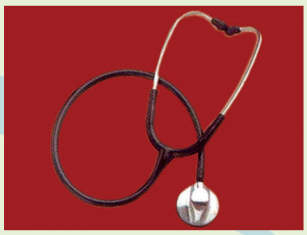
July 2013

Ministry of Health & Population

NHSSP

Gender Equality and Social Inclusion: from Strategy to Implementation



GESI Reflected in Family Health Division and Child Health Division Planning

Dr. Maureen Dariang
Dr. Ganga Shakya
Chhaya Jha
Cherry Bird

Strengthening Health Systems-Improving Services

CONTENTS

LIST OF ACRONYMS

ANM	Auxiliary Nurse Midwife
AusAID	Australian Agency for International Development
AWPB	Annual Work Plan and Budget
CB-IMCI	Community Based Integrated Management of Childhood Illness
CB-NCP	Community Based Newborn Care Package
CEONC	Comprehensive Emergency Obstetric and Newborn Care
CHD	Child Health Division
CMAM	Community Management of Acute Malnutrition
DFID	Department For International Development
DoHS	Department of Health Services
D/PHO	District/ Public Health Office
EDP	External Development Partner
EHCS	Essential Health Care Services
FCHV	Female Community Health Volunteer
FHD	Family Health Division
GESI	Gender Equality and Social Inclusion
HMIS	Health Information Management System
IUCD	Intra-Uterine Contraceptive Device
IYCF	Infant and Young Children Feeding
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MNCH	Maternal Newborn and Child Health
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic and Health Survey
NFHP	Nepal family Health Program
NGO	Non-Government Organisation
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NSI	Nick Simons Institute
PEER	Participatory Ethnographic Evaluation and Research
PHCC	Primary Health Care Centre
PPICD	Policy Planning and International Cooperation Division
SBA	Skilled Birth Attendance/ Attendant
SCI	Save the Children International
TA	Technical Assistance
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
WHO	World Health Organisation

EXECUTIVE SUMMARY

This paper, prepared by the Nepal Health Sector Support programme (NHSSP), documents the process by which technical assistance has supported integration of Gender Equality and Social Inclusion (GESI) into the planning of the Family Health Division (FHD) and Child Health Division (CHD) of the Department of Health Services, based on evidence from their Annual Work Plans and Budgets (AWPB). It also assesses the extent to which GESI has been integrated into AWPBs through a content review of the plans and a financial review of resource allocation for GESI related work. By considering these two divisions, this paper acts as a case study, complementing a broader review of progress and learning in mainstreaming GESI across the whole health sector[1], undertaken by the GESI secretariat (Population Division).

Mainstreaming GESI requires a focus on identifying and reaching underserved populations, defined as groups that have little or no access to and use of health services, and consequent poor health outcomes, due to poverty, low social status (caste or ethnic group) and/or living in a remote area. FHD and CHD have recognised the need to target these groups, but there are barriers at both supply and demand levels. Existing implementation challenges to be addressed include:

- Insufficient human and financial resources to effectively address the particular needs of underserved groups, which requires more resources, combined with lack of understanding of why specific groups are not using services and lack of programming to reach those groups
- Increasing cost benefit ratio of scaling up programmes in hard to reach areas, so they are often the last to be covered, even though the need for programmes, such as child nutrition, is greater
- Insufficient availability and use of monitoring data on child health and family health issues, especially related to underserved areas and unreached groups
- Shortage of qualified and skilled health workers and high levels of absenteeism, particularly in remote areas
- Inadequate internalisation among health workers of the importance of responsive behaviour for promoting service delivery to unreached groups
- The fact that Female Community Health Volunteers (FCHV), who carry out social mobilisation and health education at community level and provide home based care, are usually from higher socio-economic groups and therefore less able to reach those from marginalised groups
- Lack of flexible funds at district and sub-district level to support particular locally identified needs and activities
- Difficulties in reaching marginalised groups, men as well as women, with accessible information (in terms of language and culture) and addressing high transport costs

Process

Support to GESI in maternal newborn and child health was recognised as an opportunity for the Government of Nepal to explore the extent to which technical assistance could facilitate mapping of underserved populations and implementation of approaches to increase use of health services

[1] Population Division, MoHP, July 2013, "GESI Mainstreaming in the Health Sector: Progress Review and Process Documentation"

among underserved groups. Key enabling factors that have facilitated progress in mainstreaming GESI within FHD and CHD are:

- Strong policy mandates nationally and specifically for health, such as the Safe Motherhood Implementation Plan, which has a GESI focus
- Government leadership and ownership at all levels, ensuring a high profile for GESI principles
- Close working relationships developed with FHD/CHD colleagues through day to day interactions and participation in Government forums and working groups
- Advocacy to raise the profile of GESI and increase the understanding of FHD and CHD staff
- Donor support and harmonisation on the need for targeting underserved populations
- Gathering of sound evidence on women and children's health outcomes, including disaggregated evidence on disparities, based on studies carried out by NHSSP and other partners and shared among partners and Government
- Guidance on planning with a GESI perspective at central, regional and district levels, provided by MoHP to FHD and CHD and supported by NHSSP advocacy
- Increase in focused budget allocation

Outcomes

The enabling environment generated for GESI mainstreaming is in itself an outcome that will continue to influence progress.

Family Health Division

Developing and implementing the Remote Area Guidelines for Safe Motherhood (2009) enabled FHD to focus on expanding key services to primary health care centres, health posts and sub-health posts (including outreach clinics), which are more accessible to poor women living in remote areas. Family planning, antenatal care (four visits), skilled birth attendance and CEONC (including safe blood) are priority programmes for reducing maternal mortality, but in remote hill/ mountain areas availability and uptake of these key services is low. Proposed activities to address this are:

- Increased behaviour change communication
- Micro-planning in poorly performing areas and those with high unmet needs
- Ensuring availability of full family planning services in all public health facilities
- Integration of services to reduce the number of times women need to visit a facility
- Expanding and strengthening outreach services
- Encouraging public private partnership to increase the availability of services and supplies

The FHD 2013/14 business plan[2] commits to a special focus on poor, marginalised and vulnerable populations to improve the health status and quality of life of the population. Almost 75% of the total budget was allocated for district spending over the last three years, which is encouraging. However, localised management of resources to enable targeting of needy groups based on local

[2] A compilation of the policy and resource allocation decisions that determine the activities, programmes and services that will be delivered in the fiscal year (*source: Business Plan 20112/13, MoHP*)

knowledge in keeping with GESI principles is limited by the fact that programme amounts are set by the centre, with the districts only permitted to spend within the ceilings for each programme.

Major strategies specifically targeting women and excluded groups are: increasing the accessibility and availability of family planning services for remote and excluded populations; expanding and strengthening outreach services; referral funding for remote areas; and strengthening of community based programming, including distribution of misoprostol through FCHVs to prevent postpartum haemorrhage.

In the 20 remote/ low performing districts targeted in the 2012/13 plan for improved availability of CEONC services, 19 of the district hospitals are now providing full services, with the required service teams (including doctors able to provide caesarean sections) and infrastructure in place.

Major conclusions drawn from analysis of financial allocations over the last three years are:

- Understandably women are the main target group of FHD, but there is limited attention to disadvantaged groups within women, for example only 5% of the budget over three years has targeted women in remote locations. There has been little programme recognition that women from disadvantaged socio-economic groups, such as Dalits, Janjati groups, Muslims and Madhesi, experience greater barriers in accessing healthcare, despite the existence of disaggregated data from the NDHS 2006 and 2011 highlighting wide disparities in health outcomes.
- While the strong focus on service delivery is important, investments are needed to enhance the voice and confidence of women, enabling them to influence their families, communities and service providers to make them more accountable. Some of this work falls within the remit for advocacy and mobilisation of the National Health Education Information Communication Centre, but changes can also be seen in the most recent FHD budget (2013/14), with activities to address voice increasing to above 7%, from 2% in 2012/13. It is also essential that FHD works with decision makers and social gatekeepers to change the mind-sets and discriminatory attitudes and values which constrain access to and use of services by women of different social groups.

Child Health Division

The core objectives stated in the CHD business plans (2012/13 and 2013/14) are to reduce under-five mortality, morbidity and disability, and to improve the nutritional status of mothers and children. CHD prioritises the following activities for reaching unreached children:

- Reaching every child with immunisation through micro-planning and mobilisation of FCHVs
- Focusing interventions on areas where malnutrition is common and specifically on malnourished children within those areas
- Explicitly stating “reaching unreached children” in the CHD Community Based Integrated Management of Childhood Illness and Newborn Care Long Term Plan

Major conclusions drawn from the GESI analysis of financial allocations over the last three years are:

- Over the three years, 80% of the budget was allocated to activities intended to benefit all children, without recognition of the specific barriers to accessing services experienced by

children from low income and socially disadvantaged groups, those in remote locations and girl children, although it is to be appreciated that 16% of the budget is specifically for malnourished children and for identifying underserved children through micro-planning for immunisation. The budget for creating an enabling/ responsive environment, including micro-planning to ensure targeted interventions for underserved areas, advocacy, reviews to inform decisions and evidence based research, is increasing (by 2-3%, up to 7% in 2013/14) and the targeted budget allocation has increased from 11% in 2011/12 to 18% in 2013/14. The major portion of this was for nutrition related activities in the Karnali zone. The fact that no funds were allocated for addressing income based barriers among children or barriers based on social profile is a concern.

- Malnourished children are the main target group, accounting for 43% of the financial allocation for GESI activities over the three years. This decreased slightly in 2013/14, but with an increase in activities such as strengthening the skills and motivation of FCHVs to reach children.
- Service provision accounts for 92% of the CHD allocated budget over the three years.
- It is encouraging that there has been an appreciable increase in the allocation for activities to bring about changes in discriminatory attitudes, social norms and policies.

Mainstreaming GESI and reaching the underserved: Proposals for the future

In order to build on the achievements and learning to date, the following proposals are made.

Planning and programming

- The GESI focus needs to continue as an integral part of programme review and planning.
- Division programme implementation guidelines should incorporate directives for GESI integration in programme activities.
- Programme activities must include targeted interventions to address discriminatory practices and processes that constrain women and children of different social groups (such as Muslims and Madhesi Dalits) from accessing services.
- Learning from remote area initiatives, such the integration of family planning with immunisation and piloting of safe abortion services in remote districts (Kalikot and Myagdi), should be incorporated into national planning.
- Strengthening of district level monitoring and mentoring to enhance and expand services in remote districts should be continued through regional safe motherhood coordinators and supervisors. This will include analysis of data through a GESI lens.
- Selection of locations for new and upgraded health facilities, including birthing centres, should focus on areas where more than 50% of the catchment population is underserved, rather than looking only at overall numbers served.
- District specific local planning, based on formative research, should be strengthened to support programme implementation and communications.
- NHSSP and partners will continue to advocate for district and Ilaka level, context specific planning involving stakeholders from other sectors where appropriate, as this is essential to reach underserved populations who may be missed by centralised planning. District specific local planning to identify and reach unreached groups, with flexible budgets to implement plans, should be part of the centrally allocated district budget.

Capacity enhancement

- The skills of service providers should be enhanced to enable them to provide quality services close to the community, at sub/health posts and outreach clinics. This should include training and support for ANMs to provide IUCD and implant services and improved counselling skills of all family planning providers to increase uptake and understanding of couples on management of the method of their choice and any possible side effects.
- Critical human resource gaps must be addressed, including placement of an appropriate mix of female and male staff in each facility, improving staff attendance and increasing supervision and monitoring to reduce absenteeism.
- Multi-year contracts and training for all locally recruited health workers are needed, to increase the availability and retention of health workers and continuity of services. Although the Government supports this in principle, currently budgets cannot be assured, especially for higher salaried staff.

Coordination and collaboration

- FHD and CHD should partner with external agencies to implement services in remote districts, where unit costs are high.
- Partnerships should be developed with local civil society organisations to address social, cultural and religious beliefs that affect maternal and child health through behaviour change communication targeting women, their family gatekeepers and local stakeholders.
- Local social networks and partners should be involved in implementation of activities.

The GESI guidelines give specific guidance on the process for integration of GESI in the development of AWPBs and business plans, which NHSSP will support. In summary, these include:

- Addressing national priorities and the NHSP-2 results framework in preparation of division/ centre plans, with special attention to reaching the unreached, ensuring equitable services and resources and obtaining key evidence needed for addressing gaps in health service utilisation
- Ensuring activities for reaching the unreached include social mobilisation, advocacy, behaviour change communication, capacity building and innovative service delivery methods
- Inclusion of costed GESI plans into the business plans and AWPBs
- Division and centre level meetings to specifically discuss planned GESI related activities in the different sections
- DoHS level discussion to ensure instructions from the Policy Planning and International Cooperation Division (PPICD) on addressing GESI issues have been followed
- An internal review of draft AWPBs by the PPICD to check that GESI issues are adequately addressed, followed by review and discussion by the GESI Secretariat.

1. BACKGROUND

1.1. Introduction

In 2013, in response to a mandate to address Gender Equality and Social Inclusion (GESI) in the health sector, and a strong commitment to mainstream GESI across all aspects of the health system, the Government of Nepal introduced the GESI Operational Guidelines[3]. The Guidelines set out a framework for mainstreaming GESI into policy formation, programme design and management, service delivery and monitoring and evaluation; including the Annual Work Plans and Budgets (AWPB) produced annually by departments and divisions of the Ministry of Health and Population (MoHP).

This paper, prepared by the Nepal Health Sector Support Programme (NHSSP), documents the process by which Technical Assistance (TA) has supported integration of GESI into the planning of Family Health Division (FHD) and Child Health Division (CHD) of the Department of Health Services (DoHS). It provides evidence of progress made by the two divisions in moving GESI from strategy into implementation, based on review of their AWPBs, including specifically a GESI financial allocation review of budgets from 2011/12 to 2013/14. In reviewing the activities of these two health divisions, this paper acts as a case study, complementing a broader review of progress and learning in mainstreaming GESI across the whole health sector, which has been prepared by the GESI Secretariat[4].

GESI has in fact been a part of MoHP thinking for some time, with initiatives such as Free Essential Health Care Services (2006), the Aama programme (free delivery services with incentives for mothers, January 2009) and the Guidelines for Safe Motherhood Services in Remote Areas (July 2009) marking a stronger focus on reaching the poor and disadvantaged. Considerable inputs have also been provided by other External Development Partners (EDP), such as UNICEF and Nick Simons Institute (NSI). Agencies such as Save the Children International (SCI), Care Nepal and One Heart International are also proposing to support inputs to help hard to reach women, newborns and children. Progress cannot therefore be attributed to only one player, but rather to the joint efforts of Government, civil society organisations and EDPs, including NHSSP.

1.2. The Nepal Health Sector Support Programme

The second phase of the Nepal Health Sector Programme (NHSP-2) runs from 2010 to 2015, with the goal of improving the health status of the people of Nepal, especially women, the poor and excluded. Technical assistance to NHSP-2 is provided on behalf of a pool of external development partners (DFID, World Bank, AusAID) through the NHSSP, which is funded by DFID and implemented by Options Consultancy Services Ltd and its consortium partners. NHSSP provides capacity enhancement and technical assistance through a dedicated team of advisers based in MoHP, with supplementary visits from an external resource pool, to enable MoHP to deliver against the NHSP-2

[3] Ministry of Health and Population, 2013, *Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector*. Available at http://www.nhssp.org.np/gesi/GESI%20guidelines.pdf

[4] Population Division/MoHP, July 2013, "GESI Mainstreaming in the Health Sector: Progress Review and Process Documentation"

results framework, of which GESI is one component. Based on the recommendations from capacity assessments carried out across the sector in 2009, NHSSP TA has worked to strengthen the systems, structures and capacities of the health sector to operationalise the GESI strategy, and thus achieve the health gains for poor, vulnerable and disadvantaged populations that lie at the centre of Government policy. NHSSP Advisers have worked closely with government counterparts on the process of establishing institutional structures to support GESI mainstreaming and integration of GESI within plans and programmes.

1.3. Policy Context for GESI Mainstreaming in FHD and CHD

Following a decade of armed conflict, the Interim Constitution of Nepal was adopted in 2007, marking the beginning of a process of political transformation which has at its core the aim of creating a more just and equal society. In order to address this national mandate, MoHP, through NHSP-2, has prioritised the integration of GESI into programming. The Health Sector Gender Equality and Social Inclusion Strategy (2010) provides the foundation for mainstreaming GESI, ensuring that policy development and programme planning are viewed through a GESI lens to create a favourable environment for the use of rights based approaches and more equitable access to healthcare. Implementation of the strategy is guided by the GESI Operational Guidelines (2013).

Over recent years there has been an increasing focus on identifying and reaching underserved populations, defined as groups that have little or no access to and use of health services, and consequent poor health outcomes, due to poverty, low social status (caste or ethnic group) and/or living in a remote area. MoHP recognises the need to target these groups through the development of systems and services (supply side solutions) in parallel with demand side and community efforts. Addressing the needs of underserved populations is an essential part of Nepal's drive to achieve its Millennium Development Goal (MDG) targets as well as enabling the country to reap the benefits of the political transformation taking place. Targeting the needs of the weakest members of society is also important in terms of ethics and good public health practice. The 2009 Remote Area Guidelines for Safe Delivery demonstrated recognition of the need for different approaches in different geographical contexts, putting Nepal ahead of most developing countries

1.4. Identifying and Reaching the Underserved

Barriers to utilisation of services exist on both supply and demand sides. On the supply side these include poor quality and inaccessible location of health infrastructure, lack of medical supplies and equipment, lack of suitably qualified and skilled health staff and inadequate quality of care. Demand side factors include lack of knowledge about services and the benefits of modern healthcare, cost of services and transport, socio-cultural barriers (exacerbated by discriminatory attitudes among healthcare staff) and language (reported by Adivasi/ Janjati groups as the biggest hurdle they face in accessing services). Acknowledging and addressing these barriers is a prerequisite to increasing service utilisation and improving health outcomes among underserved populations.

The level of underserving may vary with type of service. For example, immunisation now reaches most children, with only a very small percentage (the very poor and socially excluded) not covered, whereas large sectors of the population still do not have access to pregnancy and delivery care,

including institutional delivery. Access to safe abortion remains limited for women living in remote areas and within very traditional societies. Children with disabilities and women who develop mental illness (such as post-partum depression) are still seriously disadvantaged on many levels, due partly to social attitudes and stigma, and partly to lack of the specialised services they need. The importance of adolescent health has only been recognised relatively recently, with many young people moving directly from childhood into adult roles as a result of early marriage, poverty and limited educational opportunities. Similarly, moves to raise awareness about the prevalence and negative consequences of violence against women and to address this as both a social and health issue are only now gaining universal acceptance.

Closing the service gap requires a flexible, targeted approach, based on information about *who* the underserved are, *why* they are underserved and *how* they can be better served. Data from Health Management Information Systems (HMIS) and research studies needs to be user disaggregated, service specific and context informed. Evaluation of the Aama and Free Delivery Care Programme in 2010 explored factors such as gender, socio-cultural norms, economic status, education, disability/ chronic illness, and demographic/ geographical situation, confirming that the underserved often experience multiple determinants of exclusion. Findings showed that women who live far from a health facility, are poor, uneducated and Muslim are the least likely to have heard of free delivery care. Sequential Nepal Demographic and Health Surveys (NDHS) show significant disparities between the five defined wealth quintiles and as a result of caste/ethnicity and geographical location, in terms of age of marriage, contraceptive prevalence, antenatal care, institutional delivery, continuum of Maternal Newborn and Child Health (MNCH) care and infant mortality.

1.5. Implementation Challenges

The challenges to implementing programmes in low resource situations are well known, and represent even greater constraints to the mainstreaming of GESI, multiplied as they are by the socio-economic and geographic context of underserved populations. Some of the challenges noted below and listed in recent FHD and CHD AWPBs are relevant across both divisions and even the whole health sector, while others pertain only to particular programmes.

1. ***Monitoring and data:*** At all levels there is insufficient monitoring and supervision capacity (staff numbers and skills), with sub-optimal utilisation of data that is available to underpin decision making. Piloting of a reformed HMIS has been delayed and disaggregated data (essential to GESI mainstreaming) is not yet fully incorporated into the system. Dissemination of research findings at central and district levels needs to be improved to feed into evidence based planning, particularly at district level and to identify underserved women and children.

2. ***Human resources*****:** Shortage of qualified and skilled health workers is a major constraint, particularly at many referral facilities, such as Comprehensive Emergency Obstetric and Newborn Care (CEONC) sites, and at peripheral facilities in remote areas. Frequent staff transfers and ad hoc posting compound the situation. The use of repeated one-year contracts to meet shortages of essential staff, such as Medical Doctor-General Practitioners, staff nurses, anaesthesia assistants and Auxiliary Nurse Midwives (ANM), results in gaps in service provision between contracts, increases transaction costs and affects skill development, as contract staff

may not receive the immediate training needed for new programmes such as Community Based Integrated Management of Childhood Illnesses and the Newborn Care Package (CB-IMCI/NCP). Even if/ when they do receive the training, they may not get the contract for the next year and their replacement will again require training. The result is lower quality services and less consistent availability in underserved areas, where contract staff are often the main service providers because of the difficulty in recruiting and retaining full time government employees. Discriminatory staff attitudes may discourage service utilisation among marginalised groups, and motivation to address the issues of these groups is often low (Byrne et al 2012[5]). Lack of representation of women, lower castes and Janajati groups within the public health service at all levels, including community volunteers (see below) and especially at management levels, tends to limit the capacity for "GESI sensitive" thinking and fails to provide the required role model for an inclusive service. Lack of female staff is known to reduce uptake of reproductive health services in particular, especially in remote traditional areas.

3. ***Female Community Health Volunteers (FCHV):*** The 48,500+ women working as FCHVs across the country are essential vehicles for implementing a range of health education, social mobilisation, home based care and non-health programmes. A high degree of coordination is required between government departments and divisions to ensure these women are effectively deployed and properly monitored and the FCHV fund is used to best effect. It is also important to maintain their voluntary spirit and commitment, although recent affiliation with an FCHV trade union has led to increased expectations. From a GESI perspective it is important to note that most FCHVs are from socio-economically better-off families (New Era 2007[6]), which may reduce their ability to work with poorest groups, who are in fact the ones who stand to benefit most from the services provided by FCHVs. Addressing this requires a combination of training and supervision for existing FCHVs and recruitment of new FCHVs from disadvantaged groups. However, as the FCHV operational guideline states that a new FCHV should be recruited by the relevant mothers' group, normally a member of the group is selected, thus excluding women from marginalised groups who are not regularly involved in group activities. A further challenge is the need for individual FCHVs to cover unrealistically large areas in remote districts with low density populations. Efforts are being made to address this through the creation of additional FCHV positions in some remote areas.

4. ***Reaching underserved groups:*** Although much has been done, reaching underserved populations to address unequal use of healthcare services remains a challenge, requiring huge human and financial resources to implement the intensive targeted social mobilisation and demand creation activities needed to create awareness about services and health issues among hard to reach groups. Reaching underserved groups with special needs, such as adolescents, post-partum and post-abortion women, migrants, remote rural populations, the very poor and particular ethnic groups, is even more challenging, requiring cooperation between Government and partners and detailed VDC level information about who the excluded are and where they are concentrated, which is often not available for low performing districts.

[5] Byrne et al (2012) Build and they will come? Looking beyond supply to demand side barriers to health service utilisation in the mountains of Nepal

[6] New Era (2007) An Analytical Report on National Survey of Female Community Health Volunteers of Nepal

5. ***Special issues for child health:*** External partner support for some programmes, such as maintaining zero polio status, is being scaled down, leaving funding gaps. The slow pace of scale-up for nutrition interventions, especially Infant and Young Child Feeding (IYCF), Community Management of Acute Malnutrition (CMAM), distribution of micro-nutrient powder and CB-NCP is also the result of limited resources and capacity within CHD. As external funding is withdrawn the poor and vulnerable are the most at risk, since they are disproportionately affected by under-nutrition and the associated diseases and often the last to benefit when programmes are scaled up, a process that normally starts in easily accessible areas in order to reach large numbers quickly. For programmes such as immunisation, where national coverage is (on average) high and/or national targets have been reached, it is often difficult to convince managers to expend further resources on reaching a small number of marginalised children in hard to reach areas, as the cost-benefit ratio is so high. In particular, further study is needed to fully understand the situation of Muslim children, many of whom are not immunised. The main reasons identified by the PEER study were a lack of understanding of the benefits of immunisation and concerns and misunderstandings about the vaccination process and possible short term side effects. Although this issue is recognised in many countries it has not been thoroughly investigated in Nepal, leaving a question of whether the problem is a demand or supply side issue, or a combination of the two.

2. METHODOLOGY

2.1. Review of technical support provided and the content of annual plans

NHSSP advisers were interviewed and a number of discussions took place to gain a fuller understanding of the various ways in which TA is provided and the context in which the advisers work with government counterparts. District based staff submitted information about key GESI related activities with which they are involved.

Internal documentation was reviewed related to mainstreaming of GESI across the whole health sector and specifically within FHD and CHD. This included documents pertaining to support provided for the process of developing the GESI guidelines, Powerpoint presentations on reaching underserved groups and the services provided by FCHVs made to the divisions. Reports of work undertaken to improve service availability and utilisation in remote areas and NHSSP quarterly reports were also reviewed.

Annual business plans of FHD and CHD (fiscal years 2012/13 and 2013/14) were studied in detail for specific evidence of planning that incorporates GESI related activities and perspectives.

2.2. Review of financial allocations

An analysis of financial allocations by the two divisions over the last three years (fiscal years 2011/12; 2012/13; 2013/14) was carried out by a financial analysis expert under the guidance of the NHSSP GESI Adviser and in consultation with division staff, to identify how underserved groups have

been prioritised and to assess the nature of current GESI inputs. Specific objectives were to: identify financial allocations targeting women and excluded groups; develop a trend analysis of these financial allocations; develop a methodology and baseline against which future allocations could be compared; inform future GESI planning; and contribute to process documentation on GESI mainstreaming. The analytical framework used was structured on three levels:

i) *Categorisation of activities into GESI targeted, supportive and neutral:* Targeted groups were taken as all women, the poor and socially excluded groups. All children were not considered an excluded group, only those who were excluded due to poverty, location, social identity or gender (malnourished children were taken as an excluded category as data indicates that children of poor and excluded groups have high levels of malnutrition). While all women were considered excluded, women of low income groups, those from remote locations or disadvantaged social groups were considered multiply excluded. Supportive activities were those considered to improve the environment for the needs of underserved/ excluded groups. Neutral activities were those benefiting all citizens without recognition of differential barriers faced by excluded/ underserved groups.
ii) *Identification of target groups:* These are the specific underserved groups for whom certain activities are meant. For FHD these are women (especially those in remote areas or experiencing income barriers), adolescents and couples (for family planning purposes) and for CHD the children of excluded groups.
iii) *Identification of the domain of change:* This is the area addressed by the activities, which can be for i) improving access to and use of services; ii) addressing "voice", by increasing the capacity of target groups to articulate their needs and priorities and influence decisions; iii) changing the "rules of the game" by changing discriminatory attitudes and policies.

3. PROCESS

This section looks at how NHSSP has supported the integration of GESI into FHD and CHD planning, specifically in the AWPBs, and how an enabling environment was developed through the collaborative efforts of the Government, NHSSP and other external partners.

3.1. Promoting Integration of GESI within Family Health and Child Health Planning

Although this paper focuses on the work of NHSSP in supporting government mainstreaming of GESI, it should be noted that all partners, including the Government (from the Health Secretary downwards), other external development agencies and civil society organisations have played an important role. Progress made cannot therefore be solely attributed to any one partner.

The 2010 NHSSP capacity assessment on Essential Health Care Services (EHCS) focused on reaching underserved populations and suggested that "m*ore context specific planning and implementation would help focus efforts to reach other underserved or hard to reach populations (including urban). Mapping is required to identify who is doing what and where, and to identify where it is most pressing to improve integration or coordination".* This guided the TA team to undertake further

situation analysis, including a secondary analysis of data from the 2006 NDHS and HMIS, which provided the basis for advocacy and planning.

The EHCS capacity assessment also suggested that a more targeted geographic approach, building on the work of the Equity and Access Programme[7] could help achieve substantial further reductions in mortality among the age group 1-59 months, through a focus on quality and coverage of child health interventions among poor and excluded populations in rural areas, particularly in the mid and far west and mountain areas. GESI was recognised as an opportunity for Government to explore the extent to which TA could be beneficial at central, regional, and/or district levels to support mapping of target populations, and/or implementation of approaches to community mobilisation to increase use of key health services and practices among underserved groups.

FHD and CHD staff worked with NHSSP staff to use a range of approaches and strategies in order to ensure that GESI was integrated into work plans and budgets, as shown below.

Data analysis: Analysis of the findings of studies such as NDHS 2006 and 2011, Nepal Family Health Program mid-term survey (2009) and PEER study (2013[8]) formed the basis of discussions and presentations advocating for targeting of unreached communities. Performance analysis based on HMIS data for MNCH (family planning, safe motherhood and IMCI) was undertaken to identify districts that were under-performing, so that additional supervision visits and micro-planning activities focusing on identified local needs could be provided. As noted below, an analysis was undertaken and presented to the directors of FHD and CHD, and later to section chiefs and other staff, followed by sharing with regional teams. The NHSSP team produced a compilation of the study findings, which identified key issues to be addressed, desired changes, recommended actions, responsible units and expected timeframe[9]. This was shared with all MoHP divisions and centres during a planning workshop organised in April 2013 by the Policy, Planning and International Cooperation Division for the fiscal year 2013/14, and a number of the divisions and centres have used the findings for their planning.

Forums: NHSSP advisers, like other partners, work closely with FHD and CHD and regularly attend a range of meetings, including various sub-committees and working groups related to family health and child health, as shown in Table 1. Many of these have proved useful forums for advocacy on GESI and for discussing issues related to its integration into programme planning. Their regular attendance at meetings means the advisers are accepted and listened to and have a detailed understanding of day to day issues, and how these interact to enable or sometimes inhibit progress. The GESI Institutional Structure and Technical Working Groups also include FHD and CHD members and are vehicles for GESI advocacy and mainstreaming.

[7] The Equity and Access Programme was initiated under Support to the Safe Motherhood Programme (SSMP) and taken on by FHD in 2008/9. In 2010 it was moved to the Primary Health Care Revitalisation Division

[8] Thomas D, Bell S, Dahal K, Grellier R, Jha C, Prasai S, Subedi HN (2013) Voices from the Community: Access to Health Services: A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study, Nepal

[9] Supporting Preparation of the 2013/14 AWPB with Evidence (Report of planning workshop in Nagarkot, April 2013)

Table 1: Sub-Committees and Working Groups as Forums for Influencing Integration of GESI

Name of Sub-Committee or Working Group	Comments on usefulness for GESI advocacy
Safe Motherhood and Newborn Health Sub-Committee	An active group that advisers attend regularly and within which it is easy to discuss issues related to GESI and have influence.
Family Planning Sub-Committee	An active group that advisers attend regularly and within which it is easy to discuss issues related to GESI and have influence.
FCHV Sub-Committee	Advisers attend sometimes. Since FCHVs are community based and part of a community focused programme, this should be an important forum, but it has proved difficult to convince the committee of the need to work on increasing "GESI sensitivity" among FCHVs, many of whom come from the more privileged sectors of their communities.
IMCI and Newborn Health Working Group	Advisers attend sometimes and find it easy to discuss issues related to GESI and have influence. Committee members accept the concepts and believe that IMCI and newborn care programmes are community based and thus GESI friendly. However, they are currently less open to the need to increase focus on remote districts.
Adolescent Health Sub-Committee	Advisers attend sometimes, but have so far found this committee less open to discussing GESI, as they consider adolescents to be an un-reached group in their own right. However, as the programme matures with time, there may be the potential for more influence.
Training Working Group and Skilled Birth Attendance (SBA) Forum	Advisers attend regularly, although GESI issues are not often discussed. All training is expected to incorporate GESI awareness at least, and GESI was recently incorporated into five training courses. An additional day on GESI perspectives in the SBA training is being discussed.
National Reproductive Health Review and Planning Meeting (annual)	Advisers attend each year and find this an important forum for discussing issues such as GESI and for influencing government and external partners.
Technical Working Groups – formed ad hoc as needed, eg. Misoprostol, Chlorhexedine, Calcium, Maternal Nutrition	Advisers attend any group meetings to which they are invited and find they are able to influence discussions.
Partner organised meetings, eg. NSI, UNICEF, UNFPA, NFHP, Ipas	Advisers are usually invited to partner meetings and find they are able to influence discussions, guiding the development of approaches that focus on reaching underserved populations.

Dissemination: Formal meetings are convened by different EDPs to present to government counterparts and other partners the results of studies, analyses and other reports. These are important for generating new momentum or pointing programmes in a new direction, based on sound evidence. GESI related assessments and studies conducted with the support of NHSSP have been shared with various divisions and centres. Government counterparts shared the findings at various professional body meetings and conferences such as the Nepal Society of Obstetricians and Gynaecologists and Nepal Medical Association. The process of supporting preparation of presentations for these conferences helps to generate increased "buy-in" of government colleagues, by helping them to better understand and internalise concepts such as GESI. The same is true for presentation of papers at international conferences.

Joint review and planning meetings: In December/ January each year FHD organises a three-day annual planning meeting for reproductive health, to which all partners working in MNCH are invited. This is an important forum for discussing GESI in terms of programming to reach underserved populations, and an opportunity to advocate with Government and external partners on GESI issues. After presentations by Government directors and partners on activities and achievements, technical

groups work on plans for maternal health, newborn health, adolescent sexual and reproductive health, family planning, safe abortion and monitoring and evaluation (M&E). Advisers also participate in regional level annual reproductive health and child health reviews, providing feedback on planning and implementation.

Other meetings: Additional meetings periodically organised by the divisions and supported by external partners provide opportunities for discussion and advocacy on GESI. For example:

- FHD ran a family planning re-vitalisation workshop in August 2011, with technical and financial support from NHSSP; the presentation reviewed the history, present policies and position of family planning in Nepal (including the draft 2011 policy) and looked at global experiences related to reaching the unreached.
- UNICEF supported a three-day FHD workshop on referral guidelines, at which ideas were discussed on obstetric first aid training and the logistics of providing blood transfusions at remote health facilities.
- CHD organised a number of partner meetings as part of the process of developing the IMCI multi-year plan[10] and costing, which included discussion on reaching the unreached. CHD has budgeted for a pilot in one district in 2013/14; Save the Children International and UNICEF are willing to fund one district each when they finalise their budgets for supplementary work plans in August/ September. A component on how to identify and reach vulnerable groups will be added to the recently revised IMCI protocol, which will be piloted from the beginning of the 2013/14 fiscal year in two districts.

Presentation to the divisions: A particularly useful exercise, carried out in early 2012, was the development of two presentations, on maternal and newborn health and on child health, which were shared with the two divisions. Entitled "Reaching the Underserved: What do we know and what more do we need to do?" they set out to answer four key questions:

- Why is it important to increase access to and utilisation of services by the underserved?
- Who are the underserved?
- What is currently being done?
- What more needs to be done and how?

After looking at what "underserved" means, why there is a need to focus on this group and what barriers exist to service utilisation, graphic evidence from studies and HMIS data was provided highlighting clear differences in various service utilisation and other health related practices between different wealth quintiles, ethnic/ caste groups and geographical regions. This created focused discussions that convinced key players within the divisions of the need for specific efforts to mainstream GESI within programme planning and catalysed subsequent action through the AWPBs.

Regular interactions: In addition to formal meetings, advisers use every opportunity for informal discussion with key people about GESI principles and the importance and benefits of their integration within every aspect of programme planning. In fact, it was felt that sometimes the

[10] Work continued from late 2011 and 2012, and the plan was submitted for approval in 2013

regular "drip, drip" of informal sharing and talking is more effective, as slowly people become convinced of an issue and adopt it as their own agenda, using their influence and position to take it forward. At this stage it is important that NHSSP continues to support the process in concrete ways, such as through pilot programmes, to ensure ideas are translated into action. For example: context specific planning undertaken in three under-performing districts resulted in identification of approaches for targeting unreached groups; integrating family planning with immunisation clinics showed that this approach works in remote areas and for reaching underserved groups in other areas; a package on how to identify and reach vulnerable groups has been developed for FCHVs. A study on CB-IMCI/NCP is in process and will inform the design of interventions for reaching underserved groups. The GESI approach is used for analysing service data for day-to-day operational planning, and in programme review and planning. The advisers encourage government and partners to think of programming with a GESI perspective, by selecting districts and programme activities to meet the needs of low performing districts (indicated by HMIS data), which are mostly remote and underserved.

Human resources policy: Implementation of the recently endorsed Human Resources for Health Strategic Plan (2011-15) will be an important channel for GESI across the whole health sector. Although budgetary constraints have so far limited the extent of implementation, a recent revision of the Health Service Act incorporates GESI considerations for all levels of health worker, and the Public Service Commission has advertised vacancies accordingly, with 45% of all posts set aside for defined groups[11]. Advisers were involved in discussions about how to address the poor distribution of health workers and gaps in underserved areas, with a focus on recruitment of health workers from the locality in which they will work and from marginalised groups or disadvantaged geographical areas. Two mechanisms will act to promote this: recruitment of ANMs by district health officers using a budget allocated by FHD, and recruitment of peripheral health workers by the regional director. As already mentioned, FCHV recruitment needs to draw more women from lower caste and Janjati ethnic groups, to counter the current bias towards women from higher socio-economic groups, who traditionally expect to do "social work" within their communities, and have the time, resources and confidence to do so.

3.2. Enabling Environment

An enabling environment for GESI mainstreaming in FHD and CHD has been generated through:

- ***Advocacy*** to generate a high profile for GESI: It is recognised at all levels that not only are the principles enshrined in GESI morally just and an essential part of the new Nepal, but without addressing inequality the country will not achieve its MDG targets.
- Creation of ***institutional structures*** for GESI: At Ministry level a GESI Steering Committee provides leadership and policy guidance. At DoHS level there is a GESI Technical Committee and a GESI Technical Working Group, both including representatives of FHD and CHD. All regional directorates and district health offices have their own GESI technical working groups. Health

[11] These 45% are allocated as follows: women (33%), Adivasi/ Janjati (27%), Madhesi (22%), Dalit (9%), disabled (5%), from a remote area (4%, nine districts of the mid-western and far western regions are classified as remote).

facility operational management committees are responsible for identifying and responding to exclusion issues at their health facilities.

- Changes in the deployment of ***human resources*** targeting underserved areas: The Human Resources for Health Strategic Plan (2011-15) and the revised Health Service Act aim to create a GESI sensitive workforce and mandate the incorporation of elements for addressing GESI concerns in data collection tools, data analysis, recruitment and planning.
- ***Focused budget allocation***: The Ministry of Finance provides guidance on budgeting practices designed to promote mainstreaming of GESI, such as inclusive development, targeting of excluded groups, pro-poor expenditure and gender responsive budgeting.
- ***Monitoring and evaluation***: To generate specific information about underserved groups to support GESI mainstreaming, the NHSP-2 results framework is disaggregated by caste/ethnicity, gender and wealth quintiles. Current revisions to the HMIS include some focal indicators that are disaggregated by caste and ethnicity, age, rural versus urban (by facility); Village Development Committee (VDC) and facility; region and ecological zone.

Specific factors that have influenced GESI mainstreaming within FHD and CHD include:

Government leadership and relations

- Government ownership and leadership of the concept and process of GESI, enhanced by the fact that many key government counterparts (senior officials in CHD and FHD) have experience of working in underserved districts and have a practical understanding of the issues; the Health Secretary, among many others, has been active in driving the process
- The strong emphasis placed on reaching the unreached during the NHSP-2 mid-term review and the development of GESI guidelines, reflecting MoHP commitment
- Close working relationships developed with the divisions (FHD and CHD)
- Regular participation of NHSSP advisers in joint planning and review meetings and at forums such as sub-committees and working groups, ensuring they are viewed as part of the team

Donor support and harmonisation

- Unity among partners such as NSI, UNICEF, Save the Children International, Care Nepal and One Heart International about the need for targeting underserved populations
- Specific interest of World Bank, DFID and AusAID in reaching populations in remote areas
- The goal of the new five-year plan for all UN agencies in Nepal, which is to reach the unreached

Evidence

- Availability of sound evidence based on studies carried out by NHSSP and other partners. Examples include the 2012 Household Survey, 2011 and 2012 Service Tracking Surveys, 2006 and 2011 NDHS, AusAID secondary data analysis of NDHS 2011 (produced in 2012) and literature review on remote areas (2013, draft)
- Collaboration and sharing of information between partners, including Government and EDPs, making a wide selection of data and analysis available for planning
- The presentations made by NHSSP to the divisions, based on sound evidence generated from studies and data collection

Planning

- Advocacy from the NHSSP regional teams (which include MNCH and GESI and M&E personnel) to incorporate a GESI perspective in regional and district level planning, and for monitoring and developing regional profiles with a GESI analysis
- Mandating of all divisions and centres to prepare a business plan as part of their annual planning, including a section describing GESI activities
- Development of district planning guidelines for use by District/ Public Health Officers (D/PHO), with a strong focus on GESI; these were piloted in one district this year

4. OUTCOMES

This section looks at the extent to which GESI has been integrated into FHD and CHD AWPBs and the ways in which this is evident in terms of specific activities.

4.1. Family Health Division

Review of planned activities

The FHD 2013/14 business plan[12] begins with a statement committing to a special focus on poor, marginalised and vulnerable populations to improve the health status and quality of life of the people of Nepal. Major strategies specifically targeting women and excluded groups, in line with the operational guidelines are:

- Increasing the accessibility and availability of family planning services with particular focus on remote, poor and excluded populations
- Expanding and strengthening outreach services
- Specific allocation of referral funding to remote areas
- Strengthening of community based programming, including distribution of misoprostol through FCHVs to prevent post-partum haemorrhage after home delivery

The process of developing and implementing the Remote Area Guidelines for Safe Motherhood (2009) has enabled FHD to focus on expanding key services such as family planning and maternal healthcare to Primary Health Care Centres (PHCC), health posts and sub-health posts, which are more accessible to poor women living in remote areas. Outreach clinics have been strengthened and further support provided to enable FCHVs to reach underserved groups. CEONC services have been expanded to more district hospitals serving remote areas, with improved referral mechanisms to help rural women reach a hospital in case of emergency. Safe abortion services are being expanded to PHCCs and health posts (medical abortion only) to increase access for rural women.

[12] A compilation of the policy and resource allocation decisions that determine the activities, programmes and services that will be delivered in the fiscal year (*source: Business Plan 20112/13, MoHP*)

Family planning, antenatal care (four visits), skilled birth attendance and CEONC (including safe blood) are priority programmes for reducing maternal mortality, but in remote hill/ mountain areas availability and uptake of these key services is low. Proposed activities to address this are:

- Increased behaviour change communication
- Micro-planning in poorly performing areas and those with high unmet needs
- Ensuring availability of full family planning services in all public health facilities
- Integration of services to reduce the number of times women need to visit a facility
- Expanding and strengthening outreach services
- Encouraging public private partnership to increase the availability of services and supplies

Major activities shown in the 2012/13 business plan that target the needs of underserved groups are listed below.

Planning and mapping health services

- District level planning workshops for reproductive health services, to identify underserved areas for targeted interventions
- District and facility level micro-planning of family planning services (a new initiative building on experiences in immunisation) to enable targeting of needy groups and underserved areas in low performing districts based on local knowledge; this guides the establishment of satellite clinics for IUCD and implant services

Improving service availability and quality in underserved areas

- Purchase of equipment for expansion of birthing centres, to strengthen delivery services at peripheral facilities such as PHCCs, health posts and sub-health posts, which are used more by women from poorer families; strengthening CEONC services in remote districts is also a priority
- Recruitment of 1,800 staff nurses and ANMs for birthing centres and B/CEONC sites
- Clinical updates for ANMs and staff nurses at birthing centres
- Contracting of CEONC team for CEONC services, focusing on underserved districts
- Provision of rural ultrasound services (purchase of 10 ultrasound machines), enabling women in outlying areas to benefit from ultrasound screening as part of antenatal care
- Screening and treatment for uterine prolapse (ring pessary insertion or surgery) and fistula; conditions that are more common amongst the poorest women as a result of under-nourishment and overwork
- IUCD coaching for skilled birth attendants
- Increasing the accessibility and availability of family planning services (particularly IUCD and implants, previously not as widely available as other methods) through a combination of static, outreach and referral services, with particular focus on remote, poor and excluded populations

Enhancing access to services in underserved areas

- Purchase of 25 ambulances for remote districts and stretchers for hill and mountain districts to improve access to emergency care
- Establishment of a referral fund including cover for airlifting women from remote areas in an obstetric emergency

- *Aama* programme, which includes free delivery care and a lump sum to offset the cost of travel to a health facility; free blood transfusion services at district hospitals have now been added
- New *Nyanojhola* programme, which provides a baby wrap and warm clothes for newborns delivered at birthing centres
- Obstetric first aid training for paramedics working in remote districts
- Misoprostol programme for prevention of post-partum bleeding after home delivery, particularly important for women living far from a health facility
- Incentives for completion of the recommended four antenatal care visits
- Expanding and strengthening institutional and outreach services to increase access to services (especially outreach services, which are most used by the poorest families)
- A pilot for integration of family planning with vaccination programmes in three remote districts, to reduce the number of times women have to make an often arduous journey to an outreach clinic, and thus encouraging uptake of services among unreached women
- Satellite clinics for long acting family planning methods (IUCD and implant)
- Expansion of adolescent sexual and reproductive health services in 10 districts

Behaviour change communication and social mobilisation

- Recruitment of additional FCHVs in selected districts, focusing on underserved and disadvantaged communities
- Re-activation of mothers' groups in all areas where they have ceased to function
- Activities to increase FCHV motivation (increased FCHV fund, dress fund, celebration of FCHV silver jubilee)

The review of progress against NHSP-2 indicators notes that the 2013 overall targets have been met for 12 (eight outcome level and four output level) of the 27 FHD indicators, although disaggregated information shows progress is not uniform, with disadvantaged groups continuing to lag behind. Targets for a further five indicators have been more than 90% met. However there is concern over the targets for availability of health workers, especially in remote underserved areas. Ensuring year-round and consistent availability of the full range of CEONC services, including caesarean section, remains a challenge.

Remote/ low performing districts targeted in the 2012/13 plan for improved availability of full CEONC services include:

- Eastern Region: Bhojpur, Khotang, Taplejung, ,Solukhumbu, Sankhuwasabha
- Central Region: Dhading, Dolakha(partner NSI), Nuwakot, Sindhupalchok
- Western Region: Gorkha, Gulmi (partner NSI), Arghakanchi
- Mid-Western Region: Dailekh, Jumla, Kalikot (partner NSI), Salyan (partner NSI), Rukum,
- Far Western Region: Achham, Bajhang (partner NSI), Baitadi.

As a result of inputs, 19 of the above 20 districts (with the exception of Sindhupalchok) are now providing full services, with the required service teams (including doctors able to provide caesarean sections) and infrastructure in place.

A similar focus on reaching the underserved can also be seen in external partner plans, reflecting the success of GESI advocacy efforts and increasing harmonisation between Government and partners.

Financial allocation analysis

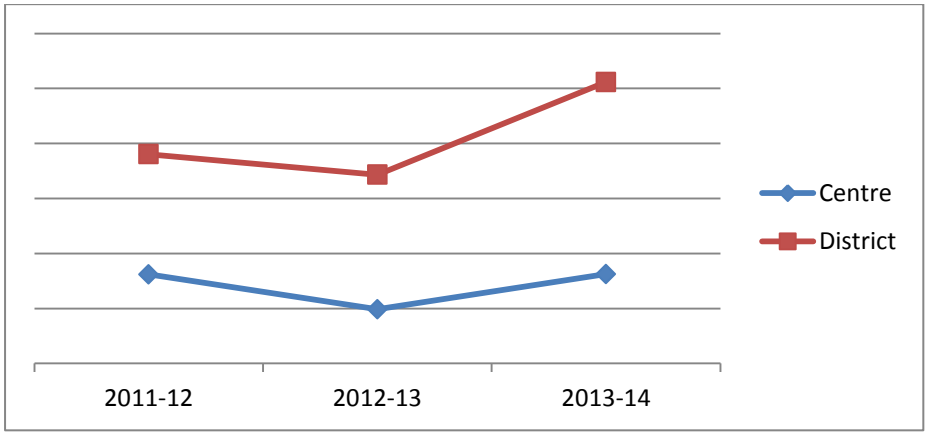
Examination of the allocation of budgets for central and district activities over the last three years shows that in total almost three quarters of the total budget (74.50%) has been allocated for district level spending (Table 2 and Figure 1), which is to be appreciated since it supports enhancement of local services that are more accessible to underserved rural communities. However, because the amounts for each programme are allocated from the centre, districts do not have the flexibility to adjust the budget in favour of programmes that more specifically respond to local needs and the priorities of underserved groups and unreached areas.

Table 2: Budget allocation for central and district level activities by fiscal year in NRs.'000

Fiscal Year	Centre	%	District	%	Total
2011-12	809,362	29.85	1,902,370	70.15	2,711,732
2012-13	491,960	22.27	1,716,710	77.73	2,208,670
2013-14	813,272	24.12	2,559,025	75.88	3,372,297
Total	**2,114,594**	**25.50**	**6,178,105**	**74.50**	**8,292,699**

Source: Family Health Division AWPBs

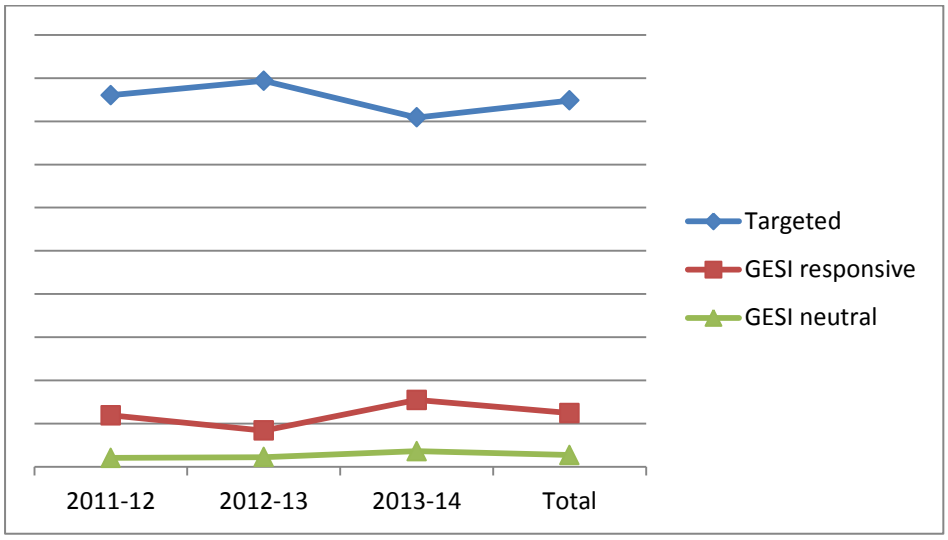
Figure 1: Centre and district budget trend by fiscal year



Source: Family Health Division AWPBs

Examination of budgets for the last three years shows a predominance of activities targeting women. This analysis assumes that all women are an excluded group, making these activities GESI specific. There is a slight increase in the budget amount for activities that help develop an environment where the needs of women can be met (termed GESI supportive/ responsive), even though they do not benefit directly. Very few of the FHD activities are GESI neutral (Figure 2).

Figure 2: Share of budget by fiscal years and GESI responsiveness



Source: Family Health Division AWPBs

The financial allocation analysis identified which of the FHD AWPB activities target sub-groups of women who are disadvantaged through living in remote locations, very low incomes and/ or being of disadvantaged caste/ethnic groups, as shown in Table 3. There has been a substantial increase in the budget for addressing issues related to remote locations (in the Karnali zone), from 0.26% to 11.90%. Aama, the maternity incentive programme, is recognised in the analysis as a measure that supports women (the majority of whom are financially dependent) by addressing income barriers, and this forms almost a third of the budget. Additionally, in this fiscal year there has been a new allocation for micro-planning, which will help identify underserved groups.

Table 3: Allocation of GESI budget for targeted activities (NRs.'000)

Indicators/Description	2011-12	2012-13	2013-14	Total
Budget related to remote locations	7,000	7,000	386,700	400,700
Percentage of GESI budget	*0.26*	*0.32*	*11.90*	*4.97*
Budget related to income barriers (Aama)	900,000	959,500	1,050,000	2,909,500
Percentage of GESI budget	*33.89*	*44.45*	*32.31*	*36.08*
Budget related to micro-planning	0	0	8,100	8,100
Percentage of GESI budget	*0.00*	*0.00*	*0.25*	*0.10*

Source: Family Health Division AWPBs

The analysis also assessed which groups were targeted by activities, broken down into women (and within women, those in remote locations or low incomes), couples (for family planning), adolescents, children, marginalised groups. Table 4 shows that 89% of activities target women (understandably as services are mostly related to motherhood). However, only 0.02% of the budget is allocated for addressing the specific barriers faced by women from poor/marginalised groups (given that Aama is for all women). This is a key gap in FHD planning.

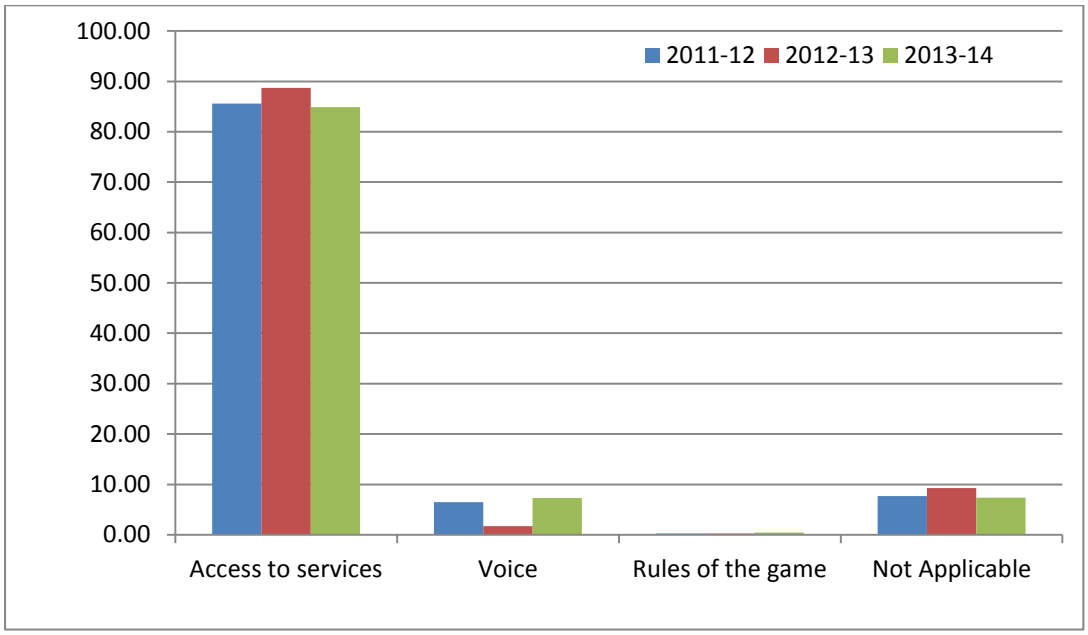
Table 4: Percentage share of GESI budget by target groups

Fiscal Year	Women	Couples	Adolescent	Children	Poor/ Marginalised groups	Not clearly targeted	Total
2011-12	89.34	10.04	0.57	0.00	0.05	0.00	**100.00**
2012-13	93.51	6.13	0.18	0.18	0.00	0.00	**100.00**
2013-14	85.20	11.87	0.58	0.03	0.00	2.31	**100.00**
Total	**88.79**	**9.73**	**0.47**	**0.06**	**0.02**	**0.93**	**100.00**

Source: Family Health Division AWPBs

Analysis of the budgets in terms of key areas of activity (domains of change), shown in Figure 3, indicates a focus on services, with very little attention to changing the discriminatory attitudes and policies which constrain women of different social groups from accessing services, and relatively little on enhancing the capacity of target groups to influence social norms, policies and services (strengthening voice). This is largely because much of this work falls within the remit of the National Health Education Information Communication Centre (NHEICC).

Figure 3: Share of GESI budget by domains of change



Source: Family Health Division AWPBs

Major conclusions drawn from the analysis are:

- Women are the main target group, as would be expected from the nature of the services, but there has been limited attention to sub-group groups of women who experience additional barriers, for example only 5% of the budget over three years has targeted women in remote locations. There has been little recognition that women from disadvantaged socio-economic groups experience greater barriers in accessing healthcare, despite the existence of disaggregated data from the NDHS 2006 and 2011 highlighting wide health disparities.

- While the strong focus on service delivery is important, a shift in social practices, attitudes and policies is needed to enable women to access these services. This requires investments to enhance the voice and confidence of women, enabling them to influence their families, communities and the service providers, to make them more accountable. The most recent budget (2013/14) indicates this is beginning to change, with activities to address voice increasing to above 7%.

4.2. Child Health Division

The core objectives stated in the CHD business plans (2012/13 and 2013/14) are to reduce under-five mortality, morbidity and disability, and to improve the nutritional status of mothers and children. Three programmes are identified as high priority, as shown below.

- The National Immunisation Programme; including vaccination against nine preventable diseases, aiming to reach every child
- Community Based Integrated Management of Childhood Illness and Newborn Care Package (CB-IMCI/NCP); addressing five major killer diseases of children under five years and the main causes of neonatal mortality
- National Nutrition Programme; addressing protein-energy malnutrition through supplementary feeding, community management, school programmes and nutrition rehabilitation homes, and micro-nutrient deficiency disorders through supplementation and de-worming; a nutrition surveillance system is also planned

It should be noted that NHSSP support to CHD is limited to central level strategic planning of IMCI and maternal nutrition, with implementation through regional and immunisation support staff. Although NHSSP advocacy may have had some influence on the extent to which GESI has been incorporated into the broader set of CHD activities listed below, this cannot be solely attributed to NHSSP inputs. Some activities have been the result of joint efforts, for example NHSSP support for development of an initiative, which has then been implemented in districts using partner funding.

The 2013/14 AWPB shows a significant increase in the total CHD budget. Funds from the Government/ pool fund were up by 39% compared with the previous year and from other external partners by 76%. The district level allocations from Government/ pool fund sources showed large increases for implementation of all three priority programmes, although this is centrally managed.

Major activities planned that will benefit underserved groups are outlined below.

Immunisation

- Use of HMIS performance data for selection of districts: the Immunisation Section selected 15 poorly performing districts in which they supported data quality verification and planning for identifying and reaching children who had not been immunised; selection of districts for micro-planning of family planning services is also based on performance of the district
- Assessment of urban MNCH clinics (immunisation services provided) as a basis for urban clinic planning in Kathmandu valley (2012/13) to identify and reach children who are not immunised
- Recruitment of vaccinators at district level

- Review and update of Reaching Every Child through micro-planning, mobilisation of FCHVs (including mapping training to enable them to identify vulnerable populations) and integration of GESI principles, with the aim of reaching underserved VDCs and health facilities using local knowledge, in line with the operational guidelines on micro-planning; lack of VDC level information and lack of budget has limited progress, apart from in areas where partners (such as UNICEF and WHO) have provided support
- Discussion with parliamentarians about the Immunisation Act, which makes immunisation the right of every child

CB-IMCI/NCP

- Revision of the IMCI protocol training for health workers to integrate GESI; for example including a session on mapping of vulnerable populations (under development)
- Operational research to increase the access of hard to reach populations to IMCI/NCP services
- Training of new health workers on CB-IMCI to ensure they are able to support community based approaches
- Expansion of CB-NCP districts (through a combination of government funding and partner support
- Incentives for FCHVs in CB-NCP districts, which will improve the quality of support for home deliveries
- Implementation of a CB-IMCI revised protocol in 10 districts, including identification and reaching vulnerable newborns and children through FCHVs (using pooled fund in three districts)
- Establishment of a Diploma in Child Health, with training for 15 doctors who will provide services at district hospitals
- Operational research on reaching unreached children with IMCI and newborn care (funded in one district each by government, UNICEF and Save the Children International)
- Supportive supervision of poorly performing districts

The CB-IMCI/NCP multi-year plan developed in 2012 integrates GESI throughout and has a section on reaching underserved groups. It notes that community based programmes have been found more effective in reaching vulnerable populations, and so the government CB-IMCI/NCP annual work plan stipulates geographic priorities in programme expansion and use of FCHVs to ensure inclusion of poor and vulnerable populations. The plan draws attention to analysis from the Nepal Family Health Program mid-term survey (2009)[13] of utilisation of FCHV services for childhood fever and diarrhoeal illnesses, which showed lower utilisation among Muslim, terai Dalit, Madeshi and Janjati groups consistent with the lack of FCHV representation among these groups, reinforcing the urgent need to recruit more FCHVs from underserved groups.

Nutrition

Coordination has been improved by additional human resource support provided by NHSSP in the nutrition section, in particular for coordinating the National Nutrition Technical Advisory Committee and nutrition working groups such as maternal nutrition and IYCF. Integration of GESI in nutrition interventions continues to be a key focus. More specific activities include:

[13] Funded by the United States Agency for International Development (USAID)

- Development of a national Strategy for Addressing Maternal Under-nutrition, which has been approved by all committees and submitted for government endorsement; this important development recognises the significance of prevailing inadequate levels of nutrition among women, especially prior to and during pregnancy and while breastfeeding, as these periods have important implications for women's health, pregnancy outcomes, child survival and growth
- A statement in the above strategy that "a system-wide focus that integrates GESI into existing interventions is needed to improve access and programme quality for socially excluded women"
- Development of a National Maternal Nutrition Plan of Action, with training manuals and operational guidelines, including a focus on GESI integration
- Expansion of micro-nutrient powder supply in 15 districts
- Provision of fortified flour to pregnant women and children aged 6-23 months in five Karnali districts and Solukhumbu
- Expansion of ready to use therapeutic food in 11 districts

Financial allocation analysis

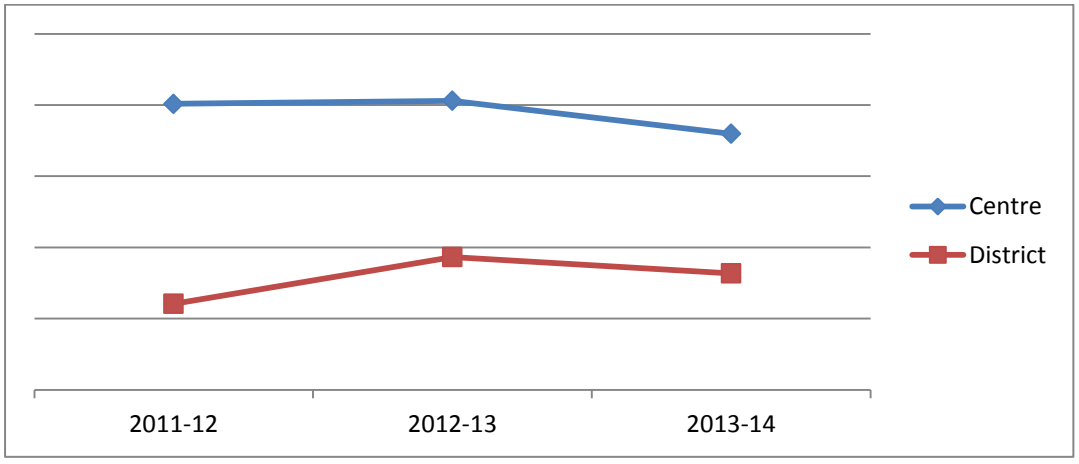
As with FHD, Table 5 and Figure 4 show that the relative budget allocated for district level activities is increasing compared with central level activities, although here too the CHD district level programmes are vertical centrally managed interventions. This means there is no flexibility for districts to reallocate money to address local priorities.

Table 5: Budget allocation for central and district level activities by fiscal year in NRs.'000

Fiscal Year	Centre	%	District	%	Total
2011-12	2,008,865	76.87	604,482	23.13	2,613,347
2012-13	2,030,155	68.50	933,388	31.50	2,963,543
2013-14	1,798,306	68.71	818,817	31.29	2,617,123
Total	**5,837,326**	**71.24**	**2,356,687**	**28.76**	**8,194,013**

Source: Child Health Division AWPBs

Figure 4: Centre and district budget trend by fiscal year

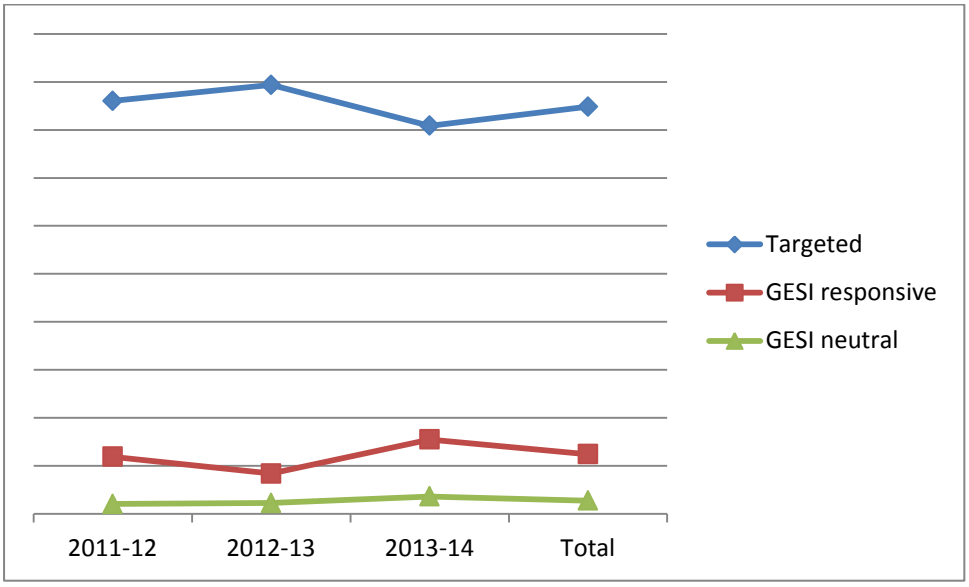


Source: Child Health Division AWPBs

Unlike in the case of women, this analysis does not consider "children" as group to be excluded, as not all children experience systematic historical exclusion or discrimination in the way women of all

social groups do. Only children experiencing income, location, social identity and gender based barriers and those who are malnourished are considered excluded. Figure 5 shows that 80% of the budget is allocated for all children, indicating an assumption that all children, including those experiencing different socio-economic barriers, can access the services provided without problems. About 16% of the budget is for children of excluded groups (those experiencing income, caste/ethnicity or location barriers, those who are malnourished and girl children), and about 5% is for developing a responsive environment. However, there are changes in the current budget, with a decrease in the percentage that is not targeted or responsive, from 85% to 75%, and corresponding increases in the targeted and supportive budgets, from 11% to 18% and from 3% to 7% respectively.

Figure 5: Share of budget by fiscal year and GESI responsiveness



Source: Child Health Division AWPBs

Of the budget allocated for activities targeting excluded children, about 9% is for services to children in remote areas (Table 6). There is no budget for specific activities for girl children, which is a concern given the lower immunisation coverage of girl children and the fact that fewer girls were taken for diarrhoea treatment compared with boys.

Table 6: Allocation of GESI budget for targeted CHD activities (NRs.'000)

Indicators/Description	2011-12	2012-13	2013-14	Total
Budget related to remote location	52,600	25,695	61,400	139,695
Percentage of GESI budget	*14.09*	*4.21*	*9.53*	*8.59*
Budget related to target group	0	0	2,300	2,300
Percentage of GESI budget	*0.00*	*0.00*	*0.36*	*0.14*

Source: Child Health Division AWPBs

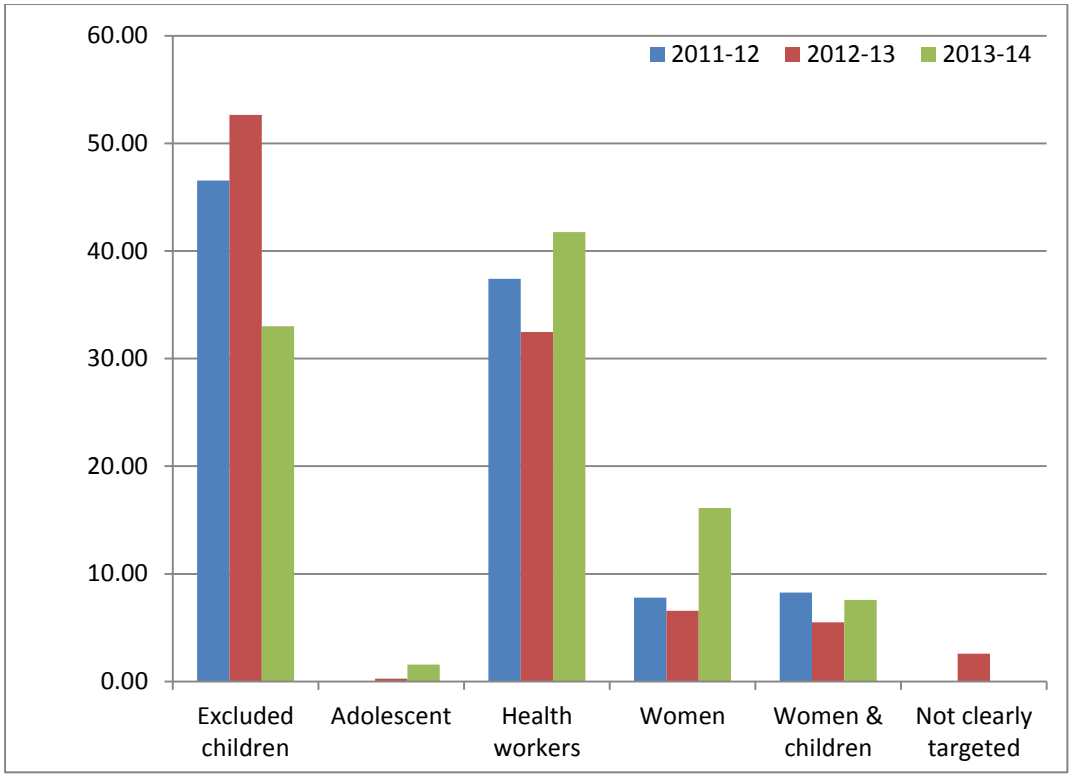
Table 7 and Figure 6 show that children suffering from malnutrition accounted for 43% of the financial allocation for GESI activities over the three years. This decreased slightly in 2013/14, but with an increase in activities to strengthening the skills and motivation of FCHVs to reach children, which will help bring services closer to communities.

Table 7: Percentage share of GESI budget by target groups

Fiscal Year	Children with malnutrition	Adolescent	Health workers & FCHVs	Women	Women & children	Not clearly targeted	Total
2011-12	46.54	0.00	37.43	7.77	8.27	0.00	**100.00**
2012-13	52.64	0.25	32.48	6.57	5.48	2.58	**100.00**
2013-14	33.00	1.55	41.76	16.11	7.58	0.00	**100.00**
Average	**43.46**	**0.71**	**37.29**	**10.62**	**6.95**	**0.97**	**100.00**

Source: Child Health Division AWPBs

Figure 6: Share of GESI budget by target groups



Source: Child Health Division AWPBs

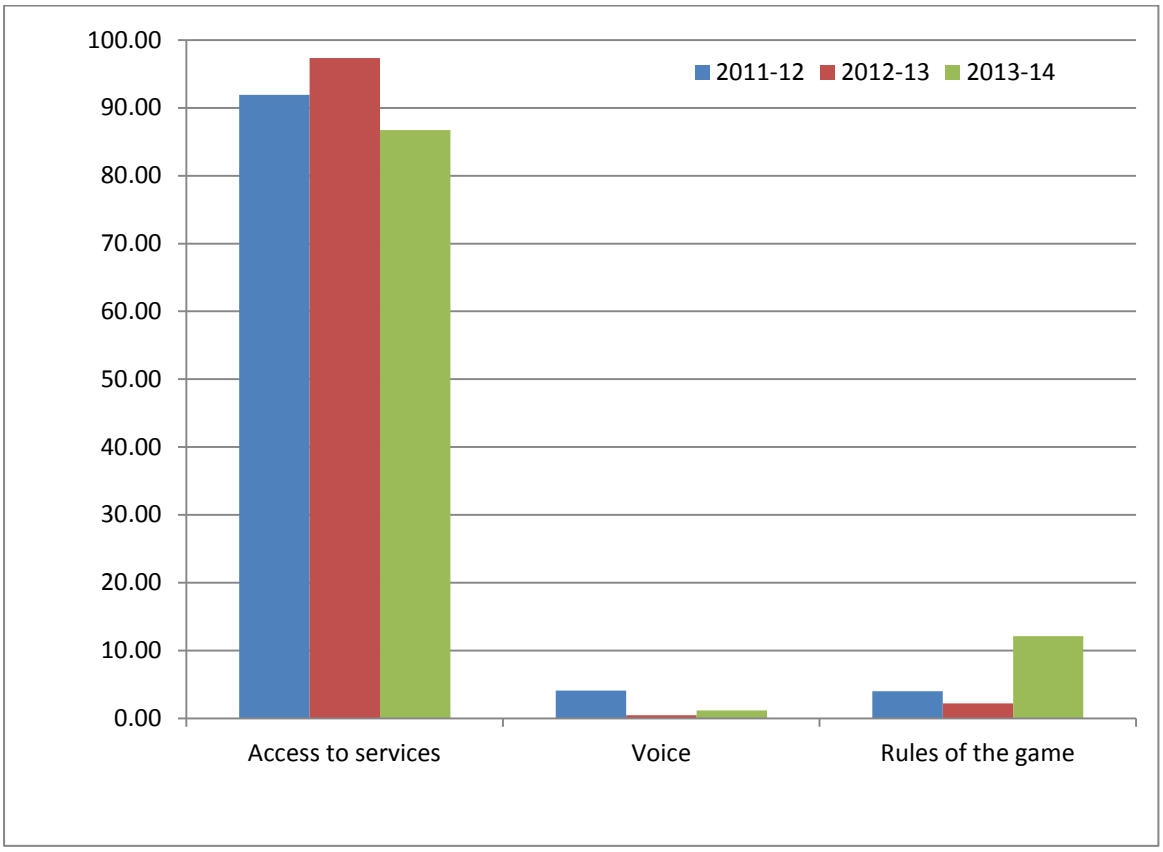
Analysis by area of work (domains of change) shows the strongest focus on access to services, with a decreasing focus on building capacity to influence decisions in favour of excluded children (voice), although as in the case of FHD, this area of work also falls within the remit of NHEICC. However there is a substantial increase in the focus on changing discriminatory policies and mind-sets (micro-planning, advocacy, review activities), from 2% to 12%.

Table 8: Percentage share of GESI budget by domains of change

Fiscal Year	Access to services	Voice	Rules of the game	Total
2011-12	91.93	4.10	3.97	100.00
2012-13	97.33	0.46	2.21	100.00
2013-14	86.71	1.16	12.12	100.00
Total	**91.89**	**1.57**	**6.54**	**100.00**

Source: Child Health Division AWPBs

Figure 7: Share of GESI budget by domains of change



Source: Child Health Division AWPBs

Major conclusions drawn from the analysis are:

- Although overall 80% of the budget over the three years was GESI neutral and only 16% targeted, the GESI responsiveness is increasing (by 2-3% up to 7% in 2013/14) and the targeted budget allocation has increased from 11% in 2011/12 to 18% in 2013/14. The major portion of this (14% of total in 2013/14) was for nutrition related activities in the Karnali zone[14], and this is increasing, but no funds were allocated for addressing income based barriers among children.
- Malnourished children are the main target group, accounting for 43% of the financial allocation for GESI activities over the three years (Table 7), this decreased slightly in 2013/14 but with an increase in activities such as strengthening the skills and motivation of FCHVs to reach children.
- Service provision accounts for 92% of the CHD allocated budget over the three years, but the allocation for enhancing voice has decreased.
- The appreciable increase in allocations for activities to address discriminatory attitudes, social norms and policies (including those which do not explicitly address exclusion) is encouraging. This trend should be continued and made more specific to service activities, to make the changes necessary for services to be used by children of excluded groups. This should include advocacy with families where data shows immunisation is incomplete and working with the family "gatekeepers" of women and children with poor nutrition.

[14] This comprised revision of programme guidelines for the Karnali zone, and distribution of nutritious food and behaviour change communication activities for nutrition in five districts in Karnali zone

5. NEXT STEPS

5.1. Challenges to be addressed

General issues for the health sector

Reaching unreached populations, whether marginalised socio-economic groups or geographically remote communities, poses many challenges that require strong commitment to overcome. The dearth of accurate information on government service provision, especially in remote areas, makes targeted programming difficult, although it is well known that services that do exist are often of inadequate quality, due to low retention of service providers, absenteeism, insufficient and inaccessible facilities, supply and communication difficulties, low levels of community mobilisation and lack of local and international NGO partners. To work with this, every district needs to generate VDC level information to identify who the excluded are, where they are and what barriers they face in accessing services, as a basis for GESI focused district level micro-planning.

Although community based programming (mainly through FCHVs) is understood to be more GESI sensitive, since the service is closer to the community, it is in fact a universal approach and therefore still needs specific adaptations to ensure underserved groups are reached. For example in one study[15] it was observed that mobilisation of NGO based women's groups mostly only reached the wealthier/ advantaged caste women, and additional efforts were needed to address the barriers faced by poor and disadvantaged caste women. The same is true for FCHV programmes, but this has not yet been fully recognised. This important learning has been incorporated into the design of the Equity and Access Programme.

Piloting of new programmes is normally conducted in easily accessible districts, to enable a high level of monitoring. Scaling up of these programmes tends to continue the focus on accessible districts, to enable high population coverage with lower budgets. This means the hard to reach districts receive programme interventions right at the end of scaling up, yet their needs are often the greatest. This can be seen in the plans for scaling up IMCI.

Programme implementation for hard to reach groups (those in remote areas or socially excluded) is more costly and, by definition, benefits a smaller number of people. This poses a dilemma for the programme manager regarding effective use of limited financial resources, balancing high population coverage, against often extreme levels of need among small remote and/or socially excluded populations. With no clear guideline, the programme manager focusing on achieving MDG targets (which have no equity component) will naturally choose areas with large easy to reach populations. Clear policy guidance is needed to change this, with specific target indicators for underserved groups in national documents (such as NHSP-2) to make programme managers accountable for reaching underserved groups. Recommendations from the mid-term review included disaggregation of indicators at national level, based on marginalised groups and locations.

[15] World Bank and DFID; Dr L. Bennett; Unequal Citizens: Gender, Caste and Ethnic Exclusion in Nepal; 2006

Awareness about health issues and the availability of services is often low among poor and excluded communities, and this needs to be increased through harnessing local social networks. It is also important to ensure services are strategically located in order to be accessible to targeted underserved populations and to provide a focus for public education and referral.

Context specific planning at district and local (even VDC) level has been advocated for reaching unreached communities, but this requires commitment and the ability to prioritise interventions best suited to the context, capacities that may not be present at district level across the whole range of issues. District and local level planning is also more sustainable if local stakeholders are involved from the situational analysis phase, but care is needed to ensure they are not overwhelmed by the scale of problems and gaps identified. Focusing planning on selected "more manageable" areas of service, such as immunisation or family planning may be easier, but this may create a dilemma between a holistic planning versus focused planning, or between identified local needs versus centrally driven evidence based interventions. Moreover, local ownership can be threatened by the transfer of the locally responsible, committed person driving the process, such as D/PHO or health facility in-charge. NHSSP facilitated context specific planning in three districts (Banke, Kalikot, Jajarkot) in May 2010, and the main challenges observed were: difficulty in prioritisation, which made it almost impossible to arrange funding and support from central Government or partners; and ensuring ownership and support of the D/PHO, in a context of frequent transfers.

It is important to acknowledge that issues related to mainstreaming GESI in the two divisions differ, since FHD services are more facility based, whereas most CHD activities are community based. The immediate challenges therefore appear greater for FHD, since greater changes are needed to reach underserved populations through facility based services. CHD, on the other hand, may feel their activities are already more GESI focused, but it should be recognised that even community based services do not always adequately reach vulnerable populations, for reasons that include lack of representation of vulnerable groups among FCHVs, and the lack of participation of these groups in community activities.

A key point that has not yet been adequately addressed by either CHD or FHD is the fact that technical service delivery must be linked with social interventions that address harmful traditional practices and values. Thus, in addition to essential behaviour change communication through NHIECC, specific interventions are necessary to change the particular practices and beliefs of families and community decision makers that may hinder progress towards desired health improvements.

Specific challenges to implementing the GESI Operational Guidelines when producing AWPBs

In a context of the general challenges discussed above, there are specific challenges to integrating GESI in AWPBs, which will need to be addressed.

- Currently there is limited understanding amongst government staff about how to effectively mainstream GESI during the AWPB development process. This is compounded by the lack of an evidence based planning system, and in particular the limited availability of disaggregated evidence at sub-national levels and insufficient understanding about how this should be used.

- Linked to the lack of disaggregated routine information, there is insufficient understanding about needs of sub-groups, which prevents targeted planning and budget allocation during the AWPB process.
- Lack of familiarity with the details of the GESI Operational guidelines, especially among lower level staff, is a constraint as orientation on the guidelines has not yet been completed and hence the skills and tools for GESI integration into AWPBs have not been developed among the concerned staff.
- Overly centralised planning and budgeting systems do not allow for sufficiently devolved planning in response to local needs; as noted, even district level spending is directed centrally.
- As yet, systems for effectively capturing how plans are targeting socially excluded populations have not been developed, so although there is evidence of GESI mainstreaming in the AWPBs, there is no methodology for assessing this.
- A key challenge in integrating GESI in AWPBs is the lack of GESI specific indicators and clarity on how to categorise the different activities.
- A wider challenge is the gender responsive budgeting process developed by the Government and mandated by the Ministry of Finance. Each ministry follows this, submitting its assessment of gender responsive budget percentages to the Ministry of Finance, but the process and indicators do not enable a practical assessment of the financial allocations and hence are not sufficiently useful for programming. This limitation is exacerbated by the fact that divisions and centres are not involved in the process, as it is carried out at ministry level. Additionally, the process is limited to allocations from a gender perspective, and does not cover social inclusion.

5.2. Proposals for mainstreaming GESI and reaching the underserved

In order to build on the achievements and learning to date, the following proposals are made.

Planning and programming

- The GESI focus needs to continue as an integral part of programme review and planning.
- Division programme implementation guidelines should incorporate directives for GESI integration in programme activities.
- Programme activities must include targeted interventions to address discriminatory practices and processes that constrain women and children of different social groups (such as Muslims and Madhesi Dalits) from accessing services.
- Learning from remote area initiatives, such the integration of family planning with immunisation and piloting of safe abortion services in remote districts (Kalikot and Myagdi), should be incorporated into national planning.
- Strengthening of district level monitoring and mentoring to enhance and expand services in remote districts should be continued through regional safe motherhood coordinators and supervisors. This will include analysis of data through a GESI lens.
- Selection of locations for new and upgraded health facilities, including birthing centres, should focus on areas where more than 50% of the catchment population is underserved, rather than looking only at overall numbers served.
- District specific local planning, based on formative research, should be strengthened to support programme implementation and communications.

- NHSSP and partners will continue to advocate for district and Ilaka level, context specific planning involving stakeholders from other sectors where appropriate, as this is essential to reach underserved populations who may be missed by centralised planning. District specific local planning to identify and reach unreached groups, with flexible budgets to implement plans, should be part of the centrally allocated district budget.

Capacity enhancement

- The skills of service providers should be enhanced to enable them to provide quality services close to the community, at sub/health posts and outreach clinics. This should include training and support for ANMs to provide IUCD and implant services and improved counselling skills of all family planning providers to increase uptake and understanding of couples on management of the method of their choice and any possible side effects.
- Critical human resource gaps must be addressed, including placement of an appropriate mix of female and male staff in each facility, improving staff attendance and increasing supervision and monitoring to reduce absenteeism.
- Multi-year contracts and training for all locally recruited health workers are needed, to increase the availability and retention of health workers and continuity of services. Although the Government supports this in principle, currently budgets cannot be assured, especially for higher salaried staff.

Coordination and collaboration

- FHD and CHD should partner with external agencies to implement services in remote districts, where unit costs are high.
- Partnerships should be developed with local civil society organisations to address social, cultural and religious beliefs that affect maternal and child health through behaviour change communication targeting women, their family gatekeepers and local stakeholders.
- Local social networks and partners should be involved in implementation of activities.

The GESI guidelines give specific guidance on the process for integration of GESI in the development of AWPBs and business plans, which NSSSP will support. In summary, these include:

- Addressing national priorities and the NHSP-2 results framework in preparation of division/ centre plans, with special attention to reaching the unreached, ensuring equitable services and resources and obtaining key evidence needed for addressing gaps in health service utilisation
- Ensuring activities for reaching the unreached include social mobilisation, advocacy, behaviour change communication, capacity building and innovative service delivery methods
- Inclusion of costed GESI plans into the business plans and AWPBs
- Division and centre level meetings to specifically discuss planned GESI related activities in the different sections
- DoHS level discussion to ensure instructions from the Policy Planning and International Cooperation Division (PPICD) on addressing GESI issues have been followed
- An internal review of draft AWPBs by the PPICD to check that GESI issues are adequately addressed, followed by review and discussion by the GESI Secretariat.