Vulnerable Community Development Plan

NEPAL HEALTH SECTOR MANAGEMENT PROJECT

MINISTRY OF HEALTH
Government of Nepal

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1. INTRODUCTION AND OBJECTIVES

1. Nepal's complex social structure makes it challenging to define the vulnerable communities. According to the 2011 census, there are 125 different social groups in the country with 123 different languages. Amongst these, the National Foundation for Development of Indigenous Nationalities (NFDIN) Act 2002 has recognized 59 different groups as indigenous nationalities/peoples (known as Adivasi/Janajatis in Nepal). Further, the Nepal Federation of Indigenous Nationalities (NEFIN) has classified Adivasi/Janajati groups into five different categories while characterizing their economic and social features: (i) endangered, (ii) highly marginalized, (iii) marginalized, (iv) disadvantaged, and (v) advantaged groups. These categories are based on their population size and other socioeconomic variables such as literacy, housing, land holdings, occupation, language and area of residence.

2. Besides the Adivasi/Janajatis, there are other groups such as Dalits, Madhesis and Muslims, residing in Nepal that are not included as indigenous group but are equally if not more vulnerable. The 2011 census has listed 15 Dalit caste groups who are economically and socially most vulnerable, underprivileged and marginalized population in the country. Besides the caste/ethnic groups, women, people with disabilities, elderly, survivors of gender based violence, individuals living with HIV/AIDs, households living below poverty line and conflict-affected people, are also living in difficult conditions and can be considered as vulnerable groups. The constitutional provisions, social assessments, and policy guidelines and strategies developed for the health sector suggests that the above described groups constitute the vulnerable communities.

3. This document presents the Vulnerable Community Development Plan (VCDP) for the IDA (International Development Association) Nepal Health Sector Management Project. The objective of this VCDP is to serve as a practical tool that will help support the Government's Nepal Health Sector Strategy (NHSS) to respect the dignity, human rights, economies and cultures of vulnerable groups, including the Indigenous Peoples (also known as Adivasi Janajatis in Nepal). The VCDP details agreed principles, guidelines and procedures to be integrated into project implementation that would ensure compliance with the applicable Nepali laws relating to indigenous peoples and other marginalized groups, and the relevant World Bank's safeguard policies and objectives relating to Indigenous Peoples. The VCDP includes Plan for consultation and participation; monitoring; institutional arrangements for implementation; and capacity building. Much of these are also included in the NHSS document as well as the Gender Equality and Social Inclusion Strategy (GESI) of the Ministry of Health (MoH).

2. DESCRIPTION OF THE PROJECT

4. The main objective of the Nepal Health Sector Management Project is to improve management of public resources of the health sector; and enhance information access to policy makers for evidence-based planning, and to citizens to hold the health system accountable for services. The project is embedded within the Government's NHSS that is based on the principles of universal health coverage, quality, access and equity and has nine goals. Six of the goals relate to improved public sector governance, health system financing, procurement and supply chain management, decentralized planning, evidence based decision making and equitable utilization of services.

5. In line with NHSS and the overall goal of strengthening health systems, the IDA operation will focus on enhancing the efficiency, effectiveness and accountability of public spending and public sector management in the health sector including its ability to get improved information for better targeting of services. The Project comprises of two major components briefly described below.

Component 1 – Improved Public Financial Management and Public Procurement in the Health Sector.

A. Improved Systems and Management for Public Procurement:

6. The structural and institutional arrangements for managing health sector procurement are weak which impacts the quality and timely availability of drugs**.** The aim of this sub-component is to support the Government's reform plan for system and supply chain improvements in order to improve efficiency and transparency. Enabling proper planning, budgeting and execution of procurement, and quality assurance would lead to reductions in drug stock outs and enable the timely availability of the basic package of drugs at all health facilities and to all populations. The following interventions will be supported:

(i) Enhanced Institutional Capacity at MOH for managing procurement

(ii) Effective operational logistics and supply chain management system

B. Improved Public Financial Management (PFM) in the Health Sector:

7. This sub-component focuses on reforms to improve the entire cycle of planning, budgeting, expenditure execution and monitoring. Improved PFM in the health sector is expected to reduce existing inefficiencies in public expenditure planning and spending, and thereby facilitate better redistribution of resources through more evidence-based resource allocation to ensure that affordable and appropriate health services are available to the Nepali population, particularly the disadvantaged. The following interventions will be supported:

(*i) Adherence by all spending units to mandated budget planning and preparation and submission guidelines*

(ii) Comprehensive and timely reporting of sector expenditure through an online system - Transaction Accounting and Budget Control System *(TABUCS).*

(iii) Timely and satisfactory responses to audit reports in the health sector.

Component 2: Improved Public Resources Management through Enhanced Accountability and Transparency.

8. Public resources are not necessarily targeted to populations and geographic areas with the poorest health outcomes. Robust disaggregated data **(**based on income, ethnicity, gender and geographical location) is not available on a regular basis, and is definitely not presented to, or used by, policy makers for decision-making. At the same time there is no system/mechanism in place to provide reliable and timely information to citizens that would enable them to hold the health system accountable for accessibility, affordability and quality of service delivery. This component will support NHSS to design and strengthen systems for regular data capture and monitoring of disaggregated data. Mechanisms for public access to information in keeping with

Nepal's Right to Information Act[1] will also be jointly developed. This will include, citizen feedback mechanisms for key areas such as availability of drugs and health care providers as well as appropriate citizen grievance redress processes. Under this component, the following interventions will be supported:

(i) Improved mechanisms for evidence based planning for service delivery:

9. While the MoH has a system for reporting on overall health outcomes, the government recognizes that availability of data and reporting on access and health outcomes for different population groups needs to be strengthened and used for decision making. This is critical as there remain significant inequalities in access and quality of care. The interventions will include (i) incentivizing the phased roll out of the District Health Information System/ Strategy (DHIS2); and (ii) preparation of annual joint policy notes based on data driven evidence, recommending measures for improving health outcomes in targeted populations. This would be reflected in allocations in the Annual eAWPB.

(ii) Robust citizen feedback mechanisms to ensure accountability in access to health care:

10. Strengthened citizen engagement can improve access by providing citizens with the information and capabilities they need to access a given service; and capturing information from citizens, via voice and feedback, to improve state responsiveness in addressing access constraints. Improved accountability can help ensure that service providers 'supply' the service as agreed, thus ensuring that affordable access is provided and maintained. At present, there is no formal mechanism in the health sector in Nepal that enables this process. International experience shows that to establish such processes, particularly in fragile and unstable countries, this endeavor is unlikely to be institutionalized during the short life of a project. However this should not hinder initiating the establishment of such systems. The project period realistically would aim for the following interventions: (i) supporting the development of a strategy and implementation mechanism/s for obtaining citizen feedback in specific areas including availability of drugs and health care providers; (ii) piloting citizen engagement mechanisms in different geographical regions while recognizing cultural and social norms and (iii) supporting public through regular public dissemination of citizen feedback reports via appropriate channels;.

3. BACKGROUND RESEARCH

11. As part of project preparation, analysis was undertaken to understand social issues. The objective of the analysis was to inform interventions and activities under NHSS, and support dialogue on social issues in the health sector among government and external partners. The main

[1] Nepal's Right to Information Act of 2007 states that all public authorities are required to respect and protect the right to information of all citizens and make access to information easy and accessible. "Information" means any document, material or information related to the functioning, proceedings or decisions of public importance." Public importance" means subjects related directly or indirectly to the interests of citizens.

findings , especially with regards to issues of vulnerable community, also termed as 'Gender and Social Inclusion (GESI)' issues in Nepal were as follows:

Major Achievements and Challenges

12. In recent years, Nepal has made good progress in most health indicators. Reports from the latest annual review meeting suggests that in the Nepali fiscal year 2013/2014 (2070/71), a total of 14,045 poor and needy people were provided with free health services; 307,281 pregnant women benefitted from free delivery services; the Female Community Health Volunteer Program (FCHVP) has expanded from an initial 27 districts to all 75 districts in Nepal; and more than 2,000 individuals, mostly women (94%) have used OCMC services.[2] Notwithstanding these achievements, many mothers still do not receive antenatal care services from skilled or trained health workers;[3] and the use of maternal health services continues to be less among the vulnerable groups. For instance, women from Adivasi Janajati (IPs), Dalits, and the Tarai-Madhesh communities have lower levels of access to antenatal care services from health workers compared to Tarai and Madhesi women, compared to women from 'privileged' backgrounds. Similarly, while 88% of women from the urban areas have access to such services, the numbers for rural women is low at only 55%. Likewise, the unmet need for family planning is highest among the Hill Dalit (35%), followed by the Hill Janajati (34%) and the Tarai Janajatis (14%). [4]

Sectoral Level Constraints and their Implications on GESI-Related Outcomes

13. Nepal's health sector has inadequate institutional capacity to implement its various policies and programs, which have also impacted the gender and social strategies envisaged in the existing policies and programs. Some of these include: unavailability of doctors and/or skilled health workers in remote areas; lack of timely availability of drugs; and insufficient evidence-based budget allocations and resource mobilization.

Information, Knowledge and Understanding on GESI-related Issues

14. In spite of the various strategies and guidelines relating to GESI, a bottleneck has been that the health workers including those responsible for the management of health institutions are either unaware or unclear about the guidelines and strategies relating to IPs and other vulnerable groups. Further, in the absence of adequate information/awareness campaigns, the beneficiaries/local populations continue to be plagued by issues relating to discriminatory practices, limited knowledge and awareness, and minimal access to health facilities.

Monitoring, Information Management and Mechanisms for Course Correction

15. There is recognition among policy makers and donors/development partners on the need to strengthen data/information in the health sector. Based on this, GESI indicators have been

[2] Ministry of Health and Population/GoN, "Annual Report, 2070/71 (2013/2014)," Department of Health Services.

[3] According to the Nepal Demographic Health Survey, 26% of mothers received antenatal care but less than 1% of them from a FCHV. Total 58% mothers received for their most recent birth and15% women received no antenatal care for births in the five years before the survey (NDHS, 2011).

[4] NDHS, 2006; 2011.

revised[5] and a template for the reporting system has been put in place. However, the health facilities in the community, village and district levels often experience difficulties in proper, timely and effective recording, reporting and managing of data/information, which in turn has made it difficult to use the HMIS effectively for policy and program planning purposes.

Construction of Health Facilities and Issues of Land Acquisition

16. Until recently, screening and selection of land for building health facilities was a challenge because there were no specific standards and guidelines nor was there any consideration given to the issues of displaced and affected people and communities due to land acquisition. Consequently, there were risks of health facilities being built/established either in low quality government land or those donated by individuals, generally in marginal lands or isolated areas. In addition, there were loopholes which made it easy for vested interests to influence decisions on the locations of these facilities. The endorsement of the 'Guidelines and Building Codes' of DUDBC and 'Guidelines for Selecting Land for the Construction of Health Facilities' of MoH in 2014 provides a vehicle to help address issues of quality of land, spaces and design of health facilities, and also make health facilities more accessible to all, including vulnerable groups.

Coordination and Governance

17. In the context of Nepal, there are government, non-governmental organizations and private health facilities involved in providing health services to people. However, coordination amongst them continues to be a challenge, including in matters relating to GESI. While there is provision for GESI co-ordination committees at the district level, and stakeholders primarily from the Ministry of Women and Child Development, Ministry of Federal Affairs and Local Development, Ministry of Home Affairs and the Ministry of Health, are part of the committee, the coordination committees have not been very effective in terms of strengthening GESI issues in the health sector.

4. POLICY PLAN SUPPORTING VULNERABLE GROUPS

18. The VCDP is developed in line with relevant Nepali laws and regulations, and World Bank Safeguards Policies as summarized below.

Constitution of Nepal, 2015

19. The constitution has guaranteed 'right to health care' as a fundamental right and provides each citizen the "right to seek health care services from the state and no citizen shall be deprived of emergency health care." In addition, the Constitution also includes the following provisions:

[5] The revised indicators include total 11 indicators that have been disaggregated by caste/ethnicity. The indicators are: 1. Per cent of fully immunized children; 2. Per cent of underweight children below 2 years; 3. Per cent of children enrolled in IMCI; 4. Per cent of institutional deliveries; 5. Per cent of abortion cases; 6. Per cent of outpatients utilizing health services; 7. Per cent of inpatients utilizing health services; 8. Per cent of HIV positive cases; 9. Per cent of Leprosy patients; 10. Per cent of Tuberculosis patients and; 11. Per cent of gender based violence cases registered in health facility (HMIS, 2014).

- Every woman shall have the right relating to safe motherhood and reproductive health (Article 38(2))
- Every child shall have the right to education, health care nurturing, appropriate upbringing, sports, recreation and overall personality development from family and the State (Article 39(2))
- In order to provide health care and social security to Dalit community, special arrangements shall be made in accordance with law (Article 40(3))
- Citizens who are economically very poor and communities on the verge of extinction, shall have the right to special opportunity and facilities in the areas of education, health, housing, employment, food and social security, for their protection, progress, empowerment and development (Article 42(2)).
- People with physical impairment shall have the right to a dignified way of life and equal access to social services and facilities, along with their diversity identity (Article 42(3)).
- The State shall gradually increase necessary investment in the public health sector in order to make citizens healthy (Article 51 (h) (5)).
- Measures shall be taken to ensure easily available and equal access to high quality health care for all (Article 51 (h) (6)).

National Foundation for Upliftment of Adivasi/Janjati Act, 2058 (2002)

The GoN has identified and legally recognized 59 indigenous communities in Nepal. They are officially referred to as ***Adivasi/Janajati*** in Nepali and **Indigenous Nationalities** in English. According to Nepal Federation of *Adivasi Janajati* (NEFIN) 10 of the 59 *Adivasi Janajati* are "endangered", 12 "highly marginalized", 20 "marginalized", 15 "disadvantaged" and 2 are "advanced" or better off on the basis of a composite index consisting of literacy, housing, landholdings, occupation, language, graduate and above education, and population size.

Local Self Governance Act, 1999

For the purpose of giving more power to local bodies, the Local Self Governance Act was promulgated. Among others, it aims to promote, preserve and protect the language, culture, religion and welfare of indigenous groups. Further, it also seeks to institutionalize the process of development by enhancing the participation of all people including the ethnic communities, indigenous people and down-trodden as well as socially and economically backward groups in bringing out social equality by mobilizing and allocating means for the development of their own region in a balanced and equitable manner. In addition to this, NFDIN helped to establish Adivasi/Janajati District Coordination Committees to enable them to influence at the district level decisions over the local distribution of public resources. The provisions for Village Council also mention that at least six persons, including one woman from amongst those social workers socially and economically backward tribes and ethnic communities, down-trodden and indigenous people living within the village development area.

Three Year Interim Plans and Approach Papers

20. In line with the constitutional provisions, the successive national periodic plans (the Three-year Interim Plans for 2007-2010 and 2011-2013) provided policies and programs for inclusive growth and upliftment of the vulnerable communities. The specific policies for

inclusive development of the vulnerable communities adopted by the government are: (i) creating an environment for social inclusion; (ii) participation of disadvantaged groups in policy and decision making; (iii) developing special programs for disadvantaged groups; (iv) positive discrimination or reservation in education, employment, etc; (v) protection of their culture, language and knowledge; (vi) proportional representation in development; and (vi) making the country's entire economic framework socially inclusive.

Specialized Institutional Mechanisms

21. The Parliament passed a bill in 2002 for formation of National Foundation for the Development of Indigenous Nationalities, which came into existence in 2003. Similarly, in 2002 National Women Commission and National Dalit Commission were formed. These foundation and commissions are to work for protection and promotion of rights of the indigenous, marginalized, Dalit and women.

22. Beside the aforementioned provisions, the National Human Rights Action Plan 2005, Environmental Act 1997, and Forest Act 1993 have emphasized protection and promotion of vulnerable groups in general, indigenous peoples' knowledge, and cultural heritage in particular. Likewise, in 1999, the Local Self-Governance Act was amended to give more power to the local political bodies, including authority to promote, preserve, and protect the indigenous community's language, religion, culture, and their welfare.

23. In 2007, Nepal also signed the ILO Convention No.169 on Indigenous and Tribal Peoples enacted in 1989 and the United Nations Declaration on the Rights of Indigenous Peoples (2007). Both of these emphasizes consultation with indigenous peoples and involving them in decision making at all levels, their rights in the decisions over their development priorities as well as their rights to participate in the use, management and conservation of these resources, the need and requirements of free, prior and informed consent.

Health Plans and Policies

24. In the health sector, the GoN has been formulating and implementing various policies and programs including:

- Second Long-term Health Plan 1997-2017
- Health Sector Strategy 2004
- Ten-Point Health Policy and Program 2007
- Free Health Service Program, 2007/08

25. Together, these policies and plans focus on improving the health status of disadvantaged and marginalized populations. Additionally, in the National Health Policy 2015, the GoN has expressed its commitment and responsibilities towards improving the access and outcomes of disadvantaged communities in the health sector.

GESI Specific Strategies and Guidelines

26. The GoN has also issued some key guidelines and strategies on GESI such as:

- Health Sector Gender Equality and Social Inclusion Strategy 2009

- Operational Guideline for Gender Equality and Social Inclusion Mainstreaming Strategy in Health Sector 2013
- Gender Equality and Social Inclusion Operational Guideline 2013

27. These guidelines and strategies are aimed at improving the access and use of health services by disadvantaged and marginalized groups. Specifically, these guidelines emphasize creating a favorable environment, enhancing capacity of service providers, improving the health-seeking behavior of disadvantaged populations based on a rights-based approach, ensuring adequate budget and monitoring arrangements, GESI responsive reporting and implementation of health services including from the private and non-state actors.

GESI-specific programs and activities

28. As per the objectives of improving and achieving gender equity and social inclusion in the health sector, the MoH has introduced and implemented various programs that are targeted to the disadvantaged and marginalized people and communities. Some of the key ones includes: Free Health Care for Essential Health Care Services; Safe Motherhood Program; Trainings and Awareness Raising Initiatives, especially to skilled birth attendants (SBA), MoH staff, and community members.

World Bank Policy: OP/BP 4.10 Indigenous Peoples

29. The World Bank's Indigenous Peoples policy (OP/BP 4.10) is designed to ensure that the development process fully respects the dignity, human rights, economies and cultures of Indigenous Peoples. As such, the policy requires that the World Bank provides project financing only where free, prior and informed consultation results in broad community support to the project by the affected Indigenous Peoples. Such Bank-financed projects include measures to: (a) avoid potentially adverse effects on indigenous peoples' communities; (b) when avoidance is not feasible, minimize, mitigate or compensate for such effects; (c) indigenous peoples receive culturally compatible social and economic benefits.

5. MEASURES FOR BENEFITTING VULNERABLE GROUPS THROUGH NHSS

30. While the IDA operation will only focus on enhancing the efficiency, effectiveness and accountability of public spending and public sector management in the health sector, NHSS addresses issues of equity, access and coverage for better health outcomes amongst the poor and disadvantaged, including indigenous people.

While the overall health sector program of MoH will adopt a number of measures during the implementation of the NHSS the following are activities that will be supported through IDA operation to enhance public spending and public sector management in the health sector especially in relation to vulnerable groups:

Improved data on access to health services by Vulnerable and Target Groups

31. The direct beneficiaries of IDA financing include the MoH and its departments and divisions, health facilities, and users of health facilities. The project will continue using the information/data from the Health Management Information System (HMIS), and also support the roll out of the District Health Information Software 2 (DHIS2). The DHIS 2 in particular will provide information about decentralized levels of service delivery, which the relevant division at MoH will use to prepare annual reports, highlighting inequities in access to vulnerable groups, including indigenous people, and the need to target resources for these vulnerable groups and remote districts. The Development Partners will together engage in discussions to enable appropriate resource allocation in the Annual Work Program Budgets.

Citizen Engagement Mechanisms

32. The Gender Equity and Social Inclusion (GESI) strategy of the MoH includes provisions on citizen engagement that seeks to strengthen citizen engagement, including that of vulnerable groups and indigenous people by providing them with information and capabilities required to access a given service; and also enable them to voice their opinions in a free and participatory manner. During the first year of the project, a strategy/plan for citizen engagement will be developed. This will include means for generating public awareness on health-related information; mechanisms to engage citizens; involve vulnerable groups, including indigenous people in free prior and informed consultations and get their feedback on the availability of essential health services; and engage in providing suggestions for improvement. Particular efforts will be made to solicit the views, hear the concerns and suggestions of vulnerable communities and target groups, including indigenous people, by preparing a communications strategy targeting these groups. In order to raise awareness amongst vulnerable groups about program benefits, improve their access to health services, and also enhance their health seeking behavior, behavior change communication programs might be required. To support indigenous people, these programs will be introduced in local languages in areas with large population of indigenous people or linguistic minorities. Further, the guidelines for citizen engagement will include specific provisions for ensuring that vulnerable groups, including indigenous people, are able to voice their opinions and concerns freely and in a participatory manner.

6. INSTITUTIONAL ARRANGEMENT

33. The Ministry of Health and Population (MoH) through its various organizational structures including its departments, divisions and centers will ultimately be responsible for implementing the measures identified in this VCDP. The GESI Unit at MoH and the GESI focal persons in the various tiers of the organizational structure will be responsible for ensuring that there is consistent GESI input, including that of IP considerations, into the detailed design of the health program on an annual basis. Further, the GESI focal persons will be responsible for designing and organizing training and awareness raising programs to ensure sensitivity to these issues at the regional, district and sub-district levels.

7. MONITORING OF VCDP

34. The responsibility of monitoring progress towards results of the sector program lies with the MoH through its various structures. The Health Management Information System (HMIS) analyzed by the Management Division of the Department of Health Services (DoHS) will be used to analyze progress on equity and access issues concerning vulnerable groups. Further, the monitoring and evaluation of the VCDP will be integrated into the monitoring and evaluation system under the GESI strategies.

8. BUDGET

The budget for the implementation of the VCDP will be integrated along with the commitment on separate units for GESI at the central and local levels, and the overall implementation for GESI strategies, including IP considerations.