Health, Gender Justice and Action Dharma in Nepal:

A field study and Buddhist narrative perspective

Introduction

This paper outlines that health promotion and Buddhist teachings share a considerable number of concepts, which may have different names or labels but which translate well from one to the other. This paper continues by focusing on one particular mixed- methods study in Nepal comprising a quantitative before-and-after study and qualitative reflective account. The former shows how health promotion has achieved considerable improvement in women's empowerment, neonatal and maternal health. The latter gives a biographical account of the challenges involved in working at individual, community and national level development work in a resource- poor country. Finally, it will discuss the challenges faced in moving forward if we are to see further improvement in the relevant Millennium Development Goals (MDGs), with suggestions of what Buddhism and we as Buddhist practitioners have to offer.

What is Health Promotion and how does this fit with Buddhist principles?

Health Promotion refers to any intervention or action that creates a positive environment for behaviour change. It may take the form of advice or support to an individual, a community, a country or any system. Health promotion cuts across all sectors of society, not just Government organizations, but also wider civil society, industry and local communities. For example, if one were to want to reduce Road Traffic Accidents by enforcing seatbelt use, this would be a health promotion activity involving public and private partnership that make appropriate policies, build roads, make cars, educate drivers and pedestrians, train and fund law enforcement agencies and incorporate the media.

There are a number of Buddhist principles that are relevant to any practitioner trying to effect change that are relevant in this field but two stand out. Firstly, the concept of conditioned co-production (*pratītyasamutpāda*), where causes and effect are linked, is well known and acknowledged by the Buddhist world. It is noted that a myriad of conditions come together at any moment to influence an action; sometimes there seems to be a simple cause and effect, but mostly the web of primary causes and secondary causes/conditions is very complex. As practitioners of both Buddhism and health promotion it is important to acknowledge that trying to bring about and sustain any behaviour change is difficult; one key to this is creating conditions that enable more positive decisions to be made, and maintaining this change requires choices to be made in every moment. In health promotion terms, we try to generate the conditions under which the healthy option is the 'easy' option.

Secondly, there is the concept of karma and in particular maturation of karma (*karma-vipāka*). Most of our behaviour is unconscious, and in order to be making more conscious choices, or in a Buddhist context, working mindfully with karmic intent and volition action (*saṃskāra*), beings need a supportive environment

to enable this. So as a health promotor and Buddhist, I see that firstly, if more positive (*kuśala*) conditions are created then it is more likely that a healthier choice will be made; secondly that the more one becomes of one's behaviour, then an element of conscious choice is introduced which we are then much more able to work with, both in ourselves and others.

As Bhikkhu Thanissaro writes:

"One of the many things the Buddha discovered in the course of his awakening was that causality is not linear. The experience of the present is shaped both by actions in the present and by actions in the past. Actions in the present shape both the present and the future. The results of past and present actions continually interact. Thus there is always room for new input into the system, which gives scope for free will." [1]

National Perspective of Millennium Development Goal progress in Nepal

In Nepal, varying progress has been made towards women's empowerment (MDG 3), improved maternal health (MDG 5), and perhaps less towards the reduction in child mortality (MDG 4). However, progress has been unequal within each MDG and across the country. Women now make up 32.8% of Parliament, yet this has not translated into an equal movement towards gender parity in the workforce or in the home: 28% report spousal violence and the national budget allocated to the Ministry for Women was 0.22% of the total budget, indicating its low priority. Under 5 mortality targets have been achieved (now 54 per 1000), but neonatal mortality targets have not been reached; indeed they have not improved since 2006. Maternal mortality targets have been reached (from 415 per 100,000 in 2000 to 170 per 100,000 in 2013), but as with neonatal mortality, there is a wide variation across the country, with more deaths in remote and poorer areas. [2] A significant barrier to improving maternal and neonatal death continues to be underpinned by the socially inferior position of women in society and their subsequent lack of empowerment and choice.

Development aid and Nepal

"Development" or "aid" is a hotly contested topic at all levels.

At the global level of political theory some argue that developing countries are poor because they are in a position of exploitation by richer countries, and that development aid does nothing but keep countries and people in this position of dependency.[3] Others have argued that aid, through the development of infrastructure and human capacity building can help developing countries to compete with developed countries on the world market. At a community level, aid can create dependency; many argue that many development projects collapse after the donor money runs out. Few authors have reflected on the hidden costs of abandoning or withdrawing development aid, which can include: "staff demoralized, people disillusioned, government discredited, 'money down the drain', benefits for the poor foregone, and opportunities lost." [4] Others have highlighted that aid which is sensitive to people's needs and which builds on locally available resources is more likely to be sustainable.[5-6] Nepal has received billions in development aid since 1950, in 2003-04 alone

the total foreign aid received was NRs 189.12 billion.[7] One could argue that had this aid been put to encourage communities to develop their own interventions that were self-sustaining in the long term from guidance by donor countries, Nepal's development in socio-economic and health outcomes would be better.[8]

Green Tara Trust Health Promotion Intervention Study

Green Tara Trust is a UK- based Buddhist Non -Governmental Organisation (NGO) whose vision is for all people to have equal and affordable access to health care and information. It works in Nepal with its sister NGO, Green Tara Nepal, to deliver a range of programmes. Its main focus is on health promotion action research, where different health promotion methods are trialled within rural communities and used as a basis to advise Government policy and health education on what is effective in different settings in Nepal. The Trust works with the support of the Universities of Sheffield, Bournemouth and Aberdeen in the UK who provide research support.

Green Tara Trust realised long ago that countries of the South are dependent on what aid dictates by first world countries, a situation which requires political change. Secondly, the organization is aware that such change is not likely to occur in the near future, hence the immediate aim to improve the lives of people within the current global structure. Thirdly, given the lack of evidence base in Nepal, Green Tara wanted to complete a study that was rigorous, had a control group and had external evaluation so that any evidence generated would be robust and could be used to influence policy and practice at a national level.

There has been little research specifically focused on the health-promotion design in Nepal; there is clearly a health promotion research gap.[9] Therefore, we searched the literature on health promotion in the field of maternity care developing countries prior to commencement. Based on appropriate needs assessment and the engagement of both (potential) users and the wider local community, the intervention aimed to: (1) improve women's empowerment to be able to make their own health decisions; (2) improve neonatal care practices; and (3) improve maternal care practices.

Most interventions evaluate results only within their own programme, or compare results to national level data. This programme is more rigorous than most in that it employed a control before and after study design. The purpose of this was to be able to deduce more effectively whether it was our interventions or national level programmes that had contributed to improvements over and above national or regional developments that were already on-going.

The intervention focused on two rural VDCs (Village Development Committee) areas, 20 km south of the capital Kathmandu. These were typical VDCs in the Kathmandu valley, which are relatively under-developed but slightly more developed than the average VDC in rural Nepal. The total population of the 2 VDCs was just under 9,000. A control community with well- matched indicators was chosen to the north east of Kathmandu, and both communities were evaluated in 2008, 2010 and 2012.

Planning the Intervention

Nepal is a patriarchal society and women are often not able to choose what health care, if any, they receive. Thus a key component of the study was to establish dynamics within the families, and to work with those who had decision making power as well as pregnant women themselves, in order to effect change.

Currently, most neonatal deaths are caused by infection and hypothermia in Nepal. The risk of this at delivery can be reduced by using a sterile blade to cut the umbilical cord, wrapping the baby immediately after birth, and not washing the baby for 24 hours. The risk of both maternal and neonatal death is also significantly reduced by having a skilled birth attendant at delivery. Maternal death is also less likely if the pregnant woman has four or more antenatal checks during pregnancy. All of these indicators are recognised proxy indicators of neonatal and maternal mortality, and thus were used to measure impact of the programme.

The Government of Nepal encourages institutional delivery and provides monetary incentives to women who deliver in a Government facility as a measure to try and reduce neonatal and maternal mortality. However, we feel this is unrealistic for all women given the geography of Nepal and distance to many health facilities: some women may be 3 hours walk from a local health post. In addition, many health posts go unstaffed and do not have the facilities or privacy women would like to deliver. There is little point in encouraging attendance at a health facility if it is ill equipped, un-staffed or not open.

In this programme, we took a more pragmatic approach. We encouraged antenatal attendance in all women. For delivery, we encouraged women to deliver in a local facility with a skilled birth attendant, and for those who would not, we encouraged the use of a skilled birth attendant at home and the use of SDKs. At the same time, we strengthened local health services by providing equipment, support and training to enable them to respond to the needs the community were presenting.

Principles employed for the intervention

Empowerment and community participation are seen as components of the design in a sustainable low-cost, health intervention project, working with the community to change both individual and group behaviour. In this programme, all stakeholders were involved in needs assessment, deciding which area of health promotion to focus on and community monitoring. This improves the chances of empowerment, programme ownership, participation and sustainability once the intervention has ended. Table 1 lists the eight key elements of a health promotion programme that were considered to be important to success.

Table 1: Underlying philosophy of the Green Tara Trust programme

The desired intervention or programme needs to be:

1. Community-based.
2. Culturally appropriate.
3. Women-centred, including working with those affecting women’s access to improved health

(e.g. mothers in law, husbands).

4. Small-scale.
5. Sustainable.
6. Making best use of existing resources, both from the government and from NGOs and INGOs operating in the locality.
7. Low cost.
8. Involve stakeholders from needs assessment through entire cycle to increase ownership and maximise chances of sustainability.

Intervention

The intervention consisted of a multi-disciplinary approach that was mainly delivered by 2 health promoters trained by the Green Tara Trust team, under the supervision of a programme manager.

The key components included:

1. Community activation: getting the community on-side, including them in setting targets and monitoring the programme's progress, and using a rights' based approach to enable them to improve their local health service and governance structures.
2. The formation and re-activation of women's groups, consisting of fertile women, new mothers and mother in laws. These groups met once a month, facilitated by the health promoters at which a curriculum was delivered over 18 months, covering the areas of women's empowerment, contraception use and birth spacing, antenatal, delivery and post natal care.
3. Mass events approximately twice a year on areas that were not improving for anyone in the community to attend, and hosted by women's groups.
4. Home visits by health promoters to pregnant women who were not engaging in antenatal care or groups, to encourage attendance and to work with key family members usually the husband and mother in law.
5. Training to traditional healers in the medical model of delivery, and to enable them to assess for emergency situations, and to refer to the local health clinic or call an ambulance swiftly.
6. Support and training to female community health volunteers in the health promotion curriculum to enable them to facilitate the groups without Green Tara's health promoters.
7. Training of local hospital staff and health post staff in being able to deliver a World Health Organisation standard antenatal and post natal check.
8. Supporting the local sub health posts with basic equipment that was missing and curtains for privacy of patients, which was organised by local women.

9. Provision of a mobile antenatal clinic once a month to 2 remote areas that were a long way from the health facility and where no-one was having an antenatal check. This was done with local government health workers as part of their vaccination clinic. Local workers were also trained and supervised to deliver this service themselves.

10. Provision of incentives: a baby blanket was given to all women completing 4 antenatal checks. Safe delivery kits were made available through women's groups at a subsidised price. Mobile phones with a small amount of credit were provided to each women's group to enable effective communication between groups, staff and health facilities.

Results

A huge amount of quantitative data was collected at time zero, mid-term and at 5 years in both the intervention and control communities. Almost all women who had delivered a baby in the past 2 years were interviewed. Qualitative data was also collected at time zero and throughout the programme. A selection of the quantitative results is presented below in Table 2.

Table 2: Impacts on selected indicators related to women's health and empowerment

Key Indicators	**Control**		**Intervention**	
	2008 (%)	2012 (%)	**2008 (%)**	**2012 (%)**
Woman can make decision herself to access healthcare	38	36	**37**	**45**
Husband is decision maker for women's health care	38	32	**41**	**25**
Woman is a member of local organization	21	18	**27**	**53**
Knowledge about HIV/AIDS: Methods of prevention	59	60	**60**	**74**
Iron in-take during pregnancy	76	79	**86**	**96**
Recommended ANC checkup (4+)	75	80	**79**	**96**
Home Delivery	45	27	**39**	**18**
Hospital Delivery	47	69	**30**	**63**
Uptake of tetanus toxoid injection	29	94	**29**	**99**
Use of safe delivery kits	11	9	**5**	**32**

Table 2 shows that for many indictors (i.e. questions) we see a slight improvement in the control community, due to societal changes in Nepal. But for our intervention community we see greater improvements in, for example 'Knowledge about HIV/AIDS: Methods of prevention', we see nearly no change in the control community as the increase in knowledge is just one percent from 59% to 60%. However, for the intervention community we see a much greater improvement of knowledge on the topic with a jump from 60% to 74%. In summary, there was a statistically significant improvement in all areas presented here in the intervention community. Tetanus toxoid vaccination improved significantly in both areas; this suggests to us that the

increase in both the intervention and control community is due to factors in the wider Nepalese society, and that it is not related to our intervention.

Women's empowerment

The results show a significant increase in women of child-bearing age in the intervention community being able to make decisions around what health care they receive themselves, whilst in the control community the trend is backwards with fewer women reported in 2012 than in 2008 that they themselves make decisions about accessing health care. At the same time, the husband being the main decision maker for health care reduced in the intervention community. Both indicators did not show significant change in the control community. Similarly, the proxy indicator of women's empowerment as measured by their membership of local organizations significantly increased in the intervention area but remained unchanged in the control area.

Antenatal and delivery care knowledge and behaviour

The results show both improvements in knowledge and changed behaviour in both antenatal and delivery care. Women's knowledge in reproductive health issues such as HIV transmission has increased significantly in the intervention area with no change in the control area. Similarly, the number of women taking a full course of iron in pregnancy has improved significantly in the intervention area compared with the control.

It can be seen here that the use of Safe Delivery Kits (SDKs) increased significantly in the intervention area with no change in control. Home deliveries reduced in both areas but the reduction was greater in the intervention area. Hospital deliveries increased in both areas, but the increase was greater in the intervention area. Tetanus toxoid vaccination greatly improved in both areas.

Discussion of results

This programme has shown significant changes to women's empowerment, neonatal and maternal health indicators in the intervention area. The control area has served to show the effect of the Government of Nepal's national level programmes, and tetanus vaccination in pregnancy to prevent neonatal tetanus has been a success. Similarly, the national drive to get women to deliver in hospital can be seen to be somewhat effective by the results from the control area. However, as the Government are not encouraging use of SDKs or home delivery at all, the effect of this can be seen here: use of SDKs improved significantly in the intervention area but did not significantly change in the control area. We encouraged hospital delivery as a first option, but accepted that many would continue to deliver at some and so encouraged the use of SDKs through the women's groups.

None of the above would have been possible without rigorous planning, long community-based meetings between different stakeholders and local women's involvement, particularly through groups. Some men were also involved, but less than we had hoped. Access and therefore barriers to health services occur at many levels including personal, family, community and systems levels. Helping to improve access by addressing

each of these levels can result in change, but there is rarely one answer to a problem. This intervention was community based, participatory, culturally sensitive and low cost, and it addressed the first 3 levels. However, the development of such an intervention is time consuming and requires significant expertise in programme planning, training and research. It requires programmatic flexibility which is possible within a small organization such as Green Tara Trust working with a small community such as this, but is much harder when looking at how one may scale this up at a national level. The challenge is how to use small scale studies such as this to create principles of health promotion that can be used at a national level, but that are flexible enough to be changed depending on the local situation.

Following Green Tara Trust hosting Nepal's first Health Promotion Conference last year, the Ministry of Health and Population are now taking notice of this approach and we are assisting them in developing and incorporating this approach. A branch of the Ministry of Health is now allocated to address health promotion, but until now it has mainly been responsible for creating educational materials only. The challenges moving ahead in Nepal include people knowing what health promotion is, seeing its value as a low cost and effective method to improve health, seeing its relevance across all sectors from roads to agriculture as well as health, and starting to train people in using this approach.

Narrative perspective: Buddhism and Health Promotion

I have been working in Nepal for 20 years and have been practicing Buddhism for the same amount of time. I am motivated by the common connection of our humanity, and feel I have been born with certain privileges and opportunities that some of my fellow beings have not necessarily had in other parts of the world. I am free to practice my religion, have the means to support myself, have been enabled to choose how I live, if I am in a relationship or not, to have children or not: most people in the world, particularly women, do not realise they have this choice. My mother's generation were expected to marry and give up work; they may have had a choice but the conditions in themselves and in society were not supportive of making alternative choices. I wish to be part of creating conditions that enable people to have a choice. The choice they then make is up to them, and it may well be different from the choice I may make for myself.

For example, one barrier to women making their own health decisions in the families in this study was lack of any personal access to money. Part of the programme encouraged saving for delivery, and savings groups were started. This grew, and women from the community formed a range of organizations to support themselves. My own preference for these organizations would have been to form co-operatives, and to make an effort to include marginalized people in the community who tend to be poorer i.e. to benefit as many people as possible. However, in reality, a range of organizational styles have emerged, where some are there to benefit many, and others to only benefit those who are healthy, well, and easy to get along with. People tend to congregate according to ethnic or caste groupings. As a health promoter and a Buddhist, I have to let go of outcomes at this level: the purpose of the programme is to enable a positive environment for empowerment and choice for everyone: what people then choose to do from that place is up to them.

At the start of this programme, many women would not come out of their houses to talk to us. Quite quickly they were coming to mass events and groups, then saving money, then being more able to negotiate their health care needs. Change occurred at a much faster rate than I would have expected from such a simple intervention. As a range of health promotion techniques were used, there is no way of knowing which were instrumental in affecting change; it is most likely that all played their part. The advantages of having a small team, dedicated staff and an engaged community has been excellent communication between programme planning and the field, so that anything that was not working could be adjusted quickly.

The GTT Trustees and staff in the UK are Buddhist, but the researchers, Nepal staff and communities themselves come from a range of backgrounds. Some have an identification with their religion (e.g. Hindu, Christian), others identify more within a social justice framework (e.g. socialism). The underlying unity has been possible through shared values of wanting to create conditions for a positive, harmonious, healthy and empowered society.

This study has shown that a small group of people from diverse backgrounds, with few financial resources and a lot of commitment, can come together and create a health promotion intervention that is cost effective and has measurable outcomes. I feel it is crucial to not only have good intentions, but also to be able to measure the impact you have had. Famously, in the *Kālāma-Sutta*, the Buddha asked us to not take his teachings on blind faith but to try them and see what works and what does not for us. He taught us to reflect and investigate our experience. In the same way, if we are to have an impact on the world and want to share this with others, it is helpful if we have some evidence to back up our methods. The *Kālāma-Sutta* also asks us to challenge the status quo or what is seen as the authority of the times; this is particularly relevant for women in this study, where the programme is creating a space for the emergence of real choice, and the consequences of this will be challenging the accepted social hierarchy of others making decisions on their behalf:

"Come, Kalamas. Do not go upon what has been acquired by repeated hearing; nor upon tradition; nor upon rumour; nor upon what is in a scripture; nor upon surmise; nor upon an axiom; nor upon specious reasoning; nor upon a bias toward a notion that has been pondered over; nor upon another's seeming ability; nor upon the consideration, 'The monk is our teacher.' Kalamas, when you yourselves know: 'These things are good; these things are not blamable; these things are praised by the wise; undertaken and observed, these things lead to benefit and happiness,' enter on and abide in them.” [10]

We are challenged in this sutta not to be acting from greed, hatred and delusion; we do not want to harm others by the conditions we create, so it is not a case of the women becoming empowered and others suffering as a consequence. An example of how this has worked in practice with encouraging antenatal attendance in women has been to work with the common desire of all family members to have a healthy child.

Moving the health promotion agenda forward in Nepal

Effective health promotion requires a range of skills and flexibility in approach that is new in Nepal, and so can be a challenge for many people. It requires a flexibility in thinking, use of methods and cuts across many disciplines; working in this way is challenging in the UK, but is even more so in Nepal. Increasing health awareness and developing positive attitudes and behaviour towards healthier living is still a crucial need of the people. The concept of health promotion is still not considered as central to the broader public health approach in Nepal. Nepal's formal education system continues to be didactic and does not promote enough creative thinking until a tertiary level. Gender disparities, caste and ethnic differences continue to act as barriers at all levels to collaborative working. Health promotion also requires the Government to invest in it people for the future, not in short term fixes, and it seems few politicians are prepared to walk this path. Those that are often do not stay in office long enough to effect change. However, for those with vision, health promotion is a long term and low cost viable solution to a range of problems; once embraced across the board, health promotion can lead to a significant reduction in health care expenditure through prevention of disease and complications which are far more expensive to treat than to prevent occurring. Effective interventions can also bring in revenue for the government; for example, reduction in alcohol consumption through taxation.

Civil society action has had a considerable impact in effecting change in Nepal since the Maoist uprising. This has shown considerable and lasting effects at a local level in our programme, for example the mobile antenatal clinic in one area was so popular that now the Government health facilities feel they have to continue to provide it due to community demand. At a national level, civil society has also been effective in various arenas but is often done in the form of protest, and any concessions given by Government tend to be short lived. Within civil society, there are a broad range of exciting developments including a strong non formal education movement, participatory learning and using a rights-based approach to problems, all of which overlap well with health promotion.

Green Tara Trust manages to bridge civil society and national level work to some extent, but this is rare. It is made possible by having a small, dedicated and well qualified team both in the UK and Nepal. This programme has shown excellent results, and warrants further studies in different areas of Nepal. It can serve as a starting point in reviewing how health systems may enable or disempower access to health information in Nepal and start to look at how this may be addressed. It is also a good starting point from which to be reviewing the national level health curricula of all health workers and how this is delivered. What is now needed is for all those working in Health Promotion in Nepal and other settings to come together and collaborate as a group to keep pushing the national level agenda forward. Through the work at community and national level activities outlined above, this has now started.

Impact of the Millennium Development Goals: what happens next?

The MDGs have had the great advantage of offering clear targets for countries to achieve, which have been the focus of policies, funding and programme delivery for some years now. With regard to MDG 5 which I

will use here as an example, the targets set in Nepal were clear, and were achieved. This has not been the case across the world. It is not clear yet what factors came together to produce such success, even with a civil war in the midst of the achievement. However, a large relevant factor includes the funding of incentives to health facilities and women themselves to deliver there. A huge amount of energy has gone into producing 'good' outcomes, but much less energy has been spent looking at why people do not access care, and addressing long term solutions to access which are less attractive to funders and politicians. Examples include women's lack of empowerment and therefore choice over what she does with her body around nutrition, contraception, sexual relationships and marriage; lack of governance within the health system to ensure efficient running and access should a woman attend, and lack of emergency transport facilities. It will be interesting to see what can be maintained in terms of behaviour if incentives are dropped and people's attention moves towards the next priority; Universal Health Coverage.

There are some disadvantages to having 8 MDGs; firstly, any other problems tend to get ignored, not funded and seen as unimportant. For example, addressing poor mental health has been a World Health Organization priority for many years, yet it continues to sit in the 'health cupboard' and not get funded. Similar to health promotion, addressing mental health is complex, long term and hard to measure, but it is still possible to do so and these are not good enough reasons for inaction. However, funders and Governments do not like complex, long term problems; they do not win votes, and funders want to see quick results.

Universal Health Coverage is a noble ideal, and there are a variety of ways this can be delivered. It is impossible to meet everyone's health needs fully, and each country will need to decide for itself what models it will use. No one model will fit for all, and delivering this will require significant health system reforms in all countries. Many countries and funding bodies are looking at public-private partnerships. There is no clear definition of what 'Universal Health Coverage' means in reality, and the concern is that there are no measurable specifics which are required to be delivered.

As a Buddhist, I am very at home with holding complex interventions, I can see the benefit of long term changes that are sustainable rather than quick fixes, and I think we all have a role to play in holding this part of the agenda as we move forward from the MDGs. We need to be able to combine giving the best care we can to the patient in front of us, whilst trying to improve the overall system for everyone. As Buddhists, we do not have to fight any 'corner'; everything we do affects everything else, all our actions affect the universe and we are able to offer dispassion and lack of polarisation in our dealings with the world, at whatever level we are operating from.

I see it is no more or less important to be working in a small community, at national or international level, and I am comfortable working in all these settings. This is not true for everyone; some people want to fight a particular corner, some have strengths working in a particular environment, and working across settings requires confidence, practice and flexibility. This impartiality and confidence is something that I can offer to the world, and I trust that many Buddhist practitioners are able to do so in their own environments. Working across sectors is crucial if we are to engender change. I have demonstrated here that it is also possible to

work with non Buddhists on a common vision. If we come together, share our experience and co-ordinate our action across the world, we are likely to be even more effective as agents of change.

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