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AN EVALUATION OF AID-FINANCED HEALTH AND
FAMILY PLANNING PROJECTS IN NEPAL

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PREFACE

An exchange of messages between AID/W and USAID/N in late fall 1979 resulted in the decision to conduct an evaluation of AID-supported health and family planning projects in Nepal. Two specific projects were identified for evaluation: Project H 367-0126, Integrated Health Services, and Project H 367-0096, Population/Family Planning. The Terms of Reference* for the evaluation, prepared by ASIA/TR/HPN and ASIA/PN/M, specified that:

This evaluation should encompass policy, management and logistical concerns. The evaluation should seek to discover basic lessons that can be applied to continuing efforts in the health and population fields in Nepal. Since the projects have been operational for a number of years, the last five to six years of activity should be the focus of this evaluation.

The Terms of Reference also includes several suggestions on the composition of the evaluation team; the make-up of that team is not discussed in this report.

The members of the evaluation team were:

- Robert Y. Grant, Team Leader (APHA)
- Laurier Mailloux, Ph.D., Social Anthropologist (USAID/N)
- Robert Mills, Program Officer (USAID/N)
- F. Curtiss Swezy, Dr. P.H., Financial Management (APHA)
- Theresa van der Vlugt, M.D., Medical, Personal Services Contract (USAID/N)

The study was carried out during February and March 1980; the team made field visits, held interviews in Kathmandu, and extensively reviewed pertinent documents. The presence in Nepal of an UNFPA Project Development Team and of a joint WHO-UNICEF-HMG team, which was reviewing the Expanded Program of Immunization, and the periodic and sometimes lengthy absences from Kathmandu of key program contractor and donor personnel were troublesome facts of life with which the team had to cope in carrying out the evaluation.

After the two APHA consultants arrived in Kathmandu and the team was assembled, the evaluation team collaborated on the development of the Scope of Work (see Appendix B), and the initial outline for the evaluation report

*See Appendix A.

was prepared. The outline was revised as work progressed, but the final report organization does not differ substantially from the original.

The Scope of Work called for an examination of family planning and health service projects and activities in Nepal, health and population policy, the HMG delivery system, and USAID/N-funded projects that support the Nepal Government's efforts. The team was also asked to assess projected support for the HMG-proposed program in the Sixth Plan period (1980-1985). The team's findings and recommendations on the various program elements are summarized in a separate section of this report (see pages xiii-xix).

The various team members each had a specialized knowledge of or interest in specific activity areas, and divided their tasks accordingly, devoting particular attention to one or more of these areas. For the most part, however, the team worked across the board. Mr. Mills provided especially useful background material on the two USAID projects, Population/Family Planning 367-0096 and Integrated Community Health Project 367-0126. Dr. Mailloux prepared the section on demographic conditions and the section entitled "Nepal Context," using data gathered from previous field trips to the Hills area.

February 6-8, Messrs. Grant and Swezy went to the city of Janakpur, in Dhanukha District, to observe a sterilization "camp" run by a HMG Family Planning/Maternal and Child Health Project team of two surgeons and support staff. (During the 44-day camp, 3,479 clients were processed and 3,101 laparoscopic sterilizations performed.) During their three-day stay, they visited the Zonal Hospital, Janakpur, Family Planning Association offices, a District Hospital, and a Family Planning Association/Small Farmers Cooperative joint project.

February 15-17, Mr. Grant visited Nepalgunj area, where the office of the Banke District Integrated Community Health Project is located. He also called on the regional FP/MCH office in Nepalgunj and joined in the field a WHO/ICHP team assessing the operation of the Expanded Program of Immunization.

Between February 16 and 21, Mr. Swezy visited the districts of Bara, Parsa, and Chitawan, where he observed work and held discussions in three District Health Offices, two District Hospitals, one Zonal Hospital, and three Health Posts. He also met with staff of the Chitawan Branch of the Family Planning Association of Nepal.

The team wishes to thank the many Nepalis, in and outside of government service, who gave unselfishly of their time to make the evaluation accurate. We were particularly struck with host country officials' willingness to discuss frankly and openly both the positive and negative aspects of the program.

The cordiality and support of the USAID Mission made our stay in Nepal pleasant and enabled us to make more efficient use of our time. Similarly, representatives of other donors to the HMG health sector were most gracious in sharing their ideas and program documents. Without this assistance the team would not have been able to assess USAID/N's contribution in support of the entire health sector.

The team would like to extend special thanks to Badri R. Pande, M.D., Chief, FP/MCH Project, and Rita Thapa, M.D., Chief, ICHP. They did everything in their power to make this evaluation of USAID/N's contribution to the health sector accurate, complete, and fair. We sincerely appreciate this effort, coming as it did in the middle of the "peak" season for rural health extension. While the team takes full responsibility for the limitations and shortcomings of this report, it does so with full knowledge that Drs. Thapa and Pande did everything possible to keep us on the right track. For this we are most sincerely grateful.

For a list of key personnel contacted, see Appendix C.

A large number of program documents, project agreements, project papers, and the like was reviewed; these are cited in the report where appropriate. A list of resource documents, other than program papers, is given in Appendix D.

Abbreviations and acronyms for many of the terms used in this report are listed in Appendix E.

EXECUTIVE SUMMARY: FINDINGS AND RECOMMENDATIONS

The evaluation team was asked to address specifically the two USAID/Nepal (USAID/N) projects on health and family planning that are nearly completed.* The evaluation was to cover policy, management, and logistical concerns; because at least one of the projects has been operational for a number of years, the team was to concentrate on the last five- to six-year period. One of the team's objectives was to try to determine what basic lessons can be applied to continuing efforts in health and population (and family planning) in Nepal.

The team evaluated the two USAID-financed projects (Integrated Health Services) and Population/Family Planning designed to provide assistance to His Majesty's Government's (HMG's) efforts to develop viable health and family planning service delivery systems. The team devoted considerable effort to examining HMG's delivery systems and the socioeconomic and political backgrounds against which they operate. The team sought to identify those areas where USAID/N might be better able to contribute to HMG's efforts to improve the effectiveness of health and family planning service and delivery (as well as population activities in general). The team did not "evaluate" the Nepalese Government's health and family planning (and population) programs but reviewed them to determine how USAID/N (or one or another donor) might better assist the Government in improving program operations.

The key findings and recommendations of the evaluation are summarized in the following paragraphs. (Note: A detailed, 50-page summary of the complete report has been published by the American Public Health Association under the title Summary Report: Evaluation of Two AID-Financed Health and Family Planning Projects in Nepal.)

*Population/Family Planning (H 367-0096), FY 1967-1979; Cost: \$7,826,551
plus Rupees 59,855,048
Integrated Health Services (H 367-0126), FY 1976-1979; Cost: \$1,820,200
plus Rupees 10,719,359

FINDINGS AND RECOMMENDATIONS

A. USAID/N Financed Health and Population/ Family Planning Projects - Goal Achievement

Finding:

The goals of the two USAID/N-financed projects have, for the most part, been met.

Recommendation:

USAID/N should continue to provide support to HMG's health and family planning/population activities. USAID/N should continue to coordinate its support with the contributions of other donors.

B. The Demographic Setting

Finding:

There is a demographic crisis in Nepal. The population growth rate, 2.6 percent annually, is at the highest point in Nepal's history and is still climbing. Marginal land is being farmed; yields are dropping. Economic growth, approximately 3 percent annually, is barely holding its own. By any standard, the health situation is poor: Life expectancy is short, infant mortality is high, and malnutrition is widespread.

Recommendation:

USAID/N should make sure that population concerns are addressed in all USAID/N-supported development projects. It should encourage HMG and other donors to address the population growth problem, as well as the health of the nation, in development projects.

C. National Population and Health Policy

Finding:

In the last 10 to 15 years, Nepal has developed a national policy to control population growth. The country also is determined to provide minimal basic health services to all through an integrated delivery system.

Recommendation:

USAID/N should assist Nepal in its efforts to implement the stated policies. It should continue to encourage the Government to establish the Population Commission (POPCOM) as a fully operational agency. USAID/N also should continue to support HMG's efforts in health and family planning by channeling support through the technical/administrative structures (i.e., FP/MCH and ICHP projects) established by the Government.

D. The Nepal Context

Finding:

Given the socio-political and cultural environment, development work is difficult and takes longer in Nepal than in most other developing countries.

Recommendation:

USAID/N should plan to provide more funds and technical assistance to support Nepal's health, family planning, and population programs than it usually provides to most developing countries. USAID/N should plan to contribute increased family planning and health program support to Nepal during the Sixth Plan and for another 10 to 15 years.

E. Service Delivery

Finding:

The health and family planning service delivery systems provide inadequate coverage and the quality of the services could be improved.

However, systems are expanding and reaching a steadily increasing proportion of the population. The number of family planning acceptors continues to rise.

The demographic impact of the family planning program is minimal. The health status of the population has not improved significantly, according to the data now available. These situations may reflect inadequate reporting, inadequate supplies, and inadequate management, staff skills, and training.

Recommendation:

USAID/N should continue to encourage HMG to increase health and family planning service availability, to improve the quality of the service delivered, to strengthen family planning motivation, to include more women in the service delivery system, and to increase its effort to retain family planning acceptors. Additional emphasis should be placed on strengthening the voluntary surgical contraception (VSC) service component of the family planning program, especially at static sites. Improved client follow-up should be stressed. Supervision, especially supervision of health-related activities, should be emphasized. Increased USAID/N support is strongly recommended.

F. Financing of Programs

Finding:

HMG is contributing substantial financial support to health and family planning programs. Government support, especially for health service development, has been increasing. Donor support (both contributions in foreign exchange and in Rupees) has covered roughly 50 percent of total program costs. However, fewer funds than are required have been provided. Fund-release difficulties have compounded the problem of insufficient support. The national expansion of health and family planning services to meet the country's requirements will place an almost intolerable financial burden on Nepal.

Recommendation:

USAID/N should try to ensure that increased local currency support will be available for health and family planning service programs; it should encourage other donors to do the same. Efforts to improve financial administration and accounting should continue. Nepal should continue to review priorities when preparing five-year plans to ensure that sufficient financial resources are available.

G. Program Supply and Logistics

Finding:

The supply of contraceptives, except injectables, for the family planning program is more than adequate, but there is a continuing and chronic shortage of medicines for the health delivery and MCH systems. Commodity management, though poor, is improving. Transport availability has been inadequate in both programs. Commodity storage, training, and administrative facilities do not meet program needs.

Recommendation:

USAID/N and other donors and HMG should seek ways to make more medicines available to the programs. USAID/N also should continue to provide assistance to HMG in improving commodity and logistics management.

H. Technical Assistance

Finding:

USAID/N has provided strong technical assistance to HMG health and family planning agencies. Other donors also have provided such assistance. The USAID-financed University of California and Management Sciences for Health teams have been instrumental in the development of family planning and health service organizations in Nepal. However, the service networks are weak technically and poorly managed, hampering efficient and effective service delivery. USAID/N health and family planning staff are effective. However, the staff appears to be too small to adequately monitor the contract teams or to monitor program surveillance.

Recommendation:

USAID/N should contract for more technical assistance to help correct service delivery problems. A single institution with a strong institutional development bias (as opposed to a purely problem-solving function) should be selected to provide assistance. USAID/N should monitor contracts more closely and try to increase the number of staff in the Health and Family Planning Office.

I. Program Staff Development and Training

Finding:

USAID/N and other donors have supported and encouraged Government efforts to train and develop service staff. Through contractors and directly, USAID/N has provided large-scale overseas technical training for program personnel. The USAID/N participant program has been instrumental in developing staff capability for the health and family planning service delivery programs. The returnee retention rate is high, and staff training is strongly emphasized. Nonetheless, both the number of staff trained and the skills acquired are inadequate and do not meet the programs' requirements.

Recommendation:

USAID/N should continue to support participant training for health and family planning staff development. It should encourage and support HMG staff training efforts, and encourage other donors to assist the efforts.

J. Non-Government Service Delivery

Finding:

Innovative, non-government service delivery modes, such as the AID/W-financed Commercial Retail Sales Project (a contraceptive distribution program),¹ have made a unique contribution to the Nepal family planning program. The Nepal Family Planning Association (FPAN) [with support from Planned Parenthood Federation (IFFP)] pioneered the development of family planning programs and continues to play an important role. The FPAN is cooperating with the AID/W-financed Association for Voluntary Sterilization (AVS) on service expansion. Other foreign volunteer groups are making useful, innovative contributions to the health field. For example, one group is studying fee-for-service health care.

Recommendation:

USAID/N should encourage HMG to allow non-government groups to enter the health and family planning service delivery fields. HMG should

¹The team feels that the concept of commercial viability, which was written into the CRS project, is not valid.

promote innovative service delivery and seek "beyond family planning" inputs. USAID/N should seek the resources needed to continue the CRS Project another two years. (Commercial viability should be de-emphasized.)

K. Population Growth

Finding:

Although the Nepal Government has adopted a national policy to control population growth, it does not, the team believes, fully recognize the serious consequences of rapid increases in population. Neither HMG officials nor the Nepalese population at large seem to understand or be aware of the detrimental effects of rapid, unchecked population growth.

Recommendation:

USAID/N and other donors should encourage HMG to establish the Population Commission as a fully operational entity and to support its work.

I. DEMOGRAPHIC FEATURES OF NEPAL

Introduction

Nepal's population is approximately 14,000,000,¹ the growth rate an estimated 2.6 percent per annum. The median age of Nepal's population is 22.3 years. Nepal has one of the highest infant mortality rates in Asia: 152/1,000 live births.

According to 1971 census data, 49.3 percent of Nepal's population were female; 39.9 percent of these women were less than 15 years old, 5.8 percent 59 or older. Between 1952 and 1961 and 1961 and 1971, life expectancy improved throughout Nepal; but while men gained 20.4 years, women gained only 16.8 years. Frequent pregnancies, nutritional deficiencies, traditional birthing practices, and a lack of prenatal and postpartum care have contributed to the increase in the female crude death rate.²

The cumulative fertility rate of Nepalese women is 6.1 children per female. However, due to infant mortality, women have a completed family size of 4.0 children by the time they reach age 50. Age-specific fertility rates indicate some variation, although peak fertility throughout Nepal is reached between the ages of 25 and 29.³

Population Growth

Data on population in Nepal are insufficient to support accurate measurement. However, various statements, or summaries, on population have been put forth. One statement summarizes the population growth rate picture from 1911 to 1954, as follows: "The average rate of growth during the period of 43 years from 1911 was 1.2 percent a year. It was 2.2 percent over the period of 24 years from 1930 to 1954 and 2.9 percent over the 13 years from 1941 to 1954."⁴ In 1971, the population was 11,289,000;

¹This figure is based on data in recent IBRD reports and is consistent with figures used in the proposed Rural Integrated Health Project Paper. However, the team notes that the U.S. Bureau of Census reported a population of 15 million. (See Country Demographic Profile of Nepal.)

²Acharya, Meena, Statistical Profile of Nepalese Women, Kathmandu, Nepal: Centre of Economic Development and Administration, 1979.

³Ibid.

⁴See MacFarlane, Alan, Resources and Population: A Study of the Gurungs of Nepal, Cambridge, 1976.

by 1980 it had increased to 14,000,000. A variety of studies indicates that the population of many villages increased roughly fivefold between 1850 and 1950. If family planning is not adopted by the year 2000, Nepal's population is projected to reach 22,000,000.¹

Nepal's family planning program is over 10 years old. The number of acceptors has increased from less than 2,000 in 1966-1967 to over 215,000 in 1978-1979. There was a decline in 1976-1977, perhaps because of adverse publicity about family planning in India, but the decrease was only temporary. Nevertheless, a disappointingly small number of couples is using contraceptives in a country where the program is over 10 years old.

In Nepal cultural norms reinforce a tendency toward large families. One hundred years ago, when the population was small, a slowly expanding rural population could be absorbed without serious difficulty. But conditions have changed. Population growth has spiraled, partly because certain epidemic diseases, such as cholera, smallpox, typhoid, plague, and malaria, have been controlled. The control of epidemic diseases has contributed to a change in Nepal's mortality rate that has not been matched by a similar change in fertility.

Health Profile

Although certain epidemic diseases have been controlled, the standard of health is poor. Polluted water is a major source of disease in Nepal. Dysentery, diarrhea, and intestinal parasites are the most common water-borne health problems. Only about 8 percent of the population has access to piped water.

Respiratory infections and measles are common among children and major contributors to high rates of infant and child mortality. Tuberculosis is widespread, afflicting both the child and adult population. Approximately 700,000 BCG vaccinations are given annually.² There has been a resurgence of malaria in southern Nepal, where mosquito resistance to DDT has been increasing.

Another serious health problem in Nepal is malnutrition. A nutritional survey found that approximately 50 percent of the children below six years of age had reached less than 90 percent of median height for age (an indication of long-term nutritional deprivation) and 17 percent of the entire survey population showed definite short-term nutritional deprivation. Although similar data are not available for the entire population, it is safe to say that much of the population exists below "minimum subsistence."

¹World Development Report, 1978.

²Economic Memorandum on Nepal, Asian Development Bank, 1979.

A large part of the health budget is used to provide health services to the urban population. Over 50 percent of the country's 1,500 hospital beds are located in Kathmandu. The majority of the country's hospitals are small, 15-bed units that are relatively expensive to equip and staff, and they are unable to provide comprehensive hospital services. The rural health effort focuses on Health Posts, small centers staffed by paramedical personnel who provide basic health services. There are approximately 500 such posts in Nepal. Most are understaffed and must contend with a shortage of medical supplies.

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II. THE NEPAL CONTEXT

II. THE NEPAL CONTEXT

Ecology

Nepal's land area, 142,000 square kilometers, is divided into three parallel regions running east and west: the Mountains, the Hills, and the Terai, an extension of the Indo-Gangetic Plain. Arable land is limited to 21 percent of the total land mass. Over 60 percent of Nepal's 14,000,000 people live in the Mountains and Hills. The population density for this area of arable land exceeds 1,500 persons per square kilometer.

Nepal is part of a larger ecosystem that includes Bihar, Uttar Pradesh, West Bengal, the Assam States of India, and Bangladesh. The effects of Nepal's population growth spill over into these regions. The floods and droughts that occur yearly in the Indo-Gangetic Plain are partly the result of ecological degradation in the catchment areas of Nepal. Therefore, Nepal's success in controlling its population growth, and its future plans for the population control program, will not only affect Nepal but have serious repercussions in northern India and Bangladesh.

The unique physical features of the Himalayas contribute to ecological problems. Because of the relatively young geologic age of the mountains, tectonic instability, and the monsoon, the steep slopes erode easily. But the increased human population in the Hills has also had an impact on this delicate ecological situation. Deforestation and the use of inappropriate agricultural techniques on unsuitable land have led to increased erosion and the loss of fertile topsoil. It has been estimated that between 20 and 25 tons of soil per hectare are lost each year. Flooding and serious siltation problems in neighboring countries have accompanied this loss.

Until recently, Nepal was able to cope with its expanding population through mass migration from the Hills to the Terai. However, this proved to be only a temporary safety valve, and most of the arable land in the Terai is now under production.

Ecological pressure is clearly evident and many villagers are aware of the deteriorating conditions and of the negative effect they are having on their environment. While this recognition is an important precursor to behavioral change, other economic and cultural factors exist which may favor immediate fertility even when long-range ecological destruction is assured.

General Economic Overview

With an estimated per capita income of \$120, Nepal is among the poorest of the Relatively Least Developed Countries (RLDCs). At least one-third

of the population lives below the official accepted minimum level of subsistence, \$60 per capita. Because it is landlocked, Nepal must depend for trade and transport on India, its more developed neighbor. Nepal's monetized economy is strongly influenced by the level of wholesale prices in India. Indian inflation is accelerating and is predicted to rise as high as 20 percent in 1980. This situation, coupled with Nepal's expanding money supply (estimated at 15 percent annually) and the increasing availability of domestic credit, is expected to contribute to inflationary pressures and weaken Nepal's balance of payments position.

Nepal's economy is primarily based in agriculture, which accounts for over 90 percent of the labor force. Population is increasing at a rate of 2.6 percent per year and is exceeding increases in agricultural production. Exports of foodgrains are declining. Due to population expansion, poor agricultural harvest, and inflation, no perceptible economic growth occurred in 1979.

Nepal is further characterized by internal inequalities in the spatial and social distribution of resources. The Hills region, which supports over 60 percent of the population, has a weaker resource base than the Terai. The vast majority of farmers own an average 0.4 hectares of land. In the Terai, the breadbasket of the country, 3.3 percent of all the farmers own 27 percent of the land, with the average size of cultivated holdings 18 hectares. Forty percent of the farmers are tenants with insecure tenancy relations, and 23 percent of all households are landless. In comparison with the Terai, there is greater economic equity in the Hills; however, it is equity in poverty.

The precise effect that equity has on fertility and population programs is difficult to assess. It can be argued, however, that wealth may enhance social status, and this may have a considerable impact on access to health care in Nepal. From an administrative perspective, Nepal's overall weak economic structure adversely affects HMG's ability to implement projects and AID's ability to assist in the process. For example, high inflation and the serious shortage of construction materials hinder efforts to construct service facilities. Furthermore, negligible investment in industry and reliance on the agrarian sector and imports for a tax base strain HMG's financial situation. This makes timely financing of project development costs and recurrent expenditures difficult.

Culture, Health, and Population

Nepal is culturally diverse, which makes generalizations difficult and sometimes deceptive. The country is characterized by a predominant Hindu cultural tradition in which Tibeto-Burman ethnic groups become involved to varying degrees. Three major religious traditions are found in the country: Hinduism, Buddhism, and Islam. A hierarchical caste system further cross-cuts these diverse traditions; the major stratas, varnas, are internally

subdivided into numerous subcastes, jats, which vary by region. Finally, over 50 Indo-Aryan and Tibeto-Burman languages are spoken in Nepal.

Despite the acknowledged diversity, careful generalizations about the society can be made. For example, much of the populace follows economic patterns characteristic of Nepal's predominantly subsistence agriculture base. Throughout the country, the varying influences of the dominant Hindu culture are evident, particularly in caste and status hierarchies. The official adoption of Nepali, which is understood by approximately 85 percent of the population, has facilitated communication.

Nepal has been open to the outside world only since the early 1950s. Many of the sociocultural responses and their implications for development must be understood from this perspective. The country never went through a period of colonial domination; consequently, it experienced neither the negative nor positive effects of foreign rule. From a developmental perspective, the latter is particularly obvious: Nepal has almost no physical infrastructure. Some educated Nepalese living in Kathmandu and a few other urban areas advocate the national integration of economic, social, and political ideals, but this notion has not been communicated to the rest of the nation's inhabitants. Although political unity was attempted under the Panchayat system of government, a multi-tiered representational structure, Nepal is still trying to achieve integration among those who owe their loyalty to diverse and discrete cultural and economic groups.

It is within this context that USAID/N's efforts in the health and family planning sector must be evaluated. Comparisons with programs in other countries can be deceptive. In Nepal, culture and fertility, cultural accommodations of modern health care, and the Nepalese development policy and policy process have a direct impact on USAID/N's health and family planning assistance. Each of these influences is discussed below.

A. Culture and Fertility

Numerous examples can be cited to support the claim that large families are perceived as the means to improve economic status or prevent its further deterioration. In Nepal, the majority of rural households adopt several strategies to deal with their precarious economic conditions. Although holdings are small and agricultural productivity low, land ownership is still viewed as security. Crop production is supplemented by livestock rearing. The availability of capital also is linked to seasonal migration of workers in search of wage labor.

The economic structure of rural Nepal is reflected in the organization of domestic life. Large families are encouraged because many people are needed to perform the different tasks of production. Children, in general, are valued because they increase the size of the household work force. Their labor value begins around age five and becomes a major contribution

by age 10.¹ There is a strong cultural preference for male children. Hindu Nepal is organized into patrilineages, where male children assume an economic value as corporate members of the household by providing labor and income. The system of property rights and inheritance requires that the household estate be distributed among sons. Residence patterns reflect this, for males bring into their natal group wives who contribute to the labor supply of the household and bear offspring.

Not surprisingly, religious values and presumptions reinforce the importance of these economic needs and the preference for male children. Hindu religious tradition is strongly pronatalist; the procreation of children is viewed as the only legitimate reason for sex and marriage. Furthermore, death rituals, which provide for the welfare of departed souls, can only be performed by sons. This is an extremely important religious duty in a society in which religion is an integral part of daily life.

Literacy, not a determinant of women's status, is important because it exposes women to modern ideas of health care and family planning. In Nepal, as in most developing countries, women have little access to educational opportunities. The disparity between male and female literacy rates is significant: The 1971 census reported that 24.7 percent of the males and 3.66 percent of the females were literate. A more recent and perhaps more reliable study placed female literacy in 1978 at 3.8 percent.²

The political and administrative participation of Nepalese women in government is minimal. The vast majority of women in Nepal know nothing of Nepalese politics or of political processes of countries outside the Kingdom of Nepal.

Although involved in some labor-intensive construction activities, over 50 percent of all women are agricultural workers. This female labor force could be targeted for increased involvement in development activities. By transferring new skills to and providing women with access to economic opportunities, the female population might be made more receptive to family planning. Women with economic leverage have far greater control over their lifestyle and reproductive behavior than do economically dependent women.

At present, Nepalese women's status is closely linked to motherhood. The cultural norms governing marriage and motherhood are thus motivational, affecting fertility decisions. Marriage is virtually universal in Nepal.

¹Peet, R. Creighton, A Report on the Anthropological Study of the Cost and Value of Children in a Nepalese Village, New York: Columbia University, 1974.

²Vaidya, Kokila, Dhungel, Bashundhara and Carlaw, Raymond, Social Network Survey of Nepali Women, Kathmandu, Nepal: FP/MCH Project, 1978.

While legislation has been passed to restrain such practices as child marriage and plural marriage, in Nepal, even in the cities, where more educated Nepalese live, these practices persist. Furthermore, despite efforts to legalize abortion, it is still considered a crime and classified as homicide.

In spite of recent national programs promoting family planning, people are culturally induced to fear and avoid the state of childlessness. The consequences of childlessness are more severe for women than for men. In Hindu Nepal, a woman's status depends on her fertility, and the childless woman is not only subject to pity and contempt but is also excluded from many rituals and social activities and is apt to be accused of witchcraft.¹

A woman's fertility is not viewed as a function of physiology, but a reflection of her moral history, or karma. It is contended that a woman's fertility rests on the spiritual merit she accrued in previous lives. Thus, a woman's ability to bear a large number of children, especially males, is proof that she was virtuous in previous lives.

Certain structural features of Hindu society discourage family planning. Polygamy is only approved in the case of a deficiency in the first wife's fertility. In fact, if after five or six years a woman bears no children or only daughters, her husband is duty bound to take another wife.² The ability to bear sons also gives women some potential power. Often they are able to affect the distribution of resources and decision making indirectly by working through informal channels to influence their husbands and sons.

Today, the cultural values that orient social life toward successful fertility appear to be holding fast and are difficult obstacles to overcome. It is also doubtful that women's status will be divorced from childbearing at any time in the near future. The cultural stress on fertility is strong, but the high fertility rate at this time is by no means absolute or irreversible.

Since 1967, close to 100,000 persons--70 percent of them men--have undergone surgical contraception (see Table 24, pages 92, ff.) Abortions are also known to occur, with moral distinctions made between early and

¹Stone, Linda, "Cultural Repercussions of Childlessness and Low Fertility in Nepal," in Contributions to Nepalese Studies, Vol. 5, No. 2, Kathmandu, Nepal: Tribhuvan University Press, 1978.

²See Bennett, Lynn, "Sex and Motherhood Among Brahmans and Chhetris of East-Central Nepal," in Contributions to Nepalese Studies, Vol. 3 (Special Issue), Kathmandu, Nepal: Tribhuvan University Press, 1976. See also, "Traditional and Legal Status of Nepalese Women," in Status of Women Project, Vol. I., Kathmandu, Nepal: Tribhuvan University, Centre for Economic Development and Administration, 1979.

late pregnancy terminations. Village women are positive about birth and motherhood, but nonetheless ambivalent about their fertility. This is clearly evident in villagers' symbolic portrayals of conception and birth which involve complex notions of purity and pollution.¹ In addition, many of the labels and stigmas attached to "inauspicious" women who are childless are the extremes of fertility failure. A woman who bears only one child and is thereafter infertile suffers a milder form of ostracism than does a woman who has never conceived.²

Nepal's lack of success in significantly altering reproductive behavior does not mean that this behavior is culturally unalterable. The potential for increasing receptiveness to family planning is present. It is held by some that if villagers were more confident that their children would survive (i.e., if improved health care was available), they would probably be less likely to bear so many children and the presently high birth rates would be lowered. Certain cultural obligations could be met without numerous children. Villagers acknowledge that funeral obligations could be fulfilled by one living son. Providing women with more economic and social opportunities could also significantly influence a couple's decision to have children. A more immediate strategy which might reach larger numbers of village women in the sexually segregated Hindu society would be to use more female motivators.

B. Cultural Accommodations of Modern Health Care

A striking feature of indigenous medicine in Nepal is the ease with which naturalistic treatments are combined with metaphysical systems of curing.³ In principle, this flexibility allows for the introduction of modern medicines with little disruption of traditional medical systems.

Specifically, religion in Nepal extends beyond the formalized Hindu, Buddhist, and Islamic boundaries to include shamans, witches, a variety of spirits, and supernatural forces. Illness is attributed to physical as well as metaphysical and supernatural forces. A person who is ill is generally taken to a local healer who possesses curative and semi-religious powers. There are various types of healers, collectively called dhami jhankri, and various levels of traditional medicines--herbal, ayurvedic, and ritual--all of which are integrated into a complex healing system.

¹Bennett, 1976.

²Stone, 1978.

³See Stone, Linda, "Concepts of Illness and Curing in a Central Nepal Village," in Contributions to Nepalese Studies, Vol. 3 (Special Issue), Kathmandu, Nepal: Tribhuvan University Press, 1976.

On one level, the success of present and future AID-supported health projects will depend on the socio-religious accommodation to modern health care. Favorable evidence indicates that this accommodation will occur in Nepal.

Modern medicines, in particularly high demand in Nepal, are combined with traditional treatments in different ways. For example, on the one hand, it is believed that even the most minor ailments, such as a cut, give a witch (boksi) the opportunity to cause additional suffering. From a villager's perspective, if you take hospital medicine, you get better faster and the boksi has less time to make you sick.¹ In these cases, modern medicines are sought often as a prophylaxis against the spirit world. On the other hand, it is not unusual for villagers to visit a jhankri to rid the body of spirits before visiting a Health Post.

While villagers accommodate modern medicine, social forces act as constraints preventing the success of health projects. The most serious of these problems is the social distinction that separates the rural population from modern, medically-trained practitioners and their institutions.

It should be noted at the outset that the number of trained personnel in Nepal is limited; many Health Posts are short-staffed. There is also a strong disinclination among trained professionals to live in rural areas. These factors affect the availability of health and family planning services and ways in which services are distributed.

In general, the medical services for poor and innocuous villagers are given the lowest priority. The effects of the caste system are carried over into the Health Posts, supposedly egalitarian institutions, and villagers who are treated condescendingly pay a high social price for medical attention. This is a common complaint of villagers and is reflected in "administrative efficiency." A low status individual may spend from six to eight hours waiting for care and, in the process, lose the day's wage or neglect the fields. Some villagers in the Terai have lost interest in hospital services because they have been unable to quickly gain admission to a doctor, even though they may have made as many as three successive visits.²

This differential delivery of services is accentuated by a scarcity of supplies. Health Posts receive medical supplies sufficient to support

¹Blaustain, Harvey S., "Levels of Medicine in a Central Nepali Village," in Contributions to Nepalese Studies, Vol. 3 (Special Issue), Kathmandu, Nepal: Tribhuvan University Press, 1976.

²Wake, C.J., "Health Services and Some Cultural Factors in Eastern Nepal," in Contributions to Nepalese Studies, Vol. 3, (Special Issue), Kathmandu, Nepal: Tribhuvan University Press, 1976.

proper operations for three or four months of the year. These commodities, which are considered scarce resources, are also distributed to Health Post clients according to the social hierarchy.

Modern medical programs are and will continue operating in a distinctive cultural context. Traditional Nepalese health and curing practices can accommodate new inputs, but at present there are different levels of accommodation. Although the demand for medicines, for cures, is high, the use of modern services at the Health Posts tends to be a negative social experience.

A number of strategies can be used to alleviate this situation. At present, there is no charge for services at the rural Health Post. The Health Post In-Charge, serving as head, receives his salary from the Government, irrespective of the number of patients seen. This reinforces the negative reception of clients by health personnel. Furthermore, villagers do in fact pay some of their traditional healers and believe there is a correlation between the efficacy of treatment and the amount paid for it. From this perspective, the establishment of a fee for services would at least encourage the Health Post In-Charge to see as many patients as possible. In addition, if Health Posts were supplied with sufficient stocks of drugs, this could eliminate the distribution of medicines on the basis of rank.

In USAID/Nepal's proposed Rural Integrated Health Project, another strategy will be used to improve the credibility of Health Posts from the villagers' perspective. "Low status" village health workers will be trained and employed in an attempt to make health personnel socially accessible to villagers. If these workers are also supplied with drugs, their effectiveness will be considerably enhanced.

The body of traditional knowledge about illness and curing practices is vast, and many villagers believe they already know the rules for good health. Consequently, health education that is not linked to drug accessibility may not be in high demand. Still, there are, undoubtedly, educational needs that should be met. Certain beliefs, derived from the philosophical notion that "balance" must be maintained in all realms of life, run counter to modern medical knowledge. The most important is the pervasive belief that diarrhea is caused by an imbalance of fluids in the system. Villagers are reluctant to use oral rehydration since adding fluids only increases the imbalance.

C. Nepalese Development Policy and Policy Process

It has been noted in the previous section that although certain cultural restraints inhibit the adoption of family planning and, to a lesser degree, modern medical health care, they are not insurmountable. The

potential for changing behavior depends not only on cultural receptivity but also on the commitment of the government and its ability to implement policy. In Nepal, political commitment to development and the implementation of policy must be viewed as the balancing of the political prerequisites of the monarchical system with the economic goals of a development-oriented ruler.

King Birendra, who ascended the throne in January 1972, is clearly committed to economic development; he has expressed this commitment in major development policies. The Long Term Health Plan, published in 1976, is the planning document that guides the health sector for the fifth (1975-1980) and sixth (1980-1985) five-year plans. The following policies are particularly pertinent:

- Develop basic village health services for the majority of the population;
- Check unwanted population growth;
- Control major infectious diseases; and,
- Educate the populace in health, nutrition, and sanitation.

Health and family planning activities were allocated approximately 5 percent of the budget for both the fifth- and sixth-year plans, with family planning receiving the larger share. A further indication of the priority HMG accorded family planning was the recent establishment of the Population Commission, with the Prime Minister as chairman.* (The Commission is not yet operational because a permanent chief executive has not been appointed.)

Political commitment notwithstanding, policy still operates within economic parameters. In Nepal, the development budget is highly dependent on donor inputs. During the Fifth Plan period, the percentage of external financing for the public sector development expenditure increased from 41 percent to 58 percent; in 1975-1976, the percentage was 41 percent; in 1976-1977, 37 percent; in 1977-1978, 47 percent; and in 1978-1979, 58 percent. An estimated 57 percent of the total support for public sector development will be supplied by external sources during the Sixth Plan period. This indicates that there has been limited mobilization of resources and that development funds largely depend on external sources. A decline in donor funding could adversely affect development activities in Nepal.

Many positive changes have been made in health and family planning within the past two decades, but Nepal still has a high population growth rate and health conditions are far from satisfactory. It cannot be denied

*Now chaired by the Minister of Home and Panchayat.

that some of the development policies have fallen short of achieving their goal. The critical issue is not policy but the institutionalization of the policy process.

In a country such as Nepal, where there is a severe lack of private sector resources, the bureaucracy assumes a major role in performing development-related tasks throughout the country. Any policy process that differentially allocates authority and resources will be characterized by conflicts, and bargaining in both formulation and implementation is common. In Nepal the competition for resources funneled through the various levels of the bureaucracy is intense. The fundamental social bonds that hold Nepalese society together--kinship, patron-client, caste, regional and ethnic ties--are used as springboards by special interest groups that vie for influence over officials responsible for policy enforcement.

During King Mahendra's reign (1955-1972), the bureaucratic structure was only modestly effective as an instrument of policy implementation. The King took a politically cautious approach and was primarily concerned with uniting diverse interests behind the royal leadership. This was understandable, given the political imperative of the monarchy's reemergence as a central institution after a century of dominance by the hereditary Rana Prime Ministers.

By the time King Birendra ascended the throne, the power of the monarchy was well established. He was able to pursue a development strategy in which policymaking and policy implementation were viewed as separate and discrete functions. Policy formulated by the King and a small influential group of individuals was implemented by the bureaucracy. This resulted in the dual structure that holds the bureaucracy together. On the one hand, policy formulation is highly centralized and controlled; on the other hand, the interrelationships of those levels of the bureaucracy responsible for policy implementation are decentralized and multiplex.

For various reasons, the palace Secretariat is now the most influential group of individuals in the entire policy process. They have broad yet vaguely defined power over the bureaucracy. Theoretically, each palace secretary has the power to intervene in "his" respective departments, at his own discretion; but this power is exercised rarely. Still, the effect has been to lessen the authority of the ministerial secretaries, undermine administrative discipline and morale, and divide the bureaucracy.¹ Given the ambiguous supervisory arrangement that exists in Nepal, personnel tend to defer all decisions to their supervisors. This has adversely affected, for example, the efficient distribution of health services to the population.

¹Scholz, John and Rose, Leo, "Trying to Control the Policy Process: Royal Strategies in Nepal" (Unpublished Paper), 1978.

During King Mahendra's reign, the bureaucracy began to rapidly expand the number of personnel it employed and its control over resources. Between 1963 and 1971, the number of civil servants nearly tripled, reaching a total of 3,535 gazetted (managerial) and 23,606 non-gazetted (clerical) positions by 1972.¹ Furthermore, budgetary expenditures increased from 259 million Rupees in fiscal year 1963-1964 to 1,796 million Rupees in fiscal year 1976-1977. In addition, political resources throughout the country and within the bureaucracy are shifting, and numerous alliances continue to develop within the bureaucracy. This is clearly illustrated by the current bureaucratic controversy over the establishment and future role of the Integrated Health Districts (discussed in Chapter III of this report).

In conclusion, the Nepalese bureaucracy largely reflects the complex society in which it operates. In the bureaucracy there are two different organizational structures that to some extent reinforce one another. Policy decision making is highly centralized and based on limited participation. Political commitment to health and family planning is clearly evident, expressed by King Birendra and the elite group of policymakers directly responsible to him. The bureaucratic implementation of policy is decentralized, characterized by shifting alliances and a vague decision making process. Due to the greatly expanded bureaucracy, enormous difficulties arise when decisions must be made on the implementation of development plans. Finally, the size and scope of development projects have expanded, and the technical complexity of those projects has increased. All of this has overloaded the administratively weak system and placed increasing strains on the bureaucracy.

Given the level of economic development in Nepal and the cultural responses to needs, the present fertility patterns and health status are not surprising. What is encouraging is the cultural potential for changing reproductive behavior and increasing the accommodations of modern health care.

USAID/N's and HMG's options are limited by the level of socioeconomic development in Nepal. But there are avenues open to AID and HMG that will allow them to have a positive impact on future family planning and health projects in Nepal. Recommendations in this report are based on the cultural milieu in which the development process is taking place.

III. NEPAL'S RESPONSE TO HEALTH AND POPULATION PROBLEMS

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Development Actions and National Development

A. Health and Family Planning Service Development and Resources

The first "modern medicine" hospital in Nepal was established in Kathmandu at the turn of the century. Several other facilities gradually evolved through government and missionary efforts. A Civilian Health School was established in 1934. By 1952, when Nepal moved into the modern world with the overthrow of the Ranas, 33 hospitals (most in the Kathmandu Valley) had been established and 33 physicians had been trained outside Nepal. The Malaria Control Program began in 1954 with WHO and U.S. Government assistance.

By 1956, the Ministry of Economic Planning (established in 1952) produced the First Five-Year Development Plan (1956-1961) which mandated the creation of the Ministry of Health (MOH). A Health Assistant Training Center was organized and several Health Centers built. A national Malaria Eradication Program was instituted as a "vertical" service.*

Under the Second Development Plan (1962-1965), initial efforts were made to control smallpox and leprosy and more attention was given to manpower planning and training (450 paramedical workers had been trained between 1934 and 1952). With the Third Plan came the first national health survey. The first steps in the tuberculosis control program were taken and a family planning and maternal and child health program was started in 1966; the National Family Planning/Maternal and Child Health Board was established in 1968.

The Family Planning Association of Nepal (FPAN) has been a leader in the development of family planning service delivery. It was one of the first organizations to publicly recognize as a national problem excessive population growth. (Interestingly enough, the growth rate then was approximately 1.8 percent per annum.) Organized in 1959, with support from the London-based International Planned Parenthood Federation (IPPF), the FPAN was "in business" long before the government program began. Indeed, it was instrumental in bringing about government action.

By the end of the Third Plan (1970), there were 37 hospitals, 9 Health Posts (peripheral service centers), and 248 physicians operating in Nepal.

*Vertical programs are uni-service programs with some degree of policy and management independence from the Ministry of Health. They were created to attack high priority problems (e.g., malaria, communicable diseases, and family planning).

In 1969, although the various "vertical" health programs were functioning reasonably well (with substantial foreign financial and technical assistance), HMG publicly recognized the desirability of providing more community-oriented health services. To meet this need, it set up a Community Health and Integration Division in the Department of Health Services (DHS) in the MOH. Pursuant to the national health policy and for reasons of economy and efficiency, the MOH incorporated the concept of integrated basic health services in its proposal for the Fourth Plan (1970-1975). It was encouraged in this direction by the World Health Organization (WHO). In 1970, an Integration Board was constituted in the MOH. Pilot integration projects were launched in two districts, Kaski, in the mid-Mountain area (1971), and Bara, in the Terai (1972). Nepal's priority health problems were identified in the Country Health Programming Exercise, conducted by the MOH in 1974.

By the beginning of the Fifth Plan (1975), the decision had been made to implement countrywide an integrated health services program. The FP/MCH project had already been expanded to include districts in the country operating largely through static clinics. Some 62 hospitals had been established; 301 Health Posts had begun operating and 311 physicians were working in the health system.

With the completion of the health planning exercise in 1974, the stage was set for the creation of the Fifth Plan health and family planning programs (including many programs in malaria eradication, leprosy and tuberculosis control, and expanded training). As noted above, foreign financial and technical assistance played an important role in the development of health services and was continued during the Fifth Plan period.

B. Population and Health Policy Development

The development between 1952 and 1975 of a national health policy is reflected in the history of the Nepal Government's efforts to expand health services, establish Health Posts, train personnel, and implement "vertical" programs to deal with specific high priority health problems. In the Fifth Plan the Government stated its commitment to provide minimum health services to the maximum possible number of people, especially the rural majority.

Health policy development moved, more or less, steadily ahead. Population growth problems were not specifically addressed in the national policy until the Fourth Plan (1970-1975) was implemented.

The main population-related objective of the First Plan (1956-1961) concerned employment. It emphasized only a strategy to absorb the increasing population by reclaiming the Terai and Inner Terai forest for resettlement. The Second Plan (1962-1965) again addressed employment, and emphasized even more strongly resettlement to absorb the increasing

population. The Third Plan (1965-1970) included a chapter entitled "Population and Manpower." It did not mention the measures needed to deal with problems arising from population changes, but recognized the importance of family planning to efforts to stem the rising birth rate.

The Fourth Plan (1970-1975) contained a clearly stated population-related objective: the effective use of manpower resources and control of population growth. The plan recognized that to reduce the birth rate, the "required changes in the economic and social conditions, cultural patterns and aspiration toward life of the common man" must be effected first, and a family planning program then instituted. The plan highlighted the need to adopt labor-intensive technology and use indigenous resources to absorb maximum manpower. The idea of creating non-agricultural employment opportunities was not supported with concrete proposals. Reclamation of new lands was further advocated.

Fifth Plan Period

A. Goals

1. Health

As mentioned in the discussion on the development of health policy, the Fifth Plan stated that HMG policy was to deliver at least minimum service to the maximum population, especially the rural majority. The Fifth Plan listed four specific health priorities:

- To develop as soon as possible integrated basic health services for villagers.
- To run a countrywide family planning and maternal and child health program that will establish necessary control over the increasing population to maintain the balance of economic development.
- To strengthen and expand the programs to eradicate and control communicable diseases such as malaria, smallpox, tuberculosis, and leprosy.
- To strengthen, develop, and expand curative services.

2. Population

The Fifth Plan (1975-1980), which gave particular attention to population, went well beyond what had been included in previous plans.

It recognized the adverse effects of growth and migration and the need for effective policies to use manpower and raise the standard of living. The following policies were adopted:

- To reduce the birth rate by direct and indirect methods. (The plan called for a reduction in the crude birth rate, from 40/1,000 to 38/1,000; a reduction in the infant mortality rate, from 200/1,000 to 150/1,000; and an increase in the number of family planning users--to 700,000, up from 90,000, according to the Nepal Fertility Survey.)
- To control immigration to minimize the role of foreigners in population growth.
- To regulate in a planned way resettlement between the Hills and Terai and from rural to urban areas.
- To increase the agricultural density of the Terai, especially the western Terai, to achieve a rational distribution of population.
- To establish urban centers in selected places by constructing modern facilities that facilitate regional development.

The plan recognized a wide range of population problems, including the growth of school- and working-age populations; pressures to provide social services, housing, health, food, and agriculture; problems of economic growth exacerbated by population growth; high dependency ratios; and high population densities. The policy measures proposed included socioeconomic measures to reduce growth and family planning services and resettlement activities to deal with density. The plan outlined no specific programs that responded to the problems that have been identified.

The Fifth Plan called for the appointment of a Population Policy Coordination Board (POPCOB) to coordinate the work of the various ministries that had implications for the structure, distribution, and nature of population and to suggest means for population control and spatial distribution. The Board was established under the National Planning Commission (NPC) in 1975 with financial assistance from USAID/N. Its membership included the secretaries of the key ministries and some Nepalese specialists on population. By the end of 1977, it was apparent that POPCOB was unable to meet its objectives.

To give greater attention to population, the HMG instituted in July 1978 the National Commission on Population (NCP). The NCP is responsible for devising and overseeing the implementation of national-level population policies and programs. Although it was supposed to be chaired by the Prime Minister, the NCP is now chaired by the Home and Panchayat Minister. Other key government officials are members. Despite the frequent assurances of

top-level Government officials, a regular executive director has not yet been appointed and the Commission is not functioning.

Service Delivery: Integrated Community Health Services Project (ICHP)*

A. Organization

The Nepal Government decided that the best way to coordinate the system of population-based health delivery was by adding a house-visiting component to the static Health Posts. The top health priority for the Fifth Plan was "to develop integrated basic health services (IBHS) in order to provide health services to the village people as soon as possible." A pilot program in two districts, Kaski and Bara, was begun during the Fourth Plan period. The Government then decided to expand the pilot project to cover two of the nation's 14 zones. By the spring of 1975, four additional districts had been added and by late 1975, the decision had been made to expand IBHS throughout the country. A fully integrated health services delivery system was established first in six districts in the Terai. Health Posts in the remaining 69 districts continued to provide static curative services.

During the Project Formulation Exercise, completed in December 1975, the following guidelines on the expansion of rural health services were prepared:

- To establish Health Posts throughout the Kingdom as rapidly as possible to cover the entire population, with targeted Health Post population ratios varying from High Mountain to Terai.
- To expand clinic and field activities in stages over a period of time, requisite staff being added at each stage.
- To undertake the recruitment, both from vertical projects and directly, and training of personnel needed to staff the Health Posts and their field programs.

* The term "Integrated Community Health Services Project (ICHP)" will be used throughout this report to designate the division-level entity within the Department of Health Services, which has functioned as the key element in the development of "integrated" health service delivery.

Under the "integrated" delivery concept, services are provided through a minimum number of Health Posts (HPs). Initially, population was the basis for HP establishment. The target for the end of the Fifth Plan was 710-800 HPs. The development base was changed later, to one HP for each area. There are nine areas for each of the 75 districts (in large districts more than one HP area is provided). On this basis, a total of 675 Health Posts are expected to be in place by the end of the Sixth Plan, 1984. The "official" target for the Fifth Plan (1979) is 700.

Health Posts are staffed with six to 17 persons, depending on the state of development, geographic area, and population size. Health workers use the HP as a base to support the largely preventive services performed by village health workers (VHWs) and their supervisors. The HP is the primary referral center for field personnel. The head of the post is the HP In-Charge (HPI).

Community participation in the HPs is promoted by a Health Post Committee, made up of leading persons from the Panchayats served. The degree of participation by the committees is not the same from Panchayat to Panchayat, but, in general, the committees have made land available, contributed labor for construction, and assisted in organizing camps for family planning and other services.

Village health workers must be literate, have an eighth grade education, be no younger than 18 years or older than 35, and be local to the community. VHWs receive approximately Rs. 200.00 a month (U.S. \$17.00).

Ideally, the VHWs, operating out of the HPs, visit each household every two months. Where malaria surveillance is taking place, they visit households once a month. In high mountain areas, they try to visit households twice a year. Two of the VHWs' many tasks are family planning motivation and supplying contraceptives to users. Eventually, the VHW will be expected to handle oral rehydration instruction and provide some basic medicine and simple curative services. Because of the chronic drug shortage (most HPs' drug supplies will last only three months) and because many VHWs have not yet been trained to provide such instruction or medical care, few perform the full range of tasks.

It must be emphasized that the VHW in the Hills area works on foot. In the Terai, some bicycles have been provided and these seem to be useful. Lack of transport curtails the District Health Officer's ability to supervise the HP.

The ICHP receives contraceptives and FP-related surgical equipment (laparoscopes) from the (vertical) Family Planning/MCH Project. Vasectomy and mini-lap equipment has been provided directly by USAID/N and the UNFPA.

B. The Integration Process

The integration effort was built on planning efforts begun in 1969 and on the pilot projects implemented in 1971 and 1972. The development operation was supervised initially by the Working Group on Integration, which was replaced in 1977 by the Central Integration Committee chaired by the Secretary, Ministry of Health; the deputy chairman is the Director General, Ministry of Health, and the chief of the ICHP Division, Member-Secretary. The chiefs of all vertical services are on the committee, with WHO and USAID/N representatives sitting as advisors. In spite of this seemingly logical arrangement, integration has been proceeding slowly amid considerable conflict.

Understandably, the various vertical systems have strongly resisted integration. This has particularly been true of the National Malaria Eradication Organization and the Family Planning/Maternal and Child Health Project. In addition, opposition to integration has been espoused in other government circles.

Further, not only the Nepalese have resisted integration. USAID/N contributed in its own way by retaining, until a year ago, both a family planning and a health division in the Mission. Supporters of the vertical malaria eradication operation made their voices heard from outside Nepal. Strong proponents of vertical family planning and population programs injected their views from AID/W by personal "communications" or other informal means.

To complicate the issue, the Government did not exercise strong political and bureaucratic authority and leadership to insist that integration move forward in accordance with the plan.

C. Organizational Constraints on Integration Process

That there have been barriers to integration is well known. A major problem seems to have been the organizational framework in which the integrated community health operation functioned. The National Malaria Eradication Organization (NMEO) and the Family Planning/Maternal and Child Health (FP/MCH) Projects were directed by boards that either were chaired by the Minister of Health or had direct access to the Minister. The ICHP was well down in the Ministry of Health organizational structure and was responsible to the Director General of Health. Figure 1, page 23, a simplified organization chart, illustrates the organizational and authoritative problems the MOH had during the Fifth Plan period.

In addition to the problem of its low position in the hierarchical structure, the ICHP's supervisory structure was so undermanned that it is

difficult to comprehend how it could have been expected to control the operations of the well organized, well staffed, and politically powerful malaria and family planning organizations, let alone integrate them. The figures cited below were obtained from the Mid-Term Review.¹ Although they may differ somewhat from the actual number of staff now working in the ICHP, they illustrate the relative inadequacy of ICHP staffing.

	<u>ICHP</u>	<u>FP/MCH</u>	<u>NMEO</u>
Sanctioned Central Staff	19	375	195
Sanctioned Regional Staff	<u>0</u>	<u>49</u>	<u>165</u>
TOTAL	<u>19</u>	<u>424</u>	<u>360</u>

By the end of February 1980, the number of ICHP central staff had been expanded to 40 through deputation from other organizations (largely FP/MCH), but this number is still insufficient for the task at hand. Office space allocated to the ICHP headquarters is equally inadequate. If the ICHP headquarters staff were to expand to a level commensurate with responsibilities, added space would be imperative.

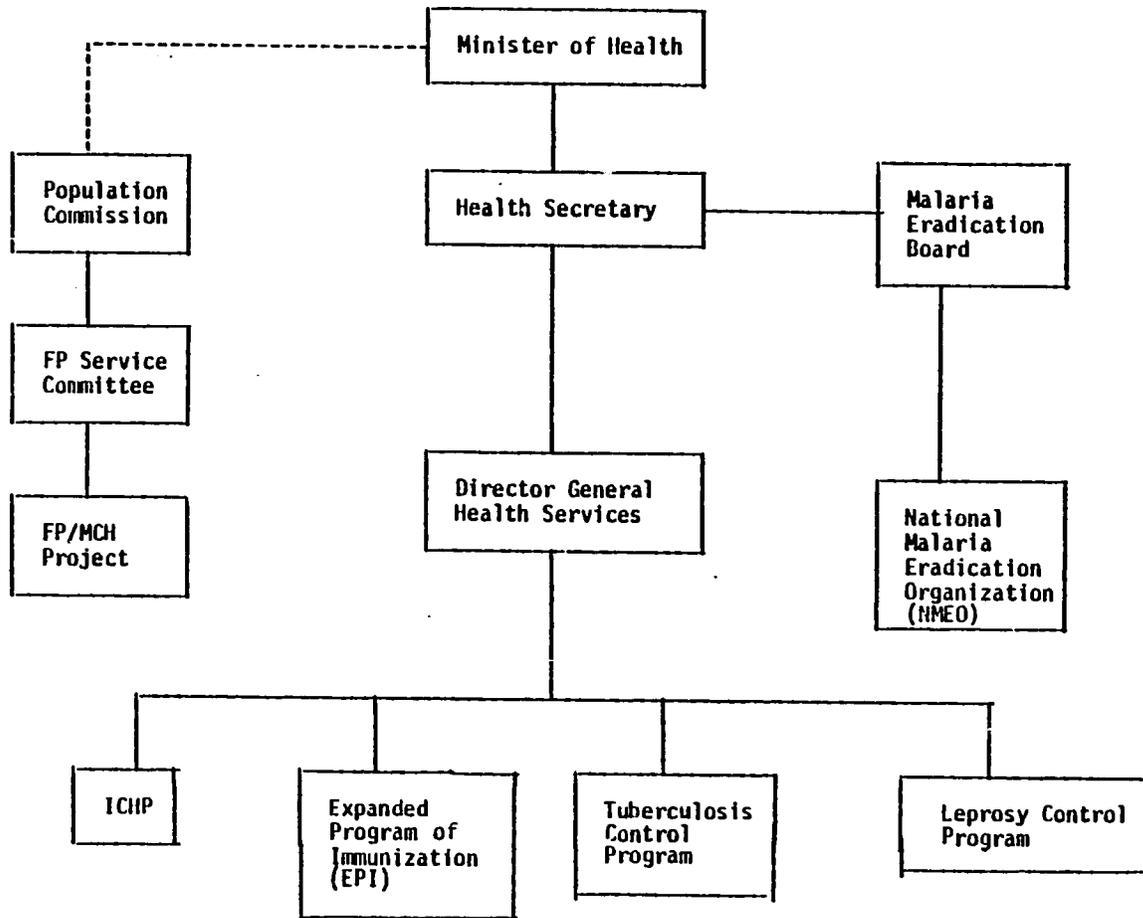
An important aspect of ICHP problems is that, while the ICHP is designated as a "project," as a practical matter, it is not a "project" in the same way that the FP/MCH operation is a "project."

According to what is supposed to be HMG practice, a development operation, such as FP/MCH or NMEO, meets three criteria to be designated a "project." It must be time-limited, governed by a board, and be supported with significant foreign assistance. (Although identified as "required," some "development" projects do not have all of these features.) The "project" designation gives organizations considerable advantage in determining staff pay, allows them greater flexibility in dealing with staff and in handling organizational and operational problems, most of which can be resolved by project chiefs whose authority is delegated by governing boards. One advantage is that "projects" can recruit "temporary" staff without going through

¹Mid-Term Health Review, 2035, Nepal: HMG, Ministry of Health, June 1979; see Table 4, page 30.

Figure 1

MINISTRY OF HEALTH ORGANIZATION CHART



the Public Service Commission. The heavy input of foreign assistance frees them of many financial concerns. Most important, for most, if not all, of their operations, the "projects" function under "development" budget procedures, which means that many funding decisions can be made by the project chief, again under delegations of authority. Non-project agencies, such as the ICHP, must function under "regular" budget procedures of the Government; this means that, among other things, funds are provided annually and for only that "budget" year. Residual "Regular Budget" funds remaining at the end of the year are not "rolled over" to the next year. A more exhaustive review process is required. (It must be noted that the difference between project and non-project activities is not as clear-cut as this description would imply. Nonetheless, the advantages are all on the side of the activity which has "project" status.)

D. Health Posts and District Offices:
Staffing and Coverage (1979)

In spite of the problems facing the ICHP, progress has been made in developing an integrated health delivery system. The pace of integration has been governed by the availability of Health Posts, which under the system are delivery bases, although other factors have been at work. The criteria on which the ICHP management and the vertical service chiefs agreed for selection of districts for integration imply, in most cases, a specific level of Health Post (and District Health Office) development. For example, more than 80 percent of the Health Posts allotted to the district selected for integration of FP/MCH services must be established before the district FP/MCH operation in that district is integrated. The 80 percent level was determined by the FP/MCH organization.

Three types of HPs were involved in the ICHP at the end of 1979: the "old type;" the E, or transitional type; and the I-type (fully integrated). The old type of HP is the traditional, static, curative care unit. Health Posts in the E-stage have home visit workers available and provide family planning services; they issue contraceptives; make arrangements for sterilization; provide health and nutrition education, disease surveillance, and immunization; record vital events; treat illnesses; make referrals, etc. The transition from the E-stage to the fully integrated I-stage involves several intermediate steps. The fully integrated I-stage Health Posts provide ante-natal and post-natal care, as well as delivery services; they also train traditional birth attendants and other health workers, conduct malaria surveillance programs, and provide treatment. These posts will have more staff strength to provide the services. Table 1, page 26, illustrates HP development between 1975 and 1979; as the record shows, 142 of the targeted 675 HPs have not been established.

At present, the 533 Health Posts are distributed throughout the 75 districts in Nepal. (See Table 2, page 27.) The staffing of the Health Posts varies with stage of development, geographic area, and population.

According to the 1978-1979 ICHP Annual Report, the "ideal" fully integrated Health Post would be staffed by:

Health Assistant/Senior Auxiliary Health Worker (Health Post In-Charge)	1
Auxiliary Health Worker (AHW)	2
Assistant Nurse Midwife (ANM)	2
Village Health Worker (VHW)	8
Mukhiya	1
Peon	<u>3</u>
TOTAL	<u>17</u>

The evaluation team was told that on the average, only four to six VHWs are sanctioned (or approved) for a HP, so the total number of staff probably does not exceed 15. By the end of 1979, 1,522 VHWs had been trained and, presumably, were delivering services.

While Health Post development was taking place, District Health Offices (these form the supervisory structure) were also receiving attention. By the end of 1979, 48 District Health Offices had begun operations. These are located throughout the country, as shown in Table 3, page 28.

The locations of the 23 integrated districts (including those fully integrated or in the intermediate stage) are shown on the map of Nepal, Figure 2, page 29.

As is the case with Health Posts, staffing of District Health Offices varies according to stage of development, population served, and geographic location (see 1978-1979 ICHP Annual Report). Table 4, page 30, lists the staff assigned to a fully integrated District Health Office.

The Health Assistant (HA) and Senior Auxiliary Health Worker (SAHW) are two different designations with equivalent civil service rank and pay. The SAHW is trained up (from the level of Auxiliary Health Worker) to the equivalent of the HA. Either may be designated as Senior Medical/Administrative Officer in the Health Post.

According to the organization plan, the senior medical officer in the District Health Office (DHO) and the District Health Inspector (DHI) supervise the HPs. There have been problems in some districts because the responsibility of these two senior officers for certain activities is not defined clearly.

Table 1
 NUMBER AND TYPE OF
 ESTABLISHED HEALTH POSTS

<u>Year</u>	<u>Type of HP</u>			<u>Total</u>
	<u>Old Type</u>	<u>E Stage</u>	<u>I Stage</u>	
1975/76	291	50	62	403
1976/77	236	132	65	433
1977/78	185	233	65	483
1978/79	185	283	65	533

Note: An additional 50 intermediate or E-stage HPs will be added by the end of FY 1979/80, increasing the total number of HPs to 583.

Source: ICHP Annual Report, 1978/1979.

Table 2
HEALTH POST COVERAGE

Eastern Zone	16 Districts	128 Health Posts
Central Zone	19 Districts	147 Health Posts
Western Zone	16 Districts	113 Health Posts
Far Western Zone	<u>24</u> Districts	<u>145</u> Health Posts
TOTAL	<u>75</u>	<u>533</u>

Source: ICHP Annual Report, 1978/1979, Annex 1

Table 3
 NUMBER AND TYPES OF DISTRICT
 HEALTH OFFICES (DHOS)*
 (By Region)

<u>Region</u>	<u>Primary Stage</u>	<u>Intermediate Stage</u>	<u>Fully Integrated</u>	<u>Total</u>
Eastern	7	3	2	12
Central	5	6	3	14
Western	5	2	1	8
Far Western	8	6	-	14
TOTAL	<u>25</u>	<u>17</u>	<u>6</u>	<u>48</u>

*December 1979.

Source: ICHP Annual Report, 1978/1979, page 13.

Figure 2

INTEGRATED HEALTH DISTRICTS

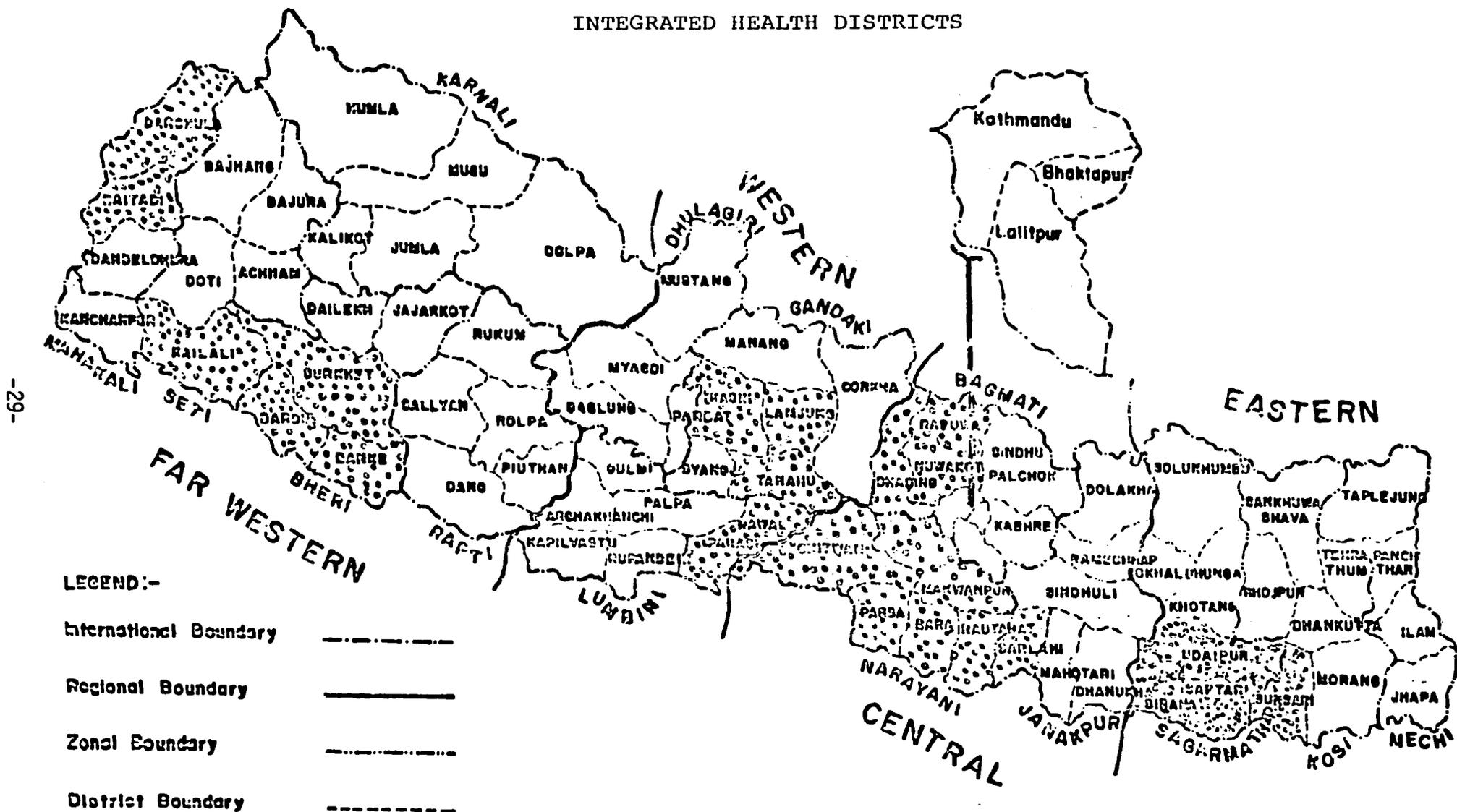


Table 4
STAFF ASSIGNED TO FULLY INTEGRATED DISTRICT HEALTH OFFICE

Senior Medical Officer	1*	Assistant Nurse Midwife	1
Health Inspector	1	Auxiliary Health Worker	1
Assistant Health Inspector	1	Laboratory Staff	3
Public Health Nurse	1	Statistical Assistant	1
Senior Malaria Assistant	1	Clerical Staff	3
Family Planning Assistant	1	Peon	2
Health Education Assistant	2		<u>20</u>
Health Assistant/Senior Auxiliary Health Worker	1	TOTAL	

*Assigned as chief technical officer (from Department of Health Services).

Source: Annual Report, 1978-1979, Integrated Community Health Project, p. 15.

Largely because of budget restrictions, until the beginning of the Sixth Plan, the number of DHOs will remain at 48. Of these 48 DHOs, six are fully integrated (i.e., they supervise the provision of all services), 17 are at the intermediate stage (i.e., they offer family planning services), and 25 are at the primary stage.

At the beginning of the Fifth Plan period, several criteria were established to regulate the integration of the various vertical programs into the integrated service project. The number of operating Health Posts often was one criterion. These criteria were not the only factors influencing the effort. General resistance to the process was also a major problem.

The difficulty the ICHP had in carrying out its mandate is reflected in the number of services it integrated successfully; by the end of 1979, FP/MCH services were said to be "integrated" into the ICHP system in only 23 of the 75 districts (with 211 Health Posts). However, even in the 23 districts, integration was only token, for the FP/MCH organization continued to deliver FP services through its own system (which operated in 10 of the 23 districts), a system that in fact paralleled the ICHP structure. (This complicates the performance reporting picture because if, for example, the ICHP conducts a sterilization camp in one of the dual districts, it takes "credit" for only 50 percent of the acceptors; the FP/MCH takes credit for the other 50 percent.)

Similarly, because of its special nature, the malaria program organization is not expected to be integrated fully into the ICHP until after the 1980-1985 Sixth Plan period. Actually, neither NME0 nor ICHP has wanted to speed up the integration effort because of malaria control problems (including insecticide resistance) in high-incidence areas. Integration of other vertical services has been moving forward slowly, in the face of reluctant vertical program managers.

E. Performance

By the end of the Fifth Plan period, an Integrated Community Health delivery system had been implemented, although it had not reached its projected development target of 675 (or 700)* Health Posts and had fallen behind in its integration efforts. The "system" is providing services across the board, from family planning to malaria surveillance, in 23 integrated districts and an additional 25 District Health Offices. The services delivered seem to be somewhat lacking in quality, quantity, and assured availability, but they are being delivered.

*See page 20.

It has been established that an ICHP does exist. It may be useful now to examine some of the elements that have a bearing on the system's vitality and potential. A discussion of the system's organization and management, supervision and reporting, finance, and service delivery functions follows.

1. Organization and Management

The headquarters is located in Kathmandu; the authorized staff of 19 has been expanded to 40 by deputation from other organizations. Seven of the 40 staff are women, including the Director, Dr. Rita Thapa. The number of staff appears to be insufficient to carry out the task of managing the expanding programs. The headquarters staff are assigned to appropriate staff sections: Planning, Research and Evaluation; Technical FP/MCH, Nutrition, and Health Education; Supervision; EPI, Malaria, TB, and Leprosy; Administration (Personnel, Supply and Construction, Finance and General Administration); and Training. Staff coverage is, however, inadequate in depth and skills levels. The ICHP headquarters does not actually handle its own personnel, finance, or supply functions, and must look to other co-equal divisions in the Department of Health Services.

Although its actual performance cannot be measured, the headquarters of the ICHP does not appear to be a well organized, smoothly functioning entity. There seems to be a distinct ad hoc air about the operation. Furthermore, available space for the headquarters is inadequate, and this may contribute to the sense of confusion and crisis management.

Despite their inadequacy in numbers and skills, headquarters staff have given attention to the supervision of field operations. It was reported that in 1979, 8 percent of the 533 Health Posts and 56 percent of the District Offices were visited by central headquarters personnel. (These figures do not indicate the depth and quality of the supervision.)

Even less clear is the degree of supervision provided to the Health Posts by the District Health Offices. One can conclude from random comments that the supervisory system is most inadequate at the field level. According to the Mid-Term Review,¹ the ICHP is substantially understaffed at the district level. In addition, even where positions have been sanctioned, the ICHP shows a higher percentage of unfilled posts than does, say, the NMEQ or the FP/MCH system.

Although not part of the ICHP, a capable planning unit has been set up in the Ministry of Health. The Management Sciences for Health (MSH) Advisory Team has been instrumental in creating the unit. The planning

¹Mid-Term Review, Ministry of Health, June 1979, page 18.4.

unit was the driving force behind the Mid-Term Review, the results of which were published in June 1979. That review was particularly useful to those preparing the Sixth Plan health plan and became a major component of the planning base. (See also pages 134-137 of this report.)

2. Training

Staff training within the limits of the ICHP's training capacity has received attention. Some 296 VHWs, 77 ANMs, 34 AHWs, and 61 HPIs participated in three- to six-week in-service training programs in 1978-1979. The absorption of staff from vertical programs has made the need for a vigorous in-service and retraining program evident. As services expand, additional personnel in all categories, from the VHWs responsible for field service delivery to the surgeon who provides sterilization services, will have to be trained. Although the present training capacity seems to be fairly adequate, management problems may interfere with training efforts. (See Number 2, Training, under Constraints, page 38.)

3. Reporting

Related to the development of a countrywide integrated health services delivery system is the development of a health reporting system. Starting with the various vertical systems, the Department of Health Services inherited approximately 137 forms and registers in 1972. By 1975, the number of forms and registers had been reduced to 45. With the decision on integration, the ICHP began in 1976 an in-depth review of reporting requirements. It undertook the review both to reduce the number of reporting requirements and to determine what other areas (e.g., nutrition) should be covered. The ICHP now requires the use of only 12 forms or registers. (In the case of malaria, some additional forms are used in the integrated districts only.) Although the ICHP reduced the number of required forms and registers, it failed to provide to the field across-the-board clear-cut instructions on recordkeeping. In many instances, field workers and district office staff labor over many "retired" registers and forms: others contend with no forms at all. However, problems are being solved, albeit slowly. (See page 38.)

4. Finance

The discussion of the development and operation of the ICHP has not addressed the critical matter of financing the system. The general subject of project and program financing is raised in the first section of Chapter V of this evaluation, page 124, ff. Table 34,¹ which accompanies

¹See page 126.

the discussion, illustrates the ICHP's financial history from its inception through 1979. It is not possible to set out a total for the period because the unexpended balances in the development accounts are carried over and subtracted from the subsequent year. Table 34 does show clearly the important role that foreign donors are playing in the development of the ICHP. It also shows that HMG financing of the ICHP (through the "regular" budget) has been increasing at an impressive rate to meet the demands of the expanding system. The Government's ability to continue to meet the increasing operating cost of expanded health services is cause for concern.

The contributors to the "Other Donors" section of the Development Budget (See Table 34, page 126, ff.) in FY 1979 were the Netherlands, the Netherlands Leprosy Relief Association, Japan, UNFPA, UNICEF, WHO, International Assistance Programs, Inc., and IDA. It is evident that HMG's Integrated Health Services Project has caught the eye of the donor community. Given HMG's resource picture, continued strong donor support is important to the future of the ICHP.

USAID/N support to the ICHP is discussed in Chapter IV. The USAID/N project is the funding mechanism through which USAID/N monies have been made available to HMG for the Integrated Community Health Project. As with other donors, the complete picture of USAID/N inputs is not reflected in the ICHP budget. Commodities, overseas training, and technical assistance to the ICHP are not shown in the HMG budget. Table 32, page 118, which accompanies the discussion of Project 0126, Integrated Health Services, shows that between 1975 and 1979, USAID/N provided \$1,818,200 in technical assistance, commodities, and training and \$10,719,359 for local currency budget support, workshops, and locally-procured commodities.

5. Supply

The overall supply picture for ICHP and FP/MCH programs is discussed elsewhere in this report (see Chapter V, page 124). The subject is also covered in the section on constraints (see especially page 41). At this point, it seems sufficient to note that:

- a. The supply of contraceptives generally is adequate to meet demand. Since the ICHP must obtain its contraceptive supplies from the FP/MCH Project, it does not have complete control over the situation. It has been reported that contraceptive supplies, though in the pipeline, do not always find their way to the field where they are needed or in the quantities requested. This does not mean that in-country supplies are inadequate, but that there are problems in the logistics system.
- b. The supply of medicines is well below what is needed to adequately stock Health Posts; the shortage is most critical

for the field-level delivery system. It is generally held that each year the Government provides medicines sufficient for only a three- to four-month operation. In addition to the problems of a generally short supply, the logistics system on which the ICHP depends makes the transport of medicines to the field very unreliable.

- c. Generally, the supply of surgical instruments needed to perform sterilizations is reasonably adequate. The ICHP has received mini-lap and vasectomy kits from USAID/N and U.N. agencies. Because laparoscopes are under the control of the FP/MCH Project, which insists that its own personnel accompany the instruments when they are loaned to the ICHP, the laparoscopes do not always appear when needed or scheduled. Unfortunately, this situation has created friction between the two services and has adversely affected the provision of female sterilizations. It is clear that before sterilization services can be expanded, the supply of instruments--laparoscopes, mini-lap kits, etc.--must be increased significantly.

6 Service Availability

Table 5 summarizes a few of the data from the 1978-1979 ICHP Annual Report on service delivery. (Obviously, this report, which covers only 23 districts [six fully integrated and 17 intermediate-stage districts], does not describe all the health services being provided through all of the 533 Health Posts and 68 hospitals. However, the list is fairly impressive.) The table reflects ICHP's preoccupation with FP/MCH, immunization, nutrition service, and malaria eradication.

7. Technical Assistance

In addition to providing financial and in-kind support to the ICHP, various members of the donor community provide advisory assistance in specific problem areas. In addition, a USAID/N-financed team from the Boston-based firm, Management Sciences for Health (MSH), has been involved with the ICHP since its inception. The in-country MSH team has provided assistance in health management, planning, training, and commodity logistics. (The team's work, which has been an important factor in ICHP development, is reviewed in Chapter V, page 124, ff.)

Table 5

ICHP SERVICE DELIVERY, 1978/1979, 23 DISTRICTS
(PARTIAL LIST OF SERVICES)

Total Individual Contacts ¹	15,096,018
Family Planning Motivation	566,255
Pill Acceptors (New)	23,371
Pill Cycles Distributed	85,833
Condom Acceptors (New)	35,247
Condoms Distributed	881,902
 <u>Sterilization</u>	
Male	4,153
Female	3,897
 <u>MCH</u>	
Ante-natal Mothers	6,623
Post-natal Mothers	1,633
Deliveries	937
Children's Clinic Attendance	38,142
 <u>Immunization</u>	
Smallpox, Primary	137,597
Smallpox, Revaccination	38,642
BCG	27,613
Nutritional Surveillance (Arm Measurement)	1,620,655
Rehydration Taught	1,002,075
Malaria, Population Contacted	8,131,922
Blood Slide Examined (Annual Rate)	159,238 (8%)
Clinical Services Provided	1,270,537

¹ This figure does not represent the "target" population; it is the total number of "contacts," many of which are multiple.

Source: ICHP Annual Report, 1978/1979, p. 27.

F. Constraints

Although the ICHP is a functioning organization with a fair record in service delivery, its ability to deliver services effectively and efficiently is constrained. A consideration of the constraints will provide a useful insight into the performance and problems of the ICHP. Some of the most important constraints are discussed below.

1. Organization and Management

Nepal only recently undertook development activities; it lacks a tradition in modern management and forward planning. This problem is not peculiar to the ICHP. Furthermore, "time" does not have the importance in Nepal that it does in the more developed countries. These factors, which were discussed in Chapter II, "The Nepal Context," must be kept in mind when talking generally about "constraints" and specifically about the management of the ICHP.

While staff shortages and lack of "project" status no doubt affect the ICHP's ability to "manage," the crux of the matter is that a firm schedule for the integration process has not been developed.

Goals have been stated, but there has not been any truly coordinated planning for the integration process. True, integration "plans" have been prepared, but, for the most part, these have been prepared independently by the ICHP or by one or another of the vertical program staffs. There has been no consensus on where, how fast, and how far to move. It appears that no one has understood that planning for integration must project at least one or two years into the future to ensure that necessary staff adjustments can be made and supply and training requirements met.

It is the opinion of the evaluation team that although the ICHP can play a role in coordinating integration planning, the Ministry should make and enforce basic decisions on integration. Merely changing the ICHP's status to "Development Project" will not be enough.

Even if the integration process is taken in hand, the ICHP management structure in Kathmandu is highly centralized, and it would probably be beneficial to strengthen the authority (and staffing) of the district-level operation, perhaps by setting up zonal offices that become part of the planning and supervisory system. If such a decision is made, the Kathmandu headquarters must make an effort to ensure that the individual district projects are fully supported with supplies, training, and funds and invested with the authority to operate.

2. Training

The integration process implies the need for significantly increased training and retraining of personnel as vertical system staff or new personnel are brought into the ICHP organization. The ICHP's training capacity is limited; there are only 11 full-time trainers on the staff. Nonetheless, a substantial training effort has been undertaken. To carry out the training, district health inspectors and other qualified staff have had to be pulled into the process. This has disrupted field service supervision, as has the diversion of training staff to non-training roles.

The ICHP has only one operational training center, at Pathlaiya. Pathlaiya was not designed as a training center and does not have proper classrooms or kitchen and dining facilities, and has almost no running water. At the central headquarters level, there are no classrooms, meeting rooms, or areas for preparing training materials.

If the budget permits, the ICHP plans to upgrade the Pathlaiya center and add at least three more centers. The key training activity at the centers will be the training of VHWs. Increased supplies of manuals and other training aids for the centers are planned.

3. Reporting

While the basic steps to improve the reporting system have been taken, problems in implementing activities have arisen. Information on the use of the new forms was provided at seminars for all DHOs and HIs about two years ago. The HIs were supposed to train the HP staff, but little of this training has taken place. Follow-up from the central headquarters and lower levels on the correct use of the reporting system has been deficient. The distribution of new forms to the field has been slow. The VHW registers were delivered nearly a year behind schedule, delaying the initiation of work by one group of VHWs. Old stocks have not been retired and stocks of other forms have been misdirected by the supplying office. (The ICHP does not have its own central store for such supplies and must rely on other sections of the DHS.)

The ICHP management seems to be addressing this matter, but corrections are being made slowly.

4. Finance

A key element in the successful development of ICHP health and family planning service delivery is the ability (and willingness) of supervisory personnel at all levels to travel to the field to meet with, instruct, and encourage workers, especially the key person in the chain, the village health worker. Several pages in the Mid-Term Review were devoted to the

TA/DA problem.¹ One constraint on supervisory travel and service delivery is the amount of travel allowance/daily allowance permitted under HMG regulations. (See Table 6, page 40.)

In contrast to the rates shown in Table 6, the travel allowance paid to Nepalese drivers working for several foreign donor organizations ranges from Rs. 100 to Rs. 180 per day. Of further interest is the fact that today in the Hills areas, a meal of rice and dal (lentils) without meat costs Rs. 4-7.

Not only does the low TA/DA level discourage supervisory and service delivery travel, but as recent audits show, payment to the traveler may be delayed several months to several years. The Mid-Term Review notes that TA/DA payment is perceived as a major problem, especially by Health Post personnel.² Part of the problem is that funds are released slowly, and this results in actual periodic shortages of resources for the health program. USAID/N-earmarked financing for TA/DA has helped to alleviate fund shortage problems for ICHP.

5. Supply

Supply and logistic support must be provided to integrated service components. This entails many problems. For example, the Expanded Program of Immunization (EPI) requires the supply and transport of vaccines, many of which are time- or temperature-limited. The provision of control and field refrigeration facilities and insulated field transport cold boxes is essential.

Effective logistic service--both supply and transport--is basic to the success of the field operation. The ICHP has had no logistic capacity at all under its direct management. It must look to other sections of the Department of Health Services for support in transporting supplies to its many field posts. The problem of coordinating all the independent units upon which the ICHP depends for logistic support is at least as critical as the distribution problems. Nepal's terrain presents a special problem: Many supplies can only be distributed by mule train or human porters.

One serious problem is the limited supply of drugs and medicines available for field distribution. Field workers frequently complain that the medicines supplied to the health facilities are sufficient for, at most, a three-month operation; after three months, VHWs and other workers cannot

¹Ibid., pp. 20.16 - 20.21

²Ibid., page 20.17.

Table 6
HMG TRAVEL ALLOWANCE/DAILY ALLOWANCE RATES

<u>Rank</u>	Rates			
	<u>Travel Allowance</u>		<u>Daily Allowance</u>	
	<u>Rs/Mile</u>	<u>U.S. \$ Equivalent</u>	<u>Rs/Day</u>	<u>U.S. \$ Equivalent</u>
1st Class Officer (Project Chief)	5	0.42	22	1.85
2nd and 3rd Class Officers (Senior Staff)	4	0.34	18	1.51
Non-Gazetted 1st and 2nd Class Staff	3	0.25	12	1.01
Non-Gazetted 3rd and 4th Class Staff (Village Workers)	2	0.17	7.5	0.63

Source: F. Curtiss Swezy, His Royal Majesty's Government of Nepal Family Planning and Maternal and Child Health Project: Financial Management, Table 7, page 15, Washington, D.C.: American Public Health Association, December 1979.

offer so much as an aspirin to a potential client. The lack of medicines and supplies is a major problem--one reason the villagers hold the health service and health service personnel in low esteem.

The problem of providing an adequate medical supply to the Health Posts is exacerbated by coordination and distribution requirements. The ICHP must coordinate the financial releases from the budget with the Finance Section of the DHS with procurement and distribution activities of the Indent and Procurement Division. Both are independent units under the Director General. Additional drugs and supplies are also provided by external agencies, such as UNICEF, UNFPA, and USAID/N, and may be provided directly to ICHP or indirectly through the existing vertical projects. To maintain essential supplies at all service points, coordination with all of these agencies, as well as with the Foreign Aid Division of the MOF, the International Health and Training Division of the DHS, Indent and Procurement Division, vertical projects, and the district ICHP offices is necessary. Although some progress has been made, much more must be done to develop an effective procurement and distribution system.

A more basic problem is that funding for medicines provided from all sources is insufficient to meet needs. The HMG budget for MCH drug supplies is about Rs. 7,000,000 annually (about \$588,000). UNICEF recently calculated that the cost of providing medicines to a countrywide health delivery system would be approximately \$11,000,000 - \$13,000,000 annually.

Obviously, meeting this level of funding is unrealistic for Nepal, but the figures do indicate what the costs of an attempt to provide a truly adequate supply of medicines would be.

6. Service Delivery

The Integrated Community Health Project aims to alleviate the many constraints on the delivery of health services to the people of Nepal. If the ICHP concept is fully realized, each constraint will be identified and overcome. Such problems as inadequate supplies of medicines and medical instruments, poor reporting and supervision, inadequate staffing and training, and poor supervision and management will be resolved. Obviously, these problems will not be resolved at any time in the near future. But if HMG places a high enough priority on the delivery of health services through a viable integrated community health delivery mode, the time needed to resolve these problems should be greatly reduced.

G. Corrective Actions

The ICHP has many problems to resolve, and it is being helped both by the Nepal Government and, where appropriate, donor agencies. The health

program described in the Government's Sixth Plan is designed to alleviate many problems, provided funding is found. USAID/N and other donor inputs are designed to support HMG efforts and are related to specific program elements. (See Chapter VI.) Some donor inputs have been made conditional upon specific government action to correct administrative and bureaucratic problems. For example, UNFPA support for ICHP and FP/MCH projects will be provided only if the ICHP becomes a "project" with a duly constituted board. This action alone, if followed by vigorous action to specify and insist on adherence to a time schedule for integration, will eliminate many of the constraints under which the ICHP has been laboring.

Major donor inputs have been included to alleviate the shortage of medical supplies. Provisions are being made for technical assistance in critical fields, such as logistics and finance; the expansion of training facilities will be supported. (See Table 36, page 147, ff.)

Service Delivery: Malaria Eradication in Nepal

Although not a recent major recipient of USAID/N funding, the malaria control and eradication project is an important component of the public health program in Nepal. An AID regional advisor periodically visits Nepal as a technical consultant to the Nepal Malaria Eradication Organization (NMEO). The advisor is a member of a team of malaria experts, the External Situation Analysis Team (SAT), which advises the HMG on malaria eradication and control activities. During the Sixth Plan period, USAID/N support to the Integrated Community Health Project will have a bearing on malaria control and case-finding.

Because malaria surveillance is a responsibility of the ICHP, the team felt that it would be useful to review the latest findings on the malaria situation in Nepal.

The evaluation team reviewed SAT's most recent report, dated February 5, 1980. The summary report includes an analysis of the current trends in malaria transmission in Nepal and a discussion of districts in which malaria is combated by the vertical NMEO project. Integrated districts, where public health measures, including spraying, are components of the broad community health program of the ICHP, are also described. The SAT notes that the highest incidence rates occur in the nine districts of the Terai (plains) that are immediately adjacent to India.

Thirty-six (36) percent of the population of all malarious areas in Nepal reside in nine (9) Terai districts of Dhanusha, Mahottari, Sarlahi, Rautahat, Bara, and Parsa, in the Central Region, and Nawalparasi, Rupandehi, and Kapilvastu, in the West Region. Rautahat, Bara, and Parsa districts are "Integrated Health Districts (IHD)" and control of malaria there is a function

of the Integrated Health Services, not the NMEO. These districts are all adjacent to India.¹

India has set her target for the reduction of malaria at an Annual Parasite Incidence (API) level of two per 1,000. Nepal is attempting to reduce the API in the adjacent Nepal Terai to 0.5 per 1,000. A significant aspect of Nepal's problem in controlling malaria is vector migration across the international boundary.

As noted in the SAT report, the epicenter of the high incidence belt in the Central Region of Nepal is in six contiguous districts:

High Incidence Malaria Districts:

ICHP: Parsa
Bara
Rautahat

NMEQ: Sarlahi
Mahottari
Dhanusha

Lower incidence rates have been reported in the immediately adjacent Eastern Region districts:

Low Incidence Malaria Districts:

ICHP: Siraha
Saptari

NMEQ: Sunsari
Morang

Interestingly, the ICHP administers malaria control efforts in the first three districts of the high incidence area, the NMEO in the other three districts. As if by design, the two immediately adjacent districts (with lower incidence rates) are administered by the ICHP and the next two by the NMEO.

Table 7, page 44, lists the numbers of malaria cases in the 10 contiguous districts for the years 1977, 1978, and 1979. For comparative purposes,

¹Malaria External Situation Analysis Team, February 5, 1980, p. 12 (Mimeo).

Table 7

MALARIA CASES IN 10 TERAI DISTRICTS
(1977, 1978 and 1979)

High Incidence Districts

	<u>1977</u>	<u>ICHP</u> <u>1978</u>		<u>ICHP</u> <u>1979</u>	
		<u>Number</u>	<u>% Over 1977</u>	<u>Number^a</u>	<u>% Over 1978</u>
Parsa	616	1,123	: 83	394	: -65
Bara	760	1,005	: 32	526	: -48
Rautahat	306	747	: 144	195	: -74
		<u>NMEO</u>		<u>NMEO</u>	
Sarlahi	273	469	: 72	594	: 27
Mahottari	317	895	: 182	1,111	: 24
Dhanusha	486	643	: 32	671	: 4

Low Incidence Districts

		<u>ICHP</u>		<u>ICHP</u>	
Siraha	9	55	: 511	2	: -96
Saptari	8	9	: 13	1	: -89
		<u>NMEO</u>		<u>NMEO</u>	
Sunsari	200	216	: 8	327	: 51
Morang	432	523	: 21	693	: 33

^a Eleven months, January-November 1979.

Source: National Malaria Eradication Organization records.

percentage increases or declines in the number of malaria cases have been calculated by the evaluation team for 1978 and 1979.

Table 7 indicates that programs in the six districts in the high incidence belt, whether administered by ICHP or NMEO, had similar problems with malaria in 1977 and 1978. A comparison of the percentage increase in the number of cases reported in 1977 and 1978 is made using 1977 figures as the denominator. In 1979, the three so-called NMEO districts showed modest increases in the number of cases reported in 1978, but the three districts administered by the ICHP showed significant declines.

The same pattern is seen in the four districts immediately to the east of the high incidence belt. Because fewer cases were reported, the percentage changes are more dramatic. Nonetheless, the two ICHP districts experienced increases in case loads in 1978 and declines in 1979 that are less than 1977 figures. The number of cases in adjacent NMEO districts increased in 1978 and again in 1979, thereby making the number of active cases comparable to the figures for the six high incidence districts.

There obviously are several explanations for these trends. The increases and declines may or may not have any relationship to the HMG service unit administering the malaria control component of the public health program. The authors of the external SAT report do not provide any insight into the trends. They only state:

It was observed that, as last year, organization and performance was generally better in NMEO areas than in integrated areas.¹

In their report, the authors focus on the three ICHP-administered districts in the high incidence belt. They state:

The SAT team believes that events over the past year in three Terai integrated districts have added further support to its views and recommendations made a year ago. Indeed, in 1978-1979 just three districts alone accounted for over 20 percent of all malaria in Nepal. The SAT team believes that those three districts are now at real risk of becoming a particularly dangerous focus for wider spread of malaria.²

¹Ibid.

²Ibid., pp. 25-26.

The evaluation team did not find in the external SAT report analytical data to substantiate the contention that the performance of the NME0 was "generally better" than that of the ICHP. While discussing the three ICHP districts in the high incidence area, the authors of the report make no reference to the impending danger in the three adjacent NME0 districts or the two NME0 districts in the Eastern Region, where the number of reported cases is comparable to the number of cases reported for the high incidence district.

More important, the external SAT team makes no substantive recommendations on how NME0 can support and strengthen ICHP malaria activities when perceived weaknesses are identified. It provides no recommendations on NME0 actions to strengthen ICHP activities (e.g., deputing NME0 staff to integrated districts; training additional logistics support; etc.), but does state:

In Parsa District, where A. annularis is resistant to DDT, the NME0 programme is planning to carry out trials with other insecticides such as Actellic (pirimiphos methyl) and Sumithion (fentitrothion). These trials will be conducted by the Research and Training Section of NME0.¹

As Table 7 shows, Parsa is an integrated district. The above quote reveals what NME0 plans to do in the integrated district. It does not, however, indicate that the NME0 plans to assist the ICHP in controlling malaria in Parsa. The evaluation team believes that rather than stating that ICHP malaria efforts are generally worse than those of the NME0, the SAT should have described in detail how the NME0 planned to strengthen ICHP malaria activities (as well as specific actions in high incidence NME0-administered districts).

Service Delivery: Nepal Family Planning/Maternal and Child Health Project

A. Organization

Though some earlier public and private activities had been initiated, the Nepal National Family Planning Program began in earnest in 1968, when a Family Planning and Maternal and Child Health Board was established. The Board, chaired by the then Health Minister, was charged with policy-making for the FP/MCH Project, a semi-autonomous agency within the Ministry of Health. USAID/N began providing assistance to the national program the same year.

¹Ibid., p. 18.

By 1975, the FP/MCH Project was operating under the auspices of the Population Policy Coordination Committee of the National Planning Commission, which had been created to implement national population policy programs throughout Nepal.

Today, under the current structure of the Ministry of Health (see Figure 1, page 23), the FP/MCH Project retains its semi-autonomous position under the auspices of the National Population Commission, created in 1978. The FP/MCH Project chief is the Member-cum-Secretary of the Commission.

1. Background

Nepal based its early emphasis on family planning and maternal and child health on the assumption of the existence of a synergistic relationship between FP and MCH and on the belief that success in family planning is impossible if infant and child mortality is high.

Before 1973, the FP/MCH Project had achieved several notable successes, both absolutely and comparatively. Its most significant successes were in the areas of staff development, publicity, public interest and support, and physical infrastructure.

The program set up a network of FP/MCH centers in 62 of Nepal's 75 districts; 150 of these centers were providing basic contraceptive information and family planning services to married couples, in addition to elementary MCH services. Ninety-two participants had completed training, and another 32 were in training. In-country training programs had trained 407 health aides. Political support for family planning was expressed in repeated public statements, and family planning public relations became highly visible.

2. Fifth Plan Period

Despite the successes, three problems plagued family planning efforts: Coverage was inadequate; performance was low; and the health facility-based delivery system was not conducive to wide expansion (there was a lack of health facilities throughout the nation). New program designs and experimentation with delivery systems suited to Nepal's special needs seemed to be needed.

With USAID/N contributions and donor assistance from UNICEF and UNFPA, a new five-year project (FY 1974-FY 1978) was developed to:

- strengthen the existing program by upgrading technical, administrative, and managerial skills and the performance of program personnel; and,

--design, through carefully planned, small-scale experiments, a set of service delivery modules with a demonstrated capacity to recruit and sustain a relatively high percentage of target couples practicing family planning.

Four programs were tested: use of clinic-based services and personnel; provision of services through non-clinic-based field workers; mobile sterilization camps; and use of commercially-based delivery systems.

USAID/N inputs to the project included technical and commodity assistance, participant training, and local currency budget support. UNICEF provided medicine and equipment. UNFPA supported the construction of new health facilities and supplied transport equipment and technical and financial assistance to the Institute of Medicine.

By the end of the project, FY 1977-1978, 492 service centers (clinics and Panchayats) were providing FP/MCH services in 62 of the 75 districts.¹ Table 8, page 49, shows the manpower required by the project in these years. As the table shows, the largest staff category is that of health worker, both clinic-based and Panchayat-based. Some 930 health workers were responsible for the promotion and delivery of community FP/MCH services.

3. FP/MCH Project Extension

In September 1978, FP/MCH project extension was approved on three conditions:

- that the FP/MCH Project be brought into step, time-wise, with the Government's Development Plan and with USAID/N's other major health sector project;
- that momentum in family planning services be maintained but that time be allowed for rational and considered planning based on the results of a sound evaluation; and,
- that time and data be provided for collaborative planning of future programs among HMG, USAID/N, and other donors.

Project expansion involved technical assistance, participant training, commodities, the expansion of voluntary surgical contraception services, and the enlargement of the force of Panchayat-based health workers.

¹Annual Report, Fiscal Year 1977-1978, FP/MCH Project.

Table 8
FP/MCH Project Staff, 1978

<u>Full-Time Workers</u>	<u>Number</u>
Project Chief and Deputy Chief	2
Doctors	15
Nurses	34
Assistant Nurse Midwives and Auxiliary Health Workers	104
Village Health Workers	930
Other Technical Officers	74
Technical Assistants	236
Administrative Officers	13
Administrative Assistants	147
Peons	<u>193</u>
TOTAL	<u>1,748</u>
<u>Part-Time Workers</u>	
Consulting Surgeon	1
Doctor	1
Research Officers	12
Interviewers	<u>120</u>
TOTAL	<u>134</u>

4. Current Management and Staffing

Beginning with the Fifth Plan period, the Nepal FP/MCH Project expressed its goals as "raising the Nepali standard of living by reducing the birth rate from 40 to 38 per thousand and reducing mortality rates in infants below 12 months of age from 200 to 150 per thousand."

In developing the rural outreach network, the FP/MCH Project established four Regional Offices, 40 District Offices (covering 62 districts), and 232 Family Planning Clinics; it also trained 714 Panchayat-based health workers.

The headquarters organization in Kathmandu has a central staff of 195; 63 are women, including the Deputy Director. The staff operate six divisions and one branch. The six divisions are: Administrative, Service, Surgical, Evaluation, Training, and Information and Education. Internal Audit makes up the one branch. (See Figure 3, page 51.)

Regional Offices have been set up in each of the four development regions to decentralize and help make FP/MCH services more directly available and acceptable to the population. The Regional Offices design programs carried out by their respective District Offices.

Each Regional Office has three technical officers, one administrative officer, three technical assistants, and three administrative assistants.

FP/MCH service extension is a primary function of the 40 District Offices. Each District Office is staffed with a Family Planning Officer, Staff Nurse, Auxiliary Health Worker, Assistant Nurse Midwife, Non-gazetted Second Class Officer, Non-gazetted Third Class Officer, Intermediate Supervisor, Health Worker, and Driver.

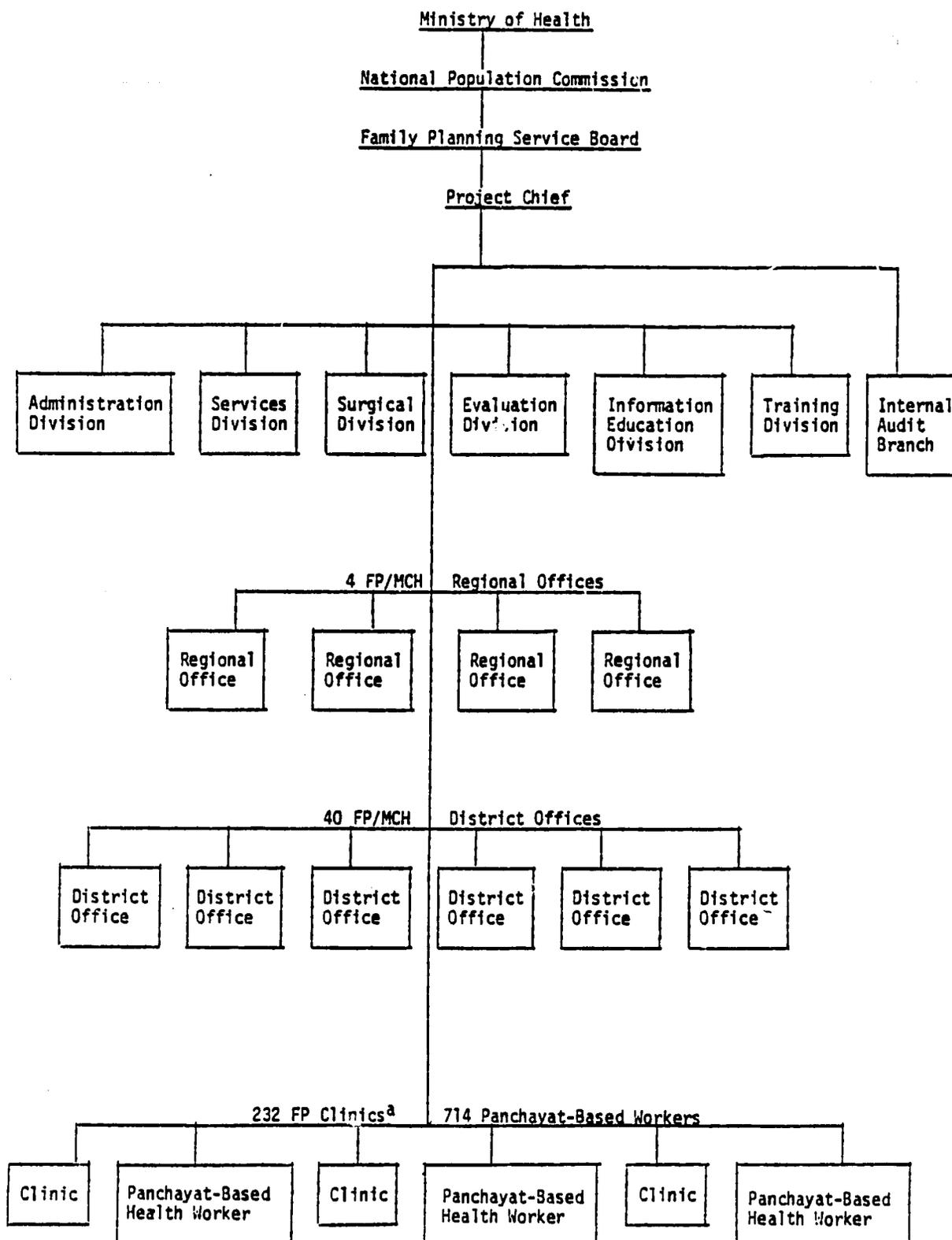
Community FP/MCH services are provided by static clinics and mobile Panchayat-based health workers. FP/MCH clinics in District Offices and Health Posts and free-standing clinics are staffed with two health workers who are responsible for the services provided to their community. In addition to family planning, pre-natal and post-natal care, nutrition education, oral rehydration education, and DPT, BCG, and smallpox immunizations and vaccinations for children below age five are provided.

In the current plan period, outreach services were extended by introducing Panchayat-based health workers (PBHWs). Each worker delivers FP/MCH services by visiting homes in a single ward.

The Panchayat-based health worker is essential; (s)he provides villagers with family planning information and contraceptives and motivates the target population to accept surgical contraception. The worker is the link to the project, from the district to central level; (s)he communicates

Figure 3

EXISTING ORGANIZATION OF NEPAL FP/MCH PROJECT, 1980



^a This figure includes clinics in district offices.

when and where surgical contraception camps will operate. The workers are recruited on the basis of their interest, their status in the village, their natural leadership ability, and motivational abilities. Their educational background may or may not satisfy the HMG regular civil service requirements.

The PBHW is trained to motivate; (s)he spends time with each family to ensure its acceptance of family planning and provides contraceptives (pills and condoms) or refers the husband or wife for sterilization, IUD insertion, or Depo-Provera injection. The PBHWs, 15 percent of whom are women, also treat common conditions (e.g., diarrhea, scabies, eye infections, anemia) and assist in obtaining immunizations at static clinics.

Table 9, page 53, shows the regional placement of FP/MCH clinics and PBHWs.

B. Performance

By the end of the Fifth Plan period, the FP/MCH Project had demonstrated (and continues to show) that it is one of the major providers of family planning and maternal and child health services. Project activities, including the Panchayat-based Health Worker Expansion Program and the expanded Voluntary Surgical Contraception (VSC) Services Program, enable the FP/MCH to increase the provision of these services. Other elements important to the project's overall performance include FP and MCH service availability, program commodities, and project financing.

1. Panchayat-Based Health Worker (PBHW) Expansion Program

The PBHW Expansion Program was designed to strengthen the ongoing FP/MCH service program by expanding the number of field-based workers who provide family planning services. By increasing the number of such workers, more fertile couples who may need and want family planning services can be reached.

Essential to the expansion has been the training of District Office accountants and administrators in HMG accounting, recording, and reporting procedures.

During FY 1978-1979, 439 Panchayat-based health workers and 36 Intermediate Supervisors (ISs) were trained. Seventeen training courses were conducted, seven by the three static FP/MCH training centers and 10 by mobile training teams. This training effort represented a fourfold increase in PBHW training over the previous year. Ongoing training in FY 1979-1980 will see an additional 547 PBHWs and 137 Intermediate Supervisors trained. The ongoing training will include the initial training of the 14 PBHWs and

Table 9

FAMILY PLANNING CLINICS AND PANCHAYAT-BASED HEALTH WORKERS
(By Development Region, 1980)

<u>Region</u>	<u>FP/MCH Clinic</u>	<u>Panchayat-based Health Worker</u>
Eastern	54	161
Central	57	176
Western	54	206
Far Western	<u>67</u>	<u>171</u>
TOTAL	<u>232</u>	<u>714</u>

27 Intermediate Supervisors recruited and employed, but not trained, in FY 1978-1979. The workplan does not provide for in-service training or re-training of operational PBHWs.

To support the administration of the PBHW/IS Expansion Program, district-level accountants and administrators will be trained in appropriate recording and reporting procedures. This will ensure that the financial management procedures of the FP/MCH Project comply with HMG rules and regulations and with the financial reporting requirements of funding sources. Training is expected for:

- 40 District Accountants;
- 6 Regional Medical Office Accountants;
- 3 Training Center Accountants;
- 40 District Family Planning Officers;
- 4 Regional Medical Officers;
- 3 Training Center Officers-In-Charge; and,
- 24 Central Office Accounting Staff.

To accomplish this effort, the project will train in three locations: Dharan for the Eastern Region, Pathlaiya for the Central and Western Regions, and Surkhet for the Far Western Region. By training at these three sites and by using mobile training teams, the FP/MCH Project has been successful in its training efforts. Doctors, paramedical staff, and health assistants, social workers, health workers, midwives, traditional village practitioners, and others have been trained in the many facets of family planning service delivery and administration.

2. Expansion of the VSC Service Program

In an effort to expand and develop the Government's capacity to reach increasing numbers of VSC acceptors, the VSC Service Expansion Program focuses primarily on:

- the expansion and upgrading of surgical skills in VSC procedures;
- the establishment of permanent service and training centers in major hospitals in Nepal;
- the provision of adequate supplies and equipment for the permanent service centers, training centers, and camps; and,

--the increase in the number of VSC camps, the extension of VSC services to heavily populated but inaccessible areas of Nepal that can be reached by air, and the expansion of land transport facilities.

In addition to providing out-of-country physician training (12 physicians have completed JHPIEGO training), the FP/MCH Project is conducting in-country training in vasectomy procedures. Laproscator and mini-lap training is being conducted in Kathmandu at the FP/MCH Central Office clinic and in camp settings. The surgical support staff (staff nurses, auxiliary health workers, assistant nurse midwives) are also receiving training in the proper use and handling of surgical equipment, especially laparoscopes and laproscators. Although data on the number of physicians trained are incomplete, it appears that 14 female physicians and 10 male physicians have been trained to perform laparoscopic sterilizations; more than 43 male physicians have been trained to perform vasectomies; and 18 physicians have completed mini-lap training under WHO auspices. If more female physicians are available, they should be recruited for training.

While no survey on the demand for static versus mobile sterilization services has been taken, mobile camp services appear to be acceptable to the eligible population. Evaluation team members observed a FP/MCH laparoscopic camp in Janakpur where more than 3,000 women received services. This high-level demand is an indication of acceptance of mobile female sterilizations; it also demonstrates the importance of providing permanent, year-round sterilization services for daily and weekly operations.

During the expansion effort, USAID/N will provide funding to purchase supplies and equipment for as many as eight permanent VSC service and training centers. These permanent service and training centers are expected to meet much of the urban demand for VSC procedures, but in Nepal, where 96 percent of the population is rural, mobile VSC camps may require several more years of support.

Since 1972, the FP/MCH Project has operated mobile VSC camps. Since 1977, 87 mobile camps, both vasectomy and laparoscopy, have been operated. The breakdown in camps is as follows:

	<u>Number of VSC Camps</u>		
	<u>FY 1977-1978</u>	<u>FY 1978-1979</u>	<u>FY 1979-1980</u>
Vasectomy	44	11	-
Laparoscopy	14	18	23 Projected

Interestingly, the number of vasectomy camps declined dramatically between 1977 and 1979, as did the number of services provided in those two years. It would appear that laparoscopic services have increased at the expense of a successful vasectomy program.

FP/MCH vasectomy services in the Panchayats are provided through the District Family Planning Office, which arranges for the services of a visiting doctor after acceptors have been motivated. Vasectomy services are available in the Terai as well as Hill areas. In the past, female sterilization camps operated only in the Terai, in hospitals accessible by road. The VSC Expansion Program intends to extend the number of camps by chartering aircraft to heavily populated but inaccessible areas in the hills and mountains of Nepal.

Mobile VSC camps do reach a great number of acceptors, but provision of such services is not without hazard. Medical personnel in isolated district hospitals are limited in number and may not have the training they need to treat the side effects or complications of laparoscopic operations. Although no recorded statistics on sterilization morbidity or mortality are available, complications and even deaths are known to occur. Adequate follow-up care after sterilization camps must be provided. District hospital personnel as well as PBHWs, who most often are the acceptors' first post-operative contact, may also require additional training. More direct follow-up care by team members may be needed in isolated areas. (For a review of service statistics on FP/MCH sterilizations and other family planning methods, see Table 24, page 92, ff., which covers the years 1966-1979.)

C. Family Planning Service Availability

Success in family planning is influenced by both the educational efforts of the health services and the availability of temporary or permanent methods. The FP/MCH Project has made available Progestogen injectables (Depo-Provera), a temporary method, and vasectomies for men and tubectomies (mostly laparoscopic) for women--two permanent methods.

Effective family planning begins with education and motivation. It is apparent that all FP/MCH Project sites are carrying out effective family planning motivation. Between 1977-1978 and 1978-1979, the number of couples motivated increased from 186,907 to 216,901 (see Table 24, pp. 92, ff., footnotes c and d).

Data indicating awareness of family planning were collected for the Mid-Term Health Review (see Table 10, page 58). They show that the level of family planning awareness ranges from 62 percent in no-service areas to 79 percent in areas where FP/MCH family planning clinics are operating.

The higher awareness in FPC areas can be attributed to the length of time FPCs have been operating and to their greater effectiveness in reaching larger numbers of couples. The rather high (62 percent) level of awareness in no-service areas probably is overestimated, given the sample bias toward districts with a greater number of health facilities. It may also be indicative of the success of the FP/MCH radio campaign. Radio was cited as the second most common source of family planning information, friends and relatives being the first. Because direct health service sources were mentioned less frequently, the Mid-Term Health Review concluded that neither HPs, FPCs, nor community workers have reached more than 20 percent of the eligible couples. For those village couples reached, PBHWs were cited as the most frequent source of FP advice. (See Table 11, page 59.)

In the FP/MCH Project, FP district offices, clinics, and PBHWs provide pills and condoms to motivated couples and instruct them in their use; they also provide information about side effects of pills. Between the FP/MCH and ICHP projects, the FP/MCH Project has recruited more acceptors (e.g., as many pill acceptors in 1976-1977 and 2.2 times as many acceptors in 1977-1978). Data on condom distribution indicate that there were 5.5 times as many new acceptors in 1976-1977 and 3.9 times as many in 1977-1978. (See Table 12, page 60.) By comparison, the largest percentage of all eligible couples now using contraceptive pills was in FPC and PBHW areas, while the largest percentage of users of condoms was in PBHW areas. The next highest percentage was in FPC areas.

If the right-hand columns of Table 13, page 61, are considered indicative of the number of continuing users, one could conclude that PBHWs and VHWs are more effective than FPCs in maintaining new pill and condom acceptors. This may be expected because PBHWs and VHWs increase their accessibility by visiting homes.

D. Maternal and Child Health Service Availability

Diarrheal disease is a primary cause of morbidity and mortality and a major component in infant and childhood mortality in Nepal. Most deaths from diarrheal disease can be prevented through early replacement of lost fluids with appropriate oral fluid and electrolyte solutions, which can be prepared commercially or at home. PBHWs have been trained to teach villagers to prepare and use homemade preparations, called assadhi pani. As reported in the Mid-term Health Review, only 21 percent of the PBHWs interviewed spontaneously indicated that oral rehydration education was an important part of their job. In comparison, 74 percent of ICHP workers noted its importance. Apparently, only a small number of PBHWs emphasize rehydration therapy and education.

FP/MCH clinics have provided DPT, BCG, and smallpox immunizations for many years. In FY 1977-1978, 125,751 children below the age of five--25.6

Table 10
AWARENESS OF FAMILY PLANNING IN NEPAL

	<u>Number</u>	<u>Percent Aware of FP</u>
Family Planning Clinic	652	79
PBHW (FP/MCH)	658	68
VHW (IHP)	613	68
No Service	622	62

Source: Mid-Term Review, HMG, p. 10.8.

Table 11

SOURCES OF FAMILY PLANNING ADVICE AMONG CONTRACEPTIVES

	<u>Number</u>	<u>FP Clinic</u>	<u>HP or Hospital</u>	<u>Health Worker</u>	<u>Other</u>
FPC	652	31%	26%	8%	5%
PBHW	658	15%	14%	10%	3%
VHW	613	9%	26%	6%	3%
None	622	16%	16%	5%	2%

Source: Mid-Term Review, HMG, p. 10.11.

Table 12
TOTAL NUMBER OF PILL AND CONDOM ACCEPTORS
(By Project)

	Number of Acceptors		
	<u>1975/76</u>	<u>1976/77</u>	<u>1977/78</u>
<u>ICHP*</u>			
Pills	-	9,267	16,053
Condoms	-	13,587	23,923
<u>FP/MCH</u>			
Pills	37,640	33,250	35,987
Condoms	87,876	74,782	92,182

*An aggregate yearly figure. There has been some under-reporting of ICHP family planning acceptors. See Table 24, pages 88-89, particularly footnotes c-e.

Source: Mid-Term Review, HMG, p. 10.13.

Table 13

USE OF PILLS AND CONDOMS AMONG ALL COUPLES
AND AMONG COUPLES EVER USING PILLS OR CONDOMS, 1977

Service Area	Number	Percent Total Couples Using		Couples Ever Using			
		Pills	Condoms	Pills		Condoms	
				Number	Now Using	Number	Now Using
FPC	652	4	4	27	30%	23	28%
PBHW	658	4	6	25	42%	39	45%
VHW	613	2	3	13	36%	17	45%
None	622	3	4	17	49%	25	40%

Source: Mid-Term Review, HMG, p. 10.16.

percent above the target figure--were immunized. Similar figures were reported for pregnant women. Some maternal health services, including delivery assistance, are provided regularly at most hospitals, FP clinics, and fully Integrated Health Posts. PBHs are trained to provide multi-vitamins and iron to pregnant women as well as nutrition education and referral advice. In 1977-1978, 21,407 new mothers were served by the FP/MCH Project.

As reported in the Mid-Term Health Review, a larger percentage (76 percent) of FP/MCH institutions claim to deliver ante-natal care and 82 percent claim to be supplying vitamins and iron pills. Nevertheless, only 10 percent of pregnant women received any kind of treatment during pregnancy.

E. Program Commodities

The general commodity situation is discussed in Chapter V (see page 124, ff.). At this time, it will suffice to note that Nepal's terrain and climate make transportation extremely difficult. The job of delivering supplies is particularly arduous.

The FP/MCH Project, which is responsible for delivering all family planning commodities, has at its disposal one central warehouse and four regional supply centers, one in each of the four development regions. Regional centers provide commodities to the district centers, which in turn provide supplies to clinics and PBHs. The central, regional, and district supply centers also provide commodities to other programs, such as the ICHP.

It appears that the FP/MCH Project's supply of contraceptives is adequate to meet field demands. However, there are shortages of medicines in clinics and some shortage of surgical instruments used in the sterilization program.

F. Project Finances

The FP/MCH Project is funded by the Nepal Government and external donors. Two agencies, the USAID/N and UNFPA, provide the largest amounts of external funds to the government program. Funding is also provided by UNICEF, which used to be the implementing agency for the UNFPA. That organization now provides support directly.

UNICEF's current role is principally to provide MCH supplies for the program. The UNFPA has been interested in supporting information/education/communication activities that promote family planning and the use of contraceptives. USAID/N has for a number of years helped the FP/MCH Project pay its general operating expenditures. Funds are allotted proportionally, matching HMG monies. USAID/N has also funded specific service program activities.

The International Planned Parenthood Federation (IPPF), the Association for Voluntary Sterilization (AVS), The Pathfinder Fund, and the Unitarian Services of Canada have made small but important contributions to government and private family planning activities. The Japanese Organization for International Cooperation in Family Planning (JOICFP) provides short-term training and conducts seminars for family planning staff. (See Chapter V, pp. 124, ff., for additional information on project financing.)

G. Future Role of the FP/MCH Project

It appears that during the Sixth Plan period, the FP/MCH Project will continue to provide family planning field services in those districts which have not yet reached the I stage of integration. Other special activities organized by the FP/MCH Project, such as mobile VSC camps, training, and education and communication programs, will continue to be supported.

As integration continues, the FP/MCH Project will continue to be responsible for family planning service delivery, although the evaluation team learned that the Health Posts of ICHP will absorb the parallel network of FP/MCH clinics and, as general clinical units, will provide services to villagers.

The FP/MCH Project is expected to retain and expand its role in family planning program evaluation and fertility research. Specialized family planning training will also be conducted and contraceptive innovations introduced into the system. The objective of the effort is to eliminate duplicative service networks. To accomplish this, the team understands that the FP/MCH Project will take over the responsibility for the technical backstopping of family planning for the entire comprehensive (integrated) rural health delivery system.

Other Family Planning Service Delivery Systems

A. Family Planning Association of Nepal

The Family Planning Association of Nepal (FPAN) was founded in 1959. As one of the pioneers in the family planning/population field in Nepal, it had an important role in the evolution of Nepal's population policy. The organization receives its basic support from the IPPF, which contributes direct monetary grants, supplies--largely contraceptives--and some equipment. The FPAN also carries out cooperative projects with the International Association for Voluntary Sterilization and World Neighbors and receives funding from these organizations. In addition, it receives direct grants from the Government of Nepal and through project activities carried out in

conjunction with the FP/MCH and ICHP projects. Some support is obtained from other donors, such as AID, whose funding is channeled through the IPAVS and IPPF.

The FPAN, the president of which is HRH Princess Prekshya, operates through 15 chapters, plus the central headquarters. (The chapters are listed in Table 14, page 65, and plotted in Figure 4, page 66.) Chapter headquarters are staffed by four to six workers and motivators (the Kathmandu Valley Chapter has 10 staff). Approximately 88 staff run the central headquarters of the FPAN, in Kathmandu. The organization of the central office is shown in Figure 5, page 67. Staff are listed in Table 15, page 68. Each chapter is supposed to have no less than 51 members, but actual membership varies and depends on the vigor of membership drives and the imminence of elections of national officers.

The FPAN operates the central clinic, plus a clinic of the Boudha-Bahunipati Family Welfare Project. Both are in Kathmandu. Temporary clinics open from time to time in connection with sterilization camps located throughout the country.

As an indication of the ambitiousness of FPAN operations, plans for 1980 initially called for 30 "project" (budgeted) activities. Funding restrictions required the association to cut back the number to 25. The projects are listed in Table 16, page 69. Several, such as the Integrated Family Planning and Parasitic Control Project (IFPPCP), are newly financed projects. The following projects appear to be important because of their potential impact as other than purely clinical programs: the Boudha-Bahunipati Family Welfare Project, Rural Family Welfare Project Centers, and Family Planning through Development Agencies. All are community based; the first two involve 300,000 largely rural people.

The evaluation team visited the Janakpur Development Agencies project (carried out in cooperation with the Agricultural Development Bank's Small Farmers Development Project). An obviously well trained and motivated Panchayat Family Planning Worker was delivering services and providing motivation. Other staff associates seemed to be well informed about family planning and support it enthusiastically.

The Voluntary Sterilization Project goal for 1980 is ambitious: 2,500 female and 3,500 male sterilizations to be performed at the central FPAN clinic and at mobile camps (40 weekend, 20 one-week, 6 two-week and 4 three-week). Central clinic staff expect to perform 650 male and female sterilizations, in addition to providing injectable and conventional contraceptives. Both the VSC and central clinic programs are increasing follow-up.

One interesting feature of the VSC program is the equipment (laparoscope) repair center, now being built with IPAVS support. As reported in the FPAN third quarter report, in discussing plans for the IPAVS component, the FPAN accepted the recommendation to limit to 50 the number of sterilizations performed by each physician on any one day. The FPAN also supported

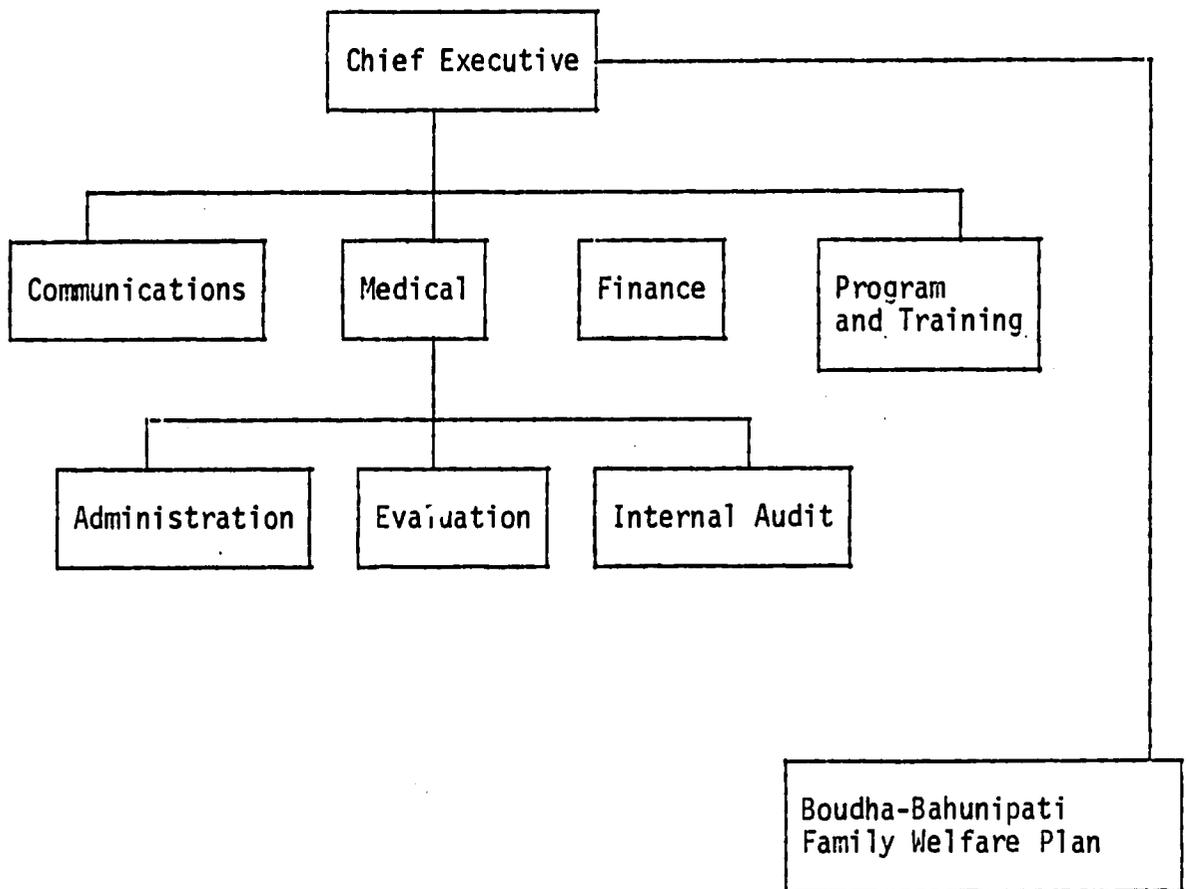
Table 14

FAMILY PLANNING ASSOCIATION OF NEPAL:
BRANCH OFFICES

<u>No.</u>	<u>Name</u>	<u>Location</u>	<u>Staff Positions</u>
1	Kathmandu Valley	Thapathali	Senior Assistant (1) Junior Assistant (2) Motivators (4) Peons (3) <u>(10)</u>
2	Kavre	Kavre, Budol	Senior Assistant (1) Junior Assistant (1) Motivators (4) Peons (2) <u>(8)</u>
3	Janakpur	Janakpur	Senior Assistant (1) Junior Assistant (1) Motivators (3) Peon (1) <u>(6)</u>
4	Saptari	Rajbiraj	
5	Phokhara	Pokhara, Kaski	Senior Assistant (1) Junior Assistant (1) Motivators (2) Peon (1) <u>(5)</u>
6	Baglung	Baglung	(5)
7	Chitawan	Narayangadh	(5)
8	Jhapa	Jhapa	(5)
9	Dharan	Dharan, Sunsari	(5)
10	Doti	Silgadi, Doti	(5)
11	Dang	Dang	(5)
12	Banke	Nepalgunj	(5)
13	Mahendranagar	Mahendranagar, Kanchanpur	(5)
14	Surkhet	Birendranagar, Surkhet	(5)
15	Dhankuta	Dhankuta	(5)

Source: Mr. Madhuran Hada, Administrative Officer, FPAN.

Figure 5
FAMILY PLANNING ASSOCIATION OF NEPAL
ADMINISTRATIVE ORGANIZATION OF CENTRAL OFFICE



Source: FPAN, Kathmandu, Nepal.

Table 15
FPAN CENTRAL OFFICE STAFFING PATTERN

<u>Sl.No.</u>	<u>Title</u>	<u>Allotment</u>	<u>Filled</u>	<u>Remarks</u>
1	Chief Executive (Executive Director)	1	1	
2	Finance Division Chief	1	1	
3	Medical Division Chief	1	1	Deputed to America
4	Programme and Training Division Chief	1	1	
5	Communications Division Chief	1	1	Deputed to America
6	Senior Evaluation Officer	1	1	
7	Training Officer	1	1	
8	Medical Officer	1	1	
9	Female Physician	1	1	Obstetrician/ Gynecologist
10	Communication Officer	1	1	
11	Administrative Officer	1	1	
12	Publication and Broadcasting Officer	1	1	
13	Field Officer	1	1	
14	Senior Accountant	1	1	
15	Sister	1	1	Nurse
16	Administration and Finance Officer	1	1	
17	Art Officer	1	1	

Table 15, cont.

<u>Sl.No.</u>	<u>Title</u>	<u>Allotment</u>	<u>Filled</u>	<u>Remarks</u>
18	Internal Auditor	1	1	
19	Store Keeper	1	1	
20	Procurement Assistant	1	1	
21	Senior Office Assistant	3	3	
22	Office Assistant	4	4	
23	Typist	6	6	
24	Field Supervisor	2	2	
25	Senior AHW	2	2	
26	Personal Assistant	1	1	
27	Staff Nurse	1	1	
28	Electrician	1	1	
29	Pathologist	1	1	
30	Mechanic	1	0	
31	Clinic Supervisor	1	1	
32	Health Aide	1	1	
33	Clinic Assistant	5	5	
34	Motivators	24	24	
35	Drivers	4	4	
36	Peons	8	8	
37	Sweeper	2	2	
38	Guard	<u>2</u>	<u>2</u>	
	TOTAL	<u>89</u>	<u>86</u>	

Source: Mr. Madhuram Hada, Administrative Officer, FPAN.

Table 16

FAMILY PLANNING ASSOCIATION OF NEPAL:
PLANNED 1980 PROJECTS

PROJECT	PROJECT
Publications, IEC	Family Planning Education to the National Development Service Students, PR/TR
Film Shows, IEC	
Radio Programs, IEC	Management Development, PR/TR
Exhibition, IEC	Family Planning Through Development Agencies, MED/CLIN
Folk Media Project, IEC	Family Planning for Newly Married Couples, IEC
Volunteer Mobilization Project (VM), IEC	Family Planning and Adult Literacy Project, IEC
Integrated Family Planning and Parasite Control Project (IFPPCP), IEC	No Marriage Year 1980 Campaign Project, IEC
Children Welfare Project (CWP), IEC	Family Planning and Religion, IEC
Boudha-Bahunipati Family Welfare Project (BBFWP), MED/CLIN	Family Planning and Law, PR/TR
Rural Family Welfare Centers (RFWC), IEC	IEC Campaign and FPAN Branches, IEC
Community-Based Distribution (CBD Sales Program)	Evaluation Project, ADM
Voluntary Sterilization Augmentation Project (VSAP), MED/CLIN	Fundraising Project, FR
Central Clinic, MED/CLIN	Training of Special Groups, PR/TR

<u>Program Categories</u>	
IEC = IEC	PR/TR = Program and Training
MED/CLIN - Medical/Clinical	ADM = Administration and Evaluation
CBD = Community-Based Distribution	FR = Fundraising
<u>Source: FPAN Draft Work Plan Budget Estimate, 1980.</u>	

the idea of requiring a junior physician to be at the camp site for three or four days after completion of the camp to provide follow-up care.

Dr. Malla, FPAN Executive Director, stated that the VSC program is beginning to emphasize mini-lap procedures. He has some misgivings about this, and is concerned that it may bring about increased interest in the use of paramedical personnel for the procedure. As described in the 1980 UNFPA Project Proposal (NEP/80/P13), assistance to the FP/MCH Project was to include funds for training 24 senior paramedics in vasectomy techniques in FPAN clinics. Under the same project, the UNFPA is financing the research on an injectable contraceptive (Depo-Provera) that will be conducted by the FP/MCH Project in cooperation with the FPAN. The FPAN has attempted to carry out several joint sterilization camp operations in cooperation with the FP/MCH and ICHP projects, but accounting problems have hindered the effort. Table 17, page 71, lists total supplies delivered to the field in 1979 through branch offices and FPAN projects. The team did not make an in-depth analysis of expenditures. The expenditure and income statements for 1979 and 1980 (projected) give a reasonably good picture of how the FPAN is financed. Table 18, page 72, lists the 1979 and 1980 (projected) expenditures. Table 19, page 73, lists the 1979 and 1980 (projected) sources of income (in U.S. dollars) for the FPAN. IPPF grant support is included. The figures do not include approximately \$180,000 in contraceptives provided in-kind by the IPPF.

There is very limited input from local resources: only \$2,402 from combined dues and contraceptive sales. Table 20, page 74, is a record of contraceptive receipts and deliveries--a major support item--for the three years 1977-1979. Funds from international donors must be channeled through the Health Services Coordinating Committee of the Social Service Coordinating Office, of which HM Queen Aiswarya is chairperson.

The FPAN appears to be playing an important role in the family planning service delivery program in Nepal. FPAN programs complement those of HMG agencies, and FPAN facilities and personnel are involved in coordinated ventures in the field. The FPAN is a source of "alternate" oral contraceptives--other than the USAID/N-supplied Norinyl 50 and 80. The FPAN's emphasis on community-based programs and the lead it has taken in stressing developmental activities indicate that as an innovator, the association is continuing to play the traditional role of a non-government agency.

B. Nepal Women's Organization

The Nepal Women's Organization (NWO) was established in 1961 "to protect and promote the rights of women and engage them in the task of national development by unifying their energies." Although established by royal proclamation, the NWO is an independent, private organization dedicated to representing and raising the status of the women of Nepal.

Table 17
CONTRACEPTIVES ISSUED TO FPAN BRANCHES AND PROJECTS, 1979

<u>Branch/Project</u>	<u>Condom (each)</u>	<u>Pills (cycles)</u>	<u>Spermicide Foam/Jelly</u>	<u>IUD (each)</u>	<u>Depo-Provera Vials (10 Doses)</u>
JPP Sales Center	43,298	7,083	563	-	-
Central Clinic	118,320	4,520	900	-	50
Baglung	40,800	600	216	100	5
Kavre	15,760	780	244	-	-
Rajbiraj	11,520	720	208	-	15
Dhankuta	11,520	420	172	-	-
Surkhet	5,760	600	36	100	5
Jhapa	1,440	720	172	-	5
Janakpur	17,760	-	100	-	-
Kathmandu Valley	35,280	2,400	144	-	-
Pokhara	6,000	600	-	-	-
Dharan	17,520	1,800	172	-	-
Bharatpur	5,760	-	112	-	-
Boudha-Bahunipati Project	23,760	5,130	-	-	65
MCH Project	-	-	-	-	60
Boudh	-	12	-	-	-
Mobile Camps	19,254	560	82	-	-
Parasite Control	2,500	900	-	-	-
TOTAL	<u>376,252</u>	<u>26,845</u>	<u>3,121</u>	<u>200</u>	<u>210</u>

Table 18
 FPAN EXPENDITURE BUDGET FOR 1979 AND 1980
 (In U.S. \$)

IE&C	\$ 75,118.00*	\$ 96,890 ^{5**}
Medical/Clinical	170,561.00	106,283 ⁵
Community-Based Sales	504.00	504
Program and Training	26,746.00	6,809
Administration/Evaluation ¹	94,473.00	98,271
Fund Raising	-	3,307
B B Project ²	-	87,994
FPAN Building Construction	-	13,536
IFPPCP ³	-	60,000
RAM Center ⁴	-	60,039
TOTAL	\$367,402.00	\$533,633

¹ Non-project personnel and office expenses

² Boudha-Bahunipati Project (World Neighbors)

³ Integrated FP and Parasite Control (JOICFP)

⁴ RAM Center (equipment repair/maintenance; IPA VS)

⁵ Combined IPPF and IPA VS funding

Source: * FPAN Work Program and Budget, 1980. This document includes a summary of actual 1979 expenditures to back up the proposed work program for 1980.

** FPAN Approved Budget, 1980. This document covers only the approved 1980 expenditure budget prepared after the IPPF review of the 1980 workplan.

Table 19
 FPAN INCOME FOR 1979 AND 1980
 (In U.S. \$)

<u>Basic Support</u>	<u>1979¹</u>	<u>1980²</u>
Donations	\$ 49,486	\$ 87,994
IPAVS	128,635	192,166
JOICFP		<u>60,000</u>
Subtotal	<u>\$178,121</u>	
 <u>Other Sources</u>		
Membership Subscription	900	(NL)
Contraceptive Sales	1,502	(NL)
Other Local Sources	-	<u>13,536</u>
Subtotal	<u>\$ 2,402</u>	<u>353,696</u>
 <u>IPPF</u>		
Grant	187,000	180,000
TOTAL INCOME	<u><u>\$367,523</u></u>	<u><u>\$533,696</u></u>

Source: ¹ FPAN Work Program and Budget, 1980.

² FPAN-Approved Budget, 1980.

Table 20

FAMILY PLANNING ASSOCIATION OF NEPAL:
CONTRACEPTIVES RECEIVED AND ISSUED, 1977-1979

<u>Contraceptives</u>	<u>Balance</u>	<u>Received</u>	<u>Issued</u>	<u>Balance</u>	<u>Received</u>	<u>Issued</u>	<u>Balance</u>	<u>Received</u>	<u>Issued</u>
Condoms (Units)	311,733	216,000	434,731	93,002	576,000	566,192	102,810	313,920	376,252
Depo-Provera (Vials)	6	210	41	175	200	142	233	200	255
Depo Oestradiol	-	100	4	96	-	8	88	-	18
Eugynem Pills (Cycles)	7,740	-	7,648	92	10,020	4,138	5,974	7,722	7,220
Delfen Foam	2,879	-	2,082	797	2,016	1,948	865	13	468
Vaginem Jelly	1,912	-	1,844	68	1,512	1,128	452	3,024	1,687
Lippes Loop	1,477	-	-	1,477	-	-	1,477	-	-
Loop Tablets	2,315	-	1,524	791	-	791	-	2,060	966
Norinyl Pills (Cycles)	70,841	-	11,230	59,611	-	35,620	23,911	-	15,252
Ovral Pills (Cycles)	7,070	-	2,180	4,890	1,200	2,911	3,179	3,000	4,373
Saf-T-Coil	-	-	-	-	2,000	410	1,590	-	200

Source: Taj S. Malla, M.D., Chief Executive, FPAN.

The NWO's objectives are to raise the status of women in society; provide opportunities to women to enjoy the same economic and social rights that men have; make women self-reliant; and assist women in achieving the capability to share responsibility for community and national development. The NWO is based in village units located in 72 of the 75 districts of Nepal. (The basic village unit is supposed to contain 50 women.)

Using the NWO district- and village-level organizational structure, Family Planning International Assistance (FPIA) funded in July 1974 a five-year family planning project. The project was designed to train village women as family planning agents to educate couples and distribute contraceptives to rural villages.

The Nepal Women's Organization/Women's Family Planning Project (NWO/WFPP) now operates through the existing NWO network in the following 12 districts:

Ilam	Banke
Jhapa	Palpa
Sunsari	Nuwakot
Siraha	Tanahu
Sallyan	Rajbiraj
Doti	Pokhara Pension Camp

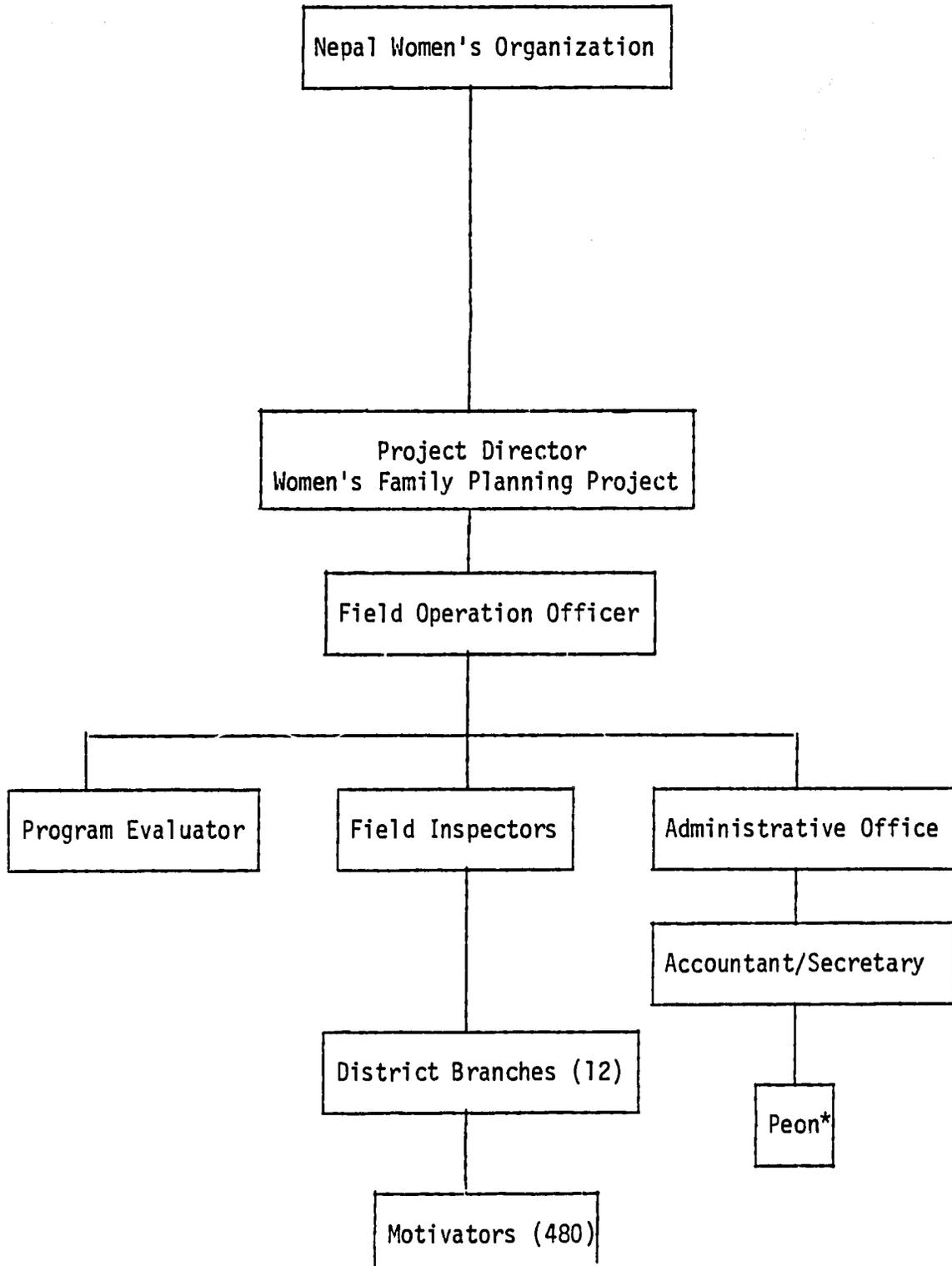
The central headquarters in Kathmandu is staffed by a Project Director, a Field Operations Officer, a Program Evaluator, an Administrative Officer, an Accountant/Secretary, and two Field Inspectors. Each district headquarters is staffed by two District Field Inspectors, one Supervisor, and four Assistant Supervisors. The district NWO president acts as an Ex-officio Supervisor. The organization of the NWC/WFPP is shown in Figure 6, page 76.

Village workers selected to participate in the project must be female, married or older than 25; literate; local; and poor or from the lower class. (See Table 21, page 77, for numbers of trainees by district.) After 10 days of training, village workers are given pills and condoms that they distribute under the supervision of the Government District Medical Officer. Each year a worker is supposed to maintain 25 acceptors on pills or condoms and refer five patients for sterilization. The recruiters average approximately 25 couples per year in temporary methods, but only 2.5 sterilization patients.

Contraceptive commodities for the project are obtained from the FP/MCH Project. Sterilization referrals are made in conjunction with sterilization camps operated by FP/MCH and ICHP staff. Continuing users in the period September 1977-March 1979 used the following methods:

Figure 6

ORGANIZATION CHART FOR THE NWO/WFPP



* Messenger/clerk

Table 21

NATIONAL WOMEN'S ORGANIZATION:
FAMILY PLANNING WORKERS TRAINED
(By District)

<u>Districts</u>	<u>Initiation Date</u>	<u>Supervisors</u>	<u>Asst. Supervisors</u>	<u>Team Leaders</u>	<u>Motivators</u>
<u>Far Western Region</u>					
Banke	1978-79	1	2	2	24
Surkhet	1974-75	1	2	6	48
Jumla	1978-79	1	2	4	33
Doti	1978-79	2	0	4	48
<u>Western Region</u>					
Palpa	1977-78	1	3	5	28
Gorkha	1976-77	1	2	0	20
Kapilvastu	1978-79	1	2	3	32
Tanahun	1978-79	1	2	3	21
<u>Central Region</u>					
Parsa	1975-76	1	1	0	22
Nuwakot	1977-78	1	2	3	32
Kathmandu	1975-76	1	2	4	50
Bhaktapur	1975-76	1	2	4	39
<u>Eastern Region</u>					
Rajbiraj	1974-75	1	2	4	60
Sunsari	1976-77	1	2	4	56
Jhapa	1976-77	1	2	3	44
Ilam	1977-78	1	3	0	36
		<u>17</u>	<u>31</u>	<u>49</u>	<u>593</u>

Source: Pradhan, Bina, The Status of Women in Nepal, Vol. 1, Part 3, Institutions Concerning Women in Nepal, Kathmandu, Nepal: CEDA, 1979, p. 25.

<u>Contraceptive</u>	<u>Number Users</u>
Condom	5,734
Orals	11,933
Male Sterilization	379
Female Sterilization	1,249
IUD	23
Depo-Provera	96

To avoid duplicating services in areas where the FP/MCH Project or ICHP also operates, NWO/WFPP began in 1978 to phase-out activities in those districts. In 1974, it had begun operating in 16 districts; by 1979, four districts (Gorkha, Kapilvastu, Surkhet, and Jumla) had been turned over to the FP/MCH Project. NWO provided FP/MCH with a list of names of motivators and their Panchayat locations and requested that these workers be considered when selections were made for FP/MCH Panchayat-based health workers. Unfortunately, the FP/MCH selected only a few NWO workers, and some experience and initiative were lost to the program.

The NWO/WFPP has been the only community-based, door-to-door family planning service delivery program to reach potential family planning clients in remote villages exclusively through women motivators. After five years of funding, the project has not demonstrated high quality management capabilities. It has been plagued with continuous problems in maintaining acceptor statistics and financial accountability. It has reported late, underspent, and failed to meet objectives. The FPIA recently completed an audit (not yet available) that confirms these problems. As a result, FPIA served notice that it is terminating funding.

The project has requested a four-month extension to complete phase-out procedures in 12 currently active districts. After reviewing the audit report, the central FPIA declined to fund the extension requested. USAID has requested the FPIA to provide extension funds to allow NWO/WFPP "to phase-out ongoing project activities, terminate staff and fill out necessary reports, and allow NWO-HGM officials time to identify alternative program(s) to utilize existing district-level infrastructure."

The evaluation team believes that an orderly phase-out of NWO family planning activities should be effected and alternative programs designed. These efforts will ensure that the NWO's momentum will not be lost, as will happen if activities are terminated abruptly. Despite financial problems, the Nepal family planning effort needs as many contributions from different sources as it can solicit.

C. Commercial Retail Sales

To increase the distribution and use of pills and condoms in Nepal and to inaugurate a commercial contraceptive sales project, a centrally-funded AID/W contract (AID/pha-C-1144) was signed in June 1976 with Westinghouse Health Systems. Under the contract, Westinghouse was to design a system which, it was hoped, would result in a greater distribution of pills and condoms.

Despite initial Mission resistance to the activity, approval was finally obtained and a Westinghouse expatriate advisor arrived in Kathmandu in September 1976 to launch the program. HGM approved the development of the Contraceptive Retail Sales (CRS) Project and designated the FP/MCH Project the implementing agency. A full-time counterpart to the project manager was assigned from the FP/MCH Project. An independent Advisory Committee, under the chairmanship of the chief of the FP/MCH, was appointed to provide policy guidance to the project manager and staff. The primary purpose of the Advisory Committee is to provide advice and suggestions on the proper and orderly design and implementation of a marketing program. The committee is made up of representatives from the Ministry of Health, the Ministry of Home and Panchayat, the Ministry of Industry and Commerce, and the Nepal Medical Association, Family Planning Association, Women's Affairs Coordination Committee, as well as other government, private, and commercial enterprises in Nepal.

Commercial sales began in June 1978. AID/W provides contraceptives, pills, and condoms for the project. In addition, AID/W funded the contract for expatriate project management and local staff. One of the original goals of the project was to become financially self-sufficient (the cost of the contraceptives excepted). Under an AID/W contract, the American Public Health Association (APHA) evaluated in December 1978 the progress in achieving this goal.*

By the end of 1979, the project had successfully instituted the sales of pills and condoms in Nepal. Four hundred eighteen retail dealers in five urban locations have agreed to sell oral contraceptive pills, and 2,149 shops and stores in seven cities and market towns sell condoms. Contraceptives, provided free by AID/W, are sold to dealers who, in turn, sell them to individual retailers. The fixed retail price has been set at 50 paisa ($\frac{1}{2}$ Rupee) for three Dhaal (condoms) and Rs. 1.50 for a cycle of Gulaf (pills). (See Table 22, page 80, for wholesale and retail costs.) CRS believes this subsidized price makes contraceptives available at a cost that most Nepalese can afford.

*T. Siens and T. Smith, "An Evaluation of the Commercial Distribution of Contraceptives Program in Nepal," Washington, D.C.: APHA, 1978.

Table 22

NEPAL CONTRACEPTIVE RETAIL SALES PROJECT:
WHOLESALE AND RETAIL PRICE STRUCTURE, DHAAL AND GULAF

	<u>Price to Dealer</u>	<u>Dealer Markup</u>	<u>Percent Dealer Profit</u>	<u>Price to Retailer</u>	<u>Dealer Markup</u>	<u>Percent Dealer Profit</u>	<u>Price to Consumer</u>
<u>Dhaal Condoms</u>							
Consumer Unit Pack (3 pieces)	Rs.0.36	Rs.0.06	16.7%	Rs.0.42	Rs.0.08	19%	Rs.0.50
<u>Gulaf Oral Pills</u>							
Consumer Unit Pack (one-month supply)	Rs.1.10	Rs.0.15	13.6%	Rs.1.25	Rs.0.25	20%	Rs.1.50

Source: Commercial Retail Sales Project, Kathmandu.

In addition to operating a commercial sales distribution system, the CRS Project has initiated a number of innovative activities that have increased the Nepalese public's awareness of the availability of contraceptives. The CRS efforts have also helped to make less controversial the topics of contraception and reproduction in the Nepal community.

Before he can sell oral contraceptives, the retail dealer (druggist or chemist) must complete a training class (complete with official certificate) on the physiological changes a woman can expect after she begins using the pill. Each dealer is trained in the contraindications of pill usage and is instructed to screen potential customers. As a result of this effort, more people in the community have a knowledge of oral contraceptives.

Another important supplement to the national family planning program is the series of CRS radio advertisements promoting the use of contraceptives, particularly as temporary methods. Posters and visual advertisements have also been designed and distributed. A motion picture is under consideration.

A particularly visible project activity was the national contest to find a brand name for the Nepal pill and condom. Twelve hundred entries were received. The name finally chosen for the condom was "shield"--"Dhaal." This is a traditional artifact that connotes masculinity and denotes protection. For the pill the Nepalese term "Gulaf"--rose--was selected. It is symbolic of rose hips, which the Nepalese eat. Posters carrying the Dhaal and Gulaf emblems are seen in shop windows and on taxis (and even at the hotel desk in Nepalgunj).

The market economy in Nepal is not conducive to a commercial retail sales program for contraceptives. Some examples demonstrate the point. After the traditional terms, Dhaal and Gulaf, were selected, the Ministry of Information decided they were virtually generic terms for contraceptives and adjudged them too risqué for the Nepalese public. The CRS is prohibited from using the terms in its radio advertisements. Some interesting terminology has since been developed to advertise the product.

The CRS has made an arrangement with the cigarette monopoly in southern Nepal to transport Dhaal and Gulaf for free. The company's trucks deliver cigarettes to Kathmandu, return to Janakpur with contraceptives, and turn the products over to dealers--at no cost to CRS. The lack of knowledge among the Nepalese of contraceptives was evident at a meeting attended by staff of the cigarette monopoly. The CRS project manager passed around some condoms for the staff to examine. A young salesman exclaimed, "I don't see how you are going to get a woman to swallow one of these."

When the CRS decided to use a full-service advertising firm, it discovered that there were none in Nepal. It has since helped establish an advertising agency which is now promoting sales of Dhaal and Gulaf.

AID/W-supplied commodities are packed on CRS premises. At the suggestion of the APHA team that was evaluating the CRS project, a special order of condoms was produced by the U.S. manufacturer without the brand name, Tahiti, to distinguish these condoms from those distributed free through the government network. The first shipment of these condoms arrived while the present evaluation team was in Nepal.

The CRS has designed distinctive packaging for its two products. Extensive efforts were made to locate a Nepalese enterprise that could manufacture the packaging. When no bids were received from any Nepalese firm, a contract was signed with a Thai non-profit family planning corporation.

Relations between CRS staff and HMG officials are excellent. This, the team believes, is due in large part to the leadership qualities of the Westinghouse project manager.

One of the Project's original goals was to shift responsibility for operations to an indigenous organization or firm. For example, it has been suggested that the Family Planning Association of Nepal should absorb CRS operations. The evaluation team feels that if this happened, the public would perceive that the private, non-profit organization was "making a profit" on contraceptive sales--a conflict of interest.

The CRS should continue to strengthen its management and promotional capabilities. Its ultimate goal should be to assume an identity of its own, one that is associated with neither a government agency nor a non-profit organization. To ensure coordination, government representatives of family planning and health delivery agencies should continue to sit on the policymaking Advisory Committee. The CRS should, however, establish its identity as a viable entity independent of any other organization. To accomplish this goal, expatriate leadership will be required for several more years.

The CRS Project will have to be subsidized for some years to come. Because of its unique contribution to the overall Nepalese population control program, the team endorses the Mission's request to extend the Westinghouse contract through October 1980. At that time, the evaluation team believes, AID/W or USAID/N should extend the contract for another two or three years.

In 1978, the APHA evaluated the CRS strictly as a commercial enterprise, and based its recommendations on that designation. The present evaluation team disagrees with some of the APHA recommendations, fully recognizing that the APHA evaluators perceived CRS as a commercial enterprise building toward financial self-sufficiency. The team does not feel the CRS will become financially viable in the foreseeable future, but acknowledges that the contribution it is making will not be accomplished by any other entity in Nepal. The team believes the CRS should not be judged as a commercial enterprise, which it is not, and recommends that AID/W not make another evaluation based on this assumption.

The APHA evaluation team recommended that dealer profit margins be reduced. They stated that the CRS should "prepare for a reduction in dealer and retailer margin." The present evaluation team recommends that dealer margins be increased, if possible. Current margins are equal to or slightly above markups for other products sold by chemists. Increasing profit margins would stimulate chemists to sell more contraceptives. The goal of this strategy would be to maximize sales, not CRS profits. The Project has already taken steps in this direction by offering prizes of additional free contraceptives in the contraceptive display contest.

In conjunction with the effort to increase dealer profits, the evaluation team would like to see the CRS attempt to determine the elasticity of prices for Dhaal and Gulaf. Some indication of the elasticity of Dhaal will be evident when sales of Suki Dhaal, two clear-colored condoms sold for 25 (suki) paisa, begin.

Relations with USAID/N staff are most cordial. The Project Manager regularly keeps the Mission informed of activities, but the evaluation team believes Mission efforts to monitor the Westinghouse contract should be strengthened. In a 1978 letter to the Secretary of Finance, the Mission Director stated:

USAID will provide continuing liaison support, advice, and cooperation and will participate in periodic meetings with the Westinghouse Health Systems Field Project Manager, the Nepal FP/MCH Project Chief and staff, the POPCOB, FP/MCH Board, Advisory Committee, and sub-contractors, as needed, for the successful development and continuing growth and operations of the program

The evaluation team urges the Mission to rededicate itself to this goal of actively monitoring this important AID/W contract.

D. Other Participants in Family Planning

A number of other activities in Nepal support the family planning sector. Some are funded from Nepal sources, but many are supported by foreign donors.

The Center for Population Activities (CEFPA), in Washington, D.C., is funded by AID/W and assists with management training of family planning administrators, particularly District Family Planning Officers (FPOs). A separate team planned to begin its evaluation of the CEFPA just as the current review was concluding.

The Mothers' Club-Based Family Planning Project will receive support for five years (beginning in June 1979) from the Nepalese Social Services

National Coordinating Council. The goal of the project is to establish 20 family planning Mothers' Clubs in four districts. The clubs will train 128 village women (the target) in techniques of motivation, recruitment, and follow-up of contraceptive acceptors.

Westinghouse, Inc., is now planning to conduct a contraceptive prevalence survey in Nepal. This AID/W-financed contract is separate from the CRS Project discussed above. The information obtained from the survey should be most useful in assessing the impact that family planning activities are having in Nepal.

The AID/W-financed Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) has trained Nepalese obstetric surgeons in female sterilization. In addition, JHPIEGO has supplied some of the laparoscopes used in Nepal (these do not show up in HMG or USAID/N summary financial data).

The Nepal Red Cross is training and placing family planning motivators. These paid staff will be stationed in 40 Panchayats in Syangja and Chitawan districts where there is neither a clinic nor Panchayat-based health workers. AID/W funds for the project are channeled through FPIA.

Each organization is making a complementary contribution to the Nepal family planning program. Importantly, in most cases, intimate community participation in the effort is encouraged. The team recommends that the organizations receive the encouragement and funding they need to continue and to expand their efforts.

Health and Family Planning Service Delivery Record

A. Health Service Delivery Record

Although there are multiple health delivery systems in Nepal, it is difficult to get a definitive across-the-board picture of the quantity and quality of health services (other than family planning) being delivered throughout the country. It is obvious that both quantity and quality vary with the geographic area in question. Generally, there are few services in the Hills area. The Kathmandu Valley receives relatively better services. In the Terai, where population density is high and transportation facilities inadequate for the distances involved, service delivery tends to be spotty and to be confined largely to communities with access to roads.

Probably the best measure of the effectiveness of health service delivery is the health status of the population. Although an accurate assessment of the health status of the population is hampered by the absence of reliable and comprehensive information, by any standard, the health situation is poor.

Just two decades ago, there were virtually no modern rural health services in a country with rampant malaria, smallpox, tuberculosis, leprosy, and high infant mortality. Since then, smallpox has been eradicated and malaria is under control.

Forty-eight of Nepal's 75 districts have health centers (District Health Offices); 68 hospitals provide curative services; and over 1,500 Village Health Workers in 533 Health Posts provide a modicum of primary health care. It should be emphasized again that medical supplies and medicines are woefully inadequate; most health system delivery points obtain annually medicines that cover no more than three or four months of the year. The mobility of field delivery personnel is greatly restricted by the difficult terrain, poor communications, lack of transport, especially for supervisors, and the failure of agencies to provide on time the necessary travel funds.

While much has been accomplished, malnutrition is common, water is polluted, infectious diseases are widespread, and mortality, especially infant mortality, is very high.

According to the 1971 census, the crude birth rate was 41.3/1,000 and the crude death rate, 21.4/1,000. The rate of natural increase was 2.0 percent. Life expectancy, another indicator of health and development status in Nepal, was estimated in the Demographic Sample Survey for 1974-1975 at 46 years for males and 42.5 years for females. The infant mortality rate in 1971 was a staggering 172/1,000. Slightly more than one of every two children reach age six.

The main causes for this high mortality are malnutrition, diarrhea, severe dehydration, and communicable diseases, such as tetanus, diphtheria, pertussis, and tuberculosis. Measles has also been reported as a major cause of death in children in rural areas.¹ For many of these children, the odds against survival were set before they were born because their mothers were malnourished, anemic, and deficient in essential vitamins.

Given these conditions, it is not surprising that Nepal has adopted a preventative health program that emphasizes population control, proper nutrition, communicable disease control, and maternal and child health programs.

1. Nutritional Situation in Nepal

Reliable and direct data on the nutritional status of the Nepal population are extremely limited. Only in the last 10 years have several surveys on the food consumption pattern and nutritional status of the

¹Country Profile: Nepal, WHO, January 1979.

population been taken. Nepal's geographical characteristics affect profoundly food production and food availability. Situated in the heart of the Himalayan goiter belt, the country has an extremely high incidence of endemic goiter and of associated cretinism, deaf-mutism, and mental retardation.

The available data and disease trends lead one to conclude, however, that child malnutrition is the most glaring problem, and protein-energy malnutrition the most predominant manifestation. Some reports recommend intervention to combat xerophthalmia and anemia. Though few data on these illnesses are available, food consumption patterns in most high-mountain areas indicate that the population's intake of Vitamin A, which is needed to prevent xerophthalmia, is alarmingly low. The extremely high incidence of parasitism and the very low intake of green leafy vegetables, almost the only source of dietary iron, indicate the possibility of widespread nutritional anemia.

A recent nutrition survey reported that approximately 50 percent of all children below age six had reached less than 90 percent of the medium height for that age. This is indicative of long-term nutritional deficiency. Seventeen percent of the entire survey population showed definite short-term nutritional deficiencies. Although similar data are not available for the entire population, one may presume that much of Nepal's population exists below "minimum subsistence."¹

WHO recently analyzed and carefully interpreted the results of 101 surveys on nutritional deficiencies. The surveys were taken in 59 countries in Asia, Africa, and Latin America over the last 10 years. The average incidence for third-degree malnutrition varied between 2 percent and 5 percent in most cases; the average in Nepal was 15.6 percent. There is no doubt that protein-energy malnutrition in children is a critical problem.

Endemic goiter has attracted much attention because its side effects include physical deformity. Several reports based on limited surveys indicate the gravity of the problem. A 1974 WHO survey report contains a fairly comprehensive description of goiter and cretinism in 17 selected survey areas.² The incidence of goiter varied between 25 percent and 40 percent in the general population in most areas.

Except for some hospital reports, there is almost no information on anemia. Given the widespread hookworm infestation, the incidence of

¹Nepal Nutrition Status Survey (January to May 1975), Department of Health Education and Welfare, Center for Disease Control, 1975.

²Pourbaix, P., Nutrition Survey in Nepal (SEA/NUT/50), New Delhi: World Health Organization, 1974.

nutritional anemia must be fairly high. The extent of the problem will not be known until the incidence of anemia among the most vulnerable population--pregnant women--is determined.

Although efforts to combat many of these nutritional problems require socioeconomic and environmental changes, a substantial reduction in their incidence can be achieved by providing widespread health education, immunizations, and MCH services.

The measurement of mid-upper-arm circumference is a simple and accepted screening method for malnutrition. Although a much less accurate method than measures of weight and height for age, it has been adopted in Nepal because of its simplicity and convenience for field use. ICHP and FP/MCH workers at district and post levels use this method to assess the nutritional status of children.

To combat childhood malnutrition, health workers teach villagers to use a home-prepared, locally developed weaning food, sarbottom pitho. An equal mixture of any two locally available food grains and soya-beans, or other protein-rich lentils (dal), this formula is fed as a porridge to weaning and malnourished children. In spite of education efforts, only one-fifth¹ of the households aware of this formula have ever prepared and used sarbottom pitho, and this has lessened the impact of this special high protein food. Health workers, no doubt, must work more effectively to motivate people to prepare and use this foodstuff.

Diarrhea as it relates to malnutrition and certainly to infant and childhood morbidity and mortality has been addressed at local levels. Home-made solutions of assadhi pani (medicine water) or nun-chini-pani (salt-sugar water) are easily prepared and, when used as an interim measure to treat diarrhea, have a substantial impact on mortality. Commercially prepared oral rehydration solutions (RD-Sol) are also available. (UNICEF is supporting Royal Drug's increased production of RD-Sol.)

While maternal care is recognized as a crucial feature of health care, it has received little attention in Nepal. Prenatal nutrition education is offered, but the provision of multi-vitamins and iron tablets depends on availability. It has been estimated that only 10 percent of pregnant women receive any kind of treatment during pregnancy. In the Sixth Plan period, maternal care will receive special attention. Pregnant women will be immunized against tetanus, which is transmitted to newborns and nearly 100 percent fatal, and iron and folic acid pills will be dispensed to prevent anemia caused by either iron or folic acid deficiency.

¹Mid-Term Review.

2. TB/Leprosy and the Expanded Program of Immunization (EPI)

According to the Ministry of Health, as of 1979, the entire population in 55 of Nepal's 75 districts had been screened for active tuberculosis and BCG immunizations had been given to all children under 15 years of age in each district visited. In FY 1977-1978, approximately 700,000 BCG vaccinations were given.

Even assuming BCG is a prophylaxis, its impact as a public health measure will not be evident for 10 to 20 years. Consequently, one must acknowledge that a tuberculosis control program based only on the number of vaccinations given runs an uncertain course. However, since the tuberculosis case in the home is the source of most new infections, the detection and treatment of infected people at home for 9 to 18 months should help to reduce the spread of the disease. A recent survey of 7,000 persons reported that 7 percent had a chronic cough; 18 percent were presumed to have tuberculosis because they spat blood.

Leprosy identification teams will continue to survey the population during the Sixth Plan period. The teams will cover 20 new districts. Education of the population and training of Health Post staff will receive greater attention.

Once the EPI has established an adequate cold chain (refrigerated storage and insulated containers for field transport) in rural areas where even kerosene refrigerators are at a premium, immunization will reach more susceptible children.

3. Malaria Control Program

Nepal has been plagued by malaria for centuries and this has contributed to its isolation from much of Asia. The malarial tracts of the Terai were a barrier, discouraging emigration from India and the Hills area of Nepal and deterring the orderly settlement of the fertile lands of the Inner Terai and forest fringe.

Before the 1950s, an estimated two million cases of malaria were reported each year in Nepal, with approximately 10 percent of the cases resulting in death. Today, approximately 50 percent of Nepal's population are at risk to malaria.

The first formal malaria control and eradication program was initiated in 1954 by HMG with the assistance of the U.S. Government. In 1955, WHO implemented a pilot project and by 1958 the two projects were combined to form the Nepal Malaria Eradication Organization (NMEO).

By 1964, the entire malarious area had been covered and by the 1970s the program of malaria eradication had been so successful that the

number of cases reported declined to a low level of approximately 2,500 cases annually. Unfortunately, malaria incidence began to rise again, prompting HMG to act quickly to strengthen malaria control activities. Between 1975 and 1978, strengthened activities prevented the kind of massive malaria explosion seen in India, Pakistan, and Sri Lanka. In the last few years, the present program has been able to contain malaria at approximately 10,000-13,000 cases annually. The malaria incidence for Nepal is illustrated in Table 23, page 90. The data cover the period 1968-1979 to indicate trends in the program.

USAID/N's commodity assistance to the NMEO during the Sixth Plan period is designed to complement the efforts of the HMG, multilateral agencies, and bilateral agencies. Stressing the importance of preventive health activities, this project focuses on an area that affects the lives and productivity of over seven million Nepalese. In short, the project inputs are aimed at a national health priority which has both economic and social benefits. Among other activities, the NMEO plans to:

- continue to apply residual insecticides;
- continue active case detection by trained surveillance workers;
- continue passive case detection at hospitals, health centers, and health posts;
- provide treatment for diagnosed cases;
- conduct continuous evaluations to determine program effectiveness;
- institute a comprehensive malaria research program; and,
- provide training and health education.

The program's objective is to lower by 1985 the incidence of malaria in Nepal to less than 12,000 cases (approximately one case per 1,000 persons).

B. Family Planning Service Delivery Record

During its formative years, family planning had little success in promoting the acceptance or use of contraceptives, despite the best efforts of HMG/N. The 1976 World Fertility Survey (WFS) reported that only 3.4 percent of all married Nepalese women had ever used an efficient contraceptive method; only 3 percent of "exposed" women were contracepting, almost 2 percent from male sterilization. As a result, the demographic impact of family planning efforts in the first decade of the project was insignificant.

Table 23
MALARIA INCIDENCE IN NEPAL, 1968-1979

<u>Year</u>	<u>Total Number Recorded Malaria Cases in Nepal</u>	<u>Plasmodium Vivax</u>	<u>Plasmodium Falciparum</u>	<u>Plasmodium Malariae</u>	<u>Mixed</u>	<u>Annual Parasite Index</u>
1968	2,468	2,274	157	14	23	0.43
1969	2,930	2,464	378	21	67	0.47
1970	2,518	2,294	156	55	13	0.41
1971	2,778	2,536	164	45	33	0.42
1972	4,067	3,433	533	20	81	0.65
1973	8,479	7,080	1,229	9	161	1.33
1974	14,647	11,600	2,812	15	220	2.32
1975	12,370	9,195	2,977	8	190	1.89
1976	10,123	7,713	2,249	5	156	1.46
1977	11,972	10,263	1,610	7	92	1.67
1978 ^a	11,165	9,646	1,467	-	52	1.95

^a Excludes those cases reported in the four ICHP districts--Sunsari, Diktel, Palpa, and Kapilvastu.

Source: Project Paper, Integrated Rural Health/Family Planning Services (Annex 12, p. 3), August 1979.

Although the evaluation team did not have access to the data now being analyzed in Bangkok, its review of acceptor rates, particularly those for the past three years, clearly indicates that public use of government-provided services is increasing.

In every year since the program began, the number of new contraceptive acceptors has increased impressively (see Table 24, page 92, ff., particularly footnotes c-e). In the most recently reported years, 1978 and 1979, there were over 215,000 new acceptors. This constitutes nearly 8 percent of eligible women protected in a single year.* Unfortunately, most of the gain has been in increased acceptors of condoms. The 1976 World Fertility Survey reported that 10 percent of current users relied on the condom. In 1978-1979, approximately 65 percent of new acceptors used the condom. The comparison of 1976 users to current acceptors does not consider the current users who accepted a method in previous years (e.g., vasectomy acceptors). Nevertheless, the team feels that the condom is a relatively less efficient contraceptive. Further, data on new condom acceptors are more subject to reporting error than are other methods.

An examination of age and parity, by specific methods, shows slight but important shifts in users of various contraceptives. Table 25, page 93, shows the percentage of acceptors, by five-year cohorts, for selected years.

Between 1968-1969 and 1975-1976, there was a shift in vasectomy acceptors, from older age groups to cohorts aged 25-34. Similarly, use of the IUD increased in all cohorts below the age of 30. Interestingly enough, between 1968-1969 and 1975-1976, use of the pill shifted from younger to older women.

Table 26, page 94, lists the percentage of acceptors by parity for selected years. Between 1968-1969 and 1975-1976, the level of vasectomy acceptance declined for men with eight or more children and increased for men with three children. The pill showed a shift toward usage in higher-parity women, those with five or more children. This is consistent with figures given in Table 25, which illustrates a shift in pill acceptors to older cohorts. The data may indicate that in the formative years of the program, women were using the pill for spacing. Today, as more acceptors enroll in the program, the pill may be attractive to women who want to limit their fertility.

For the IUD, a much less widely used method in the Nepal program, the shift has been from higher-parity women, those with four to six children, to lower-parity women. Insufficient data are available to confirm whether or not this means women are using the IUD less to limit the number of children they bear than to space them.

*Based on the calculation that 18 percent (or 2,700,000) of the current total population--15 million--are women exposed to pregnancy.

Table 24
 CONTRACEPTIVE ACCEPTORS IN NEPAL, FY 1966-1967 - FY 1978-1979^a
 (By Method)

Year/Method	Pill ^b		Condom ^b		Male Sterilization ^b		Female Sterilization ^b		IUD ^b		Depo-Provera ^b		Total ^b	
	No.	% Increase	No.	% Increase	No.	% Increase	No.	% Increase	No.	% Increase	No.	% Increase	No.	% Increase
1966-67 2023/24	13	-	33	-	n.a.	-	0	-	1,806	-	0	-	1,852	-
1967-68 2024/25	200	143.8	1,256	370.6	1,052	-	0	-	2,614	44.7	0	-	5,122	176.6
1968-69 2025/26	1,355	577.7	1,914	52.4	3,292	212.9	0	-	1,183	-121.0	0	-	7,744	51.2
1969-70 2026/27	10,263	657.4	14,480	656.5	3,888	18.1	0	-	1,109	-6.3	0	-	29,740	284.0
1970-71 2027/28	13,496	31.5	18,785	29.7	4,441	14.2	0	-	711	-35.9	0	-	37,443	25.9
1971-72 2028/29	15,868	17.6	22,908	22.0	3,900	-12.2	558	-	1,162	63.4	0	-	43,838	17.1
1972-73 2029/30	24,056	51.6	35,713	55.9	4,161	6.7	810	-	607	-47.8	0	-	65,095	48.5
1973-74 2030/31	27,141	12.8	52,075	45.8	5,166	24.2	662	45.2	862	42.0	25	-	86,079	183.3
1974-75 2031/32	26,943	-0.7	65,814	26.4	3,702	-28.3	-18.3	-	1,110	28.8	81	22.4	98,312	14.2
1975-76 2032/33	37,640	39.7	87,876	33.5	9,169	147.7	2,162	226.6	1,635	47.3	152	87.7	138,634	41.0

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Table 24, cont.

Year/Method	Pill		Condom		Male Sterilization		Female Sterilization		IUD		Depo-Provera		Total	
	No.	% Increase ^b	No.	% Increase ^b	No.	% Increase ^b	No.	% Increase ^b	No.	% Increase ^b	No.	% Increase ^b	No.	% Increase ^b
1976-77 2033/34	33,250	-11.7	74,782	-14.9	10,953	19.5	5,422	150.8	1,149	-29.7	976	542.1	126,532 ^c	8.7
1977-78 2034/35	44,346	33.4	107,112	43.2	12,172	11.1	7,923	46.1	863	-24.9	1,690	73.2	174,106 ^d	38.6
1978-79 2035/36	37,896	-14.5	106,881	-0.2	7,009	-42.4	11,208	41.5	1,231	42.6	1,549	8.3	165,774 ^e	-4.8

^a Figures provided by FP/MCH Research and Evaluation Division. (See footnotes below.)

^b Calculated by evaluation team using previous year as denominator.

^c Based upon 756 acceptors for ICHP. Community Health Integration Project, Annual Report (2033/34), 1976-1979, lists 31,042 acceptors (see p. 20). When this number is substituted for 756, the total number of new acceptors in 1976-1977 is 156,818, a net gain of 11.6 percent.

^d Based upon 27,802 new acceptors for ICHP. Community Health Integration Project, Annual Report (2034/35), 1977-1978, lists 40,653 acceptors (see p. 23). When this number is substituted for 27,802, the total number of new acceptors in 1977-1978 is 186,957, a net gain of 16.1 percent.

^e Based upon 15,562 new acceptors for ICHP. Community Health Integration Project, Annual Report (2035/36), 1978-1979, lists 66,693 new acceptors (see p. 27). When this number is substituted for 15,562, the total number of new acceptors in 1978-1979 is 216,905, a net gain of 13.8 percent.

Table 25

NEPAL FAMILY PLANNING PROGRAM:
PERCENTAGE OF ACCEPTORS, BY CONTRACEPTIVE METHOD,
FOR 5-YEAR AGE COHORTS

Age/Cohort	Vasectomy		Pill		IUD	
	1968-69 ¹ (Percent)	1975-76 ² (Percent)	1968-69 ³ (Percent)	1975-76 ⁴ (Percent)	1969-70 ⁵ (Percent)	1975-76 ⁶ (Percent)
15 - 19	0.1	0.0	5.6	4.2	2.6	4.3
20 - 24	0.9	1.9	27.9	20.6	20.5	25.6
25 - 29	11.4	12.2	26.2	23.6	22.0	27.6
30 - 34	23.9	28.2	20.9	27.8	34.3	25.1
35 - 39	29.5	23.7	12.7	16.6	13.5	11.8
40 - 44	16.6	19.9	5.6	5.9	5.5	6.8
45+	17.6	14.1	1.1	1.3	1.6	0.5

¹ Sample Size: 946

² Sample Size: 1,364

³ Sample Size: 886

⁴ Sample Size: 2,712

⁵ Sample Size: 703

⁶ Sample Size: 399

Source: FP/MCH Research and Evaluation Division.

Table 26
 NEPAL FAMILY PLANNING PROGRAM:
 PERCENTAGE OF ACCEPTORS, BY CONTRACEPTIVE METHOD,
 FOR ALTERNATE PARITY

<u>Number of Living Children</u>	<u>Vasectomy</u>		<u>Pill</u>		<u>IUD</u>	
	<u>1968-69¹</u> (Percent)	<u>1975-76²</u> (Percent)	<u>1968-69³</u> (Percent)	<u>1975-76⁴</u> (Percent)	<u>1969-70⁵</u> (Percent)	<u>1975-76⁶</u> (Percent)
2 or less	5.6	5.4	3.3	29.8	22.3	31.8
3	16.0	21.7	19.9	23.1	23.0	25.0
4	24.8	24.2	17.4	17.6	21.6	16.6
5	18.0	19.8	12.7	13.5	14.9	12.1
6	14.1	13.0	5.5	7.6	10.4	7.6
7	8.1	8.2	2.9	5.0	4.6	4.0
8 or more	13.4	7.6	2.3	3.5	3.1	2.9

¹ Sample Size: 994

² Sample Size: 361

³ Sample Size: 886

⁴ Sample Size: 2,728

⁵ Sample Size: 703

⁶ Sample Size: 399

Source: FP/MCH Research and Evaluation Division.

The FP/MCH Project and the ICHP have been conducting intensive family planning efforts in some districts in Nepal. An examination of acceptor rates in selected districts of these programs is encouraging. Tables 27a-27j, pages 96-105, list the number of new acceptors in each of 10 districts in the Terai. Five districts are served by the FM/MCH Project and five by the ICHP. Acceptors per year run from a low of 1.4 percent of eligible women to a high of 23.3 percent, based on 1971 census data for the total population.

Although not refined, the figures document some important trends. Overall, the number of new acceptors has increased. Most of the districts with intensive family planning programs have new acceptor rates that are higher than the national user rates reported in the 1976 World Fertility Survey. While the population in the Terai is not static, the numbers do not reflect the carryover acceptors in a previous year who continue to contracept the following year. For example, the number of sterilization patients has not been added to figures for succeeding years.

In sum, the evaluation team believes that the first decade of program operation in Nepal was used to establish a contraceptive service network in a sociocultural environment that was difficult to penetrate. The demographic impact of the first decade's efforts was negligible, as the 1976 World Fertility Survey documented.

In recent years, there have been indications that progress is being made and the results are taking hold. The number of new acceptors continues to rise annually. Some modest shifts in age and parity appear to be occurring. In those districts singled out for intensive FP/MCH or ICHP effort, there is some evidence that the general population--rural, uneducated, and poor--is being reached. There is reason to be optimistic that the program will begin to reach enough people to have a measurable demographic impact during the next five-year period, although this is by no means a certainty.

The team was struck by the fact that a demographic crisis exists in Nepal today. The growth rate has risen to an all-time high, 2.6 percent per annum. It is impossible to predict how much higher it will go before it stabilizes and then begins to decline. Massive foreign donor assistance will be required during the next decade to assist HMG in checking this rate of population growth. USAID/N must lend itself to this task, whatever the obstacles.

Role of Donors in Nepal's Health and Family Planning Effort

Foreign private groups were associated with the development of health and family planning services in Nepal beginning around the turn of the century. Religious missionaries helped to set up a few clinics and hospitals

Table 27a
 NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
 IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
 (1976-1977 and 1978-1979)

Banke District*, Served by ICHP

Population: 130,516

Number of Eligible Women: 23,492**

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	59	647	541
Condoms	146	1,055	992
Female Sterilization	272	0	11
Male Sterilization	22	113	46
IUD	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	<u>499</u>	<u>1,815</u>	<u>1,590</u>
Acceptors as Percentage of Eligible Women	<u>2.1%</u>	<u>7.7%</u>	<u>6.8%</u>

*The population of Banke is estimated to be 65 percent Muslim and is therefore atypical for Nepal. Nevertheless, acceptor rates have been significant over the past three years.

**Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes but not for population increase, and thus inflate percentages.

Table 27b
 NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
 IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
 (1976-1977 and 1978-1979)

Dang District, Served by FP/MCH

Population: 186,564

Number Eligible Women: 33,582*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	126	111	116
Condoms	238	304	269
Female Sterilization	0	201	149
Male Sterilization	119	12	33
IUD	<u>1</u>	<u>4</u>	<u>8</u>
TOTAL	<u>484</u>	<u>632</u>	<u>575</u>
Acceptors as Percentage of Eligible Women	<u>1.4%</u>	<u>1.9%</u>	<u>1.7%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27c
 NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
 IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
 (1976-1977 and 1978-1979)

Morang District, Served by FP/MCH

Population: 288,728

Number Eligible Women: 51,971*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	1,204	1,030	2,212
Condoms	2,046	1,703	5,753
Female Sterilization	488	640	1,717
Male Sterilization	540	136	331
IUD	<u>46</u>	<u>28</u>	<u>48</u>
TOTAL	<u>4,324</u>	<u>3,537</u>	<u>10,061</u>
Acceptors as Percentage of Eligible Women	<u>8.3%</u>	<u>6.8%</u>	<u>19.3%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27d

NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
(1976-1977 and 1978-1979)

Shapa District, Served by FP/MCH

Population: 234,631

Number Eligible Women: 42,234*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	1,264	1,316	986
Condoms	2,026	2,612	2,152
Female Sterilization	436	118	664
Male Sterilization	312	430	124
IUD	<u>68</u>	<u>18</u>	<u>72</u>
TOTAL	<u>4,106</u>	<u>4,494</u>	<u>3,998</u>
Acceptors as Percentage of Eligible Women	<u>9.7%</u>	<u>10.6%</u>	<u>9.5%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27e

NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
(1976-1977 and 1978-1979)

Bara District, Served by ICHP

Population: 233,401

Number Eligible Women: 42,012*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	601	633	559
Condoms	785	950	1,047
Female Sterilization	0	365	640
Male Sterilization	218	165	84
IUD	<u>0</u>	<u>8</u>	<u>25</u>
TOTAL	<u>1,604</u>	<u>2,151</u>	<u>2,355</u>
Acceptors as Percentage of Eligible Women	<u>3.8%</u>	<u>5.1%</u>	<u>5.6%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27f

NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
(1976-1977 and 1978-1979)

Rautahot District, Served by ICHP

Population: 254,833

Number Eligible Women: 45,870*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	523	1,459	1,102
Condoms	2,419	1,240	2,066
Female Sterilization	0	0	1
Male Sterilization	101	100	142
IUD	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	<u>3,043</u>	<u>2,799</u>	<u>3,311</u>
Acceptors as Percentage of Eligible Women	<u>6.6%</u>	<u>6.1%</u>	<u>7.2%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27g
 NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
 IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
 (1976-1977 and 1978-1979)

Siraha District, Served by ICHP

Population: 302,304

Number Eligible Women: 54,415*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	838	1,008	1,519
Condoms	1,273	1,513	3,169
Female Sterilization	0	269	906
Male Sterilization	198	62	34
IUD	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	<u>2,309</u>	<u>2,852</u>	<u>5,628</u>
Acceptors as Percentage of Eligible Women	<u>4.2%</u>	<u>5.2%</u>	<u>10.3%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27h
 NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
 IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
 (1976-1977 and 1978-1979)

Sapturi District, Served by ICHP

Population: 295,768

Number Eligible Women: 53,238*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	829	923	1,828
Condoms	2,694	2,683	4,581
Female Sterilization	523	8	1,114
Male Sterilization	333	93	338
IUD	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	<u>4,379</u>	<u>3,707</u>	<u>7,861</u>
Acceptors as Percentage of Eligible Women	<u>8.2%</u>	<u>7.0%</u>	<u>14.8%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27i

NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
(1976-1977 and 1978-1979)

Mohattori District, Served by FP/MCH

Population: 285,709

Number Eligible Women: 51,428*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	1,357	660	783
Condoms	2,533	1,930	6,792
Female Sterilization	0	0	0
Male Sterilization	404	3	1
IUD	<u>3</u>	<u>0</u>	<u>0</u>
TOTAL	<u>4,297</u>	<u>2,593</u>	<u>7,576</u>
Acceptors as Percentage of Eligible Women	<u>8.3%</u>	<u>5.0%</u>	<u>14.7%</u>

* Computed as 18 percent of total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

Table 27j

NUMBER OF NEW CONTRACEPTIVE ACCEPTORS
IN 10 TERAI DISTRICTS, BY SERVICE PROGRAM
(1976-1977 and 1978-1979)

Dhanusha District, Served by FP/MCH

Population: 330,601

Number Eligible Women: 59,508*

<u>Contraceptive</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>
Pills	1,917	1,659	2,158
Condoms	8,891	7,889	9,675
Female Sterilization	715	1,554	1,963
Male Sterilization	348	101	79
IUD	<u>11</u>	<u>9</u>	<u>12</u>
TOTAL	<u>11,882</u>	<u>11,212</u>	<u>13,887</u>
Acceptors as Percentage of Eligible Women	<u>20.0%</u>	<u>18.8%</u>	<u>23.3%</u>

* Computed as 18 percent of the total population. Total population figures are based on the 1971 census (HMG Central Bureau of Statistics, National Census, 1971, Kathmandu, July 24, 1973). The figures are revised for 1979 district boundary changes, but not for population increase, and thus inflate percentages.

in the Kathmandu Valley. Few facilities were developed before the overthrow of the Rana regime in 1952.

Foreign government and international agencies may be said to have first become involved in the health field in 1954, with the beginning of WHO and U.S. Government assistance to the Malaria Control Program, later the Nepal Malaria Eradication Organization. During the Second Plan development period (1962-1965), smallpox and leprosy control programs were started; in some cases, these were preceded by voluntary efforts often supported by foreign groups. A tuberculosis control program also was initiated during this period. In 1959, the Family Planning Association of Nepal was created, and it initiated programs associated with funding from the International Planned Parenthood Federation.

American bilateral assistance to health projects dates from June 30, 1967, when the first Project Agreement between HMG and USAID/N was signed. Under this agreement, USAID/N agreed to provide support to the family planning program. Although the initial input was limited to a few hundred thousands of Indian Rupees, additional inputs followed rapidly. USAID/N's association with Nepal's health service delivery programs began with the financing of contract services contracted for the Bara and Kaski pilot integration program, the forerunner of the Integrated Community Health Project. (A full discussion of USAID/N's involvement in HMG health and family planning programs [specifically Project H 367-0126, Integrated Health Services, and Project H 367-0096, Population/Family Planning] is found in Chapter IV.)

WHO's involvement in HMG health activities dates to the early 1950s, when the agency played a key role in the development and implementation of the malaria eradication program. WHO also helped develop smallpox and other eradication and control programs and it financed the training of health care personnel. UNICEF also was an early contributor, assisting with supplies for HMG health programs.

The UNFPA entered the picture in 1977, when it contributed \$726,916 to population and family planning activities. It contributed an estimated \$1,044,316 in 1978-1979, and \$1,365,805 in 1979-1980. Of the estimated \$3.5 million it has provided thus far, \$1.3 million has gone for direct support to family planning programs in the ICHP and FP/MCH Project. The remaining funds went for support of population education (\$0.5 million) and demographic studies, including pre-1981 census activities (\$1.6 million).¹

UNICEF and WHO contributed substantial monies to help finance the health sector during the Fifth Plan period. From 1975 to 1979, WHO assisted in the development of Nepal's health system by financing consultant services,

¹Needs Assessment, UNFPA Report No. 21, Nepal, October 1979.

foreign training of health personnel, and limited amounts of supplies. Smallpox and malaria eradication and leprosy and tuberculosis control received attention, as did manpower training, nutrition, health education, and water supply. A total of \$5,333,176 was budgeted for this period. The totals by year are shown in Table 28, page 108.

UNICEF has contributed supplies and equipment and supported basic health services as well as water supply and nutrition programs. Between 1975 and 1979, it contributed approximately \$6,286,422. The breakdown of the UNICEF input is given in Table 29, page 109.

The combined U.N. family support to health and family planning in the years 1975-1979 was approximately \$15,000,000.

Japan, the Netherlands, the United Kingdom, and other sources of bilateral assistance have been active in helping Nepal meet the health and population challenge.

While the total input is indeed impressive, it places a great strain on HMG's limited absorptive capacity, both in the technical/administrative area and on Nepal Rupee resources.

Donor demands for special program elements and special reports can be overwhelming. The team recommends that donors direct their efforts toward assisting HMG in coping with the burdens which their massive inputs impose on the weakly staffed health delivery and administrative system. An even more important area to which donor attention should be directed is financial management and financial reporting. Donor financial assistance is useless if poor financial practice and the multiplicity of accounts set up to meet donor requirements prevent the delivery system from using the available funds. Furthermore, donor agencies must recognize that although their new or expanded delivery and system support elements probably will result in better health services, they must be supported ultimately by HMG's own resources.

Table 28
WORLD HEALTH ORGANIZATION (WHO)
FINANCING OF NEPAL HEALTH PROGRAMS
(1975-1979)

<u>Year</u>	<u>Amount Provided (In U.S. Dollars)</u>
1975	\$ 737,876
1976	952,000
1977	1,101,700
1978	1,237,900
1979	<u>1,303,700</u>
TOTAL	<u><u>\$5,333,176</u></u>

Source: Letter and program documents, 14
March 1980, from Roger Chical, M.D.,
WHO Program Coordinator, Nepal.

Table 29

UNITED NATIONS CHILDREN'S FUND
SUPPORT FOR FAMILY PLANNING AND HEALTH-RELATED PROGRAMS IN NEPAL
(1975-1979)

Year	In-Kind Budget	Regular Budget		
	Supplies and Equipment Released to HMG	Nutrition Program	Basic Health Services	Community Water Supply
1975	42,461	-	-	-
1976	179,512	-	-	-
1977	188,704	-	-	-
1978	416,768	-	-	-
1979	650,977	-	-	-
TOTAL	<u><u>\$1,478,422^a</u></u>	<u><u>\$773,000</u></u>	<u><u>\$1,841,000</u></u>	<u><u>\$2,194,000</u></u>

^a May include some UNFPA-funded supplies.

Source: UNICEF/Nepal, March 24, 1980.

IV. USAID/NEPAL'S ROLE IN PROGRAM DEVELOPMENT

109a

IV. USAID/NEPAL'S ROLE IN PROGRAM DEVELOPMENT

Population/Family Planning (Project 367-0096)

A. Project Development

The Third Five-Year Development Plan (1965-1970) proposed a "modest program of family planning." Two years later, on June 30, 1967, USAID/N and HMG signed the first Project Agreement for Project No. 367-0096, "Family Planning." As stated in this agreement, the purpose of the project was "to establish an effective Family Planning Program with the objective of gradually moderating the rate of population growth" The first agreement included the provisions that HMG would:

--include the FP program in the MCH Division of the Directorate of Health Services; and

--appoint a FP Advisory Board composed of representatives of the Ministries of Health, Home and Panchayat, Education, Publicity and Broadcasting, Economic Planning, as well as the Family Planning Association of Nepal and USAID/Nepal.

Several program elements were identified, including the establishment of clinics in the Kathmandu Valley. The program basis was to be the IUD, with conventional contraceptives employed "as widely as possible."

The FY 1967 Project Agreement provided U.S. Government-owned Indian Rupees for the purchase and equipping of two mobile vans. These vans arrived in 1970. USAID/N agreed to contract the interim services of two U.S. direct-hire personnel, the chief and a program assistant of the Rural Development Division, using Mission funds outside the Project Agreement.

In 1968, only four months after signing the initial agreement, USAID/N and HMG signed a second agreement. The American contribution consisted of Rs. 480,000 U.S. Government-owned Indian Rupees (equivalent to Nepal Rs. 400,000) to support the local cost of financing the family planning project in the Directorate of Health Services. This input accounted for about 80 percent of the total project activity budget for FY 1968. Local cost support of the general budget became a mainstay of USAID/N support to the FP/MCH Project and continues to this day.

The FY 1969 agreement stipulated that coverage would be expanded by "opening 12 more HMG/N clinics (for a total of 52 clinics) which will offer IUDs, oral pills, and condoms, and perform vasectomies."¹

¹USAID/N, Project Agreement, FY 1969, October 30, 1968, p. 1.

In addition to the 12 clinics to be established, six new buildings were to be constructed. Highest priority was given to "the Hill region of Nepal," but at least one facility was to be built "in the Terai and one in the Mountain area of greatest need."¹ The new buildings were to include space for service delivery and living quarters.

Another objective was to enable the FP/MCH Project to offer services in 30 districts in Nepal. The basic budget support agreement was revised so that USAID/N would also furnish commodities and participant training obligated under PIO/Ps. Three direct-hire advisors, a family planning advisor and two junior officers, were funded by USAID/N outside the Project Agreement.

In FY 1970, another objective to "also develop an integrated maternal and child health program" was added.² Since then, the capacity to immunize mothers and children, as well as provide ante-natal and post-partum care, has been developed as an integral service component of the FP/MCH Project.

At the beginning of FY 1974, USAID/N's proposed plans for a five-year program to strengthen family planning service delivery and a small-scale evaluative research project on service delivery modules for rural Nepal were approved. This effort was to be assisted by a team of advisors from the University of California at Berkeley (referred to as the Berkeley team) under a project-funded contract. The initiative recognized the importance of "beyond family planning" but still concentrated on the development of a suitable system for family planning service delivery which, eventually, could be expanded nationwide.

USAID/N's approach was two-pronged: to continue commodity and financial assistance while expanding technical advice on organization, supervision, management, and evaluation. Further, under the project, it was intended to design, implement, and evaluate model delivery systems that would recruit more contraceptive users. These pilot efforts were to be replicable on a wide scale and implementable in the framework of HMG's personnel and financial resources. Long-term professional training of FP/MCH staff was to supplement this process. Over a five-year period, USAID/N would provide a contract team of five full-time advisors (four resident), two direct-hire Mission staff officers, and assorted consultants. The contractor was to be responsible for technical assistance and training; direct-hire USAID/N personnel would manage the contract, commodity procurement, and budget support. In the spring of 1974, the first members of the Berkeley team arrived in Nepal.

¹Ibid., p. 5.

²USAID/N, Project Agreement, FY 1970, August 29, 1969, p. 1.

In April 1976, USAID/N revised its Project Paper, adding to the FY 1974-1978 program a population policy component that included an additional contract advisor. The other basic purposes of the program were unchanged.

By the end of FY 1978, the contractor had not provided the policy advisor.¹ The other four resident advisors had been in place a total of 188 person-months and had produced or assisted HMG staff in producing 35 reports and publications (30 were written by HMG personnel). Nine experimental service delivery model studies were prepared by Berkeley and FP/MCH personnel. (Nepalese were the principal authors of eight of these studies.)

With USAID/N support, the FP/MCH Project has followed the guidelines on expanded service delivery developed by the Berkeley team. Two models for expanding service delivery in Nepal were approved for USAID/N funding in 1978. The first model requires an increase in the number of home-based, house-visiting Panchayat workers. The second calls for expanded voluntary surgical contraception (VSC) training, more VSC camps in remote areas and permanent centers in urban areas that could perform sterilizations upon demand. This expansion also required the extension of the current project through FY 1980 (this aligns it with HMG's five-year development plans). USAID/N anticipated that oversight advisory services would be continued. However, when HMG decided not to continue the services of the Berkeley team, USAID/N was unable to locate other advisors to cover the two-year interim period.

Looking at the financial support USAID/N provided to HMG's FP/MCH Project, the local currency budget support is shown in Table 33, page 125. The table clearly shows the importance of USAID/N budget support to the FP/MCH Program; USAID/N funds accounted for approximately 50 percent of the total available funds for the last three years. Table 30, page 113, sets out what might be termed "program" support, as reflected in Project Agreements, P10/Cs, P10/Ts, and other program papers. The figures do not include final expenditures because Mission records do not provide complete information on expenditures. Furthermore, early records have been retired and were not available in Kathmandu. Table 30 shows that \$2,135,108 were allocated for AID/W commodities--oral contraceptive pills and condoms supplied by AID/W to Nepal.

¹Berkeley and USAID/N agreed to employ such an advisor in January 1978, but HMG asked that hiring be delayed until the appointment of the Population Commission was announced formally. This occurred in July 1978, three months before HMG rejected the request to extend the Berkeley contract.

Table 30

PROJECT 0096: FY 1967-FY 1979
 USAID/N EXPENDITURES (\$ AND Rs.) IN SUPPORT OF
 FAMILY PLANNING/MATERNAL AND CHILD HEALTH¹

I. <u>Local Costs (In Nepalese Rupees)</u>		
A. Budget Support		Rs. 42,695,757 ^a
B. Nepal Contract Services and Field Demonstration		2,998,291 ^b
C. Panchayat-Based Health Worker and VSC Expansion		<u>14,161,000^c</u>
	Subtotal	Rs. \$59,855,048*
II. <u>Technical Services, Participants, Commodities, In Kind (In U.S. Dollars)</u>		
A. Technical Services	(U.S.)	\$2,698,610 ^d
B. USAID/N-Administered Participant Costs		1,137,245
1. Participant Air Fares and India-Based Training		223,450 ^e
2. Berkeley Contract-Administered		<u>423,417</u>
	Subtotal	(U.S.) \$4,482,722
C. <u>Commodities</u>		
1. USAID/N-Procured		\$1,114,346 ^f
2. USAID/N Air Freight		94,375 ^f
3. AID/W Commodities		<u>2,135,108^g</u>
	Subtotal	(U.S.) \$3,343,829
	GRAND TOTAL	(U.S.) <u>\$10,290,940</u>

* Approximately U.S. \$2,464,389.

¹ These are budget figures. Total expenditures cannot be calculated because unexpended fiscal-year releases were carried over (subtracted from) the succeeding year. No record of carryover amounts is available. Exchange rates have changed periodically; the current rate is Rs. 11.9 = U.S. \$1.00.

^a Includes USG-owned Indian Rupees, plus \$677,196 in appropriated funds converted to approximately Rs. 7,071,756 Nepal Rupees.

^b USG-owned Indian Rupees.

^c Nepal Rupees obtained from conversion of 1,500,000 appropriated dollars.

^d This figure does not include \$423,417 for cost of participant training administered by contractor.

^e Dollar value of Indian Rupees used for participant air fares and India-based training.

^f Dollar equivalent of Nepal Rupees used for air freight.

^g Excludes value of laparoscopic equipment received through JHPIEGO.

Source: USAID/N Program and Financial Management offices; FP/MCH fiscal management staff.

B. Accomplishments

The evaluation team considers that the essential purposes of the FY 1973-FY 1978 project support have been met. By the end of FY 1978, the FP/MCH Project's organization was in place and operating in 62 districts. Between 1968 and 1979, 136 Nepalese received long-term training abroad; 90 participated in training programs lasting three to nine months, and 54 in short-term (three months or less) training activities. While not all of these Nepalese are in place in the FP/MCH Program, the impact of the U.S. training effort clearly is present. Almost all of the participants have returned to Nepal.

Vasectomies and laparoscopies are being provided to an increasing number of acceptors each year. The operations are performed at temporary camps and in Kathmandu on demand. By the end of FY 1978, the FP/MCH Project had initiated the extension of two delivery models; more home-visiting workers were trained and posted and surgical contraception service was expanded. The Panchayat-based health worker program has progressed well. In FY 1979, the FP/MCH added over 450 new field workers and supervisors. (The entire expansion effort was funded by USAID/N.) Reports on their training and placement are incomplete. The FP/MCH did little to expand the VSC Project in FY 1979, but has begun to move forward in FY 1980.

There continue to be problems in management, reporting, and follow-up, but the FP/MCH has been attempting to correct the problems and over the past year has made suitable progress.

The team believes that program effectiveness has been diminished in the absence of full-time technical assistance to the FP/MCH Project. USAID/N staff clearly have not filled the gap, nor was it expected that they could. The problem of too few advisory staff is compounded by the fact that large numbers of Nepali FP/MCH staff are absent. Most are in long-term training programs, often working for their master's degrees. Ten FP/MCH staff expect to undertake long-term academic training in the current year. Nepal only recently began to climb the development ladder. It does not have a tradition of management. The requisite management and technical skills could not have been developed in the time that has passed. The evaluation team feels that USAID/N is taking the appropriate approach in making it possible for Nepal to develop management and technical skills for the future.

Clearly, USAID/N direct-hire personnel will have to be supplemented with in-residence contract technical services during the next five years. USAID/N also will require additional population/health staff to assist in monitoring project and contractor activities.

Integrated Health Services (Project 367-0126)

A. Project Development

Project No. 367-0126, which followed an earlier pilot activity, No. 367-0227, Integration of Health Services, was the result of the initiatives outlined in the Fifth Five-Year Nepal Development Plan. In that plan, HMG specified that health and family planning services would be made available to the entire population of Nepal. The Nepal Government had decided that the concentration of health services in a few districts was inequitable and that the majority of Nepal's population should receive at least a minimum of health services through a system based on one of two pilot integration models.

USAID/N and predecessor agencies have been involved in health activities in Nepal since the early 1950s. In the spring of 1952, the first U.S. Government-sponsored Nepalese doctor left for training in the United States. By the mid-1950s, HMG and USAID/N (predecessor) had begun a program to control malaria. Nearly 20 years later, in August 1972, a pilot activity to test the feasibility of expanding health services through an "integrated" approach was initiated. This experiment was to be undertaken in two of Nepal's 75 districts, Kaski and Bara. USAID/N support to the operation was channeled through Project No. 367-0227, Integration of Health Services.

The experiment was designed to use the Nepal Malaria Eradication Organization's (NMEO) infrastructure as the base for testing a cost-effective approach to expanding (providing) health and family planning services. The NMEO was working in both of the districts chosen. One of the districts had some basic health services; in the other malaria control activities were being conducted, but few other services were being delivered. The objectives were to integrate the Department of Health Program into the malaria program in the first district and, in the second, to broaden malaria workers' duties to encompass wider health concerns.

The NMEO strongly supported the experiment. In the late 1950s, health officials optimistically believed that malaria would be eradicated within five years. Consequently, there was some concern about the future of the NMEO. Planning for the integration of health services began as early as 1959-1960 and made use of the NMEO model.

USAID/N provided full support to the pilot operation through Project 367-0227, Integration of Health Services. It financed the services of a U.S. contractor to design the program and provided \$200,000 for the purchase of the insecticide, DDT. (The Nepal Malaria Eradication Program could no longer provide commodity support because USAID/N financing had been terminated. To ensure the success of the malaria component of the pilot project,

insecticide spraying was necessary.) The experiment on integration actually began in late 1972.

The experiment was controversial. Depending on the degree of progress they had made, categorical (vertical) institutions viewed integration as either a threat or a means to survival. The Family Planning and Maternal Child Health Program felt threatened. The smallpox and malaria organizations saw integration as a way to survive.

USAID/N was less ready than HMG to implement a countrywide health delivery system. The two-district project was scheduled to run through June 1977. USAID/N's intention was to expand the experimental area to six districts and continue the effort through June 1978. Provision was made under Project 0227 to finance the services of a two-man contract team at a programmed cost of \$570,075. In addition, \$68,882 were allocated to finance participant training costs for staff of the "six-district" project.

However, once the Government of Nepal decided to provide basic minimum health services throughout the country, it began a series of unprecedented exercises in project formulation, basic health services delivery, and long-term (15 years) planning. Donors were involved in the planning. In May 1976, USAID/N's Project Paper for Integrated Health Services was made the base of USAID/N Project 367-0126. The purpose of Project 0126 was to help establish "HMG capacity to organize and manage an effective nationwide Integrated Basic Health Service."¹

USAID/N support was to be provided through HMG's Integrated Community Health Division, now known as the ICHP.

USAID/N has provided local currency support to the ICHP since 1977. (See Table 34, page 126.) As Table 34 shows, USAID/N support has been important to the effort to strengthen the ICHP's role, but it has not been as dominant as support for FP/MCH. Furthermore, HMG inputs to the ICHP through the regular budget have been increasing at an impressive rate.

Looking at other USAID/N support to the ICHP, as reflected in Project Agreements, PIO/Cs, PIO/Ts, and other project papers, Tables 31 and 32, pages 117 and 118, have been constructed by the evaluation team.

The key component of USAID/N support to Project 0126, Integrated Health Services, was the provision for contract services. The MSH contract, which under Project 0226 was to provide two advisors for the pilot project, was revised to cover a four-man team. The team was made up of advisors in health management, planning, training, and commodity logistics.

¹Integrated Health Services (Project Paper No. 367-0027), Nepal, March 1976, p. 35.

Table 31

PROJECT 0227: FY 1973-FY 1975
 USAID/N EXPENDITURES (\$ AND Rs.) IN SUPPORT OF
 HMG INTEGRATED COMMUNITY HEALTH PROJECT¹

I. <u>Local Costs</u> (In Nepalese Rupees)		
A. To Nepal Government		
B. To U.S. Contractor		Rs. <u>46,065^a</u>
	Subtotal	Rs. 46,065* (Nepal)
II. <u>Technical Services, Participants, Commodities</u> (In U.S. Dollars)		
A. Technical Assistance Contracts (includes PASA)		\$570,075
B. Participants (USAID direct)		68,882 ^b
C. Commodities (includes \$200,000 for DDT)		<u>200,859^c</u>
	Subtotal	\$839,816
	GRAND TOTAL	<u>\$843,516</u>

* U.S. \$3,700.

¹ These figures do not in all cases reflect final expenditures because USAID/N records do not include complete information on expenditures. Further, early records have been retired and were not available in Kathmandu.

^a USG-owned Indian Rupees approximately equivalent to \$3,700 for personal services contractor support.

^b Excludes Rs. 13,000 (Indian currency; approximately \$1,700) for international air transportation.

^c Includes MSH contract, \$317,115, the amount transferred to Project 0126.

Source: USAID/N program office.

Table 32

PROJECT 0126: FY 1976-FY 1979
 USAID/N Expenditures (\$ AND Rs.) IN SUPPORT OF
 HMG INTEGRATED COMMUNITY HEALTH PROJECT¹

I. <u>Local Costs</u> (In Nepalese Rupees)		
A. Specified for Travel and Daily Allowances	Rs.	7,145,859
B. Studies and Workshops		1,013,500
C. Commodities (forms, ledgers, manuals)		<u>2,560,000</u>
	Subtotal	Rs. 10,719,359 ^{a*}
II. <u>Technical Services, Participants, Commodities</u> (In U.S. Dollars)		
A. Technical Assistance Contract (MSH)		\$1,761,200
B. Evaluation		22,000
C. Participants (USAID/N direct)		37,000
D. Participants (MSH Contract)	\$200,200 ^b	
E. Commodities (MSH Contract)	42,000 ^b	
	Subtotal	\$1,820,200
	GRAND TOTAL	<u>\$2,720,986</u>

* U.S. \$900,786

¹ These figures do not reflect final expenditures because the USAID/N records do not include complete information on expenditures. Further, early records have been retired and were not available in Kathmandu.

^a Local cost support includes Rs. 2,380,000 converted from U.S. \$200,000 appropriated funds. Exchange rates have changed periodically; the current rate is Rs. 11.9 = U.S. \$1.00.

^b Technical assistance contract includes participants and commodities, administered by contractor and valued at \$262,200. Total programmed cost of the MSH contract service: \$2,076,315. (This includes \$317,115 transferred from Project 0227.)

Source: USAID/N program office.

In part through the MSH contract and in part through direct financing, USAID/N also financed overseas training for 41 long-term, three mid-term, and 33 short-term participants (30 of whom were targeted for the National Malaria Eradication Organization).

The ICHP progressed at a much slower pace than was originally envisioned. This was partly because the ICHP was placed in a hierarchical position less favorable than that of the vertical (categorical) services (e.g., FP/MCH and the Malaria Eradication Organization) and partly because the ICHP was not a development "project." (See Figure 1.) Furthermore, not only did HMG organizational relationships limit the ICHP's authority; the donors, with USAID/N playing a part, inhibited integration by giving much more and stronger support to the categorical programs. FP/MCH in particular benefited. Given stronger donor support, it is not surprising that the vertical programs out-performed the ICHP in head-to-head competition. This is not to say that FP/MCH should have had less donor support but that ICHP should have had more.

B. Accomplishments

Notwithstanding the difficulties with the integration process, by the end of 1979, an Integrated Community Health Delivery System was in being. Although it has not reached its projected development target of Health Posts and is well behind in the actual integration process, the system is providing services (from family planning through malaria surveillance) across the board in at least 23 districts. District Health Offices have been established in 25 other districts. Although somewhat lacking in quality, quantity, and assured availability, the services are being delivered, and a system on which to build is in place.

The role of the MSH team in the development of the ICHP as a viable organization is outlined in Chapter V, page 124, ff. During this period, the task of the ICHP was made more difficult because its headquarters was chronically understaffed and the staff lacked management skills. Instead of providing purely technical assistance, the MSH team began "doing the job." It assumed this role with USAID/N's knowledge and approval.

The evaluation team feels that while the operational role of the MSH team may have departed from the concept of "institution building," as things have developed, it was because the MSH team was in place and able to supplement the inadequate staff skills of the ICHP that a viable entity is in place.

The team concluded that USAID/N is taking the correct approach by supporting the HMG health and family planning sector through the HMG-designated mechanism. Although the organization has many problems to solve, a strong and fully operational ICHP seems to be the key to health delivery. USAID/N's

provision of critical support to the ICHP during its development may be what permitted it to demonstrate its viability. It is hoped that USAID/N can continue to make the difference in how well the ICHP and the FP/MCH organizations serve Nepal.

USAID/HMG and USAID/Donor Relationships

The team did not attempt to analyze the formal working relationships between USAID/N and HMG. It had, however, many opportunities to observe the interplay among USAID/N staff and HMG project administrators and others concerned with population, family planning, and health activities.

A. Routine Contacts

USAID/N and HMG staff apparently were in touch daily, either in person or by telephone, with respect to matters relating to the FP/MCH Project. The Mission seems to be following a somewhat different pattern in handling Project 0096 (FP/MCH) than it applied to Project 0126 (ICHP). A member of the USAID/HFP direct-hire staff acts somewhat in the role of a technical assistance advisor to the FP/MCH Project, spends part of most work days at the FP/MCH headquarters offices, and meets almost daily with the project chief or his deputy to discuss project-related matters. (Officially, these duties are supposed to occupy 50 percent of the advisor's time.)

In the case of the ICHP, USAID/N seems to have looked to the project contractor (Management Sciences for Health) staff to provide the principal day-to-day contact with the ICHP project staff. The USAID/N project personnel seem to have had considerably less direct contact with the ICHP than with the FP/MCH Project, although we cannot quantify this with any precision.

B. Project Implementation

In the area of program project "implementation," relationships between USAID and HMG appear generally to have been excellent. There seem to have been the usual episodes when there was some lack of agreement between what the Mission considered to be acceptable project progress and what the "project" personnel thought. However, these have not been serious problems. Further, in the area of project implementation relationships, financial audit activities have occasionally raised tension in HMG and/or USAID/N offices; these situations generally have been sorted out without major difficulty.

While the interplay between USAID and HMG seems to have been adequate and informal and generally to have enabled both USAID/N and HMG to keep up with developments, thought might be given to arranging for periodic formal project progress review meetings, perhaps at monthly intervals, between USAID/HFP and HMG project staff--both FP/MCH and ICHP. Such meetings should help to ensure that "assumptions" about progress or project status which may spring from the good working relationships are not permitted as substitutes for actual facts.

C. Contractor Performance

Given the history and outcome of the Berkeley team contract operations, it would appear that USAID/N perhaps had not at that time kept as closely in touch with the contractor and HMG agency concerned with the technical assistance as it should have, thus permitting an unsatisfactory situation to develop.

In the case of the MSH contract, even though USAID/N utilized the contractor and contractor reports for much of the monitoring work on Project 0126 (ICHP), we feel that USAID/N should examine the situation to ensure that relationships between the contractor and HMG project administrators are appropriate and up to the USAID/N project officer's expectations.

D. Project Development

Project development is critically important to USAID/N host country relationships. It becomes even more important the longer an AID program operates in a country, particularly if there are assumed inadequacies (real or imagined) in the planning mechanisms of the host country. Host country officials understandably tire of playing the role of petitioner and receiver. They become impatient with what they perceive to be AID's continuing demand for more and more "justifications," "documentation," audits, and evaluations, and dislike being on the receiving end of what they perceive to be "how-to" lectures and ex cathedra utterances. (Note: There is no evidence that this situation exists in Nepal.)

Looking at the matter of project development relationships in Nepal, we examined the record pertaining to the development of the Project Paper on Project 0135, Integrated Health Services. We found that between February 1978 and August 1978, a series of meetings took place involving USAID/N and HMG staff involved in project planning and development. We were unable to get from the records the flavor of the actual meetings; however, it was clear that HMG staff members were involved in the process.

The PID was transmitted to the Ministry of Finance by letter on May 12, 1978. The Ministry responded on August 28, 1978. It suggested several modifications, in particular, revisions in the technical assistance proposals to be considered by the project design consultants in preparing the final paper. Following receipt of the response, there appeared to have been a continuing dialogue with HMG project officers about the "new project" to try to determine what HMG project chiefs wanted in the new project. At the request of the Secretary, Ministry of Health, a draft "talking paper" was prepared and circulated to appropriate HMG representatives on March 7, 1979. Additional copies were requested by the MOH planning unit on April 18. On April 23, a meeting with MOH staff, including the Secretary and Director General, was held to review issues. A review of the memorandum on the meeting indicates that the "issues" largely involved organizational problems and were not serious.

From April to August 1979, the drafting of the Project Paper continued. Consultants in finance, health economics, social analysis, and demography from the firm "One America" worked with HMG project personnel and with the Nepalese consultants employed under the contract. (It is impossible to judge the quality of the Nepalese inputs or to determine how much interchange with HMG project personnel took place. However, the supporting documents prepared by the consultants indicate that there was interchange.)

On August 29, 1979, the USAID/N director sent the draft Project Paper and attachments to the Ministry of Health. Copies were distributed to all concerned officers, including the Secretary, Ministry of Health. The Ministry responded by letter on November 23, 1979. It stated that the proposals in the draft were, for the most part, consistent with the basic principles (modified by the National Development Council) for the next plan period. It also suggested several modifications. (The suggestions are being considered for the final draft of the Project Paper being prepared by USAID/N.)

Several HMG project officers were asked about the draft. They gave the distinct impression that many exhaustive discussions had taken place at joint and separate meetings during the preparation and after the completion of the Project Paper. Most thought the paper was far too long and contained internal contradictions. They also questioned the need for much of the background analysis. They had no problem with the process. The team is not sure that they know why there was a long time gap between the departure of Dr. William Oldham and the initiation of the present revision exercise. The team concluded that HMG project personnel were adequately involved in the discussions on and preparation of the Project Paper.

Some persons have expressed concern that meeting AID requirements for information, project detail, and justification has become prohibitively time-consuming. However, we noted that the UNFPA assembled recently (February 21, 1980) a block of six project proposals for UNFPA support to HMG health and family planning programs, but that it did so only after an

exhaustive project review and development effort had been made. The UNFPA projects were based on the findings of a Mission assessment of the need for population assistance to the Government of Nepal. The Mission report, dated October 1979, was based on the work of the Mission, which visited Nepal from March 31 to April 30, 1979. The Mission's visit was preceded by a six-month effort devoted to assembling and, in some cases, commissioning the development of information for the Mission's use. This would place the beginning of the preparatory work sometime in October 1978. We assume that some months must have been spent before then organizing the operation.

It seems to be clear from both the UNFPA effort and the USAID Project Paper development exercise that putting together a major project in Nepal takes a great deal of time. Such an effort calls for great patience on both sides.

Given the fluidity of the political, economic, planning, and operational entities in Nepal, it is going to be increasingly difficult to make meaningful projections for as long as five years ahead--the "usual" planning period for many governments, including that of Nepal. The UNFPA has recognized this and has, therefore, restricted the life-of-project period to three years. In the case of AID, though the five-year projection may be necessary, we strongly suggest that fund releases be made annually or according to some other convenient periodic time scale. Projects should be subject to mid-term review, and positive findings on progress should be required as a condition of fund release.

USAID/Donor Relationships

The team noted that a close consultative relationship has been established between USAID/N and the community of international donors. Though they are not convened on a formal basis, discussions involving USAID/N, UNFPA, WHO, UNICEF, and other interested parties normally take place each week. The discussions are supplemented by frequent contacts, by telephone or in person, between USAID/HFP and U.N. agency staff.

V. MAJOR ELEMENTS OF USAID/N SUPPORT TO NEPAL HEALTH
AND FAMILY PLANNING PROGRAMS

V. MAJOR ELEMENTS OF USAID/N SUPPORT TO NEPAL HEALTH AND FAMILY PLANNING PROGRAMS

Finances

USAID/N has been assisting HMG in funding the Nepal family planning program almost since its inception. The first Project Agreement was signed in FY 1968. Support for the Integrated Community Health Project began in FY 1976. Tables 33 and 34, pages 125 and 126, detail the USAID/N Rupee funds committed to these two projects.

The funding mechanism and the conditions that HMG must meet before USAID/N can release Rupees have gone through an evolution over the past 13 years. Originally, Rupee funds for the FP/MCH project were obtained through the release of U.S. Government-owned local currencies which were added to HMG monies to meet the general operating expenses of the project. More recently, in addition to general budget support for the FP/MCH Project, USAID/N has specified discrete program functions for which USAID/N funds are to be used. (See Table 33, footnotes j and k.) In the current fiscal year, USAID/N has proposed the mixed model described above, as well as the funding of a component of the FP/MCH on a turn-key basis, outside any HMG budget.

USAID/N requires HMG to submit financial reports on the handling of USAID Rupee funds. The USAID/N reporting requirements also have undergone an evolution since the projects began. The conditions are placed on initial and subsequent financial releases throughout the fiscal year. Originally, USAID/N followed the standardized requirements of HMG. Quarterly releases were made. A certified statement of expenditure was required at the beginning of the second quarter following the release. (See Figure 7, page 127.)

The system depicted in Figure 7 flows across fiscal years. USAID/N has gradually softened its conditions of release. In the current fiscal year, two semi-annual releases will be made to the FP/MCH Project. The second release (scheduled in the HMG mid-fiscal year) is contingent upon a HMG-certified statement of expenditures for the entire preceding fiscal year. In addition, the request for the second-half release must certify that 100 percent of HMG funds for the year already had been released to the FP/MCH.

To better understand USAID/N's funding mechanism and release conditions, one needs to understand the basic requirements of HMG budgeting, funding, and accounting. Although the team did not feel that it was within the scope of work to review the HMG accounting system, it felt that certain generalizable constraints in HMG financial operations impinge upon effective financial management in the health sector and that they therefore should be discussed.

Nepal shares with many developing nations certain parallels in national planning and the funding of government activities. One, a divided budget,

Table 33

LOCAL CURRENCY SUPPORT TO HMG FAMILY PLANNING/MATERNAL AND CHILD HEALTH PROJECT
(FY 1968-FY 1979)

All Figures in Nepalese Rupees^a

Project Agreement	FY		HMG Budgeted ^b	HMG Released	USAID Budgeted	USAID Released	Other Budgeted	Other Released	Total Budgeted	Total Released	Total Expended
	HMG	US									
FY 68	2024/25	68	101,000		400,000						
FY 69	25/56	69	480,962		1,539,038						
FY 70	26/27	70	874,750		3,124,250						
FY 71	27/28	71	1,647,000		5,241,000						
FY 72-4	23/29	72	1,875,000		5,625,000 ^c						
FY 73-12	29/30	73	1,866,200		3,465,800						
FY 74-7	30/31	74	2,255,000		4,200,000 ^d						
FY 75-3	31/32	75	5,539,834	3,831,760	3,937,500	3,527,000	-0-	-0-	9,477,334	7,358,760	6,541,570
FY 76-3	32/33	76	7,460,474	7,460,474	3,675,000 ^f	2,899,450	664,526	664,526	11,800,000	11,024,450	10,012,371
FY TQ-7	33/34	77	4,969,500	6,273,672 ^g	4,357,500	4,316,133	2,564,000	711,212	11,891,000	11,301,017	11,058,914
FY 77-3	2034/35	78	5,653,000	6,053,000 ^h	4,357,500	4,350,073	2,370,000	1,100,829	12,380,500	11,503,902	11,208,320
FY 78-7	35/56	79	5,718,000	5,718,000	4,300,000	4,108,315	2,301,000	1,946,003	12,319,000	11,772,318	12,087,015 ⁱ
FY 78-7	35/36	79			3,600,000 ^j	1,785,000			3,600,000	1,785,000	1,025,536 ^j
FY 78-7	35/36	79			217,800 ^k	142,600			217,800	142,600	131,569 ^k

Table 33, cont.

- a General budget support includes "carry over" from previous year (e.g., over-releases not proportionally matched by HMG monies and subsequently deducted from succeeding year's commitment). Exchange rates have changed periodically. The current exchange rate is Rs. 11.9 = U.S. \$1.00. Figures provided by USAID/N Program and Financial Management offices and FP/MCH financial management staff.
 - b All FP/MCH funds are from the Development Budget.
 - c Rs. 3,122,666 de-obligated (Rev. #7, 11/10/72).
 - d Rs. 355,047 de-obligated (Rev. #3, 6/27/74).
 - e Rs. 1,358,836 transferred to FY 73 for construction (Rev. #2, 4/22/77).
 - f Excludes Rs. 145,760 for POPCOB (Rev. #6 and #9, 6/29/76 and 5/9/78).
 - g In response to a government-wide salary increase, HMG released more than was originally budgeted.
 - h Rs. 400,000 were released over the budget and adjusted in subsequent fiscal years.
 - i Project expended more than was released; will be adjusted in subsequent fiscal years.
 - j These funds were not general budget support; rather, 100% USAID/N local cost funding of expansion of Panachayat-based health worker (PBHW) activities.
 - k These funds were not general budget support; rather 100% USAID/N local cost funding of voluntary surgical contraception (VSC) activities.
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Table 34

LOCAL CURRENCY SUPPORT TO HMG INTEGRATED COMMUNITY HEALTH PROJECT
(FY 1976-FY 1979)^a

All Figures in Nepalese Rupees^b

Project Agreement	FY		HMG Regular Budget	HMG Development Budget			Total Budgeted	Total Released	Total Expended
	HMG	US		HMG Funds	USAID/N	Other Donors			
FY 76-9	2032/33	76	9,751,369	5,025,000	-0-	55,000	14,831,369	13,800,000	12,172,000
FY TQ-7	2033/34	77	8,858,700	9,418,000	1,443,500	4,257,500	23,977,700	16,687,000	14,768,000
FY 77-6	2034/35	78	15,174,800	6,737,000	5,295,000	9,575,000	36,781,800	30,821,000	22,670,000
FY 78-5	2035/36	79	20,154,753	3,808,000	2,300,000	12,405,000	38,677,753	30,075,000	27,820,000

^a Preceding this activity, USAID/N-funded Project 0227. This provided \$774,805, primarily for technical assistance, to initiate, through a pilot program, the process of delivering comprehensive (integrated) rural health services through a singular administrative unit. USAID/N Rupee support of operating costs did not begin until FY 1977. Figures provided by Management Sciences for Health. These are provisional figures and do not include reductions due to rebudgeting.

^b Exchange rates have changed periodically. The current exchange rate is Rs. 11.9 = U.S. \$1.00.

Figure 7

HMG FISCAL YEAR RELEASE AND REPORTING SCHEDULE

July 16	October 15	January 15	April 15	July 15
Advance Authorization Bill	Rastriya Panchayat Budget Approval			
1 st Quarterly Release	2 nd Quarterly Release	3 rd Quarterly Release	4 th Quarterly Release	
Statement of Expenditures, 3 rd Quarter, Previous FY	Statement of Expenditures, 4 th Quarter, Previous FY	Statement of Expenditures, 1 st Quarter, Current FY	Statement of Expenditures, 2 nd Quarter, Current FY	

referred to in Nepal as the Regular Budget and the Development Budget, is used. Two, there is repetitive budgeting. Though a line agency's (e.g., the Ministry of Health) annual budget may be approved, this does not assure that the funds will be released. Each request for a quarter's release can be (and often is) reviewed and revised (normally downward). These features are not unique to Nepal's budget process. Furthermore, there are some good reasons for the features.

The divided budget is Nepal's response to the significant amounts of funds received from non-Nepalese sources (i.e., foreign donors). The division of the budget reflects two things: one, the reluctance (admitted inability) of HMG to absorb the recurrent costs of donor-supported development projects at any time in the foreseeable future, and, two, HMG's emphasis on development.

All donor funds are put into the Development Budget (donor support of the Regular Budget is specifically proscribed by law). HMG funds are, of course, used in the Development Budget. In addition, some donor funds used for recurrent expenditures are labeled Development Budget. The entire FP/MCH Project is funded from the Development Budget. ICHP receives funds from both HMG budgets, even though it is a single activity. (See Table 34, page 126). The criteria for including an item in the Regular or Development budget are not clear. Periodically, some items in the Development Budget are transferred to the Regular Budget as the costs shift from development or investment to recurrent costs.

The HMG fiscal cycle begins with the preparation of budgets by line ministries. The ministries sometimes request initial budgets from field office (operating-level) staff. At other times, the ministries prepare the entire budget at the headquarters (central level).

All budgets are sent to the Ministry of Finance where they are reviewed. Frequently, requests for additional justification are sent back to the ministries. Normally, at some point in the fourth quarter the annual budget for the line ministry is approved by the Ministry of Finance. If an item, even an item funded by a foreign donor, is not included in the budget at this time, it cannot be added during the fiscal year.

The total annual budget, including the Regular Budget and Development Budget, is presented by the Ministry of Finance to the national legislature, the Rastriya Panchayat, at the beginning of the new fiscal year (mid-July). Usually, the Rastriya Panchayat does not significantly alter the budget. But it does insist on reviewing each program item by item. This process takes a few months. Finally, the budget for the new year is approved by the national legislature (usually in August or September) and the line ministries may then request the release of the first-quarter funds (July 16-October 15).

To cover expenditures for ongoing projects during the first quarter, the Rastriya Panchayat passes an Advance Authorization Bill at the beginning of the term (normally within the first two weeks of the fiscal year). This bill permits the Ministry of Finance to forward 25 percent of each agency's proposed HMG budgeted funds to the respective ministries. Donor funds (including USAID/N funds) are not released on the basis of the Advanced Authorization Bill, because, generally, the funds have not been deposited in HMG accounts by this time. In programs such as FP/MCH, which have large donor inputs, these HMG funds are clearly inadequate to support first-quarter operations. There have been instances when there were insufficient funds even to pay salaries during the full three months of the first quarter. One result of the process is that very little family planning work is done in the first quarter of each new fiscal year.

The repetitive budgeting process begins after the annual budget is approved by the Rastriya Panchayat. Normally, the Ministry of Finance would immediately authorize the Accountant General to issue checks. But under this process, first-quarter requests are reviewed again. Often the Ministry of Finance requests additional information on and justification of the budget. The norm in Nepal is that first-quarter releases are received sometime in the second quarter and frequently the funds are less than the "approved" budget.

This process is repeated four times each fiscal year. The operating-level (field) units are never sure what funds they will receive each quarter, even though the annual budget was approved. Field managers are unwilling to make advances from other sources of funds because the new funds may not arrive.

When foreign donor funds are involved, release procedures require another step. The Ministry of Finance will not authorize the Accountant General to issue a check for an item budgeted against foreign donor funds until the donor money is deposited in the national bank. When the annual budget is approved by the Rastriya Panchayat, the Ministry of Finance requests initial release from the donor (e.g., USAID/N). If the conditions for release have been met, USAID/N prepares a request to issue a check. The USAID/N Mission does not actually issue checks; that is the responsibility of the AID Regional Controller's Office in Bangkok. Some recent case studies document that two to six weeks may elapse between the time an HMG request is received and USAID/N funds are deposited in the Rastra Bank. This means a further delay in fund flow to the project.

To deal with the constraints within HMG and USAID/N systems, USAID/N gradually softened its conditions for release and now releases FP/MCH funds semi-annually. An initial release is made, without conditions, for 50 percent of the amount committed in the Project Agreement. A second release is made at the beginning of the third quarter upon receipt of a certified statement of expenditures for the entire previous fiscal year and certification that 100 percent of HMG funds have been released to FP/MCH in the

current fiscal year. The calculated unexpended USAID/N funds from the previous year (carryover) are deducted from the second release. In almost every year since USAID/N began to provide budget support to the FP/MCH Project, the Nepal program has lost some USAID/N funds (e.g., releases were not completely spent and the amount was deducted from new commitments the following year). Given current release procedures, a loss of funds can be expected every year, although, admittedly, the amounts are not large.

USAID/N initially provided 80 percent of the funds needed to operate the FP/MCH Project. (See Table 33, page 125.) It now provides approximately 43 percent of the amount HMG contributes from its own funds (other donors also support the FP/MCH Project). Each year, USAID/N commits a maximum amount of money. The funds are then calculated as a percentage of the total FP/MCH budget. FP/MCH regularly spends less than total budgeted funds and, therefore, USAID/N's share is proportionately reduced.

The Mission earlier tried to make its releases proportionate to HMG releases. But late and lower HMG releases slowed the project and the stipulation was dropped. When other donors were attracted to the program, USAID/N agreed to permit other donor funds to be added to HMG monies to determine USAID/N's proportion. But because other donor funds were not totally released, USAID/N's share was reduced proportionately. Today, only HMG releases for the entire previous fiscal year are taken into account when calculating carryover. However, a statement certifying that 100 percent of current year releases have been made is still required before USAID/N's second semi-annual contribution is released.

In FY 1979, USAID/N began financing specific FP/MCH Project activities in addition to providing general budget support within the framework of the appropriate Project Agreements. USAID/N support to the Panchayat-Based Health Workers (PBHW) Project and Voluntary Surgical Contraception (VSC) Program has been described. (See Table 33, page 125.) The areas are those which USAID/N has targeted as particularly important to program operation and expansion, but which the FP/MCH is unable or unwilling to fund from the general budget. Workplans for carrying out the activities have been prepared.

In the current fiscal year, USAID/N is also funding a component, on a strictly turn-key basis, of the FP/MCH Project that does not appear in the HMG budget. Under this component, existing health facilities will be modified to provide space to perform sterilizations.

USAID/N local cost funding of ICHP began in FY 1977. The ICHP funding process is less complex than the FP/MCH funding process. (See Table 34, page 126.) ICHP activities are funded by USAID in conjunction with the technical assistance provided by the USAID/N contractor, Management Sciences for Health (MSH). (For example, MSH conducted a village health workers training program.) Each Project Agreement lists the specific activities (e.g., a percentage of travel and daily allowances) for which

USAID/N will supply funds to meet local costs (percentage of line-item costs or a maximum Rupee amount, whichever is less).

Releases are tied to project activities; initial releases are for six months. Second-half releases are contingent upon certified statements of expenditures on past releases. A statement of HMG expenditures is also required to calculate USAID/N's proportionate share. If USAID/N releases more than the agreed-upon percentage, the amount is declared carryover and deducted from the next year's commitment. This mode of budget support is not general budget support (a set proportion of all program expenditures), but a varying percentage of specific line-item expenses in the ICHP budget.

USAID/N monetary and technical assistance has had a significant impact on the Nepal health sector, particularly family planning. The evaluation team believes that the family planning program in Nepal would not have progressed as far as it has if this assistance had not been available. It was not until 1976 that other donor agencies began supporting the program. From 1967 to 1979, HMG funds committed annually to family planning rose more than 560 percent (from Rs. 101,000 to Rs. 5,718,000). The team believes this proves that USAID/N funds have not driven out HMG monies in support of this most important activity.

As one of nine donors to the ICHP program, USAID/N has not played as dominant a role in the development of the ICHP as it has in family planning. Its support was designed to assist HMG in developing the institutional capacity to operate a comprehensive rural health program. HMG has now adopted this as the mode of service delivery for family planning and rural health services in Nepal for the Sixth Five-Year Plan. MSH can take much of the credit for helping the ICHP prepare for and grow into this new role. Every year for the past three years the funds HMG has been willing to budget (Regular Budget plus Development Budget) have been increased significantly. (See Table 34, page 126.) Actual expenditures, including foreign donor assistance, have risen more than 20 percent each year.

The mixed model of funding is the Mission's response to the constraints of both HMG and AID financial requirements. A series of recent audits reveal the hazards of the approach. Each funding mode has advantages and disadvantages.

The evaluation team concluded that USAID/N is dealing conscientiously with the problems involved in local currency funding. There is no "right" solution because each approach involves tradeoffs. The team is confident that USAID/N will satisfactorily overcome problems of funding modes. Regardless of funding modes, the Nepal health and family planning program will require massive doses of local cost financing for many years to come. USAID/N should be prepared to help meet this requirement.

Commodities

USAID/N has supplied a large quantity of commodities to the HMG health sector, particularly FP/MCH. Commodities have been both Mission-funded and centrally purchased by AID/W. Tables 30-32, pages 113, 117, and 118, give the total costs of commodity purchases funded both by the Mission and AID/W. Most of these funds were for contraceptives and family planning medical equipment. Table 35, page 133, lists the contraceptive purchases funded by AID/W. Not included in these figures is the cost of laparoscopic equipment received from JHPIEGO under a centrally-funded contract. In addition, the Contraceptive Retail Sales (CRS) Project is bringing pills and condoms into Nepal under an AID/W-financed contract.

There is about a six-year supply of pills and condoms in-country. Some of these stocks have reached the end of their shelf life. Mission-requested tests on condom samples from around the country show that 6 percent to 10 percent of all condoms will break below standard inflation pressure. This observation has been confirmed by Health Post personnel who note that villagers occasionally complain about condoms breaking.

A family planning logistics management specialist has just joined the USAID/N staff. He has initiated action to help the HMG destroy over-age condoms. According to this specialist, after the over-age condoms are destroyed, more condoms will not be needed until calendar year 1981. Pills also have been sent for testing, but the results were not received before this evaluation ended.

A separate logistics system exists for each of the vertical projects, in addition to that of the Indent and Procurement Division of the Ministry of Health. The logistics systems of the vertical projects seem to be somewhat better managed, but all need assistance. In Kathmandu, warehouse facilities need refurbishing. Staff need in-service training. Other donors are supporting these efforts. For example, WHO plans to establish a vehicle repair training program for Ministry of Health logistics staff. UNICEF is supporting the construction in Kathmandu of a central cold store for vaccines.

Outside Kathmandu, additional warehouses and cold storage space are needed. USAID/N is coordinating its support of these facilities with that of HMG and other donors. The contract logistics specialist, in consultation with HMG and other donors, will decide whether the current parallel logistics systems should be maintained or whether the commodity supply of the health sector should be merged as a centralized system. Vaccines require very different handling and storage than contraceptives. Some believe that oral contraceptives and malathion should be handled by two different systems.

Table 35
 CONTRACEPTIVES SUPPLIED TO NEPAL BY AID
 UNDER CENTRALLY FUNDED PIO/Cs

Pills			
<u>PIO/C Number</u>	<u>Quantity</u>	<u>Cost</u>	<u>Date</u>
367-096-5-1000 (74)	200,000 MC	\$ 34,440	November 1973
367-096-5-40068	150,000 MC	20,938	April 1974
367-096-5-40089	1,000,000 MC	250,000	June 1974
367-096-5-60016	3,000,000 MC	413,400	November 1975
367-0096-5-90003	158,000* MC	<u>41,206</u>	January 1979
	TOTAL	<u>\$759,984</u>	

* 79,000 monthly cycles were delivered to the project.

Condoms			
<u>PIO/C Number</u>	<u>Quantity</u>	<u>Cost</u>	<u>Date</u>
367-096-5-40068	20,000 gross	\$ 79,800	April 1974
367-096-5-40089	100,000 gross	500,000	June 1974
367-096-5-60016	75,000 gross	338,400	November 1975
367-096-5-80010	20,830 gross	87,486	February 1978
367-0096-5-90003	8,000,000* pcs	<u>396,416</u>	January 1979
	TOTAL	<u>\$1,402,102</u>	

* 2,004,000 pcs delivered to the project.

The Mission has ensured the availability of contraceptives during the life of the project. Rarely has a report been received of a villager being denied a pill or a condom because the local clinic or village worker had run out of supplies. This is a remarkable achievement in Nepal.

USAID/N has examined the question of supplying the HMG network with sufficient drugs and supplies so that primary health care can be provided nationwide. Staff in a number of Health Posts regularly report that, although they never run out of USAID/N-supplied condoms and pills, they have only a three- or four-month supply of drugs for primary care each year. UNICEF and HMG are the main suppliers of primary care medicines.

According to UNICEF estimates, \$13 million a year, at current prices, would be needed to provide sufficient drugs to HMG nationwide. Even if these drugs were available, the logistics system in Nepal does not have the capacity to deliver this quantity of medical supplies. The Health Posts are primarily administrative centers that oversee the extension of preventive care to rural villagers through Village Health Workers. Preventive health care is clearly the most cost-efficient health service HMG can provide. However, the team does not believe that it is either feasible or cost-efficient to attempt to provide all the drugs desired by the public for free distribution throughout the network of Health Posts and outreach workers. The impact on health status will be greater if HMG continues to emphasize preventive care.

The evaluation team is satisfied that the Mission is taking the appropriate steps to ensure the efficient use of USAID/N-supplied commodities. Its efforts are well coordinated with those of other donors. The addition of a logistics specialist was appropriate and HMG will receive needed assistance in strengthening logistic management in the health sector.

Technical Assistance

A. Management Sciences for Health (MSH)

A contract was negotiated with Management Sciences for Health in Boston, Massachusetts, in 1975, to provide consultation to HMG on a pilot project in two districts in Nepal. The project was to test the feasibility of providing health services in rural areas through a single comprehensive program rather than a series of single-service vertical projects. The first step in consolidating services under a single administration involved incorporating the specialized malaria eradication and treatment program into the network of rural primary care centers. MSH was to provide technical management assistance to expand the administrative and service roles of these primary care centers. Two advisors were recruited, but before they arrived in-country, the HMG decided to expand the project to all

14 administrative zones of the country. Eventually, four in-residence advisors and several consultants serviced the contract. In January 1980, the MSH contract was extended through October 1980 to ensure ongoing assistance to HMG until a new services contract is awarded under a new USAID/N project, Integrated Health Services.

MSH conducted technical assistance activities in health management, planning, training, and commodity logistics. One measure of its effectiveness is HMG's commitment under the Sixth Development Plan to provide rural health services through a comprehensive rural health delivery network built upon the primary care service units (Health Posts). The decision of HMG to raise the level of the administrative authority of the ICHP is, we feel, at least in part based on the recommendations of the MSH team, which were based on the team's experience in working with the project.

The evaluation team believes MSH fulfilled the most important terms of the contract. The team evaluated MSH's contribution within the overall context of USAID/N's support to the HMG health sector. MSH's sensitivity to Nepal's political and medical problems and its ability to function in that environment are laudable. (The evaluation team's review of the MSH team's performance should not be viewed as an audit or a comprehensive evaluation. We recommend that such an evaluation be carried out at an early date, preferably before termination of the contract in October 1980.)

1. Management

MSH has helped guide the integration of single-activity service projects into a comprehensive rural health network. (The effort has been successful; the approach has been adopted in the Sixth Five-Year Plan.) MSH assisted with budgeting, personnel management, supervision, feedback mechanisms, and the integration of vertical programs into the comprehensive rural health system. These have been incorporated into the training component of the project. ICHP staff have noted significant improvements in these areas.

MSH's task was particularly difficult because the ICHP headquarters was chronically understaffed. Instead of providing strictly technical assistance, MSH began "doing" the work so that certain tasks could be completed. It assumed this role with the full knowledge and approval of USAID/N. The evaluation team considers that, under the circumstances, the role was appropriate.

One stipulation of the original MSH contract which was incorporated into the first Project Agreement but later dropped was the provision for assistance in financial management beyond budgeting. A short-term MSH consultant analyzed financial operations and information needs in August 1977. He concluded that immediate technical assistance in this area was

not needed. "Initial analysis suggested this was not a priority area for further study at present".¹

A review of ICHP's financial records indicates that at the central level, records of funds by funding source are not maintained. Obviously, expenditures by funding source are not recorded at the operating level. The director of the Financial Services Section of the Ministry of Health said that a large number of operating-level accountants are deficient in basic bookkeeping and standard HMG recording and reporting procedures. Financial reports from operating-level units are chronically late. Approximately 200 Health Posts that are not under the jurisdiction of a District Health Inspector report their expenditures directly to the Department of Health Services. The Health Posts In-Charge do not know how to record expenditures and file financial statements.

The team feels that MSH should have provided more technical assistance in this area of financial management. USAID/N should have insisted that such assistance be provided. It should not have been deleted from subsequent Project Agreements. The team believes that this specifically illustrates that USAID/N contract monitoring was not as rigorous as it should have been.

2. Planning

With MCH encouragement, the planning unit of the Department of Health Services grew in staff size and skill. In 1977, the Planning Unit completed a sample survey of health services and needs in Nepal that encompassed the results in the Mid-Term Review report. (The Mid-Term Review is the planning document on which the National Planning Commission based its recommendations for the Sixth Five-Year Plan.) The increased professional stature of the Planning Unit was a significant achievement during the MSH contract period. (Development of the Planning Unit is discussed on page 33 of this report.)

3. Training

MSH has been very effective in transferring training skills to Department of Health Services staff. Training programs are now run at regional training centers. Topics range from general administration to first aid. The team believes the newly acquired skills will be retained and used long after MSH staff leave Nepal.

¹MSH/Nepal Annual Report, November 1975-October 1976, Management Sciences for Health.

MSH successfully arranged the overseas training of Nepal nationals. The majority of U.S.-trained Nepalis have returned and are now working in the program.

4. Commodity Logistics

MSH reports indicate that the problem with logistics is money, not organization. The primary care units, the Health Posts, only have curative drugs for three or four months a year. The MSH conclusion is that the problem is finding sufficient funds to keep the units supplied.

In spite of this conclusion, warehouses operated by the Indent and Procurement Division of the DHS are in great disarray. Donors complain frequently that the Department of Health Services is unable to move medical supplies to the Health Posts. Furthermore, the evaluation team observed that the District Public Health Office has stored improperly condoms and pills. Boxes are dumped rather than stacked. No first-in-first-out system exists. In some instances, ventilation is poor, or non-existent. A higher priority should have been given to the logistics problems that exist, even though supplies are insufficient.

In summary, despite the existence of the problems noted, the team concluded that MSH technical assistance significantly strengthened the management of ICHP. HMG has committed itself to delivering comprehensive health services through the ICHP during the Sixth Five-Year Plan period. Some of the credit for this commitment must go to the MSH team. Relations with host government officials and USAID/N have been excellent--a remarkable achievement, given the transition in health service delivery in Nepal. The team believes the experience with MSH demonstrates the appropriateness of providing carefully selected contract technical assistance. (However, the team cautions that its review should not be interpreted as a definitive examination of MSH activities.)

B. University of California at Berkeley

In FY 1974, a contract was signed with the University of California/Berkeley to provide consultant services to FP/MCH. Berkeley fielded a team of four in-country specialists in program management, demography, training, and experimental field programs. Additional short-term specialists augmented the in-country Berkeley team. The team worked intensively with FP/MCH Project staff for four years. At the end of the fourth year of an intended five-year contract, HMG abruptly halted the contract.

The contract specified that Berkeley would provide technical assistance to the FP/MCH in strengthening program management, designing innovative approaches to field implementation, training management and field staff, and

evaluating specific program components. The terms of the Berkeley contract did not stress development of an institutional capacity in Nepal to perform these tasks, though this was implied in reference to the involvement of HMG staff in planning and conducting evaluations. The Berkeley team had left Nepal before this evaluation began; most findings therefore are based on discussions with Nepalese and expatriates who worked with the Berkeley team. We found that there was a general consensus on the points included in this report.

1. Program Management

The Berkeley team drafted a series of operating procedures that covered a wide range of topics, including personnel management, finances, supervision, etc. Eventually, these procedures were published in an operations manual that is still being used. The team's contribution was to set the stage for effective day-to-day operations. Some operational procedures have not been followed since the team's departure, but this is not the fault of the team.

2. Innovative Field Programs

Berkeley was most successful in designing field implementation programs appropriate to Nepal. In fact, the Berkeley team originally suggested that the project use village outreach workers instead of just staff at static clinic facilities. The village outreach worker and other innovative elements have become a major component of the FP/MCH delivery system.

3. Training

a. In-Country Training

Berkeley pioneered in the training of family planning staff, particularly paramedical personnel, in Nepal. It suggested recruiting and training village outreach workers to work in their home Panchayat, where they are already known and, it is hoped, respected. This is now standard practice in Nepal. Some Berkeley-introduced training techniques have been incorporated into the training program of the ICHP (some FP/MCH training staff have been deputed to ICHP).

b. International Training

The Berkeley team was contractually responsible for participant training. HMG nominations were processed and FP/MCH personnel

sent for training, most of which was long-term training in the U.S. A significant number studied at Berkeley. (Berkeley accepted candidates who could not be placed at any other U.S. university.) Apparently, the University of California/Berkeley backstopped its team in Nepal with special efforts to assist participants on the California campus.

The handling of participant training strained relationships between the Berkeley team and host-country counterparts. It is not known whether this was due to Berkeley's inexperience with participant training or to pressures inherent in the process. But tension generated by the recruitment and placement of participants was an important factor in HMG's decision not to extend the Berkeley contract to a fifth year.

4. Research and Evaluation

The Berkeley team conducted a great deal of research and set up the beginning of a system for collating and evaluating service statistics. An impressive number of publications, the majority of which had Nepalese senior authors, was generated.

The Berkeley team was criticized for conducting research that had less and less to do with the project as the program progressed. Furthermore, there was minimal FP/MCH staff participation. In fact, in some instances, non-government field staff were hired with Berkeley funds, and the work carried out independently of the FP/MCH, so that the effort paralleled FP/MCH programs.

The Research and Evaluation (R/E) Division of the FP/MCH Project does not have the skilled manpower or tools needed to conduct family planning and fertility research. Furthermore, data analysis of the Nepal family planning program is being conducted now by expatriates outside Nepal.

Four R/E staff have received graduate training in the U.S. (One was enrolled in a doctoral program.) None has the experience needed to generate hypotheses or analyze data. Furthermore, there is only one key-punch and one card sorter at FP/MCH. Reports on routine service statistics are months behind schedule.

The evaluation team understands that the data sets from the work of the Berkeley team do not exist in Nepal. The FP/MCH Research and Evaluation Division made data tapes, but these were shipped to Berkeley, California, for analysis.

After the records went to Berkeley, they were sent back to Bangkok, where they are now. The data are now being analyzed under an AID-financed contract (using USAID/N funds) with the Population Council. Various staff of the FP/MCH Research and Evaluation Division are involved

in the Bangkok operation on short-term assignments. Some former Berkeley team staff are involved also under various types of contract arrangements. It is reported that a number of papers growing out of the Bangkok work will be published after their presentation at a seminar (in a venue yet to be announced) scheduled for September 1980.

A number of Nepalese have observed that the published results of research carried out during the Nepal residence of the Berkeley team may be useful to HMG program planners, but not as useful as they might have been, because the data are no longer current. More serious is the fact that Berkeley did not build a research capacity in Nepal. It transferred skills to very few Nepalese. In addition to the general problems of failure to build a research capacity and delays in analysis and reporting, the evaluation team also heard criticism of Berkeley for its failure to address adequately the question of data ownership. The Nepalese regard as the property of Nepal the data collected in Nepal on Nepalese programs.

C. Conclusion

The evaluation team believes that the experience with the Berkeley contract demonstrates, one, that USAID/N seems to have been unaware of HMG's discontent. USAID/N was surprised by HMG's refusal to extend the contract for the fifth year. This indicates that the contract was not monitored rigorously enough. Two, the contract did not specify the development of institutional capacity. The problem of data ownership was not recognized or addressed, even though the same problem has arisen in other countries.

In summary, Berkeley significantly strengthened operations in several areas of the FP/MCH Project. New skills continue to be used effectively to further the program. However, the large gaps in demographic and field research and development of in-house capacity in these fields remain. The evaluation team cannot say to what extent the shortfalls in the Berkeley team's performance can be attributed to inadequate contract monitoring by USAID/N. Certainly USAID/N cannot be excused entirely. However, there appears to have been an inadequacy in the actual contract. Sufficient emphasis does not seem to have been placed on the concept of skills transfer, the development of institutional and organizational capacity, and the question of ownership of data. Granted, some development of capacity did take place; however, this seems to have been somewhat fortuitous and to have depended more on the particular bent of the individual Berkeley staff member than on the concept of the contract and contract requirements. The development of institutional capacity to operate a program should be stressed in the new Integrated Health Services Project now being developed by the

Mission for FY 1981 financing.¹ The important element of the new project will be the advisory services.

Audits

A series of audits on the USAID/N health sector was conducted. In July 1979, the Mission's Office of Financial Management (FM) issued an interval report on the FP/MCH Project. The USAID Area Auditor General completed a review of the USAID/N health sector, including support to FP/MCH and ICHP, in September 1979. The two reviews found that USAID/N's support to these projects had been significant. Generally, the funds have been well spent. (FM has just completed an internal audit of the ICH Project that will be released shortly.)

Problems in financial and commodity management were identified.² These primarily concern HMG management of USAID/N-supported activities.

Some of the issues raised in the audits were not peculiar to the health sector. One involved travel costs of participants.

Specific problems in the FP/MCH Project identified by the audit are recordkeeping on USAID/N's local currency support and the storage, shipping, and inventorying of contraceptives. Although the central headquarters maintains records on funds by discrete funding source, expenditure records by funding source are not kept at the operating level. The auditors recommend that training be conducted for operating-level bookkeepers.

The senior financial management staff of the FP/MCH Project have completed three training seminars for operating-level accountants. They covered basic bookkeeping and the maintenance of expenditure accounts by funding sources. Fifty-two bookkeepers from the 47 operating-level units and headquarters staff were trained at these seminars. FP/MCH project managers plan four training sessions in the next HMG fiscal year. A total of 120 accountants and administrators will be trained in fiscal management.

USAID/N has retained on contract a commodity management specialist to work with the FP/MCH and ICHP. The auditors' recommended testing of commodities has been done.

¹The new project, including the contract advisory services, is discussed in conjunction with the consideration of the Sixth Plan. (See Chapter VI.)

²Under general budget support, USAID/N meets the cost for a percentage of each item in the FP/MCH budget. Therefore, the auditors reviewed the financial management of the entire FP/MCH Project.

The Mission was preparing a response to the recommendations of the Area Auditor General's report while the evaluation team was in Nepal. The internal audit of ICHP had not been released by the time the evaluation was completed.

The evaluation team believes the recommendations of the internal and area auditors were appropriate and timely. The Mission and the various HMG agencies have responded to their suggestions. The recommendations of the auditors and the action that has been taken have helped strengthen the financial and commodity management of the health sector, particularly that of the FP/MCH Project.

VI. THE FUTURE: THE SIXTH PLAN PERIOD

VI. THE FUTURE: THE SIXTH PLAN PERIOD

HMG's Sixth Development Plan

The objectives of the Sixth Five-Year Development Plan are to increase productivity, improve employment opportunities, and meet the basic minimum needs of the Nepalese people (including health and family planning). These three objectives are interrelated.

Priority will be given to the agricultural sector, in which approximately 95 percent of the population is gainfully employed. During the Fifth Five-Year Plan period, 69 percent of the gross domestic product was generated in this sector. Eighty percent of the export trade involves agricultural products. Specific development initiatives will include improving transportation (footpaths, mule tracks, and suspension bridges), developing cottage and light industries, and promoting exports.

To increase productivity, HMG intends to provide inducements to productivity and removal of constraints. For example, it will move ahead to institutionalize tenant cultivators paying a fixed fee instead of sharing-cropping. In this manner increased yields will go to the tenant and there will be an incentive to increase productivity.

HMG intends to reduce governmental administrative constraints on the private sector. In addition, it intends to optimize the use of existing capital investment (e.g., build feeder canals in conjunction with irrigation works).¹

To improve employment opportunities, labor-intensive industries rather than capital-intensive projects will be emphasized. The cottage industry will be developed and tourist facilities extended. Tax incentives will be offered to the private sector to initiate labor-intensive industries.

The Government will attempt to meet the country's basic minimum needs, which include health and family planning. HMG considers three activities as essential to this effort: increasing grain production to combat malnutrition, providing safe drinking water, and providing family planning services. (It is important to note that in the section on the fundamental principles of the Sixth Plan, it is stated: "In the case of hospitals and health posts, doctors and health workers, and drugs and apparatuses have not been put to good use".²)

¹Fundamental Principles of the Sixth Plan, 1980-85 (Rev. Draft), Kathmandu, Nepal: HMG National Planning Commission, November 1979, p. 17.

²Ibid., p. 17.

HMG plans to provide basic health services nationwide during the Sixth Plan period, through an integrated health services network. This effort will be directed by a coordinating board at the national level. During the Sixth Plan period, the Health Services will concentrate on the expansion and improvement of the service delivery component.

To expand coverage, the Government will try to incorporate the Ayurvedic system of medicine, which the population now accepts, into the overall design of coverage. HMG believes this step is more efficient than an effort to establish a parallel government delivery system.

The provision of clean drinking water is viewed as a cornerstone of the effort to improve health status in Nepal. The fecal-oral cycle is a major element in the transmission of organisms and a leading cause of morbidity in Nepal. Water-borne disease clearly contributes to high infant mortality. In addition, the current practice of women carrying water is inefficient. The Sixth Plan paper states:

In fact, if account is taken of the huge amount of time spent by village women folk, particularly by those belonging to the mountainous regions in carrying and fetching water, it becomes quite obvious that provision of drinking water not only relieves them from the back-breaking household chore. It will also leave them with more time to devote themselves to gainful occupations. As proper and adequate water supply scheme has such a direct bearing on the health of the rural poor and then prospects for high standards of living, one of the basic policies of the Sixth Plan will be to give urgent attention to this pressing problem.¹

Special emphasis will be placed on family planning services. The Government views this both in the micro-context of better individual health and in the macro-context of being essential for economic development. The evaluation team agrees with the Planning Commission's statement that:

In the last analysis, all our efforts at multiplying job opportunities and increasing income levels will be simply wasted, no matter how well conceived the programs of that nature are and how brilliantly executed, if effective steps are not taken to rein in the runaway population growth, which is now increasing at the rate slightly higher than 2 percent. Failure in this direction will create an economic and social situation fearful to contemplate. If success, even remarkable success, in bringing about improvements on production and service facilities is to be offset and eaten off by the present birth rate, one will have to be an incurable optimist to see any silver lining in the dark

¹Ibid., p. 39.

cloud. It follows, therefore, that the population control program should be pursued with greater intensity and wider effect than now.¹

USAID/N and Other Donors

The donor community's plans for health and family planning clearly support Sixth Plan priorities. This is not surprising, given the close interactive consultation between donors and host country officials. The donor plans reflect careful coordination among external funding agencies to eliminate duplication and to allow each agency to provide support in those program areas in which it is particularly interested. Collectively, the donors are most responsive in meeting the challenge of the too-rapidly rising population in Nepal and of supporting at least minimal countrywide health care.

USAID/N has had under development and reviewed with the HMG Ministry of Health a major five-year program, Integrated Health Services. This project proposes to provide to the HMG Integrated Health Services Project and Family Planning/Maternal and Child Health Project services approximately \$30 million for local currency support of operations, commodities, training, and advisory services. While strong USAID/N support is directed specifically at the Integrated Community Health Service organization, important, selected activities within the purview of the FP/MCH Project also have been singled out for support. The evaluation team feels that it is important that family planning continue to receive such clearly identified funding.

The UNFPA has designated some \$7.6 million (to be available over three years) for commodities, training, construction of facilities, advisory assistance, and local cost support. Its set of six proposals is the outcome of the 1979 Needs Assessment Study prepared in consultation with HMG agencies. While the UNFPA covers both health and family planning, it is concerned primarily with the improvement of family planning service delivery, particularly the provision of facilities and staff training for sterilization service expansion. On the health front, the UNFPA is giving particular attention to two urgent needs: upgrading ICHP facilities and increasing the staffing of the ICHP headquarters in Kathmandu. The UNFPA is ideally suited to address these problems.

UNICEF plays its traditional role, emphasizing the provision of pharmaceuticals and vaccines and the establishment of supply-support facilities. Coordination with the USAID/N-proposed support is clear in the case of the

¹Ibid., p. 7.

cold chain facilities for vaccines. UNICEF also is providing assistance to Royal Drugs to increase the production of rehydration salts, essential to the treatment of diarrhea (especially in children).

For 1980-1981, WHO budgeted \$3.2 million, largely to support the improvement of the health delivery system; training, advisory assistance, and some commodities were emphasized. In keeping with the priorities of the Sixth Plan, WHO is directing a portion of its support to community water supply and sanitation programs.

Bilateral sources provide other discrete program inputs on which the team had no specific information. In many instances, bilateral support is provided in conjunction with U.N. agency inputs.

Tables 36 and 37, pages 147, ff., and 148, ff., illustrate the coordination of inputs from USAID/N and U.N. family agencies. The tables do not cover every element of the FP/MCH and ICHP programs, but the major inputs are identified. USAID/N's emphasis on the supply of pharmaceuticals, commodity logistics, and advisory assistance in program direction and management, supply and financial management, and health and family planning service delivery is clear.¹

This evidence of collaborative country programming, as it is being practiced in Nepal, is both noteworthy and encouraging.

The team recommends that USAID/N support HMG health and family planning programs during the Sixth Plan period and beyond through those mechanisms which HMG chooses to use and according to the terms of appropriate project documents.

The team has pointed out the demographic crisis facing Nepal and feels that USAID/N should do everything possible to help the country meet this crisis. It recommends that USAID/N ensure that all USAID/N-supported development projects for the Sixth Plan period and beyond address population concerns. It also recommends that USAID/N encourage other donors and the Nepal Government to address these concerns in development projects.

¹The exact makeup of the contract/advisory service team was still under discussion when this evaluation was completed. The evaluation team recommends that the following personnel be appointed to the contract/advisory service team:

Long-Term: Senior Family Planning/Health Advisor; Family Planning Program Advisor; Financial Management Advisor; Commodity Management Advisor; and Health Education Trainer (Rural Health).

Short-Term: Family Planning Surgical Specialist; Survey/Special Studies Specialist; Program Research and Evaluation Specialist; Data Management/Computer Specialist; and Health Manpower Specialist.

Table 36

PLANNED DONOR SUPPORT FOR IMPROVEMENT OF FP/MCH SERVICES
(SIXTH PLAN PERIOD, 1980-1985)

Support Source	Organization/Management	Training	Finance	Supply Logistics	Manpower	Service Delivery
	Research and Evaluation Planning	Training Centers Training Staff	Budget Income Financial Management	Logistics Facilities Contraceptives Medicines Surgical Equipment	Service Delivery Surgical Specialists Paramedics	Facilities Equipment (Personnel) (Training)
USAID ¹ TA: Participants FP Services Administration Training Methodology ⁴ Short Term Overseas Training	Senior FP/Health Advisor ⁴ LT* Program Evaluation and Research Specialist ⁴ ST* Data Management and Computer Specialist ⁴		(\$4.5 Million Budget Support) Financial Man- agement Specialist ⁴ LT*	(\$4.0 Basic Pharma- ceuticals) ³ Contraceptives (AID/W) ⁵ Commodity Management Specialist ⁴ LT*		\$0.2 Camp Equipment VSC (\$0.3 Air Charter, VSC) Family Planning Specialists LT* FP Surgical Specialist ST*
-147- UNFPA ² (P-12)(P-13) (P-15)	Establish Infertility Clinic Kathmandu P-13 Individual Training for Physicians Surgical/Lab Equip- ment Renovation Hospital Rooms Laparoscope (Diagnostic) Evaluation (W/FPA) P-13 Feedback on Injectables Evaluation (P-13) Side Effects, Steri- lization	(Training of 120 Physicians VSC-See Service Delivery) (P-12) (6 Laparoscopy Teams Trained; see Service Delivery (P-13) (Train 24 Para- Medics in Vasectomy; see Service Delivery) (P-13) (Upgrade Institute of Medicine; see ICHP) (P-15)	(\$110,880 Honoraria for VSC) P-12	Supplementary Drugs and Supplies for FP/MCH through 211 Health Posts/780 VFWs (P-12) Medical Equipment for 105 HPs (P-12) Furniture for 211 HPs (P-12) Supplementary Drugs for FP/MCH for 23 DHPs (10,000 Vials (Depo-Provera) (P-12)	(6 Laparoscopy Teams Trained; see Service Delivery, P-13) (Physicians Training in VSC 90 Males and 20 Females; see P-12) (Paramedic Train- ing in Vasectomy; see P-13, Ser- vice Delivery.	Renovation of 19 Operating Theaters for VSC (If Trained MO present) (P-12) (Honoraria for VSC; see Financial) (P-12) Physician Training in VSC (P-12) 90 Males: Vasectomy 20 Females: mini- laparoscopy 6 Laparoscopy Team Training (p-13) (Overseas and In- country)

Table 36, cont.

<u>Support Source</u>	<u>Organization/Management</u>	<u>Training</u>	<u>Finance</u>	<u>Supply Logistics</u>	<u>Manpower</u>	<u>Service Delivery</u>
UNICEF	UNICEF will provide MCH drugs for rural health services (not shown in supply/logistics column).			Mini-Lab Kits Table, Cabinet for 19 District Hospitals (P-12)		(Food for 130, Clients in FP; see P-13)
WHO: 1980/81 Budget ⁶ \$338,200 Family Health	WHO will provide support to MCH activities in 1980-81, with emphasis on consultants, training, and health education (not shown in manpower column).			Tents, 8-100 Clients (P-13)		Paramedic Training in Vasectomy (24) in FPAN Clinics (P-13)
				Mini-buses (4) Client Transport (P-13)		
				Emergency Laparoscopy Kits (12) (P-13)		
				Food for Clients (130,000) WFP (P-13)		
				Facilities and Equipment for 40 District Hospitals for VSC (P-13) 30 Mini-Lap, 90 Vasectomy Kits		
				Equipment for Mobile Camps (P-13) 70 Mini-Lap Kits, 210 Vasectomy Kits for District FPOs		
				151 Bicycles for Camps (P-13)		
				12 Generators (P-13)		
				Renovate 20 Operating Theaters for Mini-Lap and Vasectomy (P-13)		
				Contraceptives (P-13)		
				50,000 Vials Depo-Provera, Syringes, Needles		

- ¹ Dollar/Rupee figures are in millions and are illustrative only, pending project approval. Figures in parentheses (000) are Rupee expenditures.
- ² Letter/number in parentheses (P-12) refers to specific proposals now being considered.
- ³ Pharmaceuticals for health services; presumably portion will go to FP/MCH, especially Panchayat-based health workers.
- ⁴ Dual role; also work with ICHP.
- ⁵ AID/W will provide pills and condoms as required and justified by USAID/N, using central funding.
- ⁶ Dollar figures budgeted only: Source: WHO Major Program Summary.
- * Advisors.

Table 37

PLANNED DONOR SUPPORT FOR EXPANSION AND IMPROVEMENT OF
INTEGRATED HEALTH SERVICES NETWORK (INCLUDING AYURVEDIC)
(SIXTH PLAN PERIOD, 1980-1985)

<u>Support Source</u>	<u>Organization/Management</u>	<u>Training</u>	<u>Finance</u>	<u>Supply/Logistics</u>	<u>Manpower</u>	<u>Service Delivery</u>
	Project Status Headquarters Staffing Headquarters Facilities Planning/Evaluation	Headquarters Capacity Upgrading Pathlalya Additional Training Centers (Institute of Medicine) Specialized Training	Project Status Budget Increase TA/DA Financial Management	Logistics Facilities Contraceptive Supply Supply of Medicines (Ayurvedic) Surgical Equipment Specialized Program Support (EPI) (Malaria) Logistics Management	Service Delivery Surgical Specialists Specialized Training	Facilities Equipment Personnel Training R & E
-148- USAID/H ¹						
TA: Participants (LT) Public Health Administration Training Methods Health Education Malaria Specialist Logistics Management (Indent Procurement) Health Plan Business Administration Public Ad- ministration (Short-Term-15)	(\$0.2 Health Planning Unit Studies) Health Planning Equipment IHP Management Equipment Health/FP Advisor (LT)* Survey/Special Study Advisor (ST)* Program Evaluation and Research Specialist (ST)* Data Management/Computer Specialist (ST)* Health Planning Advisor (ST)*	\$0.120 Health Education Training Supply Health Education Trainer (LT)*	(\$3.5 Budget Support Financial Management Specialist (LT)*)	(\$0.5 TEMO Facilities) (\$4.0 Basic Pharmaceuticals) ³ (\$0.1 NMEQ, Insecticide Safeguard) (\$0.77 Medical Supply Facilities, 50, District) (\$0.10 Cold Rooms-Region, Warehouse-3) \$4.6 Malaria Insecticide and Commodities Trucks (4) Refrigerators (100) \$0.10 Refrigerator Units, Regional (3) Commodity Management	Paraprofessional Health Trainer (LT)*	(\$0.15 Special Field Operations) (\$1.0-50 Health Posts, Stores, Health Center/ Hospital)

Table 37, cont.

<u>Support Source</u>	<u>Organizational/Management</u>	<u>Training</u>	<u>Finance</u>	<u>Supply/Logistics</u>	<u>Manpower</u>	<u>Service Delivery</u>
UNDP/WHO/UNIDO (NEP/78/009/C/ 01/14 (Start Date 1 Nov. 1979) \$407,000 UNDP \$1,000,000 Netherlands		Train Village Health Worker in Ayurvedic Medicines		"Buffer" Stock of Medicines - 19 Districts Pilot Integrated Distribution for Drugs in 3 Districts IV Fluid Production Nepalgunj Expand Drug Manufacturing Capacity of Royal Drugs, Ltd.		
WHO (1980-81 Budget) 4	WHO proposes the following activities in 1980-81: \$878,000 Health Services Development; \$742,400 Community Disease Prevention-Control Malaria, TB Leprosy, EPI; \$387,700, Environmental Health (Water Supply); \$525,100, Health Manpower					
Netherlands		Upgrade Pathlayia Centers (in process-1979)		See UNDP/WHO/UNIDO above		(Construct 50 Health Posts) (in-process, 1979)
U.K.		Training Center, East				

¹ Dollar/Rupee figures are in millions and are illustrative only, pending project approval. Figures in parentheses (000) are to be Rupee inputs.

² Letter/number in parentheses (P-11) refers to specific program proposals now being considered.

³ Pharmaceuticals for health services; presumably ICIP will share with FP/MCH.

⁴ Dollar figures budgeted only. Source: WHO Major Program Summary.

* Advisors.

Table 37, cont.

<u>Support Source</u>	<u>Organizational/Management</u>	<u>Training</u>	<u>Finance</u>	<u>Supply/Logistics</u>	<u>Manpower</u>	<u>Service Delivery</u>
<u>UNFPA</u> ² (P-11)(P-12), (P-14)(P-15) Pre-Condition Development Project Status Director Appointed Create all Positions Sliding Scale of Support	Rental of Headquarters Office Space (P-11) Construction of Headquarters Office (P-11) Vehicle/Motor and Bicycles (P-11) Furniture and Equipment for Headquarters (P-11) New Personnel 20 - Gazetted 51 - Non-Gazetted Cost Share (P-11) Fellowships (4) for Section Heads (P-11) Training Facility in Headquarters Building (P-14)	Upgrade Pathlalya (P-14) Warehouse Construction of Centers-West and Far West (P-14) Equipment Centers Training Management (P-14) Upgrade Training Capacity Institute of Medicine (P-15)		Supplementary Transport 211 HPs (P-12)	Basic Training for VHMs and others 476 new HPs for 23 Districts (Total all types, 3,510-three years) (P-14) Refresher Training VHMs HIs etc. (P-14)	Study of use of Traditional Practitioner for Delivery of Services (P-19)
<u>UNICEF</u>				Equipment for Rehydration Packets (Royal Drugs) Regional Storage Facilities Basic Drugs Supplies for MCH/Paramedics Vaccines for EPI Cold Chain Equipment Chemicals/Equipment for Rural Health Labs Consultant on TEMO Facility Regional Warehouses Upgrading (3 plus contract)	Training of Lab Technicians Training Storekeepers (40 per year)	Rural Health Laboratories (42)

VII. ALTERNATIVES FOR FUTURE USAID/N SUPPORT TO NEPAL
HEALTH AND FAMILY PLANNING PROGRAMS

VII. ALTERNATIVES FOR FUTURE USAID/N SUPPORT TO NEPAL HEALTH AND FAMILY PLANNING PROGRAMS

USAID/N has played a pivotal role in helping HMG launch a national public health service that strongly emphasizes family planning. It provided most of the project funds, including those for local costs, for family planning during the formative years. More recently, it has provided technical assistance and funds to support the integration of uni-service projects into a national comprehensive public health network in this country which is 95 percent rural.

A rudimentary public health service network is in place. The 533 Health Posts that have been established are supplemented with 232 family planning clinics and 714 Panchayat-based health workers, most of whom are stationed in Panchayats where there is no fixed medical facility. A parallel cadre of village malaria specialists complements the other services. Despite recent setbacks in districts along the Indian border, malaria has been curtailed in Nepal, and this has facilitated the opening up of the Terai to cultivation. While the numbers of contraceptive acceptors has continued to climb each year, the family planning program has had no measurable demographic impact. Indeed, the population growth rate is at its highest point in history and is still rising. As primary care facilities, the Health Posts offer little in the way of treatment (their basic medical supply is sufficient for perhaps three months). As administrative units they do manage a cadre of multi-purpose village outreach workers.

There is a demographic crisis in Nepal. Economic growth barely surpasses population growth. A nation that is 95 percent agricultural is becoming food-deficient. Increasingly intensive farming is denuding the hillsides, precipitating soil erosion and decreased yields per cultivated hectare. Attempts at fundamental development--schools, health facilities, clean water--barely keep pace with population growth. And the growth rate continues to climb. It is impossible to predict accurately how high the rate will go or when it will stabilize and finally begin to decline. Economic growth and the development of an infrastructure are almost at a standstill, with gains negated by increases in population.

The evaluation team explored three alternate strategies that USAID/N can pursue in the health sector during the next five years. Its options: the provision of little or no support, of Mission-proposed support, or support for the establishment of a comprehensive primary care and public health system in Nepal. These options are discussed below.

A. Provision of Little or No Support

Although HMG and foreign donors have made significant contributions over a span of five development plans, health conditions in Nepal have not been significantly altered. One notable exception is malaria eradication, an intensive effort that was conducted for a significantly longer time than

most other health components. Because of the success of malaria eradication, the Terai is habitable today and has become Nepal's breadbasket.

Other health program efforts have been less successful. Family planning had no significant, measurable demographic impact. ICHP Health Posts do not provide true primary care. It is true that smallpox has been eradicated, and infant and child death rates have been declining rapidly as malaria has been contained and villagers, including children, immunized against communicable diseases. However, the return on the investment has been small. Therefore, as Option One, USAID/N should provide no assistance to the health sector during the next five years, or only carefully targeted and limited support.

The health sector is receiving a great deal of support from HMG and other donors. If USAID/N cut off all aid or contributed only limited funds, programs would continue, but their activities would be curtailed. The proposed USAID/N support has been carefully coordinated with other funding sources so that the negative impact of no support would be greater than the dollar amount saved. For example, USAID/N is committed to funding the refrigeration units for cold storage facilities in the rural areas. UNICEF has assumed responsibility for a central cold store and for the vaccines for a national immunization campaign. But the vaccines cannot be shipped from the capital if there are no refrigeration units in the rural areas. A cutoff of USAID/N funds would put the family planning program in even greater jeopardy. Predictably, the number of new acceptors would decline, probably for the first time in the history of the program.

The move toward integrating the various components of public health into a comprehensive rural health system would undoubtedly continue, but at a diminished pace. Many of the skilled workers, particularly those in non-career vertical programs, could not be absorbed into the system if USAID/N local currency support were discontinued. Their skills and experience would be lost.

If USAID/N were to provide little or no support, the evaluation team believes that much of the momentum achieved to date would be lost. Predictably, infant mortality would begin to increase, and the number of family planning acceptors would decline. It is also likely that a major resurgence of malaria would occur in the Terai.

B. Support at Level Proposed by USAID/N

As Option Two, the team suggests that the support proposed by USAID/N, as outlined in the Project Paper on the Integrated Health Services, is appropriate.

The support proposed by USAID/N is in accordance with HMG goals for the Sixth Five-Year Plan. The HMG will commit a significant amount of its own funds to the task. USAID/N support, while not more significant than other donors' contributions, is very important. It supplements the inputs of HMG and multilateral funding sources.

The team believes that with the support proposed, the public health projects, including family planning, in Nepal can continue to move forward, and a unified public health service program will be strengthened. The team does not believe that primary health care will be improved significantly during the next five years. The Health Posts will continue to be primarily administrative centers for the village public health outreach program. HMG's emphasis on prevention is well designed and is certainly more cost-efficient than an effort to provide comprehensive primary care for Nepal's rural population. In addition, the support proposed by USAID/N and other donors for family planning and MCH services should result in a stronger, more effective family planning delivery system.

C. Funding Primary Care and Public Health for Nepal

As a third option, an optimal strategy would be to provide primary and preventative health care for the population of Nepal by the end of the Sixth Five-Year Plan.

One hears repeated again and again the lament that Health Posts have basic medicines for only three months of the year. UNICEF has estimated that it would cost \$13 million annually to keep Health Posts and hospitals supplied for a full 12 months. A University of Chicago study noted that the number of physicians would have to increase from the current 484 to 4,608 by 1985; comparable increases in all categories of paramedical personnel would be required as well.

Notwithstanding the quantum increase in recurrent costs that staffing at these levels would require (if USAID/N and other donors were willing to commit the funds), the goal is not, the evaluation team believes, realistic. Furthermore, the HMG Sixth Five-Year Development Plan does not call for such action.

Nepalese paramedical and medical staff cannot be trained and placed in sufficient numbers to staff a national health network in five years. Even if UNICEF or some other donor were willing to fund the additional medicines, the requisite logistics system and trained personnel are not in place, and the increased quantities of supplies could not be handled physically. Furthermore, it is unlikely that such a system could be established successfully during the five-year period. The necessary management and supervisory staff are not available to operate a national network. The team feels that HMG should retain as its goal the establishment of a national health system,

but cautions that such a system will take much longer than five years to implement. Money, which theoretically could be provided by foreign donors, is not the only problem. The Nepal health system can absorb only so much financial support.

Returning to the second and preferred option, the evaluation team feels that the Government of Nepal is proceeding step by step; its approach appears to be realistic and feasible. USAID/N should continue to support this approach at the pace outlined by HMG.

APPENDICES

Appendix A

TERMS OF REFERENCE FOR EVALUATION OF NEPAL

MCH Family Planning Project (0096)

Integrated Health Services (0126)

Appendix A

TERMS OF REFERENCE FOR EVALUATION OF NEPAL*

This evaluation should encompass policy, management, and logistical concerns. It should seek to discover basic lessons that can be applied to continuing efforts in the health and population fields in Nepal. Since the projects have been operational for a number of years, the evaluation should focus on the last five to six years of activity.

1. A major issue noted in a recent AID audit of family planning activities was the disposition of AID-procured commodities, especially contraceptives. Are there lessons to be learned and applied in the new integrated health and family planning project regarding special commodity management and logistical problems in Nepal? Regarding family planning program support?
2. Were the results of project experience and previous project assessments useful in improving program and project management and planning? Did conceptual redesign occur as a result of research carried out by and/or with the assistance of the University of California (Berkeley) contract group? Changes in program implementation? Did HMG make full and adequate use of contract services?
3. The 1979 audit suggests serious deficiencies in HMG inputs to the rural health and family planning program. For example, medicines, drugs, and contraceptives seemed to be lacking at many sites. Are these finds generalizable to the entire country? Do they, as the audit report suggests, indicate a lack of government commitment to the health and population effort? What are the implications for future program and project efforts? Is the scale of resource inputs realistic, given identified constraints?
4. The May 1973 PROP revision for Project 0096 discusses the need for substantial effort to study the interaction of population and development and to seek to help HMG more fully incorporate population considerations in national, social, and economic planning. How much of this was actually done? Were major changes made in the capacity of Nepalese planners to incorporate population concerns in their work?
5. Other subjects which the evaluation should address are:
 - AID/HMG working relationships in project implementation;
 - program-related versus socioeconomic explanations for continuing low contraceptive prevalence;

*MCH/Family Planning Project 0096 and Integrated Health Services Project 0126.

- special problems of transportation, communications, and management information feedback in program implementation;
- the record of financial management, AID and HMG; and
- other issues.

It is suggested that the evaluation be jointly conducted by a team composed of His Majesty's Government, the USAID Mission to Nepal, and AID/W. In the interest of efficiency, we might consider a team composed of four from HMG and two each from USAID/Kathmandu and AID/W. An alternative would be to substitute independent outside evaluators for AID/W personnel.

Tentative Timing: Second Quarter, FY 1980 (January - March)

Drafted by: ASIA/TR/HPN: SSinding: 11/6/79
ASIA/PN/N: HThomas: 11/9/79

Appendix B

**SCOPE OF WORK
HEALTH AND FAMILY PLANNING EVALUATION, NEPAL**

Appendix B

SCOPE OF WORK HEALTH AND FAMILY PLANNING EVALUATION, NEPAL

PURPOSE: It is the purpose of this evaluation to seek out the basic lessons to be learned and to record the strengths and weaknesses to be found in the continuing USAID-HMG/N efforts in health and family planning and to suggest where these lessons may apply in future USAID-HMG/N health and family planning activities in Nepal.

EVALUATION PROCESS: In order to obtain a comprehensive evaluation, the following major variables will be isolated and investigated:

- A. Health and family planning within the Nepal cultural context
- B. HMG/N's health and family planning activities
- C. AID's role in health and family planning activities in Nepal

Due to the changing nature of the health and family planning program, an historical approach will be used in the analysis of these three variables. This approach will illuminate the process at work and will enable the evaluation team to identify general principles and to make recommendations as to future health and family planning program support.

- A. **The Nepal Cultural Context:** This section will provide a cultural analysis with which to interpret health and family planning activities. General ecological conditions and constraints of the country will be described. Population pressure will be viewed as a central feature in the ecological balance and will be evaluated in terms of present health and population objectives and activities. An analysis will be made of the nature of the cultural systems of Nepal and factors that directly relate to health and family planning. Particular attention will be given to cultural responses to and socioeconomic consequences of population growth, density, and disease; economic development and the relationship between humans and available resources; educational level of the populace; economic and social status of women and children; and migration as a factor in population problems. Religious beliefs and rituals, the flexibility between indigenous shamanistic systems and modern medical systems, and the ideological relationships between Hinduism, Buddhism, and animism and health and family planning activities will be analyzed. Finally, an analysis will be made of the political environment, including recent developments, and its relationship to the administrative effectiveness of health and family planning activities.

- B. HMG/N's Activities: HMG/N's responsiveness and capacity to implement health and family planning activities will be evaluated. An analysis of the goals, objectives, and accomplishments of HMG/N's 5th Plan (1975-1980) and the Long Term Health Plan (1975-1990) will be undertaken. Measurements of money earmarked and actually expended, activities proposed, including the variable of other donor activity, will provide a macrobasis for a comparison between the goals of the plans and the accomplishments. The 5th Plan will be briefly compared to the guidelines for the 6th Plan to evaluate changes in the emphasis and priorities of HMG/N. An analysis will also be made of the administrative capacity linkages as well as HMG/N's provision of qualified personnel and the timely financing necessary for project implementation. Particular attention will be directed to the movement of personnel, funds, and commodities into rural areas. An evaluation of health and family planning activities into "integrated" and "non-integrated" rural districts will be included.
- C. AID's Role: An evaluation will be made of the relationship between HMG/N and USAID/N: their approach, collaboration or non-collaboration, and respective priorities. An analysis will be made of USAID/N's role in health and family planning; two projects which are approaching termination--Population/Family Planning Project (0096) and Integrated Health Services Project (0126)--will receive special attention. In addition, relevant material on the recently evaluated Malaria Control Project (0115) will be included. AID/W support, AID mission support of health and family planning activities, and the effectiveness of the Office of Health and Family Planning will be evaluated. Finally, cooperation and coordination with other donors will be discussed.
- D. Schedule, Procedures and Personnel: The evaluation will last approximately one month. Data will be gathered through field visits, interviews with HMG/N officials and health and family planning resource personnel, and through an analysis of AID-related documentation. The team will include Robert Y. Grant, Team Leader (APHA); Curtiss Swezy, Dr.PH, Family Planning Administrator (APHA); Laurier Mailloux, Ph.D., Anthropologist (USAID/N); Robert Mills, Program Officer (USAID/N); and Theresa van der Vlugt, M.D. (Contract).

Appendix C
KEY PERSONNEL CONTACTED

Appendix C

KEY PERSONNEL CONTACTED

Ministry of Health

Omkar Prasad Gauchan, Assistant Minister
Tirtha Raj Tuladhar, Secretary
Laxman Poudyal, Director General
H. D. Pradhan, M.D., Chief, Indent and Procurement
F. B. Malla, M.D., Chief, Planning Unit
Bainateyananda Vaidya, M.D., Deputy Chief, Planning Unit
B. B. Singh, Chief, Financial Services
L. K. Pokharel, Financial Services
Shuvus Shakya, Financial Services
Devarika Chalise, Financial Services
Pitambar Jha, M.D., Civil Surgeon, Janakpur
N. D. Joshi, M.D., Civil Surgeon, Nepalgunj
Durba Lal Singh, M.D., Acting Civil Surgeon, Birganj
Chandra Prasad Maskey, M.D., Surgeon, Narayani Zonal Hospital
Jyotsona Maskey, M.D., Anesthesiologist, Narayani Zonal Hospital
D. P. Manandhar, M.D., Senior Medical Officer, Bara District
R. P. Shrestha, M.D., Surgeon, Chitawan District Hospital
S. K. Bhattarai, M.D., Goiter Eradication Project

Integrated Community Health Project

Rita Thapa, M.D., Chief
Panche Manandhar, M.D., Deputy Chief
Harinandan Upreti, M.D., Senior Public Health Administrator
Maya Shrestha, Family Planning Section
Sitaram Choudry, Financial Section Officer
Padma Raj Rajbhandari, Health Educator
Bishnu Bahadui Shrestha, Health Inspector, Parsa District
Dinesh P. Srivastev, Health Inspector, Bara District
S. H. Sharma, Health Inspector, Chitawan District
Rampathkiri Khan Pandit, Health Inspector, Banke District

Family Planning/Maternal and Child Health Project

Badri Raj Pande, M.D., Chief
Kokila Vaidya, M.D., Deputy Chief
Achut Mani Acharya, M.D., Chief, Services Division
P. L. Joshi, Ph.D., Chief, Research and Evaluation Division
U. R. Dhakhwa, M.S., Research and Evaluation Division
Pramila Sharma, M.D., Chief, Surgical Division
Yeshodhara Pradhan, M.D., Surgical Services Section

Family Planning/Maternal and Child Health Project, cont.

Chaudra Shrestha, Surgical Services Section
Hem Hamal, Chief, IE&C Division
Ramesh B. Shrestha, Head, Fiscal Administration Section
Gobinda P. Mishra, Internal Auditor
Keshab Kunwar, Central Region, Senior Accountant
Siya B. Verma, District FPO, Janakpur
P. K. Rajendra, M.D., Regional Medical Officer, Far West

National Malaria Eradication Organization

M. B. Parajuli, M.D., Chief
Sakhya Gautam, M.D., Deputy Chief

Expanded Program of Immunization

K. B. Singh, M.D., Chief

National Planning Commission

Mohan Man Sainju, Ph.D., Honorable Member

Ministry of Finance

Biswa Nath Sapkota, Section Officer

Population Commission

Prakash Upreti, Ph.D., Acting Executive Director

Institute of Medicine

Heman Dixit, M.D., Dean

Health Services Coordinating Committee

Tara Dev Bhattarai, Ph.D., Secretary*

*Formerly, Health Secretary

Rastriya Panchayat

Sushila Thapa, M.D., Member*

Family Planning Association of Nepal

T. S. Malla, M.D., Chief Executive Officer
Krishna Giri, President, Janakpur Branch
R. K. Shrestha, Senior Office Assistant, Narayangarh

Nepal Medical Association

M. R. Baral, M.D., President
G. A. Narayan, M.D., Vice President
M. L. Shrestha, M.D., Treasurer

Nepal Women's Organization

Lajja Karki, Director, Family Planning Project

United Nations Fund for Population Activities (UNFPA)

Peter Witham, Chief
D. B. Lama
Mark Lediard

United Nations Children's Fund (UNICEF)

Malcolm Kennedy, Director
Minto Thapa, Ph.D.
Stuart McNab

World Health Organization (WHO)

Rodger Chical, M.D., Resident Representative
J. Koztrewski, M.D., Epidemiologist, Geneva

*Formerly, Minister of State for Health

~~C/A~~

Management Sciences for Health

Duane Smith, M.D., Chief
Jan Hoey
Donald Chauls, Ph.D.

Commercial Retail Sales Organization

James Messick, Westinghouse
Subarna J. Thapa, FP/MCH

United States Embassy, Kathmandu

Robert Goold, Deputy Chief of Mission

United States Agency for International Development
Mission to Nepal (USAID/N)

Samuel Butterfield, Director
Thomas Rose, Assistant Director
William Nance, Program Officer
Paul Guedet, Program Development and Implementation
George Smith, Controller
Chandra Man Pradhem, Financial Management
Mohan Raj Sharma, Financial Management
David Mutchler, Ph.D., Special Assistant, Population
G. V. van der Vlugt, M.D., Dr.PH, Chief, Health and Family Planning
Sigrid Anderson, H/FP
Phillip Weeks, H/FP

Appendix D

PRINCIPAL RESOURCE DOCUMENTS FOR
NEPAL HEALTH AND FAMILY PLANNING EVALUATION

Appendix D

PRINCIPAL RESOURCE DOCUMENTS FOR NEPAL HEALTH AND FAMILY PLANNING EVALUATION

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Appendix E
ABBREVIATIONS

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AHW	-	Auxiliary Health Worker
AID/W	-	Agency for International Development, Washington
ANM	-	Assistant Nurse Midwife
CDO	-	Chief District Officer
CEDA	-	Centre for Economic Development and Administration
CNAS	-	Research Centre for Nepal and Asian Studies
CTSDC	-	Curriculum, Textbook and Supervision Development Centre
DHS	-	Department of Health Services, Ministry of Health, HMG
FP	-	Family Planning
FPAN	-	Family Planning Association of Nepal
FP/MCH	-	Family Planning/Maternal and Child Health Program (HMG)
HI	-	Health Inspector
HMG	-	His Majesty's Government
HP	-	Health Post
HPI	-	Health Post Inspector In-Charge
IBRD	-	International Bank for Reconstruction and Development
ICHP	-	Integrated Community Health Project (HMG)
IEC	-	Information Education Communication
IHP	-	Integrated Health Post
IPAVS	-	International Project of the Association for Voluntary Sterilization
IPPF	-	International Planned Parenthood Federation
JOICFP	-	Japan Organization for International Cooperation for Family Planning
KAP	-	Knowledge, Attitude and Practice

LTH	-	Long-Term Health Plan
MCH	-	Maternal and Child Health Care
MOH	-	Ministry of Health
MOHP	-	Ministry of Home and Panchayat
MSH	-	Management Sciences for Health (Boston, Massachusetts)
NCP	-	National Commission on Population
NFS	-	Nepal Fertility Survey
NMEO	-	Nepal Malaria Eradication Organization
NPC	-	National Planning Commission
NRB	-	Nepal Rastra Bank
NWO	-	Nepal Women's Organization
PBHW	-	Panchayat-Based Health Worker
PDO	-	Panchayat Development Officer
POPCOB	-	Population Coordinating Board
POPCOM (NCP)	-	Population Commission (National Commission on Population)
SFDP	-	Small Farmers Development Program
TU	-	Tribhuvan University
UNDP	-	United Nations Development Program
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Children's Fund
USAID/N	-	United States Agency for International Development, Nepal
VHW	-	Village Health Worker
VSC	-	Voluntary Surgical Sterilization
WFP	-	World Food Program

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- WFS - World Fertility Survey
- WHO - World Health Organization
- WLV - Ward-Level Volunteer
- WSCC - Women's Services Coordination Committee