April, 2010

WORKSHOP
[PROCESS REPORT]

PRIMARY HEALTH CARE REVITALIZATION IN NEPAL

Workshop on PHC Revitalization in Nepal
jointly organised by
PHC Revitalization Division/Department of Health Services
&
World Health Organization
April 05-06, 2010

Abbreviations

BCC	Behaviour Change Communication
CBO	Community Based Organization
CBR	Community Based Rehabilitation
CBS	Central Bureau of Statistics
CHD	Child Health Division
CMC	Centre for Mental Health and Counselling
D(P)HO	District (Public) Health Office/Officer
DDA	Department for Drugs Administration
DDC	District Development Committee
DoHS	Department of Health Services
DPPW	Department of Physical Planning and Works
DWS	Department of Water Supply
EDPs	External Development Partners
EHCS	Essential Health Care Services
EIA	Environment Impact Assessment
FCHV	Female Community Health Volunteers
HMIS	Health Management Information System
HP	Health Post
I/NGO	International/Non Governmental Organization
ICD	International Classification of Diseases
IEC	Information, Education and Communication
MD	Management Division
MDG	Millennium Development Goals
MEST	Ministry of Environment, Science and Technology
MoE	Ministry of Education
MoF	Ministry of Finance
MoFSC	Ministry of Forests and Soil Conservation
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoLTM	Ministry of Labour and Transport Management
MoWCSW	Ministry of Women, Children, and Social Welfare
MVA	Manual Vacuum Aspiration
NCD	Non Communicable Diseases
NFPA	Nepal Family Planning Association
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal health Sector Programme
NHTC	National Health Training Centre
NLSS	Nepal Living Standards Survey
NPC	National Planning Commission
NRCS	Nepal Red Cross Society
PAF	Poverty Alleviation Fund
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHC-R	Primary Health Care Revitalization
PRD	Primary Health Care Revitalization Division
RHD	Regional Health Directorate
SBA	Skilled Birth Attendant
SHP	Sub Health Post / Social Health Protection
STI	Sexually Transmitted Infection
VDC	Village Development Committee
WDO	Women Development Office
WHO/SEARO	World Health Organization/ Regional Office for South East Asia







Context

In 2009, Ministry of Health and Population (MoHP) constituted *Primary Health Care Revitalization Division (PRD)*, a new division, under the Department of Health Services (DoHS). The new division will assume the mantle to revitalize PHC in Nepal by addressing emerging health challenges in close collaboration with the other DoHS divisions and different supporting actors. The division is also expected to make inroads into translating the constitutionally stipulated fundamental right of basic free health care into practice by addressing the disparities in health service delivery and promoting equitable health services.

As part of its inception phase, PRD is in the process of organising several consultative forums with relevant state and non-state actors to share its mandate, gain insight into its strategic direction, and identify potential areas of collaboration. This event is the first among series of consultative workshops planned.

Objectives

This was a first workshop in a series of technical consultations, with different stakeholders, planned by PRD/DoHS. The overall objectives of the technical consultations are to:

- Engage with various stakeholders in technical discussions to build consensus around a harmonized approach to PHC-R
- Explore outputs, possible strategies, major activities and methods for implementation, including measuring progress and results

The specific objectives for the workshop were to:

- Identify what constitutes PHC-R and how do different divisions and programme relate to this
- Explore elements needed to progress towards successful PHC-R – specifically identify structure, system and institutions
- Explore ways to measure PHC-R – what indicators are practical and valid to use?
- Identify potential areas for capacity development and leadership development for PHC-R

Expected Outputs

Remaining within the periphery of the specific objectives, the one and half day workshop expected the following outputs:

- Partners and Stakeholders *(Who will deliver?)*
- Interventions (*What will be delivered?)*
- Structure, Systems and Institutions *(How we will deliver?)*
- Research and Monitoring. *(How we will know if we deliver?)*

Participants

Around 30 invitees representing MoHP, DoHS, DHOs, and national and international resource persons, including Secretary of Health and Director General of DoHS, participated in the workshop. The working sessions were attended by mid-level technical managers and resource persons, under the guidance of Director, PRD.

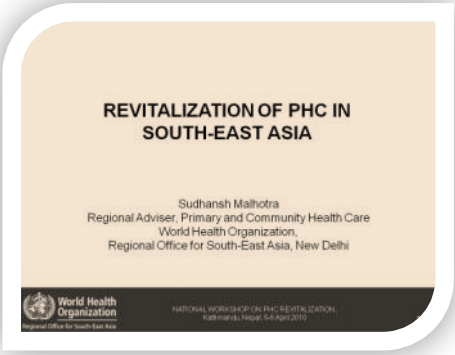
Proceeding

The morning session was chaired by Dr. Praveen Mishra, Secretary of Health. Dr. B.S. Tinkari, Director of PRD/DoHS welcomed the participants. After explaining that this workshop is the first among series of technical consultations planned with different stakeholders, he gave a brief overview of the objectives and the expected outputs.

Dr. Gunawan Setiadi of WHO, in his opening remarks, said that the workshop comes very timely as most other countries in WHO-SEARO region have also started to revisit their policies on revitalising PHC services. He said the reason most countries are looking to revitalise PHC is because it remains the most cost effective way to improve the health of the citizens. He further explained four components of PHC-R World Health Report: **Universal Coverage Reform** to reach all segments of the population, specially marginalised and disadvantaged groups; **Health Service Delivery Reform** to ensure people centric service delivery; **Public Policy Reform** to make the policies health friendly; and **Leadership Reform** to make health sector governance more effective. He then delved into the Nepal specific health challenges which warrant revitalising PHC. He talked about low utilisation of healthcare due to various barriers like financial and geographical; he pointed towards a challenge to meet the healthcare need of growing urban and peri-urban population; and providing social health protection to all segments of the population. He closed his opening deliberation by highlighting the importance of the newly formed PRD to coordinate with other DoHS divisions to ensure optimum coordination and minimize overlapping of activities.

Presentations

This section provides the synopsis of the presentations made during the session. *Slides of all three presentations are available in annex 1.*



Revitalisation of PHC in South-East Asia

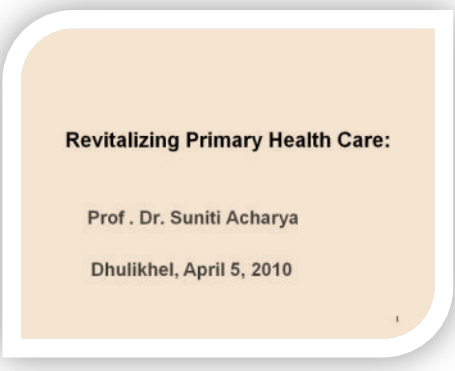
The first presentation of the day was by Mr. Sudhansh Malhotra, Regional Adviser Primary and Community Health Care of WHO-SEARO, New Delhi. His presentation focused on basic principles of PHC-R, how the concept of PHC has evolved since the Alma Ata Declaration in 1978, and some PHC initiatives taken by the SEARO countries.

After briefly going over the basics like core elements, underpinning principles, different dimensions, and misconceptions about PHC, Mr. Malhotra's presentation concentrated on the evolution of PHC. He juxtaposed the current concerns of PHC reform with the early attempts in implementing PHC to illustrate how experience over the years has shifted the focus of PHC movement.

Early Attempts at Implementing PHC	Current Concerns Of PHC Reforms
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels.
PHC is cheap and requires only a modest investment.	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives.

Dwelling on a question whether people believe PHC has worked since its implementation 30 years ago, he said there is no unequivocal answer either way and the matter is still open for discussion. However, he pointed out few positive benefits brought about by PHC. He highlighted some positive changes like increased life expectancy, reduction in child and infant mortality, increased coverage for endemic diseases, increased recognition of health as a human right, etc. that could be attributed to the 30 years of implementing PHC. Next, he talked about some growing areas of concern that the PHC has to address; inequitable access to healthcare services, attaining universal coverage, and rapid privatization of healthcare were some areas he felt PHC approach is yet to tackle.

After briefly going through the four areas of PHC reforms, in the last part of his presentation, Mr. Malhotra brought to light few selected innovations on PHC from the rest of SEARO countries. Some of these were: community empowerment through micro-credit in Bangladesh; National Rural Health Mission of India; Community Health Security (*Jamkesmas*) programme of Indonesia; and equitable health financing from Thailand.



Revitalising Primary Health Care in Nepalese Context

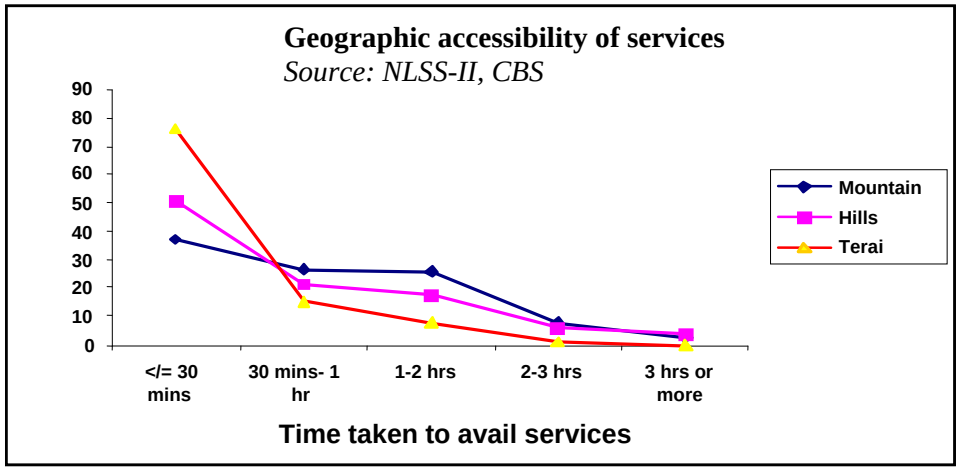
Professor of Community Health and Family Medicine at Institute of Medicine, Dr. Suniti Acharya, was the second presenter of the session. After briefly reiterating the principles and basic of PHC, Dr. Suniti talked about how PHC was open to multiple interpretations leading to most actors focusing on quick solutions and not giving due and holistic attention to the eight core elements of PHC. She exemplified

the point by highlight a Nepal's case where the donors initially focussed on child survival as a quick solution, leaving the essential elements of developing a sustainable system and fostering inter-sectoral collaboration aside. Capitalising on the point earlier made by Mr. Malhotra on PHC being perceived as an antithesis of the hospital, Dr. Acharya gave a corresponding example from Nepal saying that curative services at the hospitals were neglected compared to the preventive services that were expanded to the grassroots under PHC approach leading to, among other things, poor maternal mortality compared to what is achieved in infant mortality.

Focusing on Nepal's experience with PHC, Dr. Acharya highlighted few areas such as human resource training, expansion of service delivery infrastructure, improving maternal child indicators, and community empowerment (FCHV, management committees) where Nepal has made progress. Conversely, deployment and retention of human resources, quality of service delivery infrastructure, inter-sectoral mechanisms, continuum of care, and access/equity issues were some she thought were areas where Nepal still needed to make inroads and improve. The two cumulative future implications she drew from Nepal's history of implementing PHC were:

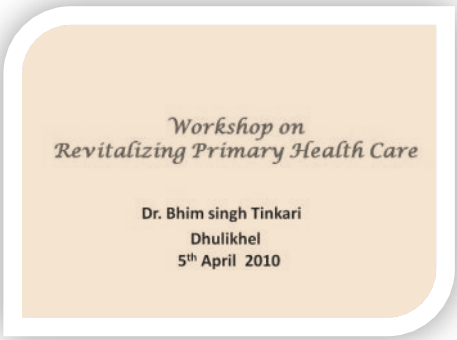
- After reaching certain level of reduction of morbidity and mortality ,further reduction is not possible unless preventive health programmes are backed by quality curative care
- Compelling need to improve preventive, promotive and curative services at least up to the district hospitals

Next, she talked about topographical variance (mountain, hill, and Terai) in accessing health care services. She further highlighted this variance by bringing in the dimension of poverty to highlight the fact that poor people have the minimal access to services across all topographical regions. She also talked about delivery conducted by SBA vis-á-vis the wealth quintiles clearly showing that poor people have lesser deliveries conducted through SBA. Such inequity, she thought, needed to be monitored by the newly formed PRD.



Dr. Acharya's last part of the presentation focused on how the next five year (2010-2015) health sector strategic plan of Nepal, the Nepal Health Sector Programme (NHSP II), has catered to the revitalisation of PHC. She briefly went over the recommended programmes and output indicators produced by the NHSP II thematic group setup to draft a chapter on PHC-R and how the 3rd draft of the NHSP II has incorporated PHC-R agenda in its vision, mission, strategic directions, and results

framework. She concluded her presentation by providing some discussion points on how MoHP can implement PHC-R agenda within the framework of NHSP II.



Revitalising PHC in Nepal – Current Status, Outlook and Next Steps

In the first part of his presentation Dr. B.S. Tinkari, Director PRD/DoHS, discussed the current national environment upon which PHC-R has been conceptualised. Highlighting the current scenario Dr. Tinkari reflected upon the fact that health status of Nepalese citizens has improved over the years, albeit inequitably. Disparities in health status continue across wealth quintile, region, caste, ethnicity, and urban settings. He talked about new emerging challenges for health and health systems. Scaling up of HIV, TB, Malaria and immunization; urban health issues, mental health, disabilities, chronic diseases; stagnating outpatient contacts, etc. were some core challenges he highlighted. He pointed at the inverse phenomenon of growing dissatisfaction but rising expectations regarding health care services among the citizens. Elaborating on the expectations of the citizens, he said, everyone expects for themselves and their families access to quality health care services and communities where health is protected and promoted. Similarly, everyone expects for their society an equitable health care and health authorities that are accountable and can be relied upon. Dr. Tinkari surmised that the growing mismatch between expectations of the citizens and actual performance of the health systems is leading to a crisis in confidence. After briefly walking the audience through the progress on health sector MDGs, he gave a brief overview on the milestones in PHC in Nepal for the last three decades.

Next, he shared the rationale behind revitalising PHC in Nepal:

- To provide free basic health service to all citizens as stated in the *law*
- To ensure easy access of health services
- To provide quality health services
- To provide health services to urban poor, *vulnerable and marginalized*, and for people with disability
- To achieve the Health sector MDGs by making the delivery of free health care services effective
- To develop future program and strategies commensurate with regular monitoring and evaluation of free health care services
- To implement health insurance
- To implement program ensuring citizens right to clean environment
- To mobilize community participation for cooperation at local level

He also shared the three components of the newly formed PRD/DoHS:

1. Free Healthcare Service
2. Social Health Protection and Insurance
3. Urban Health

He concluded his presentation highlighting the need for the PRD/DoHS to work in harmony with the other actors by fostering collaboration with the other divisions and promoting inter-sectoral linkages.

Remarks from the Health Secretary

Dr. Praveen Mishra, Secretary of Health, thanked all the presenters and the participants.

He said to break the vicious cycle of poverty and health, nutrition and sanitation require special focus in strong collaboration with other Ministries and sectors. There are many issues, such as sanitation, that are outside the purview of MoHP despite their intrinsic linkages with health. Half of Nepal's population is forced for open defecation and this is a worrying factor. Issues like these which cut across different sectors need strong collaboration to tackle

He further said that as disease paradigm is shifting from communicable to non-communicable; a holistic approach, beyond curative services, which takes into account diet, exercise, and behavioural changes, is required. Similarly, health challenges brought upon by urban migration also needs to be addressed. Specific focus on urban health, in issues such as immunization, sanitation, and occupational hazards, must be granted because of rising urban population

He said indicators for the good perception of health services at the grassroots level needs to be developed. This would be an important yardstick to judge our performance. The society has demanded that PHC be revitalised and we need to consider it and develop adequate mechanisms and tools to operationalise it. He said we need to consider cost effectiveness and also the effectiveness of service. Ultimately our duty, he said, is to translate the constitutional provision of health as a fundamental right into reality.

He said there is a need to monitor policies, planning, implementation, and results simultaneously therefore, M&E systems should not only focus on the results but also encompass these other aspects.

Talking about capacity development, he said, there is a need to develop the capacity of existing structures like FCHV to ensure they are able to tackle the changing disease patterns and new emerging challenges.

Retention of human resource at the grassroots is another major challenge, he said, that needs to be tackled. Because of poor or complete lack of infrastructure for the health workers to reside in the premises of health facilities is further hampering the retention of health workers.

He said many Medical schools of the country are not given any significant role in revitalisation of PHC. There is a need to somehow induct them in PHC and identify specific roles these institutions can play.

He concluded his remarks by stressing that unless the country has good PHC, national productivity will not improve and national investments in health may go in vain.

Next Steps

Following the workshop, interaction with district health authorities and stakeholders is planned to grasp district level perspectives and further refine the workshop outputs. Visits to six districts of mountain, hills, and Terai regions are planned. Subsequently thereafter, a separate workshop with development partners is also planned.

Group Work

A group work commenced after the presentation session. Participants were divided into five groups according to the thematic components of PRD:

Group 1: Extending PHC Services

Group 2: Municipal Health Services

Group 3: Environmental Health

Group 4: Disability and Community Rehabilitation

Group 5: Social Health Protection

Each group was given the following set of guiding questions:

- *Partners and Stakeholders (Who will deliver?)*
- *Interventions (What will be delivered?)*
- *Structure, Systems and Institutions (How we will deliver?)*
- *Research, Monitoring, and Evaluation (How we will know if we deliver?)*

The following day (April 06) each group presented their outputs in a plenary where the outputs were further refined through a joint discussion. The following section details the final output of each group after incorporating relevant comments and suggestions from the plenary.

Group Work 1: Social Health Protection

Social Health Protection

Group Members: Mr. Madan Shrestha, Ms. Prabha Baral, Mr. Ghana Shyam Gautam, Dr. Gunawan Setiadi

Objective

- Ensure equitable access to health care services including the protection against catastrophic expenditure

Partners and Stakeholders

- MOHP- Policy formulation
- Revitalization Division- for program Implementation
- In coordination with stakeholders
  - Different Division of DOHS
  - WHO, GTZ, World Bank, ILO, UNICEF, etc
  - NPC, Line Ministries, Private (for profit/not for profit) Agencies, Local Government,
  - Independent Agency (third party administration if required)
  - Private/Public Health Facilities

Interventions

Major Programs we already have

-Free Health Care Policy

-Aama Surachya

-Community Health Insurance

-Uterine Prolapse Camp

-Social Inclusion(Dalit, Elder,Urban Poor,Disabled)

-Special Program for <15year,>75Year(support for Cancer, Kidney,Heart)

-TB, Kala azar

Group Work: Social Health Protection

What will be delivered

- Take initiation for integration of existing programs on social health protection (identify new intervention for Senior citizen, disabled etc)
- Implement programs/activities for Social Health Protection according to the policy to be drafted by MoHP
- Capacity development of health workers with regards to SHP
- Coordination with line ministries/divisions /National level committees and other stakeholder
- Monitoring/Evaluation of SHP programs
- Revise the list of drugs under free health care policy (Coordination with DDA for all drug related issues)
- Ensure continuous availability of listed drugs in each level of health facilities
- Ensure Rational use of drugs and linking the listed drugs with the relevant disease based on ICD code
- Collect prices of the drugs from GMP certified manufacturers and standardize for its use all over the nation

Structure, System and Institutions

- Using the existing government channel for implementation of programs/activities
- Contracting out could be the option for carrying out some specific activities/tasks
- Coordination with Poverty Alleviation Fund (Identification Card)
- e.g. Monitoring of Free Health Care Services program

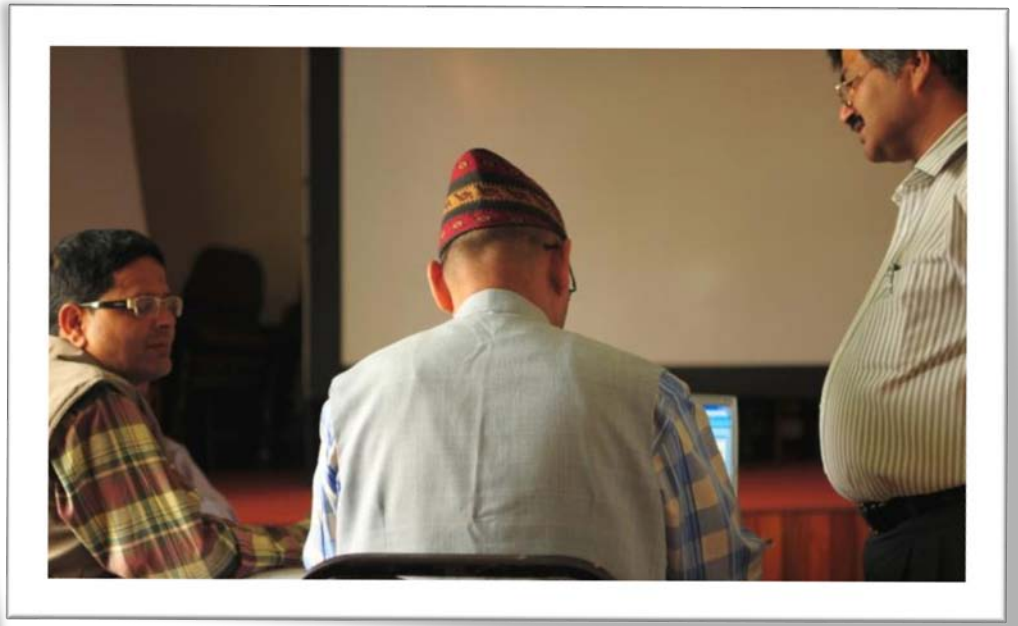
Research, Monitoring and Evaluation

- Compilation of the existing relevant study findings
- Review and assessment of existing programs on SHP in coordination of MoHP
- Impact assessment of benefit of the targeted and non-targeted schemes
- Monitoring progress from time to time
- More study on categorizing VDCs to identify target groups and services
- Operational research for appropriate model on community health insurance

Costs and Resources

- Exploring the disease pattern in the communities and giving emphasis for allocation of resources based on needs
- Alternative financing Schemes (e.g. health insurance, user fee, tax financing, donor funding etc)
- Annual budgeting on the basis of unit cost analysis

Group Work 2: Environmental Health



Environmental Health

Group Members: Dr. L.N. Thakur, Mr. Chudamani Bhandari, Mr. Ghana Shyam Pokhrel, Mr. Dol Raj Sharma

Objective

General:

To promote the health of the people through healthy & supportive environment

Specific:

- To create healthy environment at
  - individual/family
  - Community (Rural/Urban)
  - Institutional for provision of quality health services.
- To develop national environmental health Policy & strategy

Partners & stakeholders

- Ministry of Environment, Science and Technology
- Ministry of Local Development
  - Municipalities, VDCs
- Ministry of Physical Planning & Works
  - Nepal Water Supply Corporation
- Ministry of Health and Population
- Different actors involved in Environmental Health (I/NGOs, CBOs & EDPs)
- Partners working in issues of climate change
- Ministry of Forests and Soil Conservation
- Other concerned line agencies

Interventions

- Formulation of Environment Health Policy
- Prepare strategy at different sector
- Prepare joint Implementation plan

Group Work: Environmental Health

Activities

Health care Waste management

- Orientation/capacity building
- Supplies (Disinfectant, Utility gloves, Safety box, Bucket, Autoclaves)
- Construction pit (local made),incinerator(Environment friendly - replace old ones), recycling

Water & Sanitation

- Supply of safe drinking water
- Construction of toilets
- Awareness campaign

Environment friendly physical facility management (House, dust, smoke, air, sound, land)

Research

- Implement EIA/Operation research

(Environmental Induced disaster/Vector shifting hill, mountain ????)

Intervention

Area of intervention	Individual /Family	Community	Institution
Health care Waste management •Orientation/capacity building •Supplies •Construction pit, incinerator			★
Water & Sanitation •Supply of safe drinking water •Construction of toilets •Awareness campaign/Capacity building •Solid waste management	★	★	★
Environment friendly physical facility management (House, Dust,smoke,Air,Sound,Land) Food safety, Pesticide	★	★	★
•Research: Implement EIA			★

Structure/System/Institutions

Institutions	Health care waste mgmt	Water supply & sanitation	Mgmt of Environment friendly physical facilities	WQA (water quality assurance)center (PPP)
MoHP PRD	★	★	★	
DHO/DPHO	★	★	★	★
Municipality	★	★	★	★
HF/VDCs	★	★	★	
DWS		★		
Department of Physical Planning &Works			★	

Research

- Environmental Impact Assessment
- Climate Change & Health
- Resource & Actor Mapping
- Operational Research at Local Level (District)

Group Work: Environmental Health

Monitoring

- Define role and responsibilities of diff. sector
- Prepare integrated monitoring plan
- Integrate in HMIS

Evaluation

- Identify input, process ,output ,outcome level indicators
- Periodic Evaluation System to be established
- Social Audit
- Prepare Joint Strategy and Implementation Plan

Group Work 3: Municipal Health

Municipal Health Services

Group Members: Mr. Achyut Lamichanne, Mr. Bhanu Yengden, Ms. Mangala Manandhar, Mr. Mahendra Shrestha, Mr. Rakesh Thakur

Objectives (what we want to achieve?)

General:

- To meet the national and international health related goals (including MDGs, 2nd long term health plan, three year interim plan) in municipalities.

Objectives

Specific:

- Improve access of PHC for universal coverage
- Decrease inequities in health service
- Address with new challenges and expectation
- Insure quality health services.

Partners and stakeholders (Who will deliver?)

Primary responsibility:

- MoHP/ DHO/Municipality

Coordination (Compliance, Collaboration, Contribution) & PPP Model

- MoLD/ DDC/ Tole sudhar samiti
- UN agencies, Donors, Bilateral and multilateral donors at central as well as local level
- Education Office
- Women Development office
- Water and sanitation office
- Nepal Red Cross/ NFPA/Medical college Nursing school/ Paramedical training school
- NGOs/ INGOs
- Private medical college, Nursing homes, Pharmacies

Group work: Municipal Health

Interventions (What will be delivered?)

- Basic essential health services as currently provided by MoHP
- Care of the trauma and accident prevention activities (awareness)
- Health facilities Waste management (?)
- Public awareness activities on NCD (Like Diet, exercise, Yoga and BCC)
- Integration Mental health On PHC program.
- Intervention based on local needs and resources available(e.g. Services for HIV /AIDS, STI, Disabled, helpless people)

Structure, system and institution (how we will deliver)

- Community/ Tole level (based on population) health volunteer (Urban FCHV)
- At ward level-urban health clinics (HSP, HP/ PHC level depending upon the local capacity and needs)
- Public Health Department/ Division/ unit/ section at municipality (Focal persons should be identified- Municipality Health Officer)
- District Public Health Office
- RHD
- PRD

System

- Policy formulation and coordination at central level (MoHP, MoLD, MoF)
- Development implementation mechanism and coordination PRD, RHD, DDC, DHO
- Functional horizontal coordination between DHO, DDC, and Municipality
- Service delivery by health clinics and outreach clinics (fixed sites)
- Physical infrastructure by Municipality

System

- Health service delivery logistics and technical support by DHO
- Formation of management committee from municipality to community level,
- Health promotional activities by volunteers at community level
- Ward management committee is responsible to select the Urban Health Volunteers,
- Recognition of Urban Health Volunteers by MoHP (as VDC).

Group work: Municipal Health

Research, Monitoring and Evaluation (How we will know if we deliver?)

- Periodic research by PRD (Focal point)
- Regular Supervision, monitoring and evaluation by Municipality, DDC, D(P)HO, Management committee and PRD.
- Periodic Review and Planning jointly by DHO and Municipality.
- Periodic review with service provider and management committee.
- Social audit annually

Cost and resources (How to pay for and provide?)

- Health workers expenditure by MoLD
- Review meetings cost and research cost by MoHP
- Supervision, monitoring and evaluation cost by DDC, Municipality and MoHP
- Physical facilities, Furniture's and Utility cost by Municipality
- Health commodities by MoHP/ MoLD
- Capacity building of the health workers by MoHP
- Urban Health Volunteer support will be provided from MOHP and local government (similar to VDC FCHVs)

Group Work 4: Disability and Community Rehabilitation

Disability & Community Rehabilitation

Group Members: Mr. Bhogendra Dotel, Ms. Savitri Gurung, Mr. Ramji Ghimire, Mr. Narahari Sharma

Outline

- Overview on disability in Nepal
- Existing Policies and guideline
- Services for people with disability as EHCS

Situation of disability in Nepal

Estimates of Disabled Persons By Age New ERA/UNICEF Situation Analysis			
Age Group	**Total Population**	**Persons with Disabilities**	**Prevalence Rate**
0 - 4	10,772	97	0.90
5 - 9	10,908	103	0.94
10 - 14	9,644	117	1.21
15 - 19	8,251	111	1.35
20 - 59	31,673	687	2.17
60 - 70	4,745	125	2.63
Total	75,993	1,240	1.63

Source: *A Situation Analysis of Disability in Nepal, 2001*

Contd....

- Another estimate – about 5% of the total child population is with one or more than one kind of disabilities.

Group Work: Disability and Community Rehabilitation

Acts, Policies…

- Civil Code 2020
- Contract Act 2023
- Education Act 2028
- Disabled Protection and Welfare Act 2039
- Labour Act 2048
- Social Welfare Act 2049
- Disabled Service National Policy 2053
- Special Education Policy 2053
- Tenth Economic Plan (2059-2064)
- National Policy and Plan of Action on Disability (2063)
- Policy on prevention of Childhood Disability-2065

Services that improve functional independence and quality of life

- Interventions
  - Prevention of disabilities,(IEC,BCC)
  - Rehabilitation measures- early detection, and intervention, counseling and medical interventions, provision of assistive devices
  - Referral
  - Review and adapt CBR package/ interventions
- Specify Disease/ conditions, specify disability e.g. Congenital disorders, MVA, Falls/Injuries, life-related conditions e.g. stroke, learning disability, alcoholism

Structure, Systems and Institutions (How we will deliver?)

- Interventions need to targeted at 3 levels
  - Family/community
  - Health facility and
  - Tertiary care
- Strengthen existing networks
  - District Disability Committee/ Village disability rehab committee
  - Mobilize resources allocated under free health care services for referral-conditions – services that improve quality of life- social health protection measures
- Capacity development
  - Health worker force on early detection and rehab measures
  - Coordinate with medical schools to introduce training modules on prevention, detection and rehab measures

Structure, Systems and Institutions (How we will deliver?)

Structure: MOHP (SHP to District hospital)

- FCHV: advocacy, provide support to client and family members, coordinate to provide supportive/adaptive devices, environmental modifications
- SHP and HP: Conduct BCC on early childhood development, prevention on life style related conditions, Identify and refer to appropriate institutions.
- PHCC: Identify conditions, provide available services (e.g. fracture reduction, contracture correction, prevent shoulder subluxation)
- District Hospital: As PHCC and introduce Physiotherapy services, contracture correction,

Group Work: Disability and Community Rehabilitation

Structure, Systems and Institutions (How we will deliver?)

- **Financing**
  - PPM
  - Collaborate with agencies providing services such as WDO, DDC, I/NGO
  - Coordinate with existing programs / division, NHEICC, Child Health Division
- **Research, and Monitoring**
  - Develop coherent/ conceptual clarity on definition of disability
  - Identify possible correlation between environmental factors and disability e.g.
  - Utilization of disability related services by people with disability

Partners and Stakeholders

- Social Welfare Council
- MOHP
- WDO, DDC, Municipalities, VDC, DHO, DHOs and its tiers, tertiary care, Police and Army
- Supporting agencies- JICA, Handicap International, National CBR Resource Centre, NRCS, CBR, EU/French embassy, Hospital and Rehabilitation Centre for Disabled Children (HRDC), Khagendra NavJeevan
- Disabled People Organization (National Disabled Fund)

Recommendations

- Take responsibility for oversight and coordination of disability related functions of various divisions.
- Develop referral mechanisms/modality

Issues that need immediate attention

- Focus more on prevention
- Disability- categories, ranking
- Society –rehabilitation, encourage independence, social esteem/ stigma
- Services- preventive, corrective, referral/connectors??
- Human resources- upgrading? Capacity building

Group Work 5: Extending PHC Services

Extending PHC Services

Group Members: Mr. Parashuram Shrestha, Mr. Pawan Ghimire, Dr. Sudhanshu Malhotra, Dr. B.K. Subedi

Basis of the group work

- Universal coverage reforms
  - Increasing the range of services in essential health care package
  - Cover disadvantaged population groups
- Service Delivery Reforms
  - People centered care
  - Comprehensive
- Public Policy Reforms
  - Promote continuum of preventive, promotive, curative and rehabilitative care
- Leadership Reforms
  - Inclusive
  - Working with diverse stakeholders

Core Questions

- Objectives (What we want to achieve?)
  - We want to expand the package of services
- Partnership and Stakeholders
  - Many !!!
    - Other divisions of DOHS
    - Other ministries (MOH, MOE, MOLD, MoLTM)
    - WHO and other EDPs
    - Civil Society organizations

Service Points (units)

- Health posts
- PHC Centers
- Hospital (District and below)

Interventions (What will be delivered?)

1. **Curative services**
2. **Reproductive Health**
3. **Child Health**
4. **Communicable Disease**
   1. Japanese Encephalitis
   2. Rubella
5. **Eye Services**
   1. Vision check
   2. Cataract screening
   3. Trachoma

Interventions (What will be delivered?)

6. **Hygiene and sanitation at health facility**
   1. Provision of soap and water
   2. Toilet facility
7. **Mental health services**
   1. Epilepsy
   2. Psychosis
   3. Depression

Interventions (What will be delivered?)

8. **ENT Services**
   1. Pus discharge
   2. Deafness (???)
9. **Oral Health Services**
   1. scaling
   2. Dental filling
   3. Referral

Interventions (What will be delivered?)

10. **School hygiene and sanitation**
    1. Support schools for hygiene and sanitation
    2. Collaboration for water and sanitation
11. **Trauma and injury**
    1. Prevention
    2. First aid
    3. Ambulance services
    4. Referral (Tele medicine)

Interventions (What will be delivered?)

12. Emergency preparedness and management
1. Awareness creation
2. Services for mass casualties (Package)

13. Community based rehabilitation

14. School health program
1. Vision Check
2. ENT checkup
3. Oral health services
4. Non communicable diseases
5. Communicable diseases
6. Drug Abuse

Interventions (What will be delivered?)

15. Non communicable diseases
1. High BP
2. Diabetes
3. Malignancies

16. Services for senior citizens

17. **Telemedicine**

18. **HIV/STI**

Structures, Systems and Institutions

- Service delivering units:
  - Hospital (district and below)
  - PHC
  - HP
- Monitoring/ Reporting
  - D(P)HO
  - RHD
  - Revitalization Division/HMIS
- Collaboration
  - Other divisions of DOHS
  - Other ministries (MOH, MOE, MOLD, MoLTM)
  - WHO and other EDPs
  - Civil Society organizations

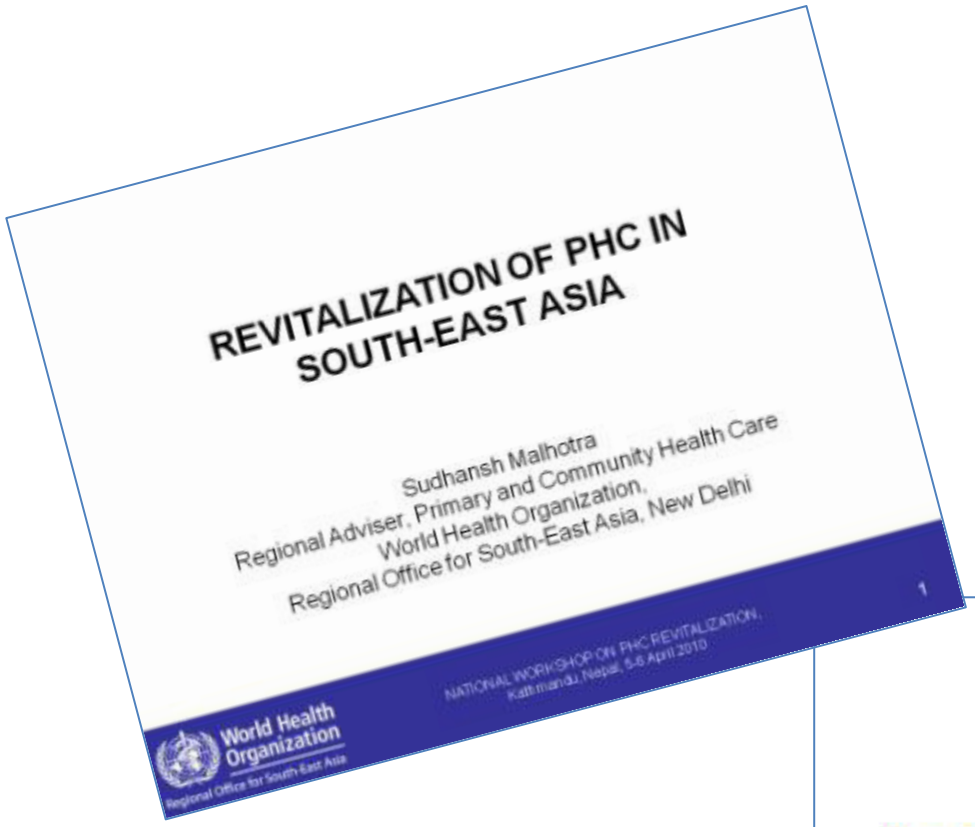
Group Work: Extending PHC Services / Part -2

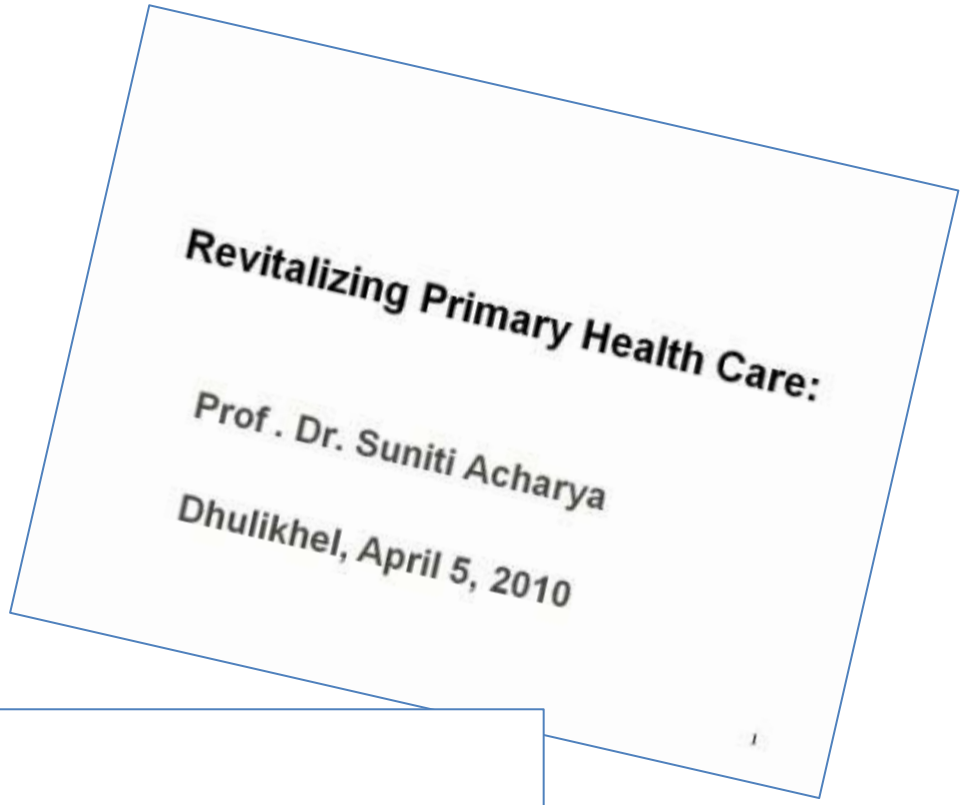
Health Interventions	New Services to be added	Responsible	Requirements	Reporting & Monitoring	Stakeholders
1. Communicable Diseases	1. Japanese Encephalitis 2. Rubella	CHD/RD/EDCD/ NHTC/NHEICC	1. Training 2. IEC Materials	1. HMIS 2. RD	WHO/USAID
2. Eye Services	1. Vision check 2. Cataract 3. Trachoma	RD/NHEICC	1. Snellen's chart 2. Screening and referral 3. Treatment for trachoma 4. IEC for prevention	RD	Nepal Netrajyoti Sangh/ WHO(Vision 2020)
3. ENT Services	1. Pus discharge (SOM) 2. Deafness (?)	RD/MD/NHEICC	1. Anti biotic treatment(local) 2. IEC for prevention	??	Bir Hospital/WHO
4. Oral Health Services	1. Scaling 2. Dental Filling 3. Referral	RD/MD	1. Equipment 2. Treatment	HMIS to be developed	WHO/Hospitals (Public/private Medical colleges)
5. Hygiene and Sanitation in Health Facilities	1. Provision of soap and water 2. Toilet Facility	RD/NHEICC	1. Arrangement for Safe Water 2. Construction of toilets 3. IEC Materials	RD	WHO/UNICEF/WaterAid
6. Mental Health Services	1. Epilepsy 2. Psychosis 3. Depression	RD/NHTC	1. Training 2. Community Support 3. Counselling 4. Referral	HMIS to be developed	WHO/Mental Hospitals/ CMC
7. Emergency/Disaster preparedness and management	1. Awareness creation 2. Services for mass casualties (package)	RD/ EDCD/NHEICC	1. IEC Materials 2. Training 3. Drugs and equipment	RD/NHEICC	WHO
8. School Health Programme	1. Vision check 2. ENT services 3. Oral health services 4. Non-communicable diseases 5. Communicable diseases/vector borne	RD/NHEICC	1. Snellen's chart 2. ENT set 3. Dental diagnostic set 4. IEC Materials	RD/HMIS	WHO/UNICEF/ Hospitals/ NGO

Group Work: Extending PHC Services / Part -2

	diseases 6. Nutrition 7. Drugs abuse				
9. School hygiene and sanitation	1. Support schools for hygiene and sanitation	RD/NHEICC	1. IEC Materials 2. Collaboration for water and sanitation	NHEICC/RD	WHO/UNICEF/WaterAid
10. Trauma and injury	1. Prevention 2. First aid 3. Ambulance services 4. Referral	RD/NHEICC MOH, MoLTM	1. IEC Materials 2. Drugs 3. Splints and supportive tools 4. Ambulance services 5. Communication equipment	RD/HMIS	WHO/Other EDPs/MOH/MoLD/MoLTM/ INGOs
11. Non-communicable diseases	1. Hypertension 2. Diabetes 3. Malignancies	RD/NHEICC/NHTC/ Curative Division(MOHP)	1. IEC Materials 2. Training to health workers 3. Counselling	NHEICC/RD/HMIS	WHO/Other EDPs/Hospitals (Public and private and Medical college INGOs
12. Services for senior citizens	1. Day care centre 2. General check-up services 3. Specific services at hospitals 4. Referral 5. Meditation (Yoga) 6. Physiotherapy	RD/Curative Division/NHEICC	1. Equipment 2. Training 3. Protocols 4. Supplies	HMIS/RD	MOWCSW/ INGOs/ WHO/ EDPs, Yoga Centres

Annex 1: Presentations





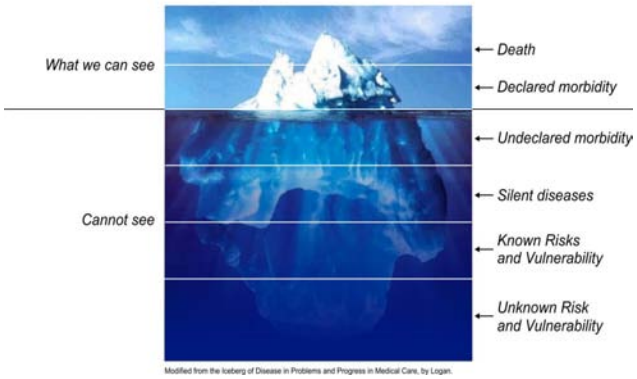
REVITALIZATION OF PHC IN SOUTH-EAST ASIA

Sudhansh Malhotra
Regional Adviser, Primary and Community Health Care
World Health Organization,
Regional Office for South-East Asia, New Delhi

Primary Health Care

"Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-determination"

Iceberg of Health Problems



Modified from the Iceberg of Disease in Problems and Progress in Medical Care, by Logan.

Elements of PHC

- Education about prevailing health problems and methods of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- Adequate supply of safe water and basic sanitation.
- MCH including family planning.
- Immunization.
- Prevention and control of endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.

The underpinning principles of PHC

- Equity.
- Universal coverage.
- Inter-sectoral collaboration.
- Community participation.

The various dimensions of PHC

a) A package of services.
b) Level of care.
c) A “concept” or “approach”.

Misperceptions about PHC

- PHC is only for the poor.
- PHC is for developing countries.
- PHC is inexpensive and low quality care.
- PHC is for rural populations.
- PHC is care at first point of contact.

The evolution of PHC

How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a **basic package** of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for **universal access** and **social health protection**
Concentration on **mother and child** health	Dealing with the **health of everyone** in the community
Focus on a small number of **selected diseases**, primarily infectious and acute	A comprehensive response to people’s expectations and needs, spanning the **range of risks and illnesses**
Improvement of **hygiene, water, sanitation** and **health education** at village level	Promotion of **healthier lifestyles** and **mitigation** of the health effects of social and environmental hazards
Simple technology for **volunteer**, non-professional **community health workers**	**Teams of health workers** facilitating access to and appropriate use of technology and medicines

The evolution of PHC (contd…)

How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Participation as the mobilization of local resources and health-centre management through **local health committees**	Institutionalized participation of **civil society in policy dialogue** and **accountability** mechanisms
Government-funded and delivered services with a **centralized top-down management**	**Pluralistic health systems** operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the **antithesis of the hospital**	**Primary care as coordinator** of a comprehensive response at all levels.
PHC is cheap and requires **only a modest investment.**	**PHC is not cheap**: it requires considerable investment, but it provides better value for money than its alternatives.

So, has PHC worked?

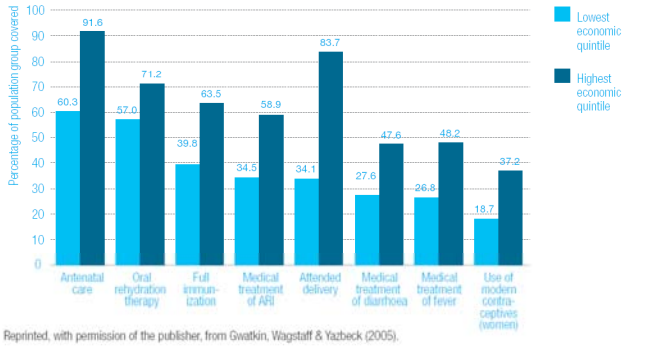
- Increasing life expectancy.
- Spectacular reduction in infant and child mortality.
- Improving access to safe drinking water and sanitation.
- Improving immunization coverage and ante-natal care.
- Increasing coverage for endemic diseases.
- Increasing number of countries have essential drugs list.
- Right to health recognized by most as a national duty.

Areas of concern

- Growing inequities in health status and access to health services.
- Modest progress towards universal coverage in the 1980s and 1990s undermined by efforts at cost-containment and reducing role of the State.
- Health services getting more oriented towards specialized curative care.
- Verticalization of health programmes.
- Health sector getting increasingly privatised.

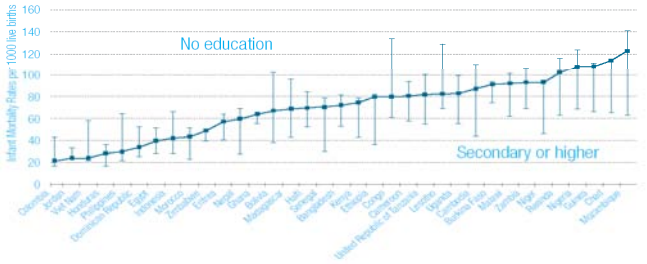
Inequity in Access

Use of basic maternal and child health services by lowest and highest economic quintiles, 50+ countries.



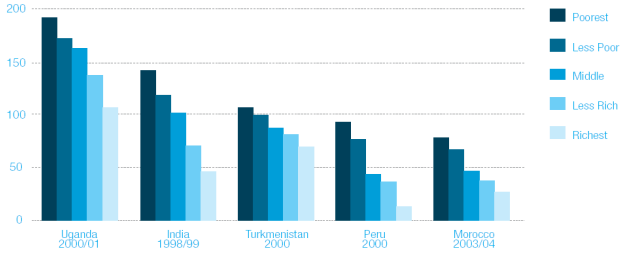
Reprinted, with permission of the publisher, from Gwatkin, Wagstaff & Yazbeck (2005).

Inequity in infant mortality rates between countries and within countries by mother's education



Data from the Demographic and Health Surveys (DHS, nd) derived from STATcompiler. The continuous dark line represents average infant mortality rates for countries; the end-points of the bars indicate the infant mortality rates for mothers with no education and for mothers with secondary or higher education.

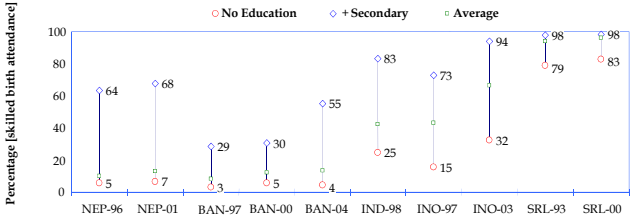
Under-5 mortality rate per 1000 live births by level of household wealth



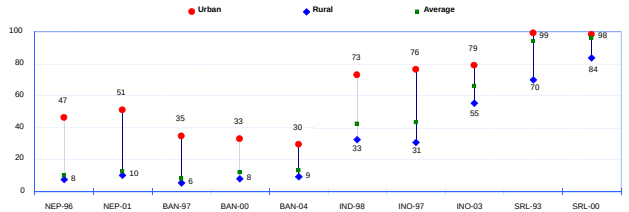
Source: Gwatkin et al. (2007), using DHS data.

The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romeri, Baker & Griffiths, 2006). The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.

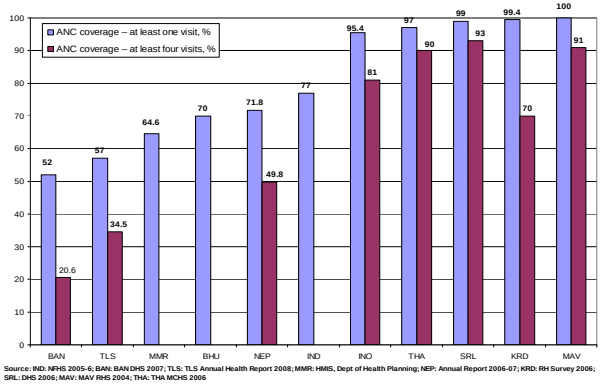
Inequities in skilled birth attendance by mother's education by country



Inequities in skilled birth attendance by urban/rural residence by country



Antenatal care coverage, SEAR, 2004-2008



Source: IND: NFHS 2005-6; BAN: BAN DHS 2007; TLS: TLS Annual Health Report 2008; MMR: HMIS, Dept of Health Planning; NEP: Annual Report 2006-07; KRD: RH Survey 2006; SRL: DHS 2006; MAV: MAV RHS 2004; THA: THA MCHS 2006

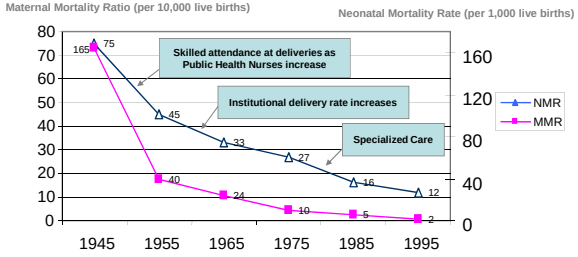
Unmet need for family planning, SEAR

Countries	Unmet need for family planning
Bangladesh, 2003	15.3
Bhutan	n/a
DPR Korea, 2003	16.7
India, 2003	15.8
Indonesia, 2003	8.6
Maldives, 2003	34
Myanmar, 1997	20
Nepal	28
Sri Lanka, 2000	8
Thailand	5.9
Timor-Leste	n/a

Source: Family Planning Saves Lives! An investment in Development, WHO/SEARO, 2005

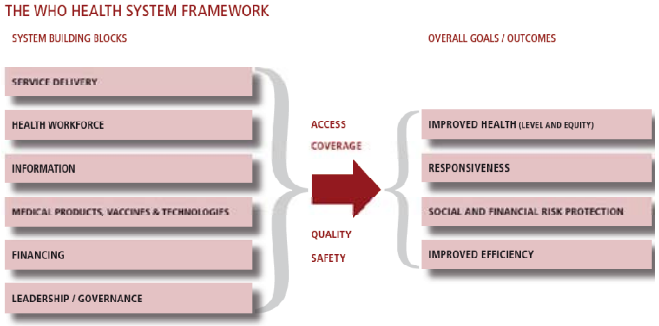
Systematic scale-up and universal coverage makes a difference

Trends in Maternal and Neonatal Mortality: Sri Lanka (1945-1995)



Source: Registrar General's Department

Health systems strengthening using PHC approach



The four PHC reforms of 2008

- Universal Coverage Reforms
  - Out of pocket expenditure
  - Increasing the range of services in the essential health package
  - Cover disadvantaged population groups
- Service Delivery Reforms
  - People centered care
  - Comprehensive
  - Integrated vertically and horizontally

The four PHC reforms of 2008 (contd…)

- Public Policy Reforms
  - Policies to support universal coverage
  - Public health policy to promote continuum of preventive, promotive, curative and rehabilitative care
  - Promote intersectoral collaboration
  - Ensure that no public policy has deliterious effect on health
- Leadership Reforms

  Pragmatic leadership in health that is:
  - Inclusive
  - Participatory
  - Negotiation based
  - Works with diverse stakeholders

Selected innovations in PHC in South-East Asia

Bangladesh

- Community empowerment through micro-credit scheme to improve community health.
- Conditional cash-transfers for improving skilled attendance at birth.
- Community Health Clinics.

Selected innovations in PHC in South-East Asia (contd…)

Bhutan

- Using Gross National Happiness and holistic development approach
  - Overall development – socio-economic, spiritual, emotional and cultural.
  - Using health information and communication to promote 8 elements of PHC.

Selected innovations in PHC in South-East Asia (contd…)

India

- National Rural Health Mission
  - Decentralized planning, management and monitoring
  - Service delivery close to people (health and nutrition days)
  - Community participation (ASHA)
  - Conditional cash transfers *(Janani Suraksha Yojna)*
  - PPP

Selected innovations in PHC in South-East Asia (contd…)

Indonesia

- Community Health Security (Jamkesmas)
- Community-based health activities
  - Posyandu
  - Polindes
- Desa Siaga (Alert Village)

Selected innovations in PHC in South-East Asia (contd…)

Maldives

- Healthy Villingli Island
  - Multi-sectoral collaboration
  - Stewardship
  - Financing
  - Human resources
  - Empowerment of other sectors
  - Community action
  - Education

Selected innovations in PHC in South-East Asia (contd…)

Thailand

- Equitable Health Financing
  - Social security scheme for formal sector
  - Civil servants medical benefit scheme
  - Universal health coverage scheme (30 Baht scheme)
- Community Participation and Empowerment
  - Strategic Route Map

Country support by WHO/SEARO – *future directions*

- Community Education and Empowerment (self-care)
- Strengthen CBHWs and CHVs
- Socio-cultural approach to health
- Decentralization
- Health of the Urban Poor
- Health financing options
- Health Policy and Health Systems Analysis
- Family Medicine

Revitalizing Primary Health Care:

Prof . Dr. Suniti Acharya

Dhulikhel, April 5, 2010

1

Definition

- "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'

2

Definition Contd…

- It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process

3

Pillars of PHC

- PHC is regarded as a cost-effective approach and its principles in social justice, equity, human rights, universal access to services, community involve and priority to the most vulnerable and underprivileged.

4

Core elements of PHC

- Universal coverage of basic services, education on methods of preventing and controlling prevailing health problems; food security and proper nutrition; adequate safe water supply and basic sanitation, maternal and child health care, including family planning; vaccination against infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries, and provision of essential drugs.

5

What happened after Alma Ata

- Primary health care has been recognized as the main principle in policies and strategies of many developing countries.
- Progress was made in taking preventive services to most of the population in developing countries IMR decreased
- Not implemented in true spirit because of several reasons.

6

Multiplicity of interpretations of PHC

1-A package of interventions (8)

(Education; Food and nutrition; Water and sanitation; MCH & family planning; Immunization; Prevention and control of local endemic disease; Treatment of common diseases and injuries; Essential drugs)

2-An approach/strategy

(Community participation, Intersectorality, Appropriate technology)

3-A level of care

Note the strenuous efforts to distinguish PHC from primary care

7

Implications of multiplicity of interpretation/

- Focus on quick solutions
- Quick results
- Very little attention to development of sustainable health system ,intersectoral actions etc

8

Major changes in the past 30 years globally

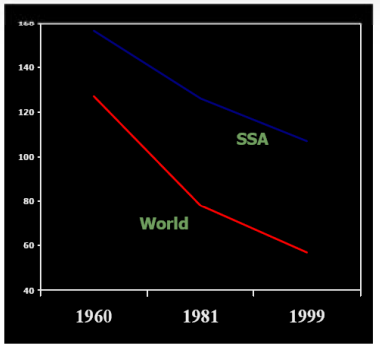
- Improvement in health status generally
- Increased recognition of and concern for health equity
- Change in the epidemiological profiles- the NCDs, **BUT**a large unfinished agenda
- The appearance of HIV/AIDS
- The growth of health pluralism
- Commitment to achieve MDGs

9

Growing inequalities in global health: the widening gap in infant mortality experience

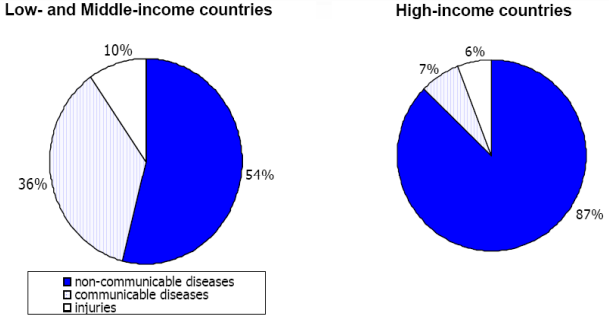
IMR decline (Percent)	1960-1981	1981-1999
World	38.5	26.9
Sub-Saharan Africa (SSA)	19.2	15.1

(UNICEF, 2003)



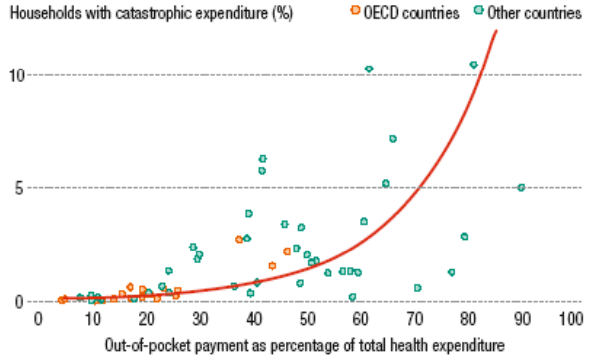
Developing countries carry a double disease burden

Percentage of deaths by cause



11

Figure 2.1 Catastrophic expenditure related to out-of-pocket payment at the point of service[1]



12

25th Anniversary of Alma Ata

- Review of progress madein 25 yrs
- Primary health care still valid
- Another conference in Almaty which decided to Revitalize PHC
- World Health report 2008 devoted to strengthening health system through revitalization of Primary health care

13

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT THIKING ON REVITALIZATION OF PHC
1) Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
2) Concentration on mother and child health	Dealing with the health of everyone in the community
3) Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses

14

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT THIKING ON REVITALIZATION OF PHC
4) Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
5) Participation as the mobilization of local resources and health-center management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
6) Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context.

15

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT THIKING ON REVITALIZATION OF PHC
7) Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
8) Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
9) PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment but it provides better value for money than its alternatives.

Challenge for the developing countries is to address the unfinished agenda of earlier concept and address the principles raised in the Revitalization of PHC

16

Why revitalization of PHC now?

- Governments and Donors committed to attain MDGs and committed to health sector reforms
- Growing realization that maternal and Neonatal mortality can not be effectively unless the health system is capable of managing complications
- Role of sustainable health system for addressing other conditions –HIV/AIDs,TB. Malaria

17

The PHC reforms necessary to refocus health systems towards health for all

Source: WHO 2008

18

What has happened in Nepal in PHC ?

- Human resource training: major progress but deployment and retention still big problem.
- Service delivery infrastructure expanded, still in adequate, quality needs to improve.
- Maternal child health indicators improving
- Efforts at Intersectoral actions/healthy public policies minimal
- Community empowerment- some progress
- Lack of concept of continuum of care in major policies
- Access Equity issues remain as major challenges. Some examples follow:

19

Nepal context: Who and what institutions provide care ?

Intervention EHCS/Beyond	Levels of service provision											
	Individual self care	FCHV other	Private Medical Shop	SHP	HP	PHC	District Hospital	Zonal Hospital	Regional Hospital	Speciality Hospital	Private Hospital	NGO's Hospital
a) Maternal Health Delivery Care	√	√		√	√	√	√	√	√	√	√	√
b) Child Health Newborn Care	√	√	√	√	√	√	√	√	√	√	√	√

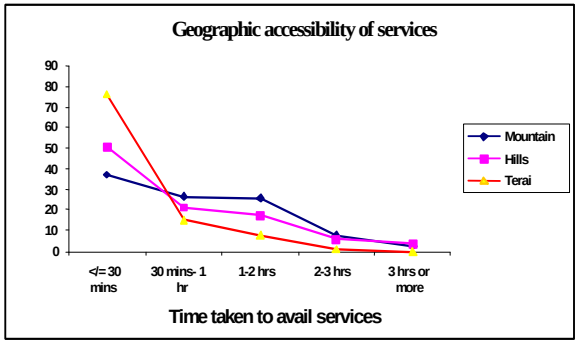
20

Implication

- Once we reach certain level of reduction of morbidity and mortality ,further reduction is not possible unless preventive health programmes are backed by quality curative care .
- Compelling need to improve preventive, promotive and curative services at least up to district hospital (included in EHCS NHSP2)

21

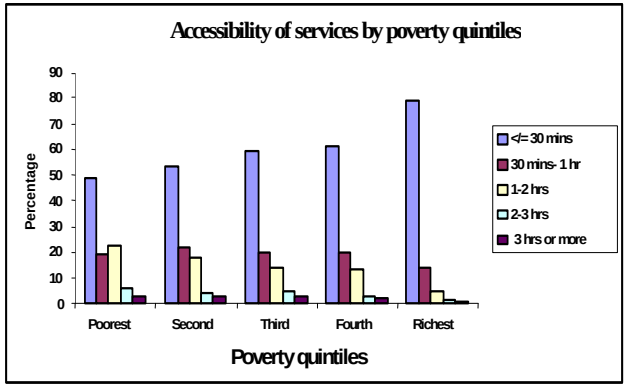
Nepal context service accessibility by eco belt



Source: *NLSS- II, CBS*

22

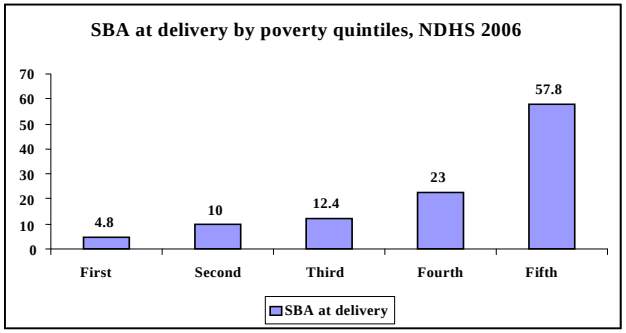
Nepal context service accessibility by the poverty quintiles



Source: *NLSS- II, CBS*

23

Nepal context status of the Skilled/trained Birth Attendants during delivery by wealth quintiles



Source: *NDHS 1996, 2001, and 2006, further analysis by CHPRD*

24

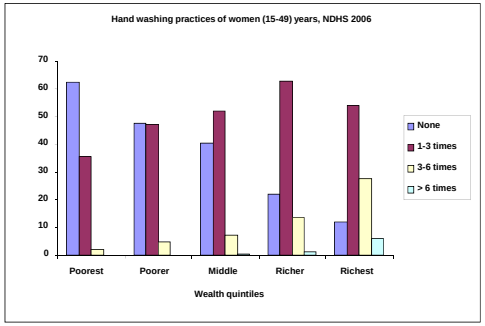
Nepal context: ***Correlation of hygiene and sanitation status with IMR***

Development Region	Population with access to water	Toilet coverage	Incidence of Diarrhea among five/1000	IMR	Use of soap	Frequency of hand washing
EDR	74.80	44.60	259	53.00	67.50	2.20
CDR	82.08	40.50	218	60.00	64.30	2.20
WDR	81.56	50.93	205	53.00	74.10	2.40
MWDR	60.20	23.40	260	99.00	55.90	1.80
FWDR	61.82	19.52	239	104.53	51.20	1.70

Source: *District health profile UNDP 2002, DHS 2006*

25

Nepal context: Hand washing status of women (15-49) years by their economic status



Source: *NDHS 2006, further analysis by CHPRD*

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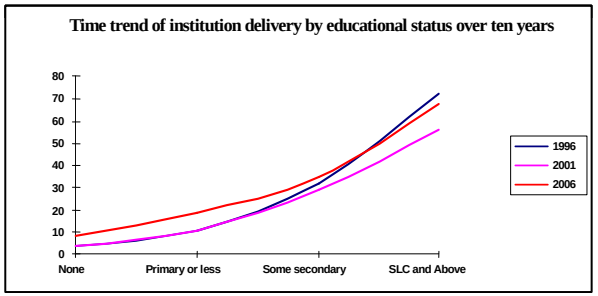
Institutional delivery by educational status



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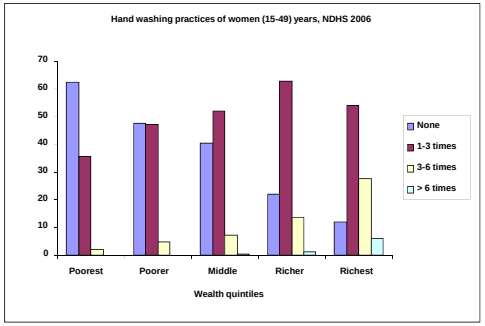
Correlation of hygiene and sanitation status with IMR

Development Region	Population with access to water	Toilet coverage	Incidence of Diarrhea among five/1000	IMR	Use of soap	Frequency of hand washing
EDR	74.80	44.60	259	53.00	67.50	2.20
CDR	82.08	40.50	218	60.00	64.30	2.20
WDR	81.56	50.93	205	53.00	74.10	2.40
MWDR	60.20	23.40	260	99.00	55.90	1.80
FWDR	61.82	19.52	239	104.53	51.20	1.70

Source: *District health profile UNDP 2002, DHS 2006*

28

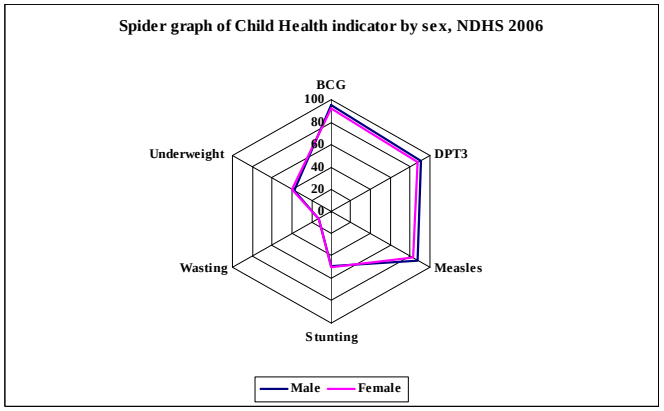
Hand washing status of women (15-49) years by their economic status



Source: *NDHS 2006, further analysis by CHPRD*

29

Gender equality in Child health indicators



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Source: *NDHS 2006, further analysis by CHPRD*

Status of access coverage and equity in Nepal

- Access only 50% of the poor have access to a health facility within half an hour of waking distance
- SBA delivery in the first wealth quintile 4.8 compared to 57.8 in the fifth quintile.
- SBA delivery in rural areas 13.5 where as in urban 47.8 only
- 40% have access to health facility within half an hour of walking distance compared to around 80% in teraii and about 55% in hills.
- Most peripheral facility is estimated to be one for 7000 population.
- Poor people seek care from HP, SHP, ORC and community health workers whereas rich people seek care from hospital.

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Status of access coverage and equity in Nepal

Ecological zone	Population per hospital bed	Developmental region	Population per hospital bed
Mountain	7623	Eastern	3045
Hill	4052	Central	1969
Kathmandu	294	Kathmandu	294
Terai	1951	Western	2021
		Mid western	**2523**
		Far western	**5236**
National		**1753**	

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Objective and strategies of Revitalization of PHC recommended by Theme group NHSP 2

Objective is to strengthen health system of Nepal and attain universal coverage of EHCS

Strategies

- Increasing access coverage and utilization of quality essential health care and reducing inequity
- Empowerment of, community leaders in planning and management at all levels
- Promoting Healthy public policy to protect health of people and the communities through intersect oral actions .
- 4 ..Human resource development reforms through involvement of academia and public health institution

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Recommended Programmes

Programs for increasing access coverage and reducing inequities

- Establishment of three thousand sub health posts in remote mountainous and hilly districts through upgrading existing PHC/ORC and EPI post and further extending access by establishing new PHC/ ORC /EPI posts by using micro planning to bring EHCS within half an hour of walking distance in the remote areas
- To address inequities existing in health policies need to be reoriented to pro equity policies, which include mechanisms for equity targeting and monitoring.
- Recruitment of health workers in the new as well as existing SHP,HP, from the community
- Strengthen quality of existing Free Health services through ensuring availability of Essential drugs and reducing stock outs which will improve the coverage
- Expansion of free health care policy upto the district hospital level
- Qualitative studies will be undertaken to understand circumstances and demand and supply side barriers for certain social and ethnic groups which prevent them from accessing the services
- Appropriate socially inclusive strategies to BCC and service provision need to be developed in consultation with those communities and implemented and monitored.
- Qualitative studies need to be undertaken to understand circumstances and demand and supply side barriers for certain social and ethnic groups which prevent them from accessing the services

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OUT PUT INDICATORs

- Number of HP/SHp established by districts
- Number of Health workers recruited locally
- Number and characteristics of patients treated at health facilities
- Number of private medical colleges and hospitals allcocating free beds
- Number of facilities promoting socilly inclusive BCC strategies

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Recommended Programmes

Programmes for Community empowermement

- Establishment of HFDMCat all levels of health facilities I.e. SHP,HP ,PHC.and District. Scondary and Tertiary care hospitals through involvement of local representatives from Health,Local government, Education, Agriculture Homeministry as well as influential community leaders
- Provisiob of orientation training, providing tethnical and other guidelines
- Empowering them by giving the delegation of legal and financial authorities as per the Development Act of B.S 2013
- Increase accountability of HFDMC by providing Block grants which will be subject to audit arrangements as provisioned in the Development Committee Act 2013
- Involvemrent of community members by creating **users group** in identifying, prioritizing, execution and follows up of services.
- Involvement of users group in Community Meeting, Participatory Rural Appraisal, Review of the Local Demand and Services delivery.
- Strengthen existing FCHV programmes by increasing their numbers and reducing the population being covered by them . This will be started starting with mountain and hill region.

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OUT PUT INDICATORs

- Number of HFDMC formed
- Number of orientation training conducted
- Number of HFDMC receiving Block grants
- Number of users group created
- Number new FCHVs recruited
- Mechanisms of collaboration with MOLD established at National and VDC level

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Recommended Programmes

Programmes for Promoting Healthy public policy to protect health of people and the communities through intersect oral actions

- A comprehensive study to assess Environmental disease burden in Nepal involving experts from other sectors also .
- Health impact assessment of several policies such as Local development. ,poverty reduction fund, roads and transport and education,tax and tariff will be done to understand their effect on health of the people through the active involvement of these sector in order to understand the magnitude aqnd type of impact of these sectors on Health .This study will be utilizes for developing healthy public policy through including health concern in the related sector policy
- 3 Development of strategy for Intersectoral action in health with involvement of other sectors.
- 4 . Formation of Committee ob Intersectoral action for health at highest National level for providing policy guidance for programme development .. Designation of HFMDOC at all levels for intersectoral actions at all levels .
- Package of Health promotion activities icludingvarious measures such as hand washing,cleanliness,environment pollution,road safety,health promoting schools will be developed and implemented
- Environmental sanitation, hygiene promotion- and in particular hand washing-, and water supply will be will be actively promoted through BCC acti8vitieas

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OUT PUT INDICATORs

- Study on Environmental Impact assessment conducted
- Number of sectors doing Health impact assessment
- Strategy for Intersectoral actions for health developed and implemented
- Package of Health promotion activities for intersectoral action developed and implemented

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Recommended Programmes

Programs for increasing access coverage and reducing inequities

- Establishment of three thousand sub health posts in remote mountainous and hilly districts through upgrading existing PHC/ORC and EPI post and further extending access by establishing new PHC/ ORC /EPI posts by using micro planning to bring EHCS within half an hour of walking distance in the remote areas
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- Qualitative studies need to be undertaken to understand circumstances and demand and supply side barriers for certain social and ethnic groups which prevent them from accessing the services

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"Revitalization of PHC"in NHSP2draft 3

- Word 'Revitalization of PHC" does not appear anywhere but most of the elements of group recommendations included partially
- Objectives as mentioned in the Results framework confirm with the principles of Revitalization of PHC reforms

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Result framework NHSP II/Revitalization PHC

Specific Objectives of result framework

1. Increase access to and utilization of quality essential health care services
2. Reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors.
3. To improve health systems to achieve universal coverage of essential health care services

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NHSP II/Vision Statement for Health Sector

The Ministry's vision or goal of the health sector is to improve the health and nutritional status of the Nepali population and provide equal opportunity for all to receive quality health care services free of charge or affordable thereby contributing to poverty alleviation.

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NHSP II/Mission Statement

The Ministry will promote the health of Nepal's people by facilitating access to and utilization of essential health care and other health services, emphasizing services to women, children, poor and excluded and changing risky life styles and behaviors of most at risk populations through behavior change and communication interventions.

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NHSP II/Value Statement

The Ministry believes in

- Equitable and quality health care services;
- Patient/client centered health services;
- Rights-based approach to health planning and programming;
- Culturally and conflict sensitive health services; and
- Gender-sensitive and socially inclusive health services.

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NHSP II/Strategic Directions

For the Ministry to achieve its three objectives for the second NHSP, it will embrace the following key directions.

- Poverty reduction
- The agenda to achieve the health MDGs by 2015
- Essential health care services free to patients/clients and protection of families against catastrophic health care expenditures

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NHSP II/Strategic Directions Contd..

- Gender equality and social inclusion
- Access to facilities and removal of barriers to access and use
- Human Resource Development
- Modern Contraception and safe abortion
- Disaster Management and Disease Outbreak Control
- Institutionalizing health sector reform
- Sector-wide approach: improved aid effectiveness
- EDP harmonization and international Health Partnership
- Improved financial management
- Inter-sectoral coordination, especially with MLD and Education

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Discussion Points

- How does MOH/DOHS operationalize Revitalization of PHC within the context of NHSP2 ?
- Several options

- include Revitalization of PHC as an overarching statement encompassing all the three objectives in the results Framework

-Regroup the strategic direction and sharpen it so that they lead to attainment of strategic objectives and include Revitalization as one of the strategic direction .

Delegate responsibility for some programmes such as intersectoral collaboration , Community empowerment and equity monitoring to the Division

Division develop activities and use some of the recommended indicators

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Thank you
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Workshop on Revitalizing Primary Health Care

Dr. Bhim singh Tinkari

Dhulikhel

5th April 2010

Presentation Outline

- Current Environment
- Milestones in PHC
- Component Focus
- A Need for Strategic Orientation
- Outlook and Next steps

Environment

- **Operating policy framework**
  - Universal coverage in essential health services –(Rural Focused) National Health Policy (1991)
  - Health as a fundamental human right; Interim Constitution & 3-yr Interim Plan (2008-10)
  - Strategy Draft on urban health being prepared (2010)
  - National Policy and Plan of Action on Disability (2006)
- **Fragmented sector**
  - There are a multitude of agencies, and different models of operation
  - Many underlying health problems are beyond health sector
  - Growing roles of non-state actors
- **Financing**
  - Encouraging sector budget as % of total development budget increasing
  - Long-term sustainability of current financing
- **Inequities**

  Health Status has improved but inequitably- unequal improvement

  Assuming business as usual, will further perpetuate gaps.

CURRENT STATUS

1. Unequal improvement and growing gaps
   - Health Status has improved but inequitably
   - Disparities across Rural vs.urban, wealth quintile, Region Caste and Ethnicity
2. New challenges to health and health systems
   - Scaling up services for HIV, TB, malaria, immunization
   - Urbanisation,mental and social health, aging ...
   - Chronic diseases, disabilities, multimorbidity
   - Stagnating Outpatient contacts/ curative services
3. Inequities
   - In access,
   - In the way people are treated
   - In financial burden,
   - In outcomes

.....status cont'd

4. Growing dissatisfaction, rising expectations

Expectations:

- What citizens expect for themselves and their families
  - *Access to quality*
  - *Communities where health is promoted and protected*
- What citizens expect for their society
  - *Health equity- solidarity, social inclusion*
  - *Health authorities that can be relied on (accountability)*

Hence, mismatch between expectations and performance is leading to a crisis in confidence

Health Outcomes and Progress Towards Health Sector MDGs-1

Indicators	1990	2001	2006	2009	2015
MDG-1: Nutritional stunting (height for age) %		57	48		30
MDG-4:Neonatal mortality rate/1000 live births	50	39	33	20	16
MDG-4: Infant mortality rate/1000 live births	108	79	48	41	34

Health Outcomes and Progress Towards Health Sector MDGs-2

Indicators	1990	2001	2006	2009	2015
MDG-4: Under five Child mortality rate/1000 live births	161.6	91	61	50	54
MDG-5: Maternal mortality ratio/100000 live births	515	539 (1996)	281	229	134
Total Fertility Rate	4.6	4.1	3.1	2.9	2.4

Health Outcomes and Progress Towards Health Sector MDGs-3

Indicators	1990	2001	2006	2009	2015
MDG-6: HIV prevalence in 15-49 year/100,000 population	-	290	550		Halt & reverse
MDG-6: Tuberculosis prevalence rate/ 100,000 population	460	310	280		Halt & reverse
MDG-6: Malaria prevalence rate/100,000 population at risk	196	52	25		Halt & reverse

Core Intermediate Health Indicators

Indicators	Current status	Target for 2015	Remarks
Contraceptive prevalence rate	49.6% (any) 45.1% (modern -2009)	67%	
Skilled Birth attendance rate	28-8% (2009)	60%	Institutional 24.4%
Immunization rate – DPT3	81% (HMIS-2008)	100%	
Knowledge on Prevention of HIV Infection (at least one method)	Female-58.3% Male- 81% (NDHS-2006)	Female-100% Male-100%	

Milestones in Primary health Care Nepal (WHO, 2008)

Indicator	1980	1990	2000	2005
1. Health Education	NA	NA	NA	NA
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% (HMIS, 1998)	a. 57.0% b. 43.0% (DHS, 2001)	a. 49.0% b. 39.0% (DHS, 2006)
3. MCH a. ANC 1st visit b. ANC 4th visit c. % of births attended by SBA d. CPR		a. 15.5% of expected pregnancy (CBS, 1994) c. 3.1% d. 24	 c. 13% d. 35% (DHS 2001)	a. 72% expected pregnancy from SBA c. 19% d. 44% (DHS 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	a)80.2%(rural) 89.2%(urban) b)19.8%(rural) 36.9%(urban) (DHS 2006)

Milestones in Primary Health Care Nepal

	1980	1990	2000	2005
5. Immunization a. BCG b. DPT3 c. Measles d. Polio	a. 32% b. 16% c. 2% d. 1%	a. 68% b.NA c. 63% d. 30%	a.91%(HMIS,2008) b. 71% c. 92% d. 71%	a. 83% b. 89% c. 85% d. 85%
6. Control of Endemic Diseases a. Diarrhea % of children Affected b. ARI % of children affected c. Malaria positive cases d. Leprosy e. Tuberculosis care rate	c.1.99/1000	c.2.7/1000(1987) e.79(1996)	c.4/1000(1997) e.89	a)11.9 % b)5.3% d.1.65%(HMIS-2008) e.89 (NHSP-IP 2)
7. Treatment of Common Illnesses and Injuries	NA	NA	NA	NA
8. Essential Drugs Availability	NA	NA	NA	NA

Missed opportunities-
Inequity and Continuum of care

What do we talk about when we talk about PHC?

- *The mobilization of forces in society – health professionals and lay people, institutions and civil society – around an agenda of transformation of health systems that is driven by the social values of equity, solidarity and participation.*

Possible areas for Revitalization:

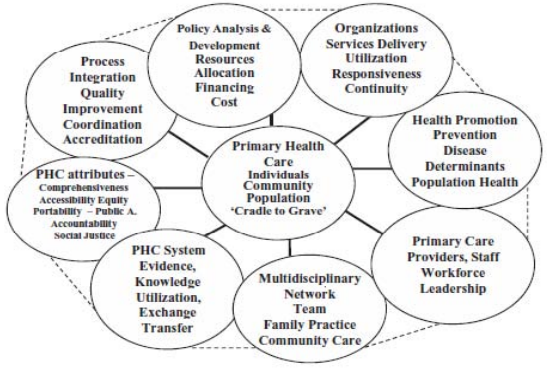
- Existing Functions, Functionaries and Fund.
- New Areas to be addressed.

In congruence with the framework WHO Report (2008)

- *In Nepalese context, the reforms are relevant and can be initiated: specifically universal coverage and service delivery reforms which can* constitute the conceptual foundations for implementation strategies.

Mapping of the

Primary Health Care Concepts and Components



Rationale

- To provide free basic health service to all citizen as stated in the *law*
- To provide quality health services
- To ensure easy access of health services
- To implement health insurance
- To develop future program and strategies commensurate with regular monitoring and evaluation of free health care services

… Rationale (cont'd)

- To provide health services to urban poor, *vulnerable and marginalized*, and for people with disability
- To implement program ensuring citizens right to clean environment
- To mobilize community participation for cooperation at local level
- To achieve the Health sector's MDG by making the delivery of free health care services effective.

Component Focus

Component 1: Free Health Care Services

Component 2: Social Health Protection and Insurance

Component 3: Urban Health

A Need for Harmonization

- Why not learn from the past performance to improve performance?
- Business as usual will not lead to achievement of national targets and service levels
- Key Issues require careful analysis and joint division programme development and inter-sectoral linkages to harmonize approaches and avoid duplication; Quality assurance, Social Protection, Mental Health, Disability Prevention, Environmental Health, Urban Health

...the way forward?

Annex 2: Participants List

S.N.	Name	Designation	Office
1	Dr. Praveen Mishra	Secretary	MoHP
2	Dr. Y.V.Pradhan	Director General	DoHS
3	Dr. B.K. Subedi	Joint Secretary	MoHP
4	Mr. Yogendra Gauchan	Under Secretary	MoHP
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6	Dr. Bhim S. Tinkari	Director	PRD
7	Dr. Gunawan Setiadi	Technical Officer	WHO
8	Dr. Sudanshu Malhotra	Regional Adviser	WHO-SEARO
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12	Mr. Madan Shrestha	DHO	Nawalparasi
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14	Mr. Bhanu Yengden	Sr.PHA	LMD
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17	Mr. Rakesh Thakur	Sr.PHA	EDCD
18	Mr. Pawan Ghimire	Chief ,HMIS	MD/DoHS
19	Mr. Chudamani Bhandari	DHO	Doti
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23	Mr. Sudip Pokhrel	Consultant – Facilitator	WHO
24	Mr. Rudra Thakuri	Program assistant	WHO
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