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Editorial

Public Health Scenario in Nepal

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Nepal is a landlocked country between India and China and one of the poorest developing countries in the world. Twenty five percent of its population lives below the poverty line and it ranks 157 out of 87 countries on United Nations Development Programmes (UNDP's) Human Development index. The country has gone through a prolonged transition to peace and stability after twenty years of political instability and ten years of violent conflict that ended in 2006, with a peace agreement between the Maoists and the Government. The economic growth and human development including poor access to power, the lowest road density in South Asia, high susceptibility to climate change, vulnerability to earthquakes and weak governance are the major challenges in Nepal [1].

This country is extremely in danger to various types of disasters, e.g. floods, landslides, earthquake, fire, epidemics as well as the effects of climate change. According to the Disaster vulnerability and risk assessment study report, Nepal ranks 11th country most vulnerable to earthquakes in global map. Similarly, as per the joint International Centre for Integrated Mountain Development and United Nations Environment Programme (ICIMOD-UNEP) prepared details, out of 2315 glacial lakes in Nepal, 22 are in imminent danger of bursting [2]. Fire breakouts in rural Terai remain a major problem during summer season when temperatures soar to 45°C. The economy of Nepal is solely dependent on agriculture and forestry that contribute about a third of the Gross Domestic Product (GDP) of the country whereas the industry sector comprises a mere 15% of GDP. Agricultural value depends very much on the monsoon pattern and has a direct impact on GDP growth [3].

Nepal is in the middle of a demographic transition and is experiencing a triple burden of diseases from communicable diseases, nutrition associated diseases and progression of non-communicable diseases (NCDs). Acute respiratory infections and diarrhoeal diseases remain the leading causes of children morbidity and mortality in Nepal. Incidences of diarrhoea and Acute Respiratory Infections (ARIs) were respectively 598/1000 (2010) and 244/1000 (2013) children under five years. In 2014, NCDs accounted for 39 percent of the total country's disease burden, and nearly a half of all deaths were due to NCDs as CVDs, Cancer, Chronic lung Diseases and Diabetes [4].

While there has been an overall reduction in undernutrition, disparity between socio-economic groups and between urban and rural areas is growing. But, anaemia continues to be very high at 46% among children aged 6 - 59 months and at 35% among women aged 15 - 49 years. There has been significant reduction in the maternal mortality ratio, and less than 5 year and infant mortality rates have also been improved.

In contrast to the improvements in child nutritional status, nutritional status of women has not improved greatly in the past 15 years. In 2011, 18 % of women were malnourished. Neonatal mortality has also been sluggish at 24/1000 live birth since 2006. The neonatal mortality accounts for two-thirds of infant mortality rate and its reduction remains a priority [5]. Availability and access to health services in Nepal remain challenging especially in rural and remote areas. In some mountainous and hilly regions, people have to travel 1 to 4 hours to reach the nearest health or sub health post. In urban areas, there are insufficient health-care facilities providing public health programmes such as immunization and antenatal care.

Analysis of Nepal Demographic Health Survey (NDHS) outcomes data suggests increasing inequities between socioeconomic groups and geographical regions. Furthermore, out -of- pocket expenditure (OOPE) remains very high (55% of total health expenditures). Nepal ranks 133 out of 190 in terms of their health capacity, based on number of physicians, nurses/midwives and hospital beds. Access to water and particularly, sanitation is sub-optimal. According to the latest available WHO/UNICEF Joint Monitoring Programme data (2012), 88% of the population has access to improved water, yet only 21% of this is piped on premises. Such water is not necessarily safe or free from faecal contamination, especially protected springs. The sanitation situation is far worse with only 37% of the population with access to improved sanitation and 40% of the population practicing open defecation which poses a serious risk to water sources and potential disease outbreaks [6].

Stagnant growth and political instability have contributed to acute food shortages and high rates of undernutrition in Nepal. It mostly affects vulnerable women and children in the hills and mountains of the mid and far western development region. Though rates of stunting and underweight have decreased and the rate of exclusive breastfeeding has increased in the past seven years, 41% of children under five remain stunted [7], a rate that increases to 60 percent in the western mountains [8]. There is a positive association between household food consumption score and lower prevalence of stunting, underweight, and wasting [9]. Children in food-secure households have the lowest rates of stunting (33%), while children in food-insecure households have rates up to 49% [10]. Maternal education, socio-economic status and nutrition have an inverse relationship with childhood stunting.

Nepal has made significant progress in controlling micro-nutrient deficiencies of essential dietary components such as vitamin A, iron, and iodine. Despite these successes, there is still an ongoing problem of protein energy malnutrition. Micronutrient deficiencies are widespread, with almost half of pregnant women and children under five, as well as 35% of women of reproductive age being anemic [7,10]. Good nutrition starts during pregnancy. Due to the lack of awareness and poor access to health services, only 58% of women in Nepal receive antenatal care during pregnancy, and only 36% of deliveries are assisted by a skilled birth attendant. The low level of supervised antenatal and postnatal care and poor maternal nutrition directly contributes to higher maternal mortality rates. Only 24% of children consume iron-rich food, 24% of children meet a minimally acceptable diet, and only half of

pregnant women take recommended iron supplementation during pregnancy [7].

In addition, 44% of the population does not have access to toilets, and open defecation contributes to higher diarrheal disease morbidity, with further detrimental effects on nutritional status. Socio-economic, geographic, and educational factors, along with regressive gender norms, contribute to the poor health status of Nepalese particularly women and children. A contributing factor to deteriorating nutrition is high diarrheal disease morbidity, aggravated by the lack of access to proper sanitation and the common practice of open defecation in Nepal [11].

United States Agency for International Development (USAID) has made substantial contributions to health and nutrition, in partnership with the Government of Nepal (GON) and other development partners. As part of its strategy to strengthen the country's health and nutrition programs, USAID, in consultation with the Ministry of Health and Population (MOH) and other relevant partners, designed the Integrated Nutrition Project now known as Suaahara "Good Nutrition". It focuses on improving nutrition and health standards of women and children by focusing on better maternal, new-born and child health services. It also aims to improve reproductive health/family planning services, create awareness regarding sanitation and hygiene, improve access to clean water, and introduce home-based gardening as a way to encourage a balanced and healthy diet. Suaahara's unique approach is based on applying the latest evidence-based interventions in health, nutrition, family planning, water, sanitation and hygiene, backyard poultry and food production at scale in over half of the districts in Nepal [13].

The Government of Nepal has recognized health care, reproductive right, women right, safe environment right, as a basic fundamental right, as acknowledged in the Interim Constitution of Nepal 2063 (2007), and has declared that it's the state's responsibility to ensure people's health. The vision of an inclusive society, where people of all races and ethnic groups, genders, castes, religions, political beliefs, and socioeconomic status live in peace and harmony, and enjoy equal rights without discrimination, as outlined in the Interim Constitution, is the guiding principal for all policies, plans and programmes of Ministry of Health and Population (MoHP). This has placed increasing pressure on the government to improve the delivery of health services, quantitatively and qualitatively down to the grassroots levels [14].

Despite prolonged political instability, Nepal is likely to achieve most of its Millennium Development Goals (MDGs) targets, including halving extreme poverty, reducing child mortality by two-thirds, and improving maternal health by more than two thirds. Nepal has cut its rates in infant, under-five, and maternal mortality roughly in half since 1996 is a major feat for a struggling low-income country [12].

The preventive and curative approach to the health situation in Nepal is essential to overcome many of the obstacles. Social and cultural factors need to be addressed properly before developing and implementing any nutrition developmental programme. The health sector is heavily dependent on external resources. At the same time, people spend a significant amount of money on health care from their pocket. The private health sector is growing without much regulation and supervision from the Ministry of Health. Due to a lack of clarity in political vision to promote health issues, Nepal has failed to achieve complete target of Second Long Term Health Plan (SLTHP), MDG and many more. Still, the challenges towards health and it's right in Nepal are in looking backward and forward situation with it's the social, political, economic and geographical history.

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