NHSSP Nepal Health Sector Support Programme

Gender Equality and Social Inclusion

Capacity Assessment for Health Systems Strengthening

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Gender Equality and Social Inclusion Capacity Assessment and TA Design

An assessment of capacity building for health systems strengthening and the delivery of the NHSP 2 results framework

Contents

List of Acronyms

ANM	Auxiliary Nurse Midwife
AWPB	Annual Work Plan and Budget
BCC	Behaviour change communication
CHD	Child Health Division
CSO	Civil Society Organisation
DDC	District Development Committee
DFID	UK Aid
DG	Director General
DoHS	Department of Health Services
EAP	Equity and Access Programme
EDP	External Development Partner
EHCS	Essential Health Care Services
FCHV	Female Child Health Volunteer
FHD	Family Health Division
GAAP	Governance and Accountability Action Plan
GBV	Gender based violence
GESI	Gender equity and social inclusion
GFP	Gender Focal Person
GTZ	German Technical Aid
HDI	Human Development Index
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HR	Human resources
HRH	Human resources for health
HSIS	Health Sector Information System
IEC	Information, education and communication
JS	Joint Secretary
LHGSP	Local Health Governance Strengthening Programme
LGCDP	Local Governance and Community Development Programme
MDG	Millenium Development Goal
MNH	Maternal and newborn health
MoA	Ministry of Agriculture
MOF	Ministry of Finance
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoWCSA	Ministry of Women, Children and Social Affairs
NDHS	Nepal Demographic and Health Survey
NFHP	Nepal Family Health Programme
NHEICC	National Health Education, Information and Communication Centre
NHSP-2	Nepal Health Sector Programme 2
NHTC	National Health Training Centre
NPC	National Planning Commission

PPICD	Policy, Planning and International Cooperation Division
RAG	Remote Area Guidelines
RHD	Regional Health Directorate
RHTC	Regional Health Training Centre
RPHC	Revitalising Primary Health Care
SSMP	Support to the Safe Motherhood Programme
SSU	Social Service Unit
TA	Technical Assistance
TB	Tuberculosis
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Women
VDC	Village Development Committee
WHO	World Health Organisation

Executive Summary

Deborah Thomas and Hom Nath Subedi undertook an initial assessment of the institutional capacity and technical assistance required under the new health sector support programme to NHSP-2 in gender equity and social inclusion. The initial assessment was conducted in September with follow up work in November 2010.

Background

Gender and social inclusion have emerged as political priorities in the New Nepal, and they are priorities across Government. Although the health sector has no GESI policy, the Ministry of Health and Population's (MoHP) Gender Equality and Social Inclusion (GESI) Strategy (2009) is an important milestone, placing it ahead of most other line ministries. The Ten Point Health Policy and Programme (2006) with the introduction of Free Essential Health Care Services has ushered into the sector a stronger focus on reaching the poor and disadvantaged, and is showing results. More recently, the transfer of the Equity and Access Programme to within Government has signalled commitment to community based, rights and empowerment approaches to address the multiple barriers that poor and disadvantaged communities face in accessing maternal and newborn health care.

Institutional Challenges and Opportunities

Important strides have clearly been taken by the Ministry to respond to the new political environment and the priority now is to translate the GESI Strategy into practice. This capacity assessment found widespread acceptance of gender and social inclusion as priorities for health among stakeholders. However, internal leadership of GESI, and the institutional framework for implementing the GESI strategy are yet to be formalised. Building on the structures in place, namely the informal GESI Unit in Policy Planning and International Cooperation Division, and the nominated Gender Focal Person in Population Division, there is, we believe, the need to create a High Level Steering Committee for GESI encompassing representatives from each of the divisions within the Ministry and the Director General. Empowered to take decisions, this committee will be pivotal to translating the GESI strategy into an implementation plan connected to annual planning and budgeting, and with assigned deliverables and accountability. This will require strengthening the capacity of the GESI Unit as the focal driver of GESI and establishing GESI focal persons in each of the divisions in the Ministry and Department, within the regions and at district level to widen the GESI net and build a critical mass of change agents. We also recommend that a GESI Working Group be established at the central level to promote technical exchange and learning on GESI programming across divisions in the Ministry and Department.

Cross-cutting TA to support GESI

While the Nepal Demographic and Health Survey (2006) provides robust evidence on the extent of health inequity for key indicators by poverty, gender, caste and ethnicity, some evidence gaps remain. In particular, more detailed understanding is needed of how the

health system and services currently operate in a context of such socio-economic and geographical disparities, and therefore how inequities can be reduced. Strengthening the evidence base to direct GESI programming is a priority, as recommended in the M&E capacity assessment. This will require strengthening of the HMIS and HSIS to provide disaggregated information, and well-structured evaluations and studies that can identify the factors that contribute to health inequities, and the impact of policies and interventions on gender and social inclusion.

As a cross-cutting issue, achieving gender equity and socially inclusive services demands attention to the core health sub-systems that underpin services, particularly human resources, planning and management, health financing, procurement, and monitoring and evaluation. In the area of human resources for health, critical areas for action will, for example, include attracting and retaining staff in remote and underserved areas, attracting female doctors to the service, and increasing the numbers of women in senior positions in the health sector particularly at divisional and district levels (see HR capacity assessment). Procurement is another building block of the health system that has significant impact on access and use of services by women and disadvantaged groups. One critical bottleneck at present is the practice of single year contracting of service providing NGOs. This introduces long delays to programming, due to bureaucratic processes involved, and undermines the community mobilisation and solidarity NGOs are often engaged to foster. Moving to multi-year contracting of NGOs, where this makes programmatic sense, is strongly recommended.

While strengthening the core health sub-systems to be GESI-responsive is undoubtedly a major area of work, this needs to be balanced with progress on the ground, and the application of GESI in practice. Evidence and demonstration of the impact of GESI programming on access and utilisation of poor and disadvantaged groups needs to be put centre stage. Practical experience and evidence will be key to building political and institutional commitment to GESI, and maintaining momentum and confidence in the transformational process.

Strategic Focus of TA

At implementation level, the priority is to support high profile Government-led GESI initiatives to be successful and to draw strategic, programmatic and practical lessons from them. Key amongst these are: the piloting of Social Service Units; the roll-out of one-stop crisis centres for victims of gender-based violence; the scaling up of the Equity and Access Programme to 15 districts; the strengthening of social protection measures for the poor and disadvantaged such as Free EHCS and Aama; and the operationalisation of the remote area guidelines and local area planning. Supporting these initiatives will call for high quality IEC/BCC products and services.

The findings of the GESI capacity assessment lead us to propose a capacity development strategy that aims to strengthen the systems, structures and capacities of the health sector to operationalise the GESI strategy in a systematic and coordinated manner, and achieve the health gains for poor, vulnerable and disadvantaged populations that lie at the centre of Government policy. We believe this will be best achieved by building on government initiatives and driving forces for GESI and exploiting opportunities for quick wins that can

feed into a virtuous circle of building commitment and capacity. We see several core pillars of work:

- Putting in place the institutional structures to drive the strategy forward
- Building a critical mass of champions and allies to provide leadership and direction
- Building ownership of GESI across and down the sector by forging consensus on what gender and social inclusion means for the health sector and the values that underpin it
- Building the capacity and willingness of providers and managers to transform services to be more gender equitable and socially inclusive
- Demonstrating the practical application of GESI principles into programming and delivery through a small number of high profile initiatives that have the potential to make a significant impact, and by doing so, sustain and build the interest of programmers, managers, and service providers.

Our proposed approach for supporting government is to provide strategic and technical support in the areas of GESI systems strengthening, equity and access programming, and BCC technical design and production. Through dedicated GESI experts and systems strengthening experts in the areas of policy and planning, human resources for health, procurement, health financing, and monitoring and evaluation, the NHSSP technical team will support implementation of the GESI strategy.

Proposed Capacity Development Strategy

We propose dedicated long term GESI technical assistance to work with counterparts in the MOHP and DOHS, supported by short term TA. Additional GESI support to the five regional health directorates is envisaged. The Regional Assessment will provide recommendations on working modalities, but it is anticipated that GESI support will provide GESI/BCC technical support and leadership to regional teams, districts and below, and support coordination with local government.

The **Gender and Social Inclusion Adviser** will work at the Ministry level. Her/his focus will be on mainstreaming GESI into policy and planning; strengthening the GESI Unit and the institutional mechanisms for leading and coordinating GESI action; supporting the integration of GESI into health systems building through lead advisers for human resources, procurement, health financing and monitoring and evaluation; raising awareness of GESI and building the capacity of policy makers, managers and service providers; and guiding and supporting GESI evidence generation and application. Specific streams of work include:

- Supporting government to establish an effective institutional framework for GESI in the medium term, and putting in place working arrangements for GESI leadership and coordination in the short term
- Supporting the GESI Unit to lead the development of an implementation plan to translate the GESI strategy into prioritised actions with accountability and deliverables
- Working with sub-system specialists to mainstream GESI in HRH, finance, planning, procurement, monitoring and evaluation

- Supporting government and UNFPA to undertake a GESI diagnostic and capacity needs assessment across the sector and to develop a GESI capacity building plan
- Supporting government to develop innovative and influential sensitisation and awareness raising programmes for policy makers and senior managers, and supporting the delivery of such programmes as necessary
- Supporting NHTC, regional training centres and other capacity building organisations to design GESI awareness-raising and capacity building programmes for health workers and managers using appreciative methodologies
- Supporting NHTC and professional bodies to integrate GESI into in-service and pre-service training
- Facilitating coordination on GESI within the ministry and between external stakeholders including other ministries, CSOs and EDPs
- Providing strategic and strong analytical inputs and guidance to the development of robust gender and social inclusion indicators in the health evidence base in order to ground policy development, programming, and staff mobilisation and capacity development
- Development of high quality dissemination products.

The **Equity and Access Adviser** will be based at the DoHS level with the task of supporting government to apply the principles of GESI into programming and service delivery. To be effective, the Adviser will focus on a limited number of high profile GESI programme initiatives. S/he will also support and guide the provision of short term technical assistance to NHEICC for the development and production of quality IEC/BCC products in selected priority areas, and strategic short term support to assist NHEICC to review the impact and direction of its programme of work.

The priority of the Equity and Access Adviser in the immediate future will be to sustain and strengthen the Equity and Access Programme (EAP), which is a flagship GESI programme. The transfer of EAP into government in 2008 was a milestone, but delays caused by the processes of contracting and budget release, and the limited support and supervision available has impacted on the quality of implementation. Much is at stake to ensure EAP delivers to its potential by strengthening the quality of its implementation, getting back to the rights based and empowerment principles on which the model is based, and establishing strong monitoring and evaluation to produce the evidence needed to continue to build political and institutional support for GESI demand side programming. This will require hands-on support to Family Health Division in their management of the programme.

Specific tasks include:

- Management support to the contracting process and a shift to multi-year contracting
- Technical support and supervision to district implementing NGOs, including sharing of lessons learned from earlier cycles, and orientation training
- Technical and practical support to the D/PHOs and Public Health Nurses that provide local support, management and coordination of the programme
- Technical and practical support to NHEICC in the design, facilitation and development of locally appropriate complementary IEC/BCC materials
- Technical and practical guidance to government in NGO monitoring and learning

- Support to the department, regions and districts in EAP evidence gathering and lesson learning
- Technical support for the broadening out of EAP to include broader public and primary health care, and social accountability for health issues
- Forging linkages with MoLD GESI and LGCDP's social mobilisation initiatives
- Advocacy and dissemination of EAP achievements and learning across the sector and to external stakeholders.

In addition to EAP, the Equity and Access Adviser will support a small number of other high stake, priority equity and access, and social accountability initiatives. S/he will work closely with NHSSP technical advisers for EHCS, MNCH, health financing, monitoring and evaluation, and training. Key areas will include support to:

- The reach of Free EHCS to poor and disadvantaged groups who are not currently accessing their entitlements through, for example, strengthened evidence gathering; district and local assessment and planning; development of targeted BCC and community initiatives; and strengthening of social accountability mechanisms
- Strengthening social auditing of Aama in areas without EAP
- The design, testing and implementation of one-stop crisis centres for GBV victims, and of coordinated multi-sectoral prevention and response programmes
- Piloting of Social Service Units
- Operationalisation of the remote area guidelines, and development of gender and socially inclusive area planning tools
- The Revitalising PHC Division to develop urban health models that include and protect the rights of women, the poor and the socially excluded, and incorporate their specific needs in the design
- The design and piloting of initiatives to increase access of the poor and disadvantaged to family planning; and the monitoring and evaluation of new approaches
- Strengthening of HFMCs to be more gender and socially inclusive and active in the emerging federal and decentralised governance structure.

We recommend that **Regional GESI/BCC Technical Support** be provided in each of the Regional Health Directorates. Experience shows that Kathmandu managers and technical teams are too removed from districts to provide the practical support and technical guidance that district teams need. This is particularly the case for equity and access, which is community based, and often involves working with CSOs. Moreover, the spirit of GESI requires a mindset shift, the introduction of new working practices, priorities, accountability relationships, and values and attitudes. Regional GESI/BCC technical support to foster the values change, and build capacity to introduce new GESI responsive working at district level and below, will we believe be vital.

Modalities for provision of regional TA will be recommended in the Regional Assessment. However, it is anticipated that GESI/BCC technical specialists will work to build GESI and BCC technical and supervision capacity among the regional teams. They will technically guide, support and monitor the integration of GESI into district planning, management and coordination and the implementation of BCC, equity and access, and social accountability

programmes, approaches and pilots. They will provide GESI and BCC capacity building support to the regional training centres and district training teams. Regular communication between the two Kathmandu based GESI advisers and the regional GESI support, will provide opportunities to feed back progress, bottlenecks, opportunities and learning.

The proposed portfolio of support will reinforce efforts to nurture champions across the sector, broaden ownership of GESI, and promote closer working across vertical divisional structures. Government counterparts in each area of work will be essential. Through the proposed cross-sector GESI Working Group and augmented attention to GESI through government machinery, it is expected that the flow of information, communication and learning on GESI from the grassroots up to the programming and policy levels and back down will be enabled. This will assist in building the evidence base and know-how to make services more equitable, accessible and effective, and to foster the understanding, capacity and commitment for GESI as a value of the health system.

Summary Matrix of Issues, Recommendations, Proposed Technical Approach and Related Other Support

	Issues	Recommendations	Technical assistance approach	Other support
1.	**Policy Level:**			
1.1	The GESI strategy is an important first step, a sector wide GESI approach and is comprehensive for mainstreaming.	- Take a systematic and structured approach to implement the GESI Strategy. - Development of an implementation plan with cost and monitoring framework that allocates responsibility. - Provision of committed FA for GESI each year.	- LTTA and if necessary (STTA) for development of the GESI implementation plan. - LTTA to support in GESI plan implementation.	- Workshops and other support coordinated within MoHP and with other stakeholders.
1.2	**Social Service Units** (SSUs) at central, regional, zonal and major district hospitals was introduced as a concept in the GESI strategy.	- Piloting, monitoring and documentation of learning of Social Service Unit in selected hospitals. - Develop an appropriate mechanism for building ownership of implementation.	- LTTA and if necessary STTA for facilitation, monitoring and documentation of piloting process.	- FA will cover implementation budget.
1.3	Quota system introduced that allocates 45% of vacancies to target groups (33% for women; 27% to Janajatis; 22% to Madhesis; 9% to Dalits; 4% to remote areas; 5% to the disabled).	- Make changes in the Health Service Act to apply the new decision/policy in implementation.	- LTTA to assist MoHP with necessary input.	- No logistics necessary.
1.4	GESI Institutional structure yet to be strengthened	- Strengthen intra and inter-sectoral coordination for synergy and to create GESI structure. - Establish a High Level Steering Committee for GESI in Health.	- LTTA to facilitate the process	- FA to cover training costs.

		- Strengthen the capacity of the GESI Unit in PPICD. - Form GESI Technical Working Group to include stakeholders from MoHP and DoHS. - Nominate GESI focal person in each division. - Include GESI section in DOHS sub/committees as appropriate.		
	Issues	**Recommendations**	**Technical assistance approach**	**Other support**
1.5	Develop a common understanding of what GESI means for the sector, and how systems, services, and individuals need to change.	- Build a critical mass of champions and allies to lead and take decisions. - Build ownership and consensus of what GESI means for the health sector. - Build capacity and willingness of managers and providers to transform services.	- STTA to carryout GESI capacity needs assessment and develop capacity building plan with UNFPA. - LTTA to design GESI awareness raising for policy makers/ strategic actors. - STTA to develop capacity building training for different teams of health providers	- FA to cover training and capacity building costs.
1.6	Perceived drifting out of women in senior positions across the sector.	- Promote women leadership in the decision making process at all level, particularly at divisional and district level. - Agree a target of % of women leaders in decision making posts at each level.	- LTTA to lobby to support policy and procedure development. - Linked with HR.	-
1.7	One year contracting of NGOs for equity &	- Collect evidence from other ministries about multiyear contracting.	- LTTA to gather evidence and lobby as	-

	access programming is inefficient and hinders community programming and social empowerment	- Develop a policy provision of multiyear contracting for service providing civil society organisation.	appropriate. - LTTA to organise meetings. - Linked with Procurement.	
1.8	Retention challenges and frequent transfer of staff in remote and underserved areas.	- Link with HR recommendations.	- LTTA to give input to HR TWG. - Linked with HR.	-
1.9	HMIS does not include social disaggregation.	- Support piloting of HSIS to demonstrate feasibility and value of social disaggregation.	- LTTA to support social disaggregation with M&E	-
1.10	Evidence base on GESI in health is patchy with weak evidence of whether resources and benefits are reaching the poor and disadvantaged.	- Develop GESI M&E plan to understand how services can become more GESI and support more equitable health outcomes. - Analyse the current evidence to identify what works in different contexts and to justify higher expenditure to reach target groups. - Develop evidence to support programming and approaches tailored to specific types of geographical and social contexts.	- LTTA to work with M & E for GESI monitoring plan - LTTA to coordinate with GESI evaluative studies across ministries.	- Impact and process studies to be commissioned under FA.
	Issues	**Recommendations**	**Technical assistance approach**	**Other support**
2.	**Implementation level:**			
2.1	There is strong awareness of the barriers faced by different social groups in accessing health services and	- Provision of dedicated or nominated GESI focal persons in each division. - Formation of technical working group of GESI focal person.	- **Please see above under 1.5** - LTTA to develop GESI capacity	- FA to cover training and capacity building inputs.

	the existence of harmful traditional practices, but need to develop common understanding and evidence base about targeted programming for GESI and how non-targeted services can become more gender and socially inclusive.	- Build a critical mass of champions and allies to lead and take decisions. - Build ownership and consensus of what GESI means for the health sector. - Build capacity and willingness of providers and managers to transform services.	building plan, - STTA to design of GESI awareness raising for policy makers/strategic actors, - TA to develop capacity building training for different teams of health providers.	
2.2	Implementation and institutionalisation of **Equity and Access Programme (EAP)**	- Gather evidence base and promote cross learning - Demonstrate practical application of GESI through EAP and other high profile initiatives that can demonstrate impact, produce tangible results & build political and institutional commitment to GESI. - Strengthen GESI/EAP capacity at all levels (central, regional and district). - Develop guideline to build the capacity of central, regional and district staff to oversee and support EAP implementation through training of trainers.	- STTA for rapid assessment of EAP implemented. - LTTA/STTA support to develop guideline for capacity building. - LTTA/STTA support to conduct ToT for appropriate group of people. - LTTA/STTA support for NGO capacity building. - LTTA to build regional and district capacity for EAP implementation.	- FA to cover workshops and other mobilisation costs. - FA to cover capacity building training.
2.3	**Met need for contraceptives** across all social and economic groups yet to be	- Develop more targeted programming and local initiatives to enable men and women from different communities to overcome	- STTA support to carryout detail diagnosis to identify the nature of the	- FA to implement programme approaches.

	increased.	the supply and demand side barriers they currently face – linking with CHD and FHD.	constraints and barriers faced in accessing and using contraceptives. - LT/STTA to develop responsive strategy based on the diagnosis. - LTTA to ensure EAP addresses the gaps in their operational area. - Linked with EHCS.	
	Issues	**Recommendations**	**Technical assistance approach**	**Other support**
2.4	**National Action Plan on Gender Based Violence** anticipates MOHP in setting up one-stop crisis centres for GBV victims.	- Conduct desk review to generate evidence base. - Pilot implementation of one-stop crisis centres for GBV victims. - Design and pilot GBV prevention programmes in coordination with other ministries and CSOs. - Integrate GBV prevention activities in community based programmes like EAP.	- TA to support desk review of one – stop crisis centres for GBV. - LT/STTA to support design and piloting the one – stop crisis centres. - LTTA to support development of GBV prevention package. - Linked with EHCS	- FA to cover Implement ation cost.
2.5	The enabling environment is yet to become conducive to **Health Facility Management Committees** (HFMCs) realising their full potential as a vehicle for	- To mainstream GESI into the strengthening of local health governance and HFMCs through review and development of existing training package.	- LTTA to support in developing GESI package to be integrated into HFMC strengthening process. - LTTA to support repositioning of HFMCs as	- FA to cover costs of printing package.

	local governance. In the absence of decentralisation, and locally elected government, they function without authority over finance or the staffing of the health facility.		governance environment opens up. - Linked with EHCS.	
2.6	Operationalise and expand the remit of the **Remote Area Guidelines for Safe Motherhood** to focus both on broader EHCS and targeting both geographically, socially and economically disadvantaged communities.	- Ensuring GESI and social accountability are embedded in the revision and implementation of RAG for EHCS. - Develop and undertake periodic monitoring of remote area programming.	- LTTA to provide facilitation and regular monitoring support. - LTTA to support government to ensure GESI and social accountability are embedded in the implementation of RAG. - Linked with EHCS	-
2.7	**EHCS:** Proportion of targeted groups among inpatients has risen from 15% in 2007 to 34% in 2009. However the disaggregated picture shows that, utilisation of Free EHCS by targeted and vulnerable groups is still low in some districts.	- Continue to ensure and strengthen how GESI and social accountability are embedded in the design and implementation of Free EHCS including Aama. - A rigorous impact assessment is required to understand who has benefitted from the policy, and strategic and programmatic implications.	- LTTA/STTA for impact assessment study - LTTA for ongoing support for EHCS monitoring. - LTTA support in developing specific local area planning to address low take-up by targeted groups as identified in that area.	- Linked with Health Financing and Monitoring and Evaluation. - FA to cover impact study costs. -

	Issues	**Recommendations**	**Technical assistance approach**	**Other support**
2.8	Development of urban health policy is ongoing but implementation plan yet to be developed.	- Approval of urban health policy - Development of urban health implementation plan. - Ensuring GESI & social accountability are embedded in the design and implementation of urban programmes.	- LTTA to support in development and implementation of urban health implementation plan. - Linked with EHCS	- FA to cover implementation
2.9	Scope to strengthen social accountability mechanism in districts (such as through public hearings) yet to be identified.	- Map and review existing social accountability tools and approaches and work with stakeholders to strengthen space for social accountability - Review and strengthen public private partnership process in social auditing.	- STTA/LTTA to review the social accountability mechanisms in use and scope for public private partnership involvement - LTTA to support the social auditing and monitoring process. - Linked with procurement	- FA to implement social accountability in partnership with CSOs
2.10	Development of social health insurance policy that is GESI responsive	- Review and develop social health insurance models that is GESI responsive	- STTA for desk review. - ST/LTTA to support design and piloting process to embed GESI - Linked with Health Financing	-
2.11	The institutional environment for health communications and BCC yet to be	- Conduct formative research o Assess the effectiveness of IEC/BCC media	- STTA (international input) to undertake formative	

	strengthened.	and materials developed by NHEICC o KAP study to find-out existing health seeking behaviour. -	research. - TA to support regional workshop facilitation. - LTTA for strategic support	
2.12	Technical skills/capacity to design, produce and localise quality IEC/BCC media and materials is still to be strengthened.	- Design, production and localising of quality IEC/BCC materials in agreed priority GESI related areas such as: o dissemination and awareness-raising of entitlements, including Free EHCS and Aama, o awareness raising and promotion of social auditing, o awareness raising against gender based violence, and o dissemination of targeted family planning and SMNCH messages etc.	- Provision of issue based STTA for IEC/BCC media/materials design and production. - TA for IEC/BCC localising of media and materials at regional level. - Support RHD and Districts for targeted public dissemination of information through localisation. - TA to build regional and district capacity in implementation of GESI related IEC/BCC.	- FA to cover study cost - Production budget is planned under FA. - FA to cover costs of localising.
	Issues	**Recommendations**	**Technical assistance approach**	**Other support**
2.13	SMNCH BCC Technical Sub-Committee (as a means of harmonising messages across agencies) to be further	- Strengthen intra and inter organisational coordination through the strengthening of the BCC Sub- Committee.	- Support part time TA as committee secretary - TA for strategic support - Linked with EHCS plan	-

	strengthened and functionalised.			
2.14	Micro-planning piloted in two low performance districts in order to improve child and family health - this could provide the means for locally-tailored programming to address GESI and to design access promoting interventions.	- Integration of GESI into micro planning implemented by CHD and FHD - Expand micro planning process for reaching under-served population. - Ensure targeted BCC interventions to the unreached population.	- ST/LTTA support to undertake reviews and evaluations to learn what works in different social, geographical and economic and supply contexts. - LTTA support RHD and Districts for targeted public dissemination of information through localising of IEC/BCC media and materials. - Linked with EHCS and M & E	- FA to cover study costs.
2.15	Willingness to mainstream GESI in service delivery.	- Integration of GESI concept in in-service curricula to be undertaken - Technical skills for GESI facilitation to be upgraded.	- ST/LTTA to support design and integrate GESI package in each of the in-service trainings. - Provision of GESI training to the trainers/facilitator	- FA to cover implementation of GESI in in-service training. - FA to cover ToT training costs.

1. INTRODUCTION

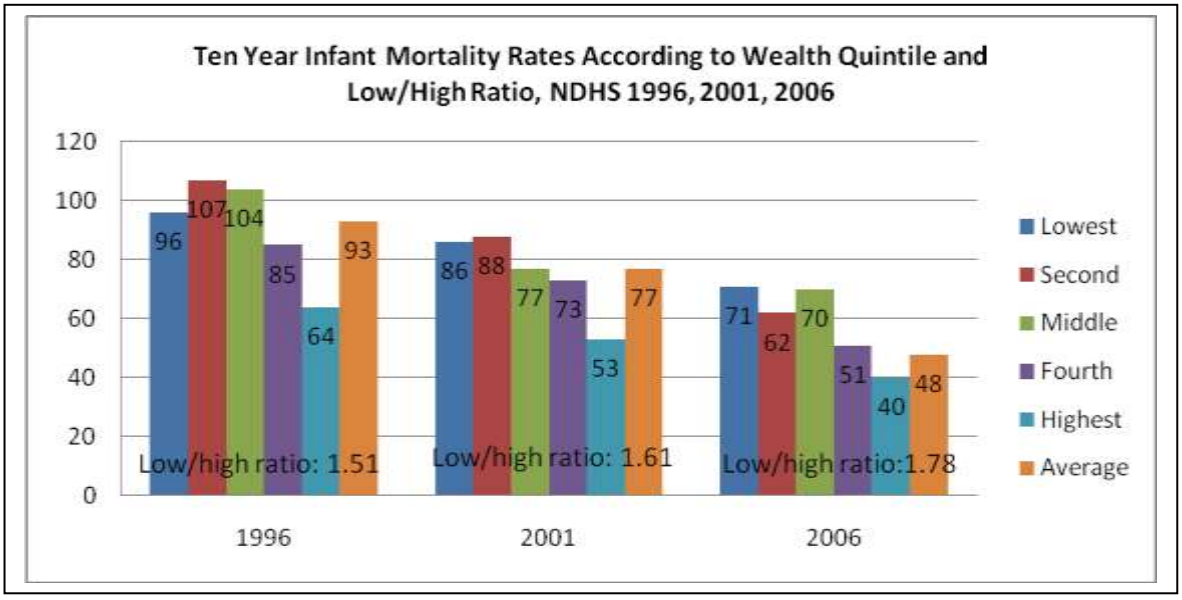
Gender Equity and Social Inclusion (GESI) are political priorities in the New Nepal, across government ministries and specifically for NHSP-2. Such a political platform opens up tremendous opportunity to make significant strides towards a more inclusive health sector; an opportunity that must not be missed.

Since *Andolan* II (April 2006), important developments, such as the introduction and expansion of Free Essential Health Care Services (EHCS), have been made in health in response to the new political realm and the commitment to greater social inclusion. At the strategic level, despite the absence of a strong policy directive on how to translate GESI into government systems, the Ministry of Health and Population (MoHP) took the initiative to develop a Gender Equality and Social Inclusion Strategy (December 2009), as a platform for mainstreaming GESI into the health sector. Although gender mainstreaming has been on the government agenda for some time, the Prime Minister's leadership of the Gender Based Violence (GBV) initiative launched this year has raised the political profile of this issue and reinvigorated sector level attention.

This capacity and Technical Assistance (TA) design assessment was thus undertaken in a context of political readiness for GESI. Key stakeholders were consulted in the central MoHP, Department of Health Services (DoHS), Central Regional Health Directorate (RHD), National Planning Commission (NPC), Ministry of Women, Children and Social Affairs (MoWCSA), Ministry of Local Development (MoLD), Ministry of Agriculture (MoA), External Development Partners (EDP) and civil society organisations (see Annex 3 for details). During a field visit to Makwanpur District, officers of the District Development Committee (DDC) were consulted, and Makwanpur District Hospital visited. A comprehensive range of documents was reviewed.

2. INSTITUTIONAL AND TECHNICAL ASSESSMENT SITUATIONAL ANALYSIS

2.1 Status of Health Outcomes and Appropriate Policy and Strategies



Evidence from the 2006 National Demographic and Health Survey (NDHS) highlights disparities in health outcomes in Nepal based on sex, caste/ethnicity, poverty/wealth, and geographical area. Despite impressive gains made at the national level on infant, child and maternal mortality, disaggregated data shows continuing, and in some cases, increasing disparity by wealth and social group. Analyses of NDHS data from 1996, 2001 and 2006 for infant and child mortality show the gap between the poorest and wealthiest (measured as a ratio) has increased over time[1]. While utilisation of maternal health services has increased significantly for all wealth groups, we also find that, for some services, the gap in levels of use has widened between the poorest and wealthiest.

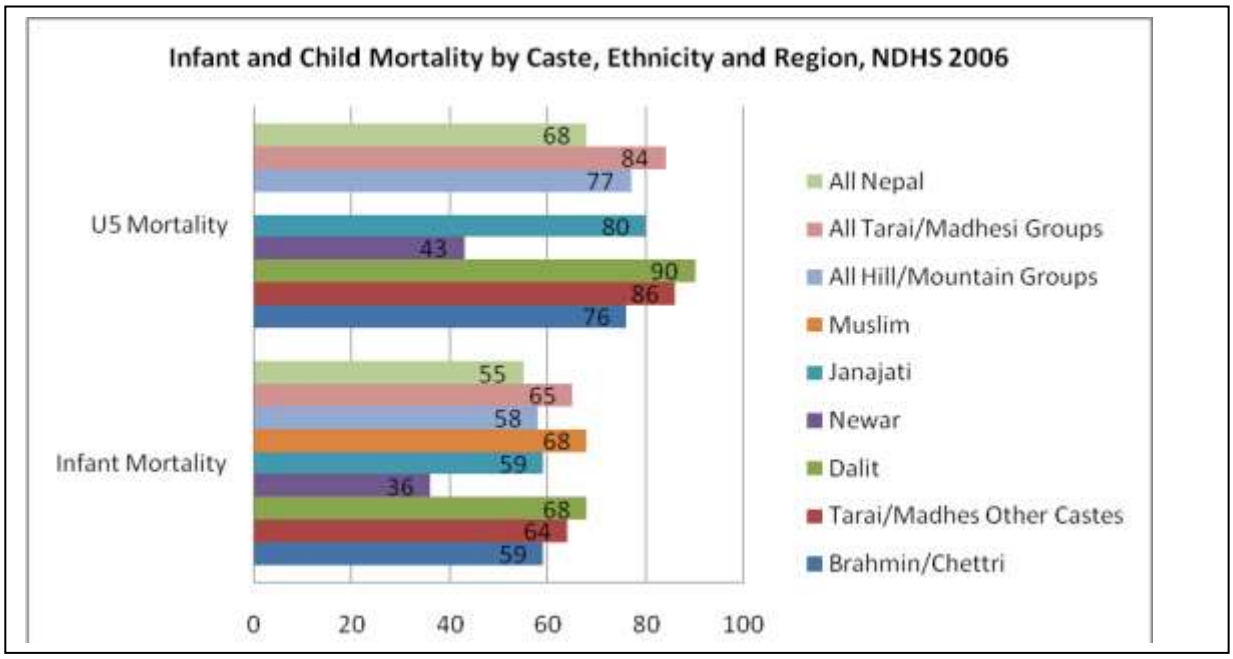
Table 1: Gap between the poorest and wealthiest for selected indicators, NDHS 1996, 2001, 2006

		NDHS		
		Lowest quintile	**Highest quintile**	**Low/High ratio**
Infant mortality rate	1996	96	64	1.51
	2001	86	53	1.61
	2006	71	40	1.78
U5 mortality rate	1996	156	83	1.89
	2001	130	68	1.92
	2006	98	47	2.09
Tetanus Toxoid	1996	29.1	70.5	0.41
	2001	37.1	78.3	0.47
	2006	48.9	89.9	0.54

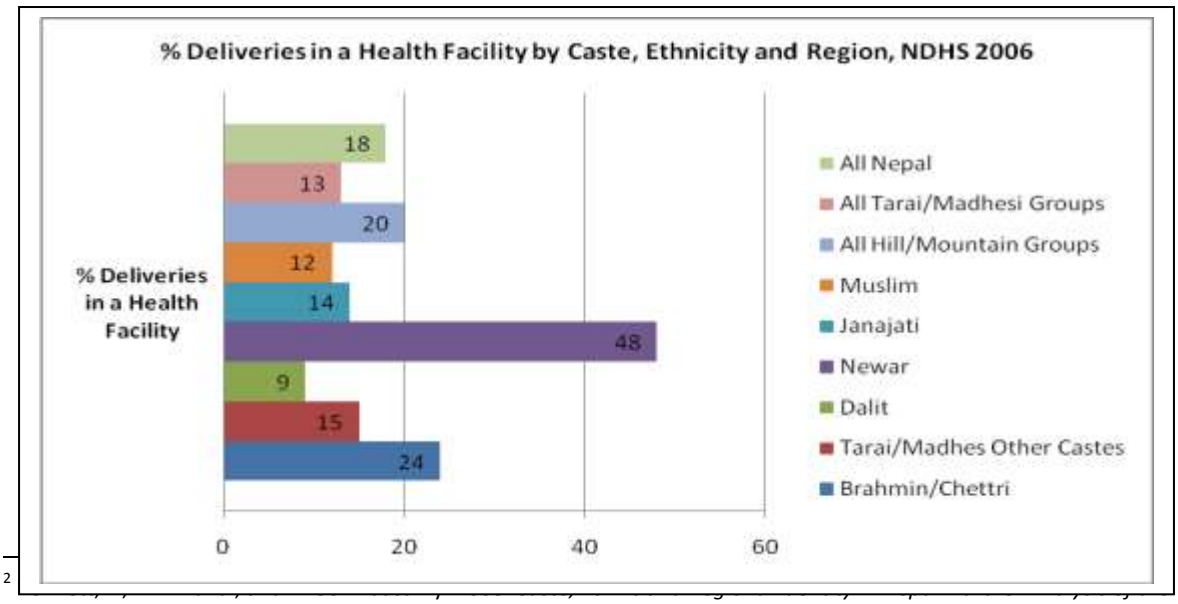
[1] Johnson, K. and S.E.K. Bradley. 2008. *Trends in Economic Differentials in Population and Health Outcomes: Further Analysis of the 2006 Nepal Demographic ad Health Survey*. Calverton, Maryland, USA: Macro International Inc.

Delivery in a public facility	1996	1.3	24.3	0.05
	2001	1.9	27.4	0.07
	2006	3.0	41.2	0.07

Analysis of NDHS 2006 data by caste/ethnicity and region[2] demonstrated the complexity and magnitude of disparities for maternal and child health.



Disaggregated analysis has provided indisputable evidence of the impact of social exclusion on health and made important contributions to advocacy. The disadvantage faced by Dalit, Muslim, disadvantaged Janajati, and Madeshi populations in accessing services, and the under-utilisation in the Tarai is now widely accepted in the MoHP and DoHS, and recognised as a cause for concern. While there is little difference in infant and child mortality by sex, the high rates of maternal mortality and poor access to reproductive and maternal health services highlight the challenges to reducing gender inequities in health.



2 *2006 Nepal Demographic ad Health Survey*. Calverton, Maryland, USA: Macro International Inc.

In addition to NDHS data, programme and project related studies, such as those from the Equity and Access Programme (EAP) have added to the evidence base. However, in the main, understanding of the underlying causes of disparities in health service utilisation, and how gender and social exclusion plays out through the functioning of the health system and services is piecemeal. Building up the evidence base on GESI is a priority. During this assessment, leading figures in the MoHP and DoHS specifically highlighted the importance of a GESI needs assessment and status report. As a response to this, discussion is currently underway to expand the terms of reference of a UNFPA sponsored gender audit to a GESI diagnostic with additional support from NHSP-2 and possibly other EDPs.

The most important **policy** related to GESI is the Ten Point Health Policy and Programme (2006). Although the sector has no GESI policy, the Ministry's development of the Gender Equality and Social Inclusion **Strategy** is an important milestone, placing MoHP ahead of most other line ministries. The strategy takes a sector wide approach and is comprehensive in its mapping of core areas for GESI mainstreaming and activity. Elements of the strategy are being carried forward through ongoing programmes that were previously addressing access, equity and gender issues, and the scope of work of the newly formed Revitalising Primary Health care (PHC) Division is likely to push forward on several other areas. However, the strategy includes no prioritisation or sequencing of activities, nor is there an implementation plan, and it is currently detached from the planning and budgeting process that drives programming and delivery. Addressing these gaps is recognised by senior officials in the Ministry as a priority if the strategy is to be translated into practice.

Although the strategy was developed through a consultative process within the MoHP, some key informants interviewed felt they had not been included. EDPs were involved in the formulation, but civil society less so. This lack of broad based participation in the strategy formulation has contributed to reduced levels of ownership in the central MoHP and DoHS divisions, despite widespread interest and concern for GESI.

The strategy took more than two years to emerge after initiation of the formulation process, a reminder of the challenges of working at policy level on cross-cutting, politically challenging agendas, even when there is very strong political support. While the strategy is a foundation from which to plan and operationalise GESI within the sector, building momentum and support, the fact that it has not been approved by the Cabinet means it is perceived by senior MoHP officers to be less embedded among policymakers, less robust to political change, and have less leverage across ministries. There may also be implications for funding allocations. Changing this status will require Cabinet approval of the strategy. More influential would be a GESI state policy developed by NPC as a framework for GESI sector strategies. Until the GESI TA is in post it is difficult to weigh up the many factors to determine whether reopening the strategy and seeking Cabinet approval will add commensurate value. Our current assessment is that the GESI strategy is the platform for moving forward, and despite its limitations the focus of NHSP-2 must be to create the

structures, commitment, understanding and capacity to operationalise the strategy to maximum benefit.

2.2 Specific Institutional Environment

The evolution of GESI in health, driven as it has been by high political agendas, has yet to find the strong internal leadership required. As a consequence, the institutional structure for translating the strategy into practice, and for communicating and coordinating on GESI across divisions and layers of the organisation, have not been developed. Clarifying and activating leadership of GESI across Government and within MoHP is a prerequisite for achieving the transformational reforms at the heart of government policy. There are champions within the Ministry and Department, but at least some feel too overloaded to take on the leadership role, the mandate for which has anyway not yet been clarified.

In the short to medium term, until the institutional responsibility for GESI has been assigned and leadership resolved, senior officers in the Ministry feel that a high level steering committee on GESI, with representatives from each of the divisions and the Director General (DG) of DoHS, is needed to provide leadership, direction and coordination. The chair and member secretary will need to be appointed by the Minister. Possible candidates for this position, which will carry most of the responsibility and workload, include the Chief of the Policy, Planning and International Cooperation Division (PPICD) and the Under Secretary of Human Resource and Management Resource Division. The former is currently Chief of the informal GESI Unit in the Ministry, and from an organisational perspective a primary candidate, as the head of a technical division. The latter previously led the creation of a GESI Unit in the MoLD and was actively involved in the formulation of the MoHP GESI Strategy. A third possibility is the Joint Secretary of Population, who has recently been nominated the Gender and Gender Based Violence Focal Person. Expanding this remit to include gender and social inclusion makes conceptual sense but has implications for the location of the informal GESI Unit, which is currently within PPICD. Given the nature of GESI, assigning leadership responsibility to a technical division seems to make best sense.

Although officers interviewed were of the view that GESI is a priority, generally a need was reported for greater understanding of what GESI means for the sector, and how the systems, services and individuals need to change to become more gender and socially inclusive. Everyone interviewed felt capacity development was a high priority, and no overt resistance to the goals of GESI was found. From our discussions, GESI is perceived as a mainstream agenda for the long term, and although people may not have internalised the goals, we found considerable interest in learning more.

The broader political environment and anticipated political changes are hindering the formalising of the institutional framework for mainstreaming GESI, and allocating responsibility among senior management. At the department level, the funding delays due to delayed approval of the annual budget is holding back planned GESI activities and dampening scope to launch new initiatives.

Inter-ministerial coordination on GESI initiatives needs to be strengthened. NPC reported the existence of a Social Inclusion Commission but noted that, as a new agenda, it is not yet very active. The Dalit's Commission and the Women's Commission are important bodies for the Ministry to coordinate and work with. An Inter-Ministerial Committee, headed by the Chief Secretary, is driving the GBV initiative, supported by the GBV Office within the Prime Minister's Office, which is shortly to launch a GBV Fund. A National Monitoring Committee for GBV, comprising government and Civil Society Organisations (CSO), has also been created, with three CSOs on this committee to be tasked with monitoring the local level response to GBV and reporting back to the Inter-Ministerial Committee.

Inter-ministerial leadership and coordination on gender equity more broadly rests on quarterly meetings of the Gender Focal Persons (GFP) nominated across Government and organised by the MoWCSA, as the lead gender ministry. MoWCSA has provided some capacity building to GFPs, and is in the process of developing terms of reference for this position, raising it from 3rd class to Joint Secretary (JS) level. The MoWCSA has limited capacity to provide technical support to gender mainstreaming in other sector ministries. MoWCSA and MoA have gender action plans, but no explicit plans, programmes or projects for social inclusion. No gender action plan has been developed for the MoHP. Raising the GFP to Joint Secretary level will open up the potential for stronger internal advocacy and leadership. Supporting the Gender and Gender Based Violence Focal Person to spearhead gender will be an important input of NHSSP.

MoLD created a GESI Section in its General Administration Division some 18 months ago, and a GESI Policy was approved earlier this year, although the level of coordination on GESI across the Ministry is unclear and seems to be primarily informal. The GESI Section has an annual work plan and receives funds from several UN bodies, including UNIFEM and UNDP. However, as an administrative unit, with limited technical capacity, the section relies on consultants to undertake technical tasks. Currently it has consultants in the field working on modalities to operationalise GESI through MoLD. Challenges reported by section staff include the limited technical capacity, delays in building consensus across the Ministry, lack of inter-ministerial coordination, and implementation difficulties resulting from the lack of elected local government. One warning flagged up was the risk of the Section becoming isolated and a "dumping ground". Activities in the GESI Section's annual work plan include the formation of "gender equality watch groups" in all VDCs and municipalities, gender responsive budgeting pilot in 10 districts, funding of local media for civic education on gender equality and human rights, development of a GESI operational manual for districts, and supervision and monitoring of para-legal committees.

The MoLD Local Governance and Community Development Programme (LGCDP) will be a key vehicle for mainstreaming GESI at the local level. There are synergies to be exploited between LGCDP's social mobilisation approach, targeting marginalised and disadvantaged groups through social mobilisers linked to local civil society organisations, and the MoHP Equity and Access Programme (EAP). The LGCDP community awareness centres and block grants are key enablers for the social mobilisation and empowerment process, with the flexibility to respond to the priorities of disadvantaged groups, and potential, as pillars for health mobilisation, to increase the reach of the health sector to those currently not benefiting. The block grants and planned capacity development initiatives for service

providers could help strengthen local health services, and increase accountability relationships between health managers and providers and Village Development Committees (VDC) and District Development Committees (DDC). Thus, from the health sector side, there is clear value in nurturing and building on LGCDP structures.

At district level, coordination with LGCDP will be through the LGCDP District Facilitator. The District Social Mobilisation Coordination Committee and the Social Development Officer in the DDC are also important agents. Supporting district health management to engage and coordinate with LGCDP, thus accessing its benefits and resources, is a role for the regional health directorates, and we believe, an area for NHSSP to facilitate. The LGCDP and MoLD structures, human resources and social mobilisation activities will be important contributors to establishment of an enabling environment at the local level, in which the health sector can move towards delivering more gender and socially inclusive and accountable services. At the national level, there is scope for improving coordination between MoLD and MoHP on GESI through participation in thematic groups, and through the more specific Local Health Governance Strengthening Pilot Programme (to be discussed more fully later). Advocacy is needed to facilitate improved coordination across ministries and departments on GESI programming, learning and impact, through an inter-ministerial forum.

UNIFEM are supporting the Central Bureau of Statistics to develop a GESI strategy and manual and providing technical support to the preparation of the questionnaires for the forthcoming census.

Civil Society Organisations (CSO) have important experience and expertise on which to draw in making and holding political space for GESI at national and local levels, this includes for example the national federations representing Dalis and Janajatis, respectively. International and national CSOs have vital roles to play in advocacy, evidence building, networking, technical assistance, and the implementation of community based GESI initiatives, such as social mobilisation, women's and community empowerment, and social accountability. They do however have capacity development needs. A major limitation to the potential contribution of CSOs to the health sector generally, and GESI activities specifically, is the practice of issuing only single year contracts, even when activities are planned for several years. The resulting delays and break in implementation negatively affect programme outcomes and community confidence, and undermine Government-CSO relations.

Developing Government-CSO relations and trust will be an important area of effort during NHSP-2. Improving dialogue and creating forums for discussion between CSOs and the health sector will be an important arena for connecting GESI in health to the broader social transformational process in Nepal, and for encouraging civil society participation and monitoring of progress in the health sector. At a more practical and implementation level, there is a need to clarify the challenges for CSOs in taking on a role in strengthening social accountability mechanisms. Although there is increasing discussion within Government about social accountability and social audit practices, and the need to bring in third party agencies to facilitate social audits, the conflict of interest created by Government funding of social accountability activities undermines their validity. There is an understandable reluctance among CSOs to use and to be seen to use government funds for this purpose.

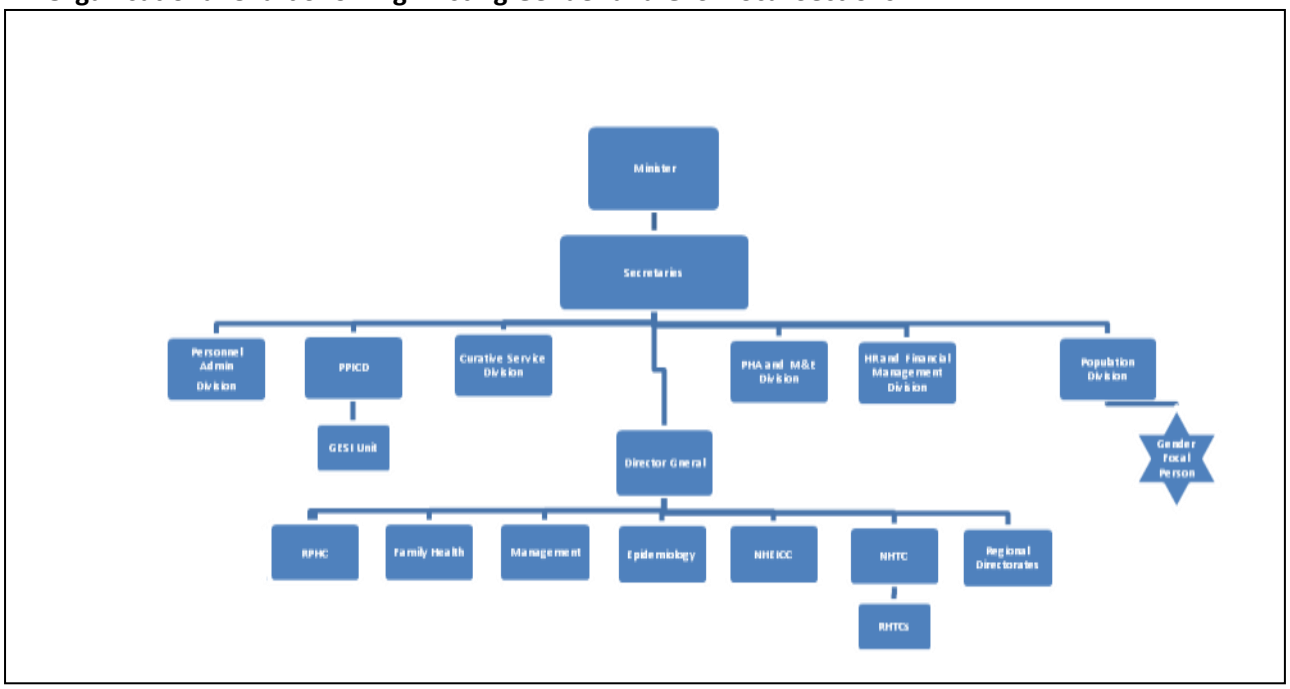
Alternative approaches, such as EDPs creating a pool fund for independent social accountability activities, require further discussion.

2.3 Organisational Structure Management and Working Environment

Ministry: The Policy, Planning and Programme Section of PPICD (MoHP) was nominated as the GESI focal section and identified three officials as focal persons for developing the GESI strategy and planning. No functional roles and responsibilities or line of accountability have yet been defined for the section, synergy and coordination with the GFP has not been developed, and the only GESI related training provided to the three individuals was an orientation on inclusive planning by Ministry of Finance (MoF). The three planners have been asked to apply a "GESI lens" when reviewing plans and proposals, but have limited authority to influence their design. They feel GESI is being taken forward in a fragmented way and requires stronger leadership and a more systemic approach, fostering a common understanding and capacity across the sector, and mainstreaming GESI in core systems including planning, monitoring, budgeting, and staffing. The GESI section is also involved in implementing gender responsive budgeting, but staff feel they have not received the necessary level of training, which may reflect a breakdown in the transfer of knowledge from the earlier GFP.

Clarifying and formalising the status of the GESI Unit is unlikely to take place independently of the broader planned reorganisation of the Ministry. Ministry staff are expecting NHSSP to revitalise debate about reorganisation and support the process of reform already initiated, which would naturally include (re)structuring the GESI Unit. Achieving Cabinet approval of the GESI Unit will help secure its legitimacy, authority and budget allocations; though any attempt to pursue this independently would we understand involve considerable additional inputs, including a separate organisation and management survey. Given that any reorganisation will need to be approved by the Cabinet, and this is unlikely to go ahead before clarification of the federal structure, this reinforces the need for a high level steering committee for GESI, as proposed above, and interim institutional arrangements to allow GESI implementation to move forward even if the institutional structures are not formalised. Further discussion on the details of the Ministry's reorganisation regarding GESI, in light of the ambitious goals and strategy, seems necessary.

Organisational Chart Showing Existing Gender and GESI Focal Sections



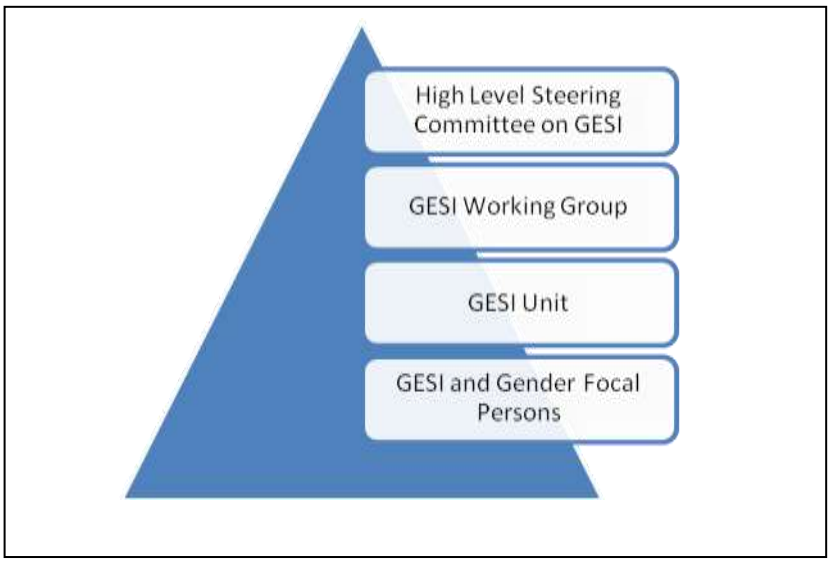
At the **DoHS level**, there is no focal point for GESI or gender, although discussion on equity and access has notably increased over the past five years. The need to target the ultra-poor and excluded groups to achieve the MDGs and break through the utilisation plateaus that some programmes are facing was articulated by several staff consulted. In contrast to a few years ago, there is now common acceptance of the value of targeted programmes, and the earlier tension between universal coverage and targeted interventions has been significantly reduced. However, the tendency for divisions to work vertically in their programme areas deters crosscutting work and discussion, including for GESI.

Within the DoHS, debate around GESI focuses on programming and the practical implications of strengthening access and equity. Family Health Division (FHD) has moved furthest, as a result of the EAP, however they will require capacity support in order to manage and guide the scaling up of this programme to 15 districts, as provided for in the Annual Work Plan and Budget (2010/11). A key focal area of GESI rests with the Revitalising PHC Division, but the limitations posed by its minimal staffing may undermine performance and the motivation of its dynamic leadership. Creating space for cross-learning and synergies around equity and access across the DoHS divisions, including for example broadening of EAP and the remote area guidelines beyond maternal and newborn health to include family planning, child health and nutrition, will be important for strengthening access programming and delivering more equitable services.

From our assessment, it appears essential for each DoHS division to have a GESI focal desk embracing gender, equity and access, social inclusion, social accountability and GBV. To support programme level coordination and cross-learning we propose a formation of a GESI working group or sub-committee, with representation from each Ministry and Department division, National Health Training Centre (NHTC), and National Health Education,

Information, Communication Centre (NHEICC). This group would be additional to the oversight/ leadership role of the High Level Steering Committee on GESI.

Core Institutional Mechanisms for Leading, Coordinating and Mobilising for GESI



GESI focal persons are recommended at **regional** and district levels. Our assessment of the regional health structure indicates that, while conceptually this plays a vital role in strengthening programming and delivery, in practice the regions have not sufficient capacity to fulfil this at present. As pivotal units for supervision and support, monitoring and evaluation, and capacity building for districts, the regional health teams are critical in institutionalising GESI into service delivery and IEC/BCC. In addition to a regional GESI focal person, we recommend that GESI is integrated into the job descriptions of all regional staff, and each team member (EHCS, Child Health, TB, HIV/AIDS) who supports and monitors GESI activities and principles during field supervision visits. To strengthen the GESI focus of the regional management team there will be a need to introduce poverty and social inclusion mapping, build a stronger understanding of the GESI issues in the region, target the efforts of the regional teams, and support local area programming. We anticipate that as GESI becomes more firmly anchored into planning and budgeting processes, there will be greater demand for GESI monitoring and evaluation at district and regional levels and for GESI planning and monitoring tools and methodologies.

District and below: At community and facility level, GESI can be delivered holistically, and real changes made in the delivery of services, especially where VDCs and DDCs are functioning well. Building the understanding and capacity of district managers to include GESI objectives in planning and management will be important; a role for regional health teams with the support of NHSSP. This will involve district planning for GESI to identify vulnerable populations and areas, gaps in service utilisation, and adapt and strengthen services to increase access of those vulnerable groups. Forging linkages with MoLD and other agencies at the district level to synergise planning and activities, disseminate learning and experience from across line agencies and programmes, and generate and maintain commitment to GESI will be essential. Given the plethora of district committees, we propose an existing multi-sectoral district committee become a forum for coordination and debate on GESI, such as the Social Mobilisation Committee or the Reproductive Health Coordinating Committee.

NHEICC should be a major driver for tackling the social and cultural barriers that women and excluded groups face in accessing services, and promoting their wellbeing. However, our assessment indicates that NHEICC is beset by considerable institutional and technical constraints (such as having only three trained health promotion specialists), and as a result does not have the capacity or credibility to steward IEC and BCC across the sector and coordinate the multiple agencies involved across the country. This leads departmental divisions to often contract out IEC/BCC activities, bypassing NHEICC. Experience from SSMP highlights the challenges of providing sustainable technical capacity development, at the level required, to the organisation, and the current operating environment suggests this has not changed. In this context, one option would be to move NHEICC away from design and production of materials to a purchasing and stewardship role, given the easy availability of IEC/BCC services in the non-government and private sectors. Such a transformation fits well with a shift to stronger public-private partnership approaches, but would require high level leadership and commitment.

The National Health Training Centre (**NHTC)** is keen to develop and deliver GESI orientation and training courses as part of its ongoing programme of in-service training of health providers. Technical support will be required to assist the NHTC and the Regional Training Centres (RTCs) to develop training modules and packages for different levels of worker and to develop the capacity of staff at the training centres. Development of GBV training modules is in progress, with WHO support, providing a starting point from which to develop a GESI training package. Our proposal would be to strengthen the capacity of NHTC and RTCs to roll out GESI training through the decentralised training system for in-service training and support. Given the scale of the task, there may be value in bringing on board NGO training capacity at local levels, to supplement government capacity.

Pre-service education of health workers and administrators also offers an important opportunity for mainstreaming GESI. Dialogue and consensus building with the Medical and Nursing Councils will be required. Civil service training at the Staff College could introduce a GESI module that cuts across government departments, as well as something specific for health specialists.

2.4 Finance for GESI and Contracting Out

GESI has no earmarked budget. Currently activities are scattered across the sector without strategic consideration of how they support (or contradict) each other, and potential synergies and linkages. The top-down planning and budget system discourages local adaptation and joint funding proposals (across divisions).

The introduction of gender responsive budgeting has encouraged greater attention to gender in budgeting, and is the most visible gender mainstreaming work currently being undertaken by MoHP. However, this does not yet embrace social inclusion.

Social protection measures are being introduced at policy level, but discussions over the higher cost of serving the remote, the ultra-poor and excluded seem rudimentary at programme level. Much more work is needed to investigate the relative financial costs of serving disadvantaged groups. Understanding and strengthening the evidence on how

health interventions and programmes, such as social protection measures, are impacting on health service utilisation and outcomes for different social and poverty groups, and the strategic and programming implications, is a must. The evidence base around Aama is an example of good practice to be held up for replication. Similarly, evidence on out of pocket spending and the impact of health spending on poverty and different social groups needs strengthening. Out of pocket spending is a critical measure of the progress the service is making in meeting the needs of the poor and vulnerable.

One major bottleneck to implementation of GESI activities is the delays caused by government contracting out processes. The current practice of issuing one-year contracts significantly reduces implementation time, as the tendering process needs to be repeated annually, and in the case of community programming, leaves community groups and mobilisers with gaps in the support provided. A move to multi-year contracting has been approved by MoF and is currently applied to the purchase of medicines, and widely practised by MoLD. Wider uptake will be essential if the department is to viably support community based equity and access activities through non-governmental organisations. As an example, last year the late passing of the budget meant FHD experienced long delays in selecting and awarding contracts to local NGOs for the EAP. As a result, one year's implementation had to be compressed into four months, undermining the quality of the mobilisation process and the rights-based nature of engagement, and threatening the empowering process which is the core of EAP. Currently FHD and the D/PHOs do not have the capacity to manage and support the contracting process. Strengthening the system is therefore a priority if Government is to fully institutional programmes such as EAP into the health system.

Streamlining the contracting out process for greater efficiency and better fit with district capacity to manage the process in a transparent and fair way, is a priority area for GESI programming. FHD's experience in contracting last year's EAP partners showed that district level contracting worked best where the Local Development Officer was invited to play an active role. Greater involvement of MoLD and the DDCs has several advantages. First, the DDC has considerably more experience of contracting out, and systems in place for doing so, including the District Development Fund, which permits multi-year contracting. Second, it would encourage broader ownership of health oriented social mobilisation at district level, and help exploit opportunities for embedding health equity, access and voice activities with MoLD's GESI mainstreaming work and LGCDP. However, reforming contracting mechanisms has political economy implications and will require hands-on, trusted facilitation and consensus building across the DoHS and below to move this agenda forward.

2.5 Monitoring

Currently the Health Management Information System (HMIS) produces reports disaggregated by sex but not by caste and ethnicity. Although caste/ethnicity data is recorded by health workers at the point of service delivery, it is not reported up the HMIS chain. Two pilots, the Health Sector Information System (HSIS) in three districts and a UNICEF funded pilot in 10 districts, included the recording of caste/ethnicity, but both have suffered from technical setbacks and supervision problems, and have so far not been able to deliver annual reports. Strengthening the HMIS to deliver caste/ethnicity disaggregated data

will require considerably more technical support to the HSIS and demonstration of its feasibility and added value to health sector stakeholders. At present it is reported that districts are not demanding caste/ethnicity disaggregated data, but we would expect this to change as capacity is built and greater responsibility is placed on districts to deliver against equity and access targets, and report on disaggregated service utilisation for a set of tracer indicators, as suggested by the Results Framework.

Given the capacity constraints of the MoHP and DoHS, it does not make sense to attempt to strengthen the HMIS for social disaggregation independently of the ongoing pilots. Thus alternative approaches for monitoring GESI will be necessary in the short to medium term. The GESI strategy does not include specific targets or monitoring indicators, a gap that will need to be addressed in developing a GESI implementation plan. Evaluation and research studies will be best coordinated with other ministries, such as MoLD and MoWCSA, and with EDPs. This could for example include: monitoring and evaluation of the distribution of finances and resources across the country by district; out of pocket spending surveys; benefits incidence analysis to benchmark beneficiaries by sex, poverty, caste/ethnicity and geographical location; user service delivery studies; and qualitative studies to track access and care of specific disadvantaged groups such as the ultra-poor. A GESI monitoring and evaluation plan should emerge from development of the GESI implementation plan.

2.6 Policies and Strategies

The GESI strategy takes a sector wide approach, is comprehensive and ambitious. As an important first step, it needs to be followed up with the development of an implementation plan allocating responsibility for activities, and accountability for delivering results. This is the logical next step for moving the GESI strategic planning process forward and building ownership, fostering leadership and developing mechanisms for coordination.

The recent amendment to the Civil Service Act introduces a quota system for vacant posts, and means that 45% of all civil service vacancies (at all grades) must be filled according to a quota system. This 45% will be allocated as follows: 33% of posts to women; 27% to Janajatis; 22% to Madhesis; 9% to Dalits; 4% to applicants from remote areas; 5% to the disabled. MoHP has yet to complete changes in the Health Service Act to apply the new policy, and until it has done so, all recruitment has been suspended by the Courts. To date no similar policy has been announced for pre-service training and further analysis would appear to be needed to assess whether this will be necessary to prepare an adequate GESI human resource pool. There is a need to strengthen the fit between human resource production initiatives and recruitment policies, as illustrated by the misfit between scholarships for ANMs and the absence of ANM recruitment.

The Free Essential Health Care Services (EHCS), introduced by the Ten Point Policy in 2006, has evolved over time and currently includes universal free outpatient care at Primary Health Care Centres (PHCCs), Health Posts (with 35 free drugs) and Sub-Health Posts (with 25 free drugs) and universal free essential drugs from an approved list of 40 at district hospitals. For the target population of the poor, destitute, disabled, elderly and FCHVs, it covers free outpatient, inpatient and emergency care and essential drugs at hospitals and PHCCs. All institutional deliveries at government facilities are also free.

Implementation monitoring of free EHCS has raised a number of financial management, service management and supply gaps, and provides a mixed picture of who is benefiting from free care. The latest report[3] in December 2009 illustrates generally positive trends in the proportion of targeted groups that make up outpatients and inpatients in the total sample survey. For example, the proportion of targeted groups among inpatients has risen from 15% in 2007 to 34% in 2009. However the disaggregated picture of use of outpatient and inpatient services by caste/ethnicity is more complex. At the aggregate survey level, use by castes/ethnicities appears generally proportionate to their representation within the survey population, however at the district level there are several anomalies. For example, in Banke where Madhesis make up 39% of the district population, in the latest round of monitoring they constituted only 2% of outpatients. Similarly, in Dolpa, Janajatis form 39% of the population but only 5% of outpatients. In Banke, Dolpa and Baglung, Brahmin/Chettris are using outpatient services in significantly greater numbers than their proportion of the population; in Baglung, they make up 63% of outpatients but form only 43% of the population. Understanding such district level anomalies is essential for creating an enabling environment in which the benefits of the free EHCS reach targeted vulnerable groups. In depth analysis of why specific social groups are not benefiting from entitlements in some districts may, for example, find the need for increased and more targeted public dissemination and IEC campaigns, greater social mobilisation through civil society, hiring staff with local language skills, and delivering more outreach services to isolated communities. Such findings would highlight the need for more specific local planning based on social and poverty analysis of the population, access to services and disaggregated utilisation rates. The regular monitoring assessments of free EHCS provide valuable insights, but a rigorous impact assessment is also required to understand who has benefited from the policy.

2.7 Programmes Initiatives and Pilots

Equity, access and voice programming are present in various forms across the sector. During this assessment we have tried to identify ongoing and planned GESI related initiatives, strengths and gaps in functioning, and priority areas for strategic technical support.

The concept of **Social Service Units** (SSUs) at central, regional, sub-regional, zonal and major district hospitals was introduced in the GESI strategy, with the aim of assisting poor, vulnerable and marginalised castes and ethnic groups access their entitlements to health care, and to mediate the health service. A pilot in six hospitals is planned (not yet started), which will be managed by the GESI Section in the MoHP. Operational guidelines have been prepared. This new high profile initiative will be an important test for the Ministry, which will stretch its capacity. It will also be a source of learning and commitment building. Discussions with senior staff in the Ministry suggest strong ownership of the proposal, and supporting the Ministry to make SSUs a success will be politically important.

The **National Action Plan on Gender Based Violence** anticipates MoHP as a key partner in setting up one-stop crisis centres for GBV victims. MoHP plans to create GBV cells within

[3] Ministry of Health and Population. December 2009. "Assessing Implementation of Nepal's Free Health Care Policy." Kathmandu: Ministry of Health and Population, RTI and CARE.

hospitals which will work with the GBV district response network, including the police, judiciary, CDO, paralegal committees. Modalities still have to be developed. WHO has provided some assistance with the design of GBV training for health workers in the treatment of victims, and capacity development has recently begun. At the implementation level, FHD will lead the response of MoHP.

The one-stop crisis centre is the focus of MoHP's response to GBV, but there seems to be limited debate on the scale of GBV, its causes, impact and possible preventative measures. The national initiative will place pressure on MoHP to take a more holistic response, and as the GBV National Action Plan is likely to attract EDP funding, momentum is likely to continue. Supporting the MoHP and DoHS to establish functioning GBV centres in hospitals, well coordinated with district agencies, and to contribute to the design and implementation of prevention programmes linked to community health vehicles (such as EAP) will be politically important in establishing the value of the GESI TA under NHSSP.

The Free Essential Health Care Services initiative is the main vehicle for delivering the right to free basic health care and responding to the Interim Constitution. In addition, the demand side financing programme, Aama (another programme, ACCESS, is under design) has benefited poor and marginalised women and impacted on demand for institutional deliveries. Governance challenges to Free EHCS and Aama exist, and remain an area of concern, requiring scaling up of public dissemination of entitlements, and introduction of greater social accountability with better management and control systems. Tools for identifying the ultra-poor are currently being developed by the Revitalising PHC Division. Strengthening social accountability will be an important area of work and fits with the GAAP; linkages with community based organisations, women's groups, networks and federations would be beneficial. In depth analysis of who is benefiting from the various social protection schemes, their impact on the poor, ultra-poor, disabled, elderly, FCHVs, and different castes and ethnicities, and areas for redesign, are areas on which GESI TA can usefully work with health financing experts.

The **Equity and Access Programme** is a central initiative in the DoHS GESI portfolio. Following advocacy from the SSMP team, the rationale for targeted social mobilisation of poor and excluded communities to increase their access to services through women's empowerment and community solidarity has taken root. FHD and concerned D/PHOs are now primary advocates of the model within the DoHS and are building interest and support to widen the scope of EAP to include broader reproductive health, child health, and nutrition. EAP presents a practical and direct route to addressing GESI, which complements and supports service and health systems initiatives, and has a growing number of advocates across the sector. However, the internalisation of EAP by Government, although a major achievement, has resulted in a lowering of the quality and rights focus of the model, due to the bottlenecks related to contracting process and the reduced levels of supervision and technical support available to local implementing organisations, compared to implementation through ActionAid Nepal. The challenge now is to support Government in addressing some of these issues and successfully institutionalising and sustaining the model.

Geographical targeting: District level targeting of programmes, for example by HDI status, is well accepted in Nepal, but the evidence base of comparative health outcomes, services,

resources and population and geographical context has not been exploited. More analytical work is needed to identify what works in different contexts and to justify higher expenditure, and develop evidence to support programming and approaches tailored to specific types of geographical and social contexts.

The **Remote Area Guidelines for Safe Motherhood** puts in place a framework for more localised area planning. This will be an important instrument for better targeting of some of the most geographically and economically disadvantaged communities. We also suggest the concept of planning for remote populations for safe motherhood be expanded to include other areas of reproductive health and primary health care. Once effectiveness has been demonstrated, this tool could also be adapted to local planning for underserved populations living within an area. Capacity to operationalise the guidelines at district level will need to be developed, and the approach will raise technical debate and have implications for human resourcing and financing. It could also stimulate other sectors to take more locally appropriate resourcing and service delivery approaches for remote and isolated areas, and to develop coordination and linkages with other sectors at district level. Monitoring and evaluation systems to measure the impact of remote area programming will need to be developed, which is likely to require more inputs than the HMIS can provide.

The Government wide focus on Karnali Zone includes cash transfer programmes to tackle extreme poverty. However, specific health initiatives and plans to strengthen the health services in these districts, including human resources, were not raised by stakeholders and no obvious cross-cutting Karnali Zone working group/ taskforce appears to be functioning.

Improved **met need for contraceptives** across all social and economic groups is an expected outcome of the programme, which will require more targeted programming and local initiatives to enable people from different communities to overcome the supply and demand side barriers they currently face. EAP will be one vehicle for addressing the gaps in the areas where it operates, but other mechanisms will be needed in non-EAP areas, with detailed work to identify the nature of the constraints and barriers to contraceptive use.

The Revitalising PHC Division has recently drafted an **urban health** policy with the MoLD, which is likely to lead to the launch of a major new programme of work, although the evidence base for this policy is not clear. Assuring the embedding of GESI and social accountability in the design and implementation of the programme will be important. The Division is also leading on the design of **community based health insurance** models, and aims to strengthen **mental health** services and develop an **environmental health** programme. It is also spearheading work to strengthen social auditing associated with Free EHCS, by contracting out to third parties. There are several potential areas of GESI TA to this division, but given its current lack of staff, it is hard at this stage to predict which of the different streams of work will be prioritised. TA will therefore need to remain flexible.

Among the **Child Health Division** (CHD) staff there appears to be a strong awareness of the barriers faced by different social groups in accessing child health services and the existence of harmful traditional practices, but limited experience of targeted programming. Micro-planning to bring together EPI, nutrition and IMCI has been introduced in 10 districts and will be scaled up to another 15 in 2010/11, and this could provide the means for locally

tailored programming to address GESI and to design interventions to promote access. Considerable scope exists to work with CHD on access and equity, and bring together learning from across the divisions.

Further development is needed to enable **Health Facility Management Committees** (HFMCs) to realise their full potential as a vehicle for local governance. In the absence of decentralisation and locally elected government, they function without authority over finance or staffing of the health facility. The shift to a federal and decentralised political system will create the conditions for HFMCs to become more influential. The Local Health Governance Strengthening Project (LHGSP) will start to pave the way to defining and building the capacity and frameworks for empowered HFMCs to function more effectively. Ensuring GESI is mainstreamed into the strengthening of local health governance and HFMCs specifically is a strategic move that will help lay the foundation for scaling up as the political map is redrawn. The appreciative inquiry approach to strengthening HFMCs, successfully tested under SSMP and by UNICEF, is a methodology and platform from which further work could evolve, alongside targeted activities through the LHGSP.

Information, education and behaviour change communication is a critical component of access and equity programming and social accountability. The lack of institutional environment for health communications, discussed earlier, impacts on performance and scope for systems strengthening in this area. In the present context, the immediate emphasis needs to be on ensuring the design, production and localising of quality IEC/BCC materials in agreed priority GESI related areas; such as raising awareness of entitlements, including Free EHCS and Aama, promotion of social auditing, increasing knowledge about gender based violence, and family planning. Efforts to sustain the encouraging levels of coordination previously achieved through the BCC Sub-Committee, as a means of harmonising messages across agencies, is also important. At a more strategic and systems level, strategic review of NHEICC's programme of work could be a means of opening up broader institutional issues and fostering commitment towards more transformational reform.

2.8 Staffing

Human resource issues are central to providing GESI services and transforming the health system. The gender and social diversity of the health workforce is largely unknown, and in the past has not been included in workforce planning, management and development. The policy of introducing a quota system for filling vacant posts changes that situation, although it has not yet been brought into force in the health sector. HURDIS collects gender and social data (caste/ethnicity, religion, remote location) on each staff member, although the social data in the system is reportedly patchy. Manipulation of HURDIS data is time consuming and social analysis of the data not possible because of data gaps.

Closing the social and linguistic gap between health workers and users and increasing the number of female doctors will help increase access to services for women and disadvantaged groups. Similarly, increasing the social diversity and proportion of women in policy making and programming positions will help increase responsiveness to women and disadvantaged groups. However, there is currently a serious lack of female senior and

middle managers in the Ministry, Department and districts. The situation has in fact deteriorated, as competent women managers have drifted out of the health sector; a trend which needs understanding and reversing. Finding appropriate rewards and incentives to attract women and qualified candidates from socially excluded groups to take up careers in health, particularly in remote areas, will be challenging, and likely to require rethinking of recruitment policies for basic and in-service training, and stronger links between training scholarships for the disadvantaged and post-qualification public service jobs.

A lack of political commitment to adhering to human resource management rules has undermined efforts to redeploy staff to underserved areas. Nurturing government enforcement of accountability for the functioning of health staff at their duty stations will be politically sensitive but central to getting the right staff in the right place at the right time. More specific skill based job descriptions, which include GESI requirements, could contribute to a more appropriately staffed service and reduce transfers that run counter to user interests and are sub-optimal for the system. The shift to a federal structure may alleviate some of the management issues if staff become state/regional employees, but much will depend on the enforcement of human resource management rules. Integrating GESI skills and capacities into management and provider job descriptions and annual performance reviews is an important mainstreaming approach, which would raise the visibility and importance attached to GESI by staff in the workplace.

GESI is currently not included in health provider and manager training. Integrating GESI into all levels of health worker training in a practical and meaningful way is therefore a priority. This is likely to require partnerships with CSOs who have more practical GESI programming experience, and field programmes where GESI can be demonstrated in practice.

2.9 History of Technical Assistance and Current and Future TA

There has been no long term embedded TA for GESI either at Ministry or DoHS level. Short term and programme based technical support has fulfilled specific tasks and contributed to the progress made in prioritising GESI, but this has not been coordinated or sector wide in focus. There is a need for systematic diagnostic work on which to base the design of GESI related approaches. Technical assistance has been provided by UNFPA for gender assessments in a number of ministries, including health, and capacity building of Gender Focal Persons. NHSP and SSMP provided GESI technical support to assist with preparation of the GESI strategy, and undertook several studies that considered equity and social inclusion issues. The SSMP Equity and Access Adviser played an advocacy role in building support for GESI, voice and equity and access programming within FHD. Further analysis of the NDHS (2006) data, looking at income and caste/ethnicity variation, was undertaken under technical support from the World Bank. No firm plans were identified for either long or short term technical assistance to GESI in health from EDPs other than NHSSP, in the short to medium term, apart from a UNFPA funded gender audit.

3. CAPACITY DEVELOPMENT STRATEGY

The GESI capacity development strategy we propose aims to build on government initiatives and driving forces for GESI, and support the government in taking a systemic and structured approach to mainstreaming GESI, while also exploiting opportunities for "quick wins" that can feed into a virtuous circle of building commitment and capacity. It takes into account the institutional and technical capacity gaps within government; the anticipated move to a federal structure and related institutional and organisational changes this will entail; and the limited progress made over the past three years in creating an institutional structure for GESI. The approach centres on TA:

- At the policy and planning level; in health sub-systems development; coordination; and the generation and application of evidence
- To build common understanding of what GESI means for the health sector, and the capacity of health policy makers, managers and service providers to integrate GESI into their roles and responsibilities
- At department and regional level to mainstream gender equity, social inclusion and social accountability into health services.

Through this approach, the objective is to strengthen the enabling environment and put in place structures and systems for GESI in health, to support the Government build its capacity to implement more equitable and more accessible services, and to empower women, the poor and socially disadvantaged to claim their rights to health. While establishing the structures, systems and capacities to implement the GESI strategy is undoubtedly important, this needs to be balanced with progress on the ground and putting GESI into practice. Practical experience and evidence of impact have policy influence in Nepal, and this will be key to building political and institutional commitment to GESI, and maintaining momentum and confidence in the transformation process.

Emphasise achievement of tangible results and putting GESI into practice in the field.

The strong political commitment to GESI presents a window of opportunity for institutionalising it into the structures and working of the Ministry and Department and into the services provided. However, bureaucratic systems, high turnover of senior officers, capacity gaps, the overburdening of a few very capable and committed officers, and the continuing political instability in the country suggest that the pace of change will be slow. In this environment, emphasis will need to be placed on building up a critical mass of champions and allies across the sector, who can lead and take decisions. This is especially important in the absence of a formal GESI institutional structure, and the likelihood that this will not be resolved in the short term. Hence the proposed High Level Steering Committee on GESI, the GESI Working Group, and nomination of GESI/Gender Focal Persons are critical.

Build a critical mass of champions and allies that can lead and take decisions.

Building ownership of GESI across and down the sector, and the shared values and attitudes that underpin this, are priorities for sustainable change and putting the GESI strategy into practice. This will require:

- *Strengthening the evidence base:* This is currently scattered and unsystematic and will need to be developed with Government, and support provided for its application at the policy and programme levels. This important area of work will bolster consensus building and commitment, and feed into policy and programme development
- *Building common understanding, consensus and capacity:* Evidence based debate and agreement on who the poor and socially excluded are, and how the functioning of the health system and services leads to inequitable access is needed. This could build on consultative processes employed in the GESI strategy formulation process but in a more inclusive, and decentralised way. Capacity building for GESI from centre to field is required, with technical inputs to a GESI capacity needs assessment, design of training and orientation programmes, strategic planning of MoHP capacity building efforts in harmony with other GESI consensus building efforts, and strategic and policy level debate around the role of CSOs in capacity building and the mechanisms by which to fund them.
- *Developing a GESI implementation plan* with assigned responsibilities, resources and accountability, to translate the GESI strategy into prioritised and coordinated actions that the many actors in the system can take forward.

At the health system level, mainstreaming GESI into the building blocks of the system is fundamental to reform, most importantly in the areas of human resources for health, policy and planning, health financing, procurement, and monitoring and evaluation. We believe progress in mainstreaming GESI into the strengthening of health sub-systems, and building on relevant government policies and initiatives, such as the introduction of a quota system for filling vacant posts, is best achieved through the work of sub-system specialists (policy and planning, HR, health financing, procurement, and monitoring and evaluation). NHSSP's thematic technical advisers will therefore work alongside dedicated GESI TA to drive this agenda forward. Key issues to be addressed include how to increase the numbers of socially disadvantaged groups enrolled in basic health provider training; how to promote the career advancement of women and socially disadvantaged groups in the sector; how to retain health staff in remote areas; as well as the integration of GESI in the health monitoring and evaluation system; the strengthening of a GESI lens in planning and budgeting; and promoting pro-poor, gender and socially inclusive health financing approaches.

The push to deliver tangible results and ensure the GESI window of opportunity is not lost in restructuring and institutional change processes, puts implementation of programmes and services centre stage. Practical application of GESI principles into programming and delivery, and specifically the support and development of existing equity and access approaches, will be vital for sustaining and building the interest of programmers, managers and service providers, and achieving targeted increases in health outcomes of poor and disadvantaged groups. Early wins for GESI will be made here.

> *The strategy at implementation level is to support a small number of high profile, high stake initiatives that have the potential to make a significant impact on access and utilisation of services by disadvantaged groups. This will contribute to the evidence base, build political and institutional commitment to GESI and strengthen practical capacities to deliver services that are GESI responsive and accountable.*

While there are many entry points for GESI programming, we believe greater impact will be made by focusing on a small number of high profile initiatives that have the potential to demonstrate impact. From a practical perspective, there is also the need to be realistic about how much ground can be covered within existing capacity constraints and the need for a sustainable balance to the technical assistance.

A broad spectrum of GESI work covering various divisions will help broaden ownership and build linkages and common understanding. Existing common platforms and joint working arrangements across divisions are few, but the community and demand side nature of much equity and access work may make this easier to forge than more technical work, which may fall into professional territory. Gaps in government staffing and capacity at DoHS and regional levels means that a degree of substitution may be essential to start initiatives up, especially in the absence of dedicated or nominated GESI/equity and access focal persons.

The highest priority for GESI support at DoHS level will be to sustain and strengthen the EAP, as a flagship GESI programme, and perceived as such by Government. The transfer of EAP into government in 2008 was a milestone, but delays caused by late budget release and contracting, and the limited supervision support available has impacted on the quality of implementation. Much is at stake in ensuring EAP delivers to its potential. This calls for strengthening the quality of implementation, getting back to the rights based and empowerment principles on which the model is based and establishing strong monitoring and evaluation to produce the evidence needed to continue to build political and institutional support for GESI demand side programming. This will require hands-on support to FHD in their management of the programme. Specific tasks include:

- Management support to the contracting process and a shift to multi-year contracting
- Technical support and supervision to district implementing NGOs, including sharing of lessons learned from earlier cycles, and orientation training
- Technical and practical support to the D/PHOs and Public Health Nurses who provide local support, management and coordination of the programme
- Technical and practical support to NHEICC in the design, facilitation and development of locally appropriate complementary IEC/BCC materials
- Technical and practical guidance in NGO monitoring and learning
- Support to the DoHS, regions and districts in EAP evidence gathering and lesson learning
- Technical support for broadening EAP to include wider public and primary health care and social accountability for health issues
- Forging linkages with MoLD GESI and LGCDP social mobilisation initiatives
- Advocacy and dissemination of EAP achievements and learning across the sector and to external stakeholders.

Given the status of EAP, and its recent transfer into government, it will be essential that technical support “hits the ground running” to facilitate implementation as planned in the 2010/11 AWPB, once the budget is approved and released. This will require an adviser who is fully conversant with both the programme and the operating practices of government, and has solid and respected working relationships with key government officers. The adviser

will need to be technically qualified in rights based social mobilisation and community empowerment programming, and the importance of supply-demand synergy. S/he will be experienced in working with government and civil society as a facilitator and support person, be a confident and capable advocate, politically astute regarding the working of government machinery, and collaborating with stakeholders at the centre and in the districts to ensure support for community programmes. This person will also have significant experience of working with CSOs at national and local levels, and in mediating between government and CSO partners to maximise results.

Technical support to government management of EAP will be a means of building bridges across divisions, especially as EAP is broadened beyond reproductive health. In addition, there are several other high priority equity, access and social accountability areas of work, including:

- Support to the Free EHCS to better reach poor and disadvantaged groups who are not currently accessing their entitlements: this is likely to involve TA to support the government in evidence gathering; district and local assessment and planning; design, piloting, support, and monitoring and evaluation of targeted BCC and community initiatives; and to strengthening social accountability mechanisms. GESI support will need to work closely with the health financing team in this area, including development of a poverty identification measure, and introduction of a health ID card
- Support to Aama in programming activities to increase demand for institutional delivery among the poor and socially excluded, and for strengthening social auditing of the programme in areas without EAP
- Support to the operationalisation of remote area guidelines, and development of gender and socially inclusive area planning tools; GESI support will work closely with the MNH Adviser, the EHCS Adviser and the Newborn Health Adviser
- Support to the design of community based health insurance pilots to ensure inclusion of women, the poorest and socially disadvantaged in coverage models, and the participation of women and the marginalised in their design and evaluation
- Supporting the Revitalising PHC Division develop urban health models that protect the rights of women, the poor and the socially excluded, and incorporate their specific needs in design
- Providing technical support to the analysis of why family planning services are not reaching all social groups; the design and piloting of initiatives to increase access of the poor and disadvantaged; and monitoring and evaluation of new approaches
- Technical support to the design, implementation and evaluation of nutrition pilots that incorporate global learning on effective strategies for reducing child malnutrition and impacting the community and family practices that encourage malnutrition, particularly of women and girls
- Support to the strengthening of HFMCs to be more gender and socially inclusive and active in the emerging federal and decentralised governance structure, and to build on the appreciative inquiry planning and management strengthening initiative funded by SSMP
- Support to the design, testing and implementation of one-stop crisis centres for GBV, and of coordinated multi-sectoral prevention and response programmes.

Two district and service initiatives led by central MoHP also warrant technical GESI support. The first, hospital SSUs, has strong government backing and visibility. The second, the Local Health Governance Strengthening Project with MoLD, is potentially a model for decentralisation, empowering HFMCs and strengthening local governance. It has high level support and opens up space for greater practical coordination with MoLD, and will be an important vehicle for promoting gender and social inclusion in governance.

The design, production and localisation of quality IEC/BCC materials in identified GESI related areas is a high priority. While recognising that longer term institutional issues related to NHEICC may lie beyond the remit of NHSSP, technical support will be important to ensure the delivery of essential IEC/BCC products.

Experience from SSMP has shown that Kathmandu managers and technical teams are too removed from districts to provide the practical support and technical guidance that district teams need. This is particularly the case for equity and access, which is community based, often involving working with CSOs, and exposes health managers to local contracting relationships and responsibilities. Moreover, the spirit of GESI requires a mindset shift, the introduction of new working practices, priorities, accountability relationships, values and attitudes. Regional GESI/BCC technical support to foster the values change, and build capacity to introduce new GESI responsive working at district level and below, will be vital.

The proposed portfolio of support will reinforce efforts to nurture champions across the sector, broaden ownership of GESI, and promote closer working across vertical divisional structures. Government counterparts in each area of work will be essential. Through the proposed cross-sector GESI Working Group and augmented attention to GESI through government machinery, it is expected that the flow of information, communication and learning on GESI from the grassroots up to policy and programming levels and back down will be enabled. This will assist in building the evidence base and know-how to make services more equitable and accessible, and to foster the understanding, capacity and commitment for GESI as a value of the health system.

4. RISK ASSESSMENT AND RISK MITIGATION STRATEGY

There is a high risk that a strong institutional arrangement within the central MoHP, DoHS, regional and district levels will take appreciable time to materialise. This will delay progress in mainstreaming GESI through key health sub-systems but will not derail the process entirely if, as proposed, a core group of champions and advocates can be mobilised, and implementation of pivotal equity and access programmes and initiatives supported. Technical and practical support to department programme managers and district managers is therefore a major focus of the proposed TA approach to ensure, at a minimum, that equity and access programmes become functional and deliver results.

There is currently no strong leadership of GESI in MoHP, and no single individual stands out as a potential driver of the process from above; the plan to forge a High Level GESI Steering Committee will mitigate some of this risk.

Although there is currently no strong ownership of the GESI strategy, the high political commitment to GESI leads us to believe that there is little risk that ownership of the GESI agenda will not be fostered within health. Sector wide capacity development will be critical to building the common understanding necessary for ownership, which is a long term agenda to be rolled out.

There is a high risk that NHTC and the regional training centres will not have the resources to roll out GESI training at the pace required. CSO led training could help fill the gap. Forging linkages across ministries, especially MoLD, will theoretically reinforce GESI objectives at district level, although this will require facilitation. The risk of staff turnover is high, and ongoing awareness raising and mobilisation of staff within the MoHP and DoHS will be essential.

Given the current organisation and working practices in the MoHP and DoHS, there is a high risk of excessive compartmentalisation of work, leading to lack of coordination; for example, until very recently files were only transferred from one MoHP division to another through the Secretary. The proposed working group, drawing members from across the Ministry and Department, and the positioning of our TA to work across the both agencies, combined with the community nature of equity and access programming, will help address this. However, even if we are able to forge closer coordination across divisions there is a risk that this will not be sustained in the absence of organisational reform.

Beyond the health sector, there is a risk of the GESI movement being driven by Dalit, Madeshsi and Janajati political agendas, excluding women and other disadvantaged social groups, such as religious minorities, the disabled, the ultra poor. Building consensus on the meaning of GESI for health is therefore a priority area of work, and will need to be an ongoing debate linked across the greater MoHP and other ministries. Guidance from NPC may help in future, but is unlikely in the short term.

Progress in mainstreaming gender through planning, monitoring and budget initiatives and building internal capacity within health has been modest. Strong political commitment to social inclusion has elevated attention and visibility to this area, and there is the risk that it will overshadow efforts to promote gender equity.

At the implementation level, there are high risks associated with the continuing delay of budget approval and release, and continuation of one-year contracts for CSOs. While the former is beyond our sphere of influence, policy TA will be targeted at moving to multi-year contracting. Linkages and working examples from other ministries may be of assistance in building a base for shifting to multi-year contracting for CSOs.

Duplication of effort at the local level is a risk if social mobilisation programmes are not well coordinated across the sectors. Regional technical support to districts combined with participation in Kathmandu based cross-ministry forums, and linkages with the MoLD, MoWCSA and EDPs will work to foster strong coordination.

There is a high risk that NHEICC will not deliver the IEC/BCC leadership, technical advice, and quality products needed to support equity and access programming. To mitigate this situation, IEC/BCC TA will be essential to work with NHEICC and CSOs on the delivery of materials for specific programme areas. In addition, strategic TA to review the programme of work of NHEICC will provide an opportunity to NHEICC and the MoHP to decide whether it wants to pursue a more transformational reform agenda.

5. RECOMMENDATIONS

5.1 The Focus of GESI TA

Drawing from above, the focus of the GESI TA will be several fold:

(a) Policy and planning, health systems building, coordination, and evidence generation and application:

- Supporting Government to establish an effective institutional framework for mainstreaming GESI in the medium term, and in the short term, putting in place working arrangements for GESI leadership and coordination
- Supporting the GESI Unit to lead the development of an implementation plan which translates the GESI strategy into prioritised actions with accountability and deliverables
- Working with sub-system specialists to mainstream GESI in HRH, finance, planning, procurement, monitoring and evaluation
- Facilitating coordination on GESI within the Ministry and between external stakeholders including other ministries, CSOs and EDPs
- Providing strategic analytical inputs and guidance to the development of a robust evidence base for gender and social inclusion in health. This will be influential and useful for policy development, programming, and staff mobilisation and capacity development
- Developing high quality dissemination products.

(b) Awareness raising and capacity building of health policy makers, managers, and service providers:

- Supporting government and UNFPA undertake a GESI diagnostic and capacity needs assessment across the sector and develop a GESI capacity building plan
- Supporting government to develop innovative and influential sensitisation and awareness raising programmes for key actors, and supporting the delivery of such programmes as necessary
- Supporting NHTC, regional training centres and other capacity building organisations to design GESI awareness raising and capacity building programmes, using appreciative methodologies

- Supporting NHTC and professional bodies to integrate GESI into in-service and pre-service training
- Monitoring the quality of GESI training and feeding this into ongoing development of GESI capacity building programmes.

(c) Supporting the implementation of GESI/equity, access and social accountability programmes, initiatives and pilots at the Department level. The focus areas of the TA support will be:

- Management and technical support to the scaling up of EAP
- Piloting and scaling up of SSUs
- Supporting the Health Financing Adviser to:
    - Strengthen claims by the poor and disadvantaged for free EHCS by raising awareness through various community level and IEC initiatives, and improving social accountability (see above)
    - Increase uptake of Aama among the poor and excluded, and strengthen social auditing
    - Design community based health insurance pilots to ensure inclusion of women, the poorest and socially disadvantaged
- Support design and implementation of GBV one-stop crisis centres, and prevention programmes
- Support the operationalisation and extension of remote area guidelines for safe motherhood, and the development of gender and socially inclusive planning tools
- Integrate GESI into urban health programming
- Design pilots and initiatives to increase access to family planning for disadvantaged and unreached groups
- Support the Nutrition Adviser to design community nutrition pilots that draw from learning on community mobilisation for health in Nepal, and empower women and families to introduce supportive feeding and caring practices for infants and children
- Support government to strengthen the inclusiveness of HMFCs and their activation for GESI, as the federal governance structures open up space for greater local governance
- Integrate GESI into the Local Health Governance Strengthening Project of MoHP and MoLD.

(d) Technical support to the Regional Health Directorates to build GESI and BCC technical and supervision capacity. This will include:

- Technical support to mainstream GESI and raise the profile of BCC in regional and district management systems
- Technical expertise and problem solving inputs to strengthen the performance of equity and access, social accountability and BCC implementation; including improving the coordination of district health management, training centres, DDCs, VDCs other line agencies, and CSOs
- Equity and access and rights based advocacy, and networking with government stakeholders and CSOs.

5.2 Technical Support for Gender and Social Inclusion

Technical support will be provided through a mixture of long and short term TA, and strategic technical support. Long term positions are proposed within the central MoHP, the DoHS, and five regional directorates. Strategic technical support will provide guidance and technical support to the long term posts in the Ministry and DoHS.

The **Gender and Social Inclusion Adviser** will work at the Ministry level. Her/his focus will be on mainstreaming GESI into policy and planning; strengthening the GESI Unit and the institutional mechanisms for leading and coordinating GESI action; supporting the integration of GESI into health systems building through lead advisers for human resources, procurement, health financing and monitoring and evaluation; raising awareness of GESI and building the capacity of policy makers, managers and service providers; and guiding and supporting GESI evidence generation and application. S/he will also provide support to specific areas of implementation level work that are led by MoHP, such as the pilot Local Health Governance Strengthening Programme with MoLD. Drawing on and learning from GESI initiatives across the Ministry and Department, this post will also generate and disseminate evidence within the sector and externally.

The **Equity and Access Adviser** will be based at Department level with the task of supporting government apply the principles of GESI into programming and service delivery. To be effective the Equity and Access Adviser will focus on a limited number of high profile GESI programme initiatives. The range of technical needs at implementation level lends itself to a mix of longer term relationship building, influencing and practical support and short term technical inputs. The Equity and Access Adviser will work across the divisions on implementation issues, with priority given to EAP, and support and coordinate short term GESI TA across the department.

Short term TA will be brought in to undertake specific technical tasks. The Equity and Access Adviser will be expected to have excellent working relationships and credibility within the

DoHS, lead on mobilising government support, and working with Government on the integration of GESI tools and approaches. For example, in the case of micro-planning it is expected that short term TA will support the Child Health Division to design a GESI-strengthened micro-planning tool, while the long term TA will facilitate, negotiate and create commitment to the new approach. In areas where there is a clear technical lead, such as health financing, nutrition, MNH, child health, the GESI Adviser or short term TA will provide GESI related support in coordination with the specialist technical lead.

The Equity and Access Adviser will also support and guide the provision of short term technical assistance to NHEICC for the development and production of quality IEC/BCC products in selected priority areas. Strategic short term support is also proposed to assist NHEICC to review the impact and direction of its programme of work, and to sustain the BCC Sub-Committee.

We propose **Regional GESI/BCC Technical Specialists** to be based in each of the Regional Health Directorates. The Regional Assessment will provide recommendations on working modalities, but it is anticipated that GESI support will provide GSI/BCC technical support and leadership to regional teams, districts and below, and support coordination with local government. They will work to build GESI and BCC technical and supervision capacity among the regional teams. They will technically guide, support and monitor the integration of GESI into district planning, management, and coordination and the implementation of BCC, equity and access, and social accountability programmes, approaches and pilots. They will provide GESI and BCC capacity building support to the regional training centres and district training teams. Regular communication between the two Kathmandu based GESI advisers and the regional GESI advisers, will provide opportunities to feed back on progress, bottlenecks, opportunities and learning.

Annex 1

Job Descriptions for Embedded GESI Posts

Gender and Social Inclusion Adviser

EMPLOYER: Options Consultancy Services Ltd

REPORTING TO: Team Leader

DURATION: 31st August 2013

LOCATION: Based in the Ministry of Health and Population, Kathmandu. Some travel within Nepal is likely.

COUNTERPART: Chief, PPICD, Ministry of Health and Population (MoHP), (until GESI Unit is created)

Background

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the MOHP along with External Development Partners have designed the second phase of the Nepal Health Sector Programme named as NHSP-2, a 5 year programme, which will be implemented from mid-July 2010. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2.

Role Objective

The purpose of this post is to support the Ministry of Health and Population (MOHP) in implementing the Government's Gender Equality and Social Inclusion Strategy. This will involve supporting the Government to establish a viable institutional framework for mainstreaming Gender Equality and Social Inclusion (GESI), creating a critical mass of champions and enablers of change, and building understanding, awareness and capacity on gender and social inclusion. S/he will play a networking and advocacy role and facilitate internal and external coordination with concerned stakeholders. S/he will provide strategic and strong analytical inputs to the development of the GESI evidence base. The Gender and Social Inclusion Adviser will also be involved in supporting a small number of high profile service initiatives though GESI support to service implementation will primarily be the responsibility of the Equity and Access Adviser. The adviser will work in close coordination with health systems specialists in the Ministry and with the Equity and Access Adviser based in the DOHS and GESI/BCC Specialists based in the Regions.

Specific Areas of Responsibility

(a) Policy, systems building, coordination, and evidence generation and application:

- Support and facilitate government to establish an effective institutional framework for taking the GESI Strategy forward, including the development of working arrangements for GESI leadership and coordination. This will include support to the proposed High Level Steering

Committee on GESI; GESI Technical Working Groups at the central level; and GESI and Gender Focal Persons in the MOHP;

- Provide technical support to the GESI Unit to lead the development and later monitoring of an implementation plan that translates the GESI strategy into prioritised actions with accountability and deliverables;
- Work with sub-system specialists to mainstream GESI in Human Resources for Health, health financing, policy and planning, monitoring and evaluation. Specific areas of work will be developed in coordination with sub-systems specialists and are likely to include:
    - Supporting the design of policies to increase the number of socially excluded groups enrolled in basic health provider training;
    - Supporting the design of incentive and career advancement strategies for women and disadvantaged groups;
    - Finding solutions to retain doctors in remote areas;
    - Strengthening gender responsive budgeting and introduce a GESI lens to planning and budgeting;
    - Supporting the development of a GESI monitoring and evaluation plan;
    - Providing social and gender expertise for the development of sector wide monitoring and evaluation, and the health management information system;
    - Contributing social and gender analysis and learning to evidence building efforts related to health financing and social protection.
- Facilitate coordination on GESI within the ministry and between external stakeholders including other ministries, Civil Society Organisations (CSOs), and External Development Partners (EDPs);
- Provide strategic and strong analytical inputs and guidance to the development of a robust gender and social inclusion in health evidence base. This will be influential and useful for policy development, programming, and staff mobilisation and capacity development;
- Develop high quality dissemination products.

(b) Awareness raising and capacity building of health policy makers, managers, and providers:

- Support Government to undertake a GESI capacity needs assessment across the sector;
- Support Government to develop innovative and influential sensitisation and awareness raising programmes for key actors, and support the delivery of such programmes as necessary;
- Develop a GESI capacity building plan with Government;
- Support National Health Training Centre (NHTC), regional training centres and other capacity building organisations to design and plan GESI awareness raising and capacity building programmes and training packages, using participatory and appreciative methodologies;
- Support NHTC and professional bodies to integrate GESI into regular in-service training, and pre-service education;
- Monitor the quality of GESI training and feed this into ongoing development of GESI capacity building programmes.

(c) Support the implementation of selected strategic and high profile GESI, equity, access and social accountability programmes, initiatives and pilots, through:

- Technical support to the GESI section of the MOHP in piloting six Social Service Units in 2010/11, and further roll out of the evolved model; this will be in coordination with the DOHS Equity and Access Adviser. Specific activities will include the development of technical guidelines, and support to the design of orientation training for health workers;
- Support for the mainstreaming of GESI into the Local Health Governance Strengthening Project implemented by the MOHP and Ministry of Local Development (MOLD). This will involve working with the Health Sector Reform Unit of the MOHP.

(d) Support the review, evaluation and documentation of GESI specific initiatives and good practices, including:

- Equity and Access Programme;
- Free Essential Health Care Services;
- Social Service Units;
- Gender based violence one-stop service centres;
- Gender based violence prevention programmes;
- Social audits.

(e) Networking, advocacy and dissemination through:

- Developing and maintaining internal and external networks to promote GESI, including Government, EDPs, development projects/programmes, and CSOs;
- Facilitating the development of government and CSO relationships and the creation of a more enabling environment in which CSOs can participate in policy processes, including the formation of Government-CSO forums for dialogue and monitoring;
- Advocating and disseminating GESI related health evidence.

Person Specification

Specification	Essential	Desirable
Education and training	• Masters in an appropriate subject and training in social, political and policy analysis and change	• PhD in an appropriate area
Experience	• At least 10 years of experience of working at the policy level • Solid experience of working with and influencing senior government officers and machinery • Experience in facilitating institutional change, and in capacity building for gender and social inclusion	• Previous technical position embedded in government, preferably in the social sectors • Building support and commitment towards social agendas • Previous experience of working in a post-conflict society
Skills & abilities	• Strong influencing skills, good analytical skills, excellent interpersonal and writing skills. Good networking and advocacy skills. Strong presentation skills	• Existing networks in Nepal
Special aptitudes	• Confident in working at senior levels of government	
Interests		
Disposition	• Team player • Gender sensitive and socially inclusive attitudes and values	
Circumstances		

Equity and Access Adviser

EMPLOYER: Options Consultancy Services Ltd

REPORTING TO: Team Leader

DURATION: 3 years

LOCATION: Based in the Department of Health Services, Kathmandu. Some travel within Nepal is likely.

COUNTERPART: Director, Revitalizing PHC Division, DoHS

Background

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the MOHP along with External Development Partners have designed the second phase of the Nepal Health Sector Programme named as NHSP-2, a 5 year programme, which will be implemented from mid-July 2010. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2.

Role Objective

The purpose of this post is to support the Department of Health Services (DOHS) with the mainstreaming of gender and social inclusion into programming and implementation. The Equity and Access Adviser will provide technical and practical support to the implementation of equity and access and social accountability initiatives, programmes and pilots led by the DOHS and its divisions. S/he will support the practical application of Gender Equality and Social Inclusion (GESI) principles and good practices into programming and delivery. The priority focus of the adviser will be to support the Government to sustain, strengthen and broaden the remit of the Equity and Access Programme.

In addition, the Equity and Access Adviser will provide technical support to social protection and social accountability initiatives, and GESI initiatives related to reaching the underserved, child health, urban health, nutrition and gender based violence. S/he will coordinate and manage short term technical assistance to IEC/BCC. S/he will work across government to build coordination on GESI and IEC/BCC. The adviser will work closely with the technical advisers for Essential Health Care Services, Maternal, Newborn and Child Health, Nutrition, Health Financing, and Monitoring and Evaluation, and regional GESI/BCC technical specialists and the Gender and Social Inclusion Adviser based in the MOHP.

Specific Areas of Responsibility

(a) Practical and technical support to the Equity and Access Programme (EAP), including:

- Management support to the contracting process and the shift to multi-year contracting;
- Technical support and supervision to district implementing NGOs including sharing of lessons learned from earlier cycles, and orientation training;
- Technical and practical support to the D/PHOs and Public Health Nurses who provide local support, management and coordination of the programme;
- Technical and practical support to NHEICC in the design, facilitation and development of locally appropriate complementary IEC/BCC materials ;
- Technical and practical guidance in NGO monitoring and learning;
- Support to the DOHS and districts in evidence gathering and lesson learning;
- Technical support to the broadening out of EAP to include wider public and primary health care, and social accountability for health issues;
- Forging linkages with Ministry of Local Development (MOLD) GESI and social mobilisation initiatives;
- Strengthening the social accountability capacity of EAP;
- Advocacy and dissemination of EAP achievements and learning across the sector and to external stakeholders.

(b) Technical and practical support to other priority equity, access and social accountability initiatives at DOHS level, in coordination with technical advisers, and by drawing on short term TA as appropriate:

- Supporting the Health Financing Adviser to:
    - Strengthen claims by the poor and disadvantaged for Free EHCS by raising awareness through various community level and IEC initiatives, and improving social auditing. This will include for example, strengthened evidence gathering; district and local assessment and planning; development of targeted BCC and community initiatives; and strengthening of social accountability mechanisms ;
    - Increase uptake of Aama among the poor and excluded, and strengthen social auditing
    - Review progress of Free EHCS and Aama to reach the poor and socially and geographically disadvantaged groups; contribute to the design of impact evaluations to ensure inclusion of GESI lens;
    - Design and support the monitoring and evaluation of community based health insurance pilots to ensure inclusion of, and that benefits reach women, the poorest and socially disadvantaged;
    - Develop appropriate poverty identification measures for the health sector.
- Guide short term technical support to the National Health Education Information and Communication Centre (NHEICC) to:
    - Undertake a strategic review of the programme of work and facilitate high level dialogue on the repositioning of the centre;
    - Strengthen coordination among partners supporting the centre;
    - Provide secretariat support to the BCC Sub-Committee;
    - Provide technical support for the delivery of agreed priority IEC/BCC products.
- Support design and implementation of Gender Based Violence one-stop service centres, and prevention programmes;
- Support application of the Remote Area Guidelines, and other targeted, local area planning, including child health micro-planning;
- Support the Revitalising Primary Health Care Division to integrate GESI into urban health programming;
- Design pilots and initiatives to increase access to family planning for disadvantaged and unreached groups, and support their monitoring and evaluation from a GESI perspective in coordination with M&E advisers;

- Support the Nutrition Adviser to design community nutrition pilots that draw from the learning on community mobilisation for health in Nepal, and empower women and families to introduce supportive feeding and caring practices of infants and children;
- Mainstream GESI into the ongoing management strengthening of Health Facility Management Committees and increase their gender and social inclusiveness, this will include the development of a GESI and Social Accountability Package and monitoring outcomes;
- Exploit opportunities for strengthening Health Facility Management Committees' (HFMCs') capacity to hold service providers to account and represent the views of the local population as the federal governance structures open up space for greater local governance;
- Work in coordination with the Gender and Social Inclusion Adviser to support the piloting and roll out of Social Service Units.

(c) Networking, advocacy and dissemination:

- The Adviser will have strong networking skills and will already have a strong network of government and CSO stakeholders;
- S/he will advocate for GESI within the Department, participate in departmental reviews as requested, and compile and disseminate evidence to government stakeholders.

Person Specification

Specification	Essential	Desirable
Education and training	• Graduate in an appropriate subject • Gender training • Social inclusion/development programming training	• IEC/BCC training
Experience	• Experience of building strong working relationships with government counterparts • Sound knowledge of government working practices, and experience in enabling government machinery • Experience of working with CSOs at national and local levels, and in mediating between CSO partners and Government • Experience managing short term TA to government • Experience of working in the health sector in Nepal	• Social development programming in Nepal • Community mobilisation programming, technical supervision and evaluation
Skills & abilities	• Team player with experience of working in a multidisciplinary team • Strong communication skills • Strong networker • Good at building consensus and mobilising diverse stakeholders behind a common agenda	• Existing good relationships with government officers in the health sector • Good analytical and problem solving skills • Strong dissemination skills

Special aptitudes	• Confident and capable advocate	
Interests		
Disposition	• Gender sensitive and socially inclusive attitudes and values	
Circumstances		

Regional Gender and Social Inclusion (GESI) / Behaviour Change Communication (BCC) Specialists

EMPLOYER:	Options Consultancy Services Ltd
REPORTING TO:	Equity and Access Advisor
DURATION:	3 years
LOCATION:	Based at the Regional Directorates of Health, regular travel within and outside the region will be required.
COUNTERPART:	To be nominated

Background

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the MOHP along with External Development Partners have designed the second phase of the Nepal Health Sector Programme named as NHSP-2, a 5 year programme, which will be implemented from mid-July 2010. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2.

Role Objective

The primary purpose of the Regional GESI/BCC Technical Specialists is to strengthen GESI and BCC technical and supervision capacity at the regional level as a means of improving the quality of equity and access, social accountability and BCC implementation at the district and field levels. Long term GESI/BCC specialists will work at the regional level to build GESI capacity of the Regional Health Directorate to integrate gender and social inclusion into the technical supervision and support, and management and monitoring functions of the Directorate. The specialists will work alongside the GESI and BCC focal persons in the Regional Directorate. They will also support the GESI and BCC capacity development of regional training centres and district training teams. With solid community programming and BCC experience, the specialists will technically guide, support and monitor equity and access programming, social accountability initiatives, and BCC implementation.

Specific Areas of Responsibility

(a) Technical support to mainstream GESI and raise the profile of BCC in regional and district management systems:

- Undertaking a GESI and BCC needs assessment and situational analysis of the Region and facilitating the development of a GESI and BCC regional action plan;
- Supporting the training and coaching of regional staff and district managers on GESI and BCC;

- Providing technical support and guidance to the regional team to integrate GESI and BCC supervision and monitoring into the working practices of all the technical staff;
- Participating in field supervision and monitoring of GESI and BCC activities and programmes, and provide advice and practical assistance in their strengthening;
- Developing GESI and BCC planning and monitoring tools for use by the regional and district management teams;
- Contributing to, and participating in, regional review and planning processes;
- Contribute to GESI related evidence gathering and lesson learning.

(b) Provide technical expertise and problem solving inputs to strengthen the performance of equity and access, social accountability and BCC implementation; including, improving the coordination of district health management, training centres, DDCs, other line agencies, and CSOs. Specifically the specialists will provide technical support to:

- Implementation of the Equity and Access Programme in coordination with the Equity and Access Adviser, and short term technical assistance;
- Piloting and roll out of Social Service Units;
- Scaling up one-stop service centres for victims of gender based violence;
- Supporting district managers and providers to develop and test new approaches to increasing access to family planning and adolescent reproductive and sexual health services;
- Providing technical BCC expertise to strengthen BCC and IEC implementation; this will include:
    - Identification of IEC/BCC local needs;
    - Localising of materials;
    - Forging and strengthening working relationships with the National Health Education Information and Communication Centre (NHEICC);
    - Monitoring IEC/BCC interventions;
    - Coordination of local implementing agencies providing BCC services.
- Strengthening social accountability tools and approaches for Free Essential Health Care Services, Aama and other entitlements;
- Application of the Remote Area Guidelines and other micro-planning tools;
- Building the capacity of Health Facility Management Committees' (HFMCs') to integrate GESI into their functioning, and become more socially and gender inclusive bodies;
- Supporting HFMCs to reposition themselves into a stronger accountability body as decentralisation and the shift to a federal state unfolds.

(c) Support coordination with Ministry of Local Government, DDCs, and VDCs at the district level to:

- Ensure coordination and promote synergy between EAP and other access and BCC promoting initiatives, and Ministry of Local Development (MOLD) programmes; exploit the community mobilisation achievements of the VDC level Community Awareness Centres and the LGCDP's resources;
- Promote Regional Directorate's participation in District Social Mobilisation Committee, District Reproductive Health Coordinating Committee, and District Health Committee. Where possible assist in the integration of GESI and BCC into existing district coordination mechanisms, but where this is not feasible support districts introduce a District GESI and BCC Committee;
- Support the District Health Office to provide inputs to the DDC's bottom-up planning process. Identify health gaps and advocate for health resources to meet shortfalls and target resources to the poor and disadvantaged.

(d) Undertake equity and access, and rights based advocacy, and networking with government stakeholders and CSOs.

Person Specification

Specification	Essential	Desirable
Education and training	• Graduate in an appropriate subject • Training in gender and social inclusion programming	• IEC/BCC training
Experience	• Working with government counterparts in Nepal • Providing technical supervision and support to field level programmes • Community mobilisation projects. • Working in a multidisciplinary team • Working with CSOs at the local level • Working in communities and with frontline providers	• Experience of providing technical support to government and building capacity of counterparts • Experience with implementation of IEC/BCC programmes • Working in the health sector
Skills & abilities	• Strong communication skills • Strong networker • Ability to mobilise diverse stakeholders and build consensus • Strong team player	• Good analytical skills
Special aptitudes		
Interests		
Disposition	• Gender sensitive and socially inclusive attitudes and values • Willingness to travel extensively	
Circumstances	• Able to relocate to a regional headquarters	

Annex 2

Stakeholders Consulted During the Capacity Assessment

Ministry of Health and Population
Dr. L.R. Pathak, Chief, Policy, Planning and International Cooperation Division
Dr. B.R Marasini, PPICD
Dr. B.K Suvedi, MoHP
Mr. Surya Acharya, Joint Secretary, Human Resource and Financial Resource Management Division
Mr. Padam Raj Bhatta, Joint Secretary, Population Division
Mr. Krishna Karki, Under Secretary, HuRDIS
Mr. Dipendra Kafle, Under Secretary, GESI Unit, PPICD
Ms. Sharada Pandey – Gender Focal Person
Mr. Lila Paudel, Section Officer, GESI Unit, PPICD
Mr. Mohan Thapa, Accounts Officer
Mr. Yedu Paudel, Section Officer, HuRDIS
Mr. Sabin Sharma, Computer programmer, HuRDIS

Department of Health Services
Dr. Bhim Singh Tinkari, Director RPHC Division
Mr. Arjun Bahadur Singh, Director, NHTC
Mr. Sagar Dahal, Family Planning Section Chief, FHD
Mr. Pawaran Ghimire, HMIS, Management Division
Mr. Dhurba Ghimire, HMIS, Management Division
Mr. Laxmi Narayan Deo, Director NHEICC
Mr. Badri Khadka, Senior Health Education Administrator, NHEICC
Dr. Puruswottam Raj Sedain, Child Health Division
Mr. Parsu Ram Shresthta, IMCI, Child Health Division
Mr. Achut Lamichhane, RPHC Division
Representative of National Centre for HIV/AIDS, Teku

Central Region Health Directorate, RHTC and DDC
Dr. Bikash Lamichhane, Director
Mr. Sagar Ghimire, Public Health Administrator
Mr. Rajendra Khatri, Senior Public Health Officer
Mr. Sunil Sharma, Chief, RHTC
Mr. Ramkrishna Thapa, Social Development Officer, Makwanpur DDC
Mr. Purusottam Dhakal, Planning Officer, Makwanpur DDC

Ministries and other Government Agencies
Mr. Madhu Regmi, GBV Unit, Prime Minister's Office
Mr. Atama Ram Pandey, Joint Secretary, Social Sector Division, NPC
Programme Director Health Desk, NPC

Mr. Prasant Pant, NPC
Mr. Gaja Bahadur Rana, Under Secretary, MOWCSA
Mr. Surya Prasad Shrestha, Under Secretary, MOWCSA
Mr. Surendra Subedi, Gender Focal Person, MOA
Joint Secretary Department of GESI, MOA
Ms. Sudha Neupane, Section Chief, GESI Section, MOLD
Mr. Bharat Karki, Section Officer, GESI Section, MOLD
Mr. Amrit Lamsal, LGCDP

External Development Partners
Ms. Bandita Sijapti, Gender and Social Inclusion Specialist, World Bank
Mr. Chaohua Zhang, World Bank
Ms. Anita Khadka, GTZ
Mr. Khem Raj Shrestha, NFHP
Team of GEMSIP, JICA
Ms. Sudha Pant, UNFPA
Ms. Saru Joshi, UNIFEM

Civil Society Organisations
Arzu Rana Deuba , Chairperson, Safe Motherhood Network Federation
Dr. Neena Khadka, SAVE