

PD-ABC-271

U N C L A S S I F I E D

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

NEPAL  
Child Survival/Family Planning  
Services  
367-0157

March 27, 1990

U N C L A S S I F I E D

PDABC-271

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY NEPAL

3. PROJECT NUMBER

367-0157

4. BUREAU/OFFICE  
ASIA/NEAR EAST BUREAU  
USAID/NEPAL/HFP

04

5. PROJECT TITLE (maximum 40 characters)

CHILD SURVIVAL/FAMILY PLANNING SERVICES

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
07 15 95

7. ESTIMATED DATE OF OBLIGATION  
(Under "B:" below, enter 1, 2, 3, or 4)

A. Initial FY 90

B. Quarter 3

C. Final FY 94

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 90			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	3,200	800	4,000	12,100	7,900	20,000
(Grant)	(3,200)	(800)	(4,000)	(12,100)	(7,900)	(20,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.						
1.						
2.						
Host Country						
Other Donors)						
<b>TOTALS</b>	<b>3,200</b>	<b>800</b>	<b>4,000</b>	<b>12,100</b>	<b>7,900</b>	<b>20,000</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO. PRIORITIZATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	533	510		300		2800		14,000	
(2) PN	433	440		1200		1200		6,000	
(3)									
(4)									
<b>TOTALS</b>				<b>4000</b>		<b>4000</b>		<b>20,000</b>	

10. SECONDARY TECHNICAL CODES (maximum 8 codes of 3 positions each)

530 542 562 430 450 460

11. SECONDARY PURPOSE CODE 583/433

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code BRW INTR TRG  
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To improve the quality and coverage of child health care, family planning, and selected malaria control services, and to improve the management and organizational issues and practices affecting the delivery of those services.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
0 9 9 2 | | | | 0 5 9 5

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of 8 page PP Amendment)

17. APPROVED BY

Signature *William Stacy Rhodes*  
Title William Stacy Rhodes  
A/Director, USAID/Nepal

Date Signed MM DD YY  
03 27 90

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY  
| | | |

*C T Rotta, Controller*

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**PROJECT PAPER**  
**CHILD SURVIVAL/FAMILY PLANNING SERVICES (367-0157)**

**Table of Contents**

<b>I. <u>EXECUTIVE SUMMARY</u></b>	<b>PAGE</b>
A. Introduction and Background	1
B. Project Components	2
C. Expected Achievements/Results	5
D. Cost Estimates	6
<b>II. <u>BACKGROUND</u></b>	
A. Context	7
1. Historical Perspective	7
2. Host Country Strategy	9
3. Relationship to USAID Strategy	10
4. Donor Coordination	11
B. Problem Identification	
<b>III. <u>PROJECT DESCRIPTION</u></b>	
A. Goal and Purpose	17
B. Project Components	
1. Service Management and Delivery	17
a. Activities	
1) Central Region Management & Service Delivery Improvement	17
2) Public Health Training	22
3) Innovative Activities	23
b. Inputs	
c. Expected Results	
2. Family Planning	25
a. Activities	
1) Public Sector	25
2) Private Sector	30
b. Inputs	
c. Expected Results	
3. Child Survival	34
a. Activities	
1) Control of Diarrheal Diseases	34
2) Immunizations/EPI	37
3) Acute Respiratory Infections (ARI)	38
b. Inputs	
c. Expected Results	
4. Malaria Control	40
a. Activities	
b. Inputs	
c. Expected Results	

C.	End of Project Status	43
D.	Summary of Inputs	45
E.	Financial Plan	49
	1. U.S. and HMG Project Costs and Inputs	
	2. Financial Management	
	3. Budget Tables	
IV.	<u>SUMMARY OF PROJECT ANALYSES</u>	
	A. Technical Analysis	57
	B. Economic and Financial Analyses	61
	C. Social Soundness and Beneficiary Analyses	63
	D. Institutional/Administrative Analysis	64
V.	<u>EVALUATION, MONITORING AND AUDIT PLANS</u>	66
VI.	<u>IMPLEMENTATION PLAN</u>	
	A. Implementation Schedule	70
	B. Implementation and Management Responsibilities	72
	C. Contractor Selection	74
	D. Procurement Plan and Waiver Requirements	74
	E. Conditions and Covenants	77
VII.	<u>ANNEXES</u>	
	A. HMG Request for Assistance	
	B. PID Approval Message/USAID Response	
	C. Logical Framework	
	D. Waivers	
	E. Statutory Checklist	
	F. Notes on Budget	
	G. SOW for Technical Assistance Personnel	
	H. Training Plan	
	I. Construction Plan	
	J. Equipment and Commodity List	
	K. Central Region Program Matrix	
VIII.	<u>ANALYSES</u>	
	A. Technical Analyses	
	B. Economic and Financial Analyses	
	C. Social Soundness and Beneficiary Analyses	
	D. Institutional/Administrative Analysis	

GLOSSARY

<b>A &amp; E</b>	<b>Architecture and Engineering (Consulting Firm)</b>
<b>AHW</b>	<b>Auxillary Health Worker</b>
<b>ANM</b>	<b>Assistant Nurse Midwife</b>
<b>ARI</b>	<b>Acute Respiratory Infection</b>
<b>AVSC</b>	<b>Association for Voluntary Surgical Contraception</b>
<b>BNP</b>	<b>Basic Needs Program</b>
<b>BNP</b>	<b>Basic Needs Program of HMG</b>
<b>CA</b>	<b>Cooperative Agreement</b>
<b>CDD</b>	<b>Control of Diarrheal Diseases</b>
<b>CDSS</b>	<b>Country Development Strategy Statement</b>
<b>CEDPA</b>	<b>Center for Education and Population Development Activities</b>
<b>CHILDTech</b>	<b>Technologies for Child Survival (Centrally contracted project)</b>
<b>CHL</b>	<b>Community Health Leader</b>
<b>CHV</b>	<b>Community Health Volunteer</b>
<b>CPT</b>	<b>Contraceptive Procurement Tables</b>
<b>CRHD</b>	<b>Central Regional Health Directorate</b>
<b>CRS</b>	<b>Contraceptive Retail Sales Company</b>
<b>CS</b>	<b>Child Survival</b>
<b>DPHO</b>	<b>District Public Health Office(r)</b>
<b>EPI</b>	<b>Expanded Program in Immunization</b>
<b>PHI</b>	<b>Family Health International</b>
<b>FP</b>	<b>Family Planning</b>
<b>FPAN</b>	<b>Family Planning Association of Nepal</b>
<b>FPIA</b>	<b>Family Planning International Assistance Program</b>
<b>PP, MCH</b>	<b>Family Planning/Maternal Child Health (Project)</b>

GON	Government of Nepal
HFP	Health and Family Planning
HMG	His Majesty's Government
HP	Health Post
IBRD	International Bank for Reconstruction and Development
ICHSDP	Integrated Community Health Services Delivery Project
IDA	International Development Association
IE&C	Information Education and Communication
IMPACT	Innovative Materials for Population Action
IOM	Institute of Medicine
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
JICA	Japan International Cooperation Agency
LCS	Local Cost Support
MCH	Maternal-Child Health (programs)
MOH	Ministry of Health
NCDDP	National Control of Diarrheal Disease Program
NEPAS	Nepal Pediatric Society
NGO	Non-Governmental Organization
NORPLANT	Surgically Implanted, Constant Release Hormonal Contraceptive Device
NMEO	National Malaria Eradication Organization
NRCS	Nepal Red Cross Society
NRTC	National Research and Training Center (Malaria)
NPCC	Nepal Fertility Care Center

ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAC	Paramedical and Auxillary Care (Training) Project (Centrally contracted)
PCD/V	Passive Case Detection/Volunteer
PPMSD	Policy, Planning, Monitoring and Supervision Division
PROC	Procurement Office, USAID/Nepal
PSC	Personal Services Contract (or)
PVO	Private Voluntary Organization
RAPID	Resources for Awareness of Population Impacts on Development
RFP	Request for Proposals
RSM	Rural Social Marketing
R/R	Recording and Reporting (System)
SCF	Save the Children Fund
SOMARC	Social Marketing for Change (Centrally-contracted) Project
ST/H	Science and Technology Bureau, Directorate of Health
ST/POP	Science and Technology Bureau, Directorate of Population
TA	Technical Assistance
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
VBC	Vector Biology and Control (Centrally-contracted) Project
VSC	Voluntary Surgical Contraception
WHO	World Health Organization, United Nations

PROJECT AUTHORIZATION

Name of Country: Nepal  
Name of Project: Child Survival/Family Planning Services Project  
Number of Project: 367-0157

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended (the FAA), I hereby authorize the Child Survival/Family Planning Services Project (the Project) for Nepal (the Cooperating Country) involving planned obligations not to exceed Twenty Million U.S. Dollars (\$20,000,000) in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of project is five years from the date of initial obligation.
2. The Project will improve the quality and coverage of child health care, family planning, and selected malaria control services, and will improve the management and organizational practices affecting the delivery of those services.
3. The Project Agreement(s) which may be negotiated and executed by officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms, covenants and conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

A. Source and Origin of Commodities, Nationality of Services

Except as A.I.D. may otherwise agree in writing:

- i. Commodities financed by A.I.D. under the project shall have their source and origin in countries included in Geographic Code 941 and the Cooperating Country; and
- ii. Suppliers of commodities or services, including ocean shipping, shall have their place of nationality in countries included in A.I.D. Geographic Code 941 and the Cooperating Country.

B. Family Planning Covenants

i. No portion of A.I.D. grant proceeds will be used to pay for motivation fees for abortions or sterilizations or to pay for the performance of abortions as a methods of family planning or for any materials, equipment or activity in support of such abortions. Nor will any portion of the grant be used in support of a program that motivates or coerces any person to practice of undergo such abortions.

ii. All family planning services, including sterilization, will be provided on a strictly voluntary basis. No portion of the grant will be used to pay for the performance of involuntary sterilizations as a method of family planning or for any materials, equipment or activity in support of such sterilizations. Nor will any portion of the grant be used in support of a voluntary sterilization program that includes coercion or an incentive in favor of sterilization over other methods of family planning.

C. Conditions Precedent

i. Conditions Precedent to First Disbursement.

Prior to the first disbursement or to issuance of documentation pursuant to which disbursement will be made, HMG/N shall, except as the Parties otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., a statement of the name(s) of the person(s) authorized to represent HMG/N for the project together with a specimen signature of each person specified.

ii. Condition Precedent to Execution of the CRS Cooperative Agreement.

Prior to execution by A.I.D. of a Cooperative Agreement funded under this grant to the Contraceptive Retail Sales Co. (CRS), CRS shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that CRS has adopted and

implemented revisions to its memorandum of association and articles of association as appropriate, to ensure effective private sector control of CRS.

Signature: William Stacy Rhodes  
William Stacy Rhodes  
Acting Director

Date: March 27, 1990

Clearance:

HFP:DHCalder: (in draft) *DR*  
HFP:DLPiet: (in draft) *DR*  
HFP:UNadolny: (in draft) *DR*  
A/FM:JClary: (in draft) *DR*  
EXO:WWanamaker: (in draft) *DR*  
PROC:AEisenberg: (in draft) *DR*  
PPD:MCalavan: (in draft) *DR*  
PPD:NCohen: (in draft) *DR*

*TAA*  
Drafted: PPD/PD:THarris:sdl:1/12/90  
Revised: RLA:PMusey:sdl:1/24/90

*PMusey*  
3/22/90

## I. EXECUTIVE SUMMARY

### A. Introduction and Background

Nepal is faced with major problems in the health sector. Although significant advances have been made, the nation still faces high child death rates, high population growth rates, institutional weakness, a difficult landscape, and many social barriers to improved health practices. Nepal suffers from some of the worst health conditions in Asia, with women and children as the greatest sufferers. Social practices favoring sanitation, cleanliness, and disease prevention are still uncommon. Diarrheal diseases, pneumonias, malaria (in some areas), measles, and maternal mortality are particularly severe. Fertility remains high and there is as yet little family planning practiced.

Although the Government of Nepal (GON), principally through the Ministry of Health (MOH), has been attempting to alleviate the situation, the most appropriate administrative, managerial and implementation systems have not yet been fully devised nor implemented. The MOH is a weak institution, with limited financial and human resources. It is just beginning to grapple with the requirements of sustained, high population coverage and integrated service delivery systems. The sector is in desperate need of improved management, integrated health delivery systems, improved health practices by the people, and a greater participation of the non-public sector in overcoming its problems.

USAID has summarized its sector strategy to the MOH in terms of five basic themes which have been accepted by the MOH as a basis for USAID support. They are:

Services For and By Women. Given the importance of changes in the perceptions and behavior of mothers for the success of child survival and family planning programs, the Mission stresses that women are the principal clients and that the best way to get services to women (in a society where interaction between the sexes is culturally limited) is to provide them through other women.

Beyond the Health Post. To counter a persistent preoccupation with staffing fixed facilities which rural people infrequently visit, the Mission emphasizes the need for village-level health services. The interventions most likely to reduce mortality and undesired fertility must be made available close to home, and additional staff, primarily volunteers, will be required to provide such assistance.

Full-Service Family Planning/MCH Services. To overcome what has been a nearly exclusive emphasis on sterilization and make Nepal's family planning (FP) program more effective in terms of both contraception services and improved maternal and child health, USAID emphasizes the balanced

motivation for, and provision of, temporary and permanent contraceptive methods, along with other priority Maternal and Child Health (MCH) services.

Decentralization and Regionalization. The MOH is struggling to operationalize the complex processes of decentralization and regionalization. A reasonable start has been made, with USAID support, in the Central Region to identify issues and resource requirements needed for the development of regional and district management systems.

"Don't Forget Malaria". Given the long-term nature of the malaria problem, USAID has encouraged MOH procurement of insecticide (MOH has depended on donor-granted supplies for 35 years), an improved training capability for malaria control, decentralization of case detection and treatment, service expansion to include other vector-borne diseases (e.g. Japanese encephalitis), intensified review of the changing entomology of malaria transmission, and sustained management and political attention to ensure maintenance of a national malaria control capacity.

#### B. Project Components

The project goal is to reduce child mortality and undesired fertility. Its purposes are to improve the quality and coverage of child health care, family planning, and selected malaria control services, and to improve the management and organizational issues and practices affecting the delivery of those services.

Project components will support major initiatives in decentralizing and improving organization of the existing infrastructure for maximizing coverage of health services and assuring sustainability and priority AID areas in child survival (CS), family planning (FP), and efficiency of service delivery. They are based on the recommendations of the final evaluation of the Integrated Rural Health/Family Planning Services Project (IRH/FPS), which recognized the need to establish management systems and address many procedural issues in integration and decentralization. Because the management changes being called for by the GON/MOH, and supported by recommendations in the final evaluation, are "revolutionary" in their scope, the evaluation recommended that the follow-on project focus service delivery management efforts in one geographical region. The evaluation also recommended that the new project expand on successful efforts in family planning (temporary and permanent methods), and in the major child survival (CS) interventions, but to not limit these to a geographical region. It also recommended exploring avenues to greater involvement of private organizations in the focus CS and FP services.

The project outlines several initiatives to improve quality of and access to health care, such as institutionalizing

a wide range of decentralized, integrated services in static facilities; reaching into the community via volunteer health workers; expanding access to health supplies (FP commodities and ORS, for example) and services through private market channels and clinic facilities, and through local and U.S. non-governmental organizations (NGOs). As such, the project's activities will join public, private, and NGO resources into a "coalition" of efforts to improve health services, promote sustainable programs, and provide flexible access to appropriate services.

In the implementation of this project, USAID will follow a flexible, responsive strategy in guiding the improvement of the health and family planning delivery systems. The project budgets allows sufficient flexibility to support investigations of operational questions and management initiatives in both the public and private sectors, as new opportunities are identified.

Public sector components of this project will not require the MOH to undertake additional budgetary commitments beyond what is already planned in the next Five Year Plan (the MOH has already budgeted resources for carrying out its responsibilities for project-related activities); nor will it impose a significant financial sustainability burden on the MOH to carry on the services supported during the project period. It will, in essence, assist the MOH to increase the efficiency and improve performance from the resources it already devotes to the health and family planning sector during that period. The project will do this by providing technical assistance, extensive training, and commodities to support the work of MOH staff primarily in the Central Region, which is already well staffed at the district and health post levels, and in other selected districts where there are already adequate staff and facilities on hand. USAID's approach to local cost support budget allocations for project activities will be through the GON's official "Red Book", and on the basis of annual workplans for specific activities in designated locations.

1. Improved Service Delivery and Management in the Central Region

The project will assist the Central Region Health Directorate to develop and strengthen its own managerial and technical capacities to deliver integrated Maternal and Child Health (MCH) services, thus developing models for service delivery and administrative management which can be applied to other regions. This effort will focus on a systematic review of MCH services on a district-by-district basis, in order to identify constraints and weakness associated with MCH service delivery, identify options for resolving them, outline a plan for their resolution, and focus technical and managerial resources on correcting these problems; and on management, planning, supervision and data analysis skills development for regional, district and local MOH staff to undertake such

reviews/analyses and implement required changes. Training and other activities in family planning and child survival (described below) will be largely complementary to, and in support of, service delivery improvement initiatives in the Central Region. Included will be training and supervision systems development for the new (female) Community Health Volunteer (CHV) program, and establishing roles and responsibilities for local, district, regional and central management levels in the implementation of this grassroots effort. Financial support for local university degree training in public health management will also be provided for a large portion of the country's health system managers.

We will also pursue a series of small scale activities to identify more effective approaches to delivering services. All possible means of increasing private and public resources for the health sector in Nepal will be pursued, including field testing of strategies for cost recovery in government facilities; further privatization of health service delivery; resource allocation, use and management; analyses of relative cost effectiveness of services; and strategies to increase coverage of preventive and promotive services. Other likely topics for investigation include the level and context of demand for health services in Nepal; CHV incentives and complementary outreach activities; delivery of Vitamin A in conjunction with Expanded Program for Immunization (EPI) services; etc. These possibilities and others will be refined, developed and implemented during the project.

## 2. Effective Family Planning (FP) Services

More appropriate, effective family planning services can be achieved by increasing the range of methods available and options for attaining such services. Training and technical assistance (TA) will enable FP workers to deliver a full range of services (clinical and non-clinical methods) in hospitals, clinics, health posts and the community. Local communication capabilities will be strengthened, and information, education and media messages on family planning and child survival will be developed and disseminated. Improvements in quality of voluntary surgical contraception (VSC) services and other clinical methods will be developed, and clinical contraceptive services will be safely expanded. A revitalized, privatized Contraceptive Retail Sales (CRS) Co. will develop its marketing/demand creation (FP and oral rehydration therapy-ORT) and management capacity, product diversification and rural social marketing activities, and plans for self-sufficiency. Full service, private family planning clinics with outreach services will be established in urban areas. Finally, private industry-based family planning services will be established, perhaps even leading to experimentation with an HMO-like organization.

## 3. More Effective Child Survival Interventions

Health workers will be trained in diagnosis,

treatment, prevention and follow-up of diarrheal disease and acute respiratory infection (ARI) cases. A trial of a smaller, more appropriate oral rehydration salt (ORS) packet standard will be launched in three districts and, if proven feasible, expanded nationwide. Field studies (a national diarrheal disease survey, diarrheal disease epidemiological studies, effectiveness of immunization coverage, etc.) will identify program improvements, and improved supervision systems will be tested and, as appropriate, implemented. Physicians will be trained in the control of diarrheal diseases (CDD) and ARI case management. Pilot activities, e.g. ARI service delivery mechanisms, will be implemented, and effective, replicable elements applied.

#### 4. Rejuvenated Malaria Control System

The National (malaria) Research and Training Center (NRTC) facilities will be expanded and renovated, and the curriculum revised. The National Malaria Eradication Organization's (NMEO) computerized data base for epidemiological, entomological and operational data will be improved. TA and training will sharpen the NMEO's capacity to identify areas of "high", "medium" and "low" malaria risk, and to carry out research on mosquito ecology. The passive case detection system will be strengthened through refresher training for Passive Case Detection Volunteers (PCDVs) and decentralization of malaria laboratories.

#### C. Expected Achievements/Results

1. MCH and FP service coverage will increase to at least 80% in project districts and quality improvements will help ensure, e.g., safe clinical contraception services and correct ORT. The Central Region Health Directorate will be a strong management unit able to administer effective health care delivery in the region. Specifically, it will be effective in planning, budgeting, personnel and logistics management, monitoring, supervision and training. District Public Health Offices (DPHOs) will be actively involved in program planning, based on epidemiologic and demographic assessments, resource constraints and realistic targets. Health system managers will have received in-country public health degree training. Local and district-level units will have a defined role for supporting the CHVs in the Central Region. The potential for further private sector health service provision will have been investigated and applied as feasible; and assessments of service delivery options will have been made and applied to programs.

2. Full service family planning/maternal child health (FP/MCH) services will be widely available in project districts (75% population coverage). Knowledge of contraception and contraceptive prevalence will have increased in project districts (20% increase). Private sector participation in family planning services will have increased (100% increase in contribution to national contraceptive prevalence rate for temporary methods).

3. Improved child survival (CS) services (CDD, ARI, EPI) will be available to the majority of the Central Region population. There will be a substantial increase in correct use of oral rehydration salts/solution (ORS), and improved ARI case management, resulting in decreased childhood morbidity and mortality associated with CDD and ARI.

4. The NMEC will maintain national malaria incidence at or below 1989 levels while reducing dependence on insecticides through more effective stratification and prioritization of control measures. The NMEC will conduct appropriate studies on environmental and biological control of malaria and other vector-borne diseases. Knowledge and skills for malaria control activities within an integrated system will be strengthened.

D. Cost Estimates

USAID and the GON/MOH will fund the project in roughly equal amounts. USAID will provide \$20,000,000 and the GON/MOH an estimated \$20,779,000. Both an inflation factor and a contingency, overall at 9% and 6% respectively, are incorporated into the total figures for both USAID and GON/MOH. Based on our understandings with the MOH and other donors, it is assumed that an estimated \$15,000,000 for insecticides and oral rehydration salts will be provided to the MOH by other donors.

Local currency requirements for USAID total \$7,879,000, including \$1,177,000 for training, \$240,000 for technical assistance, \$349,000 for oral rehydration supplies, \$4,500,000 in local cost support, \$500,000 for construction, and an estimated \$1,113,000 for inflation and contingency.

The following table outlines financial requirements showing the major categories of inputs. All figures are shown in thousands of U.S. dollars (\$'000's).

<u>Category</u>	<u>USAID</u>	<u>GON</u>	<u>Total</u>
I. Technical Assistance	5,640	480	6,120
II. Training	1,417	242	1,659
III. Commodities & Supplies	4,860	15,703	20,563
IV. Local Cost Support	4,500	1,200	5,700
V. Construction	500	50	550
VI. Evaluations	150	-0-	150
VII. Audit	75	-0-	75
VIII. Inflation	1,711	1,928	3,639
IX. Contingency	<u>1,147</u>	<u>1,176</u>	<u>2,323</u>
TOTAL	20,000	20,779	40,779

## II. BACKGROUND

### A. Context

#### 1. Historical Perspective

Traditionally, the MOH has offered public health services through large, independent, vertical "projects", each with its own staff, budget and administration. Five major vertical projects, each focused on a particular health problem, included the Family Planning and Maternal Child Health Project (FP/MCH), the Nepal Malaria Eradication Organization (NMEO), the Expanded Immunization Project (EPI), the Tuberculosis Control Project, and the Leprosy Control Project. The parallel, regular MOH system, into which these projects were to be integrated, provided regular health assistance (chiefly curative) through the Department of Health Services and its static health posts, health centers and hospitals. A major distinction between the regular MOH system and the vertical projects has been that employees in the regular MOH system are civil servants whereas personnel in the vertical projects are contract employees, with the former benefiting from job security and the latter from generally higher pay scales.

The MOH health infrastructure consisted of approximately 10 health posts per district, loosely tied to a district hospital. These posts were typically understaffed and unsupervised, with usually no more than a health assistant and a lower-level assistant ("peon") to handle the health needs for an entire area. There were no field workers at the posts.

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

#### a) Integration

Attempts to integrate vertical projects within the regular MOH health structure began in the early 1970s. The rationale for this effort, supported by the donor community, included the desirability of harnessing the outreach capability of the vertical projects, and of eliminating costly management and personnel duplication.

The first step began in 1971, when six districts in the Terai (out of a total of 75 districts in the country) were integrated over a four-year period. An evaluation of two of the experimental

districts found that the new approach offered two advantages: more services were available in the integrated districts, and the approach was more cost-effective.

For the next several years and into the 1980s, the MOH attempted to expand integration country-wide. The envisioned integration was to (1) subsume vertical projects within one administrative structure, and (2) integrate preventive services with curative services.

Two major ingredients of this effort were expansion of health post staffs and civil service status to the new employees, some of whom were being transferred from vertical projects. In addition, increased emphasis was placed on involvement of the community through two groups of multi-purpose providers: Village Health Workers (VHW) and, at a lower level, volunteers called Community Health Leaders (CHL).

Numerous problems arose, including the difficulty of developing a management and supervisory system to oversee both streams of health workers. Transferring vertical project staff into the regular program also proved extremely complex and resistance was considerable, in large part because of bureaucratic and personal career interests, particularly among the top level staff. These basic problems persisted.

Attempts at integration were overtaken in July 1987, by a much higher-level policy commitment when the GON, independent of donor urging, announced a total reorganization of the MOH and a new plan for integration, whereby the integration of all projects into the MOH was to take place immediately.

The July 1987 reorganization brought together public health activities (as distinct from curative services) with the creation of the Public Health Division. All public health services were to be integrated, and the target date for completion of the integration and the disappearance of all vertical projects is now set for mid-1990. This reorganization also calls for giving major responsibilities to five regional directorates, thus marking the first time that the then seven-year-old effort to decentralize government services in all sectors (see below) had become part of the official strategy to restructure the health services.

#### b) Decentralization

Like efforts to integrate the health services, the efforts to decentralize were designed to replace the existing arrangement in which the central government retained almost exclusive authority to carry out all planning, funding and management of public programs, as well as personnel administration authority. The effort to apply decentralization specifically to the country's health services began in the early 1980's. The MOH has not yet articulated clearly its strategy for decentralization, but a number of organizational changes currently underway are laying the groundwork for more local self-reliance.

MOH documents reflect a view that the regional offices are the focal points for management of health activities, providing technical and administrative assistance to the districts for the implementation of programs. More authority is also to be vested at the district level, where District Public Health Offices (DPHO) were created and are to be strengthened.

To date, however, the power at the regional level is very limited, the only real formal authority being the personnel administration of lower level (non-gazetted) staff within the region. Regions also have very limited authority for the budgeting and planning process, whereby regions are only authorized to make recommendations concerning the contents of the plans, and they have very limited authorities over funds.

### c) 1990 and Beyond

The MOH, including the national level offices, has adopted integration and decentralization as realistic goals to pursue. Integration will happen, as much for economic reasons as for reasons of MOH policy. At this point, we can be reasonable optimistic that efforts to help strengthen and reshape the system, by helping to establish a model for effective management, promoting the CHVs, and complementing these efforts with others as they arise, will be successful. The evolution of the integration/decentralization process over the last many years has clearly identified for all concerned the directions which must be pursued, provided "lessons learned" for application, and has created an environment which recognizes the complexities of the process and accepts the possibility of addressing these from several aspects.

## 2. Host Country Strategy and Programs

In late 1985, King Birendra committed Nepal to meeting the "basic needs" of Nepal's 18 million inhabitants by the year 2000. This initiative has become a driving force behind many of the GON's development programs. The Ministry of Health (MOH) attaches high priority to the Basic Needs Program (BNP) and reduction of infant and child mortality through immunization, diarrheal disease control and family planning. Ministry of Health commitment to basic needs is evident in the high (and increasing) portion of its budget allocated to public health/primary health care activities, as opposed to emphasis on unrealistically sophisticated curative services, over the last five years.

The Basic Needs Program brings the Ministry into close agreement with AID health and population policies and with USAID recommendations that the MOH emphasize high-impact, sustainable child survival and family planning services. HMG basic needs (BN) goals for the health sector by the year 2000 include reduction of the Total Fertility Rate from approximately 5.8 in 1989 to 2.5\*, reduction of the population growth rate from 2.66% to 1.2%\*, a decrease in infant mortality rate from 112 to 45 per 1,000 live births, and an 80% decrease in child mortality from diarrheal

disease (\*we are pleased that there is growing public awareness among health professionals that these figures are unrealistic).

Since 1987, the MOH has been reorganizing itself to phase out these projects and to integrate management and services, as well as to decentralize management functions at regional and district levels. This is a reflection of HMG policy to increase governmental responsibility at the local level. Five Regional Health Directorates have been established, and District Public Health Officers have been assigned to manage eventually integrated services in all seventy-five districts. However, progress in making them effective will require considerable improvements and changes in planning, budgeting, management and supervisory techniques.

### 3. Relationship to USAID Strategy

USAID's Country Development Strategy Statement (CDSS) sets forth a health/population strategy consistent with the MOH's emphasis on basic needs, child survival and fertility reduction. The Integrated Rural Health/Family Planning Services (IRH/PPS) Project was USAID/Nepal's first major effort to support development of national programs and systems for basic health and family planning services, and this project is based on its lessons and today's conditions in Nepal. This project will: a) build on Nepal's development of basic infrastructure and progressive policies over the past two decades, now putting into place basic management and technical systems to increase coverage with the highest priority child survival services; (b) increase demand for family planning services and provide a wider range of services to meet expanding demand through public, private and NGO channels; (c) sustain Nepal's capacity to control malaria, now a risk for 50% of Nepal's population, in Nepal's most productive and populated areas. The Mission agrees with the MOH that these objectives should be pursued through the decentralized, integrated system which the Ministry is currently struggling to put in place.

A 1988 evaluation of USAID's current project, Integrated Rural Health/Family Planning Services (367-0135), endorsed the soundness of MOH policies and the appropriateness of Basic Needs initiatives which focus on balanced family planning services, child survival, and decentralization of health services management. It recommended AID's continued support, with an emphasis on improving service delivery and management in one region and on continuing support to selected interventions but not limited to one region. Support for non-governmental organization (NGO) activities, public health training, and new initiatives in family planning were also recommended. Health care facility construction and large-scale procurement were discouraged (except for contraceptives), as was involvement with central-level issues not clearly related to better service delivery in the field.

Based on the program principles laid out in the current CDSS and the final project evaluation, USAID has summarized its sector strategy to the MOH in terms of five basic themes which have been accepted by the MOH as a basis for USAID support. They are:

Services For and By Women. Given the importance of changes in the perceptions and behavior of mothers for the success of child survival and family planning programs, the Mission stresses that women are the MOH's principal clients and that the best way to get services to women (in a society where interaction between the sexes is culturally limited) is to provide them through other women. The female Community Health Volunteer (CHV) Program is a significant move in this direction.

Beyond the Health Post. To counter a persistent preoccupation with staffing fixed facilities which rural people infrequently visit, the Mission emphasizes the need for village-level health services. The interventions most likely to reduce mortality and undesired fertility must be made available close to home, and additional staff, primarily volunteers, will be required to provide such assistance.

Full-Service Family Planning/MCH Services. To overcome what has been a nearly exclusive emphasis on sterilization and make Nepal's family planning (FP) program more effective in terms of both contraception services and improved maternal and child health, USAID emphasizes the balanced motivation for, and provision of, temporary and permanent contraceptive methods, along with other priority Maternal and Child Health (MCH) services.

Decentralization and Regionalization. The MOH is struggling to operationalize the complex processes of decentralization and regionalization. A reasonable start has been made, with USAID support, in the Central Region to identify issues and resource requirements needed for the development of regional and district management systems.

"Don't Forget Malaria." Given the long-term nature of the malaria problem, USAID has encouraged MOH procurement of insecticide (MOH has depended on donor-granted supplies for 35 years), an improved training capability for malaria control, decentralization of case detection and treatment, service expansion to include other vector-borne diseases (e.g. Japanese encephalitis), intensified review of the changing entomology of malaria transmission, and sustained management and political attention to ensure maintenance of a national malaria control capacity.

#### 4. Donor Coordination

Nepal is a donor-intensive country, and the health/population sector is proportionally even more so. Along with USAID, the major sectoral donors are UNICEF, UNFPA, and WHO; several other bilaterals have more modest programs in terms of program scope or service coverage objectives, and international NGOs have small programs of many "sizes and shapes" scattered around the country.

The important "wild cards" in the donor hand are IBRD(IDA) and the Japanese. IBRD has an intense desire to initiate lending in the sector in Nepal, largely in response to their entirely appropriate concern about population growth rates, and if they do, the alignment

of donor resources and traditional roles in the sector are likely to be drastically altered. A "small" level of input in IBRD terms could dwarf the traditional inputs of the historical donors, and could exacerbate an already existing absorption capacity problem in the MOH. Heretofore, HMG has been very reluctant to borrow, even on the softest terms, for programs in the social sectors, but IBRD feels that HMG will agree to IDA lending for health/population. The Japanese have provided ad hoc assistance to the sector thus far, preferring to respond to ad hoc HMG requests, usually for physical facilities; also, they have provided some longer-term, small coverage, JICA projects. The Japanese plans in this sector in Nepal are entirely unknown to us, despite frequent interaction with them on the subject over the past few years. Like the situation with the IBRD, however, they have the potential resource inputs that could drastically supplement or distort the traditional MOH-donor relationships.

UNICEF has been the largest donor to the EPI and CDD programs; USAID entered the arena in a substantial way beginning in 1985 to fill resource and technical gaps in those programs. UNICEF support in all 5 regions has concentrated on relevant commodities (including vaccines, syringes/needles/cold chain equipment, raw materials and packaging for local manufacture of ORS), IE&C, and local support for operations and training. UNICEF's commitment to these programs remains strong, and we expect their level and categories of support to continue indefinitely.

UNICEF resources to support large scale expansion of the CDD program are not sufficient for all needs. Thus, USAID has entered into a partnership to provide the necessary resources for coordinated nationwide training. USAID has coordinated with UNICEF by accepting responsibilities for other types of support to the CDD program, such as field research on optimal ORS packet size, CDD monitoring systems, epidemiology of diarrheal diseases, etc. UNICEF will continue the major donor responsibility for ORS manufacture. USAID will support the basic operating costs of the CRS Company, the organization which UNICEF has selected for the social marketing of ORS.

WHO has played its usual country level role in Nepal with regard to EPI and CDD, as well as other standard program themes and methods (e.g. EPI and CDD management/supervision training). WHO remains very effective at policy level work and standardized program-level training, but plays a lesser role in service delivery and infrastructure development.

Historically, USAID has been the major donor for malaria control, but with important inputs (including insecticides) from WHO and ODA especially. But WHO and ODA resources often have been small, and/or irregular, and/or limited to certain geographic areas, so USAID has attempted to "enlist" other donors to provide the continuing support the GON requires but which we cannot provide. Thus far, we have not found those other inputs, but, after several years of our lobbying, the IBRD recently has expressed some interest. The Japanese have also, though tentatively, re-initiated a dialogue.

UNFPA has been the other major donor in population/family planning. Over the past several years, areas of program overlap between UNFPA and USAID have been reduced. It is expected, for example, that UNFPA will provide the major inputs for population policy and research, Norplant and injectable progestin contraceptives, regional training center construction, the 1991 national census, as well as operating expenses for the CHV program, management training, MCH worker training, and MCH drugs in two geographical regions (east and far-west). There will be mutual support for many family planning activities, for example, demographic and health surveys, all aspects relating to VSC, institutionalization of FP services, IE & C, etc. UNFPA will supply more injectables, as they and HMG believe this can be an important method in Nepal.

IPPF consistently assists the FPAN with substantial core funding, including some contraceptive and surgical supplies (along with some special project funding). In addition to this core funding, FPAN solicits special project funding from a wide variety of NGO sources, including World Neighbors, the Center for Education and Population Development Activities (CEDPA), the Japan International Cooperation Agency (JICA), the Association for Voluntary Surgical Contraception (AVSC), Family Health International (FHI), etc.

Given the heavy donor involvement in the sector, coordination with other donors will necessarily be a high priority for USAID staff. Great strides have been taken by the major concerned donors to be cognizant of and take into consideration other donors' activities, and these united donor voices on certain issues have been extremely effective. There already exist several formal and informal fora for donor coordination--the informal generally are more effective and efficient. But these are large, complex and often aggressive donor colleague organizations with differing objectives, procedures, schedules, etc., and maximizing coordination will continue to be a major, time-consuming task for our staff. If/when the IBRD enters the arena with their mega-resources and access to high levels, our coordination task will be even more demanding.

## B. Problem Identification

### 1. High Child Mortality

Nepal suffers from some of the worst health conditions in Asia, with the brunt of morbidity and mortality falling on young children and their mothers. The major public health problems associated with these conditions in Nepal are diarrheal diseases, vaccine preventable diseases of childhood, acute respiratory infections, high fertility rates, and malaria. System, socio-economic and geographical constraints (see below) make it extremely difficult for this project to alleviate the conditions which contribute to the low health status among the general population. Thus, the problems the project will address under this heading are those pertaining to the knowledge and skills required by

the providers of health services, without which any impact on these major, basic health problems would be unlikely. The magnitude of these health problems in Nepal is summarized below.

Although reliable health statistics are few, a conservative overall estimate of infant mortality is 112 deaths per 1000 live births per annum (112/1000), with combined infant and child mortality as high as 400/1000 in some areas. Adequate sanitary practices are rare, and diarrheal diseases are rampant. Diarrhea is associated with about 45% of all under-five deaths. Emerging evidence indicates that a large percentage of diarrheal episodes may be dysenteric or chronic (rather than acute, dehydrating) and thus minimally responsive to oral rehydration therapy (ORT). Incorrect preparation and use of oral rehydration solution (ORS) and related treatment measures are more the norm than unusual.

Pneumonias (acute lower-respiratory infections--ALRI) may account for an additional 20% of child deaths and go almost entirely undetected and untreated among the rural population. Measles is nearly universal among children, with a case fatality rate of perhaps 20 or 30 per 1000. Given the unsanitary environment, unhygienic traditional birthing practices, and low rates of tetanus immunization among mothers, neonatal tetanus in the Terai probably kills infants at a rate of 20 or 30 per 1000 among unimmunized populations. Other vaccine-preventable diseases of childhood (especially pertussis) are also significant problems.

## 2. Excess Fertility

Even with high child mortality, total population is increasing at about 2.7% per year (a doubling of the population from the current 18 million within 26 years). Total fertility is about 5.8 children per woman. Average age at marriage is under 17, and the desire for surviving sons in this largely Hindu society drives fertility. Contraceptive prevalence is about 15%, 86% of which is due to surgical contraception. Most couples have little knowledge of temporary contraception, except in certain urban areas. Recent surveys show that large numbers of couples who desire to space or limit children are not using contraception due to lack of knowledge or lack of attractive, available services. Roughly 20% of all births occur at an interval of less than 24 months, even though Nepalese data (World Fertility Survey) dramatically indicate markedly improved child survival at longer birth intervals. Maternal mortality estimates are 8.5/1000 (1981 PP/MCH Pop Council Report); better spacing of children could also have a significant impact on this problem.

## 3. Malaria Resurgence

The large-scale resurgence of malaria in the Terai, Nepal's most economically important zone with over 60% of the country's cultivatable land, is a constant threat. Formerly one of the most malarious areas of the world, the Terai is now home to nearly half of Nepal's population, largely non-immune because of past malaria control efforts or immigration from higher altitudes.

Ecological change in this area has been dramatic and may have caused emergence of important new mosquito vectors. Insecticide and drug resistances are increasing, and resurgence epidemics have occurred. Yet specialized malaria control activities are being integrated (some say "diluted") into the overall health delivery system. Control measures are likely to suffer if appropriate skills, knowledge and systems are not maintained. Furthermore, insecticide usage is likely to decrease, given cost and effectiveness issues.

#### 4. Managerial and Institutional Problems

a. Public Sector: Despite some organizational changes and the use of (predominately male) field workers and volunteers over the past decade, the MOH cannot consistently reach beyond the health post to deliver priority services at the village level. Except for the malaria and, possibly, immunization programs, the MOH reaches only a minority of the populace. Those reached by programs in family planning, diarrheal diseases, a nascent effort in acute respiratory infection control (ARI), and nutrition are served irregularly and poorly. Although the MOH's tasks are greatly complicated by Nepal's formidable topography (90% of the country is hills and mountains), institutional weaknesses stemming from limited funds, meager technical expertise, and very poor management are concerns that can be dealt with. The MOH is also a young institution, only now entering its second generation of leadership.

MOH's efforts to meet basic needs, extend coverage, integrate programs and regionalize control have produced a current institutional environment in a state of considerable flux. The MOH is grappling with the problems of how services (heretofore provided by "vertical" projects) can be delivered at vastly increased coverage levels under a newly "integrated" system. Due to the earlier concentration on vertical projects, most MOH personnel have narrow fields of experience, and the training and management implications of melding disparate personnel and organizational elements into a unified, improved service delivery system are considerable.

The emergence of government as a provider of services and promoter of the general welfare is a recent, imported phenomenon, and the type of efficient, responsive bureaucracy required to manage a full range of modern HPP services has not yet evolved in Nepal. The Nepalese show great deference to authority, and power has remained overly centralized in Kathmandu with the rise of modern government replacing feudal systems. The decentralization of decision-making authority and resource allocation to capable officials outside of Kathmandu has not occurred. Local capabilities at this point are not sufficiently developed to support this goal: regional and district offices are not fully staffed, and information flows reflect historically vertical programs, rather than a cross-section of all activities provided for a defined population.

b. Private Sector: In the private sector, the Contraceptive Retail Sales Company (CRS), begun as an MOH project in 1978 and incorporated as a Nepalese-managed company in 1983, is

presently at a cross-roads. It has significantly increased public awareness of contraception and the availability of contraceptives, established social marketing as a viable tool in the sector, established a market in urban areas, and begun to market ORS packets. It still has considerable potential to expand its market. However, CRS has been unable to substantially break down barriers to continuing use of contraceptives. It is struggling to monitor retail outlets, manage its sales force, and expand its retail network. In addition, CRS's Board and management have not evolved over time to deal with the Company's evolving needs. USAID, MOH and CRS currently are searching for ways to restructure and resuscitate the company to operate as a more independent private entity.

Besides CRS, the private sector is not as active in health as it might be, although there are indications that more involvement may be possible. For example, HMG's 1987 Programme for Fulfillment of Basic Needs (1985-2000) contains several private sector targets. They include strengthening the skills of traditional midwives through training (this is underway); encouraging entrepreneurs to produce medicines, medical supplies and equipment; developing a policy to encourage private establishment and operation of health posts; the involvement of social organizations and NGOs in health, family planning and nutrition; and mobilizing local community support and involvement in health services. Two aspects of this policy that seem to be particularly important are the establishment of private clinics, and a private market in pharmaceuticals (with some government regulation for meeting public health objectives).

#### 5. Social and Cultural Constraints

The status of women is of basic importance in the health sector. Women (especially rural women) are traditionally isolated in Nepalese society, and their participation in events outside the home, other than an enormous workload, is generally less than that of men. Yet they are an important target group for many public health activities. Women bear the burden of most contraception, and they must understand how to use ORT, appreciate the importance of immunizations for themselves and their children, and seek treatment when their children are stricken with pneumonia, among many other behaviors. The MOH's ability to reach rural women is crucial to its ability to significantly reduce mortality and fertility.

The social organization of most villages in Nepal will make the goal of true community participation difficult in many parts of the country. The complex of caste and tribal affiliations result in stratified communities in the terai and hills. The horizontal social levels interact constantly but not always for mutual benefit. The lower levels have limited access to political power and consequently are often difficult to engage through a government program.

The social distance between many of the health post employees and villagers will be another constraint. The VHW and CHV are two

ways of bridging this gap. As more and more rural children complete at least a primary education, the gap will narrow further. In the interim, mechanisms for communicating across this social distance need to be strengthened.

### III. PROJECT DESCRIPTION

#### A. Goal and Purpose

The project goal is to reduce child mortality and undesired fertility. Its purposes are to improve the quality and coverage of child health care, family planning, and selected malaria control services, and to improve the management and organizational issues and practices affecting the delivery of those services.

#### B. Project Components

During the past decade, USAID assistance to the health sector in Nepal has supported MOH efforts in basic health care provision. USAID's assistance has evolved from emphasis on immediate health needs (permanent family planning, insecticide/commodity support for anti-malaria activities, and health system infrastructure development), to a broadened emphasis on child survival, birth spacing, and attention to basic management issues affecting the delivery of health/child survival and family planning services. This project will provide continued support for improving MOH management practices and for strengthening major health/child survival and family planning interventions.

##### 1. Service Management and Delivery

This project component encompasses three sub-activities, i.e. Central Region Management and Service Delivery Improvement (including the Community Health Volunteer [CHV] program, which USAID has been supporting primarily in the Central Region), training in public health, program management, and epidemiologic skills, and innovative activities for investigating (and implementing, as appropriate) service delivery and cost questions.

##### a. Central Region Management/Service Delivery Improvement

The five Regional Health Directorates were established by 1987/88 to replace the Department of Health Services. The purpose of this change was to move towards decentralization and integration, allowing resources and attention to be better focused on the periphery rather than on the center. Simultaneously, HMG was formulating its Basic Needs program (see Background section), which is also focused on the periphery. The primary role of the Regional Directorate is to promote the MOH's basic health needs program and to serve as the principal link between the MOH and the districts.

In order to meet these objectives, HMG/MOH policies call for an emphasis on the development and expansion of integrated basic health services through health posts and local female health

volunteers (Community Health Volunteers or [CHVs] -- replacing the dormant CHL program), primarily through programs which include basic preventive and curative health services (family planning, communicable disease services, respiratory-disease related services, and oral rehydration and nutrition services), and through the development and expansion of health care organization and health manpower.

The Central Region Health Directorate (CRHD) has identified the development of an effective integrated Maternal and Child Health (MCH) program as key to achievement of these national objectives. As defined in the National Strategy for MCH developed in 1985, the priorities are oral rehydration, nutrition, immunization, basic and natal care, and child spacing. The CRHD proposes to make these areas the principal foci of regional activities and district services. It is recognized that these foci imply the need for the development of management, support, training and information systems that would allow a comprehensive approach at the regional and district levels.

The project will provide technical and financial assistance to the CRHD in focusing its management and support activities on priority MCH/FP areas. The development and strengthening of management systems will be carried out concentrating on how these systems can be used to improve service coverage and quality. (N.B.: The technical aspects of the services to be strengthened are more fully discussed under the next two project components, Family Planning and Child Survival. Funding for all components of CHV and child survival [CDD, FP, ARI, immunization] activities in the Central Region will be through the CRHD.)

Activities: Technical consultants from the primary institutional contractor will work directly with the Central Region Health Director and staff (mostly relevant section officers and sub-section chiefs) on the development of the management capacity of the CRHD to support district program implementation. This will involve skills enhancement opportunities for CRHD staff (and possibly some limited specialized opportunities for exposure in organizational management for the Regional Director) in supervision, demographic and epidemiologic principles for the development and monitoring of annual workplans, basic administration, personnel system development, reporting and recording, data base development and data analysis skills.

The contractor's technical advisors will provide on-the-job assistance/training to regional CHV trainers and for the development and implementation of in-service training programs for CHVs, MCH workers, Village Health Workers (VHWs), Assistant Nurse Midwives (ANMs), and other health post staff. The CRHD, in coordination with the technical offices at the national level, will design a workplan (resource requirements, schedule, outcomes) for each training activity. Since the CRHD will be newly developing this capability and since the technical offices (heretofore the "vertical project" national level offices) are also newly beginning to define their policy/technical role in support of integrated, decentralized

services, this element will be phased in gradually (e.g., beginning with training for CDD). The specifics of the training responsibilities to be assumed by the CRHD will be defined in yearly workplans with the CRHD, supported by the requisite financial and manpower resources. They will include technical training and training of trainers for the regional directorate staff. By the end of the project, all technical in-service training will be coordinated by the CRHD for all regional/district staff.

The management, planning and supervision systems for integrated services at the district level will also be strengthened. Working with the CRHD and DPHO staff, major attention will be devoted to the improvement of management and service delivery systems for all services provided at the district level. This refers to the process whereby a district, at all administrative levels (district, ilaka, panchayat, ward), attains the ability to provide quality services regularly, routinely, and on demand through the effective use of and coordination with local resources and institutions.

This effort will initially focus on a systematic review of MCH services on a district-by-district basis, done by respective district staff and a CRHD interdisciplinary team. The reviews will allow districts to identify their own major problems and weaknesses, and will allow the Region to focus technical and managerial resources on correcting these problems. Priority areas of emphasis will be based on epidemiological assessments, training and supervision requirements, health post staff, workloads and activities.

A District MCH Service Review will be carried out in up to five districts during the first year of the project. Details of the review will be developed by the CRHD interdisciplinary team, with input requested from technical offices at the national level and divisions of the MOH. Implementation of the review will require planning meetings in the districts (CRHD staff going to the districts for this purpose). Skills enhancement opportunities will be provided for CRHD staff and training to selected district-level staff in data collection, practical in-service supervisory skills, means of correcting personnel maldistribution, technical aspects of services being provided, and a whole range of management-related issues (logistics, personnel administration, supervisory feedback and follow-up, etc.). Particular emphasis will be on health and management information systems development, and the analytical skills for using the data in planning, priority setting, monitoring and feedback. Necessary training, as identified in the reviews, will be provided to all levels of staff in the district (again, technical/service-related training is more fully discussed under the next two sections, Family Planning and Child Survival).

A system will be developed by which district reviews are formally reported to the Regional Director, and followed up periodically by CRHD staff to ensure that identified actions are being carried out. At a specified period of time after the review, there will be formal follow-up to see what progress has been made in

addressing the identified problems, and to plan next steps and regular follow-ups which may include small scale surveys.

It is relevant to highlight the CHV sub-component of Central Region Management Improvement, as it represents a new (since 1988) level of health service delivery. Given the need to reach beyond the health post with priority services provided by women, the female CHV program is extremely important. The MOH's ability to significantly reduce mortality and fertility is highly dependent on the success of this program, which will take several years to establish nationwide. (N.B. The project may support limited CHV activities in one other Region other than the CRHD if resources are sufficient.)

It is expected that CHVs will deliver services at the ward level and at the household level. It is also recognized that some services can have a greater impact than others on child mortality and morbidity (i.e., child spacing, oral rehydration, and immunization), and that CHVs will not be effective if over-burdened with service delivery responsibilities. Therefore, the CHV program will direct activity toward practical priority services and toward service delivery and follow-up to "high risk" houses. The definition of "high risk" needs refinement, but at the beginning will include houses with children under one year old, houses with pregnant women, and houses where a child under five years had died recently. The CHV will be expected to arrange for community members to consult the VHW and/or health post for services that she cannot provide herself, such as distribution of contraceptive pills, immunizations, ARI treatment, etc.; and to refer community members who are seriously ill to both the VHW and to the health post. In this way, it is hoped that the CHV program will be a realistic, practical health service "link" for the community.

Each district will have an average of 300 CHVs (considerably more in the CRHD) -- a major workforce that will require administration, management, formal and informal support, trouble-shooting and frequent re-training. These volunteers have little experience functioning in large, formal systems, and little experience as behavior change agents and service providers. Since MOH district offices have had difficulty monitoring and supporting health post and field staff adequately, it is not reasonable to expect district and ilaka health offices to be able to provide all the attention necessary to support new, inexperienced workers. Yet many of the MOH's priority programs will not be successful unless the CHVs are effective motivators and educators. This project component proposes to gradually address the requisite functions necessary for proper monitoring and support.

In light of these considerations, local and district units (e.g. local NGO's or other organizations) will be identified by the MOH as its organizational "partners" to provide support functions to the CHVs. However, these organizations' capacities and potential to support a large service program have not been tested, nor has their specific support to the CHV program been articulated.

Every support function that these organizations can provide relieves the burden on the district health system staff and allows them to concentrate on other tasks. It is reasonable to expect that, depending on the district, the organizations will be able to relieve the burden on the district health officials for simple aspects of CHV program administration, some supervision, informal support of volunteers, and some simple training. Therefore, the project proposes to provide district organizations the opportunity to prove their interest and abilities, to assist with some basic skills development in administration and management, and to assist them in outlining specific support tasks.

For this, DPHO and district organization members will receive orientation on the potential of low-literate village women to be effective motivators and educators, and on the advantages and possibilities of systems of volunteers. This will be followed by training on specific lessons from other female health/family planning volunteer systems, what has worked/failed and how/why; what supervisory and support systems are appropriate; etc. Finally, training will be provided to district level people in administration and management skills, especially as related to supporting health/family planning volunteers. These activities would begin in up to 5 districts of the Central Region, and expand as feasible (within the CRHD). The project, subsequent to the orientation and training, will support district-level planning workshops for support of the CHV activity.

For all Central Region activities, the long term institutional contractor will be involved in guiding the planning/implementation/training/follow-up process, working closely with the CRHD Director and DPHOs. As with other activities implemented directly with the MOH, yearly local cost support workplans will be developed with the CRHD that outline specific activities and expected accomplishments. For CHV support program orientation, the Family Planning Association of Nepal (FPAN) will be asked to share its experiences with women volunteers. For management and administrative training in support of the CHV program, USAID will work with the Center for Population and Development Activities (CEDPA) country office. CEDPA's objective in Nepal is to develop the capacity of women leaders to manage social programs, especially in health and family planning. Finally, the role of Peace Corps volunteers as management/administrative assistants to the MOH in defining and establishing a supportive structure for the CHV program will be explored, and implemented as feasible.

Inputs: The Central Region sub-component will receive a large amount (at least 50%) of the technical assistance (TA) input from the long-term institutional contractor, including long term TA in planning and management and selected short-term TA for data base development, training, training materials development, etc. The project will support the local costs of training (i.e. TA/DA, materials development), and local contracts for training workshops and/or special surveys, as required. Commodity support will include computer hardware/software, and vehicles, as required.

Expected Results: A regional structure experienced in performing all functions related to MCH and FP service delivery in the Central Region will be established. Regional and district-level managers from all 19 CRHD districts will have been trained in program planning and budgeting, management and basic demographic and epidemiologic skills. District MCH reviews will have been conducted in all CRHD districts; planning and budgeting exercises by district will be conducted, based on available information on resources, priority health problems, personnel availability, geographical constraints, etc., and compiled by the region as a Regional Plan for health care activities. District officers will be able to use an integrated data base to set and monitor program-specific targets and achievements. Service providers will have been trained in related systems of information collection, supervision, monitoring; and in the technical and communication/education aspects of services they are expected to provide (see Components 2 and 3, below). For this, the CRHD will have established a regional training and supervision capability and, in assuming this function, will be regularly scheduling, conducting, and monitoring the training of all program categories, i.e., immunization, family planning, CDD, etc.

For the CHV-specific element of Central Region activities, local/district organizations will be conducting CHV support activities in at least 15 of the CRHD's 19 districts. Following orientation and management training, district organizations most able to outline their own goals and procedures for supporting the CHV program will formally establish and implement these functions.

#### b. Public Health Training

Traditionally, education of health system personnel in Nepal has been clinically oriented, with little or no public health training. In addition, officials heretofore in vertical projects are now being called upon to manage complex integrated programs. As a result, there is a serious shortage of personnel who can apply epidemiologic and management principles to define public health priorities and manage programs accordingly.

Activities: Tribhuvan University's Institute of Medicine (IOM) offers a bachelor's level public health degree course, and has just begun offering a master's level public health degree course. This project will fund up to 5-15 MOH officials from management positions per annum in the IOM public health degree or certificate courses. This activity is contingent upon the MOH adapting a personnel policy that all managers in its system (DPHO and above) will be required to possess public health credentials from Nepal or abroad.

This sub-component will be handled through the long term institutional contractor, which will arrange for requisite technical assistance. Initially, short-term technical assistance will be provided to work with the MOH to set up procedures for selecting officers for training; how the entire procedure is handled vis-a-vis personnel regulations; how trainees' home positions will be covered while they are at IOM; procedures for channeling funds to cover

MOH-enrollee tuition; etc. Additional assistance will be provided to review and up-grade IOM curricula and practical field training vis-a-vis MOH management requirements for district officers and above. Complementary to this, a system will be set up whereby selected faculty will visit the "field" periodically to assess management and technology problems managers face, and/or to follow-up their graduates to verify the relevance of the education provided at IOM. Incentives will be provided for faculty research on relevant topics.

Inputs: For the public health training sub-component, inputs will cover costs of an "educational stipend" to students for books and other education-related supplies, and to offset higher living costs associated with being in Kathmandu; tuition costs to the IOM; external technical assistance (approximately 6-8 person months); the costs of additional educational opportunities for relevant IOM faculty, including observation visits to other public health faculties in the region; some classroom equipment and library and laboratory materials related to public health training; a vehicle for field work; and up-grading of classrooms. (N.B. For planning and budgeting purposes, 2 person years will be scheduled for each trainee, for a total of 50 person years. However, it is anticipated that some trainees will require only 1 year of academic training to complete their required courses.)

Expected Results: Assuming that such training can begin in CY 1991, by the end of the project 25 MOH managers will have graduated and resumed their functions within the MOH system. (This number may be exceeded depending on the pre-masters level training requirements of the selected trainees.) At least 10 will be from the Central Region.

#### c. Innovative Activities

In every health care system new service delivery questions arise continuously. Different ways of achieving an objective may need to be tested, and new tasks for old personnel may look promising. The complex social organization of Nepal and its difficult topography make the delivery of services much more difficult than in most other countries. The system and the setting will continue to challenge the implementors of health and family planning programs to find new and better ways to meet their objectives.

Activities: For the most part, technical consultants from the institutional contractor will work with the Central Region (or other region, as feasible) Health Director, the Director's staff, the districts and the health posts to select innovative approaches to service delivery, develop a variety of options' designs, and then test the approaches against the reality of the MOH's delivery system and rural Nepal. Some activities (e.g. Vitamin A-related) will be assisted through technical consultants and support provided through centrally-funded projects.

Priority areas for investigation include the following:

- That increased resources, both private and public, need to

be made available to the health sector in Nepal is obvious even to the casual observer. All possible means of achieving such increases will be pursued, including field testing of strategies for cost recovery in government facilities, further privatization of health service delivery, resource allocation, use and management, analyses of relative cost-effectiveness of services, and strategies to increase coverage of preventive and promotive programs.

- Getting health services out beyond the health post is a continuing priority in Nepal. The CHV program is the most realistic attempt to date and a major effort will go into ensuring its success. But even as this program is being implemented the search for other means of outreach needs to be continued. Some possibilities for investigation include:

- providing family planning training to ayurvedic doctors and other traditional practitioners who see many patients in Nepal and possibly could be important promoters of family planning;

- looking closely at the potential role of health post peons as educator and motivator. The peon is locally recruited, a member of the community, often assists the health workers with many of their duties, often has a much better understanding of the community than the health post staff. The peon, if actively involved with the preventive goals of the program, might set an important example for his peers.

- There will undoubtedly be issues that come out of the new CHV program that will need to be investigated. For example, might a program of incentives provide more motivation than a monthly payment of NRs 100? How many tasks can these women really be expected to do?

- Too little is known about the level of demand for health care in Nepal, e.g. under what circumstances do families make decisions on what kind of care to seek and where to get it. A simple demand (utilization) survey could give regional and district planners a much better idea of the reach of their services, their perceived quality and effectiveness, and under what circumstances people look elsewhere for help.

- An area related to demand is the question of cost recovery in government facilities. A considerable amount of work has been done with drug funds in Nepal but other approaches could be tested. One review of the available data concluded that hospital fees based on a sliding scale offered the greatest potential for significant cost recovery. A related analysis would be the amount of government funding that goes into urban hospitals and which groups benefit the most from these services.

- Different approaches to improving the nutrition of mothers and children need to be developed and tested. Specifically, programmatic opportunities in Vitamin A distribution will be explored (e.g. piggy-backing onto the EPI network), whereby a child would receive a small dosage (estimated 25,000 IU) with each immunization contact beginning not earlier than six weeks of age.

Inputs: Inputs will include technical assistance for identifying topics and developing research designs. In most cases the field work will be done by district or health post staff, although in some cases it may be necessary to contract some of the work. The project will provide funds for local costs of the research and may provide funds to extend training sessions long enough to allow presentation and discussion of the results of these investigations.

Expected Results: By the end of the project the Regional and District staff of the Central Region will have developed skills in a variety of basic (simple) research methodologies, an understanding of the strengths and weakness of various approaches to problem solving, and will have established a working environment where testing new ideas is accepted and rewarded. Effective procedures for delivering services will have been documented and outlined.

## 2. Family Planning

As in the previous project, the delivery of quality, full-service family planning services will receive priority support under this project. Activities will primarily be focused in the Central Region, with other contiguous districts in other neighboring regions receiving selected "nation-wide" support, as possible. As the MOH is committed to an integrated delivery system, the gradual institutionalization of family planning services within the integrated service system of Central Region districts will be supported.

The project will support a major information, education and communications (IE&C) program as well as increased quantity and quality of services. There will be important activities in both the public and private sectors. The project will help create an environment within the MOH that will allow for successful integration of the PP/MCH Project without diminishing services, continue the provision of VSC while decreasing reliance on camps, and increase the use of both clinical (IUDs, Norplant, injectables, VSC) and non-clinical (orals and condoms) contraceptives.

a. Public sector: Project activities in support of family planning will cover several aspects, including Information, Education and Communication (IE&C), voluntary surgical contraception (VSC), clinical contraception, logistics and motivation. In general, the project will continue to support training and service delivery systems development for improved quality and management of family planning services. On the service delivery side, as is described below, the project will focus more narrowly than in the past. In particular, these activities will include a major new complementary effort in community outreach by CHVs (see Component 1).

Activities: Major attention will be devoted to the institutionalization of the full range of family planning

methods at the district level. Of particular importance will be the year-round availability of VSC at district and zonal hospitals (in addition to other methods) as was recommended in the 1987 AVSC/MOH evaluation of VSC in Nepal, and the availability of injectibles, pills and condoms at the health post level, and of pills and condoms at the community level.

In the Nepalese context, institutionalization refers to the process whereby a district, at all levels (district, ilaka, panchayat, ward) attains the ability to provide quality family planning (male and female) services regularly, routinely, and on demand through the effective utilization and coordination of local resources and institutions. The essential components for institutionalization at the district level are:

- local commitment, support, coordination, and cooperation;
- trained manpower;
- sufficient expendable materials;
- continuous flow of family planning clients;
- quality assurance systems in place and working;
- phase out of incentive programs.

As a first step toward institutionalization, a tiered system of service delivery and referral will be established in a phased manner and new emphasis will be placed on temporary methods of contraception. Working primarily with the Central Region Health Directorate and its District Public Health Offices (DPHOs), the project will support a rational mix of temporary and permanent family planning methods. Training and reorientation will be provided for field workers, district level management and hospital staff on the importance of child spacing and permanent contraception for maternal and child health, the pros and cons of both clinical (IUD's, Norplant, injectibles, VSC) and non-clinical contraceptive methods, and the importance of regular follow-up and support of continuing users.

A major problem with current reporting systems used by districts is that the focus is on new acceptors and continuing use rates are not determined. When the priority was VSC, this was appropriate. As Nepal begins to seriously introduce temporary methods of contraception into the MOH's service delivery systems, data on continuing users becomes essential. A new ward level recording and reporting (R/R) system designed to identify and follow-up continuing users will be developed by the PP/MCH Division and the CRHD with technical assistance provided by the long term technical advisors. On-the-job training will be provided on its use. The current PP/MCH family planning client "face sheet" R/R system, which was intended also as a follow-up mechanism for continuing users, will be strengthened. Finally, the concept of using these records for management, supervisory and planning in the health post and at the district will be stressed, so that this information is not just being collected for reporting up the system.

The current PP/MCH national commodity and contraceptive logistics system will be redesigned from a "push" system (pushed

from national to district level without begin specifically requested by the district) to a regionally based system which will be more responsive to district level needs. Under the re-designed system, commodities and contraceptives will be stored at the regional warehouses with a back-up supply kept at the national level. DPHOs will request commodities and contraceptives from their regional warehouse using a simple inventory/resupply reporting system for resupply and accountability to the regional and national levels.

"Institutionalization" of the tiered system will begin in 12 districts (six of which are in the Central Region) in the first year of the project. Up to a total of 25 districts (16 of 19 CRHD districts) will have initiated the institutionalization process by the project's end. Approximately 2,000 (estimated 80 per district) medical, paramedical and support staff will have received basic and/or refresher training. Training will be provided through the Regional Directorates and respective DPHOs (especially in the CRHD) with technical oversight and guidance from the FP/MCH Division. As needed, technical assistance will be procured from ST/POP's AVSC, Population Council and JHU/PCS projects.

In addition to the institutionalized tiered system, voluntary surgical contraception (VSC) will be strengthened through improved training, counseling, screening, and quality assurance (including mechanisms to monitor compliance and certify that providers and institutions maintain adequate quality standards). Improvements in VSC, begun in the Integrated Rural Health/Family Planning Services Project (367-0135), will be further developed and implemented through the collaboration of the national level FP/MCH Division and the Regional Directorates, primarily the CRHD. The project will support FP/MCH Division and CRHD efforts to institutionalize district level VSC services in up to 50 zonal/district hospitals in the Kathmandu Valley, Terai, and more advanced districts in the middle hills. Surgical, counseling and follow-up, quality assurance, and treatment of complications procedures will be established, staff trained, and supervisory/monitoring systems established through local technical assistance and the MOH's National Certification Committee (membership from various parts of the MOH, plus NGO and private membership), additional technical assistance provided through buy-ins to central projects (AVSC, Pop Council), and the collaboration of the MOH with other implementors within the national family planning program.

USAID sponsored VSC and other clinical contraception activities will begin in 18 districts (6 in the CRHD) by the first year of the project. Up to 5 additional "clinical contraception" districts will be phased in annually. For male and female VSC services, some of the larger centers will be equipped with laparoscopes; the smaller ones will be established as mini-ap centers. All will provide vasectomies for males.

The MOH is eager to expand the use of other clinical contraception methods (IUDs, Norplant and injectables) but adequate numbers of trained personnel are not yet available for routine counseling, insertion/removal, follow-up or dealing with complications. Working with the PP/MCH Division and the CRHD, a plan for establishing and expanding the provision of these services will be developed. Site and equipment assessments of selected zonal and district hospitals and, if and when possible, health centers/posts will be made. It is anticipated that up to 70 sites (i.e., all 30 HMG and non-HMG hospitals in the CRHD, 30 sites in other "institutionalizing" districts in other regions [primarily in the Terai], and 10 health centers and/or health posts, primarily in the CRHD) will be providing services by the end of the project. Those with satisfactory institutional capability and where the retention of female staff is feasible will be selected.

Of particular importance will be the establishment of satisfactory institutional capability at these sites and their ability to retain trained staff to provide appropriate services and backup. Using local expertise, technical assistance provided through buy-ins to central projects, and existing in-country training capabilities, district level staff will be trained in clinical, education, communication and follow-up techniques. Quality assurance standards and monitoring and certification systems will be established. Operations research in the Central Region will be used to determine under what conditions it may be possible to offer Norplant and IUD insertions in health posts. The actual delivery of clinical methods will be conditioned on completion of adequate plans, service provider training and certification, and site certification. USAID will provide equipment and commodities to these facilities as needed.

Health posts will continue to provide non-clinical methods. The health posts' VHWS will take on the responsibility for supervising approximately 300 CHVs (more in the CRHD) in each district. These "grass roots workers" (VHWS and CHVs) will refer men and women to health posts and will directly supply pills and condoms. USAID will support this community based distribution system in the Central Region (where 12,000 CHVs have already been identified -- see Component 1) and may provide funding for the CHV program in selected districts in one additional region.

Relevant IE&C programs are known to have a positive impact on contraceptive prevalence since satisfied users are not only the key to high continuation rates but also the most effective promoters of family planning. While services are gradually improving, MOH programs still have weak communications components. Staff are relatively inexperienced in modern communication methods, and their efforts tend to be didactic and lacking in emotional appeal. Further, the IE&C materials produced under vertical projects/divisions often lie unused in Kathmandu and need to be re-evaluated and, if appropriate, sent to the districts for use.

To begin to address these problems, the project will work with the national FP/MCH Division; the MOH's Health Education, Information and Publication Section; the CRHD and relevant NGOs. Initially, a limited geographical region will be selected for review of in-house IE&C skills, and on-the-job training will be provided. Small scale field studies will be done to determine target population habits and preferences for informational topics, media, etc. Subsequently, focused multi-message or topical campaigns for national, regional, or other geographically relevant areas will be designed, implemented and evaluated, and the process revised or expanded.

These campaigns and other IE&C strategies will be designed and implemented with assistance provided through buy-ins to centrally funded projects (e.g., JHU/PCS, RAPID/IMPACT and HEALTHCOM) in collaboration with MOH, NGOs/PVOs and other local organizations such as CRS, Co. Due to limited MOH production capacity, the centrally funded projects will need to sub-contract directly with local firms/organizations for design, reproduction and dissemination of materials.

Inputs: Technical assistance for this large, multi-faceted component will consist of support from the major resident institutional contractor and from buy-ins to central projects and, to build in-country institutional capability, through contracts with local firms and organizations. The project will provide contraceptive supplies, VSC equipment and supplies, computer hardware and software, vehicles and other equipment, commodity and logistical support. Local cost support for training and other components will be provided to the MOH through annual workplans.

Expected Results: Through improved health/family planning service delivery systems, expanded availability of family planning services and information, and better trained staff, activities under the family planning component will result in the following:

i) Contraceptive prevalence (continuing users) will have increased by approximately 1.30% per annum from 15% in 1986 to 27.5% by 1995 [Tsui and Thapa, 1987, p. 10]. (This will be based on MOH services, plus -- see below -- NGO efforts. A stronger and more rural CRS program will have increased its contribution from the currently estimated level of 45% of all condoms and 20% of orals to 55% and 40% respectively).

ii) The Central Region will have a contraceptive logistics system providing health posts and hospitals with adequate family planning supplies year round.

iii) IE&C efforts will have increased knowledge of at least one method of contraception by currently married women aged 15-50 to 75% from the 56% found in the 1986 Fertility Survey.

iv) A management information system will be in place in the Central Region that will allow district and regional managers to perform systems analysis, target group prioritization, management and training needs assessment.

v) A plan will have been developed, and implementation underway, for phased institutionalization of clinical and non-clinical services.

vi) The demand for VSC and other clinical contraception services in project districts will be met through institutionalized services in static facilities and supported by quality assurance systems.

b. Private Sector: The Nepal Contraceptive Retail Sales (CRS) Co. is currently at a turning point where incrementally more sophisticated skills are required. Efforts by CRS to restructure company operations and strengthen program activities will be supported by the project. Continued USAID funding of CRS is conditioned on the adaptation of improved management systems and of a privatization plan (including Board membership, Chairmanship, tenure, GON shares, etc.) for company operations. (See VI. E. Condition and Covenants for specifics).

CRS has made remarkable progress in restoring company morale and sales levels in recent months. The skills and experience of a "private sector" orientation are being gradually introduced to CRS staff and Board. Given the wealth of management experience and technical expertise available locally and among CRS staff, planning for and implementation of activities will be done directly with CRS management and technical staff, and CRS Board participation as required. Limited TA will be obtained from the centrally-funded Social Marketing for Change (SOMARC) project, as required.

Continued USAID support for activities undertaken by CRS will be outlined in a new Cooperative Agreement (CA). Under the terms of the CA, CRS will be required to formulate for USAID approval annual Operating Plans describing and scheduling all aspects of the company's yearly operations, including market research studies, promotional activities, sales targets by urban/rural areas, staff and retailer training, and major commodity procurement. The plan will set forth the company's goals for the year along with concrete, time-limited objectives to be pursued by each division of the company to attain these goals.

To provide the skills required of a maturing, increasingly private company, the project will support CRS training and support for the following:

a) Conducting and using market research to improve advertising/promotion and communications for contraceptives and ORS -- qualitative and/or quantitative marketing research techniques will be applied to each product or product activity.

For example, a product's campaign will be pre- and post-tested, or a survey conducted, to determine product image, perception, and knowledge among retailers/suppliers and users. Additional consumer research relative to CRS products will be done during a major tracking study, probably in 1991. The tracking study will measure increase in awareness of method, increase in awareness of CRS brand choices, assess the image of each brand, measure positive attitude towards family planning, evaluate the advertising campaigns for all products, and develop/refine the consumer profile of each brand. The tracking study will be conducted with the help of SOMARC.

CRS, again with SOMARC assistance, will also undertake a marketing audit, a comprehensive and systematic evaluation of the process and outcomes of a marketing program. The marketing audit will have two managerial functions: 1) to monitor the achievements or failures of the marketing program over time, and 2) to offer, for its improvement, actionable recommendations on all aspects of the marketing program.

CRS will, by mid-project, assess its advertising, promotional and PR needs and consider alternatives for the long term, including continued use of an external agency, the design and staffing of an internal advertising department, and design and staffing of a separate, subsidiary advertising agency.

b) Improved communication techniques -- CRS will conduct periodic (e.g. yearly) brand reviews, outlining communication needs for each of CRS's products (currently 2 brands of condoms, 3 of oral contraceptive pills, 1 vaginal foaming tablet and 1 ORS). For each product, CRS will develop Creative/Strategy Briefs, i.e. detailed step-by step tactical plans that lay out campaigns and outline the communications process. The Creative Briefs will describe the product and its positioning in the market; state communications and marketing objectives for the product; define the communications message content and approach to be taken; define the communications/marketing mix (e.g. radio/newspaper advertising; in-store promotion, etc.); outline schedules for advertising/promotion materials and/or program development.

In addition, CRS will assess the feasibility of adopting a product/brand manager concept, whereby an individual professional staff person would be assigned the responsibility for a specific CRS product line. This would require an increase in staff (up to 2 additional communications staff). These individuals, with the assistance of the current communications manager, would benefit from approximately 3 weeks of on-the-job training from SOMARC on their responsibilities, including preparing strategies, annual marketing plans and sales forecasts, monitoring product performance, initiating and reviewing market research, keeping brand books, designing and implementing consumer trade promotion, etc.

c) Better tracking of retail outlets and expansion of the existing sales network -- CRS will maintain and expand a

nation-wide network for the commercial, retail sale of contraceptives and ORS. The current network covering the Bagmati Zone of the Central Region will be expanded by a) compiling up-to-date lists of active and potential retail outlets for these products in the vicinity of accessible urban and semi-urban areas, b) routinely monitoring these outlets to assess product availability, and c) concentrating sales efforts in areas where availability is relatively low. A computerized data base and regular procedures for monitoring each outlet (i.e. for tracking sales and predicting resupply dates and quantities for individual retail outlets) will be established.

d) Increased cooperation with NGO's to encourage their sale of contraceptives -- CRS will expand the sale of contraceptives and ORS by supplying these products to non-governmental organizations (NGOs). Individual plans with appropriate NGOs will be developed.

e) Expanded rural social marketing (RSM) efforts -- CRS will undertake "intensified RSM" by 1) reining in its current RSM activity in 6 full districts to a smaller "impact area" in each of 4 districts, and 2) experimenting ("operations research") with an intensified RSM program in one district. In both cases, there will be an increase in supervision and monitoring of RSM agents' activities, adoption of an "incentive policy" whereby RSM agents will be paid on the basis of achievement, and product distribution to agents on the basis of their previous sales trends and selling capacity only. In the district-wide program, a baseline survey will be conducted based on which the RSM strategy will be defined. As CRS's capability and effectiveness in working within an entire district for RSM activities are understood, this process will be repeated and expanded in the other RSM districts; and

f) Exploring self-sustainability options -- CRS will assess product, marketing and/or activity diversification (e.g. advertising and/or market research subsidiary), possible investments for increasing its resource base, joint ventures (e.g. ORS production), and other mechanisms. During the course of the project, CRS will have taken over some recurrent expenses, but it is not anticipated that CRS would be self-sustainable by the end of this project. However, in the long term interests of the company and, considering its current management expertise, possible options will be reviewed and outlined.

Also in the private sector, access to and availability of family planning services will be increased in urban areas by establishing 3-5 full service, private family planning clinics with outreach services. Further, to make family planning and MCH services available in the workplace, family planning services will be begun in up to 5 factory and other workplace-based enterprises, and assistance in the form of training, TA and minimal supplies will be provided. These

clinics and workplace-based enterprises will be situated in the Kathmandu Valley and the industrial areas of the Terai. As a new initiative in the provision of health care through the private sector, the Birgunj Chamber of Commerce, in cooperation with a group of concerned local business leaders and the Enterprise Program, will open a clinic for factory employees, family members and local residents. This clinic will be patterned along the lines of a Health Maintenance Organization (HMO). Limited TA will be procured from the centrally-funded Enterprise Program and local organizations and experts, as required.

Over the course of the project, the MOH will also involve all certified private practitioners, nursing homes, private clinics and other similar facilities to provide a variety of family planning services.

The role of NGOs working in the family planning program also need to be strengthened and coordinated with the MOH. The Family Planning Association of Nepal (FPAN) operates various family planning related activities and provides both clinical and non-clinical contraceptive services in a number of districts throughout the country. FPAN, on behalf of the MOH, takes a leading role in organizing family planning services; conducting counselor, aseptic and other trainings; and experimenting with innovative approaches to make family planning IE&C and service delivery programs more effective. Under the project, FPAN's role as an "implementing agency" to the national program will be better coordinated and strengthened with the MOH.

Other NGOs, too, play an important part in the national program. These organizations work to create demand for family planning services through motivational/educational activities and the provision of temporary contraceptive services through networks of social workers and fieldworkers. Over the LOP, the role and responsibilities of NGOs will be improved and coordination with relevant administrative levels of the MOH will be strengthened through continued work with centrally-funded grantees/cooperative agencies.

Inputs: For CRS activities, it is anticipated that most technical skills for the conduct of surveys, consumer research, advertising campaigns, etc., can be obtained locally. The project will provide contraceptive supplies, vehicles and some office equipment; and support limited observation/study tours for some CRS management and technical staff, local costs of CRS company operations, surveys, RSM activities, advertising materials and promotional campaigns. Special TA will be procured from the centrally funded Social Marketing for Change (SOMARC) project, as required.

For work-place based and NGO-supported family planning activities, centrally-funded projects (e.g., the Enterprise Program) will provide the requisite TA and related support.

Expected Results: Re CRS activities, by the end of the project, CRS Co. will have revised all management and personnel policies and introduced more efficient, streamlined operating procedures. CRS will be largely privatized, with the HMG maintaining enough ties to protect its policy interests, but not ties so close as to douse the company's entrepreneurial nature. Contraceptive supply distribution will have been decentralized, and a computerized system for tracking active and potential retail outlets, assessing product availability/requirements and sales potential will be in use. Rural social marketing programs based on market research and sales agent incentives will be functioning in at least 8 districts. Contraceptive product sales and marketing agreements will be in force with at least 3 NGOs involved in family planning promotion. Advertising strategies for each product will be established, and regularly modified based on periodic consumer research. Educational programs in up to 40 districts (e.g. retailer training, women's talk programs, etc.) will be implemented regularly. As a result of CRS promotional and marketing activities, national contraceptive prevalence from temporary methods attributable to CRS's efforts will have increased from approximately one-third of the total in 1989 to two-thirds by the end of the project. Finally, CRS will have assumed the recurrent cost burden of at least 50% of salaries and benefits associated with CRS Co. operations, and a long term plan for CRS Co. diversification and strategies for self sustainability will have been outlined.

Additional family planning and MCH services in workplace-based settings will provide models for private sector initiatives and will begin to reduce the MOH's burden for the provision of family planning and MCH services.

### 3. Child Survival

This component includes interventions related to the major childhood public health problems of diarrheal disease control, vaccine-preventable diseases and acute respiratory infection (ARI) control.

#### a. Diarrheal Disease Control (CDD)

In 1985, the first USAID-assisted "child survival" activity was initiated on a pilot basis in 3 districts, specifically to increase CDD and immunization awareness and coverage. Out of this pilot, specific training plans for CDD interventions were developed for use under the new, integrated system.

Activities: Activities in CDD will be primarily carried out in the Central and Western Regions with guidance and direction from the Ministry of Health's Public Health Division (MOH/PHD). To a lesser extent, complementary activities in CDD will be supported through local NGO/PVO's. Until better data on

the relative importance of acute/watery versus chronic and dysenteric diarrheas are available, the project will stress the widespread, correct use of oral rehydration therapy (ORT) primarily with packaged oral rehydration solution (ORS).

MOH/PHD/CDD Program Activities: In partnership with UNICEF and WHO, USAID is supporting a nationwide effort to increase awareness among providers and the public of the importance of diarrheal diseases and preventive and treatment options. A tiered training program for MOH field workers and managers has been initiated in the Central and Western Regions whereby all trainees at one level are trained before they (trainees-cum-trainers) undertake the next level of training. Training reaches all the way to mothers. Throughout the country, approximately 7,500 medical and paramedical staff are to be trained in clinical, supervisory and management skills on diarrheal disease control, and up to 40,000 primary school teachers, pharmacists and CHV's in diarrheal disease prevention and ORT. In the Central and Western Regions, 1,200-1,500 medical/paramedical workers, 1,600 teachers, and 14,000 CHV's are to be trained. (N.B. CHV training is in fact done by the CRHD, with TA from the PHD/CDD. See Component 1.)

Support to this training program will be continued in the new project. The intention is two-fold: 1) to provide basic training in ORT to all levels of service providers in the Central and Western Regions; and 2) to strengthen the MOH's ability to provide appropriate national level interventions in CDD (i.e., refresher training on specific topics, supportive supervision, coordination, etc.) through establishment of a monitoring and supervision system.

For this activity, USAID will work directly with the national level PHD/CDD, drawing on technical assistance from the institutional contractor, as necessary. Yearly workplans will be developed that outline training plans and objectives. As the national level gradually shifts responsibility for training to respective regions (for the purposes of this project, USAID is primarily concerned with the Central Region -- see Component 1, above), the national level responsibility for CDD activities, as reflected in yearly workplans, will increasingly shift to the establishment of a supervision and monitoring system and assistance to the region(s) for respective implementation and supervision activities. The PHD/CDD will assist the Region to conduct field training and develop regional-level training-supervision-feedback systems. Emphasis will be on reinforcing correct service delivery and supervision methods, and on educating mothers in correct ORT. Treatment services and ORT demonstrations at district hospital-based oral rehydration centers will be strengthened.

In the interest of promoting the correct and increased use of ORS, the project will assist the MOH implement a new policy on the use of a 500 cc ORS packet standard, a major change from the 1 liter size packet which has been promoted heretofore.

Field studies have indicated that there is a low rate of appropriate use of ORS of current packet size and that there is no standard container throughout Nepal for mixing oral rehydration solution. These findings led to consumer studies which indicated the optimum packet and container size to maximize appropriate use to be 500 cc. To address these findings, the MOH intends to implement a program by which 500 cc packets with a 500 ml container for mixing will be promoted throughout Nepal.

To assist the MOH implement this nascent policy, the project will work with the PHD/CDD to support trial implementation in two or three districts, provide support for start-up costs of producing new packets and containers, and assist with market and consumer research for the redesigned product. This activity will be coordinated with UNICEF, currently the supplier for ORS packaging materials, Royal Drugs Ltd., producer of ORS packets, and the CRS Company, potential retail marketer of the new product and collaborator on promotional activities.

The other major areas of CDD activity under this project will be studies/research on the relative importance of various kinds of childhood diarrheas in Nepal, and significance of the findings for MOH CDD programs; participation in a national diarrheal disease survey (initial survey done in 1985); and assistance for the development of basic health education/preventive skills within the MOH and small scale programs aimed at school age children. The project will also support educational efforts that will include continued feeding during diarrheal episodes and promotion of breastfeeding.

NGO Activities: The project will provide limited support to the Nepal Pediatric Society (NEPAS) for specialized training in CDD for physicians and medical staff. A major emphasis of this support will also (as above) be the application of training skills and supportive supervision. Training activities will be coordinated with NCDDP so as to support priority NCDDP initiatives in, e.g., establishing regional training centers and oral rehydration centers. Coordination will include NEPAS-based training of trainers for regular NCDDP training in the regions and districts (see above) in ORT, and for management/administration of oral rehydration centers/units; coordination for placement of NEPAS-trained staff in the units; and continued technical supervision of physicians in ORT centers/units by NEPAS.

Finally, CDD services will be incorporated into other NGO/PVO's service delivery programs (e.g. Nepal Red Cross Society ARI Sub-Project), as feasible. For example, where workers have sufficiently mastered ARI activities, the project will support the introduction of educational activities regarding diarrheal disease and ORT, and of ORS (Jeevan Jal) sales. Workers will receive training in causes of diarrheal disease and prevention, the nature of diarrheal dehydration, and

how to use Jeevan Jal. They will request mothers to come to them to buy Jeevan Jal. A system for monitoring sales and collecting fees will be established with assistance from CRS. Emphasis will be on education and motivation in appropriate ORT and sale of ORS to clients.

Inputs: Project inputs to the CDD component will include local cost support for all training activities, including training materials; 500 cc ORS packet/container program start-up costs; equipment and commodities for ORT demonstrations; consumer and marketing and research costs; vehicle(s); and TA for training, supervision and research activities.

Expected Results: The intended outcomes of the CDD program activities are strengthened capabilities of the MOH/NCDDP unit to increase knowledge and use of correct preventive and treatment options among providers and the public. Refined and improved IE&C messages on the proper use of ORT and the importance of feeding during and after episodes of diarrhea will be developed and disseminated; packaged ORS will be made available from community depots and/or through retail outlets for sale at replacement cost; and national and regional level planning and implementation capability for CDD efforts will be enhanced by: 1) the development and implementation of monitoring and supervisory systems for training and for service delivery, and 2) the conduct and application of findings from relevant studies (e.g. the relative importance of various kinds of childhood diarrheas in Nepal; ORS packet and container size; consumer preferences). In the Central and Western Regions, 1200-1500 medical/paramedical, 1600 teachers and pharmacists, and 14,000 CHVs are to be trained.

b. Immunizations/EPI

Activities: The bulk of support for activities under the Expanded Program on Immunization (EPI) in Nepal is provided by UNICEF (vaccine, syringes, needles, cold chain equipment, training). Thus, the project's activities in support of this important child survival component will be limited and intended to complement UNICEF's inputs. These will include communication/education activities, designed with the national level MOH/EPI unit, to develop, test, evaluate and disseminate educational messages on the importance of immunizations and the need to complete a full series of vaccinations. The project will also support small scale surveys and studies (e.g. coverage, cost, cold chain maintenance) to verify reported coverage and correctness of services. Information generated will be used for evaluation and planning of EPI activities. Both of these national level activities will be through selected buy-ins to AID/W.

Other EPI activities will be concentrated in the Central Region as related to the improved/integrated service delivery component (see Component 1, above).

USAID's most recent involvement in EPI has been largely limited to support to one district through Save the Children-USA (SCP-USA). Initial activities were designed to complement MOH/EPI efforts in the district by introducing systems to achieve high coverage levels through community education, improved supervision, improved service delivery, and through evaluation and feedback. The last phase of this activity, currently in progress, looks to work with the district to devise systems to maintain, under the new integrated health care system, the high levels of coverage achieved under the "vertical"/SCP program. Experiences gained and lessons learned from the project will guide the institutionalization of a strong EPI delivery system within the BMG/MOH structure and within local communities.

By working primarily with the CRHD and DPHO's, the project will focus on two major activities related to applying these experiences. First, through the development of annual workplans with USAID defining specific activities, schedule and inputs, the project will support the development and implementation of training for field workers at all levels, including development of annual workplans for EPI services, a workable cold chain system, health worker deployment, supervision/monitoring and evaluation/feedback. Second, the project will work with the CRHD and respective DPHO's to design and implement better reporting systems and applications for disease surveillance, outbreak investigation and control. For this, one or two districts will be selected on a pilot basis, in which a prototype surveillance system for, e.g. measles, will be established. District level staff will be trained to supervise the collection of disease surveillance information, and interpret reported cases and deaths with respect to their own immunization activities and plans. The activity will be phased into other Central Region districts through the LOP.

Inputs: Inputs for the EPI activity will be for local costs of training, including materials, and TA for systems and survey design and implementation.

Expected Results: As a result of project activities under this component, the Central Region Health Districts will be able to establish and implement detailed service delivery procedures for immunization activities under an integrated, decentralized system. All health care workers from the ilaka health post level down to CHVs will have been trained in EPI services, motivation, and, per position requirements, in supervision, and cold chain maintenance. Full EPI services will be available to the entire population of the Central Region. Nationally, awareness of the importance of immunizations will have increased.

#### c. Acute Respiratory Infections (ARI)

Experience in USAID's pioneering Jumla ARI project indicates that most ARI deaths occur amongst very young children who develop symptoms and die within one week. Despite excellent program management and performance, it seems thus far that ARI deaths have not been reduced in Jumla, possibly due to an inability to locate

and treat all cases quickly enough. This does not bode well for the MOH's ability to reduce ARI mortality using the biweekly active case detection techniques of the Jumla project approach. The Ministry's inability to keep health workers supplied with drugs poses additional problems for an effort highly dependent on the availability of antibiotics.

Given these difficulties, the project will support general MOH training activities in ARI in some districts (i.e. especially in the CRHD), but will limit special, intensive ARI activities to pilot activities with NGOs in up to two hill and two Terai districts, with possible later expansion dependent on success with this initial experience.

Activities: Both CDD and ARI programs are under the MOH/PHD (to date, priority has been given to CDD, reflecting its greater significance as a public health problem and the availability of interventions of proven value). For this activity, the project will work with the MOH/PHD/CDD and the CRHD to devise annual local cost support workplans under which ARI activities will be undertaken. The workplans will identify districts in which ARI activities will take place, and outline training plans and objectives. The project will support national level PHD/CDD staff training of health workers on a tiered system (as already being done for CDD) to detect cases as they occur, and to take appropriate action (either treatment or referral to health post personnel). A supervision system, piggy-backed on that for CDD, will monitor and correct, as needed, case detection procedures, education and referral, and track the number of cases detected, treated and cured, and case fatality rates in intervention districts.

Special pilot activities will be undertaken, as feasible, with local NGO(s) in up to 4 districts. Interventions to be stressed include education for self-referral, and preventive aspects. As these activities are considered "pilot" activities requiring specialized inputs and attention, and which are not ready for broader implementation, the national level PHC/CDD will maintain a direct programmatic link with the NGO(s) and the trial districts. The regions in which the districts are located will be involved in planning and assessment of findings.

These "trials" will look for ways to effectively perform active case detection and to sensitize and train parents to self refer for ARI diagnosis and treatment. These trials will also be used to find rational roles for CHV's vis-a-vis ARI case detection and treatment.

On a different but related level, the project will address ARI standard treatment and quality issues among curative care providers. These providers primarily include physicians at zonal, regional and district hospitals which are often the first port of call for families of children ill with ARI. In preparation for this, the Nepal Pediatric Society (NEPAS), has documented general knowledge of ARI and current methods of diagnosing and treating ARI among physicians. Based on these findings, NEPAS is outlining

recommendations for improving the diagnosis and treatment of childhood ARI, and will formulate a series of protocols for the diagnosis and treatment of severe childhood ARI. Subsequent to this and under the new project, NEPAS will design short training courses to familiarize Nepalese physicians with the protocols. Course emphases will be based on weaknesses in diagnostic/treatment understandings as identified in NEPAS's survey, and courses will be targeted for physicians. NEPAS will coordinate with the MOH/PHD/CDD to establish training and follow-up, and to ensure that the technical skills of NEPAS are appropriately applied per the priorities of the national ARI control program.

Finally, ARI control issues will be up-graded, based on Nepal and world-wide data, in pre-service training at the Institute of Medicine (IOM) for all levels of health workers trained there.

Inputs: Inputs for this project component will be limited to local costs of training, and TA for training and systems development; and limited drug purchases for trial start-up.

Expected Results: Programming in ARI control will require flexibility to respond appropriately as more becomes known about ARI in Nepal, and as the MOH's efforts in this area evolve. As a result of the project's activities in ARI, detailed service delivery procedures will provide information on operational issues, potential impact, feasibility, etc., as recommendations for national scale programs. Successful models will be applied as guides for establishment and implementation at the district level of the Central Region. Finally, ARI treatment in hospitals will be improved through more effective and efficient screening, diagnosis and treatment of these ARI cases.

#### 4. Malaria Control

USAID's 35 year history in malaria control activities in Nepal is now taking a turn away from grant assistance for insecticides toward support for environmental control methods and strengthened case detection systems; and from skill development solely for malaria control to skill development for control also of other major vector-borne diseases in Nepal (many of the skills involved in malaria control are also appropriate for the control of other vector-borne diseases). Toward these ends, the project will support activities in passive case detection systems, including decentralizing the malaria diagnostic laboratories; in-country training; and entomologic assessment capability. The project will work through the National Malaria Eradication Organization (NMEO) and regional and district officers responsible for malaria control. The required technical support will, as in the past, be provided through the centrally funded Vector Biology Control (VBC) project through short-term consultancy visits, and by the USAID/HPP Malaria Advisor.

Activities: Quick response to endemic malaria and malaria outbreaks requires an efficient system for detection of cases. In Nepal, several systems, including active and passive case

detection (ACD and PCD), mass blood surveys, etc., are in use. The greatest number of positive slides has been obtained by PCD. As most PCD work is done by volunteers (PCDVs), the PCD system is a valid, cost-effective means of detecting malaria cases. This is particularly so in light of integration activities and the resultant elimination of the special category of malaria workers for ACD, as experience has shown that malaria control is likely to deteriorate when vertical malaria programs are integrated at the district level.

Support for PCD system strengthening and expansion is a relatively straight-forward undertaking, primarily involving selection and training of volunteers, organization of bi-annual meetings/refresher training sessions, and distribution and replenishment of supplies to the volunteers. Working with the NMEO, existing volunteers will be reviewed and requirements established by district (each volunteer should cover a population of approximately 2,800). New volunteers will be recruited and trained, and a system for distributing supplies established with the DPHO. The existing monitoring/supervision system will be strengthened through training and revised supervision schedules, and coordination will be established with the evolving CHV program (see component 1, above). It is anticipated that Peace Corps assistance, as feasible, will be used for developing and implementing a strengthened supervision system of the PCD activities. Peace Corps Volunteers would provide assistance to the ilaka health post staff to help oversee PCD activities.

It is anticipated that the project will initially support PCDV system improvement in all 50 districts in which the NMEO is conducting anti-malaria activities, gradually decreasing or coordinating the PCDV role as CHVs become more competent; and continue this activity throughout the LOP. In accordance with the institution building objective of all USAID activities, specific implementation plans and budgets will be detailed in yearly workplans with the NMEO.

Prompt treatment in order to shorten the length of sickness and eliminate the disease reservoir in the community is also a critical element of malaria control. As radical treatment is given only upon laboratory confirmation of malaria, laboratory facilities must be accessible and functioning efficiently to reduce turnaround time. Due to the distances involved to reach hospital laboratories, the resulting time lag for reading of slides and reporting positives has been unacceptably high. To address this inefficiency, the NMEO has begun decentralizing its laboratory facilities down to the ilaka level. The project will support the establishment of decentralized laboratory capabilities at the ilaka level (50 malaria intervention districts, 9 ilakas per district) by providing the required equipment for surveillance activities, microscopes and related laboratory supplies. This effort will be coordinated through the NMEO with the respective DPHOs and health posts.

The expectation in the 1960-70s was that malaria would be eradicated. Therefore, the continuation of large scale training of technicians and managers for malaria control programs was not

provided for. Realizing now that malaria control will be a problem for a long time, it is necessary to prepare a training capacity for the next generation of malaria control personnel, which has become more complex in this new era of mosquito resistance to insecticides, parasite resistance to drugs, and integration. The new generation of malaria control officers will have to be well-trained in several complementary strategies of control in addition to spraying, including source reduction, larvaciding, environmental control, community organization for personal protection, etc. It is also relevant to note that many of the skills involved in malaria control are also appropriate for the control of other vector-borne diseases.

Therefore, the project will assist the NMEO establish an improved training capacity for malaria (and for all the major vector borne diseases). Previous assessments of the current NMEO National Research and Training Center (NRTC) have helped define USAID input under this project. Major activities will include up-grading, through renovation and construction of, and provision of equipment for, the NRTC classroom, laboratory and insectorium facilities, curriculum design, and training of staff.

A major foundation of the successful malaria control of the 1950-60s was accurate entomologic information, i.e., detailed information on the various types of mosquitoes transmitting malaria. Again, because of the earlier expectation of eradication, much of the entomologic work done in the 1950-60s has not been renewed since that time. Over the past 20 years, the man-animal-mosquito ecology of the Terai has changed extensively, and much of the earlier entomologic information is very likely no longer valid. Therefore, the project will provide support to the NMEO to develop the capacity and systems required for documenting the entomology of malaria transmission in all areas of significant risk.

In a properly functioning malaria/vector-borne disease control activity, the entomological services should be able to provide basic planning and stratification information, perform operational monitoring and epidemiological investigation of refractory situations, and conduct research and training. At the present time in Nepal, any detailed special investigations required are carried out by the entomology section at National Headquarters (NHQ), which is also responsible for overall planning and supervision of entomological activities. The regional teams are the main sources of regular entomological monitoring data which are fed back to NHQ for purposes of program planning and adjustment.

The project will provide assistance to the NMEO to consolidate and up-grade its entomological services, with overall planning and supervision being exercised by NHQ, operational monitoring and intelligence gathering activities performed by the regional teams, and regional support and training facilities being provided by the NRTC. The VBC and USAID's Malaria Advisor will work with the NMEO NHQ, regional officers and the NRTC to conduct a review of the organization and use of entomological manpower and supplies; assist in identifying entomological information needs, assist in organizing

NMEO entomological services to get it, and review entomology staff career structure patterns and potential.

Complementary activities primarily from the VBC project in malaria control information systems will be continued under the new project. To date, a computerized database for epidemiological, entomological and operational data has been developed, and two computer systems (for the Central and Eastern Regions) installed. Under the new project, additional training will be provided, and plans developed and refined for district malaria officers' monthly entry of their data, transfer of relevant data to NHQ, analysis and feedback, and use of the data. Expansion of this computerized information system will proceed gradually into a third (Western) Region, and into the final two regions as capability is developed.

Inputs: Inputs for this activity will include TA for technical aspects of the program and engineering/construction aspects of the NRTC; training for PCDVs, CHVs, NRTC and NMEO staff (training will be primarily in-country, with some specialized training provided outside of Nepal); complementary assistance for the PCDV activity from Peace Corps/Nepal, construction costs; equipment and supplies for the NRTC, decentralized laboratories, PCDVs and entomological teams; and some computer hardware and software. Finally, even though USAID is out of the business of providing insecticides, the project will provide, for a limited 1-2 year period only, replacement sprayers, sprayer spare parts and safety equipment for insecticide handlers. The purpose of this is to not risk the spraying operation and safety precautions during a phase-over period while GON is securing other sources of insecticides and of these routine commodities.

Expected Results: As a result of activities supported by this project, passive case detection systems will continue to function; and ilaka level malaria laboratories will be equipped and functioning. The NRTC will be able to accommodate double the number of students it now trains, thus giving it the capacity to provide specialized training to various categories of (integrated) health care worker and to advanced levels of malariologists; and will be able to conduct supportive research related to environmental and biological control of malaria and vector borne diseases. The NMEO entomological services will provide a comprehensive documentation of up-to-date information on vector biology in all Nepal's areas of moderate and high transmission risk, and have the requisite skills and organization to perform this function regularly. Finally, a malaria/vector-borne disease computerized information system will be functioning in at least 4 regions and NHQ. The NMEO will be equipped (skills and hardware/software) to produce timely and relevant monthly and annual reports (case incidence; budget and administrative); and will have the data to predict malaria trends quickly and to respond to immediate needs.

### C. End of Project Status (EOPS)

1. CRHD will be performing management functions appropriate to health care delivery in its region, i.e., planning,

budgeting, personnel and logistics management, monitoring, supervision, and training; and parallel capabilities will be developed in the 19 districts of the Central Region.

The intention here is to achieve in one region a decentralized, integrated and sustainable public health delivery system, which can serve as an example for other regions. Through training and TA supported by the project, CRHD will have begun applying the technical skills necessary for health sector planning, including use of an integrated data base for planning, monitoring and supervision. Through on-going policy dialogue and the development of annual workplans with the CRHD in concert with various technical divisions within the MOH, the CRHD will be channeling, in a phased manner over time, all regular programmatic inputs (i.e., all FP and child survival commodities, materials and supplies) for all service-related programs being implemented by the CRHD districts. These inputs will be administered and implemented through the Central Region structure under the authority of the Regional Director.

The implications of this are that the CRHD will be

- 1) providing administrative and technical backstopping to DPHOs, to assist in the preparation of district and regional plans according to district requirements/constraints, and to improve the management, monitoring and evaluation of the health activities in the districts;
- 2) channeling funds for the regular operation of health services in the CRHD from the MOP to the districts according to district-by-district summary budgets;
- 3) coordinating, scheduling and prioritizing training programs, and coordinating this training from technical agencies;
- 4) allocating and distributing essential supplies and commodities; and
- 5) assuming responsibility for activities, postings, transfers and personnel reviews of gazetted officers in the region. The CHV program will have been tested, and support for this program secured and operational in at least half of the 19 districts.

2. Full service family planning services available in project districts; CPR increased by 20% in CRHD districts.

- i) The feasibility of institutionalizing the full range of family planning services at the district level under regional management while improving the quantity and quality of services will have been demonstrated. This demonstration, along with clear administrative and managerial steps for integration of FP/MCH activities will have broken down resistance to planned/phased integration;

Project activities will have contributed to:

- ii) qualitative improvements in family planning IE&C programs and, consequently, increased awareness among providers and the public of the importance of family planning to the health of mothers and children and the welfare of families;

- iii) increased availability of year-round services through public and private sector providers;

iv) qualitative improvements in VSC and clinical contraception programs, and the establishment of counseling and quality assurance systems;

v) a regional contraceptive logistics system; and

vi) management systems for priority services compatible with the MOH's integrated, regionalized and decentralized system in "institutionalizing" districts, primarily in the CRHD and contiguous districts in other regions. The CRHD and DPHO's will be able to perform systems analysis, target group prioritization, and management and training needs assessment for relevant family planning services, and provide the requisite training, commodities and supervision.

3. Up-graded child survival services (CDD, EPI, ARI) being provided to 80% of the population in the Central Region.

While these services (particularly CDD and EPI, but to a much lesser extent ARI) are already included in the package of services to be provided by health care providers, both the BN concept and the current HMG/MOH organization are new and relatively inexperienced. There is much room for improvement in knowledge communicated by health care workers, in monitoring/information systems to assess skills, coverage, consumer acceptance, and costs, in reinforcing the "integration" concept, in supervision systems, etc.

By the end of the project, the technical skills for health care delivery and management of these services will have been imparted to all Central Region management and service provider staff. As a result of this training, these workers will be better prepared to carry out their roles by e.g., being able to discuss advantages/disadvantages of various contraceptives, the importance of immunizations, steps in oral rehydration therapy and when needed, etc. A supervision and monitoring system for CDD training, feedback and program improvement will have been established; a protocol for delivering EPI services in the context of integrated health care in the Central Region will have been established; and models for ARI service delivery will be available.

4. MOH maintaining malaria control activities in 50 districts and adopting limited environmental control measures; stratification exercises completed and control measures (including spraying) guided by stratification findings.

In the effort to maintain sufficient attention to malaria control activities in the context of integration, PCD systems will have been strengthened; and the skilled manpower and information necessary for maintaining reliable malaria control activities and adopting appropriate biological and environmental control measures will be available and applied as feasible.

#### I. Summary of Inputs

The major categories of inputs in support of project

components are technical assistance; training; commodities and supplies; local cost support; renovation/construction; and local grants and cooperative agreement(s).

1. Technical Assistance

a. Technical assistance through a resident institutional contractor will be the primary source of TA provided to the project activities. It is anticipated that the contractor will provide 3 long term resident advisors for 5 years each to work with the MOH and related agencies/organizations. Long term TA contractors will include a Chief of Party/Senior Health Administrator, a Family Planning/Training Advisor, and a Public Health Planning Advisor. The long term residents will be backed up by up to 60 person months of short term technical assistance, in various technical aspects related primarily to implementation of the first three project components, including planning, and management and information systems (estimated 30 person months), CDD, ARI and EPI (estimated 15 person months), and family planning (estimated 15 person months). The institutional contractor will be responsible for arranging external technical assistance input, in consultation with USAID and the concerned MOH unit; for procuring project commodities (except contraceptives and vehicles); and for identifying and recruiting local technical assistance, approximately 60 person months, as available and needed (roughly in the same proportion as for external TA. Local staff will provide logistics, secretarial, administrative and transport support.

b. USAID will also hire a personal services contractor (PSC) to administer and monitor the field activities of the MOH entities and the institutional contractor, and to assist them in the preparation of annual workplans.

c. Technical assistance for project activities will also be procured in the form of buy-ins to centrally funded projects for specific sector/component activities. (N.B.: While listed under "technical assistance", this input, by the nature of buy-ins, can also include some equipment, materials, training, etc.) The largest use of central resources will be for the family planning component.

Planned or anticipated buy-ins for the family planning component include the following (illustrative list):

a) Association for Voluntary Surgical Contraception (AVSC) and Population Council, for strengthening service delivery systems and related institutionalization of family planning services in selected MOH-designated institutionalizing districts, primarily in the Central Region (approximately 10 person months);

b) Johns Hopkins University/Population Communication Service (JHU/PCS), for the development of information, education and communication (IE&C) strategies/interventions/messages in support of family planning services (approximately 7 person months);

c) RAPID/IMPACT, for development of computerized policy-level programs on population growth and consequences, and

production and dissemination of materials (approximately 3 person months);

d) Family Planning Enterprise, for assisting private enterprises establish and deliver family planning services (approximately 5 person months);

e) Social Marketing for Change (SOMARC), to assist CRS Company with its social marketing activities (approximately 6 person months); and

For the child survival component, the following buy-ins are anticipated:

a) HealthCom, for production and dissemination of IE&C materials (approximately 4 person months);

b) ChildTech, for assistance with EPI program protocols within an integrated system, costs analyses, coverage information systems and disease surveillance (approximately 12 person months); and

c) Vitamin A for Health, for the feasibility of introducing simple Vitamin A distribution procedures (approximately 3 person months).

Finally, for the malaria component, the following is anticipated:

Vector Biology Control (VBC) Project, to assist with research and training center curriculum design; entomological assessments; training; and information systems development (approximately 10 person months).

## 2. Training

Project activities place considerable emphasis on planning for, and the conduct and follow-up of, training. Since new skills must be learned and applied (planning, management, technical and communication aspects of services being provided, etc.) and constantly refreshed and up-graded if quality services are to be achieved, all project components have a large training element in support of MOH initiatives to provide its staff with requisite skills.

a) In-country Training: An illustrative training plan and schedule is presented in Annex H. All levels of health workers in: 1) the CRHD, and 2) other selected districts as identified in yearly workplans will be trained to plan, manage, supervise, and/or deliver family planning, child survival and malaria services .

b) Out-of-Country Training: Specialized short term out-of-country training will be provided primarily in subjects related to public health planning and management; and to malaria and vector-borne disease control. This category also includes

anticipated observation/study tours for, e.g. management of oral rehydration hospitals/centers, and social marketing activities (approximately 40 person months).

c) Institute of Medicine (IOM): Educational stipends and tuition costs for approximately 25-30 MOH managers to attend public health degree training at the IOM will be provided.

### 3. Commodities and Supplies

The project will provide approximately \$5 million worth of commodities. The largest component of commodity costs will be for contraceptive supplies for MOH, CRS and small NGO programs (estimated at \$500,000-\$600,000/year). Other commodities include 20 vehicles (for TA contractor, CRHD, PHD/CDD, CRS, other MOH programs), 1 bus for NMEO, and 5 motorcycles (including anticipated requirements for NGO project monitoring); 10 micro-computer systems (illustrative: 3 for NMEO, 1 for CRHD, 1 for CRS and 5 for various national level activities); family planning equipment and supplies; malaria spraying equipment; laboratory equipment for the NMEO/NRTC; classroom, library supplies and training materials for the NMEO/NRTC and the IOM-related public health training; and ORS 500 cc packets and containers.

A Procurement Plan is outlined in section VI. D. This is supplemented by an illustrative list of project-funded equipment and commodities by project component and procurement agent in Annex J.

### 4. Local Cost Support (LCS)

In USAID/MOH workplan terminology, Local Cost Support largely covers costs related to in-country training, supervision, and orientations, materials, including TA/DA (travel allowance/per diem), training materials, supplies, etc. For the purposes of this PP's input section and budget, training-specific costs for in-country training are listed under the "training" input. LCS will cover such training-related costs as facility rental, meetings, selected honoraria according to existing Mission Notice No. AID/N 88-109 (dated 07/11/88), materials development, printing, etc. Other costs include stationary, supplies, small equipment requirements, and related miscellaneous expenses. LCS for each project component will be identified on a yearly basis during workplan design/negotiation.

### 5. NGO/PVO Grants and Cooperative Agreements

The project will continue and/or initiate NGO activities which contribute to the attainment of the project's purposes. Specific examples might include a Cooperative Agreement with CRS Co., for the continuation and expansion of social marketing activities (estimated \$400,000/year); and grants to NEPAS for physician training in CDD and ARI, and the development of supportive supervision systems; to the Nepal Red Cross Society (NRCS) for promoting ARI (and CDD and FP) services based largely on self referral; to CEDPA for

administrative/management training for women managers; and to the Nepal Fertility Care Center (NPCC) for family planning related TA; etc.

#### 6. Renovation/Construction

Finally, the project will finance a local contract for the engineering and renovation/construction costs of the NMEO/NRTC. Included will be all construction contracting requirements, construction materials, equipment, etc. A Construction Plan is included in Annex I.

#### E. Financial Plan

The following tables spell out the expected financial requirements for the project. Table I (Project Costs) shows the annual expected requirements for each component, both from AID and from the GON/MOH. Expected requirements initiate in year 1, which actually will correspond with FY 1991. Table II (Annual Obligations) shows the amount which AID will have to obligate, prior to expenditure. Although the project is expected to extend to FY 1995, all obligations should be made by FY 1994, subject to availability of funds. Table III (Local Currency Components) shows that portion of USAID project costs that will require Nepali rupee expenditures. Table IV presents information on line items in terms of method of financing, method of implementation and total costs.

The financial plan for a project requiring \$40,779,000 of which \$20,000,000 is from USAID and \$20,779,000 is from the GON/MOH, must be reasonably flexible. The project has four major components and many sub-components. To ensure that a fair degree of budgetary flexibility is incorporated, a combined inflation and contingency of \$2,858,000 on the USAID budget is included (\$3,104,000 on the HMG budget). Details on all the tables can be found in Annex F.

Financial management of the project will correspond to USAID/Nepal's Mission General Assessment of Mission Financing Policies and Procedures. Responsibilities for various financial transactions are shown in Table IV. The GON/MOH will be required to create annual workplans and place all project costs in the development budget "Red Book" both their own project-related expenses, as well as those USAID budget items directly channeled through the MOH. These latter items include in-country training, IOM public health training, and local cost support (training-related, general supplies).

The management of A.I.D. costs under the project will follow A.I.D. standard regulations and USAID operating policies and procedures. Administrative reservation of funds for specific purposes will be done through Project Implementation Letters (PILs) signed by an authorized signatory of this Project Agreement. Once this reservation of funds is obtained through authorized GON signatures on PILs, all earmarking of these funds will be done

through Project Implementation Orders (PIOs) signed by USAID, within the terms of the Project Grant Agreement. Local cost support, however, will be earmarked through the use of PILS.

USAID will reimburse the principal contractor on a monthly basis after approval of monthly-submitted invoices. Releases to the GON/MOH will be made every four months (trimesterly as per GON/MOH procedures) and will be reconciled in the same fashion as the principal contractor accounts are done. Centrally-funded buy-ins will be funded through Federal Reserve Letters of Credit, which can be drawn upon by the sub-contractor when there is need.

USAID will directly fund the primary contractor and the personal services contract. USAID will make direct payments for construction, vehicles, buy-ins, local NGO grants, evaluations, and the audit. AID/W S&T Population Office will purchase contraceptive commodities and will be allotted the required funds accordingly. The responsible parties for various financial transactions are shown in Table IV.

TABLE I

CS/PFS PROJECT: USAID and GON/MOH PROJECT COSTS  
(Shown in \$ 000's over five years)

Project Component	1st Year		2nd Year		3rd Year		4th Year		5th Year		LOP Funding		Combined Total
	USAID	GON											
<b>Technical Assistance</b>													
<b>A. Principal Contractor</b>													
1. Long-Term	480	36	480	36	480	36	480	36	480	36	2,400	180	2,580
2. Short-Term	240	- 0 -	240	- 0 -	240	- 0 -	240	- 0 -	240	- 0 -	1,200	- 0 -	1,200
3. Local Consultants	24	- 0 -	24	- 0 -	24	- 0 -	24	- 0 -	24	- 0 -	120	- 0 -	120
4. Support Staff	24	- 0 -	24	- 0 -	24	- 0 -	24	- 0 -	24	- 0 -	120	- 0 -	120
<b>B. Buy-Ins to S&amp;T Project</b>	240	60	240	60	240	60	240	60	240	60	1,200	300	1,500
<b>C. PSC</b>	120	- 0 -	120	- 0 -	120	- 0 -	120	- 0 -	120	- 0 -	600	- 0 -	600
<b>TA Total</b>	<b>1,128</b>	<b>96</b>	<b>5,640</b>	<b>480</b>	<b>6,120</b>								
<b>Training</b>													
<b>A. Overseas</b>	66	1	87	1	51	1	18	- 0 -	18	- 0 -	240	3	243
<b>B. In-Country</b>	287	47	281	50	207	40	180	31	123	21	1,078	189	1,267
<b>C. IOM Public Health</b>	10	5	20	10	29	15	20	10	20	10	99	50	149
<b>Training Total</b>	<b>363</b>	<b>53</b>	<b>388</b>	<b>60</b>	<b>287</b>	<b>56</b>	<b>218</b>	<b>41</b>	<b>161</b>	<b>31</b>	<b>1,417</b>	<b>242</b>	<b>1,659</b>

TABLE I (p.2)

Project Component	1st Year		2nd Year		3rd Year		4th Year		5th Year		LOP Funding		Combined Total
	USAID	GON	USAID	GON	USAID	GON	USAID	GON	USAID	GON	USAID	GON	
<b>III. Commodities &amp; Supplies</b>													
A. Contraceptives	561	- 0 -	572	- 0 -	584	- 0 -	595	- 0 -	607	- 0 -	2,919	- 0 -	2,919
B. VSC/Clinical Contraception	50	31	50	31	100	31	100	31	100	31	400	155	555
C. Malaria Equipment	152	2,827	152	2,827	194	2,827	44	2,827	44	2,827	586	14,135	14,721
D. Library/Teaching Mats	25	- 0 -	25	- 0 -	50	24	- 0 -	24	- 0 -	24	100	72	172
E. Vehicles	237	- 0 -	- 0 -	- 0 -	200	200	- 0 -	- 0 -	- 0 -	200	437	400	837
F. Computer Equipment	31	1	32	2	2	2	2	2	2	2	69	9	78
G. ORT Supplies	25	70	162	106	162	159	- 0 -	239	- 0 -	358	349	932	1,281
<b>Commodity Total</b>	<b>1,081</b>	<b>2,929</b>	<b>993</b>	<b>2,966</b>	<b>1,292</b>	<b>3,243</b>	<b>741</b>	<b>3,123</b>	<b>753</b>	<b>3,442</b>	<b>4,860</b>	<b>15,703</b>	<b>20,563</b>
<b>IV. Local Cost Support</b>													
A. Training Related	250	- 0 -	250	- 0 -	250	- 0 -	250	- 0 -	250	- 0 -	1,250	- 0 -	1,250
B. General Supplies	200	60	200	60	200	60	200	60	200	60	1,000	300	1,300
C. NGO/PVO Grants	500	200	475	190	450	180	425	170	400	160	2,250	900	3,150
<b>Local Cost Total</b>	<b>950</b>	<b>260</b>	<b>925</b>	<b>250</b>	<b>900</b>	<b>240</b>	<b>875</b>	<b>230</b>	<b>850</b>	<b>220</b>	<b>4,500</b>	<b>1,200</b>	<b>5,700</b>

TABLE I (p.3)

Project Component	1st Year		2nd Year		3rd Year		4th Year		5th Year		LOP Funding		Combined Total
	USAID	GON	USAID	GON									
<u>Construction (NRTC)</u>	- 0 -	- 0 -	250	25	250	25	- 0 -	- 0 -	- 0 -	- 0 -	500	50	550
<u>Evaluation</u>	- 0 -	- 0 -	50	- 0 -	- 0 -	- 0 -	100	- 0 -	- 0 -	- 0 -	150	- 0 -	150
<u>I. Audit</u>	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	75	- 0 -	- 0 -	- 0 -	75	- 0 -	75
<u>Sub-Total (I-VII)</u>	3,522	3,338	3,734	3,398	3,857	3,660	3,137	3,490	2,892	3,789	17,142	17,675	34,817
<u>II Inflation</u>	- 0 -	- 0 -	187	170	386	366	502	558	636	834	1,711	1,928	3,639
<u>Contingency</u>	211	200	235	214	271	242	218	243	212	277	1,147	1,176	2,323
<u>Total</u>	3,733	3,538	4,156	3,782	4,514	4,268	3,857	4,291	3,740	4,900	20,000	20,779	40,779

TABLE II  
ANNUAL OBLIGATION REQUIREMENTS  
( \$ 000's )

CATEGORY	PY 1990	PY 1991	PY 1992	PY 1993	FY1994	Total
Technical Assist.	3,500	1,000	1,000	140	-	5,640
Training	100	400	300	300	317	1,417
Commodities	100	1,200	1,200	1,200	1,160	4,860
Local Cost Support	100	1,200	1,200	1,200	800	4,500
Construction	-	250	250	-	-	500
Evaluations	-	-	50	-	100	150
Audit	-	-	-	-	75	75
Inflation	-	400	400	400	511	1,711
Contingency	200	270	260	200	217	1,147
<b>TOTAL</b>	<b>4,000 *</b>	<b>4,720 *</b>	<b>4,660</b>	<b>3,440</b>	<b>3,800</b>	<b>20,000 *</b>

\* The PY 1990 and PY 1991 Congressional Presentations (CP's) show obligations of \$2.7 million and \$3.0 million respectively. These figures do not include an estimated \$3.0 million in reobligations, which are expected from IRH/FPS (J67-0135) deobligations. This table and the asterisked figures include these reobligations.

TABLE III

LOCAL CURRENCY COMPONENTS

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<u>CATEGORY</u>	<u>Total</u> <u>U.S. \$</u>
I. Technical Assistance	240,000
II. Training	1,177,000
III. Commodities	349,000
IV. Local Cost Support	4,500,000
V. Construction	500,000
VI. Evaluations	-
VII. Audit	-
VIII. Inflation	667,000
IX. Contingency	446,000

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TOTAL \$7,879,000

TABLE IV  
METHODS OF IMPLEMENTATION AND FINANCING  
(\$000)

Type of Assistance	Grantee or Contractor	Method of Implement	Method Finance	US \$ Cost
<u>TECHNICAL ASSISTANCE</u>				
Long Term Contractors	U.S. Firms	AID Direct Contract	PX	2,400
Short Term Consultants	U.S. Firms	TA Contractor	PX	1,200
Local Consultants	Local Firms/ Individuals	TA Contractor	LC	120
Contract Support	"	TA Contractor	LC	120
Buy-ins to S&T	U.S. Firms	U.S. Contractor	PX	1,200
PSC	Individual	AID/W Direct		600
<u>TRAINING</u>				
T.C. Training	T.C. Institution	AID Direct	PX	240
In-country Training	In-country Institution	TA Contractor	LC	1,078
IOM Training	IOM	TA Contractor	LC	99
<u>COMMODITIES</u>				
	US, Foreign, & Local Firms (see Annex J)	TA Contractor	PX	1,155
		AID Direct	PX	3,356
		TA Contractor	LC	349
<u>LOCAL COST SUPPORT</u>				
Training Related	In-country Institution	HMG	LC	1,250
General Supplies	"	HMG	LC	1,000
NGO/PVO Grants	"	AID Direct	LC	2,250
<u>CONSTRUCTION</u>				
	Local Firm	AID Direct Contract	LC	500
<u>OTHER</u>				
Evaluation	U.S Firms	AID Direct Contract	PX	150
Audit	CPA Firms	"	PX	<u>75</u>
	Sub-Total			17,412
Inflation Contingency			PX/LC	1,711
			PX/LC	<u>1,147</u>
	TOTAL			20,000

## V. SUMMARIES OF PROJECT ANALYSES

### A. Technical Analysis

#### 1. Family Planning

The GON has set extremely ambitious demographic and health objectives for the year 2000, e.g., a reduction in total fertility rate from near 6 to 2.5 and an infant mortality reduction from about 110/1000 to 45/1000. The degree that family planning will be able to contribute significantly to those demographic and health objectives will depend upon major progress towards a mixed method contraceptive prevalence of 60-70% with far greater focus than present on the adoption of contraception by younger couples. The challenge will be to establish a program that allows for the expansion of availability of quality VSC services, while at the same time developing system capacity to educate, motivate and make available services for temporary methods of contraception for spacing earlier in couples' reproductive lives.

Until 1989, essentially all public sector VSC services were delivered through seasonal laparoscopy and vasectomy "camps." Due to the "camp" style of operation, there were some inefficiencies of operation, but also there were significant inefficiencies in fundamentals of counselling, availability of safety equipment, surgical standards, patient modesty and comfort, and other problems.

This project will support GON's desire to restructure its FP program by establishing static, year round services, recruiting FP clients earlier in their reproductive lives for temporary contraception, and improving the quality of VSC services in a variety of ways.

IUDs. The national FP program virtually ceased to use the IUD as a method in the early 1980s. In 1988, GON recommitted itself to offering IUD services for spacing, and also for limiters who are not ready to accept VSC. To meet the desire to reestablish IUD services but not expand unsafely, this Project will (1) establish minimum safe standards for IUD services in the Nepalese context; (2) begin training, or retraining, of potential providers; (3) establish a certification system for providers and institutions and (4) continue field studies to determine the best way to motivate and satisfy potential clients.

Norplant. Clinical results of field trials in Nepal have been good, and GON is enthusiastic to add Norplant to their program. Norplant should initially be restricted to capable hospitals and only extended to health posts when availability of adequately trained staff could be assured. UNPPA will provide Norplant commodities. This project will support the introduction of Norplant services as part of a desirable range of services in capable institutions.

Injectable Contraceptives. Where Depoprovera has been offered in Nepal, public acceptance has been good. GON is committed to making Depoprovera services more available, and UNFPA has agreed to increase the supply. AID cannot provide the contraceptive, but the project will support the safe expansion of availability.

Oral Contraceptives and Condoms: Contraceptive prevalence due to use of pills and condoms had by 1986 levelled off at about 3%; only 1/3 of that was attributable to public sector service/distribution programs. The major reasons for poor public sector performance were the low priority given to pills and condoms (temporary methods in general), weak fieldworker penetration and service to communities, small client loads at health posts, and no such services offered at hospitals.

For the next decade the majority of the rural population will not have adequate access to the hospitals and health centers in which safe clinical method services can be delivered; therefore, if a major demographic impact is to begin, pill and condom programs will necessarily have to play a major role. The project will gradually add motivation and supply responsibilities for condoms and pills into the duties the CHVs will assume. If this succeeds, Nepal will for the first time have an "army" of village women preaching family planning and providing pill and condom services.

The CRS Co., NGOs, and private enterprises will also contribute FP motivation and services to select population groups. Their major respective roles in a national program context should be to demonstrate successful alternative approaches to FP service provision and, in particular, the potential of the private sector.

## 2. Control of Diarrheal Diseases

Available data suggest that diarrheal diseases are the leading cause of death among young children in Nepal. It was generally assumed prior to 1987 that most diarrhea-associated deaths were as a consequence of dehydration and electrolyte depletion of the watery diarrheal syndromes; data from Jumla, however, showed that at least in that environment most diarrhea-associated deaths were not associated with dehydration--most were from dysenteric and persistent diarrheas.

A formal CDD program, with good leadership, has been in place since the early '80s. Amid considerable progress in the sector, program leadership demonstrated the ability and willingness to clearly identify technical and organizational problems such as the need for good epidemiologic data, inadequate field worker performance and reporting/recording, a devisive organizational structure for MCH services and policy in the MOH, confusion among providers and clients over correct oral rehydration therapy, the "unknowns" on the severity and prevalence of dysenteric and persistent (chronic) diarrheas,

etc. Good progress has been made in addressing all the above program deficiencies in the past two years, and this project will continue those efforts as part of a coordinated program with UNICEF and WHO, with the major AID responsibilities for support being training of all levels of health workers and primary school teachers in two regions, physician and nurse training, monitoring systems, program management at regional level, development of a dysentery outbreak response system, ORT centers in hospitals, research, and a change in the national ORS standard from 1000 cc to 500 cc solution.

### 3. Control of ARI-associated Mortality

Studies indicate that ARI (specifically ALRI - acute lower respiratory infection) is a major cause of infant and child mortality. It is clear that young age and measles infection are important risk factors, perhaps both for incidence and severity; however, it is not clear how important are domestic air pollution, low birth weight, pertussis, protein-calorie malnutrition, Vitamin A deficiency, or other factors.

The major program options for ALRI control in an environment like Nepal, with the information available, are (1) immunization for measles, pertussis and tuberculosis; (2) passive case detection and treatment; and/or (3) active case detection and treatment.

Given that experience thus far in Nepal and elsewhere in the world has not shown a program strategy that clearly will work in Nepal, the project proposes appropriately conservative ALRI control activities. Immunization programs should proceed with all due haste, as should Vitamin A programs; it is hoped that, in addition to other benefits, they might have a reductive effect on ALRI mortality. Also, although a clearly effective strategy for community-based ALRI case detection and treatment has not emerged, still there are thousands of ALRI cases appearing at hospitals, health posts and private practices; this project will continue earlier work to put into place higher standards of diagnosis and treatment in those settings. But the majority of ALRI cases in Nepal never reach a fixed facility in time to make a difference in clinical course, so this project will encourage and support trials into active case detection by CHVs, TBAs and other fieldworkers, and into stimulating early case detection and early care seeking behavior by parents of children with ALRI.

### 4. Immunization

There is little doubt that measles, tuberculosis and tetanus (especially neonatal) are major problems. Since 1985, the Expanded Program in Immunization (EPI) management has developed the program into one capable of large scale coverage. But as with the evolution of all organizations, especially young ones, EPI's expansion of scope and size has created a new generation of problems for the next decade: (1) how to protect

the achievements of the heretofore vertical program as it is absorbed into the MOH's evolving integrated structure; (2) the cost/effectiveness and relative efficiencies of various program approaches; (3) more refined communications for public mobilization; and (4) for program monitoring purposes, how much reliance can/should be placed on management performance indicators vs. coverage data vs. disease incidence indicators.

Because the bulk of EPI operational and commodity costs for the 1990-95 period are expected to be met by the GON/MOH and UNICEF, this new project accepts the more modest role to collaborate with MOH in solving issues of monitoring, the integration of EIP into the larger array of MOH services, decentralization of management responsibilities, communications strategies, and cost analyses.

### 5. Malaria Control

Beginning in the 1950s, AID collaborated with the GON and WHO to bring malaria under control in the low altitude Terai and river valleys. The program used standard malaria control methods of the times, stressing intra-domiciliary insecticide spraying. By the end of the 1960s, malaria incidence had become relatively insignificant, and major population, agricultural and economic shifts were underway to the Terai.

By the early 1980s, however, it was obvious that the previous fine control of malaria transmission was breaking down. The major factors involved were: (1) insecticide resistance in the mosquitoes; (2) drug resistance of the malaria parasites (P. falciparum); (3) declining political support for the malaria program; (4) organizational fatigue within the malaria eradication organization; (5) outdated entomological information; (6) deterioration of program management with "integration" of vertical programs in some districts; and (7) inadequate training programs for managers and fieldworkers.

In 1985 there was a major epidemic of malaria in the Far West Region. While significant in itself as an epidemic, it was more significant as a symptom of deterioration of the malaria control system as a whole, and the potential risk to the 50% of Nepal's population, largely non-immune to malaria due to low exposure history, now residing in the Terai.

The capacity for malaria control in the future will depend on:

- an entire new generation of health system managers and fieldworkers being trained in the skills to control malaria;
- with the shift to a more integrated health system, on shifting reliance from active case detection (ACD) workers and systems to passive case detection (PCD) and treatment systems; and
- given that the mosquito-man-animal ecology has changed drastically in the Terai since the 1950-60s, on an up-dated entomologic information base on malaria transmission.

The project's components for malaria control include specific responses to the current program requirements listed above.

#### B. Economic and Financial Analysis Summary

Public expenditures (MOH budget) for health care are low in terms of percentage of GDP (1%) and per capita (\$2.00), but represent a reasonable proportion of total HMG budget (5.8%) compared with other less developed countries, e.g. Indonesia - 2%. However, only approximately 20% of the health budget is devoted to preventive/promotive primary health care services. But that is also in line with most third world countries. Unfortunately, only about 75% to 80% of the scarce funds which are budgeted for that purpose is actually expended each year, due primarily to management constraints.

The project design takes into account the current, and anticipated medium term economic and financial constraints facing the nation and HMG government programs. Although the HMG Basic Needs strategy and the eighth five year development plan continue to elicit ambitious targets for expanded population and geographic coverage of basic primary health care and family planning services, the MOH and USAID anticipate encountering substantial budget constraints. Reductions of at least 10% in the MOH development budget are expected next year.

In view of these expected constraints, this project is designed to pose a minimal burden on the MOH budget and, more important, to strengthen the capability of MOH managers to maximize the utilization of the resources they have available and increase the cost effectiveness of their intervention programs. The project will address these issues intensively in the Central Region which is already well staffed at the district and health post levels. Project activities outside of the Central Region will concentrate where there are already adequate staff and facilities on hand. In this way the project will strengthen service delivery without imposing a heavy burden on the budget to hire and assign new staff. However, the MOH did expand substantially the number of health services positions at the district and Ilaka levels during the past ten years. This has imposed a budgetary burden that must be sustained if its ambitious goals are to be achieved. This project is predicated on MOH ability to maintain the current manpower and program levels in the Central Region, and selected other districts, even though it will have to forego expansion into still underserved remote areas.

As the project will not impose additional counterpart budget burdens on the MOH during implementation, it will also not impose a large burden to sustain the activities following Project completion. The principal assistance will be in the form of training, improved management and planning practices and related program costs and materials. These skills should be

sustainable if well ingrained, without much additional financial support from the MOH budget. Some additional budget will be required to maintain the renovated malaria regional training center building to be built in Hetauda, and the CRHD will need an expanded budget for continuation of supervisory and training functions.

HMG/MOH financial management practices have slowed implementation of the predecessor IRH/FPS project resulting in reduced achievement of objectives. Disbursement of USAID funds for local cost support was frequently delayed by several months because of problems in budget approvals and poor preparation of reimbursement claims. This frequently stalled field operations completely until the problems could be resolved. MOH field level staff turnover associated with program integration exacerbated this problem during the past year. However, these problems will be reduced substantially in the new project for several reasons: 1) by concentrating in the Central Region the CRHD staff will be responsible for managing this process, and will be dealing with only 19 districts instead of 75; 2) the T.A. contractor will provide assistance to MOH units and staff responsible for these financial management matters.

As an added measure to achieve maximum return from investment of very scarce human and financial resources in these programs, the project will also provide technical assistance and training to MOH staff in determination of comparative cost effectiveness of the health and family planning interventions. This will focus on accurate determination of program costs and monitoring of them, establishment of realistic measures of program effectiveness and monitoring of results, and determination of the relationship between the two.

Prospects for achieving substantial cost recovery through user charges for services provided are very slim. Aside from the Contraceptive Retail Sales program, which is part of this project and which is striving for self-sufficiency, there is little opportunity to charge much for services. This cannot be done with respect to the MOH family planning, immunization, and diarrheal disease control outreach programs because they are still trying to convince villagers to utilize these services or adopt the practices. However, the CHVs are expected to pay for the contents of their modest medicine kits, and sell them in turn to replenish their stocks. A number of health posts are also operating revolving drug funds in order to maintain an adequate stock to provide better service to their communities. The communities are also contributing to these programs through provision of the volunteers (CHVs). In the longer run, decentralization of health services is supposed to entail financial contributions from the village, ilaka and district panchayats to supplement budget allocations from the MOH. This has yet to materialize.

### C. Social Soundness Analysis Summary

Two of USAID's five basic themes for the health/family planning sector highlight social/administrative weaknesses of present public health system. Until it begins to reach effectively "beyond the health post", the system provides contact points too distant and too infrequent to be of much use to rural families. Also, male VHWS cannot provide "services by and for women", thus encountering a series of cultural encumbrances which, even with the highest motivation, lessen their effectiveness as motivators and service providers and, at the extreme, may deny physical access to women who are primary clients for MCH and family planning services.

USAID and the MOH have worked over the past year to pilot test and introduce an entire new category of service providers, in order to overcome the challenges of low worker:client ratios, physical isolation of villagers from health services, and inadequate support, supervision, and motivation of existing health workers. A female Community Health Volunteer (CHV) is to be selected from among local residents of each ward (37,000 total) in Nepal, and trained, monitored, supervised, and supplied under a system already initiated, but only partially developed.

Effective establishment of a realistic, model system of locally resident, female CHVs is a significant administrative challenge facing the MOH and this project over the next several years, precisely because it addresses administrative issues at the point of interface between the system's workers and its clients. This Social Analysis poses a series of administrative/cultural challenges which must be recognized, met, and overcome if the CHV system is to be effective and sustainable. Major challenges include appropriate compensation for CHVs; selection and re-selection procedures; effective training, monitoring, and field support; and worker motivation.

Compensation for CHVs: The project must support the MOH in serious, sustained efforts to identify realistic mechanisms for compensating CHVs. At least three broad approaches to income supplementation seem feasible: psychic income, such as providing CHVs with uniforms, honoring them on public occasions, and asking them to serve on specially-constituted committees on health and family planning matters; a monetary supplement from present, limited village panchayat revenue, or from an annual "health services fee" (on a sliding scale) to be paid by ward households to the CHV; and a semi-formal, fee-for-service system, at least for curative services. Since many rural groups already make payments to informal "health service providers" such as jhankris and midwives, there is ample precedent for fee-for-service.

Selection and Re-Selection Procedures: CHVs should be selected for their energy, intelligence, and willingness to serve all ward residents. These personal qualities should be

stressed during ward level selection, reiterated and tested during CHV training, and regularly observed during early field monitoring and supervision. Orderly procedures for termination of inappropriate individuals and quick, effective selection of replacements should be established early in the program. Other personal qualities being equal, candidates of higher educational attainment (and skilled in spoken and written Nepali) are preferable. But lower educational attainment (even illiteracy) can be offset in specific cases by energy, intelligence, and willingness to serve. In areas where Nepali language skills are limited, provision of Nepali literacy training to CHVs may be a much-appreciated compensation for services rendered.

Effective Training, Monitoring, and Supervision: Since the CHV program will be established nation-wide (although this project supports its establishment in only one region), and will rely heavily on rural women, there must be very careful attention to field monitoring, supervision, and logistic support during the first several months in each ward. This is fundamental to the overall success of this program. Initial monitoring/supervision visits should be frequent (at least twice monthly for six months) and should emphasize personal evaluation of the new appointee, and a structured program of "polishing" new skills acquired in training. Supervision and monitoring must be supportive and constructive and must be delivered on schedule. Establishment of inappropriate performance targets for CHVs would also be extremely deleterious to the program.

Worker Motivation: Positive CHV motivation is to some degree dependent on appropriate selection criteria, termination/re-selection procedures, and effective training and supervision programs previously discussed. In addition, it is essential to make these workers accountable to local residents and local government. CHVs should have a realistic work agenda and some work norms for CHV/client interaction should be established.

#### D. Institutional/Administrative Analysis Summary

The groups that will have major project implementation responsibilities are four operational units of the MOH, one quasi-private organization and one private company. Two other national level units within the PHD, i.e. CDD and ARI, will also be involved in implementation activities.

The MOH units are the CRHD, the PP/MCH Division, the PHD/CDD, and NMEO. Support to NMEO is similar to assistance provided in the past and can be seen as some of the final steps in institution building. There is no doubt that NMEO can carry out its part of the project. The work with the PP/MCH Division will include technical assistance and training directed at introducing a multi-method family planning program with different forms of contraceptive services available at different levels within the delivery system, along with continued supplies of contraceptives, other supplies and equipment. The changes in

service mix and the tiered delivery system represent a new initiative for PP/MCH, but is something that has been anticipated for several years and, given PP/MCH's strong leadership and field capacities, should be possible to do in a phased manner starting in the Central Region. Project activities in CDD, EPI and ARI are either extensions of ongoing activities, small new activities for which technical assistance will be provided, or will be conducted by NGOs/PVOs with already tested capabilities.

The major MOH recipient of project technical assistance, training, and local cost support will be the CRHD and the 19 districts in the Central Region. Having provided assistance to the CRHD since 1987, USAID has a good sense of its strengths and weaknesses. Strengths include leadership, as close to a full complement of management staff as any region in the MOH ever gets, and nascent management and training capabilities.

The organizational problems that need to be resolved if the CRHD is to actually implement an integrated/decentralized delivery system will require a clear set of authorities from the central MOH including planning, budget and personnel, and the support of the national-level technical offices (previously "vertical projects"), as the districts in the region gradually take over the operational aspects of their programs.

These are major changes and will not come immediately or easily. The project will deal with them in several ways. The ability of USAID to provide development budget funding to be administered directly by the CRHD will be a policy issue for the project, and a covenant for implementation by year 2. The granting of authorities to the CRHD will be negotiated as each annual project work plan is developed, as will the transfer of operational responsibility from the "vertical projects". Finally, by providing technical and other assistance to the CRHD and to the most important national level technical offices (PP/MCH, NMEQ, CDD), USAID hopes to be able to play a facilitating role in the shift of operational responsibility from the vertical projects to the integrated districts.

The Contraceptive Retail Sales Co. was established in 1976 with AID assistance. It is a private company whose purpose is to market and sell non-clinical contraceptives through commercial channels. It also helps NGOs to market contraceptives through their projects. After an encouraging start, CRS's expansion of services in urban areas has stagnated and it has not been successful in moving into rural areas. The problems that USAID has identified are a Board of Directors that does not support innovative approaches to problems and the lack of strong leadership. As a condition of continued support, the Cooperative Agreement between USAID and CRS will provide for more private sector participation on the Board. Also, the new agreement will require CRS to develop annual workplans that will be submitted to USAID for approval, and used to monitor managerial and other needed changes in CRS operation.

## V. EVALUATION, MONITORING AND AUDIT PLANS

### A. Monitoring

Primary responsibility for project monitoring by USAID will be with the Office of Health and Family Planning and with the USAID Project Committee. Project monitoring will be accomplished through site visits to Central Region activities and to activities that are national in scope (PP/MCH, malaria), and through routine progress reports provided by MOH counterpart offices and implementing agencies (NGOs). Consultations with MOH and NGO staff will also be used for monitoring purposes.

The annual workplans and budgets that will be developed and agreed upon by USAID and the CRHD, and PP/MCH, NMEC, CDD, etc., within the Public Health Division of the Central Ministry will provide yearly updated criteria against which the project's accomplishments and problems will be assessed.

Reports from the MOH and TA contractors will also provide monitoring information. The MOH units implementing portions of the project will be required to prepare trimester Progress Reports as part of the annual workplans that will be used in reviewing and developing future Workplans and Budgets. Contractors will prepare progress reports and trip reports. MOH, NGO and TA contractor reports will contain fiscal information that will be used in financial monitoring.

Surveys will also be used for monitoring. A two stage national sample survey of health and family planning indicators (funded by UNFPA with assistance from the centrally funded Demographic Health Surveys [DHS] II Project) will be conducted during this five year project (to begin in 1990/91). Sample surveys are also planned to monitor progress and verify service statistics for EPI, CDD and family planning programs. Finally, the possibility of using information collected in the 1991 census will be investigated.

The Donor Coordinating Committee will provide a way to track inputs from other donors into the CRHD and its 19 districts, as well as assistance provided to other parts of the health sector.

### B. Evaluation

USAID, selected representatives of the national level MOH, the CRHD, and PP/MCH, CDD, and NMEC from the Public Health Division will conduct annual internal project reviews in the process of negotiating the annual workplans.

In addition to these reviews, two project funded external evaluations will be conducted. These evaluations will be carried out by teams of U.S. and Nepalese consultants contracted by USAID in consultation with the MOH. The possibility of participation by the MOH Policy, Planning, Monitoring and

Supervision Division (PPMSD) will be considered, to include representation for the MOH policy of regionalization, integration, and Basic Needs.

The first evaluation will be conducted approximately two years into the project. This evaluation is considered to be extremely important, as it will concentrate on the status of the CRHD and, more broadly, whether the MOH has taken the steps needed to ensure the success of regionalization and decentralization. This information will be used to decide if continuation of the project as initially designed is possible or if a redesign is necessary. Specifically, the evaluators will review:

- whether firm guidance has been given to the heretofore "vertical projects" to provide their full support to the CRHD;
- whether the role of the CRHD has been clearly articulated as the entity responsible for implementation of all health program activities in the region and planning and budget authority given; and
- whether the CRHD has an adequate degree of control over personnel assignments/decisions in the region.

This evaluation will also review progress under the four major elements of the project: CRHD, child survival interventions, family planning, and malaria. For the CRHD, the evaluators will consider whether:

- the management capacities of the CRHD are being significantly improved;
- the project is making as much progress in strengthening the districts' capabilities as it is making in strengthening the CRHD's; and
- the CHV program is receiving the direction and support that it needs from the MOH, and district and local units.

In addition, evaluators will assess the status of the CDD, EPI, PP/MCH and malaria activities in the Central Region (and other districts included under national-level activities).

For child survival interventions, the evaluators will review:

- progress made in training MOH staff, CHVs, pharmacists and school teachers in diarrheal disease prevention and ORT;
- the trial introduction of a 500 cc ORS packet and container in two districts, and plans for expansion nationwide;

- the sustained progress in implementing standard supervisory systems;
- progress in integrating ARI, EPI and FP activities into routine service delivery;
- progress with diarrheal disease research and status of plans for the national diarrheal disease survey;
- effectiveness of CRS sales of ORS and project supported NGO/PVO CDD programs;
- progress in developing communication/education activities in support of CDD, EPI, and ARI activities;
- usefulness of small studies and surveys intended to improve EPI program performance;
- status of NGO pilot ARI activities; and
- progress towards a functional tiered ARI detection and treatment system piggy-backed on that for CDD.

Regarding family planning activities, the evaluators will consider:

- whether adequate progress has been made with the IE&C program;
- how institutionalization of clinical family planning services in static facilities is progressing;
- progress in implementing the tiered system of service provision and referrals, and in institutionalizing services in general;
- progress in shifting method mix while increasing contraceptive prevalence;
- progress in putting an information system in place that will allow the tracking and follow-up of continuing users;
- the efforts of CRS to expand urban markets and move into rural areas; and
- the participation of NGOs and the private sector in Nepal's family planning effort.

In reviewing malaria activities, the evaluators will review the following:

- status of the construction/renovation of the research and training center;

- progress achieved in entomologic activities;
- status of decentralizing laboratory capabilities; and
- the adequacy of the training programs and support for Passive Case Detection Volunteers (PCDVs).

Finally, the evaluation team will point out areas that are not covered in the project's logical framework but should be looked at in the final evaluation.

The project's final evaluation will take place early in the final year of implementation so that evaluation results can be used in the design of continued USAID support to the health sector, if USAID decides that this is appropriate. This evaluation will be a review of progress made in achieving the project purposes as described in the logical framework and will consider any questions that the previous evaluation raised for inclusion in the final evaluation.

#### C. Audit

It is anticipated that the AID Inspector General will be requested to perform a general audit of the project sometime during its implementation. HMG will undertake regular audits of the local currency financing for the project and will provide USAID with reports on these audits. The Financial Management Office of USAID will also periodically conduct financial reviews, particularly of the local currency accounts.

Audits of U.S. technical assistance contractors are normally conducted in the U.S. by the Defense Contract Audit Agency.

In addition, project funds have been budgeted for an audit of project activities using the services of a contract audit team.

VI. Implementation Plan

A. Implementation Schedule

	<u>Activity</u>	<u>Units</u>	<u>Date</u>
1.	PP Approval	USAID Committee	December, 1989
2.	Project Authorization signed; Project Agreement signed with MOH; PIL and PIO/T issued	DIR, MOH, HPP	March, 1990
3.	RFP prepared/issued	PROC, HPP	March - April, 1990
4.	Bids received/reviewed	PROC, HPP, MOH	May - June, 1990
5.	PSC hired	PROC, HPP	June, 1990
6.	Individual 1990-91 Workplans developed	MOH (CRHD, PHD, PP/MCH, EPI, NMEO), HPP and Contractor	June, 1990
7.	Project implementation begins (and new agreements with CRS and NGOs)	HPP, MOH, PROC	July 15, 1990
8.	CBD Notice on NRTC construction	PROC, NMEO, HPP PPD/E	September, 1990
9.	TA Contract Awarded	TA Contractor	Oct. - Nov. 1990
10.	A & E Consulting Firm selected for NMEO/NRTC	NMEO, PPD/E	December, 1990
11.	TA Contractors arrive in-country	TA Contractor	Dec. - Jan. 1991
12.	Budget estimates for 1991-92 workplans prepared	MOH (CRHD, PHD, PP/MCH, EPI, NMEO), HPP, TA Contractor	January, 1991
14.	Individual workplans developed	as above	June, 1991
15.	MOH adaption of policy on public health training for managers	MOH, HPP	July, 1991
16.	NMEO/NRTC construction contract awarded	NMEO, PPD/E, HPP	Sept. - Oct., 1991
17.	Public Health training (IOM) begins	MOH, IOM	September, 1991

18.	NMEO/NRTC construction begins	Contractor; NMEO, PPD/E, HPP	Nov. - Dec., 1991
19.	Budget estimates for 1992-93 CRHD concerted, and national level, workplans prepared	MOH (CRHD; PHD, PP/MCH, EPI, NMEO) and HPP	January, 1992
11.	MOH provides authorities for budgeting, personnel and planning to regional directorates	MOH, HPP	May, 1992
20.	Workplans prepared	MOH and HPP	June, 1992
21.	Mid-Term Evaluation	USAID (HPP and PD), MOH	September, 1992
22.	Second year IOM training	MOH, IOM	September, 1992
23.	Project direction revision	HPP and MOH, TA Contractor	Oct.-Nov. 1992
24.	Budget estimates for 1993-94 CRHD and relevant workplans prepared	MOH; HPP and TA Contractor	January, 1993
25.	NMEO/NRTC construction completed	Contractor; NMEO, PPD/E, HPP	June, 1993
26.	Individual workplans prepared	MOH, TA Contractor HPP	June, 1993
27.	Third year IOM training	IOM, MOH	September, 1994
28.	Workplan budget estimates for 1994-95 prepared	MOH, HPP, TA Contractor	January, 1994
29.	Individual workplans prepared	MOH, HPP, TA Contractor	June, 1994
30.	Final year IOM public health training	IOM, MOH	September, 1994
31.	Final Evaluation	MOH, USAID	April-May 1995
32.	TA Contractor depart, project ends		July, 1995

## B. Implementation and Management Responsibilities

### 1. HMG and Counterpart Project Management

The HMG entity responsible for implementing the Child Survival/Family Planning Services Project will be the Ministry of Health (MOH). Upon reorganization in 1987, and as currently constituted (but not exactly administered in accordance with the MOH organization chart), one Additional Secretary is responsible for non-technical health activities under Basic Needs; another is responsible for technical services for overall public health and curative activities. Other MOH officials, at the Joint Secretary and Chief of Division levels, head various divisions or entities within the MOH structure. The Chief of the Policy, Planning, Monitoring and Supervision Division is responsible for overall planning, for compliance of planned activities with development budgets and for overseeing data related to these functions. The Chief of the Public Health Division oversees CDD, ARI, EPI, nutrition, malaria control and other (previously) "vertical" project activities, each with its own division or section head. The Chief of PP/MCH oversees family planning activities nation-wide. While still a "project" within the MOH, FP/MCH will be placed under the Public Health Division in 1990. Respective division/section heads will be responsible for day-to-day implementation of project Components 2, 3 and 4.

Responsibility for implementation of the Central Region Management/Service Delivery Improvement component will rest with the Regional Director of the CRHD. This individual will delegate day-to-day implementation responsibilities to an appropriate member of his/her staff primarily under the public health, and planning, implementation, coordination and monitoring sections (see Ministry and Regional Health Directorate Organization Charts, in section on Administrative/Institutional Analysis.)

### 2. USAID Project Management

USAID's Office of Health and Family Planning (HFP), currently staffed by two USDH Project Officers, will be responsible for implementation and monitoring of the CS/PPS project and will supervise the various elements of the project, including technical assistance, workplan development and reporting, participant training, NGO activities (grants and Cooperative Agreements) and procurement of selected commodities. A USAID/HFP Office project commodity procurement tracking system will be established, in conjunction with the TA contractor. One PSC will be required to serve as an additional "Project Administrator" with major responsibilities being to assist with the administration, implementation and evaluation of project activities. Considerable interfacing with the host government and the prime TA contractor will be required.

A USAID Project Committee has been established to provide review, policy guidance and implementation support within USAID

for the CS/PPS project. The USAID Office of Financial Management will provide financial management for disbursement of USAID funds. The USAID Executive Office will provide support for contracting and limited procurement activities. Participant training support and overall program and budget coordination within USAID will be provided by the Office of Program and Project Development.

### 3. Technical Assistance Contractor

The Contractor will be responsible to the USAID/HPP Office for contract performance to be spelled out in the technical assistance contract. The Contractor will advise and assist various levels of MOH officials and USAID to expand the coverage and quality of health and family planning services through both integrated and remaining "vertical" delivery systems. All members of the team will be responsible for advising MOH officials at various levels who are involved with implementing the project's priority activities. All team members will spend a substantial amount of time in the field to ensure that systems modifications for service delivery expansion, supply, logistics, training, etc. are properly tested, evaluated and implemented under field conditions.

The contractor will also be responsible for the following:

- all procurement actions related to the project (see Procurement Plan, VI. D., and Annex J), with the exception of centrally procured contraceptive supplies and all vehicles (which will be the responsibility of the USAID/HPP Office), and project commodity tracking;
- the identification and scheduling of, and scope of work preparation for (in consultation with the MOH and USAID/HPP) all short-term consultants, and all travel arrangements and required clearances;
- technical oversight, with USAID/HPP, of all Grants, Cooperative Agreements, buy-ins to ST projects etc., under the CS/PP Project, as defined by USAID/HPP;
- arranging and supporting, through assisting with the development and implementation of annual workplans, of all in-country training; and of public health training at the IOM, in consultation with USAID and HMG/MOH;
- all steps for contracting actions with local firms/consultants as required under the contract to implement project activities, in consultation with USAID and MOH.

Relationships with USAID officers and HMG/MOH counterparts will be detailed in the technical assistance contract. Scopes

of Work for technical assistance personnel are outlined in VII., Annex G.

### C. Contractor Selection

USAID will contract directly with a U.S. firm to provide technical assistance, training and commodities (other than contraceptives and vehicles) based on the project design. The firm (or group of firms) winning the contract will be expected to sub-contract, as required, with Nepalese firm(s) to provide local consultants, in-country training and selected support services.

As much of the components' activities are long-term, institution-building support, and are dependent on HMG support for authorities delegated to the appropriate level(s) within the health system, contractor personnel must have considerable professional stature and experience in advising foreign officials. Technical advisors must have strong technical qualifications and, as importantly, a working style that will be effective in Nepal's complex cultural context.

Given the specialized technical assistance requirements of the project, the degree to which project success depends on the caliber of a select group of individuals, and the difficulties that many contractors have faced in staffing and implementing projects in Nepal, it is the intent of both USAID and MOH to rely on fully open competition, to advertise widely for provision of these services and to place particular emphasis on prior relevant experience. Small businesses and women or minority-owned firms will be encouraged to offer proposals for this contract individually, or in association with other firms. Bids, including participation of such firms, will be given preference, all other factors being equal.

Host country contracting was considered and determined not to be appropriate for this contract. The MOH has not had experience in negotiating and administering this type of contract with a U.S. firm, and prefers to have USAID assume administrative responsibilities for the contract.

It is anticipated that contract evaluation, selection and negotiation will be done in Kathmandu by USAID and HMG/MOH.

### D. Procurement Plan and Waiver Requirements

This section reviews each of the categories of goods and services to be procured for the Project and describes the methods to be used, the parties responsible, estimated timing of each major procurement, and identifies any waivers required.

#### 1. Technical Assistance

##### a. Institutional Contractor

The institutional contractor will provide 15 person years

of long-term expatriate advisers, 60 person-months of short-term expatriate consultants, and will subcontract an estimated 60 person-months of short-term local consultants. The contract will include local administrative, secretarial and support staff. These services will be obtained through full and open competition among U.S. firms.

Solicitation of offers for a TA contractor will include a request for information regarding procurement capabilities and past purchasing experience (see below). The USAID Contracting Officer (PROC) will be responsible for preparation of the Request for Proposal (RPP), in collaboration with HPP. The RPP will be prepared by HPP and PROC during February - March and issued in April. Proposals will be received in Kathmandu in June and reviewed by USAID and MOH, and a contract will be awarded by August 30, 1990.

b. Buy-ins to AID/W, Science & Technology Bureau Projects.

The Project will supplement the services provided by the institutional contractor with approximately 60 person months of specialized short-term consultant services from a number of S&T Bureau cooperative agreements/contracts. An illustrative list includes AVSC, JHU/PSC, Population Council, Rapid/Impact, Enterprise and SOMARC from ST/POP, and HealthCom, ChildTech, and VBC from ST/H. Most of those groups have already provided services to the IRH/PPS project and will be familiar with the issues and implementing agencies involved in this new Project. The HPP Office will prepare scopes of work and PIO/Ts for each buy-in.

c. Personal Services Contractor

USAID will also hire a personal services contractor (PSC) to administer and monitor the field activities of the MOH entities and the institutional contractor, and to assist them in the preparation of annual workplans (see VI. B. 2). The scope of work will be prepared by HPP during February - March and procurement will be handled by PROC according to prescribed competitive guidelines. The PSC will be selected by July 1990, to begin work by September. The initial contract will be for up to 2 years, renewable through the end of the project (5 years).

2. Training Services

The Project will include three types of training: short-term out-of-country training; short-term in-service training; and academic public health training at the Institute of Medicine (IOM). The USAID/PPD/Training Office will be responsible for arranging and supporting the out-of-country training, upon specific instructions of USAID/HPP and MOH. Appropriate AID participant training guidelines will be followed. The in-service and IOM training will be conducted according to normal HMG/MOH procedures, supported by Project financial and technical assistance. The institutional

contractor will have major responsibility for arranging and implementing this in-country training as stated in the contract and as defined by yearly workplans.

### 3. Equipment and Commodities

Overseas procurement of equipment and commodities will be handled both by USAID directly, and by the institutional T.A. contractor. The largest items will be procured by USAID. Contraceptive supplies (estimated \$2.9 million) will continue to be obtained through the central ST/POP system, via Contraceptive Procurement Table (CPT) summaries prepared by HPP. The vehicles (20 four-wheel drive all terrain vehicles, 1 bus and 5 motorcycles) will be purchased by USAID.

Responsibility for procuring all other dollar-funded and local currency equipment and supplies will be the responsibility of the institutional T.A. contractor who will act as the procurement and import agent for these commodities. This will include VSC and other clinical contraception equipment and supplies, computers, malaria program spraying and laboratory equipment and supplies, training and library materials, and some supplies related to the CDD field activities. The T.A. contractor will prepare a detailed plan for procuring all of this equipment and materials in close collaboration with USAID and the MOH.

A specific plan for purchasing the computer equipment will be prepared in accordance with the Guidelines for Managing Automation Assistance in AID Development Projects (September 1987). This plan will be reviewed by the USAID Systems Analyst for concurrence. The plan will not have to be approved by AID/W unless the total procurement is more than \$100,000. An automation analysis, however, will be submitted to Integrated Resource Management (IRM) in AID/W.

All vaccines and oral rehydration salts required for the EPI and regular CDD field-level activities will be supplied by UNICEF according to on-going HMG-UNICEF agreements. The 500 cc trial ORS packets and 500 ml containers will be purchased by USAID. The 500 ml containers for national follow-on, as required, will be funded by the project and purchased by the Contractor.

Any required special procurement assistance will be provided by the USAID Procurement Office. Local procurement will be conducted by the Contractor in conformance with applicable AID regulations and procedures. Annex J presents an indicative list by project component of equipment and commodities funded by the project. It does not include limited amounts of supplies and materials available on the local market which will be purchased under the Local Cost Support budget item.

A refined procurement list will be prepared and justified each year by the Contractor (excepting contraceptives and

vehicles) as part of detailed implementation planning. Exact details and/or specifications will also be part of the Project Implementation Orders for Commodities (PIO/Cs) prepared by the Contractor and submitted to USAID and the MOH for approval prior to procurement. In some cases (e.g; VSC and other clinical contraception equipment and supplies, malaria spray equipment), PIO/Cs will be prepared by the contractor in collaboration with the MOH and USAID for purchase through established AID/USG channels.

#### 4. Construction

USAID will contract directly with a local firm(s) for the renovation/construction of the National Malaria Research and Training Center. This will be handled by PROC and PD/Engineering which has appropriate engineering staff and extensive experience in project-funded construction. The construction contract will cover engineering TA, supplies, and all construction material costs, based on the construction plan (Annex I).

#### 5. Waivers

Waiver requirements will probably only extend to motor vehicles and possibly computers. Vehicles from Geographic Code 935 (1 bus and 20 4 wheel drive "jeep" type) will be procured through the "blanket waiver", which is provided annually for the region by the A.I.D. Administrator. Light-weight motorcycles (125 c.c. or less) are covered in the same waiver.

If a waiver is required for computers and ancillary equipment, this will be requested from the Mission Director per Delegation of Authority 652, Section 2.F. (2). As the Mission has been granted the right to procure other commodities from Geographic Code 941 countries, it is possible that no other waivers will be required.

#### E. Conditions and Covenants

##### 1. Conditions

USAID will include in the project authorization the following two essential conditions precedent which are considered critical to success of the project and of the CRS activity.

a. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, HMG/N shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., a statement of the name(s) of the person(s) authorized to represent HMG/N for the project together with a specimen signature of each person specified.

b. Prior to execution by A.I.D. of a Cooperative Agreement with the Contraceptive Retail Sales Co. (CRS), funded under the grant, CRS shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that CRS has adopted and implemented revisions to its Memorandum of Association and Articles of Association, as appropriate, to ensure effective private sector control of CRS.

## 2. Covenants

Further, in addition to standard covenants on evaluation and tax exemption, the Mission plans to include the following project-specific covenants in the terms of the project grant agreement. Although these covenants are important for project success, none is considered so essential as to be included in the project authorization.

Except as the Parties may otherwise agree in writing, HMG/N shall:

(a) submit, by December 31, 1990, an official plan for reorganization of the MOH which will provide for integration and decentralization of MOH services and functions;

(b) provide required financial support, as per the project budget, in a timely fashion according to mutually agreed upon annual workplans;

(c) provide financial and operational reports, on a trimester basis, on all project activities carried out by GON/MOH;

(d) provide a record of contraceptive distribution and storage handled by GON/MOH (for basic monitoring purposes), as well as equipment and supplies provided for malaria control and family planning activities, and vehicles supplied through the project;

(e) ensure that all critical staff positions at the Central Region Directorate and district levels have been filled;

(f) select and post required health staff, including Community Health Volunteers, in the outreach facilities supported by USAID through the project;

(g) require all District Public Health Officers (DPHOs) to complete diploma or post-graduate training in public health management/epidemiology and require all DPHOs trained under this project to return to their districts upon completion of training;

(h) beginning in the project's second year, permit grant funds to be provided directly to the Central Region Health Directorate (CRHD) in accordance with a Local Cost Support Workplan and delegate to the CRHD authority to plan, budget and

guide use of these funds and authority to make key officer level personnel decisions for managerial and service staff in the Central Region;

(i) authorize the Secretary of the Ministry of Health or his designee to approve the disposal of project property not required by the Ministry of Health, upon completion of the project.



His Majesty's Government  
MINISTRY OF HEALTH

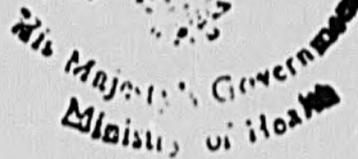
ANNEX A

2-16097  
2-12365  
2-14820  
2-11762

Ram Shah Path, Kathmandu  
Nepal.

Date April 27, 1990

Ref:- 2456



Mr. Kelly C. Kammerer  
Director, USAID/Nepal  
Rabi Bhawan, Kathmandu,

Ref: Child Survival/Family Planning  
Services Project (367-0157)

Dear Mr. Kammerer:

His Majesty's Government of Nepal, through the Ministry of Health requests the assistance of USAID/Nepal in carrying out the Child Survival/Family Planning Services Project. For this effort, assistance over the 1990-95 five year period with support of \$20,000,000 is needed. The Project's basic purpose is to improve the quality and coverage of child survival, family planning and selected malaria control services, and to improve the management and organizational practices affecting the delivery of those services.

We look forward to discussing the Project further with you at your earliest convenience.

Sincerely,

(Dr. S.P. Bhattarai)  
Chief

Manpower Development and Training  
Division,

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STATE 15763/01

PPD/AD

ACTION: AID-2 INFO AMB DCM FE (5)

ANNEX B

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PP RUFHAT  
DE RUEFC #5763/01 2142247  
ZNR UUUUU ZZR  
F 222422 AUG 89  
FM SECSTATE WASHDC  
TO AMEMBASSY BATHMANDU PRIORITY 9031  
BT  
UNCLAS SECTION 01 OF 02 STATE 245703

LOC: 143 395  
03 AUG 89 0235  
CN: 25665  
CBRG: AID  
DIST: AID

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: NEPAL CHILD SURVIVAL/FAMILY PLANNING SERVICES (367-0157)

1. SUMMARY: AME/PRC MET JUNE 22 TO REVIEW SUBJECT PID. THE BUREAU COMPLIMENTS THE MISSION ON A TECHNICALLY SOUND DOCUMENT. THE PID IS APPROVED AND YOU MAY PROCEED WITH PP DESIGN AND AUTHORIZATION SUBJECT TO THE GUIDANCE PROVIDED BELOW.

2. OPERATIONAL AND POLICY AGENDA: THE PROJECT, AS PROPOSED, PLACES US SQUARELY IN THE MIDDLE OF THE NEPAL HEALTH SECTOR DURING A TIME OF MAJOR STRUCTURAL CHANGE. ACCORDINGLY, THE PROJECT SHOULD ENCOMPASS A MAJOR POLICY DIALOGUE ELEMENT. THE PROJECT SHOULD PRESENT A POLICY AGENDA AND OPERATIONAL GUIDELINES FOR ACHIEVING THE ADOPTION AND IMPLEMENTATION OF POLICIES RELEVANT TO THE ACHIEVEMENT OF OUR PROGRAM/SECTOR GOALS, ESPECIALLY THOSE RELATED TO THE SUSTAINABILITY OF THE NEPAL HEALTH CARE SYSTEM. THIS AGENDA WOULD INCLUDE POLICY ANALYSIS, ONGOING MONITORING OF SECTOR POLICIES, FORMAL DISCUSSIONS WITH THE GOV, DONOR COMMUNITY AND APPROPRIATE PRIVATE SECTOR ENTITIES, AND ASSISTANCE, AS

NECESSARY, IN THE IMPLEMENTATION OF POLICIES. THE PP SHOULD INCLUDE THE FRAMEWORK FOR ACHIEVING OUR OBJECTIVES AND POLICY BENCHMARKS SO THAT OUR EFFORTS CAN BE MEASURED. POLICY AREAS MAY RELATE TO PUBLIC AND PRIVATE SECTOR HEALTH CARE FINANCING AND SERVICE DELIVERY, PRIVATIZATION OF THE CONTRACEPTIVE RETAIL SALES COMPANY (CRS) (WHICH YOU ARE ALREADY PURSUING), CENTRALIZATION/DECENTRALIZATION, STAFF DEVELOPMENT, BUDGET PRIORITIES, ETC; THE IMPORTANCE OF THE POLICY ELEMENT OF THE PROJECT WAS DISCUSSED WITH DEPUTY DIRECTOR RHODES AND OTHER MISSION REPRESENTATIVES.

3. DURING THE PRC, MISSION PRESENTED THE PROPOSED PROJECT IN THE CONTEXT OF ONGOING ACTIVITIES, THE RECENTLY APPROVED EXTENSION AND THE 1988 EVALUATION OF INTEGRATED RURAL HEALTH/FAMILY PLANNING SERVICES PROJECT. THIS PRESENTATION INCLUDED A DISCUSSION OF THE (1) IMPROVING POLICY ENVIRONMENT, (2) ORGANIZATIONAL CHANGES NEEDED TO ESTABLISH A VIABLE BASIC HEALTH CARE

	INCOMING	
ACTION	OFFICE	
	AD	✓
	PPD	✓
	PPD/HR	
✓	PPD/PU	
	PPU/PRC	✓
	PPD/ECON	
	ARU	
	WFP	✓
	FM	
	RMS	
	EXO	
	PER	
	TRV	
	GSO	
	PRC	
	PPR	✓

SYSTEM CONSISTENT WITH THE MISSION'S (CHILD SURVIVAL AND FAMILY PLANNING) STRATEGIES, AND (3) GON'S RECENT PROGRESS IN ASSUMING AN INCREASED SHARE OF GENERAL OPERATING/RECURRENT COSTS. PP SHOULD DISCUSS IN DETAIL LESSONS LEARNED FROM PAST EXPERIENCE AND HOW THEY ARE BEING APPLIED IN THIS PROJECT THROUGH PROJECT INTERVENTIONS AND POLICY DIALOGUE.

4. PP SHOULD SPECIFICALLY ADDRESS SHORT TERM CONSTRAINTS BROUGHT ABOUT BY CURRENT ECONOMIC CRISIS FACING NEPAL. HOW WILL PROJECT DESIGN ACCOMMODATE THIS, HOPEFULLY, SHORT TERM SITUATION? WHAT WILL THE EFFECTS BE ON COUNTERPART BUDGET COMMITMENTS AND LONG TERM SUSTAINABILITY IN THE FACE OF PROBABLE BUDGET CUTS? SEVERAL MEMBERS OF PRC THOUGHT THIS AUSTERITY SITUATION MIGHT PROVIDE A UNIQUE OPPORTUNITY TO PRESS FOR PROGRAM EFFICIENCIES AND WAYS TO PUSH SOME SECTOR COSTS OFF BUDGET. FOR EXAMPLE, MISSION MAY WISE TO PRESS MORE AGGRESSIVELY FOR PRIVATIZATION OF CRS PROGRAM. PRC ALSO FELT THERE MIGHT BE GREATER OPPORTUNITIES FOR DONOR COORDINATION IN SEEKING A SHARED POSITION. MISSION MAY WANT TO PRESS FOR JAPAN/SE TO TAKE OVER CERTAIN ASPECTS OF PROGRAM, E.G., THE CONSTRUCTION ELEMENTS OF THE MALARIA CONTROL COMPONENT. TO THIS END, BUREAU WOULD BE WILLING TO APPROACH TOYO TO ENCOURAGE THEIR FAVORABLE MOVEMENT IN THIS DIRECTION. PLEASE ADVISE YOUR THOUGHTS ON ABOVE AND WHETHER YOU WOULD LIKE BUREAU TO INTERVENE.

5. INTEGRATED THROUGHOUT THE ISSUES DISCUSSED AT THE PRC AND THE GUIDANCE PROVIDED IN THIS CABLE IS THE MAJOR QUESTION OF SUSTAINABILITY. WE REALIZE MISSION IS EQUALLY CONCERNED ABOUT THIS FEASIBILITY ISSUE AND THAT YOU HAVE MADE SOME POSITIVE PROGRESS IN DISCUSSIONS WITH GON. WHILE A DIFFICULT AREA TO PROMOTE IN NEPAL, THE BUREAU FIRMLY BELIEVES THAT GIVEN GON RESOURCE CONSTRAINTS, EVERY EFFORT MUST BE MADE TO INCREASE UNDERSTANDING OF HEALTH FINANCING ISSUES AND TO MOBILIZE NON-GOVERNMENT RESOURCES TO HELP FINANCE HEALTH CARE. THIS SHOULD BE INCORPORATED IN PROJECT DESIGN AND PURSUED THROUGH PROJECT IMPLEMENTATION.

6. ADDITIONALLY PP SHOULD ADDRESS HOW PROJECT IS ADDRESSING PROBLEMS INHERENT IN EFFORTS TO DECENTRALIZE, REGIONALIZE AND INTEGRATE HEALTH CARE DELIVERY SYSTEMS E.G. AVAILABILITY OF LOCALLY SKILLED HEALTH CARE AND ADMINISTRATIVE PERSONNEL THROUGH TRAINING, AND USE OF VOLUNTEERS.

7. RE: MALARIA CONTROL EFFORTS, PRC ENCOURAGED MISSION TO MAKE MAXIMUM EFFORTS TO SOLICIT OTHER DONOR (JAPAN

AND IERD) FUNDING FOR CONSTRUCTING AND EQUIPPING OF THE NATIONAL MALARIA TRAINING AND RESEARCH CENTER. PLEASE ADVISE HOW AID/V CAN ASSIST IN THIS EFFORT.

PRC WAS ALSO INTERESTED IN THE ROLE OF OTHER DONORS AND GOV STRUCTURE FOR MAINTAINING REASONABLE CONTROL OF OUTBREAKS AND FLARE-UPS IN A DECENTRALIZED ADMINISTRATIVE FRAMEWORK. PP SHOULD DISCUSS THIS CONCERN.

8. THE MISSION INDICATED IN THE PID, THAT WITHOUT A THIRD EPN DIRECT HIRE, IT MIGHT HAVE TO REDUCE THE SCOPE OF PROJECT ACTIVITIES. ANE WILL NOT APPROVE A THIRD EPN DIRECT HIRE FOR THIS PROJECT. THE MISSION IS REQUESTED TO CONSULT WITH THE BUREAU ON ANY CHANGES IN THE SCOPE OF THE PROJECT OR MANAGEMENT STRUCTURE WHICH ARE SIGNIFICANTLY DIFFERENT THAN CONTAINED IN THE PID.

9. PRC ALSO FELT U.S. DOLS 30,000 IN PDS FOR PROJECT DESIGN IS INADEQUATE GIVEN THE COMPLEXITY OF THE PROJECT AND WE SUGGEST YOU MAY WANT TO REQUEST ADDITIONAL FUNDING. BAKER

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STATE 245783/02

83

USAID's Comments on PID Approval Cable

State 245783, dated 8/2/89

Subject: Nepal CHILD Survival/Family Planning Services (367-0157)

The following text repeats the PID approval cable paragraphs as numbered in the original, and provides USAID's discussion on each point:

Para 2. "Operational and policy agenda: The project, as proposed, places us squarely in the middle of the Nepal health sector during a time of major structural change. Accordingly, the project should encompass a major policy dialogue element. The project should present a policy agenda and operational guidelines for achieving the adoption and implementation of policies relevant to the achievement of the program/sector goals, especially those related to sustainability of the Nepal health care system. This agenda would include policy analysis, ongoing monitoring of sector policies, formal discussions with the GON, donor community and appropriate private sector entities, and assistance, as necessary, in the implementation of policies. The PP should include the framework for achieving our objectives and policy benchmarks so that our efforts can be measured. Policy areas may relate to public and private sector health care financing and service delivery, privatization of the Contraceptive Retail Sales Co. (which you are already pursuing), centralization/decentralization, staff development, budget priorities, etc. The importance of the policy element of the project was discussed with Deputy Director Rhodes and other Mission representatives."

USAID Comment: As discussed during the PID review, HMG/MOH has made some major policy changes over the past two years: integration of the health services has been accepted as the official structure and the MOH is restructuring accordingly; the MOH is being regionalized with the Regional Directors given the responsibility for administering the integrated program; and a program is being developed that will place Community Health Volunteers in most communities.

These policies are part of a plan to phase out the traditional vertical programs and develop an integrated system. Even though these are government policies, their implementation will be difficult. USAID sees an opportunity here, not to push for new policies, but to help guide the implementation of already established policies that were judged sound in the last project evaluation. The two areas where USAID can assist are at the two ends of the operational system, i.e., the (Central) Regional Health Directorate, and the CHV program.

The project's policy focus will be on the development of a

84

regionalized, integrated delivery system in Nepal's Central Region, by strengthening the 19 districts and by assisting the head (CRHD) and the tail (CHVs) of the system find their appropriate roles.

USAID policy objectives for the CRHD include delegation of planning and budget authority; an adequate budget for its own operations; a full complement of staff; adequate control over personnel within the Region; and the support of the national level technical offices (heretofore "vertical programs") in developing an integrated service delivery system.

For the CHVs, USAID's objectives are to pace the implementation of the program so that the MOH's and NWO's support capabilities are not stretched too thin; prioritize and simplify the tasks the CHVs are expected to do; and test different types of training and support systems before national implementation is attempted.

There are a number of issues that have been identified during project design that will be set as conditions to be met before project activities start, or which will be the subject of a policy dialogue process built around the negotiation and approval of annual workplans and budgets. The following discussion will cover these issues by project component, i.e., CRHD, FP/MCH, child survival activities, NMEO.

As a condition to beginning assistance to the CRHD, the MOH will agree to allow USAID funding for local costs to go directly to the CRHD (by year 2 of project implementation). Thus, funds for family planning, CDD, etc. activities in the Central Region will not go to the central Ministry's "vertical" offices. This will put funding behind an integration and decentralization process that has been to date largely on paper, and will strengthen the position of the CRHD within the MOH. Other issues that will be addressed through a policy dialogue that is carried out during workplan/budget negotiation will include:

- continued full staffing for the CRHD;
  - agreement on position descriptions for all CRHD staff slots;
  - continuation of at least present staffing levels in the 19 districts;
  - better definition of the roles and responsibilities of the CRHD;
  - allocation of adequate training and supervisory budgets to the CRHD;
  - delegation of planning and budget authority to the CRHD and the districts;
  - delegation of personnel decisions regarding gazetted officers to the Regional Director;
  - support from the national level technical offices for integration; and
  - reasonable implementation pace and adequate support for the CHVs.
- 85

As a condition to beginning the post-graduate training in public health management and epidemiology for DPHOs and DPHO candidates, the MOH will agree to make this training a prerequisite for assignees to DPHO positions.

For FP/MCH activities there are no conditions for initiation of support under this new project. There are, however, issues that will be pursued through the annual workplan/budget negotiation process:

- continued support for integration in the Central Region (and other districts in general);
- progress in developing a multi-method approach to family planning services;
- institutionalization of VSC capabilities and progress in providing other forms of contraception in hospitals and selected health posts, including quality control system development;
- development of a Central Region logistic system that keeps hospitals, health posts and CHVs supplied with contraceptives;
- development of a reporting system that allows follow-up of continuing users; and
- promotion of private sector participation in the family planning effort.

As a condition to signing a new Cooperative Agreement with CRS, USAID will require that the Board of Directors' operations be significantly privatized, and that MOH shares in CRS and representation on the Board be decreased. The workplan process will be used to insure that there is:

- continued management improvement; and
- progress towards privatization and generation of additional resources.

For child survival activities, USAID is in agreement with the approaches being taken by the MOH. The only aspects of these programs that are necessary to pursue at this time through policy dialogue are:

- continued support for integration, particularly in the Central Region;
- agreement to piggy-back some ARI trials on the CDD management and supervisory systems;
- rapid implementation of the 500 cc ORS packet standard and containers if the trials are positive; and
- field trials to see if EPI workers can distribute vitamin A without impinging on their other responsibilities.

For NMEQ, USAID also has little new to pursue of a policy nature. These include:

- continued support for integration, especially in the Central Region;

- inclusion of funds in NMEO's budget to cover the operation of the Training Center; and
- GON's need to become more proactive, and contribute some of its own resources in assuring an adequate supply of the most appropriate insecticides.

Para 3. \*During the PRC, Mission presented the proposed project in the context of ongoing activities, the recently approved extension and the 1988 evaluation of Integrated Rural Health/Family Planning Services project. This presentation included a discussion of the (1) improving policy environment, (2) organizational changes created to establish a viable basic health care system consistent with the Mission's child survival and family planning strategies, and (3) GON's recent progress in assuming an increased share of general operating/recurrent costs. PP should discuss how lessons learned from past experience are being applied in this project through project interventions and policy dialogue.\*

USAID Comment: USAID has been involved with the health sector in Nepal since the 1960's. There are many lessons learned, one of which is that the health sector in Nepal has changed as much over this period as the health care system in the U.S. has changed. Some of the old lessons no longer apply, and there surely will be new lessons emerging for this project. There are a number of experiences that have led to particular approaches being taken under this project. The most important ones are as follows:

- Despite all the ups and downs of the integration process, eventually integration will happen, primarily for economic reasons.
- A project focus on national level management is short sighted. Central units in the MOH get shifted and reorganized. It is the district and the health post staffs that should be the "constants" in the system. They, in the end, will make the system work and support to them should receive priority.
- Geographically, Nepal is a very difficult country in which to work. The projects that have succeeded have had a limited geographic focus.
- Numerous schemes have been tried to get services out beyond the health post. The present CHV program is one of the better conceived ones and employs local women. The successes and failures of previous efforts will be studied and the results used in refining the CHV program.
- The EPI program in Ghorka district that Save the Children-USA is implementing is currently shifting from a vertical mode of operation to integrating itself into the regular health care system. Experiences from Ghorka will be used in integrating EPI in the Central Region.

- From the perspective of achieving results in the short term (5 years), it is best to work with organizations that have some strengths. Large amounts of money and time can be spent trying to improve the performance of weak organizations, sometimes with minimal results. Consequently, this project will focus on the Central Region. When activities spread beyond the Central Region (for example, establishing institutionalized VSC capabilities, or developing a tiered system for family planning service delivery), USAID will work with districts where the chances of success are good, i.e., certain criteria will have been met.

- Signing a Project Agreement with GON/MOH and then having to follow it for five years minimizes USAID ability to negotiate on important issues. The experiences over the past two years with negotiating annual workplans and budgets with operational units of the MOH (CRHD, CDD, PP/MCH, etc.) has provided USAID with much more leverage, has facilitated implementation and will be continued.

Para 4. \*PP should specifically address short term constraints brought about by current economic crisis facing Nepal. How will project design accomodate this, hopefully, short term situation? What will the effects be on counterpart budget commitments and long term sustainability in the face of probable budget cuts? Several members of the PRC thought this austerity situation might provide a unique opportunity to press for program efficiencies and ways to push some sector costs off budget. For example, Mission may wish to press more aggressively for privatization of CRS program. PRC also felt that there might be greater opportunities for donor coordination in seeking a shared position. Mission may want to press for Japanese to take over certain aspects of the program, e.g, the construction elements of the malaria control component. To this end, Bureau would be willing to approach Tokyo to encourage their favorable movement in this direction. Please advise your thoughts on above and whether you would like Bureau to intervene.\*

USAID Comment: The present economic crisis caused by the trade and transit difficulties with India renders obsolete all earlier macro-economic analyses and projections for economic growth, HMG revenues, and expenditures for the project period. At best, the current situation will cause only near-term economic and budgetary problems and will not adversely affect the Government's ability to support the project over its five year life. However, near-term dislocations could cause delay in project start-up if counterpart funds are unavailable for the first year's activities. At worst, the crisis could cause long-term retrenchment of government expenditures for social programs and preclude project implementation completely, or cause the MOH to request that a portion of USAID funds be devoted to direct budget support to sustain current levels of activity, or highest priority components.

56

In view of this situation, several assumptions and conclusions are made which guide the design of the project. First, the MOH projections for economic growth and budget expenditure expansion, and the health/family planning performance targets which are dependent on the former, are no longer relevant. Secondly, USAID assumes that the current MOH budget and sanctioned post levels will not increase, at least for the next two years. Thirdly, health and family planning activities which are not already priority elements of the Basic Needs Program will probably not be launched or expanded over the next two to three years. In short, the project will concentrate on strengthening performance and productivity of those high priority programs for which staff and essential funding presently exist (family planning, child survival, CHVs, the Central Region Health Directorate, and parts of the malaria program). This period of austerity will actually present an opportunity for the HMG to take advantage of this project's emphasis on productivity and effectiveness to make difficult but necessary managerial and service delivery reforms.

Re increased donor coordination, USAID has consistently tried to interest the Japanese in, specifically, aspects of the malaria program. To date, there has been no positive response. However, the Japanese have just recently (and tentatively) re-initiated a dialogue on collaboration with USAID on malaria activities. USAID will once again propose that the Japanese consider taking over certain aspects of the program, e.g., the construction/renovation of the NMEO NRTC, procurement of spraying and safety equipment/supplies, etc. Based on past experience, however, we cannot say for sure that the Japanese will respond favorably.

Para 5. "Integrated throughout the issues discussed at the PRC and the guidance provided in this cable is the major question of sustainability. We realize Mission is equally concerned about this feasibility issue and that you have made some positive progress in discussions with the GON. While a difficult area to promote in Nepal, the Bureau firmly believes that given GON resource constraints, every effort must be made to increase understanding of health financing issues and to mobilize non-government resources to help finance health care. This should be incorporated into project design and pursued through project implementation."

USAID Comment: The project's efforts at cost effectiveness analysis of different services and different delivery modes is designed to produce information that will assist the MOH make decisions on how most effectively to use what resources they have available for primary care. The Government has a large investment in manpower and facilities and, given the economic situation in Nepal, they must be used well.

The Government is quite aware of the health care needs in

81

the country and the inadequacy of government revenues to meet these needs. This is one of the reasons that such a large piece of the MOH budget (particularly the development budget) is donor financed. The Government can be expected to continue to seek donor assistance in this sector. Given past experience, they can be expected to attract more resources than they will be able to spend well.

The Government is also aware of the role the private sector can play in the health sector. As a part of the Basic Needs Program, the Government will be working with the private sector to:

- train TBAs;
- increase knowledge of the need for decreasing population population growth rates;
- set conditions for the development and extension of private health organizations;
- formulate programs and policies to encourage private sector entrepreneurs to produce medicines and medical equipment; and
- formulate policies to encourage private sector establishment and operation of health posts.

Some of these ideas are already taking hold in the Kathmandu valley. There are now numerous "nursing homes" which are basically private clinics, some with in-patient capabilities. The first private "Fertility Clinic" just opened in Kathmandu. It will provide VSC and other family planning methods and also assist with infertility problems. Since 1982, the MOH has been running a training program for drug retailers. Over 2,500 individuals have already been trained.

USAID plans to continue to watch developments in these areas. The Innovative Activities sub-component of the project can be used to provide funding for studies or trials of some of these ideas in addition to a possible demand (utilization) survey that will be discussed with the MOH. The project will also monitor the overall pharmaceutical situation in the country. Previous analyses sponsored by AID confirmed that Nepal has an almost completely free market in pharmaceuticals, that most drugs are imported from India, and that a very large percentage are tonics and other over-the-counter items that are of dubious value. There may be potential assistance that we can provide in the area of pharmaceutical importation policies.

The focus of this project is on improving the management and delivery of services through the infrastructure that HMG/MOH has spent the past 20 years creating. As such, we do not see a major private sector thrust as appropriately fitting into this project. Investigations under the past project pointed to fees based on sliding scales in hospitals and charges for drugs in health posts and other facilities to be the most feasible health care financing opportunities in Nepal at this time. This project will investigate the potential for fees for drugs in the Central

Region, both for drugs provided by CHVs and through static facilities. The current program in Kavre District is particularly relevant.

As this project does not have a large focus on hospitals, we do not foresee becoming involved with hospital policy and management issues such as fee for service programs. The project will develop employer-provided health and family planning services in several large industries in Nepal and will assist in the establishment of private family planning clinics. These are relatively small steps into some of the health care financing issues, but seem to be appropriate given the current situation in Nepal.

We feel that the potential pay-offs of health care financing activities, beyond what is already planned for this project, are difficult to determine and are not particularly appropriate for bilateral funding in Nepal. When ANE/TR develops its new regional project, which we understand will have a large health care financing component, we anticipate requesting that that project look into health care financing in Nepal.

Para 6. "Additionally PP should address how project is addressing problems inherent in efforts to decentralize, regionalize and integrate health care delivery systems, e.g. availability of locally skilled health care and administrative personnel through training, and use of volunteers."

USAID Comment: The project will provide technical assistance and training targeted on the process of regionalization and integration. The policy dialogue process (see above) will be used to help ensure that the people are there to be trained, that the necessary delegations of authority are provided by the central Ministry, and that staff and budget are phased over from the "vertical projects" into the Central Region's program.

Para 7. "Re: malaria control efforts, PRC encouraged Mission to make maximum efforts to solicit other donor (Japan and IBRD) funding for constructing and equipping of the National Malaria Training and Research Center. Please advise how AID/W can assist in this effort. PRC was also interested in the role of other donors and GON structure for maintaining reasonable control of outbreaks and flare-ups in a decentralized administrative framework. PP should discuss this concern."

USAID Comment: As discussed in the Donor Coordination section of the PP, despite frequent interaction between USAID and the Japanese, long term plans have not become clear and they remain an unlikely candidate for funding the NRTC. The IBRD is actively pursuing project design and is expected to provide assistance to NMEQ, most likely in "soft" loans for

insecticides. Although IBRD might be willing to support the NRTC, their project documentation process is not expected to be completed for at least 18 months and the NMEO needs the expanded training facility sooner rather than later, particularly in view of the inadequate conditions under which training and research for malaria control has been taking place. Also, as integration spreads, health post and district staff with little or no previous experience with malaria programs must assume responsibilities for malaria control activities. They need to be trained as quickly as possible.

The question about control of the malaria situation under a regionalized and integrated system is another aspect of the same problem. This training must take place so that the situation will be monitored adequately. NMEO will continue to provide technical back-up for district staff, but district staff must be adequately trained to ensure that they call in NMEO personnel when their assistance is needed.

Para 8. "The Mission indicated in the PID, that without a third HPN direct hire, it might have to reduce the scope of project activities. ANE will not approve a third HPN direct hire for this project. The Mission is requested to consult with the Bureau on any changes in the scope of the project or management structure which are significantly different than contained in the PID."

USAID Comment: USAID has decided to hire (locally, if possible) a personal services contractor who will serve as an additional "project administrator" with major responsibilities being to assist with administration, implementation and evaluation of project activities.

LOGICAL FRAMEWORK

ANNEX C  
Child Survival/FP Services  
Project 367-0157

<u>NARRATIVE SUMMARY</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
<u>PROJECT GOAL:</u>  Reduce Child mortality and undesired fertility	<u>MEASURES OF GOAL ACHIEVEMENT:</u>  - Childhood mortality associated with diarrheal disease, vaccine-preventable diseases, acute respiratory infections (ARI) and Malaria reduced.  - Total fertility rate (TFR) decreased.	Tetanus and diarrheal mortality Studies  ARI intervention/control comparisons  Contraceptive prevalence Survey KAP Survey MOH health statistics Malaria Data	<u>ASSUMPTIONS FOR ACHIEVING GOAL:</u>  FF/MCH, CS services impact on childhood mortality rates.  Increased contraceptive prevalence is translated into fertility declines.
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<u>PROJECT PURPOSE:</u>  Improve MOH management practices affecting the delivery of health and family planning services and improve the quality and coverage of child health care, family planning and selected malaria control services.	<u>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED: END OF PROJECT STATUS, (EOPS)</u>  1. Central Region performing all functions related to health care delivery in its region, i.e., planning, budgeting, personnel, training and logistics.  2a. Full Service family planning/MCH services available in project districts; CPR in CRHD districts increased by 20% (up to 5% in other project districts).  2b. Nationwide IE&C program raises women's knowledge at least one modern form of contraception; will have increased to 75% from 56% in 1986. Revised reporting system in place nationwide that can track continuing users.	- CRHD site visits and field visits to district offices and health posts  - CRHD management and health data quality assurance surveys Field Visits  - FP/MCH and PHD/CD supervisory and quarterly reports	GON support for a decentralized integrated system remains strong; regional authorities are officially established.  Other donor TA/DA rates do not cause implementation difficulties.  BMN policy is maintained.  Trade/transit crisis does not seriously affect project and MOH activities.

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>PROJECT PURPOSE, Continued</u>	<u>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED: END OF PROJECT STATUS, (EOPS)</u>		
	2c. Quality assurance systems for clinical methods established in project districts.	- NMEQ quarterly reports, field visits	Insecticide "windfall" does not materialize.
	3. Child Survival services (CDD, EPI, ARI) being provided to 80% of the population of the Central Region. 30% increase in correct use of ORS, and improved ARI case management in project districts.	- Evaluation	
	4. HMG maintaining national malaria prevalence at 1989 levels in all 50 malaria districts and adopting environmental control measures.		
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<u>OUTPUTS:</u>	<u>MAGNITUDE OF OUTPUTS:</u>		<u>ASSUMPTIONS FOR ACHIEVING OUTPUTS</u>
1. - CRHD management of decentralized, integrated services	1. a. MCH reviews completed in all 19 Districts. b. CRHD and district staff have received basic and refresher (b/r) management training, b/r planning and budget, b/r information systems, b/r supervision training c. CRHD assuring District plans and budget prepared appropriately and on time. d. Information and reporting systems for personnel, training, logistics, budget, supervision operating.	- On site and field visits - MOH reporting data - Evaluations - MOH & IOM records - Training reports - Annual Plans	- MOH adopts policy by late 1990 that all MOH district level and above managers must have a public health degree. - Large scale programs, e.g., CHV, will be implemented rationally, not by political mandate.

94.

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>INPUTS:</u>	<u>MAGNITUDE OF OUTPUTS:</u>		<u>ASSUMPTIONS FOR ACHIEVING OUTPUTS</u>
2. - Public health and health administration training for MOH managers (DPHOs)	2. At least 25 district level and above MOH health care managers enrolled/trained at IOM public health degree program. At least 10 are from the CR.	<ul style="list-style-type: none"> <li>- Quarterly reports</li> <li>- Contractor reports</li> <li>- MOH records</li> </ul>	<ul style="list-style-type: none"> <li>- CHVs receiving adequate stocks of non-clinical contraceptives and ORS from the health posts.</li> </ul>
3. - MOH personnel trained in FP, CDD, ARI and EPI; and health care planning and management (basic and/or refresher training)	<p style="text-align: center;">CR/Other districts</p> 3. a. CRHD staff 20/- b. DPHO staff 200/80 c. ANMs & AHWs 360/325 d. VHWs 550/216 e. CHVs 12,000/2,000 f. Physicians 44/18 g. Nurses 44/18 h. Counselors 22/9		<ul style="list-style-type: none"> <li>- CHVs are not overloaded with tasks</li> <li>- DPHO functions can be met while DPHO in IOM training</li> <li>- Reasonable NMO function is defined.</li> </ul>
4. CRHD and its districts develop a capacity to test innovations in service delivery and apply findings.	4. Up to 5 innovative activities/tests undertaken during the project.		<ul style="list-style-type: none"> <li>- CHV program is maintained.</li> </ul>
5. Comprehensive MCH service provided to households by health post & NMO supported outreach workers (FP, CDD, EPI, ARI) in the Central Region.	5. a. District review input/output indicators achieved by at least 50%.  b. CHVs & VHWs cover 65% of households in the Terai, 40% in the middle hills and 25% in the mountains.  c. Organizations supporting CHVs (supervision, training forming mother's groups) in at least 9 of the 19 districts. 100 members have received orientation and/or management training.		

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LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>OUTPUTS:</u>	<u>MAGNITUDE OF OUTPUTS:</u>		<u>ASSUMPTIONS FOR ACHIEVING OUTPUTS</u>
6. Social marketing and private enterprise family planning services expanded.	6. a. CRS increases Couple Year Protection through sales of orals and condoms from 55,000 (1986) to 125,000 by 1995; 50% of CRS salaries and benefits absorbed by CRS  b. At least 4 major employers are providing family planning services to their employees.  c. 10 Physicians in private practice trained in family planning.  d. More NGOs providing family planning services.	- CRS Sales data  other health services.  - Enterprise Reports  - Site visits  - Training reports from MOH	- NGO demonstrate capacity to deliver family planning and  other health services.  - MOH adapts and facilitates implementation of privatization plan for CRS.
7. Full service family planning program established.	7. a. Tiered "institutionalized" family planning services system operated in 20 districts (12 in the CR).  b. Supply/logistic system operating smoothly and assuring availability of supplies in the CR.  c. IE&C capacity developed through review of old materials; design, testing and application of new strategies.  d. 30 hospitals in the CR providing clinical methods  e. 30 other hospitals providing clinical methods.  f. 10 health centers/posts providing clinical methods.	- Annual workplans  - MOH reports  - Contractor reports	

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS								
<u>OUTPUTS:</u>	<u>MAGNITUDE OF OUTPUTS:</u>		<u>ASSUMPTIONS FOR ACHIEVING OUTPUTS</u>								
Malaria case detection and treatment response structure	g. All (above) facilities providing non-clinical methods and/or referrals.  8. 2 PCOV workshops/year in all malaria surveillance districts; all ilaka laboratories (450) functioning.										
Malaria Control a. NMEQ/NRTC renovated	9. a. NMEQ training, laboratory and research capacity doubled.										
b. Strengthened information system	b. Vector entomology documented in 50% of moderate to high transmission areas. Computerized information system covering case incidence, budget, and administrative data operational in at least 4 regions and at MHQ.										
c. Case detection and treatment response	c. 450 ilaka laboratories operational 2 passive case detection volunteer workshops per year in all malaria surveillance districts.										
<u>INPUTS:</u>	<u>IMPLEMENTATION TARGET</u>		<u>ASSUMPTION FOR PROVISION OF INPUTS:</u>								
USG Technical Assistance LT expatriate TA ST expatriate TA ST local TA and Contracts	<table border="0"> <tr> <td style="text-align: center;"><u>TA</u></td> <td></td> </tr> <tr> <td style="text-align: center;">1.</td> <td>- 15 PY long term expatriate TA</td> </tr> <tr> <td></td> <td>- 60 p.m. short term expatriate TA</td> </tr> <tr> <td></td> <td>- 60 p.m. short term local TA and contracts</td> </tr> </table>	<u>TA</u>		1.	- 15 PY long term expatriate TA		- 60 p.m. short term expatriate TA		- 60 p.m. short term local TA and contracts	<ul style="list-style-type: none"> <li>- Project progress and financial reports</li> <li>- Procurement tracking</li> <li>- Site visits</li> </ul>	<ul style="list-style-type: none"> <li>- USG funding and HMG counterpart funding are available.</li> <li>- Trade/transit crisis does not severely impact on HMG support for donor-assisted projects.</li> </ul>
<u>TA</u>											
1.	- 15 PY long term expatriate TA										
	- 60 p.m. short term expatriate TA										
	- 60 p.m. short term local TA and contracts										

91

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>INPUTS: (USG, continued)</u>	<u>IMPLEMENTATION TARGET</u>		<u>ASSUMPTION FOR PROVISION OF INPUTS:</u>
Local Staff Support Buy-ins to ST projects	- 25 py - 60 p.m.	- PIOs	Contractors provide qualified, effective consultants
2. Training	2. - 40 p.m. out of country short term training - in-country training per training plan - IOM public health training for at least 25 people		HMG provides timely clearances and counterparts
3. Commodities - Contraceptives - Vehicles (20 all terrain 5 motorcycles  - Computer hardware and software - Laboratory, spraying and safety equipment  - Classroom and Library, NRTC and IOM  - ORT supplies	3. Commodities - Contraceptives for MOH and CRS programs - 20 all terrain vehicles (w/spare parts plus 1 bus and 5 motorcycles  - 10 systems  - NRTC laboratory, and ilaka programs and spraying equipment for 50 districts  - References for 2 libraries Classroom materials for 4 Classrooms  - 500,000 ORS packets for start-up; 5000cc containers, up to 1 per family with small children (est. 1.5 million)		
4. Local Cost Support - Training-related materials/supplies; logistics	4. - Training sessions for all workplans (CRHD, CDD, NPEO, FP/MCH, CHV)		
5. Local Grants and Agreements	5. - 1 CRS, 1 NEPAS, 2-4 other		

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>INPUTS: (USG, continued)</u>	<u>IMPLEMENTATION TARGET</u>		<u>ASSUMPTION FOR PROVISION OF INPUTS:</u>
6. Construction/Renovation  HRG - Personnel (Salaries) - Training - TA/DA - Supplies - Transport - Facilities	6. - 1 NMO/NRTC		

WAIVERS

Two waivers will probably be required under the CS/FPS Project. These include a waiver for vehicles from Geographic Code 935 and for certain project-related equipment (computers, perhaps some scientific equipment), also from Geographic Code 935 countries.

At present, vehicle waivers can be granted through the Administrator's "Blanket Source/Origin waiver" as per 89 State 079274, which is valid through March 6, 1990. It is assumed that the Administrator will renew the Blanket Waiver. At the appropriate time, probably in the latter part of CY 1990, such a waiver will be drafted by the Mission.

Computer and scientific equipment from other than Geographic Code 941 will be required, probably late in 1990 or early in 1991. A waiver will be requested, probably on the basis of AID Handbook 1, Supplement B, Chapter 5B4a, as it is probable that the "the commodity is not available from countries or areas included in the authorized geographic code". This is because such equipment is found in Geographic Code 935 countries.

ANNEX - E

STATUTORY CHECKLISTS

These are up-to-date checklists and include Country, Project, and Standard Item Checklists. All applicable items have been addressed.

AID/W (ANE/SA) has been asked to prepare the country checklist. Following is a Mission draft.

I. COUNTRY CHECKLIST

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1989 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?

No.

2. FAA Sec. 481 (h). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are drug-related profits are laundered with the knowledge or complicity of the government), has the president in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

No.

- a. N/A
- b. N/A

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481 (h), above.) If recipient country is a "major drug-transit country" (as defined for the purpose of FAA Sec. 481(h), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

N/A.

4. FAA Section. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or service furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government?

No.

5. FAA Sec. 620(e) (1). If assistance is to government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations towards such citizens or entities?

No.

6. FAA Sec. 620(a), 620(f), 620D; FY 1989 Continuing Resolution Sec. 512. Is recipient country a Communist country? If so, has the President determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism? Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran, or Syria? Will assistance be provided to Afghanistan without a certification?

No.

102

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property?

No.

8. FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?

No.

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

N/A

10. FAA Sec. 6209g); FY 1989 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1988 Continuing Resolution appropriates funds?

No.

11. FAA Sec. 620(s). If contemplated assistance is development loan or come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "taking into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A

12. FAA Sec. 620(t). Has the country served diplomat relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrear ages taken into account by the AID Administrator in

103

determining the current AID Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

Current.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?

No.

15. FY 1989 Continuing Resolution Sec. 576. Has the country been placed on the list provided for in Section 6(j) of the Export Administration Act of 1979 (currently Libya, Iran, South Yemen, Syria, Cuba, or North Korea)?

No.

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e) (2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specific arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device: (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No.

19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?

No.

104

20. ISDCA of 1981 Sec. 720. Was the country represented at the meeting of Minister of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Session of the General Assembly of the U.N. of September 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken into account? (Reference may be made to the "Taking into Consideration" memo.)

Nepal diassociated itself from the communique.

21. FY 1989 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States?

No.

22. FY 1989 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

Nepal is a constitutional Monarchy.

23. FY 1989 Continuing Resolution Sec. 543. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect, to race, sex, religion, or national origin?

Yes.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY:

1. Development Assistance Country Criteria.

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? if so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No.

FY 1989 Continuing Resolution Sec. 538. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance or involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any

105

person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

2. Economic Support Fund Country Criteria:

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvements in its human rights record that furnishing such assistance is in national interest?

N/A.

FY 1988 Continuing Resolution Sec. 549. Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

N/A.

3M (2) - PROJECT CHECKLIST

This checklist is based on foreign assistance legislation through the FY 89 Appropriations Act. An up-dated checklist for FY 90 is not yet available. However, the FY 90 Appropriations Act has been reviewed and this project is considered consistent with its provisions.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

AID/W has been asked to prepare the country checklist.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Continuing Resolution Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?

Yes, prior to obligating funds Congress will be notified through AID/W.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans

106

necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes. An illustrative budget is included in the Project Paper.

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

N/A.

4. FAA Sec. 611(b); PY 1989 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act 942 U.S.C. 1962, et seq? (See A.I.D. Handbook 3 for new guidelines.)

N/A.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A.

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No.

7. FAA Sec. 601(a). Information and conclusions whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce and (f) strengthen free labor unions.

- a. N/A
- b. Yes, certain components focus on the private sector.
- c. N/A.
- d. N/A.
- e. Yes-of health systems as the principal target of the project.
- f. N/A.

8. FAA Sec. 601(b) Information and conclusions on how project will encourage U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise)

Technical assistance and commodities will be procured from the U.S.A., Nepal and other countries in AID Geographic Code 941.

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollar.

The GON is expected to provide over 50% of total project costs.

10. FAA Sec. 612(d). Does the U.S own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

11. FY 1988 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause or competing commodity?

N/A

12. FY 1989 Continuing Resolution Sec. 553. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.- made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

No.

13. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystem in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

N/A.

105

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds 9 dollars or local currency generated therefrom)?

N/A.

15. FY 1989 Continuing Resolution. If assistance is to be made to a united States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

Yes.

16. FY 1989 Continuing Resolution Sec. 541. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

These will be required if a PVO is used.

17. FY 1989 Continuing Resolution Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained?

N/A.

18. FY Continuing Resolution Sec. 515. If deob/reob authority is sought to be exercised in the provision of assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of Congress been obtained?

Yes.

19. State Authorization Sec. 139. (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Case-Zablocki Act, as interpreted, not applicable to this agreement. However, copies of agreement will be sent to AID/W.

109

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Continuing Resolution Sec. 552. (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

N/A.

b. FAA sec. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

a. Project is directed to improved health systems and access to health care by the poor of Nepal, especially in rural areas.

b. N/A. Not directly applicable to this project.

c. Yes. Local community action and participation are important ingredients.

d. Women's involvement in improved health systems is integrally incorporated in the Project.

e. Yes.

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes.

d. FAA Secs. 110, 124(d). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to whom the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country")?

GON will provide an estimated 51% of project costs.

e. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes. Tracking/monitoring systems will measure the impact on the bulk of targeted beneficiaries, the rural poor.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The health program is a continuation of initiatives designed to improve national health systems, working with health practitioners at all levels. Training is designed to increase health skills and to broaden the base of health coverage.

g. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the type of funds (functional account) being used?

Yes.

h. FY 1989 Continuing Resolution Sec. 538. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No. Voluntary sterilization is supported through the project, but no financial incentives are permitted.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No.

i. FY 1989 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

No. Family planning projects offer the broadest possible range of family planning methods and services.

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

k. FY 1989 Continuing Resolution. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities, colleges and universities having a student body in which more than 20 percent of the student are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

SBA's and minority firms will be eligible to bid on contracts. USAID/Nepal's overall target is 10% of LOP budget.

112

1. FAA Sec. 118(c) Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

Yes. Bureau Environmental Coordinator concurred in negative threshold determination in PID.

a. N/A.

m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A.

n. FAA Sec. 118(c) (14) Will assistance be used for (9a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound

manner and that the proposed activity will produce positive economic benefits and sustainable forest management system; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

a. No.

b. No.

o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in sustainable development?

No.

p. FY 1989 Continuing Resolution. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA ; (c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grass roots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income-generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and to improve basic transportation and communication networks, to maintain and restore the natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of

self-sustaining primary health care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

N/A.

q. FY 1989 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

If funds are deobed/reobed, Congress will be notified. Such funds would be used for the same general purposes.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprises' annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A.

c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A.

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

N/A.

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

N/A.

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have special Account (counterpart) arrangements been made?

N/A.

3M(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602(a). Are there arrangements to permit U.S. Small business to participate equitably in furnishing of commodities and services financed?

Yes. Full and open competition for contracts will be held, to the maximum extent feasible.

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the president or under delegation from him?

Yes. From Geographic Code 941 and Nepal, unless specific waivers are sought.

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Yes.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S. )

N/A.

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941, and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

No.

6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No.

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.

8. International Air transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

9. FY 1989 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes.

10. FY 1989 Continuing Resolution Sec. 504. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes.

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Contract for refurbishing lab will be completed locally.

3. FAA Sec. 620(K). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP) or does assistance have the express approval Congress?

N/A.

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2% per annum during a grace period and at least 3% per annum thereafter?

N/A - Grant.

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A.

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, country to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries.

Yes.

4. Will arrangements preclude uses of financing;

a. FAA Sec. 104(f); Fy 1989 Continuing Resolution Secs. 525, 538. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for

118

any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

Yes on all.

b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

Yes.

c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property except to compensate foreign nationals in accordance with a land reform program certified by the President?

Yes.

d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

Yes.

e. FAA Sec. 662. For CIA activities?

Yes.

f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicle manufactured outside U.S., unless a waiver is obtained?

Yes. Blanket waiver for RHD vehicles and small motorcycles may apply, if available.

g. FY 1989 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel;

Yes.

h. FY 1989 Continuing Resolution Sec. 505. To pay U.N. assessments, arrear ages or dues?

Yes.

i. FY 1989 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)?

Yes.

j. FY 1989 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology?

Yes.

k. FY 1989 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

Yes.

l. FY 1989 Continuing Resolution Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposed designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?

Yes.

5. FY 1990 Appropriations Act Sec. 584. Will any A.I.D. contract and solitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary of appropriate?

Yes.

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BUDGET NOTES

TABLE I  
USAID PROJECT COSTS

I. Technical Assistance

A. Principal Contractor - Costs associated with the principal contractor are divided into four items.

1. Long-Term Technical Assistance: Three persons at five years each will be required for long-term assistance. It is expected that they will arrive o/a June, 1990. Figures, at an initial rate of \$160,000 per annum per person, are used. Inflation and contingency are shown in items VIII and IX. Annual costs, which include all expenses (salary, overhead, travel, health, schools, benefits, etc...) are estimated at \$480,000 per annum.

2. Short-Term Technical Assistance: The primary contractor will require short-term technical assistance for special activities during the course of the project. It is estimated that one person year (12 person months) each year will be necessary. In all inclusive cost of \$20,000 (salary, overhead, travel, benefits, insurance, etc...) per month is estimated. This totals \$240,000 per annum for each of the five years of the project.

3. Short-Term Local Assistance: Local hire personnel, both Nepali and ex-patriate, are estimated at a cost of roughly \$2,000 per month per person. For an estimated twelve person months per annum, this totals \$24,000 per year.

4. Support Staff: The principal contractor will need local staff and ancillary personnel to support a local office. This will probably consist of an administrative officer, secretary, driver and cleaner. Their expenses will probably not exceed \$800 per month. Office rent and operations are estimated at \$1,200 per month. The annual estimated total is therefore \$24,000.

B. Buy-Ins to S&T Projects - Substantial buy-ins to S&T-administered projects will be done through the project. These will build on relationship and activities initiated under earlier health initiatives. The following illustrative list is the probable set of buy-ins to S&T-administered projects will be done through the project. These will build on relationships and activities initiated under earlier health initiatives. The following illustrative list is the probable set of buy-ins, with estimated budget amounts.

21

<u>Name</u>	<u>Annual Amount</u>	<u>LOP Amount</u>
Association for Voluntary Surgical Contraception and the Population Council	\$40,000	\$200,000
Public Communication Service	28,000	140,000
RAPID/IMPACT	12,000	60,000
FP Enterprise Project	20,000	100,000
Social Marketing for Change Project	24,000	120,000
Health Communication Project	16,000	80,000
Technology for Child Survival	48,000	240,000
Vector Biology Control Project	40,000	200,000
Vitamin A for Health	12,000	60,000
	<u>\$240,000</u>	<u>\$1,200,000</u>

C. PSC - The Mission will employ an individual on a Personal Services Contract to assist with administering and monitoring the project. Costs are estimated at \$120,000 per annum or \$600,000 over the life of the project.

## II. Training

A. Overseas - Please see Annex H for details on the training plan. Overseas training is all short-term, at an estimated total cost of \$6,000 per person-month. Person-months have been calculated as follows:

<u>Year</u>	<u>Person months training</u>	<u>Cost</u>
1	11	\$ 66,000
2	14.5	87,000
3	8.5	51,000
4	3	18,000
5	3	18,000
---	---	-----
5 years	40 months	\$240,000

B. In-Country - Annex H provides details on the training program, which consists of 25 different activities at the national, regional and local levels. Costs per activity vary greatly, depending on type, locality, intensity, level of participants, etc... The annual figures are compiled as per the information provided in Annex H.

<u>Year</u>	<u>Total NRs</u>	<u>Dollar Cost</u>
1	NRs 8,132,650	\$ 287,000
2	7,962,435	281,000
3	5,865,925	207,000
4	5,086,650	180,000
5	3,475,560	123,000
---	-----	-----
5	30,523,220	\$1,078,000

122

C. IOM Public Health Training - At the Institute of Medicine, Public Health Training is offered. Fifty person years of scholarships will be provided through the project. The estimated cost is NRs. 55,000 per person year (or \$1,950). Costs are rounded to nearest thousand.

<u>Year</u>	<u>Person Years</u>	<u>Cost</u>
1	5	\$ 10,000
2	10	20,000
3	15	29,000
4	10	20,000
5	10	20,000
---	---	-----
5	50	\$99,000

### III. Commodities and Supplies

A. Contraceptives - Figures are based on historical purchases over the last nine years (which were \$550,000 per annum). This level is increased 2% per annum, based on expected increases in acceptors through the project. Therefore, the following annual figures are used.

<u>Year</u>	<u>Increase</u>	<u>Purchases</u>
1	2%	\$561,000
2	4%	\$572,000
3	6%	\$584,000
4	8%	\$595,000
5	10%	\$607,000

B. VSC/Clinical Contraception Equipment/Supplies - For such supplies, historical rates are used. Little growth is expected, as contraceptive prevalence is expected to grow. An estimated \$50,000 in the first two years and \$100,000 annually thereafter is budgeted. Early years are lower because of current supply stockpiles.

C. Malaria Equipment - Malaria equipment will consist of spraying equipment, laboratory supplies and equipment, surveillance supplies and various materials for the National Research Training Center (NRTC). Spraying operations' supplies (sprayers, repairs, kits, safety clothing, etc.) are scheduled for a two-time purchase in year one and year two at \$108,000 each year. For lab supplies and equipment, an annual \$20,000 purchase is expected with a total of \$100,000. Annual surveillance supplies (blood testing kits, mosquito traps, stationery) are expected to cost \$120,000 in total or \$24,000 p.a. NRTC materials, to be purchased in year 3, are expected to cost \$150,000. Therefore, malaria equipment costs will total as follows:

<u>Year</u>	<u>Commodity</u>	<u>Amount</u>
1	lab, surveillance supplies, spray equip	\$152,000
2	lab, surveillance supplies, spray equip	152,000
3	lab, surveillance supplies, NRTC	194,000
4	lab, surveillance supplies	44,000
5	lab, surveillance supplies	44,000
	Total	----- \$586,000

D. Library/Teaching Materials - For the NRTC, a one-time acquisition of \$50,000 in year three for classrooms and the library is expected. IOM library and teaching materials are expected to require \$25,000 in year one and \$25,000 in year two.

E. Vehicle - Under the project, one bus, 20 all-terrain (jeep-like) vehicles, and five motorcycles will be procured. It is expected that the bus, motorcycles, and 10 all-terrain vehicles will be procured in the first year of the project. In the third year of the project, an additional 10 all-terrain vehicles will be procured. The estimated prices are; bus-\$30,000, all-terrain vehicle-\$20,000, motorcycle (125 cc.) - \$1,500. These prices include basic spares. The bus would be a 30 passenger, 6 tyre, diesel vehicle. The all-terrain vehicles would be either diesel or petrol fueled, 4 WD, long wheel-base types. In year one, vehicle purchases will total an estimated \$237,500 and in year three \$200,000.

F. Computer Equipment - An estimated 10 computer PC's and required software will be procured during the life of the project. The PC's, with 30 mb hard discs, twin floppy discs, printers (letter quality), UPS back up and required programs (spread sheet, word processing, etc...) are expected to cost around \$6,000 each. It is estimated that five systems will be purchased in year one and five in year two. Maintenance and repair costs are estimated at \$200 per unit per year or \$1,000 in year one and \$2,000 p.a. thereafter.

G. Oral Rehydration Therapy Supplies - An estimated 1,800,000 containers will be supplied during the life of the project. These have an estimated cost of NRs 5.00 each (or U.S. \$0.18). This represents one container for every two families in Nepal. It is assumed that these are supplied in years 2 and 3 of the project at a cost of \$162,000 per year. Oral rehydration salts in packets as a pilot/contingency are also to be provided through the project in the first year only. The cost is estimated at NRs 1.5 each (U.S. \$0.05). An estimated 500,000 packets will be provided, costing about \$25,000.

<u>Year</u>	<u>Containers</u>	<u>Packets</u>	<u>Cost</u>
1	- 0 -	500,000	\$ 25,000
2	900,000	- 0 -	162,000
3	900,000	- 0 -	162,000
4	- 0 -	- 0 -	- 0 -
5	- 0 -	- 0 -	- 0 -
Total			----- \$349,000

IV. LOCAL COST SUPPORT

A. Training Related - Hall rentals, meeting costs, transport expenses, logistics etc... are estimated to cost \$250,000 per annum for in-country programs.

B. Materials and Supplies - Miscellaneous materials and supplies are procured locally to support the contractors and field programs. These can include items for the offices, fuel, rentals, printing, accounting, communications, etc... These are estimated to cost roughly \$200,000 per annum over the life of the project.

C. Local NGO/PVO Grants - Support for a number of local NGO's is planned. The major organization, Commodity Retail Sales, Inc., will initially be funded at a level of \$400,000 in year one. This is expected to decline at a rate of \$25,000 p.a. Support will thus be as follows; year 1 - \$400,000, year 2 - \$375,000, year 3 - \$350,000, year 4 - \$325,000, year five - \$300,000. Total support will equal \$1,750,000. Other NGO's will be supported in the following fashion; Nepal Red Cross - \$25,000 p.a., Center for Education and Population Development - \$20,000 p.a., Nepal Pediatric Society at \$25,000 p.a., and EPI/Vitamin A and ARI pilot activities at about \$30,000 p.a.

<u>Year</u>	<u>CRS</u>	<u>NRC</u>	<u>CFDP</u>	<u>NPS</u>	<u>EPI</u>	<u>Total</u>
1	750	25	20	25	30	500
2	375	25	20	25	30	475
3	350	25	20	25	30	450
4	325	25	20	25	30	425
5	300	25	20	25	30	400
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	1,750	125	100	125	150	2,250

V. CONSTRUCTION (MALARIA RESEARCH CENTER)

Details on the construction effort, which will be carried out in years two and three of the project, are provided in Annex I. The cost estimate show a total of \$500,000. This is divided into two increments of \$250,000 for years two and three.

VI. EVALUATIONS

Two evaluations are scheduled, one preliminary evaluation at the end of year two and a fuller evaluation at the end of year four. The first evaluation will cost an estimated \$50,000 and the second \$100,000.

VII. AUDIT

Provision is made for an audit, to be conducted in perhaps year three or four of the project. The sum of \$75,000 is allocated for this effort (shown in year four).

VIII INFLATION

A compounded inflation rate of 5%, starting in year two, is applied to all project expenses.

<u>Year</u>	<u>Sub-total</u>	<u>Inflation rate</u>	<u>Amount</u>
1	\$ 3,522,000	- 0 -	- 0 -
2	3,734,000	5%	\$ 187,000
3	3,857,000	10%	386,000
4	3,137,000	16%	502,000
5	2,892,000	22%	636,000
	-----		-----
	17,142,000		1,711,000

IX. CONTINGENCY

In addition to an inflation factor, around 6% contingency on all budget items is applied to each year of the project. This is designed to cover any changes in project costs and allow greater flexibility in implementation of activities.

<u>Year</u>	<u>Sub-total</u>	(In \$ 000's) <u>Contingency</u>	<u>Total Amount</u>
1	\$ 3,522	211	3,733
2	3,921	235	4,156
3	4,243	271	4,514
4	3,639	218	3,857
5	3,528	212	3,740
	-----	-----	-----
	\$17,142	\$1,147	20,000

TABLE I, continued  
GOVERNMENT OF NEPAL COST SUPPORT

The following figures are taken from Nepali Rupees and converted at a rate of 28.3 per U.S. Dollar. They were derived from historical workplans and budgets, from Mission estimates of in-kind contributions, and from projections made by Ministry of Health Officials. Some items, such as salaries, are only for staff added as an integral part of the project. The bulk of expenses are in training (staff salaries during training), malaria commodities (insecticide, lab equipment), and local cost support.

I. Technical Assistance:

- A. Principal Contractor - The Ministry of Health will provide limited office space to long-term personnel. Also, MOP staff will prepare certain required reports (monitoring, work progress, project plans, etc.). The in-kind value is estimate at about \$3,000 per month for the life of the project. This also includes the GON's contribution to short-term technical assistance.
- B. Buy-ins to S&T Projects - The GON will be working closely in many of the special projects with outside consultants (AVSC, POP Council, PCS, PPIA, SOMARC, JSI and others). Inputs of personnel, logistics support, and administration will be crucial to success. An estimated \$5,000 per month of salary support and in-kind contributions are shown.

II. Training:

- A. Overseas - It is assumed that the average salary of GON personnel trained (short-term overseas) is NRs. 2400 per month (U.S. \$85.00). This salary, paid by the GON while individuals are in training, is shown as the GON contribution to training costs.

YEAR	P.M. TRAINING	COST PER MONTH	TOTAL
1	11	\$85	1,000
2	14.5	85	1,000
3	8.5	85	1,000
4	3	85	-
5	3	85	-

3. In-Country - The following table reflects the information contained in Annex H. It is assumed that there are 25 working days in a month.

Category	Cost P.M.	Year1	Year2	Year3	Year4	Year5	Total
1.A.1	\$85	170	-	-	-	-	\$170
1.A.2	85	-	170	85	85	85	425
B.1	85	600	-	-	-	-	600
B.2	85	-	340	170	85	85	680
C.1	85	765	-	-	-	-	765
C.2	85	-	340	340	170	170	1,020
D.1	85	425	170	85	85	85	850
D.2	55	-	770	385	385	385	1,925
E(All)	4	11,870	11,700	6,760	6,740	3,380	40,450
G.1	92	5,890	4,420	4,420	2,940	2,940	20,610
G.2&3	85	4,760	3,490	2,640	1,620	1,110	13,620
H.1	85	2,720	2,720	2,040	1,360	1,020	9,860
H 2&3	55	7,590	6,820	5,170	3,960	2,750	26,290
I.1	85	-	1,360	1,360	1,020	680	4,420
I.2	55	-	2,640	2,640	1,760	1,320	8,360
J.1	85	-	85	85	85	85	340
J.2	55	-	880	1,320	880	610	3,690
2.1-3	85	5,360	5,270	4,850	3,830	2,720	22,030
3.A1-2	85	2,380	2,640	1,960	1,700	1,110	9,790
3.B&C	55	3,740	3,850	2,860	1,980	1,100	13,530
4.A	85	-	85	170	85	85	425
4.B	55	-	1,320	1,760	1,760	880	5,720
5.B	102	510	710	820	510	410	2,960
		*****	*****	*****	*****	*****	*****
		46,780	49,780	39,920	31,040	21,010	188,530
		*****	*****	*****	*****	*****	*****

- C. IOM Public Health - Using an annual salary average of \$1,000, the GON costs for training are calculated as follows:

YEAR	TRAINING YEARS	COST
1	5	\$5,000
2	10	10,000
3	15	15,000
4	10	10,000
5	10	10,000
	===	=====
	50	\$50,000
	===	=====

III. Commodities and Supplies:

- A. Contraceptives - All contraceptives will be supplied by USAID.
- B. VSC/Clinical Contraception Equipment/Supplies - On a historical basis, over the last five years the GON has contributed an average of NRs. 871,000 in equipment and supplies. At current exchange rates, this equals \$31,000 per annum.
- C. Malaria Equipment - The major component by far for this program is insecticides. The GON will either purchase insecticides or obtain them through various bilateral arrangements. Historical requirements, largely met by USAID, averaged around NRs. 80,000,000 per annum. At a rate of 28.3 rupees per dollar, this equals \$2,827,000. Some insecticides (probably the majority) will be provided as grants. Nevertheless, it will be the GON's contribution and is shown as such. Local costs, because of the project, will increase for the laboratory, some equipment and for training. These will be shown separately and are not included here.
- D. Library/Teaching Materials - On-going requirements for the IOM library, to be met by the GON, are not shown. Support for the new library (malaria Research Center) will, however, be shown. This is estimated, starting in year three, at about \$24,000 per annum.

- E. Vehicles - Although the GON will need to support certain project activities with vehicles, the level is not known, nor when vehicles might be procured (there is currently a ban on any GON vehicle purchases). For our estimates, however, we show vehicles to support expanded field efforts, starting in year three at a level of \$200,000 and again in year five at an identical level. Because of the current ban, no vehicle purchases are shown in years one and two.
- F. Computer Equipment - The computers obtained through the project will need diskettes, printing ribbons, paper and some spares in later years. Certain software may also be required later on. This equipment is estimated at perhaps \$20 per unit per month. This equals to \$1,200 in year one and \$2,400 thereafter. This is rounded to \$1,000 in year one and \$2,000 in the later years.
- G. Oral Rehydration Therapy Supplies - The number of 500 cc ORS packets required for ORT is estimated at 4,000,000 a year. This should increase at a rate of about 50% per annum. Also most ORS will be provided by UNICEF and even though this will probably be a grant, it is shown as a GON contribution. Locally-packaged ORS for 1 liter packets costs about NRs. 0.65 each. Assuming a cost of NRs. 0.50 per 500cc packets (packaging costs are more than half of total) and that use increases 50% per annum, the following costs are derived (at NRs. 28.3 per U.S. dollar).

YEAR	AMOUNT	COST
1	4,000,000	\$70,000
2	6,000,000	106,000
3	9,000,000	159,000
4	13,500,000	239,000
5	20,250,000	358,000
	=====	=====
	52,750,000	\$932,000
	=====	=====

IV. Local Cost Support:

- A. Training - Related - The GON may have additional training expenses, but this budget only shows salaries and benefits under II Training.

- B. Materials and Supplies - Certain materials and supplies are provided to Government of Nepal staff who work directly with the project. A very conservative estimate, nationwide, of \$5,000 per month is used (\$60,000 per annum). This is at the national, regional, district and local level. For the malaria program alone, the estimate is \$13,000 p.a.
- C. Local NGO/PVO Grants - The Mission estimates that local PVO's expend, for project-related development activities, a minimum of 25% of total activity costs. Government support, through the SSNCC and line ministries, is estimated at another 10%. A flat 40% is applied to the USAID support level.
- V. Construction: (Malaria Research Center) - Costs directly borne by the GON are estimated at 10% of USAID-provided funds. These fall in years two and three of the project. Therefore, an estimated \$25,000 per year is used.
- VIII. Inflation - A compounded inflation factor of 5%, starting in year two, is applied to all project expenses.

(in \$,000's)

YEAR	SUB-TOTAL	INFLATION RATE	AMOUNT
1	3,338	0	0
2	3,398	5%	170
3	3,660	10%	366
4	3,490	16%	558
5	3,789	22%	834
	*****		*****
	17,675		1,928

- 131 -

IX. Contingency - A flat rate of 6% is applied to all project costs.

(in \$,000's)

YEAR	SUB-TOTAL	CONTINGENCY RATE	AMOUNT
1.	3,338	6%	200
2.	3,568	6%	214
3.	4,026	6%	242
4.	4,048	6%	243
5.	4,623	6%	277
			=====
			1,176

TABLE II  
ANNUAL OBLIGATION BUDGET NOTES

- I. Technical Assistance - In order to execute the principal contract, funds must be made available prior to contract execution. An initial amount of about \$2,500,000 will be needed. For the PSC and Buy-ins, another \$500,000 may be required in FY 1990. Expenditure and obligation must be viewed distinctly. Table I shows expenditures, which probably won't be initiated until FY 1991. Thereafter, obligations correspond very roughly to expenditures, until FY 1993. Funds expended thereafter are from earlier obligations. This pattern should also be valid for the other categories of expenses.
- II. Training - Some Institute of Medicine public health training may be initiated in FY 1990, as may be some in-country training. An amount of \$100,000 may be needed to initiate and forward-fund training activities. Thereafter, obligations will roughly follow expenditures.
- III. Commodities - Some commodities, like ORT supplied or contraceptives may be ordered in FY 1990. Thereafter, commodity purchases should roughly correspond to expenditures until FY 1995, when all funds should have been expended.
- IV. Local Cost Support - For PVO-NGO grants, a limited amount of funds for bridging activities may be required. A nominal amount of \$100,000 is shown in FY 1990. Thereafter, obligations of \$1,200,000 are shown, with the balance obligated in FY 1994.
- V. Construction - Construction will be carried out in years two and three of the project (actually in FY '92 and '93), but funds should be obligated in years one and two (FY 91 and 92) to make sure resources are available to meet expenses.
- VI. Evaluations - Evaluations are done at the end of years two and four (FY '92 and FY '94) and funds could be obligated in those same years.
- VII. Audit - The audit will be done, if necessary, at the end of year four (FY '94). Funds could be obligated for that purpose in the same year.

- VIII. Inflation - Funds obligated to cover inflation should roughly correspond to the needs of that fiscal year. Some forward-funding, of course, is required. The amounts correspond to an annual obligation equal to approximately one-fourth of the total LOP requirements (\$1,711,000).
- IX. Contingency - A rate of approximately 6% is applied to the net obligation for the given year.

24

TABLE III  
LOCAL CURRENCY COMPONENTS (in \$,000's)

- I. Technical Assistance - The principal contractor will pay for local consultants and support staff in local currency (Nepali Rupees). Over the life of the project, this is estimated at \$240,000.
- II. Training - All in-country and IOM public health training costs should be in local currency, totalling \$1,177,000 over the LOP.
- III. Commodities and Supplies - It is assumed that only ORT supplies will be purchased locally with Nepali rupees. It may be possible to buy other commodities/supplies locally, but probably they will have to be paid for in hard currency. ORT supplies will cost an estimated \$349,000 over the LOP.
- IV. Local Cost Support - All these costs are expected to be met in Nepali rupees, a budgeted total of \$4,500,000 over the LOP.
- V. Construction - A local firm is expected to carry out the construction at the Malaria Research Center. Although the firm may incur some hard currency costs, this fees will be paid in Nepali rupees, equivalent to \$500,000 in total.
- VI. &
- VII. Evaluation and Audit - Foreign firms will probably be contracted to conduct these efforts. Therefore, no local currency costs are applied.
- VIII. Inflation - Local currency costs are estimated at \$6,766,000 excluding inflation and contingency. This represents 39% of the project costs. Applying this percentage rate to the total inflation in the budget (\$1,711,000), the local currency inflation cost is about \$667,000 in Nepali rupees.
- IX. Contingency - A contingency factor of about 6% has been used. On \$7,433,000 (local currency costs plus inflation), this equals \$446,000. Using the same formula applied to inflation (39% of total contingency budgeted), the same result is found (\$446,000).

SCOPE OF WORK FOR TECHNICAL ASSISTANCE PERSONNEL

A. OBJECTIVE: The objective of this contract is to assist in the improvement of Ministry of Health (MOH) management practices affecting the delivery of health and family planning services and to improve the quality and coverage of child health care and family planning services.

B. BACKGROUND: Over the five year life of this contract the Contractor will advise and work with Ministry of Health (MOH) officials and private sector organizations with the goal of reducing child mortality and morbidity as well as reducing undesired fertility. Within the MOH the Contractor will work primarily with the Central Region Health Directorate (CRHD) to strengthen its management, planning, budgeting, training, support and logistics capabilities. Work with the CRHD is intended primarily to strengthen the capabilities and improve service delivery in the 19 Districts of the Central Region and is part of a broader program of His Majesty's Government (HMG) to improve the delivery of health care throughout the country by integrating the services currently provided by various vertical programs (PP/MCH, NMEQ, EPI, CDD, etc.) into one comprehensive program. To further this process the MOH has put the vertical programs, which used to operate independently, under the direction of an Additional Secretary in a new Public Health Division. The second organizational change has been to establish Regional Health Directorates for each of Nepal's five Development Regions which will have responsibility for the delivery of all health services in their Regions. An important step in the implementation of this plan will be the evolution of the vertical programs from operational field programs to central technical offices that will have support and policy responsibilities.

The process of operationalizing the Regional Directorates is expected to take several years. With this in mind the Contractor will also need to assist selected activities at the national level. In particular support will be provided to the PP/MCH, CDD, EPI, and ARI efforts of the MOH, as well as to the new Community Health Volunteer program. (USAID will provide support to the National Malaria Eradication Organization. This support will be provided through means other than this contract, but the Contractor will need to be aware of this program and coordinate with it.)

It is well recognized the government does not have the resources needed to provide an adequate level of health care for the people of Nepal. Consequently, the Contractor will also work with private sector organizations for the purpose of strengthening the health sector, particularly in the area of preventive and primary care availability in rural areas.

C. SCOPE OF SERVICES: The Contractor will carry out the following activities under the direction of USAID/Nepal:

1. Service Management and Delivery: Assistance in this area will cover two major components; Central Region planning and management, and support to in-country training in public health, management and epidemiology.

a. Central Region Management/Service Delivery Improvement: The Contractor will provide technical assistance to the CRHD in focusing its management and support activities on priority service delivery areas. The Central Region Directorate and Districts are expected to require approximately 50% of the technical assistance that will be provided under this contract. The CRHD emphasis is seen as the best way to meet the objective of strengthening the 19 Districts in the Central Region. Specific areas for improvement include PP/MCH, CDD, EPI, ARI and malaria.

Specific activities that the Contractor will be expected to assist with are:

- A phased District by District analysis of current programs, capabilities and plans. As a result of each District analysis a short and medium-term detailed plan for overcoming any impediments to better services, including but not limited to, additional staff training, personnel changes, monitoring/supervision improvements, budget changes, IE&C activities, etc. will be developed.

- Developing a regional training capability for supporting District and Health Post staffs as well as Community Health Volunteers.

- Developing systems and capabilities in planning, budgeting, personnel supervision, demographic and epidemiological principles, basic administration, supervision systems and techniques, reporting systems, and data base development and data analysis at CRHD, district and health post levels.

- Support to the CRHD in implementing the CHV program. Through this new effort, the MCH will be selecting, training and supporting local women (up to 12,000 of them in the Central Region alone) who will provide village level outreach services.

b. Public Health Training: The Contractor will assist with the development of a post-graduate program at the Institute on Medicine (IOM) of Tribhuvan University that will provide appropriate background for District Public Health Officers (DPHOs). These individuals may have had previous experience in a vertical or categorical program, but will not have had a broad exposure to the theory and practice of public health that they will need to fill their responsibilities for planning the health services that will be available in their districts.

This assistance is expected to include review of available information to formulate a basis for determining the parameters of public health and health management training needs for DPHOs; assistance with curriculum design and the preparation of teaching materials; preparation of instructors. The Contractor will also assist the MOH in developing a system for selection of appropriate candidates for this training program, and ensuring that the "home base" is covered while the DPHO is in training.

The Contractor will also provide assistance for arranging small group training at Asian sites such as ICDDR/B, the Field Epidemiology Training Program in Thailand, or the family planning program in Thailand for DPHOs, and for observational training in management, planning and budgeting for CRHD staff.

c. Innovative Activities: The Contractor will assist the CRHD (and possibly district staff in other regions) to consider and test alternative methods for service delivery. A special emphasis will be placed on delivery of services beyond the confines of the health post and on community involvement through the CHVs or other mechanisms.

2. Family Planning: Technical assistance to Nepal's family planning effort will involve both public and private sector organizations.

a. Public Sector: The focus of this assistance will be the institutionalization of a full range of family planning services at the district level. Increased availability of clinical methods at district hospitals and selected health posts will be an objective, as will the availability of non-clinical methods at the health posts and through the CHVs. This implies the development of a tiered system of service delivery and referral, with an increased emphasis on temporary methods. Technical assistance as well as assistance with training programs will be the primary mechanism for developing these capacities. Work will start with the districts of the Central Region, but will be expanded to districts in other regions later in the project.

The Contractor will also provide assistance in development of a national family planning reporting system (beginning in the Central Region) that will allow the follow-up of continuing contraceptive users. This will be essential given the increased emphasis on temporary methods of contraception.

Another area of assistance will be improvements in the national commodity and contraceptive logistics system. The Contractor will assist the PP/MCH Division to modify the present system which uses central estimates of contraceptive needs to a system that is responsive to planning figures that are developed by the regional and district offices.

Finally, the Contractor will assist the MOH and technical advisors from AID/W projects to develop a greatly expanded IE&C capacity.

b. Private Sector: USAID has supported the Contraceptive Retail Sales Co. for over 10 years. USAID anticipates providing financial and commodity assistance directly to CRS and most technical assistance needs will be met through AID/W Projects. The Contractor will, however, be expected to assist with the coordination of technical assistance from AID/W projects as well as with follow-up that may be needed between visits of advisors.

3. Child Survival Activities: Although the Central Region will receive special emphasis for initiatives in child survival, the Contractor will also be required to provide assistance to national efforts in CDD, EPI, and ARI.

a. Diarrheal Disease Control: The Contractor will provide technical assistance to the continuing training program for MOH field workers and managers in diarrheal disease control, and supervision system implementation, primarily in the Central and Western Regions. Technical assistance will also be provided for the purpose of strengthening the MOH's ability to provide appropriate national level interventions in CDD (refresher training, supportive supervision, coordination, monitoring systems). Other areas for technical assistance will be the trial use of 500 cc ORS packets (1 liter packets are currently in use) in two districts and support to studies/research on the relative importance of various forms of childhood diarrheas in Nepal.

b. Immunizations/EPI: UNICEF is the major contributor to the EPI program in Nepal and consequently this will not be a major areas for technical assistance. The Contractor will be expected, however, to assist with the implementation of the EPI through the integrated service system in the Central Region and with the design and implementation of small sample surveys to, e.g., verify immunization coverage levels.

c. Acute Respiratory Infections: The Contractor will provide limited technical assistance to training programs in selected districts (especially in the Central Region) and to pilot ARI activities with NGOs.

4. Malaria Control: The Contractor's technical assistance in malaria will be limited to the integration of malaria control activities into the services provided through the health posts in the Central Region and will focus on management and "systems" aspects only. More specialized technical assistance will be provided through AID/W Projects.

5. Workplan Development: The Contractor will assist the CRHD, FP/MCH, CDD (and, to a lesser extent, ARI, EPI, NMEO) to develop annual workplans that will cover: a) areas in which technical assistance will be provided over the upcoming 12 months, b) commodities to be procured by the Contractor, and c) local cost support that is to be provided by USAID for such things as training, special studies, supervision, orientations, training materials, supplies, etc.

6. Procurement: The Contractor will be responsible for the procurement of supplies and equipment that will come from both U.S. and local suppliers. The total estimated cost of these commodities is \$1,500,000. U.S. suppliers will provide malaria spray and safety equipment, VSC supplies, library materials for the NMEO National Research and Training Center (NRTC) and the IOM's post-graduate program for DPHOs, and lab equipment for the NRTC. Local procurement of computer hardware and software, ORT packet and containers, malaria laboratory supplies, teaching materials/equipment for IOM and NRTC, and furniture for the NRTC, is also anticipated

D. LEVEL OF EFFORT: The Contractor will provide three long-term resident advisors for a period of five years each to work with the MOH and other organizations. The long-term advisors will include:

- a Chief of Party/Senior Health Administrator
- a Family Planning/Training Advisor
- a Public Health Planning Advisor.

These long-term advisors will be backed up by up to 60 person months of short-term external technical assistance related primarily to the service management and delivery, FP/MCH and child survival activities described above. Estimated composition of the short-term technical assistance is:

- planning, management and information systems (30 person months)
- CDD, ARI, EPI (15 person months)
- family planning (15 person months).

The Contractor will also be responsible for up to 60 person months of local short-term technical assistance in approximately the same proportions as the external short-term technical assistance.

The Contractor's local staff (estimated 25 person years) will provide logistic, secretarial, administrative and transport support.

ANNEX H  
ILLUSTRATIVE TRAINING PLAN BY PERSON  
MONTHS PER PROJECT YEAR

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COMPONENT/TYPE OF TRAINING *****	UNIT COST DOLLARS *****	ENTITY *****	DURATION MONTHS *****	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL *****
				PERSON MONTHS *****	PERSON MONTHS *****	PERSON MONTHS *****	PERSON MONTHS *****	PERSON MONTHS *****	
A. SHORT TERM OUT-OF-COUNTRY									
1. Academic									
a. Malaria/VBC	6000.00	MOH/MMED	3.00	3.00	6.00	6.00	3.00	3.00	21.00
b. Public Health Planning/Management	6000.00	MOH/CRHD	2.00	4.00	4.00	2.00	0.00	0.00	10.00
c. Public Health Training	6000.00	IDM	1.00	1.00	1.00	0.00	0.00	0.00	2.00
d. CDD/ARI Clinical Course Methodolog.	6000.00	NEPAS	1.00	1.00	1.00	0.00	0.00	0.00	2.00
2. Regional Observation/Adv.									
a. Social Marketing	6000.00	CRS	0.50	1.00	1.00	0.50	0.00	0.00	2.50
b. Diarrheal Disease Treatment Ctr. Mgt.	6000.00	CDD/NEPAS	0.50	0.50	0.50	0.00	0.00	0.00	1.00
c. IDM Faculty for Public Health Training	6000.00	IDM	0.50	0.50	1.00	0.00	0.00	0.00	1.50
*** Total ***				11.00	14.50	8.50	3.00	3.00	40.00

ILLUSTRATIVE TRAINING PLAN COSTS  
(\$) BY PROJECT YEAR

COMPONENT TYPE OF TRAINING	YEAR 1 TOTAL	YEAR 2 TOTAL	YEAR 3 TOTAL	YEAR 4 TOTAL	YEAR 5 TOTAL	GRAND TOTAL
I. SHORT TERM OUT-OF-COUNTRY						
A. Academic						
1. Malaria/VBC	18000.0000	36000.0000	36000.0000	18000.0000	18000.0000	126000.0000
2. Public Health Planning/Management	24000.0000	24000.0000	12000.0000	0.0000	0.0000	60000.0000
3. Public Health Training	6000.0000	6000.0000	0.0000	0.0000	0.0000	12000.0000
4. CDD/ARI Clinical Course Methodology	6000.0000	6000.0000	0.0000	0.0000	0.0000	12000.0000
B. Regional Observation/Study						
1. Social Marketing	6000.0000	6000.0000	3000.0000	0.0000	0.0000	15000.0000
2. Diarrheal Disease Treatment Ctr. Mgt.	3000.0000	3000.0000	0.0000	0.0000	0.0000	6000.0000
3. IOM Faculty for Public Health Training	3000.0000	6000.0000	0.0000	0.0000	0.0000	9000.0000
** Total: ***	66000.0000	87000.0000	51000.0000	18000.0000	18000.0000	240000.0000

148

ILLUSTRATIVE TRAINING PLAN BY  
PERSON DAYS BY PROJECT YEAR (MRS. 000)

COMPONENT/TYPE OF TRAINING *****	UNIT COST MRS (000) *****	ENTITY *****	DURATION YEARS *****	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL *****
				PERSON YEARS *****	PERSON YEARS *****	PERSON YEARS *****	PERSON YEARS *****	PERSON YEARS *****	
1. PUBLIC HEALTH TRAINING (IOM)	55	MOH/IOM/CRHD/DPHDS	1 Year	5	10	15	10	10	50
*** Total ***				5	10	15	10	10	50

ILLUSTRATIVE TRAINING PLAN BY  
PERSON DAYS PROJECT YEAR (MRS. 000)

COMPONENT/TYPE OF TRAINING *****	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	GRAND TOTAL *****
	TOTAL *****	TOTAL *****	TOTAL *****	TOTAL *****	TOTAL *****	
1. PUBLIC HEALTH TRAINING (IOM)	275	550	825	550	550	2750
*** Total ***	275	550	825	550	550	2750

143

## IN-COUNTRY TRAINING

ILLUSTRATIVE TRAININGS PLAN BY  
PERSON DAYS BY PROJECT YEAR

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COMPONENT/TYPE OF TRAINING *****	UNIT COST MRS. *****	ENTITY *****	DURATION DAYS *****	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL *****
				PERSON DAYS *****	PERSON DAYS *****	PERSON DAYS *****	PERSON DAYS *****	PERSON DAYS *****	
1. CENTRAL REGION									
A. 1. Management Training-Basic	260	MOH/IDM/CRHD/DPHD	1 Day	43	0	0	0	0	43
2. Management Training - Refresher	260	MOH/IDM/CRHD/DPHD	1 Day	0	43	21	22	21	107
B. 1. Planning and Budgeting - Basic	560	MOH/IDM/CRHD/DPHD	4 Days	172	0	0	0	0	172
2. Planning and Budgeting - Refresher	560	MOH/IDM/CRHD/DPHD	2 Days	0	86	43	22	21	172
C. 1. Information Systems - Basic	560	MOH/IDM/CRHD/DPHD	5 Days	215	0	0	0	0	215
2. Information Systems - Refresher	560	MOH/IDM/CRHD/DPHD	3 Days	0	86	86	43	43	258
D. 1. Supervision/Monitoring - DPHD Level	250	MOH/IDM/CRHD/DPHD	3 Days	114	57	30	27	30	258
2. Supervision/Monitoring - HP Level	150	MOH/IDM/CRHD/DPHD	4 Days	0	344	172	172	172	860
E. 1. CHV Training - Basic	55	Ilaka HP	12 Days	12000	12000	0	12000	0	36000
2. CHV Training -Refresher	55	Ilaka HP	6 Days	60000	60000	42000	30000	21000	213000
3. CHV Training - Orientation	110	DPHD/CRHD/PHD/HP	2 Days	1600	800	0	0	0	2400
4. CHV - TOT Training	175	PHD/CRHD	5 Days	570	285	285	150	100	1390
F. 1. CHV Support - Observation	150	DPHD/CRHD/PHD	1 Day	15	10	0	0	0	25
2. CHV Support - Management Training	150	DPHD/CRHD/PHD	3 Days	0	90	45	45	45	225
G. 1. FP - Technical Services	200	FP-MOH/CRHD/DPHD	12 Days	1600	1200	1200	800	800	5600
2. FP - Orientation	570	FP-MOH/CRHD/DPHD	7 Days	350	320	70	0	0	740
3. FP - Institutionalization	200	FP-MOH/CRHD/DPHD	4 Days	1040	700	700	480	320	3240
H. 1. CDD (Basic/Refresher) District Level	60	CDD/CRHD/DPHD	4 Days	800	800	600	400	300	2900
2. CDD (Basic/Refresher) HP Level	55	CDD/CR/DPHD/Ilaka	4 Days	2400	2000	1600	1200	800	8000
3. CDD (Basic/Refresher) Primary School	85	CDD/CR	3 Days	1050	1100	750	600	450	3950
I. EPI (Basic/Refresher) - District Level	60	EPI/CRHD	4 Days	0	400	400	300	200	1300

IN-COUNTRY TRAINING

ILLUSTRATIVE TRAININGS PLAN BY  
PERSON DAYS BY PROJECT YEAR

COMPONENT/TYPE OF TRAINING *****	UNIT COST MRS. ENTITY **** *****	DURATION DAYS *****	YEAR 1 PERSON DAYS *****	YEAR 2 PERSON DAYS *****	YEAR 3 PERSON DAYS *****	YEAR 4 PERSON DAYS *****	YEAR 5 PERSON DAYS *****	TOTAL *****
2. EF: HF Level:	60 CRHD/DPHD/I.Lata	3 Days	0	1200	1200	800	600	3800
J. ARI (Basic/Refresher) - District Level	60 CDD/DPHD	4 Days	0	12	24	24	12	72
2. ARI - Health Post Level:	55 CDD/DPHD	4 Days	0	400	600	400	280	1680
K. Malaria (FCEVs)	150 MMED/DPHD	4 Days	5000	5300	5300	4000	3500	23100
** Subtotal **			86969	87233	55126	51485	28694	309507
** 2. FAMILY PLANNING								
1. Technical/Service-related	200 MDH, FP/MCH	12 Days	800	600	600	400	400	2800
2. Orientation	570 MDH, FP/MCH	7 Days	175	160	35	0	0	370
3. Institutionalization	200 MDH, FP/MCH	2 Days	600	800	800	720	400	3320
** Subtotal **			1575	1560	1435	1120	800	6490
** 3. CDD								
A. 1. District Level - Basic	60 CDD/DPHDs	4 Days	400	320	280	240	120	1360
2. District Level - Refresher	60 CDD/DPHDs	3 Days	300	450	300	270	210	1530
B. 1. HF Level - Basic	55 CDD/DPHDs	4 Days	600	450	300	200	100	1650
2. HF Level - Refresher	55 CDD/DPHDs	4 Days	600	800	600	400	200	2600
C. Primary School	85 CDD/DPHDs	3 Days	500	500	400	300	200	1900
** Subtotal **			2400	2520	1880	1410	830	9040
** 4. ARI (Basic/Refresher)-2 District								
A. District Level	60 CDD/DPHDs	4 Days	0	24	36	24	24	108
B. HF Level	55 CDD/DPHDs	4 Days	0	600	800	800	400	2600
** Subtotal **			0	624	836	824	424	2708

145-

IN-COUNTRY TRAINING

ILLUSTRATIVE TRAININGS PLAN BY  
PERSON DAYS BY PROJECT YEAR

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COMPONENT TYPE OF TRAINING =====	UNIT	ENTITY	YEAR 1 DURATION DAYS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
	COST MRS.			PERSON DAYS	PERSON DAYS	PERSON DAYS	PERSON DAYS	PERSON DAYS	
** S. MALARIA									
A. PCOV	150	NMED/MRTC	4 Days	8920	9000	9000	8000	7000	41920
B. Specialized	200	NMED/MRTC	12 Days	120	180	204	120	108	732
** Subtotal **				9040	9180	9204	8120	7108	42652
*** Total ***				99984	101117	68481	62959	37856	370397

146

IN-COUNTRY TRAINING

ILLUSTRATIVE TRAINING PLAN COSTS  
(MRS.) BY PROJECT YEAR

COMPONENT/TYPE OF TRAINING =====	YEAR 1 TOTAL =====	YEAR 2 TOTAL =====	YEAR 3 TOTAL =====	YEAR 4 TOTAL =====	YEAR 5 TOTAL =====	GRAND TOTAL =====
** 1. CENTRAL REGION						
A. 1. Management Training-Basic	11180	0	0	0	0	11180
2. Management Training - Refresher	0	11180	5460	5720	5460	27820
B. 1. Planning and Budgeting - Basic	96320	0	0	0	0	96320
2. Planning and Budgeting - Refresher	0	48160	24080	12320	11760	96320
C. 1. Information Systems - Basic	120400	0	0	0	0	120400
2. Information Systems - Refresher	0	48160	48160	24080	24080	144480
D. 1. Supervision/Monitoring - DPHO Level	28500	14250	7500	6750	7500	64500
2. Supervision/Monitoring - HP Level	0	51600	25800	25800	25800	129000
E. 1. CHV Training - Basic	660000	660000	0	660000	0	1980000
2. CHV Training -Refresher	3300000	3300000	2710000	1650000	1155000	11715000
3. CHV Training - Orientation	176000	98000	0	0	0	254000
4. CHV - TOT Training	99750	49875	49875	26250	17500	243250
F. 1. CHV Support - Observation	1500	1000	0	0	0	2500
2. CHV Support - Management Training	0	13500	6750	6750	6750	33750
G. 1. FP - Technical Services	320000	240000	240000	160000	160000	1120000
2. FP - Orientation	199500	192400	39900	0	0	421800
3. FP - Institutionalization	208000	140000	140000	96000	64000	648000
H. 1. CDD (Basic/Refresher) District Level	48000	48000	26000	24000	18000	174000
2. CDD (Basic/Refresher) HP Level	132000	110000	38000	66000	44000	440000
3. CDD (Basic/Refresher) Primary School	85250	92500	63750	51000	38250	325750
I. EPI (Basic/Refresher) - District Level	0	24000	24000	18000	12000	78000

147

IN-COUNTRY TRAINING

ILLUSTRATIVE TRAINING PLAN COSTS  
(MRS.) BY PROJECT YEAR

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COMPONENT TYPE OF TRAINING *****	YEAR 1 TOTAL *****	YEAR 2 TOTAL *****	YEAR 3 TOTAL *****	YEAR 4 TOTAL *****	YEAR 5 TOTAL *****	GRAND TOTAL *****
2. EP: HF Level	0	72000	72000	48000	36000	228000
J. ARI (Basic/Refresher) - District Level	0	720	1440	1440	720	4320
2. ARI - Health Post Level	0	22000	33000	22000	15400	92400
I. Malaria (PCDVs)	750000	795000	795000	600000	525000	3465000
** Subtotal **	6240400	6013345	4010715	3504110	2167220	21925790
** 2. FAMILY PLANNING						
1. Technical/Service-related	160000	120000	120000	80000	80000	560000
2. Orientation	99750	91200	19950	0	0	210900
3. Institutionalization	120000	160000	160000	144000	80000	664000
** Subtotal **	379750	371200	299950	224000	160000	1434900
** 3. CDD						
A. 1. District Level - Basic	24000	19200	16800	14400	7200	81600
2. District Level - Refresher	18000	27000	18000	16200	12600	91800
B. 1. HF Level - Basic	32000	24750	16500	11000	5500	90750
2. HF Level - Refresher	32000	44000	32000	22000	11000	143000
C. Primary School	42500	42500	34000	25500	17000	161500
** Subtotal **	150500	157450	118300	89100	53300	568650
** 4. ARI (Basic/Refresher)-2 District						
A. District Level	0	1440	2160	1440	1440	6480
B. HF Level	0	32000	44000	44000	22000	143000
** Subtotal **	0	34440	46160	45440	23440	149480

148

IN-COUNTRY TRAINING  
ILLUSTRATIVE TRAINING PLAN COSTS  
(NRS.) BY PROJECT YEAR  
\*\*\*\*\*

COMPONENT TYPE OF TRAINING *****	YEAR 1 TOTAL *****	YEAR 2 TOTAL *****	YEAR 3 TOTAL *****	YEAR 4 TOTAL *****	YEAR 5 TOTAL *****	GRAND TOTAL *****
** E. MALARIA						
A. PCOV	1338000	1350000	1350000	1200000	1050000	6288000
B. Specialized	24000	36000	40800	24000	21600	146400
** Subtotal **	1362000	1386000	1390800	1224000	1071600	6434400
*** Total ***	8132650	7962435	5865925	5086650	3475560	30527220

149

**CONSTRUCTION PLAN**

**INTRODUCTION:** The construction element of this project consists of the construction/renovation of the existing Malaria Training Centre at Hetauda for the National Malaria Eradication Organization (NMEO). This new facility will double NMEO's training capacity, accommodating 60 trainees at a time. The additional capacity is needed to upgrade the skills of health post and district staffs who will be taking on increased malaria control responsibilities under the MOH's integration plan.

**CONSTRUCTION REQUIREMENTS:** The upgrading of the present facility will include the following elements:

- a. Conversion of the existing two story class/lab building into two class rooms that will accommodate 30 students each and a library.
- b. Construction of a two story building that will contain two laboratories (each of which will accommodate 30 students), staff offices, a storage room and toilet facilities.
- c. Construction of a dormitory that will house 60 students, including kitchen, dining and toilet requirements plus office and living space for two Training Center staff members.
- d. Construction of separate quarters for the Chief of the Center.
- e. Conversion of the existing one story building (staff quarters) into living quarters for two staff members.
- f. Upgrading of the existing approach road and related site improvements.

**CONTRACTING PLAN:** Two contracts will be established competitively with local firms, one for architectural and engineering services and the other for construction and renovation. Both will be fixed-price contracts.

A local A&E consulting firm will be contracted by USAID for site survey, development of the detailed designs and drawings for the training complex, drafting of the scope of work for the construction contract and a draft construction contract, assistance with selecting the construction contractor, and supervision of construction from start to finish.

A local construction firm will be contracted by USAID to undertake the construction/renovation work. This firm will be required to procure and furnish all materials, equipment, labor and other commodities and services needed to complete the construction activities. Procurement of imported materials, equipment or other related commodities will be the responsibility of the construction contractor.

IMPLEMENTATION/MONITORING/PAYMENT: PPD/ENG will have primary responsibility for monitoring this element of the project. PPD/ENG will develop the scope of work and the draft contract for the A&E contract. The Mission Project Committee will be involved with review of this RFP as well as that for the construction contract and will assist with contractor selection. The NMEO will review and approve the detailed plans developed by the A&E firm prior to USAID issuing the RFP for construction. Progress and final payments to the A&E and construction firms will be made by USAID after review and certification by HPP and PPD/ENG that the work has been completed as planned.

After USAID and HMG sign the Project Agreement, the construction of the Training Centre is expected to take 26 months. An illustrative implementation schedule follows:

- develop & issue A&E RFP and select firm	2 month
- design and development of detailed construction plan	
- site survey	1 month
- schematic drawings & preliminary cost estimate	1 month
- development drawings	1 month
- final drawings and cost estimate, draft RFP, etc.	2 months
- issue RFP and select construction contractor	2 months
- construction	<u>18 months</u>
Total Time Estimate	27 months

ESTIMATED BUDGET

cost @ NRs  
715/sq ft

A. Construction Contract

1. Construction		
a. Laboratory Building		
-two laboratories @ 30 students ea	1,800 sq ft	
-insectarium	450 sq ft	
-store room, office, toilet, etc.	900 sq ft	
-wall, corridors, etc @ 40%	<u>1,260 sq ft</u>	
-Total (approximate)	4,400 sq ft	3,146,000
b. Dormitory for 60 Students (2 stories)		
-2 dormitory rooms (2x100x40)	8,000 sq ft	
-stairs, passage way	1,000 sq ft	
-kitchen & dining room (40x20)	800 sq ft	
-passage	<u>300 sq ft</u>	
-Total	10,100 sq ft	7,221,500
c. Staff Quarters - Chief		
-Living room, 2 bedrooms, kitchen, dining room		
store room, 2 bathrooms	1,100 sq ft	786,500
2. Renovation		
a. Other Staff Quarters		
-renovation, additions and alterations to		390,000
-existing one story building		
b. Class Rooms (renovate 2 story building)		
-2 rooms @ 30 students each, library,		650,000
office, toilet		
3. Site Development		
a. pathways, upgrading existing motorable		650,000
approach road		

Total Construction Contract

NRs 12,844,000

B. A&E Contract

1. Design Fee @ 6%	770,640
2. Supervision, 18 months @ NRs 26,000	<u>468,000</u>

NRs 1,238,640

Total A&E Contract

GRAND TOTAL

NRs 14,082,640  
\$ 497,620

or, at exchange rate of NRs28.30 = \$1.00

TOTAL ESTIMATED COST

\$500,000

13

PROJECT FUNDED EQUIPMENT & SUPPLIES  
PROCUREMENT SCHEDULE

A. USAID PROCUREMENT ESTIMATES

	\$(000)					Total
	90/91	91/92	92/93	93/94	94/95	
Contraceptives:						
public sector	374	382	390	399	405	1,950
private sector	187	190	194	196	202	969
Vehicles:						
20 4wd vehicles (10/10)	200		200			400
5 motorcycles	7					7
1 bus	30					30
Total	<u>798</u>	<u>572</u>	<u>784</u>	<u>595</u>	<u>607</u>	<u>3,356</u>

B. CONTRACTOR PROCUREMENT ESTIMATES

	\$(000)					Total
	90/91	91/92	92/93	93/94	94/95	
1. <u>U.S. Suppliers:</u>						
Public health training:						
training equip./library	15	10				25
Family planning:						
VSC equipment/supplies	50	0	100	100	100	400
NMEO:						
sprayers/parts	90	90				180
safety equipment	18	18				36
NRTC						
-library materials			50			50
-lab equipment/supplies			100			100
Sub-Total (U.S.)	<u>173</u>	<u>168</u>	<u>250</u>	<u>100</u>	<u>100</u>	<u>791</u>
2. <u>Local Suppliers:</u>						
Computers/maintenance (5/5)	31	32	2	2	2	69
Public health training:						
teaching equip/library	10	15				25
CDD:						
ORT supplies	25	162	162			349
NMEO:						
surveillance supplies	24	24	24	24	24	120
lab supplies	20	20	20	20	20	100
NRTC furniture*			50			50
Sub-Total (local)	<u>110</u>	<u>253</u>	<u>258</u>	<u>46</u>	<u>46</u>	<u>713</u>
TOTAL (USAID)	798	572	784	595	607	3,356
TOTAL (Contractor)	<u>323</u>	<u>434</u>	<u>480</u>	<u>146</u>	<u>146</u>	<u>1,504</u>
GRAND TOTAL	1,121	1,006	1,274	741	753	4,860

\* details on page 2, annex J

Furniture for the NMEQ National Research and Training Center

1) Two class rooms, 30 students each:

-individual chairs and desks @ Rs. 4,000	NRs. 240,000
-instructor's tables, chairs & chalkboards	40,000
-library shelves, tables, chairs, etc.	60,000

2) Two laboratories, 30 students each:

-6 tables for 10 students & metal stools	240,000
-insectarium furniture	60,000

3) Dormitory for 60 students & warden staff:

-bed, writing table, chair, wardrobe, mattress pillow, etc. @ Rs. 6,000	360,000
-dining tables and chairs	100,000
-wardens' office furniture	40,000

4) Offices

-tables, chairs, wardrobe, sofa, curtains, etc.	100,000
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5) Chief's quarters 50,000

6) Quarters for two staff members 80,000

TOTAL NRs. 1,370,000

(approximately \$50,000)

150



A. TECHNICAL ANALYSES

1. Family Planning

a. Context

The GON has set extremely ambitious demographic and health objectives for the year 2000, e.g., a reduction in total fertility rate from near 6 to 2.5 and an infant mortality reduction from about 110/1000 to 45/1000. Yet these objectives are in a context of a 25 year old family planning effort which has achieved a contraceptive prevalence of about 15%, with 86% of that prevalence due to VSC (and that percentage increasing during the '80s due to a nearly unipurpose program focus on VSC).

The degree that family planning will be able to contribute significantly to those demographic and health objectives will depend upon major progress towards a mixed method contraceptive prevalence of 60-70% with far greater focus than present on the adoption of contraception by younger couples. The challenge will be to establish a program that allows for the expansion of availability of quality VSC services, while at the same time developing system capacity to educate, motivate and make available services for temporary methods of contraception for spacing earlier in couples' reproductive lives (or, in fact, for limiters who are reluctant to accept VSC). Also, to the degree possible, opportunities should be developed to combine efforts of heretofore separate FP and child and maternal health services, thereby exploiting the well-known positive interrelationships between child survival, maternal health and family planning.

b. Population Policy Context

Formal population policies in Nepal are most clearly stated in a 1982 policy statement issued by the National Commission on Population. The stated policies are progressive and permissive; they are strongly supportive of broad-based FP and child health programs, and fully appreciative of the intersectoral nature of population problems and their solutions. (AID, too, fully appreciates the positive impacts on family planning acceptance resulting from economic development, education, and enhancement of the rights and participation of women in society. These will not be discussed in this technical analysis.) Nepalese leadership is very much aware of many consequences of rapid population growth and its demands on scarce resources. The need to deal with population growth as a priority issue is regularly raised at the highest levels.

Appreciation of the maternal and child health and the intra-family social and economic benefits of family planning,

while perhaps appreciated at policy and program levels, has been less in evidence until the past few years. Even now, the population problem is usually couched in terms of national population growth rather than family welfare terms. Family planning has, perhaps, been treated more as a tool of population control rather than a powerful tool for health, social and economic advantage for families. This concept of family planning (pariwar niyogen=population control) undoubtedly has affected the perceptions and attitudes of service providers and managers; it may also partially explain the heavy reliance on VSC targets to drive FP program performance. It must be mentioned, too, that illegal immigration into Nepal is a major national concern; it is impossible to accurately quantify, and it remains politically charged as well as demographically of concern.

This new project fully supports Nepal's population policy objectives in its focus on encouraging more couples to adopt family planning practices earlier and more consistently in their reproductive lives. It is hoped that better IE & C and better quality and availability of FP and child survival services will lead to better spacing of births, a smaller desired family size, and an acceptance of VSC upon attaining a smaller average family size.

### c. Family Planning Services

#### (1) VSC

Until 1989, essentially all public sector VSC services were delivered through seasonal "camps." These services were not made available during most of the year or as routine services in health institutions. In the Terai, the major locus of VSC activities, only laparoscopy procedures were offered (not minilap) to women, largely because the operating physicians preferred the high-tech lapararoscopy equipment and could perform more procedures per unit time. In Terai areas too remote even for Nepalese surgeons to do laparoscopy, vasectomy camps were held. In the hills, VSC only was offered because the circumstances were too difficult for laparoscopy.

Due to the "camp" style of operation, there were some efficiencies of operation, but also there were significant deficiencies in fundamentals of counselling, availability of safety equipment, surgical standards, patient modesty and comfort, and other problems inherent in performing surgery and patient management in such circumstances. Equally important, because "camps" dissolved and disappeared after the surgery, and because local health institutions had not formally participated in the camps (e.g., received per case financial incentives), camp patients had difficulty with post-operative follow-up services.

157

Unfortunately, the heavy management and financing focus on VSC camps led to a situation wherein workers from the FP/MCH program spent nearly all their efforts on "servicing" the VSC camps, giving short shrift to other equally important FP and MCH services for which they were at least nominally responsible. This neglect was clearly reflected in performance. Other health workers not in the FP/MCH vertical project also often were diverted from their tasks for immunization, MCH, malaria, home visits, etc. because of financial rewards and management pressures to provide "clients" for the camps. Given that the camps were scheduled for the prime season for the delivery of most health services, diversion of efforts from other programs to the VSC camps could not be compensated.

The annual number of people sterilized reached a peak of about 60,000 in 1984. Despite continuing intense management pressures and no decline in outside resources, the numbers rapidly fell to the 40,000 range. There are many possible explanations for the decline and levelling off; most likely it was a combination of increasing difficulty finding clients (the "easy" ones had been found already), negative stories circulating in the communities about bad treatment during and after the camps (real or imagined bad treatment), surgical failures (especially with the assembly line laparoscopic surgery wherein one surgeon might perform over a hundred procedures in one day, under far less than ideal circumstances), and provider fatigue with the camp approach that disrupted routine duties and functions. Other factors also contributed to a growing national concern about a VSC-camp-only approach to Nepal's demographic problems: (1) a realization that a camp approach was not likely to be able to achieve ever increasing numbers of acceptors; (2) a realization that VSC alone would never accomplish enough to meet Nepal's demographic goals, not to mention the problems the camp approach caused for other health programs; (3) a desire of the FPAN to withdraw from its annual contractual relationship with the MOH to perform thousands of VSC procedures in the "integrated" districts; and (4) donor concern that excluding the nation's health institutions from the FP program was a terrible waste of system capacity to assist the national program.

By 1988, GON had restructured its FP program so as to enlarge national capacity to deliver VSC services in the following ways: (1) beginning to provide VSC services, year-round, in the nation's hospitals and health centers, as well as continue camps where conditions for the surgery in institutions are not safe; (2) offering mini-lap in institutions and camps where laparoscopy is inappropriate; (3) recruiting FP clients earlier in their reproductive lives for temporary contraception, who then can be motivated through long-term contact to adopt VSC when they have reached desired family size. It also committed itself to improving the quality of VSC services in the following ways: (1) establishing FP counselling standards and placement of qualified counsellors at VSC service sites; (2) establishing certification systems for providers and

158

institutions engaged in delivery of VSC services to ensure that minimum safety standards are met; (3) establishing expert committees from private and public sector to review standards for VSC services and certification; and (4) provision of VSC services in hospitals and health centers where ancillary, emergency and follow-up services are more available than in the transitory camps. This new Project will support all of the above GON commitments to expanding the quality and availability of VSC services.

(2) "Clinical" Temporary Methods

IUDs. The national FP program virtually ceased to use the IUD as a method in the early 1980s, due largely to a shift to a unifocal VSC program and a negative image for the IUD that resulted from poor quality control over the program in the 1970s. In 1988, GON recommitted itself to offering IUD services for spacing, and also for limiters who are not ready to accept VSC. However, in the renewed enthusiasm for IUDs, overly ambitious targets were established which implied a risk of IUD services being spread too rapidly, to institutions with inadequate staff or facilities. To meet the desire to reestablish IUD services but not expand unsafely, the MOH and USAID agreed to: (1) establish minimum safe standards for IUD services in the Nepalese context; (2) begin training, or retraining, of potential providers; (3) establish a certification system for providers and institutions, similar to that being established for VSC services; and (4) continue field studies to determine the best way to motivate and satisfy potential clients. This new Project will continue these nascent efforts to revive the IUD program.

Norplant. AID has supported Stage I and II field trials of Norplant in Nepal. Clinical results have been good, and in 1988, in the GON enthusiasm for adding clinical temporary methods to their program, plans were made by MOH for establishment of routine Norplant services. As with IUDs, overly ambitious targets appeared in a flash, with the inherent risk of expansion of services without adequate staff or facilities. Although AID is not able to provide large quantities of Norplant (UNFPA has accepted that responsibility), we strongly counselled MOH that Norplant should initially be restricted to capable hospitals and only extended to health posts when availability of adequately trained staff could be assured. MOH now accepts UNFPA support for training Norplant providers and for developing a program monitoring system. AID and this project will support the introduction of Norplant services as part of a desirable range of services in capable institutions.

154

Injectable Contraceptives. Depoprovera services have been available on only a very limited scale due to low priority in the national FP program. Where Depoprovera has been offered, public acceptance has been good. Again in 1988, GON committed itself to making Depoprovera services more available, and UNFPA has agreed to increase the supply imported. AID cannot provide the contraceptive, but we support the safe expansion of availability if HMG chooses to include this method in its program. Again, the guiding principle we have felt it necessary to expound is that the injectable contraceptive program should be made available only when the reliable presence of adequately trained personnel has been guaranteed. We foresee injectables as eventually being a major method deliverable out of the health posts, though relatively few health posts can meet the minimum standards at this point in time.

### (3) Oral Contraceptives and Condoms

Contraceptive prevalence due to use of pills and condoms had by 1986 levelled off at about 3%. It is estimated that about 1/3 of that was attributable to public sector service/distribution programs, 1/3 to social marketing sales by CRS Company, and 1/3 to NGO service and distribution programs. Given the large infrastructure of the public sector, it is obvious that its performance was comparatively far less efficient. The major reasons for poor public sector performance were the low priority given to pills and condoms (temporary methods in general), weak fieldworker penetration and service to communities, small client loads at health posts, and no FP services offered at hospitals.

Even with the FP program rethinking of 1988, the public sector delivery of pill and condom services has not been given high MOH priority. Emphases were established for VSC and clinical methods, and MOH hoped that major pill and condom program responsibilities could be assumed by CRS Company and NGOs. AID's position is that while CRS and selected NGOs can be very effective at service provision for selected population groups, the bulk of the rural population in the near term will have no reasonable possibility of coverage by any provider other than the public sector FP services. AID also believes that, while the GON enthusiasm for clinical temporary method services is a positive change, for the next decade the majority of the rural population will not have adequate access to the hospitals and health centers in which safe clinical method services can be delivered; therefore, if a major demographic impact is to be achieved, pill and condom programs will necessarily have to play a major role. In this regard, MOH has agreed to gradually add motivation and supply responsibilities for condoms and pills into the duties the CHVs will assume. If this succeeds, Nepal will for the first time have an "army" of 40,000 village women preaching family planning and providing pill and condom services, and this should have a salutary effect on all FP services at all levels.

140

CRS Company has demonstrated that it can effectively motivate urban couples to purchase pills and condoms. If the Company's basic management problems are overcome, it is expected that CRS will remain the major force in pill and condom motivation and supply in the growing urban population. The original model of CRS Company was not suitable for rural areas in Nepal, so the potential for social marketing sales among the large rural population is still unknown. With AID and UNFPA support, in recent years the Company has experimented with some rural social marketing (RSM) techniques, and results are encouraging enough that CRS and AID wish to continue searching for effective and efficient RSM strategies. Whatever CRS Company can achieve among the rural population will reduce the burden on the public sector, freeing it up to tackle its many other program responsibilities.

Several NGO FP programs have achieved successes in motivation and service to small population groups. Although the impacts are not large in demographic terms, they have clearly demonstrated that the Nepalese public is open to the concepts and practices of FP when the messages and services are provided in a client-oriented manner and with tight management. Most Nepalese NGOs do not, however, have the potential at this time to cover large population groups with high quality services, so their major roles in a national program context should be to demonstrate successful approaches and provide training programs for other providers. This project will pursue these objectives through modest support to FP efforts of NGOs such as the FPAN, CEDPA, SCF-US, and others with lessons and/or training opportunities of benefit to the national program.

Only since 1988 have any special private clinics for FP been operating in Nepal; most of these modest start-ups were established with assistance from the Enterprise Project, as free-standing clinics and as new FP services in health clinics for employees of private industries. Although the economic upper and middle classes are small in Nepal, and although the organized industrial sector does not constitute a large workforce, these groups have been underserved in the past, it is anticipated that the size of these population groups will steadily increase in the future, and these are the population groups that would be expected to be the most receptive to FP. This project will collaborate with Enterprise to expand private services of these types. It is hoped that successful efforts of this type will encourage Nepalese to establish many new private services to create and then meet public demand for choices of providers.

## 2. Control of Diarrheal Diseases

### a. Context

Available data strongly suggest that diarrheal diseases are the leading cause of death among young children in

161

Nepal. Deaths occur in all ages of children, and all year round; however, there is a prominent incidence seasonality peaking in the warmer, pre-monsoon and monsoon months. There are few comprehensive epidemiologic data on the relative importance of different etiologies, though it is certain that many bacterial, viral and parasitic pathogenic organisms are involved. It was generally assumed by the Nepalese MOH prior to 1987 that most diarrhea-associated deaths were as a consequence of dehydration and electrolyte depletion of the watery, dehydrating diarrheal syndromes; prospective data from the Jumla ARI study, however, showed that at least in that environment most diarrhea-associated deaths were not associated with dehydration. In that environment, most were from dysenteric and persistent diarrheas.

GON and many donors are working on the provision of uncontaminated drinking water, and on sanitation programs. However, even optimistic, yet realistic, projections do not foresee that most Nepalese will be protected by adequate clean water and excreta disposal facilities in the next decade. Moreover, as the current generation of Nepalese parents is largely uneducated, it is not expected that they will provide a sanitary household environment for their children. Therefore, it is, unfortunately, unlikely that the transmission of diarrhea causing organisms, and the consequent incidence of diarrheal disease, will be reduced significantly in the next decade.

Because of resource limitations, and because so many other agencies already have a role in water supply and sanitation, this project will not invest directly in those activities. It will seek, instead, to try to prevent mortality, and minimize morbidity, from diarrheal diseases in children until Nepal has solved the water, sanitation and basic education issues and transmission and incidence are eliminated.

#### b. Mortality and Morbidity Reduction

A formal CDD program has been in place since the early '80s, with support from UNICEF, WHO and AID, and it has concentrated on making available, and creating demand for, oral rehydration therapy (ORT) at the hospital, health post and household levels. Emphasis has been given to (1) local production of packaged oral rehydration salts (ORS); (2) distribution of packaged ORS through MOH units and fieldworkers; (3) social marketing and sale of ORS by the CRS Company; (4) public education for the use of a home-made rehydration solution (nun-chini-pani) for households without access to packaged ORS; (5) training MOH fieldworkers to recognize diarrheal dehydration, provide proper rehydration treatment, and teach parents the same; (6) training physicians and other hospital-based clinicians in the recognition and management of diarrheal dehydration; and (7) management training for CDD program managers at central and district levels. The CDD program has had stable, good leadership and donor coordination has been good in support of the national program.

162

Any such new program in an environment as difficult as Nepal's will have some relative weaknesses, and this program still has deficiencies in (1) generating epidemiologic data; (2) fieldworker performance, especially in terms of coverage and quality of training; (3) distribution of ORS packets; (4) confusion among the public about mixing of home-made ORT solutions and solutions using the packaged ORS; (5) resistance to ORT among providers "wedded" to using antibiotics, anti-motility drugs, and other drugs that are often useless or harmful; (6) a divisive organizational structure for MCH services and policy in MOH under which an FP/MCH vertical project claimed responsibility for MCH but did little in diarrheal disease control, a curative section (hospitals) which had only one ORT center in the country before 1985, an "integration" project that had weak ability to deliver services but with which the national CDD program was "identified" until 1987, and an artificial division of CDD authority into "training" and "operations" until 1989; (7) harmful traditional public beliefs about the nature of diarrheal diseases and proper responses to them; (8) general lack of appreciation of the severity of the diarrheal disease problem for Nepalese children; (9) little data on the severity of the problems of dysenteric and persistent (chronic) diarrheas, small MOH capacity to respond to dysentery outbreaks, and little (worldwide) understanding of the causes and proper responses to persistent diarrheas; and (10) routine MOH reporting and recording systems for diarrheal diseases that require substantial effort but are of little practical usefulness. This list of problems should not be seen as a condemnation of the national CDD program; in fact, the ability and willingness of national program leadership to clearly identify such technical and organizational problems is one of its strengths and clearly deserves praise. Good progress has been made in addressing all the above program deficiencies in the past two years under the leadership of the national CDD program. A 1988 MOH-WHO-UNICEF-USAID Joint Plan of Operations for the CDD program has set out objectives and responsibilities in addressing each of the problem areas. This Project will continue those efforts as part of that larger coordinated program, with the major AID responsibilities for support being training of all levels of health workers and primary school teachers in two regions, physician and nurse training, monitoring systems, program management at regional level, development of a dysentery outbreak response system, ORT centers in hospitals, and research.

Another important area for AID input is the issue of the most appropriate ORS packet size and container size for mixing the solution. Under the previous project, an elegant sequence of field research activities convincingly demonstrated that mothers' performance in mixing a 1000 cc solution is poor; a 500 cc volume for the ORS solution is most preferred by mothers; there is no standard container of any size in the majority of Nepalese households; and mothers like standardized 500 cc ORS containers provided to them. On this basis, AID has recommended

163

a program shift to the 500 cc ORS standard and the distribution, and later sale, of standard containers for the 500 cc solution. MOH has expressed interest in this change, though it is properly concerned about the implications of the change in the program standard. WHO Regional Office has resisted the change, though we do not understand their grounds; UNICEF has remained neutral. Although AID counsels that further field research is not necessary to justify the policy change, the MOH at this point is willing to go ahead only with a 2-3 district field trial of the 500 cc standard, which this project will support.

### III. Control of ARI-associated Mortality

#### A. Context

There had been little work on the public health importance and control of ARI in Nepal before the early 1980s. At that time a small NGO did survey work in populations on the rim of Kathmandu Valley and in a high, remote western area (Jumla). Both studies indicated that ARIs (specifically ALRI-acute lower respiratory infections) were a major cause, if not the major cause, of infant and child mortality. An ARI control project was begun in the Kathmandu Valley site by the local NGO. In 1985, AID became involved with that same NGO and several others to organize an ALRI mortality control intervention project in Jumla District. That Jumla project demonstrated that, at least in that population, ALRI is indeed the second leading cause of death in infants/children.

It has not been possible in Nepal to obtain good etiologic data on ALRIs; it may be possible to obtain bacterial data from cases hospitalized in referral hospitals, with the biases that such data carry, but good community-based data are not likely to come available. Therefore, we must draw tentative conclusions from better data produced in other countries. Fortunately, data from other countries, and from a variety of environments, are somewhat consistent that about half of all childhood ALRI episodes (largely pneumonias) are associated with bacterial infection by two bacterial types, S. pneumoniae and H. influenza. This is of extreme importance because these bacterial pneumonias often are curable with relatively inexpensive antibiotics. Non-bacterial pneumonias are not susceptible to antibiotic treatment, and although general supportive care can be helpful, it is unlikely that treatment can make a large reduction in mortality from those non-bacterial pneumonias. Therefore, if systems can be developed which will assure early diagnosis and proper antibiotic treatment of (at least the) bacterial pneumonia cases, it is likely that a significant reduction can be achieved in ALRI mortality.

164

## B. Mortality Reduction from ALRI

All of the important risk factors for ALRI are not well understood. It is clear that young age and measles infection are important risk factors, perhaps both for incidence and severity; however, it is not clear how important are domestic air pollution, low birth weight, pertussis, protein-calorie malnutrition, Vitamin A deficiency, or other factors. Nor is it certain that the etiologic spectrum in Nepal is the same as in better researched areas of the world, or, indeed, whether the patterns are similar in different areas or different population groups of children around Nepal.

The major program options for ALRI control in an environment like Nepal, with the information available, are (1) immunization for measles especially, and also pertussis and tuberculosis; (2) passive case detection and treatment--that is, waiting for cases to present to existing health facilities for diagnosis and treatment; and/or (3) active case detection and treatment--that is, searching out children with ARI, diagnosing whether they have life-threatening ALRI, and providing the best treatment available, which will include an antibiotic, logically chosen based on the most likely bacterial infection. The Jumla control study, because there were virtually no other health services available and no appropriate care seeking behavior patterns among parents, chose to study the feasibility and effectiveness of an active case detection and treatment strategy. The Jumla program was managed extremely well, performing as designed, but, unfortunately, no overall mortality reduction from ALRI could be demonstrated. The most plausible explanations for the failure to reduce ALRI mortality are that the home visits every 2-weeks were not frequent enough to find ALRI cases early, that among Jumla's extraordinarily deprived population cases that were saved during ALRI episodes died later in a "replacement mortality" situation, that the etiologies of ALRIs were not as hypothesized, or that the tools employed to measure mortality effects were inadequately sensitive. Of course, there could be other explanations also.

Given that experience in Nepal, and that ARI studies elsewhere in the world have not shown program strategies that clearly will work in Nepal, the project proposes appropriately conservative ALRI control activities. Of course, immunization programs should proceed with all due haste, and their positive impacts on ALRI mortality will be additive upon their other benefits. Although the specific relationship between Vitamin A nutritional status and ALRI mortality has not been proved, it is a reasonable hypothesis being investigated elsewhere; Vitamin A programs should proceed in Nepal, and it is hoped that, in addition to other benefits, they might have a reductive effect on ALRI mortality. Also, although a clearly effective strategy for community-based ALRI case detection and treatment has not emerged, still there are thousands of ALRI cases appearing at

165

hospitals, health posts and private practices that can be better managed; this project will continue earlier work to put into place higher standards of diagnosis and treatment in all those settings. But certainly the majority of ALRI cases in Nepal never reach a fixed facility in time to make a difference in clinical course, so this project will encourage and support trials into active case detection by CHVs, TBAs and other fieldworkers, and into stimulating early case detection and early care seeking behavior by parents of children with ALRI.

#### IV. Immunization

##### A. Context

Epidemiologic data on the common vaccine preventable diseases of childhood ("EPI diseases") are not of good overall quality in Nepal, but there is little doubt that measles, tuberculosis and tetanus (especially neonatal) are major problems. It is likely that better surveillance tools and systems would document that polio, pertussis and diphtheria also are major problems. No good seasonality data exist, and geographic distribution data are absent except for neonatal tetanus, which appears to be a greater problem at lower altitudes. Except for neonatal tetanus, death rates from the specific diseases are unavailable except from a few hospital data reviews and outbreak investigations, and those are too weak to generalize from. The contribution of the EPI diseases to mortality reported as "diarrhea-associated" or "ARI-associated" is also unknown, though better data from other countries would suggest that measles and pertussis, especially, would be important co-factors.

As in some other countries, after eradication of smallpox that program was converted into an Expanded Program in Immunization (EPI). As was the style of the time in Nepal, that program, here called EIP, was established as a vertical program, largely administratively and in service delivery separate from other health programs. The start-up program went reasonably well in its early years, but remained very conservative in its policies and management, as perhaps was appropriate for a new program in Nepal's difficult environment. However, by 1985 it was clear that the program was stagnating: coverage levels were "stuck" at very low levels; morale was low; reporting was suspect; quality standards were low; etc.

Around 1985, with new leadership and with encouragement from UNICEF and AID, the EIP program reassessed its policies and procedures. It decided that some new policies were in order (e.g., offering tetanus toxoid to all women of reproductive age rather than only pregnant women), that different parts of the country should have EIP activities better tailored to their different circumstances, that campaigns and mass immunization efforts should be tried in some circumstances, that hospitals should begin to offer immunization services, that social

1/16

mobilization in support of EIP should be attempted in various ways, that field performance should be monitored in better ways, that massive fieldworker retraining was required, that major efforts were required to upgrade the hardware and procedures of the cold chain, etc. In short, EIP management committed itself to more flexibility, innovation and management fundamentals in order to achieve better coverage.

Building on the positive aspects of the program experience and foundation prior to 1985, the new management strategy rapidly was rewarded with renewed enthusiasm within the program, from donors, and from higher levels within Nepal. The program became more visible and better sold itself as one of importance, dynamism and potential impact. UNICEF and HMG made available much higher levels of funding--so much, in fact, that AID funding was not required for the basic program operating costs. AID's role since 1988 has been one of strong informal support, a few management system consultancies, and a district-wide program in Gorkha District in which SCP-US assisted the government EIP to refine its field management techniques so as to achieve higher levels of coverage with still potent vaccines.

#### B. Mortality and Morbidity Reduction by Immunization

The EIP has solved many problems, at first the post-smallpox transition problems to a new EIP program, and then since 1985 another set of problems to open up the program management to one capable of large scale coverage. But as with the evolution of all organizations, especially young ones, EIP's expansion of scope and size has created a new generation of problems. The major issues to be dealt with over the next decade are: (1) how to protect the achievements of the heretofore vertical program as it is absorbed into the MOH's evolving integrated structure; (2) the cost/effectiveness and relative efficiencies of various program approaches; (3) more refined communications for public mobilization; and, (4) for program monitoring purposes, how much reliance can/should be placed on management performance indicators vs. coverage data vs. disease incidence indicators.

Because the bulk of EIP operational and commodity costs for the 1990-95 period are expected to be met by HMG and UNICEF, this new project accepts the more modest role to collaborate with MOH in solving issues of monitoring, the integration of EIP into the larger array of MOH services, decentralization of management responsibilities, communications strategies, and cost analyses, as described in the body of the PP.

#### V. Malaria Control

##### A. Context

The low altitude Terai and river valleys of Nepal until the 1960s were among the world's most malarious areas, so

167

much so that only a few, small ethnic groups lived in that area of dense forests and relatively rich potential farmland. Beginning in the 1950s, AID collaborated with HMG and WHO to bring malaria under control, using standard malaria control methods of the times, stressing intra-domiciliary spraying with insecticides. By the end of the 1960s, the cases of malaria had become relatively insignificant, and major population, agricultural and economic shifts were underway to the Terai. HMG and the donors had performed extremely well, and all could be proud of their accomplishments.

By the early 1980s, however, it was obvious that the previous fine control of malaria transmission was breaking down. The major factors involved were (1) insecticide resistance in the mosquitoes; (2) drug resistance of the malaria parasites (*P. falciparum*); (3) declining political support for the malaria program due to a complex of political, sociological and awareness reasons; (4) organizational fatigue within the malaria eradication organization of the MOH; (5) outdated entomological information on the transmitting mosquitoes; (6) deterioration of program management with "integration" of vertical programs in some districts; and (7) inadequate training programs for managers and fieldworkers. In addition, donors, including AID, were becoming less interested or able to continue to provide 100% of Nepal's insecticide requirements, especially given that HMG was showing no signs of initiative in assuming any responsibility for procuring insecticides, despite promises for many years.

In 1985 there was a major epidemic of malaria in the Far West Region. While significant in itself as an epidemic, it was more significant as a symptom of deterioration of the malaria control system as a whole, and the potential risk to the 50% of Nepal's population, largely non-immune to malaria due to low exposure history, now residing in the Terai.

#### B. Malaria Mortality and Morbidity Reduction

The capacity for malaria control in the future will depend on the following actions:

- an entire new generation of health system managers and fieldworkers will have to be trained in the skills to control malaria. Because of the expectation of eradication, very few young people entering the health field have chosen to seek those skills, nor has HMG given priority to maintaining a large training capability. Now it is clear that malaria control requires a long term commitment. All the health system's managers, technical specialists and generalists who will have responsibilities related to malaria will need initial and frequent retraining. Also, malaria control now is far more complicated than in the past; mosquito and parasite

168

resistance is forcing control programs to use more toxic drugs and insecticides, and greater reliance must be placed on environmental and biological control and on community and individual mobilization for self-protection.

- with the shift to a more integrated health system, it will no longer be possible to rely heavily on active case detection (ACD) workers and systems. Alternative passive case detection (PCD) and treatment systems will be required. The MOH, with AID assistance, over the past few years has put in place in some malarious areas a highly effective PCD Volunteer system that is detecting a majority of the cases found. Also, because laboratories centralized at hospitals under the integrated system cannot be relied upon to provide timely laboratory services for malaria cases found in the communities, a more decentralized malaria laboratory system must be established. This will be done, based largely on the ilaka health post network. With these two networks functioning, the burden of malaria illness and the reservoir of parasites for transmission should be decreased. Also, the MOH should receive earlier indications of outbreaks because the case detection systems are so close to the clients.

- the entomologic information base on malaria transmission should be updated. Much of the available information was obtained in the 1950-60s; the mosquito-man-animal ecology has changed drastically in the Terai since then and it is very likely that transmission vector dynamics are changed. As an example, MOH and AID have studied two areas of persistent, troublesome transmission in the past 3 years, and prior data on the vectors have been found to be incorrect. What is more, reliance on incorrect, old entomologic information has led to inappropriate control program responses and subsequent prolongation of the malaria transmission.

- HMG must become more proactive in assuring the minimum supplies of the most appropriate insecticides. The historical total dependence on donor granted insecticides will not serve the program well in these changed times. AID has suggested several strategies for managing this problem to HMG over past years, but HMG has not shown strong signs of a different, more proactive approach. There is little doubt that more grant donors can be found in the short-term, but that should not be an excuse for postponing longer term solutions.

The Project's components for malaria control include specific responses to the current program requirements listed above (with the exception of providing insecticides), and should be important, effective, and reasonably inexpensive activities to develop national capacity to control malaria at reasonable

levels. It is a far sounder investment in the future than continued "drops" of insecticide that HMG should be taking greater responsibility for, or which, at the very least, are likely to be provided by other donors without AID's 35 year history of having done so in Nepal.

B. ECONOMIC & FINANCIAL ANALYSES

Introduction

For the past decade, the MOH has been activating its plan to have approximately 800 health posts established in the country. The construction and manpower elements for this effort have used up much of the MOH's energy. The basic infrastructure, while recognizing personnel positions are still to be filled in many parts of the country, is now in place. The challenge is to use these resources effectively.

This analysis will address several economic and financial issues which are expected to affect the feasibility of achieving the project objectives. They include the following issues:

- Current HMG health and family planning sector expenditures;
- MOH ability to provide counterpart funding;
- MOH ability to sustain project activities following project completion;
- MOH financial management performance;
- Cost effectiveness of project interventions; and
- Cost recovery prospects.

1. Current MOH Health & Family Planning Sector Expenditures

Public expenditures (MOH budget) for health care are estimated to be 1% of GDP and represent approximately 5.8% of the total HMG budget. The budget share has remained steady over the last ten years and represented approximately \$2.00 per capita in 1987 (\$34,000,000). In FY 87/88, over 75% of the total was expended through the development budget, which was 2/3 funded by the donors in 1988/89, and 25% through the regular budget (which is mostly funded by the HMG). It is estimated that up to 20% of the total budget is devoted to actual primary health care services, with the remainder allocated to secondary and tertiary care and administration. Of the total amounts budgeted, substantial proportions are left unexpended each year as the result of either over-budgeting, management problems and/or slow implementation. On average, only 80% of funds allocated to "public health" is expended each year, and for NFY 88/89 64% was expended. A major element of the unspent budget was for the malaria program which expended only 22% of its allocation. The percentages expended in NFY 88/89 were: FP/MCH - 61%, malaria - 22%, EPI - 98%, CDD - 37%, ARI - 77%, CHV - 74%. A principal objective of this project is to strengthen management of health and family planning programs, primarily in the Central Region, and thereby increase the effective use of allocated funds.

## 2. HMG Ability to Provide Counterpart Funding

This project will not require the MOH to undertake any additional budgetary commitments beyond what is already planned in the next Five Year Plan. (The MOH has already budgeted resources for carrying out its responsibilities for project-related activities.) It will, in essence, assist the MOH in increasing the efficiency and in improving performance using resources which it already intends to devote, or will actually provide, to the health and family planning sector during that period. The project will do this by providing technical assistance, training, commodities and some local cost support for the work of MOH staff and community volunteers, primarily in the Central Region. However, attainment of project objectives will require that HMG actually provide the requisite personnel and operating budget funds necessary to perform their expected duties. For example, the MOH (and USAID) is currently reviewing problems arising from the lateness or inability to provide the MOH's 100 NRs per month allowance for CHVs, and assessing the CHVs willingness to continue, based on other advantages and on potential "profit" from the sale of basic medicines from the CHV supply kit. If such incentives are not, in the longer term, sufficient for CHVs to continue working, several aspects of the service delivery element of this project will suffer proportionately.

This analysis will assess the counterpart funding prospects by: a) reviewing the current staffing situation to determine if most of the required personnel are already in place and funded; b) comparing the counterpart burden of this project with the predecessor project (IRH/PPS) and reviewing the extent to which the MOH met that counterpart commitment; and c) analyzing the current and prospective overall HMG/MOH financial condition and national economic situation, both of which will affect MOH's ability to meet counterpart budget obligations for this project.

a. Current staffing situation: The Central Region analysis (Section VIII) shows the staffing situation as of May, 1988. It reveals a generally positive situation, especially with regard to the District Public Health Officers (100% of sanctioned posts filled) and the Health Post In-charges (HPI) with 100% posts sanctioned, 94% filled, and 86% working. The Auxiliary Health Workers (AHW) were also well represented with over 90% of sanctioned posts filled and almost all in place. However, approximately 60 new AHW positions will be required to comply with the new MOH staffing pattern. The situation for Auxiliary Nurse Midwives (ANM) is not as good, with only 73% of sanctioned posts filled, and only 50% of sanctioned posts actually occupied. Furthermore, to meet current MOH targets, at least 170 more ANMs would have to be assigned. At the village level, there was a surplus of currently employed workers associated with several vertical programs, many of whom have been converted to the new VHW category. In summary, the Central Region is now reasonably well staffed in currently funded positions and is ready to meet the requirements of this project without posing an additional counterpart budget burden. Even if expected HMG budget constraints prevent the hiring and placement

172

of the AHWs and ANMs (or new MCH workers) in the Central Region, the project will not be seriously affected since they are not substantially involved in the community outreach activities beyond the health post, which is an important focus of the project.

The current staffing situation with regards to project activities outside the Central Region is less complete. It is reasonably good at the national level for staffing project-related positions but, even though all required positions are "sanctioned", either some are not yet filled or staff have been deputed elsewhere (PHD, FP/MCH, Planning). The extent to which operational activities will be conducted in other regions, where staffing is less complete (with the possible exception of the Western Region), will depend on the presence of qualified staff, rather than requiring the appointment and funding of staff not currently present. Even more important is the Regional Directorate authority over its senior (gazetted) staff placement. In terms of budgetary burden, however, project activities will not place additional requirements on the MOH.

b. Comparative Counterpart Burdens of CS/FPS Project vs IRH/FPS Project- The counterpart requirements of the two projects are fairly similar, at least when comparing the late stage of IRH/FPS with the plans for CS/FPS. Over the course of the IRH/FPS project, funding for the majority of FP/MCH field worker salaries shifted from donor funding to MOH payment (MOH converted contract employees to sanctioned posts). Both projects show support for only certain local costs of MOH employees and do not include general operating/recurrent costs. USAID will not provide insecticide for the malaria component of CS/FPS, but the MOH will probably obtain other donor funding for it. Although this may not represent a financial burden on the MOH, it probably will introduce some uncertainty about timely availability of that essential commodity. The new project will also require that the MOH finance some spraying equipment.

c. National Economic and MOH Financial Outlook: The present economic crisis caused by trade and transit difficulties with India renders obsolete all earlier projections for economic growth, HMG revenues, and expenditures for the project period. At best the current situation will cause only near-term economic and budgetary problems and will not adversely affect the Government's ability to support the project over its five year life. However, near-term dislocations could cause a delay in project start-up if counterpart funds are unavailable for the first year's activities. At worst, the crisis could cause long-term retrenchment of government expenditures for social programs and preclude project implementation completely, or cause MOH to request that a portion of the AID funds be devoted to direct budget support to sustain current levels of activity for highest priority components.

173

In view of this situation, several assumptions and conclusions are made which guide the design of this project. First, MOH projections for economic growth and budget expenditure expansion, and the health/family planning performance targets which are depended on the former, are no longer relevant. Secondly, the USAID assumes that the current MOH budget and sanctioned posts levels will not increase, at least for the next two years (until 91/92). Thirdly, health and family planning activities which are not already priority elements of the Basic Needs Program will probably not be launched or expanded during the next two to three years. In short, the Project will concentrate on strengthening performance and productivity of those high priority programs for which staff and essential funding presently exist (family planning, child survival (including CDD, EPI), CHV, Central Region management and malaria). This period of austerity will actually present an opportunity for the HMG to take advantage of this project's emphasis on productivity and effectiveness to make difficult but necessary managerial and service delivery reforms.

### 3. MOH Ability to Sustain Project Activities Following Project Completion

The project will not impose a significant financial sustainability burden on the MOH to carry out the services necessary during the project period. Because, as noted above, USAID will not be funding large expenditures which the HMG would have to assume at project completion, with the exception of contraceptive supplies, the transition should be relatively easy. The largest such item is travel, per diem (TA/DA) and training costs associated with the extensive training to be conducted primarily for Central Region staff. If that training is successful in introducing new planning and management practices into the region and the staff gain sufficient expertise in applying them during the project period, the MOH should be able to sustain that level of performance with a lower level of refresher training and periodic full training for replacement staff. We estimate that training at one-half the level provided by the project in year 5 will be required to sustain program performance. That would be approximately \$80,000 per year.

Some features of the project will actually reduce the financial sustainability burden on the MOH. To the extent that the relatively expensive mobile VSC camps can be phased out and the services can be provided from multiple service fixed facilities (hospitals) within the district by regular staff, ongoing costs should be reduced. Similarly, as services currently delivered by vertical programs (EPI, FP/MCH, malaria) are successfully integrated at the district level, attendant efficiencies will reduce costs of continuing those services in the future. The increased supervision and monitoring of field level personnel (which will be an inherent part of the project) will require more funds than are currently being spent for that purpose. In addition, this expense, which has in the past

- 174 -

largely been incurred by vertical project staffs, now must be provided by the integrated system through DPHOs and Health Posts-in-Charge. The ability to maintain this without imposing an enormous financial burden on the MOH will largely depend on the project's ability to establish simple, standard procedures and schedules for health staff which become a routine part of their normal duties. The ability to do this is already being demonstrated within the PHC/CDD program. It is expected that the CDD supervision/monitoring format and procedures will be adapted for other interventions, requiring minimal extra work.

#### 4. MOH Financial Management Performance

The ability of the MOH and other concerned HMG entities to budget, release and monitor funds required to implement this Project will impact directly on the pace and quality of implementation. Because A.I.D. local cost support funds are budgeted and managed in the same way as MOH counterpart funds, the overall MOH financial management performance will affect the rate of use for all project-related funds. This section will assess the current MOH performance in managing funds for the ongoing IRH/FP project and its impact on that project, estimate the implications of that performance on this new project, and propose measures that can be incorporated into this project to minimize adverse impacts on planned outputs.

a. IRH/FPS Financial Management Experience: HMG/MOH financial management practices have adversely affected IRH/FPS implementation by causing severely delayed release of A.I.D. cost support and MOH counterpart funds required to carry out agreed-upon annual workplans. The most serious problem has been delays of three to four months in release of initial funds for the start of each annual workplan. Therefore, work which is scheduled to begin in mid-July of each year often cannot get underway until November or December. Since the HMG fiscal year of July 16 to July 15 is divided into trimesters for budgeting purposes, the first trimester is practically lost each year.

The delays are usually caused by slow responses to Ministry of Finance/Comptroller General questions about the A.I.D. local cost support budgets submitted by MOH in the various annual work plans. The budgets included in annual work plans for each IRH/FPS sub-project (FP/MCH, EPI, CIV, CDD, NMEQ, etc.) must conform precisely with the plans submitted by the MOH previously for inclusion in the "Red Book". The MOF Comptroller General inevitably finds discrepancies between the two during its "cross check" exercise during July/August, prior to authorizing release of funds for the first trimester. Resolution of the discrepancies can take several months, resulting in loss of the first trimester for many project components. In fact, the innovative female Community Health Volunteer program start-up was delayed five months in 1988/89 for this reason. Because the A.I.D. project funds and MOH counterpart funds in each annual work plan budget are "tied" to each other to ensure parallel release, discrepancies in either budget result in delayed release of the total. Field operations are thereby stalled until the issues are resolved.

Also, reimbursements to ongoing MOH programs by USAID during the year are frequently delayed because the reimbursement claims are submitted late by MOH units, are incomplete and/or inaccurate. USAID staff must then follow up with the respective MOH unit to clarify the issues, and/or disallow portions of the reimbursement requests. This problem is compounded by the fact that some IRH/FPS activities are conducted nationwide. MOH District offices prepare and submit the reimbursement claims first through the cognizant MOH unit and then to USAID. In practice, the MOH receives reimbursement claims prepared by at least 75 different individuals with varying levels of training and experience in financial management. It is inevitable that problems arise, causing delays and disallowances. The MOH headquarters offices often do not screen the claims sufficiently to eliminate the problems before passing them on to USAID for payment. The MOH has not provided sufficient training to the district staffs responsible for claims preparation. For its part, USAID has provided the services of project-funded accountants to FP/MCH, PHD/CDD and selected districts and has tried to ameliorate the problem. This has helped the FP/MCH and PHD/CDD units, but has not solved the overall problem within the MOH and its many divisions and units.

Time delays have been substantial. Taking the large FP/MCH program as an example, USAID PILs established a 60 day period for receipt of reimbursement claims following the end of each trimester. Actual experience during the Nepalese FYs 85/86, 86/87 and 87/88 shows average submittals of 105 days after the trimester period before USAID received the claims documents.

Unfortunately, although USAID set a 21 day period for its own review and processing, this has taken an average of 90 days instead, thus adding even more to the delays. Almost all of that time is devoted to resolving questions about incomplete or inaccurate documentation. These delays have been the source of complaints by MOH that USAID's administrative procedures hurt project performance, and by USAID that HMG procedures and lack of attention seriously delay project activities.

The integration process has apparently exacerbated this problem by requiring many staff reassignments. Persons who were becoming familiar with the process have been transferred and their replacements have had difficulty mastering the required procedures. Consequently, in Nepalese FY 88/89, FP/MCH was unable to submit its first and second trimester claims at all, and just submitted the entire year's claims together to USAID on November 13, 1989. USAID must now review the entire package and reimbursement is substantially delayed. Consequently, HMG has been without USAID financial support for this component of that important program for over one year. The FP/MCH program has been most affected by this problem because it is the largest project component, spread over many districts and relying heavily on USAID support.

176

b. Financial Management Implications for This Project: Two factors will tend to reduce the severity of this problem on this project. Firstly, USAID has noticed some gradual improvement in the quality of district claims presentations, resulting in some reduction in delays and disallowances. Secondly, and more significantly, this project will concentrate the majority of local cost support activities in the Central Region. This will enhance opportunities to improve performance in reimbursement claims preparation and in financial management practices. In support of regionalization, USAID can work closely with the CRHD in preparation of the plans and help to ensure that they are closely coordinated with the MOF and will pass muster during the Comptroller General's "cross check". There will still be several smaller workplans to be negotiated with other MOH units covering project national-level activities, but these will involve far less funds than under IRH/FP.

Concentration of field-level activities in the Central Region will also limit the number of districts involved, many of which will be supervised and coordinated by the CRHD. This will enable USAID to focus efforts on improvement of financial management performance for reimbursement purposes for a more limited and manageable number of units. Consequently, the level of problems, length of delays, and amounts disallowed should be less than under IRH/FPS. But this will not occur by itself, as the project will provide technical assistance and training for this purpose. The institutional contractor will be responsible for assisting the MOH units with field level accounting for use of project funds, preparation of reimbursement claims to be submitted to USAID, and clarification and rectification of questions raised about those claims.

##### 5. Cost Effectiveness of Project Interventions

This economic analysis section will not attempt to address the relationship between project costs and ultimate health benefits because these cannot be quantified in economic terms. The eventual benefits from reduced fertility, morbidity and mortality are undeniable, but cannot be determined numerically. However, it is important to consider the relationship between project-related costs and the effectiveness of the various management and service delivery interventions. Most project costs are known, at least in terms of estimates for specific inputs. Other costs will be determined during the course of project implementation, some of which will be concrete financial costs and others will be harder to define, such as mothers' time devoted to community organizing. Appropriate indicators of effectiveness will be determined by the project participants continuously as an integral part of implementation. For example, regional and district planning and budget preparation training courses will be considered to have been effective if the DPHOs submit realistic annual plans and budgets on time. The discussion which follows will address the anticipated project costs in terms of inputs and measures that can be taken

to minimize costs and maximize both efficiency and program effectiveness. It will also assess project initiatives which incorporate cost effectiveness analysis skills into MOH health and family planning programs.

a. Project Costs: The project input and implementation strategies are based on minimum cost approaches and viable lower cost alternatives. Most of the AID funds will be used for human resource development (T.A. and training), essential commodities (contraceptives and selected family planning and malaria equipment), and local cost support to the MOH and NGOs. As such, they will not increase the costs for Nepal of providing health and family planning services. The project will not introduce expensive new technologies which would impose additional cost burdens on service delivery to the target populations.

The service delivery strategy adopted is based on low cost community outreach services provided by para-professionals and trained volunteers, supported by MOH technical specialists. By contrast, it is not a facilities-based strategy requiring construction and maintenance of expensive hospitals and clinics. Unit costs of services delivered will be the lowest possible, consistent with appropriate HMG/MOH norms and standards. For example, a minimum investment in cold chain equipment and training will be required to ensure effectiveness, but immunizations will be given by relatively low paid para-professionals.

The health sector integration strategy supported by this project will reduce service delivery costs by eliminating management and staffing redundancies inherent in operating several vertical programs in identical locations. The decentralization strategy also supported by the project will probably not impact on costs directly. It will, however, enhance program effectiveness by moving planning and decision-making down to the district and field levels where the problems and their solutions are more apparent.

b. Cost Effectiveness Measurement: During the course of the project, the Central Region Directorate and district staffs will be trained to determine service delivery costs on a per capita basis, to establish effectiveness parameters, and then to measure cost effectiveness of selected interventions. DPHOs can then compare relative cost effectiveness of performance between sub-units, different periods of time, and types of interventions (IUD's vs injectables; static vs mobile VSC facility, etc). The CRHD can make similar comparisons between districts, and MOH can begin to determine the relative value of its resource allocations. Training in cost effectiveness analysis will be initiated in a few Central Region districts following the successful introduction of prerequisite planning, budgeting, and management information systems practices.

178

## 6. Cost Recovery Prospects

The HMG has changed its policy of providing free health services to the population. It now recognizes the need to recover at least some costs, through payments for medicines and some fees for medical services at static health posts. With the notable exception of contraceptive and oral rehydration salts sales by the private, for-profit Contraceptive Retail Sales Company (CRS) and fees for services at new family planning clinics, opportunities for generating substantial user fee revenues from the recipients of project services to support the costs of, or expand, project services are virtually nil, for two reasons. Firstly, disposable income of the target population is extremely low. Secondly, health consumers give priority in allocating their meagre health care expenditures/resources to curative, or even traditional healer, services, in contrast to the promotive/preventive services supported by this project. This conclusion is supported by the findings of a 1987 study by John Snow, Intl. which concluded that the two most promising options available to the MOH were: 1) income-scaled fees at hospitals; and 2) user fee charges for medicines. The latter will be incorporated into the CHV program in the Central Region in order to enable the volunteers to maintain the contents of their medicine kits. Charges will not be levied for hospital-based clinical contraception procedures (once established), so as not to dampen demand for them.

It should be clearly understood that the costs of basic health services, provided in a very limited fashion by the Government of Nepal, will not be met by the populace through direct payments. These services, for the most part, will be funded from other sources for many years to come. Until the economic base of the country is dramatically changed, most health-related costs will be borne directly by the government.

C. SOCIAL ANALYSIS

Two of USAID's five basic themes for the health/family planning sector highlight social/administrative weaknesses of present public health system. Until it begins to reach effectively "beyond the health post", the system provides contact points too distant and too infrequent to be of much use to rural families. Without more rural workers, spread more evenly through the villages, and providing a worker who is socially accessible, the system will fare poorly in providing sustained, effective services to rural residents. Present staffing strategies provide male, migratory VHWS in a ratio of roughly one to 5000 clients and who visit a specific ward (even under bureaucratically ideal patterns) only one or two days per month (and, in reality, frequently less often). These workers are furthermore poorly supervised, undermotivated, subject to sudden transfers, and frequently assigned to areas of unfamiliar language, culture, and terrain. Male VHWS cannot provide "services by and for women", thus encountering a series of cultural encumbrances which, even with the highest motivation, lessen their effectiveness as motivators and service providers and, at the extreme, may deny physical access to women who are primary clients for MCH and family planning services.

USAID and the MOH have worked over the past year to pilot test and introduce an entire new category of service providers, in order to overcome the challenges of low worker:client ratios, physical isolation of villagers from health services, and inadequate support, supervision, and motivation of existing health workers. A female Community Health Volunteer (CHV) is to be selected from among local residents of each ward (37,000 total) in Nepal, and trained, monitored, supervised, and supplied under a system already initiated, but only partially developed.

Effective establishment of a realistic, model system of locally resident, female CHVs is a significant administrative challenge facing the MOH and this project over the next several years, precisely because it addresses administrative issues at the point of interface between the system's workers and its clients. MOH and USAID officials are to be commended for identifying a service provision strategy which: 1) assures a reasonable service provider:client ratio, of approximately 1:500; 2) identifies, trains, and supports locally resident service providers who are consistently available to clients and already familiar with local language and culture; and 3) provides services by and for women. However, this Social Analysis poses a series of administrative/cultural challenges which must be recognized, met, and overcome if the CHV system is to be effective and sustainable. Major challenges include

appropriate compensation for CHVs; selection and re-selection procedures; effective training, monitoring, and field support; and worker motivation.

Compensation for CHVs: Community Health Volunteers are to be paid an "honorarium" of NRs.100 per month by the MOH. Although cash is scarce in isolated hill and mountain areas, it is widely agreed that even this small stipend goes against the spirit of volunteerism, identifies the CHV position with that of the civil servant with all its expectations of benefits, etc., and, given the heavy financial burdens of the GON/MOH (see Economic and Financial Analysis), is not a realistic option. Yet a well performing CHV providing well appreciated services should receive sufficient recognition or compensation to keep the CHV at work and content. The project must support the MOH in serious, sustained efforts to identify realistic mechanisms for compensating CHVs. Field monitoring and case studies can identify "spontaneous" local efforts to solve this problem (e.g. efforts by CHVs and clients to establish informal fee-for-service schedules and by local government to legitimize them). USAID and the MOH can then follow up with operations research, formalizing and testing the more promising spontaneous models.

At least three broad approaches to income supplementation seem feasible. The importance of psychic income should not be discounted. Among other psychic rewards, CHVs can be provided with uniforms, honored on public occasions, and asked to serve on specially-constituted committees, advising the village panchayat and district public health office on health and family planning matters. Village panchayats can offer a monetary supplement to CHVs from present, limited revenue, or levy an annual "health services fee" (on a sliding scale) to be paid by ward households to the CHV. A semi-formal, fee-for-service system might be established, at least for curative services, with local government or the MOH sponsoring and legitimizing a semi-formal fee schedule. Since many rural groups already make payments to informal "health service providers" such as jhankris and midwives, there is ample precedent for fee-for-service.

At present there is little possibility of even meeting the proposed honoraria of NRs.100 per month. Total annual cost of providing NRs. 100 monthly compensation to CHVs would be \$1.6 million, and there is ample reason for caution in adding to MOH recurrent costs. If, however, after three or four years CHVs have clearly demonstrated their cost effectiveness in extending preventive and curative services to rural areas, the GON should review reasonable options for appropriately compensating the CHVs.

Selection and Re-Selection Procedures: CHVs should be selected for their energy, intelligence, and willingness to serve all ward residents. These personal qualities should be stressed during ward level selection, reiterated and tested

181

during CHV training, and regularly observed during early field monitoring and supervision. Nevertheless, a significant proportion of inappropriate initial choices (perhaps 10-25%) should be anticipated, and orderly procedures for termination of inappropriate individuals and quick, but more effective, selection of replacements should be established early in the program. High caste and close ties to male elites should not rule out candidates for the position. However, if selected high caste individuals are hampered by notions of ritual pollution in effectively discharging their duties, they should be dismissed. (If, due to notions of ritual pollution, high caste individuals reject the services of a CHV lower in the hierarchy, that's their choice. This should not be grounds for CHV dismissal.)

Others personal qualities being equal, candidates of higher educational attainment (and skilled in spoken and written Nepali) are preferable. But lower educational attainment (even illiteracy) can be offset in specific cases by energy, intelligence, and willingness to serve. In areas where Nepali language skills are limited, provision of Nepali literacy training to CHVs may be a much-appreciated compensation for services rendered.

It is essential that the program establish timely, effective procedures for CHV dismissal and re-selection. Through incorporation of significant "hands-on" learning experiences and consistent rhetorical support for service to all women and children into training courses, candidate CHVs who are shy, uncommitted, or hampered by notions of ritual pollution can be identified and terminated at an early date. Observation of these qualities must also be a major concern of field supervisors during the first months of service of every CHV. Where dismissal is clearly appropriate (non-performance of duties will be the clearest, most frequent indication of CHV shortcomings) the concurrence and support of the village panchayat in the dismissal procedure should be solicited.

Effective Training, Monitoring, and Supervision: Since the CHV program will be established nation-wide (although this project supports its establishment in only one region), and will rely heavily on rural women, there must be serious consideration of providing training and field supervision in languages other than Nepali, in certain isolated areas. (Perhaps literacy and Nepali language training can be offered in these areas as a de facto salary supplement.) Details of training course content have already been covered in technical and institutional analyses.

There must be very careful attention to field monitoring, supervision, and logistic support during the first several months in each ward. This is fundamental to the overall success of this program. The CHV should be formally "re-introduced" to ward residents, in her new paraprofessional role, soon after completion of initial training. If possible, the Pradhan Pancha

should be enlisted in this process. Initial monitoring/supervision visits should be frequent (at least twice monthly for six months) and should emphasize personal evaluation of the new appointee, and a structured program of "polishing" new skills acquired in training.

It is imperative for CHV morale and effective demonstration of program potential that new CHVs be given adequate, timely field support. Supervision and monitoring must be supportive and constructive and must be delivered on schedule, and CHVs must never be asked to carry out special tasks (e.g. publicity for a new family planning method, or a campaign to monitor infant growth) until appropriate equipment and materials have been delivered and training has been offered. Establishment of inappropriate performance targets for CHVs would also be extremely deleterious to the program.

Worker Motivation: Positive CHV motivation is to some degree dependent on appropriate selection criteria, termination/re-selection procedures, and effective training and supervision programs previously discussed. In addition, it is essential to make these workers accountable to local residents and local government. Perhaps soon after training is completed, there can be a ward-level public meeting at which the ward representative to the Village Panchayat, representative local residents (mostly female), and the new CHV agree on a realistic work agenda for the first year, and some work norms for CHV/client interaction.

D. INSTITUTIONAL/ADMINISTRATIVE ANALYSIS

This analysis will cover the organizational units within the MOH that will be primary project implementors. It will also review the status of private sector and quasi-private organizations that will have major implementation responsibilities.

1. Background: For almost twenty years the Ministry of Health has been interested in integrating the services provided by vertical programs into a system that would capture the outreach capabilities and management expertise of the vertical programs and also operate more efficiently. USAID has assisted, initially with operational trials of integration in selected districts and more recently with attempts to operationalize the concept.

The 1988 evaluation of the IRH/FPS project notes that many of the project's objectives relating to integration had not been achieved because some basic organizational problems had not been adequately addressed. One problem was the organizational autonomy of the vertical projects within the MOH. That USAID and other donors have provided much of their assistance directly to these vertical projects, although there were good reasons to do so, has strengthened their independence over the years. Also, the personnel system has been closely controlled from the national level, has shifted staff with little consideration of the program implications, and has not been able to absorb staff from the vertical projects, thus making them reluctant to support integration.

Two important steps have been taken over the past two years that should facilitate the integration process. Integration has become government policy and the MOH has put the five Regional Directors in charge of implementing it. The Regional Directors report directly to the Secretary of the MOH. Secondly, all of the vertical programs (EPI, FP/MCH, NMEC, etc.) will be functionally under the Public Health Division (PHD) upon completion of reorganization in mid-1990. The PHD reports to the Secretary through an Additional Secretary (see current MOH organization chart, attached).

A major portion of this project's technical assistance and training will be targeted at implementing this new regional/integrated approach in the Central Region. In this context, the project will work directly, during the first 1-2 years of the project, with the FP/MCH Division as it finalizes decentralization and integration of its service delivery function; and continue to work directly with the National Malaria Eradication Organization (NMEC). During the project period, these and the other "vertical" programs are to be integrated. This project focuses on consolidating some of the strong elements of the MOH delivery system (e.g. malaria supervision system) and applying them to the Central Region.

2. The Central Region Health Directorate and beyond:

This project will focus on the 19 districts of the Central Region and the CRHD. This decision is based on the recommendations of the IRH/FPS project final evaluation; the fast start-up and strong leadership in this region vs. the others; the fact that the CRHD's office in Kathmandu gives the Regional Director easy access to the national level MOH decision makers and technical directors whose cooperation will be essential; the fact that, under the current (pre-1990) organization chart, Regional Directorates have been placed organizationally in the MOH so as to have direct access to the Secretary; and, finally, accepting the real existence of the Nepalese "social institution" called "source-force" which operates extensively in the area of government personnel securing forward assignments in favored locations (usually this has a negative impact on programs in outlying areas, but a positive impact on the Central Region). If the program of integration/regionalization is to work, it will happen first in the Central Region.

The project will move beyond the Central Region as feasible and, particularly in the area of family planning, will assist with the institutionalization of strengthened/integrated services in other selected districts. Additional districts will be chosen based on strong DPHOs with a good working relationship with the local political structure and the national level MOH.

The five Regional Health Directorates' roles were formalized in the MOH's 1987 policy announcement on the regionalization and integration of health services. USAID has been providing assistance to the CRHD for over two years. The first workshop involving the 19 DPHOs was held in January 1988. A second was in April of that year. By July, all the DPHOs (many are former staff of the vertical projects) were officially appointed to their positions. By the end of 1988, the CRHD had its full complement of administrative and fiscal staff at the district level. In January 1989, district personnel were called in to begin development of the first plan and budget for the 19 districts. Four months later the CRHD was fully staffed.

In the context of Nepal the CRHD has had a rapid start up. The progress, however, still leaves much to be done. The authorities and responsibilities of the regional directorates are not clearly established. In particular, the CRHD needs more autonomy in planning and budgeting. The CRHD, and the districts, have far to go to develop the management capabilities they will need. Also, the vertical projects need greater commitment to the difficult process of changing into national level technical and policy units, turning field operations over to the Regional Directorates and the districts.

The serious effort to develop planning, budget, personnel authorities to the Regional Health Directorates and the re-alignment of the vertical projects under the Public Health Division of the MOH have created a situation where the Ministry

is, finally, organizationally poised for integration. Project inputs are intended to strengthen this situation. One concrete step that will be taken is to channel all funds for work in the Central Region directly to the Regional Health Directorate so they are included in its budget. In the past, most donor assistance has gone to the Central Ministry, which would turn it over to different projects or districts. Under regionalization, each Regional Directorate is to take on planning and budget responsibility. The project's procedures for disbursement of funds will strengthen this.

There has been progress in the personnel situation within the Regional Directorates. They now have the authority to make personnel decisions concerning all non-gazetted workers. This still leaves the District Public Health Officers and other senior staff at the district level subject to central personnel decisions. In the long run, these individuals need to answer to the Regional Director. For now, the Regional Director has authority, at least on paper, over only mid and lower level staff. At a minimum, the disruptive shifts of health post staff that has impeded previous USAID health sector assistance can, theoretically, be controlled, though "source-force" is far from dead, even at those levels.

The personnel situation in the Central Region is the best of any Region. At the health post level, of 203 Health Post In-Charge positions 94% are currently filled, 91% of the 333 AHW slots are filled, 73% of the 325 ANMs are in place, and 84% of the 2,269 field workers (VHW, malaria field worker, senior vaccinator, PCDV, CHV) are at their posts. There are still gaps in skills and a need to clarify many of the position descriptions in the CRHD. But the provision of technical assistance to the CRHD under the IHS/FPS project has shown that the building blocks are there.

The national level MOH support that the CRHD will need in the upcoming two years includes: further clarification of roles and authorities; more planning and budget authority; additional funding for training and other regional activities; additional personnel authorities; and the active support of the national offices (previously "vertical projects"). These will not come immediately, but USAID will push for these changes while negotiating each yearly work plan. If significant progress has not been made as of the first evaluation, USAID will reconsider the design of the Central Region portion of the project, probably adding stronger conditionalities.

A final and very important aspect of the Central Region effort is the CHV program. The topography and population distribution of Nepal make it difficult, but essential, for health services to reach out beyond the health post. The CHV program in the Central Region is an essential link in developing a viable outreach strategy. The CRHD and its districts will be assisted in developing this new approach to outreach by the NWO

and through technical assistance and training provided by this project. USAID will continue to advise that this activity be implemented gradually so that the CHVs and their support system are not overwhelmed.

3. Child Survival Activities: The project's child survival activities are either extensions of work started under the IRH/FPS project, small new activities for which technical assistance will be provided to the MOH, or activities to be implemented by NGO/PVOs with proven capabilities.

USAID support for CDD training of MOH employees, CHVs, pharmacists and primary school teachers is ongoing under the Public Health Division (PHD) and will continue in the Central and Western Regions. The PHD/CDD will also conduct a second national diarrheal disease survey. New activities for the PHD/CDD will be a program of small research projects, trials with the 500cc ORS packet and container, development of simple educational materials, and small educational programs aimed at school children. With project-provided technical assistance and local cost support for training, these activities are within the capabilities of the PHD, based on past performance by this division. In addition, as the CRHD assumes training and implementation responsibilities for CDD workplan activities in the Central Region, PHD/CDD will have more time for technical guidance, policy setting and supervision activities, as appropriate for a national-level office. Finally, NGOs with proven capabilities will be encouraged to include CDD in their programs and the Nepal Pediatric Society will provide training for physicians and medical staff.

In addition to EPI in the Central Region, the project will support national level efforts in EPI. Support will be provided for communication/education activities as well as small surveys and studies to verify reported coverage and quality of services. The EPI is a relatively strong organization, and with technical assistance and local cost support can carry out these important additions to its current program.

ARI activities implemented through the MOH will focus on training in selected districts and will be implemented by the PHD/CDD-ARI unit. This is a logical extension of the CDD training, it will be scheduled so as not to conflict with the CDD training, and it will receive technical assistance and local cost support from the project. ARI pilot activities will be conducted through NGOs with proven capabilities and the PHD/CDD-ARI will be kept involved so that results will be applied to the broader program. The Nepal Pediatric Society will provide training to physicians, based on its previous work on treatment and quality standards. Finally, the primary contractor will assist the Institute of Medicine to integrate ARI into its curricula.

137

4. The Family Planning/Maternal and Child Health Division: USAID has a long history of involvement with this previously vertical project. It has traditionally been a strong activity with strong leadership. The project will continue to support the national program, although activities in the Central Region will receive priority. The challenge for FP/MCH will be the shift from a program that has used VSC as its primary method and has set new acceptor targets from the center, to a program that builds a tiered, multi-method system at the district level and gradually shifts the operational responsibility for the system over to the Regional Directorates. The project will provide technical assistance and training towards these ends. By providing assistance to both CRHD, which will be the first to implement these changes, and to the FP/MCH national office, the project intends to act as a facilitator for these essential changes.

5. The National Malaria Eradication Organization: USAID has been working with the NMEO for many years. The NMEO is responsible for the control of malaria, and in the Terai has resulted in opening to agriculture what is now Nepal's most productive and populated area. NMEO continues to control malaria in 50 malaria-prone districts, is actively monitoring the changing vector and parasite situation, and is researching new control methods. USAID support to NMEO under this project will be for essential sprayer parts (NMEO will have developed other sources by the end of the project), assistance with investigating new control methods, construction/renovation of the NMEO National Research and Training Center, and with the continuing training of volunteers. Given NMEO's past performance there is no doubt that they can meet these objectives. In addition, continued USAID support to NMEO will put USAID in a position to assist if there are any problems with NMEO turning operational responsibilities over to integrated districts in the Central Region.

6. The Private Sector: The project will be involved with two non-governmental organizations that are important for the projects success, the Contraceptive Retail Sales Company and the Nepal Women's Organization. Other private sector initiatives will include workplace-based family planning and private, fee-for-service clinics.

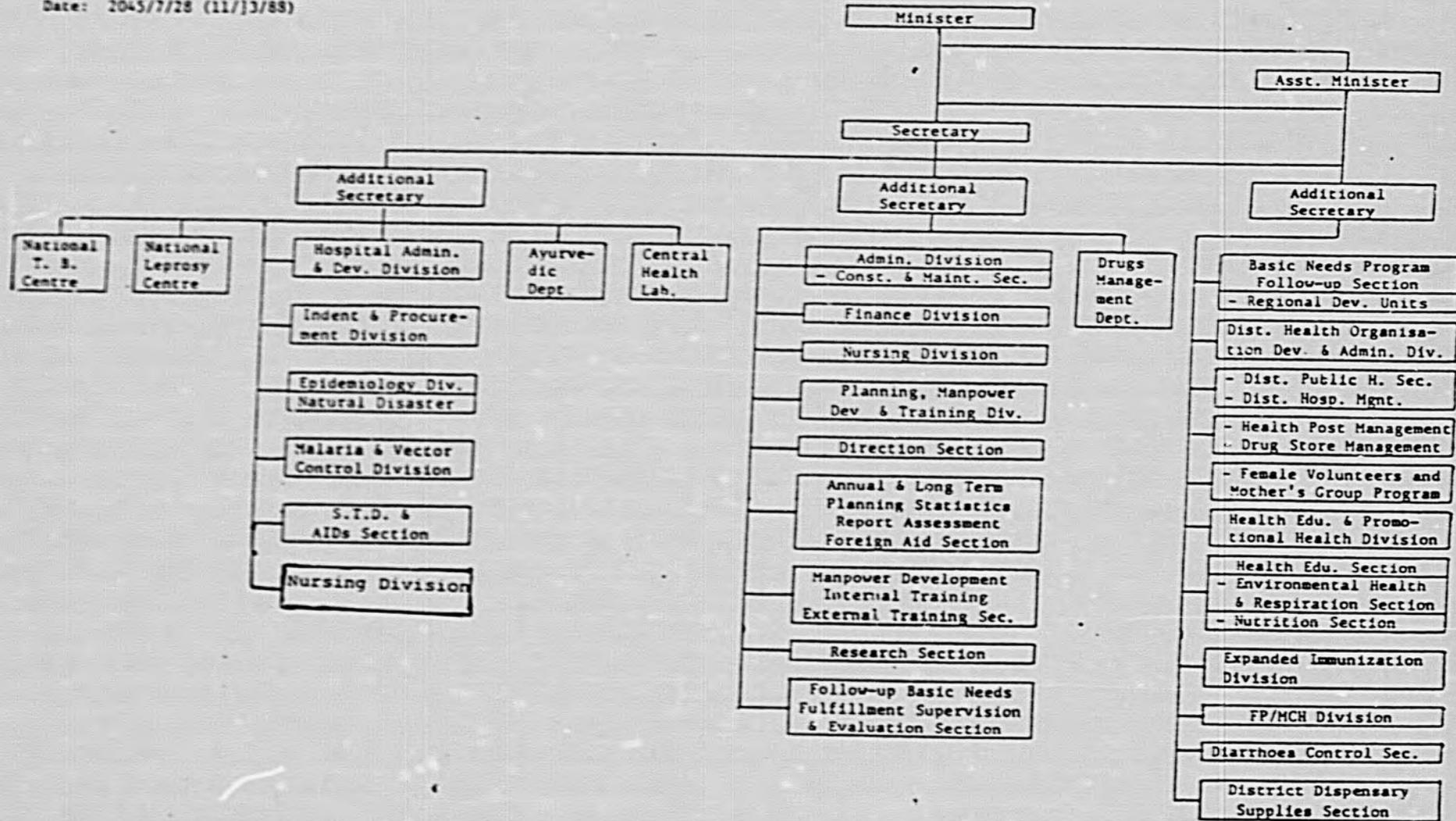
The Contraceptive Retail Sales (CRS) Co. is the other private organization that will be an important implementing agent for the project. The CRS was established in 1976 with AID assistance. It markets and sells non-clinical contraceptives and oral rehydration salts through commercial channels. It has also assisted NGOs to market contraceptives through their programs. Over the past few years, growth in CRS sales in urban areas has stagnated and the company has not been successful in its efforts at rural marketing. The lack of a strong manager for the company and a conservative Board of Directors have been identified as the major impediments to expanded operations.

158

A new manager for the Company has been recruited and is making improvements. As a condition of continued support from USAID, the next Cooperative Agreement signed between CRS and USAID will contain provision for increased private sector participation on the Board of Directors and will require CRS to develop annual workplans and submit them to USAID for approval.

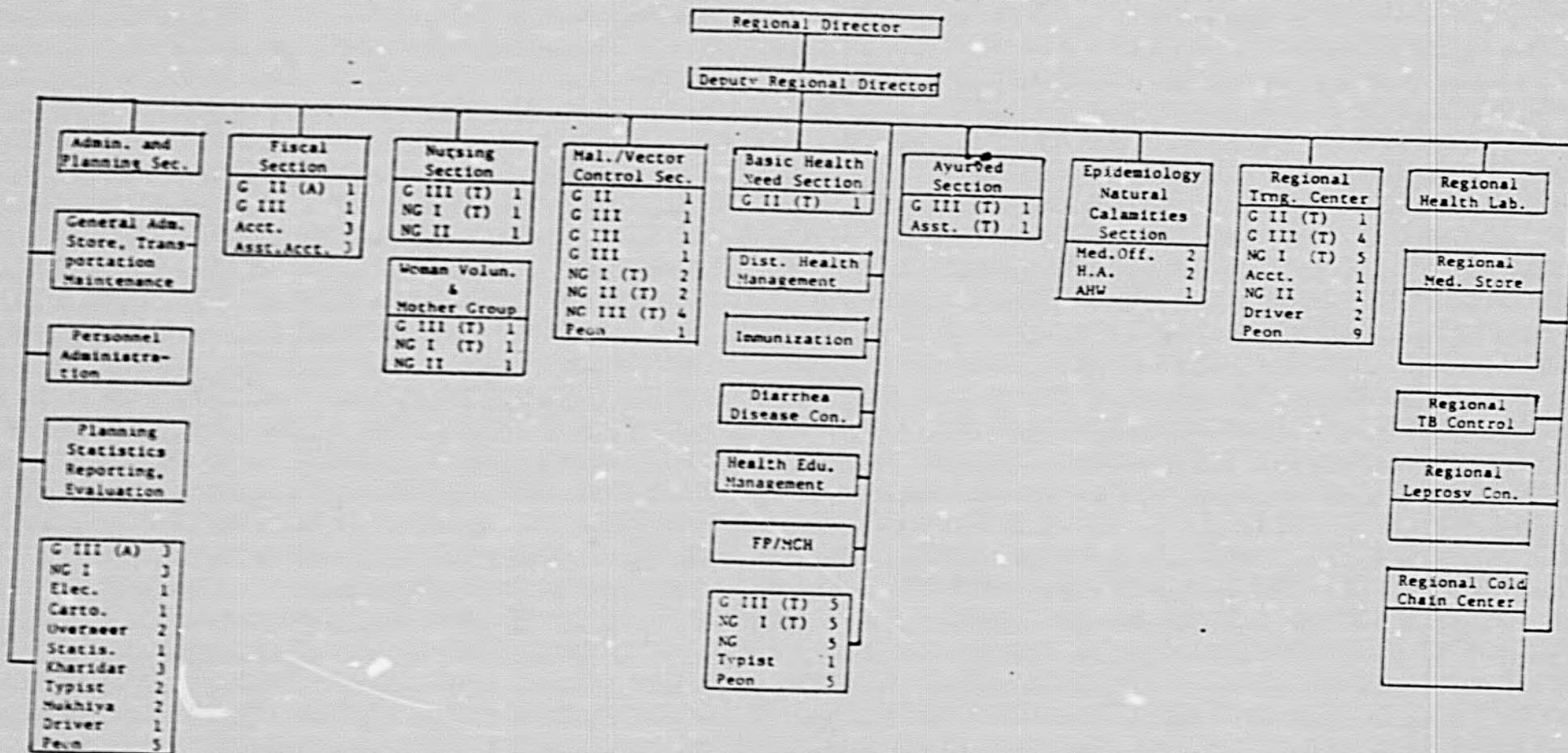
PROPOSED ORGANOGAM OF MINISTRY OF HEALTH

3rd Revision  
Date: 2045/7/28 (11/13/88)



190

Organogram of Regional Health Directorate

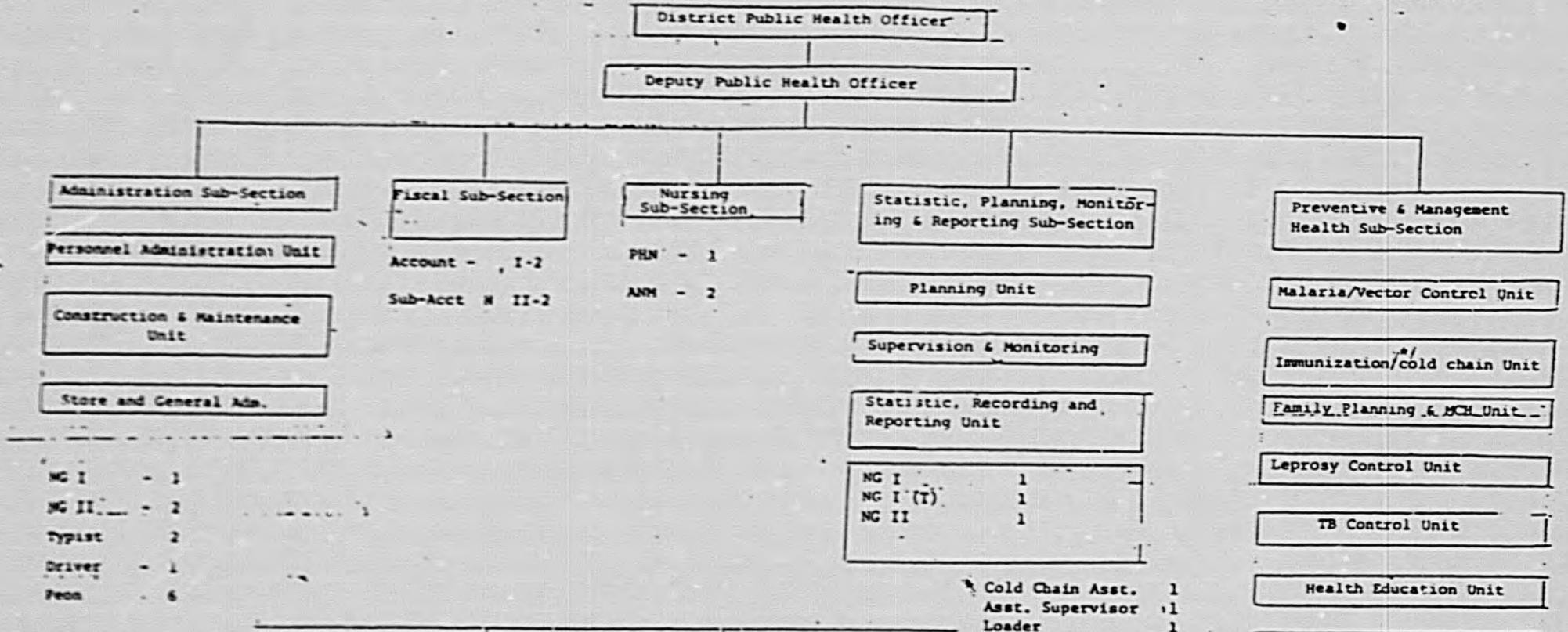


191

ORGANOGRAM OF DISTRICT PUBLIC HEALTH OFFICE

Proposed

Unofficial Translation



- MG I - 1
- MG II - 2
- Typist - 2
- Driver - 1
- Peon - 6

- Cold Chain Asst. - 1
- Asst. Supervisor - 1
- Loader - 1

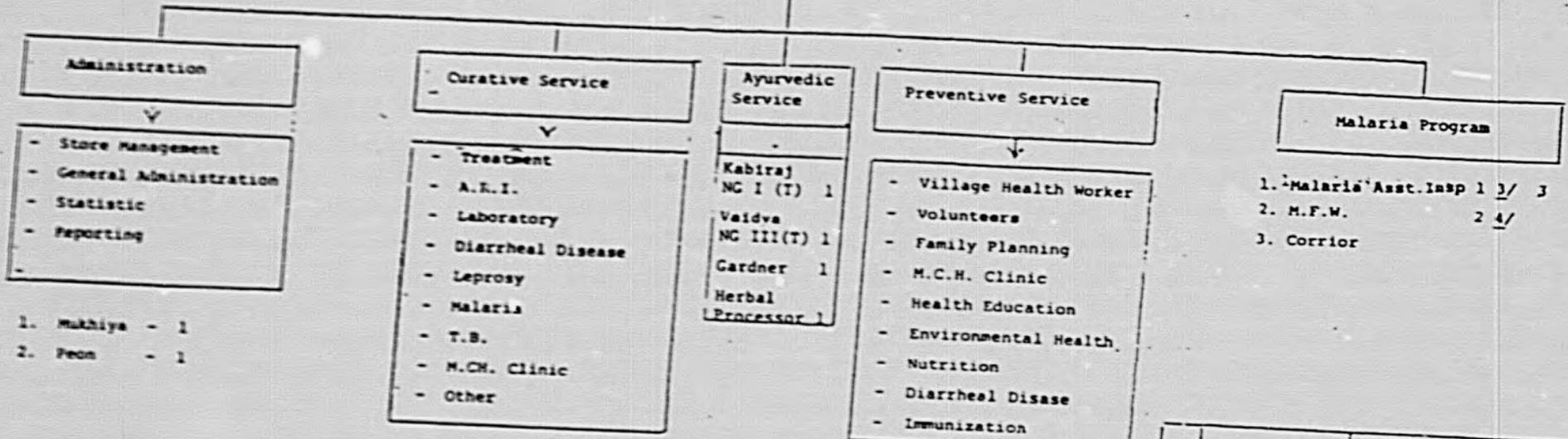
S/N	Post & Class	District 14				District 27				District 34				Total			
		Allotted		Proposed		Allotted		Proposed		Allotted		Proposed		Allotted		Proposed	
		Ad.	Tec	Ad	Tec	Ad	Tec	Ad	Tec	Ad	Tec	Ad	Tec	Ad	Tec	Ad	Tec
1.	Gaz II				1												1
2.	Gaz II								1								1
3.	Gaz III				1				1				1				1
4.	NA I			4	14			4	14			4	14			12	42
5.	NA II			5	14			5	14			5	14			15	42
6.	Typist			2				2				2				6	
7.	Driver			1												1	
8.	Peon			6				5				5				16	
				18	39			16	30			16	29			50	89

NG I (T) - 12  
NG II - 12

ELAKA HEALTH POST

Proposed (Unofficial Translation)

Health Assistant/Sr. A.H.W. - 1



**Administration**

- Store Management
- General Administration
- Statistic
- Reporting

- 1. Mukhiya - 1
- 2. Peon - 1

**Curative Service**

- Treatment
- A.R.I.
- Laboratory
- Diarrheal Disease
- Leprosy
- Malaria
- T.B.
- M.C.H. Clinic
- Other

- 1. A.H.W. - 1
- 2. A.N.M. 1 1/
- 3. La. Asst - 1
- 4. Peon - 1

**Ayurvedic Service**

- Kabiraj NG I (T) 1
- Vaidya NG III(T) 1
- Gardner 1
- Herbal Processor 1

- 1. A.H.W. 1 2/
- 2. Elaka FP Super. 1 2/
- 3. A.N.M. 1 1/
- 4. Peon 1
- 5. Corrier 2

**Preventive Service**

- Village Health Worker
- Volunteers
- Family Planning
- M.C.H. Clinic
- Health Education
- Environmental Health
- Nutrition
- Diarrheal Disase
- Immunization

**Malaria Program**

- 1. Malaria Asst. Insp 1 3/ J
- 2. M.F.W. 2 4/
- 3. Corrier

S/N	Post and Clas	Pro posed	Appr ved
1.	H.A./S.A.H.W	1	1
2.	A.H.W.	2	2
3.	A.N.M.	2	2
4.	Elaka FP Sup	1	-
5.	Lab. Asst	1	-
6.	Malaria Asst	1	-
7.	M.F.W.	2	-
8.	Mukhiya	1	1
9.	Corrier	3	-
10.	M.C. Worker		
11.	V.H.W.		6
12.	Peron and Courier	3+(2)	3

17+(2) 15

The Post of A.N.M. is allotted to all the HP of Terai and also few HP of Hilly regions. Where there is no allotment of ANM, local female worker will be hired on contract basis.

Family Planning Supervisors will carry out all program if A.H.W. is not available.

In 50 malarious districts only.

Will be utilized for Immunization + Malaria work.

1979 Organizational Chart

