

AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

REPORT ON CONSULTING ASSIGNMENT

NEPAL

A Report Prepared By:
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During The Period:
APRIL 26 - JULY 6, 1979

Under The Auspices of the:
AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
OFFICE OF POPULATION, AID/pha/C-1100

AUTHORIZATION:
Ltr. POP/FPS: 8/28/78
Assgn. No. 1100-147

I. Introduction and Background

A. Purpose

The following is quoted from a USAID/Nepal to USAID/Washington cable dated 14 March, 1979:

Croley will be the Chief Advisor to the FP/MCH Project. In this role he will provide support in planning, management, and implementation of selected FP/MCH Project activities. His specific task will be to assist the Project Chief and his designates in the preparation and implementation of plans and strategies for the expansion of Voluntary Surgical Contraceptive services throughout Nepal. So far as feasible to assist in planning and preparation of camps, of support services and transportation (ground and air) for the next camp season.

The Chief of the Nepalese Family Planning/Maternal and Child Health Project (FP/MCH) and the Chief of the USAID/N Health and Family Planning Office (HFP) were interested in obtaining an advisor on administration who would remain in Nepal to the end of the Project Agreement, 30 September 1980. Therefore, an additional purpose of the assignment was for the Project Chief to become acquainted with the consultant so he could decide whether he would like him back for a longer assignment and, similarly, for the consultant to determine if he would like to return if asked.

As the scope of the work developed and as Dr. Oldham, USAID/N Chief of the Health and Family Planning Office said at the time of orientation, there was more to the assignment than could be explained in a brief cable. The consultant was to try to become acquainted with the total program and do as much as possible within the two month assignment to help implement it.

In practice this took two forms:

1) to report to Dr. Pande, the Project Chief, the observations made, and

2) to help develop the Work Plans the Project needed in order to obtain the release of funds from USAID for the expanded Voluntary Surgical Contraception Program (VSC) and its enlarged Panchayat Based Health Worker training program (PBHW).

B. Demographic Situation

Most, if not all, readers of this report will have access to the demographic data in the offices of USAID/N or AID/W, therefore what is included here is not detailed. Another reason for not having more demographic data is that the purpose of this report is to provide a record of the consulting assignment rather than a country profile or a demographic description. Those data included are not necessarily the latest but are

considered the best available by the FP/MCH Project demographers.

More than half of Nepal's population live in the hills, about 40 percent live in the Terai, and the remainder live in the mountains. As the country is predominantly rural, 96% of the population reside in the villages. Half of the urban population is clustered in the Kathmandu Valley where the population density is the highest. Next is the Terai, but if only cultivable land is considered the density in the hilly and mountainous areas is three times as great as the Terai. This indicates that the population pressure is greatest in the area having the least population-supporting potential. Such an unevenly distributed population is the major factor for the outward migration from the hilly and mountainous areas, with their meager resources, to the agriculturally rich Terai. This migration is expected to continue as long as the present population pressures exist. Meanwhile, the internal migration within the Terai area is also expected to continue.*

Despite the fact that the infant mortality rate is estimated at 134 to 260 per 1000 live births and it is believed that only half of the children born reach their fifth year, 40% of the population is 15 years of age or less. Even without an improvement in the infant mortality rate, and given a reasonably effective family planning program, the population growth rate will continue to be high over the next several years as this large 15 and under group enters the reproductive age.

The mean age of marriage for women rose from 15.1 to 16.7 years from 1961 to 1971 but sixty-one percent are married by the age of 19 and 92% by the age of 24. Based on surveys in 1974-75 and 1975-76, the crude birth rate is estimated at 43 to 45 per 1000. If the estimates of the crude death rate are even partially valid there was a substantial drop in the CDR from 1951 to 1961 and possibly a slight decline from 1961 to 1975. The population growth rate was estimated at 2.5% in 1974-75, a 25% increase over the 2% reported by the 1971 census. It is quite possible that this will rise further as the CDR drops and the CBR increases as the large population of females under 15 enter the child-bearing years.

Most of the immigration-emigration takes place, as might be expected, along the Terai-Indian border. However, only 5% of those who emigrated were from the Terai. According to the 1961 census, 330,000 had emigrated out of Nepal, but as the 1971 census did not collect this information the number who have emigrated since 1961 is not known. The number who emigrated by 1961 balanced out the 337,000 foreign residents who were in Nepal at that time. This number remained fairly constant through the 1971 census but, in contrast to the original place of residence of the emigrants (95% from the hills and mountains), 90% of these foreigners resided in the Terai. Whether foreign immigration or internal migration, the Terai is the goal.

The 1971 population of Nepal was 11,555,983 and the estimate for 1979 is 14,000,000.

*This paragraph is a slight modification of the first paragraph in Promotive and Preventive Health Services: Program No. 12 - Family Planning and Mother and Child Health.

II. Findings and Recommendations

The consulting assignment got off to a rather slow start as Dr. Pande, Chief, FP/MCH Project, departed for international meetings two days after the consultant arrived and didn't return until 10-11 days later. There only was time for a protocol meeting before his departure, so there wasn't an opportunity to discuss his concept of the scope of work. However, this did provide opportunity to get acquainted with other staff members and do some background reading.

The Project Agreement between USAID/N and the FP.MCH Project established the availability of funds, but it is necessary for the Project to submit work plans for the different subactivities in order to obtain the release of funds. This, the Project has been slow in doing. Therefore, much of the time was spent in trying to move these work plans forward. Following is a description of their status at the end of the consultation period.

A. Construction of Voluntary Surgical Contraception (VSC)

Service and Training Centers: This work plan provides Rs. 1,700,000 for the design and construction of up to eight centers, the exact number to be determined after cost estimates for each are made by an architectural and engineering firm. The work plan was completed and accepted by the Project Chief for signature five weeks before the consultant's departure. Another modification was required due to problems raised by Dr. Pande. However, he signed and submitted it to USAID/N two days prior to the consultant's departure.

B. Training in VSC Procedures: This work plan was an outgrowth and modification of a year old work plan for vasectomy training which never got under way. Since the work plan for vasectomy training was prepared there has been an increased interest in the minilap procedure for areas difficult to reach with the more elaborate and electricity-dependent laparoscopy equipment. In addition, it was decided that it was time to provide some out-of-country training and experience for specialists in surgery and in obstetrics and gynecology and for those physicians to be trained and for those who train them.

A work plan for vasectomy and minilap training was prepared in cooperation with the Deputy Project Chief. This plan was presented to the Project Chief but he had several objections mostly related to a specificity of detail that he did not want. In cooperation with the Deputy Chief, and the recently appointed VSC Coordinator, the plan was revised, somewhat expanded, and presented again.

It made one wonder why anyone had conceived of a VSC training program and it was difficult to keep from coming up with the cynical answer, "To give people a chance for a trip abroad."

Due to further problems surfaced in the work plan review, the consultant developed a third work plan. It consisted of six activities:

1) Interviews with those physicians who have been trained in VSC procedures to determine the effectiveness of the training and to determine the contribution they have made to the program since training.

2) To implement a certification program for those non-specialist physicians who, with or without training, had been performing vasectomies and minilaparoscopies. Oral examinations would be required plus five successful operations under supervision.

3) To implement a program to train trainers in the minilaparoscopy procedure.

4) To implement a training-cum-certification program for those physicians who have not been trained in the vasectomy or minilap procedure. This would take place as the number of physicians referred to in (2) diminishes.

5) To design a program for continuing education in VSC procedures for those physicians who are isolated from professional contacts but are active in the VSC program, and for their less isolated colleagues who demonstrate their interest in the program by their willingness to staff remote VSC camps. Depending upon the recommendations, this could result in a future work plan which might include sending some physicians abroad for observation and training. The method of selection, reflecting commitment to the program and professional and geographical isolation, would be detailed in the plan.

6) To provide advanced training and experience for those OB/GYN specialists who have been active in the laparoscopy camp program. These seven specialists would attend the PIEGO program -- at no cost to HMG or USAID/N. (Some have done thousands of procedures.)

C. Surface Transportation for Expanded VSC Program

Providing transportation for staff, clients, equipment and supplies to VSC camps has been a problem. An earlier work plan provided for the rental of trucks for the 1978-79 VSC camp season. This was recognized as a short term solution and that there was a need for a longer term solution, therefore an attempt was made to develop a work plan for the purchase of two vehicles for the Project. However, it was difficult for Project staff to decide on the type of vehicles needed. Eventually one truck and one 32 passenger bus were decided upon.

As the local Tata dealer informed the Project that it would require three months to obtain the chassis and another three months to obtain the body, and as USAID first has to obtain a waiver to purchase non-American vehicles, it is quite likely that the vehicles will not arrive until the end of the 1979-80 camp season. Therefore, the initial work plan was modified to include the rental of vehicles during the 1979-80 season until the purchased vehicles arrived. The draft of this plan (minus some figures) was completed. Once these figures are obtained the plan will be submitted to

the Project Chief for approval and signature.

D. Panchayat Based Health Worker Program

This work plan was an extension of a rather successfully implemented plan in 1978-79. It was not possible to complete the new plan before the consultant's departure because the Director of Training did not know from which districts trainees would be chosen, the number of classes needed, nor how many mobile training centers would be required.

However, as a result of a visit to one of the training centers, the consultant suggested some additions to the new plan. Essentially the center had no audio-visual aids (not even a decent blackboard) and as the manual which had been developed for use during and after training had not been printed he recommended the funding of these items. The recommended audio-visual aids did not include slide or cine projectors as there is very little to project and maintenance is a problem. Although an accurate budget requires information unavailable at present, a budget for the program was projected from the previous one so that plans could be made to increase the amount programmed for this sub-activity or to reduce the number of people to be trained.

It will not be possible to complete this work plan until after the August meeting of the FP/MCH Project headquarters and field staff.

E. Use of Chartered Aircraft for VSC Camps

The number, location, and anticipated size of camps will not be decided until the August meeting, therefore this work plan could not be developed. However, the consultant did develop a schedule for the "Time and Method of access to Forty District Family Planning Offices. (See Appendix.)

Initially, the consultant was given the impression that the VSC program could be expanded by using charter aircraft to reach areas not served by scheduled flights. However, it turns out that there is only one STOL (short take-off and landing) airstrip in the country that is not served by scheduled flights. So the use of charter would have little effect on the number of places that could be reached by fixed wing aircraft. Therefore, if the number of places is to be expanded it will have to be through the use of chartered helicopters.

However, it often is difficult to obtain reservations on scheduled flights and, as can be seen from the attached, the flights to certain towns are rather infrequent. Therefore, there is a role for chartered fixed wing craft (probably STOL). The cost of charter of either type of craft (about \$375 an hour) means that the camps will have to be large and carefully scheduled for such a program to be cost-effective. It is worth a well documented try and a work plan for this purpose should be prepared after the August meeting. However, such a plan cannot be prepared unless the camps decided upon at the meeting are scheduled with such a plan in mind.

Note: The following comment was made by Dr. William Oldham regarding the above finding; it is worth noting here:

The reason for charter aircraft was always the need for aircraft control so that a team could be put on board and reach a specific airfield at a set time. Approximately 20 sites not served by the program are to be included into lap camp schedule. We have not seriously considered helicopters for lap camps, too much equipment and people. We did consider vasectomy camps by chopper but found it too expensive.

III. Problems

Other than those incorporated into the work plan, most recommendations to Dr. Pande were made orally.

The most obvious, but not necessarily the most important, weakness in the program is in the fiscal area. This does not imply corruption or dishonesty. It is a combination of a chronic shortage of funds, leading to temporary transfers of money from one category to another, and, possibly a lack of fiscal management know-how. It would be desirable to obtain a short-term fiscal management consultant to evaluate the present program and make recommendations for improvement.

A second problem, common to organizations in all countries is the delegation of responsibility without the delegation of authority. The Project Chief states that he cannot get his staff to take the responsibility he delegates. However, it appears that a large percent of the decisions are made by the Project Chief and his staff is reluctant to make decisions since they fear being countermanded.

Related to the above problem is the poor communication from the headquarters to the field. Many of the decisions made at headquarters are not communicated, or are communicated poorly, to the district and panchayat level. One possible reason for this is the seeming reluctance to put directives and decisions into writing. Oral communication is the order of the day.

The consultant worked on this to some extent by reporting to headquarters some of the problems encountered by field workers and getting headquarters staff to do something about the problem. However, this was a crisis approach to the problem. What needs to be done, and what can be done only during the season when it is possible to go to the field, is to approach communications as transportation was approached (See Appendix), i.e., how does a message get from here to there and then try to develop a system of communication that would work reasonably well independently of the people involved. To put it more elegantly--the epidemiological approach. One of the catches is that one of the reasons for poor communications is the difficulty of the Project Chief to delegate authority. As a result some people are unwilling to take the responsibility for communicating directives, instructions, etc.

The other side of the communication problem is to try to develop a system to make headquarters staff more aware of the problem of the people in the field. As the consultant was there during the season when people don't go into the field, and during a time of political unrest, it is not known to what extent field visits are made and the importance attached to them. There were examples indicating that at least for some people they weren't important, e.g., the Central Region medical officer had never visited a district FPO except as a member of a VSC team. One staff member said that the Director never goes to the field but another said that he is very good about it. Obviously one has to be around for a longer period of time, and during the field season, to get an accurate picture of the situation.

On the positive side -- there are several very competent and experienced staff members and when one realizes that in many ways the Nepalese government is less than thirty years old it is quite remarkable what has been achieved.

IV. Future Long Term Assignment

The consultant was requested by the Project Chief and by USAID to return in September on a host country contract for a thirteen month assignment. This was agreed to in principle and a contracting officer arrived three weeks before the consultant's scheduled departure and four weeks before his actual departure. Unfortunately the contract was not completed within the three week stay of the contracting officer and it was necessary for Ms. Anderson to take the responsibility of putting it into final form. It was completed on the day of the consultant's departure and given to the Project Chief for his signature. If the Project Chief signs it in time the consultant expects to return about the first of September. Contract negotiations were quite frustrating, but Ms. Anderson and Dr. Oldham were very supportive throughout the process.

APPENDICES

APPENDIX I

People Contacted

USAID

Dr. William Oldham, Chief, HFP
Ms. Sigrid Anderson, HFP
Mr. Robert Mills, Assistant Program Officer, PRM
Mr. Samuel H. Butterfield, Director, USAID/N
Mr. Steve Freundlich, PDIS
Mr. Jyoti Ratna, PDIS
Mr. David Gephart, PDIS

FP/MCH Project

Dr. Badri Raj Pande, Chief
Dr. Kokila Baidya, Deputy Chief
Dr. Achut Acharya, Chief Service Division
Dr. Pramila Sharma, Chief, Surgical Division
Mr. Surendra Amaty, Chief, Administration Division
Mr. Puspa Raj Shakya, Chief, Training Division
Mr. Hem Hamal, Chief, IEC Division
Mr. Jayanti Man Tuladhar, Acting Chief, Evaluation Division
Mr. Govinda Mishra, Chief Accountant
Mr. Mark Lediard, UNFPA Advisor
Mr. Ramesh Bhatta, P.A. to FP/MCH Chief
Dr. Sushila Pradhan, Reg. Medical Officer, Central Region
Mr. Pradhan, Supply Officer

Dharan Training Center

Mr. Joyti Raj Shrestha, Director
Dr. M. Nirola, Trainer
Mrs. Pande, Trainer

Regional Medical Office

Dr. K. Pande, Director
Mrs. Maya Shresta, Health Educator

Biratnagar Hospital

Dr. L.B. Thapa
Dr. June Thapa

Family Planning Officers and Staff

Dhulikhel
Biratnagar

UNFPA

Mr. Peter Witham, Coordinator

APPENDIX II

Time and Method of Access to the Forty District FPO's

In general the attached is self-explanatory but two things need to be explained:

1) Only the place names underlined are District FPO sites.

2) The numbers, or the word "daily", in parentheses after a place indicates the days of the week for scheduled flights from Kathmandu effective 8 Chaitra 2035 (21 March 1979).

1 = Monday

5 = Friday

2 = Tuesday

6 = Saturday

3 = Wednesday

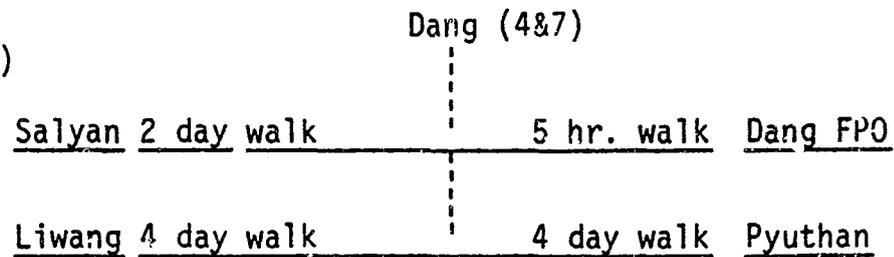
7 = Sunday

4 = Thursday

APPENDIX III

Far Western Region

By air to:
(2 days by car)



By air to:
(2 days by car)

Surkhet (1,3,4)

2 day
walk

Dailekh

By air to:

Chaurihari (2)

4 hr.
walk

Jajarkot

By air to:

Doti (7)

2-3 hr.
walk

Doti FPO

By air to:

Sanfebazar (5)

1½ day
walk

Achham

By air to:
(3 days by car
via India)

Dhanagadhi (7; 2 from Nepalgunj)

By air to:

Bajhang (6)

By air to:

Jumla (1&5; 3&5 from Nepalgunj)

APPENDIX III (Continued)

Far Western Region

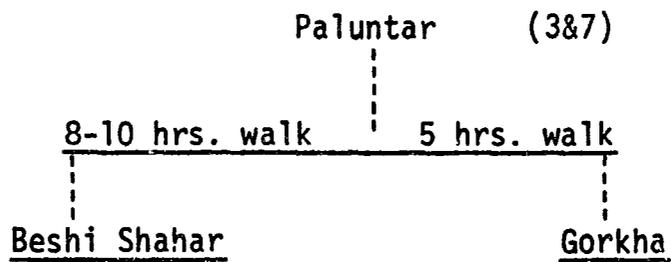
By air to:
(3 days by car
via India)

Mahendranagar (5&6)
|
via 1 day
India | by train
| or bus
|
Jhulaghat
| 4 hr.
| walk
|
Baitadi

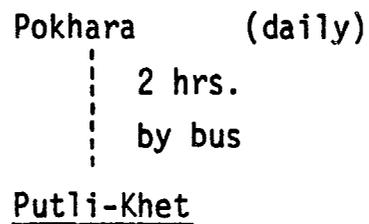
APPENDIX IV

Western Region

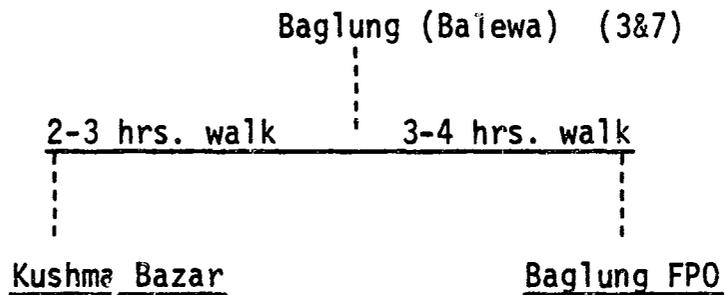
By air to:



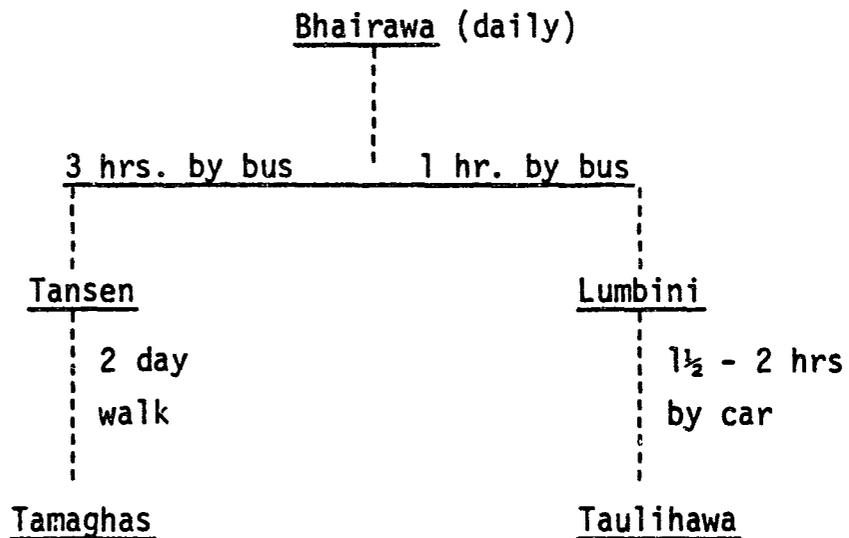
By air to:
(6 hrs. by car)



By air to:



By air to:
(14 hrs. by car)



APPENDIX V

Central Region

By air to:
(9 hrs. by car)

Janukpur (daily)

4-5 hrs.
by car

Sindhulimadi

1½ day
walk

By road to: Dhulikhel
(1 hr.)

3 day walk

Ramechhap (STOL Strip)

By air to:
(4 hrs. by road
permit required)

Jiri (1)

3 hr.
walk

Charikot

By air to:
(6 hrs. by car)

Simra (daily)

2 hrs.
by taxi

By road to:
(8 hrs.)

Hetauda

By road to:
(15 mins.)

Patan

APPENDIX VI (Continued)

Eastern Region

By air to:

Tumilingtar (1&3; 2&4 from Biratnagar)

4 hrs.
walk

Chainpur

By air to:

Rumjatar (3&7)

By air to:

Rajbiraj (1&4)

3 hrs. by
bus or taxi

Udaypurgadhi