Gender Equality, Social Inclusion and Rights (GESIR) In Health Sector In Nepal :

EAP Experience

Bharat M. Devkota Ph D

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Abbreviations used

AI	= Appreciative Inquiry
ANC	= Ante Natal Care
ANM	= Auxiliary Nurse Midwife
BCC	= Behavior Change Communication
B/CEOC	= Basic/Comprehensive Emergency Obstetric Care
CBO	= Community Based Organization
DDC	= District Development Committee
DEO	= District Education Office
DfID	= Department of International Development
D/PHO	= District/ Public Health Office
EAP	= Equity and Access Program
EASO	= Equity and Access Support Organization
FHD	= Family Health Division
GBV	= Gender Based Violence
GESIR	= Gender Equality Social Inclusion and Rights
GoN	= Government of Nepal
HFMC	= Health Facility Management Committee
HP	= Health Post
IPC	= Inter Personal Communication
JHU/CCP	= John Hopkins University/ Centre for Communication Program
KAP	= Knowledge, Attitudes, and Practice
KIM	= Key Informant Monitoring
LSI	= Livelihood Support Initiative
MoHP	= Ministry of Health and Population
NGO	= Non-government Organization
NHEICC	= National Health Education Information Communication Center
NHSP	= National Health Sector Plan
NHTC	= National Health Training Centre
PHCC	= Primary Health Care Centre
PNC	= Post Natal Care
RBA	= Right Based Approach
RHCC	= Reproductive Health Coordination Committee
SBA	= Skilled Birth Attendant
SDIP	= Safe Delivery Incentive Program
SHP	= Sub-health Post
SMNH	= Safe Motherhood and Neonatal Health
SSMP	= Support to Safe Motherhood Program
TBA	= Traditional Birth Attendant
VDC	= Village Development Committee
VCO	= Voice Capturing Organizations
WDO	= Women Development Office

Executive Summary

Interim constitution recognizes basic health as a fundamental right. Even though the country has made significant progress in empowering citizens to claim health rights through program initiatives and policy changes quality health services are yet to reach to poor and excluded. Gender, ethnicity, language, location (remoteness), poverty etc influence exclusion from access to health services which poses challenges taking gender equality, social inclusion and rights forward. Barriers to social inclusion include gender-based social stratification, ethnic, and caste based hierarchies which determines economic and social relationships and defines how lives of male and female are shaped. Health status is therefore determined by their economic, social, physical, geographical conditions with marginalized groups clearly having lower health status than others. The current health care system is neutral to all citizens and aims for universal coverage. Even though constitution recognizes health as a right, policy formulation, program design, budgeting are yet to be worked out. These gap areas have led to different levels of health service utilization between advantaged and marginalized populations. The right to health means that the state must generate conditions of basic health services in which everyone can be as healthy as possible.

In order to respond above gap areas Equity and Access program worked on increasing knowledge on SMNH among poor, creating enabling environment for excluded women and families by addressing social, cultural, economic and physical barriers, build capacity of stakeholders, collected voices from unheard right holders and service providers for policy change and management improvement, engaged on cross cutting thematic issues like empowerment, participation sustainability and advocacy.

Above action resulted increased service utilization across all social groups, with greatest changes occurring among marginalized. Women from *dalit* and excluded community are empowered and able to demand their rights. They are sensitized and more aware about underlying causes of exclusion, power structure within family, community and society, causes of discrimination, and violation of rights. They have gained knowledge and skill for doing advocacy against issues related to women's rights. Women from poor and excluded groups have become able to hold key positions in community groups. In addition, there was decreased equity gap on knowledge (of ANC, PNC delivery, danger signs), traditional practices and cultural beliefs that work against safe motherhood, better informed, better prepared to use health services and reduced social inequities in use of MNH services.

EAP's major learning are targeting the poor and excluded is essential to reach to universal coverage, data disaggregation by ethnicity is an effective means to track equity related changes, demand creation without concurrent service strengthening can de-motivate communities for care seeking, voices of community groups can be effective in improving local policies and service quality, social empowerment through women's groups impacts on other sectors and effective approach for sustainability and empowering women to claim their health rights and redefine social norms around pregnancy and childbirth is a long-term agenda.

Based on the learning, for future programming EAP recommends: Tailored programs to reach poor and excluded, programme's adaptation to other districts of the country, ensure rights based, socially inclusive, empowering approaches, ensure linkages of program with other sectors, ensure disaggregated monitoring, ensure demand creation and service strengthening go together, use networks to promote free care and support social auditing and use network, co-operative strengthening as a discrete program goal for sustainability.

1. Context

Interim constitution of Nepal 2007 recognizes basic health as a fundamental right of all[1]. The country has made significant progress in recent years in empowering citizens to claim health rights through some program initiatives and policy changes. Free essential health care services, transport subsidy for safe delivery, legal basis for safe abortion, increased family planning and other non health interventions like formal and non formal education and livelihoods programs have contributed to increasing access to health services and right holders to claim their rights. However, quality health services are yet to reach to poor, vulnerable and marginalized[2] groups. Many challenges remain including taking gender equality, social inclusion and rights (GESIR) forward within the Ministry of Health and population (MoHP) and applying lessons learned from different programs. Understanding the complementarities of demand and supply side inputs from government of Nepal (GoN) and civil society groups, as they affect equity of access to health services, remains a major sectoral challenge.

2. Rational of GESIR

In Nepal, several factors influence exclusion from access to health services. Unequal **gender** relations that have root in traditional socio-cultural structures define rules for women and limit their abilities to make care-seeking decisions for themselves and access to resources. This leads to limited or no claims on health services or delayed use of services. **Ethnicity** is a strong variable which defines different strata in the society, so called upper castes have better access on health services than lower castes. **Language** also has some level of effect on health service delivery. Most of the duty bearers are Nepali speaking and there are several places in the country where people cannot speak Nepali thus limiting the access on health services. **Spatial** exclusion is a major factor, particularly in far and mid west regions and in mountain areas where health services are much farther away than they are in the hills and terai. Levels of **poverty** are strong determinant of accessibility to health services. All these factors contribute to an unequal supply of the health services by the state and unequal claims of **health rights** by citizens.

Barriers to social inclusion include gender-based social stratification, which in turn must be placed in the prevailing ethnic, and caste based hierarchies that structure economic and social relationships. This defines how the lives of girls and boys, men and women will be shaped according to their caste and ethnic identities, their religion and the location of their community and the rules and norms that these social structures define. These social structures govern all spheres of an individual's daily life[3]. The health status of Nepalese is therefore broadly determined by their economic, social, physical, and geographical conditions with marginalized groups clearly having lower health status than others.

The right to health, like all human rights, imposes on the state the responsibility to respect, protect and fulfill this right. Because of marginalization there is a huge gap between advantaged and marginalized populations.

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[1] Interim Constitution of Nepal 2007.

[2] **Definition: Poor:** socially, economically, geographically excluded population, including women and children with low health status and low empowerment indicators in terms of HDI, GDI, and other context specific groups. **Vulnerable:** including women and children (displaced, destitute, disabled, elderly (above 60 years of age), people affected by trafficking). **Marginalized by castes, ethnicity, language, disability and other factors:** including women and children—*Dalits* (Hill and Terai), *Janajatis*, religious minorities, PLWHA, and third gender. In this paper **Poor and Excluded** (P&E) being used to represent all.

[3] VCDP Health June 2004 15/06/2004

3. Gap Areas on GESIR in health sector

In spite of the growing importance of reaching marginalized population with quality health care services this has not been articulated properly in any of the key documents of health sector programs. The current health care system is neutral to all citizens and aims for universal coverage. Unless special focus is given to the poor and excluded, the achievement of universal coverage cannot be attained. Nepal's interim constitution (2007) recognizes "basic health as a human right" but policy formulation, program design, budgeting has not been done yet for its implementation. Similarly Three Year Interim Plan (2007-10) has shown some commitment to socially inclusive programming and its pro-poor free health care policy but meaningful participation of the socially excluded in the design, implementation and monitoring and evaluation of health services is yet to come. Policies require the participation of women, the poor and the disadvantaged in health facility management committees (HFMCs) however, there has been no mechanism to ensure representation and verify whether poor and marginalized[4] members are in decision making position. GoN's recent decision to provide free health care services provides for the abolition of user fees for selective services at different types of health facility. "*Aama*" provides free maternal delivery and a fixed cash incentive to all women to cover the cost of transportation. These policies have been very instrumental to increase the health service utilization rate. However, a lot have to be done to reach ultra poor and people living in remote areas where the service is not available.

Service providers are generally not familiar with the human rights frame work and have limited capacity and sensitivity to deal appropriately with poor and excluded groups. Gender, social inclusion and rights perspective is missing in most training programs. There is poor gender balance among health service providers except for nursing care givers. Interim constitution provides right to information[5] but advantaged people have better access on information than poor and excluded ones. These gap areas have led to different levels of health service utilization between advantaged and marginalized populations[6].

- Life expectancy: 74 in Kathmandu 44 in Mugu[7] (a remote district).
- Cast and ethnicity and health service utilization are directly proportional so called higher casts have higher utilization and vice versa.
- High costs are a primary cause of failures to access health services. 41% of households reported difficulty in raising money for an institutional delivery[8]. As wealth increases, education levels for both males and females increase and health outcomes improve.
- Women's autonomy in decision making related to health has increased. One in five women now makes her own decision on care-seeking. Indigenous practices, many of which significantly dis-empower women, also affect care seeking. Examination by male health worker has been a major reason for not seeking care. Inequality increased in terms of distance to the facility and the need to take transport.

[4] Defined in Gender Equality and Social Inclusion (GESI) Strategy for Health Sector in Nepal, 2066: Marginalized by castes, ethnicity, language, disability and other factors: including women and children—*Dalits* (Hill and Terai), *Janajatis*, religious minorities, PLWHA, and third gender.
[5] Interim constitution of Nepal 2007.
[6] Greg Whiteside, Review of Unequal Citizens: Unpublished draft 2010.
[7] NDHS 2006.
[8] Borghi, Ensor, Neupane and Tiwari, Coping with the Burden of the Costs of Maternal Health, Options, April 2004.

- Although equity gap reduced between 2001 and 2006 significant disparities persist related to caste, ethnicity, ecological region and wealth quintiles. 22% of the population still lacks access to basic health facilities with 36% having to walk between 2 – 4 hrs to reach a motorable road[9].
- TFR has declined over the past decade from 4.6 in 1996 to 3.1 in 2006 but is dropping fastest among the wealthiest (below replacement) than among the poorest (4.7)[10]
- Contraception prevalence has increased from 26% in 1996 to 44% in 2006 with growth greater among the poorest groups. 54% of women in the wealthiest quintile have access 30% in the poorest quintile.
- Both infant and under-five mortality rates have been dropping but a pattern of growing inequality in child survival is evident. In 1996 infant mortality in the poorest quintile was 50% higher than that in the wealthiest but by 2006 this had risen to 78% higher. Similarly, under-five mortality rates were more than twice as high for the poorest in 2006 compared with the wealthiest.
- 84% of wealthiest women received ante natal care (ANC) in 2006, only 18% of the poorest women did[11].
- 19% deliveries by trained health workers with 5% among poorest and 58% among wealthiest[12].
- Vitamin A supplementation following delivery tripled between 2001 and 2006 with poorest women experiencing a four-fold increase while wealthiest women consumption only doubled.
- At peripheral facilities which are preferentially used by poorest. 47% of doctors, 22% of staff nurses and 9% of auxiliary nurse midwife (ANM) positions vacant in district hospitals and primary health care centers (PHCCs). There is acute shortage of skilled birth attendants (SBAs) key health staff, especially doctors and nurses, are evident with urban centers and the terai having disproportionately higher proportions of highly qualified staff.
- Volume of work necessary to create the demand particularly bringing poorest and most vulnerable to seek health service is inadequate.

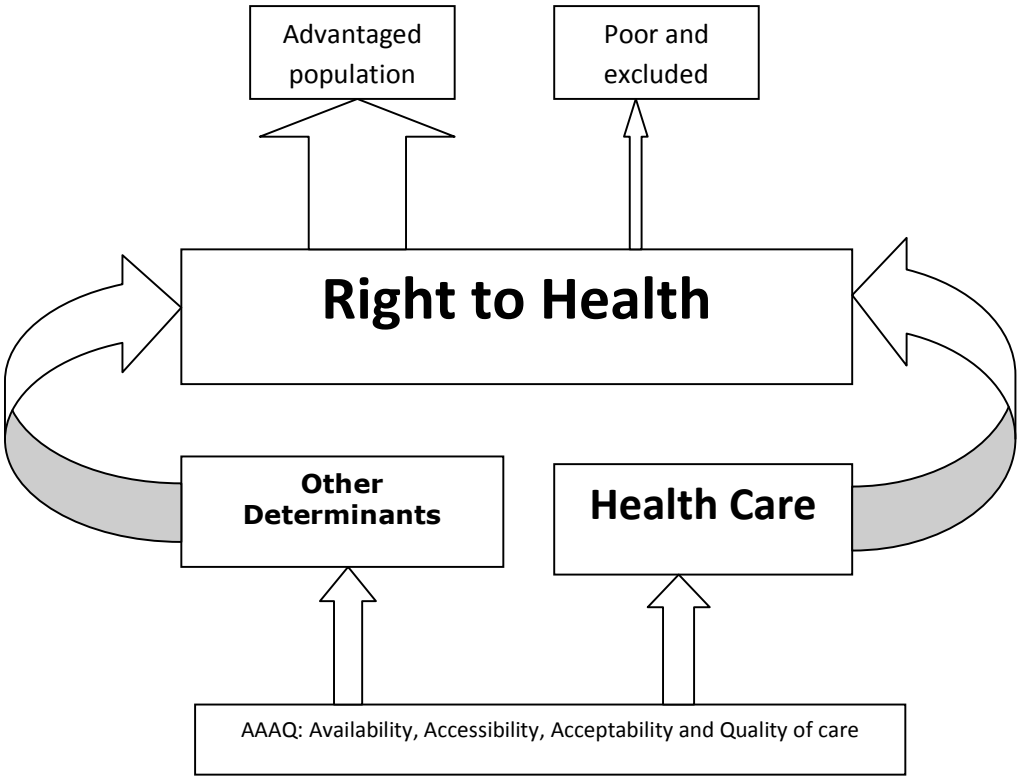
4. GESIR conceptual framework

The right to health means that governments must generate conditions in which everyone can be as healthy as possible even though the right to health does not mean the right to be healthy[13].**.** Such conditions range from ensuring reach to basic **health care** (availability, acceptability, accessibility and quality care[14]) and **other determinants** like healthy and safe working conditions, adequate water and sanitation services, housing and nutritious food by all citizens.

[9] NDHS 2001 and 2006
[10] NDHS Further Analysis Trends in Economic Differentials in Population and Health Outcomes
[11] NDHS Further Analysis, Trends in Economic Differentials in Population and Health Outcomes
[12] NDHS Further Analysis, Trends in Economic Differentials in Population and Health Outcomes
[13] Joint fact sheet WHO/OHCHR/323 AUGUST 2007
[14] Right to health is built on availability, accessibility, acceptability and quality of care.

1. Availability is functioning public health and health care facilities, goods and services, in sufficient quantity.
2. Accessibility is health facilities, goods and services accessible to everyone, without any discrimination, in reasonable distance, which is affordable and access to information.
3. Acceptability demands all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.
4. Quality of Care demands health facilities, goods and services must be scientifically and medically appropriate and of good quality.

A Conceptual Framework on Health Right Claim



The right to health has been recognized in many international human rights treaties like ICESCR, CEDAW, CRC. Nepal has signed these treaties and built in its constitution thus state is bound to ensure such rights are fulfilled to all the citizens. However, in prevailing condition health care services are not available for universal coverage to reach to all the citizens of the country. In addition, whatever health services and other determinants are available large share has been claimed by advantaged population leaving marginalized yet to claim their health right.

5. What does it take to make health right a reality: EAP[15] experience[16]

Increased knowledge on SMNH especially among poor and excluded: EAP provided information for behavior change communication (BCC) needs assessment and developed district level BCC plan. In order to give accurate message as per the standards set by MoHP, equity and access program (EAP) localized BCC media and materials and disseminated. Multimedia and interactive activities (radio, TV, hoarding board, street theater, inter personal communication (IPC) events, group meetings) were implemented.

[15] **Equity and Access Program (EAP)** is implemented by ActionAid Nepal for Support to the Safe Motherhood Program (SSMP) managed by UK based Options Consultancy Services Limited funded by DFID. EAP was implemented between 2006-2009 in 10 districts of Nepal. It had 28 [local] partner organizations implemented the program which aimed increasing utilization of safe motherhood and newborn health services particularly by poor and socially excluded.

[16] Program Implementation Plan (1 July 2007 to 30 June 2009) 2007.

Enabling environment created for excluded women and families by addressing social, cultural, economic and physical barriers: Activities included the development of community mapping aimed at establishing areas of greatest concentration of poor and socially excluded, existing access and equity initiatives, existing community based organizations and other local stakeholders, location of different type of basic and comprehensive emergency obstetric care (B/CEOC) service provision. Strengthened initiatives such as the community based emergency funds and transportation schemes, lobbying for infrastructure, and promotion and implementation of activities for overcoming barriers to access and enhancing equity and access. Key stakeholders like civil society, reproductive health coordination committee (RHCC), transport workers, journalists, traditional healers were given knowledge on safe motherhood and neonatal health (SMNH) so that they can be instrumental to facilitate to get services and disseminate SMNH message to others. EAP carried out social mobilization around SMNH, provide support to SHP/HP (service delivery points) for improving basic physical environment. EAP engaged on creating a mechanism for right holder and service provider interaction on a regular basis for quality service delivery.

Capacity of organizations (EASOs), local government, RHCCs and community groups to promote E&A for SMNH, especially among the poor and excluded enhanced: The capacity building function led on the EAP's engagement with local partner organisations. EAP identified equity and access support organizations (EASOs) at the district level, and worked closely with them to identify training needs and develop appropriate capacity development plans. It developed innovative tools like social exclusion mapping, appreciative inquiry, public hearings, social audits and conflict-sensitive development tools. In addition, EAP strengthened the capacity of RHCCs to coordinate planning, implementation and monitoring of district level SMNH/E&A activities, provide technical skills to EASOs and line agencies as part of capacity building.

Voice of right holders and service providers captured and used to influence policy and program development: The social inclusion and 'voice' promotion function focused on the provision of support for capturing of voice and disseminating at different levels so that management functions at village, district and national level formal and informal organizations can be improved. EAP identified voice monitoring organization (VMO), build their capacity and key informant to articulate their views, conduct voice monitoring using key informant monitoring (KIM), client exit interview, in depth interview with service providers, case studies and social audit, analyze data, and document for both user and provider, use the data at different level for programming and policy reform and develop guideline for voice monitoring.

Engagement on cross cutting and thematic issues: EAP is founded on the principles of a **rights based approach** (RBA). It targeted the poor and excluded; aimed to inform and empower women to seek and demand better MNH care; and mobilised communities and local stakeholders to engage with health providers and local officials to place pressure for more responsive and accountable services[17]. To ensure long term sustainability EAP implemented activities in **partnership** with local institutions, EASOs and VCOs mostly led by *Dalits*, *Janjatis* and women. EAP targeted the people or communities (**social inclusion**), which are discriminated against on the basis of their gender, caste, class ethnicity, religion, language and location (remoteness). In order to ensure their participation in EAP, priority was given to these groups while selecting program village development committees (VDCs), and in the recruitment of EASOs' and EAP staff. In addition, data were analyzed by disaggregating the caste and ethnic groups into six social groups and then further by sex (adopted from DFID's LSI monitoring). EAP staff were trained to work in a conflict environment to avoid conflict and other general risks (**safe and**

[17] Deborah Thomas, Review of the Equity and Access Program 2009.

effective development) that may occur due to attitudes and behaviors of program staff. To keep program operational and minimize risks, EAP staff at district level identified and supported activities which connect people and discourage activities that could be dividers. **Participatory** review and reflection process (PRRP) and social audits were the key approaches used for **monitoring and evaluation** of activities undertaken by EAP and partners. Joint review and analysis of the project activities were key to ensuring accountability and transparency leading to empowerment of right holders, changes in decision making process and developing ownership. In order to increase the **participation of P&E and empower** them EAP delivered socially inclusive package in the community. This included formation of groups, federating them on networks and developing them as district level NGO or health cooperatives. EAP has mobilized and helped organize groups of poor and excluded women to find and articulate their **voice** to place pressure on local health providers, have their voices heard by district officials, and support and demand better, more responsive services and service providers feel **accountable** towards common citizens.

Advocacy related activities to change the power relation and improve the quality of services through meaningful engagement and participation of poor and excluded at various level: Build the networks of community groups and empower them to raise voices, claim their rights, demand accountability and influence power holders at household and community level. Various orientations on SMNH, gender, social inclusion and RBA to different level power holders and decision makers helped increase support for ensuring rights of and accountability towards right holders. The regular interactions between right holders and service providers have made both aware about their entitlements and responsibilities.

6. What it achieved on claiming health right by poor and excluded: EAP experience[18]

Increased SMNH knowledge and practices: The Knowledge Attitude and Practice (KAP) survey results show that the knowledge about common danger signs during pregnancy, labor and post partum period (at least three) has increased by more than 30% in average. Similarly, other SMNH related knowledge also has increased significantly. Service utilization survey shows women who visited the health facilities for delivery, have increased by 29% in 3rd year. Similarly, all the other SMNH practices such as ANC (45 to 60), PNC check-up (34 to 48) and birth preparedness (35 to 69) have significantly increased[19].

The harmful traditional cultural practices such as keeping the mother and new born in a cowshed, stuffing hair into the mouth to induce vomiting and inserting hand by traditional birth attendant (TBA) into the vagina of recently delivered women for the management of the retained placenta, placing a train ticket on the fore-head of pregnant mother for the management of pro-long labour etc. have decreased remarkably.

Women empowerment: Women from *dalit* and excluded community of EAP area are empowered and able to demand their rights. They are sensitized and more aware about underlying causes of exclusion, power structure within family, community and society, causes of discrimination, and violation of rights. They have gained knowledge and skill for doing systematic advocacy against various issues related to women's rights such as rape, child marriage, *dowry* etc. Women have raised their voices to allocate resources for SMNH activities resulted more than 75% of VDCs of EAP area have allocated fund. Participation in community institutions like HFMC, school management committee, and community forestry users groups increased. The EAP internal data record

[18] Equity and Access Program Completion Report 2009.
[19] EAP, Endline Survey on Knowledge, Attitude and Practices on Safe Motherhood and Neonatal Health. Valley Research Group 2009.

source shows that around **65%** of SHP/HP/PHCC management committees have representatives of at least 3 persons including 2 women from poor and excluded communities. A high proportion (more than 70%) of women from poor and excluded groups have become able to hold key positions (chairperson, secretary and treasurers) in community groups, which is also an important indicator of women empowerment and equity aspect.

Positive impact on health services: Thirty-seven health facilities are strengthened and they are providing twenty-four-hour delivery services in EAP area, and they are recognized as birthing centers by GoN. More than 60 health facilities have built a separate room with local resources for maintaining the privacy for ANC, delivery and PNC services. Around 150 health facilities have extended their opening hours for the services.

Emergency fund[20]: 3,500 community groups have established emergency funds. Around 5 million rupees cash has been collected and out of this around 2 million allocated as emergency funds managed by community groups. The funds in community groups have removed the previous dependence on loans from local money lenders, who charge high interest rates and demand collateral. Out of total loans made from emergency funds, more than 70% has been taken by the poor and excluded.

Emergency transport: EAP promoted the importance and concept of establishing emergency transport in the community to reduce the 1st and 2nd delay (delay at home and on the way to health facility). Various kinds of emergency transports [for overcoming physical barrier] have been established and used depending on the location, availability, affordability, and group preference. **52**% of groups have emergency transport schemes and all groups have easy access to them as those transport means (cycle ambulance) are placed commonly in one group which is easily accessible to many groups. Out of total emergency transport used, **80**% was utilized by poor and excluded.

Capacity building: At community level, around 3,500 community groups especially of women, 180 networks, and 40 cooperatives have been formed and made functional. Every woman as an individual has been empowered and made able to share SMNH and other issues with husbands, mothers-in-law and other decision makers within the family. The women have also been able to raise their voices collectively to influence decision makers on women's issues such as, domestic violence, sexual abuse, early marriage, *dowry* and demand of quality services.

EAP worked with district RHCC and other local bodies as a result, around **77%** VDCs and all district development committees (DDCs) have contributed their funds to SMNH and social inclusion related activities. Out of eight, 5 RHCCs have developed seven-year district reproductive health plan (2008-2015). D/PHO and local NGOs in Gorkha and Kanchanpur have been successful to implement the equity and access activities based on EAP model with technical back-stopping of EAP.

Voice for action: The voices of rights holders and service providers produced large evidences for lobbying and advocacy. As a result, various positive changes on the part of increased accountability have been observed, such as extended opening hours, confidentiality of check up and timely referral of the complicated cases, human resource placement, availability of 24-hour services in some health facilities, issue of safe delivery incentive on time etc. are some of the examples of changes.

[20] Emergency funds are created by community groups easily accessible, 24-hour available, provide interest free loans, and help increase access [due to economic barrier] to and utilization of SMNH services for poor and excluded people.

Decreasing Equity Gap between Advantaged and Poor and Excluded: Both household and service utilization data indicate increases in service utilization across all social groups, with greatest changes occurring among *Dalits* and disadvantaged *Janajatis*.

- The equity gap between use of ANC by different ethnic group has declined. Women in EAP area have a significantly higher ANC use rate than others.
- Knowledge of the danger signs in pregnancy, labour and the post-partum more than doubled. Women in EAP area have significantly better knowledge than others, confirming women's groups as effective channels of information.
- Mobilizing women, their families and communities to act upon the social norms, traditional practices and cultural beliefs that work against safe motherhood, policy and service have synergistically increased access to services.
- Better informed, better prepared, and better availability of emergency obstetric care has translated into more rational care seeking and increased treatment of obstetric complications.
- Women have better knowledge of the danger signs, higher ANC rates, better knowledge of SDIP (*Aama*), and are more likely to use an emergency transport scheme.
- Reduced social inequities in use of MNH services. While *Dalits* and disadvantaged *Janajatis*, have benefitted particularly well, disadvantaged *Madeshi* castes and Muslims and other religious minorities have fared less well.

7. . Equity and access program learning on right to health

EAP, during its implementation (three plus years) period, gathered a lot of experiences and learning from conducting its various activities and the processes in womens' rights particularly safe motherhood rights[21].

- Targeting the poor and excluded is essential even within a universal coverage approach, if they are to be reached regardless of the resources available.
- In the absence of poverty mapping data, disaggregation using (six) caste/ethnicity groupings is an effective means to track equity related changes in MNH knowledge and service utilization.
- Demand creation without concurrent service strengthening can de-motivate communities for care seeking. Thus service strengthening and demand creation should go hand in hand.
- Raising awareness of rights and social inclusion among both right holders (service users) and duty bearers (service providers) is effective in improving service delivery and accountability.
- Working through women's groups and networks is effective in increasing equitable demand for, and equal access to, MNH services. Developing a sustainability plan for these groups and networks (e.g. group strengthening and planning) is essential if gains are to continue.
- Voices of community members/groups and service providers, used skillfully, can be effective in improving local policies and service quality.
- Localization of BCC materials including into local languages, increases local ownership and impact.
- Social empowerment through women's groups impact on other sectors notably education, livelihoods and social justice (e.g. addressing gender based violence).
- Tracking other empowerment indicators in groups e.g. responses to gender based violence, school enrolment of girls is important to track all the changes.

[21] Equity and Access Program Completion Report 2009.

- Partnering and working through district level NGOs from poor and marginalized constituencies is highly effective – particularly in addressing social empowerment and rights issues. It is also cost effective.
- Empowering women to claim their health rights and redefine social norms around pregnancy and childbirth is a long-term agenda, 3 years is too short time period.

8. . Summary and recommendations

EAP has been successful in increasing access to and utilization of SMNH services for poor and the excluded through its targeted demand side approach. Its socially inclusive and right based approach helped to empower right holders and made them able to claim their rights. Other sectors such as livelihood, education etc. also are equally important to contribute for achieving the better results in claiming health rights by poor and excluded[22]. However, EAP's effort was very limited in these sectors due to its design as well as resource limitation. Based on the learning of EAP, following are the recommendations for future health program planning:

- Future programming will need to place stronger emphasis on reaching disadvantaged groups through more tailored communication and mobilisation approaches, and addressing supply side barriers and social discrimination.
- The success of EAP in the Hills and Terai also calls for the programme's adaptation to mountain districts where development indicators of remote communities trail behind. Scale-up targeted equity and access activities across the country.
- Ensure rights based, socially inclusive, empowering approaches are at the core of community mobilization processes. Also ensure linkages of program with other sector particularly livelihood and education.
- Ensure disaggregated monitoring rolled out across the country for all major health indicators.
- Ensure demand creation and service strengthening go hand in hand.
- Use networks to promote free care and support social auditing of demand side financing schemes.
- Support group, network, co-operative strengthening as a discrete program goal for sustainability.
- Explore the potential of national Equity and Access Agency to provide technical support to local "demand side agencies". The agency could be from private or local government sector, and possibly working beyond health sector.
- Draw learning from other targeted demand side programs (e.g. UNFPA PARHI; Unicef WRL/DACAW; MIRA) and consolidate in EAP model.

[22] Equity and Access Program Completion Report 2009.