TRIP REPORT NEPAL (No. 1)

September 17 - October 10, 1987

Contract No. AID/DPE-3034-C-00-5072-00
The Enterprise Program

FOREWORD

At least one third of all couples in the developing world are still unprotected from unplanned pregnancies. Governments and donors alone cannot possibly support all the family planning services being demanded. It is evident that the private sector, especially the for-profit private sector, must be encouraged to participate more fully in the provision of family planning. In many countries, the potential of the private sector in this area remains virtually untapped.

Funded by the United States Agency for International Development, the Enterprise Program is a direct response to this challenge. The Program’s resources are directed towards assisting private sector organizations to initiate or augment their own high quality, voluntary family planning services. Profit-making entities, and to a limited extent non-profit agencies, are supported under this initiative. Strong emphasis is placed on having the private sector take on the recurrent costs of providing family services.

In its first year, 1986, the Enterprise Program initiated subprojects in Nigeria, Indonesia, Thailand, Bolivia and Mexico. Approximately 18 new subprojects are expected to begin in 1987 and in addition to workshops, numerous initiatives by the private sector will receive technical assistance from the Program. The staff looks forward to a productive second year developing, cultivating and acting on the idea that the private sector has a great contribution to make in expanding family planning service delivery in developing countries throughout the world.
TEAM MEMBER:
David F. Pyle

D暮es of Trip:
September 17 - October 10, 1987

PROJECT CTO:
Dawn Liberi

Places Visited:
Kathmandu
Biratnagar
Janakpur
Birganj
Hetauda

I. EXECUTIVE SUMMARY

In response to a request from USAID/Kathmandu, the Enterprise Program sent a consultant to Nepal for approximately one month to conduct an assessment (general market analysis) of private sector family planning activities.

The level of interest in and support for private sector initiatives in family planning was found to be high. Discussions with representatives of HMG (eg., National Population Commission), industrial managers and potential clients as well as site visits to a number of manufacturing companies indicate that there are several possible areas of private sector programming in Nepal: on-site family planning facilities at large factories, a clinic facility to address the family planning/health needs of professional women, and mobile clinics to serve moderate size factories.

The number of industrial workers in Nepal is limited, with only approximately 80,000 engaged in the sector, about 9,000 of which are women. Most of these workers are concentrated in three areas: the Kathmandu Valley, Biratnagar in southeast Terai, and Birganj/Hetauda in central Terai.

Worker benefits legislation does not provide industrial managers with strong economic incentive to justify the provision of family planning services to their employees. The interest they expressed was based more on a desire to limit future expenditures by providing family planning/health services to the workers and their dependents (ie., wives and under fives). In addition, some of the private firms have surplus funds resulting from the Bonus Act which has to be spent on worker welfare activities; the family planning/health activities could be funded out of these resources.

Five large factories expressed interest in proceeding with discussions on individual family planning operations in their respective sites. They are the Ragupati Jute Mill (Biratnagar), the Cigarette Factory (Janakpur), the Sugar Factory (Birganj), and the Textile and Cement Factories (Hetauda). These five installations all employ at least 1,000 workers and have a total of approximately 7,000 workers. Three of these facilities
have full-time doctors, and all have physical facilities which could accommodate family planning activities.

There is an identifiable market for an economically self-sustaining clinic that would serve the growing middle class female professional population in Kathmandu. This group is unhappy with what is presently available - i.e., crowded and low quality care in the public facilities and expensive/inconvenient services provided by the private practitioners. They want a moderately priced package of services that addresses a range of female-related health concerns (gynecological, family planning, pre- and post-natal, fertility, psychological, pediatric). By providing curative care for which there is greater demand and for which the facility could charge slight premiums, the clinic could cross-subsidize those services in less demand (i.e., preventive and family planning). It is essential that the center be accessible to its target population (i.e., in the New Road area).

The smaller industrial units were also interested in the provision of family planning for their employees. However, they were conscious of the fact that it would not be cost-effective to establish units for factories having only 100 to 500 workers. They raised the possibility of establishing mobile family planning/health units that would service a number of participating factories. The Chambers of Commerce in both Biratnagar and Birganj expressed interest in helping to develop such mobile operations in the two areas. If each mobile clinic were to have an annual budget of approximately Rs. 250,000 (or around $12,000) and some 20 to 25 factories participated in each, the cost to each factory would be only in the vicinity of Rs. 10,000 (or less than $500) a year, well within the capacity of the participating industrialists.

The greatest concern is identifying truly independent private organizations that are qualified to manage the private sector family planning operations in Nepal. The Contraceptive Retail Sales (CRS) group is one that is interested and appropriate to lead the industry-based effort. Their managing director is well connected to the leaders of the private sector, and he is committed to broaden and diversify CRS by adding a division that would carry out needs assessments of the potential firms, design the training curriculum and identify training facilities to conduct the training, procure and place equipment, provide technical assistance as required and monitor the progress of the operation. The Women’s Health Clinic would be run by the Business and Professional Women’s (BPW) Club of Nepal. This group is fully independent, has strong leadership, is already active in industry and in family planning, and has projects with several donor agencies (UNFPA in child care/family planning; USAID/K for bi-lingual secretarial training). The president of the BPW has been considering the establishment of a Women’s Health Clinic for several years and the Enterprise Program would enable them to make this a reality. The BPW would receive technical assistance, particularly in the development of management systems, from the Services Division of CRS which would be developed to add to CRS’s economic viability by giving it a new income generating consulting capacity.
The mobile clinics would be started at a later date after the factory-based and clinic operations were underway and functioning effectively. The Kathmandu Valley operation could be attached to the Women’s Health Clinic, increasing the cost-effectiveness of both operations. In Biratnagar and Birganj, the local chapters of the Chambers of Commerce could be most helpful in recruiting participating companies, but would want and need some group that could be responsible for running the operation. A good candidate for this would be the BPW which already has operations in these areas and will have, by the time the mobile clinics are launched, the experience of the Kathmandu Valley effort.

The market analysis identified four activities which can be viewed as four phases from which the Enterprise Program can chose:
- factory-based in large facilities (>1000 workers)
- self-supporting Women’s Health Clinic
- mobile clinic in the Kathmandu Valley associated with the Women’s Health Clinic
- mobile clinics in the Biratnagar and Birganj areas

To develop the first of these options (the one with the most immediacy), the Enterprise Program should send a member of the permanent staff to Nepal early in Project Year 3 to develop and finalize the factory-based initiative and work out the contractual relationship with CRS. In addition, a complete business plan for the Women’s Health Clinic must be carried out by someone who has done this for similar facilities. The latter two phases, if Enterprise chooses to pursue them, should be contingent upon successful completion of the first two sets of activities.

II. PURPOSE OF THE VISIT

A cable dated 3 August 1987 from USAID in Kathmandu requested the Enterprise Program to provide a consultant to conduct a general market analysis for private family planning services (see copy of cable, Attachment I). The characteristics of the potential market were to be ascertained, including the needs of the target populations and their willingness to pay.

The assessment included the investigation of the demand for factory-based family planning operations as well as a self-supporting facility providing family planning services. If the assessment of the potential role of the private sector in family planning services delivery is encouraging, it will be followed by a feasibility study which will include specifics on services to be provided, service delivery location(s), facilities, staffing and financial issues. A marketing study plus a business plan will be prepared which will determine the viability of the strategy and serve as the basis for Enterprise programming.
III. BACKGROUND

Nepal has had a national population policy for over two decades. Starting with the Third Development Plan (1965-70), concern was raised about the rapidly growing population, and the delivery of family planning services was introduced under the Ministry of Health. Family planning services are currently being provided in Nepal's 75 districts through one of two different projects. Slightly over two-thirds of the districts (52) fall under the Family Planning/Maternal Child Health (FP/MCH) Project which is responsible for making family planning and MCH services available through its network of 268 clinics and approximately 2,500 panchayat-based health workers (P BhW). The remaining 23 districts are served by the Integrated Community Health Services Development Project (ICHSDP). In this scheme, a village health worker (VHW) is assigned to cover 1.5 panchayats, delivering a package of services including family planning.

On the non-governmental side, IPPF's affiliate, the Family Planning Association of Nepal (FPAN), was established in 1958. This non-profit voluntary organization is presided over by Her Royal Highness Princess Prekshya Rajya Laxmi Devi Shah. The FPAN provides family planning services in collaboration with the government, serving at times as almost an extension of the government.

In the late 1970's, a Contraceptive Retail Sales project was initiated and in 1983 became a privately registered entity. Through a network of some 10,000 retail outlets, CRS's contraceptive social marketing efforts now account for approximately 50% of condoms and 25% of pills distributed in Nepal. In 1986, CRS was responsible for providing over 55,000 couple years of protection (CYP).

At the policy level, the National Commission on Population functions as an independent secretariat. This group coordinates and monitors national population policies but has no enforcement power which would enable it to ensure that the national population policies are being carried out.

With a population of over 17 million and an annual growth rate of 2.6%, Nepal's population will double in 17 years. However, after years of little or no progress, family planning efforts in Nepal have recently begun to show some signs of movement. According to the Fertility and Family Planning Survey in 1986, 56% of the married women have knowledge of at least one method of contraception (compared to 22% in 1976 and 52% in 1981). In the urban areas, the rate increases to almost 76%. In current contraceptive usage, over 15% of the married, non-pregnant women were employing a modern method of contraception. In the last decade, the contraceptive prevalence rate has almost doubled every five years, from 2.9% in 1976, to 7.8% in 1981, to the current 15.1%. As would be expected, the rate is highest in urban areas with almost 32% practicing family planning; the rate approaches 50% among literate urban women.
The method of contraception currently being utilized is heavily skewed in favor of sterilization which accounts for 86% of total contraception. Only slightly more women than men have accepted sterilization. Temporary methods have not been promoted as vigorously as the permanent methods. Of the 14% who have adopted temporary methods, the pill is the most popular, followed by condoms, injectibles and IUDs (see Table 1).

Table 1
Acceptance of Family Planning by Method

<table>
<thead>
<tr>
<th>Method</th>
<th>% of Married Couples Using</th>
<th>% of Contracepting Couples Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization-Female</td>
<td>6.8</td>
<td>45.0</td>
</tr>
<tr>
<td>- Male</td>
<td>6.2</td>
<td>41.1</td>
</tr>
<tr>
<td>Pill</td>
<td>0.9</td>
<td>6.0</td>
</tr>
<tr>
<td>Condom</td>
<td>0.6</td>
<td>4.0</td>
</tr>
<tr>
<td>Injectibles</td>
<td>0.5</td>
<td>3.3</td>
</tr>
<tr>
<td>IUD</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>15.1</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Despite the increase in contraceptive usage in the past decade, the total fertility rate has decreased only 5.6% (from 6.38 in 1976 to 6.02 in 1986). One explanation for this is that a large portion of those accepting sterilization have done so only after reaching a high level of parity. However, the survey data show us that the desired number of children is 3.5. This indicates that there is an existing demand for family planning services that must be met if the total fertility rate is to be decreased and the national objective of reduced population growth is to be achieved.

IV. DESCRIPTION OF ACTIVITIES

After arriving in Nepal on 17 September 1987, I had discussions with Dr. David Calder and David Piet of the Office of Health and Family Planning, USAID/Kathmandu. This was followed by meetings with a number of officials from organizations and industries in the Kathmandu Valley and in Biratnagar, Janakpur, Birganj and Hetauda during a four-day field trip to the Terai in early October (see listing of people interviewed, Attachment II). The people met with can be divided into three categories:

- industry officials: managers and personnel officers of large industrial undertakings;

- potential clients: office staff and laborers who would utilize FP/MCH services;
potential implementing agencies: private entities that might have capability to carry out private family planning activities.

Of particular interest were the two industrialists who had recently returned from a private sector family planning orientation workshop conducted by the Enterprise Program in Indonesia (Padma Jyoti and Jagadish Agarwal) and the director of a study on the role of the private sector in family planning in Nepal (Abe David). The consultancy was concluded on 10 October 1987.

V. FINDINGS

The private sector family planning activities which have not been effectively addressed to date and hold the greatest potential are the provision of factory-based services and the establishment of an economically self-sustaining clinic. By their nature these activities are confined to the urban areas where only about 7% of Nepal's population currently resides and which already enjoy the highest contraceptive prevalence rates. Because the vast majority of the people live in the rural areas, one is tempted to focus exclusively on the development of rural-based private sector family planning activities. This, however, is already being experimented with under the AID-funded CRS project. CRS has contraceptive retail outlets in all 75 districts and is presently developing a rural social marketing effort. This innovative exercise employs local residents (e.g., traditional medical practitioners and healers) to distribute contraceptives on a salary plus commission basis. With elements of a community-based distribution (CBD) system being developed, it makes little sense to explore alternative or competing approaches in the rural area until the CRS methodology has been given a chance to demonstrate its potential. Consequently this consultancy has been restricted to the urban/industrial sector and to identifying ways to improve the quality of care for clients there who are in need of and want to adopt modern contraceptives methods.

1. Market Analysis

Initial discussions with individuals in the National Commission on Population and in private sector (e.g., Management Association of Nepal, Federated Nepal Chambers of Commerce and Industry, CRS) covered a range of options which could be considered if one wanted to undertake private sector family planning in Nepal. The most commonly referred to proposals centered around two concepts - first, a private clinic that would provide family planning services and secondly, factory-based family planning services. During the remainder of the consultancy, these two approaches were explored in depth with potential client groups, factory owners/managers, and institutions which were interested and capable of managing private sector family planning activities. In this section of the report, the Nepalese market for private family planning services will be analyzed in terms of the two identified options. This will be followed by a description of a strategy for carrying out such activities.
a. Factory-based - In addition to being one of the poorest countries in the world, Nepal is also among the least industrialized. It was estimated five years ago that only slightly more than 80,000 people were employed in the industrial sector; only 9,000 of these were women (Census of Manufacturing Establishments of 1981/82). While there may have been a slight increase over the past five years, it is generally agreed that the figures have not changed dramatically. The factories that do exist are typically very small, employing less than 50 people (4,903 out of 4,903 industries or almost 94% in 1981/82). There were only seven firms with more than 1000 employees, 13 between 500 and 999 and 39 between 200 and 499. It is very difficult to get the exact number of total employees and number of women in particular installations, but it is acknowledged that the textile and tea industries employ the largest number of women.

Many of the large factories are partially or wholly owned by the government. However, little distinction is made in Nepal between totally private and parastatal organizations; they are referred to and considered "private sector" and are treated as such in this report.

Analyzing the environment and discussing the matter with managers of some of the largest industrial establishments gave the initial impression that they would not be interested in the provision of family planning services to their employees. For one thing, the labor laws in Nepal do not encourage employers to consider such services. The benefits which industrialist must provide their employees are minimal. By law women receive only 45 days maternity leave. In health all that is provided in firms with more than 50 employees is a first aid clinic, a small room staffed by a compounder or health assistant with a physician who comes once or twice a week. Only the rare firm has health insurance for their workers. No health or education benefits are given to employee dependents. To make matters worse, employees (especially women) are often hired seasonally, on contract or daily-wage basis, meaning that even maternity benefits are not granted (ie., the woman is replaced). There are no labor unions in Nepal to pressure for or negotiate more generous benefits for the factory workers and there is a surplus of unskilled labor to fill any slot that becomes available.

Despite the less than encouraging first impression, there is a basis for cautious optimism that industrial-based family planning would be accepted. According to the INTERFACE "Assessment of the Role of the Private Sector in Family Planning in Nepal" (1986), only 20% of the management officials interviewed saw no relationship between family planning and productivity; over 40% admitted that they did not know. The survey demonstrates an obvious need to educate industrialists on the rationale and benefits of family planning for their employees. The workers are much more supportive of family planning; close to 90% of the workers surveyed understood the usefulness of family planning among their fellow workers and had a positive attitude toward the introduction of contraceptive services at the work place.
As one delves more deeply into the subject several reasons why managers would be interested can be identified. First, a number of the biggest industrialists made the point that family planning alone would not appeal; it only made sense to them if combined in a package of simple curative and preventive health care. Currently large firms are paying employees a lump sum of Rs.400 to Rs.600 a month for health purposes. They have no idea how the money is spent, but they expect that very little is spent on measures that improve the workers' or their families' health. In fact, they suggest that much of it is spent on things (eg., liquor) which have a negative impact on their health status! The industrialists are interested in a more cost-effective way of handling health benefits and would be favorably disposed toward a group that could provide a package of services which address women's and children's health problems, including family planning. They stressed repeatedly that they didn't know anything about what should be provided or how, but if someone could assure the provision of such a package of services at a reasonable/affordable price, they would be interested. What appealed to the managers was that they would have more control over the services that the employees received and worker productivity would increase while the company's health benefits would be more cost effective.

It was surprising that the industrialists supported the idea of opening the services to dependent wives and pre-school children. When asked why they would be willing to provide a package of family planning/MCH services to employees and their dependents, the industrialists gave several answers. For one thing, they thought it would be good for public relations. By promoting family planning and making it available to their employees, the industrialists would be supporting a national objective, thereby demonstrating their interest and willingness to contribute to the well-being of the country. Such activities would help dispel the negative image of selfishness and greed held by many in the government and population at large.

The owners also reported that they would be willing to extend the family planning/MCH services to worker dependents because they think it will build support within the workers' families. If the wives and pre-school children receive quality gynecological and health care at the factory, several industrialists voiced the opinion that they thought the workers' family would be more supportive of management. In addition, during future wage negotiations the manufacturers could resist requests for increases in health payments by pointing to the health care being provided on site for the workers and his dependents. The company, on its part, would be sure that the money they were spending on employee health was being well spent and had maximum impact. The firms would have some amount of control over services being dispensed by means of the contract they will have signed with the service providing institution.

Reducing their costs and increasing productivity are two other factors which appeal to the owners and managers of large factories. The most obvious concern is when a female on permanent staff becomes pregnant. First, the company must provide her with maternity leave; limited as it is, there is still a cost involved. The managers also mention that when a woman has a child, there is a chance that she will resign. This is becoming more
common as the joint family system is breaking down and no one is at home to look after the children. When a skilled or semi-skilled female worker quits, the employer must invest time and resources in recruiting and training a new woman to take her place. This is all the more difficult when the job requires a literate woman since less than 12% of the women were literate in 1981. Finally, for male and female employees alike, the more children a family has, the more absenteeism there is. A few of the industrialists interviewed realized that high parity and short birth intervals result in higher rates of morbidity and even mortality which cannot but detract from the productivity of their operations. Moreover, the fewer children an employee has, the less likely the workers are to become dissatisfied with their wages and demand increased salaries.

One of the major selling points for the provision of the family planning/MCH package turns out to be a law which forces the manufacturers to set aside 10% of their profits for worker bonuses. Because a limit is placed on the size of the bonus which each worker can receive, there is typically a surplus in the fund which by law must be spent on employee welfare. The industrialists would pay for the health and contraceptive services out of these resources.

The question becomes not whether there should be industry-based family planning/MCH services; rather, the question is it cost-effective to establish units in individual factories to provide this package of services. Discussions with factory owners and managers indicate that building a separate capacity in a number of firms does not make sense unless the factory has a large number of employees. Only facilities with more than 1000 workers are suitable for such undertakings. These large installations are located in the Terai and, as shall be mentioned in the next section on the implementation strategy, five large companies in this area were found to be interested in establishing quality family planning facilities in their factories: Ragupati Jute Mills - 2250 workers; Janakpur Cigarette Factory - 1400; Birganj Sugar Factory - 1550; Hetauda Textile Factory - 1000; and Hetauda Cement Factory - 1000. Attachment III includes descriptions of these factories along with the major industrial areas of the Terai.

Typically factories in Nepal are small, making clinics in individual factories cost-ineffective. However, the owners of many of these smaller facilities of 100 to 400 or 500 employees are interested in providing family planning and MCH services to their employees and dependents. The approach that was suggested was mobile operations which would serve a number of industrial sites in the surrounding area.

*A very rough estimation of annual costs for the operation of a mobile clinic was Rs. 250,000.

Staff - Rs. 75,000 (@ MD - Rs. 4000/mo; Nurse - Rs. 1000; driver - Rs. 500; assistant - Rs. 500)

Van (depreciation) - Rs. 100,000

Operations/Maintenance - Rs. 25,000

Drugs - Rs. 50,000

If 20 to 25 factories participated in the program, each one would have to pay only Rs. 10,000 (or less than $500) per year.
The concentration of industrial sites in Nepal is favorable for the operation of mobile family planning/MCH services. The vast majority of manufacturing in the country takes place in three zones; the Kathmandu Valley, around Biratnager in the Eastern Terai, and Birganj/Hetauda in the Central Terai. Attachment III gives a detailed description of programming possibilities in each industrial concentration, focusing most attention on the Terai. Medium and small industries are clustered in industrial estates. As Attachment IV shows, there are ten of these officially developed growth centers dispersed around Nepal. The three largest industrial estates are located in Kathmandu (2) and Hetauda, and each has between 40 to 65 industries employing 2,000 to 3,000 workers. These three estates contain almost 10% of all the industrial workers of the country. Approximately 10% to 20% of these workers are female. Central clinics serve all the workers of the estate and lend themselves very easily to the provision of a package of family planning/MCH services both to workers and their dependents.

If clinical services were provided by a mobile operation, the limited personnel and facilities currently available at most industrial sites would probably be sufficient. The health workers, the compounders and health assistants and even the doctors, would require training in IEC and motivation as well as in proper follow-up activities since they would be responsible for providing day-to-day service between the visits of the mobile team. Special emphasis would be placed on counseling in contraceptive methods and treatment of side effects. The issue of counseling is particularly important in that a recent study (New Era) reports that 75% of those who stop taking the pill or DP have either not received counseling or it has been grossly inadequate. Assuming that a dozen industries with a large number of employees were willing to participate, a fortnightly schedule of clinical visits could be established; with 20 to 25 factories, monthly visits would be possible.

A fully developed industrially-based family planning/MCH program envisages three mobile operations set up on a zonal basis, one in the Kathmandu area, another in Biratnagar covering the Eastern Terai, and the third possibly in Simra serving the Birganj/Hetauda region. It would make sense to attach the mobile unit responsible for the Kathmandu Valley to the Women's Health Clinic, which is described below. By increasing volume, the costs of the services both for the women attending the clinic as well as the industrialists who have contracted for the package of family planning services at the factories would be reduced. It would maximize the productivity of the clinic staff, most of whom will only be fully occupied from 3PM or 4PM, as the professional women leave their jobs. During the morning and early afternoon hours, a portion of the clinic staff could man the mobile unit and provide services to the industrial sites. The Women's Health Clinic, as will be described, would be centrally located and easily accessible by public transportation, hence would always be available to women from the factories (either workers or dependents) at any time as part of the contractual arrangement worked out with the industries.
One innovative and creative factory health worker mentioned how eventually a Ring Road* Industrial Family Planning/MCH Association might be formed. This would permit reciprocal clinic visits; for example, a dependent of a worker living in Patan but working in a factory in Balaju could use the Patan facility rather than spending the time and money to go to Balaju. This would make the services more accessible, hence more inviting. While this would be the ideal situation, there is a number of problems that can be thought of; nonetheless, it could be a goal to work toward.

b. Clinic - Private clinics are not a new concept in Nepal. The leading medical practitioners of Kathmandu conduct private clinics in their respective specialties, often after completing their service in a government facility. In addition, in the last several years, individual physicians have applied for licenses for private nursing homes (in-patient facilities which are to be operated on a for-profit basis). Within the last six months the leading public hospital (Bir) has initiated a fee-for-service clinic for those desiring a better quality of service and care. Such efforts are in response to the government’s realization that some costs are going to have to be recovered if services are to be continued to be provided.

The professional women interviewed during a focus group discussion provided information on where they are currently receiving family planning services, their needs, what type of facility they would patronize, and how much they would be willing to pay. There was a high level of dissatisfaction among these women, who can be classified as middle to upper middle class, with the quality of the services presently available to them. To begin with, the public health system was not considered an option. Women with education and some social standing are reluctant to utilize public facilities in this highly stratified society; they wanted the best care available. However, the women were also not pleased with the treatment they received when they visited the private practitioners. Their primary complaints were:

- high cost: Rs. 50-60 for consultation plus the cost for treatment of any complication;
- long waits: typically three to four hours
- practices: requiring patients to return frequently (e.g., once a week during a normal pregnancy) to maximize income

* A circumferential highway around Kathmandu where many industries are based.
When discussing alternatives to the existing unsatisfactory situation, the women described a multi-service facility which would address women-related health problems, was reasonably priced and was easily accessible. The package of services which were said to be in greatest demand include:

- pre- and post-natal care
- pediatric care
- gynecological care (examinations, pregnancy tests, pap smears, infertility treatment, X-ray)
- family planning (all methods including implants and female sterilization)
- psychological counseling

The facility should have a laboratory and a small operation theater in which minor operations (including sterilization) could be carried out.

Referring to the facility as the Women's Health Clinic was thought to be appealing since it would signify that the center existed exclusively for the sake of women. In a society in which women have little status, the focus on women's health concerns was thought to be a promising marketing angle. Moreover, the multiplicity of services provides "camouflage" for those women who feel shy about practicing or even making enquiries concerning contraception.

In addition to the clinical services, the women in the focus group wanted a clinic that offered sensitive, courteous and personalized services. This would be in stark contrast to what patients, especially women, are used to receiving in Kathmandu, even from high cost private practitioners. It is not unusual that women are very badly treated or not treated at all; the problem becomes increasingly more serious the lower the caste of the patient. The clinic environment should be clean and cheerful ("inviting"). Clinic hours were considered of utmost importance. Working women want the facility open from 3PM to 7PM (ie., after office hours). They also expressed an interest in having it open on Saturdays, their one day off a week when it would be easy for them to visit the clinic and bring their children.

The women interviewed said they would be willing to be seen by a competent paramedical clinician for initial screening. If a problem was identified or the nurse could not diagnose the problem, the patient would be referred to the appropriate physician on duty at the clinic. This triage approach is critical if clinic costs are to be kept to a minimum while still providing quality care. The concept of screening will take some getting used to since most women are used to seeing a private doctor. However, in situations where only immunization, DP injection, or a normal pre-natal check-up is required, a well trained and supervised nurse is perfectly qualified to provide the service. Three physicians would always be there for consultation and referral as and when required.
The cost of services was discussed at length. The women thought that the facility should aim for the gap that exists between the free public treatment and the expensive private practice. On this basis, a consultation might cost in the neighborhood of Rs. 20 to Rs. 25. This is only something to aim at; a schedule of fees must be developed based on projected cost of operating the facility. Because the clinic will provide a variety of services, higher prices could be charged for those in highest demand (i.e., curative care and minor operations), recovering slightly more than cost. This would allow the clinic to charge slightly less than cost on those services which are not in such great demand (i.e., preventative care and family planning). Such cross-subsidization should help increase demand for some of the most important activities the clinic will offer by making them more affordable.

The target population for the Women's Health Clinic will be the middle class, especially the growing number of professional women in the downtown area of Kathmandu. It is hoped that some upper and even lower class women might also patronize the clinic, finding its quality of care, client perspective and location particularly suited to their needs. Others involved in family planning in Kathmandu have considered the establishment of a private poly-clinic which would include contraceptive services and be aimed at the upper class, charging fees comparable to private practitioners. The focus group thought that this group was too small to make the facility economically self-sufficient.

The location of the proposed clinic is vitally important if the target group of women is to patronize it. The clinic should be easily accessible to the women working in the large service industries (e.g., banks, insurance, airlines, tourist industry) which are located mostly in the New Road/Durbar Square area. The other concentration of professional women is not far away in the Kanti Path/Durbar Marga area where several large hotels, airline offices and tourist agencies are situated. Therefore, the ideal location for the Women's Health Clinic would be near the gate at the beginning of New Road (the end closest to Tundikhel). This will make it convenient (within a 5 to 10 minute walk) from most of the offices where professional women are now working. Another advantage of the specified location is that it is considered the center of Kathmandu (city as well as Valley), hence is well connected by public transportation. However, it will not be easy to find a place in this area that is both large enough to house the clinic and is affordable.

The prime location will give the Women's Health Clinic a number of advantages in addition to being accessible to the professional women. For one, there is also a sizable population of upper-lower and lower-middle class women residing in the general area who would be potential clients. In addition, since New Road contains many shops and is close to the main market, women from outside the area would have access to the clinic. Secondly, being located so close to the main offices of the businesses employing the professional women, the clinic could market its services directly to the corporate managers. At present firms in the area like Nepal Bank Ltd. which have several hundred women working for it reimburses women for any visit to a doctor upon submission of the bill. The bank must pay the high rates of the private practitioner and are unable to verify
that visits actually take place. In their initial reaction to the idea, the managers of large businesses in the area were interested in establishing a contractual relationship with a nearby clinic providing quality services at a reduced price to its female employees. A retainership agreement offering discounted rates could be negotiated with individual firms in exchange for the companies directing their women to the clinic for at least their preventative and family planning needs and their initial/diagnostic visit in the case of illness. This would benefit both the clinic (by guaranteeing a constant flow of patients) and the private firms (by increasing productivity by providing their female employees with verifiable quality care at a cheaper price).

The lay-out of the Women's Health Clinic is most important. Since the bulk of patients will come at one time (i.e., after office hours), there must be sufficient waiting room and space to have three streams of patients (gynecological/family planning, general, pediatric). Patient flow and the efficient and expeditious handling of large numbers of patients is essential if the clients are to be satisfied and choose the Women's Health Clinic over its competition (mainly the private physicians). Three examination rooms will be required in addition to offices for the doctors. The waiting room should be bright and comfortable where women can socialize and IEC on subjects such as family planning can be provided (literature as well as video).

2. Implementation Strategy

Accepting that there is an existing need and market for the Women's Health Clinic and industry-based family planning/MCH services, two important concerns remain to be addressed: what group(s) can be identified that are able to implement the activities as outlined and what is the most appropriate implementation schedule.

a. Implementing Agency - There are very few groups that are both qualified and fit the criteria to carry out a program as outlined above. The criteria are few - the institution must be totally independent, have demonstrated an ability to work with industry, and shown a capacity to implement social sector programs, preferably in family planning and health. Private Voluntary Organizations or PVOs (e.g., Family Planning Association of Nepal) are not options since they are subject to the Social Service National Coordination Committee (SSNCC) which is controlled by the highest level and severely restricts the freedom and flexibility of the PVOs.

Only three entities registered (or in the process) as private enterprises and concerned with family planning could be identified. One, Nepal Fertility Care Center, has applied for registration. A lengthy discussion with Dr. Tikaman Vaidya, who conceived of the facility and will serve as its president, indicates that what he envisages is somewhat different from the concept of the Women's Health Center. The fertility center would provide a full range of services including highly sophisticated and more costly procedures (e.g., micro surgery). While the center will serve low income clientele as well (through a different fee structure), it will go beyond the less sophisticated, more commonly required services that the proposed Women's Health Clinic would offer.
Moreover, the center as described by its founder would serve both men and women, thus losing the exclusive focus on women which the focus group participants said was very important to them and would be one of the clinic's main selling points. While there is undoubtedly a need and place for such a facility such as the Fertility Care Center run by a highly qualified and respected OB/GYN, the center as presently conceived neither satisfies the greatest existing need nor could its higher capital costs be afforded by USAID/Enterprise Program.

A second possible institution is CRS. This nine-year old group has launched and is implementing a national contraceptive (and Oral Rehydration Solution or ORS) social marketing campaign through a network of some 10,000 retail outlets. In the recent past it has begun a rural social marketing (could also be described as community-based distribution) approach on an experimental basis. Although concern is that its director has had increasing problems with those who think CRS has gained too much notoriety and benefited too greatly. It is hard to describe it as anything more than petty jealousy, but the fact remains that the more projects that are given to CRS, the more visible a target the group and its director will become. Finally, although the Executive Director of CRS has an appropriate background (clinical management), he will not be able to devote adequate time to the proposed activities given all his other responsibilities. This would mean a restructuring and expansion of CRS.

CRS is interested and could develop the capacity to establish and support factory-based operations. Being part of the private sector, Hem Himal has excellent relations with industrial managers and would be able to oversee the initiation of family planning activities in the five factories mentioned (i.e., responsibility for developing contracts with each group, identification of training institutions, determination of curriculum, establishment of equipment needs, procurement, installation, follow-up, provision of technical assistance, monitoring). To do this, CRS will start a new division, possibly referred to as the Services Division, which would be staffed with several well qualified/experienced professionals who have implemented family planning programs and are familiar with management systems. USAID/Kathmandu has confirmed their support for such a diversification of CRS.

The third group is the Business and Professional Women's Club of Nepal (referred to as BPW). This group was started in 1975 in Nepal and is part of an international network of business and professional women's associations. The BPW in Nepal is currently carrying out several women-related development activities. One is a multi-lingual secretarial training course for which it has received a grant from USAID. Secondly, the BPW has established day-care centers and pre-schools at four of the industrial estates (Patan, Balaju, Hetauda, Pokhara). The first of these centers were begun in the early 1980s and are currently funded by UNFPA. One of the services the centers provide is the training and support of family planning motivators who educate women and distribute contraceptives at the factories in their respective estates and in surrounding villages. The day-care/pre-school operation at the Patan Industrial Estate is scheduled to be turned over to the welfare committee of the Estate in November; it will continue to operate on funds collected from the
industries located in the Estate. When this has been done, the facility will have achieved one of the most difficult and rarest goals in development, sustainability and institutionalization.

The president of the BPW has considered and is committed to the establishment of a women's health clinic as part of a larger hostel/research center project which reportedly has the support of the Queen. While such an ambitious undertaking will take years to materialize, she is ready and willing to start work on the women's health facility.

Visits to several of the BPW projects and their central office as well as discussions with several of the group's officers impress one with their professionalism. Although the organization is very small (six full-time staff members) and its projects are not large, what they do, they do well; quality is important to the organization and obviously to its president. The latter is one of the leading professional women of Nepal; she owns and manages one of the largest tourist agencies in Nepal and was the first woman to serve as president of the Nepalese Jaycees. Everyone who has worked with her gives her high marks for organization, effectiveness and dedication. In addition, the president of the BPW is well connected to those at the highest levels of power in Nepal, yet she remains a free agent (the BPW is not a member of the SSNCC). It is an ideal combination!

It is my recommendation that CRS be contracted to establish the industrial-based family planning operations in the five large sites identified in this report. In addition, the BPW should serve as the implementing agency for the Enterprise Program private sector clinic activities in Nepal. But the BPW by itself will not be able to implement the effort. Thus, a coalition of institutions under the leadership of the BPW is envisaged; they include:

- CRS: provision of technical assistance in the development of management systems; CRS's new Services Division would develop a consulting capacity which in addition to carrying out the industry-based activity, would generate additional income for CRS by providing support for the BPW Women's Health Clinic; after establishing the industry-based facilities and building BPW into an effective organization capable of operating a quality/well-managed clinic and factory-based effort, CRS will have a management consultant capability that will allow it to respond to a range of HMG and donor agency requests.

- Maternity Hospital: provision of training, primarily to factory compounders, health assistants, and doctors to enable them to be effective motivators, educators, counselors and providers of follow-up treatment in family planning/MCH between visits by the mobile team; the dedicated leader of this impressive institution has expressed her interest in, support for and willingness to assist the Women's Health Clinic and factory-based operations.
- Industrial Service Center (ISC)/Management Association of Nepal (MAN)/Federated Chambers of Commerce and Industry: provision of workshops and seminars on the value of industrially based family planning/MCH activities; the INTERFACE study and interviews demonstrate the need for intensive efforts to increase managers' awareness of the connection between fertility and productivity; the ISC is a semi-government body responsible for the development and management of the industrial estates - involving them in the orientation of the factory managers would increase their interest in and commitment to the family planning/MCH activity; MAN, the Chambers of Commerce and the ISC all carry out workshops on various subjects for their members and would, with CRS's assistance, be appropriate bodies to enlighten the industrialists on the economic rationale for the family planning/MCH services in their respective plants.

b. Proposed Schedule - The introduction of the proposed project consisting of the industry-based operations and the Women's Health Clinic can be broken down into four phases. It is unrealistic to expect the industrial activities and the women's clinic in all three zones to be launched simultaneously. It would test even the strongest of organizations. It is suggested that the funding of each phase should be based on the successful implementation of the previous phase. Moreover, dividing the package into four parts allows USAID/Kathmandu and the Enterprise Program to determine how much of an effort they want to make; they can choose to do one, two, three parts or the whole package.

The first phase consists of establishing family planning capabilities in the five large industrial plants that have expressed initial interest in the concept (one each in Biratnagar, Janakpur and Birganj and two in Hetauda). These five factories have over 7,000 workers employed and represent a population of approximately 35,000. While the percentage of female employees is not high in most of these firms, the manager of the Ragupati Jute Mill reported that he was advocating increasing the percentage of females in the work force from 10% to 25%. Moreover, the Hetauda Textile Factory is over 50% female. The Enterprise Program should make every effort to initiate activities in these facilities as soon as possible since interest is high. Thus, the Program should determine the exact needs of each factory and finalize a working relationship with CRS at their earliest convenience. As the cliche says, they should strike while the iron is hot. CRS could then be contracted to carry out the actual establishment of the factory operations and follow them up to ensure that they are functioning effectively.

The second phase consists of the Women's Health Center in Kathmandu. This phase will include the all important recruitment of staff (both in the BPW - to manage the project, to staff the clinic - and CRS - to provide the technical assistance), their orientation and training, selection and renovation of a clinic site, procurement and setting-up of the equipment and initiation of the marketing efforts.
The third phase would be the establishment of the mobile family planning/MCH operation serving the industries of the Kathmandu Valley. As mentioned, this effort would utilize at least some of the staff from the Women’s Health Clinic which will have to be operating efficiently and effectively before the mobile activities can be launched. This phase will include orientation workshops for the industrialists, negotiation of contracts with industrial entities, training of plant health personnel, upgrading of factory health facilities, and the establishment of IEC efforts among the employees.

The fourth phase would consist of starting operations outside the Kathmandu Valley, using the Kathmandu mobile clinic experience as a model. The need for two mobile clinics has been identified. One to serve the medium size factories in the Birganj area, the other for Biratnagar and vicinity. Birganj is a fast growing concentration of industry and is well suited to a mobile operation. The local Chamber of Commerce is very supportive and already has been involved in the establishment of a large maternity hospital in Birganj. But they will require an organization to manage the mobile clinic and the BPW would be appropriate.

The Biratnagar is in the southeastern corner of the country. There are over 30 factories within a 1.5 km radius of the Biratnagar Juta Mill just south of Biratnagar (Nepal’s second biggest city) plus other factories in and around the city. The mobile family planning/MCH operation in this region would also cover the Jhapa/Ilam tea estates. The 12 estates have a workforce of over 4,000, a high percentage of whom are women. FPAN has plans to respond to requests from seven of the tea estates to provide contraceptives (pills and condoms) with minimal amount of IEC and staff training, but this is on hold until resources can be located. Although time did not permit a visit to the estates, it is expected that a full package of family planning/MCH services would be well received by the tea estate owners. Again the local chapter of the Chamber of Commerce expressed great interest in the mobile clinic concept and thought the BPW would be an appropriate group to manage the operation.

VI. RECOMMENDATIONS

The primary recommendation is that the Enterprise Program should initiate private sector family planning activities in Nepal. The immediate recommendations are three:

- Factory-based Operations: A member of the Enterprise Program permanent staff should visit Nepal before the end of the 1987 if possible, to hold detailed discussions with the five factories identified, assess staff and physical facilities, and determine training and equipment needs. At the same time, this individual should establish a contractual relationship with CRS and assure their capacity to have the training provided, equipment procured and the operations monitored.
Business Plan: A thorough business plan on the Women's Health Clinic must be conducted. This should include a complete market study, determination of precise location, finalization of facilities and staffing, development of marketing plans and promotion strategy, completion of a financial analysis (start-up costs, monthly recurrent costs, fee schedule, determination of break-even patient load, cash flow projections). This should be carried out as soon as possible by Glenn Wasek of JSI/Boston or by the team from Thailand that drafted the Business Plan for YKB Family Planning Clinic in Indonesia under the Enterprise Program.

Observation Tour: Because there is no experience in this field in Nepal, it is important that those in the BPW and CRS who will be involved in the operation of the Women's Health Clinic see what has been done in Indonesia (YKB Clinic in Jakarta) and/or in Egypt (the Model Comprehensive Family Planning Clinic in Alexandria). It would be helpful if this could be done shortly after the completion of the business plan and prior to the launching of the Women's Health Clinic so that those responsible for establishing and managing the operation in Nepal will have a chance to observe other examples and develop a clear understanding of what it is that they are expected to do.
REFERENCES

CRS, "Marketing Plan, 1987" (Kathmandu: Contraceptive Retail Sales (P), Ltd., 1987).

---, "Nine Year Report, 1978-87" (Kathmandu Contraceptive Retail Sales (P), Ltd., May 1987.


INTERFACE (P) Ltd., "Final Report - Assessment of the Role of the Private Sector in Family Planning in Nepal" (Kathmandu: June 1986).


ATTACHMENT I
TO: JOEL MONTAGUE  
ENTERPRISE PROJECT  
JOHN SNOW INC  
1100 WILSON BLVD.  
ROSSLYN, VA.  

THIS IS A CONFIRMATION COPY OF A MESSAGE ADDRESSED TO YOU.  

REFS:  (A) MONTAGUE - PIET TELEX DTD. 7/29/87.  
(B) LAMSTEIN - PIET LETTER DTD. 6/25/87.  
(C) KATHMANDU 04615  

1. PER REF A, MISSION PLEASED WITH ENTERPRISE AND AID/W CONCURRENCE OUR INDONESIA WORKSHOP PARTICIPANT NOMINATIONS.  
2. PER REF B AND C, IT APPEARS THERE HAS BEEN A MINOR COMMUNICATIONS BREAKDOWN. MISSION SENT REF C TO ST/FOP BACKSTOP ON 6/23/87 SEVERAL WEEKS BEFORE RECEIVING REF B. ASSUMING THIS WOULD CONSTITUTE ENOUGH BACKGROUND AND SERVE AS A FORMAL REQUEST FOR TA ASSISTANCE FROM ENTERPRISE. IN CASE REF C IS EITHER INSUFFICIENT, OR WAS NOT RECEIVED VIA AID/W, MISSION REQUESTS FOLLOWING SERVICES FROM ENTERPRISE PROJECT PER YOUR SUGGESTION.  
3. MISSION HAS CONCLUDED THAT IT IS NOW TIME TO FULLY EXAMINE THE POTENTIAL FOR PRIVATE SECTOR DELIVERY OF FAMILY PLANNING SERVICES. TWO ANALYSES ARE RECOMMENDED FOR DETERMINING THIS POTENTIAL.  
4. FIRST A GENERAL MARKET ANALYSIS SHOULD BE PERFORMED COVERING THE POSSIBLE MARKET AMONG THE GENERAL PUBLIC FOR PRIVATE FAMILY PLANNING SERVICES. TO DETERMINE THIS MARKET, A FIRM KNOWLEDGE OF CHARACTERISTICS, ...
CONSIDERING THE POTENTIAL OF DEVELOPING A PRIVATE SECTOR
HEALTH ORGANIZATION TO PROVIDE FAMILY PLANNING SERVICES
TO EMPLOYEES OF LARGER PROFIT AND PARASTATAL
COMPANIES. THIS STUDY SHOULD INCLUDE:
- A DESCRIPTION, COVERING THE RANGE OF SERVICES, THE
TARGET POPULATION, CLINIC LOCATION(S) AND FACILITIES
AND STAFFING OF A POTENTIAL REFERRAL NETWORK.
- A MARKETING STRATEGY, ENCOMPASSING A RECOGNITION OF
THE OTHER GOVERNMENT AND NGO SERVICE PROVIDERS IN THE
AREA, MARKETING AND PROMOTION PLANS AND PATIENT
REFERRAL NETWORKS.
- A FINANCIAL ANALYSIS OF START-UP AND CONTINUING
COSTS, BREAK-EVEN ANALYSIS, CASH FLOW PROJECTIONS,
ABILITY TO FUND SERVICES, ETC.
6. MISSION HAS IDENTIFIED THE ENTERPRISE PROGRAM TO
DELIVER THESE ANALYSES.
7. MISSION PROPOSES THAT THESE ACTIONS BE CARRIED OUT
IN TWO PHASES. A PRELIMINARY ASSESSMENT AND CONCEPT
PAPER FOR A FEASIBILITY STUDY WILL BE FOLLOWED AT A
LATER DATE BY A FULL FEASIBILITY STUDY AND BUSINESS
PLAN IF WARRANTED.
8. MISSION REQUESTS AN ENTERPRISE PROGRAM STAFF PERSON
OR CONSULTANT WHO IS FULLY FAMILIAR WITH PRIVATE SECTOR
ASSESSMENTS TO CARRY OUT THE INITIAL VISIT. SKILLS OF
INDIVIDUAL NEEDED FOR SECOND VISIT, IF ANY, CAN BE
DETERMINED AT A LATER DATE.
9. PLEASE COMPARE THIS INFORMATION WITH THAT CONTAINED
IN REF C AND ADVISE IF FURTHER BACKGROUND/INFORMATION
IS REQUIRED.
10. MISSION APPRECIATES ENTERPRISE ASSISTANCE AND LOOKS
FORWARD TO FUTURE COLLABORATION.
AMERICAN EMBASSY
KATHMANDU, NEPAL
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>(EX/151).
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ATTACHMENT II
# ATTACHMENT II

**People Interviewed**

### USAID/Kathmandu (Kalimati; 211424, 211425)
- **Dr. David H. Calder**
  - Chief, Office of Health and Family Planning (HFP)
- **David Piet**
  - Office of HFP
- **Jay Anderson**
  - Office of HFP
- **Josette Maxwell, Ph.D.**
  - Chief Economist/Private Sector
- **Lawrence Pradhan**
  - Chief, Training Division
- **Anjali Sherchan**
  - Program Office

### National Commission on Population (Singha Darbar; 216523)
- **Chandra Kala Kiran**
  - Secretary
- **Som P. Pudasaini, Ph.D.**
  - Advisor

### Ministry of Health
- **Dr. Rabindra Pd. Singh**
  - Janakpur, FP/MCH (tel: 20165)
- **Dr. Bimala Joshi**
  - Birganj, Maternity Hospital

### JSI (Patan Dhoka; 522513, 522113, 521013)
- **Eileen McGinn**
  - Population Advisor
- **Marta Levitt**
  - Consultant
- **Bimala Manandhar**
  - Population Division

### CRS (Ram Shah Path; 412673, 412080)
- **Hem B. Himal**
  - General Manager
- **Nancy Piet**
  - Consultant

### Industrial Service Centre (Balaju; 414830, 414522, 411523)
- **G.B. Shah**
  - Executive Director
- **Tek B. Karki**
  - Senior Officer, Balaju

### Patan Industrial Estate
- **Ram Prasad Niraula**
  - Office Secretary, Welfare Committee
- **Yanzi Sherpa**
  - Vice Chairman, Welfare Committee (and Secretary of BFW)

### Business and Professional Women's Club of Nepal (BPW) (Bhote Bahal; 222985)
- **Ambika Shrestha**
  - President (Durbar Square; 222289, 222511)
- **Sariswahi Manandhar**
  - Administrative Officer
- **Ratna Lamilachand**
  - Program Coordinator, Training Center
- **Monika Manandhar**
  - Senior Supervisor, Day Care Centers
- **Kaochala Kayastha**
  - Supervisor, Day Care Center, PIE
INTERFACE (P), Ltd. (521845)
A.S. David, Ph.D. Chairman and CEO

Maternity Hospital (Thapathali; 211243, 214205)
Dr. Dibya S. Malla Director

Family Planning Association of Nepal (FPAN) (Lekhnath Marg; 410554, 413107)
Shanker Shah Executive Director
S.P. Dhugana, Ph.D. Director, Program Operation Division

Management Association of Nepal (MAN) (410691)
Madhula S.J.B. Rana President
P.S. Suvedi Vice-President
Bhakta Raj Ranjit Treasurer

Industries
I. Biratnagar
Hulas Metal Craft (Rani - Mills Area; 22817, 22728)
Gyan C. Dugar Executive Director

Ragupati Jute Mill (Mills Area; 22707)
L.D. Nayan Deputy Director (Technical)

Biratnagar Jute Mill (Mills Area; 22058, 22721)
J.B. Shrestha Deputy General Manager (Technical)

Ashok Textile Industries (Mills Area; 22812, 22768)
B.L. Jain General Manager

II. Birganj
Himal Iron + Steel (Parwanipur; 22673)
Padma Jyoti Director
Gobindra Bal Shrestha General Manager

Birganj Sugar Factory (22239)
Durga Prakash Pande General Manager

Hulas Steel Industries (Simra; 22998)
S.K. Lal Chief Executive

Agricultural Tools Factory (Borganj; 22166, 22019)
Amar Bahadur Karki General Manager

III. Hetauda
Hetauda Industrial District
Keshab Pande Manager
Mrs. Amita Rana Administrative Officer
(See. BPW and FPAN)
Hetauda Cement Industries (352, 536, 537)
U. Jha  Deputy General Manager (Technical)
Dr. A.K. Jha  Medical Officer

Hetauda Textile Industry (HID; 397)
Keshab P. Pradhan  Executive Chairman
Dr. K.K. Rai  Medical Officer

IV. Janakpur
Janakpur Cigarette Factory (20149, 20150)
Derendra B. Shah  Executive Chairman

V. Kathmandu
Nepal Electricity Authority (Darbar Marg; 212815)
Surya Nath Bastola  Director Admin. & Finance
Kandodia  Admin. & Finance (Personnel)
Parajuli  Admin. & Finance (Personnel)

Nepal Bank Ltd. (New Road; 222347)
B.H. Shrestha  Department Manager

Jyoti Industries (Kanti Path; 211490, 214327)
Padma Jyoti  Director
Roop Jyoti  Director

Bansbari Leather and Shoe Factory (Bansbari; 414561)
Ajit N.S. Thapa  Executive Chairman
Dr. Ram Deoprasad Shah  Physician
Suresh Shrestha  Health Assistant

Swastik Aerated Products (412705, 411520)
Jagadish Pd. Agarwal  Director (also Secretary General of FNCCI)

Other
Dr. Tikaman Vaidya  Former Medical Director, FPAN
(currently WHO Consultant in Bangladesh)
ATTACHMENT III
Between 6 and 9 October 1987, I toured the main industrial areas of Nepal which are located in the southern lowlands along the Indian border referred to as the Terai. I met with industrialists in Biratnagar, Janakpur, Birganj and Hetauda. In this attachment I summarize my findings and identify where the greatest potential is for private sector family planning in Nepal. The only other concentration of industries in Nepal is located in the Kathmandu Valley, but most of these facilities are small (several hundred employees per unit on the average) and more suited to a mobile operation which is suggested as a third phase on an Enterprise Program initiative (after large-scale industries have received individual units and the Women's Health Clinic is functioning).

1. **Biratnagar** – This is Nepal's second largest city and appears to be the largest concentration of industries in the country. Its importance is explained by the fact that Biratnagar is located closest to Calcutta, thus is in the best position to import raw materials and export goods. For programming purposes, it is convenient because a large number of firms are located in a very concentrated area (see attached list which is several years old). For example, in a 1.5 km. radius in the mill area (south of the city) there are 20 factories with approximately 7,500 workers. North of the city, there are another 20 manufacturing units with some 1,700 workers, while 600 workers are employed in 5 units to the east and 1,700 laborers are working for seven companies in Biratnagar itself.

My primary contact in Biratnagar was Gyan C. Dugar, an Executive Director of the Golchha Organization (the biggest industrial group in Nepal) and head of the Hulas Metal Craft factory in Biratnagar. In addition, Gyan is the head of the local Chamber of Commerce and is very active in community and civic affairs. He is most supportive of family planning and has offered to help in any way he can. He is particularly interested in the mobile operation to serve the needs of the large number of moderate size factories in the Biratnagar area.

There are two very large manufacturing units in Biratnagar, both with over 2,000 employees, and both are jute mills. J. B. Shrestha, the Deputy General Manager (Technical) of the Biratnagar Jute Mill, said that he does not think that he could sell the idea of a family planning facility to his Board of Directors. The Mill already has an FPAN operation functioning out of its clinic, and the Deputy G. M. thought it would be difficult to demonstrate the added value of an Enterprise funded effort. In contrast, D. D. Nayan, the Deputy Director (Technical) of the Ragupati Jute Mill, was very supportive of the idea of having an independent family planning facility at his factory. The Mill has approximately 2,200 employees about 10% of which are female. Nayan has recently recommended that 25% of the work force should be female since they are more reliable (less absenteeism because of less drinking and gambling which are major problems among the
male workers). The Mill has a clinic with several rooms which would provide sufficient space for family planning activities. It is possible that a nurse might have to be added to the present health staff (which consists of two compounders) to provide the services. One of the concerns with the jute mills in general is that the industry is very depressed, but the mills apparently will not be allowed by the government to close even though they are losing money since they provide so much employment.

A smaller operation is the Ashok Textile Industries which has about 450 employees. This is one of the most profitable companies in the country. While it has almost no female employees, it does have a housing colony where the workers and their families live and all of them could be eligible for family planning/health services. B. L. Jain, General Manager, expressed his support for the mobile clinic operation and said that his company would be interested in participating in such a program.

2. Janakpur - This city is located to the west of Biratnagar, approximately halfway to Birganj. There is only limited amount of industry in Janakpur. However, one of the biggest and most modern factories in the country is located here, the Janakpur Cigarette Factory. Due to late arrival in Janakpur, I only saw Derendra B. Shah, the Executive Chairman, briefly, but he indicated that he was interested and wanted to know more about the program. The factory has about 1,400 employees and already provides family planning services, primarily in the form of sterilizations which are carried out at their own health facility by their health staff (includes full-time surgeon and physician). Shah was interested in a more balanced approach which would provide a full range of temporary methods as well as the permanent variety. A definite possibility.

3. Birganj - Next to Biratnagar, Birganj is probably the biggest concentration of industries in Nepal (see attached list). There are presently about 34 factories in the area and it is growing quite rapidly. Most of the factories are located on the 20 km. stretch of road from Simra to Birganj. As in Biratnagar, the Chamber of Commerce was most helpful. The Chamber in Birganj is exceptionally active and involved with civic projects. For example, in the last several years they contributed and raised some Rs. 1,00,00,000 (over $450,000) for a 100-bed Maternity Hospital. They have also built a nursing school in Birganj. The major problem with these two installations is their management since the Chamber handed them over to the government to run and the normal problems arose.

My host in Birganj was Padma Jyoti, Director of Himal Iron & Steel and a leader in the Birganj Chamber. He was very excited about the possibility of a mobile family planning operation in the Birganj region and wanted the Chamber to be involved. He said that the most important issue was who was going to manage the operation. The Chamber could assist in its financial support, but not its management. He thought that the Business and Professional Women's group was a good possibility. He also expressed an interest in the mobile clinic being associated and working closely with the Maternity Hospital.
S. K. Lal, the Chief Executive of Hulas Steel Industries, is particularly interested in family planning and is very eager to do anything he can to promote it among his workers and others. He assured that he could be counted on for maximum cooperation, either through the Chamber or directly. Family planning is something he personally feels is essential and that he is committed to.

Durga Prakash Panday, the newly appointed General Manager of the Birganj Sugar Factory, said he would be very interested in initiating family planning services for his workers. The factory has over 650 permanent employees with almost 900 seasonal workers. The latter continue to receive 60% salary and have access to all the factory benefits during the off-season. They live in the area and thus any family planning operation at the factory would be accessible to them. The factory has a three-room clinic which could be adapted easily for the provision of family planning services. The health staff consists of several compounders, a health assistant and a part-time physician. This is the third possibility for an independent factory-based family planning operation. The factory has over Rs. 12,000,000 (almost $550,000) in its Welfare Fund (as surplus after the worker bonuses have been distributed); it is possible these funds might be useful in the establishment and/or maintenance of the family planning activities.

4. Hetauda - This industrial town is approximately one hour north of Birganj. Almost all of its industry is based in the Hetauda Industrial District, which has a number of large factories (as opposed to Balaju which has moderate size and Patan which has small-scale factories). For the last several years FPAN has provided family planning services in the HID and has apparently done a good job of it; for this reason a mobile unit would not seem to make much sense in Hetauda. According to a survey carried out by them in early 1987, 897 out of 1638 married respondents (almost 55%) were contracepting. While the FPAN gives DP, they do not insert IUDs. Moreover, the facility is wholly supported by the FPAN at the cost of Rs. 12,000 a month or almost $6,500 a year, and there is no way to know how long that funding will be available. Amita Rana is the Administrative Officer of the HID as well as the Secretary of both the BPW and FPAN in Hetauda; she is definitely the one to go to if you want anything done in family planning in Hetauda. She is extremely cooperative.

The largest employer in the HID is Hetauda Textile Industry, Keshab P. Pradhan the Executive Chairman. The labor force at the factory is 1,200, with approximately half being female. Pradhan is interested in an independent family planning operation because of the large number of women working for the factory. The health facility is small, consisting of two rooms, but an examination area is available. A physician, Dr. K. K. Rai, joined the factory full-time only three months ago and expressed his full support for an increased level of family planning in the factory clinic.
The only large employer in Hetauda outside the HID is Hetauda Cement Industries. I met with the Deputy General Manager (Technical), U. Jha, who said that his company would be most interested in having family planning capabilities at the factory itself. This is something that the factory has never had before. A physician, Dr. A. K. Jha, began his assignment at the factory in October and is already making great strides (moved the clinic to a much larger facility). He would very much like to have one of his nurses trained in the clinical, educational and management aspects of family planning. He mentioned that it might be appropriate to provide services at the housing colony at the quarry (18 km. north of the factory) several days a week. Both the Textile and Cement Factories offer excellent opportunities for independent family planning operations.

5. Kathmandu Valley - Most of the factories in the Kathmandu Valley region are of the smaller variety, with no factories with more than 1,000 employees. The largest employees are government bodies or parastatals like the National Electricity Authority. While they may be possibilities in the future, they are not yet convinced about the value of the intervention and do not have the human or physical capacity to operate a private sector family planning activity. The best possibilities for independent units are the two industrial estates, in Balaju and Patan, each of which have 2,500 to 3,000 employees. In addition, each industrial estate has a clinic which could house the family planning activity. This, however, would be somewhat more complex to initiate and such clinics would lend themselves more to the mobile operation which is being considered for the third phase of the Enterprise Program in Nepal.
**LIST OF FACTORIES**

I. **Biratnagar**

<table>
<thead>
<tr>
<th>Mills Area</th>
<th>Approx. No. of Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arunoday Udyog (stainless steel)</td>
<td>123</td>
</tr>
<tr>
<td>Ashok Textiles</td>
<td>451</td>
</tr>
<tr>
<td>Biratnagar Jute Mill</td>
<td>2,285</td>
</tr>
<tr>
<td>Biratnagar Workshop</td>
<td>23</td>
</tr>
<tr>
<td>Button Factory</td>
<td>N/A</td>
</tr>
<tr>
<td>Eastern Nepal Industries (jute press)</td>
<td>N/A</td>
</tr>
<tr>
<td>Everest Hosiery</td>
<td>N/A</td>
</tr>
<tr>
<td>Ganapatı Cotton Mill</td>
<td>316</td>
</tr>
<tr>
<td>Guheswari Solvant Extraction</td>
<td>35</td>
</tr>
<tr>
<td>Hanuman Industries (jute press)</td>
<td>N/A</td>
</tr>
<tr>
<td>Himalaya Rice Mill</td>
<td>N/A</td>
</tr>
<tr>
<td>Hulas Metal Crafts</td>
<td>147</td>
</tr>
<tr>
<td>Judha Match Factory</td>
<td>269</td>
</tr>
<tr>
<td>Koshi Metal</td>
<td>59</td>
</tr>
<tr>
<td>Morang Sugar Mill</td>
<td>501</td>
</tr>
<tr>
<td>Nepal Plywood &amp; Bobbin Factory</td>
<td>58</td>
</tr>
<tr>
<td>Nepal Tanning Industry</td>
<td>125</td>
</tr>
<tr>
<td>Ragupati Jute Mill</td>
<td>2,243</td>
</tr>
<tr>
<td>Shah Udyog</td>
<td>188</td>
</tr>
</tbody>
</table>

2. North of Biratnagar

| Everest Iron & Steel (Tankisinwari)             | 65                     |
| Everest Match (Sonapur)                        | 52                     |
| Flexible Packaging (Duhabi)                     | 50                     |
| Ganesh Ferozinc (Sonapur)                       | 50                     |
| Gayatri Iron (Duhabi)                           | 28                     |
| Himalay Soap & Chemical (Tankisinwari)          | 60                     |
| Hulas Wire (Tankisinwari)                       | 84                     |
| Luxmi Maide Mill (Sonapur)                      | 35                     |
| Nepal Breverage & Food Products (Tankisinwari)  | 67                     |
| Nepal Jute Industries (Tankisinwari)            | 214                    |
| Nepal Straw Board (Duhabi)                      | 178                    |
| Pashupati Biscuit (Duhabi)                      | 259                    |
| Pashupati Foam Products (Tankisinwari)          | 56                     |
| Pashupati Iron & Steel (Sonapur)                | 25                     |
| Pashupati Packaging (Duhabi)                    | 35                     |
| Pashupati Paints (Sonapur)                      | 14                     |
| Pashupati Paper Products (Duhabi)               | 35                     |
| Pashupati Soap (Sonapur)                        | 230                    |
| Rijal Tashi (Itanan)                            | 22                     |
3. East of Biratnagar (Katahari)

Guneswari Twine
Guneswari Waxmatch
Pashupati Wire Products
Ram Refinery
Universal Leather

4. Biratnagar Proper

Dhanawat Bidi
Dhanawat Match (Tinpaini)
Hanuman Match Factory
Shiva Bidi Factory
Swadeshi Cable
Swastik Salai
Todi Hosiery

II. Birganj

1. Adarshnagar

Laxmi Steel Furniture
Madhyamanchal Kankrit Industries

2. Alakhiya Road

Prakash Lamp Works
Shree Udyog

3. Bahuwari

Nepal Leather Tanning Industries

4. Birta

Anil Hosiery Industries
Joodha Match Factory
Nepal Cigarette Factory

5. Chapakaiya

Mahabir Rice Oil Mill
Prakash Battery Industries

6. Chatapipra

Eastern Textile Industries
Gaurishankar Rooling Mill
Nepal Salseed Industries
7. Hoharpatti
   Sarad Hoeiery Industries

8. Jitpur
   Ashok Nilco
   Lath Katha Udyog
   Rara Chapal Industries

9. Murli
   Chemical & Soap Industries
   Ganesh Biscuit Company
   Nepal Chemical & Soap Industries
   Sundar Furniture Industries
   Swadesi Chapal Industries

10. Parvanipur
    Birganj Khadya Udyog
    Himal Iron & Steel
    Himal Oxygen
    Narayani Skin Tanning Industries
    Nepal Wood & Allied Products

11. Pipra
    Agriculture Tools Factory
    Birganj Sugar Factory
    Birganj Sugar Mill Distillery

12. Shreepur
    Dacora Foam Industries
    Nepal Hide & Skin Industries
    Pradip Polithin Industries

13. Simra
    Hulas Steel Industries
ATTACHMENT IV
## ATTACHMENT IV

### Data on Industrial Estates

<table>
<thead>
<tr>
<th>Name of Industrial Districts (ID)</th>
<th>Date of Establishment</th>
<th>Total Area of ID in Ropans</th>
<th>Area of Developed land in Ropans</th>
<th>Area of Land Re...ed Ropans</th>
<th>Total Investment of the ID</th>
<th>Total Investment in the fixed assets of ID</th>
<th>No. of Indus...s under construction</th>
<th>Employment by ID office</th>
<th>Employment by ID's</th>
<th>Total no. of people employed</th>
<th>No. of sheds owned by ID's</th>
<th>No. of sheds constructed by the industrialists</th>
<th>No. of buildings constructed by ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kathmandu Industrial District, Bagmati Zone, Kathmandu Damaicas</td>
<td>1960</td>
<td>695.8</td>
<td>695.8</td>
<td>466</td>
<td>27.6</td>
<td>100</td>
<td>16.2</td>
<td>50</td>
<td>3</td>
<td>9</td>
<td>66</td>
<td>3000</td>
<td>3066</td>
</tr>
<tr>
<td>2. Hetauda Industrial District, Narayani Zone, Pashupati Nagar</td>
<td>1963</td>
<td>2400</td>
<td>2107</td>
<td>1038</td>
<td>30.7</td>
<td>412.5</td>
<td>17.3</td>
<td>23</td>
<td>5</td>
<td>-</td>
<td>68</td>
<td>2991</td>
<td>3059</td>
</tr>
<tr>
<td>3. Patan Industrial Estate, Lalitpur, Bagmati Zone</td>
<td>1963</td>
<td>269</td>
<td>269</td>
<td>182</td>
<td>16.4</td>
<td>28.5</td>
<td>12.0</td>
<td>69</td>
<td>4</td>
<td>16</td>
<td>38</td>
<td>2016</td>
<td>2054</td>
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<tr>
<td>4. Nepalgunj Industrial Estate, Banke, Bheri Zone</td>
<td>1973</td>
<td>208.5</td>
<td>183.9</td>
<td>94.4</td>
<td>10.1</td>
<td>18.7</td>
<td>6.0</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>25</td>
<td>211</td>
<td>236</td>
</tr>
<tr>
<td>5. Dhulikhel Industrial Estate, Dhulikhel, Koshi Zone</td>
<td>1972</td>
<td>202</td>
<td>202</td>
<td>80.5</td>
<td>8.6</td>
<td>15.0</td>
<td>6.4</td>
<td>14</td>
<td>2</td>
<td>3</td>
<td>19</td>
<td>320</td>
<td>339</td>
</tr>
<tr>
<td>7. Butwal Industrial District, Lumbini Zone</td>
<td>1975</td>
<td>406.8</td>
<td>406.8</td>
<td>295.1</td>
<td>8.6</td>
<td>7.1</td>
<td>7.7</td>
<td>15</td>
<td>2</td>
<td>1</td>
<td>20</td>
<td>300</td>
<td>320</td>
</tr>
<tr>
<td>8. Small Scale Industries Area, Bhaktapur, Bagmati Zone</td>
<td>1978</td>
<td>75.1</td>
<td>75.1</td>
<td>38</td>
<td>24</td>
<td>8.1</td>
<td>-</td>
<td>1.0</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>90</td>
</tr>
<tr>
<td>9. Prime Mover Industries Project Surkhet, Bheri Zone (under Construction)</td>
<td>1980</td>
<td>90</td>
<td>90</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>10. Dhankuta Industrial District, Koshi Zone (under Construction)</td>
<td>1984</td>
<td>50</td>
<td>50</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total** | 4908.2 | 4651.9 | 2411.7 | 1213 | 616.3 | 78.0 | 211 | 23 | 40 | 293 | 9911 | 10104 | 179 | 136 | 111 |

**N.B.** 1. The above mentioned informations & dates have been derived from the statement of accounts of F.Y. 2040-041 & 9041-042 (Butwal, Hetauda, Patan & Butwal I.DS. up to 2041-042 and others I.DS. up to 2040-041)