Chapter nine

Health Improvement through the Primary Health Care Approach

Case of Nepal

Kedar Prasad Baral, Nadia Diamond-Smith, and Rita Thapa

Nepal is one of the signatories of the 1978 Alma-Ata Declaration on primary health care (PHC). Forty years later, Nepal still endorses and continues to practice the core values and principles of PHC as fundamental approaches in policy formulation and program implementation. Furthermore, Nepal has made rapid progress on health indicators compared to other countries with a similar level of benchmark indicators (see chapter 2). This chapter reflects on Nepal’s successes as lessons for future implementation of the PHC goals outlined in the Astana Declaration. Nepal’s delivery of the promise of PHC in its policies and programs has evolved over the past forty years across changing landscapes of political, economic, and epidemiological contexts.

Nepal is a landlocked country bordered by India in the east, west, and south, and China in the north. It occupies 147,181 square kilometers, rising from as low as 59 meters at the tropical Terai (the northern rim of the Indo-Gangetic Plain) up to Earth’s highest summit (Mount Everest) at 8,848 meters. Nepal has three distinct ecological belts—namely, the mountainous, hilly, and Terai—occupying areas of 51,817, 61,345, and 34,019 square kilometers, respectively (Central Bureau of Statistics 2015). Most mountainous areas are uninhabitable and are therefore sparsely populated. The population density varies across the regions, with a population density of 34 people per square kilometer in the mountains, 186 in the hills, and 392 in the Terai (Central Bureau of Statistics 2015). The first national census of Nepal, conducted in 1952–1954, estimated Nepal’s population to be around eight million (Pant 1955), and as of 2017 the population stands at roughly twenty-eight million.
Nepal’s feudal history and a complex social fabric with deep-rooted traditions and culture, endowed with natural resources along with diverse ethnic identities, challenging terrain, and frequent natural disasters, make it a challenging place to provide health care. The 1951 revolution broke the 104-year rule of the autocratic Rana family, opening the country to development and legalizing girls’ formal schooling. Over the subsequent period, there were two popular movements and a protracted ten-year spell of violent civil conflict, and Nepal has undergone a tremendous social transformation, from feudal monarchy to a secular republic. The 1990 People’s Movement brought in a multiparty political system while transforming the king into a constitutional monarch. Following the violent 1996 Maoist People’s Movement, which ended in 2006 with a peace accord, the Constitution of Nepal institutionalized a Federal Democratic Republic of Nepal. The Constitution of 2015 guarantees an inclusive society, multiparty democracy, equitable social and economic development, the rule of law, and human rights. Basic health services, safe motherhood, women’s reproductive health, and children’s health were also enshrined in the constitution as fundamental rights, for the first time in the history of Nepal.

Despite decades of political instability, frequent natural disasters, poor infrastructure, challenging terrain, and lackluster economic growth, Nepal’s health indicators have shown amazing progress over the past forty years (table 9.1). However, inequalities in absolute and relative terms persist for women, ethnicity, and rural areas, despite two decades of programmatic priorities directed to address the gap.

Background and Contextual History

For most of the twentieth century, Nepal was a subsistence economy, overwhelmingly dependent on agriculture and primarily controlled by landowners. Nepal’s near-total lack of physical infrastructure, including roads, telecommunications, hospitals, and schools, further contributed to poor development and health outcomes before 1950. Rugged topography, lack of statistics, and an apathetic central government would have made it impossible to realize development needs.

In the 1950s, only 2% of Nepali people were literate, and there were only three hundred college graduates in the country. An estimated one in four individuals in the Terai region suffered from malaria before the malaria program was started in 1956. Unattended home delivery was universal, and the maternal mortality ratio was estimated at above fifteen hundred per one hundred thou-
sand live births. The under-5 mortality rate was more than three hundred to four hundred per one thousand live births (Worth and Shah 1969), and the percentage of married women using modern contraceptives was at zero (Nepal Family Planning 1976). Life expectancy was around 28 years (Boch-Isaacson et al. 2001) overall, and it remained lower for women than men until the 2000s.

The 104-year-old Rana regime came to an end in 1951, and there was a brief beginning of a democratic system under a monarchy. However, in 1960

Table 9.1. Nepal’s health and development indicators over time

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<tr>
<td>GNI per capita</td>
<td>160&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>210&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>210&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>240&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>340&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>600&lt;sup&gt;1a&lt;/sup&gt;</td>
<td>730&lt;sup&gt;1a&lt;/sup&gt;</td>
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<td>Total fertility</td>
<td>6.3&lt;sup&gt;2b&lt;/sup&gt;</td>
<td>5.6&lt;sup&gt;2b&lt;/sup&gt;</td>
<td>4.64&lt;sup&gt;1b&lt;/sup&gt;</td>
<td>4.12&lt;sup&gt;2b&lt;/sup&gt;</td>
<td>3.12&lt;sup&gt;2b&lt;/sup&gt;</td>
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<td>2.3&lt;sup&gt;1b&lt;/sup&gt;</td>
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<td>IMR</td>
<td>117&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>97&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>73.74&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>64&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>48&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>46&lt;sup&gt;2a&lt;/sup&gt;</td>
<td>32&lt;sup&gt;2a&lt;/sup&gt;</td>
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<td>Youth female literacy</td>
<td>17.38&lt;sup&gt;3&lt;/sup&gt;</td>
<td>24.86&lt;sup&gt;2&lt;/sup&gt;</td>
<td>34.88&lt;sup&gt;3&lt;/sup&gt;</td>
<td>48.83&lt;sup&gt;3&lt;/sup&gt;</td>
<td>64&lt;sup&gt;2c&lt;/sup&gt;</td>
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<td>Literacy rate</td>
<td>23.3&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>39.6&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>54&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>65.9&lt;sup&gt;2c&lt;/sup&gt;</td>
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<td>Total</td>
<td>12&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>25&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>42.8&lt;sup&gt;2c&lt;/sup&gt;</td>
<td>57.4&lt;sup&gt;2c&lt;/sup&gt;</td>
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<tr>
<td>Female</td>
<td>750&lt;sup&gt;1&lt;/sup&gt;</td>
<td>539&lt;sup&gt;4&lt;/sup&gt;</td>
<td>415&lt;sup&gt;4&lt;/sup&gt;</td>
<td>281&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>258&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>MMR</td>
<td>47.25&lt;sup&gt;6&lt;/sup&gt;</td>
<td>55.13&lt;sup&gt;6&lt;/sup&gt;</td>
<td>59.34&lt;sup&gt;6&lt;/sup&gt;</td>
<td>63.08&lt;sup&gt;6&lt;/sup&gt;</td>
<td>66.07&lt;sup&gt;6&lt;/sup&gt;</td>
<td>68.33&lt;sup&gt;6&lt;/sup&gt;</td>
<td>70.25&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>Life expectancy</td>
<td>47.61&lt;sup&gt;6&lt;/sup&gt;</td>
<td>55.75&lt;sup&gt;6&lt;/sup&gt;</td>
<td>60.21&lt;sup&gt;6&lt;/sup&gt;</td>
<td>64.17&lt;sup&gt;6&lt;/sup&gt;</td>
<td>67.36&lt;sup&gt;6&lt;/sup&gt;</td>
<td>69.83&lt;sup&gt;6&lt;/sup&gt;</td>
<td>71.88&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>Water supply coverage</td>
<td>69.8&lt;sup&gt;8&lt;/sup&gt;</td>
<td>84.5&lt;sup&gt;8&lt;/sup&gt;</td>
<td>81.8&lt;sup&gt;8&lt;/sup&gt;</td>
<td>86.5&lt;sup&gt;8&lt;/sup&gt;</td>
<td>87.0&lt;sup&gt;8&lt;/sup&gt;</td>
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<td>Sanitation coverage</td>
<td>22&lt;sup&gt;8&lt;/sup&gt;</td>
<td>43&lt;sup&gt;8&lt;/sup&gt;</td>
<td>41&lt;sup&gt;8&lt;/sup&gt;</td>
<td>59&lt;sup&gt;8&lt;/sup&gt;</td>
<td>87.3&lt;sup&gt;8&lt;/sup&gt;</td>
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<td>Gender development Index</td>
<td>0.75&lt;sup&gt;9*&lt;/sup&gt;</td>
<td>0.77&lt;sup&gt;9**&lt;/sup&gt;</td>
<td>0.832&lt;sup&gt;9***&lt;/sup&gt;</td>
<td>0.885&lt;sup&gt;9&lt;/sup&gt;</td>
<td>0.921&lt;sup&gt;9&lt;/sup&gt;</td>
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Note: GNI, gross national income; IMR, infant mortality rate; MMR, maternal mortality ratio.
*Denotes the data from the nearest date: *1997**2002***2007.
1 https://www.indexmundi.com/facts/nepal/mortality-rate
1a https://www.indexmundi.com/facts/nepal/gni-per-capita.
1b https://www.indexmundi.com/nepal/total_fertility_rate.html.
King Mahendra dissolved parliament, outlawed all political parties, and established a party-less panchayat political system consisting of five tiers of governance, from local to central. The absolute power remained with the king. The party-less panchayat system would rule Nepal for thirty years, until 1990.

In 1956, Nepal entered into a centralized planning system, with the first five-year plan covering 1956 to 1962 (Nepal National Planning Commission 1956). This was the beginning of national-scale public health programs, starting with the malaria eradication project in 1956, followed by smallpox eradication in 1962, family planning and maternal child health (FP-MCH) (Taylor and Thapa 1972) in 1965, as well as tuberculosis (Das 1996) and leprosy control (Mali 1996) in 1965.

Between the late 1970s and the 1990s, Nepal experienced an awakening of consciousness. Political leaders emphasized helping the common people realize their rights. They focused on developing skills, enabling the common people to join local issues of interest and establish a link to national issues. Particular emphasis was given to political freedom, rights, and social justice. During the 1980s, tension could be felt across careers and professions as a result of the political awakening of the common man and woman. Many left their jobs to contribute to political movements. Many promising professionals and students left their urban positions to go back to their villages and volunteer their time and skills to the political parties. The popular ways of mass consciousness-building were through youth, student, schoolteacher, professional, and village informal leaders. Therefore, human investments have had an extremely important bearing on Nepal's social development and transformation, including health. In 1990, political parties formed an alliance of all parties and organized a people's movement, which compelled the king to establish parliamentary democracy with a constitutional monarch. Since 1991, parliamentary democracy started and continues to date.

During the 1990s, people’s expectations reached an aspirational high, and leaders committed themselves to delivering services. Nepal liberalized its economy by entering into the open market system. Gradually, profit and non-profit private organizations brought their initiatives into Nepal for development purposes. The new generation of leaders opened doors to new ideas and encouraged risk-taking in policy decisions. Nepal adopted innovative local initiatives and global best practices from within and outside in all sectors, including health.

In 1991, a multiparty democracy saw the promulgation of a new constitution and new leadership in the country. This era emphasized and further strengthened periodic plans. The overall delivery structure was continued, but
the direction for development shifted drastically toward reaching rural people. In 1991, the first National Health Policy (Nepal Ministry of Health 1991) was enacted and enshrined PHC as the foundation. This was a watershed moment in the development of Nepal’s public health system and is credited for providing much-needed momentum to PHC initiated earlier as the Integrated Community Health Service Development Project (ICHDP) in achieving the health developments Nepal has achieved today.

Unfortunately, during the 1990s, the nation found itself in the middle of another tumultuous period. The multiparty democracy could not live up to the people’s expectations, and the economy especially failed to address the concerns of unemployed youth. The country was once again thrown into conflict, with a section of leaders organizing the Maoist People’s Movement for violent conflict. The Maoists’ goal was to establish a socialist system, including a constitutional assembly election.

Women’s Status in Nepal

Nepal has long struggled with issues related to gender equality. Culturally, Nepal is a patriarchal society, and men have been the dominant decision-makers and actors in households and communities. Nepal used to score very low on measures of gender equality and women’s empowerment, even compared to other South Asian countries (Smith et al. 2003). Son preference exists in Nepal, leading to a gender gap in education and health care-seeking behavior (Pokhrel et al. 2005). In adulthood, gender discrimination leads to high levels of domestic violence and unequal distribution of food within households (Atteraya et al. 2015). Qualitative research of women found that they felt that they and their communities had become more empowered through the 1990s and 2000s, aligning with large efforts to improve gender equality and women’s status in Nepal (Leve 2007). An interesting study by Lauren Leve (2007) explored the meaning behind the large role that women had in the Maoist insurgency in Nepal, including women holding many high-level positions. In the past fifteen to twenty years, Nepal has made impressive progress, as shown in the growth of the Gender Development Index in table 9.1. Evidence exists about women’s empowerment groups providing critical disaster relief and emergency response in their communities (Dhungel and Ojha 2012). As another example, women’s groups that were part of the Nepal health development project identified a need for clean cookstoves in their communities, gained the skills to build these stoves, and then helped their own community members build them and taught their communities how
to use them (Purdey et al. 1994). There are numerous examples of women-led community development projects, and these are only a few. Ultimately, extensive experience with multipronged, multisectoral development interventions led to a wide acceptance that women’s rights are indispensable to realizing all human rights. From this foundation, the seventh constitution of Nepal extended and protected many fundamental women’s rights in 2015.

Gender parity, an idea that once held little meaning within the sociolegal composition of Nepal, today is discussed with significant gravitas. This transformation in national consciousness gained momentum through education and was supported by political movements including the Maoists’ activist actions. Over the years, Nepal’s activists have crusaded against gender disparities to address obstacles faced by women. Recognition of women’s needs and challenges struggled against a culture in which traditional values were laced with male superiority. It gradually was accepted that women face barriers that men may not deal with. Coordinated efforts across sectors were launched for education and consciousness-building among the female population as part of political movements in Nepal. This gave new impetus to Nepal’s women’s movement. The Local Self Governance Act of 1999 made special provisions for women, economically and socially disadvantaged ethnic groups, and indigenous groups to be represented in the village- and ward-level development committees. It also gave operational and management responsibility of health services to village-level committees. Social auditing was used to devolve authority and improve accountability to communities served, especially the poor and marginalized (World Health Organization 2018). What was in the beginning a movement to redress private inequalities gained widespread momentum to affect the public sphere, ensuring women’s participation in various sectors including the parliament and the judiciary and executive branches. Although there is still much to be desired, the recognition of women’s rights as a fundamental right under the latest constitution of Nepal is definitely a step in the right direction.

Nepal’s Health Achievements: What Has Worked?

*Policy, Structure, and Program Evolution: From Past to Present*

Nepal is known to be one of the few countries that has managed to achieve the Millennium Development Goals, despite geographical and economic barriers, and it continues to improve life expectancy even after decades of political instability. This section narrates the changes to the health development
sector over time in Nepal and highlights factors that contributed to health system improvement and improved health outcomes.

Nepal’s Department of Health Services and the Civil Medical School were established in 1933. In 1956, Nepal started a centralized periodic planning system for the development of all sectors, including health, with the first five-year plan (Nepal National Planning Commission 1956). Subsequently, regional development plans and administrative mechanisms were also advanced. Credit is due to academics and development experts of that time for providing technical input into the development plans, especially plans concerning regional development. In addition to the periodic five-year plans, the first long-term health plan spanned the fifteen-year period of 1975–1990 and introduced basic minimum need goals.

In 1972, the Institute of Medicine was established at Tribhuvan University, and all mid-level health training was brought under it. It also started an innovative community-oriented bachelor of medicine and bachelor of surgery program in 1978, a groundbreaking step that helped motivate most medical graduates to work in rural areas. Until the mid-1970s, the focus of health policy was a rather concentrated approach for controlling endemic communicable diseases. These were vertical target projects managed semiautomatically and financed primarily with foreign aid. These were envisioned as short-term, temporary projects, wrapping up as soon as their purpose was achieved. There were efforts to improve public health administration, develop long-range national plans, and ultimately integrate all the vertical projects into the public health system in the 1970s. Subsequently, in 1975, the ICHDP was established under the Department of Health Services and started an agenda of comprehensive PHC. The integration process was piloted in six districts and gradually scaled up. All vertical projects and programs were reorganized under one overall umbrella of the Department of Health Services by 1993.

The aim of the ICHDP was to integrate services provided by vertical projects into district health systems. The system includes district hospitals and district public health offices, under which all peripheral-level health facilities (PHC center, health post, subhealth post) and outreach activities are linked and supported by community-based, salaried village health workers (VHWs) and unsalaried female community health volunteers (FCHVs) to provide an integrated package of PHC services. The ICHDP subsequently institutionalized community participation in health planning within village development committees (VDCs) with the implementation of the Local Self Governance Act.
of 1999. The district public health offices were responsible for the delivery of public health services through health post and outreach activities working together with community-based health workers such as VHWs and FCHVs. By 1985, there were 745 health posts. In the mid-1980s, responsibility for Nepal's basic minimum needs goal was brought under the National Planning Commission, which was managed by the prime minister's office. The reason was to bring all the ministries together for coordinated intersectoral actions.

During the 1980s, a concept was introduced where at least nine ilika (sub-district) health posts (Dixit 1995) in each of the seventy-five districts were to organize PHC through a team headed by a health assistant, who oversaw auxiliary health workers (AHWs), auxiliary nurse midwives (ANMs), and a VHW for each VDC area. A VDC divided into nine small geographical localities called wards. One FCHV was trained in each ward. VHWs are responsible for outreach activities through home visits and by organizing outreach clinics. At the VDC (then panchayat) level, an integrated service delivery package was envisioned to be delivered by FP-MCH health aids, malaria field workers, and vaccinators during early phases of the integration process.

Although Nepal established a Department of Health Services and its Civil Medical School as early as 1933, the seeds of PHC were sown in the late 1950s, well before the Alma-Ata Declaration. It started with the training of mid-level health workers such as male AHWs and female ANMs. These cadres of health workers, though limited, were responsible for providing the first level of care in rural health posts. Earlier, the five vertical public health projects started training their respective community-based workers as frontline workers to deliver basic and proven packages of PHC services at the population level from the late 1950s onward.

Vertical projects had a parallel system of service delivery and were managed outside the Department of Health Services. The focus on PHC allowed the Department of Health Services to maintain its identity and merge available resources to establish the ICHDP in 1975 under the Department of Health Services. Nepal's malaria eradication project, using almost 50% of the total national health budget, had reached its targeted maintenance level by 1972, but there was no basic health service infrastructure to maintain this gain. The external donors were pulling out their previously agreed-upon support. This is when the government changed its policy from a “vertical approach” to an “integrated approach,” establishing the ICHDP. This was a mega-project, born out of an imminent need of maintaining malaria eradication efforts while creating an integrated basic health infrastructure that could deliver PHC services at doorsteps in rural areas.
It was a prescient, pro-poor public health decision. Had this not been done, one or more vertical projects would have dominated the public health delivery system of Nepal, without having any basic structures to deliver PHC services to rural communities. The ICHDP allowed space for all vertical projects to gradually come under one structure.

Evolution of Female Community Health Volunteers

Community mobilization was part of Nepal’s public health program. From early on, different projects deployed salaried community health workers under different names. In the FP-MCH program, they were called health aides. They were called malaria home visitors in the malaria program and smallpox vaccinators in the smallpox program. These three categories of community-based, salaried health workers were unified as VHWs under the ICHDP. FCHVs evolved as an important missing link that ensured PHC services reached households. The ICHDP realized quite early that it was not possible for one VHW to deliver outreach services to all nine wards of a village development area. Thus evolved the idea of piloting the training of one FCHV from each ward of the respective village panchayat (later VDC). FCHVs are ward-based volunteers recruited for training with the support of local mothers’ groups. The FCHV idea was pilot tested based on a twenty-day staggered training module at respective health posts in 1977 (Thapa et al. 1973). FCHV candidates are chosen by local mothers’ groups, and this enhances their acceptability to the people they serve. The ICHDP had piloted the concept of training nonsalaried FCHVs in the late 1970s. In 1988, based on the demonstrated effectiveness of FCHVs, the health minister made the Female Community Health Volunteer Program a national program of the Ministry of Health (Nepal Ministry of Health 1988). The program was subsequently rolled out throughout the country, reaching every ward. The FCHV program’s thirty years of success has made a remarkable contribution to PHC in Nepal.

FCHVs are an interesting example of women (potentially) gaining more status in their communities (Perry et al. 2013) and obtaining a role in which they have the opportunity to impact community health. We might expect FCHVs to be more empowered in their communities because of their role in providing critical health information and services based on the additional knowledge acquired through training and experience. Furthermore, one might expect them to be empowered in their households because of their added income (through limited incentives) and their ability to improve the
Integration of Vertical Projects Started in 1975 and Completed in 1993

- Nursing and Health Assistant Training
- Birth Preparedness & Antenatal Iron Program Pilot ing
- IMNCI
- CBAC
- CB-IMCI
- CB-NCP
- CB-IMCI

Major Vertical Projects:
1. Malaria
2. Tuberculosis
3. Leprosy
4. Smallpox
5. Family Planning/Maternal and Child Health

Legend:
FP: Family Planning
CB CDD: Community-Based Control of Diarrheal Diseases
CBAC: Community-Based Acute Respiratory Illness Care
CBMCI: Community-Based Integrated Management of Childhood Illness
+: Addition

Party-Less Panchayat Rule
Multiparty Constitutional Monarchy
Federal Republic
Promulgated Constitution of the Federal Republic of Nepal

Legend:
FP: Family Planning
CB CDD: Community-Based Control of Diarrheal Diseases
CBAC: Community-Based Acute Respiratory Illness Care
CBMCI: Community-Based Integrated Management of Childhood Illness
+: Addition

CHW: Malaria Field-Worker, Smallpox Vaccinator, Family Planning Health Aid
FCHV: Female Community Health Volunteer
MCHW: Maternal and Child Health Worker
CBNCP: Community-Based Newborn Care Package
↑: Upgradation

Major Events:
1956
1975
1988
1991
1993
1994
1996
1998
2001
2003
2005
2007
2009
2010
2011
2013
2015
2017

- National, Local, and Provincial Elections
- Earthquake
- Royalist Coup
- Peace Accord Signed
- Maoist People's Movement
- Democ racy Movement

- Chlorhexidine
- Nutrition
- Safe Motherhood + Misoprostol
- Nutrition (*Iron folate)
- Nutrition (*Zinc)
- Deworming
- FCHVs Scaled in 1988 and Achieve National Coverage
- Malaria Field-Worker and Subhealth Post
- Urban FCHVs
- CBNCP Partial Scale-Up
- Maternal Child Health Workers and Subhealth Post
- ↑ to AHW
- ↑ to MCHWs HPs
- VItA
- Integrated Community Health Development Project
- CB CDD
- CB CDD + ARI
- CB CDD + CBAC
- CB-IMCI
- CB-IMCI + CBAC
- CB-NCP Expansion Chlorhexidine

- Community-Based Primary Health Care
- Community-Based Newborn Care Package

Legend:
- CB CDD: Community-Based Control of Diarrheal Diseases
- CBAC: Community-Based Acute Respiratory Illness Care
- CBMCI: Community-Based Integrated Management of Childhood Illness
- CB-NCP: Community-Based Newborn Care Package
- CB: Community-Based

Timeline:
- 1975: Community-Based Health Workers Established
- 1993: Integration of Vertical Projects Completed

Note: The diagram includes additional details and connections that are not transcribed here.
health of their households based on the knowledge they have gained. Past qualitative research with FCHVs found that the main reason they worked on this mostly volunteer basis was a sense of obligation to their community and to earn religious merit (dharma) (Glenton et al. 2010; Swechhya and Kamaraj 2014). Previous studies have found that FCHVs valued the recognition from their communities, suggesting that the status component is important (Glenton et al. 2010). Some qualitative research has suggested that FCHVs do feel that their role has empowered them. Specifically some have stated that being a FCHV has given them knowledge to improve the health of their own families (Swechhya and Kamaraj 2014). Because they are self-employed volunteers, they often achieve more respect and power than salaried, community-based health workers such as VHWs. The structure of the FCHV program also potentially provides the opportunity for other women in the community to have a voice and impact because local mothers’ groups and the Village Development Committee are involved in the selection and oversight of FCHVs (Perry et al. 2013). Apart from the government, FCHVs are highly sought after by NGOs intending to promote PHC in communities. In this way, FCHVs are self-employed and empowered women. However, there is still inadequate evidence about whether being a FCHV actually changes a woman’s level of empowerment, either in her household or community, and more definitive work is necessary.

Community-based systems and FCHVs improve access for disadvantaged populations in rural and remote areas and have been effective at carrying out increasing activities over time despite their low educational level and skills at the time of recruitment. FCHVs are selected from the mothers’ groups within each community, and the basic requirement is that she must belong to the catchment area, should be married, and should display interest and willingness to serve as a volunteer for her community. As shown in figure 9.1, the responsibilities of FCHVs have increased over time. FCHV attrition is low—4% of FCHVs leave their posts annually. According to a national survey conducted in 2014, FCHVs had an average of 13.9 years of experience, with 46% of FCHVs having served for sixteen years or more (Family Health Division 2014). In addition to receiving government incentives, FCHVs became a valued resource sought after by several NGOs/INGOs to engage with them in community-level work, which provides additional training and various incentives. These incentives provide direct and indirect benefits that contribute to a supportive environment and recognize the importance of

Figure 9.1. Evolution of primary health care in Nepal.
FCHVs’ work. Nationally, FCHVs are recognized, and Nepal celebrates FCHV day on December 5 nationwide. A dress allowance (blue saris designed with the FCHV logo accompanied by an official name badge) gives FCHVs recognition in the community. The government provided well-designed, meaningful wallboards that are strategically placed to identify each FCHV’s house. Work by FCHVs has been nationally recognized, and good practices are endorsed through the national FCHV day.

Over time, the demographic profile of FCHVs has changed. As of 2007–2008, they were younger, with a median age of 38 and only 4% older than 60, unlike before that time. They are more educated, with 62% of all FCHVs literate (New Era 2008). FCHVs’ current work portfolio includes services related to family planning, HIV/AIDS, maternal and newborn care, community-based pneumonia treatment, diarrhea care, vitamin A and deworming, and immunization. They have remained frontline workers of Nepal’s PHC system to this day (figure 9.2).

Nepal’s community health system has slowly expanded to include a comprehensive package of MCH services delivered by the village teams. The FCHVs are strategically placed as an interface between the formal and community system. Regular contact with local citizens enables them to be cognizant of the problems and concerns of the community. As part of the communities, FCHVs enjoy the advantages of being included in the community-based solving of health problems. Their familiarity with local context gives them communication advantages as compared to outsiders. FCHVs often have personally acquired the ability to identify with pain and suffering, as well as the sociocultural constraints of women in the community. They have come to understand the essentials of a rural woman’s life. Their cultural competence allows other women to share their problems, giving FCHVs a chance to be supportive and search for solutions together. Bonds between FCHVs and women strengthen over time, which in turn helps to build confidence and self-esteem in their fellow mothers. FCHVs’ communication is not limited to mothers’ group meetings. Outreach activities happen during work; while walking to fetch water, firewood, and fodder; in the forest or the field; or in other forums organized for other activities.

Developing a community program on a nationwide scale is a gradual process, as shown in figure 9.3. It is important to recognize that Nepal’s public health leaders have made choices that were locally as well as socioculturally appropriate. Interventions were very strategically rolled out over time and were responsive to emerging common health needs of the population. The stewardship and harmonization of community-level service provision has
been critical. In contrast to workers offering services in a clinic, FCHVs are present in their communities at all times. There is no facility to be absent from and no clinic that can be closed or offer inconvenient hours. The most important dimension of the community is building trust, bonding, and strengthening the traditional cohesiveness around the topic of shared health concerns. Until now, most of the villages in remote parts of Nepal were in a subsistence economy. Relationships with neighbors and relatives are based on shared values and resources. Helping and respecting each other is part of day-to-day life. Elders and mothers are the most respected people. Public health professionals are observant that resolving issues during community meetings along with delivering service strengthens members’ confidence, self-esteem, and

*Figure 9.2. Organogram of Nepal Department of Health Services. Source: Department of Health Services, *Annual Report 2016/17*
A VDC Consisting of Nine Wards: Health Post

Schematic Presentation of a Ward of a VDC: Community-Based PHC and FCHV Catchment Area

- FCHV
- MCH Activities
- Water User’s Group
- Mothers’ Group
- Local Development Processes
- Child Club
- Other Community-Based Organizations Engaged in Development Activities
- Cooperatives
- Other Community Groups and Organization

Local Development Processes

HP: HFOMC
EPI Outreach
VDC: Local Government
AWard out of Nine

A Ward out of Nine

PHC ORC
skills, and increases the likelihood of contact with other persons, including health workers and visitors.

Gradually, the communities have started recognizing FCHVs as their leaders, going so far as to endorse them as informal community leaders. Now, a FCHV’s role transcends just health since they are key stakeholders in local development programs. Over time, FCHV representation has also been mandated by guidelines. A pertinent example is their inclusion on operation and management committees for local health facilities. FCHVs served as election educators in the last election, a decision accepted by all at the national to village level because of the trusted and neutral role they play in communities. For the past several years, FCHVs have increased their representation in women cooperatives, water user groups, and other village development initiatives. In the last election, a sizeable number of FCHVs campaigned for leadership, and many of them have been elected to serve in their local government.

The Era of Democratic Government: Beyond 1990

Nepal’s political transition from the traditional, party-less panchayat system to a multiparty democracy opened new doors of opportunity for expanding health and development interventions. In 1991, the health minister for the interim government formulated the first National Health Policy (Nepal Ministry of Health 1991). The new democratic government’s National Health Policy in 1991 identified the reasons behind the poor improvement in health. It was attributed to weakness in implementation of preventive, promotive, and curative health programs at the grassroots level (Nepal Ministry of Health 1991). The statement set out a goal to expand services to peripheral levels. The focus concentrated on reducing child and maternal mortality, reducing fertility, and increasing life expectancy. The 1991 first National Health Policy prioritized resource investment to further scaling of the PHC services by establishing subhealth posts along with increased human resources. These new investments promoted health research, community participation, better monitoring, better supervision, and better mobilization of resources. A new organogram developed to realize the objectives as policy evolved.

The 1991 National Health Policy further prioritized and revitalized health care service delivery at the community level and made services accessible to

Figure 9.3. Village development committee and female community health volunteer catchment area.
<table>
<thead>
<tr>
<th>Events</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health Service Established</td>
<td>1933</td>
</tr>
<tr>
<td>End of Rana Regime</td>
<td>1951</td>
</tr>
<tr>
<td>Insect Borne Disease Control Bureau</td>
<td>1952</td>
</tr>
<tr>
<td>Nepal General Election-Parliament</td>
<td>1959</td>
</tr>
<tr>
<td>King Mahendra Dissolved Cabinet</td>
<td>1960</td>
</tr>
<tr>
<td>Constitution-Established Party-less Panchayat System</td>
<td>1962</td>
</tr>
<tr>
<td>The Food Act</td>
<td>1966</td>
</tr>
<tr>
<td>First Long-Term Health Plan</td>
<td>1975</td>
</tr>
<tr>
<td>Expanded Program on Immunization</td>
<td>1977</td>
</tr>
<tr>
<td>National Immunization Program</td>
<td>1979</td>
</tr>
<tr>
<td>Control of Diarrheal Diseases</td>
<td>1983</td>
</tr>
<tr>
<td>Solid Waste Act; Control of Acute Respiratory Infection Program</td>
<td>1987</td>
</tr>
<tr>
<td>Higher Secondary Education Act; Nepal Drinking Water Corporation Act</td>
<td>1989</td>
</tr>
<tr>
<td>Nepal Health Research Council Act; Nepal Agriculture Research Council Act; National Health Policy; Pesticides Act; Birth, Death and Other Person or Private Incident Act</td>
<td>1991</td>
</tr>
<tr>
<td>National Blood Policy; Council for Technical Education and Vocational Training Act; Primary Health Care Outreach Strategy</td>
<td>1993</td>
</tr>
<tr>
<td>National Drug Policy; National Mental Health Policy; National HIV and AIDS Policy</td>
<td>1995</td>
</tr>
<tr>
<td>Iodized Salt (Production, Sale, and Distribution) ACT; Human Body Organ Transplantation (Regulation and Prohibition Act; Nepal Veterinary Council Act; Slaughter House and Meat Checking Act; Local Self-Governance Act; Local Self-Governance Regulations; Community-Based Integrated Management of Childhood Illness (CBIMCI) Program</td>
<td>1999</td>
</tr>
<tr>
<td>Poverty Alleviation Ordinance; National Safe Abortion Policy; National Health Research Policy of Nepal; Strategic Plan for Human Resources for Health; Nepal Health Sector Strategy; National Guidelines for Counseling, Testing, and Referral Drinking Water Management Board Ordinance; Drinking Water Tariff Charge Fixation Commission Ordinance; Human Rights Commission Ordinance; Information Technology Academy Ordinance; Poverty Alleviation Fund Ordinance; Safe Delivery Incentive Program</td>
<td>2003</td>
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<tr>
<td></td>
<td>2012</td>
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<td></td>
<td>2014</td>
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<tr>
<td>Dates</td>
<td>Events</td>
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</tr>
<tr>
<td>1934</td>
<td>Civil Medical School Established</td>
</tr>
<tr>
<td>1952</td>
<td>Total Hospital Beds 600</td>
</tr>
<tr>
<td>1956</td>
<td>Nepal Malaria Eradication Organization; Five-Year Periodic Plan Started, First Nursing Training Started</td>
</tr>
<tr>
<td>1960</td>
<td>Established National Planning Commission</td>
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<tr>
<td>1961</td>
<td>Banned Political Party</td>
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<tr>
<td>1964</td>
<td>Nepal Citizenship Act; Small Pox Control Act; Infectious Disease Act; Nepal Medical Council Act</td>
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<tr>
<td>1971</td>
<td>National Education Committee Act; Education Act</td>
</tr>
<tr>
<td>1976</td>
<td>Birth, Death, and Other Personal Event Registration Act; Narcotics Drugs (Control) Act</td>
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<tr>
<td>1978</td>
<td>Drug Act; Under-graduated Medical Program Started</td>
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<tr>
<td>1982</td>
<td>Natural Calamity (Relief) Act; Disabled Persons Protection and Welfare Act; Disaster Management Policies in Nepal</td>
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<tr>
<td>1986</td>
<td>Trafficking in Human beings (Control) Act</td>
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<td>1988</td>
<td>Ayurveda Medical Council Act; Female Community Health Volunteer (FCHV)</td>
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<td>1990</td>
<td>Municipality Act; District Development Community Act; Village Development Community Act; Communication-Related Act</td>
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<tr>
<td>1992</td>
<td>National Dairy Development Board Act; Children’s Act; Water Resources Act and Regulation; Mothers Milk Substitute (Control of Sale and Distribution) Act</td>
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<tr>
<td>1994</td>
<td>Nepal National Policy on Sanitation</td>
</tr>
<tr>
<td>1998</td>
<td>Drinking Water Regulation; Safe Motherhood Policy; FCHV Strategy</td>
</tr>
<tr>
<td>2004</td>
<td>Education (Eight Amendment) Ordinance; National Nutrition Policy and Strategy; Rural Water Supply and Sanitation; National Policy and Strategy; Health Sector Strategy; An Agenda for Reform; Nepal Health Sector Program-Implementation Plan (NHSP-IP); SWAP Adopted; National Neonatal Health Strategy; Nepal Red Cross Society Health Policy</td>
</tr>
<tr>
<td>2009</td>
<td>Domestic Violence Act; Aama Program; Community-Based Newborn Care Package; Five-Year Operational Plan for In-Service Training of Skilled Birth Attendants; Health Sector Gender Equality and Social Inclusion Strategy; National ART Gridlines</td>
</tr>
<tr>
<td>2016</td>
<td>Human Organ Transplant Act; National Strategy for Reaching the Unreached; Directive for Treatment of Ultra Poor (Bipanna) Fund; Nepal Health Sector Strategy; Implementation Plan</td>
</tr>
</tbody>
</table>

Note: The first Constitution Assembly Election of the Federal Democratic Republic of Nepal was held in 2008, but the assembly failed to finalize the constitution and the second election was held in 2013. The assembly promulgated the constitution of the Democratic Republic of Nepal in September 2015. The constitution established three levels of government, and the election for all levels was held in 2017; since then, all the levels of government are in place.
even the remotest communities. It considered sociocultural context and viability, and therefore trained health workers to have expertise and sensitivity to these factors. It was designed to have adequate supervision of the system and to be suitable to reach the rural, underserved, and disadvantaged populations. Over a period of several years, the public health system decentralized, and specific policies, protocols, and guidelines on health service delivery, human resources, health information systems, and the cost of services guided the health delivery mechanism. The policy milestones shown in table 9.2 illustrate that Nepal’s health policy environment was progressively evolving over the decades since the 1960s. Policy changes had been initiated based on the application of established international best practices and informed by the results from local pilot and feasibility studies. One of the best examples for research translated into program policy was the vitamin A supplementation program among children aged 6–59 months (Gottlieb 2007).

Nepal was able to attract foreign assistance and received substantial resources to support government efforts for scaling up evidence-based interventions, and government investment in public health priority sectors increased after 1991. This was primarily due to advocacy by health professionals and civil society along with responsive leadership. Since the adoption of a sector-wide approach in 2004, fragmentation and duplication have been greatly reduced. Subsequent joint annual work plans and a review process undertaken together with stakeholders assisted in maintaining a less fragmented approach to program planning and implementation, and has created more ownership, joint accountability, and strong government stewardship. There was strong national ownership and stewardship of the health strategy especially after the initiation of the Nepal Health Sector Strategy Implementation Plan, which was first started in 2004 (Nepal Ministry of Health 2004). Currently, Nepal is implementing the third plan (2016–2021), along the lines of the second long-term Health Plan and National Health Policy 2014.

The primary orientation toward providing essential health care services for free has been sustained through changes in the political system. The Nepalese health system utilizes a mix of public and private service delivery. There is a degree of coordination and support from nonprofit and for-profit sectors for selected public health interventions or selected areas. Notable examples are FP-MCH services. The Ministry of Health is the sole guarantor of publicly funded health services for rural, disadvantaged, and underserved populations. The health policy is developed, standardized, and governed at the central level by the Ministry of Health.
Health services are delivered from the central level to the community level, as shown in figure 9.3. The community level includes the VDC and the ward. PHC services at the VDC are delivered through health posts, which are staffed by salaried employees of the Ministry of Health: health assistants, AHWs, and ANMs. The nonsalaried FCHVs provide PHC at their respective ward with technical backup support of the health post for their VDC catchment area. The PHC services are provided below the VDC in two modes:

1. At the community level, there are regular periodic outreach activities that are organized from the health post and coordinated and supported by the FCHVs. The outreach packages, including health promotion, are provided by teams consisting of an AHW, an ANM, VHWs, and a FCHV, who sensitize the community well before each of the outreach events. The outreach teams offer almost the full range of outreach services as those provided by the health post.

2. At the ward level, routine services are provided in the community by FCHVs. This cadre of service providers delivers a basic, routine essential services package that has expanded over time. These services include elements of essential maternal and newborn care, child health services, family planning, antenatal care, immunization, and nutrition, as well as distribution of vitamin A and iron tablets to pregnant women, awareness of HIV/AIDS, the importance of using condoms for safe sex, and avoiding reuse of used syringes. These PHC services provided by FCHVs are linked with formal referral services at health posts, district hospitals/district health offices, and zonal hospitals. The establishment of health facilities in each VDC, with its regular monthly outreach clinics delivering scientifically proven and operationally feasible interventions at the community level, was the most significant contribution for achieving high coverage with equity accruing good health outcomes.

Nepal’s health system introduced reforms in the comprehensive sense of Alma-Ata, and the platform of delivery and community participation also upheld this vision. Community health workers such as VHWs and FCHVs are the backbone of public health in Nepal to date. They are conveniently located in communities to address health across multiple sectors, and they provide scientifically tested, nationally prioritized packages of health interventions at the defined platforms of the community.
Modern Drivers and Movers of Health Development in Nepal

The Constitution of Nepal 2015 guarantees that “every citizen shall have the right to free basic health care services from the state, and no one shall be deprived of emergency services.” These results have not been an overnight success. Progress began more than fifty years ago, with the intensity of the efforts increasing in the 1980s. The struggle was for the recognition of fundamental rights, especially freedom of organization, speech, and association.

As one of the signatory countries, the government of Nepal endorsed and committed to implementing the Alma-Ata Declaration. The principles of the Alma-Ata Declaration were woven into the country’s integrated community-based health service system as appropriate.

Despite political instability, social consciousness has steadily increased. People have harnessed their rich cultural traditions that encourage cohesiveness and community kinship. People have used traditional norms of solidarity to find their unique path in maintaining functional local communities even during the country’s weakest moments. Although the Panchayat era severely restricted the growth of civil society and community group initiatives, it established several community-based public health programs, including FCHVs, which have become the foundation for PHC. The tide began changing in 1991, with the growth of civil society and community groups. Since then, nongovernmental organizations, community groups, and users’ groups have started to directly involve themselves in the local development process, and they have become development partners in government efforts. More importantly, they have taken a place as free voices in a democratic society.

For a long time, political instability had been a part of Nepal’s political sphere. Nepal has made steady progress toward stable government and basic law enforcement but very slow progress controlling corruption. At the community level, different mechanisms evolved including social auditing and users’ groups for village-level development projects (e.g., water user and forest user groups). In the health sector, establishment of the mothers’ groups in each ward of the VDC and organization of health facility operation and management committees are examples of institutions with limited roles but that offer points of entry for people to express their voices. These also served as watchdogs for service accountability, alongside NGOs and community-based organizations and users’ groups.

For the past twenty-five years, Nepal, with its low gross national income, has been contributing a minimum of 3% to a maximum of 7% of the national government budget to the health sector. Since the sector-wide ap-
A progressive approach has started, Nepal has also succeeded in garnering donors’ support in a progressive manner. For the first time in 1995–1996, the central government started providing 300,000 rupees (about $US2,700) as a development grant directly to all the VDCs. This paved the way for local bodies to prioritize local needs. Until then, only centrally itemized budgets went to the VDC level; thus, the opportunities for development of local needs were infrequent. The guideline of the village development fund mandated that its 5% had to be invested in social sectors, including health. The amount increased as time went by, and it served as a catalyst for cascading locally prioritized development activities that facilitated its local ownership among four thousand VDCs then in the country. This decision has a historic bearing for the grassroots movement and has had a tremendous impact in the health sector.

Maintenance of Health Systems Despite Political Conflict

While there were negative consequences of the Maoist People's Movement, there were some collateral benefits that came from it. The Maoist People’s Movement led to a social awakening of the people, especially regarding fundamental human rights. Although the movement was violent, participants characteristically refrained from hostile acts toward health facilities and activities. Even during the first national measles vaccination campaign, conducted during a time when the western districts of Nepal were ravaged by conflict, the Maoists allowed access to the program. During intense periods of conflict, during which the government was absent at VDCs and subdistricts, community members had to devise their own strategies to ensure physical access. Some health services were continuing during the conflict in rural and remote areas. Wherever the Maoist Party was, all government activities were under surveillance, and thus projects were made accountable and retention of health workers improved. Therefore, despite the conflict Nepal’s public health indicators continued to progress during this period. Gender equality, abolishing the caste system, and inclusion of the rights of ethnic minorities were among the important social agenda items of the Maoists and are important issues in Nepal’s context. The Maoists recruited women within their ranks and attempted to implement education and awareness programs in communities where they had a stronghold. This gave rise to an unseen but healthy competition between the government and the Maoists. Consequently, the government also increased participation of women in the Nepal Army and the Nepal Police, as well as in other sectors. Ultimately, through a peace accord both sides came into agreement and continued to pursue a progressive movement.
agenda together. Finally, the 2015 Constitution of Nepal mandated a one-third female composition in parliament and also other ethnicities’ and castes’ representation in different positions.

Conclusion and Lessons

Nepal’s achievements were not an accident but required conscious effort in policy formulation, implementation, and community mobilization by the health system over time, with review and lessons drawn periodically. A progressive policy environment, early piloting of community involvement, establishment and recognition of community volunteers, and initiation of interventions with clear objectives were important turning points for health in Nepal before the 1990s. Appropriate selection of interventions, utilization of global evidences, and local research for the development of a national system began as early as the 1970s. Placing mid-level health workers for service delivery together with VHWs and FCHVs at an interface between the national health system and the community in the public health delivery system was appropriate and successful. Careful introduction of interventions, empowerment of FCHVs for delivery of selected interventions, and development of a well-supported, community-based health system helped attain high coverage that was sustainable. More recently, civil society movements, improved literacy and women’s status, and improved demand for services facilitated by better road access, communication, and media were linked to an improved supply of services. Progress in health development was possible because Nepal’s public health leaders made a deliberate choice to identify and maintain strong community engagement in health facilitated by the FCHVs (see box on page 221).

Historically, Nepal faced the challenge of preventing appallingly high rates of maternal and child mortality, with a severe lack of materials, budget, and trained health workers. Universal home delivery of infants was the historical norm. In order to meet these challenges, Nepal took initiatives that have worked well.

Unlike in neighboring countries, the Family Planning Programme developed in Nepal as an integral component of MCH. The system created a new cadre of community-based health workers together with FCHVs in every village. Working together with local health posts and with a technical backstop of respective district health offices, they form the backbone of Nepal’s health system today.
Case Study of one Female Community Health Volunteer: 
A Common Happening in Villages of Nepal

Maya Devi Thakuri is a 57-year-old female community health volunteer (FCHV) in the Dailekha district, a remote village in Nepal. She is also an active member of a cooperative and participates in the local community forestry group. She is a devoted crusader for the Water and Sanitation User’s Group during the regular village drinking water and Sarsafai (cleanliness) Campaign.

It’s time for Maya to resume her responsibility as the moderator in the forthcoming monthly mothers’ group meeting. It is scheduled to begin tomorrow, and there are important items to be discussed along with regular updates and education. The proposed agenda items are the upcoming biannual vitamin A supplementation and deworming campaign, the campaign for measles supplemental immunization activities, and contribution to the declaration of open defecation free village, as well as regular updates. This morning Maya met with Rup Kumari, a 20-year-old Dalit woman who is from a more remote part of her village, to discuss health issues. Maya has specifically invited Rup to attend the upcoming meeting.

Compelled to drop out of school at age 12 to help support her family, Rup joins an adolescent life-skills program facilitated by FCHVs. There she is exposed to various issues pertaining to her sexual and reproductive health, and grows to understand the reason behind the death of her mother’s firstborn son. Married at the age of 12, twenty-five years earlier, her mother suffered the loss of her first child at the age of 15. Learning from this, Rup chooses to marry Krishna, whom she has known for several years, but decides to wait until she is 21. They then adopted a temporary family planning method, which they receive from the FCHV regularly. Two years later, Rup and Krishna decide to have a child. In the previous mothers’ group meeting, she was informed about the benefits of antenatal checkups as well as danger signs to look out for during pregnancy, delivery, and the postpartum period.

Subsequently, a pregnant Rup attends a health post primary health care outreach clinic, and the FCHV lends support by accompanying her there for the first time. She gains further information during antenatal care. Having already received two tetanus toxoid injections, she makes sure to take iron and folate regularly during her pregnancy. On her final visit, she is advised to go to a primary health care center (PHCC), where a skilled birth attendant is available.

Rup and Krishna put aside some rupees as suggested by the mothers’ group, and Krishna discusses transport options with his neighbors for when she enters into labor. When Rup goes into labor, friends help carry her to the nearest PHCC. There, Rup is examined by Jhuma Limbu, an auxiliary nurse midwife and a skilled birth attendant. In a normal procedure, Rup gives birth to a healthy baby girl, whom Jhuma dries and wraps after washing her hands with soap and water. Jhuma waits for the umbilical cord to stop pulsating, then clamps and cuts it with a sterile blade and applies chlorhexidine to the cord stump. Rup immediately puts her new baby on her belly to keep her warm and commences breastfeeding. The baby also receives 200,000 IU of vitamin A.

Three days later, Rup and her daughter are visited by a FCHV, who confirms that her
supplies of iron and folate are replenished. She discusses exclusive breastfeeding, family planning, vaccination of her baby in six weeks, and vitamin A supplementation, but only after her child reaches six months.

The FCHV counts her supplies and prepares her report, which will be submitted for review at the monthly FCHV meeting at her health post next week. There, all of the FCHVs will discuss their progress and the challenges of the past month and plan for the next.

Thousands of mothers across Nepal are receiving such care and support from FCHVs each day. Over the course of the past twenty to twenty-five years, FCHVs have changed the landscape of access to PHC services in Nepal.

Community-based health workers were responsible for delivering a set of safe and proven basic MCH-FP technologies. A few examples of these are health education and communication about basic hygiene, family planning, a homemade oral rehydration solution (Noon-Chini Aushadhi Paani) that cuts diarrhea mortality by half, immunization, the promotion of breastfeeding, infant and child nutrition, and the treatment and prevention of protein-calorie malnutrition with homemade and affordable foods such as sarbottam pitho. There are many other examples.

With the imminent risk of malaria reemergence in 1970s, the government changed its policy from a vertical to an integrated approach, creating an integrated community health services development project. This project focused mainly on delivering the basic health care provided earlier by five vertical projects through health assistants, community-based VHWs, and FCHVs.

Along with the integrated community health services development project came the establishment of the integrated district health offices, which pooled the district-level resources of the previously existing five vertical projects. For example, the resources of twenty-five FP-MCH district offices established by 1971 were reorganized under the integrated district health offices. By the end of the sixth five-year plan (1980–1985), an integrated health care delivery system was operational in forty-eight out of seventy-five districts. Over time, Nepal's national health system evolved into a community-based pyramid whose base was rooted at the community level.

An appropriately designed scale-up plan guided strategies to target the population through a suitable selection of delivery platforms together with meaningful community participation. Having national ownership and stew-
ardship of the PHC approach was critical for Nepal’s past health development. The country is now scaling up universal coverage through a strategy of health insurance. The lessons learned from Nepal’s comprehensive and result-oriented PHC offer an excellent foundation for future health development.

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Nepal Family Planning. 1988. Female Community Health Worker Program.


