SUBJECTS TO CITIZENS:

FROM SAFE MOTHERHOOD TO SAFE WOMANHOOD

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“WHY DID THESE TWO WOMEN HAVE TO DIE?”

No Safe Motherhood Initiative

+

No Safe Womanhood Initiative

DEFINITION

Safe Motherhood

A series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high quality gynecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for mother, foetus and infant during pregnancy, child birth and post partum.

Real Women Talking

Definition

Safe Womanhood:

Eliminating or reducing the effects of critical legal, economic and social risks on the health, welfare and well being of a woman during her entire life cycle. They are a set of experiences assigned to women by history, society, culture and politics which vary across time and space that have to be redressed in favour of women (by women most of the time).

OVERARCHING - RIGHTS FRAMEWORK AND PROGRAMME APPROACH:

- Right to life
- Right to health including SRH
- Right to privacy, liberty and security including right to be free from inhuman or degrading treatment
- Right to be free from discrimination on the basis of race, caste, ethnicity and gender
- Right to Equal Protection of the laws
- Right to reproductive freedom
- Rights relating to pregnancy and childbirth

MILESTONES IN WOMEN'S LEGAL, HEALTH AND SOCIAL DEVELOPMENT

- Convention to Eliminate all Forms of Discrimination against women, NYC (1979)
- Safe Motherhood Conference and Initiative, Nairobi (1987)
- ICPD Declaration and Platform for Action, Cairo (1994)
- Beijing Declaration and Platform for Action on Wome and Development(1995)
- Millennium Development Goals 2000-15
- The World Social Forum, Brazil (2001)
- Sustainable Development Goals (2016-2030) ?

HDI 2013: Peace Dividend?

Table A: Nepal's HDI trends based on consistent time series data, new component indicators and new methodology

	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2005 PPP$)	HDI value
1980	48.2	4.5	0.6	0,566	0.234
1985	51.1	5.5	1.2	0,633	0.285
1990	54	7.4	2	06,33	0.285
1995	57.5	8	2.2	0,811	0.37
2000	61.6	8.8	2.4	0,960	0.421
2005	65.6	8.9	2.7	0,960	0.429
2010	68.5	8.9	3.2	1,090	0.458
1011	68.8	8.9	302	1,137	0.463
2012	69.1	8.9	3.2	1,137	0.463

Table D: Nepal's GII for 2012 relative to selected countries and groups

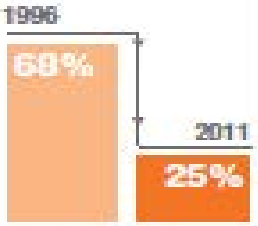
	GII Value	GII Rank	Maternal Mortality Ratio	Adolescent Fertility rate	Female seats in parlimement (%)	Population with at least secondary education (%)		Labour force participatation rate(%)	
						Female	Male	Female	Male
Nepal	0.485	102	170	86.2	33.2	17.9	39.9	80.4	87.6
Srilanka	0.402	75	35	22.1	5.8	72.6	75.5	34.7	76.3
Afghanistan	0.712	147	460	99.6	27.6	5.8	34	15.7	80.3
South Asia	0.568	_	203	66.9	18.5	18.3	49.7	31.3	81
Low HDI	0.578	_	405	86	19.2	18	32	56.4	79.9

EDUCATION + GAINFUL EMPLOYMENT = EMPOWERMENT = GOOD HEALTH AND WELL BEING

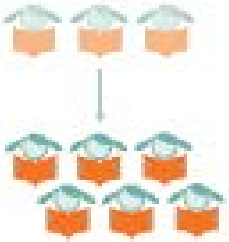
NEPAL'S STORY: IMPROVING MATERNAL HEALTH

CHANGES IN HOUSEHOLD BEHAVIOUR

RISING INCOMES
Extreme poverty ($1.25/day) fell from 68% of the population in 1996 to 25% in 2011



GIRLS' EDUCATION
Women with secondary-school education or higher increased
48%
in the last 5 years

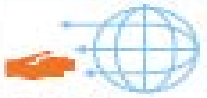


WOMEN'S EMPOWERMENT
Women had an average of
2.6
children in 2011, reduced from almost six in the early 1980s

GOVERNMENT PRIORITISATION

SUSTAINED POLICY FOCUS
Driven by committed technocrats, well-organised civil society, improved data and international attention

INCREASED EXPENDITURE
Doubling of health expenditure per capita between 1995 and 2010, 40% of which was aid



COOPERATION
Close work with international donors and INGOs to increase resources and capacity

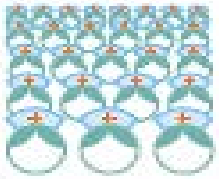
FOCUSING ON DEMAND
Abolishing user fees and providing cash incentives has improved access for the poorest

LARGE SCALE REDUCTION IN MATERNAL MORTALITY

DESPITE DIFFICULT TERRAIN, CONFLICT AND POLITICAL UPHEAVAL, NEPAL HAS – ACCORDING TO MOST ESTIMATES – REDUCED ITS MATERNAL MORTALITY RATIO BY OVER 50% SINCE THE EARLY 1990s

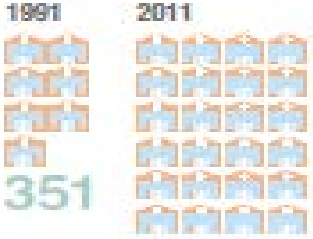
BETTER ACCESS IN REMOTE AREAS

COMMUNITY HEALTH VOLUNTEERS
Addition of almost
50,000
female community health volunteers



DRUGS AND PHARMACIES
Expanding pharmacies in rural areas, enabling mothers to treat illness and increasing access to family planning

HEALTH FACILITIES
Increased number of health posts



ANTENATAL VISITS
Over
50%
of expectant mothers seek the recommended four antenatal visits, a fivefold increase over 15 years

ROADS AND BRIDGES
The road network expanded by
33%
between 1999 and 2008 enabling mothers in remote villages to reach help

FINANCING BETTER MATERNAL HEALTH IN NEPAL

1995

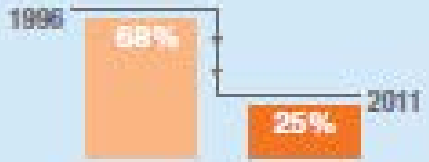
TOTAL HEALTH EXPENDITURE PER PERSON INCREASED FROM $34 IN 1995 TO $68 IN 2011*

2010

HOUSEHOLDS INCREASE HEALTH SPENDING

HIGHER HOUSEHOLD INCOMES

Extreme poverty ($1.25/day) fell from 68% of the population in 1996 to 25% in 2011



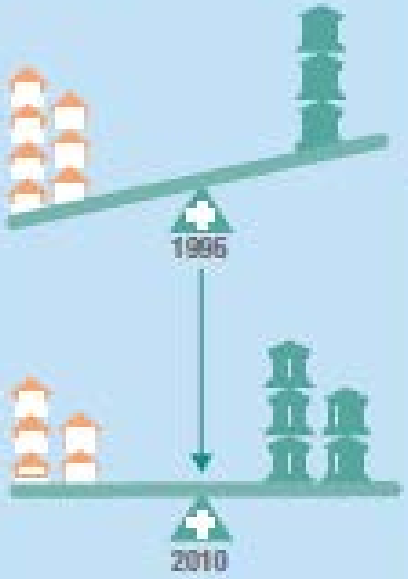
RISING REMITTANCES FROM MIGRANT WORKERS

Remittances now account for over 20% of GDP – over half of households receive them

* CONSTANT 2005 INTERNATIONAL $, PPP

SHIFTING BURDEN FROM HOUSEHOLDS TO GOVERNMENT

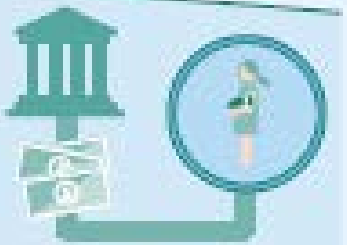
In 1995, households funded 70% – 80% of total health expenditure. By 2010, it was closer to 50%



GOVERNMENT INCREASES HEALTH SPENDING

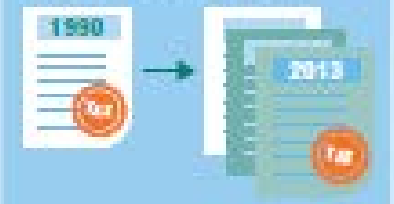
GREATER ALLOCATION TO MATERNAL HEALTH

The Nepali government contribution to a pooled fund for safe motherhood and family planning increased from **NRs 41.1 million** in 2004/05 ($560,000 in 2004 $) to **NRs 562.7 million** in 2008/09 ($8.6 million in 2008 $)



MORE TAX REVENUES AND IMPROVED FINANCIAL MANAGEMENT

During the 1990s, revenue collection was 8% of GDP. Today it is closer to 13%



INCREASED PRIORITISATION BY DONORS

Aid finances around 40% of the health budget. As a share of total aid, spending on health has risen from under 2% in 1990/91 to almost 14% in 2012

MMR in Nepal and regional comparators

Year	Nepal	India	Bangladesh	Srilanka	Bhutan
1990	770 [430-1400]	600 [390–920]	800 [450–1400]	85 [59–120]	85 [59–120]
1995	550 [310–990]	480 [320–730]	560 [320–1000]	74 [52–110]	670 [340–1200]
2000	360 [210–640]	390 [260–600]	400 [230–720]	58 [40–81]	430 [220–790]
2005	250 [140–430]	280 [190–420]	280 [190–420]	44 [31–62]	270 [140–490]
2010	170 [100–290]	200 [140–310]	240 [140–410]	35 [25–49]	180 [95–320]
Total change (annual change)	78% (3.9%)	66% (3.3%)	70% (3.5%)	58.8% (2.9%)	82% (4.1%)

Source: MMEIG MMR = deaths per 100,000 live births

POWER

Powerlessness of women in my professional experience is a serious health hazard. Women have to fill this prescription themselves and keep a sustainable stock of it and their **self esteem".**

My advice is to take as much as you can get (and where you can get it). There is **no risk** of over dosage, and there are no (real) side effects.

SAFE WOMANHOOD: THE REAL PEACE DIVIDEND

- National Safe Motherhood and new born plan 2006-2017
- National policy on SBA 2006,
- NHSP 1 and II (2006-10-15)
- Adolescent Health (ASRH) strategy (1997), programme 2006-
- The Nepal Demographic Health Survey (NDHS) 2006 and 2011
- Gender Responsive Budgeting 2007/8
- FCHV Programme Strategy (2003/4) and Fund establishment (2009/10)
- Aama Programme (2005) Safe Delivery Incentives Programme 2009(SDIP).
- Policy on quality assurance in health care 2010
- Health sector gender equality and social inclusion strategy 2010
- One Stop Crisis Centres, part of GBV Strategy 2010-15
- RH research policy brief 2011
- The Service Tracking Survey (STS) 2011
- The Benefit Incidence Analysis, 2012
- The Multi Stakeholder Nutrition Plan (MSNP) and the Strategy for Maternal Under-Nutrition (draft 2012) and its training manual 2012/2013
- National Health Policy 2014
- National blood transfusion policy 2014

What did Dilmaya and my Sister have in common?

No.1 Root Cause of Health Risk to Women
Discriminatory Laws in Nepal

"Nepal still had 96 discriminatory provisions and 92 schedules in various acts and provisions, including the (interim) Constitution itself, which has discriminatory provisions (against women) and which provides various rights and responsibilities only to men which (directly) indirectly encourages son preferences.

Substantive discrimination exists in the field of nationality, marriage and family relations, (gender based violence), sexual offence and property rights."

No. 1 Core Problem for Women
SON PREFERENCE
(DHS 1985-1997)

Extreme Preference for Sons: India, Bangladesh, Nepal and Egypt
Pure Preference for Sons: India and Nepal

2012: SON PREFERENCE ATTITUDE IN NEPAL

High: 69%
Moderate: 27%

ISDS, ICRW and CREPHA, Study on Gender, Masculinity and Son Preference in Nepal and Vietnam, 2012

There is significant association between men’s son preference and their gender equitable attitudes (GEM scale) and men’s control (or power) over their wives (relationship control index) in Nepal.

WOMEN'S EXPERIENCE OF DIFFERENT FORMS OF VIOLENCE

- Physical or sexual violence: 26%
- Physical violence only: 14%
- Sexual violence only: 5%
- Physical and sexual violence: 8%

The percentage of women who have ever experienced violence increases with age and this pattern is consistent for most forms of violence across the wealth quintile and caste/ethnicity .

- Violence during pregnancy: 6%
  - Divorced, separated or widowed: 10%
  - Married -Rural areas: 7%
  - Married -Urban areas: 4%
  - Married -Terai: 9%
  - Married Ecological zones - Mountain Hill: 4-5%

NDHS 2011

Early /Child Marriage

•Among women age 25-49, 55 % were married by age 18 and 74% by age 20. The median age of first marriage for a woman is 17.5 and for a man it is 21.6

•The proportion of women married by age 15 declines from 24 % among those aged 25-49 to 5% among those age 15-19 indicating clear evidence of rising age at first marriage

• 47% and 28% of married women who had **forced first sexual initiation** are <15 years and 15-19 years respectively. It's 16% for women who married at 25-29 years.

NDHS 2011

Teenage Pregnancy

At a time when UNFPA released its **annual World Population Report 2013**, the girl, 17, living in Slum of Bagmati gave birth to a child.

"About 1 in 5 girls aged 15 to 19 in Nepal are mothers or pregnant. Yet the vast majority doesn't use contraceptives (86% of married adolescents aged 15-19) and have the highest unmet need for family planning (about 42%, highest in South Asia). Hence the risks of a child giving birth to a child are very high".

Chaupadi and the Practice of *Nachhuni* and *Chokhauney*

- First time *Chaupadi* - 4% in Far West region of Nepal (shed far from house)
- First time *Nachuni* - 37% (dark room/separate room)

On monthly basis:

- Avoid offering/prayers 39%
- Stay away from kitchen 30%
- Avoid physical contact 13%
- Sleep *in Chaupadi* hut 1.4%
- Avoid touching plants 9%
- Sleep in separate room 8%

Sex Selective Abortion

About 11 percent of Nepali women residing in the border areas visited India for sex selective abortion.

M.P Lamichanne, 2011; D. Subedi 2011;
MD Frost 2013

Alarm Bells: Mental Health

- **262 suicide cases** were registered in Kathmandu alone.
- Of the **348 cases of suicide** recorded in 2010-11, 154 (44 percent) were from the age group of 15-29 while 29 percent were from the age group 30-44.
- **78 % of suicide cases** are due to psychological or mental trauma

The Human Face or Aged Population in Nepal

Ageing

- The elderly account for 7% of the population in Nepal, 6 out of 10 are in their 60s.
- More men than women are alive in the category 60-75 years, after which male mortality exceeds that of women.
- Since 1962 - provision of programmes in the public sector - none of which are operating at optimal level.
- Family models are changing rapidly due to modernisation and migration affecting the elderly especially women.
- National Ageing Survey 2014

Safer Womanhood:
Life Cycle Approach to Empowerment

Overall Context for Health Policy

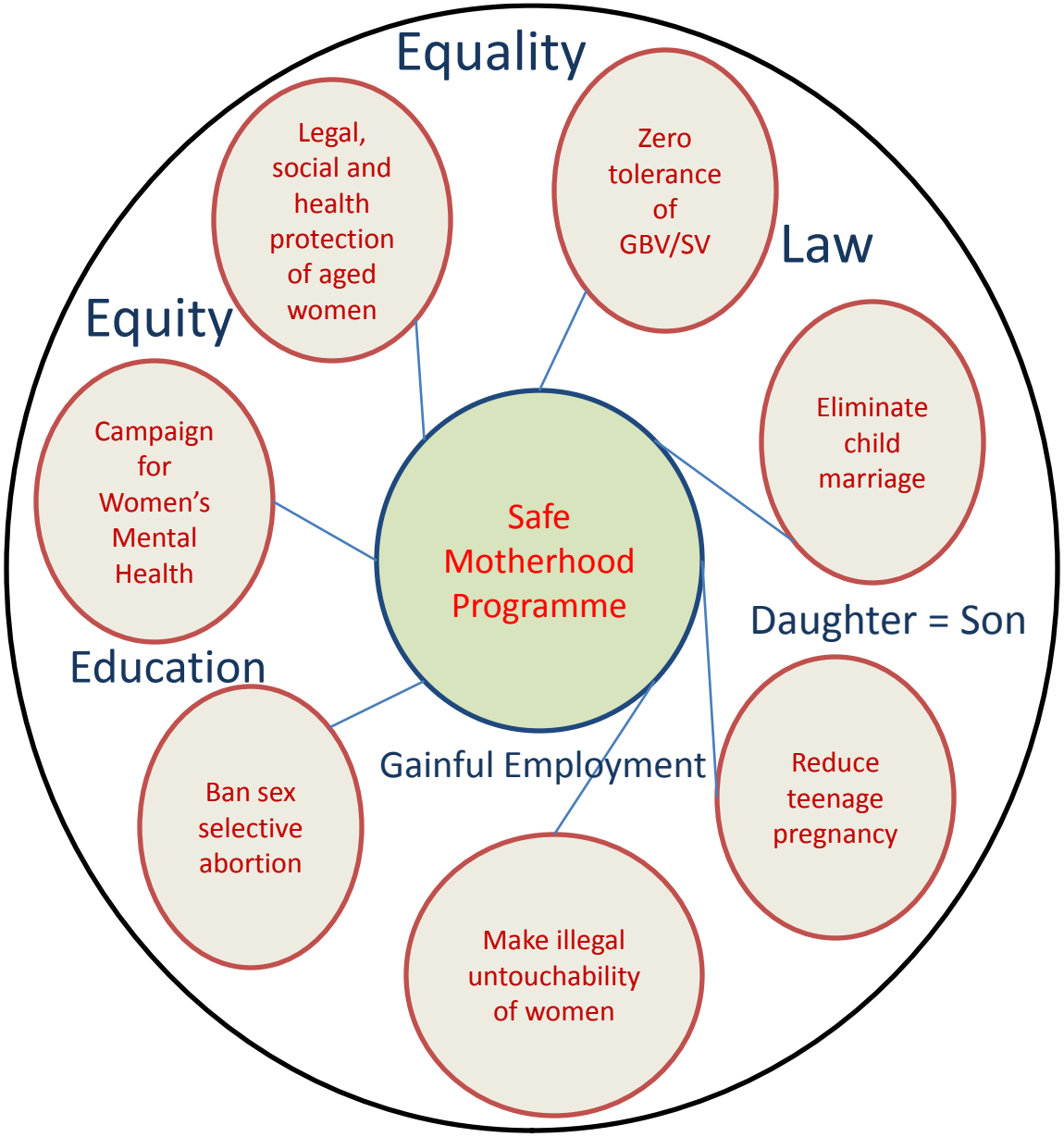
- Expanding health system = financial pressure = attempts by government to ration health care.
- Growing recognition fact: Spending on health care alone does not necessarily improve population health outcomes.
- The focus on life cycle approach in prevention programmes will lead to more widespread interest in the various community models based women centred interventions.
- No choice but to further strengthen multi-sectoral, inter-institutional linkages and on the ground partnerships and meaningful involvement in advocacy and activism by NGOs

Potential Contribution of a Safe Womanhood to Safe Motherhood Initiative

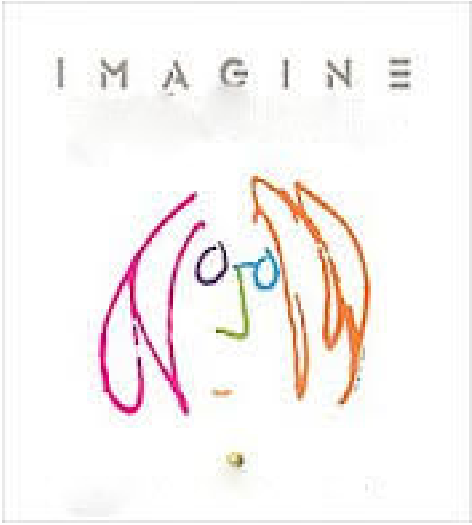
Start with Objectives that will:

- Allow Policy makers to address issues of **resource allocation** in a way that recognises the **differential social and health risk facing women**.
- Increases understanding of which preventive policies would be generally effective in the population as a whole and which policies have to **specifically targeted to minimize women specific social, health and legal risks that affect maternal health**.
- Measures to be taken so that women are active in all aspects of health policy, planning, budgeting programming and service delivery: **Implement fully HR for Health**.

Safe Womanhood



Life Cycle Approach to Empowerment



“What would Nepal be like if, Nepalese women could achieve health as a complete being”?