

December 24, 1987

Prepared for:  
USAID\Nepal  
Kathmandu, Nepal  
Under Contract No. DPE-3024-Z-00-7079-00  
PIO/T 398-0249-3-7006

BACKGROUND PAPER FOR  
FINAL EVALUATION OF POPULATION HEALTH:  
IRH/FPS PROJECT 0135 OF NEPAL

Prepared by

Matthew S. Friedman  
Research Associate

Edited and Produced by:

Population Technical Assistance Project  
International Science and Technology Institute, Inc.  
Arlington, Virginia 22209  
Telephone: (703) 243-8666  
Telex No.: 271837 ISTI UR

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ABBREVIATIONS

AID	Agency for International Development
ANM	Assistant Nursing Midwife
ARI	Acute Respiratory Infection
BCG	Tuberculosis Vaccine (Bacillus Calmettee-Guerin)
CBW	Community-Based Workers
CDC	Center for Disease Control
CEO	Chief Executive Officer
CHIP	Integrated Community Health Plan
CHL	Community Health Leader
CIB	Central Integration Board
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CRS	Contraceptive Retail Sales
CSFPS	Child Survival/Family Planning Service Project
DDT	Insecticide (Dichoro-diphenyl-trichloro-ethane)
DHS	Department of Health Services
DPH	Department of Public Health
DPT	Diphtheria Treatment
EIP	Expanded Immunization Project
FP	Family Planning
FPAN	Family Planning Association of Nepal
FP/MCH	Family Planning/Maternal Child Health
FY	Fiscal Year
GON	Government of Nepal
HA	Health Assistants
HPD	Health Planning Division
HMG	His Majesty's Government
HP	Health Post
HPU	Health Planning Unit
ICHSDP	Integration Community Health Services Development Project
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IRH/FPS	Integrated Rural/Health Family Planning Services Project
ISTI	International Science and Technology Institute, Inc.
IUD	Intrauterine Device
IWG	Integrated Working Group
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LCP	Leprosy Control Project
LDC	Less Developed Country
LSDP	Leprosy Service Development Board
LTHP	Long-Term Health Plan
MCH	Maternal Child Health
MOH	Ministry of Health

MPH	Masters in Public Health
NCP	National Commission on Population
NFP	Natural Family Planning
NFY	New Fiscal Year
NGO	NonGovernment organization
NMEB	Nepal Malaria Eradication Board
NMEO	Nepal Malaria Eradication Organization
NPC	National Planning Commission
ORT	Oral Rehydration Therapy
OT	Operating Theater
PBHW	Panchayat-Based Workers
PDLT	Panchayat Development Land Tax
POPCOB	Population Policy Commission Board
POPTECH	Population Technical Assistance Project
RTC	Regional Training Center
SAHW	Senior Auxiliary Health Workers
SEP	Smallpox Eradication Project
SOW	Scope of Work
TA	Technical Assistance
TBCP	Tuberculosis Control Project
UNFPA	United Nations Fund For Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
VSC	Voluntary Surgical Contraceptive
VSCA	Voluntary Surgical Contraceptive Association
WHO	World Health Organization

## I. INTRODUCTION

### I.1 Purpose of Background Document

ISTI/POPTECH was asked to field a consultant team to undertake an evaluation of the USAID-assisted activities in Nepal during January/February 1988. The lessons learned and the recommendations made as part of this four-week assignment were to be used by the USAID mission and HMG to design a new focused, balanced, and implementable project relevant to Nepal's current program needs.

In order to facilitate the team's effort, this background document has been prepared using current population and health related materials submitted to POPTECH by the USAID/Nepal mission (see Annex 1 for a listing of the documents reviewed.) The purpose of the document is to provide the team with a summary of specific background information which directly relates to the Scope of Work provided for the assignment. All of the documents used in preparing this report will be available to the team members during the briefing session in Washington D.C. and within the USAID mission in Nepal.

It should be noted that the recommendations and conclusions presented within this paper are taken from documents used to prepare this report and do not reflect the views or analysis of the ISTI/POPTECH project. In addition, because the information provided within the paper depended on the materials available to POPTECH, some of the chapters present a more comprehensive description than others. Where gaps in information do exist, additional details will be provided by the USAID mission.

### I.2 Organization of Background Document

This background paper is divided into seven chapters (excluding this chapter). In Chapter II, a general description of Nepal is provided, followed by a more detailed description of the health and population programs presently in existence within the country. (Annexes 2 through 8 provide an extensive description of the five vertical health and population projects.)

Chapter III focuses on USAID's contribution to Nepal's health and family planning efforts. Outlined in the chapter is a general description of USAID's project entitled "Integrated Rural/Health Family Planning Services Project (IRH/FPS)." This chapter includes a description of the project, its inputs and expected outputs between the 1980-85 period, a section covering the 1984 midterm evaluation, and a summary of the donor support provided to Nepal's health and population programs. No information was available covering the project beyond 1984. The

USAID mission will provide the team with information covering this period.

Chapters IV through VIII discuss in some detail specific issues of importance to the evaluation, the integration process, decentralization, institutionalization of sterilization programs, temporary contraceptive methods, and the Health Planning Division.

### 1.3 Scope of Work for Evaluation

Technical assistance (TA) is requested to assess progress against revised project impact targets, outputs, and implementation schedule approved by AID in March 1984 following the midterm 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, the mission wishes the evaluation team to focus on five main topics to feed into development of The new Child Survival/Family Planning Service (CSFPS) project (367-0157) PID and PP. The evaluation team will also be expected to review, synthesize, and incorporate findings from overall recent studies/reports as well as from various completed studies commissioned by HFP office as they relate to key issues outlined in this Scope of Work (SOW). Mission is particularly interested in addressing the following topics, which are also currently being debated at the highest HMG levels of His Majesty's Government (HMG):

#### I.3.1 Integration

Integrated health and family planning service delivery remains an HMG 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: 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? What have been ICHSDP's specific successes and failures in family planning (FP), maternal child health (MCH), oral rehydration therapy (ORT), the expanded immunization project (EIP), malaria, and in the regional training centers (RTC). and what are prospects for replication of positive impacts?

#### I.3.2 Decentralization

While decentralization and institutionalization are akin to each other, mission is interested in addressing decentralization 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: Within this context does USAID have a role to play in decentralization? If so, what can USAID do to assist the MOH to develop and implement a policy and plan of action of decentralization? What are the implications for donor funding (level and duration of resources) if decentralization is initiated? How best can decentralization be achieved--e.g., as a phased, or countrywide, or focused program? What operational efficiencies would be obtained, thereby freeing potential resources for alternative uses?

#### I.3.3 Service Mix

Under Project 0135, service mix has been considerably skewed toward family planning, and in particular voluntary surgical contraception (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: What is a proper service mix for Nepal, and how can USAID assist in achieving that balance? What are resource implications for The government of Nepal (GON), donors, and at the local level (e.g. community support, user fees)? Are there organizational or operational efficiencies that could be achieved, thereby freeing up resources for alternative uses? Are opportunities present for expanded private sector involvement and resources in health/FP services delivery?

#### I.3.4 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: What is USAID's future role in assisting the MOH to develop and implement a policy for institutionalizing family planning into fixed facilities? What are reasonable expectations for institutionalizing VSC and temporary methods in both the short and the longer term? What can reasonably be expected, given the current administrative situation?

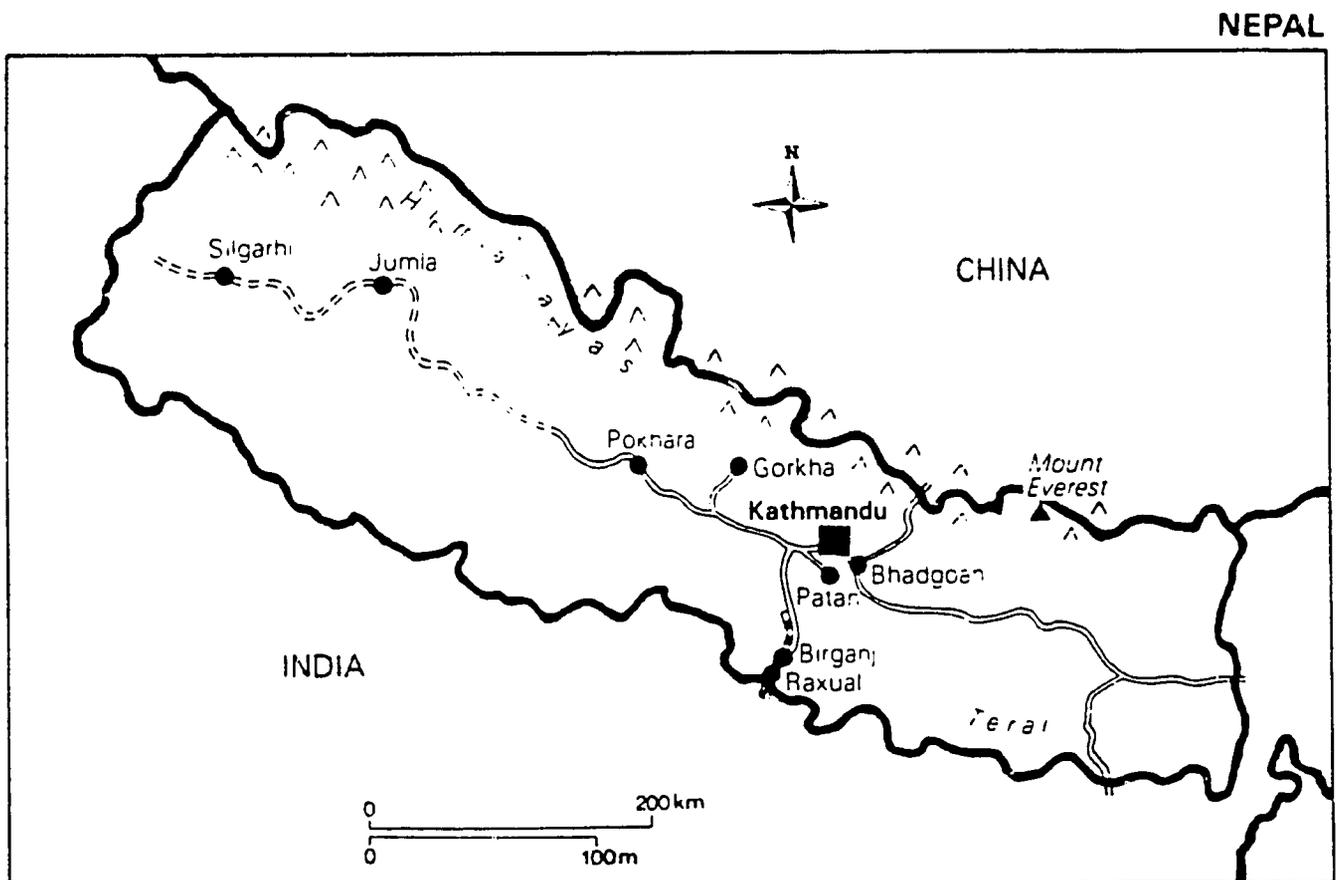
I.3.5 Health Planning Division

USAID has financed a significant portion of health planning division (HPD) costs, including recurrent operating costs, since the mid-seventies. Team shall address: To what extent is the MOH interested in continuing, strengthening, and utilizing HPD? What are HPD's achievements to date, and do they warrant continued funding under the new project?

## II. HEALTH AND POPULATION CONTEXT

### II.1 General Background of Nepal

Nepal is a landlocked country in central Asia that covers an area of 140,797 square kilometers. It is 500 miles long and 100 miles wide, and is bordered by India to the south and China to the north. Nepal has three distinct topographical regions that run from east to west. In the south, the "Terai" is a fertile strip of land that forms part of the Ganges Basin Plain. This region constitutes roughly half of Nepal's arable land and contains 44 percent of the population. Central Nepal (the "hill country") is crisscrossed by the lower ranges of the Himalayas and by swiftly flowing mountain rivers. This area contains 38 percent of the arable land and contains 48 percent of the population. To the north are the Himalayas, which form the border with Tibet. This mountain range contains eight of the ten highest mountains in the world, including Mount Everest. Although this region comprises 35 percent of the country's total land area, only 5 percent of the land is arable. Because of the region's hostile environment during most of the year and its lack of productive land, less than 10 percent of the population live in it. With regard to the weather, Nepal's overall climate ranges from subtropical summers and mild winters in the south to cool summers and severe winters in the northern mountains. (Refer to map.)



Nepal's government system is a consitutional monarchy in which his Majesty the King presides over three government bodies. The first is the legislature, or law-making body, known as the Rastriya Panchayat. This assembly consists of 140 members, of which 112 are elected. The remaining members are nominated by the king. Although officially a partyless state, elections to the national and village panchayats (councils) are by universal adult vote, and competition is often vigorous. The second body is the judiciary, which includes the Supreme Court, the Regional Courts, and the District Courts. This body is responsible for maintaining individual rights under the constitution. Finally, the government cabinet, which functions as the executive arm of the government, provides policy advice to the king and runs the country under the direction of the prime minister. The country is divided administratively into five development regions, fourteen zones, and seventy-five districts. The development regions run north to south, providing a cross section whereby all of the zones have essentially the same mix of geographical conditions. Thus, in principle, no region has any advantages over any other.

The population of Nepal can be divided ethnically into two major groups: Tibeto-Nepalese (Sherpas, Newars, Gurungs, and Magers) and Indo-Nepalese (Brahmans, Kshatriyas, and Chhetris). The Indo-Nepalese group tend to inhabit the Terai and low hill region, while the Tibeto-Nepalese can be found in the higher elevated hills and in the Himalayan Mountains. Within these two generalized categories, Nepal has a great cultural diversity that comprises nearly seventy-five different ethnic subgroups. Although nearly fifty percent of the population speak Nepali, there are also as many as 50 other languages spoken within the country. With regard to the country's religious beliefs, over 90 percent of the population are Hindu, while the remainder belong to the Buddhist, Muslim, and Christian faiths. Unlike other countries in the region where conflict often arises over religious ideologies and beliefs, in Nepal, there are close relations between Hindus and the other religions. Festivals are held in common, and the temples and shrines of both groups are held in mutual respect.

Agriculture is Nepal's principal economic activity; however, in recent years, tourism has become an important industry. Although the contribution of industrial products has been less than 4 percent, since 1966 the number of factories has grown from 1,200 to over 4,000. According to a 1981 census, more than 90 percent of the population were employed in agrarian pursuits. Rice, wheat, maize, barley, and jute are the main crops. Historically, Nepal has always had a surplus of grains, however in recent years the country has had to import a percentage of its food from other countries.

Nepal is one of the world's poorest countries, with a per capita income of about \$160. The country began the post-World War II period with virtually no schools, hospitals, roads, telecommunications, electric power, industry, or civil service. Nepal's five postwar economic development plans have resulted in notable progress, especially in social service and infrastructure development. Communications and transportation systems have improved, and several hydroelectric projects have been completed. Nevertheless, more still needs to be done to improve present transportation systems in the northern region. At present, the hill population (47.7 percent of the total) and those who live in the mountains (8.7 percent of the total) are beyond easy reach of roads (more than a two-hour walk). This lack of easy access to roads is a major obstacle to Nepal's efforts "to provide social services to all."

## II.2 Nepal's Health Context

### II.2.1 Nepal's Health Services: Historical Perspective

In 1933, the Department of Health Services (DHS) was established. Until 1951, the main responsibilities carried out by the department included the promotion, regulation, and management of the following facilities: thirty-three HMG hospitals, several traditional Ayurvedic dispensaries, an Ayurved school, and a production unit for Ayurvedic medicine. The DHS staff also trained compounders in the Civil Medical School. Between 1951-55, emphasis was placed on training doctors in India through a combined plan which was set up by the Indian Aid Mission and the Colombo Plan. During this period, a nursing school and Nepal's first nongovernmental hospital were also established.

Between 1956-61, the First Five-Year Plan was developed. This period also saw the organization of the Ministry of Health (1956), the establishment of a health assistant training school (1956), the organization of the Nepal Malaria Eradication Organization (NMEO) (1956), the upgrading and modernization of existing hospitals, and the building of the first specialized maternity hospital (1959). With respect to Nepal's health policy, priority was given to curative medicine, with the NMEO project representing a means of introducing a resettlement program for people from the mountains and hills into the Terai.

During the Second Plan (1962-65), as part of the overall health program, emphasis was placed on both preventive and curative medicine for the first time. In 1962 a survey was initiated for smallpox. In addition, pilot projects for leprosy (1963) and TB (1965) control were launched. In 1964, the Royal Drug Research Laboratory (1964) and the Assistant Nursing Midwife

(ANM) training program were also started (1962). By 1965, 102 health centers were in existence, providing health-related services throughout the country.

For the Third Five-Year Plan (1965-70), more extensive efforts were developed to help plan health strategies for the future. Although many of the health-related services still focused on the provision of curative activities, the concept of preventive medicine had become fairly well established in the planning and program budgeting process. In addition, the idea of rural health Posts was introduced, and nine of these posts had been built by 1970. Other achievements during this period included the development of three vertical projects, namely, the Smallpox Eradication Project (1967), the Expanded Leprosy Control Project (1967), and the Family Planning and Maternal/Child Health project (1968). Furthermore, in 1967 the Central Health Laboratory was established.

As part of the Fourth Five-Year Plan (1970-75), Nepal's health priorities changed from emphasizing curative services to focusing more on preventive services. To help implement this preventive strategy, the HMG established the Institute of Medicine, which sought both to produce new paramedical workers and to train existing medical personnel further. In 1970, the Community Health and Integration Division was established to help deal with overlaps in services and to make the health programs more cost-effective. To do this, the Division experimented with the process of integrating the vertical projects under one administrative body.

During the 1975-85 period, this process of integrating the vertical programs into the overall health infrastructure was further developed. The catalyst for this activity was the development of a Long-Term Health Plan (LTHP: 1975-90). As part of the process, in 1975 an elaborate strategy was formulated with participation from not only the Crown but also the National Commission on Population (NCP), the National Planning Commission (NPC), and the Ministry of Finance and Education. The plan called for the expansion of the basic health care services, to rural areas on a gradual basis. The policies of the LTHP included providing basic health services at the village level for the majority of the population and checking population growth to promote national development. In addition, the priorities included developing these basic health services, popularizing family planning and maternal and child welfare services and producing health manpower.

Prior to the plan, health services were provided by two different mechanisms. First, basic curative health services were provided through the Ministry of Health hospitals, health centers and health posts. These services were static in nature, with no

outreach. Although the facilities were located throughout the country, in some cases geographical conditions posed an obstacle for establishing effective centers in some of the more remote areas. Because of this situation, it was difficult for a percentage of the population to receive adequate medical attention using these centers.

Second, Nepal's five vertical projects provided a variety of health services, including The Nepal Family Planning and Maternal/Child Health Project (FP/MCH), The Nepal Malaria Eradication Organization (NMEO), The expanded Immunization Project (EIP), The Tuberculosis Control Project (TBCP), and The Leprosy Control Project (LCP). Unlike the static health services provided by the hospitals, health centers and health posts, these projects had a large number of field workers that provided outreach services. For example, for the EIP project, field workers provided door-to-door visits to provide immunization services. The TBCP workers actively sought out TB cases and provided referral services and follow-up care when needed. In both cases, the two projects provided health services; however, these services were specific to their unique specialization. The problem with this approach was that there was often a great deal of overlap and the separate administrations were not found to be cost-effective. Thus, the objective of the integration process was to somehow combine the two approaches, with the focus being placed on the district health posts. In 1980, the Integration Community Health Services Development Project (ICHSDP) was initiated to manage the integration process. (Refer to Chapter IV for a detailed description of the integration process.)

The Seventh Five-Year Plan (1985-90) focuses on minimum basic health needs of the people. Primary health care and sanitation were mentioned as two of these needs. The objectives of the plan include reducing the infant mortality rate to 98.3 per thousand live births, reducing the total fertility rate to 4.00, and increasing life expectancy to 55.4 years by 1990.

#### II.2.2 Nepal's Present Health Status<sup>1</sup>

Because to an absence of reliable basic health data, it is difficult to accurately assess Nepal's present health status. From what data is available, however, the situation appears to be poor. For example, the average life expectancy from birth is estimated to be only 47 years for men and 45 years for women. With respect to newborns, the infant mortality rate in 1985 was 143 per thousand live births. The four major causes of death for infants included respiratory diseases, diarrhea, birth-related trauma, and convulsions.

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<sup>1</sup> UNFPA Needs Assessment Report, 1987.

For children between the ages of one to four, the mortality rate was 21 per thousand (1985). The five major determinants of mortality were diarrhea, acute respiratory infections, malnutrition, measles, and neonatal tetanus. The five major determinants of morbidity were malnutrition, diarrhea, acute respiratory infections, injuries, and polio. In Nepal, the prevalence of childhood malnutrition is high. For example, it has been estimated that nearly 70 percent of the rural child population is malnourished, with the incidence of third-degree malnutrition varying from 5 to 15 percent. The combination of malnutrition and undernutrition, combined with Nepal's high level of infectious diseases (especially diarrheal diseases and measles), causes an even more pronounced mortality rate. There is also a high incidence of iodine deficiency disease, including goitre and cretinism, nutritional anemia, and vitamin A deficiency/xerophthalmia. With regard to the maternal mortality rate, in 1986 the figure was between 8.3 to 10 per thousand. The deaths were most often associated with puerperal infection and hemorrhage.

These estimates reflect the need for additional steps to be taken to help improve the overall health of the Nepalese people, especially women and children. To alleviate these problems, the HMG's Strategy for MCH, which has been adopted by the Ministry of Health, includes the following priorities: oral rehydration, nutrition, immunization, basic and natal care, and child spacing.

A major factor contributing to Nepal's health situation is the dearth of medical personnel, facilities, equipment, and drugs. To alleviate some of these problems, Nepal's health resources, including facilities and manpower, have been increased moderately. For example, at the end of the Sixth Five-Year plan (1985), the number of doctors in the country had risen from 445 to 600. Despite these increases, the ratio of doctors to population has remained low at 1:27,271. Figures relating to the ratio of hospitals, health posts, beds etc., also remain low (refer to Table 1). Thus, it appears that the provision of health services has a long way to go before it catches up with the country's present population. With regard to the medical facilities, by the end of the Sixth Five-Year Plan (1985) there were only 80 hospitals, 26 health centers, and 794 health posts.

Other problems relating to the HMG health programs included the following: much of the medical manpower was confined to the Kathmandu Valley; recruitment and appointment of medical personnel was slow; operating funds for medical facilities were seldom on time; supply shortages were chronic; construction plans were constantly falling behind schedule.

Table 1  
Nepal's Health Resources as of 1985<sup>2</sup>

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Institution/Post	1980 End of Fifth Plan	1985 End of Sixth Plan
A. <u>HEALTH FACILITIES:</u>		
Hospitals	73	80
Beds	2,586	3,522
Beds/population ratio	1:5,515	4,661
Health centers	26	26
Ayurvedic dispensaries	85	125
Health posts	586	794
Health post/population ratio	1:24,463	20,677
B. <u>PERSONNEL</u>		
Doctors	442	602
Doctors/population ratio	1:32,277	27,271
Nurses	445	600
Midlevel/other technicians	1:2,678	3,919

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<sup>2</sup>UNFPA Needs Assessment Report, 1987

### II.2.3 The Health Sector Institutional System<sup>3</sup>

The health sector institutional system provides management infrastructure and service facilities at the national, regional, zonal, district, and local levels.

II.2.3.1 National Level. The system at the national level consists of the Ministry of Health and the Department of Health Services with its various divisions and units (Epidemiology and Statistics, Health Laboratory, Nutrition, Health Education, Environmental Sanitation, Zoonotic Diseases, and Department of Ayurved). The organizational structure of these two institutions, prior to July 1987, is shown in Chart 1 and 2. In addition, List 1 provides a summary of Ministry of health officials.

Also at the national level are the national hospitals and the vertical projects of the ministry, which include the following: FP/MCH project, ICHSDP, NMEO, EIP, TBCP, and LCP. (Refer to Annexes 2 through 7 for a detailed description of the six vertical development projects).

II.2.3.2 Regional Level. At the regional level, regional directorates have been established. ICHSDP and FP/MCH also maintain regional training centers at this level.

II.2.3.3 Zonal and District Levels. At the zonal level are the zonal hospitals, which serve as referral resources for the district facilities. The health management resources infrastructure at the district level is significant, including district public health offices, and in nonintegrated or partially integrated districts, malaria, EIP, and FP/MCH offices in addition to the district hospitals. In accordance with the objectives of the Decentralization Act, HMG emphasized management more and more at the district level.

II.2.3.4 Local Level. The peripheral level is served by one fixed facility, the health posts, and by a variety of field workers, including Village Health Workers (VHWs), Panchayat-Based Workers (PBHWs), and volunteer Community Health Leaders (CHLs), who bring primary health care to the community level. In non-integrated or partially-integrated areas, the other vertical projects may also have field workers their own.

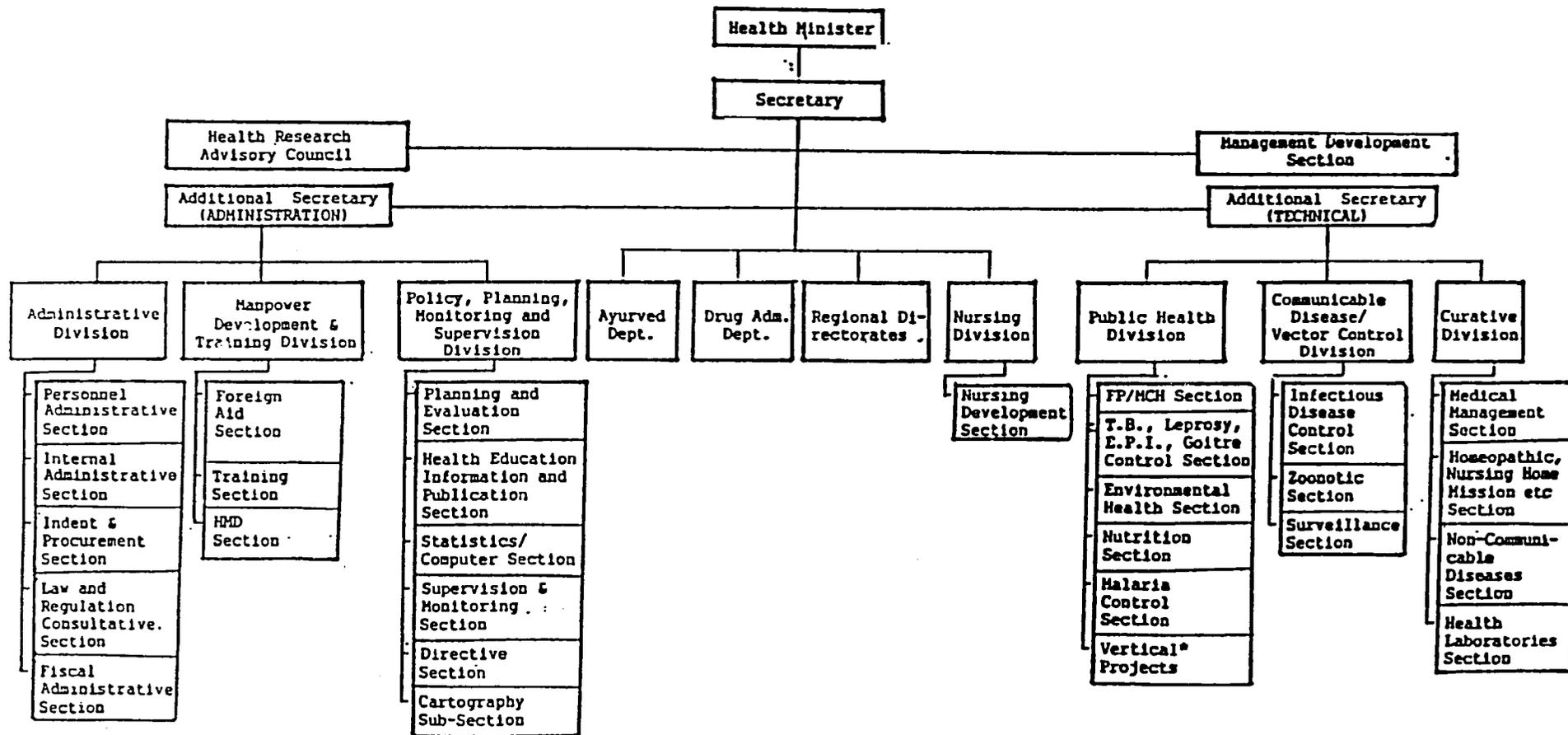
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<sup>3</sup> Information for the next two sections came from an unpublished background paper prepared by JSI entitled "Nepal Health System Summary," September 1985.

Organogram of the Ministry of Health, Regional Health Directorates, District Public Health Offices and Health Posts (Unofficial translation)

CHART I

MINISTRY OF HEALTH



\* Projects, under the Health Ministry, will be gradually integrated.

List 1:

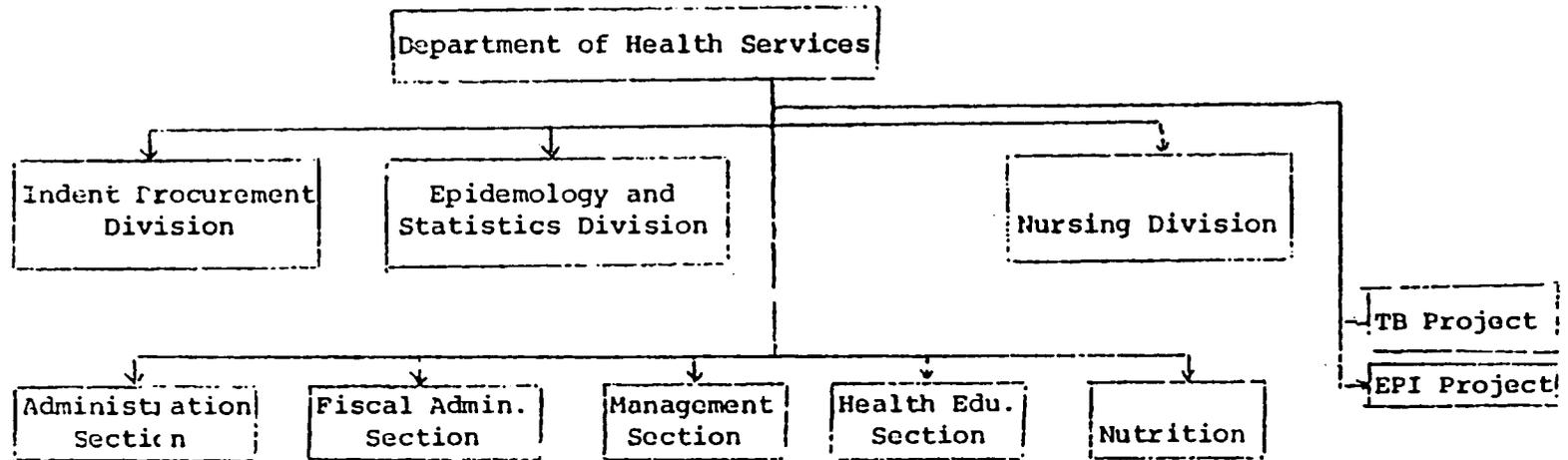
MINISTRY OF HEALTH

LIST OF OFFICIALS

1. Minister - Mr. Gunjeswori Prasad Singh
2. Secretary - Mr. Basudev Pradhan (Acting Secretary)\*
3. Additional Secretary (Administration) - MR. Basudev Pradhan\*
4. Additional Secretary (Technical) - Dr. Indra Bahadur Khattry
5. Administrative Division - Mr. Harihar Sharma Wagle (Joint Secretary)
6. Manpower Development and Training Division - Dr. Shyam Prasad Bhattarai (Joint Secretary)
7. Policy, Planning, Monitoring and Supervision Division - Dr. Yogendra Man Singh Pradhan (Joint Secretary)
8. Public Health Division - Dr. Dwarika Nath Regmi
9. Communicable Disease and Vector Control Division - Dr. Megh Bahadur Parajuli
10. Curative Division - Dr. Fatte Bahadur Malla
11. Nursing Division - Dr. Rukmini Charan Shrestha
12. Ayurved Department - Mr. Ram Prasad Mishra
13. Drug Administration, Department - Dr. Gokul Das Shrestha
14. Eastern Regional Director - Dr. Kalyan Raj Panday
15. Central Regional Director - Dr. Kokila Vaidya
16. Western Regional Director - Dr. Badri Lal Shrestha
17. Mid-Western Regional Director - Dr. Hari Nath Acharya
18. Far-Western Regional Director - Dr. Keshab Bahadur Singh

Chart 2:

Organization of the Department of Health



## II.2.4 Health Care Facilities

II.2.4.1 Health Centers. These facilities are manned by a physician and other appropriate staff. Because it became clear when these centers were first being established that it would not be feasible to provide enough physicians to meet the country's needs, only twenty six of these centers were built.

II.2.4.2 Health Posts. In place of the health centers, HMG established the concept of the health post. The health posts were to be manned by paramedical personnel known as Health Assistants (HAs), or in some cases by Senior Auxiliary Health Workers (SAHWs). The health post, which is now the lowest level fixed facility of the health system, is responsible for providing primary health care to the people of Nepal. In 1986, the number of health posts reached 794 throughout the country in contrast to 113 in 1970. From this total, 450 are considered integrated, providing a complete range of services including field visiting through the VHWS and the CHLs.

## II.3 Nepal's Population Context

Nepal, with its long-standing Hindu culture, has always been pro-natalist. In the Hindu culture, a large family represents well-being, both socially and economically. This is reflected in a saying often heard in the country: "May your progeny fill the hills and mountains." High fertility is desired because by producing children, particularly sons, a woman raises her status in the family, avoids the chances of having a co-wife, makes herself socially eligible to inherit some property from the family and, above all, wins the support and affection of her husband and the other family members, especially the mother-in-law.<sup>4</sup> If a couple does not bear children, it is considered a disgrace to the family.

To date, the population of Nepal exceeds 16.5 million, which represents an increase of nearly 100 percent over the last thirty years. This rapid growth has been attributed to a decline in mortality resulting from improved health programs, accompanied by a high total fertility rate of nearly 5.94 and a current annual growth rate of 2.28. As a result of this trend, the total population within the 0-14 age group exceeded 41 percent of the total population by 1981. Should this trend continue, it is estimated that the population will double again in another thirty years. (Refer to Table 2 for a comprehensive listing of Nepal's present demographic situation).

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<sup>4</sup> Population Monograph of Nepal, 1987.

## NEPAL

## Demographic Facts

Population by sex		Population density (/sq. km.) .....	117
Total (in 1000) .....	16,482	Average annual change	
Male (in 1000) .....	8,453	Population increase (in 1000) .....	397
Female (in 1000) .....	8,030	Births (in 1000) .....	689
Sex ratio (/ 100 females) .....	105.3	Deaths (in 1000) .....	292
Population in year 2000 (in 1000) .....	23,048	Net migration (in 1000) .....	0
Population by age group		Rate of annual change	
Age 0-14 (in 1000) .....	7,136	Population change total (%).....	2.28
Age 15-64 (in 1000) .....	8,874	Urban (%) .....	6.7
Age 65+ (in 1000) .....	473	Rural (%) .....	1.9
Age 0-14 (percentage) .....	43.3	Crude birth rate (/ 1000) .....	39.4
Age 15-64 (percentage) .....	53.8	Crude death rate (/ 1000) .....	16.7
Age 65+ (percentage) .....	2.9	Natural increase (/ 1000) .....	22.7
Age indicators		Net migration (/ 1000) .....	0.0
Median age .....	18.3	Fertility and mortality	
Dependency: age 0-14 .....	80.4	Total fertility rate .....	5.84
Dependency: age 65+ .....	5.3	Completed family size .....	5.77
Dependency: total .....	85.7	Gross reproduction rate .....	2.85
Youth: 15-24 (in 1000) .....	3,112	Net reproduction rate .....	1.96
Women: 15-49 (in 1000) .....	3,659	General fertility rate (/ 1000) .....	176
Urban-rural population		Child-woman ratio .....	N/A
Urban population (in 1000) .....	1,270	Infant mortality rate (/ 1000) .....	128
Rural population (in 1000) .....	15,213	Life expectancy: male .....	48.6
Per cent urban (%) .....	7.7	Life expectancy: female .....	47.1
Per cent rural (%) .....	92.3	Life expectancy: total .....	47.9
Agricultural population density		GNP per capita	
(/ hectare of arable land) .....	5.61	(U.S. dollars, 1984) .....	160

Some of these figures are estimates. Government figures may differ somewhat from those given here. Figures for population by sex, population by age group, age indicators, urban-rural population, and population density (/sq. km.) refer to the year 1985, and other figures such as average annual change, rate of annual change, and fertility and mortality are the five-year averages for 1985-1990. Most of these data were provided by the Population Division, Department of International Economic and Social Affairs of the United Nations. See "Introduction" for further information regarding sources.

At present, the Nepalese government supports a policy of population growth control in order to raise the living standards of the people, provide adequate education and health services, and increase employment opportunities. The official policy is to decrease fertility, control external migration, and modify the spatial distribution of the population, with the greatest emphasis being placed on socioeconomic restructuring. However, despite the government's attempts to decrease the population's growth, Nepal's family planning programs have not achieved the success the country's economic planners and family planning leaders had hoped for.

Source ↑  
For example, although the Contraceptive Prevalence Rate (CPR) in Nepal has increased from 2.3 percent in 1976 to 15.1 percent in 1986, it still remains one of the lowest in Asia. (Refer to Table 3 for a listing of the present percentages by method.) Historically, the Nepal family planning program has emphasized voluntary sterilization. This is reflected in the Contraceptive Prevalence Survey (CPS) results, which indicate that 86 percent of Nepal's contraceptive prevalence represents both male and female sterilization. While targets for all contraceptive methods are established each year, in the past the achievement of the sterilization goals was often given special emphasis through community support efforts and incentive payments to both acceptors (100 Rs.) and service providers. Since 1980, the annual number of sterilizations has risen from 18,500 to over 60,000 in 1984. Because of this emphasis, the CPR resulting from these permanent procedures has increased steadily since 1976, while temporary methods have remained nearly unchanged (refer to Table 4).

There also exists a large gap between the rural and urban populations with respect to their patterns of contraceptive use. For example, in 1986 the CPR figures showed that only 23.5 percent of the urban population used contraception, as opposed to only 5.8 percent of the rural population. Since nearly 90 percent of the population lives in rural areas, it is apparent that a great deal remains to be done to reach the rural populations. This need was further supported within the CPS report, which indicated that 40 percent of the women of reproductive age do not desire additional children, while another 27 percent plan to practice family planning in the future.<sup>5</sup>

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<sup>5</sup>Nepal Contraceptive Prevalence Survey, 1981.

Table 3: Current Use of Specific Methods of Contraception among Currently Married and Nonpregnant Women.<sup>6</sup>

Method	Percent
Female sterilization	6.8
Male sterilization	6.2
Pill	0.9
Condom	0.6
Injectable	0.5
IUD	<u>0.1</u>
TOTAL	15.1

TABLE 4: Percentage of Those Using Family Planning among Currently Married Women by Specific Method of Family Planning: 1976, 1981, and 1986.<sup>7</sup>

Method	NFS, 1976	NCPS, 1981	NFFS, 1986
Female sterilization	0.1	2.4	6.2
Male sterilization	1.5	2.9	5.7
Pill	1.9	3.1	1.8
Condom	1.2	1.2	1.2
Injectable	---	0.4	0.6
IUD	<u>0.2</u>	<u>0.2</u>	<u>0.2</u>
TOTAL	4.9	10.2	15.7

### II.3.1 Family Planning Activities in Nepal: Historical Perspective

Historically, Nepal followed other south Asian nations by supporting early public and private voluntary family planning efforts. During the First (1956-61) and Second (1961-65) Five-Year Plans, although no official population policy had been adopted within Nepal, the GON did establish a policy which attempted to absorb the high hill population through resettlement. In the private sector, provision of family

<sup>6</sup>Nepal: Fertility and Family Planning Survey Report, 1986.

<sup>7</sup>Nepal: Fertility and Family Planning Survey Report, 1986.

planning services began in 1958 with the formation of the Family Planning Association of Nepal (FPAN), an affiliate of IPPF.

By the Third (1965-70) and Fourth (1970-75) Five-Year Plans, because of increasing governmental concerns over population growth, policy issues were recognized and new emphasis was placed on population growth reduction and service delivery. For example, in 1966, the Ministry of Health established several permanent FP/MCH clinics and temporary camps for male and female voluntary sterilization efforts on a pilot basis. Two years later (1968), a full-scale FP/MCH project was initiated within the Ministry of Health. In addition to this project, during the early 1970s an Integrated Community Health Plan (CHIP) was established. This plan was initiated to help HMG deliver primary health care and family planning services within two districts, replacing the field activities of the "vertical" health programs. (The latter became the ICHSDP program in 1980.) To coordinate the population activities being carried out by these projects, a Population Policy Commission Board (POPCOB) was formed in 1974 under the National Planning Commission (NPC). The POPCOB was chaired by a member of the NPC, and its members included representatives from a number of different ministries.

With regard to population issues, the Fifth Five-Year Plan (1975-80) was more specific and clearer than the other plans had been in relation to its objectives. The plan called for optimum use of manpower, consistent with the aims of broader economic growth and a faster rise in the standard of living for the masses. To realize this objective, the government focused on several key policy elements including 1) reduction of the crude birth rate through direct anti-natalist and preventive programs of FP and MCH, 2) control of immigration, and 3) organization of internal migration and urban development. This plan marked the first time that quantitative targets had been set for the crude birth rate. For instance, the government hoped to reduce the birth rate from 40 to 38 per 1,000 population and infant mortality from 200 to 150 per 1,000 live births. During this period (1975-80), POPCOB was dismantled because it was felt that the board had not been able to meet its objectives. In its place, the National Commission on Population (NCP) was formed in 1978 under the chairmanship of the Prime minister. In addition, following the CHIP program's successful implementation, the HMG extended the activities to the entire country and changed the name from CHIP to the Integrated Community Health Services Development Project (ICHSDP) in 1980.

In the Sixth Five-Year Plan (1980-85), population initially figured less prominently in the overall strategy than in past years. However, in 1981 following the census, population control issues began to receive additional attention when it was determined that the growth rate had remained nearly unchanged.

To deal with this situation, the NCP established an elaborate National Population Strategy in 1983. A population growth target was established as part of the strategy, requiring that the "rate of increase" be reduced from 2.6 percent annually to 1.2 percent by the year 2000. To attain this target, population targets were integrated into development policies and plans, and incentives were offered for those who had two children or fewer, and for sterilization.

The long-term goal of the Seventh Five-Year Plan (1985-90) is to reduce the "total fertility rate" to 4.0 from its current rate of 6.3. In addition, five policies have been adopted under this plan to 1) expand family planning services and meet the unfulfilled demand for such services, 2) integrate population programs into development programs, 3) emphasize women's development programs, 4) increase the participation of panchayats and class organizations, and 5) control the flow of immigration. The plan also emphasizes the need for an improved population program that would "make the people control-conscious and motivate them to adopt control measures." To do this, the strategy calls for consolidation of the management and organization of the family planning delivery system to make the program more "competent."

### II.3.2 Present Family Planning Programs

II.3.2.1 Temporary Family Planning Providers. At present, there are over twenty institutions involved in providing temporary contraceptive services in Nepal. Within the government, the two major FP service providers are the Nepal Family Planning and Maternal and Child Health Project (Nepal FP/MCH Project) and the Integrated Community Health Services Development Project (ICHSDP). Together these two programs provide population control services, i.e. temporary methods, to all of Nepal's seventy five districts. (Refer to Annexes 2 and 3 for a detailed description of these two programs.)

In addition to the two government programs, other, non-governmental organizations provide family planning services. Since 1978, the Nepal Contraceptive Retail Sales (CRS) Company, Limited began distributing condoms, pills, foaming tablets, and oral rehydration salts at subsidized prices to over 11,000 retail stores. This initiative was started with funding from USAID. At present, CRS is the largest provider of condoms, the second largest provider of pills, and the only provider of foaming tablets. A second NGO provider is the Family Planning Association of Nepal (FPAN), which provides a full range of services in Kathmandu. As part of its activities, FPAN offers motivational and educational services, and distributes condoms and pills throughout its 19 branches. It also operates vasectomy

and laparoscopy camps all across the country. (Refer to Table 5 for a summary of the temporary contraceptive methods distributed by institution.)

Finally, several smaller, private national organizations such as the Mothers' Clubs, Nepal Women's Organization, the Ex-Servicemen's Organization, the Youth Health Organization, and the Nepal Red Cross provide educational and motivation services and sometimes distribute pills and condoms. (Refer to chapter VII for a description of the general public's attitudes toward temporary methods.)

Table 5: Temporary Methods Contraceptive Distribution By Institution  
(1984)

Institution	Condom		Oral Pill		Foaming Tablet	
	Units Distributed	Share	Cycles Distributed	Share	Tablets Distributed	Share
I. FP/MCH	2,525,475	35	289,480	58	NA	-
II. ICHSDP	674,926	10	66,753	13	NA	-
III. CRS	3,327,840	47	111,575	22	165,312	100
IV. FPAN	602,963	8	25,814	5	NA	-
V. Other Commerical	NA	NA	6,947	2	NA	-
TOTAL	7,131,204	100	505,570	100	165,312	100

SOURCE: Foreign Trip Report (AID/RSSA): Nepal, Logistics Assistance, January 8-29, 1986.

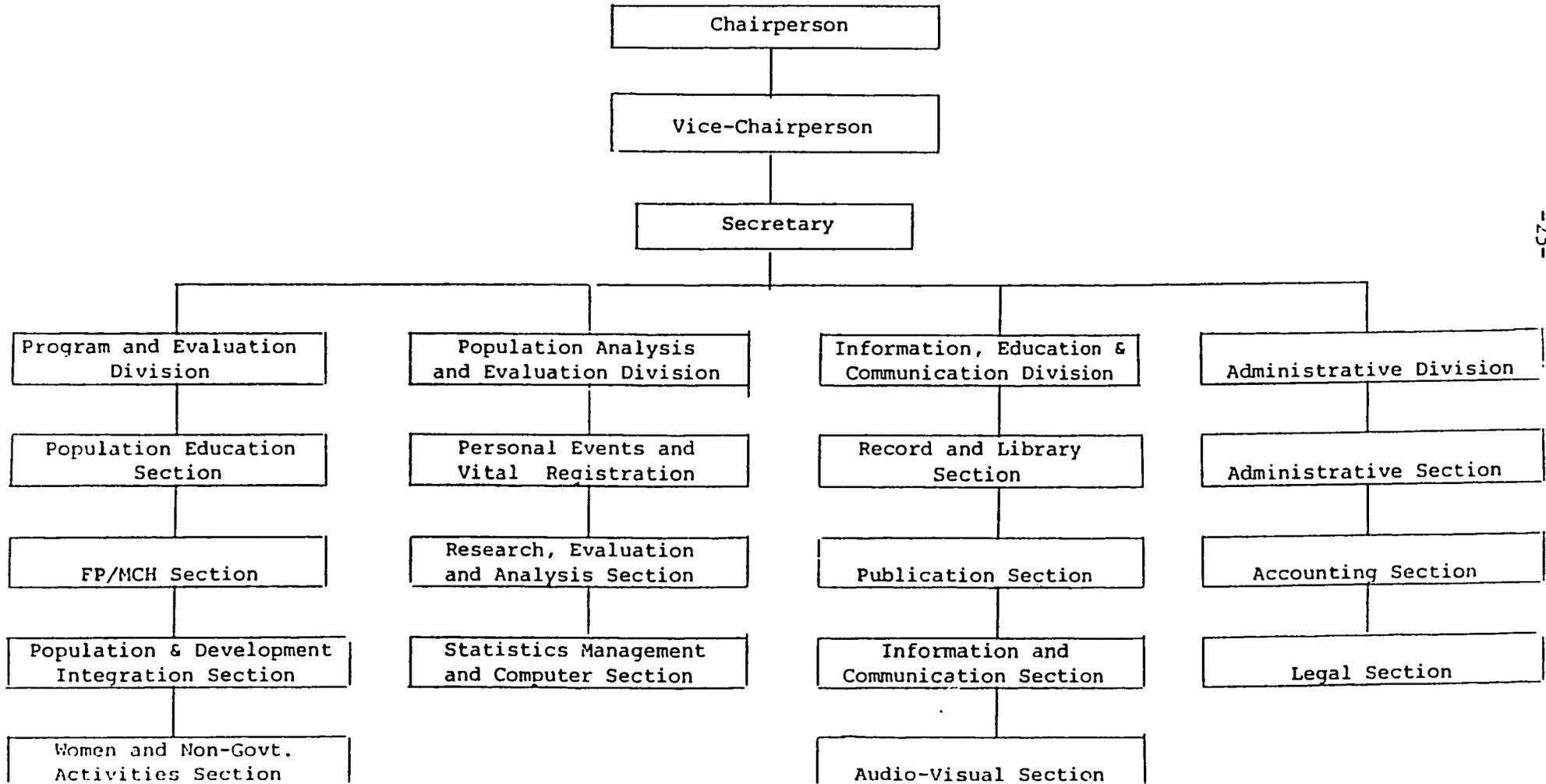
II.3.2.2 Sterilization Service Provision. Nepal's Voluntary Surgical Contraceptive (VSC) services are usually provided on a seasonal basis using short-term camps. This approach, which was first started in the late 1960s, was used primarily because of the climatic, geographic, and infra-structural characteristics of the country. Despite attempts to extend these services year round, with the exception of the Kathmandu area, this effort has only been moderately successful. At present, sterilization services are provided by several different organizations including the ICHSDP, FP/MCH, and FPAN. (Refer to chapter VI for a detailed description of the VCS programs.)

II.3.2.3 National Commission on Population. In 1982 the National Commission on Population (NPC) was institutionalized as a policy formulating and coordinating body to supervise all of the family planning service providers. The NPC oversees sectoral and multisectoral population programs and is responsible for issuing policy directives and guidelines for devising policies to influence population growth rates, migration, and distribution; and regularly reviews and evaluates population programs at both government and nongovernment levels to ensure their effectiveness. The organizational structure of this Commission, is shown in Chart 3. In addition, List 2 provides a summary of Ministry of health officials.

Chart 3:

SECRETARIATE OF NATIONAL COMMISSION ON POPULATION

ORGANOGRAM



SECRETARIATE OF NATIONAL COMMISSION ON POPULATION

LIST OF OFFICIALS

1. Chairperson - Priminister (ex-offico)
2. Vice-Chairperson - Mr. Shanker Raj Pathak
3. Secretary - Mrs. Chandra Kala Kiran
4. Program and Evaluation Division - Dr. Raghab Dev Panta
5. Population Analysis and Evaluation Division -  
Dr. Pushpa Lal Joshee
6. Information, Education and Communication Division -  
Mr. Dhruba Lal Shrestha
7. Administrative Division - Mrs. Sugandha K. Shrestha
8. Population and Development Integration Section -  
Dr. Som Pudasaini
9. FP/MCH Section - Mrs. Panch Kumari Manandhar
10. Population Education Section -  
- Miss Hasina Shrestha  
- Mr. Markandaya Upadhyaya
11. Wome and Non-Govt. Activities - Miss Syanja Prasai
12. Research and Evaluation and Analysis Section -  
Uttam Shrestha

### III. INTEGRATED RURAL/HEALTH FAMILY PLANNING SERVICES

#### III.1 Phase One Summary: (1980 - 1985)

The USAID project entitled "Integrated Rural Health/Family Planning" (No. 367-0135), which was approved in April 1980, was designed to improve Nepal's general health status and reduce the fertility rates of the rural poor throughout the country. To achieve this objective, USAID contracted with John Snow, Inc. (JSI) to provide technical assistance. As part of the project, local cost support was to be provided to the Ministry of Health in cooperation with other international donors. Furthermore, the project was envisaged to improve the management and expand the effective delivery of rural health and family planning services. This emphasis differed from earlier USAID-supported activities in Nepal because it not only focused on developing the capacity of the Ministry of Health to deliver services, but also concentrated on the actual service delivery itself.

As part of the project, funding from USAID was also to be used to assist the Secretary of Health in combining all rural health services into a system of integrated management. This goal was stated in HMG's Long-Term Health Plan. The project envisaged that forty eight of Nepal's seventy five districts would be integrated by 1985. Because a major aspect of the project focused on the development of a framework for organizational change, the exact implementation approach was kept flexible. With this in mind, the project paper stated that the "format and mix will depend upon further experience in development and implementation." Thus HMG was left to develop effective rural health and family planning services, "regardless of the precise annual details of delivery format."

Below is a summary of the four key areas emphasized within USAID's project paper (1980).

#### III.1.1 Management and Planning

Management and planning support was to be provided to the government of Nepal in the following areas:

- o Provision of technical assistance (222 person-months of long-term and 34 person-months of short-term assistance);
- o Continued support to strengthen the Health Planning Unit (HPU) of the MOH;

- o Participant training (15 long-term months and 18 short-term months in the United States, 80 short-term months in Asia, and 20 long-term and 75 short-term months in India); and
- o Special field operations studies.

### III.1.2 Rural Health Services

With regard to the rural component, USAID sought to

- o strengthen the central offices and expand the current USAID-supported ICHP project from thirteen districts to forty eight districts on a fully integrated basis,
- o provide support to help renovate HMG rural health facilities and build several new ones,
- o improve the drug procurement situation in rural health centers,
- o strengthen the logistics management within the Ministry of Health,
- o provide support needed to construct three regional warehouses,
- o improve the "cold chain" capability for an expanded immunization program, and
- o provide local cost support for training and administration to improve the services rendered by the rural facilities and village health workers.

### III.1.3 Family Planning Services

Family planning services were to be expanded and improved by

- o providing local cost support to ongoing USAID-backed FP/MCH activities; i.e., panchayat-based health workers (PBHW) and voluntary surgical contraception (both hospital and camp based);
- o improving the family planning services to all seventy five districts within Nepal through both the integrated and nonintegrated service programs; and

- o providing continued commodity support through the centrally funded provision of oral contraceptives and condoms as well as medical supplies.

#### III.1.4 Malaria control

Efforts in approximately forty districts, covering 7.2 million people, were to be supported through the provision of commodities (DDT, Malathion) and a new technical advisor to oversee Malathion safety considerations. Malaria surveillance and varying degrees of control were to be active in both integrated and nonintegrated districts.<sup>8</sup>

#### III.2 Project Inputs

The estimated cost of the program was determined to be \$143,376,900 over a five-year period beginning in 1980. USAID agreed to provide \$34,200,000, while HMG/N's contribution was to be \$109,177,000 (this total includes monies from other donor bilateral and multilateral agreements). This USAID funding was to be used for the following inputs: long-term advisors, short-term consultants, participant training, medical supplies, equipment, insecticides for malaria control, construction costs, and local cost support to rural health programs. Below is a detailed breakdown of the inputs provided to the program by USAID.

##### III.2.1 USAID Inputs for the 1980-85 Period

###### a. Technical Assistance:

- o Five long-term technical advisors for 222 person-months (experts in health education, health planning, and family planning services).
- o Short-term consultants for 34 person-months (two consultants per year for three or four-month periods).

###### b. Participant Training:

- o Graduate training in the United States for fifteen long-term participants to obtain an MPH focusing on topics such as health management, training administration, logistics management epidemiology,

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<sup>8</sup>Information collected in the Nepal Project Paper, Integrated Rural Health/Family Planning Services (April 1980).

health planning, entomology finance/business, administration, and family planning.

- o Short-term training in the U.S. (eighteen persons for three months), and Asia (eighty persons for two months).
- c. Commodities:
  - o Drugs for each post annually, totalling \$460 per post.
  - o Malaria insecticides
  - o Furniture, instruments, and 5 KW generators for the fourteen voluntary surgical contraceptive (VSC) centers.
  - o Equipment and materials including typewriters, calculators, refrigerators, vehicles, etc.
- d. Construction:
  - o Construction costs to design, supervise, and construct two rural health centers, three regional health centers, and ten health posts; and to rehabilitate twenty existing health posts.
- e. Support to Rural Health Operations:
  - o Seven percent of HMG/N's health budget for the Sixth Five-Year Plan (1980-1985).

### III.3 Expected Outputs of the Project

#### III.3.1 Integration Planning and Management of Effective Services

- a. Evidence that operational planning and management for service delivery is functioning effectively:
  - 48 districts under integrated management system.
  - 200 additional integrated health posts established during project period for a total of about 800.
  - Adequate and timely staff and budget allocations to districts.

- Planning and management control districts effectively decentralized due to HPU assistance.
  - Effective program evaluation capability.
  - Construction completed on 12 new rural health facilities, 3 warehouses, and the rehabilitation of at least 20 existing health posts.
- b. Evidence that health planning unit is functioning effectively:
- Effective monitoring of programs and progress of overall integration.
  - Planning/management surveys, including design and implementation of midterm (mid-Plan) review.
  - Decentralized planning and administration operative in all integrated districts.
  - Disease-specific surveys and field operational studies performed under HPU supervision and management.
- c. Evidence that management systems are functioning effectively:
- Adequate supply of essential drugs available in at least 48 districts.
  - Unified methods of distribution, storage, use, and resupply of drugs effectively performed in at least 48 districts.
  - System for local reimbursement for drugs and services being tested.
  - Supervisory systems and personnel in place at central, district, and HP levels that coordinate all health services in 48 districts.
  - Development of unified management information system.
  - Institutionalization of special field operations studies as a management tool.

### III.3.2 Community Participation in Health Services Established

- a. 50 percent of the districts with integrated management have functioning community health services, including village health committee.

- b. MOH and community-level health programs have effective supply reporting and supportive supervision/retaining linkages established.
- c. Adequate evaluation mechanism is in place, involving village inputs and village health committees.

### III.3.3 Training and Health Education Needs Met

- a. 80 percent of MOH nonacademic paramedical manpower training requirements met (approximately 1,600 new health and family planning workers trained).
- b. Routine refresher training program for all field staff institutionalized.
- c. Training process effectively planned, supported, and implemented.
- d. Health posts and village health workers supplied with at least 50 percent of recommended basic health education materials.
- e. 75 percent of participants (U.S. and LDC) trained and assigned.

### III.4 Midterm Evaluation of the IRH/FPS Project

In 1984, a midterm evaluation of USAID's IRH/FPS project took place. The evaluation reviewed the progress made by the project during the 1980-84 period. Unfortunately, POPTECH did not receive a copy of this document as part of the package provided by USAID/Nepal. Therefore no information was available regarding the outcome of this evaluation. (A copy of the evaluation report will be made available to the team members upon their arrival in Nepal.)

In place of the evaluation report, another document entitled "Status of Key Indicators Selected for the IRH/FPS Project 367-0135" was made available to POPTECH. This background report was prepared by JSI to act as briefing paper for the evaluation. The report presents each of the indicators drawn from the "Project Output" section of the original project paper entitled "Integrated Rural Health/Family Planning Services, No. 267-0135." Each indicator is addressed in terms of its status as of July 1984, while any additional comments, clarifications, or considerations were added when needed. Because the report provides a detailed, comprehensive description of the USAID

project over the course of the 1980-84 period, the paper can be found in its entirety within Annex 9.

III.5 Donor Assistance Provided to the Health and Population Programs in Nepal

III.5.1 Multilateral Assistance

a. International Planned Parenthood Federation (IPPF)

IPPF provides program support for IEC activities; a voluntary mobilization service (sterilization); a national contraceptive retail sales project; and training programs for students, teachers, community leaders, and women's groups (see Table 8).

b. United Nations Children's Fund (UNICEF)

UNICEF provides assistance to Nepal in the following areas: MCH; drugs; health education; cash commodity; health promotion and nutrition; rural water supply and sanitation; drug policy (training); prevention and control of acute respiratory infections (survey, environmental intervention); communicable disease control; iodine deficiency (injection); drugs (DDS Set) and vaccine supply; oral rehydration pills; and production and storage. (Additional background information relating to UNICEF's work in Nepal will be provided to the team during the briefing in Washington.)

c. United Nations Fund for Population Activities (UNFPA)

The United Nations Fund for Population Activities (UNFPA) has provided funding for twenty two health and family planning related projects implemented since 1980. The project covered four major areas including 1) health and family planning, 2) population education, IEC and Women's Programs; 3) demography; and 4) population policy and coordination (see Table 8).

d. World Bank

Since 1980, the World Bank has provided funding to Nepal to carry out a number of projects relating to the following topics: small-scale enterprise, agriculture and rural development, transportation, education, telecommunications, energy, and water supply and sewage. (Further information concerning the World Bank's efforts in Nepal will be provided during the briefing in Washington.)

e. World Health Organization (WHO)

WHO aids with research promotion and development; managerial process for national health development; health situation and trend assessment; health manpower development in nutrition; FP/MCH; community water supply and sanitation; traditional medicine; disease control and prevention (including immunization, malaria, diarrhea, ARI, tuberculosis and blindness); and health information systems.

III.5.2 Bilateral Assistance

a. Japan International Cooperation Agency (JICA)

JICA is providing assistance in construction, equipment, and in-services training for the FP/MCH project in two districts.

b. Norwegian Ministry of Development Cooperation

Assistance to FP/MCH programs.

c. The United States Agency for International Development (USAID)

USAID is assisting Nepal through John Snow, Inc. (see Chapter III, section III.1), and through centrally funded projects (see Table 8). The table shows the grantee, title of the project, host institution, beginning and ending date, fiscal year budget totals through 1987, and total expenditures over the life of the project.

Table 6: Summary of Population Projects Funded by USAID, UNFPA, and IPPF

Population Projects Funded by USAID, UNFPA, and IPPF  
 Funding Information for Life of Project (LOP), FY1984 - FY1987, and Prior Years (in 1,000s)  
 Date: 11/17/87

Country: Nepal

Grantee	Title	Host Institution	Begin Date	End Date	Prior Yrs	FY '85	FY '86	FY '87	LOP
AID Mission	AID BILATERAL PROJ.	NA			\$0	\$0	\$2,100	\$1,229	\$0
	INTGTD RURAL HLTH/FP SERVICES	MOH			\$2,300	\$2,600	\$0	\$0	\$0
	PVO CO-FINANCING	NA			\$100	\$0	\$0	\$0	\$0
AVSC	NATL I&E CAMPAIGN	FPAN	12/01/82	01/31/84	\$30	\$0	\$0	\$0	\$30
	VSC SERVICE PROG	FPAN	07/01/82	01/31/84	\$747	\$0	\$0	\$0	\$747
	MULTI-YR VSC PROG OF FPAN	FPAN	05/01/85	03/31/87	\$0	\$323	\$123	\$118	\$564
	MULTI-YR VSC PROG OF FPAN	FPAN	02/01/84	04/30/85	\$298	\$0	\$0	\$0	\$298
	MULTI YR VSC PROG FPAN	FPAN	04/01/87	03/31/88	\$0	\$0	\$0	\$167	\$167
	NATL I&E CAMPAIGN	FPAN	05/01/81	11/30/82	\$162	\$0	\$0	\$0	\$162
	REPAIR & MAINTENANCE PROG	FPAN	07/01/82	10/31/83	\$198	\$0	\$0	\$0	\$198
Battelle	WOMEN'S EMPLOYMENT & FERT	IDS INC	09/16/81	12/31/82	\$31	\$0	\$0	\$0	\$31
CEDPA	COMMUNITY BASED FP & NUTRITION	FPAN	11/01/86	10/31/89	\$0	\$0	\$0	\$41	\$82
FHI	CONTRACEPTIVE RETAIL SALES	NEPAL CRS CO LTD	08/01/85	11/30/86	\$0	\$13	\$9	\$1	\$23
FPIA	NEPAL RED CROSS FP PRIM HLTH	NEPAL RED CROSS SOCIETY	04/15/85	04/14/88	\$0	\$111	\$0	\$115	\$226
	EX-SERVICEMEN ORG FP PROJECT	NEPAL ESO FP PROJECT	01/15/83	05/14/88	\$231	\$0	\$139	\$157	\$527
	NEPAL RED CROSS FAM & HLTHCARE	NEPAL R C SOC HLTH SRV COOR	01/15/80	04/14/84	\$302	\$0	\$0	\$0	\$302
	YOUTH CLUB FP PROJECT	YACC	01/15/80	11/14/83	\$102	\$0	\$0	\$0	\$102
	MOTHERS CLUB-BASED FP PROJECT	SOC SERVICES NATL COOR COUNC	01/15/80	05/14/88	\$218	\$14	\$46	\$82	\$360
	WOM DEV SEC FP PROGRAM	WOM DEV SEC HMG OF NEPAL	12/16/85	11/15/87	\$0	\$18	\$0	\$2	\$20
Futures	CSM PROJECT - TECHNICAL ASST	NEPAL CRS CO	01/08/86	09/30/86	\$0	\$0	\$0	\$0	\$0
	CSM PROJECT - TECHNICAL ASST	NEPAL CRS CO	09/01/85	11/01/85	\$0	\$0	\$0	\$0	\$0
	RAPID NEPAL	POPCOM SECRETARY	11/01/79	11/30/82	\$42	\$0	\$0	\$0	\$42
IPPF	FPA NEPAL	NA			\$1,690	\$791	\$811	\$0	\$3,292
JHU-PCS	FINANCIAL ADMIN FP/MCH PROJECT	DORC	04/01/84	07/31/86	\$2	\$2	\$1	\$0	\$5
	FILM SPOTS FOR CINEMA HALLS	COMMAT INC	12/01/84	05/31/86	\$0	\$14	\$15	\$0	\$29
	PRINT MATERIALS	FP NEPAL-MCH PROJ-MOH	04/01/84	06/30/86	\$3	\$24	\$17	\$0	\$44
Pop Council	COST-EFFECTIVENESS FP PLAN PGM	NA	06/01/84	09/30/85	\$24	\$0	\$0	\$0	\$24
RTI	COST BENEFIT FERTILITY DECLINE	INTEGRATED DEV SYSTEMS	04/01/81	05/31/83	\$59	\$0	\$0	\$0	\$59
UNC INTRAH	ADM/FISCAL SVCS-NEPALI FP PROJ	NA	07/01/85	06/30/87	\$0	\$4	\$0	\$0	\$4
	FP/MCH TRN-FOR TBAS-5 DISTRICT	NA	09/01/85	08/31/88	\$0	\$95	\$0	\$0	\$95
	FP/MCH-INTRAH DIST LEVEL TRN-2	NA	08/01/85	12/01/85	\$0	\$14	\$0	\$0	\$14
	FP TRNG PAC II-APR/ASIA	NA	03/01/86	12/31/86	\$0	\$0	\$67	\$0	\$67
	CBD TRN FOR CRS PERSONNEL	NA	07/01/85	07/31/86	\$0	\$8	\$0	\$0	\$8
UNFPA	SUPPORT TO WOMEN S SERVICES	NA	01/01/80	12/31/86	\$63	\$15	\$20	\$0	\$98
	ALL OTHER	NA		12/31/86	\$3	\$3	\$6	\$0	\$12

Table 6: Cont.

Population Projects Funded by USAID, UNFPA, and IPPF									
Funding Information for Life of Project (LOP), FY1984 - FY1987, and Prior Years (in 1,000s)									
Date: 11/17/87									
Country: Nepal									
Grantee	Title	Host Institution	Begin Date	End Date	Prior Yrs	FY '85	FY '86	FY '87	LOP
	TECHNICAL ADV. SERVICES	NA	01/01/84	12/31/86	\$41	\$0	\$0	\$0	\$41
	FAMILY WELFARE EDUCATION	NA	01/01/84	12/31/86	\$39	\$11	\$27	\$22	\$99
	TEACHING AT IOM	NA	01/01/80	12/31/86	\$452	\$65	\$232	\$0	\$749
	SRVC. DELIVERY SYSTEM	NA	01/01/85	12/31/86	\$1,401	\$546	\$452	\$0	\$2,399
	ICHP/CENTRAL LEVEL	NA	01/01/85	12/31/86	\$314	\$332	\$644	\$0	\$1,290
	MCH/FP	NA	01/01/85	12/31/86	\$31	\$10	\$48	\$0	\$89
	VITAL REGISTRATION	NA	01/01/82	12/31/86	\$305	\$17	\$12	\$0	\$334
	POPULATION EDUCATION	PA	01/01/82	12/31/86	\$88	\$27	\$95	\$48	\$258
	FP/PARASITE CONTROL/NUTRITION	NA	01/01/86	12/31/86	\$185	\$64	\$81	\$0	\$330
	NAT. COMMISSION ON POP.	NA	01/01/85	12/31/86	\$112	\$11	\$35	\$0	\$158
	FP/MCH SERVICES	NA	01/01/84	12/31/86	\$9	\$61	\$64	\$0	\$134
	INFO. ED. AND COMM. SUPORT FP	NA	01/01/85	12/31/86	\$25	\$46	\$91	\$0	\$162
	POP. EDUC. PROG.	NA	01/01/84	12/31/86	\$21	\$26	\$74	\$6	\$127
	FP AND FERTILITY SURVEY	NA	01/01/84	12/31/86	\$0	\$42	\$59	\$5	\$106
	TECHNICAL SUPPORT	NA	01/01/85	12/31/86	\$0	\$86	\$182	\$120	\$388
	POP. ED. THROUGH MOE	NA	01/01/82	12/31/86	\$155	\$0	\$0	\$0	\$155
	POP. ED. THRU MINISTRY OF AGRI.	NA	01/01/80	12/31/86	\$134	\$0	\$0	\$0	\$134
	FP AND MCH PROJECT	NA	01/01/85	12/31/86	\$176	\$147	\$536	\$0	\$859
	ICHS DP HUMAN RESOURCES	NA	01/01/80	12/31/86	\$409	\$84	\$382	\$0	\$877
	COTTAGE INDUSTRY FOR WOMEN	NA	01/01/81	12/31/86	\$373	\$11	\$37	\$0	\$421
	POP. EDUC. THRU COOPERATIVES	NA	01/01/82	12/31/86	\$102	\$49	\$110	\$10	\$271
Univ of Hawaii	TRNG OF FP GRASS-ROOT VOLUN	FPAN	09/11/83	09/28/83	\$8	\$0	\$0	\$0	\$8
	LOGISTICS MANAGEMENT TRAINING	DORC	06/01/84	08/31/84	\$12	\$0	\$0	\$0	\$12
	RECORDING & REPORTING SYSTEM	NFP NEPAL-MCH HLT PROJ TRN DIV	06/15/83	02/29/84	\$26	\$0	\$0	\$0	\$26
	TRN PHNS ANMS IN TRN TBAS	DIV NURSING-MOH	05/01/83	12/31/83	\$9	\$0	\$0	\$0	\$9
	FINANCIAL & ADMIN MANAGEMENT	NFP NEPAL-MCH HLT PROJ TRN DIV	06/01/83	09/30/83	\$16	\$0	\$0	\$0	\$16
	REF TRAINING FOR TRAINERS	NFP NEPAL-MCH HLT PROJ TRN DIV	11/01/83	11/30/83	\$9	\$0	\$0	\$0	\$9
	DISBURSEMENT OF FUNDS IN NEPAL	DORC	06/30/83	12/31/83	\$3	\$0	\$0	\$0	\$3
	FINANCIAL MANAGEMENT TRAINING	DORC	05/01/84	08/31/84	\$18	\$0	\$0	\$0	\$18
	INST OF TBA TRN	RTSA-A SCH OF PUB HLTH	10/31/84	11/02/84	\$1	\$0	\$0	\$0	\$1
	ADMINISTRATIVE MGT TRAINING	DORC	04/01/84	08/31/84	\$17	\$0	\$0	\$0	\$17
Westinghouse	DEM/HLTH SURVEY NEPAL IN-DEPTH	HEW ERA	09/01/86	12/31/87	\$0	\$0	\$89	\$0	\$89
	CPS II NEPAL	FP-MCH PROJECT MOH	08/01/80	08/31/83	\$147	\$0	\$0	\$0	\$147
	CRS NEPAL	NEPAL MOH FP-MCH PROJECT	01/01/81	07/31/83	\$1,422	\$0	\$0	\$0	\$1,273
					\$12,665	\$5,686	\$6,604	\$2,123	\$18,641 TOTAL

## IV. INTEGRATION

### IV.1 Definition

In the field of international development, the concept of "integration" means different things to different people. The difficulty with this concept is that the same word is often used to describe a variety of functional and organizational health related events. For example, integration might include any one of the following definitions:

1. "A multipurpose health worker performs several tasks in health care, each requiring specialized training, and is supported by a single organization;
2. the multipurpose worker is supported administratively by one organization but technically by several others;
3. several single-purpose workers under separate organizations are collected physically and administratively in one health center or district, with their work more or less coordinated;
4. a single-purpose organization gradually gathers unto itself several additional functions; and
5. independent health care organizations, each pursuing a single goal, are collected under one administrative umbrella and managed through some coordinating council. Support services (planning, budget, logistics, personnel, etc.) may or may not be held in common."<sup>9</sup>

To some extent, examples of these models can be found in various aspects of Nepal's integration program. For example, in the CHIP program the following integration activities took place: multipurpose workers were used to provide specific health and population services (item #1 above); CHIP workers were assisted by other organizations such as NMEC and FP/MCH in some cases (item #2); with respect to the provision of sterilization, FP/MCH and CHIP efforts sometimes overlapped and combined coordination took place (item #3); and within the FP/MCH project, both primary care and family planning are combined (item #4).

Despite the diversity of different potential models, the overall goal of Nepal's integration strategy is to incorporate all of the vertical, single-purpose projects under a common administrative structure for each of the levels of health

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<sup>9</sup>Briefing paper prepared by John Snow, Inc. for the 1984 midterm evaluation.

infrastructure, namely, village, district, regional, and ministerial. This process calls for the functions, staff, and resources of these relatively autonomous projects to be assimilated into a larger emerging administrative structure through a series of gradual steps. This strategy was based on the premise that a collective group of unipurpose workers supported by one organizational structure would be more cost-effective than a series of unipurpose workers attacking single problems and supported by separate organizations.

Thus, integration is ideally defined to mean absorption by the Ministry of Health, regional directorates, district health offices, and health posts of all the development projects being run by the Ministry in the form of development boards. It implies the discontinuation of projects under the given legal status and absorption of all the project staff as regular personnel in the employ of His Majesty's Government, where such people are needed and qualified for the job in the context of the service policies and rules of HMG.

#### IV.2 Historical Context

Prior to the early 1970s, two types of service delivery structures existed. The first type was the Ministry of Health system which provided regular health assistance through the Department of Health Services, health posts, health centers, and hospitals. The second system represented a series of five vertical projects, such as the Smallpox Eradication Project or the National Malaria Eradication Project. These projects, which were often donor supported, were set up to handle a single health issue. Although the vertical projects were envisaged to be temporary, this has not been the case in Nepal. Part of the reason for this was that the regular health service activities offered were out of fixed facilities, while the vertical projects had significant numbers of trained mobile field workers who were needed to provide services at the village level.

In the early 1970s, HMG experimented with integrating vertical activities into the regular health structure in the Bara and Kaski districts. The purpose of the experiment was to expand the health post involvement to increase health efforts at the village level using the vertical project field workers. A second purpose was to eliminate multiple and duplicative management structures. The plan called for a decentralization of decision-making through district public health offices.

In a 1974 evaluation of the experiment, it was determined that the number of services provided within the two integrated districts was much higher than the number of services provided in districts in which the regular and vertical

activities were carried out separately. It was also determined that the integrated approach was more cost-effective. On the other hand, the management of the integrated system was found to be less flexible, especially with regard to unexpected events. Despite this defect, the evaluators recommended that the integrated approach be pursued. Thus, in 1975 HMG set as its long-term goal the expansion of the program throughout the country.

The project's conceptualization was articulated in the Long-Term Health Plan (1975-80), which sought to devise a more effective strategy for providing services to the rural population. As part of the strategy, the integration of public health services was to have two fundamental policy elements: 1) integration of all the vertical, single-purpose projects under a common administrative structure for each of the levels of health infrastructure, namely, village, district, regional, and ministerial; and 2) integration of preventive and curative medicines in a least-cost manner. The plan called for integration to be finished by 1985, which involved establishing 1,052 fully integrated health posts in all seventy five districts. It also meant the establishment of fifteen district and four regional hospitals within this time frame.

The chief organizational body responsible for the development of the integration concept was the "Integration Board," which was founded in 1970 and chaired by the MOH Secretary. The Board was supported by the Community Health and Integration Division, which was established in 1969 to oversee a program of integrated community health services. In addition, an Integrated Working Group (IWG) was also set up. The IWG met periodically to review the integration process and solve problems as they arose. In 1977, the Integration Board was dissolved and replaced with a new "Central Integration Board" (CIB), which was again chaired by the Ministry of Health Secretary. Other members included the Director General, Department of Health Services; the Chief, Community Health and Integration Division; chiefs of all vertical projects; and representatives of WHO and USAID (who acted as advisors). The primary aim of this board was to coordinate the integration of the multipurpose village level health workers and develop an integrated management system for rural health services.

Prior to the process of integration, the old health infrastructure consisted of approximately ten health posts per district, which were managed by district hospitals. These posts were often understaffed, with usually no more than a health assistant and a peon to handle the health needs for an entire area. There were also no field workers based in the posts. Because of understaffing within the district hospitals, the posts were rarely supervised. Parallel to this structure, within the

districts there were offices for specific vertical projects. For example, there might be a Tuberculosis Project office or a FP/MCH office, depending on the needs of that district. These projects had their own traveling field workers, who often made regular visits to assigned areas.

By contrast, within the integrated districts, the health posts were strengthened to consist of a health assistant (HA), two auxiliary health workers (AHWs), and two auxiliary nurse midwives (ANMs), who were all government salaried. The expansion of the health post structure and the addition of salaried field workers were two of the main components of the process. The district public health offices, which were staffed by a health inspector as well as fifteen to twenty staff members, acted as the vehicle for decentralizing management of health services. After the integration process got under way, it was found that the VHWs in the hilly and mountainous regions of Nepal were overburdened. As a result, a lower level of village volunteers, the community health leaders (CHLs) was added. The program included a provision for the selection and oversight of the CHLs by the communities themselves, and for community generation of local monies for drug resupply for the CHLs.

In practice, the transition from the vertical/old style service structure to the integrated structure proved to be difficult with regard to creating a single management and supervisory system able to administer the expanded efforts. In addition, the HMG's practice of transferring personnel from project to regular status created problems. In the process of addressing these difficulties, the integration process became a separate development project, entitled the Integrated Community Health Services Development Project (ICHSDP), whereby integration proceeded on a post by post basis rather than district to district. Also in the effort to solve the problems caused by integration, during the early 1980s, HMG elected to pursue a strategy of consolidation and slower expansion. For this reason, only twenty six out of the forty eight districts intended for integration were integrated. Out of this total, six were fully integrated while the remainder were only partially integrated.

In July 1987, HMG announced a major reorganization of health services. A separate Public Health Division of the MOH was established under which vertical projects, such as the FP/MCH Project and ICHSDP, were to be integrated. In addition, a separate Curative Division was also created which, among other functions, was to oversee the hospital system. Under the reorganization plan major responsibility for the implementation of the plan was to be delegated to the regional health directorates. At present, the implications for health and family planning services of this new integration of vertical projects and delegation of responsibility to the regions remains unclear.

#### IV.3 USAID's Involvement in the Integration Process

The Integrated Rural Health/Family Planning Services (IRH/FP) Grant provided by USAID was designed to support both the vertical services that satisfied rural health needs and the longer range transition to the integration strategy. Unlike past USAID grants to Nepal, which provided funding to only one component of the MOH, the IRH/FP project provided support for a variety of components including the regular health services of the DHS, the vertical projects, and the integration effort. As a result, the project was reported to have been flexible in responding to the changing needs and schedules across all activities of the MOH, while moving wherever possible toward the longer range structural changes which HMG is striving to implement. (Refer to chapter III for a description of the IRH/FP project.)

The midterm evaluation report addressed a number of issues relating to the integration process. For example, it reported that the GON regularly adjusted the schedule and strategy for the integration process. It also reviewed the issue of waning donor funding in the health and population sectors in spite of the limited ability of HMG to itself fund the continuing expansion of service needs. Unfortunately, the section of the report that covers these important topics was not available to the POPTECH project. As a result, the findings of midterm evaluation on these topics could not be presented in this background document. However, a copy of the evaluation report will be made available to the team by USAID in Nepal.

#### IV.4 Recommendations Made within the 1985 Integration Report<sup>10</sup>

##### IV.4.1 Model for Absorption of Vertical Projects

The 1985 Integration Report indicated that the ideal model of integration was one in which nearly all services were delivered through health posts. The report also provided a series of model plans for integrating the various vertical projects. (Refer to Annex 8 for a summary of these models.) In developing these models, the complexity and size of the project was taken into consideration. In addition, a number of governing principles were used, including the following:

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<sup>10</sup>Review of the Delivery of Health Services for Improving Integrated Services Including Family Planning and Maternal Child Health, HMG Task Force, October 1985.

- o "Place regulatory roles in the Ministry and RDHs or DHOs depending on the extent of decentralization and delegation of authority;
- o Place planning and budgeting functions in the Ministry, PRDs and DHOs by having projects' rationale, objectives and strategies safeguarded by the Ministry by their incorporation as Divisions therein but as specialized functions in the DHOs and RDHs.
- o Place all highly professional level and commercially oriented functions outside the civil service system (e.g., create HERCTI, construction company, etc.);
- o Use strengths of each project to benefit the integration process (e.g., NMEO's planning, programming, administrative system, etc.);
- o Seek checks and balances between
  - political and administrative authority,
  - developmental and regulatory roles,
  - line and staff functions and their professionalization, and
  - household and societal interests.
- o Reorganize existing project boards to work in the manner of boards of management with the chair being taken by the concerned Project Chief and consisting of his Deputy Chiefs and senior functional executives. Outside professional representation may also be indicted if needed."

#### IV.4.2 The 1985 Integration Report's Proposed Plan of Action for the Seventh Five-Year Plan

The Integration Report's proposed plan of action for integration for the seventh Five-Year Plan is summarized as follows:

By the end of 1985, there were twenty six partially and fully integrated districts. As part of the Seventh Five Year Plan, efforts are to be made to integrate health activities in an additional twenty new districts, and to complete the integration already under way in seven districts. If achieved, the total number of integrated districts will be forty six by the year 1990. Factors determining whether this number can be reached include the management and administrative capacity of ICHSDP;

cooperation of the different vertical projects; leadership by the Director General of the Department of Health Services; guidance by the Ministry of Finance, the Planning Commission, etc.

To carry out the integrated health program, a mechanism is needed whereby trained, experienced, and qualified personnel from the vertical projects can be absorbed into Integrated Health Services (see Models for Absorption of Vertical Projects). One suggestion is that integrated districts should have only one type of health service, not the mixture of Old Type, E-Type and I-Type health posts. Converting the Old Type and E-Type health posts into I-Type means that more staff have to be recruited. In such cases, only the personnel from the vertical projects who are already qualified for the vacant posts or who will be eligible to occupy those posts after training for a certain period of time (twelve to eighteen months) should be hired on a permanent basis. For the interim period, if necessary, the posts should be filled only on a temporary basis. In the already integrated districts, there are 12 Old Type and 206 E-Type health posts. Out of the 744 health posts in the country there are 306 E-Type and 294 Old Type health posts. If the health posts are all converted to the I-Type, many personnel from different vertical projects can be absorbed in the course of time. (Refer to Annex 3 for a description of the I, E and Old Type of health posts.)

Per the policy of decentralization of HMG, the Minister of Health has already established a regional directorate's office in two regions, western and midwestern. This may be an opportunity for ICHSDP to improve the integrated activities. The old and well-established integrated districts should be handed over to the regional directorates when the regional offices are fully staffed and equipped. ICHSDP should have an integration section in the regional office to supervise and guide the integrated activities in the region. This is suggested to strengthen the integrated health activities, to provide direct administration, and stronger supervision, and to take any action needed to improve performance. From the Center, ICHSDP should provide technical and logistic support to the regional offices.

## V. DECENTRALIZATION

### V.1 Definition

As part of the Seventh Plan (1985-1990), the government emphasized the importance of decentralization. With respect to the local panchayats, the following description was made within the plan: "To try to satisfy all the wants and requirements, whether big or small, of all the village and town panchayats scattered all over the kingdom cannot be regarded as a practical proposition. The appropriate thing would be for the local panchayat units functioning as the representatives of the local people to take in hand those small development works which have great importance in the local context. Decentralization Act 1943 has also been planned on the statute book. The aim of the act is to speed up the process of development by entrusting the local panchayats with the task of local development. In order to realize this objective it is of utmost importance that the administration of the local panchayat units be strengthened and stored up and that their competence to mobilize local means and resources be geared up. Institutionalized development is not a matter that can be achieved at a stroke. It must be built from the bottom up. It calls for a good deal of time and energy. During the Seventh Plan period, concrete steps will be taken to develop in the village, town, and district panchayats the ability to formulate and execute development projects and to mobilize resources. The policy of decentralization will be put into effect step by step."<sup>11</sup>

### V.2 Decentralization Context<sup>12</sup>

Until recently Nepal has had a highly centralized government system. Thus the power, fiscal resources, and program development capacity remained at the national level, while participation at the district and village level was limited. Beginning in 1980, a new dimension was added to local development through the provision of a policy of gradual decentralization. During this time, it was recognized that for of climatic, geographical, and monetary reasons, the country could not be adequately run from the Kathmandu Valley. The change called for the formulation of annual integrated multisectoral plans at the

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<sup>11</sup>Excerpt for the document entitled "Basic Principles of The Seventh Plan (1985-1990)."

<sup>12</sup>Information for this section came from a John Snow report entitled "Health Financing and Cost Recovery in Nepal" and the "Nepal Report of Second Mission on Needs Assessment for Population Assistance" (UNFPA, 1987).

village and district panchayat levels. The objective of the decentralization policy was to encourage increased "bottom-up" planning. In addition, the plan attempted to delegate much of the responsibility for project planning and implementation to the local panchayats.

Financial and material support for the district development plans were to come from three principal sources: a) block grants, b) grant-in-aid funds from the HMG (MPLD) block grants and c) funds from HMG line agencies allocated for district-level sectoral activities. In addition, the 1980 Decentralization Act empowered village and district panchayats to levy taxes, including the Panchayat Development Land Tax (PDLT). The proceeds from these taxes were to be retained locally, thus allowing local panchayats to have more direct control over their own resources. The PDLT also provided a means of generating revenue to support local health projects. The enactment of Decentralization Act 2039 (1982) gave the village/town panchayats and the district panchayats clear-cut responsibility and adequate authority to formulate, implement, and supervise village/town and district development plans to synchronize with the Five-Year Development Plans for the whole country. The Seventh Plan (1985-90) provides for continuing these procedures through socio-economic development at the local level.

Since the establishment of the decentralization policy, service centers have been established in the districts, providing support to local panchayats and user groups for preparing, implementing, and evaluating projects. Projects proposed by the village panchayats (with assistance from the service centers) are forwarded to the district- and region-level panchayats, where they are matched with the budgetary provisions of the line ministries.

One advantage of this plan is that decentralized activities will gain both political and economic strength through increasing local participation. At the most peripheral level, village panchayats will become the focal point for the implementation of development projects. Since the introduction of the decentralization plan, user groups have already been formed in some areas for managing the implementation of community development projects, including school committees, drinking water committees, and health committees. A possible disadvantage of the approach is that because it is up to each district to carry out its own plan, local health services may result in programs of varying standards depending on the effort put into them.

### V.2.1 Health Program Decentralization

As a part of the decentralization process, structural changes were made within the Ministry of Health. For example, by August 1986, five regional health directorates had been established. These directorates were set up in accordance with the Long-Term Health Plan and the regional Administration Plan of HMG within regional development centers. The main responsibility of the directorates was to inspect, supervise, and implement all health programs in the region in accordance with central policies and directives. The directorates were also to improve and evaluate the work of the district health offices, and assist them in planning and executing the rural health service program.

At the district level, plans are under way for the district health offices to become the most important agencies in health administration, coordination, and funding for the entire health program at this level. To oversee these offices, a medical officer is to be posted at this level.

V.2.1.1 Conclusion and Recommendations Made during UNFPA Needs Assessment Mission.<sup>13</sup> The report of the UNFPA Needs Assessment assignment carried out in 1987 made reference to Decentralization. According to the authors, "decentralization and regionalization are paramount in HMG's primary health care strategy. As a consequence of decentralization, the district health office will become the key institution for planning and implementing health services, based on the needs of local people."

The UNFPA Needs Assessment document also made a number of recommendations stemming from the authors' views on project administration. According to the team members, "The central administration should provide the overall services in all regions, leaving the district more autonomy for implementing the program. This might improve the administration of health projects." They went on to say that "this approach (decentralization) [was] fully compatible with the primary health care strategy and [was] recommend support by UNFPA where appropriate."

V.2.1.2 Recommendations Made in the 1985 Integration Report.<sup>14</sup> The 1985 Integration Report indicated that certain distinctions in power should be made between the district health

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<sup>13</sup>UNFPA Needs Assessment Report, 1987.

<sup>14</sup>Review of the Delivery of Health Services for Improving Integrated Health Services Including Family Planning and Maternal Child Health, October 1985.

offices and the Ministry in order to make decentralization work effectively. For example, the report recommended that the District Health Officer should have complete authority over personnel management within a district. In addition, the report advised that the authority to spend the budget be vested in the District Health Office (DHO) once the budget had been reviewed and approved by the Ministry and Regional Directorate of Health Services.

## VI. INSTITUTIONALIZATION OF VOLUNTARY SURGICAL CONTRACEPTION

### VI.1 Institutionalization Assessment<sup>15</sup>

In August/September 1987, a team of representatives from HMG's FP/MCH Project, USAID, and consultants from JSI and AVSC carried out an assessment of the voluntary surgical contraceptive (VSC) program in Nepal. The assessment report for this assignment provided a detailed discussion of the efforts being made to carry out institutionalization of family planning services within Nepal, with emphasis on the VSC component. Below is a summary of the main points brought up within the report.

#### VI.1.1 Definition of Institutionalization

The definition for institutionalization of family planning services that emerged from the 1987 VSC assessment was as follows: "In Nepal, institutionalization happens when a district has the ability to provide quality family planning and VSC (male and female) services regularly, routinely and on demand through the effective utilization and coordination of local (district) resources and institutions." This statement followed a less focused definition provided in the scope of work for the assignment defining institutionalization as "the provision of VSC services on a routine, year-round basis in government facilities." It was felt that the original definition needed more clarity in the following areas to fully describe the concept of institutionalization: a) the importance of quality of care; b) the importance of offering temporary birth control methods and VSC together; and c) the desirability of creating a framework for resources, coordination, and cooperation among local governmental and NGO units.

#### VI.1.2 Objectives and Expected Outcomes of Institutionalization<sup>16</sup>

- o "Improved contraceptive availability and use through year-round, on-demand provision of a range of contraceptive options suited to the needs and desires of contracepting couples at different stages of their reproductive cycles.

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<sup>15</sup>In August/September 1987, Terrence W. Jezowski and Alison Ellis (AVSC) carried out an assessment of the "Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal." The findings of this assessment were used as the basis for this segment of the paper.

<sup>16</sup>All quoted material is from the assessment report.

- o Improved viability and sustainability of services as a result of integration with and utilization of existing local institutions and resources to the maximum extent possible.
- o Improved cost-effectiveness as a result of utilizing existing local resources, routinizing service delivery, use of appropriate low cost technology, and expected increases in caseload.
- o Increasingly less reliance on external donors as a result of 2. and 3., above.
- o Minimal disruption of other curative and public health services and programs; less peak period stress on provider personnel, and facilities.
- o Improvements in the quality of services, including both medical safety and voluntarism.
- o Better client satisfaction with services."

#### VI.1.3 Requirements for Institutionalization

At the local level, the assessment team determined that the necessary requirements for institutionalization should be as follows:

- o "Local commitment, support, coordination and cooperation;
- o continuous and sufficient numbers of FP and VSC clients;
- o trained resources from the district;
- o adequate facilities and equipment;
- o sufficient supplies of expandable materials; and
- o quality assurance systems."

At the central level it was recommended that support should be provided in several ways, including:

- o "Affirmative policies, administrative commitment, supportive program guidelines and management;
- o financial resources;
- o quality training for local personnel;
- o provision of equipment and expendable supplies; and
- o supervision and monitoring."

## VI.2 Institutionalization of the VSC Program

### VI.2.1 History

One of the unique characteristics of "Nepal's VSC program was its seasonality and use of short-term camps for providing services." This seasonal approach was established in the late 1960s for the delivery of vasectomy services and in the early 1970s for the delivery of laparoscopy services. The reason for this seasonal schedule was based primarily on the climatic, geographic, and infrastructural characteristics of the country.

During the late 1970s, HMG began discussing the development of year-round "static" service sites with various donors. By early 1980, the first program was initiated to construct operating theaters (OTs) to carry out VSC year round. At this time, both UNFPA and USAID provided funding for this purpose. UNFPA financed the construction of thirty two OTs at district and zonal hospitals, and USAID provided funds to construct five family planning service centers, which were completed in 1982. In addition, with assistance from AVSC, FPAN established VSC services at selected district branches.

Despite the investment made by donors and HMG alike, the "static" approach has not changed the seasonal distribution of VSC patterns. With the exception of the Kathmandu Valley facilities, in many cases these services are not being provided on a year-round basis. If used for VSC, more often than not they serve only as bases for seasonal camps.

### VI.2.2 Assessment Findings for the Voluntary Surgical Contraceptive Program

VI.2.2.1 Referral Approach. As part of the present VSC program, outreach and client referral for family planning methods were conducted by a variety of community-based workers (CBW). These workers included panchayat-based health workers (PBHW) (FP/MCH project), village health workers (VHW) (ICHSDP), and clinic-based health aides. With regard to VCS activities, referrals were often made on a seasonal basis, usually during the dry, winter months. Field workers were asked to have interested clients assemble at a given time and location for the mobile surgical team (camps) or for transport to a static facility. Clients receive Rs. 100 compensation for the procedure. In addition, for each person who acts on the referral, the CBW received Rs. 5. In the summer of 1986, donor support for this compensation was discontinued. However, the GON still provides funding for these incentives.

The assessment team felt that this present referral approach was counterproductive for a number of reasons, including the following: 1) Information and education was sporadic; 2) during the seasonal acceleration for VSC, other work carried out by the field workers was disrupted, including the distribution of temporary methods; and 3) because the time frame was short, inappropriate clients were sometimes referred. Furthermore, this approach was found to be expensive in terms of vehicles, fuel, travel, and daily amount of time taken away from other activities. For example, during the camp periods, many medical personnel would often leave their regular duties behind, which greatly interrupted their regular service delivery. The assessment team indicated that if institutionalization were to take place, the present referral system would have to be reoriented.

As for the possibility of static VSC sites, it was noted that the use of camps was necessary in some areas, particularly in the mountainous and hilly districts because of their inhospitable topography and remoteness. However, in other districts such as the Terai and in some hilly areas, it was felt that VSC could be provided on a year-round basis where staff and facilities were available. This was already happening in the Kathmandu Valley.

VI.2.2.2 Manpower and Training. In order for temporary FP and the voluntary surgical contraception project to be year round, enough trained personnel must be available to provide these services. In order to determine the present need for the services, the AVSC assessment team collected information on the number of doctors trained in VSC methods and the number of nurses trained to insert IUDs. The team found that very few nurses were trained in IUD insertion and that the number of doctors trained to perform VSC was only slightly greater. As might be expected, there were fewer trained doctors in the hills and mountainous areas than in the Terai. The report also noted that the frequent reassignment of government medical personnel and the lack of cooperation in using the skilled manpower resources available in some of the local areas hampered the efficient provision of FP.

One of the priority areas discussed in the report was training. The authors indicated that regular training in the use of VSC techniques was especially needed throughout the country. At present, FPAN provides both vasectomy and minilaparotomy training while the university medical school provides none. Furthermore, training was often provided on an ad hoc basis (only a few trained at a time), with no standard curriculum or trainee certification criteria. To institutionalize the program, it was felt that a standard curriculum was needed in the medical school, and that eligible doctors in outside districts should be trained. Possible sites for this training include the FP/MCH Central

Clinic, Bir Hospital, the Maternity Hospital, and the FPAN Central Clinic (favored). To coordinate such an effort, it was suggested that a program management unit be established to manage a decentralized and dispersed training program.

VI.2.2.3 Facilities, Equipment and Supplies. The team felt that adequate facilities, equipment, and supplies were essential for the institutionalization of VSC. As part of their assignment, the team visited a number of VSC sites including two USAID-funded centers, three UNFPA-funded centers, nine MCH/FP clinics, three FPAN clinics, and ten zonal and district hospitals. "The service sites were assessed with regard to their physical condition, the availability of functional space for FP and VSC activities, the allocation of space in terms of logical client flow, client and staff comfort, and isolation of surgical area and the availability of equipment and supplies."<sup>17</sup>

The team members concluded that the visited sites presented a wide variety of conditions with respect to "preparedness," potential, and suitability for the provision of year-round VSC services. Several recommendations were made for possible future activities: 1) Priority should be given first to service sites in the Kathmandu Valley where the institutionalization process has already begun and where adequate serviceable facilities exist; 2) priority should be given to the USAID-funded FPS centers and UNFPA-funded centers; 3) all sites should be revisited to assess equipment needs, the functioning of available equipment, and the adequacy of functional space; and 4) in a few cases, space should be reallocated to improve safety and working conditions. In addition, some common observations were noted for all of the facilities:

- o "None reported significant problems with the availability of expendable surgical supplies;
- o most of the sites did not have designated areas where counseling could be conducted;
- o most of the sites had neither space designated for lab tests nor the capability to perform them;
- o most of the service sites had the full complement of emergency equipment; and

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<sup>17</sup>The report emphasized that this assessment exercise was by no means definitive in nature and the results should be considered with some caution.

- o in the central district area, all service sites visited had supplies of pills, condoms, and depoprovera, and some of the sites had IUDs."

VI.2.2.4 Counseling and Informed Consent. Effective and thorough counseling of those who requested VSC was found to be limited in the national program. The team felt that the system's orientation toward motivation of the client for VSC at the field level and documentation of informed consent at the clinic level, with little counseling offered, might result in inadequately informed clients. The present situation appeared to be recognized by the FP/MCH project. As part of their future activities, plans were under way to initiate a counseling program during the next fiscal year. Staff involved in VSC efforts were to be identified, trained, and posted at service sites to provide better VSC counseling. On a larger scale, the team recommended that HMG develop a national counseling training program for both the camp and institutionalized VSC efforts. To assist in the development of this training, it was recommended that FPAN be consulted because of its experience with counselor training.

With regard to the topic of informed consent, the team found that the forms used were being signed and marked correctly within the clinics. During the summer of 1987, a revised informed consent form was sent to the FP/MCH and ICHSDP projects. This form was to bring the Nepal VCS into compliance with AID regulations. (Refer to Annex 8 for a summary of AID's policy concerning informed consent.)

VI.2.2.5 Policies and Program Management. The team felt that supportive policies and management practices were needed to assist in the institutionalization process. Although HMG had provided guidelines to institutionalize VSC services, recommending that such actions be taken as increasing the availability and use of temporary methods and deemphasizing camps, the team found that there were a number of other practices that appeared to conflict with these goals. For example, special payments were still being provided for VSC operations. In addition, VSC continued to be encouraged at the expense of the year-round methods, and more emphasis was placed on reaching sterilization targets than on reaching targets for other methods. Another practice that hindered the year-round efforts was the preference for laparoscopy methods over minilaparotomy methods. There were fewer doctors trained in the former, specialized procedure than in the latter procedure, and most of them were based in the Kathmandu area. Furthermore, the doctors trained in the minilaparotomy procedure were not allowed to offer the service. The lucrateness of the short-term seasonal approach for the specialized doctors was another factor hindering the institutionalization of VSC.

VI.2.2.6 MCH/FP Project. As part of the current FP/MCH project workplan, several objectives and activities were outlined which had direct relevance to the institutionalization of quality family planning and VSC services. They included:

- o "Training of counselors and initiation of first phase counseling programs in six sites (VSC Workplan, Subactivity 1); orientation of intermediate supervisors in counseling and informed consent (VSC Workplan, Subactivity 7.C);
- o Implementation of a VSC quality surveillance program (VSC Workplan, Subactivity 3); training of nurses in aseptic techniques and routine surveillance (VSC Workplan, Subactivity 7.B);
- o Implementation of a VSC complications treatment, reporting and investigation system (VSC Workplan, Subactivity 4); and
- o Full utilization of the FPS centers (VSC Workplan, Subactivity 5)."

VI.2.2.7 Conclusions and Recommendations made in the Assessment Report.

- o Status of Institutionalization - The report's principal conclusion was that there was good potential for institutionalizing FP and VSC services in Nepal. At present the process of institutionalization appears to be moving forward; however, some locations were further along than others. At the national level, some essential central support systems (see above) were in place and work was under way to develop other support systems such as general training in the provision of services, training in counseling and supervision, and monitoring systems. The assessment team stated that "for the future, planning for institutionalization should be a process of assessing the unique situation in each district and developing programs tailored to each district's needs."
- o Preferred VSC Sites - Although zonal and district hospitals could provide the manpower to perform VSC, because of their overcrowding, poor conditions, and focus on curative services, they might not be ideal. Instead, the assessment report recommended that HMG "give priority to improving and fully exploiting the

existing clinic and OT facilities that have already been created for VSC service delivery at district FP/MCH centers and district health offices. (In recent years nearly thirty five such clinics/OTs have been constructed with UNFPA and USAID funding.) In a few districts, FPAN has VSC facilities and may be viable options."

- o Camps - Whereas the "camp" approach was still required in the hilly and mountainous areas, it was recommended that it be discontinued in the districts where regular, routine service delivery was available. The report pointed out that the camps were costly, disruptive to other services, stressful to staff and clients, and difficult to maintain in terms of the quality of service offered.
- o Institutionalization Initiative - "The team proposes that HMG consider an institutionalization initiative in a selected sample of districts. The purpose of this initiative would be to test a) whether camp-style mobilization can be completely eliminated without reducing achievement, b) whether the dramatic peaks in seasonal performance can be reduced to more manageable proportions, and c) whether temporary contraceptive acceptance/prevalence can be significantly improved."
- o Priority Programs and Support Systems - "The team recommended that HMG move ahead to put in place new and improved national-level support systems required for local (district) level program implementation."
- o Kathmandu Valley Programs - "Considering [that] district programs in the Kathmandu Valley were a) farthest along in the institutionalization process, b) closest to the national nerve center, and c) play a leading role in setting the pace and standards for the national program--special efforts should be made to accelerate the institutionalization process in this area."
- o VSC Training Program - To establish a year-round VSC service delivery program, it was "imperative that a coordinated national VSC training program be established." This includes placing emphasis on curriculum development, and training in vasectomy and minilaparotomy.

VI.2.2.8 Next Steps<sup>18</sup>

- o Implement key components of the current FP/MCH Project workplans.
- o Conduct a comprehensive review of medical quality.
- o Conduct a comprehensive review of VSC client satisfaction and voluntarism issues.
- o Survey central, regional, and district stores to identify existing equipment and supplies.
- o Develop a pilot postpartum project at the maternity hospital in Kathmandu.
- o Conduct a study of costs and cost-benefits in the Nepal family planning program.

VI.3 Institutionalization of Temporary Contraceptive Methods

Refer to section II.3.2 for a summary of the present organizations providing temporary family planning services. In addition, the next chapter provides a description of Nepal's use of temporary contraceptive methods, including a discussion of attitudes toward them by the general public.

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<sup>18</sup>Refer to report for a more detailed description of "Next Steps" section.

## VII. TEMPORARY CONTRACEPTIVE FAMILY PLANNING METHODS

### VII.1 Attitudes Toward Temporary Contraceptive Methods

The use of some form of contraceptive increased from 9 percent to 19 percent from 1981 to 1985. Despite this rise, only 2.3 percent was for temporary methods, while the remaining 16.7 percent was for sterilization procedures. At present, most of those going for sterilization operations are older parents who have already produced their desired number of children (average 5-6) and therefore want to terminate their fertility. Thus, this trend has had only a limited impact on population growth because most of those undergoing sterilization have already produced a large family. Furthermore, while there has been success in controlling fertility in older women, this effort has been counterbalanced by higher fertility in younger women who are presently entering the reproductive period.

Part of the reason for the low acceptance of temporary methods is that the population does not feel that a small family is necessary. In fact, one survey indicated that two-thirds of the parents interviewed chose not to use contraceptives because they wanted a large family. Other factors cited which appear to influence a couple's decision to use birth control include; the status of the woman, location in either an urban or rural area, the number of sons that had been born, and knowledge of available methods.

Between January and June 1986, a research study was carried out by a SOMARC consultant "to investigate the opportunities for and constraints facing the Contraceptive Retail Sales Company's efforts to increase market penetration in remote, off-road areas of the country."<sup>19</sup> During this field-based activity, which took place in an isolated rural setting, the author found that temporary contraceptive methods were not well understood or popular among villagers. This resulted from the combination of deep cultural biases along with the absence of an aggressive IEC campaign to dispel myths associated with temporary methods. Some of the biases included shyness about sexuality, lack of positive incentives to practice temporary contraception, and what appears to be a lack of concern for pregnancy-related risk factors.

Another reason for not using contraception was that many women indicated that they were not fertile after giving

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<sup>19</sup>Final Report of Findings and Recommendations: Village Marketing Study Nepal, SOMARC Research Visit, January - June, 1986.

birth or after reaching their late twenties; therefore, there was no need for contraception. A possible explanation for this was that because of their poor diet, hard work, and prolonged lactation, extended amenorrhea was common. This contributed to their feelings of being no longer fertile. It was further pointed out that the concept of family planning was more often than not associated with terminating fertility because the concept of child spacing was not readily understood or recognized.

In addition to the general objections raised by the villagers, a number of method-related biases were also discovered. For example, condoms were associated with illegal or extramarital sex. Other objections to the condom included decreased sexual pleasure, dirtiness, having no place to dispose of them, and unreliability due to bursting. The pill on the other hand, was most often associated with negative side effects. Since Nepalese women were often reluctant to approach male health workers or medical shop owners, the husband often obtained the pills. As a result, many Nepalese women never receive a medical exam or any form of supervision while on the pill. In addition, in many cases the husband does not accurately convey the information provided to him concerning the pill's use and side effects. Thus, many women either use the pill improperly or are unaware of the side effects. The author felt that this improper use of the pill and its use by women who should not be on it for medical reasons, may contribute to the high failure rates and abnormally severe side effects.

In addition to the above-mentioned study, another study was carried out in 1987, which also focused on attitudes toward temporary methods. As part of this effort, a focus group study was carried out by New ERA to determine why contraceptive methods were not being used by Nepalese women.<sup>20</sup> As part of the study, a mix of women from the hills and the Terai areas was selected. The groups were further subdivided into rural and urban sectors. In total, sixteen focus group discussions, containing between five and eight participants, took place. The major question posed to the groups was "What are the reasons for non-use of contraceptives?" The findings of this study were similar to those described above.

For example, with respect to the pill, the researchers found that most of the women indicated that they would not use this method because of health concerns. Many associated the pill with severe side effects such as headaches, weakness, nausea,

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<sup>20</sup>Report entitled "Reasons for the Non-Use of Contraceptives" (New ERA, 1987).

weight loss, and bleeding. Another common belief was that the pill would dry up their breast milk. The IUD method was found to be less known than the pill. The reasons for non-use of this method were also related to potential physiological complications including bleeding, an uneasy feeling during intercourse, a burning sensation, fear of losing it within their bodies, and death. Although few side effects were cited with the condom, some women were concerned that it fall off and become lost inside them. Other reasons given for non-use of this method were that their husbands felt that it interrupted intercourse and that the negative social image imparted by buying condoms caused embarrassment. The main reason for non-use of sterilization was that the operation made the recipients weak and unable to work. Others felt that they had insufficient money to purchase the nutritious foods they believed were necessary to maintain their health following the operation.

The report concluded that many of the women were misinformed about the various methods. For example, a number of women thought that most contraceptives would kill their youngest child because their breasts would stop producing milk. Others were unaware that the pill was a temporary method. In fact, some women were unaware that any temporary method existed. A possible reason for this was that family planning workers did not place much emphasis on temporary methods. To improve this situation, the authors of the study recommended that strong IEC be provided to educate the public, and that this effort be complemented by service providers who are effective in their motivational follow-up activities. It was further recommended that more emphasis be placed on temporary methods.

#### VII.2 Temporary Contraceptive Method Strategy within the Long-Term Health Plan (1983)

Within the 1983 Long-Term Health Plan (1983), emphasis was placed on the need for more serious efforts toward popularizing the acceptance of temporary methods of family planning. This was in light of the fact that most sterilization acceptors were generally those who had already passed through the most fertile period, as was explained above. Thus, before the present fertility level could be lowered, it was felt that more emphasis was needed to convince younger couples to adopt temporary family planning methods. With this in mind, the following strategy was to be pursued:

- o "Information, education and communication activities in the popularization of temporary methods of family planning will be stepped up through development of an appropriate communication strategy;

- o Such strategies should help improve both prevalence and continuation rates; the follow-up system, which is almost nonexistent at present, has also to be strengthened through adoption of appropriate programs in areas of maternal and child health;
- o Special emphasis, in addition to condom and pill distribution, will be given to the expansion of deprovera injection and IUD services; and
- o The National Commission on Population will serve as a Clearing House for all data related to family planning. All organizations concerned with such activities will submit to the Commission, every quarter, statistics on occupation, education and economic status of family planning acceptors. Information which can be derived from the records of family planning acceptors will then be analyzed for use in policy and program development."<sup>21</sup>

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<sup>21</sup> Information quoted from HMG Long-Term Health Plan, 1983.

## VIII. HEALTH PLANNING DIVISION

Limited information concerning the Health Planning Division was available in the documents provided to POPTECH to prepare this background paper. As a result, this chapter is limited to a description of the Division's structure and objectives for FY 2041/42 (1984). This information is presented to provide an example of the type of work carried out by the Division. More recent information relating to the Health Planning Division will be provided to the evaluation team while in Nepal.<sup>22</sup>

### VIII.1 Structure and Functions of the Health Planning Division (2041/42)

In FY 2041/42 1984, the Health Planning Division was divided into four sections; namely, Program, Health and Management Information, Evaluation and Research, and Administration. The functions and responsibilities of each of these sections are summarized below.

#### a. Program Section

The major responsibilities of this division were as follows:

- i) Health program review and analysis,
- ii) Health program development,
- iii) Planning and management training,
- iv) Coordination and support for NGO's,
- v) Development of women's programs,
- vi) Technical cooperation and coordination, and
- vii) Preparation of regular (annual, five-year, and long-term) plans.

This section was divided into three subsections: Health Systems Development, Programing, and Technical Coordination. In 1984, it was proposed that a Women's Development subsection be added to the Program Section.

#### b. The Health and Management Information Section

The Health and Management Information Section had major responsibility for accumulation, storage, retrieval, and

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<sup>22</sup>Information for this chapter came from a briefing paper prepared by JSI in preparation for the 1984 midterm evaluation of the IRH/FPS Project.

dissemination of health and management information. Its major responsibilities were:

- i) Operating the data bank,
- ii) Establishment of a National Health Information Clearinghouse,
- iii) Planning and management illustration,
- iv) Production of the Health Information Bulletin, and
- v) Preparation of country and district health profiles.

The Health and Management Information Section consisted of the three subsections, including the clearinghouse, data bank and cartography. The information provided by this section included:

- i) Program budgeting data,
- ii) Program/budgeting monitoring data,
- iii) Health manpower data,
- iv) Health facilities data, and
- v) Nursing manpower data.

c. The Evaluation and Research Section

The Evaluation and Research Section was responsible for the following activities:

- i) Project/program review,
- ii) Health resources analysis,
- iii) Computerized data processing,
- iv) Health services coordination, and
- v) Research coordination.

The Evaluation and Research division was composed of

VIII.2 Program Objectives for the NFY 2041/42

The major program objectives of the Health Planning Division for FY 2041/42 were as follows:

- a. To examine financial and technical appropriateness of periodic plans, annual programs, and budgets in order to increase the implementability of the plans and the absorptive capacity of the MOH. This objective required an in-depth examination and discussion of annual plans and budgets with all the service-providing agencies within the Ministry.
- b. To analyze the programs and budgets of the various health organizations outside the Ministry.
- c. To hold approximately twelve seminars/workshops on planning procedures, health management issues, and the various vertical projects' annual plans, including staff at the district and panchayat levels. This objective aimed at assisting in coordinating efforts in plan formulation for future years.
- d. To upgrade the Health Planning Division Data Bank.
- e. To further develop and administer the national Health Library and Literature Information System, including an information diffusion service with the capacity to reproduce documents.
- f. To further develop and administer the Nepal Medical Research Committee, and to review proposals and publish findings of the various studies it undertakes.
- g. To strengthen the automated data processing capacity of the HPD. To continue and expand the current manpower analysis, and begin development of a data base for health institutions.
- h. To conduct various field studies of health institutions as appropriate.
- i. To assist in coordination of primary health care activities between HMG and the various NGOs who provide health services in Nepal.
- j. To establish a Women's Development Unit within the Program Section to develop and coordinate programs for improvement of women's status as related to health activities.

ANNEX 1

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).

## ANNEX 2

### Description of the Material Child Health/Family Planning Project

#### A. Project Objectives

- i) Reduce infant mortality rate from 200 per 1,000 live births to 150.
- ii) Reduce crude birth rate from 40 to 38 per 1,000 population.
- iii) Reduce total fertility rate from 6.3 to 5.0.

#### B. Activities Carried out as Part of the Project

- i) Child health: BCG, DPT, polio immunization, rehydration, and nutrition education.
- ii) Maternal health: home delivery service, pre- and postnatal clinical services, and menstrual regulation promotion.
- iii) Family planning: condom, pill, deproprovera, IUD distribution; vasectomy and laproscopy operations.
- iv) Manpower development: in-service training for sterilization camp and field personnel.
- v) Information, education, and communication.
- vi) Planning, research, and evaluation.

#### C. Description of Project

The Nepal Family Planning and Maternal/Child Health Project (FP/MCH) was first established in 1968 after family planning services were integrated into an existing Department of Health MCH program. There were two main reasons for the integration of the FP component into the MCH program: (1) Because of Nepal's high child mortality, a need existed to provide services for surviving children and to provide ways to prevent future births; and (2) it was felt that the MCH activities might help to develop rapport for the promotion of family planning among MCH clients.

Over the years, a number of changes took place in the services provided by the FP/MCH project. Until 1975, the service delivery took place in static sites where MCH care and

sterilization were provided in clinics within sixty four of the seventy five administrative districts. (The number of districts fell following the introduction of the Integrated Community Health Services Development Project (ICHSDP)). After 1975, an outreach strategy was initiated whereby panchayat-based health workers (PBHW) were recruited to provide additional door-to-door services. Furthermore, during the late 1970s a nutrition education component was added to the program by the government. Finally, in 1980, emphasis shifted from temporary methods to sterilization because it was felt that the latter method was the only one that appeared to work in Nepal.

To oversee the activities of the project, a semiautonomous FP/MCH Board was established to set guidelines for the implementation of program activities. From 1968-77, the chairmanship of this board was held first by the Minister of Health, then by a full-time chairman, and finally by the Director General of the Department of Health. In 1978, the board was reorganized and subsequently renamed the Family Planning Service Board.

At present, the Nepal Family Planning and Maternal Child Health (FP/MCH) Project provides FP and MCH services and information to fifty two of the seventy five districts. The organizational structure of the project is decentralized on a four-tier system, including 1) the central office, 2) five regional offices, 3) forty district offices, and 4) 258 clinics, and 2,596 panchayat-based centers. As of November 1985, the staff consisted of 4,568 people, of which 36 percent are regular staff while the remainder are under contract. (Refer to Chart 4 for a summary of the organizational structure of the FP/MCH project.)

Three different service approaches are provided by the project: stationary, mobile, and door-to-door. For the stationary services, FP/MCH centers are attached to an existing health institution, such as health posts, health centers, or hospitals. As of July 1986, there were 256 FP/MCH centers of this type. The centers attached to the health posts usually employ two family planning workers (male and female) in addition to the existing institution staff, while the hospital-based centers may have as many as five or more extra staff including auxiliary nurse-midwives, auxiliary workers, and public health nurses.

Depending upon the availability of trained medical doctors and equipment, the hospital FP/MCH centers sometimes provide additional services such as male and females sterilization, IUD insertion, and depoprovera. The FP/MCH centers attached to health posts distribute condoms and oral pills to those who come to the center. The center also provides maternal and child

health services including diagnosis, nutrition, and environmental health care. Some of the FP/MCH centers, particularly district offices, operate satellite clinics in nearby areas. These clinics sometimes distribute oral pills and condoms, provide family planning education, and offer maternal child health services. As part of their work, FP/MCH personnel are required to provide follow-up visits to an acceptor's home and motivation to potential acceptors within a radius of three miles from the center.

A second service provided by the project is mobile sterilization camps. These camps are divided into two categories: laparoscopy or minilaparotomy camps (staffed with central office medical doctors from hospitals and the FP/MCH central clinic), or vasectomy camps (organized and run by the district personnel). During the first quarter of a fiscal year (July-September), district plans for a sterilization camp (vasectomy, laparoscopy, and minilaparotomy) are made in consultation with the central office. Once the budget and supply requirements are established, the plan is submitted to the central office for approval. While the camps are in progress (November-February), there is often plenty of help from community organizations, including local village panchayat members and volunteers from Women's Organizations, the Red Cross, and Youth Clubs. In addition, district and central staff often conduct motivation and education campaigns. Finally, nearly all of the sterilization camps are assisted by a district-level steering committee, which consists of the local elite. These committees help in getting the public's participation and in bringing potential acceptors to the campsite.

The third service is the panchayat-based center. This service was created in 1975, when it was discovered that most villagers were not willing to come to the FP/MCH center to obtain family planning services. Under an area system, a family planning worker spends one or two days per week in a FP/MCH center and the remaining four to five days in the field making door-to-door visits in order to motivate, educate, and distribute condoms and oral pills to couples at home.

Between 1975 and 1986, the number of panchayat workers has increased from 190 to 2,500. At present, a panchayat-based worker is expected to provide the following door-to-door services: 1) maintain a ward register which identifies potential acceptors in his/her village panchayat; 2) motivate and educate on family planning; 3) provide information on various family planning methods; 4) distribute condoms and oral pills; 5) distribute RD-Sol (Oral Rehydration Solution) for the treatment of dehydration; 6) distribute iron tablets to mothers; 7) provide education on sanitary hygiene; 8) refer sick children and mothers to a health post, health center, or hospital; and 9) disseminate

information about sterilization camps. In order to gain community support for the program, district-level Family Planning and Maternal Child Health Coordinating Committees were established. These committees assist the project by drawing up a tentative program in connection with the FP/MCH mobilizing local resources to run the sterilization camps and by selecting village workers (panchayats) for a panchayat-based center.

In order to monitor the field-level activities, four regional and forty district offices were established. Each regional office is headed by a senior medical officer who is assisted by a senior public health nurse, a statistical assistant, an IEC assistant, and additional administrative staff. Sole responsibility for carrying out the district family planning and maternal child health activities lies with the district officer. To supervise clinics and panchayat-based centers, there are a number of intermediate supervisors. Approximately one intermediate supervisor controls four to seven panchayat-based workers. Technical assistance needed by the regional offices and district offices is provided by the six divisions located at the control office.

## D/E. Project Strengths and Weaknesses

### Strengths

- o FP/MCH received wide support and participation from all levels, from the grassroots up.
- o A capacity had been created to generate indigenous strategic manpower: i.e., training officers, health aides, etc.
- o The project has proven competence in carrying out surveys within acceptable standards; e.g., Nepal Fertility Survey, Contraceptive Prevalence Survey, national papers, etc.
- o The project has effectively developed linkages with a large number of government and nongovernment organizations.
- o Knowledge and awareness gains regarding the benefits of small families have been made at the community level.
- o Planning targets were being set for each district and clinic.
- o An ample supply of funds was available for project activities.
- o National leadership was conscious of the grave economic, political, and environmental consequences of the population program.
- o A long-term population policy was available, with targets set for intervals of every five years.

### Weaknesses

- o Because the FP/MCH Program was a development project, most of the employees were not regular HMG staff. As a result, the attrition rate for employees was high due to uncertainty over their future status and a lack of promotion opportunities.
- o Insecurity among the FP/MCH staff has arisen because of a feeling that the integration process will not be able to absorb all the staff from the FP/MCH vertical project.
- o The FP/MCH Project was heavily dependent on foreign aid because no attempts had been undertaken to make the project self-reliant. In addition, most strategy or component changes were externally induced, which limited the managerial effectiveness.
- o The use of temporary birth control methods was very low.
- o PBHs (outreach workers) lacked motivation and knowledge of their role.
- o Supply shortages existed because of logistics shortcomings.
- o Delays existed in the release of funds because of faulty programming, nonreconciliation of accounts, and excessive centralization.
- o Involvement of local community in planning was insignificant.
- o Preventive services such as immunization and maternal care were rudimentary.
- o Low community awareness and use of family planning and maternal child health services existed.
- o Relationship between training curriculum and job description was vague.
- o There were no penalties for those workers who failed to perform and no rewards for those workers who did.

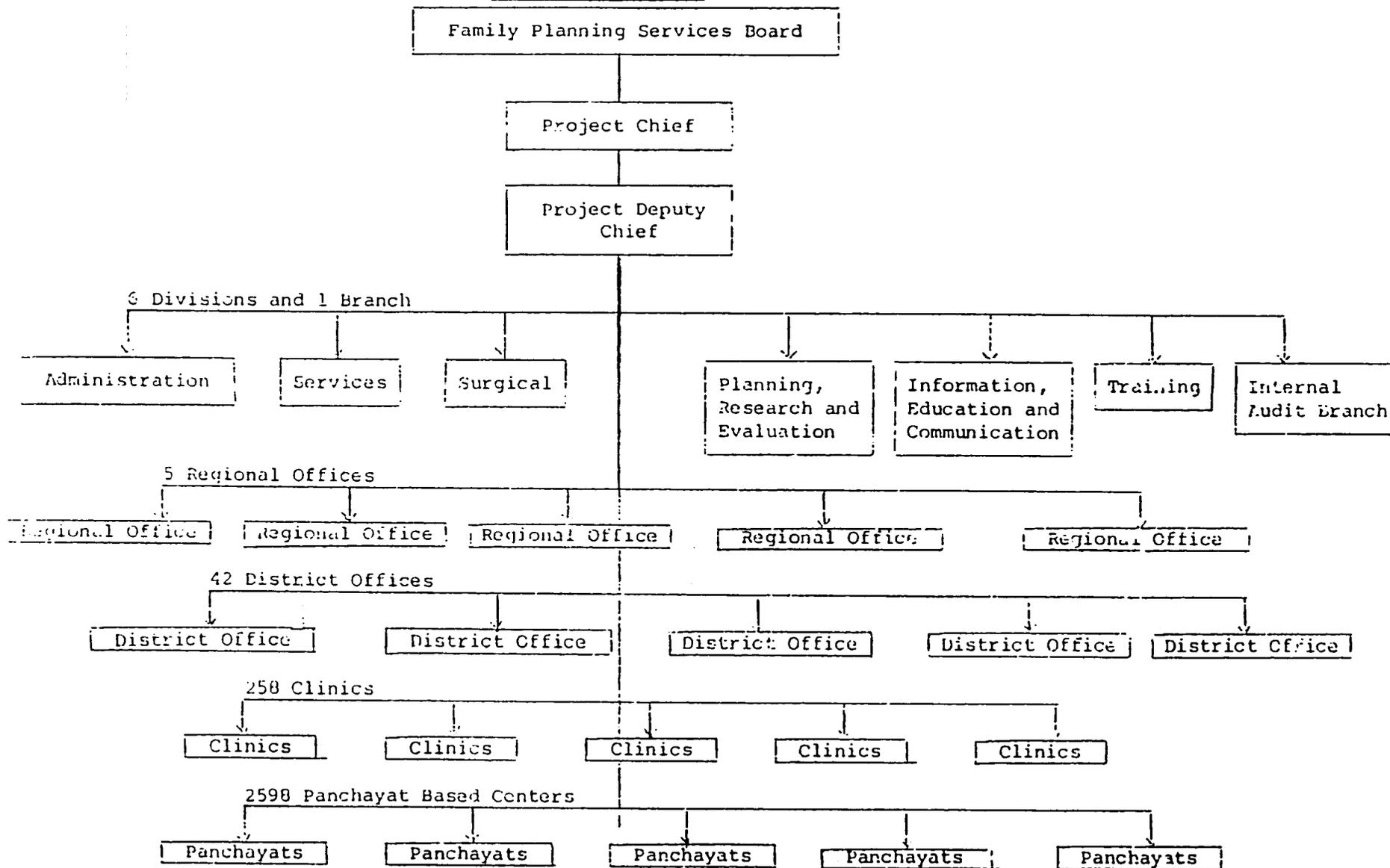
F. Summary of the Recommendations Made in the 1985 Integration Report<sup>23</sup>

- i) Increase effective outreach of field workers by increasing motivational training, increasing supply availability, generating more community participation, reducing individual worker's case load, and increasing extent, purpose, and quality of supervision.
- ii) Place emphasis on developing an effective training program; i.e. developing an operational manual for PBHWs, providing refresher training periodically, giving instruction on the pill and its side effects, etc.
- iii) Develop criteria to evaluate the work performance of the staff.
- iv) Give permanent status to the FP/MCH Project and regularize all staff as civil service personnel.
- v) Make the promotion of aggressive population control, including increased FP education and distribution of materials for temporary contraceptives (especially for younger age groups), an essential component of future health care planning.
- vi) USAID should assign the highest priority to the population situation in Nepal.

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<sup>23</sup>HMG Task Force report entitled "Review of the Delivery of Health Services for Improving Integrated Services Including Family Planning and Maternal Child Health" (November 1985).

NEPAL FAMILY PLANNING AND MATERNAL CHILD HEALTH PROJECT  
ORGANIZATION CHART



ANNEX 3

Description of the Integrated Community Health Services Development Project (ICHSDP)

A. Project Objectives

- i) Eliminate the present duplication of effort and investment in the field of preventive health care by absorbing all rural health services into a unified system of management at the village level.
- ii) Coordinate health care activities by developing an adequate system of referrals to the district- and regional-level hospitals from the village-level health posts.
- iii) Build and establish health posts and district health offices in the districts selected for integration in order to speed up the delivery of health services, especially to the poor, and improve the quality of the services so delivered.
- iv) Create a dynamic outreach service based on door-to-door visitations by health workers.
- v) Absorb the field-based personnel of all the vertical projects and ensure their optimum use as multipurpose health workers.

B. Activities Carried out as Part of the Project

- i) Family planning: motivation, organization of sterilization camps, distribution of pills and condoms for temporary methods.
- ii) Health education: rehydration and nutrition.
- iii) Immunization: BCG, DPT, polio, TT, and measles.
- iv) Nutrition monitoring: measurement of arm circumference.
- v) Case locating, treatment and holding: TB, leprosy, malaria, and diarrheal diseases.
- vi) Treatment of common illnesses: worms, headaches, skin, minor injuries, eye problems, measles, diarrhea.
- vii) Recording of vital statistics: birth, death, migration.

- viii) Referral services: to district, regional hospitals.
- ix) Construction: health posts, district health offices.
- x) Training: local health volunteers, traditional birth attendants.
- xi) Malaria surveillance: identification, treatment, and follow-up of confirmed cases.
- xii) Prenatal and postnatal care: at home, in health posts.
- xiii) Supply logistics: pills, condoms, vaccines, drugs, insecticides, medical aids and equipment, RD-Sol, and blood smears.
- xiv) Integration of vertical projects.
- xv) Finance, auditing, and budgeting.
- xvi) General management: planning, evaluating, reporting.

### C. Description of Project

The "Integrated Community Health Services Development Project" (ICHSDP) was established following two successful pilot activities: 1) the Kaski district project, which was set up in 1971 to create additional services for malaria workers; and 2) the Bara district project, which was set up in 1972 to centrally manage the health services provided by multifarious institutions.

The concept of integration for public health services had two fundamental policy elements: 1) integration of all the vertical, single-purpose projects under a common administrative structure for each of the levels of health infrastructure, namely, village, district, regional and ministerial; and 2) integration of preventive and curative medicines in a least-cost manner. Its evolution was based on the experiences gained from pilot projects and on experimentation with various policy decisions.

Although the conceptualization of the integration process can be traced to the early 1960s, the first real policy impetus for this process was laid down clearly at the time of the Fifth Five Year Plan in 1975. As part of a long-term health plan initiated by his Majesty the King, the integration of the vertical programs was to be completed by 1985, and involve the establishment of 1,052 fully integrated health posts in all of the 75 districts. In addition, fifteen districts and four

regional hospitals were to be established within the same time frame. The process was to be gradual with respect to the integration of the vertical projects, and was to follow a five-stage model.

Prior to this event, six districts were already providing comprehensive rural health services through 62 integrated and 289 nonintegrated health posts as a result of earlier efforts. Of the 351 health posts, 62 were fully integrated or said to be of the I-type, while none were partially integrated or of the E-type.

The chief organization responsible for this innovation was the Integration Board, which was founded in 1970 to launch the pilot projects. The board was supported in its functioning by the Community Health and Integration Division, which was established in 1969 to execute the program of integrated community health. In 1971 Integration Working Group (IWG) was also set up which lasted until 1977. The IWG met periodically to review progress and identify and solve problems.

A major development, which took place in 1977, was the dissolution of the Integration Board and its Working Group and their replacement by a Central Integration Board. The new board was chaired by the Secretary of the Ministry of Health. Other members included top health personnel, chiefs of all vertical projects, and representatives from WHO and USAID (who act as advisors). The primary purpose of the Board was to coordinate the integration of the vertical projects into the Community Health and Integration Division. In 1980, the division was dissolved and the ICHSDP was established in its place as a development project under "Development Board Act 2013." The Central Integration Board was also discontinued as the execution organ responsible for integration.

At present, the ICHSDP is governed by an eleven-member board of directors and is chaired by the Secretary of Health. The main function of the board is to formulate policies for the execution of the project, approve plans and review project performance, control the operations of the project, and coordinate the inter- and intraministerial decisions concerning the functioning of the project.

The project was organized on a decentralized, area-based plan consisting of forty eight district offices which oversee 744 health posts (HPs). These HPs are spread over all the seven five districts. As of November 1985, the status of the 744 HPs with respect to their integration was as follows: i) seven four fully integrated (I-type) HPs ii) 376 partially integrated (E-type) HPs and iii) 294 non-integrated (O-type) HPs. Within the forty eight districts, ten districts were fully integrated, which meant that they provided curative services together with the absorption

of all of the services of the five vertical projects. Another sixteen districts were "partially integrated" (having the curative medicine component, but with four or less of the services of the five vertical projects being absorbed). Finally, twenty two districts provided no integration services. Delays in integrating more of the districts resulted from administration difficulties, including an inability to resolve interproject rivalries and conflicts, reluctance by the vertical projects to hand over resources, weaknesses in project management at the level of the district health offices, and severe strains in coordination in the wake of ministerial and secretarial leadership changes.

Within the forty eight districts, the family planning and maternal child health activities were fully served under the Integrated Community Health Development Project using stationary, mobile, and door-to-door approaches. Although the FP/MCH Project had no responsibility in the "fully integrated" districts with regard to service delivery, the project did provide commodities, particularly oral pills and condoms, and facilities for sterilization and other special campaigns.

The chief executive officer for the project (CEO) oversees four functions: i) planning and training, ii) family planning, iii) communicable diseases, and iv) administration. In addition, this person is also responsible for four regional training centers and the forty eight district health offices, which are line authorities. The total staff strength was 3,700 as of November 1985. (Refer to chart 5 for a summary of the organizational setup.)

The district health offices were each to have a team of eight different personnel 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 nursing midwife (ANM). At the health post level, the staffing pattern for the fully integrated posts was one health assistant; two auxiliary health workers, two ANMs, six village health workers; one Mukhiya, and three peons (fifty eight posts in all).

As part of the organizational structure, each health post under the integrated program served four to six veks (one and a half panchayats). A village health worker (VHW) was assigned to serve one vek. It was reported that the VHW made two visits a year in each household in the mountains and six visits a year in the plains and hills. Wherever the ICHSDP had a responsibility for malaria surveillance and containment, each household was supposed to be visited monthly.

## D/E. Project Strengths and Weaknesses

### Strengths

- o Strong political support emanating from all levels of the government and embodiment in the long-term health strategy.
- o Good financial backing from multilateral and bilateral agencies.
- o Community participation through the provision of land and labor to the project.
- o Broad-based organization and vast outreach activities.
- o Government service status was provided to the project staff, which broadened their chances for career progression and pension rights.
- o A major capacity for manpower development had been established.
- o Leadership had not been exercised in this project because most of the personnel were under the Department of Health Services instead of the Project Chief. Thus, staff transfers were often made without project consultation, which in turn strained the project management.
- o No formal organization was responsible for ensuring that integration took place within a definite period of time.
- o Delays, graft, and corruption were not dealt with by forceful political and bureaucratic sanctions to correct malpractice.
- o Logistic management had been unable to solve the problem of continuity and timeliness in the supply of medicines and other materials.
- o There were no management-oriented and relevant plans of action to implement given policy decisions in line with given priorities.

### Weaknesses

- o The rationale and objectives of the project were not firmly laid down, leaving too much room for interpretation.
- o The board of directors was found to be basically non-functional, partly because the autonomy of development projects from ministerial authority was not a reality.
- o Decision-making was found to be made without research or baseline support.
- o The inability of the leadership to explain to staff the policy changes relating to objectives, targets, strategies, and job descriptions has led to role confusion.
- o The project is not able to spend all the money it has been allocated, which causes project delays.
- o The involvement of so many donors, interest groups, levels of administration and centers of power meant that policy-making was severely fragmented. This fragmentation prevented the project from taking an overall view of and coordinating sectoral needs, aims, and strategies.
- o Some health posts were busy only as long as the medicines held out, which in most cases was for 3-4 months of the year.

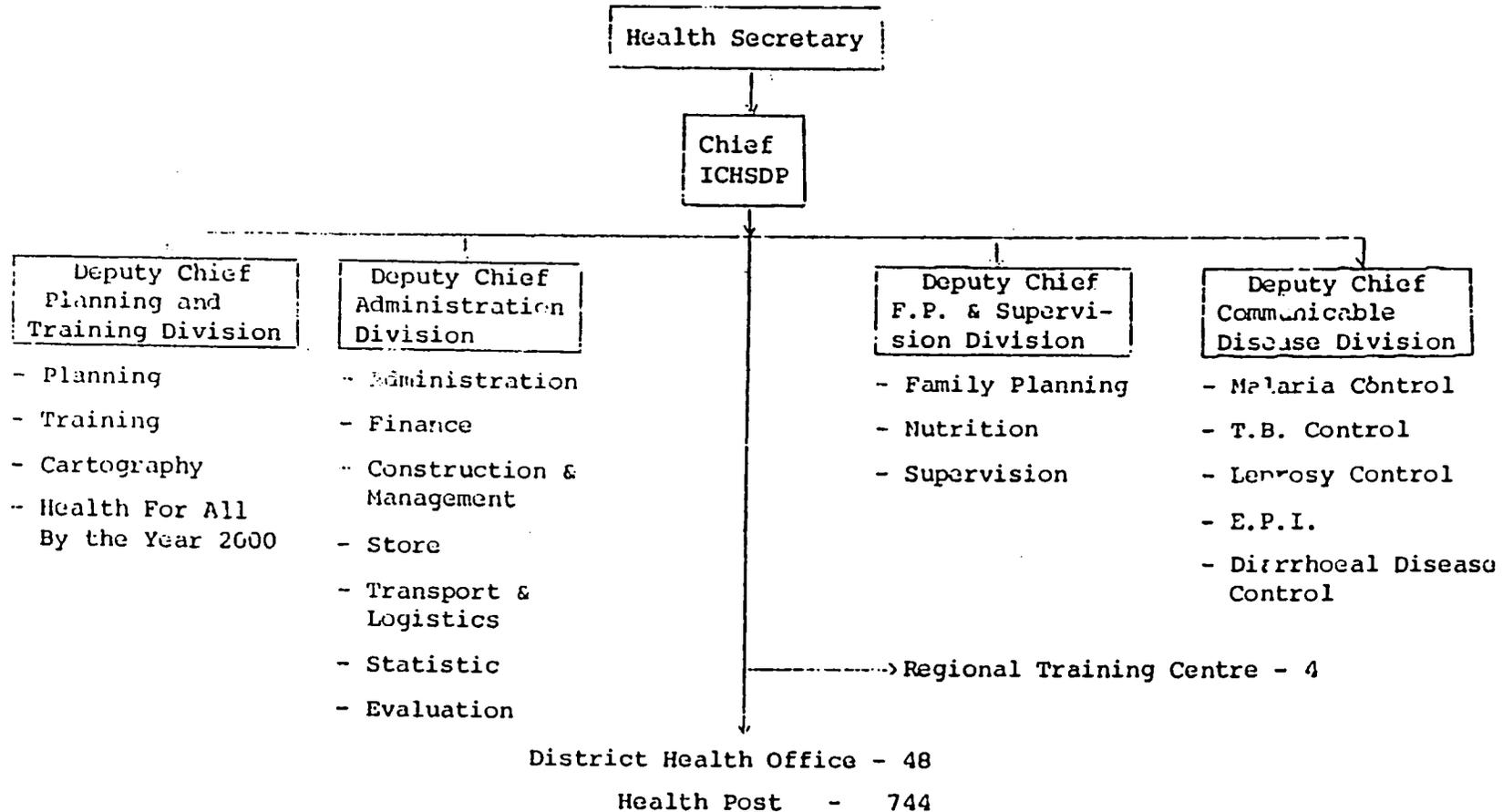
F. Summary of the Recommendations Made in the 1985 Integration Report

- i) Authority should be located in one chain of command. The authority to transfer or retain personnel working in the integrated districts should be delegated to the ICHSDP.
- ii) There should be clear-cut criteria regarding the transferring of personnel from one district to another. Trained and experienced personnel in the Integrated Health Services should be transferred only to other integrated districts.
- iii) Personnel should not be allowed to go for prolonged leave and should not be transferred to another place unless arrangements are made to provide a substitute.
- iv) In integrated districts, health posts of E-type and O-type should be upgraded to I-type by providing a full complement of staff for the purpose.
- v) There should be sufficient trained staff and capable manpower within the ICHSDP central office to check, record, analyze, evaluate, and respond to the reports received from the periphery.
- vi) For all the personnel working in the Integrated Health Service, there should be well-defined job expectations and a job analysis for each individual in terms of his or her job objectives, key result areas, authority, accountability, and the required minimum standard of performance. There should also be a system of reward and punishment for good and bad performance based on an evaluation by the immediate supervisors concerned.
- vii) The ICHSDP should have regional offices outside Kathmandu to supervise the field activities.
- viii) A definite action plan should be laid down to convert all HPs to I-type by 1990, with known standards and norms for service delivery levels. Experienced and qualified personnel in the district from the vertical projects should be appropriately absorbed. Those found below par in terms of education and experience should be trained and hired on probation.
- ix) An intensive program of supervision development should be introduced in ICHSDP whereby all frontline supervisors would be required to show initiative, drive, and commitment in their area of responsibility. Those key personnel should be evaluated for their

performance as supervisors under a system of evaluation that is fair, open, and results-oriented. Model organizational manuals and standard operating procedures and systems should be developed.

Chart 5:

Ministry of Health  
INTEGRATED COMMUNITY HEALTH SERVICE DEVELOPMENT PROJECT  
ORGANIZATION CHART



ANNEX 4

Description of the Nepal Malaria Eradication Organization (NMEO)

A. Objectives

- i) Maintain the level of malaria control already achieved and reduce morbidity from malaria.
- ii) Stop spraying in hilly areas where transmission is low.
- iii) Transfer low risk districts of the Terai where malaria control has been achieved for integration.
- iv) Control the spread of chloroquine-resistant P Falciparum.
- v) Adopt alternative methods of malaria control.
- vi) Strengthen the Research and Training Center.
- vii) Ensure better coordination between sectors and departments.

B. Activities

- i) Spraying: mapping, field inspection, and use of insecticides.
- ii) Surveillance: field inspection, reporting, and program budgeting.
- iii) Parasitology and entomology research.
- v) Health education: development of education materials and bulletins.
- vi) Training: primarily of field workers (entomology, spraying, logistics).
- vii) General administration: personnel management, organizational planning, statistical work, reporting, accounting, auditing, budgeting, and fund disbursement.

C. Description of Project

In 1954 and 1956, HMG/USO initiated two pilot projects to help reduce the malaria prevalence in Nepal. The first was to set up control of insect-borne diseases, and the second studied the feasibility of eradicating malaria within the country. Two

years later (1958), the Nepal Malaria Eradication Organization (NMEO) was established as a direct result of these efforts.

The NMEO began providing malaria eradication services first to central areas, then to the eastern region in 1962, and finally to the western region in 1964. By 1965, all of the malaria-infested areas were covered (50 percent of the country).

In 1966, the government devised a plan to eradicate malaria by the year 1973, using a four-phase system. The phases were 1) preparatory, 2) attack, 3) consolidation, and 4) maintenance. The last phase was to be carried out by the Department of Health as part of its regular duties. Although the project's original intent was to completely eradicate malaria, in 1975 the government came to realize that it was not possible to eliminate the disease completely. Thus, the NMEO changed its goal from eradication to "[controlling] the occurrence of malaria to an Annual Parasitic Incidence of 0.5 cases per 1000 population."

During the 1970s, the government began experimenting with the idea of integrating malaria workers into the basic health system at "pilot" locations. After a series of successful integration attempts, a primary health care development strategy for the country was initiated in 1975. As of 1985, fourteen out of the thirty nine malaria districts have been integrated, while twenty five remain non-integrated.

To oversee the operation of the project, a Nepal Malaria Eradication Board (NMEB) was established in 1958. The board is an autonomous public institution under the supervision of the Ministry of Health and has as its chairman the Secretary of the Department of Health. The day-to-day activities of the NMEO are coordinated by the chief executive officer (CEO) who oversees administration, fiscal management, technical program operations, and the planning, research, and training activities of the project.

The internal management structure is organized using an "area-based decentralized form" that includes four regional offices, twenty six district offices, 145 units, and 764 localities. In all, there are nine line and staff authorities that are directly supervised by the CEO. The total staff strength of the NMEO was 2,661 in October 1985, of which 30 percent are regular post holders. The labor force consisted of 1,125 malaria field workers, 450 service aid providers 295, malaria field inspectors, and 192 malaria assistants. (Refer to Chart 6 for a summary of the organizational structure of the project.)

D. Strengths

- o The project's budget had been increasing annually at a rate of 17 percent.
- o The project's supervision and leadership were effective.
- o Manpower was trained, experienced, motivated and committed to the project.
- o Organizational systems and processes were well established.
- o High professional standards of safety had been maintained in spraying DDT and Malathion.
- o The project had years of experience in the decentralization of managerial authority and had developed a fairly advanced system of planning, monitoring, and evaluating.

E. Weaknesses

- o Research capacity was absent for indigenous socio-economic, epidemiologic, and technological activities.
- o Supply lead times were exceedingly long.
- o The rate of integration had been slow because of budgetary limitations within the HMG and continued innovation changes made toward decentralization.
- o The current rationale and objectives for the project were not always well known or recognized.
- o The salary and allowances provided to the staff were often insufficient to provide for their needs, especially in light of their excessive workload.
- o Within communities, misconceptions existed concerning the spraying process, e.g., some thought that the spraying caused bugs.
- o Many problems existed, including inadequate coordination and management, inadequate physical facilities such as training centers, lack of field supervision, lack of regular sanctioned posts, shortage of feedback between integrated health posts and district malaria offices, staff absenteeism, and high prevalence of inexperienced personnel.

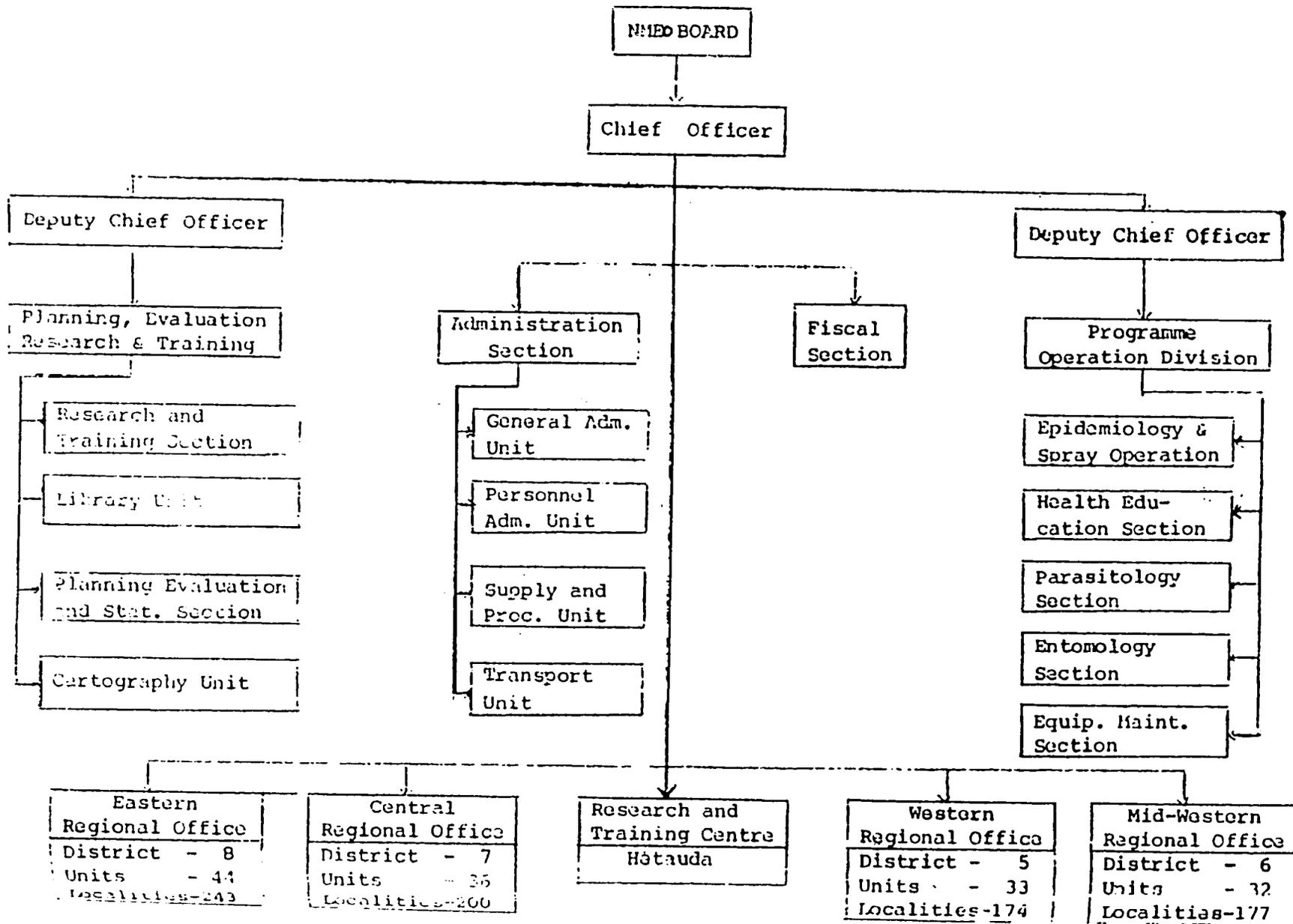
F. Summary of the Recommendations Made in the 1985 Integration Report

- i) A clear policy needs to be confirmed and established that outlines the role of district offices in planning or target preparation.
- ii) The development staff should be regularized as civil service personnel.
- iii) Since the laboratory technicians have to stay indoors, they should be given some kind of incentive to compensate them for the travel benefits offered to other staff.
- iv) Adequate local financial support, with timely release of NMEO funds, should be assured by HMG.
- v) HMG should seek donor support in providing necessary insecticides and other commodities.
- vi) NMEO should be given regular government status under the Ministry of Health as a directorate.
- vii) Plans are needed to integrate NMEO districts into the ICHSDP Project. The required number of sanctioned posts should be established prior to integration, and provision should be made for all NMEO personnel to be provided with posts within the integrated project.

Chart 6:

ORGANIZATION CHART FOR FISCAL YEAR

2041/042 (1984/85)



ANNEX 5

Description of the Expanded Immunization Project (EIP)

A. Objectives

- i) Reduce morbidity and mortality among children between the ages of 0-3 years old.
- ii) Protect the health of expectant mothers and prevent neonatal tetanus.
- iii) Reinforce the national population policy to bring down the overall fertility rate.

B. Activities

- i) Vaccination of children below the age of five all over the kingdom. Provision of immunization measles, poliomyelitis, diphtheria, and pertussis.
- ii) Injection services for pregnant mothers and children below the age of five years, throughout the country.
- iii) In-service training to reorient smallpox vaccinators, newly recruited vaccinators, and supervisors. Curriculum design to facilitate this training.
- iv) Technical supervision of the vaccination and immunization procedures provided by the ICHSDP project.
- v) Working out of the logistics to supply service delivery points better. General management, including record keeping, reporting, and standardization of cold chains.

C. Description of Project

Beginning in 1968, BCG and smallpox vaccines were provided on a limited scale in an attempt to eliminate these diseases. In 1972 diphtheria treatment (DPT) was also added. Following the success of the smallpox eradication effort which rid the country of smallpox three years ahead of schedule, the Expanded Immunization Project (EIP) was initiated in 1978. The factor that made the EIP effort different from earlier immunization projects was that it provided a "package" of services through clinics, health posts, and hospitals to children and expectant mothers instead of just one specific intervention. From the beginning, the program's integration into the existing health systems progressed gradually, from two Terai districts and

one hill district in 1978 (pilot test) to eighteen districts in 1980. By the end of 1985, the project planned to extend its activities into sixty three of the seventy five districts. One of the advantages of the project was that it provided the government with an opportunity to use already available trained manpower from the smallpox campaign to help consolidate the policy of integrated health services.

The EIP project represented a departmental program executed as a separate line agency within the Department of Health Services. Thus, the project chief was directly under the Director General. This person supervised six central staff functions, along with five regional, thirty five district, and six unit offices. As of 1985, the total manpower for the project numbered nearly 2,000. Of this total 98.2 percent were of the nongazetted class, with the dominant position being held by technical occupations. With regard to the project's budget (FY 1983-84), the following funding percentages were used in each area: DPT vaccine (25 percent), BCG vaccine (10 percent), TT vaccine (20 percent), Polio vaccine (25 percent), measles (10 percent), and evaluation and supervision (10 percent).

At present, the program maintains a network of linkages with ICHSDP (training of health post staff); the Planning Division, MOH (program review and monitoring); UNICEF (supplies and storage); WHO, AID (fellowships, technical assistance, vehicles and refrigerators); and the Department of Health Services (facilities and staff). (Refer to Chart 7 for a summary of the project's organizational structure.)

#### D. Strengths

- o The program's departmental form of organization was working well.
- o Growing budgetary allocations were provided by HMG.
- o Skilled and experienced field level staff were available to the program.
- o Integration was progressing rapidly.

#### E. Weaknesses

- o Because the Nepalese health administration was unable to integrate bilateral and multilateral aid donors, EIP functions were being duplicated by the FP/MCH project.
- o Little vital baseline epidemiology data were available to the project.
- o There was Excessive staff turnover.

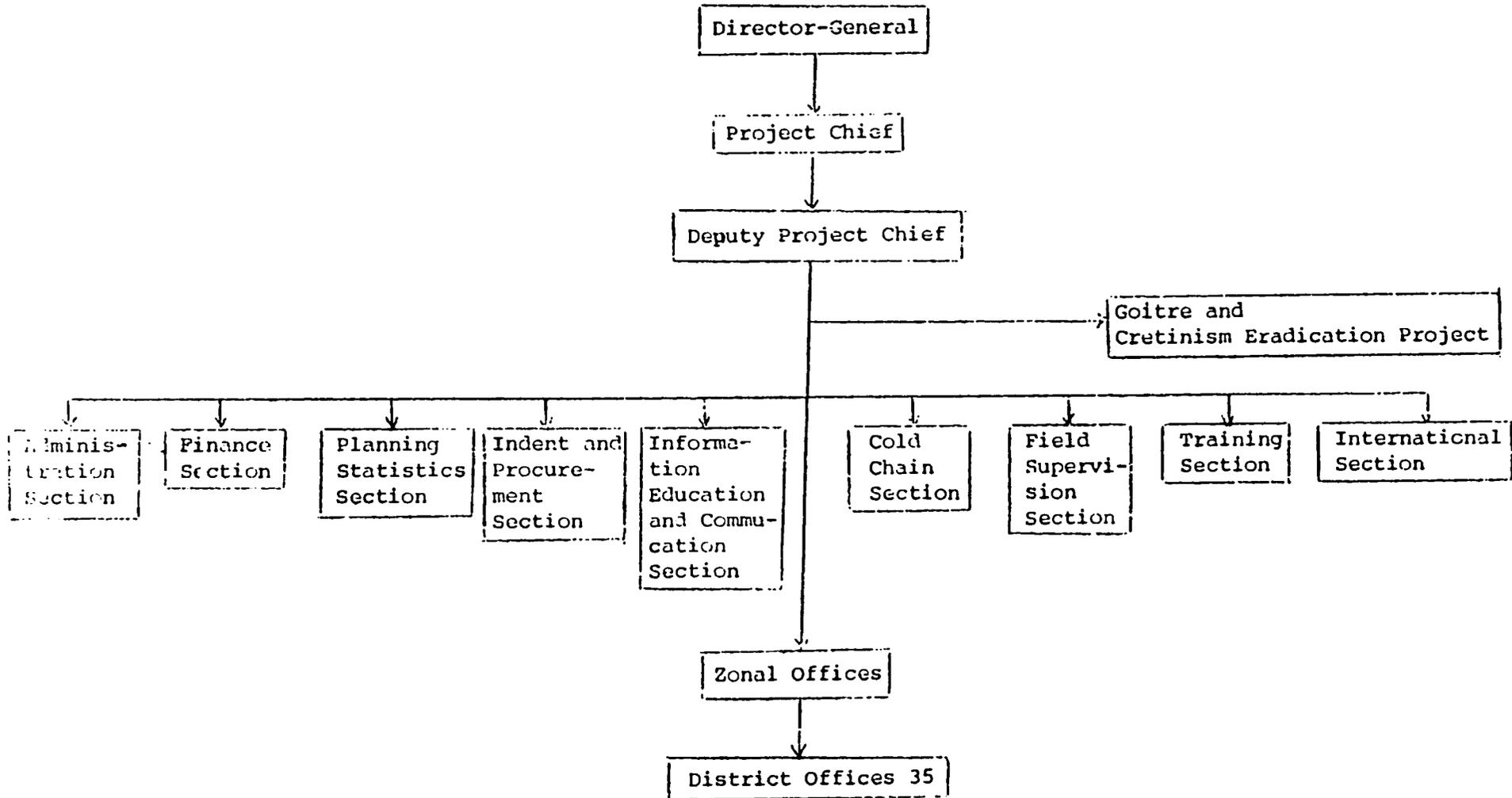
- o Difficulties with respect to the supply situation resulted from problems relating to supply storage, the amounts received, and the timeliness of the deliveries.
- o Public awareness of the benefits of immunization had not reached significant levels.
- o Motivation was low because EPI staff were not regular service staff for the HMG.
- o The program was hampered by a lack of adequate supervision, transportation, and target setting.

F. Summary of the Recommendations Made in the 1985 Integration Report

- i) Increase supplies in district offices/health posts, investigate local supply purchase options, and review the present supply distribution policies.
- ii) Establish an immunization policy and plan for the district offices.
- iii) Establish a basic surveillance system in the Department to ensure constant monitoring of the immunization progress. Measles, pertussis, neonatal tetanus, and polio should be given consideration as major priority areas for monitoring.

Chart 7:

EIP ORGANISATION



## ANNEX 6

### Description of the Tuberculosis Control Project (TBCP)

#### A. Objectives

- i) Offer permanent tuberculosis services to the people in consonance with the limited resources and prevailing socioeconomic conditions.
- ii) Initiate case finding on an active door-to-door basis and refer those infected with TB to health posts for treatment (identify at least 75 percent of all prevailing cases in each community).
- iii) Periodically assess, monitor, and coordinate tuberculosis control methods used by all governmental and nongovernmental agencies.
- iv) Train staff and all concerned health institutions in the methodology of TB control.
- v) Do sample surveys in all development regions of the country in order to obtain precise information on the incidence of TB.
- vi) Change the status of at least 75 percent of all those identified as infectious to noninfectious through effective and adequate chemotherapy.

#### B. Activities

- i) Case finding: During household visits, locate those members of the household who are fifteen years of age and older who show TB symptoms. Collect spot sputum specimens and diagnose illness.
- ii) Treatment: Visit positive cases in their own houses, motivate patients to undergo treatment through counseling and the provision of drugs (sufficient for thirty days' requirement), and refer the case to the health post for continued treatment.
- iii) Assessment: Eight weeks following the BCG campaign in a given district, make an assessment consisting of random sampling of children below fifteen years of age to determine the extent of BCG scarring. This is done to ascertain the campaign's results versus targeted coverage.

- iv) Supply: The program aims to provide DCG vaccines and anti-TB drugs to hospitals, health posts, and other agencies providing treatment.
- v) Manpower development: Health personnel training covering vaccination techniques, screening, diagnosis, and treatment of symptoms is provided to the supervisors of all the ICHSDP districts.

C. Description of Project

In 1965, the Tuberculosis Control Project (TBCP) was initiated in the Kathmandu area. (Other projects also provided TB services to other regions, particularly the British Nepal Medical Trust.) When the project began, BCG vaccinations were given only to those children who showed negative reactions to the Mantoux test, but in 1967 the program was expanded and door-to-door visitations were introduced to vaccinate all children between the ages of 0-14 years. In 1973, the program was further extended to areas outside Kathmandu. Because of the magnitude of effort required to vaccinate all those 0-14 years old, the TBCP collaborated with the Smallpox Eradication Project (SEP) to integrate their functions by having smallpox vaccinators do the BCG vaccinations. By using this strategy, BCG vaccination coverage rose significantly from fourteen districts to sixty four districts (90 percent of the eligible population) in a short time.

In 1976, the TBCP enlarged its strategy to include "case finding" on a door-to-door basis. Once cases had been located, treatment was to be provided at local health posts in the area. Between 1980-85, the project again expanded its scope by launching a new strategy seeking to integrate "maintenance" vaccination services into all of the health posts.

The TBCP represents a specialized "functional" program within the Department of Health Services. Because this project is directly attached to the government, all of the 161 (1985) employees were part of HMG. Out of this total, 82 percent were technical staff, whereas 4.3 percent were gazetted. At present the project leadership consists of a project chief, who is under the Health Department Services Director General, and a deputy project chief. These two persons oversee six sections of the project including administration, accounts, statistics and planning, medical, training, and stores. With regard to the budget (FY 83/84), the largest portion went to the treatment of TB (54.8 percent), followed by case holding and case finding (40 percent). Less than 3 percent went for training and land acquisition for a regional training center. (Refer to Chart 8 for a summary of the project's organizational structure.)

The TBCP supports a fairly weak system of linkages, while minor relationships have been developed with several other service providers including United Mission Nepal, Nepal TA Association, and the Nepal Red Cross Society. However, the project supplies some anti-tuberculosis drugs to ICHSDP and provides limited training at their integrated health posts. As a result of the program, it has been estimated that the TB incidence may have been lowered from one percent to a half of a percent.

D. Strengths

- o Budgetary provision has been increasing annually because the project has a strong absorptive capacity.
- o Project staffing was small and compact, and turnover was low.
- o The project had a rapid rate of penetration into registered households.

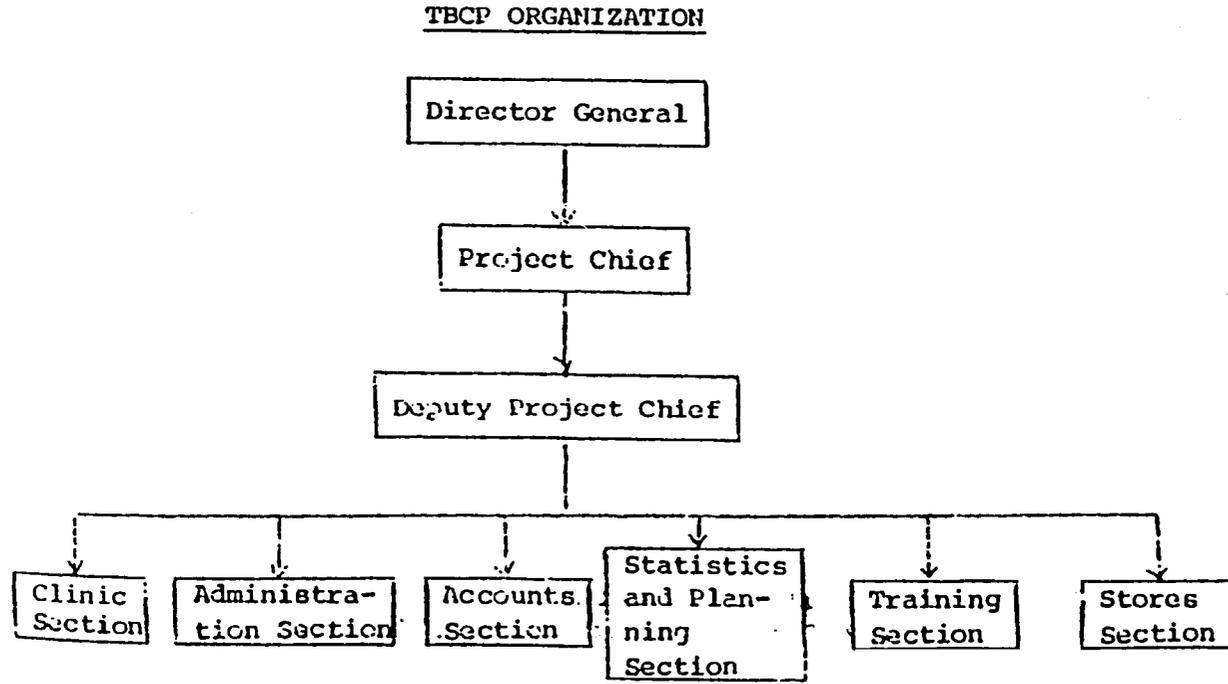
E. Weaknesses

- o The project was not effective in recording data and information on TB prevalence.
- o The system for supplying drugs and vaccines was inadequate.
- o Unreliable recording and reporting was pervasive.
- o Too much reliance was placed on "campaigns" instead of on full-time, intensive community participation in control and prevention efforts.
- o The project's rationale, objectives, and priorities were unclear, and consequently its future was uncertain.
- o ICHSDP participated insufficiently in TB control activities.
- o There was a high defaulter rate and insufficient recourse to sputum testing for diagnosis.
- o Getting people to believe that TB could be cured and to motivate others to abandon their apathetic attitudes toward the victims of the disease had not been achieved.

F. Summary of the Recommendations Made in 1985 Integration Report

- i) Enhance the participation of ICHSDP in TB activities. A joint TBCP-ICHSDP action plan should be developed for the 1985-90 period.
- ii) Motivate health workers to increase their productivity, particularly in the area of promoting sputum testing.
- iii) Modernize purchasing and storage methods, procedures and policies at health posts and hospitals.
- iv) Educate the community on basic TB control and prevention.

Chart 8:



ANNEX 7

Description of the Leprosy Control Project (LCP)

A. Objectives

- i) Obtain correct information on the prevalence of leprosy.
- ii) Assist in the rehabilitation of the disabled.
- iii) Train health post staff to detect, diagnose, and treat leprosy cases.
- iv) Strengthen the system of supervision in the delivery of services to patients.
- v) Educate every school and panchayat.
- vi) Create five regional referral centers and nine sub-regional centers in the remaining nine zones.

B. Activities

- i) Case holding.
- ii) Education: Inform people on causes and cures of leprosy, help to eradicate prejudices, and promote detection and voluntary submission for treatment.
- iii) Provide training for preventive, curative, and rehabilitative functions.
- iv) Improve existing rehabilitation facilities.
- v) Management: Stimulate and expand community participation, strengthen logistics systems, improve quality of service, and encourage research.

C. Description of Project

The first health service for leprosy victims was started in 1958. This service was provided through a dispensary set up by "Mission International" in Chapagaon. Four years later, a 100-bed leprosy hospital was established in Anandaban by the same organization. This referral hospital was equipped with laboratory testing, a reconstructive surgery capability, nursing services, physiotherapy, a pharmacy, and a training and research capacity.

In 1963, the government took its first step in recognizing the leprosy problem when it passed an annulment of an act that restricted those suffering from this illness to leprosaria. Two years later, WHO carried out a joint leprosy-tuberculosis pilot project. However, because of administrative and medical problems, the program was terminated. In 1967, an "Expanded Leprosy Project" was initiated by the government with donor support. This project, which was centered in the Bagmati and Narayani zones, was one of the chief contributors to the establishment of a Central Leprosy Clinic in 1970. During the 1970-75 period, five more zones were targeted to provide leprosy control services. The treatment strategy adopted involved visits to hospital sites by mobile teams from the Central Leprosy Clinic.

The present Leprosy Control Project (LCP) was established in 1978 to protect the healthy population, reduce prejudices against those who were infected, and integrate leprosy into the basic health service treatment strategy. One of the project's main activities was vigorous district-wide surveys for case finding (see listing above for a summary of additional activities). As of 1981, these surveys recorded over 26,000 cases (1.87 percent of the population). At present, the project delivers services to 48 districts throughout Nepal.

To oversee the project, a Leprosy Service Development Board (LSDB) was established in 1978. The board was chaired by the MOH Secretary and its members included the Director of the Department of Health Services; the Chief of the MOH, Planning Division; the Secretary of the Foreign Aid Division; and the Project Chief. The chief executive officer of the project heads five regional offices and four staff authorities organized to provide administrative, financial, planning, and clinic services. As of 1985, 358 people were employed by the project. A total of 62.2 percent of the workforce are senior paramedical workers, junior paramedical workers, and leprosy supervisors.

During the 1984/85 fiscal year, 56.8 percent of the budget was spent on case holding, followed by health education (22.2 percent), health services (17.8 percent), and training (3.2 percent). Since the project began, it has enjoyed consistent budgetary growth due in part to its absorptive capacity.

Although the project does not have extensive system linkages, it was pointed out that ICHSDP health post staff received training in techniques of caring for leprosy victims. In 1985, the project achieved all of its case holding and mobile clinic targets, and overshot its multidrug therapy, health education, and training targets. Despite this achievement level, the impact of the program was still uncertain.

In addition to the LCP, a number of other organizations provide leprosy services including the International Nepal Fellowship, United Mission Nepal, the Nepal Leprosy Association, and the British Nepal Medical Trust.

D. Strengths

- o Clear objectives exist, which result in a committed and dedicated leadership.
- o HMG has been providing the budget support.

E. Weaknesses

- o No more than 25 percent of the 26,000 cases were receiving treatment.
- o The defaulter rate varied between 20-30 percent, while follow-up programs were not being implemented.
- o No strategy for making referrals to subregional centers had been implemented.
- o Annual targets for case holding, mobile clinics, and multidrug therapy were erroneously set and often had no bearing on the project's objectives.
- o The project often suffered from supply shortages.
- o Workers in the field suffered from a lack of incentives.

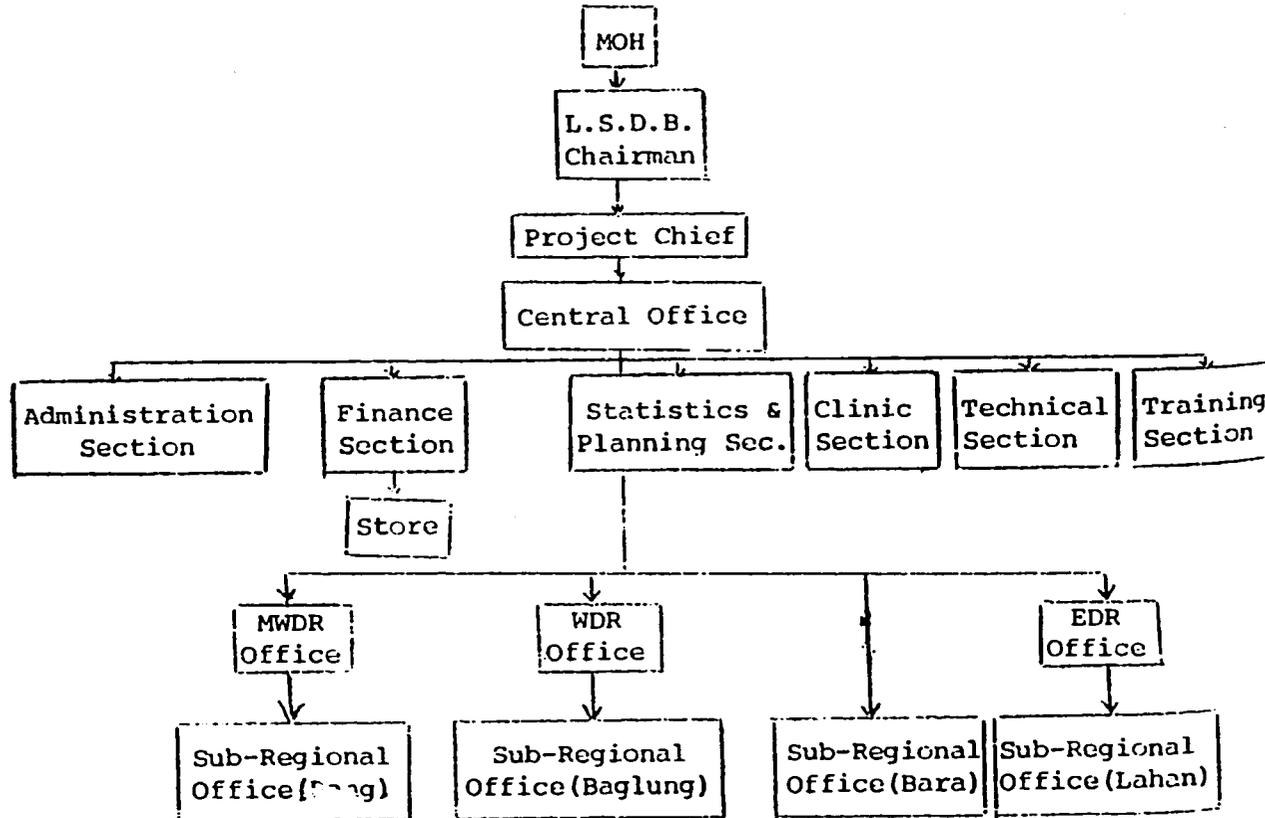
F. Summary of the Recommendations Made in the 1985 Integration Report

- i) Improve linkage between LCP and ICHSDP for coordination of defecation and follow-up programs.
- ii) Investigate local supplementary supply purchase schemes.
- iii) Confirm and establish a policy regarding the role of regional and subregional offices in planning, and formally establish a procedure to undertake the preparation.
- iv) Give more attention to taking into account differences in tribes, local languages, technical limitations, etc. in preparing health education materials for wide circulation.

- v) Make more use of mass media, particularly radio, to provide health education on leprosy. Prepare announcements for TV as an additional medium.

Chart 9:

LCP Organization



ANNEX 8

AID'S Policy Regarding Informed Choice<sup>24</sup>

AID's policy regarding informed choice is clearly enunciated in its 1982 AID Policy Paper on Population Assistance, which states:

AID support for family planning service programs is based on two fundamental principles: voluntarism and informed choice. AID does not support programs in which there is any element of coercion of individuals to practice family planning or to accept any particular method of contraception. In fact, AID supported programs must include a description of the effectiveness and risks of all major methods of family planning and an agreement either to provide other family planning methods if requested or to refer couples to programs offering other methods, as appropriate.

The Policy Paper states that one of the major objectives of AID's population assistance program is "to enhance the freedom of individuals in LDCs to choose voluntarily the number and spacing of their children."

Particular attention has been paid to the issue of voluntary surgical contraception, since it is considered irreversible. AID's Policy Paper requires fully informed consent in the provision of voluntary surgical contraception services:

An explanation must be made to the client in his or her own language of the nature of the procedure, its risks and benefits, and its irreversibility. The client's witnessed signature or mark is required on the consent document, which must be retained for three years. . . . Other family planning methods must be readily available to ensure that the client has a free choice of approved methods.

The Policy Paper also provides a definition of informed consent: "An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducements or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation."

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<sup>24</sup>Report of the Informed Choice Task Force of the Bureau for Science and Technology/Office of Population. Awaiting publication, December 1987.

Voluntarism has been the basis of AID's population program since its inception in 1961. AID's policy on informed choice has its origins in the 1967 Foreign Assistance Act, which authorized the U.S. government to support "voluntary family planning programs to provide individual couples with the knowledge and medical facilities to plan their family size in accordance with their own moral convictions and the latest medical information." Similar language was repeated in congressional reports issued in 1968, 1973, 1974, 1978, and 1979.

AID's policy of informing clients about a range of methods and requiring agencies to refer clients for services they themselves do not provide was reaffirmed in the FY 1986 Continuing Resolution passed by Congress (see Appendix B), which included language introduced by Senator DeConcini stating that:

... funds shall be available only to voluntary family planning projects which offer, either directly or through referral to or information about access to, a broad range of family planning methods and services...

The FY 1987 foreign assistance appropriations bill specifically required all recipients of AID funding for natural family planning (NFP) to comply with its policies regarding informed choice.

The theme of voluntarism and choice was emphasized in President Reagan's message to the International Conference on Population, held in Mexico City in August 1984:

We believe population programs can and must be truly voluntary, cognizant of the rights and responsibilities of individuals and families, and respectful of religious and cultural values.

The President's statement was underscored by Ambassador James Buckley, head of the official U.S. delegation to the conference, who called for "ready access to the knowledge and services that will enable couples to exercise their right to determine when they will conceive a child."

**ANNEX 9**

**Status of Key Indicators for the IRH/FPS Project 367-0135**

This paper was prepared by JSI in August 1984 as a briefing paper for the midterm evaluation. The indicators listed on the following papers were drawn from the PROJECT OUTPUTS section of the April 1980 Nepal Project Paper entitled "Integrated Rural Health/Family Planning Services," No. 367-0135.

Each of the indicators were addressed in terms of their status as of July 1984, along with additional comments, clarifications, and considerations as appropriate.

I. INTEGRATED PLANNING AND MANAGEMENT OF EFFECTIVE SERVICES

A. EFFECTIVE FUNCTIONING OF OPERATIONAL PLANNING AND MANAGEMENT FOR DELIVERY OF SERVICES.

Indicator 1. 48 districts under integrated management system

Status: In addition to the 6 fully integrated and 17 partially integrated districts that existed at the outset of Project 0135, 8 more districts were taken into partial integration in 1983. District Public Health Offices have been created and manned by Health Inspectors in all 48 of the districts designated for integration during the sixth five-year Plan.

Comment: It was clear from the time of arrival of the JSI team in September 1981 that the original targets for integration of additional districts were unrealistically rapid. No new districts were integrated for several years because: 1) problems of management in the 23 partially integrated districts could not be resolved by the central ICHSDF organization, 2) Chiefs of the Vertical Projects have been reluctant to have districts taken away from their direct authority, and 3) multiple actions of agencies in several different Ministries (i.e. Ministry of General Administration, Civil Service Commission, Ministry of Finance) were required to convert personnel from the Vertical to the integrated pattern. HMG's current, and more realistic, policy is to integrate at a slower pace, both to allow consolidation in already integrated districts, and to allow the above difficulties to be addressed.

Indicator 2. 200 additional integrated health posts established during project period for a total of about 800

Status: A total of 744 health posts were established by 1981/82, of which 450 were "integrated". This is 149 more than the 595 health posts established by HMG as of fiscal year 1980, according to the Project Paper. During 1982-84 a list of 99 additional health posts was approved, and 50 more have been proposed for 1984/85. Approval of personnel for health posts on both of these lists is still in process.

Comment: The need to improve management of already existing health posts has led the National Planning Commission to emphasize consolidation and improvement of such management as being more important than rapid expansion beyond the existing facilities.

Indicator 3. Adequate and timely staff and budget allocations to districts.

Status: Sanctioned posts at the district level have been reasonably adequate except for the lack of Public Health Nurses and Malaria Assistants in the newly integrated districts. Twenty-three accountants have been recruited and trained for district service. Common guidance/training manuals for accounting have been developed in conjunction with the FP/MCH Project. In 1983 HMG decentralized the budget offices to the district level, and Health Inspectors have since applied directly to the local district office of the Ministry of Finance for their budget releases. Delayed receipt of approved budget, however, continues to be a problem for the several projects, particularly ICHSDP.

Comment: Getting posts sanctioned in the newly integrated districts has been slow. Capturing for ICHSDP the experienced personnel who had been working in the vertical projects in a district just prior to integration has been difficult. In some instances, because of the confounding multiple layers of authority over personnel, Civil Surgeons have recruited new personnel before the local vertical project workers could be considered for change of status from Temporary to Regular employees. The greatest problem in personnel management, generally recognized but still unresolved, is that of absence of an actual worker from a post that is both sanctioned and filled but nevertheless vacant due to transfer, or special leave. During the Management Review of Integrated Health Services, for example, Group Two found that the following percentages of sanctioned posts in partly integrated districts actually had staff in place: Health Assistant or Senior Auxiliary Health Worker (92%), Auxiliary Health Worker (50%), Auxiliary Nurse Midwife (33%) and Village Health Worker (30%). Handling requests for transfer consumes a large amount of the time of central administrators.

Financial management capacity has improved significantly in FP/MCH, ICHSDP and HPD from 1980 to 1984. Blocked multi-year backlogs of unsatisfactorily accounted expenditures were finally resolved. In 1983-84, however, an extraordinary political event complicated financial management for all the projects. During four months or more of that year, budgets were frozen in the wake of a change of government at a crucial time for fiscal allotments. All budgets were frozen until they could be thoroughly rescutinized and debated by the new government, which accounts for lower expenditure rates and delayed schedules in some projects in the just-ended Nepali fiscal year.

Indicator 4. Planning and management control effectively decentralized to districts due to Health Planning Unit assistance.

Status: A WHO sponsored workshop on health planning for the training of district level personnel was conducted by the Health Planning Unit in Pokhara in December 1981 with JSI assistance. District level planning for the training of personnel was increased with the creation of the four regional ICHSDP training centers in 1982. District planning for and management of sterilization camps was strengthened through the annual meetings, for this purpose, of Health Inspectors with Family Planning Officers that was begun in 1982. Prior to 1983/84, however, the Health Planning Unit had too little manpower and influence to be of significant practical assistance to district level planning and management.

During that Nepali fiscal year, a senior public health administrator was appointed as Chief of an upgraded Health Planning Division with a large increase in budget, sanctioned manpower, and influence on the several services and projects in the Ministry of Health. A strategy for increasing the credibility and usefulness of the HPD was developed, and a National Workshop for improvement of district managers' planning and management skills was planned for August/September 1984. The Decentralization Act of 1983 provides the policy basis of expanded control over planning and management at district level, but the specifics of its application have been debated nationally for a year and guidelines have not yet been issued.

Comment: Downward delegation of power and authority that would be necessary to increase control of planning and management of ICHSDP services at the district level awaits clarification of the implementation guidelines and regulations for the Decentralization Act, as well as clarification of the authority over health personnel between the ICHSDP's Health Inspector and the Department of Health Services' Senior Medical Officer. In the meantime, effective steps are being taken through annual workshops to increase the skills and capacity of Health Inspectors and Family Planning Officers for planning and management at the district level. In the integrated districts the Health Inspectors are responsible for the management of all rural health facilities and services below the hospital level.

Indicator 5. Effective program evaluation capability.

Status: Indicators and formats for evaluation of the progress and effectiveness of each project in the MOH were developed by the National Planning Commission and the MOH in 1981. Using them, reports are prepared by each of the services and projects every four months. These are reviewed by and discussed with the Health Planning Division, and then the National Planning Commission. The annual conjoint workshop of HI's and MOH's has become an effective instrument for evaluating VSC

program capability. With regard to capacity of personnel, several senior public health administrators, who actively participated in the Management Review of Integrated Health Services, and who are now in decision-making positions in MOH agencies, are quite capable of conducting program evaluation, as are a number of other MOH senior administrators and section chiefs. Currently, the operation of integrated health services in Nuwakot district is being thoroughly evaluated by all-Nepali teams fielded by ICHSDP, with technical assistance from WHO and JSI.

Comment: A sizeable number of MOH personnel have the capability of judging whether programs are functioning effectively or not, and what might be done to improve them. However, these trained and experienced personnel are frequently 1) overburdened by many routine administrative tasks, and 2) aware that many options for improving services are not feasible due to multiple constraints in the system. The best example of the capability for program evaluation is the excellent internal assessment of the National Malaria program conducted annually by NMED.

Indicator 4. Construction completed on 12 new rural health facilities, 3 regional warehouses, and the rehabilitation of at least 20 existing health posts.

Status: At the formal request of AID/Nepal, JSI has no involvement in construction activities.

Comment: --

#### E. HEALTH PLANNING UNIT FUNCTIONING EFFECTIVELY.

Indicator 1. Effective monitoring of programs and progress of overall integration.

Status: The Chiefs of ICHSDP and the other projects and services meet every four months with the HFD to review progress against indicators. During the 0135 Grant period, to date, 8 additional administrative districts were transferred to ICHSDP (in July 1983). A review of the problems and progress in integration was conducted in the fall of 1983, the Management Review of Integrated Health Services. A National Workshop of Health Personnel to review the progress of integration was held, under WHO sponsorship, in 1982; another, to focus on management analysis at district level, is to be held in August 1984 under AID/Nepal sponsorship. The Health Planning Division in 1983 set up a system of indicators to monitor the major programs in the MOH. It is currently updating progress against targets every four months with aid of a computer program designed, with JSI assistance, for its now functional microcomputer. At the end of

NFY 1983/84, the HPD conducted an unprecedented five-day review of the proposed programs and budgets of all services and projects in the form of a plenary of Chiefs, their deputies and key staff.

Comment: Progress in terms of additional districts being integrated has been slow due to the reasons mentioned above. In terms of programs, monitoring is good for several, and minimal for others, and the role of the Health Planning Division in this monitoring varies from program to program. Monitoring is excellent for malaria control because of the well devised and implemented annual internal assessment of malaria performed by NMEC with the collaboration of ICHSEEP. It is good and improving for family planning because of the annual workshop of FPO's-HI's-FPAN officers that looks closely at performance of sterilizations in all districts, and is beginning to monitor temporary methods of contraception and, from 1984, aspects of maternal and child care. This year, the Health Planning Division will have an increased role in this process. Prior to 1984, coordination of the immunization program was not formalized between the Expanded Immunization Program and ICHSDP, but takes place sporadically and informally between the officers of both agencies, with some input from the HPD. Tuberculosis and Leprosy control programs in the past have not been well coordinated with ICHSDP, due to insufficient manpower in ICHSDP.

The role of the Health Planning Unit in monitoring progress either of programs or overall integration was minimal before 1983. With the increased staff, budget, computerized program-tracking capacity, mandate and credibility of the Health Planning Division, however, it should be able to accomplish effective monitoring of programs and progress of overall integration during 1984/1985.

Indicator 2. Planning/management surveys, including Mid-term (Mid Plan) Review--designed and implemented.

Status: The Management Review of Integrated Health Services was conducted in 1983 with collaboration of the HPD. In the same year, the Health Planning Division initiated, and is now completing, a management survey of sanitation and infection control in hospitals. In 1982 the Health Planning Unit designed a form to assess progress and management problems in the seventeen projects and units of the MOH that reported to the National Planning Commission through the HPU. The mid-term health review of the 1980-85 Five-Year Health Plan was conducted in 1983/84 by the MOH, and did not involve a major national survey as did the 1979 Mid-Term Review.

Comment: Planning/management surveys of the HPU in the past have been designed and managed mostly by foreign advisors due to HPU's limited staff, capacity, and resources. This has hindered their use for improvement of policy and admin-

istrative decisions. Current development of manpower and technical capacity of the HPD, and its increasing collaboration with other units and projects in the MOH, encourages hope that it may in the next several years have Nepali staff able to design and implement such studies. The just-completed Five-Year Plan Review, which did not utilize outside assistance, is a first major step in this direction.

Indicator 3. Health Sector Input to the 7th (Five-Year) plan prepared.

Status: The HPD has provided input to the National Planning Commission in development of the health sector policy guidelines for development of the 7th Plan, and will provide continuing assistance in development of the plan itself. This process will extend through much of the coming year. The HPD is also revising the Long Term (15 year) Health Plan, with assistance of WHO and JSI.

Comment: The capacity to provide such assistance did not exist prior to the just-completed Nepali fiscal year. The past six months have seen the HPD assume its proper role in the annual, five-year, and long-term planning processes.

Indicator 4. Decentralized planning and administration operative in all integrated districts

Status: The role of district Health Inspectors, Family Planning Officers, and officers of the other vertical projects in decentralized planning is still being defined. All districts have sanctioned posts for such officers, hence the administrative structure necessary for such decentralization has been created. A sizeable amount of routine administration is handled directly by these district officers. Regional health offices are scheduled for a slow phase in from 1984/85.

Comment: How to implement the Decentralization Act has been under debate nationally for a year, and procedures are still not formalized. The respective roles of these officers together with the Civil Surgeons and Senior Medical Officers of the DHS is under active discussion but remains to be clarified. Although the HPD is an active participant in these discussions, only higher authorities can finalize the respective roles of the several units.

Indicator 5. Disease-specific surveys and field operational studies performed under HPU supervision and management.

Status: No such surveys or studies have been performed under HPU supervision and management from 1980-84.

Comment: The HPU could not oversee such surveys and studies due to lack of manpower. Such surveys and studies have been carried out, however, by a number of other organizations, e.g. the FEHW Survey by New Era, the Health Post team functioning analysis by the IOM, the study on treatment of women in family planning clinics by JSI, the study on women's measuring of oral rehydration solution by FP/MCH and JSI, the effectiveness and efficiency of natural family planning by SATA's Integrated Hills Project, operations research on different ways of teaching oral rehydration to mothers by ICHSDP, effectiveness of different kinds and doses of insecticides by NMEO, etc. A special study on the incidence of meningococcal meningitis in the Kathmandu epidemic was carried out in 1983 under the auspices of the Department of Health Services' Epidemiology Division, with the technical assistance of the Communicable Disease Centers (Atlanta, Ga.) and JSI, and the effectiveness of the mass immunization of a target population with a bi-valent A-C polysaccharide vaccine was subsequently evaluated.

It is in fact more important for the Health Planning Division to review the results of the several surveys and research projects in order to be able to interpret for the Ministry of Health lessons and practical applications, and less important that the HPD itself supervise or manage such studies. Nonetheless, HPD's objectives for the coming fiscal year include a larger and more active role in such studies.

### C. MANAGEMENT SYSTEMS FUNCTIONING EFFECTIVELY

#### Indicator 1. Adequate supply of essential drugs available in at least 48 districts.

Status: Considerable progress has been made toward ensuring adequate supply of drugs nationally—Until Nepali Fiscal Year 2039/40, the drug budget for health posts had been constant at a low level sufficient only to supply most health posts for three to six months of the year. In FY 2039/40, HMG increased the drug budget to 1.5 times its previous level, in addition to providing monies for "buffer stocks" and emergency medicines. This commitment was expanded further in FY 2040/41, and has been increased again in FY 2041/42. All these additional funds have been provided by HMG, not by foreign donors.

With the assistance of several technical analyses, the MOH in 1983 formalized a smaller list of essential drugs for health posts than had been used for years. The new list contains approximately eighty items, of which half are included in "Class 1". Effective with the annual delivery which was just completed, health posts have been supplied with only "Class 1" items, which will mean larger quantities of a much smaller number of effective drugs will be available in the health posts. Beginning in the just-completed fiscal year (2040/41), health posts in the three

westernmost regions were allowed to choose quantities they desired from the standard list within their approved budget. In the current fiscal year, all health posts will have this option posts (i.e. in rural areas). Two systems for better indenting, storage and distribution of drugs (and potentially for their eventual purchase by peripheral health facilities) were designed in 1982/83 and began initial phases of implementation in 1984: the Regional Medical Stores System and the District Medical Stores.

Experiments in community purchase of drugs and first-aid items through the Community Health Leader Program began in 1981. Results of this CHL program, along with those of NCC-sponsored health post level user payment schemes, were assessed in an ICHSDP workshop in 1984.

Comment: Although good progress has been made against this long-term goal, it is a complex challenge that will require the working out of local financing, control and purchase mechanisms as well as improved organizational efficiency and flexibility in the indent, procurement and supply functions of the MOH. Achieving "adequate supply" in Nepal, even in the 48 districts with DHO's, will probably take at least five years. The efforts described above are aimed at improvement nationwide, not just in the 48 districts targetted by the Project Paper; this more global strategy is more technically appropriate as well as politically necessary.

Indicator 2. Unified methods of distribution, storage, use, reports and resupply of drugs effectively performed in at least 48 districts.

Status: Progress toward this goal, through the Regional and District Medical Stores, is now aimed not just at the 48 districts with DHO's but at the entire country, as mentioned above. Implementation is just beginning; workshops to develop the rules and procedures for the Regional Medical Stores began in July 1984. Current plans call for inclusion of ICHSDP in the Regional Medical Stores System as quickly as possible, but the exact interface between ICHSDP and the Indent and Procurement Division of DHS remains to be worked out.

Comment: Considering the complexity of the task and the organizational constraints, progress in this area has been satisfactory. Given the communication and logistical difficulties of rural Nepal, general good functioning of a unified supply system, however, is not likely to be achieved in less than five years.

Indicator 3. Systems for local reimbursement for drugs and services being tested.

Status: The Drug Resupply Scheme of ICHSDF's Community Health Leader Program has been testing, since 1981, ward level community willingness to pay for drugs and supplies. In the roughly three thousand wards where this approach has been tried, about 20-35% of communities have collected significant funds for local resupply of first-aid materials and a few basic drugs. Approximately a dozen different ways of collecting funds have been devised locally by different Ward Health Committees in collaboration with their Community Health Leaders. Although provided only aspirin in their initial stock, CHL's are allowed to add other medicines after the first year provided that communities will pay for them and that the local health post will provide training and oversight in their use. Most communities -- and especially those that are in areas remote from the health post, hospital or other health facility -- have chosen to add additional drugs including antibiotic eye ointment, anti-amebic drugs, piperazine, sulfadiazine, etc.

Non-governmental organizations have been testing systems for local reimbursement of drug costs at the health post level:

- the United Missions to Nepal is testing an insurance scheme using one fixed premium for all enrolled households
- the Swiss Agency for Technical Assistance's Integrated Hill Development Project is testing both a fixed fee per health post prescription and a fee per prescription item as alternative methods for reimbursement and for breaking unnecessary polypharmacy
- the British Nepal Medical Trust is testing fixed fee per prescription payments (Ehojpur Drug Scheme) and ways to encourage rural, low cost retailing of essential medicines (the Hill Drug Scheme).

Comment: The results of this active, intelligent testing of ways to recover drug costs at the periphery are being examined with considerable interest by both the MOH and the National Planning Commission.

Indicator 4. Supervisory systems and personnel in place at Central, District and health post levels that coordinate all health services in 48 districts.

Status: Supervisory systems and sanctioned personnel are in place at central, district and health post levels in all integrated districts. The staffing is more complete in the 6 fully integrated than in the 25 partially integrated districts, and thinner yet in the 17 districts that have District

Public Health Offices and Health Inspectors but remain to be integrated. In terms of manned posts, however, there are many vacancies, particularly in the more remote and difficult areas. Transfers and special leave status result in perhaps 20-45% of supervisory posts being unmanned.

Despite the presence of a reasonably designed supervisory system and the presence of a large number of personnel, it is generally recognized that supervision in the integrated districts is inadequate. In an effort to improve ICHSDP supervision, new check-lists and schedules were developed in 1983/84. To assure better supervision of CHL's, who are visited by their VHW's only 20-50% of the time, a new system of centripetal supervision has been introduced in 1984/85; CHL's will come in small groups to health posts at regular intervals for supportive discussions with each other, with VHW's and with the other health post staff.

In the vertical programs, as well, supervision has been a problem. During the IRH/FPS Project period technical supervision has deteriorated in NMEQ secondary to a sizeable percentage of unfilled technical supervisory positions. This is due to the relative undesirability of these positions which lack opportunity for advancement.

Comment: Even when posts are manned, supervisors unfortunately often do not travel to find and work with their supervisees, sometimes due to delayed or unobtainable travel and daily allowances, sometimes because they themselves are not supervised, sometimes because they have become discouraged at their inability either to discipline or to obtain support at higher levels for the problems they encounter during supervisory visits. NMEQ has proposed, as a solution to deteriorating supervision, that it be converted from a special development project to a regular Ministry of Health Division, thus converting malaria workers to regularized public service commission civil servants. ICHSDP work suffers most from the poor functioning of its reasonably well structured supervisory chain (HI & Assistants > HFIC > AHW > VHW > CHL; PHN > ANM > VHW > CHL & TEA). This is because integrated services require teamwork and because a multiplicity of tasks must be performed by multipurpose workers, a difficult situation even in developed countries.

#### Indicator 5. Development of unified management information system.

Status: Although the several services and projects in the MDH all have their own particular needs for managerial information, considerable collaboration and unified efforts have developed during the project period in the areas of logistics, training, financial management, monitoring indicators, and reporting formats. The computerized monitoring by HFD of progress of projects and services, and by the DHS's Nursing Division of personnel inventories (both developed in 1983/84) have served to standardize reporting and increase the central

availability of information managerially important to a number of services.

Comment: During the period of the IRH/FPS Project, the organizational structure and operation of ICHSDP, the nature of decision-making within it and the MOH, and the prickly nature of the relations between ICHSDP and the vertical projects have conspired against full development, proper functioning, and effective use of an Integrated Services Management Information System. Considerable progress has been made, however, in increasing coordination, collaboration, information sharing, and consensus on common formats for reporting among functional units within the several projects. It should be noted that development of a single, Ministry-wide information system is not a reasonable objective: the needs for information of the diverse units of the MOH require diverse responses. It is reasonable, however, to attempt collection of consistent information across the various units.

Indicator 6. Institutionalization of special field operations studies as a management tool

Status: A number of special field operations studies have been conducted (See Indicators B2 and E5 above), but it is not clear exactly what their "institutionalization as a management tool" should mean. Both ICHSDP and FP/MCH have conducted field studies on the kinds of oral rehydration solutions mothers would prepare when given different kinds of instructions. FP/MCH has conducted family planning clinic observational studies on the kinds of treatment received by clients of different castes or apparent economic status. FP/MCH has also studied the effect of decentralizing planning authority to district or panchayat committees (Decentralization Pilot Project). ICHSDP is evaluating the results at community level of establishing a policy and training personnel for a ward drug resupply scheme. NMEQ is testing the effects on vectors of using different areal concentrations of sprayed insecticide, of using different insecticides, and of combining various forms of larval control with spraying. All of these studies produce information that is useful in management of the several programs and projects.

Comment: The Project Paper is not clear on what kind of "institutionalization" of such useful "special field operations studies" might be possible or meaningful as a "management tool" in Nepal. Field trials of new techniques or administrative procedures before they are generalized has certainly been useful. However, it is the very nature of field operations studies that they are devised ad hoc to make headway against a particular, identified problem, or to test in practice a solution that seems feasible. What is needed to make such studies "management tools" is to have their results considered carefully by those with the appropriate decision making power. There is not a sufficient excess of technical expertise in ICHSDP to make it feasible to constitute a special "operations research division". Only in NMEQ, where there is a sufficient collection

of appropriate expertise and also a focussed arena of discrete operational problems in need of field investigation, is there cogent reason to create a special organizational unit for conducting "special field operations studies as a management tool". A small field investigations/training unit was established in 1979, and proposals for strengthening the unit to make it adequate were formulated and submitted to AID/Nepal in 1980/81. Needed field operations studies in the other services and projects can be adequately planned, conducted and used on an ad hoc basis.

II. COMMUNITY PARTICIPATION IN HEALTH SERVICES ESTABLISHED

A. 50% OF DISTRICTS WITH INTEGRATED MANAGEMENT HAVE FUNCTIONING COMMUNITY HEALTH SERVICES, INCLUDING VILLAGE HEALTH COMMITTEES. (Indicator)

Status: In 13 of the 26 integrated districts there are more than 2,600 Ward Health Committees that functioned at least to the point of selecting a Community Health Leader.

Comment: Whereas Health Post Health Committees have rarely functioned effectively, approximately one third of Ward Health Committees have seemed to be activatable by the CHL they chose. At least this many of them have been able to raise some money to purchase resupply of drugs and supplies in the CHL's kit. In more remote areas, many WHC's have shown active interest in what they can do to improve health care through their CHL, and some have been willing to mobilize community effort to protect health, as in building latrines.

B. MCH AND COMMUNITY LEVEL HEALTH PROGRAMS HAVE EFFECTIVE SUPPLY, REPORTING AND SUPPORTIVE SUPERVISION/RETRAINING LINKAGES ESTABLISHED. (Indicator)

Status: In half the integrated districts the MCH linkage to community level programs has been established through almost three thousand Ward Health Committees and their chosen Community Health Leaders. The CHL's are trained and retrained by the local health post staff, and are supervised by the house-visiting Village Health Workers attached to the health post. These VHW's, in turn, are supervised by the health post's Auxiliary Health Workers and occasionally by the Health Assistants (Health Post In-charge) or the Auxiliary Nurse Midwife present in the fully manned, integrated health posts. The health post staff, in turn, are supervised by visits from the District Public Health Office of the Health Inspector, or his assistant for family planning, health education, etc. During training the CHL's receive guidance manuals and kits containing a start-up supply of first-aid supplies and aspirin from the Regional Training Centers or the ICHSDP Logistics Section sent via the DHO. Resupply is up to the Ward Health Committee and the CHL, both for collecting community funds and for finding commercial sources of supply.

FP/MCH has just begun a field experiment in Morang District, creating CHL's who will be supported by PEHW's. FP/MCH, in collaboration with JSI, has managed a Decentralization Pilot Project since 1982. This attempt to increase the involvement of both District and Panchayat committees in the FP/MCH program has

proven to be difficult, time-consuming, and only marginally productive.

In NMEO in 1983, there were 2,012 community volunteer posts, whose responsibilities include passive case detection, reporting of fevers, and so forth, organized by the NMEO unit officer in charge. These volunteers collected 74% of the slides, and detected 60% of the positive cases in the NMEO program for that year.

Comment: ICHSDP has discussed selling low cost resupply items to CHL's, notably at the MRIHS Workshop in October 1983, but has decided not to do this. The Regional and District Medical stores might eventually become sources for purchase of low-cost essential drugs and supplies needed by CHL's for their Drug Resupply Scheme. Using a standard form, the DHO is supposed to report to the ICHSDP central office on the CHL program every two months. The DHO receives monthly reports for each health post, which currently collects information on CHL/WHC activities through the VHW's, who are supposed to visit and supervise them monthly. Currently, VHW's only see and hence report on about 20-50% of their CHL's. Many CHL's are not currently seen by their VHW's because the latter are "overloaded" and too busy checking off house visits. Sometimes neither the VHW nor his supervisory staff at the health post accord much priority to support of the CHL program. Through the new centripetal system of gathering CHL's periodically in their health posts in small groups it is hoped that a larger proportion of their activities will actually get reported.

Although it is only a transient feature of this initial phase of the CHL program, the presence of 5-10 Peace Corps Volunteers in particular health posts or DHO's has been very important in establishing effective links between the community programs and the central administration of the MOH. They have been able to concentrate on the CHL/WHC program (which is usually a divided responsibility of ICHSDP personnel at both DHO and central levels), to send candid three-monthly reports to ICHSDP, to hold annual reviews of progress and problems in implementation, and to summarize their findings and recommendations in excellently prioritized reports, the last of which was verbally presented to the Secretary of Health. The IRH/FFS Grant support of the training of these PCV's and of a few of their local initiatives for development of the CHL program, along with JSI assistance to their efforts, have been significant project inputs into the morale and quality of the CHL program.

The community workers of the FP/MCH project, the FBHW's, are supposed to work regularly with the panchayat committees that nominated them. However, this approach has not been consistently well implemented. Whereas the CHL is unsalaried and can expect benefits, other than small training stipends, only from the Ward Health Committee, the FBHW is a salaried worker of the FP/MCH project. Also, the CHL/WHC relates to a local community of about 500 persons while the the FBHW/Panchayat Committee must

consider a frequently scattered population of about 4,500. Five FBHW's are supervised by one Intermediate Supervisor, who reports to the Family Planning Officer. These supervisory links were weak prior to reforms in the PBHW salary, and the selection criteria and procedures in 1983; often personal appointees of the Pradhan Panchas, they were little accountable to either panchayat committees or to FP/MCH supervisors. This accountability is now increasing in both directions.

C. ADEQUATE EVALUATION MECHANISM FUNCTIONING AND INVOLVING VILLAGE INPUTS AND VILLAGE HEALTH COMMITTEE. (Indicator)

Status: At the ward level program progress, needs, and new directions are being evaluated adequately through the existing WHC/CHL mechanism. This is seen in the widespread requests for approval of and training in the use of additional drugs that communities will purchase using the diverse ways of collecting money that they have worked out. It is also seen in the latrine construction (e.g. Dolakha district) and other public health programs that particular WHC's have launched. However, the ~~assessments, judgements, and evaluations~~ of WHC's have rarely been forwarded for consideration by decision makers at higher levels in ICHSDP or the MOH. Notable exceptions are 1) the recommendations from the assembled CHL's of Kaski District in their 1983 workshop conducted with technical assistance of Peace Corps Volunteers and the Regional Training Center of ICHSDP, and 2) the opinions of WHC members, pradhan panchas, and CHL's gathered at the 1984 workshop on Local Financing of Health Services at Pokhara.

III. TRAINING AND HEALTH EDUCATION NEEDS MET

A. 80% OF MOH NON-ACADEMIC PARAMEDICAL MANPOWER TRAINING REQUIREMENTS MET (APPROXIMATELY 1,600 NEW HEALTH AND FAMILY PLANNING WORKERS TRAINED (Indicator))

Status: Details of training activities for the various units of the Ministry of Health are appended to this report. In summary, since Nepali Fiscal Year 2037/38 (1980/81), the following in-country new and refresher training has been provided for field staff of the various units:

	Initial Training	Refresher Training
FP/MCH	2,061	2,174
ICHSDP	1,233	545
NMEO	144	380
Leprosy Project (Combined)	2,467	
TB Control Project (Combined)	672	
EPI (Combined)	610	
Health Education (Combined)	774	

Comment: The target for new workers trained has been exceeded. Effort is still required, however, in improving the quality and content of training in several areas, and in ensuring consistency between the types of training provided to field workers in different units who have similar field responsibilities.

B. ROUTINE REFRESHER TRAINING PROGRAM FOR ALL FIELD STAFF INSTITUTIONALIZED (Indicator)

Status: As indicated by the attached in-country training statistics, refresher training is a regular part of the training program of all units of the Ministry. This indicator has been met.

Comment: It is still necessary, however, to

increase the flexibility and responsiveness of the refresher training courses of the various units of the MOH, in order to allow such courses to be more responsive to the individualized needs of staff receiving the refresher training. This is particularly difficult in light of the weak communications channels between the field and Kathmandu.

C. TRAINING PROCESS EFFECTIVELY PLANNED, SUPPORTED, AND IMPLEMENTED (Indicator)

Status: Training cells of the various units of the Ministry of Health now routinely prepare annual training plans and schedules. Copies of the current plans for the various training units are attached. While changes in these schedules as the year progresses are inevitable, training cells in general meet their training targets. In terms of support, the training effort suffers from the same budget delays and administrative difficulties as other activities of the Ministry.

Comment: There is still a need for more effective and frequent collaboration among the various training cells. JSI has attempted to foster such collaboration in its technical assistance activities, and AID/Nepal support under the Grant has also furthered this effort. For example, the current training effort for logistics staff will include trainers (and trainees) from various vertical projects, in addition to regular DHS staff.

D. HEALTH POSTS AND VILLAGE HEALTH WORKERS SUPPLIED WITH AT LEAST 50% OF RECOMMENDED BASIC HEALTH EDUCATION MATERIALS (Indicator)

Status: There is not a standardized "recommended" list of basic health education materials for either health posts or village health workers, so this indicator cannot be measured as written. Significant progress in this regard has been seen over the past several years: audio visual equipment, slide projectors, film strips, slides, and more basic training materials such as charts and markers, pads, pencils, and so forth have been distributed and set up at regional training centers. JSI has assisted with significant revisions to various field worker training manuals (PBHW, Hospital Sanitation, Financial Management, Logistics) in coordination with AID/Nepal and other donor agencies. Training materials produced by other donors (e.g. UNICEF Nepali version of "Where There Is No Doctor") have been distributed to training centers and health posts and from there to the field workers themselves.

Comment: Considerable effort in this area is still required. The current collaboration between the various training cells of the MOH, JSI, and other donor technical assistance personnel is effective. Important at this stage is better collaboration with agencies outside of the MOH: for example, coordination of the Institute of Medicine curriculum and training materials with the MOH job descriptions and training

efforts for its field workers. As a "recommended" list of health education materials would change continuously, this indicator needs to be rewritten in a measurable form.

E. 75% OF PARTICIPANTS (U.S. AND THIRD COUNTRY TRAINED) AND ASSIGNED (Indicator)

Status: Of fifteen long-term U.S. participants to be trained under the Grant through JSI, all have been placed in U.S. institutions. As of June, 1984, eight had returned from training and resumed their duties in the Ministry; the other seven are expected to return within the year. Of the eighteen short-term U.S. training slots, fifteen had been used as of June, and tentative assignments had been made for the remaining three. It is expected that this activity will be completed by the fall of 1984. Of 80 short-term third-country participants scheduled under the Grant, 58 had completed training by June 1984, and tentative plans had been made for an additional nine trainees; most of these third-country training slots have been used in Asia.

Comment: This activity is ahead of schedule. By the fall of this year, no out-of-country training slots will remain, except for approximately thirteen slots for third-country training.

IV. HEALTH AND FAMILY PLANNING SERVICES DELIVERED EFFECTIVELY

A. FAMILY PLANNING TARGETS

Indicator 1. 500,000 continuing acceptors of temporary contraceptive methods

Status: Temporary contraceptive method service statistics for 1983/84 are not yet available. While the exact meaning of this indicator is not clear, the intent is clearly to demonstrate the success of the program in promoting the use of temporary contraceptive methods by a sizable population. As one measure of such success, the following attempts to calculate the total couple-years of protection afforded during 1983 by all the different temporary methods. This resultant approximate total current protection in 1983 from all forms of temporary contraception promoted during the Project period is based on the reported pills, condoms, and foaming tablets dispensed that year, on the number of women protected that year by Depoprovera, and on the women under protection from IUD's inserted during 1980-83.

	FF/MCH	ICHSDP	FPAN	CRS	TOTAL
Couple-years of protection (CYP) by oral contraceptives	35,600	5,519	3,240	6,112	52,471
CYP by condoms	38,412	7,207	14,650	26,212	86,481
CYP by foaming tablets	-	-	-	1,618	1,618
Women protected by Depoprovera	4,939	-	-	-	4,939
IUD acceptors ('80-83)	4,065	-	324	-	4,389
<b>TOTAL COUPLE YEARS OF PROTECTION</b>	<b>83,016</b>	<b>12,726</b>	<b>18,214</b>	<b>35,942</b>	<b>149,898</b>

In the first three years of the IRH/FP Project, over 700,000 acceptors of temporary methods were reported by the several services. Continuation rates of pills and condoms are known to be very low in Nepal. Implied one-year continuation rates in 1981 were estimated by IBRD to be: 16% for pills, 3% for condoms,

34% for IUD's, and 39% for Depoprovera. However, a continuation study done by the FP/MCH Evaluation Division in 1973/74 showed the following one-year continuation rates, according to the Deputy Chief of FP/MCH: 36% for pills, 66% for IUD's, and 80-90% for Depoprovera. The table above shows that, during 1983, the maximum total couple-years protection for all temporary methods rose to about 150,000. This is a considerable (300%) rise from the estimation made by ISRD of the number of couples protected by temporary methods in 1981, which was less than 50,000.

Comment: Between 1980 and 1984 there was a considerable rise in the distribution of temporary contraceptive methods. Their impact on fertility is still quite limited due to high discontinuation rates. Many person-hours are required to promote them. It has been estimated that temporary methods account for 50% of program expenditures in Nepal, but that they account for only 30% of births prevented. It is not known what the additional cost would be in this environment to double these continuation rates. Of course, temporary methods require continued promotion for younger couples who wish to space their pregnancies.

The return in births prevented, however, is considerably greater for additional expenditures on voluntary sterilization at the current ages and parities of VSC acceptors. The most promising temporary method in terms of potential for rapid expansion, good acceptance in the rural population and good protection against pregnancy, is Depoprovera. This would require a reinforced medical referral backup, however, if the occasional complications are not to be mishandled. If such backup is established through the Family Planning Service Centers built under the IRH/FPS Grant, then it is likely to be possible to regain credibility and increased acceptance of the IUD.

Indicator 2     230,000 voluntary surgical contraceptive procedures carried out in the plan period.

Status: During 1980-84 there were 164,180 voluntary surgical contraceptions performed in Nepal. Total sterilizations have expanded rapidly in each of the past four years (by 48%, 34%, 47%, and 46%). In 1983/84 a surprisingly high 65,773 were done. If the same number were performed in 1984/85, the plan period total to date would be almost exactly 230,000. However, although the national target for 1984/85 is formally set at 65,000, current discussions are being held regarding the possibility of raising the target to 100,000. If this were achieved, the 1980-85 total would be 264,160.

Comment: Since budget for the high target of '84/85, which was based on further augmentation of the unexpectedly high VSC performance of the past three years, is not currently available, it is likely that the indicator will be met but not exceeded.

B. MALARIA ANNUAL PARASITE INCIDENCE (API) IS 1.0 PER 1,000 OR LESS (Indicator)

Status: The total API in districts controlled by ICHSDP dropped from 1.6 in 1981 to 1.00 in 1983. In the more hyperendemic areas controlled by NMEC the total API was held to slightly over 2, varying from 2.02 in 1981, to 2.44 in 1982, to 2.17 in 1983.

Comment: These results were obtained despite non-delivery to Nepal in 1983 of malathion ordered by NMEC, and a sharp fall-off in anti-malaria control activity, especially spraying, in the 8 additional districts that passed from NMEC to ICHSDP control on 6 July 1983. The latter was due to poor coordination, preparation and management of districts abruptly integrated for malaria. In the face of these set-backs, the surprisingly favorable outcome in terms of total API's is due, in part, to both drought and then prolonged, larvicidal rains, and also to increased emphasis on detection and treatment of cases.

These total API's, however, mask the alarming increase in Plasmodium falciparum malaria, the killer form that develops resistance to the cheaper anti-malarial drugs. From 1981 to 1983, P. falciparum indigenous cases in NMEC areas rose almost seven-fold, while imported cases rose 2.5 times.

Collaboration between ICHSDP and NMEC has increased since 1980. Specific mechanisms for consultation between the services are being worked out, e.g. the recommendation submitted at the 6 July 1984 Malaria Board meeting, that provides for automatic consultation between the NMEC Regional Office and the district MI when his reported ABER falls below a pre-agreed minimum performance level for that integrated district.

The major problems for malaria control in 1984/85 will be 1) the exhaustion of the last supplies of DDT, the least toxic and least expensive of the effective insecticides, 2) the lack of budgetary support for insecticide beyond 1985, and 3) lack of an adequate unit to mount a strong field research program to test alternative and cheaper approaches to vector control and treatment of resistant cases. Another problem is the relatively low political priority accorded to the control of malaria, perhaps because no dramatic malaria epidemic crisis has occurred in recent years, and because the services have been successful in maintaining reasonably low prevalence levels of malaria. This may put the expensive gains of the malaria control program in jeopardy.

C. ORAL REHYDRATION FOR DIARRHEA--30% OF ALL CASES OF PEDIATRIC DIARRHEA IN DISTRICTS COVERED BY INTEGRATED OR FP/MCH PROJECT SERVICES TREATED WITH REHYDRATION SOLUTION (R.D. SOL).  
(Indicator)

Status: There are no reliable nation-wide figures for the coverage of childhood diarrheas with oral rehydration therapy. In the ORT KAP survey conducted by ICHSDP in Fokhara in 1981 ORT had been prepared in less than 5% of households. Several experts working in the control of diarrheal diseases guess that the national use of ORT for severe diarrheas in the home is surely less than 15%, and probably less than 5%. Of childhood diarrheas presented for treatment in HMG health facilities, however, probably more than 30% currently receive education and instruction in the use of ORT. In 1983/84 ICHSDP received reports of 269,146 "persons taught" ORT in an area with a 0-5 age population of about 700,000; this might be optimistically construed to indicate that 38% of children had parents who were instructed in ORT. However, there is not any necessary connection between this report on the number of persons "educated", with the number of children treated for diarrhea, or with the number who had "pediatric diarrhea" and were thus in need of education. In the FP/MCH program, FPO's report monthly numbers under "rehydration"; this, too is vaguely defined, and not routinely totalled by the FP/MCH statistical service. In Gorkha district, for example, 3,002 "rehydrations" were reported in 1983/84 in a population with about 40,000 children 0-5 years old. Assuming an average of one dehydrating diarrhea per child per year, this would mean a coverage of roughly

Comment: Despite active radio promotion of ORT and large numbers of workers in all districts armed with assignments, job descriptions, and training for ORT outreach (i.e. 1,800 PEHW's in 52 districts, 2,800 CHL's in 13 districts, and 4,000+ VHW's, AHW's, ANM's in 26 districts) the impact on population knowledge, attitudes and practices regarding ORT in diarrhea remains minimal. Outreach work for ORT by front-line health workers, although "part of the program", has received short shrift. In 1983/84, in response to the apparent need to revitalize this life-saving program, a number of new initiatives were launched: ICHSDP, supported by WHO, launched a national program for control of diarrheal diseases, starting the training of physicians and other service providers from the top down; FP/MCH, with the assistance of JSI, examined the ORT performance of its PEHW's and developed a strategy for improving it; the Commercial Retail Sales Ltd. organization began the commercial marketing of ORS packets; field studies were done to determine the most effective, safe ways to instruct mothers for "pinch and scoop" home preparation of sugar-salt ORS; and FP/MCH, with UNFPA help, tackled the problem of developing a National Strategy for MCH with appropriate emphasis on ORT. Hence, although ORT use in the population remains very low, promising initiatives for improving it and for improving ORT services within the existing MOH infrastructure were begun in the last 1 1/2 years. Through the IRH/FPS Grant, effective consultation on improvement of the ORT

program was provided by Dr. N. Hirschhorn (JSI) and William Bowers (Hesperian Foundation), with continuing follow-up by JSI/Nepal.

#### D. RUDIMENTARY PRENATAL CARE

Indicator 1. 40% of pregnant women receiving iron and folic acid treatment in integrated or FP/MCH covered districts

Status: This information is not reported for ICHSDF districts. "Anemia" is reported from FP/MCH districts, but these statistics are only vaguely defined and have not been routinely totalled. According to the FP/MCH Supply Division, approximately 3,000,000 tablets (ferrous sulphate 200 mg. plus folic acid B.P. 80, 0.25 mg) have been distributed from the central supply depot to the 250 family planning clinics during each of the last several years. Assuming the usual prescription of 28 tablets to each pregnant woman, this would represent approximately 100,000 women covered. In the PEHW evaluation of 1981, only 11% of PEHW's actually had iron tablets in their kits, a shortcoming which has probably not improved.

Comment: Since both malnutrition and anemia are widespread in rural Nepal, greater attention should be given to providing this service. These blood building fortifiers are currently provided in the health posts and hospitals, but are not being as widely distributed by front-line health workers (i.e. the PEHW, CHL, VHW, ANM, AHW), as they might be.

Indicator 2. 20% of women age 15-44 receiving regularly scheduled tetanus immunizations in integrated or FP/MCH covered districts.

Status: In 1983-84, the approximately one million women of reproductive age (in a population of 5,034,000 in the integrated services districts) received 89,346 first tetanus toxoid and 51,500 second tetanus toxoid immunizations. Thus about 5% of women 15-44 years old received a second tetanus toxoid immunization in one year. The ICHSDF achievement in tetanus toxoid 2 had progressed from 8,685 in 80/81 and 67,324 in 81/82. In Expanded Immunization Program districts the 82/83 tetanus toxoid 2 totalled 238,144 against a targetted 542,000, up from 138,284 in 81/82 and 102,060 in 80/81. Tetanus toxoid has not been supplied in the FP/MCH districts, thus coverage of reproductive age women has been close to 0%.

Comment: Current rates of tetanus immunization of women of reproductive age fall far short of targets, but coverage and volume of service is increasing. In 1984/85 increased collaboration between EIP and ICHSDF has been planned. Also, FP/MCH has reached an accord with EIP to provide tetanus toxoid in about twenty of its districts starting in 1984/85.

E. TUBERCULOSIS AND LEPROSY: 40% OF THE ESTIMATED ACTIVE CASES DETECTED AND UNDER ACTIVE TREATMENT AND FOLLOW-UP IN INTEGRATED DISTRICTS. (Indicator)

Status: In 83/84 the number of active cases treated in integrated districts was 7,764 for tuberculosis. Due to the joint effort of Leprosy Project and ICHSDP staff, 3,675 active cases of leprosy were under treatment. Assuming an annual incidence of smear positive of tuberculosis of 9,061 new cases, and a prevalence of 18,324 persons with active TB in ICHSDP areas, 42% of active cases would have been under treatment last year, as reported. Assuming a prevalence of about 35,240 cases of leprosy in the integrated areas, about 11% were under treatment.

Comment: In ICHSDP districts, it appears that greater progress has been achieved for control of tuberculosis than for leprosy. In fact, ICHSDP management of both these service components is hampered by insufficiency of technically competent-central staff to oversee them: there is only one senior public health administrator to cover malaria, control of diarrheal and other communicable diseases, immunizations, tuberculosis and leprosy. These prevalent, ubiquitous, disabling and lethal diseases thus cannot receive the organizational attention they merit. Analysis of the role of the control of these diseases in the development of primary health care under ICHSDP is complex, but it is analyzed in the JSI report for HMS, "Tuberculosis and Leprosy Services in Integrated Districts", prepared by Dr Andrew Cassels in July 1983.

F. KEY PEDIATRIC IMMUNIZATIONS

Indicator 1. In 48 integrated districts, 60% of children receive DPT, measles, and BCG immunizations on scheduled basis.

Status: In ICHSDP districts in 1983/84 the following immunizations were given to children under one year of age

DPT 1--79,616	BCG--99,804
DPT 2--45,807	MEASLES--9,950 (only in district centers, ages 9-35 months)
DPT 3--26,674	

Assuming a crude birth rate of 42/1000 population and an infant mortality rate of 120 deaths/1000 livebirths, approximately 190,300 children aged 0-1 years received these immunizations. Hence 42% received a first DPT, and 14% completed the DPT series. BCG was received by 52% in the first year of life, while the costly and fragile measles vaccine was made available to less than 5% of infants and young children.

Comment: Problems of refrigerator and cold chain maintenance have hampered ICHSDP, and there has been inadequate central staff to manage the district effort for immunization. When districts have been taken by ICHSDP from EIP there has frequently been a rupture in the resumption of immunizations. Increased collaboration planned between EIP and ICHSDP in '84/85 hopefully will upgrade achievement in pediatric immunization. ICHSDP recently communicated immunization targets for its districts to EIP for the first time. Measles is a feared major killer of children in Nepal, many of whom are made fragile by malnutrition; extension of measles immunization would effectively lower infant mortality. The definition of populations targeted for immunization in Nepal has (sensibly) changed since the project paper was written: from '77-80 it was < 5 years, then in '81-82 it became < 15 months, and since 82/83 has been < 1 year for DPT, and at birth for ECG. For measles it is 9-35 months.

Indicator 2. In FP/MCH covered districts, 80% of children receive DPT, ECG, and measles immunizations

Status: In 11 of the 52 FP/MCH districts appreciable immunization work has been carried out by FP/MCH. In these 11 districts, with a 1981 population of 3,112,128, the following total immunizations were given in 1983/84: DPT1 -- 18,237, "old DPT" (DPT2 + DPT3) -- 13,654, ECG -- 18,216. Thus, less than 12% of 0-1 year olds received complete DPT immunizations, and about 14% of newborns got ECG last year from FP/MCH in the 21% of its districts where immunizations were provided. In the 41 other districts, FP/MCH coverage was close to 0% for both DPT and ECG.

Comment: In most FP/MCH districts immunizations are given either by EIP or scarcely at all. FP/MCH negotiates with EIP for limited supplies of vaccine, and has provided immunizations through a few of the larger clinics, but not through an outreach effort in the community. FP/MCH has renegotiated with EIP to obtain larger amounts of vaccine for 1984/85, however, and has planned to increase considerably the areas covered and the number of immunizations.

**ANNEX 10**

**Integration Models**

As part of the report entitled "Review of the Delivery of Health Services for Improving Integrated Services Including Family Planning and Maternal Child Health", the authors came up with integration schedules for each of the six vertical projects into the Ministry of Health Infrastructure. Annex 10 provides a summary of these proposed integration timetables for each of the projects.

Annex 10: Cont.

PLAN OF ACTION FOR FP/MCH PROJECT

Activities/Year	1986	1987	1988	1989	1990	Remarks
Board	-					Umbrella Board of MOH.
Project Chief	-					Division Chief, MOH
Planning, Research and Evaluation Division	.	-				National Commission on Population.
Training Division	.	.	-	-		As part of HERCTI
Information, Education & Communication Division			-	-		As part of HERCTI
Service Division	-					As part of Hospitals
Surgical Division	-					As part of Hospitals
Administration Division	-					Administration Division, MOH
Supply & Procurement Sec.	-					Indent & Procurement Division, MOH
Administration Section	-					Fiscal Div., MOH
Eastern Regional Office		-				Eastern Regional Directorate
Central Regional Office		-				Central Reg. Direc.
Western Regional Office	-					Western Reg. Direc.
Mid-Western Reg. Office	-					Mid-Western Reg. Directorate
Far-Western Reg. Office			-			Far-Western Reg. Directorate
Regional Training Centres			-			As part of HERCTI
Districts	-	-	-	-	-	Absorbed as Sections in DHO
Clinics			-		-	Absorbed by Health Posts
PBHWs				-	-	Absorbed by Health Posts.

Annex 10: Cont.

INTEGRATION MODEL: PLAN OF ACTION FOR INTEGRATION OF ICHSDP INTO THE MINISTRY

Activities/Year	1986	1987	1988	1989	1990	Remarks
ICHSDP Board	-					Umbrella Board in MOH
ICHSDP Chief	-					Division Chief (Primary Health Care) in MOH
Planning, Evaluation and Statistical Section			-			Absorbed in MOH Planning Division
Training Section			-			Will be absorbed by HERCTI
Immunization Section			-			Will be absorbed in IEPI Division in MOH
Finance & Audit Section		-				Will be merged in Fiscal Division in MOH
Administrative Section		-				Absorbed in Adminis- trative Division in MOH
Family Health Section			-			Will be merged in h Division, Div. in MOH
Malaria Section			-			Will be merged in Malaria or preventa- tive Div.
Supervision Section					-	Will be merged in HERCTI
Transport Section					-	Will be merged in TEMO
Supply + Procurement Sec.		-				Indent & Procurement Div. in MOH
Regional Training Centre Eastern Region			-	-		Will be merged in HERCTI
Regional Training Centre Central Region			-	-		Will be merged in HERCTI
Regional Training Centre Western Region			-	-		Will be merged in HERCTI
Regional Training Centre Mid-Western Region			-	-		Will be merged in HERCTI

Annex 10: Cont.

INTEGRATION MODEL: PLAN OF ACTION FOR INTEGRATION OF NMEO

Activities/Year	1986	1987	1988	1989	1990	Remarks
NMEO Board	-					Create an Umbrella Board in MOH for integration
NMEO Chief	-					Place as Divisional Chief in MOH.
Planning and Evaluation		-				Absorbed by Planning Division/MOH
Training and Research Centre				-		Absorbed by HERCTI
Administrative Services		-				Decentralized to RHD
Fiscal Management		-				
Programme Operations Division		-				
Eastern Region Office			-			As a section in RHD
Western Region Office	-					As a section in RHD
Mid Western Region Office	-					As a section in RHD
Health Education		-				Absorbed by HERCTI
District Offices	-	-	-			As a section in each District Health Office
Peripheral Workers	-	-	-			Absorbed in Health Posts
Terminate Project Status					-	All accounts to be reconciled and completed
Re-Examine the Impact on Project Objectives as a result of Integration						Redesign the structural parameters for effective organization

Annex 10: Cont.

PLAN OF ACTION FOR INTEGRATION OF EIP

Activities/Year	1986	1987	1988	1989	1990	Remarks
Board	-					Umbrella Board of Ministry of Health
Project Chief	-					Section Chief in Ministry of Health
Evaluation, Planning and Statistics		.				As a section in respective RHD offices
Training Section		-	-			As part of HERCTI
Education		-				Health education section in HERCTI
Administration		-				Absorb by Administrative Division MOH
Finance		-				Absorb in Finance Division, MOH
CDR		-	-			RHD
EDR				-		RHD
FWDR						RHD
MFWR					-	RHD
District Office		-	-	-	-	As a section in District Health Office (DHO)
Units		-	-	-	-	As a section in Health Posts (HP's)

Annex 10: Cont.

PLAN OF ACTION FOR INTEGRATION OF TUBERCULOSIS CONTROL PROJECT

Activities/Year	1986	1987	1988	1989	1990	Remarks
Project Chief	-					Nominate Project Chief as Member, Umbrella Board of MOH for Integration
Project Chief	-					Transfer as Section Chief in MOH from DHS
Planning		-				As part of Planning Division, MOH
Administration		-				As part of Administration, MOH
Accounts						Merged with MOH, Accounts Section
Statistics						As part of Planning Division, MOH
Follow-up Clinics		-				Under district hospital
Training			-			As part of HERCTI
Store		-				Merged into RHD, Indent & Procurement Section or New Company to undertake supplies function
Field		-				As sections in Health Posts
Research			-			As part of HERCTI

Annex 10: Cont.

PLAN OF ACTION FOR INTEGRATION OF LEPROSY CONTROL PROJECT

Activities/Year	1986	1987	1988	1989	1990	Remarks
Leprosy Board	-					Umbrella Board of Ministry of Health
Project Chief	-					Section Chief in Ministry of Health
Administration, Finance, Statistics and Clinic	-					As a unit in respective RHD Offices
Regional Offices						As sections of RHD's with hospitals and leprosoria being incorporated as autonomous institutions under development board act.
Field		-	-	-	-	As units in health posts