॥ समता फाउण्डेशन ॥
SAMATA foundation

Health is Wealth: Health Care Access for Dalit communities in Saptari, Nepal

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I. Executive Summary

Historically, Dalits have been socially, economically, and politically discriminated against within Nepal. In order to address issues of historical marginalization, the government of Nepal has created health care provisions such as the National Health Sector Program – Implementation Plan II (2010- 2015) that aim to directly mitigate vulnerabilities for marginalized groups as they pertain to health care access. Despite the national efforts to create inclusive health care policies there remains concern regarding health care access for Dalits in the Saptari District of Nepal. This research examines health care access for Dalits in six communities of Saptari, as defined by five dimensions of access: physical access, information access, financial access, discrimination, and social capital. Within the six selected communities, nineteen focus group discussions and nineteen key informant interviews were conducted with a total of 209 participants.

Based on these five dimensions of access, Dalits reported they lacked access to health care due to information, physical, and financial barriers, discrimination, and the lack of social capital in comparison to non-Dalits. Dalits lacked information regarding health education on causes, symptoms, and treatments for diseases when contrasted with non-Dalits. Dalits were also less aware of available health care services. Both Dalits and non-Dalits reported lacking information regarding medicines and incentives provided by the health care system. Dalits lacked physical access to higher level health care services in comparison to non-Dalits who typically bypassed lower level health facilities for care and obtained care at either zonal or district hospitals and primarily private clinics. Both Dalits and non-Dalits highlighted the importance of proximity to health facilities as a physical access indicator. Dalits and non-Dalits similarly emphasized the importance of social capital as a key coping mechanism – the ability to utilize social networks and relationships for information and greater access to incentives, services, and loans. There were few explicit examples of direct caste-based discrimination at the point of service delivery; however, there were accounts of discrimination in access to health care and entitlement to specific government incentives for marginalized groups. Discussions around caste illuminated this duality of caste as economic status. Both *'Dalit'* and *'poor'* were used interchangeably, thereby exemplifying the complexity of caste based discrimination not as an explicit barrier to equity but a subversive, sometimes systemic or culturally compounded, marginalization. Finally both Dalits and non-Dalits reported financial accessibility as a barrier to health care access. The situation of Dalits was exacerbated by high interest rates on loans and lack of information regarding financial incentives targeted to marginalized groups, often resulting in increased health-related expenses. Therefore, the major finding of the research lies in the nexus of socioeconomic factors that contributes to the poorer health status of Dalit communities and their limited access to health care services.

Acknowledging the limitations of this study, the implications of the findings highlight the need for increased education and outreach for effective policy implementation of National Health Sector Program – Implementation Plan II. These findings also emphasize the need for policy makers to include Dalits in decision-making at the local level. It is recommended that Samata Foundation advocate for innovative grassroots approaches that address the needs of local communities. It is advised that the government strengthen internal and external-monitoring mechanisms, which will increases transparency and accountability, through strategic partnerships.

II. Acronyms and Abbreviations

District Development Committee	DDC
District Health Office	DHO
Essential Health Care Services	EHCS
Expanded Program on Immunization	EPI
External Development Partners	EDP
Female Community Health Volunteer	FCHV
Focus Group Discussion	FGD
Gender Equality and Social Inclusion Strategy	GESI
Health Center	HC
Health Post	HP
Information Education and Communication Programme	IEC
International Non-Governmental Organization	INGO
Key Informant Interview	KI
Millennium Development Goal	MDG
Ministry of Health	MoH
Nepal Health Sector Program- Implementation Plan	NHSP-IP
Nepal Health Sector Program- Implementation Plan II	NHSP-II
Nepal Human Development Report	NHDR
Non-Governmental Organization	NGO
Primary Health Center	PHC
Second Long Term Heath Plan	SLTHP
Sub-Health Post	SHP
Traditional Birth Attendant	TBA
United Nations Children's Fund	UNICEF
Village Development Committee	VDC
World Health Organization	WHO

III. Introduction

Samata Foundation, formerly known as Nepal Centre for Dalit Study, is a Nepali think tank committed to ensuring equitable justice, rights, and development for all marginalized communities, especially the Dalit community in Nepal. Established in 2008, their work primarily focuses on policy research and advocacy for the rights of Dalits, historically considered the untouchable caste by Hindu tradition. The Foundation aims for social inclusion of all marginalized peoples and to end discrimination in Nepali society and politics by disseminating knowledge through research and publications, advising policy makers, encouraging civic participation, and empowering individuals from the Dalit community to become the next generation of leaders.

Working in collaboration with Samata Foundation, a five-person team from Columbia University's School of International and Public Affairs conducted a seven-month research project on the health status of Dalits in the Terai region. Research teams were deployed in January and March 2012 to conduct key informant interviews, community observations, and site visits to health facilities as well as focus group discussion. This ethnographic research examined five dimensions of health care access for Dalits in six communities in the Terai.

With the advance of the deadline of Nepal's constitutional reform, the development of this research arrives in an opportune time. It is hoped that health policymakers in Nepal would find the analysis and findings of this research helpful in approaching health policy and delivery of health services in a way that achieves social inclusion of marginalized communities and addresses the human rights of Dalit communities.

IV. Country Context

4.1 Political Context

Nepal has been in a state of perpetual political turmoil for approximately the past fifteen years. Today, Nepal continues to rebuild from the consequences of this political unrest.

The monarchy exercised uninterrupted and absolute domination over Nepal until 1991 when, due to growing political pressure from a people's movement, His Majesty King Birendra was forced to institute a house of representatives with limited powers. Despite this gesture, the Maoists continued their armed struggle against the state and in 1996 this struggle erupted into war. The ensuing decade-long people's war decisively altered the political landscape of Nepal by mobilizing marginalized groups on an unprecedented scale. The immediate result of the final armed offensive was one of the most celebrated upsurges of recent times: the "Jan-Aandolan II", a non-violent people's movement in 2006. This people's movement, which was led by an alliance of seven political parties, overthrew the monarchy and ushered in the secular, democratic republic of Nepal.[1]

Nepal's fledgling democratic experiment has been offset by a series of political party turnovers and political conflicts. Despite these disruptions, two positive developments have taken place over the past five years arguing for stable democracy in the future. First, the Maoists have demilitarized in cooperation with the electoral process, which resulted in a political triumph during the 2008 elections, during which the Maoist party of Nepal came to power at the center. Second, the rise of regional political parties, particularly in the Madhesh region, has given a new-found voice to a broad range of social groups, which had historically been excluded from political participation. The resulting political mobilization by a variety of interested stakeholders has heightened the interest and attention to the Nepali political structure and function. This level of invested interest has allowed democracy to take root in Nepal in a relatively short period of time. The most recent report on the State of Democracy in South Asia demonstrates a robust belief in democracy among the people of Nepal.[2] These regional and ethnic democratic aspirations are expected to find concrete articulation in the new constitution, which is due by the end of May 2012.

4.2 Economic Context

Nepal is one of the poorest countries in the world with as much as 40 percent of its population still below the poverty line, as indicated by the latest Human Development Index (HDI) report of

[1] S. Einsidel, D. Malone and S. Pradhan, *Nepal in Transition: From People's War to Fragile Peace* (London: Cambridge University Press, 2012).
[2] Centre for the Study of Developing Societies, *State of Democracy in South Asia* (New Delhi: Oxford Univesity Press India, 2007).

2011, which ranked Nepal 157th among 187 countries.[3] Agriculture is 40 percent of Nepal's national GDP and manufacturing is less than 15 percent.[4] The diminished role of the manufacturing sector in Nepal's economy is a direct consequence of the civil war, which resulted in a flight of both domestic and foreign investors. Furthermore, the continuing state of political instability has done little to restore investor confidence. Lack of investment combined with a severe paucity of skilled labor, has resulted in Nepal's slow economic recovery.[5]

4.3 The Terai

Nepal is divided into three main geographical regions from the North to the South: "Mountain", "Hill", and "Terai". The research presented here was conducted in the Terai, which is a narrow strip of fertile alluvial plains running East to West across Nepal and continuing into the Gangetic plains of North India. The Terai constitutes only about 23 percent of Nepal's total land-area but is inhabited by close to half of its population; this is the most densely populated region in Nepal.[6] The cultural and linguistic diversity of the Terai is due to its regional proximity to neighboring communities in India. The population of Terai is classifiable into three categories: Indigenous groups or *Jana-jati*, Madhesis or communities with extensive cultural and linguistic cross-border links, and the Hill migrants, now the largest sub-population.[7] The Terai is the backbone of the national economy, accounting for close to 60 percent of the agricultural land and contributing to over two thirds of the country's GDP.[8]

Madhesi communities have historically been discriminated against as second-class citizens within Nepal.[9] The "Nepali" identity has traditionally been considered the culture of hill-dwelling higher Chhettri-Brahmin castes often excluding other regional cultural identities.[10] Education across Nepal, for most of its modern history, was conducted in Nepali, a language not understood by most of the inhabitants of Terai.[11] Inhabitants of the region were denied citizenship rights in other examples, on the pretext that they were Indian immigrants.[12] However, in 2007, led by regional political parties and rallying under the identity of "Madhesi", people in the region were successful in articulating their concerns and staking a claim in the political process underway at the center. The "Madhesi movement" marked a turning point in the politics of the region and brought the issue of federalism to the center-stage of Nepali politics.

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[3] United Nations Development Programme, *Human Development Report 2011,- Sustainability and Equity: A Better Future for All* (New York, NY: Palgrave Macmillan, 2011).
[4] Y. Ghimire and S. Sharma, *Nepal: Country Study Report* (Kathmandu, Nepal: IIDS, 2002).
[5] The World Bank, *Nepal Economic Update 2011.* Web. 25 April 2012. <http://siteresources.worldbank.org/NEPALEXTN/Resources/223554129605546370 8/NepalEconomicUpdate1192011.pdf>.
[6] J. Miklian and International Institute for Peace and Conflict Research, *Nepal's terai: constructing an ethnic conflict* (Oslo, Norway: International Peace Research Institute, 2008).
[7] Ibid
[8] Economist Intelligence Unit, *Nepal: Country Report 2006.* Web. 25 April 2012. <http://www.un.org.np/sites/default/files/report/tid_188/2006-march-EIU_Nepal_March06.pdf>.
[9] Samata Foundation, *Confusion in Dalit Transformation in the New Constitution. SAMATA Policy Paper-1* (Kathmandu, 2010).
[10] M. Lawoti, *Contentious politics and democratization in Nepal* (New Delhi: Sage, 2007).
[11] Ibid
[12] U. Sigdel, *Citizenship Problem of Madhesi Dalits* (Kathmandu: Social Inclusion Reseach Fund, 2006).

4.4 The Dalits of Nepal

"Dalit", literally meaning "oppressed", is a self-label employed by low-caste groups across South Asia, especially for the purposes of political mobilization.[13] In Nepal, Dalits constitute between 13 and 20 percent of the population and consist of more than 20 caste groups. These numbers are subject to debate owing to the fact that the Nepal decennial census does not collect caste-disaggregated data.[14] Belonging to the lowermost strata of the Hindu hierarchy, the caste groups generally subsumed under this label were until recently considered to be untouchables due to their perceived ritual impurity. While the actual practice of untouchability is in decline throughout Nepal, caste prejudices still exist and appear to be quite strong in areas such as marital practices. More importantly, such discriminatory practices have compounded as a result of the historical marginalization of Dalits, often resulting in the exclusion of participation within the public sphere.[15] Therefore, very few Dalits have traditionally engaged in politics, while still fewer have been elected to political office or other public positions. Such social disadvantage is further compounded by economic hardship. According to one estimate, 40 percent of Dalits are landless laborers. Although exact figures are elusive, poverty statistics for Dalits are estimated to be considerably higher than national averages, as demonstrated by the economic welfare indicators in *Table 1*.

***Table 1*: Economic Indicators of Welfare, Dalit Populations compared to National (2001)**		
INDICATORS	**NATIONAL**	**DALIT**
Under-five mortality rate (per 1,000 live births)	104/1000	171.2/1000
Infant mortality rate (per 1,000 live births)	75.2/1000	116.5/1000
Fertility rate (per woman of child bearing age)	4	4.07
Literacy Rate (%)	54	33
Average Years of schooling	3.62	2.1
High school graduates and above (%)	17.6	3.8
Graduates (college) and above (%)	3.4	0.4
Poverty (% of population below national poverty line)	31	47
Landless households (%)	13	47% (Terai); 15% (Hill)

Source: Thapa, N. (2009)

[13]M. Lawoti, *Government and Politics in South Asia* (Michigan: Westview Press, 2008)
[14]N. Thapa, *Country Profile of Excluded Groups in Nepal*: *Draft* (Kathmandu, 2009). Web. 13 Feb. 2012. <http://www.unescap.org/ESID/hds/development_account/mtg/EGM_Bg_doc/Nepal%20020909.pdf>.
[15] United Nations Development Programme, *The Dalits of Nepal and a New Constitution* (Kathmandu : UNDP Nepal, 2008).

Although scattered across Nepal, Dalits tend to reside in the Terai in higher numbers. In the Terai region, eleven geographically heterogeneous caste groups, of whom Doms, Mushars, and Chamars are the most disadvantaged, are subsumed under "Dalit".[16] As mentioned in *Table 1*, landlessness among the Terai Dalits is prevalent, and most work as wage laborers. This characteristic is significant since agriculture is the predominant occupation in the region, indicating that landlessness is a risk factor for poverty in the Terai. By depriving Dalits of any bargaining power, landlessness forces them to work as daily agricultural laborers at very low wages and thus leads them into a pattern of ever increasing dependency on the landlords.[17] Many studies have highlighted this connection between low-caste status and low agricultural wages.[18] Similarly, the informal credit markets limit economic opportunities for Dalits and other low-status ethnic groups as they are driven by high interest rates established by higher castes. Thus, in the rural parts of Terai, the economic hierarchy is largely determined by caste and ethnicity.

4.5 The Health Situation

Nepal's overall health indicators are poor by international standards and are comparable to those of other South Asian countries. According to the latest data available through the Nepal Demographic and Health Survey of 2006, the infant mortality rate is 40 per 1000 live births, while the maternal mortality ratio is 281 per 100,000 live births.[19] Nepal also has high rates of child malnutrition at 72 percent in 2001, and high levels of under-five mortality, with 91.2 deaths per 1,000 live births in 2001.[20] Sanitation and access to safe drinking water are limited, particularly in rural areas. According to data available from the National Management Information Project only 33 percent of people in rural Nepal had access to improved sanitation facilities in 2008.[21] Moreover, 21 percent of Nepali rural households do not have access to improved drinking water sources and 95 percent of rural households do not have a functioning water connection.[22]

Health care disparities in Nepal exist along several axes. As in the rest of South Asia, women in Nepal suffer several disadvantages relating to health care but this fact is often missed by conventional indicators. (Refer to *Table 2* in *Annex 1*.)

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[16]Y. Ghimireand S. Sharma (2002)

[17]M. Hatlebakk, *Economic and social structure that may explain the recent conflicts in the Terai of Nepal* (Bergen, Norway: Chr. Michelsen Institute, 2007). Web. 18 December 2011. <http://www.norway.org.np/NR/rdonlyres/0993F5660B3548A98F819167B4FD596C/72944/http___wwwcmi.pdf>.

[18]Ibid

[19] Ministry of Health and Population Nepal, New ERA, and Macro International Incorporated, *Nepal Demographic and Healthy Survey 2006* (Kathmandu, Nepal: Ministry of Health and Population, 2007). Web. 18 December 2011. <http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf>.

[20] Ibid.

[21] World Health Organization and United Nations Children's Fund, "Joint Monitoring Programme for Water Supply and Sanitation: Estimates for the use of Improved Drinking-Water Sources" (Nepal, 2010) Web. 18 December 2011. <http://www.wssinfo.org/fileadmin/user_upload/resources/NPL_wat.pdf>.

[22] Ibid.

Similarly, health care indicators that appear to put Terai on par with the rest of Nepal hide significant intra-regional health care disparities.[23] Finally, health care status appears to have a positive relationship with caste indicating that as one descends the caste ladder health indicators also worsen. Health care disparities between Dalits and upper castes are examined through this research.

4.6 Human Rights and Health Care Access for Dalits

"The right to health" was first reflected in the 1946 World Health Organization (WHO) Constitution, reiterated in the 1978 Alma Ata Declaration, and finally adopted by the World Health Assembly in 1998.[24] The right to health is defined as the right to the highest attainable standard of health, which is inclusive of a set of social indicators, norms, institutions, and laws.[25] The most authoritative interpretation of this right is outlined by Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[26] Including Nepal, 145 countries have ratified the ICESCR.[27] There are four criteria that measure the right to health: availability, accessibility, acceptability, and quality. Many policy makers around the world frame health policy as service delivery without consideration for the complexity of overlapping accessibility issues. However, international standards indicate that it is unacceptable to pursue health care with this "if you build it they will come" mentality.[28]

Accessibility as interpreted by the ICESCR is defined as follows: "Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party." This definition can be seen as capturing four dimensions of health care access: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.[29] Out of these the most complicated dimension to measure is discrimination, as it can be overt, passive, or institutionalized. Moreover, discrimination manifests itself in a variety of complex often overlapping dimensions occurring at any point between policymaking and actual health care delivery. This picture is further complicated by the fact that largely the populations that most lack access to health care are also the populations that are the most discriminated against with regards to such access.

Recently there has been a shift in development practices that emphasize a rights-based approach. A rights-based approach to health applies a human rights framework to health care systems and can be applied to "assessing and addressing the human rights implications of any health policy, programme or legislation; making human rights an integral dimension of the design,

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[23]G.C. P. Singh, M. N. Ruth, B. Grubesic and F. A. Connell,"Factors associated with underweight and stunting among children in rural Terai of eastern Nepal", *Asia Pacific Journal of Public Health*, 21. 44 (2009).
[24] World Health Organization,"25 Questions & Answers on Health & Human Rights", *Health & Human Rights: An International Journal*,1.9 (2002). Web. 22 Feb. 2012. <http://www.who.int/hhr/activities/en/25_questions_hhr.pdf>.
[25]Ibid
[26]Ibid
[27]Ibid
[28]L. London, "What is a human rights-based approach to health and does it matter".*Health and Human Rights: An International Journal*, 10.1 (2008). Web. 16 Feb. 2012. <http://www.hhrjournal.org/index.php/hhr/article/viewArticle/25>.
[29] World Health Organization (2002)

implementation, monitoring and evaluation of health-related politics and programmes in all spheres, including political, economic and social."[30] One crucial element in this approach is the identification of vulnerable groups in order to enable service delivery in a way that protects the right to health for all individuals within the catchment area.

The protection of all individuals' right to health is fundamental to accomplishing the highest attainable standard of health. This approach has the potential for strengthening health systems and empowering marginalized communities and increases social, economic and political development, nationally as well as internationally, by increasing progress towards international support in accomplishing the Millennium Development Goals (MDGs).[31] "Framing access to health care and the conditions for health as a matter of service delivery is a political choice that demobilizes effective rights advocacy."[32] A human rights-based approach to health is best facilitated by participatory approaches, which enable the most disadvantaged groups to voice their health needs and priorities. [33] "This model is considerably different from those that frame rights as simply standards for state conduct, since it moves away from notions of benevolent handouts by state or third parties to ameliorate suffering of passive recipients of assistance."[34] This approach requires clear definitions of who is a rights holder and who is a duty bearer and what the obligations of facilitation are for accountability purposes.[35] These responsibilities towards upholding a rights-based approach to health manifests at multiple levels with a variety of stakeholders; however, these guidelines depend entirely on the capacity of institutional frameworks of regulation within formal and informal health systems.[36] Incorporating human rights language into the health system and national health priorities strengthens the health sector's ability to protect the right to health for all; however, this is only operationalized if there is a strict accountability framework and protocol with consequences for violators.

Save the Children in Nepal found that incorporating inclusion practices within service delivery or programming "for all" was more effective and accepted than providing special provisions for disadvantaged populations.[37] Another mechanism that has been used to make health care more inclusive of marginalized populations is the recruitment of practitioners from disadvantaged communities – this demonstrates commitment by the state to mainstream inclusion policies and practices.[38] It is also equally important not to create parallel heath systems that reinforce societal structured discrimination. If the health system caters towards a marginalized population while separating their services from the general population, instead of including them the system will end up reinforcing segregation and discriminatory practices.

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[30]Ibid
[31] World Health Organization (2002).
[32] London (2008).
[33] Daginfo, "Participatory Method for Mapping of Disadvantaged Groups (DAG) in DACAW." Web. 22 Feb. 2012 <http://daginfo.deprosc.org.np/>.
[34] London (2008).
[35]Ibid
[36]Ibid.
[37]N. Kabeer, "Social Exclusion and the MDGs: The Challenge of 'Durable Inequalities' in the Asian Context." , Institute of Development Studies, 2006. Web 19 Feb. 2012. <http://www.eldis.org/vfile/upload/1/document/0708/DOC21178.pdf>.
[38]Ibid

4.7 Dalits and Health Care Access

Dalits in Nepal experience a complex nexus of historical, societal, and institutionalized discrimination. This discrimination has led to intergenerational poverty, which is an important determinant of access to health care.[39] "Discrimination against Dalits has metamorphosed over time from overt, open and accepted norm to subtle, invisible, hidden and 'unacceptable' behavior"[40], yet it still occurs within multiple levels of the health care system. According to the Nepal Human Development Report (NHDR) of 2001, Brahmins (an upper caste) had significantly better infant mortality figures as compared to Dalits, 50 and 116 per 1,000 births respectively.[41] Malnutrition among children in Terai increases steadily as one descends in the caste system from Brahmins to middle-castes to Dalits.[42] Another example of caste-based disparities in health care is provided by the figures on place of delivery in *Table 3*.

Table 3: **Place of last delivery by caste/ethnicity: Dalits compared to National average, Brahmin/Chhetri and Other Caste/ethnic Groups**

	Caste/Ethnicity					
	Brahmin/ Chhetri		**Dalit**		**Total** (including communities not included in this table)	
Place of Birth last child	N	%	N	%	N	%
Hospital/Health center	133	45.1	58	33.3	327	40.3
Private Nursing Home	11	3.7	1	0.6	21	2.6
Home	149	50.5	112	64.4	454	56.0
Others	2	0.7	3	1.7	9	1.1

Source: Devkota , B.(2008)

Dalits reported 33.3 percent hospital-based births while Brahmin/Chhetri were 45.1 percent and similarly Dalits reported home births 64.4 percent while the high caste had home births 50.5 percent of the time. The World Health Organization (WHO) emphasizes the importance of institutionalized births as a mechanism of improving both maternal and infant mortality and is often used as an indicator of better access to health facilities.[43] It is clear from *Table 3* that Dalits with only 33.3 percent institutional deliveries are at greater risk of mortality and complications while also alluding to decreased access to health facilities compared to Brahmins and Chhetris.

[39]S.S. Acharya, "Children, Social Exclusion and Development: Working Paper Series.", Indian Institute of Dalit Studies, 2010. Web 18 Feb. 2012. <http://dalitstudies.org.in/wp/wps0102.pdf>.
[40] Acharya (2010).
[41] United Nations Development Programme, *National Human Development Report 2001*. Web. 18 December 2011. <www.undp.org.np/publication/html/nhdr2001/NHDR2001.pdf>.
[42]G.C. P. Singh, M. N. Ruth, B. Grubesic and F. A. Connell (2009)
[43]World Health Organization, "Health Statistics and Health Information Systems" ,WHO, 2012. Web. 5 May 2012. <http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html>.

The State has not yet explicitly defined "marginalized communities," and yet it is essential to have an agreed upon formal definition of exclusion which clearly identifies specific groups and categorizes them according to the degree of exclusion they have experienced.[44] In India, Dalits experience discrimination in access and utilization of health care at all points of service delivery in health care facilities and during home visits by all levels of health care staff.[45] One study indicated that Dalits experienced discrimination in the following ways: untouchability during examination and during the dispensing of medicine, interactions with health care workers including the use of derogatory language, referrals, counseling, pathological testing, distance traveled to points of service delivery, length of time waiting for care, and level of care including if health care workers would enter homes of Dalits for care.[46]

"In brief, social exclusion reflects the multiple and overlapping nature of the disadvantages experienced by certain groups and categories of the population, with social identity as the central axis of their exclusion. It is thus a group or collective phenomenon rather than an individual one."[47] Holding demographic characteristics such as assets and education constant, Dalits were still 19 percent more likely to be poorer than the rest of the population."[48]

[44] Thapa (2009)
[45] Acharya (2010)
[46] Acharya (2010)
[47] Kabeer (2006)
[48] Kabeer (2006)

4.8 Millennium Development Goals

In recent years, there have been criticisms of the Millennium Development Goals (MDGs) and their linear model of monitoring and evaluating progress within countries. As Freedman notes, "…Strategies for meeting the MDGs should be premised on an understanding of health systems as core social institutions that help define the very experience of poverty and citizenship."[49] This understanding reveals health inequities in health care systems and the widening gap between the wealthy and the poor.[50]

Standing indicates that "there is an equally important discourse of rights as situated in experience and gained and maintained through empowerment and struggle: that is, rights from below."[51] Freedman supports this saying, "Peoples' interactions with that system, thus defines in critical ways their experience of the state and of their place in the broader society."[52] When access to health care depends on the ability to mobilize assets, resources, and networks, it effectively excludes the most marginalized populations.[53] "Thus, in the context of Nepal, in order to bring out the true picture of each MDG goal and target, data need to be disaggregated by sex in totality, as well as further disaggregated by sex in relation to different caste, ethnicity and sub national groups. Otherwise, while the MDGs target would be met at the national level, a large section of the excluded population shall still remain deprived."[54]

4.9 Nepal Public Health Sector

A landlocked country in South Asia, Nepal is administratively divided into 75 districts. The districts are also regrouped into 14 zones, which are then regrouped into five development regions along geographic distinctions (Eastern, Central, Western, Mid-Western, and Far-Western). Administrative districts are broken into smaller administrative units consisting of municipalities and Village Development Committees (VDC), which are also regrouped into Electoral Constituencies. Each VDC is generally composed of approximately 500-700 households.[55] The Nepali health system is broken down in a way closely resembling the administrative breakdown of the state, as can be seen in *Figure 1*.

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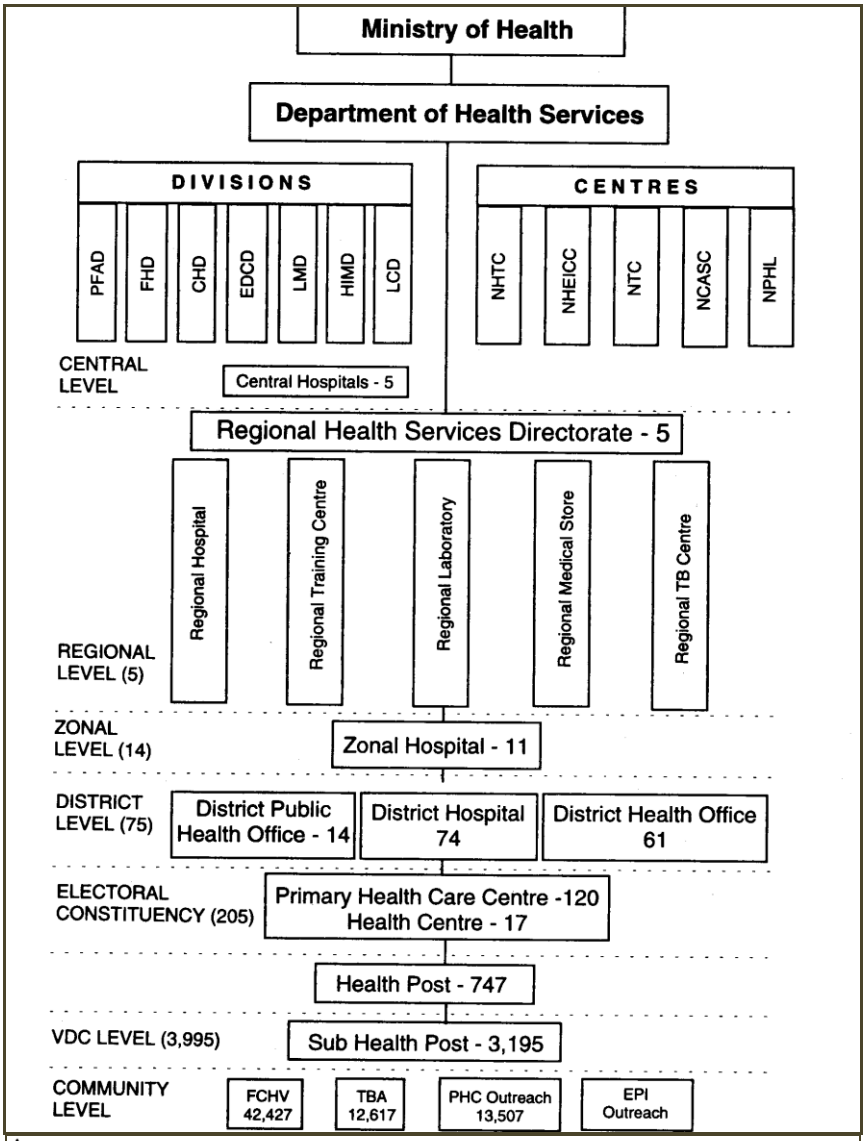
[49]L.P. Freedman, "Achieving the MDGs: Health systems as core social institutions." Web 14 Feb. 2012. <http://ipsnews.net/indepth/MDGGoal5/MDG5%20Freedman.pdf>.
[50]Ibid
[51] H. Standing, "Understanding the 'demand side' in service delivery: definitions, frameworks and tools from the health sector.", DFID Health systems Resource Centre, 2004. 15 Web. 24 Feb. 2012. <http://www.youthnet.org.hk/adh/4_4Sframework/3_Services_n_commodities/3_Families%20and%20community/Demand%20Creation.pdf>.
[52] Freedman (2012)
[53]Ibid
[54] Thapa (2009)
[55]S.K. Rai , G. Rai, K. Hiraji , A. Abe and Y. Ohno, "The Health System in Nepal – An Introduction". *Environmental Health and Preventive Medicine*. 6 (2001) 1-8.

Figure 1 **- Organization Chart of Department of Health Services, Nepal**[56]



Acronyms

PFAD	*Planning and Foreign Aid Division*	*NHEICC*	*National Health Education, Information and Communication Centre*
FHD	*Family Health Division*	*NTC*	*National Tuberculosis Centre*
CHD	*Child Health Division*	*NCASC*	*National Centre for AIDS and STD Control*
EDCD	*Epidemiology and Disease Control Division*	*NPHL*	*National Public Health Laboratory*
LMD	*Logistics Management Division*	*FCHV*	*Female Community Health Volunteer*
HIMDD	*Health Institution & Manpower Development Division*	*TBA*	*Traditional Birth Attendant*
LCD	*Leprosy Control Division*	*PHC*	*Primary Health Care*
NHTC	*National Health Training Centre*	*EPI*	*Expanded Programme on Immunization*

[56] Fielden, R. Assessment of the Health System in Nepal with a Special Focus on Immunization for UNICEF. 2001. Web. 23 February 2012. <http://www.unicef.org/evaldatabase/files/NEP_00-019.pdf>.

The Ministry of Health oversees the entire health structure through its Department of Health Services. Tertiary care is delivered at the Central and Regional Hospitals, whereas secondary level of care is delivered at the Zonal and District Hospitals. Primary health care is delivered at the VDC and Electoral Constituency levels through Primary Health Centers (PHC) and Health Centers (HC), Health Posts (HP) and Sub-Health Posts (SHP). Further outreach into the community and health care delivery is conducted through various outreach entities, including Female Community Health Volunteers (FCHVs), Traditional Birth Attendants (TBAs), PHC outreach and EPI (Expanded Program on Immunization) campaigns and clinics. Overseen by the District Health Office (DHO), the PHC/HC, HP and SHP are of particular importance in rural areas, forming the basic and most accessible units of health care in these communities. Likewise, the various community health workers and campaigns are equally important, serving as their direct extensions into remote areas. These primary health care delivery points embody primary tenets of recent health care policies developed in the country, specifically the elements of decentralization and provision of Essential Health Care Services (EHCS). The FCHVs serve as the communities' first point of contact with the health care system, promoting health, healthy behavior and providing basic health services with the support of SHPs, HPs and PHCCs

Throughout the health structure, there are 15 regional and zonal hospitals. At the regional level there are also Regional Training Centers, laboratories, TB centers and medical stores. On the local level there are 296 Primary Health Care Centers, 676 health posts and 3,134 sub-health posts in the country.

4.10 Non-State Health Sector

An extensive non-state health sector exists parallel to the government/public health sector. This parallel system is heavily utilized by citizens. The 2003-2004 NLSS reported that 40 percent of those seeking treatment for acute illness visited private pharmacies and 9 percent went to private hospitals, while only 44 percent sought care in government facilities.[57]

The non-state health sector is divided between both for-profit and not-for-profit entities. The Government of Nepal seeks to support and collaborate with non-state actors and utilizes this network as the service provision arm of the formal health system in order to allocate government resources to management, finances, and policy. Apart from being involved with private pharmacies, which often provide examinations along with dispensing medications, the for-profit sector is involved in medical education, training, and health laboratories. The non-state not-for-profit sector consists of NGOs, INGOs, civil society and community-based organizations.

The use of *Ayurveda*, a tradition of medicine indigenous to South Asia, is still quite widespread in Nepal with the government trying to institutionalize this system by founding a Department of Ayurveda under the Ministry of Health (parallel to the Division of Health Services and Drug Administration). In addition, traditional healers are often utilized at the community level, complementing this more formalized branch of alternative medical care.

[57]Central Board of Statistics, *Nepal Living Standards Survey 2003/04* (Kathmandu: G. o. N. Planning Commission Secretariat, 2005).

4.11 Health Policy Overview

Nepal consists of a fairly comprehensive framework of health policies, plans, and strategies. Although, the first policy directly relating to health was not drafted till the 1990s, the Government of Nepal has created several five-year plans since the 1950s. The first eight plans have focused on different aspects of development, such as employment, infrastructure, and economic stability.

With increased participation in international bodies and mobilization of External Development Partners (EDP) within the country, Nepal has shifted its national policies to accommodate internationally agreed agendas. In 1978, at the International Conference on Primary Health Care co-sponsored by UNICEF and WHO, Nepal re-affirmed its commitment to providing the Nepali people "a level of health that will permit them to lead a socially and economically productive life."[58] Through this conference and the declaration of Alma-Ata, it was stressed by the world community that the key to realizing this goal by 2000 was to focus on investing, implementing, and supporting the PHC through technical and financial means. This was a part of the "Health with All" agenda that aimed to bring "health" for all people because health was seen as a human right and it was the responsibility of all humanity to realize this common goal.

As one of the consequences of this paradigm shift in development and human rights, the first Nepali national policy directly related to health was passed in 1991. The aim of the National Health Policy (1991) was to expand the primary health care system to the rural. It focused on service delivery within the administrative structures of the health care system. In 1992, the Eighth 5-year plan also reflected the impact of health in the development of Nepal. The Eighth Plan (1992-1997) focused on population policies primarily on family planning and programs while the Ninth 5-year plan (1997-2002) centered around poverty alleviation through improvements in education that were all cross-cutting to the issue of health and development.

In 1997, the Ministry of Health created the Second Long Term Health Plan (SLTHP) (1997-2017). The SLTHP aimed to close the disparities in health care by outlining 15 health targets for the country as a whole. It assured the people of Nepal access to quality health care services by gender sensitization and equitable community access. The plan's long-term vision is to provide health care with equitable access and quality in both rural and urban areas. It targets the most vulnerable and under-privileged groups such as women and children, the rural, and the marginalized by promoting access to the low-cost high-impact EHCS.[59]There are 20 components to the EHCS package, ranging from promoting primary health care at the community level to strengthening partnerships with international NGOs.

Since its introduction in 1997 the SLTHP has been complemented by a number of implementation plans. In 2003, the "Health Sector Strategy: An Agenda for Reform" was prepared and approved by the Council of Ministers as a response to the analytical works

[58]M. Ono, "From 'Health for All' to 'Health with All' in Nepal- Through Empowered Civil Society as Rights and Responsibilities of All Humanity", 2001. Web. 19 February 2012. <http://www.hsph.harvard.edu/research/takemi/files/RP183.pdf>.

[59] World Health Organization Country Office for Nepal, "Health System in Nepal: Challenges and Strategic Options" . 2007. Web. 19 February 2012 <http://www.nep.searo.who.int/LinkFiles/Health_Information_HSC.pdf>.

undertaken by EDPs during the last few years. The analysis of the frameworks and plans done throughout the last few years had revealed that the MoH should focus on health problems, which were disproportionately affecting the population. Reviews also called for the development of a common strategy where all interested parties could collaborate in contributing to better health outcomes in Nepal. Following this agenda, the first Nepal Health Sector Program-Implementation Plan (NHSP-IP) (2004-2010) was formulated in 2004. This plan took a multi-stakeholder, sector-wide approach that aimed to improve health care in Nepal by prioritizing eight outputs: 1) improvement of EHCS, 2) decentralized management of health facilities, 3) partnerships between public and private sectors, 4) strengthening of sector management, 5) financing and resource allocation, 6) improved management of physical assets, 7) human resource development, and 8) integration of a management information system and quality assurance policies.[60] Within these outputs, the targeted indicators were linked with the achievement of the MDGs framework. In 2010 this plan was replaced by Nepal Health Sector Program-Implementation Plan II (NHSP-II), which introduced some crucial modifications while carrying forward the basic thrust of its predecessor. The NHSP-IP II, which shall be in effect until 2015, can be seen as addressing four aspects of health care access.

It aims to address matters of financial access to health care by aiming to universalize the EHCS program to all levels below the district hospital. This includes the provision of free health care services, both preventive and curative, for all Nepali citizens at SHCs, HCs, and PHCs. In addition, a range of common medical investigative procedures for diseases such as TB and Malaria among others, are supposed to be free of charge. Although this scheme provides for a nominal service charge at district hospitals and above, this fee can be waived for members belonging to 'marginalized communities' on presentation of adequate documentation. The plan also provides for 40 free medications at the district hospitals and 32 free medications at all levels below it.

It tries to aims to improve physical accessibility, especially for mothers, by offering a range of pregnancy-related incentives. More precisely, a sum of NPR 100 is to be provided for each of the four prescribed antenatal checkups (ANC), while a lump sum of NPR 500 is provided for all institutionalized deliveries. In addition to these, financial incentives are also provided to offset the costs of transportation.

Matters of informational access are addressed on two levels. First, it provides for the institution of Information Education and Communication (IEC) programmes to improve the health behavior of the poor and excluded. The second measure is more indirect and has to do with an increase in the total number of FCHVs in the country by 5000. The health care system of Nepal relies primarily on the Female Community Health Volunteers for the task of increasing health care related awareness within the community. These FCHVs are tasked with providing community members information regarding free health care services available at the local level, informing them about the symptoms of common diseases, and advising them in cases which require referral to higher centers. The specific areas that require an increase in numbers shall be decided by the District Development Committee (DDC) with the help of input provided by the various VDCs.[61]

[60] United Nations Nepal Information Platform, *Nepal Health Sector Programme- Implementation Plan (NHSP-IP)* 2004. web. 19 February 2012. <http://www.un.org.np/node/10321>.
[61] Ibid

NHSP-IP II also explicitly acknowledges the need to specifically target 'marginalized' communities. This approach is taken even more seriously by the Gender Equality and Social Inclusion (GESI) Strategy, which is one of the milestones recently approved by the Ministry to reduce cultural and financial barriers to health services for women and children, Dalits, Adibasi Janajatis, Muslims, Madhesis, and other disadvantaged groups. A collaborative effort between three international development partners (Asian Development Bank, UK-DFID, and the World Bank), GESI is particularly relevant in the context of Nepal as there is significant overlap between gender, caste, and ethnicity-based exclusions in the country, which are further cut across various hierarchies, sectors, institutions, religions, and languages. This strategy has the following three stated objectives:

1) Focuses on developing policy, plans, and programmes that mainstream GESI in Nepal's health sector by ensuring the inclusion of the GESI framework in Nepal's development policies and strategies, both at the central as well as local levels;
2) Aims to "enhance the capacity of service providers and ensure equal access and equitable use of health services by the poor and excluded castes and ethnic groups in regard to a rights-based approach."[62] This will be accomplished by making service providers accountable for the equitable delivery of EHCS to marginalized populations, by identifying target groups in excluded populations, and by making existing service delivery sensitive to the needs of women and socially excluded groups; and
3) Seeks to improve health behavior of poor and excluded groups through a rights-based approach.

Taken together, these goals reflect a growing concern on the part of the Ministry of Health to ensure discrimination-free health care delivery to all groups.

[62] United Nations Population Fund, *Nepal Health Sector Programme-Implementation Plan II (NHSP-IP 2)* Web. 18 February 2012. <http://www.unfpa.org/sowmy/resources/docs/library/R090_MOHNepal_2010_NHSP-IP II_Final_Apr2010.pdf>.

V. Objectives

In collaboration with Samata Foundation, the Columbia University team sought to achieve the following objectives through this project:

(1) Research existing health policies and structures in Nepal;
(2) Collect data on the health care experiences of Dalits and non-Dalits in several communities in Saptari District (in the Terai region of Nepal);
(3) Investigate and assess Dalits' access to health care using five dimensions of "access" (information access, physical access, financial access, discrimination and social capital);
(4) Provide next step and policy recommendations for Samata Foundation to pursue in advancing Dalits' access to health care and right to health;
(5) Provide Samata Foundation with an actionable strategy; and
(6) Help inform the Gender Equality and Social Inclusion (GESI) team's plans for a national study on health care accessibility for Nepal's marginalized populations by sharing key findings and tools.

VI. Methodology

This research aims to examine health care access for Dalits in Nepal through the experiences of stakeholders throughout the health care system. The primary objective of this research is to identify health care policies and practices which contribute to the basic health status of the Dalit community in the Terai region (Southeast Nepal) and to make recommendations on how to improve health policies and implementation practices to be more inclusive of Dalits. This research utilized ethnographic research methodologies while employing a participatory approach.

The research questions and approach were informed by an extensive literature review. This literature review highlighted four dimensions of access, which were utilized throughout the research.[63] Concluding the first field visit a fifth dimension was uncovered and incorporated into the research. The five access dimensions, which informed the research, included financial accessibility, information access, discrimination, physical accessibility and social capital. All five of these dimensions informed the research questions, the research approach, and finally the analysis.

Several tools that were developed in the first field visit that informed the investigative approach for the duration of the research included a stakeholder analysis and an institutional analysis. Both of these tools provided insight as to the power dynamics, politics, norms and decision making processes that influence health care access or delivery of health care services to both the general population and marginalized communities.

Several participatory research tools were employed throughout the research including key informant interviews (KI), focus group discussions (FGD), and participatory ranking methodology.[64] The KI interviews were used to include perspectives of individuals working within the health care system such as health care providers and both low and high-level policy makers. KI interviews were used to obtain more details into a topic that may have only been highlighted in FGD with beneficiaries.[65]

FGD were conducted in two parts. The first activity conducted during a focus group discussion included participatory ranking methodology. During this activity, participants highlighted the main health care issues that caused them to seek health care. Participants defined these issues, provided explanations and then they ranked them according to importance. The second activity built off of the first activity in which participants examined the health care issue that was ranked as the most important issue and a discussion was facilitated in which participants identified care responses to that issue. Participants would narrate what a family would do if a family member were affected by this issue inclusive of health seeking behaviors, decision-making processes, consequences, assets and problems or barriers during this process.[66] All health seeking behaviors and consequences in response to this very important health issue were identified and discussed.

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[63] World Health Organization (2002).

[64] The research methodologies will be shared with the Gender Equity and Social Inclusion team to inform for a national study on health care accessibility for Nepal's marginalized populations by sharing key findings and research methodologies. This information was requested during a 'preliminary findings' meeting held at Samata Foundation concluding the final field visit. Additional technical support will be provided to the GESI team upon request.

[65] Please refer to Annex 2 for the semi-structure interview guides that were utilized during key informant interviews.

[66] Please refer to Annex 2 with the semi-structure interview guide that was used for focus group discussions.

For all stages of the ethnographic research, interviewers interacted with a diverse cross section of the community and the health care sector. Participants were selected based on a two-stage convenience sampling and with consideration to sampling a variety of levels within the health care system including beneficiaries. Communities were selected based on a matching approach.[67] In order to have an appropriate number of participants within each FGD, communities were matched based on three strata criteria. Communities were matched based on demographics such as high and low population levels of Dalits, FGDs were then disaggregated based on gender and caste. A minimum of four FGDs were held in each community, one set with non-Dalits (both male and female), and one set with Dalits (male and female). Each community was then matched with another community based a community assessment of the high-low demographic of Dalit populations. This matching approach improved the team's ability to isolate incidences and relate associations to similar demographics, gender, location or caste thereby strengthening the final analysis. This process ensured that no one group or demographic biased our results.

[67] Please refer to Annex 4 for a map of the communities that were selected and the number of KI interviews and FGDs that were conducted in each.

VII. Limitations

The desk review was limited by the lack of detailed information on the Terai and the Saptari district. These limitations were exacerbated due to language constraints as most of the documented material was in Nepali and not in English. The scope of this project was limited by logistical constraints of time and geographical accessibility to Saptari. The combination of these two constraints resulted in the research focusing the data collection to one district in which Samata could facilitate access. The greatest single limitation was the amount of data collection that could be accomplished in a total of 4 weeks in the field. The research team prepared for this constraint in advance; however, it still narrowed the research focus and scope.

Field visits were both facilitated and limited by individual relationships held by the field coordinator who guided the data collection and community selection for participation. Without the assistance of a field coordinator the research team would not have had access to particular communities or populations for data collection; however, those same networks that were utilized by definition implies there were some communities or populations that may have been excluded from data collection due to a lack of knowledge or social relationships. Despite social networks and general accessibility to communities the research team was able to access both urban and rural settings as well as Dalit and non-Dalit communities. The research methodology was constrained by the ability of the research team, field staff and assistance from community discussion to match communities based on similar demographics. This constraint was exacerbated by lack of up-to-date data on population figures by the VDC and the lack of population data disaggregated by caste. The research team therefore relied on local reports and perceptions of concentrations of Dalits in VDCs across Saptari, and as such the matching of demographics was based on informal traditional knowledge.

Translation presented many major limitations, as translators were required for all focus group discussions and many interviews. The research team mitigated some difficulties with translation by discussing the planned methodology and approach in advance while emphasizing the role and expectations of the translation. Despite clear understanding of the methodologies, approaches, roles and expectations due to the very nature of translation, it was difficult to measure the degree of accuracy to which the questions are asked and the responses are translated. Cultural differences and nuances may have affected the questions being asked, in particular the terminology used, and the responses received. Inquiries regarding caste often warranted precaution and cultural sensitivity in the translation and directness of language used during interviews and focus group discussions. This indirect use of language by the translators may have diverted the discussion away from the original question and perhaps influencing the results captured in our data collection.

Being aware of this dynamic, the research team carefully adapted the data collection technique to account for this more appropriate method of approaching the issue. Local understanding and indirect translations may have also influenced participant responses received to questions of important diseases and their ranking during activities of participatory ranking. What constitutes an “important” disease varied from group to group and in general groups were unfamiliar with the ranking process. For these reasons, the most important illnesses ranking should be considered carefully with these limitations in mind.

In addition, the research team utilized the services of two translators. Each translator had varying levels of experience and differing styles of translation thereby influencing the quality of data captured. In some cases translations required a three-way translation between English, Nepali and Maithili also influencing the level of quality of the translation. These differences among the translators may skew comparability. The research team also captured information using both audio recordings and hand written notes these two mechanisms facilitated the transcription process. Few audio recordings were limited by the quality of the audio recording for which the research team relied on notes from the field. This adaption may have also influenced the quality of the transcription.

VIII. Key Findings

8.1 Structure

When analyzing Nepal's health care structure, access to health care proved to be a concern for both Dalit and Non-Dalit populations due to its weak structure and limited capabilities. The analysis revealed that a lack of resources, absence of a monitoring mechanism for different levels of health care and problems with decentralization were the main causes of a weak Nepali health system.

In all levels of care, the lack of resources was evident based on interactions with both beneficiaries and providers. Medicines, supplies, equipment and skilled health attendants were short in supply at hospitals, posts and centers throughout the district. A Dalit woman from Joginya explained that the PHCs *"[don't have] the medicines, they don't have the skills. And they don't have the government-provided medicines. They only provide saline water and give the slip to buy those things outside."* Patients are required to purchase supplies at private clinics, pharmacies and shops because the local health centers do not have the capacity to provide them. A non-Dalit male from Chinnamasta further described the lack of resources, not just in material supply but also in personnel:

> *"There are six districts and only one zonal hospital in the region. The hospital is [very dirty]. Doctors don't come on time; sometimes they don't come at all. Doctors have their own private clinic, where they spend more time. The treatment is unsatisfactory. The hospital is not well equipped. Even for small diseases they refer to Dharan or Biratngar. Especially brain related problems, they refer to India."*

The shortage of resources is a systemic problem throughout the health care structure. However, both providers and beneficiaries have an assumption that the higher levels of care include more skilled personnel and resources available. This assumption contributes to a "Ping-Pong" effect, where providers often refer patients to other forms of care within the structure, usually a higher-level care from the referee's. Though patients are referred to higher levels of care, it is not guaranteed that they receive adequate care or resources at these higher levels, subsequently burdening the patients by prolonging an adequate diagnosis and increasing financial constraints such as additional costs including transport fees.

The absence of a strong mechanism of checks and balances for different levels of health care is alarming. Findings revealed several accounts of corruption, mismanagement, and abuse of authority in some hospitals, posts, and centers. The lack of a functional monitoring and reporting system with strong disciplinary measures for reprimanding ill-performing health professionals is crucial for the transparency and accountability of the health care system.

Though policy indicates that Nepal's health service delivery is a decentralized structure, the findings from the field reveal that this decentralized method is not effectively implemented. The mandates of health care personnel in all levels are highly centralized at the core, and the delivery of resources to the lower levels remain varied according to each health post and the capacity of its chain in command. The failure to provide health care services with a decentralized model creates a perception of mistrust from the beneficiaries to the providers of the health care system.

8.2 Perceptions

The findings of this research highlight how the system is perceived by health care providers and officials working within it, while also capturing the perceptions of beneficiaries.

Health care Providers and Officials

A rather surprising finding that emerged from interviews with higher officials and bureaucrats was that they characteristically tended to lay the blame for the existing health care disparities on the communities themselves. While referring to the Dom community, a top-level bureaucrat in the health ministry stated the following: *"if some communities do not like to utilize health services, no government health officials can do anything. We can only educate them. If they themselves refuse, we cannot do anything"* We also frequently encountered biases regarding certain populations among these officials, with women and Dalits often being described as possessing *"low capacity."*

When asked about their perceptions of the health system itself, the responses of health care providers and officials varied according to their place within the hierarchy. A recurrent pattern that emerged from interviews was that higher officials tended to take an optimistic view of the quality of work of their subordinates, for whom they were indirectly responsible. For instance, when asked about the estimated number of health centers working well a high level official reported *"more than 80 percent of sub-health posts and more than 85 percent of health posts are doing well. Almost 100 percent [of] PHCs are doing great."* At the same time, however, lower officials tended to view the levels above them as characteristically opaque and corrupt. The above official when asked about his superiors had the following to say: *"there should be improvement but we cannot intervene. They can do everything. They can also take back everything. It is a problem of decentralization. All the power rests with the ministry of health. They are the bosses."* Similarly, an Assistant Health Worker (AHW) in referring to his superiors told us that *"…all the officials sitting at the District level are thieves."*

Such perceptions towards superiors were often accompanied by a perceived lack of accountability within the system. A Health Assistant at a Primary Health Center (PHC) reported that the doctor who was officially posted at the center had not shown up for six months. When asked about the steps he had taken to correct the situation, he explained that, *"we have been trying to convince the doctor to come here, but she makes a lot of excuses…apart from trying to convince her, we are powerless"* From the perspective of lower level health care workers, the Nepali health care system emerges as corrupt and unaccountable. With little capacity for actual decision-making, lower level officials and health care providers moreover appear to have no significant stake in the proper functioning of the system.

Beneficiaries

The predominant perception of the health care system among the Dalit population of Saptari is reflected in the fact that Dalits, who traveled long distances from their villages to government hospitals in big cities, frequently required assistance, both in completing the complicated documentation process, as well as pressuring health care staff to provide services that were expected to be free of charge. One Dalit had reported advocating on behalf of other Dalits in a government hospital, explaining that *"... (we) try to push to get it (services) for free or for half price,... it's not the hospital's cost, it's the government's cost but still the administrators don't want to give these free services"* In contrast, non-Dalits tended to be relatively better informed about the workings of the health care system but commonly looked upon it as corrupt.

8.3 Information Access

Dalits do not have adequate information or knowledge of the causes and cures of diseases; the symptoms are often mistaken for causes. In contrast, Non-Dalits tend to have more knowledge of chronic diseases and can identify their presence at early stages. It is common for Dalits to not be well informed of the health care services that should be made available by the government system, which limits their ability to access the system in the correct way and to demand services from the system.

Generally, both Dalits and non-Dalits lack awareness of medicines and incentives made available by the health system. Of the 32 medicines listed as free by the official government policy, Dalits tend to receive between 2 and 5 of them while non-Dalits only marginally more. Incentives provided for delivery in a government facility are known by non-Dalits and some Dalits, though many Dalits are not aware of the system of incentives for antenatal care checkups.

This quote from a Dalit woman in Chinnamasta exemplifies the confusion and lack of knowledge around medicines and incentives:

> *"We go for check-ups but we don't get any money. We don't know about any incentives. We get the [antenatal care incentive] cards, but we don't know what they are for, or how it works. We don't know what's supposed to be free, but we know when medicines are supplied because we see it arrive in the car... We know about the 500 rupees [incentive for birth in a government health center] but the hospital is closed... We don't know about post-natal check-ups or incentives..."*

Sources of information for both Dalits and non-Dalits include primarily doctors, community members, and family. The community often convenes to share advice on the health care avenues that should be pursued in emergency cases, with Dalits regularly turning to more knowledgeable non-Dalit community members. The media, including radio and in some cases newspapers and TV in urban areas, in addition to in-person announcements, is an effective way of communicating available government services and upcoming programs. FCHVs are also mandated with the task of providing information on both services and prevention, and while

policy officials perceive this as an effective channel of communication, FCHVs report a lack of training and therefore inadequate knowledge themselves. Dalits reported that there is not an educational component to the role of the FCHV outside of the provision of polio drops and occasionally family planning. One successful example of information sharing encountered in a community is a women's forum of both Dalits and non-Dalits that discusses the causes and cures of medical concerns that commonly affect women and advises the community on related issues.

8.4 Physical Access

Several key themes emerged under the dimension of physical access. A more comprehensive definition of "physical access" was used to assess statements, looking not only at the proximity of facilities and services, but also at what was physically available and utilized by the communities visited.

Proximity

Not uncommon in rural areas, distance and available facilities were cited as a challenge for accessing care by both Dalits and non-Dalits in all villages visited. Likewise, both Dalits and non-Dalits stated that the roads were poor and there was a need for better transportation in order to improve access to health care. Tellingly, several stakeholders and community members mentioned the importance of proximity to highways as automatically advantaging individuals towards better access to care. A high-level health official recognized this by stating that *"near the highway it [health services] is better, near the border it is worse"* supporting the observation that remote communities had greater difficulty accessing care. The most extreme of the observed communities was the village of Malhaniya, where FGD participants highlighted physical isolation because of being surrounded by rivers- making it particularly difficult to reach facilities outside the village, especially when there are floods.

Modes of Transportation

In discussing their ability to reach health care, FGD participants would also mention what mode of transport they utilized to get health facilities. Both Dalits and non-Dalits acknowledged that access to transportation varied between the two groups. When asked how he gets to the zonal hospital, a non-Dalit man in Chinnamasta responded that with public transportation *"it takes half an hour, but poor people, usually Dalits, walk to save money"* As indicated by this statement, it was found that non-Dalits accessed facilities utilizing buses, ambulances, and cars more frequently, while Dalits, citing high costs of transport and lack of ambulances, would often walk. This, of course, impacts their ability to reach care in a timely fashion.

Levels of Care

Discussions revealed that higher levels of health care (such as zonal PHCs and zonal hospitals) offered better services and had greater capacity. These institutions also offered more services than lower-level facilities, and were better equipped to handle more complex diseases and health issues.

There was a notable distinction between Dalits and non-Dalits in this realm as well. The data revealed that non-Dalits bypass lower levels of care and almost always go directly to zonal and district hospitals. By contrast, in describing their trajectory of seeking care, Dalits would almost always first go to the lower health centers (going to either Sub-Health Posts or Health Posts) before ultimately being referred to higher-level facilities to get the care they needed. Given their increased interaction with community-based care, it is not surprising that Dalits also reported having more interaction with FCHVs than non-Dalits did. Though admittedly non-Dalits had less interaction with community-based health care providers, there was also a difference between the two groups in terms of how they each interacted with these actors. Specifically, non-Dalits often specified that doctors and FCHVs entered their homes when providing care, whereas there were mixed reports of this happening among Dalits.

Financial Implications

All modes of transportation were associated with financial costs. Often possessing more financial resources than Dalits, non-Dalits were better able to access faster modes of transportation (such as buses and ambulances) when trying to get to health facilities. Dalits, however, stated that utilizing these modes of transport posed a greater financial burden, which in turn influenced how they got to health facilities. Apart from delaying access to care given their chosen mode of transport, these financial implications also postponed Dalits' seeking care at higher level facilities to a later point in time- further delaying their utilization and receipt of the care they sought.

8.5 Financial Access

Financial accessibility is an access dimension that was central in linking numerous barriers to health care services and greatly influenced health-seeking behaviours. Overall both Dalits and non-Dalits reported financial barriers to health care access; however, Dalits were more disadvantaged than non-Dalits due to a variety of reasons highlighted in the areas of financial incentives, barriers, and coping strategies.

Overview

According to the participants in our sample, non-Dalits reported using higher-level health facilities such as the zonal hospitals or private health facilities 63 percent more often than Dalits. Dalits inversely used lower level health facilities such as PHCs and health posts 66 percent more often than non-Dalits. Non-Dalits on average reported not paying for health services including health tests and medication more often than Dalits. Non-Dalits cited FCHVs with both positive and negative experiences and utilizing India's health care system, requiring the financial ability to do so. Dalits cited issues of financial discrimination, fragmented financial incentives including difficulty with administrative processes and financial hardship due to referral processes. The following three sections will unpack some of these findings in more detail.

Incentives

Both non-Dalits and Dalits typically received 500 rupees for institutionalized deliveries. However, non-Dalits typically received the 400 rupees for four consecutive antenatal check-ups while Dalits rarely reported knowing about this or receiving this incentive. One FCHV noted *that "500 rupees are transportation costs, persons must be active, communities must be active, [the FCHVs] inform [communities] about the card and other things …but they are not active."* This quote captures a tension that was noted in many focus group discussions as an explanation for why some individuals were not receiving some incentives while others were; however, it is important to highlight that 70 percent of Dalits reported not receiving this service while 70 percent of non-Dalits reported having received it. One Dalit woman discussed this difficulty by explaining, *"We go for check-ups but we don't get any money. We don't know about any incentives. We give, the cards, but we don't know what they are for or how it works."*

Another tension that was mentioned particularly from the Dalit perspective was the inadequacy of the 500 rupees, considering that additional financial barriers must be overcome in order to seek health care. One Dalit man echoed what many claimed, saying, *"It's not enough… that the transportation is not enough. For deliveries [we] spend about 3000 Nepali rupees. So [we] have to buy everything, gloves, saline water, blades."* Dalits explained that on occasion they would not receive the 500 rupees for an institutional delivery because they were in addition charged for all of the materials for the delivery such as the birthing kits and medication, thereby reducing or eliminating the principle incentive. Dalits reported paying for additional health services such as medication and materials 66 percent of the time while more non-Dalits reported not having to pay for those items. Non-Dalits also cited the use of blood tests and vaccinations while Dalits did not mention those health services implying a higher level of care obtained by non-Dalits.

Barriers

Both Dalits and non-Dalits reported that a major barrier to health care services were health care-associated expenses. Non-Dalits reported high expenses for services; however, typically in reference to utilizing private clinics and with minimal use of the lower level health facilities. Non-Dalits also reported quality of care as a deterrent of care or an underlying factor in their decision-making processes in terms of what kind of facility they would pursue. Non-Dalits reported that ambulance expenses were too high. Other associated health care costs were high but one non-Dalit woman noted *"two three times, groups of women had to pressure the PHC in the past. Most people don't know that you get free medicines there."* While Dalits comparatively highlight *"people who can talk and act smart can get [medicines] for free and people who can't [don't get it for free]."* Dalits reported three times more often than non-Dalits that medications and additional services such as tests and vaccinations were too expensive required payment.

Dalits reported that they experienced additional barriers that were not highlighted with non-Dalit focus group discussions such as financial discrimination, loans, and lack of information regarding financial incentives and failed incentives. On Dalit man explained that *"approximately if 100 Dalits come in one month for check up only 10-12 people will get services for free."* Other Dalits noted that social status influenced the incentives that they received and that they experienced a reduction in discrimination due to their status within the Dalit community. One Dalit man explained:

> *"[Health care providers] don't give [Dalits] medicine. You ask 10 times but you still don't get it. [Health care providers] don't give it. Even the free medicines… because the doctors and health workers, because he's more well known of a Dalit, for him they'll consider it and give him the medicine [because he is well known in the community they give him free medicines], but for other Dalits who don't have a social position, they'll mistreat [them] and give [them] medicines late."*

Both Dalits and non-Dalits highlighted this link between health and financial assets. A non-Dalit woman summarized this tension by stating, *"Those who have the money go for the treatment, those who don't – they die."* One coping mechanism that is discussed in the next section is loans for health care. Many Dalits also consider these loans a barrier, as the interest rates are very high. One Dalit man recounted, *"no one gives us loans without interest. There are only high interest loans here, 3-7%...serious [illnesses] 7% interest, otherwise 3-4%. All poor people's diseases are serious, emergency cases."* The interest from these loans plagued Dalit families for years to pay off if ever and they had lasting effects on families as they had to sell assets such as land or became indentured servants to repay them typically to non-Dalit lenders.

Coping

Coping mechanisms to mitigate the effects of financial barriers primarily fell under the category of loans for both Dalits and non-Dalits. Loans were the most reported coping mechanism for both Dalits and non-Dalits; however, the origin and terms of those loans varied according to affiliation. Non-Dalits reported using their family, friends and neighbours as financial supports in emergencies. Typically these loans had little to no interest. Similarly, Dalits reported that they use loans as a coping mechanism for financial barriers; however, one Dalit woman reported *"sometimes when there is a very serious case, the Dalits come together and go to a non-Dalit to get some loan…if we don't take loans, we shall die."* This quote is an example that Dalits reported taking loans primarily from non-Dalits as they lacked social supports that could provide financial assistance. Dalits also reported using microcredit and community savings groups more often than non-Dalits.

Non-Dalits also reported changing health care facilities as a coping mechanism typically as a way to pursue high quality health care as one non-Dalit woman noted, *"Good treatment is the first consideration. Money is secondary matter."* Non-Dalits also reported using lower level health facilities such as PHCs and health posts for minor health issues as services were free and easily accessible. Dalits were reported to change their service delivery points to traditional healers again with dual purposes of improved quality of care – in the event that a government facility did not cure their aliment or because of proximity, they were located in the community and therefore would save transportation expenses. One Dalit man explained that *"they try to go to Rajbiraj but they're not going to have the money to go there because they're Dalits and they're poor. They go to the traditional healers in times of need."*

8.6 Social Capital

Both Dalits and Non-Dalits note "social capital" as key to accessing better care and in addressing barriers to access. Primarily, social networks are sources of information about services and diseases. The information and incentives received at the point of health care access in a government facility depend on who accompanies a patient and the perception of his level of influence in the community and sometimes in politics. If a patient has a personal relationship with someone in the health care system, they will often be guaranteed better access to treatment, incentives, and medicines, as this non-Dalit woman reports, saying, *"the doctors look at the person, and see how influential he/she [is], and then decide to give free medicines or not."* It is also echoed by a non-Dalit man, who is keen to point out his personal experience: *"I saw it with my own eyes that if one knows someone at the Biratnagar Hospital you get better treatment, free medicines and treatment."*

This question of influence brings together the nexus of socio-economic factors being examined, in that Dalits that are becoming politically active and are engaging in economic activities that improve their income levels are garnering a position of higher socio-economic status, granting them the benefits of being influential. A Dalit man remarks of a fellow community member, *"...because he's more well-known of a Dalit, for him they'll consider it and give him the medicine, but for other Dalits who don't have a social position they'll mistreat him and give him medicines late."* This is widening the gap within the Dalit community between the influential Dalits and the lowest castes of Dalits, though this has also proven to be an opportunity for Dalit community members to build a greater network of social capital and support the most marginalized in accessing health care services.

There are financial implications of this as well: non-Dalits can take loans from parents or other financially secure members of their networks, while Dalits reported greater difficulties obtaining loans due to their stagnation within less financially secure networks. Instead, Dalits attempt to pool money from their community, though it is often insufficient to cover the costs of accessing health care. There are, however, cases where Dalit and non-Dalit members of the community help one another in this respect, in terms of sharing information and of non-Dalits advising Dalits on conditions and services. Non-Dalits are also able to provide loans to Dalits through joint savings and credit cooperatives in some cases, which may be a potential point of entry for utilizing social capital in a positive manner.

8.7 Discrimination

The fifth and final dimension used to examine access was discrimination. Two experiences poignantly capture the main findings surrounding this issue. A Dalit woman in the village of Chinnamasta gave the following account:

> *"The doctors in the village are Yadavs and Chaudhary caste. When poor people like us go and ask for medicines, they send us away saying that there are no medicines. But when other caste people or rich people go, they get medicines."*

In this instance, and in this particular community, a distinct act of discrimination towards Dalits took place. Another example of clear discriminatory acts towards Dalits was provided by a non-Dalit man in the community of Malhaniya. When asked whether Dalits were treated different at medical centers, he responded saying: *"Yes, they don't speak properly to Dalits. They just drive them away, tell them there is no doctor."* At the point of treatment, the examples of clear-cut discrimination took on various manifestations through denial of services and referrals, acts of violence, displays of disrespect. Only in one case was *"untouchability"* mentioned in the context of receiving treatment. Notably, the most extreme and distinct examples of discrimination occurred in the communities of Chinnamasta and Malhaniya.

Nevertheless, while these were not isolated events, overall there were very few explicit examples of direct caste-based discrimination at the point of treatment. That said, while there were few instances of discrimination at the point of treatment, there were many more subtle acts of caste-based discrimination relating to accessing care. These included things such as denial of loans (or raising interest rates) to Dalits because of their caste affiliation, denial of services, or health professionals refused to enter Dalit homes, as is indicated by the following conversation in the community of Kanchanpur:

> *Interviewer: "When these [vaccination] campaigns happen do these workers enter [your] homes? So if someone's sick, will they go in to help take care of them?"*
> *Dalit Man: "Nobody comes in [our] house."*

The findings and methodology also suggested that caste was always framed in the language of poor vs. non-poor or poor vs. rich (i.e. Dalits were poor and non-Dalits were the non-poor or rich). This was both contextual, but also resulted from the fact that the topic of discrimination was brought up using softer language in the translation. By inference, if this stratification was included as a proxy for Dalit and non-Dalit, there are even more instances of discrimination, at both the point of treatment and overall access opportunities.

It is important to note that this treatment also occurred mostly at government facilities, and less so at private and other health institutions where provisions of care were contingent on payment. It comes as no surprise, therefore, that where services are meant to be free (at government-run facilities), Dalits were confronted with more frequent denials of service than at places where payments were expected. Illustrated distinctly by the following statement by a Dalit woman, money and purchasing power are the keys to receiving care- irrespective of caste and the facility approached:

> *"… They go inside the house, the doctor is from the non-Dalit but they are professional so they charge the money and come inside. The money is the main factor to divide the Dalit and non-Dalit. If they give the money to the government doctors they come in the night- yes, if you give them extra money they come at night instead of during the day."*

IX. Recommendations

The recommendations derived from this research are founded on the Samata Foundation mission as a social inclusion think-tank and advocacy organization, and as such they are presented within two categories: Policy Advocacy and Partnerships. This section further includes a developed strategy on how Samata Foundation can advance these recommendations through partnerships.

9.1 Policy Advocacy

Recognizing the strengths and capacity of Samata Foundation to advocate for changes to government policy to increase inclusiveness for marginalized groups, namely Dalit communities, the research and data gathered and analyzed here can serve to importantly assist Samata Foundation in informing policy recommendations.

Under this category are recommendations for modifications to the existing system that Samata can advocate for in order for the government to achieve its goals of social inclusion outlined in the NHSP-IP II and to fulfill its commitment to the Millennium Development Goals.

1. Strengthen internal and external monitoring mechanisms, leading to increased transparency and accountability.
    a. Internally:
        i. Strengthen the system's internal monitoring mechanism by supplementing the existing channels through which grievances can be heard by an additional channel to encourage potential whistleblowers;
        ii. Establish a vigilance body, whose sole responsibility is to act on the complaints raised through existing channels. This body may be given powers to reprimand offenders;
        iii. Establish a more reliable monitoring mechanism or body to ensure accurate record keeping and transparency at all levels, creating reliable channels of accountability.
    b. Externally:
        i. Encourage public monitoring of this system to ensure this accountability and transparency translate to the public sphere;
        ii. Pursue legislation requiring public institutions to provide written information about their activities to any citizen who requests such documentation (which can be modelled after the successes of India's Right to Information Act);
        iii. In tandem with its partner organization, Jagran Media Centre, encourage its network of grassroots journalists to monitor the system. This can be done by adapting the existing program through which grassroots journalists report on a weekly basis any story of discrimination against Dalits, but focusing the program on specific instances of corruption and failures of the health care system, not only in the national media but also through local media (newspapers, FM radio, and TV).

iv. In reference to the MDGs, further examination is needed to assess if Nepal's achievement of the MDGs are reflecting the improvement in marginalized communities.

2. Include Dalits in decision-making at the local level through participation in user groups, VDCs, and DDCs to allow them a chance to participate in making decisions regarding health care facilities and budgeting.

3. Improve health education for:
    a. Doctors – local doctors that understand local contexts (including Dalit doctors and female doctors) with MBBS degrees should be accessible to remote communities, which may be accomplished through a government system of support for medical school education in exchange for a number of years of service with marginalized populations;
    b. FCHVs – as the first point of contact for communities, FCHVs require on-going field-based training and education programs so they are able to better inform the communities on conditions, causes, and cures as well as government services;
    c. Community – this can include programs based on sanitation and hygiene, nutrition, literacy, government services, and health care access points;
    d. Schools – work with the Ministry of Education to strengthen existing health education programs within schools to stop the generational issue of lack of information.

4. Advocate for grassroots self-reported recommendations addressing needs of local communities:
    a. Examples include mobile clinics for remote areas, a refund system for reimbursement of incentives, efforts to establish 24-hour service delivery options and staff at government facilities, improved infrastructure to improve access, ambulances, and improved facilities including more beds, more doctors, female doctors, and updated equipment such as x-ray machines.

9.2 Partnerships

At the same time, it is important to recognize a holistic approach to addressing health care access that is inclusive of both the development and human rights spheres. We recommend the establishment of partnerships for joint projects that address both human rights and development through education, implementation, and funding. In this way, with Samata Foundation focusing on human rights concerns and development agencies focusing on capacity development, partnerships at all levels – with local community-based, national, and international non-governmental organizations – Samata Foundation can contribute to the ongoing human rights and development dialogue.

This set of recommendations addresses how Samata Foundation can integrate their policy advocacy with development initiatives through informing partnerships with local, national, and international bodies.

1. Conduct Human Rights community-based education to complement policy advocacy in partnership with local organizations working on education with marginalized communities. These can be modelled after "know your rights" programs that have proven effective in other similar contexts that entail workshops on particular health rights and the best way to secure those rights, grievance policies, information forums, and more. The idea behind this program is that if people are more aware of their rights then they might exercise them more often or be more successful at securing their rights when challenged.

2. Encourage the formation of women's groups, both informally but also through the formal institution of mothers' groups intended to be established by the government's FCHVs. Where they are established, these groups have proved successful in Saptari at addressing issues that women face and improving knowledge regarding mother and child health by educating women to become community ambassadors.

3. Share research results and tools with the Gender and Social Inclusion team with the Ministry of Health to inform policy through this channel, and potentially form a partnership to support their interest in scaling up this research nationally.

4. Use the findings of this research to inform donors and implementers supporting development programming in order to channel resources towards needs and gaps in the system.

A Note on MDGs:

In approaching both the government and partners, it will be important for Samata Foundation to highlight the necessity of meeting Nepal's commitment to the Millennium Development Goals (MDGs). Three MDGs relate directly to health care: reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases.[68] While development indicators may be improving in other parts of the country, the Terai is lagging behind national averages. As those with improved socio-economic status can afford accessing better health care, the disadvantaged remain further marginalized by the growing gap between those who have the means to access care and those who do not. This research indicates that, by focusing attention on health care access for the most marginalized, particularly Dalit communities, this gap can be addressed leading to a dramatic advancement in health status of poorer communities. In this way, Nepal can, in a sustainable and real way, improve health care indicators and meet the targets set out by the MDGs, enhancing Nepal's reputation internationally.

[68] UN Department of Economic and Social Affairs. "Official List of MDG Indicators". Web 14 Feb 2012. <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>.

9.3 Strategy

The strategy outlined here highlights the opportunity for Samata Foundation to be the catalyst of change towards mobilizing various institutions in Nepal to work towards empowering Dalits and making the health system more inclusive of them. This is the holistic vision of potential methods to achieve this, with five thematic foci, as well as specific preliminary recommendations and potential partners for doing so.

Themes for Action

A. Human Rights education
B. Health education
C. Advocacy
D. Public inclusion
E. Dialogue on Health as a Human Right

Action per Theme

A. Human Rights education

1) **Goal:** Community advocates for itself
2) **Potential activities:**
    a. "Know Your Rights" workshops
    b. Education campaigns
3) **Potential partners and capacities:**
    a. Local community-based organizations (existing and new partnerships)
        i. Access to community
        ii. Knowledge of local communities
        iii. Programs in place to build on
        iv. Existing networks within communities and with other organizations
    b. Media
        i. Strong existing partners
        ii. Wide reach and community influence

B. Health education

1) **Goal:** Increased community awareness of health conditions and available government services
2) **Potential activities:**
    a. Nutrition and sanitation campaigns
    b. Training for FCHVs
    c. Women's groups to discuss female health issues with experts
    d. Strengthened health education campaigns in schools
3) **Potential partners and capacities:**
    a. Development organizations (existing and new partnerships)
        i. Programs in place to build on
        ii. Existing networks within communities and with other organization
    b. Ministry of Health

i. Financial and human resources
ii. Country-wide reach

c. Ministry of Education
i. Access to students within schools

d. Media
i. Strong existing partners
ii. Wide reach and community influence

C. Advocacy

1) **Goal:** Stronger, more transparent health care system adaptive to socioeconomic conditions
2) **Potential activities:**
   a. Recommend the creation of a monitoring body for accountability within the health system at all levels
   b. Encourage that the health system address the particular socioeconomic disadvantages of Dalits in addition to overt discrimination
3) **Potential partners and capacities:**
   a. GESI team with Ministry of Health
      i. Mandate to ensure health system and Ministry of Health is sensitive to gender equity and social inclusion
      ii. Financial and human resources
      iii. Country-wide reach
      iv. Existing partnership

D. Public inclusion

1) **Goal:** Space for dialogue on health issues, accountability, and transparency
2) **Potential activities:**
   a. Increase accountability and transparency of health care system by allowing the public to interact with the system and obtain any information requested, acting as an external monitoring mechanism
   b. Create a space for dialogue on issues relating to health and the health care system and a space for the public to voice concerns to the government
   c. Advocate for inclusion of Dalits in decision-making levels within the health care system in terms of resource allocation
3) **Potential partners and capacities:**
   a. Media
      i. Strong existing partners
      ii. Wide reach and community influence
      iii. Interest in improving transparency
   b. GESI with Ministry of Health

i. Mandate to ensure health system and Ministry of Health is sensitive to gender equity and social inclusion

E. Dialogue on Health as a Human Right

1) **Goal:** Inform funding, programming, and discourse around health as a human right
2) **Potential activities:**
    a. Engage in the international dialogue around health as a human right and create more spaces for this discourse
    b. Present the findings of this research to development organizations to inform and target their funding and programming
    c. Continue to monitor the progress of Nepal on achieving health and human rights indicators, including the MDGs
3) **Potential partners and capacities:**
    a. International organizations
        i. Interest in fulfilling MDGs
        ii. Existing partnerships with UNICEF and DFID
    b. Local researchers at Samata
        i. Opportunity to build local capacity
    c. Media
        i. Ability to engage public in dialogue and increase awareness on the development status of Nepal
    d. GESI with Ministry of Health
        i. Interest in utilizing findings to inform Ministry of Health policy and expand research

X. Conclusions

The research presented here examined and identified health care access for Dalits in six communities of the Saptari District in the Terai region. By examining the NHSP-IP II and the formal and informal structures of the health system, it was revealed that both Dalits and Non-Dalits are disadvantaged in access to health services due to systemic weaknesses of the health care system. Within the policy research findings, it appears that the trickle-down effect and the implementation of policies such as NHSP-IP II are limited. The policy addresses the importance of reaching these services to marginalized communities such as Dalits, but the implementation fails to effectively reach the populations it intends to serve. With the recent decentralization of health care services, the need for a strong checks-and-balances mechanism to address the shortcomings of the system is crucial for improved delivery.

While implementation of policy is limiting and the health structure remains weak, the research revealed that Dalits are at a disadvantage in all five dimensions of access to health care services, namely physical access, information access, financial access, discrimination, and social capital. The nexus of these factors results in the weaker socioeconomic status of Dalits that compounds their barriers to accessing health care. As a result, in order for the Government of Nepal to successfully address the delivery of health care services to the Dalit population, it is vital that these dimensions of access and its relations to the Dalit population are considered. It is essential for policy makers to take into account these compounding issues that create disadvantage for Dalits and initiate a multi-faceted policy so the right to health can be successfully achieved for Dalits. It is in this vein that Samata Foundation should gear its programming in order to further inclusive health care access and policies for marginalized Dalit communities.

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ANNEX I: Background – Tables and Maps

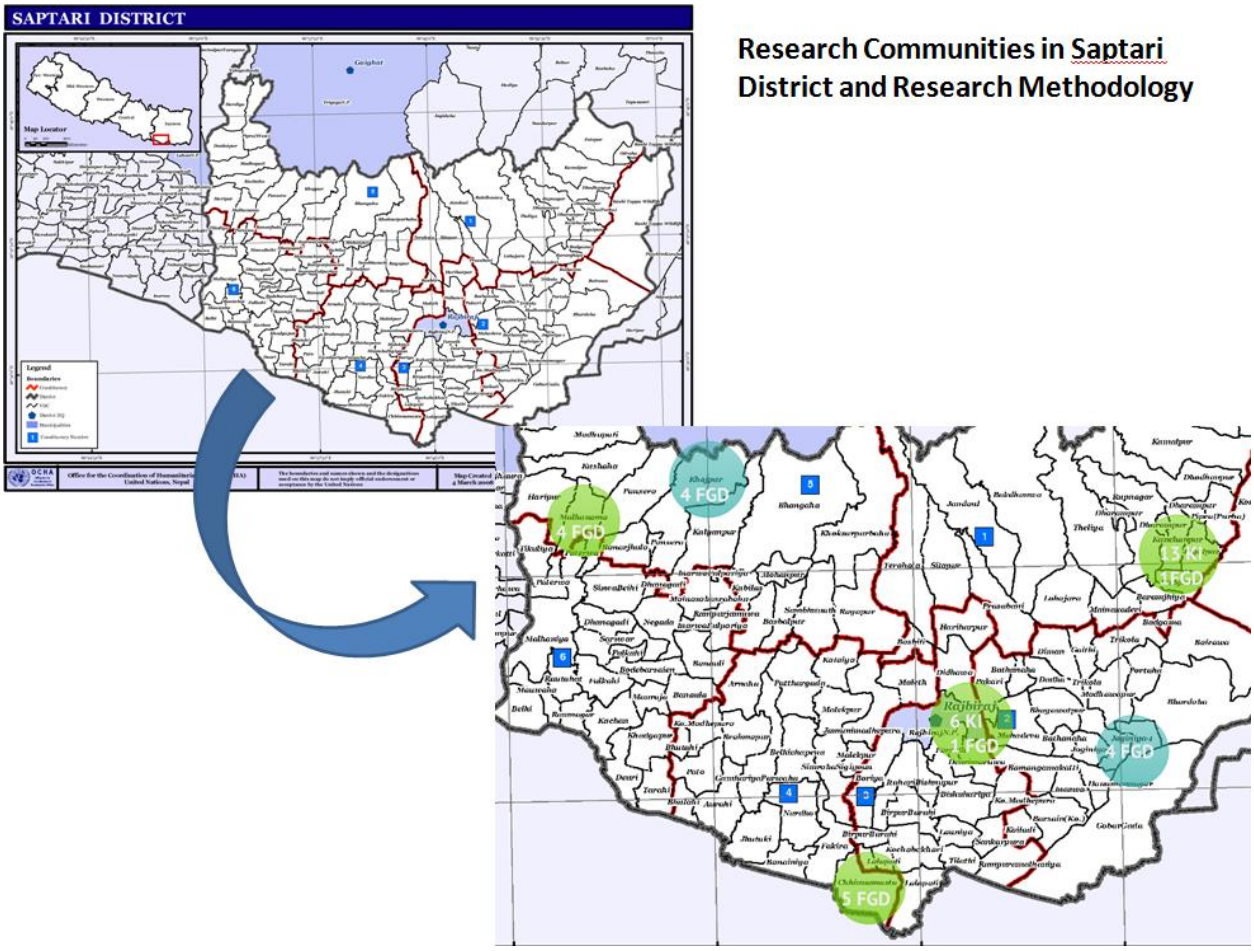
Table 2: **Gender differentials in National child health**				
Indicators	**Year**	**Male**	**Female**	**Ratio F/M**
Under 5 Mortality Rate (per 1,000 live births)	1996	142.8	135	0.95
	2006	80	78	0.98
Infant Mortality Rate (per 1,000 live births)	1996	101.9	83.7	0.98
	2006	60	61	1.02
Neonatal Mortality Rate (per 1,000 live births)	1996	65.6	50.4	0.77
	2006	39	37	0.95
Stunting Rate (% of children with height to age ratio under below 2 standard deviations of the median)	1996	46.6	50.2	1.08
	2006	49.0	49.6	10.1
Immunization coverage (% of children immunized)	1996	46.7	39.9	0.85
	2006	84.9	80.6	0.95
Prevalence of Acute Respiratory Infections (per 1,000 children)	1996	34.6	33.6	0.97
	2006	506	4.9	0.88
Prevalence of diarrhea (per 1,000 children)	1996	28.7	26.2	0.91
	2006	12.8	10.9	0.85
Coverage of Medical Treatment of Acute Respiratory Infections (per 1,000 children)	1996	18.2	18.2	1
	2006	42.2	43.8	1.04
Coverage of Medical Treatment of diarrhea (per 1,000 children)	1996	14.7	12.9	0.88
	2006	29.1	24.3	0.84

Source: Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. (2007)

Map of Nepal:

Source: Ezilon Maps: http://www.ezilon.com/maps/asia/nepal-physical-maps.html

ANNEX 2: Map of Communities



ANNEX 3: Table of Timeline of Relevant Policies, Plans, Framework, and Agendas

First 5-Year Plan (1956-1961)

Third 5-Year Plan (1965-1970)

Nepal Government's National Health Policy (1991)

Eighth 5-Year Plan (1992-1997)

Ninth 5-Year Plan (1997-2002)

Second Long Term Health Plan (SLTHP) (1997-2017)

Millennium Development Goals (2000)

Tenth 5-Year Plan (2002-2007)

Health Sector Strategy: An Agenda for Reform (2003)

Nepal Health Sector Program- Implementation Plan (NHSP-IP) (2004-2010)

Eleventh 5-Year Plan (2007-2012)

Gender Equality and Social Inclusion Framework (GESI) (2009)

Nepal Health Sector Program-Implementation Plan (NHSP-II) (2010-2015)

ANNEX 4: Stakeholder Analysis

Stakeholder	Stakeholder's status/ role	Likely Attitude	Capacity and Resources related to health care services	Importance	Influence
Samata Foundation	Client	Favorable	Access to Dalit communities in the field. Intermediary between grassroots and mid-level policy makers.	High	Moderate
UN Affiliated Organizations					
World Health Organization	Technical and Financial Support for Government of Nepal	Favorable	Technical and financial capacities.	High	Moderate
UNICEF ROSA/Country Office	Technical and Financial Support for Government of Nepal	Favorable	Advocacy, social mobilization, Technical and financial capacities.	High	Moderate
NGOs					

Sabal	Local NGO that works on water and sanitation issues in local communities.	Favorable	Grassroots network and access to local communities in the field.	High	Moderate
FEDO	Local NGO that works to empower and advocate for Dalit women.	Favorable	Grassroots network and access to local communities in the field. Experience in advocating for pro-Dalit female policy.	High	Moderate
Government					
Ministry of Health	Creates health related policies and supervises on its implementation.	Favorable	Technical and policy related capacities. Ability to implement and change policy.	High	High
Gender and Social Inclusion Team (GESI)	Interested in using our tools and findings for their research on inclusion. In the midst of creating an action plan for gender and social inclusion.	Favorable	Technical and policy related capacities. Ability to influence policy and implementation. Funded by World Bank, Asian Development Bank and UK-DFID.	Moderate	High

Planning Committee	Responsible for assessing the development of Nepal and creating policies.	Favorable	Provides the guidelines for planning and development. Technically focused.	Moderate	High
District Development Office	Supervises the implementation of development policies and programs on district level.	Favorable	Access to district level. Technical and policy implementation knowledge.	Moderate	Moderate
District Health Office	Supervises the implementation of health policies and programs on district level.	Favorable	Access to district level. Technical and policy implementation knowledge.	Moderate	Moderate
Village Development Committee	Oversees the implementation and programmes provided to the village level. Works with local villages for development projects.	Favorable	Local knowledge and access to communities.	Moderate	Moderate

Formal Health Structure Facilities					
Zonal and District Hospitals	Upper level health access points. Secondary level of care from Central and Regional Level.	Favorable (better care and services); Unfavorable (revealed flaws of system and service)	Technical capacity. Health care service provider.	Moderate	Moderate
Sub Health Post/ Health Post	Electoral Constituency level with primary health care services.	Favorable (better care and services); Unfavorable (revealed flaws of system and service)	Technical capacity. Health care service provider.	Moderate	Moderate
FCHVs	Community health extension volunteers responsible for basic health services such as distribution of iron and vitamin pills, vaccinations, and education on family planning, maternal health.	Favorable (better care and services); Unfavorable (revealed flaws of system and service)	Access to the community level. Health care service provider.	Moderate	Moderate
Informal Health Structures					

Traditional Healer	Part of alternative informal structure of Nepali health care system.	Favorable	First and last access point of health care for many Dalits. Access to communities. Respected and trusted in communities.	Moderate	Moderate
Mother's Groups	Informal group of women working on village level. Assists the FCHV in the community.	Favorable	Capacity for social networks. Access to communities.	Moderate	Moderate
Pharmacists	Individual store keepers that buy and sell pharmaceutical products. Not affiliated with the Government.	Perhaps Favorable	Provider of supplies and resources for patients and providers. Sells medicine for personal profit.	Moderate	Moderate
Private Hospitals/Clinics	Doctors with own private clinics that provide health services for a cost. Sells medicines at these clinics.	Perhaps Favorable	Informal provider of health care services.	Moderate	Moderate

Beneficiaries					
Dalit Leaders	Beneficiaries	Favorable	Ability to influence and reach Dalit populations. Access to local Dalit communities.	High	Low
Dalit Communities	Beneficiaries	Favorable	Able to share firsthand experience of access to health care services. Information-sharing.	High	Low
Non-Dalit Communities	Higher-caste individuals and communities outside the "Dalit" population.	Perhaps Favorable. Depends on individual perceptions and beliefs.	They can be either supportive or unsupportive of the policies. Therefore serve as a barrier or catalyst for change.	Low	Moderate
Political Parties					
Local Political Parties	Local Political Parties that mobilize in local areas.	Perhaps Favorable. Depends on political parties' perceptions, goals and beliefs.	Ability to mobilize communities. Push for certain agendas.	Moderate	Low

National Political Parties	Major Political Parties that mobilize near the capital, Kathmandu.	Perhaps Favorable. Depends on political parties' perceptions, goals and beliefs.	Ability to mobilize communities. Pressure government and ministries for policy change.	Moderate	Low
Media					
Local Media	Local newspapers and Dalit reporters.	Favorable	Sensitization and highlighting the issues. Can help promote accountability and pressure for government to take action. Ability to spread information and reach vast populations.	Moderate	Low
National Media	National newspapers, TV and radio sources.	Perhaps Favorable	Sensitization and highlighting the issues. Can help promote accountability and pressure for government to take action. Ability to spread information and reach vast populations.	Moderate	High

Scholars, Experts, and Academia	Local and foreign experts in the fields of health, policy and research.	Favorable	Influence research and new findings. Can advise the Government on policies and action plans.	Moderate	Moderate/ Low
Missionaries	Foreign missionaries that work on humanitarian aid- health services and education in rural communities.	Favorable	Spread awareness, education and service provisions.	Moderate	Moderate

ANNEX 5: Institutional Analysis

Level	Organization	Rules/Policies	Activities	Constraints	Coordination/Communication
Central	Ministry of Health	Second Long Term Health Plan 1997-2017	Expand health institutions, formulate policies. Establish relationships with foreign countries and institutions. Maintain data and statements regarding health services. To ensure supply of drugs, equipment, and other material at regional level by properly managing these resources.	Financial constraints in allocation relating to health services.	Communicates directly to regional levels. Communicates to international organizations, institutions and foreign countries.
Regional	Regional Training Center, Hospital, Facilities	Established in 1993 but the roles of regional health directorates are unclear and have had little impact to date.	Support MoH in training and implementing policy related initiatives.	Financial constraints in health services.	Communicates to Zonal hospitals. Receives information directly from the Center.

Zonal	Zonal Hospital	15 Regional and Zonal hospitals.	Secondary level of care.	Lack of staff and resources. Medicines are often exhausted during the first few months of the fiscal year. Corruption.	Reports to Regional and MoH.
District	District Development Office	Assists in the funding of health related initiatives. Responsible for the development and wellbeing of its district.	Guide the VDC in programs and funding. Support FCHV in local funds.	Lack of funding. Opaque processes and decision-making.	Reports to Central Planning Committee and collaborates with local VDCs.
	District Hospital	Serves as advanced health care for district. Testing facilities, human resource and equipment to treat more advanced forms of diseases.	Secondary level of care.	Lack of staff and resources. Medicines are often exhausted during the first few months of the fiscal year. Corruption.	Communicates to DHO.

	District Health Office	Oversees PHC, HC, HP and SHP.	Support FCHVs by strengthening their capacity through trainings and commitment.	Management and finance controlled by center.	Communicates directly to regional and center. Supervises all community and electoral level units of health care.
Electoral Constituency	Primary Health Care Centre/ Health Centre	Consists of 1 doctor and 1 assistant health worker.	Free TB services, blood and urine testing, 32 free medication and services.	Lack of staff and resources. Medicines are often exhausted during the first few months of the fiscal year. Corruption.	PHCs report to DHOs.
	Health Post	Consists of health assistant and ANC.	Primary health care services.	Lack of staff and resources. Medicines are often exhausted during the first few months of the fiscal year. Corruption.	Health Post reports to PHCs.

VDC	VDC	One VDC per ward- consists of 1 elected chief, 1 ward chief, 4 ward members, 1 village secretary who is appointed by government	Manages utilization and distribution of state funds to local levels. Collect and monitor data for census. Support FCHV in local funds.	Opaque processes and decision-making. Lack of funding.	Status as an autonomous institution and authority for communicating with centralized institutions.
	Sub Health Post	First contact point for basic health services	Primary health care services.	Lack of staff and resources. Medicines are often exhausted during the first few months of the fiscal year. Corruption.	Sub Health Post reports to the Health Post and PHCs.
Community	FCHV	National FCHV Program Strategy 2003. 1 FCHV in every ward nationwide, who is knowledgeable, trained and well supported health resource person.	Distribution of iron pills, vaccines, and other program related functions as directed by the DHO such as maternal health, family planning, child health and infectious diseases.	Lack of knowledge and adequate training to advise communities. Respect from communities varies. No monetary incentives. Lack of resources to distribute among communities.	FCHVs report to the Sub Health Posts for data collection, resource accumulation and program implementation.

	Mothers Group	Informal women's group that nominates FCHV and supports her work in the community.	Supports FCHV activities in village level. Assists community through savings and credit loans.	Inclusive group of women that tend to be connected through marriage, relations, etc. Difficult for marginalized community members to participate.	Communication is directly with FCHV of that area.

ANNEX 6: List of Organizations and Individuals Interviewed Through KIs or FGDs

Kathmandu, Nepal

Feminist Dalit Organization (FEDO)
Gender and Social Inclusion Team, Government of Nepal
Jagran Media Centre
Medical Anthropologist
Ministry of Health, Government of Nepal
National Non-Dalit Journalists
Patan Academy of Health Services (Professor)
Planning Committee, Government of Nepal
Samata Foundation
United Nations Children's Fund- Regional Office for South Asia
World Health Organization

Saptari (Communities in Rajbiraj, Kanchanpur, Joginya, Chinnamasta, Malhaniya, Khojpur)

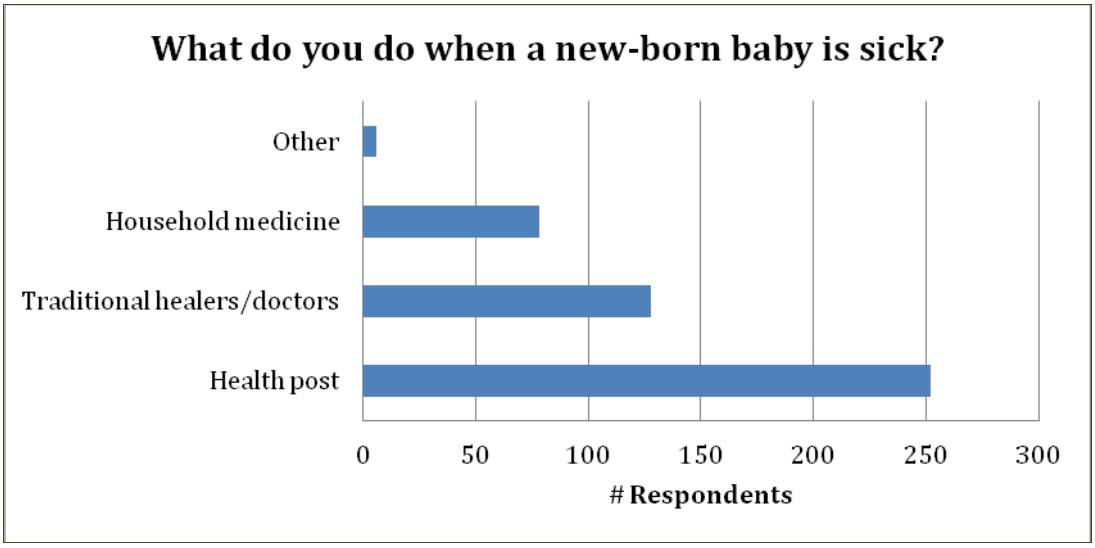
Dalit Women and Men
District Development Office
District Health Office
FCHV
Local Dalit Reporters
Local Government Employees
Non-Dalit Women and Men
Nurse
Pharmacists
PHC
Retired Government Workers
SABAL Nepal
School (Headmaster)
Sub-Health Post
Traditional Healers
United Nations Children's Fund- Nepal (Field Staff)
VDC Secretary
VDC Worker

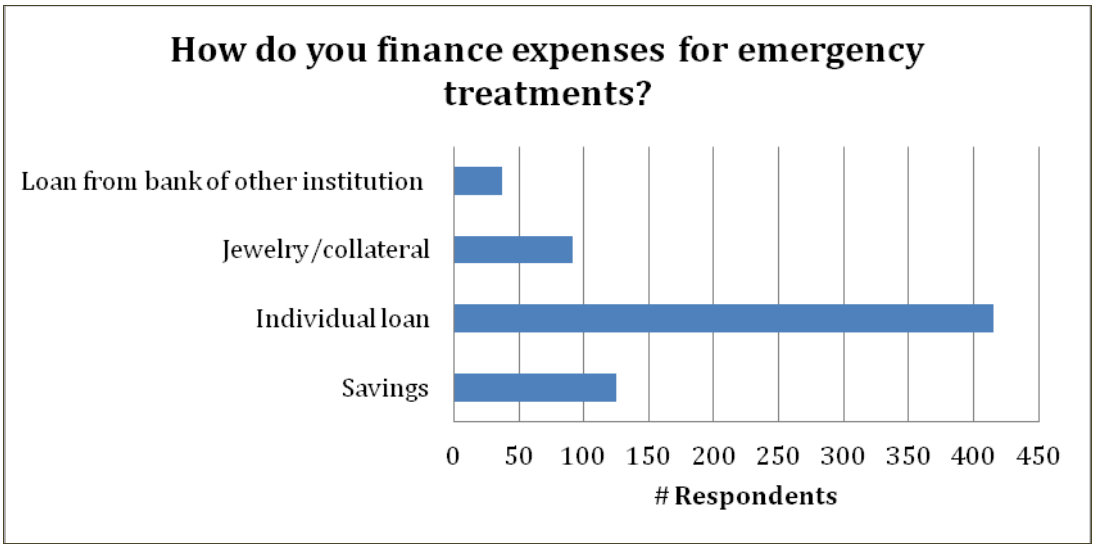
USA

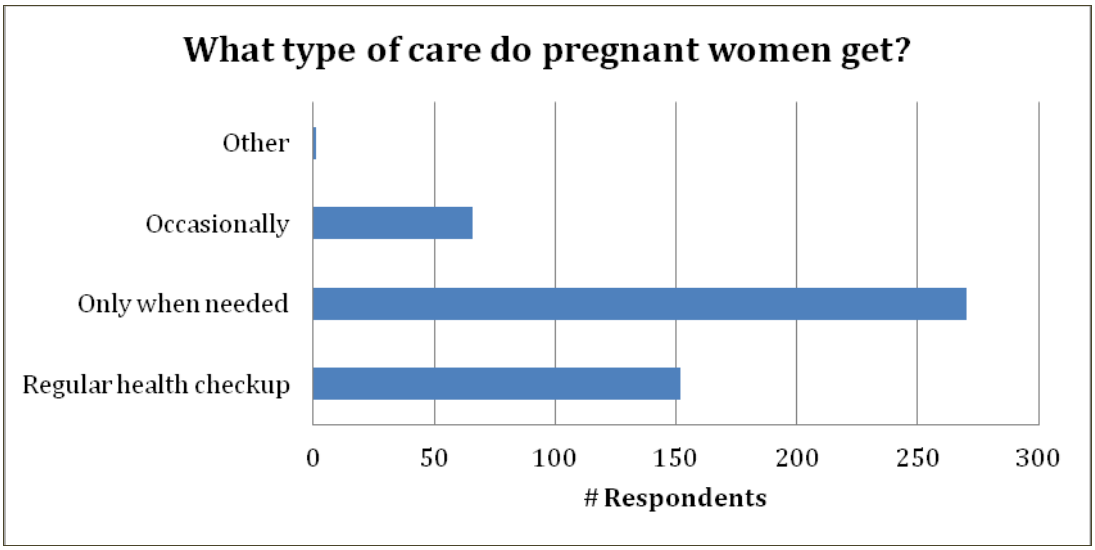
UN Women Headquarters
Innovations for Successful Societies
Columbia University School of Public Health (Professors)

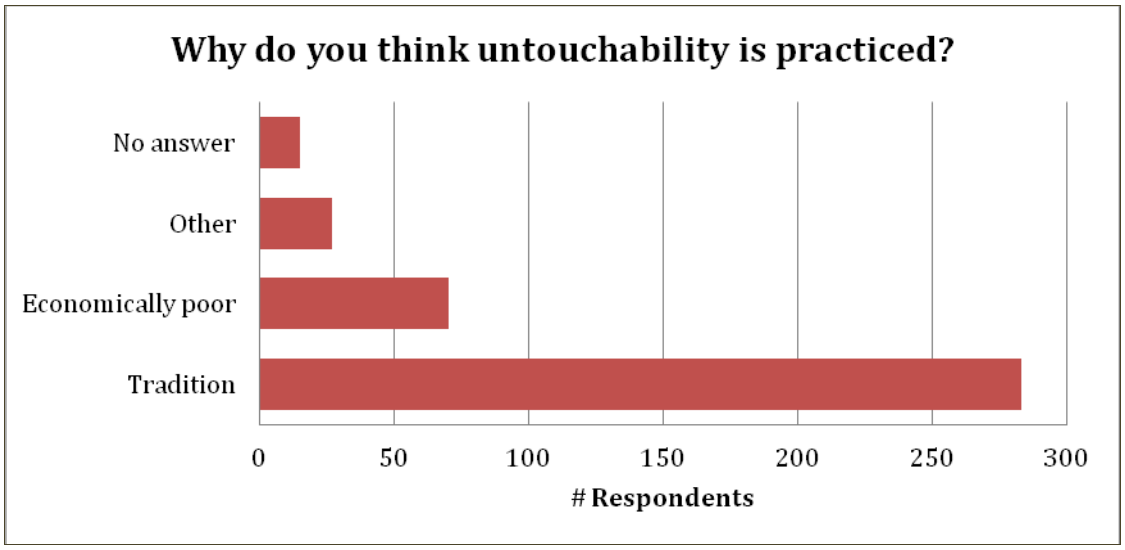
ANNEX 7: Survey Data on Health Status in Terai

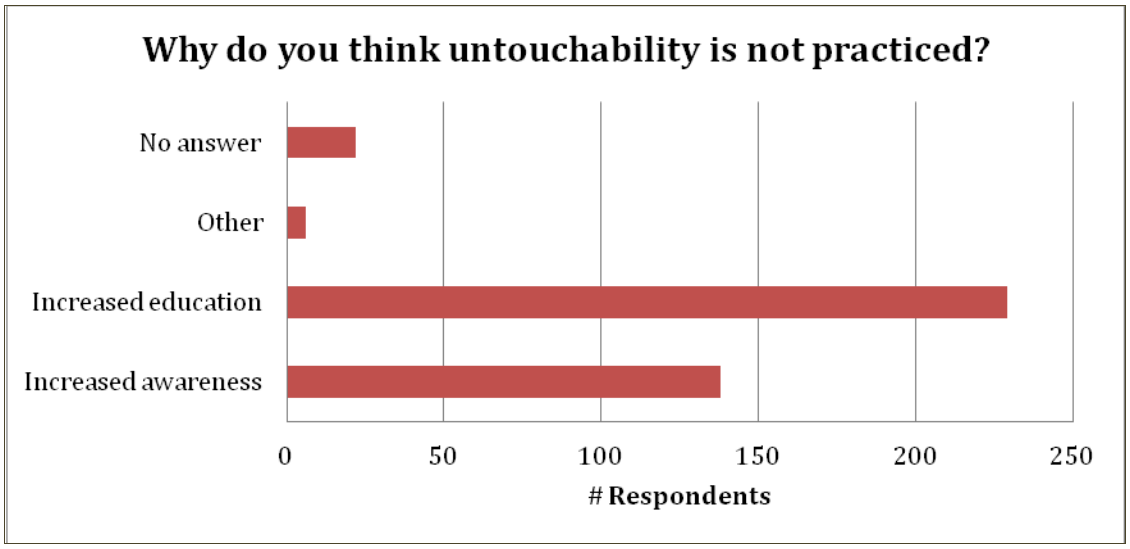
**Based on survey of 395 members of various Dalit castes conducted by Samata Foundation in 2001 in communities across the Terai, namely Saptari, Dhanusha, Parsa and Moran districts.*

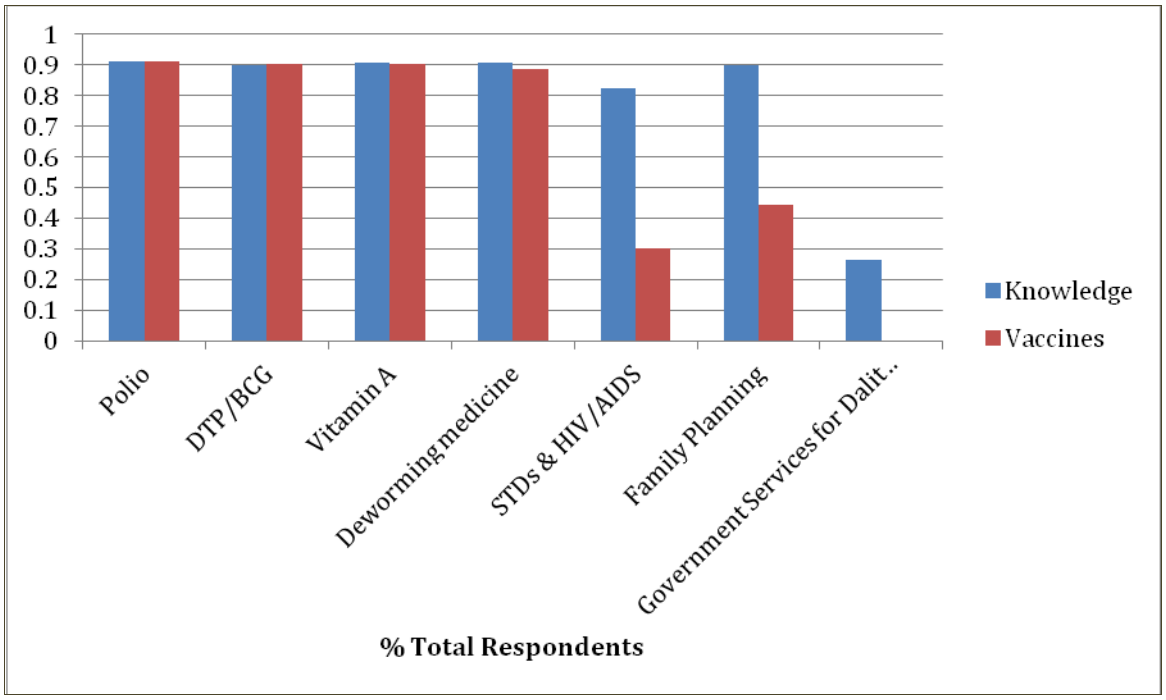





What type of care do pregnant women get?
Other
Occasionally
Only when needed
Regular health checkup
0
50
100
150
200
250
300
Respondents


Why do you think untouchability is practiced?
No answer
Other
Economically poor
Tradition
0
50
100
150
200
250
300
Respondents


Why do you think untouchability is not practiced?
No answer
Other
Increased education
Increased awareness
0
50
100
150
200
250
Respondents


1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Polio
DTP/BCG
Vitamin A
Deworming medicine
STDs & HIV/AIDS
Family Planning
Government Services for Dalit..
Knowledge
Vaccines
% Total Respondents

Annex 8: Common Diseases in Dalit and Non-Dalit Communities in Saptari District

**Based on reports from FGDs of surveyed communities in six communities in Saptari*

Top Diseases in Dalit Communities

Dalit												
	Joginya	Joginya	Chinnamasta	Chinnamasta	Malhaniya	Malhaniya	Khojpur	Khojpur	Rajbiraj	Total	Median Ranking	Number mentioned
(d) Pneumonia	1	1	3		3	1	3	1		13	1.44	7
(d) Diarrhea	3									3	0.33	1
(d) Gastric	4	5					4	5		18	2.00	4
(d) Cough/Asthma	5			1				4		10	1.11	3
(d) White Water		2	4	3		4			1	14	1.56	4
(d) TB	2	3	1	5	5	3				19	2.11	6
(d) Malaria		4								4	0.44	1
(d) Kala-azar			2							2	0.22	1
(d) Leprosy				2						2	0.22	1
(d) Yellow Fever				4						4	0.44	1
(d) Malnutrition					1					1	0.11	1
(d) Blood Cancer					2					2	0.22	1
(d) Arthritis					4					4	0.44	1
(d) Pregnancy						2				2	0.22	1
(d) Dental/Cancer						5				5	0.56	1
(d) Health disease							2		3	5	0.56	1
(d) Uterus problem								2	2	4	0.44	1
(d) Whole body swelling								3		3	0.33	1
(d) Cancer							1			1	0.11	1
(d) Diabetes							5			5	0.56	1
(d) Fever									5	5	0.56	1
(d) Ear problem									4	4	0.44	1

Top Diseases in Non-Dalit Communities

Non-Dalit													
	Kanchanpur	Joginya		Chinnamasta		Malhaniya		Khojpur		Rajbiraj	Total	Median Rank	Number mentioned
(nd) TB	1				4	2	1				8	0.8	4
(nd) Uterus Prolapses	2		1		3						6	0.6	3
(nd) Pregnancy	3			5				4	1		13	1.3	4
(nd) Diabetes	4	1		2							7	0.7	3
(nd) Cancer	5					3	2	5			15	1.5	4
(nd) Gastric		2						2	3	1	8	0.8	4
(nd) Blood Pressure		3								4	7	0.7	2
(nd) Miscarriage		4									4	0.4	1
(nd) Pneumonia		5	5		2	1		1	2		16	1.6	6
(nd) Child Illness			2								2	0.2	1
(nd) Child Mortality			3								3	0.3	1
(nd) Weakness			4								4	0.4	1
(nd) White water				1			3			5	9	0.9	3
(nd) Fever and Cough				3		4			4		11	1.1	3
(nd) Toothaches				4							4	0.4	1
(nd) Diarrhea					1	5		3			9	0.9	3
(nd) Chicken Pox					5						5	0.5	1
(nd) Eyes and Ears							4				4	0.4	1
(nd) Asthma							5			2	7	0.7	2
(nd) Nerves Hurt										3	3	0.3	1