Progress Report on
Gender Equality and Social Inclusion for NHSP-2
2011/12

Report Prepared for Joint Annual Review (JAR)
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Government of Nepal (GoN)
Ministry of Health and Population (MoHP)
Ramshah Path, Kathmandu, Nepal

EXECUTIVE SUMMARY

In 2012, the Gender Equality and Social Inclusion (GESI) agenda was taken forward with full attention to the different aspects of the functioning of the health sector.

One-stop Crisis Management Centres were established and strengthened, and direct services were provided to survivors of Gender Based Violence. Preparatory work for the establishment of Social Service Units (SSUs) was completed. This involved conducting a study and developing guidelines. The Equity and Access programme was reviewed and issues constraining its effective implementation are being addressed. Key issues identified included single year contracting of EAP implementing NGOs; delays in receiving budget approval; lack of capacity at the district level to manage the programme and political, administrative and social pressure on the selection of NGOs. A range of strategic options for addressing those constraints were identified. Based on draft guidelines, some Regional Health Directorates are undertaking mapping of unreached VDCs within the districts and wards, and of social groups within the VDCs.

Using Participatory Ethnographic Evaluation and Research Methodology (PEER), a study was conducted to identify more specifically the barriers experienced by selected social groups with poor health outcomes. The findings will inform MoHP's interventions to address Objective 2 of NHSP-2.

An Institutional Structure Guidelines, which establishes the structures responsible for GESI at different levels, has been approved. To make these committees and working groups more functional, directives were included to allocate small budgets for the essential activities necessary to integrate GESI in the review, mapping, planning, programming and training/orientation processes undertaken at district and regional levels.

GESI Operational Guidelines are being developed to provide practical guidance to health institutions and service providers on how to recognise and address issues impacting women, the poor and excluded.

The capacity and skills of Technical Working Groups, district and regional teams and GESI Focal Persons to address GESI aspects in planning, programming and supervision were strengthened.

Comprehensive social audit guidelines were developed through a participatory process and piloted. Social audit was conducted in 147 health facilities using the revised social audit guidelines.

GESI was integrated in the Annual Work Plan Budget and the Annual Business Plan. The NHSP-2 Implementation Plan has a section on GESI and has also integrated GESI in other national programmes. A process is on-going for improved disaggregation of selected indicators in the Health Management Information System.

The National Health Training Centre conducted a GESI review of five curricula and has initiated a process for developing GESI modules and materials to be inserted into these curricula.

While many lessons have been learned, a number of challenges still constrain the mainstreaming of GESI effectively and rapidly in the sector. These range from a low implementation of GESI sensitive policies to practical challenges of identifying the poor for the services of SSUs and the need for a multi-sectoral approach to address barriers of different social groups. Measures to maintain the momentum for implementing GESI related activities have been identified and are being implemented.

LIST OF CONTENTS

ACRONYMS

AHW	Assistant Health Worker
AWPB	Annual Work Plan Budget
BCC	Behaviour Change Communication
CHD	Child Health Division
DoHS	Department of Health Services
D(P)HO	District Public Health Office(r)
EAP	Equity and Access Programme
FCHV	Female Community Health Volunteer
FHD	Family Health Division
GAAP	Governance and Accountability Action Plan
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
HFOMC	Health Facility Operation and Management Committee
HRH	Human Resources for Health
IMCI	Integrated Management of Childhood Illnesses
LMD	Logistics Management Division
MFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MWCSW	Ministry of Women, Children and Social Welfare
NDHS	Nepal Demographic and Health Survey
NGOs	Non-governmental organisation
NHTC	National Health Training Centre
NPC	National Planning Commission
OCMC	One-stop Crisis Management Centre
PEER	Participatory Ethnographic Evaluation and Research Methodology
PHCRD	Primary Health Care Revitalisation Division
RHD	Regional Health Directorate
SBA	Skilled Birth Attendant
SSU	Social Service Unit
ToR	Terms of Reference
TWG	Technical Working Groups
VDC	Village Development Committee

1 INTRODUCTION

1.1 Background

NHSP-2 has a clear mandate to address Gender Equality and Social Inclusion (GESI). The vision, mission, goal and objectives, results framework and accountability plans have specified clear directions for addressing GESI issues. A GESI strategy for the health sector has been included in the NHSP-2. A National Action Plan on Gender Based Violence (GBV) coordinated by the Office of the Prime Minister and Council of Ministers and with the commitment of 11 ministries, including the Ministry of Health and Population (MoHP), has been implemented since November 2010. MoHP has responded to the national mandate and has initiated various responses to address inclusion. This report presents the progress, achievements and lessons regarding GESI in the year 2012.

1.2 Objectives

The objective of this report is to provide an update on the initiatives taken by MoHP and its partners in mainstreaming GESI and addressing key issues experienced by women, the poor and excluded in accessing health services.

2 PROGRESS AND ACHIEVEMENTS

This progress update is against the GESI strategy framework and objectives, the Governance and Accountability Action Plan (GAAP) indicators and activities undertaken as required by the NHSP-2 results framework.

2.1 Mainstreaming Gender Equality and Social inclusion

The GESI Institutional Structure Guidelines has been approved in January 2013. This specifies the location of GESI responsibility in the health structure of the government and the functions of the different committees and working groups. The GESI Steering Committee at MoHP has held its biannual meetings under the Secretary as Chair and has given clear directions for operationalising GESI in the health sector. Decisions were made about establishing One-stop Crisis Management Centres (OCMCs); the roll out of GESI institutional structures and the establishment of Social Service Units (SSUs) by the GESI Steering Committee.

A GESI Committee was formed in 2011 at the Department of Health Services (DoHS) under the chair of the Director General, DoHS. Technical Working Groups (TWGs) at MoHP and at DoHS have been formed and oriented on GESI and about their roles. TWGs have been formed in five Regional Health Directorates (RHDs) and fifty-one districts. GESI focal persons have been nominated in all RHDs and seventy-five District Public Health Offices (D(P)HOs). All five regions and fifty-one districts now have functional TWGs. Terms of Reference (ToRs) have been developed for all groups and committee members have been given GESI orientation.

GESI Operational Guidelines are being developed under the guidance of a Technical Committee. These will provide guidance to all level of health service providers on mainstreaming GESI in planning, programming, budgeting, monitoring and reporting.

2.2 Addressing Gender based Violence

- Hospital-based One-stop Crisis Management Centres: OCMCs established in eight hospitals (including the Maternity Hospital, Kathmandu) were strengthened. Six months of basic training on psychosocial counselling was provided to OCMC staff nurses. Preparations for a referral protocol and users' guide for GBV are underway. Pamphlets have been distributed on disseminating correct information to communities. Discussions with the Prime Minister's Office and the Ministry of Women, Children and Social Welfare (MWCSW) for a unified comprehensive guideline bringing the different ministries together are on-going. OCMCs in eight other hospitals are to be established in the current fiscal year.
- 16 Days GBV campaign: Just as last year, this year also awareness programmes, radio jingles, review workshops, rallies, orientations, interviews and meetings with journalists were organised at the regional and district level during the 16 days of activism against GBV.

2.3 Social Service Units (SSU)

The MoHP conducted a study in 2012 on Free Health Care Services and the Provision of Subsidies in Koshi, Bheri and Bharatpur Hospitals. Given the findings of this SSU study, MoHP has identified the need to revise the SSU guidelines and apply them to the start-up of SSU pilots in eight hospitals. A road map for establishing and strengthening SSUs was developed. Based on the study findings and consultations at different levels, the SSU guidelines were revised. SSUs will be established in eight

hospitals (central, regional and zonal) in 2013 on a pilot basis and scaled up only after two years of piloting experiences. Orientation and backstopping support will be provided to the SSUs in 2013.

2.4 Piloting of social audit guidelines

Under the guidance of a technical committee chaired by the Primary Health Care Revitalisation Division (PHCRD), comprehensive social audit guidelines were developed and piloted. The social audit guidelines were provisionally approved by MoHP and implemented in 18 districts (147 local health facilities) in 2012. Of these, 21 health facilities in two districts were audited through NHSSP Technical Assistance. Action plans prepared at the end of social audit will be monitored in NHSSP supported facilities and a thorough review of the social audit process will also be conducted next year. This process has enabled many women and people from excluded groups to participate in the social audit, thus ensuring a more thorough and inclusive process. The social audit guidelines will be finalised in January 2013, incorporating feedback from districts where the social audits were conducted.

2.5 Review of Training Curricula

The Training Curriculum Review Technical Committee identified five curricula – Health Facility Operation and Management Committee (HFOMC), Female Community Health Volunteer (FCHV), Behaviour Change Communication (BCC), upgrading Assistant Health Worker (AHW) and Skilled Birth Attendant (SBA) for in-depth review from a GESI perspective. The findings were shared with the SBA forum and the Training Working Group. It was decided to develop GESI modules and training materials in a participatory process for integration in the five curricula. The ToR is being finalised for this.

2.6 Equity and Access Programme (EAP)

The Equity and Access Programme was implemented in selected VDCs of 21 districts to mobilise targeted communities (women, the poor and excluded) by applying a rights based social mobilisation empowerment approach. Local non-governmental organisations (NGOs) and FCHVs were mobilised in promoting health rights and disseminating messages to the community by using the methods of mass communication, group facilitation, BCC and interpersonal communication. Messages were included that related to the entire health programme, including safe motherhood, new-born care, nutrition, institutional delivery, immunisation, family planning, free health care and so on .

The EAP was reviewed to identify system related factors constraining programme implementation. Key issues identified included single year contracting of EAP implementing NGOs; delays in receiving budget approval; lack of capacity at the district level to manage the programme and political, administrative and social pressure on the selection of NGOs. A range of strategic options for addressing these constraints was identified. A road map will be developed to implement suggested strategic options early next year.

2.7 GESI Specialists at the Regional Level

GESI specialists in each region worked with the RHDs and provided technical support for GESI mainstreaming. GESI specialists are working particularly to promote GESI in the RHDs' regular programme activities such as forming, facilitating and providing GESI orientation to the regional GESI Technical Working Groups in all regions; conducting annual regional health reviews and conducting district monitoring from GESI perspective. In addition, mapping of unreached VDCs within the districts and wards, and mapping of social groups within the VDCs was carried out based on draft guidelines.

GESI orientation was provided to more than 50 different district teams. In the same districts the regional GESI specialist supported the formation and facilitation of district GESI working groups and the mainstreaming of GESI into district programme planning, implementation and monitoring and review processes. Support is also being provided to the RHD to review and analyse health service utilisation information from a GESI perspective.

2.8 GESI Activities in the Annual Work Plan Budget (AWPB) and the Business Plan

MoHP allocated a reasonable amount of health budget for GESI, including GBV. This year the AWPB included a budget provision specifically for capacity development at different levels, to establish OCMCs for GBV survivors and SSUs at eight hospitals in order to address the needs of women, the poor and excluded. Similarly, a budget provision was also targeted for the Equity and Access Programme, to functionalise disaggregated reporting in selected districts, to provide youth and adolescent focused information and counselling support, and for specific funding for referral from remote districts.

Individual divisions and centres of MoHP and DoHS (including the Family Health Division (FHD), the Child Health Division (CHD), the Logistics Management Division (LMD), the Management Division (MD) and the PHCRD) reviewed work plans and budgets for FY 2012/13 from a GESI perspective. The Annual Business Plan was developed with a specific section on GESI related activities. For example, the PHCRD budgeted for GESI orientation and a GESI regional review. The Population Division also made budgetary provision for the training of GESI focal persons in secondary hospitals and medical colleges, for conducting a GESI audit of national programmes, and is planning to roll out OCMCs in sixteen districts.

2.9 GESI integration in the NHSP-2 Implementation Plan

A specific section on GESI was included in the NHSP-2 Implementation Plan. The responsibility for implementation of this plan is with the Chief of the Population Division, the GESI Secretariat. Plans include GESI targeted interventions such as establishing and making functional SSUs in eight selected hospitals and OCMCs in 16 hospitals. The Equity and Access Programme is designed for mobilising community to access and use health services. Refer to Annex 1 for the major GESI strategies and activities in this plan.

Plans of other divisions (e.g. immunisation programme and the nutrition programme) also integrated GESI aspects.

2.10 Study for identifying barriers to accessing health services

A study to identify the barriers for poor women and men of selected social groups such as Hill and Madhesi Dalits, Chepangs, Muslims, Hill Brahmin/Chhetris, and Other Backward Classes was conducted using a qualitative methodology called Participatory Ethnographic Evaluation Research (PEER). Community level women and men were trained to hold conversations with people of their social networks. The conversations they had and the issues they identified were triangulated with key informant interviews and secondary data information. The final draft of the study was shared by Population Division with MoHP and External Development Partners. The report was finalised in December 2012. Dissemination of the findings was started with a sharing in the Safe Motherhood Federation Convention by the Chief Population Division. (Refer to Annex 2 for the Executive Summary of the report.)

2.11 GESI integration in the Health Management Information System (HMIS)

The possible levels of caste/ethnicity and regional disaggregation in HMIS were discussed with HMIS and the need for further work at the National Planning Commission (NPC) level was identified. Indicators have been identified which need to be disaggregated by sex, age, location, and caste/ethnicity.

2.12 Further reanalysis of Nepal Demographic and Health Survey (NDHS) data

For the further disaggregation of NDHS from a GESI perspective, a technical committee was formed under the chair of the Chief of the Population Division, the GESI Secretariat of MoHP. Different teams worked on identified themes. Draft chapters have been prepared and are in the process of being finalised.

2.13 Capacity building on GESI

Seven regional workshops on GESI mainstreaming were conducted with DHOs and other district level health personnel covering all 75 districts. This enabled a common understanding of GESI concepts and strengthened skills for GESI mainstreaming in planning, programming and monitoring. The participants also provided inputs for the GESI operational guidelines being developed by the Population Division.

Heads of divisions and centres participated in a consultation meeting where they developed a common understanding on GESI concepts and the GESI mainstreaming framework. They provided inputs for the GESI operational guidelines and for the NHSP-2 Implementation Plan.

Skills and methods for mainstreaming GESI in the programme guidelines were practiced in a two-day GESI training of GESI focal persons from different divisions and centres of DoHS and MoHP. Programmes from FY 2068/69 were reviewed from a GESI perspective to identify strengths and areas of improvement as inputs for the next FY AWPB.

2.14 GESI integration in capacity assessment of National Health Training Centre (NHTC)

GESI integration was incorporated in the institutional capacity assessment of NHTC. Using a GESI perspective, the institutional capacity assessment process found that no specific responsibilities were mandated for ensuring that GESI should be addressed in the process of curriculum design or in delivery of the training. Furthermore, there was no systematic method to ensure that all trainers had competency on GESI and knew how to integrate GESI into technical subject themes.

2.15 GESI integration in strategies and surveys

The Human Resources for Health (HRH) Strategy was developed through participatory consultations which enabled GESI aspects to be integrated into the analysis and the provisions. GESI inputs were provided in the Maternal Under-nutrition Strategy and the Integrated Management of Childhood Illnesses (IMCI) Plan of CHD. Similarly the Service Tracking Survey and the Household Survey questionnaires incorporated GESI issues after GESI orientation to the team.

3 KEY CHALLENGES

3.1 Integrating social aspects into technical interventions

The different barriers that impact negatively on the access and use of health services by women, the poor and excluded require that the health sector integrate social aspects into its interventions. For example, uterine prolapse clinics must incorporate components for social mobilisation and health education of men and family decision makers alongwith targeting women. Without these aspects, women cannot benefit from the medical intervention fully and chances of relapse are high.

3.2 Identifying the income poor and extreme poor

Tools to identify the poor and extreme poor are not robust enough for targeting. At times this allows misuse and access by the more advantaged to resources meant for a specific target group. This is especially important for the effective implementation of the Social Service Units. Although the NPC has a process on-going for distribution of identity cards to the poor, it is yet to be finalised.

3.3 Multi-sectoral coordination to address issues of women, poor and the excluded

Developing an effective mechanism for coordination and collaboration between different ministries to address the complex issues impacting women and other excluded groups is a challenge that has been experienced. Services related with OCMCs in particular need to be better coordinated and the challenge is to convince and motivate different actors to work in a holistic manner towards a common goal.

3.4 Working with men and family decision makers

Working with women and empowering them is important but it is equally essential to work with husbands and other family decision-makers. A specific focus is needed to address attitudes, socio-cultural values and discriminatory practices that constrain access to health services for women and people from specific social groups such as Dalits. This requires other non-technical activities linked to medical interventions.

3.5 Effective implementation of GESI provisions in policies, plans and guidelines

A key challenge is to ensure implementation of plans that have been included by different divisions and centres in their AWPBs and Annual Business Plans. Budget cuts have also affected GESI sensitive interventions that they had planned. Effectively implementing the social audit guidelines, the GESI operational guidelines and the EAP, and ensuring that the institutional structures for GESI are functional require adequate resources and dedicated attention by all concerned.

3.6 Regular opportunities to strengthen skills of service providers

Continuous interventions are required to strengthen the skills of service providers to recognise the issues of women, the poor and excluded and to identify what measures can be taken in response. A key challenge is to find the required time for such continuous efforts.

The skills needed to integrate GESI in planning, programming and monitoring come with experience. However, opportunities to work on these issues with relevant staff are insufficient.

3.7 Making GESI Technical Working Groups (TWGs) functional

Without a budget defining activities, it has been difficult for district and regional level GESI TWGs to hold periodic review meetings, conduct orientation, collect evidence and take any action on decisions. Without a clear budget line, making the TWGs functional is a challenge.

3.8 Making EAP implementation effective

The major challenge to EAP's viability and the achievement of results is related to the delays incurred as a result of the long contracting process. Issuing one-year contracts significantly reduces community implementation time, leads to large gaps in community programming and support, and compromises the capacity of NGOs to facilitate the empowerment process. Social empowerment through the mobilisation of women's groups is at the heart of the EAP model. Without this, EAP is reduced to hurried, information giving programming rather than functioning as a powerful enabler of social change and empowerment.

4 LESSONS LEARNED

4.1 Mandatory directives are essential for GESI integration

The approved Institutional Structure guidelines have clearly established the location of responsibility for GESI mainstreaming within the health sector. This has given direction to the different committees and working groups concerning the mandatory tasks they must implement to ensure GESI mainstreaming.

Similarly the format of the Annual Business Plan demanded separate GESI specific activities. This ensured that each division and centre identified activities and assigned the responsibility for carrying them out.

The NHSP-2 Implementation Plan also included GESI aspects throughout based on the directives from PPICD making it mandatory for each plan to include GESI issues.

4.2 Multi-sectoral coordinated effort is necessary for effective service delivery from OCMCs

Due to the multi-pronged needs of GBV survivors it is important for different aspects of care, rehabilitation, protection and communication to be addressed. A comprehensive guideline outlining the interventions of the different ministries (MoHP, MWCSW, Ministry of Federal Affairs and Local Development (MFALD), Ministry of Law and Justice (MoLJ) and Ministry of Home Affairs (MoHA) is necessary for comprehensive care of GBV survivors. It is also essential to work on issues of prevention of GBV at family and community levels.

4.3 Robust system necessary for identifying the poor to provide services through SSUs

A robust system is necessary to identify the poor and extreme poor and those to whom the SSU should provide services. This makes it important to establish systems which will protect the service delivery and ensure that it reaches the target groups. It is also important to inform the target groups about the services.

4.4 Social mobilisation is essential for reaching the unreached.

The Rapid PEER study has reinforced the understanding that social mobilisation with groups that are not accessing or using health services is essential. Social mobilisation must also be context and social group specific since the reasons why people are not accessing services vary for different social groups.

4.5 Strengthening skills of service providers to apply GESI perspectives

Different methodologies are required for enhancing the skills of health service providers to apply a GESI lens in their work. Repeated interactions and discussions (e.g. during the preparation of AWPB and Implementation Plans) enabled the concerned staff of divisions and centres to recognise methods to address issues impacting women, poor and the excluded. The experiences of the Population Division have demonstrated that continuous dialogue and discussions, sharing about process and regular engagement on different activities increases analytical and responsive skills. Similar capacity building processes are necessary at district and health facility levels.

5 THE WAY FORWARD

5.1 Developing a multi-sectoral plan to address barriers of women, poor and excluded

Learning from the Multi-Sectoral Nutrition Plan and the National Action Plan on GBV, discussions to develop a multi-sectoral plan to address socio-economic and cultural barriers of women, poor and excluded will be started with NPC and relevant ministries. Addressing the cultural, social and religious determinants that impact the health outcomes of women, the poor and excluded requires multi-pronged interventions. Due to the complexity of the issues, only concerted efforts by all stakeholders will be able to create a difference for the people who still experience difficulties in accessing different services, including health services.

5.2 Local context specific planning with evidence

To actually understand who are the excluded and the reasons why they are unable to access and use health services, context specific planning efforts will be continued and up-scaled where possible. The practice of mapping who uses what services and who does not and why will be promoted. HFOMCs with the support of FCHVs should do this mapping as they have a good understanding of their catchment areas and will be able to inform health facilities accordingly.

5.3 Roll-out of GESI operational guidelines

Once the GESI operational guidelines are approved, they will be rolled-out to create a common understanding amongst different levels of health service providers about the mandatory provisions and the guidance for integrating GESI in the whole project cycle.

5.4 Continued strengthening of OCMC and SSUs

The functioning of OCMCs and SSUs will be strengthened. The issues identified in the process of implementation will be addressed. Comprehensive guidelines for OCMCs will be developed. Likewise, appropriate accountability mechanisms will be developed to ensure that SSU services reach the target groups.

5.5 Strengthening EAP implementation

The need for multi-year contracting and other issues hampering the effective implementation of EAP will tried to be addressed. This programme is essential to address the socio-cultural barriers to accessing and using health services experienced by women, the poor and excluded.

5.6 Budgetary provision for Technical Working Groups

The GESI Institutional Guidelines have specified that small budgets will be provided for TWGs to conduct activities necessary to facilitate the integration of GESI in review, mapping, planning and orientation/training. Efforts will be made to allocate some resources from the next AWPB period.

5.7 Integration of GESI in the AWPB and Annual Business Plan of FY 2013/14

The good practice initiated this year of GESI integration in the AWPB and Business Plan will continue. The GESI Focal Persons in each division and centre will undertake the necessary efforts to ensure that

the activities related with reaching the underserved areas and unreached groups are identified and costed. The TWGs at all levels will need to ensure that these aspects are well addressed in their plans and programmes.

5.8 GESI responsive indicators with disaggregation in HMIS

Work with HMIS will continue so that the levels of disaggregation and the indicators that will be most appropriate for disaggregation will be identified and integrated into the HMIS system.

5.9 Development of GESI modules and materials for selected training curricula

Joint work with NHTC will be done to develop modules and materials required for specific training curriculums under the guidance of a technical group. Materials will be developed in consultation with regional and national trainers, key concerned divisions and with inputs of GESI and curriculum design experts.

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ANNEX 1: MAJOR STRATEGIES AND ACTIVITIES ON GESI IN THE NHSP-2 IMPLEMENTATION PLAN

Major Strategies for addressing GESI

- Mainstreaming GESI in policies and programmes
- Institutionalising GESI in health systems and practices
- Promoting an inclusive and GESI-competent health work force
- Promoting state/non-state partnerships for GESI
- Maintaining equity in delivering health care services
- Addressing the social, cultural and economic barriers faced by the unreached
- Addressing the health needs of GBV survivors
- Empowering women, the poor and excluded so they can access health services
- Improving the care-seeking behaviour of women, the poor and excluded
- Enabling GESI-related evidence-based M&E.

Major Strategies	Major Activities
Mainstreaming GESI in the health sector	Develop GESI operational guidelines for the health sector
	Review and revise selected policies from a GESI perspective
	Ensure GESI integration in new policies, strategies and guidelines
	Review national programmes (e.g. kala-azar, nutrition) from a GESI perspective and address GESI integration
	Include GESI related activities in all programmes of MoHP
	Mainstream GESI in the annual programme guidelines of divisions and centres
Institutionalising GESI in the health sector	Develop a MoHP approved concept note for mainstreaming GESI in the health sector
	Form a GESI Steering Committee at MoHP and a GESI TWG at DoHS, RHD and district levels
	Strengthen and make functional GESI TWGs and Focal Persons at all levels (DoHS, RHD and DHO)
	Strengthen the capacity of the HFOMC to address GESI- and governance-related issues
Inclusive and GESI-competent HR (cross reference HR and Safe Motherhood)	Strengthen the capacity of the health workforce to work in a GESI-responsive manner through orientation, training, on-the-job coaching, and mentoring
	Support the implementation of HRH Strategy to promote diversity in the health work force
	Select, train and deploy ANMs from among Dalit and other disadvantaged groups (*rahat*)
	Facilitate Mothers Groups for Health to select FCHVs from among Dalits and excluded groups

Major Strategies	Major Activities
Review training curricula of health sector and GESI integration	Review and revise selected training curricula from a GESI perspective
	Strengthen the capacity of NHTC on GESI integration in training programmes
Improve the care-seeking behaviour of women, the poor and excluded	Develop and implement context-specific IEC materials targeting issues constraining health outcomes of women, the poor and excluded
	Air messages on community radio in local languages about addressing structural GESI-related issues and on health services in general
Empower women, the poor and excluded	Develop and implement targeted programmes to empower the target groups to claim their rights (promoting equity and access)
	Develop and make functional GoN's and NGOs' multi-year partnership model to promote equity and access
	Promote active participation of women, the poor and excluded in social audit programmes
Maintain and promote equitable universal health coverage for the delivery of health care services	Establish health facilities in underserved areas
	Mainstream GESI into initiatives and programmes of other divisions (e.g. of CHD, FHD, MD)
	Conduct operational research as required to identify good practices
	Develop and implement health-sector-specific gender-responsive budgeting guidelines
	Identify and address socioeconomic and cultural barriers of specific target groups
	Review and revise the HFOMC guidelines to make them more inclusive and governance-responsive
	Strengthen the capacity of the HFOMC from GESI and governance perspectives
Addressing GBV	Develop OCMC Implementation Guidelines and revise based on review and assessment
	Pilot hospital-based OCMCs in seven districts and roll out to additional districts
	Provide capacity strengthening of OCMCs on providing services (treatment, psychosocial counselling, and coordination) to make them effective and functional
	Develop screening and referral protocols for GBV cases and a user's guide on GBV
	Develop unified guidelines for addressing GBV (MoHP, MFALD, MWCSW, MoHA and MoLJ)
Establish and strengthen Social	Conduct a study of existing practices of social services in central, regional and zonal hospitals

Major Strategies	Major Activities
Service Units (SSUs) at central, regional and zonal hospitals	Establish and strengthen SSUs as a pilot
	Assess the piloting of SSUs, revise the guidelines and roll out in additional hospitals
Promote accountability	Conduct social audits up to the level of selected district hospitals and peripheral health facilities in selected districts
Gender audit in health sector	Develop a Gender Audit Framework and Terms of Reference for the audit
	Conduct a gender audit of MoHP
Supervision and M&E	Revise the existing supervision checklist and methods from GESI and governance perspectives
	Develop monitoring tools and checklists for service delivery from a GESI perspective
	Carry out data management disaggregation by caste/ethnicity and wealth quintiles
	Integrate GESI-related variables in health financing, the Service Tracking Survey and the Household Survey.

Source: NHSP 2 Implementation Plan (draft), 2012: Part 3.3

ANNEX 2: VOICES FROM THE COMMUNITY, ACCESS TO HEALTH SERVICES (PEER STUDY, NEPAL) (DRAFT)

1. Introduction

The objective of this study was to gain an in-depth understanding of the socio-cultural, economic, and institutional barriers to accessing health services experienced by poor and excluded women and men in Nepal. The study focussed on examining community members' experiences of accessing specific services provided within the Essential Health Care Services (EHCS) package. These included Family Planning (FP), maternal health care, safe abortion, and child immunisation services provided at Village Development Committee (VDC) level through Sub-Health Posts (SHPs), Health Posts (HPs), and outreach extension activities.

2. Methodology

PEER (Participatory Ethnographic Evaluation and Research) is a participatory qualitative research method which captures the voices of ordinary members of a community and obtains an insider's view of social relationships and health-related behaviour and beliefs. Rapid PEER is an adapted version of PEER. It is designed to inform policy and programme development through gaining an in-depth insight into the beliefs, behaviours, and understandings of service beneficiaries, in the full context of their lived experience, within a short time frame.

Between August-October 2012, 12 Rapid PEER studies were undertaken with men and women from six ethnic/caste groups in six districts across Nepal. The sampling framework is illustrated below.

HILL DISTRICTS:		
DOTI	MAKAWANPUR	DHADING
1. Hill Dalit	3. Hill Janajatis (Chepang)	5. Hill Janajatis (Chepang)
2. Hill Brahmin/Chhetri	4. Hill Brahmin/Chhetri	6. Hill Dalit
TERAI DISTRICTS:		
RAUTAHT	BANKE	SAPTARI
7. Madhesi Dalit	9. Muslim	11. Madhesi Dalit
8. Muslim	10. OBCs	12. OBCs

This study design allowed for comparative analyses of access to health care services by gender, social group (e.g. Hill Dalits, Hill Brahmin/Chhetri, Chepang, Muslim, Other Backward Class (OBC), and Madhesi Dalit), and terrain (Hill vs. Terai districts). It complements quantitative data from other national surveys in Nepal (e.g. Nepal Demographic and Health Surveys (NDHSs) in 2006 and 2011, the 2011 Service Tracking Survey (STS) and the Nepal Maternal Mortality and Morbidity Study (MMMS) 2008/2009), helping to explain the *how* or *why* of social issues which these studies raised. As in many in-depth qualitative studies, findings discussed are not based on a nationally representative sample. The detailed information in this report does, however, provide indicative findings that may be relevant for policy development and service delivery in a range of other rural settings with excluded groups.

Each of the 12 studies followed the same process. Sixteen members of the target community (12 women and four men) were selected to be trained as PEER Researchers. More women than men were selected to ensure a focus on excluded women's experiences and perceptions. Only people from poor households (those selected were not in regular employment or earning regular income,

and had a food sufficiency of less than six months) were selected. After two days' training in conversational, qualitative interviewing, each spoke with two members of their social networks about: the health services used locally; factors which enhanced use of local services; factors which inhibited use of local services; experiences of those who found it difficult to use local services; and factors that would enhance local access in the future. In each study, 32 interviews were carried out (a total of 384 interviews across the 12 studies). The aim of data collection was to collect narratives, stories, and quotes that provide insights into how interviewees conceptualised and gave meaning to the experiences and behaviour of 'others' in their social network. Questions were asked in the third person to prevent normative responses. The narrative interview data were analysed thematically, looking for similarities and differences across the 12 study sites according to gender, terrain, and social group, and in relation to each of the four health areas.

Ethical considerations were taken into account throughout the research and analysis process. In summary, strategies were adopted to: ensure confidentiality and anonymity; gain appropriate consent from PEER Researchers and respondents; ensure realistic expectations regarding the outcomes of the study amongst all stakeholders; protect relationships of trust between PEER Researchers and their respondents; and correct misinformation reported by PEER Researchers.

Results are presented in Chapters 3-6, and recommendations are presented in Chapter 7.

Source: Voices of the Community, Access to Health Services, A Rapid PEER Study, Nepal – DRAFT, Population Division/NHSSP, December 2012

ANNEX 3: REPORT ON GENDER EQUALITY AND SOCIAL INCLUSION AGAINST ANNEX 3, NHSP-2

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
OBJECTIVE 1: DEVELOP POLICIES, STRATEGIES, PLANS AND PROGRAMMES THAT CREATE A FAVOURABLE 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.	1. Integrate GESI in existing health policy, regulations and guidelines. 2. Advocate for health as a fundamental human right in the constitution. 3. Include the standards for integration of GESI in NHSP-2. 4. Develop mechanisms for regular policy feedback. 5. Revise HMIS to improve health monitoring on GESI. 6. Identify and recommend expansion of health facilities to locations with high concentrations of underserved poor and excluded groups.	1.1 Review of Health Policy 1991 – this has identified a number of issues from a GESI perspective which need to be included in the revised policy. 1.2 Health Sector Strategy for addressing Maternal Under-nutrition was developed and GESI issues incorporated through a participatory process of consultations. 1.3 Nepal Community-based Integrated Management of Childhood Illnesses (CB-IMCI) Multiyear Plan 2012-2017 was reviewed and GESI aspects discussed with the concerned team in CHD. 1.4 The NHSP-2 Implementation Plan for different programmes in the health sector was influenced to include GESI related interventions. A separate section was included on GESI activities under the Population Division. 1.5 A review of the institutional capacity of NHTC was done, with the incorporation of GESI aspects. 1.6 Health Communication Policy was developed and GESI issues were incorporated through a consultative process. 1.7 A thorough review of the social audit practice in Nepal was conducted, covering both the health and non-health sectors. Based on the review recommendations, comprehensive social audit guidelines were developed and piloted. Social audit guidelines were provisionally approved by MoHP and implemented in 18 districts in 2012. Social Audit Guidelines were finalised by December 2012, incorporating feedback from districts where social audits were conducted. 1.8 One-stop Crisis Management Centre (OCMC) Guidelines were revised in 2012, making provision for OCMC in the Maternity Hospital and incorporating field level experiences. 1.9 The concept note of GESI institutional modalities was adapted as guidelines by the GESI Steering Committee in August 2012 after one year of piloting experience. 1.10 Social Service Unit (SSU) Operational Guidelines were revised after extensive consultations. 5. The possible level of caste/ethnicity and regional disaggregation in HMIS was discussed with HMIS and the need for further work at the NPC level was identified. Indicators have been identified which need to be disaggregated by sex, age, location, caste/ethnicity/regional identity.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting.	7. Develop policy for identification of poor and excluded groups. 8. Develop implementation guidelines and ensure implementation. 9. Develop policy measures to promote GESI in human resource management. 10. Develop provisions for poor and excluded groups to receive free secondary and tertiary health care services. 11. Formulate provisions for compulsory social auditing to make health services inclusive, transparent and accountable. 12. Incorporate GESI in e-AWPB programmes and MoHP activities. 13. Advocate to the MoF and NPC for regular budget provisioning of GESI in AWPB. 14. Formulate provision for health cooperatives for easier access of poor and excluded to health services. 15. Develop provision for Health Insurance to increase access to health services of poor and excluded. 16. Formulate provision for media to disseminate health care messages and inform about facilities for poor and excluded groups.	7. Mapping tools to identify poor and excluded groups were drafted and piloted. GESI regional review and planning activities were incorporated in the AWPB of 2012/13. 8. Development of GESI operational guidelines – these guidelines have been developed under the guidance of a technical committee chaired by the Chief of the Population Division and will be submitted for approval in February 2013. They provide guidance for GESI integration in policy development, planning, programming, budgeting, monitoring, evaluation and reporting. 9. A Health Sector Human Resource Strategy was developed to address the need for human resource management, and GESI issues were incorporated through a participatory process of consultations. This strategy also aims to address issues of absenteeism and of regularising health services in remote areas. 10. Provision for poor and excluded groups to receive free secondary and tertiary health care services in eight selected hospitals through Social Service Units has been finalised and submitted to the Ministry for approval. 11. Social Audit was conducted in a total of 147 HFs (of these, 21 HFs were audited through NHSSP TA in two districts - Rupandehi and Palpa, and 126 HFs of 17 districts were audited through the AWPB) in the last FY (2011-2012); The action plan prepared at the end of the social audit will be monitored in NHSSP supported facilities and a thorough review of the social audit process will also be conducted next year. 12. GESI activities were discussed and identified with different divisions and centres for the AWPB 2012-2013. For the Population Division and PHCRD, detailed plans covering GESI activities were developed with the relevant staff. A business plan format was provided by PPICD to all the divisions and centres which had a section on GESI. An Annual Business Plan was developed by different divisions and centres which specified GESI related activities. 15. The Health Insurance programme in 6 facilities of 6 districts (1 in each district) will be continued. 16. A series of national IEC/BCC strategies was developed, especially on SMNCH, ASRH and FP, that included targeted (GESI related) interventions for people living remote areas, and people with different languages and contexts. The strategies also provide for localising media and materials to address local contextual needs and requirements.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
Strategy 2: Prioritise 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 marginalised castes and ethnic groups.		
Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programmes, budgeting, monitoring and evaluation.	17. Address GESI issues in plans, programmes and budgets. 18. Develop GESI indicators as necessary, disaggregate the HMIS, monitor and report performance of target groups. 19. Define roles and responsibilities for monitoring and evaluating performance of target groups. 20. Develop mechanisms/ processes to review the progress from a GESI perspective periodically.	17. Inputs for including GESI related directives in the programme guidelines issued by division and centres for districts were provided as relevant for the preparation of the AWPB and the guidelines. 18. Health programme monitoring indicators under HIMS are being reviewed and updated to incorporate GESI provisions. Indicators have been identified which need to be disaggregated by sex, age, location, caste/ethnicity/regional identity. Recording and reporting formats are also being updated and will be piloted in 2013. 19. Annual regional health reviews were conducted from a GESI perspective. GESI issues and innovations were incorporated in the annual review report and will be incorporated in next year's AWPB.
Include GESI related issues in programme implementation by health service providers.	21. Operationalise guidelines to facilitate access and utilisation of health services by the poor and excluded. 22. Ensure that the work of every health institution includes GESI.	21. The equity and access programme for rights based empowerment was implemented in 21 different districts in partnership with local NGOs.
Coordination and participation among concerned organisations for GESI.	*23.* Coordinate with MLD, MoF and NPC to allocate more budget for GESI in DDCs, VDCs and Municipalities. *24.* Coordinate and implement with DDCs, VDCs, and Municipalities to attract their social development budgets in the health sector. *25.* Continue handover of health facilities at local level and make the HFOMCs inclusive. *26.* Coordinate/partnership with district- and village-level NGOs working in the health sector. *27.* Coordinate with Ministries, I/NGOs and local bodies to integrate GESI in their programmes. *28.* Create trust between health care providers and communities. *29.* Create policy provisions to make local bodies responsible to develop participatory inclusive plans, and to implement and monitor them. *30.* Transfer knowledge, skills, resources and materials to local bodies to meet the needs of the target groups.	26. All the districts that implemented social audits also utilised NGOs as third parties through partnership development. 28. One of the major activities carried out under the equity and access programme is organising interaction between service providers and service users to develop coordination and create trust between them. This will enable health facilities to provide responsive service for the poor and excluded. 29. The local health strengthening programme is piloted in 8 out of 75 districts of Nepal to enable VDCs, including health facility management committees, to identify and address local health needs through local planning. These inputs also encourage the generation and mobilisation of local resources to implement local health planning.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
Strategy 3: Establish and institutionalise 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.	31. Establish and operationalise Social Service Units in central, regional, sub-regional, zonal, and district hospitals.	31.1 The Ministry conducted a study in 2012 with TA support of NHSSP on Free Health Care Services and the Provision of Subsidies in Koshi, Bheri and Bharatpur Hospitals. Given the findings of the SSU study, MoHP identified the need to revise the Social Service Unit (SSU) guidelines and apply them to the start-up of the SSU pilots in eight hospitals. MoHP formed a task force to revise the guidelines. 31.2 Population Division developed a road map for the revision of the SSU guidelines and the strengthening of SSUs. The task force had prepared the draft guidelines in consultation with hospitals, DoHS and MoHP officials. A final consultation workshop on the draft guidelines was organised and was chaired by the Secretary of MoHP. The guidelines were finalised incorporating inputs and feedback provided in the final workshop and submitted to the Secretary for approval. 31.3 SSUs will be established in eight hospitals (central, regional and zonal) in 2013 on a pilot basis and scaled up only after two years of piloting experience. Orientation on the SSU in hospitals will be organised in 2013.
b) Establish GESI Unit/Desk at different levels of the health sector.	32. Establish GESI and internalise a GESI unit within MoHP, DoHS, RHDs, and D(P)HOs.	32. 1 A GESI Steering Committee was formed in 2011 at MoHP under the chair of the Secretary and regular meetings have been called as provisioned in the guidelines. The Steering Committee has been able to guide and give policy direction to address GESI related issues. Similarly a GESI Committee was formed in 2011 at DoHS under the chair of Director General, DoHS. Technical working groups at MoHP and at DoHS have been formed and oriented on GESI, including their roles. A GESI Institutional Structure guideline has been approved. GESI technical working groups have been formed in five RHDs and fifty-one districts. GESI focal persons have been nominated in all RHDs and seventy five D(P)HOs. Technical working groups have had meetings but they need to be made more regular. 32.2 Population Division has planned to request zonal and regional hospitals and medical colleges to select GESI focal persons and organise training for them on GESI mainstreaming in service delivery. 32.3 PHCRD has been planning to organise GESI mainstreaming training to D(P)HO staff of ten districts.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
OBJECTIVE 2: ENHANCE THE CAPACITY OF SERVICE PROVIDERS AND ENSURE EQUITABLE ACCESS AND USE OF HEALTH SERVICES BY THE POOR, VULNERABLE AND MARGINALISED 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, marginalised 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 marginalised caste and ethnic groups.	33. Sensitise health workers, SSU and GESI focal points at all levels, FCHVs, and HFOMCs on GESI. 34. Implement behaviour change training for the health workers, FCHVs and local HFOMCs. 35. Strengthen capacity of FCHVs and NGOs to provide proper information to target groups on health services. 36. Include GESI content in the health sector education and training curricula.	33.1 GESI orientation was provided to the Secretary, MoHP; the Chiefs of divisions and centres of MoHP and DoHS; the GESI Secretariat (Population Division in MOHP and PHCRD in DoHS); and GESI focal persons of MoHP and DoHS. 33.2 GESI orientation was provided to technical working groups in five regions and fifty one districts. GESI orientation was provided to RHD officials and D(P)HOs and focal persons of seventy-five districts. 35. Capacity building training to NGOs and FCHVs was provided under the EAP programme, and health messages were disseminated to target groups, especially women, the poor and excluded. 36. A draft report was prepared on the review of five training curricula (SBA, upgrading AHW, FCHVs, BCC, HFMC). Findings of the GESI review of these five training curricula were shared by NHTC with the Training Review Committee and next steps identified. A ToR has been developed by NHTC to prepare GESI related modules and materials for integration of GESI in selected curricula.
Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasising programmes to reduce morbidity and mortality of the poor, vulnerable and marginalised castes and ethnic groups.		
Increase access of the target groups to universal and targeted free care programmes.	37. Develop criteria to identify poor and excluded groups and provide them with "Free Health Check-up Cards" for secondary- and tertiary-level health care services and referrals. 38. Ensure equitable and meaningful participation of target groups and women in HFOMCs. 39. Ensure meaningful participation of poor and excluded groups in social audits of health services.	37. OCMCs were established in eight hospitals in 2012 and basic orientation about the OCMC establishment and operation was provided. Backstopping organisational and management support was provided to all established OCMCs. 39. Social audit guidelines have provisions to include women, the poor and socially as well as geographically excluded in the consultation process during the auditing.
Increase the use of Mother and Child Health and Free delivery services by the target group.	**i) Develop special programmes for women, poor, and excluded groups (women and children) to increase their access to MCH services and free deliveries.** 40. Support increasing use of neonatal and postnatal care services, institutional deliveries, nutrition, and childhood immunisation. 41. Mobilise and train/strengthen FCHVs and NGOs to increase target groups' access to services. 42. Provide assistance on awareness raising, IEC/BCC programmes, outreach services to pregnant women.	41. EAP implementation for community mobilisation was carried out in 21 districts through local NGOs.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
	ii) Address gender based discrimination which constrains access of women (of different social groups) to health care services, especially institutional deliveries. 43. Collaborate with women's CBOs /NGOs on gender and social based discrimination. 44. Conduct community and family counselling on GBV. 45. Promote regular work attendance of female health workers.	44. Hospital based OCMCs were established in eight districts in the last FY including Maternity Hospital, Thapathali, Kathmandu. OCMC guidelines were revised after incorporating feedback from implementation. *16 Days GBV campaign:* Awareness programmes, radio jingles, review workshops, rallies, interviews were organised at regional and district levels during the 16 days of activism. This has contributed to developing some sensitivity about violence against women and girls and an understanding of GoN's plans to address GBV.
Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalised caste and ethnic groups and areas (Regional and/or District).	**iii) Promote service expansion in geographically inaccessible/remote regions.** 46. Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the target groups. 47. When establishing new HP/SHPs, select sites most appropriate for the target groups' access and use.	46.1 Based on the draft guidelines, mapping of unreached VDCs was conducted in ten districts and mapping of unreached wards and social groups was conducted in three VDCs. 46.2 A study to identify the barriers for women and men of selected social groups such as Hill and Madhesi Dalits, Chepangs, Muslims, Hill Brahmin/Chhetri, and Other Backward Classes was conducted using a qualitative methodology called Participatory Ethnographic Evaluation Research (PEER). The findings were disseminated widely.
	iv) . Expand services in low HDI districts. 48. Focus on community and outreach programmes in the 35 low HDI districts. 49. Ensure programmes are focused at less populated areas to make the target groups feel health as their fundamental right.	
	v) Make provision for regional programmes to address unmet health issues and needs of women, poor and excluded groups. 50. Promote programmes like publicity campaigns, outreach services, counselling services and orientations to free care. 51. Conduct special activities to reach Dalits. 52. Implement special programmes such as providing monetary incentives to those using EHCS.	
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.	53. Ensure the presence of female doctors at all district hospitals. 54. Make a provision for local language speaking staff at service delivery sites. 55. Allow the district-level health organisation to adopt district-specific GESI policy, if needed. 56. Conduct social audits.	56. Social audit was conducted in 147 health facilities of 18 districts in FY 2068/69 – 2012/13.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
OBJECTIVE 3: IMPROVE HEALTH SEEKING BEHAVIOUR OF THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behaviour of the poor, vulnerable and marginalised groups.		
Develop and disseminate targeted IEC materials that will bring changes in behaviour of target groups.	57. Prepare and distribute enough audio visual, pictorial, etc. information and publicity materials. 58. Include the target groups' programme in publicity and communication materials of MoHP. 59. Develop skills at the local level for producing information materials, especially in remote areas.	57. Development, production and distribution of variety of communication media materials – radio jingles, health tele-serials, and print materials was continued. 58. The localisation strategy of centrally developed media and materials in SMNCH, FP and ASRH BCC/IEC Strategies was continued. 59. Capacity building of district BCC/IEC focal persons of all 75 districts was carried out, focusing on use of local media and materials.
Increase the use of appropriate media.	60. All media allocate appropriate time for broadcasting health service news. 61. Emphasise use of effective media and local languages. 62. Increase information communication on GESI among health institutions. 63. Include appropriate media programming for low HDI districts and districts with diverse language. 64. Conduct regular monitoring on quality of communication services.	61. Capacity building of district BCC/IEC focal persons of all 75 districts was carried out, focusing on use of local media and materials.
Strategy 8: Empower the target groups to demand their rights and conduct their roles while realising their responsibilities.		
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.	**vi) Empowerment.** 65. Conduct activities for the target groups to make them aware of their rights/responsibilities and capable of taking leadership roles. **vii) Information, Education and Communication** 66. Conduct publicity campaigns on how to access and properly utilise health services. 67. Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups. 68. Develop and conduct orientation and awareness campaigns for change in health seeking behaviours. 69. Promote women's participation and conduct awareness on equal treatment of both male and female children. 70. Provide orientation on women's reproductive health rights.	65. The equity and access programme was implemented in 21 districts to mobilise targeted communities (women, the poor and excluded), applying rights based social mobilisation. NGOs and FCHVs were mobilised to promote health rights, and they disseminated messages to the communities by using the methods of mass communication, group facilitation, behaviour change communication and interpersonal communication. Messages related to the entire health programme including safe motherhood, new-born care, nutrition, institutional delivery, immunisation, family planning, free health care etc. were included in the programme.