

AN EXAMINATION OF THE  
ORGANIZATIONAL, ADMINISTRATIVE,  
AND FINANCIAL STRUCTURES OF THE  
COMMUNITY HEALTH AND INTEGRATION PROJECT  
OF THE MINISTRY OF HEALTH, NEPAL

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The author takes full responsibility for any errors or shortcomings in this report. It is his sincere hope that the report will be of use to the many people who assisted him in his work.

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## ABBREVIATIONS

AHW	Auxiliary Health Worker
AID/W	Agency for International Development/Washington
APHA	American Public Health Association
CHID	Community Health and Integration Division
CHIP	Community Health and Integration Project
DHS	Department of Health Services
FP/MCH	Family Planning/Maternal and Child Health
GNP	Gross National Product
H/FP	Health/Family Planning
HMG	His Majesty's Government
IRH/FPS	Integrated Rural Health/Family Planning Services
MOH	Ministry of Health
MSH	Management Sciences for Health
NFPA	Nepal Family Planning Association
NMEO	Nepal Malaria Eradication Organization
RMA	Regional Malaria Adviser
RTSA/A	Regional Training Services Agency/Asia
TA/DA	Travel Allowance/Daily Allowance
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

## I. INTRODUCTION

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### Purpose of Assignment

The consultant was asked to come to Nepal to work with the staff of the Community Health and Integration Project (CHIP). He was assured of the support of the Health and Family Planning (H/FP) Division, USAID/Nepal. As stated in the original Scope of Work, it was intended that the consultant "assist the Government of Nepal in designing organizational, administrative and financial structures for CHIP." The scope of work was modified after the consultant arrived in Nepal (see Appendix B), and the major objective of the consultation became the analysis of the major problems facing CHIP now that it has been established as a special project. A series of recommended solutions to these problems was also to be developed.

The Management Sciences for Health (MSH) contract (ICHP-0126) with His Majesty's Government of Nepal (HMF) ended in December 1980. The contractor for the Integrated Rural Health/Family Planning Services (IRH/FPS) Project (No. 367-0135) is being selected. USAID/Nepal requested some intermediate input into CHIP in the interval between visits of the two technical assistance teams. It was decided that both CHIP and the incoming technical assistance team should have an updated assessment of the major problems now confronting CHIP. This assessment was particularly relevant, for the detailed evaluation report which was written by Robert Y. Grant and his colleagues in January-March 1980 predated the designation of CHIP as a special project within the Ministry of Health (MOH). Special project status gives to CHIP much greater autonomy; with this status, CHIP should be able to establish an administrative, financial, and organizational structure congruent with its expanded role. When the consultant arrived in Nepal, the Health and Family Planning Division, USAID/Nepal, made it quite clear that conditions during this inter-project period were so fluid that no definitive, finalized actions would be requested of the consultant. It is hoped that this document will provide Dr. K. M. Dixit, USAID/Nepal, and the technical assistance team for the IRH/FPS-0135 Project with useful insights into the problems which CHIP must solve.

### Nepal: A Country Profile\*

Nepal is a small, land-locked nation located on the southern slopes of the Himalayan Mountains. It is bordered by China on the north and by India on the south, east, and west. It has an area of 141,000 square kilometers;

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\* This section incorporates material from "Health Services Development in Nepal," an unpublished paper by C. Hays et al.

within its boundaries are some of the greatest topographical and ecological variations to be found anywhere in the world. These variations occur within a range of 225 kilometers, spreading from the plains in the south, at an elevation of 200 meters, to Mount Everest, more than 8,840 meters, on the northern border with China. The country has three main ecological zones: the flat plains (terai) in the south, an area which was once forested but which is now prime agricultural land; the middle hills; and the Himalayas and Tibetan plateau in the north. Ecosystems as different as alpine and humid tropical co-exist in close proximity, creating diversity in disease patterns as well. Although topographical extremes are commonplace, the larger part of the country's area consists of rugged hills, with elevations reaching more than 3,000 meters. These hills are intersected by many north-south stream valleys, making transportation exceedingly difficult. Most of the movement of people and goods is along a system of footpaths and trails. The implementation of health programs in this kind of terrain is fraught with difficulty, and especially so during the four-month monsoon, when streams become swollen and landslides block roads and footpaths.

The people of Nepal are almost as diverse as the country's geography. Twelve different languages and some 30 different dialects are represented among Nepal's 14 million people. Nepal is the meeting place of two major cultural groups, the Indo-Nepalese (Hindu) and the Tibeto-Nepalese (Buddhist). The two groups are amalgamated within Nepal; hence, the complex cultural mixture which reflects elements of both parent cultures. The economy is predominantly agrarian, with 96 percent of the population living in rural areas. In the mountainous areas, houses and villages are widely dispersed, but in the terai large, compact villages are frequently found. The per capita GNP is \$110 and the literacy rate is 19 percent. By any standard measure of development, Nepal is one of the least developed countries in the world.

Nepal is beginning to show the signs of population pressure, which is, in part, related to a decreasing crude death rate--from 29/1,000 in 1960 to 21/1,000 in 1978--and a stabilized crude birth rate of 45-46/1,000. Nepal's population growth rate is at least 2.2 percent annually. Population density has increased markedly since the early 1950s (see WHO, Country Profile, pp. 30-32).

Nepal's disease pattern reflects the country's ecological diversity and the widespread presence of poor sanitation, inadequate water supply, and poverty. This environment supports a wide variety of infectious and nutrition-related diseases, the most predominant of which are intestinal parasitosis, gastroenteritis, malaria, tuberculosis and other respiratory infections, malnutrition, and leprosy. Nepal's health problems do not differ significantly from those of many other developing countries. They are a result of major deficiencies in environmental sanitation, poor nutrition, a rapidly growing population, and the lack of sufficient knowledge of health and disease within the population.

## The Development of Health Services in Nepal\*

Until the constitutional monarchy was restored in 1951, there were few formal health services available to the Nepalese people. Some limited services were available to a small number of the elite, but for the rest of the population the only health care available was from Ayurvedic and other types of folk healers. In 1951, the health services staff consisted of 12 western-trained physicians, a few nurses, and an unknown number of indigenous healers.

For more than 100 years, Nepal had been closed to foreigners, but with the institution of a new government the country was opened to different international and bilateral agencies and programs. Nepal soon established foreign aid relationships with the United States, the United Kingdom, and other donors, and some of this aid began to flow into the health sector. In addition to official government programs, there were a number of privately-sponsored health program activities, including a non-denominational mission hospital.

Nepal joined the World Health Organization (WHO) in 1953. Within two years pilot projects were launched to test the feasibility of malaria control. Nepal embarked on a malaria eradication program, based on the results of these pilot activities, in 1958. This activity was the country's first major health effort, and it brought a government-sponsored health program to the 50 percent of the population who lived in malarious areas. As a result of this effort, malaria was drastically reduced and many Nepalese villagers received relief from an age-old problem. During the 1960s, a number of other categorical disease control programs were launched in cooperation with the World Health Organization. These included tuberculosis and leprosy control and smallpox eradication. The smallpox eradication program was quite successful; the last case was reported in 1975.

The need for family planning services was recognized quite early. The Nepal Family Planning Association (NFPA) was formed in 1958. In 1965, the government initiated a Family Planning and Maternal and Child Health (FP/MCH) Project, which has functioned since that time as an autonomous entity within the Ministry of Health. A wide variety of both family planning and maternal and child health services had been provided by this program, and the integrated approach has been more acceptable than efforts to offer family planning services in isolation. The development of health services in Nepal between 1951 and 1972 was focused on these categorical programs, and a good deal of progress was made for the modest yearly expenditure of about \$0.50 per capita.

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While Nepal was expanding programs in different categorical areas, the development of the basic health services infrastructure was proceeding slowly. During the 1950s and early 1960s, efforts were made to develop services. A health assistant school was opened in 1956 and several health posts were established. Over the next few years, these activities continued to progress, and by 1972 193 health posts were in place. The Institute of Medicine was developed and began to function in 1972. It assumed the responsibility for much of the health manpower training.

In the early 1970s, there was also a great deal of activity related to the design and implementation of pilot projects in basic health services. These projects have provided some of the basic information needed to develop a nationwide health system, and they have also facilitated efforts to integrate categorical programs into basic health services. The integration of community health services is a major focus of the five-year health plans, and it is being supported by WHO, United Nations Children's Fund (UNICEF), and bilateral donors. The goal of these efforts is "to make general medical and preventive services available to the rural people as rapidly as possible."

To achieve this goal, the Government of Nepal is developing a health system which is based primarily on a large number of health posts. Each post serves from 5,000 to 25,000 people (depending on the terrain and the density of population) and is staffed by a variety of personnel, including auxiliary health workers (AHWs), assistant nurse-midwives, and village health workers (VHWs). By the end of 1980, 583 health posts had been established. These posts are fairly evenly allocated among the regions (CHIP, Annual Report 1979-1980). The health posts reach into the community via village health workers, who provide domiciliary services to the villagers in their assigned area. VHWs deliver both preventive and curative medicine, and they also serve as a referral agent to the health post for any problems that are beyond their scope of competence.

The history of CHIP dates back to 1969, when a Community Health and Integration Division (CHID) was established in the Department of Health Services (DHS). This division was to work with the vertical projects to identify problems in the implementation of an integrated health services network. Two pilot projects were set up to develop integrated health services. Kaski District, in the middle hills, was established in 1971 and was supervised by the Nepal Malaria Eradication Organization (NMEO). The second pilot project was established in the terai district of Bara and was administered by CHID.

The two projects were carried out between 1972 and 1975. They provided the basis for the further expansion of the integrated services network, as promulgated by His Majesty King Birenda in his directives to the Rastriya Panchayat in June 1974. The growth of CHID was retarded somewhat by the administrative difficulties which were engendered because CHID is a division

of the Department of Health Services. In 1980 it was decided that CHID would be established as a special project with the same status as the Nepal Malaria Eradication Organization and the Family Planning/Maternal Child Health Project.

CHID was redesignated as CHIP. The program is responsible for six fully-integrated districts and for another 23 partially integrated districts (FP/MCH only).

## II. OBSERVATIONS AND FINDINGS

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### Organizational Development

#### A. Financing and Fiscal Management

The most frequently mentioned problem is the lack of a fiscal management system for CHIP. Before CHIP became a freestanding project, all financial management activities were handled by the Department of Health Services. At this time, CHIP has a small financial section which is headed by a statistician, not an accountant. CHIP has recognized the inadequacy of the arrangement, and it has requested that the Board appoint a 28-person Financial Management Division headed by a Gazetted I chief accountant (see Appendix C).

The Board appointed a personnel committee to study the proposed staffing pattern. The Board's approval is expected soon. Recruitment of division personnel will begin thereafter. It is important that the division be in place by the beginning of the next fiscal year (July 16, 1981) to receive funds from USAID and other donor agencies.

Dr. F. Curtiss Swezy and this consultant have met with the head of the financial section and discussed the details of the uncleared financial advances for \$235,209. USAID/Nepal has not received an accounting of the expenditure of these funds, and without some accounting it will not release new funds. This is not a deficiency in the program, for this and other such problems predate CHIP's designation as a separate project. Dr. Swezy is working with the USAID mission and CHIP to develop a mechanism that will allow CHIP to receive the requisite USAID funding (see Appendix C).

Another major problem in financial management is lack of a financial management system. When the Financial Management Division is created, short-term training should be provided for the staff, perhaps by USAID under the Regional Training Services Agency/Asia (RTSA/A) agreement with the University of Hawaii. Following this training, a financial management system could be developed that is modeled on the systems developed by the Nepal Malaria Eradication Organization and the FP/MCH programs of HMG.

The development of a financial management capability for CHIP is underway and should be followed closely by USAID/Nepal staff. (Additional details on this activity will be included in Dr. F. Curtiss Swezy's consultant report.)

## B. Facilities and Staffing at CHIP Headquarters

CHIP headquarters staff in Kathmandu occupy what was once a personal residence. The building is too small and cramped to accommodate even the present staff. CHIP is negotiating with the Government of the People's Republic of China to purchase that country's former embassy, and it hopes to reach a suitable agreement soon. If the building is not purchased, CHIP will not have room for the additional staff it intends to recruit.

CHIP has too few headquarters staff to accomplish all the tasks which it must accomplish in its new role as a separate project. A staffing pattern has been submitted to the Board for approval. If it is accepted, the staff will be expanded to 208 people (including additional staff for the regional training centers). It appears likely that the proposal will be approved in the near future. If it is accepted, the additions to the staff should be sufficient to enable CHIP to carry out its designated work.

## C. Logistical Support System

As was described in the American Public Health Association (APHA) evaluation by Robert Grant and his colleagues (pp. 34-35, 39, 41) and in the Mid-Term Health Review (pp. 12-13, 242-255), the supply of drugs and equipment to health facilities is inadequate. In discussions with fieldworkers at health posts and district offices, this consultant found that the drugs and supplies provided by HMG are adequate for only three or four months of the year. UNICEF-supplied drugs and pills and condoms for family planning activities usually are available in adequate quantities. The USAID IRH/FPS Project (367-0135) and the United Nations Fund for Population Activities (UNFPA) project, No. NEP/80/P12 (service delivery system), have agreed to provide basic drug stocks to the health posts. This arrangement should result in a major improvement in the availability of drug supplies at the health post level.

It was pointed out to this consultant that all the estimates of the drug needs of the projects were based on limited information, and they may not represent the real needs of the health facilities. There are health projects in Bhojpur District and Dolakha District which are supported by the British-Nepal Trust and Swiss Aid, respectively. One objective is to provide accurate information on drug use and needs. When this information becomes available, the drug estimates for health posts should be revised accordingly.

Even if a sufficient supply of drugs and supplies becomes available, the logistical system is inadequate to distribute them. There is a plan to develop a regional warehouse system to facilitate the storage of drugs and other commodities. It is unclear at this time whether CHIP will develop a separate supply and distribution system similar to the systems developed by the NMEO and the FP/MCH Project or whether it will work under the indent and procurement system of the DHS. Dr. Dixit of CHIP and Dr. H. B. Pradhan of the Indent and Procurement Division feel that the

arrangement with Sajha Swastha Sewa is not working at all well. (Sajha is a private firm which contracts to purchase and deliver drugs for the DHS.) Sajha delivers the drugs late, and, apparently, it is inefficient and expensive as well. The consensus is that a new, more effective system should be developed. This important dimension of the health services system should be monitored closely during the inter-project period, for it is a major area where USAID can contribute input under the new IRH/FPS project.

CHIP is planning to expand its supply and logistics section as part of the staff expansion effort. When this section is in place, CHIP should have the capacity to deal more efficiently with supply problems.

#### D. Administrative and Personnel Procedures

When CHIP was part of the DHS, it did not have any flexibility with regard to personnel and administrative policies and procedures. As a separate project, it has more flexibility. A manual of administrative procedures (similar to the manual developed by the NMEO) and a personnel manual need to be developed. The latter should contain complete job descriptions for all personnel at all levels of the CHIP organization.

CHIP does not have an accurate list of the personnel associated with the project. CHIP headquarters staff are preparing a list of personnel, including their current status. This is the first step in establishing a personnel system.

#### E. Supervision

In earlier evaluations of CHIP, lack of supervision was cited as a major problem (see Mid-Term Health Review 2035, pp. 14, 20, 303-336; Grant et al., APHA, 1980, pp. 32, 39). The establishment of CHIP as a separate project has done little to alleviate this situation. Inadequate supervision was mentioned as a major problem at all levels, from the health post to CHIP headquarters.

The two most important factors contributing to this problem are low travel and daily allowance (TA/DA) rates (see Grant et al., APHA, 1980, pp. 39, 40) and insufficient supervisory staff. The former is an inherent problem; the subject of increased TA/DA rates is being discussed within the government. The staffing problem should be resolved gradually at the central level as more staff are hired. However, the staffing problem at the periphery will be difficult to solve. Because supervision is one key to a well functioning program, serious attention must be given to this problem. A supervisory plan and a schedule need to be developed and implemented at all levels of the program. Supervision at this time is handled by a separate section of the headquarters staff. This consultant believes that supervision should be organized not as a separate activity, but as an integral part of the work at all levels. If a separate section is created, people may believe that it is handling all supervisory activities.

## F. Reporting System

There are a number of problems with the reporting system. Much effort was expended under the MSH project (367-0126) to reduce the number of forms in the reporting system. The project was successful: the number of forms and registers was reduced in 1977 from 137 to 12. CHIP is having the required forms and registers printed; USAID/Nepal is monetarily supporting the effort. USAID will not, however, release additional funds. This is creating a problem because the printer must be paid before the materials can be delivered. USAID/Nepal and CHIP are trying to resolve this problem. If they are successful, the forms and registers will become available for use in the reporting system.

A second major problem is that reports do not flow smoothly from the periphery to the center. The consultant does not understand clearly all the problems with this flow. The matter should be followed up when the contract team arrives.

A third problem is the insufficient number of staff at headquarters to record and analyze information from the field. This problem should be resolved as additional staff are recruited. When the proposed staff become available, CHIP headquarters should have no difficulty handling the forms as they come in from the field.

## G. Training Activities

The responsibility for training village health workers (VHWs) rests with CHIP. The VHWs are domiciliary health workers who are based at health posts and perform curative and preventive activities in the villages in the service areas. These VHWs are eighth-grade graduates. They receive six weeks of training from CHIP, at the training center in Patailaya, before they are assigned to their health posts. The training component of CHIP received considerable attention under the MSH contract. A detailed curriculum for VHWs was developed. The chief of training at CHIP stated, however, that CHIP's operational experiences indicate that a longer training program is needed to adequately prepare VHWs for field service. The curriculum is being modified to meet this need.

To date, CHIP has trained more than 1500 VHWs. It is proposed in the Sixth Health Plan (1980-1985) that the health system be expanded. To ensure that this occurs, the training program must be expanded. The need for a longer training period for the VHW has intensified further the need for more training resources.

CHIP will receive UNFPA support for the proposed expansion of training, and three new regional centers will be developed in Surkhet, Dhankutta, and Pokhara. There will be one center for each development region. In this arrangement, the VHWs can be trained in areas closer to their assigned health posts. The center at Patailaya will be expanded, and, eventually, each

center will have four trainers and 13 supporting staff. Thirty VHVs will be trained in each session. Refresher training also will be provided for health workers already in service.

If the proposed staffing pattern is approved, the recruitment of staff for the training centers can begin. It is important that this activity be carefully monitored by USAID/Nepal.

#### H. Program Objectives for Fiscal Year 1981-1982

A program proposal document for the next fiscal year, 2038/39 (1981-1982), has been developed by CHIP and submitted to the planning unit of the Ministry of Health (see Appendix E). This document is quite brief; it lacks the details needed to set objectives and activities for the next fiscal year.

The consultant was asked to "provide technical advice to CHIP Central Office on developing an initial work plan for FY 2038/39 (1981-1982)" (see Appendix B). The consultant and Dr. K. M. Dixit initiated this activity by developing a prioritized list of the major problem areas of CHIP. Discussions were held with the personnel of the Health and Family Planning Division, and it was decided that the list could be used as a basis for developing a more specific workplan after the consultant's departure. A problem-list was developed (see Appendix D) which Dr. Dixit and USAID/Nepal can use to develop program objectives and a workplan for FY 1981-1982. This task has a high priority, and USAID/Nepal's Health and Family Planning Division should support the work until the technical assistance team arrives.

### Technical Problems

#### A. Malaria

Malaria continues to be a significant problem in several of the integrated districts.

The recent reports of the internal and external situation analysis teams (NMEO, Situation Analysis Report 1980, March 1981; External Situation Analysis Team, Summary Report to NMEO, April 3, 1981) indicate that malaria remains a significant problem in three of the six fully integrated CHIP districts: Bara, Parsa, and Rautahat. (The districts are located in the terai along the Indian border.) The analytical teams cited a number of problems in the districts, the most important of which were the increased incidence of malaria in Bara and Rautahat and an inadequate annual blood examination rate in all three districts.

The increasing incidence of malaria is probably understated because the surveillance mechanism is becoming less efficient. The situation analysis teams are legitimately concerned about the malaria problem. Spraying operations are expected to begin in the three districts this year. A plan of action needs to be developed to properly implement these activities.

The external situation analysis teams recommended that a "working committee" of CHIP and NMEO staff be formed to jointly plan malaria and malaria-related activities in the integrated districts and to provide information on those activities. This committee could develop a workplan for reducing the incidence of malaria in the integrated districts. CHIP and NMEO could aid efforts designed to solve malaria problems.

## B. Health Care Delivery

The health care delivery activities are functioning at different levels of efficiency in each of the six fully integrated districts.

As might be expected in any program as complex as CHIP, there are differing levels of efficiency in each of the integrated districts. The differences in efficiency can be attributed to the capability of the personnel staffing each district health service and to differences in the infrastructures in the districts. It would be advisable to work out the mechanics of the supply, logistics, supervision, and information flow systems in the six fully integrated districts before attempting to extend full integration to other districts. It is obvious that these systems will never be perfect and that they will need to be improved and further developed for an indefinite period. The difficulties of integration will be compounded, however, if other districts are fully integrated before the original six districts begin to function at the most basic level. In collaboration with the donors that are contributing to CHIP's development, CHIP should determine what constitutes a minimum level of acceptable operation.

## C. Integration

An adequate methodology and a process for identifying districts that are ready for integration have not been developed.

As CHIP expands during the Sixth Health Plan period, the integration effort will be extended to a number of other districts. No criteria are available for determining whether conditions in a district are suitable for including that district in the integration process. In developing these criteria, a rational process would be established for expanding CHIP to new districts, and at the same time it would be possible to maximize the resource utilization that this expansion represents.

It was suggested that an "integration committee" be formed to develop the criteria for integration and to determine whether districts are ready for integration. This committee should include members from the vertical projects. It could meet with the health planning unit of the MOH, which is responsible for planning the expansion of the health services network in Nepal. The unit would be a logical place to base the "integration committee." The technical assistance team for the IRH/FPS Project includes a health planner. This person should be involved with the development and implementation of the new planning process.

### Family Planning Services

While on two field trips, the consultant had the opportunity to observe voluntary sterilization activities in three localities. Two laparoscopy camps and one mini-laparotomy camp were observed. The most important elements not observed at the laparoscopy camps were good organization and planning.

Delays in establishing the camps sometimes caused prospective acceptors to return home without having undergone the sterilization procedure. These delays were primarily the result of logistical and transportation problems (e.g., lack of vehicles to move supplies and equipment at the appointed time).

Physicians at the camps indicated that laparoscopy is a popular procedure for female sterilization in Nepal. They pointed out, however, that they do not believe it is the best solution to the problem of providing voluntary sterilization because it is a complex, costly procedure that requires a well trained obstetrician-gynecologist and sophisticated equipment. District physicians are being trained to perform the mini-laparotomy as a regular procedure at the district hospital. The mini-laparotomy requires less training and much simpler equipment, and it is more appropriate in the Nepalese context, according to the physicians with whom the consultant talked. It is in this direction that the voluntary surgical contraception (VSC) program for women should go. Unfortunately, in Nepal the mini-laparotomy apparently has a higher complication rate (primarily because of infection) and it produces more postoperative discomfort than the laparoscopy. The higher rate of infection and complication is not found in some other developing countries, and it should be evaluated further in Nepal.\* If these problems can be reduced, mini-laparotomy will probably become the main method of female VSC in Nepal.

The consultant inquired about the availability of pills and condoms at a number of health posts. There seem to be adequate supplies of pills and condoms (in the health posts visited), but the drugs frequently are stored improperly and may be damaged as a result. The FP/MCH program is training supply personnel. With trained personnel on site, some of the existing supply and logistics problems should be alleviated (see Philip O. Weeks, Report on Contract AID 367-193).

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\* Personal communication from Dr. Stephen Mumford. See also The Lancet, November 15, 1980, pp. 1,066-1,070.

During the field trip to Gorkha, the consultant had the opportunity to observe part of an educational program for dhami-jhankris, or folk-healers. It is estimated that as many as 800,000 such folk-healers may be found throughout Nepal (see Shrestha and Lediard, Faith Healers: A Force for Change). These healers have the trust and acceptance of the rural population, and they are a large, potential resource for health education and motivation in Nepal.

The FP/MCH program is conducting a series of five-day workshops for small groups of dhami-jhankris to introduce them to the basic concepts of family planning, treatment of diarrhea, and use of weaning foods. If further evaluation indicates that the dhami-jhankris are an effective resource for motivation and education, the training programs should be expanded and supported on a much larger scale.

#### USAID/Nepal and CHIP

##### A. Liaison and Support of CHIP in Inter-Project Period

CHIP has reached a critical phase in its development, now that it has been accorded project status. A number of major problem areas need to be addressed in the interim between projects. It is important that USAID/Nepal maintain close liaison with CHIP during this period and that it provide whatever support the mission's resources will allow. It is crucial that financial management and planning be addressed at this time.

##### B. Monitoring of IRH/FPS Project (No. 367-0135)

The evaluators of the health and family planning projects indicated in their report (Grant et al., 1980) that contracts need to be monitored closely by the Office of Health and Family Planning. This consultant concurs with this recommendation. The IRH/FPS Project is complex; it deals with a large number of variables, including commodities, construction, technical assistance, and training. In many ways, the new project is more complicated than the three separate projects it encompasses. If the project is to be successful, it must be monitored closely and supported by the H/FP staff.

#### USAID/Nepal and NME0

##### A. Communications

There is a need for frequent, ongoing input in the periods between the consultancies of the regional malaria adviser (RMA).

USAID/Nepal is continuing to support the NMEO under the new project; it is providing malathion, a malathion safety program, and periodic technical assistance. In many areas of the country, the success or failure of the integrated health system will be attributable in large part to the ability of the health services to keep malaria under control. The regional malaria adviser can provide technical advice during his visit, but continued input and liaison with the NMEO will be needed between the RMA's quarterly visits, especially when the malathion safety training program begins.

B. Technical Assistance to NMEO

A member of the technical assistance team needs to work with the NMEO.

In reviewing the project paper for the IRH/FPS Project, this consultant found that little emphasis was given to the technical support of malaria control activities. Malaria is becoming a problem in several of the six fully integrated districts. It is essential that the project team establish a strong linkage with the NMEO to combat this problem. Failure to keep abreast of developments within the malaria program could have severe consequences for the effort to establish integrated services in malarious areas of the country.

### III. RECOMMENDATIONS

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1. USAID/Nepal should follow closely the development of a financial management section at CHIP. Dr. F. Curtiss Swezy, an APHA consultant, should assist this effort.
2. USAID/Nepal should make every effort to dissociate the problem of uncleared advances (from the time CHIP was under the DHS) from the reorganized CHIP program. CHIP funding should not be delayed. A process should be established to account for uncleared advances.
3. CHIP should find a larger, more adequate building in which to house its expanding staff. USAID/Nepal should assist this effort.
4. CHIP is proposing a major staff expansion. Assistance by USAID/Nepal in funding this expansion (fiscal management and logistics) has been proposed and should be implemented.
5. USAID/Nepal should collaborate with CHIP in the development of appropriate training programs for the fiscal division and the logistics section. This activity could be conducted with the assistance of the new technical assistance team. Another alternative is to include training in the Regional Training Services Agency/Asia (RTSA/A) contract with the University of Hawaii.
6. Supply and logistics are major foci of the new IRH/FPS contract. A decision needs to be made about an autonomous supply and distribution system for CHIP. USAID/Nepal should help to determine whether such a system is needed.
7. CHIP should develop a manual of administrative procedures and a personnel manual. The effort to list current personnel and their status should be completed.
8. Field supervision should be increased at all levels of the program. A plan for supervision should be developed, and the supervision section should be abolished and its activities reassigned to other sections of the headquarters.
9. USAID/Nepal should allocate as rapidly as possible the funds needed to purchase forms and registers for the reporting system.

10. The training activities of CHIP should be regionalized and the class sizes of VHWS increased.
11. Specific program objectives and a workplan to accomplish them in the next fiscal year should be developed by CHIP. USAID/Nepal and the technical assistance team should assist this effort.
12. A staff member or a member of the H/FP Division, USAID/Nepal, should be assigned to CHIP in the interim between contracts to establish close liaison with CHIP and to make input as appropriate.
13. The malaria situation in integrated districts needs to be closely monitored by CHIP and USAID/Nepal. A mechanism to coordinate malaria activities in integrated districts should be developed jointly by the NMEO and CHIP.
14. A mechanism for assessing the readiness of a particular district for integration should be developed. A possible focus for this activity would be the Health Planning Unit in the Ministry of Health.
15. USAID/Nepal should improve liaison with the NMEO during the inter-project period and after the technical assistance team arrives.
16. One member of the IRH/FPS team should be given the responsibility for monitoring malaria-related activities in cooperation with the USAID/Nepal insecticide monitor.
17. USAID/Nepal should promote further the use of the mini-laparoscopy as a technique for voluntary surgical contraception.
18. Research on the complication rate for the mini-laparoscopy should be conducted (with the support of the USAID, if it is available). Based on the outcome of the research, recommendations to reduce the complication rate should be made.
19. USAID/Nepal should closely monitor the IRH/FPS contract during the life of the project.

#### IV. SUMMARY

#### IV. SUMMARY

CHIP has been designated a special project with increased autonomy for programmatic development and expansion. This holds great potential for the further development and integration of Nepal's health services. CHIP must solve a number of problems and difficulties in the months and years ahead. These problems do appear to be solvable and, in the author's opinion, given its new project status, CHIP can find solutions. Problems will be solved gradually, however, and only with the energy and patience of CHIP staff and supporting agencies.

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## APPENDICES

Appendix A  
LIST OF KEY CONTACTS

Appendix A  
LIST OF KEY CONTACTS

Ministry of Health

H. D. Pradhan, M.D., Chief, Indent and Procurement  
F. B. Malla, M.D., Chief, Planning Unit  
B. N. Vaidya, M.D., Deputy Chief, Planning Unit  
C. P. Maskey, M.D., Surgeon, Naryani Zonal Hospital  
G. R. Karki, M.D., Senior Medical Officer, Nuwakot District  
Kumar Rana, M.D., Public Health Officer, Gandaki Zone

Community Health and Integration Project

K. M. Dixit, M.D., Chief  
Suniti Acharya, M.D., Deputy Chief  
B. B. Karki, M.D., Head, Communicable Disease Section  
S. B. Shrestha, Head, Statistics, Planning and Evaluation Section  
P. R. Rajbhandari, Head, Training Section  
B. K. Manandar, Head, Supply and Logistics Section  
S. R. Chowdry, Financial Section Officer  
Kumar Lamichane, Health Inspector, Kaski District  
G. R. Pradhan, Health Inspector, Nuwakot District  
H. H. Sharma, Health Inspector, Dhading District  
Rameshar Shrestha, Acting Health Inspector, Kabre-Palanchok District

Family Planning/Maternal and Child Health Project

Herra Dungal, M.D., Obstetrician-Gynecologist

Pramila Sharma, M.D., Chief, Surgical Division

Madhuka Shrestha, Information, Education and Communication Section

Nepal Malaria Eradication Organization (NMEO)

M. B. Parajulli, M.D., Chief

G. M. Sakya, M.D., Deputy Chief

S. L. Shrestha, Head, Research and Evaluation Section

World Health Organization (WHO)

Hun Toon, M.D., Adviser to CHIP

United States Agency for International Development  
Mission to Nepal (USAID/N)

Dennis Brennan, Director

Thomas Rose, Deputy Director

G. V. van der Vlugt, M.D., Dr.P.H., Chief, Health and  
Family Planning Division (H/FP)

Sigrid Anderson, H/FP

Carl Hunter, H/FP

Philip O. Weeks, Logistics Adviser, H/FP

F. Curtiss Swezy, Dr.P.H., APHA Financial Consultant to H/FP

Lawrence Cowper, Regional Malaria Adviser, USAID/W, Asia Bureau  
(based in Sri Lanka)

Alan Steffen, Malaria Adviser, USAID/W

**Appendix B**  
**SCOPE OF WORK FOR CONSULTANT**

UNITED STATES GOVERNMENT

# Memorandum

TO : Dr. Charles Hays, APHA Consultant

FROM : Sigrid Anderson, Acting Chief, HFP

SUBJECT: Scope of Consultant Duties

DATE: March 23, 1981

We have requested you to come to Nepal to work with Dr. Kalyan M. Dixit and his staff at the Community Health and Integration Project (CHIP), Ministry of Health, to accomplish the following tasks:

1. Analyze CHIP activities and make recommendations based on items 3, 4, 5 and 6 below.
2. Provide technical advice to CHIP Central Office on developing an initial workplan for FY 2038/039 ('81/'82).
3. Review the proposed administrative, logistic and financial functions and staff requirements necessary for CHIP.
4. Review past and present budgets and expenditure statements. This will entail working with Dr. Curt Swezy, APHA consultant.
5. Review logistic management system. This will entail consulting with Mr. Phil Weeks, Logistics Management Consultant for USAID/N.
6. Field trips to Kaski, Gorkha, Bara, Parsa, Dhading, and Nuwakot Districts to observe and review CHIP program with focus on malaria and family planning activities.



Appendix C

MEMORANDUM ON FINANCIAL AND LOGISTICS SECTION AT CHIP  
AND FISCAL MANAGEMENT ACTIVITIES  
(Anderson to Rose)

Thomas L. Rose, Deputy Director

March 25, 1981

Sigrid Anderson, Acting Chief, HFP

USAID/N Support to CHIP

The Community Health and Integration Project (CHIP) was officially designated a vertical project by the Cabinet on Dec. 17, 1980 per the Development Board Act of 2013 (Formulation Order No. 2036). This important management change elevates CHIP to a semi-autonomous body with broad powers concerning personnel, financial management and logistical support.

At a CHIP Board Meeting on March 16, 1981 a proposal was made to hire 23 financial management staff headed by a senior HMG accountant. The Board accepted the proposal and formed a committee to implement the decision. The nucleus of this staff should be in place and prepared to receive funds by the beginning of FY 2038/039 (July 16, 1981).

Proposed CHIP Financial Management Division:

Financial Management Division

<u>Position</u>	<u>HMG Grade</u>	<u>Title/Number</u>
Chief Accountant	Gazetted I	Division Chief: 1

Account Section

Chief Accountant	Gazetted II	Section Head : 1
Senior Accountant	Gazetted III	Accountant : 1
Accountants	Non-Gazetted I	Accountants : 4
Junior Accountants	Non-Gazetted II	Accountants : 4
Mukhiya	Non-Gazetted III	Clerks : 4

Internal Audit Section

Senior Accountant	Gazetted III	Section Head : 1
Accountant	Non-Gazetted I	Accountants : 2
Junior Accountant	Non-Gazetted II	Accountants : 4
Mukhiya	Non-Gazetted III	Clerks : 4

The estimated cost of operating the Financial Management Division for one year is Rs. 265,425 (\$22,305).

- 2 -

Prior to CHIP being designated a vertical project financial management was conducted by a separate financial section within the Department of Health Services (DHS). The financial section was responsible for a wide array of DHS service units in addition to CHIP.

Certain inadequacies have been noted in the functioning of the DHS financial section. A USAID/N audit of USG funds (never released) documented a series of account inconsistencies. An evaluation of the USAID/N support to the HMG health sector noted some problems in management. The last USAID/N release of funds to CHIP (under Project 0126) was in December, 1979. No statement of expenditures has been forwarded to USAID/N accounting for these funds.

According to a recent memo by the USAID/N Controller (Smith to Brennan, February 24, 1981) a total of USAID/N provided Rs 2,793,992 (\$235,209) remains unaccounted for.

Unaccounted USAID/N Rupees: ICHP

<u>Project No.</u>	<u>Title</u>	<u>Project Agreement No.</u>	<u>Amount</u>
0126	ICHP	FY'77-6	974,345
0126	ICHP	TQ-6	32,143
0126	ICHP	FY'79-5	1,742,000
TOTAL:-			2,793,992

The new Grant Agreement (367-0135) anticipates USAID/N support to CHIP of Rs 1,190,000 (\$100,000) in the current fiscal year. As noted above, no release of funds has been made. Currently, the new vertical project, CHIP, has no mechanism for receiving, disbursing or accounting for funds. The financial section of DHS has proven inadequate to this task.

Reconciling the outstanding Rs 2.3 million for the old project, 0126, will require a considerable amount of time. Since one of the inadequacies noted in the USAID/N audit is failure of field units to report there is a strong likelihood that a number of field visits will be necessary to obtain the financial information. USAID/N staff assistance will be required if a significant proportion of these funds are to be accounted for.

Recommended Action

1. If, and when, CHIP can submit a certified statement of expenditures for the current fiscal year USAID/N should reimburse CHIP up to the agreed upon ceiling of Rs 1,190,000.
2. When CHIP has a financial management division in place USAID/N should provide the Ministry of Finance (MOF) an advance of working capital for the CHIP program. The target date for this would be August 1, 1981 in time for MOF to provide a first quarter advance in the new fiscal year.

3. USAID/N should assign staff to work with the DHS financial section in an intensive effort to account for the outstanding Rs 2.3 million.

cc: Paul Guedet, PDIS  
George Smith, FX

Appendix D

PRELIMINARY LIST OF PROBLEM AREAS OF CHIP  
(Dixit and Hays)

Appendix D

PRELIMINARY LIST OF PROBLEM AREAS OF CHIP  
(Draft)

Dr. Kalyan M. Dixit

Dr. Charles W. Hays

<u>Problem</u>	<u>Suggested Solution</u>
1. There are not enough staff to do the work centrally.	1. Develop new staffing pattern (done). Recruit staff.
2. Fiscal management is inadequate.	2. Need a fiscal section and a fiscal management plan.
3. Physical facilities are inadequate at CHIP headquarters.	3. Need to buy or rent a larger facility.
4. Personnel management is a difficult problem.	4. Job descriptions for all categories need to be prepared and a personnel system, with plans for transfers and discipline of non-working people, needs to be developed, as does a reward system to encourage better work.
5. Administrative capacity needs to be enhanced as CHIP expands.	5. Develop administrative plan and administrative manual and an administrative training plan.
6. Supervision at all levels is not adequate.	6. Need more TA/DA, more personnel; need to develop a supervision system with proper logistical support, including vehicle.
7. Logistics and supply system is not functioning properly.	7. Establish section centrally; other solution (?).
8. Reporting system is not functioning well.	8. Need to procure forms and records and develop a network for sending forms out and getting information back.

<u>Problem</u>	<u>Suggested Solution</u>
9. Malaria is a problem in some of the integrated areas.	9. Form a coordinating committee to involve NMEQ and CHIP in discussions of these problems.
10. Planned phasing of integrated districts is not well developed.	10. Develop a mechanism (i.e., committee involving other projects and health planning unit) to develop phasing of integration.
11. Training is proceeding well but needs to be expanded.	11. Build and staff regional training centers.

Appendix E

PROPOSED WORKPLAN AND BUDGET  
FOR FISCAL YEAR 2038/39

PROGRAM PROPOSALS  
FOR FY 2038/39

Ministry: Ministry of Health  
Department: Department of Health

Prepared By:

Approved By:

Date:

- 
1. Project: CHIP
  2. Project Location: Throughout Kingdom
  3. Current Status of the Project:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

4. Date Started: FY 2031/32

5. \_\_\_\_\_

6. \_\_\_\_\_

7. Project Description:

- a. In conformance with the NPC's terms of reference for the Sixth Plan Preparation channeled through the MOH, the Terms of Reference for the project will be as follows: According to HMG's Long-Term Health Plan and the working policy of the Health Sector, as spelt out by the CPO, HPU, MOH and the HPU's letter, dated 35/10/28, specifying the policy governing the ward-based panchayat health workers and their function.

b. Programs:

To allocate one panchayat-based health worker in each ward of panchayats under each HP's jurisdiction and deliver the following health services:

1. Family Planning
2. Control and Prevention of Communicable Diseases
3. Preventive Services
4. Epidemics
5. Data on Public Health.

8. Need of the Project:

To create a cost-effective and technically sound system for the delivery of basic health and family planning services by integrating various preventive services currently being delivered by the vertical projects and to continue indefinitely the delivery of such services to the rural population.

9. Project Benefits:

a. Services/Production: The creation of an efficient basic health and family planning services delivery system through the expansion of integrated HPS throughout the Kingdom will enhance the capacity to tackle the high mortality, morbidity, and fertility rates which will, subsequently, upgrade the health status of the rural population which, in turn, will contribute to the economic development of the whole country.

b.

- 1.
- 2.

c.

- 1.
- 2.

d. Revenue Increase: To increase the productivity of the country by improving the health status of the people at large by checking birth and death rates.

e.

- f. Class of People Most Benefited by the Project: Rural Population.
- g. Benefits which HMG, Department, and Other Development Projects will Derive From the Project: Other development programs of HMG will benefit directly from availability of healthy human resources.
- h. Other Benefits:

## 10. Project Expenditures:\*

	Total Expenditure (In Rupees)
a. Overall Project Expenditure	As ongoing expenses, continue total estimate.  Expenditure cannot be predicted.
b. Actual Expenditures Until End of Asadh 2037 (end of FY 36/37)	5,040,024
c. Actual Expenditures for FY 36/37	5,040,024
d. Revised Estimate for FY 37/38	24,849,000
e. Estimate for 38/39	36,315,000
f. Ongoing Expenses after Completion of Project	Cannot specify

\* Includes estimated budget for Rasuwa-Nuwakot, Sagarmatha, Koshi Hill area, Mahakali, and Rapti Rural Integrated Development Projects.

## 11. Breakdown of Expenditures:

<u>Type of Expenditure</u>	<u>36/37 Actual</u>	<u>Revised Estimate for 37/38</u>	<u>Estimate for 38/39</u>
1. Ongoing Expenses (1, 2, 3, 4, 5, 6, 7)	4,491,450	11,459,200	16,264,530
2. <u>Capital Expenses:</u>			
A. Non-Expendable Supplies (10)	10,000	254,000	1,358,000
B. Land and Building Acquisition (11)	-	-	12,000
C. Construction and Im- provement (12)	-	11,692,000	16,945,000
3. Grants (8)	504,274	1,404,800	1,639,800
A. Current			
B. Capital			
TOTAL	<u>5,005,724</u>	<u>24,810,000</u>	<u>36,219,330</u>

Inclusive Estimated Budget for  
Integrated Rural Development Projects

## 12. Funding Sources:

<u>Source</u>	<u>36/37 (Actual)</u>	<u>37/38 (Revised Estimate)</u>	<u>38/39 (Estimated)</u>
1. HMG	2,247,321	5,517,000	8,638,000
2. Foreign Assistance	2,792,703	19,342,000	27,677,000
3. Foreign Grants			
4. Foreign Loans			
5. Community Partici- pation			
 TOTAL	 <u>5,040,024</u>	 <u>24,859,000</u>	 <u>36,315,000</u>

## 13. Description of Community Involvement During FY 38/39:

Cannot Be Specified.

## 15. Manpower Requirement:

<u>Type of Staff</u>	<u>Actual in Position Until End of FY 37/37</u>	<u>Revised Estimate of Requirement By End of FY 37/38</u>	<u>Additional Requirement for FY 38/39</u>
HA/Senior AHW	583	-	100
AHW	1,066	-	200
ANM	1,066	-	200
VHW	1,600	-	400

16. Statement of Construction Material Requirement:

Cannot be specified.

17. Regional Distribution of Projects to be Included in FY 38/39 Program:

Regional distribution not possible.

Appendix F

BUDGETS FOR 1981-1982:  
USAID/NEPAL'S CONTRIBUTIONS TO CHIP

## Appendix F

### BUDGETS FOR 1981-1982: USAID/NEPAL's CONTRIBUTIONS TO CHIP

Attached is a copy of the proposed CHIP budget for FY 2038/39 (1981-1982). USAID's proposed share is Rs.4,600,000 (U.S.\$386,555), not including construction.

The CHIP's Board will be meeting next week. At that time, the staff is going to propose that 28 persons be recruited to establish a financial management and internal auditing section. The total cost for the new financial management section, for one year, is estimated to be Rs.265,425 (U.S.\$22,305). The H/FP staff recommend that USAID/N offer to provide this amount, in addition to the Rs.4,600,000, if CHIP actually fills these positions.

In addition, the CHIP staff intend to propose that 7 persons be hired to establish a logistics management section. The first-year operating cost is estimated to be Rs.54,865 (U.S.\$4,611). H/FP recommends that USAID offer to provide these funds for the first year, if these positions are filled.

The budget for CHIP lists Rs.1,000,000 for construction in the Rapti Zone. This is not a rupee expense, but it will be paid for directly by USAID (see USAID dollar support, 0135, attached).

It should be noted that the last release by USAID to CHIP was in December 1979. Since that time we have not received a statement of expenditures.

ANNUAL PROGRAM FOR FY 2038/39

Project: CHIP

Project District: All

Ministry/Department: Health

Development Region: All

<u>Sv. No.</u>	<u>Activity</u>	<u>Annual Budget</u>	<u>Weight</u>	<u>Unit</u>	<u>Annual Target</u>	<u>1st Quarter Target</u>	<u>2nd Quarter Target</u>	<u>3rd Quarter Target</u>	<u>4th Quarter Target</u>	<u>Remark</u>
1.A.	HP Establishment	3,131,000	12.57	Ea.	100	Preliminaries	Preliminaries	Selection of Site	Opening HP	HMG
B.	Community Health FP (new couples)	2,083,000	8.36	Pers.	65,000	16,250	16,250	16,250	16,250	UNFPA
	Transportation	500,000	2.01	-	Deliver Equipment, Drugs, and Other Supplies to DHOs and MPs	16,250	16,250	16,250	16,250	USAID
	Immunization	243,000	0.98	Pers.	100,000	25,000	25,000	25,000	25,000	HMG
	Nutrition	55,000	0.22	Pers.	280,000	70,000	70,000	70,000	70,000	UNICEF
	Malaria	675,000	2.71	Pers.	170,000 Slide Examinations	42,500	42,500	42,500	42,500	HMG
	Health Information System	1,100,000	4.42	Pers.	Print and Distribute Necessary Forms	Arrange Budget	Printing	Print and Distribute	42,500	USAID
C.	<u>Training</u>									
	1. Training New Trainer	32,000	0.13	Pers.	Recruit and Train 19 New Trainers	Recruit 19	Train 19	-	-	UNFPA
	2. VHM Training	500,000	2.01	Pers.	Train 300 VHMs	80	60	120	120	UNFPA

Program, cont.

<u>Sv. No.</u>	<u>Activity</u>	<u>Annual Budget</u>	<u>Weight</u>	<u>Unit</u>	<u>Annual Target</u>	<u>1st Quarter Target</u>	<u>2nd Quarter Target</u>	<u>3rd Quarter Target</u>	<u>4th Quarter Target</u>	<u>Remark</u>
3.	Training to HPTs/AHMs/AMMs	135,000	0.54	Pers.	Train 210	30	-	90	90	UNFPA
4.	Training to HTs DHO staff	213,000	0.85	Pers.	Train 110	60	-	25	25	UNFPA
5.	Refresher Training in Districts for DHO and HP Staff and VHWs	20,000	0.08	Pers.	Train 200	-	40	90	70	UNFPA
6.	Workshop Participation	30,000	0.12	Pers.	Train 23	23	-	-	-	UNFPA
7.	Establishment of Regional Training Center	780,000	3.13	Ea.	Establish Four Regional Centers	7	3	-	-	UNFPA
8.	Preparation, Modification, and Development of Curricula	30,000	0.12	Ea.	Prepare, Modify and Develop 10 Curricula	6	4	-	-	UNFPA
D.	<u>Supervision</u>	4,150,000	16.60	Dist.	Supervise Affairs of 45 Districts	5	15	15	10	HMG/USAID

Program, cont.

<u>Sv. No.</u>	<u>Activity</u>	<u>Annual Budget</u>	<u>Weight</u>	<u>Unit</u>	<u>Annual Target</u>	<u>1st Quarter Target</u>	<u>2nd Quarter Target</u>	<u>3rd Quarter Target</u>	<u>4th Quarter Target</u>	<u>Remark</u>
<u>E. First Aid Treatment</u>										
1.	Orientation to DMO Assistants and HP Staff	78,000	0.31	Pers.	Orientation to 146	146	-	-	-	WHO
2.	Training New CHWs	1,168,000	4.69	Pers	Train 1,000 CHWs	-	-	200	800	WHO
3.	Training Old CHWs	737,000	0.55	Pers	Train 500 Old CHWs	125	125	125	125	WHO
<u>F. Construction</u>										
	DMO Building	700,000	2.81	Ea.	Build 2 DMOs	Preliminary Works	Estimate Preparation	Contractual Works	Start Construction	HMG
	DMO Building (Old)	300,000	1.21	Ea.	Build 2 DMOs	Continue Construction	Continue Construction	Continue Construction	Complete Construction	HMG
	Central HQ Building	3,900,000	15.66	Ea.	Construct HQ Building	Preliminary	Estimate	Contractual Works	Start Construction	UNFPA
	Regional Training Center Building	1,000,000	4.02	Ea.	Two Regional Training Centers	Site Selection	Estimate	Contractual Works	Start Construction	UNFPA
	Extension Building at Pathlaiya	500,000	2.01	Ea.	One Building	Contractual Works	Start Construction	Continue Construction	Continue Construction	Netherlands
<u>G. Consolidation of System</u>										
	Center	2,618,000	10.51	Ea.	Consolidate Central Office	Contractual Works	Start Construction	Continue Construction	Continue Construction	HMG/USAID UNFPA



PROPOSED BUDGET FOR HMG/N, FY 81/82 (038/39)  
 USAID-ASSISTED PROJECT  
 (In 000s Rs.)

Project Number: \_\_\_\_\_  
 Department/Division: CHIP  
 Ministry/Agency: MOH

PROPOSED BUDGET

	<u>Budget Headings</u>	<u>HMG</u>	<u>USAID</u>
	1. Salary	2,683,000	
	2. Allowance	420,000	
	3. TA/DA	1,550,000	3,000,000
	4. Service	310,000	800,000
	5. Reag.	0	0
	6. Repair and Maintenance	210,000	
	7.1 Office Equipment	205,000	600,000
Expendable Goods	7.2 Books and Magazines	21,000	
	7.3.1 Fuel for Transport	400,000	100,000
	7.3.2 Fuel for Other Purposes	55,000	
	7.4 Clothes and Food Grain	95,000	
	7.5 Other Goods	315,000	
Non-Expend- able Goods	8. Financial Assistance: Donation and Reward	705,000	
	9. Unforeseen	28,000	
	10.1 Furniture	405,000	
	10.2 Transport Devices	0	
	10.3 Tools and Machinery	0	
	11.1 Purchase of Land	0	100,000
	11.2 Purchase of Building	0	
	12.1 Construction and Improvement: Building	1,000,000	*
	12.2 Construction and Improvement: Future	0	
	TOTAL	8,402,000	4,600,000* = 13,002,00

\* In the CHIP budget, Rs.1,000,000 (U.S.\$84,034) is shown as a USAID contribution to construction. This will actually be a direct USAID expenditure.

(35%)