Gender Responsive Budgeting Guideline for the Health Sector, 2019

Government of Nepal

Ministry of Health and Population

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Acronyms

AWPB	Annual Workplan and Budget
BMIS	Budget Management Information System
DoHS	Department of Health Services
e-AWPB	Electronic Annual Workplan and Budget
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
GFP	Gender Focal Point
GoN	Government of Nepal
GRB	Gender responsive budgeting
GRBC	Gender Responsive Budget Committee
HMIS	Health Management Information System
HURIS	Human Resource Information System
LMBIS	Line Ministry Budget Information System
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MDAC	Ministry level Development Action Committee
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
NDHS	Nepal Demographic Health Survey
NHFS	Nepal Health Facility Survey
NHSS	Nepal Health Sector Strategy
NHTC	National Health Training Centre
NLSS	Nepal Living Standard Survey

OCMC	One Stop Crisis Management Centre
PPMD	Policy, Planning and Monitoring Division of the Ministry of Health and Population
SDG	Sustainable Development Goals
SUTRA	Country wide provincial and local level budget information system
TABUCS	Transaction Accounting and Budget Control System
TC	Technical Committee

Chapter 1 Introduction

1.1 Background

Gender responsive budgeting (GRB) is the mainstreaming of gender into macro-economic policy and the national budgeting system to achieve national commitments to gender equality and women's empowerment. GRB integrates a gender perspective into the budget cycle from the setting of policy objectives and spending options through to audit and budget evaluation.

The Constitution of Nepal includes provisions for gender equality, social inclusion and women's empowerment. The National Policy and Plan of Action on Gender Equality and Empowerment of Women, 1997 has led gender equality actions in the country, and national periodic plans integrate gender into the national development framework. The current Fourteenth Periodic Plan includes the goal of institutionalizing GRB down to local government levels in all sectors.

Gender responsive budgeting was introduced in Nepal in 2007/2008. The Ministry of Finance Gender Responsive Budgeting Manual, 2012has provided a uniform framework for government sectors to integrate gender into the budget formulation stage of the budget cycle and to classify the level of gender responsiveness of their programmes and budgets. Likewise, the Ministry of Finance has integrated the principles of GRB into the Budget Management Information System (BMIS) and the Line Ministry Budget Information System (LMBIS). In view of the importance of gender equality to achieve improved health in the country, the Ministry of Health and Population (MoHP) has developed this health specific gender responsive budgeting guideline to tailor GRB to the sector context, and strengthen gender inclusion in the programming and budgeting cycle.

1.2 Rationale of the GRB Guideline

The overall purpose of this guideline is to provide a guiding framework for undertaking gender responsive budgeting in the health sector to achieve the Government's gender equality and health objectives. The guideline provides tools and processes for integrating gender at each stage of the budget cycle in a phased approach tailored to the capacity and institutional context. The guideline maintains consistency with the overarching national classification of budgets for gender responsiveness as set out by the Ministry of Finance but has adjusted the indicators to better fit with the health sector.

The specific objectives of the Guideline are:

a) Provide the basis for common understanding of gender responsive budgeting among the functionaries of the health sector at the federal, provincial and local levels.

b) Develop an operational guideline on the definition, purpose and application of GRB tools and processes and introduce a gender lens into the steps undertaken by the MoHP at each stage of the budget cycle. Specifically, to:

   - Appraise health policies and medium-term spending plans for their gender impact.

- Strengthen the gender assessment of programmes and plans and the identification and prioritization of gender actions to achieve programme results.
- Draw on evidence and analysis to direct budget allocations and spending towards priority gender actions.
- Track performance of and spending on gender responsive health programmes and activities in the Annual Work Plan and Budget (AWPB).
- Introduce a gender perspective into budget monitoring, audit and evaluation.
- Define indicators for measuring the gender responsiveness of health programmes and budgets in line with the GRB Guidelines of the Ministry of Finance to maintain consistency in national gender coding of budgets.

c) Identify sex-disaggregated data requirements for gender-responsive budgeting.

d) Support the institutionalization of GRB into the planning and budgeting system of the health sector at provincial and local government levels.

1.3 Users of this Guideline

This Guideline provides conceptual, technical and operational information to enable application of GRB in the health sector. The key intended users of this Guideline are:

a) Officials responsible for policy making and planning in the Ministry of Health and Population.
b) Officials of departments and agencies involved in health sector plan and budget formulation and implementation.
c) Organizations involved in the management committees of hospitals and health institutions.
d) External development partners, national and international non-government organizations.
e) Civil society organizations, community organizations and interest groups.
f) Research organizations, experts and professionals from relevant fields.

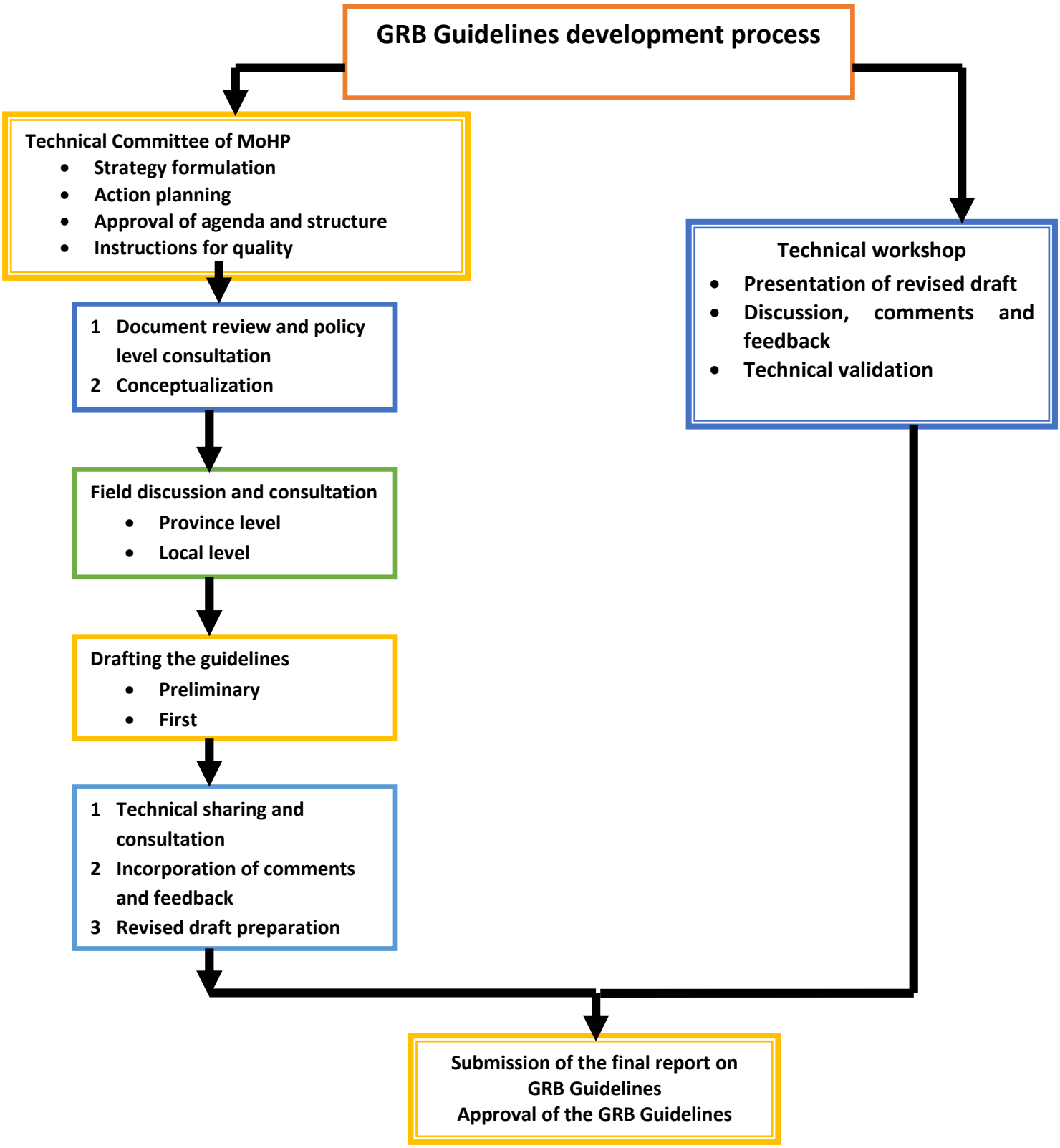
1.4 Methodology for developing the GRB Guideline

The Ministry of Health and Population led the GRB guideline development process through a Technical Committee (TC) which included staff expert in health planning and budgeting of the Ministry and the Department of Health Services (DoHS). The TC approved the plan for guideline preparation, the scope and contents of the guideline and the processes of review, consultation and information generation. The TC undertook a review of relevant health and social policies, analysis of secondary data related to GRB, health sector planning and budgeting and related trends.

Consultations and focused discussions at the federal, provincial and local levels were carried out to collect experiences and reflections on the present governance and operating context, needs and measures for effective implementation of GRB in the health sector at the three tiers of government. At the federal level, consultations were held with the Ministry of Federal Affairs and General Administration and the Ministry of Finance on strategic issues related to GRB, revisions to be considered while preparing the GRB

guidelines for the health sector, measures for localizing GRB in the federal context, and measures for cross-sectoral and multi-governance level coordination and harmonization. At provincial level, consultations were held with Ministry of Social Development, Health Directorate officials on the appropriateness and applicability of GRB. At the local level, Social Development Division health units were consulted on localizing GRB. At both levels, gender-responsive budget classification exercises were held to familiarize provincial and local level health service teams responsible for planning and budgeting.

A national workshop on 'GRB Guidelines in the Health Sector' was organized to review and finalize the gender-responsive budget classification system, appropriate methods for gender assessment, formulation of gender-responsive programmes and budget, gender responsive budget implementation, monitoring and evaluation, and gender auditing in the health sector. After incorporating inputs, feedback and suggestions from a wide range of stakeholders, the Technical Committee finalized this Guideline for approval by the Ministry of Health and Population.


GRB Guidelines development process
Technical Committee of MoHP
Strategy formulation
Action planning
Approval of agenda and structure
Instructions for quality
1 Document review and policy level consultation
2 Conceptualization
Field discussion and consultation
Province level
Local level
Drafting the guidelines
Preliminary
First
1 Technical sharing and consultation
2 Incorporation of comments and feedback
3 Revised draft preparation
Technical workshop
Presentation of revised draft
Discussion, comments and feedback
Technical validation
Submission of the final report on GRB Guidelines
Approval of the GRB Guidelines

Chapter 2 Gender Responsive Budgeting Explained

2.1 What is gender responsive budgeting

Gender responsive budgeting (GRB) aims to mainstream gender in the macro-economic policy and the budgetary system of the country to promote gender equality. It is not a budget for women but a budget that works for everyone by ensuring gender equitable distribution of resources and equal opportunities for all. GRB integrates a gender perspective into the budget cycle from the setting of policy objectives and budget formulation through to audit and evaluation of budget impact. GRB assesses the differential impact of the budget on women and men and girls and boys and the norms that underpin gender in a given context. Based on this analysis, GRB involves transforming budgets to achieve gender equality. By examining the needs of women, men, girls and boys, and how budgets respond to those different needs, gender budget tools identify deficits and contribute to the better allocation of resources for women's empowerment and gender inclusion.

GRB evaluates the execution of budgets against results to measure gender equity and accountability and encourages women's participation and transparency at all stages of budgeting. The objectives and methodologies of GRB contribute to the broader goals of transparent, evidence based and accountable public expenditure management more generally.

2.2 Definition of key terms

The following key terms and definitions are used in the GRB Guideline. These terms and definitions are compatible with those used in prevailing national laws and policies.

Capacity development encompasses institutional, system and individual capacity development.

Empowerment refers to increasing the personal, political, social or economic strength of individuals and communities. Empowerment of women and girls involves women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality.

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

Gender and sex: Gender and sex are different but interlinked. Gender is a social attribute and sex is a biological attribute where individuals are almost always clearly male or female. Society shapes and normalizes different roles and behaviours based on people's male or female sex and these socially determined roles and relationships are referred to as gender attributes.

Gender analysis refers to a critical examination of how differences in gender roles, activities, needs, opportunities and rights/entitlements affect men, women, girls and boys in certain situations or contexts.

Gender analysis examines the relationships between females and males and their access to and control of resources and the constraints they face relative to each other.

Gender awareness: Is an understanding that there are socially determined differences between women and men based on learned behaviour which affect their ability to access and control resources. This awareness needs to be applied through gender analysis into policies, programmes and budgets.

Gender-based violence is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the genders, within the context of a specific society. Women and girls are the main targets of gender-based violence but it may also be inflicted on men and boys who transgress society's gender norms. It includes all forms of violence that inflict physical, psychological, sexual harm or suffering or the threat of such acts, coercion and deprivation of liberty. The violence may be based on social malpractices and related behaviour including gender-based discrimination as in the Domestic Violence (offences and punishment) Act 2009.

Gender disparity refers to statistical differences (often referred to as "gaps") between men and women, boys and girls that reflect an inequality in some quantity. The gender gap is the disproportionate difference between men and women and boys and girls, particularly as reflected in attainment of development goals, access to resources and levels of participation. A gender gap indicates gender inequality.

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

Gender equity refers to the fairness of treatment for women and men, according to their respective needs. This may include equal treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women.

Gender needs leads on from the fact that women and men have differing roles based on their gender, and have differing gender needs. These needs can be classified as either strategic or practical needs.

Gender relations refer to the social relationships between women and men. Gender relations are simultaneously relations of co-operation, connection, and mutual support, and of conflict, separation and competition, of difference and inequality. Gender relations are concerned with how power is distributed between the sexes. They create and reproduce systemic differences in men's and women's position in a given society. They define the ways in which responsibilities and claims are allocated and the way in which each are given a value.

Gender responsive budgeting integrates gender equality principles into all stages of the budget process. Gender responsive budgeting seeks to ensure that the collection and allocation of public resources is carried out in ways that are effective and improve budget results generally, and contribute to advancing gender equality and women's empowerment. Ministry of Finance classification of the gender responsiveness of government budgets is broken down into three categories: directly gender responsive, indirectly gender responsive and gender neutral based on scoring of programmes against set indicators. Ministry of Health and Population follows this classification. In Phase 2 of the roll-out of gender responsive budgeting in the health sector, the Ministry plans to extend this classification to four categories by adding an additional category, this will be known as exclusively gender responsive.

Participation implies that women and men have the potential to articulate their needs and interests, and take responsibilities for development actions. Participation ranges from people participating as passive recipients to active change agents. It also refers to the composite capacity of meaningful engagement, ownership, contribution, responsibility and accountability.

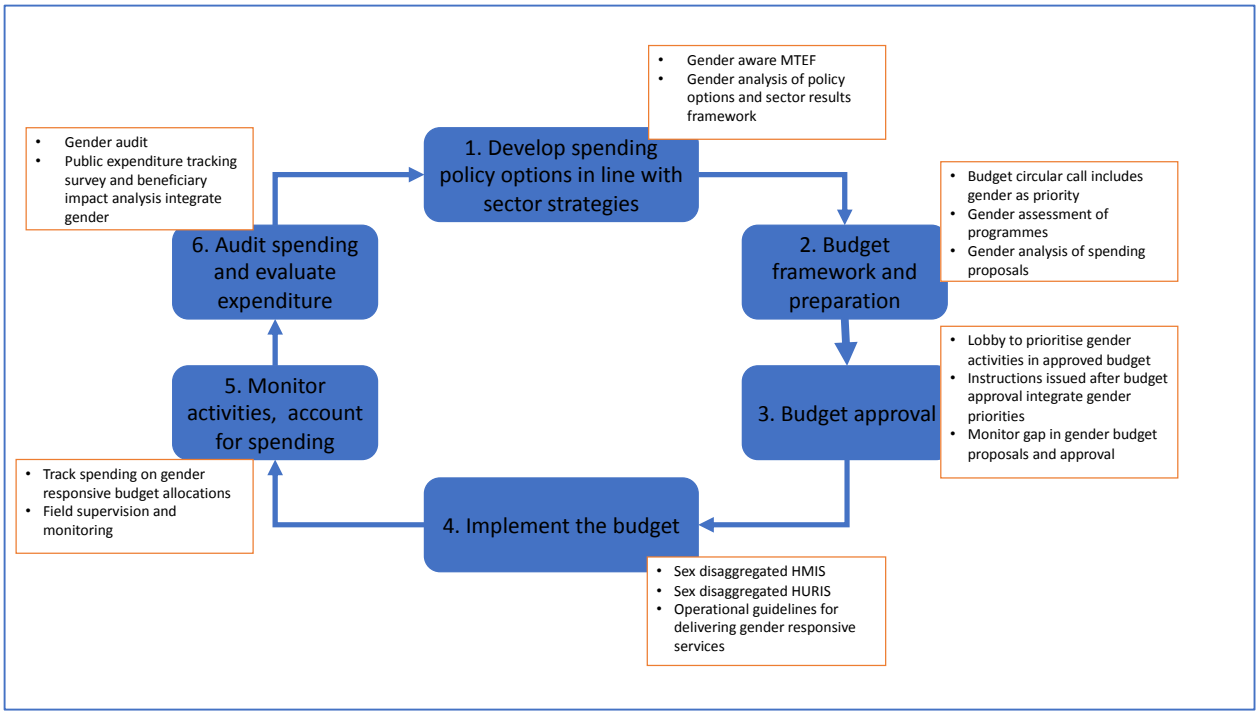
Reproductive and sexual health refers to reproductive and sexual health care in the context of primary health care. This includes a range of family planning; obstetric and gynaecological care; prevention, care and treatment of STIs and HIV/AIDs; education and counselling on human sexual and reproductive health; prevention and surveillance of violence against women and elimination of traditional harmful practices.

Sex disaggregated data: refers to data that is classified by sex, presenting information separately for men and women, boys and girls. When data is not disaggregated by sex, it is more difficult to identify real and potential inequalities. Sex-disaggregated data is necessary for effective gender analysis. For a gender analysis, all data should be separated by sex in order to allow differential impacts on men and women to be measured. Sex disaggregated data is quantitative statistical information on differences and inequalities between women and men.

2.3 Tools for integrating gender into the budget cycle

GRB can take many forms. It can look at the whole budget or a section. It can focus on national or sub-national levels of government. GRB involves the use of a wide range of tools and methods to mainstream a gender perspective in the budgeting process as shown below in Figure 1. It has to be tailored to context and the relevant entry points for gender budgeting in a particular setting.

Figure 1: Stages of the budget cycle and entry points for gender budget tools



Chapter 3 Review of Gender Responsive Budgeting in Nepal

3.1 Constitutional provisions for gender equality

The fundamental rights and duties enshrined in the Constitution of Nepal guarantee the rights of all and enshrine the principles of substantive equality, non-discrimination and social justice. Article 18 of the Constitution includes affirmative action for excluded populations including women. Under the rights of women, as stated in Article 38(2), women have the right to special opportunity in health with a special focus on the right to safe motherhood and reproductive health. The directive principles, policies and obligations of the State enshrined in the Constitution provide the rationale and framework for gender equality in the health sector.

3.2 Policies, strategies and plans underpinning gender responsive budgeting

3.2.1 National policy and plan on gender equality

Nepal's National Policy and Plan of Action on Gender Equality and Empowerment of Women 1997 sets out the country's commitment to achieving gender equality and women's empowerment in all sectors. The UN Convention on the Elimination of all forms of Discrimination against Women which Nepal ratified in 1991, includes gender responsive budgeting as a strategy for achieving gender equality and women's empowerment.

3.2.2 Sustainable Development Goals

Achieving gender equality and women's empowerment is integral to each of the 17 Sustainable Development Goals (SDGs). These goals comprise a healthy life for all, ensuring gender equality in health, empowerment of women and leaving no one behind. The national SDGs developed under the coordination of the National Planning Commission[1] include reducing the level of extreme poverty to five percent, increasing the budget for social protection from 11 percent to 15 percent, reducing the maternal mortality ratio to 70 per 100,000 live births, increasing the health sector budget from the existing 5.5 percent of the total budget to 7 percent, raising the utilisation of skilled birth attendants to 90 percent, ending all forms of gender-based violence, and ensuring the delivery of basic health services to allby 2030.

3.2.3 The Fourteenth Periodic Plan (2016/17 – 2018/19)

The Fourteenth Plan includes the goal of institutionalizing GRB down to the local level in all sectors of governance and development. It has set the goal of allocating at least 27 per cent of the budget to direct gender responsive activities (the mean average of all government sectors in 2017/18 was 37%), achieving a Gender Empowerment Measure of 0.58 and achieving policy, institutional and financial capacities for realizing these objectives[2]. For achieving gender equality in the health sector, the periodic plan stresses effective implementation of the existing multilateral nutrition plan, ensuring reform in reproductive health and safe motherhood, strengthening basic health services in maternal health and reproductive

[1] National Planning Commission, 2015, *Sustainable Development Goals (2016-30), National (Preliminary) Report.* National Planning Commission 2017, *National Review of Sustainable Development Goals*.

[2]Gender Empowerment Measure includes indicators of political participation and decision-making, economic participation and decision-making, and power over economic resources.

health, and reinforces the development, enforcement and monitoring of gender in all phases of the plan and programme of the health sector.

3.2.4 Gender-Responsive Budget Localization Strategy, 2015

The Ministry of Federal Affairs and General Administration[3]is spearheading gender responsive budget formulation at the local level. The Gender Responsive Budget Localisation Strategy[4] aims to institutionalize GRB in programme formulation and implementation at the local level by local executives and sectoral agencies. The strategy uses the same method of gender responsive budget formulation included in the Ministry of Finance (MoF) Gender Responsive Budgeting Manual, 2012 described below.

The strategy was developed prior to the election of provincial and municipal governments and fiscal, legal and administrative federalisation. Once the sub-national governance structures and related government legal and budgeting systems are in place, the strategy may need to be revised to ensure compatibility.

3.3 Institutional structure for gender responsive budgeting

GRB was initiated in Nepal in 2007/8 by the Ministry of Finance to use the budget cycle to progress the Government's gender equality and women's empowerment commitments. The national institutional structure for GRB is headed by a high level multisectoral Gender Responsive Budget Committee led by the Ministry of Finance. Within each sector there is provision for a Sectoral Gender Responsive Budget Committee and Gender Focal Persons. A Gender Responsive Budget Implementation Committee at the Ministry of Federal Affairs and General Administration is steering the GRB localisation strategy. See Annex 1.

3.4 Operationalising gender responsive budgeting

3.4.1 Ministry of Finance Gender Responsive Budgeting Manual, 2012

The MoF GRB Manual, 2012 provides a framework for GRB for all government sectors. The Manual focuses on the integration of gender at the budget formulation stage and provides a uniform method for classifying and coding budgets for gender responsiveness for all sectors. The mandatory requirement for government sectors to classify and code their budgets has provided the basis for MoF to report on the gender responsiveness of the Government's national budget. Central government guidance on GRB has not facilitated the progress of GRB at other stages in the budget cycle.

The fundamental values and principles enshrined in the guidelines are described below:

Values and Principles	Explanation
Gender mainstreaming	• Prioritization of gender concerns in the macro-economic policy and budgetary system • Assessment of impact of budget on women and men from gender equality perspective • Advocacy and sensitization on gender responsive budget
Transparency and accountability	• Ensuring transparency in all aspects of budget formulation and implementation • Ensuring accountability on gender equality results of the budget

[3] The former Ministry of Federal Affairs and Local Development.
[4] Ministry of Federal Affairs and General Administration, 2015*, Gender-responsive Budget Localization Strategy, 2015.*

Participation	• Ensuring inclusive, meaningful and active participation of women in budget formulation and implementation • Active participation of stakeholders
Localization	• Building capacity to transform gender responsive budgeting into local level systems • Facilitation and harmonization for effective realization at the local level
Efficiency and equity in results	• Measuring the outputs of budget execution through objectively verifiable performance indicators • Ensuring gender equity in results and benefits
Evidence-based	• Assessment and analysis of the budget on the basis of sex-disaggregated data • Use of data generated from independent study and research
Institutional capacity	• High-level political commitment and involvement • Policy harmony and clarity • Dedicated and capable institutional arrangement
Restructuring and reform	• Structural and system-related reforms on the basis of independent gender-oriented evaluation of the budgetary system

The key steps in the MoF GRB Manual 2012 at the budget formulation stage are:

- Gender assessment and identification of gender concerns and needs
- Gender analysis of programme and budget
- Inclusion of actions and budget to address gender issues.

Five domains of gender classification of budgets:

- Participation of women in plan/programme formulation and implementation
- Capacity enhancement of women
- Ensuring women's benefit and control of the programme
- Increase in women's employment and income generation
- Qualitative improvement in women's time-use and reduction in women's workload

The methodology for classifying the level of gender responsiveness of programmes and budgets is framed around five domains which are measured according to a number of indicators and sub-indicators. The scoring of each indicator and sub-indicator is aggregated to make a composite score. Depending on the composite score, budgets are classified into three categories, direct gender-responsive, indirect gender responsive or gender neutral. This classification is tied to a budget code which is entered into the government's national electronic Line Ministry Budgeting Information System. This methodology has enabled the government to track and compare gender responsive budgeting across sectors and over time.

3.5 Gender responsive budgeting in the health sector

3.5.1 Ministry of Health and Population planning and budgeting system

a Annual Work Planning and Budgeting System

The electronic annual work planning and budgeting system (eAWPB 1.0) is a bilingual (English and Nepali), simple, interactive database developed for the Ministry of Health and Population (MoHP) to facilitate the Annual Work Planning and Budgeting (AWPB) process. It generates analytical tables in a systematic way

from different perspectives. This system has made the planning and budgeting system of the health sector simpler, more transparent and harmonized, and increased efficiency in the whole process.

b Line Ministry Budget Information System (LMBIS)

The Government of Nepal is using the Line Ministry Budget Information System (LMBIS) for annual budget and programme formulation and to ensure budget preparation takes a bottom up approach and is evidence based. The Ministry of Finance has integrated gender responsive classification and coding of budget allocations into LMBIS based on the methodology described above. Outputs from the e-AWPB are inputs into the LMBIS.

c Annual Plan and Budget Formulation in the Health Sector at the Local Level Directives, 2018

In line with the constitutional provision and the 'Local Government (operation) Act, 2017', the MoHP has put into force the *'Annual Plan and Budget Formulation in the Health Sector at the Local Level Guidelines, 2018'*to coordinate and facilitate the formulation of plan and budget in the health sector at the local level and to harmonize the planning and budgeting functions at different levels. However, this directive has not included provision for gender analysis or gender responsive budgeting. In addition, the lack of technical GRB capacity, the lack of sex-disaggregated data and the absence of an enabling environment are bottlenecks to the introduction of GRB at the local level.

3.5.2 GRB in the Ministry of Health and Population: practice, challenges and opportunities

The MoHP has included gender classification of budget lines in LMBIS since fiscal year 2009/10.However, the institutional environment, human resource capacity and system requirements to underpin gender responsive budget formulation has been lacking. For example:

- Institutional:
    - The sectoral GRB Committee is non-functional.
- Analytical:
    - Assessment of the health needs of women, men, boys and girls and gender analysis of programs and budgets to support evidence and result based gender inclusive programme planning and budgeting decisions has been absent.
    - Gender analytical work at the sectoral level has also been lagging and the gender audit conducted in 2002 has not been repeated. The opportunity to integrate gender into the Medium Term Expenditure Framework has not been taken up.
- Narrow focus of GRB tools
    - The focus of GRB in MoHP has centred on the gender classification of budgets by central planners in the Policy, Planning and Monitoring Division (PPMD) at the time of compiling the sector's budget proposal.
    - The Government's focus on budget formulation as the entry point for GRB carries limitations. In MoHP this has translated into lack of attention to gender at budget implementation, budget monitoring and budget evaluation stages. Tracking of budget allocations classified as directly gender responsive has not taken place though anecdotal evidence suggests these budget items frequently get cut when the sector budget is

approved. Higher-level results analysis such as the contribution of budget expenditure to the Ministry's gender equality objectives has also not been undertaken.

- Staff capacity:
    - Divisional and programme staff engaged in annual work planning and budgeting have not received the necessary training or toolkits for them to integrate a gender perspective and they are not engaged in the gender classification of budget proposals.
- Sex disaggregated data:
    - Gaps in sex disaggregated data in HMIS for some health services including child health and malaria, and systemic weaknesses in the human resource information system (HURIS) so that reliable data on the workforce including the total number of staff, their sex, and position are not available.

Despite the gaps in how gender responsiveness has been applied to budget formulation in the health sector, there are a number of factors that compel the capacity development of the health system to better deliver gender responsive budgeting. First, the constitutional, policy and legal emphasis on gender equality and women's empowerment, and the importance of health in the achievement of gender equality demands deliberate and prioritized attention to gender by the health sector in line with policy commitments. Second, federalisation of the health sector and localization of planning and budgeting offers opportunity to integrate and roll-out gender responsive budgeting in health as part of the broader transformational change. Third, GRB itself can contribute to the development of transparent, equitable and result based planning and budgeting at the three levels of governance.

Chapter 4 Gender Responsive Budgeting Guideline for the Health Sector

4.1 Policy and strategies underpinning GRB

Gender equality and women empowerment is enshrined in the Constitution. The National Health Policy 2014and National Health Sector Strategy 2015-2020set out a path towards universal health coverage. The Gender and Social Inclusion Strategy of the Health Sector, 2018 provides the more detailed framework for achieving the Government's gender objectives and priorities in the health sector and includes the institutionalisation of gender responsive budgeting as an instrument to achieve gender equality and mainstream gender in the sector.

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

Strategic objectives

1. To mainstream gender equality and social inclusion (GESI) in the policy, planning and budget cycle of the health sector at the federal, provincial and local levels
2. To strengthen GESI institutional mechanisms and make them functional at the federal, provincial and local levels
3. To enhance the capacity of target groups to demand their rights to and use basic health services
4. To internalise GESI into the mainstream health services to achieve equitable access and inclusive delivery of essential health services
5. To deliver targeted programmes that meet the specific health needs of vulnerable and excluded populations for ensuring their equal access to and utilisation of health services

4.2 Gender inequality and health in Nepal

In Nepal, women and girls have lower human development indicators than men and boys irrespective of poverty, geographical area and caste/ethnicity. Cultural norms and gendered social practices reduce women's and girl's control over their well-being and safety, affect their risk of violence, their access to health services, health decision-making and health outcomes.

Progress has been made in improving the life expectancy of women and men in Nepal. Women now have a higher life expectancy than men, 71.6 years versus 68.8[5]. Maternal mortality has declined significantly from a high of 539 deaths per 100,000 births in 1996 to 239 in 2016 and use of institutional delivery has increased from 18% in 2006 to 57% in 2016. However, disparities in the use of institutional delivery by poverty, geographical area and caste/ethnicity reflect continuing inequities in access to health services and the inter-sectionality of gender and other social determinants of health.

While the average age of marriage is increasing and the median age of marriage is 17.8 years, still 17% of women aged 15-19 have begun childbearing with added risks for the young mother and child. Anaemia among women is increasing, rising from 35% among women aged 15-49 in 2011 to 41% in 2016. Anaemia increases the risk of maternal morbidity and mortality, poor birth outcomes, and reduces work productivity.

[5] https://www.who.int/countries/npl/en/

Reproductive health is impacted by poverty, social norms and cultural practices that frame women's lives, opportunities and control. Use of modern family planning methods by married women has stalled and there has been no increase between 2006 and 2016, 44% and 43% respectively. The burden of family planning falls disproportionately on women and use of male sterilization is much lower than female (5.5% and 14.7%). NDHS 2016 found 24% of the total need of family planning was unmet. Social pressure and fear of gossip mean that women whose husbands are working away as labour migrants are constrained in their access to reproductive health services. Cultural practices that restrict women's diet and interaction in the family during menstruation and post-pregnancy put them and their newborns at risk, and *chaupadi* remains in practice especially in the far-west despite being illegal[6]. Female shame around reproductive functions inhibits discussion of reproductive matters and hinders access to reproductive information and care especially of adolescents. Poverty and women's lack of empowerment underpin the incidence of uterine prolapse.

Gender based violence is widespread and affects women from all socio-economic and caste/ethnic backgrounds. NDHS 2016 found that 22% of women aged 15-49 have experienced physical violence most often perpetrated by their current husbands (84%) and 7% have experienced sexual violence. The controlling behaviour of husbands reflects the patriarchal nature of society and 35% of women report being afraid of their husband most of the time. The Ministry's introduction and rolling out of One Stop Crisis Management Centres to improve treatment and counselling and referral of GBV survivors and a platform for multi-sectoral coordination is a positive step.

There has been some improvement in measures of women's empowerment. However, women's participation in decision making over their own health is far from optimal and 29% of women aged 15-49 report that husbands alone make these decisions. Women's participation in decision making is an indicator of empowerment and is correlated with lower infant and child mortality levels[7].

The Nepal Demographic and Health Survey, 2016 found the advantage that girls have compared to boys in neonatal mortality reversed in infant and under five mortality. Notably no difference between boys and girls in infant and under five mortality have been found in the 2011 and 2006 surveys and this new gap is cause for concern. Girls were less likely to be taken to a health facility or provider when they had diarrhoea than boys (56% and 72%) and more likely to receive no treatment (20% and 12%). Strong son preference may be one contributing factor to these disparities in family care practices.

Figure 2: Child mortality by sex, NDHS 2016

Sex	Neonatal mortality (per 1000 live births)	Infant mortality (per 1000 live births)	Under five mortality (per 1000 live births)
Girls	17	34	41
Boys	24	31	36

Gender disparities in health care utilisation of non-reproductive and maternal health services: The Nepal Living Standards Survey 2011 found that

[6]Chaupadi is the isolation of a woman from the household and community during her menstruation and after childbirth when she is considered "impure". In May 2005, the Supreme Court of Nepal directed the government to ban the practice.
[7]Nepal Demographic and Health Survey, 2016

women benefit less from inpatient and outpatient services than men if non-reproductive and maternal health is excluded.

Barriers women face in accessing health services: More women (42%) have encountered barriers in accessing health care services compared to men (35%). The NDHS 2016 found that more than 8 in 10 women reported at least one problem in accessing health care for themselves. More than two-thirds reported not wanting to go alone (68%) or the absence of a female health service provider (67%) as problems in accessing health care. More than half of women reported that getting money for treatment and distance to a health facility were problems in accessing care. Travel time to a facility for delivery varies across the country but on aggregate 29% of women reached the health facility within 30 minutes, 45% took 30-60 minutes and it 16% between one to 3 hours. Many women need family permission to seek health care, find someone to care for children and the elderly, and someone to accompany them. Among women who could not avail of services, 18% reported this was due to distance, and 12% lack of money, 39% sought the services of traditional healers because of cultural barriers[8].Access to information varies for men and women. For example, women have less access to internet than men (23% and 50%).

Health system gaps: There has been progress in increasing attention to gender and social inclusion in the health sector over the past ten years including step changes in demand and delivery of institutional delivery. Gender has been integrated into infrastructure standards, in-service training and there is increased availability of sex disaggregated data for some areas of service provision. However, important gender gaps in the health system remain:

- **Leadership**: Inequality in the participation of women in decision-making and leadership at all levels of the health sector persist. At the health facility level, the Service Tracking Survey, 2012 found that only 51% of health facilities met the criteria for having at least 3 female members on the Health Facility Operation and Management Committee[9].
- **Human resources for health**: Gaps in the human resource information system (HURIS) mean that reliable and up-to-date data on the sex disaggregation of health staff is not available. The 2013 Human Resources for Health Profile reported that 46% of the total health sector staffs were women but they were only 25% of general medical practitioners and 19% of specialists. Service Tracking Survey, 2012 found that in the facilities sampled, positions that are largely filled by males are obstetricians, paediatricians, medical officers, health assistants, Auxiliary Health Workers, Village Health Workers and laboratory technicians/assistants. The positions largely filled by women are nursing positions, sisters/matrons, staff nurses, Auxiliary Nurse Midwives and Maternal and Child Health Workers. The gender imbalance in health staff inhibits women's access to services due to their preference for female providers.
- **Capacity development:** Almost half (49%) of the health workers providing delivery and/or newborn care had ever received training related to delivery and/or newborn care. Only 57% of the nurses who are posted to birthing centres and maternity wards have received birth attendant training. There is virtually no training programme on leadership development and management.

[8] Ministry of Health and Population, 2012, Service Tracking Survey, 2012.
[9] Ministry of Health and Population, 2012, Service Tracking Survey, 2012.

- **Quality of care**: Quality of care is poor. Only 12% of health facilities have tracer drugs for maternity, 12% of health workers washed their hands while examining pregnant women during antenatal care (ANC), 29% of ANC clients reported that the provider discussed with them the planned delivery site, and only 21% said they had talked with the provider about supplies to prepare for delivery. Cleanliness of health institutions is poor and the right to privacy and confidentiality is compromised. Client satisfaction is weak and for example only39% of pregnant women are satisfied with antenatal services.
- **Health infrastructure:** Many hospitals, Primary Health Care Centres and Health Posts particularly those in old buildings are lacking basic amenities such as separate toilets for female clients, breast feeding room, and counselling room.
- **Information**: Child health related service statistics in the HMIS are not sex disaggregated nor are data for some disease control programmes. The HURIS is not updated though the system is programmed to document sex of staff. The e-AWPB includes the three gender budget codes (directly gender responsive, indirectly gender responsive and gender neutral) but not codes for the five gender domains included in the gender budget classification tool. The logistic management information system is considered a neutral tool and does not produce a sex disaggregated drug expenditure report.

Priority areas for further systems development as proposed by the GESI Strategy for the Health Sector, 2018 such as the strengthening of the GESI institutional structure, women leadership development, integration of GESI into policy and systems and stronger sex disaggregated information and gender evidence will help create the enabling environment for gender responsive budgeting and achievement of better gender results.

4.3 Gender priorities for achieving national health sector results

Based on the provisions and special focus areas for women in the Constitution, the Nepal Health Sector Strategy (NHSS) and the Gender Equality and Social Inclusion Strategy in the Health Sector the gender priorities for the health sector are presented in the table below.

Figure 3: National gender priorities for the health sector and links to the Constitution, NHSS and GESI Strategy for the Health Sector

Gender objectives and priorities of the health sector	Constitutional provisions and special focus	NHSS and results framework	GESI Strategy for the Health Sector Strategy
1. Improved health outcomes		✓	
Improve women's reproductive and maternal health	✓	✓	
Improve women's nutrition including reduction of anaemia	✓	✓	
Equitable child health outcomes for boys and girls		✓	
2. Equitable utilisation of quality health services		✓	

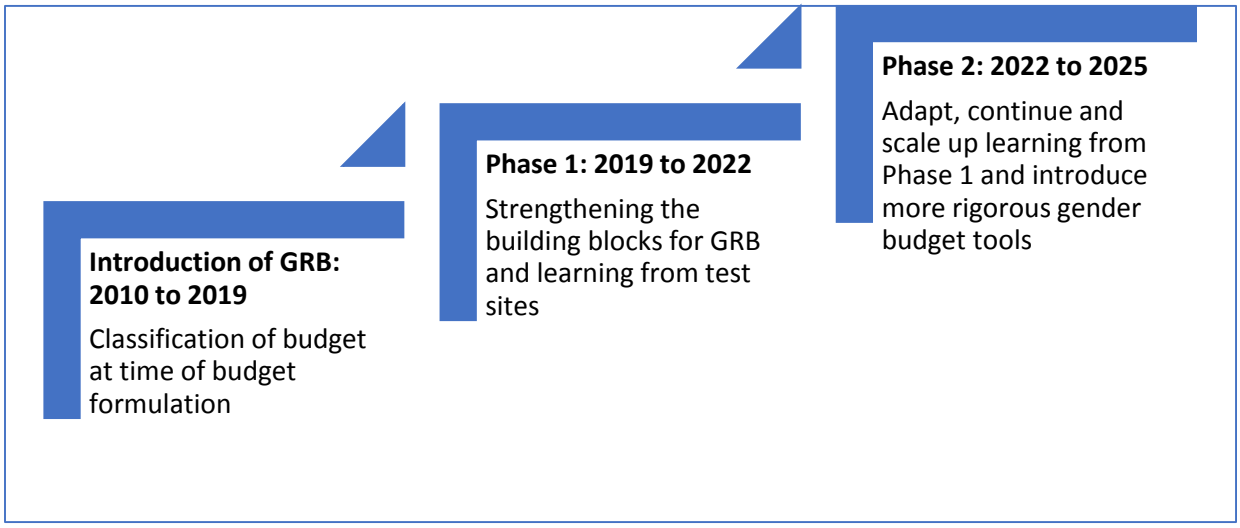
Deliver quality health services in a gender responsive manner that empowers women to have greater control over their health			✓
Reduce the financial, socio-cultural, geographic and time barriers women face in accessing services		✓	✓
Deliver targeted programmes and services to underserved and disadvantaged populations	✓	✓	✓
Improve the health system response to survivors of gender based violence		✓	✓
3. Increase women's participation	✓		✓
Increase the participation of elected, civil society and community women in decision-making and management committees	✓		✓
4. Increase the proportion of women in leadership	✓		
Reduce the gender disparity in leadership and decision-making within the health system, including management of health institutions			✓
5. Create a gender equitable and inclusive workforce and workplace	✓		✓
Create inclusive and women-friendly workplaces			✓
Strengthen human resource policies and systems for equal employment opportunities for all including equal pay for equal work, placement, merit-based provision of opportunities for obtaining professional continuing education, career development and promotion			✓
6. Strengthen information, planning and budgeting systems		✓	✓
Institutionalise gender into the information, planning and budgeting systems including sex-disaggregated data			✓

4.4 Roadmap for gender responsive budgeting in the health sector

Building on the achievements to date in introducing gender responsive budget formulation into the health sector and the enabling legal, policy and governance environment for GRB, the Ministry has decided to take an incremental and phased approach to strengthening GRB given capacity constraints and weaknesses in the institutional environment. The phased approach recognises the necessity to establish and strengthen the mandatory requirements for GRB as a foundational step before introducing stronger evidence-based approaches, and the time and learning that it will take to align and embed GRB into the emerging federalised structures.

- The first phase focuses on strengthening the building blocks for GRB, introducing simple gender assessment tools and testing GRB in a limited number of sites to learn how GRB can work within the federal structure. In Phase 1, the focus of GRB extends beyond budget preparation to include participatory budget monitoring and auditing.
- The second phase adapts, continues and rolls-out learning from phase 1 and extends the focus of GRB in the budget cycle to include more rigorous budget monitoring and evaluation methodologies and stronger gender analytical tools.

Figure 4: Roadmap for gender responsive budgeting in the health sector



4.5 Phase 1: Strengthening the building blocks of GRB and learning from practice

The priority areas for strengthening the foundations for GRB in the health sector are:

- Functionalising the GESI Steering Committee to be the lead institutional structure responsible for oversight of GRB in the health sector and empowering GESI Committees at provincial and local levels to coordinate and facilitate GRB.
- Establishing mechanisms for vertical and horizontal coordination and harmonization between different levels of governance (federal, provincial and local) and across government agencies (health, social development, finance and federal affairs) to demonstrate how GRB can be meaningfully implemented under federalisation.
- Directives or guideline on the methods for GRB to be used in the health sector (this guideline).
- Development of toolkits and user-friendly materials to guide staff in application of GRB methods.
- Capacity enhancement of personnel involved in programme planning and budgeting in divisions and units, and at each level of the health system.
- Strengthening the comprehensiveness of sex disaggregated health management information and sex disaggregated data on the human resources of the sector.
- Ensuring IT compatibility and scope to include gender responsive classification and coding of budgets in budget management systems; e-AWPB in the health sector, SUTRA at sub-national levels and LMBIS at national level.

Phase 1 includes testing the adapted GRB methods in selected sites to learn how the GRB process can work in the decentralised federal structure. This is intended to demonstrate the value of GRB to health planners and fund managers, show tangible benefits to be gained from GRB, build interest in GRB among stakeholders, and generate an evidence base to inform the further enhancement of GRB methods.

4.5.1 Scope of GRB

GRB will continue to include all health programmes which covers more than 40 budget heads. To date GRB activities have centred on the gender classification of budgets at the time of budget formulation which has been undertaken centrally by PPMD. While this activity will continue in order to maintain gender responsive budget tracking data, responsibility will be transferred to the programme planners in each programme area. In time, provincial and local governments are expected to absorb this function under the localising strategy, and coordination across the three levels of government to standardise the process will be important. The focus of the new gender budget tools continues to be at the budget preparation stage with extension of a gender perspective into budget monitoring. This incremental approach is a pragmatic response to the limited capacity for GRB at present and the significant demands on the system resulting from federalisation.

4.5.2 Institutional structure for GRB in the health sector

The GESI Committee will coordinate and facilitate GRB. PPMD is the main agency and GESI Section will facilitate[10].

4.5.3 Stage 1: Policy review and sector spending options

During the latter part of Phase 1, a gender analysis of health policies and the National Health Sector Strategy, the Medium Term Expenditure Framework and trend in sector spending on gender responsive actions and results will be undertaken. This will provide strategic level guidance on priorities for gender inclusion in future policy development, the MTEF and budget implications. This strategic analytical work will provide direction on gender budget priorities across the sector including sub-national levels of government. (See Annex 2)

4.5.4 Stage 2: Budget preparation stage

Gender inclusion will be integrated into several steps involved in budget preparation by the ministry. These entry points for gender integration are the most immediate areas where current practice related to GRB in the health sector will be strengthened.

Month	Budget preparation step	Integration of gender perspective	Responsibility
Mid December	NPC and MoF request sectoral review report of development plan and programme and resource requirement.	Gender integrated into sectoral review.	GESI Committee GESI Section

[10]The GESI Committee is a higher level body than the sectoral GRB Committee which has not functioned well in the health sector.

January	MoHP develops objectives and targets based on policy and NHSS.	Gender to be meaningfully considered in development of objectives and targets.	GESI Committee GESI Section
January	MoHP provides sector budget guideline and ceilings for each department/programme/project.	Meeting of GESI Section and PPMD to prepare budget circular to instruct inclusion of gender in plan and programme based on GESI Strategy and calculate anticipated GESI outcomes.	PPMD GESI Section
End February	Division/department/centres/projects prepare plan, program, priority and budget.	Participatory gender assessment to identify needs, gaps and system bottlenecks of programmes and contribute to prioritization and budget choices. GESI Section participate in gender assessment and priority setting and propose evidence based gender and social inclusion programmes and activities. Gender classification and coding of budget through participatory process using revised indicators and weightage included in this guideline.	Planners in divisions, departments, centres GESI Section Also refer to Annual Plan and Budget Formulation in the Health Sector at the Local Level Guidelines 2018 (p.18) for participatory gender assessments in the health sector.
End February	MoHP consolidation and review of proposals.	Evidence based advocacy and preparation of fact sheet and policy briefs to protect gender and social inclusion budget in consolidation of spending proposals Trendline analysis and incremental change in direct gender responsive budget by Budget Development Team with participation of GESI Section.	Budget Development Team GESI Section
End March	MoHP finalises budget and recommends to NPC and MoF.	Evidence of trend in gender responsive budgeting presented to Secretary MoHP.	PPMD GESI Section
May	NPC finalizes development plan/programme/budget. MoF finalizes resource allocation.	Disseminate policy briefs on gender and health. Advocacy groups lobby to protect gender budget items.	PPMD GESI Section
July	Parliament approves budget, MoF issues authorization to MoHP with instructions. MoHP issues instructions to Departments to prepare operational workplan; trimester allocation plan with objectives and targets; M&E plan; procurement plan.	Include gender as priority in instructions.	PPMD

a Gender assessment

Gender assessment is the first step to identifying gender gaps in policies, programmes and public spending. It helps to assess whether a particular policy or programme is likely to worsen gender inequalities, have no impact, or improve gender equality. Given capacity constraints, rapid gender assessment methods will be introduced during Phase 1. Three rapid gender assessment tools are available to programme managers and planners to choose from:

i. A five-step gender assessment framework
ii. A participatory rapid gender assessment tool for use with community people, clients and health staff
iii. A checklist to assess the gender responsiveness of building blocks of the health system.

The choice of rapid gender assessment method will depend on a range of factors including the scope and nature of the programme, project or activity; the scope of work and capacity of health planners in understanding and assessing gender equality; and availability of data. The decision on which method to use will be decided by the planning team.

Figure 5: Five step gender assessment framework

Major steps and key questions for assessing gender gaps: A five step method

Step 1: Identify gender issues in the sector and assess the situation: What is the situation of women and men in the sector programmes? What are the interests, needs, priorities of men and women? Are there differences between women and men that should be taken into account? What are existing inequalities between women and men? What are the main challenges regarding gender equality in the sector?

Step 2: Collect information about the programme: What are the objectives of the programme? Are there specific objectives oriented towards improving the situation of women or men? What are the main activities within the programme? How much budget is available for the programme and on what activities is it spent? Which statistical data regarding the programme, especially target group and beneficiaries, is available?

Step 3: Conduct gender analysis of activities: How many women and men benefit from the activities? Do women and men make different use of different services? Are there potential obstacles to use the services? Are specific services offered for women and men? How satisfied are women with the quality of services offered? And how satisfied are men? Do the services take into account the possibly different needs and interests of women? What is the impact of the public activities on women and men? Are the public activities changing existing gender roles, norms and stereotypes and how are they changing?

Step 4: Conduct gender analysis of related budget allocations: Is the available budget adequate to implement the programme in view of the size of the target group? Is the available budget enough to provide services and activities responding to possibly different needs of women and men? How have budget allocations for the programme developed over the last year? Have there been increases or decreases? Has the money allocated in the budget been fully spent in implementation? Are the services affordable for all women and men among the intended target groups?

Step 5: Develop objectives and recommendations to improve gender equality: How to ensure equal access of women and men to different activities? How to target services better to reach some groups of women or men? What changes in activities are necessary to better meet gender equality objectives and better meet the needs, interests and priorities of women and men? Are specific additional activities recommended to specifically address women or men? How to make sure gender perspectives are integrated in the implementation of the programme activities?

Women's participation in the budget preparation stage is a crucial step to ensuring that budget allocations are responsive to the needs of women and girls. Active participation of women, gender equality advocates, women's groups and networks in the budget process is important, especially at the local level. Women are to be encouraged to participate in budget meetings during budget preparation and budget monitoring. Budget hearings provide an important space for women to learn about the budgeting process, government's priorities and public spending and enables them to voice their concerns and budget priorities. Women's priorities are then to be conveyed to the appropriate budget making authorities at different levels for resource allocation and execution.

Figure 6: Method for undertaking a participatory gender assessment of health programmes and services

Process

1. Facilitate stakeholder group discussion of the statements listed in the checklist below.
2. Use the discussion to identify gender gaps and the priority unmet health needs of women, men, girls and boys and how the programme and budget can be adjusted to fill the gaps.
3. Once all the statements have been discussed, discuss which areas of the programme need strengthening to be more gender responsive, how budget adjustments can be made to accommodate this, and if additional budget is a priority.

Checklist of guiding questions

1. Is the health programme or service meeting the health needs of women and girls and are these different to those of men and boys?
2. Is the programme reducing the barriers women, men, boys and girls face in accessing health services or promoting their health and safety?
3. How is the programme addressing socio-cultural norms and practices that discriminate against women and girls and hinder their access to services or health status?
4. What mechanisms exist for women and men to voice their health needs and shape the programme to meet their needs?
5. If there is perceived or evidence-based disparity in the use of services for men and women or boys and girls, how is the programme seeking to reduce the gap?
6. What is the level and quality of women's participation in decision-making forums related to the programme.
7. To what extent is the programme empowering women and girls to take control of their health and promoting gender equality? What are the obstacles to this?
8. How is the programme reaching underserved and excluded women and families; are programme strategies to leave no one behind effective, what more is needed?
9. Are health services and staff sufficient and equitably distributed to benefit all women and girls? Are community-based services and functionaries such as the female community health volunteers (FCHV) adequately supported and recognized?
10. What are the priority areas for improvement?

An evidence based gender analysis of the health system is central to mainstreaming gender into the systems and structures that support health services. The table below sets out key questions to explore across the building blocks of the health system.

Figure 7: Framework for undertaking a rapid gender assessment of the building blocks of the health system

Health system building block, outcome or thematic area	**Key questions for identifying and addressing gender issues and gaps**
Health outcomes	• What are the sex disparities in outcomes and who is left out? • Are women's and girl's specific health needs being met?

	• Are women and men protected from financial risks?
Health policies	• Is gender a policy priority? • Are policies appraised for gender and social inclusion during preparation?
Governance and leadership	• Is leadership gender balanced? • Are women equally involved in decision-making? • Are women user voices included in policy making and management of services?
Workforce	• Do women and men have equal opportunities to employment, promotion, training and professional development? • Are women and men equally paid and compensated? • Is there a policy and system to prevent and address sexual harassment fairly? • Are human resource management information systems and the evidence to track gender equality in the workforce adequate?
Health information and research	• Do information systems include sex disaggregated data? • Is evidence collected and analysed on sex disparities? • Is evidence collected on how the health service can effectively address the specific health problems of women and girls such as violence against women and girls?
Delivery of health services	• Does health promotion and behaviour change communication address gendered behaviours and risks, e.g. adolescent pregnancy? • Do health service delivery mechanisms address the access barriers that women and girls face including social norms and cultural practices, financial and geographical? • How do women users and female service providers participate in health service management?
Quality of health services	• Are systems for ensuring quality of health services gender inclusive? • Is privacy and client confidentiality maintained? • What is the experience of using health services for women, men, girls and boys? Are providers respectful, do they show empathy and compassion? • Is the breadth of services responsive to the health needs of women, men, girls and boys? • Are informed consent practices upheld? Are women given the authority to make service decisions by themselves or do health providers insist on male or family permission? • Is the supply of medicines and consumables sufficient, how do gaps impact women differently to men?

Medical technologies and products	• Is there any gender discrimination in technologies available? • Are there any shortages in contraceptives or the products/technologies women need for their sexual and reproductive health?
Infrastructure	• Is health infrastructure gender and disability accessible? • Are building codes gender sensitive. Are separate toilets for women included in health facilities and do women staff have separate changing and restrooms. Is privacy and confidentiality factored into building design?
Health financing	• Are resources being used to close gender gaps and meet the needs of women and girls? • Are gender mainstreaming activities adequately financed? • What is the trend in funding for directly gender responsive activities?
Health behaviours and risks	• What behaviours place women and girls at risk? • How do gender norms, roles and relations affect health practices and risks? • What control do women and girls have over health care seeking? • What is the health service doing to address gendered health behaviours?

b Priority setting

In Phase 1, the gender assessment and any existing evidence reviews available to programme teams provide the basis to set programme and budget gender priorities. Where possible this should include participation of elected representatives, women from civil society and the community.

Priority setting will consider how the objectives of the programme contribute to:

- Meeting the gender objectives and priorities of the sector as outlined above
- Gender gaps in the programme and service delivery and how this impacts achievement of programme objectives and targets
- Cost of adapting or introducing new interventions to address gender gaps
- Budget envelope and scope to increase gender actions and budget including through leveraging local government funding

See Annex 5 for a matrix that structures the priority setting process. GESI Section will participate and provide support to the gender assessment and priority setting process, including proposing gender and social inclusion activities to address the identified gaps. Programme and budget priorities that emerge from the priority setting process are to be included in budget formulation.

At the outset, priority setting for gender responsiveness will take a pragmatic and practical approach building gender into current practice and wherever possible opening the process up to elected and community women and civil society representatives. As more robust analysis and evidence becomes available and capacity to implement gender budgeting tools improves, priority setting will become more evidence-based.

c Gender responsive classification and coding of budget lines

The sector will continue to undertake gender classification of programmes and coding of budget lines to enable continued tracking of the percentage of the budget allocated to directly gender responsive, indirectly gender responsive and gender neutral activities. In contrast to the past this classification and coding will be tracked at the three stages of budget preparation, budget approved and budget spent and will be a means of monitoring commitment to GRB at different levels of governance.

This guideline includes modifications to the MoF framework for gender budget classification that have been agreed with the MoF. The revised classification maintains the five broad domains of gender equality classification directed by the MoF but has adapted the indicators and sub-indicators and weightage to better fit the health sector scope of business.

The classification will cover the MoHP's federal health budget and the conditional grants provided by MoHP to provincial and local government levels. The provincial and local governments will be encouraged to adopt the GRB classification and apply this methodology to the various other sources of funding they have available to them for health, including unconditional funds, special funds and locally generated revenue.

Figure 8: Five overarching domains of gender equality for gender classification of budgets and weightage for the health sector

S.No.	Five domains for measuring gender equality	Weightage
1	Participation of women in plan/programme formulation and implementation	20
2	Capacity enhancement of women	20
3	Ensuring women's benefit and control of the programme	30
4	Increase in women's employment and income generation	20
5	Qualitative improvement in women's time-use and reduction in women's workload	10

Figure 9: Indicators, sub-indicators and weightage for scoring health programmes and plans and their related budgets

S.No.	Indicators and Sub-Indicators		Percentage
1	**Participation of women in decision making in plan/programme formulation and implementation**		**20**
1.1	Participation of women in annual and periodic plan, programme and budget formulation (tick any one)		10
	• 40 percent or more participants in decision-making meetings are female	10	
	• Between 25 percent and 39 percent of participants in decision-making meetings are female	8	
	• Below25 percent of participants in decision-making meetings are female	5	
1.2	Ensuring women's participation in implementation decision making (tick any one)		8
	• 40 percent or more participants in decision-making meetings are female	8	

	• Between 25 percent and 39 percent of participants in decision-making meetings are female	5	
	• Below 25 percent of participants in decision-making meetings are female	3	
1.3	Programme monitoring team includes mandatory provision of women participants		2
2.	**Capacity enhancement of women**		**20**
2.1	Provision of capacity enhancement programme for women working at policy decision-making and policy implementation levels including leadership development • At least one basic training for the capacity development of the targeted women at the policy and decision-making level including leadership*(2) • At least one provision of refresher or advanced training for the capacity development of the targeted women at the policy and decision-making level including leadership*(1) • Provision of basic or refresher training for the capacity development of women involved in policy decision making bodies who are not MoHP staff e.g. elected representatives, civil society representatives. (1) * leadership training is counted as either conducted as stand-alone leadership training or leadership training integrated into other areas of training		4
2.2	Provision of capacity enhancement programme for women working at implementation levels • At least one provision of basic training for the capacity development of the targeted women working at the implementation level (2) • At least one provision of refresher or advanced training for the capacity development of the targeted women working at the implementation level (1) • Provision of basic or refresher training for the capacity development of women involved in implementation bodies who are not MoHP staff e.g. elected representatives, civil society representatives. (1)		4
2.3	Sex ratio of participants in capacity development sessions/programmes like seminar, short-term training, on-the-job training, sensitization and orientation programmes at the policy level (tick any one)		4
	• Excellent (40 percent or more are women)	4	
	• Moderate (25 to 39 percent are women)	2	
	• Ordinary (below 25 percent are women)	1	
2.4	Sex ratio of participants in capacity development sessions/programmes like seminar, short-term training, on-the-job training, sensitization and orientation programmes at the implementation level (tick any one)		8
	• Excellent (40 percent or more are women)	8	
	• Moderate (25 to 39 percent are women)	4	
	• Ordinary (below 25 percent are women)	2	
3	**Ensuring women's benefit and control in the programme**		**45**
Part A – *Increase in access to health information and services*			**20**

3.1	Setting up and operation of 'static outlet' in the underserved areas/communities [for example: birthing centre for women, BEONC, CEONC, ward clinic, community health service unit, added vaccination centre/sub-centre, urban health centre, primary health centre and hospital, passive case detection unit, extension services for laboratory and radiology services]	6	
3.2	Setting up and operation of mobile/outreach and satellite clinic for women focused on underserved areas/communities [for example: mobile clinic for women, outreach clinic, health service camp, temporary vaccination sub-centre, temporary urban health service camp, extended health services in the hospitals, extended services for uterus prolapse, active case detection services, extended services to respond to the needs of women affected from disasters and in emergencies]	6	
3.3	Programme activities to reduce barriers women face in accessing health information and services: • social and cultural and religious (3) • economic (3)	6	
3.4	Programme for increasing access of women through information technology [for example: telemedicine, mHealth, eHealth, online appointment system, different health-related apps]	2	
Part – 2	Utilization of health services by women		**15**
3.5	Ratio of women utilizing the service and getting benefits (tick any one)		
	• Excellent (40 percent or more)	15	
	• Moderate (25 to 39 percent)	10	
	• Ordinary (below 25 percent)	5	
Part – 3	Increasing the quality of health services for women (tick any one)		10
3.6	Programme support to increasing the quality of health services for women		
	Programme support to at least 7 out of 10 areas of NHSS health service quality enhancement	10	
	Programme support to at least 5 out of 10 areas of NHSS health service quality enhancement	7	
	Programme support to at least 3 out of 10 areas of NHSS health service quality enhancement	4	
	As per NHSS, quality enhancement includes: 1. Comprehensive regulatory framework and independent body for quality assurance and accreditation; 2. Update quality assurance policy for health sector and strengthen existing quality assurance mechanisms within MoHP; 3. Develop quality control mechanism for equipment; 4. Strengthen capacity of National Laboratory in regulation and quality assurance, as an international reference laboratory; 5. Strengthen National Drug Regulatory Authority capacity in regulation and quality assurance covering all pharmaceutical supplies; 6. Develop anti-microbial drug resistance action plan, including expanding laboratory capacity; 7. Review and implement regulatory system for combatting antimicrobial resistance; 8. Review and implement price adjustment of essential drugs and ensure transparency; 9. Review and enhance regulatory capacity for rational use of drugs, including over-the-counter sales. Collaborate with		

	Ministry of Agriculture to regulate the use of antibiotics in animals; 10. Establish quality assurance mechanism for Ayurvedic medicine production and supply.		
4	**Increase in employment and income generation for women**		**10**
4.1	Programme for reducing the malnutrition of women and under 5 children	2	
4.2	Programme for health promotion for enhancing healthy life of women	2	
4.3	Programme for management and rehabilitation of women living with disability	2	
4.4	Health programme that integrates employment generation for local women [for example: poultry, kitchen garden]	2	
4.5	Coordination and linkages to rehabilitation, skill development and income generating programme for female adolescents, disadvantaged women from Dalit, extremely poor, endangered communities and women survivors of gender-based violence	2	
5	**Qualitative improvement in the time and use by women and reducing workload of women**		**5**
5.1	Programme for reduction in the time women take to use health services [for example: provision for transportation services or outreach services like home visits for socially, culturally and psychologically disadvantaged women, such as disaster-affected women]	2	
5.2	Programme to reduce the waiting time for women to receive services through fast track services	2	
5.3	Programme for improved delivery of services through rapid diagnosis and treatment	1	
	Total		**100**

In accordance with the MoF GRB Manual, 2012, the health sector plan and programme gender classification will be based on the composite score of the indicators and sub-indicators as per the figure below.

Figure 10: Budget classification and coding

S.No.	Basis of Budget Classification	Classification	Budget Code
1	Total composite score of the weightage of different indicators scaled to 50 or more	Direct Gender-Responsive	1
2	Total composite score of the weightage of different indicators scaled from 25 to below 50	Indirect Gender-Responsive	2
3	Total composite score of the weightage of different indicators scaled to below 25	Gender Neutral	3

d Entry of budget codes into e-AWPB and LMBIS

After completion of the gender classification and coding of budgets, the gender codes are to be entered into e-AWPB and SUTRA; this data will be transferred to LMBIS in reporting.

e MoHP consolidation and review of budget proposals

At this step in the budget preparation stage, the GESI Section will a prepare fact sheet and policy brief for senior management with the aim of protecting gender and social inclusion budget items during the consolidation of spending proposals. This will include a trendline analysis showing incremental change in the direct gender responsive budget which is to be prepared by the Budget Development Team with GESI Section participation.

f Final sector programme and budget proposal submitted to NPC and MoF

After the MoHP has finalised the consolidated budget, PPMD with support from GESI Section will develop a policy brief for the Secretary MoHP showing the trend in GRB allocations.

PPMD will disseminate the gender and health policy brief to NPC and MoF to maintain the visibility of gender during budget decision-making.

4.5.5 Stage 3: Budget approval

After receiving the budget authorisation letter and instructions from the Ministry of Finance and National Planning Commission for the allocation of federal and conditional budget to the health sector programme to federal, provincial and local levels, the Ministry of Health and Population will set priorities and benchmarks based on the national targets. GESI Steering Committee and GESI Section will reinforce the importance of including gender priorities at this stage.

Once the national priorities and targets are set, PPMD will issue instructions to departments and spending centres/units to ensure trimester workplan and budgets include prioritised gender activities and budget items.

GESI Section will undertake an analysis of the difference in proposed direct and indirect gender responsive budget approved by the MoF.

4.5.6 Stage 4: Budget implementation

To support the implementation of gender actions and related budgets there may need to be revision in existing operational guidelines and tools or the development of new ones. This process will be undertaken by the relevant programme managers. A pragmatic and prioritised approach will be taken to revising guidelines and tools to ensure this does not overwhelm programme managers and negatively impact implementation.

4.5.7 Stage 5: Monitoring budget spending

a Sex-disaggregated information

Availability and analysis of sex-disaggregated data is critical for monitoring gender disparity in use of services such as child health, communicable and non-communicable disease through the HMIS and

tracking employment, promotion and capacity development opportunities of male and female staff through the HURIS. In Phase 1 an assessment of gender information gaps and a plan for correction will be undertaken for HMIS and HURIS. This is an essential step in creating the foundation for more robust gender responsive planning and budgeting.

b Direct monitoring

Programme supervision, field monitoring and field assessment of gender gaps and gender responsive activities will be integrated into existing monitoring arrangements at each level of the system to inform course corrections, future trimester AWPBs and programme review. Targeted field monitoring of gender budgeting will be carried out in less performing areas by the programme division to identify and resolve bottlenecks. Beneficiary assessments and participatory monitoring with community women including through social audit mechanisms will be undertaken.

c Indirect monitoring

Gender gaps in use of services, and the implementation of gender activities will be monitored via HMIS and programme reporting. Monitoring of the proportion of women in management and leadership positions will be tracked via HURIS. Monitoring of spending on directly gender responsive actions and any related unutilised fund will be monitored via TABUCS; this will flag bottlenecks that require programme management responses.

Internally, GESI section, financial administration section, monitoring section and the programme section will meet together every trimester to review and assess directly gender responsive expenditure and examine whether or not this is on target.

Monitoring of GRB will be included in the Ministry level Development Action Committee (MDAC) review of how national policy and strategies are being implemented[11].

d Periodic and annual review

In the course of every periodic and annual review of the programme and budget, review of the gender-responsiveness of expenditure will be undertaken. The depth and quality of this review will improve over time as capacity and experience is gained. To begin this is likely to focus on performance and expenditure of directly gender responsive activities at the different levels of government and draw on HMIS, TABUCS and HURIS data for this purpose. The review will identify problems in underspending and execution of gender responsive activities and solutions for better budgetary performance. Once evaluation and audit tools are strengthened in Phase 2, the evidence from these will feed into periodic and annual reviews.

One output of the periodic review will be a review of the performance of gender responsive budgeting facilitated jointly by PPMD and GESI Section. The report of the GRB review will be submitted to the Office of the Prime Minister and Council of Ministers, National Planning Commission and Ministry of Finance as well as being made available to the public.

[11]The MDAC is chaired by the Honourable Minister and includes MoF, NPC and related agencies and meets every two months.

4.5.8 Stage 6: Budget audit and evaluation

Implementing gender responsive budget audit and evaluation is not a priority focus of Phase 1. It is however suggested that during the redesign of the MoHP's social audit programme (as it is reframed to fit into the decentralised governance context) opportunity for the inclusion of participatory gender audit through a gender score card be considered (see Annex 2 for description).

The Office of the Auditor General may be requested to integrate a special focus on gender equity and effectiveness into the statutory audit. The programme division and the financial administration section of the Ministry will need to provide gender-related evidence and information to the auditor to assess financial performance from a gender perspective. The preliminary outcomes/report of the special statutory audit on gender performance should be shared with the programme management, monitoring and financial administration team of the Ministry and feedback received before the audit report is finalised.

4.5.9 Test case sites

The new and revised Phase 1 GRB methods presented in this guideline will be tested in selected sites to learn how the GRB process can work in the decentralised federal structure. Three sites will be selected to cover provincial and local governments and their respective planning and budgeting processes. The test case sites will receive dedicated support from the GESI Section which will facilitate a learning by doing approach to capacity enhancement of systems and staff capabilities. The test case sites will be supported and monitored for three years and learning used to inform the further development of gender budgeting methods, how to enable planning and budget coordination mechanisms between the three tiers of government to work effectively together on gender integration, to identify and strengthen information, planning and budgeting system gender gaps at sub-national level, and to learn how the effective participation of elected representatives, civil society and community women in the budget cycle can be strengthened. Opportunity to attract additional funding for targeted interventions by leveraging local government funding sources, including matching funds that favour women and poverty focused activities, will be explored.

4.6 Phase 2: Scaling up learning and using more rigorous budget tools

Monitoring and evaluation of the performance of the GRB tools and processes in Phase 1 will inform the design of Phase 2. It is anticipated that Phase 2 will include the continuation and adaptation of processes and tools developed in Phase 1 with strengthening of the gender assessment methods and gender audit and budget evaluation tools. More rigorous tools which may be introduced in Phase 2 include:

- Independent gender audit
- Sex-disaggregated benefit incidence analysis
- Gender sensitive public expenditure tracking survey
- Cost effectiveness analysis and cost-benefit analysis of gender interventions
- Sex disaggregated internal revenue analysis

See Annex 2 for a description of a range of gender audit and budget evaluation tools.

During Phase 2 it is planned that the categorisation of budgets into three domains of gender responsiveness will be expanded into four categories. A higher and additional category of directly gender responsive classification will be introduced. This will be labelled ‘exclusively gender responsive’ and will include budgets which score 80% and above on the gender classification method.

Chapter 5 Implementation and Monitoring and Evaluation of GRB

5.1 Implementation

5.1.1 Effective implementation of the Guideline

The following actions will be taken to enable the effective implementation of the Guideline:

a. Secure political and administrative commitment, support and cooperation for implementing the Guideline from senior management in the MoHP.
b. Sensitise stakeholders on the objectives and scope of the Guideline.
c. Activate and empower GESI committees at all levels of government to guide, coordinate, facilitate, monitor and evaluate implementation of the Guideline. The GESI Committee members will provide capacity enhancement.
d. Form and activate one technical group in PPMD to deliver technical advice and support for the implementation of gender responsive budgeting in the health sector at all levels.
e. Clarify responsibility and accountability of all divisions, sections and agencies involved in the implementation of the Guideline.
f. Carry out regular follow-up and review of gender responsive budget implementation in the health sector and integrate the review process with the periodic review of the plan and programme of the health sector and the review system of the National Development Action Committee and Ministry-level Development Action Committee.
g. Integrate gender responsive budget codes into e-AWPB.
h. Strengthen availability of sex-disaggregated data in HMIS and HURIS.
i. Set up a mechanism to manage documentation and information related to gender responsive budgeting in PPMD.
j. Develop costing framework for determining the unit cost of health service delivery and integrate such framework with the budgetary allocation linked to PPMD.
k. Promote vertical and horizontal collaboration between the three tiers of government (federal, provincial and local) and federal ministries (health, women, finance, federal affairs). This will include provincial and local levels collaborating directly with federal agencies.
l. Promote collaboration and partnerships between different agencies, different levels of government, stakeholder groups, elected representatives, civil society organisations, beneficiaries and development partners to secure contributions to implementation by enhancing ownership of the Guideline.
m. Revise the operating methods and procedural arrangements related to the programme and budget of the health sector to ensure harmonization with the Guideline.
n. Strengthen the institutional capacity of the GESI section of the Ministry to enable it to carry out coordination and facilitation of GRB and support implementation, monitoring, evaluation of the methods and advocate for gender related reforms.
o. Carry out continuous improvements in the Guideline by reviewing and evaluating the effectiveness of implementation.

5.1.2 Coordination and facilitation at provincial and local levels

This Guideline shall be used as the guiding document for gender responsive budgeting in the health sector at provincial and local levels. In line with the multi-level governance system enshrined in the Constitution, the following measures shall be adopted to coordinate and facilitate the realization of the Guideline in the design and implementation of gender responsive budgeting in the health sector of provincial and local governments:

a. Sensitize and advocate for the formulation, implementation, monitoring and evaluation of GRB under the leadership of the GESI committees/mechanisms at the provincial and local levels.
b. Create an enabling environment for GRB through a 'Memorandum of Understanding' with the Social Development Ministry of the provincial government and the respective local government for the implementation and institutionalization of gender responsive budgeting in the health sector.
c. Formulate and implement a localization strategy in a participatory and coordinated way for the development and institutionalization of GRB in the health sector at the local level.
d. Promote coordination and collaboration by conducting periodic meetings of GESI committees/mechanisms at all levels to review GRB implementation.
e. Develop information exchange network between the three tiers of government on GRB experiences and achievements and integrate such system with the existing health management information system.
f. Ministry will provide capacity development to Provincial level and Provincial level will roll out capacity development at local government levels.
g. Provide managerial and technical support to the agencies responsible for health sector plan and programme formulation and implementation at the provincial and local levels by the GESI committee and PPMD in a coordinated way.
h. Conduct gender responsive budget audit of the health sector at provincial and municipal levels and carry out measures for necessary reforms.

Figure 11: Coordination and harmonisation to support GRB at provincial and local levels

5.1.3 Roles and responsibilities of different agencies of the health sector

S.No.	Health-related agency	Role and responsibility
1	GESI Steering Committee, Ministry of Health and Population	a. Ensure the policy and plan of the health sector is gender-responsive and inclusive. b. Coordinate and facilitate gender analysis of health sector policy, plan and programme. c. Coordinate and instruct use ofGRB guidelines in the periodic and annual programme and budgeting system. d. Oversee formulation and implementation of training and capacity development plan for enhancing the capacity for GRB in the health sector. e. Coordinate provision of technical and managerial support to the GESI committees/mechanisms at the provincial and municipal levels to enable formulation, implementation, monitoring and evaluation and institutionalization of GRB. f. Review overall implementation of GRB guidelines and coordinate and facilitate necessary revisions and reforms. g. Support inclusion of a review of GRB implementation during the periodic review of health sector plan, programme and budget. h. Facilitate the strengthening of GRB in the health sector.
Policy, Planning and Monitoring Division, Ministry of Health and Population		
2	Policy and Planning Section	a. Mainstream gender in the policies, strategies and the planning system of the health sector. b. Prepare and include gender-responsiveness instructions in the formulation and implementation of periodic and annual plan and programme. c. Enforce GRB guideline in the annual and periodic planning and programming system. d. Prioritize plan and programme based on the gender analysis results of the health sector.

		e. Ensure inclusion of gender-responsiveness in the formulation and implementation of foreign aided plan and programme. f. Formulate plan and programme for gender budget-related capacity development of the institution and the human resources in the health sector. g. Coordinate and advise on issues related to the formulation of gender-responsive programme and budget. h. Carry out functions entrusted by the GESI Steering Committee of the Ministry.
3	Monitoring and Evaluation Section	a. Carry out gender analysis of the health sector and inform all relevant agencies of the results. b. Include the monitoring and evaluation of GRB in the monitoring and evaluation system of the health sector. c. Formulate action plan for monitoring and evaluation of the health sector according to the GRB guidelines and implement accordingly. d. Carry out cost-effectiveness assessment, cost-benefit analysis and cost utilization analysis of the budget expenditure of the plan and programme of the health sector in line with the concept of gender-responsive budgeting. e. Review the implementation of GRB during the periodic review of programme and budget of the health sector. f. Identify capacity requirements for monitoring and evaluation in line with the demands of GRB and coordinate capacity development. g. Strengthen sex-disaggregated information management system. h. Make arrangement for studies and research on the effectiveness of GRB implementation. i. Conduct gender audit of the health sector.
Administration Division, Ministry of Health and Population		
4	Financial Administration Section	a. Ensure gender-responsiveness in the formulation of financial policy and budget preparation and implementation. b. Enforce gender-responsive budgeting guidelines in the annual and periodic budgeting system. c. Carry out necessary coordination in relation to financial administration in pursuit GRB. d. Coordinate capacity development of the employees of financial administration section on GRB.
Population Management and Information Division, Ministry of Health and Population		
5	GESI Section	a. Carry out necessary coordination and facilitation to ensure the policy and plan of the health sector is gender-responsive and inclusive; b. Coordinate and facilitate gender analysis of the health sector policy, plan and programme. c. Advocate for GRB in the health sector. d. Facilitate implementation of GRB guidelines in the periodic and annual programme and budget. e. Coordinate and facilitate technical and management support to the GESI committee/mechanism of the provincial and municipal governments to develop the capacity and institutionalization of GRB formulation, implementation, monitoring and evaluation. f. Coordinate and facilitate necessary revisions and reforms based on a review of the implementation of GRB guidelines. g. Include the review of the implementation of gender-responsive budget during the periodic and annual review of the health sector plan and programme. h. Implement strengthening of GRB in the health sector as instructed by the GESI Steering Committee.
Provincial Government		
6	Ministry of Social Development	a. Adapt GRB in the health sector at local level. b. Formulate budget through GRB lens. c. Give high priority to direct gender responsive budget items in budgetary exercise.

		d. Develop capacity on GRB. e. Conduct women leadership development at provincial level. f. Promote women participation in decision making. g. Provide oversight support to GRB. h. Analyse service statistics by sex.
Local Governments		
7	Local Governments	a. Adapt GRB in the health sector at local level. b. Undertake gender responsive planning and budgeting exercise and include locally generated resources. c. Give high priority to GRB in the operational plan. d. Conduct women leadership development. e. Promote women participation in decision making. f. Report sex disaggregated data.
Civil society		
8	Academia and research institutions	a. Provide high priority to gender equality and gender mainstreaming in health research. b. Generate sex disaggregated evidence. c. Increase evidence base on women's health. d. Provide more opportunities to female researchers for capacity development.
9		a. Advocate and lobby at local level to increase the funding to women's health. b. Provide support to participatory gender assessment. c. Facilitate link between women/mother's groups and government organisations. d. Promote women participation in planning and budgeting process. e. Participate in monitoring of GRB. f. Undertake capacity development programmes for women.
Community		
10	Community people	a. Participate in situation analysis, priority setting and local resource mobilization. b. Promote the participation of FHCVs in local level planning. c. Promote the participation of women in social audit and public hearing.

5.1.4 Non-government health stakeholders

a. Health-related civil society organisations, community organisations, health user groups, private sector organizations, etc. shall provide necessary support and apply creative pressure to prioritise gender-responsive budgeting during budget formulation, result-oriented implementation, and budget and programme monitoring and evaluation. Stakeholders will support the continuous improvement of gender-responsive budgeting.

b. International cooperation institutions and development partners shall prioritise inclusion of GRB in their assistance to the health sector, and provide necessary technical and managerial assistance.

5.2 Training and capacity development for the formulation and implementation of GRB

The following actions shall be undertaken to develop the institutional and functional capacity related to gender-responsive budgeting in the health sector and ensure the effective implementation of the Guideline at all levels:

a. Conduct institutional capacity assessment of the institutions responsible for the implementation of GRB at the federal, provincial and local levels.

b. Undertake a needs assessment to inform the design of GRB training including the capacity enhancement needs of trainers to deliver GRB training at all levels. Develop standardized curriculum and training manual for capacity development.
c. Conduct training of trainers in GRB in the health sector and formulate programme to use the trained persons as trainers at the provincial and local levels for imparting training on GRB.
d. Entrust the responsibility of providing GRB training to the National Health Training Centre of the Ministry of Health and Population.
e. Include GRB in all training curricula and the training methods of all health-related trainings.
f. Carry out continuous improvements based on evaluation of the effectiveness of the gender responsive budgeting training.

5.3 Operational manual and tools to be developed

a. Operational manual and toolkit to support implementation of GRB Guideline.
b. Training manual on GRB.
c. Strategy to sensitise stakeholders on GRB through information, education and communication materials.
d. Manual on the collection and use of sex-disaggregated data for gender responsive budgeting.
e. Assistance to provincial and municipal governments for the preparation of GRB related materials.

5.4 This Guideline shall serve as the directives

The Constitution of Nepal has entrusted the power to govern to the three tiers of government including the authority to formulate and execute policies, laws, plan and programme and budget as per their respective needs. In this respect, the governments of the respective levels may regard this guideline as directives for gender responsive budgeting and inclusion of gender priorities in formulating, implementing, monitoring, evaluating and auditing the health sector plan, programme and budget.

5.5 Amendments and revisions to the Guideline

a. Implementation of the federal governance structure as set out in the Constitution, policy, and law-making efforts are on-going. Structural reforms including legal and procedural arrangements at different levels are in progress. In this context, it will take time before the appropriateness of this strategy for GRB can be assessed. Once the policy, legal and structural systems are established at all levels of government, it will be necessary to harmonise the GRB Guidelines with those set-ups and systems. The Guideline will therefore be reviewed and revisions made accordingly when appropriate.

b. The Guideline shall endure as a dynamic document and necessary review and revisions to the Guidelines shall be carried out based on the feedback received and the recommendations made by the GESI Steering Committee of the Ministry. The Ministry shall ensure necessary coordination and harmonisation between the federal, provincial and local levels by requesting reviews of the Guideline and consequent revisions be carried out by the provinces and local governments in a timely way.

5.6 Provisions to remove difficulties

If any difficulty in the form of obstacles, problems, or ambiguities arises in connection with the execution of the Guideline, the Ministry may, upon the recommendation of the GESI committee address and resolve such obstacles or problems or ambiguities on a priority basis. The Ministry may interpret, add, amend, and make changes on the provisions of the Guideline as and when required in a participatory way.

5.7 Implementation plan for GRB

The implementation plan for implementing the GRB Guideline is presented in Annex 4.

5.8 Monitoring and evaluation of GRB

The monitoring and evaluation indicators for gender responsive budgeting in the health sector are guided by the goals and objectives of the National Health Policy, 2015, Nepal Health Sector Strategy, 2016-2020, Gender and Social Inclusion Strategy of the Health Sector, 2018 and the Gender Responsive Budget Formulation Guidelines, 2012. On the basis of those guiding documents, the health sector results indicators for GRB are presented below. Process monitoring indicators are included in the Implementation Plan for GRB in Annex 4.

Figure 12: Results framework for gender responsive budgeting

Achievement indicators	**Base year**			**Target**			**Means of verification**	**Assumptions**
	Data	Year	Source	2020	2025	2030		
Federal level budget allocation								
Direct gender responsive budget in percentage	6	2017	Budget analysis report, MoHP	10	20	30	Budget analysis report MoHP	High level political and administrative commitment for GRB Macro economic policy remains unchanged Institutional harmonization of three government tiers and no substantive change in existing structure
Indirect gender responsive budget in percentage	57			60	55	50		
Neutral budget	37			30	25	20		
Result indicators								
Percentage of women reaching the nearest health facility within 30 minutes of traveling time.	61.8	2011	NLSS	70	85	95	NLSS	
Women clients as a proportion of total outpatient visits excluding human reproduction, Obstetric/gynaecological related services	NA		Annual report of DoHS		45	50	Annual report of DoHS	

Participation of women in HFOMC (HP) in % 4 out of 11 is baseline benchmark	27%	2013	Household Survey 2013	33	40	50	Household Survey	Provincial and local level governments adapt GRB to their context and adopt in policies and systems HMIS generate routine sex disaggregated data Development of HURIS undertaken by MoHP Availability of adequate budget
Percentage of women who make decisions about their own health care by herself (empowerment)	23.3	2016	NDHS	40	50	60	NDHS	
Percentage of senior management positions (Grade 11+) filled by women at Federal level			HURIS				HURIS	

Annex 1: Institutional Arrangements of Gender Responsive Budgeting as per the Ministry of Finance Gender Responsive Budgeting Manual, 2012

Gender Responsive Budget Committee (GRBC)

In line with the initiation of gender-responsive budgeting in Nepal, the Government's 2005-06 budget statement stipulated the formation of a GRBC as the high-level body within the Ministry of Finance with the following members at present:

Joint Secretary, Budget and Programme Division, Ministry of Finance	Coordinator
Under Secretary, National Planning Commission	Member
Under Secretary, Ministry of Women, Children and Senior Citizens	Member
Under Secretary, International Economic Cooperation Coordination Division Ministry of Finance	Member
Under Secretary, Ministry of Federal Affairs and General Administration	Member
Deputy Financial Comptroller General, Financial Comptroller General Office	Member
Under Secretary, Budget and Programme Division, Ministry of Finance	Member

The terms of reference of the GRBC are as follows:

1. To monitor patterns of budget allocation and implementation to make the budget gender-responsive
2. To evaluate public expenditure from gender perspective
3. To regularly analyse the impact of economic policies on women and incorporate the findings in the economic survey
4. To strengthen the capacity of gender focal points and planning divisions of the sectoral ministries responsible for budgeting
5. To disseminate information on GRB for providing inputs to the government to make the budget gender-responsive.

As the dedicated governing mechanism, the GRBC is engaged in the institutionalization of the GRB in all the sectors of development with capacity development of planning divisions and gender focal points across Ministries, harmonization of budget formulation process, revision in budget forms, manual and software like Budget Management Information System (BMIS), Line Ministry Budget Information System (LMBIS) to make them compatible with GRB system.

Sectoral Gender-Responsive Budget Committee

The MoF GRB Manual, 2012 directed the formation of a Gender Responsive Budget Committee at the sectoral level under the convenorship of the Chief of the Planning Division responsible for plan and budget formulation. The Committee was to include representation of related section heads. The objective of the Committee is to make the sectoral plan, programme budget gender-responsive, identification and analysis

of gender disparity and women empowerment in the plan, programme and budget. In the health sector this committee has not been effective because of the lack of gender responsive budget-related conceptual, technical and practical knowledge and skill, absence of an enabling institutional environment and lack of sex-disaggregated data.

Gender-Responsive Budget Implementation Committee for facilitation at the local level

The Gender Responsive Budget Localization Strategy, 2015 has formed the Gender Responsive Budget Implementation Committee at the Ministry of Federal Affairs and General Administration under the convenorship of the related division chief with representation of related section heads. The objective of the committee is to make the sectoral plan, programme and budget of the local level gender responsive by identification and analysis of gender disparity and women empowerment in the plan, programme and budget formulated by the local level and the local level sectoral agencies and other relevant actors.

Gender Focal Point

The Government of Nepal, under the umbrella of the Ministry of Women, Children and Senior Citizens, has set up Gender Focal Points (GFPs) in all ministries and national level government agencies to expedite the process of gender mainstreaming in the respective agencies. Being the national women's machinery and national gender equality agency, that Ministry coordinates, supervises, facilitates and develops the capacity of GFPs. GFPs where functional are expected to support GRB.

Annex 2: Description of Gender Budget Tools

Priority tools for Phase 1

<table>
<tr><th>Tool</th><th colspan="3">Explanation</th></tr>
<tr><td colspan="4">Policy review and sector spending appraisal: Evidence-based formative assessment of policy and impact on gender equality and women's empowerment to support sector spending proposal with priority, technical justification and assurance for optimised use of budgetary resources in achieving the desired results.</td></tr>
<tr><td>1. Policy appraisal for gender equality and women's empowerment</td><td colspan="3">The appraisal involves scrutinizing the explicit and implicit gender implications of national and sectoral policies, and examining the ways in which priorities and choices are likely to reduce or increase gender inequality. It looks at policies and programmes funded through the budget from a gender perspective and tries to seek answers related to the following questions:
• In what ways are policies and strategies and their associated resource allocations likely to reduce or increase gender inequalities in health?
• How the budgetary policies have addressed and prioritized the differential needs and concerns of women and men?
• How the gender responsive budget contributes to poverty reduction, achieving universal health coverage and meeting sustainable development goals?
• How the gender responsive budget increases women's access to and utilization of quality health services?
• What are cost-effective strategies and interventions for meeting the health needs of women, men, girls and boys?
For clarifying the above-mentioned issues, a policy brief of the health sector should be prepared to advocate and sensitise the policy makers on the health-related gender equality needs and concerns.
<u>Indicator for Appraisal</u>
"Increase in the access and utilization of health services by women and girls of deprived, Dalit and endangered caste and ethnicity (Contribution to achieving universal health coverage)."</td></tr>
<tr><td>2. Gender-aware Medium-Term Expenditure Framework</td><td colspan="3">• This tool enables the health sector to incorporate gender variables into the medium-term expenditure framework and medium-term budgetary framework.
• In this framework, the gender disparities, gender needs, gender priorities and prioritised interventions drawn as inference on the basis of gender-aware policy appraisal, gender analysis and gender audit should be included.
• Likewise, for ensuring high-level priority is given to gender equality issues in the health sector, evidence-based policy advocacy is required, and for which a policy brief needs to be prepared to sensitize policy makers on the budgetary aspects related to gender equality in health.
• Assured commitment to continuity in funding from economic policy framework.</td></tr>
<tr><td colspan="4">M and E Indicator</td></tr>
<tr><td>Indicator</td><td>Monitoring frequency</td><td>Source</td><td>Responsibility</td></tr>
<tr><td>Percentage of needs and concerns identified by the gender analysis addressed by the MTEF in the gender-responsive budget</td><td>Once in a three-year period</td><td>Gender analysis
Review/Evaluation of MTEF</td><td>1. Policy plan section
2. GESI section
3. Monitoring and Evaluation section
4. Financial Administration Section</td></tr>
<tr><td colspan="4">Budget formulation</td></tr>
<tr><td>3. Programme and budget formulation</td><td colspan="3">• The programme and budget in the health sector are prepared on the basis of the priorities, strategies and the key interventions as determined by the medium-term expenditure framework.
• The health sector gender-responsive budget statement should be prepared with corresponding strategy for budgetary dialogues at the Ministry of Finance and the National Planning Commission. Such statement should include information on the share of total expenditure targeted to gender equality programmes, gender balance in health services, the share of expenditure devoted to the specific needs of women and men from health services, capacity development and empowerment of women in health.</td></tr>
</table>

	• It needs evidence-based advocacy and justifications to mitigate the risk of curtailing the budget amount proposed. • It needs objective means to monitor and track programme and budget approval process based on checklist.
4. ***Rapid gender assessment***	• Rapid gender assessment led by concerned divisional and programme teams at their respective level of operation. • Three methods are provided in this Guideline and are to be selected according to context and capacity of planning team.
5. ***Priority setting process***	• Based on the findings of the rapid gender assessment and the availability of supporting evidence reviews and data, the programme and planning team undertake a participatory prioritization of gender responsive actions. This takes into consideration how the programme contributes to achieving national gender objectives, the impact of gender gaps on the performance of the programme, the budget envelope and opportunity to leverage additional funding especially from local government funding streams and development partners.

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Percentage of gender-responsive budget for each programme reduced during approval in comparison to the budget proposal	Once in a year	Proposed and approved budget	1. Policy plan section 2. GESI section 3. Monitoring and Evaluation section 4. Financial Administration Section
Number of gender equality points mentioned in the budget statement	Once in a year	Budget statement	Policy plan section, GESI section, Monitoring and Evaluation section, Financial Administration Section

Budgetmonitoring

6. ***Beneficiary assessment***	This is a participatory approach to monitor the benefit of the programme and budget. It involves exploring the extent to which health programmes and service deliveries match the priorities and needs of actual or potential women, men, girls and boys. This can be done through opinion polls, attitude surveys, focus group discussions or key informant interviews. Questions may focus on the overall priorities for health service spending or upon the details of the operation of health services.

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Percentage of women responding back that the budget expenditure is on track for meeting the needs of target beneficiaries	Once in 3 year	Beneficiary assessment	GESI section
Percentage of women with response that the quality of service delivered is excellent	Once in 3 year	Beneficiary assessment	GESI section

7. ***Supervision and field monitoring and field assessment***	This is the programme management tool to ensure implementation capacity for the achievement of quality results. The following measures shall be applied for this • Responsibility given to supervision team to monitor the implementation of gender responsive budget: expenditure and revenue tracking. • Supervision of the quality of gender responsive health services delivered. • Institutional capacity to deliver quality services shall be assessed. • Clientele survey to assess the satisfaction and impact level shall be done.

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Percentage of expenditure in gender responsive budget during the trimester	3 times in a year	Integrated supervision report	Supervision team

8. ***Online Monitoring***	The expenditure and benefit of the health sector programme and service delivery interventions of the gender responsive budget can be monitored by using TABUCS with

	online data networks. This paves way for programme evaluation and review for objective resource transfer in making the health services effective.
Gender audit and budget evaluation:	
9. ***Participatory gender budget audit by beneficiaries and stakeholders***	• Participatory gender budget audit involves the active engagement of beneficiaries and stakeholders in the auditing of the programme and budget from gender perspective. This is also known as social audit. • This method takes into account the objective data and beneficiary perceptions of the achievement of gender results. It often includes the public sharing of findings and conclusion of the social auditing with the participation of beneficiaries and stakeholders. • Gender score card can be used to draw inference on the average score of health sector budget implementation and benefits. • Gender scoring can be done on increasing the access of women to quality health services, utilization and benefits by women, quality enhancement in health service delivery, expansion of the coverage of women's health services, capacity enhancement of women and increasing meaningful participation of women in health sector programme management and service delivery system. • Focus group discussions and key informant interview can also be used to triangulate the data and information.

Additional tools for Phase 2

Tool	Explanation
Gender audit and budget evaluation	
1. ***Sex-disaggregated public expenditure incidence analysis***	**Expenditure tracking for spending performance** • This is a useful tool for helping to assess the gender distribution of health sector public spending and benefit incidence analysis. • It compares public expenditure from a given programme with data from household surveys to reveal the distribution of expenditure between women and men, boys and girls. • This tool can also suggest the gender impact of supposedly gender-neutral budget cuts. • This needs gender/sex disaggregated data on public expenditure in the health sector. • This requires costing framework and unit cost for each health service. • The expenditure trend lines should be analysed and monitored to ensure the gender-responsive share of expenditure for women and men. • Use of eAWPB and TABUCS for allocation and expenditure on women's health. **Benefit Incidence Analysis** • The benefit of health sector expenditure from the perspective of different economic groups, ethnic groups and geographical regions should be monitored. • How much benefits are utilized by women and men from the health services should be tracked. In this, the grant and expenditure targeted to funding women's specific health needs like reproductive health should be deducted. • The expenditure benefits to women should be analysed and monitored on the basis of inter-sectionality of women groups.
Formula for benefit incidence analysis (Total public expenditure in health service – total service cost) _____ Total units of health service delivered	
M and E Indicator	

Indicator	Monitoring frequency	Source	Responsibility
Percentage of directly gender-responsive budget in total budget expenditure	Once a year	TABUCS	Policy and plan section Monitoring and evaluation section

Percentage of indirect gender-responsive budget in total budget expenditure	Once a year	TABUCS	Policy and plan section Monitoring and evaluation section
Percentage of gender-neutral budget in total budget expenditure	Once a year	TABUCS	Policy and plan section Monitoring and evaluation section
Percentage of government/donor component in gender-responsive budget expenditure	Once a year	TABUCS	Policy and plan section Monitoring and evaluation section
Percentage of expenditure in women and men in monetary units	Once in 3 years	Review and analysis report of public expenditure	Health Economics and Finance Unit
Percentage of benefit incidence by males and females in public expenditure	Once in 3 years	Review and analysis report of public expenditure	Health Economics and Finance Unit

2. ***Gender-sensitive public expenditure tracking survey***	This survey is a tool for targeted expenditure tracking that tracks the fund flow in the implementation of health programmes and health service delivery. This also tracks the problems in making targeted expenditures. This establishes the relationship between the expenditure and service utilization by women with focus on objective use of the budget amount. This requires sex-disaggregated data on the expenditure and benefit of the health service intervention. This tries to seek information on the following questions for monitoring and tracking purposes: • The budget allocated for gender equality programmes is used for the same purpose or not? • The budget amount allocated for gender equality has reached down to the field level health facility or not? Reached down to the ward level or not? Reached down to targeted women community or not? How much of the budget has been allocated and used for women and men? • How the budget allocated for free healthcare services and free medicines has been utilized by women and men? • What are the delaying factors, problems, barriers in reaching the budget down to the target communities? • Does the Comptroller General Office monitor the sectoral fund flow and expenditure tracking or not?

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Percentage of expenditure targeted to women	Once in 3 years	Review and analysis report of public expenditure	Policy and plan section Monitoring and evaluation section Financial administration section

3. ***Sex-disaggregated internal revenue analysis***	• This tool examines direct and indirect taxes and user fees to calculate how much tax/user fees are paid by women and men to use health services. • This analysis focuses on the gender-differential effects of tax/user fees paid by women and men. • This also analyses the use of such revenues in women-related services. • This requires sex-disaggregated data on revenue generated from the health services and the use of revenue source.

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Percentage of revenues from women in total internal revenue (user fee)	Once a year	Review and analysis report of public internal revenue	Programme and budget section Monitoring and evaluation section Financial administration section

Percentage of revenues from men in total internal revenue (user fee)	Once a year	Review and analysis report of public internal revenue	Programme and budget section Monitoring and evaluation section Financial administration section
Percentage of user fees in women-related services	Once a year	Review and analysis report of public internal revenue	Programme and budget section Monitoring and evaluation section Financial administration section

4. **Sex-disaggregated impact of the budget on time and use**	This tool examines the relationship between the health sector budget at federal, provincial and local levels and the way time is used by women in the households and the community in relation to the presence or absence of that health service. In particular, it draws attention to the ways in which the time spent by women in seeking health is accounted for. This monitors the following impacts of health system on time and use by women • Impact on women by service use • Increased number of health service users • Impact on reproductive health • Impact on maternal mortality • Economic, cultural, social and psychological impact on women • Changes in trend lines Apart from these, impact on the level of empowerment of women, capacity enhancement of women, participation of women in health, access of women to resources, ownership and control of women over resources, impact on poverty reduction are also monitored. For the assessment, the International Initiatives for Impact Evaluation -3ie method and Spectrum 5.72 version software can be used.

M and E Indicator

Indicator	Monitoring frequency	Source	Responsibility
Impact/change of Rs 1 million budget on construction or upgradation of primary health centres, (leading to reduced waiting times for pregnant ladies and better quality of care)	Once in 5 years	Impact evaluation report of public expenditure on time and use	GESI section
Impact/change of Rs 1 million budget on mobile messaging to mothers/parents as reminders, to track health (immunization) outcomes and savings because of reduced visits	Once in 5 years	Impact evaluation report of public expenditure on time and use	GESI section
Impact of Rs. 1 million budget on One Stop Crisis Management Centres for victims of violence in saving time, money and energy and building confidence and improving mental health	Once in 5 years	Impact evaluation report of public expenditure on time and use	GESI section

5. ***Independent Assessment***	An independent or third party assessment shall be done to examine the contribution of gender-responsive budget expenditure in increasing the access of women to quality health services, increasing the incidence of service use and expanding the coverage of health services for women, enhancing the quality of health services for women, capacity development of women and increasing meaningful participation of women in policy and decision making with respect to health programming and execution along with the monitoring of health services.
6. ***Special auditing by the Office of the Auditor General***	• Gender budget audit examines the formulation and execution of GRB from the perspective of efficiency, participation, benefits and impacts with respect to the achievement of gender equality along with the weaknesses in the implementation of the budget.

	• Constitutional provision to carry out statutory audit of public sector programme and budget by the Office of the Auditor General on the basis of regularity, economy, effectiveness, efficiency and rationale.
	• The basis of auditing is comprised of financial, performance, compliance and special focus audit (gender equity, gender efficiency and gender effectiveness).
	• Gender-responsive budget audit is done with special focus on gender performance of the budget by using gender lens with the application of special tools and techniques of auditing. For example, the audit examines:
	  ○ How women and men are benefitted from free health services or from the deprived people health care fund?
	  ○ How the budget is distributed and utilized for addressing gender gaps in health?
	  ○ What is the budget management capacity of the institution responsible for gender equality in the health sector?
	  ○ What are the key gender equality results in the health sector from the implementation of the plan and programme?
	  ○ What is the effectiveness of health service delivery on improving women's health?
	• The [policy and plan division and the financial administration section of the Ministry should provide gender-related evidence and information to the auditor to manage queries and the raised questions on the financial performance from the gender perspective. There should be timely response on the queries and questions raised with respect to the gender performance of programme and the budget. Special effort should be done to expedite the clearances of the audit irregularities.
	• The preliminary outcomes/report of the special statutory audit on gender performance should be shared with the programme management, monitoring and financial administration team of the Ministry and receive feedback before finalizing the audit report.

7. ***Independent audit by the group of gender experts***	• It is an independent and evidence-based technique to examine the relevance, compliance and performance of the budget and provides a way of assessing the impact of government revenue and expenditure on the health of women and men, girls and boys. • Gender audit plan should be formulated succeeded by the scope of work and terms of reference, selection of expert team and assignment for the audit work. • The audit can be done for the whole health sector or sub-sector specific (e.g. sexual and reproductive health) or programme specific (e.g. HIV/AIDS prevention).

Annex 3: Sex Disaggregated Information Management Systems and Analysis

The gender-disaggregated information management system is a logical and systematic process of planning with development of indicators, acquisition, processing and analysis, dissemination and utilization, updating and improvement of the information with clear stratification on the basis of women and men.

S.No.	Components of Information System	Activities
1	Information Management Planning	• Strategic planning exercise • Objectives of the gender-responsive budget • Identification of key results • Development of monitoring and evaluation indicators • Strategies and action plan for information management
2	Information collection and aggregation	• Development of data collection instruments and tools • Qualitative and quantitative data • Collection and aggregation of data • Primary and secondary sources, documentary and people sources • Health institution-related, service delivery system-related, access to health service-related, beneficiary-related data • Economic and financial data from TABUCS and LMBIS • Sources like HMIS, NDHS, NHFS, HuDICS, LMIS • Source like public expenditure analysis reports and annual financial reports • Field study reports from independent sources • Gender audit reports • Quality, objectivity, adequacy and appropriateness of data
3	Processing and analysis of information	• Development of data processing and analysis tools and instruments • Processing and analysis of data by using appropriate software • Bi-variant and multi-variant analyses • Gender-disaggregated processing and analysis based on inter-sectionality of women and men
4	Dissemination and utilization of information	• Strategies and plan for dissemination and use of information • Encouragement, advocacy and sensitization in use of data • Use in formative assessments and ex-post assessments • Use in formulation, implementation, monitoring and evaluation of gender-responsive programming and budgeting • Integration with programme and budget review system
5	Feedback, updating and reforms	• Review of the adequacy and appropriateness of the data system • Feedback

		• Recommendation and reform actions • Updating and improving • Institutionalization of gender-disaggregated information management system • Capacity enhancement of institutions and human resources

Annex 4: Three Year Implementation Plan for Gender Responsive Budgeting

S.No.	Action to be taken	Responsible Agency		3-year time plan												Monitoring indicator
		Principal Agency	Supporting Agency	Trimesters												
				1	2	3	4	5	6	7	8	9	10	11	12	
A.	**Orientation on gender-responsive budgeting guidelines**															
1	Prepare informational booklet on GRB in the health sector	GESI Section	Policy Planning Section													Booklet prepared and disseminated
2	Orientation on the GRB toolkit and how to implement the GRB guidelines	Policy Planning Section	GESI TWG/Section													Toolkit on GRB Sensitization on GRB
B.	**Analysis of institutional capacity and human resource development**															
3	Internal institutional review of GRB and GESI.	Policy Planning Section	GESI TWG/Section													Report prepared on institutional review
4	GRB capacity assessment of the Ministry, Department, Social Development Ministries of the Provinces	Health Directorate of the Province	GESI TWG/Section													Report prepared on capacity analysis
5	GRB capacity assessment of the local levels	Health Directorate of the Province	GESI TWG/Section													Report prepared on capacity analysis
6	Training need analysis on GRB in the health sector	NHTC	GESI TWG/Section													Report prepared on training need analysis
7	Preparation of training of trainers' manual on GRB	NHTC	GESI TWG/Section													TOT manual prepared
8	Conduct MTOT at the federal level	NHTC	GESI TWG/Section													20 trained master trainers produced
9	Conduct TOT at the provincial level	NHTC	Provincial Health Directorate													70 trainers produced
10	Include GRB in health-related training curriculums	NHTC	GESI TWG/Section													Inclusion of GRB in all health-related training curricula
C.	**Coordination and facilitation at the provincial and local levels**															

11	Organise joint meeting at the provincial level for implementing GRB	GESI Section	Provincial Health Directorate													Mutual understanding developed for GRB implementation in all provinces
12	Organise joint meeting at the local level for implementing GRB	Provincial Health Directorate	GESI TWG/Section													Mutual understanding developed for GRB implementation in all local levels
13	Formulate strategy to implement GRB at provincial and local levels	Policy Planning Section	GESI TWG/Section													Implementation strategy formulated
D.	**Conduct rapid gender assessment and priority setting of gender actions for budget formulation**															
14	Conduct rapid gender assessment at programme and sub-sector level	Monitoring Section	GESI TWG/Section													Gender assessment completed
15	Priority setting for the GRB in the health sector on the basis of the rapid gender assessment	Policy Planning Section	GESI TWG/Section													Prioritisation of gender actions produced
16	Interventions/activities for increasing the access and use of women to health services and enhancement of the quality of the health services to women included in budget	Policy Planning Section	GESI TWG/Section													Interventions identified for increasing the access and quality health service for women
17	Action for increasing the participation of women in senior management/leadership included in budget	Policy Planning Section	GESI TWG/Section													Action identified for increasing the participation and leadership roles of women
18	Action to promote gender equitable and inclusive workforce and workplace included in budget	Policy Planning Section	GESI TWG/Section													Action identified for gender equitable and inclusive workforce and workplace
19	Formulating action plan for making the health institutions gender-friendly	GESI Section	Provincial Health Directorate													Action plan for gender-friendly health institutions formulated
E.	**Conduct participatory gender monitoring of spending and participatory gender audit**															
20	Conduct beneficiary assessments and participatory gender	Monitoring Section	GESI TWG/Section													Beneficiary assessment report and participatory gender monitoring

	monitoring including field assessments																and field assessment report
21	Conduct participatory gender audit of the health sector	Monitoring Section	GESI TWG/Section														Participatory gender audit report prepared
22	Reform plan formulated on the basis of participatory monitoring and gender audit report	Monitoring Section	GESI TWG/Section														GRB reform plan
F.	**Strengthening sex-disaggregated information of the health sector**																
23	TOR developed to assess sex-disaggregated data gaps and strengthen sex-disaggregated information in the HMIS	Monitoring Section	GESI TWG/Section														TOR developed
24	Develop indicators for the integrated monitoring of GRB	Monitoring Section	GESI TWG/Section														Indicators developed for monitoring
25	Strengthening sex-disaggregated data	Monitoring Section	GESI TWG/Section														Sex-disaggregated information availability strengthened
26	Integrating sex-disaggregated data into the health management information system	Monitoring Section	GESI TWG/Section														Gender harmonization in information management
G.	**Implement testing of GRB methods in selected sites**																
27	Design and plan testing	PPMD	GESI TWG/Section														Design document
28	Implement and continuous review and learning	PPMD	GESI TWG/Section														Periodic review reports

Annex 5: Priority Setting of Gender Actions at the Programme Level

National gender priorities	Score how the programme directly contributes to national gender priorities: scale of 1-4 with 1 being low and 4 being high	List gender gaps in the programme as per the domains of the national gender priorities. Score gaps for degree of exclusion: 1=single exclusion, 2= double exclusion, 4= triple or more exclusions	Score the impact of the gender gaps on programme outcomes: scale of 1-4 with 1 being low and 4 being high	Identify solutions to the gender gaps	Score the cost of each gender solution on a scale of 1-4 with 1=major cost; 2=sizeable cost; 3=minimal cost; 4=zero cost	Rank priority order of gender actions. Aim for high impact actions that can be accommodated within the budget envelope of the program or can pull in additional resources
Health outcomes: • Improve reproductive and maternal health • Improve women's nutrition and anaemia • Improve gender equitable child health						
Equitable utilisation of quality health services • Gender responsive services • Reduce the barriers to access • Targeted interventions for underserved/disadvantaged • Improve health response to GBV survivors						
Increase women's participation in decision making and management forums						

Reduce the gender disparity in leadership in the sector						
Create a gender equitable and inclusive workforce and workplace						
Institutionalise gender into the information, planning and budgeting systems including sex-disaggregated data						

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