.34 billion in the form of economic (1.3 billion) and military (40 million) assistance. Per capita disbursement of funds in the form of economic assistance has also increased during the last 14 years (2001–2014), from USD 1.1 in 2001 to USD 3 per person in 2014. The sectoral composition of USAID's contribution in Nepal shows that the health sector is the prime recipient of USAID's support, followed by the economic growth and governance sectors. From 2007 to 2014, the health sector fund has hovered around 50 percent of USAID's total contribution for Nepal. In per capita terms, USAID's contribution in the health sector has also more than doubled from USD 0.7 in 2007 to USD 1.5 in 2015. USAID invested a total of USD 82.7 million in Nepal's health sector during the 10-year period from 1996 to 2005, which, on average, is USD 8.3 million per annum. During this period, family planning services and MCH services were the dominant components, respectively sharing 40 percent and 38 percent of the total USAID contribution to Nepal's health sector. Later, USAID's obligations for the health sector increased to USD 16.6 million per year during the period 2006–2008, when HIV/AIDS was the dominant component, receiving one third of the resources, followed by family planning services, which received 31 percent of the budget. USAID support in the health sector increased at a rapid pace in the successive years to reach USD 41.4 million in 2015, from USD 9.9 million in 2008. Thematically, nutrition has gradually received increased support, reducing the budgetary share for HIV/AIDS. Nevertheless, continued priority is given to MCH and family planning services, which have shared approximately two thirds of the budget.

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<sup>90</sup> Piva and Dodd, 2009



## 5. USAID SUPPORT TO HEALTH PROGRAMS

As discussed above, between 1990 and 2015, USAID has supported the GON's health sector through a broad range of innovations and technical interventions. People interviewed (e.g., GON officials, other EDPs, and former USAID staff and partner organizations, etc.) were consistent in identifying the following major areas as benefitting from USAID support: family planning and reproductive health, MCH, HIV/AIDS and health logistics. Although USAID/Nepal includes nutrition as a key technical component, interviewees only recently associate USAID with nutrition, except for vitamin A, which was closely identified with USAID support. USAID was credited with early and long-term support for the crosscutting FCHV program. USAID was not directly associated with health system strengthening, except for logistics management and evidence-based (i.e., research, pilot projects and DHS<sup>91</sup>) policy and program development. USAID also lists environmental health as a major technical component, but interviewees did not identify this as an area of major contribution, except for a few who said that USAID should be encouraged to continue supporting WASH. Support for social marketing was primarily associated with CRS, which is discussed below under the subsection on family planning.

Because it is not possible to describe all areas supported by USAID, a brief description of the most frequently identified interventions and innovations are given below. Longer discussions for health logistics and HIV/AIDS are available in the annexes.

### 5.1. LOGISTICS

#### Background

Until 1993, Nepal had a vertical health logistics system with a separate system for each health program. Logistics and supply chain management was not a government priority. No logistics curricula had been developed, no staff had been trained, and no logistics information system existed at any level. After the establishment of the Logistics Management Division (LMD) in 1993, the need for a proper logistics system and supply chain management was realized.

In 1994, the Logistics System Improvement Plan was initiated jointly by the MOH and USAID, with the involvement of multiple stakeholders: Family Planning Logistics Management Project (JSI), U.S. Centers for Disease Control and Prevention, Rational Pharmaceutical Management Project (Management Sciences for Health), UNFPA, UNICEF and the World Bank. It envisaged designing an integrated logistics management information system (LMIS) that would serve all programs and organize functional areas of logistics system management. The plan's human resource management component envisioned creating a cadre of logistics management trainers and establishing a logistics training program.

Since 1994, USAID, through its support for several projects, provided technical and financial assistance to the LMD to improve the overall dimensions of health logistics, such as forecasting, procurement planning, inventory management (pull system), storage infrastructure, quality assurance, distribution and transportation, pipeline monitoring, auctioning and disposal, capacity building and supervision and monitoring.

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<sup>91</sup> Since 1976, USAID has supported the MOH (in partnership with New Era) to conduct the DHS, beginning with the World Fertility Survey Nepal and thereafter every five years. These surveys provide a comprehensive database of information on fertility, mortality, family planning, child health, nutrition, safer motherhood, HIV/AIDS and women's empowerment. The GON has used the survey data to identify and analyze problems, plan appropriate responses and monitor impact. The MOH, together with the National Planning Commission, has used the survey data/estimates for health-related target setting in its three- and five-year planning process. The DHS has also served as a benchmark for program design and evaluation by other EDPs.

### **USAID's support and strategies**

USAID was at the forefront of the family planning program in Nepal and was the sole EDP to provide all the contraceptives required by the GON. The USAID project, led by JSI, gave special emphasis to contraceptives and the logistics system and created awareness through the slogan, "No Commodities, No Program." Since 1996/97, USAID has gradually phased out of supplying contraceptives to the GON, but has continued to provide them to CRS for the social marketing program.

USAID technical assistance to the GON on logistics and supply chain management included all components of the logistics cycle (product selection, forecasting, storage, distribution/transportation, LMIS, inventory management, capacity building), except procurement. In 1995/96, KfW began supporting the LMD in essential drug procurement (preparing detailed specifications and bid documents, bid analysis, execution of bids, pre- and post-testing of procured goods, etc.), which later was extended to other health commodities, including family planning and MCH commodities. After KfW's support ended in 2010/11, Crown Agents, through DFID, supported this activity. A point for consideration is that had there been complete support from USAID (including procurement) to the GON, this crucial component might now be stronger or more institutionalized and capable due to complete support for logistics management, and it also would have been better coordinated with other components of the logistics cycle. At present, procurement is the LMD's weakest component. For the last two years, the LMD could not conduct any international procurement contracts. Thus, procurement is the weakest link among logistics components and is adversely affecting the overall functioning of supply chain management.

One of USAID's key strategies is ownership and sustainability of the logistics activities that were started and supported for the GON, but the success of this largely depends on proactive and strategic decisions by the GON. As with many government agencies, the GON has its own limitations and constraints. USAID has been quite successful in many components, such as the LMIS, funds to procure family planning commodities, budgets for distribution and transportation, district store construction and logistics trainings, which are now owned and provided with sustained support (although not complete) by the GON.

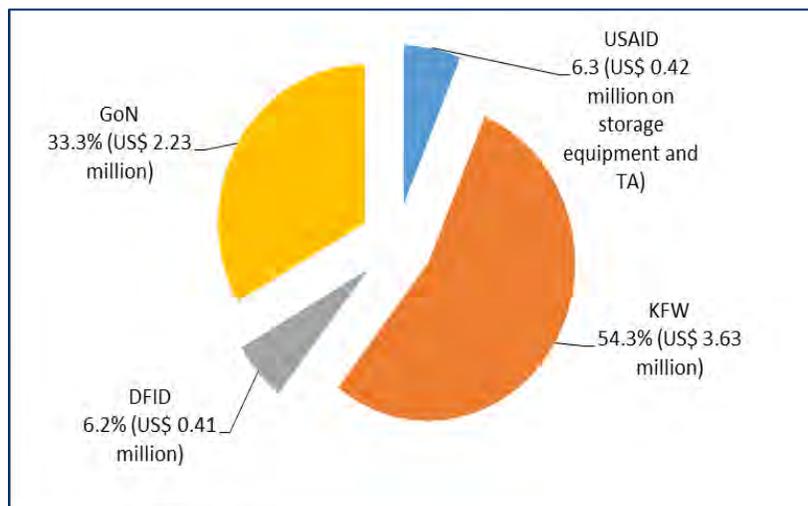
USAID's strategy for national coverage of its technical assistance was seen and proven to be very effective and substantial in terms of reach and results. After decades of technical assistance to the GON, USAID desired that many of the logistics activities be taken over by the GON. Therefore, after the September 2013 completion of the USAID | DELIVER Project, led by John Snow, Inc., USAID contracted a locally based company to support health logistics activities from 2013 to 2018. The support was confined to 14 selected districts out of a total of 75. USAID support for logistics and supply chain management has decreased by 81 percent in terms of district coverage. Because the GON was not prepared for this reduction, it was very direct in expressing disappointment about the "downgraded/lesser" support for health logistics.

### **Key support**

The LMIS was implemented in 1995 and scaled up in 1997 in all 75 districts of the country. In 1999/2000, consensus forecasting and quantification for family planning commodities was initiated, and gradually reproductive health and MNCH commodities were included. By 2012/13, almost all health commodities (family planning, reproductive health, MNCH, vaccines, essential drugs and HIV/AIDS commodities) were included. The integrated consensus forecast report identifies the long-term costs and requirements for family planning and other needed commodities, allowing better identification of funding gaps and procurement and distribution schedules. This exercise helped program divisions to identify quantity and funding needs for their annual work planning. This annual practice set up a crucial stage for GON officials to recognize the importance of family planning commodities and to set aside GON budget for their procurement.

In 2003, the GON began a phased shift to a “pull system” that provides more flexibility and control. Under this new system—a hybrid “push-pull” system designed specifically for Nepal—half of the annual estimated consumption of a health facility is dispatched directly to the facility. The remaining half is stored at the district level for demand-based supply. Health facilities use the established LMIS to forward their demands quarterly to the appropriate district store. After the construction of district stores, the hybrid was replaced by actual “pull” system, with supply based on health facilities’ demand.

**Figure 12. Cost share in district store construction**



Source: DELIVER Project. LMD

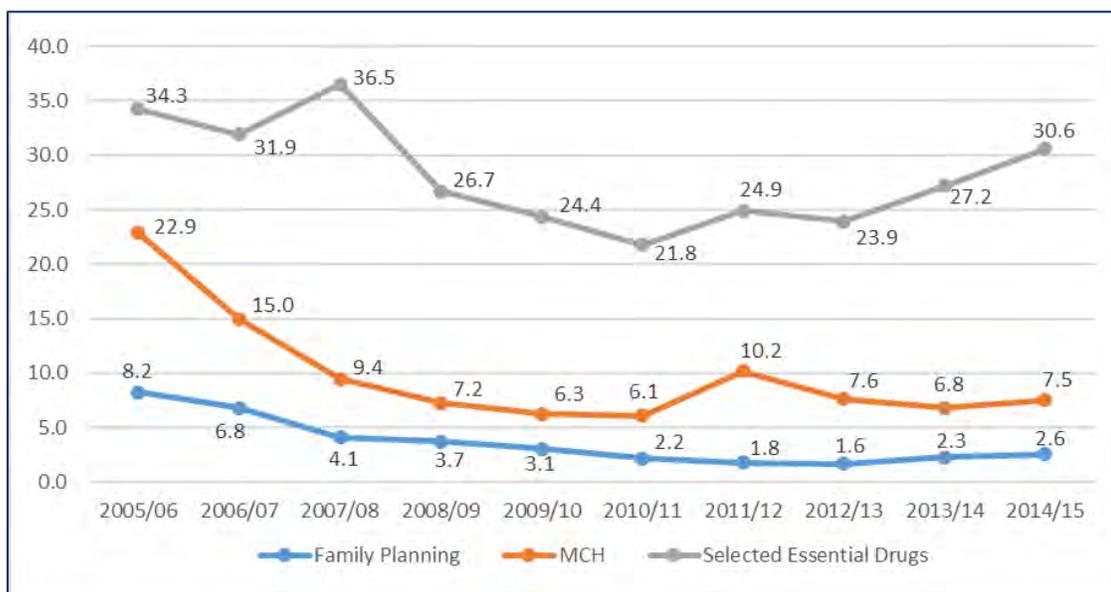
In 2001/02, a separate district store construction program initiated by the USAID/JSI project and funded primarily by KfW, DFID and the GON provided much-needed infrastructure for implementation of the pull system. Of the total cost (approximate) for the district store construction program, KfW covered 54.3 percent, the GON 33.3 percent, DFID 6.2 percent, and USAID 6.3 percent. Ownership and commitment of funds from the GON was noteworthy (Figure 12). USAID's funds are used for technical assistance and procurement of storage equipment.

### Results and key findings

- USAID technical support to the GON on logistics and supply chain management has played an important contributing role in the success of Nepal’s programs in FCHV, vitamin A supplementation, CB-IMCI/community-based maternal and newborn care (CB-MNC), chlorhexidine (Navi Care), and the Expanded Program on Immunization. Years of continuous USAID support for logistics and supply chain management has played a pivotal role in strengthening the GON’s health management system.
- Nepal has a national LMIS producing reliable logistics data for decision making at all levels and functions of health supply chain, including forecasting, inventory management, distribution and pipeline monitoring of essential health commodities. Policymakers accept LMIS data as credible and use it to make nationwide policy and operational decisions. The LMIS reporting percentage has increased from 36 percent to over 90 percent and was consistently maintained at that level for over 10 years. Recent reports demonstrate a declining trend.
- With the pull system implemented nationwide, the availability of essential health commodities (family planning, MCH and essential drugs) increased at service delivery sites over the years.

USAID projects worked closely at central, regional and district levels and improved effective service contracts with private transportation parties for delivery of health commodities to health facilities. However, during the last three years, USAID’s technical support has been decreased significantly, from 75 to 14 districts, which is reflected in the increase of stock-outs of essential drugs, MCH and family planning commodities at health facilities (Figure 13).

**Figure 13. National stock-outs of key health commodities at health facilities**



Source: LMIS, LMD/DoHS

- Storage space in the country has increased fivefold. USAID provided significant technical assistance to strengthen district store construction. These stores improved storage capacity in the districts and currently serve as the lifeline of the logistics system. With the construction of 72 district stores and the cold chain storeroom in the central warehouse (Pathalैया), the total storage space for warehousing drugs, allied health commodities and vaccines increased from 28,800 square feet in 1999 to 131,400 square feet in 2015.
- USAID projects worked with LMD and ensured WHO Good Manufacturing Practices certification for manufacturers to compete in the bidding process.
- A Reproductive Health Commodities Security Policy was written and endorsed by the GON.
- Improved logistics and supply chain management with trained human resources (more than 28,000 GON staff were trained during this timeframe) had a positive impact on national health indicators, such as contraceptive prevalence rate, total fertility rate and availability of key health commodities at service delivery sites.

### Lessons learned and challenges

- Complex and delayed procurement procedures and inadequate human resources to handle procurement at all levels: More effort is needed to make procurement reliable, strong and transparent.
- Poor, old and unscientific storage facilities at central and regional levels: There has not been a serious follow-up on the construction of central and regional warehouses, even after a master plan for both was prepared and the GON was willing to provide funding for construction.

- Frequent turnover of trained district storekeepers: New recruits of store personnel are often from sectors other than health. Health facility staff's accountability and seriousness in carrying out their responsibilities pose a major concern.
- Minimum qualifications: District storekeepers should have a Bachelor's degree in Pharmacy, and similarly qualified staff should manage district stores.
- Integration of HIV/AIDS and TB commodity logistics into the GON's mainstream (LMD) logistics still needs much groundwork and political will.
- With years of GON advocacy to staff the LMIS unit, the LMD has finally planned to establish an Information System Unit, with payroll staff to operate the LMIS unit. However, this is only a plan, and since the promulgation of the new constitution, which has seven new provinces, government has been barred from inducting any new staff in the ministries. Therefore, the realization of this new LMD structure is tricky and may take longer than expected.
- Policy-level advocacy and teamwork among stakeholders are vital in carrying out logistics activities, such as forecasting, LMIS, the pull system, capacity development in health logistics, construction of district storerooms and logistics for the HIV/AIDS program.
- There is a lack of effective and sustained supervision after training. The misconception among health workers that training will solve all performance problems hinders their ability to analyze gaps and subsequently address them effectively.
- Declining support for health logistics: KfW no longer supports the LMD for procurement, DFID support for procurement is ending soon, and USAID support for health logistics management decreased by 81 percent, now working only in 14 focus districts.
- Interviews noted that although Nepal has reached a stage of rebuilding after the massive earthquake on April 25, 2015 and has implemented the new constitution with a federal structure, the political situation remains fragile. Interviews described the country as facing increased corruption, limited discipline and lack of accountability<sup>92</sup> in the public sector, which includes the health sector, and therefore needing long-term support to sustain and build on what has been achieved thus far in health logistics and supply chain management over the coming years. Without sustained support for health logistics, Nepal was viewed as being susceptible to falling behind 20 years or more, which will adversely affect all its health programs and interventions, such as universal health coverage.

## 5.2. FEMALE COMMUNITY HEALTH VOLUNTEERS

### Background

Community participation has been a focus of primary health care delivery and health education in Nepal since the 1980s. In 1980, the GON started recruiting and mobilizing health volunteers called Community Health Leaders (CHLs) as a way to provide community-based health care services and health education in rural areas of Nepal.<sup>93</sup> A few years after the introduction of the program, it became clear that it had a significant gender problem. The CHLs, almost all men, were expected to support outreach activities in

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<sup>92</sup> "Nepal is placed in 130th position among 168 countries. Nepal is among the most corrupt countries..." from Transparency International Report, 2015.

<sup>93</sup> Houston, R. et al. 2012. Early Initiation of Community-based Programmes in Nepal: A Historic Reflection. *Journal of Nepal Health Research Council*, 10(21): 82-87.

maternal health and family planning.<sup>94</sup> As a consequence, the CHL program was modified and the GON started the FCHV program in 1988 with support from USAID, UNFPA, UNICEF and other organizations. Although the program started in only a few districts in 1988, by 1995 it had expanded throughout the country. Nepal's then Health Minister, Sushila Thapa (a female), was instrumental in the introduction of the FCHV program.<sup>95</sup>

FCHVs play a vital role in linking communities to the national health system.<sup>96</sup> Recent estimates suggest that there are approximately 50,000 FCHVs, with at least one per ward, based on the population of the Village Development Committee (VDC). Since the program's inception, FCHVs have been a pillar of Nepal's health care delivery system, with their primary focus on MCH and family planning.<sup>97</sup> Mothers' groups in every ward select FCHVs, and their regular meetings offer an arena for the volunteers to provide health education to mothers of reproductive age.<sup>98</sup>

FCHVs have considerable authority because of their proximity to the community they serve. A recent survey shows that almost all (95 percent) live in the ward where they performed FCHV functions.<sup>99</sup> Although literacy is not a requirement, FCHVs' literacy rate is estimated at 83 percent, and 67 percent had been to school. Their average age is 41.3 years, with only 4 percent under 25 years. The turnover rate of FCHVs is not high (4 percent annually), and 59 percent had served for longer than 10 years. Almost 90 percent of FCHVs are married. The survey showed that a large percentage (40 percent), came from high caste groups and 38 percent came from Janjati groups. Representation from marginalized groups, such as Dalit and Muslim, is less than 10 percent.

### **USAID support**

The FCHV program has emerged as a foundation of Nepal's public health system.<sup>100</sup> As part of its focus on services for and by women, extending services beyond the health facilities and promoting MCH, USAID has continued to provide technical and financial support for the program's expansion. Earlier, almost all USAID-funded health programs (including the Nepal Family Health Program (NFHP) and NFHP II, Suaahara, Saath-Saath, Nepal Vitamin A Program (NVAP), etc.) had a component for support to FCHV.<sup>101</sup> Through its bilateral projects, USAID has consistently supported training, supervision, monitoring, evaluation and overall technical support for strengthening of the FCHV program,<sup>102</sup> in addition to support to institutionalize the program, such as establishing the FCHV fund and database. USAID also has provided support for several studies and reviews of the program.<sup>103</sup>

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<sup>94</sup> Ibid.

<sup>95</sup> Interview notes.

<sup>96</sup> USAID. 2014. Empowering women, saving lives. *The Health Bulletin*; Hua, V. 2015. The women who keep Nepal healthy. *The Atlantic Magazine*.

<sup>97</sup> NFHP. 2012. Female Community Health Volunteers. *NFHP Technical Brief*.

<sup>98</sup> Ibid.

<sup>99</sup> *Female Community Health Volunteer National Survey*. August 2015.

<sup>100</sup> Interview notes; NFHP. 2012. Female Community Health Volunteers, *NFHP Technical Brief*; Hua, V. 2015. The women who keep Nepal healthy. *The Atlantic Magazine*.

<sup>101</sup> NFHP. 2012. Female Community Health Volunteers. *NFHP Technical Brief*; USAID/Nepal. 2012. *Nepal Family Health Program (NFHP-II) Final Project Report, December 2007–November 2012*.

<sup>102</sup> Ibid.

<sup>103</sup> For example: Gurung, S., J. Justice, and P. Miller. 1993. *Diagnostic Assessment of the Female Community Health Volunteer Program in Nepal*. New Era; Justice, J. 2003. *A study of the concept of volunteerism: Focus on community-based health volunteers in selected areas of Nepal*. Kathmandu: The Maternal and Neonatal Health Program; New ERA. 2007. *An analytical report on female community health volunteers (FCHVs) of Nepal*. Kathmandu: USAID and Government of Nepal; FHD and USAID. 2015. *Female Community Health Volunteer National Survey*.

The MOH Family Health Division (FHD) is responsible for the management of this program. USAID provides support through the FCHV subcommittee under the Reproductive Health Committee to coordinate and develop policy and guidelines.<sup>104</sup> USAID supported the development of revised National FCHV Program Strategy in 2006, which encourages the GON and other development partners to work together in support of the program and to provide coordinated, continuous and consistent support to FCHVs.<sup>105</sup>

### **Key achievements**

FCHVs serve as frontline health workers in Nepal. In addition to the promotion of awareness and health education for the general population and delivery of selected health services, this cadre is an excellent example of the participation of Nepalese women in the public sphere and of their empowerment.<sup>106</sup>

FCHVs have been pillars of lifesaving public health initiatives in MNCH and the provision of family planning in communities. They have been responsible for the biannual distribution of vitamin A under NVAP, community mobilization for polio vaccines and increasing immunization coverage, oral rehydration, nutrition education and distribution of condoms and family planning pills.<sup>107</sup> Since the early 1990s, they have been widely recognized for their success in reaching over 90 percent vitamin A capsule distribution, community-based treatment of acute respiratory infection and diarrhea, and increasing immunization coverage through pilot interventions that have been scaled up. In recent years, FCHVs have been involved in providing community-based health services to mothers and newborns using the birth preparedness package, family planning and other activities, including distribution of iron folate. In selected program districts, FCHVs have been trained and supported by NFHP II to distribute chlorhexidine to pregnant women for improved neonatal cord care and misoprostol to prevent postpartum hemorrhage.<sup>108</sup>

Over the years, FCHVs have been involved in major health programs, which has increased their workload, visibility and expectations. In addition, FCHVs have become a default point of contact at the ward level for any development intervention beyond health initiated by NGOs and the GON, which has provided opportunities for the FCHVs but has also resulted in an increased workload and their expectations for incentives and salaries.<sup>109</sup> They are also frequently approached by community members for help, such as accompanying pregnant women to the health facility for delivery. There is no doubt that the FCHV program has not only contributed to the improved health outcomes, especially in mothers and children, but also to empowerment of women. There are several examples of FCHVs

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<sup>104</sup> NFHP II Final Report.

<sup>105</sup> NFHP. 2012. *Female Community Health Volunteers, NFHP Technical Brief*.

<sup>106</sup> Glenton et al. 2010. The female community health volunteer program in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science and Medicine* 70:1920-1927; Justice, J. 2003. A study of the concept of volunteerism: Focus on community-based health volunteers in selected areas of Nepal. Kathmandu: The Maternal and Neonatal Health Program.

<sup>107</sup> USAID/Nepal. 2012. *Nepal Family Health Program (NFHP-II) Final Project Report, December 2007–November 2012*. Also, interview notes.

<sup>108</sup> Ibid.

<sup>109</sup> Glenton et al. 2010. The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science and Medicine*. 70: 1920-1927; Justice, J. 2003. A study of the concept of volunteerism: Focus on community-based health volunteers in selected areas of Nepal. Kathmandu: The Maternal and Neonatal Health Program.

emerging as local leaders, a significant step towards increasing public participation of women in Nepali society.<sup>110</sup>

### **Challenges and issues**

FCHVs have been an important link between the national health systems, NGO-implemented projects and the local community. They are the representatives of both the community and the government; as local and accessible individuals, this intermediary role has been critical to the success of the program.<sup>111</sup>

A challenge brought about by the success of the FCHV program has been the additional responsibilities given to FCHVs over the years. FCHVs spend a considerable amount of time in various national health programs and are also drawn into projects run by NGOs. While these additional roles have increased their visibility, status and motivation, especially when they are tasked with the responsibility to distribute medicines (or other tangible services), the clearly defined increase in responsibilities within national health care programs raises questions about the voluntary nature of their work. Interviewees noted that there is a need for a national policy that preserves the FCHV role as community health volunteers and protects them from doing work that is considered to be the responsibility of paid health workers. The increasing use of FCHVs in the delivery of national health programs should be balanced with the supervision, support and mentoring needed from government health workers. Other ongoing challenges, documented by the many surveys, reviews and evaluations of the FCHV program, confirm the need for a more regular supply of commodities, in addition to supervision and support and addressing the unresolved issue of incentives. Other issues are related to the GON's concern about FCHVs' efforts to organize a union and the MOH's proposal to place trained auxiliary nurse midwives at the community level.

## **5.3. HIV/AIDS**

### **Background**

Initiatives to respond to the emerging threat of HIV/AIDS started early in 1987, prior to the reporting of the first HIV case from western Nepal in 1988. In 1987, the MOH established the National HIV and Sexually Transmitted Disease (STD) Project (supported by the WHO), which was upgraded to a more formal structure, called the National Centre for AIDS and STD Control (NCASC), with the mandate to develop policy, coordinate and conduct monitoring and surveillance.

The GON developed the first and second Medium Term HIV/AIDS Plans for the periods 1990–1992 and 1993–1997 respectively. In 1995, Nepal formulated its first National AIDS Policy, which was revised in 2011.

The initial response to HIV in Nepal started with an awareness campaign and behavior change communication. As the nature of the epidemic unfolded, service provision was an essential element of program interventions, i.e., HIV testing and counseling, provision of treatment for sexually transmitted infections, condom distribution, needle/syringe program and treatment of opportunistic infections. Later, ART services, community and home-based care and elimination of vertical transmission became the primary focus of the program. From the beginning, surveillance and monitoring, studies, capacity building and engagement of affected people were major activities.

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<sup>110</sup> Glenton et al. 2010. The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science and Medicine* 70:1920-1927; Hua, V. 2015. The women who keep Nepal healthy. *The Atlantic Magazine*; USAID. 2014. Empowering women, saving lives. *The Health Bulletin*.

<sup>111</sup> Houston, R. et al. 2012. Early initiation of community-based programmes in Nepal: A historic reflection. *Journal of Nepal Health Research Council* 10(21):82-87.

## HIV epidemiology

With 0.2 percent HIV prevalence among the adult population, Nepal is considered to be among the best performing countries in terms of reducing new HIV infections and the prevalence among the key populations in selected areas. During the past 12 years (2003–2015), prevalence among key populations declined from 3.9 percent to less than 1 percent in female sex workers (Terai highway districts) and from 68 percent to 6 percent in people who inject drugs. However, HIV prevalence is still high, with 4 percent prevalence among men who have sex with men and male sex workers.

Annual HIV infections peaked between 1998 and 2004 and started to decline after 2004. This decline is more prominent among a few populations, such as female sex workers and their clients and injecting drug users, but among the low-risk male and female populations, the decline is not as sharp.

Program coverage data also indicate that coverage among migrants (low-risk population) is a huge challenge. Because of the size of the population, most new HIV infections are from this group, whereas because of risk behavior, HIV prevalence is high among other key populations (sex workers, injecting drug users, men who have sex with men).

## USAID support

A systematically designed project with medium- to long-term goals did not start until 1993, when the AIDS Control and Prevention Project (AIDSCAP I) was initially funded by USAID with FHI as the prime implementing agency. Since this time, USAID has been consistently supporting the HIV response in Nepal, primarily through the same partner (FHI). During this period, many other agencies contributed for a shorter duration or for specific projects. Beginning in 2003, the Global Fund to Fight AIDS, TB and Malaria started supporting the HIV response in Nepal.

Collecting, collating or estimating financial investment in the HIV sector from international, bilateral and multilateral sources has been a challenge. It is only after 2003 that Nepal first prepared a proposal for the Global Fund, in which a financial gap analysis was required as part of the proposal. After this, the NCASC started to collect at least some information, though often incomplete, for this purpose from major donors.



**CRS infotainment game for behavior change**

The timeline suggests that since 1993, USAID has continued its HIV assistance in Nepal. By 2013, USAID had already invested more than USD 80 million in Nepal's HIV/AIDS program,<sup>112</sup> including the current investment (Saath-Saath Project) of an additional USD 27.5 million.<sup>113</sup> USAID's total investment in HIV/AIDS by the end of 2015 totaled USD 107 million. The earlier supplemental budget for HIV is no longer available.

In addition, USAID/Nepal facilitated building the capacity of

<sup>112</sup> USAID. 2013. Two Decades of HIV and AIDS in Nepal. Press release.

<sup>113</sup> Saath-Saath Fact Sheet, 2011.

implementing partners funded directly by U.S. Government in order to best utilize the Global Fund grant in the field.

During this time period, many other agencies, INGOs and foundations have funded HIV projects with long- and short-term goals, including specific priorities (i.e., focused on geographical area and affected groups). UN agencies, particularly UNAIDS and the WHO, played catalytic roles from the beginning, supporting the government in its coordination and policy development process. Currently, USAID and the Global Fund are the two major funding sources for HIV, in addition to a few small grants available from the UN and other agencies.

### **Key achievements and innovations**

Because of this long-term funding support, one of the major opportunities for the USAID-funded project was to apply the learning from earlier phases. As a result, the USAID-funded project and the working modality that evolved over the period was considered to be the “gold standard.” Some of the major achievements are as follows:

#### **a) Emergence of an implementation model**

Through FHI/USAID’s long engagement with the key affected populations, an intervention model emerged for implementing a program for vulnerable and stigmatized groups, such as female sex workers, and for community and home-based care and early infant diagnosis.

#### **b) Strategic information and use of evidence**

For the first time, behavioral surveillance among sex workers and clients along the highway route was conducted, which later evolved into a standard Integrated Bio-Behavioral Surveillance Study (IBBS) that is now conducted with all key populations, generating valuable data for planning and policy development. USAID has supported more than 41 IBBS and other studies. This process has contributed substantially to the national monitoring and evaluation process.

#### **c) Manual and guidelines**

In all project phases, USAID joined with other partners (UNAIDS, WHO, GIZ) in the development of manuals and guidelines for various activities, e.g., guidelines for treatment of sexually transmitted infections and training manuals/curricula, testing and counseling manuals, and laboratory and clinical management. These manuals are currently widely used.

### **Achievements that can be attributed to USAID support**

While there were a number of partners involved and investments made from various sources in the HIV response in the last 25 years, there are a few areas where the USAID contribution was significant:

#### **a) Declining prevalence among female sex workers**

The first intervention (AIDSCAP I) started with a focus on female sex workers and their clients. Although USAID/FHI had provided prevention education services to other groups, such as migrants, it has focused on female sex workers consistently. As a result, the HIV prevalence among female sex workers declined from 3 percent to less than 1 percent over the period. During this



**CRS non-traditional outlet selling condoms**

period, the contribution and support from other stakeholders and partners was either short-term or not highly focused on this group. (See comparative figures in Annex 10.)

**b) Strategic information and use of evidence**

FHI/USAID, in collaboration with other partners (WHO, UNAIDS), initiated the first behavioral survey in 1998 (BSS round 1) in highway districts. Between 1998 and 2010, IBBS studies were regularly conducted with other groups (injecting drug users, migrants, men who have sex with men/TG, sex workers and clients), which generated critical behavioral and other strategic information.

**c) Human resource development**

Although the specific data are not available, it was stated by staff of partner organizations (NGOs) and FHI/USAID staff that working in a focused and professional organization has been an excellent opportunity to advance their professional skills and working style.

**Less effective interventions and initiatives**

Some activities and interventions were considered to be less effective or had no long-term effect.

**a) Policy Project**

The first phase of this project was implemented through Futures Group, and the second phase through FHI, with the aim of building the capacity of government and NGOs and bringing policy changes in the country's HIV response. The project made efforts to bring about new policies, e.g., the HIV Bill, as well as a multisectoral response to HIV through integrating HIV in relevant ministries and capacity-building activities (training, NGO support, etc.). However, none of these activities were picked up after the project's resources ended.

**b) Costing model (GOALS model)**

Futures Group introduced this model and conducted training workshops for government and NGO representatives (1996–1997). In the government system, the budgeting practice is traditional, and the NCASC cannot adapt a new method. Similarly, NGOs are primarily dependent on donor funding, and therefore their own costing would have no meaning if donor funding is not available. Thus, there was no interest in or need to apply this model.

**c) Introduction of new condom brand (Number 1)**

The earlier condom promotion campaign, called “Dhal Dai” (Dhal=shield, Dai=brother) was considered to be successful. Later in 2007–2008, USAID, through the Academy for Educational Development/Population Services International, ostensibly launched another campaign to introduce a new brand of condom called “Number 1.” By 2009–2010, the campaign ceased, all Number 1 brand condoms remaining in the market were withdrawn, and the program was suddenly stopped. Adequate information is not available for further discussion on this issue.

**d) HIV/AIDS logistics management**

USAID assistance (through DELIVER) helped set up a system of drug forecasting, developed standard operating procedures, and placed additional staff to support supply management, but despite additional support, institutionalization was not possible. There has been little progress in the integration of the HIV supply chain with mainstream logistics.

**Coordination, collaboration and harmonization**

**a) Member of national HIV response teams**

In collaboration with other major players in the HIV/AIDS sector, USAID/FHI staff are in almost all technical working teams, task forces, or any other short task team formed as needed (e.g., the Strategy Development Task Team). USAID/FHI had ample opportunity to contribute and influence, particularly from the perspective of coordination, collaboration and harmonization of the HIV

response in Nepal. After 1993, when the country started receiving Global Fund grants, USAID was actively involved in the Country Coordination Mechanism and made several efforts to make it functional, as required by the Global Fund for the country to be eligible to receive the grant.

#### **b) Harmonization and collaboration**

None of the donors, including USAID/FHI, share detailed annual work plans and budgets with the government. If they do share, it is only about very broad activities, in the form of a letter of intent (in line with the national strategy) without the detailed implementation arrangement. In the absence of sharing the work plan and budget with the national authority, and despite the explicitly expressed willingness of harmonization and collaboration from donors, government is increasingly finding it difficult to coordinate and harmonize the program.

#### **c) Program duplication**

In USAID/FHI-implemented activities, duplications are reported, both in programmatic and geographical areas. These include training of health worker and NGO staff. Activity duplication existed at the district level, and there is a lack of cross-referral within the district to and from USAID/FHI-implemented facilities. Similarly, the PMTCT program was implemented by UNICEF, WHO and USAID. Strengthening HIV logistics and supply management was also a Global Fund activity.

### **Technical assistance approach**

The overall approach to providing technical assistance in HIV remained basically the same, with some adjustments in implementation modality based on lessons learned and experiences. While the main focus of USAID/FHI's work has been female sex workers, over the years the areas of support have expanded to almost all aspects of HIV with varying degrees of consistency and continuity. USAID/FHI has been flexible in responding to GON requests, if they are small and can be accommodated within the agreed budget, but no major shift in HIV has been observed. The working modality of USAID is limited to few, small consultations with specific people in the MOH during the design phase and preparation of the RFP, and then later the project is awarded directly to an institution outside the government. Also it is the role of the implementing partner to do all the legwork with government.

### **Challenges and issues**

#### **a) Capacity building**

One issue that is consistently highlighted in many reviews and assessment is the overall capacity and role of the national coordinating authority. A lack of clarity in the national governance and coordination framework for HIV/AIDS in Nepal has led to the NCASC being overburdened, which has adversely impacted its capacity for coordination, oversight and accountability. This raises questions about the effectiveness of the much-lauded capacity-building inputs by longstanding partners like USAID, UNAIDS and others.

#### **b) Access to ART services**

Although HIV testing coverage has increased substantially, there are still important gaps in the provision of health system-based testing facilities.<sup>114</sup> There has been a robust expansion of ART services to 60 sites within a decade. However, only approximately 10,000 people are currently enrolled in ART. Even with the consistent increments of ART enrollment for the last five years, approximately 21.8 percent of eligible adults and children living with HIV are receiving ART, which highlights the alarming gap between the estimated population and a total of 22,994 reported cases that needs to be bridged.<sup>115</sup>

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<sup>114</sup> NCASC. 2013. *National Review of HIV and AIDS Response in Nepal 2013*.

<sup>115</sup> NCASC. 2014. *Global AIDS Response Progress Report, Nepal Report 2014*.

### **c) Integration into health system and health system strengthening**

The integration of HIV recording and reporting into the national HMIS has been completed for the selected HIV indicators. However, most other services like ART, PMTCT, HIV testing and counseling, and training are run in parallel within the health system, often directly managed by the NCASC and NGOs. While USAID/FHI initiated the integration of family planning services into HIV services in its directly managed service sites, the model cannot be replicated in the government system.

### **d) Sustainability of interventions**

While this question is common to most donor-supported initiatives, some initiatives are more critical in terms of capacity (and willingness of government to assume responsibility) and impact on the quality of life. The particular concern is interventions among female sex workers implemented by USAID/FHI. As discussed earlier, this intervention has been a great success in bringing down HIV transmission and prevalence to less than 1 percent over the period. Other than the Global Fund, there are potentially no other donors to take over this program. The government's funding modality and current institutional structure do not have the opportunity and flexibility in reaching populations who are outside the current social and legal boundary.

### **e) Transparency and accountability**

The issue of transparency, accountability and donor harmonization has been an ongoing concern. The National Report, submitted to the UN in 2013, recommended that "Improving transparency, clarification of responsibilities and holding the players (both national and international, government and non-governmental) to shared responsibility and accountability is essential to move forward."

### **f) Injecting drug use (narcotic drug use)**

Here also FHI/USAID were careful (and at times felt constrained) to work on risk-reduction activities with drug users and men who have sex with men. The view was expressed that USAID did not implement the most effective needle/syringe exchange program for injecting drug users.

## **5.4. FAMILY PLANNING**

### **Background**

In Nepal, family planning services have been available for almost 60 years, primarily from the public sector health system, in addition to NGOs such as the Family Planning Association of Nepal (FPAN), which has had a long-term role. Since 1978, the private sector has been involved through the social marketing of contraceptives after the establishment of the Nepal CRS company. During the last 40 years, Nepal has made significant progress in the use of family planning methods, which increased from only 3 percent in 1976 to 50 percent in 2011.<sup>116</sup> The public health sector health system remains the main provider of family planning services in Nepal, as four out of five family planning users receive services from the government system.<sup>117</sup>

A majority of people interviewed for this review mentioned family planning as an essential part of USAID's early and ongoing support in Nepal. Initially, the focus of family planning was explicitly on population control and socioeconomic development.<sup>118</sup> Accordingly, there was an emphasis on voluntary surgical methods that required less follow-up support than the temporary methods and were

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<sup>116</sup> Ministry of Health and Population, New ERA, ICF International Inc. 2011. *Nepal Demographic and Health Survey 2011*.

<sup>117</sup> See Nepal DHS 2011 for details. According to Nepal DHS: The government sector provides 69 percent of contraceptives, including the large majority of female and male sterilization, more than two thirds of injectables and implants, and about half of the pill. Private medical facilities provide 21 percent of contraceptives, including about half of the pill and one-quarter of injectables. NGOs provide 8 percent of contraceptives.

<sup>118</sup> Cleland, J., S. Berstein, A. Ezeh, A. Faundes, A. Galsier, and J. Innis. 2006. Family planning: the unfinished agenda. *Lancet*, 368 (9549):1810-27.

considered to be more effective in addressing population growth.<sup>119</sup> Later, it was discovered that voluntary surgical methods had little demographic impact, as it was, in general, chosen by those over 30 and who already had four to six living children.

In September 1982, USAID developed its global comprehensive population policy that described specific policies on abortion, voluntary sterilization, natural family planning, contraceptives and the relationship between family planning and general development. USAID's work in family planning has been guided by U.S. congressional legislation. In 1999, the Tiahrt Amendment was introduced in USAID-funded family planning projects, which reaffirms many of the policies and principles that have guided USAID family planning assistance, including voluntarism and informed choice.<sup>120</sup> Also, since the Helms Amendment of 1973, U.S. Government funds cannot be used to support or encourage abortion as a method of family planning. The Mexico City Policy requires foreign NGOs to certify that they will not perform or actively promote abortion as a method of family planning as a condition for receiving USAID assistance for family planning.<sup>121</sup> The Mexico City Policy was established by Ronald Reagan in 1984, rescinded by Bill Clinton in 1993, reinstated by George W. Bush in 2001 and rescinded again by Barack Obama in 2009.

Since the late 1980s, USAID support in Nepal has focused on the norm of small family size, birth spacing and the benefit of family planning for the health of mothers and children.<sup>122</sup> These concerns are also reflected in Nepal's Eighth Plan (1992–1997), which includes the strategy to promote the norm of small family size (two children) and emphasizes the concept of birth spacing and use of temporary birth control methods. Nepal's Ninth Plan (1997–2002) focused on generating awareness of a small and happy family through the promotion of family planning methods, together with initiatives to improve the health of mothers and children. During this period, the promotion of temporary family planning was emphasized, although this presented other challenges because temporary methods required regular support, counseling and follow-up.

Since 1990, Nepal has experienced a major demographic transition. During the review period, there has been a consistent decline in the TFR, from 5.2 births per woman to 2.4 births between 1991 and 2011—a drop of almost three births per woman in the past 20 years. This decline was most pronounced between 2001 and 2006—a one-child decline.<sup>123</sup> While disaggregating the data by regions, the TFR is

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<sup>119</sup> Also, the GON's focus was on voluntary surgical contraception camps and provider incentives, which diverted service providers away from other important MCH services. (Interview notes.)

<sup>120</sup> According to this legislation, any such voluntary family planning project shall meet the following requirements: (a) Service providers and referral agents shall not implement or be subject to quotas or targets for total number of births, number of family planning acceptors (USAID no longer uses the word acceptors), or acceptors of a particular family planning method. Quantitative estimates for planning purposes are acceptable, however. (b) There should be no payment of incentives to an individual for becoming a family planning acceptor or to program personnel for achieving a target of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning. (c) The project shall not deny any right or benefit as a consequence of an individual's decision not to accept family planning services. (d) Family planning acceptors must receive comprehensible information about the health benefits and risks, inadvisabilities and side effects of the family planning method that they choose to use. (e) Experimental drugs and devices should be provided in the context of a scientific study in which participants are advised of risks and benefits.

<sup>121</sup> In August of 2003, the President extended this policy to “voluntary population planning” assistance provided by the Department of State. The President's memorandum excludes from the Mexico City Policy “foreign assistance furnished pursuant to the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003.” Therefore, assistance only for HIV/AIDS activities is not subject to the Mexico City Policy. For detailed information on the Mexico City Policy requirements, please refer to CIB 01-08 (R), Restoration of the Mexico City Policy, White House Memorandum for the Acting Administrator of the U.S. Agency for International Development, 03/28/01, (REVISED 03/29/01), which sets forth the Mexico City Policy clauses.

<sup>122</sup> J. M. Isaacson et al. 2001. *Half-a-Century of Development: The History of U.S. Assistance to Nepal, 1951–2001*. Kathmandu: USAID.

<sup>123</sup> MOH, New ERA, and ICF International, 2012.

highest in rural areas, the Mountain regions and Midwestern development region. Also, the TFR is significantly higher among the lowest wealth quintile (4.1), and the lowest is among the highest wealth quintile (1.5).<sup>124</sup>

The adolescent fertility rate, i.e., age-specific fertility rate for ages 15-19, has also experienced a consistent decline during the same review period, from 127 in 1996 to 81 in 2011.<sup>125</sup> The same pattern applied to the unmet need for family planning, which also declined between 1996 and 2006—from 32 percent in 1996 to 28 percent in 2001, and to 25 percent in 2006—but then increased slightly to 27 percent in 2011.<sup>126</sup>

It has been suggested that many factors, including greater access to modern contraceptive methods, may have contributed to this precipitous decline in fertility.<sup>127</sup> The data clearly show the rise in use of both modern and other contraceptive methods. The CPR for all methods increased from 22.7 percent in 1991 to 49.7 percent in 2011. While looking at disaggregated data, the CPR (all methods) is higher among urban couples, couples residing in the Terai region and couples belonging to the Central development region. However, the pace of CPR increase between 1991 and 2011 is much higher among rural couples compared to urban. Although there are differentials in the CPR across wealth quintiles, the magnitude of that difference has significantly reduced in recent years. Among the poorest, the CPR for all methods has more than doubled between 1996 and 2011. Such change is only 5 percentage points among the richest.

Despite political, infrastructural, logistical, general inequality and educational challenges, Nepal has made remarkable progress in the use of contraceptives, most rapidly between 1996 and 2006. However, the increase has not been sustained in recent years, according to the 2011 DHS data.<sup>128</sup> It was noted that between 2006 and 2011, while the use of modern methods has declined by almost one percent, there has been a 4 percent increase in the use of traditional methods, from 3.7 percent to 6.5 percent. Although an interesting development, it was also noted that although there has been a decline in the use of female sterilization and injectables, the use of implants and IUDs has increased.

Male labor out-migration and spousal separation is a major reason for the rapid fertility decline, despite the stagnation of contraceptive prevalence.<sup>129</sup> A further analysis of Nepal DHS 2011 data shows that among women whose husbands were co-resident at the time of the survey or had been living elsewhere less than one year, the fertility rates were similar to the overall average. However, women with husbands who had been away for at least one year had much lower fertility than women who were living with their husbands at the time of the survey (3.0 in 2006 and 2.6 in 2011).<sup>130</sup> Further DHS analysis shows that while the overall CPR is 50 percent for use of any contraceptive method, it was substantially higher (62 percent) among couples who are living together. Although the 2011 DHS report shows that overall, 27 percent of married women have unmet need for family planning, further analysis shows that

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<sup>124</sup> Ibid.

<sup>125</sup> ASFR (15-19) for the 1998 survey is not comparable with the other subsequent four surveys, as the former rate relates to only one year preceding the survey, while the later estimates relate to three years preceding the survey.

<sup>126</sup> Khanal, M.N., D.R. Shrestha, P.D. Pant, and S. Mehata. 2013. *Impact of Male Migration on Contraceptive Use, Unmet Need and Fertility in Nepal. Further analysis of the 2011 Nepal Demographic and Health Survey*. Calverton, MD: Nepal Ministry of Health and Population, New ERA, and ICF International.

<sup>127</sup> MOH, New ERA, and ICF International. 2012; Brunson, J. 2010. Son preference in the context of fertility decline: Limits to new constructions of gender and kinship in Nepal. *Studies in Family Planning* 41(2):89-98. (See page 90).

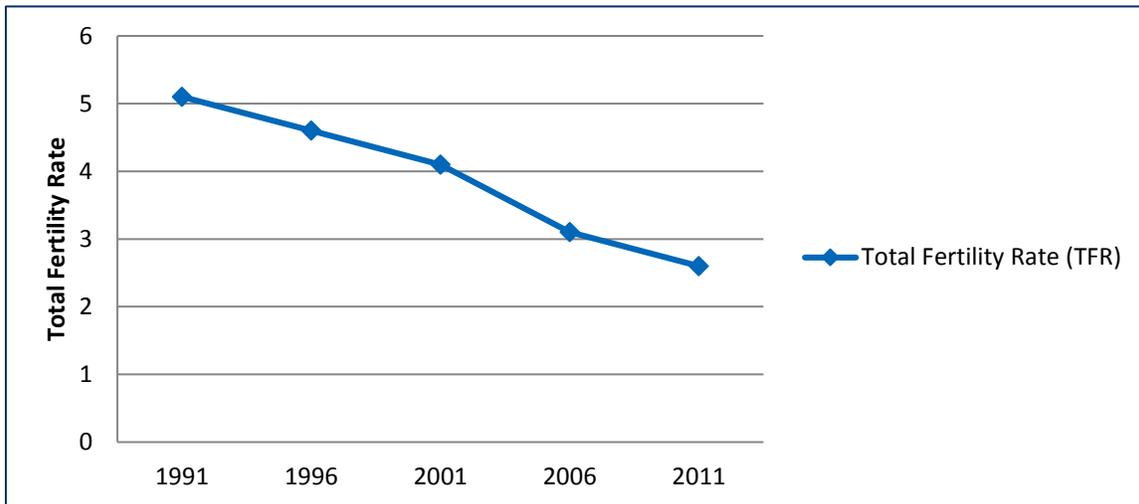
<sup>128</sup> MOH, New ERA, ICF International, 2012.

<sup>129</sup> Khanal, M.N., D.R. Shrestha, P.D. Pant, and S. Mehata. 2013. *Impact of Male Migration on Contraceptive Use, Unmet Need and Fertility in Nepal. Further analysis of the 2011 Nepal Demographic and Health Survey*. Calverton, MD: Nepal Ministry of Health and Population, New ERA, and ICF International.

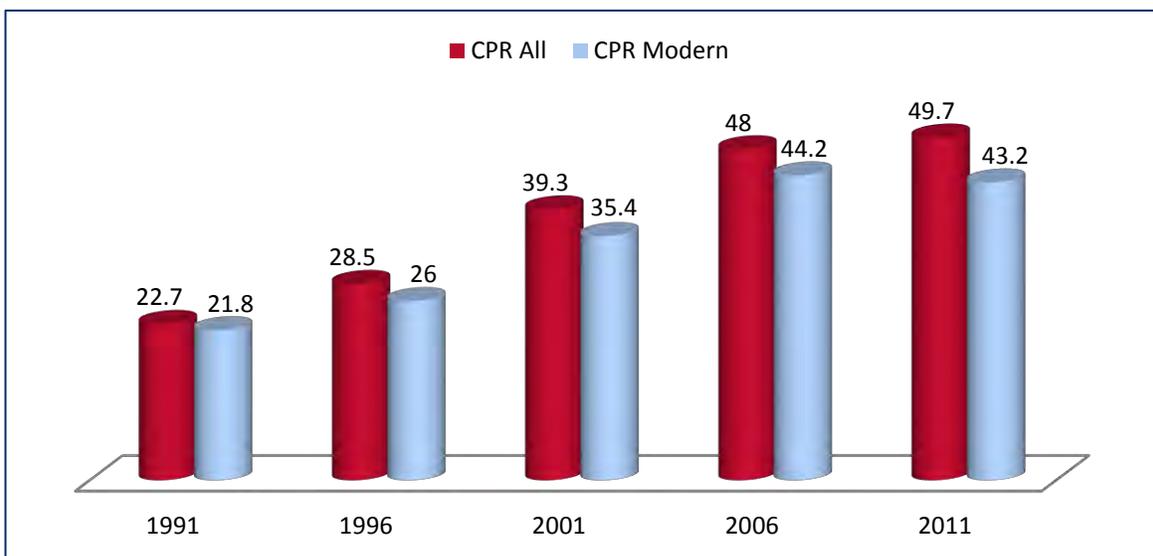
<sup>130</sup> Ibid.

only 16 percent of couples living together have an unmet need. In fact, the unmet need declined among women whose husbands were resident at the time of survey.

**Figure 14. Total fertility rate, 1991–2011, Nepal**



**Figure 15. Contraceptive prevalence rate: all and modern method, 1991–2011, Nepal**



### USAID’s contribution

Family planning has been a major focus of USAID’s work in Nepal since 1966,<sup>131</sup> including strengthening the technical and management capacity to provide quality family planning services through development of policies, strategies, standards and quality assurance protocols, training and mainstreaming of family planning services. At the national level, support has included supply of instruments and equipment, in-service training, behavior change communication, and monitoring and onsite mentoring.

<sup>131</sup> J. M. Isaacson et al. 2001. *Half-a-Century of Development: The History of U.S. Assistance to Nepal, 1951–2001*. Kathmandu: USAID.

USAID's assistance in family planning is delivered through its partnership with the GON, INGOs, NGOs and the private sector, as per Nepal's Second Long-Term Health Plan. Historically, USAID has provided the majority of contraceptives to Nepal for distribution by the government, private commercial outlets and NGOs. In 1996/97, USAID withdrew funding for contraceptives, although it continues to provide contraceptives for the social marketing program. In 2001/02, the GON contributed to less than 5 percent of total costs for family planning commodities. By 2011/12, the GON was contributing 74 percent of the total cost for family planning commodities, indicating a positive shift in commodity security and less dependence on external donor funding for procurement.<sup>132</sup> USAID has supported a private, non-profit company (CRS) that markets contraceptives and health products, accounting for over 67 percent of oral contraceptives and 49 percent of condoms in Nepal.<sup>133</sup>

In the early 1990s, as a part of the Child Survival/Family Planning Services Project, USAID emphasized providing high-quality, full family planning services in Nepal. In addition to voluntary surgical contraception, which was made available in institutions throughout the year, there was a new focus on promoting temporary contraceptives as a way to reach younger couples at the beginning of their reproductive period who wanted to space or limit pregnancies.

There were challenges in making high-quality, temporary contraception available in Nepal. Unlike permanent contraception, temporary methods require regular follow-up, widespread information, education and communication and logistical support. Logistical support for family planning, in terms of the supply of contraceptives and supplies needed for surgical procedures, has been an important part of USAID's support. USAID worked with JSI to conduct an assessment, which identified frequent stock-outs and accordingly established a logistics management information system. Retired Gurkha servicemen were hired to reorganize the district management system and warehouse space, which was being used for storing out-of-date drugs. The improved logistics system helped meet the need for permanent and injectable family planning services.

In 1992, USAID staff discovered that many couples with at least 1-2 sons, especially in the Terai, wanted permanent contraception, although the permanent methods had declined to 25 percent because of limited supplies for surgical procedures. During the winter season, there were no supplies and key staff were not available. USAID worked to ensure that the supplies and service providers were available, which resulted in an increase in the use of permanent methods from 18,000 to 60,000 per annum.

USAID worked with the Department of Health Services and FHD on developing national policies, standards, guidelines and training for family planning. The National Medical Standard for Contraceptive Services was first published in 1991. The USAID-funded NFHP supported the Department of Health Services in preparing annual family planning work plans, including training, voluntary surgical contraception services, procurement and supply of instruments and supplies, and behavior change communication activities. USAID has supported the coordination and technical support for the national-level response on family planning, including the national family planning subcommittee and annual review meetings. Throughout the review period, USAID has provided technical support for a comprehensive review of the family planning program strategy. It worked closely with various departments, such as the FHD, LMD, National Health Training Center (NHTC) and the National Health Education Information and Communication Centre, for ongoing management of services at the national level (e.g., planning; training; supplies of family planning commodities; airing of radio messages; information, education and communication/behavior change communication; complication management; and reversal of sterilization procedures).

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<sup>132</sup> USAID/Nepal. 2012. *Nepal Family Health Program (NFHP-II) Final Project Report, December 2007–November 2012*.

<sup>133</sup> DHS 2011.

Training for effective implementation of family planning programs has been an important part of USAID support. As a part of its assistance to reduce fertility and improve MCH, USAID has supported the Department of Health Services through a number of training programs to increase the availability, access and use of family planning and reproductive health services. Through Jhpiego, USAID has supported activities to produce skilled health workers who are able to provide family planning services throughout the country. Jhpiego collaborated with the NHTC to develop family planning training courses and a trainer development system.<sup>134</sup> As part of USAID funding for NFHP, assistance was provided to develop a training curriculum, select training sites and conduct training and follow-up after training, in collaboration with the MOH, NHTC, partners and NGOs, with the expectation that this would build capacity for similar activities in the future.

NFHP worked closely with the NHTC, FHD, Maternity Hospital, Koshi Zonal Hospital, Institute of Medicine, nursing schools and the Council of Technical Education and Vocational Training for national-level training. NFHP II provided support to establish the Training Working Group (TWG) in May 2009 and ensure that it functioned optimally. Prior to establishing the TWG, coordination among stakeholders was poor, and training data were not properly kept, creating difficulties in maintaining a cadre of appropriate trainers. Establishing the TWG helped to develop integrated training plans, proper reporting and recording of training data and better coordination among stakeholders. Similarly, NFHP II supported the NHTC and District Health Offices to form the District Training Coordination Group in Siraha and Rolpa Districts.<sup>135</sup> NFHP II trained 1,941 service providers in clinical family planning methods and comprehensive family planning services.<sup>136</sup>

USAID-funded projects also focused on integration of family planning into maternal health programs. For example, through ACCESS, Jhpiego helped the NHTC develop the national skilled birth attendant training package that integrated family planning and maternal and newborn health. The integration of family planning has continued to be a focus for Jhpiego in Nepal with three large-scale, USAID-funded health programs providing the opportunity to reach more people with family planning/MNCH services. As part of NFHP, USAID worked with the MOH to deliver high-quality family planning and MNCH services to their communities, including further strengthening of clinical training capacity. NFHP II supported strengthening postpartum family planning interventions by integrating family planning with MNCH. It was initiated in two hospitals in Parsa and Banke in fiscal years 2008/09. Based on the lessons learned from these two districts, this approach was gradually expanded to eight additional hospitals.<sup>137</sup>

Through its partnership with Jhpiego, USAID supported family planning integration into nutrition services within the Save the Children-led Suaahara Project and HIV and sexually transmitted infection services with the FHI 360-led Saath-Saath project in 34 districts. Since 2012, Jhpiego has been working with RTI International on the five-year, USAID-funded Health for Life Project (follow-on to NFHP II) to strengthen MOH capacity to deliver high-quality, equitable family planning and MNCH health services.

In addition to the government health facilities, USAID began to work with private providers and NGOs to promote family planning methods. A number of community-based initiatives and social mobilization activities were promoted.

USAID worked with NGOs and the private sector to provide awareness and community-based provision of family planning services. USAID projects continue to mobilize FCHVs to provide education and information as a part of USAID's strategy to promote community outreach in family planning.

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<sup>134</sup> Jhpiego in Nepal (n.d.).

<sup>135</sup> USAID/Nepal. 2012. *Nepal Family Health Program (NFHP-II) Final Project Report, December 2007–November 2012*.

<sup>136</sup> Ibid.

<sup>137</sup> NFHP II Technical Brief No. 30.

## Key challenges and issues

One of the key challenges in family planning has been to address the particular demographic issue related to the high rate of male labor out-migration and spousal separation, with the result that there has not been a significant increase in contraceptive use in recent years. Reaching out to families with migrants, i.e., both to the migrants and to the family members left behind, remains a challenge in Nepal. This has also meant that unmet need and/or CPR, without disaggregation by spousal separation, are not the best indicators of family planning. Therefore, interventions taking into account the cultural and socioeconomic considerations of people living in rural areas, the Midwestern development region and those in the low wealth quintile are needed.

Although there has been considerable training support to the providers of family planning services, family planning counseling continues to be neglected by service providers and requires considerable institutional support. Supportive supervision and mentoring of these providers are needed to build on the knowledge and skills gained from training. Onsite follow-up and monitoring of services, with supportive coaching and feedback to providers, are necessary to maintain the quality of services. Many service providers do not begin delivering new services, even after training, because of a lack of confidence. If a complication arises, they often stop providing services. Therefore, trained health workers need regular follow-up support to become fully confident in providing new services.

There has been a significant decline in the use of vasectomy as a method of family planning, partially because training for sterilization has declined, and therefore there are not enough trained providers to perform vasectomies.

As noted for other health services, frequent transfer of health workers means that there is a need to take into account staff transfer to ensure that health facilities are equipped with trained human resources. In addition, regular supply, trained staff, infection prevention systems and equipment support are needed as part of broader health systems strengthening. Structural constraints such as strikes, political unrest, frequent shortage of fuel and perennial power cuts must be factored into any support USAID provides for family planning services.

In addition to comprehensive abortion care services, which started in 2004, medical abortion technology is available throughout Nepal. Its easy availability has meant that the number of women seeking abortions has been increasing. Available information suggests that about three out of five women use medical abortion as a method to space or prevent unwanted pregnancies.<sup>138</sup> There also is evidence of an increase in the use of emergency contraception as a method of family planning in Nepal. The use of these methods as an alternative to family planning services could have significant impact on women's health.

## 5.5. MATERNAL AND CHILD HEALTH

### Background

Nepal's progress on improved maternal and child mortality rates has been recognized as a global success story.<sup>139</sup> Explanations for this success have ranged from specific interventions in the health sector (such

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<sup>138</sup> A survey of 672 clients in a hospital in Nepal found that nearly three out of five gave their primary reason for termination as already having the number of children desired. See: Shyam Thapa, Kasturi Malla and Indira Basnett. 2010. World Health & Population, 11 (3): 55-68. Also, see page 111 in the publication already cited in the report: Shrestha, D. R., A Shrestha and J. Ghimire. 2012. Emerging challenges in family planning programme in Nepal. Journal of Nepal Health Research Council 10, no. 21.

<sup>139</sup> Engel, J. et al. 2013. Nepal's Story: Understanding improvements in maternal health. *Development Progress*. London: ODI; Hussein, J., J. Bell, M. Dar lang, N. Mesko, J. Amery, et al. 2011. An appraisal of the maternal mortality decline in Nepal. *PLoS ONE* 6(5): e19898.

as safe motherhood programs built on results-based financing models, technical interventions such as misoprostol, and technical and financial support of donors), to the contribution of non-health drivers.<sup>140</sup> Nepal's public health system, which has received consistent support from a number of EDPs over the last six decades, has certainly laid the much-needed foundation for impressive gains.<sup>141</sup> In addition, the contribution of non-health changes, such as the inflow of remittances, expansion of road networks and transport and increased education of women and girls, have contributed to improvement in MCH outcomes.<sup>142</sup>

The political transition in 1990 brought a major transformation in the MCH sector and increased the focus of external development assistance on MCH. The sustained political interest on the part of the government is reflected in the National Health Policy (1991), the subsequent five-year development plans, Second Long-Term Health Plan (1997–2017) and many other policies, plans and programs. The objective of the 1991 National Health Policy was to upgrade the health standards of the majority of the rural population by extending basic primary health services and making modern medical facilities available at the village level. "Safe Motherhood" was a priority area, and, for the first time, it set targets for the reduction of maternal mortality to 400 per 100,000 live births by 2000. In 1993, the Safe Motherhood Policy and Plan of Action (1994–1997) was developed. The National Safe Motherhood Policy, formulated and endorsed by the government in 1998, placed an emphasis on strengthening maternity care (including family planning services), enhancing technical skills of health care providers at all levels and strengthening referral services for emergency obstetric care. Safe motherhood was in turn integrated into the Reproductive Health Strategy (1998), with a central focus on avoiding delays in seeking, reaching and receiving care. The National Safe Motherhood and Newborn Health Long-Term Plan (2006–2017) emphasized institutional delivery care and focused particularly on the development of more emergency obstetric care and birthing centers.

The financial and technical contribution from EDPs to tackle high maternal and child mortality since 1990 has been well acknowledged. As Nepal's long-standing development partner in the field of health and family planning, USAID has been a major player in MCH in Nepal. DFID is another important donor, which started its maternal health work in Nepal in 1997 with the Nepal Safe Motherhood Programme. UN agencies such as UNICEF, WHO and UNFPA are other key players. NGOs, INGOs and private sector organizations such as Save the Children, CARE Nepal, HKI, JSI, Adventist Development and Relief Agency, RTI, Plan and Jhpiego, among others, have worked with donors, local implementing partner NGOs and the GON to manage and provide managerial and technical assistance over this period.

### **USAID's Contribution**

As noted earlier, family planning and child health were a central focus of USAID's work in the early 1990s. Gradually, USAID began to incorporate maternal and neonatal health in its assistance in the mid- to late 1990s. A key modality of USAID's assistance in MNCH has been generating evidence through programmatic interventions in partnership with the Department of Health Services and scaling up provision of technical assistance to government departments such as the FHD, Child Health Division, NHTC and the District Public Health Offices/District Health Offices by supporting training, reviews and the development of various policies, strategies and guidelines. The most notable bilateral projects include the Child Survival/Family Health Services Project and generation of evidence through the vitamin A programmatic intervention in the early 1990s and its scaling up through the Nepal Technical Assistance Group (NTAG), NFHP (I and II) in the first decade of 2000, and a project more focused on health systems (Health for Life) from 2012–2017. In this period, USAID, through Jhpiego, supported a number of projects, such as the Maternal and Neonatal Health Program, Access to Maternal and

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<sup>140</sup> Ibid.

<sup>141</sup> Engel, J. et al. 2013. Nepal's Story: Understanding improvements in maternal health. *Development Progress*. London: ODI.

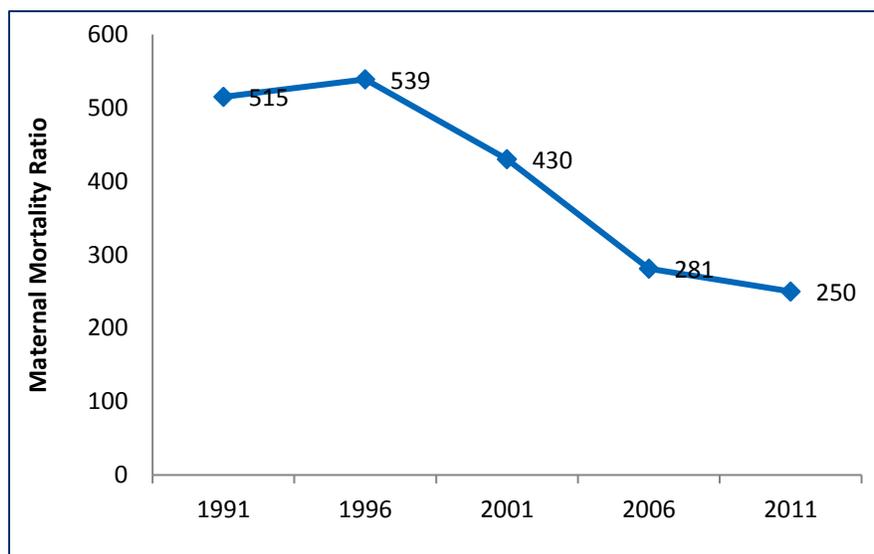
<sup>142</sup> Interview notes. Also: <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8625.pdf>

Newborn Health Program (ACCESS) and Maternal and Child Health Integrated Program. A key modality of USAID’s assistance has been to generate evidence through its support for pilot programmatic interventions at the level of service delivery and using the evidence generated to persuade policy makers to scale up those interventions. In addition to its support for the strengthening of health facilities such as sub-health posts, health posts, primary health care centers and public hospitals, USAID has had a strong focus on community-based interventions (such as CB-IMCI and CB-MNC), and its assistance has been consistently implemented through Nepal’s well-known frontline health volunteers, FCHVs.<sup>143</sup>

**State of Maternal, Neonatal and Child Health**

As noted earlier, achievements in MCH have been particularly impressive, including a reduction in maternal mortality ratio from 515 to 250, infant mortality rate from 80 to 46, under-5 mortality rate from 121 to 54, and neonatal mortality rate from 46 to 33, between 1991 and 2011.<sup>144</sup>

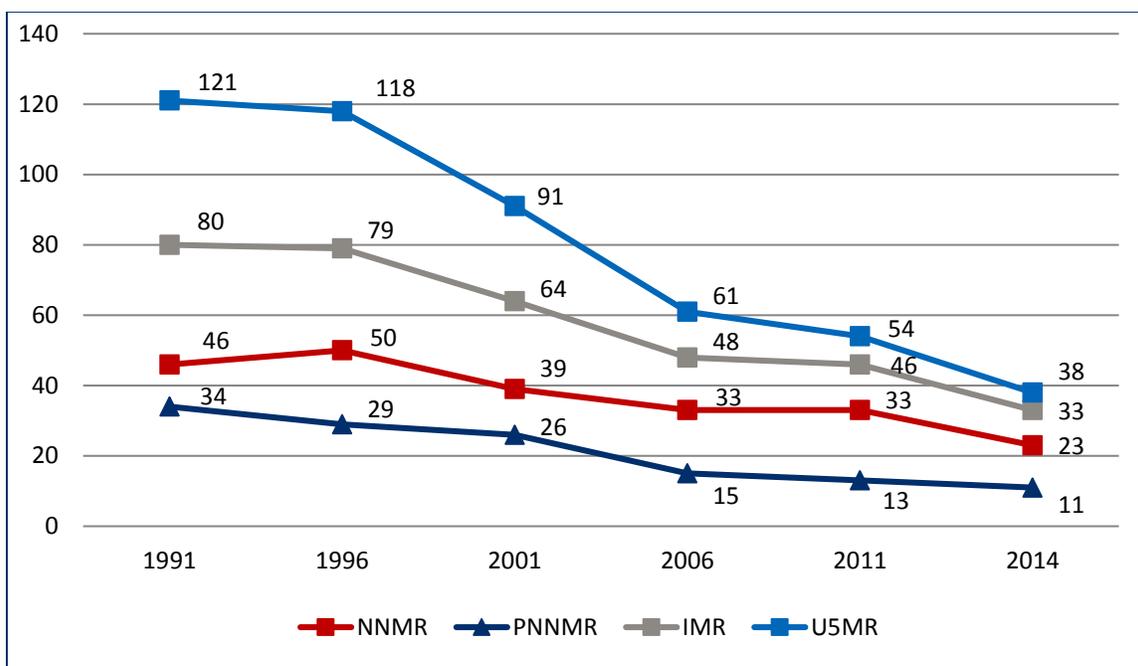
**Figure 16. Maternal mortality ratio, 1991–2014, Nepal**



<sup>143</sup> As noted, MMR is a very contentious ratio in Nepal and currently ranges between 190 to 250 to 480, depending on the report and survey methods used. For example, the Population Monograph of Nepal (Volume I, GON, National Planning Commission Secretariat, Central Bureau of Statistics and UNFPA, 2014) reports a rate of 480. The MMR also varies by ethnic group and geographic location.

<sup>144</sup> These figures are from several reports, including the DHS 2011, NMICS 2014 and Economic Survey 2012/13, Ministry of Finance/GON.

**Figure 17. Infant and child mortality, 1991–2014, Nepal**



### USAID-supported interventions and projects

During the last 25 years, USAID has provided MNCH assistance. In the early years, USAID’s assistance focused on child health. Given the high child mortality rate, USAID categorized Nepal under the Child Survival Priority Countries in 1990. A major USD 43 million, five-year project called Child Survival/Family Health Services was implemented, which supported the GON’s emphasis on basic needs, child survival and reduction in population growth. It focused on services for and by women, extending services beyond the health post into the communities and promotion of MCH services. It helped reduce child mortality and undesired fertility by improving the quality and coverage of services, primarily in the Central Region. The project was extended three times and continued until 1998.<sup>145</sup>

A crucial USAID intervention in child health was the introduction of vitamin A supplements through a programmatic intervention. As a part of its effort to develop a replicable intervention that could save children’s lives, USAID supported the Nepal Nutrition Intervention Project in Sarlahi district from 1988–1991.



**Vitamin A dosing**

Implemented by Johns Hopkins University, the project looked at the impact of giving high-dose vitamin A capsules to children 6–72 months old. The study showed a 30

<sup>145</sup> J. M. Isaacson et al. 2001. *Half-a-Century of Development: The History of U.S. Assistance to Nepal, 1951–2001*. Kathmandu: USAID.

percent reduction in infant mortality among the children who received the capsules. The success of this intervention led to the development of the national vitamin A policy.<sup>146</sup> By November 1992, guidelines for implementation of the National Vitamin A Deficiency Control Program were adopted. The funding for this program came from USAID and UNICEF. USAID provided its support through the Vitamin A Field Support Project (VITAL). With the completion of the VITAL contract in April 1994, USAID continued its support through the Opportunities for Micronutrient Interventions Project (OMNI). In 1995, OMNI subcontracted HKI to provide technical assistance in Nepal. To support the program, NTAG was registered as an NGO and was tasked to support the NVAP. NTAG was funded by USAID, AusAID and UNICEF. Vitamin A tablets are distributed through FCHVs.

USAID supported a pilot programmatic intervention on community-based management of acute respiratory infection in Jumla, which was scaled up in 1994. It included using Village Health Workers (VHW), Maternal and Child Health Workers (MCHW) and FCHVs to diagnose and provide treatment. This emphasis on community-based interventions was very much in line with government's policy to provide services beyond the health facility to the communities.

USAID has supported a number of community-based interventions in addition to supporting health facilities in the first decade of 2000 through NFHP I and II. The NFHP projects worked closely with the FHD and Child Health Division to help formulate policy and guidelines. They worked with FHD in initiating new approaches to enhance the knowledge and essential skills of skilled birth attendants working in health facilities. They provided technical assistance to the FHD to strengthen annual work planning, develop training materials and improve quality of services in core program districts. The FHD was also provided support for conducting regular Safe Motherhood Neonatal Subcommittee meetings and various Technical Advisory Group meetings.<sup>147</sup>

NFHP worked with the FHD to pilot and scale up innovations such as misoprostol for postpartum hemorrhage and chlorhexidine for cord care. To address postpartum hemorrhage at home birth, a major cause of maternal mortality, NFHP supported a pilot intervention to test feasibility, acceptability and safety of misoprostol distribution using FCHVs in 2005. The results were published in 2007 in the *Journal of Perinatology*. Based on the research findings, the misoprostol intervention has been scaled up in 27 districts.

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<sup>146</sup> Ibid.

<sup>147</sup> *NFHP II Final Report*.

Likewise, NFHP supported the GON to pilot a chlorhexidine intervention in four districts in 2009. Results from the pilot showed high rates of both coverage (receipt and use of chloro-hexidine) and correct use (full tube used, application immediately after cord-cutting, application on cord tip and surrounding area). Success of the pilot led to the formal endorsement of chloro-hexidine as a national program by the GON in 2011. Chlorhexidine has been included in essential newborn care practices and has been integrated with other government programs such as the community-based neonatal care package (CB-NCP) and misoprostol expansion and recently into the integrated CB-IMNCI. It has also been included in the skilled birth attendant curriculum, and chlorhexidine gel has been included in the government's Essential Drug List.

NFHP supported the development of an interim strategy of community-level MNH activities that focused on high-impact interventions through a continuum of care from pregnancy through the postpartum period and from the community to health facilities. For this, FCHVs were mobilized to identify pregnant women living in their catchment areas, visit them in their homes to provide counseling on birth preparedness (money, transport and service providers), identify danger signs, strengthen referrals, promote hygiene, nutrition and self-care, and promote essential newborn care. FCHVs provided iron to all mothers, and misoprostol to prevent postpartum hemorrhage to those living in districts where misoprostol activities were implemented. They also carried out post-delivery visits to reinforce counseling messages, screen for danger signs in mothers and newborns and treat or refer as appropriate, and they provided vitamin A to all mothers. Significant improvements were observed in pregnant women receiving antenatal counseling and the full course of iron tablets, institutional deliveries, and the use of misoprostol in home deliveries.

NFHP's support to enhance knowledge and skills of health workers resulted in an increase in the number of functional basic emergency obstetric care sites and birthing centers, as well as improvement in the quality of care. NFHP provided support visits and mentoring at basic emergency



**USAID Administrator Rajiv Shah provides The USAID Pioneers Prize 2014 to the Health secretary of MoH, Dr. Praveen Mishra in appreciation of indispensable leadership of GON in the pioneering research, development and expansion of simple, low cost antiseptic for umbilical cord care as part of the national Newborn Care package.**



**Application of chlorhexidine to a newborn in a maternity hospital**

obstetric care sites and birthing centers to ensure that services were available on a regular basis and in compliance with national standards.

To address the high neonatal mortality rate, USAID supported the implementation of CB-NCP. This new neonatal care package had additional components of sepsis and birth asphyxia management to address the full spectrum of contributors to neonatal mortality. Based on the lessons learned from CB-IMCI and the Morang Innovative, NFHP supported the development of CB-NCP training materials, job aids, and reporting forms for health facilities and communities.<sup>148</sup>

The current USAID-funded Health for Life Project (2012–2017) was designed to strengthen the MOH's capacity to plan, manage and deliver high-quality family planning and MNCH services at the district and local levels. In addition to national-level efforts, the project focuses specifically on 14 districts.

### **Key challenges and issues**

While Nepal has made significant improvements in maternal and child mortality rates over the last 25 years, reduced mortality is often conflated with MCH, which is much broader. Beyond the focus on these measurable indicators, interventions are needed to bring about greater and sustainable changes in the overall health of women and children. There is a danger that much of the external development assistance has focused on bringing about a quick impact, ignoring the need for wider changes in the health system and the need to address gender and structural inequalities.

There is need to look at Nepal's progress on MCH with a focus on health inequalities. The overall gain has not been consistent for different regions and social groups in Nepal.

While global health technical innovations have contributed to saving lives of mothers and children, a more meaningful and sustainable approach also requires acknowledging the contribution of non-health drivers for bringing about change in health outcomes and engaging with issues of gender and structural inequalities.

Global health innovation, generation of evidence through programmatic interventions, technical assistance and training are important, but more is needed to improve the quality of care. In addition to training and technical and managerial inputs, USAID will need to continue to support social mobilization and mobilization of local resources to ensure sustainable changes.

It was noted in the interviews that the rush to achieve the MDG targets by 2015 led to a range of technical interventions and the rapid expansion of birthing centers. While these lifesaving interventions need to be supported, quality of care has been a major challenge due to the absence of appropriate physical facilities, equipment, supplies and availability of skilled service providers.

## **5.6. NUTRITION**

Malnutrition, particularly for children and women, remains a major challenge in Nepal. Although rates of stunting and underweight have decreased and the rate of breastfeeding has increased recently, according to the latest DHS (2011) data, 41 percent of children under 5 are stunted, which increases to 60 percent in the western mountains. Among children under 5, 28.8 percent are underweight. In addition, one in four women of reproductive age has chronic energy deficiency. Women and children also suffer from some of the world's highest levels of vitamin and mineral deficiencies.<sup>149</sup>

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<sup>148</sup> USAID/Nepal staff gave additional information, beyond the interviews, regarding USAID support for the evaluation of CB-NCP and that the findings encouraged the MOH to revisit the earlier package of services and later to integrate CB-NCP and CB-IMCI, in collaboration with other EDPs.

<sup>149</sup> [http://reliefweb.int/sites/reliefweb.int/files/resources/Full\\_Report3936.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Full_Report3936.pdf)

Nutrition has been on the policy agenda in Nepal for the last four decades. Over the years, various strategies, programs and policies have been developed and implemented to improve the nutritional status of the population in Nepal.

In 1976, the National Nutrition Coordination Committee was established. In 1978, the committee organized a workshop to develop a national multisectoral strategy for improving nutrition, followed by a number of initiatives, including the formation of nutrition focal points in health, agriculture, education and Panchayat ministries, and the establishment of the Nutrition Section under the Department of Health Services. From 1985–1990, WHO and UNICEF supported the Joint Nutrition Support Programme as a joint activity with the government (agriculture, health, education and local development ministries) in five districts, which aimed to bring a positive change in nutritional status. However, the program was discontinued because of limited inputs from the designated ministries and community involvement at the local level. In 1993, another effort was made to implement a multisectoral nutrition program through the National Nutrition Policy Coordination Committee, but it was not continued for similar reasons. In 1998, the National Plan for Action on Nutrition was developed. It was not until the introduction of the MDGs in 2000 that nutrition became a major priority in Nepal.

In 2004, the National Nutrition Policy and Strategy was prepared and published by the MOH. With support from UNICEF in 2007, the National Plan of Action on Nutrition was prepared, which aimed to improve the nutrition status of children under 5 years and women of reproductive age. According to the plan, the major nutrition issues facing Nepal included high prevalence of low birth weight, childhood undernutrition, chronic energy deficiency in mothers, vitamin A deficiency, iodine deficiency disorders, and iron deficiency anemia. In 2009, the Child Health Division, together with a number of EDPs, including the World Bank, USAID, WHO, UNICEF, World Food Program, and others, supported the Nutrition Assessment and Gap Analysis (NAGA). This assessment synthesized the existing evidence and analysis necessary to develop a detailed multisectoral Nutrition Action Plan for the next five years.

The development of the NAGA was linked to Nepal's five-year development planning, which also began in 2009. This process eventually led to the GON's Multi-Sectoral Nutrition Plan (MSNP) 2013–2017, which is led by the National Planning Commission. This plan serves as a common results framework for improving nutrition outcomes and setting out plans of action for implementing nutrition-sensitive policies and strategies for key sectors, including agriculture and food security, public health and education. The objectives are to reduce the prevalence of stunting among children under 5 to below 29 percent, the prevalence of underweight to below 20 percent, the prevalence of wasting among children under 5 to below 5 percent, and undernutrition among women 15-49 years of age (Body Mass Index of less than 18.5kg/m) by 15 percent.

In 2011, Nepal joined Scaling up Nutrition (SUN), a global movement that unites national leaders, civil society, bilateral and multilateral organizations, donors, businesses and researchers in a collective effort to improve nutrition. The World Bank is the donor convener for SUN in Nepal. SUN's priority commitments in Nepal are to implement and scale up evidence-based, cost-effective nutrition-programs of the MSNP; develop and implement a long-term National Food Security and Nutrition Action Plan; strengthen key sectors to implement the MSNP and National Food Security and Nutrition Plan; and strengthen monitoring of MSNP implementation, with links to existing food security early warning systems, in addition to the Health Sector Strategy for Maternal Undernutrition.

### USAID's contribution

USAID has made substantial contributions to health and nutrition, in partnership with the GON and other EDPs. In terms of nutrition-related efforts, it is most frequently associated with the introduction of Vitamin A supplementation. As part of its effort to develop a replicable intervention that could save children's lives, USAID supported the Nepal Nutrition Intervention Project in Sarlahi district from 1988–1991. Implemented by Johns Hopkins University, the project looked at the impact of giving high-dose vitamin A capsules to children 6-72 months old. The study showed a 30 percent reduction in infant mortality among the children who received the capsules. The success of this intervention led to the development of the national vitamin A policy. By November 1992, guidelines for implementing the National Vitamin A Deficiency Control Program were adopted. Since its inception in 1993, the program has achieved high, sustained coverage in every district. NTAG—funded by USAID, AusAID and UNICEF—was registered as an NGO and tasked with supporting the NVAP. The program used a phase-in approach, adding 10-12 districts each year, reaching national coverage in 2001. Vitamin A tablets are distributed by FCHVs, who received wide recognition for their role in this program.



Child enjoying Jaulo during cooking demonstration in Kailali

Currently, USAID supports two bilateral nutrition-related projects in Nepal:

- **Suaahara** (2011–2016), a multisectoral project aimed at reducing the national stunting prevalence rate from 41 percent to 27 percent
- **Knowledge-Based Integrated Sustainable Agriculture and Nutrition (KISAN, 2013–2018)**, designed to reduce poverty and hunger in Nepal by achieving inclusive growth in the agriculture sector, increasing income of farm families and improving nutritional status, especially of women and children

Suaahara is a USAID-funded five-year (2011–2016) integrated nutrition project that supports the GON's MSNP to address the poor nutritional status of women and children in the first 1,000 days of life in 41 districts. It is led by Save the Children with six implementing partners: HKI, Jhpiego, Johns Hopkins University Center for Communication Programs, Nepal Water for Health, Nutrition Promotion and Consultancy Services and Nepal Technical Assistance Group. Suaahara is being implemented in partnership with the GON. The project works closely with the government's Child Health Division and National Health Education, Information and Communication Center, as well as the FHD and the NHTC, Ministry of Agricultural Development, Livestock Department, Department of Water Supply and Sewerage, and Ministry of Federal Affairs and Local Development, from the central to the community level. Suaahara integrates health, nutrition, agriculture and food security activities. The project's overall goal is to increase and sustain the health and well-being of the Nepalese by improving the nutritional status of women and children under 2 years of age through achieving four intermediate results:

- I. Improved household health and nutrition behaviors

2. Increased use of quality nutrition and health services by women and children
3. Increased consumption of diverse and nutritious foods by women and children
4. Strengthened coordination on nutrition between government and other stakeholders

The program focuses on improving health and nutrition behaviors at the household level through promotion of essential nutrition actions, particularly infant and young child feeding, and addressing other determinants of undernutrition, such as availability of and access to food, water, sanitation and hygiene, quality health care, child spacing and sociocultural factors, including gender and marginalization. FCHVs are mobilized for health education activities.

KISAN, managed by Winrock International, is described as the flagship project for USAID's global Feed the Future initiative. The objective of this integrated project is to reach up to one million rural Nepalese by working with 160,000 farm households, pregnant and lactating women, and children under 2. To scale up small-scale commercial agriculture, KISAN uses private service providers, agribusinesses, government extension agents and leading farmers as "change agents" to promote the adoption of conservation agricultural packages, a variety of soil and water management techniques, and community production of climate-adapted seeds. Training on micro-dams, fish farming, linkage strategies to markets, and creating farmer cooperatives are also provided. Initially, nutrition interventions were delivered through FCHVs and mothers' groups, who delivered messages on essential nutrition and hygiene actions and infant feeding practices. However, these activities were removed from KISAN's scope of work in 2013, and currently KISAN is an agriculture project without nutrition activities. Two Feed the Future agriculture/economic growth initiatives, Nepal Economic Agriculture and Trade Activity and Hill Maize Research Project, were programmatically linked to KISAN and completed before 2012.

### **Challenges and issues**

As indicated at the beginning of this section, USAID was not earlier noted for its support for nutrition, except for vitamin A and the Nepal Nutrition Intervention Project in Sarlahi. In fact, other EDPs who were described as providing long-term and steady support expressed disappointment and frustration that USAID did not join the nutrition coalition earlier, even after the GON developed nutrition policies and a nutrition section in the MOH. Although NFHP was described as being one of the strongest health programs in Nepal, it was noted that USAID would not let NFHP take on nutrition, despite its good relationships with other partners in the nutrition coalition. However, in response to U.S. global initiatives (e.g., the Global Health Initiative (GHI) in 2010 and GHI plus in 2012, among other global policies and programs), USAID is now supporting major nutrition-related projects in Nepal (Suaahara I and II, KISAN and others). Many interviewees commented about the current nutrition projects. Although USAID's support for nutrition is appreciated, many raised concerns about Suaahara, for example, questioning whether it is in alignment with GON and other EDP-supported approaches, challenges related to its multisectoral structure, sustainability and relationships among the partners in the Suaahara coalition. In addition, the needed human resources to take forward nutrition work in Nepal was viewed as being limited, especially because there are few graduates in public health with nutrition training. Observations about KISAN were also mixed, including what was described as "confusion within USAID about the nutrition component" (in addition to challenges working across sectors, e.g., agriculture, health, etc.), as well as KISAN's approach, e.g., did it fit with established local structures and practices. Others noted that although local organizations such as the United Mission to Nepal had a history of supporting successful integrated nutrition projects in Nepal, it was not clear if projects such as KISAN and Suaahara took lessons from such experiences.

### **CONCLUDING SUMMARY**

In summary, as seen from the above review of programs and projects, USAID support is viewed as making a major contribution, especially to these key interventions, although as with all health-related issues, there are also inconsistencies, complications and ongoing challenges.

## 6. FINDINGS

Analysis of the data from the 62 interviews provided a rich source of information from several perspectives. The data reflect the experiences, views and perceptions of government (especially the MOH, Ministry of Finance and Planning Commission), other EDPs, consultants, USAID partner organizations (e.g., INGOs and NGOs) and USAID staff. In all categories, the interviewees represented people involved throughout the 25-year time frame and included current and former government officials, USAID staff and others. Therefore, interviews drew on a broad range of professional positions and personal experiences. Comments were made in response to questions from the interview guide and not as criticisms, but rather as observations and views about USAID's structure, policies, procedures and relationships, and, of course, all were related to its approaches to health sector development assistance. If the same questions had been asked about the approaches and types of support provided by other donors, some of the responses might have been similar, but this review focused on USAID's health sector support, although it included questions about USAID's role and relationship as part of the broader donor community.

### **Key findings from the interviews are listed below:**

- Most interviewees were consistent in identifying USAID's contribution to the health sector as including family planning and reproductive health, vitamin A, community health (FCHVs), MCH, HIV/AIDS, logistics and DHS. Its wide ranging support in family planning, which included support in service delivery; private sector mobilization; information, education and communication; training; logistics; and quality assurance has not only helped in decreasing the fertility rate but also helped in women's decision making and contributed significantly to improve MNCH. Vitamin A was a lifesaving intervention that had immediate visible results in reducing child mortality. Working closely with FCHVs, a number of community-based interventions have contributed to improving MCH. MNCH has remained a central focus of USAID's assistance over the last 25 years. As the first donor that supported HIV work in Nepal, USAID has continued to provide regular HIV/AIDS support. USAID's integrated program on nutrition, WASH and its new focus on health governance/systems are still in the early phases, and long-term outcomes are unknown. However, the recent midterm evaluation of Health for Life has raised many questions about the effectiveness of this project and its alignment with current and future proposed MOH strategies.
- USAID's support for evidence generation, research, innovative pilot projects and scaling up—including support for vitamin A, acute respiratory infection and CB-IMCI, chlorhexidine and misoprostol—was viewed as a very positive contribution. USAID has consistently relied on this model of generating evidence around lifesaving interventions and their scaling up as a way to bring about improving health outcomes. Generation of evidence and measurable results has been an important modality of USAID's health sector assistance. This has helped USAID attribute health outcomes to its financial and technical assistance. Further, over the years, USAID has helped build the capacity of New ERA, especially for conducting the DHS, which provides much-needed evidence for planning, monitoring and evaluation of health programs in Nepal.
- USAID's long-term support for logistics is widely appreciated. However, it was noted that recently there has been a reverse in the curve, which may be associated with a decrease in USAID support for logistics. USAID's move away from supply chain management was seen as a mistake.

- USAID and other donor-supported investments are viewed as increasing access to health care, although many interviewees noted the need for an increased focus on the quality of care. Over the years, donors have focused on getting more people into health facilities, but the quality of care has not been a major priority. Some interviewees noted that quality of care is closely linked to governance. Although EDPs can support the proposal of plans and guidelines, government must implement and undertake such actions as reform of the civil service, which was noted as a long-term need.
- Wide recognition was given to Nepal's overall achievements in health outcomes, including the international recognition for meeting MDG targets (e.g., TFR, maternal mortality ratio, under-5, neonatal and infant mortality rates, etc.). Although many interviewees noted the increases in private-sector and government health facilities and the number of trained health professionals and paramedical staff, they also attributed these achievements to broader changes and overall developments in Nepal, such as increased roads contributing to improved access, education, especially for girls, improved economy, including out-migration and the availability of cash income from remittances.
- Several interviews noted that the focus on achievements masked internal issues related to disparities and equity. Getting health services to the most marginalized remains a major challenge. It was noted that USAID and other donors need to go “where to get the biggest bang for the buck” and therefore implement projects where there is a large population and available services, which is usually not where the greatest need and hardest-to-reach groups exist. In general, programs supported by USAID and other EDPs were described as often being based in districts with larger populations and coverage, and not in the hard-to-reach, poor, underserved districts, which are sparsely populated. Such practices were viewed as resulting in service disparities and inequity.
- USAID-supported projects and activities are viewed as being target- and results-oriented. Although many projects are viewed as producing results, they were also described as being costly. There are good reasons for focusing on targets and results, as they provide much-needed accountability to the U.S. Congress and others. However, the focus on targets means that services are not always delivered where the greatest need is, and they can take place at the expense of supporting the health system.
- USAID is viewed as being the donor that is most risk-averse. Although many people recognized that this approach is in response to internal regulations and congressional oversight, it was also viewed as influencing and often restricting (or limiting) USAID's approaches and relationships. USAID is seen to be investing its technical and financial assistance where the results can be more easily attributed to its support.
- USAID, in general, is not viewed as being responsive to GON requests as compared to some other EDPs, but was described as being more responsive only when GON requests were within the sphere of work of USAID-supported projects.
- USAID is viewed as being guided by global rather than country priorities. When global and local priorities align, then USAID was described as being a strong partner. One interviewee said, “The Government is never clear about the actual objective of USAID in supporting the health sector. They seem to have their own globally influenced agenda. USAID-supported areas are guided by its own mandate and its own need rather than the country's need. It is not flexible to address the country's need.” A few interviewees raised the issue of transaction costs. Another said, “USAID seems to give priority to strengthen certain US-based organizations to deliver programs. This, of course, results in the committed resources of USAID not being effectively translated into the communities—a lot of intermediary agencies and organizations absorb

resources. Thus, despite being one of the top donors in terms of volume of aid, the results on the ground are not commensurate to the money spent. USAID is seen to create dependency. They invest in particular projects and then they create new structures and procedures but at some point in time, they stop the projects and leave, and the government is not able to take over on its own.”

- USAID was described as preferring to work with the private sector, INGOs and NGOs. Many USAID-funded projects were described as being implemented by a consortium of contracting organizations, usually headed by an INGO, which has the expertise, networks and resources to be able to make competitive bids. For example, groups such as JSI and FHI have been long-term partners with USAID in Nepal and have contributed to significant program interventions. A number of local and expatriate experts who work within USAID-funded projects have long-term experience working in Nepal, and several were earlier Peace Corps Volunteers.
- Many interviewees, especially GON officials, commented on USAID funding modalities and the limited budget support put through the Red Book, in comparison to project-related assistance through U.S.-based organizations. However, some officials at the department level (Child Health, Family Health, etc.) appreciated the benefit to community- and district-level activities from the project approach. Others noted the challenges related to U.S. Government budget support, which is on a reimbursement basis and subject to strict auditing procedures—requirements described as being difficult for the GON to meet. One interviewee expressed the view that it was easier for the GON not to receive direct budget support because of the U.S. Government procedures and requirements, although this was not a view shared by senior officials at the MOH and MOF.
- USAID was perceived as having had stronger partnerships and influence with the GON in earlier years. However, changes in technical background, negotiation skills and the experience of USAID staff (globally and at country/mission level) have resulted in USAID having less influence. Unlike other donors such as DFID and the World Bank, USAID was viewed as having less interaction and influence with the GON. There was some speculation about whether USAID considers influencing policy as an explicit focus of its assistance.
- There was a widespread observation among people interviewed that at the global and country levels, USAID’s contracting office currently has a greater influence in decision making, type of funding mechanism and internal USAID relationships during project implementation. These factors have affected relationships with the GON and partner organizations. This has meant that technical aspects of the projects may receive less priority than compliance.
- USAID was seen as shifting from more flexible to tighter funding mechanisms and managerial oversight, which was viewed by partners as USAID being less flexible, with more control and project micromanagement.
- Many people interviewed also commented on the different types of agreements for projects, primarily cooperative and contractual, with the widespread perception that there is an increase in the use of contracts. This perception is linked to the general impression that USAID is viewed as being increasingly less flexible and providing more/tighter oversight.
- Many in all categories of interviewees noted changes in the relationship between USAID and partner organizations, e.g., less appreciation for the technical skills of partners, more formal relationships between partners and USAID staff, more oversight and increased micromanagement.
- The location of USAID within the U.S. Embassy was viewed as a barrier to communication and collaboration with the GON and stakeholders. In addition, this move was frequently linked to

the perception that it has resulted in USAID being more closely aligned with U.S. political priorities and less oriented to the local country situation. Thus, there are implications of the U.S. Government's integration strategy for USAID's public relations with a wide range of stakeholders.

- USAID is viewed as not paying competitive salaries for FSN staff and having difficult contracting processes for consultants, which was described by many as discouraging well-qualified people from working with USAID. This is not just likely to impact USAID's ability to attract experienced professionals and emerging qualified graduates, but also its ability to retain well-trained staff and obtain qualified consultants.
- USAID's project design process was described as being so minutely defined that the process provides limited scope for GON and stakeholder inputs during project planning. In fact, several examples were given describing observations of USAID's limited consultation with the GON and others (e.g., other EDPs) regarding development of new policies and project planning. For example, it was reported that there was limited consultation regarding Suaahara or Health for Life.
- USAID's recent increase in support for nutrition is appreciated, but many viewed the current projects (such as KISAN and Suaahara), as having some difficulties, including not being aligned with MSNP, problems with multisectoral collaboration at central level, post-project continuity and other issues. Interviewees observed that there are design flaws in Suaahara, as it is not seen to be doing multisectoral work at the central level. Suaahara was also described as a huge program (working in 41 of Nepal's 75 districts), and functioning in parallel to the GON, although USAID says it is working within the GON nutrition plan and that Suaahara is a project designed to support that plan. As is the case with USAID's modality of assistance, it was noted that USAID did not provide funding to the GON and instead contracted this project to a large consortium led by two INGOs, Save the Children and HKI. It was also noted that USAID maintains close oversight and monitoring of this nutrition program to ensure that the funding is used appropriately—in line with USAID's concern with value for money and viewing nutrition as a good investment. Interviewees also commented that the current focus on nutrition work does not seem to build on the experiences of integrated programs of the 1980s in general and of the United Mission to Nepal in particular.
- Although interviewees did not associate environmental health as an area of major contribution, USAID's support for WASH was recognized and encouraged to continue.
- USAID's assistance to the private sector was associated primarily with its long-term support for CRS.
- Although the review attempted to identify USAID's support for capacity building, this was difficult to assess because there did not appear to be a common understanding of the meaning, approach and implementation modality. One of the important contributions of USAID has been in supporting government staff to deliver a range of health services in family planning, MNCH and HIV through training and mentoring. Outside of the government, it has supported various institutions, such as CRS, FPAN and New ERA, and trained many individual professionals, who are used to provide short-term technical inputs in programs.
- USAID's earlier support for scholarship and fellowships (e.g., for Master's in Public Health in the U.S. or other regional countries) was viewed by many as building capacity and relationships, but it has been discontinued. Several people noted that USAID "paid a price"—i.e., a loss of good relationships and access to governments—related to changes in this policy and practice.

- Donors were described as having focused on developing the GON's capacity for service provision, rather than on stewardship and regulatory capacity. Whether in the form of service delivery or technical assistance enclaves, donor support has not resulted in sustainable development of the health system. It is possible that in some ways donor support has created an increasing dependency.
- Although USAID Forward was a major initiative under the Shah administration, it did not appear to have much visibility in Nepal and was not mentioned by interviewees. In fact, responses to interview guideline questions about USAID indicated limited support for local organizations. In general, USAID was not viewed as supporting local organizations, except for those few mentioned above (New ERA, FPAN, CRS), but rather building capacity of INGOs (e.g., Save the Children, CARE, HKI) and large U.S.-based contracting groups (FHI, JSI, Jhpiego and others).
- During Nepal's armed conflict, USAID and other donors began closer collaboration, which has continued post-conflict. Several interviewees described the early informal meetings (e.g., beginning in 2002), which evolved into the formal EDP Health Forum. USAID and other donors to the health sector still meet twice a month. USAID health officers have served as deputy and chair of the forum.
- Despite U.S. Government regulations, both donors and the GON expressed appreciation for the efforts of USAID's country office to find a way to participate in the aid effectiveness agenda by signing joint agreements, e.g., the Joint Financial Arrangement/SWAp, and participating in other joint mechanisms, such as the Joint Annual Review.
- Although USAID is seen as an active participant in the EDP Forum and other collaborative mechanisms, it is also frequently viewed as doing things in its own way, despite feedback from other donor partners.
- Some GON officials observed that the EDP Forum is not adding value to the GON, because as a group, they are not able to rise above their individual bilateral agreements with the GON.



## 7. MOVING FORWARD

Based on the findings of the review, including interviews and review of documents, the following recommendations are made for moving forward.

- Because of USAID’s strong results orientation and long experience in delivery of technical interventions, its comparative advantage is viewed as technical and managerial assistance in the actual implementation of programs at the level of service delivery rather than national policy. However, some interviews viewed USAID’s project support as also strengthening the health system at district and local levels.
- Many observed that USAID’s consultation with government (and other donors) during planning of projects could be increased. Lack of consultation and engagement with government officials appeared to fuel the perception that “USAID does its own thing.”
- In order to address the critical view of current recruitment and contractual policies and procedures, in addition to its low salary structure compared to other donors, USAID will need to develop a strategy to retain and attract staff and consultants to support its programs.
- A frequent theme during interviews was that EDPs expect the GON to provide detailed information, but that USAID and other EDPs are not forthcoming or transparent with the GON. A more equal exchange of information could help improve the relationship between USAID and the GON.
- USAID should reconsider comprehensive support for logistics to ensure commodity security, building upon its past experience and investment. Sustainability of earlier achievements has been especially challenging, given Nepal’s recent history of armed conflict and ongoing political instability. However, a well-functioning health logistics system is essential for the successful implementation of current and future health interventions and the country’s proposed universal health coverage.
- USAID should consider supporting renovation and construction of the health infrastructure and equipment. The poor infrastructure base has an impact on the quality of services. Support for infrastructure, power supply and equipment should be provided, together with technical and advisory support.
- USAID and other donors have invested in improving access to care; now there is a greater need to support improving the quality of care. While there has been expansion in reach over the years because of the focus on targets, there are consistent concerns about quality.
- Because of the shifting burden of disease, Nepal needs to focus beyond communicable disease to address the merging non-communicable diseases and injuries (e.g., mental health, diabetes, cancer, road traffic accidents) and public health threats from natural disasters and climate change.
- USAID and other donors, jointly with the GON, should undertake a sector-wide capacity assessment of the GON to develop a capacity development plan and mutually implement it. In addition to the current focus on measurable results in specific health outcomes, USAID’s assistance in the health sector should also be judged by its impact in building the organizational and institutional capacity of the GON, NGOs and the private sector.
- As noted above, a major change in Nepal’s health sector is the development of private health facilities and services, which are widely used by the public throughout the country, both in urban

and rural areas. However, there have been very limited efforts to document the comparative use of government (public) and private health services, which are basically unregulated. In addition, there has been a rapid increase in the number of private medical colleges, nursing schools and paramedical training institutions, which also are unregulated. USAID and other EDPs could work with the MOH and Ministry of Education to review this situation and support the development of a system of oversight and regulation, including the quality of education and training.

- Although interviews were positive about USAID's long-term support for FCHVs, it was noted that the increasing use of FCHVs in the delivery of health programs should be balanced with the supervision, support and monitoring needed from GON health workers. USAID and other donors need to follow up on this and other ongoing challenges, documented by the many USAID-supported reviews of the FCHV program, which confirm the need for more regular supply of commodities, supervision and support, and addressing the unresolved issue related to incentives, plus future roles related to MOH's proposal to place trained auxiliary nurse midwives at the community level.
- USAID and other donors should be more committed to addressing the inequalities in health outcomes, including the needs of marginalized and hard-to-reach populations. Unequal health outcomes, embedded in gender and caste relations, remain a major challenge in Nepal. Conducting a political and economic analysis through an equity lens is very important prior to undertaking any technical interventions.
- Resource mapping (following the money and the institutions) would be important as a way to better understand the relationships between different organizations and institutions working in the health sector. At present, it is difficult to map USAID and other donor-funded projects and programs in Nepal. The GON's attempt to map external assistance through the Aid Management Platform is incomplete and does not capture all of the assistance.
- Although USAID has helped to build the technical and managerial capacity of individual professionals to support the health sector, support for institutional capacity has been limited. USAID is encouraged to explore initiatives designed to build more sustainable capacity. Despite USAID Forward, local organizations are often excluded as prime recipients of USAID funding and must work as subcontractors. Direct funding of local organizations would not only help reduce transactional costs, but also would make USAID's assistance more accountable, sustainable and closer to the beneficiaries.
- USAID's long-term partnership with international organizations such as FHI, JSI and Jhpiego has made an important contribution to supporting the health system and service delivery. Many of these organizations have had a long tenure in Nepal, and USAID should now work with them to start transferring more administrative, managerial and technical skills to local partners.
- USAID will need to ensure that its assistance is accountable not just to the U.S. Congress, but also to the GON and the actual beneficiaries. It was also noted that USAID-supported health-related activities need to be more closely aligned with GON strategies, goals and objectives, including for projects noted in interviews, e.g., Suaahara and Health for Life.
- USAID is strongly encouraged to continue its support for research/operational research, piloting projects and other forms of generating evidence, which has made a major contribution to Nepal's health sector, including in policy development, planning and implementation of health interventions. This focus on evidence has helped assert USAID's important contributions.
- In planning future programs, USAID, together with other donors, needs to consider the constitution and its forthcoming federal structure. As warranted by the constitution, the

government is currently in the process of reorganizing functions and structures of the different sectors, including health, for transitioning to a federal form of governance. The current discourse within the government has not yet produced concrete plans on some significant issues, such as the formation of local governance units and setting up fiscal decentralization mechanisms under federalism, which may have important bearing for future USAID investments. USAID and other EDPs will need to keep informed about such changes, as they could greatly affect the way donors and the GON work together in the future.



# ANNEX I. SCOPE OF WORK

## Global Health Program Cycle Improvement Project–GH Pro Contract No. AID-OAA-C-14-00067

### EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

September 30, 2015

Amendment #1

- I. **TITLE:** Nepal: Health Program Review Assistance
- II. **Requester / Client**  
 USAID Country or Regional Mission  
Mission/Division: USAID Nepal/Office of Health and Family Planning
- III. **Funding Account Source(s):** (Click on box(es) to indicate source of payment for this assignment)
- |  |   |
|--|---|
| <input type="checkbox"/> 3.1.1 HIV                         | <input checked="" type="checkbox"/> 3.1.6 MCH       |
| <input type="checkbox"/> 3.1.2 TB                          | <input checked="" type="checkbox"/> 3.1.7 FP/RH     |
| <input type="checkbox"/> 3.1.3 Malaria                     | <input type="checkbox"/> 3.1.8 WSSH                 |
| <input type="checkbox"/> 3.1.4 PIOET                       | <input checked="" type="checkbox"/> 3.1.9 Nutrition |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.2.0 Other (specify):     |
- IV. **Cost Estimate:** GH Pro will provide a final budget based on this SOW
- V. **Performance Period**  
Expected Start Date (on or about): August 3, 2015  
Anticipated End Date (on or about): February 29, 2016
- VI. **Location(s) of Assignment:** (Indicate where work will be performed)  
Kathmandu, Nepal. With possible visits outside Kathmandu to conduct key informant interviews.
- VII. **Type of Analytic Activity** (Check the box to indicate the type of analytic activity)
- EVALUATION:**
- Performance Evaluation** (Check timing of data collection)  
 Midterm  Endline  Other (specify): **Review of USAID/Nepal's contribution to the health sector over the past 25 years.**  
*Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.*
- Impact Evaluation** (Check timing(s) of data collection)  
 Baseline  Midterm  Endline  Other (specify):  
*Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.*

### OTHER ANALYTIC ACTIVITIES:

**Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

**Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

**Other Analytic Activity (Specify):** An analytical review of USAID’s contributions to health outcomes in Nepal over the past 25 years (1990–2015).

**PEPFAR EVALUATIONS** (PEPFAR Evaluation Standards of Practice 2014)

**Note:** If PEPFAR funded, check the box for type of evaluation

**Process Evaluation** (Check timing of data collection)

Midterm  Endline  Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

**Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

**Impact Evaluation** (Check timing(s) of data collection)

Baseline  Midterm  Endline  Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

**Economic Evaluation (PEPFAR)**

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

## VIII. BACKGROUND

Background of project/program/intervention: USAID/Nepal: Health Program Review Assistance

USAID’s more than 60-year history of support to Nepal’s health sector qualifies as one of the most longstanding and successful development assistance programs in Nepal. Despite a 10-year civil insurgency, Nepal has experienced two decades of steady improvement in health outcomes and has emerged as one of the few countries on track to meet the Millennium Development Goals (MDGs) to reduce child mortality and improve maternal health. Nepal is also making steady progress towards several other MDGs, including the eradication of extreme poverty and hunger and combating HIV/AIDS, malaria and other diseases. However, challenges remain, with significant disparities between urban and rural populations’ access to health care. For example, the infant mortality rate in

rural areas is 1.5 times higher than that in urban areas (2011 Nepal DHS). The other major challenges facing the health system are: a stagnant contraceptive prevalence rate (43 percent), low rates of skilled attendants at birth (36 percent), and high stunting rates (41 percent) among children under 5 years (2011 Nepal DHS).

In 2010, the U.S. Government's Global Health Initiative (GHI) officially designated Nepal as a focus country. The GHI compels the U.S. Government to make strategic, evidence-based investments in HIV, family planning/reproductive health, maternal, newborn and child health, nutrition and water supply and sanitation. Through close alignment with the Government of Nepal (GON)'s health strategy, the GHI is building on existing efforts to address the needs of women, girls and other vulnerable groups, promoting research for policy-making and engaging other donors and civil society in health.

Towards the mid-2000s Nepal's health sector also made a strategic shift. The MOHP developed the "Nepal Health Sector Strategy: An Agenda for Reform," and a multiyear "Nepal Health Sector Program—Implementation Plan 2004–2009," to guide the joint planning and programming by government and the EDPs in the health sector. In addition, a "Statement of Intent to Guide the Partnership for Health Sector Development in Nepal" was jointly signed in 2004 by the MOHP and 12 EDPs, including USAID. In 2010, the Nepal Health Sector Program II (2010-2015) was developed, and in the same year a Joint Financing Arrangement was co-signed both by pooling and non-pooling partners, including USAID, to set forth joint provisions and procedures for financial support to NHSP II.

**Program Overview:** USAID, as one of the largest health sector donors, invested approximately more than USD 40 million annually in 2013 and 2014 and remains committed to helping the GON improve the survival and quality of life of all Nepalese through equitable and well-governed health systems. Through a strong and collaborative partnership, activities currently reach more than 14 million men and women of reproductive age and nearly 3 million children under the age of 5 (National Population and Housing Census 2011, Central Bureau of Statistics). USAID activities support the GON's long-term goal of reducing maternal and child mortality, expanding access to health services, and protecting the lives of families and communities in Nepal.

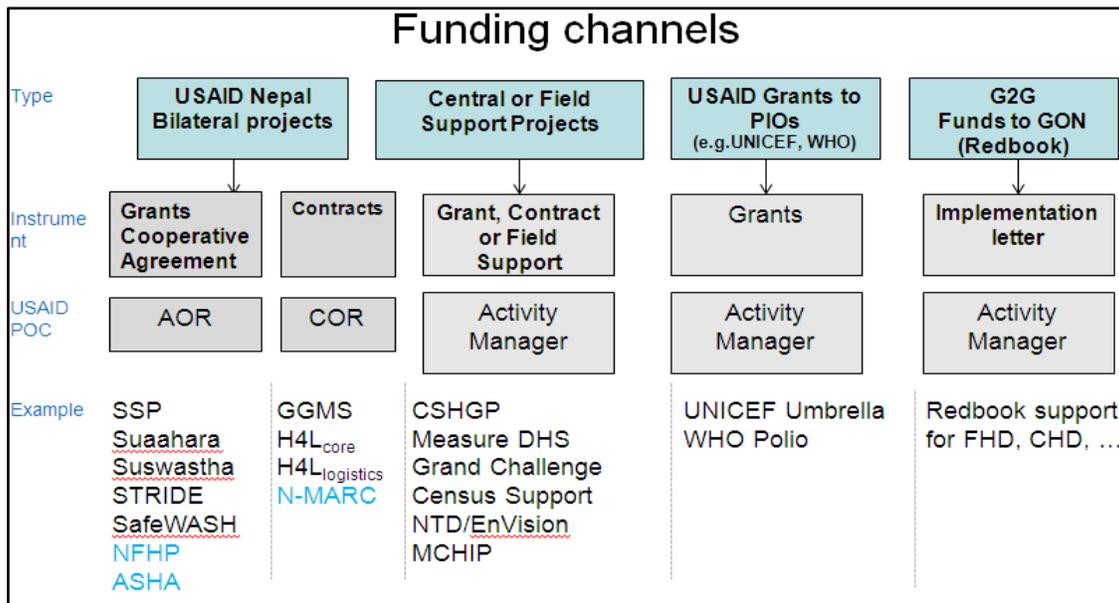
USAID programs support the GON to provide sustainable, accessible and quality basic health services to its citizens, particularly the poor, and strengthen its governance and delivery systems. Assistance to the GON continues to expand proven interventions that reduce maternal, newborn and child mortality to more challenging geographical areas. All programs address crosscutting issues including gender, civil society, local institutional system strengthening, trafficking in persons and youth. The programs also contribute to areas recognized in the GON's health plan, such as disability, water and sanitation, and disaster preparedness. The key technical components of USAID/Nepal's health program are described in the following list:

- **Family planning/reproductive health:** expanding access to and the use of quality, voluntary family planning services.
- **Maternal, newborn and child health:** reducing maternal, infant, and child mortality by increasing access to quality, high-impact MCH services.
- **Nutrition:** supporting new and integrated efforts to promote nutrition, clean water, sanitation and hygiene nationally, with a special focus on improving access to and consumption of diverse, vitamin-rich foods.
- **HIV:** preventing the spread of HIV and treating other sexually transmitted infections among most-at-risk groups and migrants.
- **Social marketing and private sector development:** increasing consumer awareness,

- demand, reach and access of quality health products and supporting access to those products.
- **Environmental health, infectious diseases and other public health threats:** improving access to clean water and sanitation and supporting the GON’s National Action Plan for preparedness and response to avian and pandemic influenza.
- **Health system strengthening:** supporting the GON, private sector and civil society to plan, implement and evaluate public health programs and improve logistical management system of drugs and commodities.

USAID funds activities to support these areas through various approaches. Figure I illustrates the major types of funding mechanisms and some examples. The various funding mechanisms include bilateral projects with international and national agencies (referred to as “bilateral projects”); field support to centrally funded programs including contribution to public international organizations (referred to as “field support” hereafter); government-to-government (G2G) assistance to the MOHP (referred to as “Red Book contribution”); and contributions or cost-sharing in conjunction with centrally funded projects (referred to as “centrally funded projects,” such as Food for Peace).

**Figure I: Funding channels and examples of project/activity in USAID/Nepal**



Describe the theory of change of the project/program/intervention.

USAID’s more than 60-year history of support to Nepal’s health sector qualifies as one of the most longstanding and successful development assistance programs in Nepal. USAID is Nepal’s largest health sector donors and is committed to helping the GON improve the survival and quality of life of all Nepalese through equitable and well-governed health systems. USAID activities support the GON’s long-term goal of reducing maternal and child mortality, expanding access to health services and protecting the lives of families and communities in Nepal.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

All USAID-funded health activities throughout Nepal over the past 25 years. These programs have had a wide range of beneficiaries

## **IX. SCOPE OF WORK**

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

This review will provide an overview of USAID/Nepal's investments and its approach to providing technical assistance to the MOHP over the past 25 years. It will do this by tracing evolving strategies and changes in USAID investments in the health sector over time. In addition, it will also highlight important technical contributions, interventions and innovations, and explore why a given intervention was selected and how USAID's strategies, leadership, production of evidence, partnership with the MOHP in Nepal has positively influenced changes in Nepal's health policies and programs over time.

This review will also examine USAID's contributions in the context of a larger donor effort to improve health outcomes and health services and systems in Nepal. Thereby, the review will provide a more analytical overview of the USAID/Nepal partnership with the MOHP over the past 25 years to introduce, scale up and sustain key technical interventions and innovations, improve the quality of services and expand access to health services. It will explore USAID/Nepal's role in the donor community to strengthen aid effectiveness and improve health systems, to ultimately influence changes in MOHP national strategies and policies, scale up and sustain interventions and innovations, and change health outcomes and health systems. Although the review is not designed to establish causal links of USAID's efforts to health outcomes, the review will explore the concept of 'plausibility criteria'; the idea that key technical and programmatic investments implemented through USAID/Nepal's programs and policy over the last 25 years and the large target population reached through these programs, contributed significantly to influencing positive change in the Nepal health sector.<sup>150</sup> To explore this concept and provide a context in which to understand USAID's contributions, the report will acknowledge the major financial, technical and programmatic contributions of other major donors such as the MOHP and other EDPs.

Unlike past reviews of USAID's assistance program in Nepal, the proposed review's focus on the health sector will provide a useful health resource for USAID/Nepal, Nepal's MOHP and greater donor community to identify which approaches to providing technical assistance have been most critical to achieving better health outcomes and strengthening the health system in Nepal. For USAID and USAID/Nepal, the review will offer a better understanding of how the organization's approach has evolved and matured over time. In addition, the critical analysis of USAID/Nepal's decisions over the past 25 years, conducted through this review, will also provide the mission with insights into how USAID can contribute to the health program in Nepal in the future.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID/Nepal and Nepal's MOHP, as well as the greater donor community working in Nepal

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<sup>150</sup> *Success Factors in Women's and Children's Health: Mapping Pathways to Progress Nepal: Working Draft for Review*, June 2014.

- C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

This review will inform USAID/Nepal, the Nepal MOHP and the donor community about what approaches to providing technical assistance have been most critical to achieving better health outcomes and strengthening the health system in Nepal.

For USAID/Nepal, information will also be provided on how USAID's approach has evolved and matured over time. The review will also provide a set of considerations for how USAID can contribute to health outcomes in Nepal in the future as part of the larger donor community.

- D. **Evaluation questions:** Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

#### Evaluation Question

1. What have been the main financial investments that USAID and other key donors have made to the health sector in Nepal over time?

The purpose of this question is to provide an overview of the amount of financial support USAID has provided to the health sector in Nepal over the past 25 years. As sectors other than health contribute to health indirectly, it will be important to obtain information about (1) overall donor support to Nepal and (2) to the health sector specifically. If possible, disaggregate funds provided by USAID/Nepal for the health sector by funding categories (MNCH, family planning, nutrition, etc.)

As noted in the background section, USAID provides funding to the health sector using a variety of 'channels.' Part of this analysis will be to determine how much funding by major type has been provided to the health sector by USAID/Nepal over time. It will be useful to present the data in such a way that the reader can easily grasp the trend of USAID funding to the health sector over the past 25 years through the various channels.

It will be important to obtain data relating to the overall funding other major donors have provided to the health sector over time (World Bank, DFID, Australia, Global Fund for AIDS, TB and Malaria, etc.) and compare those to the contributions of USAID.

Data sources to address this question include the Ministry of Finance, Foreign AID Coordination Division as well as other sources. Information about USAID/Nepal's funding to the health sector (to support activities, etc.) may be obtained through USAID/Nepal's Program Office and through searching for activity-related documents on USAID's Development Experience Clearinghouse (DEC).

2. What have been the main accomplishments in health outcomes in Nepal over the past 25 years?

Summarize the main trends over time of major health outcomes, including but not limited to the following: maternal mortality ratio, total fertility rate (TFR), adolescent fertility rate (15-19 years old), contraceptive prevalence rate (CPR), neonatal mortality rate, post-neonatal mortality rate, infant mortality rate, under-5 mortality rate, percent underweight children, percent stunting, TB case detection and success rate, malaria annual parasite incidence per 1,000, immunization coverage (percent) 12-23 months, percent of children 6-59 months who received vitamin A capsule within the past 6 months, HIV incidence.

Using maps, tables and other means to display the trends over time, present the data that clearly show the trends over time. Using maps, present the overall trends in the country as a

whole and by development regions (such as Mountain, Terai, etc.) and/or those presented in the DHS reports (regions and subregions).

Data sources to address this question include, but are not limited to, the Nepal Family Health and Demographic and Health Surveys (1991, 1996, 2001, 2006 and 2011).

3. What have been the key technical interventions and innovations USAID has introduced, and what are the related health outcomes in Nepal?

The purpose of this question is to provide an overview of each of USAID’s technical components and provide an opportunity to highlight the key technical interventions and innovations that USAID has introduced over the past 25 years that have been most significant to improve health outcomes. (Note: Some work on the identified key interventions/innovations started prior to 1990. If important to ‘tell the story’ of USAID’s more recent history in Nepal, these can be address in the review.)

Technical Component	Key Interventions/Innovations to be Highlighted
Crosscutting: Female Community Health Volunteers	<ul style="list-style-type: none"> <li>• Female Community Health Volunteers to introduce and scale-up community-based interventions (family planning, MNCH, nutrition, etc.)</li> </ul>
Crosscutting: Health Systems Strengthening	<ul style="list-style-type: none"> <li>• Health system strengthening, focusing on the following key interventions/innovations: (1) logistics management including LMIS, (2) Health Facility Operations Management Committees (HFOMC), and (3) evidence-based policy development</li> </ul>
Crosscutting: Gender, Equality, and Social Inclusion (GESI) Family Planning	<ul style="list-style-type: none"> <li>• Reaching marginalized populations with Family Planning and MCH services</li> <li>• Valued Behavior for Healthy Families—A Model for Social Inclusion</li> <li>• Community-based distribution of family planning</li> <li>• Postpartum family planning</li> <li>• Provision of Depo-Provera by VHWs/MCHWs</li> <li>• Support to Chhetrapati Family Welfare Center</li> </ul>
Maternal, Newborn and Child Health	<ul style="list-style-type: none"> <li>• Misoprostol to prevent postpartum hemorrhage</li> <li>• Chlorhexidine to prevent sepsis in newborns</li> <li>• CB-IMCI</li> <li>• CB-NCP</li> <li>• Kangaroo Mother Care</li> <li>• Morang Innovative Neonatal Intervention (MINI) program</li> <li>• Pregnant women’s group</li> </ul>
Nutrition	<ul style="list-style-type: none"> <li>• Vitamin A</li> <li>• Scaling up of nutrition-focused programs (multisectoral nutrition plan roll-out, community-based integrated nutrition activities, and revision of IMCI package to include more emphasis on nutrition)</li> </ul>
HIV	<ul style="list-style-type: none"> <li>• Reaching marginalized and vulnerable populations</li> </ul>
Social Marketing	<ul style="list-style-type: none"> <li>• Contraceptive Retail Store</li> </ul>
Environmental health	<ul style="list-style-type: none"> <li>• Integration of water and sanitation into health</li> </ul>

4. In what ways has USAID contributed to the MOHP’s capacity to use of data and evidence to inform the formation of new strategies and policies, the adoption and scale-up of technical interventions and innovations, and the strengthening of the health system?

In this section, highlight key ways in which USAID has built the capacity of the MOHP to use data and evidence to inform the initiation of strategies, policies, guidelines, etc. designed to scale up and increase coverage of interventions and innovations to improve health outcomes

and strengthen the health system. (Note: make reference to what was covered in the previous questions/sections above; do not repeat what was already addressed).

Describe how and to what extent USAID has built the capacity of district-level and VDC-level health managers and for what purpose(s). Describe the support USAID has provided to support the development of new entities and built local capacity to generate data for the Nepal health sector program, in particular New ERA to implement surveys such as the Nepal DHS.

See Annex I for a preliminary table showing the various surveys and studies conducted in Nepal over time, including the name of the study, year implemented, relevant national strategy or policy initiated, year strategy or policy initiated and relevant national program initiated and/or scaled up.

It will be important to complete the table (with USAID/Nepal assistance, confirming the extent to which USAID supported the surveys and studies listed). Explore how USAID influenced the development and implementation of key MOHP strategies, policies, and guidance over time. Identify lessons learned for USAID in understanding how best to provide technical assistance to build the capacity to use data and evidence for health program design and management.

5. In what ways has USAID's approach to providing technical assistance to the MOHP evolved over time and what approaches have been most effective?

This question addresses the evolution and maturation of how USAID has delivered technical assistance and partnered with the MOHP over time to deliver and expand access to quality health services, build capacity and strengthen health services.

Discuss in what ways, the type and approach to delivering technical assistance to the MOHP has evolved over the past 25 years. Explore and discuss what approaches have been most effective. In this question, address Gender, Equality, and Social Inclusion (GESI) and ways that USAID has influenced the GON and MOHP to consider focusing more on marginalized populations.

#### Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

6. What are the key ways in which USAID has provided leadership among the donors to support aid effectiveness Nepal's health program?

Based on the review of key documents relating to the donor community in Nepal and based on interviews with key stakeholders in the donor community, representatives from USAID, MOHP, World Bank, DFID, and other external development partners and donors, summarize the findings and conclusions relating to this question.

7. Moving forward, what might be the main ways that USAID should continue to contribute to health outcomes and strengthen health systems and services in Nepal?

Based on the review of program and other relevant documents that have been published in more recent years and on interviews with stakeholders, in particular USAID, MOHP and other donors, summarize the findings and conclusions relating to this question and put forth a set of recommendations for USAID to consider.

8. Moving forward, what are the key ways that USAID could contribute to aid effectiveness among the donor community in Nepal?

Based on the review of program and other relevant documents that have been published in more recent years and on interviews with stakeholders, in particular representatives from USAID, MOHP, World Bank, DFID, and other external development partners and donors, summarize the

findings and conclusions relating to this question and put forth a set of recommendations for USAID to consider.

- E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

■ **Document Review** *(list of documents recommended for review)*

USAID/Nepal will provide the team with documents for review. Once a document is reviewed, it must be indexed, and a summary form must be completed. The summary form will record what area of health the document focused on, the type of intervention described, key results, and, important successes and obstacles. Documents include:

- USAID/Nepal health sector documents from the past 25 years, such as:  
Health-related mission Country Development and Cooperation Strategy and strategic plans; health-related project reports (e.g., Request for Proposals/Applications [RFP/As], funded proposals, annual reports, closeout reports, studies and project evaluations); health sector assessment; other health-related USAID documents from the past 25 years.
- Nepal health sector documents from the past 25 years, such as:  
National Health Surveys (DHS data, Multiple Indicator Cluster Surveys (MICS)) ; Nepal Ministry of Health and Population (MOHP) implementation and strategic plans; MDG reports; Strategic plans and health status reports from UNICEF, WHO, UNFPA, World Bank, Global Fund and other donor agencies/foundations; Any other evaluation, research and other health sector reports.

■ **Secondary analysis of existing data** *(list the data source and recommended analyses)*

Data Source ( <i>existing dataset</i> )	Description of data	Recommended analysis
Nepal DHS (2011, 2006, 2001, 1996, 1987)	DHS data are available through DHS Statcompiler ( <a href="http://dhsprogram.com/data/STATcompiler.cfm">http://dhsprogram.com/data/STATcompiler.cfm</a> )	Trend analyses over time
Nepal MCH SPA (2015)	MCH Service Provision Assessment ( <a href="http://dhsprogram.com/what-we-do/survey/survey-display-400.cfm">http://dhsprogram.com/what-we-do/survey/survey-display-400.cfm</a> )	Data are not yet available, but the team should check when preliminary findings are available.
Nepal MICS (2014, 2010, 1995–1997)	From UNICEF, Multiple Indicator Cluster Survey with indicators on education, child protection, health, nutrition, water, sanitation and hygiene (WASH), etc.	Data available ( <a href="http://mics.unicef.org/surveys">http://mics.unicef.org/surveys</a> )

MOHP Survey Data

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

The team will conduct semi-structured interviews and in-depth interviews with individuals who now or previously have worked in the Nepal health sector under the MOHP, USAID, USAID implementing partners (IP), other donors and/or their IPs. As much as possible, the team will track down people with historical memory for 25 years ago through current time. Interviews will be conducted by phone or in person, depending on the location and availability of the respondent. A question guide will be developed in order to obtain information critical to answering the review questions.

□ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

- Group Interviews** (list categories of groups, and purpose of inquiry)
- Client/Participant Satisfaction or Exit Interviews** (list who is to be interviewed, and purpose of inquiry)
- Facility or Service Assessment/Survey** (list type of facility or service of interest, and purpose of inquiry)
- Verbal Autopsy** (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)
- Survey** (describe content of the survey and target responders, and purpose of inquiry)
- Observations** (list types of sites or activities to be observed, and purpose of inquiry)
- Data Abstraction** (list and describe files or documents that contain information of interest, and purpose of inquiry)
- Case Study** (describe the case, and issue of interest to be explored)
- Rapid Appraisal Methods** (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)
- Other** (list and describe other methods recommended for this evaluation, and purpose of inquiry)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

- Yes  No

List or describe case and counterfactual”

Case	Counterfactual
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## **X. ANALYTIC PLAN**

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data are to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the assessment questions. Additionally, the assessment will review both qualitative and quantitative data available through project reports and surveys over the past 25 years.

If secondary analyses of existing survey and HIS are warranted, quantitative data will be analyzed, primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the assessment questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what has happened over the past 25 years, and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project performance indicator, DHS, MICS and MOHP data) will allow the team to triangulate findings to produce more robust evaluation results, where feasible.

The assessment team shall explicitly identify and communicate any methodological strengths and limitations, such as potential for bias, language constraints, etc. Furthermore, evidence supporting a finding will be cited in the report (e.g., 'MOHP official stated....', 'Several project reports.....', 'DHS data found...' etc.).

## **XI. ACTIVITIES**

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

### **Month I:**

- **Team planning meeting:** Organize and facilitate a team planning meeting with local staff (estimated two days, within two weeks of the award) before starting the assignment. USAID/Nepal's POC will participate in the team planning activities, and other USAID HFP staff and MOHP staff may be invited as appropriate. The team planning meeting will cover the following:
  - Clarify team members' roles and responsibilities, in particular how the work will be organized and divided, such as who will be responsible for drafting various sections of the final report and who will be responsible for compiling and analyzing data and creating maps, figures, tables, etc. (Note: further refinement of responsibilities will be made under the leadership of the team leader during the first month of the assignment as the literature is reviewed and strategies are made to address each question/task in the SOW).
  - Discussion among team members the following issues and creation of a strategy to address them: working styles, potential conflict of interest and plans for dispute resolution;
  - Clarify roles and responsibilities among the team members relating to administration and logistics, and clarify with USAID/Nepal what support may be realistically expected and provided;
  - Draft a work plan, assignment timeline and travel schedule (a final version to be submitted by the end of Week 4—see elements below);
- **Desk Review:** Review of USAID's and MOHP program documents, including strategies, program planning documents and implementation plans, project/activity briefs, project/activity completion reports, project/activity M&E plans, evaluation reports, etc.
- **Finalize Work plan:** Develop work plan for this SOW (to be approved by USAID/Nepal's health office prior to implementing) including:
  - Timeline;

- Plan (including ‘scripts’) for engaging stakeholders and introducing the review prior to conducting interviews;
- Develop (with assistance from USAID/Nepal) lists of persons to interview;
- Develop data collection instruments for interviews and approach to be used to analyze the qualitative data from the interviews;
- Plan for data compilation and/or further analysis that will be done to address each question in the SOW. Include the specific data source(s) (specific survey(s), information system, published reports) that will be used and the specific outputs of the analysis (chart, figure, framework, map, etc.) to be created;
- Develop a draft outline of the final report showing chapter headings and subheadings and a brief description of what will be covered under each heading and subheading and what visuals will be presented under each.

### **Month 2-3:**

- Continue to review relevant documents and materials.
- Hold an in-country planning meeting: The team will convene in Katmandu for a three-day planning meeting. At this meeting, the team will finalize the implementation plan and divvy up the workload. The team will also prepare for the USAID in-briefing.
- Conduct an in-briefing with USAID: The GH Pro team will meet with the USAID/Nepal team that is supporting this review. The in-briefing meeting will review the SOW and expectations, and further review the review implementation plan. They will also discuss communications between the team and USAID/Nepal and points of contact, as needed.
- Key informant interviews:
  1. Conduct interviews with USAID/Nepal’s Health Office staff (current and past).
  2. Conduct interviews with USAID/Nepal’s activity implementing partner staff (from both current and past health activities), in particular with those who are most familiar with the evolution of USAID’s health program over the past 25 years (or portions of the past 25 years).
  3. Conduct interviews with national-level MOHP staff (current and past employees) and other GON officials, as appropriate.
  4. Conduct interviews with other donors contributing to the health sector in Nepal.
  5. Conduct interviews with those who have worked with the Nepal health program at various levels, including the following:
    - MOHP staff at the district and Village Development Committee (VDC) levels (including those responsible for overseeing logistics)
    - Staff (current and past) involved with entities created by USAID efforts (such as New ERA staff (data) and staff of CRS (Contraceptive Retail Sales)),
    - Community-based health workers, HFOMC members, FCHVs, etc.
- Compile and analyze existing data, and where appropriate conduct further analysis, to address the questions in the SOW.
- Create, as appropriate, visuals (maps, charts, tables, figures, etc.) showing such things as financial inputs, programmatic coverage areas, results, etc., over time, by donor, etc., as appropriate and necessary to convey the larger story of USAID’s contributions to health outcomes in Nepal.
- Create a very detailed outline of the final report with placeholders or drafts of the visuals by the end of Month 4 (to be reviewed and approved by USAID/Nepal before fully drafting final report).

### **Month 5:**

- Draft full analytical review document and submit to USAID.

- The assessment team, under the leadership of the team leader, will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:
  - 1) Team leader will submit draft assessment report to GH Pro for review and formatting.
  - 2) GH Pro will submit the draft report to USAID.
  - 3) USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro.
  - 4) GH Pro will share USAID’s comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.
  - 5) GH Pro will review and reformat the Final Report, as needed, and resubmit to USAID for approval.
- If necessary, conduct further interviews/consultations and analyses requested by USAID/Nepal.
- Prepare presentations for USAID and other stakeholders.

**Month 6:**

- In collaboration with USAID/Nepal, share findings at the national level through the dissemination event.
- Finalize and submit report to GH Pro, which will format and submit to USAID.
- Once the Final Report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC
- Send printed hard copies to USAID/Nepal.

Note: This schedule is tentative, and the contractor may propose revisions in the plan to complete the work with justification. The assignment is expected to be completed within six months of start of work. The contractor must provide periodic updates, at least on a bi-monthly basis, with a brief one-pager or PowerPoint Presentation to USAID.

**XII. DELIVERABLES AND PRODUCTS**

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines
<input checked="" type="checkbox"/> Launch briefing	On/about August 3, 2015
<input checked="" type="checkbox"/> Work plan with timeline	August 28, 2015
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	August 28, 2015
<input checked="" type="checkbox"/> In-briefing with mission	August 18, 2015
<input type="checkbox"/> In-briefing with target project/program	
<input checked="" type="checkbox"/> Routine briefings	Weekly
<input type="checkbox"/> Out-briefing with mission or organizing business unit, with PowerPoint presentation	
<input checked="" type="checkbox"/> Draft Executive Summary	November 20, 2015
<input checked="" type="checkbox"/> Draft report	November 20, 2015
<input checked="" type="checkbox"/> Final report and Executive Summary	January 11, 2016
<input checked="" type="checkbox"/> Raw data and 20-25 PowerPoint slide presentation with the review’s findings	January 11, 2016
<input checked="" type="checkbox"/> Dissemination activity with MOHP and donor community	week of January 17, 2016
<input type="checkbox"/> Other (specify):	

### **Estimated USAID review time**

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

### **XIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)**

**Assessment team:** When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team leader experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team Qualifications:** Please list technical areas of expertise required for this activities  
Health System strengthening; Nepal health system; USAID and other bilateral donors.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

#### **Team Leader:**

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team and (5) leading briefings and presentations.

#### Qualifications:

- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in Nepal
- Familiarity with USAID and its health projects

#### **Key Staff 2**

Title: Senior Research Consultants

Roles & Responsibilities: The senior research consultant will:

- Assist in identifying and gathering background documents
- Identify and contact key informants

- Work with team leader to conduct desk review and key informant Interviews.
- Assist with logistics and translations as needed.
- Qualifications: The senior research consultant must have at least 10 or more years' public health work experience. He or she must have a holistic understanding of Nepal's health system as well as experience working with USAID. Preferred candidates will be fluent in both Nepali and English and have strong writing skills. Experience working with the MOHP and other donors is highly desirable.
- Number of consultants with this expertise needed: Three.

### **Key Staff 3**

Title: Health Economist

Roles & Responsibilities: Number of consultants with this expertise needed: One.

### **Key Staff 4**

Title: Statistician

Roles & Responsibilities: Number of consultants with this expertise needed: One.

### **Key Staff 5**

Title: Logistics Management Specialist

Roles & Responsibilities: Number of consultants with this expertise needed: One.

Note: In order to facilitate document retrieval from USAID/Nepal archives, at least one of the three senior research consultants must be a retired Nepalese HFP Foreign Service National.

Other Staff: Titles with Roles & Responsibilities (include number of individuals needed):

A **Logistics /Administrative Coordinator** will support the Nepal Health Program Review team in all aspects of their work for carrying out this assignment. This includes making provision for workspace, copying, internet, local transport and meeting rooms needed for the teams' internal consultations. The administrative coordinator will have a good command of written and verbal English. S/He will have knowledge of key actors in the health sector and their locations, including GON, donors and other stakeholders including the private sector partners. S/he will be able to efficiently liaise with hotel staff, arrange car rentals (using approved mission or hotel cars) and ensure cell phones, business center support (e.g. copying, internet and meeting space) is available for the team. S/he will work under the guidance of the team leader to make preparations, arrange meetings including round table meetings, and the dissemination event. S/he will conduct administrative and support tasks as assigned and ensure the process moves forward smoothly. S/he will be attentive to team requirements and anticipate needs for computers, AV equipment or other last-minute requests as required. S/he will also assist the team and the research consultants as needed. S/He will report to the team leader and liaise directly with GH Pro as required to satisfactorily complete assignments for support to the team. (1 consultant)

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

- Yes – If yes, specify who:  
 No

### **Staffing Level of Effort (LOE) Matrix (Optional):**

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'subtotal' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of effort in **days** for each evaluation/analytic team member

Activity / Deliverable	GH Pro Health Program Review Team							
	Team Leader (Int'l)	Senior Researcher (2)	Senior Advisor (1)	Senior Research (1)	Statistician (1)	Health Economist (1)	Logistics Management Specialist (1)	Logistics Coordinator (1)
Number of persons →	1	5						
1 Launch	1	0.5						
2 Background document review for project start up	2	2						
3 Logistics coordination/planning								
4 International travel	2							
5 Team planning meeting	3	3						
6 In-briefing with USAID	1	1						
7 Initial in-person key informant interviews	5	5						
8 Desk review: initial phase	5	5						
9 International travel	2							
10 Desk review	20							
11 Key informant interviews (virtual and in person)	10	10						
12 International travel	2							
13 Analysis team meeting	5	3						
14 Preliminary findings presented to USAID/Nepal	3	3						
15 International travel	3							
16 Virtual team meeting and project monitoring (throughout review process)	5	5						
17 Weekly USAID updates	1							
18 Draft report and executive summary	10	1.5						
19 Final report and executive summary	5	3						
<b>Subtotal LOE</b>	<b>85</b>	<b>60</b>	<b>25</b>	<b>20</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>45</b>
<b>Total LOE</b>	<b>85</b>	<b>60</b>	<b>35</b>	<b>20</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>45</b>

If overseas, is a 6-day workweek permitted  Yes  No **Travel anticipated:** List international and local travel anticipated by what team members.

International travel to Nepal for the team leader and one senior research consultant. Possible local travel to within Nepal to conduct key informant interviews.

#### XIV. LOGISTICS

**Note:** Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access:

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace

Specify who will require workspace at GH Pro:

Travel -other than posting (specify):

Other (specify):

#### XV. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production—If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

#### XVI. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

##### USAID Roles and Responsibilities

**USAID** will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

##### Before Field Work

- SOW:
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant conflict of interest (COI): To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- **Documents:** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Local consultants:** Assist with identification of potential local consultants, including contact information.
- **Site visit preparations:** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items' costs.
- **Lodgings and travel:** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

#### **During Field Work**

- **Mission point of contact:** Throughout the in-country work, ensure constant availability of the point of contact person, and provide technical leadership and direction for the team's work.
- **Meeting space:** Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting arrangements:** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate contact with implementing partners:** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

#### **After Field Work**

- **Timely reviews:** Provide timely review of draft/final reports and approval of deliverables.

## **XVII. ANALYTIC REPORT**

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

For each technical component, provide a brief narrative overview/summary of the main strategies USAID used (and highlight where and when they evolved over time) and USAID main health activities (mechanisms (contracts or agreements)) and interventions to address identified needs and gaps.

Provide a table summarizing the USAID activities initiated during each strategy period, and indicate the years that each major activity was active.

For each key intervention/innovation listed above beside each of the technical components of USAID's health program, present the following:

- USAID's strategy and objectives as relevant to the intervention's program area and intervention/innovation
- Description of intervention/innovation, including how it works
- Maps (may be supplemented with tables, graphs or figures) showing baseline (1) relevant health status and (2) coverage areas
- Description of why intervention/innovation was selected, how intervention/innovation was introduced, including the USAID activity under which the intervention/innovation was introduced, and what cadre of health workers are involved
- Description of how the intervention/innovation was tested to demonstrate effectiveness and provide evidence to support scale-up into Nepal's health program. Cite the studies and other evidence to demonstrate effectiveness of the intervention/innovation, citing the studies (name, implementers, dates, results, etc.).
- Description of how USAID worked with the MOHP/GON and what other donors and/or INGOs were involved in the introduction, testing, scale-up and/or implementation
- Description of effect/result on related national health strategies, policies, guidelines, etc. Provide the name of the health strategy, policy, relevant guidelines and briefly describe what would be implemented on a national scale.
- Describe to what extent the intervention/innovation has been implemented and incorporated into the MOHP's program. Provide a brief description of its current status.
- Maps (may be supplemented with tables, graphs or figures) showing evolution of status of (1)

relevant health outcome(s) and (2) status of coverage and scale-up over time since introduction of intervention/innovation

Annex I provides a summary of some of the main studies and surveys USAID (and others) conducted to inform Nepal’s health program. It will also be important to review the final reports and evaluations of the activities implemented by USAID. USAID/Nepal strategies and activity reports by be found on USAID’s electronic Development Experience Clearinghouse (DEC).

It will be important to include a table(s) summarizing the above findings, demonstrating the relation of USAID’s efforts and activities to adoption/scale-up/policies of the MOHP program.

**The following deliverables are attached to this assignment:**

1. An executive summary of the draft report, limited to 8 pages, targeted to policy makers.
2. A draft report not exceeding 100 pages (with additional info in the annexes)
3. A final PowerPoint Presentation of 20-25 slides for final dissemination in MS PowerPoint version
4. A final dissemination event to be organized targeting key stakeholders (tentatively for half day with about 100 participants)
5. A final report (1 unbound and 10 bound copies, multicolor) not exceeding 100 pages of main body, with additional executive summary targeted to policy makers and with additional annexes, to USAID Nepal no later than 10 calendar days prior to the end of the contract for final review and feedback by USAID Nepal. The final report should be submitted in final hard copy and electronic media (CD ROM or thumb-drive) in MS Word/Excel/PowerPoint format no later than five days prior to the end of the contract for final review and feedback.

GH Pro will edit the final report to ensure the content is clear and grammatically correct. The report should feature simple maps, charts, tables and figures that clearly convey and summarize major points. All figures should be designed so that they can be readily interpreted if printed in black and white. A final version of the report must be submitted to USAID/Nepal in hard copy as well as electronically and should abide by USAID’s branding and marking guideline, available online at <http://www.usaid.gov/branding>. The report format must be restricted to Microsoft products (MS Word, MS Excel, MS PowerPoint), and 12-point standard type font should be used throughout the body of the report, with page margins 1” top/bottom and left/right. The main body of the report should not exceed 100 pages, excluding references and annexes.

USAID/Nepal may format the final report to adjust with organizational standards for printed materials. The report will be printed and distributed by USAID to GON, other donors, partners, academic and relevant individuals/stakeholders. The report will also be publicly available for download from USAID/Nepal’s website.

**XVIII. USAID CONTACTS**

	<b>Primary Contact</b>	<b>Alternate Contact</b>
Name:	Sabita Tuladhar	Daniel Verschneider
Title:	Maternal and Newborn Child Health Specialist	Health Development Officer
USAID Office/Mission	USAID/Nepal	USAID/Nepal
Email:	stuladhar@usaid.gov	dverschneider@usaid.gov
Telephone:		
Cell Phone (optional)		

List other contacts [OPTIONAL]

**XIX. REFERENCE MATERIALS**

Documents and materials needed and/or useful for consultant assignment, that are not listed above

The following documents and resources will be useful to consult for this assignment; however, many more documents and resources are relevant and will be important to access and review. Additional documents will be identified by USAID/Nepal, the team itself hired to conduct this assignment and possibly stakeholders who have been involved with the health program in Nepal over the past 25 years.

### **Past Reviews of USAID/Nepal Assistance**

- 1) *Half-a-Century of Development. The History of U.S. Assistance to Nepal. 1951–2001.* [http://pdf.usaid.gov/pdf\\_docs/PNACP500.pdf](http://pdf.usaid.gov/pdf_docs/PNACP500.pdf) This document includes an overview of USAID's health program, including the years 1990-2001.
- 2) *50 Years of Success: 1947–1997. Diplomatic Relations between the Kingdom of Nepal and the United States of America.* Published by U.S. Information Service, Kathmandu.
- 3) *A Quarter Century of American Assistance to the Development of Nepal.* U.S. Information Service, 1976.

### **Recent Papers on the Success of the Nepal Health Program**

- 1) *Success Factors in Women's and Children's Health: Mapping Pathways to Progress Nepal.* Working Draft for Review. June 2014. Partnership for Maternal, Newborn and Child Health (PMNCH), WHO. [http://www.who.int/pmnch/knowledge/publications/nepal\\_country\\_report.pdf](http://www.who.int/pmnch/knowledge/publications/nepal_country_report.pdf). This document will be important to review, as it presents key factors that have contributed to health outcomes in Nepal; however, the role of USAID and other donors is not highlighted.
- 2) *Success Factors for Women's and Children's Health: Policy and Programme Highlights from 10 Fast-Track Countries.* 2014. Partnership for Maternal, Newborn and Child Health (PMNCH), WHO, World Bank and AHPSPR. Includes an overview of Nepal's health situation, health program and future areas to strengthen the health program. [http://www.who.int/pmnch/knowledge/publications/success\\_factors\\_highlights.pdf?ua=1](http://www.who.int/pmnch/knowledge/publications/success_factors_highlights.pdf?ua=1)
- 3) *Accelerating Progress on Women's and Children's Health.* Editorial. Carole Presern, Flavia Bustreo, Tim Evansc and Abdul Ghaffard. Bulletin World Health Organization. 2014; 92:467–467A | doi: <http://dx.doi.org/10.2471/BLT.14.142398> Related website: [http://www.who.int/pmnch/media/news/2014/success\\_factors/en/](http://www.who.int/pmnch/media/news/2014/success_factors/en/)

### **Recent Review of USAID's Health Program**

50 Years of Global Health: Saving Lives and Building Futures. Tonya Himelfarb. 2013. USAID/Washington.

[http://www.usaid.gov/sites/default/files/documents/1864/USAID\\_50-Years-of-Global-Health.pdf](http://www.usaid.gov/sites/default/files/documents/1864/USAID_50-Years-of-Global-Health.pdf)

### **Select USAID Websites**

- 1) USAID Nepal external web page: <http://www.usaid.gov/nepal>
- 2) USAID's Development Experience Clearinghouse (DEC): <https://dec.usaid.gov/dec/home/Default.aspx> (Search using ("Nepal" and "Health") as keywords)
- 3) Nepal page for the GHI Strategy: <http://www.ghi.gov/country/nepal/>
- 4) Users Guide to USAID/Washington Health Programs: <http://www.usaid.gov/sites/default/files/documents/1864/UG2013.pdf> Contains information relating to field support and centrally funded projects (e.g. MEASURE DHS, MEASURE Evaluation, MEASURE Census Bureau, Maternal and Child Health Integrated Project, Central Contraceptive Procurement)

### **USAID/Nepal's Current Program**

- 1) Country Development and Cooperation Strategy
- 2) USAID/Nepal Performance Management Plan (PMP) <https://dec.usaid.gov/dec/content/Detail.aspx?ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjk tZTcxMjM2NDBmY2Uy&rID=MzUxMTcw>

### **USAID/Nepal's Activity Websites**

- 1) Saath-Saath Project: <http://www.fhi360.org/countries/nepal>
- 2) Suaahara Project: <http://www.k4health.org/toolkits/suaahara-nutrition-project>
- 3) Health for Life Project: <http://www.rti.org/page.cfm?obj=81B02282-444D-4437-82884CB0D7A7AA9D>
- 4) Ghar Ghar Ma Swastha Project: <http://pshi.fhi360.org/whatwedo/projects/ggms.html>
- 5) Su-Swastha: <http://www.enpho.org/29-programs/community-based-water-sanitation-and-hygiene/132-su-swastha.html>
- 6) Nepal Family Health Program: [www.nfhp.org.np](http://www.nfhp.org.np)
- 7) N-MARC Project: <http://pshi.fhi360.org/whatwedo/projects/nmarc.html>
- 8) ASHA Project: N/A
- 9) STRIDE: N/A
- 10) Red Book support: N/A

### **USAID/Nepal -Supported Surveys and Studies**

- 1) *Nepal Demographic and Health Survey Reports 1996, 2001, 2006, 2011*; including relevant further analysis reports [http://www.measuredhs.com/Publications/Publication-Search.cfm?ctry\\_id=13&country=Nepal](http://www.measuredhs.com/Publications/Publication-Search.cfm?ctry_id=13&country=Nepal)
- 2) *Trends in Demographic and Reproductive Health Indicators in Nepal: Further Analysis of the 1996, 2001, and 2006 Demographic and Health Surveys Data*. DHS Trend Report No. 5. Anjushree Pradhad and Prakash Dev Pant. Dec 2007. USAID and New ERA, Kathmandu, Nepal and Macro International, Inc. Calverton, Maryland, USA.
- 3) *Nepal Family Health Program (NFHP) II Evaluation*, July 2011.
- 4) *Nepal Family Health Program II Final Project Report*, December 2007-2012. USAID, JSI.
- 5) *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Mid-term Survey for NFHP II*. Rudramati Marga, Kalo Pul. New ERA. March 2010.
- 6) *Changes in Health System and Services: Comparisons between 2008 and 2011*. March 2012. USAID and Nepal Family Health Program II, Kathmandu, Nepal.
- 7) *Nepal Maternal Mortality and Morbidity Study: Summary of Preliminary Findings*. 2008/2009. USAID, DFID, SSMP/Nepal, Government of Nepal.
- 8) *Nutritional Assessment and Gap Analysis (2009)*.
- 9) *An Analytical Report on National Survey of Female Community Health Volunteers of Nepal*. June 2007. USAID, New ERA, GON.

### **Nepal's Ministry of Health and Population (MOHP) and Nepal Health Sector Program**

- 1) *Nepal Health Sector Plan I (2004-2010) and II (2010-2015)*: <http://un.org.np/node/10321>; [http://www.mohip.gov.np/english/files/new\\_publications/NHSP-IP%20II%20.pdf](http://www.mohip.gov.np/english/files/new_publications/NHSP-IP%20II%20.pdf)
- 2) Health-related policies, programs of Ministry of Health and Population: <http://www.mohip.gov.np>
- 3) Nepal Health Sector Programme: Implementation Plan (NHSP-IP) 2004-2009. October 2004. His Majesty's Government Ministry of Health.
- 4) Annual Reports: Department of Health Services. MOHP, Government of Nepal, Kathmandu. [http://dohs.gov.np/wp-content/uploads/2014/04/Annual\\_report\\_2067\\_68\\_final.pdf](http://dohs.gov.np/wp-content/uploads/2014/04/Annual_report_2067_68_final.pdf)  
Published annually since about 1993. Provides overview of Nepal's health program, national policies and plans, objectives, targets, strategies, overview of its programs. Includes section on development partners.
- 5) Aide-Memoire. Nepal Health Sector Programme 2010-2015 (NHSP II) Fourth Joint Annual Review (JAR). January 27-29, 2014. GON. Kathmandu, Nepal. Contains recent list of donor stakeholders. [http://www.nhssp.org.np/jar\\_rpt.html](http://www.nhssp.org.np/jar_rpt.html)

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<http://www.internationalhealthpartnership.net/en/news-events/ihp-news/article/joint-annual-review-of-the-nepal-health-sector-programme-ii-2010-2015-324878/>

### **Government of Nepal (GON) Donor Community-Related Documents and Reports**

- 1) Statement of Technical and Other Assistance, Ministry of Finance.  
[http://www.mof.gov.np/ajw/uploads/uploaded\\_image/TA\\_english.pdf](http://www.mof.gov.np/ajw/uploads/uploaded_image/TA_english.pdf)
- 2) Collaborative Framework Signed between MOHP and Ministry of Federal Affairs and Local Development for Strengthening Local Health Governance in Nepal. 2013. Government of Nepal. Annexes provide overview of Local Governance and Community Development Program II (2013–2018), health sector decentralization, policy context and framework, lessons learned from LGCDP I.
- 3) *Development Cooperation Policy: International Cooperation for Development Effectiveness, 2014*. Ministry of Finance, Government of Nepal. Provides current position of the GON in terms of the responsibilities of development partners.

### **Studies on Health Aid Effectiveness in Nepal**

- 1) Aid Effectiveness in Nepal's Health Sector: Accomplishments to Date and Measurement Challenges. Denise Vaillancourt with Sudip Pokhrel for International Health Partnership (IHP+) February 2012.  
[http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results\\_Evidence/HAE\\_results\\_lessons/Nepal%20Aid%20Effectiveness%20Report%202012%20final.pdf](http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results_Evidence/HAE_results_lessons/Nepal%20Aid%20Effectiveness%20Report%202012%20final.pdf)
- 2) *Health Aid Effectiveness in Nepal: Paris, Accra, Civil Society and the Poor*. Alice Schmidt. Action for Health. September 2009.  
[http://www.actionforglobalhealth.eu/fileadmin/user\\_upload/doc\\_library/Aid\\_effectiveness\\_in\\_Nepal\\_Final\\_01.pdf](http://www.actionforglobalhealth.eu/fileadmin/user_upload/doc_library/Aid_effectiveness_in_Nepal_Final_01.pdf)

### **Selected International Papers on Improvement in Key Health Areas**

- 1) National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis, *The Lancet*, 2013.  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)62204-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)62204-1/abstract)
- 2) National, regional, and worldwide estimates of preterm birth rates in the year 2010 with time trends since 1990 for selected countries: a systematic analysis and implications.
- 3) Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. [http://dx.doi.org/10.1016/s0140-6736\(10\)60518-1](http://dx.doi.org/10.1016/s0140-6736(10)60518-1),
- 4) Countdown to 2015, 2012 Report <http://www.countdown2015mnch.org/>
- 5) Levels & Trends in Child Malnutrition, UNICEF/WHO/World Bank.  
[http://www.who.int/nutgrowthdb/jme\\_unicef\\_who\\_wb.pdf](http://www.who.int/nutgrowthdb/jme_unicef_who_wb.pdf)

Nepal Country Progress Report 2012, UNAIDS.

[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_NP\\_Narrative\\_Report.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NP_Narrative_Report.pdf)

### **Other Resources**

Morra-lmas, Linda G. The road to results: designing and conducting effective development evaluations.  
[www.worldbank.org/r2r](http://www.worldbank.org/r2r)

## List of Health-related Surveys and Studies Implemented in Nepal and National Policies and Programs Initiated Based on Evidence Generated

SN*	Name of Surveys/Studies	Year	Funding Agency	Nepal Policy and Strategies Developed/Initiated
1	MDG baseline and midterm review	2005, 2010	UNDP	<ul style="list-style-type: none"> <li>National Health Policy</li> <li>Health Policy 1991</li> <li>Second Long-term Health Plan (1997-2017)</li> <li>Nepal Health Sector Plan (NHSP)-I (2004-2009)</li> <li>Human Resource Strategy Options for Safe Delivery (2003)</li> <li>Health Sector Strategy: Agenda for Reform (2004)</li> <li>NHSP II (2010–2014)</li> <li>NHSP III (under development)</li> <li>Revised Health Policy (2014)</li> <li>Business plan for health sector (2006...)</li> <li>Free Health Care Policy (2007)</li> </ul>
2	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	
3	Nepal Living Standard Survey (NLSS), CBS, Nepal	2004, 2010	World Bank	
4	Nepal National Health Accounts, MOHP	2006/07-2008/09		
5	Joint (MOHP and EDPS) Annual Review			
6	Nepal Health Sector Program, midterm review	2013		
7	Progress Report on Governance and Accountability Action Plan (GAAP)	2012/13	HSRSP/DFID	
8	Assessing Implementation of Nepal's Free Health Care Policy: Health Facility Survey	April, June, December 2009	HSRSP/DFID	
9	Overview of Public-Private Health Care Service Delivery in Nepal–November 2009 Health System Performance	November 2009	HSRSP/DFID	
10	Cost and Equity Implications of Public Financing for Health Services at District Hospitals	April 2009	HSRSP/DFID	
11	Service Tracking Survey Nepal Health Sector Program II, MOHP <a href="http://www.nhssp.org.np/monitoring/Service%20Tracking%20Survey%202013.pdf">http://www.nhssp.org.np/monitoring/Service%20Tracking%20Survey%202013.pdf</a>	2011, 2012, 2013	DFID	
12	DHS further analyses <ul style="list-style-type: none"> <li>Sexual and Reproductive Health of Adolescents and Youth in Nepal</li> <li>Impact of Male Migration on Contraceptive Use, Unmet Need, and Fertility in Nepal</li> <li>Maternal and Child Health in Nepal; the Effects of Caste, Ethnicity and Regional Identity</li> <li>Women's Empowerment and Spousal Violence in Relation to Health Outcomes in Nepal</li> </ul> <a href="http://www.newera.com.np/research/20s/20_health48.htm">http://www.newera.com.np/research/20s/20_health48.htm</a>	2013	USAID, DFID	
<b>Family Planning/Reproductive Health</b>				
13	Family Planning Access and Barrier Study			<ul style="list-style-type: none"> <li>Family Planning Strategy</li> <li>Long-term Population Perspective Plan</li> <li>National Adolescent Health and Development Strategy (2000)</li> <li>Reproductive Health Strategy (1998)</li> </ul>
14	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	
15	National Population and Housing Census 2011, CBS	2011		
16	Falling Sex Ratios and Emerging Evidence of Sex Selective Abortion in Nepal (from DHS survey data 1996 to 2011)	2013		

SN*	Name of Surveys/Studies	Year	Funding Agency	Nepal Policy and Strategies Developed/Initiated
17	Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Mid-term Survey for NFHP II	2010	NFHP II/USAID	<ul style="list-style-type: none"> <li>• Reproductive Health Research Policy Brief 16 (2011)</li> <li>• Reproductive Health Research Strategy (2000)</li> </ul>
18	Nepal Adolescent and Youth Survey, MOHP	2010		
19	Family Planning Needs of Migrant Couples in Nepal <a href="http://nfhp.jsi.com/Res/Docs/FamilyPlanningNeedsOfMigrantCouplesinNepal2012.pdf">http://nfhp.jsi.com/Res/Docs/FamilyPlanningNeedsOfMigrantCouplesinNepal2012.pdf</a>		NFHP II/USAID	
20	A Review of Evidence: Suicide Among Women in Nepal	2011	DFID	
21	Post Training Assessment of Voluntary Surgical Contraception Providers	2012	NFHP II/USAID	
22	A Report on Health News Clipping Service	2011	NFHP II/USAID	
23	Assessment of Training System and Capacity of Three Family Planning Training Sites in Nepal	2010	NFHP II/USAID	
24	Assessment on Special Approaches/ Activities of Family Planning Program	2010	NFHP II/USAID	
<b>Maternal, Newborn and Child Health</b>				
25	Maternal Morbidity and Mortality Study	2009	DFID, USAID	<ul style="list-style-type: none"> <li>• Long-term safe motherhood strategy (2002–2017)</li> <li>• National Safe Motherhood and Newborn Long Term Plan (2006–2017)</li> <li>• Female Community Health Volunteer (FCHV) strategy (1994 and revised versions... 2010...)</li> <li>• MNCH Communication Strategy (2011)</li> <li>• CB-IMCI package (1999)</li> <li>• Birth Preparedness and Maternal Newborn Health Program Package and revised birth preparedness package</li> <li>• Integrated management of newborn care and childhood illness (IMNCI) (Under development, will finalized in 2014)</li> <li>• Safe motherhood and Newborn Health Care Act (2013–under development)</li> <li>• Multiyear immunization strategies</li> <li>• Safe Motherhood Policy (1997...)</li> <li>• Safe Motherhood and Skilled Birth Attendant (SBA) Policy (2006)</li> <li>• Maternity incentive guideline</li> </ul>
26	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	
27	Evaluation of CB-MNC Program including Misoprostol Pilot Study Summative Report on Program Activities and Results in Banke, Jhapa and Kanchanpur districts	from September 2005–September 2007	USAID	
28	Community-Based Integrated Management of Childhood Illness assessment			
29	Assessment of Community-based Newborn Care Package	2012	USAID	
30	National Female Community Health Volunteer Survey	2008, 2014	USAID	
31	Randomized Controlled Trials on use of Chlorhexidine in Sarlahi district of Nepal			
32	Coverage and Compliance of Chlorhexidine ( <i>Kawach</i> ) in Banke, Jumla and Bajhang Districts	August 2011	NFHP II/USAID	
33	A Synthesis of Recent Studies on Maternal and Newborn Survival Interventions in Nepal	2014		
34	Polio Surveillance report			
35	Newborn Death Verbal Autopsy	2013	USAID	
36	Quality of Care in Birthing Centers Study	2013	USAID	
37	A Study on Acceptability and Compliance of Calcium Supplementation among Pregnant Women in Two VDCs of Banke District	2010	USAID	
38	Evaluation of Calcium Supplementation Program for Pregnant Women in Dailekh District, Nepal, Maternal and Child Health Integrated Program	2014	USAID	
39	Independent studies related to access and quality of care			
40	Impact of the integrated radio communication project	1999		
41	Joint Annual Review (JAR) report			

SN*	Name of Surveys/Studies	Year	Funding Agency	Nepal Policy and Strategies Developed/Initiated
42	Evaluation of broadcast radio component of MCH Project Ghar Aagan radio magazine program	2012	USAID	<ul style="list-style-type: none"> <li>• Primary health care out-reach strategy</li> <li>• Multiyear immunization strategies</li> <li>• Maternity incentive guideline</li> <li>• Health Sector Gender Equality and Social Inclusion Strategy</li> </ul>
43	Impact assessment on Jeewan Jyoti radio program	2012	USAID	
<b>Nutrition</b>				
44	Micronutrient Status Survey	1998		<ul style="list-style-type: none"> <li>• National Nutrition Policy and Strategy (MOHP)</li> <li>• National Nutrition Policy and Strategy (MOHP) (2004, updated in 2008)</li> <li>• Multi-Sectoral Nutrition Plan (MSNP) (2012)</li> <li>• Maternal Nutrition Strategy (2013)</li> <li>• School Health and Nutrition Strategy (2006)</li> <li>• Anemia Control Plan (2004, working on revised plan)</li> <li>• Infant and Young Child Feeding Strategy (under development)</li> <li>• Maternal and Young Child Nutrition Action Plan (under development)</li> <li>• Integrated Management of Acute Malnutrition package (2014)</li> <li>• Communication Framework for Maternal and Young Child Nutrition (under development)</li> <li>• Five-year plan for Sustained Iodine Deficiency Disorder Elimination (under development)</li> <li>• Multi-Sectoral Nutrition Plan (MSNP)</li> <li>• Maternal Nutrition Strategy</li> <li>• Anemia Control Plan</li> <li>• Infant and Young Child Feeding Strategy</li> <li>• Maternal and Young Child Nutrition Action Plan</li> <li>• Integrated Management of Acute Malnutrition package</li> <li>• Communication Framework for Maternal and Young Child Nutrition</li> </ul>
45	Nutrition Assessment and Gap Analysis (NAGA)	2010, 2014		
46	Multiple Indicator Cluster Survey (MICS), CBS	2009	UNICEF	
47	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	
48	Nutrition Innovative Lab POSAN Longitudinal Study and Process Study on Nutrition and Food Security	Since 2013		
49	Nepal Thematic Report on Food Security and Nutrition	2013		
50	Vitamin A effectiveness studies by Nepal Nutrition Intervention Project (JHU), including vitamin A trial in newborns			
51	Factors that Constrain or Prevent Optimal Infant and Young Child Feeding Practices in Rural Nepal: Findings from a Formative Research Study in Three Districts	2011	USAID	

SN*	Name of Surveys/Studies	Year	Funding Agency	Nepal Policy and Strategies Developed/Initiated
				<ul style="list-style-type: none"> <li>Five-year plan for Sustained Iodine Deficiency Disorder Elimination</li> <li>National Emergency Nutrition Policy</li> </ul>
<b>HIV</b>				
52	Nepal Country Progress Report	2012		HIV/AIDS strategy 2006–2010, 2011–2016
53	Integrated Biological and Behavioral Survey (IBBS)			HIV/AIDS action plan National guideline for HIV testing, counseling and referral (2003)
54	Independent/project-specific studies			Nepal HIV/AIDS Policy 1995 National Policy on HIV and Sexually Transmitted Infections 2011
55	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	National Advocacy Plan on HIV/AIDS 2008-2011
<b>WASH</b>				
56	Demographic and Health Surveys, MOHP, Nepal	1996, 2001, 2006, 2011	USAID	Nepal National Policy on Sanitation (1994)
57	Nepal Living Standard Survey, CBS	2004 and 2010	World Bank	Hygiene and Sanitation Master Plan (2011)
<b>Others</b>				
58	Sustainability Assessment of Health Outcomes in Three NFHP II Supported Districts: Jhapa, Banke and Kanchanpur		USAID	<ul style="list-style-type: none"> <li>Policy on Quality Assurance in Health Care Services (2007)</li> <li>National Health Research Policy (2003)</li> <li>Primary Health Care Outreach Clinic Program to reach hard-to-reach areas and groups (1994)</li> <li>Local Health Governance Strengthening in Nepal: Collaborative Framework (2013)</li> <li>Integration of GESI in HFOMC capacity-strengthening curriculum (2014)</li> <li>National Training Strategy (1997)</li> </ul>
59	Health Facility Readiness and Functionality Assessment in Health for Life Project districts		H4L/USAID	
60	Assessment of Local Health Governance Strengthening Program (LHGSP)		H4L/USAID	
61	Evaluation of Health Facility Management Strengthening Program (HFMSPP)	2012	NFHP II/USAID	

## ANNEX 2. LIST OF CONSULTANTS

Judith Justice, PhD, MPH, MSW  
School of Medicine, University of California at San Francisco

Sudip Pokhrel, MA  
Independent Public Health Professional

Jeevan Raj Sharma, PhD, MA  
University of Edinburgh, Scotland

Mahesh Sharma, MA  
Independent Public Health Professional

Ashoke Shrestha, MA  
Independent Public Health Professional

Sanjaya Singh Thapa, MPH  
Independent Public Health Professional

### **Specialists:**

Ghanshyam Gautam, PhD, MA  
Health Economist  
Tribhuvan University

Heem Shakya, MBA  
Health Systems and Supply Chain Management Expert  
Independent Public Health Professional

Devendra Shrestha, PhD, MA  
Health Economist  
Tribhuvan University



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## ANNEX 4. INTERVIEW GUIDE

**Interview Questions: General (Past and present government, external development partners, USAID local partners and independent experts)**

Evaluation Question	Interview Questions	Respondents
1. Introductory questions	<ol style="list-style-type: none"> <li>1. <i>Introduce self and role with the review; give short description of purpose of the review, including assurance that the interview will be confidential, that is, names will not be associated with information given during the interview. No quotes will be made without permission of the person interviewed.</i></li> <li>2. Introductory questions about the background, experience, and current position of the person being interviewed</li> <li>3. How long have you known/worked with USAID? What has been your experience with USAID, for example with specific projects, contact/interaction with USAID staff, etc.? <i>Probe for dates</i></li> </ol>	<ol style="list-style-type: none"> <li>1. All</li> <li>2. All</li> <li>3. All</li> </ol>
2. What have been the main accomplishments in health outcomes in Nepal over the past 25 years?	<ol style="list-style-type: none"> <li>1. What do you think have been the major achievements in Nepal's health sector, including changes in health outcomes in the last 25 years?</li> <li>2. What has contributed to improved health outcomes over the years? (probe for examples—contribution of health and beyond health)</li> <li>3. What still needs to be accomplished? What are the top health priorities the GON must address in future?</li> <li>4. Despite overall progress made in health outcomes, internal disparities and inequities persist. What can be done to reduce these inequities? What roles can development partners play?</li> <li>5. Is current level of investments—both domestic and international—enough to sustain the achievements made in the health outcomes?</li> <li>6. Is the current structure of the MOHP adequate to sustain and further improve the achievements made in health outcomes to date?</li> <li>7. What has been the contribution of non-state actors in improving the health outcomes? How can state and non-state partnership be better leveraged in future to further improve the health outcomes?</li> <li>8. What are other key challenges that GON must address to ensure the current momentum and achievements are sustained and emerging health challenges tackled?</li> </ol>	<ol style="list-style-type: none"> <li>1. All</li> <li>2. Past and present senior government officials and EDPs</li> <li>3. All</li> <li>4. All</li> <li>5. Past and present senior government officials and EDPs</li> <li>6. All</li> <li>7. All</li> </ol>

Evaluation Question	Interview Questions	Respondents
	9. What do you think are USAID’s contributions to achievements of the outcomes discussed above?	
3. Key technical interventions and innovations USAID has introduced and what are the related health outcomes in Nepal	<ol style="list-style-type: none"> <li>1. In your view what are the major key technical programs, interventions and innovations (examples: FCHV, CRS, CBMCI) that USAID has supported? How have the other partners and stakeholders collaborated with USAID to support these programs and innovations?</li> <li>2. What USAID-supported programs and innovations are largely seen as successful and how have they been scaled up? What are some of the USAID-supported innovations that didn’t take off or are largely seen as failures? Why did they fail?</li> <li>3. What can be done to sustain and further scale up these programs and interventions?</li> </ol>	<ol style="list-style-type: none"> <li>1. All</li> <li>2. All</li> <li>3. All</li> </ol>
4. USAID contributed to the MOHP’s capacity in: <ol style="list-style-type: none"> <li>a. use of data and evidence to inform the formation of new strategies and policies</li> <li>b. adoption and scale-up of technical interventions and innovations</li> <li>c. strengthening of the health system</li> </ol>	<ol style="list-style-type: none"> <li>1. What are some of the major capacity gaps that need to be addressed to sustain and further improve health outcomes?</li> <li>2. Have there been capacity need assessments of the MOHP? How are capacity development requirements/inputs determined?</li> <li>3. How can USAID and other development partners support the GON?</li> <li>4. How can future investment/inputs in capacity development be made more effective?</li> <li>5. Over the past 25 years, in what ways has USAID contributed in developing capacity of the MOHP as well as the sector at large? Please cite some major examples.</li> <li>6. To what extent have USAID capacity inputs contributed to improved performance and health outcomes (individual, system, department/units, program–probe for examples)? How?</li> <li>7. What has been the practice in using evidence, data for better health programming and implementation? Has it changed over the years? How have USAID and other development partners contributed to this?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Past and present senior government officials and EDPs</li> <li>3. Past and present senior government officials and EDPs—including program managers</li> <li>4. Past and present senior government officials and EDPs</li> <li>5. Past and present senior government officials and EDPs</li> <li>6. Past and present senior government officials and EDPs</li> </ol>
5. USAID’s approach to providing technical assistance to the MOHP evolved over time and	<ol style="list-style-type: none"> <li>1. During the last 25 years, have you observed changes in how development partners, including USAID, work with the GON? <i>Probe for examples.</i></li> <li>2. In what way does USAID’s working modality differ from other development partners? Is it comparatively easier or harder to work with USAID?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Past and present senior government officials and EDPs</li> </ol>

Evaluation Question	Interview Questions	Respondents
<p>what approaches have been most effective</p>	<ol style="list-style-type: none"> <li>3. How do you describe USAID approaches to providing assistance? How have USAID's approaches to providing technical assistance changed over time?</li> <li>4. Over the time, has the USAID assistance been more integrated with the SWAp and broader aid effectiveness agenda? How has this evolved over the time? Is it more effective now?</li> <li>5. From your perspective, compared to other development partners, what are the plus points and areas for improvement of USAID's approach in providing assistance in the health sector? What is the comparative advantage of USAID's assistance?</li> <li>6. How responsive is USAID to GON requests (e.g., flexibility vs. rigidity in USAID response)? Have you observed any changes in USAID's responsiveness to government requests?</li> <li>7. How did USAID operate during the armed conflict years? In what way did the conflict affect USAID's strategies, programs and activities? And how did USAID collaborate with other development partners during the conflict years?</li> </ol>	<ol style="list-style-type: none"> <li>3. Past and present senior government officials and EDPs</li> <li>4. Past and present senior government officials</li> <li>5. Past and present senior government officials</li> <li>6. Past and present senior government officials</li> </ol>
<p>6. What have been the main financial investments that USAID and other key donors have made to the health sector in Nepal over time?</p>	<ol style="list-style-type: none"> <li>1. What are your views on increasing domestic investment in health and decreasing donor investment in health over the 25-year period?</li> <li>2. What are your views on past and future investments in financial vs. technical assistance? (funding channels)</li> <li>3. How many donors use the government public financial management system, i.e., financial report?</li> <li>4. What are the implications to government if development partners use their own financial system?</li> <li>5. How have the reporting requirements changed over the period? Do different donors require different financial reports?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Present senior government officials</li> <li>3. Past and present senior government officials and EDPs</li> <li>4. Past and present senior government officials and EDPs</li> <li>5. Past and present senior government officials</li> </ol>
<p>7. USAID leadership among the donors to support aid effectiveness in Nepal's health program</p>	<ol style="list-style-type: none"> <li>1. Have you observed changes in how donors work with each other over time? For example, has there been a change in the way donors collaborate with each other? <i>Probe for examples.</i></li> <li>2. How do you see development partners' effort to harmonize their assistance programs with each other? Is it more integrated and/or harmonized now than in the past?</li> <li>3. How has USAID aligned its support with national priorities over the past 25 years, and how has it changed during this period?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Past and present senior government officials and EDPs</li> <li>3. Past and present government and EDP officials—including USAID officials</li> <li>4. Past and present EDP officials—including USAID officials</li> </ol>

Evaluation Question	Interview Questions	Respondents
	<ol style="list-style-type: none"> <li>4. How is USAID perceived as a development partner by other EDPs? Has this perception changed over time? In what way? Is USAID perceived as harmonizing its efforts with other development partners?</li> <li>5. What added value does USAID bring to the EDP forum and other partner forums?</li> </ol>	<ol style="list-style-type: none"> <li>5. Past and present EDP officials</li> </ol>
<ol style="list-style-type: none"> <li>8. Moving forward, what might be the main ways that USAID should continue to contribute to health outcomes and strengthen health systems and services in Nepal?</li> </ol>	<ol style="list-style-type: none"> <li>1. What specific program areas or health priorities would you like to see USAID focus on in the future?</li> <li>2. Would you like to see USAID change its approaches in providing assistance in the future, and how? (<i>Probe: technical aspect, working modality, etc.</i>)</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Past and present senior government officials and EDPs</li> </ol>
<ol style="list-style-type: none"> <li>9. Moving forward, what are the key ways that USAID could contribute to aid effectiveness among the donor community in Nepal?</li> </ol>	<ol style="list-style-type: none"> <li>1. What can be done to further improve aid effectiveness in the health sector? What should the development partners do? What should the GON do?</li> <li>2. What can USAID do to further improve its aid effectiveness?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. Past and present senior government officials and EDPs—including USAID officials?</li> </ol>
<ol style="list-style-type: none"> <li>10. Questions specific to USAID implementing partners</li> </ol>	<ol style="list-style-type: none"> <li>1. Describe your working experience as a USAID implementing partner. What are some of the major changes?</li> <li>2. As an implementing partner, what type of autonomy do you have in executing USAID-funded programs?</li> <li>3. Do you collaborate with other development partners, and if so, in what ways? Has this changed over the years? In what way does USAID facilitate such collaboration?</li> <li>4. Has USAID developed your organization’s capacity, and how?</li> <li>5. Describe the working relationship between your program and the GON? And has this changed over the years?</li> <li>6. In your perception, how does the GON feel about USAID’s approach of using implementing partners as opposed to channeling funds directly through the government system?</li> </ol>	
<ol style="list-style-type: none"> <li>11. Wrap-up Questions</li> </ol>	<ol style="list-style-type: none"> <li>1. Are there other things that we haven’t asked about, which you think are important?</li> </ol>	<ol style="list-style-type: none"> <li>1. Past and present senior government officials and EDPs</li> <li>2. All</li> </ol>

## ANNEX 5. MDGS AND HEALTH: AN OVERVIEW

Nepal was one of 189 signatory countries of the Millennium Declaration and aligned its health sector plans and strategies with the MDG goals and targets. Of the eight goals, MDG 4 on child mortality, MDG 5 on maternal mortality and MDG 6 on HIV/AIDS, malaria and other diseases are referred to as the health MDGs. MDGs 4 and 5 are the most relevant to the 25-year review of the health sector; therefore, this brief overview focuses on those.

Nepal has made significant progress in achieving its MDG targets and has received global recognition for the impressive outcomes, despite the decade-long armed conflict, constitutional and political transitions, economic vulnerabilities and natural disasters (NPC, 2015). In September 2010, Nepal received the MDG award in New York for its outstanding progress toward achievement of improved maternal health under MDG 5.

Four MDG progress reports (2002, 2005, 2010 and 2013) have been published. The latest report (2013) provides the most updated insights on the status of the MDGs and the challenges they pose. The progress report states that Nepal has achieved the target of reducing the maternal mortality ratio by three quarters, while other health-related targets are likely to be achieved by 2015 (NPC/UNDP, 2013, Table 1, p. 3). The report offered a comprehensive look at Nepal's efforts to meet the MDGs and the gaps that are likely to constrain further progress.

A review of the achievements made in MDGs 4 and 5 in relation to the targets set for 2014/15 follow. Data presented in the table below illustrate the achievements made in the different indicators under these two MDGs.

### Status and Targets of MDG 4 and 5 Indicators, Nepal

Number	Indicators	Status <sup>151</sup> 2014	Target 2015
<b>A. MDG 4 Indicators</b>			
1	Infant mortality rate (per 1,000 live births)	33	36
2	Under-5 mortality rate (per 1,000 live births)	38	54
3	Proportion of 1-year-old children immunized against measles (percent)	92.6	>90
<b>B. MDG 5 Indicators</b>			
1	Maternal mortality ratio (per 100,000 live births)	190 <sup>152</sup>	213
2	Proportion of births attended by skilled birth attendant (percent)	55.6	60
3	Contraceptive prevalence rate (modern methods) (percent)	47.1	67
4	Adolescent birth rate (births per 1,000 women age 15-19 years)	71	70
5	Antenatal care coverage (at least four visits) (percent)	59.5	80
6	Unmet need for family planning (percent)	25.2	15

<sup>151</sup> CBS, 2014.

<sup>152</sup> UNICEF/WHO, 2014.

Nepal has achieved two out of three indicators in the MDG 4 targets and is considered to be one of the “fast track” countries. The infant mortality rate (per 1,000 live births) has declined to 33 in 2014, which is very close to its target of 36. Similarly, the proportion of 1-year-old children immunized against measles through routine immunization has more than doubled in the last two decades, from 42 percent in 1990 to 92.6 percent in 2014. Therefore, the target has already been achieved. However, the target for U5MR is not “likely to be achieved,” as stated by the MDGs progress report 2013.

For MDG 5, the target of reducing maternal mortality by three quarters has been achieved. Though different estimates of the maternal mortality ratio are available, the most recent report from UNICEF/WHO confirmed that it has been reduced to 193, against its target of 213 in 2015. Also, births attended by SBAs have been close to the target.

In view of the above discussion, an assessment of factors contributing to this impressive progress made in MDGs 4 and 5 follows:

The successful programs for immunization, control of diarrheal diseases, semiannual vitamin A supplementation and deworming, CB-IMCI and moderate coverage of breastfeeding of children under 6 months are considered to be the most significant contributors to the decline in child and infant deaths.

Large reductions in the maternal mortality ratio have been attributed to a consistent decline in fertility, resulting from the increased use of family planning services. The TFR has decreased to 2.3 in 2014 from 5.3 in 1991, and the CPR has increased to 49.6 percent in 2014 from 24 percent in 1990. The Oot study (2011) made the observation that efforts to expand access to facility-based deliveries, supported by SBAs, have resulted in dramatic changes in the place of deliveries, and together with the decline in fertility, have contributed to reductions in maternal mortality in Nepal. The goal would have been difficult to achieve without access to medical assistance for basic and comprehensive obstetric care in health facilities.

The country has undertaken serious efforts to reduce the high level of maternal mortality and morbidity, including establishing comprehensive emergency obstetric care centers, promoting quality of care, training SBAs and service providers and behavior change communication initiatives at the village level to increase access to available services. The most recent available data demonstrate the progress made in the safer motherhood program. Comprehensive emergency obstetric care districts have increased to 67, basic emergency obstetric care sites to 162, the number of 24/7 birthing centers to 1,623 and SBAs to 7,104.

USAID’s assistance to the health sector through several innovative interventions is viewed as contributing to the health system and service facilities at various levels. USAID’s support for MNCH and associated interventions, such as CB-IMCI, CB-NCP, misoprostol to prevent postpartum hemorrhage and chlorhexidine to prevent sepsis in newborns, have strong maternal, newborn and child health service components. The significance of CB-IMCI and CB-NCP in reducing child mortality has been documented in the MDG Progress Report 2013, and they are considered “proven interventions” (NPC/UNDP, 2014). The report further states, “Their success is testimony to the strength and vision of the national leadership, which promoted their implementation at the community level and especially among marginalized and excluded groups” (NPC/UNDP, 2014, p 43).

USAID’s nutritional support program, e.g., SUA AHARA, is another intervention designed to address the health problems of mothers and children arising from nutritional disorders. In this integrated nutrition program, nutrition, personal hygiene, agriculture, family planning, reproductive health and child health activities are integrated into one program. The midterm review of this project has evaluated its positive

impact on improving the health and nutritional status of pregnant and lactating women and children (Save the Children, 2015).

Other USAID-supported health interventions, such as the postpartum family planning program, has also had an effect on reducing the unmet need for family planning. USAID's support for logistics, which focuses on the timely delivery of contraceptives, has also contributed to increasing the CPR and thereby reducing the fertility rate.

Therefore, USAID's innovative health interventions are viewed as contributing to attaining the health MDG goals.

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## ANNEX 6. TRENDS IN KEY HEALTH INDICATORS 1991-2011

Health Indicators	Year					
	1991	1996	2001	2006	2011	2014 <sup>153</sup>
<b>A. Mortality</b>						
Life expectancy	54	57	62	65	68	
Maternal mortality ratio (MMR)	515	539	430	281	250 <sup>154</sup>	170 <sup>155</sup>
Neonatal mortality rate (NMR)	46	50	39	33	33	23 <sup>156</sup>
Post-neonatal mortality rate	34	29	26	15	13	11 <sup>157</sup>
Infant mortality rate (IMR)	80	79	64	48	46	33 <sup>158</sup>
Under-5 mortality rate (U5MR)	121	118	91	61	54	38 <sup>159</sup>
<b>B. Fertility</b>						
Total fertility rate (TFR)	5.1	4.6	4.1	3.1	2.6	2.3
Adolescent fertility rate (ASFR 15-19)	98 <sup>160</sup>	127 <sup>161</sup>	110 <sup>162</sup>	98 <sup>163</sup>	81 <sup>164</sup>	71
<b>C. CPR</b>						
All method	22.7	28.5	39.3	48	49.7	49.7
Modern method	21.8	26	35.4	44.2	43.2	47.0
<b>D. Child nutrition</b>						
Percent underweight children <sup>165</sup>	NA	46.9	48.3	38.6	28.8	11.3
Percent stunted children <sup>166</sup>	NA	48.4	50.5	49.3	40.5	37.4
<b>E. TB</b>						
TB detection rate (percent)	NA	48	NA	65	73	NA
TB success rate (percent)	NA	56	NA	88	90	NA
<b>F. Malaria</b>						
Malaria annual parasite incidence rate per 1,000 population	NA	NA	0.50	0.3	0.16	NA
<b>G. Immunization coverage</b>						

<sup>153</sup> Nepal MICS 2014

<sup>154</sup> Ministry of Finance. 2012.

<sup>155</sup> NPC/UNDP. *Nepal MDGs Annual Progress Report*. Table 5A.

<sup>156</sup> Five years preceding the survey

<sup>157</sup> Five years preceding the survey

<sup>158</sup> Five years preceding the survey

<sup>159</sup> Five years preceding the survey

<sup>160</sup> One year preceding the survey

<sup>161</sup> Three years preceding the survey

<sup>162</sup> Three years preceding the survey

<sup>163</sup> Three years preceding the survey

<sup>164</sup> Three years preceding the survey

<sup>165</sup> Weight for age (percent below -2sd)

<sup>166</sup> Height for age (percent below -2sd)

Immunization coverage (12-23 months), all	37.2	43.3	65.6	82.8	87	67.1 <sup>167</sup>
BCG	72.9	76	84.5	93.4	96.5	87.5
Measles	57.4	56.6	70.6	85	88	84.5
Vitamin A coverage among children 6-59 months	NA	32.2 <sup>168</sup>	81	87.5	90.4	90.3 <sup>169</sup>
<b>H. HIV</b>						
HIV incidence (percent)	NA	NA	0.5	0.49 <sup>170</sup>	0.30 <sup>171</sup>	NA

<sup>167</sup> Nepal, MICS 2014. Percentage of children aged 12–23 months who received all vaccinations recommended in the national immunization schedule by their first birthday (measles by second birthday)

<sup>168</sup> 6-35 months

<sup>169</sup> 6-35 months

<sup>170</sup> HIV Prevalence 15-49, 2007

<sup>171</sup> MOHP. 2012. *Nepal Country Progress Report*.

## ANNEX 7. HEALTH FINANCING TABLES

### Expenditure of MOHP by Financing Source

Source	2004/ 05	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15
GON	3,117	3,649	4,118	6,131	7,059	9,231	11,903	13,815	12,385	15,412	17,840
EDPs: pool	690	1,145	1,335	1,757	2,711	3,631	4,153	4,694	4,945	6,048	5,018
EDPs: non- pool	791	929	1,988	1,957	2,962	3,052	2,120	1,731	1,719	1,394	1,661
MOHP total	4,598	5,723	7,441	9,844	12,731	15,914	18,175	20,240	19,049	22,854	24,519
1 USD= NPR	72.1	72.3	70.5	65	76.9	74.5	72.3	81.0	88.0	98.2	98.7

Note: Amount in million NPR

Source: Estimates of Expenditure "Red Book," Ministry of Finance, Various Fiscal Years

### USAID Yearly Overall Obligations and Disbursement to Nepal

Year	Obligation (in millions USD)	Disbursements			
		Amount (in millions USD)	As percent of obligation	In per capita USD	As percent of total GON expenditure
1990	21.0	NA	-	-	-
1991	29.1	NA	-	-	-
1992	19.6	NA	-	-	-
1993	23.9	NA	-	-	-
1994	19.5	NA	-	-	-
1995	17.2	NA	-	-	-
1996	15.9	NA	-	-	-
1997	19.6	NA	-	-	-
1998	29.7	NA	-	-	-
1999	20.1	NA	-	-	-
2000	22.4	NA	-	-	-
2001	50.2	24.6	49.0	1.1	2.4
2002	39.3	26.6	67.7	1.1	2.5
2003	42.8	37.5	87.7	1.6	3.5
2004	42.6	39.4	92.5	1.6	3.3
2005	71.7	64.6	90.1	2.6	4.5
2006	55.9	64.1	114.6	2.6	4.2
2007	68.7	63.0	91.6	2.5	3.3
2008	89.6	77.6	86.6	3.0	3.1
2009	81.2	72.2	88.8	2.8	2.5
2010	65.1	57.7	88.6	2.2	1.7
2011	91.1	70.9	77.8	2.7	1.7
2012	77.0	70.9	92.1	2.6	1.7
2013	117.2	83.0	70.9	3.0	2.0

Year	Obligation (in millions USD)	Disbursements			
		Amount (in millions USD)	As percent of obligation	In per capita USD	As percent of total GON expenditure
2014	78.2	83.3	106.5	3.0	1.9
2015	118.6				

Note: Amount in million USD

Sources: <https://explorer.usaid.gov/data-download.html>; downloaded on Nov 16 2015.

Ministry of Finance, Estimates of Expenditure, "Red Book," various years.

### Sectoral Composition of USAID Budget for Nepal

SN		2007	2008	2009	2010	2011	2012	2013	2014	2015
1	Peace and security	3.1	1.0	4.8	3.0	6.0	4.3	2.6	1.5	1.5
2	Governing justly and democratically	10.5	6.5	9.9	3.0	6.0	7.5	7.9	7.4	8.8
3	Investing in people	18.9	19.9	22.2	26.5	34.6	45.6	50.0	45.9	51.4
3.1	Health	17.9	19.9	22.2	25.0	32.6	40.6	40.5	40.9	41.4
	HIV/AIDS	6.0	5.0	5.0	5.0	5.0	3.0	3.0	3.0	3.0
	Other public health threats	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Maternal and child health	5.2	7.4	8.2	6.4	10.5	15.5	15.5	15.5	15.5
	Family planning and reproductive health	6.4	7.5	9.0	9.6	11.0	13.0	13.9	14.4	14.4
	Water supply and sanitation	0.0	0.0	0.0	0.0	0.0	2.1	1.4	0.0	0.5
	Nutrition	0.0	0.0	0.0	4.0	6.2	7.0	6.7	8.0	8.0
3.2	Education	1.0	0.0	0.0	1.5	2.0	5.0	9.6	5.0	10.0
3.3	Social assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
4	Economic growth	5.9	11.1	6.6	19.5	22.0	24.3	19.3	20.0	17.0
5	Humanitarian assistance	0.0	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0
	Total	38.4	38.5	44.4	52.0	68.6	81.7	79.9	74.8	78.7

Note: Amount in million USD

Source: USAID country office, Nepal

### USAID Contribution in the Health Sector by Projects

Projects	Agreement type	Support type	Key implementing partner	Start date	End date	Budget (in million USD)
Saath-Saath	Cooperative	Bilateral	FHI 360	2011	2016	24.07
Health for Life (Core)	Contract	Bilateral	RTI	2012	2017	18.25
Health for Life, Logistics	Contract	Bilateral	Lifeline	2013	2018	2.20
Suaahara	Cooperative	Bilateral	Save the Children	2011	2016	54.90
NFHP I	Cooperative	Bilateral	JSI	2001	2007	25.00
NFHP II	Cooperative	Bilateral	JSI	2017	2012	30.00
CNCP (Chlorohexidine Navi Care Programme)	Cooperative	Field support	JSI	2014	2017	1.85
Nepal DHS	Contract	Field support		2008	2016	0.72
Safe WASH I	Cooperative	Bilateral	SEBAC Nepal	2011	2014	0.41
Safe WASH II	Cooperative	Bilateral	SEBAC Nepal	2014	2019	0.20

Projects	Agreement type	Support type	Key implementing partner	Start date	End date	Budget (in million USD)
ASHA	Cooperative	Bilateral	FHI 360	2006	2011	21.71
GGMS TA	Contract	Bilateral	FHI 360	2010	2015	9.88
GGMS CRS	Cooperative	Bilateral	CRS	2010	2015	5.80
Health Communication Capacity Collaborative (HC3)	Cooperative	Field support	John Hopkins University	2012	2017	5.90
SIFPO (Support for International Family Planning Organisation)	Cooperative	Field support	IPPF/FPAN	2014	2019	2.82
SIFPO (Support for International Family Planning Organisation)	Cooperative	Field support	MSI	2014	2019	2.78
Fertility Awareness and Community Transformation (FACT)	Cooperative	Field support	Georgetown's Institute of Reproductive Health	2014	2019	4.15
Nutrition Lab	Cooperative	Field support		2010	2020	1.10
Action Against Malnutrition through Agriculture (AAMA)	Cooperative	Field support				0.43
UNICEF Umbrella	Grant	Field support	UNICEF	2011	2011	0.50
UNICEF Umbrella	Grant	Field support	UNICEF	2015		2.10
WHO Polio	Grant	Field support	WHO	1996	2022	0.52
WHO Polio	Grant	Field support	WHO	2011		0.45
WHO Polio	Grant	Field support	WHO	2012		1.07
WHO Polio	Grant	Field support	WHO	2013		1.10
WHO Polio	Grant	Field support	WHO	2014		1.10
WHO Polio	Grant	Field support	WHO	2015		0.80
N-MARC (Nepal Social Marketing & Franchise Project)	Contract	Bilateral		2016	2011	11.22
DELIVER	Contract	Field support		2010	2014	0.50
STRIDE (Strengthening Rehabilitation in District Environs) Project	Cooperative	Bilateral	Handicap International	2010	2016	2.71
Family Planning Project (DFID) basket fund	Grant	Central	DFID	2014	2017	10.00
MEASURE Census, Interagency Agreement	Contract	Field support	U.S. Census Bureau	2008	2016	0.72
Maternal Mortality and Morbidity Study 2008-09	Contract	Field support		2009		4.43
Maternal Mortality and Morbidity Study 2008-10	Contract	Field support		2011		24.00
Maternal Mortality and Morbidity Study 2008-11	Contract	Field support		2016		3.00
Measure Evaluation (trainings/studies)	Contract	Field support	Training	2013		0.20
Measure Evaluation (trainings/studies)	Contract	Field support	GPM, impact evaluation	2014		0.18
Measure Evaluation (trainings/studies)	Contract	Field support	GPM, impact evaluation	2016		0.68

<b>Projects</b>	<b>Agreement type</b>	<b>Support type</b>	<b>Key implementing partner</b>	<b>Start date</b>	<b>End date</b>	<b>Budget (in million USD)</b>
Measure Evaluation (trainings/studies)	Contract	Field support	Training	2016		0.27
Su SWATHA (School-led Safe Water, Sanitation and Hygiene Improvement) Project	Not known	Bilateral	ENPHO	2011	2014	0.31
Opportunities for Micronutrient Interventions Project (OMNI)	Not known	Central		2014	2017	1.60

Note: Amount in million USD

Source: USAID country office, Nepal.

## ANNEX 8. LIST OF USAID PROJECTS 1990-2015

Support Area/Project	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19
Nepal Nutrition Intervention Project																														
Child Survival and Family Planning Services (CS/FHS)																														
National Vitamin A Deficiency Prevention and Control Program (NVAP)																														
Vitamin A Field Support Project (VITAL)																														
Opportunities for Micronutrient Interventions Project (OMNI)																														
AIDSCAP I: USAID's First Phase Attack on the HIV/AIDS Pandemic																														
Control of Diarrheal Disease Reactivation Program																														
Opportunities for Micronutrient Interventions Project (OMNI)																														
Acute Respiratory Infection Strengthening Program																														
Environmental Health Project (EHP)																														
Radio Communication Project (RCP)																														
Vector-borne disease program (Environmental Health Project)																														
AIDSCAP II (HIV/AIDS)																														
Family Planning and Logistics Management Project (FPLM)																														
Logistics and Child Health Support Project																														
Nepal Family Health Program (NFHP I)																														

Support Area/Project	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19
IMPACT: USAID's Second Phase Attack on the HIV/AIDS Pandemic																														
DELIVER Project																														
Advancing Surveillance, Policies, Prevention, Care Support and Treatment to Fight against HIV/AIDS (ASHA)																														
Nepal Family Health Program (NFHP-II)																														
Saath-Saath Project																														
Suaahara																														
Chlorhexidine Navi Care Program (Phase I)																														
Chlorhexidine Navi Care Program (Phase II)																														
Fertility Awareness for Community Transformation (FACT) Project																														
Health for Life (H4L)																														
Health Communication Capacity Collaborative Project																														
Knowledge-based Integrated Sustainable Agriculture and Nutrition (KISAN) Project																														
Ghar Ghar Maa Swasthya (Healthy Home) Project																														
Strengthening Rehabilitation in District Environs (STRIDE) Project																														
School-Led Safe Water, Sanitation and Hygiene Improvement (Su-SWASTHA) Project																														
Health for Life (H4L) Logistics Project																														
SABAL																														
Safe Practices on Water, Sanitation and Hygiene (Safe WASH) II Project																														
Family Planning Service Strengthening Program (FPSSP)																														

# ANNEX 9. USAID BUDGET BY PROGRAM AREA

## A. FY 2007 to FY 2011

NEPAL	FY 2007 653(a) Allocations				FY 2008 653(a) Allocations				FY 2009 653(a) Final			FY 2010 653(a) Final			FY 2011 653(a) Allocations			
	Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID		Sum of Accts	USAID		Sum of Accts	USAID		
		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		GHP-USAID	ESF		GHP-USAID	ESF		DA	GHP-USAID	ESF
<b>TOTAL</b>	38,391	9,201	17,940	11,250	38,450	9,136	19,891	9,423	44,351	22,200	22,151	52,000	25,000	27,000	68,624	19,000	32,645	16,979
<b>1 Peace &amp; Security</b>	3,050	-	-	3,050	1,000	500	-	500	4,775	-	4,775	3,000	-	3,000	6,000	-	-	6,000
1.1 Counter-Terrorism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.2 Combating Weapons of Mass Destruction (WMD)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.3 Stabilization Operations and Security Sector Reform	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.5 Transnational Crime	-	-	-	-	-	-	-	-	1,500	-	1,500	2,000	-	2,000	1,000	-	-	1,000
1.6 Conflict Mitigation and Reconciliation	3,050	-	-	3,050	1,000	500	-	500	3,275	-	3,275	1,000	-	1,000	5,000	-	-	5,000
<b>2 Governing Justly &amp; Democratically</b>	10,525	2,675	-	7,850	6,500	1,500	-	5,000	9,925	-	9,925	3,000	-	3,000	6,000	-	-	6,000
2.1 Rule of Law and Human Rights	3,750	-	-	3,750	-	-	-	-	2,500	-	2,500	-	-	-	-	-	-	-
2.2 Good Governance	600	-	-	600	-	-	-	-	3,140	-	3,140	1,000	-	1,000	2,000	-	-	2,000
2.3 Political Competition and Consensus-Building	3,500	-	-	3,500	4,000	1,000	-	3,000	4,285	-	4,285	2,000	-	2,000	4,000	-	-	4,000
2.4 Civil Society	2,675	2,675	-	-	2,500	500	-	2,000	-	-	-	-	-	-	-	-	-	-
<b>3 Investing in People</b>	18,940	1,000	17,940	-	19,891	-	19,891	-	22,200	22,200	-	26,500	25,000	1,500	34,645	-	32,645	2,000
3.1 Health	17,940	-	17,940	-	19,891	-	19,891	-	22,200	22,200	-	25,000	25,000	-	32,645	-	32,645	-
3.1.1 HIV/AIDS	6,000	-	6,000	-	4,960	-	4,960	-	5,000	5,000	-	5,000	5,000	-	5,000	-	5,000	-
3.1.5 Other Public Health Threats	400	-	400	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.1.6 Maternal and Child Health	5,165	-	5,165	-	7,431	-	7,431	-	8,200	8,200	-	6,400	6,400	-	10,479	-	10,479	-
3.1.7 Family Planning and Reproductive Health	6,375	-	6,375	-	7,500	-	7,500	-	9,000	9,000	-	9,600	9,600	-	10,978	-	10,978	-
3.1.8 Water Supply and Sanitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.1.9 Nutrition	-	-	-	-	-	-	-	-	-	-	-	4,000	4,000	-	6,188	-	6,188	-
3.2 Education	1,000	1,000	-	-	-	-	-	-	-	-	-	1,500	-	1,500	2,000	-	-	2,000
3.3 Social Assistance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>4 Economic Growth</b>	5,876	5,526	-	350	11,059	7,136	-	3,923	6,600	-	6,600	19,500	-	19,500	21,979	19,000	-	2,979
4.1 Macroeconomic Foundation for Growth	-	-	-	-	1,000	77	-	923	900	-	900	1,000	-	1,000	440	-	-	440
4.2 Trade & Investment	-	-	-	-	1,059	1,059	-	-	900	-	900	1,000	-	1,000	439	-	-	439
4.4 Infrastructure	2,800	2,800	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.5 Agriculture	1,076	1,076	-	-	1,500	1,000	-	500	3,000	-	3,000	9,000	-	9,000	10,000	10,000	-	-
4.6 Private Sector Competitiveness	2,000	1,650	-	350	2,000	2,000	-	-	800	-	800	2,500	-	2,500	2,100	-	-	2,100

NEPAL	FY 2007 653(a) Allocations				FY 2008 653(a) Allocations				FY 2009 653(a) Final			FY 2010 653(a) Final			FY 2011 653(a) Allocations			
	Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID		Sum of Accts	USAID		Sum of Accts	USAID		
		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		GHP-USAID	ESF		GHP-USAID	ESF		DA	GHP-USAID	ESF
4.7 Economic Opportunity	-	-	-	-	2,500	-	-	2,500	-	-	-	-	-	-	-	-	-	-
4.8 Environment	-	-	-	-	3,000	3,000	-	-	1,000	-	1,000	6,000	-	6,000	9,000	9,000	-	-
5 Humanitarian Assistance	-	-	-	-	-	-	-	-	851	-	851	-	-	-	-	-	-	-
5.2 Disaster Readiness	-	-	-	-	-	-	-	-	851	-	851	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>38,391</b>	<b>38,391</b>			<b>38,450</b>	<b>38,450</b>			<b>44,351</b>	<b>44,351</b>		<b>52,000</b>	<b>52,000</b>		<b>68,624</b>	<b>68,624</b>		
<i>Update: April 3, 2015</i>																		

## B. FY 2011 to FY 2015

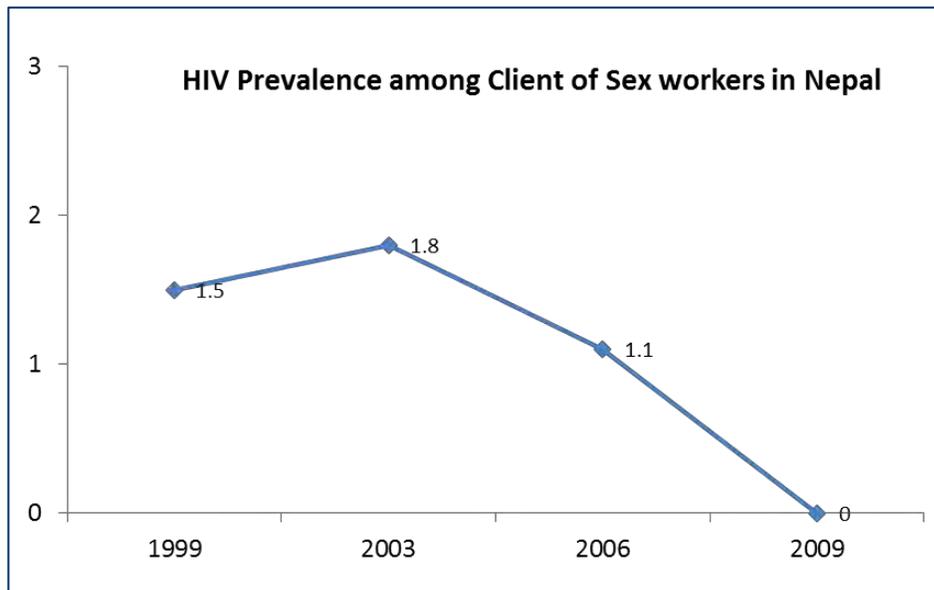
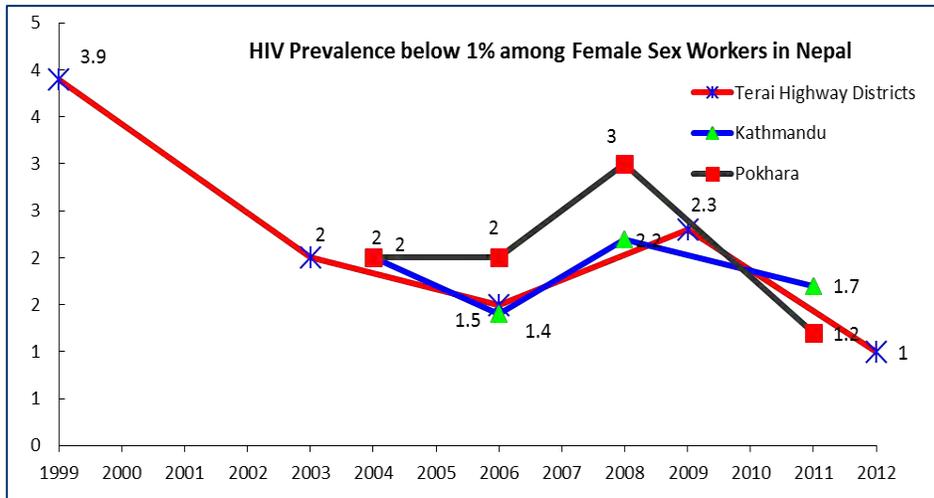
NEPAL	FY 2012 653(a) Allocations				FY 2013 653(a) Allocations				FY 2014 653(a) Allocations				FY 2015 653a Initial Distribution (4-2-2015)			
	Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID		
		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF
<b>TOTAL</b>	<b>81,667</b>	<b>16,188</b>	<b>38,500</b>	<b>26,979</b>	<b>79,905</b>	<b>21,020</b>	<b>39,056</b>	<b>19,830</b>	<b>74,833</b>	<b>-</b>	<b>40,900</b>	<b>33,933</b>	<b>78,700</b>	<b>-</b>	<b>40,900</b>	<b>37,800</b>
1 Peace & Security	4,295	-	-	4,295	2,629	-	-	2,629	1,500	-	-	1,500	1,500	-	-	1,500
1.1 Counter-Terrorism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.2 Combating Weapons of Mass Destruction (WMD)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.3 Stabilization Operations and Security Sector Reform	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.5 Transnational Crime	1,695	-	-	1,695	1,629	-	-	1,629	1,500	-	-	1,500	1,500	-	-	1,500
1.6 Conflict Mitigation and Reconciliation	2,600	-	-	2,600	1,000	-	-	1,000	-	-	-	-	-	-	-	-
2 Governing Justly & Democratically	7,520	-	-	7,520	7,906	1,349	-	6,556	7,433	-	-	7,433	8,800	-	-	8,800
2.1 Rule of Law and Human Rights	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2.2 Good Governance	1,840	-	-	1,840	3,106	50	-	3,056	1,535	-	-	1,535	3,800	-	-	3,800
2.3 Political Competition and Consensus-Building	5,680	-	-	5,680	3,500	-	-	3,500	4,862	-	-	4,862	3,000	-	-	3,000
2.4 Civil Society	-	-	-	-	1,299	1,299	-	-	1,035	-	-	1,035	2,000	-	-	2,000
3 Investing in People	45,600	7,100	38,500	-	50,043	10,987	39,056	-	45,900	-	40,900	5,000	51,400	-	40,900	10,500
3.1 Health	40,600	2,100	38,500	-	40,489	1,433	39,056	-	40,900	-	40,900	-	41,400	-	40,900	500
3.1.1 HIV/AIDS	3,000	-	3,000	-	3,000	-	3,000	-	3,000	-	3,000	-	3,000	-	3,000	-
3.1.5 Other Public Health Threats	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.1.6 Maternal and Child Health	15,500	-	15,500	-	15,501	-	15,501	-	15,500	-	15,500	-	15,500	-	15,500	-
3.1.7 Family Planning and Reproductive Health	13,000	-	13,000	-	13,893	-	13,893	-	14,400	-	14,400	-	14,400	-	14,400	-
3.1.8 Water Supply and Sanitation	2,100	2,100	-	-	1,433	1,433	-	-	-	-	-	-	500	-	-	500
3.1.9 Nutrition	7,000	-	7,000	-	6,661	-	6,661	-	8,000	-	8,000	-	8,000	-	8,000	-

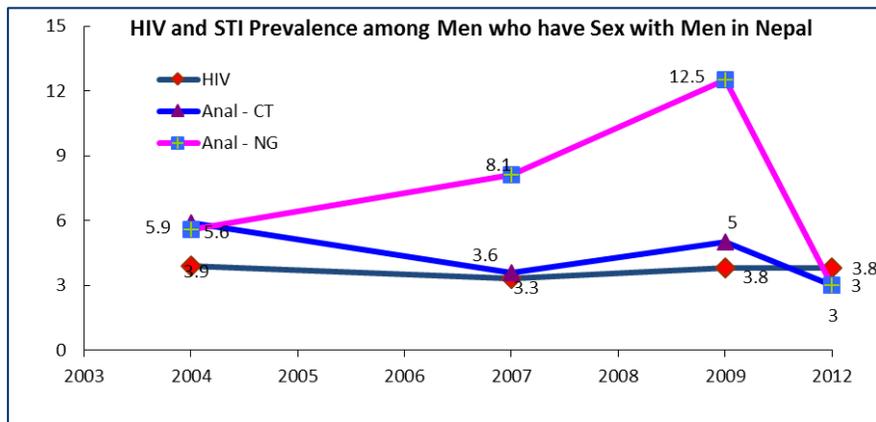
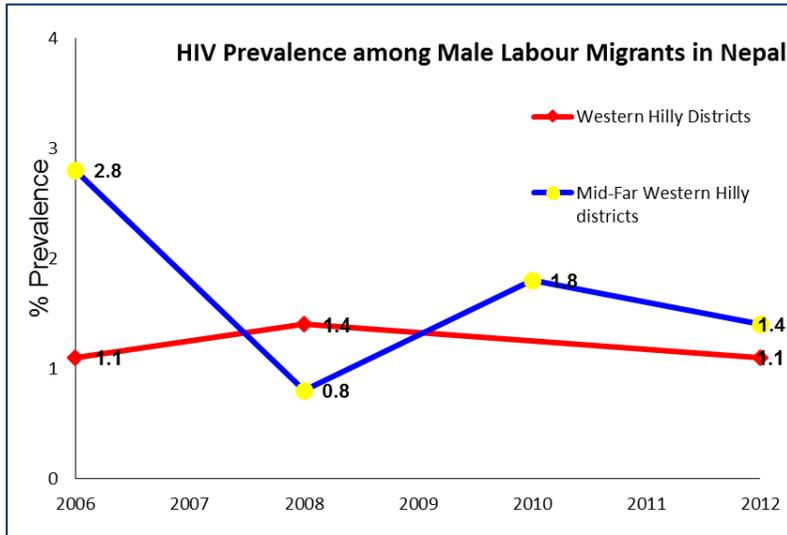
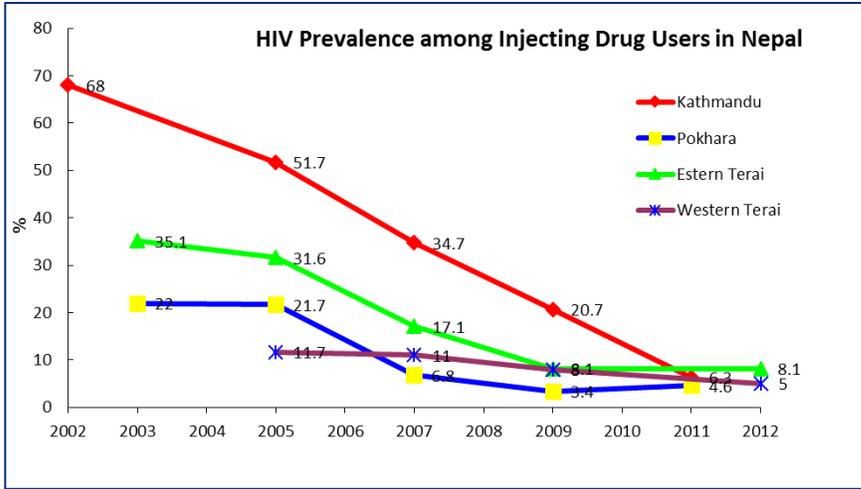
NEPAL	FY 2012 653(a) Allocations				FY 2013 653(a) Allocations				FY 2014 653(a) Allocations				FY 2015 653a Initial Distribution (4-2-2015)			
	Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID			Sum of Accts	USAID		
		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF		DA	GHP-USAID	ESF
3.2 Education	5,000	5,000	-	-	9,554	9,554	-	-	5,000	-	-	5,000	10,000	-	-	10,000
3.3 Social Assistance																
4 Economic Growth	24,252	9,088	-	15,164	19,327	8,683	-	10,644	20,000	-	-	20,000	17,000	-	-	17,000
4.1 Macroeconomic Foundation for Growth	405	-	-	405	-	-	-	-	-	-	-	-	-	-	-	-
4.2 Trade & Investment	404	-	-	404	500	-	-	500	-	-	-	-	-	-	-	-
4.4 Infrastructure					-	-	-	-								
4.5 Agriculture	10,000	-	-	10,000	9,644	-	-	9,644	10,000	-	-	10,000	8,000	-	-	8,000
4.6 Private Sector Competitiveness	2,355	1,500	-	855	500	-	-	500	-	-	-	-	-	-	-	-
4.7 Economic Opportunity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.8 Environment	11,088	7,588	-	3,500	8,683	8,683	-	-	10,000	-	-	10,000	9,000	-	-	9,000
5 Humanitarian Assistance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5.2 Disaster Readiness	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>81,667</b>	<b>81,667</b>			<b>79,905</b>	<b>79,905</b>			<b>74,833</b>	<b>74,833</b>			<b>78,700</b>	<b>78,700</b>		

Update: April 3, 2015



# ANNEX 10. HIV/AIDS INFORMATION





## USAID HIV/AIDS Contributions

Period	Project	Achievements/comments
1993–1997	AIDSCAP I	<ul style="list-style-type: none"> <li>• 1<sup>st</sup> HIV-focused project in Nepal.</li> <li>• Condom promotion, treatment of sexually transmitted infections, awareness, policy advocacy</li> <li>• Baseline study on sex work</li> </ul>
1997–2001	AIDSCAP 2	<ul style="list-style-type: none"> <li>• Continuation and expansion of program districts</li> <li>• Government capacity building</li> <li>• Surveillance and 1<sup>st</sup> behavioral study initiated</li> </ul>
2001–2003	Implementing AIDS Prevention and Care (IMPACT)	<p>The IMPACT/Nepal strategy was structured on the three intermediate results to establish and expand the prevention-to-care continuum of services:</p> <ul style="list-style-type: none"> <li>- Increase national capacity to manage an effective response to the HIV epidemic;</li> <li>- Improve prevention of HIV and other sexually transmitted infections; and</li> <li>- Implement appropriate care and support strategies to mitigate the impact of the HIV epidemic</li> </ul> <ul style="list-style-type: none"> <li>• Continuation of previous work</li> <li>• Introduced home-based care for people living with HIV/AIDS</li> <li>• Established HIV testing and counselling services</li> <li>• Total funding available: USD 18,720,000</li> </ul>
2001–2002	Nepal Initiatives	<ul style="list-style-type: none"> <li>• Consortium funding, mostly DFID with USAID, AusAID, UNDP, UNAIDS</li> <li>• Risk reduction services to key populations</li> <li>• First time included population of men who have sex with men</li> </ul>
2005–2013	DELIVER	<ul style="list-style-type: none"> <li>• Support in developing a commodity security approach for HIV/AIDS products so that ART and voluntary counseling and testing services can be expanded as smoothly as possible</li> <li>• Technical assistance in the development of standard operating procedures for HIV/AIDS logistics and lab</li> <li>• Forecasting, quantification, products, distribution and transportation of HIV/AIDS commodities</li> <li>• Capacity building (training) of store staff working on integration with main logistics system of LMD</li> <li>• Funds available: approximately USD 50,000 per annum (about 4 million for eight years)</li> </ul>
2003–2007	IMPACT-2	<ul style="list-style-type: none"> <li>• Continuation of previous activities</li> <li>• Organized cross-border program</li> <li>• National capacity building</li> </ul>
2007–2011	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal (ASHA) Project	<p>ASHA works toward achievement of five results:</p> <ol style="list-style-type: none"> <li>1. Reduced HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations</li> <li>2. Increased capacity of the GON MOHP and civil society to manage and implement HIV/AIDS activities and to inform policy formulation</li> <li>3. Improved planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response</li> <li>4. Increased access to quality care, support and treatment services through public, private and non-governmental sources for persons living with HIV/AIDS and their families</li> </ol>

Period	Project	Achievements/comments
		5. Creation of linkages among stakeholders and support for national coordination of Nepal's cross-sectoral HIV/AIDS program
2004–2009	Policy Project	<p>Achieve a coordinated multisectoral response to mitigate HIV/AIDS and provide equitable access to prevention, treatment and care</p> <ul style="list-style-type: none"> <li>• Two-phase: first was implemented through Futures Group, second was linked with ASHA project</li> <li>• Focused on policy development process and capacity building of government and NGOs</li> </ul>
2011–	Saath-Saath Project	<p>To reduce the transmission and impact of HIV and AIDS and improve reproductive health among selected most-at-risk populations in a manner that supports GON services at the district and local levels.</p> <p>The program is guided by four key principles: strengthening host-country and local ownership; increasing effectiveness; institutionalizing coordination and collaboration; and building local capacity.</p> <ul style="list-style-type: none"> <li>• 33-district coverage, focused on most-at-risk population</li> <li>• GON capacity on policy process and use of strategic information.</li> <li>• Available funding: USD 27.5 million</li> </ul>



**Global Health Performance Cycle Improvement Project**

1299 Pennsylvania Avenue NW, Suite 1152

Washington, DC 20006

Phone: (202) 625-9444

Fax: (202) 517-9181

[www.ghpro.dexisonline.com](http://www.ghpro.dexisonline.com)