NHSSP Nepal Health Sector Support Programme

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Assessment of Gender Equality and Social Inclusion (GESI) Mainstreaming Training (2014/15) in Nepal's Public Health Sector

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Foreword

The government of Nepal is strongly committed to mainstreaming gender equality and social inclusion (GESI) in the health sector. GESI is seen here not as a goal in itself but as a pragmatic approach to integrating equity objectives within policy decisions, legal frameworks, programme strategies, monitoring frameworks and community level activities. GESI mainstreaming is therefore a principal means by which access to and utilization of health services can be increased and those disparities that inhibit service delivery for women and poor and excluded groups, systematically tackled.

Considerable progress has been made by the Ministry of Health (MoH) in creating an enabling environment for GESI including establishing an institutional framework for mainstreaming. The ministry has further recognised the fundamantal importance of strengthening the capabilities of government staff at all levels if GESI objectives are to be advanced. Building a common understanding of GESI principles and working to change deeply set attitudes prevelant in society are long-term processes that MoH recognises must be addressed at both institutional and systems levels and, critically, during the orientation and training of government staff.

GESI training has been used as an educational tool to enhance the capabilities of policy-makers and service providers to mainstream GESI at all levels. To date, more than 2000 service providers (health facility in-charges, district supervisors, district (public) health officers (D(P)HOs), staff nurses, one stop crisis management centre (OCMC) and social service unit (SSU) focal persons) from 31 districts have been trained. The main focus of this training has been to ensure that key actors and especially those involved in policy-making and service delivary are GESI-aware, enhance their GESI expertise and are able to mainstream GESI on a day-to-day basis in their work places.

Reflecting the high priority given to GESI by government, this evaluation has been commissioned to better understand the effectiveness of GESI mainstreaming training and how to improve such training and support in the future. In assessing the effectiveness of training, the consultants have identified capacity gaps and made recommendations based on the insights of multiple respondents including service providers who have previously received the training.

For carrying out this evaluation, I would like to express my appreciation to all those who have contributed their time and efforts. My special gratitude goes to the health personnel from Baglung, Dang, Kailali, Kaski, Kathmandu and Panchthar districts. The consultants who conducted the evaluation, Ms. Susan Acharya and Mr. Bir Bhadra Acharya, also deserve our sincere thanks. In addition, I would like to acknowledge my appreciation for the crucial role played by NHSSP's GESI team - Mr. Sitaram Prasai, Ms. Deborah Thomas and Ms. Rekha Rana.

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EXECUTIVE SUMMARY

A. Background and context

The Government of Nepal is committed to improving the health status of its citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health sector-wide approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was very successful and brought about many health improvements. Building on these successes, the Ministry of Health and Population (MoHP[1]) and its external development partners designed a second phase of the programme (NHSP-2, 2010-2015), which began in mid-July 2010. Gender equality and social inclusion (GESI) was a key area of support of the Nepal Health Sector Support Programme (NHSSP). This support covered the mainstreaming of GESI into health plans and system, operationalizing GESI into service delivery (by supporting one-stop crisis management centres [OCMCs], social service units [SSUs], the Equity and Access Programme [EAP], and the social auditing of health care provision), and developing a common understanding on GESI in the health sector.

The Population Division, as the then GESI Secretariat[2], recognised the importance of strengthening the competence of government personnel on GESI mainstreaming. Building a common understanding of GESI, and changing the attitudes of people working within the health system are long-term processes that need to be tackled through institutional and system change and capacity building. Since 2012 GESI training has been provided to policy-makers and service providers working at various levels to support the mainstreaming of GESI into the health system and the interactions of the system with communities. To date, more than 2000 service providers (health facility in-charges, district supervisors, district health officers, district public health officers, staff nurses, and OCMC and SSU focal persons) from 31 districts have been trained to build their GESI expertise and integrate GESI considerations into policies, programmes, and especially service delivery.

This report documents the findings of an assessment of the effectiveness of GESI training delivered to health personnel at the district level and at the health facility level.

The assessment found that in general, the GESI training has been useful and the content of the training programme has been relevant and adequate. However, the training content delivered at the practitioner level needs to be reduced, better tailored to their everyday realities and contexts, and be more practical so that participants can link training to their everyday practices. The perceived level of competency of the trainers, as reported by training participants, varied, though this may be due to participants' mixed understanding of GESI.

Knowledge levels:

- Participants have become more knowledgeable about GESI. They have become familiar with the basic ideas and significance of GESI. They felt that the training had helped to clarify the meaning of GESI as an inclusive approach which is a broader subject than just gender issues. They also became more knowledgeable about how existing resources can be used more effectively to deliver more equitable services focusing on the needs of unreached

[1] Now the Ministry of Health (MoH)
[2] Note that from January 2016 then PHAMED took over as the GESI Secretariat.

communities including women, Dalits, the poor, Janajatis (ethnic groups) and other marginalized groups.

Attitude levels:

- Participants' attitudes towards women, elderly people, people with disabilities, Dalits and other marginalized and excluded groups have become positive. The in-charge at most of the health posts visited reported that they now give preference to the seriously ill, elderly, people with disabilities and people from remote areas. They provide special care to Dalits and the poor. For example, in Sankhu and Baglung health posts they give sufficient medicine to these patients so that they do not have to revisit the facility frequently just to continue their medicine. Targeting service providers, GESI training has triggered participants to consider how they could avoid exacerbating or perpetuating gender and other social inequalities through the delivery of health services.

Practice levels:

- Although new staff tend to be more sensitive than older ones, service providers' attitudes and practices tend to be more GESI-friendly than before. Following training, participants are motivated to explore GESI related problems (for example Dalits not using health facilities and women not coming for antenatal care [ANC]), focusing on people who are left out, and how to increase access. They have become more aware of the hindrances that hamper access to health services even at nearby health facilities. Health facility operation and management committees (HFOMCs) and the in-charges have helped make outreach clinics[3] more accessible to women and have enabled female staff to reach outreach clinic sites.
- After training, most health facility in-charges have become more able to convince HFOMC members about the importance of using the Health Management Information System (HMIS), and other procedures such as preparing action plans, holding review meetings and the supervision of health service delivery to ensure equitable service delivery to unreached and underserved populations of their catchment areas. In the past, in-charges viewed these things as rituals to be performed to satisfy higher authorities. These days, even in monthly meetings, targets and achievements, gaps and problems related to women, Dalits and Janajatis are discussed, reviewed and reported.
- Health post in-charges are actively collaborating with HFOMC members to identify unreached and underserved areas.
- The mapping of available health services is helping to identify unreached areas and accordingly set up immunization camps and outreach clinics.
- Female community health volunteers (FCHVs) reports (mostly oral), plus the HMIS forms that they complete and health facility mapping provide information on unreached and underserved communities and settlements. Health facilities now plan community mobilization, immunization camps and awareness campaigns based on this information.

[3] An outreach clinic is a need based model of service delivery. In this model, clinical services are provided usually to a group in one or more adjoining sites who are unable to access services at the static clinic. In this model, the clinic structure is not fixed and can be held at any convenient and suitable place at the site. The day and timing of the clinic is again not fixed and is decided jointly by the outreach and clinic team every month. In addition to delivering services, outreach has an educational role, raising the awareness of existing services.

- Health camps are organized particularly for women suffering from uterine-prolapse. These camps are particularly organized in rural and remote needy communities as identified by FCHVs.
- It was found that training participants were not formally sharing the knowledge and skills they had learned from the GESI training with their co-workers. The reason for this was often lack of funds to do so. Transfer of knowledge and skills should be an integral part of GESI mainstreaming.

GESI technical working groups

- GESI technical working groups (TWGs) have been formed at the district level. They have played a role in increasing access to and the use of health services and have helped identify underserved groups and unreached areas. The examples of decisions made by TWGs include the mainstreaming of GESI in all programmes and reviews undertaken by DHOs and DPHOs, mainstreaming GESI in all services provided by group members and the holding of DDC organized GESI planning meetings to make all district programmes GESI friendly. However, although they usually meet as mandated, TWGs are not as active as expected. Major problems include difficulties in coordination between different agencies and the presence of the same personnel in similar district-level groups and committees thus putting undue pressure on their time.

Synergy among multiple mutually inclusive efforts to mainstream GESI

- Inputs such as monitoring and evaluation tools (i.e. disaggregated HMIS forms, social auditing), OCMC arrangements, 24 hour birthing centres and SSUs are contributing to mainstreaming GESI. Additionally support from the United Nations Population Fund (UNFPA) and Health for Life (H4L) in the districts have strengthened GESI mainstreaming. Training has also enabled participants to undertake a deeper analysis of the barriers women and excluded populations face accessing health services and reasons for their low use of services thus motivating them to correct the situation. Consequently, GESI training has helped change their outlooks and thinking patterns. Following training, participants have begun to see inequality, discrimination and biasness that they had not seen before and to consciously use resources to ensure GESI in health service delivery. Learning from training has therefore given impetus to other gender mainstreaming efforts.

Barriers to gender mainstreaming

- Planning, programming, and budget allocations are generally undertaken by central level health authorities. It leaves little room for district and sub district level authorities to devise context-specific interventions to address issues related to GESI (that need funding). Therefore, planning at the district level primarily revolves around regularly allocated programmes (e.g. awareness raising and motivating mothers regarding the importance of vitamins, nutritious food, vaccination, growth monitoring, ANC, postnatal care [PNC], etc.).
- The locations of health facilities, which have often been established in line with the inflence of different interest groups rather than on the basis of service access mapping, usually leaves some communities underserved. Thus the norm that a health facility should be located within one hour's travel distance of all communities it is designed to serve has often not been applied.

- The 'push' system of medicine distribution and the absence of a supply need feedback system prevents the flow of medicines as per the demand of health facilities. The frequent inability of health facilities to provide basic medicines to needy people reduces trust in the government health system while the continuing use of the push system contradicts the concept of the SWAp, which requires a decentralized system of health care.

C. Suggestions

C.1. Training related

Content and method

- Three levels of training packages are needed with content specific for each level of personnel with ones for master trainers, mid-level personnel such as DHO and DPHO supervisors and for frontline service providers such as health post in-charges and their staff.
- The use in the training programmes of exercises and methods based on trainees' contexts and circumstances would more effectively get the messages across.
- Training programmes should be organized in the second trimester of each year so that participants can begin implementing what they learn from the third trimester.
- Trainers need to be carefully selected and if necessary training could be outsourced.
- Regular follow up is essential to institutionalize the changes brought by GESI training. For this to happen, monitoring teams should be adequately equipped with health-focused GESI-related technical knowledge and skills that enable them to address contextual issues.
- The current practice needs to be changed of focusing on 'targets versus coverage' to assess service use. For this to happen, qualitative data is needed to identify, understand, and address the GESI-related barriers to accessing health care.

Capacity enhancement and motivation

- Health facility staff are directly in contact with clients and are more regularly in contact than their in-charges. It is therefore necessary to orient staff members as well as HFOMC members on GESI to effectively mainstream GESI into the everyday work of facilities.
- FCHVs are the key actors who act as a bridge between service providers and seekers by collecting and sharing detailed information about the health needs of marginalized communities. Most of them have a good understanding of their contexts and cultures. The up-scaling of GESI training for FCHVs is a priority.

Knowledge and skill transfer

- Expanding training and providing tools for knowledge and skill transfer and gender analysis in the context of health should be a focus of future GESI mainstreaming training.

C.2. Broader GESI mainstreaming related

Access and service use

- Village clinics should be managed locally by separate management committees comprising of local people.
- HFOMCs are active and functional in some village development committees (VDCs), and generate resources locally, hire auxiliary nurse-midwife (ANMs) in coordination with their

VDCs and contribute towards increasing the availability of quality health services for needy people. HFOMCs need revitalizing and strengthening.

- The updated mapping of available health services and facilities is needed. In hilly areas and in the periphery of big towns, mapping is necessary particularly to ensure efficiency, and for improved access and use of health care facilities among women and disadvantaged groups.
- A number of standard HMIS indicators that health facilities report on are now disaggregated by caste and ethnicity. As well as this, decision making on the basis of evidence (e.g. service access mapping, disaggregated data) should be promoted at every level of the health system.
- Medicine should be supplied on a demand basis. Random supply reduces underserved groups' and unreached areas' trust in government health facilities; thereby reducing their service use.

CONTENTS

ACRONYMS AND ABBREVIATIONS

AHW	auxiliary health worker
ANC	antenatal care
ANM	auxiliary nurse midwife
BS	Bikram Sambat (Nepalese era)
DAG	disadvantaged group
DDC	district development committee
DFID	Department for International Development
DHO	district health office
DPHO	district public health office
FCHV	female community heath volunteer
GBV	gender based violence
GESI	gender equality and social inclusion
H4L	Health for Life
HFOMC	health facility operation and management committee
HMIS	Health Management Information System
HP	health post
MoH	Ministry of Health
MoHP	Ministry of Health and Population
NGO	non-government organization
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NPR	Nepalese rupee
OCMC	one-stop crisis management centre
PHCC	primary health care centre
PNC	postnatal care
SANM	senior auxiliary nurse midwife
SSU	social service unit
SWAp	sector-wide approach
ToR	terms of reference
ToT	training of trainers
TWG	technical working group
UNFPA	United Nations Population Fund
VDC	Village Development Committee
WRTC	Western Regional Training Centre

1 INTRODUCTION AND BACKGROUND

1.1 Background

The Government of Nepal is committed to improving the health status of its citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was very successful and brought about many health improvements. Building on these successes, the Ministry of Health and Population (MoHP)[4] and its external development partners designed a second phase of the programme (NHSP-2, 2010-2015), which began in mid-July 2010. NHSP-2's goal was to improve the health status of the people of Nepal. Its purpose is to improve the use of essential health care and other services, especially by women and poor and excluded people.

Gender equality and social inclusion (GESI) has been a key area of support provided by the Nepal Health Sector Support Programme (NHSSP). NHSSP was funded and managed by the Department for International Development (DFID) UK, began in January 2011 and ran through to July 2015 (http://www.nhssp.org.np). NHSSP supported the mainstreaming of GESI into health plans and the health system; the operationalization of GESI into service delivery (by supporting one-stop crisis management centres [OCMCs], social service units [SSUs], the Equity and Access Programme [EAP], and the social auditing of health care provision); and developing a common understanding on GESI across the health sector.

1.2 Specific background

The government of Nepal has shown a strong commitment to mainstreaming GESI. It is not a goal in itself but an approach to integrating GESI concerns into policy decisions, legal frameworks, programmes and activities. GESI mainstreaming in the health sector is recognised as an important strategy to increase access to and the use of health services by women and excluded groups, and to address disparities in service delivery between different geographical and ecological areas.

Considerable achievements have been made by MoH in creating an enabling environment for GESI and establishing an institutional platform for its mainstreaming. The Population Division, as the GESI Secretariat[5] recognises the importance of strengthening the competence of government personnel to advance GESI mainstreaming. Building a common understanding of GESI and changing the attitudes of people who work in the health system are long-term processes that need to be tackled through institutional and system changes, and capacity building.

While many lessons have been learned, a number of challenges still constrain the mainstreaming of GESI in the health sector. Progress on GESI mainstreaming in the health sector requires the addressing of gaps in knowledge and expertise and building the capacity of people working through various approach and at various levels. The overall need is for service providers who are capable of identifying and addressing GESI issues as part of their day-to-day business. Without sufficient knowledge of GESI issues, it is impossible to mainstream gender and social inclusion in policies and programmes.

[4] Now the Ministry of Health (MoH)
[5] The PHAMED is now the GESI Secretariat since January 2016.

GESI training has therefore been used as an educational tool to raise the awareness and understanding of policy-makers and service providers working at various levels. So far, more than 2000 service providers (health facility in-charges, district supervisors, district health officers, district public health officers, staff nurses, OCMC and SSU focal persons) from 31 districts have been trained to enhance their effort to integrate GESI into all policies, programmes and service delivery. The main thrust of the GESI training programme has been to ensure that key policy actors and service providers are aware of the concepts of GESI, and have the basic expertise to mainstream GESI in their work at all levels. The objectives of GESI mainstreaming training have been to

- develop a common understanding of GESI related concepts including its importance, measures and methods of analysis;
- enhance the knowledge and skills of programme managers on GESI responsive programme planning, implementation, monitoring and evaluation; and
- strengthen the capacity of service providers in handling sexual/gender-based violence (GBV) survivors while providing medical services at different facilities.

1.3 Rationale

Mainstreaming GESI into programmes and service delivery has been an inspiring and challenging initiative for Nepal's health system. Various factors ranging from personal traits and individual attitudes to the readiness of the health system affect how learning from GESI trainings has been applied. Several phases of GESI training and orientations have been conducted for cadres of the health system to raise their awareness on GESI to enable them to respond to the disparities in service delivery that affect women and excluded groups as well as the delivery of quality services at all levels.

GESI trainings are largely a dynamic platform for sharing knowledge and experiences by service providers who work at various levels. These trainings are designed in a way that addresses and focuses on solving problems, showcasing good practices, and supporting one another to apply what works best in different situations and with communities.

Supporting GESI, including GESI mainstreaming training, was a priority area of NHSSP's support to the government to increase access to equitable health services to all, especially women and the excluded. Understanding the different ways in which GESI mainstreaming training is applied will help the government better understand how best to direct future support.

1.4 Objectives of the assignment

The overall objective of the assignment was to understand the effectiveness of GESI training delivered to health personnel at the district and health facility levels. The specific objectives were as follows:

- Understand capacity gaps and needs. Find out what the perceived needs are in terms of the capacity to implement GESI mainstreaming training.
- Assess the effectiveness of GESI trainings being provided and taken vis-a-vis service delivery and access to services.
- Identify key issues related to GESI experienced by trained service providers.

1.5 Methodology

The assessment was carried out in the six districts of Baglung, Dang, Kailali, Kaski, Kathmandu and Panchthar during November 2015 – January 2016. These districts were selected by MoH in collaboration with NHSSP. Three of the districts were included had been in the first batch of GESI training and the other three had received the training in 2015/2016 (early 2072 BS). The selection of assessment respondents was made at two levels:

- First the districts were selected based on regional representation as well as performance.
- Second, the six DHOs/DPHOs selected health facilities based on their performance and accessibility.

A list of the persons consulted is given at Annex 1 while a list of the Health facilities visited is given in Annex 2.

The methodology included:

- reviewing GESI training materials and implementation guidelines; and
- field visits to each of the six districts to consult with DHO and DPHO personnel, GESI trainers, GESI training participants and health service users. Two facilities were visited in each district.

The following tasks were undertaken in the districts.

- Consultations and key informant interviews with health facility staff including OCMC staff at selected facilities.
- Review of meeting minutes of GESI technical working groups (TWG), HMIS reports and health facility operation and management committee (HFOMC) meeting minutes.
- Review of micro-plans prepared by DHOs and DPHOs.
- Review of annual reports prepared by the DHO.
- Observations of the working environment of health facilities such as gender friendliness, proportion of male-female staff at facilities, interpersonal interactions between staff and clients, and the state of physical facilities.

The consultant developed checklists, including interview guides for data collection for different types of informant (e.g. health providers, OCMC staff, police officers) and observation checklists (see Annex 3). The terms of reference of the assignment are included at Annex 4.

1.6 Limitations

The assessment faced three main limitations:

- First, some of the planned respondents were not available during the field visits. For example in Panchthar, no one from the district health office who had participated in the GESI training was available as they had been transferred away or were undergoing further training. Most GESI TWG members were similarly not available in this district. Only the police woman was available at the OCMC. Similarly, in Kailali district (as informed by the trainers), no one from the DPHO had participated in the GESI mainstreaming training provided in 2014/15 (2071 BS). Only one public health nurse who was available at the time of the visit had taken the training.
- Second, during the winter season (when the assessment was carried out) the flow of patients is reduced in most heath facilities. This is partly because of the less illness, particularly diarrheal diseases, at this time of year and partly because of out-migration for work after the

harvests are completed in October and November. As such, patients were less available in the visited health facilities for consultations.

- Third, it was a great challenge to isolate the effects of GESI training as the trainings had taken place simultaneously alongside other institutional and health systems developments that are likely to have contributed to more GESI sensitive behaviour. This being said, valuable learning acquired through the trainings reinforced the implementation of other activities. Participants were also found initiating new efforts as a result of the trainings.

2 ASSESSMENT OF GESI TRAINING

Since 2012 MoH organized a series of GESI training of trainers (ToT) sessions to prepare master trainers for regional health directorates, DHOs, DPHOs and the national and regional health training centres. The regional and district level master trainers then in 2013 – 2014 provided a three-day training to DHO and DPHO personnel and health facility in-charges including OCMC in-charges. The main objective of these training programmes was to raise self-awareness, to encourage providers to deliver quality health services so as to increase service use by women and excluded groups. Supervisors and facility in-charges were given priority in these trainings because they are the primary agents of change in health care practices and are more likely to transfer their knowledge and skills into GESI mainstreaming efforts. For example mobilizing FCHVs and increasing access through outreach clinics to reach the unreached and underserved population are visible efforts that in-charges can undertake. Based on this assumption, GESI training was organized in 31 districts in 2013 -2014 and 2014 - 2015. More than 2000 service providers participated in the latter training programmes.

2.1 Capacity Gaps and Needs

Training participants reported that they were generally satisfied with the coverage and methodology of the GESI training programmes. They all agreed that the training focused on the procedures for reaching the unreached and the underserved. Participants from Baglung pointed out that the contents as well as the methods, which included discussion, problem analysis and sharing, made the training programmes effective. While participants from other districts also found the training effective, they pointed out the following areas for improvement:

- *Timing of training programmes:* Because of the massive earthquakes of April 2015 and the continuous aftershocks, some GESI training sessions had been shifted towards the end of the fiscal year.[6] Most participants suggested that the holding of the training in the Baishak to Ashad period (May to July) was not appropriate due to the pressure of time/rush (*hataro*) as this period is the closing time of the government budget cycle when much expenditure and many activities take place in line agencies including health. Another major reason for the late organization of the training was the late release of the budget from the Ministry of Finance. Participants from Dang and Kathmandu said the training was organized towards the end (e.g. June/July) of the fiscal year giving the impression that they were only organized to spend the allocated budget.
- *Training methods:* Most assessed participants agreed that the training programmes had opened their eyes on gender and social inclusion. The concept was dealt with in depth and comprehensively. Some participants suggested that more practical and activity-based training was needed. The in-charge of Geta Health Post, Kailali suggested,

  "If the training was provided through a role-playing method it would be easier to memorize and implement learning in practice".

  She said that having to play the role of a poor person who is unable to access health services due to poverty, or showing how a health worker exhibits positive attitude and behaviour toward a Janajati patient, would be more effective. However, since practical training requires more time, it is the concern of trainers and organizers that the inclusion of more practical

[6] The fiscal year ends in mid-July

training would require either some of the less important sessions being cut or the training running for more than three days.

- *No provision of follow-up:* The trainers from Kaski and Kailali emphasized the need for follow-up and monitoring from the training centre and trainers particularly focusing on GESI.
- *Training approach:* A trainer who is a nurse and both a GESI and GBV trainer from Dang suggested,

  "The training content is extensive but practice is inadequate. ToT is fine but at the district level it should be very context based. As GESI is a multisectoral phenomenon, it needs to be linked with other aspects and sectors in the training. It would be more effective if it is designed on the basis of the district level situation and existing gaps."

  Likewise, a trainer from Kathmandu also opined that the contents of the ToT were satisfactory although for practitioners some contents are not required. He said that, for example, the sessions on international instruments are not necessary and the focus should be on stimulating behaviour change rather than imparting knowledge. Although the methodology as per the training manual is interactive, with questions and answers and group discussions alongside the lectures, most participants and trainers found the training to be more lecture-based and brief. They said that the issues dealt with in the training required more discussion and practical work such as actual case-based discussion, role play and ways to integrate GESI in daily work and action plan preparation.
- *Trainers' competence:* Training participants reported that most trainers were capable in terms of content knowledge, but because of the time constraints they could not use their ability to the full extent, i.e., they were not able to delve into the subjects in an interactive and practical manner, which made some sessions shallow.

2.2 Effectiveness of GESI training as Reflected in Service Delivery and Access to Services

All informants (training participants, trainers and external development partners) indicated that the GESI training had impacted at the three levels of knowledge, attitude and practice.

2.2.1 **Knowledge**

The assessment found that training participants have become more knowledgeable about GESI after the GESI training. Most respondents said that they are now familiar with the basic ideas and significance of GESI. They felt that the training had helped them clarify the meaning of GESI as an inclusive approach that is broader than gender alone. For example, a GESI trainer from Dang observed that initially most health workers were of the opinion that GESI meant something that is only linked to women. Training participants and other health staff now understand that it is more than this. According to the GESI trainer, there is now a common understanding that GESI is about mainstreaming all disadvantaged groups including women, girls, the elderly, people with disabilities and particularly people from marginalized and underprivileged communities. Her observation was reinforced by the perception of the health post in-charge of Seshaniya Health Post, Dang. He said,

"The training made us aware that there is problem on the ground. Before the training we used to say that there is no discrimination; now we know it exists".

All training participants reported that they are more knowledgeable and sensitive about how the health system and services can operate more equitably in a context of socio-economic and

geographical disparities. The in-charge of Armala Health Post, Kaski also stated that the concept of GESI learned in the training has made it easier to identify GESI issues in the daily activities of their health post.

It was reported by all the training participants interviewed that the GESI training imparted knowledge about how resources can be used to promote equity in health and meet the health care needs of marginalized and poor communities. For example Maanpur Health Post in-charge, Dang suggested,

> *"Apart from the theoretical knowledge of GESI, I am now contemplating over how to use existing resources and services effectively and equitably focusing on the need of unreached communities, mainly Dalit women, and the poor, Janajati and other marginalized people."*

He added that he needs to do more work to ensure the equitable delivery of health care services by analysing the needs of the various caste and ethnic groups. Likewise, a health post in-charge in Kathmandu said that the GESI training had made him contemplate the issue of domestic violence and how to minimize it so that all family members can live peacefully and children grow up with positive mind-sets.

2.2.2 **Attitude**

Assessed training participants' attitudes towards women, elderly, people with disabilities, Dalits and other marginalized and excluded groups has become more positive. They are now more sensitive to the needs of these groups of people. There are many examples where health post staff have examined ill patients from remote places even after the closure of their health facility. Here it is important to emphasize that health facility staff have become more aware of the needs of marginalized and excluded groups after the GESI training. Health facility staff now have a much less disdainful attitude towards Dalits and other marginalized groups; rather they are given priority for the treatment of their illnesses.

> *"Training helped us change our attitude towards socially excluded groups — women, children, Dalits, Janajatis — and we are increasingly aware of providing extra attention and care to these groups. We are also aware of the groups that are excluded from health services and what is essential for providing health services to those particular groups". — in-charge, Geta Health Post, Kailali*

Targeting service providers, the GESI training has triggered participants to consider how they could avoid exacerbating or perpetuating gender and other social inequalities through the delivery of health services. As a participant in Kailali shared,

> *"I am now very much concerned about my service delivery and practices. Every time I offer services, I ask myself whether I am contributing to minimizing gender and other social inequalities."*

Likewise, the in-charge of Seshaniya Health Post, Dang said that he had not been able to implement all he had learned, but it had changed his mind-set. The GESI training has been instrumental in developing a more positive attitude towards marginalized groups and it is expected that this will translate into the delivery of more equitable health services.

2.2.3 **Practice**

Changes in attitude and behaviour of health staff

Changes in attitude have led to changes in individual behaviour and practice. An auxiliary health worker (AHW) from Sankhu Health Post, Kathmandu who had taken the GESI training reported that people from the remote settlements in Nanglebhare VDC were given priority for examinations when they visited the health post. The in-charge of Naudanda Health Post, Kaski also reported that after the GESI training the facility had started to attend serious and emergency cases before and after the standard opening hours (10 am to 5 pm). He also reported that he had initiated the re-modelling of the health post building to make it friendlier for people with disabilities. However this health post had not yet arranged separate toilets for women and men. The Armala Health Post in-charge on the other hand said that he had arranged separate toilets for men and women after participating in the GESI training.

Learning about GESI has been reflected in enhanced personal commitments. For instance, the in-charge of Maanpur Health Post, Dang said:

> *"There have been several instances of inequality and gaps [in service provision]. Since attending the GESI training, I have made a commitment for treating everyone equally without discrimination. And, I am now committed to serve the marginalized, excluded and poor, providing them with priority services. The GESI training made me aware that there is a group in society that doesn't know about the health services that are provided by the government. And analysing HMIS data, we have to make a realistic plan to provide all with basic health services."*

Changes in health post logistical arrangements

The GESI training not only contributed to developing a positive attitude among participants towards socially excluded people in relation to the provision of health services; they have become increasingly aware of the hindrances that hamper service seekers from accessing health services from even their nearby facilities. After the GESI training, the Maanpur Health Post in-charge replaced male nurses with female nurses at the village clinics, and provided them a small travel allowance in order to ensure access of women to health services. In his observation, due to time constraint and family members' disapproval pregnant women found it difficult to visit health facilities for antenatal care.

> *"Generally health care personnel deputed to village clinics were male and service seekers were women, girls and children. Most of them were reluctant to share their problems with the male service providers. In order to address this problem, female nursing staff are now sent to village clinics. The Operation and Management Committee (HFOMC) made a decision to provide them a travel allowance of NPR 100. This has helped the village clinic become more GESI friendly." — In-charge, Maanpur Health Post, Dang.*

The actions of the HFOMC and the in-charge have thus helped make village clinics more accessible to women. The HFOMC members also added that the FCHVs are mobilized to collect data of pregnant women who are and are attending and not attending ANC check-ups, couples using family planning devices, and other issues. They are now using this data to plan their health service campaigns and other services for the coming year.

According to the in-charge of Armala Health Post, Kaski, there are now no underserved groups in the catchment area of his health post; but considering women, senior citizen and children, "we give priority to them" he said. He added that there the hard to reach wards of the VDC (wards 3 and 6 of the previous Armala VDC, which is now under the Pokhara Municipality). The Health Post staff visits these wards and provides primary health services to their communities.

Likewise, in order to ensure citizen's right to information, all the visited health facilities of the selected six districts display the names of available free medicines along with other relevant information (e.g. birthing centre services, safe abortion) on the walls of the facility. Health centre in-charges and HFOMC members of all the visited facilities from the selected six districts attributed all such changes to the participation of in-charges in the GESI training.

Reaching out to the unreached and underserved

Following the GESI trainings, participants were motivated to explore GESI-related problems such as Dalits not using their health facility and women not attending ANC, focusing on who is left out and why, and how to increase access. The in-charge at Geta Health Post, Kailali said:

> *"We are now seeking more disaggregated information from various sources, including FCHVs, patients, mothers group, NGOs, local leaders and users, to identify the factors that contribute to health inequalities, and the impact of our practices and interventions on gender and social inclusion on the ground."*

For example, Geta Health Post has formed two mothers groups, one in Chaitanyapur with a predominantly Dalit population, and one where a ward level FCHV could not be assigned due to the unavailability of a suitable person. The in-charge added that she and her staff pay extra attention to the marginalized groups who come to the health post by ensuring that the waiting time is less for elderly people and those who come from faraway places. In Kaski the technical working group updated the database and launched different programmes to the unreached and the underserved of 10 Kaski VDCs. The VDCs were identified based on the disadvantaged group (DAG) mapping by NHSP-2, two years ago. The assessment found the health post staff to be attentively listening to an elderly woman who was reported to often visit the health post and was said to be “a bit senile”. Likewise, Maanpur Health Post, Dang is mobilizing the local ward citizen forums to encourage community members to use the available health services.

Mother’s groups: Mobilizing mothers' group to increase awareness among Dalit and other disadvantaged communities about health services and to encourage them to access health services was found to be in practice in all six districts. All consulted GESI training participants gave credit to the learning they had acquired from the GESI training to improving and systematizing this practice. They claimed that the situational analysis technique they had learned in the training had made this change possible. Due to the raised awareness community members the number of home deliveries in specific under-reached and underserved areas identified by the health facilities has been reduced, and ANC and PNC visits to health facilities has increased. For example, at Geta Health Post, Kailali the number of Dalit and Janajati women delivering their babies in the health post has increased.

Gender and GBV: All consulted health providers who participated in the GESI training said that they had become more concerned about gender sensitivity, and more sensitive about avoiding gender and social discrimination during treatment and while planning programmes. They said they

now paid more attention and care to serving people from underprivileged communities. The GESI trainer from Dang said that nowadays health post staff tell her that if a woman comes to them repeatedly with the same problem they try to understand what is really going on in her life that might have caused the illness. According to her, some have also begun to refer cases to the local OCMC. In Sankhapur Health Post of Sankhu Municipality, women have started to approach the senior ANM (SANM) with cases related to domestic violence and since the SANM knew she should not counsel the perpetrators and the victims in public she visits the victims' houses to deliver counselling. These changes were attributed largely to the GESI and GBV trainings that the in-charges and their staff had attended.

HFOMC membership: Since the current HFOMC regulations require their membership to include people from excluded communities, newly reformulated HFOMCs have included more members from unreached and underserved communities. For example, the Pharping HFOMC that was recently reformed includes a Dalit member

Older health staffs are slower to change: Change is a time-consuming process. While the new generation seems to be more adaptive to new concepts, older people are generally slower to change their practices and habits. On the basis of his district-wide experiences, a United Nations Population Fund (UNFPA) person in Dang said:

> *"Service providers' attitudes and practices are more GESI-friendly now than before. New staff seemed sensitive but older ones are still conventional".*

A public health nurse from Kailali had a similar experience. She opined that it all depends on attitude and changing attitudes is difficult. she added that there are two types of service providers — those who are more sensitive to the unreached and underserved and those who are indifferent to such groups. Both said that the GESI trained ones tend to be more sensitive on the basis of their district-wide experiences. At Gopetar Primary Health Centre, Panchthar the in-charge who thinks that GESI is unavoidable has been able to make laboratory services free for over 65 year old patients and FCHVs as an initiative to ensure access and equity in health services.

User perspectives: Although they could not point to the reasons for improvement, some users also shared their satisfaction about the behaviour and services at their health posts and the service providers.

> *"I am happy with the service provided by the health post. The service providers are kind and careful, treat me sincerely, and take a longer time than before. They communicate with me very well and respond to all my questions genuinely. This had not been the case before. And now I don't have to wait. I get the medicine. There is a lab facility as well". — Muslim woman patient, Dang.*

Patients from Panchthar, Kathmandu and Kailali health facilities expressed their satisfaction with the services received and service providers' behaviour. For example, Dalit women from Pharping said that the health post staff do not ignore them, they do not have to wait, and they get immediate attention. Patients from Malakheti hospital, Kailali also shared their satisfaction. They said that chairs and benches have recently been added in the waiting area, medicines are provided free of charge and facilities such as lab tests are cheaper. They are also satisfied with service providers' behaviours. One patient told how she had been taken to a private facility by her son for a lab test but was then taken to Malakheti hospital because the test was cheaper there.

2.2.4 **Review and planning**

The partaking of many DHO/DPHO personnel and health post in-charges of GESI training has led to a certain level of common understanding on GESI in the health system, which is enabling GESI responsive efforts at the ground level. GESI practices are being reflected in local planning and review. According to all GESI training participants consulted for this assessment, health planning and reviews now have a particular focus on marginalized and poor people. For example, the in-charge of Armala Health Post, Kaski reported that he and his colleagues discuss service gaps at review meetings, while the in-charge of Payounpata Health Post, Baglung said that although GESI is not specifically mentioned, discussions in review and planning meetings revolve around how to reach targeted groups. However both reported an absence of follow-up regarding GESI.

Besides annual and bi-annual review meetings, consulted training participants said that monthly cluster meetings (HMIS report collection and review meeting among clusters of health facilities) and FCHVs' monthly meetings, are the main forums for reviewing their work. These forums mainly focus on targets, achievements and data quality. Data quality is judged against the indicators, which are disaggregated by gender, caste/ethnicity and age.

FCHVs' monthly meetings focus on the status of underserved and unreached population and areas. For example, at Pharping Health Post, Kathmandu, the monthly meetings often discuss access to health care in ward 3 (an unreached Dalit settlement) and ward 9 (an underserved Magar settlement). Keeping in view the difficulty in mobilizing and creating awareness about health care (particularly in ward 3) on one hand and the distance factor (particularly in ward 9) on the other, two FCHVs have been assigned in each of the two wards (normally only one FCHV is appointed per ward). The in-charge at this health post reported that after the training he has investigated GESI issues more. He reported that this has made FCHVs more aware about the GESI situation. Participants from other districts also reported that FCHV monthly meetings and cluster-wise review meetings are the forums where they cross check the GESI situation, raise issues (for example, some parents not bringing their children for growth monitoring, some women not attending ANC or why morbidity is higher among women from one area) and make the yearly plan of action accordingly.

Some health post staff and supervisors reported that though GESI terminology is not used at review and planning meetings there are discussions on how to reach targeted groups and how to make the services at facilities more convenient and available. Other supervisors said that, since women and disadvantaged population have always been their target population, they are attentive to their access to and use of services.

Most health facility in-charges reported that the GESI training has made them better able to convince management committee members about the importance of using HMIS data, the preparation of action plans, review meetings and supervision to ensure equitable service delivery to the unreached and underserved population in their catchment areas. In the past they viewed these things as rituals that have to be performed to satisfy higher level authorities. The senior AHW of Narayanthan Health Post, Baglung said that these days targets and achievements, gaps and problems are regularly discussed, reviewed and reported in monthly meetings. It was said that FCHVs are mobilized on the basis of meeting and review outcomes.

2.2.5 **Monitoring and supervision**

Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion say: "MoHP's monitoring and evaluation system is carried out through regular supervision and annual reviews" (MoHP, 2013a, p. 10). At the health facility level, management committees and in-charges are responsible, and at the district level, DHO and DPHO personnel are responsible for monitoring and supervision. Monitoring and supervision are important mechanisms to institutionalize more equitable health service delivery and are thus a key area in the GESI training curriculum.

At the health facility level health in-charges were found to be actively collaborating with their management committee members in identifying unreached and underserved areas. For example in Dang, Seshaniya and Maanpur health posts had identified underserved areas through FCHVs and HFOMC members, and had mobilized FCHVs and citizens' forums to increase awareness about health issues and thereby increase access to services. Moreover HFOMC members reported that they supervised health facility activities together with the in-charges. For example an important activity of Seshaniya Health Post's plan of action for 2015/16 was the supervision of the immunization and village clinics by HFOMC members and the in-charge.

Similar attitudes were echoed in other health facilities. For example, the in-charge of Geta Health Post, Kailali said:

> *"GESI training is helpful for making health services more inclusive and gender-responsive. For example Barbatta and Chaitanyapur are Dalit settlements. Chaitanyapur is topographically hard to reach. We go there and conduct mothers group meetings, discuss their health issues, inform them about medical support including medicines available at the health post, and encourage them to visit the health post for treatment".*

The in-charge of Gopetar PHCC, Panchthar said that whether or not someone has taken GESI training GESI concept applies everywhere — in planning, monitoring and evaluation. "We can't do without it" he said. He has done service access mapping of the available health services for inhabitants of Panchami VDC. He said that the PHCC has set up immunization camps and village clinics accordingly for underserved communities to access services. He added that GESI training is necessary for all involved in the health sector to understand the concepts and to learn how to put it into practice.

DHO and DPHO personnel reported that health worker supervision focuses on whether targets are met, HFOMC meetings are held as mandated, and immunization and village clinics are held as planned. Although there are no set formats and forms for monitoring and supervising health facility performance over the year through a GESI lens, health post in-charges in Panchthar and Dang reported that they had started to collect GESI related information for annual review and planning meetings. The planned use of HMIS data to devise GESI related efforts is another noteworthy impact of the training. For instance, DHO personnel from Panchthar reported that the district will soon have two years' data (HMIS) to compare and use for review and planning purposes. One Dang participant reported, "Data from 10 health posts showed an increase in access of Dalit and Janajatis to health post services compared to other ethnic groups". These examples supported the GESI trainers' general observations that the training programme has

developed inquisitiveness and zeal to explore health service use through a GESI lens, something that was quite unlikely to happen before.

2.2.6 **Service access mapping**

The GESI training programme had shown participants how to produce service access maps to identify unreached areas and underserved communities and to explore reasons behind the non-use of services. Health facility in-charges said that FCHVs' reports (mostly oral), HMIS data, and maps of available health facilities are the main sources of information on unreached and underserved communities. Health facilities are using this information for organising community mobilization, immunization camps and health awareness campaigns. According to the training participants from Kailali and Dang, uterine-prolapse camps are specially organized in rural and remote needy communities identified by FCHVs. A health post in-charge and an HFOMC member in Dang reported that such camps had recently been organized in two Dang VDCs. They said that the mapping exercises had identified these VDCs and made it easier to know where to target services.

2.3 GESI Technical Working Groups

GESI training aims to support TWGs, many of whose members have taken part in GESI training, to produce synergy among partners and ensure attention to GESI issues in the health sector at the district level. Other agencies, such as UNFPA and H4L, have provided GESI training to TWG members in Kailali and Dang.

GESI TWGs are at different stages of development. According to Kaski district health officer:

> *"on the basis of the DAG mapping conducted two years ago by NHSP-2, the GESI TWG launched different programmes in the unreached 10 VDCs and updated its database."*

He said that the DHO had also organized GESI orientations at HFOMC meetings.

UNFPA Dang personnel said that the GESI TWG had played a positive role in increasing access to and use of health services. He said that it had helped to identify underserved groups and unreached areas. H4L personnel from the same districts said that the TWG was a good forum for group discussions and idea sharing.

The assessment reviewed the meeting minutes of the GESI TWGs of the assessed districts. See Table 2.1 for examples of decisions taken.

In all the districts where TWG meeting minutes were available GESI TWGs meeting are held as expected. This year since the budget was released late the second meeting is due in some districts.

However, it was found that the GESI TWGs are not as active as expected. Kaski district health officer said: "The major problem of the GESI TWG is coordination between different offices." Currently, even if the group meets no significant outputs are recorded. The same was observed in Dang, Kailali and Panchthar TWGs. In Baglung district the technical group meeting had not convened due to coordination problems.

Table 2.1: Examples of decision taken by assessed district level GESI TWGs

District	Date	Decision taken	Follow up action/notes
Dang	25 Apr 15	To organize a GESI planning meeting with all concerned agencies' to make the DDC's implemented programmes GESI sensitive.	DDC organized this meeting.
Kailali	7 Jul 15	Every programme implemented and service delivered by DHO shall be made inclusive from GESI perspective	No information
Panchthar	16 Jul 15	To sensitize the public on GESI issues for the more effective implementation of GESI friendly programmes.	No information
Kaski	6 Sep 12	10 unreached VDCs were selected for service delivery from GESI perspective.	Field visits were made to the 10 VDCs by TWG members.
	17 Oct 12	GESI focal persons to be appointed at each health post	No information
	26 Mar 14	More focus needed on coordination	No information
Note: In Baglung, since all the supervisors were on field visits, the TWG meeting minutes were not available at the time of visit. In Kathmandu the minutes were not available as the supervisor didn't have time to search for it.			

The general lethargy of GESI TWGs is primarily attributed to the presence of many similar groups and committees in each district. A DPHO person from Dang said,

> *"There are a couple of similar committees at the district level with the same people and organizations as members. Maybe because of that health the GESI Technical Group is not that active."*

He added that the district reproductive health coordination committee met regularly:

> *"Its meetings are sponsored by members in rotation so there is no issue of budget or financing of meetings. Even if there is no budget it meets. This is how it should be."*

This observation was reflected in the difficulty that available TWG members were having in recalling what actually happened in their group meetings and when the last meeting was held in Dang and other districts visited for the assessment. The poor functioning of TWGs indicates that since TWGs are a multisectoral effort, in addition to the GESI training provided to its members, other factors need attention to make it function as desired.

2.4 Multiple Efforts Combined Effect

GESI mainstreaming includes institutional and systemic changes as well as developing the capacity of health personnel. The specific objective of the assignment was to assess the effectiveness of GESI training. However, since other interventions and support has been simultaneously implemented it was a challenge to isolate the effect of the GESI training. Nevertheless, interactions and field observations revealed that the learning obtained from GESI training had reinforced the implementation of other GESI efforts and vice-versa.

Inputs such as monitoring and evaluation tools (i.e. disaggregated HMIS forms and social auditing), OCMCs, 24 hour birthing centres, and SSUs all contribute to mainstreaming GESI. Additionally, support from external development partners such as UNFPA and Health for Life (H4L — a USAID

funded project) at the ground level have strengthened GESI mainstreaming efforts. The major contribution of the training is that it has refreshed, reminded and enabled participants to undertake a deeper analysis of how GESI affects access to and the use of health services by women and excluded groups, and how the way services are delivered impacts on this. Consequently the training has helped change participants' outlooks and thinking patterns. Training participants reported that they began to see inequality, discrimination and biasness that they had not seen before. Moreover with this increased consciousness of GESI, health staff reported they are now using resources to ensure GESI in health service delivery.

The public health nurse of Kailali DHO, who had taken the GESI training and who was recently made the DHO's gender focal person reported:

> *"We have a large number of women with uterine prolapse problems, mainly from underserved and remote communities. They are mainly from poor Janajati and Dalit communities. We thus focused our services to these communities. Next, we made it mandatory to include women on local HFOMCs by sending a notice to each facility. Now practices are in place to include adolescent girls and boys on these committees. We also provide safe abortion services. We treat such cases very carefully if it is a case of rape, or because of gender-based violence. Through decisions of the HFOMC, we also provide free services to those who cannot afford services."*

Social auditing as a tool for reviewing and planning actions is an effective exercise for mainstreaming GESI and reinforcing the messages included in GESI training. Health facility in-charges reported that they have found the social auditing process to be effective. NGOs are hired by DHOs to conduct the social auditing of health care provision at facilities. According to the assessment participants, issue and gaps identified by social auditing are addressed by relevant entities. For example, the social audit of Geta Health Post found that Chaitanyapur VDC (a hard to reach location with predominantly Dalit people), as not having any FCHVs. This problem was addressed by the FCHV of the nearest ward forming two mothers groups. The in-charge reported that this had led to increased health service use by the people of Chaitanyapur.

Additionally, to make health services more inclusive, H4L has been supporting the implementation of GESI through different activities such as annual VDC health planning exercises. For example, at Badeha Health Centre, Kailali a mass meeting of stakeholders was organized by the HFOMC on 22 December 2015 as per H4L records. The discussions focused on community health and nutrition, vaccination, public awareness, birthing centre construction, management of staff salaries, FCHV facilitation costs and hygiene and sanitation.

2.5 Barriers to Implementing Learning from GESI Training

2.5.1 **Centralized decision making**

Most participants said that planning, programming and budget allocation is generally undertaken by central level authorities and that this inhibits the scope for districts to respond to the specific needs of underserved and disadvantaged groups. The Kaski district health officer said:

> *"Planning and budget allocation is generally the area of the ministry, so that the DHOs do not have much say in the allocation of resources. The health programmes are already determined at the centre and resources are allocated at the centre. Therefore, review*

and planning meetings at the district level are more concentrated on the targets and achievements rather than on long term planning. Health post in-charges participate in the review and planning meetings to present their progress and discuss problems encountered in implementing services. In the process, how to provide for example immunization, ANC and PNC services to the unreached and underserved population and areas is also discussed and planned accordingly."

Kailali, Dang and Panchthar respondents shared the issues and practices of local level planning. One issue is that planning is not always extensive and participatory. A Dang supervisor said:

"Planning is not participatory. We have a two-day annual review meeting in which a few participants present their ideas, raise issues, and propose the programme. And, planning is done".

It was learnt that most regular programmes are not cut down. But:

"even if the planning is done according to the district health profile, which is based on HMIS, it doesn't work because everything is decided from the centre"

A health post in-charge from Kathmandu district had similar experiences:

"The DHO is already prepared. They listen to our presentations and put a stamp on it. And we bring back a copy of it and file it. It is a kind of ritual."

The assessment participants underscored the difficulty in putting planned programmes in to practice. A supervisor from Panchthar said:

"Where does the budget come from for the GESI related activity that we announce to undertake?"

He also referred to the locations of health facilities as being a hindrance to providing health services as many of them have been established in line with the interests of various interest groups to locate them in a particular place rather than on the basis of social needs and service access mapping. He opined that programmes, budgets and supplies (i.e. medicines) that are allocated/forwarded from the centre primarily revolve around the regularly allocated programmes (e.g. awareness raising and motivating mothers regarding the importance of vitamins, nutritious food, vaccinations, growth monitoring, ANC and PNC) irrespective of the specific requirements of local level plans. Top-down planning, programming and budgeting tends to be at odds with tailored responses to local needs and reaching underserved and excluded communities. The latter are essential for GESI.

2.5.2 **Push system of medicine supply**

The 'push' system of allocating medicines to health facilities is an example of a centralized system. The push (from the centre) system demotivates and creates barriers to trained personnel mainstreaming gender in their regular work. Most health post in-charges said that as long as the push system is not reversed and the 'pull' (to the facilities) system applied for distribution, the concept of GESI cannot be fully implemented. For example, there were boxes of Met-100 medicine which will expire in April/May 2016 in a health centre in Panchthar which were not requested nor required.

Geta Health Post staff, Kailali, reported that:

- large quantities of Metronidazole syrup had been sent when the number of clients suffering from diarrheal diseases was decreasing;
- epilepsy patients were mostly taken to higher level facilities in Kailali, but large quantity of the treatment drug phenobarbitone was sent to the health post with 600 bottles about to expire soon; and
- about 50,000 condoms were in stock.

This was the case when the health post was short of medications for skin diseases and gastrointestinal problems. The in-charge said that the underserved groups and people from unreached areas had been increasingly visiting the health post but when they are unable to receive the needed medication they would say:

> *"You ask us to come here. You tell us that it is our right. But when we come you say you don't have medicine!"*

Paiyounpata Health Post staff observed: "If the Health Post is unable to provide medicine to the patient, they will not come for a second time". At the time of the assessment visit this health post did not even have paracetamol tablets. Gopetar PHCC in-charge said that the lack of a feedback system is responsible for this situation. He also had stories about receiving unnecessary medicines and wished that a pull system was established for medicine supply:

> *"HMIS doesn't have a data system for medicines. On the other hand the PHCC doesn't get a budget to buy medicines."*

The availability of the standard basic medicines that the different levels of health facilities should stock is a prerequisite for mainstreaming GESI. But the push system in medicine distribution and the absence of a feedback system from facilities to supply centres has prevented the flow of medicines as per the demands of health facilities. The inability to provide common required medicines to needy service seekers undermines their trust in the government system. Also, the push system is contradictory to the SWAp, which requires a decentralized health care system to be in place.

2.5.3 **Location of health facilities**

The location of some health facilities was identified as a critical barrier to making services more accessible to women and poor and excluded people.

- For example, in Panchthar, Gopetar PHCC is located in Ward 1 of Panchami VDC. According to the PHCC in-charge due to the difficult topography it takes about six hours to reach the PHCC from wards 8 and 9 of the VDC. The health post in the neighbouring Amarpur VDC is closer to these wards, but the clients do not get the same facilities there. As a result, Gopetar PHCC, which provides higher level services, treats few service seekers. On the other hand Tharpu Health Post in Tharpu VDC, which is a lower level facility, deals with more service seekers.
- The supervisors from Panchthar DHO gave examples of other parts of Panchthar where it takes almost an hour by bus to reach the nearest health facility. This is a barrier to accessing health services especially for women to get their third and fourth PNC check-ups.

- In the case of Sankhu Health Post, Kathmandu, wards 12 and 13 are still unreached with health services because of their remoteness. Due to the temporary nature of the outreach clinics the inhabitants are compelled to travel to the health post for serious problems.

The above cases highlight that the norm (availability of health facility within one hour's travel distance) often does not apply and the long distance to a health facility for many people is a major constraint for achieving universal health care coverage.

2.5.4 **Lack of sharing culture**

MoH is gradually including GESI-related sessions in most health personnel trainings and assumes that participants formally share their knowledge and skills with co-workers both forally and informally. However, this hardly happens. Only one participant of a GESI training, an AHW from Sankhu Health Post, reported that he had organized a GESI orientation for his facility's community and members including FCHVs, other staff, and HFOMC members. At this orientation in-depth discussions were held on the roles of fathers, mother-in-laws and daughter-in-laws. Other training participants have not organized such events, the most common reason being a lack of funds. They stated that it is possible to organize events only if a budget is allocated from the centre: "Health facilities can't even provide tea and snacks for participants" said one participant. Expanding GESI training and providing tools and resources for this purpose should be a focus of future GESI mainstreaming initiatives.

3 SUMMARY OF KEY FINDINGS

The assessment found that GESI training us generally useful and the content coverage is relevant and adequate. But the training content delivered to the practitioners' level needs to be reduced; be based on their everyday realities and contexts; and be more practical to enable participants to link the learning to their everyday practices. The perceived levels of competency of the trainers as reported by training participants varied, though this may be due to their mixed levels of understanding of GESI.

Knowledge levels

- Training participants were found to have become more knowledgeable about GESI. They are had become familiar with basic GESI ideas and its significance. They felt that the training helped to clarify the meaning of GESI as an inclusive approach broader than gender alone. They had also become more knowledgeable about the ways of using existing resources and services effectively and equitably focusing on the need of unreached communities, mainly Dalit women, the poor, Janajatis and other marginalized groups.

Attitude levels

- Participants' attitudes towards women, elderly, people with disability, Dalit and other marginalized and excluded people had become positive. The health post in-charges of most assessed health posts reported that they now gave first preference to the seriously ill, elderly, people with disabilities and people from remote areas. They provided special care to Dalits and the poor. For example, in Sankhu and Baglung health posts they give sufficient medicine to these groups of patients so that they do not have to revisit the health posts frequently just to get medicine. Targeting service providers, the GESI training was purposefully linked with health services and programmes and was felt to have triggered participants to consider how they could avoid exacerbating or perpetuating gender and other social inequalities.

Practice levels

- Although new staff tend to be more sensitive than older ones, service providers' attitudes and practices in general have become more GESI-friendly. Following the training, participants had become motivated to explore GESI related problems (for example why Dalits were not using the health facilities and women not coming for ANC), particularly focusing on who is left out and why, and how to increase access. They have become increasingly aware of the hindrances that hamper access to health services even at nearby health facilities. In some cases, HFOMCs and in-charges have helped make outreach clinics more accessible to women.
- After training most health facility in-charges are better able to convince HFOMC members about the importance of using HMIS data, the preparation of action plans, review meetings and supervision to promote equitable service delivery for unreached and underserved populations of their catchment areas. In the past, they viewed the collection of HMIS data, planning, the holding of meetings and supervision as rituals to be performed to satisfy higher level authorities. These days targets and achievements, gaps and problems related to women, Dalits and Janajatis are discussed, reviewed and reported at monthly meetings.
- Health post in-charges are actively collaborating with HFOMC members in identifying unreached and underserved areas.
- The mapping of available health services has helped identify unreached areas for holding immunization camps and village clinics.

- FCHVs' mostly oral reports, HMIS data forms they complete and service access mapping are the main sources of information on unreached and underserved communities. This information is used by facilities to plan and locate community mobilization, immunization camps and awareness campaigns.
- Health camps are organized particularly for women suffering from uterine-prolapse. Such camps are mostly organized in rural and remote needy communities identified by FCHVs.
- Only very few training participants were found to be formally sharing the knowledge and skills learned from the GESI training with their co-workers. The main reason given for this was lack of funds to do so. The transfer of knowledge and skills should to be an integral part of GESI mainstreaming.

GESI technical working groups

- GESI TWGs play a positive role in increasing access to and the use of health services and have helped identify underserved groups and unreached areas. The examples of decisions made by the technical group included mainstreaming GESI in all the programmes and reviews undertaken by the DHOs/DPHOs; mainstreaming GESI in all services provided group members; the holding of DDC organized GESI planning meetings to make all district programmes GESI friendly. However, nowadays, although they meet as mandated TWGs are not as active as expected. Major problems include difficulty in coordination between different offices and the presence of the same people in multiple groups and committees putting undue pressure on their time.

Synergy among multiple mutually inclusive efforts to mainstream GESI

- Inputs such as monitoring and evaluation tools (i.e. disaggregated HMIS data, social auditing), OCMCs, 24 hour birthing centres and SSUs have jointly contributed to the mainstreaming of GESI. Support from external development partners like UNFPA and H4L have helped mainstream GESI. On the other hand training has refreshed, reminded and enabled participants to undertake a deeper analysis of the barriers women and excluded populations face in accessing health services and the reasons for low service use; and has motivated them to act to correct inequalities. Consequently GESI training has helped change their outlooks and thinking patterns. Following training, participants have begun to see inequality, discrimination and biasness that they had not seen before and to consciously use resources to ensure GESI in health service delivery. Learning from the training has therefore given impetus to other gender mainstreaming efforts.

Barriers to gender mainstreaming

- Planning, programming, and budget allocation is generally undertaken by central level authorities leaving little room for district and sub district authorities to creatively devise context specific interventions to address GESI related issues. Therefore, planning primarily revolves around regularly allocated programmes (e.g. awareness raising and motivating mothers regarding the importance of vitamins, nutritious food, vaccinations, growth monitoring and ANC and PNC).
- The location of health facilities established through the pressure of different interest groups rather than on the basis of social mapping leave some communities underserved. Thus the norm that health facilities should be within one hour's travel distance of all people it is meant to serve often does not apply.

- The push system pf medicine distribution and the absence of a feedback system from facility prevents the flow of medicines as per the demand of health facilities. The inability to provide common required medicines to needy service seekers reduces trust in the government health system. On the other hand the push system goes against the health SWAp that requires a decentralized health system.

4 SUGGESTIONS AND CONCLUSIONS

4.1 Suggestions

Interactions and observations undertaken at the field level generated suggestions related to the GESI training as well as other efforts employed for mainstreaming. The suggestions are GESI training related and broader GESI mainstreaming related.

4.1.1 **GESI training related**

Content and method

- It would be ideal to have three levels of GESI training packages with content specific to each level with one for master trainers, one for mid-level personnel like DHO/DPHO supervisors, and one for frontline service providers like health post in-charges and health post staff.
- Training events should employ exercises and methods based on trainees' context and circumstances. Such an approach will help trainees relate concepts to practice and also inspire them for change. GESI training should be more practice-based.
- Ideally training events should be organized in the second trimester of each year so that participants can begin implementing the learning from the third trimester. In addition, if training is organized in the second trimester, trainers and organizers will not need to rush to finish the training programme.
- Trainers need to be carefully selected and training could be outsourced.
- Regular follow up is essential to institutionalize the changes brought by GESI training at the individual level. For this to happen, the monitoring team should be adequately equipped with health focused GESI related technical knowledge and skills that enable them to address contextual issues. Regular follow up can also be a means to assess the usefulness and consequences of training.
- The current practice of focusing on 'targets versus coverage' to assess service use needs to be changed. In addition to using quantitative data for this purpose, qualitative data is also needed to help identify, understand and address barriers to access.

Capacity enhancement and motivation

- Health facility staff are directly in contact with clients and in some cases are more regularly in contact than their in-charges. It is therefore necessary to orient all staff members to effectively mainstream GESI in the everyday work of facilities. Since mainstreaming cuts across all activities including planning, supervision, monitoring and decision making, HFOMC members also need sensitising on GESI. The GESI concept and related practices can be institutionalized by enhancing the capacity of health workers and HFOMC members.
- FCHVs are key actors and act as a bridge between service providers and service seekers by collecting and sharing detailed information about the health needs of marginalized communities. Most FCHVs have a good understanding of the local context and culture. They also provide counselling services. Training FCHVs on GESI can motivate them in their work alongside enhancing their knowledge and skills. It is therefore necessary to up-scale GESI training for FCHVs.

Knowledge and skill transfer

- GESI training participants are rarely engaged in knowledge and skills transfer. Community level discussions related to gender and social inclusion and its impact on women's and other

disadvantaged groups' health rarely occurs. Therefore, expanding GESI training to a wider pool of health providers, HFOMCs and FCHVs, and providing tools for knowledge and skill transfer and gender analysis in the context of health should be a focus of future GESI training and mainstreaming.

4.1.2 Broader GESI mainstreaming related

The use of the knowledge and skills acquired from GESI training is very much influenced by other health systems strengthening efforts. Keeping this in view some suggestions related to broader GESI mainstreaming are proposed.

Access and service use

- VDC outreach and immunisation clinics should be managed locally with separate management committees comprising of local people. This would increase participation and ownership.
- Some HFOMCs are active and functional, and have been doing commendable activities such as generating local resources locally, hiring ANMs in coordination with the VDC and contributing towards increasing quality health services for needy people. Thus one suggestion is to revitalize and strengthen HFOMCs.
- Updated mapping of available health facilities is needed. In hilly areas and the periphery of big towns, mapping is necessary particularly to ensure efficiency, and for improved access and use of health care facilities among women and disadvantaged groups.
- A number of standard HMIS indicators are now disaggregated by caste and ethnicity. This and other data (e.g. service access mapping and other disaggregated data) should be used to inform decision making at every level of the health system.
- Medicine should be supplied on a demand basis. Random supply reduces underserved groups' trust in government health services; thereby reducing the service use rate.

4.2 Conclusions

Although the idea of GESI has been used and discussed for a long time in Nepal, many people are still unclear about the concept. GESI training is therefore necessary to develop an understanding of GESI among health service providers. This enables them to better understand the situation of women and socially excluded groups. This approach helps identify the real health problem and how to deal with them. Previously, many health personnel thought that gender inequality and social exclusion did not concern them, did not exist, or was not their responsibility. The GESI training that MoH has provided has helped break this mind-set. It has also made health care providers realize that it is not only the prescription, but also their verbal and nonverbal behaviour that matters while ensuring equitable health care services for all. Moreover the training has taught providers how to identify underserved groups and areas.

It is important that all the people engaged in Nepal's health sector have a common understanding of GESI so that they are working for a common cause. GESI mainstreaming training was organized with this realization. Organizational culture is based on shared beliefs, attitudes and values. Therefore GESI mainstreaming orientation is necessary to cultivate a shared attitude, belief, behaviour and values related to GESI among frontline staff of health facilities (nurses, AHWs, ANMs and FCHVs) that come in direct contact with the service seekers. A culture of sharing, which leads to the transfer of knowledge and skill, will fill this gap. However, due to the absence of such

a sharing culture, most trainees tend to wait for external directives to share their learning from training in their institutions.

Since GESI as a concept and a practice is a fairly new phenomenon for service providers, continuous monitoring and technical backstopping is needed on the subject at district and sub-district levels. This will help institutionalize the GESI knowledge and skills acquired from training programmes.

Multiple inputs collectively yield positive outcomes. The same is observed in MoH's GESI mainstreaming efforts. Efforts made through the HMIS, GESI TWGs, birthing centres, OCMCs, village clinics, SSUs, and others have reinforced the efforts of GESI mainstreaming training and vice versa.

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ANNEX 1: NAMES OF PERSONS CONSULTED

	Name	Position	District/Office
Kathmandu			
1	Ms Anita Bhattarai	Senior AHEBA	Sankhapur HP, Sankhu, Kathmandu
2	Mr Arjun Shrestha	AHW	Sankhapur HP, Sankhu, Kathmandu
3	Ms Laxmi Shrestha	Senior ANM	Sankhapur HP, Sankhu, Kathmandu
4	Ms Tulaja Bhabani Lama	Health post in-charge	Sankhu, Kathmandu
5	Mr Bir Bdr. Tamang	HFOMC member	Sankhu, Kathmandu
6	Ms Tej Laxmi Dangol	FCHV	Sankhu, Kathmandu
7	Ms Tamang	Mother of infant patient	Sankhu Health Post, Kathmandu
8	Mr Nabaraj Karki	Health post In-charge	Pukulachi, Kathmandu
9	Mr Prakash Bhatta	Chief, DHO	Kathmandu
10	Mr Geeta Acharya	Supervisor	Kathmandu
11	Ms Indira Pandey	FP/supervisor, DHO	Kathmandu
12	Ms Yam Maya Thapa	Supervisor	Kathmandu DHO
13	Mr Ashok Neupane	Supervisor	Kathmandu DHO
14	Mr Dhruba Adhikari	Supervisor	Kathmandu DHO
15	Mr Keshab Kharel	Supervisor	Kathmandu DHO
16	Mr Rajendra Phuyal	Supervisor	Kathmandu DHO
17	Mr Parba Sapkota	GESI Section Chief	MoH
18	Mr Mukunda Sharma	Section officer	MoH
19	Mr Sitaram Prasai	GESI advisor	NHSSP
20	Ms Shova Lama	GESI expert	Health for Life
21	Mr Sharad Chandra Singh	In-charge	Seshnarayan Health Post
22	Mr Santa Singh Suwal	Senior AHW	Seshnarayan Health Post
23	Ms Rama Tiwari	ANM	Seshnarayan Health Post
24	Mr Baal Mukunda Khatri	AHW	Seshnarayan Health Post
25	Mr Pradeep Basnet	Chairperson, HFOMC	Seshnarayan Health Post
Kaski			
26	Mr Sagar Pd Ghimire	Chief, DPHO	Kaski
27	Mr Mitra Pd. Aryal	GESI focal person	DPHO, Kaski
28	Mr Bodh Raj Subedi		DPHO, Kaski
29	Mr Ramesh Pd. Adhikari	Chief, Western Regional Training Centre	Western Regional Training Centre (WRTC), Kaski
30	Mr Bhuwan Kunwar	Trainer	WRTC, Kaski
31	Mr Phuldev Timsina	Health Post in-charge	Armala Health Post, Kaski
32	Mr Ballav Kunwar	Health Post in-charge	Naudanda Health Post, Kaski
Baglung			
33	Mr Maheshore Pd Shrestha	Chief, DPHO	Baglung
34	Ms Gyan Kumari Sahi	ANM	Payunpata Health Post, Baglung

	Sharma		
35	Mr Dal Bdr. Kunwar	AHW	Payunpata Health Post, Baglung
36	Ms Tika Devi Sharma	ANM	Payunpata Health Post, Baglung
37	Mr Yadu Nath Subedi	Senior AHW	Narayanthan Health Post, Baglung
38	Ms Saraswoti Sharma	ANM	Narayanthan Health Post, Baglung
39	Mr Indra Bahadur Thapa	Health post in-charge	Laharepipal Health Post, Baglung
40	Mr Bishnu Sharma	Health post in-charge	Singana Health Post, Baglung
Kailali			
41	Ms Jayakala Rawal	Health post in-charge	Geta Health Post
42	Ms Sangeeta Gautam	Senior AHW	Geta Health Post
43	Ms Hema Kunwar	ANM	Geta Health Post
44	Ms Parbati Pant	ANM	Geta Health Post
45	Mr Akendra Budha	In-charge	Malakheti Hospital (recently upgraded from PHCC)
46	Ms Parbati Pathak	HFOMC member	Malakheti Hospital
47	Ms Jamuna Paneru	Patient	Malakheti Hospital
48	Ms Uma Pun	Patient	Malakheti Hospital
49	Ms Hima Devi Khadka	Patient	Malakheti Hospital
50	Mr Shiv Dutta Bhatta	Chief, DPHO	Kailali
51	Ms Tara Tamang	Public health nurse/GFP	DPHO, Kailali
52	Mr Madan Dev Bhatta	Supervisor/former GFP	DPHO, Kailali
53	Mr Surya Bista	Supervisor	DPHO, Kailali
54	Mr Narendra Jung Karki	Chief, Far Western Regional Health Training Centre, GESI trainer	FWRHTC, Kailali
55	Ms Saraswati Adhikari	GESI Trainer,	FWRHTC, Kailali
56	Mr Bishnu Pokharel	Health for Life	Kailali
57	Mr Bhuwan Thakurathi	Health for Life	Kailali
Dang			
59	Dr Bhuvan Paudel	Chief, DPHO	Dang
60	Mr Bhuvan Rana	Supervisor	DPHO, Dang
61	Mr Janardan Gautam	Supervisor	DPHO, Dang
62	Mr Kishore Acharya	Family Health Officer	DPHO, Dang
63	Mr Madan Pokharel	Statistic Officer/new GFP	DPHO, Dang
64	Ms Radha Paudel	Nursing officer, GESI trainer, OCMC	Dang
65	Ms Bina Shrestha	Women development officer, GESI TWG member	Dang
66	Mr Shivahari Sharma	In-charge, Seshaniya Health Post	Dang
67	Ms Bishna Rawat	HFMOC member, Seshaniya Health Post	Dang
68	Ms Kalpana Pandey	Mother of child patient	Seshaniya Health Post, Dang
69	Ms Sapiko Nisha	Mother of child patient	Seshaniya Health Post, Dang

70	Mr Narayan Gharti	In-charge, Maanpur Health Post	Dang
71	Mr Khadga Bdr Bhandari	HFMOC member, Maanpur Health Post	Dang
72	Ms Kumari Gharti	Patient	Maanpur Health Post, Dang
73	Ms Dhana K. Chaudhary	Patient	Maanpur Health Post, Dang
Panchthar			
74	Mr Narayan Joshi	Supervisor/statistics officer	District Health Office, Panchthar
75	Mr Hem Dhungana	Supervisor	District Health Office, Panchthar
76	Ms Goma Kafle	Women development officer, GESI TWG member	Panchthar
77	Mr Bijaya Shrestha	Police inspector	Panchthar
78	Dr Prashant K. Gupta	In-charge, Gopetar PHCC	Panchthar
79	Mr Lok Nath Bhattarai	HFMOC member, Gopetar PHCC	Panchthar
80	Mr Manoj K. Sah	In-charge, Tharpu Health Post	Panchthar
81	Ms Shova Katuwal	ANM, Tharpu Health Post	Panchthar
82	Mr Kiran Rai	Staff (khardar)	Panchthar
83	Woman Police	OCMC	Panchthar

ANNEX 2: HEALTH FACILITIES VISITED

Kathmandu

1 Sankhapur Health Post

2 Seshnarayan Health Post

Kaski

3 Armala Health Post

4 Naudanda Health Post

Baglung

5 Payounpata Health Post

6 Narayanthan Health Post

7 Laharepipal Health Post

8 Singana Health Post

Kailali

9 Geta Health Post

10 Malakheti Hospital (recently upgraded from a PHCC)

Dang

11 Seshaniya Health Post

12 Maanpur Health Post

Panchthar

13 Gopetar PHCC

14 Tharpu Health Post

ANNEX 3: ASSESSMENT CHECKLISTS

Annex 3.1: Interview guide for supervisors' focus groups discussions and GESI focal persons

- How was the 3 day GESI training?
- What were the objectives of the GESI training?
- What knowledge and skills did you gain from the training?
    - Knowledge:
    - Skills
- Have you been able to use those knowledge and skills in your daily work?
    - If yes, how?
    - If no, why?
- What has been your experience incorporating GESI in your daily work ?
- What are the new initiatives that you have started after the training?
- How do you find the attitude and behaviour of the health post in-charge and health workers (ref. health post and urban clinic with trained human resources) towards underserved and unreached patients?
    - Responses
    - Dealings (dealing with women, men of different ethnic, language and caste groups and location)
- How have you responded (technical backstopping) to their attitude and behaviour if and when you found them unfriendly and inappropriate?
- How do you get to know which health post requires medicines/supplies? And how do you deliver them?
- What is the process of micro planning?
- Who are the participants of the annual micro-planning exercise?
- Target setting (who? and how?) How is the issue of underserved and the unreached being addressed in the plan?
    - Case of remote settlements
    - Medicine management in remote areas
    - Information dissemination
    - Referral
- How do you perceive the effectiveness of the training in terms of content and delivery? (with e.gs)
- What were the positive points of the training?
- What are the areas to improve in the training? (be specific)
    - Content
    - Method
    - Delivery
    - Participants (heterogeneous)
    - Trainer
- How often (monthly, quarterly, annually) do you meet? Duration of the meeting?
- Who participates in the meeting?
- What are the usual agenda of the meeting? (is GESI agenda included, for example on serving the underserved and the unreached)
- What are the usual outputs of meetings? (meeting minutes and the GESI being implemented)
- How are implementation gaps identified in review meetings and how are they dealt with?
- Do you have an HMIS? If yes? How is it being used? (GESI related disaggregation exists or not?, examples-most malnourished areas, more underserved population, more unreached areas...)
- How is district level data (e.g. VDC/DDC produced household data) incorporated in your planning? Yes — how? No — why not?
- Supervision and monitoring:
    - how often?
    - where?
    - how is joint supervision done?
    - what is the usual outcome? how is it incorporated in the planning?

Annex 3.2: Interview guide for HFOMC members

- Composition of the committee in terms of gender, caste ethnicity:
- How was the 3 day GESI training?
- What were the objectives of the GESI training?
- What knowledge and skills did you gain from the training?
    - Knowledge:
    - Skills:
- Have you been able to use those knowledge and skills in your daily work?
    - If yes, how?
    - If no, why?
- What has been your experience incorporating GESI in health post management?
- What are the new initiatives that you have started after the training? (Utilizing VDC data, accessing unreached population and areas, etc.)
- How do you find the attitude and behaviour of the health post in-charge and the health workers (ref. health post and urban clinic with trained HR) towards underserved and unreached patients?
    - Responses
    - Dealings (dealing with women, men of different ethnic, language and caste groups and location)
- How often (monthly, quarterly, annually) do you meet? and duration of the meeting?
- Who participate in the meeting?
- What are the usual agenda of the meeting? (is GESI agenda included; for example, serving the underserved and the unreached)
- What are the usual outputs of the meetings? (meeting minutes and the GESI being implemented)
- How are implementation gaps identified in the review meeting and how are they dealt with?

Annex 3.3: Interview guide for health post in-charge or staff

- How was the 3 day GESI training?
- What were the objectives of the GESI training?
- What knowledge and skills did you gain from the training?
    - Knowledge:
    - Skills:
- Have you been able to use those knowledge and skills in your daily work?
    - If yes, how?
    - If no, why?
- What has been your experience incorporating GESI in your daily work?
- What new initiatives have you have started after the training?
- Any example of patience's reaction of your changed behaviour?
- How do you perceive the effectiveness of the training in terms of:
    - Content
    - Method
    - Delivery
    - Participants (heterogeneous)
    - Trainer
- What were the positive points of the training?
- What are the areas to improve in the training? (be specific)
- Does Village Development Committee /*Nagar Palika* collect health related household data? Do you use that date?
    - If yes, how?
    - If no, why?

- Does this facility have HMIS? If yes? how is it being utilized? (GESI related disaggregation exists or not?, examples-most malnourished areas, more underserved population, more unreached areas...)

Annex 3.4: Checklist for patients

- Name of the respondent:

- District, VDC, health facility:

Why did you come to this facility today? _____ _____ _____
Can you please tell me how much time you spent at this facility today, including the time spent waiting to see the provider? hours minutes _____
How long did you wait before you saw a health provider today? hours minutes _____
Do you have to come repeatedly to the health facility for the same problem because the health facility worker did not respond well to your problem? _____
Can you please tell me whether you are very satisfied, satisfied, or unsatisfied about the following aspects of your visit today:
1. Waiting time …….. why? …….
    - Where did you have to sit during the waiting time?
    - Did somebody overtake you in your turn?
2. Time with the health provider …….., why? …….
3. Privacy during examination …….., please explain
4. Staff attitude and behaviour……. please explain
6. Discussion with provider …….
7. Availability of free medicine……..
8. Cost of the medicine……..
9. Do you find the structure and the facilities of the health post satisfactory?
10. Do you find the arrangements of the furniture, examination rooms and beds appropriate?
11. Overall services received today……..

Annex 3.5: Checklist for trainers

- Overall impression about 3 day GESI training in terms of contents, methodology and delivery mode .
- Impression about the trainees
- Perception about the training's ability to change knowledge and behaviour.
- Any follow up or encounter by any chance? i.e. how are the trainees performing?
- Suggestions for the future.

Annex 3.6: Checklist for UNFPA and H4L field based personnel

- What has been your experience and observations regarding access and equity in health service delivery in this district?
- How have you been supporting GESI initiatives of the DHO/MoH?
- What have been your initiatives in ensuring access and equity in health service delivery?

Annex 3.7: Checklist for GESI training manual designer and trainer from H4L

- Experience and observation regarding the GESI training
- Experience and observation regarding the GESI training impact
- Suggestion particularly related to GESI training

Annex 3.8: Checklist for MoH and NHSSP

- Background of and intent behind the training
- Reasons behind the gaps related to GESI training as identified by the participants
- Observations and suggestions

ANNEX 4: TERMS OF REFERENCE

TERMS OF REFERENCE
FOR
Assessment of GESI Mainstreaming Training
September, 2015

1. BACKGROUND

The Government of Nepal is committed to improving the health status of its citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health sector-wide approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was successful and brought about many health improvements. Building on these successes, the Ministry of Health and Population (MoHP) and its external development partners designed a second phase of the programme (NHSP-2, 2010-2015), which began in mid-July 2010. NHSP-2's goal is to improve the health status of the people of Nepal. Its purpose is to improve the use of essential health care and other services, especially by women and poor and excluded people.

Gender equality and social inclusion (GESI) is a key area of support provided by NHSSP. This work covers mainstreaming GESI into health plans and system; operationalising GESI into service delivery (by supporting one-stop crisis management centres, social service units, the Equity and Access Programme, and social auditing); and developing a common understanding on GESI among health sector personnel.

2. SPECIFIC BACKGROUND

The government of Nepal has shown strong commitments to GESI mainstreaming. It is not a goal in itself but an approach to integrating GESI concerns into policy decisions, legal frameworks, activities and programmes. GESI mainstreaming in the health sector is an important strategy to increase access to and use of health services and address disparities in service delivery for women and excluded groups.

Considerable achievements have been made by MoHP in creating an enabling environment for GESI and establishing an institutional platform for its mainstreaming. The Population Division, as the GESI Secretariat, recognised the importance of strengthening the competence of government personnel to advance GESI mainstreaming. Building a common understanding of GESI, and changing the attitudes of people that make up the health system are long-term processes that need to be tackled through institutional and system change and capacity building.

While many lessons have been learned, a number of challenges constrain the mainstreaming of GESI effectively and rapidly in the sector. Making progress on GESI mainstreaming in the health sector requires actions that address gaps in knowledge and expertise and building the capacity of people working in various avenues and levels. It requires service providers who are capable of identifying and addressing GESI issues as part of their day-to-day business. Without sufficient knowledge of GESI issues, it is impossible to mainstream gender and social inclusion in policies and programmes.

GESI training, therefore, has been used as an educational tool to support policy-makers and service providers working at various levels. So far, more than 2000 service providers (health facility in-charges, district supervisors, DHOs, DPHOs, staff nurses, OCMC and SSU focal persons) from 31 districts have been trained to enhance their efforts to integrate GESI considerations into all policies, programmes and especially in service delivery. The main thrust of the training was to ensure that key actors and service providers involved in policy-making and service delivery are GESI-awareness,

building their GESI expertise and enabling them for in their work at all levels. Furthermore, the objectives of GESI mainstreaming training have been to develop a common understanding of GESI related concepts including its importance, measures and analysis techniques; to enhance knowledge and skills on GESI responsive programme planning, implementation, monitoring and evaluation; and to strengthen the capacity on handling/dealing with sexual and gender-based violence survivors while providing medical services at different facilities.

3. RATIONALE

Mainstreaming GESI efforts in programmes and service deliveries has been an inspiring yet challenging initiative for Nepal's health system. There are various factors including personal traits and attitudes of individuals to system readiness that may affect the appropriate application of learning from trainings/orientations. There have been several phases of trainings and orientations conducted for health cadres to raise awareness so that they can respond to disparities in service delivery for women and excluded groups as well as deliver quality services at different levels.

GESI trainings are largely a dynamic platform for sharing knowledge and experiences by service providers working at various facilities and levels. These trainings are designed in a way that addresses and focuses on solving problems, to showcase good practices, and to support one another in applying what works best in different situations and communities.

Supporting GESI is a priority area of NHSSP support to the government to increase access to equitable health services to all, especially women and the excluded. An understanding of the different ways in which GESI mainstreaming training is applied would go far in helping understand our efforts and how best to direct support. This ToR is for a consultancy assignment to assess GESI mainstreaming training to understand its effectiveness at various levels.

4. OBJECTIVES OF THE ASSIGNMENT

The overall objective of the assignment is to understand the effectiveness of the GESI training programme for health personnel at the district and health facility levels. The specific objectives are as follows:

- Understand capacity gaps and needs. Find out what perceived needs are in terms of capacity to implement GESI mainstreaming training,
- Assess the effectiveness of the trainings being provided/taken vis-a-vis service delivery and access to services.
- Address key issues experienced by service providers (those who have received trainings).

5. METHODOLOGY AND TASKS

Review of documents

Available secondary documents related to the GESI training of health staff will be reviewed by the consultant before embarking on the field visits. This will help to form the conceptual framework for the assessment. The documents will include:

- GESI Implementation Guidelines in Health Sector
- GESI training manual and reference materials
- Health Sector GESI Strategy
- Social Service Unit and OCMC Operational Guidelines
- GESI training completion reports

- Job descriptions of health facility in-charges, district supervisors, DHO/DPHOs, staff nurses, OCMC and SSU focal persons.

Design a framework for data collection

The consultant will develop an assessment framework for information collection including key questions and lines of enquiry for each area/level, and type of informant (e.g. health provider, safe home staffs, police officer, GBV survivor).

Consult with national stakeholders and visit selected districts to assess the situation

The consultant will consult with service providers of different facilities (DHO, PHCC, HP) and visit six selected districts where GESI mainstreaming training has been conducted. District visits will provide an opportunity to contextualise existing practice, and identify gaps and challenges that need to be factored into future arrangements. In summary, the following activities need to be conducted:

- In-depth consultations and key informant interviews with hospital staff, OCMC staff including those at selected health facilities.
- Review of meeting minutes of GESI technical working groups (TWGs) and any related reports available and consultations with key persons of the TWGs including coordination with district level government organisations and I/NGOs.
- Review of micro-planning prepared by DHOs and DPHOs.
- Review of annual reports prepared by the district.
- Observation of office environment vis-à-vis gender friendliness, male to female ratio, etc.

6. SCOPE OF WORK

The consultant will visit six districts representing the five development regions and hold interactions with health facility in-charges, district supervisors, DHO/DPHOs, staff nurses, OCMC and SSU focal persons and NHSSP officials at the centre. Besides the district personnel, two health facilities in each district will be visited for the study. The trainers' experiences and their perceptions will also be taken for the overall assessment of the training.

7. DELIVERABLE

- Assessment report (with analysis of data and information) of the GESI mainstreaming training.

7. TIMEFRAME

The consultant will be contracted for 21 days in total starting from 1st October to 30th November 2015. The details are as follows:

SN	Activities	Proposed number of days
1	Meeting with GESI team and Population Division review Review of documents and design a framework for data/information collection	1 day
2	Field visit including travel (in six districts)	16 days
3	Analysis, prepare and submit report	4 days
	Total days for the consultancy	21 days

8. REPORTING

The consultant will report to Mr Sitaram Prasai, the GESI Advisor of NHSSP and will work closely with the Chief of the Population Division, MoHP.

9. QUALIFICATIONS, COMPETENCIES AND SKILLS REQUIRED

Requirements for the consultant are as follows:

- Experience of working in GESI/GBV preferably in health and development sectors.
- Master's degree in social science or women's studies with extensive knowledge and experiences in gender and health.
- Experience of working in design and implementation of training.
- Demonstrated reporting skills in the English language.

The assignment will involve a consultant having a strong understanding of GESI in the Nepal context, and experience of working on GESI issues and the government systems.

10. APPROVAL

These terms of reference have been reviewed and approved by the Chief of the Population Division, who will be kept informed of progress during the assignment and receive a copy of the deliverable.