IDRC-105e

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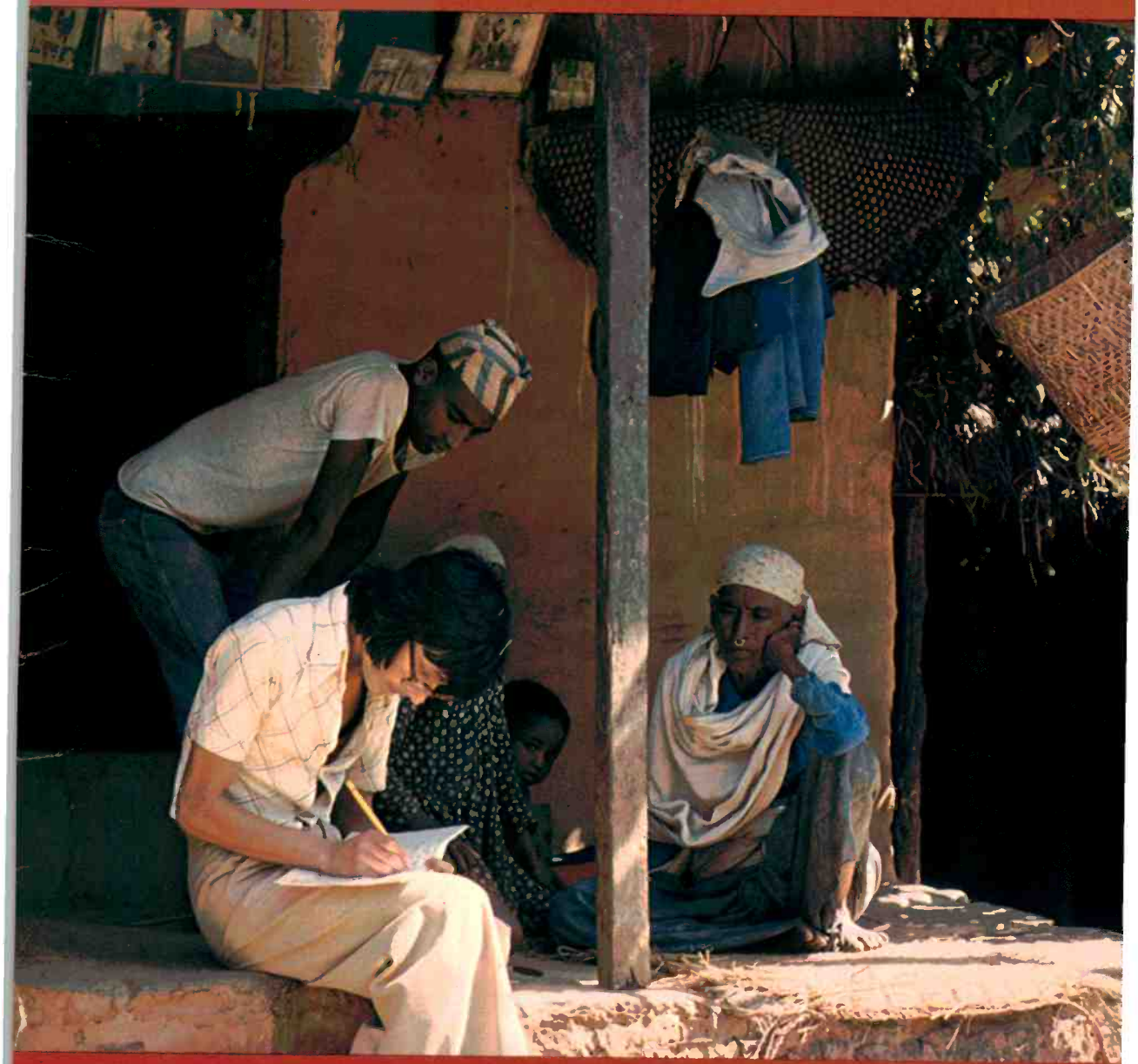

Report of a Seminar held at Pokhara,
October 1977

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Campbell, M. IDRC-105e
Rural health needs: report of a seminar held at Pokhara, Nepal, 6-12 October 1977. Ottawa, IDRC, 1978. 64p.

/IDRC publication/. Report on /health service/s and needs in /rural area/s of /Nepal/, including information on the Nepal Health Manpower (/medical personnel/) Development /Research Project/ — (1) examines /survey/ /methodology/ and /data collecting/ procedures; application of /research result/s and role of applied /social research/ in /health planning/ (2) presents country papers from selected countries of /South Asia/ and /South East Asia/, examining /basic needs/, personnel /training/, /maternal child health/, etc. (3) includes annotated /bibliography/, sample /questionnaire/s.

UDC: 613(541.35) ISBN: 0-88936-165-7

Microfiche Edition $1

Cover: An interviewer with the Nepal Health Manpower Development Research Project questions an elderly woman about her health in a small village in the Pokhara Valley of Nepal.

Credits: All photographs, including cover, by Marilyn Campbell.

IDRC-105e

Rural Health Needs

Report of a Seminar held at Pokhara, Nepal, 6-12 October 1977

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Philippines

Population	**44.3 million**
Infant mortality rate	**74/1000**
Crude birthrate	**35/1000**
Crude death rate	**8/1000**
Rate of population growth	**2.7%**
Per capita GNP	**$370**

All figures from 1977 World Population Data Sheet of the Population Reference Bureau, Washington, D.C.

The Philippine Experience in Health Care Delivery to the Villages

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The Philippines has an estimated population of 44 million, three-quarters of whom live in rural areas — isolated villages in the plains and mountains and on widely scattered islands. The major health problems affecting the population are: communicable diseases, predominantly respiratory and gastroenteric; malnutrition, which affects most children (only about one-quarter of preschoolers are adequately nourished, while the rest suffer from different degrees of malnutrition: 6% from first degree, 24% from second degree, and 46% from third degree); poor environmental sanitation as shown by the fact that only 42% of the population have a potable water supply, 5% have sewerage facilities, and 62% have toilets, although only 39% have sanitary toilets; special endemic diseases, particularly malaria and schistosomiasis; and drug abuse.

Problems in relation to health resources include the following: maldistribution of manpower (e.g., 43% of all doctors are located in one of the 12 regions of the country, the Metro Manila area; 25% of all nurses are in the same area); a concentration of facilities in the urban area (e.g., 52% of hospital beds are in the same area cited above); and, a limited budget for health.

The magnitude of health problems affecting most of the population, particularly those in the villages, compounded by their inaccessibility to health care, has spurred both the government and private sectors to explore other strategies in delivering health services to this underserved population. Developments in health service delivery during the last 25 years reflect the increasing

concern for the provision of health care to more people. In the early 1950s rural health units (RHUs) were established in practically all municipalities in the country. These are manned by either a full complement or a combination of two or three of the following staff: doctor, nurse, midwife, and sanitary inspector, depending on the size of the population. To some extent, the system provided health care to more people in rural communities who previously had either minimal or no contact at all with health services except with those of traditional/indigenous health practitioners. However, there still persisted that nagging problem of lack of adequate care of people in peripheral villages, because the RHUs were based in the town proper and outlying villages were visited infrequently and irregularly, if at all, thus limiting health services to those within and around the town proper.

At about the same time that the RHUs were being put up, the potential contribution of "hilots" or traditional birth attendants (TBAs) in the delivery of health services to mothers and children was recognized, as most births in rural areas were attended by them. Subsequently, 9000 TBAs were trained and supervised by nurses and midwives in the RHUs.

In spite of the above, the system still could not respond adequately to the situation and the search for realistic and practical approaches in meeting the basic health needs of the rural population continued. The inadequacy of resources for health care delivery was recognized and, to enable the system to reach more people, the efficiency of existing resources had to be maximized. To this end, an operations research study was undertaken in 1972 to increase the efficiency of existing RHUs. The study generated very encouraging results that served as a basis for the restructuring of the health care delivery system, nationwide implementation of which started in 1975. The major changes in the system include: (*a*) establishment of barangay village health stations, each of which would serve one or more villages with an aggregate population of an average of 5000; (*b*) the staffing of the village health station with a resident registered midwife[1] who is responsible for providing primary health care to the people within the catchment area; (c) a redefinition of functions and relationships of the RHU staff such that activities and tasks are allocated to the appropriate level of worker; (*d*) the provision of three levels of health care within the RHU, the first level to be provided by the midwife, the second level by either the nurse or the sanitary inspector, depending on the type of problem; (e) establishment of a referral system so that cases could be referred to the appropriate level of care; and (*f*) greater involvement of the community in their health development. In this set-up the public health nurse supervises the midwife.

The implementation of the above requires a reorientation in attitudes of the RHU staff, other health care providers in the community, and the village people themselves who would now be partners in health development and not merely recipients and consumers of health services. A massive reorientation and training program for the RHU staff has been and still is being carried out to prepare them for their new roles and relationships in relation to the health team as well as to the community. Because the midwife is expected to carry out functions beyond her preparation, a radical revision of the midwifery curriculum was made (the duration of the program was increased from 18 months to 2 years, and the content was made more community-oriented), and the first

[1]A high-school graduate with an 18-month training in the old curriculum and 2 years in the new curriculum.

group in the revised curriculum will graduate in March 1978. The nursing curriculum was likewise strengthened to incorporate the necessary changes to enable the nurse to work in the above system. Along this line, too, an innovative ladder-type/progressive curriculum is being implemented in one of the depressed regions in the country on a collaborative arrangement between the medical school of the University of the Philippines System and the Department of Health as a response to the inadequate health manpower in the area. Students enrolled in the program are chosen by the village people, given scholarships by the school, and go back to their villages after finishing the program. The first stage of the curriculum (3 months) would prepare the student to function as a Barangay-Village Health Worker; the second stage (1 year) as a midwife; the third stage (1 year) as a public health nurse; the fourth stage (6 months) has not been decided as yet but would probably be either a B.S. Rural Medicine or a nurse practitioner. In this program the student can either make an exit at the end of any one stage or continue to the next stage, depending upon his or her capabilities and interest and the decision of his or her village.

Another complementary development was the broadening of the health manpower base to further penetrate the peripheral villages. One of the major projects in this area is the strengthening of the participation of the "hilots" (Traditional Birth Attendants) in health care in which the initial step undertaken in 1975 was an enumeration of hilots throughout the country. It was no surprise to discover that 42 000 hilots are practicing, of which only 6000 have been trained in previous years (the other 3000 who have been trained have either died or retired). Considering their number, geographic distribution (an average of one hilot per village), accessibility to and acceptance by the villagers, the hilots are indeed a potent force in delivering services to their own people. Consequently, the training of the untrained members of the group has been resumed for their eventual integration into and broader participation in the health care system.

Other village outreach projects have been initiated by both government and private sectors. Extension workers have been trained for any or a combination of family planning, nutrition, health, and health and related community development work. A number of the above workers have been trained but considering the more than 40 000 villages in the country, we still have a long way to go in terms of making health care accessible to more people.

The prospects for achieving the above is encouraging considering the government's thrust in countryside development, local planning at the village level, and the increasing involvement of communities in their development. This augurs well for a more relevant health program at the village level. One of the strategies and a priority identified in the National Health Plan is the training of indigenous village-level health workers as a means of filling the dearth of manpower in certain areas; hence, an interagency team is currently in the process of formulating a multiphased national program.

Another project to strengthen health services in the villages and make use of existing resources includes a very recent development wherein primary school teachers have been designated as health guardians for the school population. This scheme would certainly go a long way as teachers are strategically located in peripheral areas, are accepted by the people, and exert a strong influence on the community and village.