Social Management Plan

Nepal Health Sector Management Project

**Ministry of Health
Government of Nepal**

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1 Background

1.1 Project Background

The World Bank's support to the Nepal Health Sector Strategy (NHSS) aims to improve the efficiency of public resource management systems in the health sector. The project is embedded within the Government's NHSS that is based on principles of universal health coverage, quality, access and equity and has nine goals. Amongst others, these 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.

As described in the NHSS document, weak oversight and management of public resources in the health sector is one of the key binding constraints for improving health outcomes and equity. The IDA operation includes two components to improve resource management through (i) supply-side interventions such as improved procurement, contract management systems, supply chain systems; and budget planning, execution and reporting; and (ii) demand-side interventions focused on effective citizen engagement for enhanced accountability.

Component 1 – Improve Public Financial Management and Procurement in the Health Sector (US$ 115 million)

A. *Improving Public Procurement (US$ 65 million)*: 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 success of these interventions and the release of IDA funds will be linked to the achievement of the following disbursement linked indicators (DLIs) in the following areas:

A (i) Enhanced systems and institutional capacity at MoH for managing procurement:

> DLI 1: Systems and organizational reforms at MoH carried out, based on Procurement Reform Action Plan (US$21 million). This DLI will focus on reforms aimed at upgrading contract management software so that contracting and procurement is done on-line, as well as support to the roll out of a capacity strengthening plan including the establishment of trained functional units to manage critical procurement functions contributing to enhancing management capacity and accountability.
> DLI 2: Percentage of procurements done by the Logistics Management Division (LMD) using standard specifications (US$14 million). This DLI will focus on reforms aimed at creating greater transparency in the procurement of the basic package of drugs and equipment by establishing standard specifications.

A (ii) Effective operational logistics and supply chain management system:

DLI 3: Percentage of districts reporting on integrated a Logistics Management Information System (LMIS) (US$16 million). MoH currently does not have a robust logistics and supply chain management system which makes it difficult to assess the availability of drugs at regional and district level. This DLI will focus on supporting the establishment of a LMIS and training personnel on its use in order to produce real time web-based information for managing and reporting inventory of drugs

DLI 4: Percentage reduction of stock-outs of tracer drugs (US$10 million). This DLI will incentivize MoH to use the information available through the revised LMIS to better analyze stock outs and create systems to manage stock inventory thereby resulting in timely availability of drugs to the population

DLI 5: Percentage improvement in EVM Score[1] over 2014 baseline (US$4 million). This will incentivize improvements in the quality of pre shipment, cold chain and warehouse management, stock management and information systems for vaccines; and therefore serve also as a marker for management of the entire cold chain.

B. Improving Public Financial Management (PFM) (US$55 million): This sub-component focuses on reforms to improve the entire cycle of planning, budgeting, expenditure execution and monitoring. Improved PFM in the health sector will 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 success of these interventions and the release of IDA funds will be linked to the achievement of DLIs in the following areas:

B (i) Enhanced systems for annual planning and budgeting:

DLI 6: Percentage of all MoH spending entities submitting annual plan and budget using (eAWPB) (US$15 million). This DLI focuses on reforms that support better convergence and coordination in plan and budget preparation through incentivizing on –line planning and budgeting. This will result in less duplication and ultimately enable better prioritization and costing and monitoring of a sector program.

B (ii) Enhanced systems for expenditure reporting:

DLI 7: Percentage of eAWPB spending captured by an online expenditure tracking system – TABUCS (US$20 million). This DLI will focus on reforms to improve internal budgetary control systems by incentivizing the use of an on-line expenditure reporting system at the level of every spending unit. This will result in better reporting, tracking and monitoring of the use of public resources in the health sector and allow for evidence based financial management.

B (iii) Timely response to audit reports

DLI 8: Percentage of audited spending units responding to OAG's primary audit queries within 35 days (US$15 million). A lack of response to audit queries have been

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[1] Effective Vaccine Management Score (EVM) is a standard score consisting of nine parameters to determine the management and quality of vaccine management in a country at the central, regional and service delivery levels. It is measured every two years by a standardized methodology by WHO and UNICEF.

a major cause of ineligibilities identified by the annual OAG report for the health sector. This DLI focuses on reforms to improve accountability through improving the internal control framework for financial management in MoH. This will result in establishing institutional mechanisms for tracking of and responding to audit queries in a timely fashion by audited spending units.

Component 2: Improve Reporting and Information Sharing for Enhanced Accountability and Transparency (US$35 million).

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 the GESI Strategy and Nepal's Right to Information Act[2] will also be jointly developed. 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. 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. The success of these interventions and the release of IDA funds will be linked to the achievement of DLIs in the following areas:

C (i) Improved monitoring mechanisms for service delivery:

> DLI 9: Percentage of facilities reporting annual disaggregated data using DHIS 2 (US$20 million). This DLI focuses on reforms to improve planning and monitoring for evidence based decision making through incentivizing the establishment and use of DHIS 2 in order to access data disaggregated by geography, gender and ethnicity. This will allow for better targeting for improving access and equity.

C (ii) Enhanced citizen engagement:

> DLI 10: Citizen feedback mechanisms and systems for public reporting operational (US$15 million). Citizen feedback mechanisms for holding policy makers and providers accountable for service provision is lacking. This DLI will focus on developing and piloting citizen engagement mechanisms in different geographical

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[2] 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.

contexts to gain feedback on availability of drugs and facility level services to both institutionalize demand side monitoring and create better accountability.

While Nepal has achieved some significant results in health outcomes, further movement towards universal health coverage could be slowed by persistent systemic weaknesses. The proposed project will focus on results – an approach which has been welcomed by Government of Nepal (GoN) and the Development Partners (DP) who realize that mere input based financing is unlikely to lead to further gains. The new project will therefore focus on key strategic policy and institutional changes in the governance of the health sector and on institutional strengthening.

1.2 Country Context and Objective of the Social Management Plan (SMP)

Country Context: 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. 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.

The overarching objective of this Social Management Plan (SMP) is to support NHSS to enhance positive social outcomes, from the perspective of gender and social inclusion. The SMP is based on the World Bank's social safeguard policies as well as GoN's policies.

Specifically, the purpose of the SMP is to:
   a) Identify, analyze and assess the existing legal and institutional aspects of key social issues and management challenges in the health sector;
   b) Review and document the work done on gender and social inclusion through the government's Gender and Social Inclusion (GESI) strategy ,identify constraints and provide some key recommendations to ensure the reach of quality health services to disadvantaged population groups during NHSS;
   c) Assess and analyze the feasibility and reality of existing guidelines that govern the location of health facilities including land acquisition and explore implications; and make some policy-related recommendations based on the findings;

d) Document the adequacy of existing strategies and institutional mechanisms to monitor health outcomes for different population groups, and explore challenges to these strategies and mechanisms.

e) Recommend/suggest, appropriate strategic measures based on the analysis for ensuring adequate social safeguards in the health sector.

In short, a key principle of the SMP is to prevent and mitigate any harm to people by incorporating social issues as an intrinsic part of the government's program.

2 Legal and Policy Framework Relating to Social Issues

2.1 Legal and Policy Framework

To improve the access of disadvantaged and marginalized groups to basic and quality health care services; policy makers, international partners, political actors and NGOs (especially after the political change in 2006) have expressed strong commitments to gender equality and social inclusion. Accordingly, the issue of Gender and Social Inclusion (GESI) has been brought to the fore in the development agenda, and also reflected in various acts, policies, strategies and programs, including in the health sector.

a) Constitution of Nepal, 2015

Article 35 of the Constitution of Nepal, 2015 states: 'Every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care.' Additionally, it states that 'each person shall have the right to be informed about his/her health condition with regard to health care services, each person shall have equal access to health care and each citizen shall have the right to access to clean water and hygiene.

b) GESI in Health Plans and Policies

In the health sector, the GoN has been formulating and implementing various policies and programs such as the Second long-term Health Plan 1997-2017; Health Sector Strategy 2004; the Nepal's Health Sector Program-Implementation Plan 2004-2009; Vulnerable Community Development Plan 2004, Ten-Point Health Policy and Program 2007; and the Free Health Service Program, 2007/08, all of which have focused on improving the health status of disadvantaged and marginalized populations. Additionally, the GoN has also plans to increase the number of family planning users, number of maternity services from health facilities, and reduce the total fertility rate, maternal mortality ratio, and infant and child mortality rates (DHS, 2011). Similarly, 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 (GoN, 2014; 2015).

c) GESI Specific Strategies and Guidelines

The GoN has also issued some key guidelines and strategies on GESI such as the Health Sector Gender Equality and Social Inclusion Strategy 2009; the Operational Guideline for Gender Equality and Social Inclusion Mainstreaming Strategy in Health Sector 2013; and the

Gender Equality and Social Inclusion Operational Guideline 2013, all of which are aimed at improving 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 effective governance and implementation of health services including those involving the private and non-state actors.

2.2 GESI-specific programs and activities

In keeping with the objective 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 disadvantaged and marginalized people and communities. Some of the key ones includes:

a) Free Health Care for Essential Health Care Services

The free health care service programs (for emergency and inpatient services) for target groups, namely, the ultra-poor, vulnerable, senior citizens, people living with physical and psychological disabilities, was launched in 2006/07 in hospitals and primary health centers for inpatient and emergency services. Since 2007/08, these benefits were extended to all citizens in all health posts and sub-health posts. Further, from 2008 onwards, hospitals with at least 25 beds have to provide listed medicines to all citizens free of cost, and essential drugs and all services have been made free to all disadvantaged and marginalized groups (Prasai, 2013; GoN, 2007).

b) Safe Motherhood Program

Since 2008, the GoN has also made institutional child delivery free for all women in all health facilities. While a 'Safe Delivery Incentives Program' had already existed,[3] a 'Safe Motherhood Program' was introduced in 2009 ('Aama Surakshya Karyakram') and the Equity and Access Program (EAP)[4] was introduced in 2006 to ensure greater access to maternal health care, and reduce maternal/neonatal mortality/morbidity during pregnancy and childbirth. Specifically, these programs were introduced to encourage more women to deliver in a health facility as well as provide training of health care workers, and sensitization on the issue (MoH 2012; MoH, 2009).

c) Training and Awareness Raising Initiatives

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[3] The 'Safe Delivery Incentives Program' provided a lump-sum payment to offset travel costs to those who come to health facilities for delivery.

[4] The Equity and Access Program was funded by the Department for International Development (DFID), and implemented in between 2006 and 2009 by Action Aid Nepal (AAN) in association with New Era in 8 districts of Nepal, which since then has expanded in many other districts. The program aimed at women's empowerment and rights-based community mobilization program for health.

In further support, the GoN has also been providing training to skilled birth attendants (SBA) to reduce maternal and neonatal mortality in the country (ADB, 2010).[5] Simultaneously, orientation programs have been carried out to raise awareness amongst MOH staff for being more citizen-friendly and give greater priority to disadvantaged, poor and excluded persons, communities and regions. Radio campaigns and printed materials with information on available health services and health rights of citizens available in local languages have been used to increase awareness of amongst target groups.

d) Future Plans

The GoN has expressed the following commitments in its Nepal Health Policy 2014:

- Improve easy and free access of the disadvantaged and marginalized groups to medical services and treatment in local level health care centers and hospitals for 24 hours a day;
- Provide disadvantaged groups with increased number of free medicines and free of cost maternity and child delivery services including from private hospitals;
- End all kinds of violence against women;
- Create more vacancies for doctors in all district hospitals and first-aid health centers;
- Launch campaigns like 'Let's have a doctor in our village' and 'health human resources for remote areas'; and
- Install basic health laboratory test service in health centers (GoN, 2015).

Likewise, the Family Health Division (FHD) within the MOH also has plans to develop strategies to improve access to and use of maternal and neonatal health services in remote districts.

3 Key Social Issues Related to the Project

Background analysis was carried out to better understand and support dialogue on social issues in the health sector among external partners. The main findings of this analysis, especially with regards to issues related to vulnerable communities, also termed as 'Gender and Social Inclusion (GESI)' issues in Nepal are summarized below.

3.1 Major Achievements and Progress

In recent years, Nepal has made good progress in most health indicators (UNDP, 2014).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 have been provided free health services; 307,281 pregnant women have been provided free delivery services; 551,108 pregnant women have been vaccinated with TT, and 5,500 women have received free womb operation service (GoN, 2014). The Female Community Health Volunteer Program (FCHVP) has expanded

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[5]MoH has provided trainings to a total of 1,347 health workers for skilled child delivery, to 284 for safe abortion, to 475 for implants (MoH, 2014)

across the country. It is reported that more than 2,000 individuals and mostly women (94%) have used OCMC services.

Notwithstanding these achievements, many mothers still do not receive antenatal care services from skilled or trained health workers.[6] The use of maternal health services continues to be less among Janajati, Dalit, Tarai, and Madhesi women, compared to Newer, Brahman, and Chhetri women; and it is less (55%) among rural mothers than (88%) among the urban women (NDHS, 2006; 2011). Amongst those who received health services, Dalit and Hill Janajati fared the worst. Likewise, the unmet need for family planning is highest among the Hill Dalit (35%), followed by the Hill Janajati (34%), and compared with a low of 14 percent for the Tarai Janajati (NDHS, 2011). Likewise, neonatal and postnatal mortality as well as infant mortality, child mortality and under-five child mortality is higher in rural areas than in urban areas.[7]And the maternal mortality rate too is higher among the disadvantaged groups, especially in the mid-western and far-western region of Nepal (NDHS, 208).

Evidence suggests that despite the government's commitment and priorities in improving GESI in health sector as well as the progress made, inequalities in terms of access and health outcomes of disadvantaged groups continues (Bennett, Dahal and Govindasamy 2008; DFID, 2011; NDHS, 2011; UNDP, 2014). As a result, there is a need for identifying key barriers, challenges and limitations that have hindered the effectiveness in improving GESI related outcomes in the health sector. While most of these issues are related to overall governance of the heath sector, the discussions below highlight some of the ways in which these factors have been affecting the achievement of GESI related goals and objectives.

3.2 Sectoral Level Constraints and their Implications on GESI-Related Outcomes

Nepal's health sector has is constrained by institutional capacity and resources to implement its various policies and programs. Some of these include:

a) Inadequate Number of Doctors and/or Skilled Health Workers

Data suggests that the availability of a full complement of doctors and health workers in specific geographical areas remains a constraint. This, amongst other factors, impacts the provision of services for women and people from disadvantaged groups who visit health facilities to benefit from the free services that they are eligible for.

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[6] According to the Nepal Demographic Health Survey (2011), 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).

[7]The neonatal mortality was 36% in rural and 25% in urban, and postnatal mortality 19% in rural and 13% in urban. The infant mortality was 55% in rural and 38% in urban, child mortality 10% in rural and 7% in urban and under five child mortality 64% in rural and 45% in urban, respectively.

[8] 16% among Tarai Madhesi castes, 14% among Janajati, 13% Muslim and 11% among Dalit women, compared to the 50% and 26% among Newar and Brahman Chhetri women. A separate study (Subedi et. al., 2009) done in 40 districts of Nepal has also identified a much higher maternal mortality ratio among Muslims (318 maternal deaths per 100,000 live births).And it is 2% in mid-western and far-western, 17% in eastern and 15% in the central development region (NDHS, 2011).

b) Drug Stock outs

As per the Ten Point Health Policy and Program 2007, the Free Health Service Program, 2007/08, and the Three Year Plans formulated since 2011-213, disadvantaged groups are meant to receive drugs for reproductive health as well as family planning devices, including contraceptives, free of cost from district hospitals and village and local level health facilities. However, these drugs and devices are often not available in time and in sufficient varieties (ADB, 2011; GoN, 2014; MOH, 2009). Further, while most women are aware of modern contraceptives (less of emergency contraception) and modern methods of family planning,[9] these services too are not easily available in the most rural areas (NDHS, 2011; Budathoki, 2012).

c) Inadequate Provisions for Ancillary Services

For many of the GESI related interventions, especially those relating to women and adolescents, the issue of privacy is critically important. In the lack of sufficient space and rooms with privacy, most health facilities at the local level face challenges while providing services to women and other poor people who visit particularly for pregnancy tests, vaccination, and other sensitive illness (Milne, et. al.,2015; Morrison et al. 2014). These problems are also pervasive in the occasional Health Camps and Roaming Health Clinics organized in remote and hill areas.

d) Budget Allocations and Resource Mobilization

Both the delayed and insufficient budget allocation to district and local level health facilities are factors which constrain the achievement of the overall GESI objectives. For example, GESI-related programs such as Safe Motherhood Program ('*Ama Surakshya Karyakram'*), Equity and Access Program, and institutionalized Skilled Birth Attendance trainings etc. are supposed to start being implemented in the first quarter of the fiscal year. But oftentimes, implementation gets delayed.

3.3 Information, Knowledge and Understanding on GESI-related Issues

In spite of the various strategies, guidelines and objectives relating to GESI, an implementation constraint lies in the fact that many health workers especially newly appointed ones, are either unaware or unclear about the guidelines and strategies.

Besides the low levels of awareness amongst the health service providers, many people, especially the disadvantaged groups continue to be plagued by problems relating to traditional practices, lack of education, limited knowledge and awareness, and minimal access to health facilities. For example, although the Safe Motherhood Programme offers women NPR 500 in the Tarai (plains) and NPR 1,500 rupees in the mountains if they give birth in a facility, still some women and their families are unaware of these incentives. Similarly, despite the law on domestic violence and services availed through the One-Stop

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[9]The current Contraceptives Prevalence Rate in urban areas is 60%, compared to 48% in rural areas (NDHS, 2011).

Crisis Management Centres (OCMCs), there are many women victims of violence in rural areas who lack information and awareness on seeking legal support and medical support. However, there are very limited GESI sensitization initiatives being carried out at the local levels by the government and non-governmental organizations.

3.4 Monitoring, Information Management and Mechanisms for Course Correction

Another pertinent challenge identified during the assessment is related to information management. There is increasing focus both on the part of MoH and donors/partners on strengthening the data/information in health sector based on which GESI indicators have been revised[10] and online reporting system has been put in place.

It is encouraging to see that the revised HMIS tool reports on disaggregated data and Nepal Health Sector Strategy has committed to do evidence based planning and resource allocation in order to improve the delivery of health services to those unreached in the past.

3.5 Construction of Health Facilities and Issues of Land Acquisition

Under the IDA project, no civil works will be financed. There is therefore no issues of land acquisition. Hence, the issue of involuntary resettlement is not a concern under the project.

3.6 Coordination and Governance

Another challenge identified by the assessment is related to issues of governance and coordination among various stakeholders and institutions at the central, regional, district and local levels. In particular, there are government, non-governmental organizations and private health facilities involved in providing and improving health services to people in several districts of Nepal but coordination amongst them continues to be a challenge. There is provision for GESI co-ordination committees at the district level, with stakeholders representing the Ministry of Women and Child Development, Ministry of Federal Affairs and Local Development, Ministry of Home Affairs and the Ministry of Health. However these committees have not been very effective in terms of fostering GESI in health sector.

4 Social Management Plan

The Social Management Plan comprises of two parts. The first includes specific measures that will be supported through the IDA operation to enhance efficiency in public resource management systems in the health sector while part two contains a set of broader recommendations for improving the overall social outcomes of NHSS.

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[10] 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).

4.1 Project Specific Actions

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

NHSS commits to reporting disaggregated data through a Health Management Information System (HMIS). In addition project financing will also support the roll out of the District Health Information 2 (DHIS2) to health facilities. The DHIS 2 in will provide information on service utilization at the decentralized level disaggregated by gender, ethnicity and geographical area; it will also be able to analyze this data. This analysis will support evidence based planning by MoH which in turn can lead to better targeting of resources to the most vulnerable and disadvantaged groups and geographical areas.

Citizen Engagement Mechanisms

The Gender Equity and Social Inclusion (GESI) strategy of the MoH includes provisions on citizen engagement that seeks to strengthen citizen engagement by providing citizens 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 framework for citizen engagement will be developed. This will include means for generating public awareness on health-related information, and mechanisms to engage citizens and get their feedback on the availability of essential health services, and suggestions for improvement. Efforts will be made to solicit the views, hear the concerns and suggestions of the vulnerable communities and target groups by preparing a communications strategy targeting these groups. In order to raise awareness of the 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. 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 are able to voice their opinions and concerns freely and in a participatory manner and information will be made available that is culturally and socially appropriate. The project will support the roll out of these citizen engagement mechanism through selected pilots and dialogue with government on how to best institutionalize the findings of these pilots.

4.2 Recommended Actions for Social Management

Institutional capacity building

There is a need for strengthening the capacities of the health institutions in order to achieve the objectives of GESI in the health sector. A number of improvements outlined below could be undertaken to achieve that end.

- Periodic orientation and trainings on GESI and its significance to the health sector provided to DHOs, health workers, management committee members and other concerned stakeholders. Training and orientation like 'Appreciative Inquiry' could be provided to health workers in order to deter unfriendly behavior and promote better communication and interaction between service providers and beneficiaries, which would encourage people, especially those from disadvantaged groups visit health facilities.

- Flexibilities in mobilizing budgets in local level facilities could be discussed. This is important due to differences across districts with regards to the situation of women and other marginalized groups. Further, additional budget could be allocated to district level facilities with priorities on GESI.

Awareness and sensitization on GESI

To encourage and motivate people who do not visit health facilities despite facing some serious health issues, awareness-raising activities could be carried out among these population about free services, free medicines, and incentives for birthing in a facility, and health institutions that provide free services. To this end, coordinated and joint initiatives of media, local trustworthy leaders, teachers, religious leaders, civil society organizations and stakeholders could be mobilized. In several districts of the Tarai and mountain region, people lack information due to language barriers. In these areas, information could be disseminated through various medium in the local languages of those groups who cannot understand the Nepali language.

Construction of Health Facilities

The new guideline, 'Guidelines for Selecting Land for the Construction of Health Facilities 2014 would need to be followed and executed while selecting land for the construction of health facilities. This would help ensure accessibility of health facilities to all, including vulnerable groups.

5 Institutional Arrangements

The Ministry of Health (MoH) through its various organizational structures including its departments, divisions and centers will ultimately be responsible for implementing the measures identified in this SMP. 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. The current institutional mechanisms in place to support mainstreaming of GESI is included in Annex 1.

6 Monitoring of SMP

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) is the responsibility of the Management Division of the Department of Health Services (DoHS). The monitoring and evaluation of the SMP will be integrated into the monitoring and evaluation system under the GESI strategies.

7 Budget

The NHSS implementation plan will contain within it a budget for the implementation of the GESI strategy. The continued dialogue that the partners will have with MoH will focus on social issues and ensuring that commitments in the SMP are financed.

Annex 1. GESI related institutional arrangements

S.N.	Institutions	Level	Remarks
1	A GESI Unit	Central Regional District	Under the Programs Planning and International Coordination Division of the MOH. Under the Regional Health Directorates. Under the chief of district public health office.
2	A GESI technical working group	District	In 71 districts of Nepal
3	A focal person	Regional District	Under the regional health directorate In all district health offices
5	Social Service Units (SSU)	Centre Community	In all central level hospitals In the community level facilities
6	GESI Implementation Committees	District	
7.	Integrated Planning Committees	Municipal VDC	
	A GESI network	Regional	Under the coordination of the regional health director includes organizations representing women, Dalits, Janajatis (ethnic groups), Adivasis (indigenous groups), NGOs and organizations working in the health sector

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