

**From “Health for All” to “Health with All”
in Nepal**

*- Through Empowered Civil Society as Rights
and Responsibilities of All Humanity -*

Harvard School of Public Health

Takemi Program in International Health

2000 - 2001

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If one part suffers, every part suffers with it,

If one part is honored, every part rejoices with it.

- 1 Corinthians 12:26-

“Love your neighbor as yourself and serve one another”

- Galatians 5:21-

“If you have come to help me, you are wasting your time.

**But if you have come because your liberation is bound up with mine,
then let us work together.”**

Lisa Watson

(Australian aboriginal women leader)

List of Acronyms

ALC	=	Adult Literacy Class
ANC	=	Antenatal Checkup
ANM	=	Assistant Nurse-Midwife
ARI	=	Acute Respiratory Infection
BLC	=	Basic Literacy Class
CBDP	=	Community Based Disaster Preparedness
CBO	=	Community Based Organization
CBR	=	Crude Birth Rate
CHW	=	Community Health worker
CSO	=	Civil Society Organization
C to C	=	Child to Child
DDC	=	District Development Committee
DHO	=	District Health Office
DPTC	=	Disaster Prevention Technical Center
EPI	=	Expanded Program of Immunization
FA	=	First Aid
FCHV	=	Female Community Health Volunteer
GHW	=	Government Health Worker
GO/NGO	=	Government Organization/Non Government Organization
HMG/N	=	His Majesty's Government of Nepal
HP/SHP	=	Health Post/Sub-health Post
IMF	=	International Monetary Fund
JICA	=	Japan International Cooperation Agency
JMA	=	Japan Medical Association
KG	=	Kitchen Gardening
LA	=	Lab Assistant
MCHW	=	Maternal and Child health Worker
NACRMP	=	Nepal Australia Comm. Resource Management Project
NEWAH	=	Nepal Water for Health
NID	=	National Immunization Day
NPC	=	National Planning Commission
ODA	=	Official Development AID
ORS	=	Oral Re-hydration Solution
PCDV	=	Passive Case Detection Volunteer
PHC	=	Primary Health Care
PLA	=	Participatory Learning and Action
PLC	=	Post Literacy Class
PRA	=	Participatory Rural Appraisal
PME	=	Participatory Monitoring and Evaluation
PO	=	Popular Organization
SCHP	=	School and Community Health Project
SHG	=	Self Help Group
SPHC	=	Selective Primary Health Care
TBA	=	Traditional Birth Attendant
TFR	=	Total Fertility rate
TH	=	Traditional Healer
TNC	=	Trans-national Corporation
TU	=	Tribhuvan University
UN	=	United Nations
UNDP	=	United Nation Development Program
VDC	=	Village Development Committee

WB	=	World Bank
WHO	=	World Health Organization
WTO	=	World Trade Organization

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Abstract

“Health for All” has not been very successful although many different approaches have been invented and implemented in local and national level by various NGOs, international agencies or governments. Primary Health Care (PHC) has been promoted to bring “Health” for all people. Despite the recommendation of participation and world commitment, traditional top-down (“for”) development approaches are still prevalent. But now new movement to challenge the current value and system of neo-colonialism has been emerging. Powerlessness, non-sustainability and fragmentation are three main features of traditional community development programs. This paper evaluates the role of **Civil Society** that would stand for the rights and responsibilities toward the fullness of all humanity. Empowerment of multi-level Civil Society (from local to global) is emphasized to balance the current power leverage and to initiate this new development paradigm which is the people-centered Participatory (“with”) Development. Sustainability needs to be sought through institutionalization of this new paradigm. This requires the transformation and full participation of all actors in every sector. Fragmentation has to be solved by building the alliance and network in larger society with those intra and inter-sectoral actors. Through collaboration with those partners advocacy role of Civil Society will be strengthened. The role of global Civil Society has been increasingly critical in current global sufferings of humanity and the crisis of natural resources and environment. **“Health with All”** symbolizes all these processes and the goal of this new paradigm in which all citizens are working together for the common goal as rights and responsibilities of all humanity. The role of NGOs specially to facilitate these three steps is also reviewed. This paper describes one community health development project (SCHP) supported by Japan Medical Association (JMA) in cooperation with the Japan International Cooperation Agency (JICA) to illustrate “Health with All” efforts in Nepal. SCHP and its programs are evaluated according to the new indicators of empowerment and institutionalization. This paper intends to present the action framework of “Health with All” as a new paradigm for the future health development.

Introduction

The World Health Organization has defined “Health” as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This was reaffirmed in the statement issued at the International Conference on Primary Health Care co-sponsored by WHO and UNICEF in 1978. In this declaration of Alma-Ata, the main social target was clearly described as the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. And it further continued that primary health care (PHC) is the key to attaining this target as part of development in the spirit of social justice. In this declaration, it was also mentioned that PHC involves, in addition to the health sector, all related sectors and aspects of national and community development and also it requires maximum community and individual self-reliance and participation with fullest use of local, national and other available resources. It called to governments and the whole world community for urgent and effective action and commitment to implement PHC and technical and financial support for it.

We are now in the year 2001, the new millenium. Have all the people of the world attained an acceptable level of “Health”? Unfortunately answer is no. Still there are more peoples who continue suffering from social injustice and poor “Health” in worsening environment. Was the target “Health for All” by the year 2000 declared by the conference mistake or unrealistic? Is PHC so difficult to be brought to all the people technically, socially, politically and economically using all the resources available in the world community? What are the reasons?

Basic 8 components in PHC mentioned in the Alma-Ata declaration are

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of proper nutrition
3. Adequate supply of safe water and basic sanitation
4. Maternal and child health care including family planning
5. Immunization against the major infectious diseases

6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs

Since Alma-Ata, 1978, there is no doubt that much research and many projects have been planned and done, and funds have been poured to bring PHC components more equitably and efficiently to all the people who have not yet been able to access them. These efforts and strategies can be translated as “providing PHC for All” or “bring Health for All” approach. Despite the importance of community self-reliance and participation in every process and inter-sectoral coordination and the commitment of whole world community clearly mentioned in the declaration, most projects except for a few examples have been implemented out of charity or in a paternalistic manner with the power leverage of neo-colonialism. This can be said like “given by haves to have-nots”, imposing what haves organized according to their own personal view of reality (value and systems) without facing the challenge of comprehending the reality with have-nots and transforming it together with them. The oppressors are the ones who act upon the people to indoctrinate them and adjust them to a reality that must remain untouched. Revolutionary leaders often forget that their fundamental objective is to fight alongside the people for the recovery of the people’s stolen humanity. Their role is to liberate and to be liberated with the people.

Freire wrote in his book “Pedagogy of the Oppressed” that authentic education is not carried on by “A” for “B” or by “A” about “B”, but rather by “A” with “B” mediated by the world. His education is co-learning and problem-posing rather than banking education. (Freire 1970). “Health with All”, in contrast to “Health for All”, is the new paradigm requiring all of us to learn and act together for common goal of liberation and transformation from wrong value and systems. Sen also has described a paradigm shift in development. His idea is that development should primarily be concerned with enhancing the lives we lead and the freedom that we enjoy. And among the most important freedoms that we can have is the freedom from avoidable ill-health and from escapable mortality. He has emphasized the importance of the public in participatory politics and informed public dialogue in seeking a better deal for the basic requirements of good living (Sen 1999).

Primary Health Care (PHC) has been promoted and used as a cost-effective approach to accomplish “Health for All” in a shorter time. But the idea of bringing PHC (Health) to all poor people has a fundamental weakness as long as current power relationships continues. This idea has tendency to formulate policy and program according to the interests of governments, donors, the market and even NGOs instead of the interests of community people themselves. Selective primary health care interventions (SPHC), like GOBI-FFF, Family planning or Vertical disease control programs may be very cost effective and get results in a short time. But they may raise false hopes for improving health, and neglect the root causes of ill-health and the process whereby better “Health” is sustained. Within the selective approaches many good methods and strategies have been developed. Now is the time for the best of selective approaches to be integrated into comprehensive health development programs (Muller 1995).

“Health for All” approaches will not necessarily challenge the control and responsibilities of haves and will not require the transformation of themselves and the social, political and economical systems in which their power resides.

Through learning past ideas, projects and programs, from both successes and failures, several new concepts and strategies have now been proposed and applied in the field of health and development, not only in the developing countries but also in developed countries like USA or Japan. Their goal is to challenge and transform traditional power leverage, and the values and systems that are the deep-seated root causes of current growing sufferings of the world’s poor. The ideas are mostly coming from academics and NGOs, but some also come from governments or International agencies.

Examples of these ideas include

1. Holistic medicine
2. Community care
3. Civil society
4. Empowerment
5. Bottom-up approach
6. Participatory development
7. Institutionalization

8. Decentralization
9. Alternative development paradigm
10. Global people's movement

Some of the moral concepts being used in advocacy are

1. Spiritual well-being (human dignity, self-worthiness)
2. Fullness of humanity
3. Human rights and responsibilities
4. Social injustice
5. Inequity
6. Gender (women & men)
7. Ecology and Environment (sustainability)
8. Good governance
9. People-centered
10. Social conscience
11. Diversity, inclusive vs. cultural invasion
12. Fair trade vs. free trade

Some of the programs and methods being practiced are

1. Dialogue
2. Empowerment education (Cycle)
3. Participatory learning and action (PRA, PME)
4. Training for transformation
5. Adult literacy program
6. Savings and micro-credit
7. Support organization (facilitator or catalyst)
8. Organization building and its capacity building
9. Promotion of inter-sectoral collaboration
10. Institutionalization of participatory development
11. Global civil society network formation

These are different from "Health for All" ideas and approaches which are more top-down, blueprint and delivery-oriented. The "Health for All" approach rarely challenges society to change fundamentally. In contrast these new movements and approaches are intended to involve the haves with the have-nots in liberating and transforming us all and the systems which keep us in bondage. These "Health with All" approaches require everyone to participate as equal partners. Everyone is equally responsible and must collaborate to achieve "Health with All".

The attainment of "Health with All" will require the empowerment of civil society (from individual to global community) to defend people's basic rights and to develop responsible coordination among people in all parts and sectors of society. This approach will be needed to attain real equitable human and social development including equal access to health care services.

This paper reviews and evaluates some of these ideas and approaches of this new paradigm, "Health with All" and presents the framework for new planning and action and offers lessons for the actors in this development.

The new enhanced role of NGOs (Support Organization) as a unifying and transforming power toward "Health with All" will be examined through the case study in Nepal.

Definition and Historical Review

Definition

- **Civil Society:** A sphere of social interaction between household and the state and market which is manifest in norms of community cooperation, structures of voluntary association, and networks of public communication.
- **NGO:** Private, professionally staffed, non-membership and intermediary development organizations which are founded on the basis of a commitment to an alternative, more democratized and inclusive development
- **CBO (PO, Grassroots Org.):** Membership organizations made up of a group of individuals who have joined together to further their own interests (e.g.:women's groups, credit circles, youth clubs, cooperatives and farmer's associations).
- **Empowerment:** The process of generating and building capabilities to exercise control over one's own life and influencing the organizational and social structures in which one live

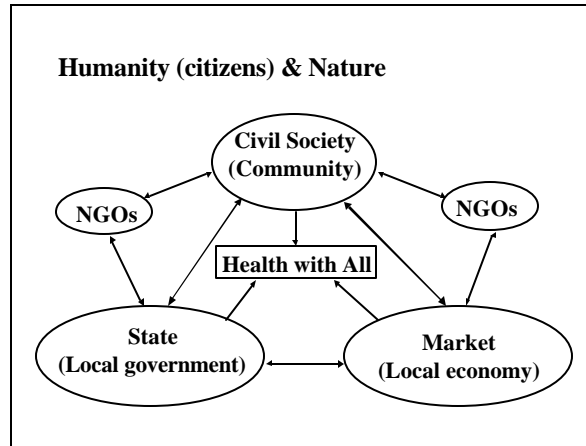
Civil Society

Definitions of some words used in this review are described above. Most of other words will be defined in each section. Civil society (Bratton 1994) and increasing its social capital have been focused and emphasized in development field. Social capital refers to features of social organization, such as trust, norms, and networks, that can improve efficiency of society by facilitating coordinated actions (Til 2000) (Kennedy and Kawachi 1998). Building social capital will not be easy, but it is the key to making democracy work. Where large social capital exists, people can come together to understand what needs to be done and work to accomplish needed tasks. Where it is absent, they will stay home and let the TV set explain that much is going wrong in the world around them but there is not much that anybody can do about. If TV programs are controlled and edited for the benefit of power-holders and let people remain ignorant to realities, the situation will be worse.

Civil society is difficult to grasp its concrete concept, probably because it has two distinct features in definition. One is the feature as the voluntary and independent sector functioning in contrast with the state or market sector and the other is the feature synonymous with civility or humanity in general as a value concept. The most commonly agreed aspect of civil society is that it represents the balance between rights granted to individuals in free societies and the responsibilities required of citizens to maintain those rights.

The diagram below is summarizing those relationships in "Health with All". I would like to propose that fullness of Humanity (citizens) and harmony with Nature is a greater background which all existing sectors and members are based on and supposed to have responsibilities to serve for present and coming generations. As long as even a small part of this entire humanity and nature is suffering, all sectors and members are responsible. This background concept is the same idea as O'Conner's second feature of civil society (O'Connell 1999).

In this understanding, actors in the state are also members of citizens and Humanity. They are given the role of representing all Humanity (citizens) and serving them. They have to be accountable to them.



Full participation of citizens in polity through various ways is essential in good democratic governance. The essential role of state must be in enabling and protecting citizens' participation in the first place. The market sector is an undervalued partner in Humanity. Few businesses are renowned for Humanity and social conscience, but those that accept and fulfill their social responsibility contribute significantly to the quality of people's lives and the attainment of full Humanity. Civil society in this diagram is the sector in which the values of the full humanity of all citizens and harmony with nature are nurtured and demonstrated by the actions of its member organizations. Its role is to influence and work together with the other sectors against the power and systems that would constrain the accomplishment of this common goal.

Civil society should not be automatically mistaken for a magic remedy for all the problems that humanity is facing now. The important thing to ensure is that the civil society truly represents all of humanity, speaks only part of it. Viable civil society is of course the key to true democracy, but as long as it is made with the voices of only middle and upper class people, it can not be called democracy. This type of so-called democratic government should be the target of transformation. At Gettysburg, Abraham Lincoln has addressed that "government of the people, by the people, for the people shall not perish from the earth". We hope that his "people" meant and still means all humanity and all citizens instead of a few powerful citizens.

Civil society sector should have characteristics (social capital) written below and those must be strengthened continuously. Civil society is the sector that has been oppressed and exploited for a long time by the more powerful state and currently even more powerful market sector. But only the civil society sector representing majority of poor who are long waiting for their full realization of humanity can balance the current unequal power leverage and initiate the transformation of every citizens and sectors toward true human and social development. Civil society sector can show the value of Humanity and Nature to other sectors and its members who also are based on and who have same rights and responsibilities to them. This can be initiated through starting genuine dialogue and action together.

- Civil Society Sector**
- Value of full humanity of all
 - Rights and responsibility
 - Third space (Non-profit sector)
 - vs. State and Market
 - Community, National, and Global level
 - Grass-root initiative
 - Voluntarism (caring for others in serving)
 - Structure of associational life(organizations)
 - Trust, reciprocity and cooperation
 - Network of public communication

Actors in “Health with All”

Before exploring the detail of a new health development paradigm, “Health with All”, it may be wise to overview all the actors who are currently related to it in various way, either promoting or constraining and also who are to be liberated and transformed to new direction together. From the past experiences, local, regional, and even national health development programs have had critical weakness, even though they were very successful in the intended area. It is because they require countless replications to thousands of communities, all within a basically hostile political and institutional context. Each individual step toward transforming a society, polity or institution is subject to reversal by the still larger forces generated by backward looking national and international institutions and invalid development vision (Korten 1990).

Actors in “Health with All” must be seen always in multi-level from micro to macro as they are closely interdependent and mutually influenced. The experiences of PHC implication in past decades can be organized into various groups: the local project-type experiences, the countrywide efforts in socialist and non-socialist countries and the worldwide campaigns or programs. They have been planned and implemented during the time of rapidly changing political and economical transitions. Those transitions may be from socialist system to democratic system, from socialist economy to free-market economy, from single party to multiparty-system and from absolute monarchy to constitutional monarchy. Currently prevailing political and economic systems are the so-called multi-party democracy and capitalist free-market economy. It is widely known that human and social development in most of developing countries is not advancing and “Health” and quality of life of ever-increasing poor majority are in fact deteriorating. Continuing debt crisis and exploitative nature of neo-liberal global free market economy, and greed- and growth-oriented development are expanding rapidly without much control. The level of inequity and social injustice is also increasing more in a way of social and economical oppression and exploitation rather than direct violence as neo-colonialism expands its effect.

First, actors of each sector in local and national levels are following.

Principal Actors for “Health with All”

1. State, Ministries, & Line agencies
2. Political parties
3. Bureaucracy (DHOs, GHWs)
4. Market (Business)
5. Local representative bodies
 DDC, VDC, Ward Committee
6. Communities (CBOs, FCHVs, THs)

7. Households, Individuals
8. NGOs (Support Organizations)

Actors of each sector in global-level are following.

- Actors in the World for “Health with All”**
- Industrialized countries
 - International credit agencies (WB, IMF)
 - International development agencies
 - Market
 - WTO
 - Transnational corporations
 - International civil society
 - International NGOs
 - Academic institutions
 - International associations
 - Individuals

State and “Health for All”

Before going into the case study of community health development program in Nepal and reviewing the new paradigm “Health with All” approaches, it may be good to review some of the national efforts of “Health for All” approach and their results in these three decades. As Warren summarized in the conference report “Good Health at Low Cost” in 1985, those countries that accomplished the high standard of “Health” despite the continuing low GNP have four important elements in common in their approaches. This report was from the study of three countries and one state in India which are China, Sri Lanka, Costa Rica and Kerala State.

Those four elements are

- Good Health at Low Cost**
- Basic Elements**
1. Political and social will
 2. Education for all with emphasis on primary and secondary schooling
 3. Equitable distribution of public health measures and primary health care
 4. Assurance of adequate caloric intake for all
- (from experiences of China, Kerala, Sri Lanka and Costa Rica)

Those states defined “Health” as a right of its citizens and emphasized equity and total coverage of health care services. They have strengthened the community health care and village health workers instead of hospital and professionals-oriented health care. Traditional medicine and participation were also emphasized. It can be said that those were initiated and advanced more by the political will that is based on the historical background of equity-oriented society and polity of these countries rather than by the social will alone. Those common historical characteristics of these countries are following.

Social and Political Factors for Good Health at Low Cost

- Historical commitment to health as a social goal
- Social welfare orientation
- Participatory orientation
- Equity orientation
- Intersectoral linkage for health
(from experiences of China, Kerala, Sri Lanka and Costa Rica)

Malaysia, Vietnam, Cuba, Chile and Nicaragua under the Sandinista era were also at least once in this group of countries. But those politically led, top-down, integrated basic health services for all proved to be vulnerable to changes in political and economic environment as it is heavily dependent on the support from the centralized political and economical system. They also failed to create efficient human resources at the local and grass-root level. They tended to leave community people just as passive recipient of services. Accomplishments of these countries are under serious threats. Current global free market economy system and increasing debt crisis are main factors for the deterioration of once accomplished good health.

As seen in the characteristics of these countries, health care did not seem to be the only answer for a good health. Thomas Mackeown showed that 65-90% of the decrease in specific mortality was not due to health care but to improved standard of living (Mackeown 1976). The need for an integrated (comprehensive) approach became obvious. Traditional “Health for All” approaches tended to be more blueprint type, top-down, and professionals-oriented characteristics. It would be good to compare the difference between hospital-based health system and community health care (McKnight 1994). Health is not a commodity, but it is a condition. Health is the by-product of strong associative communities. Health is the unintended side effect of citizens acting powerfully in association. Without those citizens’ power in associative relationships, we will be reduced to a nation of individual clients and impotent consumers feeling the unhealthy disease from the manipulation of our lives as they are managed and controlled by hierarchical systems. McKnight has emphasized the need of both system and community to build a healthy society. Basic source of health are powerful citizens and vigorous associations.

Hospital-Based Health System vs. Community Health Care

- | | |
|----------------------------------|-----------------------------|
| • Health-commodity | • Health-condition |
| • Client-object | • Citizen-subject |
| • Standardization, control, cost | • Creativity, consent, care |
| • Curative | • Promotion, prevention |
| • Focus on deficiency | • Focus on capacities |
| • Disempowerment of community | • Creation of citizen power |

Market and “Health for All”

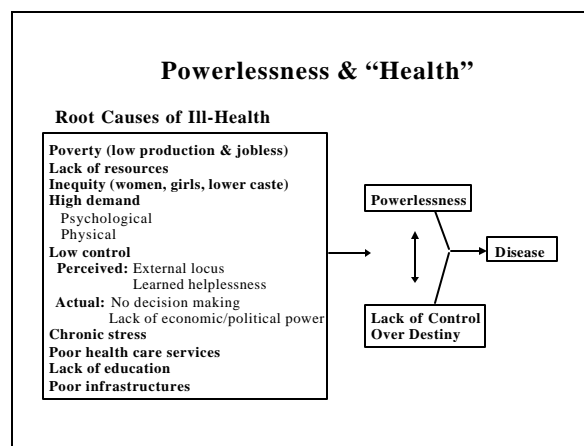
In the late eighties and nineties, the accomplishments of those countries had been under severe attacks and started losing their ground. The enormous debt crisis, accepting SAP of WB and IMF for further loan

from industrialized countries, and pressure to be involved in global free market economy further burdened the already poor countries and deteriorated the standard of living of poor people. The situation of developing countries seems to be just like bonded laborers bound up by an ever-increasing debt. Now global market, especially transnational corporations (TNCs), has huge power to influence and control even the states and international policies directing only to the benefit of a few powerful rich classes. Here in the global scene, civil society is still weak and even has no formal place to have dialogue with state and market even though we have votes to elect state representatives and we are clients of markets. Mass protests and global communication network using internet and mass-media for sharing information are strategies of civil society taken to give pressure and draw response from those sectors. Now it seems that state and market have close linkage and mutually supporting their power and control, and both are representing and seeking the value of a few rich and middle-class citizens with the sacrifice of poor majority and their environment. Current civil society is too powerless against these two sectors to start a dialogue and work together even though new value based movement and development are appearing in the scene.

Powerlessness and “Health”

Those who have the power have control over the determinants of health. People with little or no political and economic power lack the means to gain control and access to the resources for change in their lives. When the root causes of ill health are considered, powerlessness or lack of control over own destiny emerges as a broad-based risk factor for disease. Diagram below is modified from the work of Wallenstein (Wallerstein 1992). Those conditions are common in many poor communities either in developing or developed countries as well. Those are root causes of ill health and unhealthy community and those are the causes of powerlessness of the people and community in micro-level.

This diagram can be applicable to the macro-level powerlessness of developing countries against industrial countries and their economic power. National level standard of living and environment are also deteriorating in most of developing countries. Powerlessness of peoples, communities, and nations and its devastating consequence will continue unless this uneven power leverage is challenged. Transformation of a powerful few state and market that has extreme capital and control has to be initiated urgently for them to become partners of sustainable participatory people-centered development. They need to realize that they too are in a way powerless and need empowerment if they can't see the reality leading them to destruction and can't change themselves. They need to recognize their responsibility and take necessary actions to change the value and systems sacrificing majority of humanity. They need to stop seeking their own fullness of their greed, and instead they have to start seeking equal and universal fullness of humanity and nature of present and future generations.



As a sector, civil society may be powerless in general, but also within the civil society itself many issues have to be questioned and transformed. They may be gender inequity, social class hierarchy, apathy, lack of empathy, and lack of sense of community etc.

Here we see some representatives of powerful and powerless groups. They may be inter-sectoral or within the sector. Some of the typical features in this relationship are oppression, exploitation and violence. As long as these power leverages are not challenged and corrected, inequity and social injustice will continue. Fullness of humanity and human rights of all peoples will continue to be neglected and responsibilities of the powerful will not be questioned.

<p style="text-align: center;">Powerful and Powerless</p> <ul style="list-style-type: none">• Industrialized countries vs. Developing countries• TNCs vs. Poor workers & farmers• WB,IMF vs. Debtors• Rich vs. Poor, urban vs. rural, central vs. local• Men vs. Women• High vs. Low social class• Landlord vs. Landless peasant• Bureaucrats vs. People• Doctors vs. Patients• GHWs vs. CHWs• Donors, INGOs vs. Local NGOs vs. COs <p style="text-align: center;">Control, oppression, exploitation Inequity, injustice, violence Neglect human rights and responsibilities</p>

WHO's "Ottawa Charter for Health Promotion" in 1986 clearly mentioned that health promotion is the process of enabling people to increase control over their health and to improve it. At the heart of this process is the empowerment (participation) of communities, their ownership and control of their endeavors and destinies (WHO 1986). Empowerment is important for the powerless to see the reality (root causes), analyze and take action to transform themselves and the system around them together with others. But it is also necessary for the powerful to realize that they too are powerless against the binding power of wrong value of life and humanity. Empowerment is not the process and goal to win against others. Both powerless and powerful need to work together to be liberated together. As long as empowerment is discussed in a fragmented local level, this idea is again viewed as another decoration that makes no fundamental difference. Empowerment of civil society must be considered in all levels from micro to macro and from local to global. Participation of civil society in policy-making at the national and international level has to be institutionalized as reflection of people's movements toward participatory sustainable development.

From "Health for All" to "Health with All"

<p style="text-align: center;">From "Health for All" to "Health with All" - Questions on New Paradigm Shift -</p> <ol style="list-style-type: none">1. Who can/will initiate transformation?2. What is the role of Civil Society?3. How is the power of Civil Society measured?4. How can new paradigm be sustained and scaled up?5. What is the role of NGOs?

Review of the paradigm shift from "Health for All" to "Health with All" approach through evaluating the "School and Community Health Project" in Nepal will be presented here. We have seen so far why "Health for All" approaches has not yet accomplished "Health for All" as a goal as expected since 1978. On the

contrary the living standard and health status again started deteriorating in most poor countries. Now market and states that are representing capitalist market force (greed-oriented) have more powerful control and forcing their values and systems over the civil society which represents poor majority's longing to fulfill their humanity. First this power leverage has to be challenged and balanced for the sake of both sides through the empowerment of civil society as an initiator. Here are some questions to be answered through this case review.

"Health with All" approaches always require all of us in every sector to participate in the process together from micro to macro level, from individual, household, community, regional, and national to international and global level. Because all of these sectors and levels are closely interrelated, and even local people's movements have potential and may be able to influence other stronger norms and larger systems and vice versa for the better equitable healthy society.

"Think locally and globally, and Act locally and globally"

Nepal and "Health" - Background

Health Status in Nepal

As we see the maternal mortality and under five mortality of Nepal in 1996 (DHS 1996), the current health status in Nepal is one of the poorest countries in the world.

Health Status of Nepal	
1. Maternal mortality rate	539/100,000
2. Under-five mortality rate	urban 82/rural 143 mountain 208/Hill 127
3. Men/women life expectancy	55 / 53.5
4. TB incidence	110/100,000 (MDR-TB=48.0%)

Women's life expectancy is also not only low but also is shorter by about two years compared to men (UNDP 1998). Nepal is one of a few countries where women have shorter life expectancy. These clearly show that there is a regional and gender inequity in health status of Nepal. TB incidence is high and MDR-TB rate of acquired case is 48%; that is one of the highest rates in the world (Cohn, Bustreo et al. 1997). This also suggests that the health system is not functioning properly and requires more strict execution of standard treatment and pharmaceutical regulations (Hurtig, Pande et al. 2000). Community health care coordinating with government health system has to be urgently established before this serious disease spreads further (Fryatt 1995). The number of Nepalese infected with HIV was expected to reach 50,000 by the year 2000. This number may increase in near future when many adults move as migration workers and in and outside of Nepal because of poverty.

Nutrition Status of Nepal

Nutrition

- Child stunting = 54.1%
- Night blindness (Vit. A)
 - Pregnant women = 6.1%
 - School aged children = >1.0%
- Iodine deficiencies= 39.1%
- Anemia (iron deficiency)
 - Pregnant women = 74.6%
 - Children (6-23months) = 88%

There has been little improvement in the nutritional status of children as measured over the last 23 years. Nationally, 24.7% of the women were found to have low BMI, with the highest prevalence in the Terai area (36.9%). This shows that too little attention has been given to the nutritional care of women, for themselves and as mothers, in an attempt to break the intergenerational cycle of under-nutrition. Vitamin A deficiency and iron deficiency anemia are alarmingly highly prevalent in Nepal especially among critical preschool children and pregnant women. The proportion of low urinary iodine excretion values has declined to 39.1%, however high rates of palpable goiter were seen (HMG/N 1998).

Society in Nepal

Nepal is a land-locked country located between two large countries, China and India. They have influenced Nepal in various ways, socially, politically and economically. Nepal restored multiparty democracy in 1990. But it is still politically unstable. It has three distinct topographical regions, which are mountain, hill and Terai. There are difficulties in transportation and scarcity of cultivatable land especially in the hill and mountain regions. Most people (88%) live in rural area and are engaged in subsistence agricultural work. 45% of people live in absolute poverty level. There is a great diversity of cultures, which come from 61 people groups (ethnic/caste) and 60 living languages. There are two groups of people in which one is of Indo-Aryan origin and the other of Tibet-Mongol origin. The main religion in Nepal is Hindu in which 86% of the people claim to belong.

Society in Nepal

- 61 people groups(caste/ethnic), 60 living languages
- Low caste, mountain(low literacy & high mortality)
- 86% Hinduism, prevalent fatalism
- 45% absolute poverty, GNP/capita=210US\$
- High underemployment, unskilled labor
- 88% living in rural areas
- Low productivity in agriculture
- Landless, bonded labor, child labor (41.7%)
- Poor infrastructures(roads, irrigation, safe water, sanitation)

The Hindu caste system came into Nepal with the Indo-Aryans and though it has been eroded, still it has significant influence on social and cultural life of the Nepalese people. Especially the belief of fatalism is strong and it influences the lives of the Nepalese people. People tend to accept their lower status in society, poverty and inequality as their fate, and hesitate to initiate changing any of their condition (Bista 1991). Quality of life (living standard) in Nepal varies widely according to the living area, caste, asset and gender. People in the lower caste and in the western and mountain regions have a lower literacy rate and also a higher mortality rate (UNDP 1998). Many people are unskilled and landless. Many children (41.7%) aged between 5-14 years work regularly. Bonded labor and serfdom exist in Nepal. They are known as Kamaiya and Haruwa-Haliya systems. Over 100,000 individuals are affected by the Kamaiya system, mostly from Tharu community that constitutes 6.5 % of the country's population. In rural area, access to safe water is low and sanitation level is absolutely low. Road system is poor and transportation is very difficult because of rugged terrain.

Girls and Women in Nepal

Nepalese girls and women constitute a more deprived group because of intra-household as well as social and legal discrimination between sexes (Messer 1997). Gender disparity starts right from the birth, continues through different stages of the girl's life. Sons are considered assets while daughters are considered liabilities, although girls and women have on average 40% more workload than boys and men.

- Girls and Women in Nepal**

 - Unequal food and health care allocation
 - Higher female child and adult mortality rate
 - Lower literacy rate (male 50%, Female 21%)
 - More work burden (1.4 times)
 - Lack of property right
 - Less access to resources
 - Less access to public decision-making structures
 - Early marriage and high fertility rate
(TFR mountain= 5.60)

Girls' school enrolment is much lower than boys. Intra-household allocation of food and health care of women and girls are also much lower than that for men and boys, particularly in rural area. Girls and women suffer more severely from the consequences of poverty. The cultural and religious emphasis on the sacrifices of women, and disparity in access to economic resources and social services are the major causes for the larger deprivation of females. When employed, their wages normally are 25% less than those paid to men. A malnourished and illiterate mother giving birth suffers from birth complication, and the baby suffers from birth injuries, neo-natal tetanus, low birth weight and high mortality rate. The plight of poor women is a serious issue because health and education of mothers strongly correlate with the well-being and the future of their children and other family members. Among the several socio-economic factors, female literacy (as defined as being able to read, write and count) is found to be a powerful factor in lowering infant mortality in the districts in Nepal especially through increased use of modern health services (Thapa 1996).

Health Resources in Nepal

Doctors and nurses are still few and highly concentrated in the capital, Kathmandu, and in a few urban areas. The numbers of health posts and sub-health posts has increased and almost each VDC has at least one public health facility. In 1996, approximately 45% of the households could access a health post (HP) within a travel time of 30 minutes. But still many people have to walk 2 to 3 hours to get there and find medical personnel often absent from the rural-based health posts and sub-health posts (HPs/SHPs), and even from regional and district hospitals. Thus in the 1995 survey of 10 districts, out of 94 positions of doctors

sanctioned, those actually on duty were only 28. Similarly out of the 117 positions of nurses sanctioned, only 42 were on duty. Moreover, it was reported by Nepal Television in 1997 that there were no doctors on duty in at least 35 of the 75 districts.

The annual drug rations allocated to health posts are adequate for only 3 – 6 months (UNDP 1998).

Nepalese health service has 8000 private pharmacies all over the country even in far remote community. They can be a powerful resource if they are properly trained and monitored. Otherwise they may deprive people's scarce capital by selling unnecessary drugs and also be hazardous for the people's health by selling wrong drugs. This may be one of the reasons for high MDR-TB rate in Nepal.

Health Resources in Nepal

- 1500 physicians (1/13333), 99% in urban area
- 35 of 75 districts have no doctor on duty
- 117 primary health centers
- 754 health posts
- 3187 sub-health posts (3912 VDCs)
- HA, AHW, ANM, MCHW, VHW
 - High absenteeism and less drug availability-
- 8000 pharmacies
- CHW (42000), traditional healers (4-800000)
- 21473 primary schools (82645 teachers)

Rural community people used to consult traditional healers (THs) about their diseases and problems. Every community has more than one TH. They are highly respected and people listen to their opinion and receive treatment. They could be integrated in community health care as CHWs and be trained with simple modern curative skills and health promotion role.

Here numbers of primary schools and teachers are included, because they are most accessible institution in rural communities and have large potential to be PHC resource. Health promotion among school children can be spread to their family and community as well. Children can be health promotion messengers and participate in various PHC activities including EPI and community survey. Their health status, nutrition and worm infestation can be monitored and given necessary care in the school.

Public health care services are hampered by low wages and morale among civil servants, insufficient incentives for government employees (GHWs) to operate in the field, and corruption and political interference in hiring of the whole range of public officials from central ministry staff right down to village school teachers. In the social sectors, health in particular, these problems are compounded by an inadequate allocation of funds, even on paper, and poor motivation and skills. Public health expenditure barely exceed 1% of GDP and education is less than 3%, as against a combined 10 – 15% in countries that have done better in human capital development (World Bank 1998).

Aitken studied the behavior of personnel in the Nepalese public health services. This shows that apparently irrational and inefficient behavior can be explained and understood as evidence of a much wider system of values in use which actually determine how health services are provided. Examples of values learned from his study are as follows (Aitken 1994). People lack the knowledge about their rights and services that they are entitled to receive. This may hinder the civil society to pressure on public officials and institutions to be sensitive to people's needs and responsive to them.

Government Health Workers in Nepal

- Purpose of DPHO is to provide incomes for staffs
- Training and supervision mean extra allowances
- Service quality is not a priority
- Absent workers can,t be fired
- No clear job description
- No emphasis on the right skill for any job
- Posts are seen as salaries and not work
- Fulfilling targets is more important than quality
- Misreporting is highly tolerated

Polity in Nepal

The authoritarian panchayat system with absolute monarchy was ultimately overthrown on April 9, 1990 strongly supported by civic and professional groups. Nepal has started functioning as a parliamentary multi-party democracy after the national election held in May 1991. A new democratic order has been established which endorses constitutional monarchy, supremacy of parliament, multiparty system, protection of human rights, and so on. But it has not changed the political culture.

The political leaders and the political parties are bent upon to capture political power, not to build the state and its institutions, nor to serve the people. They are motivated to enrich themselves, their family and their community. Government and parties are not accountable to people and losing their legitimacy. It is claimed that Nepal has many laws but the rule of law is not well executed. In the absence of institutionalization of good governance, the current trend toward democratization appears as if politics was revolving around temporary power arrangements or opportunism since the bulk of population is still far away from the mainstream politics.

Rampant corruption, lack of transparency, and accountability are the major constraints for functioning democracy and good governance. Unless those issues are tackled properly and successfully, it will be always difficult to maintain genuine democracy. Current Maoist insurgency in many districts of Nepal may be the sign of disappointment and frustration of people who have been waiting for the change patiently for the last 10 years.

Political Structures in Nepal

- Central level
 - Parliament, Political parties
 - NPC, Finance and Line ministries
- District level
 - DDC, Line agencies
- Village level
 - VDC, Service centers
 - Ward committee (5 members-1 woman)
- Community

Since 1990, one of the major achievements is the introduction of the local self-governance system. The local self-governance legislation was passed by the parliament. It is intended that people should be able to govern themselves through district, municipal, and village level political units (DDC, VDC, and Ward committee) which are known as local governments. The legislation, of course, is not sufficient in radically

empowering the local bodies and making self-governing institutions; but it does provide a framework for reforms, a better environment for people to involve themselves in local politics. Hopeful vision is that local governance is gradually evolving and transforming themselves from bureaucratic authoritarian model to participatory model where people have more chances of being heard than before. Democracy is not simply confined to the formal process in which elections are held every few years. It is rather a system under which citizens are secured to participate actively in the state affairs by overseeing the actions of government (Thapa 1999). Empowerment of community (especially political efficacy) and institutionalizing the participation in political are critical factors for the development of genuine democracy in Nepal. Women's participation in polity must be further progressed to secure their voice and needs may be always counted.

Decentralization in Nepal

As most of developing countries did, Nepal's local development has been led, controlled and managed by central government and its line agencies in the districts. Many projects did not meet the needs of local people, maintenance and management has not been well done, and programs were not scaled up and sustained. Financial resources of DDC used to be much smaller than that of line agencies. Ownership of development didn't belong to the local people. Local self-governance act has been enacted in 1999 for the purpose of transforming this traditional approach. DDC and VDC are expected to initiate own development planning and management. They are given more authority to collaborate with line agencies and mobilize their resources.

Decentralization in Nepal

Institutionalizing people's participation in local development

Local Self-Governance Act (1999)

- DDC, VDC can manage own development
- Line agencies can be transferred to DDC
- Seed grant allocation for locally proposed project

Requires empowered civil society

But again unless the civil society (individual, organization and community) is empowered and the system of holding accountability of DDC and VDC is institutionalized, development programs will not reflect the real need of every people in the communities, especially of the poorest and women. According to the act, each community or community organization plan own development programs according to their priority in needs and propose them to VDC. Then planning workshop will be held with all related actors, VDC, line agency, NGOs and community. Finally DDC will finalize the development plan.

UNDP's support program for decentralization in Nepal has learnt this critical factor from their previous insufficient success and it modified the program to focus more on the empowerment of entire community people and on the capacity building of representing community organizations. It has introduced savings and credit programs and small income-generating activities for starting the empowerment cycle in every ward in the district. These community organizations are composed of one member from every household in the ward community. By the year 1998, 1911 community organizations have been built in 85 villages and 765 wards. 1028 of them started income generating activities and infrastructure building projects with small loan and seed fund. Through this community empowerment, instead of benefiting a few powerful, every ward and every people can now participate in their own development planning for fulfilling their needs (Masaki 1999). This is the example of institutionalization of Participatory Development, though it is initiated and strongly led by the UNDP. Similar example of the effort to institutionalize Participatory Development is seen in Kerala State in India (Bandyopadhyay 1997; Isaac and Harilal 1997).

**Rural Development
- Micro-level Actors -**

- Local government
- Line agencies
- Community
 - Organizations, leaders
- NGOs (Support organizations)
 - Field facilitators
- Local business

DDC and Line Agencies in Kavre District

DDC income:Rs.92.6 million in 98/99

DDC fund (local taxes) = 13.8%

Line Agencies:Rs.161.5 million

1.Education	59.6%
2.Drinking water	10.2%
3.Forest	6.6%
4.Public health	5.5%
5.Irrigation	5.3%
6.Soil conservation	4.6%
7.Agriculture development	3.2%
8.Livestock services	2.4%
9.Small and Cottage industries	1.5%
10.Women development	1.0%

The collaboration between DDC and line agencies through utilizing their expertise and exerting their responsibilities is also a key factor for successful decentralized participatory development. But so far the bottleneck is the weak financial background as seen above. DDC budget is around a half of total of line agencies' budget and also the majority of DDC fund is given from central. In the case of Kavre district in 98/99, only 13.8% of total DDC income are from local tax. These must be improved. True devolution of financial management and raising own incomes to the local governments are urgently necessary.

All of these micro-level actors in rural development field have to coordinate and cooperate together as equal partners toward institutionalized Participatory Development and "Health with All"

Economy in Nepal

Agriculture is the predominant sector and contributes more than 51% of national income and employs more than 81% of the total population. Nearly 75% of Nepalese foreign export is based on the agriculture products (including animal and forest products). Agriculture is the major source of government revenue that comes from the land revenue.

Features of Nepalese Agriculture

1. Subsistence agriculture
2. Small size of land holdings
3. Agriculture depend on Monsoon
4. Excessive pressure of population
5. Low productivity
6. Underemployment

Nepalese agriculture is generally based on subsistence level. Commercial, collective and cooperative agriculture is very limited. The total area under irrigation was only about 34% of the total agricultural area. Average size of land holding was 0.96 hectare in 1992. According to the census report of 1991, annual population growth rate was 2.1%. The excessive pressure of population is badly affecting the agricultural productivity. The per capita land holding area is declining. That was 0.14 hectare in 1992. Due to inadequate irrigation facilities, double cropping is not made possible. The agricultural employment is seasonal, and secondary and tertiary sectors have not developed to absorb excessive labor forces. Many rural community people have to migrate to the city for work during winter months.

The following remedies can be suggested for solving the underlying problems of Nepalese agriculture that are basically responsible for the agricultural low productivity (Sijapati 1998).

Solving Agricultural Problems

1. Irrigation facilities
2. Adoption of suitable agricultural technology
3. Education and training
3. Animal husbandry
4. Marketing
5. Cooperative credit societies
6. Transportation and communication
7. Prevent land erosion and improve wasteland
8. Promotion of agro-industries
9. Cottage and small scale industries

Big irrigation projects may require huge capital investment, small-scale irrigation schemes can be facilitated better. Crop rotation, mixed crop production and other locally suitable improved technologies should be adopted. Adequate manure quantity should be available. Protection of crops from insects and diseases must be studied and provided. Livestock has to be fed well and taken good care with adequate quantity of fodder. Developing cooperative marketing institutions may discourage large number of mediators from exploitation. Ware housing facilities should be established to preserve crops safely. Transportation and communication should be increased and improved for attaining faster agricultural and industrial development. There are frequent land slides in the different parts of hilly regions that not only destroy the cultivable land but also take human lives. This situation is becoming worse day by day owing to the regular deforestation in the country. Proper forest management, re-plantation of trees and the construction of drains need to be made. Any mechanism of credit provision for farmers that are simply, easily and quickly available is very critical for development. State of mass illiteracy and lack of the knowledge of improving agriculture among farmers are

big problems. Those may continue to keep farmers bound in traditionalism and fatalism. Proper agricultural training system has to be established, forming farmer's clubs and farmer to farmer training mechanism, collaborating with government agricultural extension workers. Promotion of livestock industry and small-scale industries will not only provide the employment opportunities but also will add substantial income to the people that will help to raise the living standard of the people.

“Health with All” Case Study in Nepal

School and Community Health Project

**School & Community Health Project
(SCHP)**
(Japan Medical Association and HMG/N
in cooperation with JICA from 1992)

- Comprehensive participatory community health development project
- Kavrepalanchowk District in Nepal
- 15 VDCs - 135 Wards, population 50,000
(Tamang people - Buddhism)
- **Goal: Creating healthy community by**
 - Improving living condition
 - Providing better health services

Soon after the political transition from absolute monarchy to multi-party democracy in 1990, eighth five-year national plan has been launched especially aiming to improve the health status of the majority of people living in rural communities. The School and Community Health Project (SCHP) officially responded to the call in December 1992, under an agreement between the Ministry of Health, His Majesty's Government of Nepal (HMG/N) and the Japan Medical Association (JMA) in cooperation with Japan International Cooperation Agency (JICA). Project fund has been supported by JMA. Two Japanese experts have been sent from JICA.

SCHP is a comprehensive participatory community health development project that focuses on health promotion and human resource and infrastructure development. The project area covers 15 Village Development Committees (VDCs) located on the southern and northern hill-slopes of the great Mahabharata range in the Kavrepalanchowk district of the Central Region. They belong to two areas that are Bhugdeo and Tardhunga in which about 50,000 people live. Main ethnic group is the Tamang people and their religion is mainly Buddhism. The main goal of SCHP is creating healthy communities through improving living conditions and providing better health services. The empowerment of individuals, groups (organizations) and communities, and the institutionalization of the Participatory Development (human, social, political and economical) are two key components of the new framework of “Health with All” approach to reach objectives of SCHP. These two components interact and strengthen one another toward the goal of this project that is healthy community and “Health with All” during its whole activities.

The SCHP set up the following programs.

- Implement school and community health promotion programs
- Control major diseases in schools and communities
- Increased health issue awareness
- Improve human resources for health care at the grassroots level
- Enhance local government capacities to manage health-related problems

This map is showing the project areas. Primary Health Care (PHC) center that was upgraded by SCHP is located in Kopasi. Communities in project areas are within 2 to 16 hours walking distance from Kopasi.



SCHP area (Bhugdeu and Taldhunga)

Baseline Study of SCHP

In 1997, baseline study was done in these two areas using Participatory Rural Appraisal (PRA). The following is the list of appraisal contents (HMG/N, JICA et al. 1997).

Baseline Study of Bhugdeu through PRA (1997)

1. Infrastructure (HP, school, water, sanitation, irrigation, access to road)
2. Wealth ranking (income sources and migration)
3. Seasonal food security
4. Community organizations
5. Relationship with various institutions
6. School enrollment, drop-out and literacy
7. Child health (nutrition, EPI, diarrhea, ARI, worm)
8. Gender issue, reproductive health, safe delivery
9. Hygiene and sanitation (personal, community)
10. Health services (HP, TH, FCHV, TBA, referral)

The results of this study in Bhugdeo reveals some of the serious difficulties of daily lives of the people living in this area.

**Participatory Baseline Study
in Bhugdeo (1997)**

- Households whose farm production is enough for 1 year family consumption: 32.7%
- Nearest HP/SHP: 45min - 3hrs walk
- Worm infestation: adult=61%, school children=66%
- Adult literacy rate: men=49%, women=13%
- School enrollment: boys=64%, girls=40%

Reasons for low enrollment

1. Household work burden of children (girls>boys)
(smaller child care, share farm works)
2. Income poverty (cost for uniform & stationeries)
3. Physical distance
4. Low perceived relevance of education

Almost 70% of households can not produce food for their family enough for 12 month. Transportation is poor and public health services are still very far from many communities and quality is low. Lack of safe water and proper sanitation are serious problems as seen in high worm infestation rate. Literacy rate is low, especially among women. School enrollment rate is also low and show similar tendency. Children especially girls have to share the household work sacrificing the time of schooling and fun.

General needs are expressed as follows.

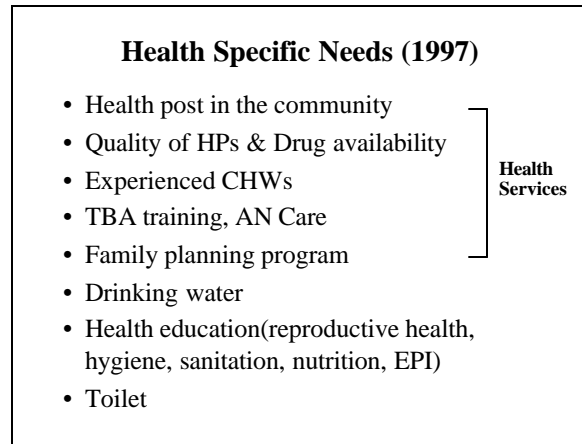
**General Needs Assessment
by Community (1997)**

1. Income generating activities
2. Agricultural training
3. Irrigation canal
4. Control soil erosion
5. Veterinary service
6. Road & bridge
7. Drinking water, toilet
8. Literacy class, secondary school
9. Smokeless Stove
10. Electricity

**Production
& Income**

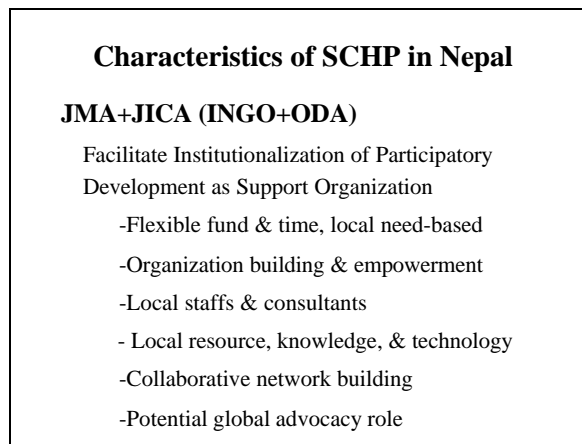
In poor countries, people generally do not give health-related issues high priority. In the study of Bhugdeo production and income-related problems are expressed as higher priority of needs. These people's high priority needs have to be respected and should be integrated in any development programs.

The health specific needs were also assessed separately.



Accessibility and quality of health care services are the main concerns of people. People have high expectations in improvement of quality of both public health services and community health workers in their own communities. Safe water, sanitation and health education were the needs following to those of direct health care services.

Characteristics of SCHP



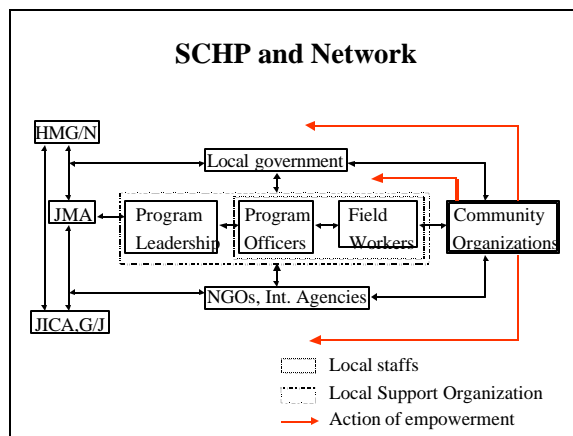
SCHP has two distinct characteristics that are of the international NGO and the Official Development Aid (ODA). Since the project is supported by Japanese ODA through JICA, it has an advantage in building macro-level international dialogues and collaboration networks between two nations and with other donors. This would work better in global advocacy role of SCHP. Two expatriate experts are supported financially by JICA. So all the funds from JMA can be utilized for the programs themselves.

SCHP intends to facilitate empowerment and institutionalization of participatory development process in micro- and macro-level. Community empowerment through groups and organizations formation and their capacity building have been emphasized. SCHP recruited and trained local staffs and consultants to be able to function as local support organization (local NGO) including field facilitators (workers) elected and recommended by each 15 VDCs. Local resource mobilization, through human resource development and local finance, technology and material utilization, is one of the strategies.

Together with those, institutionalization of the participatory process is important for the purpose of sustainable and self-reliant development. This will be done especially through building the inter-sectoral collaborative networks with local government and line agencies that continue to have large responsibility for

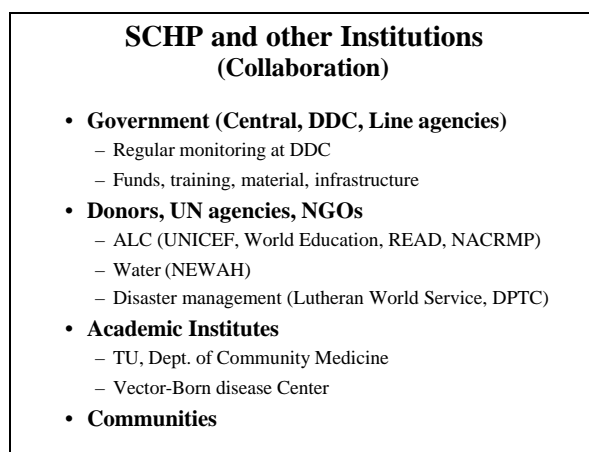
new paradigm “Health with All”. This will require their own empowerment and transformation to become true liberated partners with community (JMA 2000).

Next diagram is showing the network of collaboration that SCHP has intended to strengthen for institutionalizing the development project. These interactions between each actor should be two-way and collaborative as equal. Red arrows represent the direction of appeal and action that empowered community has to increase to sustain and scale up the development.



Groups and organizations are formed in the community as process or outcome of the empowerment program. Intra-community interactions, dialogue and sharing will be initiated. They need to mobilize internal and external resources. Local government, line agencies and their extension workers, are requested to respond to people’s needs in financial, technical and legal support. NGOs and International Agencies are also required to collaborate with those by using their expertise and financial assistance. To institutionalize these network, relationship of collaboration, regular workshop, forum and meetings have to be organized with attendance of representatives from every group of people, especially from women, lower caste and poorest. Both empowered community and responsive public agencies having the same value are necessary in Participatory Development and “Health with All”.

SCHP has built networks with several institutions and agencies. Coordination and mutual resource mobilization for common goals are sought. Empowered communities are expected to initiate further necessary network expansion according to their evolving needs.



Programs of SCHP

In the first phase, SCHP had upgraded the Khopasi health post (HP) to PHC center that has 14 staffs and one doctor now. It is expected to function as a center of PHC activities in the area supervising HPs/SHPs

and CHWs, managing health promotion and primary health care in the communities. During the first phase, SCHP also started several pilot projects for community health development.

<p style="text-align: center;">SCHP in Kavrepalanchowk District</p> <p>1st phase (1992-1995)</p> <ol style="list-style-type: none">1. Upgrading Khopasi HP to PHC2. Starting various pilot programs <p>2nd phase (1995-2001)</p> <ol style="list-style-type: none">1. Women's empowerment2. School & community health promotion3. Human resource development at grassroots4. Infrastructure development

The second phase has four programs. Women's self-help groups (SHGs) and school's child to child clubs are two main groups formed which started the empowerment cycle. Community health promotion is intended to be led by these two groups in schools and communities. Scholarships have been provided for prospective GHWs to receive official training and qualification. Each community elected them. Most of them had been working as field facilitators in SCHP for some time. They are expected to be stationed in HPs/SHPs and serve in their own community bridging between government health services and CHWs in the community more efficiently. In the second phase, infrastructure development has been concentrated in schools especially building safe water supplies and toilets (JMA and JICA 2000).

<p style="text-align: center;">Second Phase Activities of SCHP (1995-2001)</p> <p>1. Women's empowerment Adult literacy class (BLC-PLC) - kitchen garden - SHGs, health literacy</p> <p>2. School & community health promotion Child to Child clubs, school de-worming Health education,</p> <p>3. Human resource development Scholarship, Skilled laborer, CBDP training CHWs (TH, TBA, FCHV, PCDV) training</p> <p>4. Infrastructure development Buildings, Water supply & Toilets for schools & HP/SHPs, management (user) committee formation</p>
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SCHP has introduced Adult Literacy Class (ALC) for highly illiterate adult women as an entry point of empowerment and group formation.

1. Women's Empowerment Program

- **Adult literacy class (BLC+PLC) + KG**
 - PLC:more health and organization study
 - KG:kitchen garden-as immediate benefit
- **SHG formation**
 - ALC as entry-point, KG as immediate result
 - Saving and credit, income-generating
 - Interaction with other organizations
 - Initiate own activities (toilet, library, FA kit)
 - Participate in community activities
 - Helping other communities (w to w expansion)

Post Literacy Class (PLC) follows Basic Literacy Class (BLC) in the second year. Classes are held during winter season that has less farming activities. Kitchen garden projects are recommended for every participant in ALC during the time between BLC and PLC. This project helps women to see the immediate result of their learning and action. This gives them the sense of self-efficacy and increased self-esteem. And also group cohesion increases and it proceeds to the formation of SHGs (Sato, Jimba et al. 2000).

Women's Self-Help Groups (SHGs) in SCHP

1. Goal: empowered organizations (women)
2. Method: participatory learning action (PLA)
3. Process:
 - 1) Group formation:
 - 1]ALC as entry-point (BLC followed by PLC)
(specially designed for health literacy)
 - 2] Kitchen garden as a activity to see quick result
 - 2) Start empowerment cycles
 - 1] savings and credit program
 - 2] income generating activities
(poultry, pig, goat, crafts)

SHGs introduced small savings and credit program and various income-generating activities using loan from it. They have now more access to resources.

School health promotion is organized not only for improving health status of school children but also expected the new perception and healthy behavior to be spread to other children, families and even to communities.

2. School & Community Health Promotion

1. School health

1) Child to Child clubs

Improve hygiene practice, assist NID, handle FA kit
Linkage to community health

2) School de-worming activity

2. Community health awareness program

1) Extensive health education

Hygiene, ANC, AIDS, IDD
Sanitation (household and environmental)
Action for application(water, toilet, soap, ORS)

Community health education has been done extensively in every occasion available. Students, teachers, HP/SHP staffs, management committee members, and ALC participants have been given opportunities to learn, discuss and plan actions.

Child to Child club

1. Goal: empowered organization (school children)

2. Method: PLA

3. Process:

1) Group formation, training & club membership(wear badges) as entry-point

2) Start empowerment cycles

1] group learning about health & rights

2] promote hygiene & sanitation practice at school, training for first-aid kit

3] promote community health (speech and quiz contest, drama, dance, singing)

4] join community health survey & NID

To initiate school health promotion, Child to Child club as students' group has been formed in every school in the areas. Then empowerment cycle and institutionalization process began. Activities performed by clubs are in the list above.

Third program of SCHP is the human resource development. Scholarship has been given to four women who graduated from ALC and passed the placement test for further education in public school. They are expected to become women GHWs (ANM or MCHW) in near future that is needed most in communities, especially for women's and children's health.

3. Human Resource Development

- Scholarships
 - Students (4 ALC graduates)
 - Health workers (HA, ANM, AHW, LA)
- Community health volunteers training
 - TH, TBA, FCHV, PCDV (malaria control)
- Skilled laborer training
 - construction-water piping, latrine, building
 - kitchen garden, animal husbandry
- Local SCHP staffs training
- Community based disaster preparedness training (CBDP)

Each village elected one candidate mostly from former SCHP field facilitators and 18 have received scholarship to become health workers. Only one of them is a woman. Various volunteer community health workers have been trained and received first-aid (FA) kits.

Through active participation in the infrastructure building program, many have been trained as skilled laborers. Together with community people, SCHP local staffs and field workers have also received various training for capacity building and facilitation skill improvement.

Community Based Disaster Preparedness Training (CBDP) has been organized and many people have received training for frequent disasters of flood, soil erosion and landslide.

Human resource development program not only empowers the individuals but also enable them to be the key persons for initiating the new paradigm of Participatory Development and “Health with All”.

The deteriorated and poor facilities and lack of water and sanitation in schools, HP/SHPs and other public places are the major factors behind the inadequate health institution staffing, low academic performance, and poor health of students.

4. Infrastructure Development Program

- Participation, local expertise and material
- Skilled laborer training
- Construction committee
 - school, library, hostel and VDC buildings
 - HP, SHP buildings, training center
 - Toilets for schools and HPs
 - water supply for schools and HPs
 - New system, rehabilitation, pipeline extension
- User(management) committee
 - Maintenance & cost sharing

Providing safe water supplies and toilets in schools are the minimum needs for school health promotion and Child to Child program to be successful.

Construction committees have been formed before any construction and community people actively participated in planning, resource mobilization and construction. Through these processes, the committee

members and skilled laborers could be trained in each community. The newly gained and improved skills will contribute for future maintenance, construction and also improve their personal job-opportunity and income.

Outcomes of SCHP

Through the mid-term evaluation of the SCHP in July, 2000 (JMA and JICA 2000), following outcomes were reported. Impacts on empowerment and institutionalization process are added.

Outcomes
1. Women's empowerment program
1) Increased adult women's literacy (from 28 to 55%, missing out-of-school girls)
2) Individual empowerment: increased skills, self-esteem & self-efficacy increased resource access increased decision-making in the family limited improvement of well-being & equity
3) SHG formation(157) & empowerment increased saving & credit, income generation, empathy, innovation, & collective action (library, first aid training), increased influence on communities (support other SHGs, NID, join UNDP project)

Literacy program has covered only adult women and not included men and out-of-school children, especially many girls. SHGs' capacity needs to be strengthened, and interaction and network building with other actors and groups must be facilitated to make this program self-reliant and sustainable.

Outcome
2. School & community health promotion
1) C-to-C clubs (28/84) Improved student's hygiene practice limited usage of FA kits limited influence on out-of school children, parents & community
2) School de-worming: only limited to school
3) Health education: reached 32% of people still poor in personal hygiene, household & community sanitation practices Improved women's health awareness (timely immunization, nutrition, ORS, FP AIDS, AN care (Av. 1,09 times)

Child to Child clubs are not yet self-reliant and well empowered. Health promotion of traditional style of teaching (banking education) has weakness in raising enough conscientization to see the reality, analyze and take action to change their own behavior. Community-wide de-worming program has to be organized with DHO because communities have more than 60% worm infestation rate.

Outcomes

3. Human resource development

- 1) Scholarship: HW(1), ANM(1), AHW(15),
LA(1), students(4)
graduates open village clinics(3)
work as field facilitators of SCHP
LA works for malaria control
- 2) Skilled laborers training: job opportunities,
increased wage
- 3) Training TH(96/570), TBA(60), FCHV(133),
PCDV(22), limited increase of consultation
& referral practice
- 4) CBDP training: total 2,514 trained

Graduates of health worker training are not necessarily appointed in HP/SHP in their community. This must be reemphasized and made in regulation to fulfill the object of this program to provide better health services in the community. TH, TBA, FCHV and PCDV have been trained but their quality and performance so far depend on personal enthusiasm that may easily fade away unless regular supervision, refresher course and community support are institutionalized. Not only preventive and promotional works but also curative care skills and material supplies are key factors for CHWs to gain trust and support from community people.

Outcomes

4. Infrastructure development

- 1) Increased water supply (52) & toilets (61) to
schools & HPs, better hygiene practices at
school, increased girls enrollment
- 2) Increased schools(7), hostels(2), library(1),
training center(1), &HP/SHPs(2) buildings
Renovation of VDC building(1)
- 3) Construction & management (user) committee
formation: limited capacity building & cost
sharing

Infrastructure development is important to make the health promotion more effective and provide opportunity for the community to organize collective learning and action process. People can be encouraged when they can see the concrete result of their collective efforts and learn various skills for future development and self-reliance. Committees' capacity has to be built more to function as intended. They need to have more leadership capacity and political-efficacy to organize community people and negotiate with DDC, VDC, and local line agencies.

These programs have produced several impacts on health related issues, especially at schools. All these infrastructures have to be well maintained and those numbers have to be increased more to reach the goal of creating a healthy community. Other types of infrastructures closely related to the people's life and health have to be considered.

Impacts on Health

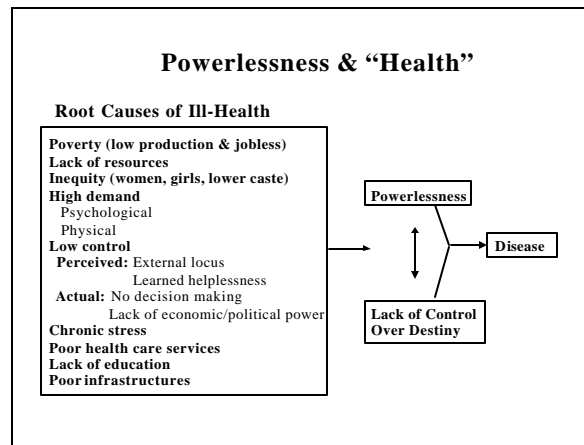
- CBR: 32.5 (national/rural= 38)
- Contraceptive prevalence: 22.9% (0%)
- Immunization coverage: 90.8% (41.7%)
- Diarrhea incidence: 23.2% (90%)
- Usage of modern ARI therapy: 25%
- Average number of ANC: 1.09 times

Immunization coverage has been dramatically increased. SHGs and Child to Child clubs actively participated especially on the National Immunization Day (NID). Other quantitative data shows some improvement, but they need to be improved further. School hygiene and students practices have been improved, but at their homes and in the community as a whole, hygiene level is still low. Some increase of referral patients to HPs/SHPs from trained THs and CHWs is seen but needs to be greatly improved. The idea of Antenatal Checkup (ANC) has been gradually accepted, but more work is needed to reach 4.0 times that WHO recommends during pregnancy. More health promotion and TBA skill training and their supervision need to be organized.

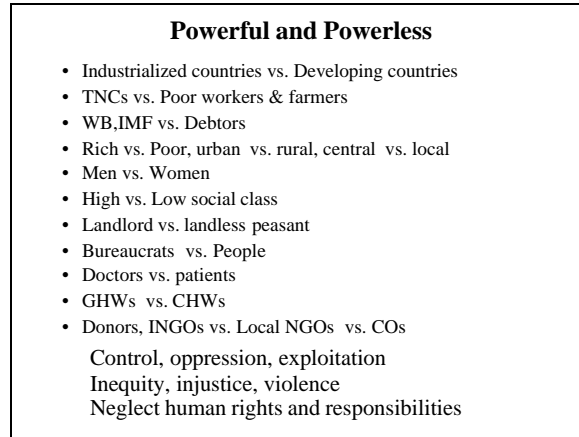
“Health with All” and Empowerment

Concept of Empowerment

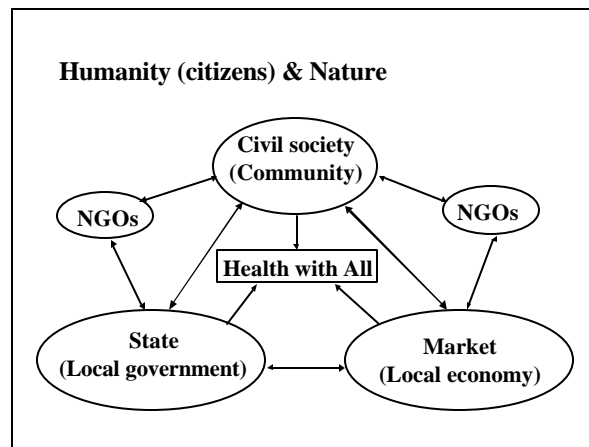
We have studied that the individual, community and national ill-health are rooted in powerlessness. This powerlessness has to be challenged and transformed to accomplish “Health” and “Health with All” This whole process is empowerment. Before going into the empowerment evaluation of SCHP, we better review empowerment, its concept, methods and indicators.



In entire human history, always the powerful and powerless, and haves and have-nots have existed in the society.

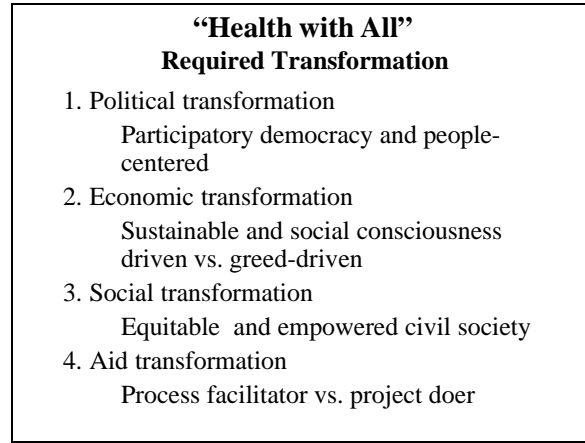


Control, oppression, exploitation, social injustice and inequity have been prevalent in various manners in these societies. Because the powerful are also too powerless to change their value and behavior to have empathy and serve for the fullness of all humanity and the preservation of nature.

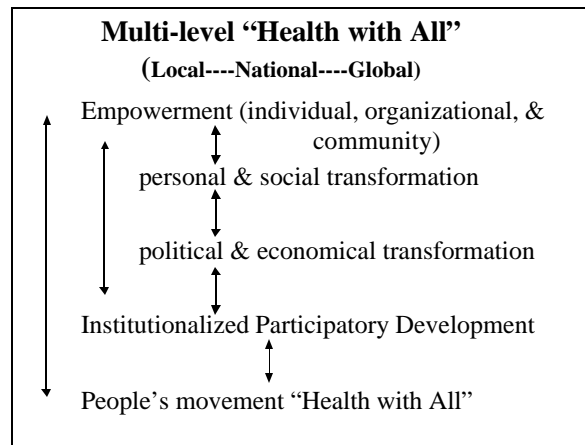


All the levels of Civil Society (from household to the global) need to be empowered to change the current power leverage in all levels. State's power is based on the authority and armed forces and Market's power is based on the capital. Since they are supposed to serve civil society, both have responsibilities to fulfill the social and human development of all humanity, not only for a few rich. But unless state and market sector is also empowered, transformed from self-centered and greed-oriented way to the people-centered and humanity-oriented, only empowerment of civil society sector will cause win-lose results and true collaborative network building and institutionalization of participatory development process will be difficult.

To institutionalize the “Health with All” process, all the sectors have to be transformed. These are the required transformations in each sector.

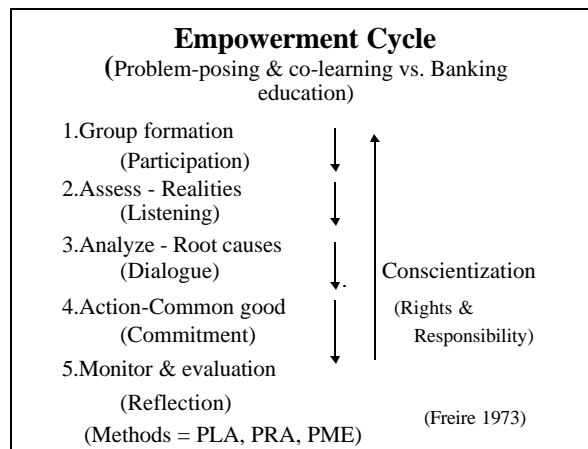


Empowerment, transformation and Participatory Development of all sectors in all levels of society will enhance each other and lead to the true “Health with All”.



As previously described, these processes are required in all levels from local community level to national and international levels. Otherwise all the efforts of local empowerment programs will continuously localized, fragmented and have difficulty in their sustainability and scaling-up.

Methods of Empowerment



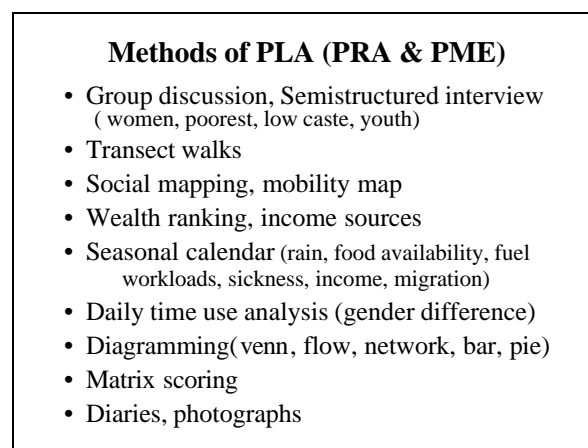
Empowerment occurs when people increase their capacity to act individually and collectively with others to affect change. Capacity building results from an ongoing and repetitive cycle of assess, analyze, action and reflection cycle (Purdey, Adhikari et al. 1994).

Participatory learning and Action (PLA), Participatory Rural Appraisal (PRA), and Participatory Monitoring and Evaluation (PME) are members of growing family of approaches, methods and behaviors for empowerment. They enable people to share, enhance and analyze their knowledge and reality of life and conditions. They enable them to plan and act for change, and monitor and evaluate for the next cycle (Chambers 1994; Chambers 1994; Chambers and Blackburn 1996; Leurs 1996; Guijt and Gaventa 1998).

These approaches help people to see and realize the realities, understand their rights, and analyze the root causes of their realities. These conscientizations lead them to accept their responsibilities to change those through planning, action, and monitoring collectively.

Group formation around special interests according to their priorities of their needs will be the first step. They may be related to natural resources, agriculture, women, health, or other (Chambers 1994).

The main methods of PLA are as follows. These are using codes to visualize the reality so even illiterate people can join in the recording and analysis.



Groups must be inclusive especially paying attention that women and the poorest are always involved and heard equally in either the same or separate group. Groups and organizations should also be formed, not only in rural community but also among different sectors or different levels. They could be the forms of forum, workshop, alliance or federation. Groups will be the place in which listening and dialogues take place face to

face as partners. Groups are the space where learning and action cycle functions and empowerment and transformation will yield equally in all the members of the group.

There are various entry points of group formation and empowerment cycle.

PLA applications
1. Natural resources management Watershed, Land policy, Forestry, Fisheries Wildlife reserve, Village resource plans
2. Agriculture Farmer participatory research, Irrigation, Livestock and animal husbandry, Markets
3. Poverty and social programs Adult literacy, Savings and credit, Income-earning, Women and gender, Selecting poorest, Participatory poverty assessment
4. Health and food security Water, Sanitation, Food security, Nutrition Assessment, Health assessment, Health services

It must be kept in attention that participation has various level of intensity. The end-point of process and outcome of participation should be at least the level of self-mobilization or the level of full liberation to be able to institutionalize the movement. In these levels, people's collective will for equal and just society would be reflected on the state and market policy and direction.

Intensity of Participation
1. Information-sharing
2. Consultation
3. Functional
4. Interactive
5. Self-mobilization for development
6. Liberation (active in advocacy)

“Health with All” and Participatory Development

Concept of Participatory Development

“Health with All” is the process and outcome of the part of a new paradigm of Participatory Development. Participatory Development requires full level of participation of all citizens, especially of poor, women, and deprived majority, as it is a basic human right. This paradigm has different values and approaches from the traditional one.

Participatory Development ("Health with All")

Shift from growth to people-centered
growth to sustainability
growth to equity and justice
top-down to bottom-up
standard to local needs based
blueprint to process
recipient to partner ('for' to 'with')
charity to rights and responsibility

This shift can be possible through empowerment of all levels of Civil Society and by institutionalizing this new development paradigm. Participatory Development is also aiming self-reliant and sustainable social and human development.

Those are the objects that rural people are seeking (Burkey 1993). These three aspects will be the people's fulfillment as human beings (Uphoff, Esman et al. 1998).

Objectives of Participatory Development

1. Productivity
Improve sustainable rural economy and
Agricultural production- increase income
2. well-being
Quality of life, health, education, environment
Self-worth, dignity, opportunity
Equity, justice, cultural diversity
3. Empowerment of all levels
More control and influence on polity
Resist economic and cultural invasion

Institutionalization of Participatory Development ("Health with All")

Sustainability and scaling up of any development is the serious question that has to be answered. Building a sustainable self-reliant development needs to institutionalize Participatory Development as a new value and system. All the sectors of all the levels have to be transformed and built in close collaborative linkage with full commitment to this common goal. In micro-level, rural civil society, local government and line agencies, NGOs and business people together should have forums, workshops or set-up regular meetings as a first step. In macro-level as well, those from all the sectors should have common space to start dialogue and the Empowerment Cycle.

Who will initiate transformation? State and Market sectors have a fundamental weakness because their current value system is against the one that "Health with All" and Participatory Development are based on and aiming at. Civil Society is representing the value of equal fullness of humanity of all. Increased power of social capital that is its norms and organizations of Civil Society would influence and induce the better responses from other two sectors, and ultimately lead to their own empowerment and transformation.

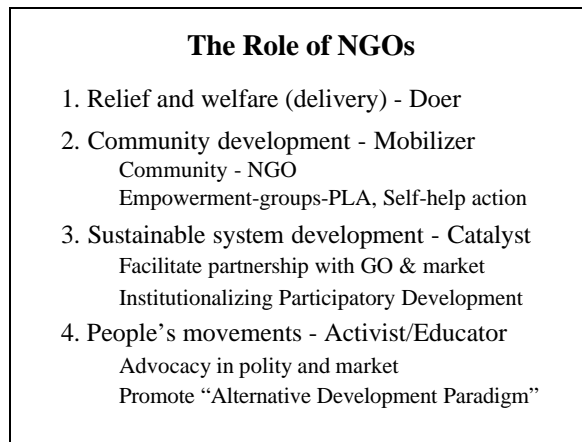
For institutionalization of Participatory Development, each sector must exert its own responsibilities and commitments.



“Health with All” and NGOs

The Role of NGOs

Empowerment of powerless community and institutionalization of Participatory Development may need external facilitation and assistance.



Korten has proposed four generations of NGOs according to their level of functions (Korten 1990). These generations show the evolution of NGO’s vision and function. They moved from narrowly focused and symptom treatment type to comprehensive, more root causes attacking type. These generations also show the expansion of involvement of more actors and larger areas and systems. Along with this evolution of NGOs, increased intensity of participation and empowerment of civil society are required and aimed. The second generation is focusing more on community empowerment. Third generation is more on institutionalization by building network (linkage) with other sectors to collaborate and mobilize more resources for sustainability and scaling up. These local transformations brought by third generation activities have to be propagated across every sector in every nation to attack and change the fundamental root cause of ill-health that is the wrong value and its supporting systems.

The fourth generation NGOs will function to facilitate people’s movement in national and global level. This generation is important to solve the basic weakness of most of previous NGO initiated development programs which are localization and fragmentation without influence and change on larger area and system. Participatory Development needs to expand from micro-level to larger levels. This must be achieved primarily through the power of values, ideas and communication links. The job of the fourth generation NGOs is to

coalesce and energize self-managing networks. It is becoming clear that there is a need to mobilize a people's movement around the value of a people-centered Participatory Development. The NGOs that accept this challenge will be well advised to move rapidly in building alliances with other people's movements that deal with related elements of global crisis (Korten 1990).

The Role of Support Organization

The second, third and fourth generation NGOs can be called as Civil Society Support Organizations. They bear increasingly important roles in empowering Civil Societies toward Participatory Development. Its name emphasizing the function of NGOs as facilitator and catalysts supporting Civil Society's own empowerment. According to Brown's definition, Support Organizations are independent, value-based, civil society organization whose primary tasks are to provide technical services such as training, research, information, advocacy, and networking to empower their Civil Society constituents to accomplish their missions (Brown and Kalegaonkar 1999).



Bridging between CSOs and the institutions of other sectors, like government agencies or corporate actors, is the important role of support organizations. Bridging organizations help CSOs learn how to influence government policies and programs through advocacy. Bridging organizations may also promote corporate initiatives to join civil society and state. In transmitting knowledge, resources, and concerns across sectoral boundaries, these support organizations act as catalysts for inter-sectoral activities. In these processes, they help to reduce sector parochialism and restricted focus. Linking CSOs to market actors is relatively a new idea in most countries, since the role of business as a development actor has been emerging only in recent years. Bridging organizations provide information and orientation to both business and civil society actors, identify possibilities for mutual gain, and mediate agreements to realize those gains.

Network, federations or alliances would provide wider space and more opportunities for people to discuss and share understanding the development issues. They would also encourage coordinating strategies to influence policy and resolve those issues. Federations and alliances among CSOs can increase social capital and power to give impacts on all the sectors well beyond the reach of individual organizations.

These new process and systems have to be institutionalized step by step to sustain the momentum of new movements, Participatory Development and "Health with All". Global civil society and other sectoral actors in states, market and international agencies have large responsibilities to put new development paradigm on the track and provide favorable space for poor peoples in poor countries to develop themselves to attain the fullness of humanity as their rights.

The Role of Field Facilitators

NGOs and support organizations that are working with scattered rural community far from capital must have dedicated field workers elected from their communities. They must have firm commitment to all the people in the community and also to the value and objectives of Participatory Development. Many different

names have been given to those facilitators in different programs. This is a list of works of field facilitators in the community.

The Role of Field Facilitators for Participatory Development

Social motivator, Cluster officer, Group organizer, Community organizer, Institutional organizer, Field facilitator, Banker on bike (They are from community)

- Firm commitment to community
- Facilitate empowering process
- Motivate, mobilize and organize rural people
 - Group(cooperative, self-help, clubs) formation
- Create self-management capacities for self-reliant development
- Maintain mature support to sustain process

“Health with All” and Measurement

Indicators of Empowerment

Good indicators have to be developed to evaluate the progress toward the goals of empowerment, institutionalization and global advocacy movement of Participatory Development and “Health with All”. Empowerment can be defined in different levels for analysis and practice, for example, individual, organizational and community. Empowerment of each level is strengthening each other and it is also both a process and an outcome (Schulz, Israel et al. 1995). In larger perspective, progressing toward institutionalization and national and global advocacy movement may be a stage included in empowerment process itself. The definition of empowerment is “a social-action process that promotes participation of people, organizations, and communities towards the goals of increase individual and community control, political efficacy, improved quality of life, and social justice.”(Wallerstein 1992)

Power attained through the empowerment cycle is not the power over others, but it is the power to work with others as equal partners.

Individual empowerment can be seen through qualitative indicators of perceptual and behavioral transformations listed below. Those can be used as the indicators of outcome of empowerment and also as those of process in which empowerment is progressing.

Empowerment

Multi-level concept

1. Individual
2. Organizational
3. Community

↓ ↑

Indicators of individual empowerment

- 1) Increased sense of rights and responsibility
- 2) Increased resources and skills for action
- 3) Increased self-esteem, self-efficacy
- 4) Increased critical-thinking, decision-making
- 5) Increased empathy, action, commitment
- 6) Increased participation and influence on group
- 7) Increased well-being

Empowered organizations are those which develop and exert influence in the larger community and society to promote system-level changes. A competent community is one whose members and organizations

within it can collaborate effectively in identifying problems, can reach consensus on goal and strategies, and can cooperate in the necessary actions to acquire internal and external resources to solve those problems. Critical thinking about the social context through listening and group dialogue unites people as members of a community to transform inequitable social relations that are root causes of one's situation in society and ill-health. An empowerment process would also increase the intensity of participation in that people demand changes in systems. So they would receive redistributed power and resources from the larger society.

Indicators of Organizational Empowerment

- 1) Increased empowered individuals
- 2) Increased self-efficacy, group-bonding
- 3) Increased democratic management
- 4) Increased critical-analysis, decision-making
- 5) Increased empathy, collective action
- 6) Increased resource mobilization
- 7) Increased network and collaboration
- 8) Increased influence on community & system
- 9) Increased well-being, equity and justice

Indicators of Community Empowerment

- 1) Empowered individuals & organizations
- 2) Sense of community, empathy
- 3) Critical analysis, decision-making
- 4) Collective community action
- 5) Resource access & mobilization
- 6) Larger networks & collaboration
- 7) Influence on larger society & system
- 8) Increased well-being, equity and justice

Group-bonding and sense of community with empathy are the first features of empowerment. Cohesive and functioning group and community have to be seen. They function using the Empowerment Cycle of analysis-action-reflection. They would start to interact actively with other actors for collaboration and resource mobilization. Their influence will spread to other communities and even to the larger societies and systems. Ultimately they would attain aimed goal of fullness of their humanity.

Indicators of Institutionalization

Empowered civil society (organizations or communities) moves to demand institutionalizing the Participatory Development involving other sectors creating collaborative working relationships. For institutionalization, the first step is to organize the spaces for every actor to participate in the Empowerment Cycle, listening, dialogue, critical thinking and action as equals. Civil society that could institutionalize their Participatory Development would be further empowered to exert more influence and advocacy to a larger national and global societies and systems. One of the scaling-up types of empowered and institutionalized organizations and programs is to broaden indirect impact to affect the behavior of other actors. Indirect impact can be through training, advocacy, knowledge creation, or advice. Targets can be other CSOs, state agencies, from the local to the international level, and private for-profit business such as banks and transnational

corporations (Uvin, Jain et al. 2000). The aim is to change the value and behavior of these actors in ways that proceed to the goals of the civil society and benefit the poor majority.

Indicators of Institutionalized Participatory Development

- Empowered individuals, organizations & Communities
- Continual innovation - learning process
- Resource mobilization - self-reliance
 - internal and external (GO, Donors, business)
- Mature intra and intersectoral network
 - from dependency to partnership
- Diversification
 - functional, horizontal & vertical integration
- Scaling up
 - coverage, size and larger advocacy role

These indicators are both for the process and outcome. Institutionalized Participatory Development is moving forward fulfilling those criteria and will have those characteristics as outcome.

Evaluation of SCHP as “Health with All”

SCHP and Empowerment

Evaluation of Individual Empowerment in SCHP

- Women:
- Students:
- Men, farmers
- Poorest, widows, youth
- Infants, children, girls, elders, disabled
- CHWs (TH, TBA, FCHV, PCDV)
- Gov. officials, Gov. HWs
- Word committee, VDC, DDC members
- SCHP field facilitators
- SCHP staffs

SCHP is especially focused on women’s SHGs and school children’s Child to Child clubs for group formation and starting the Empowerment Cycle using PLA methods. But although other individuals have opportunities to receive training and education, or to be involved in various activities, they have not formed any particular groups or organizations where they can continue to be empowered. In those cases individual empowerment has been very limited and depended on their personal strong and good will. Especially community health workers, like TH, TBA, FCHV and PCDV, need continuous supervision, training, material, and mental support from public health services and communities. They need not only those vertical integration but also horizontal peer group formation or inter-village communication. Some of the impacts on women’s empowerment are evaluated as follows.

Impacts on Women's Empowerment of SCHP

- Open sharing of views and ideas
- Economic security, Access to resources
- More decision-making
- Developed leadership quality
- Participation in public affairs

Women are particularly empowered, because they formed groups for ALC and increased sense of bonding and self-efficacy through kitchen garden building. They have started savings and credit activities and improved their access to the resources. They have started further activities in the community and even visited other villages to facilitate their empowerment. But they need more empowerment for the next step of institutionalization of process. They need to interact with other groups inside and outside of community, and improve political efficacy to start dialogue with local government members and line agency officials especially for further resource allocations, funds, material, training and for improving legislation favorable for women. SHGs needs to communicate with Child to Child clubs and teachers to support each other for better health promotion in their communities.

Men and farmers need to participate in group-activities to be empowered for the transformation of themselves, the community and the larger society. They can initiate the change through agricultural production related activities. Men who have participated in infrastructure development program gained skills and self-efficacy. They could find better job, and more income personally and for their family. But they have not formed organizations yet. Local elected bodies (Ward, VDCs and DDCs) and line agency officials also have to be empowered to be transformed to be more sensitive to local people's needs and to exert their responsibilities to support community requests and efforts. All these actors need to gather together around each specific needs and interests of community people. They can be official regular meetings, forums or workshops. Those have to be inclusive and participants have to be equal partners. Women, poorest and lower social class people have to be always included and heard.

Evaluation of Organizational Empowerment in SCHP

- Women's SHG
- Child to Child club
- Committees
 - School management, Water-user, Health
- Gov. health care system(PHC, HP/SHP)
- VDC, DDC, Line agencies
- NPC & Central line ministries
- SCHP support office
- NGOs, Donors, UN agencies,
- Market(local, TNC)

In a rural community, individuals are more easily empowered in the groups through interaction with others and collective actions (PLA). Women's SHGs, Child to Child clubs and various committees have been formed in SCHP programs and facilitated the empowerment process within the groups. They have reached the various level of empowerment. Other groups are not particularly focused and introduced PLA approaches. All

of these groups and institutions are particularly important for “Health with All”. Some of them have resources and control over the current political and economical systems and constrain the Participatory Development. Without institutionalizing Participatory Development by involving those groups to participate as partners of the poor majority sustainable human and social development will never succeed. More over macro-level market and political power as deepest root cause of global inequity and ill-health have to be challenged to transform their value and systems and participate in Participatory Development and “Health with All”.

Community empowerment in SCHP have to be further developed by involving men to form groups around various needs that are given priorities by community. Those needs are especially more in agricultural production related issues, like irrigation, soil preservation, forestry, agricultural technology training, animal husbandry, other income generating activities, water, sanitation, road and bridge building. Groups’ capacity and competence building have to be facilitated. External resource mobilization has to be encouraged through bridging them with other sector actors for collaboration.

SCHP and Institutionalization

Institutionalization Level of SCHP	
1. Empowered organizations	Women’s SHGs(157/168) and C to C clubs(28/84) Some management & user committees
2. Continual innovation	Some among SHGs & C-to-C clubs
3. Resource mobilization, self-reliance	Share construction & maintenance cost Small savings & credit, CHWs, skilled laborers
4. Mature intra and inter sectoral networks	Need more with CBOs, DDC, line agencies, NGOs
5. Diversification	Need more programs for production & environment
6. Scaling up	Need more political efficacy and advocacy

When the Participatory Development programs in the community and region are institutionalized they may show these characteristics written above as processes and as outcomes. Those having more of these characteristics will have better chance of becoming sustainable Participatory Development programs. In SCHP, women’s SHGs and school children’s Child to Child clubs are two main groups that are to be empowered. But those are the only part of large community. Unless community as a whole is further empowered by forming more groups involving men, youth, out-of- school children etc, around various interests, institutionalization level of “Health with All” in the community won’t be strong enough to be self-reliant and sustainable. Since SCHP has characteristics of both NGO and ODA, it was in better place to build inter-sectoral collaborative networks bridging communities to government, other NGOs and business sector. From the beginning of SCHP, facilitation has been intended to build capacity in both communities and local governments. Effort has been focused in human development especially in women, children and community health workers. At the same time staffs and facilities of PHC center and HPs/SHPs are strengthened to be more accountable and responsible for providing better health services and support community efforts as external resource. DDC and DHO continue to have highest responsibility for Participatory Health Development (“Health with All”) in the region. They have to be empowered and take a very important part of institutionalization as a coordinating body and resource institution. Once institutionalization of local Participatory Health Development (local ”Health with All”) is established, local “Health with All” would be able to form alliance and start scaling up to influence a larger society and system to move to national and global “Health with All”.

Recommendations to SCHP Programs

Recommendations for each program components of SCHP are as follows.

Recommendations

1. Women's empowerment

- 1) Literacy: need to continue more ALC
need classes for out-of-school children
- 2) SHGs: need more facilitation and support for
further empowerment, follow up of saving &
credit activities, capacity training, network &
linkage building within and outside the
community
- 3) Kitchen garden: refresher training, support
from DAO for more production & marketing

Recommendations

2. School & community health promotion

- 1) Child to Child clubs: follow-up, more training
of FA kit, interaction with parents & SHG to
improve household & community sanitation
- 2) School de-worming: coordinate with DHO,
expansion to out-of-school children & whole
community, strengthen school committee
- 3) Community health awareness: application of
PLA for toilets, hygiene practice, water source
protection, sanitation, more ANC, male
awareness of AIDS, more on nutrition, &
strengthening water user committee & health
committee

Recommendations

3. Human resource development

- 1) TH, TBA, FCHV, PCDV: increase number of
trained personals, more supervision & support
from PHC, HP/SHPs & GHWs, strengthen
health committee & community support, more
curative skill & drug supply, regular report
system
- 2) Skilled-laborers: refresher training, group-
formation, collective action for community,
job making, community support, training
women's skill
- 3) Scholarships for qualified health workers:
increase numbers, secure their work at
HP/SHPs in the community, encourage
continuous commitment to & support from
community

Recommendations

4. Infrastructures development

- 1) Refresher training for skilled laborers
- 2) Strengthen management(user) committee
secure maintenance cost sharing
- 3) Need skilled laborers group(team) formation for
trainers training, coordination with
management(user) committee for
maintenance & program expansion, access to
resources & participate in planning
- 4) Need to train women's skills for this program
to participate more actively

Those recommendations are focused on improving effectiveness and efficiency of each program. But those individual programs have to be integrated with programs of other groups and other sectors for more comprehensive and institutionalized Participatory Development. SCHP staffs and field facilitators have to monitor the entire process with the indicators of empowerment and institutionalization toward the goal of "Health with All". Every effort needs to be done to bridge them to other sectors to build collaborative network. Every actor needs to learn human rights and to share responsibilities and their resources.

Summary

Evaluation on Goal of SCHP

Goal: Creating healthy community by

1. Improving living condition

- Improved infrastructures(water, toilet in school)
- Improved health awareness and practice
- SHGs' credit and income generation
- Increased skilled laborers

2. Providing better health services

- Supported PHCcenter, HP/SHP, NID, C to C clubs, Health education, Scholarship for HWs
- Trained TH, TBA, FCHV & supply FA kits

Outcomes of four programs of SCHP are sort out according to two initial objectives in the list above. First object of improving living condition is a wide concept that may include many different issues of rural community and people. Each of the root causes of social, economical and political powerlessness has to be challenged and acted upon. The more the total sum of these transformations become, healthier communities can be created defined as physical, mental, social and spiritual well-being. Horizontal and vertical integration of any program has to be kept in mind for transforming the powerful system and value that are the root cause of those root causes.

Better health services can't be accomplished only by the efforts of community and poor people. Public health services continue to have large responsibility to respond to people's needs and work with people in difficult conditions. Together the community, local government, and support organizations have to coordinate their activities especially to continue capacity-buildings of CHWs through frequent visit, supervision, refresher course and regular sufficient material support. The job-description of PHC and HP/SHP and their staffs for these works have to be clarified and systematized. And necessary funds and staffs must be allocated. Community must organize functional health committee or larger development management body to institutionalize community support to CHWs' activities with financial cost sharing and regular meeting with

CHWs. They need also regular meetings with support organizations and GHWs, local governments and line agency officials. Those actions will drive communities, districts, and nation further toward a healthy community, “Health with All” in all levels.

General recommendations to SCHP are the large frameworks of SCHP to support empowerment and

General Recommendations for SCHP
1. Multi-level empowerment
1) Facilitate more group formation and PLA for agricultural production, education, health, nutrition
2) Facilitate participation in more decision-making (Ward, VDC, DDC level)
2. More self-reliance and resource mobilization
1) Savings & credit for more production & job creation
2) Facilitate internal & external resource mobilization (human, financial, & technological)
3. More network building and advocacy role
1) Facilitate intra & intersectoral collaboration & partnership with all related actors toward multi-level “Health with All”

institutionalization of local “Health with All”. When SCHP scales up to a larger area and level, it would increase the capacity of advocacy to accomplish “Health with All” in a larger level of society. For this goal, SCHP needs to make effort to build alliances and networks with other support organizations in national and global level. Empowering global Civil Society and raising people’s movement toward new paradigm Participatory Development and “Health with All” as rights and responsibilities of all humanity should be the ultimate goal of all development and aid programs.

Acknowledgement

Finally I would like to thank Japan Medical Association and Takemi Program that gave me this special opportunity. I am very grateful to all the faculty members and staffs of Harvard School of Public Health and other schools in Harvard University who gave me this wonderful year of research. Especially I owe very much to Director of Takemi Program, Professor Michael R. Reich and my advisor Professor Iain W. Aitken who have been so patient and given me continuous encouragement. And also I have to say that my year has been blessed so much through fellowship with other Takemi Fellows from all over the world. May God bless all of their future works with people.

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