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Jumla Project Consultancy Report

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Prepared by:

Dr. Mathura P. Shrestha
Professor and Chairman,
T. U. Institute of Medicine
Maharajgunj Campus
Community Medicine Department
Kathmandu

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UMAP/Red Cross.

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PREPARED BY: Dr. Manmara P. Shrestha, Professor and Chairman, Tribhuvan University, Institute of Medicine, Community Health Department

ASSIGNED BY: Mr. P. J. Feeney, Technical Advisor Jumla UMAP/Red Cross Project

1. OBJECTIVES:

1. To evaluate training of Health Committee members, Community Health Leaders and Sudeois (CHL) to initiate program evaluation design work for future impact evaluation and cost effectiveness.

2. To probe priority settings and to explore all possible application of health survey outputs to achieve five objectives of Jumla Project.

3. To probe and advise on system development of coordinated and integrated primary health care and community development works which are directly related to the health of the community, mobilisation of community support and participation, developing, existing rural technology, introducing simple and effective technology, supervision and support system within the primary health care and its interaction with the district health service.

2. Consultation period: - 6th to 16th April 1982

3. Description of activities in brief:

I came to Jumla on 6th April 1982. Mr. Peter Feeney and one of the staff of the project, Mr. Tako Ganal too flew with me. Other staff of the project were waiting for the passage to Jumla.

My activities in Jumla included meeting and interviews with Anchal chief, Red Cross District Chairman, District Panchayat Chairman, CDO, Senior Medical Officer and his staff, Mr. Lenny Asher and his staff of UMN, Trade School, Local Development Officer, Maha Shunkar Devkota, Mr. Shiva Prasad Shrestha, Kunga Nath Adhikari, Red Cross Society district committee and other dignitaries of Jumla including two traditional healers and several Sudeois (CHL).

I also was involved in a meeting of Red Cross Society, AHW training programme of Trade School and day to day activities of Jumla Hospital.

As a part of the assignment I travelled to Depalgaon, Garjyangkot, Talphi, Parachaur and other parts of Jumla with Mr. Peter Feeney and his staff and conducted detailed interviews with different health

committee members, community health leaders, Sudeni and other community leaders. Two mothers in Jumla Bazaar who had recently delivered and used the services of Sudeni were also interviewed.

The interviews and meeting started after the presentation of survey results and initiating the discussion on what they mean and what are the possible alternatives to solve the health problems in Jumla. The discussion included the problems and prospects of community participation in initiating programmes to solve the health problems.

I had review session with Mr. Peter Feeney and Tako Gurai, the engineer and staff of the Jumla Project everyday while I was in Jumla.

4. Meetings with the dignitaries in Jumla

Every body realised that the health problems as shown by the survey were of serious nature and needed urgent attention and cooperations of not only health personnel but also of other personnels in administration and development works and community. Anchaladhis, CDO and other authorities, Red Cross personnel and influencial community members are more than eager to help and cooperate in the activities of IHAP/Red Cross Project. They unanimously viewed that solutions to health problem in Jumla are to be found not only in health sector but also in other development and social activities. Crucial facts will be community participation, support and supervision. The training programme of the Jumla project is taken to be an important step towards this. Although there are lot of problems related to logistics, finance and socio-economic set backs, practical solutions are being generated to promote community participation and project activities. However the process will be slow.

Authorities in Jumla Hospital and Family Planning Project viewed that the survey results will be valuable aid to determine priorities, planning, logistics and training personnel.

5. Meetings with Health Committee members and community leaders:

At different sessions at Jumla, Malpalgaon and Garjangkot, the health committee members were aware of importance of survey outcome presented to them in simple words. They were also aware of the moral and social obligation for the community support, supervision and participation in Jumla project and health post and hospital activities. Their realisation and determination that they should not examples by themselves by improving personal and environmental hygienes, by digging latrines and by digging kitchen garden, taking initiative in health, social and community development works etc. were remarkably brought out by themselves. I am impressed by their high level of understanding of health problems and the solutions suggested by them and their motivation and readiness to play their parts in health and development activities in

their areas especially over the public education to propogate the use of ORT, 'sarbotam pitho' as weaning food for infants and children, smokeless chula (stoves with chimneys) and supervising the CHL and Sudenis. That they could identify the above activities were important first steps to solve the problems shown by health survey.

Remarkable contrast to this observation was found in Talphi and Matachaur areas where training programmes of HC and CHL has not been given. There the awareness of health problems, understanding importance of survey result presented to them and understanding of importance of community participation and supervision of future CHL were vague, although they were interested and anxious to begin going through the Jumla project processes for forming health committee at Panchayat level in which some women members would be included, getting H.C. training, selecting CHL for training. Talphi and nearby villages do not have Sudeni. However they will try to find some women to be trained for the same as they are convinced that service of Sudeni is important.

This contrast gives important indication to the need and credibility of training H.C. members. Their awareness, motivation and ability to supervise and support CHL and health activities at community level will be crucial to the success of the programme. Training programmes of HC members and supervision by the Jumla Project are the important variables for this.

In both cases the leaders viewed that Jumla Project activities are to be accelarated and propogated. Any impediment in its activity will be unfortunate.

b. Meeting with Sudenis (TBA)

Six out of twenty trained sudenies were interviewed. Their experiences ranged from 2 yr. to 20 yrs. Their duty as traditional birth attendants could be divided into the categories of social and actual care and attendance. Their social responsibility is to be prepared to remain "impure" with the mother during and after delivery which would last for a month, to participate in the various ceremonies after the birth of child especially during 6th, 10th and 30th day after birth and during rice plantation ceremoney (Chopain) the same year, if a son is born. 'Chopain' of a household where a son is born is conduced with a special pomp, vigor and ritual proceedings. The concept of "impurity" is related only to the delivery case she attended or helped. While she may be "impure" to more than a family where she attended birthing, she is not "impure" to others. Their activities related to service and attendance were to support the mothers psychologically with encouragement, assurance and sympathy and physically by massaging abdomen, back and head with warmed oil, by giving syrupy sugar to drink to supplement their strength, by giving magic or "incanted" water to drink, cutting and cutting umbellical cord with any agriculture equipment at hand, (they cut umbelicus only if mother is too unwell after birth), cleaning and caring the baby and mother after delivery including breast care

and, if necessary, traction of baby and manual removal of placenta. Ligature of placenta is done by woollen thread or by cotton cords. They attend only during and a month after delivery. They do not participate in any kind of ante-natal, other postnatal and non-natal problems. She does not practice faith healing. Sometimes if a Dhami or faith healer is called to help, he is made to wait outside the delivery room. She (Sudani) acts as go-between to describe the symptom of mother and to take back 'incanted' water or ash from Dhami for the mother to take. This process is believed to facilitate delivery. She also attends the births in higher class with the same responsibilities. Though she may attend the births in lower cast women, her responsibility involves only helping and manual traction and evacuation of placenta. She does not cut the placenta of lower cast baby and are not involved with their social responsibility. She is 'pure' as soon as she conducts delivery of a low-cast mother and washed herself.

Previous to the training they cleared their hands with cowdung, an excellent medium for colostridium tetani before attending deliveries and were not of aware of many problems and complications of delivery. According to them, the training provided them the understanding of importance of cleaning their hands with soap and water, of discarding the use of cowdung, agricultural and other septic or dirty equipments of need to boil water and cords to be used for conducting delivery, of maintaining cleanliness and personal hygiene of both mothers and herself etc. They also learned the importance of looking at various signs and symptoms of mother and baby during and after delivery. The training increased their skill to conduct normal deliveries and to recognise complicated deliveries which are to be referred to ANMs, nurses or hospital. However, they think that they should have several similar training sessions in future to update and increase their skill. They also wanted to be supported with delivery kits, gloves, razors etc. They also think that their activity should extend to the care of pregnant and post-natal mothers and babies. For this, they expected to be trained and supported.

Their payment system by the community is variable and insufficient. They are on the scale mainly for their moral and social responsibilities. However they are paid by some in kinds of food and clothings. They realise that the payment system should be updated and the system could be worked out by initiating a dialogue with the community members by the support of Jumla Project and Health Committee members.

Similar information were obtained by interviewing two mothers who delivered five and three months back and who used the service of Sudani. However they both think that a Sudani should have better skill and she should give more time and care for the mothers in labour. They use Sudani as traditional practice, because they are readily available, stay with them during whole of delivery time, clean and washes some of their clothes and because hospital is inconvenient for them.

7. Meetings with CHLs

I interviewed some trained CHLs in Depalgaon and Ganjamkot. Except for a few non-interested persons, majority were keen, could understand implication of health problems generated by the survey, recognize certain common diseases, could explain correctly the use and ingredients of ORT, surbottom pitho, importance and construction procedure of pit latrines, compost manuring, kitchen garden, horticulture etc. and diagnosis and treatment of simple and common diseases.

They also realised that several such training should be conducted in future to update their skill. They realised that they need periodic supervision and support system from the project and community. While they do not expect any monitory incentives from the project, they think that community should be developing some kind of paying system to them. One method was the possibility of developing charging process for their service and medicine. They think that they depended upon the project for their intellectual support like continuing educations, exchange and distribution of simple reference materials, discussion sessions on skill development and new health technology, organising seminars etc. I was impressed by their resourcefulness and promise of initiatives.

8. Discussion:

1. So far 117 Health Committee members (106 males and 11 females), 46 community health leaders (35 males and 11 females) and 30 sudenis (all females) are trained by the Jumla Project. The impact of the training is already felt in relation to the level of understanding and awareness created by the programme compared with the untrained groups. In Jumla situation where literacy rate is so low and where logistic and economic problems remain insurmountable, the community leaders should be trained to be able to supervise the CHL, Sudeni and other village level health programmes and to prepare ground for community support and participation. With the coming impact evaluation in mind, the project needs to strengthen supervision, support and follow up of their activities in coordination with the health committee members and community leaders in one hand and with the government health and development personnel in the other hand. In view of tremendous logistic and other difficulties in Jumla time factor is important in addition to unhindered and active implementation of the project activities. The project should also be working to develop and implement simple follow-up system which could be easily quantified, analysed and utilised for optimisation of project objectives. This might be facilated by periodic review meetings of the project staff sometimes extended to the participation of Red Cross members, government health and development personnels and influencial Panchayat and community leaders, periodic seminar at district and national levels, by periodic evaluation by experts, - international and domestic and by mid-term and final evaluation.

Future impact evaluation could be done by:

(a) comparing knowledge, attitude and practices with special stress in practices in the project area and non project areas. As mentioned in the section 5 (Meeting with HC members and community leaders) remarkable difference in knowledge and attitude is already noted. Recently completed health survey in Jumla has shown that Jumli people are remarkably aware in health problems, their causation and their treatment. But they are weak in translating their awareness in practices. This would indicate the need to stress in health practices.

(b) comparing final health data with base line data provided by health survey

(c) comparing health statistics in the primary coverage areas of the project and other areas

(d) comparing status of health services in panchayat Health committee coverage areas with other areas without Health committee coverage. Similar variables could be incorporated for evaluating cost effectiveness in addition to quantifying met objectives.

2. Though the health survey team and community dialogue team have always been careful not to raise expectations beyond the stated limits set by the Jumla Project, people in Jumla want programmes implemented without unnecessary delay and hindrances. They are fed up of promises. National and international support to be provided to Jumla project should not be delayed or hindered. The delay at this level would considerably increase the cost of the project and reduce credibility and productivity. With pay of Project unpaid for more than 3 months and with the supplies and other support to the Project not reaching Jumla, the Project activities are virtually at a standstill inspite of the commendable optimism of Mr. P. J., Feeney, Tako Ganai and other staff.

3. Health survey team shared with the community dialogue team its experiences and data even during training phase, after preliminary field analysis and tabulation and during data analysis. Diagnosis of epidemic viral conjunctivities at Talichaur during the first week of activity at Jumla by the Survey Team provided base for coordination between the two teams and enaction of simple and effective treatment and preventive procedure by the campaign of mass bath and personnel hygiene and mass application of terracycline eye ointment. This prevented the epidemic. More such activities like contending epidemics of whooping cough at Matachaur, epidemics of diarrhoeas of some villages of Sinja diagnosed by survey team could have been realised if there were not slow in hiring procedure and transport of the project staff.

Even though the C.D. team could not be involved with the survey activity to the extent stated in the survey paper, two teams worked together in consultation and sharing experiences. However, the effective utilisation of survey results would be crucial for the fulfillment of objectives of Jumla Project. Following are the some possible areas and means through which survey results could be implemented for the advantage of the project:

(a) Project activities should consider the seasonal activities of the people in Jumla. At the same time, it is necessary to have complete understanding communities in Jumla with whom the Project has to work. Survey could provide their socio-cultural characteristics, their understandings, attitudes and practices in health and development matters etc.

(b) Quantitative estimation of some target populations like infants, under five population, pregnant women, eligible couples, etc. for any intervention and care procedure could be simplified and made useful.

(c) Higher IMR and malnutrition rate among poor socio-economic group would indicate for high priority of them for health education, ORT, and nutritional education and after preventive measures. Women and "low caste people" who generally belong to poor socio economic status should have some priority to be included in health committees, CHL and Surani training programmes.

(d) High animal heads per capita and the intimate relationship between man and animal in Jumla would warrant improvement of veterinary health, compost pit and animal waste disposal system. As almost every household have a "khado" an open (or unroofed) enclosure for dumping animal waste and refuse, this could be easily modified to convert into aerobic compost of animal waste and refuse.

(e) High CBR, IMR, CDR, 1-4 age specific death rate and maternal mortality rate and analysis of their causes, fertility rates and malnutrition would indicate priority for FP and MCH activities, Surani training, popularising ORT, earthbottom pitho, latrine digging etc.

(f) High morbidity rates, illness - disability rates, and their analysis would facilitate the priority setting for developing and modifying training curricula, providing services, coordinating health and developmental activities, propogating smokeless chula, latrines etc.

(g) Patterns and use of health and FP services would help develop training, providing base for supervision and support, planning logistics for seasonal variation of births, pregnancies, morbidity, utilization patterns etc., including Dumla in CHL programmes.

(h) High smoking rates and high prevalence of respiratory diseases specially chronic obstructive bronchitis among adults would warrant the urgency of health education on this aspects, though the process would be slow and difficult.

(i) High domestic smoke emission rate, poor ventilation, narrow window and roof-holes and poor housing would indicate a need to train and educate on smokeless chulo, to provide counselling services on housing specially over ventilation and wide windows.

4. Community dialogue team have visited and started their works in many parts of Jumla. However continuety and expansion of activity have not been much accomplished as desired by the Project because of lack of personnel and logistic difficulties. The activity should be properly supervised and supported and followed up by supervisors in general and also by Technical Advisor. Flow of finance should not add to the natural barriers like remoteness, difficult terrain, harsh physical and social conditions.

5. Local development project in Jumla and KBIRD have a elaborate system of planning, development, implementation and evaluation of village level programmes. The felt need is processed at first at village level then to panchayat through District Panchayat, local development office and KBIRD office. After the acceptance of a development project, a User's committee is formed by the initiative of Panchayat. Following a dialogue between agencies and User's committee, the community participation, community investment and government or agency's investment, working procedure, evaluation system, fund release and other conditions are negotiated and implemented. Initially 25% of the subsidy is released for the work. Further payments are released following periodic supervisions, evaluations, and completion of construction items.

The NRCS/IHAP project have initiated and started various construction and demonstration projects in order to promote community health and create atmosphere of understanding and cooperation among various agencies related to the health promotion.

However many demonstration projects are to be started after the formation and activation of all health committees, availability of funds and community participation in planning and implementation process.

My own impression is that the project is not getting adequate support from its organisations. This is causing delay in implementation of many stated objectives and hampering activities. Other problem gravely faced by the project is the difficult supply and transport system.

(a) As the project activity grows it would need strengthen its supervision, support and follow up systems to help guide the Health committee to supervise and back up CHL and sudeni, demonstration projects and other village level health services.

(b) It needs to establish workable and intimate relationship with government health institutions like Jumla Hospital and health post. They should be involved to supervise, support and follow up the activities of Health committees, CHL, Sudeni and village level health care. They also should be encouraged to take up the village level health services through CHL and Sudeni.

(c) Though primary health care would have major priority in the context of Jumla, failure to strengthen district level health services with clear defined working process, logistics, supervision, support, follow-ups and referral system including development of secondary health service at district level, primary health care itself would have poor base for development and strengthening.

9. Recommendations:

1. The process of formation health committee at Panchayat levels, in all primary coverage areas* should be hastened and completed as soon as possible.

2. To complete selection procedure and training of as many CHL as is possible within the specified objectives - 432 CHL in all 24 Panchayats. As the member of Panchayats in Jumla has grown from 24 to 30, six additional panchayats should be incorporated in training CHL. Project also should take some initiatives to help Health committees to develop support system for CHLs and Sudenis.

3. To train additional Sudeni with fair geographic and caste distribution.

4. To initiate community dialogue, primary or basic health care delivery, setting up demonstration projects to promote community health though CHL and Sudeni and to coordinate their activities through the Health committees, the Project office and the health institutions.

5. To develop comprehensive supervision, support and renourable follow up systems both by community health team as well as project staff to update CHL's and Sudenis skill and to monitor the implamentation.

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* Primary coverage area is defined as the area comprising all the household within two hours walking distance from the health post or hospital in order to provide integrated family oriented health service to the household members. This could grow with the capacity of health institution.

6. To continue to coordinate other health and development activities in Jumla.

7. To utilize all possible ways to apply survey results in Jumla. This is discussed more thoroughly in "Discussion" section of this paper.

8. To evaluate the project periodically by national and international experts in view of stimulating its activities and disseminating its useful outcomes in other areas of Nepal and other countries.

9. To develop simultaneously district health service to back of primary health care service as well as to provide secondary health service.

10. To simplify and regularise back up system to the Jumla Project so that implementations are not hindered, delayed or jeopardized. In view of immense logistic difficulties, remoteness, and rugged terrain, supporting organization should have more flexibility and understanding for the project.

11. Jumla has one of the worst demographic, health and developmental statistics in the world and in Nepal. At the same time, Jumla is very difficult area. Need to improve the health and development statistics is urgent. But this is going to be slow process. Short term project, no matter how vigorously implemented, may not bring any convincing result and as a matter of fact may be frustrating to both the people in Jumla and the implementing or aiding agencies. I would recommend extension of the programme for the further period of three years.

12. To integrate the project with K-BIRD, UNI and other GON development programs and projects, viz., Jumla Hospital, District Agriculture Development office, Local Development Office etc.

13. Simplified version of survey data in Nepal to be worked out for the use of HL members and health personnel in Jumla.

14. To include with some preference the low caste and lo-economic group people in the CHL and Sudeni training programs.

15. As women form important decision makers in household health matters and also because women is more suppressed in Jumla socially and in view of high MMR and other diseases, women should be involved at all levels of activity of Jumla health care delivery system.

16. To promote optimization of community resources already existing for the promotion of health and development and to envolve community at all levels of project activity.