

memorandum

DATE: May 29, 1986

REPLY TO
ATTN OF: David H. Calder, Chief, HFP, USAID/Nepal

PN-AAY-677

SUBJECT: Child Survival Strategy

TO: Paul Hartenberger, ANE/TR/HPN

Refs: (A) State 099765 (attached)
(B) 85 Kathmandu 03306 (attached)
(C) 85 Kathmandu 01906 (attached)
(D) Epidemiologic Review of Data on Primary Health Problems in Nepal, N.H. Wright, February 1986 (attached)

I. Background

A. From the first AID presence in Nepal until about 1970, essentially all the health sector programming was for malaria control, which was a tremendously successful effort. In the early '70s USAID supported in a modest way the establishment of a family planning program. Then in the late '70s, as malaria inputs were decreasing, the mission concentrated on increasing FP coverage, population policy development, and on organizational and management improvement in the MOH (planning, integration of services and management, financial management) and some physical infrastructure development (especially health posts and warehouses). The current major HFP sectoral commitment to Nepal (begun in 1980), the IRH/FP Project (0135), is along these lines and in late 1984 was extended from a TDD of Sept. 1983 to March 1988. Activities that now would be classified as "CS-type" were not a prominent part of this project. In fact, other than a small input for cold chain equipment for EPI and the inclusion of packaged CRT into the product line of a social marketing sub-project, there were no direct project inputs toward EPI, CRT, ARI or Vitamin A programs. The FP inputs into MOH programs were monopolized by VSC camp programs, with relatively minor attention to spacing and basic MCH services.

In response to this situation, the Mission in March 1985 committed itself to putting additional focus on issues of child survival (with or without the label), reduction of severe childhood morbidity, and reestablishment of the balance in public sector

services among MCH, birth spacing and permanent contraception. We committed to do this to the degree possible within existing Project 0135 commitments and obligations (but remaining funds already are heavily mortgaged, so little flexibility remains) and with any supplemental CS funds we could obtain.

Thus, we requested \$1 million supplemental CS funds (Ref C), which we were granted and applied to new initiatives in EPI, ORT and ARI. Without enough funds to support new programs in spacing, we resolved to use Project 0135 leverage to the degree possible to bolster the GON's poor performance in temporary contraception and general MCH outreach services. The CS funds were of enormous help to us; they permitted us to become seriously involved for the first time in EPI and ORT programs and they allowed us to pioneer in ARI work in Nepal. Now, one year later, all of our planned CS activities have been started in the field and USAID has become an active partner in these important GON programs. On the FP side, the GON now agrees that its spacing and MCH services were being neglected in its passion for VSC and it is struggling with the implications of this realization.

We should note that we made a conscious decision not to include major protein-calorie malnutrition (PCM) nutrition activities in our plans. In no way do we underestimate the impact of undernutrition on childhood morbidity/mortality. The situation here, though, is that the government's capacity to deliver nutrition services already is greatly over-extended handling a multi-sectoral village-based nutrition intervention program supported by WHO/UNICEF. We probably won't be programming in the area of iodine deficiency, a major problem in the mountains, again because UNICEF and the Indian Govt. have major support programs. Vitamin A is an area of great interest to us, as will be described below. We foresee no separate programs for iron deficiency, but certainly will advocate proper attention to iron in all MCH and nutrition programs.

B. Other Donors

In brief, this is what other donors are doing in CS-type activities:

1. UNICEF - historically the major donor in support of EPI (vaccines, equipment, IE&C

materials, training, transportation); iodine deficiency (mass campaigns with iodized oil, surveys); diarrheal disease control (ORT packets, training). Joint support with WEO of village-based nutrition program.

2. WEO - TA, advocacy and small financial contributions for EPI, CDD and nutrition program.
3. UNFPA - Along with USAID, a major donor for FP. Recently increasing support for basic MCH services, but such largely limited to about 5 districts (out of 75 in Nepal).
4. No other bilaterals or multilaterals substantially involved.
5. Many active NGOs in Nepal, some of which (SCF-US; SCF-UK; Nepal Red Cross; and others) do CS-type work, but these groups provide coverage to only small segments of the population.

C. GON

At the policy level the GON is quite progressive. Emphases are on community-oriented services, preventive services as well as simple curative, service equity and voluntary reduction of fertility. There are coordinating committees for national immunization, oral rehydration, FP/MCH, and integrated services. Long-term HFP plans are ambitious. There are many committed officials and citizens.

But the economy is stagnant and resources available domestically for HFP are not growing. Sectoral technical leadership is dominated by informal power channels at political and palace levels. Civil service performance is weak. Overambitious and unrealistic programming has been the rule.

There is a 10-year history of GON commitment to replacing the prevailing vertical programs (FP/MCH, malaria, EPI, TB and leprosy) with an integrated management/service structure. This conversion has stagnated with only 6 of 75 districts "fully-integrated" and 19 "partially integrated" (read: "confused"). Modest levels of coverage attained by vertical programs pre-integration have tended to deteriorate post-integration due to a variety of factors. Added to this is a GON policy to

regionalize in 5 administrative regions (just beginning but with no impact yet) and to decentralize significant authority to the 75 districts (just beginning). Add again the harsh reality that even the modest HFP coverage thus far is highly donor dependent for financing (perhaps 70% donor financed) and that the programs must operate in Nepal's famous milieu of difficult terrain, poor seasonal communications, pervasive poverty, 80-90% adult illiteracy and inability of the vast majority of the population to purchase most modern health services.

All of the above lead to the conclusion that we must be realistic in our programming objectives. The "Health for All by the Year 2000" rhetoric is absurd for Nepal, and while we should applaud its good intentions, we should not let it cause us to program over-ambitiously.

Based on the USAID sectoral experience thus far, we can see several other important lessons learned:

- We, and other donors, have limited ability to change the way GON decisions are made and management is actually done, as opposed to our power to change things on paper.
- The private sector is not likely to play a major role in population coverage with basic FP services (with the exception of temporary contraception and ORT) for the next couple of decades. So if people are to have even the most modest services, the public sector will have to bear most of the load.
- The GON HFP service capacity (and budget) is relatively fixed, and an over-commitment to any one service will, unfortunately, mean a concomitant reduction in capability to deliver other basic services.
- The system will "drift" to fixed-facility, low coverage, relatively capital intense services (and to a VSC-dominated approach to FP), if permitted by the donors.
- USAID is the best able of the major donors to help GON provide better (not great, but better) coverage of the population with EPI, ORT, ARI and balanced FP services.

II. EPI

A. Incidence of Major Vaccine Preventable Diseases of Childhood

Since we sent Ref. B one year ago (see Ref B Para 3 and 4B), we have had an epidemiological review of all obtainable published data on many important health problems in Nepal, including the "EPI diseases" (see Epidemiologic Review of Data on Primary Health Problems in Nepal, N. H. Wright, Feb. 1986 - attached). As expected, the available data are neither comprehensive nor conclusive. Based on what data exist, however, and on what might be expected to be the disease incidence in Nepal based on comparative data from other countries, the following conclusions seem reasonable (and making some programming decisions based on them also is reasonable):

- Neonatal tetanus is a (or the) major cause of neonatal mortality, at least in the Terai (45% of the population), with estimated incidence of 20-30 per 1000 live births. Incidence in the hills/mountains is less clear.
- Measles is a major childhood killer and contributor to various morbidity consequences. Childhood death rates attributable to measles may reach 2-3% overall.
- Pertussis is a severe, hidden problem that causes some deaths and probably causes major morbidity.
- The impact of diphtheria and childhood TB (especially pulmonary and meningeal) are unclear.
- Polio is a problem (especially morbidity), and it might be expected to worsen in the future.

B. GON EPI

The vertical Expanded Immunization Program (EIP) has immunization activities in 52 districts, the integrated services program (ICHSDP) in about 20 (there is some overlap in "partially integrated" districts). The integrated program is supposed to replace EIP in all districts over time, but this is stalled. Where ICHSDP has supplanted EIP, usually immunization coverage has deteriorated. It is planned that within 4 years all 75 districts will have some immunization services, but coverage levels are not predicted clearly.

EIP has dynamic new leadership, willing to work to overcome organizational stagnation and rigidity. Personnel are on contract, thus easier to manage than poorly performing ICHSDP civil servants. On the other hand, phase out of vertical programs to integration still is national policy, but issues of how to improve ICHSDP performance are not resolved. Few immunizations are offered at static facilities (health posts and hospitals), due to disinterest, bureaucratic territoriality and cold chain problems.

Coverage statistics are notoriously unreliable and usually overstated. Based on reported statistics, observation by us and others and anecdotal information, we estimate coverage of the nationwide cohort of about 600,000 0-1 yr. olds in 1984-85 Nepali Fiscal Year to be the following:

DPT III	-	20%
Polio III	-	10%
BCG	-	45%
Measles	-	20%

and coverage of married women of reproductive age (MWRA):

MT2	-	20%
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GOV commitment to EPI is improving, not to a small degree due to pressure from UNICEF, WHO, UNFPA and USAID. Some of the reasons for low coverage until now, aside from the organizational confusion among EIP, ICHSDP and the Dept. of Health Services (responsible for hospitals/health posts), are:

- low public awareness/interest;
- low population density, difficult travel, cold chain logistical nightmares;
- seasonality (cannot do outreach and logistics work during and soon after monsoon season);
- human portage required to/from majority of districts;
- public suspicion (confusion with Depo-provera);
- usurpation of manpower for VSC camp campaigns.

C. USAID's role

We as an organization are technically, financially, philosophically and managerially able to complement/supplement GON and other donor resources in a constructive way. Our objectives are in terms of both increasing coverage and quality of services through the following:

<u>Coverage</u>	<u>Quality</u>
- varying the static/ outreach target group strategies according to terrain, epidemiology, available manpower, season;	- greatly increased training;
- TT campaign in Terai for all married women of reproductive age (MWRA); urban program;	- greatly improved supervision;
- more productive use of manpower;	- program monitoring techniques for supervison;
- Improved strategies for ICRGDP and use of static facilities.	- information systems (with necessary hardware).

USAID's competitive advantage is in its ability to support local costs for widespread field programs, provide on-site technical expertise, and provide medium term (minimum 5 year) commitment.

D. Other Donors

UNICEF's advantage normally is in vaccine and commodity support. It is likely that they also may be receiving substantial Italian funding for immunization, which would enable them also to support local costs, but probably they cannot sustain this level of support beyond 2-3 years.

W.H.O. will continue to provide observation tours and TA, whether or not they are useful (fortunately, current WHO EPI LTC is excellent). Intermittently WHO may also provide relatively small funding for training.

UNFPA may provide funding for immunization in a few districts.

E. Major Unknowns

- GON's pace and procedures for integration of services (and abolition of vertical programs)
- UNICEF's level of funding over medium and long-term.

III. ORT

A. Magnitude of Problem

The only decent national incidence data come from a 1985 30-cluster survey sampling 92% of Nepal's population. Estimates from this survey are:

- Average under 5 year old child has 6.1 episodes of diarrhea per year.
- Under 5 diarrhea-associated death rate is 16/1000.
- 44% of all under 5 year old deaths are diarrhea-associated.
- Annually under 5 year olds experience 17 million episodes of diarrhea and 45,000 deaths.
- 14% of children's diarrhea episodes are treated with ORT made with packaged salts; 12% are treated with home salt-sugar solution.
- At least 98% of all episodes of childhood diarrhea are never seen in the static health facilities.
- 42% of surveyed mothers had heard of ORT.

There is pitifully little data available on the contribution of various etiologies of diarrhea in Nepal, nor is there much comprehensive data on the epidemiology, other than incidence data from the survey noted above. As with ARI (discussed later), in the absence of better laboratory facilities we must draw conclusions based on anecdotes and on data from other countries with similar environments.

B. GON Program

There is a national diarrheal disease control program (CDD) coordinating committee, but it is quite new and as yet ineffective. (Almost by default) the ICHSDP has had the major responsibility for the field program because the FP/MCH vertical

project has nearly totally neglected diarrheal diseases, and only one hospital has established and maintained a functioning ORT unit. Unfortunately, ICHSDP is active in only a minority of districts, and has serious coverage deficiencies in those districts, so national coverage is weak. Resistance of the medical community to ORT is not as strong in Nepal as in some other countries, yet the overuse of IVs, antibiotics and useless drugs and dietary regimens is still a major problem. ORT is produced by the GON Parastatal Royal Drug Company, but production is only a small fraction of calculated need, and somewhat below demand. GON policy promotes the use of both packaged ORT and home-made salt-sugar solution. There has been some pilot project experimentation with rice-based solutions.

Several years ago, packaged OR salts were added at subsidized prices to the product line of the Contraceptive Retail Sales (CRS) program. Despite competition from Indian brands and the availability of the same product free through GON health programs, CRS already has a 50% market share. So this vehicle has good potential, at least in the population in frequent contact with large bazaars where the 10,000 retailers sell CRS products. A major impediment, though, is that the majority of Nepal's population are beyond regular contact with the large bazaars and are, therefore, unlikely to purchase OR salts from the retailers.

Training in ORT for health service personnel at the district level has begun at 39 districts of 75; at the health post level it has occurred throughout only 7 districts with any thoroughness.

Currently there is no active research program on diarrheal diseases in Nepal.

C. Other Donors

WHO has provided TA, advocacy and opportunities for some officials to attend CDD management courses.

UNICEF has been the most active, providing production equipment and ingredients for packaged OR salts; packaged OR salts to CRS Company; training; and educational materials.

Small NGOs (like the SCFs; missionary health units, etc.) have been introducing ORT, even rice-flour ORT, into their programs. No other major donors are involved.

D. USAID's Program

One year ago we entered the ORT field in Nepal (see Ref B) with CS funds. Because of limited funds we couldn't try to be too comprehensive or grandiose, so we elected to limit those inputs to the following activities:

- send 28 physician-nurse pairs from around the country to the ICDDR,B clinical ORT course;
- train 200 health personnel in the national pediatric hospital's ORT unit (probably the only functioning unit in a government institution in Nepal);
- contract the Nepal Pediatric Society to help establish up to 15 new ORT units in hospitals;
- establish a small grants program to encourage local research in diarrheal disease control;
- sponsor a pre-Congress Workshop on ORT at the National Pediatrics Congress;
- establish in two districts an ORT training outreach program with high coverage using contract women trainers.

In addition, we are sponsoring a study of the issues surrounding proper package size for ORT salts; producing training materials; strongly encouraging the large FP/MCH program to stress ORT in its program in 52 districts; and, of course, providing most of the operating resources of the Contraceptive Retail Sales Company.

E. Future Plans

If the contracted outreach training program in two districts proves successful, we will encourage major expansion of this program. If not, we will go back to the drawing board to seek other coverage methods. Simultaneously we will seek technical, management and supervisory tools for assuring greater attention of government health workers, especially at health posts and the various outreach workers, to promotion and support of ORT at far greater coverage levels.

Based on the experience from the Pediatric Society contract to establish new hospital ORT units, we

will seek MOH commitment to expand this effort, and to modify the ORT unit concept to health centers and health posts.

Researchers who prove themselves through the small grants research program will be encouraged to organize larger scope research efforts for AID funding. This research could be related to diarrheal disease control in many ways - epidemiology, etiology, socio- anthropology, economics, nutrition, etc.

IV. ARI

A. Magnitude of Problem

There have been only a very few competent and limited studies of ARI childhood mortality in Nepal. They suggest that ARI may be the largest cause of infant and childhood mortality in high hill populations. Anecdotal information supports this, and it is probably reasonable to assume that ARIs are major killers in both the high and mid-hills. The degree of the problem in the Terai is less clear; there are no decent data, but data from comparable environments in other countries suggest that childhood pneumonias will be significant contributors to infant/childhood mortality in the Terai also.

B. Control Options

In reality, little can be done to cure that percentage of childhood pneumonias caused by viruses. Bacterial pneumonias, on the other hand, often can be cured if the proper therapy is administered in time. And some severe ARIs can be prevented by immunization in children; this is especially true for the serious ARIs consequent to measles and pertussis infection. So there really are three intervention options (aside from nutrition improvement, domestic smoke pollution reduction, etc.):

1. passive case detection/treatment (PCD) - ie, waiting for cases to appear for treatment at routine treatment points;
2. active case detection/treatment - ie, actively searching for cases and providing treatment;

3. immunization to prevent ARI (generally in LDC's limited to measles and pertussis, but new vaccines for pneumococcus and H. influenza may change this picture in the near future).

C. GON Program

GON has no special ARI program. ARI cases are treated as they present to routine treatment points. While a large percentage of cases presenting to health facilities are in fact mild ARIs, only a tiny percentage of life-threatening ARIs are ever treated, and even then they are often seen too late in the course of the disease and/or appropriate therapy is not available/provided.

D. NGO Programs

Only one very small, local NGO has any experience with active case detection (ACD) systems for ARI mortality reduction. Its field intervention site is a small hill area near Kathmandu. According to preliminary results, the ACD system is reducing mortality significantly.

E. USAID Program

USAID has developed and is supporting a new district-wide ARI ACD program in the high-hill Jumla area in the west (Ref 3 para 5 E). This is the first large-scale ARI intervention program in Nepal. It is too early for any conclusions. Also planned for parts of a neighboring, remote district, where now no health services exist, is a "pure" measles and DPT immunization program (regretably, intervention on only a small scale is feasible in this harsh environment) from which we hope to get some information on reduction of ARI deaths from that intervention alone.

F. Program Plans

1. Jumla ACD Field Trial - we plan to fully implement stage I of this trial as planned, through March '88. Then, based on evaluation findings, we plan to refine the interventions if it appears that doing so will increase program efficiency, and perhaps move on to a Stage II maintenance phase, in which we would expect the problems to be somewhat different than during the start-up phase.

2. Other field trials through NGO's - we would be more comfortable about drawing policy conclusions about ARI program feasibility in Nepal if we had information from other than the one field trial in Jumla. Therefore, we hope to initiate another hill/mountain area field trial through another NGO within the next two years. If another could be found for the Terai also, we would be pleased.
3. Field trials through GON - we hope to interest GON in examining its ARI mortality reduction capabilities and help them work through the practical issues of how best to deal with ARIs through their existing static and mobile systems. We would expect this would be well-served by field trials in several locations around the country, each of modest enough scale to be manageable by the frail government service capacities.
4. Small grants and training programs through medical societies - if our current program of this type for ORT through the Nepal Pediatric Society proves successful, we anticipate trying to initiate a similar program for ARI case detection and management.
5. Prospective incidence study in the Terai - if we can find an appropriate implementing organization, we would like to address the question of how severe is the ARI problem in the Terai.

G. Major Unknowns

- results of Jumla area intervention trials;
- MOH interest in systematically addressing its ARI through its service systems;
- whether etiologies of severe ARIs in Nepal are significantly different from other LDCs for which data are available (especially Papua New Guinea). We judge, unfortunately, that given current technologies, truly reliable etiology studies are not now feasible in Nepal, so we are proceeding on certain assumptions based on the world literature on the subject;
- extent to which the severity of the ARI problem varies in the different ecologic zones in Nepal (Terai vs hills vs mountains vs urban);

- concern over WHO's future role in ARI. If they induce the GON to make premature and restrictive national ARI policy decisions in the absence of further appropriate field data and intervention experience, it could be difficult to approach the problems systematically.

E. Other Donors

- WHO thus far inactive (but our concern as noted above).
- UNICEF support limited to financial backing of the small intervention trial near Kathmandu.

V. Vitamin A

Magnitude of Problem

An excellent eye morbidity survey in 1980-81 clearly demonstrated xerophthalmia to be a "significant problem" (by WHO criteria) in several locations in the Terai. Data on incidence/prevalence in the hills are less clear (see Wright's report). There are almost no data on serum Vitamin A levels or associations of xerophthalmia with other illnesses. There are few data on seasonality of xerophthalmia (other than some hospital data) or on potential fortification vehicles.

B. GON Program

The joint "Nutrition Program" sponsored by UNICEF/WHO includes capsule distribution (only 10,000 IU doses) as one of its desired interventions, but this program has as yet little field presence and will face major implementation obstacles. GON has no other Vitamin A programs.

C. NGO Programs

Several NGOs provide curative and clinical ophthalmologic services, but there are no community based Vitamin A intervention programs.

D. USAID's Current Program

In light of the encouraging findings in Indonesia on the statistical association between Vitamin A intervention and mortality reduction, and in light of the demonstrated xerophthalmia problem in at least some parts of Nepal, the Mission has been

seeking capable implementing agencies for a Vitamin A intervention program in several Terai districts of proven high prevalence. We have judged that only NGOs are appropriate at this point in time. Recently we have agreed with a small PVO on the submission of a proposal for a community-based capsule distribution program for the reduction of xerophthalmia. We cannot find any organization yet capable of implementing a full mortality-reduction field trial, but of course we are hopeful that through a xerophthalmia prevention/treatment program there might be additional, even if unmeasurable, benefits to children's overall health status.

E. Program Plans

- initiate capsule distribution program in at least two Terai districts (as above);
- in association with that field program (or separately, if necessary), study the issues of the severity of the Vitamin A deficiency problem in the hills; seasonality of Vitamin A deficiency; and potential vehicles for fortification;
- based on the above, draw up and promote recommendations for action by other NGOs and government services around Nepal.

VI. Childhood Malaria

A. Magnitude of Problem

Due to a variety of factors, malaria is likely to make a major resurgence in Nepal's Terai. (Fortunately, transmission is unlikely to be a significant problem at altitudes above 1000 meters.). Data are not currently available on the mortality impact of malaria on children in the Terai (see Wright's report). We suspect it has been low over the past 20 years when malaria has been under quite good control.

We are aware, however, of how severely children can be affected in an epidemic situation, especially with high transmission of P. falciparum, and especially in relatively non-immune populations (such as the Terai where transmission has been primarily P. vivax and at low levels since the 1960's). Therefore, if the epidemic occurs in large areas of the Terai we would expect significant direct and indirect mortality in children related to the malaria.

B. GON Program

USAID has informed GON (and other donors) of our concern about the deteriorating malaria situation, the health risks (as well as economic risks), the options we see available for GON action, the problems in current malaria program operation, and the unlikelihood that USAID will be able to respond in the future (as in the past) with greatly increased resources to manage the problem.

C. USAID Program

USAID has over the past decade been phasing out its inputs into the Nepalese malaria control program (after more than 30 years of being the major donor). Currently we provide only 300 metric tons of malathion per year. We will supplement this in the coming fiscal year with small local cost assistance to strengthen a volunteer case detection and treatment system, help gather some basic entomologic data, and help upgrade the malaria control capabilities in the integrated services districts.

In view of the limited resources likely to be available from AID for malaria program support in Nepal, we will have to make difficult choices. Looking at the long term, probably we will concentrate on upgrading the inadequate malaria training and research system (with research emphasis on obtaining basic entomologic information and on methods to minimize the risk to children from malaria) and strengthening the volunteer case detection and treatment system. Whether we will be able to provide any insecticides beyond 1988 is problematic.

VII. Birth Spacing

A. Scope of the Problem

Contraceptive prevalence in Nepal is low. A 1981 Contraceptive Prevalence Survey (CSP) carried out by Westinghouse found that only 6.8% of married couples of reproductive age were currently using modern contraception methods. Of these 6.8%, 76% were protected by permanent voluntary surgical contraception (VSC). Of the remaining 24% using temporary methods, most reported wanting no further children. In other words, family planning is adopted primarily to limit family size, not to space

births. Although data are not yet available from a recently completed GON/UNFPA fertility/CPS it is unlikely that overall contraceptive prevalence will show more than a modest increase (perhaps to 15%) of which most will be accounted for by increased reliance on VSC. It is not likely that use of contraception for birth spacing purposes will have increased much, except perhaps among the small urban population.

Data suggest that in Nepal probably 25% of all children born are "short-interval births", i.e. the child is born less than 2 years after a previous birth, and many more less than 3 years after the previous birth. Given that shorter birth intervals are associated with higher rates of childhood mortality/morbidity, and that there are other profound social/economic consequences of short birth intervals, better birth spacing should be a high priority in any child survival/welfare program here.

B. Current GON Policies and Programs

As mentioned earlier and as the 1981 CPS data indicate, GON family planning programs are largely supportive of VSC, thus sacrificing opportunities to reduce infant/child mortality (and maternal mortality/morbidity) through improved birth spacing. FP/MCH outreach workers and multi-service health workers are theoretically supposed to provide MCH services, motivate couples to use family planning, distribute pills and condoms, and refer couples, where appropriate, for IUD insertion, injectable contraception, and VSC. However, in reality, we know that these outreach workers spend the overwhelming majority of their time motivating couples for VSC.

It is only in the past year, as a result of considerable donor (largely USAID and UNFPA) dialogue, that the MOH has begun to seriously discuss improving the mix of temporary and permanent family planning methods. But this will be a struggle; although many MOH officials understand the concept of birth spacing, there is as yet too little commitment to making the systems changes necessary to support successful birth spacing programs (other than contraceptive retail sales, which is viewed as "extra-governmental").

C. USAID's Role

USAID is the only supplier of pills, condoms and IUDs to the GON family planning program and to the private sector CRS program. The Mission also provides considerable local cost support to MOH activities primarily centered around outreach workers and family planning motivation. It is only within the past two years that USAID has placed considerable emphasis on the potential child/maternal health benefits to be derived from temporary family planning methods, in addition to the demographic advantages.

D. Other Donors' Role

UNFPA is the other major donor in this area. To date their assistance has focused on improving family planning IEC services and on training outreach workers and mid-level multipurpose health workers. They are also the supplier of injectable contraceptives. In the past several years they have significantly increased their emphasis on MCH and temporary family planning.

In addition several local PVOs, including Nepal Red Cross, Mothers' Clubs, Ex-Servicemen's Organization, SCF-US, etc), provide MCH and temporary family planning services in small project areas. Although coverage is often confined to several panchayats in only one or two districts, their client use and continuation rates of pills and condoms are far better than those achieved by GON programs.

E. Future Program Plans

Through FY 87, USAID will continue to assist the GON to identify and implement activities which increase not only the use of temporary family planning methods but also the concept of birth spacing. Within the current IRE/FPS Project, that will likely be limited to more targetted training for outreach workers. Mission is also working with the MOH to identify ways and means for recruiting more female outreach workers under the assumption that females will more provide better services, including birth spacing and MCH. It is likely that in the next several years the MOH will carry out several small studies or research activities in this area with USAID assistance. (We will not neglect VSC; we consider it an important component of any healthy FP system. However we will concentrate on quality assurance rather than the pursuit of excessive targets.)

The new project will identify strategies for assisting GON programs, PVCs, and private organizations in expanding outreach and follow-up of temporary contraceptive services, improving client continuation rates and disseminating information on the concept of birth spacing.

VIII. Overall Plans

AID has a long history and major investments in various aspects of the health/FP/population policies and programs in Nepal. We have provided a significant portion of the GON sectoral budget, and any alterations in our support must be careful to protect the positive achievements and not too severely disrupt MOH programs. In addition, our major sectoral project commitment (Project 0135) continues until March 1988, and the remaining resources are heavily mortgaged toward existing commitments for malaria commodities, healthpost construction, MOH general operating expenses, VSC, contraceptives, etc.

What the above imply is that we cannot shift gears precipitously to become a "pure" CS program. However, based on our assessment of program experience in Nepal and on our own interest and AID/W.new interest in CS, we elected to begin shifting mission priorities in the direction of "CS-like" activities, specifically EPI, ORT, birth spacing, ARI and, possibly, Vitamin A, and the systems support that will be necessary to increase coverage with quality services.

To the degree possible we have been trying to use what flexibility remains in 0135 to address these new priorities, but in reality previously made commitments make that a limited exercise. Without the arrival of \$1 million CS funds one year ago, we would have had to wait until we had new project funds after March '88 to shift emphasis. However, the CS program begun during this past 9 months has given us a 2 1/2 year "running start", permitting us to become involved for the first time in EPI, ORT and ARI work, and to learn some lessons which can be built into any new project.

During the next 1 1/2 years the mission will work with GON (and other donors) to develop our new assistance program to begin in mid-'88. As part of this process we will be refining preliminary overall objectives and targets cited herein and establishing within the new project a system to monitor and measure progress on a regular basis. There will be greater orientation toward achieving higher coverage with a few basic, higher quality services, especially in EPI, ORT, birth spacing

and ARI, and relatively less emphasis on macro-organizational, general budget support and broad-brushstroke management activities that have proved less rewarding in the past. We aim for a pragmatic, field-oriented, coverage-oriented program that accepts the unchangeable realities of management and administration in the Nepal context, yet doesn't sacrifice alertness to opportunities to improve basic policies and systems should they appear.

Although our PVO co-financing portfolio is small, we are hoping to expand NGO activities in support of CS. Specifically, we are developing with SCF-US a proposal for greatly increased immunization coverage in all of Gorkha District, and with SEVA a Vitamin A capsule distribution program (both of these will require AID/W funding because we did not get CS PVO funds for this year). In addition we will continue, and hope to expand, current efforts with NGOs for ORT and ARI. The AID/W funded FP "intermediaries" we work with in Nepal are being encouraged to work more with local organizations on re-establishing a proper mix of spacing-VSC-MCH, which should be strongly beneficial for child survival and overall family welfare.

With regard to the Mission's overall program, health and family planning will continue to be an important component. Assuming Mission budget levels remain static or even decrease slightly, approximately \$4 M per year will be allocated to health/family planning activities from FY 86. During FY 86 and FY 87, CS activities will be constrained to activities which can be carried out within the current IRH/FPS Project as described in sections II-VII of the paper. Were CS funds to be made available to the Mission on an additionality basis, these activities might be expanded somewhat prior to the new follow-on project which will target selective CS activities. USDH staff level should remain constant at three throughout the new follow-on project.

Clearances: PRM _____
 DD _____
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Drafted: *W. Calder*