

Public health and peace building in Nepal

The unexpected departure of the Maoist Government in Nepal brings uncertainty for peace and public health efforts in the country as it recovers from a 10-year civil war. Thomas C Tsai reports.

On May 4, 2009, Pushpa Kamal Dahal, the Maoist Prime Minister of Nepal, resigned, adding yet another stage to the transformation of Nepal from bullets to ballots.

The Maoists had initiated a legislative agenda to “secure rights for all minority people in Nepal”. Politicians and everyday Nepalese alike spoke of the “New Nepal” with great promise, and health as a human right became a central component of that promise. But with the resignation of the Maoist cabinet, after only 9 months in power, and the ensuing impasse in forming a coalition government led by the new Prime Minister Madhav Kumar Nepal, it remains to be seen if promoting public health will still be a priority.

Since the cessation of the civil war in 2006, Nepal has seen a large influx of development aid, with around US\$700 million committed for fiscal year 2008–09—a substantial proportion of its \$3 billion budget according to the Ministry of Finance. When the Maoist party announced its budget in September, 2008, it was accompanied by the slogan “New Nepal, Healthy Nepal”.

Nepal has committed to meeting the Millennium Development Goals (MDGs) by 2015. Already faced with a large disparity in health outcomes between urban and rural, high caste and low caste, Nepal’s progress towards the MDGs is further challenged by its precarious political situation.

Nepal offers an intriguing case study of the challenges of meeting development and public health goals in post-conflict countries. According to Claude Bruderlein, the director of the Humanitarian Policy and Conflict Research Center at Harvard University, Cambridge, MA, USA, “Nepal is not a standard case. In order to understand public health in Nepal it is important to

stay above the cynical view of Nepal as a failed state and below the development narrative of the ‘New Nepal’. The truth is somewhere in between.”

The case of Nepal illustrates how political legacies and social forces mould the public health agenda. Most

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importantly, it shows that health is a transformative political issue and a cornerstone to successful peace building.

Nepal was a Hindu monarchy until 1991, when constitutional reforms established a parliamentary system that nevertheless left the monarch with substantial political and military power. As a consequence of the monarchical system, Hinduism was the state religion. Much of the social privilege went to high-caste Nepalese, while many of Nepal’s over 100 caste

and ethnic groups were economically and politically marginalised. Tapping into the widespread discontent of discrimination and inequity, the Communist Party of Nepal began a 10-year civil war in 1996 which ended with the abdication of the highly unpopular King Gyanendra and the formation of an interim government according to the Comprehensive Peace Accord in 2006. The peace accord established elections for a constituent assembly with the purpose of drafting a permanent constitution for Nepal’s new status as a federal republic. In a surprise to the traditional political parties, the Maoists won a majority in the elections in April, 2008, forming a government in August of that year.

As one of the first acts, the Maoists introduced the “New Nepal, Healthy Nepal” budget proposals. “A garden must be managed well if the flowers are to bloom. The Maoists want to create a garden of human rights and social rights for everybody”, says Janardan Sharma, former Maoist Minister of Peace and Reconstruction. Fulfilling that vision, in January, 2009, the Ministry of Health and

The printed journal includes an image merely for illustration

Prime Minister Madhav Kumar Nepal came to power in May this year after the Maoist cabinet resigned

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Reuters/Copal Chitrakar

Nepal has committed to achieving development goals on maternal and child health

Populations announced free maternal care and a transportation subsidy for mothers delivering at government hospitals through its Ama Surakchhya Karyakram programme.

The government was encouraged by the Demographic and Health Survey (DHS), which showed a surprising decline in the maternal mortality rate (MMR) from 539 women per 100 000 livebirths in 1996 to 281 women per 100 000 livebirths in 2006. With the new maternal health programme, the government aims to reduce the maternal mortality rate down to 134 women per 100 000 livebirths to meet the MDG on maternal health. The improvement in maternal mortality despite the disruptions of the 10-year civil war has posed an interesting paradox to international health experts.

"There are very wide confidence intervals around MMRs from the DHS. Nevertheless, it appears there has been a real reduction. I would attribute this to the marked increases in literacy among young women and the associated relative empowerment. These gains are durable and we expect further gains as a result of further improvement in population-level coverage of life-saving services and interventions", says Steve Hodgins, the director of the Nepal Family Health Program, a project funded by USAID and managed by John Snow, Inc.

However, some international health experts doubt the gains in maternal mortality reported by the DHS, attributing the lower MMR in 2006 to under-reporting in rural and less-accessible areas. Underlying the DHS data in Nepal are wide regional disparities in the MMR and other health outcomes. To achieve the MDGs by 2015, there must be more births by skilled attendants and health professionals in rural areas argues Nepal Society of Obstetricians and Gynaecologists, which reports that 85% of obstetricians and gynaecologists are in Kathmandu and other urban areas.

Despite the regional and ethnic inequities, some like Hodgins remain optimistic. "There are certainly constraints—geographic access problems, poverty, lack of accountability in the civil service, human resource gaps. But Nepal also has great resources, most notably quite robust arrangements at the most peripheral level with active female community health volunteers, maternal-child health workers, and village health workers."

With the change in government, it remains to be seen what part health will play in Prime Minister Nepal's administration. As of mid-June, the new coalition has yet to reach a consensus on key ministerial posts. In an interview with the *Kathmandu Post*, a Nepalese Congress official stated that the Congress party wants control of the Ministry of Health and Populations to regain the connection with the Nepalese population. In post-conflict countries such as Nepal, health is not only a human right, but can also be a political prize.

Although the peace and security issues dominate the attention of Prime Minister Nepal's cabinet, the Ministry of Health and Populations is still operating under the *Three-Year Interim Plan of 2008–2010* that lists achievement of the MDGs as a primary goal. "Compared to many developing countries, Nepal has achieved much in the fulfilment of the MDGs", says Mingmar Sherpa, director of Logistics in

the Ministry of Health and Populations. "Primary health care has been taken as a right of the Nepalese people and is in the Nepalese constitution."

Therein lays the paradox of Nepal. Nepal offers many surprises—improving health indicators despite a civil war, a rebel group that resigns after gaining power, 16-h rolling blackouts but free maternal care—all under the blanket of achieving peace. "Development work in Nepal is all about the peace process—addressing root causes and delivering the 'peace dividend', to buy time for the political process to start showing tangible results", observes Robert Piper, the UN Resident Coordinator in Nepal. Yet, the definition of peace remains elusive. Claude Bruderlein cautions, "For the NGOs peace is justice, for the United Nations peace is development, and for the Maoist combatants peace is something you die for. Whose peace should the agenda reflect?"

What Nepal illustrates is that fundamental to any definition of peace is good health. Achieving the MDGs has been the one policy objective that all political players in Nepal can agree on. In Nepal, promoting public health transcends linguistic divides, caste discriminations, and ethnic factionalism. Perhaps that is why, despite being a country with a caste system, a 35% poverty rate, and a 48% illiteracy rate, the Supreme Court mandates explicit antidiscrimination laws for HIV/AIDS. In the post-conflict scenario in Nepal where garbage gathers uncollected in the streets of Kathmandu and a 16-h per day blackout is the norm, the health system has been the last institution to break down. "Any development concept cannot be materialised without health; therefore health plays an important role in the 'New Nepal'", says the Ministry of Health's Sherpa.

Although much attention in post-conflict peace building focuses on the political process, fulfilling public health objectives may very well be the key to successful peace building.

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