

**IMPLEMENTATION OF THE GENDER
RESPONSIVE BUDGETING IN PEACE BUILDING
AND HEALTH PROGRAMMES IN NEPAL**

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ISBN 9789937247603



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Preface

In the past half decade, the central target of application of Gender Responsive Budgeting (GRB) in Nepal has been the planning and budgeting processes in the government ministries, departments and other related institutions. In this period UN Women played a pivotal role for initiating and strengthening the GRB system in partnership with the Government of Nepal, specifically the Ministry of Finance. The introduction of GRB can be seen as one of the landmark initiatives to operationalize the government's strong commitments towards gender equality and women's empowerment as demanded by the country's Constitution, plans/policies and international instruments, to which Nepal is a signatory, particularly CEDAW, BPfA, MDGs, UNSCRs 1325 and 1820.

The Ministry of Finance initiated the GRB work in 2001 with technical and financial assistance from UN Women which led to the institutionalization of GRB as a tool for development planning, programming and implementation beginning 2005. For this purpose, a Gender Responsive Budget Committee (GRBC) was established in the Ministry of Finance. The GRB system is functional in all ministries at the national level since the fiscal year 2007/08. Operationalization of the GRB by feeding qualitative indicators and quantitative weightages in the computer software of various budgetary tools has made it possible to setup a baseline and measure progress over succeeding fiscal years. With the adoption of the system, the directly gender responsive budget increased from 11.3 percent in 2007/08 to 19.05 percent in 2011/12. Similarly, during the same period, the indirectly gender responsive budget increased from 33.16 percent to 45.78 percent and the gender neutral budget decreased from 55.54 percent to 35.17 percent.

Gender equality is a multi-dimensional issue and linked with each and every development sector warranting priority from all development partners. Nonetheless, until and unless Ministry of Finance, the highest level national functionary for the allocation and monitoring the budget, internalizes GRB, it is not possible to achieve the national commitment of gender equality. In this context, UN Women would like to commend and express appreciation to the Ministry of Finance, Government of Nepal for the initiation of GRB and for its continued commitment. As the implementation of GRB system in Nepal has completed its five years, it was felt necessary to review and assess the current status of the GRB application into the national budgeting system in order to assist further in streamlining the GRB efforts. This publication is the compilation of two studies carried out to assess the implementation of GRB in the peace building and health programmes under the EC/UN Women partnership programme on "Integrating GRB into the Aid Effectiveness Agenda" implemented in Nepal during 2010-2012. This is one of the series of studies being conducted for identifying major issues and bottlenecks for financing and tracking for gender equality and the empowerment of women. In line with this, UN Women has previously conducted "Mapping Foreign Aid in Nepal from Gender Perspective" and "Country research on GRB and Aid Effectiveness in Nepal" in 2008 with the support from EC.

The studies have brought up number of recommendations i.e. to increase the allocation in gender responsive programmes, women's targeted programmes, capacity enhancement of the government agencies on GRB as well as Civil Society Organizations and gender advocates, strengthening the monitoring

and tracking system among others. In this respect, UN Women looks forward to continue its partnership with the MOF, National Planning Commission, Ministry of Women, Children and Social Welfare, Ministry of Local Development and other relevant ministries, Civil Society Organizations, academia, gender advocates and media for the effective implementation of these recommendations.

At the end, I would like to thank the Gender Responsive Budget Committee, Ministry of Finance for kindly coordinating the study and SAHAVAGI for taking the technical responsibility of conducting the study.



Sangeeta Thapa

Programme Coordinator

UN Women Nepal

January 2012

Acknowledgements

Nepal has been committed to gender equality and women's empowerment by its Constitution and by her assent to the various international instruments of gender equality, particularly CEDAW, BPfA and MDGs, UNSCRs 1325 and 1820 and many others. Starting from mid-nineties, the country's development plans have specially emphasized gender equality, gender mainstreaming and women's empowerment. These commitments were further strengthened by adoption of gender equality and inclusion as one of the four pillars of poverty reduction programmes in the Tenth Five Year Plan, the Interim Constitution and the post 2006 Three Year Plans dedicated to building "gender equitable, just and socially inclusive state". The Gender Responsive Budgeting (GRB) has been adopted as one of the tools for advancing gender equality goals since the fiscal year 2007/08. The government budget allocations have been classified in three categories: directly gender responsive, indirectly gender responsive and neutral across all sectors, on the basis of five criteria (women's participation in programme formulation and implementation, benefit accruing to them, their capacity building, contribution to women's employment/income generation, and reduction in women's work load and qualitative improvement in their time use) adopted by the Ministry of Finance for these classifications. SAHAVAGI, particularly Dr. Meena Acharya has been associated with these exercises from the very beginning.

The current publication presents two case studies, which formed a part of a larger exercise designed to develop indicators and sub-indicators within the existing common five criteria. These case studies discuss how the GRB is being implemented in the peace-building and the health sector programmes by the related institutions in some detail and recommend set of indicators and sub-indicators within the five GRB criteria, which could be applied for gender responsive budgeting in these sectors.

SAHAVAGI is grateful to all those, who entrusted and collaborated with us in this important job of review and revision of the existing GRB guidelines, manuals, GRB criteria and software with development of in-depth case studies of important ministries which contribute to the process of further institutionalization of the GRB system in the government and other agencies. Our special thanks go to UN Women, the Advisory Committee and the Gender Responsive Budget Committee members for entrusting this task to us.

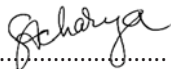
In the process of the larger study and the case studies, the SAHAVAGI team interacted with numerous institutions, government officials at the Ministry, district and VDC levels, who were very generous to share their experience and knowledge with the team. A number of people who deserve our gratitude are very large to list all of them here. The Finance Secretary Mr. Krishna Hari Baskota, the GRBC Chairpersons Mr. Bodh Raj Niraula and Lok Darshan Regmi, Programme Coordinator of UN Women/Nepal, Ms. Sangeeta Thapa, Programme Officer, Mr. Durga Khatiwada, the GRB advisor in the MOF Ms. Nigma Tamrakar, Under Secretaries of MOF Ms. Chandrakala Poudel and Ms. Shiva Devi Dahal deserve special gratitude for their constant support to the research team. We express our indebtedness to all those high level government officials at various levels, specially, the Secretary at Ministry of General Administration Mr. Pratap Kumar Pathak, Joint Secretaries Mr. Reshmi Raj Panday and Mr. Teertha

Dhakal (from Ministry of Local Development), Under Secretaries Mr. Hari Lamsal (Ministry of Education) and Mr. Bharat Acharya (Ministry of Peace and Reconstruction), and Section Officer Mr. Leela Raj Paudyal (Ministry of Health and Population), who took time to read our report, and gave feedback, and all other officials and dignitaries who attended series of our workshops and consultations including the pre-test and the Validation Workshops. We are also thankful to the district authorities, without whose contributions and comments, this report and the GRB manual would not have taken its current shape. We have taken the liberty to mention only a few of them, which does not mean that we are ignoring the others. We are grateful to each and every one of them. All other persons we met and consulted in the various ministries and departments, with whom the team had discussions and who gave us valuable information and suggestions, also deserve our sincere gratitude.

We would like to express our heartfelt gratitude also to all the district authorities, particularly LDOs and DHO of Rolpa, Banke, Dhanusha and Chitwan for their contributions to testing the applicability of the GRB indicators proposed in the district planning and programming process, the focus group discussants and individuals that we interviewed in the field.

Similarly, we are grateful to Mr. Arvinda Rimal and Mr. Shalik Ram Sharma for editing the volume and giving shape to this publication.

SAHAVAGI is grateful to Dr. Meena Acharya and her team members Mr. Birbhadra Acharya, Mr. Sitaram Parsai, Dr. Chapala Koirala, and Mr. Rituraj Bhandari for undertaking this task for SAHAVAGI and the Research Associate Ms. Bhabani Sapkota. Lastly, Mr. Govinda Dulal and Mr. Sitaram Chaudhari deserve special thanks for the logistic support.



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Sushan Acharya
President
SAHAVAGI
January 2012

Abbreviations & Acronyms

ADB	Asian Development Bank
ANM	Auxiliary Nurse Midwife
BPfA	Beijing Platform for Action
BS	Bikram Sambat
CA	Constituent Assembly
CDO	Chief District Officer
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DAO	District Administrative Office
DDC	District Development Committee,
DFID	Department for International Development
DHO	District Health Office
DOHS	Department of Health Services
DTO	District Technical Office
FCHV	Female Community Health Volunteer
FPIEC	Family Planning Information, Education and Communication
FY	Fiscal Year
GDI	Gender Development Index
GESI	Gender Equality and Social Inclusion
GFPs	Gender Focal Points
GON	Government of Nepal
GRB	Gender Responsive Budgeting
GRBC	Gender Responsive Budget Committee
GTZ	German Development Cooperation (Currently GIZ)
HFMC	Health Facility Management Committees
HPs	Health Posts
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
LDO	Local Development Officer
LGCDP	Local Governance and Community Development Programme
LPCs	Local Peace Committees
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOPR	Ministry of Peace and Reconstruction

MOWCSW	Ministry of Women Children and Social Welfare
NGO	Non-governmental Organization
NPC	National Planning Commission
OECD	Organization for Economic Co-operation and Development
OSCC	One Stop Crisis Center
PHCC	Primary Health-care Center
PMO	Prime Minister's Office
PRSP	Poverty Reduction Strategy Paper
Rs.	Nepalese Rupees
SBA	Skilled Birth Attendants
SHPs	Sub-health Posts
SWAp	Sector-wide Approach
TYIP	Three Year Interim Plan
UDBC	Urban Development and Building Construction
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNMIN	United Nations Mission in Nepal
UNSCR	United Nations Security Council Resolution
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VDCs	Village Development Committees
WDO	Women Development Officer

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EXECUTIVE SUMMARY

I. Introduction

Nepal has adopted the Gender Responsive Budgeting (GRB) as one of the major tools for fulfillment of her national constitutional and international commitments to gender equality under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPfA) and the Millennium Development Goals (MDGs) since the fiscal year 2007/08, with assistance from UN Women (then UNIFEM), within a framework of overall reform in the budgetary processes. For the coordination and implementation of the GRB activities a Gender Responsive Budget Committee (GRBC) was set up at the Ministry of Finance in August 2005, based on the Budget Speech of the then Finance Minister. The government budget expenditures have been classified in three categories: directly gender responsive, indirectly gender responsive and neutral across all sectors. The GRBC is providing guidance for the operationalization of the system and giving continuity to the GRB processes.

The GRBC has developed five criteria for evaluation of the gender responsiveness of the budgeted government programmes and projects. These criteria include women's participation in programme formulation and implementation, benefit accruing to them, their capacity building, contribution to women's employment/income generation, and reduction in women's work load and qualitative improvement in their time use. Each criterion carries maximum of 20 points. Programmes scoring 50 points or more are classified as directly gender responsive, those scoring 20 to less than 50 points as indirectly gender responsive and those scoring less than 20 points as neutral.

The introduction of the GRB has moved the issue of resource allocation for gender equality and women's rights to the forefront, strengthened the gender mainstreaming mechanisms within the government, increasing allocations to gender specific needs and the gender responsiveness of the tax policies. However, many earlier reports have identified multiple problems in its full operationalization. The current case studies are part of a larger exercise designed to develop indicators and sub-indicators within the existing common criteria developed by the GRBC. These case studies examine the peace-building process and the health sector in some detail in the GRB perspective and recommend set of indicators and sub-indicators within the five GRB criteria, which could be applied for gender responsive budgeting in these sectors.

II. Peace-building and the Ministry of Peace and Reconstruction (MOPR)

Nepal's commitments to gender equality and inclusive state has been enshrined in several formal documents including the Comprehensive Peace Agreement (CPA) and the Interim Constitution, which mandated for 33 percent reservation for women in the candidacy in the election to the Constituent

Assembly/Parliament. The current CA has nearly 33 percent women among its members. The CPA of 2007 signed between the then government and the CPN (Maoist) after the historic 2006 April movement has committed the Government of Nepal (GON) to protect the rights of women and children, ensure justice and their participation in the process of peace-building. Nepal a signatory to the UNSCRs 1325, 1820 and 1612¹, has prepared action plans to implement the commitments and is implementing them. A separate Ministry of Peace and Reconstruction (MOPR) has been created to implement the agreements and to oversee the peace process.

Nepal Government and the development partners have devoted substantial resources for peace-building initiatives. The MOPR, which is the executing agency for peace initiatives in the government sector, has received 3 to 4 percent of the government budget in the last three financial years (2008/09-2010/11). This year is likely to see a big jump in this, as more than Rs 4 billion may be required for the ongoing process of army integration and retirement of the combatants from the camps.

However, the implementation of the action plans has been slow. Two bills, one on Disappearance and another on Truth and Reconciliation are presently under consideration in the Parliament. Much remains to be done in making the peace-building process fully gender responsive.

Gender responsiveness of the MOPR budget

As to the gender responsiveness of the budget of the MOPR, in the FYs 2007/08 - 2009/10, more than half of its budget was classified as indirectly gender responsive. No significant amount was shown as directly gender responsive in this period. But in the FY 2010/11 about 33 percent was shown as indirectly gender responsive, 0.7 as directly gender responsive and rest as neutral. As in other ministries, these classifications have not been consistent through time.

Analyzing the overall MOPR activities in the context of the GRB criteria, we have focused on three criteria only-- women's participation in the peace process, benefit sharing, and allocation of resources for women's specific needs and gender equality-related activities, as the scope of these activities is transitional and limited.

Women's participation in the peace process

The High Level Peace Committee and the MOPR are the primary government structures, through which activities related to peace-building are implemented.

Women's participation in mechanisms established to implement the commitments and agreements has not been uniform. Particularly at the central level, excepting in the Parliamentary Committee on

¹ UNSCRs 1325 and 1820, among other things, require that the parties to the peace process and the United Nations increase participation of women at decision-making levels in conflict resolution and peace processes and adopt a gender perspective when negotiating and implementing peace agreements.

Security, few women are involved in these mechanisms, for example in the High Level Peace Committee and the MOPR, primarily because of the absence of women in the higher party positions and public administration. Recently, classification of combatants for integration in the army, resettlement or retirement has been completed. There were no women in these classification teams.

The picture, however, is different at the local level. There is a mandatory requirement of 33 percent women's membership in the Local Peace Committees (LPCs) at the district and VDC levels. It is more or less fulfilled at the district level. In the case of VDCs it is not uniformly implemented in all cases. By the end of July 2011, LPCs had been formed in 67 district, 7 municipalities and 598 VDCs. These Committees are authorized to work for ending all types of violence and disruptive activities, institutionalize peace at the local level by dialogue and discourse and support the implementation of peace and reconstruction process at the local level. Some of the district LPCs and their women members were found quite active while others were dormant.

Benefits to women

The Ministry has implemented three types of activities: (a) cantonment management, (b) relief and rehabilitation, and (c) reconstruction and rehabilitation of physical infrastructure.

Under the Cantonment Management, the Ministry is responsible for verification of combatants, physical infrastructure and health management, distribution of monthly stipend to the combatants and management of food. There are seven main camps and 21 satellite camps housing the ex-combatants. The Ministry provided support in the construction and maintenance of physical infrastructure like housing, approach roads, electrification, telephone, drinking water facilities in these camps. The health and sanitation programmes were also included. The ex-combatants, both men and women were housed in the same building with common toilet facilities. There was no separate room for checking women's specific health problems, e.g., pregnancy, except in Kailali and Surkhet. Most of the medical officers were male but other nursing staffs were female. In the case of pregnancy, women combatants were advised to rest at home, during which time they were provided their daily and monthly pay.

Major activities under the Relief and Rehabilitation heading included financial support to the nearest relative of the persons killed during conflict, relatives of the missing and kidnapped, those with disability caused during conflict, single women who had lost their spouse in the conflict, internally displaced, scholarship to the children of the martyrs and the wounded, and pensions to the wounded, etc. The programme is all encompassing, and no special provisions have been made for women except single woman. But majority of the relief recipients were reported to be women by the authorities. This was confirmed during our field visit to the three districts. Nonetheless, the MOPR could not provide sex-disaggregated data on the number of beneficiaries of their activities. Handling the cases of relief is not uniform. It seemed to depend on the leadership of the peace committee. Delays have resulted in fatalities also. The information-flow from the government side to the grassroots level was very poor and ineffective.

Under the Reconstruction and Rehabilitation of Physical Infrastructure, altogether 1,357 projects were implemented during 2009/10 of which 566 had been completed. The literature on reconstruction does not talk about gender sensitiveness of the infrastructure. It is also not clear what percentage of women participated in the construction work. Even when more than one toilet were constructed in the reconstructed government, District Administration Office (DAO), or VDC buildings, no need was felt for allocating one to women. This was a case for sensitization rather than that of shortage of finance. No conscious attention was given to women-friendly facilities while constructing these buildings.

Gender in development partner programmes

A substantial part of the programme budget of the MOPR is funded by the development partners. For example, 50 percent of the cantonment budget, 99 percent of the relief for the conflict victims and 92 percent of the Local Peace Committee budget were to be financed by the development partners in the FY 2010/11. Development partners use several channels of funding the overall programme. The government budget is only one of the channels. Other channels include direct implementation of programmes and funding NGO activities. Coordinated by the UNDP they have come up with a new joint Action Plan entitled "Peace and Development Strategy 2010-2015" (UN RC/HC Office, 2011). This programme shows that almost all donors active in Nepal are assisting in the peace process by funding one or other part of the peace-building initiatives. Particularly on women's issues, UN Women and UNDP have actively assisted both the government and non-government sectors in the peace-building activities.

Gaps, challenges and recommendations

Ensuring women's effective participation at all levels of decision-making process is a big challenge. At higher formal bodies, women's representation is constrained by the limited number of women at decision-making party positions and public administration. There is a system in place for involving women in the peace process at the district and local levels. There are, however, no provisions for facilitating women's participation in the implementation phases also. The current process of implementation does not take into account the three major barriers to women's actual participation, i.e., time constraint, lack of access to economic resources even for travel to places of committee meetings and information gap. These need to be addressed effectively.

Effective monitoring is another challenge. Although the Local Peace Committees are mandated to monitor the activities of the District Administration Office, District Technical Office and the Urban Development Board, no specific mechanisms have been developed so far for institutionalization of this process. There is no system for monitoring of the district level activities. The district offices are not accountable to the Ministry of Peace and Reconstruction.

A final list of victims is yet to be prepared. According to the local authorities, list of victims to be compensated changes every time a new Minister is appointed, this creates confusion and results in extra work for the implementing agencies.

As mentioned above, classification of combatants for integration in the army, resettlement or retirement has been completed and there were no women in these classification teams. Most women combatants have chosen to retire as they are with children or incapacitated. Many feminists have commented that this is unfair, but it is not clear whether it is by informed choice or compulsion. Since many of the marriages within the camp have been inter-caste, it is feared that they may face much more difficulties in adjusting to civil life than men. No specific attention has been given to this aspect in retirement package. It will be a big challenge to resettle them properly. The MOPR cannot even provide sex-disaggregated information on the number of combatants or their recent classification for army integration and rehabilitation.

Given the capacity of the MOPR and the LPCs, the greatest challenge to full application of the GRB system is their capacity-building to understand properly the process of the GRB as recommended in Chapter IV below.

In the above context, the recommendations made may be summarized as:

- The peace process should be audited on the basis of the GRB criteria of MOF, a tentative example of which is given in Chapter IV. The whole peace structure and the members of the peace committees also should be oriented on GRB.
- The whole peace-building process needs to be gender sensitized as the current process does not give considerations to the three major barriers of women, i.e., time, lack of access to economic resources and social attitude. When these barriers are addressed, women will be facilitated to get involved in the planning and implementation of the peace process more effectively.
- Funds must be provisioned for capacity-building of the district LPC members, so that the rehabilitation and reintegration process will be smooth.
- Proper monitoring mechanism for information feedback to the CDO, district LPCs and the MOPR should be developed and implemented.
- All information on cantonments, rehabilitation, children's scholarship and employment generated by reconstruction should be sex-disaggregated.
- Programmes should be GESI audited and publicized through public hearing system

III. The health sector

Nepal is a party to all international conventions and declarations on health including, the Alma Ata Declaration, ICPD and MDGs. These commitments have shaped her health policies and programmes. She has also participated in international campaigns on almost all diseases. Consequently, Nepal's HDI and health indicators have improved significantly in the last two decades. However, the health gains have not been distributed equally among the various sub-groups of the population. Dalits,

Muslims and some ethnic groups have lagged far behind in health improvement. Similarly urban/rural and regional gaps are still large. Current policies, strategies and programmes are focused on reducing these gaps.

Current commitments, policies and strategies

The Interim Constitution of Nepal and policy documents such as PRSP with its gender and social inclusion pillar, and the development plans all provide clear directives for making basic health accessible to all, with specific focus on inclusion and gender issues. The Interim Constitution has recognized specifically the fundamental rights of Nepali citizens to free basic health-care services and child health, along with freedom from violence and reproductive rights for women. The National Development Strategy Paper (2009) and the Three Year Development Plan (2010-2013) also have specifically focused on gender and inclusion issues.

Health sector financing and its gender responsiveness

Following these commitments, the Government has increased health budget significantly, from Rs. 4.6 billion in the FY 2004/05 to Rs.23.8 billion in FY 2010/11. As a proportion of the total government budget, the health budget had increased from 6 to 7 percent in this period. Actual expenditure on health has been increasing with increased absorptive capacity of the system. There is also an increasing trend in per capita private and public sector expenditure on health and population. The per capita public sector expenditure increased from Rs.187 in the FY 2004/05 to Rs. 568 in 2009/10.

A large part of the government's health programmes is funded by external partners. The share of foreign aid in the sector's budget hovered around nearly about 50 percent between the fiscal years, 2006/07-2008/09. In the subsequent years, however, it has declined coming down to 30 percent in the FY 2010/11. Since the FY 2007/08, the sector is funded under SWAp and joint funding arrangements.

The health sector is one of the largest areas where considerable amount of budget has been classified as directly gender responsive. However, there does not seem to be consistency in the classification of the budget under the three different GRB categories as in other sectors. There is much fluctuation in the proportions classified as directly and indirectly gender responsive and neutral in the four years under review. This is a consequence of confusion about the methodology and lack of clarity on how to apply the five criteria developed by the GRBC in actual practice.

Gender responsiveness of the budget in the health sector as in other sectors needs to be viewed in terms of the five criteria laid out in the MOF guidelines, discussed in the introduction. Each programmes needs to be evaluated as per the five criteria. The following section tentatively examines the overall health sector activities and processes in the context of above criteria.

Participation

At the local level women's participation in planning and programming is planned in the basic health-care activities but not uniformly implemented in the field. The district health office starts the budgeting

process after receiving guidelines of NPC and budget ceiling fixed by the MOF. Generally the budget is estimated to continue the previous year's programmes except in cases when some particular programme need to be focused or if there is some special direction for some particular programme. The planning process does not start from the village level as mandated by the policies. At the district level if there is a woman staff in the planning section of district health office, she will participate in the planning. Otherwise there is no mandatory provision for women's participation. As per MOHP officials there is no uniformity in the planning process. In some places mother's groups are involved in the planning, in others even the district health office chiefs complain, that the programme sent by the districts is not even discussed with them and the Ministry approves programmes on its own.

There is mandatory provision of women's participation in the Health Facility Management Committees (HFMC) but presently they are defunct in some places. Although specific training programmes are organized only for women in some cases, in other training programmes women's participation is not mandated.

At the higher levels there is no specific consultation with women's groups or involvement of the gender units/gender focal points from the government, or outside experts or stakeholders on regular basis although some stakeholders were consulted in the preparation of various strategy papers and action plans.

Capacity-building

There is no specific capacity-building and career development plans for women health workers except in specific professions such as ANMs and FCHVs.

Benefits

However, specific efforts have been made to ensure benefits to women and the other targeted groups, specifically the poor, Dalit and marginalized Janajatis and other groups. As a significant departure from the past, the post-2006 policies and strategies attempt to address the demand side problems. Earlier policies, strategies and programmes were focused on supply side - - expanding facilities, reaching remote areas etc. Post -2006 policies have started to focus on demand side problems and the Government has initiated several programmes to address them. Particularly, free safe delivery services to women with financial assistance for transportation, and free health services to the poor in government institutions coupled with free medicines for several kinds of elementary health problems and certain clinical services are the most important initiatives in this respect. The emphasis on strengthening quality of services and supply mechanisms remain.

The Health Strategy Paper for the first time seeks to address the gender-based violence (GBV). It includes establishing OSCCs. MOHP has also developed a Gender Equality and Social Inclusion Strategy in 2010 and is implementing it.

Committees have been set up at various levels in the MOHP to oversee the implementation of the GESI policies and strategies.

The policies and strategies also seek to improve the Health Management Information System (HMIS), with focus on gender and inclusion. The reports, compiled and published annually by the Department of Health provide information on utilization of services in the health institutions and their coverage, by sex and major population groups, district and region. In theory, on the basis of this information and monthly reports from the health posts and primary health-care centers, the districts are directed to conduct monthly review. The district health office is required to send reports of these reviews to the region and central office. The region is supposed to conduct reviews every trimester and the central office annually.

There is no system of keeping sex-disaggregated information on employees in the sector, even for the government sector.

The health sector, for long has organized specific camps and vaccination and other campaigns to reach the population in remote areas and to take care of their time constraints. The birthing centers at the health posts and health-care centers, although not always functioning, are good examples of such efforts to take care of women's time constraints.

Gaps, challenges and recommendations

As of July 2011, the classification of health budget along GRB categories has not been systematic and linked to pre- budget activities either at the center or districts. Generally the programming units have not been aware of them. The Health Sector, as other sectors lack basic understanding of the GRB process. Capacity-building to implement the system as recommended in Chapter IV is the greatest challenge.

Many of the birthing centers are not well-equipped with attached toilet for labor room, separate toilet for women, ramp, curtain, separate examination room for women's reproductive problems, etc.

Information dissemination on the free medical services and safe delivery incentive is not uniform. At the grass-roots level in some places, particularly in Tarai and remote areas women may not be aware of the facilities and they may not be receiving the intended cash compensations.

There is no sex-disaggregated overall information in PHCC/HP/SHP about the use of services, although they fill up the forms for each patient indicating their sex. They send the data to DHO and it sends them to HMIS unit in Kathmandu. The district wise information is compiled at the center and published in English, which may or may not be available in the district. At the hospital level also, the practice of keeping sex and social group- disaggregated information is not regular. The HMIS also does not provide sex-disaggregated information on children.

Minimizing the political interference in the health management is the most difficult challenge at this time. For effective management and ownership, community leader's participation is a must. But many communities are also divided along the political party lines and intense battle takes place to control local institutions and resources, which affects effectiveness of these institutions.

The following recommendations seek to address some of the challenges noted above:

- The health sector needs to develop its own manual for implementation of the GRB system as recommended in Chapter IV, and undertake a massive capacity-building exercise in collaboration with the MOF for its effective institutionalization in the sector.
- The training should cover both the concept and practice of gender mainstreaming and GRB and involve the planning divisions/units and gender units/focal points, health management committee members and senior officials at various levels.
- The health facility management committees (HFMCs) must be reorganized to include members from excluded groups in order to address their perspectives and to make them more active and responsive to the community needs. The DHO, the Department and the Ministry at the central level should seek the opinion of the local level staff and HFMC members in the planning and budgeting process,
- Appointment of trained health workers and supply of adequate and proper equipment to health facilities is a must. Similarly the facilities must be made women-friendly, equipped with attached toilet for labor room, separate toilet for women, ramp, curtain, separate examination room for women reproductive problems, etc,
- An emergency fund needs to be created at the hospital and other health facilities for transport and delivery incentives, which can be utilized when the regular funds release is delayed. This amount can be later reimbursed from the regular budget, when it arrives. Such practice has been started in Banke and Dhanusha at the VDC-level as per the district health offices,
- All health information needs to be sex, caste, ethnicity and location disaggregated. Health service information needs to be disseminated to the grassroots level using proper channel and in local languages so that the deprived groups could avail the services at times of need,
- A capacity-building plan for the HFMCs needs to be formulated and implemented, and
- Health education to excluded women and men at the household level is a must through FCHVs and mother's group. Health information brochures should be simplified for the grass roots population and produced in local languages as well. They also need to talk about women's work burden, their health consequences for the women and the family and the need for work sharing by men.

IV. Effective operationalization of the GRB

The indicators and sub-indicators recommended in this report needs to be systematically applied to all programmes and sub-programmes. The MOF and NPC have to integrate them them in the annual planning and budgeting circulars making it mandatory for all concerned to present a GRB classification

of their programs and budgets on the basis of the GRB criteria, indicators and sub-indicators. Both MOHP and MOPR need to develop the specific GRB operational manual as per the GESI policy to capture their own functions staying within the broad framework of the GRB guidelines of MOF. For effective implementation of the GRB system in the sectors, all programmes and projects should be evaluated as per the indicators and sub-indicators developed by this team for the GRBC/MOF and scored as indicated in Tables 4.1 and 4.2 . These indicators and sub-indicators have been developed after an extensive interaction with various groups of stakeholders at the center and district levels.

The indicators and sub-indicators

Each of the five criteria, i.e., participation; capacity building; benefit sharing; employment and income generation; and reducing women's work load or improvement in the quality of their time use, have several indicators and sub-indicators, which together ensure the following:

- Participation of women stakeholders or experts in planning and programming exercises at all levels, implementation and monitoring mechanisms,
- Specific capacity-building provisions for women at decision-making levels in various committees and community groups, equal opportunity to women in other capacity-building trainings, and gender responsiveness of the training delivery and the subject matters covered,
- Equal access of women including for the excluded groups in the outputs and outcomes of the sectoral activities, by provisioning resources for removing economic, social and educational barriers of women in accessing these services; gender-sensitivity in the related laws, regulations and environment for facilitating women's access to services provided; adequate financing for gender-related activities; and gender responsive monitoring and the evaluation system,
- Equal opportunity for women in the employment and income generated in the process of programme/project implementation and career development current and future, and
- Adequate attention to reducing women's work burden, changes in gender roles etc by introduction of new women-friendly technology and processes or/and education about these issues.

It is crucial to keep in mind that:

- We are dealing with the budgeting and programming stage and not their implementation. At this stage, what we can do is only to plan specific interventions to ensure that women benefit equally with men from all development activities,
- We are rating programmes or sub-programmes as a whole and not individual expenditure items,
- The indicators in each sector must capture women's quantitative and qualitative participation in planning and decision-making process of the budget, benefits accruing to them and extent of attention given to specific financial, educational and social barriers women face in the process,

- It has been difficult to separate employment generation from benefit. Therefore, it is proposed that this indicator cover only income and employment, career opportunities generated in the process of programme/project implementation. Final income and employment generated as output and outcome should be covered under benefits.

The scoring system

- The scoring system must capture the primary objective of the each sector. The objective of every programme/project/sector should be generating equal benefit for men and women from their programmes and activities. Hence highest score has been recommended for ensuring equal benefit to women including to those from the excluded groups.

Capacity-building

The GRB is a new concept in Nepal and needs to be oriented to the general staff of the government, DDCs, VDCs and other stakeholders. Extensive capacity-building training on the GRB is needed. Current understanding of the GRB at the district and below is limited to special allocations of budget for women. The gender mainstreaming part is hardly understood, although participation of women in management of programmes has been formally made mandatory.

The MOF preferably through its affiliated training institutions should provide intensive crash training to the staff of the larger service provider in the first place and then advocate and provision resources for integration of the GRB process in all government and government funded regular training institutions.

While applying the GRB, budgetary cycle, i.e., project cycle needs to be considered, which means that mentoring is necessary for integration of the GRB in the annual review and budgeting (identification of gender gaps, implementation gaps) of the ministries and the departments.

I. INTRODUCTOIN

Nepal has adopted the Gender Responsive Budgeting (GRB) as one of the major tools for fulfillment of her national constitutional and international commitments to gender equality under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPfA) and the Millennium Development Goals (MDGs) since the fiscal year 2007/08. A new classification of Budget was introduced, which applies throughout the government system -- all ministries, commissions, and committees. To start with, specific focus was placed on 13 ministries. These included ministries of women children and social welfare, education and sports, local development, physical planning and construction, health and population, industry, commerce and supply, culture, tourism and civil aviation, agriculture and cooperatives, water resources, forestry and soil conservation, environment, science and technology, labor and transport management and the Prime Minister's Office.

The GRBC has developed five criteria for evaluation of the gender responsiveness of the budgeted government programmes and projects. These criteria include (Table 1.1) women's participation in programme formulation and implementation, benefit accruing to them, their capacity building, contribution to women's employment/income generation, and reduction in women's work load and qualitative improvement in their time use. Each criterion carries maximum of 20 points. Each programme or sub-programme is to be evaluated through these criteria and allocated to one of the three categories, directly gender responsive, indirectly gender responsive and neutral, as per the scores accrued. If the expenditure item scores 50 points or more it is directly gender responsive; if it scores 20 to less than 50 points it is indirectly gender responsive; and if it scores less than 20 points the programme is neutral. For example, resource allocated to school buildings can be allocated either to indirectly gender responsive or to directly gender responsive as per the points it receives.

Table 1.1: Criteria for evaluating gender responsiveness of the government budget

S.N	Indicators	Points
1	Women's participation in formulation and implementation of programme	20
2	Women's capacity development	20
3	Women's share in benefit	20
4	Support in employment and income generating for women	20
5	Quality reform in women's time-use and minimization of their work-load	20
	Total	100

The budgetary allocations have been classified accordingly. Overall allocations to directly and indirectly gender responsive programmes have been increasing slowly (Table 1.2). The table shows classification of the estimated budget expenditure (development partners and the GON contributions) from FY 2007/08 to FY 2011/12.

Table 1.2: National budget allocation in terms of GRB classification

(Rs. in million)

GRB Classification	2007/08		2008/09		2009/10		2010/11		2011/12	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Directly Responsive	19,095	11	32,909	14	49,457	17	60,610	18	73,333	19
Indirectly Responsive	56,034	33	83,578	35	104,158	36	122,646	36	176,213	46
Neutral	93,866	56	119,529	51	132,316	46	154,644	46	135,353	35
Total*	168,996	100	236,016	100	285,930	100	337,900	100	384,900	100

Source: Estimated expenditure of FY 2007/08 to 2010/12, Ministry of Finance, Government of Nepal

*Totals may not tally with their component units due to rounding effect

So far the visible gains from the introduction of the GRB may be summed up in three major points. First, the introduction of the GRB has moved the issue of resource allocation for gender equality and women's rights to the forefront. It has helped to create a general awareness in the government system and the politicians, that gender mainstreaming is not only the responsibility of the designated gender focal points or units but of the whole system, particularly of all the planning, budgeting and monitoring units across the system. It has strengthened the gender mainstreaming mechanisms within the government. The Government had created gender units/divisions in a few ministries and since 2004, appointed gender focal points (GFPs) to all ministries and departments. Yet the need for resources to address the gender mainstreaming efforts in various sectors and Women Development Offices in the district still remains largely unattended.

In addition to the GRB classification of the budget, allocations have been made for different gender specific needs along with increasing allocations to facilitate women's access to services such as education and health. It includes scholarship for all girls in public schools up to eighth class, allocations to early childhood classes etc. For example, total allocation for scholarships increased from NRs. 103 million in the FY 2003/04 to NRs.1, 941 million in FY 2010/11, and more than half of this amount was for girls. Unfortunately, all allocations for scholarship have been lumped in a single item in the education budget (SAHAVAGI 2012). Similarly provisions have been made for direct cash assistance to pregnant women for professionally attended delivery, free selected essential medicines and free minimum outdoor and hospital services for the poor. The allocations to safe motherhood programmes have been greatly increased (See the chapter on health). In addition the Government has made special allocations for temporary shelters for those women who are victims of gender-based violence and trafficking. It has also placed women labor attaches in countries with a large number of Nepali women migrant workers and also created a large fund for rehabilitation of those who face problems in the receiving country and return with problems. In addition to old age social security, provisions have been made for specific social security assistance to widows. In programmes for elderly, disabled and Dalits also, specific stipulations are made that at least fifty percent of the beneficiary should be women. Some of the allocations for visible women-only programmes in the FYs 2008/09 and 2011/12 are listed in Annex 1.1.a

Gender responsiveness of the policies and programmes are also increasing. For example, women also get 10 percent rebate on income tax and 25 to 30 percent (rural 30 and urban 25) rebate on land transaction fees. Provision has been made for rebate on converting single ownership of land, house and buildings, into joint ownership with the wife. This can be done now just paying Rs 100. Otherwise such transactions command much higher registration fees.

However, a series of studies (SAHAVAGI, 2009, Acharya and Prasai, 2010, and SAHAVAGI, 2010) have found that implementation of the GRB itself has been problematic due to its conceptual complexity, lack of linkage with the specific institutional objectives of the various ministries and indicators on gender mainstreaming in use, and severe lack of understanding and capacity of the concerned government officials about the GRB process. The system remains far from fully operational.

To minimize these problems, the GRBC with assistance from the UN Women (previously UNIFEM) has commissioned two studies; (a) the first one to further develop the indicators and sub-indicators within the five criteria developed by the GRBC, and (b) another one to assess the capacity of the various government stakeholders to implement the GRB properly. The current case studies are part of a larger exercise² designed to develop indicators and sub-indicators within the existing common criteria developed by the GRBC.

In this publication we examine the peace-building process and the health sector in some detail in the GRB perspective and recommend set of indicators and sub-indicators within the five GRB criteria, which could be applied in the gender responsive budgeting processes in these sectors.

²*Review and revision of the existing gender responsive budgeting (GRB) guidelines, manuals, GRB criteria and software of MOF, NPC and line ministries and development of case studies on the GRB experiences and good practices.*

II. PEACE-BUILDING AND THE MINISTRY OF PEACE AND RECONSTRUCTION (MOPR)

The country entered an era of peace-building after a decade-long armed conflict led by CPN (Maoists) and the historic Jana Andolan II with an agenda of fundamental transformation of the state and society. The process of peace-building in the country must, therefore, address the broad issues of social transformation as also restructuring of the state. The social transformation must lead among other things to "a prosperous inclusive and gender equitable Nepal." This commitment for gender equality and inclusive state has been enshrined in several formal documents.

The first comprehensive basis for an inclusive and gender equitable peace-building is provided by the Comprehensive Peace Agreement between the Government of Nepal and the then CPN (Maoist) signed in 2006. This document, among other things, chartered a roadmap for the specific peace-building process which included reintegration and rehabilitation of the CPN (Maoist) combatants, dismantling of the CPN (Maoist) established alternative structures of governance, reconciliation and peace-building at the grassroots level and free and fair election for a Constituent Assembly (CA), which is to function as a Parliament also until a new constitution is promulgated and new Parliament is elected. This roadmap was later formalized by the Interim Constitution, 2007. Formally, dismantling of the CPN (Maoist) - established alternative structures of governance was also effected immediately after the Comprehensive Peace Agreement.

At the early stage of peace negotiations and series of agreements between the state and the CPN (Maoist), visibly no women were involved, as all top party leaders happened to be men. The Committee instituted to frame the Interim Constitution, had no female representation initially. But the issue of women's inclusion in the peace process was taken up vigorously by the women's movement and finally four women were included in the Interim Constitution Framing Committee of 16 (see Acharya, 2010). As a result, the Interim Constitution mandated for 33 percent reservation for women in the candidacy in the election to the Constituent Assembly. The current CA has nearly 33 percent women among its members. The Interim Constitution also mandates that women along with other disadvantaged groups, be involved in all structures of state on proportional basis (Article d1).

Coming back to the other part of the peace-building process, the Three Year Interim Plan (2007-2010) laid down its basic outline in terms of the policies and strategies for the reintegration and rehabilitation of the CPN (Maoist) combatants, reconciliation and peace-building at the grass roots level.

2.1. The Three Year Interim Plan (TYIP)

As per the government statistics, during the 10-year armed conflict led by the CPN (Maoist), 16,719 people were killed; 78,708 people were displaced and 1,327 people are reported missing (NPC, 2010).

Furthermore, the continuing violence by various armed groups has rendered people's lives intolerable in the country as a whole. Other human rights reports quote much higher figures (for example, see annual INSEC Reports and UNFPA, 2007). To address the situation the TYIP (2007/08-2009/10) followed the Peace Accord set objectives, strategies, policies and programmes for the post-conflict peace and reconstruction (NPC, 2007). Its objectives were to establish sustainable peace in the country through immediate relief, rehabilitation and social reintegration of conflict-affected individuals and groups, and reconstruction of damaged physical infrastructures. It set following targets:

- ✓ Relief to the families of all those killed in the conflict,
- ✓ Relief to all the displaced families,
- ✓ Subsistence allowance to families of all the martyrs,
- ✓ Scholarships to the children of all martyrs,
- ✓ Relief to all the widows and single women affected by the conflict,
- ✓ Reconstruction of all damaged infrastructures,
- ✓ Rehabilitation and reintegration of all the displaced families, and
- ✓ Adjustment and rehabilitation of Maoist combatants in accordance with an agreed process.

The strategies laid down among other things included (a) participation of service recipients in formulation, implementation, monitoring and evaluation of programmes and projects, (b) wider participation of women in all the processes, (c) increased flow of resources for the Peace Fund, (d) coordination with the line agencies, local bodies, UN agencies, and (e) institutional strengthening for reconstruction and rehabilitation.

Similarly the policies included (a) immediate relief and social rehabilitation of the individuals and groups affected by the conflict, (b) reconstruction of physical and social infrastructure damaged during the conflict, (c) formulation and implementation of special programmes for institutionalization of the peace to provide opportunities for psycho-social counseling, employment, or self-employment and security, with involvement of people affected, especially women, youth, orphans, widows Dalits, Adibasi Janajati, Madhesi, physically incapacitated, and other marginalized groups, (d) readjustment and rehabilitation of Maoist Combatants as per the recommendation of the Committee, (e) formation of Peace committees at the center, district and village levels for effective implementation of the rehabilitation, reconstruction and reintegration process and (f) creating an updated information base on the displaced, missing and the deceased and establishment of an effective monitoring system.

The above strategies, (especially a and b), and policy together seek to ensure both participation of women in the peace process and specific programmes for them along with other most affected groups.

Along with strategies and policies TYIP outlines several programmes, which are to be implemented by the Ministry of Peace and Reconstruction, created in 2006 with the responsibility to implement the peace programmes of the government.

2.2. International commitments – UN Security Council Resolutions 1325 and 1820 and the related action plan

The Government of Nepal, as a signatory to the UN Security Council Resolution 1325 and 1820, is also committed to women's direct participation in the peace-building process and addressing the problems of the victims of sexual violence and molestation during the conflict. Its signature to the UN Security Council Resolution 1612 commits to protecting children below 18 from being used in armed conflicts. UNSCRs 1325 and 1820, among other things, require that the parties to the peace process and the United Nations should increase participation of women at decision-making levels in conflict resolution and peace processes and adopt a gender perspective when negotiating and implementing peace agreements. They also require the parties to pay specific attention to the needs of women and girls during repatriation and resettlement and for rehabilitation, reintegration and post-conflict reconstruction, among others.

The UN Security Council Resolution 1612 (2005) strongly condemns the recruitment and use of child soldiers by the parties to armed conflict, and directs the Secretary General to implement without delay a monitoring and reporting mechanism, to provide timely, objective, accurate and reliable information on child soldiers and on other violations and abuses committed against children affected by the armed conflict.

The Comprehensive Peace Agreement 2007, itself has committed the Nepal Government to protect the rights of women and children. The Peace Agreement specifically mentions:

- Immediate halt on any type of sexual or other kind of violence against women and children,
- No use of children 18 or under in any type of armed forces,
- Immediate rescue of the children affected by armed conflict and arrangement for their reintegration, and
- Establishment of a Truth and Reconciliation Commission.

Following these commitments, the Government of Nepal has come up with the National Action Plan (NAP) to implement the UNSCRs 1325 and 1820 in 2011. It has been implementing a National Plan of Action for Children in Nepal (2004-2014), for protecting children and ensuring their other rights as per the UNSCR 1612, since 2004.

Nepal' National Action Plan 1325 was developed in a highly consultative manner in 2011. The Ministry of Peace and Reconstruction worked closely with the High Level Steering Committee on UNSCR 1325

chaired by the then Deputy Prime Minister and included members from other line ministries, secretaries and members of civil society organizations in consultations. The UN institutions, foreign embassies and international organizations were also widely consulted. About 3,000 grassroots women including those affected by violence and the representatives of women's organizations, the security forces and local district authorities from districts were included in these consultations. The wide range of questions that were raised by the participants is clustered under five pillars of NAP 1325 objectives as follows (<http://www.gwi-boell.de/web/peace-security-nepal>):

Pillar 1: Participation: to ensure participation of women at all levels of decision-making, conflict transformation and peace processes including in electoral processes, political parties and Local Peace Committees,

Pillar 2: Protection and Prevention: to protect rights of women and girls and prevent violations of these rights in conflict and post-conflict situations by strengthening institutional capacity of the Women and Children Service Centers in police stations; provision of legal assistance; medical services and psycho-social counseling for survivors of sexual and gender-based violence, and to ensure justice,

Pillar 3: Promotion: to promote rights of women and girls and mainstream gender perspective in all aspects of conflict prevention, conflict resolution and peace-building,

Pillar 4: Relief and Recovery: to address the specific needs and ensure participation of women and girls in the design and implementation of all relief and recovery programmes including reparation and compensation for the victims of conflicts and their families; economic assistance to conflict-affected women; and a provision of educational scholarships to women and girls affected by the conflict,

Pillar 5: Resource Management and Monitoring and Evaluation: to institutionalize monitoring and evaluation and ensure required resources for the implementation of the National Action Plan through collaboration and coordination of all stakeholders.

The NAP 1325 (2011) has supported the pillars and its objectives by formulating corresponding strategies and programmes and detailed framework and indicators for monitoring results. It also identifies the actors responsible for each activity and a timeframe for each action.

The NAP also includes the following features to ensure its effective implementation:

- ✓ Training and capacity-building provisions for all stakeholders, for their informed and meaningful participation in the peace programme implementation, monitoring and evaluation,
- ✓ Integration of a media outreach and communication strategy to facilitate sustained awareness raising and increased ownership and participation,
- ✓ Monitoring and evaluation system that uses a combination of activity, result and outcome indicators, building on the existing government structures and involving women's organizations.

2.3. Institutional development for peace-building

The Ministry of Peace and Reconstruction

A Ministry of Peace and Reconstruction has been established to assist in all activities of the Government, related to the process of peace-building. It is responsible for the formulation and implementation of policies, strategies and plans and programmes for peace-building, reconstruction and rehabilitation of the conflict-affected and the CPN (Maoist) combatants and their implementation in coordination with sector agencies. The Ministry of Peace and Reconstruction acts as the secretariat of the cabinet on the matter of peace, with separate mandates and functions. Two bills, one on Disappearance and another on Truth and Reconciliation are presently under consideration in the Parliament.

The Ministry is also responsible for providing procedural and technical support in the peace-building process and to monitor it, and to maintain a Repository and Documentation centre and Technical Resource Centre for conflict management related information, study materials and reports as well. The formation of Truth Reconciliation Committee is one of its major responsibilities. The management and monitoring of the Peace Fund activities and cantonments housing the Maoist combatants, is also within the scope of its activities.

Accordingly, the Ministry is actively engaged in the peace process since its establishment. Its activities include reconstruction of properties destroyed during the conflict, compensation to and reintegration of the displaced and conflict-affected persons, and cantonment management. It also acts as the secretariat to the High Level Peace Committee.

Committees and commissions

The Comprehensive Peace Accord envisaged different commissions and committees for the implementation of the peace process. A High Level Committee under the chairpersonship of the Prime Minister has been established for the management of combatant camps and the rehabilitation and reintegration of the Maoist combatants. The members are either ex-officio ministers or army and party nominees. The committee has no female representation par se. The Ministry of Peace and Reconstruction acts as its secretariat.

Under the transitional justice, two commissions – one on **Disappeared Persons and another one on Truth and Reconciliation** are proposed. The Government constituted a High Level Committee to recommend members for the Commission on Disappeared during the period of armed conflict, 1995 to 2006. This Committee comprised the Chairperson (Speaker of the House of Parliament), one member nominated by the Chairperson of National Human Rights Commission, one member from among human rights activists, psychologist, legal expert, forensic specialist, conflict expert, sociologist or persons involved in peace process or any other person nominated by the Government of Nepal. This Committee needed to recommend at least one woman member for the Commission.

The MOPR has prepared a draft of the act for **Truth and Reconciliation Commission**. It defines the missing as the persons taken in custody but not allowed to be examined by the lawyer and whose whereabouts is being kept secret by the security personnel or the kidnapper. The affected one is defined as missing person and the person's family. Here, family is defined as husband, wife, son, daughter, father, mother, father-in-law, mother-in-law, grandfather and grandmother, grandson and granddaughter or brothers and sisters. Maximum punishment proposed for the culprits is seven years of imprisonment and five hundred thousand rupees fine.

As per the proposed Act, the Truth and Reconciliation Commission will have seven members including the Chairperson and a member secretary. The Commission must include at least two women from among human rights activists, psychologist, legal expert, forensic specialist, conflict expert, sociologist or persons involved in peace process, as recommended by the committee formed for this purpose. But constitution of a Truth Commission does not seem to be on the priority list of the CPN (Maoist), which is the decisive party in the peace process.

Local Peace Committees (LPCs)

For ensuring stakeholder participation in the implementation of the peace process, peace committees have been envisaged at the center, district and VDC levels. However, the central level committee has not been formed as envisaged, except the Committee chaired by the Prime Minister mentioned above. But the local peace committees have been formed at the district and VDC levels. These committees are mandated to maintain peace in their respective areas.

The district level committee comprises maximum 23 members of the VDCs, and municipality committees comprise nine members. The members of the committees are selected in a joint meeting of the representatives of the political parties, women, Dalit, Adivasi, Janajati, Madhesi, conflict-affected families, marginalized groups, social leaders and religious organization heads, etc. This meeting is required to form a committee inclusive of women, Janajati, Dalit and other marginalized groups.

Objectives of the local peace committees are:

- Work according to the spirit of the Comprehensive Peace Agreement,
- End all types of violence and disruptive activities and institutionalize peace at the local level by dialogue and discourse,
- Support in the implementation of peace and reconstruction process at the local level,
- Support to end the effect of conflict at the local level by encouraging local people towards democratic values and sustainable peace, and
- Support in implementation, monitoring and coordination of Comprehensive Peace Accord and agreements/understandings reached with Madeshi parties and other movements at the local level.

The objectives do not specifically talk about women in the peace-building but has incorporated provisions for women in the formation of the committee and secretariat of the committee, roles and responsibilities of the secretariat and the committee officials.

There is a provision for one-third representation of women in the local peace committees. Additionally, two representatives from the group of Adivasi, Janajati, Madhesi, Dalit and Muslim communities are also mandated. Duties and functions of the Local Peace Committee include: a) facilitating peace promotion and conflict transformation, b) supporting and monitoring relief and rehabilitation initiatives, c) facilitating reconciliation among the conflicting parties, d) healing, e) confidence-building among the conflicting parties, f) watching the political development, g) supporting the social development process, h) ending the local political scuffle, and i) disseminating information on peace process. The functions of the committee do not specifically mention gender concerns. However, the TOR of the committee is all encompassing. It is a specified duty of the coordinator of the committee, to ensure that all members attend each meeting as far as possible.

The decision of the Committee should be through consensus as far as possible. The Committee needs to involve women, Dalit, physically challenged, conflict-affected and representatives from other marginalized groups in its activities and decision-making process as much as possible. The working procedure is thus inclusive. Its implementation, however, was not found equally effective in the three districts visited by the study team (see Section 2.5).

2.4. Financing of the peace initiative and gender responsive budgeting

The peace process in Nepal is funded through various channels. One of them is the government budget, which is managed by the Ministry of Peace and Reconstruction. Another large part is funded by development partners under a jointly agreed programme coordinated by the UNDP. The government budget part is primarily spent on management of the (CPN) Maoist camps housing the ex-combatants. The resources allocated to the MOPR increased significantly in the fiscal years 2008/09 and 2009/10 but has declined somewhat in the FY 2010/11, as it should, since many of the MOPR activities are only transitional (Table 2.1). In the current fiscal year (2011/12) the Ministry's expenditure is likely to jump in a big way, as more than Rs. 4 billion may be required for the ongoing process of army integration and retirement of the combatants from the camps.

Table 2.1: Share of the MOPR in the national budget

(Rs. in million)

Budget Estimates/FY	2007/08	2008/09	2009/10	2010/11
National Budget	168,996	236,016	285,930	337,900
MOPR (programme budget)	1,124	9,084	11,467	8,628
Percent share of MOPR	0.67	3.85	4.01	2.55

Source: Estimated expenditure of FY 2007/08 to 2010/11, Ministry of Finance, GON

A substantial part of the programme budget of MOPR is funded by the development partners. For example, in the FY 2010/11, 50 percent of the cantonment budget, 99 percent of the relief for the conflict victims and 92 percent of the Local Peace Committee budget was to be financed by the development partners, although in the overall budget of the MOPR, foreign aid contribution amounted to only 30 percent. The entire GON budget was allocated to the Central Level Coordinator's Office (Table 2.2).

Table 2.2: Estimated expenditure financing of the Ministry of Peace and Reconstruction by source, FY 2010/11

(Rs. in million)

Heading	Sources		Total Budget	Percent contribution by heading	
	GON	Foreign Aid		GON	Development Partners
MOPR Total	6,064	2,564	8,628	70.3	29.7
MOPR--Central Level	6,048	2,376	8,424	71.8	28.2
MOPR	75	0	75	100.0	0.0
Cantonment Management Central Coordinator's Office	1,208	0	1,208	100.0	0.0
Peace Trust Fund--including cantonment management, food, shelter and allowance	1,828	1,828	3,655	50.0	50.0
Reconstruction and Rehabilitation Programme	2,935	0	2,935	100.0	0.0
Peace support Project – for conflict victim's family	3	548	551	0.6	99.4
District level					
Local Peace Committees	16	188	204	7.8	92.2

Source: Estimated expenditure of FY 2010/11, Ministry of Finance, GON

Note: Totals may not tally with their component units due to rounding effect.

Within the national budget the development partners are funding the peace process through three jointly managed programmes -- the Emergency Peace Support Project (IDA/World Bank), Nepal Peace Fund supported by seven partners (UK, Norway, Switzerland, Finland and Denmark, Germany and EC, commitments are yet to materialize), and ADB support to the Local Peace Committee through the Local Governance and Community Development Programmes (LGCDP). The Local Peace Committees may be granted Rs.500, 000 to Rs.700, 000 on presentation of programmes for following activities:

- Capacity enhancement of the VDC peace committee members,
- Programmes benefiting conflict-affected,

- Exchange visits,
- Mediation training to VDC peace committee members,
- Publication of progress reports.

The salary of the staff of LPC secretariat is borne by the Government of Nepal while the LPC activities have been supported by the ADB under the LGCDP as discussed above.

2.4.1 Approaches and strategic plan of action of the development partners

Development partners use several channels for funding their overall programme. The government budget is only one of the channels. Other channels include direct implementation of programmes and funding the NGO activities. Coordinated by the UNDP they have come up with a new joint Action Plan "Peace and Development Strategy 2010-2015" (UN RC/HC Office, 2011). This programme shows almost all development partners active in Nepal are assisting in the peace process by funding one or other part of the initiatives.

The Joint Peace and Development Strategy identify 178 specific areas of ongoing or potential support for development partners. These have been compiled into the 'Action Plan' that has been released as a companion document to the Peace and Development Strategy. It is mentioned that the status of the Action Plan will be reviewed and updated periodically to ensure that the actions identified are moved along. However, it is also mentioned that actions are ultimately contingent upon requests being made by the Government.

The new approaches laid out in the Action Plan include, among other things, ensuring voice of all parties, particularly women and marginalized groups in the conflict-related assistance, increased use of public hearings for transparency and accountability, social audits and/or public auditing (or other social accountability mechanisms) that enable the participation of women and those from excluded groups. It also requires vetting all new projects against the guidelines developed by the UNSCRs 1325 and 1820 Peace Support Working Group for ensuring that the gender aspects are adequately considered. In addition, consultation with the civil society representatives on the strategy for civil society support, a pool-funding mechanism for their capacity-building and their engagement in the peace process are provisioned. Allocation of funds at the district level using severity-mapping data (by sex, caste, ethnicity and religion) combined with information on VDC resource allocations is also planned. Establishing effective social inclusion monitoring systems (baseline database, yearly staff composition survey, diversity audit, etc.) to measure change and progress achieved over time by development partners features as another important point in the approaches outlined.

The Strategic Action Plan is very comprehensive and covers almost all aspects of development partnership. Major areas of immediate (short term priorities) support as envisaged in the strategic plan of action are; a) law and order, which includes an independent police service commission (or equivalent body)

and support to the Government in affirmative action to increase the representation of women and traditionally excluded communities in the security forces; b) transitional justice – support in the establishment and functioning of a Commission of Inquiry on Disappearances and a Truth and Reconciliation Commission in accordance with international standards; c) interim support to the conflict-affected -- continuous support for temporary relief payments to families by the MOPR, education of the children affected by conflict, employment and skills/vocational training for conflict-affected families and widows, psychosocial counseling for conflict-affected persons, outreach programmes to ensure that all the victims can avail their entitlements, rehabilitation support to sexual violence victims, support in the implementation of internally-displaced persons and assistance to returnees ; and d) support to reconstruction of conflict-damaged infrastructure through a SWAp mechanism. Other identified items for support include e) miseries directed to property return and land reform ensuring that the needs of the widows and household headed by single women are given adequate attention; f) elimination of mines laid out during the conflict³; and g) gender-sensitive implementation of the national plan of action for youth employment via cash for work, entrepreneurship and vocational training.

The development partners have provided support in the management of the CPN (Maoist) combatant cantonments and the maintenance of the eligible combatants, and rehabilitation and reintegration of the discharged minors and late recruits. And monitoring those discharged in line with UNSCRs 1325 and 1612 and support for the readjustment, rehabilitation and reintegration of the combatants will be funded as and when the Nepal Government comes out with a definite plan of action.

Next activity claiming a big chunk of foreign aid is the assistance to the key institutions and mechanisms for peace including Local Peace Committees and other local mediation mechanisms making them more gender sensitive. The development partners assisted in the election of the Constituent Assembly/Parliament in a big way. The support was also provided in the constitution-writing process in the form of expert assistance, public consultations or public awareness campaigns and capacity-building of the Constituent Assembly members, particularly women and other disadvantaged groups and the development and implementation of an inclusive National Peace Communication Strategy. These kinds of supports are still ongoing. The major development partners -- the UN system, multinational organizations, OECD countries, Japan and others are involved in the support of the Peace Process, in one way or other.

Particularly on women's issues UN Women (previously UNIFEM) has actively assisted both the government and non-government sectors in the peace-building activities, for example in preparation of the Action Plan on UNSCRs 1325 and 1820, voicing women's concerns on the constitutional drafts of the various drafting committees, supporting generally the gender mainstreaming process within the government system through institutionalizing the gender responsive budgeting and many other related activities.

Similarly, the UNDP has established a Center for Constitutional Dialogue (CCD) which is jointly funded by several donors -- the United Nations Development Programme (UNDP), Danish Embassy, and UK

³ *Nepal was declared the mine-free country on June 21, 2011.*

Department for International Development (DFID), Austria and Norway. It has provided a neutral forum for open discussions of various constitutional issues to all political groups, promoted an open and fact-based dialogue between Constituent Assembly (CA) members and their constituents throughout Nepal with special emphasis on promoting gender equity and social inclusion. The CCD also assisted the CA in the public opinion collection. It has acted as an information base for all stakeholders making related materials available in various local languages; organized discussions and interactions on federal structure and inter-state relations in different centers involving the CA members and other stakeholders, from the national to the VDC level. It has also supported different parliamentary caucuses in order to ensure that the concerns of the communities have been addressed and provided training to media networks, media houses and individuals in constitutional reporting.

2.4.2 Gender responsiveness of the government budget

Coming back to the gender responsiveness of the government budget, as noted in the first chapter, the MOF introduced the Gender Responsive Budgeting (GRB) in the fiscal year 2007/08. Since then GRB classifications of GON budget have been published annually. Table 2.3: features classification of the Ministry budget as per the GRB categories. It shows more than half of the MOPR expenditure as indirectly gender responsive in the three FYs 2007/08- 2009/10. No significant amount was shown as directly gender responsive in this period. But in the FY 2010/11, 33 percent has been classified as indirectly gender responsive, 0.7 as directly gender responsive, and rest as neutral.

These classifications have not been consistent through time on assignment of expenditure items to the three GRB categories. In the FY 2008/09, nearly 73 percent of the expenditure for the central secretariat of the Ministry has been classified as indirectly gender responsive and the rest under neutral (Annex 2.1b). But in the subsequent two years one hundred percent of such expenditure has been shown as directly gender responsive.

Table 2.3: Percent distribution of MOPR sector budget by GRB classification

(Rs. in million)

GRB Classification	2007/08		2008/09		2009/10		2010/11	
	Amount	%	Amount	%	Amount	%	Amount	%
Directly Responsive	---	---	---	---	2	---	65	0.7
Indirectly Responsive	660	58.7	6,294	69.3	6,231	54.3	2,870	33.3
Neutral	464	41.3	2,790	30.7	5,234	45.6	5,693	66.0
Total*	1,124	100	9,084	100	11,467	100	8,628	100

Source: Estimated expenditure of FY 2007/08 to 2009/10, Ministry of Finance, Government of Nepal

These expenses include mostly administrative costs of various committees, media expenses, establishment costs, etc., with small allocations for relief of the affected children, monitoring, etc. The expenditure

under this sub-heading can be considered indirectly gender responsive or neutral rather than directly responsive. Similarly, one hundred percent of the expenditure from the Peace Fund has been considered neutral whereas it also contributes to the betterment of the women. Since there are about 20 percent women combatants inside the camp, the funds spent on their food and stipend should have been under the category directly gender responsive. On the other hand, allocation of the total amount to reconstruction and physical rehabilitation, which includes activities such as purchase of photocopy machine and computers and furniture, building of road and bridges, Peace Park etc, as indirectly gender responsive is not justifiable, since these have not been vetted through the GRB criteria (see 2.5.3 below).

2.5. Implementation experience

The MOPR, as already mentioned, is engaged in three areas of peace-building activities, i.e., cantonment management, compensation to the victims and their families and reintegration of displaced and reconstruction of properties destroyed during the conflict, besides acting as a secretariat to the Cabinet and the High Level Peace Committee.

2.5.1 Cantonment management

The cantonment management involves three kinds of activities (a) verification of combatants, (b) physical infrastructure and health management, and (c) distribution of monthly stipend to the combatants and management of food for them.

Verification of combatants

Altogether 4,008 combatants were disqualified and 19,602 qualified in the UNMIN-conducted verification process. Authorities in the Ministry were unable to say how many of them women were. A high level committee was formed with representation from the UN Resident Mission, UNMIN, UNICEF, GON and the CPN (Maoist) by a cabinet decision for the verification and discharge of the unqualified combatants. The Minister of Peace and Reconstruction chaired the Committee. This High Level Committee formed a Technical Committee coordinated by the Joint Secretary of the MOPR, for implementing the decisions of the main Committee. The unqualified combatants were discharged from the camp in six steps, e.g., information and consultation, survey and personal detail collection, discharge from the camp and placement in the transitional rehabilitation centre, orientation and advice, training and educational services and reintegration. Neither the main Committee nor the Technical Committee had women's representation.

The reintegration package for the discharged and combatants in the camps included vocational training, micro-enterprise development training and health education with support from the UN Country Team, jointly monitored by the UNICEF and the UN Human Rights Commission. A total of 2,151 ex-combatants had contacted the office for reintegration and among them 1,563 received different advisory services. A total of 941 ex-combatants have been trained during 2009/2010 (MOPR Progress Report 2009/10). The reports do not give sex-disaggregated information.

The programme was applied in blanket form to all combatants; no special considerations have been given to the needs of the women, past and present combatants. These training and advisory activities do not fall under the regular funding of the government. They are independently organized by development partners and it is their onetime programme.

Recently, classification of combatants for integration in the army, resettlement or retirement has been completed. There were no women in these classification teams. Most women combatants have chosen to retire as they are with children or incapacitated. Many feminists have commented that this is unfair, but it is not clear whether it is by informed choice or compulsion. Since many of the marriages within the camp have been inter-caste, it is feared that they may face much more difficulties in adjusting to civil life than men. No specific attention has been given to this aspect in retirement package. It will be a big challenge to resettle them properly. The MOPR cannot even provide sex-disaggregated information on the number of combatants or their recent classification for army integration and rehabilitation.

Physical infrastructure and health management

Until the recent classification of combatants for army integration, there were seven main camps and 21 satellite camps housing the combatants. The Ministry provided support in the construction and maintenance of physical infrastructure like housing, approach roads, electrification, telephone, drinking water facilities in these camps. The health and sanitation programmes were also included. In the FY 2009/10, the Peace Fund was utilized for the maintenance of the three infrastructural facilities in the camps. Besides, GTZ is also providing support for drinking water, sanitation, education, and skill training in the camps. There is a provision of medical team headed by Medical Officer in the main camps. Similar facilities are available in the satellite camps.

The combatants, both men and women are housed in the same building with common toilet facilities for both sexes. There is no separate room for checking women's specific health problems, e.g., pregnancy, except in Kailali and Surkhet. Most of the medical officers are men; nevertheless other nursing staffs are women. In case of pregnancy, women combatants are advised to rest at home, during which time they get their daily and monthly stipends. They do not get extra facilities during this time (Box 1). In many instances they have to stay in rented spaces in the case of inter-cast marriage, because their in-laws do not accept them.

Box 1: Findings from Shaktikhor Camp

(April 27-29, 2010 Observation Tour Report by Honorable Binda Pandey)

Shaktikhor camp houses 3,924 ex-combatants of which 20 percent are women. Number of children in the camp is about 300. But the camp has no child-care center or school for the children. The women ex-combatants can stay outside the camp two months before delivery and up to six month after child-delivery. These women do not get extra facilities during pregnancy and delivery. It is surprising that so far none of the monitoring and observation team had women members, leading to the fact that women's concerns were mostly ignored.

Another major finding of the team was that the VDC did not recognize/register birth of a child without fathers' name. The schools in turn did not enroll the child without birth certificate, which leads to difficulty in getting citizenship for the child.

2.5.2 Relief and rehabilitation

There are many programmes under the relief and rehabilitation heading. Major activities include financial support to the nearest relative of the persons killed during conflict, relatives of the missing and kidnapped, those with disability caused by the conflict, single women who have lost their spouse in the conflict, internally displaced, scholarship to the children of the martyrs and the wounded, and pensions to the persons wounded during the April 2006 mass movement. Table 2.4 shows the total number of affected and those who have received compensation from the government. The programme is all encompassing, and no special provisions have been made for women except single woman.

The officials of the Ministry opined that since the relief funds were for all the affected, it is not necessary to disaggregate the data by sex.

Table 2.4: Relief, rehabilitation and financial support to conflict affected, cumulative upto Mid-July 2011

(Rs. in '000)

Programmes	Persons identified	Persons benefited	Total financial support
Financial support to nearest relative of the deceased	17,828	13,893	1,389,300
Financial support to the nearest relative of the missing	1,452	1,302	130,200
Financial support to those who lost their physical body part during conflict	5,912	2,951	165,070
Financial support to nearest relative of the kidnapped	2,985	1,219	30,475
Pensions to nearest relative of the martyrs of the historical people's 2006 movement, Jana Andolan II	26	26	5,384
Pension to those wounded during Jana Andolan II	23	23	2,296
Scholarships to wounded or the family of the wounded	26	26	1,413
Monthly pension to the 50% wounded during Jana Andolan II	23	23	2,296
Financial support to women in the conflict	9,000	4,873	121,825
Financial relief for physical property destroyed during the conflict	14,438	7,085	198,799
Relief and rehabilitation support for the internally displaced	79,171	25,000	240,144
Rehabilitation of the children orphaned during the conflict	242	121	7,750
Skill development training to the conflict-affected		327	5,250

Source: Ministry of Peace and Reconstruction, Progress Report, October, 2011 (Aswin 2068)

There are still a large number of affected families who have not received their entitlements. This is mainly due to cumbersome process of allotment of entitlements on the one hand and logistic problems at the District Administrative Office (DAO) on the other. The DAO it is not financially supported to process the papers or to administer the relief distribution. The DAO is short of logistics and staff for relief distribution. Moreover, the decisions are politically biased at the Ministry level, depending on the political base of the MOPR minister. This has delayed the decisions and in many cases right persons do not get the relief in time, while non-entitled persons may get it.

There are different committees in the districts engaged in peace-building, e.g. Scholarship Committee with the Chief District Officer (CDO) as the chairperson and the District Education Officer as secretary. There is also a Reconstruction Committee – chaired by the CDO with the District Technical Officer as member-secretary, which looks after reconstruction in the VDCs. Reconstruction in the urban areas is handled by Department of Urban Development and Building Construction.

The team visited the families of the conflict-affected in Banke, Dhanushadham and Rolpa districts in order to find out their experience in receiving the compensation. It was revealed in the discussions with members of the conflict-affected households that most of them were aware of the provision of the relief funds of Rs. 100,000 and the additional Rs 25,000 relief to widowed women. But almost none in Dhanushadham including the VDC - Technical Assistant was aware of the scholarship for the children of the affected.

Handling the cases of relief was not uniform across the districts. Delays had resulted in fatalities also. The two cases below show the contrast. In Banke, women said that it was very difficult to receive Rs. 100,000 compensation due to indifferent attitude of the DAO in processing the papers. According to a LPC member, in Fathepur VDC of Banke, wife of Bishnu Tharu (missing) killed herself because she could not raise her three children due to financial constraint. Before committing suicide she had approached the DAO for relief funds many times, but the CDO office had lost her file and could not provide her the amount without proper paper work. After her death, the LPC helped to dig out the file from the store of CDO office. This is just one example of blatant negligence by the administrative arm of the government in handling the relief cases.

However, in the case of Ratan Kumari Yadab, Dhanusha (Box 2), she followed a simple procedure for getting the relief and easily received the entitled amount. She had no complaint against the CDO office or the DDC. Comparing the case of Bishnu Tharu of Banke and Ratan Kumari Yadab at Dhanusha, it seems that the attitude of the authorities in the CDO office is crucial in timely distribution of relief.

Box 2: Ratan Kumari Yadab (Dhanushadham VDC, Dhanusha)

"It was in the evening of Baishak 25, 2059 B.S. (May 8th, 2002) that they came to my house. My husband and I were sitting inside the room. The CPN (Maoist) combatants came into the room and forcefully took my husband from the room and shot him dead when he was outside the main gate. They threatened the family and ordered us to leave the house." Ratan Kumari Yadab had two young sons and one daughter. She was afraid that they would also be killed if she did not heed their command. So she moved from her husband's parental house at Tejnagar to the present house at Dhanushadham Ward No 1. At first, she was living in a rented hut, now she had erected a bamboo and mud house from Rs. 250,000 received as compensation for diseased and displaced. She also received Rs. 25,000 relief for widowhood from the District Development Committee (DDC) without much hassle. She said that she got the information about the relief funds from the Nepali Congress party office instead of the CDO or the VDC office. She is now sustaining her family through wage labor and income from the sale of incense she has been trained to make by the SUPPORT Nepal. She also has two goats from the goat exchange programme of the Women's Rehabilitation Centre (WOREC) Nepal.

According to her, it was not difficult to receive the relief once she had applied for it. She needed a picture of herself, death certificate of her husband, relationship certificate and her citizenship to get it.

Of the three districts, visited by the team, Rolpa had highest number of relief receivers in all categories. A total of 1,392 people had received various kinds of compensation (Table 2.5). There were about 20 to 25 cases of widowed women not receiving the widow-entitlements, because the deceased's family had been officially represented by the father-in-law. In the focus group discussions the women said that the entitlement usually went to the family and the women did not have much say in the use of the money.

In Banke, so far 259 families of the dead and 51 families of the missing had received compensation of Rs. 100,000 each. Similarly, 89 single women had received Rs. 25,000 each as widow-relief and 257 children of the dead and missing had received scholarship.

In Dhanushadham VDC many widows had yet to receive their entitlements. For example, Jipai Devi Yadab's family members including her husband were killed by the Nepal Army during the conflict. But she had not been able to get the widow-compensation from the DAO so far. Similarly, her children had not received any scholarships from the government. Moreover, there were families of the missing, who were not aware that they were also entitled for compensation.

Among those who received relief funds in Rolpa, about 20 to 25 cases were repeated while 8 to 10 households had no address, thus had not received any relief. As of July 2011, no funds had been allocated for the orphaned children.

Table 2.5: Number of applicants receiving relief in Banke, Dhanusha and Rolpa

Type	Banke 2009/10			Dhanusha 2009/10			Rolpa 2008/09		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Deceased	212	47	259	9	2	11	799	129	928
Wounded+	-	-	-	-	-	-	NA	NA	170*
Missing	34	9	51**	-	-	-	29	5	34
Widow	89	-	89	-	-	-	260	-	260

Source: Field survey

* Sex break-down not available. A total of 594 wounded (77 women and 517men) had applied, but only 170 had received the relief.

** It includes eight recipients, for whom no sex break-down is available.

The information flow from the government side is very poor and ineffective. Most of the affected families had heard about the relief package either from the local political party leader or the membership organizations like Conflict-Affected Family Organization, Displaced Family Organization, Single Women's Organization, etc. In the cases where the affected were from the security forces, the parent organization informs the families about their entitlements. These organizations also facilitate the processing of the papers. The security forces are well organized and have direct approach up to the families of the affected while no such link existed between the government and the civilian families. Box 3 illustrates a case of the family of former police personnel while Box 4 represents a civilian's case.

Box 3: Dharma Laxmi Thapa

Ms. Dharma Laxmi Thapa, a 33 year old is the widow of police personnel late Mr. Harka Bahadur Thapa. She is living with her father-in-law and mother-in-law in Bageshori VDC, Ward No 1, Dhaulagiri village, Banke. Mr. Harka Bd. was killed in the Rolpa, Sulichaur Police Post attack by the CPN (Maoist) in 2000. Dharma Laxmi has two children, one son and one daughter. Her son is now studying in 11th grade and daughter in 5th grade. She has received Rs 100,000 and widow allowance Rs. 25,000 from the government. Additionally, she received Rs. 750,000 from the police headquarters. Besides, the Nepal Police gave her Rs. 10,000 each for the study of her son and daughter and Rs 66,000 medical facility. She still has to get Rs. 36,000 medical allowance from the Nepal Police, but she has to go to Rolpa to get the amount. She also receives a pension of Rs. 3,600 monthly. However, her son has stopped getting scholarship from last year due to 18 years age bar for scholarship.

She did not face any difficulty while processing the papers for relief and compensation. She heard about the relief amount from the Ashakta and Amar Pariwar Samaj of the security forces. But she had to visit the ADO three times. She bought one bigha of land and built a one-storey house from the compensation amount. She has opened fix deposit accounts of Rs. 100,000 each in her own and her daughter's names, in the local bank.

Box 4: Dambar Bahadur Ranabhat

Bam Bahadur Ranabhat, age 71 and Ms. Ujeli Ranabhat, age 51 residence of Bageshowari VDC, Ward No 1 Dhaulagiri of Banke district live in sorrow of losing their 25 year old son and 23 year old daughter during the CPN (Maoist) conflict. Ujeli takes a long breath and recounts the memories of her dead daughter and missing son. Her daughter Kopila Ranabhat was just 23 when she was shot dead by the security forces at Pokhara Langhalel attack in June 2006. She was a married woman with one daughter. She became a CPN (Maoist) combatant when her husband kicked her out of their home. She lived a solitary life for some time and later with peer pressure became a CPN (Maoist) combatant. Kopila spent 16 months in Jail after she became a CPN (Maoist) member. Similarly, Ujeli's second son Dambar Bahadur Ranabhat, also a member of the CPN (Maoist) was later listed as missing by the government.

According to the parents of these two combatants, at first they were not aware of the compensation they will get for their dead and missing children. When they heard about it from the other conflict-affected households in the village, they approached the District Administration Officer in Banke for the relief funds. But the office staff was very uncooperative and they had to visit the office many times. The CDO office lost their files twice. Finally, they received Rs. 100,000 after a year of waiting, while the CA member Hon'ble Ashok Rokaya got the compensation amount for his dead and missing children in the first attempt, they complained.

In the case of Kopila, her husband (informally divorced by party records) claimed the relief. Ujeli went to Pokhara and stopped him from getting it. The relief amount is now deposited in the name of Kopila's daughter until she becomes eligible to receive it.

This old couple was still not aware of the provision for scholarship for their grandchildren, the children of their dead daughter. For the scholarship funds they have to apply to the District Education Office along with a recommendation letter from the school and the relationship certificate from the VDC. But due to ignorance about this provision they had not yet availed the scholarships for the children.

There were also cases where the widowed women had not been able to use the compensation funds due to negative attitude of her in-laws. A case of a Muslim widow highlights this kind of problem faced by some widows (Box 5).

Similar case of Ms. Mina Nepali was reported to the study team in Rolpa. Her husband was a teacher and was killed by the CPN (Maoist) during the war period. She had received the widow-relief and the compensation for her deceased husband. Her children are also receiving scholarship. However, her in-laws are all against her. She has been stigmatized by her in-laws and is not allowed inside the house and she is forced to live in a cow-shed. It was repeatedly reported that the police attitude and behavior was not women-friendly.

Box 5: Sekh Khan

Mr. Sekh Khan was killed by the security forces in 2001 in Udarapur VDC, Banke. His widow was to receive Rs 100,000 compensation from the government. But her in-laws planted an imposter in her room, who acted as her lover. They locked the imposter and the widow in a room and spread a rumor in the village about her improper act. They then shaved her head and beat her in an inhuman way. Ms. Mobina Khatun (presently Banke LPC member) saved the widow at the right time and took the family to the police office and the CDO. She was finally able to hand over Rs 100,000 compensation to the rightful heir.

2.5.3 Construction and rehabilitation of physical infrastructure damaged during conflict

As per the Ministry sources, altogether 1,357 projects were implemented until 2009/2010 of which 566 were completed. The literature on reconstruction does not talk about gender-sensitiveness of the infrastructure. It is also not clear what percentage of women participated in the construction work. All of the reconstruction by the District Technical Office (DTO) and the Urban Development and Building Construction (UDBC), in the visited districts, were implemented through private contractor instead of users committee. But there was no clause for the employment of women in the contract documents. The wage rates and hiring of labor were under the discretion of the contractor rather than the government office. The study team visited two under-construction buildings, one government office in the Municipality area and the other a VDC building. There were three toilets in the VDC building but none was planned for women. Since generally, the male contractors do not see the necessity of a separate women's toilet, it is necessary for the Ministry to make female toilets mandatory in the newly constructed government buildings. However, it was revealed in the group discussion with the peace secretariat staff that the newly reconstructed school buildings usually had provision of toilets for girl students, but they could not assure the study team about the construction design of the health facilities.

By the end of 2010, the DTO of Banke had completed many buildings (VDCs, service centers, health posts) and many others in various sectors were under construction. However, there was no set policy to guide the design of these building as per the necessity of women. But, in cases of dispute between the contractor and the labor about equal wages to women, the DTO was reported to intervene. In Kalafanta VDC, the DTO made the contractor pay equal wages to women when there was a dispute between the contractor and labor. The UDBC was constructing four buildings in the district (Forest Office, Livestock Office, Education Office and Survey Office). All the building designs had provision for women's toilets. UDBC seems to be more sensitive to gender issues as the divisional engineer in Rolpa was aware that all the public buildings should have separate toilets for men and women.

The DTOs in the districts which the team visited complained that there was no separate budget for construction of women's toilet, indicating a sever lack of understanding of gender mainstreaming

principles. Even when more than one toilet was constructed, no need was felt for allocating one to women. The team felt that it is the case of sensitization rather than shortages of finance.

In Rolpa, the DTO office had completed 12 government buildings including the VDC building, agriculture and livestock service centers, sub-health post, etc. Because of lack of male labor in the district, most of the construction works were completed by women. Even then no conscious attention was given to women-friendly facilities while constructing these buildings.

2.5.4 Local Peace Committees at work

As evident from the discussions in the section 2.3 above, the Local Peace Committees are designated to play crucial role in the distribution of relief and rehabilitation of the conflict-affected and monitoring reconstruction and rehabilitation of properties damaged during the conflict, and to promote reconciliation at the local level. By the end of July 2011, local peace committees had been formed in 67 districts, 7 municipalities and 598 VDCs. In many cases they have been quite successful in identifying the real victims and promoting peace in conflict situation, in others they seem to be defunct. Of the three districts this team visited, in Rolpa and Banke they seemed well functioning with 33 percent women's active participation, performing many activities effectively; in Dhanusa the committee was not as effective. Efficacy of these committees depended on many factors, some of which are discussed below.

Representation of women in the Local Peace Committees

The mandatory requirement of 33 percent women's membership in the Peace Committees is more or less implemented at the district levels. In the case of VDCs it is not uniformly implemented in all cases. For example, in Banke, the present LPC has eight women members (among them four are conflict-affected) and some of these women members are quite active. The coordinator of the committee is selected from among the members of the committee for six months on a rotation basis. There is an opportunity for all the members to become the coordinator of the committee once. One of the woman members of the committee is planning to become the next coordinator of the committee. The Rolpa district LPC comprises 18 members of which six are women. The membership of the LPC is in accordance with the LPC guidelines. In the case of Dhanusha, the district LPC has 21 members comprising seven women members. Women members were nominated by the CDO by consulting political leaders of the district on personal approach.

However, the District Committee members in all three districts opined that it was not easy to find women members for the VDC-level committees. For example, even in Banke the district LPC had successfully formed 32 VDC-level local peace committees comprising nine members each, but women's membership in them was only 25 percent. These members, according to the District Committee members were like ornaments. They also stated that it was easier to find women members in the hill people-majority VDCs than in VDCs with Madhesi majority.

The Rolpa LPC had formed grassroots level LPCs in 17 VDCs out of 51. However, in Rolpa also, the district LPC members stated that they were not able to include enough women in the local level LPCs, because its activities involved much travel and women already had much work at home/farm, and that the women's membership in the VDC LPCs was less than 33 percent. Another major reason cited by the LPC members for lower representation of women in the local LPCs was the absence of women members in the VDC-level All-Party Mechanism. They said that the political parties tended to send male representatives to the LPCs rather than nominating women.

In Dhanusha out of the 101 VDCs, LPCs had been formed only in 20 VDCs. They were reported to have 33 percent women. But the District members opined that women were included just to fulfill the quota stipulated by the guidelines than their qualitative input in meetings and decisions. They reported that decisions were dominated by male members of the committee representing different political parties.

LPCs in implementation of programmes

The broad range of activities that the LPCs could undertake and contribute effectively to the process of conflict resolution and peace-building are illustrated by the case of Banke LPC (see the best practice below) and to some extent by Rolpa. Because of its wide political base the LPC Banke has been effective in correctly identifying the victim families, bringing peace in the case of a religious conflict, forming LPCs in 32 VDCs, providing orientation training to various stakeholders, government, NGOs and undertaking many other activities. The members of the district LPC have understood their main role as coordinators and mediators for peace and harmony, which was lacking in Dhanusha.

In Rolpa, the district LPC had conducted capacity-building training, radio programme, workshops and interactions, street drama, observation tours, etc, besides forming the LPCs in 17 VDCs, from the Rs. 700,000 annual budget it got. They aimed to form 51 LPCs in 2011/12. The reintegration programmes have been conducted in different VDCs.

Although the political base of LPC Dhanusha is also wide, it was totally dysfunctional and had confusion about its role and authority. There are 17 political parties active in the district, but they did not seem to be fully aware of the government provisions for the conflict-affected, especially about compensation to missing families and the scholarship for martyrs' children. It also came out in the discussions that because of the temporary nature of the office, the other government offices did not give much importance to the role of the LPC or its secretariat. They complained about the shortage of funds but did not say what they did with the Rs. 700,000, which each District Peace Committee is entitled to get on presentation of programmes.

The LPC secretariats at Banke and Dhanusha also mentioned that the LPCs do not have provision for the transportation and snacks for the meeting, which hampers the regular meeting of the committee and the participation of women, as they hardly have extra cash to spend on travel. This was a problem particularly for the poor women.

Factors that promote or hamper efficacy of the LPCs

Spirit of collaboration among the local political leaders

The functional efficacy of the Local Peace Committees has depended on the degree of collaborative spirit among the local political party members. Women's membership is also influenced by the political party. For example, in Banke district a 23-member Local Peace Committee (LPC) was formed in April 2008, but because of political scuffle among the major political parties the coordinator of the LPC could not be nominated till December 2009, which rendered the Committee dysfunctional till that date.

In Dhanusha, the ADO officials opined that the Committee was not functional mainly because it was dominated by political party members and there was no incentive for members to attend meeting and undertake activities required from Committee members, the team was told. Moreover, since the members were from political parties they could not devote sufficient time for the Committee activities.

Authority of the LPCs and cooperation from the officials

Although the LPC is an autonomous entity, it does not have executive authority and rehabilitation and compensation functions are implemented by the DAO, which again does not have enough financial resources to expedite these functions. The reconstruction function is implemented by the DTO at the VDCs and the UDBC Division within the municipal areas. Because of the advisory status of the LPCs, it is natural that the effectiveness of LPC depends on the discretion of the CDO, who is the sole authority for relief and compensation. Scholarship scheme for the children of the martyrs and other conflict-affected is distributed through District Education Office with recommendation from the DAO. There is a separate scholarship scheme for the children of security forces who were killed in the conflict or missing since then. This facility can be availed either from the security force or the MOPR. There is an age bar of 18 for the scholarships.

It also came out in the discussion that, although the LPC is an autonomous body the budget of the committee is also channeled through the CDO office. The LPC has to submit all the expenditure details to the CDO office for reimbursement.

The functional efficacy of the LPCs, thus, depends on the cooperation from the concerned officials. For example, in the case of Dhanusha, the district LPC was first formed in 2005, but remained non-functional and was reorganized in February 2008. One of the major concerns of the members of the LPC at the time of our field visit was non-recognition of the role of LPC by the CDO, DTO, LDO offices. Decisions on relief were taken without consulting the LPC members. The LPC on its part also had not initiated any written communication with these organizations in this respect. The LPC members complained that the CDO office had not initiated any actions on the list of 665 properties damaged and 183 displaced cases that the LPC had recommended for action. The temporary tenure of the staff of the Secretariat was pointed out as another cause of non-effectiveness. The Secretariat Management Committee comprised four women members out of nine but it had not been able to organize meeting even once, until last fiscal year.

No mechanism exists to coordinate the LPC activities with the DAO Office. Similarly, the activities of DAO are not officially communicated to the LPC members. In fact, no official channel exists and coordination depends on the activeness of the LPC secretary.

Information Diffusion

It is the responsibility of the DAO to disseminate information about rehabilitation, compensation, scholarship and relief in the district. But because of little logistic support to the office these functions were poorly performed by this office. According to the DOA officials, they just wrote letters to the concerned VDCs and aired notice from FM radio about the decision of the Ministry and availability of funds. VDCs, on their part, had not properly communicated such messages to the public. The role of LPC becomes crucial in this context. But even after formation of district LPCs, many victim families were found lacking information on the process of getting the relief funds. Very few were aware of the provisions for scholarships to the children of the victims. The newly formed VDC-level peace committees had been of little help in the process of information diffusion.

For example, it was revealed in Dhanushadham that, not all the government notices reach the community. They were mostly relayed by the political parties, that also to their own supporters only. This means that the notices reached to the conflict-affected households only if the concerned local political leader was active. It was surprising that even the Technical Assistant of the Dhanushadham VDC was not aware of the scholarship funds for the children of the affected. No missing families had applied for compensation in the DAO office until the end the FY 2010/11, may be because they were not aware of the provision of compensation for the missing. There was no record of the missing at the VDC-level. Even the NGO group organizers working in the women's rights and peace issues in the VDC did not know about various provisions for women, Dalits and girl students, made recently by the Ministry of Local Development (MOLD) in its GESI policy and guidelines on local governance. The extent of information gap is illustrated glaringly by a case in the VDC whereby a woman LPC member was not aware that she was a member of the VDC LPC, although she had already attended one meeting of the Committee as informed by the VDC Technical Assistant. The district LPC had organized mediation trainings for the VDC-level LPCs, but they do not seem to have been effective so far.

Even the LPC of Banke had overlooked the role of WDO in the peace process especially in the implementation of UNSCRs 1325 and 1820. The LPC members realized that they had not been sensitized to women's special needs and no instructions had been given by the Ministry for the same. The LPC members opined that it was necessary to organize orientation and trainings for the Ministry officials, peace committee members and women in general on UNSCRs 1325, and 1820, so that involvement of women will be significant and meaningful in the peace process. The National Action Plan for 1325 and 1820 has mentioned that LPCs may propose to the Ministry separate activities relating to those resolutions; but due to lack of experience the LPC was not in a position to formulate programmes for such activities.

Monitoring

One of the major functions of the LPCs is to monitor the activities of the DTO and other concerned offices in reconstruction and relief distribution. However, because of inadequacy of the resources, the LPCs were not able to fulfill effectively their monitoring function. Moreover, even if a monitoring report was written, it was forwarded to the MOPR and not shared with the DTO, UDDB or the DAOs feedback.

Moreover, there was no standard format or planned schedule for monitoring of either the reconstruction work or the relief funds distribution. It was done in an ad-hoc manner by the members, that also only of the reconstruction part. The relief distribution and scholarship management (was) were not monitored. Similarly, there was almost no follow-up of the activities at the VDC level by the district LPCs or the DAO.

This weaknesses was somewhat addressed in the 31 VDCs in Banke where VDC-level LPCs were formed. According to the LPC members, after the formation of LPCs in the VDCs, there have been no complaints from the affected families on the preparation of documents (recommendation from VDC and the police) to be submitted to the DAO. The process includes verification at the local level and recommendation by the VDC and the police office to the DAO. However, these and other functions were completely ignored by the VDC-level committees in Dhanusha district. The members argued that since the district level LPC was inactive, it was very difficult to activate the VDC-level LPCs to their role.

Cases were reported even in Banke where the police office and the VDC had recommended wrong persons and they had actually received the relief funds. But after the formation of LPC such misappropriation has been curbed to some extent.

2.6. Best practice--Banke Local Peace Committee

In Banke district a 23-member Local Peace Committee (LPC) was formed in April 2008, but because of political scuffle among the major political parties the coordinator of the LPC could not be nominated till December 2009. But once, the coordinator was nominated the LPC has been functioning very effectively. At present there is no competition for the post of coordinator since the coordinator of the committee is selected from among the members of the committee for six months on a rotation basis. The present LPC has eight women members (among them four are conflict-affected). Some of these women members are quite active in peace process. One woman member is planning to contest for the post of the coordinator in the coming election.

Activities of Banke Peace Committee

The members of the LPC have understood their main role as coordinators and mediators for peace and harmony. The LPC members stated that the main functions of the LPC were; monitoring of the implementation status of Peace Accords (Comprehensive Peace Accord and Madhesi Peace Accord); collection of information about conflict victims; and mediation for maintaining peace in the district.

Even in the absence of executive role of the Committee, because most of the members are politically active and also because the Secretary of the District Peace Committee is quite active, the District Peace Committee in Banke is functioning effectively. Although the Committee does not have the mandate for rehabilitation and compensation functions, due to its good coordination with DAO, the CDO decides on the authenticity of the applications for relief and other benefits on the basis of its recommendations. The LPC members were also planning to supervise the construction of buildings by the DTO and the UDDB Division. This Peace Committee had completed following activities since its formation till the research team's field visit:

List of activities

- ✓ Identified genuine cases from the list of the applicants in DAO with support from different human rights organization, especially for site verification and recommendation to the DAO.
- ✓ Formed 32 village level LPCs with the support from different human rights agencies. According to the Committee members, it was not easy to find women members for these committees. Because of their efforts, they had been successful to have 25 percent women members in the 32 VDC- level peace committees.
- ✓ Organized two orientation programs for VDC- level peace committee coordinators on their role in the peace committee, human rights, relief, compensation, etc, and one similar program for the female members for their capacity- building,
- ✓ Four district level orientations had been completed for the members from the government agencies, political parties, NGOs and conflict-affected organization on relief and compensation.
- ✓ Distributed education materials to 60 conflict-affected poor children.
- ✓ Aired Jingles from the local FM on peace and social harmony.
- ✓ Organized peace walks to maintain religious harmony.
- ✓ Organized all-party and civil society meetings to maintain peace and harmony and to bring the accused to justice in the case of two students kidnapping and bomb blast in Nepalgunj.
- ✓ Organized skill development training for 60 conflict-affected women.

The relief and compensation distribution is the function of DAO. Generally because of poor logistic support, the DAO was not effective in disseminating information about the relief measures to the general public, more specifically to the conflict-affected; and many conflict-affected persons were not aware of their entitlements. In Banke, however, this gap in information dissemination has been somewhat bridged by the local LPCs in the 32 VDCs. When the local LPC members get the information from the DAO, they visit the house of the conflict-affected one by one in the vicinity and transmit the information

to the affected person. The LPC also helps the affected families to prepare documents from the VDC and the local police office, and sends the document to the DAO, along with its own recommendation. The role of LPC has become crucial in this context.

The effectiveness of the Banke LPC may be illustrated by the following example. The District LPC challenged the name list of the conflict-affected persons recommended by the DAO to the Ministry and brought down their number from 61 to 8 persons. As per the Committee members, some of the names were repeated in the list while some others did not belong to conflict-affected. As per the members of Banke LPC, there have been cases where the police office and the VDC had recommended wrong persons, and they had actually received the relief funds. But after the formation of LPC such misappropriation has been curbed to some extent.

Similarly, the LPC has been effective in maintaining religious goodwill among different religious groups in the district. A religious fray was stopped between Hindu and Muslim communities in the district with its intervention at right time (See Box 6). Another major achievement of the Committee is its ability to maintain balance among different political parties, so that it is now easier to call all party meetings as and when necessary using this network. Thus, the LPC has become a neutral platform to bring together members of all political parties and religious group in the implementation of the peace process.

Box 6: Successful mediation in inter-religion marriage dispute

A complaint of underage marriage between a Muslim girl and a Hindu boy was lodged in Banke DAO. The CDO made the two sides understand that this marriage was illegal and the girl and boy need to live separately in unmarried status till they both become eligible for marriage. An understanding was reached between the two sides that both sides would not harm each other because of this incidence.

However, as the couple walked out of the DAO, some Muslim persons from the girls' side beat the boy. This took a nasty turn and the next day a Hindu Siv Sena walked on the street with sticks and swords. This incidence incited religious scuffle in the district. The LPC then called a meeting of both the religious heads. After long hours of discussions the two sides organized a peace rally on the street. This helped to develop understanding between the two groups and stopped the potential religious fray in the district.

2.7. Gaps, challenges and recommendations

2.7.1 Gaps and challenges

Ensuring women's effective participation in the peace process

The major challenge in the implementation of the GRB is the lack of adequate capacity of MOPR for gender budgeting and gender audit of its programs. There is a general attitude that since the relief is

for 100 percent of the conflict-affected, there is no need to pay specific attention to gender issues or maintain sex-disaggregated information on the benefits accruing to the victims. However, this assumption is fallacious and should be reconsidered. These assumptions have resulted in following gender-blind activities in the peace building process.

There is a system for involving women through LPCs in the planning and budgeting of the ministry's programs at the district level. There are however, no provisions for involving women in the implementation phases. This has certainly affected the information dissemination technique, collection of the name lists of the affected family members, processing of the papers; and delayed distribution of the relief funds.

The current programme-implementation system of the Ministry does not consider the practical needs of women in new constructions. In the absence of policy to guide the design of the new constructions, these structures do not have necessary toilets and sanitation facilities for women in these buildings.

Although majority of the conflict-affected are women the Ministry does not maintain sex-disaggregated information; in the absence of which women are not considered the prime beneficiaries of the conflict, and subsequent planning and implementation of the programmes do not take their needs into account.

Further analysis of the implementation process of the peace initiative showed that there is little provision of funds in the LPC to make women aware of their rights and to capacitate them to claim the relief funds. Similarly, there is no provision of funds in the District Administration Office for the capacity development of women. The UNSCR 1325 envisages identification of specific needs of women during and after conflict and their involvement in the process of post-conflict reconstruction and peace-building activities. While the peace-building process in Nepal has envisaged women's participation, the issue about their specific needs and barriers to participation, have been completely ignored.

There were some cases where women could not receive relief funds or could not use them because of family pressure and information gap. Multiple barriers to women need to be addressed in the process of implementation, to enable them to receive the maximum benefit from the relief measures of the government. They have to be oriented and supported in the process on their rights and responsibilities, so that they will be able to receive the benefits that are actually meant for them.

Although the LPCs are mandated to monitor the activities of the DAO, DTO and the UDBC, no specific mechanisms have been developed so far to monitor the progress and effectiveness of relief and reconstruction work. There is no system for monitoring of the district level activities. The district offices are not accountable towards the MOPR. Rather they submit their report to their respective line-authorities. In the absence of proper monitoring of the implementation, it is difficult to measure benefits to the actual target group. The recommendation from the district is channeled through the LPC to the MOPR but the implementation is not directly reported to the MOPR and CDO or the LPC.

Administrative problems

The peace and reconstruction work of the CDO office is limited to fulfilling the formality because, CDO has many regular responsibilities. The CDO has to chair 14 committees under the MOPR. In addition,

because of lack of logistic support the CDO office is not in a position to conduct formal examination of applications that comes through political party offices.

Because of the frequent time extension without a concrete plan, a single applicant applies for relief many times piling up the work at the CDO office. This discourages the actual applicants and encourages imposters. The directives from the MOPR changes each time a new Minister is appointed. This creates confusion as to who is the real victim of the conflict. There have been cases, whereby both the natal family and husband's family have applied for the entitlement if the victim was a married woman. There is no monitoring and follow-up from MOPR at the district. There is no budget assigned for monitoring.

There is no health benefit for the martyrs' families.

Data problems

The MOPR is unable to give sex-disaggregated data on any of the information it keeps. For example, it does not have information even on the number of women in the combatant camps, how many of them were disqualified, or the result of current classification for army integration, rehabilitation or retirement.

Given the capacity of the MOPR and the LPCs, the greatest challenge to full application of the GRB system is their capacity-building to understand properly the process of the GRB as recommended in Chapter IV below.

2.7.2 Recommendations

In the above context, other recommendations made may be summarized as:

- The peace process should be audited on the basis of the GRB criteria of MOF, for which a tentative list of indicators is attached. The whole peace structure and the members of the peace committees also should be oriented on GRB criteria and methodology.
- The whole peace-building process needs to be gender- sensitized as the current process does not give considerations to the three major barriers of women, i.e., time constraint, lack of access to economic resources and social attitude. When these barriers are addressed, women will be facilitated to get involved more effectively in the planning and implementation of the peace process,
- Funds must be provisioned for capacity-building of the district LPC members, so that the rehabilitation and reintegration process will be smooth,
- Proper monitoring mechanism for information feedback to the CDO, district LPCs and MOPR should be developed and implemented,
- All information on cantonments, rehabilitation, children scholarship and employment generated by reconstruction should be sex-disaggregated,
- Programmes should be GESI-audited and publicized through public hearing system.

III. THE HEALTH SECTOR AND THE MINISTRY OF HEALTH AND POPULATION (MOHP)

Nepal has been committed to improving her people's health from the very First Five Year Plan. Nepal has also committed herself to all international conventions and treaties on people's health, Alma Ata Declaration on "Health for all by 2000" (1969), ICPD (1997) commitments to life-cycle approach to women's health and rights to reproductive health, BPfA, MDGs (2000) and many others. She has expanded her health services vastly to reach the remotest districts and participated in almost all international disease control and health campaigns. Since signing of the Alma Ata Declaration, access to primary health has been a part of the basic needs strategy and elements of reproductive health such as family planning and pre-natal and post-natal care have been integral part of all health planning in the country. Consequently, the overall health status of the Nepalese population, men, women and children has improved significantly.

Nepal's HDI and health indicators have improved significantly in the last two decades. For example, the HDI improved from 0.309 in 1980 to 0.532 in 2007 (HDR, 2009), despite the ten long years of armed conflict and continuing political disturbances. Similarly, the GDI moved from 0.312 in 1991 to 0.545 in 2007. Nepal topped the list of countries in health status improvement. Both education and health have contributed significantly to this improvement. Particularly in health, women's life expectancy has increased from 53.5 years in 1991 to 66.9 years in 2007 while the male life expectancy improved from 55 to 63.7 years in the same period (Ibid). Maternal, infant and child mortality rates – all have improved significantly in this period. Women's access to family planning services, improved maternal care, and child-delivery services have also increased significantly. Total Fertility Rate (TFR) has declined from 5.4 in 1991 to 2.9 in 2009.

However, Nepal's HDI, GDI and health gains have not been distributed equally among the various sub-groups of the population. Dalits, Muslims and some ethnic groups have lagged far behind in health improvement. Similarly urban/rural and regional gaps are still large. Poverty intensifies the impact of other factors limiting the access of the poor of all groups of the population to health and education services. Therefore, current policies, strategies and programmes are directed particularly to addressing the multiple factors responsible for of unequal access, including gender.

3.1. Public sector health service delivery structure

In Nepal health and population services are provided by the government, a few NGOs and the private sectors. The government system is providing basic as well as curative health-care services, while the private sector is providing only curative services. The NGOs provide some family planning and family health services.

In the government sector, basic health services were provided during the study period by 117 hospitals, 208 primary health-care centers (PHCCs), 675 health posts (HPs) and 3,127 sub-health posts (SHPs) (Annual Report, 2009/10). Child health, reproductive health, disease control, national health training, health education, information and communication, among others are key public health programmes currently implemented in the country (Table 3.1).

The Ministry of Health and Population (MOHP) is the primary arm through which the Government of Nepal implements its health policies, plans and programmes. The overall responsibility for providing the basic health-care and formulation of health and population policies, plans, strategies and programmes lies with the Ministry. The Ministry is also responsible for regulation and supervision of the private health institutions and medical supply-related activities as also control of narcotic drugs. Thus, it is responsible for both health service provisions and regulatory functions. Specifically, the MOHP responsibilities include formulation of all health and population policies, plans and programmes and their implementation, research and development of public sector health and population services and related training of the health personnel. Besides, it is also responsible for research and regulation of import, sales and distribution of drugs including control of narcotic drugs. Most importantly, it is also responsible for the control of quality and prices of the drugs.

In order to achieve its objectives and fulfill its responsibilities, the MOHP has established a system with small and large health-care facilities all over the country, administrated by the Department of Health Services (DOHS), Department of Ayurveda (DOA) and Department of Drug Administration (DODA) under which the public sector health-care institutions work.

Table 3.1: Institutions providing health services, July 2010

S N	Type of Health Institutions	Number
1	Hospitals (government, non-government and private teaching hospitals)	117
2	Primary health-care centers(PHCCs)	208
3	Health posts (HPs)	675
4	Sub-health posts (SHPs)	3,127
5	Primary health-care outreach clinic	13,180
6	Female community health volunteers (FCHVs)	48,489

Source: DOHS Annual Report 2009/10, p.1

3.2. National health plans and policies

For achieving her health goals Nepal has formulated multiple plans, policies and strategies in the past. Many of these continue to guide the current programmes. Particularly following may be noted:

- The National Health Policy, 1991
- The Second Long-term Health Plan 1997-2017 (SLTHP)
- The National RH/ Family Planning Information, Education and Communication (FPIEC) Strategy-1997
- “Health Sector Strategy: An Agenda for Change,”2004
- The Strategic Plan for Human Resource for Health, 2003 -2017
- Safe Motherhood Policy and National Safe Motherhood Plan (2002-2017)
- Health Sector Strategy: an Agenda for Change, 2004
- Nutrition Policy 2004

These together have provided a framework for health and population programmes in the country. The successive strategies, plans and programmes have aimed at expanding the primary health-care system for the rural population so that they benefit from modern medical facilities and the services of trained health-care providers. Initially the policies, plans and programmes focused on expanding basic health facilities to rural areas. The National Health Policy, 1991 aimed to expand the primary health-care system up to the grassroots level in rural areas, providing all three preventive, promotional and curative services. Maternal child health and family planning were included at all three levels. Coming after ICPD, the SLTHP, 1997-2017, expanded its aims to include quality improvement, human resource development, ensuring sustainability, full community participation, decentralization, gender-sensitivity, effective and efficient management and collaboration with the private sector and NGOs. The SLTHP's reproductive health part was based on holistic coverage of women's health. The FPIEC Strategy-1997, based on SLTHP 1997-2017 for the first time addressed the issue of reproductive health from a woman's perspective (See below). The National Reproductive Health Strategy - 1998 developed it further recognizing reproductive health as an integral part of women's human rights and taking a life-cycle approach to women's health. It covered reproductive health issues related to infants, adolescents and to elderly, as a package. In addition to family planning, safe motherhood and new-born care, the package included family health, preventive services for abortion complications, RTI/STD/HIV, uterine, cervical and breast cancer, etc.

Most importantly, this package was visualized to be implemented through the regular health infrastructure rather than on a programme basis. It emphasized advocacy for creation of an enabling environment for women to increase her access to reproductive health, strengthening the participatory mechanisms in management of health services and assessment of women's other reproductive health needs, besides safe pregnancy and child-delivery.

The “**Health Sector Strategy: An Agenda for Change, 2004**” focused on attaining the Millennium Development Goals (MDGs) of reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria, and other diseases by 2015. Wide-range of consultations were conducted over three years with other Ministries, the NGOs, the private sector, consumers, development partners and health-care providers in preparation of this Strategy. Subsequently, the Nepal Health Sector Programme – Implementation Plan (NHSP-IP) was prepared in 2003, incorporating the strategy. This plan was appraised by all partners in 2004 and approved as the framework for development assistance to the health sector (UNFPA, 2007).

Nepal Health Sector Programme – Implementation Plan I, 2004 – 2009, based on the SLTHP and the strategy paper, NHSP-IP strategic programme activities were broadly organized in two components : (a) strengthened service delivery through the expansion of essential health-care services, greater local authority and responsibility for service provision, and public-private partnerships; and (b) development of institutional capacity and management through sustainable health financing and its efficient management, human resource development, establishment of a health management information system, strengthened health infrastructure management and quality assurance. It had a goal to increase the coverage and raise the quality of essential health-care services (EHCS), with special emphasis on improved access of the poor and the vulnerable groups through an efficient sector-wide health management system with adequate financial resources. This plan provisioned services in the area of (a) family planning, safe motherhood and neonatal health, (b) child health, (c) communicable disease control, and (d) out-patient-care.

3.3. Safe Motherhood Policy and National Safe Motherhood Plan (2002-2017), and the Nutrition Policy, 2004

The Safe Motherhood was identified as a priority programme by the Government in the National Health Policy of 1991; which was followed in 1994 by the formulation of a National Safe Motherhood Policy that placed emphasis on strengthening maternity care, including family planning services, at all levels of health service delivery including the community. The National Safe Motherhood Plan 2002-17 developed a long term vision to scale up the coverage of maternal and newborn health-care at all levels. The strategies outlined in the plan include upgrading the technical capacity of maternal health providers and their appropriate deployment at all levels, implementation of a cost-sharing scheme (in health facilities or at home) mobilizing skilled birth attendants to provide home-based delivery services. This includes provisions of financial incentives to pregnant women and skilled birth attendants (SBA) and subsidies to health institutions for child delivery services (See below on details of this programme). Given the socio-economic structure, women and the poor socially and economically excluded groups face multiple barriers to accessing the available health services, on the demand side as well. All earlier programmes were aimed at strengthening the supply side of the health sector. The demand side remained unaddressed. Current initiatives and incentive structure address the demand side as well, by the provision of financial assistance to pregnant women for child-delivery in health institutions.

Similarly, the Nutrition Policy is also very much women and children focused. The underlying principles of the policy clearly specify children and women as the prime target groups:

- ✓ Priority must be given to infants, young children, pregnant and nursing mothers for the protection and promotion of their nutritional well-being,
- ✓ Special attention should be given to the nutrition of women during pregnancy and lactation. All forms of gender discrimination including traditional practices detrimental to women must be eliminated in accordance with the 1979 Convention on Elimination of All Forms of Discrimination against Women.

3.4. An assessment of past policies, strategies and programmes from a gender perspective

The idea of a cost-sharing and financial assistance for safe delivery both to the clients and the service-providers under the Safe Motherhood Programme was particularly a new initiative, which recognized the resource constraints of the poor women in accessing the health services. It also seemed to recognize, that the earlier system which entailed payments to the skilled birth attendants (SBAs) by the household automatically excluded the poor women from their services. Although, the SLTHP, 1997-2017 had talked about addressing the women's health issues from a gender perspective, it was only in 2002, the major barrier of the women to accessing the safe delivery service, the resource constraint was recognized in the health policy.

The gender-based social practices directly impact on health outcomes for women and girls of all social groups, though the degree varies with caste/ethnicity, age, location and wealth. The son preference is generally high. The infant mortality rate has improved, but under-five mortality rate is still higher for girls. They are still 1.5 times more likely to die before age five than their brothers, and two times more likely to be malnourished. The gender-based discrimination in access to food, education, household resources greatly hinders a woman's ability to access health services (Bennett et al. 2008).

Furthermore, as mentioned above, although Nepal has made big strides in improving health of its citizens, the health gains have not been distributed equally for all population groups. For example, the Nepal Demographic Health Survey (NDHS), 2006 showed that Dalits, Muslims, some Janajatis, and Madhesis, have consistently low health indicators, including higher stunting among children and higher vulnerability to multiple communicable diseases. While the three DHS surveys from 1996 to 2006 indicate that there has been a decrease in the difference between wealth groups for several indicators, wide disparities still exist (Bennett et al. *ibid*). Therefore current policies, strategies and programmes have been directed primarily to relieving women's economic and social barriers to accessing health services, with specific attention to the poor, Dalit and other disadvantaged groups.

3.5. The Interim Constitution and current plans and policies

Interim Constitution

The Interim Constitution of Nepal, 2063 BS (2007), promulgated after the historic People's Movement of April 2006 and subsequent restoration of democracy has established the following health-related fundamental rights of Nepali citizens.

- ✓ Every citizen shall have the right to receive basic health-care services free of charge from the state as provided for in law.
- ✓ The child health and reproductive health services are fundamental rights of children and women.
- ✓ Freedom from violence has been guaranteed for women.

Although earlier policies and plans and programmes tried to expand the primary health services and ensure women's reproductive health, the Constitution provides a new frame for consolidating and expanding them.

The Government's 10-point policy guideline

In 2007, the Government issued a 10-point policy guideline (2007) which among other things emphasized the rights to health of all citizens with special priority to gender, caste and ethnicity, communities and regions that are socio-economically disadvantaged; and committed the government to deliver all types of preventive, rehabilitative and curative services to disadvantaged people, encourage the donors for support and assured corruption-free administrative and financial system. It further aimed to increase resource allocations for health-care and improve its effectiveness.

On the supply side, the policy aimed to develop special initiative to create working environment for doctors and health workers in rural and remote areas and activate the two way referral system. Other steps planned were development of human resources in accord with Nepal's needs, involvement of the private sector educational centers in expanding the services for the people and provision for necessary assistance, policy directives and supervision to make them more responsive to the people's needs. The promotion of health cooperatives, decentralization and community empowerment were adopted as the main strategies for promoting people's participation and ownership.

Three Year Interim Plans

The Three Year Interim Plan (2007-2010) outlined its health sector objectives as: (1) to provide quality health service, (2) to ensure easy access to health services to all citizens (geographical, cultural, economic and gender), and (3) to ensure enabling-environment for utilizing available health services. The plan had set strategies and working policies to achieve a set of objectives, which included provision of

essential and basic health services to all, sectoral reform and health infrastructure development, decentralization of management of health institutions and public-private partnership. The current Three Year Plan (2010-2013) also continues the same policies focusing on providing quality health services with easy access to all citizens.

Nepal Health Sector Programme – Implementation Plan II (2010-2015)

Based on the above policy documents, the NHSP-IP2 continues the emphasis on increasing the access and utilization of quality essential health-care services, reducing harmful cultural practices in partnership with non-state actors and improving the health system to achieve universal coverage for essential health services.

Gender and Inclusion Strategy, 2010

The Interim Constitution, policy documents such as PRSP with its social inclusion pillar, and the Three Year Interim Plan (2007 – 2010) provided a clear mandate for addressing inclusion and gender issues. The Three Year Development Plan (2010-2013) also specifically addresses gender and inclusion issues in the health sector.

Nepal has made global commitments by signing various international conventions and instruments to address these issues. Following these mandates and commitments, the health sector has made immense efforts to improve the health conditions of the people through its pro-poor and pro-women programmes. The pro-poor, essential free health-care services and the free maternity services coupled with safe delivery incentives started in 2007 has increased the access of the poor and the targeted groups to essential health services. The NHSP-IP2 incorporates many of these and GESI-related initiatives.

To operationalize the GESI policy commitments the MOHP has developed a Gender Equality and Social Inclusion Strategy which was approved in 2010. This strategy has proposed a GESI section in the Ministry, a unit/ desk in the department and divisions with the responsibility of monitoring the implementation of the strategy, collecting information and data and analyzing them. It also proposed a GESI section in the Ministry with the responsibility of: (1) making the policy, plan and programs GESI-responsive, (2) collection and analysis of information and data on the implementation of the strategy and monitoring whether the available health services have reached the targeted groups, (3) building the capacity of the GESI units/ desks and mobilizing resources for gender equality and social inclusion, (4) coordinating the information dissemination on gender equality and social inclusion for the management, and (5) coordinating with NPC, MOHP, departments and divisions for implementation of targeted GESI programs (MOHP, 2010).

Instead, the MOHP has developed a five-tier institutional set up. A Steering Committee has been formed at the central level in the Ministry in September 2011, to provide leadership and policy guidance and ensure financial resources for implementation of the GESI related programmes, advocacy, and coordination with related ministries/organizations for technical advice. At the DOHS level, a GESI

technical working group (TWG) is to be formed which will be chaired by the Director General (DG). Similar GESI technical working groups are proposed for the Regional Health Directorates (RHDs) and District Health Offices (DHOs), all to be chaired by the concerned office chiefs. The district Technical Working Group (TWG) will include representatives from hospitals, WDO, Social Development Officer/DDC and partner NGOs, the Health Facility Management Committee (HFMC) members, social mobilizers, and health service-providers from the facility and from non- governmental health services in the area. The existing HFMCs will serve as the grassroots unit in the chain.

MOHP envisages establishing GESI units in central hospitals, and including gender equality and inclusion in the terms of reference of all health service providers. The process has started for establishing GESI social units in two zonal hospitals outside Kathmandu. For initiating the process, the MOHP has accomplished a rapid assessment of such units in three hospitals of Kathmandu--Bir Hospital, Paropakar Maternity Hospital, and Patan Hospital. The GESI strategy has proposed various activities for the regional and zonal level, district as well as community-level health delivery agencies for addressing the problems of the targeted groups. The targeted groups are defined as per the Interim Constitution 2063 (2007), which includes three social groups namely, the poor, groups at risk and marginalized ethnic groups. In all three groups it has specified women and children as specific focus group.

The GESI Strategy Paper for the first time seeks to address the gender-based violence (GBV). Implementation of the GBV related activities is the responsibility of the Population Division of MOHP. It includes establishing hospital-based One Stop Crisis Centers (OSCCs). The OSCC manual has provisioned for establishing 15 such centers one each in 15 districts. A rapid scoping of 10 districts was undertaken for the feasibility of this center. Presently, seven districts are selected for establishment of the OSCC as suggested by the study. Next year, eight more will be established. The OSCC manual has been prepared and approved from the Prime Minister's Office (PMO), and is under implementation from this Fiscal Year 20011/12.

Two outside GESI experts have been hired with DFID funding for technical assistance in operationalizing GESI strategies and policies, in the sector. This includes application of the GRB.

3.6. Funding and financing of the health sector budget

The national health budget increased significantly from Rs. 4.6 billion in the FY 2004/05 to Rs.23.8 billion in FY 2010/11. As a proportion of total government budget, the health budget had increased by about 1.2 percentage points, from 6 percent in the FY 2004/05 to 7.2 percent in 2007/08. But in the following years it declined recovering to 7.0 percent in 2010/11 (Table 3.2). There is also an increasing trend in per capita private and public sector expenditure on health and population (Table 3.3). The per capita public sector expenditure increased from Rs. 187 in the FY 2004/05 to Rs. 568 in 2009/10.

Table 3.2: Share of health and population expenditure in the national budget estimates

Budget/FY	2007/08	2008/09	2009/10	2010/11
National Budget (Rs. million)	168, 996	236,016	285,930	337,900
MOHP Budget (Rs. million)	12,178	15,578	18, 677	23,814
MOHP share in total budget(%)	7.2	6.6	6.5	7.0

Source: Budget Speeches, 2007/08 to 2010/11 MOF, Government of Nepal

Table 3.3 Per capita actual public spending on health

Details/FY	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Total expenditure on health (Rs. million)	4,597.6	5,722.7	7,440.7	9,844.4	12,693.0	15,914.9
Population (million)	24.5	25.2	26.2	26.8	27.4	28.0
Per capita public expenditure on health (Rs.)	187	227	284	362	464	568
Per capita public spending on health in US Dollar	2.5	3.2	3.8	5.5	6.7	7.6

Source: (a) Statements of expenditure 2004/05-2011/12 and Annual Report of DOHS 2007/08; (b) RTI International, 2010, p 7)

3.6.1 Sources of funding -- the SWAp (pool and joint funding)

A large part of the government' development budget in Nepal is funded by external partners. For example, in the FY 2011/12, the GON expected to receive 35 percent (MOF, Budget Speech, 2011/12, p 82) of its development budget from them. The external funding has been particularly heavy in health, education and infrastructure. The bulk of the programme budget is funded by them. For instance, nearly 48 percent of the health budget in the FY 2009/10 was expected to be funded by the external partners (Table 3.4). However, in the FY 2010/11, the share of expected foreign aid in the sector, declined to 30 percent.

Three modalities of foreign aid-flow are in practice, pool-funding, joint funding and the individual funding of programmes. With the Paris Declaration on Aid Effectiveness, the modality of foreign aid delivery is changing towards a more coordinated Sector Wide Approaches (SWAp) and the joint funding of programmes. In Nepal the SWAp modality was adopted in the education and health sectors even earlier. In the health sector the SWAp modality of funding started with the Health Sector Reform Strategy, 2003, which set out three programme outputs (prioritized essential health-care services, decentralized management of health facilities, and the public private partnership). The SWAp is characterized by a single agreed-upon sector policy, approach, expenditure programme and outputs, under the government leadership, with majority of development partners contributing to the pool-

fund in the Government sector. It brings ongoing projects into line with the SWAp, initiating work to capture the direct expenditure of development partners that is not reflected in the Government accounts, and developing common implementation and monitoring procedures. Although starting with modest beginning, currently more than half of the total health sector foreign aid is received under the SWAp arrangement (Table 3.4).

Table 3.4 Estimated health budget and source of funding

Fiscal Year	Rs. in million				Percent			
	Nepal Govt.	Pool-fund	Other foreign aid	Total	Nepal Govt.	Pool-fund	Other foreign aid	Total
2004/05	3,899	953	1,789	6,641	58.7	14.4	26.9	100
2005/06	4,340	1,630	1,585	7,555	57.4	21.6	21.0	100
2006/07	4,516	1,550	3,164	9,230	48.9	16.8	34.3	100
2007/08	5,915	2,697	3,487	12,099	48.9	22.3	28.8	100
2008/09	7,450	2,929	4,567	14,946	49.8	19.6	30.6	100
2009/10	9,318	4,992	3,531	17,840	52.2	28.0	19.8	100
2010/11	16,579	3,422	3,813	23,814	69.6	14.4	16.0	100

Source: MOHP (2007, p.156 & MOHP, 2011)

Note: Totals may not tally with their component units due to rounding effect.

The external development partners within and outside pool-funding are listed in the Annex 3.1 Up to the Fiscal Year 2008/09 there were only two partners, DFID and IDA in pool-funding and the Aus-AID joined it in the FY 2009/010. In the FY 2010/011 there were four partners in the pool -- Aus AID, DFID, GAVI and IDA. The larger development partners outside the pool in the sector are USAID, UNICEF, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Vaccines and Immunizations (GAVI).

The actual expenditure on health has also been increasing with increased absorptive capacity of the system. Actual expenditure trend is presented in Table 3.5. The budgeted amount and the expenditure are increasing from all of the three sources. However, there is a consistent shortfall of 15-20 percent in the actual expenditures when compared to the budgeted amounts. The shortfalls are visible in all accounts, the GON, pool and other funding. There are multiple reasons of this shortfall, but in recent years political instability has been the most prominent cause for such shortfalls.

Table 3.5: Actual health sector expenditure by source

(Rs. in million)

Fiscal Year	Nepal Govt.	Pool-fund	Other foreign aid	Total
2004/05	3,117	690	791	4,598
2005/06	3,649	1,145	929	5,723
2006/07	4,118	1,335	1,988	7,441
2007/08	6,131	1,757	1,957	9,844
2008/09	7,073	2,697	2,923	12,693
2009/10	9,519	3,346	3,049	15,914
2010/11*	NA	NA	NA	19,979

Source: MOHP (2067, p.157, MOHP File document & Budget Speech FY 2011/12)

* Revised Estimates

Note: Totals may not tally with their component units due to rounding effect.

A major plank of the health sector strategy to increase the efficiency of services is the decentralization of expenditure authority and funds together with the community participation. Accordingly, the Government has made efforts to shift the resources from the central to district level. Spending authority for expenditure on safe motherhood and family planning and for child health has been transferred to the district level. So too is the authority to distribute funds for construction of health posts (HP), primary health-care centers (PHCC) and hospitals. Responsibility for procurement of drugs and medical supplies has also been transferred to the district health offices. The central level budget decreased from 58 percent in the FY 2006/07 to 41 percent in 2009/10; the district budget, in turn, increased from 13 percent to 34 percent in the same period (Table 3.6). In the FY 2010/011, the share of central budget has increased. This increase is attributed to allocations to some central hospitals for specific purposes and for strengthening of monitoring and evaluation mechanism (MOHP file document, 2011).

Some of the health budget goes directly to the district public health office (DHO) and some to the Local Development Officers (LDOs) in the district, HPs and PHCCs get medical supply and the staff salaries paid from this office. For capital costs in the case of building construction, up to rupees one million is channeled through the Local Development Office and the District Health Office (DHO), while larger demands are approved individually at the center and expenditure channeled through the Department of Housing Construction.

Table 3.6: Percent central and district shares in the health sector budget

Level/FY	2006/07	2007/08	2008/09	2009/10	2010/11
Administrative	29.1	26.5	31.4	25.7	23.1
Central	57.8	52.7	41.9	40.6	44.4
District	13.1	20.9	26.7	33.7	32.5
Total	100	100	100	100	100

Source: RTI International, (2010, p 13; MOF. Statements of expenditure -2011/12)

Note: Total percent may not tally to 100 on last number due to rounding effect.

Many programmes are funded from the pool. However, the largest share goes to maternal health. The pool- fund contribution to maternal health increased from 23 percent in FY 2004/05 to 68 percent in 2008/09 showing a greater commitment in improving maternal health by both the GON and development partners (Table 3.7).

Table 3.7: Expenditure on safe motherhood and family planning

(Rs. in million)

Fiscal Year	Pool-fund			Earmarked by programmes	Total Expenditure
	GON	DFID/ IDA	Total		
2004/05	41.2	24.3	65.5	215.9	281.4
2005/06	67.5	140.8	208.3	213.4	421.7
2006/07	364.0	276.9	640.9	281.8	922.7
2007/08	249.5	255.0	504.5	608.6	1,113.1
2008/09	562.7	800.6	1,363.4	636.1	1,999.5
Percent share by sources					
2004/05	14.6	8.6	23.4	76.7	100
2005/06	16.0	33.4	49.4	50.6	100
2006/07	39.5	30.0	69.5	30.5	100
2007/08	22.4	22.9	45.3	54.7	100
2008/09	28.1	40.0	68.1	31.8	100

Source: RTI International (2010 p.14)

Note: Total percent may not tally to 100 on last number due to rounding effect.

3.6.2 GRB responsiveness of the budget

The health sector is one of the largest areas where considerable amount of budget goes to directly gender responsive programmes. However, there does not seem to be consistency in the classification of the budget under the three different GRB categories (Table 3.8). As evident from the table there is much fluctuation in the proportions classified as directly and indirectly gender responsive and neutral in the four years under review. This is a consequence of confusion about the methodology and lack of clarity on how to apply the five criteria developed by the GRBC in actual practice. This situation is slowly improving. In the FY 2010/11, the largest proportion of budget i.e., 50 percent is classified as indirectly gender responsive and 37 percent as directly gender responsive. A review of allocations under these categories in the FY 2010/11 (Annex 3.2) shows that programmes exclusively addressed to women in terms of beneficiaries and service-providers are in directly responsive category. Similarly training, accessories, construction etc related to these programmes are also put in this category. Other programmes which can have 50/50 male/female beneficiaries such as children and adolescent directed programmes, HIV AIDS, also are put in this category. Only the criteria of benefit seem to be applied so far. Other criteria are just on the paper. Similar tendencies were observed in the categorization of programs in the FY 2011/12.

Applying the five criteria for the GRB classification in the health sector has been problematic also because it is not clear how to apply the last two criteria in this sector. For example, it has not been clear so far as how to apply the criteria of employment generation and reducing women's work load to the main institutional objectives of the health sector. These can only be subsidiary to the main objective of the health sector "improving people's health". The table 4.2 presents specific indicators and sub-indicators and chapter IV explains how to apply them to the health sector.

Table 3.8: Distribution of health sector budget by GRB classification

(Rs. in million)

GRB Classification/FY	2007/08		2008/09		2009/10		20010/11	
	Amount	%	Amount	%	Amount	%	Amount	%
Directly supportive	7,549	62	5,087	33	7,437	40	8,873	37
Indirectly supportive	1,728	14	6,065	39	10,413	56	11,988	50
Neutral	2,901	24	4,426	28	827	4	2,953	12
Total*	12,178	100	15,578	100	18,677	100	23,814	100

Source: Estimated expenditure of FY 2007/08 to 2009/10, MOF, Government of Nepal

3.7. Programmes/activities⁴

Following the right-based approach to health and emphasis on gender and inclusion, a major shift has been affected in health programmes in recent years. The emphasis has changed from expansion of supply chains to addressing both supply and demand side problems, particularly in the case of essential health services and safe motherhood programmes. This is important for gender equality, because the women have little access to household resources for their own health-care in the households with severely limited disposable income. The first priority is given to meeting the needs of men and the boys.

- **Free Essential Health Services**

In 2007, the Government declared all health services at health posts and sub-health post free of charge to all. In July 2008, outpatient services for vulnerable people were made free in the next tier of health supply chain, primary health-care centres, and district hospitals (DHs) in all districts. Earlier (in 2007), this facility was limited to 35 districts. Then, in January 2009, universal free care was extended to the PHCC, then the district hospitals (DHs) with up to 25 beds.

The free health-care policy targets poorer, marginalised, and destitute populations in order to increase their access to curative care. The programme provides free-care for the poor (those

⁴ Selected programmes and projects under MOHP are provided in Annex 3.2.

whose income is enough to feed their families for less than six months), the destitute, the elderly, and the differently capacitated and female community health volunteers. The free-care policy covers consultation and treatment, minor surgeries, obstetric emergencies, both comprehensive emergency obstetric care (CEOC) and basic emergency obstetric care (BEOC) (where available), X-rays and laboratory services, essential drugs (for a week), and logistics. In the district hospitals, 52 types of medicines; in the PHCCs, 42 types; in the HPs 32 types; and in the SHPs 22 types of medicines are made freely available (Helfter, 2009).

- **Safe Delivery Incentive Programme**

Under this programme, free child-delivery services with ante-natal care (ANC) incentive for four visits and transport cost are provided to women. Health institutions are also provided with some lump sum amount to meet ante-natal and post-natal service costs as follows:

- a) Transport costs for beneficiary women to go to the health facility.
- b) Cash incentives to skilled birth attendants for providing safe delivery services.
- c) Subsidy to health institutions to compensate for the free delivery service they provide

Transport and other incentives to the beneficiary women are:

- a) For **Mountain** Districts: Rs.1,500
- b) For **Hill** Districts: Rs 1,000
- c) For **Tarai** District: Rs. 500.
- d) ANC incentive for completion of four visits in 4th, 6th, 8th, and 9th months: Rs 400.

The incentives for **service-providers** for safe delivery service are:

Rs. 300 for each delivery attended at a health institution and at home of the client and Rs. 700 to the birthing centers for necessary medicines and equipment. Thus for the **health institutions** of the districts, a lump sum amount of Rs. 1,000 is provided for each delivery attended (MOHP, 2005, Operational Guidelines).

- **Safety-net for the poor**

In addition to the aforementioned free health-care policy, a social security scheme has been formulated to assist the poor clients visiting secondary and tertiary hospitals. At least five percent of the grant provided from the central level and five percent of user fees have been mandated for the social security schemes, and the poor and destitute are treated by using these funds. Beginning in the FY 2005/06, the Government increased this rate to seven percent. A demand-side financing scheme (of Rs. 1,000) was introduced in the FY 2008/09 to increase the access to the treatment of kala-azar patients; free renal dialysis for senior citizens above 75 years of age, and free cardiac surgery for those under fifteen years or above 75 years at Shahid Gangalal National Heart Centre, Kathmandu (RTI International, 2010).

- **Gender-neutral diseases**

Beside these, the MOHP has widespread immunization activities which are free and include BCG, protection from TB, DPT, and Hepatitis B, Whooping Cough, Polio, Hep B Hib and Homophiles-B, Polio, Poliomyelitis and Measles for children and anti-Tetanus vaccine for pregnant women. The emphasis is on universalization of the programme.

Recently a programme has been initiated to reduce the major risk factors (tobacco use, alcohol consumption, physical inactivity and unhealthy diet) in the case of non-communicable disease (NCDs) also. It aims to develop a national surveillance system for the NCDs and their risk factors by strengthening the capacity of health system to diagnose manage and to prevent the NCDs, through standard guidelines and protocol appropriate to various levels of health care.

- **Information, Education and Communication (IEC)**

Besides, the MOHP produces a wide-range of Information, Education and Communication (IEC) materials directed to women, children, and adolescents and also on gender-neutral diseases. Information directed to women are on prolepses, family planning methods, safe motherhood and incentive package, basic service package for reproductive health in emergency and gender-based violence. Immunization and nutrition materials are focused on both women and children.

The information and education on adolescent health, gender discrimination and adolescent health are directed to both boys and girls. However, IEC materials directed to controlling acute respiratory disease/pneumonia, diarrhea malaria, cancer, and tuberculosis do not address gender issues particularly.⁵ Moreover, the distribution of the IEC materials is very ineffective. They are hardly seen in the field and nobody mentioned about these materials to the research team in the field visits. Also these materials do not address specifically male attitudes to women's and girl's problems.

3.8. Results

Nepal has made a big stride in supply of essential health services to her population. Women's priorities have been duly taken care of. The Government has continuously increased per capita allocations to the sector. The programmes have been liberally funded by the development partners. Funding modalities and coordination is improving. The Government is rightly addressing both supply and demand side problems by its policies and programmes. The results have been encouraging although many problems remain in implementation and monitoring and supervision. The country has gained much in terms of its population's health status in the last two decades. The MMR has come down to 229, IMR to 41, and under five mortality to 50 (Nepal GHI Strategy, 2010) and Nepal is very much on track to meet MDG goals 4 and 5.

⁵ List of brochures reviewed is attached as Annex 3.3

Table 3.9: Impact – health indicators

(Rs. in million)

MDG/ Impact Indicator	Achievement			Target	
	2001	2006	2009	2011	2015
Maternal Mortality Rate (MMR)	415	281	229	250	134
Total Fertility Rate	4.1	3.1	2.9	3.0	2.5
Adolescent Fertility Rate (15-19 years)	110	98	NA	98	70
CPR (modern methods) 0.14	35	44	45.1	48	55
Under-five Mortality Rate	91	61	50	55	38
Infant Mortality Rate (IMR)	64	48	41	44	32
Neonatal Mortality Rate	43	33	20	30	16
Percent of underweight children	48.3	38.6	39.7	34	29
HIV prevalence among pregnant women aged 15-24 years	NA	NA	NA	Halt and reverse trend	
TB case detection (Number)	70	65	71	75	85
TB cases successfully cured (Number)	89	89	88	89	90
Malaria annual parasite incidence per 1,000	0.40	0.28	NA	Halt and reverse trend	

Source: (MOHP, 2010, NHSP-IP II, p ii)

With the implementation of the free-health services, the number of institutional child-deliveries has increased significantly. For example, the deliveries in hospitals in Banke have increased almost threefold according to hospital authority. The DHO in Rolpa made a rough estimate that the institutional delivery which was about 2 percent three years back, had reached approximately 20 percent in 2010. The PHCC, and HP/SHP, which were visited by the study team, reported that more women visited them than men. Such visits were either, pregnancy related or for the children's problems.

Pregnant women were also tested for HIV. Generally, 2 to 3 of them were found HIV positive or with HIV, (Banke Zonal Hospital) in a month. Majority of women visiting PHCC, HP/SHP were found with prolepses and pelvic inflammatory disease (PID) discharge problems.

3.9. Monitoring and evaluation

The Health Management Information System (HMIS), established by the Department of Health, provides information on utilization of services in the health institutions and their coverage by district and region and feeds back into the system. On the basis of this information and monthly reports from the HPs or PHCCs, the district conducts similar monthly review and sends report to the region and central office. The region conducts reviews every trimester and the central office annually.

The joint annual reviews are conducted by the Ministry in collaboration with the external development partners and other major stakeholders. The reviews are based on macro-level indicators and focus on

planning and budgeting, performance and achievements. The Joint Annual Planning Meeting is usually conducted in June and a review meeting in December. An aide memoir follows each meeting.

There are different periodic sources of status information on health and population -- the Population Census, Family Health Survey, Nepal Living Standard Survey, trimester health facility surveys and annual household survey on free care, and a maternal mortality and morbidity studies. The government reporting on services is regular, and nationwide except for underreporting by central level hospitals. The reporting by non-state actors in the health sector is not routine or comprehensive.

The HMIS, as the Ministry's principal monitoring system, reports on utilization of child health services, family health, disease control, and curative care. It also reports on supporting programmes, such as training, IEC, financial and logistics management and laboratory services to support policy development and planning and budgeting. It has been reporting patient data disaggregated by age and sex. The reporting forms were recently revised to disaggregate such information by caste/ ethnicity and the target groups at district hospitals as well. Revisions will also lead to tracking the contributions from private and community (including NGO) health institutions. Further improvements and integration with other information systems are planned (NHSP-IP II 2010-2015). In the field at the service-provider level, however such information is lacking (See section 3.11).

3.10(a) Best practice -- Safe Delivery Incentives and Free Health Services

Focus on inclusive service provision -- addressing the demand side problems

In Nepal, for the first time, the Interim Constitution, 2007 enshrined the concept of "health for all" declaring free primary health services as basic human right. The Three Year Plans (2007-2010) and (2010-2013) lay stress on the realization of universal free essential health services in line with Millennium Development Goals (MDGs).

To translate these commitments into practice, the Government has for the first time started to address the demand side problems. The earlier policies and programmes had emphasized on creating accessible institutional network of health institutions from the grassroots to the central level and improving the quality of services. Still many women and also men from the socially excluded groups like Dalits and the marginalized ethnicities had very low access to the services provided by these institutions. The urban-rural divide and social inequity in the utilization of these services were evident. Particularly the fact about women's limited access to household resources for their own health needs, had never figured as a policy issue in the health sector. Only after the democratic upheavals of mid-2000s, these issues are getting attention. A prominent example of this change in approach is the Safe Delivery Incentive Programme (SIDP) for the pregnant women.

In January 2009, the government initiated free maternity service with transportation incentive for the mothers who could not afford to pay fees. Though the transportation incentive scheme was first introduced in 2005, the services were not free. A more significant initiative to address the poor women's low access to resources for safe delivery is the **Safe Delivery Incentive Programme**. Under this incentive, free delivery services along with the ANC incentive and transport cost are provided to women. Health institutions are also provided with some lump sum amount to meet the cost of the free delivery services. Components of the programme include: (a) free safe delivery services, (b) transport costs for beneficiary women to go to the health facility, c) cash incentives to health personnel for providing safe delivery services at health facilities as well as to the Skilled Birth Attendants (SBA) providing services at home, and d) subsidy to health institutions to compensate for the free delivery they provide. The amount of incentives to the beneficiary women varies by transport - accessibility of the districts; and the amount of compensations to the service-providers vary by seriousness of the problems treated. Women completing four visits for antenatal check up are entitled to a cash incentive of Rs. 400.

There is significant progress in the utilization of the facilities after the introduction of the scheme. By the FY 2008/09, 89 percent of women delivering in health institutions had received the cash incentives. Such percentage had increased to almost 100 percent in the FY 2009/10. In the FY 2008/09 the total number of complicated deliveries treated was 11,157 compared to 2,896 in 2007/08 -- an increase of 285 percent. Similarly, the number of C-sections had increased from 12,650 in the FY 2007/08 to 18,546 in 2008/09 and the figure further increased to 22,924, a growth of 23.6 percent in the FY 2009/10 (DOHS, Annual Report 2009/10).

The DOHS, Annual Report 2010/11, (p. 105) notes:

“Before the introduction of Safe Delivery Incentive Programme (SDIP), the coverage of deliveries assisted by SBAs and health workers used to increase marginally (1 percent per year) but --- ----- after the introduction of free delivery care, it has jumped to 42 percent in case of deliveries attended by health workers and 29.4 percent in the case of SBA assisted deliveries” (DOHS, Annual Report 2010/11, p. 105). In the FY 2009/10, 258,350 pregnant women got free delivery services under Safe Delivery Programme (MOF, 2010).

Information from the case study districts visited by this research team also shows positive results. For example, the health authorities in Banke reported an increase in the pregnant women's visits for the ANC 1st and 4th services. Similarly, the child-delivery assisted by SBAs and health workers is also increasing significantly. In the FY 2007/08 the delivery assisted by the SBA at health facilities was 55.8 percent of expected pregnancy which reached 63.9 percent in 2009/10 (DHO, Banke Annual Report 2009/10). In the same way in the Rolpa district ANC 1st visit as percent of expected pregnancy increased to 85 percent in the FY 2009/10 from 49 percent in 2007/08. Similarly, ANC 4th visit also increased significantly to 38 percent in the FY 2009/10 from six percent in 2007/08. The share of institutional delivery as percentage of expected pregnancy also increased to 16 percent in the FY 2009/10 from five percent in 2008/09. The number of birthing sites has also been expanding. Thus, the impact of the free services has been substantial for bringing the poor women to health facilities for the ANC and delivery services.

Another initiative which addresses demand side problems of the poor men and women is the provision of free primary health-care services. It was started in 2006 with emergency and in-patient care services at the health-care centers (PHCC- the 2nd tier of health service providing institution) in 24 lowest HDI districts for the most vulnerable groups of the population including women. Currently, the programme has been universalized throughout the country. In October 2007, the Government declared all health services free of charge in health posts and sub-health posts, which are the first tier of the formal health institutional base. The programme universalizing services at the grassroots level commenced in January 2008. In February 2008 the pro-poor policy was extended to PHCCs and the district hospitals in all districts. Since January 2009, this programme has been implemented in all PHCCs and district hospitals (DHs) with up to 25 beds (RECPHEC, 2010).

In the SHPs, HPs, PHCCs and DHs consultations as well as some medicines are made free for everyone. The basic free medicines comprise of 22 items in SHP, 32 in HP, 42 in PHC and 52 items in DH (Helfter, 2009). No charges are levied even for registration (GTZ, 2009).

At the upper-level health institutions such as in zonal, regional and national hospitals, the people below poverty line and the vulnerable groups are exempted from registration fees. Some medicines are free but other services are charged. Six categories of people who are entitled to get free services are: the poor, ultra poor (whose income is insufficient to buy food for the family for up to six months), physically challenged persons, senior citizens, under-served (ethnic minorities, Dalits) and female community health volunteers (FCHVs).

A rapid assessment survey of free essential health-care services conducted by the GTZ (2009) in three districts Bardiya, Dailekh and Jumla has shown a substantial increase in service utilization after the introduction of the free services. It is reported to have increased as much as by 133 percent in SHPs, 215 percent in HPs, 57 percent in PHCCs, 200 percent in the case of hospital outpatients, and 52 percent for inpatients. This comparison relates to the last six months of 2007 and the first six months of 2008 (GTZ, 2009). The major strength of the Essential Free Health Services is that the programme has utilized regular structure of government and the medicines are available to general public for free. There is less donor dependency since necessary drugs are being procured from government resources (RECPHEC, 2010).

The report notes that many problems remain and the services could be improved by providing adequate funds, tailoring the adequate supply of medicines and drug to needs and quality improvement. However, it concludes that these programmes have increased the access of the poor women and the vulnerable groups to the essential health services.

3.10(b) Best practice -- Female Community Health Volunteers (FCHVs)

State promoted volunteerism in health-care facilities

The FCHVs constitute the base of the health-care pyramid. They provide the direct and permanent link for the community to the health institutions. They serve as a grassroots health resources, providing

community-based health education and services in rural areas. Though they work for the whole communities, their focus is more on women and children in rural areas. The goal of this FCHV programme is to create demand for health facilities by raising awareness among community people on health issues and accordingly extend their supplies. Specifically, the objectives of this programme are to:

- increase utilization of health-care services through demand creation,
- enhance the participation of community in improving the efficiency of health services,
- activate the women for tackling common health problems by imparting relevant knowledge and skills,
- prepare a pool of self-motivated volunteers to act as a bridge between the communities and the institutional health system and provide services for community-based health programmes, and
- develop FCHV as health motivator.

The basic features of this programme are:

The FCHV programme is a state promoted voluntarism in Nepal. Young trained women volunteers have proved to be very useful in providing basic and primary health facilities in the rural areas (Neupane, n.d). The FCHVs are selected by the members of mothers' group with the help of the local health personnel. They are given 18- day basic training in two phases (9+9) on selected primary health components. After completion of the training they are given Certificate with a Medicine Kit Box with necessary drugs and supplies. They are also provided with manuals, flip chart, ward register, IEC materials, FCHV bag, signboard and identity card. For family Planning services, regular supply of family planning devices (pills and condoms only to FCHVs) is channeled through local health facility (DOHS, Annual Report, 2010/11).

FCHVs' main functions are to:

- work as voluntary health educators and promoters, community mobilizers, referral agents and community-based health service providers,
- promote the utilization of available health services and enable the community people to adopt preventive health practices,
- diagnose, refer, and treat pneumonia cases in CB-IMCI districts,
- provide antenatal counseling by, using the Birth Preparedness Package and Iron-Intensification–provision of iron /folate and albendazole to pregnant women.

They act as a linkage between community and the next tier of the health services -- SHP, HP/SHP and PHCCs, besides playing an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level. Their role is very significant in public health programmes on family planning, maternal health care, and child health, biannual distribution of vitamin A capsules / de-worming, National Immunization Programmes and, distribution of family planning devices, and oral dehydration salts throughout the country. They also play active role in the district-based programmes such as Community Based- Integrated Management of Childhood Illness (CB- IMCI) and community level safe motherhood and neonatal activities. Broadly, their scope of work includes:

- Family Planning : education and promotion of FP methods and provision of pills and condoms,
- Maternal and Newborn Health: education in pregnancy and promotion of antenatal care, iron supplements and tetanus toxoid, Child Health,
- Other services: education and promotional services for other diseases (e.g., HIV/AIDS),
- Administrative duties: activating and serving as the secretary for the local mother's group, reporting to the local health facility monthly using the Ward registers through their local supervisor.

Currently, FCHVs number 48,489 and cover 97 percent rural Wards of Nepal (USAID, 2006). Each FCHV generally cover 100 to 150 households.

They do not receive regular pay for their service. The government support to them consists of following:

- Basic training on selected health components,
- Orientations on various diseases as needed,
- A five-day refresher training course every five years to update their knowledge and skill,
- Initial Kit with primary drugs and medicines,
- Distance education (Radio programme) for motivating and giving FCHVs confidence for explaining healthy behaviors to the community (NFHP, Technical Brief # 16),
- Rs. 3,000 annually since the FY 2010/11 and some allowance on the occasion of immunization days.

A revolving fund of Rs 50,000 has been created in each VDC and municipality for supporting and empowering the poor and excluded groups of population. The concept of establishing the *FCHV Endowment Fund* (EF) has been proposed to motivate the FCHVs and ensure continuity of FCHV interest in the implementation of community-based health programmes (VaRG, 2006).

The FCHV-EF programme is being supported by the Ministry of Local Development by encouraging the DDCs, VDCs and municipalities to provide funds from their sources and other supports required in its implementation. The principal amount of this fund cannot be used, the interest earned from this are to be used for the activities that help in enhancing the performance of the FCHVs (USAID, 2006).

The FCHV programme in Nepal is thought to be one of the most successful community health volunteer programmes in the world. The Nepal Demography and Health Survey (2006, as cited in WHO n.d) found that about 10 percent of children suffering from ARI in Community-Based Integrated Management of Childhood Illness (CB- IMCI) districts go to FCHVs. An evaluation of this programme in four initial districts, conducted with technical support from the WHO, UNICEF and USAID in 1997, found that FCHVs were able to deliver quality pneumonia assessment and management in their communities (NFHP Technical brief #3). People feel more comfortable to discuss their health issue with these FCHVs because they are from their neighborhood and can communicate in local languages (Shrestha et al, 2010).

Evidences show that if the FCHVs are trained, 88 percent of them treat patient successfully. They also treat one-fifth of the children with diarrhea, who go to any service provider for treatment. As indicated

by the NDHS (2006) they assist in 90 percent of Vitamin A and 84 percent of de-worming drugs distribution and play a significant role in routine immunizations and Polio campaigns.

More than 50 percent of the FCHVs have been working for more than 10 years and their attrition rate is about 4 percent annually. They work about 5.1 hours per week and majority of them are willing to work more.

As mentioned above, Nepal has gained much in terms of its population's health status in the last two decades. Much of these gains are attributed to broad institutional base of the health-care network, the foundation of which is provided by the FCHVs. They are a major contributory factor for achieving the health-related Millennium Goals (4, 5 and 6). They brought stunning reduction in child mortality (USAID, 2007). Nepal also got award for MDG Goal 5 – “Improve Maternal Health” in 2010 (Press release, Permanent Mission of Nepal to the UN, 20 September, 2010).

The FCHV's contribution has been highly regarded in various ways by the Government and the communities. In 2004, to honor the contribution of FCHVs, the MOHP declared October 1st as National FCHV Day. The FCHV Day is now celebrated annually at the national, district, and VDC levels with different programmes and awards are given to them. Under the NFHP II, the Government is also producing a FCHV magazine “Hamro Kura” which is distributed to them in 75 districts (NFHP II Technical Brief # 1, 2010).

3.11. Gaps, challenges and recommendations

3.11.1 Gaps and challenges

Actually, the SWAp and decentralization policy which have been adopted in health sector calls for planning from the bottom. In principle the programme budgeting process should start from the PHCC/HP/SHP levels. The DHO supposed to compile all these budgets after several discussions at district level and then send it to the Health Department, which is to examine the collected district level demands, reconcile and rework them after discussions with the districts and forward the overall demand to the Ministry. The Ministry then forwards it to the NPC and the MOF. Discussions are supposed to take place at each level and final programmes and budget included in the overall budget. However, district authorities often complain that plans and budgets forwarded by the districts are cut down greatly and new programmes added. Similarly, the demands from the HPs and SHPs are hardly discussed in the community or mother's groups. The amount of resources they get depends on the strength and clout of the political leaders from the area, with the DHO.

The GRB classification is undertaken at the ministry-level, by planning units, jointly with MOF. Authorities in the districts are not aware of the GRB criteria to apply them at the district level. However, they do recognize need for specific allocations for addressing women's needs in the reproductive health. The focus has been on safe motherhood and family planning only. In many gender-neutral programmes,

including immunization of children, nutrition etc no gender perspective is integrated as yet. The health planners do not see the need, even if under-five mortality rate is higher for girls than boys. Much remains to be achieved in improvement in planning and budgeting and expenditure mechanisms. The following section summarizes the problems that need addressing in implementation from a gender perspective.

➤ ***Women's participation in the Budgeting Process***

- Health sector budgeting process hardly involves grassroots institutions- SHP/HP and PHCC. The District Health Office (DHO) starts the budgeting process after receiving guidelines of NPC and budget ceiling fixed by the MOF. Generally, the budget is estimated to continue the previous year's programmes except in cases when some particular programme need to be focused or if there is some special direction for some particular programme. The planning process does not start from the village level. At the district level if there is a woman staff in the planning section of DHO, she may participate in the planning. Otherwise there is no mandatory provision for women's participation (Response from Banke). Nevertheless, as per MOHP officials there is no uniformity in the planning process, in some places even mother's groups are involved in the planning. On the other hand even the DHO chiefs complained (for example in Dhanusha), that the programme sent by the district is not even discussed with them and the Ministry approves programmes on its own.
- There is a mandatory provision of women's participation in the health facility management committees (HFMC) but presently they are defunct in some places. It was reported in the field (Dhanusha) that political intervention in the selection of the committee members make them non-functional. However, in other districts (Banke, Rolpa) they were reported active, meeting regularly on monthly basis (HFMC, PHCC, Lewang) and effective. The voices of women members were duly heard and respected. Moreover, some committees were headed by women members. For example, in Rolpa the committee responsible for construction of the waiting hall of PHCC in Lewang was headed by a woman member. But the mandatory provision of women's participation in HFMCs is not uniformly applied even in Rolpa. For example, the HFMC of PHCC of Sulichower did not have a female representation, there was one before but her husband has taken the place due to her absence. Nevertheless, the HFMC meets every 7th day of the month.
- Although specific training programmes are organized only for women in some cases, in other training programmes women's participation is not mandatory (Banke).

➤ ***Mismatch of supply and demand of various kinds of medicine***

- PHCCs, HPs/SHPs get free medicine from DHO and hospitals have to buy medicine for which they get conditional budget. Some of the medicine will not be sufficient for distribution and some remain unused in the case of PHCC/HP/SHP. Vitamin A, Iron pills and Jeevan jal are always in short supply in some districts. But this is not the case in all districts, for example in Rolpa, the

DHO, the hospital and the health post reported that the medicines were adequate. In the case of hospitals the free medicines have to be purchased through bidding and if the supply is inadequate it will not be able to purchase directly due to rigid financial procedure (Director of Zonal Hospital in Janakpur).

➤ ***Difficulty in identifying the poor***

- Free essential health services are for some target groups such as poor, ultra poor, etc which has to be recommended by the VDC, in the case of hospital services. It is difficult for the hospitals to verify the income status, so it is left to the clients. Free services are given on the basis of income status stated by the clients in the form on demand in Dhanusha and Banke hospitals and the district hospital in Rolpa is providing free services to all citizens on demand.

➤ ***Shortage of funds, staff and budget release problems***

- Hospitals are operated by the Development Committee and 70 percent of the staff is under this committee, only 30 percent of the staff is under government service. There is always shortage of funds for the salary. For example, there was a deficit of about Rs 900,000 per month in the Zonal Hospital in Janakpur. The hospital gets Rs. 28 million of which Rs. 17.5 million goes to the salary of the staff. The hospital has reduced the outdoor patient department (OPD) charges also to Rs. 5, Rs. 10 and Rs. 20 from the previous Rs. 50, Rs. 100 and Rs. 200 and above (Zonal Hospital Janakpur).
- The field staff opined that the incentive to the FCHVs was too low, they were getting Rs. 1,000 up to the FY 2009/10, and that year's budget speech raised this amount to Rs. 3,000. However, the FCHVs are demanding Rs. 500/month. Some of the FCHVs in Banke also informed that they got Rs. 3,000 and others said they got only Rs.1, 400; but they do not know which organization gave them the money.
- It was also reported by the Director in the Zonal Hospital in Janakpur that, because the budget is not released in time, sometimes safe delivery incentive cannot be given at the time of discharge from the hospitals, but they are given later. In Banke and Rolpa all -- the staff of the hospital, PHCC and HP, as well as the mothers' group members, however, reported that everyone was getting the incentive as provisioned.
- To deal with such shortages, an Education and Health Emergency Fund has been created in the Local Development Office in Banke, by allocating one percent from the collections of the land registration fee. This Fund is generally spent for the programs for women. This is an additional source for funding social sector development activities. A committee coordinated by the Local Development Officer comprising representatives from the line agencies and major political parties, has been formed to manage the funds. Generally, the DDC collects the demands from local communities which could not be incorporated in the DDC annual plan in spite of their

importance. The Committee meeting reviews the demands and decides where the money should be spent. The education and health activities are the first priorities. Usually the activities funded have included physical constructions addressing the practical needs of girls and women, for scholarship and toilets for girls in schools and maternity facilities in health institution etc.

➤ **Lack of coordination with development partners and INGO programmes**

- The DHO does not have any role in managing the programmes implemented directly by external development partners in partnership with the NGOs. Majority of such programmes were reported to be on reproductive health, epidemics, and children's diseases. Such direct implementers in Banke were Plan Nepal, Nepal Family Health Programme (NFHP), DFID, UNICEF, Save the Children and WHO.

➤ **Information gap**

- Information dissemination on the free medical services and safe delivery incentive is not uniform. At the grassroots level in some places, particularly in Tarai, women may not be aware of the facilities and they may not be receiving the intended cash compensations. For example, of the two VDCs visited by this team in Dhanusha, in one, women were quite aware of the facilities and receiving them, while in the other they did not. In Banke and Rolpa women were aware of the incentive provisions and getting them. Further, although women were informed by the FCHVs about Rs.400 incentive for completing four visits for antenatal care, they did not follow the rule. In Rolpa hospital, out of 65 cases of delivery only one case had completed four such visits.

➤ **Inadequate transportation cost disbursement**

- In Tarai, the delivery incentive is Rs. 1,500 per head for ordinary delivery, which is distributed as Rs. 500 for the client, Rs. 300 to medics attending the child-delivery and Rs. 700 for the hospital for necessary goods and services. For complicated cases the amount is Rs. 3,000 and for caesarian cases Rs. 7,000 per head. Sometimes up to Rs. 35 to 40,000 are needed for the operation cases and that has to be borne by the hospitals (Janakpur Zonal Hospital). The attendants of the delivery cases get the incentives at the end of the year. It was complained that for Tarai the transport facility which is fixed at Rs. 500 is inadequate to meet the cost because it costs about Rs. 2,000 to take a patient to Janakpur Hospital even from Dhanushadham.

➤ **Possibility of misuse of medicines**

- There was also possibility of misuse of medicines supplied under essential free health services in the PHCC/HP/SHP, because people had a tendency to take more medicines than needed and throw away. Therefore, it was suggested by the service-providers that clients should be made to pay nominal charges for those medicines.

➤ ***Lack of sex-disaggregated information at service provider levels***

- There is no sex-disaggregated overall information in the PHCC/HP/SHP about the use of services, although they fill up the forms for each patient indicating their sex. They send the data to DHO and it sends them to HMIS unit in Kathmandu. Though HMIS has started to compile sex, caste and ethnicity- disaggregated data of service in the case of adults, it is not doing so in the case of children served. Moreover, the information is compiled at the center by district and published in English, which may or may not be available in the district.
- At the hospital level also, the practice of keeping sex and social group-disaggregated information was not regular. For example, the officials in the Zonal Hospital Janakpur, said the hospital did not keep the sex-disaggregated data, but the hospital in Banke had followed the HMIS system and had sex-disaggregated data of all clients getting indoor services, operations (major, intermediate and minor), and the number of babies at birth.
- Minimizing the political interference in the health management is the most difficult challenge at this time. For effective management and ownership, community leader's participation is a must. But in Nepal, frequent changes in political and bureaucratic leadership have made managing the health services difficult. Although there is political commitment to the GESI agenda and health sector policies and programmes have made it a priority, political interference is impeding their implementation. In some places HFMCs and hospital development committees are functioning very well, meet regularly and make decisions for the development of PHCC/HP, involve women members but in other places they are completely defunct. The eastern Tarai districts seem to have specific problems in this context. The absence of local elected bodies further hampers the decision-making, good governance and accountability at the local level, negatively impacting on the devolution process.
- The Government's annual budgets as well as external development partners' commitments have been increasing, but at the field level there seems to be problems of both adequacy and management of funds.
- As per MOHP Annual Report, 2010), difficult geographical terrain and lack of other infrastructure make it difficult to reach remote areas on the one hand and to keep the medical personnel in such areas on the other. Thus, inadequate staffing, frequent staff transfer and poor maintenance hamper the accessibility and quality of health services provided by the supported health facilities.
- On the demand side, poverty and illiteracy perpetuate traditional beliefs, superstitions and unhealthy practices. This is a major challenge to providing effective health services to the target groups. Women are not aware of the importance of ANC and do not meet the requirement of checkups in spite of information provided by FCHVs, which implies that there is a need for more awareness creation and information dissemination among women and families

- There was a shortage of ANM and Staff nurse in the birthing centers, more so for 24-hour service. Birthing centers need to be technically well-equipped and have adequate human resources and vehicles. In some places air ambulance may also be needed (suggestion from the hospital, Banke).

3.11.2 Recommendations

- Despite its introduction in the FY 2007/ 08, GRB has not been fully integrated in the budgeting system. Current exercise has developed more detailed indicators and sub-indicators within the five criteria developed by the GRBC, which is given in Table 4.2. The health programmes and budgets should be evaluated on the basis of the indicators and sub-indicators listed in the Table for the next two years. Then the practice and indicators evaluated and if necessary revised (see Chapter IV). The Health Department needs to develop its own more detailed GRB manual within the overall MOF framework.
- Extensive capacity-building training on gender mainstreaming and the GRB for the planning units and gender units/focal points, health management committee members and senior officials at various levels, is a must across the system. The health sector needs to develop its own manual for implementation of the GRB system as recommended in Chapter IV, and undertake a massive capacity-building exercise in collaboration with the MOF for its effective institutionalization in the sector.
- There is lack of knowledge about the budgetary cycle among the government staff. Presently, the budgetary process is limited to allocation of resources only, not integrating the project cycle. However, while applying the GRB, budgetary cycle, i.e., project cycle needs to be considered, which means that mentoring is necessary for integration of the GRB in the annual review and budgeting (identification of gender gaps, implementation gaps) of the Ministry and the department.
- The health facility management committees (HFMCs) should be reorganized to include members from excluded groups in order to address gender and social inclusion perspective in these committees and make the committees active and responsive to the community needs. The mandated system of decentralized planning should be followed strictly in practice. For this the Health Department and the DHOs need to make specific efforts.
- Presently, there is an acute shortage of health worker in the health facilities which has rendered health service delivery ineffective. Still thousands of mothers deliver child without trained birth attendants. There is lack of proper equipment and trained staff in birthing centers. Appointment of trained health workers and supply of adequate and proper equipment in these facilities is a must to make the health service delivery efficient and effective.
- Women-friendly infrastructure is another urgent need in the health facilities, e.g., attached toilet for labor room, separate toilet for women, ramp, curtain, separate examination room for women's reproductive problems, etc.

- All health information needs to be disaggregated by sex, caste, ethnicity and location and fed back into the system.
- The health service information needs to be disseminated at the grassroots level using proper channel and in local languages so that the excluded could avail the services at times of need.
- An emergency fund needs to be created at the hospital and other health facilities for transport and delivery incentives, which can be utilized when the regular funds release is delayed. This amount can be later replenished from the allocated budget. Such practice was started in Banke and Dhanusha at the VDC level as per the DHO.
- More intensive health education to excluded women and men at the household level is a must through the FCHVs and mother's groups.

IV. EFFECTIVE OPERATIONALIZATION OF GRB

The GRB criteria adopted in Nepal are based on the philosophy that the gender responsive budgeting is more about mainstreaming women in the development process so as to enable them to enjoy 50 percent benefits from development process rather than making specific allocations to women's programmes. Since women have been discriminated for centuries and have specific natural needs, specific allocations are also needed and programmes directed to addressing their needs must be funded adequately. The main issue, however, is ensuring equal benefits to women from all development activities, which also calls for specific allocations to bridge the existing gaps in their access to education, information and resources.

The GRB is about (a) effective gender mainstreaming including monitoring and evaluation, (b) ensuring resources for facilitating equitable benefit from the government development programmes to women, and (c) ensuring resources for meeting women's specific needs. To be effective the GRB system needs be based on gender audit and encompass the complete budget cycle and include detailed assessments of each programme against the following criteria step by step:

- Analyzing the situation of women, men, girls and boys,
- Examining the gender responsiveness of the policies and programmes,
- Assessing budget allocations to various programmes and activities,
- Identifying the gaps, estimating expenditure required to bridge gaps and reallocating the budget,
- Tracking actual spending and how decisions are implemented
- Assessing outcomes and impacts in terms of benefit sharing, empowerment.⁶

4.1. The indicators and sub-indicators

After an extensive interaction with various groups of stakeholders at the center and district levels, an overall summary framework on the GRB indicators and sub-indicators has been developed. These indicators and sub-indicators have been developed after intensive review of existing, policies, strategies and programmes of various ministries/departments, discussions with members of the GRBC and with the planning and budgeting division and gender units/focal points at the center and district in seven⁷ districts. The indicators proposed try to integrate the above process in the budgeting system. The study

⁶For details on methodology see (1) Acharya Meena (2003), *Gender Budget Audit in Nepal*, UNIFEM, New Delhi, India; (2) Budlender Debbie (2003), *Engendering Budgets, A practitioners' Guide to Understanding and Implementing Gender Responsive Budgets*, Commonwealth Secretariat and (c) Quinn, Shiela (2009): *Gender Budgeting: Practical Implementation: Hand Book Directorate of General Human Rights and Legal Affairs*, Council of Europe.

⁷Although only three district field visits were planned in this consultancy, the team has used other opportunities to discuss the indicators at the district level in four more districts. These included Morang, Kavre, Chitwan and Okhaldunga.

team has also recommended the revision of the scoring system to make the system applicable across the sectors, taking the sector objectives into account. A separate manual has been developed in Nepali language for explaining the need for each of the indicators and sub-indicators with examples. What is proposed is that each budgeted programme be passed through a list of gender responsive indicators and sub-indicators before the expenditure is approved and budgeted.

All sectoral Ministries and the offices need to develop their own set of GRB sub-indicators to capture their core functions and scope of work. Examples as to how these criteria, indicators and sub-indicators could be applied to the peace-building activities and institutions and in the health sector are presented in Tables 4.1 and 4.2.

Several points need to be kept in mind in application of the proposed system:

- We are dealing with the budgeting and programming stage and not their implementation. At this stage, what we can do is only plan specific interventions to ensure that women benefit equally with men from all development activities,
- We are rating programmes and sub-programmes as a whole and not individual expenditure items,
- The indicators must capture women's quantitative and qualitative participation in planning and decision-making process of the budget,
- They must be relevant and link with the gender mainstreaming processes and indicators in use in various development programmes in each of the sectors.

It should be clear that we are dealing with the budgeting process and not its actual implementation. Therefore, what one looks for is participation of women in the budgeting process and quality of such participation, which is captured by the content of the programmes, implementation and monitoring mechanisms planned, provision of capacity-building for women and specific measures to addressing the barriers the women face in accessing the programme benefits, and also their specific needs.

The following section discusses each of the indicators proposed and the logic behind proposing it.

1) Participation: This indicator tries to capture whether women have been involved in the planning, (programming and budgeting) and whether the programme has provisions for adequate participation of women or gender experts in implementation, and monitoring and evaluation at various levels at center, district, Ilaka/ VDC and community levels. Since the implementation arrangement is equally important as planning in project cycle management, women's participation in management and coordination committees is crucial. However, sometimes, committees are formed by ex-officio members, in such instances, presence of gender focal points or gender unit or external experts needs to be ensured. This is required both for the efficiency of the programme to meet the gender equality goals and to empower women. The participation is the first step for empowerment. Attempts have been made to capture the qualitative aspect of this participation in the benefit section by evaluating what they have planned for, whether adequate attention has been given to women's specific barriers such as lower educational access, lack of assets, constraint on mobility and workload.

The participation will empower women by involving them in the decision-making process, which affects their livelihood and daily life. Since more than half of the population of Nepal is women, every project affects their lives; therefore, their active participation in the planning and implementation of such projects is essential. Moreover, in order to ensure their voice, their representation in the vital posts, e.g., chairperson, general secretary and treasurer in every committee has to be ensured. Additionally, since they have to fulfill their domestic duties before appearing in the public arena, their social constraints, e.g., time and mobility should be taken into consideration. The meeting time and venue should be favorable to the representative women and their presence made compulsory. Otherwise, their participation often seems to be taken as a formality. To cope with such problems it is recommended that their presence be made compulsory for decisions, at least at field levels.

2) Capacity development : The second major criteria in the MOF GRB system is *Capacity development*, which tries to ensure that sectors/programmes pay adequate attention to capacity development of women in the communities so that quality of their participation is improved. Since women have been in the back seat for centuries, their decision-making capacity needs to be enhanced. It is often observed that, men make the decisions first and get endorsed afterwards by women even in those committees where women are in decision-making posts. This is mainly due to lower educational levels and exposure of women to the governance and budgeting process as also low level of confidence as compared to men. Therefore, special efforts need to be made to enable women to take decision by providing them training and exposure. Women's proportional participation needs to be ensured in all types of technical training, workshops and skill development programmes also to enable them to compete in the market. Moreover, the training curricula need to be made gender-sensitive in all types of workshops, awareness raising efforts and skill development programmes. Trainings must be delivered as much as possible in local language, as women in many communities may not understand the Nepali language. Women often do not have necessary minimum education for accessing many trainings; this must also be considered in planning trainings.

3) Benefit and control ensured with specific attention to women from the targeted groups: Benefit to women and the targeted groups in the main outputs and outcomes of the programme and activities needs to be ensured at least in proportion to the population in the programme areas. Similarly, it needs to be provisioned that women also get equal control over the benefits, for example, compensation to the victims of conflict, maternity benefits etc.

For ensuring that women benefit equally from all programmes, it is necessary for the implementation mechanism to be gender responsive. Gender responsiveness of the implementation mechanism may be viewed concretely in terms of women's participation, gender-sensitivity of the staff and the working environment, efforts to address the barriers to women's active citizenry, gender responsiveness of the monitoring and evaluation mechanisms, and most importantly adequacy of resource allocation for the planned gender-related activities. Participation of women throughout the project cycle has been captured under participation.

Gender- sensitivity of the staff and the working environment: This indicator has been broken down in several sub-indicators. First of all the sub-indicator identified is gender-sensitivity of the related acts and regulations. Specifically identified reforms under this sub-indicator include provision of adequate maternity leave, infant-feeding times and similar other provisions, reform in the promotion rules and examination process that, given women's reproductive responsibilities and social behavioral expectations, invisibly discriminate against women and a code of conduct for combating violence against women in the work place. Women often lag in promotions because they cannot leave young children and take up outside postings. Similarly, even if women pass in written examinations, they fail in interviews because they are shy and do not respond promptly to the questions.⁸ Often such rules and regulations are made nationally, but the sectors and programmes can do their best to address such issues. Also women are continuously harassed and often face violence in the work place. These must be addressed by a code of conduct. Another important component of women-friendly working environment is provision of physical facilities for meeting specific needs of women (e.g. toilets, child-care centers, infant feeding space, etc). Similarly, it is crucial to gender-sensitize all management staff (men and women) on the practical and strategic needs of women through gender-training, workshops, exposure tours etc. This indicator accords scores to the programmes that provision for such activities.

To enable women to benefit equally from programme activities, economic and other barriers to women benefiting from the programmes, e.g. lower educational levels, time constraint, lack of access to household resource, lack of citizenship, mobility, gender-based violence (domestic and public) etc., need to be analyzed and addressed in every project. Women are often deprived from benefits from projects just because the project overlooks these barriers to women's active citizenry.

Ensuring gender- sensitivity of monitoring mechanism and indicators: Monitoring and evaluation are the vital part of the project management. Both process, and output and outcomes must be monitored. The process information is utilized in planning, programming and budgeting and is most important for mid-term corrections in the projects/ programmes. Sex-disaggregated information is a must for gender responsive planning and budgeting. In Nepal lack of gender responsive monitoring, has been the most glaring gap in gender mainstreaming efforts (UNFPA, 2007). Therefore, gender-sensitive monitoring indicators need to be developed by every sector to measure women's participation, implementation of activities planned and budgets allocated and spent and benefit accrued to women and girls from their programmes. Such monitoring should be integrated in their general quarterly and annual monitoring system. Additionally, participation of women needs to be ensured in monitoring and evaluation process, which has been discussed above. Besides, not only the output but the impact must be assessed from time to time.

The last point in this section, **allocation of adequate budget** for the activities planned for gender equality and women's empowerment is most important part of the gender responsive budget exercise. Along with allocation, it must be ensured that the allocations are spent on the activities planned; no

⁸See MOWCSW/ MGEP/UNDP and SAHAVAGI, 2003

reallocation of budget from the related sub-heads should be allowed. This can be achieved by a specific circular from the Ministry of Finance/NPC.

4) Income generation and employment. Further, the programme and projects need to ensure employment opportunities for women in the jobs created by the programme in the process of programme-implementation also. Income generation and employment generated as programme/project output will already be covered under benefits. What this indicator is intended to capture is the income generation and employment created in the process of project/programme implementation, e.g., recruitment of health personal at all levels, construction workers in the reconstruction work under MOPR. Further, this indicator also emphasizes that sector activities must try to generate alternative avenues of better employment and career development for women. *Ensuring equal wages for men and women in created employment* is another major consideration during planning and implementation of projects. For example, most of the construction programmes are implemented through private contractors, even by the user committees. In such cases women are usually paid at lower rates. There should be a clause in the terms of contract, which ensures employment of women and equal wage for equal job. This criterion tries to ensure women's economic empowerment, in the process of project implementation also.

5) Improvement in the quality of women's time-use: Additionally, expected outcomes of the project needs to be planned at the outset in a way which ensures that quality of women's labor is improved (her productivity increased) and/ or her work burden is reduced, at least not increased. The time-saving and more productive use of women's time is one of the vital indicators for gender balanced development and equality. Often programmes just promote equal participation of women in all walks of life, without paying attention to their already existing work loads in the household economy and the care work. This only puts more work load, particularly on the poor women and even poor men for that matter, and they find it difficult to participate. Introduction of the technological innovations for improvement in the performance of jobs traditionally assigned to women, time-saving devices for such work, and awareness generation in the community for sharing of household work by men/boys, etc. should be planned and resources provisioned for them. Only then, women may take opportunities for more productive employment; find time for public participation, education etc and also gain leisure time.

These indicators together try to ensure gender responsiveness of the benefit sharing mechanism, process and system whereby women can claim benefit and influence decision-making process, along with ensuring adequate allocation and expenditure for achieving gender equality goals mandated by the Interim Constitution, TYIP and Nepal's international commitments.

4.2. The scoring system

Scores for the major headings have been recommended on following logic. First of all, the scores must capture the primary objective of the each sector. The objective of every programme/project/sector should be generating equal benefit for men and women from their programmes and activities. For example, the health sector must ensure girls/women have equal access to health outcomes and their specific health needs are met. The score must capture the importance of the indicators and sub-indicators in question. On these considerations, it is proposed that highest score, i.e., 30 percent be assigned to the benefit sharing. Participation in planning, programming and budgeting is assigned 20 percent as it is important for achieving the goal of women's empowerment and can be applied almost equally to all sectors; it has many sub-indicators. Capacity development is assigned 20 percent. The indicator on income and employment generation has been assigned 20 percent and improvement in quality of women's time-use 10 percent. Such scoring system will, for example, result in women-only programmes, programmes such as School Sector Reform Programme (SSRP) in education or safe motherhood under directly gender responsive category. Distributing scores evenly among the five main criteria as is proposed by the GRBC may result in even safe motherhood falling in the indirectly responsive category.

Proposed indicators and sub-indicators for the peace and the health sectors are presented in the Tables 4.1 and 4.2 respectively.

In conclusion, it should be repeated that we are talking about the planning/programming/ budgeting stage, where everything is planned. But to gauge whether these are implemented, actual evaluations must be undertaken along these lines, applying the above indicators and the scoring system. Secondly, it should be remembered that only the programmes and sub-programmes can be classified -- not the expenditure items. All expenditure on programmes and sub-programmes irrespective of on what item they are spent should be classified as per the score received by the specific programme.

4.3. Capacity-building of the GON, DDCs and VDCs and other stakeholders

The GRB is a new concept in Nepal and needs to be oriented to the general staff of the government, DDCs, VDCs and other stakeholders. Extensive capacity-building training on the GRB is needed. Current understanding of the GRB at the district and below is limited to special allocations of budget for women. The gender mainstreaming part is hardly understood, although participation of women in management of programmes has been formally made mandatory. Even at the center, for example in the MOHP, many officials think that, since the health sectors in Nepal spends a large proportion of its budget on child health and safe motherhood, there is no further need to mainstream gender in other programmes and activities. Similarly, the officials in MOPR do not see the need for keeping sex-disaggregated information on combatants or beneficiaries of the compensation for the conflict victims, even though

there is several gender issues involved in their programmes and activities, for example, in the current classification of the CPN (Maoist) ex-combatants.

The MOF preferably through its affiliated training institutions should provide intensive crash training to the staff of the larger service provider in the first place and then advocate and provision resources for integration of the GRB process in all Government and Government-funded regular training institutions.

While applying the GRB, budgetary cycle, i.e., project cycle needs to be considered, which requires mentoring with focus on integration of the GRB in the annual review and budgeting (identification of gender gaps, implementation gaps) of the ministries and the departments.

Table 4.1 Gender responsive budget indicators and sub-indicators for the Ministry of Peace and Reconstruction

S N	Major indicators, sub-indicators and the check list	Score
1.0	Women's participation in planning and implementation	20
1.1	Provision of women's participation in planning/programming and budget formulation process from central to district levels as per following <ul style="list-style-type: none"> ○ <i>Excellent (participation of Joint Secretary or above this level women officer and gender focal person at the Ministry level and participation of 33% or more women from local peace committee (LPC), women development officer and representatives of conflict-affected women at the district level);</i> ○ <i>Good (participation of Joint Secretary or above this level women officer or gender focal person at the Ministry level and participation of 20-33% women from local peace committee, woman development officer and representatives of conflict- affected women at the district level).</i> ○ <i>Fair (participation of women staff from non decision-making level at the Ministry level and participation of 5-19% women from local peace committee, woman development officer and representatives of conflict-affected women at district level).</i> 	4 3 2
1.2	Ensuring women's participation in implementation	12
1.2.1	Provision of women's participation in the implementation (at the project or district level) -in staffing, management and coordination committees including major posts (president, general secretary, treasurer) <ul style="list-style-type: none"> ○ <i>Excellent (≥ 33 %)</i> ○ <i>Good (20-32 %)</i> ○ <i>Fair (05-19 %)</i> 	5 4 3
1.2.2	Provision of (stakeholder)/women's participation in the executive committees, in users' committee, LPC and other committees including major posts (president, general secretary, treasurer) <ul style="list-style-type: none"> ○ <i>Excellent (> 33 % (including decision-making posts and users committee)</i> ○ <i>Good (<33% in decision-making positions but >33% in users committee)</i> ○ <i>Fair (10-32.9 % in decision-making positions and users committee)</i> 	4 3 2
1.2.3	Provision of compulsory presence of women staff/member in project management or implementation meetings	3
3	Provision of women stakeholders or gender expert's participation in project monitoring	4
2.0	Capacity enhancement of women	20
2.1	Provision of capacity enhancement of women members of committees, community groups and associations who are at the decision-making levels <ul style="list-style-type: none"> ✓ <i>At least one training on decision-making skills</i> ✓ <i>Provision of refresher training</i> ✓ <i>Targeting women from disadvantaged groups in such training</i> 	6 (2) (2) (2)

S N	Major indicators, sub-indicators and the check list	Score
2.2	Provision of participation of women staff and members in capacity enhancement programmes--orientations, seminars, workshops, skill development programmes and training as per below: <ul style="list-style-type: none"> ○ <i>Excellent</i> ($\geq 33\%$) ○ <i>Good</i> (20-32 %) ○ <i>Fair</i> (05-19 %) 	7 5 3
2.3	Gender-sensitive and context-specific content of the training, workshops, orientations and skill development programmes ensured <ul style="list-style-type: none"> ✓ <i>Gender-sensitive contents (Violence against women as war instrument, UNSCRs 1325 and 1820, CEDAW etc and Nepal's commitments, constitutional provisions etc)</i> ✓ <i>Context- specific contents and presentation (language, space, geography)</i> 	7 (4) (3)
3.0	Benefits to and control of women over project outputs and outcomes ensured (including targeted programmes)	30
3.1	Ensuring benefits to women--provision of direct benefits to women from project/programme as per the following <ul style="list-style-type: none"> ○ <i>Excellent</i> ($\geq 50\%$) ○ <i>Good</i> (30-49 %) ○ <i>Fair</i> (05-29 %) 	8 6 4
3.2	Provision to identify gender gaps, women's basic and strategic needs and barriers to women accessing the services of the Ministry (women's low access to economic resources, low educational levels and mobility constraints) and programmes to address them (skill development, income generation, collateral free loan and other special economic empowerment programmes for women ex-combatants and conflict-affected women; programmes to address lower educational status may include, functional literacy, and simplified rules and regulations etc; arrangement of markets for raw materials and finished products near the village, and other programmes to address the other barrier to mobility of women) <ul style="list-style-type: none"> ○ <i>Excellent (if the programmes address all the three barriers mentioned above)</i> ○ <i>Good (if the programmes address only two barriers mentioned above)</i> ○ <i>Fair (if the programmes address only one barrier mentioned above)</i> 	6 4 2
3.3	Provision of gender-friendly implementation mechanisms and work place environment to ensure benefits to women. Besides women's participation as provisioned above in criteria (1) the following are provisioned: <ul style="list-style-type: none"> ✓ <i>Provision to review and make acts and regulations gender responsive (promoting gender equity and removing discriminatory laws) and to address gender-based violence at work place (code of conduct, complaints hearing , women- friendly office layout)</i> ✓ <i>Provision of the physical facilities to address the needs of women (separate toilet, breast feeding room, workplace layout, etc.</i> ✓ <i>Provision of activities to increase gender responsive service delivery (exposure visits, citizen charter, sensitization trainings etc)</i> 	7 (3) (2) (2)

S N	Major indicators, sub-indicators and the check list	Score
3.4	Ensuring budget for programmes to benefit women <ul style="list-style-type: none"> ✓ Adequate budget allocated for programmes promoting gender equality and equity ✓ Provision of non-transferability of the amount allocated for gender equality and equity related activities 	2 (1) (1)
3.5	Provision of gender monitoring and impact evaluation systems to ensure benefits to women <ul style="list-style-type: none"> ✓ Provision of sex-disaggregated information/data collection and recording system at all levels of project / programmes and in the impact evaluation ✓ Provision for incorporating sex-disaggregated information in the Ministry and projects/programmes under them) annual progress report by <ul style="list-style-type: none"> (a) Critical analysis of whether the provisions made under 1 to 3.2 points above addressed or not (b) Review of the budget allocated for gender- specific programme ✓ Provision of next year's planning based on the findings of this year's programme and budget. ✓ Provision of gender audit and impact evaluation of implemented programmes/projects 	7 (2) (1) (1) (1) (2)
4.0	Promoting employment and income generation for women	20
4.1	Provision to guarantee employment for women in the jobs created by the projects and programme (reservation, employment priority, specifically for women in reconstruction works and office set up, etc) <ul style="list-style-type: none"> ○ Excellent (> 33 %) ○ Good (20-32 %) ○ Fair (05-19 %) 	8 6 4
4.2	Provisions to ensure alternative income for women in the created jobs and opportunity for career development from the implemented programme	7
4.3	Provision to ensure equal wages to women and men in the created jobs, e.g. in reconstruction and other work	5
5.0	Qualitative improvement of women's time-use or reduce workload	10
5.1	Provision of new time-saving technology, and working procedure in women's work with direct benefits to women, e.g., in women specific jobs in reconstruction, supervisors etc.	5
5.2	Long term result oriented efforts to change the traditional roles of the women <ul style="list-style-type: none"> ✓ Provision for transformation in women's traditional labor role by the programme/project ✓ Discussions of the importance of the unpaid household work of women and their household role in training and publicity material etc ✓ Positive examples of work sharing by men/boys in the above materials. 	6 (2) (2) (2)

Note: If the percentage score is in decimal 5 or above the score should be added to the higher full mark and if it is less than 5, it should be added to the lower mark.

Table 4.2 Gender responsive budget indicators and sub-indicators for the Ministry of Health and Population

S N	Major indicators, sub-indicators and the check list	Score
1.0	Women's participation in planning and implementation	
1.1	Provision of women's participation in planning/programming and budget formulation process from central to district levels as per following : <ul style="list-style-type: none"> ○ Excellent (participation of Joint Secretary or above this level woman officer and gender focal person at the Ministry level and participation of 33% or above health volunteers, mothers group and women representatives of other stakeholders at the district level) ○ Good (participation of joint secretary or above this level woman officer or gender focal person at the Ministry level and participation of 20-33% women stakeholder group, e.g. of health volunteers, mother's group and representatives of other stake holders groups at the district level) ○ Fair (participation of women staff from non-decision making level at the Ministry level and participation of 5-19% health volunteers, mothers group and women representatives of other stake holder groups at the district level) 	4 3 2
1.2	Ensuring women's participation in implementation	12
1.2.1	Provision of women's participation in the implementation (at the project or district level) -in staffing, management and coordination committees including major posts (president, general secretary, treasurer) <ul style="list-style-type: none"> ○ Excellent (> 33 %) ○ Good (20-32 %) ○ Fair (05-19 %) 	5 4 3
1.2.2	Provision of (stakeholder)/women's participation in the subjective specific executive committees and other committees including major posts (president, general secretary, treasurer), (inclusion in users' committee, HFMC and other committees) <ul style="list-style-type: none"> ○ Excellent (> 33 % (including decision making posts and users committee) ○ Good (<33% in decision making positions but >33% in users committee) ○ Fair (10-32.9 % in decision making positions and users committee) 	4 3 2
1.2.3	Provision of compulsory presence of women staff/executive and other members in project management or implementation meetings	3
1.3	Provision of women stakeholders or gender expert's participation in project monitoring.	4
2.0	Capacity enhancement of women	20
2.1	Provision of capacity enhancement of women members of committees, community groups and associations who are at the decision-making levels <ul style="list-style-type: none"> ✓ At least one training on decision-making skills ✓ Provision of refresher training ✓ Targeting women from disadvantaged groups in such training 	6 (2) (2) (2)
2.2	Provision of participation of women staff and members in capacity enhancement programmes--orientations, seminars, workshops, skill development programmes and training as per below: <ul style="list-style-type: none"> ○ Excellent (> 33 %) ○ Good (20-32 %) ○ Fair (05-19 %) 	7 5 3

S N	Major indicators, sub-indicators and the check list	Score
2.3	<p>Gender-sensitive and context-specific content of the training, workshops, orientations and skill development programmes ensured</p> <ul style="list-style-type: none"> ✓ Gender- sensitive contents (problems of prolepses, complications from birth control methods, pelvic cancer, violence against women and its health implications for the family etc) ✓ Context- specific contents and presentation (language, space, geography) 	<p>7</p> <p>(4)</p> <p>(3)</p>
3.0	Benefits to and control of women over project outputs and outcomes ensured (including targeted programmes)	30
3.1	<p>Ensuring benefits to women -provision of direct benefits to women from project/programme as per the following</p> <ul style="list-style-type: none"> ○ Excellent (> 50 %) ○ Good (30-49 %) ○ Fair (05-29 %) 	<p>8</p> <p>6</p> <p>4</p>
3.2	<p>Provision to identify gender gaps, women's special strategic needs and barriers in accessing the services offered by the Ministry (women's low access to economic and financial resources to access health services, lower educational status which inhibit the women to approach the health facilities and mobility constraints due to Purdha and domestic workloads etc) and programmes to address them (provision of cash grants for institutional delivery, free medical services, medicines etc; simple and local language IEC materials; health facilities in the village, birthing centre, health camps, mobile clinics, etc. to address the women's mobility barriers).</p> <ul style="list-style-type: none"> ○ Excellent (if the programmes address all the three barriers mentioned above) ○ Good (if the programmes address only two barriers mentioned above) ○ Fair (if the programmes address only one barrier mentioned above) 	<p>6</p> <p>4</p> <p>2</p>
3.3	<p>Provision of gender-friendly implementation mechanisms and work place environment to ensure benefits to women. Besides women's participation as provisioned above in criteria (1) the following are provisioned:</p> <ul style="list-style-type: none"> ✓ Provision to review and make acts and regulations gender responsive (promoting gender equity and removing discriminatory laws) and to address gender- based violence at work place (code of conduct, complaints hearing , women- friendly office layout) ✓ Provision of the physical facilities to address the needs of women (separate toilet, breast feeding room, workplace layout, birthing rooms, HP, SHP, PCC and hospitals to address the women's reproductive and other health needs). ✓ Provision of activities to increase gender responsive service delivery (exposure visits, citizen charter, sensitization trainings, etc) 	<p>7</p> <p>(3)</p> <p>(2)</p> <p>(2)</p>
3.4	<p>Ensuring budget for programmes to benefit women</p> <ul style="list-style-type: none"> ✓ Adequate budget allocated for programmes promoting gender equality and equity ✓ Provision of non-transferability of the amount allocated for gender equality and equity related activities 	<p>2</p> <p>(1)</p> <p>(1)</p>
3.5	<p>Provision of gender monitoring and impact evaluation systems to ensure benefits to women</p> <ul style="list-style-type: none"> ✓ Provision of sex-disaggregated information/data collection and recording system at all levels of project / programmes and in the impact evaluation 	<p>7</p> <p>(2)</p>

S N	Major indicators, sub-indicators and the check list	Score
	<ul style="list-style-type: none"> ✓ Provision for incorporating sex-disaggregated information in the Ministry and projects/programmes under them) annual progress report by <ul style="list-style-type: none"> (a) Critical analysis of whether the provisions made under 1 to 3.2 points above addressed or not (1) (b) Review of the budget allocated for gender specific programme (1) ✓ Provision of next year's planning based on the findings of this year's programme and budget. (1) ✓ Provision of gender audit and impact evaluation of implemented programmes/projects (2) 	
4.0	Promoting employment and income generation for women	20
4.1	Provision to guarantee employment for women in the jobs created by the projects and programme (reservation, employment priority, specifically for women E.g. in construction of health facilities, office workers, professionals etc) <ul style="list-style-type: none"> ○ Excellent (> 33 %) 8 ○ Good (20-32 %) 6 ○ Fair (05-19 %) 4 	
4.2	Provisions to ensure alternative income for women in the created jobs and opportunity for career development from the implemented programmes (e.g. doctors, health specialists besides FCHVs and ANMs, opportunities for career development for them etc)	4
4.3	Provision to ensure equal wage to men and women in the created job above 4.1 and 4.2)	5
5.0	Qualitative improvement of women's time-use or reduce workload	10
5.1	Provision of new time-saving technology, and working procedure in women's work with direct benefits to women	4
5.2	Long term result oriented efforts to change the traditional roles of women <ul style="list-style-type: none"> ✓ Provision for transformation in women's traditional labor role by the programme/project (2) ✓ Discussions of the importance of the unpaid household work of women and their household role in text books/training /IEC materials etc (2) ✓ Positive examples of work sharing by men/boys in the above materials. (2) 	

Note: If the percentage score is in decimal 5 or above the score should be added to the higher full mark and if it is less than 5, it should be added to the lower mark.

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ANNEXES

**Annex 1.1: Budget allocation for women's programmes:
FY 2008/09 and 2011/12***

(Rs in '000)

Sector	FY 2008/09	FY 2011/12
Education	300,137	290,710
Health	1,727,024	3,590,100
Agriculture	1,000	95,310
Peace and Reconstruction	-	100,000
Physical Planning and Works	-	-
Industry	44,878	69,383
Prime Minister and Council of Minister's Office	2,000	99,913
Tourism and Civil Aviation	-	2,500
Labour and Transport Management	200	141,335
Environment	-	3,950
Women, Children and Social Welfare	605,202	1,263,192
Local Development	281,605	1,579,078
Total	2,962,046	7,235,471
Percent of programme Budget	2.4	3.2
Total programme budget	124,190,947	223,062,786

Source: Accountant General Office: Budget Management Information System for the respective years.

*Note: This is different from allocation shown as directly gender responsive in Table 1.2 because directly gender responsive programmes are classified as per the scores they receive on the basis of GRB criteria, which allocates only 20 percent for direct benefit. The figures in this table include only those items which are visible in the overall sectoral budgets, without going into the details of each programme. For example, this does not include scholarship for girls, because it is not shown separately for girls.

Annex 2.1a: Classification of the Ministry of Peace and Reconstruction's Budget by the GRB category
(Rs. in'000)

Particulars/FY	FY 2008/09*			FY 2009/10			FY 2010/11				
	Indirectly benefiting	Neutral	Total	Directly benefiting	Indirectly benefiting	Neutral	Total	Directly benefiting	Indirectly benefiting	Neutral	Total
Ministry of Peace and Reconstruction	6323588	2800645	9124233	67349	6230424	5235724	11533497	64664	2869550	5693441	8627655
Total											
Ministry of Peace and Reconstruction	29288	10965	40253	65349			65349	64664			64664
Camp management central coordinator's office		149936	149936			13400	13400			1207434	1207434
Peace Fund (camp management, food and stipend for combatants)			0			2356052	2356052		100000	1359040	1459040
Reconstruction and rehabilitation program		27644	27644			163770	163770			475629	475629
Post-conflict peace and reconstruction project		2000000	2000000			11080	11080				0
Peace Process-Support Project (Relief programme for the families of the killed and missing)			0		1953193		1953193			548767	548767
Local Peace Committee	105000	1000	106000		189453		189453		204092		204092
Ministry of Peace and Reconstruction		1100	1100			1000	1000			10076	10076
Camp management central coordinator's office			0			1300	1300			193	193
Peace Fund (camp management, food and stipend for combatants)	5041700		5041700		1903278	2679122	4582400		103858	2092302	2196160
Reconstruction and rehabilitation programme	1134600		1134600		2184500	7500	2192000		2459187		2459187
Post-conflict peace and reconstruction project	13000	600000	613000			0	0				0
Peace Process-Support Project (Relief programme for the families of the killed and missing)		10000	10000	2000			2000		2413		2413
Local Peace Committee			0			2500	2500				0

*There is no directly benefiting budget in the FY 2008/09.

Annex 2.1b: Percent distribution of the Ministry of Peace and Reconstruction's Budget by the GRB category

Particulars/FY	FY 2008/09*			FY 2009/10			FY 2010/11		
	IDR*	Neutral		DR**	IDR**	Neutral	DR**	IDR**	Neutral
Ministry of Peace and Reconstruction Total	69.3	30.7		0.6	54.0	45.4	0.7	33.3	66.0
Ministry of Peace and Reconstruction	72.8	27.2		100.0	0.0	0.0	100.0	0.0	0.0
Camp management central coordinator's office	0.0	100.0		0.0	0.0	100.0	0.0	0.0	100.0
Peace Fund (camp management, food and stipend for combatants)				0.0	0.0	100.0	0.0	6.9	93.1
Reconstruction and rehabilitation programme	0.0	100.0		0.0	0.0	100.0	0.0	0.0	100.0
Post-conflict peace and reconstruction project	0.0	100.0		0.0	0.0	100.0	0.0	0.0	100.0
Peace Process-Support Project (Relief programme for the families of the killed and missing)				0.0	100.0	0.0	0.0	100.0	0.0
Local Peace Committee	99.1	0.9		0.0	100.0	0.0	0.0	0.0	100.0
Ministry of Peace and Reconstruction	0.0	100.0		0.0	0.0	100.0	0.0	0.0	100.0
Camp management central coordinator's office				0.0	0.0	100.0	0.0	4.7	95.3
Peace Fund (camp management, food and stipend for combatants)	100.0	0.0		0.0	41.5	58.5	0.0	100.0	0.0
Reconstruction and rehabilitation programme	100.0	0.0		0.0	99.7	0.3			
Post-conflict peace and reconstruction project	2.1	97.9							
Peace Process-Support Project (Relief programme for the families of the killed and missing)	0.0	100.0		100.0	0.0	0.0	0.0	100.0	0.0
Local Peace Committee				0.0	0.0	100.0			

*There is no directly benefiting budget in the FY 2008/09.

**DR= Directly Responsive; **IDR = Indirectly Responsive

Annex 3.1: Development partners' commitment and share in the health sector

S.N	Donors/FY	2009/10		2010/11	
		Amount in Rs '000	Percent	Amount in Rs '000	Percent
1	Pooled IDA/DFID,	4,992,326	58.6	3,421,698	47.3
2	USAID	835,937	9.8	678,488	9.5
3	DFID	745,039	8.7	16,372	0.2
4	IDA	-	-	293,952	4.1
5	Global Fund for AIDS, TB, Malaria (GFATM)	493,878	5.8	777,676	10.7
6	Others	297,424	3.5	-	-
7	Global Alliance for Vaccines and Immunizations (GAVI)	269,814	3.2	1,181,756	16.3
8	UNICEF	249,945	2.9	303,286	4.2
9	WHO	240,586	2.8	130,704	1.8
10	KFW	186,800	2.2	122,200	1.7
11	ADB	-	-	69,000	1.0
12	SDC			66,670	0.9
13	UNFPA	77,298	0.9	41,981	0.6
14	UNDP	52,555	0.6	-	-
15	Norway	31,495	0.4	31,348	0.4
16	HRI	-	-	30,000	0.4
17	SCF USA	-	-	25,317	0.3
18	JICA	19,435	0.2	19,435	0.3
19	Plan	17,000	0.2	10,000	0.1
20	GTZ	-	-	8,245	0.1
21	Care	7,000	0.1	-	-
22	NLR	6,162	0.1	6,792	0.1
	Total	8,522,694	100	7,234,920	100

Source: MOHP (2066, 2067)

Annex 3.2: Details on GRB classification of MOHP budget

(Rs. in'000)

Organization/Programme	Directly Responsive	Indirectly Responsive	Neutral	Total
Primary Health Service (DHO, HC,HP, SHP)	3,945,985	-	-	3,945,985
Health Training Centers including Regional and Sub-regional	-	26,617	-	26,617
Regional and Zonal Hospitals	-	623,000	-	623,000
Hospitals	-	395,182	-	395,182
Ayurved Hospitals	-	34,940	-	34,940
Ayurved clinics	-	252,398	-	252,398
Pashupati Homeopathic Hospital and Unani clinics	-	9,733	-	9,733
National Population Programme	-	20,665	500	21,165
National Academy of Medical Science including Bir Hospital	395,000	-	138,000	533,000
Kanti Children's Hospital	97,300	94,850	-	192,150
Maternity Hospital Thapathali	153,000	-	-	153,000
Manmohan Cardio-Vascular Center	-	10,000	86,000	96,000
Shahid Gangalal Heart Centre	-	241,000	-	241,000
Tuberculosis Control	-	254,271	437,385	691,656
Rural Health Development Programme	66,718	-	-	66,718
Control of AIDS and STDs	167,510	125,473	-	292,983
Family Planning, MCH, FHV Programme	601,469	181,760	-	783,229
National Polio and Immunization Programme	806,091	240,180	5,880	1,052,151
Integrated Management of Child Immunization Program (IM-CIP)	574,036	72,710	-	646,746
Drug and Equipment Supply	-	1,936,453	150	1,936,603
Integrated District Health Programme	1,300,000	6,114,678	-	7,414,678
Primary Health-care Revitalization Programme	308,382	107,450	-	415,832
Programme Operated from Health Tax Fund	-	431,200	-	431,200
Monitoring, Evaluation and Project Strengthening	458,000	815,407	-	1,273,407
Others	-	-	2,284,620	2,284,620
Total	8,873,491	11,987,967	2,952,535	23,813,993
Percentage	37.3	50.3		12.4

Annex 3.3: Some of the IEC materials consulted

Material produced during the FYs 2008/9 and 2009/10

MOHP. Akasmik Swas Prawas Rog (Emergency respiratory disease/pneumonia)

-----Chhayarog (Tuberculosis))

-----Auolo (Malaria)

-----Cancer

-----Pakhala (Diarrhea)

-----Laingik Hinsa Eak Parichya (Gender based violence)

-----Swasthya Sansthama Prasuti Garaunda ke Phaida Huncha ra Tapainle ke Kasta Sewa ra Subidha Paunuhuncha (Benefits of institutional delivery and facilities provided)

-----Poshan (Nutrition)

-----Khop (Immunization)

MOHP/UNFPA. Laingik Bived thata Kishwor Kishworiko Swasthya (Gender discrimination and adolescent health)

-----Kishworwasta (Adolescence)

-----Aaptkalin Awasthama Prajanan Swasthyaka Lagi Nyunatam Sewa Package (Minimum package for emergency child-delivery)

-----Mahilako Patheghar Khsne Samsya (Prolepses problems)

-----Pariwar Niyojanko Upayogita (Usefulness of family planning)

-----Pariwar Niyojanko Asthai Sadhan Pills (Temporary family planning methods, Pills)

-----Pariwar Niyojanko Asthai Sadhan kapar Ti (IUD) (Temporary family planning methods, IUD)

-----Pariwar Niyojanko Asthai Sadhan, Depo-Provera (Sui) (Temporary family planning methods, Depo-Provera)

Gender Audit and Gender Budget Studies and Publications in Nepal

S.N	Title/ Author/ Publisher	Date
1.	Gender Audit of MOES, Kathmandu, Nepal (Mimeo), DOE/ MOES/ GON,	2002
2.	Gender Budget Audit in Nepal: Follow the Money series South Asia (2) Meena Acharya, UNIFEM, New Delhi, India.	2003
3.	Gender Assessment and Gender Budget Audit of the Ministry of Local Development, (published) MOWCSW/MGEP/UNDP and SAHAVAGI	2004
4.	Executive summaries of studies of Agriculture (2002), Health (2002) and Education Sectors (2005) and Ministry of Women Children and Social Welfare (2003), Ministry of Local Development (2004), Ministry of Forest and Social Conservation (2006), Ministry of Labor and Transport Management (2006)	2008
5.	Executive Summary of the "Country Research on Gender Responsive Budget and Aid Effectiveness in Nepal" (Meena Acharya) UNIFEM/ITC/ILO/EU. Kathmandu	2008
6.	Summary, Conclusions and Lessons Learnt of the study: "Mapping Foreign Aid in Nepal from Gender Perspective" (Meena Acharya) UNIFEM/ITC/ILO/EU. Kathmandu	2008
7.	Situation Analysis of Gender Responsive Budgeting in the Education Sector, (Meena Acharya and Chapala Koirala), (Mimeo) UNESCO and SAHAVAGI. Kathmandu.	2010
8.	Gender Responsive Decentralized Governance, A study of Nepal, Australian National University/ Institute of Integrated Development Studies/ Asian Development Bank, (Mimeo). Kathmandu	2010
9.	Gender-Responsive Decentralized Governance in Asia: Gender Sensitivity in the Local-Level Planning Process) Nepal, Australian National University/ Institute of Integrated Development Studies/ Asian Development Bank, (Mimeo). Kathmandu.	2012



ISBN 978-9937-2476-0-3

