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ACTIVITY REPORTS TO CDC

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Activity Report - Integration of Health Services Project
Nepal

Period: April - July 1974

I. Summary of Activities

Date of last report March 18th, 1974
 March 25th - returned from States
 April 1 - visited by Mr. J. Cox, Geographer, American Embassy, Delhi
 April 4 - 22nd - participated in Country Health Program
 April 21 - arrival of Dr. R. Trowbridge/CDC for reconnaissance of proposed Nutrition Survey
 April 23 - 29th - participation in VII Indo-Nepal Anti-Malaria Border Conference in Lucknow, India
 May 13th - June 6th - Health Team from AID/Washington to assist in the development of the Development Assistance Program (DAP)
 May 19 - 22 - field trip (accompanied by DAP Team) to Bara Pilot Project for Annual Review
 June 5th - field trip to Katunje Health Post - supply situation review
 June 6 - 8th - Carl Taylor, Professor of International Health to follow up progress of participants in Johns Hopkins School of Public Health Planning Course
 June (3 weeks) - Dr. E. Brink, for second phase of Nutrition Survey Planning and Reconnaissance
 June 10 - July 12 - MAO/Auditor
 June 25 - July 4 - field trip to Pokhara District for Maki Pilot Project Annual Review - 2030 (portion of trip with Auditor)
 July 6 - 16 - Manila - accompanied Nepal delegation to First Asian Regional Conference of Public Health Associations

II. Overview for this period

It is getting increasingly difficult to just stop and describe progress in a cogent way. Many new directions are forming simultaneously. The amount of documentation, meetings, visitors etc. is growing in an

inverse ratio to the time available to do justice to all of them. The need to be responsive to the new initiatives in the health sector as well as keep up with the ongoing project documentation has reached its peak during these weeks. We have completed the health sector assessment with the help of a Washington team, the Congressional presentation, the field budget submission (FBI) for FY 75 and 76, the Project Appraisal Report (PAR), a score of work for new initiatives in the private subsector and have begun on a project proposal (PROP) amendment for capital investment of \$1.5 million for two paramedical schools. In addition to fulfilling the documentation requirement this has been an important time for evaluation of the pilot projects through the medium of the annual review. We have been continually involved in the improvement of project management through review of supervision methodology, the service information system, the supply methodology, the job descriptions and are now making preparations for a revision of the training manuals, job descriptions and the recording and reporting system.

I have enclosed copies of all relevant documentation and of the documents which I described in my last memorandum which were not available. I have reminded all concerned that copies of all relevant cables, letters, documents etc. are to be sent to the Tropical Disease Bureau.

III. Integration of Health Services Project

A. Perspective

The basic technical thrust of the IHS project began with the desire to create an effective transition for a mature malaria program awaiting the development of a basic Health Service to carry on its maintenance activities. Under the stimulation of the new initiatives, a broadened perspective was suggested going beyond just the transition period of malaria into the five year PROP. Technical assistance, training opportunities and some commodity assistance are being provided all in an effort to develop a basic health care delivery system capable of not only maintaining malaria as well as other mature mass campaign programs, but also evolving an equitable, efficiently run and technically sound, accessible health care system providing at least a minimum of health care for all Nepalese. We have attempted to encourage NGOs to work with what they have: specifically a mature technically sophisticated, logistically and administratively capable malaria organization, several mass campaigns in various states of maturity and an infantile basic health service concentrated in urban areas providing essentially no services to the 97% of rural Nepalese.

The 2 District level Pilot Projects evolved as separate models of differing administrative and health conditions that were broadly representative of Nepal's geographic, communication, logistical and agro-economic/climatic characteristics. Initially 2 Zones were selected which abutt on each other to provide a total North-South continuum. It was with this in mind that the present PKOP was funded.

B. Pilot Projects - Phase II

Field testing of two prototype systems of health care delivery responsive to the various phases of maturity of the different mass programs and the basic health services has been carried out over the past three years. The three annual and interim quarterly benchmark assessments have indicated that an integrated delivery system is feasible. In country assessment of feasibility was completed in FY 74. Initial findings confirm the technical feasibility of the test approaches. A Project Appraisal Report (PAR) was completed and a copy is enclosed. A formal independent external evaluation (HMG, USAID, WHO) to assess technical and administrative elements of the project in these two districts is planned for the second quarter of this year.

The remaining elements of the planned field activities in Kaski and Bara are to be introduced during FY 75. Initiation of the second phase of the Pilot Projects expanding the experience of the two pilot districts to approach the final model is to be undertaken in 6 additional districts. A draft Plan of Action for a hill district, Tanahun, is enclosed. The Plans of Action for the Terai districts are in preparation.

Revision of the training curriculum and manual in the light of the experience gained is to be underway in preparation for the training of the 402 new staff for these 6 new districts to be included in the pilot scheme. The total population to be served in the pilot area is 1,841,747 (1975 projection of 1971 census) increased from the 385,150 at the outset.

In preparation for the development of services to the areas over 4,000 feet in Kaski District and as a prototype for the area of the country over 4,000 feet, a geographical reconnaissance and baseline health survey is to be carried out after monsoon. A Plan of Action is in preparation.

A copy of the KPP Annual Review for 2030 is enclosed. The BPP Annual Review has not yet been cyclostyled. Minutes of the Working Group on Integration and copies of all field trip reports are enclosed. FYI the total annual budget for the Directorate of Health Services is enclosed. It demonstrates the \$2.5 million that IMG is putting into the pilot projects as compared to the \$246,000 of USAID and \$192,000 of WHO makes IMG the most responsible agent and the largest 'donor'.

The budget for the project in FY 75 is \$246,000; however, I anticipate if we can do all the participant training that is planned we may be up at \$269,000. The breakdown is roughly as follows:

Personnel - \$125,000

- (1) Public Health Advisor - CDC/PASA (9mm)
- (1) Field Operations Specialist - Personal Service Contract (12mm)
- (1) Architectural Coordinator - Personal Service Contract (4mm)
- (1) Curriculum Specialist (7mm)
- (4) Short term consultants - budget allocated; formal representatives not yet made
 - 2 - from CDC, for multiple antigen vaccine demonstration
 - 1 - from CDC, Tropical Disease Bureau - site Visit
 - 1 - from CDC, BCG Consultant

Participant Training - \$81,000

(specifics explained in attached letter to Foreign Aid Division of Finance Ministry)

Commodities - \$20,000

- \$15,000 - demonstration vaccines
- \$ 5,000 - hardware for Project areas

Other Support Costs - \$20,000

In-country travel etc.

C. Present Thrust and Discussion

In the period since the inception of the project many of the technical elements defining the ingredients of an integrated matrix for the delivery of preventive, promotive and curative care has evolved. The Project is presently moving into its 2nd phase from the Districts to the Zonal level to define the administrative, logistical and financial elements of this health care delivery system. Over the last several months, because of the reversion of malaria, the question of a geographical vs. a purely administrative model has come under discussion in order

to evolve a delivery system as rapidly as possible avoiding those areas of malaria resurgence (e.g. eastern terai; eastern inner terai; western mountains; central hills etc.). With the new regionalization concept and attempts to decentralize to the District level the question of what is a suitable model is still evolving. It is clear, however, that a single District is not sufficient size nor does it encompass sufficient management elements to define even some of the most basic determinants necessary to be understood before replication can be recommended, such as: what does it really cost to deliver this kind of service, and can IMG afford it, what is realistic staffing pattern etc. It is at this stage, in moving from the single District to the completed model, that we stand in FY 75.

IV. The Development Assistance Program (DAP) - and Proposed Future Assistance as Projected in the Field Budget Submission (FBS) for FY 75

A Team of a Health Planner, a Public Health Physician and an AID Programmer came to assist myself and the Mission but together this in-house policy paper as a general overview program document to give direction to the next several years of assistance given the new initiatives. The Health Sector Chapter of the Mission DAP is in essence a health sector assessment. A copy is enclosed. It provides an overview of sectoral components and strategies focusing primarily on an assessment of the major problems, issues and plans in the sector. These directions have been translated into program for FY 75 as follows:

1. IHS Project

A. Technical Assistance

In order to facilitate this process as well as the application of technical advances (such as the use of multiple antigen vaccine) to facilitate and streamline the delivery system, we are recommending that the USAID assist IMG through technical assistance, commodity assistance (primarily demonstration vaccines and some hardware), and participant training through the IHS Project. The technical assistance is to continue to consist of two people, a Public Health Advisor with public health administration skills and epidemiologic training; with an understanding of health information systems and disease control to be the project manager; and a field operations specialist to assist IMG in focusing on general design, implementation, management/operational components of the delivery system.

The planned addition of a medical epidemiologist in FY 75 cannot, at least for the present, be fully utilized since the IMC Senior Epidemiologist has gone to work for WHO for an undetermined period of time. However, the sophistication and magnitude of the training and curriculum development needs for the implementation of the project suggest that a curriculum/training specialist could be usefully provided instead (State 055156).

B. Participant Training

In FY 75 we are exploring the contents of A 769 Airgram "Teaching Community Medicine and Public Health: Harvard School of Public Health" in a combined participant/technical assistance effort called "training of trainers". This is proposed in support of IMC efforts toward the development of training capabilities in-country within the Ministry of Health. The training is designed to provide relevant technical skills for the members of the DHS in-service training cell. The program is designed to make their training fit the existing, unique cultural and geographical setting and health situation of Nepal. It is planned that the six months of proposed training will be especially tailored for these participants by a member of the faculty who will come to Nepal (1 IM - hopefully in the second quarter of FY 75) to draw up with the DHS the specific guidelines, objectives and needs for training. After their US training it is planned that the trainers' education would continue in-country under the guidance of this same faculty during the implementation of the extensive in-service training planned during the next fiscal year. We do not have a response from Harvard as yet. I am enclosing a letter to the Foreign Aid Division of the Finance Ministry describing the specifics of the proposed participant training for FY 75 which I believe will adequately explain the overview of the thrust of the program.

2. Institute of Medicine

A. Capital Assistance through IHS

USAID feels assistance to the Institute of Medicine clearly is to be a major effort over the next number of years. There have been a year of nearly continuous discussions with Dr. Moyn Shih, Dean of the Institute of Medicine, on the kind and quality of assistance required. The thinking at present about assistance is divided into three levels: (1) that support of the Institute which is

considered a direct sequitor of the IHS project and is most urgently required i.e. the provision of sufficient physical facilities to produce adequate numbers of paramedical workers to staff the replication of the basic health post integrated matrix methodology for health care. We believe that no matter how much mobilization of the community and private sector one could imagine that a minimal presence (both technically and administratively) of government Health Posts is required both to provide the necessary standards, public health measures and inputs that are not likely to come from the private subsector e.g. vaccination, sanitation standards, health education, etc. Presently, the total of 850 Health Posts planned to be operational at the completion of the 5th Five Year Plan are not likely to be staffed in many cases with the present output of students from the Institute. It is this capability of increasing their output by increasing their physical facilities that we are proposing to assist.

The Canadians have given preliminary approval for CIIDA's participation in financing of two AMW schools (one in Dhankuta, and one in Birkhet).

We are carrying on a feasibility study to understand the use of indigenous materials and local labor and to come up with preliminary sketches that will reflect function and form for schools in Pokhara and Bharatpur. This study is to be completed August 30th and we anticipate that the Prop Amendment will be in Washington by October 1. Copies of a Field Trip Report and Work Plan for our Architectural Coordinator who is doing this feasibility study is enclosed. The concept of "4 schools" relates to regional equity, sufficient student training capacity, and an attempt to implement the concept of local recruitment, local training and local job placement. UNICEF has proposed providing the hardware (vehicles, audiovisual equipment) and software (teaching aids, texts etc.) for all 4 schools to assure a uniformity of method and maintenance.

B. Institutional Development - Technical Assistance

The second area relates to Institution Development at a technical level. The Institute has suggested that USAID provide the technical assistance of persons experienced in developing rural health services in paramedical education, training of trainers and education evaluation to aid in developing the faculty of these centers.

C. Development of a District Manager Program

The third area of assistance relates to the development of a program/curriculum within the Institute for the training of senior level health personnel who are to be District Managers. The specifics of this program are not entirely worked out, but seem to reflect in many ways the laudor, Ethiopia, experiment.

3. Private Subsector

Traditional native medicine continues to both meet needs and perhaps deters popular utilization of "western" facilities or medicines where they are available. Can these traditional services offer any basis on which to graft new methodologies, controls, health education etc. Every government since 1951 has announced its intention to get medical care services to the populace but in practice facilities continues to remain largely concentrated in KTM and a few other localities. Emphasis remains upon following conventional "western" models of health care service and as a consequence of the high capital-intensity of investment required in such models it has proven impossible for any government to deliver in large part on the promises of expanded care.

In consideration of the private subsector, if this emphasis is retained in the DAP, the Mission will propose a feasibility study to be carried out by a sociologist/anthropologist/economist. This might be an individual with 10 years of experience in Nepal who will be leaving his UNICEF job soon. It might be done under the proposed institutional contract which will replace CDC. The study would describe the characteristics of the private subsector and indigenous practitioners, to help us to understand whether there is sufficient potential for private subsector mobilization that would merit USAID support. A tentative proposed scope of work is enclosed.

4. Planning Cell

The assistance to the Planning Cell proposed is somewhat unclear at the moment since both USAID and WHO are offering technical assistance to the Planning Cell. IBQ has not yet decided on the mix of skills it desires but seems at this moment to be concerned with research and evaluation capability and its translation into the continuous planning process. However, IBQ has not decided which donor they will request for assistance. We expect that a response will be forthcoming in the context of the DAP review and IBQ's formal reactions to it.

5. Short Term Consultants

In addition to these activities we are proposing in the PAsA 2-3 months of TDY for a demonstration of a multiple antigen vaccine, which may or may not materialize depending on the actual date of my departure and the return of USAID's Senior Epidemiologist.

I believe the climate is receptive within USAID to begin considering the full application of vaccines as manifested by the multiple antigen vaccine studies. We had several discussions about the possibility of these efforts with Drs. Witte and Conrad about a year ago. Since that time I have been able to fulfill the requirements of funds for vaccine, and funds for CDC assistance. I believe a demonstration of the potential of multiple antigen application as a cost-effective tool especially in Nepal where it is not the obtaining the vaccine, but the logistics of application that is problematic. Tentatively budgeted during FY 75 is \$15,000 for demonstration vaccine and sufficient funds for two people from CDC to come for 2-2½ months each to assist in the demonstration. Because the Senior Epidemiologist, Dr. N. K. Shah, has just joined WHO for 6 plus months and his exact date of return is not clear I am hopeful that this demonstration may materialize in the late 3rd or early 4th quarter of the year. Those specifics and a formal request will follow if it materializes.

In addition, the DHS is interested in the intradermal technique of BCG vaccination used in Japan. It is essentially a 16 pronged Tine (Rosenthal) plastic disposable module with lyophilized vaccine on the tips of the prongs. If you can locate someone who is familiar with the technique, the costs, problems etc. we have the funds for a TDY to discuss the methodology with the government.

6. Contractor for the Health Sector

An institutional contract is written into the FBS for FY 76 in anticipation that the three areas of basic development of Health Services, assistance to the Institute of Medicine and assistance to the Planning Cell could be administered by a single institution. This has a number of merits technically and administratively primarily providing links between USAID agencies in the health sector which are not yet mature, and avoiding in USAID multiple small projects which are difficult to administer, evaluate, and coordinate. There is imminent economy in a single Contractor Chief of Party and specific project implementors.

Every effort is being made, as you can tell by the cable traffic, to meet the April 1st deadline for my departure without a hiatus in technical staff. It is difficult to assess at this point whether AID will be able to find a suitable contractor but all the machinations are underway.

V. Non-Project related Health Sector Activities

A. Malaria

I am enclosing a copy of the report of the Malaria Review Team - 1974. It has become clear that malaria is on the rise in several previously hyperendemic areas, with focal outbreaks and the threat of more general loss of control unless prompt action is taken. This slippage is traced to largely exogenous problems of migration and resettlement of susceptible populations in marginally controlled areas, importation of infection from nearby endemic areas of India, emergence of a DDT resistant vector playing a significant role in transmission in Lumbini and now in Barahi in the eastern terai. The emergence of what is presumed as relative drug resistance of the parasite as well as to what is felt to be a prematurely accelerated consolidation phase in many areas. In addition there has been attrition of program personnel and facilities and some decline in the organizational efficiency of the NMO. Entomologic assistance from USAID confirmed the extent vector resistance was playing in the resurgence; however, no definitive studies on the dimension of the parasite resistance has been carried out. It is generally believed by Dr. Darwish, the USAID Entomologist, that the 'resistance' is in most cases not having taken the drug, but of the lot of cases suspected no more than 35-40 were worthy of investigation and only two could be said to be R3. A copy of the original letter describing this 'resistance' sent by Dr. Kana to Dr. Rao of the NMO of India is enclosed. No specific case information exists in a consolidated form. The details mentioned in the letter is really 500 separate case cards which are not now available.

The potential manageability of the present situation (summarized below) is complicated by interpersonal problems between the Deputy Chief Officers causing significant disruption of operational activities. In addition INO is reluctant to loan for malaria and AID is unwilling to provide grant funds. So here we sit with a significant resurgence on its way. Two cycles in reverted areas with inadequate spraying; because of shortage of DDT, USAID having completed its terminal grant, our last shipment of DDT on the docks of Calcutta (only enough for the next 3 cycles) and none in the pipeline. Cases rising; and no likelihood

of foreign assistance on the horizon. The \$14 million investment in malaria is slowly going down the drain. A detailed district-wise, yearwise and monthwise breakdown of cases by phase of activities is enclosed.

The VII Indo-Nepal Anti-Malaria Border Coordination Conference was held in Lucknow in April. I accompanied the Nepalese delegation as an observer. The conference formally noted with concern the slow progress in implementing the various recommendations of previous meetings. Specific recommendations were made to consider the border of 20 miles (10 miles on each side) as an area of joint technical concern; to exchange information and maps on the border "situation" so that outbreaks and reports of outbreaks could be effectively communicated and containment coordinated. Discussions about the future of the Indian Program was a bit grim. In the U. P. more than 62% of the previously malarious areas are now in "maintenance". In 1973 57,000 cases have come from these maintenance areas and 40,000 from those in attack and consolidation. The case incidence has risen annually since the program was handed over to the DHS and is now beyond the control of NMSF. Discussion how Nepal might learn from India's lessons of premature phasing of the program and of transferring responsibility to the DHS that was ill prepared (human and financial gaps) to handle the surveillance and containment activities were most important for the Nepalese and this observer.

In view of the severity of the recent recrudescence of malaria in the economically important terai and inner terai and the potential spread of this resurgence and the magnitude of this resource gap INM has requested USAID to resume assistance to the malaria program. USAID sees the required assistance limited to 3-4 years of carefully defined capital and technical assistance to get the reverted areas under control and to reasonably ensure INM is in a position to manage any future malaria regressions from their own resources. Assistance to malaria program appears wholly appropriate and highest priority in the health sector to assure continued economic viability of previously malarious areas, to enable the development of the health services, and to guard previous substantial USAID investment in the program in light of WHO inability to provide any financial assistance or adequate technical assistance.

The present plan provides that the funding for an appropriate response to the resurgence of malaria will be forthcoming. However, the funding level clearly is beyond INM resource capabilities and will rely heavily on donor support (see USAID strategies in DAP).

Figure IMalaria Cases Recorded in Operational Areas from 1968 - 1973 *

<u>Year</u>	<u>Consolidation</u>	<u>Attack</u>	<u>Total Positive</u>
1968	105	2357	2362
1969	343	2558	2901
1970	415	1985	2400
1971	548	2034	2582
1972	1871	1896	3767
1973	4128	4351	8479
1974			2109 (up to May)

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- * 1968 was the entire country under 4,000 feet was covered by the MHO activities.

Recognizing that the malarious areas north of Mahabharat are economically less important and that with increasing costs intersectoral and intrasectoral competition for resources will become increasingly intense, it will be difficult to continue to maintain a vertical unipurpose malaria program for many more years in these areas. It would seem appropriate that consideration be given to speeding the process toward integration by making the malaria workers in these hill districts polyvalent i.e. add to their duties smallpox and BCG vaccination and some vital events recording (already proved to be within their capability in the Kaaki Pilot Project) in preparation for being taken over by the DHS with services that are fully integrated and are of the fullest complement possible.

Worthy of note is that malaria personnel are being taken from the Development Service to the Regular service. Some 108 malaria staff have taken and are to be working in malaria in the integrated areas.

B. Country Health Program (CHP)

The CHP was an exercise designed under the auspices of WHO to assist the Nepalese in preparation for the Fifth Five Year Plan which is scheduled to begin in July 1975. I attended these conferences representing USAID as a technical advisor and representative of a donor agency. The documentation is too voluminous to forward. Specific important areas are referred to be the DAF Health Sector Assessment.

C. Nutrition Survey

Under the joint auspices of the Food and Agriculture (FAD) and the Population and Health Division (PH) the assistance of CDC was requested in performing a Nutrition Status Survey. Broadly the purpose of the survey is to assess nutritional status in defined development regions, terrains and subregions; to quantitate by survey methods undernutrition using anthropometric measurements, selected clinical signs and laboratory measurements; to complement data from the Food Consumption Study being conducted by the Food Research Division of the Ministry of Agriculture; to provide a reliable data base for reference in planning nutrition and agriculture development priorities and monitoring changes in nutritional status occurring as a response to development programs; as well as to institutionalize this capability to monitor nutritional change through anthropometric methods.

Rick Froubridge and Ed Brink were here in the reconnaissance and planning phase of the survey. I participated with the FAD supportive staff in discussing the contents and methodology of

the proposed study with Ministry of Health Planning Cell and Directorate of Health Service staff and through the Ad Hoc Working Group on Nutrition. The survey is tentatively planned for January 1975 for 2-3 months. IMG is anxious to see the results since it will fill an immediately actionable data gap as well as provide data for the finalization of the Fifth Five Year Plan to begin in July 1975.

D. First Asian Regional Conference of Public Health Associations

The primary purpose of USAID sponsorship of a Nepalese delegation to this meeting was to have Nepalese participate in the two day workshop on the 'Mobilization of Response Structures at the Grass Roots level in Public Health'. In addition to this two day workshop two additional days were devoted to planning sessions on other general public health problems. Of special interest to Nepalese and myself were the descriptions of a New Zealand Physician from the Western Pacific Regional Office of WHO on the New Approaches to Health Problems: The example of the "Barefoot Doctor", and other experiments on rural health care delivery systems in Indonesia, India, Sri Lanka, Iran and Ethiopia.

The workshop built on some fundamental assumptions about basic problems in the provision of health care. Essentially the group accepted that health problems of the community must be largely resolved within the community and by community members themselves. Generally this has not been true and services originating outside the community have not become the "property" of the total community. The people do not feel that outside programs belong to them and therefore do not have much interest. On the other hand, programs provided by outsiders do not easily become a part of the way of life of local community members, and for many health problems (especially in prevention, sanitation, nutrition, mother and child care etc.) this means that effective health action is not taken where it must be taken.

It was recognized that cost and manpower are important factors. In most of the countries represented in the workshop, there simply are not enough professional or trained health personnel to provide services to local - primarily rural - communities. Thus, there are several basic reasons why local communities must be involved in their own health programs. It was also recognized that health care, however, important by itself, must also be related to other activities within the general content of community socio-economic development. Most of the experiences presented by the numerous participants

pointed to specific ways in which communities had been involved in the provision of health care. It was emphasized that community awareness and sense of responsibility expressed in the involvement of the people in community health program gives the program a momentum which accelerates to become a continuing movement. It was mentioned how local health workers in several instances had taken on major responsibility for community health care. The training programs for these workers were described as well as supervisory and referral arrangements.

In all of the situations described, the process of actually involving the community was a crucial point. Much of the discussion was directed toward trying to understand and analyze this process so that effective experiences could be replicated and small-scale projects could evolve to cover much larger population groups.

E. Miscellaneous - Health sector

The evolving attitudes of the government and health sector as a whole deserve some brief mention. All foreign aid inputs are being reviewed for their appropriateness. All projects, especially those that require expatriot external assistance are being carefully scrutinized. This rather sudden burst of nationalism has created a healthy environment of greater intersectoral involvement by the Planning Commission and the Foreign Aid Division of the Finance Ministry and has served as a stimulus to review all new project proposals more critically. This has not effected USAID but seems primarily directed at UNDP and WHO who have large numbers of technicians in-country.

Worthy of note is that the health sector is scheduled to receive 5.35% of the National budget in FY 75 as compared to 4.81% in FY 74. This means an increase from 6.31 to 9.31 crores of rs.

In recognition of the urgent need for a degree of presence in the health sector, the Directorate of Health Services has taken up a system of mobile camps offering surgical, gynecological eye, ENT, laproscopic and vasectomy capabilities. The camp provide Kathmandu physicians to remote areas after about a month of advertising to collect people. Overall the methodology has been successful.

Administratively the entire Ministry of Health has been in flux. The Minister of Education has also assumed the

responsibility for Health, a new Assistant State Minister for Health has been appointed, both Deputy Director General posts were abolished and the incumbents sent to the rural areas, and there is constant rumor that the DG, and the Chief of Family Planning are both to be imminently changed. All this under pressure from the Planning Commission and the Palace to perform. To complicate this 3 senior officers, who properly should not be spared, are to be drafted by WHO. Alas. It is in this environment that a 20 Year Plan for Health has just been completed and a 5 Year Plan is under preparation. In spite of what appears to be a great deal of turmoil and confusion I see real progress and change (e.g. the participant we sponsored for the Planning Course at Johns Hopkins School of Public Health in FY 74 has returned and is making a significant contribution to the Planning Cell).

F. Miscellaneous - USAID/CDC

Dick Johnson, an R.N. with an M.P.H., Peace Corp experience and Public Health Nursing experience officially joined the project on March 1, 1974. He fills the position of Field Operations Specialist and has proved to be a real asset.

The PAIA also calls for a site visit for someone from the Tropical Disease Bureau to visit the project. You talked about coming last year, but you apparently were unable. I think it would be important if you could manage during this year.

G. Miscellaneous - Hepatitis Outbreak

The specifics of the epidemic that I describe in my last memorandum is enclosed. Copies are being sent to Dr. Gregg.

ENCLOSURES

I. Health Sector Related Activities

1. Population and Health Division Activities Report Jan 1 through March 31, 1974.
2. Population and Health Division Activities Report, April 1974.
3. Health Sector Assessment.
4. Comments on Country Health Program.
5. Annual Budget for Health 1974/75.
6. Proposed Scope of Work: A Feasibility Study to Define the Potential for Mobilisation of the Private Sector Medical Resources to Complement Nepal's Health Services.
7. A Proposal for Cooperation of TB and Leprosy Control Projects in the KPP.
8. Project Agreement Amendment - 4/8/74 - For Architectural Feasibility Study (Richard F. Garfield).
9. Field Trip Report - Richard F. Garfield, Architectural Coordinator - April 30, 1974.
10. Work Plan for R. F. Garfield August 1974.

II. IHS Project Related Activities

1. Field Trip Report - Bara Pilot Project - April 1-3, 1974.
2. Field Trip Report - Bara Pilot Project - May 19-22, 1974.
3. Field Trip Report - Kaski Pilot Project - June 26-July 4, 1974.
4. Minutes of Working Group on Integration - June 18, 1974.
5. Minutes of Working Group on Integration - July 1 - July 4, 1974.
6. Kaski Pilot Project: Summary of Activities for the year 2030 - 1973/74.
7. Project Appraisal Report (PAR) - July 1974.
8. Draft Plan of Action : Preparation for Integration of Health Services for Tanahun District - 2031/32 (CY 1974-75).
9. Field Budget Submission - FY 75, 76 PP 118 - 130.

III. Non-Project Related Activities - Malaria

1. Report of the Program Review Team - 1974 on the Nepal Malaria Eradication Organization - February 7 - February 28, 1974.
2. Letter to L. Cowper from K. Bart - April 15, 1974.
3. Memorandum on VII Indo-Nepal Anti-Malaria Border Coordination Conference, April 25 - 27, 1974.
4. Letter to Dr. Rao from Dr. Rana - April 27, 1973.
5. MEO Status Report : Yearwise, Districtwise, Monthwise Summary.

IV. Miscellaneous

1. Summary of Hepatitis Outbreak.