Network of Asia-Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG) Annual Conference 2005
Beijing, PRC, 5-7 December 2005

Theme: The Role of Public Administration in Building a Harmonious Society

Workshop on Health Care for the Poor in Asia

Health Care and Poverty in Nepal

Dinesh Raj Sharma
Director of Studies, Nepal Administrative Staff College
And Founder President, NAHUDA- Well Women Clinic
Lalitpur, Nepal

Durga Sharma
Joint Secretary (Nursing), Ministry of Health and Population, Kathmandu, Nepal
Current situation: Nepal with 24.6 million people (2002) stands 140th position in Human Development Index having 59.6 years of life expectancy at birth, 44 Percent literacy, per capita GNP US$ 233 (2005), and life expectancy index is 0.36. Forty eight per cent children under five are under weight, maternal mortality per 100,000 live birth is 540, HIV/ AIDS prevalence per cent (15-49 years) in 2003 is 0.3 and percentage of condom use by high risk age group (15-24 years) is 52 per cent by male and women are not using yet (HDR report 2004). Illiteracy, poor health services, comparative lower years of life expectancy at birth, higher rate of unemployment or under employment are forcing people remain on vicious circle of poverty. “You are what you eat and drink”. Poor people will not have healthy food and enough calories intake on time that reflects their poor health condition and become sick time and again. ‘Poverty reduction cannot be achieved in Nepal without effective governance…The cost of not moving towards more pro-governance will be catastrophic for Nepal and its people’1.

Disparity in income consumption is so critical that ten percent rich grab 29.8 percent whereas poor ten percent do have only 2.3 percent. This makes income disparity ratio of 1:9.3. Nepalese poor suffer in a state where the per capita income is the lowest, $233 in compare to other Asia Pacific Least Developed Countries’ having $513 (UNDP 2005). ‘Income level of politicians, professionals, and business has gone up. The poor are not becoming any richer, they are not withstanding the inevitable trickle down effect2. The plight of the Kamaiya (bonded labor) of western Nepal had long been ignored by the central government. It was a media campaign, launched and kept up over three years that led to this terrible practice being outlawed in 2002. The media worked alongside a number of NGOs in this campaign3. One of the reasons for the wide spread conflict is the income gap between those at the bottom and those at the top is widening.

Sagarmatha zonal hospital in Rajbiraj, 450 Kilometers from the capital city in the Terai region, out of the required nineteen positions for medical doctors, only nine doctors’ positions are filled in since last ten years. Majority of Doctors open private clinic near by to their hospital duty station. It is observed that some of them do have private clinics, for the people who can afford to pay, in the government supplied free residential quarters. Another observation is of the Changunarayan Primary Health Care Center five kilometers from Bhaktapur district head quarters. Most of the time, the medical and paramedical staffs posted in the center are not found on duty hours sighting some excuses. The primary health care center are meant to provide twenty hour health care services in the area in written documents but in practice it is hardly two to three hours service provided by the paramedical staff. In this context, poverty stricken people are not getting services when they need it.

The other case is so pathetic that in Doti district, four people having diarrhea cases in a village, 25 KM from the district head quarters were kept away from the village in a cave, let those people die in the cave. This is the state of awareness level and medical support system to the patients having simple problem of dysentery and diarrhea cases too.

Only 11 percent births are attended by skilled health personal (1995-2000). Five physicians are available per 100,000 people (2003). Availability of essential drugs ranges from 0 to 49 percent (HMGDOH&P 2004). The availability of physicians per 100,000 populations is five (2003AD) in number in Nepal. This is the simple average but the most of those health service providers are in urban centers especially in the capital city, Kathmandu. The poor section of the society being in the remote area or being unable to visit the place where drugs and services available or unable to afford to pay the price of the medicine or services hinders them to receive even the supplied drugs in the area. In this backdrop, some empirical cases are sighted below.

References:
1 Michael E. Lowe, Program Manager, Enabling State Program, Pro-poor Governance Assessment Nepal, ESP, Kathmandu, 2001, page - Foreword
2 The Himalayan Times, Kathmandu, October 10,2005, page- 8
3 Ibid 1, page - 86
In this context, poor remain in lowest range for receiving the essential drugs because of their location factors and capacity to pay and opportunity to visit the service points too. Poor will remain comparatively deprived of health care facilities unless a focused attention is paid to make participation and extension of representative ownership on the resources of poor people. The numbers of mental illness cases are in increase due to on-going conflict. 'Even though prevalence of mental illness in the country is very high, there are only 30 psychiatric doctors to take care of them, besides the brain drain- Dr Nirakar Man Shrestha. Dr. K.D. Upadhyaya elaborates that 850 patients were admitted and treated out of 21,000 patients.4 The experts’ view is that there are around 30 percent of the total population suffering from one or the other type of mental illness at any point of life, where as, there are only 30 psychiatrists in the country.

'Death due to tooth outing by a quack doctor; since four years there are no medicine in Aurbed, herbal medicine clinic of a remote district, Mugu; a gang rape to women by bus employees; four hundred shelters of landless people has been dismantled; and demand to release Chairman of Chepang Association from custody in Makwanpur District are the heading of news in the same page of the news paper5. Further, ‘700 huts of squatters demolished, 16 held. One of the displaced person says that “despite our pleas, they tore down our houses. Where are we supposed to go now”?6. Those people were displaced from internal conflicts or are landless or unemployed mass. Those people mentioned in newspaper are all poor people.

‘Anti-HIV package for mothers launched…. among the 500 cases, 30 percent are women, out of the nine hundred thousand annual pregnancies, eighteen hundred are estimated to occurring HIV-positive women, leading to an annual cohort of 450 too 810 new born - Dr. R.P. Shrestha, director of National Center for AIDS and STD control7.

The government efforts alone are not enough to address the delivery of health services to the poor in Nepal. Some individuals, National and International Non governmental organizations are also doing services to make health services reach of the poor people. Mustang, one of the remote Himalayan districts where only traditional healers and medicine is the hope of local people for their cure. Recently, 85 years old Japanese fellow has established fifteen beds reasonably equipped hospital to serve the people in the remote hilly district.

There are 84 hospitals, 188 Public health care centers, 698 health posts, 3129 sub-health posts in the country. Total central level hospital beds are 1110 Out of 9,800,451 patients visited in the health facilities 6.07 percent with skin diseases, 4.36 ARI, 3.87 percent with Diarrhea, and 2.73 percent are with intestine worm (MOH&P 2005). The majority of people suffering from these diseases are from the poor sector of the society.

Poor and health A poor minor girl from Majhi, a tribal community was raped by security forces, the concerned authority said that they are ‘probing the incident’8. Mr. Shahi Man Rai writes a pathetic situation of one of the hospital in Bhojpur district head quarters in eastern Nepal with news head as Hospital without doctor. There are structures of hospital and health centers in the district without required professional staff or no staff at all due to various reasons. The conflict situation is also one of the causes. Generally, health personal that go on leave do not come back to join the duty. Staffs do not like to be remaining and posted in the hilly districts where majority of poor live. ‘Last year's allocated medical supply has been arrived only after the end of the year9. These are the reflection of health service delivery situation and plights of poor.

There are factors worst than the above-mentioned points. People are discriminated on the basis of birth – high class and untouchables. There is another dimension of discrimination in between and among the discriminated untouchables as well. In remote rural poor areas, still, people are

---

4 Ibid 1, Kathmandu, October 10,2005, page 1  
5 The Kantipur,Kathmandu, October 21,2005, Page 8  
6 Ibid 1, October 29,2005, page- 8  
7 Ibid 1, February 28, 2005 - page 4  
8 Ibid 1, December 2, 2004 - page 1  
9 Ibid 2, September 11, 2005, page - 7
intertwined with issues like who is superior or inferior by birth. However, both are from the poor area and deprived from many of the opportunities and they are wasting their time and energy on such issues. In the cities and better off areas, these issues are going out of agendas of the society. Governmental, non-governmental and civil society are doing various programs to make them aware and make good practice in the society as equal members and fight with the common problem poverty. Still, there are problems. It might be eliminated only with wide spread education and better standard of living and interaction with other society members or moving in new places.

‘The prevalence of democracy in India ensured that deaths from starvation and malnutrition were kept to the minimum because of the publicity they received’ (Nobel laureate Amartya Sen). The problem needs to be publicize so that due attention can be received from others and local themselves will also work out the strategy to face the problem and work out for the future course of actions.

The state of health of poverty stricken people is definitely under cared in general and the poor women in particularly more suffered even with early attend able problems like productive organ prolapse, post abortion care, regular supply of family planning means and opportunity to use that. The prolapse cases are so rampant seen among the rural poor women that ‘53 women to undergo free uterine surgery…The total expense incurred in one uterine prolapse operation is around $570 that includes medicines, the Nepal Gunj Medical College said…..The problem was mostly seen in women over 22 years of age with children’. As per a study in selected area, one out of four women of reproductive age group having some degree of Productive Organ Prolapse. It is just plain truth that how women below poverty level will be able to get the treatment by themselves where the national average per capita income itself is $233 (2004).

Medical supplies: The government procures medicine centrally to be supplied freely to poor patients from the local health facilities and transfers the medicines to hospitals and health centers. The common happening starts that receivers are getting almost date expired medicines from the government central procurement system office so within very sort period of time received medicines become date expired and need to start process of disposal. Recently, Rs. two million (US$30,000) worth of governmental supplied medicine in Chitwan hospital was found stored in a warehouse letting it to be date expired. Central government agency and local hospital both are blaming each other but the medicines are wasted and poor are deprived.

Considering all these anomalies, transparent supply system allowing enough room to incorporate the local needs as well as creating environment to make the ownership of poor in particular and mass in general is the need of time. The budget, government spends need to be spending by the local concerned people rather than procuring and supplying medicines from the center. The central level government system may identify the list of suppliers and the competitive pricing. The local level authorities should allow having enough liberty to procure or make competition within the identified agencies for the best bargain and quality medicine supply.

The following points were noted while discussing with under secretary Mr. Krishna Murari Neupane, Ministry of Health and Population on September 30, 2005. There are no special programs particularly to poor. Health is a general need it has to be provided to all. There is a provision to use five percent of the allocated budget for the treatment of poor people identified locally. This is very vague provision. Recently, a program has been introduced to make financial assistance to pregnant women, if delivery is done in health facilities, can receive financial support of around $21 in mountainous part, $14 in Hilly region and $7 in plain area. This is a program to motivate women who cannot afford to or with some reason do not visit health facilities are encouraged to do so.

10 Ibid 1, October 29,2005, page- 4
11 Reproductive Morbidity (2002), GTZ,UNFPA and HMG/Nepal, page 26
As regards health facilities, remoteness and poverty are linked. A comparatively rich mountainous region become poor to receive health services because of the distance of the service centers and need to spend more on to and fro costs and lodging and food costs as additional burden. The amount of treatment costs might be low but the gross costs become high. So poverty or inaccessibility can be looked through income level, remoteness or accessibility, availability of health services and level of education and awareness. Public health system is urban focused.

The government has a policy of enhancing local level participation by allowing local people to be in health institution management committees. However, many health centers are almost in a state of without local level management committees for years due to absence of elected or selected representatives in those institutions.

Non-governmental efforts
Korean doctors provide health services to 2,200 people …and medicine worth $30,000 were provided to poor and needy people residing in the periphery of the Lord Buddha’s birthplace in Lumbini. International and national non-government organizations are also contributing to provide health facilities to the public in general and poor in particular.

Field realities: Dadhikot Primary Health Care Center (PHCC) has a provision to be staffed with 11 persons headed by a Medical Officer qualified as MBBS. There are three sources of medicine supply. The central government sends some medicines from its regional medical supply store located in Hetauda, 150 K.M. from the center. The government has allocated budget for procuring medicines to its public health units throughout the country as shown below:

<table>
<thead>
<tr>
<th>Health Units</th>
<th>Procurement through District Health Office US $</th>
<th>Central procurement US $</th>
<th>Total budget per annum US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care Center (PHCC)</td>
<td>570</td>
<td>170</td>
<td>740</td>
</tr>
<tr>
<td>Health Post (HP)</td>
<td>360</td>
<td>715</td>
<td>1075</td>
</tr>
<tr>
<td>Sub-health Post (SHP)</td>
<td>170</td>
<td>360</td>
<td>530</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Population

The district public health office procures for the health facilities and makes controlled supply of medicines in the district. The centrally procured medicines are also arranged send medicines through their appointed agent to the health facilities. There are for and against arguments for procuring medicines on behalf of the concerned health facilities. Theoretically, it may not be understandable to the general public of making such budget control by the central authorities. In this context, decentralization, devolution and transparency are considered as sweet slogans to express not to practice by the authorities. Ultimately, the local health facilities are allowed to manage even financial resources in local level if they have to have medicine procurement of their choice. Dadhikot PHCC had an opportunity to have one Japan supported project. Under the project the PHCC had some fund. Now the fund is around $500 dollars (discussion with Dr JK Shah, Dadhikot 2005). The local management committee procures the required medicine and sells on cost-to-cost basis from the PHCC itself. It has been found that the medicines supplied from the center and district stores are mostly not matching with the local requirements. The major problem with the centrally supplied medicines is in the process of prescribing some medicines are found already date expired. It might be due to long process and time taken from procurement and sending medicines to the PHCC. There is mismatch between local demand and the supplied medicines. In the past, every year some medicines had to be disposed off in a pit with fulfilling

12 Ibid 1,October 9,2005 - page 3
long process. It is learnt that government is encouraging local management committees to generate fund locally and government also has started to provide some resource as capital fund so that local committees can manage to procure medicine and make sustainable pricing.

The PHCC covers population of 7649 people from four village development committees. In the month of Aswin (September/October), 301 patients visited the PHCC. Out of that 110 patients or 36.5 percent were allowed not to pay registration charge of around four cents considering them as poor people of the area. There is no any substantial documentation or identification system devised as yet. Every person attending the PHCC is supposed to receive medicines of general category. However, there is least chance to have the required medicine on stock for free distribution. There is no provision to make free distribution of the required medicine especially to poor on the spot. Poor will get it only if there is available stock.

In the national level, some the PHCCs have started to identify the poor patient and issue identity cards. The single women, old people aged 60 and over or poor are theoretically privileged to have supply of free medicines and treatments. But in practice, it has to be seen in the perspective of the allocated budget.

There are not specific program directed to poor only. But five percent of the budgets allocated to hospitals are meant for treatment costs of the identified poor. The poor patient has to visit local village development committee and or district development committee officials for certification of their poverty status for getting the free treatment in the hospitals. In some of the cases, the medical superintendent can provide this facility directly if he or she did felt the patient is really a poor fellow.

The burden of proof lies with the patients themselves. The poor fellow suffering from diseases have to visit far off offices and see the officials where the bureaucratic formalities demand long time and process to get the recommendation to get the free treatment. There is no any system to identify the poor fellow to receive the medical treatments in public sector hospitals and health facilities as an identity to show (Basedon discussion notes with under secretary Mr. Murari Prasad Neupane, MOH&P on 30th September 2005).

The poor itself is a vague term unless it is defined under some established system. The per capita income varies depending up on the person’s residential area. The poor in Terai, southern parts of the country are not comparable with the poor in the hilly regions. The poor of the urban and the rural area are not standing in the same line. The variation in income level of the area also affects the paying capacity to stand for the medical bills. The service seeker from the area where they have to travel for hours or days requires paying the transportation, lodging and food bill in addition to the medical bills. This makes the poor from remote and poor area further sufferers in compare to the same level of poor in comparatively accessible areas.

**HIV/AIDS and poverty**

Poverty stricken persons and family members are highly likely to be trapped in HIV/AIDS. There are estimated sixty two thousand HIV/AIDS affected people in Nepal. However, the National AIDS and Sexually Transferrable Disease Unit has recorded figure of 5,465 persons. Male population from the comparatively less developed districts like Achham, Doti, and Baitadi go for employment outside the country in mega cities like Bombay working and living in a pathetic conditions and many return with HIV/AIDS infection without having any knowledge and ultimately, they may transfer it to their partners and other family and society members too.

There are close linkages between poverty and poor health. There is a vicious circle of poverty: low income, low nutrition intake because of less buying and bargaining power, low capacity and efficiency at work, less chance to be aware and educated, weak health condition cycle makes. So
there is close relation between poverty and health conditions in general and even the deadly HIV/AIDS infection in particular.

There is a pattern of changing or transferring from policy to working level key health personals with the change of government in the center. In some of the instances, minister’s change of the portfolio also affects movement of departmental director. It makes inconsistency on style, pattern and priority of working.

Health and conflict

The existence of civil war like situation in the country has compelled many families to be out of their place of residence. Those victims’ families do or bound to accept any kind of first available job to start their earnings to support the family. Particularly, the female members who are migrant to the cities “are bound to accept as sex workers to support themselves”13. The conflict has been aggravating the poverty situation even of the well off population who had to do circumstantial internal or external migration.

Townsend defines poverty as inability to run life according to the prescribed standard by the society. Nobel laureate Amartya Sen links poverty to a condition of deprivation of option for social and political opportunities. He sees absence of opportunities to select healthy and creative life, freedom to enjoy good living standard, dignity, and respect for others are furthering factors of poverty. The above condition can be harnessed only in the democracy. After the short-lived democracy, 1990 to 2001 AD, people in Nepal are again in a situation of political bewilderment. The tenth five-year plan, 2001 to 2006, had envisaged reducing poverty level from 38 percent to 32 percent by the end of the plan period. However, having 38 percent (2000) people below the poverty level precious four years have passed without any achievement.

Fifteen percent of population of Nepal lives in urban centers or cities, and the rest eighty five percent (2003) in the rural Nepal. Seventy percent Nepalese live in mountainous region where main means of transportation are human beings, mules, and ships. Small percentage of privileged people can have access to aeroplane for goods and human transport from the near by cities. In this situation, the established health services are not easily accessible at the time of need and the question of affordability remains unanswered. The same health service is cheaper to the person in the urban centers. However, the people from distance have to devote day or days to be in the health facilities and get facilities. In some of the situation, they have to prepare to spend more on to and fro costs or lodging and food costs then medical bill. The poor people simply do not have capacity to stand for all the expenses, so in many instances, they will give up the hope for getting treatment. The Chinese experience of ‘due to the lack of government al investment and effective management of public education facilities, the civilization in poverty regions is even becoming worse: gambling and eroticisms is being flooded into these areas’14 The situation in Nepal is not different may be even worse. Due to the accelerating internal conflicts because of different viewpoints between and among underground leftist movement, democratic political parties and the king with his allies; the remote and rural parts of the country people are suffering further in general and poor people in particular.

Causes of meager health service delivery in poor areas:

Out of 42 percent people, in reality 90 percent are isolated people under the poverty line in Nepal (Dr. Harka Gurung). Isolated people are exploited in social, economical and cultural terms having as bounded labor like Haliya, Balighare, Doli, Charuwa, and even not permitting to sell their milk products in the market. The exploitation and poverty are barring representation in the governance system and deprived from sharing the resources both in local and national level.

13 Maina Dhital, Condom, AIDS and Poverty (in Nepali) The Kantipur, Daily, Kathmandu, Nepal- October 22, 2005
14 Prof. Hongjun Zhao, Beijing Administrative College, Paper submitted in NAPSIPAG conference in Kula Lumpur 2004, papers collected and published By Dinesh Raj Sharma, Effective Service Delivery a challenge needs to be addressed, Nepal Administrative Staff College, Kathmandu January 2005- Page 28
The first step to eradicate poverty starts once 'the informed poverty stricken people begin to understand clearly the reasons behind the poverty after that they will actively participate to get out. Further to this, isolated peoples' poverty is not only the lack of physical resources but also of thoughts and substantiation.'\(^{15}\). Poverty stricken people have to move forward with realistic action programs to eradicate poverty in a democratic movement and pressurize the government to respond properly. The concern people should be empowered with policy decisions, supply of trained human resources, transparency, transferring ownership in planning and implementing the services, facilitating concern people to participate actively to address their own health problems will speed up the getting better health services. The tragic part is that ‘various organizations are becoming their leaders’ "beggars bag", means to fulfill personal interest, are being agent of political parties and isolated people used as vote banks’\(^{16}\).

The poverty is not the product of one-dimensional issue. It has got multi factors deeply rooted in the society, economic structure and value system. Poverty alleviation is of priority of national governments and international agencies. In real ground, nothing much could have been done in Nepal. ‘Poverty alleviation should not only be a responsibility of the national government but should be lodged to local government units where the poor are located. Innovative local government officials can be directed...in responding to the plight of the poor in a more innovative way- capitalizing on such principles as people participation, focused targeting, convergence and human development’\(^{17}\).

**Poverty and Poor health**

Even in the United States of America 'voluntary charity alone would never be enough to overcome the grinding combination of poverty, discrimination, and lack of opportunity that held so many of my fellow citizens back'\(^{18}\). The state should take a lead role to provide focused quality health services. Non-governmental efforts can supplement for introducing new services and going in far off parts but can not take the total burden. Like wise, the government without having support of civil society and NGOs cannot meet the health needs of so many poverty stricken people of Nepal.

**Analyses:** An attempt has been made to analyze the health situation and its delivery focusing to poverty-stricken people. Seven S-s strategies have been taken as a technique based on Thomas J. Peter and Robert H. Waterman Jr's, concept. Shared value has been given pivotal role so that all other efforts will be fully understood and utilized to achieve the perceived and stated goals. Strategy, structure, system, style, staff, and skills are the other six factors needs to be balanced and integrated to each other. For the last decade, a trend to make local management committees to local representatives had positive impact for better service delivery based on the local requirements. However, there need a lot of change of attitude of government officials to allowing working of the committees independently within the broader policy framework of the government.

**Shared values**

Physical and financial resources are important aspects but more than that shared "values and beliefs" of the concerned poor people are critical factors for the betterment of the health care system in general. Participation of the ordinary people is so important that 'The top performers create a board, uplifting, shared culture, a coherent framework within which ....their ability to extract, extra ordinary contributions from very large numbers of people turns on the ability to

\(^{15}\) Mr. Moti Lal Nepali, Poverty Eradication and identification of Isolated People, Ibid, page 9

\(^{16}\) Mr. Chakra Man Biswokarma, Problems of Isolated Peoples’ Movement, Ibid _ page 11

\(^{17}\) Prof. Dr. Victoria A. Bautista, Ph., A Critique of the Local Poverty diagnosis and Planning system, National College of Public Administration and Governance, University of the Philippines, Paper submitted in NAPSIPAG conference in Kula Lumpur 2004, papers collected and published by Dinesh Raj Sharma, Effective Service Delivery a challenge needs to be addressed, Nepal Administrative Staff College ,Kathmandu January 2005- page 119

\(^{18}\) Mr. Bill Clinton (2004), My Life, Alfred A. Knopf Page -
create a sense of highly valued purpose...the excellent companies are way they are because they are organized to obtain extraordinary effect from ordinary human beings. The government has envisioned and established local level committees to look after the management of the local health institutions. The problem lies in the process of formation of the committee, understanding and integrating the representation of the stakeholders to share their values and beliefs for the management of the health system. The resource handling government officials’ values and beliefs are not matching with the real stakeholders. The government officials’ role is not observed as one of the stakeholders but the whole sole authority in practice. The policy documents are prepared to make high-level participation of the local actors but the actors are selected and appointed by the government in the health management committees. The government seriously needs to make representation of 38 percent people from the below poverty line including oppressed (Dalit) having gender balance. This mechanism will help build own “values and beliefs” in the local health institutions. The shared value emerges by allowing stakeholders to get into the problem and understand and own it for their own shake.

**Strategy** The government has been preparing various strategy papers. Every year the strategy is revisited or worked out new one for making better health service delivery. The strategy as document is well worked out but in practice it is highly government officials focused concentrating in the cities. Ultimately, it results; health services are better available in the cities and to the well off people. The rural people in general and poor in particular are not getting benefits as they deserve. As Alfred Chandler wrote in Strategy and Structure that strategy follows structure. The right strategy with good intention to implement it will definitely start improving the health service quality to poor.

**Structure** Basically, the organization structure is centralized. The centralize structure cannot address the requirements in the health sector especially to address the needs of the poor effectively. The structure has not been allowed to be organic it is rigid. There is no scope to make local level structuring as demands in the local situation. The government has started to introduce local level flexibility on public school structure to address the local needs. Likewise, it is high time government started the initiation to make vibrant structure to address the local needs with the active participation of the local stakeholders in general and poor people in particular.

**Systems** Health service delivery is better when there are required health staffs and standard health facilities with mechanism and medical supplies to address the need of the poor people. The health officials are posted, transferred, allowed to be on long or short-term leave by the government authorities. The hospital or health center management committees do have no effective role to evaluate the performance of the employees. Unless, the system performance evaluation and some linkage on their career development with the level of service delivered in the working area are linked, there is no prospect to improve the health service delivery in poor area or to people. The first step is to establish the two-way communication system with poor people seeking the health services. The Millennium Development Goals (1990 to 2015) are centered around eight goals having three of them on health, reduce child mortality, improve maternal health and combat HIV/ AIDS, malaria and other diseases. The first goal is to eradicate poverty and hunger. Thirty eight per cent of population is below national poverty line (HMGN-2002) having less than a dollar a day. In this context transparency, practices of good public service delivery system are essential. The poor should be trusted and allowing local people to plan resources, both local and outsourced and be partner in managing and receiving the services. The focus of attention is needed to transfer from supplier’s viewpoints to receiver’s interest and concerns.

**Staff** The most important factor for the better health service delivery is the role of staffs. Government health staffs do not like to be posted outside the capital city or major cities in the country. Due to internal conflicts and lack of opportunities to have full employment or work load,

---

staffs resist going and joining duties in rural Nepal especially in the hills and mountains. There is a typical practice of transferring health staffs with the change of government or ministers in the center. It is general believe with the government staffs that “the more you are near to the center authorities there are chances to get better opportunities for training, education, and posting in selected place”. There is problem of over staffing with under attendance and being on leave or on deputation in the remote and rural areas. The local committee is just on looker as regards staff movement. In this scenario, it is highly unlikely to have better health service delivery. So, government needs to pay attention to this point for quality health service delivery.

**Style** The government plan envisages management of local health institutions under the leadership of the local people. In practice, the leader is selected on the political or individual biasness of the person in authority. The government preaches transparency, good governance, public service delivery, and customer first as management practices intended to be made throughout the country. These are more on plan documents while degenerating at work old feudal-bureaucratic authoritarian style of managing has not been transferred as mentioned in the plan document.

**Skills** The private sector health facilities are emerging in the urban centers and cities. There is opening of job opportunity in private sector as well. The government-trained human resources do have opportunities and options to have alternative job prospects in town and cities with lucrative benefits and comfortable living. The staffs posted in the far off regions are comparatively under skilled and even if they are skilled one there are no environment and facilities to practice. This makes the underdeveloped regions and poor people deprived of services from the reasonably skilled hands. The government do have skills enhancing programs through trainings, but the problem is that either the trained persons manage to leave the place by themselves or government itself keeps on transferring the people mostly, irrationally. There are skilled staffs but the service to the poor and deprived are not available because of the non-availability at the nearby area or they cannot afford to pay.

**For, Poor friendly health service delivery**

Focus: Poverty stricken individuals and communities have to be identified and targeted to address their health requirements with their active participation within the local development plan. Otherwise, poor sector of the society will not be able to receive the benefits envisaged for them even in the plan documents.

Identify: People who need special attention in the community must be identified and provide identification card to receive the benefits from the public sector health institutions. At present, every time a person needs to visit many persons and institutions to receive monetary or medical support for the treatment. The person or family members who are in urgent need of the medical services have to waste time visiting people to have recommendations or sanctions for the service. However, they will be in need of immediate support for getting health services.
Insure health:

For oppressed (Dalit), old aged people and poor people free primary health care service arrangement needs to be arranged. Those people should be provided with insurance scheme for medical treatment. The premium needs to be shared by the government up to 100 percent depending on the level of capacity to pay. This needs to be renewed and revisited every year for updating purpose. For this provision, a strategy has to be worked out for fund for primary health services and insurance premium. The government has recently started to have insurance service in its four Primary health care centers. Though it needs home work and internalize the system in the selected area. It is too early to discuss further on because of its initial period. Shanti Nepal and around other nine NGOs are attempting to make local level insurance scheme for primary health care. Shanti Nepal in Lalitpur district do have started insurance service to take care of primary health care needs to around 700 families ((2005).

For introducing and strengthening health insurance scheme to poor, the government can encourage national and international non-government organizations under wide policy framework allowing to work freely for the benefit of the poor.

Utilize local resources Local people, institution like insurance companies (both public and private) can be encouraged to start insurance scheme to address the need of the poor and oppressed people. Government instead of starting own schemes needs to concentrate on policy decisions and support or subsidy.

The above steps will help Nepali poor and oppressed people to be get out of the poverty cycle making health issue as central point for starting.