

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office <u>USAID/NEPAL</u> (ES# _____)		B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>93</u>	C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>
--	--	--	---

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
367-0157	Child Survival/Family Planning Services	1990	1995	22.5 million	15.0 million

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director	Name of Officer Responsible for Action	Date Action to be Completed
Action(s) Required		
1. Refocus project technical assistance on Logistics Management. Change Chief of Party to provide Senior Logistics Management Advisor.	MMG DAO	8/93
2. Prepare a USAID/MOH plan for a national Vitamin A program to be supported by the new Vitamin A component.	MMG	12/92
3. Focus the Child Survival interventions supported by T.A. contractor on CDD and ARI.	MMG DAO	7/93
4. Refocus the strategic objectives of the CRS project to social marketing and not privatization of the CRS Company.	DAO MF MMG	2/93
5. Ensure that VSC sites in the 15 institutionalizing districts are properly equipped, renovated and staffed with trained manpower.	MF	12/93

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation:	(Month) 06	(Day) 21	(Year) 1993
--	---------------	-------------	----------------

G. Approvals of Evaluation Summary And Action Decisions:				
Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
	Molly Gingerich Matthew Friedman	Jagdishwar Upadhyay Acting Sec., MOH	Richard Byess	Gerald Johnston Acting Director
Signature	<i>Molly Gingerich</i> <i>Matthew Friedman</i>	<i>Jagdishwar Upadhyay</i>	<i>Richard Byess</i>	<i>Gerald Johnston</i>
Date	<i>July 13, 1993</i>	<i>July 15, 1993</i>	<i>July 19, 1993</i>	<i>July 15, 1993</i>

a.

H. Evaluation Abstract (Do not exceed the space provided)

The project aims to help the government of Nepal (GON) improve the quality and coverage of health care, family planning, and selected malaria control services, and improve management and organizational issues and practices affecting the delivery of those services. The project is being implemented by 8 American contractors, 8 Nepali agencies, and departments/divisions of the Ministry of Health (MOH) at national, regional, and district levels. This mid-term evaluation (6/90 - 2/93) was conducted by a team of external evaluators on the basis of a review of project documents, visits to District Public Health Office (DPHO) in Bara, Chitwan, Kaski, Makwanpur and Rupendehi districts, and interviews with USAID/M officials, MOH officials, other GON officials, representatives of other donor agencies, contractors, and DPHO officials. The purpose was to assess the progress-to-date, and to address a set of project-wide as well as component-specific issues, and to provide feedback on implementation of the Child Survival/Family Planning Services Project (CS/FPS) to project managers and implementors. The major findings and conclusions are:

- The CS/FPS has made considerable progress toward achieving its project goals and objectives, and it should attain most objectives by 1995. Progress has been good in increasing the contraceptive prevalence by more than 20% in the project areas, training private sector physicians, increasing sales of contraceptives, strengthening Maternal and Child Health (MCH) activities in 4 districts, conducting Control of Diarrheal Disease (CDD) training in 8 districts, supporting the testing of implementation strategies for Acute Respiratory Infection (ARI) and vitamin A, supporting Female Community health Volunteer (F/CHV) in 19 districts, and training Passive Case Detection Volunteers (PCDVs) for malaria control in 50 districts.
- These achievements have been made in spite of the disruptions related to the recent elections in Nepal, reorganization of MOH and incomplete staff complement in the Health and Family Planning (HFP) office of USAID/M.
- The plans of MOH to reorganize itself in the near future will provide additional challenges to the project.
- In order to respond to these challenges, it is recommended that the focus of project activities shift from the region to the national level with district-level implementation efforts focussed on the 15 institutionalizing districts.
- Family Planning Services through private sector employers which are small and do not employ a large number of women, would not bring wide-scale benefits.

The evaluators noted the following "lessons".

- Family Planning institutionalization needs to be undertaken in a phased approach insuring requirements are in place before discontinuing earlier approaches.
- A project with as many disparate elements as the Child Survival/Family Planning Services tends to diffuse the focus of the project from the project's goal and purpose. Only those most closely associated with the project understand its intricacies, and it is difficult to convey what the project is about. Concentration on the most important technical and geographic areas for project emphasis should increase the probability of project impact.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Dayl Donaldson	POPTECH, DUAL, Inc.	DPE-3024-Z-00-	\$ 79,000	POPTECH, DUAL Inc.
Anthony Costello	" " "	6078-00		
Irene Koek	R&D/POP			
Rita Thapa	WHO, Geneva			
2. Mission/Office Professional Staff Person-Days (Estimate) _____ 45 _____		3. Borrower/Grantee Professional Staff Person-Days (Estimate) _____ 60 _____		

b

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)

Address the following items:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Purpose of evaluation and methodology used • Purpose of activity(ies) evaluated • Findings and conclusions (relate to questions) | <ul style="list-style-type: none"> • Principal recommendations • Lessons learned |
|--|--|

Mission or Office: USAID/Nepal	Date This Summary Prepared: 06/18/93	Title And Date Of Full Evaluation Report: Midterm Evaluation of the Child Survival/ Family Planning Services.
-----------------------------------	---	---

PURPOSE OF ACTIVITY EVALUATED: The purpose of the Child Survival/Family Planning Services (CS/FPS) is 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 (CS/FPS Project Paper)."

PURPOSE OF EVALUATION AND METHODOLOGY USED: The purpose of this mid-term evaluation is "to assess the progress-to-date under the bilateral agreement; and assess the validity of the present design and assumptions, particularly with respect to issues related to the following topics: 1) regionalization, 2) GON program-support training, 3) USAID administration/implementation, 4) family planning institutionalization and priority country strategy, 5) community health volunteers, 6) malaria program, 7) services for and by women, and 8) private sector health and family planning support (Scope of Work)."

The methodology used included document review, observation, informal and semi-structured interviews, and a systematic consensus-building procedure.

FINDINGS AND CONCLUSIONS

General: The evaluation team believes that the CS/FPS has made progress toward achieving project goals and objectives despite the social, political, economic, and bureaucratic constraints that are a part of the current, but changing, context in Nepal. In light of the (Ministry of Health) MOH's organizational changes, the team recommends that the focus of project activities be shifted from the regional to the national level with district-level implementation efforts focussed primarily on the 15 institutionalizing districts. Upon the adoption of recommendations made by the evaluation team, specific plans will have to be formulated to guide a shift from the current project focus. This will require project staff to rewrite the logframe and description to make clearer the changes in expected project outcomes.

Disbursement Mechanism and Processes: MOH officials have the perception that most of the project activities are implemented through contractors at very high cost with limited transfer of skills to MOH personnel. However, implementation of project activities through MOH is much slower than through contractors. Given the pros and cons of this issue, there is not a single best approach for the programming of local currencies under the project. Therefore, it is recommended that both MOH and supplementary work plans be continued for the programming of local currency support.

Improved Management and Service Delivery: The evaluation team recommends that the project should, through efforts coordinated at the national level, continue efforts aimed at strengthening management skills, particularly at the district level. System development work should be focussed on the MIS (Management Information System) and logistics' systems for family planning, and on development of quality assessment and supervision tools in FP/MCH (Family Planning/Maternal and Child Health). The project should consider contracting with a local consultant with an excellent track record in planning and management in the health sector at the district level to provide planning and management training and follow-up consultation services to District Public Health Officers (DPHOs).

Public Health Training: To date, little has been accomplished with respect to this component of the project for a variety of reasons. The need for support for public health training for DPHOs is no less strong than at the time of the project Paper design. In the context of a changed political and administrative environment, renewed attention can be placed on this component. Should a decision regarding public health training not be taken within the designated period, then it is recommended that funds for public health training be reprogrammed.

Innovative Activities: Specific funding for this component was not included in the Project Paper as it was thought that regional and district level personnel would develop innovative ideas; and that the contractor would provide technical assistance to assist in research methods and data analysis. However, by September 1992 it became clear that the contractor would have to play a more active catalytic role and would need a budget for local currency expenses. It is early to evaluate the orientation and impact of activities under this component, however, it is possible to note that the potential impact ranges from small to large, and that the subject matter covers both management and clinical issues. Funds available for innovative activities should continue to support innovations in service delivery, however, with higher ceilings for activities proposed by DPHOs.

FAMILY PLANNING:

The project was intended to increase the range of family planning methods, and to strengthen voluntary surgical contraception and other clinical contraceptive services through improved training, counseling, screening and quality assurance. Most attention has been given to the program and process of institutionalization, hence, the evaluators were asked specifically to review this effort.

Overall Design: While the broad objectives of the program are appropriate, there are some weaknesses in linkages between inputs and broad objectives. Specific inputs are fragmented and not linked together sufficiently to be certain of an impact on the whole. USAID should re-focus its family planning program support on four broad elements: 1) logistics, MIS, and contraceptive supply, 2) quality assurance, 3) private sector support, and 4) support for testing implementation strategies. District-level family planning activities related to institutionalization should continue to be focussed in the original 15 institutionalizing districts.

Institutionalization: Institutionalization is the program and process whereby a district delivers a full range of family planning services at all levels of the health care system. To date, 15 districts have been designated as institutionalizing districts. These districts no longer carry out VSC (Voluntary Surgical Contraception) camps or give provider client incentives. Services are offered through static facilities, as part of hospitals' ongoing programs. The team feels that institutionalization is an important program relevant to both immediate and long term health and family planning needs in Nepal. There is real potential for the success of institutionalization. The team visited a hospital that was successfully providing VSC services as a result of the institutionalization program. USAID should continue to support GON's institutionalizing district program, eventually expanding this program nation-wide.

Contraceptive Prevalence and Method Mix: The Contraceptive Prevalence Rate (CPR) in the 15 institutionalizing districts seems impressive compared to that in the 60 non-institutionalizing districts. The CPR in these districts was 2 to 2.5 times higher than in the non-institutionalizing districts. The estimated CPR of 30 to 40 percent in the 15 institutionalizing districts has exceeded the CSVFP's target by 20 percent. However, the baseline CPR for these districts may have been higher than the other 60 districts. The full range of family planning methods in the GON's family planning program includes VSC (vasectomy and tubal ligation), depoprovera, IUDs, pills, NORPLANT and condoms. The available information indicates that the nationwide contraceptive method mix is about 78 percent permanent methods, and about 22 percent temporary methods. There appears to be a decline in VSC acceptors over the last few years. This decline seems not to be limited to the institutionalizing districts.

Quality Assurance: This component was set up to improve the quality and coverage of child health care and family planning services. Quality assurance includes institutionalization of family planning services in selected districts, a smoothly operating contraceptive logistics and supply system, development of IEC (information, education, and communication) capacity and clinical method training, and counselling. Much of USAID's family planning efforts should be refocused on quality assurance, defined as ensuring the availability of a full range of family planning services, with proper counselling and medical screening. To operationalize "quality assurance" USAID should strengthen and activate the existing quality assurance team, and give them a clear cut role; institutionalize quality assurance at all levels, and develop indicators.

Logistics, MIS (Management Information System) and Supply: USAID is one of the primary suppliers of contraceptives, and has also assisted in the development of an MIS system. USAID should increase its efforts to assist GON with development of a national, well-functioning, systematic demand-driven logistics management system. USAID should assist MOH in working with service delivery NGOs to insure that their service statistics feed into the national MIS.

Contraceptive Retail Sales Company (CRS): Over the period 1986 to 1990 CRS's performance was adversely affected by changes in the general manager position and other senior personnel and by reluctance on the part of MOH to increase privatization of the organization. Sales have improved since the arrival of the current general manager, however, the organization needs encouragement to review and undertake changes in operation to improve marketing and sales of existing and new product lines. CRS is faced with conflicting messages: on the one hand, USAID requires privatization of CRS's organization, on the other hand, USAID through the audit process, ties CRS's hands with respect to any management decisions it wishes to take. USAID and CRS should initiate a dialogue on options which would allow CRS to operate with more autonomy. Another conflict of interest is to increase financial sustainability of CRS, at the same time, increasing distribution of contraceptives in rural areas. CRS would probably not pursue this line of activity if it were giving primary consideration to financial sustainability.

Private Sector Family Planning Initiatives: The project is to 1) engage 4 major employers in the provision of family planning services to their employees, 2) train 10 physicians in family planning for private practice, and 3) involve more NGOs in the provision of family planning services. In 1992 the project financed a study to ascertain the possibility of engaging major employers in the provision of family planning services to their employees. AVSC (Association for Voluntary Surgical Contraception)/NFCC (Nepal Fertility Care Center) provided training and family planning equipment to 23 private sector physicians. Two NGOs, SCF/U.S. and Nepal Red Cross are involved in family planning.

Policy and Strategy Development: USAID has supported policy related activities through the RAPID (Resources for Awareness of Population Impact on Development) project, and is about to provide technical assistance to National Planning Commission/ Population Division and MOH by supporting a resident technical advisor for over one year. The team did not review the RAPID activities. However, both sets of activities seem to be appropriate.

Priority Country Strategy: Nepal has recently been designated as a "Priority Country" under A.I.D.'s Priority Country Strategy for population. This opens the door for Nepal to receive increased resources and attention in an effort to help curb high population growth. As part of this strategy, a detailed country plan outlining areas of focus and specific areas of support from the central office of population resources will be developed.

CHILD SURVIVAL, FEMALE COMMUNITY HEALTH VOLUNTEERS AND MALARIA CONTROL

Child Survival: This component of the project comprises diarrheal disease control (CDD), vaccine-preventable diseases (EPI), and acute respiratory infection (ARI) control. Several activities including EPI were dropped in the course of USAID's focussing exercise. The project is supporting CDD activities at the national and central-regional level. A pilot study of the use of F/CHV in diagnosis and treatment of ARI is ongoing in the Chitwan district. This survey will be repeated next year. USAID is supporting a project for ARI control in Jumla, and a similar smaller scale project in Dang. These efforts have made major contributions to ARI research in Nepal.

Female Community Health Volunteers (F/CHVs): To date, the F/CHV component of the project has been one of the most successful activities under the Central Regional Health Directorate. USAID's support for F/CHVs in the Central Region is complemented by UNFPA's support for it in 8 districts of the Western Region. The estimated number of F/CHVs to be trained and retrained is about 6,000 (300 F/CHVs per district in 19 districts).

Malaria Control: USAID's support for malaria control has shifted away from the purchase of insecticides to support for environmental control measures, development of case detection and information systems, and development of skills in vector control. To this end, USAID awarded a tender for the renovation of the National Research and Training Center building in Hetauda, and purchased Labophot-2 microscopes. Many of these microscopes are still lying in storage because some of the health posts where these microscopes are supposed to be used have no electricity. Training for passive case detection volunteers has been successful. Passive case detection identifies 60-70% of positive malaria cases. In addition, USAID has supplied \$ 350,000 worth of pumps and spare parts, uniforms, masks and so on to the malaria division of GON since 1990.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

1. Midterm Evaluation of the Child Survival/Family Planning Services Project: NEPAL (367-0157) by Dayl Donaldson, Anthony Costello, Irene Koek and Rita Thapa. Fieldwork: August-September, 1992.

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

USAID/Nepal and the grantee are satisfied with the evaluation.

Jr

15A 81239

Prepared for

USAID/Kathmandu
Under PIO/T 367-0157-3-10174
and Office of Population
Bureau for Research & Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

**MIDTERM EVALUATION OF
THE CHILD SURVIVAL/
FAMILY PLANNING SERVICES
PROJECT: NEPAL (367-0157)**

by

Dayl Donaldson
Anthony Costello
Irene Koek
Rita Thapa

Fieldwork
August-September, 1992

Produced by

Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

April 12, 1993

Prepared for

USAID/Kathmandu
Under PIO/T 367-0157-3-10174
and Office of Population
Bureau for Research & Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

**MIDTERM EVALUATION OF
THE CHILD SURVIVAL/
FAMILY PLANNING SERVICES
PROJECT: NEPAL (367-0157)**

by

Dayl Donaldson
Anthony Costello
Irene Koek
Rita Thapa

Fieldwork
August-September, 1992

Produced by

Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

April 12, 1993

TABLE OF CONTENTS

List of Tables	ii
List of Figures	ii
List of Maps	ii
Glossary	iii
Project Identification Data	v
Acknowledgements	vii
Executive Summary	viii
I. INTRODUCTION	1
II. PROJECT-WIDE ISSUES	2
A. Refocusing Project Activities	2
B. MOH and Project Liaison	6
C. Disbursement Mechanisms and Processes	7
D. Donor Coordination	9
III. SERVICE MANAGEMENT AND DELIVERY	10
A. Central Region Management/Service Delivery Improvement	10
B. Public Health Training	13
C. Innovative Activities	15
IV. FAMILY PLANNING	19
A. Introduction	19
B. Overall Design of Family Planning Component	19
C. Institutionalization	21
D. Conceptive Prevalence and Method Mix	27
E. Quality Assurance	31
F. Logistics, MIS, and Supply	36
G. Contraceptive Retail Sales Company	37
H. Private Sector Family Planning Initiatives	42
I. Policy and Strategy Development	44
J. Priority Country Strategy	45
V. MATERNAL AND CHILD HEALTH, CHILD SURVIVAL, AND FEMALE COMMUNITY HEALTH VOLUNTEERS	46
A. Introduction	46
B. Comprehensive MCH Strengthening	46
C. Child Survival Activities	48
D. Female Community Health Volunteers	50
VI. MALARIA CONTROL	54
APPENDICES	
A. Scope of Work	62
B. List of Persons Consulted	68
C. Bibliography	71
D. Family Planning: Progress Toward Achieving Logframe Objectives	76

E.	Quality Indications: Review of Clinic Cards	78
F.	Child Survival and Maternal and Child Health Program Options	81

LIST OF TABLES

Text Tables

3.1	Local Cost Support	8
4.1	Nepal Contraceptive Prevalence Rates	27
4.2	CPR for Project Districts Compared to Targets	28
4.3	Method Mix: Continuing Users of Various Family Planning Methods in 15 Institutionalizing Districts and Nationwide	29
4.4	Age, Parity and Gender Preference Trends by VSC and Depo Acceptors	31
4.5	Number of Hospitals/Health Posts/Sub-Health Posts Providing Family Planning in Institutionalizing Districts	32
4.6	CRS Company Expenditure and Revenue, 1988-1991	39
6.3	Receptivity-wise Malaria Profile, 1989-1991	58
6.4	Slides Collected and Positives Detected by Different Case Detection Mechanism, 1989-1991	59

Appendix Tables

B.1	Findings of Family Planning Record Review of DMPA Clients, 5-11 September 1992	80
-----	---	----

LIST OF FIGURES

1	Current USAID Links in Health and Population	4
2	Proposed Future USAID Focus in Health and Population	5

LIST OF MAPS

1	Projected Activities in Nepal's Central Region	11
2	Institutionalizing Districts	22

Glossary

ABER	annual blood examination rate
ACD	active case detection
AHW	assistant health worker
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Care and Prevention (project)
ANM	auxiliary nurse midwife
API	annual parasite incidence
ARI	acute respiratory infection
AVSC	Association for Voluntary Surgical Contraception
BPH	Bachelor's of Public Health
CDC	Centers for Disease Control
CDD	Control of Diarrheal Disease (program)
CHV	community health volunteer
CPR	contraceptive prevalence rate
CRHD	Central Region Health Directorate
CRS	Contraceptive Retail Sales (company)
CYP	couple years of protection
DPHO	district public health office/officer
EOP	end of project
EPI	Expanded Program of Immunization
F/CHV	Female Community Health Volunteer
FP	family planning
FPAN	Family Planning Association of Nepal
FPLM	Family Planning Logistics Management (project)
GON	government of Nepal
HFP	Health and Family Planning office (USAID)
HMG	His Majesty's Government
HP	health post
HPI	health post in charge
IEC	information, education, and communication
IOM	Institute of Medicine
JSI	John Snow, Incorporated
MASS	Management and Support Services
MCH	maternal and child health
MIS	management information system
MMT	Mrigendra Medical Trust
MOH	Ministry of Health
MRTC	Malaria Research and Training Center
MSCI	Medical Services Corporation International
NFCC	Nepal Fertility Care Center
NFFS	Nepal Fertility and Family Planning Survey
NFS	Nepal Fertility Survey
NGO	non-governmental organization
NNIP-S	Nepal Nutrition Project-Sarlahi
NNJS	Nepal Netra Jyoti Sangh
NPC	National Planning Commission
NRs.	Nepalese rupees
ORS	oral rehydration salts
ORT	oral rehydration therapy
PCD	passive case detection

PCDV passive case detection volunteer
PF p. falciparum
PRISM program performance information system
QAT quality assurance team
RAPID Resources for the Awareness of Population Impact on
Development (project)
RSM rural social marketing
SDP Systems Development Program
SOMARC Social Marketing for Change (project)
SPR slide positivity rate
TA/DA travel allowance/daily allowance
TFR total fertility rate
UNDP United Nations Development Programme
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
VBC Vector Biology Control (project)
VDC village development committee
VHW village health worker
VSC voluntary surgical contraception
WHO World Health Organization

Project Identification Data

1. **Project Title:** Child Survival/Family Planning Services
2. **Country:** Nepal
3. **Project Number:** 367-0157
4. **Project Dates:**
Agreement Signed: June 1990
Amendment #1 Signed: August 1992
End Date: July 15, 1995
5. **Project Funding:**
USAID \$22.5 million
Host Country Funding: \$20.8 million
6. **Mode of Implementation** Agreements with several U.S. and Nepali organizations
7. **Previous Evaluation:** Evaluation of the USAID/Nepal Integrated Rural Health/Family Planning Services Project, 366-0135, Robert Pratt et al., Population Technical Assistance Project, February 22, 1989.
(Predecessor Project)
8. **Activities:**
 - Technical and financial support for decentralization of health services management at the regional level (to date).
 - Technical and financial support for innovative activities in management.
 - Training and support for F/CHVs, Central Region.
 - Technical and material support for institutionalization of family planning services (15 districts including renovation and equipment of clinical areas, training, and applied research).
 - Technical and financial support for CRS company.
 - Provision of contraceptive methods.
 - Technical and financial support for improvement of MCH and child survival services (ARI, CDD) primarily in districts of Central

Region, including development of workplan training and applied research.

- Training of malaria volunteers in 50 districts in passive case detection.
- Provision of microscopes for subdistrict-level health facilities.
- Technical and financial support for Jumla Community Health Study (ARI Vitamin A and CDD case management)
- Technical and financial support for National Vitamin A deficiency control program (to begin January 1993)

ACKNOWLEDGEMENTS

The team would like to acknowledge those individuals and organizations which have provided support to the team during the course of the evaluation. Mr. M.S. Thapa and the staff of the Ministry of Health were very open with their time and views regarding this project. Particular thanks is due to the Director of FP/MCH, Dr. Kalian Raj Pandey, and also to two members of his staff, Pushpa Lal Shrestha and Ajit Pradhan for their assistance in providing demographic and family planning service statistics to the team. The team would like to also acknowledge the many others in the voluntary and private sectors in Nepal who shared their experience and thoughts. We are grateful to David Oot, Molly Gingerich and Matt Friedman for their interest and involvement in the evaluation and to Puru Pokhrel, Pangday Yongzone, and Badri Manandhar for their translation and logistical assistance for the team. Finally, the team wishes to thank POPTECH for their logistical and technical support.

EXECUTIVE SUMMARY

USAID's Child Survival/Family Planning Services Project is an ambitious and complex project which aims to "improve the quality and coverage of child health care, family planning, and selected malaria control services, and (improve) management and organizational issues and practices affecting the delivery of those services". The project was designed to address five major themes ^{1/} through 4 different project components, with each component having several sub-components. Implementation of project activities involves several departments/divisions of the MOH at national, regional, and district levels, and has involved the input of 8 American contractors and 8 Nepali agencies. District level activities are focused on both the 15 family planning institutionalizing districts as well as the 19 districts of the central region.

The objectives of the present evaluation have been to assess progress to date, and to address a set of project-wide as well as component-specific issues. Collection of information to meet these objectives has been through interviews, field visits, and review of documents. The assistance of the staff of USAID/Nepal's Health and Family Planning Office has been invaluable to the team.

Since the initiation of the project in August 1990, progress has been made towards achieving project goals and objectives. For example, a purpose of the project is to increase contraceptive prevalence by 20 percent in the institutionalizing districts. Current data indicates that contraceptive prevalence in these districts has already increased by more than 20 percent. Further, in the area of family planning the project is to train 10 private sector physicians in family planning and 20 have already been trained. CRS sales have increased with the arrival of a new General Manager, and the organization currently generates revenues equal to over 50 percent of its salaries and benefits. With respect to child survival, MCH service strengthening activities are underway in 4 districts of the Central Region, and CDD training and/or intensive supervision activities are being conducted in 8 districts of the Central and Western Regions. In addition the project is supporting the testing of implementation strategies for ARI and Vitamin A with the results expected to contribute to development of policy regarding these interventions. F/CHV activities are being supported in the 19 districts of the Central Region, and 94 percent of the target malaria PCDVs for 50 districts have been trained. These outputs have been achieved in spite of the disruptions related to the recent elections in Nepal, and

^{1/} "Services by and for Women", "Beyond the Health Post", "Full Service Family Planning/MCH Services", "Decentralization and Regionalization", and "Don't Forget Malaria".

incomplete staff complement in the HFP Office of USAID.

The plans of the MOH to reorganize in the near future will provide additional challenges to the project. Elements of the reorganization which will have particular impact on project activities are: i) creation of separate Child Health and Family Health Divisions instead of a single FP/MCH Division, ii) probable disbanding of the regional offices, iii) process of reposting of staff from development to regular posts.

The team was asked to develop recommendations as to how the project should respond to the above changes in the MOH, and how the project might be better focussed to achieve the project's goal and purpose. The team recommends that the focus of project activities be shifted from the region to the national level with district-level implementation efforts focussed primarily on the 15 institutionalizing districts ^{2/}. In addition, some of the technical focus of specific components has been refocussed.

Activities at the national level in family planning should be refocused in support of: i) logistics and MIS systems development and commodities provision nation-wide, ii) quality assurance (including training), iii) private sector support, and iv) testing of strategies for service delivery. District level activities would continue to support the institutionalization efforts with a quality assurance emphasis including a number of activities currently underway. Private sector initiatives to train physicians in family planning should continue, however it does not appear that there would be wide-scale benefits to developing family planning services through employers which are small and do not employ large numbers of women. Support for CRS should continue but effort is needed to resolve the "mixed messages" of privatization and sustainability vs. public service.

Activities at the national level in child survival (ARI, CDD, and Vitamin A) should focus on: i) testing implementation strategies and assisting with policy modifications as needed, ii) work with GON to develop a national strategy and plan for Vitamin A supplementation, and iii) quality assurance activities. District-level activities would support completion of existing

^{2/} Exceptions to this general rule will be necessary. For example, F/CHV activities are currently on-going in all of the districts of the Central Region and should continue there, and malaria activities also should continue in the 50 districts where they are currently underway. Testing of strategies for Child Survival and MCH service delivery may require sites other than the Terai/Hill districts that are institutionalizing. However, the team would recommend that the minimum number of non-institutionalizing districts required for the test be selected, and that these be among the districts in the Central Region that have already received assistance under the project.

CDD activities and start-up of Vitamin A activities.

The F/CHV program has been very successful in achieving geographic coverage by F/CHVs, and in the short run it is recommended that support be continued for F/CHV activities in the Central Region. However, less information is available about what F/CHVs do and how this achieves health and family planning benefits. It is recommended that USAID review studies on this issue, and commission others if necessary, to determine the future level and type of support for this program.

With respect to public health and management training, efforts should be redoubled to move the MOH to take decisions which would allow this training activity to take place. USAID should take a strong stand with respect to a timetable in which the MOH take a decision. Provision of training and workshops to DPHOs in overall program planning and management should be supported, including the hiring of a Nepali consultant who can support the training and provide management consultancy services to the DPHOs.

In the area of cost recovery, UNICEF and WHO are already involved in policy dialogue with the HMG. One mechanism for USAID to participate in this dialogue to seek to join future task forces on health financing. USAID could play a unique role in this area by focussing on health financing questions at the level of the district hospitals and DPHOs.

A listing of the specific recommendations of the evaluation appear on the following pages. If recommendations of the evaluation are adopted by USAID, specific plans will have to be generated to guide a shift from the current project focus to a new one. Some rewriting of the logframe and description would be advised to make clearer the changes in expected project outcomes.

Lessons learned from project implementation to date include:

- o Family Planning institutionalization needs to be undertaken in a phased approach insuring requirements are in place before discontinuing earlier approaches.
- o Focus of a project on strengthening of a regional structure does not facilitate development of strong associations with national level personnel and concerns. Further should the regional structure remain weak or be disbanded this requires a reestablishment of project linkages.
- o A project with as many disparate elements as the Child Survival/Family Planning services tends to diffuse the focus of the project from the project's goal and purpose. Only those most closely associated with the project understand its intricacies, and it is difficult to convey what the project is about. Concentration on the most important

technical and geographic areas for project emphasis should increase the probability of project impact.

SUMMARY LIST OF RECOMMENDATIONS

Listed below is a complete list of the recommendations found in the various chapters of this evaluation. While most recommendations are repeated verbatim, the more detailed recommendations in the text are only summarized below.

Refocussing Project Activities

1. In light of the MOH's organizational changes, the team recommends that the focus of project activities be shifted from the region to the national level with district-level implementation efforts focussed primarily on the 15 institutionalizing districts ^{3/}.

MOH and Project Liasion

1. As FP and MCH services are inextricably linked at the health post and below, the project will have to strengthen links with national officers concerned with both MCH and FP services.

2. Given the MOH's shift away from the regional offices, and the proposed shift to national and district levels, the JSI team should be given adequate office space on the grounds of the MOH to facilitate day-to-day interactions with national counterparts and other staff.

3. JSI should use the space provided by the MOH to the greatest advantage for building collaborative relationships with MOH counterparts and other staff towards the success of the project.

Disbursement Mechanisms and Processes

1. To simplify the process of workplan development shifting to multi-year as compared to single year plans seems appropriate, especially for activities that will take place at the national rather than district level. The text of proposals should not be more complicated than necessary, and reports of achievements can appear instead in annual project reports.

2. Given the pros and cons on both sides of the issue, it is

^{3/} Exceptions to this general rule regarding districts will be necessary. For example, F/CHV activities are currently on-going in all of the districts of the Central Region and should continue there. Testing of strategies for Child Survival and MCH service delivery may require sites other than the Terai/Hill districts that are institutionalizing. However, the team recommends that only the minimum number of non-institutionalizing districts required for the test be selected, and that these be among the districts in the Central Region that have already received assistance under the project.

recommended that both Redbook and Supplementary workplans be continued for the programming of local currency support. Candidates for Redbook programming would be activities that are intended for GON financing after the EOP, activities at the district level and below, or activities which are not urgently required in a short time span. Candidates for Supplementary programming are those which are more one-time investment in nature, are carried out above the district level, and are more urgent for completion in a short time frame.

Donor Coordination

1. USAID should encourage and facilitate the establishment of regular coordinating meetings for the major donors in the health/family planning sector.

Improved Management and Service Delivery:

1. The project should, through efforts coordinated at the national level, continue efforts aimed to strengthen management skills, particularly at the district level. Specific efforts would include training to the DPHOs of the 15 institutionalizing districts through seminars/workshop and on-the-job training on general management skills, as well as on program planning and implementation specifically for FP/MCH. Care should be taken to develop management seminars/workshops to complement the planned UNDP training, perhaps by carrying specific topics onto more advanced concepts. Should these workshops prove successful, avenues to extend it to other districts, e.g. through other donors, could be pursued.

2. The project should consider contracting with a local consultant with an excellent track record in planning and management in the health sector at the district level (e.g. a retired DPHO) to provide planning and management training and follow-up consultation services to DPHOs.

3. Systems development work should be focussed on the MIS and logistics' systems for family planning, and on development of quality assessment and supervision tools in FP/MCH.

Public Health Training

1. The TA team, under the direction of the Secretary of Health, should set up a task force group in the MOH which will have the task of developing a proposal which can be approved to permit the start of this training.

2. The task force should engage the services of a short-term consultant to develop a training program proposal which meets the requirements of the MOH.

3. USAID should inform the Secretary of Health of a time limit,

say 3-4 months, within which the working group has to conclude its work and receive approval by the Secretary of Health.

4. Should a decision regarding public health training not be taken within the designated period, then it is recommended that funds for public health training be reprogrammed. Funds could be allocated to support long term training in the USA, additional short term participant training, and/or to develop management training materials which could be used in USAID-funded DPHO workshops.

Innovative Activities

1. Funds available for innovative activities should continue to support innovations in service delivery, however with higher ceiling for activities proposed by DPHOs. If overall funding for this activity is sufficient, then funds should be also allowed to support small grants which support testing and analysis of service delivery options.

2. To participate in policy dialogue on health care financing USAID should request to the MOH to be invited to participate in future task forces on health care financing.

3. Regarding the drug cost recovery schemes the project has several options: i) initiate a drug cost recovery scheme in a district which has not received assistance from another donor, and ii) strengthen the MOH information reporting system on existing drug schemes.

4. Should USAID wish to make a unique contribution to the discussion of health care financing in Nepal it is recommended that this assistance be focussed on financing issues at the district level. Specific analyses in this area would include: i) study of zonal/district hospital costs, revenue, utilization, management and quality; ii) exploration of mechanisms to provide additional financing for DPHOs (e.g. local taxes, proceeds from an economic activity, a surcharge added to the fees collected by health posts); iii) development of a district-wide financing scheme through health insurance, and iv) comparison by district over time of HMG budget and donor financing for FP/MCH programs by type of input. Technical assistance and financing for these activities might be sought from centrally-funded projects.

5. Determination whether other studies or actions in health financing should be undertaken should follow the August 1993 Second Seminar on Health Economics and Health Financing at which it will be possible to determine the quality of the research commissioned for that meeting and to participate in discussions which lay out future research and actions to be undertaken.

Family Planning - Overall Design

1. USAID should re-focus its family planning program support on four broad elements. These elements are: i) logistics, MIS, and contraceptive supply, ii) quality assurance, iii) private sector, and iv) testing implementation strategies. Recommendations pertaining to each of these areas follows a detailed discussion below. Choice of these four areas is consistent with the project paper and A.I.D.'s comparative strengths and is in keeping with discussions with HMG officials, health staff interviews, observations of the team.

2. District-level family planning activities related to institutionalization should continue to be focussed in the original 15 institutionalizing districts. Expansion to new districts will depend upon the adequate completion of tasks in the original districts and upon the GON's designation of other districts as institutionalizing.

Family Planning - Institutionalization

1. USAID should continue to support HMG's institutionalizing district program, eventually expanding this program nation-wide. The quality assurance efforts described below should be a key effort in facilitating institutionalizing.

2. Incentives should not be reinstated in the 15 institutionalizing districts. Rather, support to the institutionalizing effort should be continued. While the program should compensate doctors for their time and develop mechanisms to make the provision of FP services an attractive program, a per case incentive system has far too many quality and voluntarism implications to be acceptable and we believe would damage the program in the long run. At the same time, USAID should assist the GON to find ways to insure that there are enough service providers to meet the expected demand.

3. USAID should support the expansion of SDP activities beyond the four operations research districts to the rest of the 15 institutionalizing districts as soon as feasible.

4. USAID and HMG should proceed very carefully in expanding institutionalization to additional districts. This expansion should be done in a phased manner, with careful attention to insuring that facilities and personnel are in place before mobile camps and incentives are dropped. Preferably this expansion should begin with the districts where a District Health Officer is in place as proposed in the MOH's reorganization plan.

Family Planning - Quality Assurance

1. Much of USAID's family planning efforts should be refocused

under the rubric of quality assurance, defined briefly as ensuring the availability of a full range of family planning services, with proper counselling and medical screening. This should be implemented on a district by district basis, beginning with the investment already made in the institutionalizing districts.

2. To operationalize "quality assurance" USAID should: i) strengthen and activate the existing quality assurance team, and give them a clear cut role, ii) institutionalizing quality assurance at all levels, and develop indicators.

3. USAID should provide leadership in clinical methods training. The selection of trainees should be guided by a district by district needs assessment, and tied with the counselling training, to insure that service providers can discuss all method options with clients. In addition, USAID should work closely with the HMG's training coordination working group that is chaired by UNFPA and includes other donors, in conducting needs assessments and in developing and implementing training programs.

4. USAID should continue to support HMG's institutionalizing program. This includes support in the following areas: i) facilities, ii) outlets, iii) staffing, iv) training, v) information on methods, vi) alternative rewards, vii) coping alternatives, viii) take account of district variations, ix) booking/scheduling system, x) support the adoption of post partum/post-natal family planning programs in institutionalizing districts, xi) broaden efforts to institute a clinic card system which mandates medical screening and facilitates adequate follow-up.

Logistics, MIS, and Supply

1. USAID should increase its efforts to assist HMG with the development of a national, well-functioning, systematic demand-driven logistics management system. Support to the MOH for this effort from the Office of Population's Family Planning Logistics Management Project with JSI/CDC should be explored.

2. USAID should assist the MOH in working with service delivery NGOs to insure that their service statistics feed into the national MIS.

Contraceptive Retail Sales Co.

1. SOMARC should provide additional input to strengthen CRS marketing efforts. Additional funds may need to be added to the SOMARC buy-in to provide CRS with TA support for the Major Tracking Study.

2. The RSM program should be re-thought given its tangential

relationship to central role of CRS. One possible alternate strategy is collaboration with public sector, i.e. provision of temporary contraceptives to VHWS and CHVs with CRS focussing on development of media and other communications means to promote knowledge of and demand for FP methods among rural populations. In addition, during the phase-out period, the creation of rural depots might include essential drugs as well as contraceptives to better insure financial sustainability.

3. USAID should, on an annual basis, specifically follow up with CRS on the issue of performance with respect to recurrent financing of salaries and benefits. CRS should show trend figures for a five year period and include simulations which indicate how revenues will be increased during the following 2 years.

4. Technical assistance should be provided to CRS to reinforce efforts to train druggists and shopkeepers in appropriate methods of medical screening. This effort at improving quality will be especially important should CRS become involved in the distribution of Depo-provera.

5. In support of efforts to control the spread to Acquired Immune Deficiency Syndrome, funds should be provided (perhaps from the centrally funded AIDSCAP program) for intensified program of condom promotion and distribution along major transportation routes in Nepal.

Family Planning - Private Sector Initiatives

1. Given limited female population in the industrial sector interventions with employers should be limited either to the industrial park clinics or firms with over 500 employees (and where the majority of these being women). Either NFCC or FPAN could be used to provide training and educational materials. CRS can be involved to provide contraceptives on wholesale basis.

2. Greater priority should be given the current effort to provide family planning training to private physicians. Emphasis should be given to training doctors in major towns, especially those with practices for women (Ob/Gyn). Quality assurance measures, such as described above for the public sector program, should be introduced. CRS should be involved so as to provide FP methods (inc. IUD, Depo, Norplant) to physicians at wholesale prices. CRS should take over this role from NFCC.

3. USAID and the MOH should continue to work closely with FPAN and explore ways of expanding support to FPAN and broadening areas of contact.

Family Planning - Policy and Strategy Development

1. The project should provide support for testing implementation strategies and issues. There are several issues and questions about implementation strategies that USAID can provide assistance in. In some cases, these studies may more appropriately be carried out by other donors. Suggestions made to the evaluation team which could be considered by USAID: i) follow-up NORPLANT study, ii) follow-up Depo study, iii) two-son factor, iv) reasons for decrease in VSC acceptors, v) determination of what clients really want, and vi) define specific multi-sectoral linkages.

Family Planning - Priority Country Strategy

1. Under the priority country strategy, USAID should expand efforts in the family planning sector in the areas suggested in the project focus by calling on additional resources from the Office of Population. Specifically, central resources over and above the current bilateral project inputs should be pursued in logistics management and IEC.

2. In addition, USAID can explore the use of central resources to cover current buy-in costs for AVSC, SOMARC or the Population Council. If one or more of these buy-in costs are covered with central funds, bilateral monies freed up should increase local cost support in the institutionalizing/quality assurance efforts.

3. More effort to expand resources directly to the government should be explored. Discussions evaluation team members had with government officials indicated that there is a pervasive notion that too much money and effort is going outside the government to U.S. and local contractors. USAID can use central resources to help mitigate this.

Child Survival

1. The project should continue to provide support for the testing of strategies for implementation of child survival interventions.

2. Existing work in CDD intensive supervision, ARI control by outreach workers and Vitamin A supplementation should be concluded and be linked in to national level decision making. It is more likely that lessons learned from strategy implementation work in Vitamin A, CDD and ARI will be incorporated into national programmes if the MOH officers responsible are more closely involved in the planning and evaluation of these studies.

3. Project funds should be made available to support the production of joint GON/USAID papers on: i) control of Vitamin A deficiency in Nepal, ii) the use of outreach workers for rapid diagnosis and treatment of ARI, and iii) expanding the correct use of oral rehydration solution for acute diarrhoeal disease.

4. In the longer term, USAID should give strong consideration to focussing their child survival efforts for just one of the child survival interventions on an expanded national basis. Vitamin A supplementation would be the logical choice for an expanded intervention, in which case support for other child survival activities might be phased out over LOP.

MCH Strengthening

1. The project should expand work in improving the quality of MCH services at the health post and beyond through support to DPHOs. Specifically this support should include:

- o Formation of FP/MCH service quality teams at national level.
- o Development of district level FP/MCH service quality indicators and rapid appraisal methods for monitoring service quality at district level.
- o Co-ordinate meetings of DPHOs from selected districts to evaluate progress in MCH service quality, to develop planning and management skills, to encourage innovative activities in FP/MCH service quality and to allow peer group review.

Female Community Health Volunteers

1. USAID support for F/CHV activities in the Central Region should continue. Information from interviews and the team's field experience show that the F/CHV program has been an important development. Large numbers of F/CHVs are trained and active in their communities, serving as an important resource for future improvements in family planning and health at the village level.

2. USAID should urgently assist GON to develop a clear policy about the future role of F/CHVs. Among the policy questions to be addressed are:

- o The precise expectations for and functions of F/CHVs.
- o The F/CHVs linkage to VDCs and female MCH workers.
- o Clarification of whether F/CHVs should be supplied with drugs, including those for treatment of ARI. If so, then problems with drug resupply need to be addressed.
- o The management of the program - who is responsible and how will CRHD activities be continued if regional offices decline in importance and the MOH is re-organised?
- o Future training - should it be integrated with the training division of the MOH and the regional training centres or

left to the discretion of DPHOs?

- o How can F/CHVs be used more effectively as client representatives in quality assurance work?
- o The need for studies to evaluate different support systems for F/CHVs.
- o The role of major donors in co-ordinating support to the national F/CHV program.

3. The project should concentrate on developing local and district-level managerial support systems for F/CHVs already trained before expanding training of new F/CHVs.

4. Although the literacy activities undertaken under the F/CHV program have had an impact in increasing functional literacy they were not foreseen in the Project Paper and may not fit in with longer term USAID plans in health and family planning. These pilot efforts should be completed and phased out over the LOP. Lessons learned should be shared with the MOH and discussions held as to whether to include a literacy component in the CHV strategy with possible funding for its implementation from UNICEF and/or other donors.

Malaria Control

1. USAID should encourage the planned reconstruction of a National Training Center at Hetauda as a national and regional training and research center for vector-borne diseases including malaria, leishmaniasis, Japanese B encephalitis and other viral diseases (but probably excluding AIDS). This type of center will require substantial technical support for the development of laboratory facilities, management of insectoria, and training and research programs in vector entomology and the epidemiology of these diseases. USAID should provide additional technical assistance to provide this support.

2. The development of ilaka laboratories with microscopes has not been achieved. USAID should determine with the MOH whether there are other ilaka level health posts with electricity to which the scopes in storage can be distributed. Other options for the distribution of the remaining scopes, e.g. distribution to other facilities, teaching programs, or laboratories, should be considered with emphasis on distribution in the near term. If no suitable use in Nepal can be found for the scopes, distribution to another USAID program in the Asian region should be considered.

3. The PCDV programme is by far the most successful part of the USAID input to malaria and warrants full continuing support. This programme should be maintained but a target of twice yearly training sessions may be excessive and might be reduced to

once-yearly.

4. Proper storage and maintenance of sprayers and other supplies seems to be a problem. A review of the MOH's management of these supplies is recommended, and further purchase of these supplies is not indicated prior to such a review.

5. On the basis of the present evaluation it is difficult to make detailed recommendations about what should be USAID future long-term support to the malaria programme. It is recommended that USAID conduct a more detailed assessment of this question after November/December 1992 when USAID will better be able to judge the MOH's future plans for the control of malaria and other vector-borne diseases and to determine the level and type of USAID support indicated.

CHAPTER I INTRODUCTION

On June 29, 1990, the Child Survival/Family Planning Services Project (367-0157) was signed to provide US\$ 22.5 million to Nepal over a 5 year period. The goal of this assistance is to "reduce child mortality and undesired fertility" through "improvement of the quality and coverage of child health care, family planning, and selected malaria control services, and of management and organizational issues and practices affecting the delivery of those services". In August 1992, an additional \$2.5 million was added to develop and implement a Vitamin A deficiency control program.

The present mid-term evaluation takes place about two years after the project was launched with the arrival of the long-term technical assistance team. The scope of work for the evaluation outlined two principal objectives:

- o Assess the progress-to-date under the bilateral agreement; and
- o Assess the validity of the present design and assumptions, particularly with respect to issues related to the following topics: i) regionalization, ii) training, iii) USAID administration/implementation, iv) family planning institutionalization and priority country strategy, v) community health volunteers, vi) malaria program, vii) services "by and for women", and viii) private sector support.

The evaluation was conducted over the period of a month by a team of four consultants, all of whom had prior working experience in Nepal.

Prior to the team's arrival in Nepal a document was prepared which provided detailed descriptive information about the health sector, project components and contractors, and documentation of activities under the project to date ^{4/}. Additional information was collected through interviews (see List of Persons Contacted in Appendix B), review of other documents (see Bibliography in Appendix C), and field visits to 5 districts in the Terai and Hill areas. Interviews were conducted during the field visits with DPHO staff, Health Post staff and clients, Female Community Health Volunteers (F/CHVs), Village Development Committees, and focus groups of village women. In addition, family planning clinical records and service facilities were reviewed to assess aspects of service quality (see Appendix E).

^{4/} Friedman, Matthew (July 9, 1992) Background Paper for Mid-Term Evaluation of USAID/HFP's Child Survival/Family Planning Services Project, USAID/HFP, 91 pp. plus annexes.

CHAPTER II PROJECT-WIDE ISSUES

A. REFOCUSING PROJECT ACTIVITIES

1. Issues and Discussion

The Child Survival/Family Planning Services Project serves as an "umbrella" project for a variety of activities in the health sector in Nepal. The project was designed to address five major themes ^{5/} through 4 different project components, with each component having several sub-components. Implementation of project activities has involved several departments/divisions of the MOH at national, regional, and district levels, and has involved the input of 8 American contractors and 8 Nepali agencies ^{6/}. District level activities are to focus on both the 15 family planning institutionalizing districts as well as the 19 districts of the Central Region, however different subsets of these districts have been selected as sites for different project activities. One question addressed to the evaluation team is whether the project should be more focussed in order to ensure achievement of measurable, sustainable impact.

One dimension along which questions of project focus was considered was a geographic one. One of the initial objectives of the project was to strengthen the decentralization of health services through technical and managerial support to the Central Regional Health Department (CRHD) and to districts of the Central Region. Over this period there is evidence of some increased responsibility delegated to the regional offices, e.g. for the transfer of personnel, and for provision of budget to the districts. However, the team was told by district personnel that the CRHD seemed to function as a "CC Office" that is sent copies of correspondence between the districts and the national program departments. Perhaps as a consequence of perceptions of the lack of utility of regional offices the proposed reorganization of the MOH is reported to eliminate regional offices.

MOH Reorganization Plans

The MOH has plans to reorganize the health services in the near future. Details remain very tentative and the overall shape of the newly reorganized Ministry may be somewhat different from that which was being discussed at the time of the evaluation. The elements that appeared most firm and that would be expected to have particular bearing on project activities are shown in Figure 2 and

^{5/} "Services by and for Women", "Beyond the Health Post", "Full Service Family Planning/MCH Services", "Decentralization and Regionalization", and "Don't Forget Malaria".

^{6/} See Figure 1.

are as follows:

- 1) Creation of separate Child Health and Family Health Divisions in place of a single Family Planning/Maternal-Child Health (FP/MCH) Division,
- 2) Probable disbanding of the regional offices and transfer of program control (e.g., for the F/CHV program) back to the national level, and
- 3) Efforts to move staff in development budget posts (posts that were originally created for the implementation of development projects and often funded from foreign assistance funds but which, as a consequence, are not permanent and do not carry benefits) to regular budget posts.

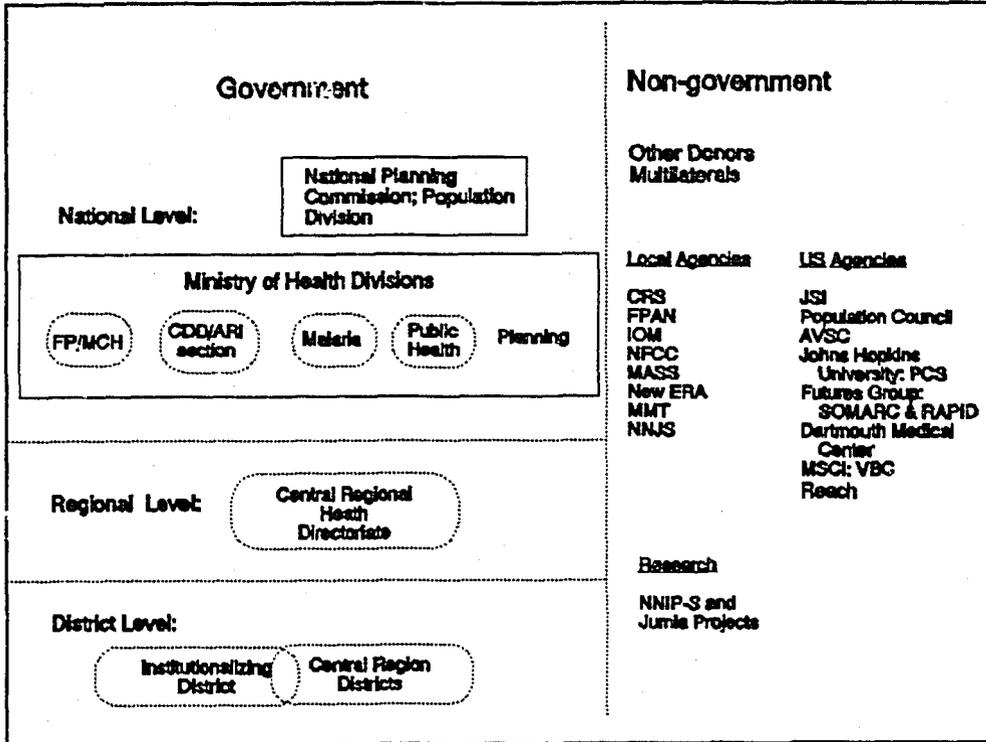
2. Conclusions and Recommendations

1. In light of the MOH's organizational changes, the team recommends that the focus of project activities be shifted from the region to the national level, with district-level implementation efforts focussed primarily on the 15 institutionalizing districts^{7/}. (See Figure 2)

^{7/} Exceptions to this general rule regarding districts will be necessary. For example, F/CHV activities are currently on-going in all of the districts of the Central Region and should continue there. Testing of strategies for Child Survival and MCH service delivery may require sites other than the Terai/Hill districts that are institutionalizing. However, the team recommends that only the minimum number of non-institutionalizing districts required for the test be selected, and that these be among the districts in the Central Region that have already received assistance under the project.

Figure 1

Current USAID Links in Health and Population

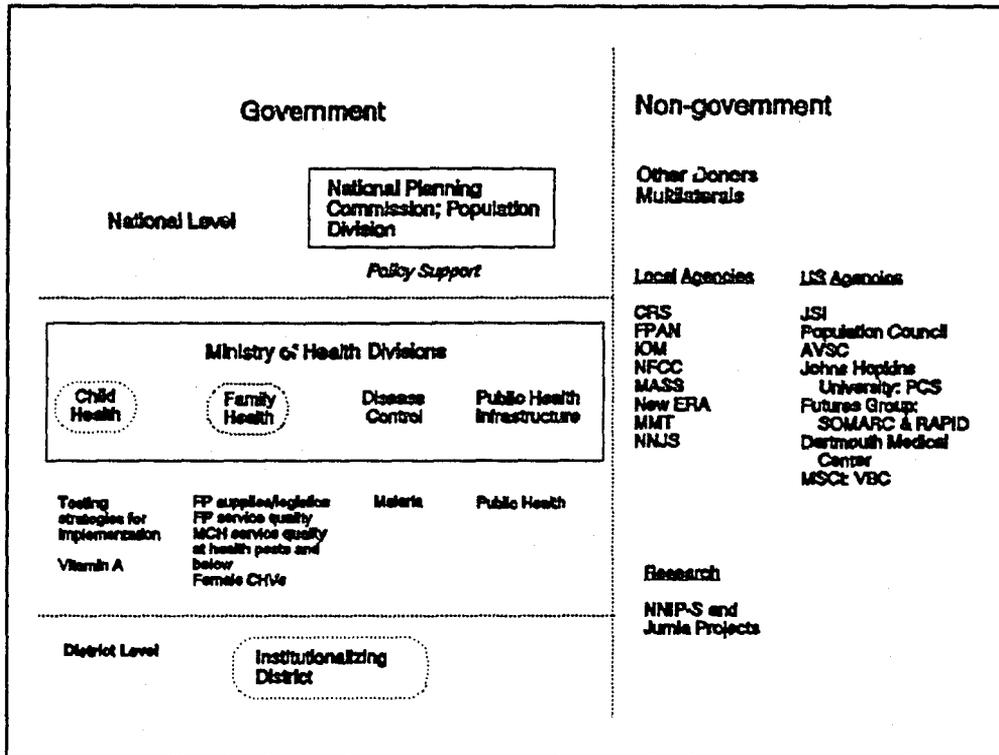


Source: Evaluation Team

Note: Circled lines denote bodies with which project interacts.

Figure 2

Proposed Future USAID Focus in Health and Population



Source: Evaluation Team

Note: Circled line denote bodies with which project interacts.

B. MOH AND PROJECT LIAISON

1. Issues and Discussion

It was estimated that the time requirements of the project's original orientation to strengthening of the CRHD and of services in districts of the central region would require at least 50 percent of institutional contractors time. Given the lack of space at the CRHD, it was fitting that the JSI team have offices nearby. JSI also initially had an office in the Family Planning Division of the MOH, but this was taken back due to lack of its use. In addition, JSI has recently opened a regional office in Hetauda to facilitate their work with districts in the Terai.

Given the proposal of this evaluation that the project focus be shifted from the regional to the national level, the question arises as to the location of the team in Kathmandu. There seemed unanimous agreement among Nepali officials in the MOH that closer interactions with the team are needed and would be welcome^{8/}. Provision of space for the team within the MOH seems feasible. The challenge will be for the JSI team to use this space and opportunity for collaboration in a constructive and satisfactory way. The shift of focus of intervention districts from those in the Central Region to principally the institutionalizing districts does not affect the JSI field office as many of the Terai districts of the Central Region are institutionalizing.

2. Conclusions and Recommendations

1. As FP and MCH services are inextricably linked at the health post level and below, the project should strengthen its links with national officers concerned with MCH as well as FP services.

2. Given the MOH's shift away from the regional offices, and the proposed shift to national and district levels, the JSI team should be given adequate office space on the grounds of the MOH to facilitate day-to-day interactions with national counterparts and other MOH staff.

^{8/} A number of officials indicated that they felt they were not adequately involved in the planning, implementation and monitoring of the project. For example, while MOH officials appreciate the assistance of USAID contractors, (local and international) and while these inputs meet the immediate needs, there was concern that this would not build up the long-term strategic needs of building human resource capability needed to institutionalize the program at all levels of the government's health system. An example given was that individual ministry personnel are trained technically but this technology transfer is not done on a broad enough basis to insure continuity when individuals move on to other things.

3. JSI should use the space provided by the MOH to the greatest advantage for building collaborative relationships with MOH counterparts and other staff towards the success of the project.

C. DISBURSEMENT MECHANISMS AND PROCESSES

1. Issues and Discussion

The evaluation team was asked to consider how the development of workplans and disbursement of local currency funds could be streamlined so as to increase the timeliness of disbursement.

It is worth first noting the importance to the MOH of running project funds through the GON system. MOH officials have the perception that most of the project funds are run through contractors, some of whom provide services at very high cost. Further there is the perception that skills that are developed by the contractors are not transferred to MOH personnel. The justification of using a private contractors because TA/DA rates are too low may be true for Kathmandu training and workshop activities, but does not appear to provide as strong a rationale for district-level activities where the TA/DA rate appears more adequate to attract participation of district-level personnel. In addition, activities financed through the Redbook are more likely to be financed by the GON after the EOP.

On the other hand, the low rate of disbursement of funds obligated under the workplans does suggest that allocation of funds under the Redbook will slow project implementation. Since the start of the project only about 25 percent of the project funds programmed under Redbook accounts have been disbursed. In contrast, about 65 percent of funds programmed with Nepalese agencies have been disbursed (see Table 3.1). Given pros and cons on both sides of the issue it would not appear that there is a single best approach for the programming of local currencies under the project.

Table 3.1

Local Cost Support
(in \$s)

Redbook Account

Commitment Description	Commitment Amount	Disbursement	Unliquidated Balance	Percent Unliquidated
Workplan 47/48 ¹ CDD	80,430	28,375	52,055	65
Workplan 47/48 CHV	322,384	182,317	140,067	43
Workplan 48/49 MCH	94,908	31,446	63,462	67
Workplan 48/49 CDD	35,882	876	35,006	98
Workplan 48/49 CHV/CDD/MCH	209,536	15,836	193,700	92
Workplan 49/50 CHV/CDD/MCH ²	145,229		145,229	100
Workplan 47/48 MCH	172,556	56,806	115,750	67
Workplan 49/50 CDD ²	51,054		51,054	100
Workplan 49/50 MCH ²	71,088		71,088	100
Workplan 49/50 CHV ²	68,560		68,560	100
Total	1,251,627	315,656	935,971	75

Source: USAID/Kathmandu

¹Numbers in this column represent the Nepali fiscal year²Activity began in July 1992. Insufficient time for disbursements to appear.

Supplemental Account (to Local NGOs/PVOs & CAs)

Commitment Description	Commitment Amount	Disbursement	Unliquidated Balance	Percent Unliquidated
Endoscopic Ram Center	15,946	14,222	1,724	11
CRS	165,800	165,800	0	0
CRS	525,435	387,410	138,025	26
Logistic Support PH/CDD-FP/MCH/MASS ¹	119,962		119,962	100
Passive Case Detection PRM-MASS	27,184	24,913	2,271	8
Logistic Support CRHD/PHC and CDD from MASS	78,021	53,512	24,509	31
Logistic Support MCD from MASS ¹	132,208	11,692	120,516	91
Liquidated	100,000	100,000	0	0
Total	1,164,556	757,549	407,007	35

Source: USAID/Kathmandu

¹Activity began in July 1992. Insufficient time for disbursements to appear.

2. Conclusions and Recommendations

1. To simplify the process of workplan development shifting to multi-year as compared to single year plans seems appropriate, especially for activities that will take place at the national rather than district level. The text of proposals should not be more complicated than necessary, and reports of achievements can appear instead in annual project reports.

2. Given the pros and cons on both sides of the issue, it is recommended that both Redbook and Supplementary workplans be continued for the programming of local currency support. Candidates for Redbook programming would be activities that are intended for GON financing after the EOP, activities at the district level and below, or activities which are not urgently required in a short time span. Candidates for Supplementary programming are those which are more one-time investment in nature, are carried out above the district level, and are more urgent for completion in a short time frame.

D. DONOR COORDINATION

In all of the areas of activity under this project there is at least one other donor significantly involved. However there appears not to be established at this time any regular mechanism for communication and coordination about programs in the sector.

1. Conclusions and Recommendations

1. With respect to donor coordination the team recommends that USAID should encourage and facilitate the establishment of regular coordinating meetings for major donors in the health and family planning sector.

CHAPTER III
SERVICE MANAGEMENT AND DELIVERY

A. CENTRAL REGION MANAGEMENT/SERVICE DELIVERY IMPROVEMENT

1. Description

Activities under this component of the project are intended to strengthen management systems at the Central Region Health Department (CRHD) and in Central Region districts, concentrating on those aspects of management that would lead to an improvement of coverage and quality for FP/MCH services (see Map 1). Specific activities for support include: i) development and funding of annual workplans, ii) systematic district reviews and follow-up for MCH services, iii) basic and refresher training in management, planning and budgeting, information systems, and supervision, iv) development of reporting and information systems for personnel, training, logistics, budget, and supervision. Combined with district activities in the technical areas of FP/MCH it was estimated that assistance to the CRHD and associated districts would utilize 50 percent of the long-term technical assistance (TA) team's time.

2. Activities to Date

To date, the TA team has assisted the CRHD with the development of three workplans (1990/1, 1991/2, and 1992/3) covering activities and support for Family Planning, MCH Strengthening, CDD, and CHV in the Central Region. Districts in which support has been provided are as follows:

Family Planning: Bhaktapur, Chitwan, Dhanusha, Kathmandu, Lalitpur, Makwanpur, Parsa

MCH Strengthening: Bara, Dhading, Makwanpur, Rautahat

CDD Supervision: Dhading (new), Dolakha (new), Makwanpur, Mahotari, Rasuwa, Ramechap, Sarlahi (new), Nawalparasi (Western Region).

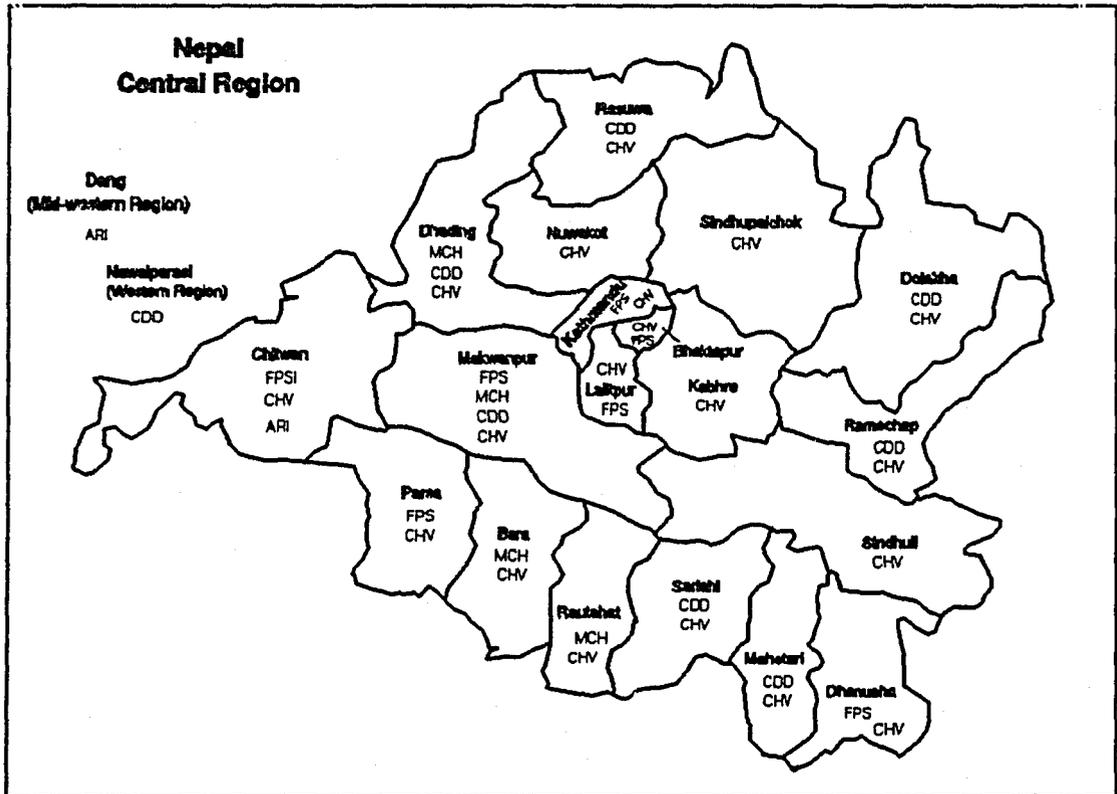
CHV: All Central Region Districts.

Details of achievements under each of the above technical areas are covered in Chapters 4 and 5 of this report.

To date, the project has not provided training in general management skills. During the period 1992-1997 PHC Management courses financed by UNDP of 4 to 5 weeks are to be offered to all DPHOs and their assistants. Through New ERA/Population Council a national FP MIS system has been developed and the computer-based information management system at the CRHD has been strengthened. MIS for MCH services remains weak.

Map 1

Project Activities in Nepal's Central Region
(Family Planning, MCH Strengthening, CDD Support, CHV)



3. Issues and Discussion

The design of this component seem to have been based on three assumptions:

- o The management skills of regional and district personnel required improvement in order to improve the efficiency of operations of the health system.
- o Improvement of management skills could be achieved through basic training in management areas, and through application to programs in FP/MCH - particularly MCH, CDD, and CHV.
- o FP/MCH program activities planned and budgeted for at the regional level (rather than the national level) would be successfully implemented at the district level, due to an increased level of involvement and support from the regional level.

While the evaluation team does not question the first 2 assumptions, it would revise the third assumption to place the responsibility of target setting, planning and budgeting at the district instead of regional level to obtain a higher level of commitment to the program. In addition, the team would add an assumption, that improvement of the efficiency of operations of the health system may depend on the operations of national systems, and cannot be developed and supported starting from the regional level.

4. Conclusions and Recommendations

1. The project should, through efforts coordinated at the national level, continue efforts aimed to strengthen management skills, particularly at the district level. Specific efforts would include training to the DPHOs of the 15 institutionalizing districts through seminars/workshop and OJT on general management skills, as well as on program planning and implementation specifically for FP/MCH. Care should be taken to develop management seminars/workshops to complement the planned UNDP training, perhaps by carrying specific topics onto more advanced concepts. Should these workshops prove successful, avenues to extend it to other districts, e.g. through other donors, could be pursued.

2. The project should consider contracting with a local consultant with an excellent track record in planning and management in the health sector at the district level (e.g. a retired DPHO) to provide planning and management training and follow-up consultation services to DPHOs.

3. Systems development work should be focussed on the MIS and logistics' systems for family planning, and on development of

quality assessment and supervision tools in FP/MCH.

B. PUBLIC HEALTH TRAINING

1. Description

The project includes a component in support of public health training for DPHO management staff. This component was to address concerns that the vertical project backgrounds of DPHO management staff, and their lack or weak administrative training, were insufficient to allow these officers to define and manage and integrated set of public health services. In addition, the provision of training was to provide certification of the officers to allow their recruitment into Regular Budget posts. This component is to provide 6-8 person-months of short-term technical assistance to: i) set up procedures related to the selection and recruitment of officers for training, and ii) review and upgrade Institute of Medicine (IOM) curricula and practical field training. In addition, the component was to cover the tuition and living costs for approximately 50 student-years of study (25 students with up to 2 years each), with almost half of the trainees to come from the Central Region. Additional funding was to be provided: i) to IOM faculty for observation visits within the region and for appropriate faculty research, ii) classroom upgrading and equipment, and iii) vehicles.

2. Activities to Date

To date, little has been accomplished with respect to this component of the project for a variety of reasons. In late 1990, a study regarding the development of a public health training program for DPHOs was prepared (Shipp, 1990), which highlighted a number of issues related to the implementation of this component:

- o In 1990, approximately 50 DPHO management staff required public health training, 32 candidates holding a bachelor's degree and 18 candidates without a bachelor's degree.
- o Were the IOM to develop a 5 month or 1 year Diploma course in Public Health suitable for the training and certification needs of current DPHO staff, the course content would then not serve as a useful course of study for other students.
- o Political changes, as well as redefinition of the role and restructuring of the DPHO, provided uncertainty in 1990 and through 1991 about the actual training requirements of DPHO management staff.

Shipp concluded that while the need for public health training was urgent, that it might be desirable to suspend activities related to the component until after the multiparty elections of 1991 when the work could be undertaken in a continuous fashion.

The MOH proposed that a 5 month course be developed in order to certify DPHOs and assistants for regular posts. This was modified by the IOM into a year long Diploma course. Students in the Bachelor's in Public Health (BPH) course of the IOM mounted a protest to the Diploma program angered that someone might qualify in one year for a post that it was taking the BPH students two years to qualify for. Since this time the JSI team and HFP Office have had meetings with the Steering Committee but decisions which would allow renewed activity haven't been taken, in part to await for the shape of administrative reform to become known.

3. Issues and Discussion

The need for support of public health training for DPHOs is no less strong than at the time of the PP design ^{9/}. Perhaps now that the conduct of general and local elections has passed, and that the specifics of the administrative reforms will shortly be made clear, renewed attention can be placed on this component of the project.

Options for this training include:

- o Short Course in Nepal (through MOH or IOM)
- o Short Course in Asian region (India or Thailand)
- o Bachelors or Masters Course in Nepal (through IOM)
- o Masters' Course in USA

Of the above options the MOH favors conducting a special 5 month course run by the MOH based on an existing curriculum ^{10/}. What seems to be required is the development of a proposal which would contain: i) a re-assessment of the number of persons requiring such training, ii) review of the curriculum and re-identification of appropriate faculty, iii) identification of a training site, preferably in Kathmandu, iv) development of a budget.

In addition, the MOH would like to have the option of sending individuals for long term overseas public health training in order to continue to develop a cadre of Nepali professionals committed to public health. Individuals selected for training might either be those overseeing outstanding family planning performance in institutionalizing districts, physicians who will be appointed as managers of public health activities in the districts, or others making important contributions to public health in Nepal.

^{9/} Unfortunately the delays in this component will mean that some in post who haven't had public health training will be unable to shift to a Regular Budget post.

^{10/} Such an in-service course should not run afoul of the student protests attached to a course at the IOM.

4. Conclusions and Recommendations

1. The TA team, under the direction of the Secretary of Health, should set up a task force group in the MOH which will have the task of developing a proposal which can be approved to permit the start of this training.
2. The task force should engage the services of a short-term consultant to develop a training program proposal which meets the requirements of the MOH.
3. USAID should inform the Secretary of Health of a time limit, say 3-4 months, within which the working group has to conclude its work and receive approval by the Secretary of Health.
4. Should a decision regarding public health training not be taken within the designated period, then it is recommended that funds for public health training be reprogrammed. Funds could be allocated to support long term training in the USA, additional short term participant training, and/or to develop management training materials which could be used in USAID-funded DPHO workshops. Long term training can be supported through the Mission's bilateral Development Training Program.

C. INNOVATIVE ACTIVITIES

1. Description

The Project includes a component of technical assistance and local currency support to permit and encourage the development and testing of innovative approaches to improving health and family planning programs. Examples of specific topics include: demand/utilization studies, field testing of alternative methods of cost recovery, studies of alternative means of extending services beyond the health post, studies related to improving the effectiveness of the CHV program. By the EOP, Regional and Central District staff were to have developed problem solving skills, and a working environment was to have been established in which new ideas could be tested and implemented. In quantitative terms, up to 5 innovative activities are to be tested over the LOP.

2. Activities to Date

Specific funding for this component of the Project was not included in the Project Paper as it was thought that regional and district level personnel would develop their own innovative ideas and that the Institutional Contractor would provide TA as requested to assist in research methods and data analysis. By September 1992 it became clear that the Contractor would have to play a more active catalytic role and would need a budget for local currency expenses in order to do so. An amendment to the JSI contract, dated January 1992, added funds for the purpose of supporting

innovative activities. Since that date, these funds have been used to support:

- o A study of the potential for increasing private sector involvement in the provision of FP/MCH services in Nepal.
- o Participation of 2 GON officials in a one-week management course on finding innovative solutions to problems.
- o A study of the early post-operative complications reported by VSC clients (200 laparoscopy, 200 minilap).
- o An activity which provided up to NRs. 15,000 (level set by CRHD) for innovative proposals of DPHOs. Of the five DPHO proposals received by the project, two were funded, one to conduct a "District Team Building" exercise (Makwanpur), the other to provide signboards advertising FP/MCH services for HP (Chitwan). Reports are to be provided by the DPHOs on the impact of these innovations on service delivery.

3. Issues and Discussion

It is a bit early to evaluate the orientation and impact of activities under this component as few activities have been undertaken, however it is possible to note that the potential impact of the activities ranges from small to large, and that the subject matter covers both management and clinical issues.

The potential for expanding activities under this component of the project exists if increased emphasis is placed on influencing policy and strategy development at the national level through the testing of strategies for service delivery at the district level and below.

Regarding support for an innovative activity in cost recovery it is useful to review what is currently going on in this area in Nepal. Few would argue that the recurrent budget for the public health system in Nepal is inadequate. Government expenditure for the health sector as a percent of total government expenditure has been declining to under 5 percent, donors finance a significant proportion of recurrent as well as investment expenditure, and drugs allocated to health posts are usually reported to be sufficient for only 4-5 months of the year. Government policy permit hospitals to form boards which have the authority to set fee levels and retain revenue for use by the hospital, including increasing salary payments. The government has also permitted donors such as WHO and several NGOs to develop health post level cost recovery schemes, of which there are about 10 different models in Nepal, involving from 5 to 80 health posts in each scheme. Two donors have been active in policy dialogue with respect to health care financing. WHO and UNICEF have facilitated the formation of the task forces on "Health Economics and Health Financing Studies"

and "Essential Drugs" respectively. Both task forces have and are in the process of conducting studies on health economics and health care financing, with the studies primarily being carried out by Nepali officials or academicians ^{11/}.

4. Conclusions and Recommendations

1. Funds available for innovative activities should continue to support innovations in service delivery, however with higher ceiling for activities proposed by DPHOs. If overall funding for this activity is sufficient, then funds should be also allowed to support small grants which support testing and analysis of service delivery options.

2. To participate in policy dialogue on health care financing USAID should request to the MOH to be invited to participate in future task forces on health care financing.

3. Regarding the drug cost recovery schemes the project has several options:

- o Initiate drug cost recovery scheme in a district which has not received assistance from another donor. Training for HPI in standard treatment guidelines and revolving fund management skills is recommended.
- o Strengthen the MOH information reporting system on the drug schemes by having all schemes report on the same forms as for the WHO program, and by assisting in analysis of the reported financial data.

4. Should USAID wish to make a unique contribution to the discussion of health care financing in Nepal it is recommended that this assistance be focussed on financing issues at the district level. Specific analyses in this area would include: i) study of zonal/district hospital costs, revenue, utilization, management and quality; ii) exploration of mechanisms to provide additional financing for DPHOs (e.g. local taxes, proceeds from an economic activity, a surcharge added to the fees collected by health posts); iii) development of a district-wide financing scheme through health insurance, and iv) comparison by district over time of HMG budget and donor financing for FP/MCH programs by type of input. Technical assistance and financing for these activities might be sought from centrally-funded projects.

^{11/} While in general further rigor might have been applied in the studies, they are useful contributions to policy discussion in this area, and may be more readily applied because of their authorship by Nepalis.

5. Determination of whether other studies or actions in health financing should be undertaken should follow the August 1993 Second Seminar on Health Economics and Health Financing at which it will be possible to determine the quality of the research commissioned for that meeting and to participate in discussions which lay out future research and actions to be undertaken.

CHAPTER IV FAMILY PLANNING

A. INTRODUCTION

The family planning component of the project includes a number of elements. Specific activities under this component include:

- o Institutionalization
- o Quality assurance
- o Private sector provision of family planning
- o Family planning policy initiatives
- o Commodity and logistical support
- o Management information system
- o Other family planning activities
- o Multi-sectoral activities

The project was intended to increase the range of family planning methods provided, strengthen voluntary surgical contraception and other clinical contraceptive services through improved training, counseling, screening and quality assurance. Most attention has been given to the program and process of institutionalization, whereby a district at all levels attains the ability to provide quality family planning services, regularly, routinely and on demand.

The evaluation team was asked to specifically look at institutionalization, the Government of Nepal's commitment to the program, any changes that should be made to the program and USAID's support to it, and additional inputs USAID should make in non-institutionalizing districts. The team was also asked to identify areas of support for Nepal under the Priority Country Strategy. This following chapter focuses initially on institutionalization, contributions the project is likely to make toward the broader project objectives, and recommendations for future areas of focus for the project and areas of support under the Priority Country Strategy. Progress achieved by the project to date against logframe objectives for family planning appears in Appendix D.

B. OVERALL DESIGN OF FAMILY PLANNING COMPONENT

1. Issues and Discussion

The objectives of the project are appropriate and relate to the objectives of the GON's new health policy as articulated in the 8th Five Year Plan (1992-1997) which specifically aims at reducing infant mortality rates (from 102 to 80), maternal mortality (from 850 to 750), under-five child mortality (from 165 to 130) and total fertility (from 5.8 to 4.5) in an integrated and sustainable way. USAID should continue the broad objectives of this program and approach, with some adjustments to implementation focus.

While the broad objectives of the program are appropriate, there are some weaknesses in linkages between the inputs and the broad objectives. Although the specific inputs should be mutually interactive, they are fragmented and not linked together sufficiently to be certain of an impact on the whole. In family planning alone, there are seven major program elements and at least 14 sub-elements - some of which are fairly discrete - implemented through 11 institutions, and several sub-institutions. There are not very many linkages among these elements. Training, for example, is a component under almost every element, with little apparent synthesis of how each specific training program (asepsis, IUD insertion, etc.) contributes to overall service delivery. Moreover, while one of the project objectives is to insure that a wide range of family planning services are available, the inputs are geared toward vertical elements, i.e. IUD training, asepsis training, with little attention to insuring that all methods are offered.

Fragmentation in the project design also extends to the selection of districts. The Central Region with its 19 districts are to receive at least 50% of overall project resources; most of the family planning inputs are in the set of 15 institutionalizing districts of which a subset of seven are in the central region, another subset of four are designated operations research districts, with another two designated as control districts. Specialized program elements are aimed at each of these subsets, in varying degrees of effort.

2. Conclusions and Recommendations

1. USAID should re-focus its family planning program support on four broad elements. These elements are: i) logistics, MIS, and contraceptive supply, ii) quality assurance, iii) private sector support, and iv) support for testing implementation strategies. Recommendations pertaining to each of these areas follows a detailed discussion below. Choice of these four areas is consistent with the project paper and A.I.D.'s comparative strengths and is in keeping with discussions with HMG officials, health staff interviews, observations of the team.

2. District-level family planning activities related to institutionalization should continue to be focussed in the original 15 institutionalizing districts. Expansion to new districts will depend upon the adequate completion of tasks in the original districts and upon the GON's designation of other districts as institutionalizing.

C. INSTITUTIONALIZATION

1. Description

Institutionalization is the program and process whereby a district delivers the whole range of family planning services at all levels of the health care system, including hospitals, primary health care centers (when built), health posts, sub-health posts and outreach workers routinely, year-round and on demand. This definition assumes that each level of the health care system has the equipment, appropriate facilities and trained manpower to deliver services or the ability to refer clients for services as necessary. It also assumes coordination of personnel and facilities at the district level to insure that all clients' needs are met effectively.

2. Activities to Date

To date, 15 districts have been designated as institutionalizing districts (see Map 2). These districts no longer have VSC camps or provider or client incentives. Services are offered through static facilities, as part of the hospitals' program. Specific USAID inputs into this program include: i) local cost support to FP/MCH for clinical training, maintenance and repair of facilities, complications treatment and basic equipment; ii) counseling and clinical training through AVSC/NFCC, iii) a survey to identify equipment and facility needs and the subsequent provision of equipment; iv) quarterly coordination meetings including DPHO and medical superintendents from all 15 districts through New ERA; and v) technical assistance from JSI.

Four of the 15 districts have been designated as part of a operations research "Systems Development Program (SDP)" supported by NFCC, AVSC, the Population Council, and New ERA. In each of these districts, a new VSC operating theatre is being constructed, and should be completed in October 1992. In addition, IEC support is provided through Johns Hopkins University/Population Communication Services project, an alternative reward system is being piloted, and a baseline and final survey will be conducted to assess these inputs.

To date, the equipment/facilities surveys have been taken and are being finalized, coordination committee meetings have been held, and all 15 districts have been visited by JSI. In the SDP districts, the baseline survey has been taken, construction of the VSC service sites will be completed in October 1992, and a pilot community IEC program has just been launched.

Map 2
 Institutionalizing Districts



C. Issues and Discussion

Institutionalization is a process that is nowhere near complete. There are a number of factors which account for the delay in the process, and which raise a number of issues. It is worth noting that virtually all of these issues were raised in the 1987 AVSC "Assessment of the Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal" but have yet to be fully addressed.

Most of USAID's inputs are appropriate, particularly the attention to site renovation and training, however they are too widely disbursed in too many program components and geographic demarcations. Specific factors affecting the process of institutionalization to date are:

Preconditions for the removal of incentives were not met. Most notably, facilities and human resources were not in place necessary to build the hospitals' capacity to meet the VSC demand throughout the year, and particularly in the winter season. The only activity that took place according to schedule was the discontinuation of the provider incentives. The effective implementation of this program is dependent on the fulfillment of several basic conditions that should have been assured prior to the discontinuation of the VSC camps and incentives:

- o Availability of appropriate and safe facilities at the static service site. These static sites were not renovated nor equipped before the camps were discontinued. A phased transition would have alleviated much of the disruption in services.
- o Availability of trained service providers at the static sites. While training and staffing are currently going on, in most of the sites we visited, not even the minimum contingent of trained, available staff were in place, particularly for VSC. In all districts visited, we met only one family planning doctor, (Rupendehi) and he had not been paid in two months. All hospitals indicated that they would have difficulty meeting demand this winter.
- o Seasonality. Seasonality of demand for VSC services is an important issue for Nepal's family planning program, and very little was done to address this prior to the discontinuation of the seasonal camps. More people have VSC done in the winter because: i) this traditionally was when the service was offered through camps; ii) there is a wide belief of higher incidence of infection in the summer; iii) people do not want to be operated on in the heat of the summer; iv) during the winter, the planting/harvesting requirements are less and people have more time to have the operation. A number of people told us that an extensive recovery period was required,

some believed as long as one month. Theoretically, as the notion of constantly available services becomes widespread, people may begin to avail themselves of services year-round. This makes service provision much easier, since institutions won't have to prepare to meet such a large demand at limited times of the year. An appropriate, targeted information campaign could mitigate these problems tremendously. Because the issue of seasonality was not addressed, the existing hospital system is not equipped to cope with the expected large demand in the coming winter.

Preconditions were not laid out at the beginning. Not only were necessary preconditions not met before institutionalization started and the program disrupted, but these basic conditions were not considered. However, the 1987 AVSC assessment recommended the provision of all these "necessary inputs" during their Phase II of institutionalization, while camps and provider incentives were to be eliminated in Phase III.

Management Issues. The way in which the new program is to be managed was not discussed with hospital superintendents nor DPHOs the team spoke to. While the hospitals were asked to carry-out VSC as part of their regular hospital services, they were not given clear-cut guidance, authority nor resources to carry this out. In many of the hospitals we visited, the medical superintendent, while agreeing to take on this responsibility, indicated that if the hospitals are to take this responsibility, they would need additional staff ^{12/}, facilities, equipment and expendable commodities under their administrative control.

A second concern is that it is not clear to district personnel what the division of labor and responsibilities are between the medical/hospital staff and the DPHO staff. In addition, with the revision of roles and the possible demise of regional offices, there is a potential disruption during the transitional period. Thus care should be taken so that the management and supervision of the district programs is not disrupted and continues effectively during both the transitional period and in the long term.

The MOH's reorganization plan calls for the posting of a District Health Officer, who will oversee the curative and preventive (Medical Superintendent and DPHO) elements of a district's health program. The District Health Officer is to have public health degree and be responsible for administration, finance, MIS, training and logistics and supplies for the district. Eventually,

^{12/} The MOH plans to post teams of six people including one full-time medical officer to district hospitals in institutionalizing districts to assist with the family planning workload. These teams will be part of the hospital staff, and it is not assumed that they will do only family planning.

the districts will have single health budget, but in the interim, there is a separate curative and preventive/public health budget. While this is an ideal situation, it may be some time before this structure is in place and functioning in all districts. In the interim, careful joint planning between the medical superintendent and the DPHO will be required to insure that personnel, facilities, and equipment are appropriately staged to meet the demand for family planning services.

Incentives. A strongly expressed view was the incentives should not be reinstated in 15 institutionalizing districts. If they are put back now, they will always be there. One doctor questioned how long the government would be able to pay incentives. Doctors and officials interviewed in Chitwan, Rupendehi and Kaski all felt that incentives do not matter all that much to providers. (It should be noted that by and large these officials were either the FP doctor, the DPHOs or the Medical Superintendent, and not necessarily the ones hit hardest by the discontinuation of payments.) At the same time however, there was a unanimous concern about staffing shortages and lack of capacity/time/trained personnel required to meet the expected demand for VSC this winter.

Target Mentality. On a number of occasions, we encountered the pervasive notion that providers will try to meet target for number of procedures, but no more. For example, in one district last year, the institution had a target of 500 procedures, and had performed 498, and had 6 clients wanting a VSC procedure. The family planning doctor was told by DPHO to do only two more.

4. Conclusions and Recommendations

The team feels that institutionalization - the program and process whereby health institutions and service delivery points at all levels provide the full range of family planning services on a regular basis - is an important program and relevant to both immediate and long term health and family planning needs in Nepal. However, as in all new programs, the transitional phase is difficult, and in this case has barely begun. The implementation has also been effected by the political transition of the last several years as well as a number of programmatic disruptions.

There is real potential for the success of institutionalization. For example, in one of the institutionalizing districts visited by the evaluation team, we found a hospital that was providing VSC services for the first time as a result of the institutionalization program. Chitwan not only fulfilled its targets, but 40 percent of these procedures were done by the district hospital, where in previous years, all VSC targets had been met by the FPAN. This shows a tremendous increase in the capacity of the MOH hospital to take on clinical family planning.

Specific recommendations regarding institutionalization include:

1. USAID should continue to support HMG's institutionalizing district program, eventually expanding this program nation-wide. The quality assurance efforts described below should be a key effort in facilitating institutionalization.

2. Given the confusion that exists as to what exactly is meant by institutionalization, the project should make some efforts to develop materials (e.g. hospital and DPHO posters and staff brochures) whereby the specifics of institutionalization can be understood.

3. Incentives should not be reinstated in the 15 institutionalizing districts. Rather, support to the institutionalization effort should be continued. While the program should compensate doctors for their time and develop mechanisms to make the provision of FP services an attractive program, a per case incentive system has far too many quality and volunteerism implications to be acceptable and we believe would damage the program in the long run. At the same time, USAID should assist the GON to find ways to insure that there are enough service providers to meet the expected demand.

4. USAID should support the expansion of SDP activities beyond the four operations research districts to the rest of the 15 institutionalizing districts as soon as feasible.

5. USAID and HMG should proceed very carefully in expanding institutionalization to additional districts. This expansion should be done in a phased manner, with careful attention to insuring that facilities and personnel are in place before mobile camps and incentives are dropped ^{13/}. Preferably this expansion should begin with the districts where a District Health Officer is in place as proposed in the MOH's reorganization plan.

^{13/} The 1987 "Assessment of the Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal" by AVSC gives recommendations on phasing in institutionalization. These recommendations are still relevant, and provide a useful reference.

D. CONTRACEPTIVE PREVALENCE AND METHOD MIX

1. Progress to Date

Available information indicates a country-wide increase in the contraceptive prevalence rate (defined as a percentage of married women of reproductive age practicing contraception) over the last 15 years. The CPR rose from 2.9 in 1976 to 21.4 in 1991 - a seven-fold increase (see Table 4.1).

Year	1976	1981	1986	1991
CPR	2.9	7.6	15.1	21.4

Source: 1976: NFS; 1981, 1986: NFFS; 1991: FP/MCH MIS

Early indications from the 1992 Nepal Fertility and Health Survey, although not published yet, confirm the rise in CPR with a national CPR slightly above the data from the FP/MCH Management Information System.

The CPR in 15 institutionalizing districts seems impressive compared to that in the 60 non-institutionalizing districts, as it is 2 to 2.5 times higher in institutionalizing than in non-institutionalizing districts. Starting at an assumed baseline of 25 percent CPR in institutionalizing districts at the beginning of the project, the estimated CPR of 30 to 40 percent in the 15 institutionalizing districts has already exceeded the CS/FP's target of increasing CPR in project districts by 20 percent.

The comparative trend between institutionalizing and non-institutionalizing districts before and after the start of the institutionalization program (1989/90) indicates a slightly sharper rise in CPR in the 15 institutionalizing districts than in the remaining 60 districts (see Table 4.2).

TABLE 4.2
CPR FOR PROJECT DISTRICTS COMPARED TO TARGET

	1990 Baseline	Target Increase	1992 Estimate	Percent change
15 Institutionalizing Districts	25%	To 32%	30%	20%
Total Nepal	18%	To 25%	21.4%	16.6%

Targets as defined in PRISM
Source: FP/MCH MIS and Survey data

However, given the relatively better socio-economic situation of these 15 institutionalizing districts ^{14/}, the baseline CPR for these districts may have been higher than the other 60 districts.

The full range of family planning methods in the GON's family planning program includes VSC (vasectomy and tubal ligation), depo-provera, IUDs, pills (combined low dose oral pills), NORPLANT and condoms. The available information indicates that the nationwide contraceptive method mix is about 78 percent permanent methods, and roughly 22 percent temporary methods.

2. Issues and Discussion

There appears to be a decline in VSC acceptors over the last few years. This decline seems not to be limited to only the institutionalizing districts, but to be nationwide. Figures 4.1 and 4.2 compare new acceptors for different methods in all 75 districts of Nepal and in the 15 institutionalizing districts. In fact, the 15 institutionalizing districts account for over half of sterilizations performed, and virtually all of NORPLANT and IUD insertions. In these districts, the number of sterilization acceptors is slightly lower than the national average in favor of a broader range of temporary methods. This movement is in line with one of the project's objectives of a broader range of method choice (see Table 4.3).

^{14/} This classification scheme comes from "Nepal Family Planning Sector" by Shyam Thapa, March 1992.

TABLE 4.3
Method Mix:
Continuing Users of Various Family Planning Methods
in 15 Institutionalizing districts and Nationwide

Location	Continuing Users by method					
	Cond	Pills	Depo	Norpl	IUDs	VSC
Nationwide	5.5	4.9	8.9	0.9	1.4	78.4
15 Institut. Dist	2.54	2.79	12.66	1.66	2.04	77.96
Share of 15 dist. in national total	24.06	29.26	73.52	92.74	91.39	51.63
Source: HMG/MOH/FP/MCH MIS, updated 2049.4.1 (September, 1992)						

There are a number of theories about the decline in the number of VSC acceptors. One theory is that the critical mass of persons desiring VSC services have already been served. Another possible reason is the shift in the GON's targets. In past years, the program was heavily, if not completely, skewed toward VSC, and districts were given specific VSC targets; now districts are given overall contraceptive prevalence targets. Also, because of the national transition phase to democracy, program services may also have been disrupted. A combination of these factors may have brought about the decline in VSC procedures nationwide.

Another possible factor contributing to this decline is the withdrawal of provider incentives and centrally operated camps in the institutionalizing districts. This withdrawal was done before the essential preconditions for institutionalization were met - particularly with regard to the placement of appropriate facilities and adequate numbers of trained staff. Our observation and the consensus of those interviewed is that the withdrawal of incentives is not the primary cause of the decline in VSC procedures.

It is important to note that Nepal has very good natural spacing. According to the 1986 NFS, the average birth interval is over two years, due to an average of nearly 25 months of breast-feeding with about 18 months of post-partum amenorrhoea ^{15/}. This

^{15/} Shyam Thapa, "Determinants of Fertility in Nepal: Applications of an Aggregate Model", Journal of Biosocial Science, Vol. 19, 1987, pp. 351-365.

extensive breast-feeding practice and long birth intervals does not seem to have declined significantly. This factor should not be overlooked in determining method mix.

The HMG is currently recommending a method mix of 65% permanent methods and 35% temporary methods. What is important to keep in mind is that a family planning program should offer all available methods and the client should be encouraged to choose the method best for her or him. Furthermore, the acceptors profile (from FP/MCH MIS, 1992) indicate that the number of sons surviving for VSC acceptors is 2.1, versus 1.6 for Depo-provera, the most popular temporary methods. There is also a difference of 0.5 for total number of children ever born to these two groups of family planning acceptors. This indicates that rising utilization of temporary methods may be serving the felt need of postponing pregnancy.

Several people noted that women were reluctant to use temporary methods and preferred to have all the children they wanted, then go for sterilization. In some discussions with women, they indicated that there was no where to go with questions about these methods, and there were many concerns, rumors and misinformation. One Depo client, who became amenorrheic, was told at the health post that she was infertile. Many people reported that women do not like to use pills because they don't like to take them every day, pills make them dizzy or light headed, etc. Also many noted that one of the most commonly felt problems is that depo and NORPLANT sometimes cause irregularities in menstrual cycles, particularly excessive bleeding which many women can not tolerate given the already high prevalence of nutritional anaemia and societal constraints associated with menstruation.

There are indications that the age and parity of VSC acceptors is declining. That may be also due to declining infant and child mortality, which provides the security of survival for already born children (see Table 4.4). One of the most important factors seems to be the desire for two sons. Because of this temporary methods are very important for women who have not completed their desired family size.

TABLE 4.4
Age, Parity and Gender Preference
Trends by VSC and Depo Acceptors

YEAR	Women's Age			Surviving Children			No Surviving Sons		
	Vas	Tub	Depo	Vas	Tub	Depo	Vas	Tub	Depo
89/90 (2046 - 2047)	28.0	28.2	28	3.7	3.7	3.3	2.1.	2.2	1.7
90/91 (2047 - 2048)	27.6	27.9	27.4	3.5	3.6	3.1	2.1	2.1	1.6

Source: FP/MCH Division, MOH, MIS data system

E. QUALITY ASSURANCE

1. Activities to Date

The purpose of the project is to improve the quality and coverage of child health care and family planning services. According to the logframe, one output of the project leading to the successful achievement of this purpose was to establish a full service family planning program. Components of this included institutionalization of FP services in selected districts, a smoothly operating contraceptive logistics and supply system, development of IEC capacity and clinical method training, and counseling training.

To date, counselling training for 134 district staff has taken place. In addition, training has also taken place for 32 staff in IUD insertion, 171 staff in asepsis and OT management, and 49 staff in VSC and basic minilap training.

PRISM includes four indicators related to quality assurance. The first called for 15 hospitals providing the full range of family planning methods year-round (institutionalizing). To date, while 15 hospitals in institutionalizing districts provide family planning, they have yet to achieve full institutionalization (see Table 4.5). The second PRISM indicator referred to the percentage of family planning clients in the 15 districts receiving counseling according to protocol increasing to 90 percent (PRISM did not provide the baseline percentage). The third indicator called for the institutionalization of clear cut quality standards. A national medical standards guideline has just been released by the

MOH. Lastly, PRISM called for the decline of infection rate from family planning methods, but did not indicate either a baseline nor target level.

TABLE 4.5
NUMBER OF HOSPITALS/HEALTH POSTS/SUB-HEALTH POSTS
PROVIDING FAMILY PLANNING
IN INSTITUTIONALIZING DISTRICTS

DISTRICT	NO. HOSPITALS	FP?	HEALTH POST	SUB- HEALTH POST Actual /Plan
Jhapa	1	Y	9	4/9
Morang	2	Y	16	4/9
Saptari	1	Y	12	2/8
Sunsari	2	Y	9	2/7
Bhaktapur	1	Y	9	0/3
Chitwan	1	Y	9	2/5
Dhanusha	1	Y	13	4/8
Kathmandu	6	Y	10	1/4
Lalipur	2	Y	11	0/4
Makwanpur	1	Y	12	3/7
Parsa	1	Y	11	2/7
Kaski	1	Y	14	3/7
Rupandehi	2	Y	11	4/8
Banke	1	Y	11	2/5
Kailali	1	Y	11	2/5
TOTAL	24		168	35/96
Source: MOH, FP/MCH Division, 1992				

2. Issues and Discussion

Critical elements of a basic quality program are relatively weak in Nepal, including adequate counseling, adequate information about all methods of contraceptives, and adequate medical screening and follow-up.

Basic quality family planning service provision is one of the most important elements of a successful family planning program. When high quality voluntary family planning services are offered, prevalence increases dramatically. Basic quality services include several elements:

- o Availability of all methods.
- o Concern for client satisfaction.
- o Information about each method provided to clients in a private, non-coercive atmosphere.
- o Medical screening for contraindications, information about possible side-effects and follow-up, and more importantly the availability of that information to both providers and clients.
- o Safe provision of both surgical and non-surgical methods.
- o Satisfactory condition of facilities.
- o Availability of trained human resources.
- o Clinic monitoring system that allows for retrieval of client records and history for assessing client continuation and follow-up for possible side effects.

Wherever the team visited, family planning counselling was found to be weak. We were often told that one staff member had been sent for counselling training, but there was never any time to do the counselling. Counselling is certainly not seen as one of the basic elements of family planning provision, clients tend to be given whatever method they've heard about before they come into the clinic and therefore ask for, or whatever method the provider has been trained in. Providers tend to be more concerned with meeting the method targets set for each district by the center, rather than encouraging a demand-driven method mix. Overall, there is not enough emphasis on importance of choice and more particularly on informed choice.

During our field visits, we conducted a rapid analysis and review of the following select quality assurance indicators:

- o Availability and condition of facilities, including the

availability of trained human resources.

- o Medical screening information on clinic cards.
- o Client satisfaction through exit interviews.

The analysis found that of a sample of 60 client cards for Depo acceptors, in only 33 percent of the cases was a medical history taken and only 47 percent of clients had blood pressure checked. None of the cards had information on breast-feeding, an important element for medical as well as demographic/information reasons. Clinic cards, where available, were not filed systematically to insure appropriate follow-up, and for assessing continuation rates. A detailed discussion of this review appears in Appendix E. The findings indicate that the quality index of the family planning services provided in a number of institutionalizing districts does not meet a basic quality standard.

3. Conclusions and Recommendations

1. Much of USAID's family planning efforts should be refocused under the rubric of quality assurance, defined briefly as ensuring the availability of a full range of family planning services, with proper counselling and medical screening. This should be implemented on a district by district basis, beginning with the investment already made in the institutionalizing districts.

2. To operationalize "quality assurance" USAID should:

- o Strengthen and activate the existing quality assurance team, and give them a clear cut role. An important mechanism for implementing quality assurance objectives is the existing quality assurance team (QAT) located within the FP/MCH Division, Ministry of Health. This should be a small flexible team, and include members of the JSI technical team, an FP/MCH staff member, and possibly the WHO local consultant on safe motherhood or staff from local NGOs such as NFCC. The quality assurance team should spend a good deal of time in the districts and provide technical support to the district health team (Medical Superintendent, DPHO and staff) to find practical ways and means for solving problems and constraints related to quality, delivery, and availability of family planning services.
- o Institutionize equality assurance at all levels, and develop indicators. The QAT should work with district health teams to develop an index of service delivery achievement that incorporates quality of service dimensions as well as counts of the quantity of acceptors. This should be used nationally to assess progress.

3. USAID should provide leadership in clinical methods training. The selection of trainees should be guided by a district by district needs assessment, and tied with the counselling training, to insure that service providers can discuss all method options with clients. In addition, USAID should work closely with the HMG's training coordination working group that is chaired by UNFPA and includes other donors, in conducting an overall needs assessment for family planning training and in using results of this assessment in developing and implementing training programs.

4. USAID should continue to support HMG's institutionalization program. This includes support in the following areas:

- o **Facilities:** USAID should continue to support the renovation of FP operating theatre facilities by continuing those in process, working with other donors to support other renovations, and provide assistance to districts to do it themselves.
- o **Outlets:** The project should work with the district health team to develop alternative ways to meet the family planning services demands (particularly for VSC), such as mobile clinics, etc. The quality assurance team will be a key resource in working with districts in this regard.
- o **Staffing:** USAID should support the MOH's efforts to place a six person team in each district. This can include clinical skills training, monitoring to ensure staff are in place, and training needs assessments.
- o **Training:** USAID through the QAT should work with the district health team and to identify training needs at the district level.
- o **Information on Methods:** IEC aimed at providing basic information about all methods, their advantages, contraindications, possible side-effects should be developed. This information should be made available to all providers at all levels, particularly outreach workers and F/CHVs, so that this information is readily available to all clients.
- o **Alternative Rewards:** Each district's performance should be assessed with qualitative and quantitative standards for both targets and quality of services. The highest performing districts in both categories should be rewarded through academic and/or clinical training, study tours, financial bonuses to the institutions, recognition by the Prime Minister, etc.
- o **Coping Alternatives:** The district team should be encouraged and supported to find alternative ways to cope with the seasonal demand for VSC, which may be more than the standard

capacity of the hospital. Possible alternatives should be left to the local team, but could include mobile clinic where staff are compensated with appropriate and realistic TA/DA as well as salary. A mobile clinic system, which offers all methods of FP and is sent out from the district, can also help mitigate the problem of diminished accessibility due to static services. Another alternative is to contract with a local NGO, such as NFCC to assist with filling in the staffing gaps during the transition years.

- o **Take Account of District Variations:** Given the wide range of needs and capacities and social situations in all the districts, strategies for coping, motivating and rewarding service providers will vary considerably. Decisions on the most appropriate method should be left to the district, with strong support from the center.
- o **Booking/Scheduling System:** A system for scheduling VSC clients should be established so that the relatively limited daily capacity of district hospitals (10-15 per day in some cases) can be managed to meet the need.
- o **Post Partum/Post Natal Programs:** Support for adoption of these programs in institutionalizing districts.
- o **Clinic Card Systems:** Broaden efforts to institute clinic card systems which mandate medical screening and facilitate adequate follow-up ^{16/}.

F. LOGISTICS, MIS AND SUPPLY

1. Activities to Date

USAID is one of the primary suppliers of contraceptives, and has also put effort into the development of an MIS system. While strengthening the logistics system for contraceptives is included the Project Paper, it is focused within the regional context. Whereas a nationwide system is a critical element in insuring quality, availability and coverage of family planning services.

The Project Paper called for the redesign of the commodity and contraceptive logistics system from a "push system" to a regionally based system responsive to district-level needs. There are apparently still problems with the contraceptive logistics system, the team heard reports of shortages in contraceptives, particularly in Depo-provera, although this latter case seems to have been a donor-supply issue.

^{16/} See National Medical Standard for Contraceptive Services, HMG, Ministry of Health, FP/MCH Division, Nepal November 1991.

2. Issues and Discussion

There are two MIS systems. The first is the FP/MCH service statistics system run by FP/MCH with assistance from New ERA. This system seems to be very effective in getting data from all districts on numbers of new and continuing users of family planning. Assistance from New ERA helped shift the formerly manual system to a regularized, systemized system that focuses more on continuing users. Previously the system only collected data on new acceptors. An important element of its success seems to be due to the fact that financial disbursements to districts are contingent upon their submission of the service statistic data.

There is another MIS system for logistics reporting and recording. Unfortunately, this is not tied to the service statistic system, thereby missing a good opportunity to tie contraceptive supply to actual service statistic data. At present, the logistics/supply reporting system seems to be more of an inventory/supply driven reporting system, than a demand-driven contraceptive supply system.

3. Conclusions and Recommendations

1. USAID should increase its efforts to assist HMG with the development of a national, well-functioning, systematic demand-driven logistics management system. Support to the MOH for this effort from the Office of Population's Family Planning Logistics Management Project with JSI/CDC should be explored.

2. USAID should assist the MOH in working with service delivery NGOs to insure that their service statistics feed into the national MIS.

G. **CONTRACEPTIVE RETAIL SALES COMPANY**

1. Activities to Date

The Project Agreement (PROAG) included a conditions precedent calling for an increase in the private sector control of CRS (Section 4.2):

"Prior to execution by A.I.D. of a Cooperative Agreement with the Contraceptive Retail Sales Co. (CRS), funded under this 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".

Achievement of this conditions precedent was achieved after some delay. The MOH did not wish to reduce its control over CRS and so

for a period of one year CRS operated from its retained earnings without USAID financial or commodities support. By mid-1991, CRS had revised its memorandum and articles of association permitting shares to be distributed to non-governmental organizations and purchased by private sector firms with the net affect of reducing HMG's share in CRS from 51 to 24.5 percent ^{17/}. Prior to this change, the Chairman of the Board was the Secretary for Health and members of the Board were appointed by him. After this change election of the Chairman and members of the Board is made biannually from among those government bodies and private companies holding shares.

With regard to other major activities, CRS has made progress in some areas, but there remains progress to be made in others. Overall, CRS has a good chance of fulfilling the terms of its Cooperative Agreement by the EOP.

Market Research: With respect to marketing audits, CRS has developed specific marketing strategies for each product. SOMARC is assisting with strengthening of these strategies. The conduct of a major tracking study remains to be done, and will be expensive. While the Project Paper indicates that SOMARC will assist CRS with this activity, the SOMARC contract does not include this task. Finally, CRS did develop a proposal to develop a for-profit advertising subsidiary which was approved by the Board, but rejected by USAID. Advertising efforts utilizing the services of existing firms have been launched.

Improved Communication Techniques: While CRS claims that it included brand reviews and creative/strategy briefs in its Plan of Operations for 1992, in fact these strategies are not very different from those used in 1986/7. SOMARC is promoting the concept of product/brand managers, and CRS has included a proposal for this in their 1992 Plan of Operations. They are still awaiting USAID's approval of this plan.

Better Tracking of Sales Network: CRS collects handwritten lists of point of sales from salesmen which are computerized to compile an annual list.

Increased Cooperation with NGOs: CRS is to provide contraceptives to 3 NGOs by EOP. It is currently providing contraceptives to SCF/US and to the Nepal Red Cross. CRS experienced problems in reaching other NGOs during the period of the election but efforts to work with NGOs will resume.

Expand Rural Social Marketing (RSM) Efforts: On a pilot basis CRS

^{17/} While HMG is no longer a majority shareholder, HMG remains the largest shareholder with no other entity having more than 7% of total shares.

is working with 8 VDC in 4 districts. Female workers get a salary of NRs. 200/month and are provided supplies at a 50 percent discount. Prizes are provided to workers with the highest sales and best continuation rates. Refresher training is provided on a bimonthly basis. After CPR reaches 40 percent the program effort will be shifted to creation of a rural depot and the RSM moved to another area. CRS feels that the program is expensive and wants to keep as a pilot exercise. Issues of replicability and sustainability will affect this as other community worker programs in Nepal.

Educational Programs in Up to 40 Districts: This is called for in the Project Paper but otherwise doesn't seem to be recognized as part of the Cooperative Agreement.

Financing of the Recurrent Costs of the Program: The goal of the project is that CRS finance 50 percent of salaries and benefits of CRS program by 1995. CRS's revenues have covered over 50 percent of salaries since at least 1988, and over 20 percent of total recurrent expenditure (see Table 4.6). However, revenues have covered a decreasing percentage of each category, due at least in part to failure to increase prices while adjusting to pressure to increase salaries to keep pace with inflation.

Table 4.6

**CRS Company Expenditures and Revenues
1988-1991
(in NRs)**

Year	Wages	Total Expenditure	Revenue		
			Amount	% Wages	% Expnd
1988	2,011,866	7,017,098	1,737,895	86.4%	24.8%
1989	2,492,956	7,576,661	1,814,470	72.8%	23.9%
1990	2,875,260	7,169,323	1,509,270	52.5%	21.1%
1991	3,802,195	10,415,996	2,130,505	56.0%	20.5%

Increases in the prices of CRS products ranging from 20 to 50% in June 1992 will increase revenue assuming: i) demand price inelastic at these prices, ii) costs of operations do not increase, iii) personnel levels do not increase (e.g. in marketing). Given continuing inflation of 10-20% p.a. it is unclear that these one-time price increases will alone be able to keep revenue to at least 50 percent of salaries. SOMARC is providing TA to assist CRS in the development of a plan to increase financial self-sufficiency.

Promotion of Temporary Methods in Nepal's Method Mix: One objective of the project is for CRS promotion of temporary methods to facilitate an increase in the role of temporary methods from 1/3 to 2/3 of method mix by EOP. This target does not match that of the GON which aims for 35 percent of method mix to be attributable to temporary methods.

Increase in CYP through sales from 55,000 (1986) to 125,000 (1995): CRS experienced several years (1986-1990) of internal and external problems (e.g. changes in the general manager, one year hiatus of USAID funding) which led to a leveling off of CYP. Under new management, the CYP has increased from 49,000 in 1990 to 72,000 in 1991. Renewed efforts and addition of new product lines (e.g. IUDs and Depo) should facilitate CRS's efforts to reach the 1995 target.

2. Issues and Discussion

Over the period 1986 to 1990 CRS' performance was adversely affected by changes in the general manager and other senior personnel and by reluctance on the part of the MOH to increase the privatization of the organization. Sales have significantly improved since the arrival of the current general manager however the organization needs encouragement to review and undertake changes in operations to improve marketing and sales of existing and new product lines.

One factor which may contribute to CRS sticking to existing strategies is that CRS is faced with conflicting messages regarding USAID oversight vs. privatization. On one hand, USAID requires the privatization of CRS's Board (of which USAID is a non-voting member) presumably to increase the private sector orientation of CRS. On the other hand USAID, through the audit process, ties CRS's hands with respect to any management decisions it wishes to take^{18/}. While there are several options that CRS might follow^{19/}, it would be useful for USAID and CRS to have additional dialogue on options which would allow CRS to operate with more autonomy.

A second mixed message for CRS from this project the push to increase financial sustainability, while at the same time increasing distribution in rural areas. As long as the RSM is a

^{18/} CRS wishing not to have any difficulties with respect to USAID's auditors will defer taking any major management action until approval is received from USAID.

^{19/} e.g. i) status quo (USAID funded) but with increased decision-making autonomy, ii) fully-private sector accepting contract from USAID and other donors for provision of marketing and distribution of contraceptives and other CS products.

pilot project it serves as a means to learn about new ways to distribute to rural areas. Nevertheless, CRS would probably not pursue this line of activity if it were giving primary consideration to financial sustainability concerns.

3. Conclusions and Recommendations

1. USAID should clarify for CRS what are sufficient procedural and reporting requirements for auditing purposes. Efforts should be made to minimize requirements so as to permit CRS to operate as independently as possible. Delineation and consideration of feasible alternative organizational strategies for CRS is recommended.

2. SOMARC should provide additional input to strengthen CRS marketing efforts. Additional funds may need to be added to the SOMARC buy-in to provide CRS with TA support for the Major Tracking Study.

3. The RSM program should be re-thought given its tangential relationship to central role of CRS. One possible alternate strategy is:

Collaboration with public sector, i.e. provision of temporary contraceptives to VHWS and CHVs with CRS focussing on development of media and other communications means to promote knowledge of and demand for FP methods among rural populations in Nepal.

In addition, during the phase-out period the creation of rural depots might include essential drugs as well as contraceptives to better insure financial sustainability.

4. USAID should, on an annual basis, specifically follow up with CRS on the issue of performance with respect to recurrent financing of salaries and benefits. CRS should show trend figures for a five year period and include simulations which indicate how revenues will be increased during the following 2 years.

5. Technical assistance should be provided to CRS to reinforce efforts to train druggists and shopkeepers in appropriate methods of medical screening. This effort at improving quality will be especially important should CRS become involved in the distribution of Depo.

6. In support of efforts to control the spread to Acquired Immune Deficiency Syndrome, funds should be provided (perhaps from the centrally funded AIDSCAP program) for intensified program of condom promotion and distribution along major transportation routes in Nepal.

H. PRIVATE SECTOR FAMILY PLANNING INITIATIVES

1. Description

In the area of family planning, the project is to support new initiatives to increase the participation of the private sector in the provision of family planning services. Specifically the project is to: i) engage 4 major employers in the provision of family planning services to their employees, ii) train 10 physicians in private practice trained in family planning, and iii) involve more NGOs in the provision of family planning services.

2. Activities to Date

In 1992 the project supported the conduct of a study of the potential for increasing the role of the private sector in the provision of family planning. The study proposed that the most feasible option might be to link large employers with private sector providers who would provide family planning and other services for a modest fee which the employer would pay. AVSC/NFCC have already provided training and family planning equipment to 20 private sector physicians. In exchange for commodities, the physicians provide their service statistics to FP/MCH through NFCC^{20/}. Two NGOs, SCF/US and the Nepal Red Cross are purchasing contraceptives for their programs from CRS.

3. Issues and Discussion

In 1988/9 the population employed in manufacturing enterprises was estimated to be some 140,631 persons in 2,334 manufacturing units with some 12 percent of employees being women (16,875). Most of these enterprises are small with less than 50 employees. Firms with over 100 employees are required to have a first aid box and health assistant to provide health services, firms with over 500 employees are required to have a clinic on the premises run by a doctor. The management of firms which have either of these health services gave generally positive responses regarding the addition of family planning and MCH services and educational materials to those they already provide assuming no significant additional capital and recurrent costs.

Regarding private practitioners, evidence that the urban population utilizes physicians in private sector for medical services suggests that these providers represent a growing avenue for provision of family planning services.

^{20/} Criteria for physician selection? Number of potential physicians to be trained? Evaluation of level of services provided? What are future training plans? Conflict with CRS role of distributing to private physicians.

Regarding non-governmental organizations active in family planning, the Family Planning Association of Nepal (FPAN) is the oldest family planning organization in Nepal and is currently active in 24 districts, 21 of which have permanent clinics, and has plans to expand to another three districts. USAID's direct support to FPAN is currently limited to some quality assurance activities with AVSC and NFCC. The evaluation team was impressed by the few FPAN sites visited during field visits. FPAN apparently plays a large role in supporting MOH service delivery. For example, when MOH service sites ran out of Depo supplies last year, many facilities reported that they referred clients to the FPAN facility. A number of the FPAN facilities were model quality service provider sites, with attention to client choice, availability of a wide range of methods and well maintained facilities.

4. Conclusions and Recommendations

1. Given limited female population in the industrial sector interventions with employers should be limited either to the industrial park clinics or firms with over 500 employees (and where the majority of these being women). Either NFCC or FPAN could be used to provide training and educational materials. CRS can be involved to provide contraceptives on wholesale basis.

2. Greater priority should be given the current effort to provide family planning training to private physicians. Emphasis should be given to training doctors in major towns, especially those with practices for women (Ob/Gyn). Quality assurance measures, such as described above for the public sector program, should be introduced. CRS should be involved so as to provide FP methods (inc. IUD, Depo, Norplant) to physicians at wholesale prices. CRS should take over this role from NFCC.

3. USAID and the Ministry of Health should continue to work closely with FPAN and explore ways of expanding support to FPAN and broadening areas of contact.

I. POLICY AND STRATEGY DEVELOPMENT

1. Activities to Date

USAID has supported policy related activities primarily through the RAPID project, and is about to provide technical assistance to the Planning Commission/Population Division and Ministry of Health by supporting a resident technical advisor for approximately six months. The team did not review the RAPID activities. However, both sets of activities seem to be appropriate.

2. Conclusions and Recommendations

1. The project should provide support for testing implementation strategies and issues. There are several issues and questions about implementation strategies that USAID can provide assistance in. In some cases, these studies may more appropriately be carried out by other donors. Suggestions made to the evaluation team which could be considered by USAID:

- o Follow-up NORPLANT study: A concern was raised by the relatively high removal rate of NORPLANT.
- o Follow-up Depo study: This should focus on the continuation rate, reasons for discontinuation, and contraindications in acceptors, and follow-up care for side-effects.
- o Two-son factor: There is a strong preference for having two sons before accepting permanent contraception, and having at least one son before temporary methods such as Depo are accepted. This has enormous demographic, programmatic and social consequences. Research should be done on how to affect this tendency, and what actions need to be taken, and how to promote the importance of daughters.
- o Reasons for decrease in VSC acceptors: Given the importance of VSC for health as well as demographic reasons, it is important to look at why the numbers are declining. Is this a temporary shift or is it related to problems within the program or are there other demographic reasons?
- o What do the clients really want? There are two sides to this question, the first relates to true family size/timing/spacing questions (beyond survey data) and the second relates to method choice and what the true method mix according to user preferences really is.
- o Define specific multi-sectoral linkages: Other sectors in addition to the health/family planning sector are very important in promoting and increasing the use of family planning. A study looking at specific activities that can be

undertaken in other sectors such as agricultural programs aimed at improving women's economic status, should be explored.

J. PRIORITY COUNTRY STRATEGY

Nepal has recently been designated as a "Priority Country" under A.I.D.'s Priority Country Strategy for population. This opens the door for Nepal to receive increased resources and attention in an effort to help curb high population growth, increase prevalence and reduce high risk births. As part of this strategy, a detailed country strategy outlining areas of focus and specific areas of support from the central Office of Population resources will be developed.

1. Conclusions and Recommendations

1. Under the priority country strategy, USAID should expand efforts in the family planning sector in the areas suggested in the project focus by calling on additional resources from the Office of Population. Specifically, central resources over and above the current bilateral project inputs should be pursued in the following areas:

- o Logistics management: assistance from the Office of Population's Family Planning Logistics Management Project with JSI/CDC;
- o IEC: additional assistance from Johns Hopkins University/Population Communications Services Project to expand current SDP activities beyond the SDP districts and to explore developing and providing information cards/manuals for service providers on all contraceptive methods.

2. In addition, USAID can explore the use of central resources to cover current buy-in costs for AVSC, SOMARC or the Population Council. If one or more of these buy-in costs are covered with central funds, bilateral monies freed up should increase local cost support in the institutionalization/quality assurance efforts.

CHAPTER V
MATERNAL AND CHILD HEALTH, CHILD SURVIVAL AND
FEMALE COMMUNITY HEALTH VOLUNTEERS

A. INTRODUCTION

Project support for activities in maternal and child health (MCH), child survival, and Female Community Health Volunteers (F/CHVs) has been organized through both the MOH and CRHD ^{21/}. Given that under the MOH reorganization the regional offices will no longer exist it is necessary to address the question of how the regional and district-level activities under these components should be considered. In addition, the team was instructed to consider how more focus might be brought to the complexity in multiple areas of activity of the project. Three options to address these issues were considered for the child survival and MCH components of the project (see Appendix F). The most promising elements of each of these options are reflected in the recommendations below.

B. COMPREHENSIVE MCH STRENGTHENING

1. Description

MCH activities under the project are described under several headings in the Project Paper, most specifically as an element of "Service Management and Delivery" for the Central Region. The objective of MCH activities is to work through the regional and district levels to co-ordinate and strengthen all basic MCH activities at ilaka health posts in order to improve the quality and quantity of services available to mothers and children. The activities were to initially focus on a systematic reviews at the district level of MCH services, beginning with 5 districts during the first year of the project. These reviews were to serve as the basis for improvement of regional and district level staff's skills in a whole range of management-related issues.

2. Activities to Date

USAID inputs are outlined in a supplementally funded annual workplans which are prepared and implemented by CRHD staff with technical assistance from JSI. Activities in the 1990/91 workplan were minimal due to political instability, but equipment was provided and orientation workshops were conducted in the 4 districts of Makwanpur, Dhading, Rautahat, Bara. In 1991/92 activities in the 4 districts have included training and supervision visits, initiation of MCH days at health posts when

^{21/} Discussion in Chapter II under "Central Region Management/Service Delivery Improvement" also pertains to the areas of MCH, Child Survival, and F/CHVs.

mothers come for antenatal care and under-fives clinic activities (EPI, growth monitoring, simple curative care, health education), supply of furniture to the CRHD, and supply of recording and reporting forms including antenatal and postnatal registers to the districts. Seventy-six (76) percent of CRHD supervision and monitoring/evaluation visits to districts were completed during the year. More than half the supervision visits occurred in the final trimester after the formation of an MCH strengthening team at the central region. The development this team approach at district level, including regional staff, since March 1992 has significantly increased the analytical approach to service quality with a more critical assessment of service statistics and district review data, and discussion of interventions for improvement. Activities in the 1991/92 workplan are still ongoing. The 1992/93 workplan was submitted in June 1992 and has modified the original objective of expansion to 4 districts each year to 2 additional districts (not specified).

3. Issues and Discussion

MCH strengthening activities have been conducted in 4 of the 19 districts, a rate slower than the rate of about 5 per year projected in the Project Paper. Reasons for this slow pace of implementation include delays in signing of workplans, transfer of personnel, and delays in procuring equipment. P r o b l e m s associated with the signing of workplans have been addressed and workplans for 1992-1993 were completed by June 1992. Problems have also arisen at the district level where DPHOs were transferred after completion of the initial 4 district reviews. Initially there was no team approach at the district or CRHD levels in trying to improve MCH service quality. Achievements were usually the result of individual rather than team effort and there were serious problems in gaining the commitment and active supervision from CRHD staff despite their eligibility for supplemental TA/DA rate. Since the formation of a team approach in March 1992 these problems have significantly diminished. In order to solve many problems identified at district level, close liaison with national government officers is necessary. Regional staff have not been able to fulfil this role.

4. Conclusions and Recommendations

1. The project should expand work in improving the quality of MCH services at the health post and beyond through support to DPHOs. Specifically this support should include:

- o Formation of FP/MCH service quality teams at national level.
- o Development of district level FP/MCH service quality indicators and rapid appraisal methods for monitoring service quality at district level.

- o Contract with a local consultant to provide training in planning and management in the health sector at the district level (e.g. a retired DPHO).
- o Co-ordinate meetings of DPHOs from selected districts to evaluate progress in MCH service quality, to develop planning and management skills, to encourage innovative activities in FP/MCH service quality and to allow peer group review.

C. CHILD SURVIVAL ACTIVITIES

1. Description

This component of the project is to provide support to interventions related to major childhood health problems: diarrheal disease control (CDD), vaccine-preventable diseases (EPI), and acute respiratory infection (ARI) control.

CDD activities include: i) basic training activities in ORT are to be carried out in the Central (and to a lesser extent Western regions), ii) development of monitoring and supervision systems, iii) introduction of a 500 cc ORS packet, iv) support for NGO activities in physician and other health worker training, and v) studies and research.

EPI activities, primarily supported by UNICEF, are to be complemented by project support for: i) communications and educational materials and activities, ii) small scale surveys and studies that would be used for evaluation and planning of EPI services, and iii) Central Region activities in support of improved/integrated services (e.g. training and improved surveillance and reporting systems).

ARI activities under the project are for support of intensive pilot activities with NGOs in up to two hill and two Terai districts, and in the Central Region for more general training activities. Selection of this approach was based on USAID's experience under an earlier project which suggested that development of an effective service delivery strategy remained to be developed.

2. Activities to Date

Several areas of activity under this component were dropped from the project as part of USAID's focussing exercise. These include the plan to evaluate an ORS packet with a 500 ml container, and any EPI related activities.

Regarding CDD, the project is providing support to CDD activities at both national and central regional level. Support to the national Public Health Division/CDD section includes Redbook funding support for training in diarrhoea case management, printing of posters, support for supervision and reporting and promotional

activities. Basic training is given to all levels of service providers (district public health and health post staff), primary school teachers and scouts. Routine training activities in CDD were conducted in 7 central region districts in 1991-92 included 150/153 (98%) of DPHO staff and 717/755 (95%) at health post level of planned training. Posters are printed and distributed through the national CDD section.

CDD supervision and reporting is also coordinated by the national CDD section but should involve regions and districts. Intensive supervision activities carried out under a technical consultant to MASS with technical assistance from JSI. The objectives of intensive supervision are to promote the conduct of supervision activities for CDD by district staff based on the DPHO/CDD manual developed by the central CDD division, and to assess the extent to which knowledge and use of ORS by village mothers can be improved. This program has thus far been conducted in 4 Central Region and 1 Western Region districts, and will be expanded to 3 other districts in 1992/93. Analysis of the effect of this intensive supervision suggests that: i) CDD management by health post staff improved, ii) the quality of health education by VHWS and CHVs was less affected because they were less frequently involved at follow-up visits, and iii) the percentage of mothers making ORS correctly has increased from 32 to 66 percent in the sample studied.

There are no formal national or regional level USAID inputs to ARI control except that in the 1992/93 workplan JSI is to "provide assistance to national efforts in CDD, EPI and ARI as required". At the district level, a pilot study of the use of F/CHV in the diagnosis and treatment of ARI is ongoing in Chitwan district. The study was planned and conducted by the Public Health Division ARI section with the technical assistance of JSI and the DPHO in Chitwan. A preliminary analysis of the study results identified problems with diagnostic accuracy, follow-up and supervision by VHWS and DPHO staff, and inadequate provision for drug resupply. The CDD/ARI section staff have included activities in the 1992/1993 workplan to address these problems and discussed this with the DPHO in Chitwan. A repeat survey will be conducted next year. USAID is also supporting the Jumla project for ARI control which has made a major contribution to ARI research in Nepal, and a smaller project in Dang operated through the Nepal Red Cross with technical assistance from JSI. Dartmouth College are contracted to develop Jumla project activities to include family planning and nutrition inputs, and to make the program sustainable for future take-over by GON.

3. Issues and Discussion

Concerns were raised about the quality and value of routine CDD training at government TA/DA rates. At these low rates the commitment and interest of health post staff is variable and thus

the overall impact of the training is in question. Further, interest and commitment to CDD at the national level is in some question as there have been 3 different national directors of the CDD division during the past 2 years. Finally, while the use of a local technical consultant for intensive supervision activities has been effective problems have arisen with the ownership of the program.

4. Conclusions and Recommendations

1. The project should continue to provide support for the testing of strategies for implementation of child survival interventions.

2. Existing work in CDD intensive supervision, ARI control by outreach workers, and Vitamin A supplementation should be completed and be linked to national level decision making. It is more likely that lessons learned from strategy implementation work in Vitamin A, CDD and ARI will be incorporated into national programmes if the MOH officers responsible are more closely involved in the planning and evaluation of implementation activities.

3. Project funds should be made available to support the production of joint GON/USAID papers on:

- o Control of Vitamin A deficiency in Nepal: medium and long term strategies.
- o The use of outreach workers for rapid diagnosis and treatment of ARI.
- o Expanding the correct use of oral rehydration solution for acute diarrhoeal disease.

4. In the longer term, USAID should give strong consideration to focussing their child survival efforts for just one of the child survival interventions on an expanded national basis. Vitamin A supplementation would be the logical choice for an expanded intervention, in which case support for other child survival activities might be phased out over LOP.

D. **FEMALE COMMUNITY HEALTH VOLUNTEERS**

1. Description

A component of the project aimed at improving the service delivery and management in the Central Region supports the establishment of a cadre of Female Community Health Volunteers (F/CHVs) throughout the region. This component was described as a priority implementation activity by the PROAG, no doubt in part because F/CHVs fit under two of the project's themes: "Beyond the Health Post" and "Services By and For Women". USAID's support for F/CHVs in the Central Region is complemented by UNFPA's support in

8 districts of the Western region. Training targets were not included in either the FP nor PROAG, although it could be inferred that the number of F/CHVs to be trained or retrained would be upward of 6,000 (300 F/CHVs per district times 19 districts). A key activity of this component as described in the PP is the identification of local or district-level organizations, initially in 5 districts, which could serve to provide support to F/CHVs in lieu of the DPHOs providing this support. The PROAG described the development of training and supervision systems for F/CHVs as encompassing the local to the national level, but did not suggest that these need be non-governmental.

2. Activities to Date

To date, the F/CHV component of the project has been one of the most successful activities under the Central Regional Health Directorate (CRHD). F/CHV activities funded under the CRHD Work Plans (Redbook) include: i) training - basic and refresher, ii) trimester meetings for DPHOs and HPIS, iii) biannual meetings of F/CHVs, iv) supervision, and v) printing of forms and registers. F/CHV activities funded under Supplemental Work Plans include: i) periodic district assessments (1 of 4 completed)^{22/}, ii) orientations and TOTs for new health post and DPHO staff (3 of 3 completed), iii) VHW training in information and supervision (19 of 50 completed), iv) supervision (8 of 16 visits completed), v) regional meeting (completed), vi) F/CHV exchange visits between districts, vii) radio program, viii) CRHD accountant and logistical support, and ix) conduct of a literacy program in 3 ilakas of one district (2 of 3 ilakas started). To date, no activities have been undertaken to develop non-MOH organizations for the support of F/CHVs.

3. Issues and Discussion

In spite of the successful implementation of activities under the F/CHV component of the project several changes have taken place since the design of the project which may require adjustments in the program. Specifically, there seems to be emerging debate about the longer term function of F/CHVs. Are they supposed to be service providers, or health educators, or user group representatives who monitor the delivery of outreach services? Or a combination of all three functions? The entry of the MCH Worker at the sub-health post level also suggests a need for review of the role of the F/CHV. Finally, the cessation of the payment of NRs. 100/month to the F/CHVs has lowered morale and determination of possible means to provide non-salary incentives may need to be found to ensure the F/CHVs continue to be active. The training and management needs for the F/CHV program will obviously differ

^{22/} When these are complete they will serve as a source of information for evaluation of the program.

depending upon the GON view of how F/CHVs should operate.

Little material evaluating the F/CHV program is available ^{23/}. For example, information is not available about attrition rates, nor about time spent in service, service or counseling outputs, etc. Given MOH and donor investments in the program, further effort to evaluate the output and impact of F/CHVs is warranted. Were such information available it would be of use to the MOH in developing clear policies and modifying programs for the future. USAID should provide technical assistance for the conduct of an evaluation, and further should finance a workshop to review evaluation findings with all interested parties.

To date, the management of the F/CHV program has been located within the Public Health Division of MOH and the CRHD. After the reorganization of the MOH responsibility for the F/CHV program is likely to be transferred to the Family Health Division with a declining role for the CRHD. USAID should liaise closely with the MOH during this reorganization so that existing activities are continued and that newly appointed officers are aware of the details of the program component.

4. Conclusions and Recommendations

1. USAID support for F/CHV activities in the Central Region should continue. Information from interviews and the team's field experience show that the F/CHV program has been an important development. Large numbers of F/CHVs are trained and active in their communities, serving as an important resource for future improvements in family planning and health at the village level.

2. USAID should urgently assist GON to develop a clear policy about the future role of F/CHVs. Among the policy questions to be addressed are:

- o The precise expectations for and functions of F/CHVs.
- o The F/CHVs linkage to VDCs and female MCH workers.
- o Clarification of whether F/CHVs should be supplied with drugs, including those for treatment of ARI. If so, problems with drug resupply need to be addressed.
- o Program management - how will CRHD activities be continued if regional offices decline in importance and the MOH is re-organized?

^{23/} One evaluation (Gurung, 1992) of F/CHV program has been over 2.5 years in preparation but only a very rough draft was available for the team's review.

- o Future training - should F/CHV training be integrated with the training division of the MOH and the regional training centers or left to the discretion of DPHOs?
- o Should F/CHVs be used as client representatives in quality assurance work? If so, how?
- o The need for studies to evaluate different support systems for F/CHVs.
- o The role of major donors in coordinating support to the national F/CHV program.

3. The project should concentrate on developing local and district-level managerial support systems for F/CHVs already trained before expanding training of new F/CHVs. Experimentation with innovations should explicitly take concerns for replicability into account.

4. Although the literacy activities undertaken under the F/CHV program have had an impact in increasing functional literacy they were not foreseen in the Project Paper and may not fit in with longer term USAID plans in health and family planning. Thus, these pilot efforts should be completed and phased out over the LOP. Lessons learned should be shared with the MOH and discussions held as to whether to include a literacy component in the CHV strategy with possible funding for its implementation from UNICEF and/or other donors.

CHAPTER VI MALARIA CONTROL

1. Description

USAID's support for malaria control under the Child Survival Family Planning Services project has shifted away from provision of grant aid for the purchase of insecticides to support for environmental control measures, development of case detection and information systems, and development of skills in vector control. Specifically activities of the project include: i) renovation and upgrading of a National Research and Training Center (NRTC) at Hetauda, ii) decentralization of laboratory facilities (microscopes) to the ilaka health post level so that 450 ilaka laboratories are functioning, iii) training of passive case detection volunteers (PCDVs) in 50 districts, iv) provision of training fellowships for district and regional public health staff to receive 2 month revision courses in malaria in Delhi, and v) provision of spraying pumps, spare parts and uniforms to insecticide spraying program. Technical assistance to this component of the project is provided by USAID/HFP's Malaria Advisor and through short-term assistance provided by the centrally-funded Vector Biology Control project.

2. Activities to Date

Significant progress has been achieved with respect to several activities under this component:

- o A tender for the renovation of the National Research and Training Center at Hetauda (cost \$ 499,000) has been awarded, although the construction work has not yet started.
- o Labophot-2 Nikon microscopes (cost \$180,000) were purchased and transferred to regional storage. However few of these are in use as because they are dependent on electricity and therefore are largely unsuitable for ilaka health posts. In selected Terai districts where the prevalence of malaria is high and electricity is often available at health posts (e.g Morang, Jhapa, Rupandehi) about half of the health posts have been supplied with microscopes. The rest are in storage for use in planned (but not yet constructed) primary health care centers.
- o Training for passive case detection volunteers has been highly successful. In 1990-91 4,684 PCDVs received training (i.e. 94% of the estimated total) (see Table 6.1). The co-ordination of logistics and transport for training workshops seems to have been conducted efficiently by the private contractor Management and Support Services (MASS). Passive case detection provides 60-70% of malaria slide positives (of which half come from the volunteer program)

whereas active case detection by VHWS and other health workers contributed only 13% of positive cases in 1991 (see Table 6.2).

- o Two DPHOs have completed training in malaria in Delhi. A further 20 DPHOs and other health workers are scheduled to go to Delhi for training starting in November 1992.
- o USAID has supplied \$350,000 worth of pumps and spare parts, uniforms, masks etc to the malaria division since 1990.

3. Issues and Discussion

Trends in malaria cases detected, annual blood examination rate (ABER), annual parasite incidence (API), slide positivity rate (SPR), and percentage of *P. falciparum* cases (%PF), show a slow but significant upward trend over the past 3 years which is due, in part, to the decline in the insecticide spraying program (see Table 6.3). In addition, there has been concern expressed in the Nepalese media and among politicians about the apparent increase in kala-azar cases in the terai, the epidemic spreading from Bihar in India. Kala-azar is endemic in 11 districts of Nepal and 700-1000 cases are recorded every year although there is no regular surveillance mechanism. The malaria division is collecting information about the changing epidemiology of kala-azar from a survey of case records in affected districts and USAID is already providing technical support for an analysis of vector entomology.

Management and morale at all levels of the GON malaria program is in a poor state. Many malaria workers are likely to be laid off within the next month as part of the rationalization of development staff. The great majority of malaria staff, along with other vertical programs like FP/MCH and EPI, are paid from development budget. If development staff are to take advantage of a GON bonus of 1 months pay for every year of service they must submit their resignation by October 11th 1992. They may re-apply for permanent posts when these are advertised. The numbers of permanent posts in the malaria division have not been finalized and discussions are still going on with the Administrative division. Because of the uncertainty all levels of staff have been affected and routine activities have suffered. Low morale and poor facilities contributed to the apparent lack of activity by NRTC staff in Hetauda during the team's field visit. There had been no training activity during the previous 3 months and no training schedules had been received from central office. The MOH clarified that during the monsoon months there are usually fewer training activities.

4. Conclusions and Recommendations

1. It is difficult to support the planned reconstruction of a National Training Center at Hetauda if the current management and

GON funding structure for malaria remains in place. However re-organization of MOH is projected to occur in the next 2 months with the formation of an expanded Disease Control Division subsuming the current malaria division. The building will therefore have an expanded role as a national and regional training and research center for vector-borne diseases including malaria, leishmaniasis, Japanese B encephalitis and other viral diseases, but probably excluding AIDS. These plans would need to include substantial technical support for the development of laboratory facilities, management of insectoria, and training and research programs in vector entomology and the epidemiology of these diseases. USAID should provide additional technical assistance to provide this support. Without additional technical support the building alone will not be very useful.

2. The development of ilaka laboratories with microscopes has not been achieved. It appears that most of the \$180,000 worth of Labophot-2 Nikon microscopes remain in storage. To the extent that some scopes are being kept aside for the PHC Centers to be constructed in each of the 205 political constituencies this will not achieve decentralization of laboratory facilities to the district level and below. USAID should determine with the MOH whether there are other ilaka level health posts with electricity to which the scopes in storage can be distributed. Other options for the distribution of the remaining scopes, e.g. distribution to other facilities, teaching programs, or laboratories, should be considered with emphasis on distribution in the near term. If no suitable uses can be found for the scopes, distribution to another USAID program in the Asian region should be considered.

3. The PCDV program is by far the most successful part of the USAID input to malaria and warrants full continuing support. About 30 percent of all reported malaria cases are detected by the PCDVs, although slide collection has fallen since the malaria program was integrated. The use of MASS as a private contractor to liaise directly with DPHO staff for the co-ordination of twice yearly training sessions for PCDVs (in the 50 districts where the malaria project exists) has been reasonably efficient. This program should be maintained but a target of twice yearly training sessions may be excessive and might be reduced to once-yearly.

4. Proper storage and maintenance of sprayers and other supplies seems to be a problem. A review of the MOH's management of these supplies is recommended, and further purchase of these supplies is not indicated prior to such a review.

5. On the basis of the present evaluation it is difficult to make detailed recommendations about what should be USAID future long-term support to the malaria program. It is recommended that USAID conduct a more detailed assessment of this question after November/December 1992. By this time the MOH's rationalization of development staff and re-organization of the MOH should have been

completed, in-country reports about recent outbreaks of kala-azar will be available, and the Minister of Health will have returned from the Amsterdam conference on global malaria control. Subsequently USAID will be better placed to judge the MOH's future plans for the control of malaria and other vector-borne diseases and to determine the level and type of USAID support indicated.

Table 6.3

Receptivity Malaria Profile, 1989-1991

Receptivity	Year	Population	Cases	API	ABER	SPR	%PF
Low Terai	1989	4,679,635	4,050	0.9	10.0	0.8	11.2
	1990	4,777,449	5,134	1.1	8.3	1.3	8.5
	1991	4,881,990	6,259	1.3	7.5	1.7	10.5
Moderate	1989	3,705,114	11,509	3.1	10.4	2.8	14.2
	1990	3,794,667	12,101	3.2	8.2	3.8	10.5
	1991	3,864,233	15,505	4.0	7.7	5.1	26.2
Low Hill	1989	2,122,158	6,807	3.2	7.8	3.8	3.5
	1990	2,283,080	5,621	2.5	5.4	4.4	2.5
	1991	2,320,590	7,371	3.2	4.6	6.7	4.7
Country	1989	10,506,907	22,366	2.1	9.7	2.1	10.4
	1990	10,855,196	22,856	2.1	7.7	2.7	7.9
	1991	11,066,813	29,135	2.6	7.0	3.7	17.1

Source: Malaria Division/MOH

Note: API - Annual Parasite Incidence
 ABER - Annual Blood Examination Rate
 SPR - Slide Positivity Rate
 PF - P. Falciparum

Table 6.4

**Slides Collected and Positives Detected by Different
Case Detection Mechanisms, 1989-1991**

Source	Year	Slides	% from Total Slides	Positives	% Total of Malaria Slides Positive
ACD	1989	718,732	67	4,780	21
	1990	546,662	65	3,500	15
	1991	449,705	58	3,923	13
Total PCD	1989	210,627	20	13,582	61
	1990	213,554	25	16,091	70
	1991	242,913	31	18,442	64
PCD (Volunteers as part of total PCD)	1989	(108,452)	(10)	(5,615)	(25)
	1990	(91,721)	(11)	(6,708)	(29)
	1991	(116,439)	(15)	(8,523)	(30)
Others ¹	1989	139,740	13	4,004	18
	1990	87,275	10	3,265	14
	1991	78,262	10	6,272	22

Source: Malaria Division/MOH

¹Hospitals and private clinics

APPENDICES

Appendix A

Scope of Work

B. SCOPE OF WORK

Technical assistance is requested from POPTECH to plan and implement a four-week mid-term evaluation of the Child Survival/Family Planning Services Project (0367-0157). The purpose of the evaluation is to:

- 1) Assess the progress-to-date under the bilateral agreement;
- 2) Assess the validity of the present design and assumptions, particularly in the context of issues discussed below.

In the context of assessing the overall progress, the mission wishes the evaluation team to focus on the issues listed below.

B.1 Project Related Issues

B.1.1 Regionalization

The concept of regionalization is professed in MOH documents, which identify regional offices as the focal points for management of health activities, providing technical and administrative assistance to districts for the implementation of programs. More authority is also to be vested at the district level, where District Public Health Offices (DPHOs) were created and are being strengthened. At present, USAID provides major support to the Central Region as part of this regionalization process.

To date, some strides in this direction have been made, although the process is not complete. We need to consider what is a reasonable pace and what are reasonable indicators that "regionalization" is indeed taking place, as an indication of the appropriateness of our continued support for the actualization of this concept. With this in mind, the evaluators will consider:

- To what extent the government is committed to supporting the regionalization concept, e.g. has the GON developed guidelines and policies to further facilitate the regionalization process? Has the GON assigned responsibility for planning and budgeting, and assured inputs into financial allotment for the program? Has the GON provided logistical and facility support for minimal functioning?, etc.
- To what extent USAID should support the regionalization process: what benchmarks should we strive for? What changes should be considered, e.g. more direct support to the districts, etc?

B.1.2 GON Program-Support Training Issues

According to the Project Paper, USAID was to provide resources to carry out 1) Public Health and Health Administration Training for 25 MOH managers, and 2) 40 person-months of short-term training for selected GON managers/officials. To date, start-up of these activities has been delayed. The evaluators will consider:

- Whether the Public Health Training, as originally planned, remains a viable option; and whether the project should identify alternative means of meeting the training needs; and
- How can USAID facilitate the process of providing participant training support?

B.1.3 USAID Administrative/Implementation Issues

Absorptive Capacity - Questions about absorptive capacity are most obviously reflected in percentages of donor/USAID funding spent by the MOH for programs which we support. This should be reviewed briefly. However, some programs identified for support (e.g. public health management, logistics, etc.) do not always get the attention (manpower, time, etc.) needed for moving them forward. As such, we need to review realistic expectations for areas of support.

This issue should also be considered in light of recent focussing exercises (both overall Mission and O/HFP) and against the potential to expand our assistance as resources (human and financial) are identified. With these issues in mind, the evaluators will review:

- Results of focusing exercises, e.g. appropriateness of emphasis areas, vis-a-vis mutual (MOH and USAID) priorities.
- Are there obvious gaps that USAID should consider? Under what circumstances should additional emphasis areas be pursued?

Disbursement Issues - The issue of timely disbursements is one of the most hindering (with that of TA/DA rates) of all to successful and timely implementation of important MOH programs supported by USAID (however, the problem is not unique to USAID). O/HFP has just been involved in a several months-long exercise with relevant players (MOH policy level and technical and financial/accountants staff; HMG Comptroller General; USAID Director, FP and HFP staff) designed to facilitate communication and identify the means of alleviating this problem (documented in background materials). While the path agreed upon is still quite new, there remain cumbersome aspects for all sides involved. In addition, despite open discussion of stumbling blocks and agreements reached on procedures to be followed, routine kinks in the system continue to plague us. Questions on a realistic pace of disbursements for mutual MOH-USAID funded activities remain. Based on work done to date, the evaluators will consider:

- How can the workplan planning process be streamlined? What factors do we (MOH and USAID) have under control or are able to influence? What factors are beyond our control?

Sustainability - This issue is certainly not new to any donor-funded program. Realistic program and prospects should be discussed. The Evaluators will consider:

¹ During November 1991, USAID/HFP carried out an exercise to review the existing health and family planning portfolio in an effort to "focus and concentrate" the overall program. As a result of this process, a number of activities outlined in the original project paper were eliminated or reduced in scope (e.g. EPI efforts, family planning IEC, etc.).

- What steps is the MOH taking toward sustaining programs? What are relevant "policy dialogue" topics? What long-term goals should USAID/Kathmandu set for improving the overall sustainability of it's present health and family planning portfolio?

B.1.4 Family Planning Issues

Institutionalization of Family Planning Services - Starting in fiscal year 1988-89 the MOH initiated a program of "institutionalization" of family planning services in selected districts of the country. The word "institutionalization" refers to both a program and a process. As a program, "institutionalization" refers to a systematic effort geared toward developing the infrastructure (manpower, facilities, etc) required to make a full range of family planning services available through the Ministry of Health's existing health network, e.g. hospitals, health posts, fieldworkers, etc. Institutionalization also refers to the process whereby a district, at all administrative levels, attains the ability to provide a full range of family planning services (including VSC) regularly, routinely, and on demand through the effective utilization and coordination of local (district) resources and institutions. At present, USAID provides resources to the GON to implement this concept in 15 districts within Nepal. To date, the concept has faces some stiff opposition at the District level. (Refer to assessment on the institutionalization of family planning services in Nepal carried out by JSI/USAID.) The evaluators will consider:

- To what extent the government is committed to supporting the institutionalization concept, e.g. has the GON provided personnel to provide family planning services within hospitals?, etc.
- What changes, if any, should be made in USAID's present support for the institutionalization approach?
- Are there additional inputs USAID should explore in other districts (non-institutionalized) which could help the government to increase the contraceptive prevalence rate?

Priority Country Strategy - It is assumed that by the time this evaluation takes place, Nepal will have been officially accorded Priority country status. As such, the mid-term review of CS/FPS should help us identify

areas of potential support under this status. The evaluators will consider:

- Where are there obvious gaps that could benefit from additional resources without diluting the program, and how do these mesh with MOH and USAID priorities?

B.1.5 Community Health Volunteers (CHV)

Since 19, USAID has been supporting CHV activities, e.g. training, supervision, manual development, etc. Much of the MOH's efforts to reach the peripheral (village) level depends on the success of this program. Some assessments of the CHV program have been undertaken, which outline problems and possible solutions. Based on information available, the evaluators will:

- Confirm MOH commitment to the program; discuss the validity of the CHV approach and support mechanisms to ensure its viability; and discuss areas of overlap/mutual concern among donors.

B.1.6 Malaria Program Issues

Decentralized Lab Facilities - As part of the present project paper, USAID has agreed to provide microscopes to the GON as part of their plan to decentralize case detection. Although a number of microscopes have been procured and provided to the government over a year ago, this plan has not been implemented. With this in mind, the evaluators will determine:

- The extent to which the present approach is still viable? What changes should be considered?

Passive Case Detection Volunteers - Since 1988, USAID/HPF has been support a program where by local volunteers are trained to take blood smears from community members who show signs of having a fever. The slides are then sent to the DPHO offices for analysis. The evaluators will:

- Review progress and impediments to this approach and suggest actions needed for its implementation.

B.1.7 Services for and By Women

USAID, as part of its present program, stresses that women are the MOH's principle clients and that the best way to get services to women is to provide them through other women. An example of this emphasis can be seen in USAID's support for the CHV program and the MCH

strengthening program. With this emphasis in mind, the evaluators will consider whether:

- Service delivery has been improved through MCH strengthening, CHV program support, training, district innovative activities, intensive CDD supervision and monitoring;
- Service delivery mechanisms are increasing services provided to women by women; and
- The inputs provided by the project at the regional level are actually improving health service management and delivery at the district and beyond.

B.1.8 Private Sector Health and Family Planning Support

During April 1992, a team comprised of private sector family planning/health experts visited Nepal to assess the current and potential role of the private sector for expanding its share of FP/MCH services. As part of this study, the team focused on employers (individual companies, groups of companies, industrial estates, and employer associations) and current market-based providers of health care (direct service providers, drug retailers, and insurance companies). Based on the results of their report, the evaluators will consider:

- How much emphasis should be placed on providing resources to expand USAID/HFP Office's existing private sector health/family planning support activities. Do the potential options appear to be cost-effective?

Appendix B

List of Persons Consulted

USAID MISSION:

Kelly Kammerer - Mission Director
Theodora Wood-Stervenou - Deputy Director
David Oot - Chief, HFP Office
Molly Gingerich - Deputy Chief, HFP Office
Matthew Friedman - Population Fellow, University of Michigan
Puru Pokhrel - HFP Office
Pangday Yangzone - HFP Office
Charles Strickland - Agriculture and Rural Development Office
Michael Calavan - former USAID staff member

MINISTRY OF HEALTH:

Mr. M. S. Thapa - Secretary of Health
Y. M. S. Pradhan - Additional Secretary
Dr. Suniti Acharya - Planning Division
Dr. Kaliyan Raj Pandey - FP/MCH Division
Dr. Sharida Pandey - FP/MCH Division
Dr. Sabatri Pahari - Public Health Division
Dr. Bikaas Lamichane - CDD Section, Public Health Division
Mr. Kumar Lamichane - CDD Section, Public Health Division
Dr. Sinha - Training Division
Rukmini Charon Pradhan - Training Coordinator
Bimala Maskey - Division of Nursing
Dr. B. L. Shrestha - Malaria Division
Dr. Jitendra - Malaria Division
Dr. P. Aryal - CRHD
Maya Shresta - CHV Coordinator, CRHD
Dr. Karki - Western Region Health Directorate
Laxmi Malla - Public Health Nurse, Western Region Health Division
Bimla Kharka - Sr. Public Health Nurse, Western Region Health Division

OTHER MINISTRIES AND GON ORGANIZATIONS:

Dr. R. Pant - NPC
Shyam Thapa - Consultant to NPC
R. Pradhan - Nepal Eye Hospital and NNIPS
Dr. S. Khatry - Nepal Eye Hospital and NNIPS
Dr. P. C. Karmacharya - Dean, IOM
Dr. Mathura Shrestha - Community Medicine, IOM
Dr. S. K. Gupta - Family Medicine, IOM
Dr. R. Adhikari - IOM

OTHER DONORS:

Dr. Michel Brissot - Swiss Development Cooperation

Qussay Al-Nahi - UNICEF
Jeanette Kesselman - UNICEF
Dr. Guy Carrin - WHO Geneva
Dr. Ottar Christiansen - WHO Representative to Nepal
Dr. Vijaya Manandhari - WHO Advisor, Safe Motherhood
Judy Carlson - WHO Nursing Advisor
Dr. Rusdi Aliudin - WHO
Dr. Marta Levitt - Nursing Advisor, Redd Barna
Omer Ertur - UNFPA Representative
D. B. Lama - UNFPA
James Smith - World Bank
Bigyan Pradhan - World Bank

NON-GOVERNMENTAL ORGANIZATIONS:

Rajendra P. Singh - Managing Director, CRS
Jennie Goodwin, Save the Children Federation, UK
Dr. Tjerk Nap - Chief Medical Officer, United Mission to Nepal
R. K. Neupane - Director General, FPAN

CONTRACTORS:

Wilda Campbell - Chief of Party, JSI
Dr. Penny Dawson - MCH and Child Survival Specialist, JSI
Dr. Paul MacKenzie - Family Planning Specialist, JSI
Om Rajbhandari - Managing Director, MASS
Sayeb Malla - Office Manager, MASS
Dr. Rita Leavell - Regional Manager, SOMARC
Anton Schneider - Porter/Novelli
Ashoke Shrestha - New ERA
Yogendra Prasai - New ERA
Ran Risa - New ERA
Dr. T. M. Vaidya - Executive President, NFCC
Birendra Shrestha - Program Director, NFCC
Dr. Yesho Pradhan - Assistant Medical Director, NFCC

KATHMANDU: - members of focus group

Dr. D. Malla
Mrs. Indu Pant
Mrs. Munu Thapa
Dr. Suparta Koirala
Dr. Vijaya Manandhar

BARA DISTRICT:

Dr. Ram Prasad Yadav - DPHO
Staff Patliya Training Center
S. Sharma - ANM, Nijgadh Health Post
Arun Kuman Mahto - Health Post in Charge, Pheta Health Post
Sushila Rijal - ANM, Pheta Health Post
Joku Prasad Shah - Assistant Health Worker, Pheta Health Post

CHITWAN DISTRICT:

Dr. Ojha - Medical Superintendent, District Hospital
Shrihari Sharma - DPHO
Ms. Thapa - FPAN Staff Nurse
Khairani health post staff, CHV, members of Mothers' Club

KASKI DISTRICT:

Dr. S. Tulachan - Medical Superintendent, District Hospital
Mr. Keshar B. Pradhananga - DPHO
Jeevan Shrestha - Public Health Nurse
Shishuua *Naka* health post staff
MCH worker trainees
Batulechowar village focus group: Mothers' Club members, VHWS

MAKWANPUR DISTRICT:

Jyoti Shrestha - DPHO
Dr. N. Jha - Medical Superintendent, District Hospital
Dr. R. B. Basnet - Medical Officer, District Hospital
Dr. G. Upandhaya - Medical Officer, District Hospital
Dr. J. N. Giri - Medical Officer, District Hospital
Champa Koju - Staff Nurse, District Hospital
Helen Barlow - VSO, UK

Aaambhanjyang Health Post:

Narendra Lal Koirala - health assistant
Tulsa Pokhrel - ANM
Meena Pun - ANM
A. Chandhari - Assistant Health Worker
B. P. Sharma - Mukhiya (clerk)
Aram Bhanjyang - CHVs and members of Mothers Club

Makwanpur Health Post:

Ek Nath Marasini - Health Post in Charge

Palang Health Post:

Staff

RUPENDEHI DISTRICT:

Dr. P. B. Thapa - Butwal Zonal Hospital
Dr. Jyoti Shrestha - Ob/Gyn, Butwal Zonal Hospital
FP Staff and Clients - Butwal Hospital
Dr. Sharma - Medical Superintendent, Bhairawha Hospital
Dr. Bhatta - Bhairawha Hospital
Lumbini health post staff (health assistant and ANM)

BIBLIOGRAPHY

Acharya, S., Carrin, G., Herrin, A. (25 June 1992) Macroeconomic Environment and Health, Country Case V: Nepal, WHO, pp. 271-297.

Bienen, H., Kapur, D., Parks, J. and Riedinger, J. (1990) "Decentralization in Nepal", World Development, 18(1): 61-75.

Committee on Essential Drugs (July 1992a) Essential Drugs, to be Supplied to Sub-Health Posts, MOH, 6 pp. plus annexes.

Committee on Essential Drugs (July 1992b) The Proposed Cost Recovery Scheme for Drug Supply, MOH, 11 pp.

Computer & Marketing Divisions, Nepal CRS Company (March 1992) CRS Comprehensive Annual Sales Report, 1991.

CRS (March 1992) Comprehensive Annual Sales Report, 1991.

CRS (September 1992) Report on Rural Social Marketing Program, 22 pp. appendices.

Daly, P.M. (April 1987) Health Financing and Cost Recovery in Nepal, 99 pp.

David, A.S. et.al. (June 30, 1986) Assessment of the Role of the Private Sector in Family Planning in Nepal, Interface Ltd., 49 pp. plus annexes.

Dawson, Penny (1992) Background papers on MCH Strengthening, Diarrhoeal Intensive Supervision, and ARI Control through CHVs in Chitwan.

FPAN/AVSC (1992) "Progress Reports in Static Clinic from Jan - June 1992".

Family Planning/Maternal and Child Health Division, MOH, Government of Nepal (1992) Programme Budget for the Period of Nepali Fiscal Year 2049-50 (1992-93).

Family Planning/Maternal and Child Health Division, MOH, Government of Nepal (1992) A Family Planning Target-Setting Model, 1991-2000, (internal document).

Family Planning/Maternal and Child Health Division, MOH, Government of Nepal (1992) Acceptors' Profile for All Nepal for the period 1989-90 and 1990-91.

Friedman, M. (July 9, 1992) Background Paper for Mid-Term Evaluation of USAID/HFP's Child Survival/Family Planning Services Project, 91 pp. plus annexes.

Gurung, Sumitra (1992) Diagnostic Assessment of the Community

Health Volunteer Program in Nepal, New Era, (rough draft).

Hemal, Hem B. and Sharma, Jyoti R. (31 May 1988) Nepal Contraceptive Retail Sales Company Ltd. 10 Year Report, 1978-1988, 40 pp. plus tables (#184).

HMG (1992) Eighth Five-Year Plan for 1992 - 1997: Population Policy, Objectives Strategy and Policy Actions.

HMG (1992) Eighth Five-Year Plan 1992-1997: Strategy for Female Community Health Volunteers.

HMG with WHO (1992) Safe Motherhood Initiative in Nepal: Situation Analysis with Suggested Policies and Objectives.

IDS (August 1989) "Improving Family Planning Acceptance through Panchayat Based Clinics and Outreach Service using Women Volunteers: Final Report of the Phase II Survey".

IDS (August 1991) Knowledge, Attitude and Practice Towards Health and Essential Drugs in Rural Nepal, UNICEF, 106 pp.

Institute for Integrated Development Studies (1992) A Strategy for Rural Service Delivery.

Jezowski, Terrence et.al. (1987) Assessment of the Institutionalization of Family Planning and Voluntary Surgical Contraception Services in Nepal, AVSC.

Kafle, Kumud Kumar (March 1992) In-Depth Study of Existing Drug Schemes in Nepal, UNICEF, 44 pp.

Kafle, Kumud K. and Shrestha, Shreebatsa P. (September 1991) Situation Analysis of Five Districts for Strengthening Primary Health Care through Essential Drugs in Nepal, UNICEF, 63 pp. plus annexes.

Mackenzie, Paul (June 1, 1992) "Options for Increasing Availability of Voluntary Surgical Sterilization in Institutionalizing Districts of Nepal: A Discussion Paper", Draft 4, JSI/Nepal.

Maskey, C.P. and Maskey, J.K. (1981) "Mini-lap Technique and Achievements in Nepalese Context", Journal of Nepal Medical Association, Vol. 19, No. 1, pp. 126-130, Kathmandu, Nepal.

MOH, Government of Nepal (November 1991) National Medical Standard for Contraceptive Services.

MOH, Government of Nepal (1992) The New Health Policy.

MOH, Government of Nepal (1992) Family Planning performance by district.

MOH/WHO (August 14-16, 1991) Seminar on Health Economics and Health Care Financing, 89 pp.

MOH/WHO (September 3, 1992) Task Force for Health Economics and Health Financing Studies, Guidelines for Applied Research, 34 pp.

National Planning Commission Secretariat, Population Division, (January 1992) "His Majesty's Government of Nepal: Population Policy and Programme".

Olsen, I.T. (June 1992) The Financing of Mission Hospitals, Case: UMN Nepal, Phase I, DIS-Centre for Partnership in Development, 56 pp.

PHD/MOH with WHO (June 1990) Diarrhoeal Diseases Household Case Management Survey.

Population Council, New ERA (August 1992) "A System Development Program for Strengthening the Family Planning Program in Nepal: Interim Achievements".

Poudel, D., Sharma, S., Bista, B. and Dawson, P. (1992) "Preliminary Results from a Survey conducted in Chitwan District to Assess the Effectiveness of a Ward Level ARI Project carried out by Female Community Health Volunteers".

Pratt, R. et.al. (February 22, 1989) Evaluation of the USAID/Nepal Integrated Rural Health/Family Planning Services Project, 367-0135, Arlington: POPTECH, 62 pp. plus appendices.

Riparip, Jet C. and Lichauco, Anton A. (1992) Study on the Potential Role of the Private Sector in Privatizing Family Planning and Maternal and Child Health in Nepal, JSI, 119 pp. plus annexes.

Schuler, Sidney R. and Goldstein, M.C. (1986) "Family Planning in Nepal from the Users and Nonuser's Perspectives" Studies in Family Planning, Vol 17, 2:66-77

Schuler, Sidney R., McIntosh, E.N., Goldstein, M.C. and Pande, B.R. (1985) "Barriers to Effective Family Planning in Nepal" Studies in Family Planning, Vol 16, 5:260-270.

Shipp, P.J. (11 November - 20 December 1990) The Development of a Public Health Training Program for District Public Health Officers in Nepal, JSI, 38 pp.

Shrestha, Ashoke, Stoeckel, John, and Tuladhar, Jayanti Man, (January 1988) "Factors Related to Non-Use of Contraception Among Couples with an Unmet Need for Family Planning in Nepal", report prepared for Demographic and Health Survey Project, Institute for Resource Development, Columbia, MD.

Shrestha, Ashoke (July 23, 1992) "Progress Report on "Strengthening

Family Planning Delivery Systems in Nepal" for the Period July 1, 1991 to June 30, 1992", memo to Dr. John Stoeckel, Population Council/New ERA.

Thapa, Shyam (1987) "Determinants of Fertility in Nepal: Applications of an Aggregate Model" Journal of Biosocial Science, Vol. 19.

Thapa, Shyam (March 1992) "Nepal Family Planning Sector: Background and USAID Sector Strategy".

United Nations Population Fund (1991) A Follow-up Study on Depo-Provera Acceptors, Nepal.

United Nations Population Fund (1992) Recommendations by the Executive Director, Assistance to the Government of Nepal, Support for a Comprehensive Population Programme.

USAID (March 27, 1990) Nepal Child Survival/Family Planning (367-0157) Project Paper,

USAID/Nepal (March 1991) Project Assistance Completion Report for the Integrated Rural Health/Family Planning Services Project, 367-0135, 13 pp. plus annexes.

USAID/HFP (August 4, 1992) "Logistics Clean-up at DPHO and Health Post Storerooms", unreleased draft.

WHO (1987) Mechanism of Action, Safety and Efficacy of Intrauterine Devices, Report of a WHO Scientific Group.

WHO (1989) NORPLANT Contraceptives, Managerial and Technical Guidelines, (provisional version).

WHO (1990) Injectable Contraceptives.

WHO (1988) Technical and Managerial Guidelines for Vasectomy Services.

WHO (1989) Rapid Evaluation Methodology, Maternal/Child Health and Family Planning, (unpublished note, FHE/18.1.89), Geneva.

World Bank (April 19, 1989) Nepal, Social Sector Strategy Review, Vol. II: Sector Reviews, Washington, DC: World Bank, pp. 79-84.

World Bank (1991) Nepal - Poverty and Incomes, Washington, DC: World Bank, 230 pp.

World Bank (March 16, 1992) Nepal - Public Resource Management in a Resource-Scarce Economy, 197 pp. (Report No. 10324-NEP).

----- (April 15, 1991) Nepal CRS Company Ltd. Operating Plan 1991, 34 pp. plus appendices (#150).

----- (January 6, 1992) Nepal CRS Company Pvt. Ltd. Plan of Operation 1992, 54 pp. plus appendices.

----- (April 1992) Work Plan for Family Planning and MCH Activities, FY 2049/50.

----- (April 1992) Diarrheal Disease Control Program, Nepal, Work Plan for NFY 2049/50 (1992/93).

----- (June 1992) CRHD Work Plan for CHV, Family Planning, and Control of Diarrheal Disease, NFY 2049/50 (1992/93).

----- (June 1992) CRHD Supplemental Work Plan for CHV, MCH Strengthening, Family Planning, and Control of Diarrheal Disease Activities, NFY 2049/50 (1992/93).

----- (1992) Executive Summary of a Vitamin A Policy Workshop.

Appendix D
Family Planning:
Progress Toward Achieving Logframe Objectives

Project Indicators	Progress	Impact/Comment
GOAL: Decrease TFR	Latest national survey shows TFR decrease from 5.8 in 1986 to 5.1	
Purpose/EOPS:		
- Full service FP/MCH available in project districts in CRHD	Some progress	FP efforts have focused on instit. districts rather than CRHD.
-CPR in project districts increase by 20% and 5% in non-project districts.	Institut. Districts: CPR from 25% to 30%; in other, 18% to 21%	Full project EOPS has been already achieved.
- Quality Assurance systems established for clinical methods in project districts	National standards just published. Little other progress	If impact is to be achieved toward this indicator, need to refocus efforts on quality assurance.
Outputs:		
1. MOH Training:¹		
-360 ANMs/AHWs in CRHD;	Total: 166 ANMs/AHWs and nurses trained: 32 IUD training for all three, 134 FP for HP staff. Training for ANMs and AHWs.	PP called for attention to CRHD. FP inputs were focused instead on institutionalizing districts, which include 7 from Central Region.
-325 ANMs/AHWs in other districts		
-44 Nurses in CRHD	Total 171: 122 asespis training and 49 operating theater management training completed.	
-18 Nurses in other districts		
-44 Physicians in CRHD	Total: 40: 28 orientation trainings; 3 VSC refresher training; and 18 minilap basic training.	
-18 Physicians in other districts		
-22 Counselors in CRHD		
-9 Counselors in other districts		

¹Completed under USAID workplans.

Project Indicators	Progress	Impact/Comment
2. Full service FP program established		
-Tiered institutionalization in 20 districts	Begun in 15, seriously in 4. Some progress, but not much.	Need to step up and refocus activities on implementing institutionalization.
-Supply/logistics system operating smoothly	Efforts have been made to begin	Need increased, systemized effort.
-30 hospitals in CRHD provide clinical methods	At least 18 hospitals in instit. districts provide FP	Focus has been on instit. districts rather than CRHD.
-30 other hospitals provide clinical methods	at least 6 other hospitals	
-10 health centers/ posts provide clinical methods	At least 5 HP or other currently provide IUDs	
-All facilities provide non-clinical methods and referrals	-----	

APPENDIX E
QUALITY INDICATIONS: REVIEW OF CLINIC CARDS

In the course of the team's field visits, a simple diagnostic approach based on rapid evaluation method was adapted to obtain and analyze information on a set of quality assurance indicators listed below:

- o Availability and condition of family planning service facility including human resource situation and clinical card filing boxes.
- o Recording of medical screening information on clinical card.
- o Client satisfaction - client exit interview and focus group discussion with mothers group.

Findings

- o There was no separate/private space available for counselling in all six family planning clinics (2 district hospitals and 4 health posts). The existing counselling facilities do not seem adequate and satisfactory. No separate operation theater facilities was observed in any of the four district hospitals visited. The available operation theater space is not adequate.
- o Clinic cards, where available, are not filed in filing boxes. Consequently, a systematic assessment of continuation rates for a given family planning method and client follow-up for any side effects is difficult. Continuation rate is an important element in assessing the impact of contraceptive prevalence rate (CPR) on total fertility rate (TFR) as an average. Follow-up particularly for Depo and NORPLANT clients is a critical element of quality service delivery.
- o Each F.P. clinic visited had 4-5 trained paramedical staff (HA, AHW, ANM), which seemed adequate. However, only one district hospital -- Bhairawa -- was provided with a full time medical officer for voluntary sterilization services, one of the preconditions of institutionalization.
- o While the demographic information required by the service statistic MIS (face sheet information) were found in all 60 DMPA clinical cards reviewed, recording of medical screening information -- information for the client -- was found only in 33 percent of cards reviewed (see Appendix Table B.1). Fifty-three (53) percent cards had no information on client's blood pressure, and similarly 72 percent recorded no information on the weight of client. None of the cards had information on breast feeding, an important element from both demographic and medical aspects of DMPA particularly in relation to prolonged duration of post-partum amenorrhoea (S.

for

d.

- o The exit interview further confirmed that the providers did not check B.P. and weight as fact of the routine physical examination of DMPA client. However, the clients expressed satisfaction with the services received.

APPENDIX TABLE B.1
FINDINGS OF FAMILY PLANNING RECORD REVIEW OF DMPA* CLIENTS
 Selected District Hospitals and Health Posts
 5-11 September 1992

	Name of District by Service Delivery Level									
	Makwanpur		Chitwan		Rupendehi		Kaski		Total/ Percent	
Total No. of DMPA cards	10	10	10	10	0	10	0	10	60	
Age	10	10	10	10		10		10	60	100%
Parity	10	10	10	9		10		10	59	98%
No. living children	10	10	10	10		10		10	60	100%
LMP	7	6	9	10		8		6	46	91%
Medical History	0	0	9	10		0		1	20	33%
Blood Pressure	0	0	9	3		7		9	28	47%
Pelvic Exam	0	0	0	0		0		0	0	0
Weight	0	0	0	2		0		9	11	18%
Breast-feeding	0	0	0	0		0		0	0	0
Appointment kept	6	2	3	2		0		10	23	38%

* Depotmedroxy progesterone acetate

APPENDIX F
CHILD SURVIVAL AND MATERNAL AND CHILD HEALTH
PROGRAM OPTIONS

Options reviewed by the team for future program development of child survival and MCH components of the project are outlined below.

A. OPTION 1: DECENTRALIZATION OPTION

Integration and focussing of child survival and MCH intervention in selected districts of the Central Region through district, rather than regional, public health office support.

With the lack of commitment by the GON to strengthening the regional office OPTION 1 explores a USAID program which: i) by-passes the regional office, ii) focusses and integrates child survival interventions through district public health offices, and iii) develops planning and management capacity at DPHO level.

If one assumes that integration of child survival activities is essential both for maximum impact and for managerial sustainability then the current method of selection of areas for separate child survival interventions within the CRHD support project is piecemeal and unsatisfactory. Both center and region retain a vertical mentality in the planning, implementation and budgeting of separate MCH, CDD, CHV and ARI activities. USAID could try to integrate the various inputs (from center, region and private contractor) at district level and avoid expanding single interventions into new districts before existing districts have developed the integrated package of child survival intervention.

For such a decentralized district-focussed rather than region-focussed project USAID and GON would need to agree on: i) the number of districts to be supported, ii) the selection criteria for including and/or excluding districts in the program, and iii) a realistic rate of expansion of the project over the next 3 years. Logically the districts included in this program would come from the Central Region, although future expansion might include neighboring districts in the Western Region.

Experience from many countries, and repeated donor-led analyses of primary health care and family planning services in Nepal, have come to the conclusion that the planning and management capabilities of a DPHO are perhaps the most important factor in the success or otherwise of program implementation at the health post and below. For real integration there needs to be planning of inputs at district level by the DPHO who should indicate to either regional or central level his need for technical supervision and training. In this way there would be much more effective use of human resources. Supervision visits from center or region would be multi-purpose and therefore more efficient, administration at

district level would be simplified, and training for health post staff would also be more efficient as content could be integrated to include a number of related subjects.

In the past financial year there have been significant changes in the budget release process and the integration of health program budgets at district level. In theory this will increase the power of the DPHOs to plan and manage their own programs. In practice many DPHOs lack the necessary planning and management skills to do this and central health officials will almost certainly be resistant to devolved planning of programs at district level.

It follows that the management and planning support given by USAID and its private contractor (JSI) during the course of district supervision should be formalised and expanded. This might best be achieved by hiring a local Nepali Consultant with management and planning skills in the health sector especially at the district level to act as a change agent and resource for the DPHOs involved in the program.

The JSI field office in Hetauda would continue to act as a district public health office support resource. Technical assistance could be provided as before. Release of workplan funds would be dependent on submission of district-specific rather than regional workplans.

B. OPTION 2: NATIONAL-LEVEL MCH SERVICE STRENGTHENING PROJECT

Project to work with the new Child Health Division at National Level in 2 main areas:

- o Development and testing of strategies for implementation of child survival interventions, e.g. use of F/CHVs in ARI control, effects of CDD supervision, expansion of Vitamin A supplementation.
- o Improve MCH service quality through the development of quality indicators, monitoring of district MCH service quality performance, development of innovative interventions.

USAID has an impressive record of support for operational research in Nepal which has directly and indirectly influenced national policy on child survival interventions. These activities might be integrated by linking them more formally into the new Child Health Division of the Ministry of Health. USAID should continue to provide direct technical assistance through JSI to assist this process. Discussions with GON would need to cover: i) identification of the key liaison officers at central level, ii) production of GON strategy implementation papers in CDD, ARI and Vitamin A (with USAID/JSI assistance), iii) use of funds in the 1992-93 workplan for this process. In this way USAID-supported research would have a more rapid and direct influence on national

program implementation.

At present the project supports independent activities in CDD, ARI and Vitamin A. CDD activities are currently primarily concerned with the promotion of ORS and training to ensure that health workers and mothers know how to make up and use ORS correctly. Although available data suggest that 45 percent of childhood deaths in Nepal are diarrhoea-related the Jumla study showed clearly that most of the diarrhoea-related deaths in that area were not due to dehydration. Most were due to dysentery or to persistent diarrhoea associated with malnutrition. The Project Paper states that "until better data on the relative importance of acute/watery versus chronic diarrheas are available the project will stress the widespread, correct use of ORT primarily with packaged ORS".

The work to date on CDD intensive supervision to improve ORS use by mothers should allow

- o Analysis of the maximum potential effect of CDD supervision for better ORS use on reducing child mortality from diarrhoeal disease.
- o Modifications to routine CDD training.
- o The feasibility and sustainability of this program if implemented nationally.

Further studies in CDD could examine the question of the role of chronic diarrhoea and dysentery in child morbidity and mortality and possible interventions.

The lessons from the independent USAID-supported studies in Jumla and the Chitwan study of ARI diagnosis and treatment by F/CHVs need to be summarized and built in to national program development. At present there is no approved national policy on ARI control and USAID could use its experience and influence to implement ARI policy within the new Child Health Division. Issues to be addressed include:

- o The use of CHVs or VHVs (especially in remote areas) for delivery of cotrimoxazole in treatment of ARI.
- o What are appropriate ARI training schemes for CHVs or VHVs?
- o How can the program be expanded and monitored? Can CHVs maintain supply and resupply of cotrimoxazole? Can these issues be left to the discretion of DPHOs?
- o What additional field-based studies are needed?

Policy questions also apply to Vitamin A deficiency. The ongoing USAID-supported work in Sarlahi (Johns Hopkins) and several

other districts (University of Michigan), and the Jumla study, have provided a major stimulus to ideas concerning a medium term (supplementation) and long term (nutrition education, household food security) strategy for tackling Vitamin A deficiency. The lessons from these studies have been brought into GON policy development but now need to be built into the implementation strategy of the new Child Health Division (in co-operation with nutrition officers under the new MOH organogram).

Currently USAID supports MCH service strengthening in 4 districts of the central region. Even with rapid expansion the project is unlikely to reach more than 10 districts during the lifetime of this project. An alternative approach would be for USAID/JSI to assist GON to develop an MCH service quality team either within the new Child Health Division or the new Family Health division or a combination of the two. This concept is similar to that used to develop the MCH Strengthening team at the CRHD.

The functions of this team would include:

- o Development of quality indicators for MCH at district public health office level.
- o Monitoring of district MCH service quality performance through rapid review.
- o Innovative interventions to improve service quality (e.g. quality circles, involvement of user groups, non-financial reward systems for quality improvement by DPHOs.
- o Improvement of health and nutrition education in health posts^{1/}.

Existing district level support by JSI could be built into this quality program, but the program would develop along national rather than regional priorities. Institutionalizing districts would be the first area of focus.

The GON/JSI MCH quality team might provide formal planning and management support to selected district public health offices in addition to the existing technical support. This might best be achieved by:

^{1/} Health post visits by mothers and children present opportunities for education about important topics such as birth spacing, preparation and use of weaning foods, and simple hygiene. During our field trip it seemed that health post staff rarely give health education except on an ad hoc basis, and education materials, apart from posters, are either missing or unused. Weighing of infants and children in the health posts visited during the evaluation mission was not routine, and only 1 out of 5 health posts had a routine system for weighing children and entering the weights on a Road-to-Health card. DPHO-led discussions with health post staff about health education and growth monitoring practices at health posts and mobile clinics is indicated.

- o Recruitment of a local Nepali consultant with an excellent track record in planning and management in the health sector at the district level e.g. a retired DPHO.
- o Four (4) to 6 monthly meetings of DPHOs from a particular region to evaluate progress in MCH service quality, to develop planning and management skills, to encourage innovative activities and to allow peer review.

Access to supplemental donor funds for DPHOs should be agreed with the relevant central authorities. These supplemental funds would only be released upon production of an acceptable workplan by the DPHO. In other words the existing format for regional workplans and supplemental funds would be devolved to district level.

The GON/JSI team could encourage and develop innovative activities aimed at increasing the participation of local development committees and user groups so that the DPHO is more accountable for service quality at district level.

The GON/JSI team could work with central policymakers to develop guidelines for performance appraisal of DPHOs and to consider possible rewards/penalties in the light of appraisal. Accountability of DPHOs implies that they should know the criteria for gaining and sustaining support. GON and JSI should agree their own guidelines for initiating, expanding or terminating support activities within a district in the light of DPHO performance.

C. OPTION 3: NATIONAL LEVEL FAMILY PLANNING PROJECT

Project to work with the new Family Health Division and National Planning Commission in 3 main areas (over and above direct FP inputs).

- o Co-ordination of FP/MCH inputs (e.g. EPI, MCH days at health posts) which improve the coverage and quality of family planning services, especially temporary methods.
- o Safe Motherhood service quality: outreach antenatal and perinatal care.
- o Female community health vounteers (CHVs).

If USAID were to rationalize its program by dropping regional office support, focusing on family planning issues, and expanding support at a national level through the new Family Health Division, then its support for MCH might be focused simply on those inputs which are most likely to assist family planning.

The integrated antenatal/MCH/EPI day at health posts and mobile clinics (developed during the central region MCH strengthening program) appears, anecdotally, to have increased the

uptake of temporary family planning methods ^{2/}. Within the new MOH Family Health Division USAID/JSI could provide support to:

- o Report on the existing experience in the project districts and analyse the uptake of Depo and other temporary methods at health posts where the focussed day is running: e.g time trends: Depo utilization before and after the focussed day was started, case/control: comparison of Depo utilization at health posts with and without focussed MCH days.
- o Expand integrated MCH days to all health posts across selected districts prioritizing those in which ANMs are present and active.

Support for certain Safe Motherhood interventions, particularly outreach antenatal care (and possibly perinatal interventions), could be developed from existing MCH strengthening activities along the same lines as the MCH quality project in Option 2. Such a development would need to liaise closely with other donors - WHO, UNDP and UNFPA - who are active in this area.

The CHV program is likely to be under the new Family Health division of the MOH and is therefore logically included under Option 3. The issue of greater female representation on VDCs especially by CHVs would be addressed here.

^{2/} This link between MCH days at the health posts and the delivery of temporary methods of contraception may have great potential for the institutionalized expansion of temporary contraceptive methods and an improvement in CPR. There is a strong analogy here with the dramatic changes in immunization uptake which have occurred in Nepal over the past 5 years - these were achieved by the integration of mobile clinics with provision of EPI at the health post, both being given at fixed times so that mothers knew clearly when services would be available. A similar process could be used with Depo so that mothers were enrolled into the Depo programme at the health post focussed clinic and could receive routine follow-up injections provided by the VHW at the EPI mobile clinics.