The Japan Medical Association's Medical Cooperation Activities in Nepal: Towards the establishment of school health program

—NGO endeavors—

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Hisashi TSURUOKA*1

Introduction

Nepal is one of the world's poorest countries, and various national government aid organizations, multinational aid organizations, international NGOs, and private enterprises are engaged in supportive activities within Nepal. The most serious problem is the low standard of health nationwide, with infant and maternal mortality rates extremely high. Some of the supportive activities of these organizations are producing results in city areas, but in the mountainous regions which comprise most of the country's land area, the combination of the extreme ruggedness of the terrain at the foot of Mt. Everest and political factors has meant that support activities in these areas are currently still inadequate.

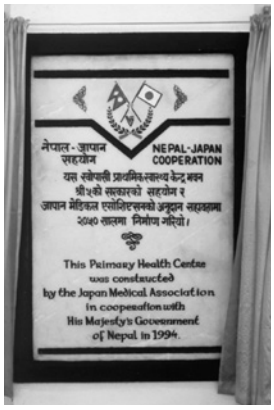
Thus, with the objective of improving the health situation in the mountainous regions of Nepal, the Japan Medical Association (JMA) in 1992 dispatched Japanese healthcare staff as Japan International Cooperation Agency (JICA) specialists at the request of the Nepalese Government to begin healthcare cooperation activities in Nepal to establish a primary healthcare center as a base for healthcare activities under the JMA's "School and Community Health Project (SCHP)."

Launched in 1992, this project has implemented various activities with the key words "school" and "community." Preliminary surveys undertaken in the targeted mountainous regions confirmed that extremely high infant and maternal death rates were major factors in the worsening of health conditions, and that furthermore these stemmed from bad hygienic conditions. From these results it was decided to concurrently implement health guidance for mothers and children and improve health clinic functionality with the aims of, firstly, addressing the urgent issue of infant and maternal mortality, lowering the mortality rates, and secondly, the long-term maintenance of improved health standards. The selection of Khopasi Village (now Panauti City) in Kavre District, located 40 km southeast of the capital, Katmandu, as the first region for implementation of the project was also based on this policy. In this area there is a place where a school and a simple health clinic, called a "health post," are located side-by-side, and this was regarded as an ideal location for promoting health education in the school. Furthermore, having attained certain results in Khopasi Village, the project was successful in spreading healthy and hygienic thinking and practices throughout the region with the school as the core through a combination of providing health education know-how in Khopasi Village and efforts to motivate members of the local community.

In this way, the JMA's "SCHP" was a project that sought measures for improving health standards in an environment where healthcare provision was inadequate through school-based health activities and made persistent efforts to implement these measures. This paper describes how the concept of school health, which contributed to the improvement of health standards in postwar Japan was applied and achieved success in

*1 Manager, International Affairs Division, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

Primary Healthcare Center established by the JMA donation



Memorial plate at the entrance of the primary healthcare center commemorating its establishment

Nepal—which is geographically, politically, and culturally different from Japan—discussing the project's features and progress and providing specific examples of activities, and demonstrating the potential of school health as a merit of international cooperative activities.

This project began in 1992 and concluded in 2004.

Project Characteristics

This project had two main characteristics: firstly, it was a pioneering project in introducing the concept of school health to Nepal; and secondly, it developed new approaches for building village health on the foundation of school health.

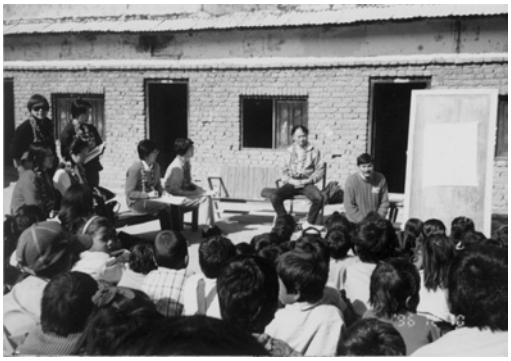
In school health activities in Japan, from a young age children are thoroughly immersed in health knowledge and acquire hygienic practices, with the result that an extremely high standard of health is maintained, a situation that has greatly contributed to the longevity of Japanese people. From this the significant impact of the school health approach, which teaches children hygienic practices based in schools, can be reaffirmed.

In Nepal, however, basic hygienic practices that are routine for Japanese children, such as "washing hands before meals," are lacking, and it was necessary to first convince Nepalese people of the reasons for such practices before instilling these as regular habits. It was also necessary to provide mothers, whose role it is to educate children in the home, with health guidance, creating a reciprocal relationship between mothers and children aimed at improving health.

The basic healthcare activity concept of school health which had been cultivated in Japan was adjusted and revised in accordance with local conditions, and a variety of activities such as the below-mentioned literacy education were combined with the aim of improving the health of the entire community. This was the objective and also a characteristic of the JMA's international cooperative activities.

The project's second characteristic was that it comprehensively promoted the building of health in the village as a whole. In Nepal's rural areas, where it is said that when they become ill, 9 out of 10 people will first of all visit a tradition healer in the village called a Dhami Jhankri, thinking and attitudes towards health are completely different from those we hold in Japan. In order to change such behaviors, it is also necessary to spread healthy practices and knowledge about health and preserving health, and unless such health activities are carried out by members of the local community themselves, it is difficult for such attitudes and practices to take root.

Thus in addition to the above-mentioned school health activities, the project focused on providing literacy education as well as disease control measures such as polio vaccinations and preventative measures against infectious diseases such as diarrhea which kill many people during the rainy season, with members of the local community playing a central role in all these activities. In other words, these health activities could be called "grassroots" or "bottom-up" model activities. This incorporates the concept of "empowerment," which is a method of motivating members of the local community to maximize as far as possible their latent abilities.



Health education for local students

This "bottom-up model for health activities" is imperative for ensuring that the essence of the activities remains within the region even after the support project has concluded, and the existence of excellent health workers to sustain these activities in the region is very important. Thus, this project implemented an approach of training health workers to promote local health activities and promoted the building of village health.

In addition to providing training for Dhami Jhankri, the project implemented literacy education and various other educational activities. In Nepal there are also government-built village health clinics, but certification is required to work there. For this reason, selected village youths were provided with scholarships with the aim of supporting their studies to gain the necessary qualifications for working in the village health clinic. Furthermore, local health volunteers were trained, and project representatives visited the Nepalese Ministry of Health and local government offices to introduce and deepen understanding of the project.

Transitions in Project Activities

The following is a description of the transitions in the actual activities undertaken and of the main activities.

Phase I: 1992–1996

Launched in 1992, the SCHP first of all targeted the Khopasi Village region, located 40 km southeast of the capital, Katmandu. A health clinic-standard Primary Healthcare Center was constructed and training of healthcare workers initiated. Then, using the school situated next to the Primary Healthcare Center, school health activities—of which many of the Nepalese people had had little experience at that time—and community participation-centered health activities were begun. In addition to health clinic functions, the Primary Healthcare Center also provides an ambulance for emergency transportation and medical examinations performed by Nepalese doctors. Operating costs for the facility were covered during the initial stages by the SCHP, but since then it has been operated voluntarily by a community association. However, health activities were also initiated as pilot projects in remote mountainous regions where support from the Nepalese Government and other international NGOs is inadequate because of limited access.

Phase II: 1997–2000

Project activities focused on Khopasi Village were implemented until 1996. From 1997, the pilot activities in remote regions were expanded utilizing the healthcare activities that had been implemented in Khopasi Village.

Activities in these villages began with the villages gathering together for a meeting at which the villagers themselves considered their situation. Through these activities, it was learned that villagers regard the school as the most important facility in their village, a fact that held great significance for the JMA, which was attempting to advance the project by introducing the concept of school health into such villages. Accordingly, in mountain villages the project did not construct new facilities but utilized existing schools as bases for implementing various health activities. Moreover, due to the emergence of scientific evidence that literacy education reduces mortality rates, literacy education was begun for approximately 3,500 adult women in order to raise the literacy rate, which was a low 10% at that time.

Phase III: 2000–2004

These local health activities that provided school health and literacy education as a set were gradually implemented in and spread throughout targeted regions from 1997 onwards, producing results such as an increase in the number of women's groups and invigoration of activities, as well as the establishment of school toilets in all the schools in the region. From 2000, the strengthening of community groups for the sus-

tained development of the region became an issue. The reason for this was that, in addition to the project's objective of empowering community members to carry out activities independently, throughout Nepal safety was worsening rapidly and dramatically due to political conflict.

Fortunately, however, the women's groups that had been supported up until this point each continued their activities towards independence. Such groups became the core of local health activities, with the goal of independently implementing local health activities that had until then been implemented in conjunction with the SCHP. Subsequently, other women's groups, schools, and community associations within the same region were organized, and effort poured into training human resources to enable even larger, combined activities to be implemented.

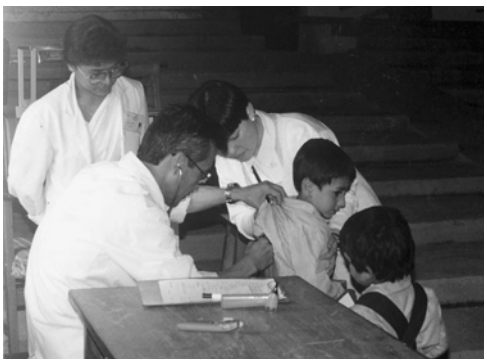
Important activities common to all phases

School health activities in mountainous regions: Construction of toilets and health clubs

The school health program in mountainous villages focused on two main pillars: improvement of the hygienic environment, such as the construction of school toilets; and health promotion activities through children's health clubs.

Fist of all was the construction of school toilets. Several schools in the targeted regions had existing toilets, but only 20% of the schools overall had toilets that were adequately maintained and many of them were extremely unhygienic. The project regarded these school toilets are an important place for students to acquire hygienic practices, and so construction of new toilets with hand-washing facilities was energetically carried out, enabling all the schools in the targeted regions (84 schools) to be equipped with school toilets by 2000.

The second pillar was "Children's Health Club" activities. These were student groups, similar to student councils in Japanese schools, comprising students with a strong interest in health selected from the student body who took a leadership role in health activities. School health activities were not led by teachers or project staff but by Children's Health Club members. The aim of this was to ensure the continuation of school health. In Nepal, school teachers are transferred frequently, and so centering activity leadership on teachers was observed in numerous cases to interrupt school health activities.



Health check by the Japanese doctor at a primary school in a remote area

Children's Health Clubs took the initiative in health activities, putting on plays and singing songs to deepen the understanding of younger children with regard to health activities. Plays introduced basic hygiene knowledge such as washing hands before meals and eating a range of vegetables prevent disease that causes night-blindness.

Due to factors such as relatively low school attendance rates, adults in Nepal, especially in rural areas, have little knowledge or understanding of health issues. Thus the intention of the project was to enable children to learn hygienic practices and information about health at school, equipping them to manage the health of their siblings and, in the future, protecting and maintaining the health of their families. School health activities also included the distribution of first-aid kits to schools and implementation of a campaign to administer anthelmintic drugs to children in all the schools in the targeted regions.

The importance of literacy education

Another centerpiece of activities in mountainous regions was literacy education for mothers.

Today, supportive community health activities are being implemented in many developing countries around the world, and the tremendous influence of mothers, whose role it is to care for their homes and children, on health activities has been reported frequently, and for this reason, the project also poured effort into support for adult women. This began with literacy education.

At the time, Nepal's average literacy rate was still a very low 59% for men and 14% for women. Moreover, it is now known that there is a strong correlation between adult literacy education and infant mortality rates, and so literacy education

textbooks that included health subjects were used.

The project provided adult women aged 15 to 49 with approximately 6 months of basic literacy education in the first year, and in the following year provided more practical literacy education on subjects such as health and nutrition. The training period was 6 months for both the basic course and the practical course, but including the harvest seasons, took 2 years to complete. This is because most mothers could only study at times of the year other than harvest times.

Between the two courses, the creation of home gardens was promoted. This was an innovation enabling the women to experience visually the benefits of their literacy education, in addition to the improvement in nutrition for the family resulting from the mother's participation in literacy education.

Mothers who had completed this two-year literacy education were next provided with guidance in creating groups known as "Self-help Groups" in each of their communities. These are women's groups that put into practice the health knowledge and activities learned in literacy education. Activities include the maintenance and expansion of home gardens, first-aid training, construction of portable toilets, activities creating shared income, such as raising goats and pigs, and administration of mutual aid. Currently the self-help groups in each region are growing to become central leaders in local health activities. The project holds regular discussions with each of these groups and supports their activities.

Results and Significance of the Project

The "SCHP" has implemented activities requiring "human resource training" as an answer for ensuring the continuation of health activities. "Human resources" are local Nepalese staff, and of course, local community members. Based on recognition of the current situation from the perspective of the local community, the project pursued activities raising awareness of the problems facing local people and emphasizing support in such places as schools and regions. The significance of this project can be said to lie in the fact that it exemplifies the tremendous potential of health promotion activities with empowerment at the core.

As these JMA project activities proceeded, they contributed greatly to the expansion of school health in Nepal. Over the approximately 12 years of the project, the JMA worked in collaboration with the central Nepalese Government and local government bodies, international organizations such as UNICEF and WHO, international and local NGOs, and various other groups, spreading the project concept and ways of implementing project activities.

As a result, awareness of the concept of school health has gradually spread widely throughout Nepal, with the Nepalese Government established a school health division within the Ministry of Health in 2001. The project worked with the Nepalese Government to promote the systemization of school health in Nepal, and after 10 years this dream became a reality. This indicated the awareness of the Nepalese Government of the necessity of improving health education for children in order to spread the broader concept of community health.

From the planning stage in 1992, the "SCHP" developed with the cooperation of JICA, and it is doubtful that similar results could have been achieved if either one of the partners were absent from these cooperative activities operated by these two organizations—an NGO (JMA) and a governmental organization (JICA). These international cooperative activities, standing as they do on collaboration, have begun to draw attention due to their high efficiency and issues such as ODA, and in the future, will no doubt provide an excellent reference for Japan and other countries implementing international cooperative activities.

Concluding Remarks

The "SCHP" implemented by the JMA in Nepal was a project which shared the pain and joy of local community members—cooperative activities, so to speak, that returned to the origins of medicine. These activities taught us what the origins of medicine are.

It is my hope that in future this international cooperation model established by the JMA shall be proven to be a powerful means of efficiently improving the health standards of people in communities not only in Nepal but regions throughout the world. I would also be pleased if as many people as possible came to understand the meaning and purpose of the JMA's steady hardworking efforts as an NGO to provide cooperation overseas in the field of healthcare.