Background thematic report no. 8

Progress Report on

Gender Equality and Social Inclusion for NHSP-2

2013/14

Report Prepared for Joint Annual Review (JAR)

February 2015

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

EXECUTIVE SUMMARY

JAR background report on GESI achievements in 2013/14

This report provides an update on the initiatives taken by the Ministry of Health and Population (MoHP) and its partners in 2013/14 to mainstream gender equality and social inclusion (GESI) in the health sector and to improve the access of women and poor and excluded people to health services. Progress is given in a write-up and in a matrix against the indicators presented in Annex 3 of the Nepal Health Sector Programme 2 (NHSP-2) Results Framework.

A. Progress on mainstreaming GESI into the national health system in 2014

- Up to the end of 2014, GESI technical working groups (TWGs) have been formed in all 75 districts and GESI focal persons nominated in 75 district health office/district public health offices (DHOs and DPHOs).
- The 'Operational Guidelines for GESI Mainstreaming in the Health Sector' (MoHP 2013) were approved by MoHP and are being implemented.
- The GESI Section, which was formed in the Population Division in 2013, continued working on mainstreaming GESI in the health sector.
- One new hospital-based one-stop crisis management centre (OCMC) was established (in Jumla) to bring the total number to 16 while the existing ones were strengthened to provide integrated support to survivors of gender-based violence.
- One new pilot social service unit (SSU) was established (in Bir Hospital, Kathmandu) to bring the total number of SSUs to eight to facilitate subsidised and free health care for poor and excluded people. Capacity building support was provided to the existing SSUs.
- The Primary Health Care Revitalisation Division (PHCRD) and seven external development partners signed an MoU establishing a collaborative framework for the social auditing of health service provision. The external development partners have since started to provide technical assistance to PHCRD and the DHOs and DPHOs in their programme districts. PHCRD conducted social auditing in 45 districts in 2013/14, covering 602 health facilities.
- The first round of baseline information collection was completed in 10 health facilities in Jhapa and Ilam districts for the 2014 and 2015 process evaluation of social auditing in health facilities.
- Progress was made on working out the future course of the Equity and Access Programme (EAP). MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) decided to carry out operational research on integrating health into the Local Governance and Community Development Programme (LGCDP) with a focus on strengthening the local governance and accountability system and integrating health into social mobilisation activities.

B. Progress on GESI organizational and management strengthening in 2014

- The Population Division allocated 30% of its budget for GESI specific activities for 2014/15.
- DHO, DPHO and district development committee and media persons from all 75 districts were trained on GESI in population training courses.
- The Population Division ran a training of trainers course for National Health Training Centre (NHTC) and regional health training centre (RHTC) trainers on GESI mainstreaming in planning, programming and service delivery. These trainees subsequently implemented training courses in 13 districts for health facility in-charges and district supervisors on mainstreaming GESI in planning, programming and service delivery.

- The Health Management Information System (HMIS) Section identified 11 of its standard indicators for disaggregating reporting by health facilities. This reporting will be by sex, age, location, and caste/ethnicity and is being operationalised under the revised HMIS.
- The NHSP-3 draft document integrates GESI concerns throughout.

C. The Way Forward

This report also highlights the major lessons learned and challenges to overcome. The following are the major ways forward for mainstreaming GESI in the coming years:

- Ensure that newly formulated, revised, updated and amended policies integrate GESI concerns.
- Strengthen the Population Division to work as the GESI Secretariat.
- Produce a training manual on GESI and implement training of trainers for NHTC and RHD trainers and a rollout plan in 16 districts for the GESI Operational Guidelines.
- MoHP to continue integrating GESI into its annual workplans and budgets (AWPBs) and business plans and include adequate funding for GESI mainstreaming activities in forthcoming AWPBs.
- Ensure that GESI concerns are integrated into the district programme implementation guidelines that are prepared by divisions and sent to districts to direct programme implementation.
- Strengthen and expand the functioning of OCMCs, SSUs, and social auditing by providing back-stopping support and, for OCMCs, improve collaboration and coordination between the various agencies that are involved in supporting survivors.
- Carry out operational research on integrating EAP into the Local Governance and Community Development Programme.
- Promote the use of disaggregated data and evidence from HMIS during planning, programming and monitoring.

CONTENTS

ACRONYMS

AHW	assistant health worker
AWPB	annual work plan and budget
BCC	behaviour change communication
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
EAP	Equity and Access Programme
FCHV	female community health volunteer
FHD	Family Health Division
FY	fiscal year
GBV	gender based violence
GESI	gender equality and social inclusion
HFOMC	health facility operation and management committee
LGCDP	Local Governance and Community Development Programme
MNCH	maternal, newborn and child health
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MoU	memorandum of understanding
NGO	non-governmental organisation
NHSP	Nepal Health Sector Programme
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 Council of Ministers
PDT	Programme Development Team
PHCRD	Primary Health Care Revitalisation Division
RHD	regional health directorate
SBA	skilled birth attendant
SSU	social service unit
ToR	terms of reference
TWG	technical working group
VDC	village development committee

1 INTRODUCTION

1.1 Background

The Nepal Health Sector Programme-2 (NHSP-2) has a clear mandate to address gender equality and social inclusion (GESI). NHSP-2's vision, mission, goal, objectives, results framework and accountability plans have clear directions for addressing GESI issues. A GESI strategy for the health sector is included in NHSP-2. A National Action Plan on Gender Based Violence (GBV) has been implemented since November 2010. The plan's implementation is coordinated by the Office of the Prime Minister and Council of Ministers (OPMCM) and has the commitment of 12 ministries including the Ministry of Health and Population (MoHP) plus the National Planning Commission, the National Human Rights Commission, and the National Women's Commission. MoHP has responded to the national mandate and initiated various responses to address gender and social inclusion.

1.2 Objectives

This report provides an update on the initiatives taken by MoHP and its partners to mainstream GESI and address key issues experienced by women, the poor and excluded in accessing health services in 2013/14.

The following progress update is compiled against the GESI strategy framework and objectives, the Governance and Accountability Action Plan (GAAP) indicators and activities undertaken as required by the NHSP-2 Results Framework (Annex 1). Annex 2 gives a summary on the progress on GESI so far under NHSP-2.

2 PROGRESS AND ACHIEVEMENTS

2.1 GESI Programme Interventions

2.1.1 Mainstreaming Gender Equality and Social Inclusion

The GESI Institutional Structure Guidelines were approved in 2012. They specify the location of GESI responsibilities in the government's health structure and the functions of different committees and working groups. MoHP's GESI Steering Committee has made decisions about mainstreaming GESI in planning, reviews and annual work plans and budgets (AWPBs); about establishing one-stop crisis management centres (OCMCs); about rolling out GESI institutional structures and about establishing social service units (SSUs).

Up to the end of 2014, GESI technical working groups (TWGs) have been formed in all 75 districts and GESI focal persons nominated in all regional health directorates (RHDs) and all 75 district health offices/district public health offices (DHOs/DPHOs). The terms of reference of all groups and committee members that are mentioned in the GESI Institutional Structure Guidelines have been covered in GESI orientations. From FY 2013/14 the Population Division's AWPBs have provided budgets to fund biannual (6-monthly) reviews of GESI mainstreaming at the district level and quarterly meetings of district-level GESI technical working groups (TWGs). Health for Life and the United Nations Population Fund (UNFPA) have provided technical support for the biannual GESI reviews in districts where they have district officers.

The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' (MoHP 2013) were developed and approved by MoHP in December 2013. These guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery, monitoring and reporting. GESI mainstreaming training (based on the GESI Operational Guidelines) for health facility in-charges and district supervisors was initiated in 13 districts in 2013/14 and is planned for a further 16 districts in 2014/15.

The GESI section, which was formed in the Population Division in 2013, coordinated and implemented GESI-related programmes in the current reporting period.

The Population Division has incorporated GESI-related programmes into its programme implementation guidelines since FY 2013/14, continuing in 2014/15. These programmes include the operation and strengthening of one-stop crisis management centre (OCMCs) and social service units (SSUs), strengthening GESI TWGs, and gender-based violence (GBV) orientation/training to health staff in all 75 districts, including the health personnel at 16 OCMC hospitals.

2.1.2 Addressing Gender Based Violence

One new OCMC was established in 2014 — at the Karnali Health Academy, Jumla — to bring the total number to 16. Substantial progress was made in this reporting period on strengthening OCMCs:

- In February 2014, a high level joint monitoring visit to Saptari and Sunsari OCMCs was led by the responsible secretary at OPMCM. The director general of the Women and Children Department, the deputy attorney general, a Home Ministry representative, the director of the Police Headquarters' Women and Children Directorate, the chief of the Population Division, the GESI Section Chief and NHSSP's GESI advisor took part. They visited the OCMCs, district shelter homes and the police offices' women and children service units and listened to a presentation by the OCMC district coordination committees. Orientation and policy instructions were

provided by the secretary. Visit participants discussed how to resolve problems and improve the effectiveness and functioning of the OCMCs. The major issue is for OCMCs to provide integrated services that are the responsibility of different agencies.

- Several OCMC-related publications were produced in 2013/14: Pamphlets on OCMCs for providing information on OCMCs to the general public; an NHSSP pulse report that articulates the issues to do with strengthening OCMCs; and a resource book was reprinted on legal provisions and procedures for GBV victims, which was disseminated to OCMCs, district women and children offices and the Nepal Police.
- Three types of training programmes were run for OCMC staff
  - The medico-legal training for 17 medical officers from 14 OCMC-based hospitals was paid for out of the Population Division's AWPB. It was organised by the Institute of Medicine and the quality of training was appreciated by participants.
  - A 6-month training course on psychosocial counselling was provided to three OCMC staff nurses.
  - Basic training on psychosocial counselling was provided to 52 health staff and focal persons who work in OCMCs. These personnel have the first contact with victims of violence.
- Orientations on GBV and GESI, reviews of progress and discussions on resolving problems were organised in 13 OCMCs.
- In October 2014, a national workshop was held to review and give future direction to OCMCs (see its recommendations in Box 1).

Box 1: Key interventions recommended by October 2014 OCMC review

1. Develop umbrella guidelines on GBV for effective coordination and teamwork.
2. Make provision for single district level GBV committees (instead of the current six committees that cover GBV issues) to improve coordination on GBV issues and prevent duplication of activities.
3. Develop integrated workplans by agencies working on GBV at district level and get district coordination committees (DCC) to approve such plans.
4. Make women development officers (WDOs) the focal points for district-level coordination on GBV issues.
5. OCMCs to carry out regular follow-up with survivors by phone, home-visits and other ways.
6. Explore the scope for OCMC district coordination committees to make MoUs with residential schools to house under 16-years rape survivors. These arrangements should be implemented in coordination with women development offices in response to a decision of the Prime Minister's Office.

- GBV awareness programmes, radio jingles, rallies, interviews and meetings with journalists were organised in districts during the 16 days of activism against GBV.
- An OCMC Monitoring and Reporting Manual was developed with support from NHSSP and is under approval. The draft framework was tested at Hetauda Hospital OCMC.
- The OCMC guidelines were revised based on feedback from the 2013 and 2014 annual reviews and mentoring visits to OCMCs. The guidelines are under approval.
- A draft Gender Based Violence Clinical Protocol was prepared for frontline health workers and is being finalised.

2.1.3 Social Service Units

Social service units (SSUs) are being established to facilitate the access of disadvantaged people to free and subsidised health care. Several important pieces of work to strengthen and institutionalise SSUs in hospitals were carried out in 2014:

- An annual review workshop on the overall progress of SSUs was held in January 2014 attended by medical superintendents, chiefs and account officers from the seven SSUs. The workshop was chaired by the MoHP secretary with the PPICD chief and chief of the Population Division present. Participants reviewed progress and lessons learned and identified issues to be addressed. It also identified areas to be incorporated into the SSU guidelines and approved the M&E framework for SSUs as developed by the Population Division.
- An Excel-based information system for SSUs was developed and piloted in four SSUs (Bharatpur, Bheri, Seti and Western Regional hospitals). These hospitals have been documenting and reporting their provision of services using this software.
- A new pilot SSU was established in Bir Hospital to bring the total number of SSUs to eight. Orientation and backstopping support was provided to all SSUs.
- Performance reviews were held of all SSUs along with orientation programmes on GBV and the GESI framework for hospital officials including all SSU staff.
- The SSU guidelines were revised to take forward recommendations from the SSU study (August 2013), inputs from the SSU review workshop (January 2014) and feedback provided during follow-up visits to SSUs. The revised guidelines were approved by the health minister in December 2014.
- Guidance was provided to three SSUs (Bharatpur, Bheri and Seti) on documenting case studies to show good practices. These studies will be used in the annual review workshop in January 2015.

2.1.4 Equity and Access Programme

Background — The Equity and Access Programme (EAP) was launched in 2006 to support women and children from poor and excluded groups to access health services and their entitlements through a social mobilisation package of activities. The programme has strengthened public participation in local health governance and improved the health outcomes of poor and excluded people.

Challenges —The Department of Health Services (DoHS) took over the programme's management and funding from an NGO consortium in 2009. This brought about a number of administrative and financial challenges for EAP. The annual contracting of NGOs to implement the programme curtailed actual implementation to only 2-4 months per year. Hurried and superficial activities have compounded the weak accountability of how funds have been used. Up to the end of FY 2013/14 EAP was implemented in selected VDCs of 20 districts. However, the Ministry of Finance stopped AWPB funding for EAP in 2014/15 saying that the Ministry of Federal Affairs and Local Development (MoFALD) should be the lead ministry for EAP's social mobilisation activities as per the 2013 collaborative framework between MoHP and MoFALD.

Integration of EAP into LGCDP — In 2013/14 there was a significant shift to cross-sectoral collaboration for promoting more equitable access to public health services in Nepal with MoFALD agreeing to integrate health programmes and the opportunity for integrating EAP into the social mobilisation part of its Local Governance and Community Development Programme (LGCDP). In December 2013, MoHP

and MoFALD signed a collaborative framework to integrate health issues into LGCDP's social mobilisation programme. This includes local governance system strengthening, demand side accountability and the targeted empowerment of excluded communities. A rapid assessment of health and governance social mobilisation programmes was carried out in Dhading and Rupandehi districts in mid-2014 and the findings shared with the Primary Health Care Revitalisation Division (PHCRD) and LGCDP.

Based on the assessment findings and recommendations, an action plan was developed to carry out further operational research in two VDCs of one district with technical assistance from NHSSP. This plan will be shared with MoFALD in early 2015.

2.1.5 Social Auditing Guidelines

The social auditing of health service delivery is enabling many women and people from excluded groups to participate in improving the governance of health facilities.

Comprehensive social auditing guidelines were approved by MoHP in June 2013. With AWPB funding, PHCRD conducted the social auditing of health services in 45 districts in 2013/14, covering 602 health facilities including 50 Health for Life (H4L)-supported facilities in an additional five districts. Orientation programmes about the objectives, institutional mechanism, process, documentation and reporting of social auditing were also carried out.

In February 2014, PHCRD and seven external development partners signed an MoU establishing a collaborative framework for the social auditing of health service provision. External development partners have since started to provide technical assistance to PHCRD and the DHOs and DPHOs in their programmes' districts. Technical support from multiple development partners at central and local levels has been important, feeding into the design and implementation of social auditing.

In March and April 2014, four orientations were run for DHO and DPHO personnel, focal persons, NGO representatives and EDP programme representatives from social auditing districts on the social auditing of health facilities. The orientations covered the rationale, objectives, steps, tools, analysis, organisation and facilitation of public meetings and reporting. NHSSP's Technical Assistance Response Fund (TARF) paid for this.

PHCRD has started a process evaluation of social auditing in health facilities. The first round of baseline information collection was completed in 2014 in 10 health facilities of Jhapa and Ilam.

PHCRD decided not to increase the number of districts for social auditing in 2014/15; but the number of health facilities was increased from 602 to 802 based on the previous year's work performance of the districts and the findings of the process evaluation.

2.2 Organisation and Management Strengthening

2.2.1 GESI activities in MoHP's AWPB and Business Plan

MoHP allocated a reasonable amount of funding for GESI activities in its annual work plan and budgets (AWPB) for 2013/14 and 2014/15. Examples of this are that, in 2013/14, the Family Health Division allocated 96%, the Population Division 31% and the Child Health Division 25% of their budgets for GESI-related activities. And for 2014/15, the Population Division has allocated 30% of its budget for GESI-specific activities. These amounts included budgetary provisions for GESI-related capacity development at different

levels, to make GESI technical working groups functional, and to establish and operate OCMCs in 16 hospitals and SSUs at 8 hospitals. Most of the Family Health Division's budget goes for women's health.

The use of MoHP's new business plan format has helped ensure that GESI-related activities are identified, planned and budgeted within MoHP.

2.2.2 Capacity Building on GESI

- Since 2013, GESI has been integrated into population training courses to improve the conceptual clarity and impact of local health authorities on GESI. The staff of regional health directorates, district health officers, district public health officers, DHO/DPHO GESI focal persons, local development officers and the planning officers of district development committee from all 75 districts took part in these courses in 2014.
- A GESI training of trainers course was held in April 2014 for National Health Training Centre (NHTC), RHD and regional health training centre trainers with technical support from NHSSP and the World Health Organisation (WHO). Under the auspices of NHTC, these trainees went on to run AWPB-funded training courses in 13 districts on mainstreaming GESI in planning, programming and service delivery for facility in-charges and district supervisors. These courses enable participants to roll out GESI at the facility level.
- The subject of GESI and its application (including OCMCs, SSUs, social auditing, and EAP) has been integrated into NHTC-run induction training for newly appointed doctors and health staff since 2013. In addition, training was provided to upgraded health staff on GESI and its application. The Population Division also provided training on GESI to officers of the Department of Ayurveda.
- A draft GESI training of trainers manual was prepared and is being finalised in February 2015.
- In 2014, staff from NHTC, RHTC, DPHO/DHOs and health facilities took a master ToT on the revised curriculum for HFOMCs to test the new GESI-integrated curriculum. The NHTC has endorsed the final revised updated HFOMC curriculum. HFOMCs are being reformed in 16 districts and orientated on their roles using the revised curriculum.

2.2.3 GESI Integration in NHSP-3

GESI issues have been integrated into the draft NHSP-3 strategic document and by including more GESI disaggregated indicators in the results framework.

2.2.4 GESI Integration in the Health Management Information System

The revised Health Management Information System (HMIS) requires that health facilities provide disaggregated data by sex, age, location, and caste/ethnicity on 11 key indicators. This revised HMIS is being operationalised in FY 2014/15. The revised HMIS reporting system and its software enables sub-district level disaggregated data to be generated. The revised system is also improving hospital recording and reporting systems so that mortality and morbidity data is generated by age, sex and cause. The disaggregated data will enable more inclusive monitoring and planning in the health sector.

3 CHALLENGES

a) *The effective implementation of GESI provisions in policies, programmes and guidelines* — The inclusion of GESI in policy processes requires further advocacy and influencing work. Effectively implementing the GESI operational guidelines, the social audit guidelines, the social service unit guidelines, the OCMC guidelines, and ensuring that the institutional structures for GESI are functional requires dedicated attention.

b) *Multi-sectoral coordination to address issues of women, poor and excluded people* — Another major challenge is developing a coordination and collaboration mechanism between ministries to address the complex issues that impact the access and use of health services by women, the poor and other excluded groups. OCMC service provision in particular need to be better coordinated, with the challenge being to convince and motivate different actors to work in a holistic way. The challenge is to make OCMCs real 'one-stop' service centres through exemplary collaboration between district and central levels and the different involved sectoral organisations.

c) *Identifying the income poor* — Tools to identify the poor are insufficiently robust to accurately identify poor people for the targeting of subsidised and free health services. This allows misuse and access by the more advantaged. The proper identification of the poor is especially important for the effective implementation of SSUs.

d) *Regular opportunities to strengthen service providers' and health managers' skills* — Continuous interventions are needed to improve the skills of service providers to recognise the barriers women, the poor and excluded people face accessing and using health services, and to identify what measures need to be taken to overcome these barriers. A key challenge is for service providers to find time and the additional resources required to run such interventions. The skills needed to integrate GESI in planning, programming and monitoring come with experience.

e) *Strengthening hospital-based SSUs* —

   - The main challenges that could undermine government support for SSUs is if they stimulate such a large demand for subsidised and free health services that the demand exceeds the government's capacity to meet it.
   - Delayed budget release to SSUs affected SSUs' abilities to operate in 2013/14.
   - SSUs are crucial for improving access to health services for the underserved and yet remain a long way from being institutionalised. It should be mandatory for public and private referral hospitals to run SSUs (and for MoHP to provide assured funding for public hospitals to run SSUs).

f) *Social audits need properly implementing* — It needs to be assured that social audits are carried out properly as per the guidelines and that work plans resulting from audits are implemented with good follow-up support from district level authorities including EDPs (where present) and central authorities.

4 LESSONS LEARNED

a) *Mandatory directives essential* — A strong policy mandate on GESI is essential. Only then can officer personnel across all levels of the health system be made accountable for taking forward the GESI agenda. Also, the approved institutional structure guidelines clearly identify the responsibilities for GESI mainstreaming within the health sector. This has given direction to different committees and working groups on the tasks they must implement to ensure GESI mainstreaming. Similarly MoHP's annual business plan format calls for separate information on GESI-specific activities. This helps divisions and centres to identify activities and assigns responsibilities for carrying them out.

b) *Government leadership and ownership* — Government leadership and ownership of the GESI agenda is crucial and needs to be reinforced and supported by external development partners and the technical assistance they provide.

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

d) *Coordinated efforts needed for effective service delivery by OCMCs* — It is important for the multiple needs of GBV survivors (health care, shelter, protection, legal support, rehabilitation and follow-up) be addressed. There needs to be good coordination between central level agencies to direct their district level agencies on the support to be provided. There also needs to be a second tier of stewardship and coordination at the centre involving other key ministry level stakeholders at the joint secretary level, chaired by the OPMCM secretary. Integrated guidelines outlining the roles and interventions of the different concerned ministries are needed for the comprehensive care of GBV survivors. OCMCs are now understood as facilitating an integrated response, but not in one place. Alternative models are being developed for separate areas including the health system response for health care (treatment, medico-legal services, psychosocial counselling and mental health services), and re-modelled OCMCs.

e) *Strengthening service providers' skills* — Building the capacity of health personnel on GESI is at the core of mainstreaming GESI. This will take several years of sustained effort and requires innovative interventions. Repeated interactions and discussions (such as during the preparation of AWPBs and implementation plans) will enable concerned officers to recognise ways of addressing the issues that impact women and poor and excluded people.

f) *Targeted GESI programmes are easier to establish* — It is easier to address GESI through GESI-targeted programmes, such as SSUs, OCMCs and the Aama Programme. Incentives are needed to encourage health personnel to focus more on reaching unreached and under-reached areas and groups in regular programmes.

5 THE WAY FORWARD

a) *Policy level* — Ensure that all newly formulated, revised, updated and amended policies, such as the Urban Health Policy and NHSP-3, integrate GESI concerns.

b) *Local Health Governance Strengthening Operational Guidelines* — The Operational Guidelines of the Collaborative Framework for Local Health Governance Strengthening are being implemented in six pilot districts in 2014/15. They call for local bodies (VDCs, municipalities and DDCs) to lead health planning in consultation with all local stakeholders including women and poor and marginalised people to achieve more inclusive access to and use of health services. This process will see periodic health plans developed and then implemented using a flexible fund provided by MoHP, the local body block grants provided by MoFALD, and local resources.

c) *GESI institutional structure* — The Population Division needs strengthening to work as the GESI Secretariat and to make the GESI Committee, GESI TWGs and HFOMCs fully functional. The skills of their members need to be strengthened. Support from EDPs is needed to support the integration of GESI in health at the district level, including strengthening GESI TWGs.

d) *Capacity strengthening* — Produce a standard training manual on GESI to roll out the GESI operational guidelines to the district level and below. Then organise an advanced training of trainers courses for NHTC, regional health training centres (RHTC) and RHD trainers using the manual. And train district supervisors and health facility in-charges of the remaining 62 districts on mainstreaming GESI in service delivery.

e) *Integration of GESI in AWPBs and annual business plans* — The good practice of integrating GESI into MoHP's AWPBs and business plans needs to be continued. GESI technical working groups at all levels need to ensure that GESI is well addressed in all relevant plans and programmes.

f) *Supervision and monitoring* — Support the implementation of the revised HMIS indicators and promote the use of disaggregated data and evidence in planning, programming and monitoring.

g) *Health integration into LGCDP* — Carry out operational research on integrating health into LGCDP social mobilisation in two VDCs of one district, as agreed by MoFALD and MoHP. This research will focus on identifying ways of strengthening the local governance and accountability system, and integrating and harmonising health into community mobilisation activities. If appropriate then health should be integrated into LGCDP in NHSP-3.

h) *One stop crisis management centres*:
   - Provide continuous back-stopping support to OCMCs and improve collaboration and coordination with other government sectors, EDPs and civil society.
   - Institutionally reposition OCMCs through policy coordination and evidence monitoring by the Population Division, the integration of GBV issues into health services and the capacity building of health staff by the Family Health Division.
   - Finalise the integrated guidelines for addressing GBV and get them approved.
   - Functionalise the new OCMC monitoring and reporting system.
   - Finalise and approve the GBV clinical protocol for health workers, and promote its use.

i) Social service units:
   - Carry out a process evaluation of the pilot SSUs; develop the SSU model (e.g. better coordination with hospital social protection programmes) based on evaluation findings; and then gradually establish SSUs in all referral hospitals during the NHSP-3 period.

- Harmonise SSUs with health insurance models (information to and engagement with the public and one window entitlement).

j) Social auditing:
   - Complete the social audit process evaluation, and based on its findings streamline the social audit process and guidelines.
   - Assess the scope and quality of social auditing by local government and pilot an integrated approach in the six Local Health Governance Strengthening (LHGS) districts. (LHGS is the main initiative to implement the MoHP-MoFALD collaborative framework).
   - Design and test how to harmonise health social audits with local government social audits.
   - Monitor and evaluate the implementation of social audit action plans.

k) Reaching the unreached and the less reached
   - Run integrated public health campaigns in an additional 40 districts (covering public health as well as curative services).
   - Strengthen existing community health units and establish 58 new ones in under-reached parts of VDCs.
   - Run targeted programmes through flexible funds in 20 districts to improve service provision to unreached communities and geographically remote areas (where regular programmes are not addressing barriers poor and excluded people face). This programme was initiated by the Management Division in 2013/14.
   - Complete the FHD and PHCRD pilot programme in Taplejung district on improving access to and use of MNH services in remote areas and then develop a roll out plan based on lessons learned (if it is recommended to scale-up this initiative).

REFERENCES

MoHP (2010a). Health Sector Gender Equality and Social Inclusion (GESI) Strategy, 2010. Kathmandu: Ministry of Health and Population.

MoHP (2010b). Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual 2010. Kathmandu: Ministry of Health and Population.

MoHP (2010c). Nepal Health Sector Programme (NHSP) II (2010-2015). Kathmandu: Ministry of Health and Population.

MoHP (2011). Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming across the Ministry of Health and Population 2011. Kathmandu: Ministry of Health and Population.

MoHP (2013). Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector. Kathmandu: Ministry of Health and Population.

MoHP (2014). Social Service Unit Implementation Guidelines (revised) 2014. Kathmandu: Ministry of Health and Population.

MoHP and NHSSP (2013). GESI Mainstreaming in Nepal's Health Sector: Progress Review and Process Documentation. Kathmandu: Ministry of Health and Population.

OPMCM (2012). National Strategy and Action Plan for Gender Empowerment and to End Gender Based Violence (2012/13 to 2016/17). Kathmandu: Office of the Prime Minister and Council of Ministers.

PHCRD and NHSSP (2013). Evaluation of Social Auditing Pilot Programme in Rupandehi and Palpa Districts. Kathmandu: Primary Health Care Revitalisation Division and NHSSP.

PHCRD and NHSSP (2014 and 2015). Process Evaluation of Social Auditing in Ilam, Jhapa, Rupandehi and Palpa Districts. Kathmandu: Primary Health Care Revitalisation Division and NHSSP.

Population Division and NHSSP (2013) Progress Review of Pilot Social Service Units. August 2013. Kathmandu: Population Division and Nepal Health Sector Support Programme.

Population Division and NHSSP (2014) Annual Progress Review and Future Direction of One-stop Crisis Management Centres. October 2014.

Population Division, UNFPA and NHSSP (2013) Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres. October 2013. Kathmandu: Population Division, United Nations Population Fund and Nepal Health Sector Support Programme.

ANNEX 1: REPORT ON GENDER EQUALITY AND SOCIAL INCLUSION AGAINST ANNEX 3 OF NHSP-2

Note: The original NHSP-2 Annex 3 matrix (Strategy Table/Strategic Framework) did not number the working policy points but just gave put plain bullets. The following numbering system (to 70) was applied in the JAR 2014 report and the same system is used here.

Strategy	Working policy	Report on GESI related progress in 2014 against the working policy provisions
OBJECTIVE 1: DEVELOP POLICIES, STRATEGIES, PLANS AND PROGRAMMES THAT CREATE A FAVOURABLE ENVIRONMENT FOR INTEGRATING (MAINSTREAMING) GESI IN NEPAL'S HEALTH SECTOR.		
Strategy 1. Ensure inclusion of GESI in the development of policies, strategies, plans, setting standards, and budgeting, and advocate for use of such policies, standards and budget provisioning at the central level.		
Review the existing policy, law and guidelines to make them GESI inclusive	*1. Integrate GESI in existing health policy, regulations and guidelines.* *2. Advocate for health as a fundamental human right in the constitution.* *3. Include the standards for integration of GESI in NHSP-2.* *4. Develop mechanisms for regular policy feedback.* *5. Revise HMIS to improve health monitoring on GESI.* *6. Identify and recommend expansion of health facilities to locations with high concentrations of underserved poor and excluded groups.*	1.1 GESI elements integrated into New Health Policy 2014. 1.2 The Health Sector Gender Equality and Social Inclusion (GESI) Strategy has been updated considering the current changed context and the revised version is under approval. 1.3 The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' were approved by MoHP in 2013 and are now being implemented. 1.4 GESI has been integrated into the Population Policy, which is under approval. 1.5 'Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming' across MoHP were approved by the minister in 2012 and are now being implemented. 1.6 The Urban Health Policy is under approval. Its implementation will improve access to health services for the urban poor. 1.7 Social auditing was implemented with AWPB funding across 45 districts in 602 health facilities in 2013/14. PHCRD is conducting auditing in 45 districts in FY 2014/15, in 802 facilities (including 200 new facilities). 1.8 The revised One-stop Crisis Management Centre (OCMC) Operational Manual is under approval after incorporating feedback from the assessment and national review. 1.9 The revised Social Service Unit Operational Guideline are under approval after incorporating inputs and feedback from the annual progress review and study of piloted hospitals. 5. Data on 11 HMIS indicators is now to be disaggregated by sex, age, location, and caste/ethnicity. The revised HMIS incorporating these 11 key GESI related indicators is being operationalised in 2014/15 (FY 2071/72). Also, improvements are being made to hospital recording and reporting systems in the revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised HMIS reporting system and its new software will enable sub-district level data to be generated. 6. The study on access to and use of maternal and newborn care health services in remote areas of Nepal found that remote and mountain districts and remote VDCs in such districts were worse off in most aspects of access to and use of MNCH services. The study recommended a core service delivery and demand side package of interventions to pilot the overcoming of barriers in one mountain district. This is being implemented in Taplejung district.

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Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting	7. Develop policy for identification of poor and excluded groups. 8. Develop implementation guidelines and ensure implementation. 9. Develop policy measures to promote GESI in human resource management. 10. Develop provisions for poor and excluded groups to receive free secondary and tertiary health care services. 11. Formulate provisions for compulsory social auditing to make health services inclusive, transparent and accountable. 12. Incorporate GESI in e-AWPB programmes and MoHP activities. 13. Advocate to MoF and NPC for regular budget provisioning of GESI in AWPB. 14. Formulate provision for health cooperatives for easier access of poor and excluded to health services. 15. Develop provision for health insurance to increase access to health services of poor and excluded. 16. Formulate provision for media to disseminate health care messages and inform about facilities for poor and excluded groups.	8a. Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector were approved by the health minister in December 2013. These will provide guidance to all levels of health service providers and managers on mainstreaming GESI in planning, programming, budgeting, monitoring and reporting. 8b. The Population Division has incorporated GESI related programmes (OCMCs, SSUs, strengthening GESI TWGs, training health staff of OCMC hospitals on GBV, GBV training to health staff in all 75 districts, and GESI mainstreaming training to district supervisors and health facility in-charges of 13 districts) into their programme implementation guidelines since current fiscal year 2070/71 (2013/14). 8c. GESI was integrated into the programme implementation guidelines of the Management Division and Population Division for FY 2071/72. 10. SSUs were established in eight hospitals in 2013 and 2014 to improve the access of poor and excluded groups to subsidised and free secondary and tertiary level health care services, Based on the assessment of SSUs, MoHP developed a monitoring and evaluation framework for SSUs. 11. Harmonised social auditing guidelines were approved by MoHP in June 2013, after incorporating feedback from the districts where social audits were conducted. With AWPB funding, a harmonised social auditing approach was implemented across 45 districts in 602 health facilities in 2013/14. This process has given many women and people from excluded groups the opportunity to voice their concerns on health service delivery. PHCRD is carrying out a process evaluation of social auditing in health facilities in 2014 and 2015. The first round of baseline information collection was completed in 2014 in 10 Jhapa and Ilam facilities. 12. GESI activities were discussed and identified with different divisions and centres for the 2014/15 AWPB. For the Population Division and PHCRD, detailed plans covering GESI activities were developed with relevant staff. Annual business plans were developed by different divisions and centres, which specify GESI related activities.
Strategy 2: Prioritise GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHO, DPHO and VDC) to ensure services are accessible and available to the poor, vulnerable and marginalised castes and ethnic groups.		
Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programmes, budgeting, monitoring and evaluation.	17. Address GESI issues in plans, programmes and budgets. 18. Develop GESI indicators as necessary, disaggregate the HMIS, monitor and report performance of target groups. 19. Define roles and responsibilities for monitoring and evaluating performance of target groups. 20. Develop mechanisms/ processes to review the progress from a GESI perspective periodically.	17. Inputs for including GESI related directives in the programme guidelines issued by divisions and centres for districts were provided as relevant for the preparation of AWPBs and the guidelines. 18. The HMIS has incorporated 11 key GESI-related indicators that are to be disaggregated by sex, age, location, and caste/ethnicity. This is being operationalised in FY 2014/15. Also, improvements are being made to hospital recording and reporting systems in the revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised HMIS reporting system and its new software enables sub-district level data to be generated. 19. Annual regional health reviews were conducted from a GESI perspective. 20. The institutional structure for mainstreaming GESI, headed by the health secretary as chair of the GESI Steering Committee, and including committees and technical working groups at each level of the health system, provides the mechanism to regularly review progress on GESI in the health sector. For 2014/15, MoHP has allocated funds to support biannual reviews of GESI progress at MoHP and district levels.

Strategy	Working policy	Report on GESI related progress in 2014 against the working policy provisions
Include GESI related issues in programme implementation by health service providers.	21. Operationalise guidelines to facilitate access and utilisation of health services by the poor and excluded. 22. Ensure that the work of every health institution includes GESI.	21. The Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector were approved by the health minister in 2013. These guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery and monitoring. 22. Training on GESI mainstreaming in service delivery for district supervisors and health facility in-charges began from 2013/14 in 13 districts, is planned for 16 districts in 2014/15 and will continue in the following years. EDPs have been providing support to districts and below where they are present for capacity enhancement on GESI mainstreaming in service delivery and progress reviews.
Coordination and participation among concerned organisations for GESI.	*23.* Coordinate with MLD, MoF and NPC to allocate more budget for GESI in DDCs, VDCs and Municipalities. *24.* Coordinate and implement with DDCs, VDCs, and Municipalities to attract their social development budgets in the health sector. *25.* Continue handover of health facilities at local level and make the HFOMCs inclusive. *26.* Coordinate/partnership with district- and village-level NGOs working in the health sector. *27.* Coordinate with Ministries, I/NGOs and local bodies to integrate GESI in their programmes. *28.* Create trust between health care providers and communities. *29.* Create policy provisions to make local bodies responsible to develop participatory inclusive plans, and to implement and monitor them. *30.* Transfer knowledge, skills, resources and materials to local bodies to meet the needs of the target groups.	26a. All the districts that implemented social audits used NGOs as third party social auditors and involved community based organisations in the audits. 26b. SSUs work in partnership with local NGOs and OCMCs coordinates with district level NGOs on the GBV agenda. 28a. A major activity carried out under the Equity and Access Programme is organising interactions between service providers and users to develop coordination and create trust between them. This will enable health facilities to provide more responsive services for poor and excluded people. 28b. Social auditing seeks to foster partnerships for improving health services with communities, and through the process of auditing generates greater communication and trust between service providers and communities. 29. The Local Health Governance Strengthening Programme (LHGSP) is being implemented in 6 of Nepal's 75 districts to enable VDCs, including health facility management committees, to identify and address local health needs through local planning. These inputs also encourage the generation and mobilisation of local resources to implement local health planning. This programme is being implemented to operationalise the collaborative framework between MoHP and MoFALD, which aims to improve local health governance.
Strategy 3: Establish and institutionalise GESI unit/desk at the MOHP, DOHS and divisions of the DOHS, regional directorates, and DHO/DPHO, and Social Service Units for GESI at central, regional, sub-regional, and zonal hospitals.		
a) Establish Social Service Units (SSU) in hospitals.	31. Establish and operationalise Social Service Units in central, regional, sub-regional, zonal, and district hospitals.	31.1 A 2012 study on the provision of free health care services and subsidies identified the need to establish social service units (SSUs). Eight pilot SSUs have been established in hospitals. Capacity building support is being provided to the SSUs through training, mentoring and reviewing the performance. 31.2 A progress review of the 8 SSUs was carried out in 2013. Based on the findings, MoHP developed and operationalised a monitoring and evaluation framework for assessing the performance of SSUs. 31.3 A progress review workshop on SSUs, chaired by the health secretary, was held in January 2014. It reviewed the achievements, issues, lessons learned, recommendations for effective functioning of SSUs and areas of revision/improvement of guidelines. The SSU guidelines were revised and approved by the minister based on assessment findings, workshop inputs and feedback from SSU visits. MoHP is organising annual reviews and making a capacity building plan considering the review workshop's inputs.

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b) Establish GESI Unit/Desk at different levels of the health sector.	32. Establish GESI and internalise a GESI unit within MoHP, DoHS, RHDs, DPHOs and DHOs.	32.1 A GESI Steering Committee was formed in 2011 at MoHP under the chair of the secretary and regular meetings have been held. The committee has been able to guide and give policy direction to address GESI related issues. By the end of 2014, GESI technical working groups (TWGs) have been formed in all 75 districts. GESI focal persons have been nominated in all regional health directorates (RHDs) and all district health office/district public health offices (DHOs/DPHOs). All technical working groups have been formed and oriented on GESI concept and its application. The ToRs of all groups and committee members mentioned in the GESI Institutional Structure Guidelines have been covered by the GESI orientations. From 2013/14 MoHP has provisioned budgets for TWG meetings and biannual reviews of GESI mainstreaming in the health sector in MoHP and 75 districts. 32.2 The Population Division has incorporated GESI related programmes (OCMCs, SSUs, strengthening GESI TWGs and GBV orientation to health staff of 75 districts and held focused GBV training in 16 OCMC districts) into their programme implementation guidelines since 2013/14 continuing in FY 2014/15. 32.3 In 2013 a GESI section was formed and began functioning in the Population Division. It is headed by the under-secretary as a dedicated section to work on GESI in the GESI Secretariat (the Population Division).
OBJECTIVE 2: ENHANCE THE CAPACITY OF SERVICE PROVIDERS AND ENSURE EQUITABLE ACCESS AND USE OF HEALTH SERVICES BY THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 4: Enhance the capacity of the service providers to deliver essential health care service to poor, vulnerable, marginalised castes and ethnic groups in an equitable manner and make service providers responsible and accountable.		
Improve service delivery mechanism by service providers for the poor, vulnerable and marginalised caste and ethnic groups.	33. Sensitise health workers, SSU and GESI focal points at all levels, FCHVs, and HFOMCs on GESI. 34. Implement behaviour change training for the health workers, FCHVs and local HFOMCs. 35. Strengthen capacity of FCHVs and NGOs to provide proper information to target groups on health services. 36. Include GESI content in the health sector education and training curricula.	33. To the end of 2014, GESI orientations (concept and its application in planning, programming, service delivery, progress review and supervision) were provided to the technical working groups of all 5 regions and 75 districts, in 15 OCMC hospitals and the 8 hospital-based SSUs. GESI orientations were also provided to RHD officials and DHOs, DPHOs and focal persons of 75 districts. GESI training (concept and its application in planning, programming and service delivery) was provided to supervisors and health facility in-charges of 13 districts. 35. Capacity building training to NGOs and FCHVs was provided under EAP, and health messages were disseminated to target groups, especially women, the poor and excluded people. 36.1 The National Health Training Centre reviewed five curricula from the GESI perspective (health facility operation and management committee [HFOMC], female community health volunteer [FCHV], behaviour change communication [BCC], upgrading assistant health worker [AHW] and skilled birth attendant [SBA] curricula) and finalised the materials of these curricula in 2013. The revised HFOMC, AHW and SBA curricula have been implemented in 2014. 36.2. GESI concepts and application has been integrated into the induction training package for new health sector personnel (officer and non-officer), and implemented by NHTC from 2013. GESI has also been integrated into the training curricula for upgraded health workers at different levels.

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Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasising programmes to reduce morbidity and mortality of the poor, vulnerable and marginalised castes and ethnic groups.		
Increase access of the target groups to universal and targeted free care programmes.	37. Develop criteria to identify poor and excluded groups and provide them with "Free Health Check-up Cards" for secondary- and tertiary-level health care services and referrals. 38. Ensure equitable and meaningful participation of target groups and women in HFOMCs. 39. Ensure meaningful participation of poor and excluded groups in social audits of health services.	37. SSUs have been established in eight zonal, regional and central level hospitals and have been providing subsidies and free health care services to the poor, the helpless, the disabled, senior citizens and GBV victims. All established SSUs were provided with backstopping organisational and management support in 2014. 39. The social audit guidelines have provisions to include women, the poor and socially and geographically excluded people in consultation processes (patient exit interviews and focus group discussions) during social auditing. The process has enabled many women and people from excluded groups to participate in social audits for a more thorough and inclusive process.
Increase the use of Mother and Child Health and Free delivery services by the target group.	i) Develop special programmes for women, poor, and excluded groups (women and children) to increase their access to MCH services and free deliveries. 40. Support increasing use of neonatal and postnatal care services, institutional deliveries, nutrition, and childhood immunisation. 41. Mobilise and train/strengthen FCHVs and NGOs to increase target groups' access to services. 42. Provide assistance on awareness raising, IEC/BCC programmes, outreach services to pregnant women.	40. The findings of the 2013 FHD study on access to MNCH services in remote areas led to the decision to pilot a package of supply and demand side interventions with management strengthening inputs in one remote mountain district. Based on the study recommendation piloting in Taplejung district was initiated in 2014. Depending on effectiveness, this package will be adapted and rolled out to other remote districts. 41. The Equity and Access Programme (EAP) implemented its community mobilisation programme in 20 districts through local NGOs involving the orientation of FCHVs and NGO partners. 42. PHCRD added 22 new community health units to bring the total number to 42 to target underserved populations.
	ii) Address gender based discrimination which constrains access of women (of different social groups) to health care services, especially institutional deliveries. 43. Collaborate with women's CBOs /NGOs on gender and social based discrimination. 44. Conduct community and family counselling on GBV. 45. Promote regular work attendance of female health workers.	*43.* Awareness programmes, radio jingles, rallies and interviews were organised at district levels during the 16 days of activism against GBV. Interaction programme and television talk shows with high level government officials were organised at central level during the 16 day campaign. This contributed to developing sensitivity about violence against women and girls and has improved understanding of the government services and plans to address GBV. 44. In 2014, a new OCMC was established in Jumla to bring the total number to 16. They are based in hospitals to support survivors of gender-based violence.
Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalised caste and ethnic groups and areas (Regional and/or District).	iii) Promote service expansion in geographically inaccessible/remote regions. 46. Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the target groups. 47. When establishing new HP/SHPs, select sites most appropriate for the target groups' access and use.	46a. The barriers to accessing MNCH care and the use of MNCH services were assessed in five remote districts. The study found that not only remote/mountain districts but also remote VDCs within these districts were worse off in most aspects of access to and use of MNCH services. A pilot programme was launched by FHD and PHCRD in 2014 in Taplejung district to improve access to and use of MNH services in remote areas. 46b. In 2013/14, PHCRD organised integrated public health campaign in 20 districts to provide both public health related and curative services to reach unreached populations. PHCRD is organising these campaigns in 40 new districts in 2014/15.
	iv) . Expand services in low HDI districts. 48. Focus on community and outreach programmes in the 35 low HDI districts. 49. Ensure programmes are focused at less populated areas to make the target groups feel health as their fundamental right.	48 & 49. Since 2013/14, the Management Division has been implementing targeted programmes in 20 districts providing flexible funds to increase access to health services for unreached communities and in geographically remote areas.

Strategy	Working policy	Report on GESI related progress in 2014 against the working policy provisions
	v) Make provision for regional programmes to address unmet health issues and needs of women, poor and excluded groups. 50. Promote programmes like publicity campaigns, outreach services, counselling services and orientations to free care. 51. Conduct special activities to reach Dalits. 52. Implement special programmes such as providing monetary incentives to those using EHCS.	
Strategy 6: Enhance or modify services to be sensitive to GESI and ensure access is equitable and services are delivered uniformly without regard to social status.		
Give emphasis to special activities to provide adequate and quality services.	53. Ensure the presence of female doctors at all district hospitals. 54. Make a provision for local language speaking staff at service delivery sites. 55. Allow the district-level health organisation to adopt district-specific GESI policy, if needed. 56. Conduct social audits.	56. Social audits were conducted in 602 health facilities of 45 districts in 2014.
OBJECTIVE 3: IMPROVE HEALTH SEEKING BEHAVIOUR OF THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behaviour of the poor, vulnerable and marginalised groups.		
Develop and disseminate targeted IEC materials that will bring changes in behaviour of target groups.	57. Prepare and distribute enough audio visual, pictorial, etc. information and publicity materials. 58. Include the target groups' programme in publicity and communication materials of MoHP. 59. Develop skills at the local level for producing information materials, especially in remote areas.	57. The development, production and distribution of a variety of communication media materials continued including radio jingles, health teleserials and printed materials. 58. The localisation strategy of centrally developed media and materials on safer motherhood and newborn child health (SMNCH), family planning, and adolescent sexual and reproductive health (ASRH) BCC/IEC strategies were continued. 59. The capacity building of district BCC/IEC focal persons of all 75 districts focused on the use of local media and materials.
Increase the use of appropriate media.	60. All media allocate appropriate time for broadcasting health service news. 61. Emphasise use of effective media and local languages. 62. Increase information communication on GESI among health institutions. 63. Include appropriate media programming for low HDI districts and districts with diverse language. 64. Conduct regular monitoring on quality of communication services.	

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Strategy 8: Empower the target groups to demand their rights and conduct their roles while realising their responsibilities.		
a) Increase the target groups' awareness of their health rights and of free health care services, and enhance their capacity to make the service providers accountable.	vi) Empowerment. 65. Conduct activities for the target groups to make them aware of their rights/responsibilities and capable of taking leadership roles. vii) Information, Education and Communication 66. Conduct publicity campaigns on how to access and properly utilise health services. 67. Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups. 68. Develop and conduct orientation and awareness campaigns for change in health seeking behaviours. 69. Promote women's participation and conduct awareness on equal treatment of both male and female children. 70. Provide orientation on women's reproductive health rights.	65. The Equity and Access Programme was implemented in selected VDCs in 20 districts to mobilise targeted communities (women, the poor and excluded people) by applying a rights-based social mobilisation approach. NGOs and FCHVs were mobilised to promote health rights, and they disseminated messages to communities through mass communication, group facilitation, behaviour change communication and interpersonal communication. However, the single year contracting of EAP implementing NGOs undermines the value of community empowerment with limited effect on creating an enabling environment to increase service use.

ANNEX 2: RESULTS OVER THE LAST FOUR YEARS ON GESI (2010–2014)

A. Progress

GESI mainstreamed into policies — Nepal's Interim Constitution (2007) and the political commitments to gender equality and social inclusion (GESI) have ushered in new opportunities for sectoral ministries to address GESI and integrate it into their systems and services.

- *Strategy* — MoHP laid down the policy framework for GESI in its Health Gender Equality and Social Inclusion Strategy (2010) and the Second Nepal Health Sector Programme (NHSP-2, 2010-2015). The GESI strategy provides strategic direction for GESI mainstreaming and is the basis for further work on GESI. Building on the strategy's mandate, three overall health sector policy documents address GESI (the National Health Policy, the Population Policy and the Urban Health Policy), as well as strategies, manuals and guidelines.
- *Structure guidelines* — The GESI Institutional Structure Guidelines were approved in 2012 to specify the institutional means for integrating GESI into the health sector. They specify the location of GESI responsibilities in the government's health structure and in different committees and working groups.
- *Operational guidelines* — The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' (MoHP 2013) guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery, monitoring and reporting.

The increasing importance assigned to the GESI agenda by the government is evident from the Population Division allocating more than 30% of its budget for GESI activities in 2013/14 and 2014/15. A key enabling factor for the entire GESI agenda has been the leadership and commitment shown by successive health secretaries and Population Division chiefs.

GESI institutional structure — An institutional structure has been established for mainstreaming GESI in the health sector with a GESI Steering Committee (chaired by the health secretary), a GESI section formed in the Population Division in 2013, GESI focal persons appointed in all regional health directorates and all 75 DHOs/DPHOs and GESI technical working groups (TWGs) formed in all 75 districts

Gender based violence has been addressed by establishing and strengthening one stop crisis management centres (OCMC) to provide integrated support to victims of gender-based violence:

- OCMCs Operational guidelines produced and since revised;
- 17 OCMCs established in hospitals across the country;
- 2,090 individuals (94% women) have used OCMC services;
- psychosocial counselling training provided to staff nurses and ANMs; medico-legal training to doctors and case management training to OCMC staff;
- GBV clinical protocol for front line health workers prepared and being finalised; and
- OCMC monitoring and reporting manual developed and under approval.

Social service units (SSU) have been established to facilitate the access of needy and entitled people to subsidised health care in hospitals:

- SSU operational guidelines developed and amended.

- Eight SSUs established.
- Follow up and capacity building (training, review and mentoring) support provided.
- Management information system established and monitoring framework implemented.

Social auditing: Much progress has been made on the social auditing of health service provision:

- Social audit guidelines developed, piloted and approved.
- The PHCRD and concerned EDPs signed an MoU establishing a collaborative framework for the social auditing of health service provision.
- The PHCRD has conducted social auditing in 45 districts covering 602 health facilities.
- A process evaluation of social auditing was carried out in 2013 in two districts. A process evaluation of social auditing in four districts is ongoing.

Equity and Access Programme — EAP was reviewed and issues constraining its implementation are being addressed. Key issues identified included single year contracting of EAP implementing NGOs; delays in receiving budget approval; lack of capacity at the district level to manage the programme and political, administrative and social pressure on the selection of NGOs. Progress has been made on working out the future course of the programme. MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) decided to conduct operational research on integrating health into the Local Governance and Community Development Programme (LGCDP).

GESI integration:

- GESI has been integrated in AWPBs and annual business plan formats, and the NHSP-2 Implementation Plan has a section on GESI.
- Several health worker training curricula are being revised to include the GESI perspective. The revised HFOMC curriculum is being used to train HFOMCs in 16 districts. GESI perspectives have also been incorporated in the induction training package for new health personnel.

Capacity building:

- The Population Division ran a ToT course for National Health Training Centre (NHTC) and regional health training centre (RHTC) trainers on GESI mainstreaming in planning, programming and service delivery. These trainees subsequently implemented training courses in 13 districts for health facility in-charges and district supervisors. Training courses are being implemented in 16 more districts in 2015.
- Orientations on GESI concepts and GESI Mainstreaming Framework have been run for 2,000 MoHP and DoHS personnel at all levels of the health system.

GESI mainstreaming in NHSP-3, monitoring, surveys and studies

- GESI-related evidence for policy making and programme decision making was strengthened by the further analysis of the 2011 Nepal Demographic and Health Survey (NDHS) and the 2012 PEER study on the barriers poor people face accessing health services.
- The HMIS Section identified 11 standard indicators for disaggregated reporting.
- Progress review on mainstreaming GESI carried out and process documentation produced.
- GESI issues have been integrated into the draft NHSP-3 strategic document and by including more GESI disaggregated indicators in the results framework.
- Study carried out of barriers to accessing maternal and newborn care in five remote districts.

B. Challenges

- The space for mainstreaming GESI and the speed of related processes have been affected by prevailing institutional and structural conditions including staffing constraints and capacities; the centralised nature of decision-making, programming and budgeting; and limited incentives.
- There has been mixed implementation of the GESI provisions in policies, plans and guidelines. These range from the low implementation of GESI sensitive policies to practical challenges of identifying the poor for the services of SSUs and the need for a multi-sectoral approach to address barriers of different social groups. Measures to maintain the momentum for implementing GESI related activities have been identified and are being implemented.
- The challenges of ensuring the implementation of GESI-related plans included in the AWPBs and annual business plans of the different divisions and centres and implementing the GESI operational guidelines.
- The challenge of developing a coordination and collaboration mechanism between ministries to address the complex issues that impact the access and use of health services by women, the poor and other excluded groups.