PRIMARY HEALTH CARE SERVICES IN NEPAL

Program Options in Response to Conflict

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ACRONYMS AND FOREIGN TERMS

AIN	Association of International NGOs in Nepal
ARI	Acute Respiratory Infection
CBO	Community Based Organization
CDD	Control of Diarrheal Diseases
C-IMCI	Community Integrated Management of Childhood Illnesses
CPD	Country Program Districts
CYP	Couple Years of Protection
DCHA/OFDA	Democracy, Conflict, and Humanitarian Affairs / Office of Foreign Disaster Assistance (USAID)
DDC	District Development Committee
DFID	Department for International Development
DHCC	District Health Committee
DHO	District Health Office
DHS	Demographic Health Survey
DHSP	District Health Strengthening Project
DPP	District Partnership Program
EPI	Expanded Program for Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
FPAN	Family Planning Association of Nepal
GIS	Geographic Information System
GON	Government of Nepal
GTZ	German Technical Cooperation
HMC	Health Management Committee
HMG/N	His Majesty's Government of Nepal
H/MIS	Health/Management Information System
HP	Health Post
HuRDIS	Human Resource Development Information System
HW	Health Worker
ICRC	International Committee of the Red Cross
INGO	International Non-Governmental Organization
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MH	Maternal Health
MOH	Ministry of Health
MSF	Médecins Sans Frontières
NFHP	Nepal Family Health Program
NGO	Non-governmental organization
OCHA	Office for Coordination of Humanitarian Affairs (UNDP)
PHC	Primary Health Care
PHCC	Primary Health Care Centre
RHD	Regional Health Directorate
SF	Security Forces
SHP	Sub Health Post
SO2	Strategic Objective 2
SoE	State of Emergency
TBA	Traditional Birth Attendant
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activity
UNICEF	United Nations International Children Educational Fund
USAID	U.S. Agency for International Development

USG	United States Government
VDC	Village Development Committee
VHW	Village Health Worker
WFP	World Food Program

CONTENTS

ANNEXES

1. Scope of Work
2. List of Interviewees
3. Bibliography

EXECUTIVE SUMMARY

The imposition of the State of Emergency in late 2001 and the subsequent intensification and escalation of Maoist activities during 2002 have increased the challenges for an already affected public health system in Nepal. In order to assess the impact of the conflict on the delivery of primary health care services, and to provide recommendations for current and future health programming efforts, USAID/Nepal undertook a two-part situational analysis of the impact of the conflict on Nepal Primary Health Care Services.

The first part of this review, a countrywide field assessment, was conducted between August 17 and September 6, 2002, and included collection of detailed information regarding the impact of the conflict on PHC services, identification of immediate needs, conclusions/recommendations for program implementation and analyses of health care on a regional basis. The results of this first part of the review are presented in the document "Primary Health Care Services in Nepal: Field Report" by Dr. Esperanza C. Martinez and Mr. Hari Koirala (October 2002).

The second part of the situational analysis was conducted December 2 – 18, 2002 by Ms. Julie Klement and Dr. Barry Silverman, building on the work of Dr. Martinez and Mr. Koirala, and was augmented by interviews with selected district and local government health authorities, PVOs, NGOs, Nepal Family Health Project staff, and other donors, as well as extensive review of various documents.

The report proposes a conceptual framework for analyzing and structuring health program activities in a changing conflict scenario, in order to allow USAID/Nepal to better manage the programmatic risks and to identify appropriate realistic adaptive and coping strategies. The framework consists of **Development Program** to **Transition Program** to **Complex Humanitarian Emergency** scenarios, overlaid with variable levels of low-medium-high conflict conditions. It assumes that USAID/Nepal development program approaches will continue in areas where possible (such as in no conflict or low-medium conflict areas).

The framework application recommends that flexible transitional approaches would be most appropriate in low-medium conflict areas. Such approaches would allow USAID to address changing community needs, modify NFHP maternal and child health interventions as appropriate, and increase their potential effectiveness given the often unpredictable and fluctuating conflict conditions. It also suggests that if the security situation deteriorates further and the Government of Nepal, with support from USAID and other development agencies, is no longer able to deliver health services in the high conflict areas (as currently exists in the Far-Western and Mid-Western Regions), then humanitarian agencies with experience in conflict settings should be given the responsibility to carry out these tasks.

Data from the national 2002 MIS/HIS were analyzed. For the most part, the effects of the conflict were not reflected in the indicator trends. However, Couple Years of Protection

(CYP) demonstrated a 1 percent reduction, nationwide. CYP might be a useful leading indicator of the effect of the conflict and requires further analysis. The report recommends that USAID develop and implement a complementary, informal community-based monitoring system to track localized changes in health service accessibility and quality.

Specific recommendations for USAID programming options appropriate for each Development Program to Transition Program to Complex Humanitarian Emergency phase of the framework are put forward for USAID consideration. These are listed in Section IV of the report.

I. INTRODUCTION

The imposition of the State of Emergency (SoE) in late 2001 and the subsequent intensification and escalation in Maoist activities during 2002 have increased the challenges for an already affected public health system. In order to assess the impact of the conflict on basic, primary health care service delivery in Nepal and to provide recommendations for current and future USAID/Nepal health programming efforts, USAID/Nepal undertook a two-part situational analysis of the impact of the conflict on Nepal Primary Health Care (PHC) Services. The goal of this analysis is to develop recommendations for options to:

- Maintain gains of USAID-assisted health and family planning program efforts;
- Continue improvement in primary health care delivery and health status;
- Mitigate the effects of the conflict on the delivery of improved health services; and
- Respond to worsening conflict conditions if they occur.

The first part of this review (Annex 1, Scope of Work), a countrywide field investigation, was conducted between August 17 and September 6, 2002. The results of this assessment include:

- Information regarding the impact of the ongoing conflict on specific PHC programs across the country;
- Identification of existing resources dedicated to the sector, highlights of immediate health care needs;
- Conclusions/recommendations for program implementation in conflict situations; and
- Analyses of the components of health care on a regional basis and how it has been affected by the conflict within the particular region.

The results of the first part of the review are presented in the document "Primary Health Care Services in Nepal: Field Report" by Dr. Esperanza C. Martinez and Mr. Hari Koirala (October 2002, reference #17). The report has already provided updated field information valuable for raising awareness of the impact of the conflict on health care services delivery in Nepal, and has identified key issues to be addressed by HMG/N and the international donor community. It has also opened a constructive dialogue between donors and NGOs regarding approaches and follow-up actions.

The second part of the situational analysis was conducted between December 2 and 18, 2002, built on the work of Dr. Martinez and Mr. Koirala, and was augmented by

interviews with selected district and local government health authorities, PVOs, NGOs, Nepal Family Health Program (NFHP) staff and other donors (Annex 2, List of Interviewees), as well as extensive review of a wide variety of current documentation on the conflict situation and relevant programming efforts (Annex 3, Bibliography). The information collected during the second part of the analysis and presented here includes:

- Development Program to Transition Program to Complex Humanitarian Emergency Response framework for analysis of the health service situation;

- Strategies and options which address key health delivery issues; and

- Recommendations for USAID/Nepal on how the Mission health sector strategy can be implemented in the current conflict situation.

II. BACKGROUND AND PROGRAM CONTEXT

BACKGROUND

Infant and child mortality have declined substantially in Nepal throughout the 15 years preceding the current 2001 DHS Survey. During this period, national indicators of immunization coverage increased and vitamin A supplementation was expanded at the rate of 10 new districts per year since 1993 to reach 72 of the 75 districts in 2001. Recently, effective community-based pneumonia treatment has also expanded from 4 districts in 1997 to more than 14 districts in 2000. Child mortality was reduced by approximately 40 percent; the fertility rate reduced by 20 percent. However, while important gains have been made in maternal and child health, there remain wide variations in health status between the rural and urban populations, and between different ethnic and socio-economic groups. Much has been written about the current health situation and the reader is referred to the documents in this report's bibliography (specifically, references #29, 30, 31, and 32). Continued donor, and particularly USAID programmatic and financial support is essential to maintain improvements in maternal and child health status and to strengthen the expansion of health services to address the major systemic inequities limiting equitable access to and provision of quality health services. The current conflict poses a major challenge to the Government of Nepal (GON) and the international donor communities' commitment to continued health sector development in Nepal.

The origins of the current Maoist conflict have been extensively examined and well-described in numerous excellent reference documents and will not be repeated in this report (see references #16, 25, and 26). However, for the purposes of this analysis, it is important to recognize that while the current conflict situation continues to escalate and expand, most health development efforts have not stopped permanently in most parts of the country. The degree to which development activities are affected by the conflict varies by region and district, and continues to change over time. While it is useful to review and examine lessons learned from the various donor and PVO experiences, it is dangerous to extrapolate and apply these general lessons without a careful understanding of the unique local factors which were essential for their adoption and application.

According to information reported to Martinez and Koirala (reference #17) from Government of Nepal and NGO health workers, health services continue in most parts of the country (except those of the Mid and Far-Western Regions where health services have been more severely affected), and health workers seem to be the least affected of the government workers, and they continue to have access, though sometimes extremely limited access, to the populations they serve. Although health facilities have not been purposely targeted, service delivery has been disrupted. In general, the vast majority of the USAID-supported Terai District program sites continue to deliver services despite interruptions in vaccine, drug and medical supply distribution. Local health workers remain in most of the peripheral health units even as services are cut back. Protection of the peripheral health workers' "neutrality" (as humanitarian workers) is key to effective GON and international donor, particularly USAID, program approaches.

CONTEXT

In 2000, USAID/Nepal prepared and began implementation of a new 5 year Country Strategic Plan (FY2001 – 2005). Of relevance for this report is the revision of USAID's Strategic Objective 2 (SO2) from *improved maternal and child health* to *reduced fertility and protected health of Nepalese families*. (reference #18) The focus of the sector is to support continued improvements in the delivery of the Government of Nepal's health and family planning services, thereby indirectly contributing to better governance, greater women's empowerment, and regional stability. In addition, the Mission proposed a Special Objective (SpO) for Conflict Mitigation with the objective of *mitigating conflict through improved governance and incomes in targeted areas*. To implement the revised Strategic Objective, the Nepal Family Health Program (NFHP) was designed and implemented (reference #9). NFHP strategies provide opportunities for the Mission to use the health development program as a means for conflict mitigation through linked and mutually reinforcing activities.

APPROACH

It is difficult to be specific about the health impact of the conflict to date. During field visits to each of the five development regions, and interviews with a broad range of stakeholders in the field and Kathmandu, Martinez and Koirala (reference #17, Section II Regional Analysis provides extensive information regarding the status of facilities, human resources, PHC programs and drugs/supplies as of August 2002) attempted to collect and organize the abundant anecdotal information. While they report a wide variety of disruption to primary health services (varying between and within the regions) as a result of the conflict, they find the following recurring pattern:

- Destruction of sub-health posts [as a consequence of being part of Village Development Committee (VDC) buildings (so it doesn't contradict that they aren't being targeted)];
- Increased absence of health care providers at peripheral facilities;
- Blockades of essential and other health commodities into certain health facilities;
- Difficulties in conducting supervision and monitoring visits by regional and district-level health officers; and
- Disruption of the cold chain vaccines and fuel due to road blockades and power outages.

While these factors have affected the delivery of essential health services such as outreach immunization activities, primary health care mobile services, treatment of ARI/CDD, and surgical sterilization camps, to name a few key maternal and child health interventions, the quantitative evidence is not yet available due to many factors. As part

of the analysis of the impact that the conflict is having on health system performance, data from the 2058/59 (2001/2002) Annual Report of the Department of Health Services were analyzed and compared to data from the 2056/57 (1999/2000) and the 2057/58 (2000/2001) reports. Preliminary examination of the current year MIS/HIS data (July 2001/July 2002) revealed that in most cases health indicators have either improved or remained unchanged from previous years. (specific indicators are shown in Section III).

In general, the MIS/HIS data did not seem to be sensitive enough to measure changes in health service provision as a consequence of the conflict. This insensitivity could be attributed to several factors. Interviewees indicated that the worst interruptions to health service delivery have occurred in the last six months, a period not covered in the most recent MIS/HIS report. The Nepal MIS/HIS system was not developed in a manner that allows attribution for changes in indicator values without further investigation and evaluation. Suggestions for rapid assessment of the conflict's impact and for complimentary sensitive data collection and analysis are discussed below.

Martinez and Koirala (reference #17) identified a number of priority needs in the health sector that should be addressed in the near term in order to prevent further deterioration of the health care system and to be better prepared to respond to a possible humanitarian crisis should the security situation continue to worsen. These include the following:

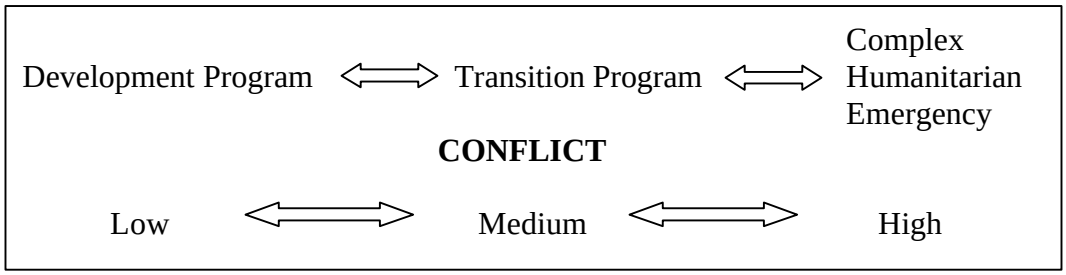
- Improve the delivery of primary health care services to rural communities in conflict-affected districts;
- Improve the access of rural communities to essential drugs and medical supplies;
- Monitor the nutritional status of populations in areas at risk of food shortages;
- Support the integrity of the food chain; and
- Improve reporting mechanisms from conflict-affected districts.

As Martinez and Koirala explain, with the onset of intensive conflict, beginning in November 2001, Nepal can no longer be considered a normal development setting, but it is not yet a classic humanitarian emergency. Therefore, in order to continue addressing the root causes of the conflict it is vital that international donors remain engaged in the development of Nepal. Key donors, including USAID, have reconfirmed their commitment to ongoing health development assistance to Nepal during this conflict situation.

However, in order for this assistance to be relevant and appropriate, USAID needs to continuously assess the affects of the conflict in Mission health program areas and recognize the key elements of the development program which must be supported in the changing environment. A conceptual framework for analyzing and structuring health program activities in this changing conflict scenario, in order to better manage the

programmatic risks and to identify appropriate realistic adaptive and coping strategies, is proposed here.

Chart 1
Analytical Framework for USAID



The analytical framework assumes that development programs will continue in areas where there is no or low/limited conflict as a result of Maoist/SoE presence. In all conflict-affected areas, but particularly the low-medium conflict areas, flexible transitional approaches would be most appropriate. These programs would allow USAID to address changing community needs, and modify the interventions as needed to increase their potential effectiveness given unpredictable and fluctuating conflict conditions. However, if the security situation deteriorates and development agencies, including USAID are no longer able to deliver health services in high conflict areas, then humanitarian agencies with experience in conflict settings should be given the responsibility to carry out the task. The sections below identify the characteristics of the development-transition-complex humanitarian response phases and discuss approaches for USAID programming options within each phase. Recommendations are also put forward for USAID consideration.

DEVELOPMENT PROGRAM

USAID is committed to continuing support for **sustainable health and family planning development programs in Nepal**. The current Mission health portfolio (predominantly comprised of the integrated NFHP), addresses the longer-term chronic poverty and inequity problems, even as it ensures that activities are demand driven (as opposed to needs based), accountable and transparent to the community, and focused on women, ethnic minorities, and underserved rural populations. While NFHP was designed as a development project with implementation sites primarily located in the highly populated and usually stable areas of the lowland Terai, recent evidence has shown that expansion of the conflict is already affecting all components of the program in all program district areas and at all operational levels. Despite the fact that the conflict poses serious challenges, the NFHP cooperative agreement mechanism allows for flexible programming, shifts in intervention priorities and approaches, and changes in resource allocation as the conflict intensifies and changes over the life of the project.

USAID must begin now to develop phased contingency plans for the changing conflict-related conditions as described in Martinez and Koirala, other donor documents, and further elaborated in this report. This should be done at two levels:

1. **Mission level - planning for increasing/decreasing resource scenarios and program options; and**

2. **NFHP program level - planning for resource/activity shifts among low-medium-high conflict intensity areas in the 17 country program districts (CPDs), and between service delivery and systems strengthening/capacity building approaches.**

Security

Field staff and health workers repeatedly told us how frightened and vulnerable they felt as reports of random violence, ambushes and intimidation by Maoists and the security forces circulated in the press and among the health workers themselves. In order to help manage the increasing levels of personal and program risk, **USAID and NFHP partners must develop a unified set of operational security procedures, and ensure that all project staff are trained in these procedures as soon as possible**. These procedures should address communication systems, field security guidelines, and negotiation skills, in addition to the basic personnel and organizational safety procedures. DCHA/OFDA maintains a grant with Red*R*[1] to provide technical assistance for development of security and safety procedures and training. While this grant is designated for the PVO community, it may be accessible for NFHP purposes.

TRANSITION PROGRAM

The linkages between development programs and humanitarian relief interventions are complex and bi-directional. As the conflict intensifies and expands, there will be increasing pressure on the Mission, and especially the health portfolio to:

- Respond to immediate and basic health needs;

- Maintain visible evidence of USG support for the GON;

- Maintain basic health services in districts affected by the conflict; and

- Ensure availability of essential drugs, supplies and services at health facilities in the NFHP districts.

The challenge for USAID and all the donors will be to manage the increased risk posed by the conflict in order to continue long term development programs while

[1] Red*R* is a London based NGO that provides a variety of training for humanitarian personnel. To date, Red*R* has offered security management workshops and "training-of-trainers" courses in Eastern Europe, Africa and the United Kingdom, to international NGO managers and staff. Red*R* may be contacted through their website, at www.RedR.org

responding to short term emergency demands. Maximum flexibility of resources and programming are necessary to support emerging demands. A high level of active involvement by the Mission and NFHP will be required in order for this approach to succeed.

Transition planning, which identifies adaptive approaches (to spread risk by adjusting behavior - for example, when periodic upsurges in incursions force health workers to temporarily close posts or delay community outreach activities), and coping strategies (to minimize the direct impact of the conflict - for example, moving the sub-health post to a separate and more secure location away from the VDC building when possible), should allow for shifting/phasing between long term development objectives for capacity building/systems strengthening, and short term service delivery depending on the intensity of the conflict, the field situation, and the strength of the health services and systems in a local area.

NFHP has already completed much of the health services and systems assessment work in their CPD areas, documenting the status of health facilities and human resources. This status information used in combination with a conflict risk assessment (using criteria to be developed with USAID for designating low-medium-high impact conflict areas within each of the districts) would form the basis for more intervention-specific and flexible program planning in the CPDs during the Transition Phases. One suggestion is to classify the CPDs into three groups based on selected indicators/trigger-points such as Measles coverage, percentage of health facilities that can be supervised/visited, Cotrim supplies, CYP, etc., for example.

Once the mapping has been completed, the next step would be to establish program performance targets based on the specific health program activities in the districts/sub-districts. USAID may wish to accept both activity outcomes and/or program results in agreed upon target ranges for programs in these designated conflict areas. (For example, a range of targets for the percentage of measles coverage could be selected to reflect the low/medium or medium/high conflict intensity and the affect on service delivery).

Also, it would be useful for USAID and NFHP to identify and track the program planning assumptions which have been considered when the revised programs and target ranges were developed (i.e., disruption in services and supply of essential drugs will be temporary and for short durations, or that health workers and facilities will continue not to be targeted by the Maoists). These assumptions should be periodically tested and reviewed as the environment changes and program components are modified to respond to the changing field situation.

FP/MCH Services and Systems

USAID is fortunate in that NFHP is well-designed and positioned to serve long term development assistance and more immediate service delivery requirements, as well as various combinations of the two required in a Transition Program. In order to do that, **NFHP must remain focused on the delivery and use of high impact family**

planning/maternal and child health (FP/MCH) services (particularly ARI/CDD, EPI, MH, FP, and Vitamin A interventions - Component I) and maintenance of essential management systems at the District Health Offices linked to the community (Component II - particularly supervision and logistics management).

Additional information about successful high impact child health services and the best systems for delivering those services is forthcoming from the recent BASICS II review. Documenting child health improvements in Nepal can guide this approach. Disaggregated data (if available, through the DHS, or through a to-be-designed monitoring scheme) would be required for better local level activity targeting in order to maximize public health impact.

The focus for USAID assistance during the Transition period should be one of **support and maintenance** – at a minimum – fluctuating as field conditions change and access increases or decreases. Given the limited, often inadequate, and decreasing resources which are typical to conflict situations (particularly if the situation is prolonged), there are key choices that health care providers and system health planners must make in order to cope. Adjusting the shifting balance between systems and services (preventive and curative, and integrated and vertical programs; enhancing the quality of services and approaches that are more population and public health-oriented; establishing priorities among a range of potentially competing needs) are important characteristics of the Transition period. **NFHP should begin to map out and target the delivery of essential FP/MCH services and the systems necessary to deliver those services based on low-medium-high conflict impact scenarios in their 17 implementation districts (CPDs)**.

Concentrating on NFHP program Components I and II can serve as a future base for supporting ongoing service delivery, as more CPDs become medium/high impact conflict areas, and/or the delivery of humanitarian emergency assistance, should that be required. Maintaining basic services and systems during the conflict period will also allow for relatively faster resumption of a comprehensive development program when the conflict is resolved.

Continued work on Component III (strengthen capacity of national level programs to support the District Health systems and community-based FP/MCH services) should not absorb a disproportionate amount of resources and time, given the need to focus on service delivery at the district level and below. Differing strategies may be necessary, depending on access: one for the low/medium impact areas which can follow a more phased implementation plan (e.g., continued strengthening of C-IMCI), and another, for example, for the medium/high impact areas which will require more dynamic and opportunistic programming (e.g., targeted vertical campaigns, mobile community clinics).

Some key priority strategies from NFHP Project Components I, II and III to be addressed in the transition period may be:

Component I: To strengthen the delivery and use of high impact FP/MCH services delivered at the household and community level.

1. Improve the quantity and quality of FP/MCH provided by health facilities, community health workers and private sector providers through regular on-the-job training, supervision, monitoring; and using the findings from these activities for further improvement.

2. Strengthen management and coordination of community-based services by ensuring the local management committee (VDC/HP/SHP/PHC) meetings are held regularly and address relevant FP/MCH issues.

3. Improve sustainability of FP/MCH service improvements by increasing financial and in-kind support provided to FCHVs by local management committees.

4. Strengthen capacity of community-level providers (VHW/MCHW/FCHV) to deliver FP/MCH services.

Component II: To strengthen the essential management of the District Health Offices (DHOs) in the 17 core program districts (CPDs).

1. Support ongoing district-level government and NGO coordination.

2. Strengthen DHO capacity, accountability and performance in managing FP/MCH commodities.

3. Improve provider and manager performance in using the HMIS/LMIS.

4. Upgrade FP/MCH services at selected district hospitals.

Component III: To strengthen the capacity of national-level programs to support district health systems and community-based FP/MCH programs.

1. National Family Planning/ maternal health/Vitamin A/EPI/ARI & CDD Program Strengthening

2. FCHV Program

3. Logistics

4. National NGO Coordination

Based on extensive information culled from interviews, reports and other documents regarding recent health program and field experiences in conflict areas, several examples of how NFHP could modify selected program strategies (priority strategies as identified

above) to respond to changing field realities are presented here. This list is not intended to be comprehensive nor prescriptive but merely illustrative.

PVO/NGO/CBO Partners

There is increasing evidence that activity implementation methods are crucial to acceptance of projects by the Maoists. Evidence shows that implementation should be carried out with the support of local CBO groups and individuals with a high level of trust and acceptance in the local area. Some PVOs/NGOs are heavily politicized, and have not been able to continue working at a local level as the conflict escalates. Therefore, as the need for accelerating work with local partner's increases, USAID should exhibit caution in assessing the neutrality and selection of local partners.

Careful selection of local partners is critical and necessary to ensuring the continued delivery of services to the community when access from the district level is limited. Community leaders and groups are more sensitive to changing local situations, will be able to measure local risk, and will advise local health workers on adaptive service delivery strategies. While NFHP is designed to focus on strengthening and supporting public sector health services, NFHP partners are assisting the MOH with implementation of specific activities to strengthen delivery and use of high impact FP/MCH services at the household and community levels. To this end, they have begun to direct capacity building efforts towards community level providers such as village health workers/female community health volunteers (VHW/FCHV).

NFHP should accelerate VHW/FCHV capacity development, supervision and participation, and strengthen their linkages with local NGOs, CBOs, mothers groups and other community leaders, and community networks <u>now</u> to prepare and plan for their increased health related roles and responsibilities as the conflict increases. This may require extra resources. If other donors and international organizations are more focused on social mobilization and community participation, then NFHP's role may be one of linking these community groups with the government services and workers, establishing networks, and identifying appropriate health activities for them to jointly support - rather than doing the mobilization itself. NFHP may benefit from community participation and technical assistance to strengthen and accelerate community participation approaches. Additional staff may be required in order to increase the level and intensity of engagement with the community.

Supervision

While supervision and program monitoring systems from the district level to health post and sub-health post levels are frequently cited as deficient, these systems are critical for effective delivery of PHC services at the local level. Martinez and Koirala noted that according to UN and NGO field personnel, supervision and program monitoring are severely affected in the medium and high conflict areas. They will most likely deteriorate further with continued funding cuts and severe access constraints. However, this may be an ideal opportunity for the GON and the donors to reassess their approach

and address major implementation issues in order to improve worker performance and help ensure their presence at their work places.

Perhaps the introduction of greater accountability through activities such as debriefing with joint district and village management staff to discuss who was met, topics discussed, follow-up actions, could be built into the implementation of services delivered at the village level, rather than seen as a separately implemented and funded "supervision" function (e.g., check the boxes and file for per diem). While there are no easy solutions and many groups struggle with this problem, some interesting trials are underway (e.g., MSF in Bajura, JSI/DFID - reference #24) where the number of local field coordinators who are more adept at identifying local problems, and empowered to implement local solutions has been increased.

Conducting joint NFHP/PVO/donor, and GON supervision and monitoring visits is another possible approach which has proven to be moderately successful (e.g., joint UNICEF/UNFPA/NFHP/DHO/FPAN field supervision and monitoring visits among partners working in the districts - reference #22). Joint visits would not only reduce the risk to staff, but would also strengthen the quality and coordination of monitoring and hopefully, as a result, the services as well. **As NFHP's success in community participation and outreach is closely tied to their ability to address the supervision and program monitoring challenge, they are urged to seek local solutions in conjunction with national policy reform efforts to be undertaken by USAID and the international donor community**.

VDC/HMC Capacity Building

In the recent conflict, the least affected of the local GON sector-specific management committees has been health (references #17, 2, 6, and 8). This finding presents a unique opportunity for USAID and other donors to support and strengthen these nascent government structures as part of a broader focus on strengthening key civil society entities which will be able to respond locally and effectively to the crisis. Serving as the interface between the DHO, the community health services, and the local community groups, there is evidence from Siraha District of how the health management committee has increased pressure on the DHO to adequately staff and provide services at the local level. Despite the fact that the government has recently disbanded these groups and dismissed the elected chairmen, many are still functioning. Since resolution of this situation is part of a larger political drama, **it is recommended that USAID and NFHP accelerate the VDC and HMC development process, targeting the 17 NFHP CPDs to strengthen the management skills and capacity of the group in order to address immediate health needs**. This will in turn strengthen local leaders and empower them to continue health and other development efforts in the face of conflict. While NFHP should take the lead, additional funding and technical assistance maybe required to accelerate and systematize this process. The new Mission Conflict Mitigation SpO is ideally suited to this role.

One interesting and potentially important activity being developed by NFHP is the "partnership agreement" with VDCs for strengthening sub-health post management committees. **The GON, with NFHP support, should accelerate partnership agreement negotiation and implementation in order to improve the transparency and accountability of health facilities and service providers for delivering quality services to their communities**. Martinez and Koirala, and others (references #9, 12, 14, 17, 23) have pointed out that a high level of involvement by the particular organizations (and by extension, the more peripheral GON health workers) with the local communities is more likely to enhance security because the community tends to value and protect these activities and personnel. It could be anticipated that the partnership agreement approach will strengthen the close community and health facility links and allow for continued service delivery during the transition phase of the conflict.

Decentralization

USAID and the international donor community must remain committed to decentralization of public services, including health, in Nepal. More than any other reform effort underway today, decentralization will empower local government bodies to better plan and implement development activities. It will push resources and program management foci out to the peripheries of the government systems, in order to ensure greater accountability for those resources and more transparent implementation. This process links closely with reform of the DDC/DHO and development of VDC/HP/SHP/PHC entities (which exists independent of the decentralization). It has been pointed out that there are limitations to the extent of reform that can be affected at the DHO level at this time. However, there is cautious optimism that real reform (as opposed to cosmetic), including both improved transparency and accountability, can probably occur at the VDC level.

Coordination and Communication

It was generally agreed by many of the interviewees that there is a high level of information sharing among donors but that improvements could be made in common problem-solving and/or development of common approaches to the various challenges posed by the conflict situation. **USAID, in its capacity as chair for the National Donor Coordination Committee, is urged to play a strong leadership role in encouraging donors to more effectively pool information, resources and expertise, and to apply them more effectively**. This will become more important should the conflict escalate and deepen and resources become more constrained.

While communications and information sharing among donors and between donors and the government is occurring at many levels, there is a need to improve and maximize vertical communication and information transmission, especially with regards to security concerns. Martinez and Koirala noted that at the central level, the Association of INGOs in Nepal (AIN) discusses security issues during their regular meetings as does UNDP. However, many NGOs feel they do not have an adequate forum to share experiences, and discuss security and program implementation matters with other organizations (reference

#17). **The establishment of regular and more effective fora (at both central and district levels) where organizations can exchange information and problem-solve in a confidential and safe environment would be extremely useful**. Ideally this type of forum should be organized and managed by an agency with relevant experience working in conflict situations, for example, OCHA.

One issue of immediate importance for field-based organizations is the need to strengthen their communications procedures and telecommunications systems to more effectively link field staff to local and district offices and national headquarters. This relates to the security recommendation presented above, and may require additional resources to upgrade radios, install satellite phones, or recruit additional village level workers to be trained on data collections, etc.

During periods of increasing conflict it is important that communication and information exchange (with the GON and the international community) related to security and program disruption (particularly at Regional/District/local levels) be maximized. There are existing fora such as the Regional Health Committee (RHCC), the District Health Committee (DHCC), the general District Health Office (DHO) staff, and the Health Facility meetings, for example, which could be come the foci for these efforts. While it is reported that these groups do exist and meet regularly (depending on the leadership), **the GON, USAID, and other donors are strongly urged to discuss security at district level meetings. They are also urged to share conflict related information, identify common problems, lay out action plans assigning responsibility for follow-up, and ensure that this information is shared with regional, district and central levels for appropriate resolution of issues**. The GON is urged to continue efforts to strengthen their commitment to and leadership of these important local meetings, especially during periods of increasing conflict and disruption.

Policy Dialogue

There is evidence that the ability of the already affected Nepal public health system to continue to perform as the conflict intensifies may be seriously jeopardized. As development resources (both financial and human) become more constrained, there is a danger that the district to community systems will contract and withdraw to a limited "security" perimeter, while the national level continues to marginally function with little coordination or outreach capacity. Of concern are recent Government statements that they will be unable to continue funding the current development budget levels as more and more funds are shifted to the higher priority military budget in the Emergency Situation. Whether USAID and other donors are willing (or even ABLE) to assume additional health sector development costs in order to protect hard won systemic gains, needs to be carefully discussed.

The alternative may be collapse of the systems and a reversion to reactive, short term targeted health inputs. **USAID is strongly urged to develop a common policy agenda with the other donors and to increase the dialogue with the government to address common funding and program implementation issues**. Topics for this dialogue might

include the following: increasing transparency of the budgeting process and funding flows, ensuring that the GON releases the supervision budget on time, protecting health worker neutrality, protecting health workers from harassment and intimidation by the security forces, HW promotion incentives for service in high conflict areas, HW insurance for assignments to high conflict areas, clarification of casualty treatment and reporting requirements, to name a few. Additional policy dialogue suggestions can be found in Martinez and Koirala (reference #17).

COMPLEX HUMANITARIAN EMERGENCY

The public health effects of complex humanitarian emergencies include high direct and indirect mortality, and the collapse of health systems. While there is an overall increase in the health needs of individuals and communities, mass population displacements, a breakdown in infrastructure, isolation, a lack of food security, and an increase in insecurity due to insurgency and instability are also characteristics of a humanitarian emergency situation. Often there is an increase in communicable diseases due to failure of the logistics system to provide vaccines or other commodities, coupled with limited access to the target community and households. Evidence of the collapse of marginal health systems, coupled with significant population movements, large scale food insecurity and limited access is already documented in major areas of the Far-Western and Mid-Western Regions (references #1, 2, 3, 4, 5, 10, 11, 12, 14) exacerbating the situation for a those who are chronically underserved , and severely impacted by poverty.

During the acute phase of humanitarian emergencies, the population needs for appropriate technical interventions are usually clear (e.g., measles campaigns or therapeutic feeding centers). Obviously, in order to minimize mortality and morbidity, emergency programs must ensure the provision of adequate food, water, shelter, and sanitation. Women are at particularly high risk. Therefore, it is essential that reproductive health and family planning services be made available in order to decrease maternal and child vulnerabilities. Quick assessments and the development of sensitive, ongoing monitoring efforts are key to effectively addressing and managing the situation. Following a rapid assessment, the World Food Program (WFP) identified districts that were at high risk for food insecurity. WFP then established a network of monitors that are implementing a monitoring system using a checklist of local relevant indicators, including health.

However, the rationale for making program choices during a more protracted conflict situation, such as that underway in the Far-Western Region of Nepal is far less obvious. Efforts must be made to ensure that the demands and dynamics of the communities are taken into account, and that the remaining vestiges of health services and systems are not totally undermined during the response. Health services during these complex circumstances must be negotiated in the context of the nature of the conflict, the adaptive and coping strategies of the communities, and the capacity of the remaining elements of the health system to respond to short and long term health needs. Community outreach and the effective case management of ill patients must be addressed. Stress migration, war-related deaths, disability, and military conscription change the structure of

households. Already, evidence of a shift in labor pools has occurred in the Far-Western Region, coinciding with the collapse of the limited health services (references #17, 24).

Should it be necessary for the international community to support a Complex Humanitarian Response in the Far-Western and Mid-Western Regions, **it is recommended that USAID work through other international organizations (such as WFP, UN/OCHA), experienced external development partners (such as DFID), international PVOs (such as MSF, ICRC, etc.), and local CBOs, who have more strategic and secure access to these heavily conflicted areas**. USAID has not historically worked in these remote areas and therefore, has limited experience and important community-based contacts necessary to mount such a substantial response.

However, USAID should actively work with response planning and program groups in order to ensure that activities are focused on supporting a more "livelihood–oriented" relief approach to strategically intervene to save lives (references #28, 10), which could mitigate the danger of long term donor dependency, and prevent undermining any remaining vestiges of community coping strategies. A livelihoods approach addresses the productive means by which people survive over time and uses a new set of tools for analyzing the critical trade-offs between implementing immediate survival interventions, fostering self-sufficiency to ensure longer-term survival, that is, saving lives and livelihoods. USAID/OFDA (through Tufts University) and DFID have been instrumental in developing, testing and applying these strategies in various complex humanitarian emergency situations worldwide.

III. INFORMATION SYSTEMS

MIS/HIS ANALYSIS

There currently are three different information systems in operation in the Nepal health system. They are the Health and Management Information System (H/MIS), the Logistic Management Information System (LMIS) and the Human Resource Development Information System (HuRDIS). Each of the systems has shortcomings in terms of accuracy of data, and the ability to disaggregate information by geographical or other social breakdowns. Some interviewees in both Kathmandu and in Morang District expressed skepticism about the validity of data reported through the MIS/HIS, indicating that data from areas known to have major disruption in services due to the escalation of the conflict did not reflect this disruption. They also implied that there were informal disincentives to reporting reduced service provision statistics.

As discussed above, a review of MIS/HIS data from the past three years indicates that traditional data collection and analysis systems are not, in general, sensitive enough to map the impact of the conflict on changes in health delivery services (references #29, 30 and 31) nor are they sensitive enough to indicate the reasons for changes in health service indicators. For example, Figures 1-4 below indicate an increase in total services provided at the Health Post, PHC, Sub-health Post and Outreach Clinic levels in spite of reported conflict-related disruptions.

Figures 5 and 6 indicate increases in Antenatal and Prenatal Care visits. Total services provided might be considered a proxy indicator for access to services. This is in contrast to the anecdotal information that these services have declined due to the increase in conflict. Therefore, none of these indicators appear to be sensitive to the disruptions caused by the conflict.

Figure 1: Total Services Provided (Health Post)
(For the periods 1999/2000, 2000/2001, 2001/2002)

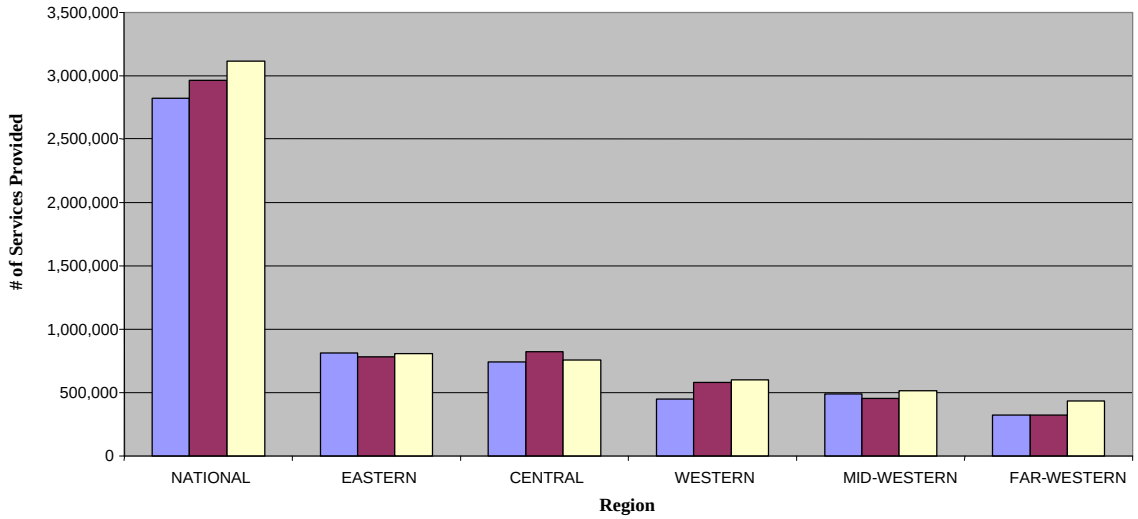


Figure 2: Total Services Provided (PHC)
(For the periods 1999/2000, 2000/2001, 2001/2002)

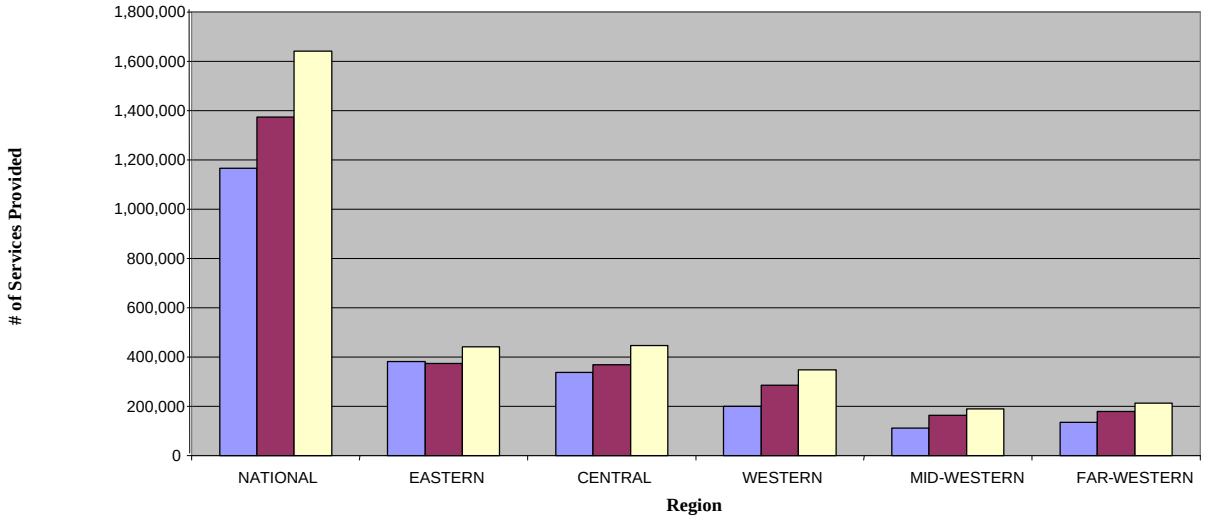


Figure 3: Total Services Provided (Sub Health Post)
(For the periods 1999/2000, 2000/2001, 2001/2002)

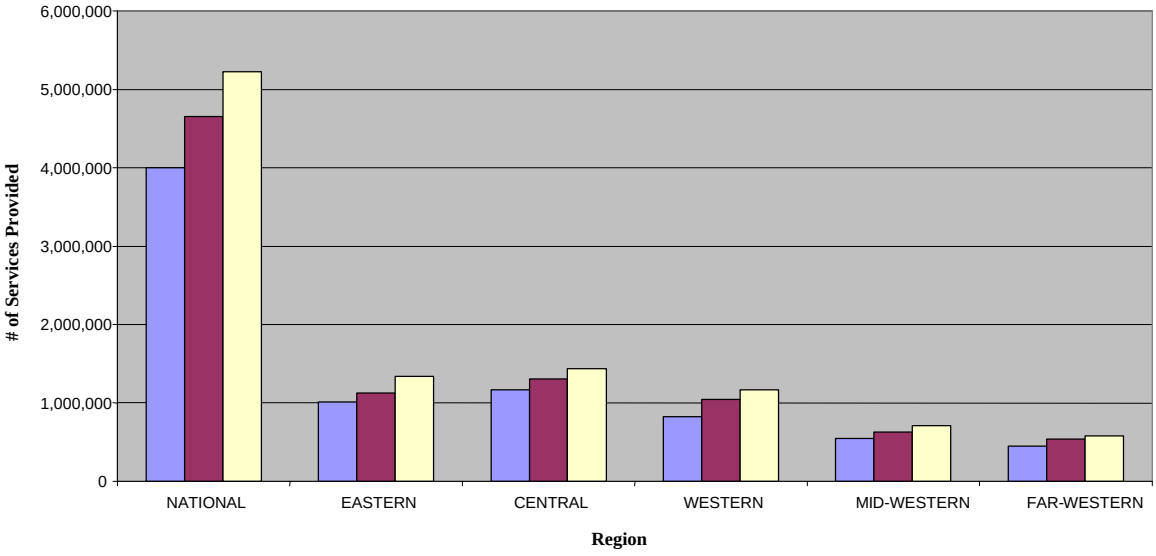


Figure 4: Total Services Provided (Outreach Clinics)
(For the periods 1999/2000, 2000/2001, 2001/2002)

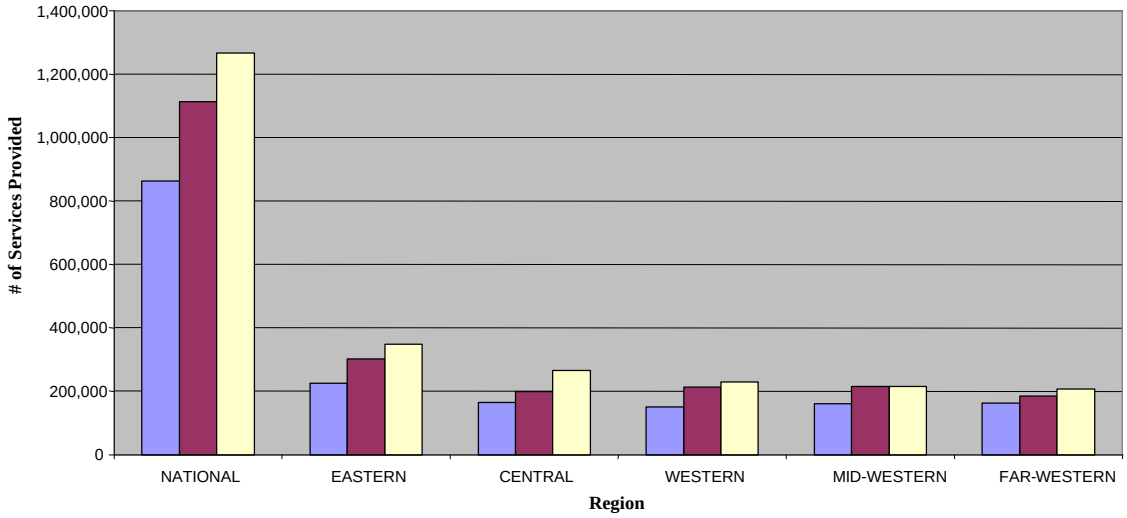


Figure 5: ANC First Visits as % OF Expected Pregnancies
(For the periods 1999/2000, 2000/2001, 2001/2002)

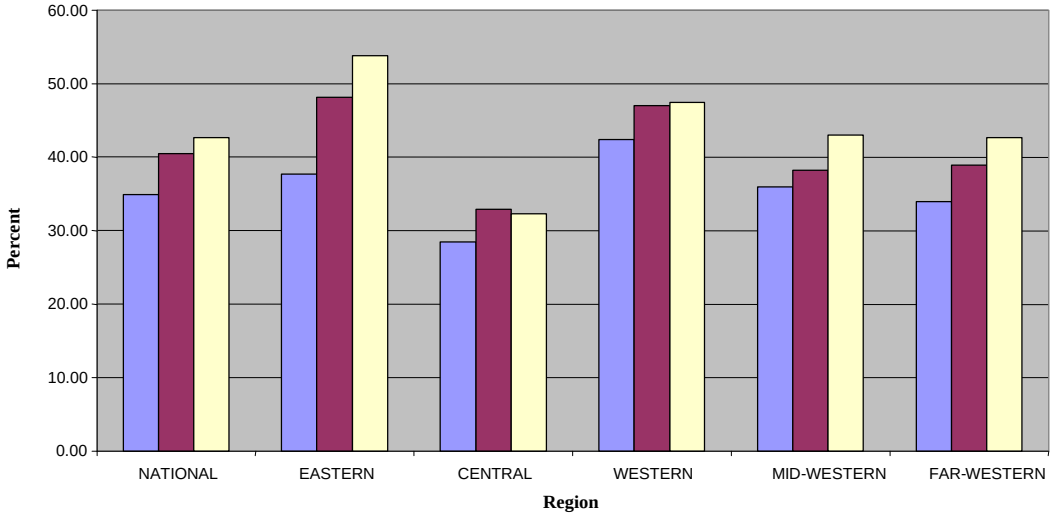
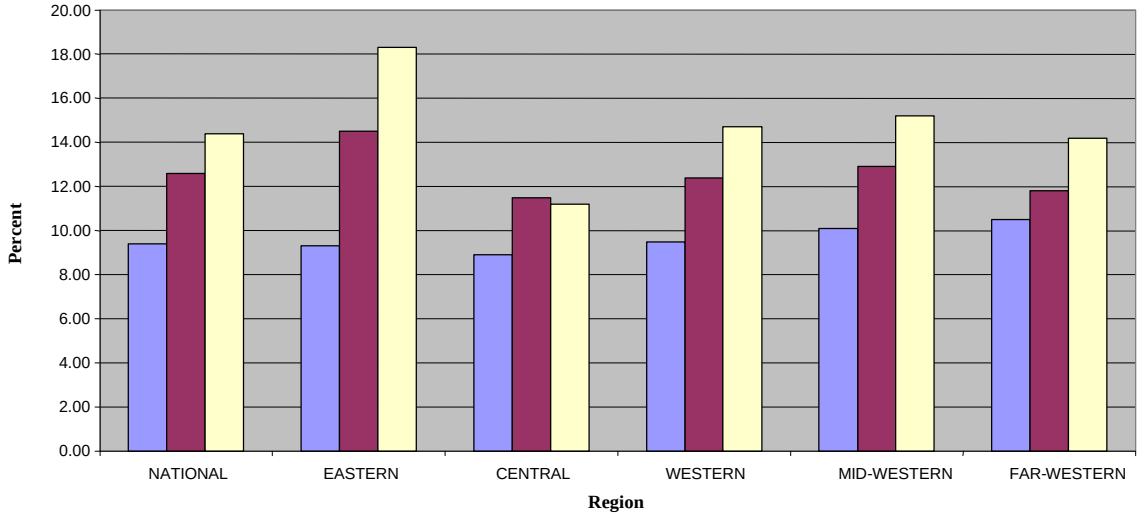


Figure 6: PNC First Visit as % of Expected Pregnancies
(For the periods 1999/2000, 2000/2001, 2001/2002)



As data is aggregated to each higher organizational level (from health facility to district to region) sensitivity in detecting focal disruptions in health services declines. Service delivery interruptions in many districts have been limited in both time and place. Interruptions in many districts have been temporary, sometimes only for a short period of time. Many districts reported chronic shortages of medical supplies prior to the conflict-related disturbances. This would imply that disruption to services might be unrelated to the conflict. As stated above, the MIS/HIS system can not distinguish been conflict-related disruption of services and disruptions caused by other factors. Shown below are analyses of various indicators discussed by Martinez and Koirala (reference #17).

Further analysis of the most recent 2001/2002 MIS/HIS report indicates that several indicators, such as EPI and CYP, appeared to be lower (in some districts) than in previous years. Measles vaccination coverage, for example, appears to have declined in some districts. The reduction in coverage might be attributed to factors including: shortage of vaccines, interruption of cold chain and vaccine supplies, roadblocks, reduction in population mobility, and other factors. The MIS/HIS was not designed to be sensitive to the causes of increases or decreases in indicator status. Further investigation is necessary to make inferences about specific attribution of the causes of indicator changes.

Figure 7 demonstrates a reduction in measles coverage in Mugu, Jajarkot, Kalikot, Jumla, and Salyan Districts. The figure also shows either maintenance or an increase in coverage over the three previous reporting years for the remaining districts.

Figure 7: Mid-Western Region Measles Coverage (1999/2000, 200001/01, 2001/2002)

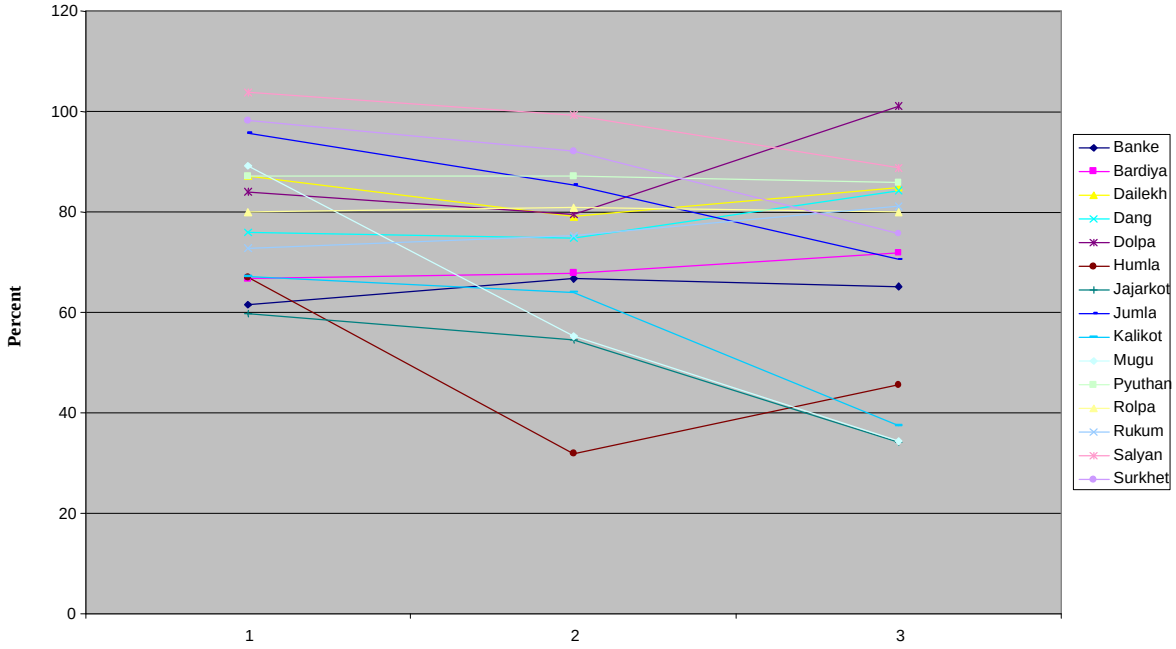


Figure 8: Measles Coverage by Region (For the periods 1999/2000, 2000/2001, 2001/2002)

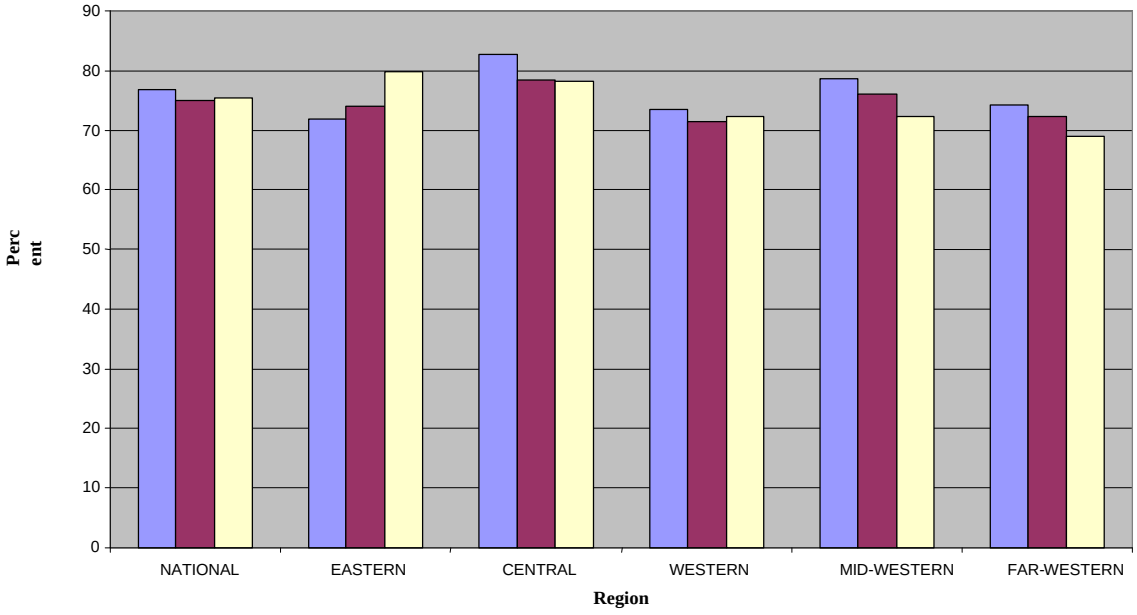
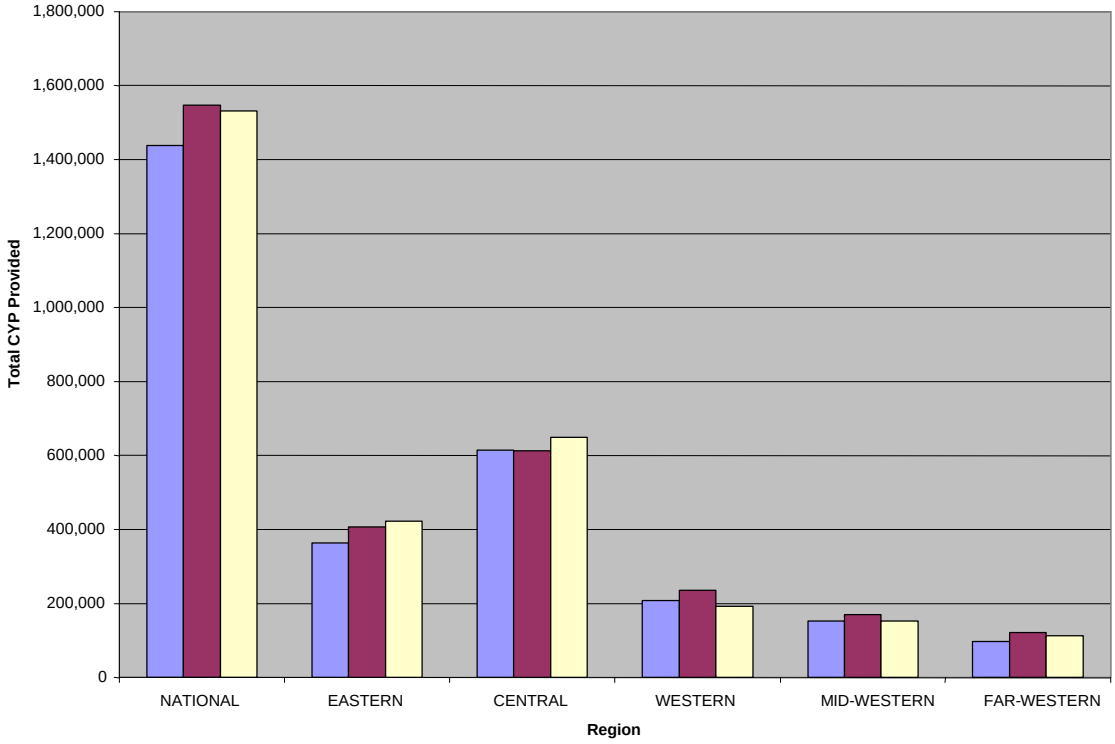


Figure 8 demonstrates the loss in sensitivity as data are aggregated at the regional and national levels. Coverage rates in the Mid-Western and Far-Western do show a slow,

consistent decline over the three year period, but less than would be expected given the intensive and extensive conflict levels in the Far-Western and Mid-Western regions.

Figure 9: Total Couple Years Protection (CYP) by Region
(For the periods 1999/2000, 2000/2001, 2001/2002)



Total CYP, in Western, Mid-Western and Far-Western as seen in Figure 9, decreased last year (2002). This may be attributed to a decrease in use of long-term methods (minilaps, laparoscopy, vasectomy and sterilization) and disruption to services, as reported anecdotally in the Western, Mid-Western and Far-Western Regions, the most seriously conflict impacted regions. This decrease may have been a result of the inability of mobile units to be deployed due to the threat of conflict. It has been suggested that this decrease in Total CYP (1% nationwide) might be a leading indicator of conflict-related service delivery disruption. This should be studied further.

MONITORING APPROACH

In order to identify and track programmatic and systemic effects of the conflict, **it is recommended that NFHP assist in the development and implementation of a complementary informal community-based monitoring system to track localized changes in health service accessibility and quality. Following an assessment of local impact of the conflict, a system employing key, locally sensitive indicators should be developed, using local informants for data gathering**. This system would be an information management tool to be used at the community level, which would enable the community to collect, compile, analyze and utilize health information in the village or settlement. This would ensure the timely collection and use of data.

Local data gatherers could include the following members:

- Farmers
- Housewives
- School teachers
- Community workers
- Local leaders
- Health Post staff

This data collection mechanism would support the monitoring and supervision functions of the Community Health Management Committees, and would assure collection, analysis, and transmission of data in a timely fashion, to allow rapid response to changing local conditions.

With the assistance of NFHP, locally relevant indicators of service quality and accessibility should be developed. For example, two independent interviewees, one in Kathmandu working in the Western and Mid-Western Regions, and one working in the Eastern Region, told us that their very earliest indicator of potential health service disruption is the absence of wild rice, biscuits and chow chow in the local market. Locally-feasible methods for data collection and analysis and a system to vertically communicate the data may be necessary.

NFHP should also assist the district health office in developing and implementing systems to collect and respond to community health needs as determined from the data collected. This assistance should include the mapping (GIS where appropriate) of health service provision status and health demands of the communities. The information collected at the District Health Office should also feed into the Logistics Management Information System (LMIS) so that appropriate types and quantities of drugs and medical supplies will be delivered when and where they are needed.

IV. RECOMMENDATIONS

The recommendations identified in this report are listed here as follows:

DEVELOPMENT PROGRAM

1. Contingency Plans: USAID must begin now to develop phased contingency plans for the changing conflict-related conditions as described in Martinez and Koirala, and other donor documents, and further elaborated in this report. This should be done at two levels: 1) Mission level - planning for increasing/decreasing resource scenarios and program options; and 2) NFHP program level - planning for resource/activity shifts among low-medium-high conflict intensity areas in the 17 country program districts (CPDs) and between service delivery and systems strengthening/capacity building approaches.

2. Security: USAID and NFHP partners must develop a unified set of operational security procedures and ensure that all project staff is trained in these procedures as soon as possible.

TRANSITION APPROACH

The challenge for USAID and all the donors will be to manage the increased risk posed by the conflict in order to continue long term development programs while responding to short term emergency demands. Maximum flexibility of resources and programming adaptation are necessary to support emerging demands. A high level of active involvement by the Mission and NFHP will be required in order for this approach to succeed.

NFHP Program Level

3. FP/MCH Services and Systems: NFHP must remain focused on delivery and use of high impact FP/MCH services (particularly ARI/CDD, EPI, Maternal Health, Family Planning and Vitamin A interventions - Component I) and maintenance of essential management systems at the District Health Offices linked to the community (Component II - particularly supervision and logistics management).

4. Targeted Service Delivery: NFHP should begin to map out and target the delivery of essential FP/MCH services and the systems necessary to deliver those services based on low-medium-high conflict impact scenarios in their 17 implementation districts (CPDs).

5. Priority Components: Concentrating on the NFHP priority Components I and II can serve as the future base for supporting ongoing service delivery as more CPDs become medium/high impact conflict areas and/or the delivery of humanitarian emergency assistance, should that be required.

6. PVO/NGO/CBO Partners: NFHP should accelerate VHW/FCHV capacity development, supervision and participation, and strengthen their linkages with local NGOs, CBOs, mothers groups and other community leaders and community networks now to prepare and plan for their increased health related roles and responsibilities as the conflict increases. This may require extra resources.

7. Supervision: As NFHP's success in community participation and outreach is closely tied to their ability to address the supervision and program monitoring challenge, they are urged to seek local solutions in conjunction with national policy reform efforts undertaken by USAID and the international donor community.

8. VDC/HMC Capacity Building: It is recommended that USAID and NFHP accelerate the VDC and HMC development process, targeting the 17 NFHP CPDs to strengthen the management skills and capacity of the group in order to address immediate health needs.

National Level

9. Decentralization: USAID and the international donor community must remain committed to supporting the decentralization of public services, including health, in Nepal.

10. Coordination and Communication: USAID, in its capacity as chairperson for the National Donor Coordination Committee, is urged to play a strong leadership role in encouraging donors to more effectively pool information, resources and expertise and apply them more effectively.

11. Fora: The establishment of regular and more effective fora (at both central and district levels) where organizations can exchange information and problem-solve in a confidential and safe environment would be extremely useful.

12. Security Agenda Items: The GON, USAID, and other donors are strongly urged to include security agenda items (at district level meetings) to share conflict related information, identify common problems, lay out plans for action which assign responsibility for follow-up, and to ensure this information is shared with regional, district and central levels for appropriate resolution of issues.

13. Policy Dialogue: USAID is strongly urged to develop a common policy agenda with the other donors, and increase the dialogue with the GON to address common funding and program implementation issues.

COMPLEX HUMANITARIAN EMERGENCY

14. Collaboration: It is recommended that USAID work through other international organizations (such as WFP, UN/OCHA), experienced external development

partners (such as DFID), international PVOs (such as MSF, ICRC, etc.), and local CBOs, that have more strategic and secure access to these heavily conflicted areas.

15. Livelihood Approach: USAID should actively work with response planning and program groups in order to ensure that their activities focus on supporting a "livelihood-oriented" relief approach to strategically intervening to save lives which could mitigate the danger of long term donor dependency and prevent undermining any remaining vestiges of community coping strategies.

MONITORING APPROACH

16. Community-based Monitoring: It is recommended that NFHP assist in the development and implementation of a complementary, informal community-based monitoring system to track localized changes in health service accessibility and quality. Following an assessment of local impact of the conflict, a system employing key locally sensitive indicators should be developed using local informants for data gathering.

17. Systems: NFHP should also assist the district health office in developing and implementing systems to collect and respond to community health needs as determined from the data collected.

ANNEX 1
SCOPE OF WORK

Scope of Work
USAID/Nepal Assessment of
Primary Health Care Services in Nepal

I. Background

A. Health Sector

The most recently conducted Demographic Health Survey in Nepal (DHS 2001) demonstrated that Nepal has achieved significant gains in the health status of women and children in the past decade. Most notably, child mortality was reduced by approximately 40 percent and fertility reduced by 20%. However, challenges still remain and Nepal continues to have some of the worst social indicators in the region.

Currently, the national under-five mortality rate is 91 per 1000 live births (DHS 2001) and maternal deaths are estimated at over 500 deaths per 100,000 births (DHS 2001), some estimates are as high as 1500 deaths. Only 14% of deliveries occur in health institutions, and nationally, only 12.5% of deliveries are attended by a trained health provider. Twenty-six percent of newborns are born with low birth weight, which leaves them prone to illness and death in infancy. The contraceptive prevalence rate among married women is 35% (DHS 2001). The most widely used method is sterilization followed by the injectable hormone, Depo-Provera. Twenty-eight percent of currently married women have an unmet need for family planning. The total fertility rate is 4.1 (on average, women are having four children in their lifetime) (DHS 2001), almost twice as high as desired family size. This means women are pregnant more frequently than they want and are exposed to the dangers of childbearing more often than ideal.

Acute respiratory infections (ARI) are responsible for 30-40% of deaths in children under five and diarrhea for 16-25% of deaths. The percentage of chronically malnourished children is very high and there has been very little improvement in the nutritional status of children over the last two decades. Full childhood immunization coverage is estimated at 66% (DHS 2001). Currently only 45% of women receive at least two doses of tetanus toxoid vaccine (TT) (DHS 2001).

There is wide variation in health status between the rural and urban populations, and between different socio-economic and ethnic groups. Inequitable childcare practices favoring boys in which girls receive less nutritious foods and have less access to health care, also contribute to poor health status especially among girls and women. Nepal is now the only country in the world where life expectancy for women is lower than men (53.5 years and 55 years respectively, World Health Report, 1996).

His Majesty's Government (HMG), in collaboration with a number of donor partners is implementing the Second Long Term Health Plan. The overall objective of the Plan is to improve the health of all Nepalese people, particularly those whose health needs are often not met; the most vulnerable groups, with an emphasis on women and children; the rural population; the poor, under-privileged and marginalized. In addition,

HMG is decentralizing the responsibility of the delivery of health care services to the lowest level of government, the Village Development Committee, who will be responsible for overseeing essential health care services in the community.

During the past year, the delivery of essential health care services throughout Nepal has been significantly challenged by the Maoist insurgency. While national-level indicators depicting the current status of health care services throughout Nepal do not currently indicate a significant impact on the delivery of health care services, several districts have reported differently. Examples of district-based information reported includes stock-outs in essential drugs and other health commodities at the most peripheral-level of health care delivery (the health post and sub-health post); difficulties in conducting supervision and monitoring visits due to travel constraints by district-level health officers; increased absence in health care providers at primary health care centers, health posts and sub-health posts; refrigerator cooling equipment to maintain vaccines is not functioning in places where electricity is out; valuable health commodities being transported to health facilities are being confiscated at check points; and telephone towers have been destroyed isolating several health care facilities. All of these issues significantly impact the delivery of essential health care services within districts, specifically routine immunizations, treatment of child pneumonia, reproductive health care, and ambulatory care for minor injuries.

B. Maoist Conflict

Nepal has "fertile" ground for a grass roots insurgency. Eighty percent of Nepal's citizens live as subsistence farmers in a country where only 20% of the land area is arable. Large populations live in inaccessible and remote mountainous areas far from the urban centers. Annual population growth averages 2.4 percent. Illiteracy, hovering at about 40%, is considerably more prevalent among females and the general rural population. A large percentage of people in rural areas speak Nepali as a second language. The median annual income is around US$241 but 42% of Nepal's citizens live on less than US$100 per year. Development efforts have improved the standard of living in some parts of the country, but significant disparities between urban and rural areas remain. Patronage and nepotism continue to undermine the state's credibility and there is no substantial middle class outside of the major cities. Upper castes in urban areas dominate political and economic power in spite of open elections. These problems, compounded by ethnic and class inequalities, corruption, and the lack of development impact at the local level, have provided fertile ground for a Maoist insurgency.

Over 3,000 people have died since 1996 when the Maoists' formally declared a "peoples' war" against the Government of Nepal (GON). Approximately 50% of those deaths have occurred since November 2001 when the GON declared a nation-wide "State of Emergency". The Maoists strategy is consciously modeled on Peru's Maoist Shining Path Movement. The resulting conflict is producing similar disturbing projections regarding Nepal's and the regions future economic and political security. The GON's reform and developmental efforts are largely paralyzed and the fragile economy is

seriously damaged. The delivery of social sector services is being impacted at the district-level.

The conflict's origin dates back to a 1994 national election dispute in which one communist party faction was excluded from participation, and subsequently started a campaign of retribution against the ruling Nepal Congress Party. The GON response was to unleash the police force to repress the movement. Human rights abuses: torture, rape, detention, and murder were widespread. Citizens living in the most affected areas began joining the Maoists and these districts now comprise the Maoist heartland.

The support that the Maoists enjoy beyond this heartland however, is due mainly to the failure of successive governments to alleviate poverty, provide access to justice, reduce unemployment, curb corruption, eliminate socio-economic inequalities and deliver services – particularly in rural areas - such as health care.

While the GON has taken some steps to address the root causes contributing to the insurrection, it lacks the capacity and resources to carry out its programs without donor support. The conflict has disrupted the fragile national economy; adversely affected development programs; and stymied recent GON decentralization initiatives to transfer authority, funds, and responsibility from central control to locally elected bodies in Nepal's 75 districts. On April 30, 2001, the GON responded to the insurrection with the Integrated Security and Development Program (ISDP), under which the military was to provide a security shield, behind which development works would be carried out. The ISDP, initiated in seven districts, with plans to add another six and eventually thirty more districts was scaled back to a single district after the emergency was declared, because the GON does not have sufficient resources to sustain both the ISDP and the emergency measures.

After the state of emergency was declared the nature of Maoist actions turned increasingly cold blooded and brutal. Torture, mutilation, terror, murder and intimidation became routine, all but vitiating the Robinhood image that they had cultivated earlier. Their tactical shift from reliance on popular support, to control by fear, along with their unilateral abandonment of the peace talks suggests that the most militant elements have seized control of an already radical movement.

Stopping the violence and addressing the legitimate grievances that the Maoists successfully exploit to justify their anti-government campaign are critical to restoring and maintaining stability, both within Nepal and in the South Asia region.

II. Scope of Work

A. Objectives

The primary objectives of the assessment are detailed below:

is to describe the current status of health care service delivery in Nepal given the issues related to the Maoist insurgency; propose possible scenarios for future issues and potential impact should the conflict continue; and provide recommendations for implementation of activities to support HMG's delivery of essential health care services and their response to addressing health care delivery issues as a result of the conflict.

Objective 1: Describe the current status of health care service delivery in Nepal compared to prior years and identify those services and delivery systems that have been most impacted by the conflict.

Objective 2: Map out the immediate health care needs of those areas most impacted by the conflict and identify the most effective modalities for addressing those immediate needs.

Objective 3: During the next 12 months to 2 years, identify the essential primary health care services which are most likely to be the most vulnerable and propose strategies to strengthen these services to minimize the vulnerability.

Objective 4: Provide recommendations to USAID/Nepal on how the current health sector strategy can be implemented in the current conflict environment.

The following questions should be addressed:

1. Have services declined in the past 12 months compared to the past 3 to 4 years? If so, at what period time(s) did they decline? Which services were most impacted, which geographic areas, and at which level of service delivery? What level of health care service has been most impacted? Which level of health care provider has been most impacted and why? What were the primary reasons for the decline? What aspects or elements of health services (e.g. infrastructure, staffing, supplies, etc) have been specifically targeted by Maoists?

2. Which services, if any, have continued or been maintained during the past 12 months compared to prior years? Why have these services been able to continue, what actions and steps have been taken to maintain health services, and what have been the systems and/or infrastructure in place to support these services? Which geographic areas have had minimal effect or no effect? What level and type of health care provider (Level - district-level, primary health care center, health post or sub-health post, community-based? And type - HMG vs INGO vs NGO ?) has been most able to continue delivery services in areas most seriously affected by the conflict?

3. Which geographic areas (region, district, sub-district, VDC?) have the most immediate health care needs? What are those immediate needs? Who (e.g. NGO, government health care system, etc) is the most appropriate to address those immediate needs? During the next 12 months to 2 years, what will be the primary health care needs for these geographic areas and other neighboring geographic areas?

4. Have NGO and INGO activities to deliver health care services increased or decreased significantly? And if so, why? Have they been "filling the gap" in the absence of HMG health care delivery as a result of the conflict? What measures have NGOs and INGOs taken to continue working or providing support in a situation of increasing risks to program staff and property?

5. Is there a pattern in health care service delivery as a result of this conflict? If so, what is the pattern (e.g. of declining services) and what may be the next thresholds if the current situation maintains itself? What are the possible scenarios, if the current situation escalates and worsens?

6. What are the most critical elements of the HMG health care service delivery system, which need to be supported? What are the best approaches to providing that support given the uncertainty and unpredictability of the conflict? Please provide examples of innovative approaches or more regular approaches that to seem to be working.

7. How will decentralization impact upon service delivery given the current issues with service delivery as a result of the conflict?

8. What, if any, new activities have been successfully initiated in the past 12 months? If some, where have they been initiated and by whom?

9. How can USAID implementing partners improve coordination and link activities with the recently designed USAID Special Objective? How can USAID implementing partners address issues related to implementation of the current USAID health sector strategy in the current conflict environment?

B. Involvement of External Development Partners (EDPs)

As many EDPs as possible with programs supporting the GON delivery of health care services should be consulted as a part of the assessment. Those include GTZ (German Development Agency), DFID (British Development Agency), SDC (Swiss Development Agency), JICA (Japanese Development Agency), UNICEF and UNFPA, and their implementing organizations. Many of the EDPs have already conducted district or region specific assessments the health sector. And, some EDPs (e.g. DFID) have either conducted a broad assessment of the conflict across sectors. These consultations and background documents should be used to complete this assessment.

C. Background Resources

Several background resources are available and the team should review and if appropriate, incorporate information from these resources into the assessment. USAID/Nepal will provide the team with a copy of all available resources. Some of the key documents include:

-Nepal Demographic Health Survey 2001 Report

-Nepal Census 2001 Report

-HMIS Data Annual Reports 1996 - 2000 (note: 2001 is currently being compiled; raw data may be available)

-Impact on NGO Health Sector Partners Assessment (conducted in Kathmandu June 2002)

-Internally Displaced Persons Assessment (conducted in Nepal May - June 2002)

-MSF Follow-Up Mission Report (conducted in Nepal April 2002)

-USAID/Nepal District Assessments for the Nepal Family Health Program (conducted May - August 2002)

-Security and Risk Management Report for DFID (conducted February 2002)

C. Deliverables

1. Upon arrival in country, conduct briefings with USAID and other interested bilateral, multi-lateral EDPs, and key implementing partners (of either USAID or EDPs) to discuss SOW and approach to conducting the assessment, and gather initial assessment information.
2. Prior to departure from Nepal, facilitate a meeting to present and discuss assessment findings with EDPs and implementing partners. Facilitate individual EDPs or implementing partners meetings as requested for further or more in-depth discussion of assessment findings.
3. Prior to departure from Nepal, provide a written "close to final" draft of the assessment to USAID.
4. Thirty days after completion of the fieldwork provide a final written document.

D. Other

Timing: The assessment should begin immediately or as soon as a team of consultants is identified. Field visits will be required to gather additional information through interviews with local partners and health care providers as well as further validate findings from already prepared documents and conducted surveys (e.g. Demographic Health Survey, Nepal Census, annual HMIS data, etc).

Travel Constrictions: If the consultant(s) is hired under a USAID contract, the consultant(s) will need to adhere to the US Embassy Regional Security Travel Policy and request travel concurrence to various districts in Nepal. If the consultant is hired under a grant or cooperative agreement, the consultant only needs to inform the US Embassy of its travel within Nepal.

Suggested Team Composition: The proposed or suggested team composition includes a team leader who is an experienced public health professional familiar with USAID health sector programming and has experience working with USAID bilateral activities; a health sector monitoring and evaluation professional experienced with analyzing health sector delivery trends using HMIS-type data; a clinical health care professional familiar with health care delivery in conflict situations; and a person who is fluent in Nepalese who is familiar with Nepal's health care service delivery system and is able to organize and facilitate the team logistics on the ground as well as provide additional translation support when needed. Several professionals who are currently working in Nepal may be available as members of the team.

ANNEX 2
LIST OF INTERVIEWEES

WORKING DOCUMENT

LIST OF INTERVIEWEES

SN	Name	Designation/Organization
1	Dr. Esperanza R Martinez	External Consultant
2	Ms. Navin Kumari Dahal	FCHV, Mangalbare, Morang
3	Dr. Chumal Lal Das	Medical Officer, PHC Mangalbare
4	Mr. Mahendra Nath Singh	Health Assistant, PHC Mangalbare
5	Mr. Bhola Nath Adhakari	Auxiliary Health Worker, PHC Mangalbare
6	Mr. Ganesh Mallik	VHW, Mangalbare, Morang
7	Ms. Menuka Thapa	FCHV, Urlabari
8	Ms. Dambar Kumari Thapa	TBA, Urlabari
10.	Mr. Samir Kumar Gautam	SHP Incharge, Belbari
11	Ms. Safala Basnyet	MCHW, Urlabari
12	Ms. Renu Adhikari	FCHV, Urlabari
13	Mothers group	Urlabari
14	Mr. Bhim Prasad Gautam	Section Officer, DPHO, Biratnagar
15	Mr. Bishnu Bahadur Chhetri	Statistician, DPHO, Biratnagar
16	Mr. Prem Giri	FP Supervisor, DPHO, Biratnagar
17		Account Officer, DPHO, Biratnagar
18	Mr. Lila Mani Sharma	Program Manager, SCF/US, Siraha
19	Mr. Hari Rana	Program coordinator- Health, SCF/US, Siraha
20	Mr. Keshav Bhurtel	Program Officer, GTZ, Siraha
21	Dr. Murali Prasad Singh	Medical Superintendent, Siraha Hospital
22		Public health Officer, Siraha
23	Mr. Janak Das Shrestha	Regional Field Officer, UNFPA, Biratnagar
24	Dr. Padam Bahadur Chand	Regional Health Director, Eastern R
25	Mr. Pan Bahadur Chhetri	In-charge, Regional Medical Store, Biratnagar
26	Mr. Keshav Sharma	Branch Manager, FPAN, Biratnagar
27	Ms. Radhika Subba	Field Officer, UNICEF, Biratnagar

28	Ms. Sita Gurung (UNICEF, Biratnagar)	Human-right activists, Panchthar
29	Mr. Prem Ojha (UNICEF, Biratnagar)	Human-right activists, Panchthar
30	Mr. Indra Bhattarai	Field Officer, NFHP, Biratnagar
31	Mr. Devendra Karki	Field Officer, NFHP, Biratnagar
32	Mr. Sunil Singh	Field Officer, NFHP, Biratnagar
33	Ms. Krishna Prasai	Field Officer, NFHP, Biratnagar
34	Mr. C. P. Tamang	Admin. Officer, NFHP, Biratnagar
35	Dr. Anjelika	Program Manager, GTZ, Kathamandu
36	Mr. John Prout	Deputy Country Director, WFP
37	Dr. Puskar Bharati	Program coordinator, JSI/DFID
38	Dr. Penny Dawson	Chief of Party, NFHP
39	Mr. Frank White	Deputy Chief of Party, NFHP
40	Mr. Ashoke Shrestha	Deputy Chief of Party, NFHP
41	Mr. Kumar Lamichhane	Field Coordinator, NFHP

ANNEX 3
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BIBLIOGRAPHY

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