

Gender Equality and Social Inclusion Policies: Considerations in Health Sectors in Nepal

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Abstract

This article tries to highlight the existing gender equality and social inclusion GESI policies and practices in health sectors in Nepal. Nepal has participated and ratified the gender policies in all Conventions and Conferences. To fulfill this very obligation, it has introduced some legal provisions and made an attempt to implement them. Due to this region, Nepal has started to address the gender issues in health sectors from Interim Constitution 2007AD addresses health as a fundamental right and that have very citizen shall have the right to basic health services free of cost from the state, as provided in law. Ninth, Tenth and Three-Year Interim Plan have pursued gender equality and women's empowerment through a gender mainstreaming strategy. The governance framework, fundamental rights and directives of the constitution provide the impetus for revising the 2009 Gender Equality and Social Inclusion (GESI) Strategy of the Health Sector and to align the strategy with the new governance arrangements and state obligations. The institutional structure to lead and coordinate the mainstreaming of GESI into the health system was created in 2012. The Health Sector Gender Equality and Social Inclusion Strategy (2010) provides the foundation for mainstreaming GESI, ensuring that policy development and programme planning are viewed through a create a favourable environment for the use of rights based approaches and more equitable access to healthcare. Implementation of the strategy is guided by the GESI Operational Guidelines (2013). Constitution of Nepal 2015 AD has also considered the rights of women as the right to receive special opportunities based on positive discrimination in education, health, employment, and social security. The Sustainable Development Goals by 2030 and the Nepal Health Sector Strategy (2015-2020) embrace the importance of gender equality, and leaving no one behind to achieve health goals.

Key Words: Gender equality, international policy, national policy, periodic plans

Introduction

Gender equality and social inclusion is one of the recurring agenda in the present policy context of Nepal where Nepal aims to consolidate its preparedness to end discrimination between men and women in Nepalese societies. Gender equality and social inclusion mainstreaming is the process whereby barriers and issues faced by women, poor and excluded people are identified and addressed in all functional areas of the health system: policies, institutional systems, work environment and culture, programme and budget formulation, service delivery, monitoring and evaluation, and research. It also involves

evaluation of the institutional capacity to mainstream GESI, the responsiveness and work environment of health agencies to be gender equal and socially inclusive (GON, 2009).

This revised Gender Equality and Social Inclusion Strategy for the Health Sector aims to guide the Government in fulfilling its obligations to provide universal coverage of basic health services, achieve equitable, quality and accountable health services, take a multi sectoral approach and uphold the fundamental right to equality, non-discrimination and social justice in reforming the health system.

A basic human right that was mentioned in the 1948 Universal Declaration of Human Rights was health. As with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR, 1966). The 1948 UDHR's Article 25 on health states that everyone has a right to a living standard sufficient for their health and well-being, with special consideration given to mothers and their children (OHCHR, 2008).

The right to health is mentioned in the Beijing Platform for Action (1995), the Programme of Action of the International Conference on Population and Development (1994), the Convention on the Rights of the Child (1989), and the Declaration of Alma Ata (1978). According to the WHO, everyone has the fundamental right to the best possible quality of health, irrespective of their caste, religion, political beliefs, or other characteristics (UN, 2010).

The [WHO] is in charge of the health component of human rights. The World Health Assembly has developed over 60 resolutions that address human rights on a range of WHO programs, including health development, women's health, reproductive health, child and adolescent health, nutrition, HIV/AIDS, tobacco, violence, mental health, essential medicines, health of indigenous peoples, and emergencies. States have reaffirmed their commitment to health as a human right on multiple occasions (Meier, 2017).

The first World Population Bucharest Conference in 1974 integrating family planning with the maternal and child health strongly emphasized while well come to changes in the overall strategy for promoting the welfare of women and children. The International Conference on Population and Development (1994) was particularly focused on women's reproductive health and rights. The Beijing Platform for Action has proposed actions toward five strategic objectives for women's health. Similarly, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) have committed to take appropriate measures to eliminate discrimination against women in health care (UN, 1995). The Millennium Development Goals (MDGs) adopted in 2000 addressed women's health in two of the eight goals. Where MDG5 focused on improving maternal health by reducing by three quarters, between 1990 and 2015, the maternal mortality ratio, MDG focused on combating HIV/AIDS, malaria and other diseases (www.un.org). The first five goals of the sustainable development goal (SDGs) have also focused on women's issues like hunger, food security, healthy life, education, and equality are linked to women's health (Government of Nepal, 2017).

Despite the dedicated Act Relating to Rights of Persons with Disabilities, 2017, there is room for improvement in terms of access to information, employment, equal recognition before the law, and sign language which is critical for accessible information.(GON,2021). Nepal has participated in the formulation of a variety of international human rights instruments which have an impact on children and women is a party to a number of them.

In the context of Nepal, a paradigm shift from women in development to gender and development was evident in the Ninth Five-Year Plan (1997–2002), the subsequent Tenth Five-Year Plan (2002–2007), and the Three-Year Interim Plan (2008–2011). These periodic plans have pursued gender equality and women’s empowerment through a gender mainstreaming strategy. Issues of social exclusion and discrimination against Dalits, Adivasi Janajatis, Muslims, and Madhesis have come to the forefront more recently, once the post-1990 democratic movement opened the space for public debate on Nepal’s ethnic groups. The 1991 health was addressed since 1991 National Health Policy although does not specify on meeting the needs of adolescents reproductive health, yet it gives stress on areas like safe motherhood, FP/ MCH and prevention of STDs, HIV/AIDS. The new strategy is consistent with the 1991 health policy and 1997-2017 second long term health plan (Pokhrel, 2008).

The government’s Three-Year Interim Plan (2007–2010) and the National Development Strategy (2009/10–2011/12) aim to redress these implementation gaps. Improved access to services for the excluded groups may be achievable within the time frame but the institutional and attitudinal changes that are needed will require more time. The Ministry of Local Development) have yet to make significant progress in developing and implementing policies, programs, and action plans to address the needs of Adivasi Janajatis (ADB, 2010).

As stated in the Social Security program's 2008–09 budget. When the elderly allowance was first implemented in 1994, it provided a monthly pension of NRe100 to all citizens who were 75 years of age or older. Later, this amount was raised to NRe200. In Nepal, the main social security initiatives include cash or in-kind transfers like food for work, scholarship programs, and social assistance programs (disabled, widowed, and elderly allowances). Among the Adivasi Janajatis are widows, single women (60 years of age and older), people living with full disabilities (NRe1,000 per month), and people with partial disabilities (16 years of age and older; NRe300 per month). Incentives of this kind helped improve the health of Nepali women (World Bank, 2009).

The health status of women varies across nations and for various reasons within each nation. Although various health development policies and plans incorporate the idea of a human rights-based approach, the Nepali health system still faces numerous obstacles in realizing health as a human right. The Nepalese Constitution of 2072 has taken into account women's rights, including the right to employment, social security, health care, and special opportunities based on positive discrimination. Because of this, women's health varies between nations and within nations for various reasons (Nepali Constitution, 2072).

Holistic nutrition programs that take into account the whole life cycle, safe motherhood, family planning, HIV/AIDS, and other STDs, among other things. Enhancing the availability of high-quality RH services in Nepal has been prioritized by the National Health Policy (1991) and the Second Long Term Health Plan (1997–2017). In order to provide integrated reproductive health services, a National Reproductive Health Strategy was created in 1998.

A National Reproductive Health Strategy was created in 1998 to offer comprehensive reproductive health care. However, there is a lack of essential drugs at public health facilities, an uneven distribution of the health workforce and facilities, poorly regulated private service providers, insufficient government spending on health, inadequate infrastructure for providing healthcare, and a low rate of provider retention in Nepal's rural areas (NPC, 2018).

Objectives

The overall objective of this study is to review the international and national policies and practices regarding gender and social inclusion on health mainstreaming agenda. The specific objectives of this study are to review the policy acts and conventions at international level and to examine the major gender laws and policies enacted by periodic plans and long term health plan and the constitution of Nepal.

Methods

This study primarily builds upon desk reviews of policy acts, United Nation Conventions, WHO Journal papers and articles. The desk review follows the major discourses a review of relevant health and social policies, analysis of secondary data related to health sector performance and trends in health outcomes, that influence the gender mainstreaming and health agenda in the form of statements in policy documents, women's movements, constitutions, laws and press materials, captured through existing research.

History of Gender Reform in Nepal

The history of the women's movement in Nepal begins in 1814, during the Nalapani War, when women fought against British imperialism. In an effort to suppress and control the "sati pratha," Jung Bahadur Rana created a set of regulations in the 1850s in Nepal, which is gender reforms first began to take place. Although Rana put in place a number of measures to deter "sati" and was thought to have been successful in stopping his brothers' wives from engaging in it, after his death, his own wives engaged in sati. Although the Sati has been outlawed for a long time, Nepal still has a lot of other discriminatory practices against women (Giri, 2012).

Women are continue struggled in various movements like Women marched shoulder to shoulder with men in the civil right movement of 1948. Women took active part in the democratic revolution of 1951 which overthrew the 104 year autocracy of the Rana family. The first women organization the "Nepal Women Association" was established in 1948, it worked to inculcate political awareness among women. Through grass-roots

mobilization, women's nongovernmental organizations (NGOs) have emerged as dynamic institutions working against deeply ingrained gender inequities to address violence over the last three decades. The 1990 also witnessed intensified campaigns in the international arena for women's rights. The 1995 Beijing conferences and CEDAW that led new environment, many women's rights groups emerged and could network with national and international organizations with similar goals (Giri, 2012).

The constitution of Nepal enshrines women's rights as fundamental rights. Crucial accomplishments for the empowerment of women in Nepal include the rights to reproductive health, equality of pay, safe maternity, property ownership, education, and social security. According to Nepal's 2007 Interim Constitution, everyone has the legal right to receive basic healthcare services from the government at no cost to them. Health is also recognized as a fundamental right. In addition, it has been said that one of the duties of the state is to implement a policy that guarantees the right to health for all citizens. The framework for the launch of Nepal's free health care program has been established by the constitution. In order to lessen disparities in access to, use of, and health outcomes from health services, Nepal later eliminated user fees on primary health care services (NPC, 2018).

Social exclusion is determined by a number of factors, including: gender-based, caste, ethnicity and religion-based, poverty-based, geography and location, disability including physical and mental illness, age-related vulnerability that children, adolescents and the elderly face, and disaster affected areas. These determinants intersect and create multiple layers of vulnerability and risk that are amplified when they come together (ADB, 2010).

In response to evidence of notable and enduring health disparities in Nepal and the Interim Constitution (BS 2063, AD 2006)'s guarantee of every citizen's right to free essential medical care, the Gender Equality and Social Inclusion (GESI) strategy was created. The strategy is centered around three goals and adopts a rights-based approach: (i) to design policies, plans, and programs that will facilitate the mainstreaming of GESI in the health sector (ii) to build the capacity of health providers and ensure equal access to and use of health services by the poor, vulnerable and marginalised castes and ethnic groups; (iii) and improve the health seeking behaviour of the poor, vulnerable and marginalised populations so they can obtain health services based on their rights (GON,2009).

Health Policies on Women Issues in Nepal

The Millennium Development Goals (MDGs) MDG goal 4 and goal 5 aimed to cut the under-five mortality rate by two thirds and half respectively by 2015 and 1990 respectively, by increasing attention to and funding for maternal and child health programs. Immunization rates and the Safe Delivery Incentive Programme were raised—which subsequently became the Aama Surakshya Programme or Safe Motherhood Programme—offered all mothers free deliveries. Additionally, there were financial incentives for attending four scheduled antenatal care (ANC) check-ups and for giving birth in a medical facility (MDG, 2005).

Safe Motherhood Policy, 1998

The Country Code (11th Amendment) Bill 2054 B.S. (1997 A.D.) was registered in the Parliament on 7 July 1997 (as a government Bill). The 11th Amendment Bill incorporated various rights related to women including the legalization of conditional abortion. The Bill provided for three different instances in which abortion would be allowed, namely, (1) freedom to abort within the first 12 week, with the permission of husband if the woman is married, (2) freedom to abort up until 18th week of pregnancy if the pregnancy is a result of rape or incest, and (3) freedom to abort at any time if in the absence of it the woman's life could be endangered, or harm her physical or mental health or if she is likely to give birth to a deformed baby (CREHPA, 2006). The Bill that was presented to the House of Representatives on 11/8/1997 had passed through several stages before it lapsed as a result of the dissolution of the House of Representatives on 15/1/1999. The government reintroduced the Bill to the House on 20/9/1999, within a few months of the General Elections in 1999. Amendments to the bill was made when the bill was presented to the Parliament for the second time that proposed, among other things, to make abortion the sole right of the pregnant women and on her own free consent (without the consent of the others) (FWLD, 2003).

Improving maternity care services, including family planning, at all levels of the Health Care Delivery System, including the community, will be the focus in the upcoming years under the auspices of PHC's Safe Motherhood program. HMG/N's Safe Motherhood Policy (NMIS) for Nepal Multiple Indicator Surveillance In order to generate data helpful for planning at the national, district, community and household levels. The NMIS was created as an ongoing monitoring program.

The Ministry of Health and Population of the Government of Nepal initiated the Safer Motherhood Program in January 2009 with the goal of decreasing the financial burden and expanding access to safe delivery services. The program's main effect has been an increase in the percentage of births attended by trained medical professionals, which has gone from 19% in 2006 to 36% in 2011 and 50% in 2013. (7) The Ministry of Health's Social Security Program offers financial aid for the treatment of kidney issues, heart disease, cancer, Alzheimer's disease, and Parkinsonism (Khanal, 2014).

National Safe Abortion Policy (2002)

The National Abortion Policy (2002) and the Safe Abortion Service Procedure (2003) serve as guidelines for the nation's abortion law implementation. The focal point and primary coordinating body for the nation's implementation of the safe abortion program is the Family Health Division, which is part of the Department of Health Services, Ministry of Health and Population (FHD/DHS/MoHP). The Director General of the Department of Health Services chairs the National Safe Abortion Advisory Committee, which provided guidance to the government on reforming abortion policies and reviews the status of the implementation of abortion laws.

In February 2002, the Abortion Task Force (ATF) was formed by the Family Health Division (FHD), of the Department of Health Services (DHS) to plan and implement the steps to move from legalization to action. The ATF assisted the FHD/DHS in drafting and finalizing the policy guidance and the safe abortion procedural order.

A fundamental national legal document that describes it as an offense against life. If found guilty of abortion, a woman could spend up to three years in jail. A vague clause exempts punishment for abortions carried out for "welfare," but there is no clear exception to the rule permitting abortions when a woman's life is in danger. The early 1990s saw the rise of a women's movement in Nepal which coincided with awareness of the disastrous public health effects of the abortion ban (CREHPA, 2006).

Awareness of the devastating public health effects of the abortion ban, coinciding with the emergence of a women's movement in Nepal in the early 1990s, led to a series of efforts to reform the abortion law. The most recent legislative effort to reform the law is the Muluki Ain 11th Amendment Bill, 1997 (11th Amendment Bill), which proposes to amend all gender discriminatory laws in the Country Code, including the prohibition on abortion. Rejected by the National Assembly because of a disagreement over provisions relating to women's inheritance rights, the bill is due to be reconsidered by the lower house during the next legislative session and if re-approved will become law (FWLD, 2002). Abortion was equated with infanticide and with other kinds of murder or homicide and many women were routinely thrown into prison for having abortions and many died from unsafe abortion procedures. Women who sought abortions did so clandestinely with the providers. Safe abortion care is integrated in safe motherhood program of Nepal to make it more accessible and acceptable. Safe abortion service is scaled up in all the districts up to primary health care center level (CREHPA, 2006).

National Nutrition Policy, 2004 is another milestone for health promotion in Nepal. Every human being has the fundamental right to a healthy diet. One of the main responsibilities of the government is to improve people's nutritional status, which is crucial to raising people's quality of life and health. The National Nutrition Policy spelled out in detail how the biggest risk factors influencing people's health and disease status are underweight mothers and children. The Nepali government implemented a number of initiatives to lessen nutritional problems. The foundation of nutrition policy and guiding principles were described; these are crucial and necessary for the development of nutrition programs as well as the execution of all nutrition-related activities (CREHPA, 2006).

In recent years, there has been growing concern on reproductive health issues. However, reproductive health is not a new programme, but rather a new approach which seeks to strengthen the existing safe motherhood, family planning, sexually transmitted diseases including HIV/AIDS, child survival and nutrition programmes with a holistic life cycle approach. The current National Health Policy (1991) and Second Long Term Health Plan (1997-2017) have duly emphasized on improving the access to quality RH services. In 1998, a National Reproductive Health Strategy was developed for providing integrated reproductive health services (Bist, 2015).

Health Sector Strategy (2015-2020).

The objectives of the Health Sector Strategy (2015-2020) and the Sustainable Development Goals. This entails making sure that groups who have been marginalized or disadvantaged—such as those with disabilities—have access to high-quality healthcare; advancing women's empowerment and gender equality in the health sector, including supporting survivors of gender-based violence and promoting gender equality in the workplace; and institutionalizing gender equality and social inclusion into the reform of health systems (MoHP, 2018).

Nepal Demographic and Health Survey, 2016 (NDHS, 2016)

The NDHS 2016, findings on wealth-based disparities in health outcomes highlight the persistent obstacles that the poor and extremely poor encounter when trying to obtain healthcare, as well as the extra dangers they must take to maintain their health and well-being. Poverty increases the risk of poor health for certain populations and interacts with other factors that contribute to exclusion such as gender, geography, and disability. Trend information on important reproductive, maternal, and child health indicators is provided by the Nepal Demographic and Health Survey (NDHS) series. Additionally, data from NDHSs is broken down by geographic area, child sex, mother's education, economic status, and, for more recent surveys, major caste, ethnic group, and religion (NDHS, 2016).

Although they are still uneven, institutional delivery rates by major caste, ethnic group, and religion have greatly improved since 2006. *Dalits* continue to have the lowest institutional delivery rate, albeit with a narrower gap than in 2006. Such proof demonstrates the justification for the Constitution's affirmative action clauses for *Dalits*.

In Nepal, as in many other countries, there are well-documented geographic disparities in health and nutrition outcomes. Although the exact indicators vary, remote areas tend to perform worse than more accessible areas. According to NDHS 2016 data, child stunting varies by province and is more common in mountainous regions than in Terai or hilly areas. There was no discernible variation in children's nutritional status based on gender.

When it comes to childhood vaccinations, there is also regional variation in the use of health services. In general routine vaccinations are a highly accessible health service that are in high demand and reasonably simple to administer. The Terai region experiences more violence against women than the Hills or Mountains. Human rights are violated, violence against women undermines the priority given to it in the Constitution and it has a negative impact on one's own, one's family's and the nation's health (NDHS, 2016).

Nepalese Government's Periodic Plan and Policies on Gender and Health Issues

The gender-related laws and policies of the Nepalese government date back to its first five-year plan (1956–1961). However, at that time, the state's policy regarding women was developed using a "welfare approach" that prioritized women's reproductive roles as mothers and homemakers. The Ministry of Health and the Family Planning Association of

Nepal were founded in 1956 as part of the first five-year plan. The first maternal hospital was built in 1959, and Nepal produced nurses for the country's female health sector (Dulal, 2020).

Second three year plan (2062-65) adopted the concept of family planning was accepted in policy level. The Nepal family planning and maternal-child health board was established in 1968 as part of the third five-year plan (2065–70) and was housed under the Ministry of Health. Another semi-autonomous organization under the Ministry of Health was established in 1968: the Nepal Family Planning and Maternal and Child Health Board. Since then, reducing fertility has continued to be a common theme in all of Nepal's population-related policies and initiatives (Bista, 2015).

Fourth five year plan(1970-75) adopted also recommended the implementation of vital registration system, entry permits, promotion of female education, intensive family planning programmes in high population density districts.

The Fifth Plan (1975-80) adopted the major to reduce CBR through basic development and reforms in social, economic, cultural and educational aspects as well as through family planning and maternal child health programmes. During the fifth plan period, vital registration system was introduced in some districts. Permanent methods of family planning were officially promoted as cost-effective methods requiring minimum follow-up and supervision. Mobile camps for sterilization became a popular approach for delivering family planning services in the country (NPC, 2018).

The Sixth Plan (1980-85) adopted to make available family planning services to high fertility rural areas with the aim of:

Promote permanent methods of family planning instead of the temporary methods. The target group will be married women in the age range of 20 to 39years. In areas with a high population density, intensive family planning programs will be introduced. Highlight the initiatives that support women's advancement in the workforce in education, and in status. Organize NGOs, class associations and local government bodies for all population and fertility reduction initiatives (CREHPA, 2006).

The Seventh Plan (1985-90) plan took a long term perspective on population growth and set targets with respect to fertility and population growth rates. Secondly, it became clear that population concerns needed to be taken into account during the development phase. Thirdly, it stressed the significance of improving women's standing in terms of influencing fertility practices. To increase access to family planning services and address the underserved need for them. Heightened a greater focus on women's work and education is anticipated to spread the notion that small families are the norm, which will then affect fertility patterns. There were distinct chapters on women's development and child development in the seventh plan document. Raising women's social and economic status was the goal of increasing their involvement in development. Implementing a maternity and child health program as a priority was one of the policies in this context (NPC, 2018).

The Eighth Plan (1992-97) this was the first plan after the restoration of democracy in Nepal. The national population policy's long-term health plan aimed to limit each couple's desire for only two children by fostering the development of small family size norms through socioeconomic incentives. Population-related issues were also covered in the eighth plan document's sections on women in development, family planning and health. One could argue that the government's promise to advance population policies, programs and practices in an integrated manner made in the 1994 ICPD was fulfilled in 1995 with the establishment of the Ministry of Population and Environment (MoPE) (Bist,2015).

The Ninth Plan (1997-2002) was developed in the perspective of a 20 years long term plan. This plan's primary goal was to reduce poverty in order to hasten the nation's economic growth. Reducing the overall fertility rate to replacement levels within the next 20 years was the ninth plan's long-term goal. The plan's immediate goals were to: • Encourage couples to have two children. Delivering high-quality services while raising public awareness of the significance of prenatal and postnatal care in lowering infant and maternal mortality (MOHP, 2018).

- Enhancing safe motherhood and breast feeding.

To provide preventive and curative health services for reducing child and maternal mortality in rural areas.

- To conduct informational and educational programmes concerning various aspects of population management as well as safe motherhood, family planning and additional programmes which encourage control in the prevention of AIDS and diseases concerning reproductive and venereal diseases.

.To undertake special programmes for social security and welfare of elderly population.

Intensifying the awareness regarding the benefits of small family.

The Tenth Plan (2002-2007)

The tenth plan's main goal has been to reduce poverty by accelerating broad-based economic growth, ensuring social inclusion and providing the poor and disadvantaged with equitable access to resources and social and economic infrastructure. One of the three primary causes of poverty according to the Tenth Plan, is social exclusion. It also serves as the primary cause of disadvantage for women, people living in remote areas, and members of specific castes and ethnic groups. To involve individuals in development initiatives by creating small, high-quality families. Breastfeeding, delaying marriage, and having easy access to reproductive health services will all be promoted (ADB, 2009).

Three years Interim Plan (2007/08-2009/10)

FHD was able to concentrate on expanding critical services to primary health care centers, health posts, and sub-health posts (including outreach clinics) which are more accessible to low-income women living in remote areas, thanks to the creation and implementation of the Remote Area Guidelines for Safe Motherhood (2009). Priority programs for lowering maternal mortality include family planning, skilled birth attendance, antenatal care (four

visits), and CEONC (including safe blood). However, in remote hill and mountain areas of Nepal, women's health providers report low availability and uptake of these essential services (FHD, 2013).

Three years interim plan (2010/11-2012/13)

The FHD 2013/14 business plan commits to a special focus on poor, marginalised and vulnerable populations to improve the health status and quality of life of the population. Almost 75% of the total budget was allocated for district spending over the last three years, which is encouraging. However, localised management of resources to enable targeting of needy groups based on local knowledge in keeping with GESI principles is limited by the fact that programme amounts are set by the centre, with the districts only permitted to spend within the ceilings for each programme.

Major strategies specifically targeting women and excluded groups are: increasing the accessibility and availability of family planning services for remote and excluded populations; expanding and strengthening outreach services; referral funding for remote areas; and strengthening of community based programming, including distribution of misoprostol through FCHVs to prevent postpartum hemorrhage (FHD, 2013).

The second phase of the Nepal Health Sector Programme (NHSP-2) runs from 2010 to 2015, with the goal of improving the health status of the people of Nepal, especially women, the poor and excluded. Technical assistance to NHSP-2 is provided on behalf of a pool of external development partners (DFID, World Bank, AusAID) through the NHSSP, which is funded by DFID and implemented by Options Consultancy Services Ltd and its consortium partners (MOHP, 2013).

The three-year interim plan (2013–14–2015–16) improved the health services system for a healthy life, integrated gender equality and social equity and developed sex and reproductive health, family planning services as a right-based approach among other things. Ensuring that vulnerable, impoverished and marginalized communities have access to state-provided health services is one of the policy's guiding principles; it is founded on social justice and equality (MOHP, 2018).

14th Three Years Plan (2016/2017- 2018/2019) – Approach paper, where the estimated investment by private sector in transport and communication and other sectoral representative of the public and private sectors, as well as civil society and development, health, education, water and sanitation, the Sector wide Approach yielded better results.

Other objectives include introducing reforms in the economic and social sectors, ensuring sound and accountable public finance, delivering quality public services in a transparent manner and promoting good governance by protecting and promoting human rights. Moreover, focus has been laid on cross-cutting issues such as gender equality, inclusive society, environmental protection and capacity development of different institutions (The Kathmandu Post, 2017).

The 15th five-year plan (2019–20–23–24) was centered on the following: addressing the health needs of the population across all age groups using a life cycle approach, with a greater emphasis on maternal and child health; increasing provincial and local investment in the health sector.

The Gender Equality Policy (2077), which was created under the direction of the Ministry of Women, Children, and Senior Citizens (MoWCSC), has received the endorsement of the Nepalese government. The Policy places a high priority on the eradication of harmful practices and gender-based violence, as well as the economic empowerment of women and their meaningful participation in all spheres of society (GESI, 2021).

The Social Inclusion Policy, which (MoFAGA) led in its drafted and have gone through the Parliament's endorsement process. With the help of development benefits and existing mechanisms the draft policy seeks to empower marginalized and excluded populations. The legal foundation for guaranteeing a secure workplace for everyone is provided by the Sexual Harassment at Workplace Prevention Act, 2017. The government of Nepal made a crucial step in 2007–08 by integrating the principles of gender responsive budgeting into the budget management information system (GON, 2021).

Conclusions

Nepal has participated and ratified the all conventions and conferees. Thus, Nepal has addressed the gender issues in health sectors from first five year plan. Social exclusion is determined by a number of factors, including: gender-based, caste, ethnicity and religion-based, poverty-based, geography and location, disability including physical and mental illness, age-related vulnerability that children, adolescents and the elderly face, and disaster affected areas. These determinants intersect and create multiple layers of vulnerability and risk that are amplified when they come together.

The Constitution of Nepal guarantees every citizen the right to equality, social justice and freedom from social discrimination. It includes the fundamental right to free basic health services from the state and equal access to health services. The Constitution identifies specific disadvantaged groups that have the right to participate in the functioning of the state and equal access to public services, including people with disability. It promotes the rights of women, protects them from violence, and offers women, the economically poor and endangered communities' special benefits in health and other social sectors; and includes a policy directive to priorities backward regions.

The GESI Strategy for the Health Sector, 2009 has made a significant contribution to the progress made in improving the responsiveness of the health sector to gender equality and social inclusion at the policy level. Policy-level commitment to GESI has been raised as shown by the integral attention to gender and social inclusion in the Health Policy 2014, and Health Sector Strategy 2015-2020. The high-level national political commitment to GESI means that stronger emphasis is placed on ensuring GESI is given due attention during the development of new policies and strategies across the sector. The institutional

structure to lead and coordinate the mainstreaming of GESI into the health system was created in 2012.

Gaps in the availability of basic health services and disparities in the utilisation of health services by income groups, caste/ethnic/religious groups and geographical areas including GESI, the health sector will not be able to realize the health goals of the constitution. Thus in recognizing the poor, vulnerable, marginalized castes and ethnic groups, the physically and mentally disabled, including women, children and senior citizens as target groups and to provide services to this segment of the population, it has been deemed necessary to develop a GESI-specific strategy. In some situations, targeted GESI interventions are necessary to empower vulnerable and excluded populations to realise their right to health, overcome barriers to accessing quality services and hold providers accountable.

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