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NEPAL HEALTH SECTOR SUPPORT PROGRAMME -III

A case study from Nepal at a time of transformational change 2010-2022

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Options
30 YEARS OF IMPACT
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Institutionalising Gender Equality and Social Inclusion into the Health System: A case study from Nepal at a time of transformational change, 2010-2022

Gender equality and social inclusion is integral to achieving the Sustainable Development Goals and ensuring no one is left behind. In Nepal, the post-conflict political context provided a fertile ground for gender and inclusive transformation of governance and government systems. This paper documents the experience in Nepal between 2011 and 2022 with institutionalising gender equality and social inclusion (GESI) into the health system. It aims to inform continuing health systems development in Nepal, and global practice on institutionalising GESI in the pursuit of Universal Health Coverage. The paper presents the Nepal context and enabling environment for GESI in the health system, and the conceptual framework and twin track approach taken by the UKaid funded Nepal Health Sector Support Programme to support government achieve this objective. It drills down into key areas of GESI mainstreaming to explain progress and challenges, and contrasts this to the experience of two GESI targeted innovations that have been taken to scale. From this basis, the paper reflects on the value of the twin-track approach, and the priorities for the future.

A. Introduction to the Nepal context

Political struggle led to a progressive Constitution. Following a decade of identity based political struggle and conflict in Nepal up to 2006, the Constitution (2015) defines a vision of an inclusive and equitable society. The Constitution guarantees the right to equality, social justice and freedom from discrimination for all and provides special provisions and affirmative action to protect the rights of women and historically excluded groups. From this constitutional mandate for gender equality and social inclusion, momentum for reducing inequalities in health and social development outcomes has been catalysed. The Constitution also heralded political transformation through the introduction of Federalism, and consequent fundamental changes in the governance and delivery of health services across the country.

Traditional gender norms and harmful gender practices perpetuate gender inequality and continue to normalise violence against women and girls. Improvements in the Gender Gap Index from 60.2% in 2006 to 69.2% in 2022, is a sign that Nepal is moving in the right direction but slowly. Despite reports of increasing gender equal attitudes, unequal gender norms and discriminatory gendered practices such as child marriage and menstrual exclusion remain strongly embedded in some communities[1]. Women's political representation has significantly improved since the Constitution. In the 2017 elections, women made up nearly 41% of those elected in local governments and 33% in state and federal assemblies and were 93% of deputy leadership positions at local level. However, these gains have not been sustained in the 2022 local elections which dropped the earlier women's quota. In 2022, women were elected to 562 deputy leadership posts compared to 700 in 2017, though the number of women elected to Mayor and

[1] World Economic Forum. 2022. Global Gender Gap Report 2022.

Ward Chair positions marginally increased. This uneven landscape of women's empowerment reflects the continuing hurdles that women face to be treated as equals[2].

The social exclusion landscape is a mixed picture of aggregate progress but sustained pockets of structural disadvantage. A culturally and geographically rich and diverse country, Nepal is home to 127 ethnic, caste and religious groups speaking 104 mother tongue languages and living across the three terrains of mountains, hills and the Terai. National opinion surveys conducted by The Asia Foundation from 2017-2020 show that perceptions of social identity-based disadvantage have declined[3]. At the national level, 25.5% of respondents reported feeling disadvantaged by their non-Nepali mother tongue when accessing health services at a health post or hospital in 2017 and this declined to 15.6% in 2020. While those reporting feeling disadvantaged by their caste/ethnicity/religion was 5.1% in 2017 and declined to 3.6% in 2020. The distribution of feeling linguistic disadvantage when accessing health services in 2020 was highest in Madhesh Province (22.6%) and Lumbini Province (24.5%). The groups that more often report feeling disadvantaged by their caste/ethnicity/religion in accessing health services in 2020 were Muslims (14.1%) and Madhesi Dalits (9.7%).

Multidimensional poverty was declining prior to Covid-19. Intersecting with gender inequality and social exclusion, multidimensional poverty declined from 30.1% in 2014 to 17.4% in 2019 with wide variation across provinces. Some 39.5% of people in Karnali Province were multidimensionally poor in 2019 and just 7.2% in Bagmati Province. Once post-covid poverty data is available, this may show a reversal in the trend. The socio-economic impact of Covid-19 was more severe for women, the poor and disadvantaged groups such as people with disability who also faced additional barriers to accessing health services[4]. The Human Development Index which had been steadily increasing until 2019 (0.611) dipped in 2020 (0.604) and 2021 (0.602)[5]. Other external shocks including the earthquakes of 2015 and the embargo in 2015/2016 also put strains on the health sector.

Health sector policies commit to equity and inclusion. In line with the progressive and inclusive mandates of the Constitution, policies in the health sector have embraced a commitment to equity and inclusion. The National Health Policy, 2014 takes a human rights-based approach to achieve health for all. It aims to ensure health services provisioned by the state are accessible to poor, disadvantaged and vulnerable communities based on equity and social justice. The Nepal Health Sector Strategy 2015-2022 builds from this policy position and evidence of the magnitude and nature of inequity and barriers to access and use of health services for women, poor and disadvantaged populations. It lays out the importance of equitable access and utilisation of health services, quality health services for all, health system reform, and addressing the social determinants of health to achieve Universal Health Coverage[6].

[2] See CEDAW. 2019. Concluding observations on the sixth periodic report of Nepal, CEDAW/C/NPL/CO/6, 14 November 2018.
[3] Giri, D., Pyakurel, U. & Pandey, C. L. 2020. A Survey of the Nepali People in 2020. Hattiban (Lalitpur): School of Arts.
[4] Ministry of Women, Children and Senior Citizen, Government of Nepal, CARE and Save the Children. 2020. Rapid Gender Analysis Report on COVID-19 Nepal, 2020.
[5] United Nations Development Programme. 2022. Human Development Report 2021/22.
[6] Originally from 2015-2020 but extended to 2022. NHSS_english_book_2015.pdf (nhssp.org.np)

"Gender equality is a state of balanced power relationship that gives equal rights, responsibilities, opportunities and decision – making authority to both women and men. Social Inclusion is deliberate and planned inclusion of historically excluded groups by addressing barriers embedded in the prevailing institutions, policies, systems, mindsets and values."

GESI Working Group, 2017: Gender Equality and Social Inclusion Working Group, International Development Partners Group, Nepal

Gender equality and social inclusion (GESI) is intersectional and combines dimensions of inequality, exclusion and vulnerability. In Nepal, GESI encompasses groups of people who experience systemic and structural disadvantage and those who experience situational disadvantage[7]. Figure 1 below depicts those groups that Federal Ministry of Health and Population (FMoHP) identified as disadvantaged in 2018. These target groups have subsequently been included in various Federal and Provincial health policies, guidelines and instruments[8].

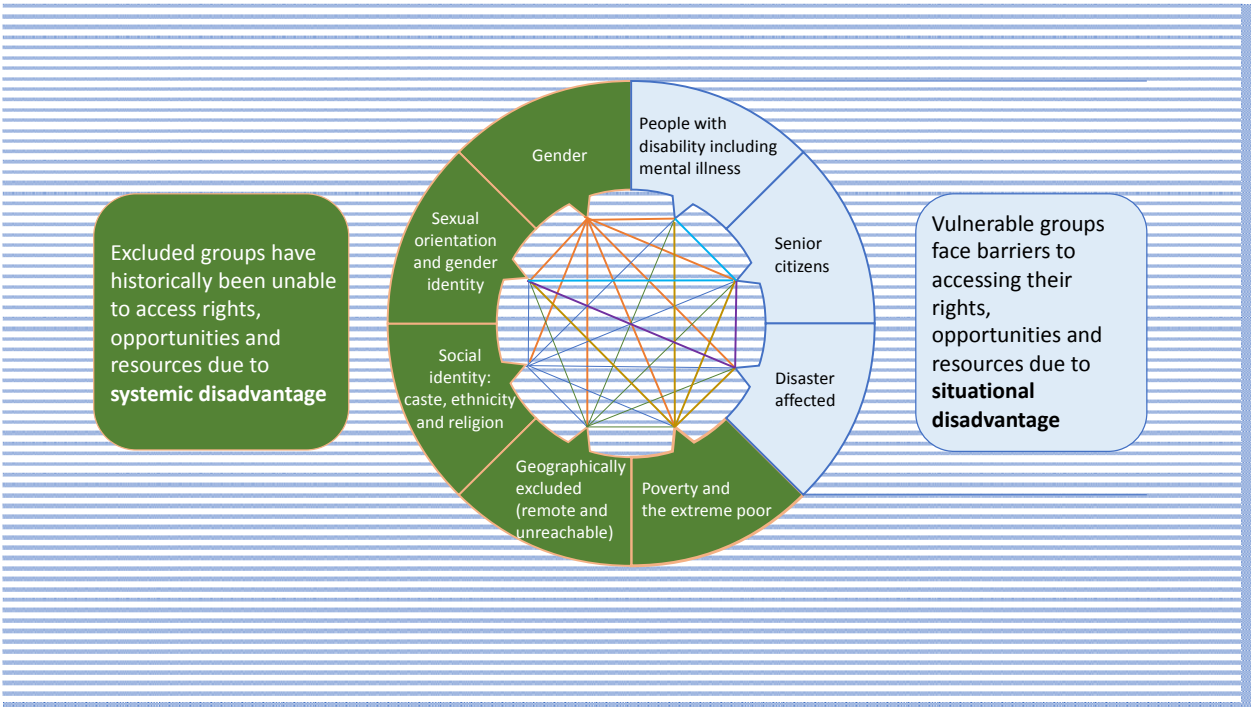

Figure 1: Disadvantaged populations in Nepal [Federal Ministry of Health and Population, 2018]

Inequalities and social norms impact health outcomes. Despite significant improvements in reducing the equity gap in core health indicators over the past twenty years, data shows that some populations are still lagging behind. For example, Nepal Demographic and Health Survey (NDHS), 2022 shows that almost 80% of deliveries take place in a health facility at the national level but this is just 65.8% for the

[7] Asian Development Bank. 2020. GESI Diagnostic of selected sectors in Nepal.
[8] Social Service Operational Guideline, 2021; Leaving No One Behind Budget Marker 2021; Madesh Province GESI Strategy for the Health Sector in Nepali.

lowest wealth quintile compared to 97.6% for the highest wealth quintile, and 59.6% for mothers with no education. Gender, poverty, geographical remoteness, mother tongue-language and social identity impact people's health outcomes and access to services in multiple ways. These social determinants of health increase the risk of poor health or injury, and the barriers to health services and resources for those who are disadvantaged. For example, harmful gender norms underpin high levels of gender-based violence and discourage survivors from seeking help. NDHS 2016 reported that 26% of married women have experienced physical, sexual or emotional violence from their spouse, and 66% of survivors never told anyone about their experiences or sought help[9].

B. Institutionalising GESI in the health system and pursuit of UHC

Against this backcloth of societal change and complexity, the UKAid funded Nepal Health Sector Support Programme (NHSSP) supported the Government of Nepal from 2010-2022 to strengthen the health system to adapt to the changing context, and achieve Universal Health Coverage (UHC). This included technical assistance to support Government institutionalise gender equality and social inclusion (GESI) into the health system as part of three successive UKaid funded health sector programmes from 2005 to 2022[10].

The rationale for institutionalising GESI into the health system and how this can be achieved is presented in Figure 2. It draws from the growing body of work on the importance of gender equality and social inclusion to achieve UHC through a health system that is programmed to be gender equitable and inclusive[11]. The conceptual framework asserts that a gender equal and socially inclusive health system is essential to achieving Nepal's policy goals and State obligations to provide equitable and inclusive health services and ensure the needs of excluded and vulnerable populations are met in the pursuit of UHC. This means integrating GESI into each of the health system building blocks to ensure GESI is intentional, prioritised and accountable, including through:

- *Governance* that is equity oriented, inclusive and advances gender equality.
- *Information systems* that include routine sex, age, location and other identity-based indicators such as caste, ethnicity, religion and disability status.
- *Infrastructure* that is accessible to all, promotes privacy and confidentiality and considers the safety and gender specific needs of women and girls. Construction sites that are safe, inclusive and free of GBV.
- *Workforce* that is gender equitable and inclusive, equitably hired, distributed and advanced, and values and enables the progression of women and diverse populations into leadership and decision-making positions.
- *Service delivery* that is gender responsive, inclusive, free of discrimination and empathetic.

[9] NDHS 2022 data not yet available.

[10] NHSSP is delivered by a consortium led by Options Consulting Ltd, managing a team of Nepali advisers embedded within government.

[11] WHO and World Bank. 2017. UHC2030 International Health Partnership. Healthy systems for universal health coverage – a joint vision for healthy lives. UN Women. 2020. Universal Health Coverage, Gender Equality and Social Protection. A Health Systems Approach. Morgan et al. 2018. Gendered Health Systems: Evidence from Low- and Middle-Income Countries. Health Research Policy and Systems (2018) 16:58.

- *Financing* that is equity driven and gender responsive and inclusive.
- *Supplies* that prioritise the essential medicines, contraceptives and products needed by disadvantaged women, men, adolescents, children and especially vulnerable populations such as people with disability.

It also means integrating GESI into the intangible soft connections that make up a health system: the values, norms, trust, relationships and power dynamics that connect people together and make the system work.

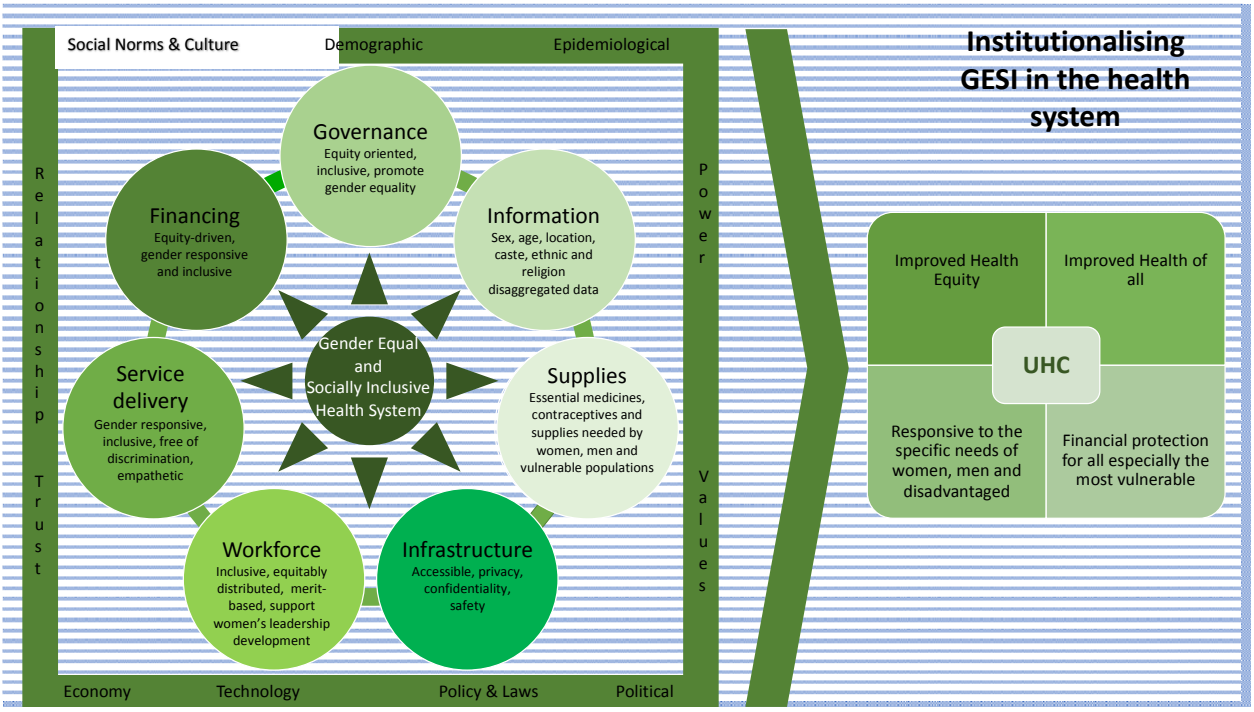

Figure 2: Institutionalising GESI into the Health System in Nepal: A Conceptual Framework

A twin track approach. Drawing on good programming practice, NHSSP supported Government take a twin track and interconnected approach to institutionalise gender equality and social inclusion with activities in one area catalysing and contributing to progress in the other. The two tracks were:

i. mainstreaming GESI into the health system building blocks
ii. targeted innovations to pilot and test service delivery models for especially vulnerable populations.

The mainstreaming activities specifically focused on catalysing institutional change for GESI by directly working to strengthen and adapt government structures, policies, mechanisms and processes, and influence the organisational culture and ways of working. While the targeted innovations piloted new services, developed capacity to deliver them, built government ownership and learned how to make these services work within the Nepal context and take them to scale. Less overtly challenging than institutional change, targeted interventions were also a way of building understanding and acceptability of GESI in government, and generating the space and appetite for institutional reform which was slower and more contested.

In the mainstreaming track, key areas of work have included mainstreaming GESI into policy processes, planning and budgeting, and the strengthening of health management information systems to include routine sex, age, location data, and for specific indicators, disaggregation by caste, ethnicity and religion. Support to strengthening essential health services has focused on remote areas, accessibility and equitable distribution. GESI has also been mainstreamed into health infrastructure through the development of accessible, gender responsive and inclusive infrastructure standards.

Targeted innovations have focussed on populations at risk of being left behind by the focus on incremental strengthening of primary health care as the strategy towards achieving UHC. This has included the One Stop Crisis Management Centre (OCMC) for GBV survivors, Social Service Units at hospitals to facilitate access of poor and disadvantaged target populations to hospital level care, the introduction of geriatric wards for the elderly, and policy guidelines for disability inclusive health services and mental health.

C. Study methodology

The study draws on a review of Nepal grey literature between 2010 and 2022 including health policies, surveys and studies, and NHSSP programme documents related to gender equality and social inclusion in Nepal and the broader health sector. The study also reviewed comparative studies in other regions to help situate Nepal's experience. In addition to literature review, the study undertook 30 consultations with purposively selected policy makers and sector experts actively involved in health system strengthening in Nepal during the program period. The open ended interviews explored perceptions of progress and barriers to institutionalising GESI in the health system, and opportunities and priorities for the future. The study also draws on the outcome of various reflective learning and dissemination events held towards the end of the programme.

D. Strengthening GESI of the health system in practice

In view of the objectives of NHSSP as a programme and the specific interventions on GESI, this paper focuses on analysing the experience of strengthening GESI in the domains of governance, policy, data and services.

GESI governance: leadership and organisational structures

Studies have shown the importance of effective leadership and organisational structures to drive transformational agendas and the process of change for GESI in the health sector. In Nepal as in other countries, the GESI architecture in the health sector is relatively weak, and lacks the clout to coordinate and drive institutional change through a complex system. Leadership and management in the FMoHP is male dominated and overwhelmingly representative of men from advantaged caste and ethnic groups. CREPHA (2021) found that during 2016-2021, 89% of senior management positions in the FMoHP were held by men while women make up.[12]. This counts because evidence shows that women leaders implement policies that are more supportive of women and girls, and diverse leadership teams perform

[12] Center for Research on Environment Health and Population Activities and Global Health 50/50. 2022. Gender and Health 50/50 Nepal: Catalyzing change for gender equality and health equity. Kathmandu, Nepal, 2022.

better[13]. While the GESI Section in the Federal Ministry of Health and Population (FMoHP) has played a key role in spearheading initiatives such as GESI-targeted innovations related to GBV, it has been less able to drive GESI mainstreaming across policy, planning and budgeting systems and processes that are embedded in government business processes and touch a broad set of power holders.

During the program period, leadership and the institutional arrangement for GESI in the health sector changed several times as the ministry was reorganised and experienced frequent turnover of political and executive leaders. For example, between 2011 and 2022 there were 10 Ministers and 13 Secretaries. The formal establishment of a GESI Steering Committee in 2011 and a GESI Section located in Population Management Division signalled a period of concerted GESI activity in the sector, and correlated to a time of intense political and national interest in GESI and negotiations and preparation of the Constitution. The choice of the Population Management Division to house the GESI Section from its inception was due to the lack of interest of other more central divisions such as that responsible for policy and planning. When the Population Management Division was relocated outside of the Ministry of Health in 2015, there was discussion about disbanding the GESI Section but instead, it was parked with Policy, Planning and Monitoring Division (PPMD). When the Population Management Division rejoined the FMoHP in 2018, the GESI Section moved back on the grounds that PPMD was overloaded. This shifting of responsibility illustrates the fragile nature of GESI mechanisms and ownership in the ministry. Furthermore, in the context of federalism and the large investment of effort required to steward systemic governance and systems reforms, the momentum behind GESI faded and the leadership capital it was able to leverage within the sector around the time of the Constitution evaporated.

During the programme period, NHSSP worked most closely with Population Management Division, Nursing and Social Security Division, Curative Service Division, Epidemiology and Disease Control Division and the Policy Planning and Monitoring Division providing technical guidance, capacity building and facilitation support to strengthen government coordination of GESI activities, and build understanding, foundational skills and a sense of ownership of the agenda. Government leadership and staff turnover impacted these inputs and the results of the technical assistance varied depending on this, and the space available for transformational agendas given external shocks on the health system such as the earthquakes in 2015, the political upheaval of federalism and the Covid-19 pandemic.

GESI Strategy for the Health Sector. NHSSP supported Government to refresh and revise the 2008 GESI Strategy for the Health Sector to fit with the new Constitutional and policy context. The revised strategy in 2018 was developed through a broad consultative and government-led process and made important adjustments. However, the health sector GESI strategy was allowed to lapse and the revised strategy remains waiting for approval as of 2022. In their analysis of gender mainstreaming in health in Guatemala, Guyana and Peru, Velez et al. (2020; pg 4) state "i(I)n all cases, institutionalization within the health sector constitutes the weakest flank in terms of mainstreaming. The efforts are fragile (in terms

[13] Downs JA, Reif LK, Hokororo A, Fitzgerald DW. 2014. Increasing women in leadership in global health. Acad Med 2014 ;89:- 7. McKinsey and Company. 2020. Diversity Wins. Why Inclusion Matters.

of human and financial resources and monitoring), discontinuous (institutional mechanism or strategy changes are common), and specific (without an action plan). This is reflected in a strong concentration on policies, laws, and regulatory frameworks, but incipient implementation within the health sector."[14] Several of these conditions apply to Nepal.

The demands of federalism and high turnover of political and bureaucratic leaders at the federal level were contributing factors to the delays in approving the revised GESI strategy, but as sector experts reflected so was the lack of diversity among predominantly male, higher caste policy makers and management. Political economy, resistance to change, and conscious and unconscious bias resulted in the GESI Strategy being side-lined while other priorities advanced. Weak national machineries for gender equality, and for protecting the rights of historically excluded populations also failed to unblock the impasse. The transition to federalism is complex and complicated, and the experience is varied across spheres of government, sectors and geographical areas in Nepal. NHSSP has however found that specific to GESI, there is an appetite to act. With technical assistance, Madhesh Province developed and approved a GESI Strategy for the Health Sector in 2022[15]. Such action shows promise that subnational governments will advance GESI in the absence of a federal policy framework, and as other provinces do likewise, could nudge the federal ministry into action.

Policies and protocols for specific vulnerable groups have advanced with relative ease. In line with the constitutional mandate and the policy gap surrounding access to health care of especially vulnerable populations such as people with disability and the aged, NHSSP supported FMoHP to develop policy frameworks and protocols in these areas. This included the Disability Management (Prevention, Treatment and Rehabilitation) Policy, Strategy and 10 Years Action Plan (2017-2026), Disability Inclusive Health Service National Guidelines 2019-2030, National Geriatric Health Service Strategy, 2021; Geriatric Health Service Operational Guidelines 2021; Geriatric Health Service Operating Protocol 2022; Social Accountability Federal Directives for Health Sector, 2020; Mental Health Standard Treatment Protocol for Prescribers in the primary health care system, 2016[16]. In comparison to the GESI Strategy for the Health Sector, these focused policy products specific to vulnerable populations were developed and approved with little resistance. Covid-19 amplified the vulnerability of these two population groups which has helped reinvigorate policy commitment and contributed to progress in the policy space, but while there is headway in putting the protocols and guidelines into practice, the pace is slow and uneven[17]. For example, dedicated geriatric wards have been established in 61 hospitals in 2022 and government plans to scale this up to 50 and above bedded hospitals in 77 districts by 2024/25. In the area of disability inclusive health, a training curriculum and manual have been developed and piloted in 2022 to support implementation of the disability management policy and national guidelines.

[14] González Vélez AC, Coates A, Diaz Garcia V, Wolfenzon D. 2020. Gender equality and health equity: strategic lessons from country experiences of gender mainstreaming in health. Rev Panam Salud Publica. 2020;44:e129.
[15] Provincial Government of Madhesh. Ministry of Social Development. Health Sector Gender Equality and Social Inclusion Strategy, 2022 (in Nepali)
[16] For select documents see https://www.nhssp.org.np/GESI-Report.html
[17] Ministry of Health and Population, Government of Nepal. 2020. Case study on access to essential health services and care of people living with severe disabilities during lockdown and COVID-19 emergency.

Universal mindset. Translating policy commitments on equitable access and reaching the poor and underserved and more lately, leaving no one behind, has fuelled debate on universal versus targeted approaches among policy makers. Despite strong evidence of inequalities in health outcomes by wealth, geographical location and social identity, policy makers have articulated resistance to targeted and differentiated approaches that benefit the most disadvantaged and the political narrative this presents in a highly contested environment.

One example of this tension about when to progress universal incentives to targeted ones is the strategic roadmap for AAMA. AAMA is a demand side financing instrument that provides financial incentives for women to receive antenatal care and institutional delivery[18]. Introduced in 2005 with financial and technical assistance from UKaid and NHSSP, when the national institutional delivery rate was just 9%, AAMA was designed as a universal investment for which all women were eligible regardless of wealth or other status; pregnant women received differing transportation payments for mountain, hill and Terai areas. AAMA also provides reimbursement payments to public and private facilities for deliveries. The low rate of institutional delivery justified the universal approach.

Since 2005, institutional delivery has risen impressively across the country in all income and social identity groups and geographical areas. The Nepal Demographic and Health Survey, 2022 reports that 79.3% of all women had an institutional delivery, ranging from 97.6% for women from the wealthiest quintile and 65.8% for women from the lowest wealth quintile. Disparities by province exist and two have lower rates than the national average, Madhesh Province (66.6%) and Karnali Province (72.5%). Some disadvantaged populations also have lower institutional delivery rates than the national average including Muslims, (67.3%), Dalits (70.1%) and Madeshi (76%), though coverage is higher for each of these groups than in 2016 when the national institutional delivery rate was 57% and for Muslims (51.6%), Dalits (45.4%) and Madeshi (48.1%).

Despite such high levels of institutional delivery among the wealthiest groups, and given the high cost of AAMA for the government budget, AAMA remains universal in coverage. AAMA has contributed to the massive uptake of institutional delivery nationally and the lowering of the equity gap at the national level. However, some population groups are not benefiting from institutional delivery and face continuing barriers to access quality delivery services. The AAMA Review (2020) found that the reasons for non-users of AAMA, the women left behind, vary according to context. For women living in geographically remote mountain areas, distance, time and cost are the main barriers to institutional delivery, and for women from Dalit, Muslim and Madeshi backgrounds living in geographically accessible areas it was their lack of agency, language barriers, the need to seek permission and restrictions on their movement. Sector experts interviewed reported that despite evidence of high national take up, and the rationale for harmonising AAMA with new social health protection programmes with better targeting of women facing the most difficult barriers to accessing institutional delivery, they perceived no appetite among policy makers to transition AAMA to a targeted programme. They noted a reluctance to sharpen

[18] Nepal Health Sector Support Programme. 2020. Review of the Maternity Incentive and Free Delivery Care Programme (the AAMA Surakshya Programme) in Nepal.

the targeting of financial benefits to left behind groups or reduce coverage of better off women, and reconfigure universal coverage of AAMA to a more targeted and equitable approach[19].

Availability, demand and use of routine GESI disaggregated data is less than optimal. The need for routine disaggregated HMIS data to identify gaps and inequalities for planning, management and decision-making is essential for a gender equal and socially responsive health system, and accountability. Strengthening of the HMIS has been a long-term project for NHSSP. In 2014 the burden of collecting caste/ethnicity/religion disaggregated data for each service was considered too onerous and government decided that this would be recorded at the point of service delivery for focal indicators only. Sex, age and location data are routinely recorded. However, even though disaggregated data is collected at source this is not routinely reported up into the system as there is no demand for such data by planners and managers. Two examples speak to this lack of demand for equity disaggregated data. First is the lack of importance given to sex disaggregated data which sector experts noted was not a priority in the roadmap for digitalisation of the HMIS. Second is the fact that equity dashboards which were developed in 2016/17 with technical assistance from NHSSP have not gained traction. Designed to assist policy makers and senior management to identify gaps by social and geographical indicators, they are not being regularly updated, and sector experts report that they are not being used by policy makers and only intermittently by program managers during annual planning and budgeting. The momentum pre-Constitution behind the routine collection and use of sex, age, location, identity disaggregated data to track equitable access has dissipated. One explanation by a sector expert was that the political agenda and space has been diverted to federalism and decentralisation so the priority demand is for data by governance sphere of federal, provincial and municipality, and interest in data disaggregated by population group has dropped away.

GESI targeted innovations have been institutionalised. In contrast to the challenge of sustaining gains in core areas of GESI mainstreaming in a highly contested political environment, more discrete and GESI targeted service innovations supported by NHSSP proved more robust and sustainable.

One Stop Crisis Management Centres (OCMCs) which serve gender-based violence survivors, is one example of a model piloted by the Federal Ministry of Health and Population and then taken to scale. From seven hospital based OCMCs in 2011 serving 187 clients, the continuous evidence and learning supported by NHSSP has informed the policy, design, strengthening and institutionalisation of the model. In 2022, there are 88 OCMCs operational across the country serving over 13,000 clients per year. OCMCs follow a multi-sectoral and locally coordinated approach to provide GBV survivors with a comprehensive range of services including health care, psycho-social counseling, medico-legal services, access to safe homes, legal protection, personal security, income generation and rehabilitation support. Because of the multi-faceted needs of GBV survivors, hospital based OCMCs act as secretariats, coordinating with multi-sectoral partners to ensure services are provided to clients.

[19] WHO and World Bank. 2017. UHC2030 International Health Partnership. Healthy systems for universal health coverage – a joint vision for healthy lives.

Over the programme period, NHSSP supported FMoHP to fill critical capacity and systems gaps. Studies show that training improved the quality of care provided to survivors especially in the areas of medical forensics and the quality of medico-legal reporting, psychosocial counselling, and record keeping[20]. NHSSP supported government to develop and operationalise instruments to enable a whole of hospital response to GBV and support the provision of dignified, confidential and survivor-oriented treatment including the OCMC operational guidelines, GBV clinical protocol, GBV medico-legal service implementation guideline, and six-month psycho-social counselling curricula[21]. Federal and sub-national governments have also standardised and ensured human resources and infrastructure needs of OCMCs are met.

OCMCs have become an integral part of participating hospitals, coordinating among various healthcare units within the hospital, local governments and external agencies such as the police, safe homes, district attorney and women's rights organizations, and driving the systems-response. However frequent staff changes in hospitals, agencies and government bodies means that continuing orientation and capacity building are needed to bolster the systems that have been developed. The multisectoral approach has been fundamental to the success of OCMCs but it has been challenging to ensure standards across all partners to offer a collective quality response to individual survivors. As OCMCs are hospital based with catchment areas independent of new federal governance spheres, federalism has demanded adjustments. New mechanisms of subnational coordination and information sharing of multiple municipalities within the catchment area of an OCMC have needed to be introduced. These new coordination mechanisms are proving key to forging collective responsibility and commitment for addressing GBV across spheres of governance and for enabling multisectoral coordination; and will be an area for continued strengthening. Challenges remain high, consistent and coordinated action and monitoring across sectors and spheres of governance such as Provincial GBV Management Coordination Committee, will be needed to prevent and address GBV in a systematic and holistic manner. However, there are several examples of policy and resourcing initiatives to address GBV and strengthen OCMCs by provinces and municipalities and this has been enabled by federalism.

Social Service Units (SSUs). From a pilot in five referral hospitals in 2012, SSUs have been scaled up to 58 hospitals in 2022 benefiting more than 255, 000 patients. SSUs are a gateway facilitating access to free and partially free hospital services for poor and targeted disadvantaged patients. The Government budget will expand this to 87 SSUs by 2023. NHSSP supported evaluations and value for money studies have informed policy and institutionalisation of the SSU[22]. SSUs are a public private partnership of public hospitals and local civil society organisations. SSUs identify target group patients eligible for subsidized healthcare, promote awareness of subsidies, guide patients, facilitate drug collection, prevent false claims, and record and report who receives benefits. They have reduced the burden of screening and identifying target group patients on strained hospital workforce and management, who report saving

[20] Ministry of Health and Population. 2020. Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres.
[21] See OCMC operational guidelines 2020 in Nepali; GBV clinical protocol 2021 in Nepali; Medico-legal service implementation guidelines 2020 in Nepali; Psychosocial counselling training manual in Nepali.
[22] NHSSP. 2015. Social Service Unit Pilot Initiative (2013-2015) Evaluation Report.

10-20% of their time each day with the introduction of SSU[23]. Patients also save time mediating the hospital system to access subsidies and services.

Financed by FMoHP through conditional grants, some provincial ministries and hospitals have started topping up the SSU budget allocation. The effectiveness and cost savings of SSUs led FMoHP to expand the model to all public hospitals, select community and private referral hospitals above 50 beds and teaching hospitals in 2015. Government also expanded the remit of SSUs in 2022 to coordinating, harmonising and facilitating access to all social security related subsidies at the hospital level including deprived citizens treatment fund and social health insurance and coordinating and facilitating access to services for especially vulnerable groups including the aged. Evidence shows that cost-efficiencies are being achieved through the harmonised administration of schemes to beneficiaries through SSUs; delivering a benefit cost ratio of 2.3-3.1[24].

Reflection and learning

NHSSP's decade of support to institutionalising GESI in the health system in Nepal strategically navigated the complex environment in which the program was working by taking a twin track approach to GESI. The two pathways and spheres of engagement provided a wider pool of entry points to lever as the policy space and political appetite for GESI mainstreaming opened and closed, while the GESI innovations followed a more stable technical and evidence driven trajectory.

Early gains in establishing GESI mechanisms and structures pre-2015 were difficult to sustain as the transition to federalism soaked up the political space and the enabling environment was highly contested. In theory, a devolved health system provides opportunities to advance equity and GESI through greater public participation and social accountability though international evidence shows in practice this pathway is unclear and influenced by the pre-existing socio-economic and organisational context[25]. NHSSP's experience of advancing GESI in the devolved health context (2020-2022) is limited but from work in Madhesh Province where NHSSP supported the government develop a Health Sector GESI Strategy, we see there is political will in some spheres to advance GESI despite the absence of strong FMoHP leadership and policy. NHSSP experience at the local government level has found the space between political and technical decision-making is narrow and where a strong case has been made to target disadvantaged populations, such as by topping up GBV funding or AAMA benefits, local governments have stepped up.

In addition to political economy, social norms and gender discrimination in society permeate the health system and are a structural barrier to transformation within it, be it at the national or sub-national level[26]. In this respect, institutionalising GESI into governance and government planning and budgeting systems has been more contentious and challenging than initiatives that focus on services targeting

[23] NHSSP. 2022. Value for Money Case Study: Strengthening and Scaling up of SSUs in Nepal.
[24] NHSSP. 2022. Value for Money Case Study: Strengthening and Scaling up of SSUs in Nepal.
[25] Abimbola S, Baatiema L, Bigdeli M. 2019. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. Health Policy Plan. 2019 Oct 1;34(8):605-617.
[26] Hay K. et al. 2019. Disrupting gender norms in health systems: making the case for change. Lancet 2019.

specific vulnerable populations. In the case of the latter, evidence has been more compelling, the agenda is seen as less political, and champions have been willing and able to navigate technical and institutional dynamics to generate commitment to take innovations to scale.

The other major challenge to GESI mainstreaming is the very complexity of the health system itself with multiple stakeholders, agendas and interests, which was further exacerbated by the reorganisation and governance transformation triggered by federalism. Against a backcloth of fundamental political change, it was inevitably difficult to sustain momentum and bring about organisational change in favour of GESI. Even in the area of GBV and the significant strides made in developing a systems response via OCMCs, this focus on gender did not break through into a broader and more strategic framing of gender equality and inclusion in policy, governance, human resources or services. Discussion of women leadership and the barriers faced by female health staff in a patriarchal culture and system have been difficult to foster.

In addition to proving their value and benefit as service models, SSUs and OCMCs have put a spotlight on the gaps in the health system for some disadvantaged populations. The SSU model for example amplified to policy makers the challenges of the aged who are a significant share of SSU beneficiaries, some 39% in 2021/22, and how the lack of continuing care for elderly patients in the community was problematic and costly for hospitals who were unable to discharge them from oversubscribed hospital beds. Evidence from SSUs was a key contributing factor to the decision to create geriatric wards in hospitals. However, translating GESI specific policies into implementation is slow and requires continued support and advocacy especially given that the fiscal space is limited, there is a large gap in capacity, and the competition for resources is tight.

The way forward

The twin track approach to institutionalising GESI into the health system remains relevant in Nepal given the structural barriers to change, and the complexity and contested nature of the health system. During a decade of technical support, awareness and a common language on GESI has been created in the sector but there is significant work still to be done to achieve a gender equal and inclusive health system. Federalism and the devolved health system have created a new fabric to implement the rights enshrined in the Constitution, and the challenge for the next Health Sector Strategy is to put this to work through a pathway to UHC which is equitable, gender responsive and inclusive. This also calls for revitalising the social accountability directives and social audit mechanisms for health anchored into emerging and reshaped systems of social accountability in the devolved context.

Looking forward, the priorities for GESI mainstreaming continue to be functionalising the leadership and governance structures for GESI in the sector, navigating approval of the revised GESI Strategy and its monitoring and evaluation plan, integrating GESI into planning and budgeting and data for decision making, and supporting Provinces to develop a plan for advancing GESI that fits with the context and priorities of their arena. The OCMCs and SSUs are evidence of what can be achieved, and similar testing and scaling could be an effective way to step up on disability inclusive health, continuing care of elderly people, and finding solutions for remote populations and disadvantaged identity groups that lag behind in health such as Madhesi, Dalits and Muslims. With a decade of experience to build from, the health

system is better prepared to progress towards inclusive and gender equitable UHC but this will require continued investment and adaptive learning to achieve.

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