Background thematic report no. 8

Progress Report on

Gender Equality and Social Inclusion for NHSP-2

2012/13

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Government of Nepal (GoN)
Ministry of Health and Population (MoHP)
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EXECUTIVE SUMMARY

Progress report on GESI achievements in 2013

This report provides an update on the initiatives of the Ministry of Health and Population (MoHP) and its partners in 2013 to mainstream gender equality and social inclusion (GESI) and improve the access of women and poor and excluded people to health services.

A. Progress

Progress was made on mainstreaming GESI into the national health system by forming a GESI section in the Population Division, and up to the end of 2013, by forming GESI technical working groups in 71 districts and appointing focal persons in all regional health directorates and district health offices. Two overarching guidelines were approved this year — the 'GESI Institutional Structure Guidelines' and the 'Operational Guidelines for GESI Mainstreaming in the Health Sector'. The increasing importance assigned to the GESI agenda is evident from the Population Division allocating 31% of its budget for GESI activities in 2013/14.

Good progress was made on making health service provision more GESI responsive. Seven new one-stop crisis management centres (OCMCs) were established and strengthened in hospitals for integrated support to survivors of gender-based violence. Seven pilot social service units (SSUs) were established in hospitals to facilitate subsidised and free health care. And the social auditing of health facilities progressed through the approval of harmonised guidelines and the carrying out of audits in an additional 21 districts in 2012/13 and in 40 districts in 2013/14. Progress on the Equity and Access Programme (EAP) saw a new demand side package of interventions (EAP Plus) under preparation for remote districts and the decision to integrate health into the Local Governance and Community Development Programme (LGCDP).

The main progress on GESI capacity building were the incorporation of GESI into five health training curricula and the induction training package for new health personnel and the training of personnel from 75 districts on GESI. The documentation on GESI for policy making and programme decision making was strengthened by finalising the further analysis of the 2011 Nepal Demographic and Health Survey (NDHS) and the 2012 PEER study on the barriers that poor people face accessing health services. The identification of 10 standard Health Management Information System (HMIS) indicators for disaggregated data collection on GESI will also provide improved data for decision making.

B. The Way Forward

The main ways forward for mainstreaming GESI in the coming years are as follows:

- Ensure that new policies integrate GESI concerns and scale-up context specific planning.
- Produce a training manual on GESI and pre-test the five revised training curricula.
- MoHP to continue integrating GESI into its annual workplans and budgets (AWPB) and business plans and include adequate funding for GESI mainstreaming activities in AWPBs.
- The Population Division to develop a rollout plan for the GESI Operational Guidelines.
- Integrate GESI concerns into district programme implementation guidelines.
- Strengthen the functioning of OCMCs, SSUs, and social auditing and improve collaboration and coordination between the various agencies that are involved in OCMCs.
- Support the integration of EAP into LGCDP's social mobilisation programme and pilot EAP Plus.
- Promote the use of disaggregated data and evidence from HMIS.

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ACRONYMS

AHW	assistant health worker
ASRH	adolescent sexual and reproductive health
AWPB	annual work plan and budget
BCC	behaviour change communication
CHD	Child Health Division
DoHS	Department of Health Services
DHO	district health office
DPHO	district public health office
EAP	Equity and Access Programme
EPI	Expanded Programme of Immunisation
FCHV	female community health volunteer
FHD	Family Health Division
GAAP	Governance and Accountability Action Plan
GBV	gender based violence
GESI	gender equality and social inclusion
GoN	Government of Nepal
HFOMC	health facility operation and management committee
HRH	human resources for health
IMCI	integrated management of childhood illnesses
LMD	Logistics Management Division
MFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MWCSW	Ministry of Women, Children and Social Welfare
NDHS	Nepal Demographic and Health Survey
NGOs	non-governmental organisation
NHTC	National Health Training Centre
NPC	National Planning Commission
OCMC	one-stop crisis management centre
PEER	participatory ethnographic evaluation and research methodology
PHCRD	Primary Health Care Revitalisation Division
RHD	regional health directorate
SBA	skilled birth attendant
SMNCH	safe motherhood and neonatal health
SSU	social service unit
ToR	terms of reference
TWG	technical working group
VDC	village development committee

1 INTRODUCTION

1.1 Background

The Nepal Health Sector Programme-2 (NHSP-2) has a clear mandate to address gender equality and social inclusion (GESI). NHSP-2's vision, mission, goal, objectives, results framework and accountability plans have clear directions for addressing GESI issues. A GESI strategy for the health sector is included in NHSP-2. A National Action Plan on Gender Based Violence (GBV) has been implemented since November 2010. The plan's implementation is coordinated by the Office of the Prime Minister and Council of Ministers and has the commitment of 13 ministries including the Ministry of Health and Population (MoHP) plus the National Planning Commission, the National Human Rights Commission, and the National Women's Commission. MoHP has responded to the national mandate and initiated various responses to address inclusion.

1.2 Objectives

The objective of this report is to provide an update on the initiatives taken by MoHP and its partners to mainstream GESI and address key issues experienced by women, the poor and excluded in accessing health services in 2013.

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

2 PROGRESS AND ACHIEVEMENTS

2.1 GESI Programme Interventions

2.1.1 Mainstreaming Gender Equality and Social Inclusion

The GESI Institutional Structure Guidelines were approved in 2013. They specify the location of GESI responsibilities in the government's health structure and in the functions of different committees and working groups. MoHP's GESI Steering Committee meets twice-yearly under the chairmanship of the health secretary and gives clear directions for operationalising GESI in the health sector. The committee has made decisions about mainstreaming GESI in planning, reviews and annual work plans and budgets (AWPBs); about establishing one-stop crisis management centres (OCMCs); about rolling out GESI institutional structures and about establishing social service units (SSUs).

Up to the end of 2013, GESI technical working groups (TWGs) have been formed in almost all districts (71 out of 75). GESI focal persons have been nominated in all regional health directorates (RHDs) and in 75 district health office/district public health offices (DHOs and DPHOs). All five regions and 71 districts now have functional TWGs. Terms of reference of all groups and committee members mentioned in the GESI Institutional Structure Guidelines has been covered in GESI orientations.

The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' were developed under the guidance of a Technical Committee and approved by MoHP in December 2013. These guidelines guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery, monitoring and reporting.

In 2013 a GESI section was formed in the Population Division headed by the under-secretary as a dedicated section to work on GESI.

The Population Division has incorporated GESI related programmes (OCMCs, SSUs, strengthening GESI TWGs and GBV training to health staff of OCMC hospitals) into their programme implementation guidelines since the current fiscal year (2013/14).

GESI was integrated into the following five programme implementation guidelines for FY 2070/71 (2013/14):

- the Primary Health Care Revitalisation Division's AWPB Implementation Guidelines and Community Health Unit Guidelines;
- the Management Division's AWPB Implementation Guidelines; and
- the Family Health Division's AWPB Implementation Guidelines and Uterine Prolapse Programme Guidelines.

In 2013 an Urban Health Policy was developed and is now in the final stages of development prior to approval. The implementation of this policy will improve access to health services for the urban poor.

2.1.2 Addressing Gender Based Violence

In 2013, seven new one-stop crisis management centres (OCMCs) were established to bring the total number to 15 (including the public private partnership in Dhulikhel Community Hospital, Kavre). They are based in hospitals to support survivors of gender-based violence. The following initiatives were carried out in 2013 to strengthen the centres:

- A resource book on legal provisions and procedures for GBV victims was prepared and disseminated to OCMCs.
- Pamphlets on OCMCs were made to disseminate information on OCMCs to the general public.
- An assessment of the performance of OCMCs was carried out in mid-2013. The assessment looked at the functioning and quality of services provided including how hospitals have coordinated with other district agencies to provide livelihood, legal and rehabilitation support to GBV survivors.
- In August 2013, a national workshop was held to review and give future direction to OCMCs. The workshop recommended the establishment of a GBV working committee with joint secretary membership from MoHP and other relevant government agencies. Discussions are underway with the Prime Minister's Office and the Department of Women and Children to establish a GBV working committee.
- Awareness programmes, radio jingles, review workshops, rallies, orientations, interviews and meetings with journalists were organised in districts during the 16 days of activism against GBV.
- Five days of training on psychosocial counselling was provided to 106 staff and focal persons who work in OCMCs, safe homes, rehabilitation centres, women development offices and Nepal police's women and children units. These are the personnel who have first contact with victims of violence. On-site mentoring and clinical support was provided as appropriate for training participants.
- A six month training course on psychosocial counselling was provided to three OCMC staff nurses.
- Preparatory work is underway to prepare referral and treatment protocols on Gender Based Violence (GBV).
- Preparatory work was carried out to provide medico-legal training to 16 OCMC medical officers.

2.1.3 Social Service Units

A study in 2012 on the provision of free health care services and subsidies identified the need to establish social service units (SSUs). This went ahead by developing guidelines for SSUs and a road map to establish and strengthen SSUs. In 2013:

- Seven pilot SSUs were established in hospitals and preparatory work was completed to establish one in Bir Hospital in 2013. Orientation and backstopping support was provided.
- A progress review of the pilot hospital SSUs was carried out on July –August 2013. Based on this MoHP developed an M&E framework and capacity development plan for SSUs.
- A review workshop on SSUs, chaired by the health secretary, was held in January 2014. The workshop reviewed the achievements, issues, lessons learned and guidelines related to SSUs, and made recommendations for the more effective functioning of SSUs. The revision of the guidelines based on the workshop's recommendations is underway. MoHP plans to revisit the road map for strengthening SSUs considering review workshop discussions.

2.1.4 Equity and Access Programme

EAP: The Equity and Access Programme (EAP) was implemented in selected VDCs of 20 districts in 2013. EAP mobilises women, and poor and excluded people through a rights based social mobilisation

approach. Local NGOs and FCHVs mobilised women's groups, and promote health rights and disseminate messages to communities through mass communication, BCC and interpersonal communication. The messages relate to the national health programme, including on safe motherhood and institutional delivery, new-born care, immunisation, family planning, and free health care.

The 2012 EAP strategic review set out four conditions to be met to justify continuation of EAP: 1) multi-year contracting to NGOs, 2) strengthening supervision and monitoring, 3) central level involvement in district NGO selection, and 4) better coordination with the Local Governance and Community Development Programme (LGCDP). In 2013, a consensus was reached within MoHP to seek Ministry of Finance approval for the multi-year contracting of implementing NGOs. MoF's decision is awaited.

EAP Plus for remote areas: The 2013 study on access to health services in remote areas of Nepal found that remote and mountain districts, and remote VDCs in such districts were worse off in most aspects of access to and use of maternal, newborn and child health (MNCH) services. The study recommended a core service delivery and demand side package of interventions to pilot the overcoming of the barriers to access in one district. The demand side package, named EAP Plus, is being developed.

EAP integration into LGCDP: In December 2013, MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) decided to integrate health issues into the Local Governance and Community Development Programme's (LGCDP) social mobilisation programme. This programme includes local governance system strengthening, demand side accountability and targeted empowerment of excluded communities. A pilot project to integrate health into LGCDP will focus on strengthening the local governance and accountability system, and integrating and harmonising how health is incorporated into community mobilisation activities, to together empower and generate demand for health and achieve health gains and strengthen local health service delivery. In 2013, MoFALD agreed to integrate health into LGCDP's social mobilisation guidelines and training curricula, and the related development of information education and communication (IEC) and BCC materials.

2.1.5 Piloting of Social Auditing Guidelines

In 2012, comprehensive social audit guidelines for health facilities and district hospitals were developed and implemented in 21 districts. In two of these districts (Palpa and Rupandehi), 21 health facilities were supported by Nepal Health Sector Support Programme (NHSSP) technical assistance. The action plans prepared by the social audits were monitored in NHSSP-supported facilities and a process evaluation was carried out in June–July 2013 in the two districts that documented notable achievements.

Harmonised social auditing guidelines were approved by MoHP in June 2013 incorporating feedback from the districts where social audits were conducted. With AWPB funding, a harmonised social auditing approach was implemented across 21 districts in an additional 177 facilities in 2012/13. PHCRD is conducting social auditing in 40 districts in 2013/14, covering an additional 296 facilities. Orientation programmes about the objectives, institutional mechanism, process, documentation and reporting of social auditing have started.

Technical support from multiple development partners at central and local levels has been important, feeding into design and implementation. This process has enabled many women and people from excluded groups to participate in social audits for a more thorough and inclusive process.

2.2 Organisation and Management Strengthening

2.2.1 GESI activities in the AWPB and the Business Plan

MoHP allocated a reasonable amount of its budget for GESI activities, including GBV, for 2012/13. The annual work plan and budget (AWPB) included a budgetary provision for GESI-related capacity development at different levels, to make GESI technical working groups functional, and to establish and operate OCMCs in 16 hospitals and SSUs at 8 hospitals. The Population Division allocated 31% of its budget for GESI specific activities for FY 2070/71 (2013/14).

MoHP and DoHS divisions and centres (including FHD, CHD, LMD, MD and PHCRD reviewed their work plans and budgets for FY 2012/13 from a GESI perspective. The development and use of MoHP's new business plan format has been crucial in ensuring that GESI related activities are identified, planned and budgeted within MoHP. The joint consultative meetings in 2013 between MoHP and its external development partners to discuss the AWPB reinforced the government's message that GESI activities are to be explicitly addressed by all divisions.

2.2.2 Capacity Building on GESI

In 2013, GESI was integrated into population training courses to improve the conceptual clarity and impact of GESI focal persons. The courses were participated in by RHD staff, GESI focal persons of DHOs and DPHOs, and statistical officers of 75 districts. Government, NGO and project staff were orientated on GESI. In addition, GESI trainings were delivered in 10 districts to district health teams using appreciative inquiry. NHTC ran training of trainers on inclusive governance for 60 participants.

2.2.3 GESI Integration into Training Curricula

In 2012, MoHP's Training Curriculum Review Technical Committee identified five curricula for revision from the GESI perspective (health facility operation and management committee [HFOMC], female community health volunteer [FCHV], behaviour change communication [BCC], upgrading assistant health worker [AHW] and skilled birth attendant [SBA]). The findings of the 2013 reviews of the curricula were shared with the SBA forum and TWG. It was decided to develop GESI modules and training materials in a participatory way for integration in the five curriculums. Draft materials were prepared and reviewed and a workshop held in 2013 to finalise the contents. The National Health Training Centre (NHTC) has decided to pre-test the new materials and then finalise the modules and materials. Until reprinting happens, the GESI modules and materials and facilitator's guide will be inserted into the current printed training curricula.

GESI concepts and application has been integrated into induction training package for new health sector personnel for the first time, which have been implemented by NHTC in 2013 and will continue in future years. GESI has also been integrated into the training curricula for upgraded health workers.

2.2.4 Regional GESI Specialists

GESI specialists from all five regions worked with the RHDs and provided technical support for GESI mainstreaming. These specialists worked to promote GESI in the RHDs' regular programmes including forming, facilitating and providing GESI orientation to regional GESI technical working groups and supporting the carrying out of reviews and district monitoring from a GESI perspective. In addition, they supported the mapping of unreached VDCs within districts, and of unreached social groups within these VDCs based on draft mapping guidelines.

In 2013, orientations were provided on GESI to more than 70 district health teams by regional GESI specialists with support from the GESI Secretariat (Population Division) and NHSSP's GESI advisors. In these districts the regional GESI specialists supported the formation and facilitation of district GESI working groups and the mainstreaming of GESI into programme planning, implementation and monitoring and review processes. Support was also provided to RHDs to review health service use information from a GESI perspective. The terms of regional GESI specialists ended in August 2013.

2.2.5 GESI Integration in Health Management Information System

In 2013, the possible types of caste/ethnicity and geographical disaggregation for Health Management Information System (HMIS) data were discussed with the HMIS Section of the Management Division. Indicators have been identified that need to be disaggregated by sex, age, location, and caste/ethnicity. A revised HMIS that incorporates GESI-related key indicators will be operationalised in FY 2014/15. The DoHS has proposed 10 indicators for disaggregation. Also, improvements will be made to hospital recording and reporting systems in the revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised reporting system within HMIS and the new software will enable sub-district level data to be generated.

2.3 Research and Documentation

2.3.1 Further Analysis of 2011 Nepal Demographic and Health Survey

In 2012, a committee was formed chaired by the Chief of the Population Division for the further analysis of the 2011 Nepal Demographic and Health Survey (NDHS). The resulting five study reports were finalised in March 2013, and all are GESI responsive.[1] The reports on the effects of caste, ethnicity, and regional identity on maternal and child health and on women's empowerment and spousal violence strengthen the evidence base for policy making and programming in the health sector.

2.3.2 Study on Identifying Barriers to Accessing Health Services

A study carried out in 2012 identified the socio-cultural, economic, and institutional barriers that poor women and men from selected social groups face accessing health services in Nepal. It used a participatory ethnographic evaluation research (PEER) methodology to explore sensitive issues with non- and low literate marginalised community groups. The study found that the main barriers are gender-based decision making; women's work burdens and economic dependence on men; distance to services; social, cultural and religious beliefs; poverty, caste, ethnicity and religious identity; and supply side barriers. The final draft study report was shared by the Population Division with MoHP and external development partners. Briefing notes have been prepared on the findings of this study.

2.3.3 Process Documentation of GESI Mainstreaming in the Health Sector

The process and results of GESI mainstreaming in Nepal's health sector were documented and published in 2013. This report presents lessons and good practices that the GESI Steering Committee will be able to use for its continued work on GESI.

[1] All five reports are available via http://www.newera.com.np/research/20s/20_health48.htm

3 KEY CHALLENGES

3.1 Effective Implementation of GESI provisions in Policies, Plans and Guidelines

A key challenge is to ensure the implementation of GESI-related plans included in the AWPBs and annual business plans of the different divisions and centres. Effectively implementing the GESI operational guidelines, the social audit guidelines, and the EAP, and ensuring that the institutional structures for GESI are functional requires dedicated attention. Another major challenge is the revision of programme implementation guidelines and adjustments to the system of planning, programming, monitoring and supervision for the implementation of GESI provisions.

3.2 Multi-sectoral Coordination to Address Issues of Women, Poor and Excluded People

Another major challenge is developing a coordination and collaboration mechanism between ministries to address the complex issues that impact the access and use of health services by women, the poor and other excluded groups. Service provision by OCMCs in particular need to be better coordinated and the challenge is to convince and motivate different actors to work in a holistic way.

3.3 Identifying the Income Poor

Tools to identify the poor are not sufficiently robust to accurately identify the poor for targeting of subsidised and free health services. This allows misuse and access by the more advantaged. This is especially important for the effective implementation of SSUs.

3.4 Regular Opportunities to Strengthen Service Providers' and Health Managers' Skills

Continuous interventions are needed to improve the ability of service providers to recognise the barriers women, the poor and excluded face accessing and using health services and to identify what measures can be taken to overcome them. A key challenge is for service providers to find time and the additional resources required to run such interventions.

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

3.5 Making EAP Implementation Effective

The major challenge to EAP's viability and the achievement of results is related to the delays incurred as a result of the long process of contracting implementing NGOs. Issuing single year contracts reduces community implementation time, leads to large gaps in community programming and support, and compromises the capacity of NGOs to facilitate the empowerment process.

4 LESSONS LEARNED

4.1 Mandatory Directives Essential

A strong policy mandate on GESI is essential. Only then can officer level personnel across all levels of the health system be made accountable for taking forward the GESI agenda.

The approved institutional structure guidelines clearly identify the responsibilities for GESI mainstreaming within the health sector. This has given direction to the different committees and working groups on the tasks they must implement to ensure GESI mainstreaming.

Similarly MoHP's annual business plan format calls for separate information on GESI specific activities. This helps divisions and centres to identify activities and assigns responsibilities for carrying them out.

4.2 Government Leadership and Ownership

Government leadership and ownership of the GESI agenda is crucial and needs to be reinforced and supported by external development partners and the technical assistance that is provided.

4.3 GESI Integration into the Institutional Fabric of the Health System

Working on only one or two elements of GESI mainstreaming is insufficient for effective and in-depth integration of GESI, which requires a comprehensive and systematic approach. The entry points in the planning, budgeting and programming cycle and across the various technical divisions are fluid and often unpredictable and opportunities need to be seized and built upon as they emerge.

4.4 Disaggregated Evidence

Disaggregated evidence about the existing health outcomes of women, the poor and the excluded need to be generated, analysed and used for advocacy and programmatic interventions.

4.5 Coordinated Efforts Needed for Effective Service Delivery by OCMCs

It is important for the multiple needs of GBV survivors (care, rehabilitation, protection and communication) to be addressed. There needs to be good coordination between central level agencies to direct their district level agencies on the support to be provided. Comprehensive guidelines outlining the interventions of the different concerned ministries are needed for the comprehensive care of GBV survivors.

4.6 Strengthening Service Provider Skills

Capacity building is at the core of mainstreaming GESI. This will take several years of sustained effort and requires innovative interventions. Different methodologies are needed to enhance the skills of health service providers to apply a GESI lens in their work. Repeated interactions and discussions (such as during the preparation of AWPBs and implementation plans) will enable concerned officers to recognise ways of addressing the issues that impact women and poor and excluded people.

4.7 Technical Assistance must have a Good Understanding of GESI

Well prepared and competent technical assistance is essential for influencing and supporting decision makers.

5 THE WAY FORWARD

5.1 The Policy Level

Ensure that any newly formulated, revised, updated or amended policies (including the National Health Policy, Population Policy and NHSP-3) integrate GESI. This will mean that the issues experienced by women and poor and excluded people to access and use health services are recognised and addressed in policies.

5.2 Context-Specific Planning

Context specific planning efforts need to be continued and up-scaled to better understand who are the excluded and the reasons why they are unable to access and use health services. The practice of mapping users and non-users of various health services and the reasons for non-use needs promoting. Health facility operation and management committees (HFOMCs), with the support of FCHVs, should do this mapping as they understand their catchment areas and will be able to inform health facilities of how services need to be adjusted to be more inclusive.

5.3 GESI Institutional Structure

The Population Division needs strengthening to work as an effective GESI Secretariat and to make the GESI Committee, GESI TWGs and HFOMCs functional. The skills of their members also need to be strengthened. Support from external development partners is needed to support the integration of GESI in health in the districts where they are operational, including strengthening GESI TWGs.

5.4 Capacity Strengthening

- Produce a standard training manual on GESI (based on the GESI Operational Guidelines, 2013) that incorporates inclusive governance training materials.
- Pre-test the five curricula recently revised with GESI content added and reprint training packages including all GESI-related modules and sessions.

5.5 Integration of GESI in AWPBs and Annual Business Plans

- The good practice initiated this year of integrating GESI into MoHP's AWPB and Business Plan should continue. GESI focal persons in all divisions and centres will work to ensure that the activities on reaching underserved areas and unreached groups are identified and costed. TWGs at all levels need to ensure that these aspects are well addressed in their plans and programmes.
- The business plan format now has a separate section for GESI-related activities. This practice, which divisions tend to associate with external development partners, needs to be made a part of regular government planning. Advocacy for the National Planning Commission to use this format needs to be taken forward.
- Include adequate funding for GESI mainstreaming activities in forthcoming AWPBs.

5.6 Programming

- The Population Division needs to develop and implement a rollout plan for the GESI Operational Guidelines. This will require intense technical assistance support to ensure that the systems,

processes and mechanisms needed at different levels are established and skills strengthened for them to be made functional.

- Integrate GESI concerns into the district programme implementation guidelines that are prepared by divisions and sent to districts with directives for implementing programmes. These directives need to be sent out on time and must explicitly require the integration of activities or approaches to address constraints and barriers faced by women and poor and excluded people.
- Revise the technical programme guidelines (including the guidelines for the Aama and free health care programmes) to incorporate GESI aspects. This task requires prioritised action.

5.7 Strengthening GESI Focused Programmes

The functioning of OCMCs, SSUs, EAP and social auditing will be strengthened as follows:

- Strengthen OCMCs by providing continuous back-stopping support and improving collaboration and coordination with other government sectors, external development partners and civil society.
- Advocate with OPMCM for the improved coordination of GBV interventions by different actors including external development partners, civil society and different government bodies.
- A new OCMC will be established in Karnali National Health and Science Academy (Jumla).
- Develop accountability mechanisms to ensure that SSU services reach their target groups.
- Strengthen the capacity of DHOs and DPHOs and implementing social audit organisations.
- Develop and make functional a mechanism to ensure that social audit findings reach programme divisions and centres through PHCRD.
- Closely monitor and evaluate social audit action plans and improve district and central level responses.
- Advocate for the multi-year contracting of NGOs to facilitate the implementation of EAP.
- Support the roll-out of EAP into remote areas and EAP integration into LGCDP's social mobilisation programme. The Family Health Division (FHD) and PHCRD plan to pilot a package of interventions at different levels of the health service in a remote district to help identify how to improve access to and use of maternal and neonatal health services.
- A technical working group will be formed under the leadership of FHD and the support of PHCRD to oversee the pilot EAP Plus programme.
- The work will go ahead on the integration of EAP into LGCDP with a rapid assessment and piloting in selected VDCs of one or two districts. A draft concept note will be prepared and shared with LGCDP. MoHP and NHSSP will provide technical support to LGCDP to revise the social mobilisation approach to embrace health,

5.8 Supervision and Monitoring

- Make efforts to revise the government's standard Integrated Supervision Checklist to incorporate GESI and to promote its widespread use.
- Support the implementation of the revised HMIS indicators and promote the use of disaggregated data and evidence during planning, programming and monitoring.

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ANNEX 1: Report on Gender Equality and Social Inclusion Against Annex 3 of NHSP-2

Note: The original NHSP-2 Annex 3 matrix (Strategy Table/Strategic Framework) did not number the working policy points but just put plain bullets. The following numbering system (to 70) was applied in the JAR 2013 report and the same system is used here.

Strategy	Working policy	Report on GESI related progress in 2013 against the working policy provisions
OBJECTIVE 1: DEVELOP POLICIES, STRATEGIES, PLANS AND PROGRAMMES THAT CREATE A FAVOURABLE ENVIRONMENT FOR INTEGRATING (MAINSTREAMING) GESI IN NEPAL'S HEALTH SECTOR.		
Strategy 1. Ensure inclusion of GESI in the development of policies, strategies, plans, setting standards, and budgeting, and advocate for use of such policies, standards and budget provisioning at the central level.		
Review the existing policy, law and guidelines to make them GESI inclusive	1. Integrate GESI in existing health policy, regulations and guidelines. 2. Advocate for health as a fundamental human right in the constitution. 3. Include the standards for integration of GESI in NHSP-2. 4. Develop mechanisms for regular policy feedback. 5. Revise HMIS to improve health monitoring on GESI. 6. Identify and recommend expansion of health facilities to locations with high concentrations of underserved poor and excluded groups.	1.1 Review of Health Policy 1991 and draft of new health policy. This has identified and proposed a number of issues from a GESI perspective that need to be included in the revised policy. 1.2 The Health Sector Gender Equality and Social Inclusion (GESI) Strategy is being updated considering the current changed context. 1.3 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' were approved by MoHP in December 2013. 1.4 'Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming' across MoHP was approved by the minister in 2013 and is now under implementation. 1.5 The Urban Health Policy is in final stages of development prior to approval. Its implementation will improve access to health services for the urban poor. 1.6 A review of social auditing in Nepal was conducted, covering health and non-health sectors. Based on review recommendations, harmonised social audit guidelines were developed and piloted. Social Audit Guidelines were finalised and approved by MoHP in June 2013, incorporating feedback from 20 districts where audits were conducted. With AWPB funding, harmonised social auditing approach implemented across 22 districts in additional 177 facilities in 2012/13. PHCRD is conducting auditing in 40 districts in current fiscal year (2070/71, 2013/14), to covers 500 facilities (including new 296 facilities). 1.7 One-stop Crisis Management Centre (OCMC) Operational Manual made provision in 2013 for public private partnerships to establish and operate OCMCs. OCMC Operational Manual is under revision incorporating feedback from assessment and national review. 1.8 Social Service Unit Operational Guidelines are being revised incorporating inputs and feedback from all piloted hospitals and MoHP, and will be finalised in February 2014. 5. Possible levels of caste/ethnic and geographical disaggregation in HMIS were discussed with HMIS Section. Indicators were identified that need to be disaggregated by sex, age, location, and caste/ethnicity. Revised HMIS incorporating GESI related key indicators will be operationalised in FY 2013/14. DoHS has proposed 10 indicators to be disaggregated by caste/ethnicity. Also, improvements will be made to hospital recording and reporting systems in revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised reporting system within HMIS and new software will enable sub-district level data to be generated. 6. Study on access to and use of MNCH services in remote areas of Nepal found that remote and mountain districts, and remote VDCs in such districts were worse off in most aspects of access to and use of MNCH services. The study recommended a core service delivery and demand side package of interventions to pilot the overcoming of barriers in one mountain district.

Strategy	Working policy	Report on GESI related progress in 2013 against the working policy provisions
Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting	7. Develop policy for identification of poor and excluded groups. 8. Develop implementation guidelines and ensure implementation. 9. Develop policy measures to promote GESI in human resource management. 10. Develop provisions for poor and excluded groups to receive free secondary and tertiary health care services. 11. Formulate provisions for compulsory social auditing to make health services inclusive, transparent and accountable. 12. Incorporate GESI in e-AWPB programmes and MoHP activities. 13. Advocate to MoF and NPC for regular budget provisioning of GESI in AWPB. 14. Formulate provision for health cooperatives for easier access of poor and excluded to health services. 15. Develop provision for health insurance to increase access to health services of poor and excluded. 16. Formulate provision for media to disseminate health care messages and inform about facilities for poor and excluded groups.	8a. Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector were approved by the health minister in December 2013. They were developed under the guidance of a technical committee. These will provide guidance to all levels of health service providers and managers on mainstreaming GESI in planning, programming, budgeting, monitoring and reporting. 8b The Population Division has incorporated the GESI related programmes (OCMCs, SSUs, strengthening of GESI TWGs, training and training to health staff of OCMC hospitals) into their programme implementation guidelines since current fiscal year 2070/71. 8c. GESI was integrated into the following programme implementation guidelines for FY 2070/71: i) AWPB Implementation Guidelines and ii) Community Health Unit Guidelines of Primary Health Care Revitalisation Division, iii) AWPB Implementation Guidelines of Management Division, iv) AWPB Implementation Guidelines and v) Uterine Prolapse Programme Guidelines of the Family Health Division. 9. GESI perspectives were included in the development of the Human Resources for Health Strategic Plan, 2012. 10. To improve the access of poor and excluded groups to subsidised and free secondary and tertiary health care services, SSUs were established in seven hospitals and preparatory work completed to establish an SSU in Bir Hospital in 2013. A progress review of pilot hospital SSUs was carried out in 2013. Based on the review, MoHP developed a monitoring and evaluation framework for assessing the performance of SSUs and a capacity development plan for SSUs. 11. Harmonised social auditing guidelines were approved by MoHP in June 2013, incorporating feedback from the districts where social audits were conducted. With AWPB funding, a harmonised social auditing approach was implemented across 21 districts in an additional 177 facilities in 2012/13. This process has enabled many women and people from excluded groups to participate in social audits for a more thorough and inclusive process. The action plans prepared by the social audits were monitored in the NHSSP-supported 21 facilities of two districts and a process evaluation was carried out in June–July 2013 in the two districts. 12. GESI activities were discussed and identified with different divisions and centres for the AWPB 2013-2014. For the Population Division and PHCRD, detailed plans covering GESI activities were developed with relevant staff. Annual business plans were developed by different divisions and centres, which specify GESI related activities. 16. Final drafts were prepared of the implementation plans for two national strategies — safe motherhood and neonatal health (SMNCH) and adolescent sexual and reproductive health (ASRH). These strategies also provide for localising media and materials to address local contextual needs.

Strategy	Working policy	Report on GESI related progress in 2012 against the working policy provisions
Strategy 2: Prioritise GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHO, DPHO and VDC) to ensure services are accessible and available to the poor, vulnerable and marginalised castes and ethnic groups.		
Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programmes, budgeting, monitoring and evaluation.	17. Address GESI issues in plans, programmes and budgets. 18. Develop GESI indicators as necessary, disaggregate the HMIS, monitor and report performance of target groups. 19. Define roles and responsibilities for monitoring and evaluating performance of target groups. 20. Develop mechanisms/ processes to review the progress from a GESI perspective periodically.	17. Inputs for including GESI related directives in the programme guidelines issued by divisions and centres for districts were provided as relevant for the preparation of the AWPB and the guidelines. 18. Indicators have been identified that need to be disaggregated by sex, age, location, and caste/ethnicity. A revised HMIS that incorporates GESI-related key indicators will be operationalised in FY 2014/15. DoHS has proposed 10 indicators for disaggregation. Also, improvements will be made to hospital recording and reporting systems in the revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised reporting system within HMIS and the new software will enable sub-district level data to be generated. 19. Annual regional health reviews were conducted from a GESI perspective. GESI issues and innovations were incorporated in the annual review report and will be incorporated in next year's AWPB. 20. The institutional structure for mainstreaming GESI, headed by the secretary as chair of the GESI Steering Committee, and including committees and technical working groups at each level of the health system provides the mechanism to regularly review progress in GESI. For 2013/14, MoHP has allocated funds to support biannual reviews of GESI progress at MoHP and district levels.
Include GESI related issues in programme implementation by health service providers.	21. Operationalise guidelines to facilitate access and utilisation of health services by the poor and excluded. 22. Ensure that the work of every health institution includes GESI.	21. The Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector were approved by the health minister in 2013. These guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery, monitoring and reporting 22. Training and orientation on GESI to district teams began and will continue in the current financial year to be rolled out to lower levels.
Coordination and participation among concerned organisations for GESI.	*23.* Coordinate with MLD, MoF and NPC to allocate more budget for GESI in DDCs, VDCs and Municipalities. *24.* Coordinate and implement with DDCs, VDCs, and Municipalities to attract their social development budgets in the health sector. *25.* Continue handover of health facilities at local level and make the HFOMCs inclusive. *26.* Coordinate/partnership with district- and village-level NGOs working in the health sector. *27.* Coordinate with Ministries, I/NGOs and local bodies to integrate GESI in their programmes. *28.* Create trust between health care providers and communities. *29.* Create policy provisions to make local bodies responsible to develop participatory inclusive plans, and to implement and monitor them. *30.* Transfer knowledge, skills, resources and materials to local bodies to meet the needs of the target groups.	26a. All the districts that implemented social audits used NGOs as third party social auditors and involved community based organisations in social auditing. 26b. EAP works in partnership with local NGOs. 28a. One of the major activities carried out under the Equity and Access Programme is organising interactions between service providers and service users to develop coordination and create trust between them. This will enable health facilities to provide responsive services for poor and excluded people. 28b. Social auditing seeks to foster partnerships for improving health services with communities, and through the very process of auditing, generates greater communication and trust between service providers and communities. 29. The Local Health Governance Strengthening Programme was piloted in 5 of Nepal's 75 districts to enable VDCs, including health facility management committees, to identify and address local health needs through local planning. These inputs also encourage the generation and mobilisation of local resources to implement local health planning.

Strategy	Working policy	Report on GESI related progress in 2013 against the working policy provisions
Strategy 3: Establish and institutionalise GESI unit/desk at the MOHP, DOHS and divisions of the DOHS, regional directorates, and DHO/DPHO, and Social Service Units for GESI at central, regional, sub-regional, and zonal hospitals.		
a) Establish Social Service Units (SSU) in hospitals.	31. Establish and operationalise Social Service Units in central, regional, sub-regional, zonal, and district hospitals.	31.1 A study in 2012 on the provision of free health care services and subsidies identified the need to establish social service units (SSUs). This went ahead by developing guidelines for SSU piloting for two years. Seven pilot SSUs were established in hospitals and preparatory work was completed to establish an SSU in Bir Hospital in 2013. Orientation and backstopping support was provided to SSUs. 31.2 A progress review of the pilot hospital SSUs was carried out in July and August 2013. Based on the findings of this review, MoHP developed a monitoring and evaluation framework for assessing the performance of SSUs and a capacity development plan for SSUs. 31.3 A progress review workshop on SSUs chaired by the health secretary was held in January 2014. The workshop reviewed the achievements, issues, lessons learned, recommendations for effective functioning of SSUs and areas of revision/improvement of guidelines. The revision of guidelines based on workshop inputs is underway. MoHP will revisit the road map for strengthening SSUs considering the review workshop's inputs.
b) Establish GESI Unit/Desk at different levels of the health sector.	32. Establish GESI and internalise a GESI unit within MoHP, DoHS, RHDs, DPHOs and DHOs.	32.1 A GESI Steering Committee was formed in 2011 at MoHP under the chair of the Secretary and regular meetings have been called as provisioned in the guidelines. The Steering Committee has been able to guide and give policy direction to address GESI related issues. Up to the end of 2013, GESI technical working groups (TWGs) have been formed in almost all districts (71 out of 75). GESI focal persons have been nominated in all regional health directorates (RHDs) and in 75 district health office/district public health offices (DHOs and DPHOs). All the technical working groups have been formed and oriented on GESI concept and its application. The ToRs of all groups and committee members mentioned in the GESI Institutional Structure Guidelines has been covered by the GESI orientations. MoHP has provisioned budgets for the meeting of TWGs and the biannual reviews of GESI mainstreaming in the health sector in MoHP and 75 districts. All five regions and 71 districts now have functional TWGs. 32.2 The Population Division has incorporated GESI related programmes (OCMCs, SSUs, strengthening GESI TWGs and GBV training to health staff of OCMC hospitals) into their programme implementation guidelines since the current fiscal year (2013/14). 32.3 In 2013 a GESI section was formed in the Population Division headed by the under-secretary as a dedicated section to work on GESI in the GESI Secretariat.

Strategy	Working policy	Report on GESI related progress in 2013 against the working policy provisions
OBJECTIVE 2: ENHANCE THE CAPACITY OF SERVICE PROVIDERS AND ENSURE EQUITABLE ACCESS AND USE OF HEALTH SERVICES BY THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 4: Enhance the capacity of the service providers to deliver essential health care service to poor, vulnerable, marginalised castes and ethnic groups in an equitable manner and make service providers responsible and accountable.		
Improve service delivery mechanism by service providers for the poor, vulnerable and marginalised caste and ethnic groups.	33. Sensitise health workers, SSU and GESI focal points at all levels, FCHVs, and HFOMCs on GESI. 34. Implement behaviour change training for the health workers, FCHVs and local HFOMCs. 35. Strengthen capacity of FCHVs and NGOs to provide proper information to target groups on health services. 36. Include GESI content in the health sector education and training curricula.	33.1 GESI orientations were provided to the Secretary, MoHP; the chiefs of MoHP's divisions and centres and DoHS; the GESI Secretariat (Population Division); and GESI focal persons of MoHP and DoHS. 33.2 To the end of 2013 GESI orientations (concept and its application in planning, programming, service delivery, progress review and supervision) were provided to technical working groups in 5 regions and 71 districts and the SSUs of 7 hospitals. GESI orientations were provided to RHD officials and DHOs, DPHOs and focal persons of 75 districts. 35. Capacity building training to NGOs and FCHVs was provided under the EAP programme, and health messages were disseminated to target groups, especially women, the poor and excluded. 36.1 In 2012, MoHP's Training Curriculum Review Technical Committee identified five curricula to be reviewed from the GESI perspective (health facility operation and management committee [HFOMC], female community health volunteer [FCHV], behaviour change communication [BCC], upgrading assistant health worker [AHW] and skilled birth attendant [SBA]). Draft materials of five curricula were finalised in a 2013 workshop. The National Health Training Centre will pre-test the new materials (module on basic GESI orientation and integration of GESI into existing packages) and then finalise the modules and materials. Until reprinting happens, the GESI modules, materials for integration and facilitator's guide will be inserted into the current printed training curricula. 36.2. GESI concepts and application has been integrated into induction training package for new health sector personnel (both officer and non-officer), which have been implemented by NHTC in 2013. GESI has also been integrated into the training curricula for upgraded health workers at different levels. Two rounds of training on inclusive governance were implemented by NHTC which covers GESI concepts and mainstreaming and integration of GESI in accountability, responsiveness and integrity concepts of governance.
Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasising programmes to reduce morbidity and mortality of the poor, vulnerable and marginalised castes and ethnic groups.		
Increase access of the target groups to universal and targeted free care programmes.	37. Develop criteria to identify poor and excluded groups and provide them with "Free Health Check-up Cards" for secondary- and tertiary-level health care services and referrals. 38. Ensure equitable and meaningful participation of target groups and women in HFOMCs. 39. Ensure meaningful participation of poor and excluded groups in social audits of health services.	37. SSUs were established in seven zonal, regional and central level hospitals in 2013 and have been providing subsidies and free health care services to the poor, the helpless, the disabled, senior citizens and GBV victims. All established SSUs were provided with backstopping organisational and management support. 39. The social audit guidelines have provisions to include women, the poor and socially and geographically excluded people in consultation processes during social auditing. The process has enabled many women and people from excluded groups to participate in social audits for a more thorough and inclusive process.

Strategy	Working policy	Report on GESI related progress in 2013 against the working policy provisions
Increase the use of Mother and Child Health and Free delivery services by the target group.	i) Develop special programmes for women, poor, and excluded groups (women and children) to increase their access to MCH services and free deliveries. 40. Support increasing use of neonatal and postnatal care services, institutional deliveries, nutrition, and childhood immunisation. 41. Mobilise and train/strengthen FCHVs and NGOs to increase target groups' access to services. 42. Provide assistance on awareness raising, IEC/BCC programmes, outreach services to pregnant women.	i) The 2013 study on access to MNCH services in remote areas has led to the decision to pilot a package of supply and demand side interventions with management strengthening inputs in one remote mountain district. Depending on effectiveness, this package will be adapted and rolled out to other remote districts. 40. The combined provision of immunisation (EPI) and family planning services was successfully tested in 2013. 41. The Equity and Access Programme (EAP) implemented its community mobilisation programme in 20 districts through local NGOs, involving the orientation of FCHVs and NGO partners. 42. PHCRD added 20 new community health units to target underserved populations.
	ii) Address gender based discrimination which constrains access of women (of different social groups) to health care services, especially institutional deliveries. 43. Collaborate with women's CBOs /NGOs on gender and social based discrimination. 44. Conduct community and family counselling on GBV. 45. Promote regular work attendance of female health workers.	*ii 16 Days GBV campaign:* Awareness programmes, radio jingles, review workshops, rallies, interviews were organised at district levels during the 16 days of activism. This has contributed to developing sensitivity about violence against women and girls and an understanding of GoN's plans to address GBV. 44. In 2013, 7 new OCMCs were established to bring the total number to 15 (including the public private partnership in Dhulikhel Community Hospital). They are based in hospitals to support survivors of gender-based violence.
Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalised caste and ethnic groups and areas (Regional and/or District).	iii) Promote service expansion in geographically inaccessible/remote regions. 46. Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the target groups. 47. When establishing new HP/SHPs, select sites most appropriate for the target groups' access and use.	46. The barriers to accessing MNCH care and the use of MNCH services were assessed in five remote districts using a mix of qualitative and quantitative methods. The study found that not only remote/mountain districts but also remote VDCs within these districts were worse off in most aspects of access to and use of MNCH services. A pilot in one remote district to improve access to and use of MNH services is to be launched by FHD and PHCRD in 2014. 47. Issues to consider siting service delivery sites were included in the Operational Guidelines for Mainstreaming GESI in the Health Sector.
	iv) . Expand services in low HDI districts. 48. Focus on community and outreach programmes in the 35 low HDI districts. 49. Ensure programmes are focused at less populated areas to make the target groups feel health as their fundamental right.	
	v) Make provision for regional programmes to address unmet health issues and needs of women, poor and excluded groups. 50. Promote programmes like publicity campaigns, outreach services, counselling services and orientations to free care. 51. Conduct special activities to reach Dalits. 52. Implement special programmes such as providing monetary incentives to those using EHCS.	

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Strategy 6: Enhance or modify services to be sensitive to GESI and ensure access is equitable and services are delivered uniformly without regard to social status.		
Give emphasis to special activities to provide adequate and quality services.	53. Ensure the presence of female doctors at all district hospitals. 54. Make a provision for local language speaking staff at service delivery sites. 55. Allow the district-level health organisation to adopt district-specific GESI policy, if needed. 56. Conduct social audits.	56. Social audits were conducted in 177 health facilities of 21 districts in 2013.
OBJECTIVE 3: IMPROVE HEALTH SEEKING BEHAVIOUR OF THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behaviour of the poor, vulnerable and marginalised groups.		
Develop and disseminate targeted IEC materials that will bring changes in behaviour of target groups.	57. Prepare and distribute enough audio visual, pictorial, etc. information and publicity materials. 58. Include the target groups' programme in publicity and communication materials of MoHP. 59. Develop skills at the local level for producing information materials, especially in remote areas.	57. The development, production and distribution of a variety of communication media materials – radio jingles, health teleserials, and print materials, was continued. 58. The localisation strategy of centrally developed media and materials in SMNCH, family planning and ASRH BCC/IEC strategies was continued. 59. Capacity building of district BCC/IEC focal persons of all 75 districts was carried out, focused on using local media and materials.
Increase the use of appropriate media.	60. All media allocate appropriate time for broadcasting health service news. 61. Emphasise use of effective media and local languages. 62. Increase information communication on GESI among health institutions. 63. Include appropriate media programming for low HDI districts and districts with diverse language. 64. Conduct regular monitoring on quality of communication services.	
Strategy 8: Empower the target groups to demand their rights and conduct their roles while realising their responsibilities.		
a) Increase the target groups' awareness of their health rights and of free health care services, and enhance their capacity to make the service providers accountable.	vi) Empowerment. 65. Conduct activities for the target groups to make them aware of their rights/responsibilities and capable of taking leadership roles. vii) Information, Education and Communication 66. Conduct publicity campaigns on how to access and properly utilise health services. 67. Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups. 68. Develop and conduct orientation and awareness campaigns for change in health seeking behaviours. 69. Promote women's participation and conduct awareness on equal treatment of both male and female children. 70. Provide orientation on women's reproductive health rights.	65. The Equity and Access programme was implemented in selected VDCs of 20 districts to mobilise targeted communities (women, the poor and excluded) by applying a rights-based social mobilisation approach. NGOs and FCHVs were mobilised to promote health rights, and they disseminated messages to communities through mass communication, group facilitation, behaviour change communication and interpersonal communication. Messages related to the essential health programme, including safe motherhood, newborn care, nutrition, institutional delivery, immunisation, family planning and free health care were included in the programme. The single year contracting of the EAP implementing NGOs undermines the value of community empowerment with limited effect on creating an enabling environment to increase service utilisation. MoHP reached consensus to seek approval for multi-year contracting of NGOs from the Ministry of Finance and the file memo has now moved to the Finance Ministry. The implementation of EAP activities is planned to continue in 21 districts.