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EVALUATION OF THE USAID/NEPAL INTEGRATED RURAL HEALTH/FAMILY PLANNING SERVICES PROJECT No. 367-0135

by

Robert Pratt, MBA, Team Leader
Suniti Acharya, MD, MPH
Firman Lubis, MD, MPH
Barbara Pillsbury, PhD
Madhukar Rana, MA
Peter Shipp, BA
Mrigendra R. Pandey, MD, FRCP
(Consultant to Team)

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Edited and Produced by

Population Technical Assistance Project
Dual and Associates and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: 703-538-9271

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Glossary

ARI	Acute respiratory infection
AVSC	Association for Voluntary Surgical Contraception
Ayurved/Kaviraj	Homeopathic medicine
BMN	Basic Minimum Needs
CEDPA	Centre for Development and Population Activities
CHL	Community Health Leader
CPR	Contraceptive prevalence rate
CRS	Contraceptive Retail Sales
CYP	Couple year of protection
DFPO	District Family Planning Office
EPI (EIP)	Expanded Immunization Program
FHI	Family Health International
FP/MCH	Family Planning and Maternal and Child Health Project
FPAN	Family Planning Association of Nepal
FPIA	Family Planning International Assistance
HMG	His Majesty's Government
HPD	Health Planning Division
ICHSDP	Integrated Community Health Services Development Project
IEC	Information, education and communication
IPD	Indent and Procurement Division
IPPF	International Planned Parenthood Federation
IRH/FPS	Integrated Rural Health/Family Planning Services Project

IS	Intermediate Supervisor
Jeevan Jal	Nepal-made packaged ORS solution
JSI	John Snow, Inc.
MCH	Maternal and child health
MOH	Ministry of Health
NFFS	National Fertility and Family Planning Survey
NGO	Non-governmental organization
NRCS	Nepal Red Cross Society
Nun-Chini-Pani	Sugar and salt solution (home-made ORS)
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
Panchayat	Local governing body
PBHW	Panchayat-based health worker (grassroots family planning fieldworker)
Pradhan pancha	Local political leader
RMS	Regional medical stores
TBA	Traditional birth attendant
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development (Mission)
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Executive Summary

1. Problem and Overview

For the past three decades, the Government of Nepal--His Majesty's Government (HMG)--in partnership with the U.S. Agency for International Development (USAID), has been engaged in efforts to improve access of its people to health and family planning services. Because of the country's difficult mountainous terrain, and the country's often inadequate infrastructure, this task has been difficult and challenging. At present, infant and maternal mortality remain high and the population growth continues to be rapid.

In the 1950s, in its earliest efforts with USAID to provide services, HMG developed several single-focus vertical programs to deal with discrete activities such as provision of family planning services and malaria control. In the 1970s, the Ministry of Health (MOH), again with USAID support, began experimenting with approaches to bring the vertical programs together and provide integrated health and family planning services through multi-purpose village health workers. In the mid-1980s, the MOH moved to decentralize its administrative approach. In a significant development in 1985, HMG also made a commitment to achieve ambitious goals for health care as part of a proclamation by HMG that pledged to meet a set of Basic Minimum Needs by the year 2000.

Thus, at the end of the 1980s, HMG may be poised on the brink of a new era of health and family planning services delivery, offering advocates of reform, both in Nepal and USAID, their best opportunity ever to restructure the MOH system to meet the demands of the next century.

2. U.S. Assistance

Following its support in creating the vertical programs and initiating experiments with integration, A.I.D. designed the Integrated Rural Health and Family Planning Services (IRH/FPS) Project (367-0135) to assist the integration process. IRH/FPS was authorized in August, 1980, as a five-year project with a completion date of September 30, 1985. A.I.D.'s planned contribution was a $34.2 million grant to which HMG was to contribute a $70.1 million equivalent for a total of $104.3 million. The project purpose was to assist HMG "to improve the management of health delivery systems and to expand the delivery of rural health and family planning services." The long-term

project goal was to improve the health status and reduce the fertility rates of the rural poor. John Snow, Inc. (JSI) was contracted to provide technical assistance on behalf of A.I.D.

An evaluation conducted in 1984 concluded that the project design was over-ambitious and over-optimistic in expecting the project to use effectively $34.2 million in A.I.D. funds in only five years. It recommended that the Integrated Community Health Service Delivery Project (ICHSDP), a major focus of IRH/FPS project assistance, should be terminated but that A.I.D. should continue to support HMG health and family planning activities. The IRH/FPS project subsequently received a no-cost extension, which also corresponded to a change of USAID/Kathmandu health and population personnel. There have thus in essence been two phases of this project: the "original phase" (1980-84) and the current "phase two" (1985-present).

3. Purpose of the Evaluation

This was an end-of-project evaluation whose purpose was (a) to review progress over the eight-year project period (especially since 1985); (b) to discuss lessons learned; and (c) to make recommendations for a follow-on project with emphasis on five issues of special concern to USAID/Kathmandu: integration, decentralization, service mix, institutionalization of family planning services, and the viability of the MOH Health Planning Division. Data were collected through four weeks of interviews, field visits, and review of project documentation in January-February, 1988. The evaluation team consisted of three Nepalis and four expatriates.

4. Major Findings

Improvement of Management

The project's main thrust in the area of management was assistance to the MOH's ICHSDP project. ICHSDP was one in a series of MOH efforts to incorporate vertical programs that targeted specific health problems (e.g., family planning, immunization, and malaria) within the regular MOH system. ICHSDP was also designed to develop a system in which multipurpose fieldworkers would provide outreach services to the majority of Nepal's widely dispersed rural population.

Progress overall has been very limited. Despite both HMG's and USAID's efforts, many problems remain, including over-centralized

planning, poor financial and information management, and a personnel system that gives little or no support to fieldworkers.

The ICHSDP project was abandoned before the end of USAID's IRH/FPS project; USAID's support, though substantial, did not overcome the problems intrinsic to the ICHSDP approach. Now, by coupling integration with a new initiative--decentralization--HMG hopes finally to have developed a model that will succeed.

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The problems that marred the ICHSDP project performance, however, remain very much in evidence. In particular, there is considerable confusion about how personnel and services of vertical projects should be integrated into the MOH system. In addition, the supervisory personnel do not provide the technical and motivational support needed by fieldworkers; training is limited; and worker allowances are inadequate. On the positive side, some integrated facilities appear to be functioning very well, offering a reasonable range of services, including outreach community services.

The Health Planning Division (HPD) has not been able to perform as hoped. Vertical programs (projects) have continued to do their own planning, being reluctant to cede this function. In addition, financial constraints have prevented the Ministry from assuming financial responsibility for the HPD, as originally anticipated.

As to the village health committees, progress has been made in achieving this component's limited goals, but many committees exist only on paper. The approach needs to be refined, with better definition as to how these committees should and can function.

Thus far, the training of fieldworkers has proceeded fairly satisfactorily. The drug stocking and distribution system has proved unworkable, however, and should be abandoned.

Provision of Family Planning/Health Care Services

"As regards quantitative objectives, the project has had its greatest success in the area of voluntary surgical contraception (VSC)."

As regards quantitative objectives, the project has had its greatest success in the area of voluntary surgical contraception (VSC). The quantitative goal for 1987 was met by 1985, and VSC now accounts for 86 percent of all contraceptive use in Nepal. Since 1985, however, the number of VSC procedures performed each

year has been declining. Use of temporary methods has lagged far behind VSC, with very little progress having been made toward the goal of 500,000 continuing users. Contraceptive prevalence has increased to 15 percent--up from only 7 percent in 1981 and 2.9 percent in 1976--yet most of this increase is attributable only to VSC.

The lack of training and support for service personnel negatively affects the performance of the family planning fieldworkers, the Panchayat-Based Health Workers (PBHWs). As employees of a vertical project, these PBHWs have considerable outreach responsibilities that are extremely demanding and lead to high turnover. Moreover, the move to integrated services has resulted in considerable uncertainty for the entire hierarchy of the FP/MCH project, since it is unclear whether and how they will be assimilated within the existing MOH system. Meanwhile, HMG has set new, highly ambitious goals for reduction of the total fertility and the population growth rates. Thus, much remains to be done in the area of family planning.

With regard to child survival interventions, the project has primarily provided support to 1) the expanded program of immunization and 2) control of diarrheal diseases through oral rehydration therapy. The project has also provided some support to HMG efforts in the areas of acute respiratory infection control, maternal health, and nutrition.

5. Conclusions and Recommendations

"All signs point to the conclusion that A.I.D. should, and must, support this policy [integration]."

Integration

Although the A.I.D.-supported ICHSDP has been terminated, or subsumed, in favor of an MOH policy to integrate vertical projects nationwide, the issue remains as to whether, or to what extent, USAID should support the new efforts to integrate health services. All signs point to the conclusion that A.I.D. should, and must, support this policy. The thrust of the new policy is also consonant with USAID's own programming preferences. It is probably not advisable, however, for A.I.D. to invest its scarce resources in activities at the central level aimed at bringing about integration within the MOH.

Service Mix

The stated intent of the FP/MCH project to increase promotion and effective use of temporary family planning methods is appropriate, in particular given the emphasis on health among the Basic Minimum Needs goals. Government leadership will be needed to put stated plans into effective action. Program targets will need to be defined and family planning fieldworkers will need to be trained and motivated to promote temporary methods. New HMG resources may become available, however, as current inputs into VSC are shifted to provision of temporary services. It is also possible that consumers may be willing to pay for some of these services.

Decentralization

"Decentralization is still in its infancy, but the strongly stated commitment of the government to decentralization is a good reason for USAID to become involved."

Decentralization is still in its infancy, but the strongly stated commitment of the government to decentralization is a good reason for USAID to become involved. In part because so many practical details remain to be resolved, the wise course might be for USAID to support the new system in one region, rather than to try to support implementation nationwide.

Institutionalization of Family Planning Services

VSC services have been provided primarily through mobile efforts, which were justified by the physical conditions of the country and the urgency of the need. This approach, however, is not sustainable over the long run. A new strategy is under way to institutionalize VSC services, together with provision of temporary methods, in static facilities in the plains (Terai) and the more accessible hill districts. This is an appropriate area for USAID support in the next project.

The MOH Health Planning Division

Although the MOH's intention and ability to support the HPD is unclear at present, the importance of this Division over the next few years is not in question. Continued USAID support is justified to ensure that HPD increases its planning capabilities and develops an adequate management information system.

Transition to a New Project

USAID and its prime contractor, JSI, should work closely with HMG during 1989-90, not only to design a follow-on project but to develop a set of performance indicators that will link assistance provided to HMG's performance in connection with its professed goals of integration, decentralization, and regionalization. HMG should also fulfill conditions related to staffing of new offices created through decentralization before the new project gets under way.

The New Project

The new project should capitalize on the impetus now evident in the delivery of health and family planning services. Its framework should be founded on three general principles. The first would be to test the new approach to decentralized, integrated service delivery in one region. A large number of recommended management reforms could be tried out on a pilot basis in the region selected.

The second would be related to priorities among services to be provided and would focus on increasing provision of temporary contraceptive methods and child survival interventions.

The third would relate to the specific components that would be included in the new project. Along with an increased emphasis on the private sector, the new project should include efforts to support innovative strategies at the district level and below, to establish more static family planning facilities, to develop a management information system, and to train middle and high level health officials in public health practices.

I. INTRODUCTION

I.1 The Project

The Integrated Rural Health/Family Planning Services (IRH/FPS) project was initiated in 1980 as a five-year effort whose stated purpose was to assist His Majesty's Government (HMG) to improve the management and effectiveness, and expand the delivery of rural health and family planning services in Nepal. The project goal was to improve the health and reduce the fertility rates of the rural poor. Funding included a $34.2 million grant from USAID and a $71.1 million equivalent contribution from the Government of Nepal. Resources were provided to support administrative and managerial changes in the Ministry of Health (MOH) as well as to help finance a large number of specific family planning and health interventions. The IRH/FPS project has supported three major efforts of the MOH: two vertical projects--the Family Planning and Maternal and Child Health (FP/MCH) Project and the Integrated Community Health Services Development Project (ICHSDP)--and the Health Planning Division (HPD) of the MOH. John Snow, Inc. (JSI) was contracted to provide technical assistance on behalf of A.I.D.

An evaluation conducted in 1984 concluded that the project design was over-ambitious and over-optimistic in expecting the project to use effectively the $34.2 million in A.I.D. funds in only five years. It recommended that the ICHSDP, a major focus of IRH/FPS project assistance, should be terminated but that A.I.D. should continue to support HMG health and family planning activities. The IRH/FPS project subsequently received a no-cost extension, which also corresponded to a change of USAID/Kathmandu health and population personnel. There have thus in essence been two phases of this project: the "original phase" (1980-84) and the current "phase two" (1985-present).

I.2 The Evaluation

This final evaluation of the IRH/FPS project covers the entire project period from its start in 1980 to the present, and assesses not only USAID's achievements in meeting its project goals but also the Nepal government's own efforts to provide health care for its citizens.

The evaluation had three main purposes:

1) to review project implementation and progress since 1984 against stated indicators (later expanded to the entire project period, 1980-1988);

2) to identify lessons learned; and

3) to provide programmatic recommendations to USAID and the MOH to feed into the design of a follow-on bilateral project, with particular focus on five special topics: integration, decentralization, service mix, institutionalization of family planning services, and the Health Planning Division of the MOH (see Appendix A for Statement of Work for the evaluation).

To accomplish Task 1, the evaluation team assessed progress against the seven output measures that were included in the original Project Paper and its 1984 amendment. A brief review of the project implementation is provided in Chapter III and its performance in meeting its output indicators is reviewed in Chapters IV, V, and VI, and summarized in Appendix B.

The conclusions, lessons learned, and recommendations (Tasks 2 and 3) are contained in Chapter VIII, preceded in Chapter VII by the analysis of the special issues identified by USAID. The first two issues, integration and decentralization, processes encouraged by USAID but determined ultimately by HMG and Nepali sociopolitical structures and decision-making, have affected the outcome of some project components. Therefore, to set the stage for both Chapter VII and other parts of the report, Chapter II provides an historical overview of HMG's approach to delivering health services.

The evaluation did not include assessment of A.I.D. assistance to the national malaria control program, as a separate review of that program was scheduled for March 1988.

I.3 Team Composition

The evaluation team comprised seven members, three Nepalis and four expatriates. Two Nepalis (Dr. Suniti Acharya and Mr. Madhukar Rana) served as full-time team members. Dr. Acharya, Director of the MOH Expanded Immunization Program (EIP, referred to hereinafter as the Expanded Program of Immunization--EPI), took leave from the Ministry for this assignment, and Mr. Rana is a full-time management consultant. The third Nepali, Dr. M. R. Pandey, Additional Secretary of the MOH, served as part-time consultant to the team. The four expatriate team members were Robert Pratt (Team Leader); Dr. Firman Lubis; Dr. Barbara Pillsbury; and Peter Shipp. The skills and experience of team members covered health and family planning services delivery, immunization program management, clinical medicine, acute respiratory disease research, health manpower planning, medical anthropology, evaluation methodology, project design and management, private sector management, and development policy and planning.

I.4 Methodology

The team spent the first week in Nepal conducting briefings and interviews with officials and others in Kathmandu and reviewing documents (see Appendix C for documents reviewed and Appendix D for a list of persons interviewed). The team was divided into two three-member groups, one to consider management issues and the other to review service delivery issues. New subgroups were formed for the field visits that took place during the second and third weeks. Each subgroup contained at least one "management" and one "service delivery" person, and each had both Nepali and expatriate representation. One team visited districts in the Eastern Development Region and the other went to the Western and Central Regions. Both areas included sites in the Terai and the hills.

Before going to the field, the team members developed sets of questions based on the seven outputs to use as interview guides in the field. Use of the common questionnaire in all three regions contributed to generation of comparable information and facilitated analysis of findings for the report.

II. INTEGRATION, DECENTRALIZATION AND BASIC MINIMUM NEEDS: THE NEPALI CONTEXT

II.1 Background

Since the IRH/FPS project began in 1980, the terrain of health service delivery in Nepal has shifted dramatically. Efforts to integrate services, promoted by A.I.D. in the 1970s and already gaining currency in 1980, have been gradually intensified and were recently combined with a new plan to decentralize delivery of services by shifting major administrative responsibility to the regional and district levels. At present, a new urgency has entered the scene, with the proclamation by His Majesty the King of a set of Basic Minimum Needs (BMN) that he has pledged to meet by the year 2000 and in which health needs and goals figure prominently. At this point, then, the two goals of integration and decentralization have been joined, and the major effort to reorganize the health delivery system is faced with the challenge of achieving a revolutionary improvement in health services by the end of the century.

The issues now at the forefront of the health and family planning agenda in Nepal have deep-seated historical roots. Both the recent 1987 decision to integrate services and the strong efforts to decentralize their delivery derive from what were seen as basic flaws in the existing administrative arrangements. Of the two trends, efforts to integrate have been dominant, with efforts to decentralize having become a priority later and having had somewhat lesser emphasis, at least until very recently. In reality, the two are intertwined. Integration, a dominant theme in international health circles since the early 1970s, includes a strong undercurrent of decentralization, or strengthening of local constituencies to enhance service delivery. In Nepal, integration is an effort specific to the health services, whereas decentralization is a national movement which affects all government activities and whose principles were only recently explicitly applied to the health services. It was at this point that decentralization began to be accorded equal stature with integration as a major goal for health service delivery.

The major turning points in the slow progression towards an integrated, decentralized health service system in Nepal are summarized below.

II.2 Integration

II.2.1 The Context

In the early 1970s, efforts to integrate began, with the goal of incorporating five existing vertical projects into the MOH system. The five vertical projects, each focused on a particular health problem, included the Nepal Family Planning and Maternal/Child Health Project (FP/MCH), the Nepal Malaria Eradication Organization, the Expanded Immunization Project (EPI), the Tuberculosis Control Project, and the Leprosy Control Project. The regular MOH system, into which these projects were to be integrated, provided regular health assistance (chiefly urban and curative) through the Department of Health Services and its static health posts, health centers, and hospitals. A major distinction between the regular MOH system and the vertical projects has been

that employees in the regular MOH system are civil servants whereas personnel in the vertical projects are contract employees.

The MOH health infrastructure consisted of approximately 10 health posts per district, all managed by district hospitals. These posts were typically understaffed and unsupervised, with usually no more than a health assistant and a lower-level assistant (called "peon") to handle the health needs for an entire area. There were no fieldworkers based at the posts.

The vertical projects, in contrast, had many local offices with large numbers of fieldworkers who regularly visited outlying areas in their assigned territories. To a large extent they were donor-initiated (with A.I.D. figuring prominently among the donors) and much, if not most, of their financing came from outside donors, A.I.D. included. At their initiation, they were seen as temporary efforts, not subject to routine administrative constraints. After a number of years, however, they became institutionalized, with many of their personnel believing or hoping that they would become permanent programs. Overall, their performance was quite impressive, demonstrating that the MOH was capable of successfully mobilizing strong and effective single-purpose interventions.

Since the early 1970s, donors and the government have initiated some attempts to integrate these vertical services within the regular MOH health structure. One reason advanced was to harness the outreach capability of the vertical projects and make them part of the regular health services. A second rationale was to eliminate costly duplicative management structures.

II.2.2 Efforts toward Integration

Four efforts made to achieve integration are chronicled below:

1. <u>Six Integrated Districts</u> - 1971-1975

The first step came when six districts in the Terai (out of a total of 75 districts in the country) were integrated over a four-year period, starting with Kaski District in 1971 and Bara District in 1972. The effort was overseen by an Integration Committee established in 1970, which worked with a specially constituted division of the Department of Health.

An evaluation of the first two experimental districts found that the new approach offered two advantages: More services were available in the integrated districts and the approach was more cost-effective.

2. <u>Enunciation of Long-Term Health Plan to Expand Integration Country-wide</u> - 1975

This plan called for expansion of health services to rural areas on a gradual basis through establishment of 1,052 "fully integrated health posts" in all 75 districts by 1985. The envisioned integration was to 1) subsume vertical projects within one administrative structure, and 2) integrate preventive services with curative services.

Two major ingredients of this effort, in the districts where it was implemented, were expansion of health post staffs and provision of salaries to the new employees, many of whom were being transferred from vertical projects. In addition, increased emphasis was placed on involvement of the community through two groups of multi-purpose providers: Village Health Workers (VHW) and, at a lower level, volunteers called Community Health Leaders (CHL) (see Section IV.1.1.4).

Numerous problems arose. It proved difficult to develop a management and supervisory system to oversee both streams of health workers. Transferring vertical project staff to the regular program also proved to be extremely complex and resistance was considerable, in large part because of bureaucratic and personal career interests.

3. Integrated Community Health Services Development Project (ICHSDP) - 1980

The ICHSDP was launched by A.I.D. and part of the MOH to make a renewed effort to bring the vertical services into an integrated system. The idea was to strengthen individual health posts and to proceed with integration post-by-post, rather than district-by-district. The objective was to ensure that each integrated post would be staffed by trained multi-purpose health workers, supported by good information, education and communication (IEC) materials and sufficient drugs and medical supplies, and that communities would have strong cadres of VHWs and CHLs in place.

The project was not deemed a success. No one had addressed basic problems that had beset prior integration initiatives: the need to create and fund positions to absorb vertical staff, the resistance to integration of top-level staff in the vertical projects, and the need for a strong supervisory structure. Thus, many of those who were supposed to work toward the goal of integration were in fact opposed to it. Consequently, although its purpose was integration of the existing vertical projects, the ICHSDP turned out to be yet another vertical undertaking. Progress was slow, and as this effort made only halting advances, the vertical projects continued to operate at full capacity. In short, ICHSDP was based on unrealistic assumptions about the reaction of vertical project personnel to integration and, although a sound notion, under these circumstances, integration was not achievable.

The project lacked effective management. There was confusion as to the very definition of "integration" to be used in the project's implementation plan. In addition, the project directors decided to concentrate on upgrading to the highest level of integration those health posts in 48 districts already having some degree of integrated services, rather than expanding the basics of integration to a greater number of districts.

The ICHSDP attempt at integration was overtaken in 1987 by a much higher-level policy and commitment when HMG, independent of donor urging (and to the donors' surprise), announced a new plan for integration. The MOH integration model of delivery that replaced the ICHSDP approach is derived directly from that effort. Despite its shortcomings, positive aspects of the ICHSDP experience should offer useful lessons for the coming years (see Section IV.1.1). (See Appendices E and F for more detail on integration.)

4. Reorganization of Health Services - 1987

In July 1987, HMG announced a major reorganization of the health services. It brought together public health activities, as distinct from curative services, with the creation of two main divisions: the Public Health Division and the Curative Division. All public health services were to be integrated, including the five original vertical projects and the ICHSDP vertical project. The target date for completion of the integration and the disappearance of all vertical projects was set for 1990. This reorganization also called for major responsibility for implementing this plan to be carried by five newly formed regional directorates, thus marking the first time that the then seven-year-old effort to decentralize all government services (see below) had become part of the official strategy to restructure the health services.

II.3 Decentralization

II.3.1 National Level

Like efforts to integrate the health services, the efforts to decentralize were designed to replace the existing arrangement in which the central government retained almost exclusive authority to carry out all planning, funding, and management of all public programs. It had become clear that it was impossible to do these jobs adequately from Kathmandu. Approximately 95 percent of the 14 million Nepalese live in rural areas, with two-thirds dispersed throughout hills and mountains in areas largely inaccessible by road.

The move to decentralize all government services began in the early 1980s, with the first official act, the Decentralization Act of 1982, designed to move some of the power, fiscal resources, and program development capacity from the capital to local village, town and district *panchayats* (local governing bodies). The aim of the legislation was to encourage local self-government, promote local self-reliance, and require the accountability of state and parastatal agencies to local political representatives. The primary mechanism was to be local level planning and budgeting with the full involvement of communities and their representatives, in the expectation that local level government services would become accountable to the users of the goods and services.

The importance of strengthening the capabilities of the local *panchayats* to make decentralization work was reiterated in 1985, as part of the Seventh Five-Year Plan. The National Planning Commission now views decentralization as a policy imperative for the country and sees the delegation of some financial decision-making as a realistic possibility to make the process work (see Appendix G for more information on decentralization).

II.3.2 Health Programs

II.3.2.1 General Description. The effort to apply decentralization specifically to the country's health services began in 1986. The government has not yet articulated clearly its strategy for decentralization, but a number of organizational changes are currently under way that are laying the groundwork for more local self-reliance. These include

- the move to develop regional offices, and the strengthening of the district and community level health facilities;

- the increasing part played by the Health Planning Division (HPD) of the MOH, which is the central focal point to collect planning and budgeting inputs from the lower levels; and

- community participation in health services.

II.3.2.2 Regionalization. HMG views creation of the regional offices as the most crucial of these developments, and thus the pivotal event in the 1986 decentralization effort was the establishment of five regional health directorates, which were to replace the MOH Department of Health as the focal point of health management activities. Very modest regional offices already exist, but this upgrading is viewed as an important gesture. Even greater power, however, is to be vested at the district level, where District Health Offices are also to be expanded.

With the 1987 decision to reorganize the health services, staffing patterns were promulgated for these new decentralized entities and roles spelled out. Oddly, although considerable rhetoric has been devoted to the importance of the regional level and although staffing is expected to be substantial (31 positions per regional office), the power at this level is still relatively limited. The only formal authority of the regional offices is the personnel administration of the staff within the region. Regional Directors are to be entrusted with recruiting and appointing most top level health officials in their regions. Other than this role, however, their authority is largely advisory and supportive. Their functions are to coordinate, monitor, supervise and support field level operations.

This advisory role extends to the budgeting and planning process: Regions are authorized only to make recommendations--downward to districts concerning the contents of the plans (before their approval by the District Assembly) and upwards to the MOH in commenting on the aggregation of the district plans. The MOH sees the regional offices' planning role as taking on increased significance, and the notion is being discussed of providing regional offices with computers to consolidate district health plans into regional health plans. At this point, however, such plans remain just that--plans. Until the districts can draw on acceptable data to develop their own plans (see Section IV.2.4.1), and until the regional offices have staff with computer skills, these offices will continue to have few resources on which to draw for purposes of planning.

II.3.3.3 Planning and Budgeting. At the heart of the decentralization effort is the notion that planning and budgeting of all health activities should be an interactive process, with information and ideas feeding from the field level into the Health Planning Division (HPD) and plans and budgets that emerge from that office representing local needs and priorities (see Section IV.2 for background on HPD). Local capabilities at this point are not sufficiently developed to support this goal: Regional and district offices are minimally staffed (see Section IV.2), and the information flow reflects vertical programs, rather than a cross-section of all activities by given geographic areas (see Section IV.2.3.1).

At this time, then, the planning progress remains very centralized. The HPD sets targets based on the Five-Year Plan and the experience over the prior year in meeting targets. On the basis of this information, the HPD provides each district with a draft budget containing program/activity and line item spending levels, a set of proposed health activity targets, and policy guidance. Ideally, through the new decentralized local committee system that has been instituted on paper (see Section IV.3), the districts should react to the budget, pointing out where funds are insufficient and making other changes as appropriate to their local conditions. In fact, however, most district managers simply accept and approve the budget and targets received from the HPD. In cases in which there has been some district input, the only changes have been to request lower targets, which results only in the district's receiving a correspondingly lower budget from the HPD. Even these tentative beginnings, however, are encouraging.

Nonetheless, HPD does not appear to be very flexible nor does it make a major effort to encourage district involvement in the budgeting process. With respect to budgeting, again centralization holds sway, with the MOH having retained authority over the total amount and the distribution of the budget to districts and to activities.

II.3.2.4 Conclusion. At this point, the regional offices will play a substantive programming role only if and when district offices choose to call on their expertise. The regional office level's authority may well be accepted and even welcomed by the districts in the immediate future. Over the long run, however, it will not retain any meaningful authority unless the central MOH offices relinquish some of their budget decision-making and allocation authority.

At this point, regional offices have not even begun to exercise their authority over personnel matters. With regional positions only recently having been established, all Regional Directors are awaiting appointment of their own senior staff, who must be in place before they can begin to undertake their new functions. The only exception is the Eastern Region where integration changes were hurriedly put in place during November 1987-January 1988 to set the stage for His Majesty the King's extended visit to the Eastern Region in January 1988.

II.4 The Basic Minimum Needs (BMN) Program - 1985

This extraordinary political imperative from His Majesty the King placed the full prestige and weight of the throne behind efforts to achieve specific health and family planning targets by the year 2000.

Health needs and goals are a prominent part of the overall plan. The specific sectoral targets have been published, together with the corresponding resource requirements, which themselves are targets to be achieved (see Appendix H). The health targets address the country's most critical needs including family planning, immunization, diarrheal disease control, maternal health, acute respiratory infection (ARI) control, and nutrition improvement (components very similar to those in A.I.D.'s Child Survival initiative). Because these goals are very ambitious, and because they were set forth by His Majesty the King, they bestow a sense of urgency on the reorganization process: HMG is looking towards integration and decentralization as the means by which targets will be achieved.

II.5 Conclusion

At present, HMG may well be poised on the brink of a new era of health service delivery. The massive administrative and organizational change of the MOH service delivery system announced in 1987 to enforce the move to integration and decentralization, together with the political weight accorded to achieving basic health needs as part of the King's Basic Minimum Needs Program, are the most encouraging developments yet. This program of change is also in line with USAID's policy agenda of combining improved central institutional effectiveness with a shift of responsibility and authority from central to district and local officials, community organizations and user associations. In short, advocates of reform, both in Nepal and USAID, may presently have their best opportunity ever to restructure the MOH system to meet the demands of the next century.

III. THE INTEGRATED RURAL HEALTH/FAMILY PLANNING SERVICES PROJECT

III.1 Background

The IRH/FPS project was initiated in 1980 to help the MOH improve the management, and expand the effective delivery, of rural health and family planning services in Nepal. The long-term goal was to improve the health status and reduce fertility rates of the rural poor. USAID identified four interrelated objectives upon which improved health status would depend and which the MOH intended to carry out through the ICHSDP project. They were 1) birth spacing and family size limitation, 2) diarrheal disease control, 3) communicable disease control, and 4) nutritional improvement. These interventions are now the four cornerstones of A.I.D.'s child survival strategy.

To achieve the project's long-term goals, seven outputs were identified, each with a set of indicators to measure progress. Five of these were designed to help improve the management capabilities of the MOH. These called for:

1) the effective delivery of services through the Integrated Community Health Services Development Project of the MOH;

2) the effective functioning of the Health Planning Division of the MOH;

3) the effective functioning of management systems, especially for drug supplies--the Indent and Procurement Division (IPD) of the MOH--management information systems, and supervisory systems;

4) participation of local communities in health services delivery; and

5) the achievement of various training goals.

The sixth and seventh goals related to delivery of services, output 6 to family planning services and output 7 to other health services.

III.2 Project Emphasis

The prime emphasis overall has been on family planning and maternal and child health, on assistance to the integration effort, and on the anti-malaria program. This holds true, whether the analysis is of total allocation of all project funding (see Table 1), allocation of funds for all program activities (see Table 2), allocation of technical assistance funds (see Table 3), or allocation of local support cost funds (see Table 4).

The project has provided approximately $34 million worth of assistance since 1980 including support for commodities, contraceptives, construction, local cost support, technical assistance and training (see Table 1).

Table 1

DISTRIBUTION OF ALL USAID PROJECT FUNDING
(including Local Cost Support)
1980 - 1988

Category	US $ (000s)
Local Cost Support	13,802
Commodities	5,507
Technical Assistance*	8,665
Contraceptives	3,506
Construction	2,251
Other Implementation	594
Training	108
Total	34,433

*Including $728,000 for participant training and $400,000 for MOH equipment.

Table 2

ALLOCATION OF PROJECT FUNDS AMONG PROGRAMS*
1980 -1988

Category	Percentage
FP/MCH	39
ICHSDP	23
Malaria Office	21
Child Survival	03
Health Planning Division	01
Indent & Procurement Division (IPD)	01

*Excluding technical assistance services.

Table 3

ALLOCATION OF TECHNICAL ASSISTANCE FUNDS

Category	Percentage of Total Technical Assistance
FP/MCH	26
ICHSDP	19
HPD	17
MOH	13
Child Survival	10
IPD	07
CRS	05
Malaria	02

Table 4

ALLOCATION OF LOCAL SUPPORT FUNDS

Category	Percentage
FP/MCH	68
ICHSDP	24
IPD	3.0
Child Survival	1.5
Goiter & Cretinism	1.5
Malaria	1.0
Health Planning Division	1.0

III.3 Project Evolution

Implementation of the IRH/FPS project can be divided into two phases, the original project (1980-1984) and the project amendment stage (1985-present). During the initial phase, project resources were directed primarily toward two of the four health goals: 1) family planning through expanding voluntary surgical contraception (VSC) nationwide and providing condoms, and 2) communicable disease control through provision of substantial commodity support to the national anti-malaria program (insecticide). In addition, considerable effort was directed to establishing the health system infrastructure through construction of 10 health centers, 3 regional medical warehouses, and 5 VSC centers, as well as for meeting the output indicators related to the ICHSDP and the Health Planning and Indent and Procurement Divisions of the MOH.

During the second phase, USAID broadened the scope of health objectives being addressed to include 1) more emphasis on efforts to increase birth spacing through use of temporary contraceptive methods and 2) greater emphasis on child survival interventions.

III.4 Technical Assistance (see Table 3)

Technical assistance has been provided through a contract with John Snow, Inc. (JSI). JSI's work has been more broadly focused than have other project inputs.

Specifically, although family planning/MCH services and integration are still the two largest recipients of funds, together they represent only 45 percent of the total for technical assistance services, with a second almost equally important emphasis on management skills and strengthening priority health services. Since 1985 USAID's emphasis on priority health services has grown, with emphasis on child survival interventions, including an acute respiratory infection field study in Jumla district, a tetanus toxoid (TT) and measles campaign with EPI in four districts, and ORT/EPI programs in three districts. This change of emphasis has been made, while maintaining technical assistance support for family planning at the 1981-1985 level (see Appendix I).

III.5 Local Cost Support Funds Provided by A.I.D.

The total A.I.D.-funded $13.8 million in local cost support expenditures (see Tables 1 and 4), which over the eight-year project period have represented nearly 40 percent of total expenditures, have fluctuated sharply from year to year. They rose rapidly, from Rs.15 million in 1980/81 to a high of Rs.45 million in 1985/86, and then fell steeply to Rs.33 million this year. USAID attributes the decline to the following factors: 1) MOH has begun to pay a larger share of the operating costs, as spelled out each year in the component work plans; 2) MOH had not used all of the funds received from A.I.D. in previous years; 3) USAID decided to conserve some funds for the remaining years of the project; and 4) in 1985, USAID eliminated the General Operating Expense allocation to family planning/MCH. The account was dropped because it was only loosely attributable to concrete service delivery activities and because USAID judged FP/MCH accountability for use of A.I.D. funds to be unsatisfactory.

USAID support for VSC has remained intact in the face of the steep decline in overall Local Cost Support funding in the past two years: While the overall family planning/MCH allocation has fallen, funds specifically assigned to VSC and for the fieldworkers who motivated clients to use VSC were not cut.

III.6 HMG - USAID Cost Sharing

The Project Paper had budgeted an HMG contribution of $71.1 million equivalent to be provided over the project period, over twice the level of the U.S. $34.2 million project grant. It was not possible to determine the total level of the Nepal government contribution to date, but it was clear that the IRH/FPS project has provided a major share of the operating costs of three major efforts it supports (FP/MCH, ICHSDP, and the HPD of the MOH). USAID, however, has

recently made an effort to reduce its cost share and shift more of the burden onto the shoulders of the government. For example, in 1980/81 A.I.D. provided 63 percent of the total HMG/A.I.D. contributions for FP/MCH programs. The ratio declined slightly through 1984/85 (57 percent) and declined steeply during the next two years (42 percent and 32 percent), although it rose this year to 46 percent. A.I.D.'s share of the combined HMG/A.I.D. funding for ICHSDP started at 44 percent in 1980/1981, rose to 63 percent in 1986/87, and fell to 38 percent this year. (These calculations do not include other donor contributions to these programs, which are substantial.)

The Health Planning Division has been supported heavily by A.I.D. since 1982/83 when project funds comprised 77 percent of the combined A.I.D./HMG support. USAID's share rose to 92 percent in 1985/86, but now stands at 78 percent.

According to USAID, it has been requiring that HMG assume a larger share of project local operating costs, especially recurrent costs, during the past several years. Different percentages are specified each year for each activity in each project component. The result appears positive, but USAID's share is still far too high for there to be any prospect for HMG self-sustainability in the foreseeable future. The 1987/ 88 health development budget increased more than 300 percent over last year, however, indicating that HMG is clearly placing more emphasis on accepting a larger share of the financial burden.

Recommendations

1) USAID should continue to pursue reductions in its funding share, as appropriate, during the remaining period of the project.

2) HMG should make every effort to assume a larger share of these program costs, and seek measures to reduce costs and increase productivity.

III.7 Project Management

USAID has been placing considerable emphasis on greater financial and performance accountability by the HMG implementing units. Special efforts to introduce activity-level accounting for project expenditures, however, have been unsuccessful, mainly because the HMG budgetary and financial accounting systems are not capable of handling such innovations.

Technical assistance is now being provided to key ministries on program budgeting, and plans have been made to introduce the new system into the MOH next year. Improved budgeting and financial accounting will be necessary to support the ambitious MOH decentralization and integration plans.

USAID has also been placing more emphasis during the past several years on using the MOH annual component Work Plans as planning, budgeting and performance measurement tools. These are very informative and detailed; they specify exactly what is expected of the implementing entity, performance expected from each activity, detailed cost estimates and evaluation criteria. The Work Plan preparation process has been very time consuming for the counterparts,

consultants and USAID, which to some degree detracts from their usefulness. A major portion of JSI technical assistance time has gone to helping the MOH prepare these work plans.

In the long run, however, USAID's efforts to require improvements appear appropriate, even if they may cause some delays and inconveniences now. The investment made should pay off in the future; moreover, USAID has no choice but to be accountable for use of U.S. funds.

Recommendation

3) USAID should continue to press for improved financial accountability and program planning, within feasible limits.

IV. MANAGEMENT

The five management-related outputs in the project (see Section III.1) were in principle designed to enhance "development of a framework for organizational change" and to promote "development and institutionalization of supportive motivational supervision." These were broad dictates, which, if achieved, would have meant that a smoothly functioning MOH management system would have been in place, staffed by personnel who would take the initiative and responsibility to deliver health services throughout rural Nepal.

The project has failed to achieve this overriding goal of a smoothly functioning MOH management system. When the project was developed, USAID did not adequately assess the severity of constraints on the MOH or adequately attempt to address these fundamental problems. Instead, it selected project activities that either related to symptomatic weaknesses only (drug supply and health center construction) or that assisted an unrealistically conceived reform effort (ICHSDP).

Specifically, problems inherent in the management system included overcentralized planning and budgeting, poor financial and information management, a personnel system that depended too often on informal criteria and that had been thrown into further confusion by the efforts toward integration, overall poor staff motivation, and poor supervisory practices. The project sought to improve some of the planning, budgeting and logistics practices, but it also supported what turned out to be a minimal effort to integrate services without addressing the basic problems that were hampering integration. Moreover, by supporting a vertical program at the same time (the FP/MCH project), it detracted from its own focus of supporting integration.

HMG's recent attempts to deal directly with problems of integration and decentralization (see Chapter II) were not always directly related to USAID's project strategies. On the other hand, the USAID project's achievements with regard to strengthening the Health Planning Division, training, and supporting efforts to promote integration and community participation have helped to set the stage for what may be a more successful reform of the health services over the next 8-10 years.

The following discussion assesses progress on four of the five management-related outputs (see Section III.1).

The fifth, the training-related goal, will not be treated separately. From a quantitative standpoint, this component has exceeded its goals (see Appendix B). The quality of this training, however, relates to many facets of project performance, and so comments on training are included in discussion of other project components. Performance in the other four indicator areas is as follows.

IV.1. Integration

IV.1.1 Integration at the Health Post level

IV.1.1.1 Background. The government's attempts to integrate health services have shifted over the past 15 years from a focus on the district level to focus on lower-level health posts and then, most recently, back up to the district level. The IRH/FPS project's beginning in 1980 coincided with the inception of the Integrated Community Health Services Development Project (ICHSDP), which focused on the health post level (see Section II.2), and was designed in part to support the ICHSDP.

IV.1.1.2 Physical Facilities. One thrust of the project, particularly early on, was the building and rehabilitation of the health posts that were expected to be the focal point for the delivery of all primary health care and child survival interventions. Quantitatively, some progress has been made on this front. By July 1988, 816 health posts had been established, although most not through project funds.[1]

Qualitatively, there were some problems. Most health posts visited were small buildings (3-5 rooms), often with dirt floors and seldom with electricity. Despite the building program financed by USAID, many health posts still must use rented facilities. Housing for health post staff is badly needed, and may be an even more critical requirement than the posts themselves. Overall, USAID has found construction implementation very difficult. A major problem is that A.I.D.'s general procedures and regulations for construction have resulted in buildings that are costly and overbuilt relative to what is appropriate in these poor rural communities. Therefore, despite considerable pressure from HMG officials, USAID prefers that scarce donor foreign exchange be used for other purposes.

IV.1.1.3 Progress toward Integration. From a quantitative standpoint, an acceptable level of progress has been achieved with respect to numbers of health posts to be integrated. The government plans to integrate 675 of the 816 health posts, leaving the 141 remaining facilities as small static facilities with few staff and no out-reach facilities. Currently, the government claims that 465 out of the targeted 675 health posts have been integrated.

In some instances, particularly at health posts where special efforts are focused, the process of integration seems to be having a positive effect on health services, with integrated posts appearing more active than the non-integrated posts. The non-integrated posts function as general out-patient clinics, some also housing clinics run by the various vertical project staff. In contrast, the integrated clinics are attempting, with mixed success, to provide outreach services through the new cadres of village health workers (VHW) and community health leader (CHL) volunteers (see

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[1]Seven health centers (larger than health posts with inpatient capacity) were financed under the IRH/FPS project. These are no longer included as part of the MOH health infrastructure and will either be upgraded to hospitals, or downgraded to health posts.

Section II.2.2). These integrated health posts have work schedules for clinics, including antenatal clinics in posts where appropriate staff are available.

Even in the integrated posts, however, the quality of service is very uneven. Some health posts provide high quality service, whereas the service in others seems very ineffective. With one exception (a health post on the major east-west highway), none of the health posts visited were crowded, and health post utilization was low. Reasons for this variability of performance were unclear; management of available resources may be more important than quantity of resources available.

IV.1.1.4 Staffing. Standard staffing schedules have been developed for integrated health posts, as follows: one health assistant, two auxiliary health workers, and two auxiliary nurse-midwives--all government salaried positions that are usually filled by people from other districts. In addition, each health post has locally recruited staff including six volunteer VHWs and three peons.

- Village Health Workers

The multipurpose VHW was seen as the key for making the Integrated Community Health Services Development Project work. Although the project has now been superseded, the VHW remains the prototype for integrated service delivery at the village level. VHWs have 12 different responsibilities, which they perform according to written activity schedules. Each VHW, all of whom are men, is expected to serve a population of 3,000-6,000 persons, or about 800-900 households, over a wide geographic area, thus spending much of his time travelling from village to village.

To some degree, VHWs have the skills they need, thanks in large part to the training provided through the IRH/FPS project (see Appendix A). In their daily rounds they tend to emphasize four activities: 1) taking malaria slides; 2) family planning motivation, including for voluntary surgical contraception; 3) immunizations; and 4) oral rehydration therapy (ORT) education. They tend to carry out these roles in a fairly limited way, however, being unsure about contraindications of oral contraceptives and unclear about the importance of immunizations and other child survival activities. In short, although they perform certain mechanistic duties, these do not translate into an adequate regimen of prenatal and postnatal care for village women and children. Experience has shown that the VHW job is too broad in scope and its definition too vague to allow for acceptable performance.

In addition, some VHWs are ignorant of the number of persons eligible for family planning and immunizations in their areas. Their support system is also poor: Daily stipends and travel allowances are both inadequate and there is insufficient supervision.

Little effort is made to give lower level staff the technical support they so badly need. Rather, throughout the system, people tend to view supervision as a policing effort, not an endeavor designed to provide assistance in carrying out job responsibilities. Health post personnel seldom go to the field to give VHWs on-the-job advice or instruction. Often the data they report to headquarters are exaggerated or only guesses. Because the role of the VHW job is so poorly

defined, managing and supervising these workers would be difficult in any case. The pervasive authoritarian attitudes of Nepali supervisors toward their subordinates only make matters worse.

- **Community Health Leaders**

CHLs are a lower level village worker, added in 1981 after the inception of the ICHSDP when it became clear that the VHWs were overburdened, particularly in the mountainous areas of the country. CHLs are volunteers selected by the local communities--usually the local *pradhan pancha* or other political leaders. Although criteria used in choosing these workers are somewhat ill-defined, appropriate choices are often made, and the selection process seems to be a good way to involve the community's political leaders. The detailed study of CHL performance recently conducted by JSI provides many valuable insights and should be taken into account in efforts to improve this program (as well as similar programs in other countries that are based on unpaid volunteer workers).

CHL training is carried out by the health post and covers preventive aspects of primary health care and minor curative procedures. Although initial training seems adequate, better support and more refresher training is needed. CHL responsibilities include motivation for immunization, ORT, VSC and temporary contraception, and in some cases sanitation; some CHLs have been able to construct latrines through community support.

One of the most novel aspects of the program is the provision for community generation of local funds for drug resupplies. After training, the CHLs are provided with a kit containing a supply of medicines, which should last for about three months. To raise money to replenish the drugs after the initial supply runs out, a number of fund-raising approaches have been used: house-to-house collection, donations from the panchayat, sale of drugs, and money generated during fairs and festivals.

Community involvement is the key to the performance of the CHLs. The dropout rate (on average around 15-20 percent three years after training) is considerably lower in communities where interest and support is strong. At present, however, the MOH has not taken an active enough role in defining the role of the community in relation to the CHLs. No orientation is provided to communities, and support mechanisms are not well delineated. Many CHLs are quite highly motivated at the outset but, not receiving pay for their efforts, lose enthusiasm and gradually cease performing their assigned tasks. (See Section IV.3 for further description of the part played by the community.)

IV.1.1.5 Major Problems.

IV.1.1.5.1 Staffing. The main problem that has beset the integration process has been resistance to integrating vertical staff into the MOH civil service ranks and confusion about how to overcome this. The administrative problems are as follows:

- There are insufficient permanent posts for all the vertical project contract staff employed in a district (and hence little possibility of maintaining the level and standard of the vertical project services);

- Many employees in the vertical projects work on contract and are not eligible for appointment to regular civil service posts, although some have the requisite experience and skills; and

- Staff salaries in the vertical projects are different (lower) than salaries of corresponding government staff.

Generally, vertical project personnel fear that they will not find positions in the new MOH integrated service in their present districts, or indeed nationally. They are dissatisfied with the inability of the district health authorities to answer questions about their possible absorption into government service--method of entry (e.g., public examination), open or closed competition, credit for experience, seniority allowance for previous service, and so on. It is already clear that most of the Panchayat-Based Health Workers (PBHW) who were hired and trained by the FP/MCH vertical project (see Section V.2.2) and who lack 8th grade educations, will be ineligible for recruitment into the lowest positions in the health posts; nor will the Public Services Commission permit contract work for long periods. The problem is particularly acute at the top level, where vertical project directors have resisted the loss of status, authority and salary level that accompany their absorption into the MOH. Not surprisingly, morale is low among both regular and temporary staff in vertical projects because of these uncertainties.

These problems stem in part from a division in authority at the top level of the program. Although responsibility for program implementation has been given to the ICHSDP project chief, personnel management and control remain with the Director General of Health services. This arrangement has led to divided loyalties and to personnel changes being made without consultation with the ICHSDP project chief.

Lack of enthusiasm for the work is very evident at the level of individual health posts. In some facilities, particularly in remote areas, funded positions remain vacant, while in others, positions are officially filled but the employees are absent, frequently working on assignment elsewhere.

In addition, staff from the vertical projects often leave their own offices and move into the health posts, making them very crowded. In many health posts, the Chief Health Assistant (the senior employee in a health post), lacking both guidance on how to integrate these workers and also substantive knowledge of their areas of expertise, lets them continue to function as before, using the same vertical project forms and reporting procedures. In short, these staff are acting as a separate branch, much as they do in the non-integrated health posts.

IV.1.1.5.2 Services. There is also considerable confusion about the services that will be offered in the new integrated posts. One issue is whether leprosy, blindness, goitre and TB services, all of which are provided in ICHSDP integrated posts, will continue to be provided after the 1987 reorganization. Although the plan is to transfer blindness and goitre services to non-governmental organizations (NGO), VHWs may continue to provide information about the diseases.

A second issue is whether ayurvedic and homeopathy services will be integrated into the posts.

A third issue relates to which services will continue to be delivered on a door-to-door basis and which will be clinic-based, what their relative priority should be, and which staff will deliver them. At present, Regional Directors and district staff tend to interpret the policies and instructions in their own way.

IV.1.2 District Level

IV.1.2.1 Progress toward Integration. With the spotlight during most of the project on integration at the health post level, efforts to integrate services at the district level have lagged. Of the country's 48 districts targeted for integration (out of a total of 75), six had been integrated during the experimental integration phase (1972-1980). Although efforts began in the early 1980s to integrate another 20, only six more have been integrated to date. Thus at present, there is a total of 12 integrated districts, another 14 are still in process, and 22 districts are targeted for integration in which no effort has been made to integrate services. The current goal is to integrate a total of 46 districts by 1990.

IV.1.2.2 Staffing Problems. As at the health post level, the major problems at the district level are with filling newly created posts. Plans had called for District Health Offices to be headed by District Health Officers (DHO) and staffed by a team including i) health inspector, ii) family planning assistant, iii) health education technician, iv) statistical assistant, v) subaccountant, vi) assistant health worker, vii) health assistant, and viii) assistant nurse midwife. The three top positions in the District Health Office are all at a higher civil service level than had existed previously. In the areas where the posts have been filled, the jobs have gone to people from outside the system, mostly individuals with postgraduate degrees in public health or nutrition. Persons who had previously held the then top district post--District Health Inspector--are not qualified to move into the newly created jobs.

Because relatively few HMG health staff meet the minimum requirements for the new District Health Officer posts, it may be some years before sufficient staff can be trained to fill them all. Because nearly all the new district health services will be managed by District Health Officers new to the job, if the new services are to be effective, the new District Health Officers will require special orientation and continuing support.

Although shortage of staff shortages is the overriding problem at the district level, absorption of vertical staff is proving as difficult here as it has at the health post level. Like the District Health Inspectors, the former district chiefs in the vertical projects do not have the needed professional qualifications for many of the integrated district jobs. In addition, since they do not have civil service standing, they will have to go through the government recruitment procedures before they can be considered for permanent appointment to any post in a district office. There is naturally a strong feeling among such staff, particularly in the Eastern Region where the top appointments have already been made, that they have lost authority and status and this reorganization has hampered their career prospects.

IV.1.2.3 Other Problems. Among other problems hampering the integration process at the district level, no plan or schedule has been developed that sets forth the steps to be taken to achieve implementation. Thus there is no sense of urgency about completing the job. Likewise, there is no budget for 1988/89, with line items tied specifically to actions needed to achieve integration. These jobs are the responsibility of the District Health Offices, but they may need assistance from the MOH at the outset.

The poor quality of supervision at the health post level is characteristic of the district level as well, where supervisory personnel also are reluctant to make supervisory visits, tend to handle their subordinates poorly, and may lack some requisite skills (see Section IV.1.1.4).

Recommendations

General

4) USAID should provide no further assistance to construct health posts. Instead, responsibility for construction and rehabilitation should be assumed by district *panchayats* with help from the MOH.[2]

5) Reasons for the wide variability of health post performance should be examined, in order to determine appropriate measures for making improvements.

Village Health Workers

6) The job description of the VHW needs to be revised. Priorities should be established and they should be assigned fewer duties.

7) Consideration should be given to reducing the territory VHWs must cover. VHWs should be instructed in calculating the number of eligible couples in their jurisdictions and be encouraged to make greater efforts to know the target population.

8) VHW stipends and travel allowances should be increased if necessary.

Community Health Leaders

9) The MOH should conduct, or improve, community orientation programs that focus on the role of the CHL in the community, and the community's role in supporting CHLs (see also Recommendation 19).

10) Selection of CHLs should take place after proper consultation with the community. Criteria for selection need to be updated.

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[2]Recommendations are numbered consecutively throughout the report; the same numbers will be referred to when recommendations are selectively repeated in Chapter VII, "Major Conclusions and Recommendations."

11) Regular refresher training should be provided to CHLs. Health posts should improve their supervision and support of community workers.

Supervision

12) Supervisory personnel at health posts and District Health Offices need training in supportive supervision techniques. In particular, the training needs to emphasize that the purpose of supervision is to motivate workers and improve their performance, not to police their activities. Training is needed to improve supervisors' technical skills as well.

13) Supervisors should spend more time making site visits and providing on-the-job technical assistance to fieldworkers.

14) An analysis should be made to determine what other management factors are contributing to poor supervision, and efforts made to address any problems identified.

IV.2 Health Planning Division (HPD)

IV.2.1 General

USAID's support of the MOH's Health Planning Division, though representing only a small percentage of the overall project costs, has created at least a fledgling capability in the MOH to give shape to the reorganization process under way at all levels of health service delivery. With the 1987 health reorganization plan, the government officially recognized the major role anticipated for the HPD. In that new plan, the HPD is to have full responsibility for operating the health management system, including planning and evaluation; health education, information and publication; statistics and computing; and supervision and monitoring. Many of these tasks are still carried out by the vertical projects.

IV.2.2 USAID Role

To date, USAID has financed a significant portion of the costs of the HPD, including the funding of nine staff positions and most of the operating costs of the Division. Although the original schedule called for His Majesty's Government to absorb all these costs by 1987, it is still covering only about one quarter of the costs. The procedures for creating the nine new posts and including them in the regular budget are still under study. Limited HMG resources have inhibited movement in this area, and progress was further delayed when the 1987 reorganization plan required rethinking of HPD's position in the newly constituted hierarchy.

At present, although the MOH appears to be counting on the HPD to perform the planning, monitoring, and evaluation functions essential to managing any large operation, it is still dependent in large part on USAID funding to finance this function. Whether HMG is prepared or able to undertake the financing at this point is impossible to know. What is clear is that there

is no unit other than the HPD in either the Division of Public Health or the Division of Curative Services to carry out the planning function.

IV.2.3 HPD Achievements

USAID had envisioned an important role for the HPD (as set forth in the project output indicators), both in monitoring the progress of integration and in providing inputs into long-term and annual planning, including increasing the capability of the local authorities to be involved in planning and budgeting.

With respect to integration, HPD's capability to analyze trends in integration has grown, most notably because of its participation in management reviews and surveys on the various levels of integration at health facilities. Its limited technical capabilities, however, are still a major problem.

With respect to planning, HPD has made contributions to the Seventh Five-Year Plan and to the development of Basic Minimum Needs health goals and is the major actor in all annual health budgeting. Its current predominant role in annual budgeting, however, runs counter to the spirit of the new decentralization process, a principal goal of which is to ensure that budgeting is an interactive process, with the local communities playing an important role in target-setting. This may change in time, if the capabilities at the regional, district and local levels are increased (see Section II.3.3.3 for a description of HPD's role in planning/budgeting).

IV.2.4 HPD Limitations

Although the HPD has been involved in monitoring the process of integration in the field, its own data collecting and analysis capabilities are so severely limited that it has been unable to produce management information for regular use in the MOH. Two major reasons for this are unreliable data generated from the field and lack of computer capability at headquarters.

IV.2.4.1 Data Collection. Even in those districts that have been integrated under the ICHSDP, each vertical project still maintains its own data collection system. There is little commonality among the systems, and differences of definition in the various systems have made the compilation of national statistics unreliable. Moreover, according to an analysis of the health information system made in October 1986, there were serious shortcomings in the several separate information systems in use: Too much data is collected (and frequently of the wrong type); problems are underreported and achievements overreported; and lateness of data received has led to misleading reports.

Because of the uncertain quality of the information generated, HPD has made only limited use of the outputs of these different systems. Its main outputs are a bi-monthly assessment of the progress of health programs against targets (Development Project Monitoring System) for the National Planning Commission and a quarterly health information bulletin suitable for a general audience. Neither of these is sufficiently detailed or accurate to provide the basis of a management information system.

Efforts are under way to integrate the various information systems so that the information might have greater utility for day-to-day management. A WHO[3]-supported working group is focusing on the types of information that should be included in all systems, while the HPD itself has set up a Working Group that is focusing on ways to improve data collection, including development of forms to be used.

IV.2.4.2 Computer Capability. A second constraint relates to the computer capability within the HPD. At present, data analysis and compilation are done manually (except for the Development Project Monitoring System, which is done on Apple computers). Once reporting systems have been regularized for all 75 districts, however, neither manual compilation nor the Apple computer will be able to handle the volume of data that will be generated. An IBM microcomputer supplied by USAID has been installed in HPD to augment the capacity of the Apple computers, and HPD staff have produced an ambitious scheme calling for a minicomputer with eight satellite workstations, 27 staff (computer operators, programmers, etc.), and a full range of peripheral equipment. The experience of forming and keeping competent teams of computer staff in the MOH has not been good, however, and it seems unlikely that such a scheme would be feasible for some years.

In short, although an integrated information system must be a central feature of the integrated health system, to date progress has been very slow.

Recommendations

15) HPD should consider carefully how it can improve the reliability of the data received from the field and reduce delays in data transmission to headquarters.

16) The computer capabilities of HPD must be strengthened if it is to be responsible for the health management information system. On the other hand, introduction of computers into regional offices should wait until the basic monitoring and planning procedures are working well using manual methods.

17) Efforts are needed to make the process less centralized. As a start, simple planning procedures should be designed and tested, and district staff trained in their use, before the 1989 planning/budgeting cycle begins.

IV.3 Community Participation in Health Services Established

Community involvement in health services was seen as an important adjunct to the process of both integration and decentralization. The heart of the concept was the establishment of two levels of committees--Village Health Committees (VHC) and District Health Committees. The Village Health Committees were to be central actors in the integration process, with their principal role to select and support the multipurpose CHLs (see Section IV.1.1.4). These

[3]See Glossary for full names of this and other organizations generally referred to by their acronyms.

committees are also seen as an integral part of the decentralization planning process: Local health posts are expected to submit annual health plans to the local committees for approval before proposing them to the district health offices. Likewise, a District Health Committee is to agree on the annual health plan and budget for the district before it is submitted to the District Assembly and forwarded to HPD.

In addition to their role in setting the budget, these committees are expected to be the vehicle through which the health system works to get financial and other support from the community to supplement its basic core of resources and services provided by headquarters (the MOH). The major effort to provide local inputs to meet local needs has been in helping village health committees raise funds to replenish their drug supplies (see Section IV.1.1.4). Many other forms of community contribution also exist, however: providing funds for the repair, maintenance, or rental of health post buildings or staff accommodations; providing labor and materials for construction; and acting as volunteers for outreach activities. In future, the establishment of sub-health posts is expected to be carried out entirely through community initiatives.

The process of establishing the Village Health Committees has proceeded relatively well in some communities. Fourteen of the 28 districts with integrated or partially integrated services have formally created such committees.

On the other hand, there are many problems. For example, with 4 to 7 committees for each health post, it is unclear what role each committee should play. In some areas the committees exist only on paper. In many cases support for CHLs is only nominal.

The heart of the matter may be that these committees are not being properly used. Their role as potentially powerful players in the planning and budgeting decision-making process (see Section II.3.3.3) seems to be given less prominence than their role as contributors of resources to the local health program. In meetings with central authorities, committee members may want to complain about local health services and take issue with targets set by Kathmandu, but central authorities try to convince local participants of the correctness of the targets set rather than listen to local complaints. Moreover, the real agenda of the central authorities tends to be to promote community self-reliance, local support for program implementation, and the ratification of pricing decisions related to service and drugs. Not surprisingly, their approaches to the community with the main purpose of getting contributions meet considerable resistance. Alternative approaches, starting from the concept of beneficiary control rather than beneficiary contribution, would make for more genuine community participation.

If greater efforts were made to involve community representatives in the planning and budgeting decision-making, considerable headway could be made toward the goal of decentralization. Moreover, resources that could be mobilized by and channeled through these local bodies could provide practical support and improvements to health services that are being demanded by the communities.

<u>Recommendations</u>

18) Every effort should be made to increase community participation at health post and district levels, to encourage Village Health Committees to demand better health

services and to take active steps to obtain them through the central budget and by their own contributions.

19) Training should be provided for those in charge of District Health Offices and health posts in how to work effectively with the Village Health Committees and to encourage community participation (see also Recommendation 9).

20) Those in charge of health posts should be encouraged, motivated and trained to mobilize community participation and leadership in health post services. This might include public recognition and rewards for health post officials who achieve strong community participation. Local experiments should be encouraged, and successful experiences widely disseminated.

21) Such training should be carefully planned and then conducted according to plans (rather than hastily put together or executed, as too often happens).

IV.4 Management Systems

This output indicator dealt primarily with upgrading the capacity of the MOH to provide an adequate supply of drugs throughout the country in a cost-efficient manner. The principal strategy was to replace an outside contractor (the parastatal transport and distribution company Sajha Swasta Sewa) with regional medical stores (RMS) or warehouses. The RMSs were to take over the job of getting annual orders from health posts for drugs and of packing and transporting those drugs to the health posts. Efficiency was to be gained by having small staffs at the RMSs but making their job a year-long task, with the work spread out evenly over a 12-month period.

To make this a full-year process, new budgeting procedures were enacted that would allow the purchase of supplies in one fiscal year for distribution in the next ("buffer stock").

Although adequate funds have been budgeted, they have been used for other purposes or the buffer stock has been issued to meet other needs. The funds that have been allocated for health post drug supplies have, as before, become available toward the end of the year, forcing the staff to complete all packing and distributing of supplies within a few short months. It has been impossible for the small RMS staff to complete this task in the short time available, and so, as before, they have needed to subcontract part of the job to the Sajha company.

Another aspect of the plan was to computerize the drug ordering process. A computer program was planned that would calculate the supply of drugs to be provided, based on each post's estimate of its needs. Because of limited local resources and capabilities, this idea, too, has not worked out. Instead, health posts continue to receive standard packages of drugs, which, while sufficient for small posts, are totally inadequate for the larger ones.

Both parts of this strategy have required a high level of material and technical assistance. Its failure can be attributed to a combination of lack of technical capability and of commitment.

Very recently, cost-recovery schemes have been initiated at some health posts, which are said to have had some success in meeting the demand for drugs. This approach may well prove to be more cost-efficient than the elaborate RMS system that has been created.

Recommendations

22) USAID should discontinue its support to the regional medical stores system.

23) Monitoring of the new cost-recovery schemes, and alternative methods of community financing, should be explored to see how far they might go in achieving the goal of a cost-efficient drug distribution system that guarantees an adequate, year-round supply of drugs at the health posts.

V. FAMILY PLANNING SERVICES

V.1 Goals

V.1.1 Project Performance

The IRH/FPS project purpose was to assist HMG "to improve the management of health delivery systems and to expand the delivery of rural health and family planning services." For family planning, the "desired output" was stated as "Family planning services delivered effectively." Two output indicators were adopted as measures for effective delivery of family planning services. These were

- 500,000 continuing users of temporary contraceptive methods, and
- 230,000 voluntary surgical contraceptive procedures carried out in the project period.

With respect to meeting performance indicators, the IRH/FPS project has achieved one of its greatest successes in the area of voluntary surgical contraception (VSC), having surpassed its goal by 1985. Some 300,000 sterilization procedures (male and female) were carried out between 1980-1987, well above the goal of 230,000. In contrast, only 73,500 continuing users and new acceptors of temporary methods were counted in 1986, against a goal of 500,000 people who would be using temporary methods by that date.

V.1.2 Prospects for Achieving National Goals

The government is well aware that family planning activities must be intensified considerably if the Basic Minimum Needs goals are to be met. These goals are high priority, but also extremely ambitious, calling for a decrease in the total fertility rate (TFR) by the year 2000 from 6 to 2.5 percent and a reduction in the population growth rate from 2.6 to 1.2 percent.

Whether these goals can be accomplished in the time stipulated is highly questionable. The national will appears to exist, at least insofar as public support by His Majesty the King translates into national will. Moreover, there is no major social, religious or other cultural opposition to contraception. The contraceptive prevalence rate (CPR) is now only about 15 percent among all currently married women of reproductive age, according to the nationwide 1986 Nepal Fertility and Family Planning Survey (NFFS). While still low, the current level is more than double the 7.0 percent reported in 1981 and four times that of a decade ago (see Table 5).

Against these positive signs, however, are the stark realities of the difficulties of development in Nepal. Ethnic and caste differences, traditional political patronage systems, and the lack of road access to a large part of the population all make progress difficult. Perhaps an even more profound difficulty for family planning programs arises from the status of women: Fewer than 5 percent of rural women can read and write, and the average age of marriage for women is about 18.

Table 5

INCREASE IN CONTRACEPTIVE PREVALENCE RATE
1976 - 1986
(in percentage of population)

	1976	1981	1986
Male VSC	1.9	2.9	6.2
Female VSC	0.1	2.4	6.8
Pill	0.5	1.1	0.9
Condoms	0.3	0.4	0.6
Injectables	-	0.1	0.5
IUD	0.1	0.1	0.1
Total	2.9	7.0	15.1

Moreover, at this point, no goals have been set for the increases in contraceptive prevalence that will be needed to achieve the TFR and population growth rates targets that have been set. Without this level of analysis, it is difficult to develop a responsive programmatic strategy for method mix and delivery systems (see Chapter IV, introductory paragraph).

The National Population Commission is no longer effective as a policy making or coordinating body. Established in 1978 and supported by A.I.D. (through its Population Policy Development Project, 1979-1985), the Population Commission was influential in articulating and implementing policies through about 1983. Unfortunately, although the need remains, it is no longer active in the same capacity.

Finally, because Nepal is just beginning to modernize, it still lacks the infrastructure that has facilitated family planning success in more developed Asian countries. The entire family planning program also suffers from the managerial problems of the public (civil) service system (see Chapter IV, introductory paragraph).

V.2 Family Planning Services Division

Family planning services are provided mainly through two government programs, supplemented by a number of non-governmental organizations (NGO) and a contraceptive retail sales program.

V.2.1 Government Family Planning Services

The government provides services through two vertical projects:

- The Family Planning/Maternal and Child Health project (FP/MCH), the country's major provider of family planning services, provides services in the 52 non-integrated districts.

- The ICHSDP project provides family planning services in 23 of the 26 districts that have either been or are being integrated through this project. It has full responsibility for family planning in the fully integrated districts and partial responsibility in the partially integrated districts (i.e., it is responsible for family planning only at the health posts that have been integrated [see Section II.2.2]).

USAID is involved in both these efforts. The FP/MCH project was established with USAID support in 1968 and remains the main recipient of funds under the current IRH/FPS project. The ICHSDP project is also a recipient of IRH/FPS funds, but these funds support family planning/MCH indirectly, as part of the package of integrated services being delivered through the project.

The major difference between the two project approaches is at the field level, in the personnel who deliver services. The ICHSDP utilizes multipurpose village health workers for whom the delivery of family planning and MCH services is only one of the 12 activities with which they are charged (see Section IV.1). All VHWs are men. Not surprisingly, the project has not been able to meet its targets in family planning and MCH. In fact, ICHSDP has had to contract with a major NGO--the Family Planning Association of Nepal (FPAN)--to provide VSC services.

The FP/MCH project, by contrast, has created a category of grassroots fieldworkers called Panchayat-Based Health Workers (PBHW), whose chief responsibility has been family planning (both temporary methods and referral for VSC) and maternal and child health care. The category of PBHW was created in 1972 when a community-based distribution component was added to the FP/MCH project. Begun in two districts, this approach was subsequently expanded throughout all 52 FP/MCH districts. Today, PBHWs provide pills, condoms, and MCH advice, and advise clients of the availability of VSC services (see Section V.5.1 below). PBHWs are not civil (public) service employees, which in most cases assures lifetime employment, but work instead on limited-term contracts. Currently these are 53 percent funded by HMG and 47 percent by the IRH/FPS project. PBHW salaries account for a large portion of the project funds.

Initially the great majority of PBHWs were men. In 1985, to introduce a larger number of women into this group of workers, USAID required that all new recruits be women. At least 50 percent of PBHWs are now women. Most are married and family planning users. Given the very low level of female literacy in rural Nepal, some of the female PBHWs are not literate.

As an employee of a vertical project, the PBHW is not well supported by the regular MOH health system. They are not considered part of the health post and hospital system, and many have not even been inside a health post.

Ironically, the PBHWs are in the position of being both overextended (like the VHWs; see Section IV.1) and underutilized. Although family planning and MCH activities are their chief responsibility, their job description also contains a host of subactivities, none given priority.

Moreover, each PBHW is supposed to provide these services to a population of 2,500 (1,500 to 2,500 in hill and mountain districts) who live in a geographic area that is unrealistically large to be covered easily. Many PBHWs find walking from village to village too difficult, too time consuming, or too tedious. This overextension, along with faults in their support system--specifically recruitment, training, and supervision--leads to a high turnover and an underutilization of their potential as health care providers.

With respect to recruitment, many PBHWs are recruited on the basis of traditional patronage relationships with the local political leader (*pradhan pancha*). The notion was that involving the community in the selection process would lead to greater community interest in program activities. In practice, however, the result has not always been satisfactory: Criteria applied by the community may not include the skills and willingness to work that are essential to good performance.

Because of the imperfections of the selection process, some PBHWs do not understand what the job will entail, increasing the shock when they learn what is involved. Finally, the election of a new *pradhan pancha* may result in the PBHW's being replaced by a new person of his choosing, again largely on patronage grounds.

Training is also weak. Some PBHWs receive their initial training as much as a year or more after starting the job, and others have received no training after two full years on the job. The current training curriculum (in use for 12 years without revision) presents far too much information and presents it poorly. Refresher training is also unfocused and sporadic, and a PBHW can only receive one refresher training course. What is needed is refresher training every one or two years.

Nonetheless, PBHWs who have been trained have a fair knowledge at least of the rudiments of their job. Training tends to focus on motivation for various family planning methods and the PBHWs' knowledge in this area is adequate: Most have relatively good basic knowledge of the methods, both of VSC and of temporary methods. Most of them know also about the importance of immunization and ORT. Plans are under way to revise the PBHW manual and the training curriculum. JSI has assisted FP/MCH in developing a new curriculum but this effort is currently stalled by bureaucratic difficulties. Better documentation of both the job and of the training needed for the job would be extremely useful in ensuring not only that training is better designed but that a higher priority is given to training as a means to better job performance.

Supervision is a third problem area. Part of the problem is the structure of the program. Immediately above the PBHW there is an Intermediate Supervisor (IS). Although the ratio of ISs to PBHWs is the best among MOH programs, recruitment for these positions is poorly done: Nearly all of these supervisors are young men who are often less knowledgeable about health and family planning than the PBHWs, and few have had experience as PBHWs. The next link in the chain is the District Family Planning Officer (DFPO). At this level, the problem seems to be overextension; one DFPO reported that, in addition to many other responsibilities, he was supervising 40 Intermediate Supervisors. At the top of the supervision structure is a post for an overall program manager; this position is frequently vacant. Finally, the supervisory approach that has hampered project progress in integrated districts in the ICHSDP project also has tainted this

vertical effort (see Section IV.1). Intermediate Supervisors tend to be overbearing and authoritarian, rather than seeking ways to assist PBHWs in carrying out their duties.

In light of the weaknesses described above, it is not surprising that PBHW performance has been found unsatisfactory. The report of the PBHW Effectiveness Study conducted by JSI/Nepal in 1987 contains further analysis of weaknesses in the system in which the PBHWs work (see Appendix J).

Steps to remedy the systemic weaknesses identified above had been begun by FP/MCH project management and USAID, but the integration announcement in July 1987 stalled progress, with staff now preoccupied with how their jobs will be assimilated in the new system (see Section IV.1). Over the long run, it is likely that the PBHWs may need to expand their roles to include more health services, and eventually to be integrated in the ranks of multipurpose VHWs (see Appendix K). Present plans for the integrated system would eliminate most of the female PBHWs given that they do not meet the minimum educational criterion (8th grade completion certificate) for entrance into the government's public service system.

Recommendations

24) More female fieldworkers (PBHWs, VHWs, or others) should be recruited, and means sought to retain the present female PBHWs under the new integrated system. The PBHW job should be revised (e.g., shorter hours, less territory) so that it is feasible for women to perform effectively. The report of the PBHW Effectiveness Study conducted by JSI/Nepal in 1987 contains further analysis of weaknesses in the system in which the PBHWs work and should be consulted in the design of any new project.

25) Supervision of PBHWs at the district and health post levels should be improved (including substantive support).

26) PBHWs who have performed well should be recruited for the VHW position, whenever possible (see Section V.5 for additional recommendations on PBHWs--in particular, Recommendations 37 and 38).

27) Current initiatives to revise the PBHW training should be followed through to completion. This should be done in such a way that modules developed can be used also for training of other fieldworkers.

V.3 Non-Governmental Organizations

V.3.1 Summary of NGO Programs

Numerous NGOs supplement government efforts to provide family planning and MCH services; some have achieved high continuing use of temporary methods among clients, although their total coverage is limited. The main ones supported by USAID include the following:

- **Family Planning Association of Nepal (FPAN)**

FPAN introduced family planning in Nepal in 1958 and is the biggest partner of the government in providing family planning services. It currently has 21 branches operating in 25 districts throughout the country. FPAN is directed by local volunteer leaders, has volunteers at the village level, and is a leading organization in using volunteers. It is an IPPF affiliate whose funds come mostly from international donor agencies, directly or indirectly. In addition to funding from IPPF (45 percent), support is provided by USAID both through the FP/MCH and the ICHSDP projects, and by such other A.I.D.-funded organizations as FHI, AVSC, CEDPA, and the Freedom from Hunger Foundation. FPAN's plans for the next three years include increased emphasis on birth spacing supported by high quality clinical services, adequate counseling, and follow-up. Priority will be accorded to innovative and cost-effective approaches, with focus also on women's welfare and integrated community development.

- **Nepal Red Cross Society, Mothers' Clubs, and Ex-Servicemen's Organization**

FPIA has supported these three NGOs in projects that mainly promote the use of temporary methods (pills and condoms) to village communities, often using local women and ex-servicemen as fieldworkers.

- **New Era and Integrated Development System** are two social service research organizations that conduct population, family planning, and other social science research.

Overall, NGOs have performed well. FPAN performs 20 to 30 percent of all VSC procedures nationwide. The three FPIA-supported NGOs provide temporary methods services to about 51,000 clients at their project sites throughout the country. In addition, the NGOs have undertaken pilot activities in areas in which the government is still not able to perform successfully: Some NGOs have successfully demonstrated the use of female fieldworkers and volunteers in providing family planning services, especially temporary methods, and others have demonstrated effective community-based approaches that have generated active community participation and been cost-effective.

V.3.2 Support and Coordination by the Government

The government appears ambivalent about the role of NGOs in the national family planning program. The status and responsibility of NGOs and their relationship with the government family planning program, except for FPAN, is not clearly defined, nor does the government give clear direction and guidance to the NGOs on their role. The government does not invite NGOs to participate in planning, managing and evaluating the overall family planning program nor does it offer any substantive support on logistics, training, and rewards. NGOs have no forum in which they might discuss their activities or problems, exchange experiences, or improve coordination with the government.

V.3.3 Self-Reliance and Independence

All of the NGOs involved in family planning activities still depend largely on foreign donors for their institutional support as well as operating costs. There is almost no local funding support for NGOs from the government or private business sector. Some, however, are beginning to experiment with cost-recovery schemes, such as fee-for-service, to achieve a measure of self-sustainability. Results are encouraging and suggest that the government too might be able to charge for services.

Recommendations

28) HMG should recognize NGO roles and responsibilities and encourage them to expand their health and family planning activities as an important adjunct to government programs. The MOH should sponsor regular meetings with NGOs. USAID, UNFPA, and UNICEF should participate in those meetings.

29) Donors and HMG should help NGOs to strengthen and consolidate their management and operational capabilities.

30) Donors and HMG should help NGOs strengthen and expand the coverage of their innovative activities, especially in institutionalizing VSC, and promoting temporary methods using female fieldworkers and volunteers, community motivation, effective IEC campaigns, counseling, population education and child survival interventions.

31) USAID should provide support directly to some of the NGOs, to complement and augment funding from other sources, in order to accomplish the above objectives.

V.4 Contraceptive Retail Sales

The Contraceptive Retail Sales Company (CRS) Pvt., Limited, a not-for-profit 100-percent Nepali-owned social marketing organization, sells USAID-supplied contraceptives and oral rehydration solution (ORS) packets through more than 14,000 small shops, pharmacies and other retailers throughout Nepal. Incorporated in 1978, it is guided by a board of directors representing various governmental, parastatal and non-governmental organizations.

Almost all funding is provided by USAID under a cooperative agreement, although UNICEF has provided some funds for ORS marketing.

CRS markets condoms (Dhaal and Panther), oral pills (Gulaf, Nilocon), vaginal foaming tablets (Kamal) and ORS (Jeevan Jal). Besides commercial distribution through retail shops, it recently developed a Rural Social Marketing program, which is a community-based distribution approach employing traditional medical practitioners and faith healers. This is being attempted primarily where communications and transport are difficult.

CRS has been quite successful from the start. It has strengthened its management capability and developed a distribution network of 46 depots (stockists), 10 regional sales

representatives, and approximately 14,000 retailers in all 75 districts. (The 1988 target for retail outlets is 11,000.)

CRS has made good progress in promoting and selling contraceptives and ORS to the public. About 85 percent of its yearly condom and pill sales targets have been achieved: In 1987, 4,233,000 condoms were sold, close to the target of 4,841,000; and 147,000 pills were sold, again not far below the target of 162,000. Sales expressed in CYP have grown steadily: A level of 2,300 CYP in 1978 compares to 55,000 CYP in 1986.

At present, however, as CRS enters a new stage of corporate development, it faces new challenges. It needs to achieve some level of self-sustainability, expand product lines and markets, and move from its current parastatal orientation towards an independent commercial orientation.

With respect to generating more funds, CRS's current revenues are equal to approximately 20 percent of operating costs. Because A.I.D. funds cover 100 percent of those costs, CRS is now able to place the revenues in a capital reserve that is available for project activities. CRS, however, is aware that it must begin to increase its revenues, and is considering attempting to operate family planning clinics on a for-profit basis and possibly to broaden its health products line. It plans to invest funds generated in a subsidiary commercial advertising agency that would generate additional revenues. In addition to adding health products to its product line, CRS's new Rural Social Marketing strategy shows promise of expanding sales into remote areas.

In other areas, less progress has been made. Advertising and promotional activities still need to be strengthened and market research capabilities are limited. CRS has no representatives from private commercial enterprises, however, who could bring private sector expertise to bear on marketing operations. In addition, the board of directors reportedly tends to involve itself too closely in routine management decisions. No efforts have been made to reconstitute the board of directors or to make it better able to deal with marketing issues.

Recommendations

32) USAID should continue to support current CRS activities, in particular, expansion of its markets and product lines.

33) CRS should try to improve cost-recovery. New approaches might include marketing to private practitioners, opening low-cost quality service clinics in urban areas, and providing advertising services for other companies.

34) The CRS board of directors should be reconstituted, or expanded, to include significant commercial, private sector expertise. The board should also limit its involvement in the company's daily affairs, focusing only on important policy matters.

V.5 Family Planning Methods

V.5.1 Voluntary Surgical Contraception

VSC now accounts for 86 percent of total use of contraception in Nepal, with virtually the entire gain in contraceptive use from 1981 to the present having been generated by sterilization (see Table 6). The extraordinary success of efforts to provide voluntary surgical contraception over the past six years was possible because of a combination of consumer demand, government commitment and considerable donor support. Clearly, the underlying factor was an accumulated high level of demand for fertility termination by women (and men) who had already had their desired number of children or more.

Table 6

CONTRACEPTIVE METHOD MIX (MODERN METHODS)
1986

Method	CPR*	Percentage Use of Method
Permanent Methods:	13.0	86.1
Female sterilization	(6.8)	(45.0)
Male sterilization	(6.2)	(41.1)
Temporary Methods:	2.1	13.9
Pill	(0.9)	(6.0)
Condom	(0.6)	(4.0)
Injectables	(0.5)	(3.3)
IUD	(0.1)	(0.6)
Total	15.1	100.0

(Source: NFSS, 1986)

*Contraceptive prevalence rate

The strategy used in Nepal has centered on mobile clinics and a massive deployment of doctors and nurses, paramedics and peons, and family planning staff to run them. Mobile clinics (referred to as "camps") have long been a fixture of the Nepal scene, having been used early on for immunization and other purposes. The first mobile laparoscopy camps were held in the early 1970s. Male VSC (vasectomy) provided in fixed clinics was introduced first, however, and for many

years predominated. Following the introduction in the early 1970s of the mobile laparoscopy camp, female sterilization began to overtake vasectomies, especially in the Terai districts, and now accounts for the larger proportion of VSCs: As of 1986, contraceptive prevalence for female sterilization was 6.8 percent and, for male sterilization, 6.2 percent. Laparoscopy is more common than minilaparatomy; postpartum minilaparatomy is not common as most births occur not in a hospital but at home.

External financial support for this major undertaking has come primarily from USAID, UNFPA, and supplementary HMG resources. Costs have included not only staff salaries but wage compensation to clients as well. Costs break down as follows: HMG: $10-15/procedure; UNFPA: $18/procedure; USAID: $5/procedure plus Rs 25-100 for each client.

Because of the country's difficult topography and lack of roads, there is certainly strong justification for a mobile approach, particularly in the hill and mountain districts. The mobile approach, however, has been pursued, at least until very recently, to the virtual exclusion of provision of services on a year-round basis at static facilities. The only exception has been in the Kathmandu Valley, where clinics do routinely offer VSC.

At this time, the number of VSC procedures being performed appears to be tapering off. Although demand is reported to still be high in unserved areas, in those communities where the mobile camps have operated, the number of procedures performed annually has diminished. Procedures peaked at about 67,700 during 1983/84 and have declined in number each year since (see Table 7).

It is possible that this decrease in the number of procedures performed actually represents a decline in demand (e.g., due to the "demand backlog" having been met in some areas). Reasons for the decrease have not been systematically studied, however. On the supply side, what could be termed "provider fatigue" is reported to be setting in among many of the service providers. The Kathmandu-based laparoscopists are less willing to leave their more lucrative private practices for work in the camps than they were at the outset. Family planning officers who manage the camps have also begun to complain of the stress involved in the intense schedule and the need for constant vigilance to keep everything running smoothly.

Recently, the FP/MCH project and FPAN have developed plans to institutionalize VSC services in hospitals and other fixed facilities. Progress is expected to be slow at first, with facilities operating initially only in the Kathmandu Valley and the Terai. Issues related to institutionalization were the subject of a very thorough recent study.[4] Major entities involved in VSC service provision express verbal agreement with the report's recommendations to move ahead with phased institutionalization while maintaining levels of quality, but little action has been taken.

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[4]Jezowski, Terrence W. and Alison Ellis (AVSC) "Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal," 1987.

Table 7

REPORTED NATIONAL VOLUNTARY SURGICAL CONTRACEPTION (STERILIZATION ACCOMPLISHMENTS)

Year	Target (HMG)	Vasectomy	Female Procedures	Total
1975/76	28,000	9,169	2,162	11,331
1976/77	28,000	10,953	5,422	16,375
1977/78	28,000	12,172	7,923	20,095
1978/79	28,000	7,009	11,203	18,217
1979/80	28,000	4,277	11,130	15,407
1980/81	23,000	4,802	18,040	22,842
1981/82	40,000	10,398	20,167	30,565
1982/83	65,000	16,493	28,507	45,000
1983/84	65,000	26,311	41,428	67,739
1984/85	65,000	22,736	38,780	61,516
1985/86	65,000	18,880	30,218	49,098
1986/87	65,000	13,465	27,945	41,410
1987/88	80,000			

The financial compensation to VSC providers and assistants do not appear to be a critical determinant in continuing or terminating camps. Physicians can earn more from their regular activities and it appears that job security is more important to most MOH employees than the extra income from camps. Once the current MOH integration changes are completed, employees may have greater employment stability, which might facilitate institutionalization.

The phenomenon of peaking and subsequent decline in the number of VSC procedures performed has occurred in other countries that were also in the early stages of family planning programs. In such situations, the major effort to provide sterilizations may be seen as part of a longer-term strategy that includes progression to a greater focus on temporary methods as the next step, although with a continuing role for VSC. Nepal is presently at the point where this transition should occur.

It is fair to say that in Nepal, program efforts to promote temporary methods more vigorously should have begun earlier. The IRH/FPS project's concentration on VSC did not adhere to its originally stated objective (assist the MOH to improve the management, and expand the effective delivery, of rural health and family planning services) because USAID did not adequately assess the severity of MOH management constraints nor attempt to address fundamental problems. It pursued instead an important intervention (VSC via the FP/MCH vertical project) which offered

near-term impact while avoiding dealing directly with the prevailing resistance to integration of the existing MOH program.

V.5.2 Birth Spacing and Temporary Contraceptive Methods

The very low level of effective use of modern contraceptive methods for birth spacing (only 2.1 percent prevalence) has resulted in part from the programmatic focus on VSC, in part from limited availability of temporary contraceptives in rural Nepal, and in part from the low level of client interest. Although the traditional desire for at least two sons combined with very high infant and child mortality serve to foster a prevailing desire for large families, there is nonetheless considerable interest among women in spacing their children. According to the 1986 National Fertility and Family Planning Survey, 36 percent of currently married women expressed such a desire. At the same time, there is widespread suspicion about the use of temporary methods. This is ascribable in turn to the failure of the MOH to develop a competent program to deliver those methods, as well as to the sheer difficulty of doing so in Nepal where the lack of communications and other infrastructure impedes all government and donor attempts to provide social services. Client apprehension and mistrust is everywhere. Women resist trying pills because of fear of side-effects (like the belief that pills dry up breast milk). Drop-out rates for pill users are extremely high: 75 percent of users discontinue use within three months. Where available, Depo-Provera is preferred to the pill and clinical trials of Norplant are said to be stimulating demand for this method.

It is widely accepted that family planning service delivery programs that include good counseling and follow-up are much more successful than those that do not. In Nepal, inadequate follow-up was identified by the FP/MCH program as a major weakness and prime cause of low continuation rates. In addition, when service providers promote temporary methods, they often do not inspire confidence: In particular, women are reluctant to discuss contraception with male fieldworkers (see Section V.2). Also, very few information, education and communication (IEC) materials and activities are available to support fieldworkers.

The high drop-out rate for continuing users reflects another programmatic weakness: the way targets are set. Until recently, the MOH and family planning program managers required statistics that focused on new acceptors, not on continuing users. Focusing on new acceptors (or combining new and continuing acceptors as has been done) encourages family planning personnel to neglect counseling and follow-up. Without counseling and follow-up, many new acceptors stop using the method after a short time, especially those who experience side-effects from the pill. Not only does this new acceptor stop, but she also discourages others from starting. In contrast, continuing-use targets oblige the family planning worker to focus also on follow-up. Continuing satisfied users are usually the best promotion for any contraceptive. The MOH has recently begun to design a system and forms to direct attention to continuing users, a development that should be very helpful to program performance.

Conversely, NGOs have shown that a well-administered program promoting temporary methods can succeed in Nepal. With their more intensive management and higher priority on spacing, some NGOs (Nepal Red Cross, Mothers' Clubs, and the Ex-servicemen's Organization) have achieved contraceptive prevalence rates as high as 40 percent in their catchment

areas. In fact, NGOs and CRS probably account for more than half of the couples nationwide using temporary contraception.

From the general health perspective, it should be relatively easy to convince family planning officials and personnel of the importance of improving the delivery of temporary methods. Not only are the high infant and child mortality rates widely recognized as a problem; the maternal mortality rate in Nepal is also extremely high–80 times higher than that in the U.S. (8 deaths per 1,000 children born compared with a U.S. ratio of 10/100,000). Birth spacing is being increasingly recognized as a way to reduce maternal mortality. So too, birth spacing (along with immunization) may be *the* most effective child survival intervention for Nepal over the next generation. Dramatic data show that infant mortality declines greatly with increasing birth intervals, regardless of birth order or mother's age (e.g., 1976 World Fertility Survey). Moreover, it may turn out that birth spacing will be easier to provide (and sustain) than other A.I.D.-promoted child survival strategies, especially ORT and nutrition improvement. FP/MCH has announced its intention, as well as plans and targets, to increase continuing use of temporary methods. The intentions and objectives described in Kathmandu have not yet been translated, however, into effective promotion at the field level.

<u>Recommendations</u>

35) The family planning program needs to shift from concentration chiefly on VSC toward a greater genuine effort to provide temporary methods with referral for VSC as appropriate. FP/MCH's plans to increase promotion and continuing use of temporary methods should be vigorously pursued.

36) Promotion and use of clinic-based spacing methods (IUD, injectables, Norplant) should also be increased, particularly for people who live close enough to a service provider to be able to return in case of complications or desire to discontinue the method. It may be easier to achieve higher continuing use and satisfaction levels with these methods than with pills and condoms. More auxiliary nurse-midwives, staff nurses, public health nurses and others will need to be trained in these methods and necessary supplies made available. These efforts should also proceed in a pilot-project manner, so that quality services can be provided and the results monitored through operations research. Expanding quickly to national coverage is likely to result in inadequate counseling and side-effect management and give the method a bad reputation, as has happened with the pill and, in other South Asian countries, with IUDs.

37) Efforts to increase the continuing use of pills and condoms for spacing should be stepped up. Pills and condoms should be promoted the most vigorously as the most appropriate temporary method for people who do not live near a health facility. Training and retraining of field staff must be provided in motivating couples to space children and in counseling to handle pill side-effects and fears thereof.

38) Targets for temporary methods should be established based on continuing users rather than new acceptors. Both PBHWs and their supervisors should be trained in how to gather information on continuing users.

39) IEC materials and activities to promote birth spacing should be developed and used. IEC should promote birth spacing as (1) an essential part of child survival and as (2) essential for reducing maternal deaths. The message should be emphasized in ongoing and planned community activities--including MCH intensification programs, local elite training, mothers' groups, meetings of VHCs and with *pradhan panchas*.

40) Non-monetary ways to reward personnel for achievements in promoting birth spacing, as well as overall positive performance should be developed. Strategies used in other countries should be studied.

Permanent Methods

41) Efforts to institutionalize family planning services in static year-round facilities should be pursued,[5] but the mobile camp strategy should continue in most hill and mountain districts.

42) Promotion and provision of vasectomy for men and minilaparotomy for women should be expanded.

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[5]This should be based on an AVSC study team recommended strategy for incorporating family planning services (temporary and permanent methods) in static facilities on a year-round basis (see Jezowski et al., 1987).

VI. HEALTH SERVICES DELIVERY

VI.1 Introduction

In addition to the four child survival activities that were identified at the outset of the project (see Section III.1),[6] the IRH/FPS project has more recently ventured into two new health areas--acute respiratory disease (ARI) control and maternal health. USAID's growing concern with maternal health is paralleled by Nepal's Basic Minimum Needs policy, which set reduction of maternal mortality as one of its key goals (specifically to reduce the level of maternal deaths from 8/1000 to 4/1000). The BMN program also set the goal to reduce infant mortality from 111 to 45 deaths per 1000 live births by the year 2000.

Similar to child survival experience elsewhere in the world, the Nepal program has tended to emphasize communicable disease control and diarrheal disease control over the two other child survival interventions--birth spacing and nutritional improvement. The importance accorded to communicable disease control is evidenced in part by the existence of the vertical EPI program, the only one of the child survival interventions to have been delivered at this level of intensity. The focus on diarrheal disease came later, in 1983, when this was identified as a key problem and a national plan was developed that called for an 80 percent reduction in mortality from diarrheal diseases. The BMN health strategy has sustained this emphasis and, like USAID, has identified ORT as the prime therapy. At the field level, village health workers also reflect the central government's concern with these two interventions, allocating a good proportion of their time to giving immunizations and providing counseling on ORT (see Section IV.1.1.4).

Although a strategy to combat ARI has been included among the BMN health goals, neither nutrition-related interventions nor efforts to curb the effects of ARI have been given much emphasis by HMG or USAID. With respect to maternal health (pre-, peri- and postnatal care), although it has begun to receive some attention, the USAID project does not have separate output indicators to measure progress in this area.

VI.2 Immunization

The project effort to carry out a major immunization campaign provides an interesting case study on the relative merits of vertical programs and integrated programs. Like the FP/MCH project, the expanded program of immunization (EPI) was already on-going when the IRH/FPS project began in 1980. Currently, the EPI program provides immunization in 53 of the country's 75 districts (approximately 70 percent), while the ICHSDP provides services in the other 22 districts (30 percent).

Under the EPI, which receives most of its support from UNICEF, an EPI supervisor and two to three assistant supervisors are in charge of each district. They are expected to cover

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[6]These include child spacing and family size limitation, diarrheal disease control, communicable disease control, and nutritional improvement.

each ward once every three months, assisted by the respective health post VHWs or PBHWs. In ICHSDP integrated or partially integrated districts, VHWs are expected to provide immunizations six days per month in their respective villages.

A.I.D. has assisted the national immunization program in several ways, both directly and indirectly. The substantial operating cost support from USAID to the ICHSDP project represents indirect support insofar as immunizations are one of many activities carried out by VHWs. More directly, A.I.D. child survival supplemental funds were provided for an intensive tetanus toxoid campaign conducted in three districts by the EPI vertical program. Project support to the EPI program, on the other hand, has been very limited.

Coverage has expanded substantially in both EPI and integrated districts, although considerably more effort is needed to achieve additional coverage (see Appendix B).[7]

In integrated districts, immunization programs for children are popular with the villagers and with health post staffs. Both groups believe immunizations are beneficial and find them relatively easy to deliver and receive. Women are frequently reluctant to accept tetanus toxoid for themselves, however, and tetanus toxoid coverage lags behind the others. Integrated health post staffs regard the immunization program as their own and take responsibility for planning and managing it.

In contrast, health post staff in EPI vertical program districts are not involved in planning and managing the immunization program, as demonstrated by the absence of any targets and schedules exhibited in their posts. More serious, the typical official in charge of the health post in non-integrated districts feels his function is only to provide out-patient curative care services, not to support basic preventive services.

On the other hand, the integrated districts do not always receive the technical and logistical support they need. At least one integrated health post visited had not received any technical support or supervision from an EPI technician during the preceding year.

Both integrated and EPI districts have problems in maintaining vaccine viability in the field. Cold chain refrigeration equipment is now available at most district headquarters and ice pack vaccine carriers are used regularly. Nevertheless, many vaccinators (VHWs and others) stay out on the trail for six days without ice pack resupply, and vaccine effectiveness may diminish during the last days of each six-day cycle. Where serious equipment shortages still exist, UNICEF, the major supplier in the past, has plans for large purchases.

Vaccine, syringe and needle supplies appear to be adequate and available as needed. In the integrated districts, a peon from each health post goes to the district headquarters each

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[7]With regard to reliability of the data reported, coverage surveys are conducted routinely as a check on service data. As a further quality control measure, an International Program Review, with participation of USAID/WHO/UNICEF/HMG, was done in 1985 and another is proposed for 1989/90.

month to obtain supplies and ice packs. Each district office sends a staff member to Kathmandu or to a regional EPI distribution center periodically to replenish vaccines supplies.

Recommendation

43) Immediate attention must be paid to maintaining the cold chain for vaccines taken to the field for extended periods.

VI.3 Diarrheal Disease Control

With the announcement of the national plan for control of diarrheal diseases, ORS promotion was adopted as a regular function of all integrated health posts. A commercial ORS product (Jeevan Jal) conforming to WHO standards is produced by Royal Drug Limited and purchased and distributed throughout the country by UNICEF and the CRS program. A homemade sugar and salt solution called Nun-Chini-Pani is also promoted.

The MOH diarrheal disease control program has made substantial progress since 1983 in promoting awareness and use of ORS throughout the country. As determined in a 1986 program review by HMG/WHO/USAID/UNICEF, and more recently in several studies conducted by John Snow, Inc. and other groups, it is evident that awareness of Jeevan Jal and Nun Chini Pani is high throughout the country.

The CRS company is doing a good job of placing Jeevan Jal in retail outlets throughout the country and increasing public awareness of its use. The Royal Drug Company has produced 4.9 million packets of the product, and in 1987 the CRS company sold Jeevan Jal packets through approximately 14,000 retail outlets at the district level. On the other hand, Jeevan Jal packets are still not available in sufficient quantities at all health posts and to the outreach workers.

Actual use of ORS also remains very low. A recent national sample survey found that only 14 percent of all diarrheal episodes were treated with Jeevan Jal and 12 percent with Nun-Chini-Pani. Instead, antidiarrheal drugs and antibiotics are widely and often inappropriately used.

Moreover, major problems remain in increasing effective use of both Jeevan Jal and Nun-Chini-Pani. Recent operational research studies have found these problems to be due to imprecise instructions and understandings about preparation and use. Problems include variation in sizes of measuring containers (tea glass) and in the quantities that must be consumed to be effective. More serious is the common health worker practice of promoting ORS as treatment for all diarrheas, including dysenteries and chronic diarrhea. Workers are not trained to distinguish between these or to identify the acute watery, dehydrating cases for which ORS is appropriate. The promotion of ORS for all diarrheas may cause delayed treatment for the non-self-limiting acute types and damage the image and acceptance rate of ORS.

Part of the reason for misuse of ORS is that training and educational materials are not uniform. In addition, technical supervision and support to the health posts and their workers for these activities is inadequate.

Finally, it is inherently difficult to explain the proper use of ORS, and (unlike immunizations) workers are seldom present for the actual administration so they cannot correct mistakes and ensure correct usage.

A larger problem arises from the decision to concentrate on ORS, essentially a curative intervention, and not also on improved environmental sanitation and personal hygiene, which would help prevent diarrhea. Because improvements in sanitation will be very slow, it is probable that the number of cases needing to be treated with ORS will not diminish for many years.

Recommendations

44) Major attention should be given to improving IEC support for ORS by focusing on the technical problems identified in its use.

45) Supplies of Jeevan Jal must be made readily available to all health posts and outreach workers.

46) Further operational research should be conducted regarding effective use of ORS, including container sizes and packet shelf life.

VI.4 Acute Respiratory Infection (ARI)

ARI is estimated to cause 40,000 deaths annually among children under five in Nepal. Nevertheless, interest in developing an ARI intervention program is only very recent. A small-scale pioneering study on ARI in the Kathmandu Valley supported by UNICEF was followed by a large USAID-supported study in Jumla District in the Midwestern Region, USAID's first initiative in this area. These studies have provided enough data to show the magnitude of the problem and give insights for program development. The Basic Minimum Needs strategy for ARI includes training various levels of health workers to identify and treat ARI, public education about harmful effects of smoking and promotion of use of smokeless cooking stoves, and provision of immunization against measles and whooping cough. The program will be started in one district this year and is to cover 11 districts by the end of 1992.

Because ARI is a new area for both Nepal and most developing countries, the MOH will have to proceed carefully, ensuring thorough planning and close monitoring and supervision. Training of health post paramedical staff will be particularly important. At present, staff are unable to diagnose accurately the variety of respiratory system complaints they see or to provide appropriate treatment. Likewise, the extensive use of antibiotics required for ARI treatment will require especially careful training, monitoring and supervision.

Recommendation

47) The MOH should proceed with the proposed program to train health workers to recognize and treat ARI.

VI.5 Nutrition

The Nutrition Section of the Public Health Division of the MOH claims to carry out nutrition activities in 21 districts, focusing on growth monitoring, nutrition training and education, and distribution of iron folate, Vitamin A and deworming tablets (antihelminthics) through health posts.

Evidence of growth monitoring activities, however, was found in only one of the 20 districts visited. Mothers are generally not aware of the importance of monitoring growth of their young children as a measure of their healthy development. In addition, health post staffs and fieldworkers seem to do very little nutrition education and have virtually no IEC materials for this purpose.

Although nutrition education is clearly one of the weakest elements of the district health programs, the burden the other Basic Minimum Needs interventions already place upon the fragile health post/fieldworker system suggests that efforts to strengthen significantly the nutrition activities in the near future would probably be counterproductive.

Recommendation

48) The MOH should not attempt to introduce full-scale nutrition interventions into the health post delivery system at present. If the other child survival activities are successful, together they will make major contributions to the nutritional status of young children. Nutrition activities should be added later, however, as the delivery system matures.

VI.6 Maternal Health

Although the Basic Minimum Needs policy has recently identified maternal health as an area of critical need, to date the HMG service system has paid little attention to the health needs of women of childbearing age. The low priority assigned to birth spacing, the small number of female health workers, and the lack of antenatal and postnatal services in most health institutions are all part of the picture. Available data show that about 95 percent of deliveries are not attended by either trained traditional birth attendants (TBA) or other health care personnel.

Although some health workers recognize that birth spacing will have a beneficial effect on a mother's health, the practices that lead to high maternal mortality are pervasive in Nepal: early marriage, high fertility, short intervals between pregnancies, and lack of awareness about the importance of health services for prenatal care and delivery.

Prospects for improving maternal health care services are brightening because of the strong recognition of the problem at the top, district, and local levels. The Basic Minimum Needs health strategy calls for training one TBA to serve three wards of a panchayat, with supervision and referral services supplied by assistant nurse midwives at health posts. Significant improvement of effective services by thousands of health workers will take considerable time and effort, however. Strong pregnancy spacing efforts will be required to complement improved prenatal and postnatal services and to increase the demand for those services.

Recommendations

49) The MOH should implement its plans for a major program of training and supervising TBAs.

50) Obstetrical services should be strengthened at health posts and referral hospitals.

51) Maternal nutrition outreach services from health posts should be strengthened.

VL7 General Recommendations for Child Survival Interventions

52) USAID should continue to increase its emphasis on child survival activities. Full attention should be paid to strengthening the two major child survival interventions --immunization and diarrheal disease control--and new emphasis should be accorded to maternal health. An increased effort to promote and provide birth spacing methods in family planning (see Recommendation 35) is in accordance with this overall focus on child survival.

53) The MOH should accelerate integration of immunization and family planning (birth spacing) programs into all districts in order to make them integral parts of each health post's total child survival program.

54) The revised job description for the VHW (see Recommendation 6) should focus primarily on the key child survival activities. VHWs will need regular refresher training that focuses on these activities.

55) Those workers from vertical programs (especially PBHWs and workers from the EPI program) who become part of the integrated health post staff and above will need to enlarge their fields of expertise through training in the full of range of child survival activities.

56) The MOH must improve technical supervision of outreach workers (VHWs, PBHWs and CHLs) and strengthen their technical abilities in child survival activities. With respect to ORS, fieldworkers should be trained to refer the non-acute diarrhea cases for proper treatment at health facilities.

VII. RESPONSE TO SCOPE OF WORK QUESTIONS

The evaluation scope of work contained questions on five issues of interest to USAID: integration; decentralization; service mix; institutionalization of family planning services; and the Health Planning Division. In this chapter, questions are reordered and grouped together as appropriate to avoid repetition and ensure logical progression. Their numbering corresponds to the original scope of work.

VII.1 Integration

Question 1. To what extent, at what level (Central/Regional/District) and with what conditionality should USAID continue to support and finance administrative and organizational reform of the MOH service delivery system?

The massive administrative and organizational changes in the MOH service delivery system deemed necessary to enable the move to integration (see Chapter II) have all the earmarks of policies that are compatible with A.I.D.'s own programming emphases, particularly the plan to transfer authority and responsibility to local officials, community organizations and user associations. Various actions already taken by the MOH (e.g., staffing the regional offices) suggest that there will be a serious effort to make the new system work. Several more changes will be needed, however, some of which might offer conditions that USAID could use as indicators of progress and criteria for continued support (see Chapter VIII). In short, because health planning and management in Nepal is concerned above all with designing and consolidating the administrative and organizational reform of the MOH service delivery system, the argument appears very strong that USAID should continue its support to these efforts.

Support is needed at all organizational levels since in every case (regional, district, health post) functions and procedures are new and will be difficult to implement successfully. The most critical new activity, however, is the involvement of the community at district and health post level: This represents a necessary condition for the success of the new service delivery system, and it is at this level that the strongest support is merited.

The idea that USAID effort should be strongest at the lowest level and diminish progressively at the higher levels is also in line with USAID policy objectives: that emphasis should be on higher quality and greater impact of basic services in rural areas, and on strengthening the authority and capacity of local administration, community organizations and resource user groups.

Question 2. What have been ICHSDP's specific successes and failures in FP/MCH, ORT, EPI, and Malaria and what are the prospects for replication of positive impacts?

In a number of health centers integrated through the ICHSDP program, services are being delivered quite effectively. In particular, the innovative ideas for community involvement (CHLs and drug resupply schemes) seem to be a positive addition, increasing the manpower available to deal with minor medical problems at the local level and motivating villagers to take

some responsibility for immunizations, ORT, and family planning. On the other hand, the staffing, supervisory and job definition problems that have beset the integration process have taken a toll on the effectiveness of this approach. This is not to say that supervision and job definition are not problems in the vertical systems, in particular in the realm of family planning/MCH. The lessons learned as a result of these problems, however, should facilitate not just replication but improvement of the integrated approach. Specifically, it will be important to limit the interventions required of the fieldworkers to a few priority areas and to develop the skills of supervisors so that they will do a better job in motivating workers.

VII.2 Decentralization

Question 1. In the context of virtually no implementation of decentralization, does USAID have a role to play in decentralization?

Question 2. What can USAID do to assist the MOH to develop and implement a policy and plan of action for decentralization?

Question 3. How best can decentralization be achieved, e.g., as a phased, or country-wide, or focused program?

The promulgation of practical staffing schedules for Regional and District Health Offices, the apparent intention to fill these posts, and the authority over personnel matters (posting and salary increments) are all delegated to Regional Directors, suggesting that decentralization in the MOH is intended to work. Budgeting is still highly centralized, but the National Planning Commission views decentralization as a policy imperative for the country and sees the delegation of some financial decision-making as a practical possibility. There are signs that decentralization is making some headway. Some District Health Offices have reduced technical performance targets provided by the Health Planning Division, and the revised figures have been accepted. District *panchayats* have exercised some influence over budgets and program decisions (see Section II.3.3.3).

In sum, the policy decisions have largely been made, and the task now is to design and implement procedures and train health staff to operate them. Assistance will be called for in

- Developing flexibility in the central planning and budgeting process in order to make it an instrument for encouraging district initiatives;
- District and health post planning and budgeting; and
- Strengthening community participation at district and health post level.

Because the practical effects of decentralization are likely to be extremely important in the delivery of health and family planning services, USAID clearly has a role to play in assisting in the process.

What might make sense at this point would be to test the decentralization system within one region (see Recommendation in Section VIII.2.2.1). USAID should not presume to take

on responsibility for supporting decentralization nationwide. If an experimental approach works in one region, the products of that process can be applied nationwide, as appropriate, with techniques developed nationally having been tested and applied in the chosen region as appropriate. This would represent the best way to achieve long-term institutionalization at the regional level.

Question 4. What operational efficiencies would be obtained [through decentralization] that would free potential resources for alternative uses?

If responsibility and authority were located and used at the district level, district budgets and plans would be more realistic and therefore would probably lead to a more careful and efficient use of resources. If coupled with greatly improved financial accounting practices, decentralization should also result in allocation of available resources to priority problems; moreover, resources could be applied to their intended use rather than, as now, remaining unused or being diverted to less productive alternative uses.

Finally, community participation and commitment might attract new resources to health activities.

Question 5. What are the implications for donor funding (level and duration of resources) if decentralization is initiated?

Any donor funding with a national scope (e.g., provision of supplies) will be unaffected by decentralization. Donor funding that is more limited in scope--e.g., to support new procedures or activities--will most likely be implemented only within one or more districts, preferably all in one region.

Resources in support of decentralization will be needed for at least 10 years. It will take this long to realize the practicable potentialities of decentralization throughout the country, partly because of the changes in attitude and the development of capabilities called for in the districts, partly because of the time it will take for changes and developments to spread from pilot districts to others, and partly because of the time it always takes to move authority to lower levels of an organization.

VII.3 Service Mix

Question 1. What is a proper service mix for Nepal and how can USAID assist in achieving that balance?

Two recent developments--the issuance of the Basic Minimum Needs goals and the decline in VSC procedures performed on an annual basis--make a compelling case for strengthening the birth spacing and MCH components of the USAID project while also continuing to pursue and improve the VSC component. For the first, birth spacing and MCH services must be expanded greatly in order to achieve the Basic Minimum Needs maternal health and child survival goals by the year 2000. For the second, temporary contraceptive use prevalence must be greatly expanded in order to reduce population growth rates (along with permitting mothers to give more attention to ensuring the healthy survival of already-born children). Reduction in population growth rates

can never be achieved through VSC alone. Evidence from small-scale NGO projects suggests that temporary methods prevalence can be increased. Although information available is not sufficient to set forth service mix targets, an appropriate balance will emerge if due attention is paid to each component, as HMG policy now demands.

USAID can assist in achieving that balance by providing strong support to current HMG plans to integrate and decentralize its health and family planning service delivery system and by supporting HMG plans to institutionalize family planning services in the Terai. Together, successful integration and decentralization should result in a service mix appropriate to local conditions and demand.

USAID can also assist the MOH to achieve a more appropriate balance between temporary and permanent methods by supporting and encouraging efforts, including those of other donors, to provide clinical temporary methods (IUDs, Depo-Provera, and Norplant) where appropriate.

Question 2. How can the program emphasis be shifted from a reliance upon new acceptor data to the concept of current user data?

This change of emphasis will depend upon 1) MOH leadership in redefining family planning annual targets and motivating workers to expand delivery of temporary methods, and 2) educating the health and family planning workers to comprehend the importance of continuing contraceptive use. Mission staff and the JSI team are currently working with key MOH personnel to educate influential HMG decision-makers outside of and above the health field to understand the importance of promoting temporary birth spacing methods. Such efforts should continue.

Question 3. What are resource implications for HMG and donors and at the local level (e.g., community support, user fees)?

A more balanced service mix will have important financial and human resource implications for HMG, donors and the communities. Some significant formal changes will be involved, including additional costs of establishing and maintaining year-round VSC (and temporary family planning and MCH services) facilities where appropriate.

A substantial investment will have to be made to train (and retrain) current and new health and family planning managers and workers to provide an appropriately balanced service mix of permanent and temporary contraceptive methods and priority health services. Donors can certainly assist with this aspect of the HMG program.

Increased community financial and manpower support will be required to provide an appropriate mix of health and family planning services on a sustained basis. Fortunately, evidence from a number of MOH and NGO activities suggests that individual households, communities, and local political leaders will provide their time and money to support such priority health and family planning services.

Question 4. Are there organizational or operational efficiencies that could be achieved, thereby freeing up resources for alternative uses?

Reduction in the number of VSC camps held each year would free up the substantial financial and human resources currently directed to VSC. The financial savings could be applied to support the cost of increasing other services. Reallocation of most of the human resources currently dedicated to the seasonal camps would be more informal since personnel would simply devote more time to their regular jobs. Overall, however, the potential total savings from the reduction of camps would appear to be substantial. On the other hand, the recommended alternative of institutionalization would not be inexpensive either and would require hiring of new full-time personnel.

Question 5. Are opportunities present for expanded private sector involvement and resources in health/family planning services delivery?

There is some evidence (although not yet systematically compiled) of the willingness of rural Nepalis to pay for health and family planning services. In addition to experiments by the NGOs in local level fee-for-service schemes (see Section V.3.3) and a good CRS company experience (see Section V.4), people also provide modest in-kind compensation or gifts to traditional healers and traditional birth attendants. More affluent villagers also pay relatively large sums for drugs that are available in the local market and for after-hours "house calls" by MOH health post personnel. On the curative side, several private hospital projects are under way or planned.

Although HMG policy has been to provide free basic health services, there is a strong tacit understanding that government resources will be insufficient to provide the level of services required. In view of the experiments made to date, and in expectation that delivery of appropriate health and family planning services "mixes" (integrated and decentralized) will elicit positive community and household responses, it appears that prospects are good for generating fees for some services and thereby expanding opportunities for private sector involvement.

VII.4 Institutionalization of Family Planning Services (VSC and Temporary Methods) in Fixed Facilities.

Question 1. What is USAID's future role in assisting the MOH to develop and implement a policy for institutionalizing family planning in fixed facilities?

USAID could provide technical and financial assistance to implement the recently adopted FP/MCH plan to institutionalize VSC services in static facilities, in conjunction with temporary methods, starting in the Terai and Kathmandu Valley. Any such assistance should be coordinated closely with UNFPA and other appropriate donors. Some investment in equipment and facilities will be required if district hospitals are to offer these services on a year-round basis, but the most critical factor will be training and supervision of hospital staffs to perform the procedures and to maintain high quality standards. USAID could play a major role in this.

Although chances for institutionalizing VSC and temporary methods are good in the short term, the prospects for long-term sustainability will depend on MOH management practices. Here too, however, there is room for optimism:

1. Senior MOH officials agree that the services should be institutionalized;

2. The decline in numbers of VSC procedures being done annually means there is little justification for the expense and system dislocations inherent in the camp approach;

3. Instead, pressure is growing to channel resources into integrated services to achieve BMN goals; and

4. Doctors are increasingly unwilling to participate in the long and demanding camps; for most doctors, financial compensation is less than in their private practice, and for many other VSC providers, the compensation does not outweigh the stress and inconvenience of working in camps.

Question 2. <u>In the context of lessons learned, especially regarding institutionalization of family planning services, what are the benefits of the project that are likely to be sustained after USAID funding ends?</u>

If USAID funding of the IRH/FPS project were to terminate in July 1988, the most notable long-term effect would be the 300,000 persons who have received permanent contraception. It is true, however, that provision of sterilization services could not be sustained at the current level without continued financial support from donors.

At this time, the only viable approach to institutionalizing family planning services is to incorporate them within the HMG integrated health and family planning services program. Here, too, USAID has made a contribution through its support of the ICHSDP program. Specifically, the current model of fully integrated service delivery is based on the ICHSDP model supported through the project. Even if the model remains imperfect, it is fair to say that the project has proved to be a laboratory for its development and that the lessons learned during this process have served as the basis of the recommendations made in this report as to how services should be delivered at the local level.

Question 3. <u>What can reasonably be expected, given the current administrative situation?</u>

Realization of all of the planned innovations--institutionalization of family planning services, integration, decentralization, regionalization, community participation, and attainment of Basic Minimum Needs health goals--will require far more managerial determination by top MOH officials than has been demonstrated in the past. Their handling of key decisions during the next year will reveal their intentions and determine the course of events for the next 12 years, to the year 2000, at least.

If key decisions on staffing, planning, and budgeting permit integration, decentralization, and regionalization to proceed as intended, the "current administrative situation" referred to above will no longer prevail and progress will depend on the provision of manpower and reliability of financial support.

VII.5 Health Planning Division

Question 1. What are HPD's achievements to date?

HPD's participation in management reviews and surveys on the various levels of integration at health facilities has increased its ability to analyze trends in the integration process. In addition, the HPD was actively involved in the development of the Seventh Five-Year Plan and Basic Minimum Needs health goals.

Question 2. To what extent is the MOH interested in continuing, strengthening, and utilizing HPD?

Although the MOH has included funding for the HPD in its budget and has identified specific tasks for it to perform, whether appropriate staff, budget, and policy support will be forthcoming remains unclear. At present, HMG is covering only one quarter of HPD's operating costs.

Question 3. Is continued funding warranted under the new project?

The new project should include continued funding for the HPD for two reasons:

1. The planning process has been recognized as an important element in making decentralization work, and the HPD is an integral part of that process; and

2. An adequate information system is essential for effective management, and here again, HPD, by virtue of its management information system, will play a vital role.

VIII. MAJOR CONCLUSIONS AND RECOMMENDATIONS

VIII.1 Conclusions

The climate in Nepal is currently very propitious for launching new reform initiatives in the health sector. The government appears more committed than ever before to achieving an integrated service delivery system nationwide and to transferring the strengths of the vertical systems (outreach and strong technical supervision) to the integrated system. The government also seems committed to shifting some responsibility to the local levels and to achieving set targets.

Many constraints inherent in the system remain, however. Management systems are not well established, staffing is not in place, and many procedural issues need to be addressed before integration can proceed. In addition, supervisory techniques are not effective; recruitment criteria for FP/MCH's supervisory personnel are not appropriate; job descriptions of fieldworkers are not well conceived; and communities are often not well attuned to the supportive and involved role they might play in the new system.

Role of USAID

To date, the USAID project has focused on short-term objectives rather than on the underlying problems in the health system. During the initial project period (1980-84), the project directed its resources primarily toward family planning, and in particular toward the VSC program. On the management side, the project design tended to focus on surface problems rather than the more fundamental constraints that have impeded effective delivery of health and family planning services. Even the ICHSDP project, though an effort to integrate services at the field level, did not deal with the basic management issues that were characteristic of the HMG and MOH systems as a whole.

On the other hand, USAID's decision to focus resources on VSC may have been appropriate at the time. There was a tremendous backlog of demand for permanent contraception, the level of MOH commitment to more far-reaching reform was uncertain, and the ability of field personnel to provide integrated health services to rural communities was also unproven.

Probably the principal lesson learned from this project is that USAID should not expect to accomplish more than HMG is prepared to do. In determining whether, and for what objectives, to provide continued support for HMG health and family planning initiatives, USAID must assess carefully the prospects for accomplishing the objectives, based on the probable impact which the current political initiative will actually have on MOH management practices. Assuming a positive outcome of that assessment and the design of a follow-on project, USAID should adhere to a mutually accepted project agenda to achieve the HMG objectives as stated.

VIII.2 Recommendations

VIII.2.1 Transition to New Project

The current USAID project should be continued until 1989/1990 to provide a bridge to the new project. Maintenance of consistent A.I.D. support through the current critical transition period, from centralized, vertical projects to decentralized programs, will be important. More important, however, will be the efforts during the next 12 to 18 months in designing the new project. The key will be close cooperation between USAID and HMG to develop a strategy for the transition. Given their understanding of HMG and MOH systems, and the important intermediary role they play between the MOH and USAID, the current JSI advisors should be major participants in the design of any new project.

Specifically, the BMN program offers a chance for USAID to tie its assistance to indications that HMG is itself making progress toward its professed goals of integration, decentralization, and regionalization. In order to use this approach, however, USAID and HMG need to identify a set of critical management measures to be taken to implement the changes and to agree on a timetable for their initiation. Measures should be carefully chosen, limited to those upon which success will hinge and which both parties can use as meaningful performance indicators. One set of indicators should be used as pre-conditions for a new A.I.D. project and will need to be implemented during the next 12 to 18 months. A second set should be used as performance benchmarks throughout the life of the project; their implementation will determine the rate at which A.I.D. funds are released in the course of project implementation.

Three preconditions are suggested for starting the new projects:

- District Health Officers must be assigned and have received initial training in all 75 districts;
- Regional Directors must be given the authority they need to carry out their duties; and
- Regional Director's offices must be fully staffed.

Achievement of these three indicators will not be simple and will not solve all the problems, but at least it will signal that the administrative machinery is in place to proceed to more fundamental reform.

Finally, efforts should be made to tighten financial administration of the current project, as follows:

- **USAID should continue to pursue reductions in its funding share, as appropriate, during the remaining period of the project (#1).**[8]

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[8]The numbers in parentheses correspond to the numbers of the Recommendations as they occurred in preceding sections of this report.

- **HMG should make every effort to assume a larger share of these program costs, and seek measures to reduce costs and increase productivity (#2).**

- **USAID should continue to press for improved financial accountability and program planning, within feasible limits (#3).**

VIII.2.2 New Project

The new project should capitalize on the impetus now evident in the health sector and attempt to assist HMG to realize the promise in its effort to integrate and decentralize those services. In particular, support will be needed to make decentralization an actuality.

VIII.2.2.1 Pilot Region. Because the management changes being called for by HMG, and supported by recommendations in this report, are revolutionary in their scope, it might be prudent to test them first on a pilot basis in one region. Changes will need to take place at each level: central, regional, district, fieldworker, and community. HMG will bear the main responsibility for making reforms, but USAID can provide training and technical assistance wherever appropriate.

At the central level, some continued assistance will be needed for planning, including a special effort to improve the management information system. Specifically,

- **HPD should consider carefully how it can improve the reliability of the data received from the field and reduce delays in data transmission to headquarters (#15).**

- **The computer capabilities of HPD must be strengthened if it is to be responsible for the health management information system. On the other hand, introduction of computers into regional offices should wait until the basic monitoring and planning procedures are working well using manual methods (#16).**

- **Efforts are needed to make the process less centralized. As a start, simple planning procedures should be designed and tested. District staff also must be trained in their use before the 1989 planning/budgeting cycle begins (#17).**

At the regional level, skills will need to be developed in planning, budgeting, monitoring, supervision, training, coordination, and managing an information system;

At the district and health post level, training will be needed in supervisory practices both on how to increase field visits and how to use more supportive supervisory techniques. Staff will also need training in their new functions of planning and budgeting and working with community representatives to ensure their input in the decentralized system. Specifically,

- **Reasons for the wide variability of health posts' performance should be examined, in order to determine appropriate measures for making improvements (#5).**

- **Supervisory personnel at health posts and District Health Offices need training in supervision techniques. In particular, the training needs to emphasize that the purpose of supervision is to motivate workers and improve their performance, not to police their activities. Technical training is also needed to improve supervisors' skills (#12).**

- **Training should be provided for those in charge of District Health Offices and health posts in how to work effectively with village health committees and how to encourage community participation (#19).**

- **Supervisors should spend more time making site visits and providing on-the-job technical assistance to fieldworkers (#13).**

- **An analysis should be made to determine what other management factors are contributing to poor supervision, and efforts made to address any problems identified (#14).**

At the fieldworker level, jobs need to be redefined, with fewer functions and better training to be able to carry them out more effectively. At the same time, training will be needed to help vertical program fieldworkers assume the wider range of responsibility needed when they become assimilated into the integrated delivery system. The restructuring of the fieldworker job description also needs to be based on a national decision as to program priorities.

- **The job description of the village health worker needs to be revised. Priorities should be established and they should be assigned fewer duties (#6).**

- **Consideration should be given to reducing the territory VHWs must cover. VHWs should...make greater efforts to know the target population and number of eligible couples [in their jurisdictions] (#7).**

- **VHW stipends and travel allowances should be increased if necessary (#8).**

- **More female fieldworkers (PBHWs, VHWs, or other) should be recruited...The report of the PBHW Effectiveness Study conducted by JSI/Nepal in 1987 contains further analysis of weaknesses in the system in which the PBHWs work and should be consulted in design of any new project (#24).**

- **Supervision of PBHWs at the district and health post levels should be improved (including substantive support) (#25).**

- **PBHWs who have performed well should be recruited for the VHW position, whenever possible (#26).**

At the Community Level, efforts are needed to ensure that the involvement of the community is proceeding as originally intended, i.e., that communities are actively involved in planning ways to improve local health services, not simply being exhorted to raise funds to support community health leaders.

- The MOH should conduct, or improve, community orientation programs that focus on the role of the CHL in the community and the community's role in supporting CHLs (#9).

- Selection of CHLs should take place after proper consultation with the community. Criteria for selection need to be updated (#10).

- Regular refresher training should be provided to CHLs. Health posts should improve their supervision and support of community workers (#11).

- Every effort should be made to increase community participation at health post and district levels, to encourage village health committees to demand better health services, and to take active steps to obtain them through the central budget and by their own contributions (#18).

- Those in charge of health posts should be encouraged, motivated and trained to mobilize community participation and leadership in health post services. This might include public recognition and reward for health post officials who achieve strong community participation. Local experiments should be encouraged, and successful experiences widely disseminated (#20).

VII.2.2.2 Service Delivery Priorities. To some extent, local program emphasis should be based on the epidemiology of specific districts. The project, however, should focus on these priority services: birth spacing and referral for VSC services together with three child survival interventions--immunizations, diarrheal disease control and ARI control--and maternal health.

Family Planning Services

- The family planning program needs to be shifted from concentration chiefly on VSC toward a greater genuine effort to provide temporary methods, with referral for VSC as appropriate. FP/MCH's plans to increase promotion and continuing use of temporary methods should be vigorously pursued (#35).

- Promotion and use of clinic-based spacing methods (IUD, injectables, Norplant) should also be increased, particularly for people who live close enough to a service provider to be able to return in case of complications or desire to discontinue the method. It may be easier to achieve higher continuing use and satisfaction levels with these methods than with pills and condoms. More auxiliary nurse-midwives, staff nurses, public health nurses and others will need to be trained in these methods and necessary supplies made available. These efforts should proceed in a pilot-project manner, so that quality services can be provided and the results monitored through operations research. Expanding quickly to national coverage is likely to result in inadequate counseling and side-effect management and give the method a bad reputation, as has happened with the pill and, in other South Asian countries, with IUDs (#36).

Temporary Methods

- Efforts to increase the continuing use of pills and condoms for spacing should be stepped up. Pills and condoms should be promoted the most vigorously as the most appropriate temporary methods for people who do not live near a health facility. Training and retraining of field staff must be provided in motivating couples to space children and in counseling to handle pill side-effects and fears thereof (#37).

- Targets for temporary methods should be established based on continuing users rather than new acceptors. Both PBHWs and their supervisors should be trained in how to gather information on continuing users (#38).

- IEC materials and activities to promote birth spacing should be developed and used. IEC should promote birth spacing as (1) an essential part of child survival and as (2) essential for reducing maternal deaths. The message should be emphasized in ongoing and planned community activities-- including MCH intensification programs, local elite training, mothers' groups, meetings of VHCs and with *pradhan panchas* (#39).

- Non-monetary ways to reward personnel for achievements in promoting birth spacing, as well as overall positive performance, should be developed. Strategies used in other countries should be studied (#40).

Permanent Methods

- Efforts to institutionalize family planning services in static year-round facilities should be pursued. Until VSC capabilities have been institutionalized, the mobile camp strategy should be continued in most hill and mountain districts (#41).

- Promotion and provision of vasectomy for men and minilaparotomy for women should be expanded (#42).

General

- USAID should continue to increase its emphasis on child survival activities. Full attention should be paid to strengthening the two major child survival interventions--immunization and diarrheal disease control--and new emphasis should be accorded to maternal health. An increased effort to promote and provide spacing methods in family planning (see Recommendation 35) is in accordance with this overall focus on child survival (#52).

- The MOH should accelerate integration of immunization and family planning (birth spacing) programs into all districts in order to make them integral parts of each health post's total child survival program (#53).

- The revised job description for the VHW should focus primarily on the key child survival activities. VHWs will need regular refresher training that focuses on these activities (#54).

- **Those workers from vertical programs (especially PBHWs and workers from the EPI program) who become part of the integrated health post staff and above will need to enlarge their field of expertise through training in the full range of child survival activities (#55).**

- **The MOH must improve technical supervision of outreach workers (VHWs, PBHWs and CHLs) and strengthen their technical abilities in child survival activities. With respect to ORS, fieldworkers should be trained to refer the non-acute diarrhea cases for proper treatment at health facilities (#56).**

VIII.2.2.3 Support of Activities begun under Existing Project/New Activities. Only selected activities under the existing project should be supported under the new project. Neither construction of health posts nor support of the drug delivery system should be continued (see Recommendations 4 and 22). Instead, efforts should focus on the most successful undertakings under the current project; specific project components might include

- **Provision of contraceptive supplies nationwide;**

- **Small-scale operational research on priority services delivery issues at the community level (e.g., ARI, ORT, cost-effective drug supply efforts), including research capability strengthening (see Recommendation 30); and**

- **Support for VSC camps in hills and mountains;**

- **Continued support to an increasingly private CRS company (see Recommendations 32-34); and**

- **Continued support for NGO health and family planning programs (see Recommendations 28-31).**

Support should also be given to the following new activities:

- **Establishment of static family planning facilities in the Terai;**

- **Development and operation of an appropriate management information system for nationwide application;**

- **Support for private sector family planning clinics in urban areas;**

- **Public health skills training for middle and high level officers (e.g., MCH, epidemiology, planning, and management); and**

- **Support for innovative strategies at the district level and below.**

APPENDICES

APPENDIX A
STATEMENT OF WORK

Appendix A

STATEMENT OF WORK

A. Title: IRH/FPS End-of-Project Evaluation.

B. Contract objective: To provide administrative and Technical Assistance Support to conduct the end-of-project evaluation for Project 367-0135.

C. Background: Since 1980 US A.I.D./Nepal has provided approximately $ 31,721,000 in Health, Population and Child Survival funds to Nepal's Health and Population programs through both the Ministry of Health (MOH) and the Private Sector. A Mid-Term Evaluation was conducted in November, 1984. The purposes of the Final Evaluation are:

i. To review project implementation and progress since 1984 against stated indicators;

ii. To identify lessons learned;

iii. To provide programmatic recommendations to US A.I.D./Nepal and MOH in regard to the design of the follow-on bilateral project; and

iv. To provide US A.I.D./Nepal and the MOH with a written report outlining the lessons learned and recommendations.

It is important to note that this is primarily an evaluation of US A.I.D.-assisted activities and not an evaluation of the GON program as a whole. However, from the lessons learned and the recommendations, Mission and MOH wish to design a focused, balanced, and implementable new project relevant to Nepal's current program needs.

D. Scope of Work: Technical Assistance is requested to assess progress against revised project impact targets, outputs, and implementation schedule approved by A.I.D./W in March 1984 following the Mid-Term Evaluation and Project Extension. In particular, Mission is interested in "lessons learned" to be applied to follow-on project design. In the context of assessing overall progress, Mission wishes the Evaluation Team to focus on five main topics to feed into development of new Child Survival/Family Planning Services (CSFPS) Project (367-0157) PID and PP. Evaluation Team will also be expected to review, synthesize, and incorporate findings from overall recent studies/reports as well as various completed studies commissioned by HFP office as they relate to key issues outlined in this SOW. Mission is particularly interested in addressing the following topics which are also currently being debated at the highest HMG levels of the GON.

i. Integration: Integrated health and family planning service delivery remains a GON commitment; the vertical integration effort (ICHSDP Project) has just been abolished and its activities placed under the new Public Health Division, MOH. Team shall address the following questions:

1) To what extent, at what level (Central/Regional/District) and with what conditionality should US A.I.D. continue to support and finance administrative and organizational reform of the MOH service delivery system?

2) What have been ICHSDP's specific successes and failures in FP, MCH, ORT, EPI, Malaria, RTC, and what are prospects for replication of positive impacts?

ii) Decentralization: While decentralization and institutionalization are akin to each other, Mission is interested in addressing this issue separately. The current Civil Service System and its administration are characterized by "source and force" and patronage. Also, financial systems remain highly centralized. These systems, as currently practiced, virtually doom any hope for effective decentralization of management. At the same time, the topic of decentralization is a popular one and given abundant rhetorical time. The reality is that in the health sector decentralization has not really happened yet to any major degree. Power and authority are highly centralized. Responsibility for programs, as currently delegated--to the zones/districts, without the authority (staff, local hire, resources, budget) to carry out those programs --also basically negates decentralization. The MOH has yet to give detailed definition to what decentralization entails and how to go about it. Team shall address:

1) Within this context does US A.I.D. have a role to play in decentralization?

2) If so, what can US A.I.D. do to assist the MOH to develop and implement a policy and plan of action for decentralization?

3) What are the implications for donor funding (level and duration of resources) if decentralization is initiated?

4) How best can decentralization be achieved--e.g., as a phased, or country-wide, or focused program?

5) What operational efficiencies would be obtained, thereby freeing potential resources for alternative uses?

iii. Service Mix: Under Project 0135, service mix has been considerably skewed toward family planning, and in particular VSC. Mission desires an objective assessment of an achievable service mix to aim for under new CSFPS project, especially in terms of MCH, VSC and birth spacing (temporary methods). Team shall address:

1) What is a proper service mix for Nepal and how can US A.I.D. assist in achieving that balance?
2) How can the program emphasis be shifted from a reliance upon new acceptor data to the concept of current user data (contraceptive prevalence)?

3) What are resource implications for GON, donors, and at local level (e.g., community support, user fees)?

4) Are there organizational or operational efficiencies that could be achieved, thereby freeing up resources for alternative uses?

5) Are opportunities present for expanded private sector involvement and resources in Health/FP services delivery?

iv. Institutionalization of family planning services (VSC and temporary methods) in fixed facilities: Although the MOH agrees in theory to the policy of institutionalization, measures to accomplish this objective have still to be fully defined. Team shall address:

1) What is US A.I.D.'s future role in assisting the MOH to develop and implement a policy for institutionalizing family planning in fixed facilities?

2) What are reasonable expectations for institutionalizing VSC and temporary methods in both the short and longer term?
3) In the context of lessons learned, especially regarding institutionalization of family planning services, what are the benefits of the project that are likely to be sustained after A.I.D. funding ends?

4) What can reasonably be expected, given the current administrative situation?

v. Health Planning Division: US A.I.D. has financed a significant portion of Health Planning Division (HPD) costs, including recurrent operating costs since the mid-seventies. Team shall address:

1) To what extent is the MOH interested in continuing, strengthening and utilizing HPD?

2) What are HPD's achievements to date and do they warrant continued funding under the new project?

vi. Women in Development: Regarding this issue team shall address:

1) So far has the project had any impact on increasing the role of women in management and implementation of health and family planning services?

2) How could the role of women be increased in the follow-on project?

3) How is the new Public Health Division, MOH, set up in terms of female management and staff?

4) Would the reform of the MOH service delivery system have any impact on increasing the role of women?

vii. Reporting Requirements:

The evaluation draft report in English will be prepared in Nepal and the major findings and recommendations shared with the MOH/NCP in a seminar format prior to departure. A copy of the draft report will be submitted to the MOH and US A.I.D. at the completion of the work and prior to the departure of the consultants from Nepal. Mission and MOH will have 60 days to respond to and comment on the draft evaluation report. Upon completion of the final report ISTI will provide 50 copies to US A.I.D./Nepal for distribution to MOH.

E. A.I.D. Evaluation Summary.

APPENDIX B
PERFORMANCE OF IRH/FPS PROJECT BY OUTPUT INDICATORS

APPENDIX B
PERFORMANCE OF IRH/FPS PROJECT BY OUTPUT INDICATORS

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
1. Integrated planning and management of effective services.	a. 48 districts under integrated management system.	a. There are currently <u>six fully</u> integrated districts, and an additional <u>twenty</u> 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).	a. Six partially integrated districts have been fully integrated for a total of 12 districts, 14 districts are partially integrated and the number of districts being integrated remained stagnant at 48.
	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.	b. 216 additional health posts established for a total of 816 HP's; of 816, 465 are integrated. Post creation process has inproved.
	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.	c. Budget releases remain delayed and staff absenteeism is high.
	d. Planning and management control effectively decentralized to districts due to MPD assistance.	d. Planning and management control effactively 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.	d. Planning budgeting and management control is still highly centralized.

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	e. Effective program evaluation capability.	e. Capability to monitor and evaluate program progress and achievement 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.	e. Program evaluation capability has improved.
	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.	f. All health posts constructed and handed over to HMG by Nov, 1987 and the 3 regional warehouses in 1986. No rehabilitation undertaken.
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.	a. MIS is performing poorly.

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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 MPD, the vertical projects, and DHS. The review recommended consolidation and strengthening of efforts in already integratd 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.	b. Policy formulation capability has grown, especially in the area of integration. MOH brought out a major study in October 1985 on the 'Review of the Delivery of Integrated Health Services, including Maternal and Child Care'.
	c. Health Sector Input to the 7th (five-year) plan prepared.	c. MPD has provided input for health sector policy guidelines for the Seventh Five-Year Plan. In the six months, the MPD has assumed a strengthened role in both the annual and the long-term planning process.	c. Section programming capability has grown as seen by its input to BMHH 1986-2000 long term program.
	d. Decentralized planning and administration operative in all integrated districts.	d. Decentralized planning and administration in integrated districts has not yet occurred.	d. Helped create a positive climate for integration but effect on administrative process are limited.

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Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	e. Disease-specific surveys and field operational studies performed under NPD supervision and management.	e. To date, no disease-specific surveys nor field operational studies have been performed under NPD supervision and management.	e. No research capability developed.
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.	a. Drug supply (quantities) remain inadequate. Drug user schemes have grown in popularity and are expected to grow. Drug delivery has improved in respect of timeliness and damage control. Buffer stocks have still not been established. Drug supply is standard package for each health post irrespective of size, location, workload, etc.
	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.	b. Computer-based drug ordering and allocation have been discontinued and unification of systems have not been effected. Distribution still contracted out; regional medical stores underutilised.

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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.	c. Local reimbursement for drugs schemes applied in 32 HPs. 4,500 CHLs trained, o/w 25% replenish drugs through local funds.
	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.	d. Staff and Supervisory morale are low and motivation to work is generally poor. Work on supervisory development was initiated (e.g. evaluation studies provision by TA/DA, stipulation of field supervision norms vital check lists for supervisions etc).
	e. Development of unified management information systems.	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.	e. Proforma developed but could not be implemented on a unified basis in ICHSDP and vertical projects. A new set of unified forms has been developed and is being printed.

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Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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; NNEO is testing the effects of using 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.	f. Field operation studies have been carried out of JSI but the function has not been institutionalized into the MOH.
14. 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.	a. There are presently 4570 Ward Health Committees that function primarily to select and support CHLs. These exist in 14 districts only. The functioning of Village Health Committees (VHC's) is unclear yet since 1 HP serves 4-7 villages may be more relevant for when Sub-Health Posts are established.

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Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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.	b. Supply, reporting, supervision, retraining support for CHLs is very weak.
	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.	c. Evaluation now underway in 5 districts. Adequate evaluation mechanism is not functioning for all Ward Health Committees.
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.	a. Since 1984 230 VHWs received initial basic training and 1,749 other health workers received refresher training. A total of 2399 were trained by ICHSDP. Training capability has been ICHSDP's outstanding strengths. The concept of retraining has gained acceptibility.

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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.	b. Refresher training is done routinely in all MOH programs.
	c. Training process effectively planned, supported and implemented.	c. Training cells of the various divisions within the MOH now routinely prepared annual training plans and schedules.	c. MOH units have annual training plans.
	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.	d. IEC Kits developed jointly by FP/MCH and ICHSDP and distributed to HPs. But most VHWs, PBHWs and CHLs do not have materials for use in field. Great demand exists for further investment, which was not conceived originally.
	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.	e. All participant training planned for Project has been completed. No long-term US participants after 1984 and all returned by 1985; other Mission funds used to support additional participants training.

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	Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
16.	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 contreceptive (VSC) procedures performed in Nepal during the 1980-84 period. In the past year alone, the national target of 65,000 procedures was exceeded (65,733 total).	
17.	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 MMEO, the total API was 2.17 in 1983. Collaboration between ICHSDP and MMEO has increased considerably since 1980. At present, ICHSDP provides malaria control activities in 15 districts.	a. 1987 API estimated 3.5/1000 nationwide API in ICHSDP districts is 0.7/1000.

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Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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%.	b. Approximately 30% of all diarrheal cases are estimated to be treated with ORS. But effective use is low.
	c. 40% of pregnant women receiving Iron and Folic Acid treatment in Integrated or FP/MCH covered districts.	c. Percentages are not availabe for provision of iron and folic acid treatment to women of reproductive age.	c. Approximately 6-7% of pregnant women receive iron and folic acid.
	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 rediment pre-natal care activities and both are provided inconsistently and are poorly reported nationwide.	d. Approximately 25% of women age 15-44 receive TT immunization

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
	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 7,774. 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.	e. Approximately 80% of the total estimated 100,000 leprosy cases are under treatment. 10,814 T.B. cases are 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.	f. National coverage in 1987; 40% of infants received DPT series, 79% received BCG, 50% received measles and 42% received polio.
	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%.	g. Above results are national coverage.

Desired Output	Major Output Indicator	Major Achievements 1980 - 1984	Status 1/88
		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 MCW meningitis immunization campaign in 1984 which immunized approximately 330,000 persons in the Kathmandu Valley.	

APPENDIX C
BACKGROUND MATERIALS FOR THE NEPAL EVALUATION

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APPENDIX C

BACKGROUND MATERIALS FOR THE NEPAL EVALUATION

List of documents reviewed for background paper

- Copy of the new MOH organization and names of relevant officials;
- Peter Shipp's report, "The Potential Application of Personnel Management Technology in the Gov't. Health Services in Nepal."
- New Era report, "Fertility and Mortality Rates in Nepal" (June 1986);
- JSI/Nepal report, "Health Financing and Cost Recovery in Nepal" (April 1987);
- CDC/Atlanta report, "Nepal: Logistics Assistance" (January 1986);
- CDC/JSI report, "Contraceptives Logistics Management" (March 1987);
- AVSC/FP-MCH/USAID, "Assessment of the Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal" (October 1987);
- National Commission on Population, "National Population Strategy" (1983), (Note: Read this with care, because there is a real gap in Nepal between stated/written policy and that which has/has not been implemented);
- New Era/Population Council/FP-MCH study, "Factors Related to Non-Use of Contraception among Couples With an Unmet Need for Family Planning in Nepal" (October 1987), "Summary and Conclusions" section only;
- MOH, Nepal, "Health Information Bulletin" Vol. 3, 1987;
- SOMARC trip report (selected portions), "Village Marketing Survey: Final Report of Findings and Recommendations: (January - June 1986), prepared by Katharine A. Coon for the Nepal CRS Co.;
- HMG/Central Bureau of Statistics, "Population Monograph of Nepal" (1987);
- FP/MCH, "Nepal: Fertility and Family Planning Survey Report (1986);

- MOH/Planning Division report, "Review of the Delivery of Health Services for Improving Integrated Services Including FP and MCH" (October 1985);

- Kathmandu cable #04884 on "Nepal's Program to Meet Basic Needs by the Year 2000" (6/29/87);

- HMG/National Planning Commission, "Basic Principles of the Seventh Plan: 1985 - 1990";

- Rising Nepal newspaper articles on Basic Minimum Needs. NOTE: Basic Minimum Needs is now a major development theme from now to the year 2000, and one that has improved focus on some neglected service delivery issues in the MOH;

- WHO Project, "Report of the Joint HMG Nepal/UNICEF/USAID/WHO Comprehensive Review of the National Control of Diarrhoeal Diseases Programme in Nepal" (April 1986);

- JSI background paper, "Status of Key Indicators Selected for the IRH/FPS Project 367-0135" (August 1984);

- JSI background paper, "Integration: A Historical and Conceptual Review" (1984);

- JSI background paper, "Integration and the Integrated Rural Health/Family Planning Service Project" (10/29/84);

- JSI background paper, "Nepal Health System Summary" (September, 1985);

- JSI background paper, "Structure and Functions of the Health Planning Divisions" (7/31/84); and

- JSI summary report, "End of Tour Report: November 1981 -December 1985" (12/85).

APPENDIX D
PERSONS INTERVIEWED

Appendix D

PARTIAL LIST OF PERSONS INTERVIEWED

MINISTRY OF HEALTH

Mr. Basudev Pradhan, Secretary of Health
Mr. Y.M.S. Pradhan, Chief, Planning, Monitoring and Supervision Division
Dr. Shyam Bhattarai, Chief, Manpower Development and Training
Dr. Dwrika Nath Regmi, Chief, Public Health Division
Dr. Harihar Sharma Wagle, Joint Secretary
Dr. Kokila Vaidya, Regional Director, Central Region
Dr. Tara Bahadur Khatri, Chief, FP/MCH Project
Dr. Indra Bahadur Khatri, Additional Secretary
Dr. Kalyan Mani Acharya Dixit, Chief, NMEO
Mr. Sribatsa Shrestha, Senior Statistician, Planning Division
Dr. Benu Bahadur Karki, Public Health-Officer
Dr. Fatte Bahadur Malla, Chief, Curative Services Division
Mr. Bihari Krishana Shrestha, Additional Secretary

DONOR AGENCIES

Mr. Gerardo Gonzalez, UNFPA
Mr. Ali Mahallati, UNICEF
Mr. Dick Woodford, World Bank

Nepal Red Cross Society, Family Planning and Primary Health Care Project

Mr. T.R. Onta, Executive Director
Mr. Lovely Shrestha, Project Director
Mr. Yashpal Shakya, Tansen Palpa, Lumbini Zone
Mr. Deepak Bajracharya, Administrative Officer

NGOs and Other ORGANIZATIONS

Mr. Yadev Kharel, FPAN
Dr. Bal Gopal Baidya, New Era
Mr. Asok Shrestha, New Era
Mr. Hem B. Hamal, Nepal CRS Co.
Mr. Lovely Shrestha, Nepal Red Cross Society
Mr. Devendra Raj Pande, IDS
Dr. Nils Daulaire, John Snow, Inc.
Ms. Eileen McGinn, John Snow, Inc.
Ms. Pat Taylor, John Snow, Inc.

NATIONAL COMMISSION ON POPULATION

Mrs. Chandra Kala Kiran
Dr. Som Pudasaini

NATIONAL PLANNING COMMISSION

Professor Upendra Man Malla, Member, Planning Commission
Dr. Badnilal Shuglhe, Regional Director for Health
Mr. B. Cheukeain, Director, Public Health, Western Development Region
Mr. Birenohal Pradhan, Health Officer, Kaski District

ILAM DISTRICT

District Public Health Office
Mr. Ram Chandra Singh, District Public Health Officer
Mr. Adhimani, Senior Malaria Inspector
Mr. Shuam Kaji Shrestha, MCH Internfication Programme, FP/MCH, Kathmandu

Ilam Hospital:
Dr. Laxmi Raj Pathak, Medical Superintendent
Staff Nurses

Mr. Benu Raj Parsai, Member of Rastriya Panchayat, and R.P. Basic Needs Implementation Programme Committee
Mr. Damodar Sharma, School Teacher, Ilam

Chisapani Health Post
Mr. Ram Kumar Yadhav, Health Post In-charge
Mr. Krishna Rai, Administrative Assistant
Ms. Shanda Oja, Health Aid
Mr. Shiva Narayan Yogi, Deputy Pradhan Pancha, Chisapani
Mrs. Phul Maya Rai, mother of 5
Mrs. Pashan Tamang, villager
Mrs. Sala Bahadur Tamang, mother of 12
Many other villagers on the trail to Chisapani Health Post

Sakejeng Health Post
Mr. Ragunath Yadhav, Health Post In-charge who was absent for ten days
Mr. Dil Kumar Magar, Health Assistant

Mangal Bare Health Post
Mr. Jaya Mohan Singh, Health Post In-charge
Pradhan Pancha, Mangal Bare
Mr. Shrestha, Manager, Nepal Bank, Mangal Bare

Lungeli (Luring)Tar
Mr. Geeta Prasad Nirawla, Health Post In-charge
Mr. Ram Bahadur Shrestha, Auxiliary Health-Worker
Mr. Kirti Subedi, Junior, Auxiliary Health-Worker

Dr. Lalita Upadhaya, OB-GYN
Dr. Dipak Raj Upadhaya, Pediatrician
Dr. H.D. Shah, Pediatrician
Dr. Prabin Mishra, Dentist
Dr. R.S, Mandal
Dr. Bijaya

Dhanusha District Family Planning Office
Mr. Jagatananda Prasad Singh, Family Planning District Officer
Mrs. Indu Davi, Panchayat Based Health Worker
Mrs. Madan Kala, Panachayat Based Health Worker

APPENDIX E
INTEGRATION OF PRIMARY HEALTH SERVICES

Appendix E

INTEGRATION OF PRIMARY HEALTH SERVICES

Mr. Madhukar Rana

I. Introduction

The integration of primary health services first took shape as a working concept in the Kaski District of Nepal in the early 1970's when a country-wide anti-malaria project (begun in 1958) was coming to an end. It was thought desirable to utilize this "vertical" project's trained workers in further endeavors, thus giving rise to the idea of integrating the efforts of specific projects with static health post services in the delivery of primary health care.

II. The 1970-77 Integration Model

In 1970 an Integration Committee (1970-77) was established to launch pilot projects to serve as models for the successful integration of these primary health services. The Committee was assisted in its tasks by an Integration Working Group (1971-77) and the Community Health and Integration Division (1969-1977) of the Department of Health. The goal was set to have 1052 fully integrated health posts, as well as 75 District Public Health Offices (DPH), in place in 75 districts by 1985. (The model of integration to be followed is outlined in Table I--it may be noted that the integration of a health post is depicted as having five stages: E,D,C/B, A and I.)

In 1971 the integration model was applied in the Kaski District and in 1972 it was extended to Bara district (both in the Terai). Later, between 1972-75, the model was extended to four more Terai districts--Parsa, Siraha, Saptari and Ranthat, thus bringing the total number of integrated districts to six in all.[1]

This integration scheme was given an added impetus in 1975 by a Royal commitment to banish disease, hunger, illiteracy, and poverty from Nepal as outlined in the King's Coronation Speech. In response to this stated commitment, the Royal Palace Secretariat formulated the Long Term Health Plan, 1975-1995, which was then adopted by His Majesty's Government.

As described in the Long Term Health Plan, an integrated community health service was seen to be a system based upon the delivery of simple curative services and preventative health care

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[1]Outside these six districts during the same 1971-75 period, rural communities without endemic problems of malaria, smallpox, leprosy, or tuberculosis or which were far distanced from health centers and hospitals, often had no health care at all.

Table I

Model of Health Post Evolution

Aim: Provision of minimal health care to the maximum number of people through domiciliary field service coverage and part-time static curative services.

Initial: E-Stage Health Post

Provision of staff:
- One HA or Sr. ANM: 50% curative service and 50% field supervision.
- 2 VHW's in high mountain area for coverage of 5,000 population.
- 4 VHW's in mid-mountain area for coverage of 15,000 population.
- 4 VHW's in terai area for coverage of 25,000 population.

Frequency of field visit:
- Twice a year in high mountain area
- Six times a year in mid-mountain area
- Six times a year in terai area

Provision of supervisory staff:
- HA or Sr. ANM at health post supervises VHW's
- One HI for district level supervision located in the Zonal/District Hospital, Health Centre, District FP/MCH or SEP office.

Provision of full time static curative service in addition to the field service as above.

Ensuring the availability of physical facility for the health post and ensuring the supply of equipment and drugs during the period of Stage E.

Intermediate D-Stage Health Post

Provision of additional field staff:
- None at this stage

Frequency of field staff:
- Same as in Stage E

Provision of additional curative and supervisory staff:
- One ANM
- Field supervision will be carried out by HA/Sr. ANM three days in a week and by ANM the remaining three days, alternately.
- District level supervisor will continue to be the HI

Provision of expanded static and field service in FP/MCH:
Ensuring the availability of equipment and drugs for the expanded MCH service, during the period of stage D and starting expanded FP/MCH activities.

Intermediate: C/B-Stage Health Post

Provision of additional staff:
- Provide one ANM and one Mukhiya (Administrative Assistant)

Provision of additional field staff:
- None at this stage

Frequency of field visit:
- Same as in Stage E/D

Provision of additional supervisory staff:
- None at field level
- Field supervision pattern same as in Stage D

Provision of additional field services by HA/Sr. ANM/ANM:
- School health service
- Environmental sanitation service

Establishment of District Health Organization:
- Ensuring availability of referral hospital service
- Ensuring availability of medical officer for District Health Organization
- Ensuring availability of medical personnel for vasectomy, tubectomy and IUD camp service

Provision of Full Coverage through static and field services.

3. Final A-stage Health Post

Provision of additional field staff:
- One ANM
- One ANM
- Two VHW's in high-mountain area
- 2-4 VHW's in mid-mountain areas
- 2-4 in Terai area

Frequency of field visit:
- Thrice a year in high mountain area
- Six to twelve times a year in the mid-mountain area depending on whether it is non-malarious or malarious area
- Twelve times a year in terai

Final I-Stage

All health posts in the District in Stage A and fully established District Health Office

by Voluntary Health Workers (VHWs) through health posts with referral services to district, zonal, and national hospitals for more complex curative health care.

During 1975-77 a very rapid rate of integration was achieved. For example, in 1971-72 there were 6 districts with 192 HPs--of which 14 were of I-type, none of E-type and 179 were non-integrated; whereas in 1977-78 the number had reached 483 HPs --of which 65 were of I-type, 253 of E-type and 185 were non-integrated.

Overall, during the period 1970-77 the pattern of integration was as follows:

-- 351 health posts were set up in six (out of the target of 75) districts;
-- 62 of the 351 health posts were fully integrated or I-type health posts; and
-- the remaining 289 health posts were non-integrated or E-type health posts.

In 1977 both the Integration Committee and Integration Working Group were dissolved and replaced by a single Central Integration Board. During 1977-78 a goal was set to bring an additional 10 districts into the integrated community health program (for a total of 16 districts); however, this goal was not achieved because the Ministry of Health (MOH) was unable to resolve inter-project conflicts, there were weaknesses in project management at the DPHO level, there was great turnover in ministerial and secretarial leadership in His Majesty's Government, and the MOH was unable to coordinate the efforts of donor agencies.

III. The 1979-1986 Integration Model

In 1980 the Department of Health's own Community Health and Integration Division was dissolved and replaced by a new development project--Integrated Community Health Services Development Project (ICHSDP). This project is now seen to have been a strategic error since it left the MOH with yet one more project to integrate.

The main thrust of the project was to integrate ICHSDP staff gradually into all other MOH project activities, thus allowing them time to gain the experience necessary to take over the implementation of all project activities by 1985. This goal was never realized, however, because as ICHSDP activities grew, so did those of the vertical projects.

This uncoordinated growth scenario was compounded by a lack of effective management in ICSHDP--for example, instead of working to expand integration to more districts, it was basically

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preoccupied with trying to upgrade the 744 HPs in 48 districts from that of O-type (294) to E-type (376) to ultimately I-type (74); even then it could only succeed in fully integrating an additional four districts between 1980-1986, for a grand total of ten districts between 1971-80. It was obvious to policy makers that if integration was to be achieved, ICHSDP's method of operation was not appropriate.

In addition, at the policy level the concept of integration itself was becoming diluted and confusing for, on the one hand, there existed a definition of integration based on types (which was in turn based on service reach norms) and also a new definition based on the number of vertical project services absorbed by the HPs--i.e., "fully integrated" designated an HP having curative services and all vertical project services; "partially integrated" an HP having curative service and up to four of the vertical health services; and "non-integrated" an HP not providing any of the services of the five vertical projects.

By the end of 1986, 48 districts (DOs) had integrated services, as follows:

	No.	%
Fully integrated (I-Type) DO:	10	20.8
Partially integration (E-Type) DO:	16	33.3
Non-integrated (O-Type) DO:	22	45.8
	48	99.9

In the 744 HPs within these districts the status of integration was as follows:

	No.	%
Fully integrated (I-Type) HP:	74	9.9
Partially integrated (E-Type) HP:	367	50.5
Non-integrated (O-Type) HP:	294	39.5
ICHSDP HPs:	744	99.9

IV. The 1987 Integration Model

As a follow-up to the initiative of the Planning Division led by Dr. Badri R. Pandey, a Ministerial Task Force was created in May 1985 and chaired by the Secretary, Ms. Chandra Kala Kiran. The Task Force submitted a draft report, "Review of the Delivery of Health Services for Improving Integrated Health Services Including Family Planning and Maternal Child Health" in July 1985, which His Majesty's Government approved in October 1985, following its adoption at a ministerial workshop. The workshop considered the report and recommended that, of the four models of integration, the full integration model be adopted in line with the schedule of integration proposed by the Task Force.

In July 1986 the Council of Ministers decided that the integration of all projects into the MOH was to take effect immediately. It was also decided to integrate the project budgets

and the training institutions. The MOH later obtained another cabinet decision in June 1987 to effect integration immediately in the Eastern Development Region (EDR) and by the end of the fiscal year (15 July 1988) in all other regions of the country. The cabinet approved, as well, the organization chart for the MOH, Regional Directorate, and District Health Office, which had been prepared by a Ministerial Committee in 1987. Also approved by the cabinet were the job sheets or descriptions of all officer posts in the MOH. (Note: The Ministerial Committee had also prepared at the time a draft Job Sheet for each Regional and District Staff). Another major cabinet decision was to approve the inclusion of staff from development projects in His Majesty's Government service.

Pursuant to these decisions of the Government, the MOH has undertaken the following actions:

(i) The first of five Regional Directorates (RD) was created in November 1987 in Kartik, under the supervision of the Public Health Division.

(ii) All regional offices of all vertical projects were absorbed into RDs.

(iii) District offices of all vertical projects in the Eastern Development Region were absorbed into District Public Health Offices (DPHO) under the responsibility of the District Health Officer (DHO).

(iv) All regular gazetted staff (officers) were placed in the EDR--but not non-gazetted regulars nor project regulars nor project temporary and contractual staff.

(v) An Administrative Manual was developed which defines the aims of the DPHO, its relation to the district hospital, and its responsibilities and authority over personnel and finance.

At present, the MOH is carrying out the following activities to complete the process of integration:

(i) Bio-data is being collected on all project temporary staff to assess their qualifications.

(ii) Development of a basis for integration of staff with HMG/Ministry of General Administration is underway--the salaries of staff from projects in the EDR are to be included in their projects' budgets and they will be considered to be "on

temporary deputation" to the regular posts.[2]

(iii) An Organization Manual for RDs which specifies its function has been begun (job sheets have not yet been developed--to be done in 1988).

(iv) A study of the lessons learned from EDR will be completed by July 1988.

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[2]The MOH does not find that any qualified officers or technical staff will face a problem of non-absorption into the new system since they are in short supply. Problems could arise, however, for non-gazetted administrative staff since they must be competitive not only among themselves but be fit for jobs in other ministries, as well. Furthermore, people who are inefficient will find competition a problem.

APPENDIX F
SUCCESSES AND FAILURES OF ICHSDP

Appendix F

SUCCESSES AND FAILURES OF ICHSDP
Dr. Suniti Acharya

Successes

1. ICHSDP has had a high level of political commitment and support and has been able to attract funds from national and international sources for various activities.

2. Manpower development, consisting of recruitment and training, has been a major success of the project. During the project period, more than 4500 Community Health Leaders (CHL) have been trained and more than 3000 other health workers also received basic and in-service training.

3. It has established four regional training centers and developed training manuals for Village Health Workers (VHW), CHLs, and other specific manuals for control of diarrheal disease (CDD), the expanded immunization program (EPI), etc.

4. It has developed good quality information, education, and communication (IEC) materials for use at Health Posts (HP) and the village level covering all aspects of primary health care.

5. It has generated innovative ideas for community involvement such as the CHL program. The CHL program has great potential for country-wide expansion and for eventually increasing community awareness, thereby promoting principles of self-help and self-care.

6. It has tried various drug resupply schemes, thereby initiating community financing mechanisms in health care.

7. It has established a health information and referral system from the village level up to the district and central levels.

Failures

1. After the formation of ICHDSP, responsibility for program implementation fell to the ICHSDP project chief, but personnel management and control remained with the Director General of Health Services. This arrangement created divided loyalties among staff at various levels because the chain of command was not clear and Health Post staff was frequently transferred by authority of the Director General of Health Services without consultation with the ICHSDP project chief. This led to very poor performance at the operational level and the quality of service deteriorated.

2. The project had the statutory power to formulate its own financial and personnel management rules. This power, however, was never exercised by the project leadership.

3. Even though periodic plans had clearly written targets for the number of districts to be integrated, there were no projected dates for the implementation of operational plans for integration. Likewise, there was no allowance made for the time necessary to create a receptive atmosphere for the project's initiatives nor for other prerequisites of integration, e.g., development of new positions to absorb vertical project staff, hundreds of whom lost their jobs. This, in turn, caused service interruptions and breakdowns. All in all, this situation made the vertical project chiefs even more reluctant to support the integration scheme.

4. There were delays in budget releases--a phenomenon caused by process factors (resulting in delays), and by functional (financial and management) inadequacies--for example, there were an absence of program budgets, procurement specifications, and construction drawings; non-reconciliation of accounts with the Financial Controller General's Office; non-pursuance of account irregularities as identified by the Auditor General's Office; and multiple accounting systems to suit the interests of various donors.

5. Many of the Health Posts were located in rented offices which is contrary to the development of a permanent rural health infrastructure.

6. The inability to coordinate with various national and international agencies was also one of the causes of failure. There was no management-oriented, relevant plan of action; rather, various donors needed a plan of action in their own formats so ICHSDP had to prepare no less than three plans of action, one for each donor agency. Because there was no comprehensive project plan of action which could encompass all of those plans, duplication and confusion ensued.

APPENDIX G
DECENTRALIZATION: NEPALESE PERSPECTIVE

Appendix G

DECENTRALIZATION: NEPALESE PERSPECTIVE

Mr. Madhukar Rana

I. Introduction

Various attempts to decentralize government and social services have been made in Nepal, beginning in 1975 with the implementation of the District Administration Plan. This largely bureaucratic approach to decentralization, however, failed essentially for two reasons: (i) a failure to delegate authority to lower levels, and (ii) a failure to instill a spirit of participation in the beneficiaries and their representatives. Hence, as the Ministry of Health's Additional Secretary Bihari Krishna Shrestha has stated, Nepal thereafter resorted to a legalistic approach with the adoption of the Decentralization Act of 1982, and thereby "it literally became illegal not to decentralize."

II. Decentralization Act 1982 and By-Laws 1984

Decentralization is one of the four fundamentals of the Panchayat Policy as laid down in the Nepalese constitution, along with active leadership of the Crown, partylessness, and class coordination. On the occasion of King Mahendra Memorial and Constitution Day--December 16, 1981--His Majesty King Birendra declared:

> "It is essential that we devolve obligations, responsibilities and rights from the center to the regions, the zones, the districts, the villages and town panchayats, including all the way to the wards to make democracy a fact of our daily life."

The Panchayat Policy envisages maximum participation in nation building by all the diverse people of Nepal through local self-government. The declared aim of the Constitution, as laid down in the Directive Principles, is to create a just, dynamic, and democratic society that is free from exploitation and founded on the principle of decentralization. This decentralization is to be realized through the creation of village and district panchayats (local governing bodies) which are self-reliant and self-sustaining with respect to their relationship with central political and administrative authorities.

This interface between the center and periphery involves a complex of concepts and relationships:

- "devolution of authority" such as the creation of

national, district, and village panchayats each with their own rights, duties, and authority;

- "delegation of authority" as seen in the transfer of authority to lower decision units; and

- "deconcentration of authority" such as the establishment of the five Regional Directorates instead of one Department of Health Services in Kathmandu.

Finally, the principle of decentralization also recognizes that not all of the nation building efforts can or ought to be rendered by the government. Individuals and associations of individuals--professional, social, cooperative--also have creative ideas and, hence, should be invited to participate in the spirit of privatization and voluntarism.

III. The Mechanics of Decentralization

The fundamental institutional innovation of the Decentralization Act lies in the importance placed upon local level planning and the accountability of state and parastatal agencies to political representatives (i.e., ward, village, and district health committees headed by the presidents of the relevant panchayats).

Each district panchayat is required to formulate a periodic District Development Plan, as well as an annual district plan, based upon the expectation of its own revenue and central grants. This District Development Plan must seek to

i. fulfill basic needs;
ii. enhance agricultural productivity;
iii. maximize use of local skills and raw materials;
iv. improve overall economic productivity and create employment;
v. reflect national priorities as laid down in the national plan; and
vi. conserve the physical environment.

A National Planning Commission advises and assists the district panchayat and must grant approval of each district's plan (with changes, if necessary). The District Development Plan must also be approved by a District Planning Committee composed of ten Sectoral Committees.

The Local Development Officer is responsible for summoning a joint meeting of these various committees to formulate and approve the District Development Plan. The member of the Rastriya (National) Panchayat (Legislative Assembly) chairs these joint meetings. The District Development Plan is then submitted to the

district panchayat for concurrence. Final approval must be given by the District Assembly.

Within the framework of the District Development Plan, the town and village panchayats formulate their own annual plans and may raise land taxes after approval by His Majesty's Government. Of the amount raised, 5% is given to the national treasury, 10% goes into the District Treasury Office and 85% remains with the village or town panchayat where the taxes were raised. In addition, the district, village, and town panchayats may raise donations of between Rs. 5,000 and Rs. 10,000. When the amount of donations exceeds the stated maximum, an approval by two-thirds of the respective Assembly is required. Also, the amount raised must be spent for a pre-specified purpose.

The Decentralization Act also provides for a District Supervision Committee consisting of the District Rastriya Panchayat Member, the President and Vice President of the District Panchayat, the Chief District Officer, the Public Works Engineer, and the Local Development Officer as serving as Member-cum-Secretary.

There is also a provision in the Act creating a performance Audit Committee and a User's Committee; the latter to evaluate the benefits and the impact of the projects funded by each panchayat.

Finally, His Majesty's Government has the right to delegate additional powers or to give directives and guidelines.

IV. Conclusions

By all accounts, decentralization is an ambitious plan. For one thing, it is critically dependent on political will for its effective implementation. In addition, a high degree of administrative ability is vital for its success. It also requires adequate technical support and resources for its smooth execution. Without appropriate mechanisms for effective checks and balances, the experiment could rapidly degenerate into populist rhetoric coupled with rampant abuse of authority, corruption, and confusion.

Close monitoring of the exercise of authority and accountability by District Health Officers and District Health Committees needs to be done by the Minister and Secretary of the Ministry of Health. Those incapable of using authority judiciously must not be delegated further authority. Rather, their capacity to use authority should be reappraised. Care must also be taken to ensure that adequate resources are made available for effective exercise of authority.

APPENDIX H
HEALTH SERVICES RESEARCH IN NEPAL

Appendix H

HEALTH SERVICES RESEARCH IN NEPAL

Review

Health Services research in Nepal has received an impetus only in recent times following the directives of His Majesty the King in 1974 to develop scientific and technological research in the country. Following this royal edict, a National Council for Science and Technology (NCST) was established in 1976. The Vice-Chairman of the National Planning Commission is the ex-officio Chairman of NCST. The NCST is now mainly involved in policy planning. In the Ministry of Health, Nepal Medical Research Committee (NMRC) was established in April 1982, and was endowed with the following responsibilities:

1. To formulate policy planning and guidelines on basic and applied research at the national level.

2. To act as the national focal point on health services research.

3. To set up priority areas for research in the medical and health sciences and to approve research grant applications.

4. To promote and support research leading to the solution of priority national medical and public health problems.

5. To organize seminars and workshops on medical and health research and to disseminate the findings of research to the users.

NMRC has also formed ethical review and institution strengthening sub-committees.

Yet another step forward in the rehabilitation of research in the country was the establishment of the Royal Academy of Science & Technology (RONAST) in December 1982 under the Chancellorship of His Majesty the King.

The creation of this apex body was a blessed gift and an opportunity not only to the scientific and technological community to contribute to the country's development, but also to the people as a whole whose needs and aspirations for rapid modernization and improved living conditions cannot be easily fulfilled without appropriate utilization of science and technology for the overall development of the country.

RONAST formed several working groups including one on health and nutrition, with an objective of preparing the "institutional blueprint". In the health sector, it has

established the priorities for research and has provided small research grants. In a meeting of the academic assembly of RONAST, chaired by His Majesty the King, there was a clear Royal directive to promote research activities with the objective of fulfilling the basic minimum needs of the people by the year 2000. Health has been identified as one of the important basic needs.

Therefore, basically four bodies are involved in health services research activities viz. NCST, NMRC, Institute of Medicine, Tribhuvan University, and RONAST, with NMRC retaining the pivotal position for medical research.

NMRC, in its position as the focal point for all health and health related research activities, is actively pursuing a course of action to coordinate the research activities of the various institutions. It acts as an approving body that channels research proposals to relevant institutions and organizations.

During the period from its inception in April 1982 to January 1988, NMRC had received 121 project proposals. From that number 100 projects were approved for implementation, 11 projects were processed for subject review before finalizing for approval and 10 projects were rejected. Of the project proposals approved by NMRC, the implementation of 19 projects have been completed and 25 projects are on-going. Amongst the USAID funded projects the Jumla ARI Intervention trial and small research grants on ARI submitted through Nepal Paediatric Society (NEPAS) have been approved by NMRC.

Apart from this some private research organizations like JSI, New Era, Interface and IDS have also played a very active role in conducting quality research in the health sector.

It is reported that under USAID-HFP, 38 studies are underway/proposed. Some of these are completed, some are on-going and some are pending. These studies are found to be either carried out by a single institution or in collaboration with different institutions.

Observations

In view of the national commitment to providing the basic minimum needs to the people by the year 2000, greater emphasis must be given to the promotion of research, especially health system research which can provide guidelines on the most effective meants of achieving this goal. The Medical Research Committee (NMRC) has in a recent meeting decided to give top priority to such research.

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USAID has a very good system of regular evaluation of performance. Results of operations research will be useful for evaluation efforts to come in order to validata conclusions. Some of the areas in which operations research should be focused are:

1. Priority health problems emphasizing more on prevention rather than cure.

2. Performance of various categories of health workers by taking into consideration the following factors:

   - recruitment procedures;
   - training;
   - obstacles to effective performances;
   - motivation factors

3. Organizational issues.

Issues

1. Research results should be properly utilized. There should be as wide dissemination as possible of the research results. NMRC is making an effort in this direction and has established linkages with HELLIS net work. All the important health research in the country should be conducted with the knowledge and approval of NMRC. This will also help in avoiding duplication. NMRC should also increase their efforts in wider dissemination and greater utilization of the research.

2. NMRC at present has got inadequate infrastructure. So Efforts should be made to strengthen this institution. For this purpose, the following steps should be undertaken:

   - Basic infrastructures should be strengthened;
   - Special efforts should made to increase research manpower by conducting regular workshops on research methodology (NMRC has been doing this for the last few years);
   - Provision of maximum possible facilities should be made for collection and dissemination of research information;

   - NMRC should be able to function effectively in the context of decentralized and integrated system.

Recommendations

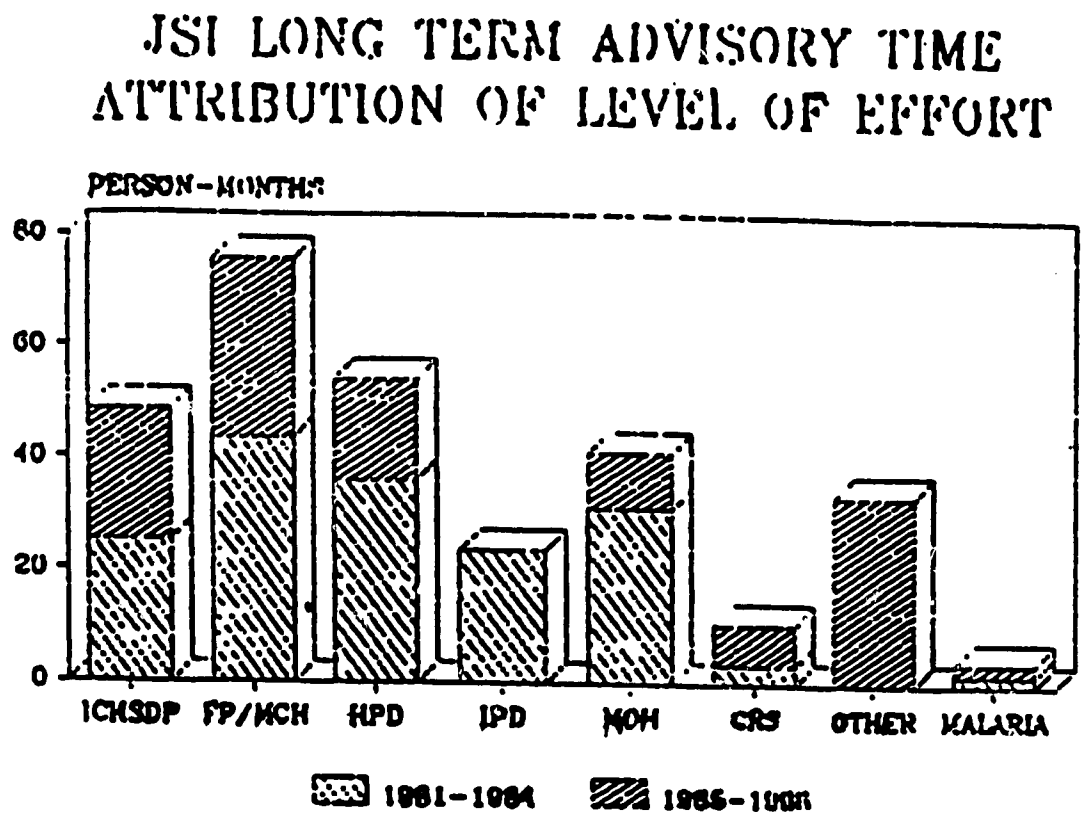
1. USAID should continue to support health services research especially health system research directed to meet the basic minimum needs objectives.

2. USAID should support institutional strengthening of NMRC so that it can play a more effective role in the future.

APPENDIX I
JOHN SNOW, INC.
DISTRIBUTION OF LEVEL OF EFFORT AMONG COMPONENTS

Appendix I

JOHN SNOW, INC. DISTRIBUTION OF LEVEL EFFORT AMONG PROJECT COMPONENTS



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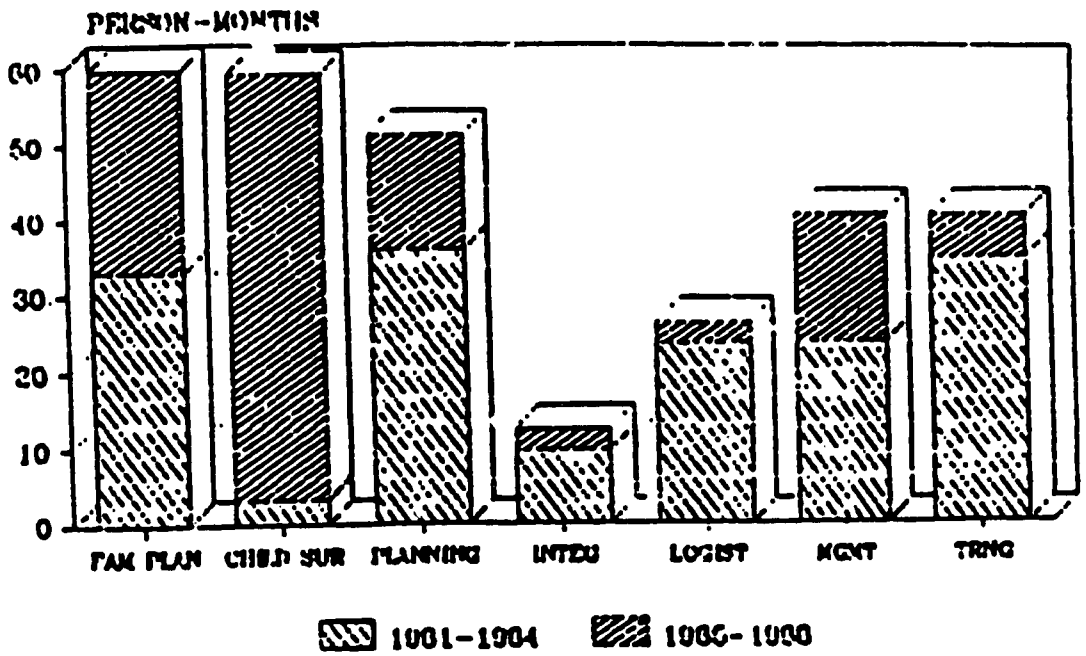

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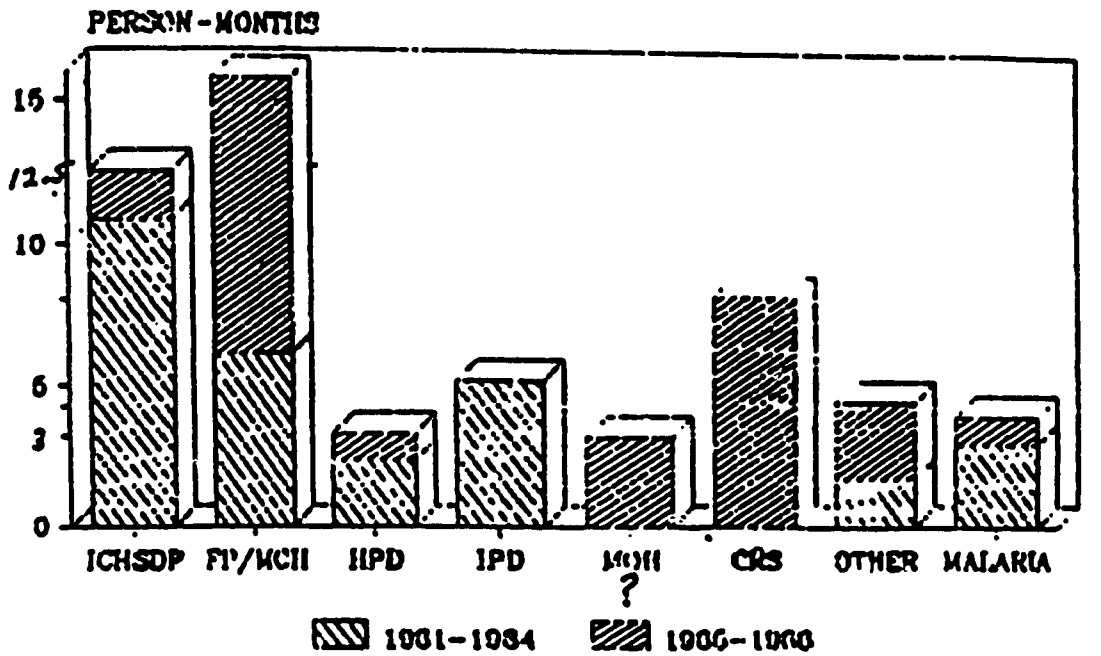

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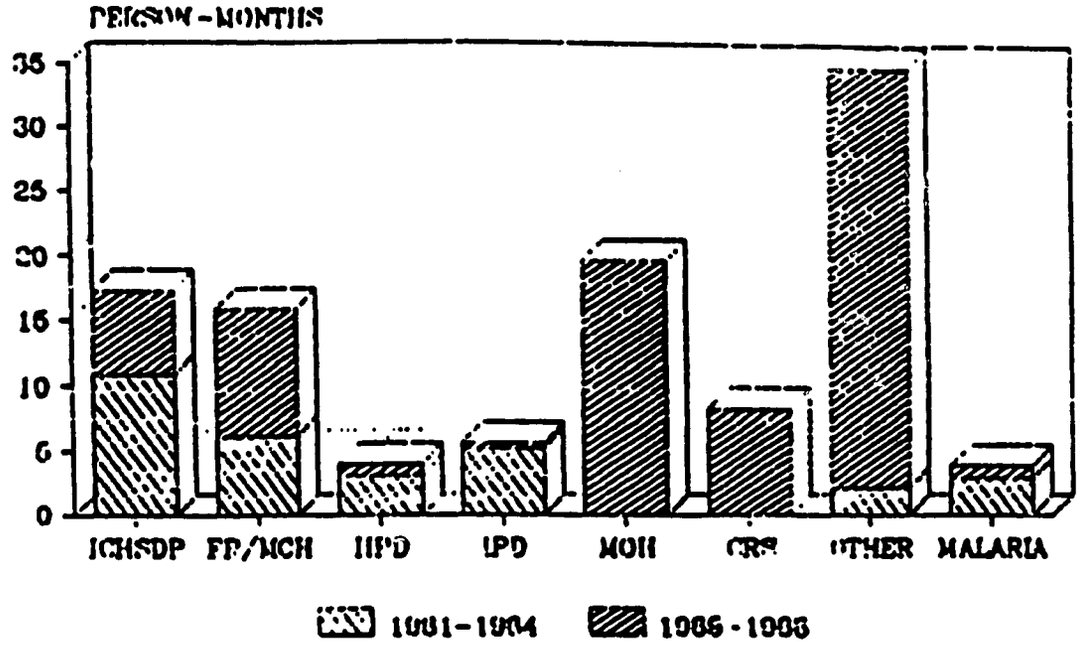

ALL CONSULTANTS

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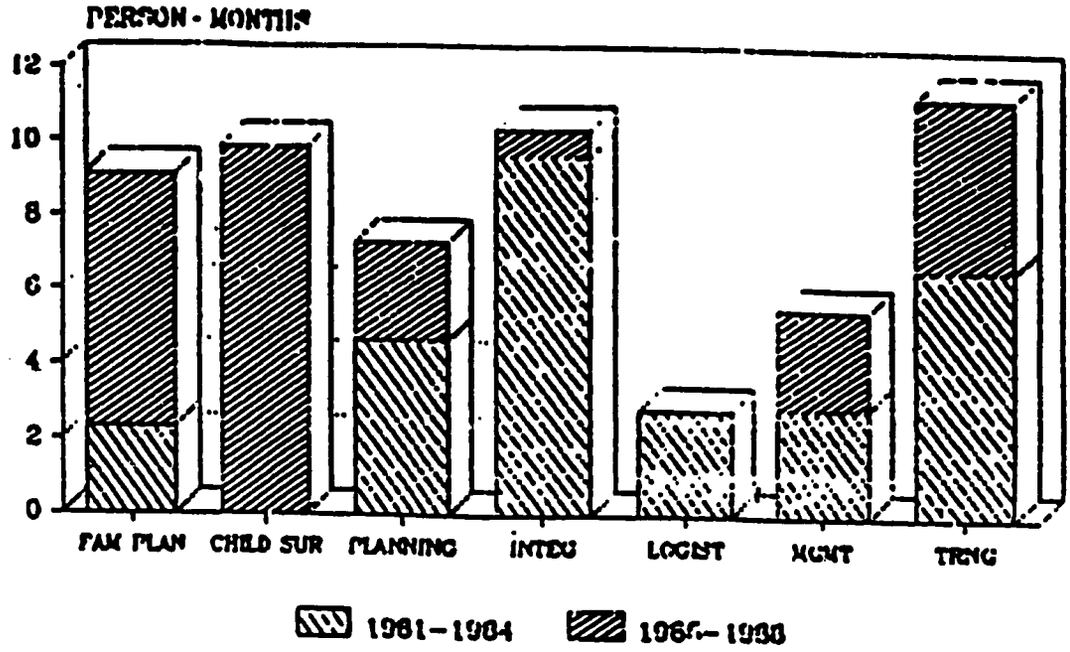

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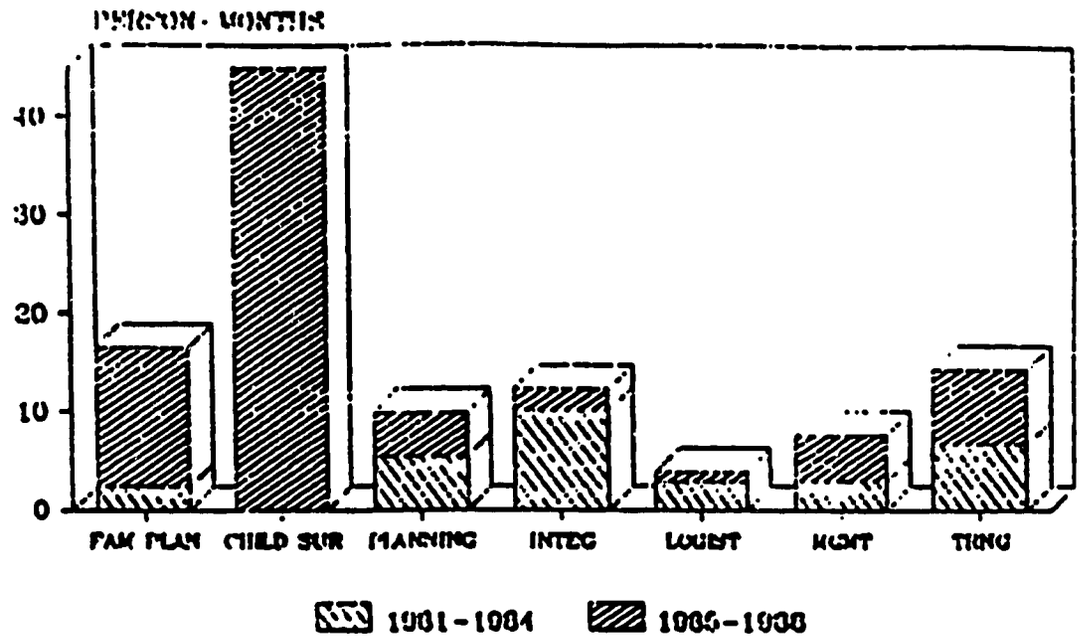

ALL CONSULTANTS

APPENDIX J
HEALTH AND FAMILY PLANNING STUDIES UNDER WAY OR PROPOSED

Appendix J

HEALTH AND FAMILY PLANNING STUDIES UNDER WAY OR PROPOSED

Subject	Study Objective	Status
1. Health Care Financing Cost Recovery Schemes Study for Nepal	to review and update information available on existing health care financing schemes in Nepal; to provide recommendations and possible strategies for providing HFP services through various cost recovery schemes.	completed.
2. PBHW Effectiveness Survey/Study	to assess PBHW effectiveness, recruitment and hiring procedures, service coverage and supervision; to assess the extent of utilization of women as PBHWs and make recommendations for increasing the use of females as FP/MCH promoters.	underway by JSI/Interface; estimated date of completion is September 1987.
3. Assessment of Temporary Family Planning Method Continuation Rates	to determine accurate continuation rates and reasons for discontinuation for pills, IUDs and injectables in Nepal in order to improve and expand the delivery of temporary methods in Nepal.	JSI/under negotiation with New ERA; draft report completed.
4. Assessment of the Role of the Private Sector in Family Planning in Nepal	to provide a current assessment of the role of the private sector in providing F.P. services in Nepal; to develop recommendations and strategies for increasing the private sector role in the provision of F.P. services.	completed.
5. IUD Acceptability Study	to review status and acceptability of the IUD in Nepal; to develop recommendations and strategies for increasing its use.	under discussion with URC; estimated completion February 1988.

Subject	Study Objective	Status
6. CHL Effectiveness Study	to assess the effectiveness of CHLs in 13 districts and determine strategies for improving their delivery of FP/MCH services at the community level.	under discussion with URC; estimated completion date is February 1988.
7. Assessment of Potential to Institutionalize Family Planning Services in Government Hospitals	to identify most options for institutionalization of F.P. services in the hospitals, effective referral, and follow-up linkages with the hospitals and surrounding health posts.	collaboration with AVSC; estimated completion date December 1987.
8. First evaluation of the CEDPA/FPAN Community-Based Family Planning and Nutrition Project	to evaluate first year of project.	under discussion by URC/CEDPA; estimated completion date is February 1988.
9. Assessment of Efficiency of CRS sales network	to examine in detail the routine operation of CRS's largest sales regions including record keeping, reporting, planning, commodity distribution and retailer education and how to improve field operations.	SOMARC, January 1988.
10. Assessment of Effectiveness of CRS Advertising	to examine how persons in areas where CRS products are sold react to various CRS advertisements through open-ended interviews (focus groups) and how to improve such ads.	SOMARC, January 1988.
11. Assessment of Availability of CRS Contraceptives	to document the degree to which CRS contraceptives are available in urban areas (excluding Kathmandu Valley) and the countryside surrounding such areas.	Draft report completed.

Subject	Study Objective	Status
12. Assessment of Use of CRS Contraceptives.	to document the current use of CRS contraceptives in areas where they are available.	Draft report completed.
13. ORT Container Study	to document the types of mixing containers generally available in Nepali households as a basis for determining the most desirable packet size for package ORS.	CRS and a Local Consultant with JSI assistance. October 1987.
14. Rural Marketing of ORS and Contraceptives by CRS	to assess rural perceptions of ORT, diarrheal disease, and temporary contraception as a basis for expanding CRS sales of ORS and contraceptives in rural areas.	CRS and JSI. Ongoing.
15. Construction end-use assessment	to assess the extent to which OIJS-funded construction is being properly staffed, stocked and utilized.	to be carried out by HFP and PDIS/ENGR by January 1988.
16. Study on unmet need for family planning	to identify factors related to the non-use of contraception among women identified as having an unmet need for family planning.	S&T/POP (DHS) funded; estimated date of completion is December 87.
17. Socio-economic and Programmatic Determinants of Contraceptive Use in Nepal	to identify those factors related to the current levels of contraceptive use in Nepal based on a further analysis of UNFPA/HMG's National Fertility and Family Planning Survey of 1986.	under discussion with John Stoeckel of Population Council, Bangkok for central funding through the DHS Project in 1987.
18. Nepal Fertility and Family Planning Survey	to obtain current information on fertility levels and patterns, and the extent of contraceptive use and knowledge in Nepal.	survey carried out by FP/MCH and UNFPA in early 1986; completed.

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Subject	Study Objective	Status
19. Epidemiologic Review of Data on Primary Health Problems in Nepal	to review available epidemiologic data on priority health problems of Nepal; to summarize data in terms of specific diseases/ conditions.	completed by Nicholas Wright under JSI Contract, February 1986.
20. Barriers to Effective F.P. in Nepal	to study fertility, contraceptive use, reproductive decision making and utilization of F.P. service clinics in the Kathmandu Valley.	carried out in 1982 by Sidney Schuler, et.al.. under the JSI Contract.
21. Reproductive Decision-making in Nepal from the User's and Nonuser's perspective	to identify determinants of contraceptive use in Kathmandu.	Sidney Schuler and Melvyn Goldstein with Population Council funding, 1982.
22. External Assessment of Malaria Control Program of Nepal	to study the overall malaria situation during 1984 and 1985 by evaluating the antimalaria activities being carried out and to recommend any change if necessary for improvement; to study the continued rising trend of malaria incidence as well as the exacerbation and spread of P.falciparum and to recommend measures to contain further rise and spread of P.falciparum infection; to review the existing workplan of entomological activities and give suggestions for further improvement; and to study the adequacy of financial and administrative support provided by HMG and donor agencies for the Seventh Plan period.	carried out in March 1986 by HMG/WHO/USAID/ODA (U.K.) assessment team.
23. Review of FP/MCH Financial System	to assess current FP/MCH financial accounting and reporting system and design an upgraded system.	carried out by Ernest Petrich in August/September 1986 through the Centrally Funded REACH Project.

Subject	Study Objective	Status
24. Review of MOH's Health Planning Division's (HPD) Central Health Information Systems	to assess and advise on health information needs, information system approaches (including child survival monitoring), data processing and technical assistance needs within the MOH's HPD.	carried out by Ernest Petric in October 1986 through the JSI Contract.
25. Review of the MOH Personnel Management System	to assess the potential application of personnel management technology within the MOH, options available, related training and organizational changes necessary to keep an improved system functioning; to assess the nature and level of commitment required of the MOH to effectively promote and take full advantage of potential management efficiencies.	carried out by Peter Shipp in January 1986 through the centrally funded PRITECH Project.
26. Health and Utilization of Health Services/Facilities	to carry out a two-phased survey in 4 districts to assess maternal and child morbidity and mortality and health service utilization.	carried out by IDS in 1983 in Surkhet, Rupandehi, Kathmandu and Kavre through PD&S funding.
27. Review of the delivery of Health Services for Improving Integrated Services in FP and MCH	review of current status of the integrated health delivery system, identification of problems and recommendations for improving the quality of service delivery; development of a Plan of Action for integrating health service delivery.	carried out by an HMG Task Force and funded by UNFPA and USAID in 1985.
28. TBA Assessment	to study the extent of use of TBAs in Nepal and to assess the impact of training on their effectiveness.	September 1987.
29. Socio-anthropologic Study of Diarrhea	to determine beliefs and treatment practices regarding diarrhea in Nepal.	completed.

Subject	Study Objective	Status
30 Child Survival Pharmaceuticals Requirements	to determine requirements, demand, availability and utilization of pharmaceuticals for CS, and to suggest systems improvements.	underway by MSH and New Era contractors.
31. Far West Malaria Epidemic Investigation	to assess status, causes, and actions related to major malaria epidemic in Far West.	completed by HFP staff, NMEO and with assistance of AID/W funded VEC Project.
32. Malaria Training Needs	to determine training system requirements to meet NMEO and ICHSDP's needs over medium term.	awaiting AID/W confirmation of dates and people.
33. Survey of Six Fully Integrated Districts	to assess health status, organization and effectiveness of integrated health service delivery, degree of coordination and decentralization and the extent of community involvement in the six fully integrated districts of Nepal.	carried out by WHO and HMG in early 1986.
34. Norplant subdermal long-acting, reversible, contraceptive trial - Phase I	to test feasibility in Nepal to use this contraceptive method - first stage testing on small populations in Kathmandu Valley through FP/MCH Project and FPAN.	FHI via AID/W funding. FP/MCH study progressing well; FPAN progressing poorly.
35. Norplant subdermal long-acting, reversible, contraceptive trial - Phase II	second stage testing in several sites; small groups of clients around Nepal. Through FP/MCH Project.	FHI via AID/W funding. Begun early 1987 in three sites. FPAN dropped due to poor performance in Phase I.
36. Acute Respiratory Infection Control Project	to determine if an ARI control program can reduce child mortality in a large, remote, high-hill population (Jumla).	Nepal Red Cross, Mrigendra Medical Trust, and JSI. One full year of fieldwork completed.