Primary Health Care development in Nepal

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Primary health care (PHC): Though this term looks to be simple it has been defined in various countries by various people in various ways. The way it reaches to the public also varies, similarly the method in which it is delivered to the rural community in different countries. But it is generally seen that most of the countries have not only been thinking but they are also working in the line that when primary health care services are given to the rural people it not only includes the simple curative services to the limited people around health institution but also they are given an opportunity to improve their other needs of most concern like improved agriculture facilities, education, communication etc.

In most of the countries efforts are being made to involve the communities in some way or the other in developing their own facilities according to their felt needs and priorities. Wherever community is deeply involved like taking important decisions about delivery of health service etc, success is generally observed more. Thus it clearly indicates that planning related to the development of the community should be done by the community itself and implemented by the authorities and not vice versa.

In Nepal PCH is almost synonymously used as basic health services which includes an effort to provide minimum, simple and effective health services to the maximum people through health workers with limited amount of training, equipment and drugs.

His Majesty King Birendra while addressing the 24th session of Rastriya Panchayat laid emphasis on providing basic health services by gradually expanding the integrated health services along the lines established by the pilot projects. Again while addressing the 27th

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session of the Rastriya Panchayat be laid emphasis on expansion of basic health services as planned in the long term health plan. Thus from time to time clear directives are being given by the able leadership of the crown, always keeping in view the interest and service of the underserved and underprivileged people.

Primary health care services development :

Before 1971 the usual health facilities given to the public in Nepal were through the hospitals, health centres and health posts all of which were static in nature of services. Thus their services were available mostly to the people around the health institution. Domiciliary visit as such to the people in house to house basis was not organised.

PHC services given from health post until 1971 and after that until July 1977

Until 1971 no of health posts all old type.	Health posts until July 1977				Total
	Old type HP	Old HP converted into integrated model (E Type)	New HP opened integrated model (E Type)	Full integrated ☼ HP	
251	237	52	80	65	434

☼ Scattered only six districts (Parsa, Bara, Routahat, Siraha, Saptari and Kaski)

Pilot projects, Integrated Basic Health Services :

Before 1971 curative services were provided by health institutions mentioned above and preventive and promotive by the vertical projects in the districts presently under the CH/I division. In early 1971 an agreement was reached between various Boards and Department of Health Service to start a pilot project in Bara district, a district situated in plane area in the Indo-Nepal border. Plan of action for this project was prepared and finally approved in December 1971.⁸ This project was not entirely a new creation. Because all the health services were already provided but by different agencies in the district. The only difference was all those services under different agencies were amalgamated and put under the authority of one person i. e. senior medical officer (SMO) of the district. Hence probably the name "Integrated Basic Health Services" or sometimes loosely "Integration Project". Its main objective was identified as to provide minimum health services to the maximum people by utilizing the already existing health facilities.

This integration scheme at Bara was gradually found to be much useful. Because it was seen that it had reduced the burden of technical staff thereby making their service available for better purpose. Basic health services were found to be reaching well to the rural people and operational cost coming down. Kaski, a hill district in Gandaki Zone was another pilot project to be started in late 1972. Being a hill district each health post had scattered population of about 15,000 and the same in Bara district had 25,000 Population.⁵

Evaluation of these two pilot projects:

A team consisting of HMG, USAID and WHO representatives were formed in January 1975 to evaluate these two pilot projects. They carried out extensive studies of the statistical records available, visited various fields and observed JAHWs (now VWH), compared them with non-integrated districts and prepared an evaluation report at the end of February 1975.

One of the main observation they made was about JAHW. His programme was found to be much cheaper than the adjoining comparable districts. It was observed that they were able to finish their visit of allotted number of houses earlier in the day. As a result of this observation 6 Veks were latter reduced to 4. This arrangement could release two JAHWs which were thought to be for special programme like mass immunizations.

The team expressed their opinion that Vertical projects had more flexibility to meet the deteriorating epidemiological situation and Integration was not to replace any of them, with a new and more perfect methods.

Few other technical observation made by the team were as follows :

Malaria :

Epidemiological information of three comparable districts regarding malaria.

Year	Integrated district-Bara				Transsient stage-Rautahat				Non-integrate-Sarlahi			
1972	230613	27718	11	0.02	251795	47871	24	0.09	325593	62634	35	0.1
1973	238613	34214	26	0.	259545	47339	45	0.17	337563	82733	187	0.5
1974*	254073	42120	316	1.24	264941	39782	143	0.53	351844	94056	481	1.4
1975=	260152	26359	265	1.01	341999	18590	89	0.26	279279	47276	250	0.9
1976⊗	267771	27887	155	0.57	347369	25309	53	0.15	292107	30531	121	0.38

* Fully integrated from 1975.

=Data mentioned to this year in Tripartise evaluation report.

⊗ Data taken from NMEO annual reports.

Family planning services:

In terms of cost per acceptor it was found to be overwhelmingly low in Bara. Similarly Kaski was compared to the adjoining district, Gorkha run by vertical project and total acceptors and couples protected were found to be three times more.

Tuberculosis and Leprosy :

Comparison of antituberculous and antileprosy activities were made with non-integrated health institutions and it was observed that in Bara and Kaski there were good record keeping, case detection, tracing defaulters, treatment follow up and BCG immunization.

Smallpox:

Smallpox activities were found to be much better than in other districts. There was better surveillance and no need to employ temporary people for mass vaccination programme.

Community participation:

It was found to be very good. Because a) service was increasingly utilised,
b) plot of land being provided and
c) building being constructed by the public.

During that period this team had rightly identified these two main challenges in Bara and Kaski pilot projects.

- 1) Regular supervision and timely action on the basis of statistical analysis was necessary to manage the personnel and get honest and effective service from them.
- 2) High number of vacancies were to be filled up by appropriate staff, otherwise a team work could not be said to have functioned effectively.

Nature of staffing pattern at DHO and the health posts

Staffing pattern at health posts:

Designation	No of posts in different types of health posts				Source
	Old type	E type C=	E type new	I Type+	
Health Assistant	1	1	1	1	Institute of Medicine
Auxilliary Health worker	1	?	0	2	I O M
Auxilliary Nurse Midwife	1	?	0	2	I O M
Village Health Workers	0	4	4	6	Prefferably from Vertical
Mukhiya (Clerk)	1	1	1	1	projects, otherwise from
Peons	2	2	1	3	open competition.

Note: Old type of health posts give static services, =C- These are old health posts converted to early integration type 'E' and give dimicillary health services in all except malaria. TB and Leprosy only the confirmed cases are given treatment.

+ Such type of health posts exist only in six 'I stage' of districts, namely Parsa, Bara, Rauthal, Siraha, Saptari and Kaski. ? In a particular health post if the posts were already there, then they are maintained. Otherwise new posts are not created.

Staffing pattern at the district health office:

Posts in 1972 i. e. Pilot project period.	No of Posts.	Posts at present.	No of Posts.	Source of the staff or the previous position they occupied.
Asst. Integration officer	- 1	+Health Inspector	- 1	HA,FP/MCH or Malaria projects.
Family Planning officer	- 1	FP Assistant	- 1	Family Planning project.
Sr. Malaria Assistant	- 1	+Sr. Malaria Assistant-	1	Malaria Project.
District Supervisor	- 1	Assistant Health Insp.	1	Smallpox Project.
Senior Lab. Technician	- 1	Lab. Technician	- 1	Malaria, TB or Leprosy projects.
Lab. Techincian	- 1	Lab. Assistants	- 2	" " "
Auxullary Health Worker-	1	+A H W	- - 1	Institute of Medicine.
Reserved J A H W	- 6	+Public Health Nurse	1	" "
Spray cum foreman	- 2	+Auxullary Nurse Midwife	1	" "
Accountant	- 1	+Nayab Subba	1	Vertical project or open
Kharidar	- - 2	+Kharidar	- - 1 *	competition. (VP or OC)
Mukhiya	- - 1	+Mukhiya	- - 1	"
Peons	- - 1	+Peons	- - 2 *	"
Watchman	- - 1	+Health Assistant	- 1	Institute of Medicine.
Driver	- - 1	Asst. Health Educator	1	(VP or OC)
		+Health Educ. Technician	2	VP Ass. Supvr. Smallpox.
		Statistical Asst.	- 1	Vertical Projects.
Total	23+	Total	- 19	

+Dr. G. M. Shakya et al, JNMA July 1972. * Staffing pattern in E type of DHO- Total 37

+ " " " " " , Special DHO-Total 5

As mentioned above this scheme is based mainly on the integration of the vertical projects activities utilizing the same people. This is clearly reflected in the above table also. In health posts and DHO the curative people are taken from institute of medicine, different campuses scattered all over the country.

In health posts VHW (Village Health Workers) who were previously called JAHW (Junior Auxillary health workers) are the basic people who go from door to door in their specified areas known as Vaks and carry out different activities. VHW are people, with education up to 8th class, locally recruited. They are given four weeks training after appointment. Recently this four weeks has been decided to extend up to six weeks. During recruitment of VHW special preference is always given to the people who have already worked in vertical projects for quite long time. They are accepted even if they may not belong to the particular village, or villages.

Six weeks training to these people mainly includes knowledge about communicable diseases, immunization, family planning, preparation of home made rehydration fluid, method of measuring arm circumference of 1 to 5 years children with measuring tape etc.

Each VHW covers 2000 to 5000 population at present depending upon the geographical belt of the country.⁹

Long term health plan (LTHP) in Nepal which has recently been approved by the government defines these VHW as people who know how to read and write, who are from local panchayat or around it. As planned in Bara and Kaski pilot projects LTHP also gives preference to the vertical project staff (senior vaccinator, malaria field workers and health aids).

A glance to the DHO and the health posts staffing pattern shows the same basis of utilization of vertical project staff an effort to maintain the same efficacy in different activities in the district.

Nature of activities of DHO:

Senior Medical Officer (SMO) of the district assisted by health inspector (HI) runs the different health activities in the district. Since SMO should also look after the curative services of the district hospital, he normally delegates most of the authorities to the health inspector and himself supervises the programme.

DHO has main responsibility to see that health posts situated in different parts of the district run properly. They are adequately staffed, properly trained, supply is maintained and

they are equipped properly. With all these necessities being fulfilled it is always keenly watched that they discharge their duties sincerely and with devotion.

DHO has responsibility to plan and organise any health need that may appear from time to time in the district.

DHO receives, analyses, compiles and sends monthly reports from health posts to the central community health and integration office. There are 48 DHOs at present and may not be opened further until 2037. Out of these 48 DHOs 13 run integrated health programme in districtwise basis.

Nature of activities of health posts:

Health post is the peripheral unit of health institution which provides simple curative, preventive and primitive health services. Sr. AHW or Health Assistant, AHW "C", "X" and ANM are mainly involved in curative and AHWs "P" and VHWs are engaged in preventive and promotive activities. In case of designation of AHW's "C" and "P" it has recently been decided to delete "C" and "P" and have only AHW.

These are the different activities of the health post in short:-

1. Simple curative services.
2. Treatment of confirmed tuberculosis and leprosy cases.
3. First aid and emergency treatment.
4. Referral of undiagnosed and complicated cases to the district hospital.
5. Radical treatment and remedial measures of malaria cases.
6. Nutrition-Arm circumference measurement of 1 to 5 years children to assess the nutritional status, demonstration of nutritious food to the mother and the public, health education for better utilization of locally available foods and education to the public about preparation of home made rehydration fluid.
7. Identification and training of traditional birth attendants (TBA) by the auxiliary Nurse Midwife (ANM).
8. Antenatal, postnatal and delivery services.
9. Immunization at ten different points of the health post area.
10. Out reach clinics, one in each VEK.

VHWs are also health post employee like AHW and ANMs. They have a regular field-visit programme for 20 days in a month in their respective VEKs. Normally one house is visited once a month in all malarious areas, once in two months in midmountains and

once in six months in high mountains.⁴ Similarly the population coverage per VHW also varies from 2000 in high mountains on an average to 5000 in plane areas (Terai). These people are supposed to go from door to door and carry out the following activities.

1. Recording of vital events. (According to the LTHP they are supposed to take it from village panchyat office and report to HP).
2. Surveillance of Smallpox.
3. Fever surveillance, blood smear collection from malaria cases and issue of presumptive treatment.
4. Case finding and defaulters tracing for tuberculous and leprosy cases.
5. Motivation of eligible couples with two or three children for permanent sterilization or use of intra-uterine contraceptive device (IUDC).
6. Motivation of eligible couples for family planing and issue pills and condoms.
7. Surveillance of nutritional status in 1 to 5 years children with use of arm circumference tape and teach the mother and family the use of locally available nutritious foods.
8. Teach the method of preparation of rehydration fluid at home.
9. Teach about the importance of better sanitation.

Conclusion:

The present provision of delimary health care services to the people appears to be only an effort to overcome monetary and skilled manpower conskions faced by the country. There fore in may not be said for sureity that it is the only answer for the present for the simple reason that probably it is too early to say that. Only the time and the people living in those rural and remote areas who are supposed to be receiving the services will be better judges to give a correct answer to this issue. However people who have been directly involved in providing such services and are taking all the pains, working day and night with support and good will from people of all walks of life feel happy and encouraged, like people delighted with an early morning sun-rise at a snowy mountain in winter with success already at sight.

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