

Health Sector Gender Equality and Social Inclusion Strategy



Ministry of Health and Population

Government of Nepal

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Forward

Nepal's interim constitution 2063 (2006 AD) has assured every citizen the right to free essential health care by law; hence it is the responsibility of the state to ensure health services are accessible to all citizens. The Government of Nepal, via the Ministry of Health and Population (MoHP) is committed to increasing the access and use of essential health care services (EHCS) by all citizens, but especially by the disadvantaged, marginalized and backward target groups specified by the State. They are also committed to improving the quality of health services, ensuring equal and equitable treatment for all citizens. In this context, Nepal's health sector laws, rules, strategies and programmes have given special importance to Gender Equality and Social Inclusion (GESI). Without considering and including GESI, the health sector will not be able to realize the health goals of the constitution. Thus in recognizing the poor, vulnerable, marginalized castes and ethnic groups, the physically and mentally disabled, including women, children and senior citizens as target groups and to provide services to this segment of the population, it has been deemed necessary to develop a GESI-specific strategy.

This strategy has been prepared to fulfill the health goals of the NPC's Three Year Interim Plan (TYIP). It also reflects significant programmatic contributions to achieving the Millennium Development Goals put forth by the United Nations, which are included in the MoHP's log frame for the NHSP-IP. It is anticipated that through the implementation of this strategy, the state will be able to achieve all the health goals of the NPC, the MDGs and greatly improve the quality of and access to health services.

The process of preparing the strategy involved the participation of policy makers, various development agencies, NGOs, the private sector and other concerned stakeholders through workshops and consultative meetings. We would like to extend our heartfelt thanks to all, especially to those who helped us prepare this strategy: the consultants from RTI International; Ms. Gita Pandey, Mrs. Nicole B. Lubitz and Ms. Bidula Shrestha; support from the Safe Motherhood Program and Mr. Hom Nath Subedi; and experts from the ministry and the GESI unit members who played an active role in preparing the strategy.

Acronyms

NHSP-IP	Nepal Health Sector Programme – Implementation Plan
GESI	Gender Equality and Social Inclusion
EHCS	Essential Health Care Service
SBA	Skilled Birth Attendant
ANC	Antenatal Care
GoN	Government of Nepal
MDG	Millennium Development Goal
PRSP	Poverty Reduction Strategy Paper
NDHS	Nepal Demographic and Health Survey
IEC	Information, Education and Communication
BCC	Behaviour Change Communication
PAMS	Poverty Monitoring and Analysis System
HMIS	Health Monitoring and Information System
NLSS	National Living Standard Survey
e-AWPB	Electronic Annual Work Plan and Budgeting.

I. Introduction

Nepal has incredible diversity based on unique geography, multicultural social norms and values, religions, castes and ethnicities, all which have impacted the socio-economic status of its citizens. Furthermore, the country's existing social and economic disparities, stemming from a hierarchical caste-based structure, patriarchal thinking and geographic and regional differences, have affected the equitable access and use of state-provided public health services, facilities and resources by the disadvantaged and marginalized groups, particularly women and children. Nepal's current low human development index (HDI) is directly related to the visible regional disparity, gender inequality and social exclusion, as experienced by the state's most vulnerable groups.

The health sector has always been considered an important area for social development. Although the state, through various policy programmes, has tried to improve services in this sector and create a sense of social progress, it has been unable to properly identify the real target groups for programme implementation, thus the GESI issue remained a mere slogan. However, with the recently altered political context health has been re-established as every citizen's right. To achieve the state's goals and goals of various international declarations and conventions, ratified by the state (MDG, CRC, CEDAW, Beijing Platform, etc), a strategic programme in this sector specific to the needs of the most vulnerable groups has been initiated.

The MDG declaration calls for creating an environment facilitating the poverty alleviation and for doing so, 18 goals and 21 results have been envisioned most of which deal directly with the health sector. The role of the health sector is crucial in order to make MDG result-oriented. And so, to fulfill these goals, the impetus created by the GESI strategy to mobilize the resources to the disadvantaged groups is undisputed.

1.1. Current Situation and barriers on GESI in the health sector

In Nepal 31 percent of the people live below the poverty line and within this 31 percent, the majority are women, Dalit, Janajati (ethnic groups) and backward communities. Among them are the groups from the Karnali zone, the Far Western region and other remote hills and mountains and the Terai Adibasi (indigenous community). Whether due to poverty, being socially excluded or geographically isolated, these groups have limited access to quality health services. In addition, Nepal's population growth rate of 2.3 percent will place more demand on already limited facilities for health services in the coming years (NLSS 2003).

In the health services that exist, there is an inequality between the rich and the poor in the use of these services. The richest class spends 25 percent more in health care than the ultra poor (Prasai 2006). According to the statistics of the 2006 NDHS, the mortality and morbidity of the poor is much higher than that of the rich class; social inclusion in the health sector takes into consideration poverty along with castes and ethnicity. In other words, poverty can and does exist within the Brahmin (higher) caste from Karnali, and they may face more risks than some other regional caste and ethnic groups.

There is a considerable economical gap between different castes and ethnic groups. Most communities within lower castes and indigenous groups are marginalized and excluded. The majority of Dalits are below the poverty line. Their average life expectancy is half of that of Brahmins and Chhettris, and one third that of Newars. According to the 2006 NDHS, the Dalits and Muslims are low in almost all health indicators.

Analysis of the 1996, 2001 and 2006 NDHS in use of family planning devices, child immunization, diarrhea control, and acute respiratory infection, shows there has been a decrease in inequality between castes and ethnic groups and between the rich and the poor. Similarly the below-five child mortality rate has also considerably decreased between high and low caste groups and ethnic groups and between rich and poor. But there is still inequality between those who use antenatal care and skilled birth attendants (SBA) in delivery. According to NDHS 2006, the increase in the use of antenatal care among the poor population is much less compared to the increase in use of such care by the rich. Similarly, the use of SBAs among the poor is 48 percent while the percentage of use is 57.8 percent among the rich. The use of SBAs among Terai Dalits is 5 percent, and among hill Dalits is 14 percent, while among high castes in the Terai it is 70 percent, and for hill Brahmins it is 38 percent (Bennet/Dahal). In the use of institutional delivery there exists a huge gap between rich and poor, different castes and ethnic groups. Overall, the Muslim community is very much backward compared to other communities in seeking any health services.

In the case of gender, there exists a different kind of problem in the health sector. The largely patriarchic Nepalese society considers women subordinates (second class citizens). The family and society do not give importance to women's health, and in addition, the reproductive cycle is considered their fate. Because of this familial and societal discrimination, women are limited in accessing education, health services and information, especially so for women from marginalized and backward communities; they lag behind in receiving general and maternal health services. Fetus screening and unequal treatment between boy and girl children has affected women's health. Even though many laws have been promulgated to end such discriminations, the religious and social discrimination overshadow the laws, challenging their enforcement. The MoHP has been implementing programmes targeting women's health, resulting in some improvements. For example, the recently implemented free child delivery service has increased the number of women seeking such services. However, there is much more work to be done to be more inclusive, setting aside caste, gender and regional differences/isolation.

There is also a gap between average life expectancy and maternal and child mortality when comparing rural and urban settings. Poor and vulnerable groups are using rural health services where the rich class use mostly urban hospital services.

The remote mountains and geography has physically separated the rural poor who live below the poverty line from many facilities and has created many challenges to the state in providing health services. Although services are free, there are many associated costs that add additional barriers to the poor being able to access them due to the considerable distance that must be covered: transportation costs; food and accommodations if they are forced to spend

the night; and other such costs. Quite simply, the locations of the facilities are not in accessible areas for many in the target group. In addition, in remote and rural areas there is an inadequate presence of health workers and a low supply of medicine and equipment. There is a tendency for NGOs and health service providers to be centered in more accessible areas; the state has been unable to provide proper health facilities to the population of remote and rural areas. Historically, the state also compares the health service delivery in these areas to operational costs. Today's need is not to compare this service with costs but to base it on the geographic diversity and disparity, and on the overall health goals of the nation.

Beyond health statistics and the geographic and economic situation of the target groups, one must also consider the actions and behaviour of the service providers that contribute to the current situation of target groups being unable and unwilling to access services. There is discriminatory behavior by health workers towards the target groups; a lack of female service providers; less responsibility and accountability of the staff towards equitable delivery of health services; a lack of health counseling skills; and a lack of general motivation among service providers. These actions and behaviors have created among the target groups and a lack of feeling of belongingness by the community.

Poverty, a lack of education and extensive illiteracy of the target groups, combined with inadequate information, information not available in local languages, or available service providers not speaking the local languages, has also led to the exclusion of target groups from accessing health services and information. Additionally, traditional thinking, social and religious barriers (such as the passivity of the Muslim communities in seeking health care), superstitions and socio-cultural beliefs (faith healing, witchcraft, etc.) has affected target groups health-seeking behaviour.

The target groups have also been less involved in policy making and have had no orientation on inclusion in health sector policy and strategies; essentially they have been unable to advocate for themselves and participate in the process. In addition, implementation of prepared policy and guidelines has not been effective, and reforms in health policy have not been socially- inclusive specific, further preventing the health sector from becoming fully inclusive.

In summary, the current situation of GESI in the health sector contains many barriers that prevent target groups from fully accessing and utilizing health services: geography; one's social, cultural/religious and economic status; discrimination by health service providers; geographical remoteness; inadequate flow of information; beliefs in traditional healing methods; language barriers, and ineffective health programmes and services.

1.2 Existing Policies on Gender Equality and Social Inclusion

The existing laws, policies, rules, strategies and programmes are provisioned as follows:

Provisions in Constitution, Laws and Acts

Nepal's Interim Constitution 2006 (BS 2063): Nepal's interim constitution has defined that “every citizen will have the right to have free basic health care service as provisioned by the State” and thus has established health as a fundamental right of every citizen. To fulfill this mandate, the MoHP has launched various programmes, making every effort to bring quality care within reach of every citizen. Considering the provision in the Interim Constitution 2006 on December 15, 2006 (BS 2063 Mangsire-29), through a cabinet decision, the Government of Nepal decided to provide essential health care services (emergency and inpatient services) free of cost to ultra poor, vulnerable, poor, senior citizens, people living with physical and psychological disabilities, and women volunteers known as Female Community Health Volunteers (FCHVs) at the level of sub-health posts, primary health care centres and district hospitals.

Local Self Governance Act 1999 (BS 2055): The Local Self Governance Act has provisioned for women, economically and socially backward ethnic groups, communities and Adibasi (indigenous) to be represented in the VDC and ward level development committees, and the handover of the operation and management responsibility of health services to village level committees. But this act does not clearly specify social inclusion and does not consider the very real barriers that largely prevent the target/vulnerable groups from participating. The act does mention women and child welfare, and has programmes for women empowerment.

Right to Information Act 2008 (BS 2065): The Constitution of the Kingdom of Nepal 1990 (2047 BS) was the first constitution to recognize right to information as a basic fundamental right. Although the constitution speaks clearly on this right, the state never took initiative to enact legal instruments necessary to exercising that right.. The Interim Constitution 2006 (BS 2063) has also established rights to information as a fundamental right according to the sentiments of the Jana Andolan (“People's Movement”). As per Article 27, every citizen has the right to ask for information that is of individual and common interest . It also states that citizens will have the right to access information on public institutions/agencies.

Policy and Strategy

Nepal's National Health Policy 1991 (BS 2048): Nepal's National Health Policy 1991 (BS 2048) has defined its objective as providing modern health services through trained health workers at the village level. Under this, in order to increase access and use of services, various public health related programmes such as family planning, immunization, nutrition, malaria, kala-azar, tuberculosis, and leprosy programmes have been implemented.

Nepal's Health Sector Strategy 2004 (BS 2061): The Nepal health sector strategy reform paper addresses challenges in the health sector and ensuring proportional access of poor, women and other vulnerable people to essential health care.

The Ten Point Health Policy and Programmes 2006 (BS 2063): The GoN which was formed after the Jana Andolan in 2005/06 (BS 2062/2063), has issued a ten point paper to guide MoHP policy and programmes, raise awareness of MoHP staff to being more citizen-oriented and to develop inclusive programmes, all according to the sentiment of the Jana Andolan. Of the 10 points, the following seven points mention that unless equality, equity and access are addressed, social inclusion cannot be implemented. The seven points are as follows (from Ten Point Health Policy and Programme, Ministry of Health and Population, 2007 (BS 2063)):

- Expressing our commitment to the universal principle that "health is a fundamental human right", while ensuring that health care is available to all Nepalese, we will continue to give special priority to those persons, genders, castes and ethnic groups, communities and regions that are socio-economically disadvantaged.
- It is our firm principle that it shall be the main responsibility of the state to deliver all types of health services—preventive, rehabilitative and curative—to socio-economically disadvantaged people. These services will be organized in accord with the principles of the Alma Alta Declaration regarding primary health care. Ayurvedic and other alternative medical systems will be conserved and promoted.
- Special initiatives will be developed to create a proper working environment for doctors and health workers in rural and remote areas. Their financial advancement and opportunities for advanced study will be ensured. The two-way referral system will be activated.
- In coordination with the Ministry of Education, universities, and other educational organizations, necessary steps will be taken to fulfill the responsibility of medical education to develop human resources in accord with Nepal's needs, and to involve educational centers in providing medical treatment to the people.
- To ensure that the private sector is organized in a manner that is responsible toward the people, necessary assistance, policy directives and supervision will be provided. A Health Cooperatives policy that ensures people's participation and ownership will be put into practice.
- Health work at the district level will be conducted in accordance with the concepts of decentralization and an integrated approach. The people will be empowered through health related works by empowering the community health workers. Special steps will be taken to make effective use of the full inner potential of these health workers and volunteer health workers, who form the link between the people and the health facilities.
- The MoHP will immediately address the issues of health security of the people injured in Jana Andolan and martyrs' family.

Plans and Programmes

Nepal's Long-term Health Plan 1975 (BS 2032): According to Nepal's long-term health plan 1975, in order to fulfill the objective of extending health services to the local level, integrated health service had to be adopted and implemented accordingly.

Second Long-term Health Plan 1997 -2017 (BS 2054- 2074): The Second Long-term Health Plan 1997-2017 has defined women, children and village populations as vulnerable groups and has mainly tried to reduce inequalities in equitable access to gender sensitive and quality health services.

Poverty Reduction Strategy Paper/10th Five Year Plan 2002/03-2006/07 (BS 2059/60 – 2063/64): This paper included plans on how to contribute to improvements in the health sector for the poor and remote populations. The PRSP was the first such plan that specified social inclusion as one of four central points. In the PRSP, special priority was given to the health of poor, vulnerable and oppressed people while implementing health sector programmes, and focused on the creation of a productive population to reduce the state of poverty.

Three Year Interim Plan 2007/08 – 2009/10 (2064/64- 2066/67): This plan accepted the universal principle of health as a fundamental human right and has emphasized equitable access to health services by the socially excluded, poor, women and disabled. It also emphasized the development of necessary human resources, establishment and expansion of health institutions and improvements in the community level organizational structure, for the implementation of its programmes and plans.

Nepal's Health Sector Programme - Implementation Plan 2004-2009: The NHSP-IP included many kinds of reform programmes and the MoHP has shown a high level commitment to providing equitable health services. Its main emphasis is on ensuring the access of poor and vulnerable to essential health services. It also addresses the achievement of the health sector MDGs, with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty. But this plan did not consider the special needs of Dalits and ethnic groups; it did not define who was vulnerable (destitute); and did not link gender, caste and age with the word vulnerable/destitute. Furthermore, the indicators in this plan were not disaggregated in terms of gender, caste and ethnicity.

Vulnerable Community Development Plan (2004): The Vulnerable Community Development Plan within the NHSP-IP addresses social exclusion in health services in Nepal and the effects and implications for vulnerable people for the NHSP-IP. The excluded (vulnerable) groups are predominantly women and girls, indigenous peoples and occupational castes. Because they inhabit all regions and districts of Nepal covered by this broad national health project, a Vulnerable Communities Development Plan is an essential prerequisite for achieving the stated objective of social inclusion in basic health services as set out in the NHSP- IP.

The VCDP provided a guide for the MoHP in 2004 to conduct programmes over the next four to five years to address social inclusion. This plan was not implemented, as there was no clear mechanism for implementation.

Free Health Service Programme: This programme's main objective was to promote essential health care services to all citizens; ensure the health rights of the citizens - especially of the poor, vulnerable and target groups - and increase their access and use of health services. The free health care service programme policy for target groups was announced in fiscal year 2006/07 (BS 2063/2064) in hospitals and primary health centres for inpatient and emergency services and was made free for all citizens in all health posts and sub-health posts from fiscal year 2007/08 (BS 2064/65 Marg 1). It was expanded in 2008 (BS 2065 Mansir 1) to include primary health services. In 2008 (BS 2065 Marg 1) hospitals with at least 25 beds provided listed medicines free to all citizens, while essential drugs and all services were made free for target groups (the ultra poor, vulnerable, poor, disabled, senior citizens, and FCHVs). In 2008 (BS 2065 Marg 1) institutional delivery was made free for all women.

1.3 Efforts and Achievements to date

- To coordinate at the policy and working level for GESI, a GESI Unit has been established under the Programme Planning and International Coordination Division of the MoHP which had prepared a GESI strategy.
- Since a quota of poor, women, Dalit and Janajati representatives on local health management committees has been set, an attempt has been made to enhance their self-esteem and empower them.
- There has been a gradual increase in the number of service beneficiaries in health facilities due to the availability of free basic health care and child delivery services.
- People living in the remote and marginalized regions where health services are not available have benefited from mobile health camps intended to deliver specialized health services.
- Attempts have been made to collect disaggregated health sector information in 10 districts through the health management information system to ensure access of health services by various castes and ethnicities.
- Opportunities to access higher education, especially medical courses, by the poor, Dalits and marginalized communities, have been made available through quotas and scholarships.
- Endowment funds at the VDC and district level have been created for FCHVs, and motivational programmes are being implemented for them.
- Women with prolapsed uteri have been provided with free checkups and operations at health camps.

- Radio and print materials with information on available health services and health rights of citizens have been translated into Abadhi and Tharu languages as part of a pilot programme to increase awareness of such information by the target groups.
- Several years ago Mother Child Health Workers (MCHWs) who had passed the SLC examination were given NMW training to upgrade their standards. This had led to increased motivation among MCHWs. To date, about 1200 MCHWs have participated in this training and are working in their respective areas.
- A separate Revitalizing Primary Health Care division has recently been established at the Department of Health Services to effectively implement free health care services; this division has started health insurance, health cooperative and rural health programmes.

1.4 Rationale

As directed by the policies and programmes in the health sector, the state has prioritized the integration of GESI in its policies, programmes and plans to make health services accessible and useable by all. In order to fulfill its mandate, the MoHP has been introducing different programmes. However, due to various reasons, the poor, vulnerable, disabled, senior citizens, and marginalized castes and ethnic groups have not been able to fully access and utilize the available services. As it is the state's responsibility to provide health services, the government after the Jana Andolan II issued a ten-point health policy and programme paper aimed at making the MoHP more effective. While preparing the ten-point health paper and the TYIP, the MoHP has shown a high level of political commitment to providing equitable health services.

There are still many visible GESI-related challenges in the health sector, and without addressing these, the health sector goals cannot be achieved. The goal of ensuring easily accessible quality services for all can only be achieved if the marginalized are mainstreamed through specific programmes and strategies. In order for the target groups to receive services and ensure health as a fundamental right as addressed by the state, and to rightly implement various programmes of the government, the MoHP has developed this GESI Strategy. When this strategy is fully adopted it is expected that the ministry will be more committed to GESI, that human and institutional capacity will be strengthened and that GESI will be internalized in a sustainable way.

1.5 Process

To mainstream GESI in the health sector, the MoHP in 2008 (BS 2065) under the Programme Planning and International Coordination Division established a three-member GESI unit. This unit has played a leading role in preparing this strategy.

This strategy has been prepared through a participatory and consultative process. Consultation and interaction has been done at different levels. The following activities were conducted:

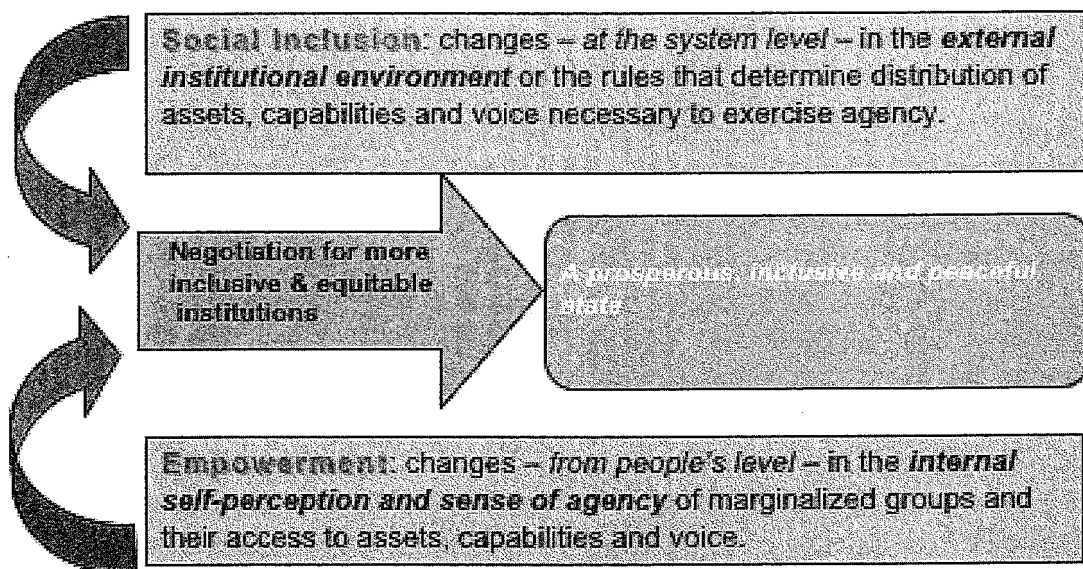
- a) An in-depth study of related documents, health sector policies, rules, regulations, strategies, guidelines, study reports and progress reports;
- b) Suggestions were collected through individual and collective interviews and discussions with the ministerial GESI unit, Department of Health, Patan Hospital, representatives from health sector projects and the GESI division of the Ministry of Education; The information, understanding and learning from such studies, reviews, interviews and discussions contributed to the foundation of this strategy.
- c) Three regional consultative workshops in the Mid-western, Eastern and Western development regions (Nepalgunj, Biratnagar and Pokhara). Participants included representatives from the MoHP, NPC, Department of Health Service, Regional Health Directorates, zonal and district Hospitals, District Public Health Offices, Village Level Health Workers, NGOs, organizations representing Dalits, Adibasi (indigenous), Janajati (ethnic groups), women, individuals from the private sector and other stakeholders working in the health sector. Based on the discussions and input from these regional workshops, the first draft of the GESI strategy was prepared and distributed to the ministry for comments and suggestions.
- d) Based on the suggestions and comments from the ministry, the first draft of the strategy was revised. A central-level workshop was organized with different stakeholders, including the MoHP, projects working in health sector, NPCs, NGOs, organizations representing Dalits, ethnic groups and women to review the draft strategy. Based on their comments and inputs, this final draft of the strategy has been prepared.

II. Definitions

Gender Equality: Gender equality is concerned with the socially constructed differences between women and men (usually inequitable), and believes that in order to gain equitable outcomes, different methods and approaches have to be adopted.

Social Inclusion: Social inclusion is defined as the removal of institutional barriers and the enhancement of incentives to increase access of diverse individuals and groups to development opportunities (World Bank Sectoral Analysis Sourcebook).

Linked closely with social inclusion is the complementary role of empowerment, as illustrated below (definition used by World Bank 2002).



Social inclusion, in the context of the health sector, means equal and equitable access to basic health services. To achieve this fully and permanently, there needs to be a combination of social inclusion and empowerment.

Empowerment: Empowerment means building the excluded groups' economic, social and emotional strength. This requires:

- increasing their access to services, resources and materials;
- providing them with information on service delivery organization's objectives, working sectors and services, via the most appropriate medium;
- improving their abilities to present their issues to service delivery organizations;
- stimulating their self-confidence and self-respect;
- organizing them for group work.

Social Exclusion: Social exclusion comes from the existing social practices, beliefs, values and norms which puts the marginalized groups outside of mainstream development and are excluded from its gains.

Equality: Equality means having no differences in facility, respect and rights. Gender and social (caste/ethnicity) equality is to recognize biological and societal differences and bring changes to the social values, norms, perspectives, thinking and beliefs such that women and men, and higher and lower castes maintain equal status.

Equity: Equity is the state or quality of neutral, fair and just behaviour. It is helpful to consider inequity: differences which are unnecessary and avoidable; and considered to be unfair and unjust. Equality cannot be gained through merely providing equal opportunities, as not everyone is able to access the opportunity equally. In order to address the differences and exclusion of the marginalized groups and communities, there is a need for more targeted resources and support to bring about a change in equity.

Gender discrimination or social gender discrimination: Gender discrimination is the relationship between women and men and the culturally and socially established difference in the roles that they play and the subsequent inequality. The difference between men and women is constructed by the society and changes with time; it differs according to place, context, cultures of castes and ethnic groups. In many societies women are treated as subordinates (second class citizens). This has affected women's ability to exercise their rights to services; there is even a situational denial of their right to access information, adequate nutrition, health services, education, access and control over finances and property, their reproductive rights, family planning, etc.

Target group(s): The Interim Constitution 2006 (BS 2063) has defined the target group as the ultra poor, vulnerable, poor, senior citizen, disabled, and FCHVs. The GESI strategy has defined the target group as the following:

- **Poor:** economically, geographically and from empowerment's perspective, marginalized and disadvantaged groups, including women and children.
- **Vulnerable:** helpless (destitute), disabled, senior citizens over sixty years, displaced, conflict-affected, slum and trafficking-affected, including women and children.
- **Marginalized castes and ethnic groups:** Dalits (hill and terai), backwards ethnic and indigenous groups, religious minorities (Muslims), including women and children and third gender.

Disadvantaged Group (DAG): a DAG group has been defined as the following (courtesy Local Governance and Community Development Programme):

- households with food sufficiency for less than 3 months
- concentration of marginalized households
- those who lack access to primary education
- those who lack access to health posts
- participation of women, Dalits and Janajatis in decision making
- prevalence of gender discrimination
- prevalence of vulnerable groups

Targeted Interventions: directed activities with the goal of ending gender discrimination and social exclusion by removal of barriers and increasing the access and use of health services by the target groups.

III. Objectives

The objectives of the GESI strategy are as follows:

Objective 1: Develop policies, strategies, plans and programmes that create a favorable environment for integrating (mainstreaming) GESI in Nepal's health sector.

Objective 2: Enhance the capacity of service providers and ensure equitable access and use of health services by the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach.

Objective 3: Improve health-seeking behavior of the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach.

IV. Strategy Table/Strategic Framework:

Strategy	Working policy
Objective 1: Develop policies, strategies, plans and programmes that create a favorable environment for integrating (mainstreaming) GESI in Nepal's health sector.	
Strategy 1. Ensure inclusion of GESI in the development of policies, strategies, plans, setting standards, and budgeting, and advocate for use of such policies, standards and budget provisioning at the central level.	
Review the existing policy, law and guidelines to make them GESI inclusive.	<p>Analyze and revise existing health policy, regulations and guidelines to make them GESI inclusive and responsive, and ensure the policy will not be gender discriminatory.</p> <p>Advocate for health as a fundamental human right in the upcoming constitution.</p> <p>Include the standards for integration of GESI in second NHSP-IP (2011-2015).</p> <p>Develop regular policy feedback mechanism for GESI policy improvements.</p> <p>Improve health monitoring for GESI by revising the information system (HMIS) and reporting on a timely basis.</p> <p>Review existing health facilities and recommend expansion of appropriate health facilities to locations where target groups are concentrated in large numbers and underserved.</p>

<p>Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting.</p>	<p>Develop policy for identification of poor, vulnerable and marginalized castes and ethnic groups.</p> <p>Develop implementation guidelines in relation to the policy and ensure implementation.</p> <p>Develop and apply policy measures to adopt a favorable environment promoting GESI, such as a quota or priority system for recruiting, training and promoting staff and FCHVs from the marginalized castes and ethnicities.</p> <p>Make policy provisions for poor, vulnerable and marginalized castes and ethnic groups to receive free secondary and tertiary health care services.</p> <p>Make policy provision for compulsory social auditing to make health services inclusive, transparent and accountable.</p> <p>Include GESI in programmes and activities in e-AWPB of MoHP as necessary.</p> <p>Advocate to the MoF and NPC for regular budget provisioning of GESI in AWPB (annual work planning and budgeting) process.</p> <p>Make a policy provision for the development of health cooperatives to expand access to health services by the poor, venerable, and marginalized castes and ethnic groups.</p> <p>Make a policy provision for Health Insurance to increase the target groups' (poor, vulnerable and marginalized castes and ethnic groups) access to health services.</p> <p>Make a policy for partnering with the media to inform the public about government health care messages and free services, targeting the poor, vulnerable and marginalized populations.</p>
<p>Strategy 2: Prioritize GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHO, DPHO and VDC) to ensure services are accessible and available to the poor, vulnerable and marginalized castes and ethnic groups.</p>	
<p>Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programme, budget, monitoring and evaluation.</p>	<p>Address GESI issues in plans, programmes and budgets to attain MDGs and NHSP targets.</p> <p>Further develop indicators for GESI as necessary, disaggregate the HMIS, monitor and report performance of target groups, and improve services accordingly.</p> <p>Define roles and responsibilities for monitoring and evaluating performance of target groups.</p> <p>Develop mechanisms/ processes to review GESI disaggregated information and its progress in four monthly semiannual and annual meetings.</p>

Include GESI related issues in programme implementation by health service providers.	<p>Operationalize guidelines to facilitate access and utilization of health services by the poor, vulnerable and marginalized castes and ethnic groups.</p> <p>Ensure that the work of every health institutions includes GESI.</p>
Coordination and participation among concerned organizations for GESI.	<p>Coordinate with MLD, MoF and NPC for making policy provisions to allocate more percentage of the budget for GESI in DDC, VDC and municipalities.</p> <p>Coordinate and implement with DDCs, VDCs, and municipalities, to attract their social development budgets in the health sector to serve the poor and disadvantaged groups and advocate at policy level.</p> <p>Continue implementing existing programme of handover of health facilities at local level, make the health facility management committee inclusive, such that the marginalized castes and ethnic groups are represented proportionate to their populations, develop its management capacity, and make it more GESI responsive.</p> <p>Coordinate with district- and village-level NGOs working in health sector and partner with them to conduct programmes to increase access by the target groups to health services.</p> <p>Coordinate with ministries, I/NGOs and local bodies to integrate GESI in their programmes.</p> <p>Create trust and good environment between health care providers and communities through regular meetings and other interactions.</p> <p>Develop policy provisions to make local bodies responsible to develop participatory plans based on the needs and demands of the target groups, implement and monitor.</p> <p>Transferring knowledge, skills, resources and materials to local bodies to continue to meet the needs of the target groups.</p>
Strategy 3: Establish and institutionalize GESI unit/desk at the MOHP, DOHS and divisions of the DOHS, regional directorates, and DHO/DPHO, and Social Service Units for GESI at central, regional, sub-regional, and zonal hospitals.	
a) Establish social service units (SSU) in hospitals.	Establish and operationalize Social Service Units in central, regional, sub-regional, zonal, and district hospitals to facilitate access to EHCS and secondary and tertiary health care services by the poor, vulnerable and marginalized castes and ethnic groups.
b) Establish GESI Unit/Desk at different levels of health sector.	Establish GESI unit or contact point (desk) within MoHP, each division of the Department of Health Services (DoHS), each regional directorate of the five development regions, and District Public Health Offices, and ensure internalization of GESI.

Objective 2: Enhance the capacity of service providers and ensure equitable access and use of health services by the poor, vulnerable and marginalized castes and ethnic groups within a rights-based approach.	
Strategy 4: Enhance the capacity of the service providers to deliver essential health care service to poor, vulnerable, marginalized castes and ethnic groups in an equitable manner and make service providers responsible and accountable.	
Improve service delivery mechanism by service providers for the poor, vulnerable and marginalized caste and ethnic groups.	<p>Sensitize health sector health workers, SSU and GESI focal point staff at all levels, FCHVs, and local-level health facility management committees through orientation, training and counseling services on gender equality and social inclusion.</p> <p>Implement behavior change training programmes for the health workers, FCHVs and local health management committees to bring changes on their behavior and attitude, and improve services.</p> <p>Orient, train and strengthen capacity of FCHV and NGOs on health services to provide proper information to poor, vulnerable and marginalized caste and ethnic groups.</p> <p>Include GESI content in the health sector education and training curricula.</p>
Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasizing programmes to reduce morbidity and mortality of the poor, vulnerable and marginalized castes and ethnic groups.	
Increase access of the target groups to universal and targeted free care programmes.	<p>Develop criteria to identify poor, vulnerable and marginalized castes and ethnic groups and provide them with "Free Hhealth Check-up Card" for secondary- and tertiary-level health care services and referrals.</p> <p>Ensure equitable and meaningful participation of target groups and women in health management committees.</p> <p>Ensure meaningful participation of the poor, vulnerable, marginalized castes and ethnic groups in social audits of health services to make health programmes people oriented.</p>
To increase the use of Mother and Child Health and Free delivery services by the target group.	<p>i) Develop special programmes for poor, vulnerable and marginalized caste and ethnic groups (women and child) to avail them to MCH services and free deliveries.</p> <p>Give special attention and emphasis to safer motherhood and maternal and child health programs to increase use of neonatal and postnatal care services, and institutional deliveries, nutrition and childhood immunization to decrease maternal mortality, neonatal, infant and under-5 mortality.</p> <p>Mobilize and train/strengthen Female Community Health Volunteers (FCHVs) and NGOs to increase access to services by these target</p>

	<p>groups.</p> <p>Provide other kinds of assistance, such as awareness raising, IEC/BCC programmes and outreach services (village clinic) to pregnant women to encourage and assist in institutional deliveries and ensure the use of trained health workers for home delivery.</p> <p>ii) Protect women from discrimination, which limits women from poor, vulnerable and marginalized castes' and ethnic groups' access to and use of health care services, especially institutional deliveries.</p> <p>Collaborate with women's CBOs /NGOs and other health development groups in the health sector to decrease gender and social discrimination in the family and in society.</p> <p>Conduct community and family counseling on gender-based violence that affects women's health (physical abuse during menstruation, delivery, schooling, work place, etc.) and social violence that affects the mental and physical health of men and women.</p> <p>Regularize attendance of female health workers to increase utilization of maternal health services at facilities, especially by women from poor, vulnerable and marginalized castes and ethnic groups.</p>
<p>Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalized caste and ethnic groups and areas (Regional and/or District).</p>	<p>i) Give emphasis to service expansion in geographically inaccessible/remote regions.</p> <p>Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the poor, vulnerable and marginalized castes and ethnic groups.</p> <p>While establishing new health and sub-health posts, build a consensus in the community to select a site most appropriate for the poor, vulnerable and marginalized castes' and ethnic groups' access and use.</p> <p>ii) Expand services in low HDI districts.</p> <p>Focus on community and outreach programmes to increase access to and use of EHCS in the 35 low HDI districts.</p> <p>Ensure programmes at less populated areas that will make the target groups feel health as their fundamental rights .</p>

	<p>iii) Make provision for regional programmes to address unmet health issues and needs among marginalized groups, such as Dalits, slum dwellers, homeless, IDPs, Muslims and third gender.</p> <p>Make provision for special programmes, such as publicity campaigns, outreach services, counseling services and orientations to free care to increase access of the target groups to health care services.</p> <p>Conduct special activities to reach Dalits by providing incentives for using EHCS, and mobilizing FCHVs to provide information and encourage their use of services.</p> <p>Implement special programmes such as providing a monetary incentive to those using EHCS, thus ensuring the Dalits, for example, access health services; mobilize FCHVs to provide target groups with more service information and how to use such services.</p>
Strategy 6: Enhance or modify services to be sensitive to GESI and ensure access is equitable and services are delivered uniformly without regard to social status.	
Give emphasis to special activities to provide adequate and quality services.	<p>Ensure the presence of female health workers (doctors) at all district facilities.</p> <p>Make a provision for local language speaking staff at the service delivery site where there is a majority of local language speakers.</p> <p>Allow the district-level health organization to adopt district-specific GESI policy, if needed, based on future political and geographical structure and context.</p> <p>Conduct social audits to make health programmes and health workers accountable to communities and to make practices transparent.</p>
Objective 3: Improve health seeking behavior of the poor, vulnerable and marginalized castes and ethnic groups within a rights-based approach.	
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behavior of the poor, vulnerable and marginalized groups.	
Develop and disseminate targeted IEC materials that will bring changes in behavior of target groups.	<p>Prepare and distribute enough information and publicity materials (focused more on EHCS, and policies and programme related to the target groups) in audio visual, pictorial, etc. for all regions in appropriate local languages other than Nepali language.</p> <p>Include the target groups' programme in publicity and communication materials of MoHP to increase poor, vulnerable and marginalized caste and ethnic groups' access to such materials.</p> <p>Develop skills at the local level for producing information materials as needed, especially in remote areas.</p>

<p>Increase the use of appropriate media.</p>	<p>Ensure all media allocate appropriate time for broadcasting health service news.</p> <p>Emphasize use of effective media (FM radio, newsprint, door-to-door campaigns, hording boards, street drama, workshops, training, rallies, etc.) and in local languages.</p> <p>Increase information communication among health institutions on GESI.</p> <p>Include appropriate media programming for low HDI districts and districts with diverse language and in local language.</p> <p>Conduct regular monitoring on quality of communication services by concerned health department /institutions.</p>
<p>Strategy 8: Empower the target groups to demand their rights and conduct their roles with realising their responsibility</p>	
<p>a) Increase the target groups' awareness of their health rights and of free health care services, and enhance their capacity to make the service providers accountable.</p>	<p>i) Empowerment.</p> <p>Conduct activities for the target groups to make them aware of their rights and responsibilities; develop their capacity for taking leadership roles.</p> <p>ii) Information, Education and Communication.</p> <p>Conduct publicity campaigns to increase awareness and orientation on how to access and properly utilize health services, focusing on the target groups and take into consideration appropriate place, tools and time for such activity.</p> <p>Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups on national health policy and programmes, health rights, EHCS, free medicines, etc.</p> <p>Develop and conduct orientation and awareness campaigns for change in health seeking behaviors.</p> <p>Promote women's participation and conduct awareness programmes to orient them on equal treatment of both male and female children from newborns to 5-years old in regards to nutrition, health care and other health related important aspects.</p> <p>Provide orientation on women's reproductive health rights.</p>

After this strategy has been adopted it is expected that the ministry will commit to revising its programmes in implementing GESI; human and institutional capacity will be strengthened, contributing to the sustainable inclusion of GESI.

V. Implementation of Strategy and Monitoring and Evaluation

5.1 Strategy Implementation Process

The following programmes will be conducted for the implementation of the strategy:

Preparation of Strategy Implementation Work Plan: In the first phase, the MoHP will clearly identify works that can be done in the short-term, mid-term and long-term based on this strategy, and prepare a GESI implementation work plan.

Revising Work Description/ToRs: In the second phase, for the implementation of GESI, the TORs of all divisions, departments, regional and district level offices and staff under the Ministry will be revised to include GESI-related responsibilities and sent to concerned places.

5.2. Institutional Structure of GESI Strategy Implementation

Central Level

The MoHP has created a GESI section within the ministry. This is a separate section within the organizational framework with full authority (see Annex 4).

a) This section will:

- Revise the health policy, plans and programmes to be GESI inclusive;
- Monitor and evaluate programmes to ensure that available health services have reached the disadvantaged target groups;
- Build capacity and mobilize resources for GESI;
- Coordinate roles for flow of information on GESI and its management;
- Coordinate with NPC, MoHP and its departments (if needed with other ministries and departments) in implementing GESI-targeted programmes.

b) Establish GESI unit/desk in departments and directorates which are under MoHP; among other responsibilities, this unit/desk will be responsible for monitoring, collection of information and data and its analysis for the implementation of the GESI strategy.

c) Establish Social Service Units (SSU) at the central level hospitals and activate them; support the target groups to get essential and tertiary health care services.

d) Include GESI requirements in all health service delivery institutions' staff and managers' TORs.

Regional and Zonal Level

At the regional level, under the coordination of the Regional Director, establish a GESI network including organizations representing women, Dalits, Janajatis (ethnic groups),

Adibasis (indigenous groups), NGOs and organizations working in the health sector; create contacts, coordinate and monitor the GESI issues.

Establish Social Service Units (SSU) at the sub regional, regional and zonal hospitals and support the target groups to get essential and tertiary health care services through these units.

District Level

At the district hospital establish a SSU as needed and facilitate the target groups in receiving essential and tertiary health care services.

Activate the district health coordination committee and coordinate and develop a partnership for the implementation of GESI strategy at this level.

Under the coordination of the district public health office Chief establish a GESI network including organizations representing women, Dalits, Janajatis (ethnic groups), Adibasis (indigenous groups), NGOs and organizations working in the health sector; create contacts, coordinate and monitor the GESI issues.

Community Level

Conduct orientation on GESI with health management committees and work on implementation of strategy, monitoring and informationsharing to upper agencies, as needed.

Conduct orientation on GESI to FCHVs and mobilize mothers group.

5.3 Monitoring, Reporting and Evaluation

In order to ensure that GESI programmes in the health sector are implemented and are improving the overall health of the target groups, regular monitoring and evaluation will be completed at all levels.

Monitoring, reporting and evaluation will be based on the GESI-sensitive indicators and activities that are developed by the ministry. Monitoring and evaluation will take into consideration the following points:

- Improve the existing monitoring forms, health monitoring and evaluation system and reporting to include GESI programmes;
- Develop (confirm) GESI programme indicators and include these in all health institutions' programmes and monitor accordingly and make improvements as needed.
- Clearly define roles and responsibilities for monitoring and evaluation at different levels of health institutions with specified timeframes;
- Monitoring at the central and ministerial level;
- Monitoring at the departmental level;
- Monitoring at the regional level;

- Monitoring at the district level;
- Monitoring at the community level.

Further develop and strengthen the GESI disaggregated data collection system.

The areas to be monitored include, but are not limited to:

- Programme implementation mechanisms;
- Qualitative services for target groups;
- Role of service providers and in-service delivery capacity;
- Health conditions of the target groups;
- Benefits to the target groups from free and targeted health care programmes;
- Access and use of health services by the target groups, etc.

Conduct regular social audits at the community level on the equity of target groups' participation in order to improve transparency, accountability and quality of services provided.

Institutionalize the process of service delivery institutions' cross review of each others' programmes, self-evaluation, and exchange of learning. Document best practices and lessons learned on GESI.

Conduct GESI audit of all health sector programme activities within specified timeframe and revise programmes as necessary.

5.4 Monitoring Mechanisms

Below are some suggested monitoring mechanisms to be employed:

Participatory Monitoring

This process will ensure participation of all stakeholders including service receivers (beneficiaries) in the monitoring process. This monitoring process will be conducted through meetings, workshops, and focus group discussions. This can be used as a regular process and/or be done periodically.

Progress Monitoring through Reporting

This process will require submitting quarterly, semiannual and annual progress reports to concerned management levels.

Beneficiaries Contact Monitoring

Beneficiary contact monitoring (BCM) is considered as the successful process of and main yardstick for overall programme monitoring. It embraces a demand-driven process. Monitoring is achieved based on beneficiaries' perspectives of access to, use of and

satisfaction with health delivery services. Random samples from the community are collected through interviews, from which responses are monitored and evaluated. Accordingly, health delivery services can be improved as needed.

Monthly, tri monthly/quarterly and annual review meetings

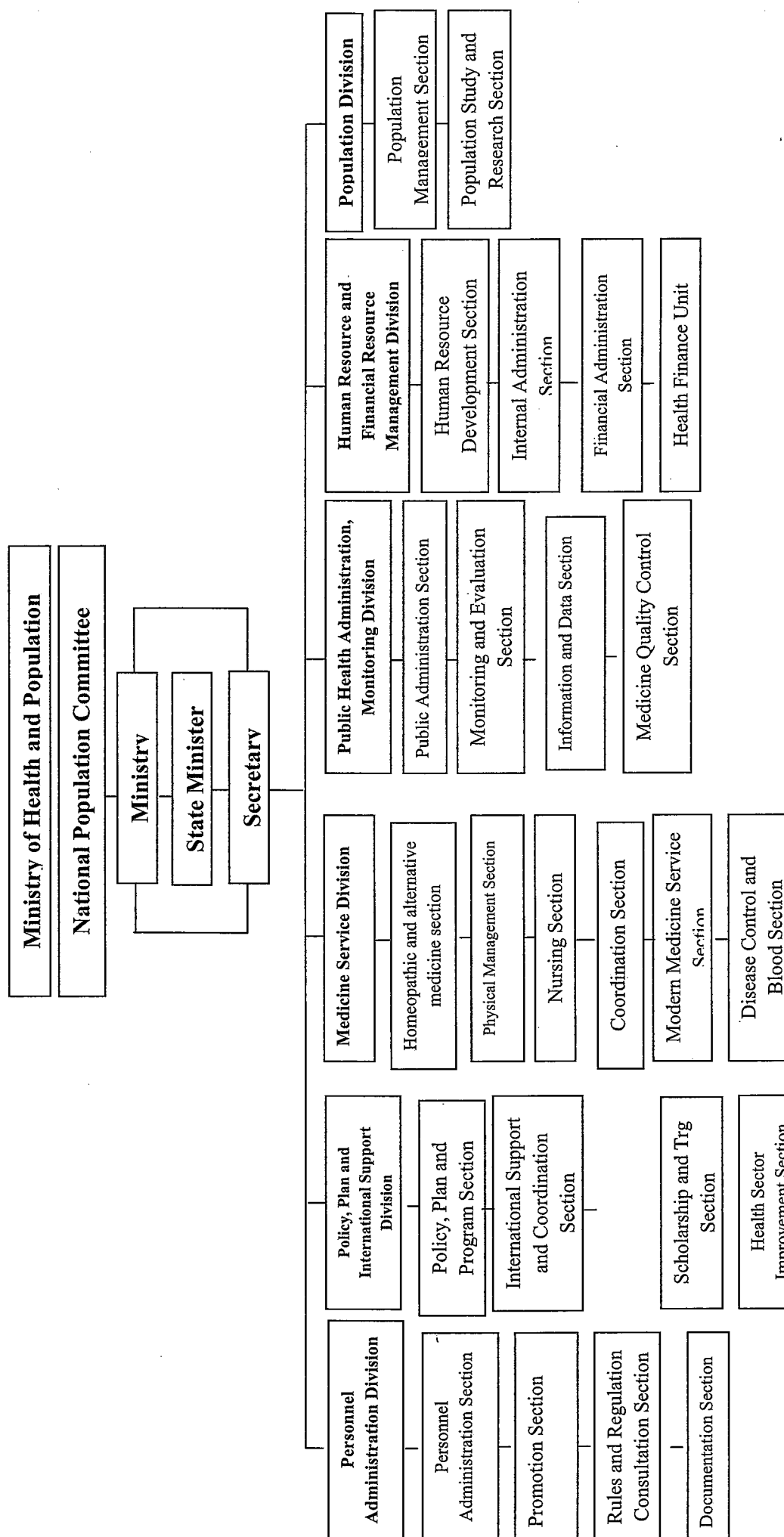
The GESI included monthly, tri/quarterly; semi-annual and annual progress reporting will be submitted to different levels of management meetings. These meetings present the opportunity to evaluate the experience and learning from year round programme implementation.

VI. Major Challenges for Implementing the Strategy

The health sector has tried to do more to address GESI issues than any other sector. The GoN and the MoPH have prioritized GESI in recent plans, policies and guidelines, but there have been weaknesses in the implementation mechanisms. Below are some potential and valid challenges to implementing this GESI strategy.

- Existing poverty and illiteracy in the country presents a major challenge to providing effective health services to the target groups. Because of illiteracy and a lack of education and information, traditional beliefs, superstitions and bad practices persist, affecting use of available health services.
- Due to resource constraints, the MoHP may not receive the budget necessary to implementing GESI-inclusive health services.
- The process of developing “new Nepal” and future restructuring may be a challenge as well as an opportunity to the implementation of the GESI strategy.
- Although there is political commitment to the GESI agenda, and health sector policies and programmes have made it a priority, political interference exists, impeding implementation; there is still the possibility of creating a more politically enabling environment.
- Service providers’ discriminatory behaviour towards the target groups have created a lack of trust in public health services; this could also affect implementation of the GESI strategy.

Annex: Proposed Organisational Structure of Ministry of Health and Population



Gender Equality and Social Inclusion Section has been proposed in the above mentioned organizational structure of Ministry of Health and Population which will include three personnel comprising Under- Secretary - 1, Section Officer - 1 and Head Assistant- 1. This section will be responsible to implement all the gender equality and social inclusion related activities of MOHP.