

Sectoral Perspectives on Gender and Social Inclusion



HEALTH

GENDER AND SOCIAL EXCLUSION ASSESSMENT 2011
SECTORAL SERIES: MONOGRAPH 4

Sectoral Perspectives on Gender and Social Inclusion

HEALTH

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Contents

Preface	v
Executive Summary	ix
Abbreviations/Acronyms	xiii
1. Introduction and Overview	1
2. Gender Equality and Social Inclusion: Making It Happen in Health	33
3. Checklist for Mainstreaming Gender Equality and Social Inclusion	67
Annexes	77
Bibliography	85
List of Tables	
1.1 Inclusive, Pro-poor, and Gender-responsive Percentages of Annual Budget of the Government of Nepal, 2009-2010	16
1.2: Summary Gender Equality and Social Inclusion Budget Analysis of Seven Sectors (Total of Program Budget), Including Direct and Indirect Contributions	17
1.3 Gender Equality and Social Inclusion Budget Analysis of Annual Programs, Kavre and Morang (%)	18
2.1 Gender Equality and Social Inclusion Budget Analysis of Annual Ministry of Health and Population Health Program	52
2.2 Gender Equality and Social Inclusion Budget Analysis of Annual Program, District Health Office Kavre and District Public Health Office Morang	53
2.3 Gender Equality and Social Inclusion in Existing Monitoring Proces	62
3.1 Analysis of Barriers	71
3.2 Responses to Exclusion	72
3.3 Monitoring and Evaluation	74
3.4 Roles and Timing in Monitoring	76
List of Figures	
1.1 Excluded Groups	4
1.2 Steps for Mainstreaming Gender Equality and Social Inclusion	5
1.3 Domains of Change	6
1.4 Diversity Profile of Civil Service Personnel in Seven Sectors	14
1.5 Diversity Profile of Civil Service Personnel by Level, Sex, Caste, and Ethnicity	15
2.1 Cultural, Religious and Social Values, Beliefs and Behaviors Shaped by Interlocking Gender/Ethnic Caste Based on Hierarchies	36
2.2 Diversity of Civil Personnel in the Health Sector	48
2.3 Diversity of Civil Personnel at Different Levels (%)	49

List of Boxes

- | | | |
|-----|---------------------------|----|
| 1.1 | What is a REFLECT circle? | 20 |
|-----|---------------------------|----|

List of Annexes

- | | | |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 1.1 | Definitions of Socially Excluded Groups | 79 |
| 1.2 | Step 1 Gender Equality and Social Inclusion Framework: Analysis of Policy, Institutional, Program, and Monitoring and Evaluation Barriers | 81 |
| 1.3 | List of Budgets Reviewed, FY 2009-2010, for Gender Equality and Social Inclusion Budgeting Covering 22 Programs and Annual Plans of Two Ministries | 82 |
| 2.1 | Proposed Sub-indicators for Gender-responsive Budgeting | 83 |
| 3.1 | Policy Analysis Format | 84 |
| 3.2 | Format for Disaggregated Diversity Profile | 84 |
| 3.3 | Program and Budget Analysis Format | 84 |

Preface

Background and Objectives of GSEA 2011/ Sectoral Series: Monograph 4

Gender equality and social inclusion (GESI) have been recognized by the Government of Nepal and its development partners as critical to equitable development. Particularly following the Second People's Movement (or Jana Andolan II) of April 2006, the efforts of the government, with the support of development partners, have been aimed at transforming the country into an inclusive and just state, with an eye to restructuring existing power relations to ensure the rights of all citizens, regardless of caste, ethnicity, religion, gender, region, age, or class. The Interim Constitution (2007) guarantees social justice and affirmative action for women, Dalits, Adivasi Janajatis, Muslims, Madhesis, and other excluded or disadvantaged groups. It also proposes the future restructuring of the state to institutionalize an inclusive, democratic and progressive governance system, maximizing people's participation based on devolution of power, and the equitable distribution of resources.

The Gender and Social Exclusion Assessment (GSEA), which was jointly produced by the World Bank (WB) and the UK Department of International Development (DFID), was delivered to the National Planning Commission (NPC) in June of 2005 and published in summary version in early 2006 as *Unequal Citizens: Gender, Caste and Ethnic Exclusion in Nepal*.

As a complement to the Gender and Social Exclusion Assessment, DFID, WB and ADB have collaborated to produce a series of mono-

graphs with practical guidance on how to mainstream gender equality and social inclusion in seven key service-delivery sectors: agriculture, education, forestry, health, irrigation, rural infrastructure (with an emphasis on roads), and rural and urban water supply and sanitation—to which additional sectors may be added in the future.

The current process of political transition provides a very significant opportunity for greater inclusion and equitable development. The Interim Constitution (2007) and the Three-Year Interim Plan (2008-2010) reflect commitments made for the social, political and economic transformation of Nepal. For the country's development partners, including DFID, WB and ADB, mainstreaming gender equality and social inclusion in their overall work is mandated by global and national agency directives.¹ For instance, in its country partnership strategy (2010-2014), ADB recognizes the need to “address gender, ethnic, and caste discrimination through policy reform, targeted investments, and the mainstreaming of equal opportunity measures in key sector investments”, and aims to guide and ensure that in all ADB operations and sectoral assistance, gender and social inclusion concerns are adequately addressed (ADB 2009). DFID's country business plan for Nepal states that, “Gender is at the heart of our work ... all our work considers impacts on women and girls.”² Efforts to promote gender equality and social inclusion are likewise an integral part of the World Bank's current interim strategy for

Nepal (World Bank, 2009) and the new strategy being developed.

In Nepal over the last few years there has been a growing practice of developing gender- and inclusion-sensitive interventions, especially in the government's sector-wide programs supported by multiple donors (e.g., Local Governance and Community Development Program [LGCDP], health, education and rural transport SWAs [sector-wide approach]). Various sectors have also developed their own GESI strategies (e.g., forestry, agriculture, health and local development). This Series attempts to provide coherence to GESI mainstreaming done by the government, donor agencies and other development actors, and to introduce a tool that can be commonly applied across sectors for mainstreaming in policies, programming, budgeting, monitoring, and reporting. The aim of the Series is to help make the Government of Nepal's goal of universal access to key public services and resources a reality for all Nepali citizens. A major focus has thus been on identifying the specific barriers faced by different groups and the resultant impact of those barriers; assessing policies, program modalities, and project mechanisms that have worked best to overcome these barriers; and identifying the measures that work best to mainstream GESI in sectoral programming.

Process of Developing GSEA 2011/Sectoral Series Monographs

Each of the sectoral assessments consisted of document review, meetings with sector specialists and stakeholders, diversity and budget analysis, some fieldwork, wider consultative workshops, and follow-up meetings. Meetings and interactions were held with more than 100 people from government, civil society, commissions, representative associations/organizations of excluded groups, and projects/programs. Sectoral consultation workshops with approxi-

mately 30 participants in each were organized with key stakeholders, namely, government, project/program staff, donor agencies, and representative organizations. Literature review was a major source of information for the development of these monographs; however, some fieldwork was also done by team members in selected districts.

Draft versions prepared by Greg Whiteside (health), Elvira Graner (education), Bijaya Bajracharya (agriculture/forests/irrigation), Jennifer Appave (water supply and sanitation), and Shuva Sharma (rural infrastructure/roads) were used as background information and built upon where possible. As the GESI framework began to emerge as an important way forward, ADB, DFID and the World Bank decided that the sectoral assessments should be structured around this framework so that practitioners using the monographs would become familiar with the approach. Due to its previous experience in the development and application of the GESI framework, the Human Resource Development Centre (HURDEC), a private management consultancy firm of Nepal, was commissioned by WB/DFID to lead the development of the sectoral series. Jennifer Appave was commissioned by ADB to work with the HURDEC team from January to June 2010 to prepare the drafts. The Swiss Agency for Development and Cooperation (SDC) provided technical support through two advisers.

The team members who prepared the different sectoral monographs in this series are as follows: 1) agriculture—Jennifer Appave and Chhaya Jha, with inputs from Yadab Chapagain and Yamuna Ghale (SDC); 2) education—Jaya Sharma and Chhaya Jha, with inputs from Yadab Chapagain (HURDEC); 3) forestry—Bimala Rai-Paudyal (SDC) and Chhaya Jha; 4) health—Chhaya Jha; 5) irrigation—Chhaya Jha and Jennifer Appave, with inputs from Pranita Bhushan and Yadab

Chapagain; 6) rural infrastructure—Chhaya Jha, with inputs from Kumar Updhayay (HURDEC) and Shuva Sharma; and 7) water supply and sanitation—Jennifer Appave and Chhaya Jha. Deepa Shakya and Sara Subba did the research for the sectoral monographs while Dharmendra Shakya and Ram Bhusal worked on the budget analysis and staff diversity analysis. Sitaram Prasai and Birbhadra Acharya (HURDEC) did the gender-responsive budget (GRB) assessment in Kavre and Morang districts. Carey Biron edited all the monographs except forestry, which was done by Mary Hobley. Chhaya Jha guided the entire process, and was responsible for the final writing of all the monographs under the guidance of Lynn Bennett, the lead researcher for GSEA.

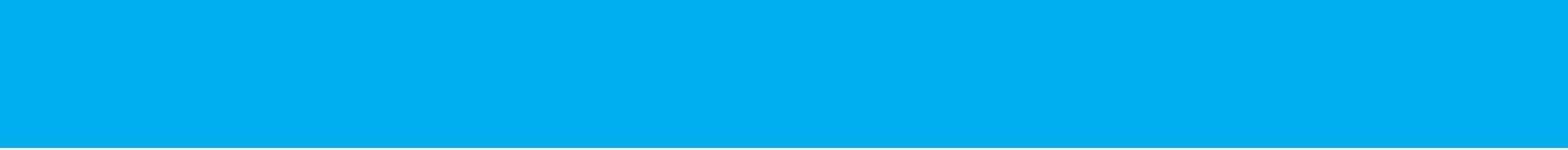
The Sectoral Series Monograph would not have made it to their current published form without the diligence and creativity of the Himal

Books team responsible for the final editorial and design support. Led by Deepak Thapa, the team included Amrita Limbu (editorial assistance) and Chiran Ghimire (layout and design).

The monographs in this series should be considered as learning documents that will allow for sectoral data and analysis to be updated and improved based on sectoral experiences and sharing of good practices. The monographs in this series all have a common introduction and a common final chapter outlining the generic steps in the GESI mainstreaming process which is intended as a handy reference guide for practitioners. The sectoral monographs have been published in alphabetical order, covering agriculture, education, forest, health, irrigation, rural infrastructure (roads), and rural and urban water supply and sanitation. Additional sectors will be included over time.

Notes

- 1 For the World Bank, the gender-mainstreaming strategy (2001) and operational policy and Bank procedures statement (2003) provide the policy framework for promoting gender issues as part of strategically focused analytical work, policy dialogue and country assistance (World Bank 2006). The policy on gender and development (1998), Strategy 2020, and ADB results framework articulate ADB's commitment to gender, and require that gender inequalities be addressed in all aspects of ADB work (ADB 2010). The principal elements of DFID's gender policy and strategy are contained in DFID (2000, 2002). A "twin-track" approach based on mainstreaming of gender issues in all areas and sectors, while maintaining a focus on the empowerment of women as a disadvantaged group, has been adopted (Jensen et al, 2006).
- 2 The UK government's program of work to fight poverty in Nepal, 2009-2012.



Executive Summary

The purpose of this chapter is twofold. First, it assesses the current situation of gender equality and social inclusion (GESI) in Nepal's health sector. It identifies the barriers faced by women, the poor and the excluded in accessing health services; considers the policy, legislative and social barriers constraining these groups' access; and analyzes how the various policies, processes and programs have worked to address them. Second, it provides practical guidance on how to improve existing responses and take further action to ensure more equitable access to health services and benefits for women, the poor and the excluded.

The health sector has made immense efforts to improve the health outcomes of Nepal's citizens, and has responded positively to the mandates of inclusion through its pro-poor and pro-women programs. While the Nepal Health Sector Program—Implementation Plan (NHSP-IP) 1 (2004–2009) did not initially have a strong focus on equality and inclusion, this was somewhat addressed after the Interim Constitution of 2007 declared health to be a fundamental right. Since 2007, the government's initiatives of pro-poor targeted free healthcare policies, coupled with a program for maternity services, have seen considerable success in reducing both the economic constraints of the poor and the social constraints of women, while improving the health indicators of both. These schemes provide free services and medicines, cash for transport for institutional childbirth delivery, and remuneration for health workers attending home deliveries. The

recently developed NHSP-IP 2, with strong support from sector-wide approach partners, has likewise recognized the barriers experienced by women, the poor and the excluded, included a specific objective to address them, and put in place impressive plans with disaggregated objectives and indicators. A GESI strategy for the health sector has been included in the NHSP-IP 2, in which three objectives and eight strategies address policy, institutional and programmatic issues, outlining actions ranging from policy revision, training and insurance to information, education and communication (IEC) and empowerment. However, further specific guidance on how these will be implemented and what funding will be earmarked for these activities is necessary to translate the GESI document into effective mainstreaming.

Lessons from multiple initiatives and program interventions have suggested that the traditional model of targeted service delivery for disadvantaged groups will not be adequate to improve health outcomes for all social groups. Apart from economic factors, the barriers experienced by women, the poor and socially excluded groups comprise social factors such as gender, caste, ethnicity, disability, location and age along with regional identity. These greatly influence who accesses what health-related services. Gender-based social practices directly impact health outcomes for women and girls of all social groups (though the degree varies by multiple factors), with the discriminatory nature of Nepali society greatly hindering a woman's ability to access

health services and protect herself from sexually transmitted diseases, even from her husband. This same dependency and various cultural practices also make women and girls vulnerable to gender-based violence (GBV), which remains widespread in Nepal. Alarming, suicide has emerged as the single leading cause of death among women in Nepal aged 15-49.

Excluded groups, too, continue to experience many problematic health-related issues. Survey data from 2006 show that Dalits, disadvantaged Adivasi Janajatis, Madhesis, other backward classes (OBCs) and Muslims have consistently low health indicators, including stunting among children and higher vulnerability to multiple communicable diseases. With specific regard to HIV/AIDS, it is important to note a strong correlation with migration, as Nepal's 1.5-2.0 million labor migrants account for 46% of the country's HIV-positive population. While three surveys from 1996 to 2006 indicate that there has been a decrease in the difference between wealth groups for several indicators, wide disparities still exist. Although the poor suffer higher rates of mortality and morbidity, the richest fifth of the population spend 25 times more than the poorest on health-care utilization. For many, healthcare services are inaccessible due to distance, unaffordable due to poverty and high costs (though free services have addressed this somewhat), unapproachable due to social/power relations, incomprehensible due to language barriers, humiliating due to cultural insensitivity, and ineffective due to poor quality. Thus, along with technical services, a demand-side approach is required—one that focuses on empowering individuals and groups to recognize the structural causes of their situations and building their capacity to transform inequitable power relations.¹

At the same time, attention to the supply side needs to continue. For instance, while the use of free health services by excluded groups has

increased, availability of drugs declined, with stock-outs of essential drugs lasting more than one week increasing at all levels—by up to 96% at hospitals and primary healthcare centers. Further, a study in 10 district hospitals revealed that most users, especially the poor, remained unaware of the free care policy, to the point where many poor registered as non-poor and thus paid fees. Meanwhile, absence of trained health personnel, distance to health facilities, and discriminatory behavior of service providers continue to be significant constraints for those experiencing exclusion. Additional barriers include lack of caste/ethnic diversity among community-level health workers (of the 19,597 government employees in the health sector, just 29% are women, while 53.0% are Hill Brahmin/Chhetri, 1.7% Dalits, and 0.8% Muslims) and inadequate decentralized authority to health facility management committees.

Since 2002, some 1,433 out of 4,070 health facilities in 28 districts have been handed over to local bodies. Yet, while local committees are responsible for overseeing the functioning of health staff, they still have inadequate authority and resources to work effectively. While government initiatives to make budgeting and monitoring more inclusive are to be appreciated, much remains to be done. For instance, gender-responsive budgeting practices have been initiated, but insufficient clarity about the indicators and the process to be followed has created confusion. Similarly, for the pro-poor and inclusive categories, figures for activities are cited in the government's annual budget speech but local health facilities are not engaged in identifying them. On the positive side, initiatives to disaggregate monitoring systems and practice accountability mechanisms (such as social audits, peer monitoring, partner-defined quality) have proven useful in increasing the accountability of service providers and community empowerment. On the

negative side, key sector-specific issues, including human resource management, delays in medicine supply, poor governance and low accountability, continue to require committed and systematic interventions.

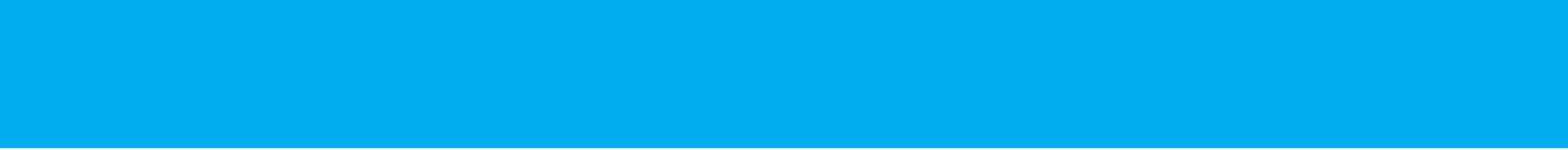
A major part of supply-side strengthening will need to be based on an improved understanding among policy-makers, administrators and care-givers of the specific barriers experienced by different social groups. Gender inequality and social exclusion in health are inextricably linked to the wider socio-cultural and politico-economic context. Often the “barriers” we need to remove or work around in order to provide more equal access to health are part of interconnected formal and informal institutions that structure Nepali society. The process of identification of “formal” and “informal” barriers will have to be followed by a subsequent commitment to develop, budget for and implement mechanisms to overcome these. A well-governed sector—ensuring timely availability of supplies and services, with

trained staff performing effectively—will indeed improve the access of women, the poor and the excluded to services, but this can only happen if focus on the supply side leads to building the capacity of the health delivery system to make it more responsive and accountable to those it serves. Multi-sectoral partnerships are also very necessary in health as many issues demand action from sectors like education, water supply and transportation.

The multiple levels of analysis and review in this chapter have provided the inputs for further operationalization of gender equality and social inclusion in the health sector. It is only through action that addresses the full spectrum of GESI throughout the program cycle—identifying barriers; designing, budgeting and implementing solutions to address these barriers; and monitoring and reporting with disaggregation and inclusion-related analysis—that the vision of equitable health outcomes for all Nepali citizens can be achieved.

Note

- 1 As demonstrated by the changes brought about by interventions addressing socio-cultural behavior and REFLECT processes in communities by programs like DFID’s Equity and Access Programme, and others by UNFPA, NFHP, and the USAID, CARE and GTZ/GIZ.



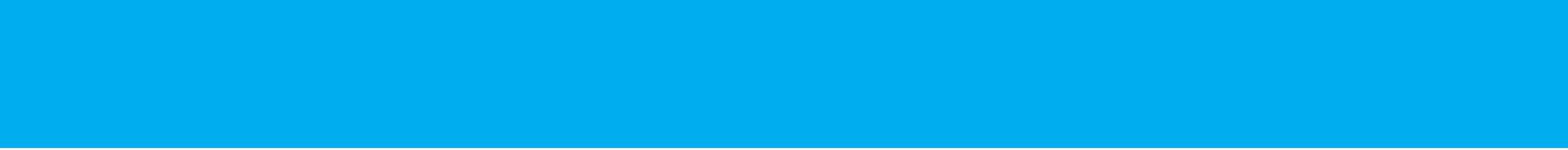
Abbreviations/Acronyms

AAMA	Action Against Malnutrition through Agriculture
ADB	Asian Development Bank
ANM	Assistant Nurse Midwife
ARV	Antiretroviral
COPE/PLA	Client Oriented Provider Efficient/Participatory Learning and Action
DDC	District Development Committee
DFID	Department for International Development
DHO	District Health Office/District Health Officer
DHS	Department of Health Services
DIDCs	District Information and Documentation Centres
DPMAS	District Poverty Monitoring and Analysis System
e-AWPB	Electronic Annual Work Planning and Budgeting
EDPs	External Development Partners
FCHVs	Female Community Health Volunteers
FY	Fiscal Year
GBV	Gender-Based Violence
GESI	Gender Equality and Social Inclusion
GMCC	Gender Mainstreaming Coordination Committee
GRB	Gender-Responsive Budget
GSEA	Gender and Social Exclusion Assessment
GTZ/GIZ	German Technical Cooperation/Agency for International Cooperation
HFMCs	Health Facility Management Committees
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HSIS	Health Sector Information System
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IPC	Integrated Planning Committee
LFP	Livelihoods and Forestry Program
LGCDP	Local Governance and Community Development Program
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MIS	Management Information Systems
MLD	Ministry of Local Development

MMMS	Maternal Mortality and Morbidity Survey
MNH	Maternal and Neonatal Health
MOAC	Ministry of Agriculture and Cooperatives
MOF	Ministry of Finance
MOFSC	Ministry of Forest and Soil Conservation
MOHP	Ministry of Health and Population
MWCSW	Ministry of Women, Children and Social Welfare
NDHS	Nepal Demographic and Health Survey
NFHP	Nepal Family Health Program
NHSP	Nepal Health Sector Program
NHSP-IP	Nepal Health Sector Program-Implementation Plan
NLFS	National Labor Force Survey
NLSS	National Living Standards Survey
NPC	National Planning Commission
NPCS	National Planning Commission Secretariat
NSCFP	Nepal Swiss Community Forest Project
OBCs	Other Backward Classes
PDQ	Partner-Defined Quality
PLHIV	People Living with HIV and AIDS
PMAS	Poverty Monitoring and Analysis System
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHDP	Rural Health Development Program
SBA _s	Skilled Birth Attendants
SDC	Swiss Agency for Development and Cooperation
SSMP	Support to the Safe Motherhood Programme
SSRP	School Sector Reform Program
SSU	Staff Security Unit
SWAp	Sector-Wide Approach
TFR	Total Fertility Rate
UMN	United Mission to Nepal
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VAWG	Violence against Women and Girls
VCDP	Vulnerable Communities Development Plan
VDC	Village Development Committee
WB	World Bank
WDO	Women's Development Officer
WSS	Water Supply and Sanitation

CHAPTER I

Introduction and Overview



1.1 Introduction

This introduction and overview chapter defines the dimensions of exclusion and presents the framework for gender equality and social inclusion (GESI) mainstreaming that has been used for all the sectoral monographs. It presents an outline of the current situation of gender equality and social inclusion in Nepal, and summarizes the findings of the seven sectoral monographs. It presents the barriers that have been identified for women, the poor and the excluded, and discusses the national, international and sectoral policy mandates for GESI, the institutional structures and mechanisms established by the government for women and excluded groups, the sectoral findings regarding institutional arrangements for GESI, the diversity of civil personnel in the various sectors, and the working environment. It summarizes the findings regarding the existing practice of gender-responsive budgeting (GRB), the results of GESI budgeting that was applied in the seven sectors, and the monitoring and evaluation (M&E) system in use. The good practices, lessons learned and way forward for the sectoral monographs are also summarized.

1.2 Gender Equality and Social Inclusion Framework and Defining the Excluded

For the last 60 years, since the 1951 overthrow of the Rana regime, Nepal has been struggling to transform its feudal economic and political system, and to leave behind the ingrained hierarchies of gender and caste. But these deep-seated systems for organizing the world and structuring power relations do not change easily. Despite formal laws that guarantee equal treatment to men and women as well as to Dalits, Tharus and Brahmins, to Madhesis and Paharis, and to Hindus, Muslims and Christians, many of the old habits of thought and daily behavior endure. The vulnerability

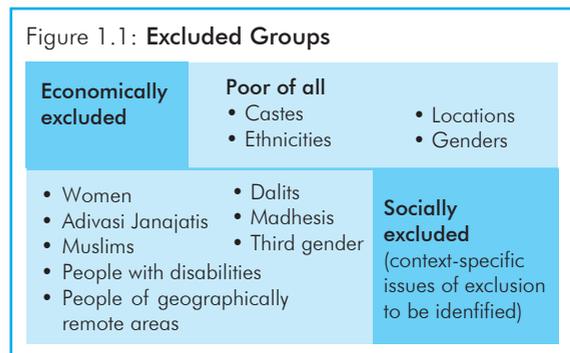
and dependency of women are persistent in a patriarchal culture where, despite the fact that their labor was critical to the subsistence agricultural economy, women were little valued, did not inherit family land, and could be cast out if the husband favored a younger wife.

Persistent too is the chronic poverty of groups such as the Dalits at the bottom of the caste hierarchy, who, in addition to the humiliation of being considered “impure” and therefore “untouchable,” have faced structural barriers to education and economic opportunities for generations. The Adivasi Janajatis, or indigenous groups in Nepal, most of whom were subdued some 250 years ago during the Gorkha conquests, have also found themselves placed within the Hindu caste hierarchy. Because of their numbers (37% of the population) and their military prowess, Adivasi Janajatis were given a place in the middle of the hierarchy rather than at the bottom, as they were in India. Ironically, even though it was a system imposed on them by outsiders, to preserve their own status in the hierarchy many Janajati groups adopted the same discriminatory behavior towards Dalits as that practiced by the “high-caste” rulers. Similarly, even the caste Hindus in the plains, or Madhes, of Nepal were looked down upon and treated as foreigners when they visited Kathmandu, the capital of their own country.

The list of grievances is long and groups that have been historically excluded are many in Nepal. As development practitioners and sectoral specialists, we need to know at least something of this historical and cultural context, so that we can design sectoral interventions in ways that are sensitive to the dense systems of exclusion that often still prevail in the communities where we hope to deliver services, infrastructure and livelihood opportunities. Our goal in this publication is to show how it is possible to design and implement the interventions we support in

ways that bring equal benefit to men and women from all these groups.

This monograph is concerned with two major dimensions of exclusion: economic and social. As shown in Figure 1.1, when it comes to poverty, or economic exclusion, we are concerned with the poor of *all* castes, ethnicities, locations and sexes.



The socially excluded¹ groups include women, Dalits, Adivasi Janajatis, Madhesis, Muslims, people with disabilities and people from geographically remote areas. What we also need to keep in mind is that the dimensions of exclusion are cross-cutting and cumulative. Some of our clients suffer some dimensions of exclusion but not others—for example, a poor Brahmin woman from Gorkha Bazaar is privileged in terms of her caste and her fairly well-connected location, but excluded by her poverty and gender. Other clients suffer from exclusion in almost all dimensions: for example, a poor Dalit woman in Jumla must contend with four dimensions—poverty, caste, gender and remoteness—of exclusion. The fact that these dimensions all interact with each other in different ways to frame the life chances of the different individuals we are trying to reach is why we need to look at exclusion in a holistic way. This is particularly true for gender, as prior efforts have taught us that it is far less effective to target gender and social inclusion separately. Further, looking at men’s and women’s realities is not enough—it is also necessary to ask “which women” and “which men.”

As will be elaborated in greater detail throughout this series, it is essential for each sector to define who the excluded in that sector are and the cause of their exclusion. The GESI framework² that is used for the sectoral monographs recognizes that both *formal* institutions (the legal framework, the policies of the sectoral ministry or even the specific procedures and components laid out in the formal project document) and *informal* institutions (the traditional norms of behavior for women and Dalits or the networks of political patronage) can present barriers to inclusion. Therefore, we keep an eye out for both of these dimensions throughout the GESI process.

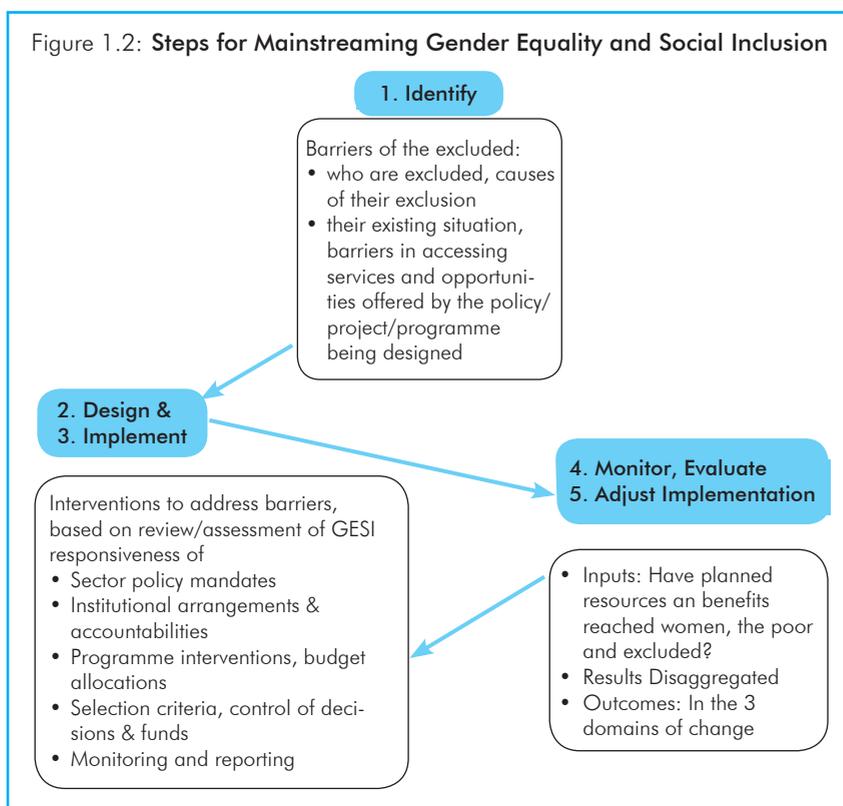
The framework follows five key steps required to mainstream GESI in sectoral programming (visualized in Figure 1.2):

- i. identifying the excluded and the reason for their exclusion from access to services and opportunities in the sector;
- ii. designing policy and/or program-level responses that attempt to address the barriers in the program cycle;
- iii. implementation;
- iv. monitoring and evaluation to check whether planned resources and actions have reached women, the poor and the excluded; and (if M&E findings show the need)
- v. adjustment/redesign and continued M&E.

First step: Identification. This requires mapping the existing status of women, the poor, and the socially excluded in the sector, based on disaggregated qualitative and quantitative data and assessment of the available evidence. Analysis of existing policies (in the sector and beyond since policies in other sectors may also be blocking access), formal institutional structures and processes, and informal institutions (kinship, gender, caste systems and business and party net-

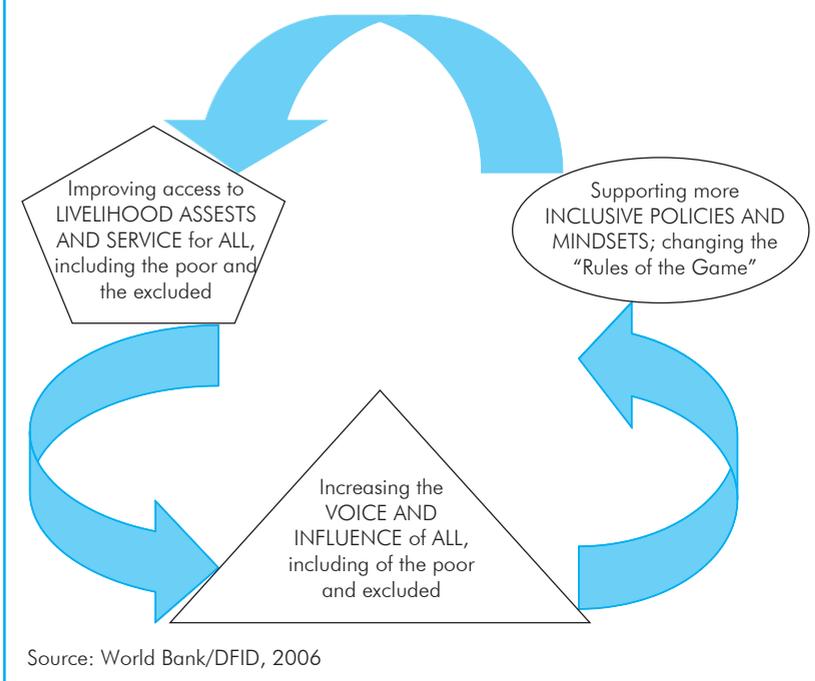
works) is necessary to understand exactly how social inequities based on gender, caste, religion, ethnicity and location have been created and/or maintained. The key actors in these existing structures also need to be critically assessed in terms of their ability (and incentives) to change their behavior and values, and to transform processes and mechanisms.

In addition to assessing the barriers constraining each group from enjoying their rights, we need to map existing policy and program responses (if any), and assess whether these are addressing, reducing or reinforcing these barriers (see Annex 1.2 for details). As we begin the design process, the situation prevailing in the sector—the set of policies and formal and informal institutions in place—will almost certainly be benefiting some individuals and groups more than others. Thus, we need to understand the political economy of the sector or subsector both nationally and locally in the sites³ where our projects or programs will be implemented. The stated intention of policies and procedures will always be positive and aimed at delivering services and benefits to all, but how do the policies work out on the ground for different groups? Do they deliver as intended; if not, what is intervening to prevent or change the intended outcomes? Usually, it is merely gaps in the delivery or communications systems that have been set up, or failure to understand the real needs of certain kinds of consumers, or other economic or social constraints that are preventing them from accessing the sector services. Either way, this is the detective work that needs to be done during the first step of the GESI process.



Second and third steps: Design and implementation. Once the sociocultural barriers and weaknesses in the policy framework or delivery system are understood, the job is to find ways to address these through interventions. This may require changes in policies, program activities, resource allocations, institutional arrangements and staff incentives as well as in the monitoring and reporting systems. Some things are easier to change than others and a single operation might not be able to make all the changes needed to respond to the diagnosis provided by Step 1. But even the larger, more intractable issues should be fed into the policy dialogue with government and other donors and be part of the longer-term sector strategy. At a minimum, *policies* need to be put in place that provide for the budget, processes (including stakeholder participation in the design) and systems needed to incorporate GESI mainstreaming into the operation under design. *Institutional arrangements* must also establish

Figure 1.3: Domains of Change



structures and mechanisms for routine work on gender and inclusion by technically competent individuals; promote diversity in staff composition; and adopt sensitive human resources policies for recruitment, promotion, transfer and performance evaluation.

To design a project or program so that it will be able to deliver real change and lasting progress for women, the poor and the excluded, it is useful to consider the content presented in Figure 1.3, which lays out three domains where change can happen. These are also domains that define exclusion and inclusion, and most projects and programs include activities in one or all of these areas. One important domain is access to assets and services (i.e., health, education, and employment opportunities), which almost all of our interventions seek to increase. What does your intervention need to do to make sure that access is open to excluded groups, and that you can track it?

The second domain has to do with *voice and*

influence. In Nepal, group-based projects and what the World Bank calls community-driven development approaches place a great deal of emphasis on organizing communities to manage resources, deliver services and construct infrastructure themselves. The way groups are formed, the depth of the social mobilization process and the level of effort to bring in people from excluded groups and give them genuine voice and influence over the group processes constitute another area where good design and careful implementation and monitoring can make a major difference. The final domain where our sector operations can make a difference is through *changing policies, institutional structures, and norms* (i.e., the “rules of the game”),

when intentionally or unintentionally these work against the interests of excluded groups. As noted above, not every operation can do this at the national policy level; but if our analysis has revealed that certain policies are perpetuating the exclusion of certain groups from the benefits our sector operation intends to deliver, then we need to be on the lookout for opportunities to get such policy changes on the agenda, and to push for their adoption. Often, even smaller project-level policies and procedures that are easier to influence can bring about important changes.

Nepal’s weak implementation capacity means that even positive policy provisions are often not implemented effectively. Meanwhile, informal norms, social practices, values and biases of officials and service providers from dominant groups continue to hamper the implementation of measures that seek to transform power relations. Thus, implementation processes need to be designed in such a way as to provide space for service providers, local leaders, men and others

who hold power to reflect on and internalize the need for such shifts. This long-term design-and-implementation commitment to gender equality and inclusion-related activities is an essential element of mainstreaming GESI, and it requires a clear commitment from the management level to this way of doing business.

Final steps: Monitoring, evaluation, and reporting. M&E systems need to be designed to collect disaggregated data on outputs, outcomes and development results, and to be linked into management decision-making in such a way that data on inclusion failures automatically trigger project actions to understand and remedy the situation. At the output level, management should be able to ensure that the planned project resources and actions have reached women, the poor and the excluded. Yet, disaggregated intermediate outcomes also need to be tracked, such as the socioeconomic profile of user groups and executive committees, labor groups, pregnant women receiving antenatal visits, school attendance, new teachers hired, the placement of water taps, etc. Finally, disaggregated data on development results need to be collected and analyzed. This may be done by the project, but in some cases with the right coordination it can also be done by periodic national-level sample surveys such as the National Living Standards Survey (NLSS), the Nepal Demographic and Health Survey (NDHS), or the National Labor Force Survey (NLFS), or through the decennial census. Indicators of results at this level include, for instance, the time required to reach an improved water source or motorable road, primary-school completion rates, child mortality, increase in agricultural-based income, etc. In all of this, reporting formats need to capture disaggregated information about outputs, outcomes and results for different social groups, and the processes that linked them. Refer to Chapter 3 for a checklist for mainstreaming GESI.

1.3 Current Situation of Gender Equality and Social Inclusion in Nepal

Gender issues have been addressed during the past few decades of Nepal's planned development. Yet, it is only more recently that social inclusion has entered the development discourse, leading to recognition of other dimensions of exclusion in addition to gender.

1.3.1 Sector-wide barriers for women, the poor and the excluded

Each of the sectoral monographs in this series demonstrates that economic, political and socio-cultural institutional barriers exist for women, the poor and excluded groups, restricting their access to assets, services and opportunities to exercise their voice and influence. Women's access to assets and resources has improved considerably through many targeted programs while affirmative action strategies have helped to increase their representation in user groups and committees in all sectors. Forest and water supply and sanitation have been the most commendable sectors in promoting women's membership and participation, yet the operational space for women to voice their issues and exercise their agency remains strongly restricted by societal rules/norms/beliefs that continue to define how women are valued and what they can or cannot do (World Bank/DFID 2006). The sectoral monographs all show that women's ability to make decisions and benefit from accessing resources and services (e.g., to take care-seeking decisions when ill, to allocate time for attending community meetings, and to engage in livelihood activities) is often shaped by gendered norms and practices. Thus, along with changing discriminatory formal laws and policies, change must also take place in the home and family sphere in order to effectively address the barriers women face.

Government initiatives to promote an inclusive

public sector through, for example, free education and healthcare services have helped to increase access for the poor. However, the need to meet their daily subsistence needs, low literacy skills, and poor access to information about services and available resources limit the poor from benefiting fully from these programs. Further, self-exclusion of the very poor from group-based community development activities is common due to lack of time to contribute as well as lack of agency to influence decisions. Since so many services and opportunities flow through groups, this self-exclusion further reduces the access to resources and livelihood opportunities of those most in need. Similarly, the high opportunity costs incurred in the initial stages of group formation, with benefits uncertain and only coming later, also restrict the membership and participation of the very poor in user groups and committees.

Geographic location is a key determinant of exclusion across all sectors, influencing the level of access to public services such as schools, health posts, agricultural extension agents and finance institutions. For example, 38% of Janajatis in the hill regions have no access to a health post within an hour's walk. The lowest life expectancy (44) is found in the mountain district of Mugu, compared to 74 in Kathmandu. Only 32% of households in Nepal can reach the nearest agriculture center within a 30-minute walk, and only 28% can reach the nearest bank in that time. A significant part of the problem is that the government lacks the human resources necessary to deliver services or offer effective outreach to the remotest communities—and the available government staff are often reluctant to serve in remote areas, and thus find informal ways to avoid such postings. This is compounded by the dismissive attitude of many providers towards women, the poor, and the excluded.

Caste-based discrimination and untouchability remain a major barrier for Dalits in accessing

services, resources and assets, and in their ability to have voice and influence in decision-making processes. This is particularly so in accessing drinking-water facilities due to the traditional Hindu belief that Dalits are “impure” and will pollute a water source. Similarly, the low development outcomes in education (e.g., the illiteracy rate for Madhesi Dalit women is over 85%) and health (e.g., Madhesi Dalit women also have the lowest health indicators) are a result of a combination of factors, including poverty, lack of awareness and the discriminatory attitudes and behavior of non-Dalits towards Dalits (Bennett, Dahal and Govindasamy 2008).

For Adivasi Janajatis, language and issues around their cultural rights are the most significant barriers to accessing resources and benefiting from services. These are compounded by the low access of the most disadvantaged Adivasi groups to information on available development resources and procedures. Muslims and some Madhesi groups, especially women within these groups, face linguistic and sociocultural barriers that affect their level of mobility and ability to access services and participate in the public sphere. Although there is greater awareness of the needs of people with disabilities, this group continues to face social discrimination with virtually no disability-friendly services and facilities available, especially in rural areas.

1.3.2 Policy and legal framework for GESI

This section⁴ discusses the GESI policy framework and mandates at the international, national, and sectoral levels.

National mandates for GESI

Positive provisions in parliamentary declarations, the Interim Constitution (2007), the Three-Year Interim Plan (2008-10), and Nepal's ratification of various international instruments, including the International Labour Organisation (ILO)

Convention 169 on Indigenous Peoples, establish the fundamental rights of women, protect the cultural rights of Adivasi Janajatis, declare untouchability a legal offence, protect the rights of children and establish the rights of the poor, people with disabilities, Muslims and Madhesis.

The Local Self-Governance Act, 1999, empowers local bodies and has made them more accountable, particularly for local development activities. It directs local bodies to formulate their plans with the active involvement and participation of local people, focusing on the special needs of the poor, and mandates 20% representation of women on village and ward-level development committees. But these provisions do not address issues of inequity and vulnerability caused by gender, caste or ethnicity. The Local Self-Governance Regulations have provided for the inclusion and prioritization of the poor and the excluded in development activities. At the district development committee (DDC) level, however, the regulations make no distinct provision for the social and economic promotion of the poor and the excluded in the duties, roles and responsibilities of the DDC. However, the DDC can form subcommittees to address the needs of women and the disadvantaged by including members from nongovernmental organizations (NGOs), community-based organizations and civil society, and other experts.

The Gender Equality and Social Inclusion Operational Strategy (2009) of the Local Governance and Community Development Program (LGCDP) of the Ministry of Local Development (MLD)⁵ has provisioned for the informed participation of citizens, including women, the poor and the excluded, in local governance processes, and for capacity building of the Ministry's structures for mainstreaming GESI. It has established mechanisms of ward and village citizens' forums and GESI implemen-

tation committees in DDCs, and identified the roles and responsibilities of the GESI section of MLD. The DDC expanded block-grant guidelines to make a direct 15% budget allocation for women and 15% for people from excluded groups at the district level. The Village Development Committee Grant Operation Manual directs 5% for poor women, 5% for poor children and 10% for other excluded groups in village development committees (VDCs) and municipalities. The manual has also provided for integrated planning committees at the VDC level, with inclusive representation from Dalit, Janajati and women's organizations, from NGOs working in the VDCs, school management committees, social organizations, political parties, and line agencies. It directs that 33% of members must be women. (This is only a sample of provisions that are positive from a gender and inclusion perspective, as several others exist as well.)⁶

International commitments

Nepal has ratified as many as 16 international human rights instruments, including international conventions and covenants on women (United Nations [UN] Convention on the Elimination of Discrimination against Women, Beijing Platform of Action), child rights (UN Convention on the Rights of the Child), indigenous people's rights (ILO Convention 169), and racial discrimination (UN Convention on the Elimination of Racial Discrimination). It has committed to international agreements on targets (Millennium Development Goals) set for women's empowerment, education, drinking water and sanitation, health, hunger and poverty. Nepal has also agreed to UN Security Council Resolution 1325 that establishes legal standards governing the protection of women during conflict, their participation in peace and security processes, and their protection against multiple forms of violence.

Sectoral policies: Gender equality and social inclusion policy provisions in the seven sectors

From our review, we find that commitments to GESI and progressive policy mandates have been made across the seven sectors, albeit to varying degrees. Revisions in policies have allowed programs addressing access to services for specific groups to be developed and implemented—for instance, free primary education, scholarships for girls and Dalits, multilingual education, incentive schemes for out-of-school children, universal and targeted free healthcare, safe delivery incentive schemes, quotas for women in community groups established by all the sectors, agriculture-related subsidies for the excluded, subsidies for poor households to build latrines, and so on.

SWAp (sector-wide approach) is increasingly being followed in Nepal, allowing for donor harmonization and more concerted efforts to address gender and inclusion issues. SWAps in health, education, and transportation—the Nepal Health Sector Program-Implementation Plan 2 [NHSP-IP 2] (2010-2015), School Sector Reform Program (SSRP) (2009-2015), and rural transportation infrastructure SWAp, respectively—have directives to address barriers experienced by women, the poor and the excluded. The NHSP-IP 2 includes a specific objective to address sociocultural barriers, a reflection of the government’s shift to recognizing the need to address deeply embedded social norms and practices that affect health outcomes. GESI strategies have been included in the NHSP-IP 2, and strategies have been prepared for the agriculture and forest sectors though these have not yet been implemented.

Policies shifting control from centralized agencies to VDC-level community-based committees (school and health facility management committees) have increased the chances for women and the excluded to participate in decision-making. Yet, there is room for improvement: both of

these could contribute more effectively if representatives from excluded groups were to be selected by their own communities,⁷ if mechanisms were available for more inclusive representation to influence decisions, and if there were better monitoring by the relevant authorities. Policy provisions for representation of women and the excluded in user groups and committees, with specific guidance for representation in post-holding positions, have also become a well-established practice. The rural water supply and sanitation (WSS) national policy, for instance, has a mandate of 30% of women in user groups and committees, while for Dalits and Janajatis, too, there are provisions for representation (e.g., in health facility operation and management committees, farmer groups, road-building groups, water supply users’ committees, and water users’ associations). The more technical infrastructure sectors, such as WSS, rural roads and irrigation, have recognized the role women have in the operation and management of these sectors and have developed policies that promote their participation, especially in the construction and management phases. But policy development is weaker in ensuring that women, the poor and the excluded have voice and agency in local-level decision-making processes and has not effectively addressed the role that political and elite capture often has in influencing access to and utilization of resources and benefits in these sectors.

Policies for public and social audits adopted by many sectors (health, WSS, rural roads) are to be appreciated as these increase downward accountability of service providers. Implementation of these audits, however, remains problematic as does the risk of their becoming just another donor requirement with no repercussions if they are not properly carried out. Thus, it is important to have the participation of all excluded groups, follow-up to address any query that may arise

from the audits, and monitoring to ensure that full and correct processes are being implemented. Many policy revisions have focused on improving access to resources and services, but without addressing the structural issues that cause the exclusion of these groups. Thus, for example, the Agriculture Perspective Plan, the overarching policy framework guiding the agriculture sector, ignores key land-specific issues, and instead deals primarily with how to increase immediate production outputs rather than with strategic and structural issues related to resource management, governance and structural agrarian reform. In the forest sector, positive provisions are being increasingly implemented in community forestry, which has become more GESI responsive. But there is no recognition by decision makers that 75% of the national forests are barred to civilians—any use is illegal and punitive action is normal, impacting primarily on women, the poor and the excluded.

Almost all sectors provide specific support to women but efforts to address the structural causes of gender-based discrimination are almost nonexistent. Only very recently has the government developed a national plan of action on gender-based violence, with the health sector recognizing violence against women and girls as a public health issue. But these aspects are not integrated in the policies developed in other sectors—for instance, the seed policy in the agriculture sector is considered liberal, but does not recognize that seed transactions are male dominated, and by men of higher-income groups. Similarly, in the forest and WSS sectors, affirmative action policies are in place to ensure the representation of women on user group committees, but gendered norms and roles of women limit the actual level of participation, voice and influence they have in these forums. Indeed, many gender-focused policies have concentrated primarily on increasing representation of women in community-level

bodies and increasing access to sectoral resources, with far less recognition of the structural issues of division of labor, including the implications of gender-specific responsibilities of childcare, breast-feeding and taking care of the ill. There are almost no policies that provide women with sufficient support to manage such responsibilities alongside professional growth.

In no sector have government agencies clearly defined who constitute the “excluded,” and the interchangeable use of terminology denoting the “excluded,” the “disadvantaged” and the “marginalized” creates confusion. There are provisions for women, Dalits and Janajatis (e.g., for scholarships, representation and access to funds), who have thus been recognized as excluded groups, but there is hardly any mention of other excluded groups (e.g., Muslims, other backward classes, or OBCs, and Madhesis) or effort to address the causes of their exclusion. There are only a few sectoral policies mandating sex- and caste/ethnicity/location-disaggregated data and analytical evidence for monitoring. For example, the education and health sectors’ management information systems (MIS) have limited disaggregation though a pilot for reporting caste/ethnicity-disaggregated data is ongoing in health. The forest sector’s recently revised MIS incorporates GESI-sensitive indicators, but these still need to be implemented. However, positive examples and initiatives do exist in several programs—e.g., in the forest sector, the Livelihoods and Forestry Program (LFP) has established livelihoods and social inclusion monitoring, which not only demands disaggregated data but also analysis at outcome levels for different social groups.

The personal commitment of policy-makers to GESI is clearly an important influence on both the quality of the policies and the seriousness with which they are implemented. It is also critical to find and convince other important players in each sector, not only through training, which builds

knowledge, but by other means that build understanding and increase the internalization of equality, inclusion and social justice principles. A major part of this will need to be based on an improved understanding among policy-makers, administrators and sector employees of the specific barriers preventing different social groups from accessing and using services and resources as well as a commitment within the respective sectors to develop, budget, implement and monitor mechanisms and processes to overcome these barriers.

1.3.3 National and institutional mechanisms for gender equality and social inclusion

The government has created various institutional mechanisms and structures over the years to address gender and inclusion issues, from the central to the district and VDC levels.

Central level

The National Planning Commission (NPC) has a Social Development Division responsible for addressing women's empowerment issues. NPC's Agriculture and Rural Infrastructure Development Division has the responsibility to work on social inclusion. The Ministry of Women, Children and Social Welfare (MWCSW) has been implementing women-focused programs targeted at reaching disadvantaged and marginalized groups such as children, senior citizens and people with disabilities. Through its Department of Women's Development, the Ministry has women's development offices in 75 districts managed by Women's Development Officers (WDOs). MLD, responsible for social inclusion, has a Dalit and Adivasi Janajati coordination committee under its mandate, while the establishment of the National Dalit Commission, National Women's Commission and the National Foundation for the Development of Indigenous Nationalities has aimed to increase the participation of women, Dalits and Janajatis in governance

through improved protection of their rights. Finally, while gender focal points are included in NPC and all ministries and departments, and mandated to work on gender issues, they have been unable to deliver effectively due to multiple reasons, including their lack of authority, the absence of any institutionalized linkage between their gender mandate and the main work of the ministries as well as having no specific programs or resources for gender-related work.

District level

WDOs are present in each district under the Department of Women's Development/MWCSW, where they head the Women's Development Office and are mandated to mainstream gender and child rights in the districts. DDCs have a social committee with a Social Development Officer, who is also designated as the gender focal point for the DDC as a whole. Various watchdog committees have been formed, such as the Indigenous Ethnic District Coordination Committee and Dalit Class Upliftment District Coordination Committee, with representation from political parties. The Gender Mainstreaming Coordination Committee (GMCC), under the WDO and with representation from line agencies, is tasked with monitoring and coordinating district-level gender work. The GESI Implementation Committee, formed by the GESI strategy of LGCDP/MLD (with the Local Development Officer as chair, the WDO as vice-chair, the social development officer as member-secretary, and representation of GMCC, Dalit and Janajati coordination committees, and district-level NGOs/federations/associations of women and the excluded) is responsible for informing program planning on gender- and inclusion-related issues, auditing all programs and coordinating GESI-related activities in the district.

These institutional mechanisms have been

established at higher levels but most have experienced inadequate resources and weak institutional mechanisms, and thus have not been effective in protecting and furthering the GESI cause. In addition, there are overlaps between MWCSW and the National Women's Commission and only minimal efforts have been made to coordinate between the different commissions and the representative institutions of women, Dalits and Janajatis for collaborative efforts on gender and social inclusion.

VDC/municipality level

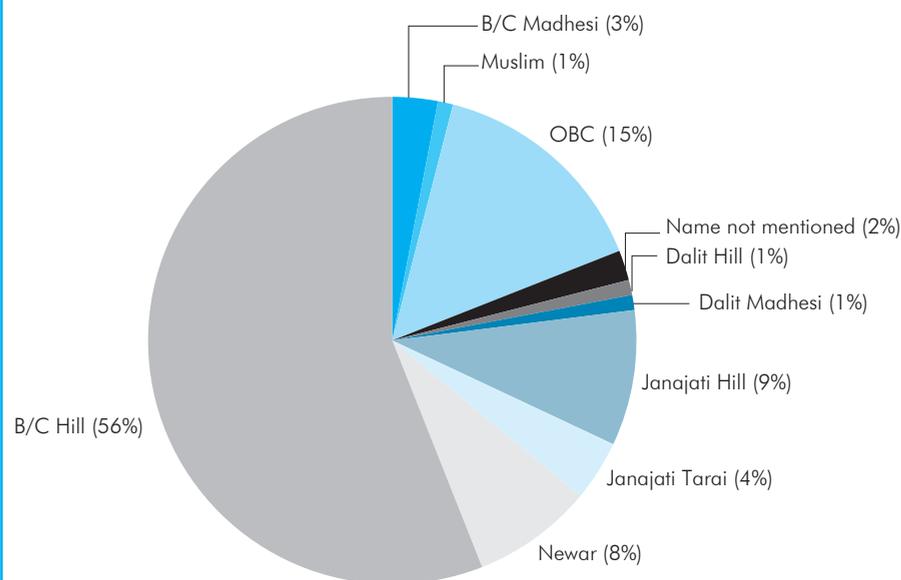
While there is no institutional mechanism with specific responsibility for GESI in VDCs or municipalities, the representative Integrated Planning Committees in each VDC are supposed to have members representing the interests of women, Janajatis, Dalits and NGOs, as mandated in the VDC Grant Operation Manual, and also have the general responsibility of ensuring that these issues are addressed. A potentially very effective new structure, established by the VDC Grant Operation Manual and GESI strategy of LGCDP/MLD 2009, are the village and ward citizens' forums. These create spaces for all citizens, including women, the poor and the excluded, to discuss, negotiate, prioritize and coordinate development efforts, and especially the allocation of block grants in their area, ensuring that they are both inclusive and equitable. A supervisory/monitoring committee has been mandated by the LGCDP/MLD GESI strategy. This mechanism has the responsibility to monitor GESI-related aspects of projects/programs. Finally, there are a number of community groups, women's federations, rights-based organizations, Dalit NGOs, indigenous people's organizations and pressure groups at the community level that have gathered experience through years of work, and have the ability to claim rights and influence local decisions.

Sectoral issues

Responsibility for GESI in the sectors is currently with the gender focal points, who, as discussed above, have not been able to work effectively. Some sectors (agriculture, education and forest) have institutional structures to address GESI issues specifically—for instance, the Gender Equity and Environment Division within the Ministry of Agriculture and Cooperatives (MOAC) and the Gender Equity Development Section and Inclusive Education Section within the Department of Education. The Gender Equity and Environment Division has a very narrow focus on gender and, in general, even when their mandate is broader and covers other excluded groups these GESI institutional structures do not have much influence on the policies and programs of their respective ministries. For one, the high turnover in government staff in ministries/departments results in changes in the political will and commitment towards GESI issues. For example, there have been frequent changes of staff charged with the role of coordinating the Gender Equity Working Group which is meant to facilitate the implementation of the GESI strategy in the forest sector. This constant turnover in the leadership has decreased the effectiveness of this group. The Ministry of Health and Population (MOHP) has planned to establish a GESI unit, but this is still in process.

Clearly defined responsibilities for any GESI unit, and routine working procedures linked to the main activities in the sector, are essential for these structures to be useful. Additionally, designated gender focal points, or even the GESI unit in general, need to have the technical expertise required to provide assistance on gender and inclusion in policy and project design, and in monitoring and evaluation. While training of gender focal points is common, practical application skills to integrate gender and inclusion from

Figure 1.4: Diversity Profile of Civil Service Personnel in Seven Sectors



Source: Nijamati Kitabkhana, February 2010; assessment by study team.

planning up to monitoring processes remain limited. Additionally, systems have not been revised to enable them to do their work (e.g., planning and monitoring processes/formats do not demand GESI mainstreaming). Although all sectors include GESI issues in their policies, strategies, and procedures, there are no sanctions for not achieving or improving GESI outcomes in the sector. The broader institutional culture might also not encourage (or, indeed, might actively discourage) GESI issues being raised or taken seriously. In the forest sector, for example, some government staff reported that other staff would simply laugh if they brought up social issues in a meeting. As such, transforming institutional culture clearly requires adopting innovative ways (e.g., appreciative inquiry, peer monitoring) to internalize and institutionalize GESI-sensitive thinking and behavior.

Workforce diversity

A diverse workforce enhances the ability of government institutions to represent and respond to the needs of specific identity groups and bet-

ter serve Nepali citizens, including those who have been historically excluded (Social Inclusion Action Group 2009⁸). Efforts are needed to make staff profiles more inclusive with regard to women and people from excluded groups and to develop human resource policies that are gender and inclusion sensitive. A review⁹ of personnel of the government in the seven key sectors finds the following.

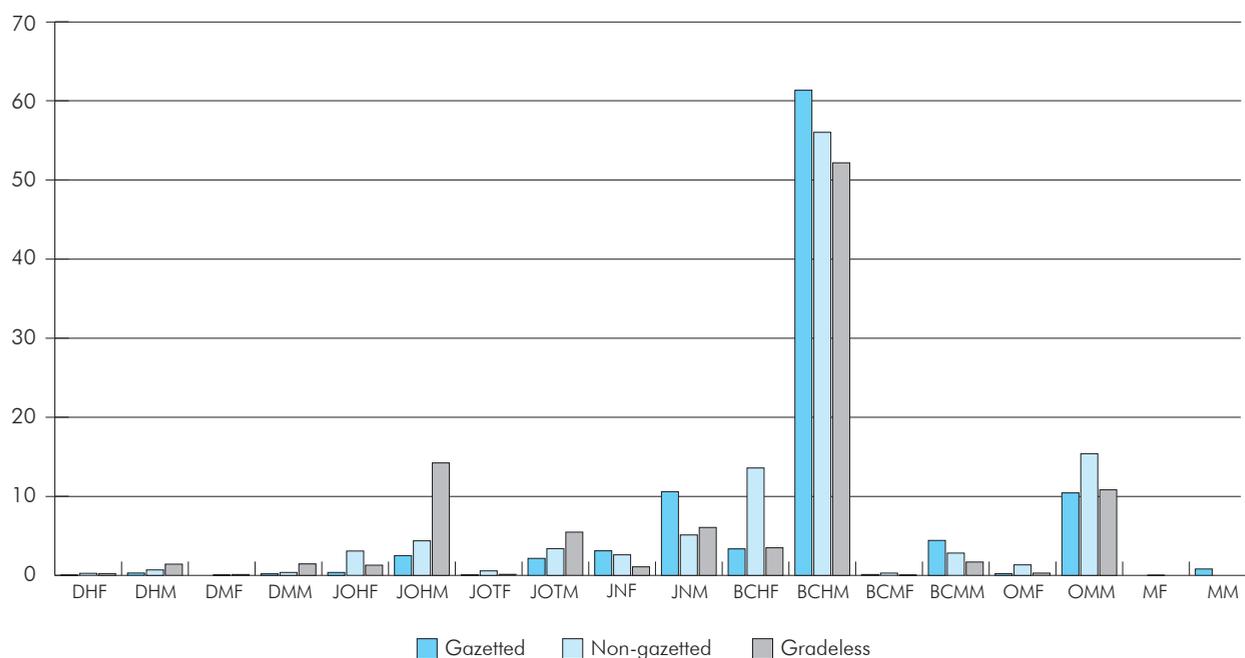
Diversity status. Altogether there are 41,183 staff members (of whom 6,742 are women, i.e., 16.37%) in the

sectors we reviewed. Compared to the national population,¹⁰ there is overrepresentation of Brahmins/Chhetris and Newars (who are primarily in key decision-making positions), almost an equal proportion of OBCs (mostly in non-gazetted technical positions), while all the other groups are underrepresented (Figure 1.4).

There are 4,594 staff at the gazetted level, of whom 7.27% are women. Among the women, Brahmins/Chhetris comprise the majority at 69.22%, and Dalits the fewest at only 0.20%.¹¹ The highest presence of women¹² is in the third-class non-gazetted positions (a majority of which are in the health sector as assistant nurse midwives and mother-and-child health workers; Figure 1.5).

Across sectors, the highest participation of women is in health, at 28.54%, and the lowest in forestry at 3.25%. Brahmins/Chhetris have the highest representation across all sectors, while Muslim representation is comparatively better in forestry than in the other sectors. OBCs are disproportionately overrepresented in the irriga-

Figure 1.5: Diversity Profile of Civil Service Personnel by Level, Sex, Caste, and Ethnicity



Note: DHF/M—Dalit Hill female/male; DMF/M—Dalit Madhesi female/male; JOHF/M—Janajati others Hill female/male; JOTF/M—Janajati others Tarai female/male; JNF/M—Janajati Newar female/male; BCHF/M—Brahmin/Chhetri Hill female/male; BCMF/M—Brahmin/Chhetri Madhesi female/male; OMF/M—OBC Madhesi groups female/male; MF/M—Muslim female/male.

Source: Nijamati Kitabkhana, February 2010; grouped for the study based on GSEA caste/ethnic groupings.

tion sector, but have the lowest representation in education. Similarly, Hill Dalits have better representation in rural infrastructure and Madhesi Dalits in agriculture as compared to other sectors.

1.3.4 Gender-responsive budgeting and gender equality and social inclusion budgeting

This section analyzes allocations/expenditures of the government and programs' budget to examine the extent to which resources are being spent on sector activities that are expected in some ways to help women, the poor and the excluded. The objective is to "follow the money" to assess what efforts have been made to address the issues that constrain these groups' access to sector benefits, analyze how much of the budget has been allocated and spent on such issues, and assess the

degree to which government funding for these issues is channeled through targeted programs or integrated into mainstream programs.

NPC issues guidelines directing ministries and line agencies in the formulation of their program budgets. In close coordination with the Ministry of Finance (MOF), NPC identifies the ministry-specific and sector-specific budget. The government's annual budget speech presents three types of analysis of the budget from a gender and inclusion perspective: expenditures in support of "inclusive development and targeted programmes"; the gender-responsive budget (GRB) exercise; and pro-poor expenditures (Annex 8a, 8b, and 8c of the annual budget speech 2009-2010, respectively).

We tried to identify how classifications were made and the process that was followed.

Table 1.1: Inclusive, Pro-poor, and Gender-responsive Percentages of Annual Budget of the Government of Nepal, 2009-2010

Sector	FY 2009-2010 budget (in '000 Nepali rupees)	Inclusive development and targeted programs		Gender-responsive budget						Pro-poor	
		Allocation	%	Directly supportive	%	Indirectly supportive	%	Total	%	Allocation	%
Agriculture	7,876,587	333,900	4.24	2,015,617	25.59	5,587,704	70.94	7,603,321	96.53	6,720,121	85.32
Education	46,616,672	18,368,433	39.40	1,300,659	2.79	22,187,486	47.60	23,488,145	50.39	40,589,748	87.07
Forest	3,449,974	60,453	1.75	71,880	2.08	1,826,637	52.95	1,898,517	55.03	1,780,218	51.60
Health	17,840,466	-	-	7,156,379	40.11	10,243,816	57.42	17,400,195	97.53	10,098,860	56.61
Irrigation	7,761,390	-	-	7,500	0.10	7,103,102	91.52	7,110,602	91.62	6,839,801	88.13
Rural infrastructure	35,693,647	4,280,025	11.99	12,996,863	36.41	12,588,029	35.27	25,584,892	71.68	34,949,331	97.91
Water and sanitation	29,500,624	-	-	6,806,427	23.07	18,740,825	63.53	25,547,252	86.60	13,890,848	47.09

Source: Annexes 8a, 8b, and 8c, Annual Budget, Government of Nepal, FY 2009-2010.

Indicators are not specified for inclusive development/targeted programs, but there are indicators for GRB¹³ and pro-poor budgeting.¹⁴ Our discussions with Ministry and line agency staff, however, indicate that the guidelines are not clear, and that, as noted earlier, it is typically left to the budget officer to categorize and score the various budget lines to the best of his (it is primarily men) understanding. Some of the ministries were not even aware of the inclusive development and targeted program analysis while at the district level none of the line agencies had applied these budgeting processes. The budget speech of Fiscal Year (FY) 2009-2010 categorized high percentages of expenditures in all sectors as pro-poor and gender responsive, but with low expenditures for inclusive development and targeted programming (Table 1.1).

Since the scoring and indicators were not clear for the other two kinds of budgeting, we have focused on reviewing the government's GRB indicators, identifying what sub-indicators are relevant and whether this approach is effective for tracking GRB expenditures in different sectors. The budget speech of 2007-2008 also declared that all ministries would need to follow gender-responsive budgeting,¹⁵ for which NPC has introduced a classification system of pro-

grams and projects, while a GRB committee has been formed within the budget division of MOF, with representation from MWCSW, MLD, NPC and UN Women.

According to the GRB guidelines, each proposed program in the sector has to be scored as per the indicators developed by the Gender-responsive Budgeting Committee, in which five aspects of gender sensitivity (participation, capacity building, benefit sharing, increased access to employment and income-earning opportunities, and reduction in women's workload) have been allocated 20 potential marks each. For each budget item/activity, the officer doing the analysis had to assess what percentage of the expenditure directly benefits women. Programs scoring 50 points or more are classified as *directly responsive* to women, those scoring 20 to 50 as *indirectly responsive*, and those scoring less than 20 as *neutral*.¹⁶

Sector staff categorize all expenditure items in the sectoral budget into these three categories based on the five indicators of gender responsiveness. However, these indicators, which were developed in the context of agriculture, are not necessarily applicable in other sectors. There are no sub-indicators to guide the scoring of budget lines or assess how the activities budgeted contribute to the indicators. Also, GRB indicators

tend to be better at capturing expenditures for targeted women's programs than at picking up expenditures for efforts made in universal programs to mainstream GESI. Finally, of course, the GRB exercise focuses only on gender and does not capture expenditures aimed at increasing outreach to excluded groups.

Gender equality and social inclusion budget analysis

While we have assessed the existing GRB practice and indicators used, and identified possible sub-indicators for GRB analysis in the different sectors, we have also developed and applied our own tentative GESI budgeting methodology.¹⁷ This is intended to capture expenditures that reach and support excluded groups and those that support women. Although there is no single rule about how to determine whether public expenditure is discriminatory or equality enhancing, there are some general principles discussed in gender-budgeting literature, which we have adapted.¹⁸ Our efforts here are intended as a first step to identifying the approximant resource flows to these different purposes; but much more work and wider consultation are needed. We hope that this initial attempt can become the basis for further collective work with MOF, the Gender-

responsive Budgeting Committee, sectoral ministries, donor agencies such as UN Women, and NGOs which are interested in tracking budget expenditures.

Again, the GESI budget analysis assesses what activities have been planned/implemented that provide direct, indirect and neutral support to women, the poor and excluded social groups to address the barriers they experience in accessing resources and benefits from the sector. We have followed the GRB practice of using three categories but have not followed the GRB indicators as they have not been very effective in application across the sectors. The GESI budget analysis was carried out at two levels. First, we assessed national-level expenditures in the sector using the above criteria. We reviewed a total of 22 programs and two annual plans (see Annex 1.1 for the list of budgets reviewed). Our analysis resulted in the breakdown shown in Table 1.2.

The next step was to move to the district level, to ground both the national-level GRB budget exercise and our own GESI analysis in two districts,¹⁹ Kavre and Morang. We first worked with the line agency staff to assess the current approach to GRB they were using in each sector. In consultations at the district level, officers shared which indicators were relevant to assess

Table 1.2: **Summary Gender Equality and Social Inclusion Budget Analysis of Seven Sectors (Total of Program Budget), Including Direct and Indirect Contributions**

S.N.	Sector	Total Nepali rupees (000) (programs)	Women	Poor	Dalits	Janajatis	Muslims	OBCs	Location	Disability	Youth and adolescents
1	Agriculture	1,622,500.0	1.64	45.00							
2	Education	14,936,192.0	6.91	14.46	5.61	3.52			11.55	1.00	1.00
3	Forest	3,449,974.0	0.49	4.83					0.63		
4	Health ^a	13,254,910.0	18.41	15.74					2.72		2.17
5	Irrigation	2,411,912.9	4.23	80.04	3.93	3.93	1.72		1.65	3.79	3.79
6	Rural infrastructure ^b	14,279,739.0	9.99	38.27					1.45		
7	Water and sanitation ^c	3,371,603.0	1.04	1.46							
	Total	53,326,830.9	9.43	21.80	1.66	1.08	0.04		4.37	0.37	0.91

Notes:

^a Excluding contribution of 0.34–0.42% to Janajatis, Muslims, Madhesis.

^b Excluding contribution of 0.01–0.06% to Dalits, Janajati, adolescents, elderly, disabled.

^c Excluding contribution of 0.10–0.16% to Dalits, Janajati, adolescents, elderly, disabled.

Source: Based on budget documents of sector ministries, selected programs, FY 2009–2010.

Table 1.3: Gender Equality and Social Inclusion Budget Analysis of Annual Programs, Kavre and Morang (%)

S.N.	Sector	Total Nepali rupees (Morang, Kavre)	Women	Poor	Dalits	Janajatis	Muslims	OBCs	Location	Disability	Youth and adolescents
1	Agriculture	63,355,341	12.46	1.35	0.29	0.15					
2	Education	1,336,366,884	14.20		5.08	0.08	0.09			0.26	
3	Forest	2,874,100	39.65	22.50							
4	Health ^a	78,720,450	53.05								9.92
5	Irrigation	72,695,000	1.32								
6	Rural infrastructure ^b	142,369,146	-	-	-	-	-	-	-	-	-
7	Water and sanitation ^c	132,054,576	0.59						1.59		
	Total	1,828,435,497	13.25	0.08	3.73	0.06	0.06		0.11	0.19	0.43

Note:

^a Excluding contribution of 0.34-0.42% to Janajatis, Muslims, Madhesis.

^b All items were found neutral, with the district staff arguing that the infrastructure is for everyone and hence cannot be targeted. It is, of course, true that we cannot build roads for Dalits, for women, etc.

^c Excluding contribution of 0.10-0.16% to Dalits, Janajatis, adolescents, elderly, disabled.

Source: Kavre and Morang annual programs, FY 2008-2009.

the gender responsiveness of items in the sectoral budgets. They said that they were aware of a number of positive policy provisions in each sector mandating that benefits reach girls/women, the poor and the excluded, but they felt that these automatically ensured that the entire budget would be responsive to women or specific excluded groups. In reality, this has proven to be a problematic assumption.

Next, we worked with the line agency staff to do a GESI analysis of the district-level health budgets, using directly supportive, indirectly supportive and neutral categories.²⁰ The results are shown in Table 1.3.

Effort has been made by the different ministries/programs to address the barriers for women and poor groups but for other groups the assumption seems to be that benefits will automatically reach them through implemented activities. The directly supportive and indirectly supportive expenditure of the budgets for women and the poor address important needs of women. But almost no activities or funds have been planned to address the barriers of women, the poor and the excluded, as discussed in Section 1.2, or the

structural issues that constrain their access. This indicates that a more conscious recognition of the need to address such sociocultural, empowerment and governance issues, along with core technical sector services, is required.

The key issues are the criteria, indicators and process of budget review. Government analysis classifies a majority of activities as directly or indirectly contributing to women, based on government directives regarding services to them. A deeper analysis, however, indicates that no activities are budgeted to address the specific gender-based barriers women experience. These are necessary even within a universal program in order that structural barriers are addressed and a more even playing field created—only then can GESI be considered to have been mainstreamed. This also highlights the need for a more rigorous analysis so that the budget speech's classification can be more realistic.

At the moment, the discourse reflects an assumption that positive formal policy provisions will ensure that all will benefit and that group membership (where relevant) will ensure access to services for all members. But this fails to

address the fact that it is mostly the extreme poor and often socially excluded groups such as Dalits who are either excluded or exclude themselves from joining groups. While groups are indeed a powerful mechanism to improve access to services and inputs, relying solely on this model without assessing its suitability for all presents a significant risk that those most in need will not gain access. Overall, our work on gender and inclusion budgeting indicates that for effective and systematic budgeting, more rigorous work has to be done, in particular with the Gender-responsive Budgeting Committee. There has to be a consensus to take gender and inclusion budgeting together; existing indicators and sub-indicators for GRB need to be revised and sharpened; unique issues of social groups need to be addressed; and the process must be improved, so that it is not left to the understanding of just one desk officer.

1.3.5 Program responses: Gender equality and social inclusion approaches

This section highlights the program responses and efforts across the sectors to promote and mainstream a more inclusive service-delivery approach. We also discuss measures and practices that have been found to be effective and successful in improving access to sector services and livelihood opportunities for women, the poor and excluded groups—increasing their voice and influence and supporting changes in the “rules of the game.”

Increasing access to assets and services

Significant progress has been made in the service-delivery sectors in increasing outreach and access to services, assets and resources for the poor and excluded groups. For instance, key reforms in the education sector, through national programs such as Education for All and the School Sector Reform Program (SSRP), represent significant efforts to improve access

and equity, enhance quality and improve efficiency through scholarships and incentives for girls, Dalits and Adivasi Janajatis. Still, remaining challenges include effective implementation of the multilingual education policy, monitoring of scholarship distribution, and ensuring funding to meet the opportunity costs for the poorest and most disadvantaged communities. There is also a need to look more carefully into the selection procedures and internal governance of the school management committees, to ensure that they fulfil their potential for giving parents from all groups a say in the running of their local school.

Likewise, in the health sector, government initiatives of pro-poor targeted free healthcare policies and the Aama (Mother) Program for maternity services have had considerable success in reducing the economic constraints of the poor and the social constraints of women, and generally improving health indicators. The recently developed NHSP-IP 2 has various activities to address the barriers of women, the poor and the excluded, and has made very impressive plans with disaggregated objectives and indicators.

In the infrastructure-related sectors, access to water supply has improved substantially over the past few decades. However, the low priority and resources accorded to sanitation have resulted in uneven coverage, especially for the very poor and in the Tarai, where lack of land poses an additional challenge. The construction of rural roads has improved access to markets, schools, health posts, government offices, and so forth, as well as provided work opportunities for women and the poor in road-building groups. In the irrigation sector, men continue to heavily dominate the management of systems even though women farmers are now increasingly involved. The group-based approach in the forest and agriculture sectors has increased access for women and other traditionally excluded groups to resources as well as ben-

efits from community forestry management and agricultural extension services and support.

Building voice and influence of excluded groups

Across the sectors, social mobilization as a process has been one of the main tools for organizing people for easier and more efficient transfer of assets and services, and also for improving reach and access. Groups (forest users, farmers, mothers, water and sanitation users, etc) are mobilized for their labor and financial contributions to support the implementation, delivery and management of services. Policy directives setting quotas for women and excluded groups have improved their representation in user groups and executive committees, which has been important in creating operational space for the voice and interests of these groups to be addressed.

However, evidence from the sectoral assessments indicates that these groups are, in many cases, still highly exclusionary of the extreme poor and socially disadvantaged groups, often reflecting and even reinforcing existing power structures. In addition, although representation of women is generally high in user groups and executive committees, their active involvement in decision-making processes is not com-

mensurate with their formal presence. While the group-based approach to development has thus increased access to assets and services, there is insufficient understanding of and focus on the barriers faced by excluded groups or on how to build their capacity to influence decision-making processes. In many of these we have found the approach is more transactional than transformational,²¹ and only in those efforts where REFLECT-type processes (see Box 1.1) have been adopted has there been effective strengthening of voice (e.g., Participatory Learning Center by GTZ/GIZ, COPE/PLA [Client Oriented Provider Efficient/Participatory Learning and Action] process by Support for Safe Motherhood Program/UN Population Fund and REFLECT by CARE/Nepal Family Health Program).

Some notable networks and federations have been able to advocate successfully on behalf on their members. The Federation of Community Forest Users has become an important political player throughout the country, while the Federation of Water and Sanitation Users Nepal and Nepal Federation of Water Users Association are additional examples of civil society groups organizing and mobilizing members to voice their interests, influence policy and decision makers as well as demand accountability and transparency from service providers. The United Nations Children's Fund (UNICEF)-supported women's federations and paralegal committees are a force to be reckoned with in many districts. Still, even in these successful second-tier organizations, important issues remain regarding inclusion and diversity in the membership, decision-making positions and governance as well as in establishing more effective and transparent management.

Box 1.1: What is a REFLECT circle?

REFLECT circle is a forum where the disadvantaged are brought together to identify, analyse and take actions on issues that directly affect them. The main purpose of the circle is the empowerment of the poor and the excluded. The facilitator of the circle helps educate members on their rights and support them to take actions to ensure access to services. It helps build the capacity of members to advocate and lobby for their rights. The circle not only takes up issues of the disadvantaged, it also encourages members to fight for the rights of the community as a whole. It encourages the poor to bargain with the richer sections in the community and also takes up issues of the whole community, including that of the rich and the elite, up to the VDC and district levels. In this way, the circle can be effective in ensuring the rights of the disadvantaged as well as garner support of the rich and the elite of the community.

Source: Field notes discussion with Action Aid 2009.

Changing the "rules of the game"

Overarching changes are required to remove the barriers that women, the poor and the excluded

face in accessing assets and services. The forest sector, for instance, has made notable progress in this area by addressing GESI issues in sector programming and operational practice. LFP's pro-poor and social inclusion strategy has been effective in developing a common understanding of social exclusion issues as well as strategic approaches to deal with them. Similarly, the health and education sectors have been progressive through the previously mentioned NHSP-IP 2, Education for All and SSRP policies. However, the informal "rules of the game"—the sociocultural values, beliefs and attitudes that underlie and shape discriminatory behavior and norms—continue to play a strong and influential role in creating barriers for women, the poor and excluded groups. It is in this area that substantive efforts are needed to overcome deep-seated resistance to changing discriminatory practices, both in the workplace and in community groups. Behavior change without systemic structural change in sector institutions, communities and families will continue to reproduce the current gap between good policies and poor implementation. Unfortunately, however, sufficient and sustained work along these lines was not evident in any sector.

1.3.6 Monitoring and reporting

Ministries, including MLD, report on M&E formats issued by NPC (specifically the Poverty Monitoring Division, which has the key responsibility to work in this area). For effective GESI mainstreaming, integrating gender and social inclusion into M&E systems is crucial. NPC has established a system of gender coding for the 10th Plan/PRSP (Poverty Reduction Strategy Paper) monitoring and demands reporting, with some disaggregation, on intermediate and outcome indicators in the poverty monitoring and analysis system (PMAS). It has also developed (with donor support) a district poverty monitoring analysis system, which has been implemented

in 22 districts and could potentially be adapted for poverty monitoring in the new federal units once these are determined. But, at present, neither system is actively used.

To a certain extent, the education and health sectoral information management systems do provide disaggregated information. The education sector has the most well-established system of monitoring and reporting, providing comprehensive, high-quality and disaggregated data by sex and caste/ethnic group on, among other things, student enrolment and numbers, teachers and non-teaching staff, student attendance and scholarship allocation. However, it only disaggregates social groups by Dalit and Janajati without differentiating the subgroups within which some are more disadvantaged than others. Moreover, its categories do not capture groups like the Madhesi other backward classes/OBCs or Muslims—both of which have low education outcomes and need to be tracked. Similarly, the current monitoring mechanisms of the health sector collect sex- and age-disaggregated data, but information on service utilization by the poor and the excluded is not integrated. The sector is piloting caste/ethnicity-disaggregated data but managing such huge amounts of data has been challenging.

The WSS, forest and agriculture sectors maintain disaggregated data on membership and participation of women in the user groups/committees and key decision-making positions while also disaggregating user-group data by caste/ethnicity. The MOFSC also incorporates monitoring indicators sensitive to gender, poverty and social equity in its MIS, but this needs to be implemented more systematically. In the forest sector, LFP and Nepal Swiss Community Forest Project (NSCFP) have established systems for maintaining a disaggregated database, monitoring and reporting against gender, poverty and social equity indicators. However, a review of the log-frames of various programs indicates that there is a general

lack of disaggregated indicators or inclusive objective statements. Only in the recent NHSP-IP 2 (health) is there consistent demand for disaggregated data at the results level, or for measuring any shift in sociocultural behavior. In SSRP (education) there is a gap, with very little demand for disaggregated measurements of progress as the indicators are mostly quantitative and neutral from a GESI perspective. Still, many programs do have indicators for representation by women and excluded communities in various groups and committees. Nepal Water and Health, for instance, has very well-disaggregated indicators, e.g., “At least 90% of completed projects [in which 90% of the beneficiaries are the poor and the excluded] remain fully functional 3 years after the project’s completion.”

The sectoral M&E review indicates that there are efforts at collecting disaggregated data and that sex-disaggregated data are most commonly requested. But consistent disaggregation against all social groups with regional identities (women and men of Hill and Madhesi Dalits, Adivasi Janajatis [except Newars], Newars, Muslims, OBCs, Hill and Madhesi Brahmins/Chhetris) is not followed. There are very few sectors with examples of an information management system that can handle such data (probably only LFP and NSCFP in forestry, and rural WSS). With NPC formats still not demanding such disaggregation nor asking for progress against outcomes in disaggregated forms, monitoring and reporting are a key area for more intense mainstreaming of gender and inclusion.

1.3.7 Good practices and lessons learned

In this section we discuss some practices that have been found effective across sectors to address the structural barriers limiting access to resources, assets and benefits for women, the poor and the excluded, and the common lessons that can be drawn from these efforts.

Good practices

Improved targeting and inclusion through use of well-being ranking and proxy means testing (indicator targeting) provide a powerful baseline for identifying the poor and the excluded for program interventions. Community members usually carry out such rankings themselves, using economic and social indicators to categorize households. In education, this is supplemented by proxy means testing to target secondary and tertiary scholarship and work-study support. Evidence that this combination has worked well is still to come in, but there is consensus among practitioners that it can bring together objective and subjective rankings. This is then used to target resources and services, and ensure more equitable distribution. The forest sector will be testing a combined community-based and proxy means testing approach to identify disadvantaged households, with independent verification to try to standardize approaches and remove existing confusion at the local level.

Empowerment and community education. Social mobilization based on individual and collective empowerment through efforts to understand and transform the unjust structures that affect their everyday lives and livelihoods has proved effective in building the voice of the excluded and the poor as well as their capacity to influence decisions. Where communities have been mobilized to reflect on the social norms that perpetuate untouchability, gender-based discrimination or violence against women, there has been an increase in access to services and greater involvement in community-level planning for these groups. The REFLECT-type approaches have been particularly effective because they draw in not only the excluded but the rest of the community as well. The whole community is organized into groups to discuss and learn about different rights-based issues, and respond through collective action.

Establishing firm quorums for key meetings. The

lack of access to information about entitlements, services and procedures to obtain available resources is a major component of the exclusion faced by women, the poor and excluded groups. Knowledge is power and more educated elite groups who have time to network in the district centers and create contacts with local politicians are more likely to know the details of incoming development programs or new government policies—and to use this information to their advantage. Setting quorums for key meetings has been effective in ensuring that all households are adequately represented and informed. If a quorum is not met, project staff members are required to cancel meetings until the required number of households is present.

Building a strong civil society able to represent and advocate for changes in the “rules of the game,” has been a major advance in some of the sectors (e.g., Federation of Community Forest Users, Nepal in the forest sector). However, these organizations and federations also need to address issues of diversity and inclusion within their own structures, where representation of excluded caste and ethnic groups is typically low. Another danger with such NGOs or second-tier groups is that they can be captured by political parties.

Policy directives for representation/participation. Setting quotas for women and excluded groups in user groups/committees, along with creating training opportunities, has ensured their representation and participation in development activities as well as strengthened their access to resources and benefits. Still, further efforts are needed to reach socially excluded groups and promote their representation in key decision-making positions in executive bodies and their ability to influence decisions.

Adoption of a workforce diversity policy is a mechanism to change the structure of organizations and the rules of the game that determine

entry. These policies (such as those adopted by NSCFP) have improved inclusiveness in individual organizations and among partners, identified groups to be prioritized, established benchmarks for diverse representation in staff categories, and followed up with affirmative action to recruit people from discriminated groups until their representation in various staff categories, committees and working teams is ensured, reflecting their representation of Nepal’s population.

Changing internal budgeting and monitoring systems to track resource allocation effects on women, the poor and the excluded has been successfully employed by a number of programs. This has positively evolved the way in which these institutions allocate and deliver services and enabled programs to identify the causes of changes in livelihood and social inclusion outcomes. LFP (through its livelihood and social inclusion monitoring) uses the three domains (see Figure 1.3) of change to track change in voice, influence and agency, access to assets and services, and also whether the poor and excluded have been able to change policies and institutions in their favor.

Social accountability mechanisms. Social audits and similar tools have provided increasing opportunities for civil society, including community groups, to press for greater accountability and responsiveness from service providers. These have become accepted tools and processes, but still need to be implemented more effectively, with meaningful participation of the women, the poor and the excluded, and with follow-up actions that demonstrate the value in participation.

Lessons learned

Women, the poor and the excluded face multiple exclusions, many of which cannot be solely tackled through sector-based interventions, as the causes are rooted in deep societal structures that

require coherence of interventions at many levels and across many sectors. For example, simply providing low-quality leasehold land is insufficient to bring people out of poverty when the initial investments to improve productivity are large and require time to deliver benefits. For the extreme poor, this could lead to an increase in livelihood insecurity and vulnerability.

Behavior change is required to overcome deep-seated resistance to changing discriminatory practices in both the workplace and community groups among those who have benefited from these practices. But changes in the behavior of a small number of well-meaning individuals will still leave gaps between well-intentioned policies and actual implementation. Changes in incentives for staff working in the sectors are also needed. Overcoming deep-set informal resistance to social inclusion and changing discriminatory and indifferent attitudes of service providers remain two of the greatest challenges facing all sectors.

Social mobilization and facilitation processes need to focus on empowerment not only on increasing access to assets and services. There is a need to build understanding of the rights and responsibilities of individuals as citizens to have a voice in decisions and a share in benefits. When this approach is used, groups are more sustainable and generally continue functioning after the project or program intervention is over to take up new activities of concern to members.

Sociocultural constraints on women are strong and thus it is necessary to work on shifting gender-based power relations both in the workplace and in communities at large. Compared to men, women of all social groups tend to have high opportunity costs attached to their participation which often involves high levels of benefit.

Dealing with the extreme poor's self-exclusion from development processes requires special targeted support to ensure that they can access

resources and associated benefits. Action should be based on analysis rooted in an understanding of the unequal power relations created by class, caste, ethnicity and gender, which have to be addressed by any support provided.

Policy mandates and affirmative action provisions are necessary for resources to reach women, the poor and the excluded along with the political commitment required for implementation. During the implementation process, all gaps need to be understood and addressed, and the reasons causing the failure need to be understood and acted upon.

Increased formal representation does not automatically lead to increased voice. Although there has been significant representation of women in user groups/committees, they still do not have sufficient voice in these groups. Their attendance is limited at meetings, they rarely speak, and if and when they do, they are often not listened to. The same is often true of Dalits and other excluded groups whose presence is mandated by donor or government funding requirements. For real change, capacity building and advocacy for shifts in discriminatory practices are necessary and need to be directed not only at the excluded but *all* members of the group/user committee. Also necessary for any effective change of the formal structures such as user groups is political and power-focused analysis to understand how these structures interact with informal structures and systems.

Targeted interventions are important but GESI needs to be integrated into mainstream programs and services. Though equity-related and, to some extent, inclusion issues are captured in some of the sector programs, too often in these programs inclusion has remained a separate component. The issue of social exclusion has not been approached holistically. For example, in the education sector, despite the change in terminology from "special education" to "inclusive educa-

tion,” the focus remains solely on disability and is separated from the gender equality section. This reveals a limited understanding of what it means to mainstream GESI in a sectoral program.

Institutionalizing gender and inclusion in budgeting requires further clarity and capacity. The methodology and process for the government’s gender-responsive budgeting are not clear enough. The current indicators are not adequate for analysis across sectors and it is not clear that the current post-allocation analysis adds value at either the sectoral or MOF level. There also seems to be an implicit bias in the point allocation system towards smaller, targeted, women-only projects and programs rather than genuine integration of women’s needs and constraints into mainstream sector programs. In addition, the approach lacks a wider inclusion dimension that, with very little additional effort, could allow it to track expenditures benefiting other excluded groups using the same basic process. Clear, consistent guidelines on process and analytical categories are urgently needed.

Institutional structures for GESI need to be made functional and integrated into the core products and services provided by the sector. Institutionally, just creating structures is insufficient, as demonstrated by the position of the gender focal points within the sectoral ministries. Rather, for any such position to be influential, it must be integrated into the sector’s core systems and organizational structure. The GESI function should be assigned to the planning and monitoring division of each ministry and ultimately be the responsibility of its chief. The responsibility should be backed with resources to bring in or create the necessary staff capacity to be able to provide technical backstopping necessary to fulfil the GESI mandate.

Increasing access to services for women, the poor and the excluded requires a multi-sectoral approach. For example, in order to improve access to health

services, other actions are required in sectors such as education (e.g., building awareness), rural infrastructure (e.g., road and trail networks), modes of transport services (e.g., availability of stretchers, public transport), water and sanitation, and access to finances (e.g., community-level emergency funds).

1.4 Mainstreaming Gender Equality and Social Inclusion: The Way Forward

In Section 1.2 we discussed the steps of GESI mainstreaming and the three domains of change, and explained any questions or queries. In this section, common measures on mainstreaming GESI in the sectors are grouped under our framework of three stages: identifying; design and implementation; and monitoring and reporting (and response to the findings through changes in project implementation). As has been illustrated, gender-, caste-, ethnicity-, and location-based exclusion are complex interlinked issues that cannot be addressed in isolation. To respond to this complexity, multipronged measures are necessary for mainstreaming, as reflected in the suggestions made here.

Step 1: Identifying the barriers

Analyze existing power relations and the formal and informal institutions that enforce and perpetuate social and economic inequalities. Gender inequality and social exclusion in the sectors are linked to the wider sociocultural and politico-economic context. First, identify the key socioeconomic constraints and harmful social and cultural practices that limit access to sector resources and assets for women, the poor and the socially excluded. Often the “barriers” that need to be removed or worked around are part of interconnected formal and informal institutions that structure Nepali society, which allocate privileges and obligations in accordance with different roles or ascribed characteristics. The sector programs

work with these systems and try to improve them so they can deliver services more effectively. Yet, it is generally recognized that changing any of these “rules” upsets some stakeholders, and this is why there always needs to be awareness of the “political economy” of the individual projects/programs. Likewise, the more “informal” institutions, which are deeply embedded in values, beliefs and norms, can also block change, and thus need to be considered. Some—like the gender system or caste hierarchy—are so deeply ingrained that people often follow them without even being aware that they are doing so. On the other hand, not all these traditional values are negative or exclusionary, and many can indeed be a strong source of renewal and positive change.

The GESI framework is a tool to increase the chances that the changes we want to bring can actually happen on the ground. GESI requires us to look at both formal and informal systems. To identify barriers, we need to look in two areas: first, how the formal project systems are likely to work for different groups of people. This will bring us to the second layer, to see how informal systems might be distorting the way the formal systems work for some individuals and groups. So, when we try to “identify barriers,” we are actually uncovering whole systems that keep some individuals and groups from gaining equal access to universal services and benefits that the project/program we are supporting is intended to deliver.

Assessing GESI in existing policy, programs, budgeting and M&E. It is important to assess the existing policy mandates that provide the space to work on GESI issues in the sectors, and where there are gaps in these policies. Likewise, the policy mandates that enable or constrain different groups need to be identified and the existing programs of the ministry and other actors in each sector need to be examined to identify how the barriers facing the excluded are being addressed—and the strengths and

weaknesses of the current approaches. Existing political economy and governance issues need to be understood: their implications for the sector in general and for women, the poor and the excluded in particular. Further, the budget needs to be reviewed through a GESI lens to identify how positive policy and programmatic provisions are being resourced, and to identify needs for improvement. Finally, an assessment needs to be carried out to determine whether the M&E system is capturing changes in a disaggregated manner, and on issues that are of central importance to increasing access to services for women, the poor and the excluded. As gender and inclusion issues are linked to wider governance and management systems, a GESI assessment might bring up issues that could be considered by some as beyond its scope. But these aspects, too, need to be understood for their impact on women, the poor and the excluded.

Steps 2 and 3: Design and implementation

GESI mainstreaming requires that project/program plans must consciously recognize and address, at each stage, the constraints experienced by women, the poor and the excluded, and must build on their existing strengths.

Address policy and organizational change issues

The aim here is to focus more on the policy and organizational level and how GESI issues can be better addressed in program/project responses.

Support and strengthen GESI at policy level. Programs/projects are applying GESI-sensitive policies, but overarching policy guidance from the government is missing. A GESI policy that provides a common framework would ensure that certain principles and a clear definition of exclusion and the excluded are consistently applied by all sector actors, and would direct revision of systems, mechanisms and processes as required.

Promote diversity in service providers. The number of women and people from excluded groups working in the sectors varies but is generally low, highlighting a need for affirmative action. This will require long-term investments through scholarships as well as individual coaching to prepare technically qualified women and people from excluded social groups. Measures to create a supportive working environment, like childcare or flexible timings and safety from sexual harassment, can be very effective in attracting and retaining women professionals. But little thought seems to have been given to how to open the way for other groups like Dalits or Muslims so that they feel comfortable and perform well in the workplace.

Develop skilled service providers to deliver GESI-sensitive services. Support for mainstreaming of GESI issues in tertiary and technical institutions will build the technical capacity of professionals. GESI-sensitive messages also need to be integrated into related training affecting the sector.

GESI in job descriptions and strengthening GESI arrangements. Work needs to be done with the Ministry of General Administration (now called the Ministry of Human Resource Development) for revision of job descriptions of all positions to integrate GESI-related tasks. GESI units and desks are required in the ministries, their departments and district-level divisions/departments to provide technical support for mainstreaming gender and inclusion in the sectors. This is also necessary in programs that have not provided dedicated responsibilities to identified structures. Mechanisms for coordination between these different structures are essential, while the capacity and skills of government and program staff to address GESI need to be strengthened and used.

Capacity building on GESI must be a process rather than a one-off event so that skills are built on to integrate gender and inclusion in everyday

work. Gender and social development specialists need to have the relevant technical expertise to respond to and guide technical staff on how to mainstream GESI while technical staff members need to be able to respond to social issues linked to their technical work.

GRB and GESI budgeting. GESI budgeting, as a tool, can identify the kinds of activities budgeted/spent for but the government's current budgeting criteria and process require revision to be more effective. GESI budget analysis should not be done only after the program has been designed and funds allocated; rather, it must be done simultaneously with program development, to ensure that activities/subprojects to address the barriers constraining access to services for women, the poor and the excluded are identified and an adequate sum allocated in the budget and work plans. Likewise, activity planning and budgeting must be linked to disaggregated data and the information generated from the use of tools such as poverty mapping, social mapping and gender analysis.

Designing program/project responses

Balance targeted and universal action. Targeting activities is necessary to address specific constraints or issues of women, the poor and the excluded, e.g., special initiatives to build capacity of women farmers to become traders/entrepreneurs in agribusiness, or specific financial services to increase access to credit of the poor, or advocacy with men regarding empowerment of women. But these need to contribute to a universal program, addressing structural constraints blocking groups from accessing resources and benefits of the sector equally with other social groups.

Promote and support partnership with civil society to invest in community education for behavior change on both sector-specific and social transformation issues, investigate governance aspects

at each step of the project cycle, and monitor investments in the sector.

Mechanisms to encourage greater downward accountability need to be strengthened. Across sectors, state and non-state actors are more accountable upwards than downwards towards the community, and these include NGOs and community-based organizations (i.e., support organizations) that are partnering with government and donors to implement tasks such as social mobilization, needs identification, etc. Their agreements demand reporting to project supervisors and donors with hardly any mechanism to ensure accountability towards the people they are supposed to serve. GESI performance incentives need to be developed and included in the evaluations of support organizations.

Longer-term investment in the capacity building of women, the poor and excluded members to enable them to participate more effectively in executive committees and groups is necessary. This requires building the leadership abilities of members of these groups.

Harmonize working approaches across programs at the local level to minimize beneficiary transaction costs. The formation of multiple groups by different projects/programs and varied requirements and working approaches adopted by different actors increase the time burden of women, the poor and the excluded, who have to attend multiple group meetings. This could be addressed if VDCs play their coordinating role better and ensure that the neediest receive services, but this would demand a disaggregated database and information about the current situation of women, the poor and the excluded, and their access to services in VDCs.

Develop localized behavior change communication materials and translate project information into local languages. To be effective, these materials must be available in local languages and use a range of media to address specific discrimi-

natory beliefs and norms. Likewise, program/project information and documents need to be translated into local languages to ensure that all groups understand the processes, rules and regulations to access services, assets, resources and other benefits.

Steps 4 and 5: Monitor and Adjust Implementation

Monitoring and reporting

Many sectors are disaggregating data by sex and caste/ethnicity. But the focus is on activities (e.g., number of women trained) and outputs, and the capacity to track GESI outcomes is still lacking. Some potential improvements are listed below.

Disaggregated monitoring and reporting to show what each project/program is contributing to assist women, the poor and the excluded, need to be established across the sectors. This is very challenging at the national level as NPC monitoring and reporting formats, which all ministries have to follow, do not demand disaggregated information. Additionally the “three domains of change” framework is very useful for tracking changes at outcome levels, and could usefully be established as a routine practice by NPC.

Objectives and indicators need to be disaggregated by sex and caste/ethnicity. Planning and programming must be based on disaggregated information and evidence. With NGO partners, PRA (Participatory Rural Appraisal) tools (e.g., well-being ranking, labor/access/control profile, resource mapping, etc) must be used as required at the community level to identify the poor and map existing social and power relations. In turn, this information must be used for identifying priorities for programming and guiding implementation practice.

Uniform MIS and disaggregated data for all sectors around some basic indicators would help reduce duplication and identify gaps and areas of

acute exclusion. PMAS needs to be revised and its implementation strengthened. Monitoring and reporting formats must be standardized with disaggregation. Sectors and programs will need to monitor their investments, and hence have more detailed indicators and monitoring systems. But they must all contribute to the indicators incorporated in PMAS.

Community monitoring and social accountability mechanisms should be institutionalized within the M&E system. Social and public audits have become accepted tools and processes, and need to be improved in implementation. To ensure this, social mobilization may be necessary until the process of giving this kind of feedback becomes a familiar activity for the excluded. This requires a carefully facilitated process to ensure that all social groups participate, that proper service evaluation occurs, and that useful understanding is developed and acted upon.

Good practices and lessons learned need to be documented and shared by sector actors through donor coordination groups, and perhaps through the Social Inclusion Action Group, a group of practitioner agencies. Enhanced capacity to prepare case studies that document and analyze positive pro-inclusion processes will accelerate the pace of change.

Monitoring and evaluation teams must be inclusive and must have people with technical competence about gender and social inclusion in the sector. The terms of reference of the M&E teams must specifically demand deliverables that have addressed GESI issues.

Adjust implementation

Project/program management needs to view the M&E system as their dashboard for steering

the project to achieve its objectives. If the inclusion indicators show that some of the intended outcomes are not emerging as expected or some groups are not getting their share of benefits, project management needs to diagnose why this is so and work with staff and project participants to develop mechanisms to change the situation as soon as possible.

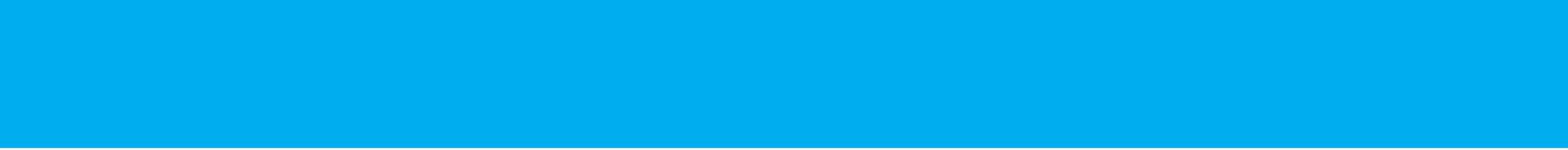
The seven sectors covered in this series have made significant progress in increasing the participation of women, the poor and excluded groups in development efforts, but rather uneven progress in addressing structural causes of gender/caste/ethnicity-based discrimination and issues of social exclusion. However, the current discourse on inclusive development provides an opportune time to learn from sectoral experience and move towards more inclusive practices, as these lessons can be adopted and mainstreamed across the sectors and institutionalized within government and non-government structures alike.

As has been noted, to institutionalize GESI, each sector will need to address the main issues uniquely facing women, the poor and the excluded: the underlying structural causes of their limited participation, voice and very low influence over decision-making processes; the reasons behind ongoing inequitable access to resources and assets; and the need to build responsive processes that address the different needs of specific social groups. At an institutional level, a variety of common issues need to be addressed, including lack of staff diversity; ineffective gender focal points; and limited integration of GESI principles in core sectoral planning, budgeting and monitoring processes, which leads to major gaps between enabling policies and actual implementation.

Notes

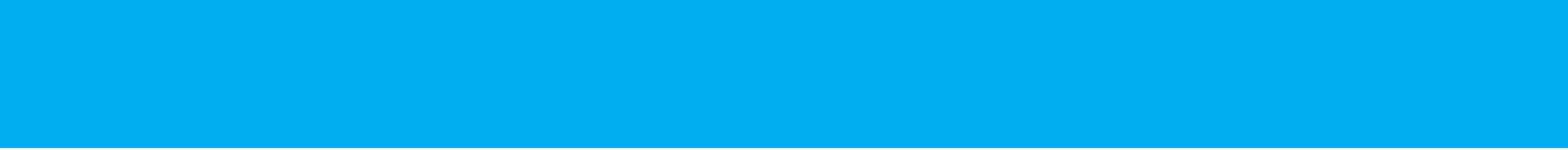
- 1 According to the Interim Constitution and Three-Year Interim Plan, excluded groups refer to those who have experienced exclusion historically and have not been mainstreamed in the nation's development: women, Dalits, Adivasi Janajatis, Madhesis, Muslims, people living with disabilities, and people from geographically remote areas.
- 2 This framework has been adapted from Naila Kabeer's social relations analysis framework (Kabeer 1994). It has been informed and refined by the GSEA framework. Field-level experience of professionals has contributed to it. It has been used in Nepal for program design, evaluation studies, and gender equality and social inclusion mainstreaming in the forest sector, LGCDP/MLD, and in various other program/NGO strategies.
- 3 In a national program, mapping the local political economy of the sector in a sample of the different types of sites where the program would be implemented would provide us with enough to go on.
- 4 This section draws from the LGCDP/MLD gender equality and social inclusion operational strategy (2009). Refer to Annex 2 of that document for a more detailed analysis of policy and institutional frameworks.
- 5 This has recently been approved as the GESI policy of MLD.
- 6 Such as categorization of Janajati groups into endangered, highly marginalized and marginalized, and prioritization of projects accordingly; disaggregated information about users; information to users regarding resources before approval of next instalment; 33% women and representation of Dalit, Janajati and deprived groups in user committees; allocation of up to 3% of total project cost estimates for capacity building and overhead costs of user committees; participatory monitoring by users; and registration of complaints at VDCs about the implementation of the project.
- 7 As has been directed by MLD for the VDC-level integrated planning committees.
- 8 This publication reviews the workforce diversity profile of 30 international agencies working in Nepal.
- 9 Records of civil servants maintained by the Department of Civil Personnel Records (Nijamati Kitabkhana) of the Ministry of General Administration were reviewed and disaggregated according to surname and place of permanent residence. Rules applied were those developed by the WB Social Inclusion Index development team, and caste/ethnicity groupings were drawn from the Census. This process can be erroneous to a certain extent, as some surnames are common to different social groups. We appreciate that a participatory process facilitated by the Nijamati Kitabkhana for the self-identification of employees has been initiated.
- 10 The national population as of Census 2001 was Brahmin and Chhetri 32.5%; Janajati (excluding Newar) 32%; Newar 5.4%; Dalit 13%; Muslim 4.3%, OBCs 14%; and others 1.4%.
- 11 Gazetted is the highest category of officers, appointed through national open competition. Non-gazetted officers are appointed by the head of department to support gazetted officers. Within the gazetted and non-gazetted, there is a hierarchy of special, first-, second-, and third-class officers. The classless officers are support staff.
- 12 Of the total 72,939 civil personnel in the government as of February 2010, only 12% were women. Of these, 12.9% were gazetted officers, 57.4% were non-gazetted, and 30.4% were without grade (Nijamati Kitabkhana records, February 2010).
- 13 The three prescribed categories are direct contribution, indirect contribution and neutral. Each sub-activity is assigned a code of 1, 2 or 3, considering the percentage of contribution to women. The formula for coding has five indicators, each valued at 20%: capacity building of women, women's participation in planning process and implementation, women's share in benefit-sharing, support for women's employment and income generation, and qualitative progress in the use of women's time and reducing women's workload (eAWPB 1.0 Operating Manual, 2009). In order to measure these categories quantitatively, five qualitative indicators were assigned quantitative values of equal denomination, totaling 100. Direct gender contribution indicates more than 50% of the allocation directly benefiting women, indirect gender contribution indicates 20-50% of the allocation benefiting women, and the neutral category indicates less than 20% of the allocation benefiting women. This is gradually being used by ministries such as the Health Ministry but due to difficulties in the application of the criteria that do not seem relevant to all the sectors, this has not been fully used by all.
- 14 Indicators for the pro-poor budget are investment in rural sector; income-generation program in rural areas; capacity-enhancement program in rural areas; budget allocated for social mobilization; expenditure focusing on poverty reduction; grant for local bodies; social security programs; and investment in social sector (especially for education, health, etc). See Annex 8c, budget speech 2009-2010. But it is not clear how these are scored and what sub-indicators are used.
- 15 Refer to the monograph on Rural Infrastructure in this series for more discussion on GRB.
- 16 Refer to the monograph on Rural Infrastructure in this series for more discussion regarding this.
- 17 This analytical framework is adapted from GRB frameworks being used, and has been applied in Nepal in different program/project assessments and evaluations and for the GESI strategy development (e.g., MFSC GESI strategy for the forest sector 2006, the International Labor Organization's GESI strategy for LED [local economic development] in Nepal 2009, and LFP social and geographic audit, 2004).

- 18 We are adapting from gender budgeting initiatives that have aimed to assess the impact of government expenditures and revenues, using three-way categorization of gender-specific expenditure, equal opportunity expenditure and general expenditure (the rest), considered in terms of its gendered impact (Budlender and Sharp 1998).
- 19 Implemented budgets of districts were reviewed to assess actual expenditure and its effect on addressing the barriers of women, the poor and the excluded. Program budgets of the current year were reviewed to assess allocations.
- 20 Directly supportive (i.e., targeted to provide direct support to women, the poor and the excluded); indirectly supportive (contributing to creating an enabling environment, supporting in any manner the access of women and the excluded to services, or addressing the structural difficulties confronting them); and neutral.
- 21 Jha et al, 2009.



CHAPTER 2

Gender Equality and Social Inclusion Making it Happen in Health



2.1 Introduction

The Nepal Demographic and Health Survey (NDHS) in 2006 found significant improvements in health outcomes, despite the decade-long conflict.¹ Indicators of infant mortality, under-five mortality, skilled antenatal care, rate of skilled birth attendance and immunization have all improved (MOHP 2007).² Decentralization of health facility management, intensive campaigns such as immunization, free essential healthcare services, reduced poverty, lower fertility levels, the growth in private sector services,³ and marked increases in literacy among young women (as well as associated relative empowerment) are all seen to have contributed to these public health gains. However, wide disparities persist in both process and outcome indicators across gender and different caste, ethnic and regional identity groups. This chapter discusses the formal and informal institutional barriers causing these disparities, the resultant impact on different social identity groups, and the existing responses and actions that those working in the sector can take for better and more equitable health outcomes in future.

Health as a fundamental right is assured in the Interim Constitution of Nepal, 2007. In response, the Ministry of Health and Population (MOHP) has taken various initiatives, including issuing a 10-point guideline framework that recognizes the state's responsibility to ensure that health services are made available for disadvantaged communities. There is general consensus among public sector health practitioners and planners as well as external development partners' (EDPs) health experts, that in order to meet the Millennium Development Goals (MDGs), access to and use of health services by excluded groups and regions is essential.

2.2 Current Status and Barriers of Women, the Poor and the Excluded to Health

The previous Gender and Social Exclusion Assessment (GSEA) discussion on health barriers remains relevant even today. Apart from economic factors, social ones such as gender, caste, ethnicity, location and age, along with regional identity, greatly influence who accesses what health-related services. The distance to health facilities, discriminatory behavior of service providers and absence of trained health personnel are additional barriers for those experiencing exclusion.

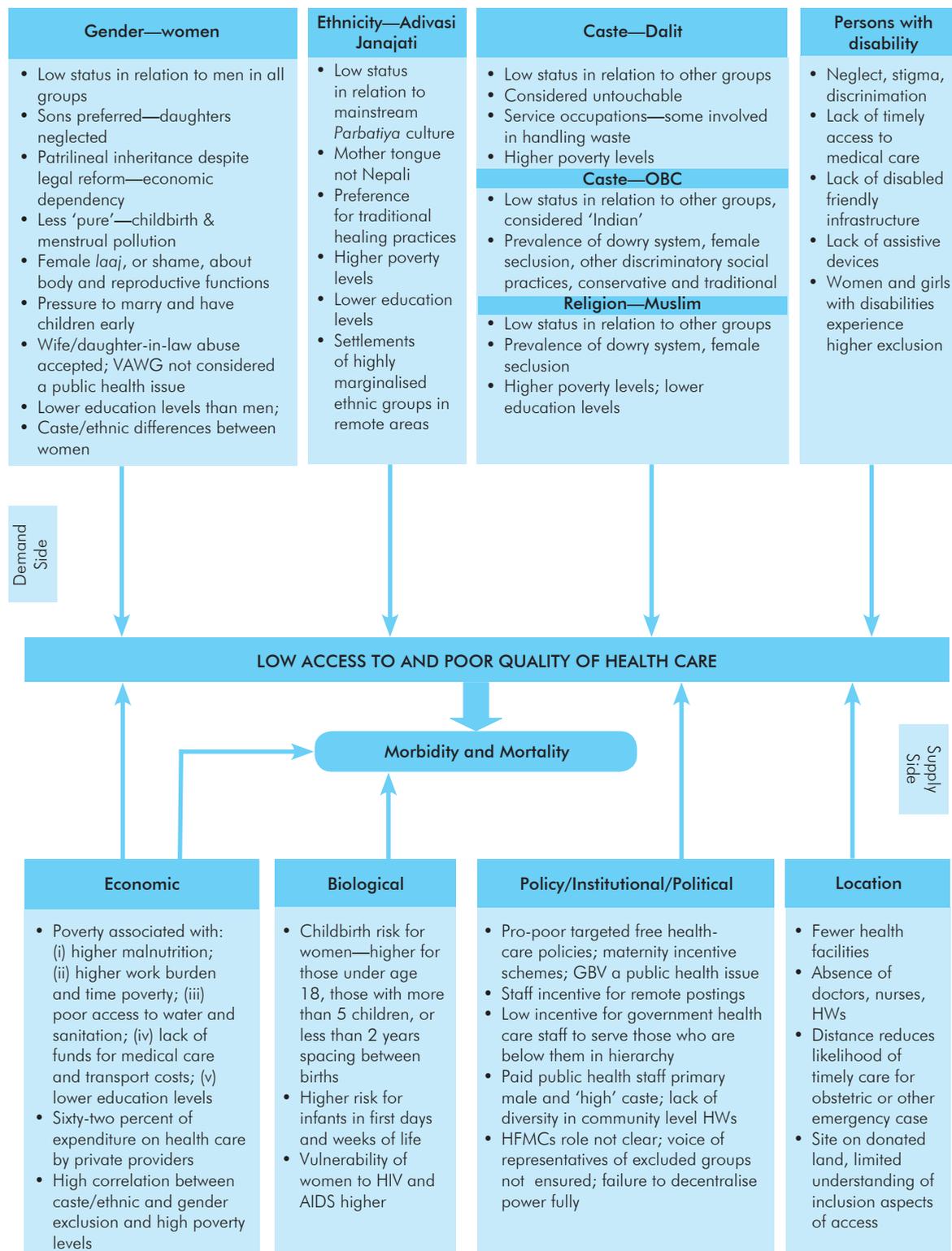
2.2.1 Determinants of health outcomes in rural Nepal

The implications of these determinants for the health of women and men of different social groups are set out in Figure 2.1. Sections 2.2.1.1 and 2.2.1.2 of this chapter deal with the cultural, social and religious determinants shown in the top four boxes, while the locational and economic issues (shown in the lower right- and left-hand corners, respectively) are dealt with in Section 2.2.1.3.

2.2.1.1 Gender-based exclusion in health

Gender-based social practices directly impact health outcomes for women and girls of all social groups, though the degree varies with caste/ethnicity, age, location and wealth. Son preference is generally high. The infant mortality rate has improved but girls are still 1.5 times more likely to die before age five than their brothers, and two times more likely to be malnourished. The gender norms of Nepali society make women dependent on men and greatly hinder a woman's ability to access health services and protect herself from sexually transmitted diseases, even from her husband. This same dependency also makes her vulnerable to gender-based violence (GBV), ranging

Figure 2.1: Cultural, Religious and Social Values, Beliefs and Behaviors Shaped by Interlocking Gender/Ethnic/Caste Based on Hierarchies



from domestic abuse to harmful practices like *chhaupadi*.⁴ Due to widespread stigma, the situation of widows and single women is still worse.

Reproductive health is a key area that is negatively affected by various cultural practices. An estimated six Nepali women die every day from maternal causes—one of the highest maternal mortality ratios in the world—despite the decrease from 531 to 281 deaths (per 100,000 live births) over the last 10 years. The unmet need for contraception is highest among young and rural women. Due to early childbearing, education and employment opportunities for adolescent girls and women are greatly reduced. Strong gender socialization and cultural practices, many of which significantly disempower women, also affect care seeking, notably the concept of *laaj*, or shame, as related to bodily functions, and, in the Tarai, the practice of *purdah*, or female seclusion, among certain communities. Discomfort with being examined by male health workers is cited as a major reason for women not seeking care.

Malnutrition is high, and almost 50% of children weigh less than they should for their age. Wasting, which reflects short-term under-nutrition or high rates of infection, is also common (17% of children have acute malnutrition, and 6.0% severe wasting). In 2006, 46% of children had mild and 16% severe stunting, though the latter figure was down from 28% in 1996. Higher stunting occurred among Dalit, Hill Janajati and Muslim children, followed closely by Madhesi other backward class (OBC) and Hill Chhetri children (NDHS data, 2006). Cultural and social factors have serious implications for the nutrition of women and their children. These factors include not only norms that women should eat after men, and in some groups that they should consume food left for them from their husband's plate—a major vector for the transmission of TB. In addition, there is also lack of time for women laborers to undertake exclusive breastfeeding,

complementary feeding, hygiene and sanitation. Lack of well-funded multi-sectoral interventions to address food availability and failure to scale up successful nutrition and household economics has resulted in widespread under-nutrition (Pokharel et al 2009).

Abortion was legalized in 2002, resulting in a scaling up of services. Today services are available at 240 sites in 75 districts, used by some 280,000 women since 2002, and contributing to a reduction in the number of maternal deaths. Still, complications from unsafe abortion remain responsible for many female deaths due to unavailability of adequate comprehensive abortion-care services and prohibitive costs. These are being addressed now as the government has been ordered by the courts to provide funding for such services.

Violence against women and girls. There is clear evidence that GBV causes physical and psychological harm, and constitutes a major health concern (WHO/WHD 1996; WHO/WPRO 1998; Astbury and Cabral 2000; WHO 2002; ARROW 2005). Violence against women and girls is widespread in Nepal, perpetrated predominantly by men in the form of: beating; gender-biased work division; social practices such as *chhaupadi* and *boksi*;⁵ dowry-related violence; sexual abuse; rape, including marital rape; torture; sexual harassment and intimidation; trafficking; and forced prostitution. Some 5,000-12,000 girls/women aged 10-20 are trafficked every year in Nepal, with 75% of them below 18 years of age, including many who knowingly migrate for sex work due to lack of economic options. In the workplace, 43% of women experience sexual harassment (National GBV Action Plan 2009). Over 80% of the respondents in a recent study⁶ reported experiencing domestic violence from family members, and 74% were forced to participate in non-consensual sex (or marital rape). The social acceptance of all this is indicated by the fact

that 23% of women and 20% of men believe that wife beating is acceptable (Ministry of Health and Population et al 2007).

Suicide has emerged as the single leading cause of death among women in Nepal aged 15-49, according to the Maternal Mortality and Morbidity Survey (MMMS) 2009 though there have been no specific studies on the causes (Subedi et al 2009). What is known is that structural dependency and disempowerment of women can create social and psychological conditions that force them to take desperate measures. There are also no specific data linking domestic violence with suicide although experts say that trauma, depression and other mental issues are among the common psychological after effects of domestic violence (Nepal 2010). Age also seems to be a factor, as 21% of suicides are committed by women aged 18 years and under. Of the 240 suicides committed in eight districts surveyed, Janajati women had the highest rates, followed by Brahmin/Chhetri and Dalits. In Kailali, the district with the highest number of suicides (at 80), 63% were Janajatis. Throughout the country, most female suicides were married. More in-depth understanding of the causes of suicide is required given that suicide was only the third leading cause of death in the MMMS 1998 (even though this could also be because efforts to address other causes of female deaths have been successful).

HIV and AIDS. For biological, socio-cultural and economic reasons, women are more likely to become infected and more often adversely affected by HIV/AIDS than men. Female sex workers⁷ and wives of migrant laborers are the most at-risk groups. Due to their highly marginalized status, female sex workers in Nepal have limited access to information about reproductive health and safe sex practices.⁸ Cultural, social and economic constraints bar them from negotiating condom use with their clients or obtain-

ing legal protection and medical services. Almost 60% of their clients—mainly transport workers, members of the police or military, and migrant workers—do not use condoms.

Sexual double standards, which permit men to have multiple partners but expect women to be virgins at marriage, mean that it is women who are generally blamed—by women as well as by men—for spreading HIV. The fact that women can infect their babies through pregnancy or breastfeeding intensifies this stigma (VSO-RAISA 2004). This blame presents a powerful barrier to HIV-positive women seeking care or even getting tested (Esplen 2007). The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV.⁹

For *women with disabilities*, legal and social discrimination are very high. Men are legally allowed to remarry if their wives suffer visual or locomotive impairment. While 67% of blind persons in Nepal are women (CBS 2001), over a three-year period 1.2 million fewer women accessed eye-care services than needed to achieve gender parity (Nepal Gender and Eye Health Group 2009).

Caste/ethnic differences between women are high. Most health indicators reveal disparities between women of different social identity groups. Dalit women, especially Madhesis, score poorly in almost all Department of Health Services (DHS) indicators. They are the worst off in receiving antenatal care from health facilities/skilled birth attendants (SBAs), are the most underweight, have the lowest percentage of child delivery by SBAs or in a health facility, have high total fertility rate (TFR), and have the highest percentage of childbearing adolescent women. Between 50 and 70% of Tarai/Madhese women suffer from low hemoglobin levels (Ministry of Health and Population et al 2007), an ailment directly related to dietary and social practices. Madhese women are also the least likely to have

discussed family planning with their spouses. In addition, because of *purdah* restrictions, 64% are not able to go to health facilities alone, compared to 50% of hill women.

Janajati women seem to prefer to follow indigenous practices, including those related to maternal and child health. Some of these practices do have medical benefits although there is limited understanding of how these work. But even this indigenous knowledge has been gradually disappearing.¹⁰ At the same time, hill indigenous women have particularly low access rates to health facilities in rural areas: 42% are without access to antenatal care, compared to just 9% of Hill Brahmin women. Muslim women have the highest TFR, a direct result of religious restrictions against family planning as well as their limited influence over their reproductive rights.

As for access to antenatal care from a health worker or in a health facility, Muslim (32%), Tarai Janajati (33%) and Hill Janajati (35%) women have the lowest percentages; Hill Brahmin (79%) and Newar (68%) women have the highest. The wealthiest women are 12 times more likely to use a trained health worker during delivery than the poorest. Also, women in the lowest quintile have fertility rates of 4.7, compared to 1.9 for the wealthiest group; the rate for rural women is 3.3, compared to 2.1 for urban women.

In Nepal, around 23% of the population are adolescents. The DHS data on adolescent pregnancy and motherhood show that 21% of adolescent girls from Madhes-origin groups have begun child-bearing, compared to 17% among the hill/mountain groups. Among all groups, Hill Dalits have the highest percentage (31%) of teenage mothers, nearly twice the average for hill/mountain groups. The overall prevalence of anemia among adolescents is 65.6%: rural (62%), urban (70%), male (52%) and female (78%).

Older women suffer more from uterine prolapse,¹¹ with symptoms ranging from a low of

2% among women under 20 years of age to 9% among women aged 45-49 years (NDHS 2006 data). Frequent childbirth, heavy workload and no rest after childbirth (in Morang, women said they return to work two to three days after delivery) are key causes, resulting in not only physical pain but also social problems, including violence in marriage and men seeking second wives. Embarrassment often compels women to maintain silence, while lack of services and the high costs associated with treatment likewise deter service-seeking behavior (NNBN and SAATHI 2009) even though free surgery was initiated in 2008-2009 by MOHP.¹²

2.2.1.2 Caste/ethnic/religion/region-based exclusion in health

The NDHS 2006 shows that Dalits, disadvantaged Janajatis, Madhesis, OBCs and Muslims have consistently low indicators across most dimensions covered (Bennett et al 2008). For many, healthcare services are inaccessible due to distance, unaffordable due to poverty and high costs (though free service has addressed this somewhat), unapproachable due to social/power relations, incomprehensible due to language barriers, embarrassing or even humiliating due to cultural insensitivity on the part of the service providers, and ineffective due to poor quality.

Representatives of Janajati groups consider language to be one the most severe barriers in accessing basic healthcare, even higher than economic and resource limitations. This, coupled with the gradual disappearance of indigenous knowledge, could have contributed to the high under-five mortality rate (80 per thousand live births) among Hill Janajatis, compared to a national average of 68. Within 35 Janajati groups,¹³ more than 50% of children under five suffer from stunted growth, are underweight, or both. About 38% of the Hill Janajati population have no access to a health post within an

hour's walk, making them the most disadvantaged among all Nepali groups in terms of physical access to healthcare. Differences in neonatal mortality rates between Brahmins/Chhetris and Dalits, and between Newars and Janajatis, have increased over the last decade (Health Sector Reform Support Programme 2008).

Sanitation facilities and hygiene practices leave large portions of the population vulnerable to debilitating diseases. The 2001 Census reported that only 23% of households had toilets with any water-flow facility. This left 68% of Brahmin/Chhetri households with no toilet, as well as an extremely high proportion of Madhesi Dalit (90%) and Tarai Janajati (79%) households. Urban/rural differences indicate sharp disparity, with 52% of urban households versus 17% in rural areas having toilets (Tanka Prasad Acharya Memorial Foundation 2005). As a region, the Tarai has the lowest coverage of toilets.

Excluded groups are also highly vulnerable to HIV/AIDS, tuberculosis, and other communicable diseases. Nepal has the highest HIV prevalence in South Asia, with 0.49% of the population aged 15-49 being infected; the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates nearly 70,000 people are living with HIV.¹⁴ Nepal's 1.5-2 million labor migrants account for 46% of the country's HIV-positive population, and thus HIV infection is reported highest in the Far-Western Region, where around 80-90% of households (predominantly Dalits and extremely poor) have at least one male member as a migrant worker. Only 86% of Tarai/Madhes males had heard of HIV/AIDS, compared to 95% of men from hill/mountain groups. For women, the difference is greater: 48% and 84%, in the Tarai and Hill/Mountain regions, respectively. In fact only 37-39% of OBCs, Madhesi Dalit and Muslim women have heard of HIV/AIDS compared to around 85% of the men of these groups. This is indicative of

both socio-cultural realities and, perhaps, past program interventions that have failed to reach out to women in the Tarai region.

2.2.1.3 *Income- and location-based exclusion in health*

While three NDHS surveys from 1996 to 2006 indicate that there has been a decrease in the difference between wealth groups for several indicators—contraceptive use, childhood immunization, diarrheal disease, acute respiratory infection, under-five and infant mortality rates, and birth weight or size at birth (Health Sector Reform Support Programme 2008)—wide disparities still exist. Although the poor suffer higher rates of mortality and morbidity, the richest fifth of the population spend 25 times more than the poorest on healthcare utilization (Prasai et al 2006; Nepal National Health Accounts 2001-2003). Wealth differentials within caste/ethnic groups are also wide. For instance, contraceptive use by the wealthiest Newars is 68% and only 26% among the poorest (Health Sector Reform Support Programme 2008); among Muslims, too, the difference in contraceptive use between the poor (4%) and the rich (42%) is very stark. Among the wealthiest Brahmins/Chhetris, the use of SBAs during delivery increased from 39% to 66% from 1996 to 2006, compared to an increase from 3% to 5% in the poorest quintile of the same group (Health Sector Reform Support Programme 2008). Differences also exist between the wealthiest in different caste/ethnic groups (100% of the richest Newar and OBC children are fully immunized, compared to just 50% of the richest Dalits). Surprisingly, 100% of the poorest Muslim children are reported as fully immunized, perhaps the result of targeted interventions.

There are strong variations in poverty levels across regions, with populations in the Mid- and Far-West three times more likely to fall into the poorest category than the wealthiest (Kishor

2000; Turmen 2003; Koenen et al 2006). Place of residence is also likely to be a stronger determinant for family planning than education, and has a strong bearing on life expectancy: which is 74 in Kathmandu, but only 44 in Mugu. The out-migration of men seeking employment increased the number of female-headed households, most notably in rural areas, from 12% in 1996 to 23% in 2006 (Kishor 2000; Turmen 2003; Koenen et al 2006), with female-headed households over-represented in the two poorest quintiles (2001 and 2006 NDHS). Overall, around 22% of the population still lack access to basic health facilities, with 36% having to walk two to four hours to reach a motorable road.

These indicators are the result of a combination of poverty, discriminatory practices based on caste/ethnicity and gender, and regional exclusion. It is thus necessary to identify the differentials between different social groups as well as between income levels in order to achieve the goal of universal access to health care.

2.3 Policy and Legal Framework and Programmatic Response: How Are the Barriers Being Addressed?

Another major determinant of health outcomes is Nepal's policy and institutional context. This section addresses the first of these factors. After a brief review of the overall policy framework,¹⁵ we discuss the mandate of NHSP (Nepal Health Sector Program) 1 from a gender equality and social inclusion (GESI) perspective,¹⁶ and analyze the planned Nepal Health Sector Program Implementation Plan (NHSP-IP) 2 program supported by the sector-wide approach (SWAp) partners.

2.3.1 Overall policy and legal framework

As noted earlier, health as a fundamental right is assured in the Interim Constitution, and there has been considerable commitment by the gov-

ernment to invest in the health of its citizens. The Local Self-Governance Act, 1999, while generally silent on the specific topic of social inclusion, provided the practical first steps by requiring the participation of women, the poor and the disadvantaged in health facility management committees (HFMCs, detailed further below). International commitments have also created a positive policy environment. Among other agreements, as a signatory of the MDGs and the International Conference on Population and Development, Nepal has a commitment to improve maternal health and achieve universal access to reproductive health by 2015.

There are a number of other government policy mandates in reproductive health,¹⁷ child health, violence against women and HIV/AIDS that are positive from a GESI perspective. Some policies, such as the National Safe Motherhood and Newborn Health Long-term Plan, have identified gender equality, social inclusion and a rights-based approach as overlapping and complementary objectives; the latter even includes equity and access as a separate output. Still, there is currently no clear definition of who constitutes the "disadvantaged," "vulnerable," or "excluded," nor are there explicit requirements that group-specific constraints be addressed.

A recent positive shift has been the recognition by the health sector that violence against women is a public health issue. In the recent national action plan against GBV, a health-sector response was detailed; in 2006, marital rape was outlawed, though in practice this lacks enforcement. A national strategy on HIV/AIDS has been in place since 2002 and an updated strategy and action plan for 2006-2011 have been developed, which aim to reach all at-risk population groups. Recognizing the low access of female injecting drug users (IDUs) to services and the high rate of sexually transmitted infections among this group, the plan has targeted

them separately. But although the strategy seeks to ensure that the response to HIV/AIDs is rights-based and gender considerations are central, these principles are not spelled out clearly enough. For persons with disabilities, meanwhile, availability of services is poor.

The traditional model of targeted service delivery for disadvantaged groups will not be enough. A demand-side approach is necessary, focusing on empowering individuals and groups to recognize the structural causes of their situations and building their capacity to transform inequitable power relations. At the same time, attention needs to be given to the supply side: building the capacity of the health-delivery system and making it more responsive and accountable to those it serves. A major part of this will need to be based on an improved understanding among policy-makers, administrators and caregivers of the specific barriers experienced by different social groups (see Figure 2.1), and a commitment to develop, budget for and implement mechanisms to overcome these.

2.3.2 NHSP-IP 1: Achievements and gaps in improving health services for women, the poor and the excluded

The Nepal Health Sector Reform Strategy (2004) is at the center of MOHP's ongoing SWAp, and is its core instrument for attaining MDGs 3, 4, 5 and 6.¹⁸ The Ministry's NHSP-IP 1, 2004-2009 (later extended to 2010), strongly backed by EDPs,¹⁹ was mandated to roll out key reforms, including decentralized healthcare delivery, free essential healthcare services, public-private partnerships and pro-poor policies. Unfortunately, conceptual clarity regarding gender and inclusion, and the need to address structural issues for marginalized groups, were absent in both.

The Vulnerable Communities Development Plan (VCDP) was prepared as a guide for

NHSP-IP 1 to address social exclusion. It clearly presented the health status and problems of women, the poor and the excluded, and provided a plan to address issues at multiple levels. However, very few of these actions have been implemented—though the Ministry says that the VCDP has influenced the health discourse in general.²⁰ While NHSP-IP 1 did not have a strong focus on equality and exclusion, this deficit was somewhat addressed after the Interim Constitution declared health as a fundamental right. Since 2007, the government has responded with a number of pro-poor free healthcare policies²¹ and interventions.

2.3.2.1 Pro-poor programs

Addressing the economic barriers to services, three government programs have increased access for the poor, socially excluded groups and women. These schemes provide free services and medicines, cash for transport for institutional delivery, and remuneration for health workers attending home delivery.

Universal and targeted free care. Since 2007, three surveys have indicated that a high proportion of Dalits have used outpatient services, illustrating that free health service has supported them. (Madhesis, Muslims and Brahmins/Chhetris have also used these services.) In particular, there has been a steady increase in the number of women using the services, rising from 53% to 73%. Similar trends are found for persons with disabilities. The very poor remain the largest group using these services, improving from 17% to 35% (Health Facility Surveys 2009). Yet, while utilization by marginalized groups increased,²² availability of drugs declined. Stock-outs of essential drugs lasting more than one week increased at all levels (NHSP-IP 1 Impact Study 2009)—by 96% at hospitals and primary healthcare centers. Further, a study in 10 district hospitals revealed that most users, especially the

poor, remained unaware of the free care policy, to the point that many of the poor registered as non-poor and thus paid fees. However, the same study revealed that poorer groups were receiving a larger share of public subsidies at district hospitals (Research Triangle Institute 2009).

Another recent study reported that the district and central bidding procurement processes impact negatively on drug supply. Additionally, more than 50% of prescribed drugs are not covered in the free drug scheme, and need to be purchased from private retailers. Service seekers report difficulties in differentiating between free and not-free drugs, and are thus suspicious of health workers' prescriptions. Often, prescribers are owners of private drugstores located just outside the health facilities (Sapkota and Shrestha 2009).

AAMA (Action Against Malnutrition through Agriculture) program. Financial assistance to women seeking skilled delivery care was started in July 2005,²³ and has contributed immensely to addressing the economic barriers experienced by women: 89% of women delivering in an institution received the incentive (Department of Health Services 2009). While most women continue to deliver at home, institutional deliveries increased from 8% in 1996 to 23% in 2009 (Department of Health Services 2009). Field interactions indicate that the financial support is affecting socio-cultural practices, too. For example, in Doti, the practice of *chhaupadi* is being reduced as women are going to health facilities instead of being isolated in a cowshed, and dietary practices are changing as women gain mobility. Health facilities are eager to provide delivery services, as they earn money and are able to save and invest in their facilities. AAMA is seen to have led to major increases in 24-hour delivery services, while a 10-district evaluation of the Safe Delivery Incentive Program (Powell-Jackson et al 2008) judged it to be effective in increasing skilled attendance at delivery.

However, no impact was discernible for women living in the hills and a number of challenges are reported related to scheme management, fund flow and reporting. Following the introduction of the Safe Delivery Incentive Program, national usage of trained health workers at delivery has risen to 41% (HMIS 2009). MOHP has also introduced cash incentives for community-level health workers and a scholarship scheme for excluded candidates to attend medical school.

Other programs. Several focused pro-poor community-level demand-side programs have been addressing equality and inclusion since 2005, including UNICEF's Women's Right to Life and Health program (13 districts), the Nepal Family Health Program (NFHP) community activities (20 districts), Mother Infant Research Activities support to women's groups in Makwanpur, CARE's Maternal and Neonatal Health (MNH) program in Doti and Kailali, the Swiss Agency for Development and Cooperation (SDC) Rural Health Development Program (RHDP), and Department for International Development's (DFID) Support to the Safe Motherhood Programme (SSMP) equity and access program. A notable success of these has been the development of localized behavior change communications materials specifically designed for poor and excluded communities, increasing the coverage, and enhancing women's empowerment and participation in local health governance

2.3.2.2 Health facilities in remote areas

Physical facilities were expanded or upgraded in remote and underserved areas. Among others, this included the establishment of four district hospitals and five health facilities in traditional medicine services (Ministry of Health and Population 2010), and the scaling up of mobile clinics from 5-10 to 30-40. Recent government policy prioritizing the construction of peripheral health facilities has led to 80% of its draft 2009-

2010 infrastructure budget being earmarked for rural facilities. While this will eventually improve access, a sizeable construction backlog currently exists. Further, the requirement that all new facilities be built on donated land has led to the construction of sites far from population centers.

2.3.2.3 *Disaggregating health service utilization data*

Since July 2009 the health management information system (HMIS) has initiated a disaggregated recording and reporting system, using 19 variables²⁴ with caste/ethnicity coded into six groups.²⁵ While all health facilities are recording by caste/ethnic groups, 10 districts have been identified to report the information upward to MOHP's HMIS under a pilot program. Discussion with HMIS staff²⁶ indicated that they were anxious about the caste/ethnicity groupings—unsure who falls where and uncomfortable with some terminology (“upper caste”). They felt a more authoritative government document was required, perhaps from the National Planning Commission (NPC) or the Ministry of Local Development.²⁷ Additionally, expanding of reporting from just those attending the health facility to cover the whole country was challenging: staff felt that the training of all health workers responsible for reporting would be expensive as would report preparation. They suggested that the number of indicators needed to be reduced and it would be more effective to focus on what was essential to make informed decisions. Importantly, these data at present reflect only people who come to government health facilities, and hence even disaggregated information would not in itself give a complete picture of the situation in any given location.

In response to output 8 of NHSP-IP 1, which focuses on HMIS improvements, a national strategy for the health sector information system (HSIS) was developed in 2005 to capture com-

prehensive disaggregated information, but has not been operationalized. Pilot implementation in three districts is planned, but has been slow to gain momentum.

2.3.2.4 *Decentralization efforts in the health sector*

The health sector reform strategy authorized local bodies to be “responsible and capable of managing health facilities” (MOHP 2004), and since 2002 some 1,433 out of 4,070 health facilities in 28 districts have been handed over to local bodies. Yet, while the health committees are responsible for overseeing the functioning of health staff, they have no authority over hiring and firing. Thus, “[t]he responsibility of the management is not transferred in a true sense. People have no access to resources” (Paudel n.d.). Further, the National Health Training Center has no mechanism to track the performance of the HFMCs,²⁸ and no study has been done on their post-handover performance.

HFMC formation is led by the health facility in-charge and members are, according to the guidelines, the village development committee (VDC) secretary, political leaders, health post officers, teachers and local health promoters. Selection is not by the people but by the VDC secretary and health post in-charge, a process that can be vulnerable to political capture. Committees are required to have a certain number of women, Dalits and Janajatis, but the management guidelines say nothing about their responsibilities to address social barriers or to represent their identity groups' view. Indeed, the understanding of members regarding the HFMCs' function is uneven, particularly that the HFMC must also address social issues and community-level health education. Further, discussions with field health workers suggest that they are rarely, if ever, involved in planning. While a study of 18 HFMCs indicated that representa-

tion of women is high, in many cases, Dalit and women members had only token participation and no hand in decision-making (Gurung 2009; Dhakal 2009).

HFMCs are an important mechanism for bringing health services closer to the people, and have great potential to address GESI issues. A rapid survey of 21 facilities²⁹ indicates that HFMCs have variously conducted immunization, nutrition and sanitation-related programs; monitored medicine supply; organized infrastructure repair work; conducted house-to-house awareness campaigns; and invested in establishing outreach (*gaun-gbar*) clinics. Importantly, communities have frequently been supportive in improving the physical aspects of health facilities. Several HFMCs have prepared a list of poor and marginalized people, and authorized them to receive health services free (<http://nfhp.jsi.com>). Appreciative inquiry work with HFMCs has led to improved capacity to address local needs,³⁰ though HFMC effectiveness is difficult to assess in the absence of any nationwide report.

The key issue identified by HFMC members is that meetings are not regular, and women, Dalit and Janajati members are often not informed about them. Further, there are very limited resources, infrastructure is poor, and there is no remuneration for volunteer members. As NHSP-IP 2 (MOHP 2010) states, “handing over of health facilities on a piecemeal basis... invited a number of management confusions... [and] did not change the decision making power structure and accountability mechanisms. Upward accountability remained as usual; therefore, the health system was not able to hear the voice of people in a meaningful manner.”

2.3.2.5 Private sector

The role of the private sector, including pharmacies, in health service provision has developed quickly in the past decade and currently

accounts for around two thirds of total out-of-pocket expenses for health care. Private providers are found primarily in urban areas and the Tarai (though in hilly areas, too, health workers run pharmacies), and have increased disparities in hospital beds per population and physicians per population by ecological and development regions. The absence of an effective regulatory body with reliable data on private sector activities is recognized as a major weakness.

2.3.2.6 External development partner support to NHSP-IP 1

Several bilateral agreements between MOHP and various EDPs³¹ in support of the national long-term health plan are in effect, many addressing gender and inclusion issues. Examples are the USAID-funded NFHP, UNFPA, SDC's RHDP, and international non-governmental organizations like CARE. Plan's continued work with female community health volunteers (FCHVs) has ensured that these volunteer workers have continuous inputs for capacity building and, with the new FCHV funds, have the resources available to provide minor services to the people. GTZ/GIZ, along with other EDPs, has worked on decentralization in health systems and improving systems. These all contribute to an improved environment to address GESI issues.

2.3.3 Nepal Health Sector Program- Implementation Plan 2

NHSP-IP 2³² has three key objectives: to increase access to and utilization of quality essential healthcare services; to reduce cultural and economic barriers to accessing healthcare services and harmful cultural practices in partnership with non-state actors; and to improve the health system to achieve universal coverage of essential health services. The results framework of NHSP-IP 2 demands disaggregated measure-

ments. From a GESI perspective, the strength of NHSP-IP 2 is that it seeks to improve *access* to essential healthcare services in order to improve *utilization* of these services so as to improve *health status*—each of these especially aimed at the poor and the excluded (including women). With the second objective specifically addressing cultural and economic barriers, NHSP-IP 2 has a more rights-based approach and a sharper focus on equity and inclusion than did NHSP-IP 1.

The other two objectives also address and mainstream GESI issues. Objective 1 prioritizes improved access to essential healthcare services (an estimated 70% of the budget), while deepening “reach” to the poor and the excluded through incentive schemes. Objective 3 strengthens the health systems and addresses issues of governance, human resources management and key aspects that affect access to services and plans to provide financial protection against impoverishment due to illness. This objective will supplement MOHP’s oversight system with third-party monitoring. While GESI has thus been well mainstreamed, strategies for empowerment of women, the poor and the excluded to ensure their health rights have not been identified (MOHP 2010).

The Governance and Accountability Plan contains a number of very positive plans and indicators addressing staffing, inclusion, accountable governance and strengthening HFMCs. Likewise, a recently approved GESI strategy provides guidance on mainstreaming gender and inclusion, and will be operationalized under NHSP-IP 2. It has defined target groups (though there is an overlap in the definitions of “poor,” “vulnerable,” and “marginalized”), and outlined three objectives and eight strategies to address policies and actions, though more specific guidance will be necessary for implementation. Previous experience (e.g., the non-implementation of the VCDP) indicates that significant political will is required and that GESI

has to be a part of routine structures for such strategies to be effective. DFID, the World Bank and the other pool funders will not earmark funds for specific components of NHSP-IP 2 but will focus on key results in the logical framework. Below, we discuss the support of two of the pool partners, DFID and the World Bank, to NHSP-IP 2.

2.3.3.1 *Nepal Health Nutrition and Population and HIV/AIDS Support Project*

The development objective of World Bank support to NHSP-IP 2 is to assist the government in improving the equitable delivery of healthcare services. The project comprises two components: service delivery and health systems strengthening. There are a number of planned interventions that can increase access to services for women, the poor and the excluded but the necessary preparations have yet to be spelled out. Currently, the monitoring indicators do not capture progress on making healthcare more accessible to these groups; and only some indicators are disaggregated by income, and none by caste/ethnicity or sex. Further, of the 13 indicators, “social audits” and “training of SBAs” are the only ones that reflect any GESI element. The Governance and Accountability Plan has a number of indicators that measure actions that can contribute to the improvement of health outcomes of women, the poor and the excluded, though without disaggregation.

2.3.3.2 *Support to NHSP-IP 2, DFID*³³

Output 2³⁴ of NHSP-IP 2³⁵ recognizes explicitly that non-technical interventions, particularly empowerment, will be important in addressing barriers and risk factors that adversely impact on excluded groups. DFID support has recognized that the GESI strategy will be key in guiding efforts to improve the supply side (e.g., improving staff diversity and addressing discriminatory attitudes of service providers) and the demand

side by reducing social risks (e.g., discriminatory social practices). Effective GESI mainstreaming from MOHP to the community level will be operationalized and barriers of different social groups will be identified and addressed. However, these outlined measures require a budgeted action plan with dedicated responsibility of selected staff, which is not yet in evidence.

2.4 Health Sector Institutional Issues

In this section we deal with the second aspect of the “policy and institutional context” (shown in Figure 2.1). Institutional arrangements, the location of responsibility for GESI, and institutional culture and attitudes of health service providers greatly determine the access of women, the poor and the excluded to health services. Following our framework, we assess various human resource-related issues. Institutional culture and attitude of service providers are difficult to assess without in-depth reports but we draw from sample field reports and key informant experiences.

2.4.1 Adequacy of staff in facilities

The key challenge of human resource management is related to sanctioned versus filled posts, deployment and retention, particularly in remote areas. Since the poor, women and the excluded have greater difficulties in accessing services that are at a distance and are more expensive, they are affected the most. An MOHP plan covering 2003-2017 aims to improve the utilization of the Ministry’s staff, but a severe shortage of staff continues to hamper provision, particularly at peripheral facilities. MOHP records a total of 25,239 employees, of whom 18,401 are technical personnel. From 1996 to 2006, there was no substantial improvement in the number of sanctioned positions of doctors and nurses. The NDHS for 2005-2006 reported that significant vacancies exist in hospitals (excluding at the central level) and primary healthcare centers: 47%

of doctor positions, 22% of staff nurse posts, and 9% of assistant nurse midwife (ANM) posts. An additional concern is the acute shortage of SBAs needed to meet the MDG target; by 2009, less than one fifth of the target had been met.

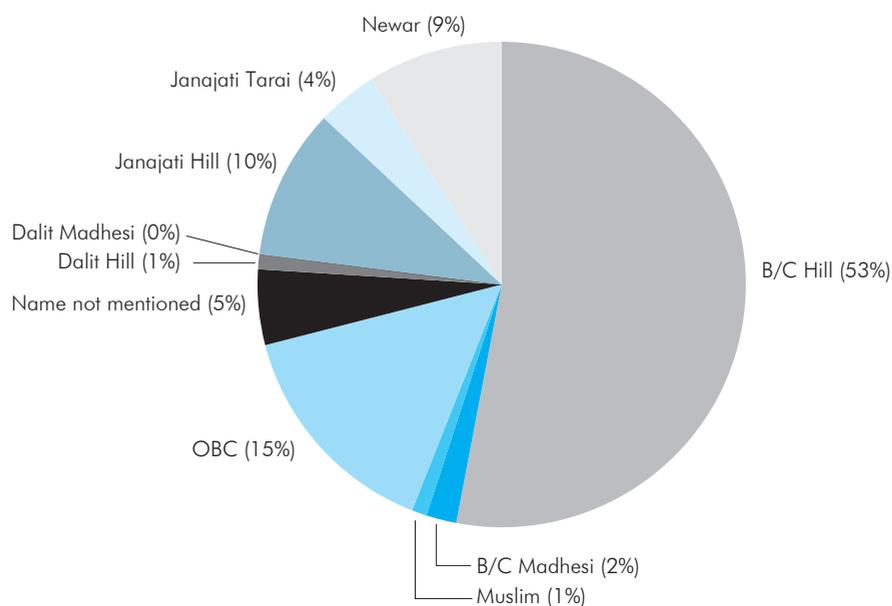
While the local contracting of additional health staff by HFMCs has improved availability and acceptability of service providers,³⁶ few discernible changes are evident in recruitment, management, promotion and transfer practices at the center. MOHP’s human resource database allows for the tracking of staff by background but it is currently out of date and underutilized. Likewise, the Human Resource Information Center can generate information to support decisions related to human resources but there is hardly any demand for this information. Sector human resource strategies have yet to be fully implemented, thereby allowing political capture of key posts and distortions in staffing patterns. Still, MOHP has implemented a two-year compulsory service scheme for physicians who have studied on a government scholarship, and, to date, 280 medical doctors have thus joined peripheral health facilities. Robust arrangements at the most peripheral level allow the system to continue providing lower-level services. Importantly, the number of FCHVs, the first point of contact for many, increased by 14% between 2001 and 2006 (NDHS 2006 data).

2.4.2 Level of diversity in Ministry of Health and Population staff

A disaggregation of 19,597 government employees in the health sector³⁷ indicates that there are 29% women and 71% men in the sector in general. Compared to the national population, there is over-representation of Brahmins/Chhetris and Newars, almost equal representation of OBCs, and all other groups are under-represented (see Figure 2.2).

Of the 1,034 staff at the gazetted level, 16.34%

Figure 2.2: Diversity of Civil Personnel in the Health Sector



Source: Nijamati Kitabkhana, February 2010; analysis by study team.

are women (including one woman secretary). Of the 14,204 staff in non-gazetted positions, 34.67% are women. Finally, there are 4,359 staff without any grade, of whom 11.47% are women (see Figure 2.3).

Brahmin/Chhetri men of hill origin clearly dominate health-related decision-making, leading to limited availability of different language skills or understanding of differing social norms. A quota system for employment has been initiated by MOHP, and, in 2009, an amendment to the Health Service Act (1996) required that 45% of vacant posts be reserved for women (33%), Janajatis (27%), Madhesis (22%), Dalits (9%), those with disabilities (5%), and those from “backward” areas (4%). However, the strategic plan for human resources has not identified any strategy by which to increase the representation of women in decision-making positions, or to increase caste and ethnic diversity.

Even FCHVs are primarily from Brahmin/Chhetri groups and relatively better-off households, largely because women from extremely

poor households (including many Dalit women) are unable to volunteer for economic reasons. Additionally, advantaged households are often unwilling to accept services from Dalit FCHVs.³⁸ A recent survey reports that FCHVs represent Janajatis and OBCs at nearly their proportion of the population, but Muslims and Dalits at only half their proportion. In quite a few Tarai districts, FCHVs have been largely recruited from Dalit castes—possibly because in that region child-birth attendance is an occupation traditionally filled by Dalit women. In contrast, in

the hills, where this tradition does not exist, there are hardly any Dalit FCHVs, reducing the likelihood that Hill Dalit women will have access to such services (USAID 2007).

2.4.3 Location of gender equality and social inclusion responsibility

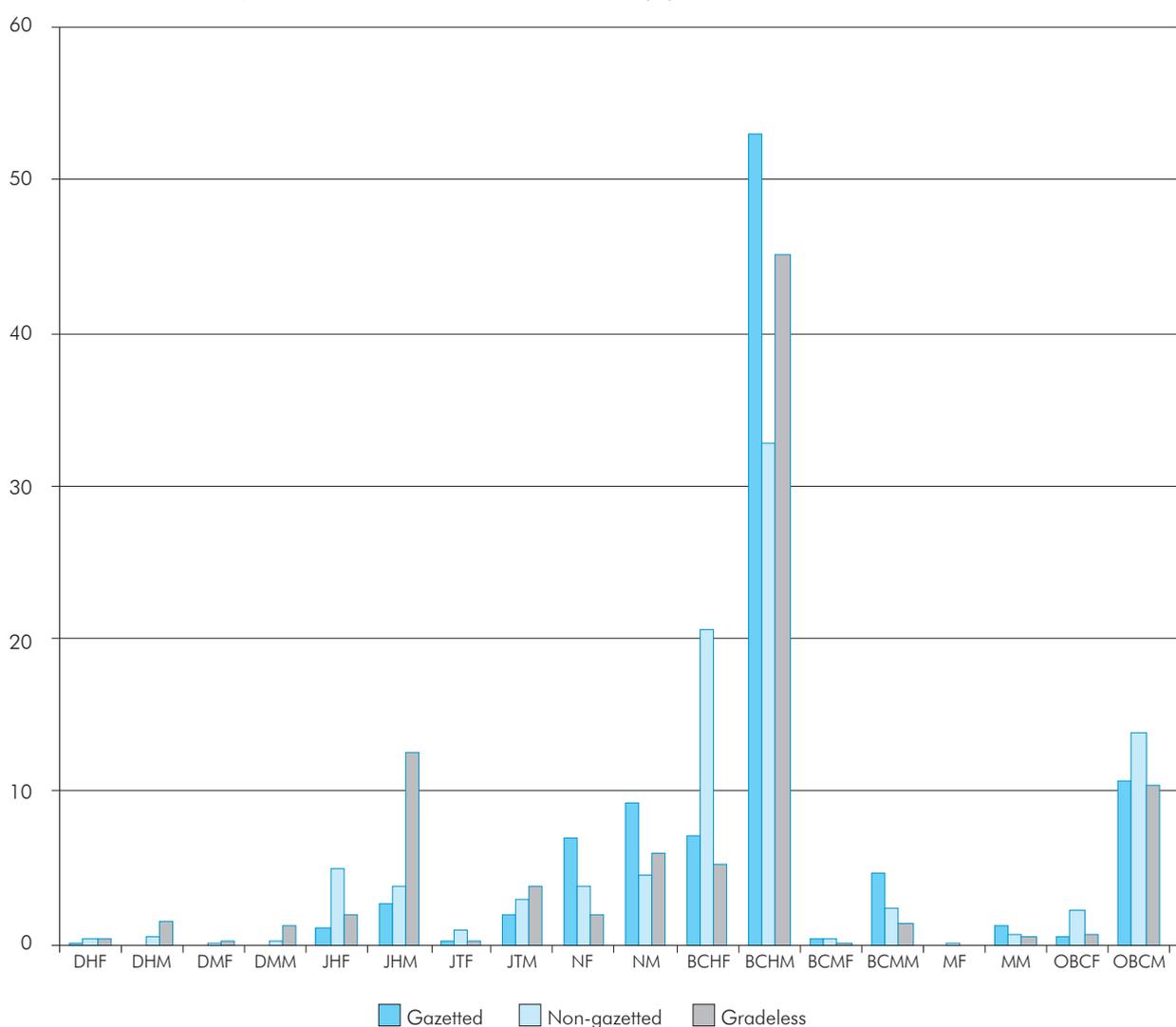
A gender focal point has been appointed in MOHP (as in all ministries) but has not been effective due to lack of resources, limited authority and an institutional failure to link gender focal point responsibilities to the routine work of the sector.³⁹ The recently approved GESI strategy has proposed a GESI section in the Ministry and in hospitals at all levels and a network at the regional level. The Ministry-level section is to provide technical assistance in policy and program development and implementation; ensure that monitoring and evaluation (M&E) capture GESI dimensions; build capacity of other units/desks and focal persons; and coordinate between departments, sections and units for GESI.

MOHP units are to monitor and coordinate, while the Staff Security Units (SSUs) in hospitals are to increase access of target groups to hospital services.

These structures are still to be operationalized and the strategy has not detailed how these steps are to be carried out nor discussed the challenges and the lessons from the current practice of having a gender focal person—generally agreed to

have had little impact. Additionally, the role of the gender focal person with respect to the GESI section is not clear nor have specific resources been allocated for implementation. Yet, without detailed specification of the activities needed to attain the desired results, assignment of responsibilities for these results to specific staff members and allocation of sufficient resources in the annual budget, implementation of the GESI strategy

Figure 2.3: Diversity of Civil Personnel at Different Levels (%)



Note: DHF/M—Dalit Hill female/male; DMF/M—Dalit Madhesi female/male; JHF/M—Janajati Hill female/male; JTF/M—Janajati Tarai female/male; NF/M—Newar female/male; BCHF/M—Brahmin/Chhetri Hill female/male; BCMF/M—Brahmin/Chhetri Madhesi female/male; MF/M—Muslim female/male; OBCF/M—OBC female/male.

Source: Nijamati Kitabkhana, February 2010; grouped for the study based on GSEA caste/ethnic groupings.

will not be effective. The VCDP also provided for GESI units and their capacity building but, as noted, it was never implemented. A review indicates that none of the other structures has been made specifically accountable for addressing GESI issues. In practice, GESI issues are primarily addressed by local-level health facilities. But, unless they are given clear responsibility, neither decision-makers nor implementers are bound to ensure that the barriers facing different social groups are recognized and responded to.

The National Health Training Center, five regional health training centers and their respective sub-centers conduct several training programs every year but these do not include mainstreamed GESI training. Data are not available about gender-related training programs but the investment is minimal.⁴⁰ Conceptual clarity regarding gender equality and social inclusion is inadequate and the skills to apply such concepts are weak. A short orientation on GESI is generally included in all training packages but inclusion issues and inequitable structures are not clearly addressed.

2.4.4 Motivation and attitudes of health service providers

Discriminatory attitudes of health workers continue to have a major bearing on user satisfaction (RTI/CARE 2009). By contrast, positive experiences with health workers are commonly cited as the principal cause of client satisfaction (SSMP 2009). Common problems of poor pay and low motivation affect health service providers, yet research has confirmed that non-financial incentives are as important as monetary remuneration in retaining health workers in Nepal (WHO 2008). In particular, the fact that there are very inadequate incentives linked to performance affects services to women, the poor and the excluded, as the effort required to provide services to these groups is higher. Work with HFMCs demonstrates that worker motivation

can be improved through processes like appreciative inquiry, which supports health facility managers to take on leadership roles and mobilize local stakeholder support to respond to their needs (SSMP 2010). GTZ/GIZ and UNFPA have supported quality of care strategies. Training of health service providers through such strategies has contributed to improving the quality of care clients receive.

2.4.5 Working environment

The working environment is not conducive to job satisfaction,⁴¹ especially for women and Dalits. For Dalit health workers, finding housing is a serious issue due to bias. Institutional discrimination also exists as even competent senior women are rarely appointed as health facility in-charges and workers from excluded groups have difficulty in accessing information on employment and education opportunities. Despite reservations, the recruitment and promotion system remains problematic due to an examination system that focuses on issues beyond practical experience, lack of support for examination preparation, and bribery and other malpractices used for transfers and promotions.

2.5 Program Activities and Budget Analysis

This section analyzes government and programs' budget allocation to examine the extent to which resources are being spent on health sector activities that are expected in some way to help women, the poor and the excluded. The objective is to "follow the money" in order to assess what efforts have been made to address the issues that constrain these groups' access to sector benefits; analyze how much of the budget has been allocated and spent on such issues; and assess the degree to which government funding for these issues is channeled through *targeted programs* or integrated into *mainstream programs*.

The government's annual budget speech presents three different types of analysis of the budget from a gender and inclusion perspective: expenditures in support of "inclusive development and targeted programs" are identified; the gender-responsive budget (GRB) exercise is presented; and pro-poor expenditures are identified (Annexes 8a, 8b and 8c of the annual budget speech 2009-2010, respectively). The government budget speech allocated Rs 17,840,466,000 for health, of which none was categorized as "inclusive development/targeted programs," Rs 17,400,195,000 (40% direct, 57% indirect) was categorized as gender responsive, and Rs 10,098,860,000 as pro-poor (57% of the total budget).

We tried to identify how classifications were made and the process that was followed. Indicators are not specified for inclusive development/targeted programs, but there are indicators for GRB⁴² and pro-poor budgeting.⁴³ Our discussions with Ministry and line agency staff indicate, however, that guidelines are not clear, and in the end it is left to the budget officer to categorize and score the various budget lines to the best of his (it is primarily men) understanding. Since the scoring and indicators were not clear for the other two kinds of budgeting, we have focused on reviewing the government's GRB indicators, identifying what sub-indicators are relevant, and whether this approach is effective for tracking GRB expenditures in the health sector.

As noted above, the annual budget speech for fiscal year (FY) 2009-2010 identified 40% of the health budget as directly supportive to women and another 57% as indirectly supportive; the remainder was neutral. However, there is a discrepancy in the government documents, as MOHP's Electronic Annual Work Planning and Budgeting (e-AWPB) (2010) has specified 17% for directly supportive and 70% as indirectly supportive, indicating the confusion that exists in doing GRB within government institutions. The

e-AWPB assessment was done by the MOHP budget officer, while the annual budget speech was done by the Ministry of Finance (MOF).⁴⁴

MOHP staff categorize all expenditure items in the health budget into the three categories (directly supportive, indirectly supportive and neutral) based on five indicators of gender responsiveness: participation, capacity building, benefit sharing, increased access to employment and income-earning opportunities, and reduction in women's workload. However, these indicators, which were developed in the context of agriculture, are not necessarily applicable in other sectors. There are no sub-indicators to guide the scoring of budget lines or assess how the activities budgeted contribute to the indicators. Also, the GRB indicators tend to be better at capturing expenditures for targeted women's programs than at picking up expenditures for efforts made in universal programs to mainstream GESI. Finally, of course, the GRB exercise focuses only on gender and does not capture expenditures aimed at increasing outreach to excluded groups.

Gender equality and social inclusion budget analysis

While we have assessed the existing GRB practice and indicators used, and identified possible sub-indicators for GRB analysis in health, we have also developed and applied our own tentative GESI budgeting methodology. This is intended to capture expenditures that reach and support excluded groups and those that support women. Although there is no single rule about how to determine whether public expenditure is discriminatory or equality enhancing, there are some general principles that are discussed in gender-budgeting literature, which we have adapted.⁴⁵ Our efforts here are intended as a first step to identify the approximate resource flows to these different purposes; but much more work and wider consultation are needed. We hope

Table 2.1: Gender Equality and Social Inclusion Budget Analysis of Annual Ministry of Health and Population Health Program

(Total budget Rs 13,254,910,000)

Targeted group	Directly supportive		Indirectly supportive	
	% of budget	Examples of activities	% of budget	Examples of activities
Poor	14.43	Free treatment, free healthcare, orientation on TB for freed Kamaiya	1.31	
Women	9.93	Maternity incentives, support to FCHVs, addressing GBV, treatment of patients in maternity hospital, nutrition support for pregnant women, abortion tools and equipment, minilap tool sets, uterine prolapse surgery, monitoring of AAMA, celebrating FCHV Day, monitoring expenses for reproductive health, etc	8.48	Equipping birthing centers, facility development and consumption cost of maternity hospital, procuring contraceptives, family planning clinic activation, procuring vasectomy sets, preparing International Conference on Population and Development+ 15 manual
Adolescents	1.00	Training on HIV/AIDs	1.17	Survey, training manual development, etc
People from remote areas	2.72	Telemedicine programs in remote districts, infrastructure support to remote health facilities, radio program in remote districts		
Janajatis, Muslims, Madhesis			0.34–0.42	Information, education and communication (IEC) materials, radio programs in different districts/languages, etc

Source: MOHP annual budget, 2009-2010; analysis by study team.

that this initial attempt can become the basis for further collective work with MOF, the Gender-responsive Budgeting Committee, sectoral ministries, donor agencies such as UNIFEM, and NGOs which are interested in tracking budget expenditures.

The GESI budget analysis assesses what activities have been planned/implemented that provide *direct* support to women, the poor and excluded social groups to address the barriers they experience in accessing resources and benefits from health (e.g., incentives for pregnant women, etc); what are the efforts made to provide *indirect* support (e.g., providing disaggregated evidence of disparities, sensitivity training for healthcare practitioners, etc); and what amount is *neutral*, as it assumes that everyone will benefit equally. We have followed the GRB practice of three categories but have not followed the GRB indicators as they have not been very effective in application across the sectors.

The GESI budget analysis was carried out at two levels. First, we assessed *national-level expen-*

ditures in the health sector using the above criteria. The annual MOHP budget for 2009-2010, covering 39 programs, came to a total of Rs 13,254,910,000.⁴⁶ Our analysis resulted in the breakdown shown in Table 2.1. Directly supportive or targeted programs for the poor and women amounted to nearly a quarter of the budget, with an additional 1% and 2.7% directly supportive of adolescents and people in remote areas respectively. There were no expenditures directly supportive of Janajatis, Dalits or Madhesis per se—though, of course, many patients from these groups were served by the system. We were able to identify between 0.34% and 0.42% of the budget as indirectly supportive of these three groups—in others words, expenditures on efforts to mainstream these groups into the healthcare system. Indirectly supportive expenditures for the poor, women and adolescents were 1.3%, 8.4%, and 1.2% respectively.

The next step was to move to the *district level* to ground truth both the national-level GRB exercise and our own GESI analysis in two dis-

Table 2.2: Gender Equality and Social Inclusion Budget Analysis of Annual Program, District Health Office Kavre and District Public Health Office Morang

(Rs 78,720,450')

Targeted group	Directly supportive		Indirectly supportive	
	% of budget	Examples of activities	% of budget	Examples of activities
Kavre (total budget Rs 31,486,450)				
Women	15.77	Services to pregnant women, safe delivery incentive, procurement and distribution of delivery equipment	24.80	Review of reproductive health at district level, printing of nutrition material, interactions for control of iron deficiency, review of nutrition program, etc.
Youth	24.80	Training about reproductive health, sex, and HIV/AIDS		
Morang (total budget Rs 47,234,000)				
Women	27.49	Services to pregnant women, safe delivery incentive, procurement and distribution of delivery equipment	33.88	Health- and nutrition-related materials, permanent family planning program, computer training to focal person of reproductive healthcare

* Combined DHO budgets of Kavre and Morang.

Source: DHO, 2008-2009, MOHP annual budget, 2009-2010; analysis by study team.

tricts,⁴⁷ Kavre and Morang. We first worked with the district health office (DHO) staff to assess the current approach to GRB they were using. In consultations at the district level, officers stated that of the five GRB indicators, only participation, capacity building and benefit sharing were relevant to assess the gender responsiveness of health budget items. They were aware of a number of positive policy provisions⁴⁸ mandating that benefits reach girls/women, the poor and the excluded, and felt these automatically ensured that the entire budget would be responsive to women or specific excluded groups. In reality, this has proven to be a problematic assumption.

Next, we worked with the DHO staff to do a GESI analysis of the district-level health budgets using directly supportive, indirectly supportive and neutral categories.⁴⁹ The results are shown in Table 2.2.

Great effort has been made by MOHP to address the barriers faced by women and poor groups, but for other groups the assumption seems to be that benefits will automatically reach them through implemented activities. The directly supportive and indirectly supportive expenditure of the annual budget for

women totals 18%, primarily for family planning, reproductive health issues and building capacity of FCHVs. As noted previously, given the immense contributions by FCHVs, funds for their capacity building are essential. But almost no activities or funds have been planned to address the barriers of women, the poor and the excluded discussed in Section 2, or the structural issues that constrain their access. This indicates that a more conscious recognition of the need to address such socio-cultural, empowerment and governance issues, along with core technical health services, is required. The key issues are the criteria, indicators and process of budget review.⁵⁰ Government analysis classifies a majority of activities as directly or indirectly contributing to women, based on government directives regarding services to them. A deeper analysis, however, indicates that no activities are budgeted to address the specific gender-based barriers that women experience. These are necessary even within a universal program so that structural barriers are addressed and a more even playing field created—only then can GESI be considered to have been mainstreamed.

2.6 Monitoring and Reporting

MOHP. Current monitoring mechanisms⁵¹ produce significant information but systems are quite scattered and there is limited analysis performed. Gender- and age-disaggregated data are collected, but information regarding service utilization by the poor and the excluded is not integrated. As discussed above, a pilot for reporting caste/ethnicity-disaggregated data is ongoing, but a number of challenges have been identified, including managing such huge amounts of data. Although regular reviews take place at multiple levels, these meetings do not systematically discuss issues of service to women, the poor and the excluded. A key issue is that progress is measured against planned targets; if there were planned targets for women, the poor and the excluded (other than for maternal health, which exists), monitoring would be forced to report against them. Joint annual program reviews are also done among central-level government officials, EDPs and other major stakeholders, focusing on macro-level indicators and progress against EDP commitments. Some earlier reviews have reported discussion about the implementation of the VCDP but there has been no action taken.

NHSP-IP 2. Addressing some of the above gaps, the results framework of NHSP-IP 2 has clearly stated objectives and indicators. While other indicators are disaggregated, the impact-level targets are the same for all groups. The impact-level targets and risks/assumptions/remarks column do not recognize this difference, or the fact that planned and properly resourced interventions will be required for groups facing additional social barriers. NHSP-IP 2 has planned to scale up the HMIS/HSIS if feasible, and mandatory annual social audits and surveys at each level are planned. The results framework does not identify any action to revise the existing moni-

toring and evaluation (M&E) processes, however, and there is a need to advocate with the National Planning Commission, which sets these formats.

DFID logframe of support to NHSP-IP 2. The logframe states that all indicators (from purpose level) are to be GESI disaggregated. Output-level indicators also require disaggregated information, and measure not only physical health outcomes but also satisfaction with healthcare at district facilities, and the number of cases recorded, treated and referred related to GBV in health facilities.

Results and monitoring framework for World Bank-supported Second Health Nutrition and Population and HIV/AIDS Project. This project's only objective is improved essential health-care service delivery, with two subcomponents on service delivery and system strengthening. The third NHSP-IP 2 objective, of tackling socio-cultural constraints and harmful practices, is not addressed. Indicators are disaggregated along income quintiles, but caste, ethnicity and sex disaggregation is not asked for consistently⁵² and there is no clear commitment to try to reduce disparities in access to services or in health/nutrition outcomes.

2.7 Good Practices and Lessons Learned

In this section, we discuss some practices that have been found effective to address the structural barriers limiting access to health of girls/women, the poor and the excluded, and the lessons drawn from these efforts.

2.7.1 Good practices

We have divided these into practices aimed at improving the delivery of health services (supply side), and those that seek to increase the ability of the potential service seekers to influence the type of services they receive and get effective access to them (demand side).

2.7.1.1 Supply side

Favorable government policies resulting in more progressive plans, programs, and provisions. With the Interim Constitution declaring health as a fundamental right, MOHP-initiated programs (universal and targeted free services, maternity incentives, etc) have contributed to improved health outcomes of women and the poor. Other provisions (grant for medicated mosquito nets, issue-specific transport compensation and subsidies, free treatment of third-degree prolapse) are positive government efforts to address group-specific issues.

Building local change agents and strengthening institutional actors (Valley Research Group 2009). Working with existing institutional structures to forge coalitions for change at district level and below has proven to be effective. Capacity strengthening of district administration and political parties, health providers and administration, VDCs, NGOs, community-based organizations, FCHVs and women's groups by SSMP, CARE⁵³ and RHDP⁵⁴ led to improved service delivery.

Strengthening HFMCs. Client-oriented, provider-efficient initiatives of GTZ (GIZ)/SSMP/UNFPA, participatory learning and action (GTZ/GIZ), Reflect (CARE/NFHP) and others, and appreciative inquiry (SSMP/UNFPA) processes have helped to improve selected HFMCs. In UNFPA/NFHP-supported project areas, HFMC members, health facility staff, all FCHVs, clients, activists and members of excluded groups use tools to identify gaps and priorities, and develop action plans to identify local solutions. Dalit health subcommittees of 11 members with 50% women have been established in UNFPA-supported program areas.

A recent study (Subedi and Paudel 2010) indicated significant benefits of *appreciative inquiry*.⁵⁵ Improvements brought about by this included awareness of the importance of quality

management, improved relations between health workers and service users (and facility managers) and greater local commitment to support health facilities. However, the principal significance of appreciative inquiry in furthering GESI objectives is its potential to strengthen HFMCs.

Efforts to *disaggregate monitoring and reporting information* have increased. The NDHS was reanalyzed for different caste/ethnic and regional groups. The facility reports now disaggregate information by income and caste/ethnicity, and MOHP has taken initiatives to disaggregate HMIS information.

Scholarships. Initiatives such as the annual scholarship fund to allow candidates from disadvantaged backgrounds to become MBBS doctors and scholarships to girls from Dalit families for ANM studies have proven to be effective, but need to be strengthened.

2.7.1.2 Demand side

Working partnerships. Establishing partnerships with local groups is an effective means of information dissemination, community mobilization and facilitating the interface between service providers and community members (especially the excluded). Significantly, in 2008-2009, MOHP approved its first use of financial aid to allow DHOs to contract local NGOs to increase access to services, particularly by women, the poor and the excluded. Some new initiatives with the corporate sector are also promising, such as domestic airlines operating out of remote mountain districts agreeing to hold seats on each flight for medical evacuations, and the supply of CDMA telephone handsets to health workers.

Community-based emergency funds. To address health needs, funds at the community level have proven very useful for the poor and women. The SSMP Equity and Access program, managed by ActionAid working through local NGOs, helped to establish over 3,500 such funds in 2005-2010,

with 80% utilized by families from poor and excluded groups. In recent years, most of the mothers' groups have a savings and loan scheme as part of their monthly meeting agenda and use this for meeting health emergencies. VDCs supported by RHDP/SDC have also established functional emergency health funds, which have been used primarily for safe motherhood services (RHDP 2009).

Empowerment and community education. Where efforts have mobilized communities to reflect on social norms that work against safe motherhood, there has been an increase in access to services (Valley Research Group 2009). In communities where various techniques of community empowerment (REFLECT, partner-defined quality [PDQ], HFMC strengthening, mobile mothers' groups and FCHV leadership building) were applied by CARE,⁵⁶ preventive measures by community have increased, quality of service has improved and service utilization has increased tremendously (e.g., coverage of under-fives' vaccination, reduced incidence of diseases related to personal hygiene, increased antenatal care visits, and institutional deliveries, and Antiretroviral [ARV] centers established [Sitaram and Acharya 2006]). GTZ/GIZ, through its project on Poverty Alleviation in Selected Rural Areas, has had a similar experience with participatory learning centers, which have seen significant success in mobilizing people for better sanitation practices. Members of a center in Majkot VDC, Jajarkot, were able to resist a cholera outbreak that took more than 300 lives by spreading good health messages among the community and promoting hygienic behavior (PLC evaluation report 2010).

Program interventions addressing socio-cultural barriers have improved practices, resulting in, among other things, empowerment of women, increased antenatal visits, better nutrition and improved knowledge of HIV and AIDS (Valley

Research Group 2009). Nutrition improved in districts like Tanahu and Jumla, where United Mission to Nepal (UMN)-supported nutrition programs were implemented.⁵⁷ Training on psychosocial issues by the RHDP has also helped in reducing fear among children and addressing the effects of conflict in health.

Social accountability mechanisms. Social audits and similar tools such as partner-defined quality (PDQ) and quality assurance initiatives (CARE, Save the Children US, Nepal Family Health Program I) have provided increasing opportunities for civil society, including community groups, to press for greater accountability of the health delivery system. These have the potential⁵⁸ to ensure the active participation of women, the poor and the excluded. The PDQ approach involves assessing quality issues from the perspective of both health facilities and the community, and then jointly developing action plans. Projects have sought to empower the management of community health services and to strengthen the partnership between the community and the health facility. NHFP/USAID, through its Community and Health Facility as Partners, has given technical input to health facility staff, HFMCs and other community members during the PDQ process, and through this has contributed to improvements in quality of services, skills and understanding of responsibilities. There has been an increased sense of ownership of health facility programs among HFMC members (<http://nfhp.jsi.com>). RHDP has worked with HFMCs in 25 districts to strengthen their capacities.

Incorporating an inclusion perspective in course curriculum. The Institute of Medicine has incorporated a community-based approach to health, offering related theoretical and practical classes.⁵⁹ This builds students' understanding of social issues and enables them to contextualize their technical learning.

2.7.2 Lessons learned

Targeted interventions are important, but GESI needs to be mainstreamed in universal programs. MOHP has addressed issues of the poor and women, contributing to increased access to services. But similar efforts to reach out to Dalits and other socially excluded groups are not evident. Gains will come when those designing and implementing mainstream programs begin to recognize that these programs can impact differently on different people. Additional activities within universal programs can make untargeted programs more accessible for women, the poor and the excluded (e.g., sanctions for discriminatory behavior of service providers and, conversely, incentives for respectful behavior).

Institutionalizing gender and inclusion in budgeting requires further clarity and capacity. The government has very seriously initiated GRB, but conceptual confusion remains in categories and criteria. MOHP has thus been unable to internalize the GRB process effectively or use the information for informed policy-making. Nor has the inclusion dimension been systematically incorporated, suggesting that much remains to be done to develop a simple, logical, relevant process of budget analysis that is able to capture multiple dimensions of social exclusion and ensure that public funds are best used to reduce it.

Institutional structures for GESI need to be made functional. Merely creating structures is insufficient as the position of gender focal point in different ministries has demonstrated. Resources, authority and capacity are essential for the position to be influential. Clear responsibilities, links with the sector's core work, and clear lines of accountability are also critical.

Governance and community-based monitoring are essential for schemes delivering services to the poor. Free healthcare has improved utilization of health services by the poor, but stock-outs have

increased due to delayed release of funds and misuse, exacerbated by lack of accountability and specifications defining standards. An active HFMC and hospital board could monitor the level of drug supply in health facilities, control local malpractice, and ensure that stock-outs are dealt with on time. The newly approved drug procurement policy will also ensure that quality drugs are procured on time with transparency.

Targeted behavior change interventions are necessary to change attitudes of service providers. Overcoming deeply set informal resistance to social inclusion remains the greatest challenge facing the health sector but experience suggests that this can be dealt with in part through participatory learning and action by health workers and reinforcement workshops (Sapkota and Shrestha 2009). The SSMP (and the Nepal Safer Motherhood Project earlier) likewise worked on improving interpersonal communications between clients and health-care providers. Such efforts reconfirmed what other studies (Crow et al 2002; D'Ambruoso et al, quoted in Clapham et al 2008) have demonstrated: patient-provider relationships greatly influence service use.

Addressing socio-cultural barriers can make a difference in improved health outcomes. Experience shows that knowledge and awareness of women and decision-makers in their families and communities regarding practices that impact negatively on health improved after continuous work for a period (e.g., nutritional levels of women and children improved after sustained field-work regarding feeding and dietary practices by National Planning Commission Secretariat).

A multi-sectoral approach to address barriers is required for women, the poor and the excluded to have increased access to health services because these groups experience multiple exclusions (e.g., CARE's non-health programs support community groups for resource mobilization and

all programs target people living with HIV and AIDS, women, the poor and the excluded, which enables these groups to improve their capacities for accessing health services). There is evidence of higher education (especially of women) leading to improved family health. Improved connectivity through better transportation infrastructure and improved water supply and sanitation facilities are necessary for improving health outcomes. Thus, MOHP needs to work systematically with other sector ministries.

Limited understanding of the impact of social issues on technical outcomes of health remains a problem. Often, GESI is considered a distraction, as professionals in the sector argue that everything is meant for all citizens. However, indicators demonstrate that there are constraints experienced by certain groups which continue to bar them from access to supposedly universal services. GESI-responsive program design and implementation, based on systematic analysis and continuous feedback, can make all the difference in access to healthcare for excluded groups.

2.8 Mainstreaming Gender Equality and Social Inclusion: The Way Forward in Health

Based on this analysis, operational guidance for application/mainstreaming of GESI in the health sector is discussed below. Ideally, GESI must be a regular part of each step of program/project design, implementation, monitoring and reporting. But what is essential is recognition of the different assumptions, beliefs and experiences underpinning the health situation of women and men from different social groups. NHSP-IP 2 has already been designed and begun operation with an inherent GESI strategy and the generic steps below should be approached in the context of this existing sector-wide program. Against the backdrop of the preceding analysis, the following

steps should be read as guidance on what might be done to complete the process of operationalizing GESI in NHSP-IP 2, and ensuring the effective implementation of the GESI strategy.

2.8.1 Identify barriers

2.8.1.1 Analyze existing power relations, and the formal and informal institutions that reinforce and perpetuate social and economic inequalities

Gender inequality and social exclusion in health are linked to the wider socio-cultural and politico-economic context. Often, the “barriers” we need to remove or work around in order to provide more equal access to health are part of interconnected formal and informal institutions or “rules of the game” that structure Nepali society. These institutions or systems allocate privileges and obligations to individuals and groups in accordance with different roles (e.g., district health officers, doctors, other health workers, HFMCs, patients) or ascribed characteristics (female, Brahmin, Dalit, Madhesi, etc). Some of these institutions are formal, with formal rules and procedures. Our projects/programs work with these systems and try to improve them so that they can deliver health services more effectively. We are aware that changing these “rules” upsets some stakeholders who have benefited from them in the past. This is why we always need to be aware of the local “political economy,” so that we can include ways to keep these stakeholders from blocking needed changes. Here, we also have to think about the more “informal” institutions, the ones that are deeply embedded in people’s values, beliefs and ways of doing things. Some of these—like the gender system or the caste hierarchy—are so deeply ingrained that people often follow such informal “rules” without being aware of it. While not all of these practices are negative (e.g., taking care/respecting elders), some of these informal “rules” keep some

groups from getting full access to the benefits of development.

2.8.1.2 Start with the formal systems

Review the sector policies. It is important to assess the existing policy mandates that provide the space to work on GESI issues in the health sector, identifying policies that enable and constrain as well as policy gaps. A review of existing programs of MOHP and other actors needs to assess awareness of gender and social exclusion and identify strengths (and potential champions), blockages and areas for improvement.

Review sectoral and project budget, and M&E system. How well are the positive policy and programmatic provisions resourced, and where are resources inadequate? How does money flow, and who makes the decisions along the way? If funds are allocated at local levels, how inclusive and transparent are the bodies making these decisions? Does the M&E system capture disaggregated information? Who collects and analyzes this data? At what level are the M&E results shared?

2.8.2 Design and implement policies and programs

It is necessary to develop new mechanisms to address identified barriers, particularly those limiting utilization of services by women, the poor and the excluded.

2.8.2.1 Demand side

Real change must happen at the local level but communities need help in breaking out of old patterns. Here are some of the approaches that have been effective and need to be upscaled.

Empower communities. Both the excluded and the non-excluded need to be empowered to address inequitable power relations and social practices. REFLECT-type processes have proven very effective in building consensus and capacity

for social action against identified issues⁶⁰ (e.g., creating an enabling environment for maternal and neonatal health [MNH] service utilization, or preventing a cholera epidemic, as noted previously). Such processes can be helpful in addressing medicine stock-outs, discriminatory staff behavior and harmful social practices that negatively impact on health.⁶¹

Create/strengthen community-based funds to make it easier for women, the poor and the excluded to get cash rapidly to bear the costs associated with getting medical care, apart from the free essential healthcare services. This is particularly important for women, who often need to ask permission from family members to use cash. These funds also help to improve nutrition supplementation, especially of malnourished children, pregnant or newly delivered mothers and ARV users.

Develop localized behavior change communication materials in local languages, using a range of media to address specific discriminatory beliefs. Materials from the National Health Education and Communication Center give key health messages but do not adequately address issues of gender-, caste- and ethnicity-based discrimination.

2.8.2.2 Supply side

Strengthen the GESI unit, staff capacity and authority from the center up to local levels

Implementation guidelines and criteria/procedures must be developed through wide consultation to orient service providers on the GESI strategy and gather inputs, followed by a budgeted roll-out plan. Working with the Ministry of General Administration, all job descriptions must be revised to ensure that they are gender and inclusion sensitive, and clearly identify responsibilities, lines of accountability and deliverables. A GESI section with desks must be established⁶² in MOHP as planned, the terms of reference for which must clearly state its role, human resource

requirements, and how its results will be monitored. The capacity of these desks must be strengthened so that they can provide technical support for GESI mainstreaming and monitoring from a GESI perspective.

Affirmative action is necessary to *increase the diversity of service providers* and fulfill the provisions of the amended Health Service Act. Multiple actions are required: scholarships; tax incentives to private medical colleges to take students from excluded communities; efforts by NGOs and medical professional organizations to coach candidates from excluded communities; selective recruitment, with conditions that candidates return to their home communities to work; and exploring options for local, transparently managed recruitment by HFMCs. The human resource strategy needs to be revisited to identify creative ways to address these issues.

Deploy skilled staff where they are most needed, increase skills and improve attitudes of service providers

Absenteeism and the lack of trained health service providers particularly affect services for women, the poor and the excluded. NHSP-IP 2 has identified a number of measures for better deployment and retention of staff serving in remote areas. These must be implemented but with an effort to localize health worker selection.

Culturally and linguistically competent care. The skills of service providers to recognize GESI issues and identify ways to respond to them have been inadequate. To address this, the curricula for different courses have to incorporate and explain, practically and logically, the GESI aspects of the technical services to be provided. There is a need to build capacity and sensitize service providers on the particular needs of different social groups, and how their own behavior can discourage clients from excluded groups. Incentives and sanctions must be created to encourage health service

providers at all levels to be sensitive to members of all social groups. Arrangements must be made with community groups for language interpretation in order to ensure effective communication with service providers. Space must be created for local groups to present information about their community's health beliefs, practices and histories. If some of these practices are seen by health providers to be negative, they should initiate a community dialogue.

Targeted behavior change interventions for health workers have resulted in positive outcomes. For instance, while three years ago 17% of community members felt discriminated against, all respondents of a subsequent survey stated they had not experienced any discriminatory behavior from health workers. This was explained as being due to continuous dialogue, interactions and training (Sapkota and Shrestha 2009).

Strengthen and give clear authority to HFMCs

HFMCs are the structures authorized by the government at the community level and are well placed to be the coordinating link between people and service providers, and also to act as the watchdog to ensure equitable and reliable service to the community. HFMCs require capacity building and technical guidance on how to perform their many responsibilities and maintain strong links with the community, thus requiring block grants⁶³ (learning from the practice in education and school management committees), with proper and effective implementation guidelines, operational procedures and accountability mechanisms. Governance rules for the formation and operation of HFMCs need to be clarified: allowing selection of women and members of excluded communities by women and the excluded people themselves, reflecting GESI responsibilities more clearly in the roles of the chair and members, and taking a prominent role in community-based monitoring activities.

Improve planning, programming and budgeting processes

Develop programs with the community, identifying what approaches would assist women, the poor and the excluded to gain easier access to services. The current MOHP planning process does not provide the space for genuine community-level consultation, and is out of sync in terms of timing with the VDC and district development committee (DDC) planning processes that do involve communities.

Use alternative methods of getting services to communities. Outreach clinics, focused health camps, adjusted timings, mobile clinics and other such measures address important time and mobility barriers of women, the poor and the excluded.

Plan and incorporate targeted activities. Targeted, group-specific interventions within the universal programs are required to reach those whose health indicators are poor (e.g., to reach the TFR target of 2.1 of NHSP-IP 2, specific efforts have to be made to reach the 30% of the population whose TFR at the moment is nearly 4.0).

Key health issues need to be addressed systematically by both government and non-government agencies, with sufficient budget allocations. For nutrition, for instance, an excellent recent study identified substantial changes in food and healthcare behaviors that are deeply rooted in cultural custom, and has recommended a truly community-based nutrition program, utilizing existing community structures as entry points. From a GESI perspective, these need to be nuanced enough to respond to vast socio-economic differences, and should be included in the MOHP annual plan.

Multi-sectoral coordination mechanisms are necessary from national to community levels to address barriers that the health sector is unable to address alone. But this will not occur unless there is in-depth work with NPC to encourage

it to issue directives for joint action plans encompassing different ministries.

GESI budgeting as a tool can identify the kinds of activities budgeted/spent for, but the current GRB budgeting criteria and process provided by MOF require revision. In particular, we suggest three points. First, GESI budgeting should be done simultaneously with program development and as part of every annual budget plan during implementation. Second, when preparing programs, ensure that activities/sub-projects address the barriers to access faced by women, the poor and the excluded, and an adequate sum is allocated for these activities. Targeted programs in health are necessary for women due to their biological needs. These targeted programs must address gender relations that limit women's health outcomes. Similarly, targeted programs to address untouchability issues in health service might need to be built into program activities. Third, part of effective mainstreaming is to create an enabling environment, by changing policies, procedures and assumptions. This requires funds for research, advocacy and capacity building of men, non-excluded and the not-so-poor. For GRB, the criteria need to be revised. Participation, capacity building and benefit sharing have to be given more weight, and the other extraneous indicators dropped. See Annex 2.1 for suggested sub-indicators.

2.8.3 Monitoring and reporting

Social audits have been planned and can be a useful tool to strengthen accountability, particularly to determine how accessible various services are for different groups. However, the guidelines will need to clearly detail the process, perhaps provide professional facilitation for the initial rounds, and ensure the participation and inputs of women, the poor and the excluded.

Community-based monitoring, with an agreement between HFMCs and community groups,

Table 2.3: Gender Equality and Social Inclusion in Existing Monitoring Process

Monitoring meetings	Existing process and discussion	Suggested process from a GESI perspective		
		Information collection/discussions	People involved	Reporting
Monthly meetings				
VDC level	No regular meetings	<ul style="list-style-type: none"> HFMC to meet and identify issues of access to health services of all people; disaggregated monitoring format* to be used 	<ul style="list-style-type: none"> FCHVs, health workers, health post in-charge, HFMC representatives, project/program staff Health post in-charge to coordinate Disaggregated attendance register to be maintained 	Report for monthly <i>ilaka</i> -level meeting to be prepared with disaggregated information
<i>Ilaka</i> level	Held regularly under primary healthcare center in-charge with health post in-charge	<ul style="list-style-type: none"> Primary healthcare center, health post in-charge to provide disaggregated reports on existing issues and barriers in accessing services, and positive examples of addressing exclusion 	<ul style="list-style-type: none"> Primary healthcare center, health post in-charge, HFMC representatives Disaggregated attendance register to be maintained 	Report for monthly district-level meeting to be prepared with disaggregated information
District level	DHO meeting with health post in-charge; progress against targets and achievements	<ul style="list-style-type: none"> Health post in-charge to come after discussion with HFMC and other health workers with disaggregated information regarding access and services 	<ul style="list-style-type: none"> DHO, health post in-charge Disaggregated attendance register to be maintained 	Report to regional directorate to be prepared with disaggregated data and information analysis
Quarterly meeting				
Regional directorate level	Regional director with DHOs; progress against targets and achievements	<ul style="list-style-type: none"> DHOs to report analysis regarding access of people to services (disaggregated); issues/challenges in reaching services to women and excluded; good examples of addressing barriers of the poor and the excluded Meeting to identify common issues and strategy required to address them 	<ul style="list-style-type: none"> DHOs, regional director, relevant regional directorate staff Disaggregated attendance register to be maintained 	Report to provide disaggregated information
Annual meeting				
Regional directorate level	Progress against targets, achievements with DHOs	Quarterly reports to be synthesized and analysis regarding access and services discussed, with possible strategies identified	DHOs, regional director, relevant regional directorate staff, primary healthcare center and health post in-charges, HFMC representatives	Report to provide disaggregated data and analytical information
DHS, MOHP/ central level	Progress against targets, achievements with regional directorate and selected DHOs	Analysis regarding barriers of women, the poor and the excluded, their access to services, and their ability to benefit from MOHP schemes; challenges of providers to ensure service access to the poor and the excluded; required future steps	MOHP, DHS, regional directorates, DHOs, HFMCs, representatives of health workers and FCHVs	Report to provide disaggregated data and analytical information

* The DHS M&E formats ask for caste/ethnicity coding but this information has not been analyzed yet. Other M&E and reporting formats do not ask for disaggregated data and a separate process is necessary for that revision. But until these are changed, service providers can ask for disaggregated data under each heading of the existing formats or identify other ways to ensure that the necessary information is collected.

was recommended in the last VCDP. This could be a useful mechanism, and combined with social audit activities, although HFMCs must first be strengthened, resourced and granted more authority.

There are some very *progressive policy provisions in the local government guidelines*: DDCs and VDCs need to conduct public and social audits; integrated planning committees in VDCs and ward citizens' forums at the ward level

(established with the guidelines) can work with HFMCs and health facilities to identify health-related priorities in the allocation of block grants and ensure strengthened accountability for the operation of local health facilities.

Table 2.3 presents existing monitoring processes, and possible ways for GESI mainstreaming in monitoring and reporting.

2.9 Conclusion

The health sector has made immense efforts to improve the health outcomes of Nepal's citizens, and has responded well to the mandates of inclusion through its pro-poor and pro-women programs. The recently developed NHSP-IP 2 has recognized the barriers experienced by women, the poor and the excluded, and has made very

impressive plans with disaggregated objectives and indicators. Key sector-specific issues of human resource management, delays in medicine supply, poor governance and low accountability are aspects that require committed and systematic interventions. A well-governed sector, ensuring more readily available supplies and services with trained staff performing effectively, will improve the access of women, the poor and the excluded to services. The different levels of analysis and review in this chapter have provided the inputs for operationalizing GESI in the sector. It is only with action that addresses different aspects of GESI in the whole program cycle of identifying, designing, implementing, monitoring and reporting that the vision we have of equitable health outcomes for all Nepali citizens will be achieved.

Notes

- 1 Ministry of Health and Population, New ERA and Macro International Inc, 2007.
- 2 Infant mortality declined by 39%, from 79 deaths per 1,000 live births in 1991-1994 to 48 deaths in 2001-2005. Under-five mortality declined by 48% from 118 to 61 deaths per 1,000 live births and neonatal and postnatal mortality also decreased by 34% and 48%, respectively. Skilled antenatal care increased from 35% in 2001 to 44% in 2006, and the rate of skilled birth attendance increased from 11% to 19% during the same period. More than 90% of children aged 6-59 months receive vitamin A supplements and deworming twice yearly. Iron and folic acid supplement coverage during pregnancy increased from 23% in 2001 to 60% in 2006, with a related decrease in maternal anemia prevalence from 75% in 1998 to 42% in 2008. Similarly, coverage of DPT3 increased from 72% in 2001 to 89% in 2005 and full immunization increased from 66% to 83%.
- 3 The private sector accounts for around 62% of total out-of-pocket expenses (National Health Accounts, 2003-2004).
- 4 *Chhaupadi* is practiced particularly in the Far- and Mid-Western regions: women and girls are expected to stay outside the home in cowsheds during menstruation, and during and after childbirth.
- 5 *Boksi* is the word for "witch" in Nepali and refers to a practice whereby women, usually elderly and single, are declared witches and publicly punished (sometimes by forcing them to eat human excrement) and ostracized.
- 6 UNFPA and an NGO, Saathi, analyzed gender-based violence in Surkhet and Dang districts.
- 7 There are 25,000-34,000 female sex workers in Nepal, with an estimated HIV prevalence of 1.3-1.6%. HIV infection rates among street-based sex workers in Kathmandu Valley are 15-17%. Nationally, clients of female sex workers have an estimated HIV prevalence of 2%. In Kathmandu, according to the 2006 Integrated Biological and Behavioral Surveillance Survey, 45% of sex workers are married and 21% of spouses have co-wives. Coverage of sex workers in terms of prevention interventions is very low: only 38% of women compared to 55% of male sex workers.
- 8 Recent reports show that targeted interventions have reached almost 80% of female sex workers (National HIV and AIDS Action Plan, 2008-2011).
- 9 Principle 3 of the ILO Code of Practice on HIV/AIDS and the World of Work.
- 10 Consultations with key stakeholders, February 2010.
- 11 UNFPA estimates that there may be 600,000 women with uterine prolapse in Nepal.
- 12 A total of 1,544 women benefited from surgical treatment of uterine prolapse through RH camps organized in 32 districts by the DHS in 2006.
- 13 Of the households in Chepang-Raji-Raute-Kasunda ethnic groups with children, nearly 49% have at least one child who is

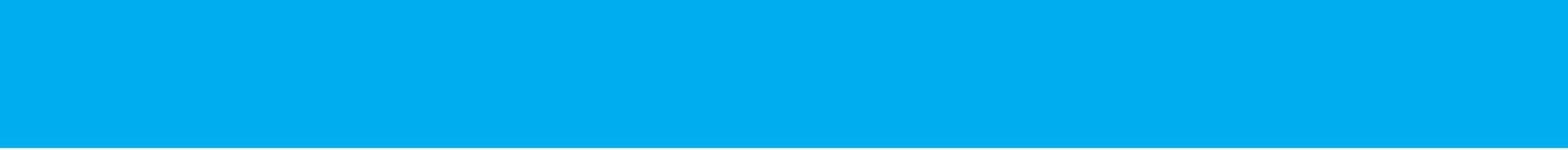
- more than two standard deviations below the normal height for age (Bennett and Parajuli 2011).
- 14 The National Centre for AIDS and STD Control reports that there are 15,000 people with HIV, including 2,700 with AIDS (www.ncasc.gov.np).
 - 15 Refer to World Bank/DFID 2005 for an update of policies up to 2004.
 - 16 Consultations were held with about 50 people in Kathmandu covering MOHP, DHS, district public health offices, international non-governmental organizations, project staff and representative organizations. Meetings and focus group discussions were held with four HFMCs of Lalitpur and Morang, and 400 community women and men of different social groups in three VDCs. Information was also gathered from HFMCs of Kailali, Bara and Sunsari.
 - 17 The National Health Policy (1991) prioritized maternal and child health and extended it to rural areas. Since its initiation in 1997, the Safe Motherhood Program has made significant progress in terms of development of policies and protocols and service delivery through staff nurses and assistant nurse midwives. The National Reproductive Health Strategy (1998) and National Safe Motherhood Long-term Plan (2002-2017), revised as National Safe Motherhood and Newborn Health Long-term Plan (2006-2017), the policy on skilled birth attendants and national blood transfusion policy (2006) also establish the government's commitment to safe motherhood.
 - 18 On gender equality, childhood mortality, maternal mortality, HIV/AIDS, malaria and other diseases.
 - 19 Including AusAID, DFID, GTZ/GIZ, KFW, SDC, UNAIDS, UNFPA, UNICEF, USAID, WHO and the Global Alliance for Vaccines and Immunisation; the pool partners are the World Bank, DFID and AusAID.
 - 20 Communication, Health Sector Reform Unit chief, MOHP.
 - 21 The free healthcare service program policy for target groups was announced in fiscal year 2006-2007 in hospitals and primary health centers for inpatient and emergency services, and was made free for all citizens in all health posts and sub-posts from fiscal year 2007-2008. It was expanded in 2008 to include primary health services. In 2008, hospitals with at least 25 beds provided listed medicines free to all citizens, while essential drugs and all services were made free for target groups (the ultra-poor, vulnerable, poor, disabled, senior citizens and female community health volunteers). In 2008, institutional delivery was made free for all women.
 - 22 Dalits and Muslims increased their use of free services by 2.5% and 5.4%, respectively. Use by Brahmins/Chhetris and Newars increased by 3.4% and 4.9%, respectively, although relatively few Newars use the services. Use by Madhesi and Janajatis decreased by 4.5% and 9.6%, respectively, between the second and third facility survey interval (RTI/CARE 2009).
 - 23 The three main components of the maternity incentive scheme are a cash payment to women presenting for delivery at a recognized BEOC or CEOC facility, which vary according to ecological area; a payment of Rs 200 to staff classified as trained health workers for attending a delivery either at home or in a facility; and, in selected districts, free delivery services at facilities for both normal and complicated deliveries. In these districts there is a payment of Rs 1,000 to the institution for each normal delivery, Rs 5,000 for cesarean sections, and Rs 3,000 for complication management.
 - 24 These cover fully immunized children, percentage of TT2 or 2+, underweight children below five years, incidence of ARI/CDD, antenatal care first and fourth coverage, delivery conducted by skilled birth attendants, PNC first visit, number of safe abortion cases, family planning new acceptors, malaria positive cases, tuberculosis new sputum-positive cases, leprosy cases, new HIV positive registered at VCT centers, OPD and inpatient cases, senior citizens visited OPD (disaggregated data in HMIS, social inclusion information system, HMIS flyer).
 - 25 Dalits, disadvantaged Janajatis, disadvantaged non-Dalit Tarai caste groups, religious minorities, relatively advantaged Janajatis and upper-caste groups. There is a view that renaming these categories "upper caste" is not fitting terminology to be used now in Nepal.
 - 26 Meeting with Pawan Giri and two other persons, HMIS/FHD, DHS, February 2010.
 - 27 The Department for Civil Personnel and Records under the Ministry of General Administration has initiated a process for civil servants' caste/ethnicity disaggregation, using six groupings with regional identity and sex disaggregation: Dalit (Hill/Madhesi), Janajatis (Hill, Madhesi, Newar), Brahmin/Chhetris (Hill/Madhesi), OBCs and Muslims.
 - 28 Interview, National Health Training Center and DHS, February 2010.
 - 29 Review of the minutes of selected HFMCs, done by the study team, February 2010.
 - 30 As part of DFID's Support to Safe Motherhood Program, a total of 50 health facilities from 28 districts, including health posts, primary healthcare centers, and hospitals were selected for training in appreciative inquiry; 82 persons received training as appreciative inquiry facilitators and were provided with checklists and guidelines for conducting workshops in the district. The main purpose of the appreciative inquiry planning process was to enable HFMCs to plan and establish improved and regular maternal health services, especially 24-hour delivery and B/CEOC, as appropriate. Various implementation modalities for taking appreciative inquiry planning down to facility level were used, including the provision of support to the district

- appreciative inquiry facilitation team by external consultants and regional coordinators, as well as the district team acting alone (SSMP 2010). Appreciative inquiry is also a major activity of the RHDP.
- 31 These include AusAID, DFID, GTZ/GIZ, the International Labor Organization, German Development Cooperation, KFW, SDC, UNAIDS, UNFPA, UNICEF, USAID and WHO.
 - 32 The estimated total cost of NHSP-IP 2 is US\$ 1,527 million. DFID, the World Bank and AusAID will contribute US\$ 220 million (14% of the total) through sector budget support to the government. DFID's contribution of US\$ 86.6 million includes US\$ 57.6 million for sector budget support and US\$ 29 million for technical assistance (on health systems and policies, aid effectiveness, maternal health and procurement). It is expected that GAVI and GDC will join the pool fund in 2010. Another eight partners support the SWAp through parallel-funded programs.
 - 33 DFID will support NHSP-IP 2 through sector budget support (66%) and technical assistance (34%). It is contributing to the pooled fund without earmarking, as NHSP-IP 2 has strong program components reflecting DFID priorities.
 - 34 The terminology used in the MOHP results framework and the DFID project memorandum is different. What is an "objective" in the MOHP document is an "output" in the DFID document.
 - 35 Output 2: Reduce cultural and economic barriers to accessing healthcare services and harmful cultural practices in partnership with nonstate actors.
 - 36 Following the appreciative inquiry planning workshops, HFMCs in four facilities took responsibility for hiring local ANMs using their own resources, with the Parasan Health Post hiring two ANMs (SSMP 2010).
 - 37 Records of civil servants maintained by Nijamati Kitabkhana were reviewed and disaggregated according to the surnames of the government staff and their place of permanent residence, following rules by the World Bank Social Inclusion Index development team and census-based caste/ethnicity groupings. We appreciate that a participatory process facilitated by Nijamati Kitabkhana, Ministry of General Administration, for the self-identification of employees has been initiated.
 - 38 Field consultations, February 2010.
 - 39 MOHP has recently nominated three staff from its planning division for the GESI focal unit. This, hopefully, will result in this unit becoming more effective.
 - 40 Discussion in DHS. MOHP has now planned a number of regional and district workshops on gender and inclusion.
 - 41 Information regarding the working environment is drawn from interviews and inputs of participants in the consultation meetings.
 - 42 The three prescribed categories are direct contribution, indirect contribution and neutral. Each sub-activity is assigned a code of 1, 2 or 3, considering the percentage of contribution to women. The formula for coding has five indicators, each valued at 20%: capacity building of women, women's participation in planning process and implementation, women's share in benefit sharing, support for women's employment and income generation, and qualitative progress in the use of women's time and reducing their workload (eAWPB 1.0 Operating Manual 2009). In order to measure these categories quantitatively, five qualitative indicators were assigned quantitative values of equal denominations totaling 100. Direct gender contribution indicates more than 50% of the allocation directly benefiting women, indirect gender contribution indicates 20-50% of the allocation benefiting women, and the neutral category indicates less than 20% of the allocation benefiting women. This is gradually being used by ministries like that of health, but due to difficulties in the application of the criteria, which do not seem relevant to all the sectors, it has not been fully used by all ministries. Also, since it gives a higher weighting to projects with a higher proportion of the budget "directly" benefiting women, this tends to give more weight to targeted programs than to national programs that work to mainstream women's access.
 - 43 Indicators for the pro-poor budget are investment in rural sector; income-generation program in rural areas; capacity enhancement program in rural areas; budget allocated for social mobilization; expenditure focusing on poverty reduction; grant for local bodies; social security programs; and investment in the social sector, especially for education, health, etc (Annex 8c, Budget Speech, 2009-2010). But it is not clear how these are scored and what sub-indicators are used.
 - 44 When we discussed these budget speech annexes with MOHP staff, they were themselves surprised by the differences in numbers and were unaware of the inclusive development and targeted programs column.
 - 45 We are adapting from gender budget initiatives that have aimed to assess the impact of government expenditures and revenues using three-way categorization of gender-specific expenditure, equal opportunity expenditure, and general expenditure (the rest) considered in terms of its gendered impact (Budlender et al 1998).
 - 46 MOHP annual budget 2009-2010 in National Planning Commission format.
 - 47 Implemented budget of districts was reviewed to assess actual expenditure and its effect on addressing the barriers for women, the poor and the excluded. Program budgets of the current year were reviewed to assess allocations.
 - 48 Universal and targeted free services program, maternity incentive scheme, etc.
 - 49 Directly supportive (i.e., targeted to provide direct support to women, the poor and the excluded); indirectly supportive

- (contributing to creating an enabling environment, supporting in any manner the access of women and the excluded to services, or addressing the structural difficulties confronting them); and neutral.
- 50 DHO budget of Kavre: Rs 31,486,450; DHO budget of Morang: Rs 47,234,000.
 - 51 There are five major data systems which track health indicators: Population Census, Demographic Health Survey, Nepal Living Standard Survey, Maternal Mortality and Morbidity Study and Health Management Information System. Monthly, four-monthly and annual reviews at different levels do take place, and are based around the review of the HMIS, which has data from the lowest level of health institution to the national level.
 - 52 The document says that there has been an agreement between MOHP and the joint partners to use a limited number of relevant and meaningful “tracer” indicators to measure progress against the objective of reducing inequity in health service utilization. The indicators are the percentage of women who deliver with the aid of an SBA, the percentage of children between 11 and 23 months who are fully immunized, and the percentage of pregnant women who receive IFA supplementation.
 - 53 CARE’s experience in some districts of the Far-Western Region, such as Kanchanpur, Doti and Kailali, has been that trained and empowered FCHVs and mothers’ groups and strengthened HFMCs facilitate healthcare delivery, run smoothly on their own, continue health messaging, ensure that the communities practice and maintain healthy behavior, and improve their health conditions and status.
 - 54 For greater empowerment of mothers’ groups, RHDP conducts capacity building, awareness raising and participatory rural appraisal, which has enabled members to function as community “change agents” to reach and raise health awareness among “discriminated” and disadvantaged populations in Dolakha, Ramechhap and Okhaldhunga districts (RHDP 2009).
 - 55 Appreciative inquiry is a management tool which focuses on positive features and achievements, rather than gaps and failings, and builds self-esteem and a belief in the ability to change.
 - 56 In Kanchanpur, Chitwan, Nawalparasi, Doti, Kailali, Dhanusha and Mahottari districts, where its child survival and NFHP program is running.
 - 57 Evaluation reports of Tanahun and Jumla, Nutrition Promotion and Consultancy Center, 2006.
 - 58 The Family Health Division introduced a social audit mechanism to monitor the AAMA program through local NGOs.
 - 59 The MBBS/BPH course of the Institute of Medicine has incorporated GESI issues in family health and medical sociology anthropology. In its MBBS course, there is a one-month residential community health diagnosis in the first year, and family-based studies in five clinical cases to learn family dimensions of causation and recovery, including social factors affecting healthcare-seeking behavior (third year), plus nine weeks’ posting to learn health service delivery by regional or zonal hospitals (three weeks), district hospitals (three weeks), and non-profit NGO-based hospitals (three weeks). In this practice they learn about the management of health services in peripheral facilities.
 - 60 Empowered communities ensured that infrastructure needs such as availability of means to dispose of placentas, water in toilets, separate delivery rooms were addressed; women staff were increased, infection prevention practices promoted, and health facility staff pressured to provide services (SSMP 2010).
 - 61 A concern about such interventions is the cost, which can be high. SSMP’s Equity and Access Program projection estimates a cost of Rs 40,757,767/district. For a three-phased intervention like the Equity and Access Program, in years 1-3, SSMP/ActionAid pioneered community-level and mass-media equity and access activities working through local NGOs from marginalized communities in 10 districts. DHOs were consulted and kept informed of activities but did not have direct responsibility for equity and access work. In year 4, SSMP/ActionAid continued its work in these 10 districts but, in addition, supported DHOs to contract local NGOs for equity and access activities in two further districts and provided facilitation and training support to these NGOs. In year 5, DHOs contracted local NGOs for equity and access activities in 10 districts with SSMP/ActionAid staff providing facilitation and training support. Costs of a scaled-up approach may reduce if national or local groups are used as facilitators, instead of NGOs (SSMP 2010).
 - 62 Consultations with MOHP staff showed that the GESI unit was to be established but this had not yet happened. Study team consultations, March 2010.
 - 63 The Ministry recently designed and approved the Strengthening of Local Health Governance Program, to be piloted in three to five districts in the near future. It includes provisions to give formula-based health grants to districts and below, increased role of local government units, and other innovative approaches. Providing some financial resources to HFMCs can make them much more effective.

CHAPTER 3

Checklist for Mainstreaming Gender Equality and Social Inclusion



3.1 Introduction

The first chapter of this monograph presented the gender equality and social inclusion (GESI) mainstreaming framework, summarizing the key findings from the GESI review of the seven sectors with the steps required to move forward. Chapter 2 focused on how to make projects, programs and policies in the health sector more accessible and useful for the poor and the socially excluded. This final chapter is presented mainly as a handy reference guide. It sets out the generic steps necessary for mainstreaming GESI in any sector with a few blank formats that practitioners may find useful in the course of their work. Of course, these need to be contextualized, made sector specific and refined to address the issues of different social groups. We follow the five steps of mainstreaming: 1) identifying; 2) design; 3) implementation; 4) monitoring and evaluation; and, when necessary, 5) responding to the monitoring and evaluation (M&E) findings by revisions in project design or policy framework. Some tools that can be used for the required analysis are also presented and discussed.

3.2 Organizational Prerequisites for Effective Gender Equality and Social Inclusion (GESI) Mainstreaming

Even though sector policies have often integrated gender and inclusion concerns, persistent gaps in implementation continue to hinder the achievement of equitable outcomes in different sectors. As discussed in Chapter 1, these gaps occur for multiple reasons, ranging from technical capacity to attitudes and beliefs of stakeholders. Mainstreaming GESI effectively requires some essential organizational prerequisites in the sectoral implementing institutions.

For instance, the senior management's personal commitment to and support for GESI is essential, as is clarity and understanding by staff at all levels on concepts of gender, empowerment and social

inclusion. A core group of selected staff must have analytical skills on gender and inclusion issues in order to provide technical support to others; time has to be created at all management levels to identify issues, design processes and implement activities; and resources need to be identified and consistently made available. A gender/empowerment/inclusion perspective needs to be integrated into all policies, activities and routine functions in the sector, with appropriate management structures in place, followed by M&E methods that are responsive to empowerment efforts/programs. Finally, strong outside technical support from local and external providers is also necessary.

3.3 Core Information Requirements for Gender Equality and Social Inclusion (GESI) Mainstreaming

- Key data should be disaggregated by sex, caste, ethnicity, class, location, age and any other relevant variable (e.g., disability or HIV/AIDs status, where required).
- Issues of division of labor, access to resources and decision-making power (who is doing what, who has access to what, who makes the ultimate decisions) have to be assessed for their differential impact on women and men of different social identity groups.
- Key policies, programming and budgeting; institutional arrangements; human resources issues; and M&E systems must be assessed from a GESI perspective by those designing the project/program or policy and then presented and discussed with stakeholders from the government, project staff, partner organizations and community groups.

3.4 Five Steps of GESI Mainstreaming: A Checklist

As discussed in Chapter 1, a five-step framework for GESI mainstreaming has been followed for all sectoral assessments in this series. We present

here the generic steps and some suggestions on how to implement them.

3.4.1 Step 1: Identification phase—Situation analysis

Objective. To identify the specific barriers of women, the poor and specific excluded groups in accessing services and opportunities, and the causes of their exclusion; and to understand the political economy of the sector or subsector, both nationally and locally, in the particular sites¹ where the project or program will be implemented. Identifying the excluded groups in a particular sector and understanding their situation involve using available qualitative and quantitative data to answer the question: “Who had access in the past to resources and decision-making, and how are different social groups doing at present?”

To understand the barriers these groups face in gaining access, it is necessary to look at and think through several levels. Table 3.1 shows the levels, what to do and some suggestions on how to do it.

We can thus assess barriers constraining each group from enjoying their rights and areas where additional measures are needed to address the barriers comprehensively or where existing sectoral efforts need improvement.

3.4.2 Steps 2 and 3: Design and implement responses that address exclusion

Objective. To address the sociocultural barriers and weaknesses in the policy framework or delivery system by revising/strengthening policies, program activities, resource allocations, institutional arrangements and staff incentives as well as monitoring and reporting systems. Responses must be developed based on the assessment and the design of the interventions must address the specific barriers of the excluded at the different levels discussed above. Key steps are detailed in Table 3.2.

3.4.3 Step 4: Monitoring, evaluation and reporting

Objective. To design/strengthen M&E systems to collect and analyze disaggregated data on outputs, outcomes and development results (Table 3.3), and ensure that the system is linked into management decision-making and the feedback loop to changes in implementation is robust.

Note that none of the existing government M&E systems in the sectors reviewed for this series has been able to monitor GESI outcomes effectively. Although some sectors like education have made a good beginning, comprehensive and consistent systems are not in place to collect, analyze and report with disaggregation. Hence, the steps and process outlined below require advocacy as well as technical support. Programs/projects have initiated some good practices but these need to be institutionalized. Major gains could be achieved if the National Planning Commission (NPC) and the Ministry of Finance could reinvigorate the collection and consolidation of sectoral output and outcome data as planned in the poverty monitoring and analysis system (PMAS). A common system for collection and analysis of disaggregated data across the sectors would allow NPC to generate a much more accurate picture of progress and problem areas on the path towards gender equality and social inclusion.

The roles of the different actors and the timing of monitoring are summarized in Table 3.4.

3.4.5 Step 5: Changing policy and project design to respond to M&E findings on inclusion.

Where government policy-makers (and politicians) have real incentives to be responsive to all groups in society, and projects are designed to be flexible and respond to what they learn, this step is automatic. But in settings where accountability and willingness to change are less than

perfect, it is important to build in formal policy reviews and project mid-term and periodic evaluations that ask for data-based analysis of which groups are benefiting from the policy or program and require specific follow-on actions to respond to the findings. If this analysis reveals

that certain groups are being left out, then the suggestions for responding outlined in Table 3.2 can be used to guide a critical re-thinking of the various processes, criteria and underlying assumptions upon which the policy or program has been designed.

Table 3.1: Analysis of Barriers

S.N.	Level	Analysis of barriers	How to do
1	Household & community	<ul style="list-style-type: none"> • What practices, beliefs, values and traditions at family and community levels constrain women, the poor and the excluded from accessing sectoral resources, opportunities and services? • What are the different rules, practices, divisions of labor, social expectations and differences in vulnerability and mobility for women and men and for different caste/ethnic groups? How have these impacted on women, the poor and the excluded? 	<ul style="list-style-type: none"> • Stakeholder consultation; participatory rural appraisal (PRA) tools like social mapping, labor, access and control profile, mobility maps, etc • Anthropological and sociological literature on Nepal
2	Status of women, the poor and the excluded	<ul style="list-style-type: none"> • Collect disaggregated data and substantive evidence to find out existing status of women, the poor and the excluded, and assess areas and level of disparities—with particular attention to data on their participation and status in sector for which the program or policy is being designed. 	<ul style="list-style-type: none"> • Review Census, Nepal Living Standards Survey, Department of Health Services data, health management information system, Nepal Demographic and Health Survey, education management information system, Nepal Human Development Report, Millennium Development Goals progress reports, etc, project/program-related information
3	Policy ²	<ul style="list-style-type: none"> • What policies exist, and how have these affected women and men of different social groups? • What new policy initiatives are being taken to address sectoral issues, and what are the likely gender/caste/ethnic/regional identity differentials in access to benefits from such initiatives? • What policies have the potential to transform existing relations of inequality, i.e., bring changes in socially prescribed division of labor and access to resources and decision-making power between women and men, and between people of excluded and non-excluded groups? 	<ul style="list-style-type: none"> • Review government policies/Acts/ regulations relevant to the sector (see Annex 3.1 for policy analysis matrix); project/program log frame, operational guidelines/other policy statements; other guidelines, partners' log frames, project guidelines, etc
4	Formal institutional structures and processes	<ul style="list-style-type: none"> • What kind of institutional structures/mechanisms/processes are there in the sector, and how responsive are they to the needs and issues of the excluded (e.g., how representative are committees, project offices, other such bodies formed at local, district and national levels)? • Is work on GESI specifically mentioned as a responsibility of any of these different institutions or their constituent units? • What kinds of structures/mechanisms exist to enable women and the excluded to be part of planning and monitoring processes in the sector? • Human resource policies for recruitment, transfer, promotion, staff performance evaluation: how diverse is the staff profile in terms of gender, region, caste/ethnicity and other variables? What provisions recognize specific issues/constraints of women, e.g., maternity leave, breastfeeding, flexible hours, security? How does the performance evaluation system capture efforts of the staff at addressing gender and inclusion issues? • What is the working culture in committees and offices? How supportive is it for women, the poor and the excluded to work comfortably? What is the behavior of the non-excluded towards these groups? Is the language used in the meetings understood well by all? How well does the language proficiency of the project staff reflect the languages spoken in the project area? What time are the meetings held? 	<ul style="list-style-type: none"> • Develop disaggregated staff profiles of project office, partner organizations, local government partner, user groups formed by project (see Annex 9.2 for format) • Review job descriptions of departments/divisions and staff such as project manager, planning officer, field facilitator, M&E (and any other relevant staff) and terms of reference of consultants and other teams • Facilitate interactions/discussions with staff on situation regarding working environment

S.N.	Level	Analysis of barriers	How to do
5	Programming and budgeting	<ul style="list-style-type: none"> • What have been the main interventions in the sector? How have these interventions affected women and people from other excluded groups (e.g., how did gender/caste/ethnic differentials support/constrain access to opportunities from interventions)? Did interventions have explicit inclusion goals and outcome indicators? Did they have an M&E system that was sufficiently disaggregated to track differential outcomes for different groups? • What is the budget allocation and expenditure on activities to address issues of women, the poor and the excluded? 	<ul style="list-style-type: none"> • Review annual budget (see Annex 3.3 for format) of government agency, program/projects/partner organization; identify how adequately activities addressing GESI issues have been budgeted for; what percentage of the entire project cost has gone for GESI related activities; how transformative are these budgeted activities? • Review M&E system and a sample of periodic and special reports and studies from the main interventions in the sector
6	Informal institutions (kinship, gender and caste systems and business and party networks)	<ul style="list-style-type: none"> • What are the income levels, social and human development characteristics of groups identified as excluded in the sector that might present barriers to their access? • What are the existing employment options in the sector and what barriers exist for women and other excluded groups in terms of skill levels, mobility, social norms, etc? • Who has access to control over what resources in the sector? • How are political parties active in this sector at different levels? At the national level what are their linkages with the sectoral ministry and other key organizations in the sector? 	<ul style="list-style-type: none"> • Consultation/interaction • Political science, economic, sociological and anthropological literature on Nepal

Table 3.2: Responses to Exclusion

S.N.	Level	Responses	Process
1	Policy	<ul style="list-style-type: none"> • Ensure policies (e.g., government directives at the national level, project criteria/guidelines at community levels, program goals and objectives) explicitly address constraints of women and the excluded, and mandate action to address them • Results planned in project plans/log frames must aim to improve assets, capabilities and voice of women, the poor and the excluded; they must address formal and informal practices that are inequitable and discriminatory, and aim to transform existing structural frameworks that disadvantage women and/or the excluded • Policies can support a targeted approach or address GESI issues in a non-targeted manner, integrating whatever special measures may be necessary (and economically feasible and sustainable) into mainstream programs to overcome barriers faced by women and excluded groups in accessing services, opportunities and benefits provided by the sector 	<ul style="list-style-type: none"> • Organize participatory workshops/consultations with stakeholders—women and men of different social groups; time, venue, methodology, language and tools should be suitable for women and the poor in particular • Phrase objectives, outputs, activities and indicator statements to reflect both technical and social issues • Review who will benefit—which women, men, girls, boys (with caste, class, location, ethnicity, age disaggregation): who is likely to have access to benefits from these policies? Who is likely to control them? Who is likely to benefit less from this intervention? Are targeted groups defined in clear terms or are general terms such as “disadvantaged” or “vulnerable” used without a clear definition of who they are? What assumptions are being made on women’s roles, responsibilities, time and access to and control over resources? On the capacity of people from excluded groups? • With the above in mind, what procedures, criteria or ways of working can shift these patterns to be more equitable? What incentives for sector staff and recipient community can be built into the interventions and operation of (government and non-government) institutions in the sector?
2	Formal institutional structures and processes	<ul style="list-style-type: none"> • There must be desks/units/sections/departments with specific GESI responsibility located within sectoral institutions/organizations from national to community levels, adequately resourced and mandated to provide technical support to address GESI issues • Terms of reference/job descriptions of all, including policy-makers and technical staff, must allocate responsibility to work on GESI issues, integrating them into their responsibilities • Efforts must be made to achieve an inclusive staff profile, with women and people from excluded groups in positions of responsibility • Human resource policies for recruitment, promotion and capacity building must be gender- and inclusion- 	<ul style="list-style-type: none"> • Identify GESI work responsibilities at different levels; review existing mechanisms to assess how they are addressing identified responsibilities—what has worked, why, what has not, why not; identify through a participatory process what existing structures and organizations can take on GESI responsibilities effectively; assess what new skills and approaches are needed and design accordingly • Review terms of reference/job descriptions of departments/divisions/key staff to assess the level of GESI responsibilities; revise and add; integrate into technical responsibilities for technical staff • Integrate recognition and incentives for staff that are successful in improving GESI outcomes • Review human resources policies: for recruitment,³ identify

S.N.	Level	Responses	Process
		<p>sensitive, and personnel policies must support gender-specific responsibilities</p> <ul style="list-style-type: none"> • Performance evaluation systems must capture responsibilities for GESI dimensions and efforts made by staff to address gender and inclusion issues 	<p>issues constraining applications from women and excluded groups; adopt alternative strategies to publicize vacancies through networks, in local languages; define “merit” to include language skills, understanding of local community cultures, etc</p>
3	Informal institutions	<ul style="list-style-type: none"> • Activities (e.g., sustained dialogue and advocacy) must be developed and implemented to address informal institutions that violate human rights of women, the poor and the excluded; strategies to work with rich, powerful, advantaged men and boys to change values and attitudes, getting buy-in from even the privileged members of the community to change the status quo. are necessary and have often been very successful 	<ul style="list-style-type: none"> • Through consultations and review of previous efforts, identify what has blocked implementation; what behavioral issues, values, social norms have been a challenge • Identify measures necessary to work with women, the poor and the excluded and with family decision makers, community leaders, local political leaders and elites, e.g., poverty analysis with leaders, decision makers, sustained dialogue with men on masculinity, advocacy campaigns against social ills like <i>chaupadi</i>, <i>dowry</i>, <i>boksi</i>
4	Programming and budgeting	<ul style="list-style-type: none"> • There must be programmatic activities and budget allocations that specifically address issues experienced by women and people from excluded groups; budget must also be allocated for activities that can create a supportive environment to address gender/caste/ethnicity and other dimensions of exclusion • Activities must ensure that livelihoods and voice of women, the poor and the excluded are enhanced, along with changing inequitable social norms and formal policies; sufficient budget allocations must be made for these activities • Estimate required resources and include human and financial resources for activities on gender and inclusion awareness for women and men and capacity building of women at program and organization level • Include resources required to support childcare responsibilities, field escort for security reasons and other specific constraints/responsibilities faced by women and people of excluded groups • Allocate sufficient resources for gender-balanced staff, training and institutional capacity building; include sufficient budget and time to build linkages and networking to strengthen different interest groups and to make sure that communication materials can be produced in several languages if need be • Those responsible for implementation must be held accountable for ensuring that planned activities are executed and the budget allocated is spent 	<ul style="list-style-type: none"> • Review program activities and budget in detail; assess likely impact of each activity on women, the poor and the excluded • Ask whether activities are addressing barriers identified: will poor and excluded women and men be able to access resources and benefits coming from this activity? What will be their benefits? Will they get these directly? Will these activities help to address structural issues constraining progress of women, the poor and the excluded, e.g., violence against women or untouchability? Or, will they provide immediate benefits by improving livelihoods or welfare? Identify percentage of budget allocated to different activities addressing barriers and assess whether these will enable groups to benefit equally

Table 3.3: Monitoring and Evaluation

S.N.	Level	Responses	Process
1	NPC	<ul style="list-style-type: none"> Revise planning, budgeting, M&E and reporting formats and processes to capture GESI dimensions according to three domains of change: changes in assets/services; changes in voice and ability to influence; changes in informal and formal policies and behavior Issue directives to all ministries to report disaggregation at output and outcome levels; provide common format for gender and social disaggregation to be used by all sectoral ministries Review and strengthen PMAS and the District Poverty Monitoring and Analysis System (DPMAS)—or whatever province-level system may be established after the new federal structure is determined 	<ul style="list-style-type: none"> Review existing formats; identify strengths and areas of improvement; advocate for revision; create pressure for change
2	Ministry	<ul style="list-style-type: none"> In every program/project at least some objectives, outputs, and indicators must be phrased in a way that captures gender and inclusion issues; these indicators demand collection of disaggregated data M&E section to be strengthened to monitor according to three domains of change ((services, voice, rules) with disaggregation, and guide departments and other key stakeholders to monitor and report with disaggregation and analytical evidence As revision of NPC formats may take time, the M&E section of the sectoral ministry involved in the project/program must develop operational guidelines that identify what disaggregated information is possible at national and district levels, and document case examples of success and lessons learned on how to ensure services and opportunities to excluded groups 	<ul style="list-style-type: none"> Log frame/results framework to be developed in a participatory manner with representatives of excluded organizations; log frame development team to have an expert on GESI Develop M&E and reporting formats requiring disaggregated information to be developed Information management system to be reviewed and strengthened M&E officers to be trained on GESI-sensitive M&E
3	Department	<ul style="list-style-type: none"> Revise necessary formats, indicators and monitoring guide to collect disaggregated information and evidence Monitor programs implemented by government and nongovernment actors in the sector Assess information provided by districts and report accordingly 	<ul style="list-style-type: none"> In joint consultation with ministry and other stakeholders, identify steps required to make existing M&E system more GESI responsive and revise accordingly Remember qualitative data and participatory M&E involving the beneficiaries can be an important source of insight about the GESI impact of interventions
4	District	<ul style="list-style-type: none"> District line agencies to monitor whether programs are implemented as planned and expected outputs/outcomes achieved, and report with disaggregation District Information and Documentation Centers (DIDCs) to be strengthened to maintain disaggregated database showing status of women and people of other excluded groups in district GESI implementation committee to be formed in district development committees (DDCs) according to approved MLD GESI strategy; collaboration and linkages between these must be established, with clarity in roles Budget expenditure and planned progress (monthly and quarterly) must be disaggregated, as must reporting In annual reports, analysis must not be activity based but should be based on data that capture outcomes for women and people of other excluded groups 	<ul style="list-style-type: none"> To achieve all this, the Ministry of Local Development (MLD) has to give a directive to the local bodies Local bodies will need technical support to understand GESI-sensitive M&E and to establish database systems that can be maintained to provide disaggregated information about progress and achievements
5	VDC/ community	<ul style="list-style-type: none"> Establish disaggregated database providing information regarding existing situation of village development committee (VDC) population; this can include “social mapping” that identifies the caste/ethnic identity and other significant features (such as female headship, etc) of each household in the project VDC Design/implement participatory M&E system 	<ul style="list-style-type: none"> Initiate participatory self-assessment process which is sensitive to social constraints like mobility, domestic work burden and family support Use mechanisms that ensure participation of women and men of different social groups

S.N.	Level	Responses	Process
		<ul style="list-style-type: none"> • Work jointly with the Integrated Planning Committee (IPC) in VDCs and Ward Citizens' Forums (which are to be established in each ward according to MLD VDC Block Grant Operational Manual 2009 of MLD) for monitoring • Develop mechanisms and work according to an M&E plan. • Establish/strengthen systems for use of social accountability tools like public audit, citizens' scorecard, public hearing, etc, and ensure that these are implemented by disinterested third parties who can be objective about the results 	
6	Project/ program	<ul style="list-style-type: none"> • All of the above • Incorporate GESI dimension in all processes, mechanisms and progress of project/program activities 	<ul style="list-style-type: none"> • Work with government bodies as required, and strengthen government systems • Efforts must be made not to establish a parallel system but rather to identify joint monitoring mechanisms that produce disaggregated data and analysis on outcomes for different social groups by gender • Reflect in log frame/results framework objectives, outputs and indicators in a consultative process

Table 3.4: Roles and Timing in Monitoring

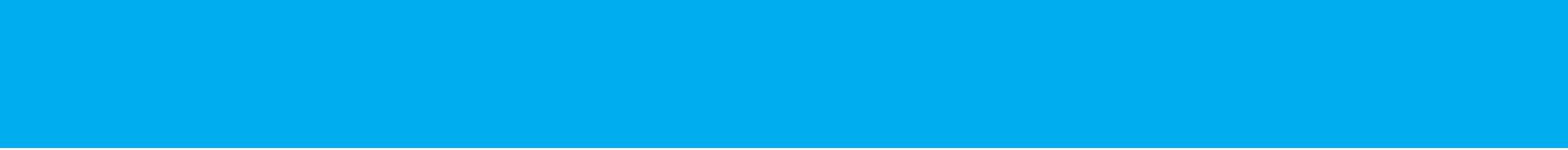
Time	Ward Citizens' Forum/ward level	Village Citizens' Forum, Integrated Planning Committee/VDC	GESI implementation committee/social committee, DDC	GESI section/division/unit of ministry/department	Projects/programs	NPC
					Facilitate setting up of GESI-sensitive monitoring and reporting systems	PMAS, DPMS: GESI aspects in formats, process
Monthly	<ul style="list-style-type: none"> Monitor progress in group participation, access to services, cases of discrimination Maintain disaggregated data about program implementation as per plan Self-monitoring 	Regular meetings, monitoring of social mobilization and program implementation	<ul style="list-style-type: none"> Regular supervision Assessment of progress as per plans Basis of monitoring to be three domains of change (services, voice, rules) 	<ul style="list-style-type: none"> Regular supervision Assessment of progress as per plans Basis of monitoring to be three domains of change 		
Quarterly review	Review progress with focus on the three domains of change		<ul style="list-style-type: none"> Monitoring visits Review with disaggregation as per the three domains of change 	<ul style="list-style-type: none"> Analyze reports of VDCs 		
Six-monthly	Public hearing, covering program implementation and social mobilizers' work	<ul style="list-style-type: none"> Public hearing Public audit 	<ul style="list-style-type: none"> Participation in public hearing and audit Quarterly report to cover GESI 	<ul style="list-style-type: none"> Integrate progress and learning to inform decision makers for strategic change Report as per three domains of change 	Supervision and review	
Annual	Gender and social audit	Gender and social audit	<ul style="list-style-type: none"> Participation in public hearing and audit Annual report to cover GESI 		Report	

Source: Adapted from GESI strategy of LGCDP, MLD, 2009.

Notes

- 1 In a national program, a mapping of the local political economy of the sector in a sample of the different types of sites where the program would be implemented would provide enough to go on.
- 2 Policy is understood here as a statement of intent, so it can be at the macro, meso or micro level, and it can be formal (government Act or program-level guidelines/criteria) or informal, such as social practices/norms.
- 3 See SIAG (2009) for suggestions to increase GESI sensitivity in recruitment policies.

Annexes



Annex 1.1: Definitions of Socially Excluded Groups

Brief definitions¹ of the *socially excluded groups* (women, Dalits, Adivasi Janajatis, Madhesis, Muslims, people with disabilities and people of geographically remote areas) are provided below.

Women. Due to existing gender relations in Nepal and a patriarchal society, women experience unequal power relations, resulting in their social exclusion. Although the depth of gender discrimination varies between social groups in Nepal, all women are excluded. However, women from excluded communities face caste, ethnicity and location-based constraints in addition to the constraints imposed by their gender. Women constitute 51% of Nepal's population.²

*Dalits.*³ People who have been suffering from caste and untouchability-based practices and religious, social, political and cultural discrimination form 13% of Nepal's population. Within the Dalit community, there are five sub-caste groups from the hills (Hill Dalits) and 22 sub-caste groups from the Tarai (Madhesi Dalits).

*Adivasi Janajatis.*⁴ Peoples or communities with their own mother tongue and traditional social structures and practices, separate cultural identity, and written or unwritten history form 37% of Nepal's population, with 5.5% Newars and 31.8% Hill and Tarai Janajatis. There are 18, 24, 7, and 10 sub-groups respectively among the Mountain, Hill, Inner Tarai and Tarai Janajati groups.

Madhesis. People of plains origin who live mainly in the Tarai and have languages such as Maithili, Bhojpuri, Awadhi, Urdu and Hindi as their mother tongue are considered Madhesis. They include Madhesi Brahmin/Kshatriyas (2% of the population), Madhesi "other" caste groups (13%) and Madhesi Dalits.

Muslims. Muslims are a religious group found predominantly in the Tarai and form 4.3% of Nepal's population.

*People with disabilities.*⁵ "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".⁶ Persons with full disabilities cannot manage daily life without assistance. They include people with total mental, intellectual or sensory impairment such as complete blindness. People with partial disability are persons who have long-term physical and/or mobility impairments, and require regular assistance to manage daily life.

People of remote geographic regions. This covers people living in geographic regions which have distinct, difficult terrain for movement, transportation and communication, and difficulties in accessing services (e.g., Karnali has been defined as geographically excluded by the government in the Three-Year Interim Plan). Similarly, in a DDC some locations (VDCs) can experience geographical exclusion due to difficult terrain and remoteness. Within these kinds of geographically excluded regions, people experiencing gender-, caste-, and ethnicity-based discrimination experience further exclusions.

The specific issues of exclusion differ between these groups. For Dalits it is caste-based exclusion; for Adivasi Janajatis it is cultural rights/language-based exclusion; for Madhesis it is identity-based exclusion; for the poor exclusion it is economic-based; while for remote regions it is distance-related. For women, it is gender-based, a characteristic that cross-cuts each of the other dimensions of exclusion.

Notes

- 1 Gender equality and social inclusion strategy, LGCDP/MLD, 2009.
- 2 Population figures are from Census 2001, CBS/NPC, Government of Nepal.
- 3 Based on the National Dalit Commission reports.
- 4 Based on NFDIN descriptions.
- 5 Based on Social Security Guidelines, MLD/Government of Nepal, 2065 (p. 1).
- 6 'Convention on the Rights of Persons with Disabilities', www2.ohchr.org/english/law/disabilities-convention.htm.

Annex 1.2: Step 1 Gender Equality and Social Inclusion Framework: Analysis of Policy, Institutional, Program, and Monitoring and Evaluation Barriers

As part of designing responses that are based on the assessment done in Step 1, the analysis of the barriers and responses must be viewed at several levels.

Policy. Analysis at this level assists us to identify which policies are addressing or reinforcing social inequalities, and reducing, maintaining or increasing disparities. This analysis will, in turn, guide us in the design of appropriate strategies for reprioritization or redefining policies. Policies exist at all levels. Some are more formal and official, others more informal and traditional.

Organizational structures. The rules and practices within organizations need to be reviewed to identify ways in which social inequity is created and maintained. The extent to which GESI policy commitments are formulated and effectively implemented depends on the understanding, skills and commitment of the staff in policy-making, planning and implementation roles. Additionally, most organizations have official rules and procedures, but unofficial norms and practices operate informally and influence results. Tools for organizational assessment in projects/NGOs/partner organizations include disaggregated staff profiles showing who has access to what opportunities and types of resources and levels of decision-making power; reviewing the job descriptions and terms of reference for including GESI in objectives, tasks/responsibilities, and key skills/competencies; and human resource policies for recruitment, promotion, capacity building and support for gender-specific responsibilities.

Program and budgeting. The program activities should be reviewed to assess the strengths and identify areas of improvement for addressing the needs and interests of women, the poor and the excluded. The program and budget should be assessed on whether they are specific, supportive or neutral towards these groups. A financial commitment to gender- and inclusion-related activities is an essential element of mainstreaming GESI, reflecting the spending choices the concerned organization has made as per its available resources. When auditing budget and program design to assess their effectiveness in reaching different excluded groups and the poor, it is important to keep a separate eye on expenditures for men and women in these various groups. Otherwise gender-based disparities may not be picked up. Similarly, when conducting a gender audit, it is important to look separately at the expenditures and outcomes for women from different social groups since women from certain social groups may not have been reached.

Monitoring and evaluation. Monitoring and reporting should follow the conceptual frame of the three areas/domains of change: 1) changes in assets/services; 2) changes in voice and ability to influence; and 3) changes in informal and formal policies and behavior. All monitoring and reporting formats must have disaggregation by poverty, sex, caste, ethnicity and location. Monitoring teams must be inclusive, with representation of women and people from excluded communities as members. Monitoring teams must consult with community women and men, including those experiencing exclusion, representative organizations and others. Monitoring must also focus on the *process* of implementation: what was done and how it was done, and from a GESI perspective, with whom it was done; and on the *outcome* or results of action.

Annex 1.3: List of Budgets Reviewed, FY 2009-2010, for Gender Equality and Social Inclusion Budgeting Covering 22 Programs and Annual Plans of Two Ministries

Sector	Number of project/ program budgets	List of budgets reviewed of FY 2009-2010 for GESI budgeting
Agriculture	3	<ul style="list-style-type: none"> Commercial Livestock Development Project, ADB Project for Agriculture Commercialization and Trade, WB Regular program of MOAC: extension services
Education	5	<ul style="list-style-type: none"> School Sector Reform Program School Sector Support Program Capacity Development Program Secondary Education Support Program, district level Education for All, district level
Health	Annual plan (covering 41 programs)	<ul style="list-style-type: none"> Annual budget of FY 2009-2010 of MOHP
Forest	Annual plan (covering 18 programs) + 2	<ul style="list-style-type: none"> Annual budget of FY 2009-2010 of MOFSC Annual program budget of Kavre and Morang, FY 2008-2009
Water supply and sanitation	6	<ul style="list-style-type: none"> Community-based Water Supply and Sanitation Program Rural Water Supply and Sanitation Fund Development Board Small Town Water and Sanitation Project Regular program of district water supply and sanitation
Irrigation	3	<ul style="list-style-type: none"> Community-managed Irrigation and Agriculture Support Program Integrated Water Resource Management Program Department of Irrigation Annual program budget of Kavre and Morang, FY 2008-2009
Rural infrastructure	4	<ul style="list-style-type: none"> Rural Access Program Rural Rehabilitation and Reconstruction Project Decentralized Rural Infrastructure and Livelihood Improvement Program District Road Support Program Rural Access Integrated Development Program Annual program budget of Kavre and Morang, FY 2008-2009

Annex 2.1: Proposed Sub-indicators for Gender-responsive Budgeting

Indicators (score)	Subindicators
Participation in decision-making (30)	<ul style="list-style-type: none"> • Regular meetings of the mothers' group • Representation of ANMs and staff nurses in the <i>ilaka</i>/district-level health annual review and planning meetings • Representation of women in the health facility management committee: community (Dalit/women/Janajati) and FCHVs select their representatives instead of nomination by health facility in-charge • Representation of women in all district-level monitoring committees (free health service, district AIDS, immunization, reproductive health, etc)
Capacity building (30)	<ul style="list-style-type: none"> • Participation of women health staff in training /workshops and seminars • Participation of HFMC members in training and seminars • Participation of FCHVs in training and seminars • Orientation to different level staff and committee members on related policies and provisions • Gender orientation to staff and committee members to create gender-friendly environment in committees, offices and workplaces
Benefit sharing (40)	<ul style="list-style-type: none"> • Access of women to available health services • Women-specific health-related programs (reproductive health, uterus prolapses, etc) • Improvement in major health indicators (where there is wide gender gap) • Proportion of women health workers (indirectly this would encourage women to access health services)

Annex 3.1: Policy Analysis Format

Policy, provision, article No	GESI analysis of policy statements, provisions, criteria, guidelines, etc		
	Addresses human condition within existing social hierarchy and division of responsibilities, does not make structural changes	Establishes equal rights and promotes structural transformation	Neutral
1.....			
2.....			

Annex 3.2: Format for Disaggregated Diversity Profile

S.N.	Post	Dalit				Janajati						Brahmin/Chhetri				Other Madhesi Castes/OBC groups		Muslims		Others		Total
		Hill		Madhesi		Others		Newars		Hill		Madhesi		F	M	F	M	F	M			
		F	M	F	M	F	M	F	M	F	M	F	M									
1																						
2																						
3																						
4																						
5																						
6																						

Annex 3.3: Program and Budget Analysis Format

Description	Directly supportive activity (1)		Indirectly supportive activity (2)		Neutral activity (3)		Total	
	Amount	%	Amount	%	Amount	%	Amount	%
Women								
Dalit								
Janajati (except Newar)								
Newar								
Brahmin/Chhetri								
Muslims								
Other Madhesi Castes/Other Backward Classes (OBC)								
Location (rural, remote, Karnali, Tarai, etc)								
Poor								
Adolescents								
Elderly								
Disabled								
.....								

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Cover shows Sangeeta Shrestha receiving her new-born
baby in Dhulikhel Hospital, Kavrepalanchowk, June 2009.
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