Aug 2013

Ministry of Health & Population

NHSSP

GESI Mainstreaming in Nepal's Health Sector: Progress Review and Process Documention

Population Division
Ministry of Health and Population
with support from the
Nepal Health Sector Support Programme

Strengthening Health Systems-Improving Services

EXECUTIVE SUMMARY

A. Background

Nepal's Interim Constitution (2007) and the political commitments to gender equality and social inclusion (GESI) in the country have ushered in new opportunities for sectoral ministries to address gender and exclusion and to integrate GESI into their systems and services. The Ministry of Health and Population (MoHP) laid down the policy frameworks for GESI in its Health Gender Equality and Social Inclusion Strategy (2010) and the Second National Health Sector Programme (NHSP-2, 2010-2015).

This report documents achievements made in mainstreaming GESI in the health sector since technical assistance was mobilised for this purpose under the Nepal Health Sector Support Programme (NHSSP) from 2011 until mid-2013. The support to mainstreaming GESI provided by other EDPs, while seen as significant, is therefore not reflected in this report. However, it is acknowledged that GESI mainstreaming is, and will require to remain, an effort to be supported by all partners to the sector.

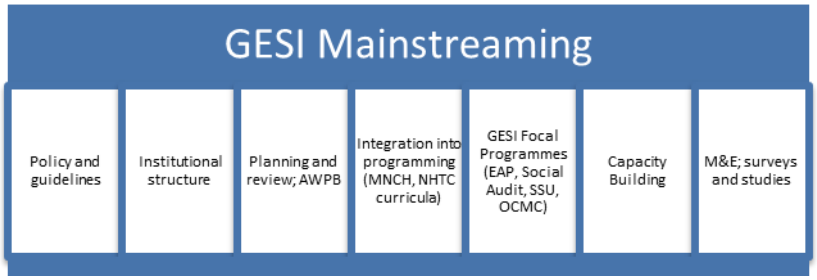
This report describes the processes followed, identifies enabling and constraining factors that have affected progress, and the lessons learned for the health sector and other areas of government. Based on these, the report presents some ways forward to build on achievements to date and to sustain hard-earned momentum in GESI.

B. Achievements

Considerable achievements have been made by MoHP in creating an enabling environment for GESI and establishing an institutional platform for its mainstreaming. Key outputs include:

- The establishment of a comprehensive institutional structure for GESI mainstreaming from the ministry level down to individual health facilities (see Chapter 4).
- The development of GESI operational guidelines to support the implementation of MoHP's GESI strategy (see Chapter 3).
- Strengthened the understanding of GESI and why it needs to be addressed by the health system among central, regional and district level policy makers and managers (see Chapter 8).
- The integration of GESI into health sector business plans and annual work plans and budgets (AWPBs) (see Chapter 5).
- An enhanced focus on reaching underserved geographical areas and communities in maternal, neonatal and child health (MNCH) programming (see Chapter 6).
- The scaling up of social auditing and piloting of social service units (SSUs) and one-stop crisis management centres (OCMCs) (see Chapter 7).
- The generation, analysis and use of disaggregated data on assessing health outcomes of women, and poor and excluded people and the barriers these people face in accessing services (see Chapter 9).
- The inclusion of disaggregated data into the revision of the Health Management Information System (HMIS) (see Chapter 9).

A key enabling factor for the entire GESI agenda has been the leadership and commitment shown by successive health secretaries and Population Division chiefs posted to MoHP over the past three years. The policy mandate plus leadership direction provided the basis on which institutional structures for GESI could be established and progress made in integrating GESI into the institutional systems and processes that govern how the health sector works. Authentic evidence on the magnitude and nature of disparities, along with the availability of responsive technical assistance across the sector were key additional enabling factors.



The government's GESI mainstreaming approach has been guided by experiences in the health and other sectors, and framed around the seven core pillars of work shown in the above diagram. Entry points and opportunities for mainstreaming GESI have been seized as they emerged aided by the availability and flexibility of technical assistance (TA) located in MoHP, the Department of Health Services (DoHS) and the regional health directorates (RHDs).

The space for mainstreaming GESI and speed of related processes have inevitably been affected by prevailing institutional and structural conditions including: staffing constraints and capacities; the working culture; the centralised nature of decision-making, programming and budgeting; and the incentives, or lack of them, that drive motivation. Against this backdrop, it has proved essential for GESI technical assistance to demonstrate an advanced understanding of GESI principles and of how the health system works – including the forces that drive change - in order to be able to build a path of influencing that has real traction. Mature process facilitation skills of technical assistance have also been key to allowing this critical work stream to move forward.

For effective gender and inclusion mainstreaming, the government must lead and own the full GESI agenda. The Population Division has learned that technical assistance must help build the confidence and competence of government personnel to advance GESI mainstreaming. TA has to be highly skilled in order to maintain conceptual rigour while applying GESI principles to different working contexts and situations and while seeking to influence a wide range and variety of target audiences. TA has to recognise the realities of those they are working with, be honest without holding hidden or personal agendas, and make intelligent use of available networks and resources (allies, champions within government, technical assistance teams, external development partners [EDPs) etc).

C. The Way Forward

Building a common understanding of GESI, and changing the attitudes of people that make up the health system are long-term processes that need to be tackled through institutional and system change, capacity building, and changes in the broader socio-political environment. Tremendous progress has been made in the past three years but for these efforts to be continued and momentum sustained, a number of key areas of work need to be taken forward as follows:

Policy level:

- Ensure that any health policies that are newly formulated or revised, updated or amended (e.g. the National Health Policy, the Population Policy and NHSP-3) integrate GESI concerns and that GESI inputs are made during the whole policy formulation process.

GESI institutional structure:

- Strengthen MoHP's Population Division to work as an effective GESI Secretariat and strengthen the capacity and functioning of the GESI Committee in DoHS, GESI technical working groups (TWGs) and to make health facility operation and management committees (HFOMC) more GESI responsive.
- Build the advocacy and application skills of GESI focal persons.
- Build the capacity of the Primary Health Care Revitalisation Division (PHCRD) on GESI to enable it to work effectively as the member secretary of DoHS's GESI Committee.

Human Resource for Health Strategic Plan:

- Influence workforce planning and the development of the long-term workforce plan and human resource projections to ensure that staffing patterns promote diversity and, thereby, easier access to health services by people from all social groups and especially women.
- Revise personnel job descriptions to integrate GESI responsibilities within and alongside technical responsibilities.

Capacity strengthening on GESI application:

- Provide advanced skills training for central level GESI focal persons and for GESI focal persons and statistical officers at the district level.
- Provide GESI orientation for key programme supervisors and service providers including public health nurses and staff nurses.
- Develop a core group of GESI master trainers.
- Produce a standard training manual on GESI (based on the GESI Operational Guidelines, 2013) that incorporates inclusive governance training materials.
- Pre-test and finalise GESI modules and materials in the five recently reviewed National Health Training Centre curricula.

Planning, reviewing, annual work planning and budgeting:

- Integrate GESI into the planning and review guidelines issued by the Management Division that are passed down to regional, district and health facility levels.
- Advocate for the National Planning Commission (NPC) to use the business plan format for presenting the AWPB activities on governance, GESI, procurement and technical assistance requirements so that this becomes a formal part of the government planning system.
- Formalise the planned district flexible (health care) fund with criteria and implementation guidance to ensure that the needs and priorities of women and poor and excluded people are identified and addressed.

Programming:

- Develop a roll-out plan for the GESI Operational Guidelines to be implemented by the Population Division. District programme implementation guidelines, which are to be prepared by the different divisions and sent to district health offices (DHOs) and district public health offices (DPHOs) on programme implementation, must integrate GESI in activity implementation, target groups, outputs, work procedures and anticipated results. The numerous technical programme guidelines (e.g. guidelines for the Aama and Free Health Care programmes) need to be revised to incorporate GESI aspects.

GESI focused programmes:

- **One Stop Crisis Management Centres** — Strengthen OCMCs to make them functional. Advocate and provide support for developing jointly owned comprehensive OCMC guidelines for various government sectors to address gender-based violence (GBV).
- **Social Service Units** — Strengthen SSUs to make them functional. Systematic monitoring and sharing of lessons learned are needed between the two pilot NHSSP-supported hospitals and other SSUs funded through MoHP's AWPB.
- **Social auditing** — Strengthen the capacity of DHOs and DPHOs and social audit organisations for the proper implementation of social audits. Also, develop and make functional a mechanism to ensure that social audit findings reach programme divisions and centres through PHCRD.
- **Equity and Access Programme** — Advocate for multi-year contracting for NGOs to make the implementation of the EAP more effective and build the capacity of these NGOs to implement EAP and roll-out the programme into remote areas.

Supervision, monitoring, surveys and studies:

- Ensure that GESI is addressed as much as possible in all supervision and monitoring processes and in major studies and surveys.
- Revise the Integrated Supervision Checklist to incorporate GESI aspects and to promote its widespread use.
- Support implementation of the revised HMIS indicators and the use of disaggregated data and evidence during planning, programming and monitoring.
- Improve the dissemination and use of study and survey findings across divisions and centres for more effective and evidence-based programming.

The design and objectives of NHSP-2 have provided the policy mandate that has underpinned the progress made on GESI. Continued progress over the remainder of NHSP-2 will provide additional lessons to feed into the design of NHSP-3 and ensure it carries forward the full policy mandate on GESI.

ACKNOWLEDGEMENTS

The Population Division of the Ministry of Health and Population (MoHP) is the Gender Equality and Social Inclusion Secretariat alongside its core responsibility of population-related works. The division has worked tirelessly since it was given the former responsibility in 2011.

The mandate of the Government of Nepal is for a more just and inclusive society with the responsibility of the health sector being to ensure that good quality health services are accessible to all citizens, including women, the poor and the disadvantaged. Institutions across MoHP have been working on these issues for many years.

As the Gender Equality and Social Inclusion (GESI) Secretariat, the Population Division has directly supported the implementation of flagship services such as one stop crisis management centres and social service units. It has established a comprehensive institutional structure for ensuring that GESI issues are addressed from ministry to health facility levels and has led the way in developing operational guidelines to integrate GESI into the functioning of the health system and service delivery. Other divisions and centres have also made tremendous efforts to improve access to, and the use of, health services by underserved and unreached groups.

In order to record the different initiatives, to take stock of achievements and progress, and to learn from related processes, the Population Division decided to document the process and progress made in GESI mainstreaming in the health sector since 2011. This document reports on the results of this exercise.

I would like to extend my sincere gratitude to Dr Praveen Mishra, Secretary, MoHP for his guidance and leadership. I am very grateful to my team in the Population Division for working so hard on this important issue. I particularly thank Dr Bhuwan Poudel, Mr Mukunda Sharma, Mr Anil Thapa, Mr Rishi Lamichhane, Ms Januka Subedi, Mr Ramji Baral and Mr Kusumakar Dhakal for their untiring support in meeting this this responsibility for the Population Division.

I am deeply appreciative of the efforts of the divisional chiefs, regional health directors and DHO and DPHO heads for their efforts to address issues faced by women and poor and excluded people. I am also grateful to all the health workers who seek to reach these groups.

I greatly acknowledge the support provided by the Nepal Health Sector Support Programme (NHSSP) for this documentation of the GESI mainstreaming process. My special thanks go to the GESI team of Mr Sitaram Prasai, Mr Hom Nath Subedi, Ms Chhaya Jha and Ms Deborah Thomas.

I hope this document helps build the institutional memory of how GESI mainstreaming is being achieved in the health sector and also provides lessons for other sectors in Nepal.

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Chief, Population Division

Ministry of Health and Population

CONTENTS

ACRONYMS

AWPBs	annual work plans and budgets
BEONC	basic essential obstetric and neonatal care
CDO	chief district officers
CEONC	comprehensive essential obstetric and neonatal care
DHO	district health office
DPHO	district public health office
EAP	Equity and Access Programme
EDP	external development partners
EHCS	essential health care services
FCHVs	female community health volunteers
GAAP	Governance and Accountability Action Plan
GBV	gender-based violence
GESI	gender equality and social inclusion
GoN	Government of Nepal
HFOMC	health facility operation and management committees
HMIS	Health Management Information System
HRH	human resources for health
IMCI	integrated management of childhood illnesses
JAR	joint annual review
MNH	maternal and newborn health
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
NCP	Neonatal Care Programme
NDHS	Nepal Demographic and Health Survey
NHSP-2	National Health Sector Programme-2
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPC	National Planning Commission
OCMC	one stop crisis management centre
OPMCM	Office of the Prime Minister and the Council of Ministers
PHCRD	Primary Health Care Revitalisation Division
PPICD	Policy Planning and International Cooperation Division
RHCC	reproductive health coordination committee
RHD	regional health directorate
RHTC	regional health training centres
SBA	skilled birth attendant
SSU	social service unit
ToT	training of trainers
TWG	technical working group
UNFPA	United Nations Population Fund
VDC	village development committee

1 INTRODUCTION

1.1 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 highly successful in achieving improved health outcomes. Building on its successes, the Ministry of Health and Population (MoHP) along with its external development partners (EDPs) designed the second phase of the Nepal Health Sector Programme (NHSP-2), which is being implemented from mid-July 2010 for a period of five years. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women and poor and excluded people. Its mission, strategic direction and values all prioritise gender equality and social inclusion (GESI). The National Health Sector Support Programme (NHSSP) provides technical and capacity building assistance to the government to help it achieve the NHSP-2 results framework.

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

MoHP introduced its Health Sector Gender Equality and Social Inclusion Strategy in 2010 and has proactively sought to establish the structures, capacities and tools to operationalise this strategy. In 2011, MoHP established an institutional framework for GESI mainstreaming that reaches from the centre down to the health facility level. GESI orientation and training has been initiated at central, regional and district levels and efforts are underway to integrate GESI into focal national training curricula. Most recently, the government has drafted GESI operational guidelines to support implementation of the GESI strategy, and attention to GESI is increasingly being integrated into annual work plans and budgets (AWPBs), and business plans.

1.2 OBJECTIVES

Against these initiatives to mainstream GESI in the health system, the Population Division, as the GESI Secretariat, decided to take stock of progress made, to learn from the process followed, and to start to map out the way ahead. It thus undertook a review of the progress made in mainstreaming GESI during the first phase of NHSP-2 (Jan. 2011 to July 2013) to identify what has been learned to date in the health sector in Nepal, and to identify GESI-related priorities for the remainder of NHSP-2.

The objectives of the review were fourfold:

- To review and document progress and key achievements in GESI mainstreaming in the health sector.
- To learn from the process, identify the challenges and enablers, and explain how and why progress has been made.

- To identify priorities for the next two years to sustain momentum and guide future action.
- To contribute to MoHP's lesson learning to strengthen GESI mainstreaming in the health and other sectors.

An additional objective of this document is to learn how technical assistance can be most effective when working with the government on GESI mainstreaming.

1.3 METHODOLOGY

The review was facilitated by NHSSP's GESI team[1] and involved consultations with a selection of stakeholders in MoHP[2], the Department of Health Services (DoHS), the regional health directorates, district public health offices and district health offices to capture perceptions of progress made on GESI mainstreaming, challenges experienced, priorities for the future, and lessons learned. Regional and district level GESI technical working groups (TWGs) were consulted. Insights from NHSSP's GESI team and other technical advisers were also sought. Relevant documents produced by the Government of Nepal, external development partners and NHSSP over the past three years were reviewed. Separate interactions with the staff at Population Division and other MoHP officials provided insights into the process, its achievements and lessons learned.

1.4 ORGANISATION OF THE REPORT

After presenting the government's framework for mainstreaming GESI in the health sector, this report is structured around the seven pillars of mainstreaming:

- policy and guidelines;
- the institutional structure;
- planning, budgeting and reviewing;
- programming;
- GESI-specific programmes;
- capacity building on GESI;
- monitoring, evaluation, studies and surveys.

Each chapter documents the achievements, the process and methods used, enabling factors, constraints, and lessons learned and gives tips for enhancing impact. The report concludes with a discussion on lessons learned and recommended ways forward.

[1] At the time of this review NHSSP's GESI team comprised a full time GESI adviser located at MoHP (this was divided between two professionals from the consultancy company HURDEC), a full time Equity and Access Programme (EAP) (GESI) Adviser located at DoHS, full time GESI specialists in each of the five regional health directorates and an international GESI mentor, who provided guidance to the team. MoHP's adviser joined in June 2011 and the regional GESI specialists in August 2011. The other two members were part of the NHSSP team from the inception phase in September 2010.

[2] Over 140 people were consulted during the review as follows MoHP: 20; DoHS: 6; NHSSP: 9; NHSSP (regions): 8; RHD: 15; Districts and below: 80; EDPs: 2

2 FRAMEWORK FOR GENDER EQUALITY AND SOCIAL INCLUSION MAINSTREAMING

2.1 MOHP'S APPROACH TO GESI MAINSTREAMING

MoHP's GESI strategy recognises that exclusion exists in Nepal and that this impacts health outcomes. NHSP-2 (2010-2015) has explicit strategic directives and objectives regarding gender equality and social inclusion issues. Its results framework, Governance and Accountability Action Plan (GAAP) and Implementation Plan demonstrate MoHP's commitment to GESI and its approach to addressing the health needs of women and poor and excluded people.

2.2 DEFINING EXCLUSION

The Interim Constitution (2007), the Three Year Interim Plan (TYIP) (2007-2010) and the Three Year Plan (2010-2013) of the Government of Nepal (GoN) all state that those who have experienced exclusion and have not been mainstreamed into the nation's development are women, Dalits, Adibasi Janajatis (indigenous and ethnic people), Madhesis, Muslims, people living with disabilities, sexual and gender minorities, and people in geographically remote areas (Box 1).

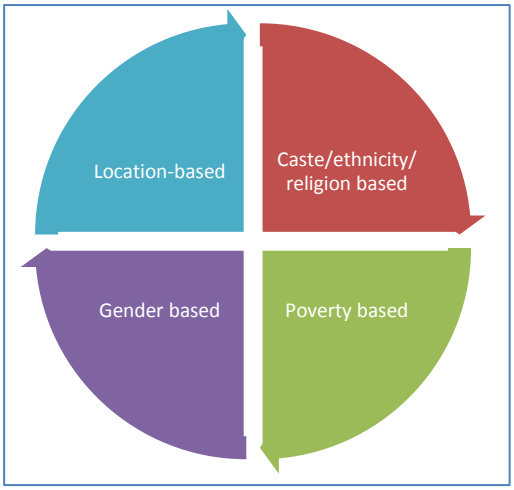
Women in general are the largest excluded population in Nepal and mostly remain marginalised economically, socially and politically. The human development indicators for Nepalese women and girls, irrespective of caste, ethnicity and geographic location, are lower compared to those for men and boys.

Box 1: The Interim Constitution and the Interim Plan's statement of excluded groups

The Interim Constitution: Section 3: Fundamental rights: Article 13: "No one will be discriminated against on the basis of religion, caste, ethnicity, gender, language... (p. 4); for women, Dalit, Adibasi Janajati, Madhesi, and socially or culturally discriminated groups affirmative actions can be taken" (p. 5). Article 21: "Economically, socially or educationally disadvantaged groups like women, Dalit, Adibasi Janajati, Madhesi community" (p. 7).

Three Year Interim Plan 2064: Message from the Prime Minister: "those who have experienced exclusion - disabled, women, Dalits, Adibasi Janajati, Madhesi, Muslim and backward regions"

Figure 1: The four dimensions of exclusion in the health sector



While recognising that different social groups have different needs, the health sector has defined exclusion as primarily:

- poverty-based;
- gender-based;
- caste, ethnicity and religion-based; and
- geography and location-based (see Figure 1).

Context specific barriers to define who is not accessing or using quality health services are understood to be essential for each specific health service.

2.3 THE AREAS OF CHANGE TO ADDRESS EXCLUSION

Recent discourse in Nepal has recognised that to address exclusion and for effective change in people's lives and for equality, development efforts need to both:

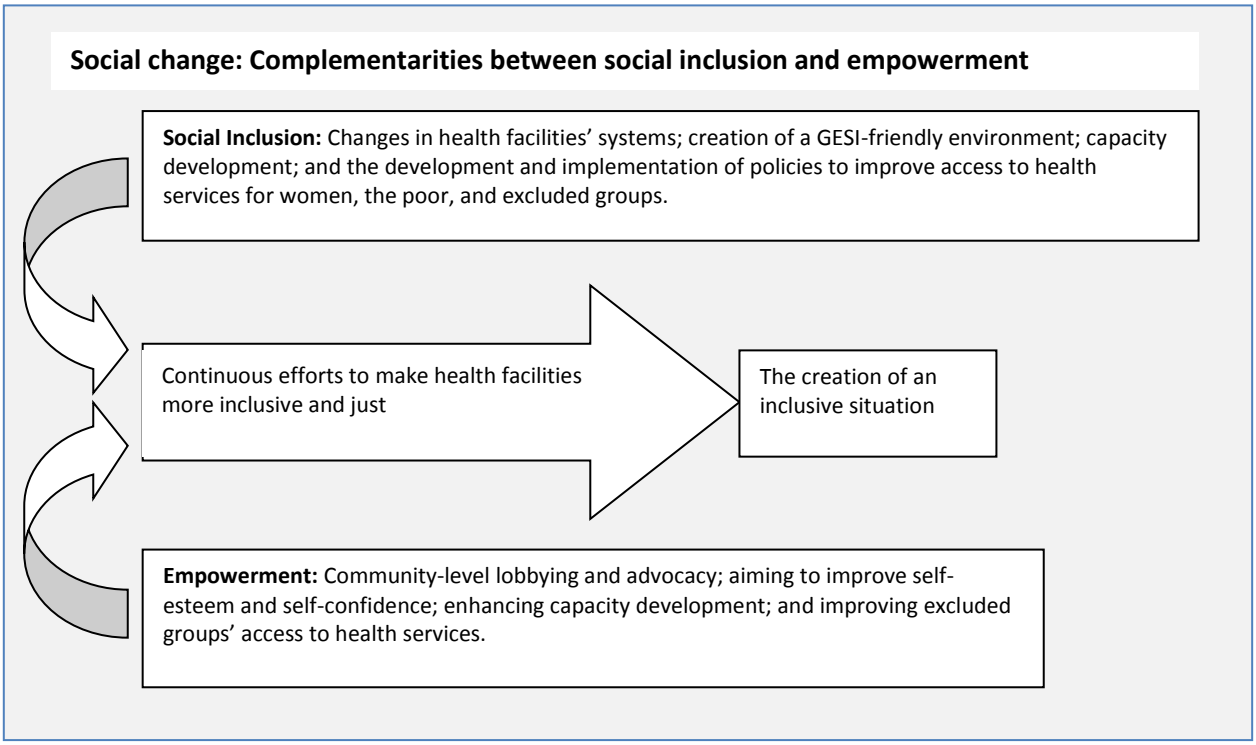
- empower women and men of all social groups, covering both livelihoods and voice empowerment; and
- change institutional rules (as manifested in informal and formal policies, behaviour and social practices from household to state levels).

This conceptual framework for addressing exclusion recognises that meaningful and sustainable development will occur only when people of different social groups improve:

- their livelihoods (i.e. improve health, education, income and employment aspects); and
- their abilities to claim rights and influence decisions (i.e. enhance their voice).

Along-with this, rules that control the distribution of assets, opportunities and voice to different individuals and groups have to be made more equitable (Figure 2).

Figure 2: Areas of change necessary to address exclusion



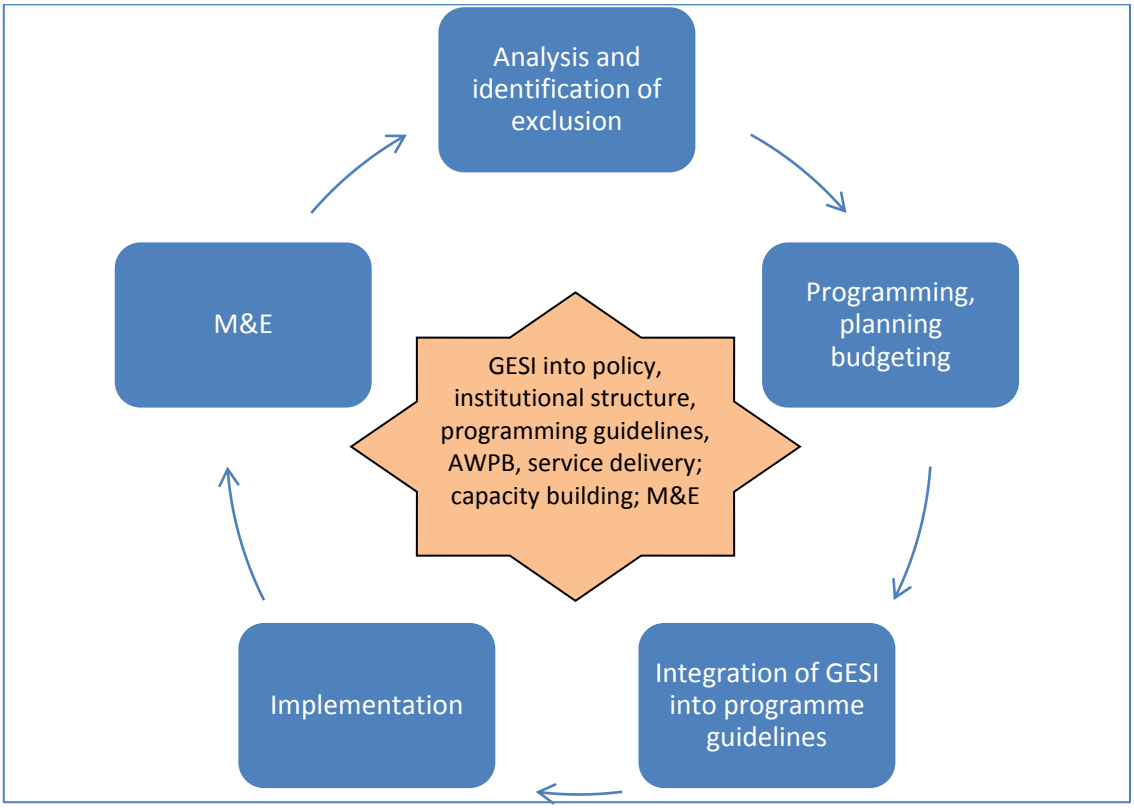
Source: Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion, MoHP, 2013.

The GESI mainstreaming process aims to ensure that a holistic approach is taken to address the health needs and rights of women and poor and excluded people.

2.4 STEPS FOR GESI MAINSTREAMING

For mainstreaming GESI in the health sector, MoHP's Population Division, which is the GESI Secretariat in MoHP, realised that it was essential that the barriers faced by women and poor and excluded people be recognised and that the policies, institutional arrangements, programming, planning and budgeting and M&E systems needed to be revised or adjusted to become more GESI responsive. Figure 3 visualises the steps for mainstreaming GESI in the health sector.

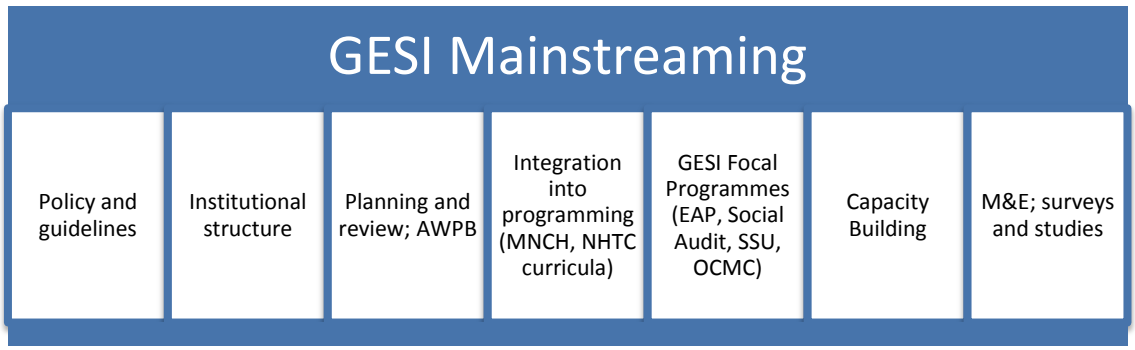
Figure 3: Steps for mainstreaming gender equality and social inclusion in the health sector



Based on these key steps, the main pillars of GESI mainstreaming work in the sector (see Figure 4) are:

- policy and guidelines;
- institutional structures;
- planning and review;
- integration into programming;
- GESI focal programmes;
- capacity building; and
- monitoring and evaluation, surveys and studies.

Figure 4: Pillars for mainstreaming GESI in the health sector



3 MAINSTREAMING GESI INTO POLICIES

This section discusses the efforts made during the period under study (Jan. 2011 to July 2013) to mainstream GESI into health sector policies, strategies, manuals and guidelines.

3.1 ACHIEVEMENTS

Building on the mandate of the GESI Strategy (2010), a number of policy documents have been developed specifically to address GESI (Table 1). Most importantly, the GESI Institutional Structure Guidelines were approved in 2012 (although the concept note on this had been accepted by the health secretary in 2011). This created the institutional means for integrating GESI into the health sector. Other broader documents that have been developed or revised have been reviewed from a GESI perspective by the GESI technical assistance team.

Additionally, policy directives have been issued for integrating GESI into sector level plans such as the NHSP-2 implementation plan (IP), annual workplans and budgets and business plans, as well the 2012 joint annual review (JAR) report (see Table 1).

Table 1: GESI policy documents and directives with aspects of GESI incorporated

	Policies, strategies, guidelines	Status or remarks
GESI specific policy documents:		
	GESI Concept Note for GESI Institutional Structure	Developed in June 2011 and converted into the Institutional Structure Guidelines in 2012
	GESI Institutional Structure Guidelines	Approved by the health minister
	GESI Mainstreaming Operational Guidelines	In approval process
	One stop Crisis Management Centre (OCMC) Manual	Approved
	Guidelines for Emergency GBV Funds (within OCMC)	Approved by regional health directors
	Social Service Unit Guidelines	Approved
	Social Audit Guidelines (comprehensive)	Approved by the health minister
Policy documents with GESI integration:		
	Urban Health Policy	Under scrutiny by MoHP's legal section
	State, Non State Partnership Policy for Nepal's Health Sector	Draft produced
	Human Resources for Health (HRH) strategic plan	Approved
	HRH Workforce Planning	On-going
	District Health Planning Guidelines	Approved (being piloted)
	Health Infrastructure Structural Design Guidelines	Approved
	NHSP-2 Implementation Plan	Approved
	Strategy for Maternal Under-nutrition	Draft produced
	Geriatric Ward Operational Guidelines	Draft produced
	Community Health Unit Operational Guidelines	Approved by director general
	Healthy Village Operational Guidelines	Approved by director general
	Integrated Public Health Campaign Guidelines	Approved by director general
Directives:		
	Directive for GESI inclusion in NHSP 2-Implementation Plan	Letter sent by chief PPICD to all divisions and depts
	Directive for GESI integration in Business plans and AWPBs	Letter sent by chief PPICD to all divisions and depts
	Directive for inclusion of GESI report in 2012 JAR	Letter sent by chief, Health Sector Reform Unit

3.2 THE PROCESS FOLLOWED

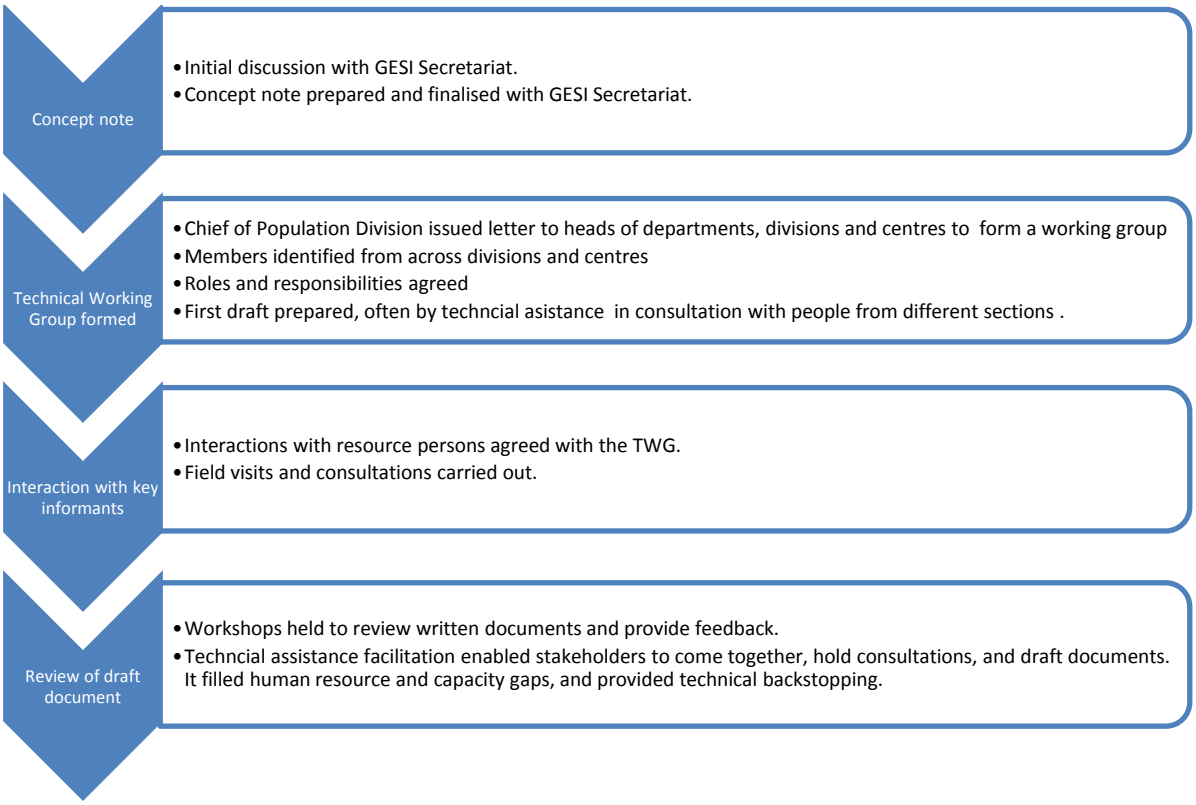
For GESI-specific policy documents

The development of GESI-specific policy documents followed a formal process, which encouraged cross-sectoral participation and was led by the GESI Secretariat. This reinforced the leadership of the Population Division on GESI, which was an important endorsement for the division and sent an important signal to other sections in MoHP and DoHS. Technical assistance played a key facilitating role by bringing technical know-how to the process, as well as by stimulating the Population Division to reach out to other areas of MoHP and take leadership. These were important steps that sought to change common practices around policy development per se, and to strengthen the institutional influence of the Population Division. The process for integrating GESI into health policies and guideline documents is illustrated in Figure 5.

Box 2: Inclusion of voices in developing GESI Operational Guidelines

All 75 district representatives were consulted through regional workshops. District health officers, primary health care centres, health workers, female community health volunteers (FCHVs), community women and men from different social groups were consulted during field trips for other work and specifically during the preparation of the guidelines.

Figure 5: The process for integrating GESI into health policies and guidelines



GESI integration into documents

For non-GESI specific documents, interactions with the team responsible for drafting them were held and inputs provided by the technical assistance team from a GESI perspective. The GESI team was invited to participate in the process by concerned divisions either due to the influence of the Population Division itself or the concerned NHSSP adviser. A number of documents were thoroughly reviewed and where possible, GESI technical assistance advisers and Population Division GESI focal persons participated in interactions, consultation meetings and workshops and have sought to get GESI aspects incorporated. This has also been done within NHSSP for ToRs (see Box 3).

Box 3: GESI reviews of ToRs

NHSSP follows a system of carrying out a GESI review of all its ToRs. This results in the integration of GESI into the content of planned work and means that GESI advisers have been requested to provide expertise.

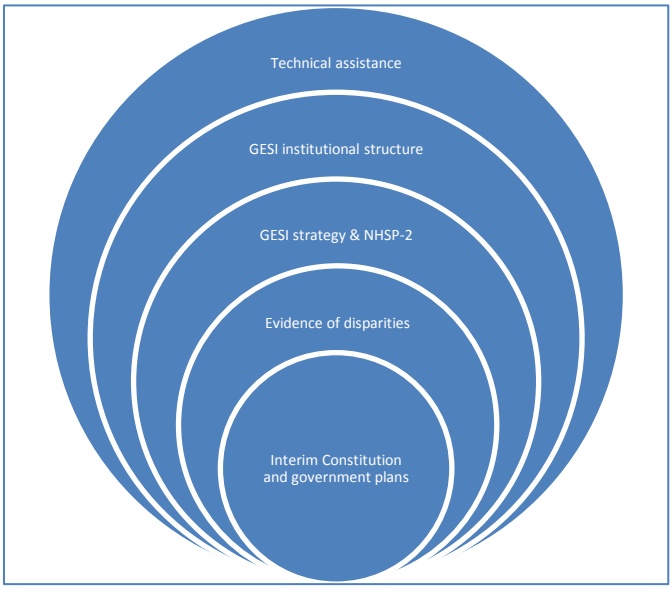
Over time, support from GESI technical assistance advisers has come to be sought earlier in policy design processes. Institutional rules to ensure GESI integration from the inception of policy development is however lacking and it is yet to become the norm that the GESI Secretariat or technical working groups or GESI focal persons are systematically involved in policy development and review.

Enabling factors

The following key factors have enabled GESI mainstreaming into policies since 2011. Figure 6 illustrates this process:

1. The political transformation in Nepal has provided a strong impetus for creating an enabling policy environment for GESI.
2. The Nepal Health Sector Programme-2 (NHSP-2) demanded GESI integration through its disaggregated targets, results and M&E frameworks.
3. The Health Sector GESI strategy (2010) provided strategic direction for GESI mainstreaming and the basis for further work to be accomplished on GESI.
4. Disaggregated evidence produced by the Nepal Demographic and Health Survey (2006) and from other government documents show wide disparities in health outcomes. This has reinforced understanding that issues of women and poor and excluded people need to be addressed if national and international commitments, targets and goals are to be achieved.
5. The creation of the institutional structures for GESI, and the GESI Steering Committee in particular, has played a crucial role in

Figure 6: Enabling factors for GESI mainstreaming



ensuring the development of GESI-specific and -sensitive policy documents and of addressing challenges in the course of their development.

6. A core group of people has been actively vigilant on the integration of GESI in different policy and guideline documents including in the Population Division, PHCRD, NHSSP and among external development partners.
7. The technical assistance support to MoHP, with two full time advisers, has enabled both the mainstreaming of GESI into policy documents and the implementation of policies. The location of technical assistance at different levels has been very important for influencing policies, programming and implementation.

Constraining factors

A key constraining factor for mainstreaming GESI in the health sector has been the country's prolonged political transition. This has impacted all government-related work. The key issues of inclusion, social identity and the equitable distribution of resources between regions have not been addressed as the restructuring of the state into a federal entity has yet to happen and cannot really go ahead until the new constitution is promulgated. This has allowed pro-status quo forces to remain dominant and argue against the issues affecting the inclusion of different social groups.

Weak institutional systems and processes and an understaffed MoHP are key challenges that affect all health sector work. At the policy level this has meant delays in discussions, in receiving proper feedback and only limited consultations with high level stakeholders. For example, sometimes it has taken more than three months to organise and hold relevant meetings. It took several months for the GESI Operational Guidelines TWG to find the time to commit to the workshop to review the draft document in detail.

A big challenge is the perception of many government personnel that the development of policy documents is carried out primarily to satisfy external development partner interests. As such working on policy documentation may not a priority for government officers. Shortfalls in GESI related skills and interests, institutional inertia and time constraints (Box 4) further compound this challenge.

Additionally, focused work on implementing the GESI provisions of NHSP-2 and of the GESI Strategy (2010) did not get up-to-speed until mid-2011, when technical assistance support to MoHP was deployed.

Box 4: The importance of participatory working

Participatory working with government counterparts for delivering technical assistance is crucial for building ownership of the mainstreaming process; even if efforts may be hampered by the differing priorities and time constraints faced by government colleagues.

Lessons learned and tips

1. It is important for the GESI mainstreaming process to be facilitated sensitively by technical assistance that has expertise on the content and also good process facilitation skills.
2. Technical assistance should be directed by the government so that it has a formal mandate and is officially sanctioned so that it can apply its expertise to maximum effect. Technical assistance should take steps to consciously build on government

owned and directed initiatives. For each initiative a formal decision making process should be initiated by government to establish clear legitimacy and authority.

3. A sharp eye should be kept on minor but important processes such as reminding authorities to send request letters for committee formation, supporting the drafting of letters to ensure that processes move forward on time, following-up to ensure that meetings are held, and ensuring that feedback is received.
4. Since it is often difficult for government staff to find the time and to comment on draft documents, it is important to recognise that this may not happen and that it is usually best to organise discussion meetings to solicit feedback.
5. It is essential to ensure that the government is fully in control and leads all the steps, minor and major, of policy development and that it is aware of what technical assistance support is doing.
6. It is important for divisions and GESI focal persons to have sufficient authority and seniority, but it is equally important to adjust and adapt to whatever is practical in any given context. For example, the acceptance by the Population Division to house the GESI Secretariat meant that the more influential PPICD was no longer the primary home for GESI (see below), but, as things turned out, the Population Division proved to be highly effective.
7. Background influencing work must continue, not only with direct counterparts and people responsible for GESI, but also with all key people in the divisions of DoHS.

The top five tips for mainstreaming GESI into policies are given in Box 5.

Box 5: Top five tips for mainstreaming GESI into policies

1. Technical assistance must appraise where it is crucial to address GESI to enhance leverage, to recognise and seize opportunities to build on existing government mandates and initiatives. This will take several years to achieve.
2. Substantive inputs need to be provided that are practical and that further the GESI agenda. There has to be conceptual clarity on recognising ways to apply GESI to the health system; and dedicated time has to be provided.
3. It is essential to also work on mainstream documents (i.e. those that are not GESI specific) and to integrate GESI perspectives into them.
4. It needs to be always borne in mind that the government is the responsible entity and not the technical assistance personnel. All messages (formal and informal) should reinforce this fact, especially in public.
5. Flexibility to respond to government requests on GESI and non-GESI areas, and conscious efforts to be timely are important as these build confidence and trust. It is also very important to nurture informal relationships to build trust.

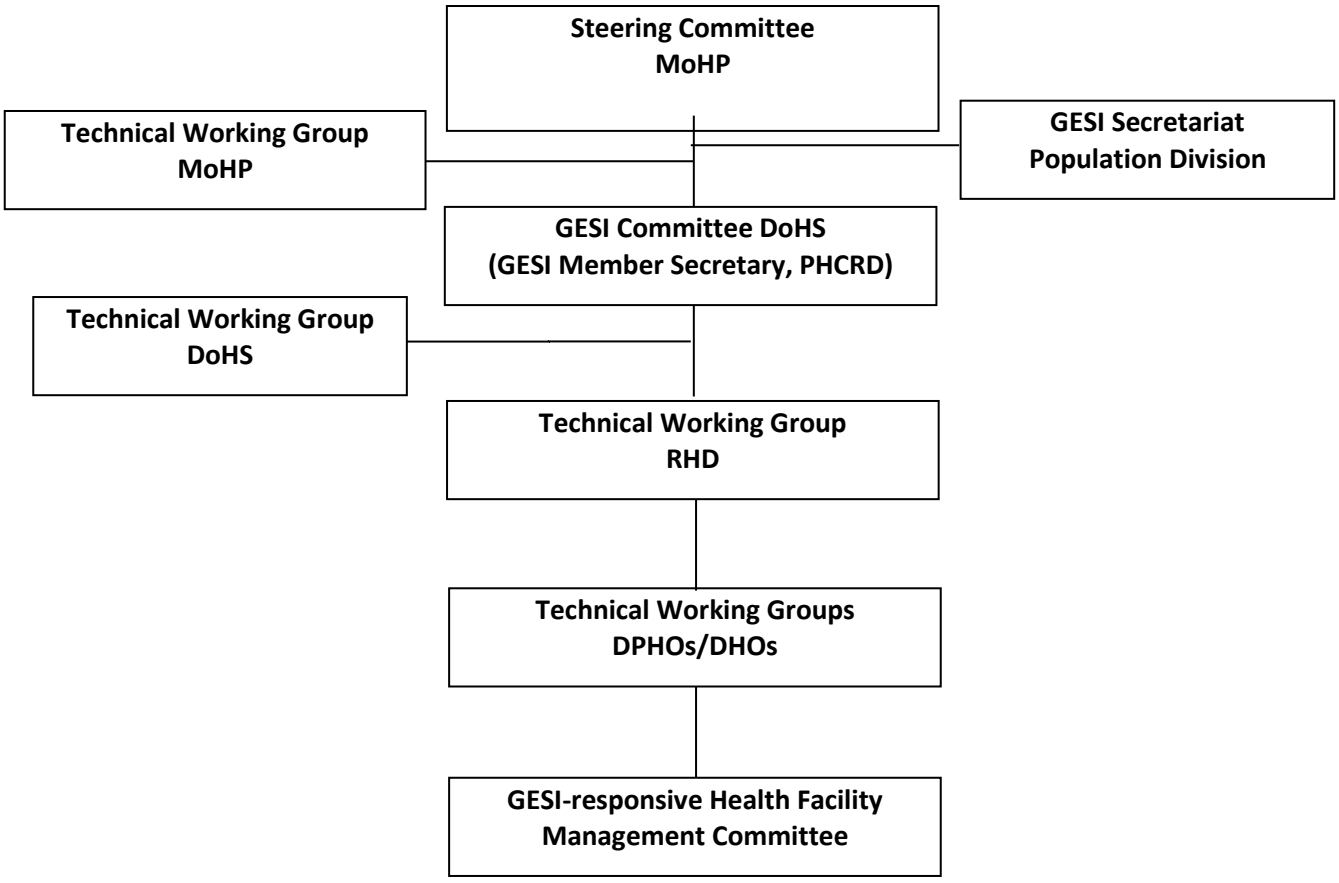
4 MAINSTREAMING GESI INTO MOHP'S INSTITUTIONAL STRUCTURE

Two critical developments for the GESI agenda were:

- the approval and establishment of an institutional structure for mainstreaming GESI; and
- the decision to make the Population Division the GESI Secretariat.

The current GESI institutional structure is illustrated in Figure 7.

Figure 7: GESI institutional structure



Source: GESI Institutional Structure Guidelines, MoHP, 2013

4.1 ACHIEVEMENTS

The main achievements since 2011 on developing an institutional structure for mainstreaming GESI are shown in Table 2.

Table 2: Main achievements since 2011 for developing an institutional structure for mainstreaming GESI

Structures	Status
Institutional Structure Guidelines	Approved by health minister in 2012
GESI Steering Committee	Formed in October 2011; meetings twice a year
GESI Committee, DoHS	Formed in December 2011; meeting once a year
GESI focal persons	One person nominated by each division and centre as GESI focal person
Technical working groups, regional health directorates	TWGs formed in all five regions in 2012; orientated on roles; met 1-3 times
Technical working groups, districts	Formed in 70 districts, meetings held at least once in many districts, and more than three times in many
HFOMC as health facility level GESI committees	GESI orientation and inputs required

4.2 THE PROCESS FOLLOWED

Meetings and consultations between the health secretary and PPICD chief and GESI advisers (technical assistance) were held in 2011 to identify what was required to implement the GESI Strategy (2010). The secretary and PPICD chief suggested that the Population Division should be made the GESI Secretariat because PPICD was already overburdened with work and would not be able to do justice to the task. The planning division (PPICD) is considered the natural home for GESI nationally and internationally, as it is there that key planning and financing decisions are made.

A series of informal discussions within the Population Division, facilitated by technical assistance, recognised the need for a defined institutional structure. It was decided that a concept note would be prepared defining modalities, roles and functions, and drawing on lessons learned from across ministries. Experiences from other sectors and gender focal persons in the health sector have shown the limitations of individual focal persons to bring about institutional change.

Based on the request of the Population Division, GESI technical assistance prepared a draft document that specified the conceptual framework of GESI, the need for an institutional structure and defined the structure, roles, membership and functions.

Through discussions with the Population Division and other key stakeholders in MoHP, recognition was built that GESI mainstreaming is a long term agenda that has to be addressed at all levels of the health system through existing structures and processes. The challenge was recognised as being to develop a structure with a strong mandate, but one that did not demand significant time inputs from senior management. The structure also had to reflect and bring on-board the various loci of power within the sector in a manageable way. This led to the decision to have a GESI Steering Committee located in MoHP chaired by the secretary, and a GESI Committee at Department level chaired by the director general. The Population Division was to be the GESI Secretariat and PHCRD the GESI member secretary for the GESI Committee at DoHS. The formation of technical working groups at regional and district levels was facilitated by regional GESI Specialists in partnership with regional health directors.

The Population Division chief was willing to take on the responsibility and was motivated to push the new agenda forwards. GESI gave visibility to the Population Division. The fact that many of the staff

had had previous postings in the social sector outside of health and were attuned and open to the importance of social issues helped embed GESI. The allocation of responsibilities for mainstreaming GESI into the Population Division supported the necessary discussions and negotiations in MoHP and DoHS to design the institutional structure and prepare the concept note. Based on this the Population Division's chief facilitated the process of forming the GESI Steering Committee under the chairmanship of the health secretary and with representation from the National Planning Commission and other concerned ministries.

The concept note, which was later converted into the institutional guidelines (2012), provided clarity on concepts and operating modalities and functions. The institutional guidelines, as a government-approved document, became a strong tool for advocacy to help form the working groups.

The Population Division has taken the initiative to establish partnerships with external development partners, including the United Nations Population Fund (UNFPA), to make the TWGs functional in their project districts. Realising that a lack of budget was hampering the functionality of these working groups, this year's AWPB (2013-14) of the Population Division now includes budgets for TWG review meetings at all levels, and participation in annual reviews.

4.3 ENABLING FACTORS

A major enabling factor for the entire GESI agenda has been the leadership and commitment of each of the health secretaries and the Population Division chief posted to MoHP over the past three years. The fact that the chief of the Population Division had worked with the division before, knew the institutional system well, and was interested in pushing the GESI agenda was a key factor.

Despite the GESI Strategy being approved in 2010, no formal structures were established for mainstreaming GESI until late 2011. Based on the concept note, the different structures were established and became critical enabling factors for taking GESI mainstreaming forwards.

As NHSP-1 shifted to NHSP-2, dedicated technical assistance for GESI became available in MoHP, DoHS and in the regional health directorates. The spread and quality of technical assistance was a key influencing factor in mobilising support for an institutional structure to be set up for GESI, to facilitate the tasks necessary to achieve associated approvals (e.g. drafting the guidelines), and for functionalising the committees and working groups. Both technical and financial support provided by technical assistance enabled the necessary discussions, consultations and workshops to go ahead.

Building a relationship of trust with designated GESI focal persons helped technical assistance at regional and central levels to facilitate various processes and provide the backstopping support as necessary. An assessment of who the key people were in the various offices, who the 'drivers' were in the regional and district health offices was important to identify those able to push the GESI agenda from inside those offices. Substantive work in this area by GESI TA helped gain the trust of regional directors, DHOs and DPHOs.

Meetings of TWGs were held more frequently in the Far Western Development Region because they were linked with the work of the region's reproductive health coordination committee (RHCC). This promoted wide participation and the integration of GESI issues into the RHCC agenda. This serves as a good example of how regional specialists sought entry points and used local opportunities to integrate and spread GESI influence. It is also noted that the GESI focal person at the Far Western Regional Health Directorate was influential in facilitating significant progress on GESI issues and, in particular, supporting the integration of GESI into service delivery at district level.

4.4 CONSTRAINING FACTORS

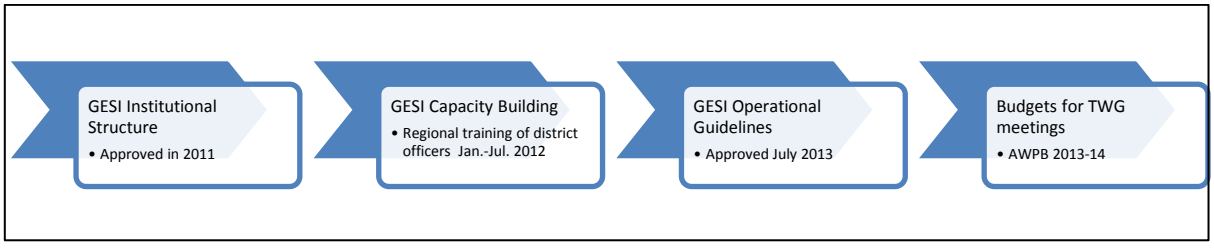
The busy schedule of the health secretary made it difficult for the government to find time to hold GESI Steering Committees meetings in 2013, although they were held as planned in 2012. While 2013's inactivity impacted on sharing of progress and issues, this did not overly hamper activities as the health secretary was positive towards GESI and approved the necessary decisions to allow progress to continue.

At the DoHS level, only one meeting of the GESI Committee was held and its key decision makers were therefore unable to engage effectively through this body. The Population Division, as the GESI Secretariat, was found not to be sufficiently powerful to pressurise the GESI Committee to convene meetings. Similarly, PHCRD as the member secretary of the Committee lacked the authority needed to influence senior leaders.

The low operational capacity of the regional health directorates (RHD) and absence of GESI counterparts in the directorates was seen to limit the functionality of the various GESI TWGs. The RHDs low status in MoHP together with frequent transfers of regional directors meant that RDs were not able to play their anticipated role in strengthening the institutional structure for GESI. A key constraining factor here was the absence of a budget for TWGs at all levels over the last two years. At the regional level, this translated into a lack of interest in holding meetings and the absence of an agenda for meeting discussions. The lack of specific directives from the GESI Secretariat to regional and district TWGs left them unclear as to how to proceed. The districts have also still to develop the capacity to manage such challenges and so make their TWGs functional. At the district level, an important constraint has been the excessive membership of the GESI TWGs. These need to have fewer members if they are to become more effective. Further, more advocacy is needed to counter arguments against the participation of external stakeholders, which health personnel perceive as burdensome.

The uneven progress in operationalising the GESI institutional structures reflects the time lag between establishing the structures and building core capacities, providing GESI operational guidelines and budgets for GESI activities.

Figure 8: Key steps in creating the institutional mechanisms for GESI



Flexible budgets for DHOs and DPHOs to run programmes for reaching underserved communities are still not available. As a result, the enabling conditions for GESI institutional structures to become active remains incomplete, and are likely to take several more years to develop. It was an ambitious plan to establish TWGs in almost all 75 districts without providing adequate technical assistance and ensuring that RHDs had the capacity and mechanisms to adequately support them.

Inadequate monitoring by the GESI Secretariat and a lack of demand by RHDs, DoHS and MoHP to learn the progress of TWGs have led to a lack of interest in making the TWGs more functional. Five district TWGs have not yet been formed due to a lack of interest from their DHOs, who in some

districts said that there is “no need for such groups”. Establishing and capacitating GESI structures across the country will take further efforts and more in-depth reflections and internalisation.

Given the large number of existing TWGs and the lack of government time to dedicate to GESI, arguments were made against forming independent GESI committees and working groups but rather subsume GESI activities into existing committees. This argument was not accepted by the government given the need to profile and undertake focused GESI work in this early stage of mainstreaming.

The Population Division experienced several challenges in carrying out its work as the GESI secretariat. Its position within MoHP does not give it the authority and power needed to ensure that its voice is heard by all. The centralisation of power across the sector, high rates of staff turnover, low staff interest due to a shortage of incentives, poor office facilities including insufficient space for staff, inadequate budgets and facilities to support regular communications with all regions and districts, low oversight capacity, and the inability to influence DHOs and DPHOs has decreased the ability of the division to work effectively as the GESI Secretariat. Additionally, mechanisms for monitoring, oversight, communications and coordination with external development partners and NGOs have yet to be institutionalised.

4.5 LESSONS LEARNED AND TIPS

The establishment of an institutional structure for integrating GESI into the health sector is a critical step in mainstreaming and is inevitably a political process subject to the balance of power and influence within the institution. The design of the structure has to weigh up many trade-offs in deciding where to locate responsibilities and who should lead at each institutional level. While organisationally a particular structure may appear the most obvious one, this has to be tempered by the level of capacity to execute responsibilities and the buy-in of key actors.

Preparatory ground work is needed to bring key decision-makers on board and for them to buy-in to a new structure before it is formally discussed and approved. This networking and advocacy can be difficult for institutional actors to undertake as it can challenge established patterns of influence and communication. Well qualified and trusted technical assistance can take this advocacy and mobilisation role on and support institutions to come to a consensus on new structures of communication and working.

Political commitment from the health secretary has created an enabling environment for institutional change, and influencing and advocacy to gain the secretary’s support has thus been critical.

An institutional structure is an important step for mainstreaming, but it needs to be quickly supported by strengthened capacities, operational guidelines and funding. Only then can new structures become functional.

Functionalising district and field level GESI mainstreaming units is an enormous task that has to be shared across development partners working at that level.

See Box 6 for the top five tips for mainstreaming GESI into MoHP’s institutional structure.

Box 6: Top five tips for mainstreaming GESI into MoHP's institutional structure

1. Proposed institutional structures must be designed to fit the institutional context and must be established with full mandates, and be part of existing structures. Care should be taken that proposed structures do not require complicated processes to be formally approved.
2. Roles and functions must be clear and must be formally approved by government.
3. Budget provisions and dedicated activities and capacities must all be part of the package of forming or strengthening institutional structures.
4. Technical assistance engaged in supporting government with GESI mainstreaming must assist government to recognise the importance and requirements of institutional structures and mandates.
5. Clear deliverables linked to routine work of the health sector must be established for the different GESI committees and working groups to be functional and accountable.

5 MAINSTREAMING GESI IN PLANNING, REVIEWS AND ANNUAL WORKPLANS AND BUDGETS

5.1 ACHIEVEMENTS

Table 3: Achievements on mainstreaming GESI into planning, reviews and AWPBs in the health sector

Event	Government provisions that have promoted GESI integration	Technical assistance contributions
1. Joint annual reviews (JAR)[3]	• Directive that a GESI report be part of the JAR reports.	• Influenced PPICD to ensure that a report on progress on GESI was included in JAR reporting. • Prepared the GESI report for the JAR with the Population Division according to the NHSP-2 GESI framework (GESI Strategic Framework, Annex 3)
2. Mid-term Review of NHSP-2	• ToR produced with specific tasks related to GESI that required a GESI expert to be part of the review team.	• Identified relevant documents and actors for the review team to meet. • Provided required secondary documents. • Discussions and consultations on progress, achievements and challenges with review consultant. • Reviewed first drafts for feedback.
3. Annual and half-yearly reviews and planning meetings		• Orientated key personnel on GESI integration in review and planning process. • Discussions facilitated with provision of disaggregated evidence. • Support provided for presentations and reporting.
4. AWPBs	• Business plan format with GESI section	• Where possible, helped select GESI-related activities. • Facilitated the GESI Secretariat to demand sufficient budget for GESI activities.
5. Budget allocations in AWPB	The Population Division, PHCRD, FHD and CHD have substantially increased their programme budgets for GESI-related activities in 2013/14 on 2012/13 levels. See Annex 1 for breakdowns. • Of the Population Division's total approved programme budget for 2013/14 (NPR 229 million, £1.8 million) 31% is GESI focused. • Of PHCRD's total approved budget for 2013/14 (NPR 95 million, £0.7 million), 81% is for drug procurement while 86% of the remainder is for GESI-related activities. • Of FHD's total approved budget for 2013/14 (NPR 372 million) 96% is for improving women's access to health care. • Of CHD's total approved budget for 2013/14 (NPR 2,617 million), 25% is specific for malnourished children and reaching children in remote locations.	• Facilitated the GESI Secretariat to demand sufficient budget in the AWPBs of the Population Division and PHCRD for GESI activities.
6. District programme implementation guidelines		• Technical assistance support to integrate GESI perspectives in district level microplans to plan and implement activities to address the needs of women and poor and excluded people.

Note: Exchange rate of @ NPR 130:£1 used

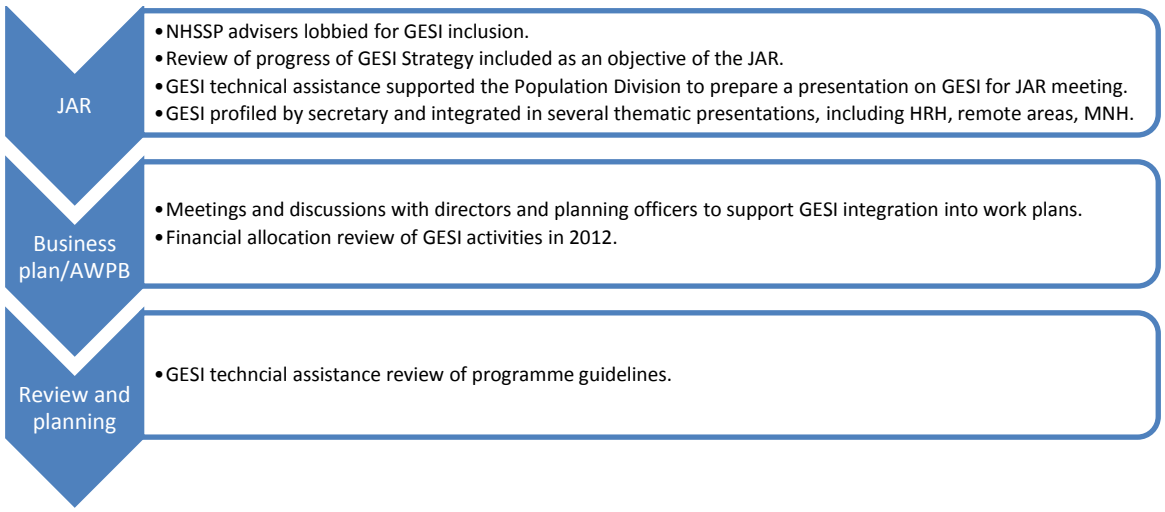
[3] Joint annual reviews are forums at which MoHP and EDPs jointly review progress across the sector and identify solutions and areas for further investment.

There have been substantial achievements on mainstreaming GESI into the health sector (Table 3). One of the most significant has been the large increase in budget for GESI related activities in the Population Division, PHCRD, FHD and CHD between 2012/13 and 2013/14 (see item 5 of Table 3 and Annex 1) – far beyond the 50.3% increase recorded in MoHP's budget as a whole (from NPR 20.24 billion to 30.43 billion). These increases are as follows:

- Population Division for SSUs (+240%), orientation programmes on GBV and GESI (+7,064%) and strengthening GESI institutional structures (+1,062%);
- PHCRD social auditing (+135%) and research (+150%);
- FHD activities to reach women in remote areas (+1,853%); and
- CHD activities to reach children in remote locations (+139%).

5.2 THE PROCESS FOLLOWED

Figure 9: Process followed to mainstream GESI in the JAR and business plans/AWPBs



5.3 ENABLING FACTORS

The JARs — The design of NHSP-2 set the stage for GESI to be systematically included in government-external development partner dialogue, and to be given due attention in monitoring and evaluation through the disaggregated results framework. An analysis of the joint annual review reports of 2011, 2012 and 2013 shows exponential growth in the attention given to issues of gender and social inclusion in the JARs (see Box 7).

Box 7: "A major area of concern"

The health secretary in his opening speech for of the 2012 JAR said that reaching hard-to-reach and socially excluded people was a major area of concern.

AWPB and business plans — The development and use of the business plan format has been a crucial factor in ensuring that GESI-related activities are identified, planned and budgeted within MoHP. NHSSP advisers supported PPICD to develop this format. The business plan format provided the entry point for GESI technical assistance to work with different divisions to identify how GESI could be integrated into their programming. This was reinforced by the DoHS GESI Committee directive to the GESI technical assistance team to identify the strengths and areas of improvement in the work of different divisions. The joint consultative meetings between MoHP and its external development partners to discuss AWPBs have reinforced the message that GESI activities are to be

explicitly addressed by all divisions. Technical assistance has enabled divisions to prepare their business plans with an explicit focus on GESI, good governance and improved procurement practices.

Consensus between the health secretary, the Population Division and PPICD to press for a substantial increase in funding for GESI related activities resulted in significant increases in allocations for the Population Division and PHCRD (see Table 3).

Review and planning meetings — The collection and use of disaggregated local evidence provided the regional GESI specialists with the information needed to convince RHDs to address access of underserved and excluded people to health services in review and planning meetings. The availability of technical assistance during preparatory meetings helped ministry GESI specialists hold such discussions.

5.4 CONSTRAINTS

AWPBs and business plans — A key constraint affecting GESI integration within AWPBs has been the politically instability in the country which has reduced line agency budget allocations. In FY 2012-13, the full budget was not released and some districts failed to receive their third quarter budgets. This meant that only the core activities of divisions and departments could be implemented.

In addition, the business plan format has still not been fully integrated into the government system and is frequently seen as a requirement of EDPs. AWPBs are prepared in Nepali, but business plans are prepared in English and are not presented to the National Planning Commission and the Ministry of Finance (MoF). Thus their preparation is given a lower overall working priority.

Gaps in understanding of what GESI actually means have also limited the incorporation of meaningful GESI activities. A number of planning officials claim that GESI is already a core component of their programmes, yet they are incorrectly attributing activities to GESI in their business plans. For example, the Epidemiology and Disease Control Division had included all malaria and kala-azar prevention activities under GESI on the grounds that these diseases mainly affected socially-excluded groups.

GESI principles appear not to have been universally understood and internalised across the ministry and this has led to variable commitments towards GESI planning and implementation. There were several cases where no GESI activities had been included in divisional AWPBs and business plans and in such cases, technical assistance had to be particularly proactive to encourage the concerned officials to include them.

Most business plans having significant GESI-related activities were the result of high levels of technical assistance inputs. This suggests an over-reliance on external TA and that GESI cannot yet be considered a priority at divisional level. An additional factor is the high reliance on EDPs to fund GESI workshops. Some EDP per diem rates for workshop attendance are significantly higher than those of government and this may be acting as a disincentive for MoHP to commit its own resources in this area. But until the ministry funds its own GESI workshops, it is unlikely that the topic will be given the support and prominence it needs within government.

Although MoF's approach to gender responsive budgeting is well established, in practice it does not appear to result in improvements to planning and the implementation of many targeted activities.

This led the GESI technical assistance team to apply another tool, financial allocation analysis, to identify activities targeted at specific groups and the creation of a GESI responsive environment.

Capacity building and advocacy activities, which are essential for GESI promotion, have often been cut by the MoF from MoHP budgets. MoF has also cut other GESI related activities which it deemed unnecessary. These actions tend to demotivate health planning officers who believe it may be futile to include GESI activities since they lack the authority and energy to challenge MoF decisions. The fact that sections in divisions tend to work in isolation and compete for funds and position also makes it difficult to coordinate GESI mainstreaming activities.

Reviews and planning — The review processes and decision making practices of MoHP reveal a number of systemic weaknesses. These include poor preparation, superficial reporting by districts and weak analysis of service utilisation data, especially on women and poor and excluded people. This has slowed the integration of GESI into the formal review system and limited opportunities for technical assistance to promote GESI mainstreaming. Additionally, the heavily centralised planning, programming and budgeting culture restricts opportunities for lower level institutions to plan using a GESI lens. The review and planning directives issued by the centre to regional health directorates and thence to district health authorities and health facilities do not include specific directives on GESI. The result is a lack of GESI-focused activities and absence of flexible budgets to respond to local GESI needs.

5.5 LESSONS LEARNED AND TIPS

Planning, review and budgeting are key processes affecting the implementation of all MoHP activities. As such, it is essential for key officials and technical assistance to seek to influence these processes in favour of GESI programming by adopting a vigilant, yet flexible and opportunistic, approach.

AWPB preparation is a period of high-pressure for government, and with many GESI-related activities seen as being of marginal importance, they are vulnerable to being cut. As such it is essential for GESI technical assistance to ensure that officals positioned to 'defend' GESI programming are motivated and able to do so. Technical assistance clearly needs to be sufficiently up to date on technical matters to be able to provide such guidance.

The diverse range of NHSSP TA specialists working across key sub-sectors has helped promote GESI mainstreaming. Advisers have made concerted efforts to introduce GESI into workstreams of the various divisions and centres. However, institutional and systemic weaknesses and internal politics in some places have occasionally countered progress made.

In Nepal, where planning capacities are relatively weak and decision making highly centralised, it is essential that central authorities lead processes of change. In less centralised settings, some scope normally exists for bottom-up innovation to play a part here.

However, while central government is providing the framework for GESI integration, its lack of operational capacity means that technical assistance has needed to play a role in helping health facilities put principles into practice at regional and district levels. Though progress has been uneven, the importance of providing technical support for GESI at local level is clear.

Box 8 below lays out the top five tips for mainstreaming GESI in planning, reviews and AWPBs.

Box 8: Top five tips for mainstreaming GESI in planning, reviews and AWPBs

1. Integrating GESI into the overall planning, budgeting and implementation process is essential to address the priorities and needs of women and poor and excluded people. This is a necessary precondition for enabling the mainstreaming of GESI into programmes.
2. Disaggregated evidence is needed to inform planning and budgeting from the micro- through to the national level.
3. Technical assistance must support government to gather and analyse the evidence required for effective GESI planning.
4. Continuous and intensive efforts are needed by technical assistance to facilitate processes of identifying GESI-related activities for inclusion in AWPBs.
5. Technical assistance must have a sufficiently sound understanding of GESI subject matter in order to guide government, and have workable ideas, options and solutions that government can implement.

6 GESI MAINSTREAMING INTO MNCH PROGRAMMING AND NHTC'S CURRICULA

This section focuses on progress made in mainstreaming GESI into the health sector programming since 2011. In line with NHSP-2, a major focus has been on mainstreaming GESI into maternal and newborn child health (MNCH), and in-service training, the latter being led by the National Health Training Centre.

6.1 MAINSTREAMING GESI INTO MNCH PROGRAMMING[4]

Achievements

The Family Health Division (FHD) was an early adopter of GESI programming, dating back to its support to the maternity incentive scheme (now 'Aama') in 2005, its funding of the Equity and Access Programme in 2008, its development of remote area guidelines for safe motherhood in 2009, and its purchase of stretchers for health facilities and communities in the mountains and hills, and bicycles for hill and Terai facilities and communities in 2009. Under NHSP-2, the stronger political support and policy mandate for GESI encouraged MNCH programming to take up additional GESI specific activities as follows.

Table 4: GESI activities integrated in FHD's AWPB, 2013/14

Areas of work	Activities
Local needs-based planning	• District and facility level mapping of health service use, and the planning of activities to target underserved communities.
Improving service quality and availability in underserved areas	• Strengthening comprehensive essential obstetric and neonatal care (CEONC) services in remote districts. • Expanding the number of birthing centres in peripheral health facilities. • Recruiting 1,800 staff nurses and auxiliary nurse-midwives (ANMs) for birthing centres and for basic essential obstetric and neonatal care (BEONC) and CEONC sites. • Contracting in of CEONC services in underserved districts. • Providing rural ultrasound services in 10 underserved areas. • Screening and treatment for uterine prolapse. • Strengthening the availability of family planning for remote, poor and excluded populations.
Enhancing access to services in underserved areas and for poor and excluded women	• Implementing the Aama programme. • Purchasing 25 ambulances for remote districts and stretchers for hill and mountain districts. • Establishing referral funds to include cover for airlifting women from remote areas in obstetric emergencies. • Providing obstetric first aid training for paramedics working in remote districts. • Launching a misoprostol programme to prevent post-partum bleeding during home deliveries (particularly important for women who live far from health facilities). • Providing incentives for the completion of the recommended four antenatal care visits. • Launching a pilot programme for the integration of family planning with vaccination programmes in three remote districts.

[4] For a fuller discussion on this issue see the paper 'NHSSP (2013) Gender Equality and Social Inclusion: From Strategy To Implementation. GESI Reflected in Family Health Division and Child Health Division Planning'.

	• Running satellite clinics providing long-acting family planning methods (IUCD and implants). • Expanding adolescent sexual and reproductive health services in 10 districts.
Behaviour change communication and social mobilisation	• Recruiting additional female community health volunteers (FCHVs) in selected districts, focusing on candidates from underserved and disadvantaged communities • Re-activating mothers' groups

- **Maternal and Neonatal Health** — FHD has been mainstreaming activities designed to reach underserved groups across its MNCH programmes in both its AWPB and business plan. Its 2013/14 business plan commits the division to focusing on poor, marginalised and vulnerable populations and its AWPB includes specific activities to reach these groups (see Table 4).
- **Child health** — Progress on mainstreaming GESI in child health programming has been slower than for MNCH with the main activities presented in Table 5.

Table 5: GESI activities integrated into CHD's AWPB 2013/14

Programme area	Activities
Immunisation	• Review and update of the Reaching Every Child immunisation programme through micro-planning and the integration of GESI. • Identifying, reaching and treating children in 15 poor performing districts. • Training FCHVs to identify and provide immunisation to vulnerable children.
Community Based IMCI and Neonatal Care programmes (CB-IMCI/NCP)	• Revision of the IMCI protocol training for health workers to integrate GESI. • Operational research to increase the access of hard-to-reach populations to IMCI and NCP services. • Implementation of the revised CB-IMCI protocol in 10 districts, including identifying and reaching vulnerable populations through FCHVs. • Operational research on reaching unreached children with IMCI and new-born care. • Increased supervision in poorly performing districts.

The integration of GESI into the National Strategy for Addressing Maternal Under-nutrition (2012) and its associated national action plan has also been achieved.

The process followed

The process followed for mainstreaming GESI into MNCH programming included supporting the provision of evidence and the carrying out of research (see Figure 10).

Enabling factors

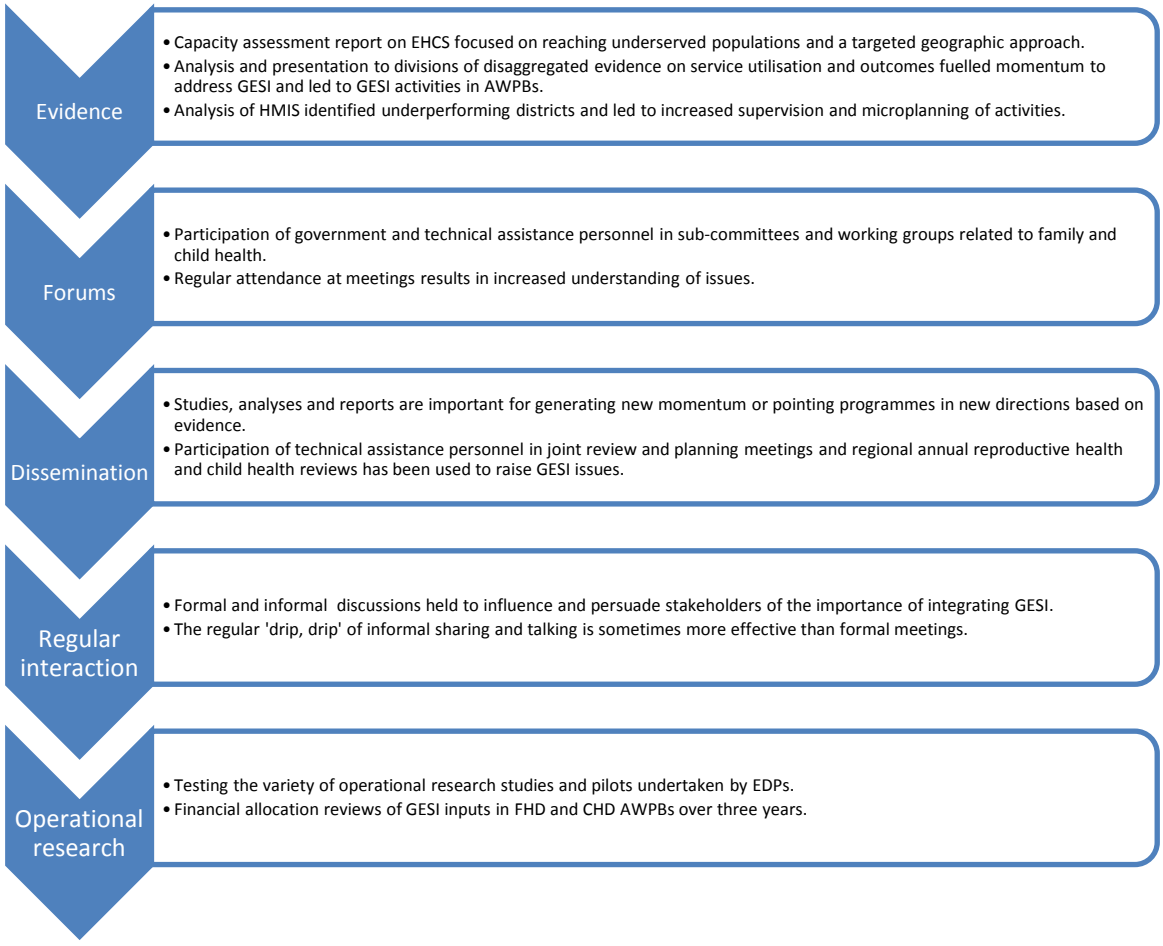
Many enabling factors noted above for mainstreaming GESI into policy and planning, and the institutional structure, also apply to mainstreaming GESI into health programming. These include government leadership of GESI, the strong GESI mandate of NHSP-2 and the Long Term Safe Motherhood Plan (2002-17), and the availability of technical assistance. Additional points specific to MNCH programming are included in Box 9:

- Many senior officials in CHD and FHD have experience of working in underserved districts and a practical understanding of key issues.
- The solidarity among external development partners, such as the Nick Simons Institute (NSI), UNICEF, Save the Children International, and Care Nepal on the need for targeting underserved populations, and the interests of the World Bank, DFID and AusAID in reaching populations in remote areas with health services.
- The collaboration and sharing of information between partners, including government and external development partners, makes a wide range of data and analysis available for planning purposes.

Box 9: Importance of workshops and conferences

Workshops and conferences have been important influencing forums to achieve buy-in for GESI. Examples include FHD's family planning re-vitalisation workshop (2011) and the annual conferences of the Nepal Society of Obstetricians and Gynaecologists and the Safe Motherhood Network Federation.

Figure 10: Advocacy methods for mainstreaming GESI in MNCH



Constraining factors

The constraining factors mentioned in earlier parts of this report also affect GESI mainstreaming in MNCH. Additional constraining factors have been as follows:

- The limited social diversity of health staff, including FCHVs, discourages women and men from different social groups from using health services. Discriminatory practices towards the poor further deter women and poor and excluded people from using health services. Men are reluctant to access family planning information and services from female providers. The lack of women doctors inhibits other women from accessing hospital services.
- The additional cost of delivering services to remote and underserved populations, compared to less disadvantaged groups, impacts on the willingness of government to use scarce resources for this, particularly when funding is reduced (e.g. 2012/13).
- Weak management systems and frequent transfers of staff without formal handovers or suitable opportunities to allow lessons learned to be shared deprive the health sector of institutional memory and increase dependence on technical assistance to bridge the gaps.
- Inadequacies in physical infrastructure affect the quality and availability of health services, which impact on women and poor and excluded people. Commonly reported problems with health facilities include a lack of space for counselling, difficulites of maintaining privacy, inappropriate locations of facilities far from settlements, and the absence of living quarters for health staff. Long term infrastructure planning remains weak.
- Barriers to health services in remote areas are particularly severe due to geographical factors and difficulties of retaining staff in challenging and isolated work environments. The resulting availability and quality of care is typically poorer than in non-remote areas.
- The absence of systems and tools to clearly identify the poor allows government to defer the adoption of targeted approaches. The coverage of outreach clinics is also inadequate and the quality of care generally poor. Most health sector targets are not GESI sensitive and so do not incentivise health staff to seek out and serve the underserved and excluded. Moreover, community based programmes are perceived to aim at universal coverage, and thus are not targeted**.**

6.2 MAINSTREAMING GESI INTO NHTC'S WORK

Achievements

The main achievements of efforts to mainstream GESI into the work of the National Health Training Centre programme are as follows:

- the preparation of an inventory of training courses provided by health sector institutions under MoHP and an assessment of their respective levels of GESI integration; and
- a review of the training curricula for FCHVs, HFOMCs, and senior auxiliary health workers and on skilled birth attendance (SBA), and behaviour change communications (BCC) from a GESI perspective.

The process followed

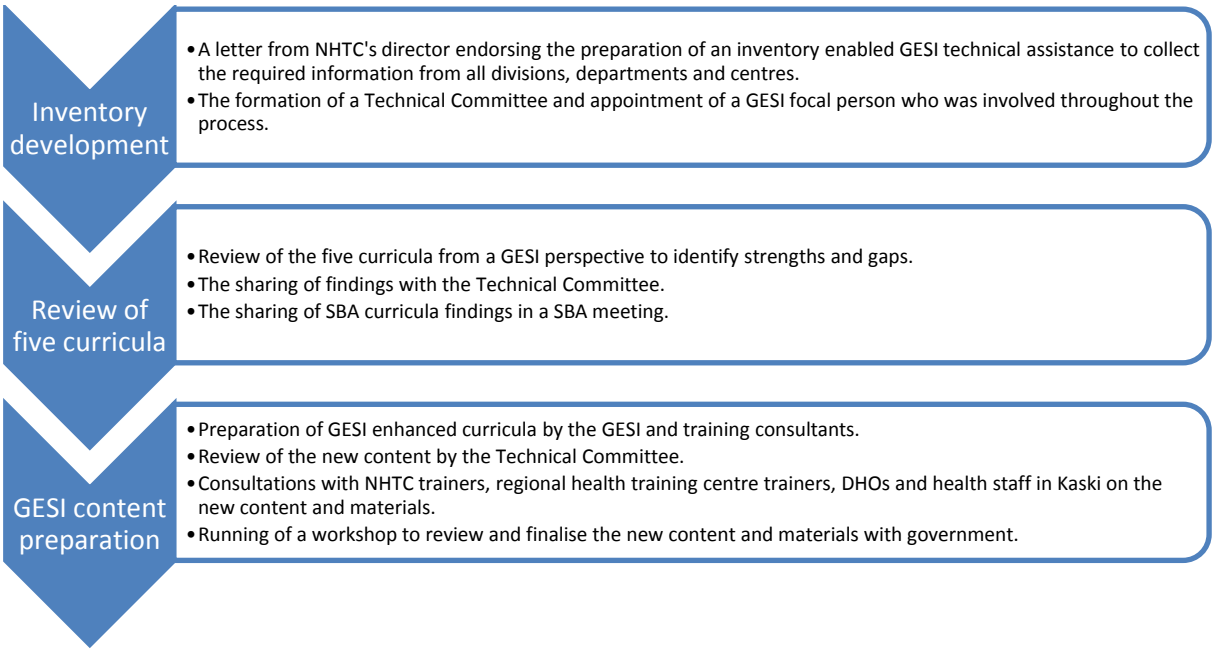
See Figure 11.

Enabling factors

The four main factors enabling the mainstreaming of GESI into NHTC's curricula have been:

- the directive sent from the health secretary to the NHTC director instructing him to review the centre's training curricula and incorporate GESI within them;
- the willingness of NHTC's director to move this activity forward;
- inputs from committee members, which resulted in the setting of a high standard for the production for training materials;
- the active support of NHTC's GESI focal person (who is also the planning officer) which included organising meetings and interactions at district and village development committee (VDC) levels.

Figure 11: The process of integrating GESI into health worker curricula



Constraining factors

The process of mainstreaming GESI into health training curricula was hindered by several of the factors referred to in earlier sections of this report. These included the limited availability of government staff as a result of heavy workloads and competing demands, high staff turnover and delays caused by other government priorities taking precedence. The retirement of two NHTC directors during the review period (2011 to 2013) necessitated the re-briefing of successors and repeat feedback and advocacy sessions to ensure project momentum was maintained.

Some constraints specific to this workstream including the need to reprint and disseminate, at significant cost, large quantities of the revised training materials and tools. The Technical Committee was responsible for ensuring that the revised materials were pre-tested, included in the curricula and printed. Another key constraint was the limited time allocated for several training courses, raising questions about their ability to adequately cover GESI issues.

Lessons learned from mainstreaming GESI into MNCH programming and in-service training

Integrating GESI into service programming is essential for determining how they are delivered and who they reach. In common with earlier sections, the government's mandate as conveyed in policy and the commitment of the health secretary to GESI have provided the platform and space for technical assistance to support and facilitate the divisions and NHTC to mainstream GESI. Technical assistance influencing can only have a limited effect *without* this mandate. Secondly, the government must own the mainstreaming process and content at every stage, take the lead and set the pace.

The readiness to integrate GESI varies among divisions and individuals and influencing strategies need to be tailored accordingly. This means that those supporting the government have to know how the health system works, and be able to apply GESI concepts to their counterparts work streams. Many EDPs, including NHSSP, have the advantage of providing multidisciplinary technical assistance which enables the team to push the GESI agenda in different areas, at different paces and from different perspectives. Relationships built over time through regular interactions and support are very important for influencing the course of events. Disaggregated data and evidence that is accepted by government must be used for advocacy purposes. It is also extremely important to seize opportunities to promote and integrate GESI as they emerge.

Programming and training are led by the centre but have to be grounded in the field realities of service delivery and the capacities of institutions and health personnel. This means that government partners have to understand these realities and be able to confidently integrate them into proposals and solutions shared with government. Moreover, to demonstrate its effectiveness, technical assistance has to be able to support the application of GESI programming at the local level, and to feed lessons learned into on-going programme development. Technical assistance to support GESI integration at regional and district levels has an important role to play, not least in building relationships among senior staff who may become future central-level counterparts.

7 MAINSTREAMING GESI IN GESI FOCAL PROGRAMMES (EAP, SOCIAL AUDITING, SSU, OCMC)

MoHP has supported several flagship programmes targeted at poor and excluded groups for some time prior to NHSP-2, including Aama and the Free Care programmes. This chapter draws out selected aspects of these four programmes, which have a strong GESI objective, to illustrate the challenges and processes of GESI programming over the past three years. The four programmes are:

- the Equity and AccessProgramme (EAP), a rights based social mobilisation programme;
- social auditing — a governance oriented initiative;
- social service units (SSUs), which provide and manage hospital subsidies for poor and other targeted vulnerable populations; and
- hospital based one-stop crisis management centres (OCMCs), which treat and respond to survivors of gender-based violence.

7.1 EQUITY AND ACCESS PROGRAMME

Achievements

- EAP is now operational in 21 districts.
- There is now policy and programme recognition that social and community mobilisation programmes that target unreached and excluded communities are necessary for improving health outcomes.
- There is a consensus, and agreement was reached within MoHP, to advocate and seek MoF Finance approval for the multi-year contracting of the NGOs that implement EAP.

Background

DoHS began supporting EAP in two districts in 2008. The programme has grown and is now operational in 21 districts. EAP is a community-based empowerment programme that specifically targets poor and excluded communities to improve their access to, and demand for, health services. It is implemented by local NGOs who are contracted by DHOs and DPHOs to mobilise communities in the most difficult to reach areas of districts. Over the last three years there has been an increasing realisation that several implementation challenges related to contracting, supervision and programme management are undermining programme effectiveness and value-for-money. A strategic review led by PHCRD (EAP's home division) in 2012 set out four management conditions that needed to be met to justify continuation of the programme (see Box 10). The first of these is the multi-year contracting of NGOs. The current single year contracting undermines programme effectiveness. Internal advocacy to build consensus support within government for multi-year contracting required time and considerable effort from PHCRD and supporting technical assistance.

Box 10: The four management conditions that need to be met to justify continuation of EAP

1. The multi-year contracting of NGOs with an incremental budget.
2. Strengthened supervision and monitoring of programme implementation.
3. Increased central level involvement in the district NGO selection process.
4. Better coordination with The Ministry of Federal Affairs and Local Government (MoFALD) and its Local Governance and Community Development Programme (LGCDP) and other social mobilisation programmes.

Enabling factors

The main factors that enabled MoHP to decide to sustain EAP by moving to multi-year contracting were as follows:

- The commitment to, and belief in, community-based targeted approaches and the value of EAP among some senior members of MoHP.
- The supportive leadership of PHCRD.
- The increasingly favourable policy environment for reaching the underserved, and the recognition among programme divisions that social and community mobilisation programmes such as EAP are essential for reaching poor and excluded communities and meeting the Millennium Development Goals.
- The recognition by district health teams of the contribution that EAP-type activities can make to improving access to health care and their demand for the continuation of EAP within an improved operational framework.

Constraining factors

The following factors delayed MoHP's decision to seek multi-year contracting of NGOs to run EAP:

- Confusion over whether government rules allowed multi-year contracting.
- The perceived risk that if multi-year contracting is provided to NGOs it could be extended to hired health staff on contracts. This could open up demands from such staff for permanent posts which the government could not endorse due to the freezing of government recruitment as well as budget constraints.
- Resistance to changing contracting norms that can foster patronage and personal gain for those who held decision making positions at the centre and in the district.
- A common distrust of NGOs and the private sector among government officers.

Lessons learned and tips

The political economy of contracting out, and resistance to changing the rules of the game that surfaced over EAP illustrate how policy commitments to GESI have to mediate institutional dynamics and interests of the status quo to translate GESI into practice. The EAP story shows how government systems can be hostile to community-based programmes that depend on external facilitation even if the nature and objective of a programme fits policy and programme priorities. Transforming the institutional systems to enable programmes with GESI objectives to thrive is more challenging in the current Nepal context than seeking political and bureaucratic ownership of GESI objectives and principles.

Intertwined with the personal motivations and benefits that some reap from the way government currently does business is the added tendency for the bureaucracy to avoid risks. These two factors explain many of the delays in institutional reform which are needed to open up space for GESI in practice.

At the operational level, the EAP experience shows how there is a continuous need to maintain government focus on the unreached to avoid the diversion of efforts. Secondly, building the capacity of NGOs on rights-based approaches, and regular monitoring and coaching are important for assuring the quality of their inputs into empowerment and community mobilisation programmes.

The top five tips learned for mainstreaming GESI from the experiences of EAP are listed in Box 11.

Box 11: Top five tips for EAP

1. Build ownership and consensus for change through government champions while using extended networks in and outside the health sector to carry messages and lobby.
2. Be opportunistic by aligning with other forces of change that can elevate the GESI agenda.
3. Timing is key and sometimes it is just a question of waiting for the right political opening to push the agenda forward.
4. Advocate for the rights and entitlements of women, poor and excluded communities.
5. Community mobilisation takes time; give it time — it takes at least three years.

7.2 SOCIAL AUDITING

Achievements

1. Harmonised social auditing guidelines developed, piloted in two districts in 21 facilities.
2. Harmonised social auditing guidelines approved by MoHP in June 2013.
3. With AWPB funding harmonised social auditing approach implemented across 21 districts in 170 facilities in 2011/12, and in 236 facilities in 2012/13.
4. Harmonised social auditing guidelines used in other districts with support from several development partners.
5. Local NGO facilitation capacity strengthened.

The process followed

Prior to NHSP-2, DoHS had developed two approaches for the social auditing of the delivery of health services. One was focused on the Aama Programme under the direction of FHD, and the other was led by the Management Division to audit the delivery of free care. NHSP-2 provided the mandate to harmonise these two approaches, and PHCRD led this process through the following steps:

- A technical committee was formed to guide the harmonisation process and technical team, including members from interested external development partners and partners (GIZ, USAID, Nepal Family Health Programme and WHO).
- A review was carried out of social audit experiences and achievements across various sectors in Nepal and in the region.
- Draft harmonised social audit guidelines were developed under the direction of the technical committee.
- The guidelines were piloted in two districts with technical assistance from NHSSP.
- A process evaluation was carried out in June-July 2013 in the two pilot districts.
- Orientations were provided to district social audit focal persons and regional representatives and selected external development partners about the guidelines.
- Coordination and experience sharing meetings were held with external development partners and district level stakeholders, which led some partners to support social auditing in their operational areas.

Enabling factors

At the national level: Several enabling factors supported the harmonisation of the two approaches, which had different purposes and different clients within government. There was, and continues to be, widespread government and external development partner commitment to improving the accountability of health service delivery, and recognition of the importance of community-led approaches such as social auditing to achieve this. NHSP-2's emphasis on accountability and governance, and the inclusion of social auditing in the GAAP framework reflects this policy priority.

At the programme level, the commitment of PHCRD to the harmonisation of approaches and the guidance and technical support available to them fostered their capacity and confidence to manage the process. One critical step was the establishment of the technical committee, which provided a forum for building ownership and consensus on design, and to manage different technical opinions. A review of national and international experiences with social auditing was appreciated by the committee and helped in the design of the harmonised guidelines.

Technical support from multiple development partners at central and local levels played an important role, feeding into design, and supporting implementation at the local level. The technical assistance funded pilot programme also provided an additional, albeit minimal, monitoring input to the social audit approach (half-yearly external monitoring visits) and helped maintain momentum and focus at the centre.

At the operational level: The widespread demand for greater transparency, openness and accountability at the district level from government, the general public and development partners has encouraged large-scale participation in the social auditing of health care provision. Mass meetings have often attracted more than a hundred people, even in the rainy season.

Box 12: The role of regional GESI specialists

Outside the two pilot districts of Palpa and Rupendehi, NHSSP's regional GESI specialists have been well placed to facilitate the roll out of social auditing. In the Far West, RHD staff with NHSSP's regional GESI specialist provided orientation on the harmonised social audit guidelines to district and regional partners, external development partners and government agencies. Following this, World Vision International, Suaahara (USAID) and Good Neighbours supported the expansion of social auditing to health facilities in additional VDCs.

District health leadership and ownership of the social auditing programme has raised the profile and importance of social auditing among health providers, and helped focus their attentions on solving problems raised by communities. The district social audit committees have also opened up space for shared lesson learning across sectors and with local government, and the transfer of tools, and are providing a platform to advocate for health. In Palpa, the local development officer (LDO) wants to undertake an overarching social audit of each VDC. The presence of technical assistance and INGOs supporting social auditing at the ground level encourages participation from communities and the government. Resulting visible improvements in health services are motivating communities to engage in social auditing.

Constraints

At the national level: Earlier social audit approaches had been supported by different development partners and harmonising the technical design of the new approach has thus had to mediate a range

of technical perspectives on the best approach, and the acceptable trade-offs between quality and effectiveness versus cost. Building consensus is an on-going challenge.

There are two design limitations of the harmonised social audit approach:

- The contracting of NGO facilitators by DHOs and DPHOs undermines NGO's abilities to mediate with conviction between government and communities on sensitive issues. The independence of government-contracted facilitating NGOs is a longstanding concern and needs further consideration.
- No mechanism exists to inform the central health authorities about important problems identified by social auditing at the local level. To avoid such problems becoming 'trapped' at the local level a mechanism or links are needed to communicate local problems to the centre through the district level.

The government's oversight of social auditing is relatively weak at the national level and reflects the excessive workloads and human resource gaps.

Limited resources and weak internal advocacy on the value of social auditing are limiting the expansion of social auditing to additional districts and facilities.

At the operational level: The corollary to several of the enabling factors are implementation constraints:

- The limited availability of local organisations that have the capacity to facilitate impartial dialogue between communities and government. Capacity building and supportive guidance is needed to overcome this constraint.
- Success depends on the willingness and leadership of DHOs and DPHOs.
- The building of the capacity of district health teams is undermined by the high rates of staff turnover as skills are not diffused or transferred.

Lessons learned and tips

Government ownership and leadership in developing and implementing programmes such as social auditing is very important. Although leadership may be fragile it is important to set up forums and committees to bring stakeholders together and assert government leadership. Such mechanisms are also useful for sharing and harmonising different but similar initiatives and methodologies.

There is a need to bring development partners and INGOs into the implementation process to ensure the quality of social auditing and to increase the coverage of health institutions.

Using government funds to support community voices for accountability carries the risk of diluting that voice. In the Nepalese context where channels and forums for voice are just beginning to be developed, government-funded social auditing can pressurise health providers to improve service delivery.

There is a need to create a mechanism or link to communicate social audit demands from facility to district level and on up to the centre, and to trigger and monitor supply side responsiveness. District officials need to participate in facility-based community gatherings to respond to immediate demands and concerns.

Box 13: Five top tips for the social auditing of health service provision

1. Government ownership and leadership of the outcome of social auditing is very important at all levels.
2. Bring stakeholders together to support the implementation of social audit action plans.
3. Create mechanisms for community concerns to be communicated to district and policy makers.
4. Orientate health managers and health service providers prior to the initiation of social auditing so they understand its value and purpose.
5. The independent selection and financing of implementing NGOs will avoid conflicts of interest.

7.3 SOCIAL SERVICE UNITS

Achievements

The aim of SSUs is to facilitate the provision of free and partially free of cost health care services to target group patients. Other aims are to increase transparency and accountability on the use of budget allocations for social security, and the better targeting and coverage of target groups.

The following progress has been made:

- A road map for establishing and strengthening social service units (SSUs) was produced in 2012.
- The revised SSU Establishment and Operational Guidelines were approved in 2012.
- The piloting of SSUs was initiated in six hospitals and preparatory work underway in a further two hospitals in 2013.

The process followed

Table 6: The steps taken for revising and piloting the SSU guidelines

	Steps
✓	Review of functioning of SSUs in 2012
✓	Revision of SSU guidelines
✓	Consensus building workshops
✓	Guidelines finalised and approved by MoHP
✓	SSU Management and Monitoring Unit established in the Population Division
✓	Piloting of the guidelines initiated in 8 hospitals
✓	Meetings and orientations held for hospital management to establish SSUs
✓	The selection of NGOs to support hospital management to implement SSUs
✓	Orientation of NGOs and hospital staff on SSUs
✓	Follow up support from regional GESI specialists
✓	Technical assistance support and coaching to SSUs; progress review and establishing the monitoring and evaluation framework of pilot SSUs

Enabling factors

The main enabling factor that has supported progress on taking SSUs forward has been MoHP's commitment to implement the spirit of the Interim Constitution and to recognise the state's responsibility to provide free health care services to target groups.

Constraining factors

SSUs seek to make the somewhat opaque management of government subsidies for free health care more transparent. However, hospital management tends to be reluctant to change the systems and informal practices of providing subsidies. For example, this happened through the past practice of redirecting some funds meant for SSUs to activities that helped to ease political pressures on hospitals, such as covering the medical benefits of hospital staff and their relatives. In addition, there has been resistance to the idea of involving outside agencies (NGOs) in facilitating SSUs. The Population Division supported by technical assistance has been able to overcome this resistance by drawing on the mandate of the SSU guidelines and suggesting alternatives to current practice.

The practical difficulty of identifying the poor in the absence of a related identity card[5] affects the targeting efficiency of SSUs. This is exacerbated by the reluctance of authorities to advertise the availability of subsidies for fear of creating demands that cannot be met. There is however a considerable likelihood that eligible poor people are being missed while it is a valid concern that the level of demand for subsidies could outstrip budget allocations and hospitals could be unable to cope with increased patient volumes and political pressures to provide more subsidised care.

Limited staff and the inadequate management capacity of hospitals to integrate the responsibilities associated with SSUs need addressing. Improving this situation will require not only technical facilitation but also greater ownership from hospital management for SSUs to become fully functional. Regular and rigorous backstopping and monitoring support will be necessary from the SSU management and monitoring unit, which in itself will be an important development.

The SSU model includes scope for social organisations (NGOs) to be contracted to facilitate implementation at the local level. However, there are few such organisations with the background and interest to take this role on, and local influence in the selection of them is difficult to manage.

Lessons learned

- As the functional line of accountability of hospital medical superintendents is to the health secretary (MoHP), and not to the Population Division, it would be very helpful for the health secretary to issue a directive to medical superintendents to make them accountable to the Population Division for the management of SSUs.
- A system of joint biannual reviews by medical superintendents and SSU chiefs is necessary to ensure regular monitoring and to address SSU-related issues in a timely way.
- Constant follow-up with technical and process support is required to ensure the functionality of SSUs.
- Internal coordination and harmonisation with different departments in hospitals is important for the smooth delivery of services. There has to be a common understanding about the need for and value of SSUs among hospital staff so they believe in SSUs' usefulness and legitimacy.
- The selection of appropriate NGOs and facilitators is crucial for the effective functioning of SSUs.

[5] The National Planning Commission is in the process of issuing identity cards for poor people in 25 districts.

7.4 ONE STOP CRISIS MANAGEMENT CENTRES

Achievements:

- OCMC guidelines approved and amended.
- 15 OCMCs established and functioning in hospitals.

The process followed

Table 7: The process followed for establishing OCMCs

	Key steps
✓	Joint scoping assessment carried out to inform revision of OCMC manual (2011) and identify sites for OCMCs with the Department of Women and Children.
✓	OCMC manual development committee formed.
✓	Consensus building workshop held.
✓	Establishment of 15 OCMCs in hospitals and orientations to OCMC district coordination committees and hospital staff.
✓	Coaching on the roles and responsibilities of OCMCs and follow-up support to OCMCs by Population Division and NHSSP technical assistance (central and regional).
✓	Review and revision of National GBV Action Plan for the next five years led by OPMCM.
✓	Psycho-social counselling training to nurses supported by UNFPA.
✓	Resource book on legal provisions and procedures for GBV survivors prepared by MoHP.
✓	Orientation on GBV and legal provisions provided by Population Division in six hospitals with OCMCs (funded by UNFPA).
✓	Public-private partnership (PPP) model implemented in Dhulikhel Community Hospital with MoU signed between the DHO and the hospital director.
✓	16 days of activism against GBV celebrated in all regions and some districts.
✓	Review workshop on OCMC organised by OPMCM and managed by MoHP
✓	Assessment of OCMCs (June-August 2013) supported by UNFPA and NHSSP

Enabling factors

The high level political support for addressing GBV in the country and the national policy framework has fuelled MoHP's leadership of OCMCs. Strong commitment from health secretaries, the Population Division and external development partners have enabled MoHP to operationalise the model. Proactive district officials have also played an important role (Box 14). Technical assistance to the Population Division has also played an important role.

Box 14: District officials promoting OCMCs

In Hetauda Hospital and Doti District Hospital there has been good coordination between the chief district officers (CDO), LDOs, women and children officers (WCO) and the hospitals. This has been a result of the proactiveness of the CDOs. Local initiatives have been taken to publicise the OCMCs via FM radio, pamphlets and in newspapers. The OCMCs were profiled during the 16 days campaign against GBV, and the districts have developed the GBV Eradication Fund Mobilisation Guidelines.

Constraining factors

While the health sector has a key role to play in responding to GBV, it lacks the outlook and human resources to lead a multisectoral response to this widespread social problem. The design of OCMCs

ambitiously staged the government's multisectoral response at the hospital level; but in practice this has not materialised. The absence of directives from the relevant central agency to their district offices has been a key constraint. The lack of collaboration between external development partners at central and district levels working on GBV has also been a challenge.

The active leadership of CDOs is crucial for OCMCs to be effective and hence has been a constraint where this has not been the case. CDOs chair many committees and it has been difficult to access CDOs to functionalise these committees. The lack of motivation of some hospital directors to operate OCMCs, and the absence of counselling skills among health providers, has affected their establishment and functioning in some places. The skills and the time needed to coordinate with different actors, such as police and legal authorities, are outside their usual competency.

The social norms that underpin gender in Nepal and make most women dependent on their husbands and restrict their ability to seek support mean that, while the prevalence of GBV is high, there is low utilisation of OCMCs and limited help-seeking among survivors. It is therefore necessary to give greater attention to raising awareness of the illegality and harm of GBV.

Lessons learned

- Functional coordination at the central level with Police HQ, the Office of the Attorney General, the Department of Women and Children and the Ministry of Home Affairs is needed to send common directives to their respective district offices.
- Formal mechanisms for coordination between the Population Division and the Department of Women and Children is needed to avoid duplication between the services provided by these two ministries (safe homes and OCMCs) and to clarify the roles of these two bodies.
- Comprehensive guidelines are needed that set out the minimum service standards to be provided by all actors mandated to support GBV survivors, along with building the capacity of these actors.
- Although the contribution of the health sector is important, it is only one element of the multisectoral response that is needed to protect and respond to GBV survivors and to prevent GBV. It is important that the health sector fulfils its mandate of treatment and counselling and strives to stimulate a more coordinated and comprehensive response from the state. This will however require considerable commitment across many sectors to put into practice.

8 BUILDING CAPACITY ON GESI

8.1 ACHIEVEMENTS

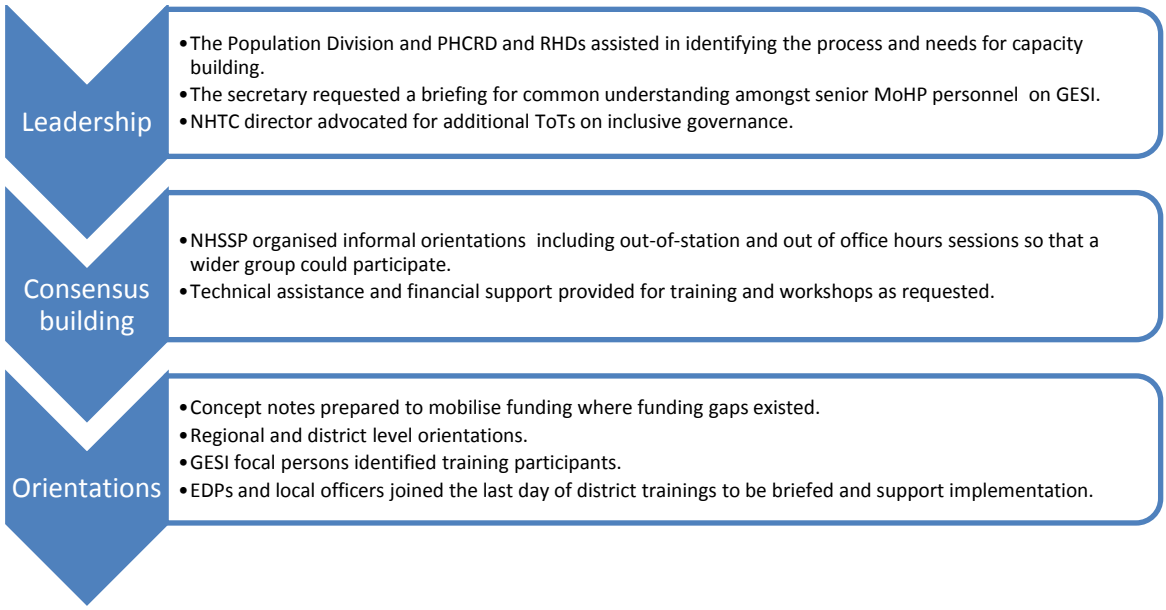
Table 8: Achievements on building capacity on GESI

	Capacity building events and processes	Objectives	Participants
1	GESI orientation (MoHP, DoHS) (April 2012)	Orientation on GESI concepts and GESI Mainstreaming Framework, inputs for GESI Implementation plan	Population Division, Steering Committee, MoHP TWG Working Group, DoHS, Division and centre chiefs and GESI focal persons
2	Three day regional training (January–July 2012)	Enhance common understanding of concepts, strengthen skills to mainstream gender and social inclusion in policies, planning, programming, budgeting, and M&E, develop contents for guidelines on mainstreaming GESI in the health sector	(i) Seven regional workshops held with DHOs, DPHOs and other district health personnel covering all 75 districts (over 150 participants trained). (ii) Three regional level trainings in partnership with government and external development partners (over 100 participants)
3	Training of GESI focal persons (September 2012)	Conceptual clarity, role of GESI focal persons, ways of mainstreaming GESI in service delivery	GESI focal persons from divisions and centres of DoHS and MoHP
4	Integration of GESI into population training at regional level (as required in 2012)	GESI conceptual clarity and integration of GESI into population activities	RHD staff, DHO, DPHO, GESI focal persons, statistical officers (75 districts)
5	Interactions and consultation on guidelines and programmes (Oct–Nov 2012)	Briefing about guideline provisions, feedback on drafts, planning for roll-out	
6	Technical working group theme-wise inputs (as required in 2012)	Planning and inputs into guideline development, PEER study, SSU guidelines, OCMC manual	TWG members
7	Orientation of GESI TWGs and RHD staff (Oct 2011–July 2012)	Orientation about GESI concepts and TWG roles	RHD staff oriented by regional GESI specialists
8	Briefings on different guidelines (as required)	Briefings on NHSP-2, GESI institutional structure, GESI strategy, OCMCs, SSU guidelines, EAP, social auditing	RHD staff and GESI focal persons
9	Focal person meetings, joint field visits, personal coaching (on-going)	Coaching, mentoring and counselling	GESI focal persons of Population Division, PHCRD and RHDs
10	District level GESI orientations through trainings, workshops, review meetings and coordination and on occasion day celebrations (ongoing in 2012-13)	Increased understanding of GESI concepts and information about GESI programmes and for planning	DHO, DPHO and line agency representatives, health related projects, women development offices, NGOs, coordination committees, women networks, NHSSP regional staff. Over 2,000 people orientated

11	GESI orientations to government personnel at district level (2012-13)	Conceptual clarity, strengthen GESI capacity, establish links between health authorities and local development	VDC secretaries, DDC staff, line agency staff, field facilitators, project staff
12	GESI training in 10 selected districts (appreciative inquiry) (2013)	Strengthening GESI capacity and creating supportive environment	District stakeholders (CDOs, LDOs, DHO and DPHO staff, etc.)
13	Mapping hard-to-reach people (2012)	To identify unreached groups in selected districts and VDCs	RHD staff and GESI focal persons
14	Inclusive governance training of trainers (July-Aug 2013)	Develop understanding of inclusive governance concepts of GESI, accountability, responsiveness and integrity. Strengthen skills as trainers to deliver training on inclusive governance	NHTC, regional health training centres (RHTC), SBA and other thematic trainers (around 60 participants)

8.2 THE PROCESS FOLLOWED

Figure 12: The process followed to build capacity on GESI



8.3 ENABLING FACTORS

There have been a number of common enabling policy factors for mainstreaming GESI across the subjects investigated by this review (NHSP-2, GESI Strategy). Another important factor has been the commitment of the health secretary for supporting capacity building on GESI. The secretary himself took the initiative in 2012 by requesting a briefing and this sent out a strong signal to others in the system about the importance of understanding and addressing GESI. A 2012 GESI Steering Committee circular made it mandatory for RHDs to organise and work on making the GESI workshops a success.

Another key enabling factor has been the inclusion of GESI capacity building activities in the budgets of PHCRD and the Population Division (through the Red Book). This has ensured that the government has recognised and planned for these capacity building events.

As noted earlier, the flexibility and responsiveness of technical assistance from a number of EDPs in providing technical and financial support has facilitated GESI capacity building. The presence of

regional GESI specialists has also been important as they undertook the personal coaching and day-to-day influencing to keep the GESI agenda visible and for facilitating change processes.

The fact that all training and capacity building efforts were linked to the health sector and customised to address the responsibilities of participants promoted strong internalisation and acceptance. In addition, GESI's 'newness' and the interactive nature of its training programme generated considerable interest. Incentives linked to participation in capacity building activities also encouraged participation.

8.4 CONSTRAINING FACTORS

Time constraints proved a challenge for capacity strengthening support. The kinds of discussions, consultations and interactions necessary for in-depth internalisation and skills strengthening are difficult to achieve in the government sector with its uneven work loads. This resulted in a need to occasionally compromise on the content and duration of sessions delivered.

Inadequate GESI training capacity within government has led to a dependence on technical assistance. Investment is needed to build up master trainers in government and apply revised training modules. The lack of a training information system, however, undermines coordination and the oversight of training implementation. The relatively weak supervision and monitoring of GESI mainstreaming means that regional and district health authorities are not pressured to develop the GESI skills of staff.

The limited diversity of health personnel also affects levels of interest and identification with core GESI issues and this can result in a lack of motivation to improve skills and apply them in the workplace.

The lack of a GESI capacity building plan – to be developed jointly with EDPs – has, so far, failed to nurture the cross agency collaboration needed leaving training dependent on individual technical assistance based centrally and at regional and district levels.

8.5 LESSONS LEARNED

- The production and implementation of a detailed capacity building plan on GESI would enable a more systematic and targeted programme of training that would reduce duplication and be more responsive to trainee needs. This would also facilitate the eventual integration of GESI training into AWPBs.
- The constraints of the institutional system for training at NHTC and RHTCs have slowed the pace at which GESI training can be rolled out and exposed a need to identify alternative entry points, such as technical assistance-facilitated training. A core team will be needed in NHTC to help absorb GESI training and orientation into the system. It will take another few years to build NHTC capacity and position them to steward GESI capacity building.
- In addition to providing staff with GESI capacity building, the working environment and individual staff responsibilities need to reflect the application of GESI principles if lessons learned in training are to be effectively applied. There needs to be in service follow-up and monitoring systems to encourage staff to apply their new GESI skills. Core groups need to be developed as GESI resource pools in districts to provide on-going support and supervision. At the centre, GESI focal persons need to be capacitated to undertake advocacy and support roles.

- Trainers need to have a strong understanding of GESI-related issues, and good facilitation skills to be able to respond and explain GESI to different audiences. A consolidated practical trainer's manual on the application of GESI in health would facilitate this.

9 MAINSTREAMING GESI IN SUPERVISION, MONITORING, SURVEYS AND STUDIES

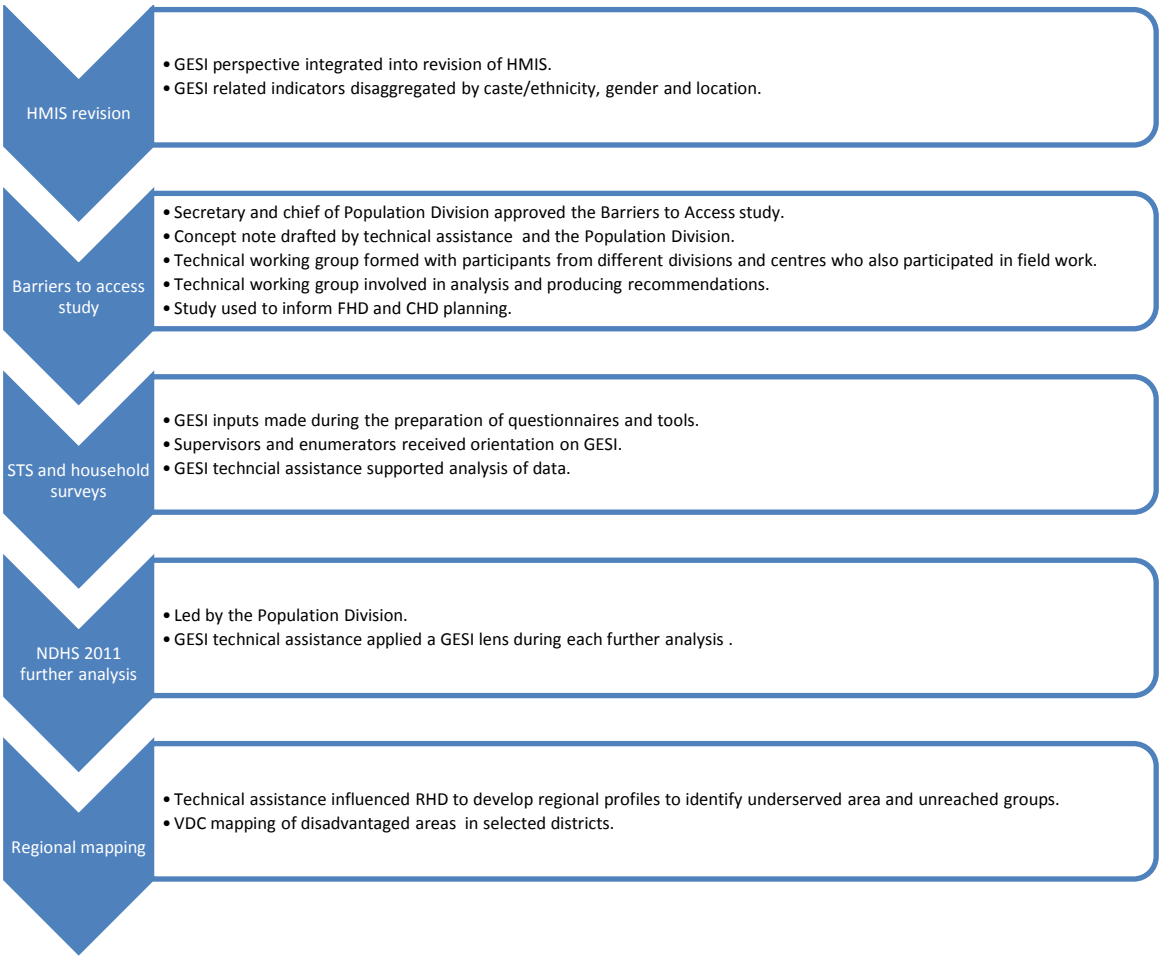
9.1 ACHIEVEMENTS

Table 9: Main achievements on mainstreaming GESI in supervision, monitoring, surveys and studies

Events and system elements	Status of GESI integration
Health Management Information System (HMIS)	The revised HMIS aims to generate disaggregated data at health facility level for selected indicators in each programme by age, sex and caste/ethnicity of clients, and type of health services provided
Review of health facility disaggregated records (HMIS)	Disaggregated information has been extracted from health facility records and presented in selected regions
Further analysis of NDHS 2011	NHDS 2011 data was further analysed from a GESI perspective
Annual Service Tracking Survey and biannual Household Surveys	Track progress on improving access to and utilisation of health services by different groups; and use the data to help reach the unreached
Voices from the Community: Access to Health Services; A Rapid PEER Study (2013)	A community-based, participatory ethnographic evaluation research (PEER) study identified socio-cultural and economic barriers of six social groups in six districts to accessing and using family planning, safe motherhood, safe abortion and immunisation services
Monitoring and Evaluation (M&E) Framework of NHSP-2 (May 2012)	Eighteen GESI-related activities monitored under four out of a total of nine output areas in the logical framework (NHSP-2 and Mid Term Review Report, 2012)
Report on Achievements against Logical Framework Targets 2011, 2012	Showed log-frame indicators disaggregated by caste/ethnic group, sex, age, and wealth quintile and compared level of inequality using traffic light system
ePopInfo	This web-based database contains population related data and has population profiles disaggregated by caste/ethnic group across both districts and VDCs
Nepal Health Sector Programme-2 (NHSP-2) Mid-Term Review	Reviewed progress on GESI, assessing that good progress has been made. This included a separate supplement on progress made in GESI
Benefit-Incidence Analysis	Disaggregated benefits from public investment by region, population sub-group and income level
Mapping Hard-to-Reach Areas and Groups	Regional GESI Specialists identified the most disadvantaged, unreached and excluded VDCs and communities in districts in relation to their access to essential health care services and determining causes (in Makwanpur, Rasuwa, Parsa, Baitadi, Achham, Bajura, Doti, Kanchanpur, Kaski and Dhankuta districts)
Regional profiles (all regions)	GESI disaggregated data and information were included in these ministry-generated profiles
Remote areas study	Assessed the barriers to accessing MNCH care and the use of MNCH services in five remote districts using a mix of qualitative and quantitative methods.

9.2 THE PROCESS FOLLOWED

Figure 13: Process followed for mainstreaming GESI in supervision, monitoring, surveys and studies



9.3 ENABLING FACTORS

NHSP-2's demand for the GESI disaggregation of health service statistics ensured that major efforts to produce disaggregated data were made in this period. The piloting of disaggregated data in HMIS had, in fact, been underway for several years and yielded useful insights into how to effectively expand and scale up the approach. By following the generally recommended practice of disaggregating data by six social groups – as also used in NDHS 2006 - data could be readily compared with other studies and surveys including, importantly, NDHS 2011 and its further analysis.

MoHP's annual monitoring of progress against the NHSP-2 indicators disaggregated by social group stands as an important GESI achievement. Its Public Health Administration, Monitoring and Evaluation Division took a lead in preparing these reports which are presented during JAR meetings. Their preparation and use has now been effectively institutionalised within MoHP.

At the regional level, notable enabling factors were the willingness of government counterparts to be part of the process and their agreement on the need to use disaggregated data in planning and review documents. The NHSSP technical assistance team was able to work relatively effectively with regional health directorates in this area.

9.4 CONSTRAINING FACTORS

A key constraining factor to the collection and analysis of disaggregated data at district level is the large volume of data generated. Additional constraints include the inability of HMIS to produce disaggregated data across a full range of health indicators and the non-availability of electronic technology at peripheral health facility level.

The lack of a consistent and officially endorsed categorisation of social groups by GoN to be applied by all ministries has also created challenges. Further, the categorisation noted above and applied by HMIS does not allow regional variations to monitored (in contrast to NDHS 2011) thus making regional comparisons difficult.

There remains a generally poor utilisation of findings and evidence regarding service use by poor and excluded people by government at all levels including in AWPBs. In not setting disaggregated targets the centre constrains disaggregated reporting and limits the ability to measure disparities between groups.

9.5 LESSONS LEARNED

- Consensus is needed at the centre on the integration of GESI into monitoring and review systems, including what has to be measured, by whom and how, at what level and how frequently. The capacity of HMIS and MoHP's monitoring and evaluation division needs to be strengthened to support this.
- Supervision and monitoring checklists and processes must capture the experiences of women and poor excluded people in accessing services.
- The objectives of each study and survey should include how GESI will be addressed and how findings will be disseminated and used to improve GESI responsive planning and implementation. Survey questionnaires should routinely capture the GESI dimension of the topic in question, otherwise GESI information will tend not to be gathered.
- Enumerator teams must be oriented on GESI in order to understand its importance and collect GESI related relevant information.

10 LESSONS LEARNED AND WAYS FORWARD

The intensive technical assistance work carried out with government on GESI between 2011 and July 2013 has generated many findings and lessons. This section discusses the main lessons learned based on the discussions presented in the previous chapters. This is followed by an outline of headline next steps deemed essential for work to continue and momentum to be sustained on each of the GESI mainstreaming pillars in the health sector.

While strong evidence will open windows of influence in some policy making circles, the views of external development partners and trusted peers may prove equally, if not more, effective. In this regard technical assistance must work intelligently and opportunistically to increase the prominence given to GESI and to find ways to give the topic real traction in the eyes of government counterparts.

10.1 KEY LESSONS

Institutional and systems level

- A strong policy mandate on GESI from the government is essential. Only then will officer level staff in the health system be made accountable for GESI activities and outcomes. A strong policy mandate will also provide a clear direction and support for taking the GESI agenda forwards.
- Similarly, government leadership and ownership of the GESI agenda are key and need to be reinforced and supported by external development partners and technical assistance. A common understanding of GESI among policy makers needs to be nurtured to ensure that programmes are coherent and consensus can be reached on the direction and targets for the sector.
- The institutional structure for GESI mainstreaming has to be sector-wide and should support both internal and cross-sectoral collaboration. The location of the GESI Secretariat needs to be tailored to the particular context and circumstances of each institution and where the best opportunity to advance the GESI agenda exists.
- GESI has to be integrated into the institutional systems that drive the health sector. The whole programme cycle (from situational analysis, planning, programming, budgeting and monitoring to reporting and replanning) has to be addressed. Working on only one or two elements is insufficient for effective and in-depth GESI integration. The entry points in the government's planning, budgeting, and programming cycle and across the various technical divisions are fluid and often unpredictable and thus opportunities need to be seized and built upon as they emerge.
- Disaggregated evidence of health outcomes for women, the poor and the excluded needs to be generated, analysed and used for advocacy and practical programmatic interventions, and for setting disaggregated targets at central and district levels. Evidence needs to be authentic and accepted by the government.
- Good practice, such as the integration of GESI into business plans and programme guidelines to inform AWPBs, must be made a routine part of government planning systems.
- Gender and social inclusion issues are experienced by officials in their everyday lives in highly personalised ways i.e. people bring their own personal experiences and circumstances to bear when understanding GESI. Efforts to change attitudes towards

gender and social inclusion have to be made using a mix of influencing and creative training approaches and through the broader forces of political and social change. This takes time! Expectations of the time needed to affect attitudes and build a common understanding on GESI need to be realistic.

- Capacity building is at the core of GESI mainstreaming and the building of government skills and competencies on GESI is essential. This will require innovative interventions sustained over several years. There is a need for a GESI resource pool at the regional level and in strategically located districts to carry out orientation and training programmes at the grassroots level and to support the application of GESI.
- Enabling women and poor and excluded people to have better access to services is a fundamental purpose of GESI. However, as the demand side falls outside health's traditional service delivery focus, factors that affect access to services which are related to the home and community, including social and cultural norms run the risk of being marginalised. Policy mandates, as in NHSP-2, are important for providing the legitimacy for addressing cultural and social barriers and are a basis for advocating for their inclusion in AWPBs and programming guidelines.
- The pace of progress depends on many factors including the institutional readiness and capacity of systems to integrate GESI. Institutional and structural constraints linked to staffing, the prevailing work culture, risk aversion, and reward and incentive systems inevitably affect the space and speed for change. In environments with strong policy mandates and leadership commitment, such as in Nepal, GESI mainstreaming has the potential to provide impetus for broader institutional reforms.
- The process of institutionalising GESI into the health sector is a long term agenda. It makes sense at the outset to address the 'low hanging fruit' and build momentum around these activities, rather than attempt to tackle deep lying institutional issues, which could derail the agenda if unsuccessful.
- Human resources for health is a core health system component in which GESI mainstreaming needs to be addressed strategically. Nepal's Health Service Act provides a mandate for doing this.
- GESI needs to be given discrete budget allocations not only to support mainstreaming activities, but also to raise the profile and importance of GESI in different parts of the health administration, and in health institutions. The inclusion of GESI activities in the government's budget is also essential if GESI is to be truly owned and sustained.

Technical assistance related:

- Technical assistance must have a strong understanding of GESI and the various ways of addressing exclusion across different situations and subjects. TA need to demonstrate that they have good knowledge of the work situation, understand the institutional context and are able to apply knowledge in appropriate ways.
- Well prepared technical assistance is essential for influencing decision makers. Competency in subject matter, the ability to apply theoretical concepts to real issues and situations and demonstate advocacy skills are very important. GESI language needs to be tuned to audiences and concepts, unpacked and explained simply so that the

somewhat conceptual language of GESI does not alienate people or cause them to lose interest.

- The provision of technical assistance must ensure that government leads change processes at every level and that the confidence and capacity of the government to lead is strengthened. TA must also be responsive to the GESI needs identified by the government. This calls for advisers that are flexible and strategically positioned across the sector, ideally blending GESI expertise with health systems technical expertise.
- Technical assistance must constantly remember that sensitive and responsive process facilitation is as essential as developing products and achieving objectives. But it is also essential to have content-related outputs and deliverables rather than only engage in processes designed to maintain visibility, fuel momentum, and to address the widest range of stakeholders.
- Influencing and advocacy by technical assistance needs to be highly skilled (not manipulative), honest – i.e. without a hidden or personal agenda – and involve the intelligent use of available networks and resources (allies, champions within government, technical assistance teams, external development partners).
- An understanding of existing staff capacity on GESI and cultural and institutional barriers to GESI mainstreaming is key to finding ways to address them. It is also vital to be clear and simple and to actively set out to demystify GESI concepts while maintaining intellectual rigour and honesty in applying GESI principles.
- Technical assistance must understand that in the absence of effective incentives it is difficult for government staff to be as committed to GESI as advocates or experts are. This reality needs to be recognised and worked with sympathetically. Technical assistance has to strengthen good governance but must also be pragmatic.
- Attitudinal changes are at the heart of GESI, but cannot be achieved in a short time or through training alone. Innovative ways of helping target audiences to recognise the value of GESI without moralising or making judgements on current outlooks are necessary. Networks and relationships need to be drawn on to lobby and influence with technical assistance working as a key change agent and fostering allies and champions to play similar roles within and beyond the health system.
- Technical assistance has to be deployed for a sufficient length of time in order to contribute substantively in core GESI areas. High levels of TA time and effort are needed to raise awareness of GESI, create interest and a willingness to address major concerns, and to convert these into concrete deliverables. Requirements for TA inputs to facilitate institutional change are significant and must be planned from the beginning.

10.2 WAYS FORWARD

Tremendous progress has been made over the past few years to create the environment for GESI and set in place the systems, processes and mechanisms critical for mainstreaming GESI. Currently, GESI mainstreaming is at an initial stage of establishing systems, processes and mechanisms. For these efforts to be continued and for momentum to be sustained, a number of key areas of work under each of the GESI mainstreaming pillars need to be taken forward. The GESI Secretariat is responsible to ensure the implementation of the next steps, which are presented below.

The policy level

1. Ensure that any policies that are newly formulated, revised, updated or amended (e.g. National Health Policy, Population Policy and NHSP-3) integrate GESI. This means that the issues experienced by women and poor and excluded people to access and use health services are recognised and addressed in policies. Additionally the necessary differentiated strategies and approaches to address gender-, caste-, ethnicity- and location-based barriers must be included along with directions to mitigate socio-cultural discriminatory practices that impact the health outcomes of specific social groups.
2. Provide GESI inputs to influence the whole policy formulation process from ToR development, team composition, consultations, through to the contents of the policy document to ensure that GESI perspectives are addressed.

GESI institutional structure

3. Strengthen the Population Division at MoHP level to work as an effective GESI Secretariat and to make the GESI Committee, GESI TWGs and HFOMCs functional. For these bodies to work as expected, the skills of the members to apply GESI need to be strengthened. Mechanisms and processes for communication, coordination, supervision, monitoring and reporting of the committees/working groups need to be established and institutionalised. Support from external development partners is needed to support the integration of GESI in health in their project districts including strengthening GESI TWGs.
4. Enhance the advocacy and application skills of GESI focal persons so they can provide technical support to their divisions, offices and committees to integrate GESI concerns in planning, programming, implementation, supervision, review and monitoring. PHCRD will require similar attention to work effectively as the member secretary of the DoHS GESI Committee.

Human Resources for Health Strategic Plan

5. Influence the on-going workforce planning and development of a long-term workforce plan and human resource projections to ensure that staffing patterns promote diversity and easier access to services by people of different social groups, especially women.
6. Ensure that the revised job descriptions integrate GESI responsibilities into technical responsibilities. The job descriptions of contract workers and ToRs of consultants must also include GESI responsibilities (note that the HRH Strategic Plan, officially launched in 2013, calls for reviewing and updating the ToRs and job descriptions of all posts and health facilities).

Capacity strengthening on applying GESI

7. Build a common understanding on GESI building on the initiatives undertaken in this review period:
    - Urgently provide advanced skills training for GESI focal persons at the centre and for GESI focal persons and statistical officers in districts,
    - Urgently orientate key programme supervisors and service providers including public health nurse and staff nurse on GESI.
    - Nominate GESI focal persons at hospital level and orientate staff and management on GESI in-service delivery.

8. Develop a core group of master trainers on GESI including inclusive governance trainees, existing subject-wise trainers and RHTC trainers.
9. Produce a standard training manual on GESI (based on the GESI Operational Guidelines, 2013) that incorporates inclusive governance training materials for the application of GESI in planning, programming, budgeting, monitoring, communications and service delivery.
10. Pre-test the five curricula recently revised with GESI content added and reprint the training packages including all GESI-related modules and sessions.

Planning, review, annual work-plan and budget

11. Guidelines from the Management Division specify the procedures for RHDs to carry out annual and quarterly reviews and planning meetings. Integrate directives in such guidelines to mainstream GESI at this level and, in turn, to direct districts to follow suit. DHOs and DPHOs must make it mandatory for health facilities to review and plan based on disaggregated evidence and on health worker experiences in addressing the barriers that women and poor and excluded people face in accessing and using health services.
12. The business plan format now has a separate section for GESI-related activities. This practice, which has however been associated with external development partners by the different divisions, needs to be made a part of the regular government planning system. Advocacy for the National Planning Commission to use this business plan format needs to be taken forward if this is to be the case.
13. Contextualise and facilitate gender responsive budgeting for the health sector by relevant sections and divisions (MoF has directed all ministries to carry out this kind of budgeting).
14. Discussions are on-going within MoHP through the Management Division about a flexible fund under the control of DHOs and DPHOs to respond to local health needs and disparities. This needs formalising with criteria and implementation guidance to ensure that the needs and priorities of women and poor and excluded people are identified and addressed.

Programming

15. The Population Division needs to develop and implement a roll-out plan for the GESI Operational Guidelines. This process will require intense technical assistance support[6] in order to ensure that the systems, processes and mechanisms required at different levels for different tasks are established and skills strengthened for them to be functional.
16. Integrate GESI concerns into the district programme implementation guidelines that are prepared by divisions and sent to districts with directives for implementing programmes. The directives need to be sent in a timely manner and must explicitly require the integration of activities or approaches to address the constraints and barriers faced by women and poor and excluded people to accessing and using quality health services.
17. Revise the numerous technical programme guidelines (e.g. guidelines for the Aama and free health care programmes) to incorporate GESI aspects. This is a large task requiring prioritised action.

[6] The level of effort required to produce such a guideline and to effectively implement it is illustrated by the example of the implementation of the "GESI Mainstreaming Guidelines (2011)" of the Ministry of Urban Development. The Asian Development Bank (ADB) is supporting a five year programme to strengthen the capacity of the relevant GESI structures to facilitate GESI responsive services from this ministry.

18. Promote effective on-going initiatives such as microplanning and context-specific programming.

GESI focused programmes

19. One-stop crisis management centres**:**
    - Strengthen OCMCs to make them functional by providing continuous back-stopping support and improving collaboration and coordination at different levels with other government sectors, external development partners and civil society.
    - Advocate and provide support for developing jointly owned comprehensive OCMC guidelines to address GBV by various government sectors.
    - Advocate with OPMCM for improved coordination of GBV interventions by different actors including external development partners, civil society and different government bodies.
20. SSUs:
    - Strengthen SSUs to make them functional by providing continuous back-stopping support.
    - Systematically monitor and share lessons learned between the two pilot NHSSP-supported hospitals and the SSUs funded from AWPBs.
21. Social auditing:
    - Strengthen the capacity of DHOs and DPHOs and implementing social audit organisations for the proper implementation of the social auditing process.
    - Closely monitor and evaluate social audit action plans and improve district and central level responses.
    - Develop and make functional a mechanism to ensure that social audit findings reach programme divisions and centres through PHCRD.
22. Equity and Access Programme:
    - Advocate for multi-year contracting of NGOs to facilitate the implementation of EAP.
    - Build the capacity of NGOs to implement EAP.
    - Support the roll-out of EAP into remote areas.

Supervision, monitoring, surveys, studies

23. Practice vigilance and grasp opportunities to ensure that GESI is addressed as much as possible in all supervision and monitoring processes, and in all studies and surveys.
24. Make efforts to revise the Integrated Supervision Checklist to incorporate GESI and to promote its widespread use.
25. Support the implementation of the revised HMIS indicators and promote the use of disaggregated data and evidence during planning, programming and monitoring.
26. Improve the dissemination and promote the use of study and survey findings across divisions and centres for more effective and evidence-based programming.

The design and objectives of NHSP-2 have provided the policy mandate underpinning the progress that government has made on GESI. Continued progress over the remainder of NHSP-2 will provide

lessons to feed into the design of NHSP-3, and ensure that NHSP-3 carries forward the policy mandate on GESI.

ANNEX 1: COMPARISON OF 2012/13 AND 2013/14 AWPB PROGRAMME BUDGETS FOR GESI RELATED ACTIVITIES FOR THE POPULATION DIVISION, PHCRD, FHD AND CHD

	Budget line	Budgeted amount				Increase	
		2012/13	2012/13	2013/14	2013/14	2012/13 to 2013/14	
		NPR	£	NPR	£	NPR	%
Population Division (central and district budgets)							
1	Social service units (SSUs)	4,000,000	30,769	13,600,000	104,615	9,600,000	240%
2	One-stop crisis management centres (OCMCs)	11,850,000	91,154	20,778,000	159,831	8,928,000	75%
3	Orientation on GESI Operational Guidelines	0	–	5,000,000	38,462	–	–
4	Orientation on GBV, GESI (TWG, district/region)	250,000	1,923	17,910,000	137,769	17,660,000	7,064%
5	Strengthening GESI institutional structures (Steering Committee, GESI secretariat, TWG)	450,000	3,462	5,230,000	40,231	4,780,000	1,062%
6	Publishing GESI materials (GESI Strategy, others)	300,000	2,308	1,100,000	8,462	800,000	267%
7	Geriatric ward protocol and senior citizen awareness programme	4,850,000	37,308	7,900,000	60,769	3,050,000	63%
PHCRD							
1	Equity and Access Programme	na	—	20,000,000	153,846	–	–
2	Social auditing	6,500,000	50,000	15,300,000	117,692	8,800,000	135%
3	Targeted programmes for target groups	29,500,000	226,923	35,000,000	269,231	5,500,000	19%
4	GESI ToT and workshops in 10 districts	5,400,000	41,538	7,600,000	58,462	2,200,000	41%
5	Research on effect of alcohol related diseases on mental health & evaluation of free health care prog.	1,000,000	7,692	2,500,000	19,231	1,500,000	150%
6	Community health units	na	—	14,600,000	112,308	–	–
Family Health Division							
1	Activities for women in remote locations #	7,000,000	53,846	136,700,000	1,051,538	129,700,000	1,853%
2	Programme addressing income barriers (Amaa programme)	959,500,000	7,380,769	1,050,000,000	8,076,923	90,500,000	9%
3	Micro-planning to plan for the underserved and unreached	No allocation	–	8,100,000	62,308	–	–

	Budget line	Budgeted amount				Increase	
		2012/13	2012/13	2013/14	2013/14	2012/13 to 2013/14	
		NPR	£	NPR	£	NPR	%
Child Health Division							
1	For malnourished children *	320,533,000	2,465,638	212,500,000	1,634,615	108,033,000	-34%
2	For children in remote locations **	25,695,000	197,654	61,400,000	472,308	35,705,000	139%
3	For health workers including FCHVs to reach excluded children	197,750,000	1,521,154	268,900,000	2,068,462	71,150,000	36%

Note: Exchange rate of @ NPR 130:£1 used

This FHD budget line for 2012/13 said: 'Contract ANMs to provide 24 hours delivery services in Health Posts and Primary Health Care Centres' (Nepali**:** स्वास्थ्य चौकी तथा प्रास्वाकेमा २४ घण्टा प्रसुती सेवा संचालन गर्न करारमा अनमी नियुक्ति). This activity was implemented across the whole of the country including in remote and non-remote districts in 2012/13. In the 2013/14 budget, the wording of this budget line was revised to: 'Contract ANMs to provide 24 hour delivery services in health posts and PHCCs in the whole country including the Karnali Zone" (in Nepali: कर्णाली अंचल लगायतका अन्य जिल्लाका स्वास्थ्य चौकी तथा प्रा स्वा के मा २४ घण्टा प्रसुती सेवा संचालन गर्न करारमा अनमी नियुक्ति). Although the wording changed to mention the country's remotest area — the Karnali Zone, in fact the budget line remained for the whole country with no separate amount dedicated for the Karnali region.

* One CHD budget line in FY 2012/13 was for both malnourished children and remote locations. This analysis has therefore included an amount in the malnourished children budget line (NPR 10 million) that was categorised by the study team to be specifically for malnourished children.
** Three activities in FY 2013/14 are related with both malnourished children and remote locations. This analysis has therefore included an amount in the malnourished children budget line (NPR 31.4 million) that was categorised by the study team to be specifically for malnourished children.