

PN-1112-755

WIND 55956

62

THE POTENTIAL APPLICATION OF
PERSONNEL MANAGEMENT TECHNOLOGY
IN THE GOVERNMENT HEALTH SERVICES IN NEPAL

000750
000186
5/10/86

A Report Prepared By PRITECH Consultant:
PETER SHIPP

During the Period:
JANUARY 5 - FEBRUARY 3, 1986

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT

Supported By The:

U.S. Agency For International Development
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:
AID/S&I/HEA: 4/6/88
ASSGN. NO: SS 109

CONTENTS

	Page
1. TERMS OF REFERENCE	1
2. THE CONTENT OF THE WORK	1
3. HMG AND ITS USE OF RESOURCES	6
Resource Allocation	6
Administrative Processes	10
The Use of Funds	13
4. DONOR AGENCIES	14
Co-ordination Between Donors	14
Training for Hand-over	15
Commitment to Continuing Support	16
5. GENERAL CONCLUSIONS	16
6. CHECKLIST FOR PROJECT SELECTION AND DESIGN	19
7. A COMPUTERISED PERSONNEL RECORD SYSTEM FOR THE DIVISION OF NURSING	22
8. STRENGTHENING THE SUPERVISION STRUCTURE IN FP/MCH	25
9. DEVELOPING A PERFORMANCE EVALUATION SYSTEM IN FP/MCH	28

THE POTENTIAL APPLICATION OF PERSONNEL MANAGEMENT TECHNOLOGY

IN THE GOVERNMENT HEALTH SERVICES IN NEPAL

by

Peter Shipp

Management Sciences for Health, Boston, USA.

1. TERMS OF REFERENCE

1.1 The mission has identified personnel administration as one of the most fundamental deficiencies in Nepal's HFP system. In order to make significant and lasting improvements in this system:

- a) how much personnel administration technology would be required, and what options are available?
- b) what related training and organisational changes would be necessary to keep an improved system functioning?
- c) would such an investment be worthwhile in the MoH? What is the nature and level of commitment required on the GoM (MoH) side to effectively promote and take full advantage of potential management efficiencies?

2. THE CONTENT OF THE WORK

2.1 It is useful at the outset to put these terms of reference into the context of the health personnel situation in Nepal. It is my impression that in Nepal the biggest problem in this area is not the lack of trained manpower, about which so much is heard, but rather the poor performance, both individually and collectively, of those trained staff who are available. Examples of individual shortcomings frequently quoted are the four-hour working days, the lack of output or achievement during this time, prolonged absences, engineered deputations to posts in Kathmandu Valley, and so on. The poor collective performance arises from lack of collaboration and co-operation between groups who are meant to be working to achieve the same objectives. It would be facile and also unhelpful to package all this as "poor morale" or "poor management", even though both of these are true. It is more useful to divide the problems into four groups:

- deputations, transfers, absences;

- lack of drive, initiative, application;
- poor skills, ability, training, knowledge;
- lack of commitment to health service objectives.

Behind these lie yet another set of factors or causes which are given a great deal of attention in official reports:

- poor physical living conditions in rural and remote areas and poor working conditions everywhere;
- low pay (other conditions of employment for permanent government staff are relatively good);
- poor or no equipment, drugs, materials, transport;
- poor or no prospect for development or career progression;
- poor or no supervision or support (lack of leadership is rarely mentioned);

and so on. Only some of these factors or causes fall within the usual definition of personnel administration.

2.2 From a technical viewpoint items 1.1(a) and (b) above call for the use of a well-established method of investigation to assess the relevant factors in such a list in the various parts of the health service in order to determine what improvements in equipment (micro-computers, card filing systems, rack storage of files, etc.) or in organisation (structure, procedures, etc.) or in monitoring and support (performance measurement, supervision, etc.) would be technically feasible, and to lay out a plan for their implementation. The main problem comes in the remaining item, 1.1(c) above - would the investment for this be worthwhile, and what changes would MoH or GoM have to make in their own ways of doing things if these improvements are to actually work well?

2.3 A broad judgement on these questions is usually made implicitly by USAID mission staff when commissioning work of this sort, based on previous experience of their own or other agencies' projects in the country. The STC may be called on for more detailed consideration of a few of the non technical aspects of the situation as they may affect implementation. However, the situation in Nepal has some unusual features which merit a more thorough consideration. In the present assignment it is the most difficult of the three items; also it is undoubtedly the most important, for two reasons. First, the effects of a personnel administration system arise not so much from its design or technology, but

from how the system itself is used. The assignments, transfers and deputations made using the current system are said to give rise to serious deficiencies in the delivery of health services in Nepal. Improvements in equipment (e.g. microcomputers), for example, may well provide quicker operation and better information but will not necessarily lead to any changes in the assignments, transfers and deputations actually made. There would be little point in helping to implement a more efficient tool whose only effect would be to maintain these deficiencies.

- 2.4 One serious difficulty I had here was in trying to establish just how big this problem is. There were plenty of references in discussions to district hospitals with three doctor posts filled but only one doctor or none actually working there, and also to other staff (usually ANMs) not willing to go to health posts in rural and remote areas. However, the anecdote usually refers to the exceptional situation - to make a good story - and can be misleading. But in trying to check the actual extent of the problem I find that the data is very thin. Official statistics of numbers on deputation are most unreliable; the data presented by Royce Jones at a Nursing Manpower Management Seminar in 1994 covered nurses in 13 districts and showed very large discrepancies between the official statistics based on personnel administration records and information obtained by visits to the 13 districts. In any case, the numbers on deputation may be somewhat misleading since there can be deputations from one health post to another. The critical question is: "how many staff of different categories are actually working at each health facility?" whatever their administrative status there may be.
- 2.5 It turned out that this is not a figure which the Centre, or Regional offices, or even District offices have readily available. The personnel records in the Department of Health Services (DHS) are designed to show which posts at a health facility are filled and which staff have been deputed away from it, but not whether any staff have been deputed into it; where the deputed staff actually are is available only from the individual personnel files themselves. In discussions, even at district level, questions about how many staff were actually at individual health facilities were always answered first in terms of sanctioned posts, then (after enquiry) in terms of filled posts, then (after further enquiry) taking account of training, deputation out, long absence, etc., but only eventually after some persistence were deputations in to the facility brought into the picture. Evidently actual staffing levels in health facilities are not seen as particularly significant by the health service managers. Further statistics from the 13 district study of nurses showed for each district the numbers present at post in health posts, health centres and DHFOs - the facilities most relevant to FHC; these averaged 61% of filled posts (52% of sanctioned posts) with the range 22-100%.

There are no comparable figures I can find for other categories of staff, particularly doctors. There has been frequent reference to "60% of doctors are in Kathmandu" but this does not mean much without a figure for how many doctors should be in Kathmandu, allowing for Centre offices, the Teaching Hospital, etc. The Health Planning Division (HPD) is collecting district profiles and has received 60 of the 75 returns; these should show what staff were actually working in each facility but data input to the HPD computer has not yet started and the information is currently unavailable. It is possible that other sources of relevant data do exist, and in the time available I simply have not been able to find them.

- 2.6 Although relevant and reasonably reliable data is available only for nurses, it does show there a situation which could be described as bad bordering on desperate. In discussion many individuals claimed, sometimes most emphatically, that the situation was worse with doctors, and that it also happens to some extent with all other grades of staff. In all that follows I assume that the situation actually is as it has been described to me i.e. transfers and deputations of staff away from posts in rural and remote areas and long absences from these posts seriously disable the health services in many parts of the country.
- 2.7 The second reason for the importance of item 1.1(c) above is the wider question of the effective use of foreign aid in the health services in Nepal. Among donors there is a growing sense of frustration at what they see as the lack of progress and results over many years, described as "aid fatigue" by Toshiyuki Niwa (on 13 December 1985 at the inauguration of the UN building). It is most desirable to review the reasons for this as they may apply to the particular case of possible developments in personnel administration. Clearly this issue goes much wider than the working location of health staff.
- 2.8 These two issues are best considered together as a larger picture in order to provide the relevant context and parameters for considering realistically the prospects for undertaking USAID-supported work to improve health personnel administration. This larger picture has two main components:
- a) HMG, and particularly its apparently sub-optimal use of the resources which are available for the delivery of health services in the country;
 - b) donor agencies, and particularly the difficulty which they have in establishing stable and robust improvements in health service delivery in the country.

These two components are inter-related and together they form the total system of health service delivery in the country. However, for the purposes of this work it is

convenient to divide this total system into a Government side or role and a Donor Agency side or role, and to consider the two separately. Although elements of this larger picture, set out below, are included because of their relevance (in my view) to the question of improvements in personnel administration here, it is likely that many of them will also be relevant to other topics and areas of work as well.

- 2.9 These elements of the larger picture provide some indications of the criteria which USAID projects in Nepal should meet, over and above the normal technical criteria of feasibility, implementability, maintainability, benefits, etc. They offer the first shot at a checklist of items which I suggest could with advantage be explicitly reviewed when any new health project is being considered by AID/Nepal. Following the consideration of this larger picture (Sections 3 and 4), and in the light of some general conclusions which I draw (Section 5) and the more detailed checklist (Section 6), it is then possible to identify some examples of potential work in the personnel administration field which (according to the checklist) have a reasonable chance of success. This leads to consideration of the more technical aspects of the assignment, items 1.1(a) and (b) above, as they apply to these examples, in Sections 7,8 and 9.
- 2.10 This whole approach is based on the following argument. The activities and developments in Health (as in all other sectors) take place within the context of a deeply-rooted culture and socio-political structure in the country. Certain factors or aspects of this culture and structure will affect what is done in health and, just as important, how it is done. Since this context is deeply-rooted and unlikely to change over the next few years, donor agencies must identify which of these factors and aspects are operating to affect their own projects. Their planning must accept these effects as constraints and limitations which are for all practical purposes fixed. Agencies should consider what is the best they can do within these constraints and limitations. It would be certainly wasteful and frequently counterproductive to assume they do not exist, or to behave as though they do not exist, or (most of all) to expect Nepalis to behave as though they do not exist.
- 2.11 One further point should be made here. In much of what follows, particularly Section 3 below, I focus on the constraints and limitations in the country, the government bureaucracy, the MoH, etc. in order to identify those areas where AID/Nepal-supported projects would have the best chance of success as measured by USAID standards. This appears to present a very gloomy view of the situation in Nepal, a view also expressed by many I met in donor agencies. There are practical benefits in focussing on the negative aspects of the current situation as I attempt to show in what follows; but my aim here is not to present a balanced view of health

services in Nepal, and this report does not do so. While the constraints and limitations in this country are very real and practical, an overall view consisting of these aspects alone ignores the very substantial advances made in the country as a whole during the last 35 years since the end of the Rana regime. In health services I believe the progress is even more striking, and the situation is very much better now than it was 20, 10, or even 5 years ago. Certainly the current services have obvious deficiencies, but these do not alter the fact that these deficient services are more widespread, more comprehensive and of higher quality than those of the past. The fact that such progress has been made in spite of the constraints and limitations here could be seen as a major positive achievement by the donor agencies active in health; it is a pity that they do not seem to take this view. Perhaps this is a symptom of Niwa's "aid fatigue".

3. HMG AND ITS USE OF RESOURCES

3.1 From the discussions I have had, three main factors have emerged which relate to the use by MoH staff of the resources available and which are relevant to this assignment. These are:

- a) the management of these resources i.e. the decisions which are actually taken about how much to allocate, where to make it available, how it is to be used, etc.;
- b) the administrative procedures which are employed to implement these decisions;
- c) the use which is made of the government health budget and of donor funds i.e. where the money actually goes to and what activities it actually supports.

Resource Allocation.

3.2 The quality of the management of the health resources in the country is a technical judgement and it is generally reckoned to be poor. (In making judgements of ability, performance, etc., here and subsequently, the standards and criteria I use are those of USAID itself, as I understand them; this point is discussed in more detail later.) Undoubtedly some of this poor management performance is due to the lack of management ability, training and skills on the part of most health staff. Apart from the obvious reasons of the lack of opportunity for most individuals here to get either training or skills, there may be another important factor contributing to the lack of management ability. The upbringing of children in Nepal strongly discourages curiosity, inquisitiveness and the questioning of things as they are. This is reinforced further in the schools where the

teacher is the absolute authority on all aspects of knowledge. By a natural extension, the textbook is also an absolute authority and most of the learning is by rote. Many people I spoke to quoted their experience of health staff who knew the theory (i.e. could answer examination questions) but could not apply it. They had not been trained in the practical use of theoretical knowledge (book-learning), nor in applying general principles to specific technical or managerial problems. Now the Western model of management is as a problem-solving activity i.e. identifying problems, hopefully well in advance, and applying management principles in order to work out solutions to them. A strong tendency to accept things as they are makes it difficult to identify a problem in advance, before it has become an actual mess. And a lack of facility in applying general principles to particular situations makes finding good solutions well-nigh impossible. Of course this will not apply to everybody in the country. People do differ. But if it is true it does mean that one can expect fewer good managers in the country by Western standards, and also that management training as it is practised in the West will generally have much less impact in Nepal.

3.3 The poorer quality of the management of health resources here, as judged by the results of the decisions actually made, is also partly due the fact that many of these decisions are based only slightly (or not at all) on technical or objective factors relating to the health system itself but are instead based mainly (or wholly) on social or political factors outside the health system. In other words, decisions are being made according to the objectives and criteria of an underlying, largely hidden, system. The practical effect of this is that (by technical or objective standards) these decisions will frequently appear to be illogical or irrational i.e. inconsistent with the publicly declared objectives of the health service. One obvious example of this is the location of staff, particularly doctors, by the operation of transfers and deputations using the good offices of powerful relations and friends, known locally as "source and force". The deputations which are made, particularly for doctors but also for other categories of staff, and particularly into Kathmandu but also to other places as well, seem to be arranged almost wholly by the use of source and force. This is particularly noticeable when His Majesty the King pays an inspection visit to an area outside the Kathmandu Valley. All staff on deputation away from this area are returned to their posts, and for a short period this has the most serious effects on the staffing of many health establishments in Kathmandu.

3.4 The point here is not that source and force is used - it happens in all countries to some extent - but it is so prevalent in Nepal that it disables the delivery of health services in many parts of the country, particularly the rural and remote areas. With such an evident, not to say blatant,

example of the operation of source and force in this underlying decision-making system, it is difficult to resist the conclusion that it operates as well for all individuals who have access to sources of force in all of the other decisions concerning individuals e.g. appointments, training abroad, and so on. The power and pervasiveness of this underlying system, and the open use of source and force, is not particularly surprising. Nepal was a thoroughly feudal country up to thirty-five years ago (i.e. only one generation ago, or two in the rural areas) and so very largely still is. Although great advances have been and are being made, undoubtedly the prospects for advancement for a mature individual today still depend almost solely on who are the relations and family friends; these are determined wholly by birth.

3.5 It is sometimes difficult to see which of these three factors - lack of technical knowledge, difficulty in applying general principles, or the workings of the underlying decision system - is operating in a particular situation. For example, some technical details of the Regional reorganisation are open to question. There is enormous pressure for HMG to do something, particularly with the impending election, and so a measure of decentralisation is understandable and even laudable. But the actual design proposed is likely to introduce problems in personnel administration which could have been avoided. One problem will arise from the replacement of the central Directorate of Health Services by five Regional Directorates each reporting directly to the Secretary. The decision has been made to divide the personnel administration of all government health employees between the Regional offices. It is difficult to reconcile this with the concept of an Integrated Health Service and a country-wide civil service of permanent government employees. Both of these seem to me to call for the central control of recruitment, posting and promotion at the very least; this is to be done for doctors but for no other category of health staff. I have picked up no indications as to why this situation has arisen and what was the thinking behind it; a case could be made for any of the three factors above. Another problem will arise from the decision to allow districts to have more than their allotted number of health posts "provided no charge falls to the government thereby". Who is to staff these extra health posts? Who is to pay these staff? What will their status be? Private practitioners?

3.6 The lip-service which is paid by many to the public objectives of the health service is general knowledge and is in effect a public statement of low esteem for these objectives; they are evidently accepted as being of little account in comparison with private or individual objectives. This attitude seems to extend further. In all my discussions I rarely picked up a sense from HMG staff of a commitment to an overall plan of action or even an aim for the health ser

VICES as a whole. There are of course strong commitments to particular and sometimes individual areas of work; this is not uncommon in any country. But rarely in my experience does the Centre come over as so divided into separate segments, even fragmented. There is no sense of overall purpose, of unanimity, of any overall coherent and acceptable guiding principle for the health services in the country and therefore no sense of a concerted drive for better health services for the country as a whole, but only at best for improvements in particular or even individual parts of it as a result of individual objectives. In most countries there is some overall plan or set of priorities, and there the individual seeks to find the most advantageous niche available. Here the niche seems to be manufactured for individual advantage (for example, positions in hospitals in Kathmandu) irrespective of any effect it may have on the overall picture of the delivery of health services in the country.

3.7 One of the effects of this lack of coherence, of consistency, of sense of purpose, and also of sense of continuity, is that the history of the health services in Nepal is littered with small projects which were successful in a panchayat or part of a District or even a whole District, but which then sank without trace except in the memories and records of the donor agencies involved. In this situation using the successful demonstration of a pilot project as the launching pad for a much wider implementation - the "working example" or pump-priming approach used by most donor agencies - does not work. Now regionalisation seems to be setting up five autonomous regions but in practice (in health anyway) divorces much of the power to make things happen from the responsibility for their effects. Although the Regions have been delegated full responsibility for all aspects of personnel administration of their staff, all other resources (drugs, materials, equipment, etc.) will in effect still be allocated direct to districts or health facilities from the Centre. I would imagine strong economic arguments (economies of scale, bulk purchase, etc.) have been put forward but this does not help to reduce the fragmentation and lack of coherence in the system as a whole.

3.8 This fragmentation works both ways. The donor system itself is very fragmented. This means that many groups in MoH are dealing with several donor agencies at the same time, each with its own schedule for disbursements, its own administrative requirements for reporting and accounting, etc. Furthermore, if some group in MoH plans to mount a sizable project, in order to increase the chance of making an impact on health status and also on the decision-makers in MoH, it may well have to get the funding from several donor agencies simultaneously, each of which will conduct separate negotiations, each of which will have its own preferred contract duration, each of which has its own administrative requirements, each of which will want its own segment to be just

ified as a separate entity according to its own set of objectives and policies, and so on. The problems of meshing together the timetables of different contract negotiations in order to get the work off to a reasonably coherent start, of setting up different reporting and accounting procedures, and so on, clearly place a severe additional workload on those motivated to do a good job. And the fact that some of these attempts will inevitably not be entirely successful or the objectives and policies of contributing agencies may be irreconcilable, means that the set-up or procedures will turn out to be deficient in some respects, and so open to criticism by the donor agencies.

Administrative Processes

3.9 There will probably be no criticism from HMG itself. There seems to be little official respect or even recognition in MoH for a job well done, and little penalty for a job done badly or not at all. There is no regular assessment of staff performance. There is a staff assessment form which should be completed each year, but this is not done. A copy is completed only when staff apply for promotion, since it is one of a number of items which are assigned scores in evaluating candidates; the total score for all these items (length of service, time spent in "difficult" areas, qualifications, etc.) determines the priority ranking of those applying for promotion and hence who is to be promoted. However, this assessment form must be countersigned by the individual concerned, and in order to avoid any unpleasantness superiors invariably award all individuals the maximum mark in each part of the assessment form. Doubtless this would also happen if the forms were completed annually. (While this method of selection for promotion does not depend on ability or performance, it is public and is strictly governed by the scoring rules; it is therefore virtually free from outside influence. However, it covers only a proportion of the promotions. The remaining promotions are selected by open competition which, I was told, is subject to source and force, although this would be difficult to substantiate.) This lack of performance assessment in any form eliminates one of the most powerful sources of motivation for staff to make a serious effort to do a good job. And since promotion does not depend to any great extent on ability or performance, there is no motivation to make the effort to do a good job unless this is what the individual chooses to do for purely personal objectives. It is easy to see how staff can slip into the habit of settling for what is by Western standards a poor level of performance.

3.10 As well as satisfying the administrative requirements of donor agencies (which well may be increasing, see below) for each donor-supported activity, there is also the question of operating within the administrative processes of the MoH

itself. All MoH activities, whether donor-funded or not, are subject to the government processes of personnel administration, financial administration, and so on. The personnel administration procedures make it possible for permanent government employees to be absent from their place of work for long periods, and the time scale for action is lengthy. If there is an official notification of an absence (which is seldom done) a number of official enquiries are sent to the place of work at intervals of 2-4 weeks; if the response to all of these is negative, the individual is put on half-pay for at least a year; if the individual is still absent, he or she is officially on leave without pay for a number of years; only at the end of this period are dismissal proceedings begun. The whole process takes about 5 years, during which time the sanctioned post is officially occupied and therefore blocked. There is also the possibility of prolonged sick leave if a doctor's certificate can be produced. I heard of a number of examples of individuals who quite legally were absent from a place of work they did not wish to go to for periods of up to 5 years, until they had secured another post in a more acceptable location.

- 3.11 Also these processes are generally slow, lackadaisical even, which is by no means unique to this country. This is partly due to the fact that they are unnecessarily cumbersome. No doubt the personnel administration procedures could be improved by a redesign which would speed them up and might also increase their rigour and reliability. Implementation of these changes would be relatively simple. It is also partly due to the technology employed; changes here, particularly the use of micro-computers, could increase the speed and power of the personnel administration system very considerably. Implementation here would require substantial investment in hardware and in training. But the current performance of the administrative systems is not caused by their design or level of technology; they could produce a much better service than they do now. It results to a large extent from lack of enforcement of personnel administration requirements (papers prepared and correctly distributed) and also to the attitudes to work of the staff who operate these systems, and here the working practices and settling for a poor level of performance (see above) is a major factor. This latter point of course is not unique to the Personnel Administration Sections.
- 3.12 Whatever the reason for the current performance of the administrative systems, they are frequently a distinct burden to the successful management of health activities. In particular, donor agencies can see themselves as suffering unnecessarily and therefore unjustly because of this level of performance. Unreasonable delays in administrative decision-making e.g. the release of funds, the appointment of staff, etc., can jeopardise a major activity; because the delay is unreasonable i.e. not explicable by objective or technical reasons, a donor agency in such a situation is

bound to get the impression that HMG does not really care and the agency's efforts and resources are held in low esteem.

- 3.13 One aspect of the operation of the personnel administration system is important here. Staff critical to the efficient functioning of a unit may be moved to positions where they are apparently far less effective. Trained staff are posted to positions where their expertise is useless, and this is sufficiently widespread to be discussed explicitly in HMG documents. While this may happen at any time, there is apparently an annual exercise in which many such moves are made simultaneously; it has been described to me as "indiscriminate transfer". This is particularly important to donor agencies when they have made a considerable investment in the training of the individual concerned. I have not been able to find any rationale for these movements, and particularly the annual exercise, only a suggestion that the custom survives from the Rana regime where it was used for a specific purpose. These movements are not the result of source and force because frequently the individual does not want the move, and sometimes uses source and force to prevent it. These postings appear to me to be done at random by the personnel administration system, but I assume this is only because I have not been able to get access to the necessary level of confidentiality. Of course some of these moves are the result of source and force initiated by the individual concerned. Whatever the underlying mechanism at work, if the individual who is moved is playing a major role in a donor-funded project, the donor agency will certainly feel that its efforts are being slighted and its resources wasted.
- 3.14 These three aspects of the current operation of the personnel administration system - low level of individual staff performance, difficulty in responding to the different and sometimes conflicting requirements of many donor agencies, and posting trained staff to inappropriate jobs - could theoretically change when the personnel administration has been passed to the Regional Directorates, but at present there is no reason for believing that it will. In four of the five Regional offices i.e. in all except the Central Region, the staff will be new to this type of personnel administration activity, since it was all previously done at the Centre. It will take some time to set up the systems of staff registers and their updating, keeping personnel files up-to-date, producing information on request from these registers and files, etc. and also in training the new staff in all these systems and procedures. The individual's approach to work seems pretty general in the country, and I would not expect the staff in the new Regional personnel administration offices to show more drive and application than those in the Central offices now. The actual evidence, although scanty, is not encouraging. I have visited one Regional office (Western Region, in Pokhara) which was set

up about a year ago. Some months ago all the appropriate personnel files were sent there, except the doctors' files; these are to be retained in Kathmandu. Nothing has yet been done with the files in the Regional office, they are simply in the care of one individual (who was absent during my visit, and I could not see the files because he had the only key to the office where they are stored).

The Use of Funds

- 3.15 Finally there is the question of how the government health budget and how donor funds are actually used and what they are actually spent on. Some parts of the government health budget are seriously underspent because the money has been used elsewhere: for example, the salary increase for health workers last year was paid for out of the drugs budget. While few would object to the salary increase in itself, many donor agencies who were already gravely concerned at the existing shortage of drugs must have experienced a sharp pang of aid fatigue.
- 3.16 Donor-funded projects are seen as a source of income by MoH staff. This income accrues formally to any who are appointed to project positions (not usual with USAID projects in Nepal, but does happen with other donor agencies) or who undertake project activities on a temporary or casual worker basis (e.g. producing translations, graphics, etc); it accrues to individuals less formally by padding (e.g. extra advisors, extra workshop staff, some trips abroad, etc.) which is to say items which are justified or rationalised on technical grounds but which would not stand up to detailed technical evaluation; and it can accrue most informally or secretly to those being downright dishonest by donor standards (e.g. bribes, theft, etc.) I have not come across any specific examples of this last item here; I assume that if it occurs it is already being combatted to the extent possible. The employment of temporary or casual workers is a useful type of patronage for the project staff who select the individuals concerned, and this can lead to results or products of poorer quality than they otherwise might have been. The remaining item, padding, could be considered as leakage of funds from the project. It is not uncommon in developing countries, in many of which it is considered to be a necessary supplement to an inadequate government salary. In effect, activities are designed by HMG staff taking account of both technical factors (output) and also income supplementation factors. Each donor agency must decide for itself where it draws the line. I have the impression that on this item things are tightening up in Nepal; one example is the reporting and evaluation forms which INTRAH is to use. In effect, the technical factors are to be given more weight in the future.

4. DONOR AGENCIES

4.1 Most of the difficulties which donor agencies experience in establishing stable and robust improvements in health service delivery in the country, and the possible reasons or mechanisms which are at work in HMG to cause this state of affairs, have already been covered in Section 3. This Section covers three points which relate to the donors themselves:

- the possibility of co-ordination and co-operation between donors to change how the system works now;
- the emphasis on designing and implementing systems which are appropriate to the financial and human resources which will be available to operate them after the project staff have left, and on training HMG staff to this end;
- donor agencies' sense of responsibility for maintaining in the longer term the systems, etc they helped to set up.

Co-ordination Between Donor Agencies

4.2 Each donor agency has its own set of objectives and policies, derived from its parent government or institution (which cover what types of activity it will support, what types of support it offers, duration of each commitment, etc.), its own set of standards (of behaviour, achievement, etc.) based on the parent national or institutional cultures, its own administrative procedures (for reporting, accounting, etc.), and so on. There is a large number of donor agencies active in health in Nepal (9 international organisations and 36 bilateral and NG organisations - at least), so there are very many different initiatives continually being offered to MoH. Because the proportion of health service expenditures in the country provided by foreign aid is so high (60%), it must be very difficult for MoH to refuse any of these offers whether or not they fit into any plan or list of priorities which MoH might have, and indeed whether or not they are actually able to spend the money. However, the donor agencies will propose projects in line with their own objectives, policies, standards, etc. Although these will differ between agencies in detail, there will be a community of interest on several major issues e.g. agencies having some improvements to show in some aspects of the health system for their resources and effort expended, maintaining resource inputs as close to budget as possible, etc. Section 3 above set out some of the possible reasons why these do not happen, and Sections 5 and 6 below consider how judicious project selection and design may help matters. But it may also be possible to move some of the current boundaries and constraints in the

government machine if sufficient pressure could be brought to bear. The benefits of co-ordination and co-operation between donor agencies is obvious.

- 4.3 The critical factor here would be deciding which boundaries and which constraints it would be worth attempting to change. For example, I would think that the operation of source and force in the underlying decision-making system is too deeply embedded, too widespread and too powerfully supported for any significant changes to be made from the outside. Since one of the major effects of source and force - deputation - was mentioned many times as a serious difficulty from the viewpoint of donor agencies, it is perhaps worth emphasising that in my view it would be a waste of both time and goodwill to attempt to do anything about it in the Health sector generally from the outside. On the other hand, it might be possible to change the annual round of apparently random postings of unwilling staff to wholly inappropriate positions. These are only two of the items which might be considered. It would be necessary for donor agencies to agree on what they were going to aim for. They would also have to agree on how much force or leverage they were prepared to apply. Threats of withdrawal would be strong, but probably politically difficult for parent governments or institutions, and effective only if the amounts involved were sufficiently large; probably one agency alone would be ignored. The WFCR, Prof. Micovic, has already embarked on a series of initiatives to promote co-ordination between donor agencies active in health, but this seems to be focussed on technical issues rather than trying to change the way the system works. The Nepal Aid Group meeting in Tokyo has just pledged \$680m over the next two years. This constitutes considerable leverage but covers many sectors other than health. I have no information on whether there is any possibility of using this particular route. What similar problems do other sectors experience? Who was the USAID representative at that meeting?

Training for Hand-over

- 4.4 If the aim of donor-funded projects is to establish stable and robust improvements in health service delivery then they must design and implement systems or processes which can continue i.e. be staffed, managed, provisioned, etc. after the project team has departed. This means that the systems and processes must be appropriate to the resources (financial and human) available in the country. There will be no positive outcome from installing a system which is too complex for the staff available to operate themselves, which staff have not been fully trained to operate, which requires data of an accuracy and completeness which is simply not available here, or whose real running costs are beyond the health budget to support. The objective of the project team therefore is not to get a system working, but to get it working in the way it will continue after they are gone. This

frequently means that the system to be implemented is not the most advanced or efficient which is technically feasible in the situation, but something less which is practical and operational in the situation. Also, since the end-point of the project is a system being operated by nationals, all the project team's activities could be seen as training and encouragement to that end. It could, for example, be a useful rule of thumb that no project team member should undertake a substantive activity in relation to the operation of a system being implemented except by way of demonstration to a national who will need to know how to do it later. As a rule of thumb it is not to be followed blindly, but it can be useful in keeping the focus of project work where it belongs. Unfortunately in my experience donor agencies, USAID included, mount evaluations which tend to concentrate on the system itself, rather than on the practicalities of its subsequent use, and contractors naturally react to these indices of performance accordingly. Also, of course, the professional interest of technical staff tends naturally to what is the most powerful even if it is the most complex as well.

Commitment to Continuing Support

- 4.5 Sometimes the attempt at closure and withdrawal at the end of a project does not work. Donor agencies can come to feel a sense of responsibility for maintaining gains which they were instrumental in achieving or systems which they helped design and set up. If this happens they may well feel obliged to give support in situations which they would otherwise not choose to do so. It is my impression that USAID is fairly free from this problem.

5. GENERAL CONCLUSIONS

- 5.1 Before embarking on the checklist, which summarises the material in Sections 3 and 4, it is useful to set out a number of conclusions which can be drawn and which apply generally, not only to possible projects in personnel administration. Some of the factors listed in Section 3, i.e.

- the use of source and force by individuals to achieve their personal objectives, particularly as regards location;
- a poor level of performance by permanent government employees if that is what they choose to give;
- the use by permanent government employers of the personnel administration system to sanction prolonged absences;
- fragmentation of the overall management of the national health system;

will continue to operate into the foreseeable future. These factors are too widespread, too deeply embedded in the government system - the everyday natural way of doing things, for them to be generally eliminated or even significantly reduced, particularly by initiatives from the outside.

5.2 There have been suggestions from inside as to how the volume of deputations and transfers might be reduced e.g.

- set a staffing limit for each health establishment (not merely a limit on sanctioned posts as now);
- all staff on deputation and long training are put into a reserve or transit pool which has a strictly limited number of places in it;
- charge the salaries of deputed staff to the facilities they work in rather than the facilities they have come from;
- all transfers in ICMSDP must be approved by the Project Chief.

The first three have the advantage of being purely mechanical devices; if they had the force of a Statutory Order, so that judgement is not involved and infringement is a punishable offence, then they would work to some extent. The fourth, being a matter of individual judgement, is unlikely to have sufficient impact.

5.3 Therefore, over the next few years at least, the current situation of permanent government employees with regard to appointments, posting, transfer, deputation, absence, commitment, individual work performance and overall health systems management will continue more or less as it is. I have not been able to obtain much reliable data on the extent of the distortion which each of these processes causes to the planned distribution of the permanent staff, and nothing on the actual effect on the delivery or impact of health services of the resulting staff shortages, levels of individual performance, system operation, etc., although anecdotal evidence is plentiful and opinions are very strong. Assuming all these do seriously disable the service, then I cannot see any reason to suppose that this will change over the next few years. No amount of investment in equipment, drugs, supplies, transport, organisation, systems, procedures, supervision, etc. will compensate for the non-delivery of services for any or all of the reasons above. Therefore, as I see it, there are no better prospects in the next few years than there have been over the last few years of getting useful results from donor investments or support designed to make general or widespread improvements in the services delivered by permanent government employees; these include hospital services, integrated health services, and

the offices at the various levels designed to manage them. If AID/Nepal's view is that these services currently do not merit its support, then my conclusion would cast serious doubt on, for example, a project designed to introduce new technology and skills to all Personnel Administration Sections in the Moll. It does not preclude finding particular situations where stable and robust improvements are possible. It is the identification of these particular situations which the checklist can be used for.

5.4 However, the outlook is not completely dark. This general conclusion does not apply to those segments of the health services which are delivered mainly or wholly by development staff (and not by permanent government employees) i.e. the Vertical Projects except ICHSDF. The development staff are administered wholly within a Project whose administrative rules can be somewhat flexible, so special arrangements can be made (e.g. temporary promotions) which are impossible in the formal government system. In addition, control over these staff is very much stronger because most of them are on annually renewable contracts. (Some are on life-of-the-project contracts but there is now a strong pressure to convert these to annual contracts.) This combination of stick and carrot appears to be very effective. As I understand it, the staff go where they are posted and stay until they are moved. In addition there appears to be a much stronger sense of mission and coherence in the Vertical Projects and their service delivery activities in the non-integrated districts. Individual performance matters, is noted, and appropriate action (reward or punishment) is taken. Although source and force must still operate, in this context its effects are very much less. Investment in or support for these activities would not suffer the crippling effects of the four factors listed in para. 5.1 and the prospects for stable and robust improvements are very much brighter. What improvements can be implemented will of course depend on the individual objectives of the Project Chief. In addition, other factors noted in Sections 3 and 4 will still operate and individual projects should still be considered in relation to the checklist given below.

5.5 Also there are distinct possibilities for improvement in the longer term. For example, the main reason why the filled posts in the rural and remote areas are not manned is that students, particularly ANMs, are selected for training on the basis of their qualifications (meeting the course entrance requirements) and many of them come from the larger conurbations. When their training is finished it transpires that they cannot or will not go to where the work is. An alternative approach would be to focus on individuals who would be prepared to live in the rural and remote areas where staff are required, e.g. those who already live in these or similar places, and to see what training such individuals could be given and what health services they could then deliver. Undoubtedly the educational standards

of these individuals would be lower, and perhaps the amount of training they could absorb would be less, so the health services they would deliver would not be those currently planned for district hospitals, health posts, etc. However, the relevant comparison is not with what health services are currently planned but with what is actually delivered. If this approach would lead to fully staffed health posts, the services they would provide might be a good deal better than those currently available from seriously understaffed health posts. Such an approach is already being implemented in DoN; the more capable TBIs now undergoing training are to be offered further training with a view to assigning them to local health posts to deliver MCH services. There is no technical reason why the same approach could not be considered for other categories of staff who do not take up their assigned posts in rural and remote areas. The underlying principle here is that since the attempts over many years to solve this location problem have been unsuccessful, it might be a good idea to accept it as a given constraint and to ask what is the best which can be achieved within its limitations. This is a particular application of the general principle set out in para 2.9.

- 5.6 Another possibility relates to the implementation of the Decentralisation Act. For the last four years or so, since District Finance Offices were set up, money approved centrally in detailed budgets for each district is remitted to the district and disbursed against these budgets. With the Act in force, a District Health and Population Committee proposes the health activities it wants, from which a selection is made to be covered by these budgets. Thus there is the distinct possibility that District Committees will begin to ask why so much of the District health budget is going on staff working full-time in Kathmandu or elsewhere and who are never seen in the district. They will also have the muscle to do something about it via their annual proposals for the health activities to be undertaken. This will put pressure from inside the system on deputations and prolonged absences. This is not to say that doctors will actually go to fill all the medical posts in the district hospitals; I expect many of them will find Bhutan or the Middle East more attractive. But it does raise the possibility that the districts will press for something to be done; they may even suggest something along the lines of the previous paragraph.

6. CHECKLIST FOR PROJECT SELECTION AND DESIGN

- 6.1 This checklist is based on the material in Section 3 and para. 4.4. I do not assume any general relaxation of current boundaries and constraints by the operation of the co-operative processes mentioned in paras 4.2 and 4.3, and I restrict myself to specific changes or commitments which might be negotiated with IMG in relation to certain individuals.

6.2 The checklist items, marked Ch below, are each related to one or more items in Section 3, marked It below. Some are by no means novel, but all are included here for the sake of completeness. For the purposes of example only, each checklist item is applied to the possibility of supporting the development of a Computerised Personnel Record System (CPRS) in the Division of Nursing (DoN). The use of the checklist on a number of possible developments in personnel administration is described in Sections 7, 8 and 9 below. Each of these three Sections describes one possible application of the different types of development in personnel administration i.e. improvements in equipment, in organisation, or in monitoring and support (see para 2.2). These developments are suggested for the Department of Health Services (DoN) and for a Vertical Project (PP/NUH).

CHECKLIST

1. It Perhaps because of upbringing and schooling, many Nepalis find management based on problem-solving and applying general technical or management principles to particular situations is difficult for them.
Ch The more general management requirement is important for whoever in DoN takes a leadership role in the project work on the MoH side, and the more specific application requirement will be important because computers are to be involved and systems analysts/programmers/computer operators will be trained and used. In both instances it is important to establish the capability of the individuals concerned to be able to perform in these two specific areas.
2. It Decisions are strongly influenced by the underlying socio-political system which allows personal or individual objectives to be given a higher priority than health service objectives.
Ch 1. Seek to select situations where staff have already demonstrated or can demonstrate a strong personal commitment to the type or area of work proposed. In personnel administration, the Division of Nursing (DoN) has already demonstrated this commitment.
2. With the agreement of the individuals concerned, seek an undertaking from HMG that those who are critical to the success of the work will not be moved for a specified period which will be related to the work content and its planned schedule. In this case the individuals concerned would be at least Miss Rukhmini Shrestha, Chief of DoN, and the computer staff. I must confess I am not sure who in HMG can give this undertaking, nor how binding it will be if senior

staff move. What would AID/Nepal do if the agreement were broken?

3. It There is little recognition given within MoH to a job well done or poorly done, and staff can settle for a poor level of performance if they choose to.
Ch Seek evidence of a willingness to work in the day-to-day situation on the part of all staff working on the project, and particularly the critical staff. There is this evidence for Miss Shrestha. It would be required for the systems analyst/programmer and the computer operator(s).
4. It The Centre is fragmented.
Ch Select projects which do not straddle contentious boundaries between major groupings. Locate them wholly or mainly either in powerful groups or alternatively in groups which are unthreatened (and usually non-threatening). The DoN is in the second category.
5. It There is a lack of coherence, of consistency, of sense of purpose and of sense of continuity in the overall management of the health services.
Ch Do not base the project on the assumption that a successful demonstration in one area would be followed by implementation elsewhere. The project should cover DoN only. Do not consider supporting other Personnel Administration Sections until checklist items 1-3 above have been met. (This is not to say that such a comprehensive implementation will not come in time, but rather that it would be unrealistic to consider including it in a formal project workplan in the near future and expect a contractor to be committed to producing results.)
6. It MoH administrative procedures are slow and unreliable, and they frequently find it difficult to meet the different requirements of multiple donor agencies simultaneously.
Ch 1. Set up the CPRS so that the updating information does not come from the personnel administration system or its paperwork.
2. If possible, set up the project so that it is centrally funded by USAID. Under present arrangements this means that the flow of funds takes place direct to the project (as in the current INTRAF work). This gives the project a much better service.
7. It The government health budget is under severe pressure and new activities are difficult to fund.
Ch If at all possible, establish the recurrent costs of the system in the regular health budget before the project support officially comes to an end.

Get the running expenses of the computer system (paper, ribbons, diskettes) into the routine budget before the AID/Nepal support is scheduled to stop. If the major work on the project is fairly short and will finish before this can be done, plan the project to extend beyond this point with support only for maintaining operations for a reasonable period in order to achieve this objective. This is the most which can be done. There is no protection against subsequent major budget changes.

8. It Planning what project activities are undertaken, when, and by whom is based on a combination of technical criteria and their effects on MoH staff incomes.

Ch AID/Nepal must decide where it wants the balance between these two sets of factors to lie, and what recording, reporting and monitoring system is most likely to achieve it. It is theoretically possible that this decision would affect the commitment of MoH staff to the work and even who would work on the project.

9. It Projects should be focussed on implementing systems which will continue to operate and also on training nationals to operate them.

Ch 1. Systems should be designed taking account of the difficulty nationals have in effective problem-solving and applying general technical principles to particular problems. The CFRS should use one of the well-documented data base management packages currently available e.g. dBaseIII.

2. Wherever possible, the substantive activities of project staff in developing, installing, running in and operating the system should be undertaken as training activities for nationals.

3. The project should include provision for designing and testing a self-teaching package for the training of staff who will subsequently replace those involved in the implementation. This will include complete documentation of the CFRS system.

7. A COMPUTERISED PERSONNEL RECORD SYSTEM FOR THE DIVISION OF NURSING

7.1 About two years ago the DoN started on the computerisation of the personnel records of all nurses employed by HMG. At that time DoN was responsible for all aspects of nurse personnel administration and held all the personnel files for nurses; it was in effect a straightforward exercise which has been implemented successfully in many other countries.

All nurses were asked to complete a bio-data form which included a thoughtful and well-selected set of items:

- Name
- Sex
- Year of birth
- Marital status
- Permanent residence
- Date of joining MoH
- Work location
- Date of start at this work location
- Title of present assigned post
- Date of start in present assigned post
- Major function
- Educational level achieved
- Most advanced course in nursing/midwifery completed
- Name and country of school where this course was taken
- Continuing education courses completed after basic education

As these completed forms were returned they were coded and entered into the Apple II+ microcomputer being used by DoN. The computer also holds:

- Listing of all sanctioned posts at all levels for nursing personnel
- Listing of all personnel in sanctioned posts and on deputation in all districts
- Listing of all unassigned nursing personnel

It can produce statistics on nursing manpower by level and by Region, Zone, District, geographical region and development area.

7.2 Updating the information on work location and present assigned post was to be done by producing and sending each month to each "supervising office" a list of the nurses who should be (according to the computer records) in the office's area. Any changes would be marked on the list, which would then be returned to DoN for updating the records. Updating the other items of information (marital status, qualification) is more difficult, but in any case these items change only very infrequently compared to the others. The CPRS was to be used to support all aspects of nurse personnel administration at the Centre, both general (using statistics of nursing staff by category, facility, district, region, etc.) and individual (using individual records). It was also designed to provide up-to-date lists and statistics to Zonal and District Offices. All this work, particularly the system design and computer programming, was strongly supported initially by AID/Nepal staff (Royce Jones), then by JSI staff (Binny van Bergen and Richard Owens), and latterly by UMN staff (Audrey Naud). One computer operator, Miss Sara Gurung, an ANN, was trained by Royce Jones; a second ANN is now also working as a computer operator.

7.3 There were problems during implementation, of course. Use of the system was suspended when the Health Planning Department moved, together with its computer which the DoN had been using. It was resumed when HPD received a new computer and the old machine went to DoN. It was suspended again for five months while there was no electricity supply to the DoN building and the machine was moved to JSI. As the amount of information in the system has increased, the slow speed of operation of the current computer and printer has become more and more of a penalty. The amount of hardware also increased; there are now six disk drives connected to the computer. With about 80% of the nurses covered, the present system is already at its limit. The computer is also being used for:

- TBA registration in 17 districts;
- records of TBA trainees;
- compilation of a household survey in Doti District;

and, of course, word processing. Doubtless these uses would expand with a more powerful system.

7.4 In the last few months there has been a major change in the functions of DoN. With the advent of regionalisation, the responsibility for getting posts sanctioned, recruitment, transfer, deputation, promotion, etc. has been passed to the Regions. The personnel files of the nurses in the West and Middle West Regions have already been sent to the Regional Offices, and more will be sent to the other two new Regions when they are set up. Although as far as I know no decision has been taken, I would assume that the files for the nurses in the Central Region will stay with DoN, which will also retain national responsibility for setting standards of nursing care e.g. staffing levels, contact with IoM, selecting staff for continuing and post-basic education, and research. While it is unusual for a CPRS to be operated separately from the corresponding personnel files themselves, the circumstances of this country make it a perfectly reasonable thing to do. The usual reason for keeping the computer and the files together is that the paperwork related to the personnel decisions provide the updating inputs to the computer. In this country much of the paperwork does not seem to reach the files, if indeed it was ever produced, so an alternative source of updating inputs would have to be found in any case (see checklist item 5.1). The current system is already being updated by DoN staff taking printouts for correction to districts which they are visiting or through which they are travelling for other purposes. Although this updating procedure seems somewhat ad hoc, again it seems a very reasonable thing to do given the communication and other difficulties in the country.

7.5 A CPRS would still be most desirable, to produce the general statistical information required centrally, and also the

individual information for inservice training, etc. It would also be the best source of comprehensive information on nurses for the Regional, Zonal and District Offices. This would require strengthening the current system by:

1. Procuring a more powerful microcomputer for DoN; this was also recommended by Richard Owens (End of Tour Report, p.35).
2. Transferring the existing data into dBase II or, preferably, dBase III format so that the power of these packages could be used without the need for extra programming. This would go a long way to meeting Richard Owens' recommendation that the DoN system should be in a form useful for other categories of staff, without investing detailed design effort in an all-embracing system at this stage.
3. Setting up a self-sufficient Computer Unit within DoN comprising at least one senior member of staff as systems analyst/computer programmer to fill the role currently played by Audrey Maud, and two computer operators (as now). This would require shifting an existing post or sanctioning a new one.
4. Arranging for the training of Computer Unit staff.
5. Negotiating with HMG that these staff will stay in post at least until the system is in normal day to day operation.
6. Documenting the system completely, and producing a set of self-teaching texts for the use of subsequent Computer Unit staff members.

These items would of course need to be worked up in much greater detail before the proposal could be evaluated by AID/Nepal.

8. STRENGTHENING THE SUPERVISION STRUCTURE IN FP/MCH

- 8.1 A two-week training of Intermediate Supervisors in the FP/MCH Project is planned for August-October this year with INTRAH support. However, there would appear to be a weakness in the organisational structure above this level. While each Intermediate Supervisor supervises 4-5 Panchayat Based Health Workers (PBHW), the Family Planning Officer (FPO) in the district is expected to supervise 16 Intermediate Supervisors on average. At present this supervision consists of the Intermediate Supervisors coming to the District Office during the last week of each month in order to get the FPO's approval for their next month's workplan. This is clearly less than the situation calls for. The currently planned training is being given to the Intermed

iate Supervisors because their skills are weak and they will need strong supportive supervision after the training. Moreover, the supervision of FBHMs would be much more important in the future if there were to be a shift of emphasis in FP activities from sterilisation to temporary methods of birth control; these will require more sustained effort on the part of FBHMs and therefore more effective supervision from the Intermediate Supervisors. The simplest solution technically to filling this supervision gap would be to introduce a new level consisting of 3-4 staff in each district between the FPO and the Intermediate Supervisors, so that each FPO supervises these 3-4 new staff, each of which would in turn supervise 4-5 Intermediate Supervisors.

8.2 A major question arises as to the financial feasibility of this suggestion. It is apparently out of the question to fund 3-4 more posts at this level in each district. There would appear to be two main possibilities. First, if the number of Intermediate Supervisors in each district were reduced to, say, 12 so that each supervised 5-7 FBHMs, then enough money would be available to employ 3 of these new staff in each district, each of them supervising 4 Intermediate Supervisors. The flexibility in a Vertical Project would allow this to be done. Presumably these new posts would be filled by promotion of the more able Intermediate Supervisors. This would mean that the supervision load of each Intermediate Supervisor would increase on average by one third. Alternatively, there are already about 4 Clinical Supervisors in each district, whose jobs might be extended to cover the supervision of Intermediate Supervisors. This would neatly avoid the financial burden of extra staff. An experiment along these lines has been under way in one district for about four months. However, it appears to consist only of Intermediate Supervisors reporting each day to the Clinical Supervisors to enter in a register what their activities for the day will be; this is hardly the supportive supervision required. The main question here is whether the Clinical Supervisors would have the time and the ability to supervise properly the Intermediate Supervisors as well as the clinics. If they have, they would need training for this new activity, as would Intermediate Supervisors promoted to the new positions, although the content of the two courses would be different.

8.3 A potential project here would consist of:

1. Investigate the feasibility and relative merits of the two possibilities in para. 8.2, and others which may arise, and recommend how to strengthen the supervision of Intermediate Supervisors.
2. When the decision has been made, produce a job description for the new posts and design a training course for the new staff, both in collaboration with the training staff in the Project.

3. Plan and schedule the implementation of the new structure in all districts covered by the Project.
4. Design and carry out an evaluation of the performance of new staff in collaboration with the training staff of the Project. Adjust the job description and training course where necessary in the light of the results.

8.4 Turning now to the checklist, what factors would be critical to the success of such a project? With little or no knowledge or experience of the individuals and field situation involved, I can do no more than pose the questions. They must be answered by USAID staff and/or by a more detailed investigation of the situation.

1. Capability of critical individuals. The individuals concerned here are the Project Chief and one or more of the Project training staff. AID/Nepal staff have had a long working relationship with the Project Chief. Presumably the INTRAH staff have some experience of working with the Project training staff.
2. Personal commitment of these individuals. From two discussions with the Project Chief it is my impression that his commitment to this work would be high.
3. Willingness to work. Presumably the answer to this for the Project Chief is well known to AID/Nepal, and the INTRAH staff have experience of working with the Project training staff.
4. Groupings at the Centre. The work is located within a Vertical Project and does not straddle contentious boundaries. It does not involve recruiting new development staff, which could give rise to objections from elsewhere.
5. Lack of coherence and continuity. The proposed work is not to set up a demonstration but to implement the new supervision structure in all districts covered by the Project. Should the AID/Nepal support cover the start up only or implementation in all districts?
6. Effect of MoH administrative procedures. The procedures within the Vertical Project are rather more flexible than those in MoH. Financial administration would presumably be governed by the bilateral agreement, so it would be an advantage if this work could be centrally funded.
7. Allocation of government funds. Once the salary effects of the new structure (e.g. increases for Clin

ical Supervisors or salaries for new posts) are in the budget, they are at equal risk with all other items if, for example, the increase in IFMG funds does not keep pace with the requirements of the bilateral agreement.

8. Staff income from project activities. This item does not refer to any explicit salary supplement from USAID to Project staff. When planning project activities there is a balance struck between technical factors and income enhancement for Project staff. AID/Nepal must decide where it wants the balance between these two to lie, and what monitoring and control system is most likely to achieve it.

9. DEVELOPMENT OF A PERSONAL ASSESSMENT SYSTEM FOR FP/MCH STAFF

- 9.1 Because of the flexibility of personnel administration within Vertical Projects, it is possible to post, promote, reward, select for training, and discipline staff on the basis of their performance. There are of course many advantages of running an organisation this way, and in order to gain these benefits it is necessary to have a personal assessment or evaluation system which will provide the information on individual performance. In discussion with the Project Chief of FP/MCH the use of this approach to personnel management was raised. Here, as everywhere, the performance information would be of two main types - quantitative and qualitative. In principle the quantitative information is easier to specify, to collect and to use. The information of this type used at present consists mainly of activity rates or volumes in relation to targets; this item would also include instances of disciplinary action taken. The qualitative information depends on individual judgement and so is more difficult to specify and to obtain reliably. Also it is usual to find that the proportion of qualitative information in the personal assessment increases with grade up the hierarchy, so a new system is easier to design, implement and use for the lower grades. This is unfortunate since theoretically such a system (as with Management by Objectives, or any other target-oriented system) is best designed and implemented from the top down. In this situation, theory should be relegated to its correct position and implementation should start at the lower levels - say Intermediate Supervisor and PBHW. This would support the better supervision and performance aimed for at these levels.
- 9.2 Within the time constraints of this assignment there was not sufficient time to investigate this possibility sufficiently to be able to substantiate a recommendation as I would have wished. The issues and factors which need to be considered, and the information I was able to obtain, are as follows:

1. Although the decisions for which this information

would be used have been specified, it is not entirely clear at this stage who makes these decisions to post, promote, reward, etc. and therefore who would require access to what information about whom. It was suggested that the Project Chief would need the assessments for staff at the Centre (but presumably not all of them), the Regional offices (Regional FPO, Admin. Officer and his senior staff, Senior PHM, Health Educator), and the District offices (FPO, Admin. Assistant, Accountant and Storekeeper); i.e. spanning three levels. Similarly the Regional FPO would need the assessments for staff down to Intermediate Supervisors (and presumably Clinical Supervisors), and the District FPO for all staff in the district. These statements would have to be tested by an investigation of who makes what decisions. The results would determine what information has to be kept where and therefore what the channels of communication must be, and also how frequently the information must be collected.

2. The information on activity rates and volumes is already collected and used. There is always a question of how accurate this is; if it has been found adequate for management use, I assume it will be adequate for performance assessment as well.
3. The current targets for each district are based on an arithmetical division of the national targets according to district population, taking no account of local culture, ethnic groups, etc. While such targets might be acceptable for the comparison of performance within a district, this would certainly lead to difficulty in comparisons between widely separated districts. No doubt a method of producing more realistic targets could be devised, but its justification would rest to only a small extent on its potential use in performance assessment.
4. Quantitative performance measures (activities and targets) for certain types of staff e.g. Admin. Officers, accountants, health educators might be quite novel in this country, which would make their acceptance more difficult. This is an added reason for starting with Intermediate Supervisors and PBHs.
5. Qualitative items for performance assessment will require careful elucidation and definition; this will not be made easier if there is a language gap between consultants and FP/MCH staff working on the development. One possible starting point would be the government performance assessment document and the handbook which doubtless goes with it.
6. Apart from the question of ensuring that the assessors do understand what it is they are looking for and are

able to recognise it as well, there is also the issue of how open they are prepared to be. Closely connected with this is the important decision of whether the individual sees his or her assessment. There are arguments both ways, but the issue may be determined by the bureaucracy or the culture; it may in practice be unavoidable that the assessments are countersigned by the individual.

9.3 There are still too many unknowns in this situation for me to be able to offer a draft outline for a project here, but the questions to be addressed are pretty clear:

1. What decisions will the performance assessment information be used for, and by whom? Therefore what items of information (quantitative and qualitative) would be useful?
2. Which of these items relating to activities or behaviour can be collected (recorded and transmitted) reasonably accurately and reliably? How should they be collected? How should they be stored?
3. How should targets or standards be specified in such a way to encourage useful activities?
4. How should the implementation be phased? In what sequence should the different categories of staff be covered (e.g. from the top down or from the bottom up)? What sequence of districts/offices? How will this timetable be affected by the introduction of new categories of staff (e.g. as suggested in Section 8)?
5. What training of staff will be required to implement the new system? How is this training to be designed and tested? How does it fit into the timetable?
6. Which individuals will be critical to the design and implementation of the new system? How does the proposal score on the checklist?