Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion

Government of Nepal

Ministry of Health and Population

GESI Steering Committee

Population Division

Ramshah Path, Kathmandu

2069 (2013)

Contents

Foreword

The Second Nepal Health Sector Programme (NHSP-2) has prioritised Gender Equality and Social Inclusion (GESI) issues in line with the spirit of Nepal's Interim Constitution, Long-term Health Sector Plan, and Three-year Interim Plan. Experience has shown that Dalits, marginalised Janajatis, marginalised Madhesi groups, Muslims, the poor, those differently abled, and people living in remote areas have not been able to access available health services as other social groups do. Similarly, women have not been able to utilise available health services as men do. The Second Nepal Health Sector Programme has provided special priority to GESI in its objectives, principles, and strategies, and the Ministry of Health and Population (MoHP) has provisioned for the institutional set-up of GESI at the ministry itself and its departments and offices. Similarly, the ministry has adopted the policy of mainstreaming GESI issues in all its policies and programmes, and implementing GESI in a collaborative manner with other programmes of the divisions, departments, and centres.

A ministry-level meeting on 2068/4/12 decided to "establish a GESI institutional mechanism at the ministry level and the offices under the ministry". According to this set-up, provisions have been made to establish a GESI Steering Committee (SC) at the ministry level, a GESI Technical Committee (TC) at the departmental level, and GESI Technical Working Groups (TWGs) at the Regional Health Directorate (RHD) and district levels. The Health Facility Operation and Management Committees (HFOMCs) are provided the responsibility of implementing GESI issues at the local health facility level. These guidelines have therefore been prepared to establish and manage the GESI institutional set-up.

I hope that these guidelines will contribute to the operation and management of the GESI committees at different levels, once they come into operation. Since institutional mechanisms alone will not be able to achieve the expected results, I would like to request that all divisions and centres of the ministry and department, RHDs, District (Public) Health Offices (D(P)HOs) and local health facilities internalise the spirit of GESI and activate the GESI committees and working groups.

Finally, I would like to express my appreciation to both the staff of the Population Division who played the coordinating role and the experts of the Nepal Health Sector Support Programme (NHSSP) who helped to prepare these guidelines. Lastly, I would like to extend my well wishes for the successful implementation of the GESI guidelines.

Dr. Prabin Misra
Secretary

Foreword

The Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion 2069 have been prepared to address the gender- and caste-/ ethnicity-based discrimination which prevails in Nepal, affecting equality, justice, and empowerment. These guidelines will help to institutionalise GESI in the ministry, department, regional directorates, and D(P)HOs. A legal framework and procedure have been prepared in order to provide access to health services, resources, and opportunities, especially for women, the poor, and other marginalised caste and ethnic groups, by removing social, cultural, economic, and institutional barriers that have existed for centuries.

These guidelines clearly underline the objective, target group, institutional arrangements, and steps of GESI mainstreaming, to allow the target groups easy access to the health services provided by the state, and available through the MoHP and offices under it. I am confident that these guidelines will help to provide health services to target groups as per the objective of GESI, and I would like to thank the NHSSP GESI Advisor and all the people involved in the preparation of these guidelines.

Dr. Badri Pokhrel
Chief
Population Division

Chapter -1: Introduction

1.1 Background

Nepal is home to a diverse range of social and cultural groups. Experience to date has shown that Dalits, marginalised Janajatis, marginalised Madhesi groups, Muslims, the poor, people with disabilities, and people living in remote areas have not been able to access the benefits of development and available opportunities as other social groups do. Moreover, the majority of women have not been able to access services and opportunities as men do. Gender Equality and Social Inclusion (GESI) issues have therefore become central and priority concerns of the Government of Nepal (GoN) in all sectors.

The Interim Constitution of Nepal 2063 (2007) has provisioned for social justice and affirmative action for women, Dalits, indigenous Janajatis, and Madhesi and other disadvantaged groups. Social inclusion is one of the four main pillars of the Poverty Reduction Strategy Paper (2002-2007). The Three-year Interim Plan (2007-2010) placed a special emphasis on equitable access to health services for women, the poor, people with disabilities, and socially excluded groups, giving priority to GESI issues. Similarly, the Three-year Plan (2011-2013) has accorded special priority to GESI issues.

With the realisation that without GESI the health sector would not be able achieve its expected results, the Ministry of Health and Population (MoHP) has laid special emphasis on GESI mainstreaming. MoHP is implementing the Second Nepal Health Sector Programme (NHSP-2) with support from external development partners. The major aim of this programme is to improve the health condition of Nepalese citizens, especially women, the poor, and excluded groups. The mission, objectives, strategies, and principles of this programme accord high priority to GESI. The health sector programmes are in line with the spirit of the GoN's efforts to make the country an inclusive and just state. The Health Sector GESI Strategy 2010 has been implemented in line with NHSP-2, Millennium Development Goals (MDGs), and the Three-year Plan.

Efforts have been made in the health sector to improve the health of Nepalese citizens; the MoHP has tried to respond to the national mandate on inclusion by implementing pro-poor- and pro-women-centered programmes. Satisfactory results have been achieved from the successful implementation of the targeted free health services programme and the Aama Surakshya Programme (Aama) for delivery services. NHSP-2 has set specific objectives and provisioned disaggregated indicators in order to respond to the needs of GESI. The National Plan of Action against Gender-based Violence (GBV) was put into operation in 2010 by the Office of the Prime Minister and the Council of Ministers (OPMCM) with the commitment of 11 ministries, including the MoHP.

An institutional mechanism with appropriate systems and human and financial resources is necessary for the formulation, implementation, and monitoring of health sector's GESI-responsive programmes. Policy environment, clear guidance, and institutional strength and capabilities are necessary to respond to the issues and problems faced by women, the poor, and other excluded groups. These guidelines have been prepared and implemented by the MoHP's Secretary-level decision 2068-4-12 (2011-7-28) "to establish permanent institutional structure for GESI mainstreaming and actions against GBV in the ministry, department and lower level offices as per the spirit of the Second Nepal Health Sector Programme and provisions made in GESI strategy. The initiative will be led by the Population Division of the ministry".

1.2 Name and commencement

a) The name of these guidelines will be "Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion".

b) The guidelines will be effective from the date of approval from the GoN.

1.3 Definitions

The following definitions of the term will be used in the implementation of these guidelines, if not otherwise mentioned.

a) **Social inclusion:** Social inclusion is defined as the effort to remove the social, cultural, economic, and institutional barriers and to improve the access of women, the poor, Dalits, and other marginalised groups on the resources, opportunities, and services related to health, and to increase their institutional representations in an equitable manner.

b) **Institutional mechanism:** Institutional mechanism refers to: the GESI Steering Committee (SC) at the ministry level; GESI Technical Committee (TC) at the Department of Health Services (DoHS); and GESI Technical Working Groups (TWGs) at the ministry, departments, Regional Health Directorates (RHDs), District (Public) Health Offices (D(P)Hos), and health facilities.

c) **Underserved groups:** Underserved groups are defined as those groups of people who are unable to access MoHP health services owing to their unavailability, or not able to utilise the available services due to geographic, economic, social, and cultural barriers.

d) **Unreached areas:** Unreached areas are those geographic locations where health services have not reached because of difficult terrain or distance, and where the people of these areas have not been able to utilise services as have people in other areas.

e) **GESI-responsive programmes:** Programmes which are implemented by the concerned agencies in response to the needs of women and other historically excluded groups through identifying barriers to uptake; neutrally designed programmes have not been able to deliver services to these groups as they have to other citizens.

f) **Excluded groups:** Those groups of people who have systematically been excluded throughout history owing to economic, caste, ethnic, gender, disability, and geographic reasons. The Health Sector GESI Strategy has defined excluded groups as those women, Dalits, indigenous Janajatis, Madhesi groups, Muslims, people with disability, senior citizens, and people living in remote regions who have fallen behind the national development mainstream.

g) **Poor and ultra-poor people:** The definition of poor people is taken from the Nepal Living Standard Survey 2009/10, according to their ability to satisfy their basic needs. Poor families or poor persons are those whose income is not sufficient to acquire the daily minimum calorific need of 2,220 calories, or who spend less than 11,929 Nepalese Rupees (NPR) on foodstuffs and NPR 7,332 on non-food items annually. A person is considered poor whose own farm production or income supports them for more than six months but less than 12 months in a year. The ultra-poor are defined as those people or families who have less than six months' food sufficiency from their own farm production and sources of income.

h) **GESI focal person:** Person who has been designated in respective divisions, centres, branches, health facilities, and hospitals for the implementation of existing GESI policy provisions, formulation of GESI-responsive programmes and budget, and integration of GESI in Monitoring and Evaluation (M&E) in order to improve the access of women, poor, and other excluded groups to health services.

g) Gender Equality and Social Inclusion Strategy: The Gender Equality and Social Inclusion Strategy 2010, which has been formulated with the objective of delivering health services to the targeted groups by creating an enabling policy environment, improving Human Resources (HR), and enhancing institutions through plans and programmes.

h) **Health Facility Management Committee:** Committee which has been officially established by the government as per the "Local Health Facility Handover and Operation Guidelines 2004" for the overall management of health facilities.

i) **GESI mainstreaming:** Initiatives related to: identifying barriers to service uptake faced by women, the poor, and other excluded groups; developing policy provisions, institutional systems, programme and budget formulations, and M&E systems responsive to GESI; and evaluating the institutional capacities, responsiveness, and work environments of the concerned agencies in order to gauge the progress made in GESI mainstreaming.

1.4 Objectives of the guidelines

The broad objective of these guidelines is to institutionalise GESI in the MoHP, and offices under the ministry, in order to mainstream GESI in the health sector. Specifically the guidelines will help to:

- Institutionalise GESI in the ministry, departments, RHDs, D(P)HOs, and health facilities, describing institutional mechanisms and their roles and responsibilities.
- Guide the working relations, communications, and reporting lines between GESI mechanisms at different levels.

Chapter -2: Conceptual framework

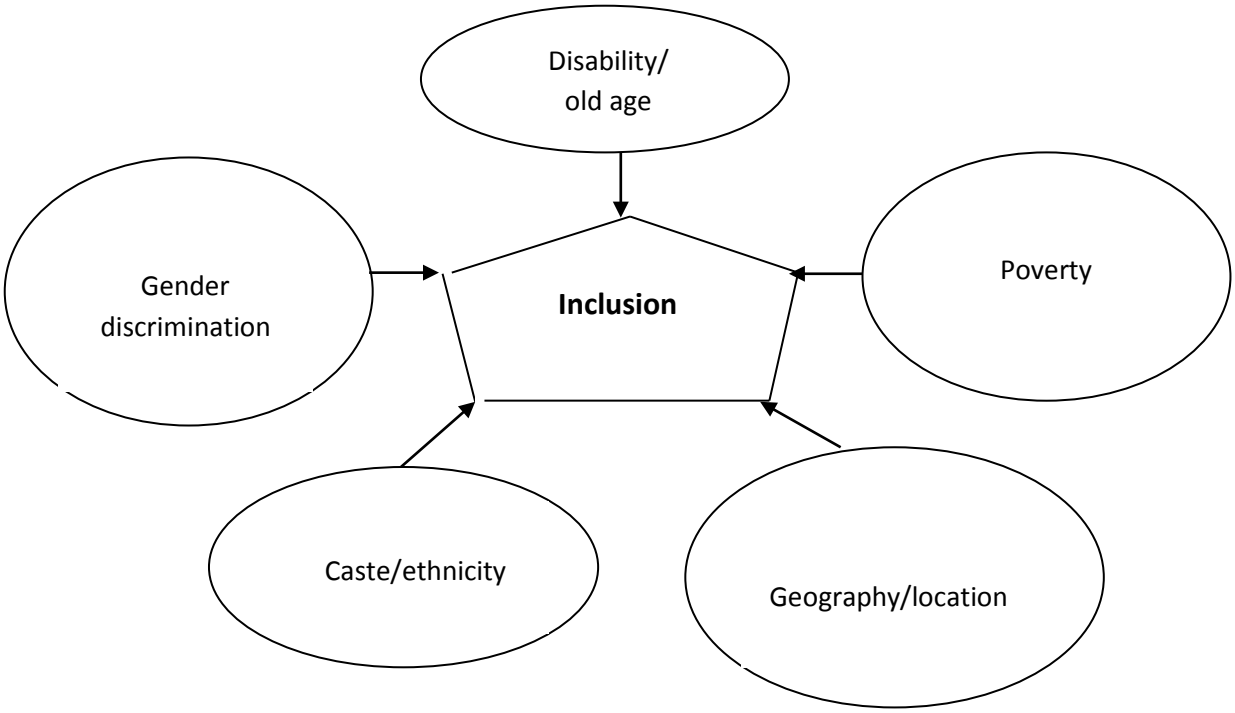
These guidelines have adopted three pillars for GESI mainstreaming. The first pillar deals with different aspects of inclusion and the different groups and regions that GESI should take into consideration. The second pillar deals with the complementary role of inclusion and empowerment: the changing role that service providers should play to ensure effective service delivery, and the efforts made to empower excluded groups through awareness raising, institution building, and capacity building. The third pillar emphasises that the target group will have access to services and benefits only if GESI is mainstreamed in programme planning, implementation, M&E, and reporting. A brief description of the three pillars is provided below.

2.1 Dimensions of inclusion

In Nepal, social exclusion refers to the systematic exclusion of groups who have been historically discriminated against on the basis their social and economic status, caste, ethnicity, gender, disability, and location. The Interim Constitution, Three-year Plan, and Health Sector GESI Strategy have defined excluded groups as women, Dalits, indigenous Janajatis, Madhesi groups, Muslims, people with disabilities, senior citizens, and people living in remote regions who have not been included in the development efforts. Women have been economically, socially, culturally, and geographically the most marginalised group among the excluded, as revealed by Human Development Index (HDI) indicators. MoHP has recognised five different dimensions of inclusion, acknowledging each group's particular needs, contexts, and barriers: these dimensions are based on a) gender, b) caste/ethnicity, c) poverty, d) geography/location, and e) disability/old age.

a) **Gender discrimination:** Gender discrimination persists in Nepal owing to social and family customs, values, and beliefs, and religious and cultural practices. Women's role, status, and authority have been constricted in most families. Economic, social, cultural, and political discrimination has been imposed on the majority of women, irrespective of caste/ethnicity, class (rich and poor), and geography (mountain, hills, and Terai). As a result, women have not been able to utilise the available health services smoothly. Moreover, they have not been able to demand services as per their specific needs. Therefore, women's access to health services can only be improved through the formulation of gender-friendly policies and regulations, responsive programme design and revision, the provision of services and incentives, and effective implementation that helps remove the barriers faced by women.

Dimensions of Inclusion



b) **Caste/ethnicity**: The health service utilisation rate of certain caste and ethnic groups is low; their health condition is poor as a result of caste-/ethnicity-based discrimination, untouchability, low self-esteem, caste- and ethnic-based practices, and for cultural reasons. Their service utilisation will be improved only if major barriers for access to and utilisation of health services (e.g. caste- and ethnic-based practices, customs, culture, and discriminatory behaviour) are identified and addressed. The health condition of these groups could be improved through policy provision, improving programmes, and the provision of special programmes and services based on their specific context.

c) **Poverty**: Poverty is a major barrier to health service utilisation: poor people are often unable to utilise available health services because of economic deprivation. Since they are not able to bear the cost of transportation, attendants, and treatment in higher-level health facilities, their health condition will only be improved if free services are provided, or if a proportion of fees is paid for them. There are numerous examples of people seeking treatment from traditional healers or using local herbs as they cannot afford to use modern health services.

d) **Geography/location**: Since health facilities are not planned based on geographic terrain and remoteness, the people of mountain and hill regions are deprived of health services. Long distances and difficult geographic terrain deny, in particular, women, senior citizens, children,

and people with disabilities access to health services. Extended absences of health providers and shortages of medicine prevent existing health facilities in remote areas from providing regular services; as a result, those living in remote areas are deprived of both preventive and curative health services. Therefore, it is necessary to formulate policies, revise programmes, launch special programmes, and arrange additional health facilities in order to ensure access to health services for people living in remote areas.

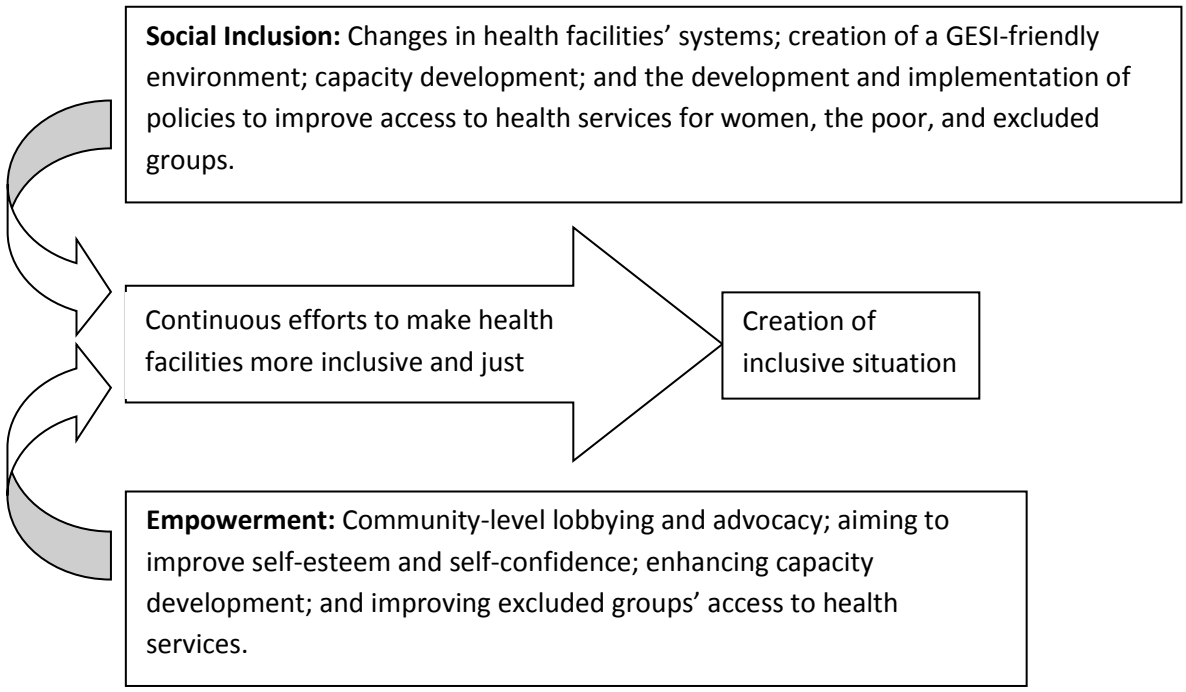
e) **Disability/old age:** People with severe disabilities are not able to access health services easily: a lack of support from family and a lack of sensitivity from health service providers can act as impediments. Similarly, senior citizens do not have easy access to health services: they may face unsupportive behaviour from family members, be unable to reach health facilities because of physical weakness, or be prone to different diseases. Therefore, physical, familial, social, and other service-related barriers need to be identified and addressed in order to provide services to senior citizens and people living with disability.

2.1.2 Complementarities between social inclusion and empowerment

Social inclusion is concerned with the changes made in health institutions which deliver services. It is related to the efforts to bring changes in the policy, systems, service delivery procedures, environment, attitude, and behaviour of the health staff, and accountability towards women, the poor, and other excluded groups, in order to improve access of these groups to available health services. The health institutions must start social inclusion practices based on institutional and policy analysis.

Empowerment is social mobilisation for awareness-raising, self-identity, and raising the voices of women, the poor, and other excluded groups. Different aspects of empowerment include: organising women, the poor, and the excluded into groups; raising awareness about health service provisions and procedures; identifying barriers faced by target groups; and building their capacity to advocate and lobby for health services.

Social change: Complementarities between social inclusion and empowerment

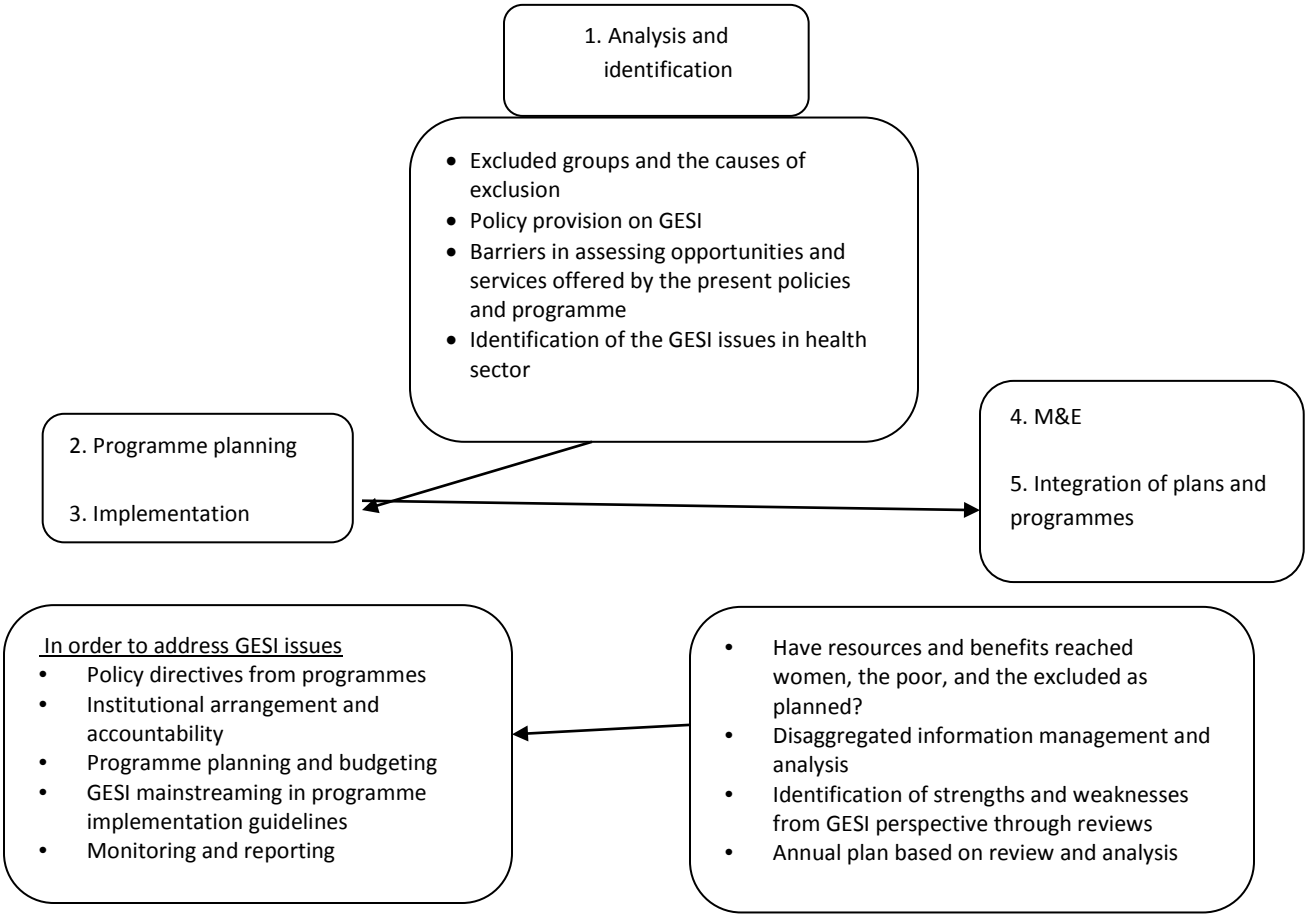


Health service delivery institutions must be made more inclusive, just, and accountable; it is also essential to empower women, the poor, and excluded groups to demand and receive services. It is only with such efforts that significant improvement in GESI can be achieved. Both social inclusion and empowerment issues must be worked on, since each is complementary to the other.

2.1.3 GESI mainstreaming

Policies, rules, and programmes should be formulated and designed only after identifying the location and contextual barriers faced by excluded groups. Identification of the barriers faced by excluded groups when accessing health services, and subsequent improvement in the policy provision, institutional mechanisms, programming, budgeting, and M&E, are necessary to allow excluded groups to make best use of the available opportunities and services in the health sector. The chart below depicts the different steps in GESI mainstreaming.

Steps in GESI Mainstreaming



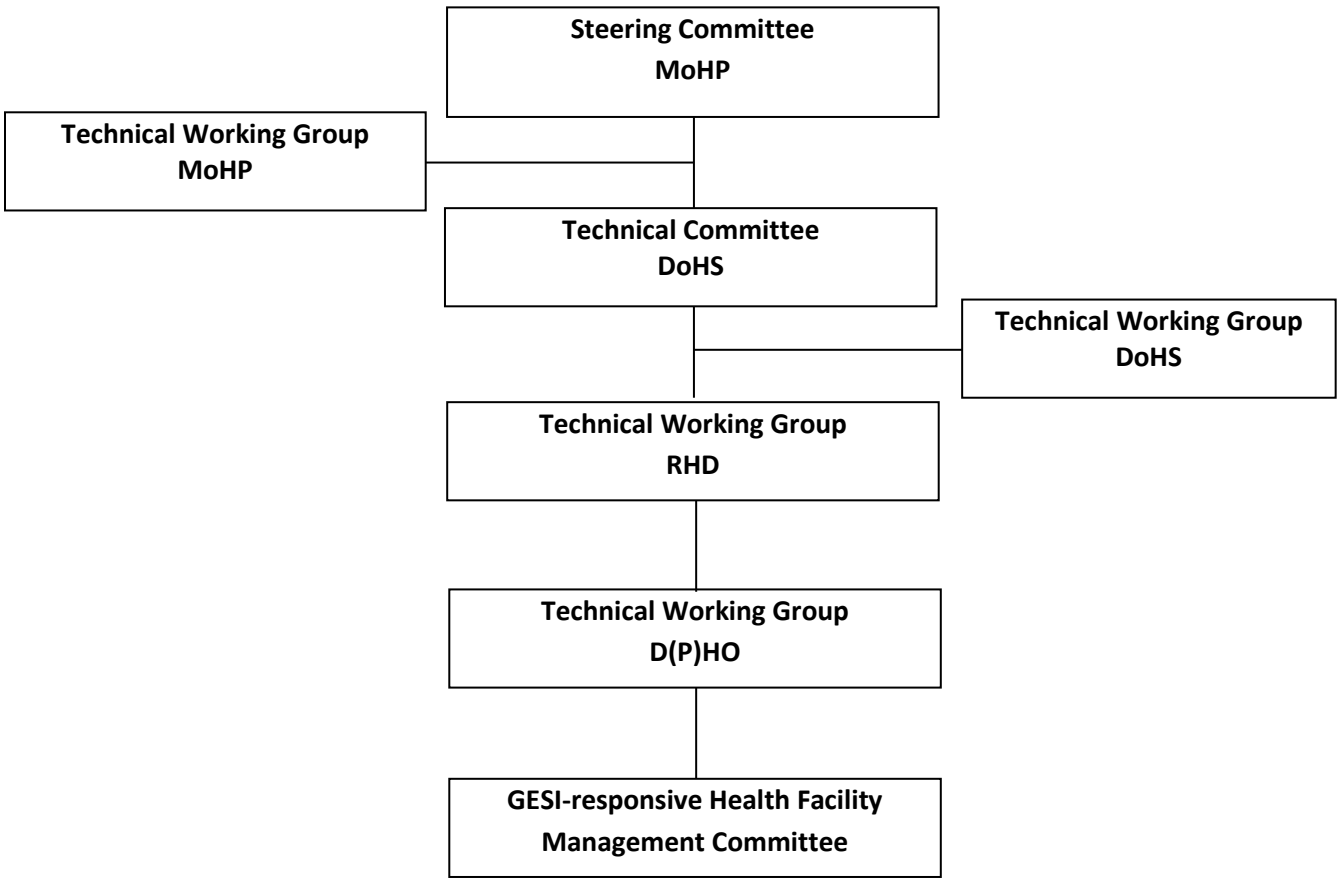
Chapter -3: Institutional arrangement

3.1 Institutional structure

Institutional arrangements, geographical location, health providers' behaviour, and institutional values greatly determine the access of women, the poor, and excluded groups to health services. Similarly, the social structure and values and beliefs determine social and gender discrimination. The GESI committee and groups formed at MoHP and the offices under the ministry will evaluate the existing practices, values, beliefs, and attitudes within the respective offices for positive transformation.

The proposed representative structures extend from ministry to health facility level. Provision is made for the representation of the Division Chiefs of concerned ministries and of the National Planning Commission (NPC), which houses GESI in the SC for inter-ministerial coordination. It is believed that the SC would be more effective with representation from NPC, since the NPC is the focal agency for planning, programme formulation, and monitoring. The following section highlights the objectives, representation, and scope of work of each structure at different levels.

GESI STRUCTURE



3.2 Formation, functions, duties, and authorities

3.2.1 Ministry of Health and Population

3.2.1.1 Steering Committee

Background

The GESI SC will be formed as per the provisions made in the NHSP-2 and the GESI Strategy 2010 in order to achieve prescribed GESI outcomes. The committee will mainstream GESI in the health sector, and take the lead role in institutionalising GESI in the ministry, departments, RHDs, D(P)HOs, and health facilities.

Formation of the Steering Committee

The formation and representation of the GESI SC will be as follows:

The Steering Committee has been formed to create an enabling environment for the implementation of the programmes and strategies outlined in the NHSP-2 and the GESI strategy. The SC will play the lead role in the institutionalisation of GESI in the MoHP, departments, RHDs, D(P)HOs, and the local health facilities. The secretariat of the t will be located at the Population Division. The Chief of the Population Division will play the role of GESI Focal Person for the entire MoHP.

Secretary, MoHP	Chairperson
Chief of Policy, Planning, and International Cooperation Division (PPICD), MoHP	Member
Director-General (DG), DoHS	Member
DG, Department of Drug Administration (DDA)	Member
DG, Department of Ayurveda (DoA)	Member
Chief of Administration Division, MoHP	Member
Chief of Curative Service Division, MoHP	Member
Chief of Public Health Administration, M&E Division, MoHP	Member
Chief of Human Resource and Financial Resource Management Division, MoHP	Member
Chief of the Division of the NPC which looks after GESI	Member
Chief of the Division of the Ministry of Women, Children and Social Welfare (MoWC&SW) which looks after GESI	Member
Chief of the Division of the Ministry of Local Development (MoLD) which	Member

looks after GESI	
Chief of the Division of the Ministry of Education (MoE) which looks after GESI	Member
Director of Primary Health Care Revitalisation Division (PHCRD), DoHS	Member
Chief of the Population Division, MoHP	Member Secretary

Invited members

Subject specialists and concerned persons may be invited, based on the agenda of the SC meeting.

Meeting and decisions of the Steering Committee

1. The Chairperson of the SC will preside over the meeting of the SC. A member selected by the SC will chair the committee meetings in the absence of the Chairperson.
2. A majority will prevail in SC decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the committee will be decided by the SC itself.
4. The SC will be convened in half yearly intervals and could convene as and when necessary.

Scope of work of the Steering Committee

The responsibilities and scope of work of the SC will be as follows:

1. To provide leadership and guidance in mainstreaming GESI in the health sector.
2. To give attention to the following by assessing the GESI-sensitiveness of present acts, regulations, policies, strategies, guidelines, and operational manuals:
   2.1. To facilitate making the present acts, regulations, policies, strategies, guidelines, and operational manuals GESI-responsive;
   2.2. To support making new health policies, regulations, and strategies GESI-responsive.
3. To establish GESI-related structures in the departments, RHDs, and D(P)HOs, and ensure the necessary resources for the smooth functioning of these structures.
4. To ensure resources for implementing GESI-focused programmes, and for mainstreaming GESI in all programmes.
5. To maintain working relations and collaboration with the NPC, MoLD, MoE, and MoWC&SW in the formulation and revision of GESI-related policies/regulations and the implementation of programmes.

3.2.1.2 GESI Technical Working Group

Background

A TWG will be formed in the MoHP in order to implement GESI-related activities and mainstream GESI in the divisional programmes. Each division will appoint an officer-level GESI Focal Person. The Focal Person will have the responsibility of institutionalising GESI in the respective divisions.

The TWG will make efforts to include the recommendations of the RHD-level TWG and the GESI-related recommendations of the regional-level annual review meetings and planning workshop in the Annual Work Plan and Budget (AWPB; it will also support the implementation of annual programmes in a GESI-sensitive manner. The TWG will review the progress, issues, and challenges in GESI mainstreaming and formulate any necessary strategies. If the problems cannot be addressed at division or centre level, these problems should be presented in the GESI SC meetings for resolution.

Formation of the GESI Technical Group

A GESI TWG will be formed, with the representation of the officer-level GESI Focal Persons from the six divisions of the Ministry (PPICD, DDA, Curative Service, Public Health Administration, M&E, Human Resource and Financial Resource Management, and Population). The Chief of Population Division will be the Coordinator, and the Focal Person of the Population Division will be the Member Secretary of this TWG.

Meeting and decisions of the Technical Working Group

1. The Coordinator of the TWG will preside over the meeting of the TWG. A member selected by the TWG will chair the meetings in the absence of the Coordinator.
2. A majority will prevail in TWG decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the TWG will be decided by the TWG itself.
4. The TWG will be convened every other month. The Secretariat of the TWG will be located at the Population Division.

3.2.2 Department of Health Services

3.2.2.1 GESI Technical Committee

Background

There is a need to establish a GESI TC as well as GESI TWG at the DoHS in order to implement the GESI Strategy effectively from department to local health facility level. The DG of the DoHS

will head the TC. The main responsibility of the TC will be to institutionalise and mainstream GESI in the department and its programmes.

Objectives

- To provide technical support for the implementation of the GESI strategy.
- To coordinate with the divisions and centres under the ministry, RHDs, and other concerned agencies.
- To share experiences and lessons learned with the ministry, divisions, centres, and RHDs.

Formation of the Technical Committee

The TC will be composed as follows:

D-G, DoHS	- Chairperson
Deputy D-G, DoHS	- Member
Six Division Chiefs and five Centre Directors (11 in total) from the DoHS	- Members
Chief of the Health Management Information Section	- Member
Chief of the PHCRD	- Member Secretary

Invited members

Subject specialists and concerned persons may be invited, based on the agenda of the TC meetings.

Meeting and decisions of the Technical Committee

1. The Chairperson of the GESI TC will preside over the meeting of the committee. A member selected by the TC will chair the committee meetings in the absence of the Chairperson.
2. A majority will prevail in the TC decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the meeting will be decided by the TC itself.
4. The TC meeting will be convened bi-annually and may convene as and when necessary. The Secretariat of the committee will be located at the PHCRD.

Scope of work of the Technical Committee

The responsibilities and scope of work of the TC will be as follows:

1. To conduct a GESI audit of health programmes and make them GESI-responsive.
2. To prepare action plan for the implementation of GESI.

3. To lead the capacity development of health service providers and managers on GESI.
4. To review and recommend solutions on the GESI issues which are in the GESI Strategy but could not be implemented.
5. To establish a GESI TWG in the DoHS, and to determine its scope of work and responsibilities.
6. To support the establishment and strengthening of GESI TWGs in the RHDs.
7. To create a friendly environment for the sharing of experiences and learning on GESI.
8. To work in close coordination with the GESI SC Secretariat (i.e. the Population Division situated at MoHP) and provide an annual GESI progress report to the SC.

3.2.2.2 GESI Technical Working Group

Background

A TWG will be formed in the DoHS in order to institutionalise and mainstream GESI in the divisions and centres. Each division and centre will nominate an officer-level member of staff as a GESI Focal Person. The concerned Focal Person will have the responsibility of mainstreaming GESI in the respective divisions and centres.

The TWG will make efforts to include the recommendations of the RHD TWGs and the GESI-related recommendations of the regional-level annual review meetings and planning workshop in the Annual Work Plan and Budget (AWPB); it will also support the implementation of annual programmes in a GESI-sensitive manner. The TWG will review the progress, issues, and challenges in GESI mainstreaming and formulate any necessary strategies. If the problems cannot be addressed from the division or centre level, these problems should be presented in the GESI TC meetings at the department for resolution.

Formation of the GESI Technical Working Group

A GESI TWG will be formed with representation of the GESI Focal Persons from the seven divisions and five centres of the DoHS. The Chief of the PHCRD will be the Coordinator, and the PHCRD Focal Person will be the Member Secretary of this TWG.

Meeting and decisions of the GESI Technical Working Group

1. The Chairperson of the GESI TWG will preside over its meetings. A member selected by the TWG will chair the group meetings in the absence of the Chairperson.
2. A majority will prevail in the TWG decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the meeting will be decided by the TWG itself.
4. The TWG meeting will be convened every other month. The Secretariat of the TWG will be located at the PHCRD.

3.2.3 Regional Health Directorate

3.2.3.1 GESI Technical Working Group

Background

TWGs will be formed at RHDs in order to operationalise effectively the GESI Strategy and NHSP-2 up to the local health facility level. The TWG, chaired by the Regional Health Director, will have the responsibility of institutionalising GESI in the RHD and the D(P)HOs in order to mainstream GESI in health programmes.

Objectives

- To provide technical support for the implementation of the GESI strategy.
- To coordinate with the DoHS and the D(P)HOs in matters concerning GESI, and to share experiences and learning.

Formation of the GESI Technical Working Group

The TWG will be formed with the following membership:

Regional Health Director	–	Chairperson
Chiefs of Planning, M&E, Essential Health Care Services (EHCS), Reproductive and Child Health, Tuberculosis and Leprosy, Information and Communication, Administration, and Accounts	–	Members
GESI Focal Person from the Regional Education Directorate	–	Member
District Women and Children Officer of the concerned district	–	Member
Chief of the Regional Health Training Centre	–	Member
Officer-level representatives from the regional/zonal hospitals and D(P)HO of the district where the RHD is located	–	Members
Head of the Regional Ayurveda Office	–	Member
Three representatives from the regional-level Non-governmental Organisations (NGOs)/networks active in areas concerning women, children, and social issues	–	Members
Head of the Women's Cell of the Regional Police Office	–	Member
Officer-level GESI Focal Person of the RHD	–	Member Secretary

Invited members

Subject specialists and concerned persons may be invited, based on the agenda of the TWG meeting.

Meeting and decisions of the GESI Technical Working Group

1. The Chairperson of the GESI TWG will preside over the meeting. A member selected by the TEG will chair the meetings in the absence of the Chairperson.
2. A majority will prevail in the group decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the TWG will be decided by the GESI TWG itself.
4. The TWG will be convened every three months and as and when necessary.

Scope of work of the GESI Technical Working Group

The responsibilities and scope of work of the TWG at the RHD will be as follows:

1. To prepare and implement the GESI action plan.
2. To provide technical and coordinating support for the implementation of major GESI-related programmes, e.g. the Equity and Access Programme (EAP), One-stop Crisis Management Centres (OCMCs), Social Service Units (SSUs), social audit etc.
3. To mainstream GESI in health programmes, and to provide technical support to D(P)HOs in the design and implementation of targeted programmes in order to reach unreached regions and underserved groups.
4. To support the capacity development of health service providers and managerial staff in the matter of GESI mainstreaming.
5. To support D(P)HOs in the formation and strengthening of the GESI TWG.
6. To work in close coordination with the GESI TC in the DoHS and provide trimesterly and annual GESI progress reports to the TC through the PHCRD.
7. To hold an annual regional review meeting and planning workshop, which will focus on efforts and achievements concerning GESI by the D(P)HO and RHD, identify major issues to be addressed, and revise and add programmes if necessary in order to make programmes GESI-responsive.
8. To draft a brief report covering GESI issues and proposed programmes/activities identified in the annual regional review meeting and planning workshop, to be submitted to the PHCRD and Population Division.

3.2.4 District (Public) Health Office

3.2.4.1 GESI Technical Working Group

Background

A TWG will be formed at the D(P)HO in order to operationalise effectively the GESI Strategy and the NHSP-2 in the D(P)HO, district hospitals, and local health facilities. The TWG, chaired by the District (Public) Health Officer, will have the responsibility of institutionalising GESI in DHOs and local health facilities in order to mainstream GESI in health programmes.

Objectives

- To provide technical support for the implementation of the GESI strategy.
- To coordinate with RHDs, HFOMCs, health personnel, and other concerned district-level health agencies in matter concerning GESI, and to share experiences and learning.

Formation of the Technical Working Group

The membership of the TWG will be as follows:

Chief of D(P)HO	–	Chairperson
Senior (Public) Health Officer	–	Member
Medical Recorder or Nursing In-charge of the district hospital	–	Member
District health supervisors	–	Members
Women and Children Officer	–	Member
Social Development Officer of District Development Committee (DDC)	–	Member
Chief of the District Ayurveda Office	–	Member
GESI Focal Person of the District Education Office	–	Member
Three representatives from NGOs and Civil Society Organisations (CSOs) working in the health sector	–	Members
Officer-level representatives from regional, sub-regional, and zonal hospitals of the concerned district where the D(P)HO is located	–	Member
Head of the Women Cell of the District Police Office	–	Member
GESI Focal Person	–	Member Secretary

Meeting and decisions of the Technical Working Group

1. The Chairperson of the TWG will preside over the meeting. A member selected by the TWG will chair meetings in the absence of the Chairperson.
2. A majority will prevail in group decisions; in the event of an equal vote, the Chairperson will cast the deciding vote.
3. All other working procedures of the TWG will be decided by the GESI TWG itself.
4. The TWG meeting will be convened every other month in the first year of establishment; meetings will be convened every three months in succeeding years.

Scope of work of the Technical Working Group

The responsibilities and scope of work of the TWG will be as follows:

1. To prepare and implement the GESI action plan.
2. To facilitate the HFOMCs to mainstream GESI in their regular activities.
3. To make programmes and the annual planning procedure GESI-responsive.
4. Take a lead role in the capacity development of health service providers and HFOMCs.
5. To provide technical and coordinating support for the implementation of major GESI-related programmes, e.g. EAP, OCMCs, SSUs, social audit, GESI-related data collection, etc.
6. To design and implement targeted GESI programmes to reach unreached regions and groups in order to improve access to and utilisation of services.
7. To work in close coordination with the GESI TWG at the RHD and to provide trimesterly and annual GESI progress reports to the RHD and PHCRD.
8. To hold a district annual review meeting and planning workshop, which will focus on efforts and achievements concerning GESI by the D(P)HO and health facilities, identify major issues to be addressed, and revise and add programmes if necessary, in order to make the programmes GESI-responsive.
9. To draft a brief report covering GESI issues and proposed programmes identified in the annual review meeting and planning workshop, to be submitted to the GESI TWG at the RHD.

3.2.5 Health Facilities

3.2.5.1 Health Facility Operation and Management Committee

Background

The HFOMC will act as a GESI TWG at the health facility level. The main responsibility of the HFOMC is to mainstream GESI in all its activities and services. The role of the Chairperson and Member Secretary will be vital for this purpose. The role of HFOMC will be to act as a bridge between service providers and the community, and its main responsibility will be to ensure reliable, equitable, and good-quality services to the community. In order to fulfill its responsibility, it should regularly seek capacity development and other support from the D(P)HO. The of health facility in-charge will act as the GESI Focal Person.

Objectives

- To take the lead role in the implementation of GESI strategies at the local level.
- To support and coordinate activities to improve the access to and utilisation of health services by local citizens, especially women, the poor, and other excluded groups.
- To monitor the benefits received by women, the poor, and other excluded groups from the available services.

Scope of work of the Health Facility Operation and Management Committee

The following responsibilities have been added to the present scope of work of the HFOMC, in order to make it more GESI-sensitive.

1. To identify unreached areas and groups, and to facilitate and improve their access to available health services.
2. To identify the issues and problems of women, the poor, and other excluded groups, through coordination with Female Health Workers and social mobilisers, and to advocate addressing these problems to the concerned health/other institutions.
3. To coordinate with the VDC, Integrated Planning Committee, Ward Citizen Forum, and other concerned institutions in order to improve access to and utilisation of health services by women, the poor, and other excluded groups.
4. Work through social mobilisers to improve the health seeking behaviour of women, poor and other excluded groups and monitor change in the health indicators of these groups.
5. To appoint the health facility in-charge as the GESI Focal Person.

3.3 GESI Focal Person

3.3.1 Appointment

Every division and centre under the MoHP or departments needs to appoint an officer-level GESI Focal Person. These Focal Persons will be the members of the GESI TWGs in the MoHP and departments, which will have the responsibility of mainstreaming GESI in the MoHP and departments. The Focal Persons of the population programmes will be appointed as GESI Focal Persons in the RHDs and the D(P)Hos; in the case of local health facilities, the health facility in-charge will act as the GESI Focal Person.

3.3.2 Responsibilities of the GESI Focal Person

Every division, centre, section, D(P)HO and local health facility is required to appoint a GESI Focal Person as per the provision made in these guidelines. The concerned offices need to enhance the capacity of the appointed Focal Persons to fulfill her/his responsibilities.

The responsibilities of the GESI Focal Persons, from the central to the local health facility level, will be as follows:

1. To provide technical support to make the policies, guidelines and programmes of the respective division/centre/section/D(P)HO/health facility GESI-responsive.
2. To identify the additional knowledge and skills necessary to mainstream GESI, and to make efforts for the capacity development of the respective staff.

3. To review the planning processes, programmes, and budgets of the division/centre/section/D(P)HO/health facility from a GESI perspective, and to recommend GESI mainstreaming in future programmes.
4. To facilitate the implementation of GESI policy provisions and programmes in an effective manner.
5. To monitor the programmes of the D(P)HO, hospitals, and local health facilities, and to report to the GESI TWG.
6. To identify underserved groups from gender, social, and geographic perspectives, and to implement programmes to increase their access to health services.
7. To implement programmes by targeting women, the poor and other excluded groups.
8. To report progress (achievements, GESI issues, difficulties, and learning) to the respective division, centre, section, and head of the D(P)HO, both trimesterly and annually.
9. To participate in the GESI TWG meetings in order to move forward GESI activities.

Chapter -4: Institutional Improvement

4.1 Capacity development and budgetary provision

It is essential to initiate discussions on the concept of GESI, its importance, and how GESI can be institutionalised in the health sector in order to enhance the capacity of GESI TWG members on their roles and responsibilities, and the concept and mainstreaming of GESI. All regular TWG meetings should review their experiences and learning, challenges and progress, discussing, amongst other issues, access of the target group to health services, service utilisation rates, difficulties in improving the utilisation rate, and ways to overcome these difficulties, etc.

Presentations and discussions must be held on all the issues related to GESI (progress, learning, difficulties, and recommendations) in the trimesterly, half-yearly, and yearly review meetings of the Ministry at all levels.

Training, orientation, and refresher workshops will be organised to enhance the capacity of the GESI Focal Persons, as provisioned in Section 3.3.2 of these guidelines, in order for them to fulfil their responsibilities effectively. GESI must be integrated into the annual staff capacity development programmes and the budgets of the divisions, centres, RHDs and D(P)HOs. Even if the nature of activity is different from the regular programmes/activities of the divisions and centres, GESI activities should be included in the annual programme and budget.

The D(P)HO, if necessary, should design training activities for the local health facility staff and HFOMC members on GESI concepts and procedures.

Capacity enhancement activities need to be organised as GESI is gradually institutionalised and mainstreamed in the respective offices. Budgetary provisions must be made to develop the understanding of GESI Focal Persons and health service delivery personnel on GESI concepts and procedures.

4.2 Review and reporting

The GESI committee and the TWGs will be aligned with the MoHP's regular decision making, monitoring and supervision, review, and reporting systems. The GESI SC will have the main responsibility for taking policy decisions and issuing directives.

The GESI TC at the department will report to the GESI SC annually. The TC at the department will have the responsibility of circulating the policy decisions and directives of the SC to the TWGs at RHD and district levels. This committee will take the decisions necessary for the operation, management, and monitoring of the TWGs at the regional and district levels. The TWG of the regional directorate will provide an annual report to the TC in the department by compiling the reports of the district TWGs under the directorate.

The GESI TWG at the D(P)HO will compile the annual progress reports of the local health facilities, and issues and learning identified in the annual review meetings, and report them to the TWG at the RHD. The district GESI TWG will facilitate the HFOMCs in submitting progress reports in the given format.

4.3 Coordination and collaboration

Since GESI issues are cross-cutting (related to social, cultural, and economic aspects), programmes should be implemented in coordination and collaboration with other sectoral agencies. The GESI SC at the MoHP comprises members from concerned sectoral ministries and the NPC in order to coordinate efforts and activities on GESI. Similarly, the TWGs at the RHDs and the D(P)HOs comprise members from local bodies, women and child development offices, district education offices, the district police, and NGOs working in the health sector. Coordination and collaboration with local bodies, sectoral offices, and NGOs is necessary for the planning and implementation of programmes at the local level.

Chapter -5: Miscellaneous

5.1 Addendum and changes or alterations

MoHP can make any necessary elaborations, additions/deletions, revisions, or changes to remove any barriers, obstacles, or confusion encountered in implementing these guidelines. MoHP may amend these guidelines on the basis of experiences acquired during the implementation of these guidelines.

5.2 Revocation and safeguard

After the coming into effect of these guidelines, the "Concept Note on Institutional Mechanisms for Gender Equality and Social Inclusion Mainstreaming Across MoHP, 2068" will be automatically revoked. All activities under the concept note will now be conducted as per the provisions of these new 2069 guidelines.