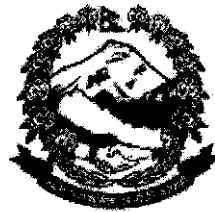




Nepal Health Sector Program – (NHSP- II)

Indigenous People's Development Framework



**Government of Nepal
Ministry of Health and Population
Kathmandu
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Nepal Health Sector Program-II

Indigenous People's Development Framework

1. Background

The Nepal Health Sector Program-II (NHSP) will expand geographical coverage of essential health services and implement policies aimed at increasing access to the poor and excluded segments of the society more systematically. It will strengthen the government's response to people's expectations of inclusive and accountable public services in the public health sector. The program is a continuation of early health programs.

The Ministry of Health and Population (MoHP) undertook Social Assessment (SA) and developed Stakeholder Participatory Framework (SPF) during the preparation of the two early health programs. Drawing from the findings of these exercises, the MoHP prepared a Vulnerable Community Development Plan (VCDP) that covered indigenous communities as well. The VCDP has laid out a number of concrete steps to be taken to comply with the Bank's OD 4.20 on indigenous people and thus remains a valid document to address issues relating to indigenous people in under the new program which is actually a continuation of the two earlier health programs. This framework presents a summary of principles and approaches regarding indigenous peoples, with supplementary analysis of priority areas under the new program. Much of these are also included in the Gender Equality and Social Inclusion Strategy (GESI Strategy) approved recently by the Ministry of Health and Population.

2. Relevant National Policies on Indigenous People

The Interim Constitution of Nepal recognizes access to health care as a fundamental right with a stress on equity and the interim government included health as one of the three priorities of the three-year Interim Plan. Furthermore, the National Health Policy, the Second Long Term Health Plan and the government's Tenth Plan documents emphasize a participatory and inclusive approach for the access and delivery of health services through special targeting of the economically and socially included groups of rural and remote areas, including the indigenous people.

The parliament passed a bill in 2002 for the formation of National Foundation for the Development of Indigenous Nationalities (NFDIN), which came into existence in 2003. NFDIN Act 2002, National Human Rights Action Plan 2005, Environmental Act 1997 and Forest Act 1993 have emphasized protection and promotion of indigenous people's knowledge and cultural heritage. In 1999, Local Self-Governance Act was enacted to give more power to the local political bodies, including authority to promote, preserve and protect the IP's language, religion, culture and their welfare.

The Three Years Interim Plan Paper (2007-2010) includes following policies for inclusive development of Indigenous Nationalities and other disadvantaged groups: (i) creating an environment for social inclusion; (ii) participation of disadvantaged groups in policy and decision making; (iii) developing special programs for disadvantaged groups; (iv) positive discrimination or reservation in education, employment, etc.; (v) protection of their culture, language and knowledge; (vi) proportional representation in development; and (vii) making the country's entire economic framework socially inclusive.

3. Indigenous People of Nepal

Nepal's complex social structure makes it challenging to define IPs in Nepal. The 2001 census has identified 100 different social groups in the country with over 92 languages and a mix of Hindu, Buddhist, Kirat, Animism and Muslim religions. The Government of Nepal (NFDIN Act) has recognized 59 different indigenous nationalities, also known as *janajatis* of Nepal who comprises about 37.2% of the country's population.

Structural and systematic discrimination based on their ethnicity, language or religions has barred the indigenous people from exercising their individual and collective rights and defend their cultural identity. Language is considered as one of the most severe barriers experienced by indigenous people in accessing basic health care services in Nepal. Language, combined with geographical distance and economical disadvantage create greater risks for *janajatis* in receiving proper health care and public services. The NEFIN has recognized the following 24 indigenous groups as highly marginalized:

- i. Mountain Districts: *Lhomi-Singsa, Siyar, and Thudam (3 groups)*
- ii. Hill Districts: *Baramu, Chepang, Hayu, Kusunda, Lepcha, Raute, Sural and Thami (9 groups)*
- iii. Inner Terai Districts: *Bote, Bankariya, Danuar, Majhi and Raji (4 groups)*
- iv. Terai Districts: *Dhanuk, Jangad/Dhangad/Urau, Khadiya, Kisan, Kusbadiya;Satar/Santhal, Meche and Munda (8 groups)*

4. NHSP Principles regarding Indigenous People

The program components of NHSP has complied with Government's Social Inclusion Agenda and Interim Constitution's policy to increase access to and benefits of public services to economically and socially disadvantaged people, including indigenous communities. The main objective of the program is to expand access to essential health care system for the underserved and excluded population. Accordingly, the type and nature of activities in the program has been designed to improve health care service delivery to the disadvantaged groups, including women, *dalits* and *janajatis* through decentralization, public private partnership and capacity building measures. The program proposes targeting of disadvantaged

groups through the use of social indicators in program information system and expansion of services in low HDI regions, and providing incentives for public and private sector providers to engage in pro-poor practices. Pilot program that includes Health Management Information System (HMIS) disaggregated by gender, caste and ethnicity has already been initiated in some districts.

The program will continue the principles and approaches in the VCDP in early health programs to ensure that the Program implements measures to cater indigenous peoples, such as:

- i. introducing local language in Behavior Change Communication (BCC) programs in areas with large population of indigenous people' or with linguistic minorities
- ii. use and retention of health providers who are local and with knowledge of local languages, where there are large populations of indigenous people or linguistic minorities who do not speak Nepali as their mother tongue
- iii. incentives for recruitment of local bilingual women service providers where necessary (already in practice in some sub-sectors and districts)
- iv. enabling partnerships between Local Health Management Committees (LHMCs) and community groups representing indigenous groups and other existing local community groups who are working in other sectors such as farmers group, forest user groups, water user group, women support services and other Janajati upliftment groups
- v. providing incentives for public and private sector providers to engage in pro-poor practices
- vi. promoting activities, services and facilities by the disadvantaged group, household and communities so that in turn they may hold the system accountable and advocacy through the use of media to gain support from other branches of government and the public including social, political and religious leaders and organizations.
- vii. disaggregating Health Management Information System (HMIS) data by gender, caste, ethnicity and special needs to permit tracking of progress on inclusive health program objectives

5. Consultations and Information Disclosure

Extensive consultations were held with a wide range of sectors, academicians, NGOs donor agencies and civil societies, including representatives from the National Commissions for Dalits and Women and the Nepal Federation of Indigenous Nationalities in the field of health, language, development gender and social exclusion issues, which contributed to the development of the VCDP, the formulation of the Gender Equality And Social Inclusion Strategy as well as the public health investment programs to be financed under the proposed program.

During the preparation and implementation of the earlier health programs, there were extensive consultations and participation of members of community organizations representing socially excluded groups, indigenous people. Field visits to health facilities were conducted to assess different social inclusion issues related to access and delivery of health services to indigenous and dalit women, and adolescent populations. These have been assessed and have been taken into consideration in the design of the proposed program. This is particularly reflected in the formulation and adoption of the GESI Strategy for the public health sector.

6. Implementation

This framework will be implemented through implementation of the GESI Strategy. The GESI Strategy commits and details an institutional establishment at various levels to implement the GESI strategy. Separate units will be established to make sure there is consistent GESI input, including that of the IP considerations, into the detailed design of the health program on an annual basis. The GESI Unit will be established with qualified staff members, with an operating budget. The GESI strategy details the implementation setup at central, regional, district and community level, with detailed responsibilities. The proposed project will support the newly developed public health investment programs. This program will be further developed, on an annual basis, into annual investment programs in selected priority areas to increase the availability of essential services, ensuring increased access to services for the disadvantaged. GESI staff members at various levels will work with various program teams to make sure the GESI strategy and principles in this framework are integrated into various health programs.

7. Monitoring and Evaluation

The monitoring and evaluation of this framework will be integrated into the monitoring and evaluation system under the GESI strategy. The GESI Strategy describes in detail its monitoring scope, establishments and methodologies. Information collected through this means is expected to be channeled through communication strategy aimed to inform beneficiaries of their rights and obligations and monitor the implementation of this framework and GESI Strategy.

8. Budget

Along the with commitment on separate units for GESI at central and local levels, the Ministry of Health and Population has also committed to set aside separate budget to facilitate detailed programming and implementation of the GESI strategies, including IP considerations.

Highlights of Key Priority Areas under Additional Financing

Additional financing seeks to achieve i) enhanced availability of and access to essential health care services supported by expanded activities in Public Private Partnerships, Human Resources management, and logistics, and ii) rapid progress on key stewardship functions such as monitoring and evaluation, accountability and transparency. The eight output areas will continue to be financed and monitored as originally planned. Some highlights of key priority areas under additional financing include,

Essential health care services interventions presently implemented in selected districts will be scaled up and its service delivery strengthened. These include, community-based integrated management of childhood illnesses, obstetric care, and the prevention and treatment of uterine prolapsed, neonatal health plan, addressing child malnutrition, control of Japanese Encephalitis, and response to HIV/AIDS

The use of essential services by the disadvantaged will be improved through removal of user fees, introduction of the Safe Delivery Incentives Program, and incentives to increase institutional deliveries and health professional attendance. Implementation and Monitoring of these policies will be strengthened to ensure that they translate into increased access for and service use by the poor and socially excluded groups. This includes additional output level indicators to assess implementation and progress on program development objectives to monitor reach to the bottom quintile of the population.

Public Private Partnerships to improve substantially to improve the availability, quality and access to health service in Nepal. Additional financing seeks to specifically promote these partnerships through contracting private sector and NGO providers.

Monitoring and Evaluation will be improved through the use of additional service delivery surveys as well as activities laid out in the governance and accountability action plan.

Building on the agenda above, the MOHP will elaborate the NHSP investment program in consultation with stakeholders.