

REVITALIZING PRIMARY HEALTH CARE

COUNTRY EXPERIENCE:

NEPAL

CONTENTS

1.	BACKGROUND	1
2.	PRESENT STATUS OF PHC	3
2.1	Health Education Program	6
2.2	Nutrition	6
2.3	Water and Sanitation	6
2.4	FP/MCH	7
2.5	Expanded Program of Immunization	7
2.6	Control of Locally Endemic Diseases	8
2.7	Treatment of common illness	9
2.8	Essential drugs	9
3.	OTHER ELEMENTS OF PHC	9
4.	TRANSLATING THE VALUES OF PHC INTO POLICY AND ACTIONS	12
4.1	Universal access to care and coverage on the basis of need	12
4.2	Commitment to health equity as part of development oriented to social justice	12
4.3	Community Participation	13
4.4	Inter-Sector Actions in Health	14
4.5	Additional Values for PHC in the 21st Century	14
5.	LESSONS LEARNT	14
6.	PHC AND THE CURRENT HEALTH ISSUES AND CONTEXT	16
6.1	Demographic changes and epidemiological transition	16
6.2	Public private partnership	17
6.3	Integrating vertical program and improving quality of care	17
6.4	Tackling issues in equity in health through addressing social determinants of health	17
6.5	Sector wide approaches	17
6.6	Local level Planning and decentralization	18
7.	WAY FORWARD	18

1. BACKGROUND

General

As a signatory of Alma Ata declaration of 1978, Government of Nepal (GoN) has fully realized the importance of continued adherence to the Primary Health Care (PHC) approaches for the development of coordinated quality health care services for the people living both in rural and urban areas. Major principles of this declaration are:

- a. Universal accessibility to available resources and services in order to provide adequate coverage of the most essential health needs of the population.
- b. Community and individual involvement and self-reliance.
- c. Inter-sectoral action for health
- d. Appropriate technology and cost-effectiveness, i.e., allocation of resources in such a manner as to yield the greatest benefits, with benefits measured by the extent to which health need of a large number of people can be met.

Within this context, it has been recognized that the ultimate objective of health development aims at the welfare of the communities through their active participation in its development, management and utilization. The effectiveness and sustainability of health development activities depends on the commitment of the public, private and NGO sectors of district, regional and central level.

Emergence of district health system

In Nepal, modern health services started since 1933 starting with establishment of Department of Health Services (DoHS). Government hospitals and Ayurvedic hospitals were set up gradually. During the 50s, the First Five Year Development Plan was developed and, as a consequence, Malaria Eradication Program came in existence in this period. More vertical projects followed it during 1960s, which are FP/MCH, Small pox Eradication and the Central Health Laboratory. With more emphasis on curative service during the Second Plan period (1962-65) emphasis was placed in preventive and curative medicine. In the Third Plan (1965-70) preventive and promotive health care service gained further attention.

Considering the sustainability dimension of health development, integration of vertical projects was introduced, first in 1971, in one district followed by full integration of all vertically run health programs in 6 more districts. Integrated Community Health Service Development Project established by the Ministry of Health (MoH) was made responsible to integrate all vertical health programs and ran under one umbrella as District Health Office.

Human resource and community participation

The Fourth Plan (1970-75) focused more on preventive and human resource development and preventive cure got priority. Institute of Medicine (IoM) was established under Tribhuvan University to train mid-level health service providers.

During this period Alma Ata declaration was made and Nepal signed in it committing itself to provide basic health care services (preventive, promotive, curative and rehabilitative health care services using Primary Health Care approach) with gradual integration of all vertically run health care services and to follow the slogan of Health for all by 2000. Efforts were made to encourage community participation and to promote community health volunteers to enable them to be self-reliant in health service delivery¹

Nepal's female community health volunteers are the excellent example of community workforce with success stories of Vitamin A, polio and immunization, anti helminthes drug distribution, now also managing some cases of ARI, distribution of ORS . This is another example of community participation as they are selected from the local area itself

Nepal has other health workers called as Village Health Worker (VHW), who is responsible for immunization, Maternal and Child Health Worker (MCH), who are selected from their own locality now they are under training to become Auxiliary Midwives (many of them are already trained)

Other AHW (auxiliary health worker) Recruited at community level to as paramedic

Beginning of strategic thinking

The First Long Term Health Plan (1975-90) was developed with an objective to ensure consistent and proper functioning of the health services. Accordingly, the Fifth Plan (1975-80) fully integrated vertical programs into a health infrastructure capable of providing effective services to the people. Emphasis was put on regulating population growth through promotion of family planning, and expansion of maternal and child health services. The Sixth Plan period broke health sector isolation emphasizing inter-sectoral coordination with food supply, safe drinking water etc.

The Seventh Plan (1985-90) witnessed an organizational integration. The Department of Health Services was dissolved and the Regional Health Services Directorate in five development regions was created in the spirit of

¹ Country Health Profile, Nepal HMG/MoH and WHO, 1988

Decentralization Act, 1982. Further Ministry of Health created two new departments for Department of Ayurved and Department of Drug Administration.

Movement of 1990 and new health policy

Following the People's Movement of 1990, a radical National Health Policy was brought out in 1991 that has set up one health facility in every village development committee ensuring PHC in peoples' door step and a Primary Health Care Center with birthing facility in every electorate constituency. There had been further restructuring of health services during the Eighth plan period with the objective of strengthening district health system which was delayed for 2 years covering 1992-97. The Ninth Plan (1997-2002) focused on poverty alleviation with the belief that healthy people could be engaged in productive activity enabling greatly contribute in poverty alleviation. Ministry of Health formulated a new perspective plan in this period which was officially endorsed as a Second Long Term Health Plan, 1997-2017.

In all these planning exercises, the government has shown commitment to provide basic health care to all citizens of Nepal by adopting the principles and approaches of Primary Health Care as declared in Alma Ata Conference of Health for all by 2000.

2. PRESENT STATUS OF PHC

The PHC service including curative health services has been provided since 1978 through a network of district and below the district level health care service delivery network. The lowest level of health facility is Sub Health Post. In order to provide basic health services nearly 50,000 Female Community Health Volunteers are mobilized throughout the country. In each of the PHC components, following progress have been realized during the period 1980-2006:

Milestones of Primary Health Care in Nepal

Indicator	1980	1990	2000	2005
1. Health Education				
2. Nutrition a. Stunting b. Wasting	a. 51.8% b. 42.0% (NNS, 1975) a. 52.2% b. 49.9% (CBS, 1984)	a. 49.0% b. 60.2% (NMIS, 1998)	a. 57.0% b. 43.0% (DHS, 2001)	a. 49.0% b. 39.0% (DHS, 2006)
3. MCH a. ANC 1 st visit b. ANC 4 th visit c. % of births attended by SBA d. FP acceptance rate e. CBR	e. 43 per 1000 (CBS, 1978)	a. 15.5% of expected pregnancy (CBS, 1994) c. 3.1% d. 26% (CBS, 1987) e. 41.6 per 1000 (CBS, 1987)	c. 13% d. 35% (2001)	a. 72% expected pregnancy from SBA c. 19% attended by trained health worker d. 44% (2006)
4. Water and Sanitation a. Population with access to safe drinking (piped) water b. Population with access to basic sanitation	a. 33% (total) 6% (rural)	a. 34% (rural) b. 19.8% (1991) 22.5% (1996)	a. 71% rural 76% urban	
5. Immunization a. BCG b. DPT3 c. Measles d. Polio	a. 32% b. 16% c. 2% d. 1%	a. 68% b. c. 63% d. 30%	a. b. 71% c. 92% d. 71%	a. 83% b. 89% c. 85% d. 85%
6. Control of Endemic Diseases a. Diarrhoea % of children affected b. ARI % of children affected				11.9 %

c. Malaria positive cases c. Leprosy d. Tuberculosis care rate	1.99/1000	2.7/1000(1987)	4/1000(1997)	5.3 %
7. Treatment of Common Illnesses and Injuries		85 %		
8. Essential Drugs Availability				Excellent 2007

2.1 Health Education Program

Health Education was being run through a section in DoHS, which was converted into an autonomous institution in 1998 as a National Health Education, Information And Communication Centre (NHEICC) with an objective to raise health awareness of the people as means to promote health and prevent diseases through full utilization of community resources. The Centre has developed and disseminated audio-visual aids, media program, TV spots, calendars with health messages flip charts and many other materials to prevent communicable diseases, water borne diseases, feco-oral diseases, TB, Leprosy, and promotion of healthy behavior, use of family planning and safe motherhood.

2.2 Nutrition

Nutrition section was established in DoHS as early as in 1970 to promote and train health workers in nutrition education, prevention and treatment of Protein, Energy Malnutrition; micro-nutrients, Vitamin A and Iodine Deficiency order. The nutritional surveys carried out in different years revealed that nutrition is one of the common problems in Nepal particularly among lactating mothers and children less than five years of age. DoHS is involved in a lot of activities to improve nutritional status of the children forging coordination with Agriculture, Education, Women Development and Poverty Alleviation programs.

2.3 Water and Sanitation

Water and sanitation promotion program was launched by separate departments outside the MoH. The main actors providing safe drinking water and improved sanitation in the country are: Ministry of Local Development, Ministry of Housing and Physical planning and Department of Drinking Water and Sewerage. As water and sanitation has been identified as one of the basic needs, the GoN has launched special program in 1987 with assistance from Asian Development Bank and World Bank involving local community as water users committee. Nepal observed the International Drinking Water Supply and Sanitation Decade (1981-90) at the call of United Nations.

In the 1980s domestic water supply situation was poor to the extent that covered only 6 % of rural population which has gone up to 71 % by the year 2000. Over the last decade there has been increasing awareness about the need to improve

sanitation situation in Nepal. The overall sanitation coverage increased from 19.8 in 1991 to 22.5 in 1996.²

2.4 FP/MCH

Since the early 1980s Family Planning and Maternal Child Health Care service was given utmost priority in delivery of health services through public health facilities. PHC services are provided at District Health Office clinics and Primary Health Care Centre (PHCC), Health Post (HP) and Sub Health Post (SHP) level facilities by basic and grass-root level health workers. At household level Female Community Health Volunteers (FCHVs) provide counseling to mothers and distribute condom, pills, folic acid, Vitamin A and oral rehydration packets. The Maternal and Child Health Worker (MCHW) position was created and trained to provide ANC, delivery, post delivery care from SHP as well as making home visits. They were also trained to give first aid treatment to complicated obstetric cases before referring to appropriate service center. An Emergency Obstetric Kit box (EOC Kit) with life saving obstetric medicines was given to them. MoHP is working towards better access and higher quality service to improve maternal health. A Maternal Incentive Scheme has been adopted since 2005 to increase demand for maternity services along with a focus on improving access to such services.

One of the objectives of Primary Health Care Outreach service was to provide ANC, FP, basic health care for minor ailments and health education at the door steps. Over the decade (1980-90) tremendous progress has been observed in contraceptive acceptors, safe-motherhood services and awareness about FP and MCH services. As a result, total fertility rate (TFR) declined from 6 (mid-1970s) to 3.1 per women in 2006.³

The Contraceptive Prevalence Rate in Nepal has also gone up to a very satisfactory level from 3 % in 1976 to 44% in 2006. On the safe motherhood side, the ANC 1st visit, 4th visit and home delivery by trained health workers has been increasing each year. However, the gap between 1st and 4th ANC visit needs to be improved.

2.5 Expanded Program of Immunization

Expanded Program for Immunization (EPI) was launched in 1978 following the success of smallpox eradication program which started intensively to reduce morbidity and mortality from vaccine preventable disease of children less than 5

² Nepal: State of Sanitation Report 1999/2000, UNICEF, Nepal.

³ Nepal Demographic and Health Survey, 2006

years of age. It covered vaccination to prevent from diseases like Polio, Tetanus, Measles, TB, Diphtheria and Whooping Cough. Grass-roots level health workers (VHW/MCHWs) provided vaccines from PHC service delivery network. Immunization coverage improved from BCG - 32%, DPT3 – 16 % and measles – 12 % in the year 1980 to 83 %, 89 % and 85 % respectively in the year 2005 which is due to PHC approach.

2.6 Control of Locally Endemic Diseases

The DoHS put great efforts in controlling diarrhoeal diseases among children of under 5 years of age through national Control of Diarrheal Disease (CDD) Program. During 1986, 45,000 children died of diarrhea. National program has highly emphasized to bring down the diarrheal morbidity and mortality and as a result the incidence of diarrhea has been drastically reduced among children under 5 years' of age. The programs introduced were distribution of oral re-hydration solution, establishment of ORT corners and massive health education. The proportion of severe diarrhea has fallen from 10% to 4% in the last 5 years and case fatality rate has decreased and is decreasing each year.⁴

Similarly Acute Respiratory Infection (ARI) Program was also introduced targeting to reduce mortality among children due to ARI. The community based ARI management program relies heavily on the knowledge and skill of health workers. The case fatality rate of severe pneumonia has fallen down from 13 to 4 per 1000 in the last 5 years. Infant mortality rate (IMR) has declined by 41% over the 15 years period. Similarly under 5 mortality has gone down by 48% - from 117 deaths per 1000 live births to 61.⁵

Malaria program was launched to control malaria. The target was to bring down Malaria Incidence Rate below 4.0 per 1000 population by 1997 and to further bring down to 2 per 1000 population by 2000 AD. Annual Parasite Incidence rate was 1.99% in 1982, 4.54% in 1985 and 2.71% in 1987. Similarly slide positivity rate was 1.12% in 1982, 2.74% in 1985 and 1.94% in 87. All these efforts are not adequate and in recent years it is speculated that malaria is rolling back. The Global Fund for Malaria with adequate fund could be targeted more comprehensively to address the roll back malaria problem.

Tuberculosis Control Project was established in 1965 and worked till 1972 and converted into a regular program later on. This was put under PHC service delivery package and the activities were case finding, treatment, case holding and health education. Target was to achieve 85% cure rate of all diagnosed new smear

⁴ Ibid

⁵ Ibid

positive cases by the year 2000. The Directly Observed Treatment Short Course (DOTS) was introduced, during late 1990s to accomplish 85% cure rate.

Established in 1978, Leprosy Control Project introduced case holding, treating, monitoring and training to health workers for preventive, curative and rehabilitative services. Now leprosy control program runs through the regular PHC service delivery system. Multi drug therapy treatment was introduced in 1980s to eliminate leprosy from Nepal by the year 2000. However, the elimination target has to be accomplished yet.

2.7 Treatment of common illness

MoPH has structure from SHP level to tertiary care facilities to provide treatment of common illness and injury. Private sector providers basically the new medical colleges have developed huge infrastructure for this beside private nursing homes in the urban centres. NGO sector has been helpful to provide service in the remote areas. Injury has been a serious dimension of health care due to difficult geography. General practitioners with bone setting skill are posted in the remote districts. A trauma centre is under development for referral purpose. Exact number of OPD attendants covering health and other GON hospitals and private sector needs to be compiled as regular HMIS activity.

2.8 Essential drugs

Reports have shown that, the availability of drugs and other health commodities has improved over the years. Recently concluded Joint Annual Review of NHSP-IP in its Aide-Memoire remarked that in the area of drugs procurement, logistics and availability, progress is encouraging but the free care policy will test the system's solidity. Implementation of the "Pull" system has shown encouraging preliminary results and should be accelerated to ensure the availability of drugs in all facilities when services become free and demand increases.

3. OTHER ELEMENTS OF PHC

Oral Health

DoHS implemented dental health care at district and community providing training on dental health care to service providers of DHO. PHCC and HPs to enable them to provide basic dental health care. Some medicine and equipment on dental care was supplied to those health facilities and those service providers

provided treatment for some minor dental problems like caries, tooth ache, abscess of mouth etc.

Eye Care

Trachoma and cataract are the major cause of blindness in Nepal. About 2.5% of population is affected with Trachoma and 72% from Cataract.

Occupational Health

Since industries are under the purview of separate ministry, MoHP has to play coordinating role to comply with occupational safety measures. MoHP in coordination with relevant ministries/departments has given input on these matters. Legislation in industrial hazard and safety have been developed and implemented including training.

Mental Health

MoHP has been engaged in providing Mental Health services. Although this service was put under PHC package, it is not comprehensive. Training was provided to the service providers. Severe cases were referred to specialized tertiary care centers. MoHP has given emphasis on community/home based care and counseling.

Environmental Health, Sanitation and Air Pollution

MoHP in collaboration with other ministries, private and NGO sectors provides training to health workers as well as staff working in the areas of water supply, solid waste disposal and sewage system, excreta disposal, food safety and food hygiene etc. Responsible departments have developed their strategic plans. MoHP has developed medical waste disposal strategy and is in implementation phase.

Urban Health

MoHP provides training to health and other social sector workers dealing with urban health, population pressure and healthy cities initiative. It also coordinates with metropolis and municipalities to run urban health clinics and centres.

School Health

MoHP has also been involved in School Health program and provides training to school teachers to promote School Health activities. It trained the school teachers in the area of health and nutrition, personal hygiene, school environment, torture and child abuse. In certain places encouraging results of child to child care has been realized. Target is to use children as vehicles to promote healthy behaviors in the family.

Medico-legal Issues

MoHP trains health service providers specially in the field of medico-legal issues. It also orients its service providers in the areas like client's right, quality of care, substance abuse, accidents and injuries - road traffic accident, falls and injuries, agricultural accident (use of pesticides), industrial accident, poisoning etc.

Problems of the Elderly

MoHP has initiated its special program for senior citizens of 60 years and above providing free health care services. Geriatric care units are in process to establish in tertiary level hospitals. Old age allowance for senior citizens has been provisioned.

Care for the Disabled

MoHP has engaged with various private and NGOs working for them. Nepal Netra Jyoti Sangh is a leading NGO making various eye hospitals in the country. Rehabilitation centres are active and MoHP provides financial as well as technical support to them. Institutions, public and private partnership in the field is exemplary.

Centre of Excellence

MoHP has promoted a number of centres of excellence in order to help people having various health problems. For example: BP Cancer Hospital at Bharatpur is one example in specialized care. Such centres in the areas of HR development and service institutions range from National Academy of Medical services to BPKIHS Dharan and Heart Centre at Bansbari. A number of private centres of excellence are funded by MoHP in eye care, rehabilitation for disable children etc.

Health Systems Decentralization

With introduction of Local Self Governance Act (LSGA) 1999, health has been pioneer in decentralizing its services to the local level. Health being one of the 4 development sectors to decentralize its authority and resource, it has worked in the spirit of LSGA. The basic aim of decentralizing local health facilities to local bodies was to promote efficiency, generate financial resources, encourage people's participants and enhance their management capacity. Till now, 1433 health facilities from 28 districts have been handed over to local bodies. Results are found encouraging. However, political process has been stuck at the local level which has impeded the pace. It will pick up soon once political process comes back to track.

4. TRANSLATING THE VALUES OF PHC INTO POLICY AND ACTIONS

The vision of Health and Development of GoN's Ministry of Health is guided by the belief that health is a human right and to have a health system in which there is equitable access to coordinated quality health care services in rural and urban areas; and health services are characterized by self-reliance, full community participation, decentralization, gender sensitivity, and effective and efficient management, resulting in improved health status of the population.

4.1 Universal access to care and coverage on the basis of need

MoHP has developed policies to provide health service for all following the principle of universal access to care and coverage on the basis of need. In 1991, the National Health Policy was implemented with objective of upgrading the health standards of the majority of the population by extending the PHC services up to the village level. In this regard PHCC, HP, SHP and Out Reach Clinics were established. The policy also aims to provide opportunity to the rural people to enable them to obtain the benefits of modern medical facilities by making these accessible to them.

4.2 Commitment to health equity as part of development oriented to social justice

To achieve equity in health, the concept of access assumes a central role. The purpose of increased access is to assure that all people but particularly those whose health needs often are not being met, are able to use services at rates proportional and appropriate to their need for care (the most vulnerable groups; women and children; the rural population; the poor; the disadvantaged and marginalised). Thus the individual dimensions of access which affect a person's ability to make use of the health system will be addressed in health sector development - geographic/physical access, economic access, social/cultural access and organizational access.

The constitutional right to health care is being translated into a policy of universal free essential health care. In December 2006, emergency and inpatient services were declared free for the disadvantaged, destitute, underserved, the elderly, the people living with physical and psychological disability, and Female Community Health Volunteers (FCHVs), at district hospitals and primary health care centres (PHCCs). Moreover, outpatient care was declared free in 35 low human development indicator districts. In October 2007, GON further decided to offer

essential health care services free of charge to all citizens at all health and sub-health posts from mid-January 2008⁶.

Commitment to health sector as part of development oriented social justice, MoHP developed Health Sector Strategy (HSS) with an aim to provide an equitable, high quality health care system for the Nepalese people residing in the poor to reach un-reached, ultra poor, marginalized and provide Essential Health Care Services. The goal of HSS is to achieve Millennium Development Health Goals (MDHGs) with improved health outcomes for the poor and those living in remote areas and consequent reduction in poverty. It aims to improve the health status of Nepalese population through increased utilization of health services by the rural poor, marginalized and vulnerable population

The Nepal Health Sector Programme - Implementation Plan (NHSP-IP) of MoHP is the road map of the Nepal Health Sector Strategy. It envisages increasing the coverage and raising the quality of Essential Health Care Services (EHCS), with a special emphasis on improved access for poor and vulnerable groups using efficient sector wide health management system and provision of adequate financial resources. Therefore, the post PHC effect has assured social justice in health sector by MoHP through implementation of NHSP-IP which will guide for undertaking all health related activities in Nepal.

4.3 Community Participation

Full community participation is recognized as an essential characteristic of an effective, efficient and sustainable health system. Community participation is not viewed as simply compliance to program activities nor the mere provision of resources. Rather, community participation includes the community in decision-making at various levels through its representatives and organizations. Within the context of full community participation, central, regional and district level personnel are expected to fulfill a supportive role in assisting and enabling the community to carry out their responsibilities. As an effect of community involvement started from the PHC approach MoHP has adopted to involve a cross section of members of community in the management of health services. In this regard Health Facility Management Committees have been formed which comprise women, *dalit* and marginalized people among others. With the implementation of Local Self-Governance Act, the health facilities were handed over to the local bodies (e.g VDCs).

⁶ Nepal Health Sector Program; Sixth Joint Annual Review (JAR)/Mid-Term Review (December 3-10, 2007). Draft Aide- Memoire

MoHP adopted the policy of Community Drug Program as an extension of Drug Scheme implemented in 1980s. This is an approach to mobilize community for their own health care and to involve promote greater involvement of community in resource mobilization and management of health facilities. It encouraged service users to purchase prescribed medicine on subsidized rate. The money accumulated through the sale of medicines is utilized to purchase additional medicines on its own to fulfill the medicine requirements.

4.4 Inter-Sector Actions in Health

MoHP has introduced policy to provide Essential Health Care Services at the District and below level Essential Health Care Services. The delivery EHCS is guided by principles of universal accessibility, adequate coverage for most of the vulnerable population. It seeks assistance from sectors other than health such as agriculture, education, local development and water supply etc for effective and efficient management. Health should not be considered as the sole responsibility of MoHP but to improve the health status a multi-sectoral development is necessary. It therefore calls for coordination and participation of public sector, NGOs, INGOs for providing and financing a sustainable health service delivery.

4.5 Additional Values for PHC in the 21st Century

The PHC approach established and implemented since 1978 in the country has established additional values in the sector of private public partnership and community involvement in health. The International Health Partnership (IHP) will be a key approach in the 21st century. The significant recent development is Nepal's inclusion among the first wave countries to benefit from the new IHP which seeks to increase aid effectiveness, and accelerate progress towards the health-related MDGs. As IHP brings more partners on board at the global level, Nepal can take fuller advantage of it by making it inclusive of all partners not merely the global signatories. Being a young SWAp, NHSP can gain valuable international exposure and learn from other countries' experiences by being part of IHP.⁷

5. LESSONS LEARNT

The PHC approach in the country has positive impact. Before its implementation, the preventive, promotive, curative and rehabilitative health care concept was not fully developed and implemented. The health service was heavily dominated by

⁷ Ibid

curative care. Furthermore, the main contribution of PHC approach was the community participation and self-reliant in terms of local capacity development. There has been smooth implementation of entire health programs through PHC approach and the improved health indicators achieved in the Nepal Health and demographic Survey have been the proof of this success. The facilitating factors are:

Political Context

The Governance during the period of early 1980s under *panchayat* system was heavily centralized. Despite this, MoH's plan and programs were in line with meeting PHC approach with commitment of Health for All by the year 2000. Now the health has been written as a fundamental human right in the interim constitution is a big way forward.

Economic Condition

Due to conflict over the years for decade, Nepalese economy could not realize growth as its big neighbors, Asian giants, have achieved. Its impact has been clear even in health sector. However, remittance has been helpful element to keep the economy going. With this and assistance from external development partners, health is doing moderately well.

Finance Resource

The health sector has been consistently seeking more funds to address the problems of the poor and to reach the un-reached. Government health budget was 4.93 % of the total national budget in 2003/4 and later in 2006/7 increased to 6.4 %. It has further moved up to 7.14 % of the national budget in this year amounting to 12.099 million rupees. However, only 49 % of the budget could be borne from the regular source. The inadequate fund has been covered by EDPs and external assistance. Two-thirds of the budget is spent on EHCS. Free public health interventions have become virtually universal (e.g. Vitamin A). Health sector strategy: an agent for reform has been instrumental in pool funding as well as joint planning and ministry health programs.

Human Resource

Availability of trained human resource to balance a skill mix has been one of the key hindrances in delivery of primary health care services. There was inadequate number of trained and competent staff in health facilities and skill birth attendant is one of the categories to name immediately. There are others in secondary and tertiary care levels. However, the presence of FCHVs in each ward has greatly contributed in delivery of Primary Health Care to the rural population

Physical Infrastructure

The physical facilities for delivery of service are not adequate and are in process of development. Majority of the fore front health facilities are in the make shift basis specially sheltered by VDCs and other organizations. There is lack of facilities for maintaining privacy due to inadequate space in these facilities. This is the area where MoHP need assistance form external support partners. The assistance rendered by the local bodies (DDC, VDC and Municipalities are notable in this area.

IMCI and Zinc to control diarrhea

In order to control diarrhea among the children under 5 year of age, community based integrated management of childhood illness has been very successful. Addition of zinc on it has shown very good results.

Community Drug Program (CDP)

Nepal experienced a great success in generating local resource for health program through CDP. It helped to ensure availability of drugs and other material round the year, promoted cross subsidy between rich and poor and gave safety net to the poor giving economic access to them. In several districts additional health and administrative staff have been hired locally to strengthen the team using the money generated through this program.

6. PHC AND THE CURRENT HEALTH ISSUES AND CONTEXT

The health issues and challenges that lie ahead in putting the PHC approach and principles on ground are:

Demographic changes and epidemiological transition

Because of the progress made over the years by PHC service delivery system in the area of behavior change, the time has now come to address other areas of importance besides Child Health, Family Health and Communicable Diseases. For example, high death and high birth rate scenario has changed into low birth and high death phase of demographic change in our country. The age structure is changing with more elderly population. Something is to be done for the care of elderly. Likewise, with population pressure in the urban areas, the issue of urban health should now be another priority. Roll back malaria and HIV/AIDS are few diseases demanding fresh look and higher attention. The non-communicable diseases such as high blood pressure, cancer, diabetes etc are increasing as a result of life-style changes in the population. These diseases now need to be addressed

through prevention and curative service at PHC service delivery level. Unprecedented diseases like Avian Influenza are a big threat for public health and MoHP has started work on it.

Public private partnership

The GON/MoHP has initiated strengthening public private partnership for providing better, quality health care service and covering more people. In order to materialize this, there is a need to give more attention in the area of human resource development working in the private sector and their involvement in public sector. The private sector should join hand with the government for delivery of primary health care.

6.3 Integrating vertical program and improving quality of care

The eight elements of PHC service delivery package implemented at all levels of health service delivery. The Health Management Information System (HMIS) keeps track of the progress. New programs like HIV/AIDS, Japanese Encephalitis, Bird Flu etc is emerging. There is a need to integrate these programs in PHC service package rather than to implement the program vertically.

6.4 Tackling issues in equity in health through addressing social determinants of health

The Second Long Term Health Plan, Health Sector Strategy and NHSP-IP have been developed and implemented in order to ensure equity, equality and gender sensitivity issues in health care. In this regards, resource allocation were made to prepare human resource who are committed and socially responsible to provide health services without discrimination with respect to gender, caste, ethnicity and economic status and by maintaining equity and equality among all service receivers. However, it still will be a challenge to meet the demand in terms of resources and training and equipment to provide PHC services maintaining equity.

6.5 Sector wide approaches

MoHP has adopted the policy of using Government fund and fund from other sectors under sector wide approaches (SWAp). This SWAp approach is to pool fund into a basket and to disburse according to agreed Government priority rather than to the priority of the implementing partners and EDPs. The issue will be to tract disbursement and allocation of fund and expenditure. It will be a challenge to

properly utilize the fund in particular activity. The Code of Conduct has been passed by major EDPs working in health for such basket funding and its disbursement.

6.6 Local level Planning and decentralization

The Local Self Governance Act (1999) is already in place. This encourages developing local planning, implementation and monitoring. MoHP/DoHS have implemented bottom up planning process, though it has not been translated into actual operation in national planning process used by National Planning Commission and Ministry of Finance (MoF) particularly for fund disbursement. So far it has been limited to academic exercise. There is a need to honor local planning for disbursement of fund by Treasury Office of MoF.

7. WAY FORWARD

A three year interim health plan 2007/8-2009/10 has been prepared. The future course of action will be guided by the objectives and activities formulated in this plan⁸. In order to achieve the objectives, some of the key activities for the initial period of planning cycle are:

- To strengthen on-going high priority EHCS and achieve MDGs in accordance with the principles of Primary Health Care, equity and social justice
- To redesign health system to make people oriented, efficient and effective through reform in institutional management and health professional education
- To ensure availability of good quality services and essential medicines to all at affordable prices
- To strengthen public private partnership
- To develop performance based planning and budgeting system
- To strengthen financial information system including monitoring and feedback
- To encourage the implementation of decentralization approaches in health service delivery system.
- To develop capacity of the health workers and stakeholders involved in health facility operation and management

⁸ National Planning Commission, Interim Plan, 2007-09