



# Auditor General

AUDIT REPORT  
ON  
THE EXAMINATION OF USAID/NEPAL'S  
HEALTH AND FAMILY PLANNING PROGRAM

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INTRODUCTION

Nepal is about the size of Tennessee and has a population of nearly 14 million. It is one of the world's 26 least developed countries. It suffers a rapid population growth rate, severe environmental degradation, low agricultural productivity and a lack of arable land. Under-employment, widespread malnutrition, and poor health are common. There is a severe lack of modern skills, essential infrastructure, appropriate technology, and a narrow resource base from which to generate growth.

The provision of health services in Nepal is impeded by the difficult and rugged topography. Two-thirds of the country is covered by mountain ranges, canyons, inter-mountain valleys and terraced mountain slopes. This topography makes communication and transportation extremely difficult, slow, and costly in most parts of the country.

The transportation and communication problems make Nepal one of the most difficult countries in which to carry out health programs. The geography features a series of east-west mountains culminating in the high Himalayas and valleys crossed by north-south rivers, with over 6,000 tributaries, creating a number of isolated segments within the country. There are only a few roads connecting the various regions and it is not unusual for a village to be a 10 to 12 day walk from the nearest road.

The general health of the population in Nepal is at a low level, coupled with inadequate and unevenly distributed services. The majority of the people have no access to modern medical services. Nepal's health and family planning systems are primitive, reaching only about 10 percent of its population. Consequently, it has one of the highest communicable disease ratios in the world. In addition, about 55 percent of Nepal's children under 5 are victims of protein-energy malnutrition. The infant mortality rate of 152 per 1,000 live births is one of the highest in Asia and life expectancy is only 44 years. Communicable diseases such as tuberculosis, typhoid fever and cholera are widespread and there has been a recent resurgence of malaria.

Currently, Nepal has 66 hospitals with a total of 2,410 beds and 533 health posts. There is about one physician for every 32,000 people as compared to one to 5,000 in India and one to 780 in the U.S.

The country's most pressing problem is the rapid population increase, approximately 2-1/2 percent a year. The potential for maintaining this high growth rate appears highly probably due to the extreme youthful character of the population, the consequent large number of females who will be entering the reproductive ages, and a marital structure which favors marriage at early ages. About 50 percent of the current population of 13.9 million is under 20 years of age and nearly one-third of Nepal's people are 10 years of age or younger.

According to a study conducted by the World Fertility Survey, Nepalese women marry at a very young age. A third of the girls aged 15 and three-fifths of 16 years-olds were married. In the age group 20 to 24 94 percent of the women were married, while for older age groups marriage is almost universal. Population is projected to increase to 22 million by the end of the century and to double in 28 years.

Given the above circumstances, for the Nepalese, having children is almost the only assurance of being provided for in old age in an economy where accumulation of wealth is virtually impossible for the vast majority. High birth rates are also sustained because children contribute vital labor to the household economy and over 20 percent of the children die before the age of 5. If a family is Hindu, it is important that the father have a son to perform religious rites after the father's death. Thus, these factors together make family planning of little interest to villagers until they have many living children.

In sum, Nepal has had major problems in terms of general health and population control for many years. USAID assistance to the health sector in Nepal has responded to these problems and dates back to 1955 when a limited pilot project in Malaria Control was funded. In 1968 assistance to the Nepalese Family Planning/Maternal Child Health (FP/MCH) Project began and in 1973 a pilot project to bring about the integration of all basic health services was started. This latter purpose was further expanded in 1976 when a new integrated health services project was funded. All four of these projects are currently active and details of their current financial status are shown in Exhibit A.

Since 1975, His Majesty's Government of Nepal (HMG) has been clear in their plans to develop a national health service program under integrated management. The HMG Fifth Five-Year Plan (1975-80) committed itself to provide a minimum of health services to the maximum number of people. The plan accepted an integration model as the most efficient way to deliver health services. Thus, HMG's long term health plan for 1975-1990 calls for the continued development of an effective rural health service, under a single organization, to better serve the needs of the rural majority.

At present, the Ministry of Health (MOH) is responsible for the administration of over twenty active health related programs including six separate projects now administering one or another component of rural health services. By 1985, HMG plans call for the integration of five of the six projects [FP/MCH, Nepal

Malaria Eradication Organization (NMEO), Tuberculosis Control, Leprosy Control, and the Expanded Program of Immunization (EPI)] under a single organization known as the Integrated Community Health Project (ICHP). ICHP has started nearly from scratch with an enormous task and a specific mandate to:

- build a system of health posts,
- make health care accessible to the remotest areas by means of a mobile village health worker walking great distances away from the health posts,
- deliver a set of effective primary care and preventive services that reflected Nepal's most acute needs,
- recruit, train and place all the workers needed for the effort,
- involve the local communities, and
- develop the management structure to support these activities.

Given the above mandate, USAID/Nepal has attempted to closely coordinate the four current U.S. assistance programs with the long-term plans of the HMG. In addition, they are also planning a 1979 program of \$2 million to assist in developing a population policy support element and have proposed a massive \$27 million project entitled "Integrated Rural Health/Family Planning Services. This latter project is planned to be implemented in late FY 1980 and will continue through 1985.

The purpose of this audit of the four active Health Sector projects was to evaluate USAID's and HMG's effectiveness and efficiency in carrying out project objectives, assure that AID funds were used for the purposes intended, and to identify problem areas requiring corrective action. Our review included an examination

of project records, correspondence and discussions with USAID and HMG officials to determine the adequacy of project monitoring and reporting. Visits were made to observe facilities and obtain first-hand information at Central Offices in Kathmandu, and at selected District and Regional offices and Health Posts located throughout Nepal's four regions. We inspected project warehouses, health centers and clinics to determine the adequacy of control over commodities and the propriety of accounting and reporting on project resources. The audit covered the period April 1, 1977 to June 30, 1979 and was performed during May to July 1979.

This is the second review by the Auditor General of the health and family planning projects in Nepal. Our prior audit report (No.5-367-77-21) was issued in August 1977 and covered the entire development assistance program in Nepal for the period October 1, 1975 through March 31, 1977. The report included three recommendations relating to the health sector.

## SUMMARY

The most significant findings developed during the audit, and presented in detail in the following sections, are summarized below:

- Our review of the four active health and family planning projects supported by AID showed that HMG progress has been less than satisfactory in developing an efficient and effective integrated health and family planning program. We found that HMG has not given adequate direction or support to ICHP to enable it to accomplish its mandate. Several parallel and duplicative management systems exist, and scarce managerial skills are being under utilized. Overall we found a very definite need for organizational restructuring. We recommended that USAID/N require development and implementation of a time-phased organization plan for the establishment of a single, unified organization having the managerial authority to effectively administer and implement the integration of all rural health services in Nepal. (See pp. 9-14).
  
- We again found that HMG financial support to their rural health services was inadequate. The lack of medicines, supplies, and equipment is so severe that it eliminates any possibility of establishing an effective rural health operation in the near future unless dramatic increases in financial support are forthcoming. In our visits we found several health posts that did not even have aspirin to give to patients. Officials at each post visited admitted that drug supplies were inadequate and generally lasted only 3 or 4 months of the year. We recommended that future U. S. Government assistance be conditioned on the HMG's ability to support an effective level of programming. ( See pp. 15-17).

- HMG's inventory control and accountability for AID-financed commodities and other commodities provided to health projects is inadequate. There is currently a multitude of supply systems that are ineffective in reaching rural health posts. There are problems with procurement, storage, distribution, and inventory control that were pointed out as far back as 1976. We recommended that a coordinated logistical supply system for all AID supported projects be developed and implemented that is capable of ensuring adequate logistical support services, including proper inventory, storage, procurement, and distribution procedures. ( See pp. 18-22) .
  
- Over the last few years, USAID has consistently and significantly understated inventories of AID-financed family planning commodities in-country. At the same time, the actual number of contraceptives issued to users was greatly overstated. These two factors, coupled with poor inventory management practices, has caused an accumulation of approximately a six year supply of contraceptives. We recommended that appropriate procedures be established to obtain the most complete and accurate data relevant to total contraceptive stocks in country and on the number of contraceptives distributed to users for use in preparing required reports. (See pp. 23-26) .
  
- Many of the contraceptives currently in stock are overage and may have to be destroyed which would incur, at minimum, an estimated loss of over \$200,000 to the U.S. Government. We attribute primary responsibility for this potential loss to a lack of monitoring by USAID. We recommended that sufficient testing be conducted to determine their usefulness before taking action to destroy them. (See p. 26) .

- As in 1977, we found HMG's accounting for U.S. -owned local currency contributions to be inadequate. This has been a long standing problem warranting forceful action by USAID/N. We recommended that the accounting difficulties with the HMG be resolved, and if the outstanding uncleared advances cannot be cleared within 90 days, that future funding be withheld. (See pp.30-31).
  
- USAID/N is in process of developing two new health projects which will require about \$29 million of USG funding support over the next few years. In our opinion, the effectiveness of an expanded rural health program in Nepal cannot be increased above present levels until the various constraints described in this report are thoroughly addressed and resolved. USAID officials have indicated that when their draft project paper is completed it will deal with all the issues raised herein. (See pp. 32-35).

A draft copy of this report was reviewed by key USAID/N officials and they concurred, in general, with the findings and recommendations.

## STATEMENT OF FINDINGS AND RECOMMENDATIONS

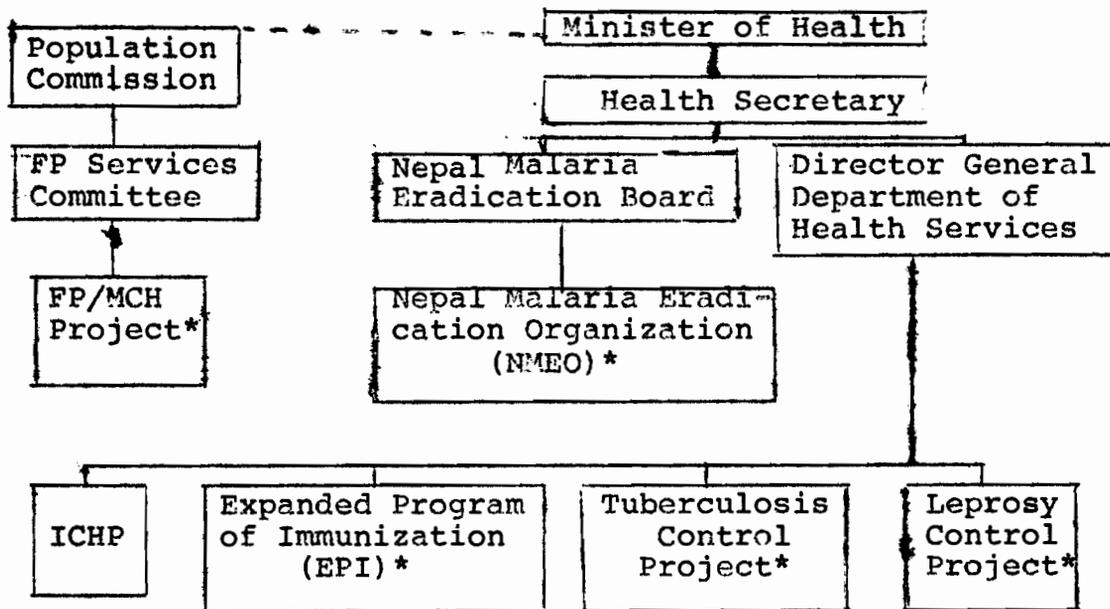
### A. STATUS OF INTEGRATED HEALTH PROGRAMMING

Our review of the four active projects supported by USAID/Nepal showed that progress toward developing an efficient and effective integrated health and family planning program in Nepal has been less than satisfactory. We found that major problems that existed at the time of our last audit in 1977 still existed as of June 30, 1979 and that there were still no concrete solutions in sight in spite of the fact that USAID/Nepal is planning two major projects that will require further U.S. assistance totalling about \$29 million.

Specifically, in 1977 we found Host Government financial support of their Integrated Health System to be inadequate, the effectiveness of FP/MCH clinics was diminished after integration, control over Family Planning commodities and reporting was poor, and the HMG's accounting for U.S.-owned local currency contributions was not adequate. To a large degree these problems still exist and some have even worsened. In addition, the organizational structure of the HMG's Ministry of Health (MOH) remains ill-defined and this, in our opinion, is contributing significantly to the lack of efficiency and effectiveness in developing an integrated health system in Nepal. Clearly, USAID/Nepal officials are aware of all these system shortcomings and have discussed them in their draft Project Paper entitled "Integrated Rural Health/Family Planning" Services which is planned for implementation from 1981 to 1985, but there have been no specific plans developed that will ensure either short-term or long-term corrective action.

B. THE NEED FOR ORGANIZATIONAL RESTRUCTURING

Health services in Nepal are provided under the authority of the MOH. As mentioned in the introduction to this report, the policy of the MOH since 1975 has been to develop an effective rural health services by integrating the services of five special purpose internal organizations under the authority of one organization now known as the Integrated Community Health Project (ICHP). The MOH plans to complete the integration by 1985, but at present, the effective line of authority in the MOH for these organizations is as follows:



(\* Organizations to be integrated with ICHP.)

In sum, this simplified diagram readily shows that ICHP does not have the authority to carry out the mandate for which it was established. As pointed out in USAID/

Nepal's draft project paper, the MOH has not given adequate direction or support to ICHP to enable it to accomplish its tasks. ICHP's mandate is to develop an effective nation-wide rural health service, under integrated management. However, they have little control over any of the means to perform their mandate. ICHP was conceived as a "multi-purpose" project within the Department of Health Services (DHS) functioning as a regular HMG program. Its purpose is to provide a delivery system for the development services now being carried out by five single-purpose projects: FP/MCH; NMEO; EPI; Tuberculosis Control; and Leprosy Control. All of these projects, in order to achieve their objectives, have development project status which gives them substantially greater flexibility in administration and greater autonomy than that enjoyed by ICHP.

For example, NMEO reports to the Nepal Malaria Eradication Board of which the Chairman reports to Minister of Health through the Secretary of Health and FP/MCH reports to the Family Planning Services Committee of the Population Commission, of which the Chairman is the Minister of Health. ICHP and the other three projects of the DHS report to the Director General of Health Services on a equal basis. Originally the ICHP was a lesser division of the DHS.

The very conception of ICHP as an eventual delivery agency for all routine services currently being provided by the five single-purpose projects casts it in an adversary role. Furthermore, since they must operate on an organizational level which is less independent and less flexible than any of the other five projects, they have little ability to command any specific integration activity.

As an illustration, implementation of the ICHP has been delayed because of their inability to effectively integrate FP/MCH clinics. The Chief of ICHP, under the authority of the Ministry of Health, scheduled and funded the integration of ten districts that had FP/MCH clinics. However, the Chief of FP/MCH unilaterally countermanded the integration order which effectively stopped the integration which was to take place in 1977-78. No additional districts were scheduled for integration in 1978-79 because of this problem. However, it is now planned to integrate the ten districts in 1979-80.

ICHP, as a project of DHS, must coordinate on a day-to-day basis its financial, personnel, and supply activities with other divisions and sections, all of which report directly to the Director General of DHS on an equal basis. Most of these same type activities in the five development projects are under the direct control of each project. Thus, very substantial amounts of time are required for the essential coordinative efforts involved in the day to day management activities in ICHP. Furthermore, this added activity must be carried out by an ICHP management staff which is much smaller than the other project's staff when measured in relation to the number of service level staff concerned. For example, the following is a comparative summary of the number of authorized positions:

	<u>ICHP</u>	<u>FP/MCH</u>	<u>NMEO</u>
Central Management Staff	19	375	195
Regional Management Staff	-	49	165
District & Field Representatives	<u>4,216</u>	<u>1,411</u>	<u>2,715</u>
Total	<u>4,235</u>	<u>1,835</u>	<u>3,075</u>

From the above, it can clearly be seen that the staffing of ICHP is insufficient to meet the managerial requirements of the project. ICHP is seriously understaffed at the headquarters level to effectively manage and administer their operations. Currently, there is only one supervisor at the central level and there are no regional level supervisors, a condition which thoroughly hinders supervision and operations throughout the system.

At the same time, both the malaria and family planning projects maintain a larger central staff in addition to regional level supervision. Two factors affect the number of personnel. First, at FP/MCH there are some personnel at the central and regional level who are actually delivering services in addition to providing management and administrative support.

Secondly, both FP/MCH and NMEC manage their own administrative support functions (personnel, budget and supply) while ICHP relies on DHS personnel for most of that type support. However, even taking those two factors into account, ICHP has a disproportionately low number of management support positions as compared to FP/MCH and NMEC. In essence, the plans of HMG are clear in their commitment to develop a national health service under integrated management but, in practice, the organization appointed to develop this program has been allotted few resources to carry out its mandate. In fact, even the offices provided the central staff are grossly inadequate. For example, there is only one private office in the small one-story building which accommodates the central staff. We found a shortage of desks, tables, and chairs to even accommodate the present staff of 19, and a lack of adequate working space to enable each employee to perform their work efficiently.

The current MOH organizational arrangement has had both positive and negative effects. Malaria control, smallpox eradication and early sterilization efforts through particular agencies dedicated to a single activity have made considerable progress. On the negative side, there has undoubtedly been duplication of efforts. USAID officials have pointed out that several parallel management systems exist under the current MOH organizational structure that are duplicative in nature and a waste of scarce managerial skills. For example, duplicative management systems for drug procurement and distribution, management information, and supervision of field workers exist in each of the projects that could reasonably be coordinated under centralized systems. Theoretically at least, this would reduce the duplicative efforts for similar functions resulting in increased efficiency and economy and better utilization of specific management skills that are in such short supply.

USAID support to these divergent and occasionally contradictory or overlapping health efforts in Nepal was necessary to help get efforts started, but we believe a re-examination of the approach is needed now to focus on developing a more effective and efficient rural health service on an integrated basis.

To some extent a reappraisal has already been done by USAID officials by virtue of their development of a draft proposal for future support of "Integrated Rural Health/Family Planning Services". However, the draft project paper did not include any specific requirements for organizational restructuring within the MOH. We believe this is a necessity that must be addressed to ensure that any future Project Agreement includes specific time-phased requirements for Host Country action that clearly establish the ICHP as the controlling authority over rural health services in Nepal.

Recommendation No. 1

The Director, USAID/N should require, as a condition precedent to financing the Integrated Rural Health/Family Planning Services Project, that the HMG develop and implement a time-phased organization plan for the establishment of a single, unified organization having the managerial authority to effectively administer and implement the integration of all rural health services in Nepal.

### C. HOST GOVERNMENT FINANCIAL SUPPORT

As in 1977, we again found that HMG financial support for operation of their integrated rural health services was inadequate. In our view, the lack of medicines, supplies, and equipment is so severe that it eliminates any possibility of establishing an effective rural health post operation in the near future unless dramatic increases in financial support are forthcoming.

Consider the following circumstances that currently exist in Nepal:

1. There are approximately 14 million people in Nepal and 533 health posts or an average of over 26,000 persons per health post.
2. The most current annual budget for drugs and medicines for each post amounts to about \$588 or just over two cents per person per year.
3. Even though drug issuance at each health post is closely controlled, the supplies are estimated to last only about one-third of the year. Thereafter, there are no medicines available.
4. During our audit we visited 27 health posts in several areas of the country.

We found that 100 percent of the Health Assistants-in-Charge of posts admitted that the supply of medicines was insufficient. We found several posts that did not even have aspirin to give to patients in need. We also noted the lack of equipment and medical instruments at the health posts.

From an overall standpoint, the HMG allocated five percent of their development budget for 1978-1979 to the

MOH. Of that amount, only 15 percent, or about three-quarters of one percent of the budget, was allocated to ICHP. However, budget figures include both donor assistance and HMG contributions. The following analysis of their 1978-79 development budget makes evident the limited amount of Host Country contributions to their program to integrate rural health services:

<u>Budget Source</u>	<u>Amount</u>	<u>P e r c e n t o f</u>	
		<u>Total</u>	<u>Development Budget</u>
HMG	\$ 320,000	21	.1
USAID	193,277	12	.1
Other Donors	1,042,437	67	.5
<b>Total</b>	<b>\$1,555,714</b>	<b>100</b>	<b>.7</b>

This lack of support is even more evident when actual expenditures are compared to budgeted amounts. For example, ICHP development expenditures for 1977-1978 were only slightly more than 50 percent of the allocated budget (\$1,628,655 allocated vs. \$880,131 released) and thus show a considerably greater shortfall than otherwise indicated. The shortfall of funds occurred because anticipated donor assistance did not materialize. The following selected examples are some of the more severe budget shortfalls in that year:

<u>Purpose</u>	<u>Allocated Budget</u>	<u>Released Budget</u>	<u>Percentage Released</u>
50 New Health Post Establishments	\$185,630	\$66,400	35.8%
Existing Integrated Health Post Strengthening	513,235	27,366	5.3%
District Health Office Construction	126,050	10,431	8.3%
Family Planning Camps	99,580	41,017	41.2%
Nutrition and Health Education	48,445	1,765	3.6%
In-service Training	118,815	27,367	23.0%

Given the above conditions, we have concluded there is little possibility of establishing effective rural health posts unless dramatic improvements in support and medical supply levels are made. Again, USAID officials are aware of these serious constraints and have included in their proposed new project an amount of \$5,000,000 for basic pharmaceuticals or an average of \$1 million per year. However, they have also included \$1 million or \$200,000 per year to help develop and supply a cadre of 30,000 ward based, community health workers throughout Nepal who would need a basic supply of medicine and this again could possibly dilute the volume of supplies provided to each health post unless the allocation of funds to each subprogram is tightly controlled.

USAID's draft project paper does not include estimates of the volume of medical supplies needed annually to provide full support to the health post and ward level community programs. Nor is there any indication where such support, other than USAID, is to come from. We believe if the project is to be seriously considered for U.S. Government funding that this data should be provided and that our obligation to release any funding should be conditioned, in the project paper and project agreement, on actual performance of the HMG to obtain other donor assistance and/or to provide and release the balance of funding necessary to support an effective level of programming.

#### Recommendation No. 2

The Director, USAID/N should determine, in collaboration with appropriate HMG officials, the annual volume of medical supplies needed and their cost to provide full support to the health post and ward level community programs. U.S. Government assistance to those programs should then be conditioned, in the project paper and project agreement, on actual performance of the HMG to budget and release, on a reasonable but specific time-phased basis, the donor and Host Country funding necessary to support an effective level of programming.

## D. COMMODITY LOGISTICS MANAGEMENT

HMG's inventory control and accountability for AID-financed commodities and other commodities provided to MOH projects is inadequate. There is currently a multitude of supply systems that are ineffective in reaching rural health posts. There are problems with procurement, storage, distribution, and inventory control that were pointed out as far back as 1976 by an independent, AID financed contractor and again in 1977 in our previous audit report. Many of those previous findings are repeated herein because there has not been adequate corrective action.

### 1. ICHP Logistical Problems

ICHP has no logistics capability under its direct management, despite the importance of maintaining adequate supplies for its widely scattered service network.

The DHS's Indent and Procurement Division coordinates the logistics for routine hospital and health post needs. The agency which procures and distributes most supplies, however, is a national health services cooperative formed over ten years ago from a government medical stores unit. All government agencies have been directed to use the services of this cooperative as much as possible.

In addition to the cooperative, each health service project has developed its own logistics system responsive to specific project needs. The cooperative system did not exist when NMEO began, but the other health service projects such as FP/MCH, Smallpox, and Tuberculosis control, post-date the cooperative. All these projects have chosen not to utilize the cooperative exclusively for their supply needs for some of the following reasons:

- The cooperative does not tailor supplies to different needs, but rather provides a series of standard packages to all similar facilities.
- Procurement procedures for imported supplies are more cumbersome than direct purchase from overseas sources.
- It does not have adequate warehousing facilities outside of Kathmandu nor does it have sufficient transport capability of its own.
- It does not have sufficient capacity for special storage and handling needs such as cold storage for vaccines.
- Many project supplies are provided directly by external agencies.

Since ICHP needs both basic curative and preventive medicines as well as supplies for specific health project activities, health posts now receive commodities and supplies from many poorly coordinated sources: the government cooperative, Royal Drugs Limited, NMEC, FP/MCH, EPI, Tuberculosis Control, Leprosy Control, UNICEF and the Indent and Procurement Division of DHS. USAID and UNFPA commodities are also provided indirectly to ICHP through the existing health projects. As rural health services expand, the need for developing a coordinated supply system increases and it clearly can be shown that the lack of a unified supply system has resulted in the loss of control and accountability for supplies and commodities which has severely hampered the provision of services at the health post level.

## 2. FP/MCH Logistical Problems

Although the FP/MCH project does have adequate physical storage facilities to properly protect AID-financed commodities, improper inventory practices have resulted in a lack of control and accountability for AID-financed family planning and maternal child health commodities which has led to extensive overstocking and waste of commodities as will be shown in the following section of this report.

Some examples of other inadequacies we found in 1977 and again in this current review of HMG's logistic management system are listed below:

- (a) Individual commodity stock cards are not maintained by the FP/MCH central warehouse. Receipts and issues are recorded in a stock ledger, however, running stock balances are not maintained on a continuing basis.
- (b) The FP/MCH central warehouse maintains a sub-warehouse, but does not maintain separate inventory records such as stock records or ledgers. Therefore, it is not possible to verify physical inventories against ledger balances maintained at the central warehouse.
- (c) Inventory records are not maintained for contraceptives donated to the FP/MCH project from private sources such as the International Planned Parenthood Federation.
- (d) At the FP/MCH sub-warehouse, commodities stored were not properly stacked to facilitate a physical inventory.
- (e) There is limited, and in many cases, no reporting from the major FP/MCH distribution points relative to commodity usage and availability. Therefore, actual commodity usage and availability levels are difficult to determine.

A short term supply consultant, financed under a University of California advisory contract, UC Berkeley, assisted the FP/MCH Project Director in designing a new supply and commodity management system. The consultant's final report, issued in August 1976, focused on establishing a new supply system. Numerous recommendations were made relative to developing an effective and responsive supply system including the establishment of individual stock record cards and other inventory control procedures. However, the same consultant, in a follow-up report issued in December 1978 reported that none of the inventory control recommendations had been implemented. Apparently, no

action has been taken to implement them as many of the recommendations, such as establishing individual stock record cards, were not accepted at the highest levels of the HMG.

In our prior audit report and at the present time, we found that the FP/MCH program has no adequate mechanism to facilitate uniform, accurate and timely inventorying, record keeping or reporting of FP/MCH commodities available within its system. Therefore, until such a mechanism is implemented, there can be no meaningful reporting on FP/MCH commodity usage and availability for effective management purposes.

### 3. NMEO Logistical Problems

USAID/N's Office of Financial Management recently reviewed the adequacy of the procurement, inventory records, and storage facilities of NMEO. Their audit report issued in April 1979 concluded that NMEO maintained proper procurement records. However, certain deficiencies were noted. For example, insecticides at storage facilities were not properly stacked to facilitate the taking of physical inventories, DDT boxes were stacked in layers which exceeded the minimum bursting strength as recommended by the supplier, and annual physical inventories were not being taken as required by the HMG.

Our audit tests of this malaria control program in Nepal were limited because of USAID's evaluation. However, our observations at the Central Regional warehouse facilities in Pathlaiya disclosed that improper storage procedures had resulted in some damaged commodities. We found many broken cartons and barrels of DDT. Additional cartons showed signs of water damage and others were sitting on a concrete floor which was in the process of breaking up. Some cartons showed extensive termite damage and we noted similar termite damage to the wooden structure of the building. We were unable to estimate the cost of the damaged DDT.

To test the warehouse records, we also attempted to count the non-AID funded malathion on hand, but we found many open and partially full bags which defeated our purpose. We also found several bags of malathion stored outside the family planning warehouse, some 30 to 40 yards from the building. According to the security guard, it had been left there months ago when the malathion shipment was unloaded.

Overall, we found DDT and malathion scattered throughout the warehouse, stacked in such an unorderly manner that an accurate physical inventory could not be taken. Furthermore, supply documents, waste paper, and empty boxes were heaped on the floor so high that they covered some of the insecticides preventing the taking of a physical inventory. Sanitation in general was very bad.

#### Recommendation No. 3

The Director, USAID/N should require the MOH to develop and implement a coordinated logistical supply system for all AID supported projects that is capable of ensuring adequate logistical support services including proper inventory, storage, procurement, and distribution procedures.

## E. CONTRACEPTIVE REQUIREMENTS

Over the last few years USAID/N has consistently understated inventories of AID financed family planning commodities in-country by a significant amount. At the same time the actual number of contraceptives issued to users was overstated. These two factors, coupled with poor inventory management practices, has caused an accumulation of approximately a six year supply of contraceptives. Many of the contraceptives are overage and may have to be destroyed which would incur, at minimum, an estimated loss of about \$200,000 to the U.S. Government. We attribute primary responsibility for this loss to a lack of monitoring by USAID/N, since most of the causative factors were pointed out to them in our previous audit.

### Contraceptive Inventory Levels

As stated above, Nepal presently has approximately a six year supply of contraceptives. In addition, on January 16, 1979 USAID/N ordered an additional 8 million condoms (\$396,416) and 158,000 cycles of pills (\$41,206) at a total cost of \$437,622 which, upon receipt, will further compound the inventory problems now being experienced.

Much of this excessive stock was accumulated because USAID officials did not adequately monitor the program or have adequate information on the level of program activity in country. The following two examples clearly illustrate the latter point:

1. In the Family Planning Services Statistics Annual Report (U-1612/4) submitted by USAID/N to AID/W as of December 31, 1978, USAID/N's Health and Family Planning Office reported 7,569,200 condoms and 2,115,800 cycles of pills, respectively, as the total stocks in-country. But, according to the FP/MCH Central Warehouse records, we found a minimum on-hand balance of

16,805,658 condoms and 2,488,439 cycles of pills as of December 31, 1978. However, even the Central Warehouse figures were not complete. They were based on reports received from only 29 of the 40 districts and did not include ICHP stock balances. A more accurate figure of in-country stocks was obtained from an AID-financed consultants' report dated December 12, 1978. In making his calculations, the consultant used figures provided by USAID/N and adjusted them to reflect the actual number of acceptors. USAID's calculations and methodology were checked by the consultant and he decided they were probably the most accurate in Nepal, given the less than satisfactory inventory reporting by the FP/MCH Logistics Division.

A comparison of the stock balances reported by USAID in the U-1612/4 report and the consultant's estimate for 1978 is shown below:

<u>Year</u>	<u>Type</u>	As reported		U-1612/4 Report	
		per U-1612/4 Report	Consultants' Report	understated by Quantity	Percent
		(Thousands)			
12/31	Condoms	7,569	21,310	(13,741)	64%
78	(ea)				
	pills				
	(cycles)	2,116	2,783	( 667)	24%

2. In the Family Planning Services Statistics Quarterly U-1612/3 Reports submitted to AID/W, we found that USAID/N, rather than using only the actual number of contraceptives distributed to users as reported by FP/MCH and ICHP, also included the stock issued to District offices by the FP/MCH Central Warehouse as being distributed to users. This has resulted in a large over-statement of condoms and pills issued to actual users. A comparison of the number of contraceptives distributed to users as reported by USAID/N and the actual number distributed as reported by FP/MCH for the same period is shown below:

<u>Period</u>	<u>Type</u>	<u>Distributed to users per</u>		<u>U-1612/3 Reports</u>	
		<u>U-1612/3</u>	<u>FP/MCH</u>	<u>Overstated by</u>	<u>Quantity</u>
		<u>Reports</u>		<u>Quantity</u>	<u>Percent</u>
		(Thousands)			
1977/78	Condoms	3,783	2,364	1,419	38%
	(ea)				
	Pills	493	315	178	36%
	(Cycles)				

In our discussions, USAID officials could provide no adequate explanation for the gross errors shown in the above reports. They agreed that utilization reports could be more accurate and indicated appropriate action would be taken. In relation to inventory levels, we were informed that they only report the amount of supplies in the central and sub-warehouses and that stock distributed throughout the country to district offices and clinics are not included in their calculations. The USAID/N Project Chief stated that the practice of reporting field stockage was abandoned in 1976 because he felt there was no reliable, timely method of reporting field inventories. Thus, the current practice of not listing or estimating stock outside the warehouses was instituted. He also stated that AID/W was aware of this and had approved the practice of stating a zero balance in Regional, District and clinic locations.

#### Recommendation No. 4

The Director, USAID/N should establish appropriate procedures to obtain the most complete and accurate data relevant to total contraceptive stocks in country and on the number of contraceptives distributed to users for use in preparing the Annual U-1612/4 and the Quarterly U-1612/3 Reports.

In our draft report we also recommended that the Director, USAID/N determine future contraceptive requirements for Nepal based on the revised inventory and usage levels indicated above and either cancel or reduce the current

supply of contraceptives on order. The Director has since advised us that a determination regarding current and future contraceptive requirements for Nepal has been made and that AID/W was requested to divert or cancel the procurement in question. Accordingly, AID/W reduced the condoms quantity on order by 6 million units and rescheduled delivery of the oral contraceptives.

#### Overaged Condom Stockage

We were told by USAID/N officials that a substantial amount of the condom stock currently in country may have to be destroyed because they have exceeded their useful shelf-life of five years. According to a July 1979 study on condom stockage levels prepared by USAID/N, the estimated minimum amount of condoms that may have to be destroyed was 4,167,830. We estimate the loss from destroying these condoms at approximately \$206,524, based on current prices and shipping costs.

USAID/N officials informed us that they are currently reviewing the situation to determine the age of all contraceptives on hand and to find out what quantities need to be destroyed. They have requested that FP/MCH officials take a countrywide inventory by date of manufacture.

#### Recommendation No. 5

The Director, USAID/N should require, before any action is taken to destroy existing overage condom stocks, that sufficient testing be conducted to determine the quality and usefulness of the substantial quantities of such commodities presently in country.

## F. EFFECTIVENESS OF INTEGRATED HEALTH SERVICES

Reportedly, the transfer of health services to ICHP integrated districts has resulted in certain services becoming less effective than those formerly provided by the single-purpose or specific service organizations. This is a problem area warranting quick attention from USAID/N officials to determine the extent of difficulty, causes therefore, and what should be done.

### FP/MCH

Although AID has been supporting HMG's FP/MCH program for eleven years, the program is now being progressively transferred to the HMG's integrated system. Interviews with key FP/MCH staff revealed a concern that the ICHP cannot effectively administer FP/MCH services, and that their services and clinics are becoming less effective after integration into the ICHP.

Unlike the FP/MCH project, which is a specific service organization designed to specialize in providing family planning services, the integrated system calls for the integration of all health services, including family planning, under one organization. Consequently, the spectrum of health services will be provided by generalists, rather than by individuals specifically trained in family planning services. It is this difference that is causing considerable concern.

Based on our review and interviews with FP/MCH officials at the central, district and clinic levels, we believe that FP/MCH activities under the integrated system do not receive the same high priority they received under the FP/MCH project.

### NMEO

The NMEO is integrated in the original six districts that are fully integrated. No additional districts have been integrated because of the resurgence of malaria. According to the plan, districts would not

be integrated until the index of API 1/ was less than .5 percent. When malaria reaches the controlled level in a district, NMEC and ICHP plan to evaluate the readiness of NMEC activities to be absorbed into ICHP. Since none of the higher management personnel of NMEC have transferred to the ICHP, it has limited capability and experience to direct a malaria program.

In 1978 there was an increase in the number of malaria cases. Preliminary data for 1979 indicates that about the same number of malaria cases will occur in NMEC controlled areas during the year as in 1978, or about 10,000. However, in integrated districts there appears to be increasing case loads over the approximate 2,400 cases found in 1978.

Annual blood examinations should be taken for 10 percent of the population in a given area. The annual blood examination rates for the past three years (1976-1978) for NMEC areas were considered satisfactory, but in the integrated districts the rates of 6.5, 7.0 and 7.7 percent were considered low.

Malaria case loads in integrated districts appear to be too great to be handled by the normal integration services. A group of consultants from USAID, WHO, and the United Kingdom recently recommended that spraying operations in the integrated districts having malaria difficulties should be totally reverted to NMEC responsibility until such time that the level of malaria can be handled by ICHP. ICHP would continue its present structure and maintain and improve its surveillance capabilities for malaria control. The group of consultants also recommended that any future transfer of malaria control activities to the ICHP be based on sound epidemiological and management decisions made by technical experts.

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1/ API is the Annual Parasite Index for the number of cases per thousand.

The above problem areas were covered in our draft report with a recommendation that the Director USAID/N determine the extent and impact that integration activities are having on service levels in the malaria control and FP/MCH areas and develop, with the HMG, a comprehensive plan to eliminate those conditions determined to be causing a reduction in program effectiveness. In responding the Director stated that the Mission does not disagree with the recommendation. "However, under the forthcoming Integrated Health/Family Planning Services program, malaria will remain as a separate project because of the inherent problems in controlling this disease. Responsibility for the action phase of malaria control in areas temporarily assigned to ICHP will revert to NMEO. The recently completed mid term review (June 1979) of the Ministry of Health concerning performance in all areas of the health sector concluded after careful analysis that there was no statistically meaningful difference between performance in the population field of ICHP's village health workers and FP/MCH'S panchayat-based or clinic based workers. Accordingly, the Mission considers that the recommendation ... is no longer pertinent. However, future performance of ICHP workers will be closely monitored during FY 80 and the subsequent five year Integrated Health/Family Planning Project."

## G. HMG ACCOUNTING FOR LOCAL CURRENCY

As in 1977, we again found that HMG's accounting for U.S.-owned local currency contributions was inadequate. This has been a long standing problem for years without a satisfactory solution. In our view USAID/N officials should take forceful action immediately to resolve this continued accountability problem.

USAID/N's Office of Financial Management conducted a review on the propriety of FP/MCH's local currency expenditures for the period July 1, 1975 to June 30, 1978. In their report issued in July 1979 they found:

1. Joint HMG/USAID funds have been commingled with other donor's contributions for fiscal years 1976 and 1977.
2. Advance ledgers were not posted on a current basis; a separate advance ledger was not being maintained for joint HMG/USAID activities.
3. The total amount expended for the joint HMG/USAID family planning project activities could not be determined because reported expenditures included transactions not authorized under the terms of the project agreement.
4. FP/MCH field office records and reports contained many accounting discrepancies.
5. Unsatisfactory performance in HMG's ability to clear advances made to contractors.

These problems have been brought to the attention of top USAID/N officials repeatedly over the years. However, USAID/N has not taken adequate steps to deal with the findings listed above.

In our 1977 report we recommended that USAID/N make a final concerted effort to clear up uncleared advances.

Although USAID/N has requested FP/MCH several times to resolve the uncleared advances, the requests have not been complied with. In October 1978, USAID/N requested FP/MCH to submit a final statement of uncleared advances for fiscal years 1976 and 1977 by November 30, 1978. However, the requested final statement has yet to be submitted by HMG.

In our view it is imperative that USAID/N, as a condition precedent for future funding, require HMG to initiate an effective system for both clearing and following up on uncleared advances.

Recommendation No. 6

We recommend that USAID/N resolve the accounting difficulties with the HMG and, if the outstanding uncleared advances cannot be cleared within 90 days, future funding should be withheld.

## H. FUTURE DIRECTION OF USAID/N ASSISTANCE

Currently, USAID/N is preparing a \$ 2 million project paper for their Population Policy Development Project (367-0130) which is planned for 1979. The purpose of this project is to develop a population policy support element and to assess determinates of fertility and their relationship and impact on development. As such, the project is aimed at assisting the Nepal Population Commission (POPCOM). This organization will then utilize various research findings for the purpose of making recommendations for new laws and policies on factors relating to the impact of the effect of population growth.

USAID/N also plans to support HMG's rural health program through a proposed \$27 million project entitled "Integrated Rural Health/Family Planning Services." The project is planned to be implemented at the end of FY 1980 and will continue through FY 1985, a period of five years.

U.S. Government inputs to the project will provide technical assistance valued at approximately \$3.0 million for 228 person-months of long term and 37 person-months of short term service. This assistance will be provided by experts in the fields of Health Administration, Health Planning, Field Management, Training/Health Education, Family Planning and Malaria. Additional inputs will consist of \$5.5 million for dollar funded malaria control and family planning commodities, \$.8 million for a participant training program for 14 long term and 130 short term participants and \$17.7 million in the form of budgetary support. More specifically, the local currency budgetary support is identified for the following:

	<u>Amount</u> (Millions)
Integrated Community Health Project	\$ 4.0
Ward-based Health Workers	\$ 1.0
Supply of Basic Pharmaceuticals	<u>\$ 5.0</u>
Sub-Total	\$10.0
Family Planning Services	\$ 4.9
Logistic Services (Recurring Costs, Equipment and Construction)	\$ 2.4
Special Studies	<u>\$ .4</u>
Total	<u>\$17.7</u>

Generally, in our review of the draft project paper we found that it closely relates to the HMG's long term health plan, which calls for the provision of minimal health care and family planning services to the maximum number of people by 1985 through a fully integrated program. The project paper also recognizes and discusses many of the difficulties included in this report such as the organizational structure problem, the duplication of effort in the supply area, the lack of host government support, the general lack of basic medicines, staffing shortages and the apparent confusion resulting from AID support of the divergent, and sometimes contradictory or over-lapping health efforts in Nepal. However, even though these major problems have been recognized, it was our general impression that there was insufficient

attention paid to resolving the critical issues discussed in this report. There was no indication that studies or planning were undertaken to identify specific corrective action or that there was any effort to include requirements that the Host Government perform even at a minimum level of acceptable standards.

Overall, the paper does not show a specific commitment or course of action by the Host Government. Rather, general statements are included such as "HMG has the clear intention of combining by 1985 all rural health services into a system of integrated management", or "It is anticipated that the Director General of the Division of Health Services will be the person responsible for the integration process" or "The exact mix of integration, management and resources are details still to be worked out", and finally, the conclusion that this USAID project is flexible enough to assist HMG "regardless of the precise details in delivery format."

In short, we do not see where the present situation will change dramatically except for the massive input of U.S. assistance. There is no real hope that Nepal can substantially increase their financial contributions nor is there any evidence of increased commitment by the Host Government. For example, the paper points out that the existing 533 health posts are, on the average, out of medical supplies for nine months of each year. In our tests we checked 27 such health posts and found them all to be poorly supplied, some without even aspirin. This is the current situation! Yet, the HMG is now proposing to add 30,000 ward-level health workers to the program, with all of them to be trained and supplied by the MOH.

There are some important, unanswered questions about the above program. For instance, where are the extra basic medical supplies and other financial support to come from considering the HMG's current

level of support? Is it even possible for such a program to be carried out in Nepal given the present constraints? Is it realistic to think HMG can afford the program in future years?

In our opinion, the effectiveness of this expanded rural health services program in Nepal cannot be increased above present levels until these questionable areas, and the various constraints described in this report, are thoroughly addressed and resolved. Our previous recommendations are directed to that end, therefore, we see no need for another recommendation here.

Management Comments:

"We generally concur with the draft report's findings and recommendations. However, we are concerned about the draft report's references to our draft project paper (PP) entitled Integrated Rural Health Services. This document consisting of 38 pages, which only included part I. Introduction and Part II. Detailed project description, was in no way intended to be a complete draft PP nor a complete draft of these two sections. It was intended to be a talking paper for use with HMG officials. Its purpose was to identify broad controversial issues to stimulate debate in the GON and to force the GON to work out decisions on these identified issues rather than have the Mission provide HMG with a set of proposed solutions. As per guidelines provided in Handbook 3, Chapter 5, the completed PP will include an administrative feasibility section. This section, when drafted, will deal with the issues raised in the draft audit report as well as other issues."

## EXHIBIT A

USAID/NEPAL  
HEALTH/POPULATION/FAMILY PLANNING  
SUMMARY OF PROJECT FISCAL DATA  
AS OF JUNE 30, 1979

Project No.	U.S. Dollars (000)		Equiv. US \$ (000)		Total	
	Obliga- tions	Expendi- tures	Obliga- tions 1/	Expendi- tures 1/	Obliga- tions	Expendi- tures
Malaria Control 367-0115	\$ 219	\$ 198	3,574	\$2,582	\$ 3,793	\$2,780
Population/Family Planning, 367-0096	\$7,703	\$5,048	\$3,281	\$2,759	\$10,984	\$7,807
Integrated Health Services, 367-0126	\$1,250	\$ 831	\$ 730	\$ 457	\$ 1,980	\$1,288
Integration of Health Service, 367-0227	\$ 901	\$ 899	\$1,691	\$ 86	\$ 2,592	\$ 985
Totals	<u>\$10,073</u>	<u>\$6,976</u>	<u>\$9,276</u>	<u>\$5,884</u>	<u>\$19,349</u>	<u>\$12,860</u>

1/ Nepalese Rupees and Indian Rupees converted  
at \$1 = 11.9 and 8.0 respectively.

LIST OF RECOMMENDATIONS

Page No.

Recommendation No. 1

The Director, USAID/N should require, as a condition 14  
precedent to financing the Integrated Rural Health/  
Family Planning Services Project, that the HMG  
develop and implement a time-phased organization  
plan for the establishment of a single, unified  
organization having the managerial authority to  
effectively administer and implement the integration  
of all rural health services in Nepal.

Recommendation No. 2

The Director, USAID/N should determine, in collabora- 17  
tion with appropriate HMG officials, the annual  
volume of medical supplies needed and their cost to  
provide full support to the health post and ward  
level community programs. U.S. Government assistance  
to those programs should then be conditioned, in the  
project paper and project agreement, on actual  
performance of the HMG to budget and release, on a  
reasonable but specific time-phased basis, the  
donor and Host Country funding necessary to support  
an effective level of programming.

Recommendation No. 3

The Director, USAID/N should require the MOH to 22  
develop and implement a coordinated logistical  
supply system for all AID supported projects that  
is capable of ensuring adequate logistical support  
services including proper inventory, storage, procure-  
ment, and distribution procedures.

LIST OF RECOMMENDATIONS

Recommendation No. 4

The Director, USAID/N should establish appropriate procedures to obtain the most complete and accurate data relevant to total contraceptive stocks in country and on the number of contraceptives distributed to users for use in preparing the Annual U-1612/4 and the Quarterly U-1612/3 Reports. 25

In our draft report we also recommended that the Director, USAID/N determine future contraceptive requirements for Nepal based on the revised inventory and usage levels indicated above and either cancel or reduce the current supply of contraceptives on order. The Director has since advised us that a determination regarding current and future contraceptive requirements for Nepal has been made and that AID/W was requested to divert or cancel the procurement in question. Accordingly, AID/W reduced the condoms quantity on order by 6 million units and rescheduled delivery of the oral contraceptives.

Recommendation No. 5

The Director, USAID/N should require, before any action is taken to destroy existing overage condom stocks, that sufficient testing be conducted to determine the quality and usefulness of the substantial quantities of such commodities presently in country. 26

Recommendation No. 6

We recommend that USAID/N resolve the accounting difficulties with the HMG and, if the outstanding uncleared advances cannot be cleared within 90 days, future funding should be withheld. 31

REPORT RECIPIENTS

USAID/Nepal

Director 5  
AID/W

Deputy Administrator (A/AID) 1

Bureau For Asia:

Assistant Administrator (AA/ASIA) 1  
Deputy Assistant Administrator  
(Audit Liaison Officer) 1  
Office of Pakistan and Nepal Affairs (ASIA/PN) 1

Bureau of Development Support:

Office of Development Information and  
Utilization (DS/DIU) 4  
Office of Health (DS/HEA) 1  
Office of Population (DS/POP) 1

Office of Legislative Affairs (AA/LEG) 1

Office of the Auditor General:

Auditor General (AG) 1  
Executive Management Staff (AG/EMS) 12  
Policy, Plans & Programs (AG/PPP) 1

Area Auditor General:

AAG/Washington 1  
AAG/Africa (East) 1  
AAG/Africa (West) 1  
AAG/East Asia 1  
AAG/Egypt 1  
AAG/Latin America 1

OTHER

Auditor General, Inspections and Investigations  
Staff, (AG/IIS/Karachi) 1