

Gender Equality and Social Inclusion Strategy of the Health Sector, 2018



Government of Nepal

Ministry of Health and Population

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Foreword

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Acronyms

DoHS	Department of Health Services
FMR	Financial Management Reporting
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HMIS	Health Management Information System
HURIS	Human Resource Information System
ICPD	International Conference on Population and Development
LNOB	Leave No One Behind
MDGP	Doctor of Medicine – General Practice
M&E	Monitoring and Evaluation
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
NDHS	Nepal Demographic Health Survey
NHFS	Nepal Health Facility Survey
NHTC	National Health Training Centre
NLSS	Nepal Living Standard Survey
OCMC	One Stop Crisis Management Centre
SDG	Sustainable Development Goals
TABUCS	Transaction Accounting and Budget Control System

Chapter 1 Introduction

1.1 Background

The Constitution of Nepal guarantees every citizen the right to equality, social justice and freedom from social discrimination¹. It includes the fundamental right to free basic health services from the state and equal access to health services. The Constitution provisions the Government as morally and legally accountable for providing inclusive public services available to all. The Constitution identifies specific disadvantaged groups that have the right to participate in the functioning of the state and equal access to public services, including people with disability². It promotes the rights of women, protects them from violence, and offers women, the economically poor and endangered communities' special benefits in health and other social sectors; and includes a policy directive to prioritise backward regions.

The Constitution transformed Nepal into a federal republic. In restructuring the governance system, the Constitution provides a clear mandate and jurisdiction of federal, provincial, and local levels of government and included in this, the concurrent authority of each level of government for health. The new governance framework, fundamental rights and directives of the Constitution provide the impetus for revising the 2009 Gender Equality and Social Inclusion (GESI) Strategy of the Health Sector³ and to align the strategy with the new governance arrangements and state obligations.

In line with the fundamental rights and protections included in the Constitution, Nepal has ratified various UN conventions that promote the elimination of discrimination against women, elimination of racial discrimination and protection of the rights of disadvantaged populations including children and people with disability⁴.

Gender equality and social inclusion are integral to achievement of the country's development objectives and health sector goals. Nepal's roadmap to achieving the Sustainable Development Goals by 2030 and the Nepal Health Sector Strategy (2015-2020) embrace the pivotal importance of gender equality, and leaving no one behind to achieve health goals⁵. This revised Gender Equality and Social Inclusion Strategy for the Health Sector aims to guide the Government in fulfilling its obligations to provide universal coverage of basic health services, achieve equitable, quality and accountable health services, take a multisectoral approach and uphold the fundamental right to equality, non-discrimination and social justice in reforming the health system.

1.2 Rationale for revising the Gender Equality and Social Inclusion Strategy for the Health Sector

The rationale for revising the strategy is:

¹ Constitution of Nepal, 2072/2015.

² This includes "socially backward women, *Dalits*, *Adibasi*, *Adibasi Janajati*, *Khas Arya*, *Madhesi*, *Tharu*, farmers, laborers, suppressed classes, Muslim, backward class, minorities, marginalized, endangered communities, youth, children, the aged, gender-based and sexually oriented minorities and the disabled or those who are physically or mentally incapacitated or citizens of backward regions.

³ Referred to as the GESI Strategy.

⁴ https://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=122&Lang=EN

⁵ https://www.npc.gov.np/images/category/1__SDG_Report_final_version.pdf

- a. To align the GESI Strategy with the federal governance structure of the country and the allocation of government responsibilities for delivering health services and achieving health and social development.
- b. To align the GESI strategy with the rights enshrined in the Constitution and Nepal's commitments to international human rights conventions.
- c. To contribute to achievement of the Sustainable Development Goals, and the directives of the Health Sector Strategy (2015-2020). This includes ensuring access to quality health services of populations that have been excluded or disadvantaged such as people with disability, to promote gender equality and women's empowerment in the health sector including responding to survivors of gender based violence and gender equality in the workplace, and to institutionalise gender equality and social inclusion into health systems reform.
- d. To leverage the institutional change process transforming the state to a federal republic so as to strengthen the importance and level of effort given to closing equity gaps in the health sector and upholding the right to health of all citizens.

To support the effective implementation of the Government's policy, programme and budget speech for the fiscal year 2018/19, which guaranteed basic health services for all based on equality and inclusion, and show demonstrable results. This includes:

- a. To build competent, functional institutional mechanisms to execute the revised GESI Strategy.
- b. To empower disadvantaged groups to demand their right to health.
- c. To institutionalise gender equality and social inclusion into the health system and services.
- d. To achieve results-based outputs through programmes that target socially excluded and vulnerable populations.

1.3 Methodology for revising the GESI Strategy

The Ministry of Health and Population (MoHP) led the review and revision of the GESI Strategy through the leadership of a multisectoral GESI Steering Committee. A Technical Working Group (TWG) was established which included experts from MoHP, Department of Health Services (DoHS), civil society organisations (CSOs) and Development Partners (DPs). The TWG undertook a review of relevant health and social policies, analysis of secondary data related to health sector performance and trends in health outcomes, and stakeholder consultations at federal, provincial and municipality levels. At provincial level consultations were held with Ministry of Social Development officers and Mayors, Deputy Mayors and members were consulted at metropolitan city, sub-metropolitan city, municipality, and rural municipality levels. Field visits to central, regional, and district level hospitals were conducted and staff and patients consulted on elements of the GESI Strategy.

At the national level, consultations were held with Secretaries and officials of the Office of the Prime Minister and Council of Ministers; Ministry of Federal Affairs, and General Administration; Ministry of Women, Children, and Senior Citizens; representatives of the Federation of People with Disability and related organisations; and representatives of the Federation of Senior Citizens and related organisations.

The revised GESI Strategy incorporated the inputs and suggestions of a wide range of stakeholders and was finalised by the Ministry of Health and Population's GESI Steering Committee.

1.4 Definition of key terms

The following key terms and definitions have been used in the GESI strategy. These terms and definitions are compatible with those used in prevailing national laws and are proposed for future sub-national laws and policies.

Constitution means the 2015 Constitution of Nepal.

Ministry means the Ministry of Health and Population (MoHP), Government of Nepal (GoN).

Strategy means the GESI Strategy of the Health Sector, 2018.

Federal level means the apex unit of the federal governance structure.

Provincial level means the provincial level of the governance structure as mentioned in the Constitution.

Local level means the local level governance structure including metropolitan city, sub-metropolitan city, municipality, rural municipality, and their respective assemblies as mentioned in the Constitution.

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

Gender defines the power relations between women and men and the different rules, roles and responsibilities society ascribes to them. Gender is socially constructed. It is learned, varies by culture and changes over time.

Gender based violence is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the genders, within the context of a specific society. Women and girls are the main targets of gender-based violence but it may also be inflicted on men and boys who transgress society's gender norms. It includes all forms of violence that inflict physical, psychological, sexual harm or suffering or the threat of such acts, coercion and deprivation of

liberty. The violence may be based on social malpractices and related behaviour including gender-based discrimination as in the Domestic Violence (offences and punishment) Act 2009.

Gender equality and social inclusion means changing the unequal power relations between women and men and between different social groups. It focuses on the need for action to re-balance these power relations and ensure equal rights, opportunities and respect for all individuals regardless of their social identity.

Equality refers to the provision of equal rights, responsibilities and opportunities to all as recognised by the Constitution. The pursuit of equality by the State of Nepal requires the adoption of policies and development of inclusive systems, institution and programmes that enable disadvantaged populations to exercise their rights, responsibilities and opportunities.

Equity is an ethical principle related to human rights. Health equity means that people are not disadvantaged from attaining their full health potential because of social constructs such as gender, socioeconomic status, religion, caste/ethnicity or location.

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

Gender equality and social inclusion mainstreaming is the process whereby barriers and issues faced by women, poor and excluded people are identified and addressed in all functional areas of the health system: policies, institutional systems, work environment and culture, programme and budget formulation, service delivery, monitoring and evaluation, and research. It also involves evaluation of the institutional capacity to mainstream GESI, and the responsiveness and work environment of health agencies to be gender equal and socially inclusive. Evaluation is necessary to inform continuous improvement and bolster ownership and commitment to GESI.

GESI-related institutional mechanism refers to the institutional structures created by the federal, provincial and local levels of government to mainstream gender equality and social inclusion. It includes the GESI committees formed at each level of the federal structure to oversee, coordinate and lead the mainstreaming of GESI into laws, policies and strategies, health systems, institutional structures and capacity, health plans, programmes, services and the budget.

GESI-responsive policy and programme refers to policy and/or programmes that are designed to be sensitive to and address the determinants of gender inequality and social exclusion. GESI responsive policies and programmes include an assessment and analysis of GESI in their formulation and implementation, the inclusion and participation of women, the poor and excluded in each stage of development and implementation, and ensure that the outputs and results of the policy and programme measure and aim to benefit target groups.

Gender-responsive budgeting integrates gender equality principles into all stages of the budget process. Gender responsive budgeting seeks to ensure that the collection and allocation of public resources is carried out in ways that are effective and improve budget results generally, and contribute to advancing gender equality and women's empowerment.

Persons affected by natural disaster are people and families affected by natural disasters including earthquakes, floods, landslides and soil erosion, cold waves, heat waves, and lightning, etc.

Health service provider encompasses Government, non-governmental and private-for-profit organisations that provide basic and essential health care services.

Barriers to using health service refers to the multiple demand and supply side factors that reduce people's access to quality health services. Barriers fall into four main categories related to geographical accessibility, availability of health services, affordability and acceptability.

Target groups refers to disadvantaged people and communities living in conditions of poverty, remoteness and social exclusion who face barriers to accessing quality health services and having their basic health needs met, and have worse health outcomes and utilisation of health services than the national average. This includes women, survivors of gender-based violence, extremely poor and deprived people, marginalised and endangered groups, people with disabilities, senior citizens, people living in remote and unreachable areas, people suffering from mental ill health and other stigmatised conditions, and other excluded persons. Target groups may be defined by each level of government using criteria and factors specific to the local cultural, geographic and socio-economic context.

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

Remote and underserved areas are geographical areas where health services are not adequately available due to various reasons including physical location, distance, difficult terrain, lack of staff and drug availability, financial and management limitations. Often the factors intersect and magnify the barriers people in those geographical areas face in availing quality health services. The result is that local people are unable to use services equitably compared to people in other areas. Remote and underserved areas may be defined at federal, provincial or local government levels based on mapping of health service availability and distribution of the population, assessment and comparison of health coverage data, and analysis of the social, economic and environmental conditions that impact access to and use of health services.

Non-governmental organisation (NGO) refers to non-profit organisations registered with the Government⁶ as an NGO. NGOs work in a wide array of sectors to support national and local development including education, health, economic development, human rights and social mobilisation.

Person with disability refers to persons with physiological, intellectual, psychological or sensory impairment and functional limitations which constrain their full and effective participation in society on equal terms with non-disabled people⁷.

⁶ In accordance with the prevailing laws.

⁷ As per the prevailing government definition of disability.

Helpless senior citizen includes senior citizens that fall into the following categories: (a) people having no means, source of income, or property required for subsistence, (b) those without family members to care for them, (3) those forced to survive in conditions of disrespect or disregard due to inappropriate care even if family members are present.

Senior citizen with impairment means senior citizens with physiological or psychological impairment.

Poor means persons or households living below the poverty line as determined by the GoN under the Government's set criteria.

Extremely poor for this strategy means people whose earnings from family owned land, other property, business or employment provides less than six-months of subsistence.

Endangered group means persons or groups of people on the verge of extinction due to backwardness, being excluded from basic state services, and being excluded from economic, social, cultural, or educational infrastructure and resources.

Person at risk means a person forced to live in hazardous and vulnerable conditions. This may include the risk of physical, emotional, psychological harm or deprivation that they lack the power to avoid.

Disabled-friendly services refers to the provision of facilities and support to enable people with disability to use services on an equal basis as those without disability. This may include the provision or adaptation of infrastructure so that it is accessible to people who are physically disabled such as ramps, lifts, specially designed toilets and the provision of assistive devices such as wheelchairs. It may also include the provision of transportation or waiver of fees in recognition of the physical and financial barriers people with disability face in accessing health services.

Temporary health centre means a health centre set up for a specified period to provide basic health services to disadvantaged people or those at risk such as people affected by natural disasters or migrants.

GESI Focal Person refers to the person charged with responsibility for coordinating and facilitating GESI provisions and GESI mainstreaming at federal, provincial and local government levels.

Health Facility Operation and Management Committee means the committee set up formally in compliance with the directives issued by the MoHP at the local level to bear the responsibility of overall management of health institutions.

Leave no one behind (LNOB) is a concept that is grounded on inclusive and rights-based development and is embedded in the SDGs. LNOB prioritises "putting the last first" and prioritises the most disadvantaged, most underserved, most left behind. LNOB leaves the definition of who is left behind to be defined according to the context.

Chapter 2

Situation Analysis of Gender Equality and Social Inclusion in the Health Sector

2.1 Constitutional provisions

The fundamental rights and duties enshrined in the Constitution of Nepal guarantee the rights of all and enshrine the principles of substantive equality, non-discrimination and social justice. The Constitution includes affirmative action for excluded populations including women, the extreme poor, endangered ethnic communities and *Dalits*. The directive principles, policies and obligations of the State in the Constitution provide the rationale and framework for gender equality and social inclusion in the health sector.

2.1.1 Fundamental rights of citizens

The fundamental rights most pertinent to the GESI strategy are presented in the table below.

Table 1: Fundamental rights in the Constitution

Right to equality	<ul style="list-style-type: none"> • All citizens shall be equal before the law. No person shall be denied equal protection of the law. • No discrimination shall be made in the application of general laws on grounds of origin, religion, race, caste, tribe, sex, physical condition, the condition of health, marital status, pregnancy, economic condition, language or region, ideology, or on similar other grounds. • The State shall not discriminate against citizens on grounds of origin, religion, race, caste, tribe, sex, economic condition, language, region, ideology or on similar other grounds. Provided that nothing shall be deemed to prevent the making of special provisions by law for the protection, empowerment or development of citizens including the socially or culturally backward women, <i>Dalits</i>, indigenous people, indigenous nationalities, <i>Madhesi</i>, <i>Tharu</i>, Muslim, oppressed classes, <i>Pichhada</i> class, minorities, the marginalised, farmers, labourers, youths, children, senior citizens, gender and sexual minorities, persons with disabilities, pregnant people, incapacitated or helpless, people from backward regions, and indigent <i>Khas Arya</i>.
Rights related to health	<ul style="list-style-type: none"> • Every citizen shall have the right to free basic health services from the state, and no one shall be deprived of emergency health services. • Every person shall have the right to get information about his or her medical treatment.
Rights of women:	<ul style="list-style-type: none"> • Every woman shall have equal inheritance right without gender-based discrimination. • Every woman shall have the right to safe motherhood and reproductive health. • No woman shall be subjected to physical, mental, sexual, psychological or another form of violence or exploitation on grounds of religion, social, cultural tradition, practice or on any other grounds. Such act shall be

	<p>punishable by law, and the victim shall have the right to obtain compensation in accordance with the law.</p> <ul style="list-style-type: none"> • Women shall have the right to participate in all agencies of the State mechanism on the basis of proportional inclusive principles. • Women shall have the right to get special opportunity in education, health, employment and social security. • Couple shall have equal rights in the property and family affairs.
Rights of children	Every child shall have the right to education, health, maintenance, proper care, sports, entertainment, and overall personality development from families and the state.
Rights of Dalits	Special provisions shall be made by law to provide health and social security to the <i>Dalit</i> community.
Rights of senior citizens	Senior citizens shall have the right to special protection and social security from the state.
Right to social Justice	<ul style="list-style-type: none"> • The indigent citizens of the communities on the verge of extinction shall have the right to get special opportunities and benefits in education, health, housing, employment, food, and social security for their protection, uplifting, empowerment and advancement. • Citizens with disabilities shall have the right to live with dignity and honour, with the identity of their diversity, and have equal access to public services and facilities. • Family of martyrs and disappeared, strugglers of democracy, victims of conflict, displaced, disabled, injured and victims in all mass movements, armed conflict and revolution for progressive democratic change shall have right to get prioritized opportunities in education, health, employment, housing and social security along with justice and appropriate dignity
Right to social security	The indigent citizens, incapacitated and helpless citizens, helpless single women, citizens with disabilities, children, citizens who cannot take care of themselves, and citizens belonging to endangered ethnic groups shall have the right to social security in accordance with the law.
Right to information	Every citizen shall have the right to demand and receive information on any matter of his or her interest or of public interest.

2.1.2 Policies of the State

The Constitution includes instructions for the State to adopt a number of policies, out of which the following are most related to the GESI strategy for the health sector.

Table 2: Policies instructed by the Constitution

<p>Policies on basic needs of the citizens</p>	<ul style="list-style-type: none"> • To increase the investment by the state in the public health sector necessary to make the citizens healthy. • To ensure an easy, convenient, and equal access for all to quality health services and to protect and promote health systems including Ayurveda, as a traditional medical system of Nepal, natural therapy, and the homoeopathy system. • To make private sector investment in the health sector service-oriented by regulating and managing such investment while enhancing the state’s investment in this sector. • To focus on health research and keep on increasing the number of health institutions and health workers to make health services widely available and providing quality care. • To increase average life expectancy by reducing the maternal and infant mortality rate while encouraging family planning for population management based on Nepal’s capacity and need. • To ensure a planned supply system by according special priority to remote and backward regions, while ensuring equal access of all citizens to basic goods and services. • To arrange access to health care services by ensuring the health insurance of citizens.
<p>Policies on social justice and inclusion</p>	<ul style="list-style-type: none"> • To make women who are vulnerable, subject to social and family exclusion, and victims of violence self-reliant through rehabilitation, protection and empowerment. • To ensure the use of basic health services and facilities during maternity. • Increasing participation of <i>Adibasi Janajati</i> in decisions concerning them by creating special provision for opportunities and benefits to ensure their right to live with identity and dignity and protecting and promoting the traditional knowledge, skills, culture, social tradition and experiences of <i>Adibasi Janajati</i> and local communities. • Creating special provisions for opportunities and benefits to maintain the identity of minority communities and exercise social and cultural rights. • Creating special provisions for economic, social and cultural opportunities and equal distribution of benefits for <i>Madhesi</i> community and protection, uplifting, empowerment and development of poor and backward class within the community. • Creating special provisions for opportunities and benefits for protection, uplifting, empowerment, development and fulfilment of basic needs of oppressed and citizens of backward regions. • Prioritizing economically poor inside all gender, area and communities on providing social security and social justice.

2.1.3 Structure of the State and allocation of State power

The Constitution stipulates that:

- a Attention should be given to the matters of regional imbalance, reduction of poverty, and inequality and ending exclusion while allocating revenue.
- b The exercise of fiscal power: The federal, provincial, and local levels shall make laws, formulate the annual budget, make decisions, and make and execute policies and plans within the respective jurisdictions of fiscal authority.

2.1.4 Unbundling of health-related responsibilities

The Government of Nepal has unbundled health-related functional responsibility in accordance with the provisions made by the Constitution:

- a *At the federal level:* policy and law-making, determining quality and standards, specialised health services, research and development, coordination and monitoring and evaluation (M&E), international relations, and capacity development.
- b *At the provincial level:* policy and law-making, regulating quality and standards and enforcement, management of health services, specialised health services, promotional programmes, coordination and M&E at the provincial level, capacity development, emergency health service management.
- c *At the local level:* local level policy and programmes related to health service management, basic and specialised health service management and promotional programmes, coordination and M&E at the local level.

2.2 Existing policies and laws related to gender equality and social inclusion

2.2.1 Health policies, strategies and guidelines

The following health policies, strategies and guidelines provide directives and guidance related to GESI:

National Health Policy, 2014

The National Health Policy 2014 embraces a human rights-based approach and provides a strong foundation for gender equality and social inclusion. The goal is to ensure health for all citizens as a fundamental human right by increasing access to quality health services through a provision of just and accountable health system. One of the guiding principles of the policy is to ensure health services provisioned by the state are accessible to poor, marginalized, and vulnerable communities; based on equality and social justice.

Nepal Health Sector Strategy (2015-2020)

The Nepal Health Sector Strategy (NHSS) (2015-2020) strives to improve the health status of all people through an accountable and equitable health service delivery system and the progressive achievement of universal health coverage. It includes four strategic principles: equitable access to health services; quality health services for all; health systems reform; and a multi-sectoral approach to address the social determinants of health. NHSS envisions equitable service utilization, strengthening service delivery and demand generation to underserved populations, including the urban poor. NHSS calls for greater

partnerships with local level institutions and community groups to empower women, promote supportive cultural practices and curb gender-based violence in society.

Gender Equality and Social Inclusion Strategy for the Health Sector, 2009

The GESI strategy was developed in response to evidence of significant and persistent health inequalities in Nepal and the provision in the Interim Constitution (BS 2063, AD 2006) to the right of every citizen to free essential health care. The strategy takes a rights based approach and is structured around three objectives: (i) to create a conducive environment for mainstreaming GESI in the health sector through the development of policies, plans and programmes; (ii) to build the capacity of health providers and ensure equal access to and use of health services by the poor, vulnerable and marginalised castes and ethnic groups; (iii) and improve the health seeking behaviour of the poor, vulnerable and marginalised populations so they can obtain health services based on their rights.

Fourteenth Plan (2016/17)

The plan includes a vision of GESI mainstreaming and empowerment by creating a decent, safe, and civilised society and ensuring equal participation in social and economic opportunities within the planned period. The mission and goals of the plan are of inclusive development in the country and the meaningful participation of all citizens. It aims to improve the human development index and empowerment index of communities left behind in terms of economic, social and cultural development.

National Strategy for Reaching the Unreached, 2016-2030

The National Strategy for Reaching the Unreached, 2016-2030 aims to contribute to the goal of universal health coverage by increasing access to and utilisation of health services by unreached populations. This includes: (i) people living in remote areas, (ii) disadvantaged groups, (iii) the poor, urban poor, informal sector workers and the elderly poor, (iv) people with disability, (v) other marginalized groups including gender and sexual minorities, people living with HIV/AIDS, commercial sex workers, prisoners, and refugees. The strategy focuses on targeted interventions to address supply and demand side barriers to reaching the specific unreached populations and seeks to complement the GESI strategy and draw on the GESI institutional structure established by MoHP.

The policy, programme and budget speech of the Government of Nepal for the fiscal year 2018/19

The 2018/19 budget speech included a strong emphasis on equitable health services and social protection of women, children, senior citizens, deprived groups, endangered and marginalised communities. It committed to carrying out special campaigns to end violence against women. The 2018/19 policy and programme prioritised disadvantaged and excluded populations. It announced the setting up of at least one health institution at the ward level within two-years with priority on backward areas, ensuring the provision of free medicines, setting up at least one 15-bed hospital with one medical doctor at local level, setting up a geriatric ward in each 100-bed and above hospital, increasing

institutional delivery payments, delivering treatment and rehabilitation services to the disabled, helpless, and mentally ill, revising and extending health insurance to cover all. For the elderly, it included setting up homes for senior citizens in each province within a five-year period and bearing insurance premiums up to 100,000 rupees for senior citizens.

Disability management (prevention, treatment, and rehabilitation) policy, strategy, and ten-year action plan

The ten year action plan includes the objective of increasing access to preventive, promotional, curative (basic and specialised) and rehabilitative health services for people with disability. To create a disability-friendly health service, the plan includes establishing accessible and adequate infrastructure, institutional strengthening and extending health insurance schemes.

The sustainable development goals, 2030

These goals comprise a healthy life for all, the elimination of all forms of poverty, empowerment of women and children, and leaving no one behind. The national SDGs developed under the coordination of the National Planning Commission include reducing the level of extreme poverty to five percent, increasing the budget for social protection from 11 percent to 15 percent, reducing the maternal mortality ratio to 70 per 100,000 live births, increasing the health sector budget from the existing 5.5 percent of the total budget to 7 percent, raising the utilisation of skilled birth attendants from 75 percent to 90 percent, ending all forms of GBV, ensuring the delivery of basic health services to all, ending the marriage of people under 18 years of age and ensuring child rights by 100 percent birth registration.

Health building infrastructure design and construction guidelines, 2017

These guidelines have made the following GESI-related provisions:

- a To set up health institutions at convenient and centrally located areas of settlement based on the health infrastructure information system.
- b The designer and the builder should maintain standards of privacy, uphold cultural values and norms and be responsive to gender needs, the needs of elderly persons, achieve disability-friendliness and child-friendliness while designing and constructing health infrastructure.
- c Provision of toilets, ramps, lift, multi-lingual sign boards and alphabets, and symbol-signs that are easily readable and understandable for illiterate people.
- d Include space for One-Stop Crisis Management Centres (OCMC) for providing services to survivors of GBV and space for geriatric wards.

Deprived People Medical Treatment Fund Guidelines, 2014

The guidelines include provisions to provide financial support to extremely poor and deprived Nepali citizens suffering from chronic, expensive and serious diseases, to enable them to access to health services from prescribed hospitals. Legal provisions related to gender equality and social inclusion in the health sector

2.2.2 Laws

The following laws underpin GESI in the health sector.

Rights of persons with disability act, 2017

This Act has made provisions for the classification of disability, issuing and maintaining records of identity cards based on proof of disability, giving people with disability the capacity to exercise their guaranteed rights under the Constitution. The Act has also made provisions not to discriminate or deprive persons of their personal liberty on the grounds of disability, to facilitate treatment for people with disability in a disability-friendly environment with due priority, to provide referral services as required, and to provide free treatment for people with disabilities suffering from classified diseases. The substantive provisions also include reserving at least two beds in government and private hospitals with the capacity of 100 or above beds for people with disability, establishing disability-friendly infrastructure and providing assistive devices, measures to protect people with disability from all forms of violence, exploitation, and harassment, providing rehabilitation services for completely incapacitated, extremely incapacitated, helpless, or mentally impaired persons and persons with mental or psychosocial disability.

Senior citizens act, 2006

This act made provisions to give priority and provide concessions to senior citizens receiving public services and facilities.

Local government (operations) act, 2017

The act has entrusted the authority and responsibility to the local level to manage health services and to operate and deliver local level health promotion, preventive, curative, rehabilitative, and palliative health services.

Good governance (management and operation) act, 2007

This act guaranteed inclusive, accountable, and quality public services for all citizens.

2.3 Impact of gender inequality and social exclusion on health outcomes

Gender inequality and social exclusion affect health outcomes in all countries. In Nepal, women and girls have lower human development indicators than men and boys irrespective of poverty, geographical area and caste/ethnicity. Cultural norms and gendered social practices reduce women's and girl's control over their well-being and safety, affect their risk of violence, their access to health services, health decision-making and health outcomes. In Nepal, poverty, geographical remoteness, social exclusion related to discrimination based on caste, ethnicity, religion, gender identity and sexual

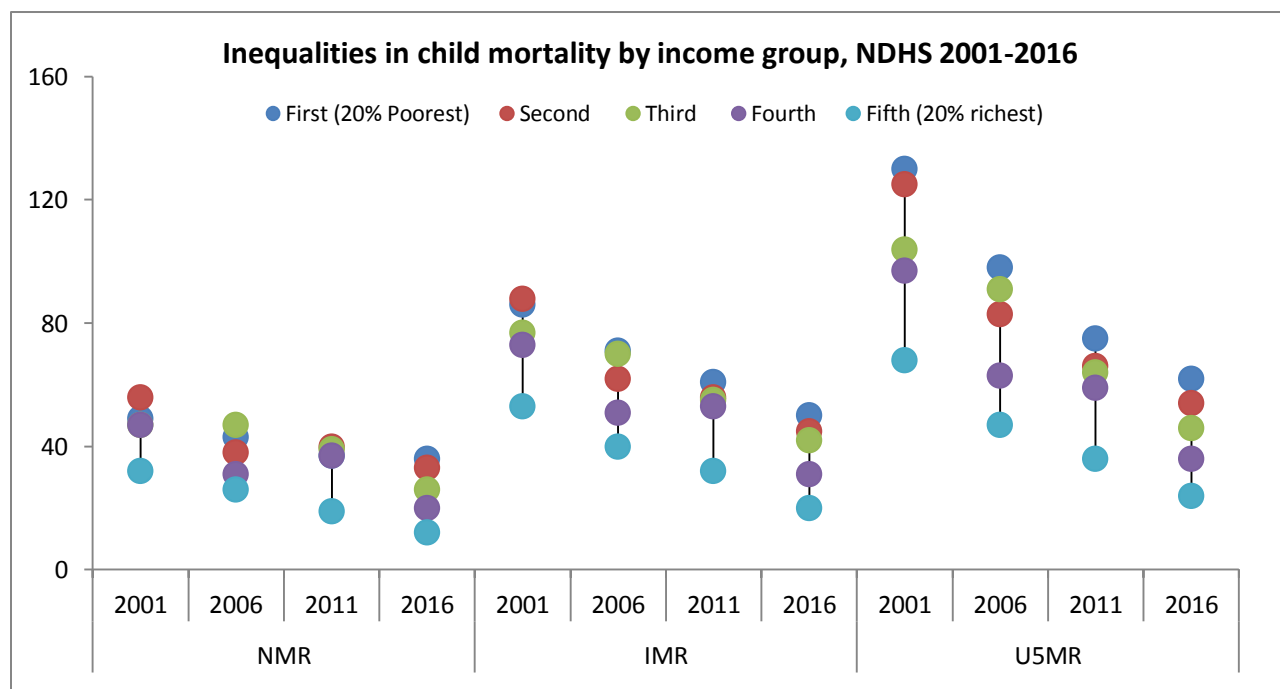
orientation, and the stigma attached to disability and chronic illness impact people’s health, their access to affordable quality health services and often the way people are treated by health providers.

For some years, the Government of Nepal has recognised the disparities in health risks, access to and utilisation of health services and differences in health outcomes based on poverty, geography and caste, ethnicity and religion. Commitment to reduce health inequities have led the MoHP to implement various programmes aimed at closing the equity gap including for example free basic health care, AAMA and community-based services which provide health care close to vulnerable populations. As the evidence presented below shows, progress has been made but much more remains to be done.

Nepal Demographic and Health Survey, 2016 (NDHS, 2016)

The series of Nepal Demographic and Health Surveys (NDHS) provide trend data on key reproductive, maternal and child health indicators. Moreover, NDHSs include data disaggregated by economic status, mother’s education, sex of child, geographical region and for the more recent surveys, data is disaggregated by major caste, ethnic and religious group.

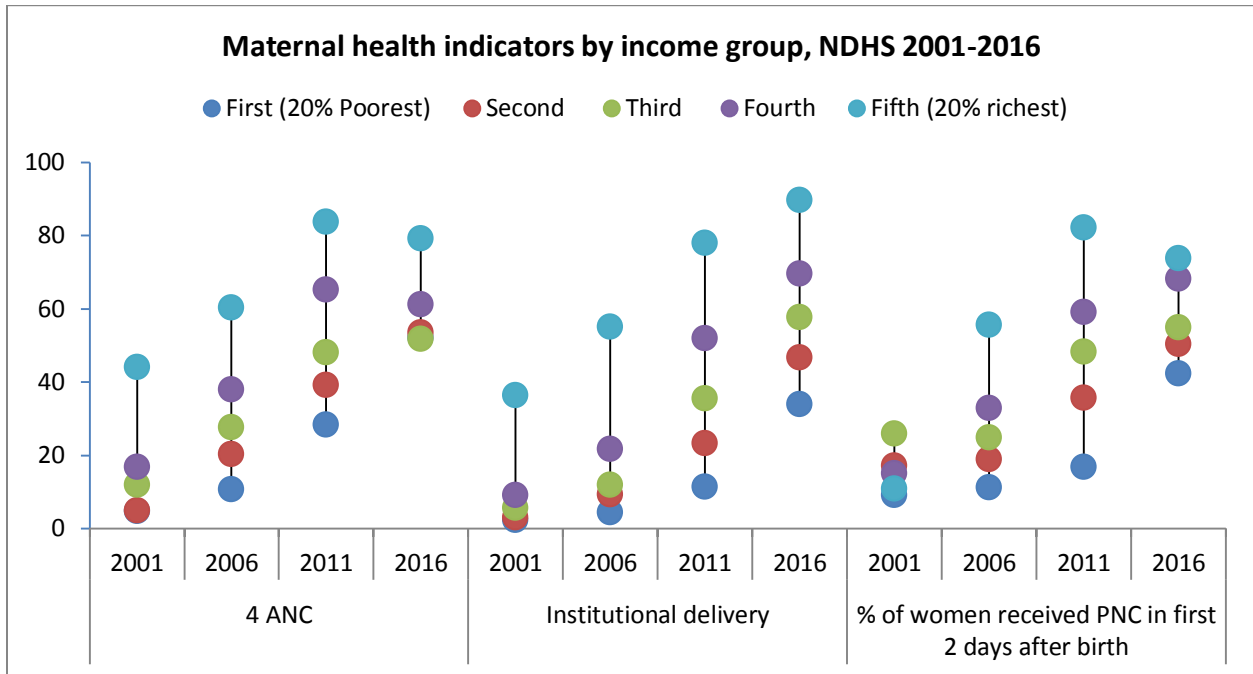
The graph below illustrates the progress over time in reducing infant and child mortality overall and the reduction in inequality in child mortality between income groups.



NMR= neonatal mortality rate, IMR = infant mortality rate, U5MR = under five mortality rate

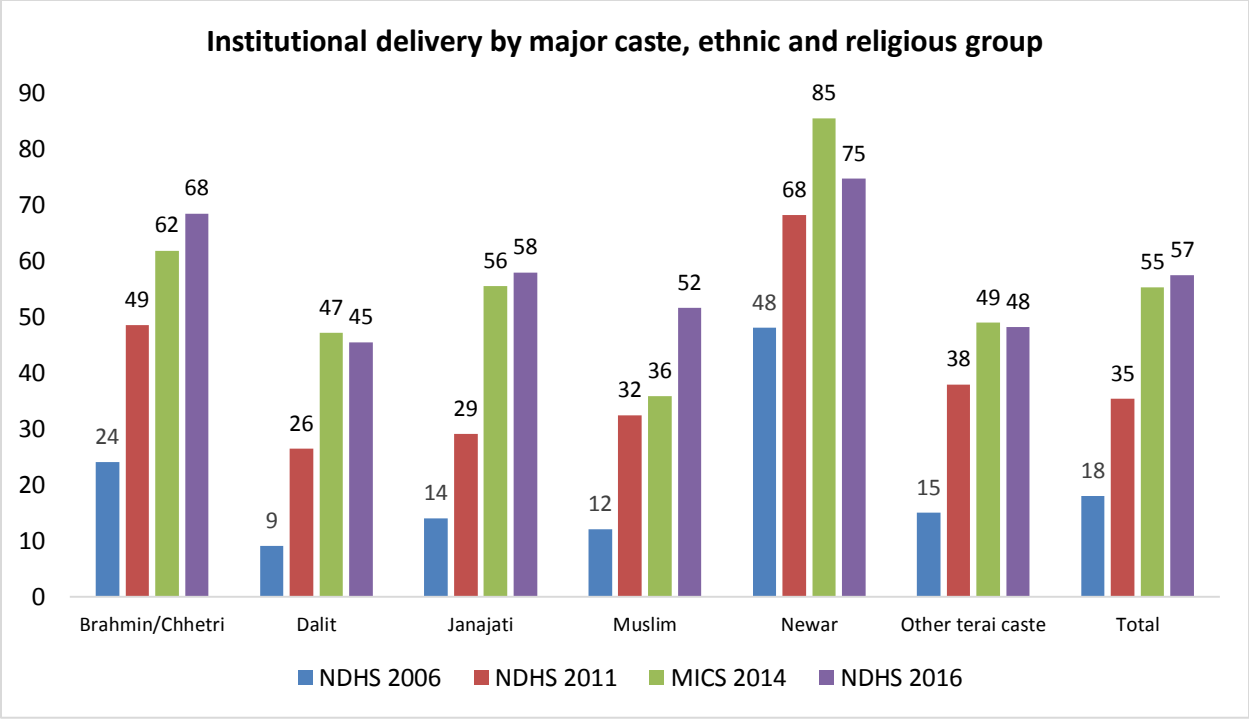
Wealth inequalities for maternal health service utilisation continue to be large but nevertheless the social gradient has reduced between 2001 and 2016 overall. Analysis of the social determinants of use of maternal health services between NDHS 1996 and 2011 found that maternal education and wealth were the strongest predictors of use with women from the poorest wealth quintile and with no formal

education the most disadvantaged regardless of age, place of residence, ecological area or caste/ethnicity. This association between wealth and education and institutional delivery has also been found internationally.

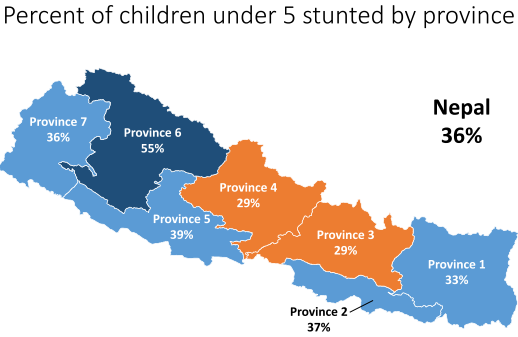
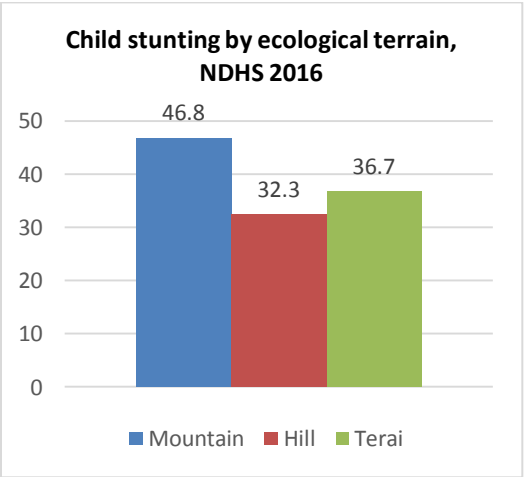


ANC = antenatal care, PNC = post natal care

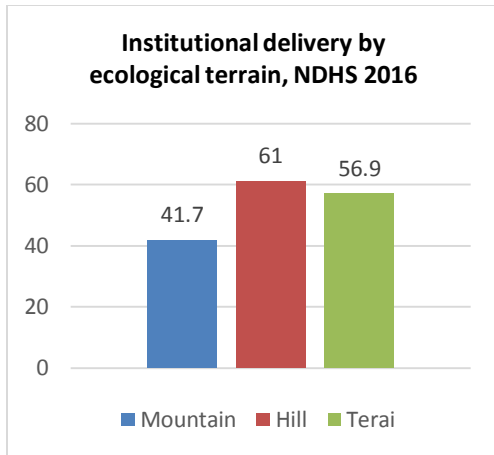
Institutional delivery rates by major caste, ethnic and religious group have improved significantly since 2006 but continue to be uneven. Dalits still have the lowest institutional delivery rate though the gap with more advantaged groups is less than in 2006. Such evidence illustrates the rationale for the affirmative provisions for Dalits included in the Constitution.



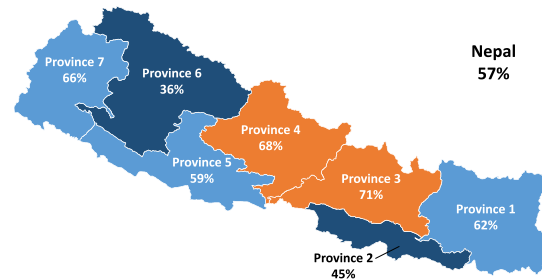
Geographical inequalities in health and nutrition outcomes are well documented in Nepal, and as in many other countries, remote areas have worse outcomes than more accessible areas though this varies by specific indicator. NDHS 2016 found child stunting to be higher in Mountain than Terai or Hill areas and to vary by province. No significant difference in child nutritional status by sex was found.



Institutional delivery is also lower in Mountain than Terai or Hill areas and varies by province; see graph below.

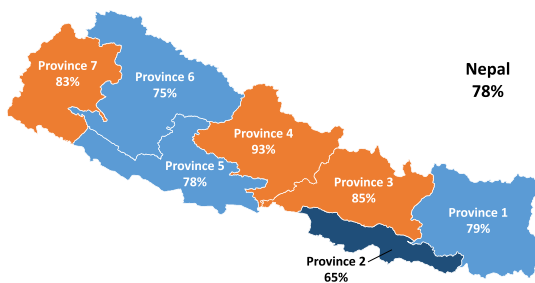


Institutional delivery rate by province, NDHS 2016



Regional variation in utilisation of health services is also seen for childhood vaccinations. Routine vaccinations are generally a strongly inclusive health service with high demand and relative ease of delivery. Nepal has achieved a national rate of 77.8% of children with all basic vaccinations with no difference by sex of child. However, province-wise, Province 2 which is in the more geographically accessible *Terai* lags significantly behind with only 65% coverage. This example illustrates the complexity of health inequity in Nepal and the intersection of multiple demand and supply side factors that impact use of specific health services.

Percent of children age 12-23 months who have received all basic vaccinations by province, NDHS 2016



Evidence of the prevalence and nature of violence against women and help-seeking behaviours are less well-developed than for other health variables. Violence against women is overwhelmingly committed by husbands and former husbands. NDHS 2016 found 26% of ever-married women reported experiencing spousal violence of an emotional, physical or sexual nature. Physical and sexual violence against women is higher for women who are divorced, separated or widowed (45.7% and 20.3%) than currently married women (25% and 7.8%). Women with more education are less likely to experience spousal violence as are women from more affluent households. Violence against women is also higher in the *Terai* than Hills or Mountain. Violence against women carries personal, family and public health implications and costs for the country, contravenes human rights and underpins the priority it receives in the Constitution.

Nepal Health Facility Survey, 2015 (NHFS, 2015)

The findings of the NHFS, 2015 illustrate disparities in availability of the necessary conditions to provide basic health services by health facility level and ecological region. Gaps in the readiness of facilities to deliver basic and emergency care contribute to the disparities in health service utilisation.

Over half of all health facilities provide all basic health services⁸ ranging from 91% of primary health care centres to 64% of health posts and 33% of urban health clinics. There is variation by ecological terrain and while 70% of all health facilities in Hill areas offer the full package this is only 53% of those in Mountain and 53.8% of Terai facilities. Province wise this varies too, with 52% of facilities in Province 6 and 69% in Province 3 providing a full package.

In terms of staffing, NHFS 2015 found that 70% of sanctioned posts in public health facilities are filled ranging from 48% of consultant positions to 74% of paramedics. Hospitals and urban health clinics have the highest staffing gaps. The percentage of sanctioned posts filled by ecological region is very similar at approximately 70% in each.

2.4 Key achievements and challenges in implementing gender equality and social inclusion

The GESI Strategy for the Health Sector, 2009 has made a significant contribution to the progress made in improving the responsiveness of the health sector to gender equality and social inclusion at the policy level. However, institutionalising GESI into the organisational culture of the MoHP, building the capacity of systems and staff to address GESI takes time and sustained effort especially given the limited resources, political change and environmental shocks that Nepal has experienced since the first GESI strategy was approved.

2.4.1 Policy level

Policy-level commitment to GESI has been raised as shown by the integral attention to gender and social inclusion in the Health Policy 2014, and Health Sector Strategy 2015-2020. The high-level national political commitment to GESI means that stronger emphasis is placed on ensuring GESI is given due attention during the development of new policies and strategies across the sector. However, it will take some time for the bank of existing policies and strategies to be revised. The new governance structure will trigger the need for revision in many cases and this will provide opportunity for GESI inclusion.

2.4.2 Institutional structure

The institutional structure to lead and coordinate the mainstreaming of GESI into the health system was created in 2012. The GESI Steering Committee convened by the Secretary of MoHP has oversight and leadership of GESI in the health sector. It leads policy coordination on GESI and includes high-level inter-ministerial representation given the multisectoral nature of gender and social inclusion. Participation of allied ministries has however been sporadic and it has been challenging for the Ministry to leverage intersectoral interest especially given the macro level changes taking place in the country. The GESI Committees at each level of the health system from the national level down to health facility have

⁸ Outpatient curative care for sick children, child growth monitoring, facility-based child vaccination services, provision of any modern method of family planning, antenatal care (ANC), and STI services.

underperformed in their expected coordination and facilitation of GESI. Weak leadership and performance management system have been contributing factors.

2.4.3 Capacity development of the health workforce

One of the main achievements since 2009 has been the development of a common understanding among health managers and health staff on what gender equality and social inclusion means. This was achieved by the development and rolling out of the Ministry's GESI Operational Guidelines and related training. GESI training curriculum and resource materials were developed and GESI orientation training was integrated into induction and in-service training of health staff provided by the National Health Training Centre and Regional Training Institutes. Targeted GESI training to programme and service delivery managers was also provided.

2.4.4 Programme, plan and budget

Efforts to integrate GESI into the programming, planning and budgeting processes have had piecemeal results. The systemic constraints around planning and budgeting in the highly centralised structure and poor monitoring and evaluation capacity, have been key contributing factors. Gender or GESI responsive budgeting has not been introduced to the Ministry and it lags behind progress made in other sectors.

Good progress has been made in strengthening attention to reaching underserved and excluded populations in the areas of maternal and child health in particular. But creating space for especially vulnerable populations that have been neglected by the health system, such as people with disability and mental illness and survivors of gender-based violence has made slow progress. The lack of clarity of where institutional responsibility for these neglected health conditions lies has been a bottleneck and require further ownership building, systems and capacity development.

2.4.5 Service delivery

Gaps in the availability of basic health services and disparities in the utilisation of health services by income groups, caste/ethnic/religious groups and geographical areas as described above, illustrate the challenge ahead for strengthening the GESI responsiveness of health services and raising demand for health services among excluded populations. The systemic problems related to poor human resource management and low staff motivation, weak supervision and support systems, gaps in supplies and equipment impacts the capacity of services to deliver equitable quality health services. Strengthening the quality of service delivery for all and ensuring this reaches those who are typically left behind is therefore essential for achieving GESI objectives.

2.4.6 Targeted GESI interventions

A number of GESI targeted interventions have been tested and are being taken to scale. This includes a system of social audit for ensuring social accountability towards GESI at the primary health care level, the functioning of Social Service Units at referral hospitals to facilitate subsidies to very vulnerable and targeted populations, and the establishment of hospital based One Stop Crisis Management Centres to provide coordinated services to survivors of gender-based violence.

2.4.7 Evidence and information systems

The evidence base on GESI and health has strengthened and there is better use of this evidence at the policy level. The lack of a results framework and monitoring and evaluation indicators for the 2009 GESI Strategy for the Health Sector is a weakness which the revised strategy will correct.

The Health Management Information System (HMIS) has integrated the collection of sex-disaggregated data and includes the collection of caste/ethnicity/religion data for a set of core indicators. Equity dashboards have been developed at the national and sub-national levels to inform planning, prioritisation and monitoring though this will require continuing support to fully realise their potential.

NDHSs and other national household surveys are providing periodic evidence of health status and health service utilisation disaggregated by sex, wealth, caste/ethnicity/religion and geographical location. Smaller scale qualitative studies have also been commissioned by the Ministry to understand the dynamics and drivers of health risks and exclusion.

2.4.8 Rising demands on the system and the scale and nature of exclusion

The rights and policies laid out in the Constitution, the articulation of especially vulnerable and disadvantaged populations and affirmative action, and the impact of the 2015 earthquakes and other environmental and economic shocks are increasing the pressures and obligations on the health system to reach and be held accountable for meeting the needs of the excluded. The complexity of exclusion in Nepal, its deep roots, and the diversity of the excluded are major challenges for society and all service delivery sectors. Rising political and public expectations and demands will place increased tension on the health system and underlines the importance of the revised GESI Strategy at this time of transformational change.

Chapter 3

Strategic Direction and Approach

3.1 Strategic priorities

In line with the rights, directive principles and policies of the Constitution, the objectives of the National Health Policy 2014 and the four approaches of the Nepal Health Sector Strategy 2015-2020, this revised GESI Strategy for the Health Sector seeks to contribute to the transformation of health into a high performing sector through the following priorities:

- a To strengthen the health system to deliver inclusive, quality and accountable health services, and increase the trust and confidence of excluded communities in them.
- b To mainstream GESI into the forefront of health policy, leadership and management, institutional structures and systems of the federal, provincial and local levels of government and their diverse constituencies.
- c To build the capacity of government at the local levels to lead, coordinate and facilitate GESI and be held accountable for GESI results.
- d To ensure protective, distributive, and rehabilitative justice to communities left behind by the sector through equitable and inclusive access to quality health services that are accountable for meeting their essential health needs.
- e To empower target communities to use their health-related rights to demand accessible, GESI-friendly quality health services which are accountable.

3.2 Guiding principles of the strategy

There are six guiding principles underpinning the strategy:

Rights-based health service:

The strategy adopts rights-based principles to ensure that the health service is equitable, inclusive and pursues substantive equality to guarantee free basic health services as a fundamental right as per the Constitution of Nepal. The rights-based approach embraces equality of results, non-discrimination, and recognition of the state's obligation and responsibilities. Rights-based health services must comply with human rights standards and be accountable. This requires citizens to be empowered to use their rights and the state having the competence to protect citizen's rights and provide affirmative action.

Inclusive and equitable access to quality health service:

Inclusive and equitable access to quality health services requires attention to achieving the following four criteria which as described earlier have both demand and supply side elements:

- a *Availability*: provision of adequate and appropriate essential health care services with available and qualified staff, physically accessible to people with disability, have sufficient and

appropriate supplies and equipment, delivered at appropriate times for clients with limited waiting time and in a manner that is inclusive, compassionate and respectful.

- b *Affordability*: any direct and out of pocket expenses including transportation and loss of earnings are affordable to all clients including those without control over the household budget.
- c *Geographic accessibility*: location of the service is accessible to the target population throughout the year including those constrained in their mobility due to social norms or physical disability. Transportation is available and affordable to clients.
- d *Acceptability*: service providers and the health facility respect cultural norms and maintain client confidentiality, privacy and dignity. Clients are treated with respect, without discrimination and equitably. Clients are informed and have control over treatment choices.

Targeted GESI interventions:

In some situations, targeted GESI interventions are necessary to empower vulnerable and excluded populations to realise their right to health, overcome barriers to accessing quality services and hold providers accountable. They may also be necessary to enable the health sector to achieve tailored responses to the specific needs and capacity of the target group.

Social mobilisation and promotion of collaboration and partnership:

Social mobilisation in the health sector in Nepal has been shown to be an effective method to empower disadvantaged groups to mobilise and find local solutions to health problems. Collaboration and partnership between relevant agencies from government (federal, provincial, and local levels), private and non-governmental sector, civil society, the community, and donor agencies is a key enabling factor.

Capacity development of health institutions for effective health service delivery:

The achievement of quality of basic health service rests on the effectiveness of the country's health institutions from the federal to community level. This requires entrusting adequate mandate, authority and responsibility to those institutions, providing adequate and suitable infrastructure, guaranteeing the provision of adequate human and financial resources, the availability and deployment of competent and motivated health personnel, participatory monitoring and evaluation and a system of continuous improvement.

Evidence-based action for GESI:

Better evidence of the health conditions and needs of disadvantaged and excluded populations, the barriers they face in accessing health services and protecting their well-being, and cost-effective approaches to reducing the equity gap is needed to inform policy-making, structural reform, programming and service delivery. This will require improvements in the HMIS, enhanced implementation and participatory research and the better use of evidence for planning and decision-making.

3.3 Conceptual framework of the strategy

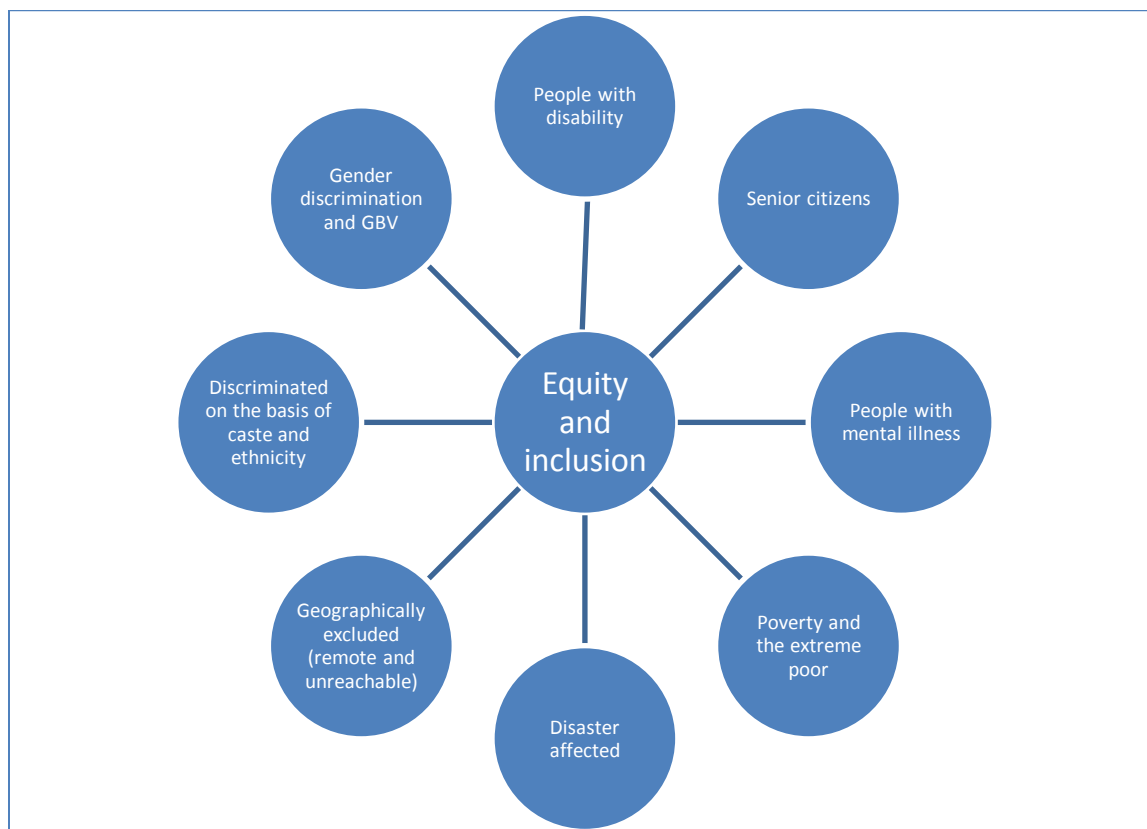
The strategy is based on the following conceptual framework:

- Target groups for equity and inclusion
- Mainstreaming GESI
- Complementarity of social inclusion and empowerment
- Barriers to accessing and utilising health services

3.3.1 Target groups for equity and inclusion:

Social exclusion is determined by a number of factors, including: (a) gender-based, (b) caste, ethnicity and religion-based, (c) poverty-based, (d) geography and location, (e) disability including physical and mental illness, (f) age-related vulnerability that children, adolescents and the elderly face, and (g) disaster affected areas. These determinants intersect and create multiple layers of vulnerability and risk that are amplified when they come together. For example, natural disasters place women at greater risk of gender-based violence; poor Dalit families face social discrimination and financial barriers when they try to use health services. These determinants of social exclusion have informed the primary target groups of this strategy.

Figure 1: Target groups for equity and inclusion



- a **Gender-based discrimination and GBV:** Nepal's social norms and culture define women's roles and responsibilities as less important than men. This limits their opportunities and the control

they have over their lives. It impacts the decision-making women have to access health services, to promote their well-being and protect themselves from violence. The unequal power between women and men, and the discrimination that women and the third gender face in Nepal underpins the gender-based violence they face. Women from all castes and ethnic communities, both rich and poor, from all regions are widely discriminated against in terms of economic, social, cultural, and political opportunities and status.

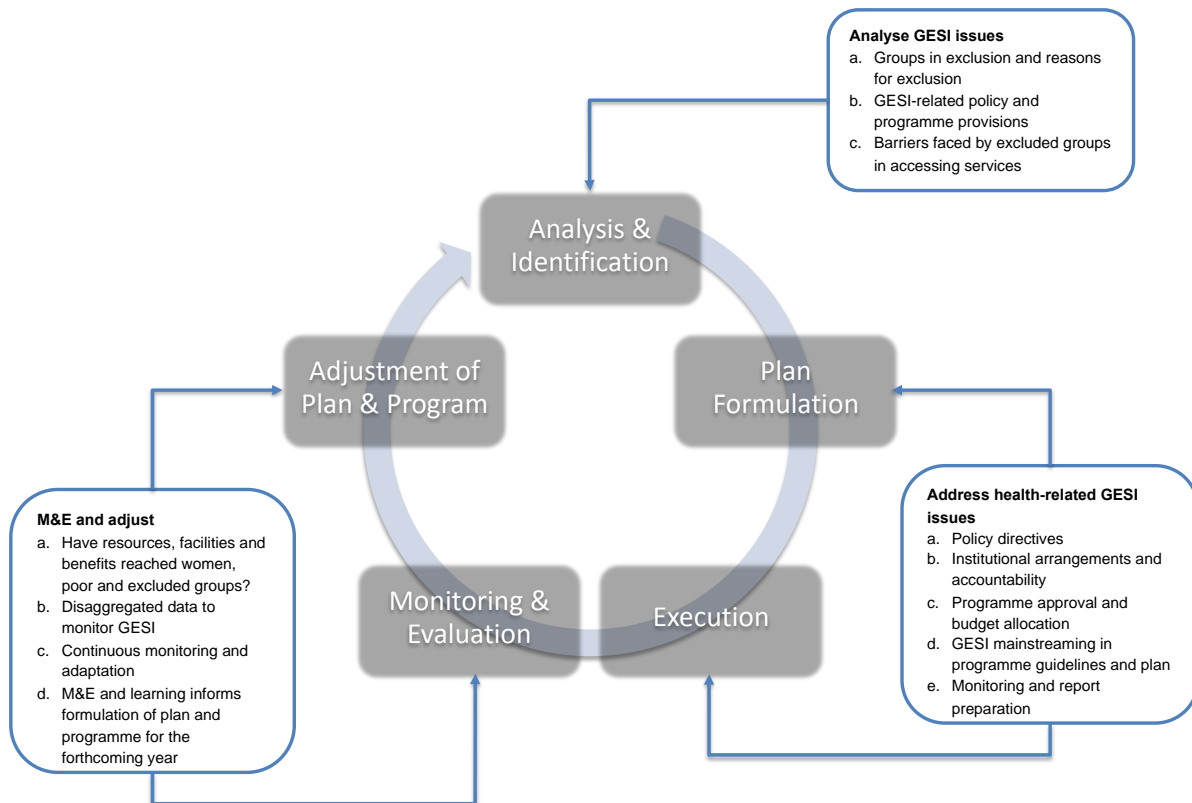
- b ***Caste and ethnic based inequality and discrimination:*** Despite progress in reducing inequality in use of essential health services by caste and ethnicity, a gap remains for some services. Demand and supply side factors contribute to this gap including cultural norms and preference for traditional healers, self-exclusion by highly stigmatised groups who avoid public shaming, restrictions on women's mobility, discriminatory attitudes of communities and health providers, and poor availability of health services close to where marginalised populations live.
- c ***Poverty and exclusion of the extremely poor:*** Inequality in health outcomes by wealth as found by NDHS 2016 illustrate the continuing barriers that the poor and extreme poor face in accessing health services and the additional risks they face in achieving health and well-being. Poverty intersects with other drivers of exclusion including gender, disability and geography, and makes some populations particularly vulnerable to poor health. Research has shown how poor people are forced to rely on traditional systems of medical treatment (*Dhami, Jhankri*) and the use of unprocessed medicinal herbs because of lack of money.
- d ***Geographically excluded living in remote and unreachable areas:*** Citizens living in remote and inaccessible areas (including *Himali* and mountainous areas and various areas of *Terai* region) are excluded from basic health services due to geographical barriers and the lack of health facilities. The social, financial and physical challenges for women, children, people with disability and senior citizens to access health services are amplified by the distance and the geographical difficulties (acute gradient, rivers, forest, etc.). The poor availability and functioning of health services in difficult to reach areas further disadvantages remote populations and those living in inaccessible areas.
- e ***People with disability including physical impairment and mental illness:*** Financial, social and cultural barriers to accessing health care, including stigma and lack of family support, plus the poor responsiveness of health institutions to the needs of people with disability results in the exclusion of people with disability from health services. Similarly, social stigma and cultural taboos around mental health and the underdevelopment of mental health services in Nepal leaves people suffering from mental illness socially excluded and neglected by the health system.
- f ***Age-related vulnerability including children, adolescents and the elderly:*** Children, adolescents and the elderly are vulnerable to social exclusion and poor health due to the lack of empowerment and control they have over their lives.
- g ***Disaster-affected populations:*** - People affected from disasters (earthquake, flood, landslides and soil erosion, cold wave, warm wave, lightning) have an increased risk of physical injury, psychological trauma and mental illness, the risk of mortality and poor access to health services due to the destruction of services and the impact on the health system. Disasters also

intersect with the other vulnerabilities that socially excluded populations face which exacerbates the risks that women and girls, the disabled, the remote and very poor face.

3.3.2 Mainstreaming GESI:

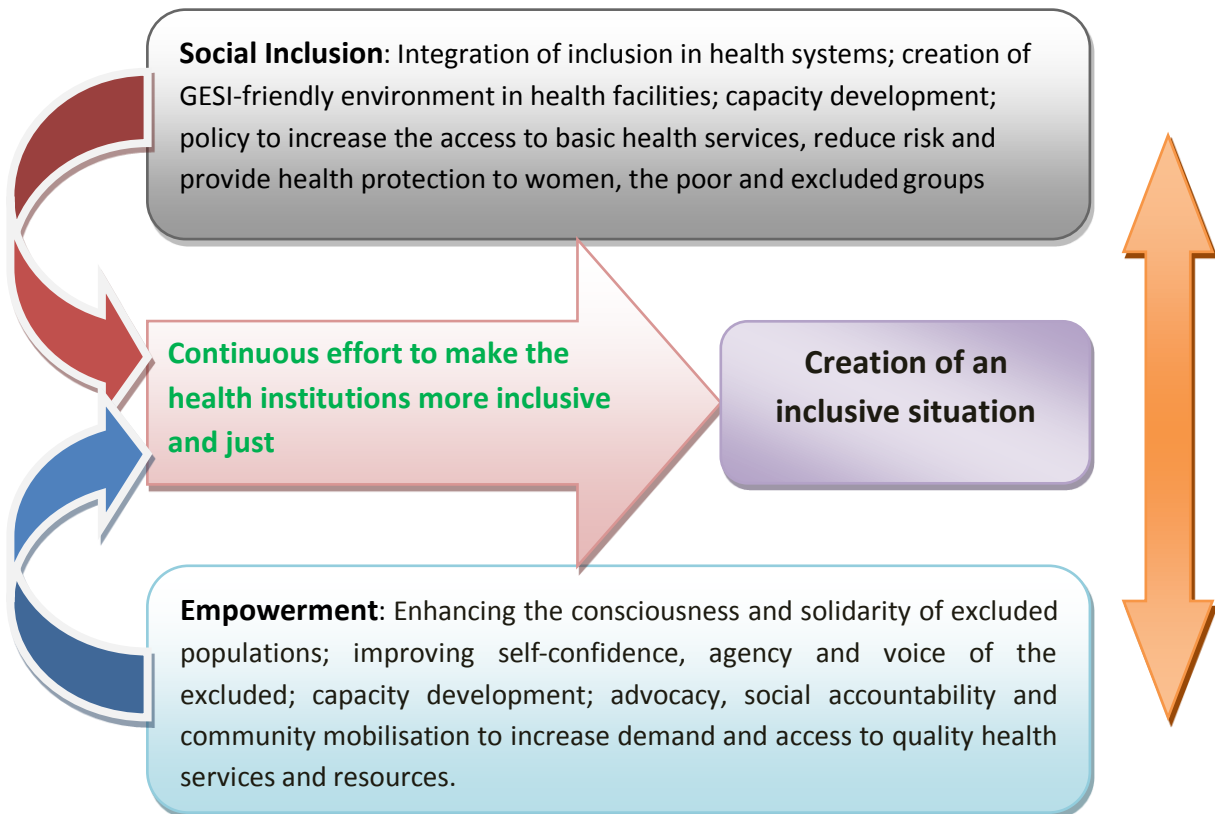
Gender equality and social inclusion mainstreaming is the process whereby barriers and issues faced by women, poor and excluded people are identified and addressed in all functional areas of the health system: policies, institutional systems, work environment and culture, programme and budget formulation, service delivery, monitoring and evaluation, and research. It also involves evaluation of the institutional capacity to mainstream GESI, and the responsiveness and work environment of health agencies to be gender equal and socially inclusive. Evaluation is necessary to inform continuous improvement and bolster ownership and commitment to GESI.

GESI Mainstreaming Cycle



3.3.3 The complementarity of inclusion and empowerment:

The pursuit of social inclusion is intrinsically connected with the empowerment of excluded populations. While social inclusion in the health sector aims to achieve structural, systems and cultural changes in the way the health system functions, to be sustainable and effective, poor and excluded populations also need to be empowered to demand their rights and hold the system to account.



3.3.4 The barriers to accessing and utilising health services:

The table below presents the key domains of access and the barriers that need to be addressed to ensure access to and utilisation of quality basic health services by women, the poor and socially excluded target groups.

Table 3: Dimensions and barriers to accessing quality health services

	Supply side constraints	Demand side constraints
Access to health services and barriers		
Geographic accessibility	Service location Facilities are not designed to be physically accessible for people with disability	Difficult terrain, landslides, flood Transportation costs Availability of transport
Availability of quality health services	Qualified and available human resources not available Irregular opening hours Long waiting time Shortages of drugs and supplies Limited availability of specialist services for people with disability Poor referral system Poor clinical and sanitary standards Lack of authority, responsibility and accountability	Information on health care services and providers available Knowledge and awareness to support positive health seeking behaviour
Affordability	Cost of services and products Public financing of the public health system	Household resources and willingness to pay Opportunity costs of seeking care (eg transport, loss of earnings) Control over family resources (eg women's lack of control) Lack of cash
Socio-cultural acceptability	Poor staff interpersonal communication skills, unfriendly and lack of trust Staff attitudes (eg non-acceptance of sex outside of marriage; stigma towards LGBTI) Lack of transparency of prices and pricing of services Gendered practices (eg male permission for women to have a procedure)	Family approval (eg women need permission to seek health care) Cultural preferences Language Low self-esteem and lack of assertiveness Stigma (eg family members with disability kept at home) Harmful traditions and practices

Chapter 4

Vision, Mission, Objectives and Strategies

4.1 Vision, mission and goal

In accordance with the vision, mission and goal of the National Health Policy 2014, the GESI Strategy of the Health Sector 2018 aims to contribute to the improved health status of all people through accountable and equitable health service delivery.

Vision

All Nepali citizens have productive and quality lives with highest level of physical, mental, social and emotional health.

Mission

Ensure citizens' fundamental rights to stay healthy by utilizing available resources optimally and through strategic cooperation between service providers, service users and other stakeholders.

Goal

The overall goal for the health sector is improved health status of all people through accountable and equitable health service delivery system.

4.2 Key Objectives

The key strategic objectives laid down by the GESI Strategy are:

Objective 1

To mainstream GESI in the policy, strategy, law, plan, programme and budget of the health sector at federal, provincial and local levels.

Objective 2

To strengthen GESI institutional mechanisms and make them functional at the federal, provincial, and local levels.

Objective 3

To empower target groups to demand their rights to and use basic health services.

Objective 4

To internalise GESI into the mainstream health services to achieve equitable access and inclusive delivery of essential quality health services.

Objective 5

To deliver targeted programmes that meet the specific health needs of vulnerable and excluded populations for ensuring their equal access to and utilisation of health services.

4.3 Strategies, working strategies and programmes to achieve strategic objectives

To achieve the objectives of the GESI Strategy, the following strategies and working strategies will be adopted and respective programmes and activities implemented. The working strategies, programmes and actions are interconnected. However, for clarity of presentation, programmes and actions are presented under one working strategy although they often benefit others too.

Strategic objective 1	
To mainstream GESI in the policy, planning and budget cycle of the health sector at the federal, provincial and local levels ⁹	
Strategy 1.1: To institutionalise GESI assessment and analysis into policy, planning and budget cycle of the health sector	
Working strategy	Programme/activities
(a) To develop the evidence base, methodology and procedures for GESI assessment and analysis.	1. Develop an appropriate methodology for GESI assessment and analysis
	2. Prepare and institutionalise procedures for GESI assessment and analysis in the development and review of policy, planning and budget cycle at federal, provincial, and local levels
	3. Strengthen HMIS and other health-related information systems to provide essential GESI disaggregated data
	4. Undertake further assessment and analysis of household surveys and HMIS data to investigate and monitor disaggregated health outcomes and the performance of the health system in delivering inclusive and equitable services
	5. Include GESI principles and content in all relevant studies and surveys of the health sector
	6. Commission GESI-evidence gathering where there are critical gaps and apply this evidence in the formulation of policy, strategy, law, systems strengthening, plans, and programmes including the budget
(b) To enhance the competence and demand at all levels for GESI evidence, assessment and analysis.	1. Identify competency required to assess and analyse the health sector at all levels to support GESI mainstreaming
	2. Develop the capacity for GESI assessment and analysis at all levels
Strategy 1.2: GESI mainstreaming into the policy, plan and budget cycle of the health sector at federal, provincial and local levels	
Working strategy	Programme/activities

⁹ Policy, planning and budget cycle includes policy, strategy, law, plan, programme, evidence and budget processes.

(a) To mainstream GESI into policies, strategies, plans, standards, systems, structures, programmes and budgets	1. Integrate GESI into the revision of existing policies, strategies, laws, systems, guidelines, standards and protocols of the federal, provincial and local level
	2. Include GESI as a priority in the formulation, implementation, monitoring and evaluation of new policies and plans, and allocate accountability for achieving GESI results
	3. Adopt the practice of mandatory inclusion of GESI fundamentals in formulating the annual programme and budget of the health sector
	4. Mandate implementation of the GoN gender-responsive budget guidelines in the health sector at federal, provincial and local levels
	5. Enforce LNOB markers in the formulation and implementation of annual programmes and budgets of the health sector at federal, provincial and local levels
	6. Support provincial and local levels to develop GESI strategies and undertake GESI audit of plans and programmes
	7. Support federal, provincial and local level governments to set targets for the representation of women, Dalits, and other excluded populations in governance bodies at the respective levels
(b) To enhance the capacity of the health workforce to internalise and prioritise GESI	1. Generate commitment of sector leaders at federal, provincial and local levels towards a gender equal and socially inclusive organisational culture including inclusive leadership and the merit-based participation of women and marginalised people
	2. Introduce human resource policies, systems and procedures for ensuring equal opportunities in the employment of women and excluded populations including equal pay for equal work, placement, merit-based provision of opportunities for obtaining professional continuing education, career development and promotion
	3. Carry out measures for increasing the participation of women and people from targeted excluded populations in the management level at the federal, provincial and local levels
	4. Foster collaboration and partnerships with academic and basic training institutions to incorporate GESI and GBV in health-related academic courses and training curricula
	5. Enhance GESI knowledge and skills of health staff through well-designed and evaluated in-service training, operational guidelines and workplace tools
	6. Form a GESI community of practice or knowledge network to enhance GESI capacity and mobilise commitment
(c) To adopt zero-tolerance for sexual harassment in the workplace and other discriminatory practices	1. Formulate and enforce a code of conduct to eliminate sexual harassment, gender-based oppression, and all forms of discrimination in the health sector workplace at all levels of governance and in all workplace settings
	2. Introduce measures to prevent sexual harassment and any other forms of discrimination, and establish a fair and effective redressal mechanism for handling any such grievances
	3. Inform and educate employees of national laws and international conventions related to GBV, sexual harassment and other forms of

	gender and social discrimination
Strategy 1.3: Collaboration and partnerships shall be promoted for GESI mainstreaming	
Working strategy	Programme/activities
(a) To build an enabling environment for collaboration and partnership for GESI mainstreaming	1. Build an enabling policy environment for government agencies, civil society organisations and the private sector to work on GESI mainstreaming in partnership in the health sector at the federal, provincial and local levels
	2. Work in partnership with governments of federal, provincial, and local levels to increase investment for inclusive and equitable health service
	3. Enhance the collaboration and partnership capacity of all levels of government (federal, provincial and local levels) to mainstream GESI effectively
	4. Share and exchange knowledge, skills, and experience between different levels of government (federal, province and local levels), civil society, development partners and other relevant stakeholders
(b) To encourage collaboration for GESI mainstreaming in the health sector	1. Allocate adequate resources and responsibility for building a collaborative system of sharing and exchange of knowledge, skills, and practices between the provinces and local levels for effective GESI mainstreaming
	2. Build the capacity of GESI institutional mechanisms and focal persons responsible for collaborating with partners for GESI mainstreaming
	3. Encourage private sector health institutions to collaborate with the health sector and integrate a focus on the socially excluded to achieve inclusive and equitable health services in the country
Strategic Objective 2	
To strengthen GESI institutional mechanisms and make them functional at the federal, provincial and local levels	
Strategy 2.1: GESI institutional mechanisms at the federal, provincial and local levels to be established and made functional	
Working strategy	Programme/activities
(a) To create GESI leadership, coordination and facilitation mechanisms at the provincial and local levels	1. Carry out facilitation and interaction programmes for establishing GESI institutional mechanisms at provincial and local levels
	2. Prepare guidelines for the formation of GESI mechanisms, leadership oversight, coordination, and facilitation at the provincial and local levels

(b) To increase the functionality of the GESI mechanisms at all levels	1. Link performance-based incentives to the effective functioning of GESI institutional mechanisms at the local level
	2. Empower members of GESI institutional mechanisms to integrate GESI into planning, review and programming at federal, provincial and local levels through provision of evidence, technical support, supervision and mentoring
	3. Ministry to provide technical and managerial support to GESI institutional mechanisms at provincial and local levels
	4. Orient representatives of provincial and local level governments on GESI issues
	5. Document GESI-related good practices and share and exchange at all levels.

Strategy 2.2: Strengthen performance of GESI institutional mechanisms at all levels

Working strategy	Programme/activities
(a) To enhance the effectiveness of GESI institutional mechanisms at all levels	1. Include measures to improve the performance of GESI institutional mechanisms into the programme and budget of respective government levels
	2. Establish GESI documentation and information resource at provincial and local levels
	3. Strengthen the management capacity of the GESI Secretariat of the MoHP
	4. Introduce a performance management system of the GESI institutional mechanisms at all levels
(b) To strengthen GESI-responsive monitoring and evaluation at the operational level	1. Prepare GESI guidelines for supervision, operational procedures, M&E at the operational level and provide orientation to staff
	2. Develop results-based indicators for effective M&E of GESI implementation at all levels
	3. Adopt a participatory appraisal system for measuring GESI effectiveness at provincial and local levels
(c) To address equity differences through use of evidence	1. Conduct studies and action research on the effectiveness and results of GESI mainstreaming
	2. Carry out continuous improvement measures based on evidence from fact-finding studies, research and HMIS
	3. Plan and collect feedback from target groups and stakeholders to ensure the effectiveness of GESI mainstreaming
	4. Update GESI disaggregated health baseline information

Strategic Objective 3

To enhance the capacity of target groups to demand their rights to and use basic health services

Strategy 3.1: Introduce a rights-based approach into existing health service standards to meet the needs of all, especially the populations that have been left behind

Working strategy	Programme/activities
(a) Develop and deliver rights based standards in the provision of basic quality health services to the target groups	<ol style="list-style-type: none"> 1. Identify and analyse the barriers and obstacles to the exercise of health rights by the target groups 2. Introduce rights-based standards in basic health services to target groups 3. Build a system of accountability to protect the health rights of the target groups 4. Improve the procurement and supply of medicines, equipment and assistive devices and other quality standards to deliver basic quality health services to target groups
(b) To provide legal protection of the health rights of target groups	<ol style="list-style-type: none"> 1. Assess and analyse the health-related risks of high risk target groups 2. Study and assess health service related laws that address target groups 3. Revise and harmonise laws to protect and promote the rights of target groups 4. Revise or formulate federal law on healthcare of persons with mental illness to protect and promote their rights 5. Reform the laws relating to health insurance to ensure adequate protection for target groups
<p>Strategy 3.2: To empower target groups to demand health services and improve their health seeking behaviour</p>	
Working strategy	Programme/activities
(a) To inform target groups about their health rights	<ol style="list-style-type: none"> 1. Mobilise local community-based organisations to inform and sensitise target groups on their rights 2. Use various means of communication to inform target groups of their health rights 3. Introduce and monitor a health service charter that has attached sanctions for service providers that fail to respect or provide equitable quality services to target groups
(b) To implement interventions to improve the health seeking behaviour of target groups and local solutions to health problems	<ol style="list-style-type: none"> 1. Implement social mobilisation and other behaviour change interventions to inform and empower target groups to improve healthy practices, reduce or eliminate harmful social and health behaviours, build resilience and local solutions to overcome barriers to health,

	<p>increase awareness and use of health services</p> <p>2. Mobilise local and mass media, social and traditional media and other communication platforms for empowering target groups</p> <p>3. Implement campaign-driven programmes to combat the values and norms that fuel discriminatory behaviour and GBV</p>
(c) To enhance the leadership capacity of the target groups	<p>1. Develop women leadership capacity and increase participation of women and marginalised groups in advocacy for health and local level health governance</p> <p>2. Develop the capacity of women, marginalised and excluded people to participate in the oversight and management of health institutions at all levels</p> <p>3. Provide scholarships to literate girls from excluded populations to enable them to undertake formal technical health and medical education so they may become health personnel</p>
Strategy 3.3: To increase access to and utilisation of basic health services of target groups through improvements in service delivery	
Working strategy	Programme/activities
(a) To enhance the capacity of health service providers to deliver services based on the rights of the target groups	<p>1. Provide local health facilities the authority and responsibility for addressing the needs of women, the extremely poor, people with disabilities, and those from marginalised communities</p> <p>2. Strengthen the capacity of health service providers to avail and use information related to the health service needs of the target groups</p> <p>3. Strengthen the referral system to higher level health institutions and increase access of target populations to referral facilities</p> <p>4. Provide financial and non-financial incentives to health personnel to deliver GESI-friendly health services, and strengthen management capacity and motivation to monitor performance and redress the grievances of the community</p>
<p>Strategic Objective 4</p> <p>To internalise GESI into the mainstream health services to achieve equitable access and inclusive delivery of essential health services</p>	
Strategy 4.1: Assess and analyse gaps in equitable access to and the inclusive utilisation of essential health services	

Working strategy	Programme/activities
(a) To ensure LNOB by assessing and analysing equitable access to and inclusive delivery of essential health services	<ol style="list-style-type: none"> 1. Assess and analyse disparities in use of health services by target groups and geographical locations and the underlying causes 2. Identify the methods of service delivery and the relevant programmes targeted at the groups and the areas not reached due to the local geography 3. Build capacity at the service provider level to assess and analyse equity gaps and design service delivery to close these gaps
(b) To strengthen health information system to be GESI sensitive	<ol style="list-style-type: none"> 1. Revise the existing HMIS by examining its' appropriateness and adequacy of presenting the disaggregated health status of the target groups clearly. 2. Revise the reporting system generated by HMIS based on equality and inclusion 3. Integrate information on health services delivered through targeted GESI programmes into the HMIS and factor into service delivery planning at the local level 4. Make the health service supervision and monitoring guidelines and checklists GESI responsive 5. Identify unreached target groups by analysing HMIS data and other sources of information at federal, provincial and local levels 6. Collect and analyse workforce data to measure and track GESI determinants such as the proportion of executive management at the federal and provincial levels that are male/female, the proportion of middle management positions filled by women, the proportion of hospital and health facility management positions filled by women etc. 7. Develop staff capacity to efficiently operate the revised HMIS
Strategy 4.2: Adopt affirmative action measures to increase the availability, access to, and utilisation of essential health services by the target groups	
Working strategy	Programme/activities
(a) To adopt affirmative action measures to ensure equitable access to and inclusive delivery of essential health services to the target groups	<ol style="list-style-type: none"> 1. Identify feasible affirmative actions to make services accessible to the target groups 2. Prioritise women, poor, marginalised and at-risk communities when designing and implementing programmes to increase their access to and utilisation of basic health services in an equal manner 3. Implement focused programmes of affirmative action to make health services accessible to the target groups
(b) To carry out special measures for delivering mainstream health services to the people of remote and unreachable areas	<ol style="list-style-type: none"> 1. Map and identify the remote and unreachable geographical locations which are out of the reach of basic health services 2. Assess and analyse the status of access and use of basic health services of remote and unreachable areas

	3. Design and implement special programmes and strategies for increasing the access of populations from remote and unreached areas
	4. Introduce mobile and temporary service delivery mechanisms in remote and unreachable areas
	5. Revise the multi-nutrition programme to ensure that access and utilisation is inclusive of target populations
(c) To make service providers capable and accountable for ensuring the effectiveness of services delivered to the target groups	1. Provide health institutions with the authority, resources, and infrastructure against which they can be held accountable for ensuring equal and inclusive service delivery
	2. Introduce incentivised performance and strengthen the support to and management of health staff to increase their motivation and morale in delivering health services to remote and unreached areas and other target groups
	3. Develop the communication and empathetic caring skills of health staff and foster respect for all clients regardless of their background
	4. Deploy health personnel with local language proficiency in areas where Nepali language is not the main medium
	5. Design programmes that contribute to the career development of health staff (scholarships, in-service training, rewards, etc.) working in remote and difficult areas
	6. Capacity development of health facility operation and management committees

Strategic objective 5

To deliver targeted programmes that meet the specific health needs of vulnerable and excluded populations for ensuring their equal access to and utilisation of health services

Strategy 5.1: Identify the specific health needs of excluded and vulnerable populations

Working strategy	Programme/activities
(a) To analyse and identify the health-related needs of excluded and vulnerable populations	1. Use evidence at the provincial and local levels to identify target groups who are consistently deprived of access to health services
	2. Identify the health needs of all target groups to inform GESI-responsive programming
	3. Adopt GESI-sensitive methods to deliver targeted programme

Strategy 5.2: Design and deliver targeted programmes to meet the specific health needs of targeted excluded and vulnerable populations

Working strategy	Programme/activities
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<p>(a) To design appropriate programmes for excluded and vulnerable groups</p>	<ol style="list-style-type: none"> 1. Conduct the cost-effective and feasibility study of programmes to address the health-related needs of the target groups, the barriers to access they face, and how these can be overcome 2. Develop a programme to introduce early identification of children born with birth defects 3. Assess and develop guidance on how health service infrastructure and service delivery arrangements can be made accessible to children, people with disabilities, survivors of GBV, incapacitated senior citizens, and people with mental health problems 4. Identify and design interventions to mitigate the barriers faced by poor and excluded women in accessing basic and essential health care 5. Introduce health-cards for target groups to increase their access to free basic and referral health services
<p>(b) To carry out health programmes targeted to the specific health needs of particular target groups</p>	<ol style="list-style-type: none"> 1. Prepare and enforce national guidelines for ensuring disability friendliness and senior citizen friendliness in all services delivered by all hospitals 2. Introduce basic health insurance for the families of all target groups 3. Provide basic health services in senior citizen care homes 4. Raise awareness of the reproductive rights of women with disabilities and provide services to them 5. Provide home visits and mobile healthcare services to senior citizens with impairments, people with disabilities, and people with mental health problems 6. Provide rehabilitative health services to survivors of GBV and people with mental illness 7. Build capacity of the health system to provide care for people born with birth defects, deafness, blindness and other hereditary disabilities 8. Provide basic health services to migrants (climate related, disaster, work, etc) 9. Review the existing health insurance packages to ensure adequate provision of free health services to people with severe disabilities, incapacitated senior citizens above 80 years of age, and people with mental illnesses 10. Undertake research of indigenous medicine and promote effective practices that promote GESI
<p>(c) To extend and strengthen the institutional capacity of Social Service Units</p>	<ol style="list-style-type: none"> 1. Set up Social Service Units in all private and community hospitals with a capacity of more than 100 beds 2. Revising the operation guidelines of Social Service Unit to entrust it with the responsibility of managing social health protection 3. Create the required staff positions by including the Social Service Unit in the organisational structure of hospitals 4. Strengthen the service management capabilities of the Social Service Units to service people with disability and achieve senior citizen friendliness 5. Align the Social Service Unit online reporting system with the HMIS 6. Introduce a performance-based incentive system for enhancing service

	management capacity of the staff working in the Social Service Units
(d) To plan and provide infrastructure for improving health service delivery to specific target groups	1. Formulate an action plan to develop appropriate and adequate health infrastructure for senior citizens, people with disabilities, people suffering from mental illness, and other target groups
	2. Set up a desk for people with disabilities in hospitals with the capacity of above 100 beds and scale up the number of beds and the capacity as per the need
	3. Establish geriatric wards in each of the hospitals of 100 above bed capacity and scale up the number of beds and the service delivery capacity as per the need
	4. Establish a help desk in the Social Service Units of hospitals for helpless people, people with disabilities, senior citizens, pregnant women, and newborn babies, and other target groups
	5. Provide mental health services in hospitals with the capacity of more than 100 beds
	6. Extend ambulance services to all hospitals and health facilities
	7. Assess the need and capacity of the health system to expand rural health clinics and prioritise new clinics located close to target groups
	8. Prioritise scaling up of Social Service Units to government hospitals where population access to hospital services is worse, based on evidence
	9. Expand urban health clinics to target the urban poor and extremely poor
Strategy 5.3: Increase accountability of programmes and health services targeted at vulnerable and excluded populations	
Working strategy	Programme/activities
(a) To develop a results-based monitoring and auditing method for the targeted programmes	1. Establish output indicators for targeted programmes to make them more results-oriented.
	2. Introduce GESI responsive budget guidelines for targeted programmes
	3. Conduct participatory review and social audit of the implementation of targeted programmes and basic health services delivered
	4. Conduct action research on the effectiveness of targeted programmes
	5. Evaluate the effectiveness of social audit and revise social audit guidelines accordingly and in line with the federal structure
	6. Regularise the independent evaluation of the impact and effectiveness of basic health services for target groups
(b) To improve the accountability of targeted programmes	1. Introduce benefit incidence analysis to examine the targeted programmes and who benefits from basic health service delivery
	2. Include GESI accountability in the formulation and budget preparation of the annual plan
(c) To extend OCMC services for survivors of GBV	1. Set up OCMCs in all district level hospitals
	2. Include OCMCs in the organisational structure of the hospitals and create staff positions including Psycho-social Counsellor
	3. Build the capacity of OCMCs and rehabilitation centres to provide free

	health services to GBV survivors in compliance with the standards and protocols of health services
	4. Provide services to GBV survivors from all hospitals in accordance with the GBV clinical protocol
	5. Provide support for ensuring sustainable rehabilitation for the survivors of sexual violence
	6. Ensure continuous improvement in OCMCs based on evaluation of the effectiveness of the services delivered
	7. Provide trained human resources to deliver psycho-social counselling services at hospitals of all levels
	8. Develop trained human resources to provide medico-legal services from all the hospitals above primary level
	9. Carry out campaigns against GBV at all levels
	10. Develop and execute the one-door reporting method related to GBV
(d) To increase the utilisation of maternity health services and free reproductive health and delivery services	1. Scale up skilled birth attendants to all health institutions with priority to the most underserved areas
	2. Introduce incentives to attract and ensure availability of female health personnel in all facilities
	3. Increase up take of institutional delivery among poor and excluded women through demand generation activities such as sensitisation and outreach clinics
	4. Provide outreach services and community mobilisation to increase disadvantaged women's access to reproductive health services (extremely poor, marginalised, discriminated against)
Strategy 5.4: Support collaboration and partnership to facilitate delivery of services to the target groups	
Working strategy	Programme/activities
(a) To enhance equal participation of the target groups	1. Encourage equal and inclusive participation of target groups in the implementation of targeted programmes
	2. Create opportunity for inclusive representation in local level health facility and operation management committees
(b) To encourage coordination and collaboration between stakeholders in the targeted programmes	1. Collaboration with national and international non-government organisations and local communities
	2. Regularise participatory interaction programmes between health service personnel and target groups
	3. Develop the capacity of community-based organisations to mobilise and promote the health of targeted groups
	4. Encourage private health institutions to provide basic health services to the people of remote and unreachable areas

The above-mentioned strategies, working strategies, programmes and actions serve as guidelines for the provincial and local levels. The provincial and local levels may determine their own strategies, working strategies and programmes/activities in line with this “GESI Strategy of the Health Sector” according to

the local context and nature of poverty and social exclusion. MoHP will provide technical and management support to the provincial and local levels to support them in their efforts.

Chapter 5

Arrangements for Strategy Implementation

5.1.1 Legal and institutional arrangements

The following legal and institutional arrangements will be created:

- a GESI in the health sector will be strategically and structurally mainstreamed through horizontal and vertical coordination, harmonisation and interrelationships between federal, provincial and local levels of government.
- b Health laws will be incrementally revised at federal level to integrate GESI principles, values, standards, and content. Legal provisions for health at province and local levels will be similarly guided to integrate GESI.
- c A coordinated and results-oriented GESI institutional mechanism will be set up at all levels with a clear mandate, responsibility and accountability.
- d The strategy will adopt implementation measures in harmony with the federal gender equality policy and the federalisation policy of the Government of Nepal.

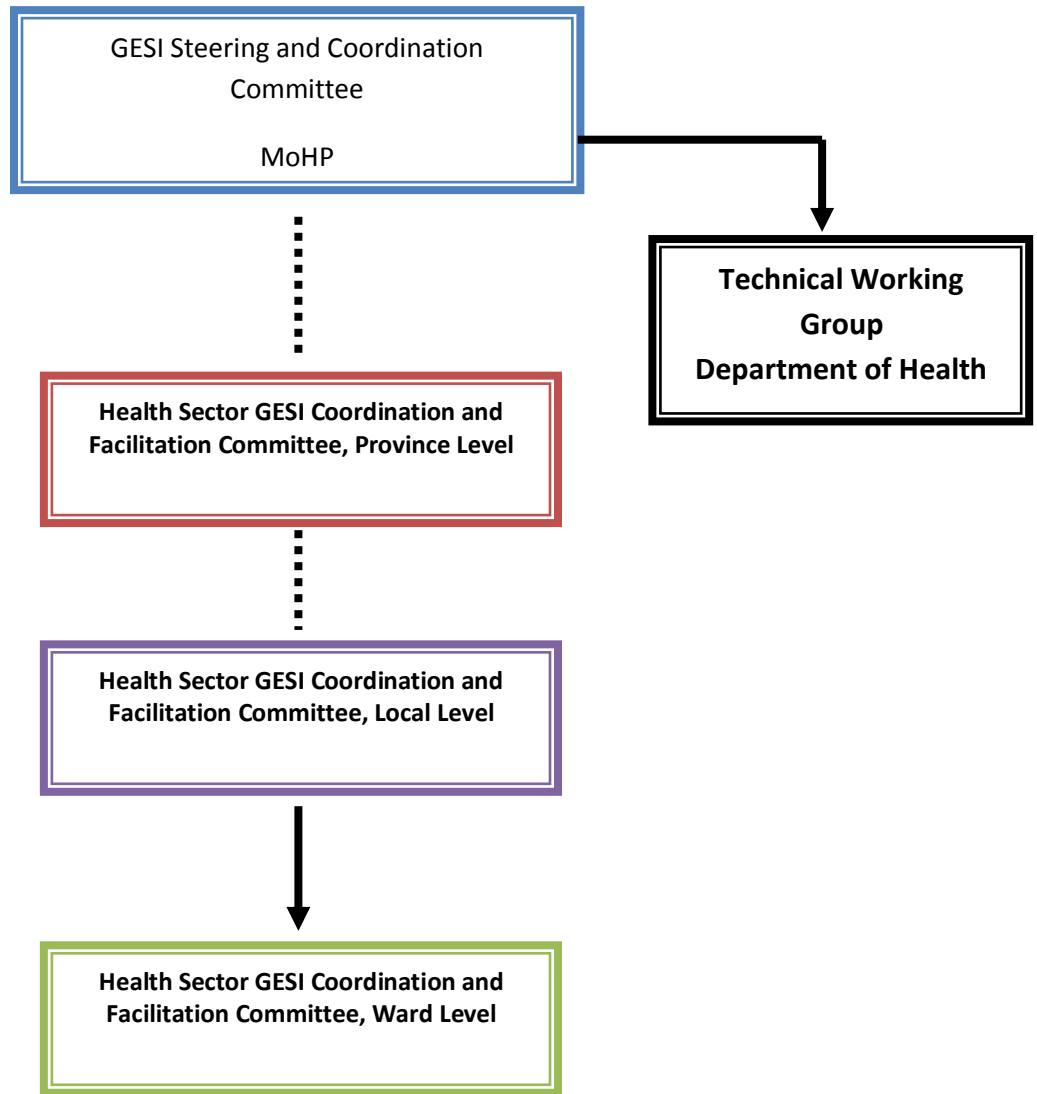
5.2 Institutional mechanism for GESI leadership, coordination and facilitation

The functionality of GESI-responsive and GESI-competent institutional mechanisms, the behaviour of health service personnel, and the institutional culture of the health service determines the degree of access to and utilisation of health services, specifically by women, poor people, and excluded groups. The social structure and values determine the creation of gender and social discrimination in society. The GESI Committees and GESI working teams to be set up in the MoHP under the federal level and at the province and local levels will lead the GESI transformation process. This will include assessing and analysing the existing culture, values and practices in the health service which reinforce social exclusion and disadvantage, and mobilising support and developing measures to transform the situation.

The institutional mechanisms mandated and designed for the federal level under the leadership of the MoHP and the mechanisms at the provincial and local level for assuming the responsibility of GESI leadership, coordination and facilitation provisioned in the strategy are extensive and representative. For inter-ministerial and inter-agency coordination and steering, the 'GESI Steering and Coordination Committee' at the federal level is well represented by the National Planning Commission and GESI relevant division chiefs of different sectoral ministries. The National Planning Commission is the main body to coordinate and prioritise policy, strategy, plans, and programmes and this agency will be instrumental in supporting the GESI Steering and Coordination Committee.

The institutional mechanisms with multi-lateral participation have been arranged objectively as follows for assuming the responsibilities of GESI steering, coordination, and facilitation at the federal, provincial, and local levels for effectively realising the GESI strategy. The formation of the GESI institutional mechanism, objectives, representation and scope of work are described in detail below:

Level-wise GESI institutional Mechanism



5.2.1 GESI Steering and Coordination Committee, MoHP

- a For Steering and coordination on GESI at the federal level, the “GESI Steering and Coordination Committee of the Health Sector” shall be set up. For the effective implementation of the strategy, the most proximate agencies designated to work in close relationship and contact for ensuring mutual coordination are Office of the Prime Minister and Council of Ministers, Ministry of Women, Children and Senior Citizens, Ministry of Federal Affairs and General Administration, Ministry of Finance and National Planning Commission.
- b The formation of the Committee shall be as follows:

Secretary, MoHP	- Convener
Joint Secretary, Office of the Prime Minister and Council of Ministers	- Member
Joint Secretary, Ministry of Women, Children and Senior Citizens	- Member
Joint Secretary, Ministry of Labour, Employment and Social Security	- Member
Joint Secretary, Ministry of Finance	- Member
Joint Secretary, Ministry of Federal Affairs and General Administration	- Member
Joint Secretary, Ministry of Education, Science and Technology	- Member
Joint Secretary, National Planning Commission	- Member
Director General, Department of Health Services	- Member
Director General, Department of Ayurveda	- Member
Chief, Women and Children Service Directorate, Police Headquarter	- Member
Chief, Policy, Planning and Monitoring Division, MoHP	- Member
Chief, Health Coordination Division, MoHP	- Member
Chief, Quality Measurement and Regulation Division, MoHP	- Member
A representative of the National level NGO working in the field of GESI nominated by the MoHP (two persons)	- Member
GESI Expert nominated by the MoHP	- Member
Joint Secretary, Population Management Division, MoHP	- Member-Secretary

c The functions, duties, and responsibilities of the “GESI Steering and Coordination Committee of the Health Sector” set up at the federal level are as follows:

- To facilitate moderating the existing and new policy, strategy, act, rules, directives, operating procedures, and guidelines and making them GESI-sensitive
- To approve and execute or plan for executing the GESI-sensitive policies, plans, and programmes for mainstreaming GESI at all levels of the health sector
- To give effect to coordination between inter-sectoral policies and to advise the GoN in carrying out necessary reforms in making the policy, plans, programmes, and institutional mechanisms GESI-sensitive
- To maintain inter-ministerial and inter-agency coordination and harmonisation between the federal, provincial, and local levels for effectively fulfilling the GESI-related responsibilities
- To review whether the implementation of GESI-related mainstreaming plan and programme in the health sector and health services delivered to the target groups are achieving GESI
- To carry out or make arrangements for carrying out M&E of the implementation of GESI strategy of the health sector at national level
- To formulate or plan to formulate the GESI-responsive budget and to carry out or plan to carry out the audit in examining whether the execution complies or not
- To make the HMIS GESI-sensitive and use accordingly
- To carry out necessary measures to strengthen the capacity of GESI-related coordination mechanisms functioning at the provincial and local levels
- To carry out or make arrangements for carrying out training and capacity development activities for enhancing the skills and competency of the human resources engaged in

GESI-related responsibilities and to achieve a workforce and leadership that is gender and socially inclusive

- To carry out activities in accordance with other responsibilities entrusted by the GoN

- d Convening the Meeting: The meeting of the “GESI Steering and Coordination Committee of the Health Sector” shall convene at least twice in a fiscal year.
- e Setting up of Technical Working Group: A Technical Working Group shall be set up by the MoHP under the convenorship of the Director General of the DoHS to assist and advice to the “GESI Steering and Coordination Committee of the Health Sector” of federal level on technical matters.

5.2.2 GESI Coordination and Facilitation Committee of the Provincial Level

- a For coordination and facilitation of GESI at the provincial level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective by the decision of the provincial level.
- b The formation of the Committee shall be as follows:

Director, Health Directorate, Ministry of Social Development	- Convener
Under Secretary, Office of the Chief Minister	- Member
Under Secretary, Ministry of Internal Affairs and Law	- Member
Under Secretary, Provincial Policy and Planning Commission	Member
Deputy Inspector General and Chief, Provincial Police Office	
Chief, Education Division, Ministry of Social Development	- Member
Chief, Women, Children and Social Security Section, Ministry of Social Development	- Member
Chief, Medical Services and Disease Control Section, Health Department	- Member
A representative of the Provincial level NGO working in the field of GESI nominated by the Provincial Government	- Member
GESI Expert nominated by the Provincial Government	- Member
Chief, Policy, Planning and Programme Coordination Section, Health Department	- Member-Secretary

- The Provincial Government may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
 - The Chief of the Social Services Unit of the hospital located in the provincial capital will serve as the GESI focal person at the hospital level.
 - The Member-Secretary of the provincial level GESI Coordination and Facilitation Committee will be the GESI focal person at the provincial level. The provincial level GESI focal person and the Chief of the Social Services Unit of the hospital shall share GESI-related information by maintaining regular mutual contacts with each other.
- c The functions, duties, and responsibilities of the “GESI Coordination and Facilitation Committee of the Health Sector” set up at the provincial level shall be as follows:
- To approve and put into implementation or plan for the execution of the provincial level GESI-sensitive policy, strategy, action plan, and programme in harmony with the GESI-related policy and strategy approved by the GoN for mainstreaming GESI in the health sector
 - To coordinate between the inter-sectoral policies, to advise the provincial government in making the policy, plan, and programme and the institutional mechanism GESI-sensitive and to recommend necessary reforms
 - To approve and implement or plan for the effective execution of GESI-related guidelines and directives in the health sector at the provincial level
 - To maintain inter-ministerial and inter-agency coordination and harmonisation for leading or making arrangement for effectively fulfilling the GESI-related responsibilities at the provincial level
 - To promote collaboration and partnerships between different provincial level agencies and institutions engaged in GESI and to encourage for organising campaigns in this regard
 - To develop and mobilise functional networks of the government and non-government agencies engaged in the GESI responsibilities
 - To conduct reviews and M&E on a quarterly, periodic, and annual basis or plan for carrying out such tasks, concerning whether the GESI-related mainstreaming plan and programme is implemented in the health sector, whether health services delivered to the target groups are achieving GESI effectiveness at the provincial level
 - To facilitate and provide support in formulating the GESI-responsive budget for result-oriented and objective implementation of GESI in the health sector and carry out GESI assessments and audits or make arrangements for carrying them out to examine whether the implementation meets the required level
 - To improve the GESI-sensitive health management information system and make it operational accordingly
 - To carry out or plan for carrying out training and capacity development activities for enhancing the competency of the human resources engaged in GESI-related responsibilities and to achieve a workforce and leadership that is gender and socially inclusive
 - To carry out activities in accordance with other responsibilities entrusted by the provincial government

- d The provincial level may change the functions, duties, and responsibilities of the provincial level “GESI Coordination and Facilitation Committee of the Health Sector” based on needs and the capacity to implement including the results to be achieved so far.

5.2.3 GESI Coordination and Facilitation Committee at the Local Level

- a For coordination and facilitation on GESI at the rural municipality level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective decided by the concerned local levels.

- b The formation of the Committee shall be as follows:

Vice-Chairperson, Rural Municipality	- Convener
Coordinator, Social Development Committee	- Member
Chief, Health and Social Development Section	- Member
Chief, Administration, Planning and Monitoring Section	Member
Chief, Education, Youth and Sports Section	- Member
Chief, Local Police Office	- Member
GESI Expert nominated by the local level	- Member
Chief, Women, Children and Social Welfare Unit	- Member-Secretary

- The rural municipality may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
- The Member-Secretary of the rural municipality level GESI Coordination and Facilitation Committee will bear the responsibility of the GESI focal person at the rural municipal level. She/he shall share GESI-related information by maintaining regular mutual contacts with the Chief of the Social Services Unit of the municipality level hospital.

- c For coordination and facilitation on GESI at the municipality level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective by the decision of the concerned local level.

- d The formation of the Committee shall be as follows:

Deputy Mayor, Municipality	- Convener
Coordinator, Social Development Committee	- Member
Chief, Health and Social Development Section	- Member
Chief, Administration, Planning and Monitoring Section	Member
Chief, Education, Youth and Sports Section	- Member
Chief, Police Office of the Municipality	- Member

GESI Expert nominated by the local level	- Member
Chief, Women, Children and Social Welfare Unit	- Member-Secretary

- The rural municipality may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
 - The Member-Secretary of the municipality level GESI Coordination and Facilitation Committee will bear the responsibility of the GESI focal person at the municipality level. She/he shall share GESI-related information by maintaining regular mutual contact with the Chief of Social Services Unit of the municipality level hospital.
- e For coordination and facilitation on GESI at the sub-metropolitan level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective by the decision of the concerned local level.
- f The formation of the Committee shall be as follows:

Deputy Mayor, Sub-Metropolitan City	- Convener
Coordinator, Social Development Committee	- Member
Chief, Health and Social Development Division	- Member
Chief, Planning, Budgeting and Information Technology Division	Member
Chief, Education, Youth and Sports Division	- Member
Chief, Legal Affairs Section	- Member
Chief, Police Office of the Sub-Metropolitan City	- Member
GESI Expert nominated by the local level	- Member
Chief, Women, Children and Social Welfare Sub-Section	- Member-Secretary

- The Sub-Metropolitan City may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
- The Member-Secretary of the Sub-Metropolitan City level GESI Coordination and Facilitation Committee will bear the responsibility of the GESI focal person at the Sub-Metropolitan City level. She/he shall share GESI-related information by maintaining regular mutual contact with the Chief of Social Services Unit of the Sub-Metropolitan City level hospital.

g For coordination and facilitation on GESI at the metropolitan level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective by the decision of the concerned local level.

h The formation of the Committee shall be as follows:

Deputy Mayor, Metropolitan City	- Convener
Coordinator, Social Development Committee	- Member
Chief, Health and Social Development Division	- Member
Chief, Planning, Budgeting and Information Technology Division	Member
Chief, Educational Administration Division	- Member
Chief, Legal Affairs Section	- Member
Chief, Police Office of the Metropolitan City	- Member
GESI Expert nominated by the local level	- Member
Chief, Women, Children and Social Welfare Section	- Member-Secretary

- The Metropolitan City may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
- The Member-Secretary of the Metropolitan City level GESI Coordination and Facilitation Committee will bear the responsibility of the GESI focal person at the Metropolitan City level. She/he shall share GESI-related information by maintaining regular contact with the Chief of Social Services Unit of the Metropolitan City level hospital.

i For coordination and facilitation on GESI at the Kathmandu Metropolitan City level, the “GESI Coordination and Facilitation Committee of the Health Sector” shall be set up and be made effective by the decision of the concerned local level.

j The formation of the Committee shall be as follows:

Deputy Mayor, Kathmandu Metropolitan City	- Convener
Coordinator, Social Development Committee	- Member
Chief, Health and Social Development Division	- Member
Chief, Planning, Budgeting and Information Technology Division	Member
Chief, Educational Administration Division	- Member
Chief, Legal Affairs Section	- Member
Chief, Kathmandu Metropolitan City Police Office	- Member
GESI Expert nominated by the local level	- Member
Chief, Women, Children and Social Welfare Section	- Member-Secretary

- The Kathmandu Metropolitan City may add or change the membership in the above-mentioned Coordination and Facilitation Committee as required. Representatives from other relevant agencies may be invited to attend the meeting.
- The Member-Secretary of the Kathmandu Metropolitan City level GESI Coordination and Facilitation Committee will bear the responsibility of the GESI focal person at the Metropolitan City level. She/he shall share GESI-related information by maintaining regular contact with the Chief of Social Services Unit of the Kathmandu Metropolitan City level hospital.

k **The functions, duties, and responsibilities** of the “GESI Coordination and Facilitation Committee of the Health Sector” set up at the local level shall be as follows:

- To approve and implement or plan for the execution of the GESI-sensitive policy, strategy, action plan, and programme at the local level in harmony with the GESI-related policies and strategies approved by the GoN and the provincial government for mainstreaming GESI in the health sector
- To coordinate between the inter-sectoral policies, to advise the local level in making the policy, plan, programme, and the institutional mechanism GESI-sensitive, and to recommend necessary reforms
- To approve and implement or plan for the effective execution of GESI-related guidelines and directives in the health sector at the local level
- To maintain inter-agency and inter-institutional coordination and harmonisation for ensuring effective fulfilment of the GESI-related responsibilities at the local level
- To promote collaborations and partnerships between different local level agencies and institutions engaged in GESI and to encourage organising campaigns in this regard
- To develop and mobilise the functional networks of the government and non-government agencies engaged in the GESI responsibilities at the local level
- To conduct reviews and M&E on the quarterly, periodic, and annual basis or plan for carrying out such tasks, whether the GESI-related mainstreaming plan and programme put into implementation in the health sector and the health services delivered to the target groups are achieving GESI at the local level
- To facilitate and provide support in formulating the GESI-responsive budget for a results-oriented and objective implementation of GESI in the health sector at the local level and carry out GESI assessments and audits or plan for carrying this out to examine whether the implementation meets the required level
- To develop the GESI-sensitive HMIS of the health sector at the local level and make it operational accordingly
- To carry out necessary measures for capacity strengthening of the GESI-related coordination and facilitation institutional mechanism functional at the local level
- To carry out activities in accordance with other responsibilities entrusted by the federal and provincial governments

l Local Level may change in the functions, duties, and responsibilities: The local level may change the functions, duties, and responsibilities of the local level “GESI Coordination and

Facilitation Committee of the Health Sector” based on needs and the capacity to implement including the results to be achieved so far.

- m Convening the Meeting: The meeting of the local level “GESI Steering and Coordination Committee of the Health Sector” shall be convened on a quarterly basis in each fiscal year. The meeting may be convened otherwise as and when required.
- n Technical Group to be formed at the Local Level: The concerned local level may designate a technical group at the local level with allocation of functions, duties, and responsibilities under the convenorship of the head of the Health and Social Development Division or the section of the local level to advise and provide consulting services on technical matters to the “GESI Coordination and Facilitation Committee of the Health Sector” of the local level.
- o Coordination and Facilitation Mechanism at the Ward Level: The local level may form a ward-level “GESI Committee of the Health Sector” as per the responsibility allocated to the ward level by the Local Government (Operations) Act, 2017 to manage public service delivery under the convenorship of the Ward Chairperson with representation of the female member of Ward Committee, representative of the ward-level community organisation involved in GESI in the health sector, chief of the ward-level police office and female health volunteer of the ward as members, and the chief of the local health institution as the member-secretary. This committee, chiefly, shall bear the responsibility of the prevention and control of GBV, identification of the geographically unreached areas and the groups unreached by basic health services, to provide services to the unreachable areas and groups, identifying the groups at risk and providing basic health services to those groups.

The head of the ward-level health institution will bear the responsibility of sharing and exchanging GESI-related information as the GESI focal person at the ward level.

5.3 Measures for effective implementation of the strategy

The following measures shall be adopted for the effective implementation of this strategy:

- a The commitment, cooperation, and support of the political leadership at the federal, provincial, and local levels shall be fostered to mainstream GESI by integrating the priority actions. Required sensitisation and advocacy will be conducted to achieve this. Communication programmes will be carried out in a planned way to acknowledge advice, suggestions and feedback from stakeholders on issues relating to GESI.
- b The federal level will formulate an implementation plan for the planned execution of the strategy. The provincial and local levels shall formulate respective plans for the execution at provinces and the local levels. The federal level will provide necessary support to the provincial and local levels for this purpose.
- c GESI shall be realised at all levels by enforcing GESI-responsive programming and budgeting on a mandatory basis. Assessments and analyses from a GESI perspective will be carried out in the formulation of the health-related programme and budget formulation.
- d The capacity of the health institutions delivering basic and essential health services will be strengthened. This will include measures such as adequate authority and responsibility,

suitable infrastructure, adequate availability of resources, application of a performance-based incentive system to motivate staff, availability of required health personnel, execution of participatory M&E, and methods to assure accountability for results.

- e For effective mainstreaming and integration of gender equality and social inclusion and to measure the results of GESI implementation in the health sector, appropriate output indicators will be put into effect. Likewise, GESI-disaggregated data and the information system will be strengthened to monitor the health status of specific target groups to ensure GESI sensitive and accountable measurement of results.
- f The implementation of the strategy shall be based on the principles of sustainability, collaboration and partnership. Every effort will be made to secure meaningful participation and ownership of stakeholders.

5.4 Plans for strategy implementation

- a The MoHP will prepare a strategy implementation plan with the participation of relevant agencies within six months from the date of approval of the strategy and in harmony and compatibility with the goals set by Nepal to pursue the realisation of SDG, 2030.
- b The Social Development Ministries of all the provinces shall formulate province-specific GESI strategies including a resource plan in harmony and compatibility with this strategy within a one-year period of the enforcement of the strategy. The provinces shall put into place the respective strategies from the implementation plan and include results-based indicator frameworks for performance measurement.
- c The local levels shall formulate respective GESI strategies including a resource plan in harmony and compatibility with federal and respective provincial strategies within a one and half year period of the enforcement of the strategy. The local levels shall put into place the respective strategies with the implementation plan that includes results-based indicators and frameworks for performance measurement.
- d All provinces shall set up and make functional the provincial level GESI Coordination and Facilitation Committees within six months from the execution of this strategy.
- e All local levels shall set up and make functional the local level GESI Coordination and Facilitation Committees within six months of the execution of this strategy. Along with this, the local level shall also set up and make functional the ward level GESI Coordination and Facilitation Committees as required for coordinating health service delivery at the ward level.
- f Within one year of the execution of this strategy, all the local levels shall make necessary arrangements for the collection and management of disaggregated baseline data with respect to the target groups of the respective local levels and their entitlement to basic health services including special health care for people with mental illness, people with disabilities, and senior citizens, in line with the GESI Strategy. The local level shall also coordinate and harmonise the data management system with the HMIS institutionalised at the federal level.
- g All provinces shall make necessary arrangements for the collection and operational management of disaggregated baseline data with respect to all the target groups of the

respective provinces and their entitlement to basic health services including the special health care required for people with mental illness, people with disabilities, and senior citizens, in line with the GESI Strategy; this will be undertaken in coordination with the local level. The provinces shall also coordinate and harmonise the data management system with the HMIS institutionalised at the federal level.

- h The MoHP will revise the GESI baseline data and the HMIS by establishing necessary coordinated linkages and networking with all local levels and the provincial levels.

Chapter 6

Arrangements for Monitoring and Evaluation of Strategy Implementation

6.1 Approaches to M&E

A planned and systematic M&E system shall be carried out to ensure quality and inclusive health service provision to the target groups by making the implementation results-oriented as internalised by the conceptual framework of the GESI Strategy of the Health Sector. As part of this, periodic and regular M&E will be done on the availability of basic, secondary, and tertiary health services for the survivors of GBV (specifically women), poor and deprived people, marginalised and endangered castes and ethnic communities, people living in geographically remote and unreachable areas, people with disabilities, senior citizens, people from at-risk communities (e.g. street children, female sex workers, and people affected by natural disasters). The periodic and regular M&E shall ensure whether those people have equal and inclusive access to healthcare, whether they have experienced improvements in health status, and whether they have benefitted as expected, including whether the problems are identified on time and resolved and whether the improvements are continuing. M&E shall be utilised as the means of continuous learning and a method for achieving the effectiveness of the strategy.

The following strategies shall be adopted for M&E of the strategy implementation:

- a **Implementation readiness:** M&E shall be carried out on a regular and systematic basis to be confident on the issues related to strategy implementation such as whether there is an enabling environment or not, the status of institutional readiness and capacity for competent execution, the availability and adequacy of resources and infrastructures, and status of accountability, etc. The implementation readiness of the strategy can be better assured with such an approach.
- b **Progress review of the performance:** The review of the implementation progress on a trimester and annual basis shall be carried out to assess the performance related to the availability of the service, status of access of the target group, the capacity of service delivery, and the status of service use by the target groups. The field monitoring shall also be done to monitor the actual status of implementation. As part of this, the implementation-related problems shall be identified, and guidance is given for solving such problems.
- c **M&E of the effectiveness of outputs and results:** A periodic and annual evaluation shall be done to assess the quality of the health services used by the target groups and the benefits of the service used along with the impact of such services. As part of this, the adequacy and appropriateness of the services delivered, and the benefits received including the quality of service results shall be evaluated. The problems related to the implementation shall also be assessed along with the effectiveness of the measures adopted to solve the problems. Under this, the immediate reforms in the strategy shall be guided along with the periodic and long-term reforms in the strategy.

6.2 Levels of responsibility and accountability for M&E

M&E of this strategy shall be executed in harmony with the jurisdiction, responsibility, and accountability entrusted to different levels of governance by the Constitution of Nepal. Accordingly, the strategy has provisioned the following responsibility levels:

- a At the federal level, the MoHP shall be responsible for carrying out M&E of policy implementation and effectiveness related to the GESI Strategy. For this, the GESI Steering and Coordination Committee of the MoHP shall be made functional and responsible.
- b At the provincial level, the Ministry of Social Development of the province shall be responsible for M&E concerning the management and system-related effectiveness related to the GESI Strategy. For this, the GESI Coordination and Facilitation Committee of the province shall be made functional and responsible.
- c At the local level, the concerned local level shall be responsible for M&E concerning the effectiveness of the implementation and operational level outputs and service delivery related to GESI Strategy. For this, the GESI Coordination and Facilitation Committee of the concerned local level shall be made functional and responsible.

6.3 Competency assurance for M&E

The following methods and techniques shall be carried out for ensuring the competence of the M&E system in line with GESI by assessing and examining the availability, access to, and use of basic and specially designed health services targeted at people from the target groups for achieving the effectiveness of GESI-responsiveness.

- a) The M&E action plan will be formulated along with the annual plan and programme at all levels. For this, the required resources for the M&E activities and capacity development shall be included in the annual programme and budget.
- b) For making M&E results-oriented, a results-based system shall be adopted.
- c) A GESI disaggregated management information system shall be made systematic to ensure the clear picture of the health status of the target groups. In this information system, the baseline information and data related to the health conditions including the availability, access to, and benefits with respect to the target groups. Such information and data will be updated in a timely manner. M&E will be conducted based on such fact and evidence-based system.
- d) For developing the capacity of the human resources of the responsible agencies accountable for M&E, required knowledge and skills shall be identified. Based on such identification, training and capacity development programmes will be conducted.
- e) For ensuring that M&E is accountable and transparent, M&E guidelines will be made applicable to all levels.
- f) For the periodic and annual review at the federal level, the status of implementation of the GESI strategy at the provincial and local levels will be carried out. During the periodic and annual review at the provincial and local levels, coordination shall be done with the federal level.

- The feedback and suggestions received from the annual review and evaluation shall be incorporated in the following plan and programme formulation as part of the reform process and in conformity with the universal norms and the requirements of the targeted programme.

6.4 Techniques for monitoring strategy implementation

The following techniques shall be adopted for monitoring strategy implementation:

- a **Participatory monitoring:** Under this technique, the target beneficiary group and the stakeholders are provided for the meaningful participation while monitoring the strategy implementation. Under this technique, stakeholder hearing, interaction, beneficiary satisfaction survey, focus group discussion, etc. shall be applied. Such techniques are applied on a regular basis and the feedback shall be acknowledged to mitigate the weaknesses and solve the problems of implementation along with building the capacity.
- b **Means and basis of information for monitoring:** Monitoring shall be conducted based on information sources like periodic surveys, NDHS, NLSS, HURIS, and HMIS etc. including the data and information received from the provincial and local levels.
- c **Monitoring the extremities of inequality:** While the monitoring and review of strategy implementation, the situation of a large difference in terms of access and utilisation between all the health service beneficiaries and the target groups shall be assessed. Necessary efforts to harmonise the programmes and goals shall be reinforced to give effect to zero-difference. In this way, the information shall be managed to have clear status on the inter-province situation of health conditions of the target groups, the extent of delivery of services and the status of utilisation. Monitoring and review shall be carried out based on such information.
- d **Monitoring and review of progress based on performance reports:** Reports on the performance of service delivery shall be prepared based on performance review and submitted periodically to the responsible agency. The performance review report shall be assessed, and based on this, the monitoring, as well as necessary supervision, shall be done as the follow-up actions.
- e **Beneficiary contact monitoring:** Service effectiveness auditing shall be conducted based on direct beneficiary contact with the entitled persons of the target groups as mentioned in the GESI strategy. Monitoring shall be done by applying community-based methods and techniques with focus on issues like whether the availability of services, access to services, and utilisation of services is focused on the target groups or not, whether the services and benefits are relevant to the target groups or not, how the beneficiaries of the target groups are utilising the services, how much meaningful use of such services are gained, and what are the problems and difficulties faced by the beneficiaries of the target groups.
- f **Guidelines and supervision:** For ensuring the timeliness of the monitoring activities, the federal level GESI Committee shall guide and supervise the activities of the province level GESI Committee and the province level GESI Committee shall guide and supervise the activities the local level GESI Committee.

6.5 Methods and techniques of evaluation of strategy implementation

- a The strategic level evaluation of the strategy implementation of the federal level shall be executed by the MoHP. Likewise, the province level shall carry out the evaluation of the management level of the implementation, and the evaluation of the effectiveness of quality of service and the beneficiary level shall be the responsibility of the local level.
- b The evaluation of the strategy shall include issues like relevance and appropriateness and compatibility with the policy.

- c The evaluation framework shall be designed to evaluate efficiency, achievement of outputs, impact, and results, and benefits with respect to the beneficiaries.
- d For ensuring the legitimacy and wider acceptability of the strategy evaluation, a multi-sectoral, participatory, and independent evaluation method shall be adopted. For this, the social audit and beneficiary survey techniques shall be applied so far. As part of this, the effectiveness of services delivered to the target group shall also be independently evaluated.
- e In the course of strategy implementation, the province and local levels shall be empowered and made responsible for evaluating the performance effectiveness and the achievements.

6.6 Other arrangements for strategy M&E

- a The objectives and the strategies shall remain as guidelines for the province and local levels. The province and local level may revise or change the working strategy and the programme based on assessment and analysis of social, geographical and economic conditions of the respective level.
- b The province and the local level may identify the target group based on assessment and analysis of social and economic conditions. The province and the local level may decide the result indicators of programme implementation and service delivery within the set framework of strategic objectives and relevant strategies described by this strategy.
- c As the result indicators of M&E, input-related indicators (financial resource management, institutional arrangements, availability of human resources, infrastructures, etc.), system-related, process-related and activity-related indicators (system development, operations, and procedures, etc.), output-related indicators, and impact-related indicators shall be used.
- d The base of knowledge and skill shall be made broad-based, horizontally and vertically by making the system of sharing between and within different levels and agencies based on learning, lessons learnt, and inferences drawn from the exercise of M&E of the strategy implementation.
- e For ensuring the planned, systematic, and deliberate execution of M&E of the strategy, the MoHP at the federal level, Ministry of Social Development at the provincial level, and the local level shall formulate and implement plans of action for carrying out M&E within the respective jurisdiction.
- f The province and local level shall manage GESI-disaggregated information and data related to the respective jurisdiction and functional scope of work for ensuring the M&E is evidence-based and GESI-disaggregated is information-based. The province and local levels may set-up and systematically operate the dedicated “Documentation and Information Centre” for this purpose. The MoHP shall make necessary revisions and improvement in the integrated HMIS to harmonise with the GESI related information of province and local levels.
- g The provincial and local levels may design and execute monitoring and supervision methods according to the respective requirements.

6.7 Results monitoring framework

The Results Monitoring Framework with the key result indicators with respect to the implementation of the strategic objectives as envisaged by the GESI Strategy is as follows:

Output Indicator	Baseline			Milestone/Target			Data Source
	Data	Year	Source	2020	2025	2030	
<p><u>Strategic objective 1</u> To mainstream GESI in the policy, planning and budget cycle of the health sector at federal, provincial, and local levels</p>							
1.1 Percentage of GESI responsive budget in the total budget of the health sector		2017	FMR TABUCS, Sutra	30	35	50	FMR TABUCS, Sutra
1.2 Percentage of utilisation of GESI responsive budget		2017	FMR TABUCS, Sutra	80	85	90	FMR TABUCS, Sutra
<p><u>Strategic objective 2</u> To strengthen GESI institutional mechanisms and make them functional at the federal, provincial, and local levels</p>							
2.1 Percentage of GESI responsive mechanisms set-up at the provincial and local levels							
2.1.1 % of the province		2018	MOHP	100			MOSD, Local Level Reports

2.1.2	% of the metropolitan city		2018	MOHP	100			MOSD, Local Level Reports
2.1.3	% of the sub-metropolitan city		2018	MOHP	100			MOSD, Local Level Reports
2.1.4	% of the municipality		2018	MOHP	100			MOSD, Local Level Reports
2.1.5	% of the rural municipality		2018	MOHP	100			MOSD, Local Level Reports
2.2	% of the province and a local level having regular meetings and decision execution of GESI institutional mechanism							
2.2.1	% of Province level		2018	MoHP	100			MoHP, MoSD, Local Level Reports
2.2.2	% of the Local level		2018	MoHP	70	80	90	MoHP, MoSD, Local Level Reports
<p>Strategic objective 3</p> <p>To enhance the capacity of the target groups to demand their rights to and use basic health services</p>								
3.1	Equity gap between the % of total outpatients and the % of the target group							

3.1.1	Health institutions		2015	NHFS HMIS	30	15	5	NHFS HMIS
3.1.2	Hospitals		2015	NHFS HMIS	30	15	5	NHFS HMIS
3.2	Difference between % of the total population reaching the health institution within 30 minutes and the % of target group people reaching the health institution		2015	NDHS	30	15	5	NDHS
3.3	% of health institution with Rapid Response Team		2015	NHFS	100			Local Level Reports, NHFS
3.4	Difference between % of all users of free basic health service in the urban health centre and the users of the target group		2015	NHFS	30	10	5	NHFS
<p><u>Strategic Objective 4</u> To internalise GESI into the mainstream health services to achieve equitable access and inclusive delivery of essential health services</p>								
4.1	% of health institution with the availability		2016	HURIS	80	90	100	HURIS

of at least 2 female health personnel							
4.2 % of health institution having facilitated birthing centre with at least 2 skilled birth attendants		2017	HURIS	73	79	90	HURIS
4.3 % of the fulfilment of approved positions health personnel and placed to work in the health institution of unreachable and remote areas		2017	HURIS	70	80	95	HURIS
4.4 % of hospitals above primary level with the availability of Medico-legal health personnel		2017	TMIS/NHTC HURIS	80	90	100	TMIS/NHTC HURIS
4.5 % of health institution having female as in-charge		2017	HURIS	33	50	50	HURIS

4.6 % of health institution as in-charge from the health personnel of marginalised and endangered community		2017	HURIS	5	10	15	HURIS
<p><u>Strategic Objective 5</u></p> <p>To deliver targeted programmes that meet the specific health needs of vulnerable and excluded populations for ensuring their equal access to and utilisation of health services</p>							
5.1 Setting up OCMCs for survivors of GBV							
5.1.1 Number of districts		2015	OCMC Information System	77			OCMC Information System
5.1.2 % of hospitals		2015	OCMC Information System	90	100		OCMC Information System
5.2 Number of GBV survivors projected to receive services from OCMC		2017	OCMC Information System	6300	8000	12000	OCMC Information System Health Facility Registry
5.3 % of hospitals above the primary level having availability of psycho-social counselling		2015	OCMC Information System	80	90	100	OCMC Information System Health Facility Registry

services							
5.4 % of hospitals above the primary level having service of the geriatric ward		2015	Health Facility Registry	60	80	100	Programme Data Health Facility Registry
5.5 % of hospitals above the primary level having service for the people with disabilities		2015	NHFS	60	80	100	NHFS Programme Data Health Facility Registry
5.6 Number of target group people utilising the service from the social service unit of the hospital		2015	HMIS	100000	200000	250000	Programme Data HMIS
5.7 % of hospitals above the primary level having the availability of basic health service from the social service units to the people of the target group		2015	NHFS	100			NHFS Programme Data Health Facility Registry
5.8 % of hospitals and health		2015	NHFS	90	95	100	NHFS Programme

institutions with GESI friendliness							Data Health Facility Registry
5.9 % of tracer drugs with stock-out of below 5 %							
5.9.1 Province level		2015	NHFS	80	90	100	NHFS, LMIS
5.9.2 Local level		2015	NHFS	80	90	100	NHFS, LMIS
5.10 % of health institutions having availability of basic health care services to the marginalised, endangered communities, unreachable and remote areas from mobile and temporary health facility							
5.10.1 Province Level		2015	NHFS	70	80	95	NHFS
5.10.2 Local Level		2015	NHFS	70	80	95	NHFS
5.11 % of health insured families (premium paid by the government) of the target groups utilising the insurance service		2015	NHFS Health Insurance Information System	50	75	100	NHFS Health Insurance Information System

5.12 Equity gap between the % of pregnant women of target groups and the whole population utilising the delivery services		2016	NLSS NDHS	80	90	100	NLSS NDHS

6.8 Review and revision of the strategy

- a The implementation of the federal governance structure as set out in the Constitution, policy, and law-making efforts are on-going. Structural reforms including procedural arrangements at different levels are in also progress. In this context, there is the need to wait to witness the total implementation of this strategy. Therefore, when there exists a stabilised set up of policy, legal and structural systems at all levels of government, it will be necessary to harmonise the strategy with those set-ups. The strategy will be reviewed, and necessary revisions shall be made accordingly after two years of the implementation of this strategy.
- b This strategy shall endure as a dynamic document for five years from the date of execution. After five years of implementation, necessary review and revisions to the strategy shall be carried out based on the feedback received and the recommendations made by the GESI Steering and Coordination Committee of the MoHP. The MoHP shall ensure necessary coordination and harmonisation between the federal, provincial, and local levels by conveying the evaluation report of the strategy reviews for necessary actions to be carried out by the provinces and the local levels in an appropriate timeframe.

6.9 Provision to remove difficulties

If any difficulty in the form of obstacles, problems, or ambiguities arises in connection with the execution of this strategy, the GoN may, upon the recommendation of the MoHP, address and resolve such obstacles or problems or ambiguities on a priority basis. The GoN may interpret, add, amend, and make changes on the provisions of the strategy as and when required.