

Aakasko Phal Aankha Tari Mar – Watch the Fruit in the Sky and Die
Accessibility of Health Services in Nepal
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Introduction:

Nepal's health care system has been more of a myth than a reality for the poor people of Nepal. They hear about the government's plan and about the large amounts of money spent on health care, however, thousands of poor people continue to suffer and die of conditions like diarrhoea, dysentery, common cold, pneumonia, encephalitis, meningitis and other treatable illnesses. The government's slogans exclaiming, "Health for all by 2000", and "Primary health care as people's rights", are used to attract donor support, but these programs are not actually implemented. For this reason, Nepal's health care system has become inaccessible to poor people. Poor persons see the hospitals and health-posts but they can not afford to buy the services or they are afraid to approach or they do not find any health personnel or medicine when needed. Rural poor people have been accepting this situation, as their "fate" or "destiny" or "karma".

Women Acting Together for Change (WATCH), a Nepalese NGO for which I work, strongly feels that there is no commitment from either Nepal's government or from so-called international agencies to reach the poor and to provide them with basic health services. The structures and facilities created by the government agencies do not allow them to reach the poor and to understand their needs and interests. How can they see, what is happening with poor people while they travel by planes or jeeps, and stay over-night at luxury hotels and lodges? They have no direct contact with the people they are supposedly trying to help.

WATCH therefore strongly advocates against the present health care system in Nepal and advocates for an alternative system that can be managed by local health-care users themselves. WATCH also feels that without improvement in other sectors like literacy, awareness, decision-making rights, livelihood, rights over resources, etc., it is almost impossible to make any improvements in the health sector alone. Based on this premise, WATCH has been trying out an alternative health care system in three districts of Nepal (Okhaldhunga, Rupandehi and Chhaimale in Kathmandu) for the last eight years with support from AIFO. I will be making a presentation based on this experience.

Background:

Nepal is a sovereign, independent, democratic and landlocked country with a constitutional monarchy. It is a country renowned for Mount Everest, Buddha's Birth Place, and Community Forests. Its population is estimated at 22 million. It is one of the poorest countries in the world with a per capita income of US\$240 per year. More than 60% (42% according to the government estimate) of the population still live in abject poverty, which affects all sorts of human development indices. For example, Nepal's level of health is indicated by a relatively high infant mortality rate (64.14 per thousand), child mortality rate (105.44 per thousand), maternal mortality rate (6 per thousand), and the average life expectancy (58 years). Diarrhoeal diseases (15%) and TB (4-5 per thousand) are major killers. Malaria continues to resurge, and encephalitis, meningitis and kala-azar

(Visceral Leishmaniosis) are reaching epidemic proportions. The prevalence of leprosy remains one of the highest (3.2 per thousand) in the world. HIV/AIDS and sexually-transmitted diseases (STDs) are expanding without any checks, despite the government's claims of investing in "health care for all".

In all of Nepal, there are 83 hospitals, 13 health centres and 275 ayurvedic hospitals with a total of 5190 beds. As well, there are 711 health posts, 160 primary health centres and 3179 sub-health posts. In terms of health care providers, there are 1259 doctors, 4655 nurses, 421 vaidyas (Ayurvedic doctors), 5295 health assistants, 3190 health workers, 4015 local health workers and 62,546 birth attendants and female health volunteers. The government is allocating a budget of US\$ 57-60 million annually for health care services, however, does this level of investment reflect effective or accessible health care?.

How Accessible are Health Care Services?

The government's annual expenditure for health care services is US\$ 2.5 per person. Most of this money is spent on infrastructure development and salaries. The rest goes to hospitals, health centres and health posts that are not within the reach of poor people. There is no special program or expenditure to reach real poor and people in remote areas, who really need medical services.

On average, one hospital bed is available for 425 people. In terms of human resources, there is one doctor for 1750 people, one nurse for 473 people, one Vaidya for 5225 people, one health assistant for 415, one health worker 315 people, and one health volunteer for 35 people. It looks quite impressive but let us look at the reality in terms of accessibility for the poor and people in the remote areas. Doctors, nurses, and vaidyas are available only in cities and metropolitan areas; even hospitals and health centres in outlying district centres are without them. Even if they are available, their fee just for investigation may cost around US\$ 2, which is almost the equivalent of three days wages. Health assistants and health workers may visit their posts but they will stay there for not more than six months. They also charge fees for investigation, which may cost their patient's around one day's wages. Furthermore, health posts are supposed to distribute free medicines but medicines are not usually available unless one decides to buy from them. Even honest workers have difficulty, because the medicine provided to them is not enough to last three months. Thus, health posts are also not accessible to poor people and have not been providing services to people in need. There are quite a lot of health volunteers, but they are trained only for about five days and they are not given any materials and medicines. Every year they are provided with five days refresher training, however, they have not been able to provide services to people, due to the lack of proper training, information and medical equipment. Consequently, they are losing their credibility and usually poor people do not visit them or trust their advice.

Regarding affordability of health care provision, as already mentioned, almost 60% of people are below the poverty line, who live a hand-to-mouth existence. In Poor and remote areas, persons needing health care services, have to travel long distances, which is costly and time consuming. Thus they must forgo the wages they could have earned during this time, which is necessary for their own survival and that of all their family members. If poor persons become sick, they are often

forced to sell whatever property they have or become indebted for life. Once they manage to reach the health services, usually they are not properly dealt with and may be blamed for late coming or humiliated for their ignorance. They may have to wait for hours and spend hours trying to figure out the procedures. As most of them have not seen or experienced such services previously, they usually need to go through a thorough investigation, which costs quite a lot of money. Then they have to start paying for beds and medicines. How can a poor person afford to pay for such services? All the health-care measures are geared towards providing services to rich and elite but not to poor persons and persons coming from remote areas. So most of them do not get an opportunity to see any health services, and die without knowing what killed them. Sometimes, they are asked to go to the private clinics owned by hospital authorities. Even if admitted, they have to buy medicines and sometimes even food. Some hospital beds are quite expensive. Thus, hospitals and hospital beds are not for poor and needy people.

Let's look at the situation, particularly at the distribution of medicines. Medicines are quite expensive and many of them are either fake or low quality because of a systematic lack of standards for monitoring. To make matters worse, people are not given proper advice for taking medicine and they do not take the full doses, prescribed to them. As soon as symptoms disappear, they stop taking the medicines and so by the time they visit the hospital, their illness has usually progressed into a sort of terminal case, requiring special and lengthy treatment.

The above scenario portrays the reality of the situation. The poorest communities have no time to report about their poor health and miseries, even if most of them have at some time of their lives, been the victims of various diseases. For example, almost all women have usually suffered from various sexually transmitted diseases. Lack of adequate food does not allow people to grow and develop physiologically properly. And their lack of knowledge about health, hygiene, and environmental sanitation does not help them to live healthy lives. Even if they have some knowledge and awareness, they cannot practice them because of lack of time. Lack of money does not allow them to get proper treatment for any kind of diseases. The health messages prepared by centralised health services are often not relevant to their local conditions and are not understood by them.

What is WATCH Doing?

As WATCH works with the poorest and most disadvantaged groups, it recognises that women are treated badly in the household as well as in the society. They lack self-esteem and self-respect. They are resource-poor and usually need to work hard for their survival, from the early morning to late in the evening. In fact, they do not have time to think about "development". They are used as vote banks and their votes are bought by political leaders. Looking at this situation, WATCH identified the poorest and most disadvantaged women in the villages and began building a rapport with them. Gradually, WATCH helped to organise themselves in groups, to build their confidence and self-esteem, to understand their struggle and situation with empathy, and worked to raise their awareness regarding their rights and responsibilities. WATCH also helped these women's groups to develop their own plans, to involve them in communal activities, and to help them assert their rights with various institutions and organisations through a federation that serves as a lobbying force. So-called

poor women's awareness is raised through functional literacy, regular interaction, meetings, and awareness raising camps, various training courses and involvement in decision-making of their own activities. Gradually, these women have felt the need for taking part in the broader development context. So they are organising to ask for their share of development. They have mobilised themselves to have their own citizenship certificates, land rights certificates, water rights, identifying common candidates for election, etc. They have started taking part in decision-making, in the implementation of a health program and in local natural resources management such as community forestry, drinking water supply, creation of irrigation ditches, etc. A few of them have been elected in the local government bodies. They are keen on safeguarding the rights of women at household level, community level and national level. However, they need continuous support, interaction, information, and morale-boosting. AIFO's support to WATCH has facilitated poor and disadvantaged women's awakening, which needs to be replicated in other areas.

Some of the activities initiated by WATCH are as follows:

Health Clinic: WATCH has established three simple clinics in three areas it has been working. They are equipped to provide primary health care services. First WATCH hired nurses to provide services, however, because many nursing homes opened in the areas, the nurses could no longer stay there. Later, health assistants and community medical assistant (CMA) were hired for running these. WATCH clinics keep family folders, health records and provide free primary health care services.

Mobile Health Services: As rural and poor people are quite busy, if services are not provided nearby, they will not be able to use those services. For this reason, WATCH has divided its area into various clusters. WATCH staff and health volunteers visit these clusters once a week, to provide primary health care services, and to discuss health and sanitation issues. This way people do not have to lose their wages for visiting health services. Local women's groups help manage such services.

Awareness Raising and Service Camps: WATCH has been conducting awareness-raising campaigns and service camps for activities like deworming (every six months), providing medical services, initiating dialogue on environmental sanitation, balanced diet, HIV/AIDS/STDs and their prevention, against women trafficking, etc.

Non-Formal Education: WATCH has been conducting functional literacy classes (20-25 every year) based on key-words methodology. Some of the key words relate to health, sanitation, sexually-transmitted diseases (STDs), HIV/AIDS, nutrition and balanced diet, etc. WATCH also conducts a one-day training course to make literacy facilitators capable of using a package of awareness-raising materials on HIV/AIDS/STDs and girls trafficking (provided free by WATCH).

Awareness and Support for Inoculations: The government and other agencies are providing various vaccinations and inoculations. As they do not have sufficient human resources for publicising such services, WATCH helps them by discussing their services in women's groups

meetings, encouraging women's groups to take part and assist in publicising, providing venues and keeping records.

School Health Program: WATCH also provides services to local schools for regular health check-up of students, for taking health and sanitation related classes, and providing necessary materials and services.

Health Volunteers: WATCH has been training local women volunteers selected by women's groups for providing first aid services. For example, they provide some simple medications for headaches or making "Jeevan Jal" (rehydration solution). The volunteers also work as birth attendants, provide information about health, sanitation, nutrition, cooking vegetables, and "Sarbotam Pitho" (multi-grain flour). They also encourage and assist people to make simple latrines, smokeless hearths, and kitchen gardens. They provide services for children to bathe, cutting nails, cleaning yards, making wastebaskets, etc. WATCH provides them with modular training, medical kits, basic medicines and regular supervision. They also help WATCH during camps and campaigns. These volunteers charge a nominal fee for their services and they also get 50% of charges raised by the women's groups or federation for health services.

Health Care Fund: WATCH provides medicines and medical services for free, but the women's group's federations charge a nominal fee for making family folder and cards (Rs. 2 or about 3 cents), for health services (Rs. 2 or so for each visit), and for the sale of medicines other than essential drugs (at Kathmandu rate). By now each federation has collected quite a substantial fund. When WATCH decides to hand-over clinics to the federation or communities, WATCH is also planning to contribute the amount necessary for the sustainability of the clinics.

Health Management Group: Women's federations have Health Management Groups selected to look after and manage health care activities. They are slowly being trained to take over the management of health care services in the area. As they are poor and newly literate, it is taking more time than expected.

Organisation of Service Seekers: Local women as health service users are organised to seek services from governmental and non-governmental agencies. Similarly, sex workers or HIV positive persons are also organised to seek services. They are organised with a hope that they would not feel marginalised from society, and that they would feel as useful members of society and fight against discrimination.

Integration with Other Activities: WATCH is involved in various activities as demanded by local women's groups. All its activities like agriculture, horticulture, livestock improvement, natural resource management; women's empowerment, etc. are integrated for the improvement of people's livelihood with the goal of living life with dignity.

Conclusions:

Nepal is one of the more impoverished countries, where the status of women is very low, where support and services for women is negligible, and where awareness about women's rights and responsibilities are discussed only among the educated elite. Thus rural women in Nepal are very much suppressed. They are kept out of the development dialogue, and the struggle for their livelihood does not allow them to take part in social development. WATCH, with support from AIFO, has been working in three areas of Nepal with most disadvantaged and poorest women groups. Gradually, these women are taking their own awareness and development in their own hands through organising and federation building. Women have been active in seeking health services and slowly stepping ahead to manage health care activities. This support has helped WATCH to work out processes and approaches that contribute to women's empowerment, awareness raising, so that they can take control of their lives and provide the necessary services including primary health care within their own communities. By working together, WATCH has created an enabling environment to organise the poorest women, who are aspiring to take part in a broader development context.