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**DEPARTMENT OF STATE**

3670096 (3)

PD AAD-026-C1

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FROM - KATHMANDU

SUBJECT - FAMILY PLANNING - PROJECT NO. 367-11-580-096

43p.

REFERENCE - M.C. 1025.1

NONCAPITAL PROJECT PAPER (PROP)

Country: Nepal

Project No.: 367-11-580-096

Submission Date: June, 1970

Original: X (Supersedes TOAID

Project Title: Family Planning

A-200, 7/28/69)

U.S. Obligation Span:

FY 68 through FY 73

Physical Implementation Span:

FY 68 through FY 73

Cross Life-of-Project Financial Requirements:

U.S. dollars: \$2,778,000

U.S.-owned local currency: \$3,546,000 equivalent

Cooperating country cash contribution: \$ 868,000 equivalent

Total \$ and \$ equivalent \$7,192,000

Attachment: Table 1 (2 pages)  
Planned Technicians Services

PAGE 1 OF 37 PAGES

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~~Mr. [Name]~~ \_\_\_\_\_

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## I. PREFACE

This PROP has been written to describe the progress made in the early years of USAID family planning assistance to HMG and will extend only into the foreseeable future, that is FY 71-73.

It has been deliberately limited in duration with every expectation that USAID will continue support beyond this initial period. The local situation has too many variables and unknowns to justify any further projection into what is expected to be a very long term program. The Family Planning Program is young and growing rapidly and we simply cannot plan the details of the program five years ahead.

The key document in family planning in Nepal is the Five Year Plan. ~~The rewriting of this PROP was delayed until the completion of the five Year Plan~~ because many of the details of our program will be governed by the Plan. Although we made a major contribution to the preparation of this document, the Plan is not a USAID document. It is, however, the document which will guide the FP & MCH Program - and us--these next five years.

However, it was decided not to make the PROP co-terminus with HMG's Five Year Plan, because of the uncertainties and flexibility of that Plan. Although the Plan is probably too unreliable for prediction, some of the projections included extend past the end of the PROP to take advantage of the thinking and planning that have been done.

In many respects, AID's population program in Nepal is the host government's program. We provide approximately 75% of the FP MCH Program's operating and construction budget, virtually all of the FP MCH Program's contraceptives, and nearly all participant training. AID technicians give advice and assistance in almost every FP MCH Program undertaking, from policy planning to clinical training, to warehouse management. The accompanying chart will illustrate the areas in which AID is involved.

There are two crucial differences between our project and the FP MCH Program. One is that as advisors we have no line function in implementing the programs of the FP MCH Program. The other is that while the goal of the FP MCH Program is to stabilize Nepal's population between 16 and 22 million within thirty years, AID's is to assist in establishing the organization that can do this.

This second distinction is quite important, and is basic to much of the current philosophy regulating aid to LDCs. In daily operation, however, the distinction blurs, since an advisor must assume and work toward the host government goals, in order to achieve his goal of building a strong organization staffed by competent technicians.

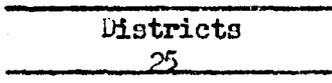
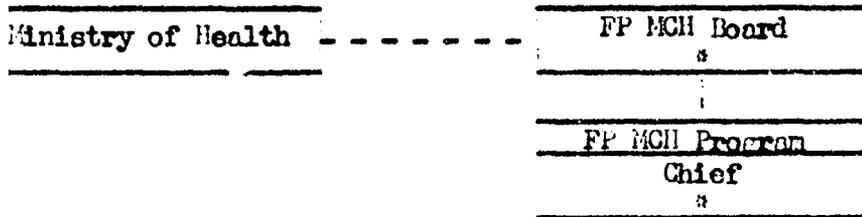
This PROOP will delineate our presence in the family planning effort in the following ways. First, quantitative tables will show various USAID inputs. Second, a table will be included illustrating the placement of AID advisors. Third, during the description of the FP/ACH Program, we will indicate those areas upon which we intend to put particular stress.

We will also delineate those areas in which we are not satisfied with the official host government program goals and will describe how we are working to effect change to our satisfaction in those areas.

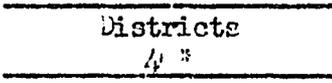
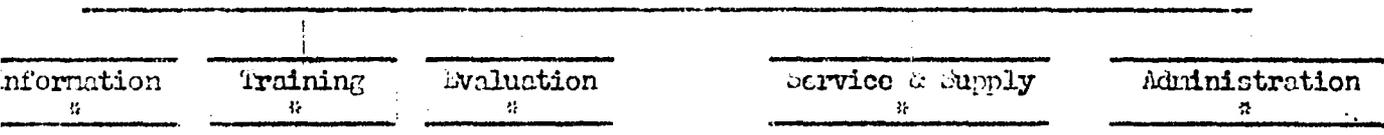
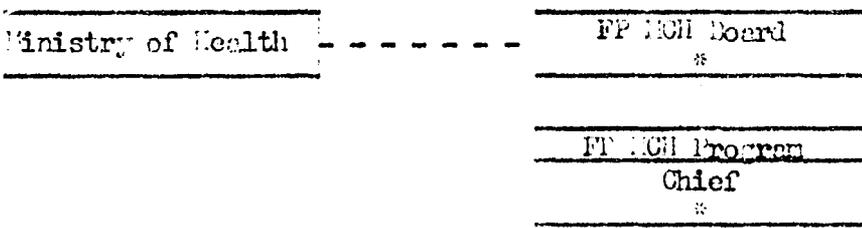
In writing the PROOP in this fashion we hope to do justice both to our deep involvement in the government program itself, and to those quantities, and particularly qualities, which define the AID presence in the family planning effort in Nepal.

\* = USAID Advisory Assistance

PRESENT



PROJECTED



## II. GOALS AND STRATEGIES

The major portion of the PROP which follows will describe in detail ING's Family Planning and Maternal and Child Health Program and the part that USAID expects to play in the planning and implementation of that Program. This section will state in broad terms the main objectives and strategies which USAID has been and will employ.

The ultimate population goal of the FP & MCH Program as contained in the Fourth Five Year Plan is to limit population to between 16 million and 22 million within thirty years. The goal during the next five years is to have 351,000 couples, or 15% of the married fertile couples in Nepal, practicing family planning.

The goal of Zero Population Growth (ZPG) by 2000 A.D. was accepted by the Board but without fully understanding the implications. From program and cultural viewpoints it is unrealistic and A.I.D. sees little chance that this overall target can be reached unless major changes occur.

The first basic strategy is that we are advising and urging the FP & MCH Board, and His Majesty's Government as a whole, to adopt a firm, strong population control policy. We think this policy direction, stated frequently and unequivocally, and acted upon to the full extent necessary, constitutes an essential ingredient in the plans to limit the population of Nepal to an acceptable level. The course of action in this connection will be two-fold. First, USAID will determine in detail what is involved in achieving ZPG. With the help of TDY specialists, the staff will investigate and study a variety of combinations of contraceptive programs and their effect on the population growth rate. From these facts and projections, the Board will be able to see clearly what is entailed in reaching ZPG and can either redefine their long-term goal or change the pacing of their intermediate objectives so that the two are consistent. Secondly, USAID/1 will marshal the facts about the ability of Nepal to support its projected population in relation to its likely increase in resources, and to present these facts in a way that makes sense to the opinion makers. Here again specialist assistance on TDY will certainly be required.

Second, Mission strategy is to help build an organization capable of slowing population growth in Nepal. The Mission has found it necessary to work very closely and in detail with the FP & MCH Program to achieve this aim, since experience and expertise in family planning programs was almost completely lacking in Nepal. Courses of action include enhancing

the capabilities and quantity of current headquarter's staff through day to day work and special training programs, here and abroad; advising in the development of a staffing plan for the districts suitable to Nepal; and in the selection and training of that staff.

This need to rely heavily on non-professional staff leads to the next strategy of concentrating on methods of contraception which do not require a medical technician for their administration. The course of action here deals with the distribution of oral contraceptives by non-professionals and pressing for widespread distribution systems for pills and condoms.

Another strategy is to promote the wider and more intensive use of vasectomy. Although this method does require the services of a physician, our course of action is to encourage the more efficient use of scarce physician time through more efficient scheduling and utilization of air support wherever indicated.

A final strategy is an emphasis on discovering means outside the FP & MCH Project to encourage the use of family planning throughout the country. It is our estimation that the problem is so severe, and its solution so difficult, that other organizations and individuals should be enlisted in support of the efforts of the FP & MCH Program. Courses of action include discussions putting emphasis on commercial retailing of contraceptives, as well as other non governmental schemes outlined in the MOP. We are also investigating the potential of other government organizations to help in family planning. As described in Section VII of this MOP, major emphasis is also placed on integrating family planning and population materials into the nationally prescribed school curriculum.

In summary, the basics of our program are an effort to get the FP & MCH board and line to adopt a strong population control policy, and act upon it, an intensive, broad advisory effort to build a strong organization, the structuring of a program to rely to a great extent on non-medical promotion of family planning and distribution of contraceptives, and an emphasis on discovering and encouraging support for family planning from organizations and agencies other than the FP & MCH Program.

### III. DESCRIPTION OF THE SETTING

The population of Nepal is approximately 11 million. The great bulk of this population lives in isolated villages, almost all of which can be reached only by foot over mountain trails. Well over 90% of the people in Nepal find their primary employment in agriculture, and only 9%, centered primarily in the cities, are literate.

For the purposes of this general discussion, Nepal can be divided into two distinct geographic areas. The fertile strip of land running the length of Nepal's southern border, geographically part of the Gangetic Plain and comprising only 9,265 square miles of Nepal's 54,362 square miles, is called the Terai. North of the Terai and extending to the border of Tibet is the area known generally as the Hills. Although great ethnic and geographic diversities exist within the Hills, the area itself can be considered, with the exception of the Kathmandu Valley, as the poor cousin of the Terai.

Two thirds of the people of Nepal live in the Hills, but only 40% of the food grains are grown there. Correspondingly, the one third of the population living in the Terai produces 60% of Nepal's food grains. The Terai, therefore, is a food excess area while the Hills suffer from a food deficit. Due to a lack of buying power in the Hills, most of the food grains produced in the Terai are sold across the border to the neighboring Indian States of Bihar and Uttar Pradesh.

The transport and communications systems in the Terai, while still underdeveloped, are better than those in the Hills. The Terai is criss-crossed by numerous bullock cart paths, and an expanding network of motorable roads. To date there are only three finished roads of any length in the Hills: The Tribhuvan Rajpath connecting the Kathmandu Valley with India; the Arniko Highway linking Kathmandu with Tibet and a road from the Indian border to Pokhara, the Siddhartha Rajmarg. The U.S. is helping to finance the construction by HMG of a road from Dhangarhi to Dandeldhura. Almost all commercial air services also lead from Kathmandu to the Terai, not to the Hills.

Efforts are being made through the Ministry of Food and Agriculture to increase agricultural production, but, again, most progress is being made in the Terai and in the Kathmandu Valley. The hills, for the very reasons that make them a food deficit area, are less susceptible to the improvements of modern agriculture.

Nepal's infant industrial sector, which accounts for only 8 percent of the GDP (FY 1969), is located almost exclusively in the Terai and the Kathmandu Valley. At this point it does not seem as if enough progress can be made in this sector to offset the problems facing Nepal's basically agricultural economy (68 percent of the GDP in FY 69) and the imbalanced distribution of the population between the Terai and the Hills.

Compounding all of these problems, and threatening to neutralize the significant progress being made in other sectors is, of course, the population growth now occurring in Nepal.

As Nepal's environment relates to the establishment of a national family planning program, there are several sets of problems which must be taken into account.

The first is the severe disadvantage of adverse topography. The absence of roads to serve the major portion of the population of Nepal creates grave problems of supply and communications. This factor also hinders the progress of other development efforts - education, agriculture, industry - that have a favorable effect on an individual's desire to limit family size.

Second, there are few trained personnel to work in the FP & MCH Program. At present it is simply not possible to assign more than a few doctors full-time to the Program. In the hills, where the health services provide only one doctor to every 200,000 people, Maternal Child Health and Family Planning will receive only a small part of the doctors' attention. Heavy reliance must be placed on nurses, assistant nurse midwives, and paramedical workers for the implementation of the FP & MCH Program. As these personnel are also in short supply, the Program is giving short-term training to men and women with no medical or health background and utilizing them in its widespread program.

Moreover, the universal problem of persuading medical and paramedical staff to serve the rural areas is even more pronounced in Nepal than in other developing countries. Kathmandu certainly isn't very cosmopolitan, but the amenities of running water, vehicular transport, electricity, and the presence of certain fashionable sets, not to mention the more important factors of reasonably decent hospital facilities, well stocked pharmacies and the promise of a fairly lucrative private practice (MIG starting salary for a physician is about \$50 a month) inevitably draw the Indian or Western trained Nepalese doctors and more sophisticated paramedics toward the capital city, even at the risk of taking extended leaves of absence from assigned hill posts. And for those that do stay in the field, the isolation, the strain of attempting to change a traditional society, the lack of basic conveniences, encouragement from outside, and of substantial material remuneration, drain the morale of many medical and paramedical workers.

Despite this list of problems facing the FP & MCH Program in Nepal there are a few positive indicators. First is the willingness of the government to set up the Maternal Child Health Family Planning Board, thereby signaling high level government support for the program and providing the basis for an efficient administrative structure. Second,

despite the positive social value placed on a large family, a substantial number of people in Nepal seem to be interested in family planning and eager to try it. In fact, in many places the demand for family planning seems to be ahead of the Program's ability to provide services. The shortage of arable land, the disappearance of forests, and the daily anxiety of providing enough food for many mouths are the too obvious reasons to the people of Nepal for limiting family size. This is most apparent in the Hill areas where personnel are few and service most difficult. People have frequently walked for days to take advantage of distant clinics. When vasectomy camps and contraceptive distributors have been helicoptered into remote areas, they are usually swamped with acceptors. Therefore, the immediate problem is to establish family planning and MCH centers, where feasible, and to serve other areas with mobile teams.

#### IV. ORGANIZATION

##### A. Board

The policy deciding group for USAID's IP & MCH Program was designed as a high level, inter-ministerial, semi-autonomous Board.

This Board was established early in 1969 and initially was under the chairmanship of the Minister of Health. Members were: Director of Health Services, Secretary of Ministry of Finance, Secretary of Ministry of Education, Chief of the IP & MCH Program, USAID Population Officer, USAID Family Planning Project Coordinator, and WHO Representative.

However, during 1969 the membership changed significantly. The chairmanship was given to a physician with high seniority, who later became Director General of Health Services. The Secretary of Health, Program Chief and Advisors from WHO and USAID continued as members. However, the Ministries of Finance and Education are now sending under secretaries to represent them.

The "semi-autonomous" nature of the Board changed. Because of the separate budget within the "development" schemes, the Board had greater freedom to pay special allowances to their staff. However, regular appointment to the staff was still subject to approval from the Public Services Commission and being one of "development schemes," staff were not appointed to permanent positions, unless they already had tenure as a result of previous service with some other government agency. The appointment of the Family Planning Board Chairman as Director General of Health Services has raised a number of new issues. The Chairman is concerned with the role of the regular cadre of officers within the Health Services since the Family Planning Program is receiving the lion's share of the increased health budget. This is evidenced by his attempts to spread some of the special pay

advantages of FP staff to the regular medical officers and other "integration" plans he has set in motion. Admittedly there are many ways in which such suggestions can benefit the FP & MCH Program. It has to rely on medical staff for many of its functions across the country. And in the recent past, cooperation has not been universally strong. The FP & MCH Program can also gain some benefits from the service and supply system of the Health Services that has long been established.

Therefore, USAID strategy is to support the negotiations and initial planning of the integration effort so that the FP & MCH Program can share in the integration decisions. USAID/N will stress, however, that the effectiveness of the FP & MCH Project should not be diluted or diverted from the primary goal of reducing the national growth rate. The cooperation of the health directorate, from top to bottom, is essential to the attainment of that goal. What may appear to be a sacrifice (perhaps, rupees for special payments for overtime work) or backward step (perhaps some reduction in the authority initially granted to the non-medical district family planning officers) may possibly lead to more rapid progress toward the goal. However, AID's concern must be to safeguard the FP & MCH Program so that it does not lose its effectiveness.

The other prong of the strategy regarding the Board is to help it regain its prestige. This can only be done by raising the rank of participating members. This is a high priority goal for FY 1971.

The course of action has already begun. The desirability of such a step has been discussed with the Director General of Health Services and the Program Chief.

#### B. Budget

We would like to see an increasing proportion of expenditure for FP & MCH come from HMG sources. However, we believe first priority should be given to a build-up in the size and quality of the Family Planning Program. During this build-up period, we would expect HMG to pay roughly the proportion of operation costs which it paid in FYs 1969 and 70 (i.e. roughly 25%). Since the costs of the Program are increasing fairly rapidly HMG will be increasing the absolute amounts of rupees during the lifetime of this PROP.

#### C. Building

Planning for the FP & MCH headquarters building began last year and land has already been purchased in the center of Kathmandu. USAID/N is providing the architectural and engineering services of an American firm in order that the building be of high quality and functional and, at the same time, have a style that is essentially Nepalese.

D. Headquarter Staff

The goals that USAID is pursuing in regard to headquarter staff have to do with both quality and quantity. Progress toward the stated objective for the first two years of helping the FP & MCH develop and staff an organization capable of mounting a nationwide family planning program has been satisfactory. The program, previously almost limited to the Kathmandu Valley, has spread into 22 other districts. In order to cope with this additional responsibility the central headquarters staff has increased from 20 in January 1969 to 63 as of April 1970, and further increases are scheduled during the 4th Five Year Plan period. Category changes are given in Table I.

TABLE I

	Jan. 1969	April 1970	July 1971	July 1973	July 1974
Chief	1	1	1	1	1
Deputy Chief		1	1	1	1
Tech. and Non-Tech. Gazetted Class III Officer	8	14	19	22	23
Tech. and Non-Tech. Non-Gazetted Class I Officer	3	14	15	35	46
Tech. and Non-Tech. Non-Gazetted Class II Officer	3	14	13	35	46
Tech. and Non-Tech. Non-Gazetted Class III Officer	5	19	22	40	46

The USAID strategy continues to support the strengthening of the headquarters staff. This includes an increase in numbers, possibly more rapidly than pictured in the Five Year Plan. If the program is to do an adequate job of initial and refresher training, especially if more field work is to be included in training, the training center needs more staff. In order to adequately expand the mass information and community education programs, that section needs additional personnel. If the evaluation section is to undertake ad hoc or continuing surveys, in addition to overseeing and analyzing the routine reporting, that section must have more people.

Quality of Headquarter personnel needs attention. As the FP & MCH Program is a very young program and staff do not achieve tenure through it, since family planning is in the development budget, recruitment has been almost entirely of very young staff. In some ways this is good. Youth usually allows for more flexibility and adaptability, qualities which are highly desirable in this new program. On the other hand the background of experience is weak and prestige of position is lacking.

The courses of action in this regard are two. First USAID exerts its effort toward strengthening the capabilities of the dedicated staff which have chosen to work for the program. At the same time we help in the search for the right type of people with experience and prestige who would increase the effectiveness of the Headquarters staff.

At least one additional category of staff is desperately needed right now. Systematic supervision of the District Officers has not been provided for in the Plan. Currently this function is partially carried out by occasional visits to the districts by the Chief of the Program, the Deputy Chief, Section Heads, and by USAID Advisors. Each may have his own viewpoints to promote and few are prepared to give across the board supervision and support. Furthermore, the visits are often fleeting in nature and follow-up communication is almost nil. Another central staff member may visit sooner or later, but there is no mechanism for one person to follow-up and build upon what another has done previously. Furthermore, travel to the far reaches of the kingdom is difficult and expensive.

The course of action to remedy some of these difficulties is to develop the position of Zonal Officer for Family Planning. Hopefully this person will be a physician who can help to untangle some of the difficulties that have arisen in attempting to interject a non-medical family planning officer into a system where the medical officer previously had complete authority. The ZFO would need to have special training which would equip him to supervise, support and be of real help the district officer. He would have to be willing to keep on the move between his districts.

In this way, supervision would be closer at hand, would be channeled through one person, and would therefore be more consistent in quality and quantity. The first of the ZFOs should be in position within a few months.

Under the proposed contract AID will provide 2 advisors for field operations and supervision, one a population generalist and the other a public health nurse.

E. Field Staff1. Supervisor Cadre

This has been discussed in connection with headquarters staff.

2. District Officers

District Family Planning Officers are similar to what the Peace Corps calls A.B. generalists. They do have a college degree and had 4 months of training here in Kathmandu. A few of them have had paramedical training and some have had previous work experience. In recruitment an attempt was made to select candidates from as many of the program districts as possible so they would know the local language and customs.

The DO has responsibility for the family planning and MCH activities within his district. Chief among his functions are to:

1. supervise and direct the family planning staff,
2. keep accounts of expenditures, such as purchase of supplies and payments to physicians for vasectomies and loop insertions,
3. collect and forward figures on clinic attendance, acceptors and other family planning activities,
4. be responsible for the publicity and educational campaign, including meeting panchayats and other groups,
5. arrange for physician services for the MCH and family planning clinics,
6. order and keep track of supplies, and,
7. persuade shopkeepers in surrounding villages to stock and sell pills and condoms.

Originally the MCH Program plan called for such an officer in each of the 75 districts. They were to be phased-in over a period of three years. However, the Draft Five Year Plan included only 40 posts for DOs with 15 new posts to be filled next year in addition to the present 25 posts. The budget for the coming financial year has finances only for the current 25 positions, but the additional 15 will probably be added in the following year. Essentially this delay in expansion allows for a more thorough development of work methods and consolidation of effort.

The new budget does allow for an increased number of health aides and auxiliary health workers so that each DO will have a large team within his district.

The current DOs are posted for the most part in the Terai and low valleys where the population is normally concentrated in good agricultural areas and communications are more satisfactory. However, population pressure, or the numbers of people per unit of arable land, and demand for family planning seem to be less in these areas than in the Hill areas.

USAID strategy concurs with the strengthening of the work in the most populous districts. By the time the next 15 districts are to be added, the census and other surveys will provide data on the basis of which additional posts can logically be selected. Meanwhile we will encourage an intensification of mobile team effort for family planning education and services in the Hill areas. This will entail a more systematic use of air support, the need for which is elucidated in Section VI.

During the coming year of consolidation, USAID will encourage the establishment of demonstration or pilot projects. This might be as small an experiment as to put one DO under the jurisdiction of the local Ministry of Health doctor to see if relationships and program can be facilitated. Or it might be a major experiment such as posting one Health Aide in every population group of 5,000 or 15,000 in a district to see whether concentration of effort is more cost-effective than the dilution of present staff pattern. Another experiment might involve the greater use of male personnel for motivational work in contrast to the very heavy predominance of female staff presently planned.

The other emphasis which USAID will encourage is that of more systematic follow-up of acceptors, ensuring their greater satisfaction and the use of satisfied customers for motivation of others.

### 3. Other Field Staff

Currently the FP & MCH Program employs quite a variety of field staff including a few public health nurses (PHN), diploma level nurse-midwives (RN), Auxiliary Nurse-Midwives (ANM), Auxiliary Health Workers (AHW) and Health Aides (HA).

The nation as a whole is extremely short of the first 3 categories but the supply will increase in FY 73 as larger nursing and ANM classes are graduated and those who are in India for training begin returning.

The FP & MCH Program is in the favorable position of being able to create new posts to absorb newly trained personnel for which the health services have no budget. However, since the persons are often required to live in isolated places, the unwillingness of the better trained staff to be assigned to remote areas forces the Family Planning Program to place greater reliance on lower cadre staff.

The present and projected position in regard to field staff is depicted in TABLE II.

TABLE II\*

Category	FY 70		FY 71 FP & PHD		FY 72 FP & MCH		FY 73 FP & MCH		FY 74 FP & MCH		FY 75 FP & MCH	
	Health Services	FP & MCH Program	Expected Available Recruits	Cumulative Total								
PMN	11	5	0	5	0	5	3	8	4	12	5	17
RN	149	1	6	7	8	15	30	45	30	75	30	105
ANM	149	8	10	18	20	38	30	68	40	108	40	148
AHW	?	22	15	37	10	47	10	57	10	67	10	77
HA	?	90	130	220	100	320	100	420	100	520	100	620
TOTAL		126	161	287	138	425	173	598	184	782	185	967

\* Revisions will be made in this table when the attrition rate for different categories can be estimated accurately.

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## V. TRAINING

It is an accepted fact that training of personnel is essential to the smooth functioning of any program. This is especially true in a new type of program such as family planning. Even the professionals involved, such as doctors and nurses, need additional training because most of them graduated before family planning was part of the curriculum. The more recent graduates need briefing on the peculiarities of the Nepal program.

It is patently very essential to train the non-professionals, such as District Officers, Auxiliary Health Workers, Auxiliary Nurse-midwives, and Health Aides. Their training in family planning and maternal and child health need not be very long but should include basic facts about bacteriology, child health and development, the physiology of conception and pregnancy, the various methods of contraception, clinic management, home visiting and community organization. In addition to facts, they need to develop skills in talking with people about child health and family planning, in cultivating the local leadership, in essential record keeping and in various procedures of the clinics.

The training section of the FPC/CH program has had great difficulty in performing its functions. It has suffered from a frequent change in leadership and from inadequate staff. The USAID training advisor has not been well and had to leave 6 months early. These factors have made it impossible to adhere to the training plan. The Center has not been able to develop a practice field, except for the several clinics established in the Kathmandu Valley so that most of its training has been didactic, with little practice of skills.

Therefore, one USAID high priority target is to see that the Training Center is adequately developed and staffed. More dynamic and effective leadership is needed and several staff additions need to be made. Recently a PIH has been assigned to the Center, which is a good step forward. The Program Chief had agreed to advertise for the post of Social Scientist for the Center, but more recently has suggested that an anthropologist assigned to the education section work part-time in training. In addition, several positions need to be created for field work supervisors so that a practice field can be developed and trainees can be given a heavy dose of practical work during their initial training. One possibility being suggested is that enterprising DOS be assigned this job. The Training Center should be adequately staffed by early in FY 72. USAID/W is in the process of recruiting a replacement for the training advisor who has recently been transferred to L/ medical complement.

Objectives in regard to the training of personnel have been delineated in the draft Five Year Plan. Courses have been projected for each year in an attempt to give initial training to the number of new recruits that will be required and at the same time conduct refresher courses for staff already in the field. In addition, provision has been made for special training courses in family planning for health service personnel, and for workers in other government ministries. Table III indicates the extensiveness of training activities planned for the next 5 years.

In addition to the training courses conducted, the Training Center staff will work with other training centers run by the Health and other ministries. This will include help in teaching large blocks on family planning in the nursing, ANM and ANM schools. It will also involve lectures or programs in the training courses conducted by other ministries and seminars held at the University.

TABLE III

	<u>No. of Candidates</u>				
	2027 FY 71	2028 FY 72	2029 FY 73	2030 FY 74	2031 FY 75
Dist Officer initial training	10*	20	0	15*	0
Dist Officer refresher training (workshop)	25	40	0	40	40
Health Aides initial training	100	100	100	100	100
Health Aides refresher training	50	75	125	125	200
ANM orientation	15	10	10	10	10
ANM refresher	22	37	50	57	67
ANM orientation	10	20	20	20	20
ANM refresher	25	18	38	58	78
Doctors Seminar	/	/	/	/	/
Nurse seminar	/	/	/	/	/
Office staff orientation	/	/	/	/	/
Workers in other Ministries	/	/	/	/	/

\* Replacement training

/ No. of candidates not yet determined

Another training function of the USAID advisor and the HMG Program Chief is that of recruitment, selection and briefing of the large number of Participants which USAID and HMG expect to send abroad in the next few years. The largest group of participants will be the 40 women who will go to India for training in nursing and auxiliary nursing schools each year. Although similar schools are functioning in Nepal, it will be years before their output can meet the needs of the health services. Therefore, it is necessary to rely upon third country training for the preparation of the major portion of the nursing staff that will be needed by the FP Program.

In addition to this basic field staff and the non-professionals being trained at our training center, persons who are expected to take positions of leadership in the Program are scheduled to go to USA for short or long-term training. The largest number of participants is scheduled for FY 1971, including those being sent for training in demography, population planning, population education, newer family planning methods, and research and evaluation. These are listed by year in Table IV.

TABLE

	FY 71	FY 72	FY 73	FY 74	FY 75
Academic training for Central Staff	10	4	1	1	1
AMN, India	20	20	20	20	20
RN, India	20	20	20	20	20
3 month seminar for administrators, US	6	6	6	6	6
3 month clinical training for doctors, nurses, US	6	6	6	6	6
1 month leadership seminar, Asia	5	5	5	5	5
3 month Technical training, nurses, Pakistan	10	10	10	10	10

In summary, we would say that the highest priority in training is the staffing and development of the training Center. Only to the extent that it has competence, will it be able to train the large numbers of field staff required by the FP & ICH Program and adequate training of the field staff is essential if the Program expects to enlist the desired number of committed acceptors.

#### VI. SERVICES AND SUPPLIES

By the end of FY 70 there will be 60 Family Planning maternal Child Health Clinics in 25 districts throughout Nepal. According to the Five Year Plan, the target for 1975 is to have established 260 clinics in all 75 districts of Nepal (1971 - 100, 1972 - 140, 1973 - 180, 1974 - 220, 1975 - 260). However, budget reductions in 1971 have reduced the FY 71 year's target to 80 and it is likely the future targets will also be reduced.

Despite the probable reduction in number of clinics the following modest goals stated in the Five Year Plan can still be met:

<u>Fiscal Year</u>	<u>Target No. of additional FP acceptors</u>
pre 71	22,000
71	21,000
72	42,000
73	65,000
74	88,000
75	<u>113,000</u>
TOTAL	<u>351,000</u>

UNL has encouraged the Program not to break down targets as to method of family planning, but to encourage interested couples to use a method suitable to their situation. It is difficult to estimate discontinuation rates in a country where little accurate information is available. However, if we presume that 75% of those who become acceptors continue to practice some effective family planning method, this would mean that by 1975 about 10-12% of married couples would be protected.

This modest acceptor goal probably means that the birth rate will fall by no more than 4 to 5 per thousand. Given the expected fall of the death rate, however, the net growth rate in 5 years will probably be close to what it is today.

In order to assure the achievement of these goals, and possibly their over achievement, USAID generally supports the following policies.

- A. The position and policies on the various family planning methods are as follows:
1. Pill: The pill is rapidly gaining popularity in Nepal. International adverse publicity regarding the hazards of pills is known in Nepal but it has not produced much resistance, either official or private, to their use. The Mission is encouraging limited studies on the pill including a Pap smear study. Despite some potential problems related to the use of the pill, both HMG and USAID support a liberal pill distribution policy because of the overriding need to slow down the population explosion and the absence of suitable alternative programs. (The dangers of pill use for a woman are much less, obviously, than the risks of child birth.) Among the reasons for popularity of the pill in Nepal are:
    - a. Availability of pills in adequate quantities any working day of the week at all FP Program clinics and at many Department of Health hospitals. The pills are easily included in the routine of post-partum check-up at MCH clinics. Free pills are available at FP Program clinics to those who can't afford to buy them.
    - b. Availability of pills at commercial outlets. These pill outlets assure easier availability to patients at a price they can afford. Contraceptive outlets for pills are established in village stores if the following conditions are met:
      - 1) The area served by the store must be so isolated that it is unreasonable to expect persons in the area to visit a FP MCH clinic to obtain pills.
      - 2) Both verbal and written instructions for customer use and some knowledge of contraindications and side effects must be given to the shopkeeper.
      - 3) The shopkeeper must be sufficiently intelligent and responsible to understand and pass on these instructions properly and he must be capable of maintaining simple records on his sales.
      - 4) The District Officer or his staff must be able to make periodic checks on the shop and arrange for an effective resupply channel.
      - 5) The shop must retail at HMG official price or below.

2. Sterilization: Vasectomy is supported by the 20 rupees (\$2.00) payment for doctors by the Program. No payment is given to patient or motivator. The FP Program has had success with mobile-air vasectomy teams. When teams arrive by the helicopter, they attract great attention and produce swell of social support "to get that vasectomy done now." This appears to be a most useful technique that appeals to the crisis minded Nepalese who usually are isolated from any medical care. The Mission supports expanded use of the helicopter for mobile vasectomy teams.
3. IUD: A serious problem in Nepal is the decline in acceptance of IUDs. A study has been done of doctors to see if they were biased against the IUD, but the respondents showed no such bias. However, there are other reasons which appear significant. The problem appears to be a mixture of frequent patient complaints due to bleeding and cramping, suspicion of women and their husbands as to the insertion procedure, and, finally, the lack of female doctors to carry out insertions. (Most women insist that the loop be inserted by a female.) The Mission is actively encouraging insertion by paramedicals through participant training programs for Nepalese nurses at Downstate Medical Center in Brooklyn, and also in Pakistan. The Mission advisory staff has succeeded in getting an unwritten policy allowing nurses after training to perform IUD insertions. It does not appear, however, that the number of IUD insertions will increase dramatically in the foreseeable future.
4. Condoms: There is almost no commercial distribution of condoms outside Kathmandu. The burden for establishing a commercial system falls on the Program. The Mission is supporting a system of condom retailing using existing shops, usually the same ones that sell pills. They buy wholesale at 1¢ per dozen condoms and sell at 5¢. These shops are supplied and supervised by the new district officers and his staff. Free samples of condoms are also given at the time of mobile camp programs. The Mission supports the condom program through supply of all condoms for the FP Program.
5. Injections: The Mission has encouraged the testing in Nepal of the injection methods which show promise as effective and safe contraceptives. The Program has ordered and received Depo-provera from Upjohn Co. for limited clinical testing, but has not started the study yet.

## B. Clinic Management

USMID Advisors will insure that new clinics are located prominently and conveniently within the area they are serving. USMID advisors will also make efforts to improve the operating efficiency of the clinics, including reporting and filing, accounting, use of personnel, and provision of services to patients. Clinic personnel will be shown how to be more customer, or patient, oriented; the hours of the clinic will be determined by the needs of the patients, and clinic personnel will be trained to be prompt and helpful. Service people in Nepal tend to be lordly rather than helpful, and indifferent rather than interested. USMID will try to insure that clinic personnel in Nepal do not follow this pattern. Clinics will also be kept very clean at all times. Two Field Operations Specialists will be hired on an institutional contract to help in clinic management.

## C. Access or Follow Up

A greatly expanded follow up of acceptors will be initiated. The purposes of this policy will be to discover sources of dissatisfaction with the various family planning methods, encourage longer continuation with the loop, pill and condom, and cultivate satisfied users as promoters.

## D. Mobile Teams

More effective use will be made of mobile teams for vasectomy and other methods by better scheduling, more extensive advance promotional activity, and longer stays or return visits of the team to provide acceptor follow up work.

## E. Maternal Child Health

Almost all the children who are brought to FP/CH Program clinics are sick, and FP/CH Program staff and supplies are frequently involved in curative work. This is only realistic where other facilities for treatment are not available, but efforts will be made to use these FP/CH Program clinics primarily as standard child health clinics with emphasis on growth, development, and preventive medicine and to be sure that whatever service is provided be aimed at increasing acceptance of family planning.

The place of nutrition in ICH clinics will be reconsidered. In some clinics powdered milk is distributed, but we have no knowledge of its effect on child and family health or on family planning practices. The Program has just hired a doctor with special nutrition training. He will help in the reconsideration of nutrition in ICH and will assist in designing and implementing new programs, in the establishment of pilot projects, and selection of new products for distribution.

USAID frankly has serious doubts, however, about the advisability of attempting to establish an extensive nutrition program. The prime function of our program is fertility control. We do not want to overburden a still infant structure designed to support this prime function with supplementary - but secondary - programs. Experience in other countries has taught us that the problems of training technicians for nutrition programs, instructing villagers to use strange foods, and accounting for bulk supplies should not be underestimated. Moreover, the problems of storage and distribution in Nepal are formidable indeed. Most goods are carried by porter over mountain trail. Condoms and pills are small and light but we are still struggling to develop an efficient system for their distribution. It is simply not realistic to consider a national nutrition program in Nepal for another five years, at least.

#### F. Distribution Through Commercial Channels

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In addition to the retail scheme described on page 21 above, investigations will also be made during 1970 into the possibility of supplying major wholesalers in Nepal with condoms for distribution down through the wholesale network into the retail system and to final user. The advantage of this system is that there are only a few wholesalers in many areas supplying a large number of retailers, and the FP ICH Program, or USAID, could consequently put supplies in at only these few points for automatic distribution down to large population groups.

#### G. Incentives

Incentives are not given to acceptors at present. There are no present plans to change this policy, nor is USAID recommending a change.

Physicians do, however, receive twenty rupees per vasectomy and five per loop introduction.

USAID is exploring with B&G various incentive schemes, e.g. USAID will urge the FP ICH Program to establish some sort of a prize system for outstanding family planning workers.

## II. Supplies

The FP ICH Program at present stocks 300 items, making warehousing, transport, record keeping, and resupply cumbersome and inefficient. USAID will encourage a reduction to major items only in the FP ICH Program's stocks.

USAID will insure that more efficient storage and stocking be practiced in the new warehouse, which is to be completed in FY 1971.

In all probability, beginning in FY 1971 all oral contraceptives will be purchased in India with rupees. It is also possible that condoms will be purchased in India with rupees. Procurement of these Indian commodities during FY 1971 will be carried out by the Mission. Beginning in FY 1972 it is hoped that the FP ICH Program will take over the procurement of contraceptives and other supplies from India.

As the District Officers get established and are better able to gauge their operations' supply needs, a system of regular indent (ordering) and distribution for delivery will be developed.

## I. Air Support for Family Planning

The availability of STOL and helicopter services is an invaluable component of the Family Planning Program. In terrain where motorable roads are so few and walking so difficult and time consuming as in Nepal, air support not only is a tremendous saver of Advisor time, but makes visits to population areas possible which would otherwise be neglected.

There are three main uses for air support of the Program:

1. Transporting USAID advisors and their counterparts to the distant places where district offices have been established. Although most of these stations could be reached by road during most of the year, trips would entail 2 or 3 days of hard and dangerous driving both ways.
2. Delivering supplies to some of the more inaccessible districts when some untoward delays or unexpected demand would damage the Program. Although the development of truck and porter or commercial air service supply system is being encouraged, there will always be emergencies when only the STOL or helicopter can save the day.

3. Providing mobility to service teams, and possibly the advance promotional workers. STOL and helicopter lifting of vasectomy teams into the difficult to reach Hill areas can make possible a much more efficient use of professional time with the surety of greatest pay off. These teams are willing to walk from one site to another, but getting them to and from a general area could help the Program raise its vasectomy goals to a great extent.

For several months we have been discussing the feasibility and desirability of having available a larger and faster helicopter. This would be of special value when teams need to be transported. Although the initial cost would be high, operating cost could be lower, as load would be increased and flying time be cut approximately in half. Further savings would accrue in going to some of the places to the north, since detours for refueling could be avoided.

However, the crucial issue is the documentation of the need for this additional capacity. When this is ready, we can proceed further.

#### III. INFORMATION AND EDUCATION

During the Fourth Five Year Plan period the Information and Education Section of H.G.'s Family Planning Maternal Child Health Program will have two basic programs. The first, a mass program, will be directed towards the general Nepalese population. The second will be geared toward opinion makers and government leaders.

The USAID's Social Science Advisor will be primarily responsible for liaison and coordination work in the USAID program to integrate family planning and population materials into school curricula.

Finally, USAID is encouraging the FP-CH Program to begin a program of local leader and community education.

##### A. The Mass Program

The mass program will have three phases, described below.

##### 1. Motivation - Spacing of Children

Primary motivational emphasis will be placed on spacing of children, in order not to come into direct conflict with the high social value placed at present upon having a large family. Four

benefits of spacing will be stressed: the health of mother and the greater possibility of education for the children, the economic benefits of having to feed fewer mouths, and the labor benefit of having a strong, healthy and non pregnant wife.

These motivational messages will be conveyed through the radio, wall paintings and posters, low literacy level publications, and some direct mailing.

This phase will begin in FY 1971 and continue through the entire Plan.

## 2. Contraceptive Methodology

The four methods of pill, loop, vasectomy and condom will be explained.

The media will be radio, direct mailing, and low literacy level publications.

This phase will begin six months after the commencement of Phase I and will continue through the Five Year Plan.

## 3. General Environmental Education

This program will consist of simple colloquial instructional messages in these five areas: nutrition, maternal and child health, ecology and conservation, human reproduction, and sanitation and public health.

The media will be radio and publications.

This phase will begin in the second year of the Five Year Plan and continue through the Plan.

## 4. The Opinion Maker Program

There is a great need for enlisting the active support of opinion makers, and policy makers, for family planning. This program will attempt to inform these persons of the fact and consequences of the population explosion in Nepal, to inform them of the FP MCH Program's activities, and to get these persons, finally, to act positively for the benefit of the FP MCH Program.

This program will use press releases, direct mailing, newspaper and magazine advertisements, and exhibitions, films, and lectures.

The program will commence with the beginning of the Five Year Plan, and will continue through the Plan.

The first phase of this program, already undertaken, is the identification of opinion and policy makers in Nepal. Among these would number civil servants, elected and appointed panchayat leaders, the press corps, university professors, popular artists, businessmen, and royalty.

C. The Education Program

The Mission Social Science Advisor is presently working with the Mission Education Division, the Ministry of Education, and the U.S. Peace Corps in the innovative Science Teaching Enrichment Program (STEP). In this program a complete reform of secondary school science teaching is being attempted. The Social Science Advisor is working to integrate into this program over the next several years a complete curriculum of population education.

The USAID Social Science Advisor will also begin in FY 1971 to work with the Mission Education Division and the Ministry of Education to include population education in primary school science curricula.

D. Local Leader and Community Education

The program of Local Leader and Community Education is based on several well founded assumptions.

First, given the skepticism and at times suspiciousness of the villager, and the closed, narrow intellectual and social environment in which he lives, it is difficult to have new ideas and practices adopted by him. It is doubly difficult for a stranger to the village, as many of our family planning personnel of necessity are, to encourage successfully the adoption of new practices and ideas. Second, a respected member of the village - what we term local leader, both formal and informal - stands a much better chance of success in encouraging the adoption of new ideas and practices than does a stranger. Third, person to person interchanges are the most effective means of changing attitudes and propagating new practices and ideas within a village.

We plan that two approaches toward achieving fertility control will grow from these assumptions. First, family planning personnel working at the district and village level - District Officers, Health Aides, ANMs and other staff - will cultivate active support for family planning among local leaders. Depending on the situation the local leaders contacted may be elected officials, school teachers, elders, retired Gurkha soldiers, formal or informal leaders of caste, neighborhood or occupational groups, or those respected for their learning, wisdom and humanity. These leaders in turn will speak to their fellow villagers about family planning. Hopefully a multiplier effect will thus be achieved in the spread of information about and use of contraception.

Second, family planning staff at the district and village level will make home visits on those most in need of family planning services. Records will be compiled on the number and sex of children in each family. In many areas this information is already available at the local malaria eradication office. Home visits will be made on the basis of the records.

We are aware that these two types of approaches are extremely difficult to implement. We are also aware, however, that these approaches can probably be the most effective long-term means of increasing the use of contraception.

We therefore believe that during FY 1971 these two approaches must be initiated, evaluated, experimented with, and expanded. A participant is being sent to the US under the FY 1970 program to learn techniques of Community Education.

VIII. EVALUATION AND RESEARCH

The main focus of the Evaluation Section is to establish a systematic flow of accurate information into and out of the Section. This has been especially difficult in light of insufficient centrally placed staff plus insufficient and poorly trained field staff. The accurate and conscientious preparation of relatively complicated records and reports is outside the normal experience of most Nepalese engaged in this task.

The strategy of USAID in helping to solve this basic problem has been to focus major attention on the training of District personnel in the techniques and skills of accurate and systematic record keeping. Focus has also been placed by USAID on trying to keep the evaluation system from becoming even more complex. This strategy will be continued at least until field personnel can become familiar with and handle the evaluative procedures presently required of them.

Central staffing has continued to be a severe problem. The Section Chief has been away on study leave during the past year, and other staff have been plagued by illness and personal problems which have hampered their effectiveness. Strategy in solving this problem has been to encourage people already assigned to the Section to perform more effectively through better supervision and in service training.

In the future the Section will continue to emphasize improvement of performance in Evaluation both within the Section and in the outlying Districts of the country. This will be done through continued emphasis on training of people in evaluation skills and procedures.

In the future the Evaluation Section will expand its activities to include follow up evaluation of acceptors, assist in a National Knowledge Building Survey which is planned for 1971 and which will provide baseline data upon which to gauge the progress of the Program, and begin a more detailed analysis of the increasing volume of acceptor data being collected by the FP-MCH Program. In addition to the foregoing USAID will place special emphasis on:

1. greater focus on the evaluation of the FP-MCH Program as a national program rather than a Kathmandu Valley program, e.g. obtain District and Village leaders opinions and attitudes on FP-MCH;
2. investigating other useful sources of information, e.g. data collected by other programs working in Health such as smallpox and malaria;

3. developing skills and procedures in the program which will eventually enable it to do more and better survey research and analysis;
4. developing the Evaluation Section into a unit which is not only useful to the needs of the Program but which is also a more integral part of the country's increasing data pool and research capability;
5. bringing the evaluative aspects of the Program more into focus with what is being done internationally so that Nepal's progress and problem areas can be compared with what is happening in other country programs.

#### Knowledge Building Survey (KB): Formerly KAP

The objective of the KB will be to conduct sample surveys and develop sample registration areas for Nepal. The sample surveys will be primarily aimed at providing a baseline estimate of birth and death rates, and the sample areas will be designed to provide a source for continuous data on changes in those factors.

The KB will supplement the decennial census of population with more detailed and complete data on birth, death and migration. Although the census will be valuable for our work in Family Planning we must have more accurate fertility, mortality, and migration data in order to establish a firm baseline for the IDJG Program.

NEG's Central Bureau of Statistics (CBS) will be responsible for the census. We plan to involve CBS in the KB survey because of their data collecting and processing capabilities and since they must accept the validity of the KB survey's figures for it to have any value.

#### IX. INTEGRATION WITH HEALTH SERVICES

During the past few months the Director General of Health Services (who is also the Chairman of the IT & MCH Board) has been discussing the possibility of closer coordination between the several special health projects and the general health services.

In April 1970 he called a meeting of the Integration Policy Board, the membership of which includes the representative of WHO, the Chief Malaria Advisor of USAID, and the Chief, Division of Family Planning and Public Health, USAID. After prolonged discussion, several points emerged:

1. that the DG's use of the word "integration" was closer to what most of us would call "coordination."
2. that an "integration cell" would be attached to the DG's office, which would act as a clearing house and coordinating body for all of the special services and the health services.
3. that the special programs, such as Malaria Eradication and Family Planning, would lose none of their autonomy but that some of the special advantages they enjoy should be shared with the general health services whenever possible.
4. that the health service staff would assist the other programs to a greater extent than they had in the past.

Later in April, the DG called together the "Integration Administrative Board" which includes the chiefs of all the special programs and the Directors and Deputy Directors of Health and Medical Services. Few decisions were reached but a number of possibilities were discussed.

The "Integration Cell" has been formed and its staff are beginning to explore its functions.

The Family Planning Program is very dependent on the general health services. All the medical and paramedical staff belong to the general health services, although within 18 months some AMMs who are in training in India as third country participants will be returning to work exclusively in family planning. Not only does the quantity of workers depend on the needs of the health services but their quality also. The quality question has two aspects: that of training, because most of the paramedicals are trained in health ministry schools; and that of assignment, because the health ministry could release only the "undesirables" for service in the FP & MCH Program. Therefore, in order to obtain enough personnel of suitable quality, Family Planning must maintain excellent working relationships with the DG and his staff.

Another aspect of cooperation between the general health services and Family Planning is the Program's need for day-to-day help in the field. With the extreme shortage of physicians in the outlying areas, FP cannot hope to place full-time physicians at the local level. Therefore, it must rely on the physician posted there by the Ministry for the surgical procedures of vasectomy, tubectomy and loop insertion. And although the MCH and FP clinics can often be mostly run by paramedicals, it is highly desirable that a referral mechanism be available for patients and procedures beyond their skills. It is well-known that many of the peripherally posted doctors are not fully occupied by the curative work assigned by the health department.

This is due to a combination of factors such as weak organizational support, terribly inadequate supplies and medicines, absence or shortage of paramedical staff, and minimal motivation and incentive for good work. The Family Planning Program is exploring mechanisms which would channel some of the potential energies of such doctors into its activities. One means already in effect is the payment of Rs 20 for each vasectomy and Rs 5 for each loop insertion. But few patients come to the health centers and hospitals and the physicians are prohibited by regulations from leaving their posts to go to distant vasectomy camps. Furthermore, some of them object to walking and there is no other way to get into the hills. The Family Planning Program may be able to persuade the Health Ministry to change the regulations about doctors leaving their posts for Family Planning work and cash incentives may help overcome the objection to walking.

The DC has suggested that, as part of "integration", a doctor in each locality be given a regular family planning allowance of approximately half his regular pay. This would amount to only \$20 to \$30 a month. USAID is maintaining that additional payments would be possible and desirable, but that they should be in proportion to activity related to family planning. Furthermore, that "integration" should mean that curative services would not always be given priority over family planning. For instance, if FP & MCH clinics are only held in a doctor's off-time, it may well be that such time is completely unsuitable for clients.

USAID and the Program have already been working towards integration by assisting in the training of nurses and auxiliary nurse midwives through the granting of stipends for local training, sending raw recruits to India for basic training and experienced staff to other countries for specialized training. In addition to these types of assistance, we are considering other ways to augment the numbers and quality of locally trained health personnel. One obvious need is more hostel space at Bir Hospital, the

only source of nurses for the Health Ministry. Whether this should be done, and whether it might be done in a separate agreement with the Health Ministry or in a revision of the current Iro-Ag, is still being considered. Another facility which needs assistance and from which the FP Program could benefit is the Auxiliary Health Workers School. Stipends for trainees and better family planning curriculum content for the courses are possible avenues of approach. There has also been some discussion under the integration plan to combine, in some way, the training centers for all health auxiliaries. Although there are some obvious advantages to this, our present opinion is that the family planning training center has such specialized objectives and that such a combination of training centers would damage the FP Program.

Another situation in which the Program has started an integration program is in the provision of maternity wards at a few hospitals. In other countries it has been proved that one of the best times to motivate women for family planning is in the immediate post-partum period. This psychological moment can be most efficiently capitalized upon if numbers of women are delivered in appropriate facilities. Although a very few Nepali women deliver in maternity homes or wards, encouragement should be given to this practice. It would reduce maternal morbidity, as well as facilitate family planning, thereby contributing in more ways than one to maternal and child health. The Program has already budgeted for the construction of some maternity facilities. It can be encouraged to plan for additional facilities, to see that those already present in hospitals are adequately equipped and staffed, and that the educational, motivational and service components of the family planning program take full advantage opportunities in existing facilities. This does not mean that we are advising a widespread network of maternity homes. Such a recommendation must be contingent on a demonstrated willingness of Nepali women to make use of such facilities and the demonstration of specific value to the family planning program.

The DG has often said that it is necessary for all of the special programs to realize that they are all programs of IRG. USAID and the FP & MCH Program certainly agree with him on this, but would also encourage him to emphasize the converse, that all of the staff of the regular health services must realize that the special programs are all part of IRG and therefore part of the responsibility of Health Ministry personnel.

Considering the importance of the several factors, USAID is supporting discussions on "integration", while at the same time striving with the FP & MCH Program to keep its priority status, its benefits, its autonomy and its individuality.

**X. COORDINATION WITH OTHER AGENCIES**

- A. The Family Planning Association of Nepal, a member of the IPPF, has been active since 1963. Its services have been limited to one full-time clinic and two or three part-time clinics in Kathmandu Valley, with the exception of three USAID Helicopter-supported mobile vasectomy camps in 1968-69. Up to July 1969 the organization operated at a slow pace fairly smoothly. The FPA had elections in mid 1969. Since then there has been difficulty in the organization due to internal conflicts, power struggles, and lack of direction by anyone with a strong family planning background. There has been little planning and what plans or ideas that are expressed tend to be clinically oriented, conservative, and organization centered, rather than actively aggressive and dedicated to serving large numbers of people.

What seems to be needed is strong, dedicated leadership by an experienced family planner. In the absence of such leadership, it would seem appropriate that the IPPF or some other agency provide a resident advisor who can help the FPA.

- B. There are 11 hospitals run by Protestant missionary societies in Nepal. Their staff and facilities are primarily curative oriented, but most of them are willing to provide family planning services. The Program staff and AID advisors are beginning to stimulate more family planning activity in these institutions.
- C. UNICEF has supplied the Program with medications useful in MCH clinics, with several vehicles, and formerly, with powdered milk. The Program will continue to receive medications and some other supplies from UNICEF.
- D. The World Food Program of the U.S. is willing to supply milk powder and other nutritional supplements for use in MCH clinics. However, until we are sure that the Program can carry the administrative and staff load of this distribution, and until we are sure that the products will improve response to family planning, USAID is cautioning against these donations.
- E. The World Health Organization is pressuring the Program to accept a medical advisor, a public health nurse and some fellowships. The pressure has come from Geneva, from the Regional MCH officer and from the local Representative.

USAID has discussed the matter with the latter two and agreed to cooperate if H4G made the request. The Director General of Health Services, however, has stated that the Program does not need another medical advisor at this time. USAID is supporting him in this stance.

We have also talked at length with the WHO nurses available here and find that they are too committed to a total public health nursing program to be willing to concentrate on FP & MCH. At the request of the FP MCH Program Chief, USAID is proceeding with the plan to have a contractor recruit a public health nurse.

The Mission believes strongly that advisory assistance from other organizations would at present be highly undesirable. We have planned our USAID assistance to the Program so that a coordinated effort can be made to strengthen the Program using the optimum number of advisors. In a young, developing and small program the presence of too many advisors - particularly if more than one of them is advising the head of the program - can be counterproductive. This is particularly so if two ~~chief~~ advisors find, as they often do in the constrained situation of rendering advise to the same person, that parent agency and personal incompatibilities prevent them from working smoothly together. We cannot therefore support the suggested addition of advisors from other agencies.

The Director General sees no reason to complicate the fellowship picture as long as AID funds support adequate participants to staff the developing and growing Program. By supporting this position, the Program and USAID can continue to select the areas in which training is to be given and the candidates to be sent.

- F. The American Peace Corps has cooperated with the FP Program. Many Volunteers, especially those in the agriculture programs, have talked about ~~and~~ promoted family planning. Some of them have even attended short courses at the Training Center.
- G. There are a number of other nations who have been involved with the Family Planning Program. SIDA has donated condoms. Japan and Germany have broached the subject of supplying Volunteers, but discussions have not proceeded very far.
- H. A semi-official organization, that of Nepali women, has contacts throughout the nation. The Program will be encouraged to cultivate and capitalize on the benefits that can accrue from cooperating with the Women's Organization.

**XI. USAID ADVISORY STAFF**

USAID expects to provide advisory staff to meet the above requirements through direct hire positions, a contract with a University and through TDY services provided directly or through contract. Full-time positions for FY 1971 will include:

1. Chief - Family Planning and Public Health Division - direct hire under Technical Support.
2. Program Analyst - direct hire, who will at the same time be administrative and logistic advisor.
3. Social Science Advisor - direct hire, assigned to the Information and Education Section.
4. Training Specialist - contract, assigned to the Training Section of the Family Planning Program, with the possibility that the person could also function as public health nursing or community organization advisor, depending on previous experience and training.
5. Research and Evaluation Specialist - contract.
6. Field Operations Specialist - 2 positions under contract. One will be a population generalist and the other may be a public health nurse or a community organization specialist, depending on personnel recruitable.

Now that the Family Planning Program has been launched, it is likely that the level of professional experience of the advisors will need to be raised. Contract recruitment will move in that direction. It is anticipated that approximately the same advisory staff will be required in FY 72 and 73.

An Advisor will also be needed to assist the Central Bureau of Statistics carrying out processing and analyzing the 1971 decennial census of population. Since an accurate census will be of direct benefit to the family planning program, it is logical to add this position to the team listed above.

NONCAPITAL PROJECT FUNDING (OBLIGATIONS IN \$000)

2

Table 1

PROP DATE June, 1970

1

COUNTRY: Nepal Project Title: Family Planning

Original E.  
Project No. 367-11-580-096

Fiscal Years	Total	Cont <sup>1/</sup>	Personnel Services			Participants		Commodities		Other Costs	
			AID	PASA	CONT	U. S. Agencies	CONT	Dir U.S. Ag	CONT	Dir U.S. Ag	CONT
Prior Through Act. FY 1969	406	105	22	-	100	98	-	181	5	-	-
Oper. FY 1970	413	247	33	-	173	44	-	89	2	-	72
Budg. FY 1971	763	580	15	-	377 <sup>2/</sup>	99	-	67	3	2	200 <sup>5/</sup>
B + 1 FY 1972	675	490	5	35	327 <sup>3/</sup>	89	-	54	3	2	160 <sup>6/</sup>
B + 2 FY 1973	521	383	-	35	250 <sup>4/</sup>	51	-	50	3	2	130 <sup>7/</sup>
Total Life	2778	1805	75	70	1227	381	-	441	16	6	562

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KATIMANDU ATTACHMENT TO TOAID A- 116

- <sup>1/</sup> Memorandum (nonadd) column.
- <sup>2/</sup> Includes \$225,000 for knowledge building contract.
- <sup>3/</sup> Includes \$150,000 for knowledge building contract.
- <sup>4/</sup> Includes \$75,000 for knowledge building contract. Also includes forward funding for contract staff for FY 74. This will need to be justified by a later PROP.
- <sup>5/</sup> Includes \$100,000 for Air Services for knowledge building survey.
- <sup>6/</sup> Includes \$60,000 for Air Services for knowledge building survey.
- <sup>7/</sup> Includes \$30,000 for Air Services for knowledge building survey.

2  
2

Table 1

Exchange rate \$1 = 10.26 Nepalese Rupees  
7.6 Indian Rupees  
4.815 Pakistan Rupees

Family Planning  
Project No. 367-11-580-096

	AID-controlled <u>Local Currency</u> U.S.- owned <sup>2/</sup>		Other Cash Contribution Cooperating Country <sup>2/</sup>
	<u>P.C.</u>	<u>I.C.</u>	
Prior through Act. FY 69	11	368	58
Oper. FY 70	2	465	88
Budg. FY 71	20	700	170
B + 1 FY 72	20	1050	300
B + 2 FY 73	10	900	252
Total Life	63	3483	868

<sup>2/</sup> U.S. P.L. 480 Section 104(g) funds, \$000 equivalent.

<sup>2/</sup> \$000 equivalent of Nepalese rupees.

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anned Technicians Services 2/

	<u>FY 1971</u>	<u>FY 1972</u>	<u>FY 1973</u>
Direct-Hire:			
Social Science Advisor, Pop./F.P.	x	x	-
PASA:			
Data Processing Advisor	-	x	x
Contract (In Country Staff) 3/			
Training Specialist	x	x	x
Research-Evaluation Specialist	x	x	x
Field Operations Specialist, Non-Medical	x	x	x
Field Operations Specialist, PH Nurse	x	x	x
Social Science Advisor, Information	-	x	x

1/ Terminates September, 1971.

2/ List excludes Division Chief and Program Analyst funded under Technical Support.

3/ Excludes staff for "Knowledge-Building" Survey.



simultaneously to prescribe the expansion of operational aspects of the project. We favor the institution-building over the operational approach. In any event, the Mission needs to clarify which strategy is being proposed, as the criteria for planning goals and measuring effectiveness are different for the two approaches. We assume the Mission would not identify the project with a specific growth rate target if our effort is to develop knowledge and an institutional infrastructure. While the Mission adopts the latter goal on p. 2 of the PROP, it aligns our project with a strategy aimed at Zero Population Growth. What is the basic strategy proposed?

3. The revised PROP also needs to clarify the Mission's role in the Nepal Family Planning program. The PROP page 9 suggests that USAID is a participating member of a GON policy making board. We know this is not the case, and the revised PROP should clearly reflect the purely advisory role of USAID in Nepal's Family Planning program.

4. The issue of GON self-help in terms of financing the Family Planning program is a serious problem. The large amount of continuing USAID budget support injections also raises problems in terms of sound long-range planning. How will the Mission avoid a long-term involvement in recurring-cost financing? For example, Part 2 of Table 1 at the end of the PROP shows the GON local currency input to the project decreasing from \$300,000 equivalent in FY 1972 to \$252,000 equivalent in FY 1973, while the U.S. local currency contribution is shown increasing from \$700,000 equivalent in FY 1971 to \$1.05 million in FY 1972 to \$900,000 in FY 1973 (an increase in absolute terms over the FY 1971 figure). When will the GON assume the major burden for carrying out the project?

5. The Evaluation, Research and Knowledge-Building sections of the PROP need some further strengthening. We feel that evaluation and research are perhaps the most critical needs at this stage, and should be emphasized in the revised PROP. Of particular importance, is the need to expedite development of the GON central evaluation staff and its skills. The PROP does not reflect any priority concern for this need, although our proposals for contract participation focus heavily on this aspect of the project. Arrival of contract personnel should help the Mission to identify targets and develop more specific plans in this area of need.

6. In addition to emphasizing evaluation and knowledge-building, the revised PROP should clearly reflect that formal and on-the-job training and work with counterpart personnel are the backbone of the project. The current PROP has clearly identified the need to develop training staff and has indicated training targets. The revised PROP, however, should place greater emphasis on the quality and content of the formal training curriculum as the project evolves. The PROP reflected no judgement as to the adequacy of the present training courses or how any weaknesses can be overcome.

7. The reference to a larger helicopter should be deleted from the PROP. We are not prepared to agree to a larger helicopter, under U.S. control, for the operational activity in the Family Planning program.

If it can be established that the GON is capable of using it for its operations (p. 26, paras 2 and 3), the Mission may wish to submit a proposal for a larger helicopter.

8. We encourage a more positive approach toward developing a more effective Family Planning Association in Nepal. The revised PROP should discuss the role of the FPAN, and how this project relates to it.

9. Since plans for a contractor have developed more specifically since the PROP submission, the PROP will need some revision to reflect these changes. The discussion on knowledge building (p. 31) should be revised to reflect the role of the short-term diagnostic team. The methods to be used in gathering more data should be defined more broadly because we anticipate the discussions between the diagnostic team, USAID, and GON will lead to utilization of methods of enhancing knowledge building not now reflected in the PROP. The role of the PASA Data processing advisor should also be defined.

10. On the operational side, we have nearly reached agreement on the plans for FY 1971. The diagnostic team should be arriving early in CY 1971. After its findings and recommendations are considered by the Mission, we hope that by May 1971 the Mission will be able to provide a full description of the scope and role of the knowledge building activity in the Nepal Family Planning program. These decisions can then be reflected in a revised PROP.

ROGERS