Workshop on: Strengthening the development results and impacts of the Paris Declaration on aid effectiveness through work on gender equality, social exclusion and human rights
London, United Kingdom • 12-13 March 2008
Session 3

Nepal Case Study

Support to the Safe Motherhood Programme
Emerging from 12 years of conflict ……
…social inclusion moving centre-stage in the political process influencing policies

Nepal: Pop: 27 million; HDI: 0.534
103 distinct ethnic groups
Caste system v. strong determinant of social exclusion
EDPs fund 21.1% (2006) of development budget

SSMP: DFID funded SWAp: £20 m over 6 yrs
Successor to Nepal Safe Motherhood Project (1997-2004)
Social Inclusion in the Health Sector

SSMP’s “Equity and Access” Programme

Key Paris Themes:

(1) Results
(2) Ownership
(3) Accountability
Nepal: Maternal Deaths by Caste/ethnicity

1. Caste, class, ethnicity (and geography) are strong determinants of maternal health outcomes

2. **Equity** requires a focused approach.

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**Average Percentage Population**
Okhaldhunga, Kailali, Rupandehi

**Percentage of Maternal Deaths (3 districts)**

- Brahmin: 18.73%
- Chhetri: 17.23%
- Tharu: 31.73%
- Magar/Bhujel: 9.99%
- Tamang/Sherpa: 2.51%
- Occupational (Dalits): 14.68%
- Yadav: 5.12%

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*"Equity" is a term used in various contexts, often referring to the fair distribution of resources or opportunities. In the context of maternal health, it suggests that efforts should be directed towards achieving equal outcomes in maternal health across different caste, class, and ethnic groups.*
Social Inclusion Approach:

Rights Based, Whole Systems

Advocacy & accountability

Citizens' & Providers' Voice

Policy & Strategy

Health Systems Development

Equity & Access

Community Interventions

Service Provision
“Equity and Access” Approach

Target poorest communities

Create enabling environment

Capture Voices

Influence Policy

National Census - caste & ethnicity data as proxy

Address, social, cultural, economic and transport related barriers to accessing care

Knowledge, awareness, empowerment
Finance incentive, community funds & transport
Capacity building of local gov. & NGOs for SMNH

Service Users
Service Providers
Short Route
Long Route
Results: Institutional Delivery in EAP Areas (% of total births)
Results: Hospital deliveries by social group in EAP districts

- BCN
- RAJ
- DAJ
- Dalit
- OE
- RM

Number of hospital delivery

Social groups:

2004-2005
2006-2007

2004-2005
2006-2007
Results: Institutional deliveries in EAP areas against % local population (2006/2007)
Policy Implications:

Poorest preferentially deliver in peripheral institutions, or at home, so need to:

1) Increase number of, and strengthen, peripheral institutions
2) Focus demand creation on marginalised groups
   • No clear attribution, but Ministry now allocating 55% infrastructure budget for PHCs and below
Maternity Incentive Scheme – Policy Impact?

• 2003: NSMP study shows transport and related costs account for over 50% cost of normal delivery

• 2005: Ministry owns findings and launches nationwide scheme:
  • contribution to transport costs,
  • cash incentives to health workers and institutions,
  • free delivery in 25 low HDI districts

• 2006, Interim Constitution acknowledges health as fundamental right; commits to free essential health care services in 25 low HDI districts and all peripheral institutions

Indicative attribution?
Ownership: Voice Capture and Accountability

- Advocacy
- Group Formation
- Awareness raising on rights
- User – Provider Interactions
- Key Informant Monitoring +

Long Route
Short Route
Ownership: “Voice” Capture and Policy Influence

Improving access to services

- **Empowerment**: Women more likely to make care seeking decisions themselves and obtain resources to access care.

- Groups visit districts to claim rights - lobby for additional health staff, contributions to emergency funds etc.

- Duty bearers more accountable to communities – regular working hours; more courteous; less discriminatory

- Drafting of exemption guidelines for the poor in primary health centers and district hospitals
**Ownership: “Voice” Capture and Policy Influence**

**Changing the “rules of the game”**

- Reserved places for women, *dalits* and *janjatis* in local health facility management committees
- Training of *dalit* and *janjati* women as nurse midwives
- Scholarships for poor and excluded to study as doctors
- Behaviour Change Communication materials in local languages
- Government budget for “Equity and Access” targeted initiatives and increased allocations for 25 low HDI districts
- Revision of national health monitoring system to include disaggregation by caste and ethnicity
Key Roles

Government

RSI Policy: e.g. affirmative action; civil society partnerships
Structure: Integrated GSI unit
Activities: e.g. screen programs, monitor, awareness raising; coordinate with other ministries

Civil Society

- Voice capture
- Build synergies between rights holders
- Facilitate interface between rights holders and duty bearers
- Feed into "system" for policy reform
- Social auditing; political advocacy

Donors

- Embed RSI within SWAp type approaches: FA+TC – "change from within"
- Harmonise approaches with gov.
- Facilitate cross-sectoral exchange
Key messages

1. The marginalised cannot claim rights without a socially empowering approach.

2. Disaggregated data is essential to assess extent of the problem and progress made.

3. Taking a whole systems approach, including embedding in national plan, makes social inclusion everyone's business, throws up new champions and increases likelihood that voices will be heard.

4. Must understand political dimension of exclusion – seize the moment to influence political policy and accountability – national and local.