

NEPAL'S FIVE-YEAR HEALTH PLAN (1970-1975) AND ITS ACHIEVEMENT

THE BARA AND KASKI PILOT PROJECTS TESTING THE FEASIBILITIES OF INTEGRATED BASIC HEALTH SERVICES AS A METHOD OF HEALTH CARE DELIVERY

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Ecological Factors Affecting The Health Care Delivery System.

The Kingdom of Nepal, has a unique physical feature spread over an area of 1,42,000 sq. kms. The country has not only the highest mountains in the world but at the same time steep hill areas, forests and jungles and low level plan areas. This means that Nepal is actually divided into several distinct areas of topography and climate, resulting in considerable disparity in the feasibility of achieving an efficient communication system which has an evident bearing on planning and management.

Most of the people (population 11.3 million by the 1971 census) are illiterate and live in the rural areas and carry out agriculture in the present arable land which is about 13%. Per capita income is about U. S. \$ 80. per annum.

The people comprises of 15 major ethnic groups who speak 36 dialects. The religions are Hinduism and Buddhism.

The political system is a three-tiered Panchayat Democracy with the village Panchayat or town Panchayat at the base. The Village Panchayat is the smallest political unit which has at least 2,000 population.

The country is divided into 14 politico-administrative zones, 75 districts and 3,927 Village Panchayats and 16 town Panchayats. Recently the country has been divided into four development regions each of which cover 3-5 politico-administrative zones.

2. Health Problems, Priorities and Resources

2.1 Problems.

With the control of malaria and near eradication of smallpox, tuberculosis and leprosy are the main communicable disease problems in Nepal. Still, the high infant mortality rate is due to gastro-enteritis and lung infections. Poor environmental sanitation and malnutrition are also contributing to high incidence of these diseases.

According to the estimate of 2% annual natural increase in population growth for the years 1970-75, the population of the country is going to be double in the next 35 years. This will pose a great problem in maintaining equilibrium between the population growth and the economic development of the country.

2.2 Priorities

Nepal has been providing the health needs of the people by identifying its health problems on priority basis. The development and expansion of the following services may be listed in order of priorities :

- a. Development of Integrated Basic Health Services,
 - b. Development of Man Power
 - c. Development of the Health Post Net work,
 - d. Expansion of such priority Programme as :
 - Maternal and Child health/Family Planning
 - TB Control
 - Leprosy Control
- Consolidation of the gains of such as :
- Malaria Eradication
 - Smallpox Eradication
- e. Development of such programmes as goitre control, environmental sanitation, nutrition and health education.
 - f. Strengthening and development of the district & zonal hospital network, particularly as referral centers.

2.3. Resources

At present, under the Ministry of Health, there exist two different types of service

- a. Categorical programmes including malaria, smallpox, tuberculosis, leprosy, maternal

Intermediate Level

The Zonal Health Office and hospital is the intermediate level of the organizational structure under the responsibility of a zonal health and medical officer known as Civil Surgeon in Nepal. This level is responsible for the implementation of the comprehensive health programmes of the concerned zone encompassing promotive, preventive and curative services. The zone is also responsible for the technical guidance and supervision of the peripheral health establishments of the districts under the zone with the assistance of the various categories of professional staff under the zonal health and medical officer. At present authority has been decentralised to the Civil Surgeon in respect of finance, personnel, equipment and building.

Limited specialized services are available in the zonal hospital, and the zonal hospital is the referral centre for the district hospitals.

Central Level

It is understood that the scheme described above is at present time operating only in the 2 pilot projects and that will expand after evaluation has shown the possibility of identifying a feasible and efficient pattern.

In this respect the central level should be modified in order to provide the health services with a management system able to match the management pattern tested at peripheral and intermediate levels.

The Ministry of Health should remain the highest decision making level of the health services but significant authority has already been delegated to the intermediate level and as tested in the pilot projects should be progressively decentralized to peripheral level. The Ministry of Health is and should be responsible for the delivery of the health services to the population in the context of the social & economical development of the country.

The Ministry of Health at the top of the pyramid should consist of a Directorate of Health Services with the Director General as the executive chief for programming, budgeting and implementation of the health programmes including the categorical programmes of Malaria Eradication.

An ad hoc working group on integration has been formed. This working group comprises of all the chiefs categorical programmes and of WHO and USAID advisers. It should be noted that the different Boards (Malaria Eradication, MCH/FP) which have been created to run the semi-autonomous programmes should disappear when the feasible health services expansion plan has been identified and when all programmes will come directly under the

Directorate of Health Services. On the other hand, the Integration Board which has been formed in order to implement the integration policy of His Majesty's Government should also cease to function when the new structure of the Directorate of Health Services will be adopted.

5. Comments and Conclusions

The Pilot studies have been going on for just over a year and are expected to continue for another year. The experience during this time has shown the potentiality of integrated health care delivery. At the end of the study period, in-depth evaluation based on feasibility and cost effectiveness will be made. The feasibility of managing the various categorical programmes by the integrated health services will be tested and the future plan for progressive expansion will be evolved from this evaluation process. This evaluation will also assess the efficiency of the management system itself in relation to the most important components i.e. problem identification, planning, decision making, implementation and supervision, recording, reporting and feed-back mechanism and the possibility of establishing an efficient permanent built-in evaluation system.

However, it should be considered that as the whole administrative system has developed within a rigid highly centralised frame work for more than a century, the capability of the existing system to accomodate changes may be slow.



RATIO : HOSPITAL BEDS/POPULATION
NEPAL FY 1972/73

Zones	Population	No. of Hospitals	No. of Beds	Bed : Population Ratio
Mechi	581,245	2	40	1: 14,500
Kosi	834,025	6	200	1: 4,200
Sagarmatha	1,306,266	3	66	1: 20,000
Janakpur	1,237,841	4	115	1: 10,800
Bagmati	1,409,826	15	1,035	1: 1,400
Narayani	1,072,727	5	130	1: 8,300
Gandaki	1,007,079	5	125	1: 8,100
Lumbini	1,142,744	9	172	1: 6,600
Dhaulagiri	274,920	1	15	1: 18,300
Rapti	759,475	1	15	1: 50,600
Karnali	180,794	1	15	1: 12,100
Bheri	559,592	3	80	1: 7,000
Seti	584,258	2	30	1: 19,500
Mahakali	339,176	1	15	1: 22,600
TOTAL	11,289,968	58	2,053	1: 5,500

Annex 1. b

**Health Centre/Health Post Population and Health Centre/Health Post/
Ayurvedic Dispensary Population, Nepal FY 1972/73**

Zone	Population	No. of			Health Centre/Post		Health Centre, Health Post		Remarks
		Health Centre	Health Post	No. of Ayurvedic Dispensary	Population Total of (3) & (4)	Ratio	Ayurvedic Disp/Population Total of (3), (4) & (5)	Ratio	
1	2	3	4	5	6	7	8	9	10
Mechi	851,245	3	4	6	7	1: 83,000	13	1: 44,700	
Kosi	835,025	2	18	3	20	1: 41,100	23	1: 36,300	
Sagarmatha	1,306,266	4	30	8	34	1: 35,500	42	1: 31,100	
Janakpur	1,237,841	3	29	7	32	1: 38,400	39	1: 31,700	
Bagmati	1,409,826	4	16	12	20	1: 70,500	32	1: 44,000	
Narayani	1,072,727	1	40	4	41	1: 26,200	45	1: 23,800	
Gandaki	1,007,079	2	20	14	22	1: 45,800	36	1: 28,000	
Lumbini	1,142,744	2	8	7	10	1: 114,300	17	1: 67,200	
Dhaulagiri	274,920	3	6	4	9	1: 30,500	13	1: 21,100	
Rapti	759,475	2	10	5	12	1: 63,300	17	1: 44,700	
Karnali	180,794	1	4	1	5	1: 36,200	6	1: 30,000	
Bheri	559,592	2	1	3	3	1: 186,500	6	1: 93,300	
Seti	584,258	3	5	6	8	1: 73,000	14	1: 41,700	
Mahakali	339,176	2	6	2	8	1: 42,400	10	1: 33,900	
TOTAL	11,289,968	34	197	82	231	1: 48,900	313	1: 36,100	

**Ratios : Doctors, Nurses, Asst. Nurses, Midwives, Auxiliary Health Workers
and Baidyas to Population, Nepal. FY 1972/73**

Zone	Population	Doctor-Ratio	Nurse-Ratio	A.N.M.—Ratio	SAHW—Ratio	AHW—Ratio	Baidya—Ratio
Mechi	581,245	7-1: 83,000	3-1: 193,700	9-1: 64,600	3-1: 139,700	10-1: 58,100	8-1: 72,700
Kosi	894,025	20-1: 41,000	19-1: 43,900	31-1: 26,900	5-1: 166,800	59-1: 14,100	2-1: 412,000
Sagarmatha	1,306,266	11-1: 118,000	3-1: 433,400	4-1: 326,600	4-1: 326,600	70-1: 18,700	14-1: 93,300
Janakpur	1,237,841	16-1: 77,400	13-1: 95,200	10-1: 123,800	4-1: 309,500	67-1: 18,500	11-1: 112,500
Bagmati	1,409,826	155-1: 9,100	102-1: 13,800	91-1: 15,500	20-1: 70,500	83-1: 17,000	17-1: 81,800
Narayani	1,072,727	22-1: 48,800	19-1: 56,500	45-1: 23,900	29-1: 37,000	95-1: 11,300	5-1: 214,500
Gandaki	1,007,079	9-1: 111,900	10-1: 100,700	27-1: 37,300	3-1: 335,700	38-1: 26,500	7-1: 143,900
Lumbini	1,142,744	20-1: 57,100	12-1: 95,200	23-1: 49,700	4-1: 285,800	34-1: 33,600	16-1: 71,400
Dhaulagiri	274,920	5-1: 55,000	1-1: 274,900	1-1: 274,900	2-1: 137,500	9-1: 30,500	3-1: 91,600
Rapti	759,475	3-1: 253,200	0-0: 759,500	2-1: 379,700	4-1: 189,900	18-1: 42,200	3-1: 253,200
Karnali	180,794	2-1: 90,400	0-0: 180,800	4-1: 45,200	1-1: 180,800	6-1: 30,100	1-1: 180,800
Bheri	559,592	10-1: 56,000	11-1: 50,900	15-1: 37,900	1-1: 559,600	18-1: 31,100	3-1: 186,500
Seti	584,258	5-1: 116,800	1-1: 584,300	3-1: 194,800	0-0: 584,300	13-1: 44,900	6-1: 97,400
Mahakali	339,176	4-1: 84,800	1-1: 339,200	0-0: 339,200	0-0: 339,200	15-1: 22,600	2-1: 169,609
TOTAL	11,289,968	289-1: 39,000	195-1: 57,800	265-1: 42,600	80-1: 141,100	535-1: 21,100	98-1: 115,200

Note ; 1. All health personnel mentioned above are under civil Service.
Health personnel working under other health facilities are not included.

2. Population according to HMG Census 1971.
3. Inclusive of 92 malaria inspectors, otherwise AHW only 443.
4. Ayurvedic Physicians

Annex 3

National and Health Budget for Fiscal Year 1968/69--1972/73

(Rs in thousand)

Budget Detail	FY 1968/69		FY 1969/70		FY 1970/71		FY 1971/75		FY 1972/73	
	National	Health %	National	Health %	National	Health %	National	Health %	National	Health %
Total	667,375	33,538 5.0	840,959	39,473 4.7	973,005	51,077 5.2	1,137,432	52,241 4.6	1,267,534	57,945 4.6
Regular	208,960	9,411 4.5	232,750	12,658 5.4	339,958	14,643 4.3	367,659	17,425 4.7	409,755	20,496 5.0
Develop- ment	458,415	34,127 5.3	608,209	26,815 4.4	633,047	36,429 5.8	769,773	34,816 4.5	857,779	36,449 4.4