Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector

Government of Nepal
Ministry of Health and Population (MoHP)
Ramshah Path, Kathmandu, Nepal
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Acronyms

AHW	auxiliary health worker
ANM	auxiliary nurse midwife
AWPB	annual work plan and budget
BCC	behaviour change communication
DDC	district development committee
DG	director general
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
EAP	Equity and Access Programme
EDP	external development partner
EHCS	essential health care services
FCHV	female community health volunteer
GBV	gender-based violence
GESI	gender equality and social inclusion
GoN	Government of Nepal
HFOMC	Health Facility Management Committee
HMIS	Health Management Information System
HRH	human resources for health
IEC	information, education and communication
INGO	international non-governmental organisation
LSGA	Local Self-Governance Act
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MSNP	Multi Stakeholder Nutrition Plan
NDHS	Nepal Demographic Health Survey
NHSP-2	Nepal Health Sector Programme
NHTC	National Health Training Centre
NLSS	Nepal Living Standard Survey
NPC	National Planning Commission
NPR	Nepalese rupees
OBC	other backward class
OCMC	one stop crisis management centre
PHCC	primary health care centre
PHCRD	Primary Health Care and Revitalization Division
PPICD	Policy, Planning and International Cooperation Division
SBA	skilled birth attendants
SLTHP	Second Long Term Health Plan
SMNHLTP	National Safe Motherhood and Newborn Health Long Term Plan
SSU	social service unit
STS	Service Tracking Survey
TWG	technical working group
VDC	village development committee
WLHIV	women living with HIV

1 INTRODUCTION

1.1 Context

Gender equality and social inclusion (GESI) is a concept which addresses unequal power relations between women and men and between different social groups. The goal of the Nepal Health Sector Programme (NHSP-2) (2010-2015) of the Ministry of Health and Population (MoHP) is to improve the health status of the people of Nepal, especially women and poor and excluded people. Its mission, strategic direction and values all prioritize gender equality and social inclusion. MoHP introduced its Health Gender Equality and Social Inclusion Strategy in 2010 and recognises the need to develop operational guidelines to operationalise this strategy.

The health sector has made large efforts to improve the health outcomes of Nepal's citizens. It has responded positively to the national mandates of inclusion through its pro-poor and pro-women programmes. Since 2007, pro-poor targeted free health-care policies, coupled with the AAMA programme for maternity services, have resulted in considerable successes. NHSP-2 has the specific objective of addressing economic and sociocultural barriers to accessing health services, and has put in place impressive plans with disaggregated objectives and indicators. A National Action Plan on Gender-based Violence has been implemented since January 2010. This plan is coordinated by the Office of the Prime Minister and the Council of Ministers with commitments from 11 ministries, including MoHP.

These mandates for addressing gender equality and social inclusion in the health sector require technical expertise to mainstream GESI into sectoral policies, health institutions, the project cycle of health programmes, service delivery and supervision and reporting. These guidelines aim to strengthen these technical skills and guide policy makers, managers and health service providers on integrating GESI into their work. These guidelines will be reviewed regularly and improved based on experiences.

1.2 Name and commencement

- These guidelines are the 'Operational Guidelines for Mainstreaming Gender Equality and Social Inclusion in the Health Sector, 2013.'
- These guidelines will be implemented from the day they are approved.

1.3 Definitions

The following definitions are used in these guidelines unless otherwise defined:

a. **Ministry** refers to the Ministry of Health and Population (MoHP).

b. **Excluded groups** are groups of people who have been systematically excluded over a long time due to economic, caste, ethnic, gender, disability, and geographic reasons and include sexual and gender minorities. The health sector GESI strategy defines excluded groups as "women, Dalits, indigenous Janajatis, Madhesis, Muslims, people with disabilities, senior citizens, and people living in remote regions who have not benefited from national development efforts."

c. **Gender** is the socially constructed power relations between women and men that establishes the roles, responsibilities, opportunities and decision-making authority of women and men in society.

d. **Gender equality and social inclusion** (GESI) is a concept that addresses unequal power relations between women and men and between different social groups. It focuses on the need for action to re-balance these power relations and ensure equal rights, opportunities and respect for all individuals regardless of their social identity.

e. **GESI responsive programmes** are programmes that address the barriers women and other historically excluded groups face. They work to strengthen the capacities of women and poor and excluded people to improve their lives.

f. **The poor** are defined by the Nepal Living Standards Survey (NLSS) 2011 as households or persons who consume an average of less than 2,220 Kcal of food per person per day and spend less than NPR 11,929 per capita per year on food and less than NPR 7,332 per person on non-food items. MoHP's Social Security Unit Guidelines (December 2012) define the poor as those who have sufficient food for more than six months but less than 12 months of each year. It defines **the extreme poor** as those who have sufficient food for less than six months of the year from their land, business or occupations.

g. **GESI focal persons** are persons designated in divisions, centres, regional health directorates, district health offices/district public health offices (DHOs/DPHOs), health facilities and hospitals for: 1) implementing GESI policy provisions, 2) formulating GESI responsive programmes and budgets, 3) integrating GESI in service delivery and 4) monitoring and evaluation in order to improve the access of women, and poor and other excluded groups to health services.

h. **The GESI strategy** is MoHP's GESI Strategy for the Health Sector (2010).

i. **Health facility operation and management committees** (HFOMC) are responsible for the overall management of health facilities as directed by MoHP's Health Facility Operation and Management Committee Guidelines, 2003/04.

j. **GESI mainstreaming** is the process whereby barriers and issues of women and poor and excluded people are identified and addressed in all functional areas of the health system: policies, institutional systems, work environment and culture, programme and budget formulation, service delivery, monitoring and evaluation, and research. It also involves the evaluation of the institutional capacities, and the responsiveness and work environment of concerned agencies to gauge the progress made in mainstreaming GESI.

k. **Unreached groups** are groups of people who are unable to access health services provided by MoHP due either to the unavailability of services or their inability to access available services because of geographic, economic, social or cultural constraints. Their health service utilization rates are generally low and health conditions poor in comparison to reached populations.

l. **Underserved areas** are geographical areas where health services are not adequately available due to various reasons including lack of staff and drug availability, geographic location, financial and management limitations. The result is that local people are unable to use services equitably compared to people in other areas.

m. **The institutional mechanism for mainstreaming GESI** is the structure established by MoHP to mainstream GESI. This includes the GESI Steering Committee at the ministry level, the GESI Technical Committee of the Department of Health Services (DoHS); and GESI technical working groups and management committees in the ministry, department, regional directorates, DHOs/DPHOs and health facilities.

n. **Social inclusion** is a process that ensures that those at risk of poverty and social exclusion gain the opportunities and resources they need to participate fully in economic, social and cultural life and to enjoy a standard of living and well-being that is considered normal in the society in which they live. It ensures that they participate more in decision making on matters that affect them and on access to resources, opportunities and services to enjoy their fundamental rights.

o. **Ward citizen forums** have been established by village development committees (VDCs) and municipalities with the representation of women, poor people, Dalits, Janajatis (ethnic groups), user groups, and community organizations. Their objective is the development of the ward in which they are based, monitoring public service delivery, coordinating between local agencies and helping reduce social discrimination and other harmful practices.

p. **Non-state actors** are organizations registered to work on health, education, economic progress, social mobilisation and other sectors.

q. **Mothers groups** are established according to MoHP's National Guidelines for female community health workers.

r. **Local bodies** include district development committees (DDC), sub-municipalities, municipalities and VDCs.

s. **Gender-based violence** (GBV) refers to all types of abuse and is experienced disproportionately by women. It takes many forms including murder, beating, sexual abuse, dowry-related violence, rape and marital rape, forced impregnation, torture, traditional harmful practices, spousal or non-spousal violence, violence related to exploitation, sexual harassment and intimidation at work and in educational institutions and elsewhere, women trafficking and forced prostitution. The realities of Nepal mean that the main focus of prevention and response efforts focuses on women and girls, although GBV also includes violence against men and boys.

t. **The Nepal Health Sector Programme** (NHSP-2, 2010-2015) is MoHP's five year programme to improve the health condition of the Nepalese people, especially women and poor and excluded people by facilitating access to, and the utilisation of, essential and other health related services, and by improving health and nutritional behaviour.

u. **Barriers** such as the economic factors of poverty; social factors such as gender, caste, ethnicity, location and age; along with regional identity greatly influence access to health-related services. The distance to health facilities, shortages of medicines and supplies, discriminatory behaviour of service providers and absence of trained health personnel are additional barriers to accessing health services.

v. **Remote areas** are geographic areas where health services have not reached due to difficult terrain or distance.

1.4 Objectives

The main objective of these 'Operational Guidelines for GESI Mainstreaming in the Health Sector' is to guide MoHP, its institutions and its services on integrating gender equality and social inclusion into the health sector.

The specific objectives of these guidelines are as follows:

- To provide guidance for a gender and social inclusion-responsive approach in order to improve access to, and the utilisation of, health services by women and poor and excluded people.
- To guide health policy and planning, programming, budgeting, service delivery, monitoring and reporting to be GESI responsive.
- To mainstream GESI in health-related programmes implemented by MoHP, the private sector and non-state actors.

2 EXISTING SITUATION OF GENDER EQUALITY AND SOCIAL INCLUSION IN HEALTH

2.1 The health situation of women and poor and excluded people

a. The barriers experienced by women and poor and socially excluded groups greatly influence who accesses what health-related services. Gender-based social practices directly impact health outcomes for women and girls from all social groups. Financial dependency and various cultural practices also make women and girls vulnerable to gender-based violence. For many excluded groups, health-care services are inaccessible for a variety of reasons. This may be due to distance, unaffordability due to poverty and costs, unapproachablility due to social/power relations, incomprehensibility due to language barriers, cultural insensitivity and ineffectiveness due to poor quality. The non-availability of drugs and equipment, the behaviour of service providers and the absence of trained health personnel are additional factors that undermine service quality for those who experience exclusion. The Service Tracking Survey (STS) 2011, the Benefit Incidence Analysis 2012, the Nepal Demographic Health Survey (NDHS) 2006 and 2011, the Nepal Living Standard Survey (NLSS) 2011 and other documents show that Dalits, disadvantaged Adivasi Janajati (indigenous ethnic groups), some other backward class subgroups (OBC, a caste category of Madhesi people) and Muslims have consistently low health indicators. These include higher stunting among children, higher risk of mortality, higher vulnerability to multiple communicable diseases and lower uptake of essential health services.

b. The Nepal Demographic Health Survey (NDHS) 2011 found that 40% of women in Nepal had no education (in comparison to only 14% of men) with 60% of Terai women without education compared to 32% of women in the hills and mountains. In 2011, Madhesi Dalit and Muslim women were the groups with the highest proportion of women without education (83% and 76% respectively). Lack of education impacts health outcomes and health seeking behaviour. With regard to family planning, the contraceptive prevalence rate amongst Newar (63.4%), Brahmin (58%) and Janajati (50.5%) women was above the national average while it was below average amongst Dalit (43.2%) and Muslim (25%) women. Unmet contraceptive need amongst Muslim (39%) and Dalit women (31%) was higher than the national average of 27.5%. While an average of 50% of women had completed four antenatal (ANC) visits, only 23.4% of Madhesi Dalit women, 35% of Muslim and 36% of OBC women had done so (80% of hill Brahmin women had done so). At the national level, NDHS (2011) found 18.2% of non-pregnant women were undernourished or chronically energy deficient and 14% overweight or obese. One in three women of reproductive age (35%) suffered from anaemia, a higher percentage of pregnant women (48%) and lactating women (38%) were anaemic. Studies have found anaemia in 73% of pregnant women in the Terai, with 88% of the cases resulting from iron deficiencies (see DoHS 2012).

c. The Service Tracking Survey (STS) 2011 found caste/ethnic/regional differentials for access to and use of health services. This included that Brahmins and Chhetris (94%) were more likely to be aware of free health care than Terai/Madhesi other castes (80%). More maternity clients from the hill districts (54%) received free delivery care than those from mountain (26%) and Terai (41%) districts.

d. The Benefit Incidence Analysis Report (2011) found the highest out-of-pocket expenditure for using public health facilities in the Far-Western region (NPR 2,134 compared to NPR 729 in the Mid-Western region), although utilisation is generally lower in the Far West than in other regions. This indicates that public health service provision needs to be made more cost effective in the Far West.

e. There is a strong correlation of migration with HIV/AIDS, as Nepal's 1.5 to 2 million labour migrants account for 46% of the country's people living with HIV. The lack of disaggregated data

remains a key issue in Nepal's HIV response as it affects the accurate analysis of the situation of HIV/AIDS. Discrimination against women and girls persists and women living with HIV (WLHIV) experience multiple challenges.

f. Malaria and kala-azar: The Terai is a high risk area for malaria transmission and kala-azar, a disease which is fatal if not treated promptly. An important strategy in controlling malaria and kala-azar is indoor residual spraying for both, and using long-lasting insecticide-treated bed nets for malaria. NDHS 2011 found that 85% of the highest wealth quintile but only 26% of the lowest wealth quintile owned a mosquito net.

g. NLSS 2011 found that the proportion of people living below the poverty line in Nepal had decreased from 31% in 2003-04 to 25% in 2010-11. However, the 2010–11 survey found Dalits to be bearing a much higher burden of poverty (42%) than non-Dalits (23%). Although the poor suffer higher rates of mortality and morbidity, the richest fifth of the population spend 25 times more than the poorest on health-care utilisation. Private hospitals are mainly located in urban areas and are used predominantly by the richest. Private sector pharmacies are widespread and provide examinations as well as treatment, and are a major recipient of out-of-pocket spending from all income groups.

Box 1: Sources of information on the health situation of women and poor and excluded people referred to in these guidelines

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Suvedi, B.K., Chand, P.B., Marasini, B.R., Tiwari, S., Poudel, P., Mehata, S., Pradhan, A., Acharya, L.B, Lievens, T., Hepworth, S., Barnett, S. (2012). *Service Tracking Survey 2011*. Kathmandu: Ministry of Health and Population.

2.2 Existing policy provisions for GESI in the health sector

2.2.1 National commitments for GESI

The Interim Constitution (2007) establishes the right to equality: "The State shall not discriminate among citizens on grounds of religion, race, caste, tribe, gender, origin, language or ideological conviction or any of these." It allows for "making special provisions by law for the protection,

empowerment or advancement of women, Dalits, indigenous ethnic tribes [Adivasi Janajati], Madhesis, farmers, labourers and those who belong to a class which is economically, socially or culturally backward; and children, the aged, disabled and those who are physically or mentally incapacitated."

The national Three Year Plan (2010-2013) states that women, Dalits, Adivasi Janajatis, Madhesis, Muslims, excluded communities, persons with disabilities, minorities, indigenous groups in danger of extinction, people living in the Karnali region and backward hill and mountain areas, and poor people and communities experiencing exclusion will be brought into the mainstream of development and their economic, social, human and cultural rights ensured.

2.2.2 GESI in health policies, strategies, plans and programmes

Health is assured as a fundamental right in the Interim Constitution and the Government of Nepal (GoN) has made considerable investments in the health of its citizens. The Local Self-Governance Act (LSGA) provisions for inclusive representation in health facility management committees (HFOMCs). Among other international agreements, as a signatory of the Millennium Development Goals (MDGs) and the International Conference on Population and Development (ICPD), Nepal has committed to improve maternal health and achieve universal access to reproductive health by 2015. In spite of the transitional situation, political instability and other challenges, Nepal is likely to achieve six of the eight MDGs by 2015.

a. National health policies

A key policy directing health services in Nepal is the **National Health Policy (1991**), which provides a framework to guide health sector development. It aims to extend the primary health care system to rural populations so they can benefit from modern medical facilities and services from trained health care providers. A 2012 review of the policy identified a number of gaps from a GESI perspective, which will be addressed in the forthcoming new National Health Policy. The Second Long Term Health Plan (SLTHP, 1997–2017) was developed to build upon the 1991 policy and to further guide health sector development in response to changing trends in society. The SLTHP considers health as a human rights issue and emphasizes the improved health status of those whose health needs are often not met including the most vulnerable groups, women and children, rural populations, the poor, the underprivileged and marginalised people.

b. GESI in reproductive health, child health and HIV/AIDS policies

There are a number of other GESI-positive policy mandates in reproductive health, child health, violence against women and HIV/AIDS. The **National Action Plan against Gender-based Violence** (2010) details the health-sector response and recognises that violence against women is a public-health issue. Also, in 2006 marital rape was outlawed, although in practice it lacks enforcement. Some policies, such as the **National Safe Motherhood and Newborn Health Long Term Plan** (SMNHLTP, 2006-17), identify gender equality, social inclusion and a rights-based approach as overlapping and complementary objectives. SMNHLTP includes equity and access as a separate output.

The **National Strategy on HIV/AIDS** was introduced in 2002, and an updated strategy and Action Plan for 2006–11 aimed to reach all at-risk population groups. The plan targeted female injecting drug users (IDUs) separately recognising their high rate of sexually transmitted infections (STIs) and low access to services.

The **National Policy on Skilled Birth Attendants** (SBA), 2006, supplements the Safe Motherhood Policy (1998). It specifies the tasks of SBAs and emphasizes the creation of an enabling legal and financial environment for SBA services in remote areas. It does not, however, recognize that the social profile of SBAs should respond to the profile of the communities they serve in order to enable

language and social dynamics to be understood by SBAs. There is a need to make SBAs gender and inclusion responsive in their delivery of services.

The **Multi Stakeholder Nutrition Plan** (MSNP) and the **Strategy for Maternal Under-Nutrition** (draft 2012) incorporate dimensions of gender and inclusion. MSNP has an outcome on providing "basic services in an inclusive and equitable manner". A specific output is to improve service utilisation "especially among the unreached and poor segment of the society". The maternal under-nutrition strategy identifies the socio-cultural norms that lead to under-nutrition in mothers and aims to reduce under-nutrition amongst women from disadvantaged and vulnerable groups. The strategy recognises that advocacy with men is necessary for "creating an enabling environment for women"; but this is not reflected in the strategy's objectives and indicators.

c. Programmes for women and the poor

Several government programmes address the economic barriers to accessing services. The universal and targeted free care and AAMA programmes have increased access for poor people, excluded groups and women by providing free services and medicines, cash for transport to institutional delivery, and remunerating health workers who attend home deliveries.

At district hospitals, outpatient, inpatient and emergency services, including medicines, are free of charge to poor, vulnerable, and marginalised group people, and 40 essential medicines are free of charge to all in principle (though there are some implementation gaps). There was a 35% increase in new outpatient contacts in 2007/08, and the increased utilisation of health services by poor and disadvantaged groups following the introduction of free services at primary health care centres (PHCCs), health and sub-health posts, and targeted free services at district hospitals. Partnerships between public/government entities, private/commercial entities and civil society have helped improve access to care of the poor by combining the different skills and resources of various organisations in innovative ways.

The AAMA programme provides incentives for mothers to give birth in health facilities and for SBA-assisted home deliveries. The programme has contributed to an increase in institutional deliveries as there is high awareness regarding the government provisions. A high proportion of people from excluded groups, like Dalits, have received such incentives indicating that strategies like these are important to improve unreached groups' access to services. But the STS 2012 found that incentives had been received by only 63% of delivery clients at the time of discharge.

Many initiatives on the ground, especially from NGOs, have focused on the needs of specific disadvantaged groups, including female sex workers (FSW), women living with HIV (WLHIV) and female intravenous drug users (FIDUs). Interventions include awareness raising, gender-sensitisation, sexual and reproductive health measures, campaigns against gender-based violence, promoting women's political participation, law and policy reform, advocacy, training the police how to respond to GBV, and test cases on gender issues.

d. GESI in human resources for health (HRH) policies

There are various challenges regarding human resources for health. Shortages of health workers, the deployment and retention of essential health workers, especially in rural and remote areas, fragmented human resource management and incomplete human resource information are key factors that have yet to be fully addressed. Limited skills of the health workforce and poor attendance and motivation affect productivity and the quality of services. The government plans to recruit an additional 14,000 health workers in the next four years to address these issues.

The four-year-long **Human Resources for Health Strategic Plan**, 2011-2015 incorporates aspects of GESI and actions to create a GESI sensitive workforce. The design of data collection tools, the analysis of data for human resource planning, and the development of a workforce plan must address GESI concerns. The government plans to adopt GESI principles to ensure that qualified

persons are attracted into the health sector and are more equitably distributed. The availability of more comprehensive information disaggregated by sex, cadre, age, caste and ethnicity through the Human Resource Information System (HuRIS) and other information systems, will enable MoHP to develop more targeted and differentiated retention packages (monetary and non-monetary incentives) to make postings more attractive to help retain staff in underserved areas. The plan also calls for addressing safety and security issues for female staff. Furthermore, training curricula will be reviewed and revised based on systematic reviews of the desired skill sets for different cadres.

e. GESI in NHSP-2 and its implementation plan

NHSP-2 (2010–2015) identifies GESI as a key principle in its mission, values and strategic direction. The programme has three key objectives:

1. to increase access to and utilisation of quality essential health-care services;
2. to reduce cultural and economic barriers to accessing health-care services and harmful cultural practices, in partnership with non-state actors; and
3. to improve the health system to achieve universal coverage of essential health services.

NHSP-2's results framework demands disaggregated data. From a GESI perspective, the strength of NHSP-2 is that it seeks to improve access to essential health care services (EHCS), in order to improve the utilisation of EHCS, so as to improve health status, all especially aimed at poor and excluded people (including women). The second objective, which addresses cultural and economic barriers, gives NHSP-2 a rights-based approach and a focus on equity and inclusion.

The other two objectives also address and mainstream GESI. Objective 1 aims to improve access to EHCS, while increasing reach to poor and excluded people. Objective 3 strengthens health systems and addresses issues of governance, human-resources management and key aspects that affect access to services.

NHSP-2's output 2 explicitly recognises that non-technical interventions, particularly empowerment, are important for addressing barriers and risk factors that adversely impact women and excluded groups. This output seeks to achieve effective GESI mainstreaming from MoHP to community levels, and identifying and addressing barriers faced by different social groups.

NHSP-2's Governance and Accountability Plan (GAAP) contains plans and indicators that address staffing, inclusion, accountable governance and strengthening HFOMCs, all of which are very relevant to GESI.

f. Health Sector GESI Strategy:

The **Health Sector Gender Equality and Social Inclusion Strategy**, 2010 provides guidance on mainstreaming gender and social inclusion, and is to be operationalised through these GESI operational guidelines (2013). It defines target groups (though there is an overlap in the definitions of 'poor', 'vulnerable' and 'marginalised'), and has the following objectives and strategies (Source: Heath Sector GESI Strategy, 2009 English version, MoHP, 2010).

Three objectives:

- Develop policies, strategies, plans and programmes that create a favourable environment for integrating (mainstreaming) GESI in Nepal's health sector.
- Enhance the capacity of service providers and ensure equitable access to and the use of health services by the poor, vulnerable and marginalized castes and ethnic groups within a rights-based approach.
- Improve health seeking behaviour of the poor, vulnerable and marginalized castes and ethnic groups within a rights-based approach.

Eight strategies:

Strategy 1: Ensure inclusion of GESI in the development of policies, strategies, plans, standard setting and budgeting, and advocate for the use of such policies, standards and budget provisioning at the central level.

Strategy 2: Prioritize GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHOs/DPHOs and VDCs) to ensure services are accessible and available to poor and vulnerable people and marginalized castes and ethnic groups.

Strategy 3: Establish and institutionalize GESI units/desks at MoHP, DoHS and its divisions, regional directorates, and DHOs/DPHOs, and in social service units at central, regional, sub-regional, and zonal hospitals.

Strategy 4: Enhance the capacity of service providers to deliver essential health care services to poor and vulnerable people, marginalized caste and ethnic groups in an equitable manner and make service providers responsible and accountable.

Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasizing programmes to reduce morbidity and mortality of poor and vulnerable people and marginalized caste and ethnic groups.

Strategy 6: Enhance or modify services to be GESI-sensitive and ensure access is equitable and services are delivered uniformly without regard to social status.

Strategy 7: Develop and implement information education and communication (IEC) programmes to improve the health seeking behaviour of poor and vulnerable people and marginalized groups.

Strategy 8: Empower target groups to demand their rights and conduct their roles while realising their responsibilities.

2.3 Institutional mechanism for mainstreaming GESI in the health sector

The institutional modalities for mainstreaming GESI in the health sector have been developed through the Institutional Structure Guidelines, which were approved by the health secretary in September 2012. A GESI Steering Committee (SC), chaired by the secretary provides leadership and policy guidance. DoHS has a GESI Technical Committee and a GESI Technical Working Group while regional health directorates, DHOs and DPHOs have GESI technical working groups. HFOMCs are responsible for identifying and responding to exclusion issues at the health facility level.

2.4 Programming and budgeting practices for GESI

The government's annual budget speech includes the following GESI related information:

- expenditure for inclusive development and targeted programmes;
- pro-poor expenditure; and
- a gender-responsive budget (GRB) exercise.

Based on the Ministry of Finance (MoF)'s guidelines for gender-responsive budgeting, MoHP categorises all expenditure items in the health budget into three categories, (direct, indirect and neutral) based on the following five indicators of gender responsiveness:

- participation of women in planning and implementation (20%);
- capacity building (20%);
- secured benefits to, and control of women (30%);

- increased access to employment and income earning opportunities (20%); and
- qualitative improvements in women's time use and reduced workload (10%).

Similar guidelines for pro-poor and inclusive development have yet to be developed by MoF.

MoHP follows MoF and National Planning Commission (NPC) directives to prepare its annual work plan and budget (AWPB). The inclusion of GESI activities in the AWPB has been initiated but needs strengthening to support GESI mainstreaming. MoHP in its AWPB for 2012/13 initiated the practice of identifying GESI related activities. MoHP is upgrading its electronic annual planning and budgeting system (e-AWPB), which will enable the description of budget allocation by NHSP-2 results framework, GAAP and GESI categories.

The annual budget for 2012/13 has a number of GESI-related programmes including for women's development, reducing gender violence, child rights, equity and access, social audits and one-stop crisis management centres for women affected by gender-based violence.

2.5 GESI in the health sector monitoring and evaluation system

MoHP's monitoring and evaluation system is carried out through regular supervision and annual reviews. MoHP's Monitoring and Evaluation Division and DoHS's Management Division are responsible for managing the supervision process within the health sector. Although regular reviews take place at multiple levels, these meetings do not systematically discuss health service delivery issues related to women and poor and excluded people and this process should be revised to include such discussions.

Current monitoring mechanisms produce significant information, but only limited disaggregated data and analysis is produced. Gender- and age-disaggregated data is recorded, but information regarding service utilisation by poor and excluded people is not adequately available due to challenges of regularly collecting such information. A pilot initiative is on-going in 19 districts for collecting and reporting caste and ethnicity-disaggregated data. But a number of challenges have been identified, including the management of the resulting huge amounts of data. The indicators of the Health Management Information System (HMIS) are being revised while the indicators for which disaggregated data should be collected are being identified. This will assist in regularly informing service providers and sector managers about inequalities in service provision and any needed changes. MoHP has established the practice of social audits being conducted at health facilities to promote transparency and establish good governance in service delivery. Social audits and the resulting action plans to address identified issues should help ensure that services provided by health facilities are of good quality and are accessed by women and poor and excluded people. Comprehensive social audit guidelines have been in place since 2011/12.

All divisions and centres carry out regular monitoring and supervision. This monitoring needs to be more focussed on disaggregation and GESI analysis. MoHP's Population Division, as the GESI Secretariat, monitors GESI mainstreaming and targeted activities.

3 GENDER EQUALITY AND SOCIAL INCLUSION MAINSTREAMING IN IMPLEMENTATION AND SERVICE DELIVERY

GESI mainstreaming is a change process that can be carried out in any governance or implementation environment. It will usually take time for such changes to come about. It can only be fully achieved where there is effective governance, efficient service delivery and political commitment and where gender equality issues and social inclusion are addressed within wider policy and institutional frameworks. The focus for mainstreaming GESI should primarily be in the four areas of policy formulation, programme design and management, service delivery and monitoring and evaluation.

3.1 Integrating GESI in policies, strategies and guidelines

All policies should address GESI related issues. It is important to recognise that all citizens do not have the same access to health services or possess the same ability to access and use health services. Policies should take into account assumptions, beliefs and the situations of women and men from different social groups so as to be responsive to their needs. The nature and extent to which women and people of different social groups access resources and services, and their authority to make decisions over their health, should inform policy development.

a) It is important to recognise the following overall points while developing policies:

- The abilities of and constraints faced by women and poor and excluded people to access and use health services.
- The impact of ender, income, caste/ethnicity, religion and location on health needs and access to and use of health services, and the health conditions and priorities of target groups.
- The differentiated strategies and approaches needed to promote access and use by target groups and, where no target groups are defined, by women and poor and excluded people.

b) It is important to address the following detailed points to mainstream GESI in policies:

1. *Policy development*: The objectives, scope of work and tasks of any policy must adequately address GESI. Policies should address the important health-related issues of different stakeholder groups. An example of this would be the high levels of anaemia of women from certain social groups. The policy should explain the economic, social and cultural reasons for this and the effects on women and children. It should also discuss service delivery initiatives and constraints.
2. *Policy formulation team*: Policy development teams should include a GESI expert who can understand the constraints faced by women and poor and excluded people. All team members should receive a basic orientation on GESI.
3. *Literature review*: Literature reviews for policy development must review related GESI issues and describe related good practices and lessons learned.
4. *Policy formulation process*: While formulating policies:
    - hold consultations and discussions with groups of women and poor and excluded people to identify their perspectives and priorities;
    - consult GESI experts to ensure that all GESI related issues are well covered; and
    - consult responsible government and non-government officials in the sector.
5. *Contents of policy documents*: Clearly specify GESI mainstreaming in all parts of policy documents including the methodology, review and the following:

- The context and situation analysis should specify the reason for formulating the policy and give disaggregated data on the situation of women, and poor and excluded people.
- The challenges and opportunities should describe the barriers women and poor and excluded groups face in accessing and using services. The opportunities to address these challenges should be discussed.
- The objectives, outcomes and anticipated results in the results framework should clearly mention the positive changes expected in the health situation of women and poor and excluded groups.

6. *Policy implementation*: Frameworks prepared to implement a policy should be inclusive and should clearly mention who and which agency is responsible for implementing GESI related activities.
7. *Monitoring and evaluation*: The following should be incorporated in the monitoring and evaluation process:
   - Include a GESI focal person on the monitoring team.
   - Collect feedback from women and poor and excluded groups.
   - Prepare disaggregated data and a monitoring report which captures benefits to women and poor and excluded people.
   - Prepare M&E formats that clearly capture disaggregation and issues impacting women, and poor and excluded people.
   - Include explicit documentation of the implications and impact of the policy on women, and poor and excluded people.

3.2 GESI mainstreaming at the programme level

MoHP and DoHS prepare and implement guidelines for the implementation of their programmes, such as the Safe Motherhood, and Free Health Service Programme Implementation Guidelines. Also, each year after programme and budget approval, divisions and centres prepare implementation guidelines to direct implementation and spending for the year. Thus, both programme and annual work implementation guidelines exist. These guidelines should specify how programmes and their implementation will contribute to improved service delivery for women and poor and excluded groups and their increased use of services. GESI mainstreaming in programme and work implementation guidelines is explained below.

a. *Programme guidelines:* The programme gudielines prepared by MoHP and its departments, divisions and centres should incorporate GESI related points. They should address the barriers and constraints faced by women and poor and excluded people including financial barriers, distance and transport barriers, social and gender-based barriers as well as remoteness and social discrimination. GESI related points should be compulsorily included while preparing new programme guidelines or modifying old ones. With support from GESI technical working groups and GESI experts, guidelines should recommend means of improving access to health services for unreached and underserved groups and areas.
b. *District programme implementation guidelines:* Programme implementation guidelines are prepared or modified by MoHP and DoHS divisions and centres once AWPBs are approved. These guide district level activities. It is very important that these guidelines address gender and social inclusion in terms of activity implementation, target groups, outputs, work procedures and anticipated results.

3.3 GESI mainstreaming in the annual work plan and budgeting process

Planning and programming systems have to integrate GESI to put it into practice. Positive policy mandates will not be implemented unless planning and programming integrate GESI issues. This

section provides guidance on how issues impacting women and poor and excluded people should be addressed in planning and budgeting.

GESI should be addressed in all stages of the health sector's review and planning process.

It is essential to target people who are excluded from accessing and using health services. Health facilities, DHOs/DPHOs, regional directorates and departments carry out annual reviews of their programmes from the beginning of the fiscal year (mid-July) to November (Nepali month: Mangsir). The following year's planning process starts from January (Magh) from the local level and is completed by February (Phalgun) at district and regional levels. At district and regional levels, the conclusions of the previous year's review are usually used to formulate the following year's plan. After the process is completed at the district and regional level, divisions and centres start their next year's planning. Planning at the central level has to be based on the ceilings and directives sent by the Ministry of Finance and National Planning Commission, and the plans received from the districts and regions.

The whole process of review and planning must consider the successes and constraints in terms of reaching women and poor and excluded people with services. The findings of these reviews and the disaggregated findings of other studies and surveys that show use by social group and the barriers and constraints they face should inform planning.

The guidelines in Table 1 must be followed to integrate GESI into each step of the health sector review and planning process.

Table 1: Guidelines for integrating GESI into health sector review and planning

	Level	Steps and tools for GESI integration
1	Local level	DHOs/DPHOs must direct health facilities, VDCs and municipalities to identify unreached groups and underserved areas, constraints to accessing services, the measures taken to address these constraints and interventions that have increased access to and the use of health services. a. Based on the directives from their DHO/DPHO, each health facility, before starting its annual planning exercise, must conduct a mapping exercise to identify unreached groups and underserved areas. It should do this in consultation with HFOMC members, health facility staff, female community health volunteers (FCHVs), social mobilizers, mothers group representatives and local community based organisations (CBOs) and NGOs. Section 3.5 of these guidelines provides guidance on how to do this mapping. b. Based on the mapping exercise, each health facility must hold consultations with HFOMC members and VDCs to identify the barriers to accessing health services. The planning for the coming fiscal year should address the identified barriers. This planning should be done in consultation with HFOMC members, health facility staff and local CBOs and NGOs working in the health sector. c. This plan must be presented to the VDC or municipal council and to DHOs/DPHOs.

	Level	Steps and tools for GESI integration
2	District level planning meetings	To support the mainstreaming of GESI into district level review and planning, the technical working group should: a. Prepare a district level map and an analysis of the information on health service utilisation in HMIS to understand the situation of women and poor and excluded persons and their access and use of health services. This exercise should identify, who are the people who have not accessed/used services because of: • the unavailability of services; • distance and geographical barriers; and • social and cultural factors. b. Prepare a progress update for presentation to district level planning meetings that gives location, gender, caste/ethnicity and age disaggregated data. Try and fill gaps in quantitative data to identify who is not using different types of services in health facilities and outreach clinics, and why. Information gaps can be filled from field visits, feedback from providers and communities, observations during outpatient and inpatient department visits and field supervision, and consultations with stakeholders such as DDCs, women development officers (WDO), VDCs and NGOs. c. Prepare a plan for the remaining period of the fiscal year based on first trimester[1]'s achievements and gaps in addressing GESI related issues. d. Prioritise actions for improving service delivery to the unreached from the evidence of the annual review, the district level first trimester review and issues identified in the district level mapping. Activities should be tailored to different services. For example, approaches to reaching left-out and drop-out children from immunisation will be different to those for reaching family planning drop-outs.
3	Regional half yearly performance review and planning workshops	a. At these workshops districts must present their achievements of the last six months and issues and constraints identified in their last year's review, including progress and bottlenecks in reaching unreached populations. b. Based on these district presentations, key priority programmes and activities must be identified for each service to reach unreached groups. Recommendations must be prepared and sent to related divisions and centres including: • activities for reaching unreached populations (disaggregated by women, poor persons and excluded persons) for each programme division and centre; • regional level monitoring and supervision activities to support district efforts to reach unreached populations; • capacity building activities (orientation, training, review, mapping); and • tentative costs of new initiatives to reach unreached populations and capacity building to mainstream GESI.
4	Discussion in divisions and	The Management Division should hold a meeting with divisions and centres to discuss the key findings of the regional review and planning workshops,

[1] The English word 'trimester' and the Nepali word '*chaumasik'* are used to refer to a four month period.

	Level	Steps and tools for GESI integration
	centres on reports of review and planning workshops	including how districts plan to reach unreached populations, and the implications of this for next years' AWPB.
5	Ceiling set by NPC/MoF to MoHP and on to its divisions and centres	While preparing directives and budget allocations to divisions and centres, PPICD must address: • national priorities and NHSP-2 result framework targets; • the necessity of reaching the unreached to achieve the results framework targets and national goals; • the distribution of resources and services to increase equitable access to services in regions, districts and remote areas; • key evidence to address gaps in service use and the health outcomes of women and poor and excluded persons; • new initiatives to address policy provisions for reaching unreached populations; • scaling-up proven interventions that directly benefit unreached populations; • capacity building required to address GESI mainstreaming across the sector from the ministry to health facility level and for targeting services to reach unreached populations; • the contents of national review reports and half yearly review reports from the regions; and • the priorities, requirements, and opportunities for achieving GESI objectives identified by the GESI Secretariat.
6	Director general level meeting	a. The DoHS director general (DG) must brief all divisions and centres about the budget ceiling and directions received from MoHP for preparing the AWPB. At these briefings the DG should insist that GESI and reaching the unreached are integrated in the AWPB. b. The DG must hold a DoHS level GESI Technical Committee meeting to identify areas of collaboration between centres and divisions, and to strengthen efforts to address issues of women and poor and excluded people. This may include for example activities for joint review, BCC/IEC and social mobilisation, integrated service delivery and disaggregated reporting.
7	Programme Planning by divisions and centres	a. Divisions, centres and other health institutions must address the following while preparing their programmes and budget for the next fiscal year: • national priorities and NHSP-2 results framework targets; • how to reach the unreached to achieve result framework targets and national goals; • the distribution of resources and services to increase equitable access to services in regions and districts; • key evidence to address gaps in service use and health outcomes of women and poor and excluded people (e.g. NDHS, STS, household surveys, and the Rapid PEER Study on barriers to services uptake); • new initiatives to reach unreached populations; • scaling-up proven interventions that directly benefit unreached

	Level	Steps and tools for GESI integration
		populations; • capacity building on GESI mainstreaming across the sector, and targeting services to unreached populations; • national review reports and half yearly review reports from the regions. To inform planning and budgeting for the next fiscal year, they must also: • identify where and who is unreached for each programme and why, and key responses and measures to address the gaps; • hold consultations with GESI technical working groups to identify priorities, requirements, and opportunities for achieving GESI objectives; • hold technical meetings with experts, external development partners (EDPs) and related divisions and centres to discuss gaps and measures, and areas of collaboration to reach unreached populations. b. While preparing the programme and budget for the next fiscal year divisions, centres and other health institutions should integrate activities for reaching the unreached in each programme into the AWPB including: • social mobilisation to address social, cultural, financial, transport barriers that women and poor and excluded people face in accessing services; • advocacy to raise political commitment and resources for reaching the unreached; • behaviour change communication to build knowledge and, raise the awareness and confidence of people to improve health behaviours; • collect evidence to track and evaluate the performance of activities targeted at reaching unreached groups; • run activities to increase the availability of services for women and poor and excluded people; • build the capacity of service providers, for example on interpersonal communication; and • use new service delivery methods and technical innovations (e.g. mobile ultrasound) to reach underserved areas.
8	Internal meetings and discussions in divisions and centres	• Directors of divisions and centres must include costed GESI plans into the business plan format provided by PPICD. • GESI focal persons should identify the GESI related activities required and work with their divisions and centres to incorporate these into the AWPB. • Directors of divisions and centres must hold meetings to discuss GESI related activities planned by different sections. • Division and centre directors must ensure that GESI related instructions from MoHP are followed.
9	DoHS level discussion	In the presentations and discussions on programmes the director general must check whether or not: • the instructions from PPICD to address GESI issues have been

	Level	Steps and tools for GESI integration
		followed; • GESI issues have been integrated in the annual business plan; and • identified programmes and activities will improve access and use of health services by women, and poor and excluded persons and improve the availability of services in underserved and remote areas.
10	Discussion and finalization of first draft of AWPB	a. An internal review by PPICD must be carried out before the discussion on the first draft of the AWPB to check that: • directives on reaching the unreached and underserved have been followed; and • proposed programmes and activities will contribute to the targets in the results framework b. The GESI Secretariat must organise a meeting to jointly review the draft AWPB with the GESI Technical Working Group (at DoHS level) and assess whether GESI is adequately addressed and how this needs to be improved. The conclusions of this meeting must be provided to PPICD for use in the next steps of this process. c. PPICD directs department, divisions and centres to incorporate the review findings into the next revision of the draft AWPB.
11	AWPB submitted to NPC/MoF	• MoHP representatives must be prepared with evidence to convince NPC/MoF of the importance of GESI related activities and defend them from budget cuts. • GESI focal persons should meet before the meeting with NPC/MoF to identify the activities, objectives and expected outputs and results of GESI-related programmes and to brief directors so they are able to defend GESI activities in their presentations. If required, GESI focal persons should accompany divisional and centre directors.
12	Revision and finalisation of AWPB	• PPICD must prioritize GESI related activities by providing sufficient budget allocations. • In case of budget cuts, interventions to address specific barriers of women and poor and excluded people should not be cut. • The GESI secretariat at MoHP must follow-up on revisions and compile GESI-related activities in the AWPB to support follow-up and monitoring.

3.4 GESI mainstreaming in micro-planning

Implementation plans for specific programmes are developed by MoHP and DoHS after the overall AWPB has been approved. The implementation plans of programmes implemented by a division or centre are developed at the central level based on the AWPB. After being authorised to implement such annual programmes by the division or centre, regional and district health authorities then develop implementation plans based on the programme guidelines of the concerned division or centre. Health facilities also prepare implementation plans for programmes after receiving directives from their DHOs/DPHOs.

To ensure the integration of GESI, these implementation plans need to be detailed for every trimester specifying:

- programme areas — like immunization, nutrition and family planning;
- expected results — the benefits to be realised by all people including target groups and broadly women and poor and excluded people;

- timing — how services will be delivered at convenient times for local women and men;
- target groups — the groups identified in the mapping exercise who have low use of services and need to be targeted;
- budget — the allocated amounts; and
- location — the locations of programme interventions (VDC, ward, hospital).

This detailed planning exercise must be based on recognition of the dimensions of exclusion caused by the poor availability of accessible services; remoteness; and factors of caste, ethnicity and gender. One example, is to plan to conduct outreach clinics in places accessible to Dalit communities after identifying that service utilisation by Dalits is low. Another example is to plan campaigns and advocacy activities in communities where gender based discrimination is high and women's health service use is low.

Programme activities should be added or expanded based on problems experienced by women and poor and excluded people. If it is possible to increase the number of outreach clinics, then these should be directed to areas where service access is low. Other examples are to run social mobilisation activities at uterine prolapse clinics to orientate men and family decision-makers on care and prevention; and to run awareness campaigns in communities to increase understanding about preventing illnesses like diarrhoea.

Such activities must be identified based on:

- low access and use of services by specific groups;
- high levels of related mortality and morbidity;
- the remoteness of areas with constrained service delivery or areas where services are non-functional; and
- the absence of services from other agencies like EDPs, NGOs, INGOs and communities.

3.5 GESI mainstreaming in service delivery

The following steps must be carried out for mainstreaming GESI in health service delivery.

3.5.1 Mapping health services

Individual districts and VDCs must identify and map:

- existing health services in different geographic areas;
- service users (especially women and poor and excluded groups); and
- service delivery approaches and institutions established to provide services including health facilities, clinics and service centres.

a. Information to be collected for mapping of districts and individual VDCs:

- A map that demarcates the borders of the district or the VDC in question.
- The DDC's list of disadvantaged (DAG) VDCs.
- A population profile disaggregated by caste and ethnic group.
- The services provided by health facilities, clinics, service centres and health functionaries and which communities have used these services to what level.
- The distance between health facilities, clinics, service centres and human settlements.
- Identify which health facilities have birthing centres and how far they are located from target populations with low rates of institutional delivery.
- The situation of filled and vacant posts at health facilities and the effect of this on service delivery.

- The communications technology and transportation facilities available in each VDC.
- The number of government and non-government institutions working in each VDC, and the number of health providers, and the types of programmes they are implementing.
- The progress of each health facility on achieving their health service targets.
- Which VDCs, wards and settlements (*toles*) are more prone to natural disasters like landslides and epidemics.

This mapping exercise must be updated annually.

b. Information analysis

The following steps must be followed to analyse the above district and VDC level information:

- All information should be analysed according to the context of each VDC and district.
- Identify the most disadvantaged VDCs. Disadvantaged VDCs are VDCs 1) that lie far away from the district centre, 2) that have no modern transportation facilities meaning that people have to walk some distance to access health services, 3) where the majority of the population is composed of Dalits or other excluded caste and ethnic groups, 4) that have low health indicators compared to other VDCs, 5) that have a low literacy rate compared to other VDCs, 5) where poverty is high compared to other VDCs, and 6) that are classified as disadvantaged by the DDC.
- Identify the level of usage of health services by the different communities within the VDC and identify communities not using any or with only a low level of use of health services and the reasons why.
- Based on the above assessment, incorporate activities to address the above gaps in VDC and health facility level plans. Those issues that cannot be addressed at the local level should be included in district level planning and issues that cannot be addressed at the district level should be included in central level planning at regional workshops or by direct request to the concerned division or centre.

3.5.2 The enabling environment for access to services

Many people, especially women and poor and excluded people are unable to access and use health services due to social, cultural, economic and geographical constraints. Additionally many people are unable to adequately access services even after reaching health institutions due to their lack of understanding of the processes involved or the lack of available services. Service provider issues can hamper the access of women and poor and excluded people.

The following points should be observed to build a positive environment for access to and provision of health services.

a. Service provider behaviour:

- Service providers must be polite and respectful. They must provide prompt services and be pleasant with all users and especially with the poor and people from excluded groups.
- Service providers must provide sensitive and client-centred counselling to all users. They should pay particular attention to the challenges that women and children from poor and excluded backgrounds face as they tend to have less education, poor health seeking practices, and live in social environments that inhibit access to health services.
- As far as possible, service providers should use the language of the service seeker, drawing on interpreters as necessary. This is to make service seekers feel at ease and for them to be able to explain their issues clearly and understand the advice given.
- As far as possible and where relevant women service seekers should be served by women service providers.

b. Supplies

- Health institutions should always make available the minimum equipment and drugs necessary to provide basic health services.
- Health institutions must plan drug procurement according to the government process to prevent stock-outs.

c. Financial support

- Identify those who are unable to pay for services that are not free and then use funds from sources like district referral funds to support their treatment.
- Try to mobilise more resources through VDCs and other social organizations.
- Provide poor and disadvantaged people with the government's free basic health services in a timely and responsive way.
- Health facilities must create an emergency fund to support the referral of poor and very poor people to higher level health facilities.

d. Information and security

- Safeguard the social and physical security and safety of service providers, especially women employees.
- Mobilise local and religious leaders, faith healers, user groups and schools to disseminate information including about services available from health facilities and their opening times to the general public and especially to women and poor and unreached people.

e. Physical facilities

- As required provide privacy for women patients.
- Provide waiting seating facilities for service seekers, especially for the disabled and elderly.
- Provide separate toilets for female and male service providers and seekers.

3.5.3 Role of health facility operation and management committees

A key responsibility of health facility operation and management committees (HFOMC) is to ensure that health facilities effectively provide services including to women and poor and excluded people. But efforts to ensure this have not been very effective.

a. HFOMC responsibilities to improve the reach and quality of health service delivery:

- HFOMCS must hold regular meetings. They must identify the people and the location of people (which ward, settlements, VDC) who are not accessing or using health services and identify the reasons why. Identify measures to address the causes and create an appropriate service response to reach unreached target groups.
- Mobilise local resources to establish emergency funds to support the referrals of poor and very poor patients to higher level health institutions.
- Provide services through outreach services like satellite clinics, immunization and outreach clinics, to bring services closer to people who are unable to access health facilities due to geographical reasons and social barriers.
- Provide 24 hour services by a nurse at birthing centres.
- Ensure women and poor and excluded people are informed about the types of services provided by health facilities.
- Ensure that health facility opening times suit the public, including women and poor and excluded people.

b. HFOMC responsibilities to improve the organisation and management of health sector resources

- Conduct social audits to ascertain the views of local communities and their recommendations on improving service provision. These social audits bring community people and health providers together to review the quality, availability and accessibility of health services and to plan for improved service provision.
- Collect feedback from service seekers, especially women and poor and excluded people, about the behaviour of service providers and the quality of the services at the time of service provision.
- Establish a system of collecting complaints from the public and address legitimate complaints.
- In local contracting of staff, appoint contract staff who can speak the local language and are acquainted with the local culture.
- Coordinate with and lobby for funding from VDCs and DDCs.
- Award appreciation certificates and merit awards to staff who deliver services in a GESI sensitive way.

c. DHO/DPHO support for HFOMCs

- Ensure the representation of women, Dalits and other excluded groups on HFOMCs as per the HFOMC guidelines. Arrange for members from diverse social groups to be invited in case representation is not inclusive.
- Facilitate a systematic process for HFOMCs to ensure services are provided to women and poor and excluded people in their catchment areas.
- Support HFOMCs to conduct social audits to improve transparency and accountability.
- Support HFOMCs to identify the unreached and underserved and the reasons why.
- Support HFOMCs to provide 24 hour services with a nurse at birthing centres.
- Monitor whether all services to be provided by the facility are actually provided. This must be monitored year-round as such services are primarily used by women, poor and the excluded.
- Hold joint discussions with HFOMCs and health facility staff on the services provided by health facilities, which services are not being accessed or used by women and poor and excluded people and the reasons why, and plan to address these issues by drawing on positive experiences.
- Support HFOMC coordination and partnership with their VDCs and other local organisations.
- Mobilise related health institutions to provide services to temporarily resident groups such as nomadic tribes like Rautes and people linked to specific tasks such as brick making.
- Monitor the work of HFOMCs and appreciate their successes in improving services to women and poor and excluded people.
- Identify training and capacity building needs to make health workers more GESI responsive.
- Support staff deployment and retention, the filling of vacant posts, and deploy human resources from similar social backgrounds to catchment communities.

3.5.4 Enhancing access to health services

The means used by the government to deliver health services to those who live relatively far from health facilities include outreach clinics, immunization clinics, satellite clinics, community health centres, family planning camps and other camps. This section provides guidance for these services

and for primary health care facilities (sub-health posts, health posts and primary health care centres) to be delivered in a GESI responsive way.

a. Common guidance for health clinics and centres

This section provides common guidance for GESI responsive planning, implementation and monitoring of outreach clinics, immunization clinics, urban heath centres, community health centres and other clinics and centres, including primary health care facilities.

The number and location of clinics and centres:

- The numbers of clinics and centres should be based on evidence on unreached populations. It is important to identify which people have poorer health indicators and a poorer history of accessing health services and which geographical areas have low health service provision.
- The number of clinics and centres in one region or district may be insufficient to reach all classes and groups of people. Therefore, the location of clinics and centres must be selected based on where more unreached people can access a service. For example, an immunization clinic should be located in areas with more left-out and drop-out children. Social mapping can assist in identifying unreached populations. Clinics and centres should be located bearing in mind the geographical situation of the area where the services are needed and the time required for people, especially women and poor and excluded people, to reach clinics or centres from different areas. While determining the location, priority should be given to reaching poor settlements, areas with less access to services and areas far from district hospital or headquarters.
- The number of clinics and centres should also address the prevailing social norms in VDCs and districts. A higher density of clinics and centres should be located in areas with high levels of gender inequality and where girls and women are unable to easily access health services. This is so that preferential investment of families in males does not impact access of females to clinic and centre services.
- Each health facility should consult its HFOMC, FCHVs and local social workers to determine the number and location of health clinics and centres.

Timing and services of clinics and centres:

- The opening hours of clinics and centres should be determined after discussions with women and poor people on convenient timings.
- Timing of clinics should consider local festivals and peak farming times.
- The services made available should be based on evidence about the key services needed by local people, including women and poor and excluded people.

Clinic and centre coordination committees:

- Form clinic and centre cooperation committees for specific services (e.g. immunization, outreach, uterine prolapse) and ensure the representation of women and poor and excluded groups on them to support the correct identification of needed services and suitable locations, and to monitor the quality and use of services especially by previously unreached people.

Disseminating information on clinics and centres:

- It is important to disseminate information to all relevant people, especially women and poor and excluded people, on when and where services will be provided, which services will be free, which need paying for and who is allowed to accompany service seekers.
- Men and family decision makers must be informed and motivated to ensure that women are encouraged and permitted to attend clinics and centres.

2. The implementation of clinics and centres

Supply-side issues:

- Service providers should be approachable, sensitive and patient with all service seekers and especially with those from excluded groups.
- Prompt services should be provided to all but especially to persons with disability, elderly people, women who have recently delivered and those who have to travel the furthest.
- FCHVs and mothers groups should mobilise and encourage communities to use the services, particularly women and poor and excluded people who do not easily access services.
- Health personnel should attend mothers group meetings to inform them about the services available.
- Any changes in the schedule of service provision should be widely disseminated especially to women and poor and excluded people.
- All necessary drugs and basic equipment should be in place to provide the planned services.
- Detailed records must be maintained about patients (disaggregated where possible), the services they take, and those who were eligible but did not access the service provided by the clinic or centre. Mobilise FCHVs and mothers groups to help identify reasons for absence and to motivate such people to attend forthcoming clinics or centres.
- Record with disaggregation (where possible) how many women and poor and excluded people visited the clinics and centres and of those how many received services. In case a high number of people from excluded groups did not receive services, the coordination committee must discuss and identify measures to address this.
- Services should be provided to temporary residents (nomads, factory labourers and others).
- Health problems that cannot be addressed at clinics or centres should be referred to higher level institutions. Where possible, subsidised or free referral costs should be provided for poor people, including women and persons with disabilities and the elderly.
- Establish a mechanism to collect feedback from service seekers on the services received and the behaviour of service providers.
- Functional clinics and centres should only be closed in special circumstances.

Demand-side issues:

- Inform women and poor and excluded persons about the place, timing and importance of the services provided by clinics and centres. Mobilise mothers groups, FCHVs, local institutions, community groups and use appropriate means of communication to do this e.g. radio and street drama.
- Inform poor people about cash incentives provided by the government and about free and subsidised services available at referral and other institutions if higher level care is needed.
- Orientate men and family decision makers about the significance of services, needed care in the family, and the importance of follow-up.
- Address the social, economic and cultural barriers experienced by poor and excluded groups though affirmative action to improve their access to services.

3. Monitoring and lesson learning

- The coordination committees formed for specific service clinics and centres must monitor the preparations and implementation of service provision. They need to ensure that

women and poor and excluded people within the catchment area are identified and motivated to access and use the centre or clinic.

- The committee must monitor whether the target group accesses the services from the clinic or centre and identify any reasons when they do not. Based on this, measures should be recommended to ensure future participation.
- Committees must regularly review the quality of services provided. They must also assess the behaviour of service providers and their attitudes towards women and poor and excluded people. Those who discriminate in any way should be punished while those who provide good services to these groups should be appreciated.
- An objective feedback system should be instituted including to provide opportunities for patients to comment on service providers.
- HFOMCs and health facility in-charges should regularly monitor whether clinics and centres operate in their specified places and on time.

b. Specific guidance

The following specific issues need to be addressed for integrating GESI concerns in specific types of service delivery approaches.

1. Camps

Planning camps:

- Decisions about what kind of camp to hold and when must be based on local context and needs, and the clinical appropriateness of camps for delivering specific services. These decisions must also address specific issues of women and people of different incomes, social groups and ecological region such as kala-azar, and malaria in the Terai and the effect of menstrual seclusion (*chhaupadi)* on women's health in the Far West.
- Camps should be located according to their objectives and the distance of communities from the district hospital.
- Camps should be accessible to poor settlements and several disadvantaged VDCs to provide expert services that cannot be accessed at district hospitals.
- Family planning campaigns should be planned for communities that lack access to these services and VDCs with a low rate of family planning use. Ascertain the number of men and women of a particular area interested in using permanent and temporary methods of family planning while planning family planning camps.

Running camps:

- Ensure that communities, especially women and poor and excluded people, are informed about camps, their location, timings and services available.
- Provide services promptly to patients who travel from afar, persons with disabilities, and poor and elderly people.
- Service providers must motivate clients (especially those from poor and excluded groups) to attend camps by being approachable and pleasant mannered.
- Identify needy people who did not attend previous camps and the reasons why; and then create an enabling environment to encourage them to attend.
- Arrange free referral services to higher level institutions for those whose problems cannot be resolved at the camp.
- Do not impose any financial burden on service seekers who attend camps.

Monitoring camps:

- Gather feedback from service seekers on the quality of services provided and the behaviour of service providers. Develop a mechanism to gather feedback from service seekers and improve future service delivery.

2 Birthing centres

The government has provisioned that all birthing centres provide services 24-hours a day. NDHS 2011 found that only 35.3% of deliveries occurred in health facilities (29% in the Far Western Region and 39% in the Eastern Region). There is a need to improve regional imbalances and to increase the rate of institutional delivery. Alongside the common points above, the following specific points must be observed to ensure that birthing centres are accessible to poor women and women from excluded groups.

- Locate birthing centres to provide women with delivery services who have problems accessing these services at any other facility. Necessary trained human resources must be arranged before a birthing centre is opened.
- Locate birthing centres in cooperation with VDCs and local institutions taking into account the geographical area, population profile, the different social groups that women come from, the presence of excluded communities, economic status, and social and cultural practices.
- Provide the cash incentives to the family straightaway after delivery so that they do not have to return to the health facility to collect the payment. Mobilise government grant and local resources to meet the costs of providing incentives.
- Provide health workers, essential drugs and equipment 24 hours a day 7 days a week.
- Arrange appropriate means of transportation in cooperation with local communities to refer women (especially from poor and excluded communities) from birthing centres to higher level institutions. Create emergency funds to pay for this need for poor women.
- Provide for the social and physical safety of birthing centre staff, especially women health workers.
- Make birthing facilities available to temporary residents.
- Provide advice and referrals to antenatal check-up and delivery patients who lack adequate nutrition or have other health problems. Health staff should be able to recognise and support patients who are victims of gender based violence.

3 Safe abortion services

The government is expanding the provision of safe abortion services. Many unsafe abortions are carried out and many deaths and much morbidity results. The following points need to be implemented to address GESI concerns in providing safe abortion services.

Selection of health facilities:

- Identify areas where safe abortion services are not conveniently available, especially to women from excluded groups. Use this information to help decide on the location of new service sites.
- Locate new abortion centres at places where women from poor and excluded groups can access the services relatively easily. Disseminate information on service availability to women from poor and excluded communities.
- Permit private service providers to provide services to women from poor and excluded communities.

Providing services:

- Establish a fund to support poor women or women with no access to funds to avail of abortion services.

- Service providers must maintain confidentiality about women who undertake abortions. Follow the provisions of the Safe Abortion Service Programme Operating Guidelines, 2068 (2011/12) if there is a need to disclose information about patients to anyone.
- Priorise the training of health workers who commit to providing regular safe abortion services in remote and rural areas.
- Assigned institutions should provide safe abortion services regularly and should not discontinue service provision under any circumstances.

4. Uterine prolapse treatment and surgery

Uterine prolapse is widespread in Nepal due to early pregnancies, lack of rest and nutritious food after giving birth, and restarting work immediately after delivery. The government has prepared operating guidelines for the treatment of uterine prolapse. Alongside the common guidance above the following points must be observed to make this service GESI-friendly.

- Hold screening camps in areas where there is a known high occurrence of uterine prolapse and in areas where women of particular social groups suffer more from this condition.
- Women who come to uterine prolapse clinics without being screened should be politely informed how they can receive services and the process to access them.
- Patients and their families need to be counselled about the care to be taken at home after surgery and about follow-up check-ups. They must also be counselled about care to prevent reoccurrence.
- This problem occurs more in communities where women have to work hard for their subsistence. Therefore health providers should identify (list) such groups and then women suffering from uterine prolapse, and their families, should be motivated to permit women to undergo treatment.

5. The prevention and control of epidemics and natural disasters

Preparedness:

- Health facilities should identify areas and communities within their catchments that are more at risk of epidemics and natural disasters .
- Identify and map areas where poor and people from excluded communities live as they tend to be more affected by diseases like severe diarrhoea, cholera, measles, influenza and malaria. Target awareness interventions at these communities.
- Poor communities tend to be more at risk from landslides and river flooding. Identify such communities and inform them about disaster prevention measures and responses.
- Seasonal epidemics impact poor and excluded communities more. Regularly take measures to prevent epidemics such as by cleaning water sources, preventing mosquito bites, using mosquito nets, and by practising cleanliness and hygiene.
- DHO/DPHOs, HFOMCs and health providers need to recognise the potential levels of disasters and epidemics that could happen, and make emergency drugs ready and prepare response teams.

The prevention and control of epidemics

- Groups affected by epidemics and disasters may hesitate to seek health services. Therefore service teams should be mobilized to provide prioritised services to them.
- During epidemics, make provision to send patients who could not get treated at the local level to higher level health facilities.

- Government and non-government organizations, local administrations, security organisations and schools in the region should work together to prevent and control epidemics and to prevent disasters.
- Health service providers should counsel poor and excluded communities that are vulnerable to epidemics and natural disasters about prevention and care.
- Health service providers must report in detail on services provided during epidemics and disasters including the area, class, sex, group, and age group; and how many people were affected.

6. Health services provision in referral hospitals

Referral hospitals provide services to patients referred from local health facilities and to patients who visit these hospitals directly. Many hospitals in remote districts are unable to provide referral hospital services, a key reason being the unwillingness of health workers to stay in remote areas, despite the government provision of additional incentives to work in remote areas. Due to this, many people, especially women and poor and excluded people face difficulties in accessing services. The following points need to be observed to provide referral services in a GESI friendly way.

- Hospital development committees that do not have women or excluded group members must invite such people to meetings as per need.
- These committees must discuss how services can be delivered to be more accessible to women, poor and other excluded groups and then implement any such recommendations.
- Hospitals must clearly mention the services they provide in their citizen charters in clear and simple language and place their charters in an easily accessible place. Hospitals must also provide information on the services they provide using local means of communication.
- Counselling services must be provided as per need to users bearing in mind the specific constraints that women, poor and excluded people face in accessing information about and availing of hospital level services.
- Although district hospitals have to provide health services free of charge to the extreme poor, the poor, persons with disabilities and elderly people, many target group patients do not know about this. Volunteers, social organizations or other persons should be assigned at hospitals to inform and support such patients.
- Women affected by violence who visit hospitals often do not inform health personnel about the violence they have experienced. Health service providers must therefore be able to recognise signs of violence on women (e.g. bruises, mental disturbance) and counsel them to access relevant services, which should be provided free of cost. They should be informed about one stop crisis management centres where they are operational.
- District hospitals should establish emergency funds to support extremely poor and poor patients who are referred from district hospitals to higher level health facilities. These funds should cover the transport costs of such patients. The level of support must be decided by the hospital committee based on the condition and needs of patients.
- Where possible arrange for health workers of the same sex to provide services to women and men. This is important for women generally and for family planning services for men.
- Ensure the physical and social safety and security of hospital employees, especially women.

3.5.5 Service availability in underserved areas

The definition of an underserved or remote area depends on the local context. Distance and transport related issues and geographical difficulties that constrain access to health services need to be identified as per the local context and for particular services.

a. Reasons for low use of health services in underserved areas

A number of studies have shown the low use of health services by people, especially women, poor and the excluded, in geographically remote areas. The reasons for this include irregular availability of services, the distance to health facilities, the unavailability of services prescribed by MoHP, greater poverty, lack of transportation facilities, higher work burdens and low awareness of health services. For example, local women in the geographically remote Karnali zone have not been able to receive services as well as women in other areas as posts for assistant nurse midwives have not been created there.

b. Issues to be addressed:

The following points must be addressed to improve access to service in underserved areas:

- Instigate partnerships between private and public service providers to counteract the tendency of high absenteeism of government health workers in remote areas.
- Implement IEC programmes to inform people in remote areas about services and their rights. This should be done by MoHP in coordination with other organizations, especially NGOs that work in education and health and on social mobilization, through integrated programmes.
- MoHP should develop a strategy for delivering essential health care services to remote areas to recognise the geographical, social and cultural differences of different remote districts and areas. Each district which has remote areas should develop a district specific plan based on this overall strategy.
- Adopt different approaches for providing health services in areas where it can take a whole day for some service seekers to visit a health institution. One approach is to run mobile clinics to provide all basic services in each ward or area of a remote district once a month.
- Fewer women tend to come to health facilities to deliver their babies in remote areas. One reason is that full services are often not available. One approach to overcome this problem is to contract nurses to provide home deliveries in specified catchment areas with the ability to contact higher level institutions by mobile phone for advice on how to deal with difficult cases, and to arrange timely referrals.
- Depending on the geographical terrain and population density, outreach (*gaun-ghar*) clinics can be upgraded to community service centres with two nurses.

c. Arrangements for referral from remote areas

- Through public-private partnerships, seats should be reserved for patients on aircraft as only air travel is possible in many remote areas to quickly access referral health services. Under the principle of corporate social responsibility, the private sector should bear three parts of the cost, the government one part and the patient's family one part. Subsidies should be arranged for those who are extremely poor and cannot even afford to pay one part.
- Establish a fund for emergency health services in each relevant VDC, district and hospital to support patients from remote areas. MoHP should develop guidelines for the implementation of these funds.
- Identify institutions for maternity referrals from remote districts and make arrangements so that referral patients receive prompt services. Through public-private partnerships, establish a maternity waiting home at selected referral institutions.

3.5.6 Female community health volunteers

Female community health volunteers (FCHVs) have a very significant role in ensuring that services are accessed and used by women, including women from poor and excluded groups. Mothers groups can also provide health information to women from different social groups, and those who have problems accessing and using services.

FCHVs should play the following roles to promote service use by women, poor and the excluded:

- In their catchment areas identify which people in need do not access or use which health services. Ascertain the income and social group they belong to, their health seeking behaviour and the reasons why they are not accessing or using particular services.
- Assess whether women of different income and social groups are members of a mothers group or not.
- Inform families without mothers group membership about health services provided by the government, including about health facility opening times and locations. Visit the homes of women from poor and excluded families to share information, provide counselling on family health issues as appropriate, provide home-based care, and encourage them to use health services.
- Make a special effort to ascertain and update the details of women and families who are poor or are from excluded social groups. Identify who is availing of which services and who is due services. For example, who is using family planning, which children are to be immunized, which woman are pregnant and when they are due to deliver, and other information important for providing health service support.
- Attend immunization, outreach (*gaun-ghar*) and other clinics and camps and identify which people in need do not attend, find out why, and help them to access needed services.
- Motivate non-users to use services with the help of health workers, local organizations and local schools, VDCs and community based organisations.
- Ensure that infants and children below five years of age, especially from poor and excluded families, receive all the required vaccinations. Ensure that pregnant women receive relevant information and counselling.
- If the location of clinics or camps is unsuitable for specific groups of people, especially the poor and the excluded, inform the responsible health facility and select a convenient area for subsequent clinics or camps.
- Ensure that FCHVs' kit-boxes always contain the relevant medicines and that these medicines are distributed to women and poor and excluded people promptly as per need.
- Motivate mothers groups to support people from excluded groups especially the disabled and the elderly.
- Motivate families that do not use health services due to economic reasons by providing them with information about free services and discussing alternate ways of accessing health services.
- Provide health information and information on entitlements and services to women from poor and excluded groups, and mobilise their families especially mother-in-laws and husbands, to support women and children's access to health services.
- Accompany women and children from poor and excluded backgrounds to health facilities as needed, especially in emergencies.

Support to be provided by DHOs/DPHOs

- When selecting new FCHVs or replacing FCHVs, try and appoint persons from social groups with low health indicators.
- It can be difficult for one FCHV to adequately cover wards with high populations and large areas. In such cases appoint an additional FCHV in consultation with local bodies.
- Honour and appreciate FCHVs who do outstanding work. If relevant, FCHVs of excluded social groups should also be selected for appreciation.

3.5.7 GESI mainstreaming in behaviour change communication and social mobilisation

Many women and poor and excluded people are unable to access health services due to social, cultural, economic and geographical barriers. These groups require a more enabling environment to

be able to recognise what services are meant for them, to negotiate family approval to seek care, and to demand services from service providers. The following information, communication and social mobilisation programmes need to be made GESI responsive to help create an enabling environment for women and poor and excluded people to access health services.

a) Information, education and communication for behaviour change

Health services and health related information should be local context-specific. Social practices, cultural events, languages and existing communication technologies should determine the content of locally relevant BCC and IEC materials. Common diseases, health issues and practices that impact local health seeking behaviour need to be identified and used to prepare local BCC/IEC materials with appropriate messages to address these issues. The key aspects to be addressed from a GESI perspective for IEC and BCC are as follows:

- Use local media, e.g. radio, TV, newspapers, individual interactions, street drama and poetry to deliver health messages. Use media that are most used by women and poor and excluded people.
- Disseminate messages at the most appropriate times to reach targeted people.
- Make messages relevant for the different groups in terms of language, cultural practices and dress.
- Identify people with less information about health services and prepare messages for them.
- Phrase messages positively.
- Use local sayings and cultural references to persuade people to make positive behaviour changes for themselves and their families.
- Design materials to affect the gatekeepers and decision-makers in women's and children's lives so that the former support and reinforce positive health seeking behaviour by the family.
- Localise national level messages.
- Base health messages on issues experienced by women and poor and excluded people.

b) Social mobilization

Traditional practices and behaviour that is detrimental to health cannot be changed by the efforts of only one person or institution. The united efforts of every caste, community, group and institution are needed. Also, coordination and cooperation needs establishing with government and non-government organizations that implement programmes in communities.

- Mobilise government and non-government organizations and community mobilizers at the district and local level to inform and motivate people to access and use different health services.
- Identify and address the barriers and constraints to service access. Use lessons from successful programmes like the Equity and Access Programme, which mobilises poor and excluded communities through women's groups, local leaders and men, to build community solidarity. Develop local community strategies such as emergency funds and local transport schemes, empower women, and speak out for better access to services for women, the poor and excluded.
- Mobilise local religious and cultural leaders to encourage local people to access health services.
- Inform political leaders, teachers and community facilitators about available health services and services provided by the government that target women, poor and excluded groups including free health services, free maternity services, social service units and one stop crisis management centres.
- Distribute and disseminate health related information and communication materials at festivals, fairs and local markets.

- Encourage service beneficiaries to encourage others to avail of health services and dispel negative myths and perceptions.
- Disseminate health messages through community groups, networks and clubs.
- Mobilize VDCs, community schools and other organizations to deliver health related messages and information, and to mobilise communities, including men and local leaders, to promote the health of women and poor and excluded people.
- Link with community development programmes, especially those supporting economic development and income generation activities, to assist poor communities to overcome the financial barriers they face in accessing health services.
- Motivate individuals and groups to set aside a portion of their incomes for health emergency funds. These funds should be used to provide emergency health services to women and poor and excluded persons.

c) Work with family decision makers

Most community programmes will target at least one member of each family. Programmes implemented by MoHP especially target mothers and other groups. For example, only one of the temporary means of family planning is for men; the rest are for women. But women alone cannot usually take the decision and usually will have to take permission from their in-laws and husband. Making decision makers realize the benefits of health services will make women's lives easier. Thus the following points need to be addressed to influence family decision makers.

- Make the family decision maker (mother-in-law, husband, elder) clear about the benefits of health services to create an enabling environment for women to access services.
- Foster communication between the key family decision maker and the woman herself on specific health issues. For example: discussions on maternal health, family planning, abortions, vaccinations, nutrition and free services should be encouraged between mother-in-laws and daughter-in-laws, husbands and wives, newly wed couples, and mothers of children whose vaccinations have been completed and other mothers.
- Social, cultural and traditional habits affect the use of health services. Senior family members have a crucial role to play in changing such habits including men (fathers, fathers-in-law, husbands and brothers-in-law) and influential women (mother-in-laws, sister-in-laws and mothers). These men and influential women need to be involved in communication and behaviour change efforts.

d) Mobilize mother groups:

Mothers groups are well informed about health services and facilities provided by the government and are a channel for communicating and sharing information with women in communities.

- Mothers groups should identify which families do not use needed health services and why. Where possible they should identify which families discriminate against women and children in accessing health services, which families follow traditional practices to treat illnesses, and which follow harmful practices that are detrimental to health during pregnancy and women's and girl's lives generally. Such families should be advised against such practices at personal or group visits. Efforts should be made to discontinue such practices by sharing emotional examples and incidents especially with the main family decision maker.
- FCHVS and members of mothers groups should not practice discrimination in their families or communities or towards poor and excluded groups.

e) Promote coordination and cooperation

Many non-health sector programmes are implemented at the local level including community schools, women development programmes, and DDC community development and poverty

alleviation programmes. Coordination and cooperation between these and health programmes should be established as the former are a good medium for targeting women and poor and excluded groups with information, resources and capacities for empowerment and health improvement.

- **Women development programmes** — Discuss health issues related to women and children in women development programmes, identify the barriers poor and excluded groups face to access health services, and identify appropriate institutions to overcome barriers and to provide services.
- **Education programmes** — Develop a 'school health education child-to-child programme' to disseminate health information from students to their families; work through teachers to disseminate health messages to communities; and disseminate health messages and information through informal education programmes for women and children.
- **VDC social mobilization programmes** — Work through local good governance, community development and poverty alleviation programmes, ward citizen forums and other community networks to reach poor and excluded groups with health messages. Orientate these programmes and groups on health-related services and information and motivate them to contribute to improving demand for health services. These programmes and groups can also help identify the barriers and solutions to enable women and poor and excluded people access health services.
- **Local organizations** — Share information on health issues with local female health volunteers, mothers groups, other women's networks, community organizations, religious groups and forest user groups and encourage them to use health services. Motivate them to unite against untouchability, domestic violence and other harmful practices.

3.6 GESI mainstreaming in organisations

It is important to address GESI issues within the health sector's institutions to facilitate access to health services by women and poor and excluded people. The management systems that frame the way decisions are made, the way people in the health system communicate and set priorities, and the organisational culture in which health providers and managers work impact how health services respond to women and poor and excluded people. The systems for sharing information, communication and decision-making, staff responsibilities for GESI, and institutional cultures and attitudes among health-service providers greatly influence the access of women and poor and excluded people to health services. Human-resource-related issues have a large impact on how well service providers are tuned and motivated to providing quality services to target groups. This includes the level of diversity amongst service providers, their motivation and incentives and willingness to serve in remote and rural areas, their performance evaluation systems and recognition of their efforts to reach the unreached and underserved, and interpersonal relations between health service providers of different social groups.

Table 2 gives guidelines on how to mainstream GESI in institutional structures, human resource issues, work culture and organisational issues at MoHP, DoHS, regional directorate, hospital, DHO/PHO, health facility and HFOMC levels.

Table 2: Guidelines to address GESI concerns in organisations and their human resources

	Institutional Issues	Proposed steps to include GESI
A. Institutional structures		
1	GESI institutional structures	• The Institutional Structure Guidelines (2013) specify the structures that must be established and their mandates to facilitate GESI: a Steering Committee in MoHP, a Technical Committee in DoHS, and technical working groups in DoHS,

	Institutional Issues	Proposed steps to include GESI
		RHDs, DHOs, DPHOs, and HFOMCs as the GESI working group at health facilities — all with ToRs and specific responsibilities. • DoHS, RHDs, DHOs, DPHOs and HFOMCs must ensure that the meetings of the above committees and groups are held as directed in the Institutional Structure Guidelines. These GESI structures must be involved in planning, programming, monitoring, supervision and reporting on GESI inputs. These structures must be supported to carry out their responsibilities with adequate human resources and budgets. • HFOMCs must identify unreached areas and underserved groups and plan to reach these areas and groups by discussing this matter.
2	Committees and their membership	• Technical committees formed for policy making, programming, studies, and other such things, should wherever possible include women and GESI experts. • The ToRs of committees must include responsibilities regarding issues and needs of women and poor and excluded people.
B. Human resource and personnel aspects		
3	Terms of reference and job descriptions of health staff and consultants	• The HRH Strategic Plan calls for reviewing and updating the ToRs and job descriptions of all posts and health facilities. The revised job descriptions must integrate GESI responsibilities into technical responsibilities. • The job descriptions of contract workers and ToRs of consultants must include GESI responsibilities. These must be linked to their performance evaluations and GESI responsive deliverables must be key parts of their deliverables.
4	Service provider GESI skills and competencies	• Build the skills and capacities of all health staff to identify barriers that women and poor and excluded people face in improving their access to health services. • Build the skills and capacities of all health staff to carry out GESI responsive planning, programming, budgeting and monitoring. • Build the skills and capacities of all health staff to deliver services in a GESI sensitive manner, including communicating with sensitivity and respect and upholding the dignity of all peoples regardless of social background, and particularly women, and poor and excluded people. • The National Health Training Centre (NHTC) and divisions must develop GESI guides and materials to integrate GESI into different training programmes. Where curriculum revision is not possible, develop and deliver GESI modules. • Train trainers on GESI concepts and implementation. • Include funding in the AWPB for NHTC and the GESI Secretariat (Population Division) to build the GESI skills and capacities of health staff from the national to facility level.
5	Diversity amongst health staff and service providers	• Where possible give women opportunities at the management level. • Address diversity in terms of sex and social background while hiring staff and while contracting staff and consultants. • Consultants should have an understanding of GESI issues in the health sector in addition to having technical expertise in the area they are hired for.
6	Staff performance evaluations	• Discussions must be initiated within MoHP to establish a system of performance evaluation where staff working in unreached areas and for underserved groups, are given higher marks and rewarded.

	Institutional Issues	Proposed steps to include GESI
		• Regional review meetings should reward staff excelling in delivering services. • Introduce a regional fund which offers financial benefits to staff that perform well against set criteria on delivering services to unreached groups and in remote and difficult areas. • Initiate discussions to establish performance-based additional payments linked to service delivery utilisation by poor and excluded populations in district and health facilities.
7	Grievance mechanisms	• Develop policies and mechanisms to address sexual harassment cases at all levels within MoHP with strict adherence to confidentiality. • Designate individuals at all levels of the health system (MoHP, DoHS, district, health facility) as point persons for hearing harassment cases and for passing complaints for action on to a higher level. • Develop a mechanism for hearing complaints in private.
C. Communication		
8	Information flow	• Different kinds of health staff have different levels of access to information. Supervisors must ensure that all relevant information is communicated in a way that reaches women within the health system as well as men at the same level. • More mobile staff tend to be better informed about decisions, opportunities within the sector (e.g. assistant health workers as compared to auxiliary nurse-midwives). There is thus a need to ensure that static workers have good access to information that impacts the sector and their careers. • Informal internal communication systems tend to be difficult to access for women and people from excluded social groups; thus appropriate means of communication such as meetings at convenient timings should be used as the main means of communication.
9	Documentation	Clear documentation is essential for GESI-related good practices and lessons to be shared amongst all: • Prepare a body of evidence on gender and social inclusion related initiatives, lessons and challenges. All health facilities must produce supervision and monitoring reports, meeting minutes, document discussions with FCHVs and patients from different social groups and note initiatives taken to address issues of women and poor and excluded people. • Include case studies that show successful initiatives to reach unreached and underserved groups while reporting to higher authorities. • Present successes, lessons and challenges at review, planning and monitoring meetings.
10	Meetings	All meetings should seek to include women and GESI focal persons and as far as possible address issues impacting the unreached, such as health service use and the human resourcing of remote areas. Points to remember for staff meetings: • Invite all levels of staff within the facility or sections or division, centre or department to meetings. • The officer in charge is responsible for creating an environment where all

	Institutional Issues	Proposed steps to include GESI
		people, including women and excluded groups, can participate meaningfully in meetings. • Meeting agendas should include discussions on the issues and challenges faced by different people. For example, take time to discuss the work-life balance of women staff, access to physical infrastructure by the disabled and the security of female health workers. • Programme, planning, review, monitoring and budget meetings should all discuss GESI issues. The agendas must include the GESI-related aspects of the topics under discussion. • Present achievements, lessons and challenges regarding GESI interventions at regular review, planning, supervision and monitoring meetings.
D. Work environment		
11	Working environment and culture	The Personnel Administration Division and Human Resource and Financial Management Division in MoHP need to provide directives for the following gender specific support: • Childcare, breastfeeding and flexible timing: If possible create space for childcare with a child minder on a cost-sharing basis. Offer flexible timings so that women can breastfeed infants at their workplaces. • Security of women service providers: In case of need, make arrangements so that a trusted person can accompany health workers to the field or when she accompanies referral cases. The Human Resources Management Division must develop a code of conduct applicable to all health personnel that emphasizes respect for all regardless of social background. This code of conduct should call for: • avoiding discriminatory language such as jokes, teasing and humiliating or dominating words; • being respectful to all, including persons with disability, sexual and gender minorities and other marginalised groups; • direct service providers to behave respectfully and sensitively with all clients in a dignified way; and • respect the views of all levels of staff.

4 GESI MAINSTREAMING IN MONITORING AND EVALUATION

4.1 Regular monitoring

Supervision is the responsibility of the respective divisions according to the guidelines prepared by the Management Division. Regional health directorates supervise districts while DHOs and DPHOs supervise their health facilities. Monitoring and evaluation is done by MoHP's M&E division along with other concerned divisions. MoHP has a number of instruments for supervision, monitoring and evaluation. These include the HMIS, the District Performance Evaluation Guidelines, the integrated supervision checklist, and surveys and studies.

4.1.1 The GESI Secretariat and DoHS technical working group

The Population Division is the GESI Secretariat and the Chief of the Population Division is MoHP's GESI focal person. The GESI Secretariat has the main responsibility for ensuring that GESI mainstreaming is addressed across MoHP. DoHS's GESI Technical Committee and Technical Working Group are mandated to monitor GESI-related activities according to the GESI Institutional Structure Guidelines. Together these structures must monitor whether the provisions of the annual budget and programme implementation guidelines are followed. They need to assess the implementation of GESI related activities and submit reports to their divisions and centres at the quarterly[2] review meetings. Their responsibilities are as follows:

- Monitor whether GESI institutional mechanisms are performing as per the Institutional Structure Guidelines. This includes checking whether or not regular meetings are held by technical committees and TWGs to identify barriers to access and use of services by excluded groups, and whether or not GESI activities are integrated in the AWPB. Monitor the implementation of GESI related programmes and activities in the NHSP-2 Implementation Plan, the AWPB, programme implementation guidelines and district level initiatives.
- Monitor the implementation of targeted interventions including one stop crisis management centres (OCMC), social service units (SSU) and the Equity and Access Programme (EAP).
- Support the development of GESI monitoring formats that can be used at each level of supervision, monitoring and review.
- Monitor the reporting of progress on GESI in quarterly reviews of divisions and centres.
- Monitor the understanding, skills and competencies of health service providers to address issues that impact women and poor and excluded persons in their programmes.
- Extract relevant information from the review reports of technical working groups at all levels to monitor progress on GESI.
- The GESI Secretariat must report all monitoring visits undertaken at different levels with disaggregated analysis twice a year to the MoHP secretary, who is chair of the GESI Steering Committee. Make a presentation to the GESI Steering Committee on the findings, lessons and good practices identified during the monitoring of the above processes.

4.1.2 GESI technical working groups and committees at regional, district and facility level

- GESI technical working group (TWG) members and HFOMC members must facilitate the normal supervision process to gather information and analyse issues and progress on providing services to women and poor and excluded people. One way they can do this is by orientating health personnel on how to identify barriers to accessing service. Means of identifying barriers include exit interviews with patients (especially women and poor and excluded patients),

[2] These meetings are held every four months.

meeting mothers group representatives and visiting social groups that experience difficulties accessing services.

- TWGs and HFOMCs must follow-up on GESI targeted programmes including SSUs, OCMCs, EAP and social audits and prepare monitoring reports for periodic review meetings.
- TWGs must ensure that the whole programme review process is informed by GESI related issues. They must follow-up with staff, HFOMCs and health facility-in-charges to identify issues related to women and poor and excluded people.
- Monitoring reports must be submitted to all quarterly and annual review meetings.

4.1.3 The Health Information Management System

- The Health Information Management System (HMIS) is a key instrument for monitoring results in the health sector, and for identifying achievements against MoHP's results framework and international commitments like the MDGs. HMIS indicators do not systematically capture sex, caste/ethnicity and location disaggregated results. Efforts to disaggregate results have been piloted and HMIS indicators are being revised to address this issue.
- Information from HMIS must be used at district, regional and central level review meetings. The available disaggregated information should be used to identify underserved groups and unreached areas. The reasons for these trends must be identified.
- The central level HMIS section must compile disaggregated data to present disparities in service utilisation by gender, caste/ethnicity, VDC and district.
- Based on this compiled information, concerned divisions should prepare plans to reach underserved and unreached people and places. For example, in Banke district the overall use of family planning methods is high, but it is very low amongst Muslims thus indicating the need to plan interventions to increase contraceptive use amongst this group in this district.

4.2 District performance evaluations

MoHP's M&E division conducts an annual performance evaluation of each district's health service delivery. This review does not have GESI disaggregation or GESI evaluation criteria. The M&E division must therefore review and revise its evaluation indicators to include the rating of district performance in addressing GESI. Revised HMIS indicators that demand disaggregated data must be included in district performance evaluation indicators. The revised evaluation indicators and rating criteria must give appropriate marks to ensure sufficient weightage is given to GESI objectives.

The revised criteria must include review indicators that assess:

- the functioning of technical working groups (regularity of meetings, level of integration of GESI in periodic reviews, review and reporting of district performance with GESI related disaggregation and analysis in annual review);
- the preparation of district profiles that identify unreached groups and underserved areas using mapping information done by districts (see section 3.5); and
- the reduction of disparities and inequalities among different social groups and between women and men (e.g. the increased proportion of immunized Dalit children).

4.3 Integrated supervision

All health institutions up to health facility levels are mandated to do integrated supervision. This supervision needs to be GESI responsive. The Management Division has issued an integrated supervision and management guideline that must be followed by the different health institutions at all levels.

4.3.1 The integrated supervision and implementation guideline

DoHS uses its integrated supervision checklist to supervise all levels of the health service from DoHS itself to sub-health posts. The composition of supervision teams, their terms of reference, their skills, supervision methods and reporting mechanisms need to be made more responsive to the needs of women and poor and excluded people.

The following revisions to the checklist are essential for mainstreaming GESI:

a. Supervision team composition: Where feasible include a GESI focal person on all monitoring teams. GESI focal persons must be included in supervision at department, RHD and DHO/DPHO levels as feasible. District level GESI focal persons must be part of teams for monitoring primary health care centres, health posts and sub-health posts.

b. Prepare supervision work plans based on evidence of where service use is low for supervision visits to purposefully visit such areas.

   These work plans should specify:

   - the supervision objectives from a GESI perspective;
   - the quarterly and monthly supervision visit times (which should be convenient to hold discussions with local women and poor and excluded people and health facility clients);
   - the locations to visit, which must include areas where women and poor and excluded people have low health service use; and
   - areas which are remote and have higher populations of excluded group people.

c. Make the following preparations for supervisory visits:

   - consult a disaggregated population profile of the area to be visited;
   - review previous supervision reports, and specifically findings related to access and utilisation of services by women and poor and excluded people;
   - review previous recommendations and suggestions to better serve unreached groups in order to track progress during the supervision visit;
   - identify programmes and services that target unreached or difficult to reach groups in the area;
   - review on-going programmes and activities from a GESI perspective;
   - review reports available at DHOs/DPHOs to identify issues experienced by local women and poor and excluded people;
   - review efforts to address the issues and constraints.

   If GESI related information is lacking, raise this as a concern in the monitoring report.

d. Things to be observed during supervisory visits:

   - service delivery by health facilities to the target group (women and poor and excluded people);
   - the provision of entitlements such as free medicines and AAMA programme entitlements;
   - the behaviour of service providers towards the target group;
   - affirmative actions by service providers to make the target group more comfortable, such as seeing people from far off places first;
   - the level and quality of counselling and information provided to clients by health providers at different institutions;
   - observation of tools used to disseminate information such as the citizens charter and the clarity of information provided.

e. Methods to be adopted during supervision:
   - Hold consultations and meetings with services users of the target group.
   - Hold exit interviews with clients from the target group.
   - Hold discussions with HFOMC members, including with women and members of excluded groups.
   - Hold community meetings with women, poor and excluded people, and VDC and other local leaders.
   - Hold consultation meeting with all facility staff.

f. Feedback and reporting from integrated supervision visits:
   - Hold feedback meetings with staff and HFOMCs as appropriate to present the main findings and recommendations to improve service access and use by women and poor and excluded people. Note that a consensus must be reached on the recommendations and if this cannot be reached, dissenting opinions reported in the supervision report.
   - Document the outcome of these meetings in the supervision register as appropriate, and report to the concerned divisions and sections.
   - Produce a supervision report that includes the findings of visits related to reaching women and poor and excluded people with action points to address problems. These reports should document achievements, lessons learned, issues to be addressed and measures that can be applied to improve service delivery to women and poor and excluded groups.

4.4 Quarterly and annual reviews

4.4.1 Quarterly reviews

The following points must be observed for carrying out quarterly health facility and district reviews.

DHOs/DPHOs must do the following:

- Direct health facility in-charges to collect disaggregated information about service provision per the HMIS format and gather information on issues of service access and use by underserved areas and unreached groups and the barriers to service use. This information must be presented at quarterly and annual review meetings.
- Direct health facility in-charges to report progress on action plans developed following social audits, and the implementation of EAP, highlighting areas of improvement and a review of experiences.

HFOMCs and health facilities:

- HFOMCs must hold discussions about services accessed and used by unreached groups and underserved areas. This includes meetings with FCHVs and mothers groups representatives to share experiences of trying to reach target groups, and to identify measures for improvement.
- Health facilities must follow the Health Sector Social Audit Operational Guidelines and conduct social audits each year (see section 3.5).
- HFOMCs must review the progress of social audit work plans in their regular meetings.
- Health facilities must hold consultations with people from underserved areas and unreached groups to recognise barriers, which should be included and addressed in their work plans. Health facilities must review the effectiveness of their citizens charters (see section 3.5) and make improvements accordingly.

4.4.2 Annual reviews

All levels of health sector institutions conduct annual reviews of their work. The Management Division guidelines specify the procedures for carrying out these reviews. This sub-section presents guidance on integrating GESI concerns into this review process at all levels of the health system.

The aim of annual reviews is to explain the achievements, gaps, areas of improvement and lessons learned against targets at health facility and district levels. From a GESI perspective it is important to identify achievements in a disaggregated way and the successes and constraints to reaching women and poor and excluded people with health services. The findings of these reviews inform the AWPB process of the following fiscal year. Table 3 shows the measures required to address GESI issues at each step of the annual review process.

Table 3: Measures needed to address GESI issues in the annual review process

Level	Steps and procedures for integrating GESI concerns
1. Health facility level	At the beginning of each fiscal year, HFOMCs and service providers at each health facility must review the previous year's targets and achievements as follows: • List the geographic area, population, village/tole where the health facility should provide services. From this list identify wards, villages and toles that are situated more than half an hour's walk from the health facility and the communities in those areas. • Identify the targets set for each of the services provided by the facility and the total number of people who used the services in the previous year. Present data or experience regarding the level of service use by local people, disaggregated in terms of gender and caste/ethnicity. • Identify which wards, villages, toles and communities in the facility's catchment area lack access to health services. • Review progress made on reaching unreached groups and underserved areas against previously prepared maps (see section 3.5.1) • Identify which factors motivate local people to access health services. • Review the areas and communities that do not access health services and identify the barriers to access. Then identify what could be done locally to overcome the barriers and the support required from the district level. Then prepare an action plan including what needs to be done, by whom and when. • Discuss the implementation status of the action points from the annual social audit. • Identify whether or not the behaviour of health workers is a barrier to women and poor and excluded groups accessing services. If so; plan for improvement. • Review how village clinics, FCHVs, maternity services, outdoor services, mothers group and other programmes implemented by health facilities are supporting women and poor and excluded people to access health services. Identify the challenges women, poor and excluded people have faced, which people have not been able to access services, and how access to services and the services can be improved. Incorporate successful approaches in future plans. • Carry out these reviews by involving local institutions, presidents of ward citizen forums, FCHVs, social mobilizers and mother's group presidents. • Review the achievements, lessons learned and improvements needed for better coordination and partnership with local stakeholder institutions, such as VDCs and NGOs, and incorporate measures to improve coordination in the plan.
2. District level	DHOs/DPHOs must hold annual district level reviews to identify unserved areas and groups and the barriers they face to accessing and using health services. These reviews should

Level	Steps and procedures for integrating GESI concerns
	identify ways of overcoming barriers and efforts made to improve access and use by unreached groups. The district review brings together the findings of each facility level review, and ilaka level reviews where they have taken place. Key steps are as follows: • At the ilaka level conduct an annual review similar to the heath facility review. This should identify the barriers faced by women and poor and excluded groups in accessing health services in the ilaka, activities to support target groups overcome these barriers, and the support required from facility, ilaka and district levels. • DHOs/DPHOs, all supervisors, health facility in-charges and other officers must map access to and the use of district health services. This exercise should identify the areas and groups with minimum service use and unreached areas and groups and review the reasons for this. The findings of this mapping exercise should form the basis of the district review meeting. The mapping exercise will build on previous years' assessments prepared for review and planning purposes (see section 3.5.1). • At district level review meetings, each facility must present their progress, constraints, lessons and challenges to increasing access to services for women and poor and excluded people. This will identify VDCs and communities that little use health services. Based on experience in the previous year, DHO/DPHO in consultation with other stakeholders will prepare a plan with local and district level actions to improve access of target groups to health services. This will include strategic level actions that require district and central level action such as staff retention, uninterrupted medicine supplies, confidentiality in service delivery, the continuity and efficient operation of village and vaccine clinics, and activities to enhance capacity and skills on GESI. • Following the review meetings, district level GESI technical working groups and focal persons must prepare a report that documents GESI-related efforts, achievements and issues raised in the review meeting, activities to be implemented at local and district levels to address these issues and matters to be addressed at the central level. The district level's presentation to the regional review process should be prepared based on this report.
3. Regional level	Regional health directorates should carry out the following tasks: • To prepare districts for the regional review meeting, regional health directors should send a format for DHOs/DPHOs to list geographic areas and communities that have been inadequately or not covered by district health services, and efforts made to address economic, social, cultural and institutional barriers and constraints to service access and use. • Identify GESI issues that need to be addressed through different programmes and activities in each district in the next fiscal year. Prioritization planning should be done based on this. • Review the situation of service delivery (presence of health workers, availability of medicines, information dissemination, and status of operation of clinic, camps and centres) in remote areas of the region and propose solutions to problems in these areas to the related divisions and centres. • Identify epidemic-prone areas and communities in the region and prepare a plan on the role to be played by district, region and central health authorities to carry out preparedness measures and to strengthen efforts to control illness post-epidemic. Share these plans with related districts, divisions and centres. • After completing regional reviews, the GESI focal person will prepare a comprehensive report that details the district-wise efforts through different programmes to enhance access to and the use of services by women and poor and excluded groups. This will

Level	Steps and procedures for integrating GESI concerns
	include achievements and challenges faced in delivering village clinics, vaccination clinics, camps and maternity centres as well as health facility service provision. In addition, these reports will include an action plan differentiating GESI matters that can be addressed in the on-going fiscal year and those for the next year's programme and budget.
4. Central level	The central level review meeting should include presentations on GESI made on the basis of the GESI-related suggestions and proposed programmes identified at regional review meetings. These presentations should identify ways to enhance access to health services for women and poor and excluded groups and in remote areas. The conclusion of these meetings will inform national level GESI actions. The following are the key tasks related to the central level review: • Based on the annual regional reviews each regional health directorate should prepare and present a report on its GESI related strategies and additional programmes and activities to be implemented in the following year. • Each division and centre should compile the suggestions received from regional reviews and lessons learned from their own experiences and prepare and present a review report. These reports should identify existing and new GESI-related activities to be implemented in the following year. • Annual review reports prepared by the Management Division should include GESI-related issues and suggestions presented in regional level review reports. PHCRD should ensure that these points are accurately reflected. • The Population Division, acting as GESI Secretariat, with inputs from PHCRD should coordinate the preparation of an annual GESI review report (see section 5.1). This will include a proposal for the provision of GESI-focused programmes and budgets for the coming year capturing GESI-related findings and recommendations received from regional level reviews. The GESI Secretariat will submit the proposal for approval by the GESI Steering Committee and the GESI Technical Committee in DoHS. • GESI focal persons should play an active role in incorporating the activities proposed from the annual review process in the coming year's programme and budget of their respective division and centre.

4.5 Surveys and studies

The Nepal Demographic Health Survey (NDHS), the Household Survey 2012 and the Service Tracking Survey provide information against health service indicators by wealth quintile, sex, region, age and facility-wise. The last two NDHSs (2006 and 2011) carried out further analysis by caste and ethnicity. The Nepal Living Standard Survey collects information on distance to health facilities.

It is recommended that GESI concerns are incorporated further into the carrying out of surveys and studies by:

- ToRs and concept notes taking into account GESI dimensions and issues;
- all survey and study teams including GESI expertise;
- collecting more disaggregated data to analyse access and use by different social groups and women and men;
- questionnaires integrating GESI issues and asking specific questions, as relevant, on GESI concerns such as gender-based violence, women's empowerment and caste discrimination;
- using methodologies that give women and poor and excluded people the opportunity to voice their concerns (e.g. through exit interviews with clients of different social groups and women;

and by holding focus group discussions with people of different social groups such as Dalits, women, Janajatis, Madhesis and Muslims); and

- for data compilation, information analysis and reporting to present disaggregated information and analysis of issues affecting women and poor and excluded people such as social and cultural practices that impact health service access and use.

5 ROLES AND RESPONSIBILITIES FOR IMPLEMENTING THESE GUIDELINES

The implementation of these GESI Operational Guidelines is the responsibility of all health institutions. The Population Division, which is the GESI Secretariat, should facilitate this process. The GESI institutional structure at different levels (technical working groups and technical committees) are responsible to ensure that the provisions of the guidelines are followed and implemented.

The secretariat will develop a road map for implementing these guidelines based on necessary consultations. This road map must begin with orientating TWGs and technical committees on the guidelines, identifying practical implementation guidelines that need developing (e.g. for mapping unreached and underserved areas) and identifying areas that require financial support. A log frame must be part of the road map. A review should be carried out every two years to assess implementation and to recommend any revisions.

5.1 Institutional mechanisms for implementing the guidelines

The Institutional Structure Guidelines specify which committees and TWGs should be set up at different levels. The MoHP secretary, the DoHS director general, regional directors, DHOs/DPHOs and HFOMC chairpersons chair the different level GESI committees and groups. Their key responsibilities are to ensure the implementation of these operational guidelines. Any identified constraints or issues (such as budget allocation, mainstreaming in planning, and lack of priority given to GESI targeted programmes) must be submitted to the GESI Secretariat and solutions identified. Table 4 gives an overview of the responsibilities of the different mechanisms for implementing these guidelines.

Table 4: Responsibilities for implementing the health sector GESI operational guidelines

Level	Mechanism	Responsibilities
MoHP	The Steering Committee	• Take decisions based on findings and recommendations presented by the GESI Secretariat at Steering Committee meetings. • Instruct PPICD to allocate a budget for the implementation of these operational guidelines.
	The GESI Secretariat	• Prepare an annual report on the implementation of these guidelines covering progress against the road map, issues encountered, good practices and lessons learned. Base this report on regional reports, on consultations in MoHP, divisions, centres and departments, and on field visits. • Monitor the implementation of the provisions of these operational guidelines. • Demand timely reports from technical committees and TWGs on the implementation of these guidelines. • Report to the Steering Committee about GESI achievements, lessons and challenges and facilitate decisions to address issues.
DoHS	The Technical Committee	• Direct TWGs to identify the progress and implementation of these guidelines (against road map, issues encountered, good practices, lessons) based on discussions with divisions and centres, and regional and district health authorities. • Ensure divisions and centres integrate GESI into the programme implementation guidelines they develop each year after

Level	Mechanism	Responsibilities
		approval of the AWPB and that necessary revisions in technical programme guidelines (e.g. AAMA and free health care) are made. • Instruct regional directorates and DHOs/DPHOs, after securing necessary budgets, to strengthen and expand programmes that have succeeded in improving the access and use of health services by women and poor and excluded people.
RHD	Technical working groups	• Ensure that progress on implementing the GESI operational guidelines is reported at review and annual planning meetings. • Facilitate the implementation of these guidelines at district and regional levels. • During monitoring visits assess progress of the implementation of these guidelines and inform the GESI secretariat about issues and lessons.
DHOs/ DPHOs	Technical working groups	• Orientate all district and health facility staff about these guidelines. • Ensure that these guidelines are discussed at review and planning meetings and are implemented. • Ensure that all activities and interventions provisioned for implementing these guidelines are included in annual plans submitted for inclusion in AWPBs. • Ensure that the detailed district level implementation plans prepared cover all relevant provisions of these guidelines. • Ensure that all provisions of these guidelines are integrated in services delivered at the district level. • Instruct health facilities to follow these guidelines. • Assess the implementation of these guidelines and identify lessons and good practices at periodic review meetings. Identify strengths and areas of improvement and submit an annual report to their RHD.
Health Facility	HFOMC	• Orientate HFOMC members and staff on the provisions of these guidelines. • Ensure that these guidelines are implemented during service delivery. • Twice every year review the progress of implementation of these guidelines, and strengths and gaps. Submit a progress report once a year to the DHO/DPHO.

5.2 Collaboration and partnership

a. Partnerships should be established between different stakeholders within the health sector and other sectors as addressing issues impacting women and poor and excluded people requires a multi-sectoral approach. Structural factors like low education, poor infrastructure, discriminatory social practices, women's subordination and violence against women and girls are issues that cannot be addressed by one sector alone.

b. Non-state actors are an important means of addressing structural issues of discrimination. MoHP has provisioned non-state actors as partners for addressing economic and socio-cultural barriers that constrain access to and the use of health services. The types of partner organisations differ at different levels. At the central level, partnerships should be formed with the National Planning Commission, other ministries, other commissions, national level NGOs and EDPs. Regional and district levels should partner with local government bodies, line agencies, NGOs, networks and representative organizations of different social groups. At the health facility and community levels, partnerships need to be established with VDCs, community based organizations, women's cooperatives, ward citizen forums and other user groups.

c. The modality of partnership should be according to the requirement and capacity of the partner. Modalities include technical assistance, financial collaboration, outsourcing, coordination during implementation and joint monitoring. All these modalities have been approved by MoHP and implemented over the years. Good practices and lessons exist and should be understood by health institutions forming partnerships.

d. Divisions and centres should approach the GESI Secretariat in MoHP to facilitate formal partnerships; for example with EDPs.

5.3 Capacity strengthening

a. Orientate all stakeholders on the roll-out of these guidelines.

b. Build the capacity of GESI institutional structures and their members to analyse and map information (especially for identifying the unreached and underserved), and for carrying out supervision and monitoring, and reviews and planning to identify barriers and address problems. This includes integrating solutions into health programmes, and into the systems and ways of working of divisions and centres.

c. The GESI secretariat must have the capacity to oversee GESI mainstreaming. It must be able to document the progress and areas of improvement in implementing GESI based on reports from districts and regional health institutions and divisions and centres. It should prepare case studies to show good practices and lessons learned from implementing the guidelines at all levels especially during service delivery.

d. A database should be maintained at the GESI secretariat on the composition and functional status of technical working groups and information collected and updated on OCMCs and SSUs. Information should also be collected on the number of social audits carried out, and the implementation status of social audit action plans and lessons learned. All research and studies providing information about different aspects of GESI (e.g. NDHS, further analysis of NDHS, STS, the Household Survey) should be collected and stored in an accessible way.

5.4 Budget arrangements

a. Allocate adequate budgets for the different activities mandated by these guidelines including for the capacity strengthening activities in section 5.3.

b. PPICD must arrange the required budget to implement activities necessary for moving forward the GESI agenda. Concerned divisions and centres must allocate adequate amounts for mainstreaming GESI in their programmes.

c. Budgeting activities will be more clearly articulated once the road-map is prepared for implementing these guidelines.

5.5 Monitoring, review and reporting

a. The GESI Secretariat (the Population Division) has the main responsibility for monitoring the implementation of these guidelines, in consultation with MoHP, DoHS and other stakeholders and through field visits. The secretariat must document changes brought about by the implementation of these guidelines based on reports from technical working groups, discussions with DHOs/DPHOs, health facility in-charge, health workers, FCHVs and target groups compiled into an annual report.

b. The twice yearly scheduled meetings of the GESI Steering Committee must review the progress of the implementation of these guidelines. The Steering Committee must make decisions based on consultations and different reports.

c. The DoHS Technical Committee must review progress in its twice yearly meetings and prepare progress reports with lessons learned and ways forward. PHCRD, as the GESI focal division, must facilitate this process.

d. Similar review meetings must be held by the regional and district TWGs every four months to assess the achievements of the guidelines and areas for improvement. These review reports must be submitted to RHD by DHOs/DPHOs and to the GESI Secretariat by RHDs. HFOMCs must hold review meetings every four months where the health facility in-charge presents the main conclusions of the review.

e. The DoHS annual report must include a section on the implementation of GESI mainstreaming. This information should be drawn from district level, regional level and GESI secretariat documentation.

6 MISCELLANEOUS

6.1 Additions, deletions and revisions

Any constraints, disagreements, lack of clarity and alternative procedures arising from the implementation of these operational guidelines, should be addressed to the GESI Secretariat/Population Division of the Ministry of Health and Population. MoHP can add, delete or revise points in these guidelines based on good practices and lessons learned.