

5.

DEVELOPMENT OF HEALTH SERVICES

The present health status of the people may be said to be the result of efforts, which followed the ushering in of a democratic government following the ending of the 104 years of Rana feudal rule in February of 1951. The pre-plan period was followed by the first elections and the installation of the government. Stability however, was not to be attained and the removal of the duly elected government in mid-December, 1960 was the harbinger of 30 years of Panchayat rule. This indigenous system of government, said to be in tune with the conditions existing in the country saw a total of six plans over the course of three decades. The *jana andolan* or “peoples’ movement” in April of 1990 was expected to bring about major changes in the matter of governance and benefits to the people. The new health policy, with stress on rural health care, which had been put forward by the Nepali Congress government, led to great expectations. Later the official documents of the Ninth and Tenth Plans and the second Long Term Health Plan were introduced. The plans, though high sounding, were not properly implemented and there was much to be desired. The political changes that followed and the installation of various coalition governments has resulted in some modifications of the original plans for health prior to attempts at implementation. The last decade of the 20th Century also saw the setting up of many medical colleges across the length and breadth of the country. This may be the harbinger of the Public and Private Mix, which had been talked about for some time. One hopes that this will lead Nepal to being turned into a country with a strong education and health service sectors.

It will be rational to consider the development of the health services in the context of the various Plans, which have been made and implemented since 1951 (1).

The pre Plan Period, 1951-1956.

During these early years stress was laid on the training of doctors under the Colombo Plan in India. A nursing school, based at the Bir Hospital was established with the aid of WHO. The first NGO hospital to be started was one by the United Mission to Nepal, which was started in a part of then existing Cholera Hospital run by the government.

In 1951 an ambitious plan was made for establishing a number of well-staffed health institutions in different parts of the country. The categories decided upon included health posts, health centres, district, and zonal, central and national hospitals. Whilst the health posts would be manned and run by a health assistant there would be a physician on duty in all the health centres.

The number of hospitals providing curative health care in 1952 was just 33. The health manpower running these consisted of some basic level workers called compounders who distributed medicines and gave injections plus dressers who applied dressings to wounds. The doctors of whom there were just about 50 in the whole country supervised such workers.

Because of these limited facilities, the population, which could avail of the health facilities provided by the government, was a very minute percentage of the estimated 8.47 million people of the country. The life expectancy at that time was just 28 years and the IMR was 255/1,000 live births (2).

There were few urban centres, the number of municipalities being just 10 in 1954 (3). The capital had limited drinking water facilities. Piped water was by way of the reservoirs at Sundarijal, Panipokhari and Pharping. Many of the ordinary folk used water from the various *dhunge dharas* or the stone waterspouts. Some of the other urban centres had minimal water supply facilities.

It was felt at that time that it would be wise to clear some of the Terai areas of the dreaded malaria as these areas could be made agriculturally productive. The expected growth in population and possible migration from the other hilly areas gave further impetus to this task. So a project for Malaria Eradication in Chitwan valley was started in 1953. The Rapti Valley Multi Sector Development Project started the following year in 1954.

The Health statistics in the country prior to the starting of the First Five Year Plan in 1956 were as follows (4):

Hospitals were 34 with a total of 625 beds.
Dispensaries were 24 in number.
Ayurvedic *aushadhalayas* were 63 only.

The First Five Years Plan, 1956-61

During this first plan period more emphasis was laid on the curative aspect of health. Nevertheless, the Nepal Malaria Eradication Organisation (NMEO) programme in the Chitwan valley went into full swing and geared towards the eradication of malaria and resettlement of the hill people in the Terai region.

In keeping with the expected expansion of the health services an organisation of the Ministry of Health was done in 1956.

Though the decision to start a Nurse Training School at the Bir Hospital had been taken in 1954, the first intake of girls took place only in 1956. As a result the first batch of thirteen nurses were produced in 1960 (5).

To provide basic health care in the rural areas it was decided to start the training of middle level health workers. Thus a Health Assistant Training School (HATS) was started in 1955.

A Nurses' Training Centre, established in Hetauda in 1958 was later moved to Bharatpur in the Rapti Valley for the training of Assistant Nurse Midwives for service in the rural areas (2).

With the focus on the curative aspects some upgrading and even modernisation of the existing hospitals was done. Together with this however there was also further organisation of the NMEO in 1958.

Additional curative facilities included the building of the first Maternity Hospital (Prasuti Griha) in 1959. Though there were 34 hospitals with 160 doctors, the number of health posts in 1961 was 24 and the estimation was that only 7% of the 9.4 million people in the country were being served by a health facility (2).

Second Plan Period, 1962-65

At the start of this plan period in 1962 the population stood at 9.8 million with a life expectancy of 33 years. The emphasis on the curative aspect was continued but more stress was laid on the preventive aspects of health during the course of this three-year plan period.

The preventive or the public health aspects were stressed by a smallpox survey being started in 1962 with the objective of eradication of the dreaded disease in the future. Soon after this, pilot projects for control of two other major diseases were started:

Leprosy control in 1963.

Tuberculosis control in 1965.

Royal Drug Research Laboratory was established in 1964.

The Assistant Nursing Midwife Programme started in 1962 with the establishment of a training school at Bharatpur. Perusal of manpower records of health personnel showed that there were a total of 450 auxiliaries trained since 1934. The different schools, which imparted this training, were - Nepal Rajakiya Ayurved Vidyalaya, Civil Medical School, Health Assistants Training School (HATS) and AHW School.

The number of health posts opened in 1964 was 9. By 1965 the National Health Survey, which had been done recently by Shah and Worth, was made public. There were by this time, as per government records, a total of 102 health posts in existence. The number of hospitals providing very minimal health services was 36. Some vertical projects such as malaria eradication, smallpox eradication, TB and leprosy control projects and FP/MCH services were in place.

Third Plan Period, 1965-70

Though the stress was still on the curative aspects of health care it was accepted that more focus on prevention was necessary. This was apparent for provision was made for this in the planning and the budgeting process. There was a thinking in 1966 to have as many as 32-district health centres categorised into two groups A and B. The sixteen of Type A were to have a posting of two medical officers, of which one would be female. There would only be one male doctor in the remaining 16 health centres of Type B (6).

The concept of provision of rural health service led to more health posts. The building of additional new health posts in 1970, resulted in a total of 113 at end of this period.

The stress on prevention led to the establishment of Vertical projects such as:

Leprosy Eradication Project launched in 1965.

Smallpox Eradication Project in 1967.

Family Planning & Maternal Child Health Project in 1968.

This meant that HMG, enthused by the possibility of eradication of smallpox, even considered the same for leprosy.

Though investigative pathological support for the patients at the Bir Hospital was available, the starting of the Central Health Laboratory in 1967, initially within the precincts of the hospital compound heralded thinking for the start of laboratory facilities on a countrywide basis.

Fourth Plan Period, 1970-75

The life expectancy had by now gone up to 42.3 years and the IMR had come down to 157/1,000 live births. The fact that the population which stood at 11.4 millions in 1971 had gone up to 12.9 millions in 1975 drew the attention of the planners to the fact that population control should be taken seriously.

More emphasis was laid on preventive aspects of health care than just the provision of curative services. The training institutions for the production of various grades of middle and basic level health workers was shifted in 1972, from being under HMG/Nepal to the Institute of Medicine under the Tribhuvan University. The training of various new categories plus upgrading courses for existing health workers were started not only in the capital but also in other parts of the country.

In 1971 a pilot project was started in Bara district under the name of Integrated Basic Health Services. Objective was to provide the basic minimum health services to the maximum number of people. A similar project was started in Kaski in 1972. Finally, an evaluation of both the projects was done in 1975. It was as a result of this that the old health post gradually became converted to integrated types and the other new posts being opened were of this type. Thus health posts became the peripheral unit of the health services, providing not just simple curative services but also stressing on preventive and promotive aspects of health care. This was the start of the provision of an integrated health service to the people (7).

Whilst in the past the different vertical projects would send in separately their health statistics, these now came in an integrated fashion. This also put the statistics coming in a composite manner, allowing the overall impact to be assessed. Thus whilst a total of 2,500 cases of malaria were seen in 1972, what was disheartening was the recurrence of these cases of malaria in 1974. Karki in a review of global smallpox eradication stated that Nepal had been classified as non-endemic since 1973 (8). On the other hand the notification and the recording of the last case of smallpox seen in Nepal was in 1974. This particular case was thought to have been due to importation from adjoining areas of India.

During this period the Community Health and Integration Division (CHID) was set up to reduce duplication and to make health programmes cost effective. This division also tried to integrate vertical projects under the administrative body.

Health manpower consisted of 311 physicians and 900 nurses plus auxiliaries in 1971. A subsequent count by a separate source put the number of doctors at 288 in 1974. A year later in 1975, there were said to be a total of 348 physicians.

A total of over 1,000 health workers of the basic level (paramedics such as AHW, ANM) and middle level such as health assistants had been trained by IOM. During this time the DoHS trained the village health workers (VHW), the FP/MCH section of the DoHS trained panchayat based health workers (PBHWs).

Towards the end of this period a Long Term Health Plan of 25 years was contemplated. An initial effort was later modified to make this into a 15-year plan for the years 1975-90. This particular document stated that by the end of the Fourth Plan Period the existing health institutions numbered:

Hospitals: 62 with a total of 2,174 beds.

Health centres: 33, where services of a doctor, was available in the out patients.

Health posts: 351, all over the country had health assistants as the personnel in charge.

Ayurvedic *aushadhalayas*: 82 in total.

Fifth Plan Period, 1975-80

Population increased from 12.9 millions in 1975 to 13.9 millions in 1978 and to an estimated 14.0 millions in 1979.

Estimates in 1977/78 showed that the life expectancy had gone up to 46 years and the IMR had been reduced to 145/1,000 live births.

Further steps were also taken to integrate vertical programmes into a health infrastructure capable of providing effective services to the people.

The IoM increased its efforts on health manpower production to meet the expected increased requirements because of the expanding health services.

The manpower for the health services showed in 1978 a relatively larger increase in the lower basic and middle levels. The official figures were about 1,000 VHW, 450 FP/PBWs, 2,000 middle level workers at the health posts and hospitals, over 3,000 malaria workers. Physicians numbered 375. All this was in keeping with the increased demands.

Nepal having signed the HFA 2000 document at Alma Ata in 1978 had accepted primary health care as being an effective method by which essential health services were to be provided to the community in an acceptable and affordable way, and with their full participation

By 1979, the number of physicians in the country had risen to 457. The number of hospitals at this time was 69 whilst the number of health posts was 483, of which 233 had been integrated.

Estimated IMR in 1976 was 134/1000 live births.

The First Long Term Health Plan (FLTHP), 1975-1990

One of the planners during the course of an informal repartee remarked that the reason for the compilation of this first Long Term Health Plan was basically to ensure consistent and proper functioning of the health services in an environment prone to be subjected to the personal whims of the political leaders and their technical and non technical advisers.

The Long Term Health Plan (LTHP) for the period 1975-90 had been developed and became official. There was no departure from the previous policy of gradual expansion of basic health care to the major section of the population living in the rural areas. Popularising family planning, plus maternal and child health gave more emphasis to checking population growth.

A mid term evaluation of this FLTHP was so critical that the actual document regarding this was never distributed.

Sixth Plan Period, 1980-85

Life expectancy at birth estimated to be 53 years for men and 50 years for women.

This plan's real intention was that "Nepalese shall not live by health alone." Among the stated stresses were increasing food supply plus the provision of clean drinking water. It was because of this second intention that Nepal started observing the International Drinking Water Supply and Sanitation Decade (1981-90) at the call of the United Nations. The idea was that with the improvement in water supply and sanitation, a major part of the causes of ill health would be done away with. Major steps were to be the checking of population growth for until such time as this was done, the improvements in the health status of the people was not expected to rise appreciably.

The number of urban centres e.g. municipalities had reached 29 by the year 1983 and some form of health facilities were provided at these urban settings. Up to this time there were still eighteen districts without a hospital. There were a total of 745 health posts in the country, with one being operated by the Institute of Medicine at Mahankal as a training site. Of the health posts 450 were integrated and provided a full range of health services including field visiting by VHW. The scheme was that by the end of this period a total of 26 health centres were to be upgraded to hospitals or downgraded to health posts or even phased out as per the Long Term Health Plan.

Round about this time when the concept of Basic Minimum Needs (BMN) came up, that pertaining to health needed to be identified. It was in line with this that following a workshop at Kathmandu, the idea of "COMBINA" as a Nepalese version of Basic Minimum Health Needs (BMHN) was mooted. This anagram denoted:

- C for child spacing
- O for oral rehydration
- M for maternal & child health
- B for basic natal care
- I for immunisation
- N for nutrition
- A for ARI - acute respiratory infection.

Health care at the grassroots level was to be provided by way of VHWs at the health posts, be they integrated or static. After fairly extensive debate the concept of VHWs was finally accepted and some effort was to be made to include this in future plans. The strategies of COMBINA were however never really implemented.

The Basic Minimum Needs goal was officially enunciated in 1985 and the Nepalese were promised that they would reach the Asian Standard. This Asian Standard was rather vague and the average Nepali did not know which Asian country's standards he was destined to attain! The National Planning Commission later produced a "Basic Needs" list, for the original promise of the Asian standard needed defining. It was on the basis of this that the caloric value of the average Nepali diet was made the yardstick to segregate people into those above or below the poverty line.

However even at this early stage discussions were underway for "attracting private investors in the development of rural and urban health services."

Seventh Plan Period, 1985-90

Organisational integration had been completed more or less by 1987 at the peripheral level and by 1990 at the central level. Because of this, data reporting had been integrated in 27 out of the 75 districts of the kingdom by this time.

A national Health Information System was being developed by HMG with WHO collaboration and has been functioning since 1988. It is being tested out at Dhading and Sarlahi. The number of Health Institutions by types that existed in September of 1985 was as given below:

Table 5.1. Number of health institutions by types.

| | |
|---------------------------------------|------------|
| Health Posts | 744 plus 1 |
| Health Centres | 26 |
| District Hospitals | 44 |
| Zonal Hospitals | 9 |
| Central Hospitals | 5 |
| Other Hospitals | 23 |
| Total Hospitals in the country | 81* |

* Corrected figure in later documents is just 79.

Emphasis was on basic minimum health needs (BMHN) of the people of which primary health care and sanitation were but two. The objectives of the plan included reducing IMR to 98/1000 live births, Total Fertility Rate (TFR) to 4.00 and increasing life expectancy to 55.4 years by the year 1990. Estimated IMR then was 111/1000 live births.

Bed: Population Ratios Nepal

At the end of the Seventh Five Year Plan period there were 12 districts without any hospitals and thus no facilities for patient admission. The old

health centres, though having a post for a doctor, had no facilities for admission like that of the PHC Centres of the post *andolan* period. The total number of hospitals, Governmental and non-governmental, including private ones, at the end of 1990 was 123 with a total bed capacity of 4,717 beds (8). This in terms of a population of 19 million worked out to just 2.4 beds for every 10,000 population.

In 1986, during the period of the Seventh Five Year Plan, the Department of Health Services was dissolved and the Ministry of Health saw the formation of ten divisions and two departments of Ayurved and Drug Administration. July 1990 saw three different projects viz. FP/MCH, EPI and NMEO being also made into divisions under the Ministry of Health.

By this time the five development regions had Regional Directorates of Health Services, which were functioning. This was as per the objectives of the Decentralisation Act 1982 and the expectation was that the integrated health services would be functioning properly and that basic minimum health services would be available to all Nepalese by the year 2000.

The concept was that the 9 *ilaka* health posts in each of the 75 districts plus the additional static health posts with their quota of the middle and lower level workers were expected to provide this service. The direct responsibility of its functioning rested on the District Public Health Office (DPHO).

Because of the concept of community participation or sometimes because of political pressure, the health institutions were not properly sited. The main problem however was the poor state and lack of proper functioning of the health posts. Minor decisions of the health system, such as the actual siting of health posts became emotional issues. In 1988 only 242 of the health posts had their own premises whilst the other 433 being in rented premises had yet to construct their own buildings. Some opinions expressed at the CHRP meetings had been that if health institutions were to be in appropriate sites, then the land for constructing the building may have to be purchased also. Similarly the prevalent practice of using or involving local personnel in the actual construction had also resulted in non-completion or sub-standard work. As far as the 114 static sub-health posts were concerned, the staff costs of one AHW and one female MCH worker were to be borne by the village panchayat or the community. This was however never put into practice. In the case of community level work, the VHW would be responsible to provide the integrated health care package to the community with the aid of the ward level health volunteer residing in that area.

In all this it was envisaged that the Decentralisation Act of 1982 would be enforced and that the concept of inter-sectoral collaboration brought into play. Provision had been made in this for the formation of a District Health and Population Committee to look after the PHC activity at that level. This in itself was a novel idea for it advocated the formation of what was referred to as *Seva Kendras* or service centres with the following services: health, education, water supply & sanitation, agriculture and postal services. Some, like the ones at Sahare and Babiya Chaur in Surkhet District, were at times partially functioning (10). However such efforts of inter-sectoral cooperation at the *ilaka* level though it was tried out in a number of places, never really succeeded. This may have been due to half-hearted attempts, limited political commitment or lack of community participation. It is noteworthy that by this time some guidelines had been formulated for the establishment of new health posts, bearing in mind such criteria as:

- walking distance
- settlement and population concentration
- population
- accessibility.

In spite of all these guidelines it seemed that other considerations took over when the final site decision was made.

This particular plan of action envisaged using Panchayat Based Health Worker (PBHW) plus malaria field worker and vaccinators to provide an integrated service at the then existing Village Panchayat level. It was in this frame work of health care delivery that the government intended to have the

Community Health Volunteers (CHV), drawn from the community itself, on the basis of one from each ward of the village panchayat, to provide both preventive and curative primary health care services.

Post Jana Andolan Health Services

Following the *jana andolan* and the subsequent changes in government, major changes were apparently in the offing for the health services.

In 1990 Malaria Eradication Project, FP/MCH Project and EPI were made into one of three new divisions at the Ministry of Health (11).

The HFA 2000 Steering Committee was reconstituted and renamed Basic Minimum Needs and Health For All 2000 Steering Committee under the Honourable Member of the National Planning Commission. This denoted that Nepal's health policies were still in conformity to the country's commitment to BNM and HFA strategies.

A process of restructuring of the health services was thought about. The continuation of the restructuring meant applying the concept of strengthening of the district health systems and WHO support was sought for this. What was agreed and done was to identify districts for special attention with a view to monitoring the implementation of some special programmes for strengthening district health systems. That the delivery of the health services was in a bad way is exemplified by no less a person than the then Minister of Health saying, "The system doesn't work and hasn't worked for 30 years. We must find out how to make it work." In the present circumstances, these seem like famous last words.

Eighth Plan Period, 1992-97

The Eighth (five years) Plan, which should have started in 1990, was delayed because of the *jana andolan*. It was mid-1992 that saw the start of the Plan. The new objectives were those that had been stated in the National Health Policy of 1991 (see Annexure III).

With this implementation the intention was to (12):

- involve lower levels e.g. regional & district in the planning and delivery of health services including responsibilities of supervision and monitoring.
- give further impetus to the integration process, which was underway since 1987
- provide a combined preventive and curative package at the District level.
- bring about more efficient management by combining together functions of finance, logistics, and training, IEC & MIS.
- have a more compact working force by eliminating development staff positions.

Somehow by about mid 1995, when the UML government had been in power for seven months there were strong rumours of having a new organogram. Mass transfers were said to have been done just at about the time when the parliament was dissolved and the elections announced.

The Annual Report (13) of 2051/52 BS stated that the four objectives, having been synthesized from the Health Section of the Eighth Plan were to :

- improve the general health condition of the people in order to provide the health manpower for the country's development,
- extend basic and primary health services to villages to improve the health status of rural people;
- extend mother and child health services and family planning to the local level to make the population control programme more effective; and

- develop specialized health services in order to provide quality services throughout the country.

It is worthwhile to note that the budgetary allocation for the health sector in 1994/95 was 5%. The rallying cry of the National Health Policy, and of the Eighth Plan, "Attainment of the highest possible level of health by the Nepalese people," sounds very shallow now. The targets of reducing IMR to 50, the U5MR to 70 and measles deaths by 90% by 2000 AD seem far fetched.

The newly elected government took steps to not only provide health care to the people but institute effective measures to try to contain the growth of the population to reasonable limits. The fact is that the rate of population growth in Nepal is very worrying and the country is likely, to soon be in a difficult situation. With the recent changes that have taken place in the country, it is but natural that the peoples, expectations have increased. With the possibility of a more socially oriented society and with a more equitable distribution of resources, it is but natural that budgetary provisions for the social sectors should increase markedly.

By 1998 eight Five-year plans have come and gone with the oft-repeated promises of improvements. But health is a neglected field in that the MoH development budget was but 4.6% of the Seventh Plan. The national budget allocation for health and nutrition during the seven fiscal years starting 1988/89 to 1994/95 varied between 3.61% and 5.57% of the National budget. The allocation during the last six years is as given below:

Table 5.2 Health Allocation during last six years 1998-2004

| Year | 1st. | 2nd. | 3rd. | 4th. | 5th. | 6th. | . |
|------------------|------|------|------|------|------|------|---|
| Health Budget(%) | 5.61 | 5.03 | 5.00 | | 5.06 | 4.93 | |

Source. Estimated Budget Expenses of HMGN, MoH was

Review of these allocated annual budgets shows this to be 4.97%. How much of the allocated budget is actually spent on the budgeted expenditure is another matter. Is this an indicator of the importance of the health of the people? Is it any wonder that both the IMR and the U5MR are high and the life expectancy of the Nepalese is relatively low? The *jana andolan* had various sectors of society, including the doctors supporting the mass of people, including the politicians fighting for human rights. Irrespective of the party in power the % of budget for health is around 5%.

What is the current situation in Nepal? What has happened, is that over the years we have become very adept at making plans. The fact that the statistics given did not tally or were wrong did not matter, for these plans were not likely to be implemented. Projection figures given for health in the year 2000 were not based on realities and target figures were not attained with the usual performance. A previous plan stated, for example that 2400 doctors are required by the year 2000 AD. The fact was that because of inadequate number of posts or non-advertisement of vacancies, posts were not filled. There were at that time a number of doctors on daily wages. A similar situation existed for various other grades of health workers. On the one hand the people were told that health services couldn't be provided because of lack of manpower whilst the actual truth was that the expansion of the health services had not taken place as per the need, nor was there enough budgetary support for social services such as health. It was heartening to note in 1991 that the major political parties stated in their manifestos that they would improve the health facilities if elected. Was it just a ploy to get the votes? The concept of "Health rights" though talked about, was not being provided as promised at times of elections.

In the planning of health matters it is necessary to include people outside of the MoH to get proper feedback. This is true in other sectors so why not in health also? The plea would be to ensure that related specialists are more involved in the planning process, that due considerations be given

to their suggestions and that a process is started by which ongoing research in the various fields gives guidance for future action.

Table 5.3 Percentage Distribution of Health Sector Budget Allocations

| Areas | Year 1986/87 | Year 1988/89 | Year 1990/91 |
|--------------------------------------|-----------------|-----------------|-----------------|
| Preventive | 46.09 | 55.00 | 63.80 |
| Curative | 32.98 | 16.32 | 15.09 |
| Laboratory | 0.84 | 0.44 | 0.64 |
| Promotive | 0.18 | 0.28 | 0.35 |
| Health Administration & Construction | 8.86 | 19.54 | 11.09 |
| Health Planning Improvement | 0.41 | 0.13 | 0.12 |
| Bio-medical Research & Training | 0.53 | 0.26 | 8.81 |
| Integrated Rural Development | 10.11 | 8.04 | 0.10 |
| Total | 100.00 | 100.00 | 100.00 |

Source. Health Information Bulletin. Vol. 7. 1991. (10).

The elected Nepali Congress government brought out the National Health Policy of 1991. In the process leading up to this and subsequently too, a large number of the health personnel were either retired with the 30 years service or 58 years of age limit. A number who had done 20 years service were either offered early retirement or given that, if they did not choose it. This step was supposed to make the health services more efficient. This together with the sudden termination of many temporary staff's contract led to difficulties in the delivery of services especially the Expanded Programme of Immunisation (EPI). The subsequent recruitment of a selected few of the tertiary care services staff on new two years contracts exemplified the ad-hoc method of functioning.

In all this the Nepal Medical Association made various representation to the Administrative Reform Commission for a separate Health Act. The argument that different provisions had been made for other sectors e.g. legal, customs and even postal services was put forward. In the period just before the *jana andolan*, the Health Services too had been put in the special category of essential services with emergency rules being enforced. The Health Act was passed and though officially put into operation, could not be implemented. A number of amendments even by ordinance made it somewhat workable.

Following this the new organogram came into being as the answer to the proper functioning and efficient health service delivery. At least this is how it was presented.

Organogram of 1993

A new organisational set up of the MoH came into effect on the 16th of July 1993 (1st Shrawan 2050 BS). The new hierarchical organisation structure of the MoH had under it the three different departments of Health Services, Drug Administration and Ayurved. The facilities provided by the Department of Health Services were as follows:

Central Level

- Central Hospitals.
- Health Education, Information & Communication.
- National Tuberculosis Centre.
- AIDS and STD Control.
- National Public Health Laboratory.
- National Health Training Centre.

The health services at the regional and lower levels were under the jurisdiction of the Directorate of Health Services in the region concerned and were as given below:

Regional Level

- Regional Hospital.
- Regional Training Centre.
- Regional Laboratory.
- Regional Tuberculosis Centre.
- Regional Medical Store.

Zonal Level

- Zonal Hospital.

District Level

District Health Office under which is the District Hospital and the District Public Health Section.

In the electoral constituency were the Primary Health Care Centre, Health Posts at the Ilaka Level (The district is divided into 9 ilakas; a total of 675 integrated health posts plus additional 14 state health posts) and at the VDC level, the sub-health posts (SHP). One SHP will be established in every VDC where there is no other health facility through community participation with a total of 3199 stated to be operational by 1998.

* * *

A chance to see health services in action occurred in April, 1994 at Surkhet District in the course of the external evaluation of the Health Development Project (10). As far as the new organogram was concerned the finding was that the intention of integrating the delivery of rural and hospital services by combining district public health and medical services under the DHO had not led to the desired result up to then. It had in fact created confusion about the roles and responsibilities between the DPHO and the DHO. At the grassroots level where proper implementation should have occurred, no proper supervisory and reporting linkages had taken place between the sub health post, primary health centre, health post and the district administration (13). In fairness it was perhaps too early then to make any judgement regarding efficient functioning.

As far as the health of the people is concerned, there is not much to show for it till the start of the nineties. True the IMR is down, the U5MR is coming down too, but the percentage of the many malnourished Nepalese as a result of the poverty that prevails is a grim reminder that all is not well. Much more could have been achieved during the almost five decades after the end of Rana rule.

Table 5.4 Number of Health Institutions by type as of 1992

| | |
|---|----------------------------|
| Health Posts | 816 |
| | (Ilaka--675 and Static141) |
| Health Centres | 18 |
| District Hospitals | 61 |
| Zonal Hospitals | 9 |
| Regional Hospitals | 2 |
| Central Hospitals | 5 |
| Other Hospitals including Nursing Homes | 19 |

Source: Health Institutions - Health Information Bulletin No.8.

As has been already stated the UML Government instituted various steps related to the Health Sector. The New Medicine Policy which had been passed some time earlier was put into practice from around 3rd April, 1995.

The mentally ill patients who used to be kept in jail were, as per previous recommendations no longer to be kept in jails from 2nd April, 1995. This same month of April saw newly reconstituted Nepal Health Research Council. Task force and committee to solve problems in various areas were:

Task force to look at the position of Naturopathy was announced in the *Gorkhapatra*, in May of 1995.

Special committee was set up to look at Post Graduate Medical Education in this country, with a view to forming an autonomous Post Graduate Institute at Kathmandu, using the facilities of the Valley Group of Hospitals. This superseded the committee formed by the previous Nepali Congress government.

The Organogram of 1993 was revised in 1995 and the restructuring that took place has been shown in the annual report (13) as follows:

The number of PHC centres, health posts and sub-health posts stated as being completed in the 9th Plan document were:

| | |
|-----------------------------|------|
| Primary Health Care Centres | 100 |
| Sub-Health Posts | 3187 |

Stress was laid on the delivery of some essential health care to far-flung areas of the kingdom by way of mobile health camps for which budgetary provision was made.

In the period prior to the Ninth Plan, pronouncements were made by the Minister of Health that much more stress will be given to the Ayurvedic system of medicine during the course of this period.

Ninth Plan Period, 1997-2002

This Plan, which was focused for the task of poverty alleviation, had the health sector to be playing a major role in its implementation (14). Having made specific and annual plans in the context of National needs, on the basis of priorities and by bringing about co-ordination between Government, NGO's and donor agencies, the Second Long Term Health Plan 2054-2074 BS was being prepared by creating awareness and on basis of community participation. The objectives were of long-term for providing essential health services to:

- persons and communities not so serviced
- communities in dangerous situation
- women and children
- those living in rural and far flung areas
- backward and deprived sections

Policies, identified for implementation are:

- Essential Health Services at District Level
- Strengthening District Health System
- Health Care Services beyond the District - Special forms of Tertiary and specialised care.
- Ancillary and Support services (Laboratory & Blood Bank) at Regional, Zonal and District level. Also IEC for nutrition, environment and School Health Services.
- Ayurvedic Services.
- Other Traditional System of Medicine - Homeopathy, Unani & Naturopathy.
- Organisation and Management of basis of decentralisation.
- Health financing on basis of internal and external resource mobilisation, health insurance and cost sharing or cost recovery schemes.
- Increased role of Private and NGO sectors.

- Coordination and Intersectoral Collaboration.
- Health Research.

FIG (Full Page)

Figure 3. Organisation structure of the Department of Health Services
Source: Annual Health Report, 2003/2004

Tenth Plan Period

This plan too has been focussed for the task of poverty alleviation and covers the period from 2002 to 2007 BS. It must be noted that though poverty reduction has been stressed from the time of the Sixth Plan (1980-1985) to date, a lot needs to be done still (14). The overall poverty is expected to be reduced from 38% to 30% and literacy raised to 70%. With overall access to drinking water to 85 percent and GDP grown rate at 6.2%, the life expectancy is expected to go up to 62 years.

Second Long Term Health Plan (SLTHP), 1997-2017

With the “vision of an integrated health system including public, NGO and private sectors in which there is equitable access to health care, self-reliance, full-community participation, decentralisation, gender sensitivity and efficient management, resulting in improved health status of the population,” HMG of Nepal brought out the draft of the SLTHP in April, 1997 (15).

In mid July, 1997 a notification published in *The Rising Nepal* by the Policy, Planning, Foreign Aid and Monitoring Division (PPFA & MD) requested the public to send suggestions for this Second Long Term Health Plan.

In late July, a draft of this Second Long Term Health Plan 1997-2017 was officially released. It was hoped that this document when finalised would provide the guiding principles to tackle all health development issues over the coming 20 years. Whilst the SLTHP was not a final blue print for the functioning of the health sector, it was to be used as a rolling plan and resource document, which would be reviewed on a periodic basis and linked to ongoing evaluations.

The scenario in the post *jana andolan* period is that there have been a number of changes of government during this period. Changes in ministers have entailed not only changes and transfers of administrative staff but also technical personnel. All this has had appreciable effect on the delivery of health care in Nepal. A NGO document of 1995 went on record to state (16):

“Again, notwithstanding the limitations of the available information on health in Nepal, what the data made clear was that there has been hardly any significant change in the health status and health scenario of Nepal during the last five years (1991-95).”

HOSPITAL SERVICES

Since 1950, the health care of the people has become the responsibility of the government. Though there are some health services provided by NGOs and the private sector, health care delivery is by and large a government affair. Whilst the health services provided by the government are said to be free, the fact is that it is only for the doctor’s services and lodging that this is so. Most of the time, the patients have to pay for the medications or procure them before they are used for treatment. Besides the western oriented type of modern medicine there were also many Ayurvedic institutions within the country. It was perhaps for promoting the indigenous system of medicine that the Ayurvedic Department was allowed to function from 1982 as a separate entity.

Up to the mid fifties the hospitals that were in existence were those under the government. Most of these were under the Ministry of Health, with the Tri-Chandra Military Hospital under the Defence Ministry being the exception. With the opening of hospitals and health posts by the missionaries, another type of hospital came into being viz. the NGO’s semi-private hospital. This has led on to the forming of nursing homes also. The early eighties saw the setting up of the hospital under other ministries. With the starting of the outpatient services in July 1983 and the inpatient services at the Tribhuvan University Teaching Hospital as from 7th March 1986, the Education Ministry too was involved in the provision of health services (17). The establishment of TUTH and subsequent support over the years since then

by the Japanese Government has been with the involvement of JICA. After the building to the Annex cabin block the bed capacity of the hospital is 401.

Similarly, the Birendra Police Hospital started with a modest number of 25 beds in April 1984 (18) under the Home Ministry. This was subsequently expanded.

Another category now is the hospitals, which are going to be attached to the private medical colleges at Pokhara, Bharatpur, Nepalgunj, Bhairahawa and Kathmandu.

Thus the hospitals now existing in the country can be broadly categorised into three main groups:

1. Governmental
 - a. Civil
 - b. For Service Personnel
 - c. Educational
2. Non-Governmental, including mission and not for profit health institutions such as private medical schools
3. Private, for profit nursing homes/hospitals

Government Hospitals

a. Civil

On the civil side, the Bir Hospital, established as long ago as 1889 AD, has the pride of place as the first institution of the western medicine type, for health care within the country. Because of its long history it has been shifted, added to and renovated periodically over the years. Following the end of Rana rule in 1951 major changes occurred in the different sectors. Renovation of Bir Hospital, construction of Surgical Block and nurses residence with support of USAID started in 1965 and was completed in a few years. New OPD facilities with help from India, opened in November 1985. Following the 1986 decision to develop different super-specialities at the Bir Hospital, the ADRA Sydney Hospital Heart Project started there in 1987 as one such (19). Others are also now functioning. On 7th June 1997 the Indian Prime Minister Mr. I.K. Gujral during the course of his three-day visit unveiled the plaque for the construction of a 200-bedded Emergency and Trauma Centre to be built with the aid of the Indian government. Unfortunately, even in mid-2005, the construction work has not started. Announcement was also made about conducting both undergraduate and postgraduate medical education at the Bir Hospital. In 2004 however, it was concurrently made into the National Academy of Medical Sciences.

b. For Service Personnel

As already described, the first and foremost of these is the Tri-Chandra Military Hospital, which had been built as a Memorial for those who had died in the World War I. It was opened in 1926 with 64 beds including cabins. Gradually over the years various specialist services have been added. Following the opening of the Birendra Military Hospital at Chowni, this health facility is only providing outpatient facilities to some of the veterans or their families. The concept of Veteran's Hospitals as in other countries has not been introduced in Nepal. Smaller army field hospitals exist in different parts of the country i.e. at Itahari, Siddhartha Nagar, Nepalgunj and Dhangadi.

The Birendra Military Hospital at Chowni was opened on 20th Dec. 1990. It was initially increased to 240 beds and in 1998 it had 300 beds. Besides looking after the service personnel it also provides emergency service plus serves as a trauma centre for use by the general public.

The Birendra Police Hospital was established on 27th Chaitra 2040 BS (1984) with a total of 25 beds. It has expanded over the years and has a total of 125 beds. Other smaller hospitals are planned in other parts of the country, the 15 bedded one at Dipayal being the first to start functioning as from mid May, 1996 has been upgraded to 25 beds and another similar one is being established at Nepalgunj.

c. Educational

The Tribhuvan University Teaching Hospital is the first. The B.P.Koirala Institute of Health Sciences, an autonomous institution has a mandate for education, service and research activities are the second government institution for the training of doctors. With the addition of beds from time to time, the hospital now of 700 beds capacity, is the largest health institution in the country. Others, some of which are private, are in the process of being expanded further (see later). Speciality institutions for different areas of health e.g. cardiac, paediatric etc. with facilities for Post Graduate Education are in the process of being set up.

General Hospitals run by Non Governmental Organisations

The International Nepal Fellowship (INF) mission had started working in Nepal with the opening of the hospital at Pokhara under the very descriptive name of the Shining Hospital.

The work of the United Mission to Nepal started a number of women's and children clinics in the Kathmandu valley and had permission to start a Hospital at Tansen (20).

The hospital at Tansen was started by Dr. Carl Friedericks and his helpers on 15th June, 1954. The maternity clinics in the Kathmandu valley became popular and overcrowded. The shared premises of the existing Cholera Hospital were not suitable to function on a more permanent basis. Ultimately in the following year, the maternity clinic, which was being unmanageable, was shifted to an old Rana palace at Jawalakhel and thus the Shanta Bhawan Hospital was born. Subsequent to this, some work started in 1957 with the object of starting a hospital at Bhadgaon on a wooded hillside known as Surya Binayak. This was to be a health institution looking specifically at the patient with tuberculosis. However with the building of a new government hospital at Bhadgaon, and with the object of keeping to the principle of not having duplication of services, the government asked the Mission to close its establishment at Surya Binayak. In the light of this government decision, both the government facilities at Tansen and Patan were closed and the mission institutions were given the task of providing the general services. The old government general hospital at Patan was made into the Mental Hospital and the Shanta Bhawan Hospital became the new Patan/Lalitpur Hospital run by the United Mission to Nepal. The Mission hospital at Tansen continues to function but the old government hospital has been reopened and functions at a low key as a result of popular demand.

In 1957 a Seventh Day Adventist Mission from the States opened a small hospital at Banepa, known as the Sheer Memorial. It has increased in size over the years and is currently involved with KU in the teaching of medical students.

In 1957 the Mission to Lepers from India received permission to open leprosy hospital at a site some sixteen kilometres from Kathmandu. The Anandaban Leprosy Hospital has facilities for inpatient and also for ambulatory patients. There has been considerable research work done at this institution, including work on leprosy vaccine.

The Green Pastures Leprosy Hospital is at Pokhara is supported by a German mission. It started with outpatient facilities in 1957 but was officially opened with inpatients in 1972. Another INGO has built recently a leprosy hospital on the outskirts of Kathmandu at Sankhu. Yet another leprosy hospital has been built at Janakpur recently.

The Evangelical Alliance Mission (TEAM) group have opened hospitals at Doti and Dadeldhura and are building a third at Jajarkot.

There were some hospitals, which were built and subsequently handed over to the government by the INGOs. One such was the 15-bedded Solokhumbu Hospital built at Phaplu and handed over to HMG/N by Sir Edmund Hillary in March 1980. The Kunde Hospital at Solokhumbu, also set up by Sir Edmund has 15 beds. In 2005 was set up a third one at Chaurikhark VDC in the Solo region known as the Pasang Lhamu Nicole Hospital.

Hospitals attached to private medical colleges

The current total number of seven, five of which are attached to KU and two to TU is expected to rise in the future. They hospitals are at varying stages of development in different parts of the country:

- Manipal Colleges of Medical Sciences Hospital at Pokhara.
- Colleges of Medical Sciences Hospital at Bharatpur.
- Nepalgunj Medical College Hospitals at Nepalgunj and Kohalpur.
- Nepal Medical College Hospital at Attarkhel.
- Kathmandu Medical College Teaching Hospital at Sinamangal and Duwakot.
- Universal College of Medical Sciences Teaching Hospital, Bhairahawa.
- National College of Medical Sciences Teaching Hospital, Birgunj.
- Janaki Medical College Teaching Hospital, Janakpur.

Private Nursing Homes and Hospitals

Because of increasing demand for better health care facilities a number of nursing homes were started in the capital and other urban centres of the country. After a few years, to avail of increased facilities given by the government, some nursing homes changed their names to hospitals and research centres. A number of other specialised hospitals were also planned and some opened - the Escort group of Delhi and the Apollo group also.

Quite a number of nursing homes have been started both in the capital and in urban centres of Nepal. Some of the ones functioning in the capital are:

Himal Hospital: This was among the first of the private hospitals in Nepal.
Medicare Hospital: Functioning since the last ten years. Initially it was at Putali Sadak but has now shifted to its permanent building at Chabahil. **Om Hospital** functioning since the last fifteen years has also now shifted to Chabahil in the capital. This hospital has been in the news recently because of the success it has had in helping infertile couples to have children by way of the 'invitro fertilisation' or 'test tube' babies. The first test-tube baby was delivered on 3rd March 2005 and subsequently one day later a set of twins was born.

The Kidney Centre. This centre has been functioning since last ten years and providing dialysis to a number of patients of not only the capital but from different parts of the country. It is helping to start such facilities at Nepalgunj.

State of hospital beds

The state of hospital beds in the country has varied over the years. At the end of the Seventh Five Year Plan period there were 12 districts without any hospital or health centre where there were facilities for admission. The number of hospitals - Governmental, non-governmental and private at the end of 1990 was 123, with a total bed capacity of 4,717 beds. (This figure of hospitals number was subsequently corrected, as many were never opened or functioning). In terms of a population of 19 millions it works out to just 2.4 beds for every 10,000 population.

At the end of 2004 the number of hospital beds in the country had come to 12,889 for a total population of 25,151,423. This works out to about one bed for 1951 population or 5.1 beds for every 10,000 of the population. This statistic compares very poorly with the figures for other SAARC countries.

To have a reasonable state of affairs with one bed for one thousand population, it means that with the current population of 25 million it will mean a hospital bed strength of 25,000 beds, which is almost twice the present state.

The hospital situation as of 2004 with the different categories of institutions was as follows:

District Hospitals. Of the 75 districts in the country only 54 had a district hospital as such with a capacity of 15 to 25 beds. An additional 11 districts however had inpatient facilities being provided by the zonal or regional hospitals sited there.

Zonal Hospitals. The nine in this category are at Mahendranagar, Dhangadi, Nepalgunj, Butwal, Birgunj, Janakpur, Rajbiraj, Biratnagar and Chandragadhi.

Regional Hospitals. There are two in existence. The Western Regional is currently functioning but the Eastern Regional at Dharan has now changed its identity to become the BP Koirala Institute of Health Sciences (BPKIHS). Some other hospital, most likely the Koshi Zonal will possibly be categorised as the Regional Hospital. Similarly Hetauda Hospital may be the Regional Hospital for the Central Region. There are plans for a mid-West Regional Hospital at Birendranagar in Surkhet.

With the coming up of new medical colleges outside of the capital at Dharan, Janakpur, Dhulikhel, Bharatpur, Pokhara, Bhairahawa, Birgunj and Nepalgunj, one can expect that centres for tertiary health care will soon be established at these places.

Central Hospitals. These at present comprise of some sited in the urban areas of Kathmandu and Lalitpur. The total bedstate of these five central hospital adds up to 1150 with the breakdown as given below:

| | |
|---|-----|
| Bir Hospital – NAMS..... | 350 |
| Kanti Children’s Hospital | 300 |
| Maternity Hospital | 310 |
| Shukra Raj Tropical & Infectious Disease Hospital | 50 |
| Mental Hospital | 100 |

There is also a tendency to refer to the above as “Valley Group of Hospitals” and following the creation of National Academy of Medical Sciences by Ordinance in 2061 a number of Certificate Bachelor and Post Graduate educational programmes for the health sector are being conducted there.

Teaching Hospitals of Universities.

The Tribhuvan University Teaching Hospital (TUTH), is at Kathmandu. Though originally of 250 it increased subsequently to 401 and plans are afoot to increase it further by way of an ENT & Head, Neck Surgery Unit plus a special accident ward. There is already functioning the BP Koirala Lions Ophthalmic Centre. The Nursing Campus at Maharajgunj is also in this same site.

The BP Koirala Institute of Health Sciences (BPKIHS) at Dharan has a deemed university status and conducts Medical, Dental and Nursing programmes both at undergraduate of PG levels. It plans to start a School of Public Health from the academic session 2005.

The Kathmandu University Medical School (KUMS) is the medical school of Kathmandu University. It presently comprises of the Dhulikhel Hospital of 150 beds and the special unit of 50 beds adjoining the B&B Hospital at Gwarko. Basic Sciences Block is in the Sheer Memorial compound.

Specialised Hospitals.

It must be noted that some of the Central Hospitals are also specialist ones viz:

- women’s’ hospitals for obstetrics and gynaecology
- children’s’ hospitals
- infectious diseases hospital
- mental hospital

a. Eye Hospitals:

The eye hospitals have come to occupy a pride of place in Nepal’s health services and have furthered the cause of Ophthalmology.

In tracing the origins of the eye hospitals one must remember that the first eye camp in Nepal was held at Butwal in 1947 with the aid of two eye surgeons from Sitapur Eye Hospital. At this same time, a free camp of about one-month duration was also held at the Shree Juddha Ghat at Tripureshwar, the place now occupied by the Nepal Eye Hospital building (21). This may be said to have ushered in the concept of eye care services in Nepal

Dr. Yagya Raj Baidya was the first eye surgeon in Nepal, who along with Dr. Nem Bahadur started eye care services in Nepal. Starting with eye departments at Bir Hospital, this specialisation has extended to major urban Centres of Nepal. There are now no less than 15 NGO run eye hospitals with a capacity of 973 beds.

Cancer Hospitals:

HMGN established the BP Koirala Memorial Cancer Hospital (BPKMC) at Yegyapuri, Bharatpur in Chitwan in 1996. It was built with the assistance of the government of the Peoples Republic of China. The hospital began its day care services to the patients from October 1995, whereas full fledged OPD services started from June 1999 and inpatient services one month later (July 1999). This hospital was officially inaugurated in Sept. 2000 has at present 100 beds but its total capacity will be increased to 300 in the near future. Because of its proximity to the East West Highway the hospital is well accessible from all over the country.

The building of an institution started as Chandra Loke Dispensary on 17th Asar 1961 BS (1904) later became the Bhaktapur Hospital. With the construction of a new building the locals converted the old part into a Cancer Hospital with help from Rotarians of Nepali origin in various parts of the world.

Cardiac Care Hospitals.

It was decided in 1995 to set up the Shahid Gangalal National Heart Centre. It was brought in to operation initially with the aid of ADRA Nepal. As from Dec 1999 the outpatient services were started. There are presently 80 beds but a 100 beds are being added soon. Facilities for open-heart surgery are being provided presently.

Hospital for Disabled Children, Banepa.

This hospital was initially functioning as Terres des hommes at Jorpati. After a number of years it shifted to new premises at Jamsikhel and finally to its own building at Banepa in 1998. This hospital looks mainly after children with orthopaedic disabilities.

Paediatric Hospitals.

A Women's and Children hospital, with community participation, has been set up at Bhaktapur. It is known as Siddhi Memorial Hospital.

The Siddhartha Children's & Women's Hospital was established at Butwal by AMDA- Nepal, a NGO working for the elevation of health situation in the country. The Japanese people and also Mainichi Newspapers have helped it. Initially started with 50 beds, the hospital hopes to increase its capacity gradually.

PHC Centres.

A new category of health institution with treatment facilities that is being introduced is the PHC Centre. Though health centres with bed facilities had been introduced years ago and numbered 33 at the end of the Fourth Five Year Plan they had over the years been reduced to a figure of 18 by 1990 or at the end of the Seventh Five Year Plan. This was because the policy during Panchayat days had been to either upgrade them to district hospitals or to downgrade them to health posts. Now with the policy of upgrading health posts or building a primary health care centre in each of the 205 election constituencies, providing the services of a doctor, it seems that we have come full circle.

Thus it was that mid-1992 saw the start of the Eighth Plan.

The plan regarding PHC Centres was that 1993 saw the building of new or upgraded health posts so that a figure of 20 was reached. Getting doctors to man these was a problem but the DoHS tried to solve it by appointing some of the Bachelor graduates of Ayurvedic medicine (BAMS) to man these PHC Centres. Some questions have been raised regarding the legality of post mortems being performed by ayurvedic physicians. Yearly increases in the numbers of PHC centres are going to lead to 100 such by 1997 and then 205 by the year 2000.

Table. 5.5 Region wise Breakdown of some Hospital Beds

| Dev. Region. | Allo. Govt. | Govt. Teachin | Service Military | Service Police | Eye NGOs | TOTAL Beds |
|--------------|-------------|---------------|------------------|----------------|------------|-------------|
| Eastern | 537 | 700 | 6 | - | 56 | 1299 |
| Central | 1912 | 500 | 178 | 125 | 553 | 3268 |
| Western | 508 | - | 6 | - | 83 | 589 |
| Mid Western | 235 | - | 6 | - | 133 | 374 |
| Far Western | 205 | - | 25 | - | 148 | 378 |
| TOTAL | 3397 | 1200 | 221 | 125 | 973 | 5916 |

Besides the government and university hospitals (TUTH and BPKIHS) given above there are a number of hospitals coming up under the private medical colleges. Though the total number stated below are not all functional the stated number of beds that the institutions are expected to run as follows:

| | | |
|---|------|-----|
| Manipal College of Medical Sciences, Pokhara – | 1050 | |
| Nepalgunj Medical College, 2 sites Banke - | 700 | |
| Nepal Medical College, Kathmandu - | 700 | |
| Kathmandu Medical College, Kathmandu - | 700 | |
| College of Medical Sciences – Nepal, Bharatpur - | 700 | |
| Kathmandu University Medical School – 2 sites Dhulikhel | 200 | |
| Universal College of Medical Sciences, Bhairahawa | 700 | |
| National Medical College, Birgunj - | | 700 |
| Janaki Medical College, Janakpur - | 400 | |
| ----- | | |
| Total beds | 5850 | |

Besides the above there were listed a total of 74 private nursing homes. However in case of six listings the number of beds in the institutions were not given. The other sixty-eight had a listed capacity of 722 beds.

The total number of beds in the country including the 65 ayurvedic beds and the six homeopathic existing in the country is as follows:

| | |
|--|------|
| Government provided allopathic beds | 3397 |
| Three Government Teaching Institutes | 1200 |
| NGOs run Eye Hospital beds | 973 |
| Service Personnel Hospitals beds | 346 |
| Community Hospital beds | 30 |
| Hospital beds provided by private sector | 722 |
| Estimated number of Teaching Hospital beds | 5850 |
| Ayurvedic / Homeopathic beds | 71 |
| ----- | |

TOTAL BEDS – 12,589

It is stated that a figure of one bed for one thousand population is a minimum one. On the basis of this Nepal would require 25,000 beds. However as we have only 12,589 estimated beds the ratio of hospital beds to a population of 25,151,423 comes to 1 bed for 1998 population. This is the figure at the end of 2004.

Ayurvedic and other health institutions

The ayurvedic institutions had been started with the objective of providing health services to the people on the basis of the traditional cures, which used

both herbs and other ingredients such as precious metals etc. The ayurvedic department thus came into being. The hospital was established in 1873 BS (1916) as a Paropakar organisation and started inpatient services with four beds the following year. To meet with the requirement of the people it was envisaged that besides the Central Hospital at Kathmandu, there will be other hospitals and dispensaries in different parts of the country. Thus it came about that besides the Ayurvedic Training School, there were also the *Vaidyakhana* and the various hospitals and dispensaries established over the years. It was as late as 1982 (2039 BS) that HMG-Nepal started a separate department of Ayurveda in the MoH. In most areas of Nepal it is now accepted that the Ayurvedic system of medicine is best for the treatment of jaundice. Because sanitation in Kathmandu is poor it comes as no surprise that viral hepatitis due to faeco-oral route is very prevalent. Many of the cases of jaundice recover as a result of the treatment provided by the ayurvedic physicians or *baidyas*. The current thinking is that there is no specific treatment for viral hepatitis. HMG-Nepal has given importance to Ayurvedic treatment by formulating the National Ayurvedic Policy 2052.

Table. 5.6 Ayurvedic / Alternative Medicine Institutions.

| | |
|------------------------------------|-----|
| Ayurvedic Hospitals. | 2 |
| Vaidyakhana | 1 |
| Anchal Ayurvedic Aushadhalaya | 14 |
| District Ayurvedic Swasthya Kendra | 55 |
| Ayurvedic Aushadhalaya | 216 |
| Homeopathy Hospital | 1 |
| Yunani Chikitsalaya | 1 |

Source: Website of MoH. www.moh.gov.np

The Ayurvedic Hospital at Nardevi, Kathmandu in the Central Region, utilised for training health manpower of different grades in this discipline has been increased to 100 beds. Another thirty-bedded ayurvedic hospital located at Bijauri, Dang in the Central Region, is now functioning, as also the 25 District Swyastha Kendras. A medicine production unit exists in the form of the Singha Durbar *Vaidyakhana* also at Kathmandu. Much stress has been laid during the last couple of years on Ayurved. It is the government's policy to have an ayurvedic health centre in each of the 75 districts and an ayurvedic clinic for each of 5 VDCs.

Homeopathic Medicine.

Homeopathic medicine is supposed to have been introduced into Nepal during the time when Chandra Shumsher as prime minister when there was a cholera pandemic. Because of its success in controlling this pandemic the then C-in-C Rudra Shumsher is said to have been instrumental in popularising homeopathy by helping to print a publication "Paribarik Chikitsa".

In 2007 BS, a homeopathic dispensary was opened at Ramghat, Pashupati during the time that Mohan Shumsher was prime minister of Nepal. Though three other homeopathic centres were opened at Palpa, Gulmi and Dhankuta, all of them soon closed down due to lack of funds. Later the Pashupati Homeopathy Hospital was opened in BS 2010 during King Tribhuvan's reign. Subsequently, this hospital was increased to 25 beds and shifted to its own building at Harihar Bhawan surroundings. There is a move to also have a homeopathic hospital in each of the five regions of the country (22).

Hospitals Through Media Eyes

The health services as provided by the government are to a certain extent always under scrutiny. The need for the services is ever there and demand for the same is ever increasing. In short it is a never-ending spiral. One has only to recall newspaper headlines about services provided by the hospitals to realise that all is not well. There seems to be much dissatisfaction of the health delivery system in the public sector. More recently nursing homes or even hospitals have been established in the private sector. Whilst it is but

natural that some complaints are always present regarding charges for the services provided, what is definitely clear is that the services provided are not always up to the standards expected.

The Future

The myth that was propagated in the past was that there were not enough health workers of different categories to provide the health services. People at large, were lulled into a false sense of security with the assurance that there would be one health worker for 3000 of the population. This gives a false sense of security for not all categories were involved in the service delivery aspect in all areas to all people.

The reality is that the expansion of the health services both in the government and the private sector is little compared to the increase of the population. In the new health policy, which has just been brought out, the government proposes to encourage private institutions.

The outline of the policy, which has been brought out, gives ground for some hope. The aim is to provide a doctor in each of the 205 political constituencies that were created for the last election. It was planned to do this will be done through the medium of the primary health care centres. This would be justified for people in the rural areas for the current ratio between urban to rural population is 10:90. It will lead to services in the rural areas improving. The supervision by the District Health Office and the services by the doctors there, will meet the local demands so that people do not have to go further afield. The existing and proposed Regional and Zonal Hospitals will widen and improve their services so that people living along our border areas do not have to go outside the country or even to the Central hospitals unless absolutely necessary. The new private medical schools will help towards that end. With this taking place, the load at the centre should decrease. The Central hospitals too will improve and expand the health services offered so that people do not have to go out of Nepal, thus saving both Indian and other foreign exchange. This means also that units like the new cancer and cardiac units at Bir Hospital are not allowed to get run down and continue to provide service of high standard. With a satisfactory "on site", fully supervised health service and a functioning referral system it should lead to a "Health service that works." This presumption simply means that :-

- i. People know about it.
- ii. People are educated about how/when to use it.
- iii. People have confidence in it and trust it.
- iv. People see that the staffing is committed.
- v. People see that the drugs and equipment are there and available for use by the people.

All very high sounding and in line with the Nepalese saying which says, "Hope for it but don't depend on it."

In an attempt to improve the standard of hospital services in the capital, HMG formed on 15th May, 1996 a 18 member Valley Hospitals Development and Management Co-ordination Committee under the chairmanship of the Health Minister. Besides the directors of the various hospitals in Kathmandu Valley the Committee also has representation of social workers and the mayors of the municipalities of Kathmandu Valley on a rotating basis, starting first with the Mayor of Kathmandu.

In this connection, the government's recent directive that government institutions, including hospitals should display, provide information regarding the services offered and whom to approach in case of need.

PRIVATE MEDICINE AND HEALTH INSURANCE

Private medicine of some sort has been present from the early days of Rana rule in Nepal. The concept of the fee for service was started by no less a

person than Jung Bahadur when he utilised the service of the British legation doctor for vaccination. Then later, during the subsequent periods of Bir Shumsher and Chandra Shumsher's premierships, a number of doctors, mostly from India were employed in the health sector by the civil and military authorities. As the scale of pay was meagre the personnel were allowed to practice with a "Fee for service" (FFS) concept. But even then the fees were not exorbitant for the population at large was very poor. Coupled with this, some health workers were brought into the country from British India on short visits and it was customary too, to pay for their services.

During the time that the British were in India a number of missionary groups were working on the borders of Nepal. From there some went inwards to the western parts of Nepal, such as Dandeldhura whilst others went northwards from the Nautanwa area in southern Nepal. At the time of the last days of Rana rule in 1951, the United Mission to Nepal was officially able to enter Nepal. It all started following a six-months trip by Dr. Robert Fleming who was accompanied by his wife Dr. Ethel and Dr. Carl Taylor to study birds in Nepal (20).

Over the course of the years as the standard of the living increase a substantial percentage of the population opted for the private facilities that had gradually come into being in the capital. WHO came up also with the concept of public and private mix. Access to both public and private facilities varies considerably by income group with the wealthier having higher utilisation of both public and private facilities

Group Practice to Polyclinic concepts

Sajha Swasthya Seva was an offshoot of the co-operative movement that had been introduced into Nepal in the sixties. The others were in transport, publications, domestic supplies and savings. The idea was to have in the major towns, chemist shops within the hospital compound or nearby it with the object of selling medicines at reasonable prices. The reason for such developments was that people at that time were being overcharged, if not forced to pay exorbitant prices for life saving drugs, which were in effect the final arbitrator of life and death. Because of the existing situation, these shops came into being. Over the course of the years, other bodies such as the Chemists and Druggists Association has come into being and has attempted to try to standardise services and prices.

The main Sajha medicine shop tried to provide services during the hours that the hospital out patient services were not functioning. Thus some young doctors of Bir and other hospitals provided almost 24-hour consultation service and the specialists provided service for a consultative fee during the afternoon or evening at the Sajha clinic. This was the start of group practice concept at Kathmandu. Following this, others such as Siddhi Polyclinic and Hargaans were also started. Up to this time some surgeons had some inpatient and operating facilities in their clinics. The pioneer in the development of admitting facilities and private medicine was the Kathmandu Nursing Home, established in 1986.

As more applications were made for the registration, availability of facilities and running of nursing homes, the Ministry of Health constituted in mid 2043 B.S. a special committee under the chairmanship of the Chief of the Planning division. Contacts were made with institutions in Bangladesh, India and Thailand with the idea of framing Rules and Regulations concerning nursing homes and their functioning. This activity, started on what may be termed ad hoc basis, was not sustained and it was not until 1994 that some regulations were framed.

In the succeeding years, as many new doctors did not opt for government service, the development of nursing homes was more rapid. Many doctors, on retiring from government service became more active in private medicine whilst others even opted for it, leaving government or semi-government jobs. From July 1984 the TU Teaching Hospital started having both morning and afternoon sessions, and some fifteen months later there was notice of "no private practice" at TUTH. Many of the staff therefore opted out and started working in the various private medicine facilities that had sprung up in the capital.

It was with the idea that the government in the developing countries would not be able to provide the desired or even the required health facilities that the concept of private medicine was put forward and encouraged. Whilst the developed countries had safeguards for the protection of the public, such facilities were either minimal or even non-existent in Nepal. It was in this context that a workshop on "Quality Assurance in Health Care" was held at Kathmandu in the September of 1994 with the blessings of WHO. Following the seminar some recommendations were made regarding health care in this country. Legislation to protect and look after the interest of the public has still to be brought before parliament. However it was much later that these rules were augmented and the Dept of Health Services sent out inspection teams.

In the meantime however other nursing homes such as Himal Nursing Home, Everest Nursing Home and Om Nursing Home started in the capital. Others were opened in other centres such as Biratnagar, Janakpur, Birgunj, Bharatpur and Nepalgunj. Some other privately run hospitals also came into being such as the Model Hospital at Bagh Bazaar. A small district hospital, Bajrabarahi People's Hospital, was started at Makwanpur during 1994 and by Feb. 1997 was running 25 beds inclusive of maternity services. Plans were announced by other NGOs to start Mother's and Children's or Women's and Children's Hospitals at Biratnagar and Bhaktapur respectively. Towards the end of 1997 the foundation was laid for the establishment of the Siddhartha Maternity and Child Hospital to be built with aid from AMDA at Butwal with the overall responsibility being borne by AMDA-Japan and AMDA-Nepal. More recently the various Nursing Homes have been converted into "Hospitals & Research Centres.

In December 1995 the then Crown Prince Dipendra inaugurated the 20 bedded Lunkarandas-Gangadevi Chaudhari Charity Hospital at Duhabi. This hospital built and to be supported by an industrial house was the first of its kind from two different angles. Whilst it was the first hospital in the country to be run by an industrial house it was also one, which as per the name, was run on a charitable basis and not for profit.

The Sushma Memorial Plastic and Reconstructive Surgery Hospital, an eight-bed complex at Sankhu established with the aid of Interplast-Germany, was inaugurated on 7th Nov.1997. Its objective is to provide free service to repair cleft lips and to correct post accident and burn deformities in the poor and helpless patients.

In the seventies and eighties of the last century, with the limited resources on hand, it was thought that there should be no duplication of services. Then, in places where there was a Mission or other NGO hospital, the government did not start a hospital or even closed the existing one. Somehow this policy has not been successful and one prime example of this was the restarting of the government hospital at Tansen.

Private health care in Nepal has been divided into four under mentioned categories (23):

- a. Public sector i.e. all government provided health institutions.
- b. Not-for-profit sector: Voluntary, Missions and Trusts run health institutions.
- c. Organised Private sector: Nursing Homes, Private Hospitals, and care provided by fee for service practitioners.
- d. Private informal sector: Care provided by traditional healers such as *dhamis*, *jhankris*, *jharpuks* and others who have not had any formal training.

The National Health Policy 1991, goes on to state that there will be increasing opportunities for the private sector and the NGOs in the delivery of the health services. The suggestion has been made that, "we also need to strengthen existing public medical hospitals so that people are not forced to go to private institutions due to lack of choice." A plea has also been made for a Nursing Home Act so that effective monitoring of the growth and quality of the services provided by the nursing homes can be done.

The Private Nursing Homes Association has periodically held seminars and meetings with a view to improving the facilities offered to the public. Newspapers have quoted the health ministry stating that "it is necessary to have legal provision for the setting up of nursing homes. However though some criteria have been set up for nursing homes to be opened by the Nepalese, nothing has been laid down for starting nursing homes with foreign investment."

The criteria set so far are on the basis of the facilities being extended by the nursing homes and the party concerned must accept these before registration can be done.

Criteria for hospitals / nursing homes are dependent on whether they are for:

- a. Fifteen to twenty-five beds.
- b. Twenty-six to fifty beds.
- c. Fifty-one to hundred beds.
- d. Hundred to two hundred beds.

The basic requirements for diagnosis are a laboratory and also a X-ray Department. On the curative side, a 24 hours emergency service must be provided including a minor theatre, major theatre, operation room and isolation room. Three essentials free services, which must be catered, for and for which related material will be supplied by the health ministry are:

1. Rehydration services
2. Family Planning & MCH services
3. Health Education services

It is also obligatory to have one free bed for poor patients for every fifteen beds being run by the hospital or nursing home. These rules are however being flouted for there are no provisions for effective implementation.

This registration for functioning is done by the Cottage Industries (*Gharelu Udyog*) on the basis of recommendation by the Health Ministry. The permission is usually given on a temporary basis for one year and there is no provision for making this either permanent or cancelling it.

There is no disputing the fact that the Nursing Homes have been responsible for the development of diagnostic facilities. Whereas tertiary care facilities of the government or the University for that matter did not do kidney transplant pleading the non-existence of a Human Organ Transplantation Act, the private medicine sector went ahead with and such an operation was performed for the first time in Nepal at the Everest Nursing Home on 27th May, 1995. It was the rush to do such operations at other places, with patients and donors from outside of the country that made the government constitute a special committee in the first week of July 1995 to look into all aspects of renal transplants. The Human Organ Transplantation Act took over four years to be enacted.

The period of more investment private medicine in Nepal was the starting in 1996 of two parties from India viz the Escorts and the Apollo Group the setting up of diagnostic and later inpatient facilities in Nepal..

Escorts Heart Institute and Research Centre, New Delhi and the Chaudhary group signed a Memorandum of Understanding (MoU) for the setting up of a 150-bedded speciality hospital at Kathmandu. The first phase of this was the starting of a Heart Centre by the Norvic Health Care and Research Centre at Thapathali, Kathmandu. Similarly Apollo Health Care and Research Centre Ltd was registered in Nepal. It has still to open its 100-bedded hospital at Balaju.

The B & B Nursing Home in Lalitpur has been providing specialized health services to the people of the capital since 1997. Since 2004 it added an additional 50 beds to be part of the Kathmandu University Medical School.

Starting first with outpatient services efforts are being made to establish the Iwamura Memorial Hospital at Bhaktapur. Dr. N. Iwamura who worked for a long time in Nepal had served part of the time in Bhaktapur working in the fight against tuberculosis. Japanese Rotarians of International District 2640 and also 2680 are helping in the setting up and the running of the hospital

Community Hospitals

Whilst nursing homes came up people in different parts of Nepal having realised the difficulty of getting health services from the government have also tried to avail of services by their own efforts. This process has been going on for two or three decades but more so since the nineties when a general awakening occurred in the country.

The first organisation in this category is the Peoples Jana Chikitsalaya, which was started at Chetrapati as long ago as 196..?? It receives support from locals and from NGOs and individuals from different parts of the world. It also provides dental services and has facilities for admission.

The Kali Gandaki Hospital (KGH) was an example of a community-based health care. KGH as an institution was started in 1989 at Rampur, Keladi Palpa by a group of social workers with their own resources and providing PHC services to a remote population. The 15-bedded hospital was similar to the District Hospital set up of HMG. As from mid August 1993 it has been shifted to Kawasoti, Nawalparasi.

The foundation stone was laid on 30th Jan.'98 of the Hetauda Peoples Hospital to be constructed by the community. Though there was initial enthusiasm periodic newspaper reports have suggested that the enthusiasm has flagged and not much has occurred since.

Mid Sept. 1998 saw the foundation laying of Satya Sai Hospital at Kirtipur. It is still to function properly.

Other recent efforts by different people with community participation have also been attempted in this direction. One reads of Mahayagya being held to collect funds to set up a school, or a health clinic or even a hospital.

- a. Bearing in mind the load at the Bharatpur Hospital the community is collecting funds to build a public hospital at Ratnanagar Municipality area in the Terai.
- b. The transfer of the District Hospital to representatives of the local community at Lamjung led to the institution being much better managed and functioning better.
- c. In May 2005, a Swiss citizen, paralysed during the course of climbing has very generously funded the setting up of a Pasang Lhamu Nicole Hospital of 13 beds with a community oriented health service set up at Chaurikhark in the Solu area. This is the third hospital in the Solu area the other two being at Namche and Faplu. Besides the locals they will also cater to the needs of the trekkers and mountaineers.
- d. A 50-bedded community hospital is also being started at Pharping in the Dakshinkali area. The VDC is taking active part in setting it up with the aid of two NGOs New Cedel and Himalayan Height.

NON GOVERNMENT ORGANISATIONS (NGOs)

Aasara Rehabilitation Centre, Rani Bari, Maharajgunj

This NGO, initially started functioning on 1st Asar 2054 (July 1996) with the objective of preventing drug abuse amongst the youths of this country. Though started the initiative of Nepal Police, this organization was after three months subsequently run by Nepal Police Wives Organisation. This organization is being supported by other NGOs working in this field.

Association for the Welfare of the Mentally Retarded (AWMR)

Founded in 1981 during the observance of the International Year of Disabled Persons (IYDP). It was registered with the SSNCC in 1985 and subsequently with the Social Welfare Council (SWC). The aims and objectives of the AWMR are to better meet the individual needs of people with mental retardation within the complexities of modern society. Besides the central office there are a number of branches in the districts. The association is currently working in 18 out of 75 districts of the kingdom and besides the central offices there are a number of branches outside the capital.

BP Eye Foundation

The BP Eye Foundation was established in 1991 with the objective of improving the eye health of the Nepalese population. It is estimated that 1.56% of the population suffer from low vision and blindness in one or both eyes. Cataract account as cause of two thirds of the blindness. Vitamin A deficiency, injury, trachoma, glaucoma and diabetic retinopathy are other causes.

Besides providing eye health services and doing research, the foundation is involved in the production of manpower at the National Eye Health Manpower Training Centre at Kathmandu in collaboration with Tribhuvan University, Lions Club and SightFirst programmes. The foundation also conducts eye camps in various parts of Nepal.

Family Planning Association of Nepal (FPAN)

This association was established at Kathmandu in 1958 with the help of the Nepal Medical Association and the Pathfinder Fund (24). The first women Asst. Health Minister Mrs. Dwarika DC Thakurani was its president. It celebrates 18th September as FP Day. It became a member of the International Planned Parenthood Federation (IPPF) in 1960. In the seventies many branches were opened and there was a lot of activity. Later in 1992 it was providing about 25% of the family planning services plus supplementing those of the government. By mid 1997, the Association had extended its activities in 33 districts, 771 Village Development Committees (VDC) and provides services to nearly 1 million married women of reproductive age (MWRA) (6). The activities of FPAN comprise educational programmes, natural family planning programmes and sterilisation programmes that are conducted through its clinics and the rural family health projects. It's estimated that 21% of married women practise contraception. Female sterilization is more popular than that of males. The Method Mix of FP acceptors in 2002 showed that Depo Provera was most popular Method (48%) followed by condom (27%) and pills (25). FPAN has been playing an active role for the liberalisation of abortion laws. As a result of this, new provisions have been made in the Eleventh Amendment of the Muluki Ain. It has currently 3 static clinics and also runs mobile ones in five districts every year. FPAN also has activities to improve women's status and is running training programmes for income-generating skills. FPAN's mission statement is for promoting and providing quality sexual and reproductive health services to women, men and youth and to support the government in meeting the demand for these services throughout the country.

Friends of Shanta Bhawan

Formally founded in 1983, this organisation was registered in Nepal in 1984 and has been providing Outpatient Clinic Services in the Jorpati area Baudha. It is providing primary health care facilities to the poor and needy patients living under the poverty line. Its agreement with the Social Welfare Council was renewed in March 1997 for a period of five years.

Friends of the Disabled

Since 1985 this NGO has been providing comprehensive rehabilitation care to underprivileged physically disabled children of Nepal. This organisation has been working with the support of the Terres des hommes that has its headquarters in Switzerland. Following shifting from its initial site at Jorepati it ran a hospital and rehabilitation centre for disabled children in a rented facility at Dhobighat, Jwalakhel. HM King Birendra formally inaugurated the permanent facility of the Hospital and Rehabilitation Centre for Disabled Children (HRDC), near Banepa on 17th April 1998. This hospital has 36 beds for inpatients and a further 30 beds in the rehabilitation section FOD

/HRDC has also a teaching partnership with Kathmandu University and has been functioning as a training centre of KU for Master Degree in Orthopaedic Surgery (26).

Heart Foundation

This was founded in 1978 and has been active in making people aware about heart disease. It is also involved in anti-smoking campaign.

Himalaya Health Care

This NGO was started in 1992, which is supported by many well-wishers in the travel trade. Besides conducting various medical and dental camps it helps in educational and income generating activities.

Lions Club

A branch of Lions International was formed on 7th May 1971. The first Lions Club was that of Kathmandu which came into being in 1972. It was initially part of a district, which also included parts of Bihar, but now it is a separate entity totally in Nepal, and referred to as District No. 325. The Lion movement then gradually increased in the country and now in 1994 there are about 60 Lion clubs. The number reaches 90 if one includes the Leo and Lionesses. The many clubs are involved in running a number of health clinics, plus periodic eye and ear camps in various parts of the country. The clinic at Naya Baneshwor, Kathmandu also has adjoining 15 bedded facilities. The various Lions, Lionesses and Leo Clubs are part and parcel of District 325. Increased stress is being laid on eye care too by this NGO.

On 11th Feb. 1995, Mr. Man Mohan Adhikari, then prime minister laid the foundation stone of the B.P. Koirala Lions Centre for Ophthalmic Studies (BPKLCOS) in the Teaching Hospital Complex at Maharajgunj. This started functioning in 1996 and has been doing eye surgery on outpatient basis.

Marwari Welfare Committee

Started in 2010 BS after a public collection of Rs. 459/-, this organisation was officially inaugurated by King Tribhuvan on Basanta Panchami of that same year. In 2014 BS it started functioning from its own premises at Phasikeba in the heart of Kathmandu. The organisation also runs a hostel for children of leprosy-afflicted persons. It recently celebrated its fifty years of existence by starting a Homeopathic Hospital at its central site.

Maryknoll Nepal

This organisation has been working in Nepal for many years in the field of providing help to the mentally retarded. It has been running a rehabilitation centre near Sundarijal. Under an agreement signed with JICA in Jan. 1998, Maryknoll Nepal will construct a 2 storey Mental Hospital at Nayapati. There will also be facilities to treat the ill on an outpatient's basis by providing services such as occupational therapy and vocational activities.

Mothers' Club - Aamaa Milan Kendra.

This is a national level NGO established in 1975 during the International Women's Year. It operates in 19 districts with 59 local branches and its overall objective is to develop and promote women in general. It is involved in the social and economic upliftment of women from grass roots level. Its strong point is that it is volunteer based and works at the community level.

Mrigendra Samjana Medical Trust

Dr. Mrigendra Raj Pandey, a physician and a social worker as Mrigendra Medical Trust in 1975 started this local NGO. Its work is devoted to promotion of health services and social welfare activities in the backward rural areas of Nepal. Besides medical care the Trust also provides education, drinking water and income and employment generating facilities. It has been working in Sundarijal, Pharping, Dakshinkali and Jumla areas. It has been actively involved in anti-smoking campaign. The present name of the Trust has been in use since 1994. Late King Birendra and late Queen Aishwarya graced the 25 years of establishment celebrations.

Nepal Anti Tuberculosis Association (NATA)

This organisation came into being as a result of the efforts of its ten founding members in July 1953 (4/4/2010 BS). It was initially known as Nepal Tuberculosis Association and had the then PM Matrika P. Koirala as its founder President. However its official inauguration by late King Mahendra only took place on 13th Mangsir, 2020 BS. Since then the association has observing this day as 'Anti TB Day'. The Central Chest Clinic services were first started in 1966 at Kalimati and expanded over the years subsequently to Biratnagar, Birgunj and Palpa. A sanatorium with 25 beds had been opened at Kalimati, but now it has been converted into the Kalimati Chest Hospital. The organisation has expanded by forming committees in many districts of Nepal.

Since 1983 the Aid Medical et Sanatoria (AMS) has been providing aid to 2 districts in Western Nepal. From 1986 the German aided project GENETUP has been helping with a TB clinic within the association premises. From 1995 Norway's Lung & Heart Association (LHL) has been helping in training and supervision of the association activities. The association recently celebrated its fifty years of existence recently (27).

The Association maintains that there are always about 80,000 affected persons and that the claims made regarding the cure rate are not substantiated.

Nepal Cancer Relief Society

This Society was formed on 31st Bhadra, 2039 BS (1982) with the four objectives of providing promotive, preventive, curative and rehabilitative services to the patients liable to suffer or suffering from cancer. In practical terms it means creating awareness in the people about cancer, its early detection and information about existing facilities for treatment plus rehabilitation.

As smoking has been a major cause of cancer, the society is also active in the anti-smoking campaign. Immediately after the *jana andolan*, it was involved in the renovation of the old building of Bhaktapur Hospital. This was converted into the Bhaktapur Cancer Hospital in collaboration with HMG Nepal and with aid from community and Rotary international since 1982. It is also planned to start Hospice facilities for cancer patients at Banepa.

NCRS has, besides its central office in Kathmandu and as of December 2004 a total of 33 branches scattered in different parts of the country with as many as 7000 volunteers.

Nepal CRS Company

This organisation was started in 1978 as a pilot project of HMG Nepal by the FP/MCH with the objective of strengthening the FP and PHC programmes. In August 1963, CRS was given corporate status when it became a non-profit, private limited company. It is being supported by USAID and the German Development Bank (Kreditanstalt für Aufbau i.e. KfA). Social marketing activities for family planning products, rehydration salts and home delivery kits are undertaken by it.

Nepal Disabled Association

In 1969 the Nepal Disabled and Blind Association started institutional rehabilitation services at its "New Life Centre", which in the course of time led to the starting of a rehabilitation centre at Jorpati. Later a separate building for disabled children was constructed and opened in the same compound with the support of SOS International.

In April of 1996 the construction of the Orthopaedic Hospital was completed with support of the Rotary International District 7090, World Community Service and Patan Rotary Club. The 20 bedded hospital is officially functioning since mid 1998.

Nepal Epilepsy Association

The Korean Epilepsy Association "Rose Club", based at Seoul, helped in the founding of the *Soon Pate Club* on 26th Sept. 1986 with the object of providing treatment facilities for epilepsy. About two and half years later it was registered with the SSNCC as Nepal Epilepsy Association. Currently it

is running the Gauri Shankar General Hospital at Dolakha Bazaar. In 2004 this organisation withdrew from its services commitment and handed this hospital to the local people. This hospital has recently come under the management of the Model Hospital at Kathmandu.

Nepal Jaycees

Nepal Jaycees, as a branch of Jaycees International, was established in 1964. This organisation has been functioning in Nepal for the past three decades. Kathmandu Jaycees was started in 1970. There are a number of branches all over the country and the members are involved in many social activities in the community field. The stress in the health field is in the control of diarrhoeal diseases.

Nepal Leprosy Relief Association

This organisation which came into being in 2026 B.S. is responsible for looking after plus running the Syanja based Malunga Leprosarium since 2033 BS and the Khokana Leprosarium since 2041 BS (1985). It has been looking after the children of leprosy patients from the very beginning and besides hostel facilities also gives stipends for study. Last but not least are the objectives of relocating former patients back in the community from which they initially came.

Nepal Netra Jyoti Sangh (NNJS)

The formation of this organisation was preceded by the setting up of the Nepal Eye Hospital in 1965 with a total of 12 beds. This capacity was however increased to 54 about a decade later when it was registered as an NGO to allow proper functioning. The **NNJS** came into being in 1977 the following year with a view to manage the Nepal Eye Hospital plus also to conduct all eye related activities. It was with the initiative of the members of this NGO together with HMG/N and WHO that the Nepal Blindness Programme was started in 1979 (28). This whole programme was turned over to **NNJS** for implementation.

A Nepal Blindness Survey was done in 1981 with the help of the Netherlands. The resulting estimate was that there were 117,623 blind in Nepal. It is with the active involvement of this organisation that an extensive eye care programme has been developed over the length and breadth of Nepal. The **NNJS** has branches in 23 districts and has activities in 13 of the 14 zones of Nepal.

Nepal Oral Health Society

This Society was formed on 15th Nov. 1983 but was registered in June of the following year. Its aims and objectives are to:

“strive for the prevention, treatment and reduction of dental, oral and maxillofacial diseases, malfunctions and related conditions among the people of Nepal in a manner integrative with and supportive of His Majesty’s Government of Nepal’s (HMG/N) efforts to improve national oral health.”

It started actual functioning with the opening of the Free Oral Health Clinic in Nov. 1984 (29). Besides the Central Clinic, in Kathmandu, it has two clinics outside of the Valley viz. one at Sankhu and another at Namche Bazaar, in Solukhumbu District. It is active not only in Kathmandu but has done work outside of the valley. It has been especially active during the course of 1994, which has been celebrated as “World Year for Oral Health.” The society has been stressing that preventive programmes are more important in the oral health services sector. It has highlighted the fact that there is only one dental surgeon for 400,000 population and also the necessity for manpower in this field of health care.

Nepal Red Cross Society (NRCS)

The Nepal Red Cross Society was founded on 4th Sept. 1963, exactly a hundred years after Jean Henry Dunant had started the parent body in Geneva. Initially an ad-hoc committee under the Chairmanship of the Late Princess Princep Shah was functioning. The following year the executive committee was elected and on 1st October 1964, the Nepal Red Cross was officially given recognition by the International Committee of the Red Cross

(ICRC). On the next day, i.e. 2nd Oct. the NRC became a member of the League of Red Cross Societies.

Whilst the initial work was with the Tibetan refugees, the Nepal Red Cross started within two years the first Blood Bank service in Kathmandu valley. Over the course of the years the Red Cross has opened District Chapters or branches in all the 75 districts of the Kingdom and other 2,777 units such as sub branches, cooperation committees. The Junior Red Cross Programme which was started in 1965 as an youth movement has expanded tremendously and had in 1994 as many as 1700 Junior Red Cross (JRC) Circles working mainly in the rural areas. These younger members of JRC are very active. The NRCS is also providing ambulance service plus relief at times of national disasters.

The Society completed its First Development Plan from 1984-90 and in the process built up an effective service delivery in the areas of Primary Health Care, Community Health and Disaster Relief Programmes. The Second Development Plan from 1992-1997 will be focusing on three inter-related and important issues for country viz. Disaster Preparedness, Health and Community Services (30,31). The Society states that in Oct. 2004 it had a total of 8.5 lacs members of which 7.5 lacs were Junior Red Cross and others adult (32).

Paropakar

This organisation was founded initially as “ *Paropakar Aushadhalaya* “on Asoj 10th, 2004 B.S. (1948) by Mr. Dayabir Singh Kansakar. In course of time an orphanage and school were also started. The efforts of this organisation led to the foundation laying of a maternity hospital in April 1954. The Shree Panch Indra Rajya Laxmi Prasuti Griha, as it subsequently became known started functioning with 40 beds in 1959 (2016 BS). It has expanded gradually over the years first with the addition of gynaecological beds and baby unit in 1968. Subsequently the baby unit was expanded in 1980 (33). It is now the main centre for maternity care in the country and is currently functioning in 1994 as a 250 bedded maternity hospital.

Rotary International

Following the inauguration of its central branch at Thapathali, it has over the years opened a number of branches. In the health field, this INGO's has through its many branches, been actively involved in social work in many different fields such as the immunisation campaign, especially polio, eye care and rehabilitation work.

Shree Panch Aishwarya Medical Relief Trust.

This was started in 1975 on the occasion of International Women's Year. Its objective is to provide assistance to the deprived and poor patients. So far the fund has helped the Tuberculosis Project and Maternity Centre. Plans are underway to set up health post in Rara of Mugu district.

Sushma Koirala Memorial Trust

This Trust in partnership with Interplast Germany inaugurated in November, 1997 the Sushma Koirala Memorial Plastic and Reconstructive Surgery Hospital at Shankhu, Lalambutar, Kathmandu. The objective is to provide reconstructive surgical service to poor Nepalese.

Vajra International

The Vajra Foundation was started in 1998 by a Dutch national to work in the Sindupalchowk area. Besides helping the schools, the organisation has been helping in drinking water and sewage disposal projects. It has also been involved with medical colleges for the holding of regular health camps with surgery on site and at a later date, at the teaching hospitals itself.

BILATERAL PARTNERS & INTERNATIONAL NON GOVERNMENT ORGANISATIONS (INGOs)

Action Aid

Working in Nepal since 1982, it has involved communities on its integrated programmes to address health care, education, agriculture, infrastructure and income generation. During the last 16 years it has worked in Sindhupalchowk, but from 1992 it started in Nawalparasi also. In recent years it has been involved in Sinduli, Kanchanpur and Jajarkot districts with a view to starting work in that area. Its area of involvement are in the agricultural, health, education and water sectors and its aim is to eradicate absolute poverty by facilitating the process of empowerment.

Adventists Development Relief Agency (ADRA)

This missionary group, as the Seventh Day Adventists went to Banepa in 1957 and opened a small hospital. This has over the years developed into the Scheer Memorial Hospital.

Later the ADRA - Nepal started work in this country in 1987. One year later a heart surgery team from Sydney Adventists Hospital, Australia and following an official agreement, the organisation extended help in setting up the Cardio Thoracic Unit at Bir Hospital with the object of developing heart surgery in Nepal. The first open heart surgery was done at Bir Hospital in 1989 with the aid of the ADRA team. It is being done on a more regular basis now. From 1991, ADRA - Nepal has been helping the TU Teaching Hospital at Maharajgunj to set up a similar unit.

Association of Medical Doctors of Asia (AMDA)

This association with its base in Japan is involved in health work in different countries. The local AMDA-Nepal, established in 1990, has a team of 27 committed medical doctors working in and outside of Nepal. It has currently been working with AMDA-Japan for the welfare of the Bhutanese refugees in Eastern Nepal. The Referral Health Centre it has been running in Damak of Jhapa district since 1992, was upgraded to a 30 bedded hospital in Jan. 1996. The official inauguration was done in mid April, 1996. Plans are afoot to make it into a 50-bedded hospital in the future. The slogan under which AMDA works is "Better Quality of Life for a Better Future."

Following the agreement between AMDA-Japan, and AMDA-Nepal the foundation laying ceremony of the Siddhartha Children and Women Hospital at Butwal was done. It is hoped to have the hospital partly functioning by end of 1998.

AMS Nepal: French Medical and Sanitary Aid in Nepal

This NGO has been working in Nepal since 1983 with the Nepal Red Cross Society. Its main work in the community health sector are in the districts of Myagdi and Parbat in the Dhaulagiri zone. It helps to improve the health conditions by way of conducting training for community health workers and also providing support for health care facilities.

Britain Nepal Medical Trust (BNMT)

The BNMT was established in 1967 with the object to assist with the health problems of Nepal. This INGO, based at Biratnagar, started functioning in May 1968 and has been involved in providing health services by way of the health posts in sixteen districts in Eastern Nepal. The main programme areas have been in drug supply, TB and leprosy control, the training and supervision of community health workers. Having accepted responsibility from HMG/N for TB control in the Eastern Region, BNMT has been able to put into place a treatment programme, which achieves an 86% cure rate. This work was given recognition by WHO when a review of TB control in Nepal was undertaken. It has done pioneering work in the institution of Hill Drug Schemes (HDS) in various places so that medicines are available at reasonable and fair prices to the patients of these particular districts (34). These schemes have varied from the Self Financing Drug Schemes (SFDS) to the Cost Sharing Drug Schemes (CSDS). These schemes are being evaluated and hopefully will provide insight towards future drug scheme functioning in Nepal. The areas where BNMT is active are: Dhankuta, Khandbari, Bhojpur, Diktel, Phidim, Ilam, Taplejung, Terhathum, and Morang.

Since Feb. 2003, BNMT through its integrated Health Improvement Programme (HIP) with its five major components viz.

- infectious diseases

- 168 Nepal's Quest for Health
- reproductive health
 - TB
 - HIV / AID / STD
 - Essential drugs

Co-operative for Assistance & Relief Everywhere (CARE)

This INGO started work in Nepal in 1978 as CARE - Medico and stress was on the training of paramedical workers. Subsequently, however, efforts shifted to building suspension bridges and agro forestry. Further work was on a community basis with stress on infrastructure development, community involvement and mobilising of the same in an attempt to meet the community felt needs. In 1991 it also started PHC activities in 2 districts of Nepal. The involvement of this INGO is in eight districts of Nepal.

Centre for Development & Population Activities (CEDPA)

This is a women-focused organisation founded in 1975 and has been working with local NGOs in Nepal since 1988. CEDPA / Nepal has been mainly involved with family planning activities. Its mission is to empower women at all levels of society to be full partners in development.

Department for International Development – Nepal (DFID-Nepal)

The objective of this project / programme which is supported by the UK government is the elimination of poverty in poorer countries. It is with this that DFID is supporting the health sector. Support is being extended to HMG in the Safe Motherhood and District Health Strengthening project. DFID also work with local NGOs and private partners.

Dooley Foundation/ INTERMED-USA

This organisation signed an agreement with HMG/N in August 1963 to do a national health survey to supply baseline quantitative for future health work in Nepal. Together with the assistance of the University of Hawaii a health survey was done in 1965-66 (35). In the subsequent years it helped the Institute of Medicine in various programmes for the development of human resources for health mainly in nursing and physiotherapy.

German Technical Cooperation (GTZ)

Technical Assistance for the health sector by Germany started in 1994 as a Primary Health Care Project. Over the course of the first seven years, projects in reproductive health and community drug management were started. From January 2001 to June 2003, a Health Service Support Programme was in force. This was subsequently continued.

Helping Hands

Helping Hands Nepal may be said to have been started in 1988 by a Health Trek NGO. It was officially registered in 1990 in Boulder City Colorado. Similarly registered at Kathmandu in 2051 BS the organisation has been involved in health care work in the Sankhawasaba district in Eastern Nepal. It has a number of branches in different part of the country and together with health personnel especially brought from abroad, it has been holding health camps in the rural areas. Helping Hands Nepal has also established three permanent health clinics – one at Khadbari and two in Kathmandu valley (36).

Indian Co-Operation Mission

The aid from India has been coming to Nepal from the fifties of the last century. Starting with the Tribhuvan Raj Path it has been in all sectors. In the health field India has been associated with the construction / expansion work in the cause of the under mentioned hospitals:

- a. Shri Paanch Indra Rajyaluxmi Devi Paropakar Maternity Hospital.
- b. Bir Hospital, now the National Academy of Medical Sciences set-up.
- c. Birendra Police Hospital

India has been assisting in Goitre Control through the supply of iodised salt.

The major work in the health sector now has been in the setting up of the deemed university BP Koirala Institute of Health Sciences at Dharan.

International Nepal Fellowship (INF)

The International Nepal Fellowship started working in Nepal in 1952. Following permission to Dr. Lily O'Hanlon, the INF had initially opened a clinic at Ramghat in Nov. 1952. Hospital services were started the following year 1953 with the Shining Hospital, so named as the original prefabricated aluminium roofs shone brightly in the sun. Five years later saw permission being given for "new building at the existing hospital ..a TB Sanatorium and a Leper Asylum." The Green Pastures Leprosarium was subsequently established in 1957.

The Shining Hospital functioned at the original site from 1957 to 1978 when in-patients and maternity cases were no longer admitted there. As per agreement with HMG/N, the beds of this were amalgamated into the Gandaki Zonal Hospital, which in course of time became the Western Regional Hospital. Consequently, between 1978 and 1992 there has been considerable input into this institution. The Shining bit continued as an outpatient clinic and became the Shining Community Health Centre. Current plans are for the INF to be involved in district health services by way of the hospital at Beni. Besides the curative services, INF's work has been broadened from just disease prevention and control to include areas of health promotion, health related development and training for health personnel. Activities centre on the community health project especially in areas of tuberculosis and leprosy in the western part of the country (37).

As from Nov. '94 the INF has been co-operating in the development of district health facilities by its involvement in the management of the Myagdi District Hospital at Beni Bazaar. Four other hospitals in the mid-Western region **viz.** Bheri Zonal, and the District Hospitals of Surkhet, Dang and Jumla have been targeted for up gradation and development in the coming years. This is in line with the current and INF's own thinking of making the "District Hospital the fulcrum of the health care delivery system for the population in the rural areas.

Japan International Cooperation

Since 1950 there has been some collaboration between Japan and Nepal in the health field. Whilst Japan helped Nepal to establish the Tribhuban University Teaching Hospital it has also been interested in 2 major areas:

- i. Promotion of public health activities especially in MCH and Community.
- ii. Promotion of health / medical service delivery (13).

Lutheran World Service/Nepal

This INGO has been working in Nepal for a number of years. Initially it's work concentrated on community development. It has been involved in looking after the Bhutanese refugees of Nepalese origin in the refugee camps of Eastern Nepal. With an office at Damak, Jhapa it is the implementing partner for the United Nations High Commissioner for Refugees (UNHCR).

Netherlands Leprosy Relief Association (NSL)

The major function of this INGO was to help with the establishment of the Eastern Leprosy Control Project in Eastern Nepal. The groundwork for this started in 1980, although the project started functioning in 1982 (38). It has built a number of district hospitals and handed them over to the government for running. Its objective is to help the government to reduce the total prevalence of leprosy so that it is no longer a major health problem.

OXFAM

OXFAM has been working in Nepal for almost a decade. Whilst programmes in the two districts of Jhapa and Sarlahi are conducted by this INGO itself, it usually works through the medium of local NGOs. The areas that it works in are in community development, adult literacy classes, income generation etc.

Marie Stopes International (MSI)

This is an INGO providing services related to the Sexual and Reproductive Health fields. Its local working partners is the Sunaulo Parivar Nepal (SPN), which has been functioning since 1994. The overall objective of MSI /SPN is to help the government to enable the people to exercise their sexual and reproductive rights freely (13).

PLAN International Nepal

This INGO initially started working in Nepal as Foster Parents from 1978 in collaboration with the then existing SSNCC at Sitapaila on the outskirts of Kathmandu. It has an overall objective of human development with a focus on children, their families and their community. From this small beginning, PLAN Nepal has expanded its activities to a number of different sites in 25 districts through NGO partners and is thereby giving benefit to many families and communities in many parts of Nepal. Its current focus is on six districts: Sunsari, Morang, Bara, Rautahat, Makwanpur and Banke.

SCF Alliance

Since 200 - the four SCF organisations, which have been working in Nepal, viz those of Japan, Norway, UK and USA have decided to work with a common objective and to coordinate matters so that duplication does not occur. This is being carried out and hopefully will be more beneficial than the system, which was in place earlier.

Save The Children Fund (UK)

SCF (UK) started work in Nepal in 1975 after having signed an agreement with the Nepal Children's Organisation (NCO) and the Social Services National Coordination Council (SSNCC). The first Mother and Child Health project was at Surkhet in 1976, followed by Dhankuta in 1977 and Bag lung in 1977. The Nutrition unit attached to the Clinic at Dhankuta has done remarkable work, which has been reported in the medical journals. A fourth project on MCH, with special boarding facilities for students was started at Tuatara, Sindupalchowk in 1982. All projects of SCF are run in close collaboration with MoH and the Institute of Medicine. An agreement regarding all four projects was signed with the MoH in 1983 and subsequently renewed for five year periods in 1986 and also in 1991.

Over the course of the years that the projects had been functioning a certain set pattern had emerged. There were in fact three interlinked components to each project:

- i. A MCH Clinic, which included a Nutrition Unit
- ii. A Health Post Support Programme
- iii. A Child Health Support Programme

Following the Bhutanese refugee influx into Nepal, SCF (UK) has been working in collaboration with the United Nations High Commissioner for Refugees (UNHCR) since mid 1992 to make conditions better and relieve suffering.

Since 1995 SCF had been slowly phasing out its direct MCH services and handing these over to the government. The process of handing over the four MCH clinics at Surkhet, Dhankuta, Bag lung and Chautara was completed in mid 1996. The focus now is to continue working with the people and help them to develop systems that the community can support and sustain.

Redd Barna

This is the Norwegian name of the SCF based in Norway and started to work in Nepal from late 1983. Following an initial agreement with the SSNCC in July, 1984, Redd Barna has been working in Nepal with a long term aim of community development. Its main objectives are:

- improving the quality of life of the children and the disadvantaged in the areas where it is working
- increasing awareness of child issues on a national perspective and doing some activities on a national scale.

SCF (Japan)

This member of the SCF has only been working in community development in the Dhanusha area of Nepal for about two years.

SCF (USA)

Following an initial agreement with the SSNCC in November, 1980, SCF (USA) started work in the Gorkha district and gradually increased its area of activity. Though the work at first entailed only immunisation services, the scope has been broadened with the starting of a Child Survival Rural Social Marketing Project. It has also been involved in AIDS awareness programme in Nuwakot district. During 1993-95 it was coordinator of 17 NGOs involved in AIDS related work as a result of American Foundation for AIDS Research (AmFAR) grants in Nepal.

Swiss Agency for Developmental Cooperation -(SATA/ Helvetas)

Initially the health aspects of aid were handled by the Swiss Association for Technical Assistance. This started in the form of help at Jiri, which took the form of a hospital, an ANM training school, and help to the health posts of Dolakha district. This later became SATA/Helvetas. Whilst SATA is coordinating all this technical work in Nepal, Helvetas is responsible for coordinating NGO's activity. Now however the SDC, through its Rural Health Development Project (RHDP) helps HMG to empower the 'Women, children, adolescent and men' to enhance their health conditions by way of improved local health facilities.

The Himalayan Trust

This Trust was formed over a quarter century ago by Sir Edmund Hillary. It has over the years built two hospitals. The Kunde Hospital at Solokhumbu was built and handed over to HMG/N to function as a district hospital. The other built in 2030 BS at Phaplu is the 29 bedded hospital that it runs itself. More recently, this particular institution has not been expanded due to land dispute. Besides this, the Trust is helping to run 25 schools in the Solu region and is also involved in reforestation work.

The Mission to Lepers (UK)

In 1956, the Mission to Lepers (UK) was given permission by the government of Nepal to open a hospital, known as Anandaban at the edge of Kathmandu valley. As from Jan. 1999 there has been a total of 125 beds i.e. 113 for leprosy and the others for general patients. Thus the institution is providing Regional level leprosy and some PHC services to the surrounding area. Laboratory research has been going on for 20 years, and many papers published on immunology and drug resistance. A dispensary for lepers was opened at Dandeldhura in 1960 and later expanded into a hospital run by another mission group in 1968. As the group concerned is The Evangelical Alliance Mission this is sometimes referred to as the TEAM Hospital.

United Mission to Nepal (UMN)

This was one of the early Non Governmental Organisations (NGOs) coming from outside to work in Nepal. The UMN is a joint effort by 26 member bodies from 17 countries and some affiliated organisations that work with HMG/N, local NGOs and individuals in Nepal. It is because of its diverse origin that led it to being called UMN. It's work in this country started with the starting of the five women's and children's clinic in Kathmandu valley. The first of these was at Bhaktapur or Bhatgaon as it was also more commonly known then. The second clinic, or rather a fifteen bedded hospital started in half of the premises of the Cholera Hospital in February 1954 on the 3rd anniversary of the attainment of democracy in Nepal (1). The opening was done by the then Prime Minister Matrika P. Koirala. One of the first workers of UMN at the Cholera Hospital stated "the hospital was shared with the maternity patients who would flee when there was an outbreak of cholera" (39).

In course of time it was felt that the siting of the mission hospital in a section of the Cholera Hospital was inappropriate (40). By January 1956 a bigger hospital was started in a former Rana palace, and retaining its original name came to be known as the Shanta Bhawan Hospital. It was in this building, of the 1920's that the American Drs. Edgar and Elizabeth Miller came to work and thus were able to sensitise the local doctors with and about the modern

curative medicine practised in the States. It was from this building and the nearby house of Surendra Bhawan where the maternity unit was sited, that the UMN continued to provide health services.

The thought of building a new facility originated in 1963 and agreement to this effect was done in 1974 after much deliberation. This project was completed only when they shifted to the site of the new Patan Hospital at Lagankhel on 9th November, 1982.

At about the same time that the hospital was started in Kathmandu, a dispensary was started in Tansen in June 1954 with the objective of upgrading it into a hospital at a later date. It was the families of Drs. Robert & Bethel Flemming and that of Dr. Carl Friedericks who with the help of other organisations set up a functioning hospital at Tansen. From its single room origin the hospital has grown to an institution with 131 beds (41).

The Mission Hospital at Amp Pipal in Gorkha district started as a rural community programme, then became a dispensary and finally a hospital.

Dr. James Dick was the pioneer and founder of the hospital at Okhaldhunga. Initially a dispensary functioned as such until 1972 when an agreement was signed with HMG to run a 25-bedded hospital on a joint basis (42). At the present time the hospital there is being run by a NGO – the Human Development and Community Services (HDSCS), which will ultimately take it over and manage it. The bed strengths of these various institutions at the end of 1994 were Patan Hospital (138), Tansen Hospital (129), Amp Pipal Hospital (Gorkha) 53 and Okhaldhunga UMN Hospital was 32 (43). By 2002 the Patan Hospital had a total of 318 beds.

Thus the UMN, over the course of the years opened a total of five hospitals. Four are still functioning but the initial attempt at Bhaktapur had to close down when the upgraded facilities of HMG/N started functioning there. In 1988, the UMN Health Services Department supported activities in 12 districts of Nepal.

Besides the specific curative aspects of health, the UMN has also been involved in community development projects in various parts of Nepal. These community development projects are creating awareness and are teaching problem solving skills so that motivation, self reliance are brought about in the people. At these grassroots levels, it has been involved in the training of *dhamis* and *jhankris* in childhood malnutrition, oral rehydration for diarrhoeal diseases and in various other aspects of public health and hygiene. The hope is that the projects will continue even when the external input stops.

With increasing numbers of hospital deliveries and the ever-present shortage of beds, the Patan Hospital has, as from January 1998 started what is termed the "Birthing Centre." This new innovation was started by renovation of its former *dharmashala*. The idea is that women with normal obstetrical histories and experiencing routine antenatal care can be delivered in such places under the supervision of trained midwives (44). The UMN has also helped train basic health manpower such as ANMs and also AHWs at Tansen. It is currently running two nursing schools and helping to meet the great shortage of nurses that exists within the country.

In April 2001a special children's ward of 82 beds named after Sahu Ganesh Lal was inaugurated by Sir Edmund Hillary.

As from November 2000, the UMN / HSD and HMG have been signing an agreement for 5 year periods with the objective of having Nepali owned and managed services. In May 2003, the Health Service Dept of UMN ceased to exist and the programmes were handed over to other transitional set ups. A number of new NGOs have been set up to carry on the work of some UNM programmes in different parts of the country.

The policy of UMN now is transition by which is meant shifting of the ownership, governance and management of certain projects, programmes or institutions from UMN to local institutions or NGOs. Currently because of some difficulties, the local NGO for running Amp Pipal Hospital has not been able to do so. Following the consent of HMG/N in December 2003, the work of UMN has now been transferred to what is now referred to as clusters (39). The clusters planned are at Mugu, Sunsari, Kathmandu, Rukum and

Dhading. (Rupendehi has also been accepted as an alternative cluster).
The Mugu and Sunsari clusters were started in 2004. For further information see UMN website: www.umn.org.np

United States Agency for International Development – (USAID).

USAID has been active in Nepal for over fifty years (13). The fight against malaria, the building of the Surgical Block at Bir Hospital, vector control in the Terai, treatment of diarrhoeal diseases etc. The present activities may be said to focus on:

- family planning
- maternal and child health
- HIV / AIDS
- infectious diseases.

SOCIAL SERVICE NATIONAL CO-ORDINATION COUNCIL (SSNCC)

An attempt at regularisation of social services was initiated with the formation of the Social Service Co-ordination Council (SSNCC), to regulate the various social service organisations that were coming into the country to do welfare work. It was stated that most of the agencies were interested in working in areas, which were easily accessible from the capital where their central office was situated. Failing that, it was in areas, which were near urban centres or tourist attracting spots. It led, thus to a situation where there was an influx of such agencies in certain areas and none in others. Then there was the question that some of the organisations may be involved in proselytisation and that funds were utilised to make religious conversion financially attractive. Last but not least were the requests to do such work in areas, which were politically sensitive, and so the request had to be turned down. Whilst various messages were read into these decisions and conclusions were made, the fact remained that social service work within the country needed to be regulated. It was this background that led to the formation of the Social Services National Coordination Council in 2034 BS with Her Majesty the Queen as the Chairperson. The work it would be involved in was divided into six main areas:

1. Health Services Coordination Committee (HSCC)
2. Child Welfare Coordination Committee (CWCC)
3. Disabled Welfare Coordination Committee (DWCC)
4. Women Services Coordination Committee (WSCC)
5. Community Services Coordination Committee (CSCC)
6. Youth Activities Coordination Committee (YACC)

Following the government decision, a number of the International NGOs decided that they had their commitment to the people who had provided them funds and so were not in a position to betray that trust by acting in the manner that was being demanded of them. The main objection was that funds could not be handed over to a semi-government body to carry out functions, which were ostensibly that of the national government. They also desired more transparency in the method of working and so a number of the INGOs decided to quit Nepal.

After the first five years of working and experience it was decided to combine the activities of the DWCC with that of the HSCC and form a new sixth coordination committee (45) viz: Hindu Religion Services Coordination Committee (HRSCC).

As far as health was concerned a substantial amount of work was done by some of the agencies that were in the HSCC. Whist the *Netra Jyoti Sangh* was involved in setting up Eye Hospitals and providing eye care, the Save the Children Fund of the different countries such as UK, USA, Norway and Japan were involved in activities related to children or the community.

Following the induction of the interim government in 1990 this Council functioned under the chairmanship of the Hon. Minister for Labour and Social Service. The registration of NGOs and INGOs has been simplified and

there has been a surge of activity in the social field. The number of NGOs and INGOs working in Nepal has increased appreciably since 1990, i.e. after the changeover in government. Whereas in the days of the SSNCC it was necessary to be registered to do social service there has now been a complete turnaround.

Those who operate at a local level and are not Western *mukhi* can be registered with the local administration or the CDO.

There has however been a lot of criticism in the local press in that many of the NGOs are not what they appear to be and have selfish individual interests. The charge is that many have been raking off the dollars meant for social service.

The Social Welfare Act 2049 B.S. (1992) was passed. Instead of the old SSNCC, a new Social Welfare Council was constituted under the new Act. It had the concerned Minister for Social Welfare as Chairperson and had representation from Parliament, National Planning Commission and from six related ministries. Representatives from NGOs doing social service of which one at least should be female plus individuals doing social work were nominated to the Council.

The new Act made it a special point not to limit the activities of the Non Governmental Social Service Organisations to just social welfare and rehabilitation but also in developmental activities. The new Executive body did not come into being immediately and the Council functioned for almost one year with just some of the executive officers, there being always a permanent vacancy of one or the other posts.

Table 5.7 No of NGOs registered with SWC by Areas

| Areas | No in 1998 | In 2005 |
|-----------------------------|------------|---------|
| Child Welfare | 164 | 508 |
| Health Service | 177 | 375 |
| Handicapped/Disabled | 203 | 342 |
| Community/Rural Development | 3641 | 9147 |
| Women's Services | 723 | 1457 |
| Youth Services | 1619 | 2929 |
| Moral Development | 197 | 442 |
| Environmental Protection | 470 | 972 |
| Educational Development | 63 | 198 |
| AIDS/Drug Abuse Control | 32 | 55 |

In fact in 2046 BS, there were said to be just 300 plus NGOs registered with the SSNCC. By the end of Asar 2055 or mid July 1998, there are said to be a total of 7,389 NGOs registered with the SWC for working in this country. There are also some others registered with the CDOs at the local level and these have not been included in these figures. The NGOs registered with the SWC have been categorised by their related activity (46) into the ten different groups as given in the Table 13.1. At the end of 2061 BS or mid April, 2005 the total number of NGOs had reached 16,425.

What was soon realised was that this division could not be watertight. As examples, some NGOs dealing with deafness, blindness or even leprosy have been registered in the health group whilst others were in the handicapped/ disabled one. Furthermore the fact that one NGO was registered with one group did not mean that it could not work in another area. Most worked in many areas/sectors and so the involvement was actually multi-sectoral. The breakdown of the NGOs working in the districts of the five development regions of the country in 1998 and 2005 is as follows:

Table 5.8 NGOs by Development Regions in 1998 and 2005

| Regions | No. in 1998 | No. in 2005 |
|----------------|--------------------|--------------------|
| Eastern | 825 | 1968 |
| Central | 4588 | 10216 |
| Western | 1104 | 2208 |
| Mid-Western | 544 | 1122 |
| Far-Western | 328 | 911 |
| Total | 7389 | 16,425 |

Any INGO wanting to work in Nepal is required to submit an application to the Social Welfare Council for permission prior to commencement of work. The number of INGOs working in Nepal at the end of June 2004 was 123 and came from 19 countries. By end of 2061 BS or mid April 2005 the total number of NGOs registered with SWC and working in Nepal was 17,661.

Though it is stressed that most of the NGOs should be rural oriented the agency concerned might go to an area for one of various reasons such as accessibility, donor visibility, political patronage etc. An example may be given of the fact that in the Sindupalchowk area, which came into prominence because of the flesh trade and AIDS susceptibility, there are many NGOs working in this area. In such a situation the question then arises as to whether credit for work done is being claimed by each of the participating NGO as its own whilst in reality it was almost a combined effort. The other aspect of this is that the involved offenders, i.e. girl traffickers moved from this area of intense scrutiny to areas where there was less interest and which were further afield.

With the frequent change in governments, there is great difficulty in proper functioning. One general complaint is that executive officers continue to run the SWC without any reference to the other members. In view of the frequent changes in executive members and the paucity of meetings it is doubtful as to how much can be really achieved.

One has therefore still to wait to see whether there will be any improvement in the functioning and the effectiveness of the body. Only time will let us know the answer.

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