NEPAL

HEALTH BRIEFING PAPER

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The Kingdom of Nepal is wedged between India and China along the backbone of the Himalayas. Multiparty democracy was established for the first time in 1991; this was followed by a long period of coalition Government with the Nepali Congress Party (NPC) and the Communist Party as major partners. Following recent elections the NPC has formed a majority Government and although internal tensions exist, notably from Maoist insurgents, the prospects for stable Government are probably better now than they have ever been.

Nepal remains an extremely poor country. Per capita income is only US$220 per head and Government faced major problems in providing basic services to a very dispersed and fragmented population estimated at 21.5million and growing at around 2.5% per year. Poverty is pervasive; half of the population live on less than US$1 per day and around one fifth are considered very poor. Those without land or marginal landholdings in rural areas, "untouchables" and those in the far west are particularly vulnerable.

Health Indicators

Overall health indicators are poor and differ significantly by region. The low status of women is reflected in a lower life expectancy for women than for men.

Place of Residence	Infant Mortality Rate	Under 5 Mortality Rate
Urban	60.4	93.6
Rural	100.2	147.0
Mountains	132.3	201.0
Hills	85.5	131.3
Terai (Plains)	104.3	147.3

Around 70% of the overall disease burden is due to communicable diseases and 50% of the burden fails on the under 5's. The main causes of ill health are perinatal conditions, acute respiratory illness, diahorrea and measles. For older age groups TB is a major problem whilst problems related to pregnancy, childbirth and burns are major causes of ill health and death for women.

Key Health Indicators

- IMR - 79 per 100 (1996)
- U5MR - 197 per 1000 (1991)
- Maternal Mortality Rate - 539 per 100,000 (1996)
- Life Expectancy 55 (56 for men, 53 for women) (1996)
- Total Fertility Rate - 4.6 (1991)
- Immunisation Rate - 100% BCG, 81 % OPV3, 80% DPT3, 88% measles (1996/7)
- Contraceptive Prevalence Rate - 23% (1993)
- Access to safe water - 67% urban, 37% rural (1994)

Health Sector Provision and Financing

The public sector continues to be the dominant provider of health services in Nepal. The 1990s have seen an enormous increase in the public health infrastructure particularly at lower levels in the system. However, since 1990 there has also been a rapid growth in the private sector and there are now 9 private hospitals and at least 10,000 private pharmacies. The role of the NGO's has also grown rapidly but their role remains relatively modest.

Significant barriers to access remain. Only 65% of the population in rural communities are within one hour of a public health centre and only one in ten within an hour of a hospital. Public facilities continue to be the dominant source of care for all income groups -household surveys indicate that around 55% of people first seek care in a public facility compared to 37% for the private sector. There are major concerns about the quality of services received at such facilities.

The system is extremely centralised despite much talk about decentralisation. Virtually all management and financial decisions are still made at central levels despite the fact that the Department of Health Services is understaffed and underpaid. Frequent staff transfers also hamper continuity. Regional Health Directorates were established in 1993 but their roles have been unclear and they have had little impact to date. District planning is still at very early stages; capacity is improving but still lacking at the local level whilst the centre is unable to provide essential guidance and technical support. The Local Self Governance Act (1999) delegates significant powers to lower levels and offer some prospect for real decentralisation.

Health services are extremely fragmented - relatively little donor funding flows through Government making it impossible for Government to assume an overall co-ordinating role.

Health expenditure is estimated at around US$11.2 per head (5.3% of GDP). Of this over 72% is accounted for by out of pocket expenditure. Of this most is spent on drugs with a large portion (42%) being spent in public facilities. Nepal is unusual in that the better off appear to spend more than the poor not just in absolute terms but also as a proportion of income. In urban areas, for example, household surveys suggest the richest 25% of the population in rural areas spend 8.7% of their income on health services; the poorest 25% only 3.2%.

User fees are common place in mission and private facilities but are less widespread in Government facilities. Zonal and central level hospitals with boards are now empowered

to raise, retain and use fees and some have made considerable progress. A number of pilots are ongoing at lower levels focusing particularly on drugs.

The Government contribution to health care has risen rapidly in recent years (by 21 % per annum in real terms between 1991/2 and 1996/7) and now accounts for around 16% of total health expenditure although it remains low in overall terms at only 1.26% of GDP. Donor's expenditure has increased rapidly in recent years and now accounts for some 15% of total health expenditure.

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Budget procedures are not transparent and it is difficult to distinguish between recurrent and development expenditure and between primary and non-primary health care expenditure. Planning tends to be based largely on an incremental basis (i.e. last years allocation plus 10%).

Current Health Policies

The goal of current health policies is to raise the health standards of the rural population by strengthening the primary health care system. The Eighth Five Year Plan focuses on enhancing health status, extending basic and primary health care services, extending maternal and child health and family planning services and developing specialised health services. More specifically the key strategies are to provide an integrated basic health care package, to improve reproductive health services, to develop specialised health services at various hospital levels, to develop and strengthen ayurvedic and other traditional services, to implement a human resources development plan and to implement an effective drugs policy. In terms of the health sector reform agenda, key areas are the development of appropriate referral mechanisms, enhancing co-operation with the private and NGO sectors, decentralisation, reforming health policies and laws, mobilising additional resources and increasing community participation.

DFID Involvement

DFID's overall strategy in Nepal, as set out in the 1998 Country Strategy Paper, is to address the main causes of poverty, promote better governance, develop more co-ordinated approaches to human development, to strengthen approaches to rural livelihoods, to help establish better physical access in remote areas and to build pressure for change through better awareness and more empowered communities.

DFID's Health and Population strategy focuses on the development of sector wide approach or sector wide thinking, building on improved management and delivery of services, supporting greater continuity in supply of essential drugs and other consumables, developing opportunities for working outside the public system and promoting wider access to safe water (especially in the mid and far west).

DFID has played a key role in developing the sector wide thinking ‘SWAp’ approach. A workshop held in May 1998 started the process and a joint donor review in September and October 1999 will review possible DFID support to development of the Nepali

strategic planning process. It will focus on the health component of the Eighth Five Year Plan and to identify a short term action plan for strengthening capacity within Government to lead this process effectively.

DFID has also been providing direct support for the district planning process through the District Health Strengthening Project and through the Safer Motherhood Project it has attempted to influence the centre and district through helping to develop and implement innovative service level interventions.

Role of Other Development Agencies

Development agencies make significant financial inputs and the levels increased rapidly in recent years. The largest commitments over the period 1997 to 2002 are USAID US$ 61 m, World Bank US$ 22.7m and UNFPA US$ 16.5m. USAID are heavily involved in family planning, maternal and child health activities, prevention and control of HIV/AIDS/STIs and an infectious disease programme. The World Bank have just completed a strategy review and are in the process of developing a new loan. UNFPA's focus is on improving reproductive health/family planning services, basic training for staff at lower levels, technical and management capacity building, infrastructure development and Information, Education and Communication.

Donor support is extremely fragmented - much of it is outside the Government system. It is usually disease based support at district level and there tend to be little or no co-ordination between donors or with government though there have been some attempts to co-ordinate within sub sectors e.g. TB, leprosy.

Key Documents

- National Health Policy 1991 Second Long Term Health Plan 1997 to 2017 - this has been resubmitted to the Cabinet Office in view of new Government Health Section of 9th Five Year Plan
- World Bank - Public Expenditure Review
- World Bank - Health Sector Strategy

Mark Pearson, September 1999

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