PDAAS-183

PD-AAS-183
ISN=42180

42

Integrated Rural Health/Family Planning Services
367-0135
PACD Extension

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TABLE OF ABBREVIATIONS

AID/W	Agency for International Development/Washington
ANM	Auxiliary Nurse Midwife
A&E	Architectural and Engineering
C.C.C.	Construction Coordinating Committee
CHL	Community Health Leader
C.P.	Condition Precedent
CRS	Contraceptive Retail Sales
CSC	Construction Service Coordinator
CYP	Couple Years of Protection
DHO	District Health Office
DHS	Department of Health Services
EA	Environmental Assessment
EIS	Environmental Impact Statement
EPI	Expanded Program of Immunization
FM	Financial Management Office of USAID/N
FP/MCH	Family Planning/Maternal and Child Health
FPS	Family Planning Service
FX	Foreign Exchange
FY	Fiscal Year - U.S. - October 1 - September 30; Nepali - July 15 - July 14
GON	Government of Nepal
HFP	Health and Family Planning Office of USAID/N
HI	Health Inspector
HMG/N	His Majesty's Government/Nepal
HPD	Health Planning Division
HPI	Health Post In-charge
ICHSDP	Integrated Community Health Services Development Project
IEE	Initial Environmental Examination
IOM	Institute of Medicine
IRH/FPS	Integrated Rural Health/Family Planning Services
JSI	John Snow Inc.
LC	Local Cost
MCH	Maternal and Child Health
MOH	Ministry of Health
MT	Metric Tons
NMEO	Nepal Malaria Eradication Organization
NR	Nepali Rupees - Currency
PBHW	Panchayat Based Health Worker
PDIS	Project Development & Implementation Support Office of USAID/N
PIO/T	Project Implementation Order/Technical
PSC	Personal Services Contract
RFP	Request for Proposal
RS	Nepali Rupees -Currency
TBA	Traditional Birth Attendant
TEMO	Transport Equipment Maintenance Office of MOH
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID/N	United States Agency for International Development/ Nepal
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

The Integrated Rural Health and Family Planning Services (IRH/FPS) Project was designed as a five year project to be completed by September 1985. Approximately $13.4 million of the total project budget of $34.2 million will remain unexpended at the PACD. Major project activities are now well-underway and on schedule with respect to a revised project implementation plan.

Substantial progress has been made in expanding health and family planning services to rural areas, but the project must be extended to accomplish original project objectives. To date organizational integration has occurred more slowly than originally anticipated. Although it remains the GON's long-term goal for cost-effective expansion of service delivery, it is now clear that original GON targets for integration were optimistic. The GON is committed to reviewing and revising the schedule and process for integrated service delivery, with the full encouragement of USAID/N and other key donors. USAID/N and GON propose that the project be extended through March 31, 1988 using remaining project funds. This paper discusses progress to date in target areas and sets forth the rationale for the extension and project directions.

A summary of achievements and proposed project activities for the extension period follows:

Institution Building

The MOH has been strengthened in key areas of service delivery management by participant training. Recognizing the MOH's increased capacity to plan and carry out effective in-country training, continued support for personnel development will focus on in-country training of field staff and outreach workers. During the project extension, USAID/N budget support will gradually be absorbed by the GON.

Technical Assistance

Technical assistance will be reduced and focused on integration, MCH activities and management constraints which impede service delivery.

Construction

Health facilities and regional medical stores (warehouses) are 40% complete. No new construction will be undertaken beyond those already committed or underway. Estimated date for full completion of construction activities is September 1986.

Contraceptive and Surgical Commodities

USAID/N provision of contraceptives and surgical supplies has enabled the GON to expand the available supply of temporary family planning methods as well as VSC procedures nationwide. This support will continue.

IRH/FPS Target Activities

Original Project Paper	PP Revision for the Extension Period
Integration	Ongoing with increased emphasis and support to GON in developing a plan and implementation schedule for integrated service delivery.
Family Planning Activities	Ongoing with continued support to VSC and temporary methods.
MCH activities	Ongoing with increased emphasis.
Outreach workers	Ongoing with support refocused on training in the field.
Malaria Control	Ongoing support in provision of insecticides; technical assistance to develop options for increased reliance on non-chemical control methods.
Health Planning	Ongoing to allow the Health Planning Division sufficient time to become well-established and effective.
Management	Reduced.
Logistics	Reduced. Focus on the Regional Medical Stores system for distribution of drugs and health supplies.

Section I: Summary of Project 1980-84

The Integrated Rural Health/Family Planning Services (IRH/FPS) Project was designed to assist the Government of Nepal (GON) in improving general health and reducing fertility rates throughout Nepal, but especially among the rural poor. The specific purposes of this project are to improve the management of health and family planning delivery systems and to expand these services nationwide.

At the time the original Project Paper was written, the GON's goal, as stated in Nepal's Long Term Health Plan, was to combine by 1985 all rural health services into a system of integrated management, with deployment of multi-purpose village level health workers. This was considered necessary because, despite the achievements of each of the five single purpose vertical programs,* the multiplicity of vertical projects also had dysfunctional effects. These included duplication of efforts within the same geographic areas and the inefficient use of scarce management resources caused by the simultaneous operation of separate administrative structures on frequently similar tasks.

Nepal saw an integrated health/family planning system as the most cost effective way to serve the people's needs. This integrated system was based on the premise that a multi-purpose worker supported by one organizational structure would be more cost effective than a series of uni-purpose workers attacking single problems through separate organizations. Hence, after integration, the functions, staff and resources of the presently relatively autonomous vertical projects would be absorbed by a single administrative structure in a series of gradual steps. This project considered an obtainable objective for 1985 (project completion) to be the integration of ongoing health and family planning activities under one administrative/ management organization in 48 of Nepal's 75 districts.

In cooperation with other international donors, this project provides technical assistance, participant training, commodities, construction assistance and local cost support to the Ministry of Health (MOH) in the following four key areas:

1. Management and Planning

   - Provision of technical assistance (222-person months long term, 34-person months short term assistance);

*Nepal Malaria Eradication Organization (NMEO); Tuberculosis Control Project; Leprosy Control Project; Expanded Program in Immunization (EPI); Family Planning/ Maternal and Child Health (FP/MCH).

- Budget support to strengthen the MOH's Health Planning Division (HPD);

- Participant training (15 long term and 18 short term in the United States, 80 short term in Asia);

- Special field operations studies.

2. Rural Health Services

- Strengthened central offices and expansion of the ICHSDP Project from 13 fully and partially integrated districts to 48 fully integrated districts;

- Renovation and construction of rural health facilities;

- Construction of three regional warehouses;

- Support to improve the "cold chain" capability for the expanded immunization program (EPI);

- Budget support for the administration of rural facilities and the training and supervision of Village Health Workers (VHWs).

3. Family Planning Services

- Budget support for FP/MCH activities, including Panchayat-Based Health Workers (PBHW) and Voluntary Surgical Contraception (VSC), both hospital and mobile camp based;

- Expansion of improved family planning services to all 75 districts of Nepal through both the integrated and non-integrated service programs;

- Continued commodity support through centrally-procured temporary contraceptives and medical equipment for the VSC program.

4 Malaria Control

- Provision of commodities (chiefly insecticides);

- Provision of a technical advisor to ensure the safe and proper application of malaria insecticide (Malathion) ;

- Malaria surveillance and control in both integrated and non-integrated districts.

It was anticipated that the following six major outputs would be achieved through this project:

1. Integrated planning and management of effective services;

2 Health Planning Division (HPD) functioning effectively;

3. Management systems functioning effectively;

4. Community participation in health services established;

5. Training and health education needs met;

6. Health and family planning services delivered effectively;

It was further anticipated that the accomplishment of these outputs would be measured against 34 indicators of improved management and expanded delivery of rural health and family planning services, as summarized in Annex A.

Section II: Project Progress to Date

To date partial accomplishment of the project purpose has been achieved in that management capability within various divisions of the MOH has been strengthened and expansion of health and family planning services, particularly the latter, has occurred. This progress, however, has not taken place solely within the context of integrating service delivery as envisaged at the start of the project. Progress to date has occurred as much through the vertical projects as through the integration effort.

Accomplishments against the six major project outputs are summarized below. A more detailed list of accomplishments against all 34 output indicators is presented in Annex A.

Output 1: Integrated Planning and Management of Effective Services

The organizational change from vertical projects to a system of integrated service delivery has proven difficult and time-consuming. Vertical project Chiefs have been reluctant to have districts removed from their direct authority, especially given the risk of reduced effectiveness of their single-purpose efforts under the integrated system. In addition, significant management problems have developed in those districts already integrated which are not easily resolved. The GON has, therefore, pursued integration at a slower pace in order to gain more widespread support for integration within the MOH and to allow adequate time to establish workable procedures for integrating districts under an effective management system.

At present, only 6 districts are fully integrated and an additional 20 districts are partially integrated. In these 26 integrated districts*, personnel have been sanctioned and assigned. Planning and management control has, however, remained effectively centralized.

Capability to monitor and evaluate program progress and achievements exists within the MOH, although capacity varies among vertical projects and divisions.

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*Further reference to integrated districts should be understood to mean all districts administered through ICHSDP, regardless of whether they are fully or partially integrated (i.e., service delivery systems do or do not yet include all components of FP/MCH, immunization, malaria control, leprosy and TB detection and treatment activities).

Construction of three regional warehouses is underway and scheduled for completion in spring 1985. In addition, two health centers and seven health posts are under construction, and an additional three health posts are planned. Plans for renovating twenty health posts have been cancelled due to high costs.

Output 2: Health Planning Division (HPD) Functioning Effectively

In the past year, the HPD has assumed a strengthened role in both the annual and long-term planning process of the MOH. Staffing, responsibilities and activities have increased significantly since the start of this project. Although disease-specific surveys and field operational studies are not yet routinely performed under HPD supervision and management, the HPD has collaborated with other MOH divisions and donors on two important studies. A Management Review of Integrated Health Services recommended consolidation and strengthening of integration efforts as well as deliberate and carefully planned expansion; a Management Survey of Sanitation and Infection Control in Hospitals in Nepal provided recommendations and proposals for improving environmental management systems at various levels of health facilities in Nepal.

Output 3: Management Systems Functioning Effectively

Although the MOH has made some progress toward ensuring adequate supplies of drugs nation-wide, largely through significant increases in the drug budget, drug supplies remain inadequate. However, standard methods of ordering, storage, reporting and re-supply of drugs have been developed for the entire country. A unified management information system has not been developed within the MOH to date. Basically, each vertical project or division has its own management information system (in various stages of development) appropriate to its own needs. Similarly, each division within the MOH has some capacity, in varying degrees, to carry out special field operations studies.

Output 4: Community Participation in Health Services

The concept of community participation in health service delivery has been established through the Community Health Leader (CHL) program in 13 integrated districts (50% of all integrated districts). There are presently 2,600 Ward (village) Health Committees (WHCs) that function primarily to select and support the CHLs. Approximately one third of these WHCs have raised some money to replenish the basic drugs and supplies in the CHLs' kits. Few WHCs have succeeded in mobilizing community effort to build latrines or otherwise promote the health of the community. CHLs receive only sporadic training and supervision by health post staff.

Output 5: Training and Health Education Needs Met

Over 2,000 health and family planning workers (approximately 27%) have received training during the project period to date. Refresher training has become a regular part of training programs in all major divisions of the MOH, and these divisions routinely prepare annual training plans and schedules. Under the Participant Training Program, 81% of all participants have been trained and assigned.

Output 6: Health and Family Planning Services Delivered Effectively

There has been a considerable rise in the distribution of temporary contraceptive methods during the project period. In 1983, an estimated 149,898 couple years of protection were being provided by temporary contraceptive methods. 164,180 Voluntary Surgical Contraceptive (VSC) procedures have been performed in Nepal during the 1980-84 period. (41,161 VSC procedures were performed during the 1975-1979 period.)

Expansion of health service delivery has occurred at a somewhat slower pace. Despite active radio promotion of Oral Rehydration Therapy (ORT) and approximately 8,600 outreach workers in all districts who have received ORT training, the ORT useage remains minimal. Less than 5% of severe diarrhea is treated with ORT nationwide. The percentage of women receiving tetanus immunizations ranges from 5% in integrated districts to 0% in FP/MCH districts. In 1983-84, approximately 42% of active TB and 11% of leprosy cases were under treatment in integrated districts. In ICHSDP districts in 1983/84, approximately 14% of children under one received the complete DPT series, 52% received BCG and approximately 5% of all infants and young children received measles vaccine. In 11 of the 52 FP/MCH covered districts approximately 12% of those children under one received the complete DPT series and approximately 14% received BCG; coverage in the remaining 41 FP/MCH districts was close to 0%.

Project expenditures to date in comparison to original PP estimates are presented in Table I, as are projected expenditures through the end of an extended project.

TABLE I Projected and Actual USAID/N Project Expenditures ($ 000)

	Expenditures Projected in PP		Actual Expenditures through 9/30/84		Projected Expenditures through FY'88				Total Revised Expenditures	
		% of Total		% of PP Total	FY'85	FY'86	FY'87	FY'88		% of Total
Technical Assistance	2787	8.2	2722	7.9	1040	608	990	946	6306	18.4
Long term advisors	2405		2181		832	486	792	756	5047	
Short term advisors	383		541		208	122	198	190	1259	
Training	1003.5	2.9	666	1.9	-	50	100	100	916	2.6
Participant	1003.5		666		-	-	-	-	-	
In-country	-		-		-	50	100	100	-	
Commodities	7770	22.7	4061	11.8	1304	900	900	900	8065	23.5
Medical Supplies	1686		-		-	-	-	-	-	
Malaria Insecticides	4600		3088		700	700	700	-	5188	
VSC Equipment	192.8		480		424	200	200	173	1477	
Other equipment supplies	1291.2		493		180	-	-	727	1400	
Contraceptives	4200	12.3	1768	5.1	1036	650	769	-	4223	12.3
Construction Activities	1939	5.7	423	1.2	1500	673	-	-	2596	7.5
Support to Rural Health	6819	19.9	4472	13.0	1370	2565	1955	1209	11571	33.8
Operation (Budget support)										
Other Costs	9681.5	28.3	308	0.9	115	100	-	-	523	1.5
Miscellaneous Inflation Contingency										
Total	34200	100.0	14420	41.8	6365	5546	4714	3155	34200	100.0

Section III: Project Mid-Term Evaluation Findings*

The current project was evaluated by an independent, five person team (3 expatriates, 2 Nepalis) in November, 1984. The principal findings of that evaluation and the Mission's reaction to them are summarized below.

The evaluation team tended to focus on broad issues related to the Nepal health sector and general strategies for USAID/N participation therein. In covering this broad spectrum, detailed guidance on the revision of the project's targets, outputs and implementation schedule was not provided. The following, therefore, reviews the general directions which the evaluators felt were important and those specific recommendations which were made regarding the current project.

The Importance of Population Control. The evaluators felt that control of population growth should be the highest priority under the project, noting that the demographic crisis in Nepal will not abate without intensive intervention and that continued population growth will likely frustrate not only efforts to improve health status, but all other development efforts as well. They recommended that the Mission concentrate on programs of outreach and education; that the quality of services provided by these programs be improved; that more women be included in the service delivery network; that the program of Voluntary Surgical Contraception (VSC) be vigorously supported and that client follow-up in that program be improved. They also recommended continued support for temporary contraception and child spacing, especially through social marketing (i.e. the Contraceptive Retail Sales Co. (P) Ltd.) which they characterized as a genuine success.

The Delivery of Health and Family Planning Services: The evaluators noted that inadequate availability of health and family planning services continued to be the norm in Nepal. They also noted that the quality of those services that are available requires improvement through better supervision, motivation and incentives to providers. The small scale of ORS distribution, low levels of immunization, a paucity of hygiene education and programs for the construction of sanitary works, inconsistently provided pre-natal care and, in some areas, a deterioration in malaria control activities were cited as specific concerns. It was recommended that MCH services concentrate on oral rehydration, immunizations, child spacing and basic first aid/curative care and that traditional birth attendants be incorporated into the service delivery system.

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* As a final evaluation report had not been completed as of this writing, the comments in this section are based on the draft report.

In addition, the evaluators noted that the ICHSDP Project should be abandoned as a vertical entity as it has little authority or control beyond its own persuasive powers. They suggested instead that integration should be pursued as an organizational concept and on a decentralized basis across a wide range of existing agencies and projects under the authority of the Secretary of Health. They indicated that the Health Planning Division of the MOH could provide valuable staff support to the Secretary in this process and recommended that we continue to support that division. They further suggested that, with regard to health planning, there has already been a plethora of studies, plans and reports completed on a wide variety of subjects and that the task of the moment is to organize the MOH as a coherent whole, set a few major affordable objectives for the delivery of services and implement programs to attain those objectives.

The evaluators also believed that the malaria control program should (1) be accorded status as a permanent agency of the MOH (rather than be maintained as a 'temporary' vertical project), (2) be preserved as a technical backstop for malaria activities independent of the integrated services, and (3) be accorded responsibility in the control of other vector-born diseases and, possibly, in environmental disease control. They also recommended that an epidemiologic surveillance unit be established.

An Emphasis on Disease Prevention: The evaluation noted that the likelihood of Nepal being able to support a truly competent system of curative care was remote and that it was in programs of disease prevention and health promotion that Nepal would achieve its principal gains in improving public health in the future. It suggested that the provision of drugs and the construction of health facilities be limited and that the project concentrate on activities which most demonstrably improve the health of the population, e.g., control of population growth, immunizations, environmental control of disease and improved nutrition.

Malaria: Aside from the organizational recommendations noted above, the team endorsed the recommendations of an external evaluation of the malaria program sponsored by WHO, ODA (UK) and USAID/N in July, 1984. Most of these recommendations are of a technical nature and not of major import to the extension of the current project. However, they did include suggestions that NMEO continue to seek insecticides from international donors, adopt alternative methods of malaria control and strengthen its research and training capability. Although not noted specifically in the report, the team indicated to USAID/N staff that the continued provision of insecticides would be necessary to keep malaria under control. The report did note that the development of alternative methods of malaria control would require considerable research and development and that the strengthening of NMEO's research center through

improvements to physical facilities and the training of a research staff was necessary to reduce dependence on insecticides over the long term.

Financial Support: The report states that GON contributions to health and family planning had increased by over 100% since 1978, but that increased donor support remains necessary, noting that any cut-back in this support could produce severely adverse consequences. A major, on-going USAID/N commitment to family planning was of special concern. Although the report recommends that USAID/N insure that increased support be available for these programs, it also notes that the GON has encountered substantial difficulties in disbursing the funds which are already available under the project.

Logistics Support: The evaluators briefly noted the importance of a functioning supply system to effective program operations and recommended that USAID/N continue to provide assistance in this area. Unspecified difficulties in the supply system of the immunization program were noted.

Training: The evaluators recommended that training for GON personnel be a high priority for USAID/N and that improved methods for trainee selection be adopted. In-country training was described as a priority concern, and it was recommended that this training be concentrated on (1) family planning and MCH training for low-level, field personnel, (2) training for financial managers at the central level and (3) training for trainers. An urgent need to train staff for the malaria research and training center was stressed, and a need for epidemiologists, social scientists, biostatisticians and computer personnel for the Health Planning Division was noted. The utility of training traditional birth attendants was also emphasized.

Mission Views on the Evaluation

The evaluation provided useful insights into possible future directions for our health assistance, and these comments will be useful as a basis for policy dialogue with the MOH over the next three years. Implementation of many of the evaluation's major recommendations (e.g., the relocation of the Health Planning Division as a staff arm of the Secretary of Health, the absorption of the NMEO as a permanent arm of the Ministry and the expansion of its responsibilities, and the emphasis on environmental control of disease) require basic changes in the structure of the MOH, changes that are not going to be forthcoming over the short term.

USAID/N therefore, proposes a two-part approach over the next three years: (1) to continue with the principal thrust of the current project (to expand the delivery of health and family planning services) while (2) setting the stage for more far reaching changes. In so doing, the Mission will tailor its current assistance to be consistent with the long-term guidance provided in the evaluation (subject to specific exceptions discussed below) and, where possible, initiate the type of fundamental changes the evaluators felt were important. Our specific comments on the principal issues raised by the evaluation follow.

Population: USAID/N fully concurs that the control of population growth should be the main focus of our health and family planning assistance and that the Mission should concentrate on improving the quality of outreach services as a means to this end. The Mission also believes that a strengthened MCH component is necessary in this regard. Although a USAID/N sponsored study of female PBHWs (August 1984) indicated several basic problems impeding the rapid absorption of women into the service network, USAID/N concurs in the importance of increasing female participation in the provision of FP/MCH services and will endeavor to expand such participation under the extended project. USAID/N also concurs in the importance of maintaining support to the VSC program and to the CRS program.

Service Delivery: USAID/N agrees that services should be improved in terms of both availability and quality and that better supervision, motivation and incentives are required. The Mission also believes that this situation will be best remedied nationwide by the reorganization of the integrated services referred to earlier in this section, as many of these problems are deeply embedded in the current structure and operations of the MOH and their solution requires basic changes. The MOH has expressed a commitment to reassess both management and organization of service delivery within the MOH during spring 1985. USAID/N will assist and forward this effort as appropriate.

USAID/N agrees that the utilization of ORT in Nepal should be increased substantially. Although the Mission will emphasize training in ORT to field workers trained under the extension and expect to expand its availability through CRS, serious production problems rooted entirely outside the MOH must be overcome before pre-packaged ORS can be made widely available.

USAID/N agrees that immunization levels should be increased, and to this end will consider increasing our immunization component in the integration and MCH programs. We see limited possibilities however for increased USAID/N assistance to EPI given the assistance currently provided to that program by UNICEF and WHO. Where appropriate, USAID/N will provide technical assistance to the immunization program.

Although basic hygiene and sanitation education would seem an apparently simple, low-cost and highly desirable intervention, it is nonetheless extremely difficult to influence behavioral change, especially among the under-developed and isolated populations which characterize much of rural Nepal. In addition, given that health workers in Nepal already have too many duties to perform over too wide a geographic area, it may be more effective to focus basic health education on areas where services are already being delivered. USAID/N would prefer to concentrate MCH services, as indeed the evaluation recommended they be concentrated, on ORS, immunizations, child spacing and basic first aid/curative care, with appropriate educational messages to reinforce service delivery in these areas.

USAID/N also feels that the construction of sanitary works is currently beyond the capability of both this project and the MOH, which does not have an environmental sanitation health division. The construction of small, rural water systems, for example, is a responsibility of the Ministry of Panchayat and Local Development, and USAID/N contributions to this work are already part of our Rapti and Resource Conservation (RCU) Projects.

USAID/N agrees with the evaluation's conclusion that the concept of integration should be reexamined with a view ultimately to integrating service delivery nationwide. The steps to be taken toward this long term goal will require time and considerable change within the MOH. Accordingly, the reformulation of the integration process will be a high priority for policy dialogue and increased technical assistance efforts over the next several years.

With regard to malaria, USAID/N agrees that the NMEO should be given status as a permanent agency. However, this is an internal GON problem which the Mission may not be able to influence in the short period afforded under a project extension. Likewise, USAID/N cannot change NMEO's responsibilities under an extension to make it a technical backstopping agent; indeed, such changes should not be made independently of a reorganization of the integrated services which provide for the regular conduct of activities to backstop in the first place. Although USAID/N recognizes the similarity of expertise required for malaria control and the control of other vector-born diseases and for environmental sanitation, the Mission cannot agree that NMEO, already hard pressed to control malaria alone, should be accorded increased responsibilities in these other areas at this time.

Prevention: USAID/N agrees with the evaluation's analysis of the merits of emphasizing preventive services. It will, therefore, construct no additional health facilities beyond those already commited or underway under the extension nor will we provide drugs. Procurement of medical supplies and equipment will be limited to those items required by the VSC and malaria control programs. Our training activities (especially in MCH) will emphasize prevention/promotion in the context of the four priority areas noted under Service Delivery above.

Malaria: USAID/N believes that the evaluators' observations on the continued need for insecticides and the importance of a properly staffed research center are well taken. The Mission agrees that high quality research is necessary to the design of alternative methods of malaria control which are required to reduce dependency on insecticides. Since such dependency will not be substantially reduced over the three years of the extended project, minimal support will be continued for the purchase of insecticides.

Financial Support: While USAID/N appreciates both the need to expand the delivery of health and family planning services in Nepal and the scarcity of the resources available to the GON to accomplish this goal, continued project budget support for this purpose is not feasible. Some transfer of this requirement is essential if institutional objectives are to be met. The Mission, therefore, plans to reduce routine budget support over the three years of an extended project. In addition, given the difficulties encountered to date in expending the funds which have been available under the project, USAID/N anticipates no significantly increased level of support for any individual project component.

Logistics Support: The Mission agrees with the evaluation's comments on the importance of an effective logistics system and will continue technical assistance in this area during the project extension.

Training: The Mission agrees with the evaluation's recommendation that priority be given to in-country training of low-level health workers, including training of traditional birth attendants. USAID/N cannot, however, at this time agree to the training of epidemiologists, social scientists, and biostatisticians for the health planning division, given the costs of this training, the lack of approved positions for these personnel in the division and the current lack of capacity of the division to use such personnel properly. Consideration of this training will be deferred for a possible follow-on project.

Section IV: Directions for the Project Extension

The IRH/FPS Project was designed to support the gradual integration of health and family planning service delivery while enabling USAID/N to adjust its support in keeping with progress in the integration process and the need to maintain vital health and family planning services provided by vertical programs in the meantime. In practice, support to ICHSDP has been less than that provided other vertical projects - largely due to unresolved issues which have temporarily slowed the integration process. USAID/N's resources, however, have also been well spent in supporting the vertical projects and other support divisions of the MOH. For example, it is unlikely that either last year's VSC target would have been achieved or the nationwide Regional Medical Stores network initiated without this assistance.

Despite the slowed pace of service integration, USAID/N, the GON and other international donors remain commited to the concept of an effective system of integrated service delivery as the more desirable and cost-effective means of providing health and family planning services nationwide. Therefore, USAID/N will continue to support the MOH in the integration effort, through the development of a plan and implementation schedule for integrated service delivery.

Given the unanticipated delay in integrating service delivery, the project will continue to support vertical projects and support divisions within the MOH to achieve the project purpose. As soon as a non-vertical organizational structure for integrated service delivery is developed, USAID/N will support service delivery through this mechanism.

Given the project accomplishments to date, conclusions and findings of the 1984 project evaluation and the slowdown in the integration process, USAID/N plans to target remaining, limited project resources to expanding rural health (especially MCH) and family planning service delivery through the following:

- Technical Assistance will focus on assisting the MOH in re-organizing the integration effort, expanding MCH activities and identifying/resolving management bottlenecks which impede service delivery;

- Construction activities already underway or commited (3 additional health posts) will be completed and no new construction activities will be undertaken;

- Commodities will be provided in support of VSC and malaria control activities;

- Contraceptives will be provided to both the MOH and CRS Company (P.) Ltd.;

- Training will be supported in-country and targeted to rural outreach workers and field level managers.

- Budget support will be reduced over the project extension.

Revised project directions are reflected in the Logical Framework, Annex C.

Section V: Revised Project Components

The project will continue to provide technical assistance, in-country training, contraceptives, limited commodities and construction assistance, and decreased budget support in the following areas:

- Basic health and MCH services in rural areas,
- Family Planning Services,
- Malaria Control,
- Management of health and family planning service delivery.

1. Basic Health and MCH Services

Expanding basic health and MCH services to rural areas remains a priority of both the GON and USAID/N. This project will continue to support this effort through various MOH projects and service support divisions within the MOH. Specifically, support will be targeted to the following:

- Technical assistance will focus on incorporating MCH activities into ongoing programs.
- In-country training will focus on training outreach field workers (e.g., PBHWs and CHLs) and those located and working at the district level (e.g., Health Inspectors and Health Assistants). Training for Auxiliary Nurse Midwives (ANMs) and Traditional Birth Attendants (TBAs) will include growth monitoring on a trial basis.
- Construction of three Regional Warehouses, two Health Centers in the Rapti Zone and ten health posts will be completed. (See page 29 for construction completion schedule.)
- Budget support to the Indent and Procurement Division (IPD) will continue in decreasing amounts through 1987 to allow the MOH sufficient time to assume support for the Regional Medical Stores system which will facilitate the distribution of drugs and health supplies throughout Nepal. Decreased budget support for FP/MCH will be targeted to support of field level personnel and MCH activities (e.g., budget support to organize mobile immunization camps in rural areas, salary support for PBHWs).

2. Family Planning Services

The increased utilization of family planning services remains a top priority to be addressed by this project - primarily through the expansion of service and contraceptive delivery through FP/MCH, ICHSDP and CRS Support will be targeted to the following:

- Technical assistance by a family planning advisor will be continued on a part-time basis through June 1986 and then phased out. There currently exist within the MOH well-trained, competent family planning program administrators who are increasingly capable of administering family planning activities. Technical assistance will focus on assisting the MOH to develop a strategy for staffing and utilizing the five Family Planning Service (FPS) centers constructed under both this and an earlier USAID/N project, as well as on the development and implementation of annual VSC and PBHW workplans.

- In-country training will focus on strengthening outreach workers' knowledge and promotion of temporary family planning methods and increasing follow-up of clients who accept either temporary or permanent methods.

- Contraceptives - As the major supplier of family planning commodities in Nepal, USAID/N will continue and expand its support in this area to both the MOH and CRS Co. (P) Ltd.

- Medical/surgical commodities and supplies will be provided for the VSC program throughout the extended project.

- Budget support to FP/MCH will be continued at decreased levels and targeted to support for outreach workers and follow-up activities. Budget support for the VSC program will continue at the present level through 1987. At present USAID/N supports approximately 22,000 VSC procedures/year through both the FP/MCH and ICHSDP budgets. Full support will also continue for the Repair and Maintenance (RAM) Center. USAID/N funding for the PBHW program will decline throughout the extended project period. Budget support to CRS will be maintained to enable the company to continue its current activities, institute a Community Based Distribution (CBD) program and increase its distribution of ORS.

3. Malaria Control

In view of the GON's long-term commitment to control malaria and the health threat that a resurgence of malaria would pose, USAID/N will continue to provide insecticide, spray equipment and safety materials through 1987. In view of AID's "Revised Agency Guidelines for Malaria Control", AID will discuss with the MOH the need to shift future USAID/N resources in a follow-on project from commodity support to establishing and strengthening research capability, and improved management and planning of chemical and non-chemical methods of control. Support in the revised project will be targeted to:

- Technical assistance will continue through a full time local malaria safety advisor and short term consultants to assist the GON in bi-annual program assessments and to assess future direction of USAID/N assistance in malaria.

- In-country training will be provided in safe insecticide spray techniques. In addition, eight positions per year will be made available to NMEO and ICHSDP in the basic Malaria Course through the India Training Program at no cost to the project.

- Commodities - 900 metric tons of malathion will be made available through 1988 for delivery to both NMEO and ICHSDP. Sprayers, spare parts, and protective clothing will also be made available.

4. Management of Service Delivery

Strong management capability within the MOH is essential to effective expansion of service delivery, especially in personnel, financial, logistics and data systems management. There is presently a wide discrepancy in management capability within vertical projects and service support divisions. Support under this project will focus on areas where management weaknesses impede service delivery. Specifically, support will be targeted to the following:

- Technical assistance will concentrate on assisting the MOH to develop a non-vertical organizational structure for the effective integration of service delivery as a top priority. Assistance will also be provided in upgrading financial, logistics, personnel and data management.

- In-country training will target specific areas of financial, logistics, personnel and data management, particularly at the field level.

- Budget support to the Health Planning Division (HPD) will be continued to allow the division sufficient time to become well-established. A recent upgrading to division status and acceptance by the GON of an expanded staffing pattern has significantly strengthened the HPD. Within the past year alone it has assumed substantial responsibility in long-term planning, surveys and evaluations. The 1985/86 workplan will contain a time schedule, agreed upon by both USAID/N and the MOH, for decreased USAID/N funding for staff and other local support costs.

Section VI: Training and Technical Assistance

Participant Training

As of 8/84 all participant training positions provided under the original PP will have been utilized, with the exception of approximately 13 slots for third country, short term training. Funds allocated for these remaining third country training slots will be redirected to in-country training/workshops to be carried out in 1985. This re-allocation of funds recognizes the MOH's increased capacity to plan and carry out effective in-country training, with minimal outside assistance.

The following slots are available in target areas through the India Training Program at no cost to the project. Health education courses will stress MCH topics as much as possible.

	# of participant slots	
	1985	1986*
Health Education (12 months)	2	4
Fiscal Management (3 months)	2	4
Logistics Training (3 months)	2	3
Computer-based Information and Design (3 months)	3	3
Basic Malaria Course (2 weeks)	8	8

In-country Training and Workshops

In-country training/workshops will be developed and targeted to strengthening MOH capability in the following priority areas:

- Incorporating MCH activities into ongoing programs (e.g., include training in growth monitoring in ongoing ANM and TBA training courses; expanded training in ORT for PBHWs, etc.)

- data systems management
- financial management
- logistics management
- repair and maintenance of VSC and other equipment
- Annual FP/MCH workshop for FPOs and HIs
- Malaria safety training

The specific topics will be agreed upon between USAID/N, and the GON on an annual basis.

* Subject to continuation of the India training program.

Long-Term Technical Assistance

The services of four long term technical advisors will be provided throughout the project extension. By agreement with the MOH, USAID/N plans to extend the JSI contract through September 1987 in order to continue the services of two full-time technical advisors. The approximately nine remaining months of technical assistance in family planning will be carried out as originally planned and will terminate o/a June 1986. Overall level of support by the JSI team will be scaled down and assistance to the MOH targeted to the following areas:

- Development of a plan for effective integrated service delivery;

- Development of an implementation schedule for integration of service delivery;

- Development of prioritized activities to resolve critical management bottlenecks which impede service delivery in logistics, financial, data systems and personnel management (e.g., develop process for more timely release of funds to district level, identify better controls over personnel, revision of hiring/firing/rewarding capability at district level etc.);

- Strengthen MOH tri-annual Progress Reports to include data on indicators noted in both logframe and USAID/N project monitoring sheets, as mutually agreed upon by USAID/N and the MOH;

- Determination of specific MCH tasks which can be incorporated into ongoing responsibilities of CHLs, PBHWs, VHWs, ANMs, and development of a time schedule for this incorporation;

- Development of a national strategy for a more effective ORT program and a schedule for implementation of activities to promote ORT;

- Development of a plan to expand and track immunization in previously uncovered districts;

- Development of MOH staffing/utilization plan for five Family Planning Service (FPS) centers constructed by USAID/N;

- Development of MOH monitoring system for rural health services and a schedule for its implementation;

- Development and implementation of annual MOH-USAID/N workplans, including an MCH component.

- Development of accurate Couple Years of Protection (CYP) data collection capability for temporary methods within FP/MCH;

- Development of a PBHW monitoring system within FP/MCH (including number, location, sex, household visits/mo, cases of diarrhea treated, etc.);

In addition to the two full-time JSI advisors mentioned above, the services of a full-time in-country training advisor will be sought through the JSI contract or through a Personal Services Contract. This person will assist the MOH in the following:

- Development of training needs assessment within the MOH, specifically for outreach field-level workers (e.g., CHLs, VHWs, PBHWs, ANMs) and district level management personnel (HPOs HPIs, accountants, logistics managers, etc.).

- Development and implementation (including logistical support) of annual training plans for USAID/N assistance in 1986 and 1987.

Finally, USAID/N will continue to fund through the end of the project the services of a local, long term Malaria Safety Advisor who will monitor the safe use of USAID/N-funded insecticides; provide training in safe methods of spraying and provide assistance to the NMEO and USAID/N in other aspects of malaria control as necessary.

Short-term Consultants

In addition to the long term technical advisors discussed above, the JSI contract will also include funds for approximately five person months per year of short-term technical assistance in support of project objectives. Areas for short-term consultant assistance have been identified as follows:

1. Data Collection and Processing

One consultant will be required for three to four months to review existing data and data-collection/analysis procedures and to recommend changes to increase the capacity of the Ministry of Health to collect and analyze information on the provision of primary health-care services. Emphasis will be given to data relating to those aspects of health care to which USAID/N assistance is currently focused or likely to be focused in the future.

2. Financial Management

One consultant will be required for approximately four to six weeks to examine the MOH's financial management systems and identify key structural and procedural problems which impede the expeditious flow of funds (both salaries and operating expenses) from the center to the periphery. The consultant will determine specific interventions to increase the efficiency and effectiveness of the Ministry's financial management system, and suggest ways in which USAID/N could support such changes.

3. Alternative Strategies for Malaria Control

One consultant will be required for four weeks to review the malaria situation, explore the feasibility of alternative strategies for dealing with the problem, assess NMEO's research and training requirements for designing and implementing these strategies, and recommend training and facility improvements to meet these requirements. This assistance will have as its ultimate purpose the enabling of NMEO to develop and carry out strategies which will lessen dependence on spraying and form the basis for re-orienting USAID/N assistance away from commodity support and toward the improvement of the Nepal Malaria Eradication Organization's capacity to implement alternative control measures. In addition, short term consultant support for the bi-annual malaria assessment will be provided as requested.

4. Development of National ORT Strategy

One consultant will be required for approximately four weeks to assist the MOH in developing a national strategy for effective expansion of ORT utilization.

5. MCH Activities

One consultant will be required for approximately four weeks to assist in identifying appropriate activities in health education, immunization and/or growth monitoring for incorporation into ongoing programs.

Section VII: Financial Analysis and Budgetary Tables

Major revised project inputs, consisting of long-term advisors, short-term consultants, participant and in-country training, medical supplies, equipment, insecticide for malaria, construction component and local cost support to rural health programs, will total an estimated $75,551,000. USAID/N will provide $34,200,000 and GON's contribution will be approximately $41,351,000. Table II provides a summary cost estimate, followed by Tables III and IV which provide USAID/N's and GON's projected annual expenditures, respectively. See Annex E for detailed financial information for actual and projected foreign exchange and local cost breakdown for each project input.

TABLE II

SUMMARY COST ESTIMATE AND FINANCIAL PLAN
($000)
SOURCE OF FUNDS

USE OF FUNDS	AID FX	AID LC	GON FX	GON LC	SUB-TOTAL FX	SUB-TOTAL LC	TOTAL
1. Technical Assistance							
Long-term Advisors	5047.0	-	-	-	5047.0	-	5047.0
Short-term Consultants	1259.0	-	-	-	1259.0	-	1259.0
Contractor Support (Local)	-	-	-	-	-	-	-
2. Participant Training	916.0	-	-	60.0	916.0	60.0	976.0
3. Commodities							
Medical Supplies	-	-	-	6718.0	-	6718.0	6718.0
Malaria Insecticides	5188.0	-	-	-	5188.0	-	5188.0
VSC Centers (equipment)	1477.0	-	-	-	1477.0	-	1477.0
Equipment and Supplies	1400.0	-	-	-	1400.0	-	1400.0
4. Construction Activities	-	2596.0	-	-	-	2596.0	2596.0
5. Support to Rural Health Operations	-	11571.0	-	34573.0	-	46144.0	46144.0
6. Other Costs	-	523.0	-	-	-	523.0	523.0
7. Contraceptives	4223.0	-	-	-	4223.0	-	4223.0
TOTAL	19510.0	14690.0	-	41351.0	19510.0	56041.0	75551.0

TABLE III

USAID/N'S ACTUAL AND PROJECTED EXPENDITURES BY FISCAL YEAR*
($000)

	USE OF FUNDS	1980	1981	1982	1983	1984	1985	1986	1987	1988	Total
1.	Technical Assistance										
	Long-term Advisors	-	16.0	675.0	687.0	803.0	832.0	486.0	792.0	756.0	5047.0
	Short-term Consultants	-	-	168.0	172.0	201.0	208.0	122.0	198.0	190.0	1259.0
2.	Participant Training	-	-	43.0	296.0	327.0	-	50.0	100.0	100.0	916.0
3.	Commodities										
	Medical Supplies	-	-	-	-	-	-	-	-	-	-
	Malaria Insecticides	-	36.0	1229.0	576.0	1247.0	700.0	700.0	700.0	-	5188.0
	VSC Centers (Equipment)	-	75.0	264.0	141.0	-	424.0	200.0	200.0	173.0	1477.0
	Equipment and Supplies	-	200.0	-	293.0	-	180.0	-	-	727.0	1400.0
4.	Construction Activities	-	-	82.0	94.0	247.0	1500.0	673.0	-	-	2596.0
5.	Support to Rural Health Operations	-	-	1425.0	1252.0	1795.0	1370.0	2565.0	1955.0	1209.0	11571.0
6.	Other Costs	-	11.0	133.0	63.0	101.0	115.0	100.0	-	-	523.0
7.	Contraceptives	-	456.0	425.0	450.0	437.0	1036.0	650.0	769.0	-	4223.0
	TOTAL	-	794.0	4444.0	4024.0	5158.0	6365.0	5546.0	4714.0	3155.0	34200.0
	Estimated Financial Obligations Required per Fiscal Year.	4800	2800	6972	4900	4050	3800	3750	3128	-	34200

* Actual expenditures through 1984; projected expenditures 1985 to 1988.

TABLE IV

GON'S ACTUAL AND PROJECTED EXPENDITURES BY FISCAL YEAR*
($000)

	USE OF FUNDS	1980	1981	1982	1983	1984	1985	1986	1987	1988	Total
1.	Technical Assistance										
	Contractor Support	-	-	-	-	-	-	-	-	-	-
2.	Participant Training	-	-	14	27	18	-	-	-	-	59
3.	Commodities										
	Medical Supplies	-	671	990	882	859	750	775	853	938	6718
	Malaria Insecticides	-	-	-	-	-	-	-	-	-	-
4.	Support to Rural Health Operations										
	ICHSDP	-	-	216	180	232	581	608	699	804	3320
	NMEO	-	1985	2332	2443	2091	1736	2519	2519	2519	18144
	Family Planning and MCH	-	729	846	924	968	1255	1313	1510	1737	9282
	District & Regional Health Offices	-	-	-	-	-	-	-	-	-	-
	Health Planning Division	-	-	-	1	3	4	4	5	5	22
	Indent & Procurement	-	-	-	-	118	796	833	957	1101	3805
	TOTAL	-	3385	4398	4457	4289	5122	6052	6543	7104	41350

* Actual expenditures through 1984; projected expenditures 1985 to 1988.

Section VIII: Measuring Project Impact

Measurement of project impact will take place primarily at the purpose level, i.e., we will attempt to measure the effect of the project on expanding the delivery of primary health care services and improving their management. We believe that it will be most useful if the project concentrates on measurements which the MOH could undertake on its own and institutionalize as basic measures of its own peformance in providing services.

The following revised outputs, output indicators and yearly benchmarks are intended to measure project purpose, not necessarily project goals which rely on multiple project and donor efforts:

Expanded Basic Health, MCH and Family Planning Service Delivery

A. Basic Health and MCH

1) Annual malaria parasite incidence of 1.0/1000 by March 1988.

1985	1.4/1000
1986	1.2/1000
1987	1.1/1000
1988	1.0/1000

2) 37% of children receive complete DPT series, 65% receive BCG, 12% receive Measles and 10% receive polio immunization on scheduled basis nationwide.

	1985	1986	1987	1988
DPT	22%	27%	32%	37%
BCG	48%	52%	58%	65%
Measles	7%	9%	10%	12%
Polio	4%	6%	8%	10%

3) 10% of childhood (under 5) diarrhea cases treated with ORS.

1985	4%
1986	6%
1987	8%
1988	10%

4) 11,000 retail outlets (CRS Co. (P) Ltd.) providing ORS packets by 1988; accomplish a minimum of 33% increase in number of outlets per year.

1984	1,029 retail outlets
1985	4,000 retail outlets
1986	6,000 retail outlets
1987	8,000 retail outlets
1988	11,000 retail outlets

B. Family Planning

1) 435,000 voluntary surgical contraceptive (VSC) procedures performed through 1988.

1984	164,180
1985	224,180
1986	289,180
1987	359,180
1988	435,000

2) 220,000 couple years of protection (CYP) provided during 1988 by temporary methods

1983	149,898
1984	160,000
1985	170,000
1986	185,000
1987	200,000
1988	220,000

3) 15% of women currently using (protected by) a modern contraceptive method by 1986.

1981	-	6.8%
1986	-	15.0%

4) 11,000 retail outlets providing contraceptives by 1988.

	Retail Outlets	Condoms Sold	Pills Sold
1984	10,359	3,327,840	111,576
1985	10,500	3,827,000	128,000
1986	10,650	4,401,000	147,000
1987	10,800	4,841,000	162,000
1988	11,000	5,325,000	178,000

5) 5 Family Planning Service Centers staffed and providing year-round delivery of FP services and follow-up care by 1986.

Reorganization for Effective Integrated Service Delivery

a. Development of a plan for effective integrated service delivery by December 1985.

b. Development of an implementation schedule for integration of service delivery by July 1986.

c. Delivery of integrated services underway in a minimum of 12 districts by March 1988.

Improved Financial, Data Systems and Logistics Management

a. Improved rates of expenditure (at least 90%) against each project workplan by March 1988.

	FP/MCH	ICHSDP	HPD	IPD
1983	84%	43%	54%	-
1984 (est.)	87%	50%	88%	30%
1985	90%	60%	90%	50%
1986	92%	75%	95%	75%
1987	95%	-	-	90%

b. HPD 100% staffed against 1984/85 HPD staffing plans and 100% MOH funded by July 1987.

	Positions filled	MOH funding
1984	60% (25 out of 42)	8%
1985	80%	25%
1986	90%	50%
1987	100%	75%
1988	100%	100%

c. Implementation of standard methods of ordering, storage, reporting and re-supply of drugs nationwide, including operation of 5 regional Medical Stores by June 1987.

d. Development of accurate CYP data collection capability for temporary methods within FP/MCH by 1987.

e. Development of PBHW tracking/monitoring system within FP/MCH by 1987 (including number, location, sex, household visits/mo, cases of diarrhea treated, etc.).

Training of Outreach Field Workers and District Level Managers*

a. Health and family planning outreach workers (PBHWs, VHW, CHLs) trained.

b. ANMs and TBAs trained.

c. District level accountants, data systems and logistics officers trained and operating at the district level by March 1988.

Measurement of the project's impact on expanding service delivery will take place through several mechanisms:

1. USAID/N project monitoring system.

2. MOH service data.

3. Periodic evaluations and surveys carried out by MOH, USAID/N and other International donors.

USAID/N's project monitoring system is based on the annual workplans developed by the MOH and USAID/N and is fairly straightforward and simple. Each workplan contains a statement of activities, interventions and targets to be accomplished with USAID/N support during the Nepali fiscal year and a timetable for carrying them out. USAID/N has designed a form (Annex F) which lists the activities down one side with a chronogram to their right showing when they are scheduled to occur. To the right of the chronogram are spaces to record progress and accomplishments against each indicator. These spaces are filled in every four months, providing an opportunity for regular review of planned targets, problems and remedial actions required. A similar form also monitors quarterly progress in training activities, commodity procurement and distribution, and construction activities.

MOH service data is currently collected in abundance and reported tri-annually in the Progress Report. Technical assistance under the project extension will be provided to the MOH to better target data collection and analysis to measuring project indicators.

* Precise numbers to be trained will be determined on a yearly basis by the MOH and USAID/N based on current projections of training needs.

Periodic evaluations and surveys carried out by USAID/N, the MOH and other International donors will also provide data useful in measuring project progress and impact (e.g., MOH's mid-term review, USAID/N's mid-term evaluation, WHO's Health Sector Assessment, Westinghouse Contraceptive Prevalence Survey, etc.).

Evaluation arrangements for the revised project do not differ significantly from those described in the project paper. The final evaluation is planned for March 1987. This evaluation will assess the extent to which the project purpose was achieved against the output indicators outlined above. It will also make recommendations and provide guidance for possible follow-on project support.

It has been determined that the Social Soundness Analysis is still valid (Annex G.1). Given that it is still the intention of the project to assist the MOH in establishing an effective mechanism for the integration of service delivery, the original economic and financial analysis, based on a positive stream of benefits due largely to the integration of health service delivery, remains valid (Annex G.2).

Desired Output	Major Output Indicator	Major Achievements
1. Integrated planning and management of effective services.	a. 48 districts under integrated management system.	a. There are currently six fully integrated districts, and an additional twenty districts are partially integrated, (i.e. their service delivery systems do not yet include all components of FP/MCH, immunization, malaria control, leprosy and TB detection and treatment activities).
	b. 200 additional integrated health posts established during project period for a total of 800 health posts.	b. To date, 744 health posts have been established, of which 450 are integrated; 99 additional health posts have been approved and are in the process of being established.
	c. Adequate and timely staff and budget allocations to districts.	c. Establishment and staffing of district positions has been satisfactory, although absenteeism from post is fairly high among all staff levels. Budget allocations to the districts continue to be somewhat less than adequate and timely.
	d. Planning and management control effectively decentralized to districts due to HPD assistance.	d. Planning and management control effectively remains centralized. Through a series of project sponsored workshops, district planning for management of sterilization camps has been strengthened and district officer's planning/management skills have been expanded.

Desired Outputs	Major Output Indicator	Major Achievements
	e. Effective program evaluation capability.	e. Capability to monitor and evaluate program progress and achievements exists within the MOH, although it varies among divisions. Indicators and formats for evaluation of the progress and effectiveness of each MOH program were developed in 1981. Each project meets periodically with the Health Planning Division (HPD) to review progress against indicators and reports are prepared by each project every four months. The internal assessment of the National Malaria program which is conducted annually is a good example of the capability which exists within the MOH for program evaluation.
	f. Construction completed on 12 new rural health facilities, 3 regional warehouses, and the rehabilitation of at least 20 existing health post.	f. Construction of three regional warehouses is underway and scheduled for completion in the spring of 1985. In addition two health centers and 7 health posts are under construction and construction of an additional three health posts is planned. Plans to renovate additional facilities have been cancelled due to high construction costs.
2. Health Planning Division (HPD) functioning effectively.	a. Effective monitoring of programs and progress of overall integration.	a. John Snow Inc. (JSI), technical assistance contractor is currently providing assistance in this area.

Desired Outputs	Major Output Indicator	Major Achievements
	b. Planning/ management surveys, including Mid-Term (Mid Plan) Review, designed and implemented.	b. A Management Review of Integrated Health Services was conducted in 1983 with collaboration of HPD, the vertical projects, and DHS. The review recommended consolidation and strengthening of efforts in already integrated districts as well as deliberate and carefully planned expansion. A recently carried out management survey of Sanitation and Infection Control in Hospitals in Nepal provided recommendations and proposals for improving environmental management systems at various levels of health facilities in Nepal.
	c. Health Sector Input to the 7th (five-year) plan prepared.	c. HPD has provided input for health sector policy guidelines for the Seventh Five-Year Plan. In the past six months, the HPD has assumed a strengthened role in both the annual and the long-term planning process.
	d. Decentralized planning and administration operative in all integrated districts.	d. Decentralized planning and administration in integrated districts has not yet occurred.

Desired Outputs	Major Output Indicator	Major Achievements
	e. Disease-specific surveys and field operational studies performed under HPD supervision and management.	e. To date, no disease-specific surveys nor field operational studies have been performed under HPD supervision and management.
3. Management systems functioning effectively.	a. Adequate supply of essential drugs available in at least 48 districts.	a. The MOH has made some progress toward ensuring adequate supplies of drugs nation-wide both through increases in the drug budget and the provision of "buffer stocks". It is still the case, however, that drug supplies are not adequate and only a three to four month supply is available each year. The MOH has also formalized a streamlined list of essential drugs for health posts which will mean that larger quantities of a smaller number of effective drugs will be available at health posts.
	b. Unified methods of distribution, storage, use, reports and resupply of drugs effectively performed in at least 48 districts.	b. Unified methods of distribution, storage, use, reporting and re-supply of drugs are under development for the entire country. Procedures for operating five regional medical stores have been developed and staff for these stores have been trained.

Desired Outputs	Major Output Indicator	Major Achievements
	c. Systems for local reimbursement for drugs and services being tested.	c. Experiments in community purchase of drugs and first-aid items through the Community Health Leader (CHL) Program began in 1981. Results of this CHL program, along with those of NGO-sponsored health post level user payment schemes, were assessed in a Community/Local Cost Financing Workshop held in 1984.
	d. Supervisory systems and personnel in place at Central, District and HP levels that coordinate all health services in 48 districts.	d. Supervisory systems and personnel have been sanctioned and assigned to most central, district and health post levels in all integrated districts, although vacancies and absenteeism due to transfers and special leave status result in perhaps 20-45% of supervisory posts being unmanned. District Public Health Offices have been created and Health Inspectors have been assigned to all 48 districts designated for integration during the sixth five-year plan.
	e. Development of unified management information system.	e. To date, a unified management information system has not been developed within the MOH, however, collaboration in reporting and information sharing has increased among the vertical projects.

Desired Output	Major Output Indicator	Major Achievements
	f. Institutionalization of special field operations studies as a management tool.	f. Special field operations studies have been or are being carried out for management purposes within each vertical project area (e.g. FP/MCH is studying the effect of decentralized planning authority on districts and panchayat committees; NMEO is testing the effects of using different insecticides and different concentrations, etc.). However, the capability to carry out these studies without outside assistance does not occur in all of the vertical projects and MOH divisions.
4. Community participation in Health Services established.	a. 50% of districts with integrated management have functioning community health services, including Village Health Committees.	a. The concept of community participation in health service delivery has been established through the CHL program within 13 (50%) integrated and partially integrated districts. There are presently 2,600 Ward (village) Health Committees (WHC) that function primarily to select and support the CHLs.

Desired Outputs	Major Output Indicator	Major Achievements
	b. MOH and community level health programs have effective supply, reporting and supportive supervision/ retraining linkages established.	b. Approximately one third of these WHCs have been able to raise some money to resupply the basic drugs and supplies in the CHL's kit. Few WHCs have succeeded in mobilizing community effort to build latrines or otherwise promote the health of the community. CHLs receive only sporadic training and supervision by health post staff.
	c. Adequate evaluation mechanism functioning and involving village inputs and Village Health Committee.	c. To date, WHC-produced assessments and evaluations have not been forwarded for consideration by decision makers at higher levels within ICHSDP or the MOH. However, feedback from the WHCs has received attention from decision makers through Peace Corps Volunteers (PCVs) working with the CHL program.
5. Training and Health Education needs met.	a. 80% of Ministry of Health non-academic para-medical manpower training requirements met (approximately 1,600 new health and family planning workers trained).	a. During the project period to date, 2,061 health and family planning workers have received initial training and an additional 2,174 have received refresher training.

Desired Outputs	Major Output Indicator	Major Achievements
	b. Routine refresher training program for all field staff institutionalized.	b. Refresher training has become a regular part of the training program in all divisions of the MOH.
	c. Training process effectively planned, supported and implemented.	c. Training cells of the various divisions within the MOH now routinely prepare annual training plans and schedules.
	d. Health posts and village health workers supplied with at least 50% of recommended basic health education materials.	d. Progress has been made in supplying basic training materials and supplies to field workers, however, no standard "recommended" list of these materials exists.
	e. 75% of participants (U.S. and Third Country) trained and assigned.	e. All fifteen long-term US participants to be trained under the project have been trained, have returned from training with degrees and have resumed their duties within the MOH. To date, 83 participants have received short term training in various areas of program management in the US or other third countries.

Desired Outputs	Major Output Indicator	Major Achievements
6. Family Planning Services delivered effectively.	a. 500,000 continuing acceptors of temporary contraceptive methods.	a. There has been a considerable rise in distribution of temporary contraceptive methods during the project period. It is estimated that as of 1983, 149,898 couple years of protection were being provided by oral contraceptives, condoms, foaming tablets, Depo-provera (not AID funded) and IUDs.
	b. 230,000 voluntary surgical contraceptive procedures carried out in project period.	b. There were 164,180 voluntary surgical contraceptive (VSC) procedures performed in Nepal during the 1980-84 period. In the past year alone, the national target of 65,000 procedures was exceeded (65,773 total)
7. Health services delivered effectively.	a. Malaria Annual Parasite Incidence (API) of 1.0 per 1,000 or less.	a. In malaria control, the annual parasite incidence (API) in ICHSDP districts dropped from 1.6 (case per 1,000 population) in 1981 to 1.0 in 1983. In the more hyperendemic areas controlled by NMEO, the total API was 2.17 in 1983. Collaboration between ICHSDP and NMEO has increased considerably since 1980. At present, ICHSDP provides malaria control activities in 15 districts.

Desired Outputs	Major Output Indicator	Major Achievements
	b. 30% of all cases of pediatric diarrhea in districts covered by Integrated or FP/MCH Project services treated with Oral Rehydration Solution (ORS).	b. Despite active radio promotion of ORT and approximately 8,600 outreach workers in all districts who have received training in ORT, the impact on population knowledge, attitudes and practices regarding Oral Rehydration Therapy (ORT) remains minimal. Nationwide use of ORT for severe diarrheal diseases is estimated at less than 5%.
	c. 40% of pregnant women receiving Iron and Folic Acid treatment in Integrated or FP/MCH covered districts.	c. Percentages are not available for provision of iron and folic acid treatment to women of reproductive age.
	d. 20% of women age 15-44 receiving regularly scheduled tetanus immunizations in Integrated or FP/MCH covered districts.	d. The percentage of women receiving regularly scheduled tetanus immunizations ranges from 5% in ICHSDP districts to close to 0% in FP/MCH covered districts. Both iron treatment and tetanus immunization are rudimentary pre-natal care activities and both are provided inconsistently and are poorly reported nationwide

Desired Outputs	Major Output Indicator	Major Achievements
	e. 40% of the estimated active cases of Tuberculosis and Leprosy detected and under active treatment and follow-up in integrated districts.	e. In 1983/84 the number of active tuberculosis cases treated in integrated districts was 7,764. Due to the joint effort of the Leprosy Project and ICHSDP staff, 3,875 active cases of leprosy were under treatment. Assuming an annual incidence of smear positive for tuberculosis of 9,061 new cases, and a prevalence of 18,324 persons with active TB in ICHSDP area, 42% of active cases would have been under treatment last year, as reported. Assuming a prevalence of 35,240 cases of leprosy in the integrated areas, about 11% were under treatment.
	f. In 48 Integrated Districts, 60% of children receive DPT (diphtheria, pertussus and tetanus) measles and BCG immunization on scheduled basis.	f. In ICHSDP districts in 1983/84, approximately 14% of children under one received the complete DPT series, 52% received BCG and less than 5% of all infants and young children received measles vaccine.
	g. In FP/MCH covered districts,30% of children receive above immunizations.	g. In 11 of the 52 FP/MCH covered districts less than 12% of those children under one received the complete DPT series and about 14% received BCG; coverage in the remaining 41 FP/MCH districts was close to 0%.

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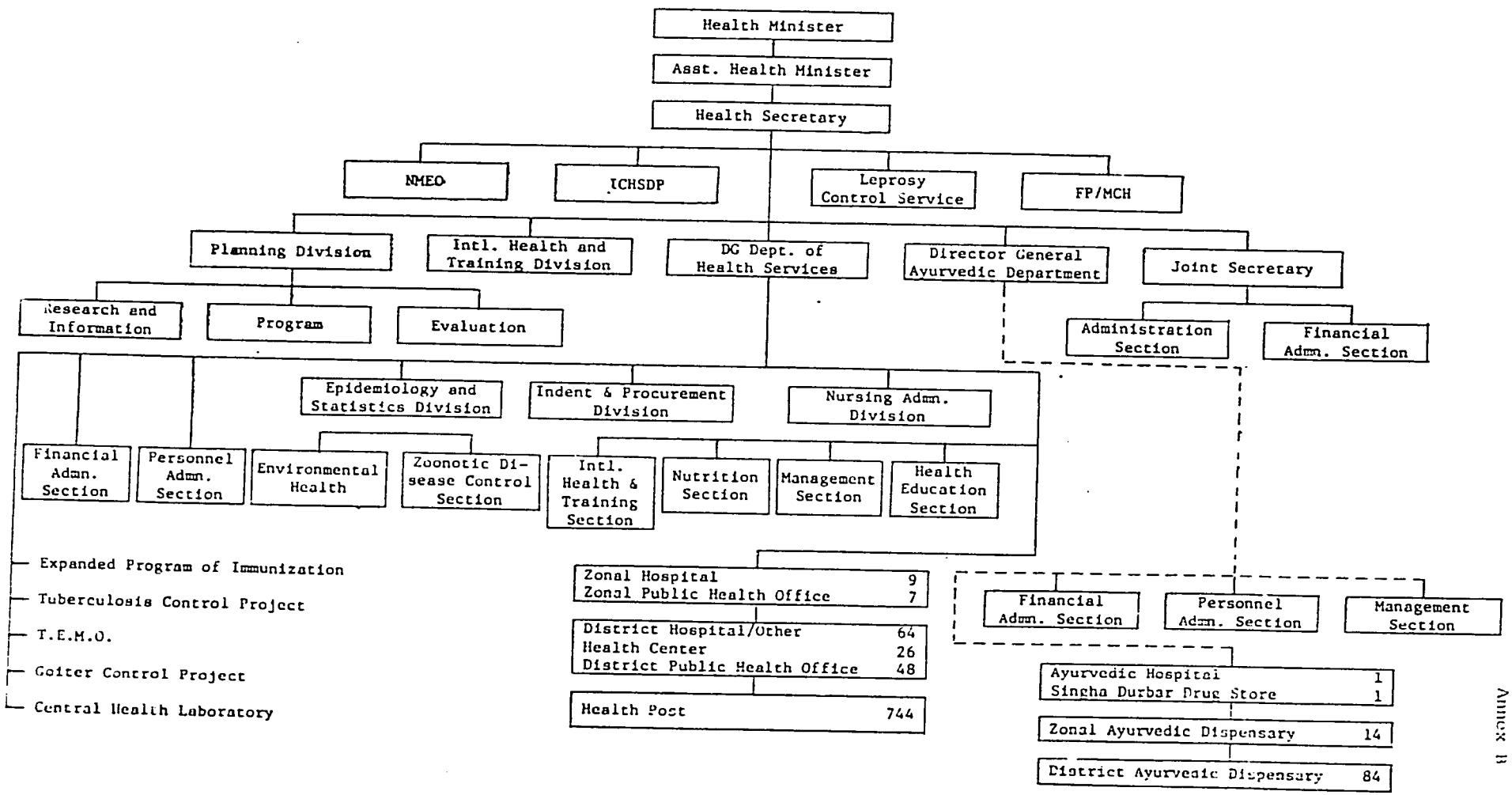
Desired Outputs	Major Output Indicator	Major Achievements
		Assistance has been provided to both ICHSDP and EPI in strengthening and expanding cold chain capability through provision of 72 refrigerators and freezers and maintenance training. In addition, vaccines and technical assistance were provided through CDC for a major MOH meningitis immunization campaign in 1984 which immunized approximately 330,000 persons in the Kathmandu Valley.

MINISTRY OF HEALTH

ORGANIZATION CHART



Annex B

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number

Integrated Rural Health/Family Planning Services (367-0135)

Program or Sector Goal: The broader objective to which this project contributes (A-1)

To improve health and reduce fertility in rural areas.

Project Purpose: (B-1)

To expand delivery of basic health, MCH and family planning services in rural areas.

Project Outputs: (C-1)

1. Expand basic health, MCH and family planning service delivery;
2. Reorganization for effective integrated service delivery;
3. Improved financial, data systems and logistics management;
4. Training of outreach/field workers and district level managers.

Project Inputs: (D-1)

AID, other donors, and HMG/N provide financing to carry out technical services, purchase equipment and materials, construct infrastructure and train staff for project.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievements: (A-2)

1. Crude Birth Rate reduced to 42/1000.
2. Infant Mortality Rate reduced to 130/1000 live births.
3. Crude Death rate reduced to 10 per 1000.

Conditions that will indicate purpose has been achieved: End of project status: (B-2)

Improved quantity, quality, appropriateness, accessability and management of health services.

Magnitude of Outputs: (C-2)

1. Expanded basic health, MCH and family planning service delivery

   A. Basic Health and MCH Service Delivery

      1) 10 Health posts constructed, staffed and operating;
      2) 2 Health Centers constructed, staffed and operating;
      3) Annual malaria parasite incidence of 1.0 case/1000;
      4) 37% of children receive complete DPT series, 65% receive BCG, 12% receive measles and 10% receive polio immunization on scheduled basis;
      5) 10% of diarrhea cases treated with ORS;
      6) 11,000 retail outlets (CRS. Co. (P) Ltd.) providing ORS packets.

   B. Family Planning Service Delivery

      a. 435,000 voluntary surgical contraceptive (VSC) procedures performed;
      b. 220,000 CYP provided by temporary methods;
      c. 15% of women currently using (protected by) a modern contraceptive methods;
      d. 11,000 retail outlets providing year-round delivery of FP services and follow-up.

2. Reorganization for Effective integrated service delivery

   a Development of a plan for effective integration of service delivery.

   b. Development of an implementation schedule for the integration of service delivery;

   c. Delivery of integrated services underway in a minimum of 12 districts.

3. Improved financial, data systems and logistics management

   a. Improved rates of expenditure (at least 90%) against each project workplan;

   b. HPD 100% staffed against 1984/85 HPD staffing plan and 100% MOH funded;

   c. Implementation of standard methods of ordering, storage, reporting and re-supply of drugs nationwide, including operation of 5 Regional Medical Stores;

   d. Development of accurate CYP data collection capability for temporary methods within FP/MCH;

   e. Development of PBHW tracking/monitoring system within FP/MCH (including number, location, sex household visits/mo, cases of diarrhea treated, etc.);

4. Training of outreach field workers and district level managers

   a. Health and family planning outreach workers (PBHWs, VHWs, CHLs) trained;

   b. ANMs and TBAs trained;

   c. District level accountants, data systems and logistics officers trained and operating at the district level.

Implementation Target (Type and Quantity D-2)

Revised Implementation plan presented in Annex D. Specific yearly targets against indicators located in Section VIII.

MEANS OF VERIFICATION

(A-3)
Sample surveys carried out by International Donors; data extrapolations carried out by International Organizations.

(B-3)
MOH service statistics; MOH, USAID and other International Donor periodic evaluations.

(C-3)
MOH service statistics and Tri-annual Progress Reports; mid-term and final evaluation; contraceptive prevalence surveys (1981 and 1986); contractor reports; USAID monitoring system.

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(D-3)

Annual project expenditure reports; USAID monitoring system; contractor reports; USAID mid-term and final evaluations.

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal targets: (A-4)

a. Government motivation, political stability and resources available.

b. Migration patterns not increasingly disruptive.

Assumptions for achieving purpose: (B-4)

HMG/N will continue its commitment to integrated and expanded service delivery to rural areas.

Assumptions for achieving outputs: (C-4)

HMG/N will continue to adequately support and implement programs detailed in the Long Term Health Plan without major revisions.

Assumptions for providing inputs: (D-4)

a. HMG/N will provide financial flows to the field in a timely fashion.

b. HMG/N will staff the project with able and experienced personnel.

ANNEX D

REVISED IMPLEMENTATION SCHEDULE

1980 Plan

4/80	Project Paper approved by HMG/N.
8/80	Project Paper approved by AID/Washington.
8/80	Project Agreement negotiated and signed by HMG/N and USAID/N.
10/80	Annual project workplans prepared for VSC and PBHW.
11/80	PIO/T and Request for Proposal for Contracting Services prepared by USAID/N

1981 Plan

1/81	Internal evaluation of NMEO.
3/81	NMEO external assessment.
3/81	Contractor workplan completed and approved by MOH and USAID/N.
4/81	Malathion safety training conducted.
4/81	Local Malaria Safety advisor contracted for monitoring insecticide safeguards.
4/81	Malaria protective clothing ordered.
4/81	Contraceptives ordered for CRS program.
5/81	Malathion safety training conducted.
6/81	Commodities for EPI ordered.
6/81	Commodities for VSC ordered.
6/81	Commodities and insecticides for malaria control ordered.
6/81	Logistics commodity needs identified and ordered (trucks, typewriters, adding machines).
6/81	600 MTs malathion ordered.
6/81	Malaria protective clothing delivered.
6/81	Malaria spraying conducted.
7/81	India participant training program began.
7/81	Logistics/Field Management Advisor in place.
8/81	Malathion safety refresher training conducted.
8/81	Contract signed with technical assistance team.
8/81	Malaria spraying conducted.
9/81	Chief of Party (Senior Public Health Administrator) in place.
11/81	Training/health education advisor in place.
11/81	Contraceptives ordered for MOH program.
12/81	Malaria spray equipment ordered.

1982 Plan

1/82	Health Planning Advisor in place.
1/82	US long-term participant training began.
2/82	Contraceptives ordered for CRS program.
3/82	Internal and external assessment of NMEO.
3/82	Malaria protective clothing ordered.
4/82	Malathion safety training conducted.
4/82	600 MTs malathion delivered.
4/82	Malaria protective clothing delivered.
6/82	Contraceptives ordered for CRS program.
6/82	Malaria spraying conducted.
7/82	Commodities for VSC and FPS centers ordered.
7/82	Conditions precedent met.
7/82	Malaria spray equipment delivered.
7/82	Family Planning Service Advisor in place.
7/82	Malathion safety refresher training conducted.
7/82	India short and long-term participant training.
8/82	Malaria spraying conducted.
9/82	Detailed plan for field staff training prepared.
9/82	Malaria commodities ordered.
9/82	Review of MOH Organizational Plan.
9/82	600 MTs malathion ordered.
10/82	Surgical equipment ordered for FP/MCH.
12/82	VSC, PBHW workplans signed by MOH and USAID/N.

1983 Plan

1/83	WHO Health Planning Advisor in place.
3/83	Internal & external assessment of NMEO.
4/83	Contraceptives ordered for CRS project.
5/83	Essential drug list for health posts completed.
5/83	Health Planning Advisor departs.
6/83	Malaria spraying conducted.
7/83	Commodities ordered for EPI.
7/83	Asia short-term participant training begins.
8/83	CRS Company (P), Ltd. established.
8/83	Malaria spraying conducted.
9/83	VSC surgical equipment ordered.
9/83	Contraceptives ordered for CRS and MOH program.
10/83	Development of standard methods of ordering, storage, reporting and re-supply of drugs.
10/83	VSC, PBHW, HPD, ICHSDP and IPD workplans signed by MOH and USAID/N.
11/83	Management Review of MOH carried out.
12/83	Construction of 3 warehouses initiated.
12/83	Contraceptives ordered for MOH and CRS program.
12/83	600 MTs malathion delivered.

1984 Plan

1/84	Contractor's workplans reviewed and approved by MOH and USAID/N.
2/84	Supplies and equipment ordered for meningitis vaccination campaign.
2/84	Construction of 2 health centers initiated.
4/84	Contraceptives ordered for MOH and CRS programs.
5/84	Local Cost Financing workshop held.
5/84	HMG mid-term Review completed.
5/84	Contraceptives ordered for MOH and CRS programs.
6/84	VSC, PBHW, HPD, ICHSDP, EPI and IPD workplans signed by MOH and USAID/N.
6/84	Malaria spraying conducted.
6/84	Construction of 7 health posts initiated.
6/84	Internal assessment of NMEO.
7/84	300,000 people vaccinated against meningitis.
7/84	Fxternal assessment of NMEO.
7/84	VSC/surgical equipment ordered.
7/84	Malathion safety refresher training conducted.
8/84	Malaria spraying conducted.
8/84	300 MTs malathion ordered.
8/84	Commodities ordered for Goiter-Cretinism vaccination campaign in Rapti Zone.
9/84	Training for regional warehouse personnel completed.
11/84	Training Advisor departed.
11/84	Mid-term project evaluation carried out.
12/84	Meningitis supplies ordered for 1985 campaign.

1985 Plan

1/85	Contraceptives ordered for MOH and CRS programs.
2/85	Project audit carried out.
3/85	300 MTs malathion delivered.
3/85	VSC/surgical equipment ordered.
3/85	Contractor annual workplans reviewed and approved by MOH and USAID/N.
3/85	Contraceptives ordered for MOH and CRS programs.
3/85	Internal assessment of NMEO.
3/85	Malaria protective clothing ordered.
5/85	Construction of three health posts initiated.
5/85	Malaria protective clothing delivered.
6/85	VSC, PBHW, HPD, ICHSDP, IPD workplans signed by MOH and USAID/N.
6/85	Malaria spraying conducted.
6/85	Completion of three warehouses.
6/85	300 MTs malathion ordered.
8/85	Malaria spraying conducted.
9/85	In-country training advisor in place.
10/85	Completion of seven health posts.

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1986 Plan

1/86	Contractor annual workplans reviewed and approved by MOH and USAID/N.
3/86	Malathion and safety equipment ordered.
3/86	VSC/surgical equipment ordered.
3/86	Contraceptives ordered for MOH and CRS programs.
3/86	300 MTs malathion delivered.
3/86	Internal assessment of NMEO.
6/86	Family Planning Advisor departs.
6/86	External assessment of NMEO.
6/86	Malaria spraying conducted.
6/86	300 MTs malathion ordered.
6/86	MOH-USAID/N workplans signed.
6/86	Malaria spray equipment ordered.
8/86	Malaria spraying conducted.
9/86	Construction of two health centers completed.
12/86	Completion of three health posts.

1987 Plan

1/87	Contractor annual workplans reviewed and approved by MOH and USAID/N.
1/87	Malaria spray equipment delivered.
3/87	VSC/surgical equipment ordered.
3/87	Final evaluation carried out.
3/87	Contraceptives ordered for MOH and CRS programs.
3/87	300 MTs malathion delivered.
3/87	Internal Assessment of NMEO.
6/87	MOH-USAID/N workplans signed.
6/87	300 MTs malathion ordered.
8/87	Malaria spraying conducted.
9/87	Contract Chief of Party, logistics advisor and in-country training advisors depart.

1988 Plan

3/88	Internal Assessment of NMEO.

Revised Estimated Costs for Project Advisor and Short-term Consultants

Project Advisor: (Spouse and two children)

Basic Salary	$50,000	
Post Differential @ 20%	$10,000	$60,000
Overhead (40% of Base Salary)		20,000
Insurance @ 2.25%		1,350
School allowance (2 children)		10,000
Oneway air fare and travel expenses (4)		4,500
Shipment and Storage of household effects and car		11,000
Local rent and Utilities		10,000
R&R travel (4)		7,000
Miscellaneous expenses		3,000
		126,850

Short-term Consultant: (one month)

Salary @ $225/day x 25 days/month	$ 5,625
Contractor's overhead factor @	-
Insurance @ 2.25%	126
Per diem in Nepal for 25 days x 63/day	1,575
Per diem in field for 5 days x 20 day	100
International/domestic airfare	3,300
Miscellaneous expenses	274
	$11,000

AID's Estimated Costs for Project Advisors and Short-term Consultants
($ 000)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	Total
Long term advisors (starting July, 1981)	16.0	765.0	687.0	803.0	832.0	486.0	792.0	756.0	5047.0
Short term Consultants	-	168.0	172.0	201.0	208.0	122.0	198.0	190.0	1259.0
TOTAL	16.0	843.0	859.0	1004.0	1040.0	608.0	990.0	946.0	6306.0

Long term advisors will consist of (1) Health Management (September, 1981 - September, 1987), (2) Management and Logistics (July, 1981 - September, 1987), (3) Training and Health Education (November, 1981 - November, 1984, (4) Health Planning (January, 1982 - May, 1983), (5) Family Planning Services (July, 1982 - July, 1986), and (6) In-country Training (September, 1985 - September, 1987). Total person months of long term advisors will be 270.

AID'S ACTUAL AND ESTIMATED EXPENDITURE FOR COMMODITIES AND OTHER COSTS*

($000)

Commodities	FY 81 FX	FY 81 LC	FY 82 FX	FY 82 LC	FY 83 FX	FY 83 LC	FY 84 FX	FY 84 LC	FY 85 FX	FY 85 LC	FY 86 FX	FY 86 LC	FY 87 FX	FY 87 LC	FY 88 FX	FY 88 LC	TOTAL FX	TOTAL LC
1. Locally procured Medical supplies for Rural Health Posts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2. Malaria supplies and insecticides	15.0		1474.0	-	195.0	-	1404.0	-	700.0	-	700.0	-	700.0	-	-	-	5188.0	-
3. VSC equipment and supplies	75.0	-	264.0	-	141.0	-	-	-	424.0	-	200.0	-	200.0	-	173.0	-	1477.0	-
4. Equipment & Vehicles, materials and Supplies	200.0	-	-	-	293.0	-	-	-	180.0	-	-	-	-	-	727.0	-	1400.0	-
5. Support to Rural Health Program	-	-	-	1425.0	-	1252.0	-	1795.0	-	1370.0	-	2565.0	-	1955.0	-	1209.0	-	115711.0
6. Other Costs	-	11.0	-	133.0	-	63.0	-	101.0	-	115.0	-	100.0	-	-	-	-	-	523.0

*Actual expenditures through 1984; projected expenditures 1985 to 1988.

ANNEX E.3

IRH/FPS Project Implementation Monitoring Sheet

Component: Budget Support
Division: VSC - FP/MCH
Year: NFY 41-42 (84-85)

Activity	FIRST TRIM.				SECOND TRIM.					THIRD TRIM.				Progress/Comments		
	J	A	S	O	N	D	J	F	M	A	M	J	J	First Trim.	Second Trim.	Third Trim.
1. 39,000 VSC procedures performed				7,000				27,000				39,000		On schedule		
2. 20 MOs deputed and utilized in VSC	20													All deputed but not utilized due to lack of training.		
3. Monitoring and Assessment of camps carried out														On site monitoring to start Jan. 1985.		
4. 5 FPS (VSC) Centers fully staffed and operating														As of Nov. 15, 1984 4 centers turned over to HMG but no staffing Plan.		
5. Training program in "Management of Intra and Post Operative Emergencies" carried out for 12 Surgeons													12	Cancelled. Program director scheduled for transfer out of Kathmandu. No other anesthesiologist available.		
6. Computer training for 10 carried out						10										
7. Expenditures against AID/MOH workplan					25%				65%				100%	Delayed to Feb.		

ANNEX F

Integrated Rural Health/Family Planning Services

Project No. 367-0135

Social Soundness of Project

The social science analysis which was originally completed during preparation of the project paper remains valid.

In terms of the general feasibility of extending modern health services to rural Nepal, the original analysis found that there is no resistance per se to modern health systems at the village level. Traditional and modern health practices can exist side-by-side, however, the problem has been the extent to which institutions of modern medicine--the organizational structure, social roles and patterns of interaction through which services are delivered--are effective both at the central and village levels. The extended IRH/FP project will continue to address this concern.

This project will continue to have a direct, positive impact on the health of Nepal's rural population and, by extension, some other consequences of Nepal's high rates of illness and mortality--e.g., time lost from farm labor and the drain on family income for medical expenditure--may ultimately be reduced.

Progress in the area of family planning has been noteworthy under this project, and increasing access to family planning services will be a continuing emphasis of the revised project. The social benefits of such an effort have been proven--e.g., improved health of mothers, more land per heir, and greater access to all family resources per family member.

As brought out in the original analysis, women and children are singled out as prime beneficiaries, and this will remain so throughout the life of the project. The project's strong emphasis not only on family planning but also on child health brings special benefits to these groups. Efforts will continue to provide a role for traditional medical practitioners in the delivery of modern medical services.

PDIS:VMiedema:nty:9/18/84

Mr. George E. Lewis, Program Officer September 14, 1984

PDM

Paul D. Morris, Program Economist

Economic and Financial Analyses in the Rapti, RCU and IRH/FPS Extensions

1. I have reviewed the original economic and financial analyses in each of the PPs for the RAD, RCU and IRH projects. The basis for each of those analyses was then compared with the changes projected to occur in each extended and redesigned project. Accordingly, my comments regarding new economic and financial analyses for the subject projects are as follows:

   a. RAD Rapti

      - The original benefit-cost analysis was based on consideration and quantification of all costs in every component of the project in comparison to the benefits from only two components: Farming Systems and the Renewable Resource Management components. Benefits for the remaining three components, Employment and Skills Development, Rural Works and Institutional Development, were not quantified but only referred to in the narrative. A benefit-cost ratio was not computed, but we know it would have been less than 1 -- i.e., costs in the project are greater than the value of project benefits over a reasonable period -- because the net present value of projected net benefits, calculated at the opportunity cost of capital, is negative. The project's internal rate of return, over 20 years, was calculated at only 10 percent, considerably less than the opportunity cost of capital. It is interesting that these negative findings for the project were just ignored in the PP. They were not explained away or justified on humanitarian grounds, etc., just ignored.

      - According to the RAD office (Nishihara), the redesign efforts will have significant impact on aspects of the Employment and Skills Development (Rural Industry, Education) component only. All material and services costs used in the analyses are now 5 years old, and allowance for inflation was not included. Even though

prices have changed over 5 years, the relationship of costs to benefits probably has not altered significantly. It is therefore suggested that a new overall economic analysis will not be required for the project extension. However, at the individual farmer level, where the financial analysis is applicable, price changes are relatively more significant than they are at the macro level. The project committee may want to call for a careful review of the prices involved (new and old), particularly those relevant to the Farming Systems component, to help in determining the need for a new financial analysis. The financial analysis is important as it is one of the main factors measuring the possibility of farmer participation.

b. RCUP

- The original benefit-cost analysis covering four catchment areas was not recalculated when the project was scaled down to two catchment areas. The narrative explanation, however, presented justification for accepting that project costs would be more than offset by benefits and that the economic internal rate of return would continue at or near to the original estimated 21.5 percent. The original analysis included consideration of all project costs and the benefits from seven of the eight components (only the Fisheries component benefits were excluded).

- According to the ARC office (Hash), the extension and redesign efforts for RCU will merely refine some of the previous emphasis and not result in any significant financial changes. Ninety-five percent of the project benefits (almost evenly distributed) will flow from four components: Forest Management, Range Management, Horticulture, Irrigation and Agronomy. Range Management programs will be altered somewhat and focus on relatively higher risk areas, with the possibility of greater benefits at no additional costs. Forest Management, Horticulture and Irrigation and Agronomy will continue as planned. The Irrigation and Agronomy programs have built-in self-evaluating aspects. For the Agronomy portion, individual farmers will make the final decisions to implement or not. The 12 percent per annum allowance for inflation in the original analysis adequately covers price increases related thereto, and the farmers' economic judgment will override any additional analysis that we may attempt. Each individual project in the Irrigation portion will undergo a rigorous benefit-cost analysis prior to implementation. Failure to meet

favorable standards at that stage should automatically cancel the concerned project. Therefore, it is suggested that new economic and financial analyses will not be required for the project extension.

c. IRH/FPS

- The original financial analysis includes adequate allowance for price changes over time. The components and targets of the project during the extension stage will probably remain the same, or nearly so, as at present. This will be decided based on the project evaluation to be conducted during October-November 1984. If these components and targets remain basically unchanged there will be no need for a new financial analysis.

  According to the HFP office (Spaid), extension of the project will probably be just that, an extension and not a redesign. The original economic analysis, and favorable recommendation for implementation of the project, was based on a cost-effectiveness approach, with a large share of the stream of benefits coming primarily from the integration of health services. However, there is a strong possibility that integration of health services will no longer be the central focus of the project. The extension will merely provide for a continuation of the same services and support to the vertically oriented ministries and agencies already encompassed by the project components. Again, this will be decided based on the upcoming evaluation. If the emphasis on integration is dropped the PP will have to undergo extensive rewriting and the economic analysis will have to be redone. The special nature of the estimated benefits in this type of project will be best analyzed if a health economist or an economist with extensive health field experience is utilized.

cc: ARC, Dr. Hash
RAD, Mr. Nishihara
HFP, Ms. Spaid