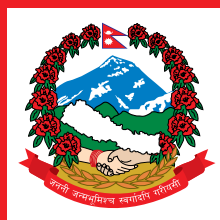# Progress of the Health Sector in FY 2017/18

NATIONAL ANNUAL REVIEW REPORT – 2018 (2075 BS)

Government of Nepal
Ministry of Health and Population
Kathmandu

December 2018

Table of Contents

Abbreviations

AA	Anaesthetic Assistant
AMR	Anti-Microbial Resistance
ANC	Antenatal Care
ANM	Auxillary Nurse Midwife
APP	Annual Procurement Plan
ART	Anti-Retroviral Treatment
AWPB	Annual Work Planning and Budgeting
BHCS	Basic Health Care Services
BMI	Body Mass Index
BOR	Bid Opening Report
BPKIH	B.P. Koirala Institute of Health
BS	Bikram Sambat
CAPP	Consolidated Annual Procurement Plan
CAPP-MC	Consolidated Annual Procurement Plan-Monitoring Committee
CBS	Central Bureau of Statistics
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	Child Health Division
CHE	Current Health Expenditure
CHU	Community Health Unit
CMS	Contract Management System
CMU	Contract Management Unit
CPR	Contraceptive Prevalence Rate
CS	Caesarean Section
CSD	Curative Services Division
CTEVT	Council for Technical Education and Vocational Training
DC	Delivery Care
DFID	Department for International Development
DG	Director General
DHO	District Health Office
DLI	Disbursement Linked Indicators
DoA	Department of Ayurveda
DoHS	Department of Health Services
DPHO	District Public Health Office
DRR	Disaster Risk Reduction
DUDBC	Department of Urban Development and Building Construction
EDCD	Epidemiology and Disease Control Division
EDL	Essential Drugs List
EDP	External Development Partners
e-GP	Electronic Government Procurement
e-LMIS	Electronic Logistics Management Information System
FCHV	Female Community Health Volunteer

FED	Free Essential Drugs
FHD	Family Health Division
FMIS	Financial Management Information System
fIPV	Fractional Dose of Injectable Polio Virus
FMR	Financial Management Review
FP	Family Planning
FY	Financial Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HEOC	Health Emergency Operation Centre
HFOMC	Health Facility Operation and Management Committee
HFS	Health Financing Strategy
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
HURIC	Human Resource Information Centre
ICB	International Competitive Bidding
ICT	Information and Communication Technology
IEC	Information, Education, and Communication
IHIDP	Integrated Health Infrastructure Development Project
IHME	Institute for Health Metrics and Evaluation
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Childhood Illness
IMS	Inventory Management System
IoM	Institute of Medicine
IP	Implementation Plan
JAR	Joint Annual Review
JCM	Joint Consultative Meetings
JICA	Japan International Corporation Agency
KAHS	Karnali Academy of Health Science
KfW	German Development Bank
LCD	Leprosy Control Division
LG	Local Government
LMBIS	Line Ministry Budgetary Information System
LMD	Logistics Management Division
LMIS	Logistics Management Information System
LNOB	Leaving No-One Behind
MDGP	Master's Degree in General Practice
M&E	Monitoring and Evaluation
mhGAP	Mental Health Gap Action Programme
MMR	Maternal Mortality Ratio

MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MPP	Master Procurement Plan
MTR	Mid-Term Review
NA	Not Available
NAMS	National Academy of Medical Sciences
NCB	National Competitive Bidding
NCD	Non-Communicable Diseases
NDHS	Nepal Demographic and Health Survey
NHIDS	National Health Infrastructure Development Standards
NHFS	Nepal Health Facility Survey
NHP	National Health Policy
NHRC	Nepal Health Research Council
NHSS	Nepal Health Sector Strategy (2015-2020)
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NLSS	Nepal Living Standards Survey
NMC	Nepal Medical Council
NMICS	Nepal Multiple Indicator Cluster Survey
NNC	Nepal Nursing Council
NNMSS	Nepal National Micronutrient Status Survey
NPR	Nepalese Rupees
O&M	Organisation and Management
OAG	Office of the Auditor General
OCMC	One-Stop Crisis Management Centres
OOPE	Out of Pocket Expenditure
OPMCM	Office of the Prime Minister and Council of Ministers
ORS	Oral Rehydration Solution
OT	Operation Theatre
PAS	Procurement Audit System
PBO	Public Bid Opening
PCL	Proficiency Certificate Level
PEN	Package of Essential Non-Communicable
PFM	Public Financial Management
PG	Provincial Government
PHCC	Primary Health Care Centre
PHCRD	Primary Health Care Revitalisation Division
PHS	Public Health Service
PIP	Procurement Improvement Plan
PNC	Postnatal Care
PPA	Public Procurement Authority
PPFM	Procurement and Public Financial Management
PPICD	Policy, Planning and International Cooperation Division
PPMO	Public Procurement Monitoring Office

PPR	Public Procurement Regulations
PRA	Procurement Risk Analysis
PTSD	Post-Traumatic Stress Disorder
QAP	Quality Assurance Plan
RDQA	Routine Data Quality Assessment
RF	Results Framework
RMP	Risk Mitigation Plan
RRT	Rapid Response Team
SBA	Skilled Birth Attendant
SBD	Standard Bid Document
SC	Steering Committee
SD	Standard Deviation
SDG	Sustainable Development Goals
SHI	Social Health Insurance
SOP	Standard Operating Procedures
SSU	Social Service Units
SWAp	Sector-Wide Approach
TABUCS	Transaction Accounting and Budget Control System
TB	Tuberculosis
ToR	Terms of Reference
ToT	Training of Trainers
TSB	Technical Specification Bank
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USD	United States' Dollar
VfM	Value for Money
WHO	World Health Organization

Executive Summary

The Nepal Health Sector Strategy (NHSS) was developed in 2015 by the Ministry of Health and Population (MoHP) to guide the health sector for the next five years (2016-2020). It was developed against a background of a unitary system of government. The vision of the NHSS is "All Nepali citizens have productive and quality lives with highest level of physical, mental, social, and emotional health" and the mission "Ensure citizen's fundamental rights to stay healthy by utilising available resources optimally and through strategic cooperation between service providers, service users, and other stakeholders." It foresees nine outcomes and 26 outputs. They are measured through 29 outcome level indicators with 56 corresponding output level indicators. This report summarises the activities carried out in the health sector financial year (FY) 2017/18 against the outcomes mentioned in the NHSS along with existing challenges and the ways forward.

As the country has imparted on federalism, multiple changes in the governance system have been observed which have implications for the implementation of the NHSS. The constitution has defined three levels of governance and functions, with local levels mandated to deliver the package of basic health services. The development of standards and policies, management of hospitals, regulation of medicines, addressing outbreaks and disasters, and international cooperation will remain with the federal and provincial governments. The federal government will also play a supporting role in enhancing the capacity of local and provincial government.

Major impacting factors for the NHSS at the national level are:
- Three levels of governance: federal, provincial, and local
- Assignments which define the responsibilities of the federal, provincial, and local levels
- Allocation of the health budget to provincial and local governments
- Allocation of health workers to the working area
- Various activities were needed to align with the new governance structure by the MoHP.

Major Achievements in FY 2017/2018[1]

MoHP carried out various activities in the fiscal year 2017/18. The majority of the activities were in continuity with the NHSS (2016-2021), but the annual work plan and budget process were changed due to the transition to the federalism. As a result, various activities have been shifted to the federal, provincial and local governments.

The following activities were the major achievements of FY 2017/2018
- Restructuring of Ministry of Health and Population and Department of Health Services.
- Establishment of Provincial Health Directorate and Provincial Health Offices.
- Three health related acts have been endorsed and are in action as follows:

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[1] Bikram Sambat 2074/75

- - Public Health Service Act
  - Safer Motherhood and Reproductive Health Act
  - Social Health Insurance Act
- The transition plan to manage federalism in health was developed together with external development partners (EDPs) and is being implemented.
- The MoHP was reorganised as per the new structure under federalism.
- The Basic Health Care Package has been defined.
- The Minimum Service Standards for Hospitals and Health Posts has been developed.
- The program implementation guideline for local levels was prepared and made available on the MoHP website.
- Dissemination of Nepal National Micro-Nutrient Survey 2016 was carried out.
- An interaction program with provinces was carried out by the MoHP to discuss on progress and challenges in the health sector in September 2018.
- Altogether 56 districts have been declared "Fully Immunized" out of 77 districts.
- Fractional dose of Injectable Polio Virus (fIPV) vaccine has been introduced in the National Immunization schedule.
- Of the total 32,747 ever reported HIV infected persons, 16,428 persons are on Anti-Retroviral Treatment (ART)
- As of November 2018, more than 1.5 million members have been enrolled in the Social Health Insurance program with 36 districts covered.
- All the Palikas have at least one birthing centre to provide delivery service.
- Procurement Improvement Plan (PIP) for FY 2016/17-2020/21 is prepared and has been endorsed. The Procurement and Public Financial Management (PPFM) committee at MoHP and Consolidated Annual Procurement Plan (CAPP) Monitoring Committee at departmental level is monitoring the progress of PIP implementation.
- Pre-bid and Post-bid information systems including technical specification bank (TSB), (electronic) logistics management information system (LMIS/e-LMIS), quality assurance plan (QAP), contract management system (CMS)s have been activated.
- Federal level CAPP prepared and endorsed.
- Two Standard Operating Procedures (SOPs) for procurement and electronic Government Procurement (e-GP) have been prepared, endorsed and distributed to local and provincial levels.
- Standardization of procurement process through new standard bid documents (SBD) for the health sector initiated and e-GP-II implemented in the bidding process.
- Internal Control Guidelines were revised and endorsed by MoHP in July, 2018.
- The financial management review (FMR) templates were revised and approved by MoHP on 16 May 2018 as a requirement of the Disbursement Linked Indicators (DLI).
- One-Stop Crisis Management Centres (OCMC) have been established, one in each of the forty-four districts.
- Total of thirty-two Social Service Units (SSUs) in referral hospitals have been established.
- Urban Health Centres expanded and Community Health Units operationalised in strategic locations across 77 districts.

- Social Audit has been implemented in 2,138 health facilities across 77 districts.
- Geriatric health services are available in eight referral hospitals.
- Development of the training manual based on the Standard Treatment Protocol for Prescribers and the Reference Manual.
- e-Reporting of the health management information system (HMIS) expanded to total 1200 health facilities.
- Health facility registry has been developed and made available on the MoHP website.
- A web-based routine data quality assessment (RDQA) tool and e-learning package have been developed and made available on the MoHP website.

Highlights of 2018/19

- Trachoma elimination achieved and certified by the World Health Organisation (WHO).
- Revision of a National Health Policy 2071.
- Development of regulations as per the Public Health Service Act 2018 has been initiated.
- Preparation of draft thematic paper for the health sector for the Five-Year National Periodic Development Plan.
- Development of the health sector paper for the 25-year Vision Paper.
- Organised the consultative meetings with the provincial officials.
- Provincial review of health activities has been conducted.
- Development of the program implementation guideline for local levels and uploaded in the MoHP website.
- A guideline for 'Health Sector M&E in Federal Context' has been developed.
- Development of Guideline for Effective Private Sector Engagement in Health has been initiated.
- A draft action plan on Antimicrobial Resistance (AMR) is being finalised.
- Development of final draft of Health Facility Operation and Management Committee (HFOMC) guideline.
- Development of Standard Treatment Protocols has been initiated.
- The Health Sector Gender Equality and Social Inclusion Strategy has been prepared and submitted to the Cabinet for approval.
- The guideline on budget markers for Leaving No-One Behind (LNOB) has been developed.
- Nepal has been able to control rubella and congenital rubella syndrome (CRS) by achieving more than 95% reduction in rubella incidence between 2008 and 2017 with international standard surveillance which was certified by SEA Regional commission.
- Establishment of Health Emergency Operations Centers (HEOC) in three provinces;
- Hospital Preparedness and Response Readiness strengthened including establishment of emergency medical logistics warehouses and finalization of contingency plans in an additional four hub hospitals.

1. Introduction

1.1 Background

The Nepal Health Sector Strategy (NHSS) was developed in 2015 to guide the country for the next five years in the health sector. The strategy explicitly states its ambition for the progressive expansion of health packages and services with continuous improvement in quality of care being delivered, making these services more affordable, and covering the larger population in need – especially the vulnerable and poor.

The NHSS focuses on universal health coverage with four strategic areas of direction: equitable access, quality health services, health systems reform, and a multi-sectoral approach. Towards this end, the NHSS has defined nine outcomes and 28 outputs which encapsulate the different components of the health system. In accordance with the NHSS, the Ministry of Health and Population (MoHP) has developed an Implementation Plan which provides a broad list of interventions to be implemented in the five-year period.

A Joint Annual Review (JAR) has been held every year since the implementation of the Nepal Health Sector Strategy (2004). This review is jointly organised by the MoHP and the External Development Partners (EDPs) to support the health sector. At the JAR meeting, the achievements of the last fiscal year are reviewed and major action points are identified for the next fiscal year. During the JAR, support from donors and other EDPs is also discussed. This is also supplemented by the signing of an "aide memoire", which directs more specific action points for the topics agreed on by the representatives at the JAR meeting. In this fiscal year (FY), the JAR and National Annual Review, which used to happen separately, are planned to be organized as a single event in a combined manner. The FY 2017/18 is the second implementation year of the NHSS 2015-2020.

This report mainly focuses on overall progress of the health sector and is intended to contribute to informed discussion and decision making in the annual review of the health sector. The report is developed in light of the outcomes, outputs and interventions as defined in the NHSS and in its Implementation Plan (IP) towards achieving the stated goals and objectives. Accordingly, major achievements made during FY 2017/18, highlights of FY 2018/19, existing challenges, and the ways forward are captured in this report. The report also presents progress made against NHSS indicators as defined in the results framework.

Nepal is experiencing swift transition towards federalism. Various laws have been enacted impacting on the health sector. Restructuring is still ongoing to comply with the spirit of the Constitution. The following overarching actions have been taken towards the implementation of federalism:

- Organization restructuring has been done for the health sector along with the overall governance structure.
- The Public Health Services Act and Safe Motherhood and Reproductive Health Rights Act have been enacted
- Grant allocation and revenue transfer mechanisms have been practiced to allocate resources to provinces and local level as per the constitutional provision in relation to overall fiscal management
- Provincial Annual Reviews of the health sector have been conducted as per the federal structure (local, provincial, and federal)

Nepal has embraced international commitments towards Sustainable Development Goals (SDG) and Universal Health Coverage (UHC) and is continuing to expedite activities.

1.2   Status of Key Actions of Last NAR

Table 1.1 summarises the status of key actions agreed in the last annual review (2016/17).

Table 1.1: Status of key actions agreed in the last annual review

SN	Heading	Agreed Actions	Current Status
Governance and accountability			
1	Health structure in line with functional analysis in federal context	▪ Finalise health sector structure with defined roles and responsibilities at all levels in consultation with concerned stakeholders	▪ Health sector structures at three levels of governance have been defined. ▪ Further revision is in progress
2	Safety and security of patient, health professionals and health institutions	▪ Security of patients and health workers should be provisioned in upcoming health service bill	▪ The Public Health Act has covered this ▪ National patient safety five year action plan draft prepared.
3	Transparency and accountability at all levels	▪ Maintain high level transparency and accountability at all levels using appropriate mechanisms i.e. social audit, public information sharing	▪ MoHP website is being upgraded to share information to the public and stakeholders ▪ Web-based grievance management system is in the process of development for prompt response to the public concerns ▪ Social audit guideline is in the process of revision
4	Decision making process: Pending File	▪ Establish File Tracking system to enhance timely decision making process	▪ File tracking system is in the process of development
5	Orientation to local government representatives	▪ Develop and implement orientation package in all local government	▪ Health system orientation package targeted to policy makers and programme managers has been developed and rolled out at all seven provinces and few local levels. ▪ The package will soon be revised based on the learning so far and published on

SN	Heading	Agreed Actions	Current Status
			the MoHP website for benefit of larger stakeholders and audience.
Service delivery and hospital management			
6	Basic health services	▪ Define free basic health care service package as per the Constitutional provision	▪ The Public Health Act has defined the BHCS areas ▪ Basic health care package has been defined and is in the endorsement process
7	Pharmacy management	▪ Establish and operate pharmacy at all PHCCs and public hospitals ▪ Implement generic prescriptions	▪ Pharmacies have been established in all public hospitals (except Manang and Chisapani) ▪ The Public Health Act has addressed the issues related to generic prescription
8	Professional councils	▪ Develop an Umbrella Act for all Councils ▪ Define functions and structures of Councils in Federal context	▪ Process of developing Umbrella Act has been initiated
9	Formation and role of HDC in the federal context	▪ Revise the formation guideline of HDC	▪ Previous HDCs were dissolved; provinces have initiated formation of new HDC
10	Ambulance services	▪ Review the policy considering 'one door approach' for distribution of Ambulance	▪ The draft new health policy covers this
11	Ayurveda and other traditional medicines	▪ Standardize Ayurveda and other traditional medicine and practices ▪ Explore possible mechanism for integration of Yoga in health facilities	▪ The revised health policy (draft) has prioritized promotion of Ayurveda, nature cure services and other traditional medicines and practices
12	Utilization of performance based grant management	▪ Review standards for the use of flexible grant and monitor regularly	▪ Standards for the use of flexible grant have been revised
Quality of care			
13	Quality of service	▪ Develop and implement minimum service standards for hospitals (above 50 beds), PHCC and HP and standard treatment protocols	▪ MSS for hospitals and HP developed ▪ MoHP has initiated the process of developing standard treatment protocol
14	Licensing, Accreditation and Quality Assurance of health Institutions	▪ Revise licensing and renewal provision for different types of health institution in federal context ▪ Develop and implement accreditation mechanisms	▪ A committee has been formed for the revision and development of accreditation mechanism
15	Quality lab services	▪ Establish/strengthen reference labs in each Province ▪ Standardize laboratory services at all levels, make lab functional in all PHCCs ▪ Provision of free blood transfusion services	▪ Cabinet has approved provincial reference laboratory in each province ▪ Process has been initiated for policy decision on free blood transfusion services ▪ Health laboratory establishment and regulation guideline endorsed
16	Management of emerging and re-	▪ Strengthen and expand prevention and care provision of NCDs and NTDs at all	▪ PEN package is being scaled up by Curative Division

SN	Heading	Agreed Actions	Current Status
	emerging diseases	levels ■ Strengthen public awareness on prevention and care	■ Curative Division and EDCD are strengthening and expanding the NCD programmes
Human resource management			
17	Staff *Samayojan* in Federal context	■ Develop position framework in consultation with health professionals representing all levels ■ Develop engagement strategy of national academic institutions to address human resource requirements	■ Health structures at the three levels of government have been defined; a committee is reviewing and recommending the structures ■ GoN has issued *Samayojan Act*
18	Continuation of short term contract staff	■ Sensitize, orient, motivate and facilitate Local Governments for timely recruitment of contract staff at local level and ensure uninterrupted service delivery	■ Local Governments are sensitized
19	FCHVs role in the federal context	■ Develop/revise FCHV mobilization framework in the federal context - define and guide	■ Authority of mobilizing FCHVs is now under the local levels
20	Procurement cadre in health sector	■ Assess need and develop dedicated professionals for procurement and supply chain in Health Sector	■ Overall O&M survey done, procurement specific need assessment has not been done. ■ For transition, training of procurement and supply chain management conducted at provincial and local level for development of dedicated professionals.
21	HR management (discrepancy in benefits) in autonomous, semi and fully government hospitals	■ Conduct a stock take exercise, identify gaps and best practices ■ Develop implementation framework based on the stock-take	■ HR master plan development process initiated
22	Availability of medical professional in remote areas	■ Develop/use appropriate mechanisms like MoU with medical colleges	■ Policy discussion initiated
23	Development of quality super specialized medical HR	■ Develop the concept of umbrella university for specialized/ super specialized medical sciences Design and implement one year fellowship course on super specialized medical studies like nephrology, cardiovascular surgery, organ transplant	■ Policy discussion initiated
24	Effective management of training programmes based on needs	■ Conduct assessment of existing training programmes ■ Develop professional trainers in specific disciplines ■ Revise training programmes in line with needs	■ Assessment not done ■ NHTC has revised its strategy in the changed context ■ Roster of professional trainers developed ■ Training programmes are being revised in the changed context

SN	Heading	Agreed Actions	Current Status
Procurement and supply chain management			
25	**'Who' procures 'what'?** Vaccines, RH commodities, ARV, anti-microbacterials, anti-rabies, anti-snake venoms etc.	▪ Define procurement of goods and services to be procured by different levels in changed context e.g. procurement of vaccine, RH commodities, ARV, anti-rabies and anti-snake venoms by center	▪ Vaccine, FP commodities, ARV, ASV, DEC are procured at federal level. ▪ Essential drugs and Nutrition related commodities are procured at Provincial and Local level.
26	Timely procurement and supply of quality assured drugs and equipment	▪ Technical facilitation for procurement and supply and pricing and periodic quality check at local levels ▪ Provision of adequate budget to local government on the basis of morbidity and population coverage	▪ Basic logistic and procurement training is conducted at provincial and local level.
27	Supply chain management of drugs and vaccines including cold chain management	▪ Revise guideline considering the federal structure ▪ Develop supply chain mapping in all local government level ▪ Federal/Province to District to Palika (Commodities other than Vaccines) ▪ Federal/Province to District to Health Facility (Vaccine)	▪ Procurement and supply chain handbook prepared and distributed.
28	Timely auction of goods	▪ Develop and implement SoP in federal context	▪ Guideline for auction developed, available in the website. ▪ Logistic and procurement training includes a session on auction management
Information management			
29	Paper based reporting system presenting delays and data quality issues	▪ Digitalization of all recording and reporting systems at Palika and below ▪ Gradual introduction of individualized health records in health facilities, i.e. Electronic Health Record (EHR) at facility level	▪ e-Reporting of HMIS has been expanded to over 1200 health facilities. ▪ All 753 local government will be capacitated for e-reporting of HMIS in the current fiscal year (2075/76) ▪ EHR has been implemented at three health facilities (Bayalpata Hospital, Charikot PHCC and Nuwakot Hospital) and generic modules of EHR have been developed for expansion at PHCCs and Health Posts. ▪ Online LMIS at district store in 75 districts. ▪ e-LMIS reporting system is functional in Province 5 and 6; 22 district stores, 30 health facilities and 4 municipalities.
30	Timely and complete reporting from all facilities	▪ Define and implement appropriate reporting mechanisms in the federal context with effective use of existing data platforms	▪ 'Monitoring and Evaluation in Federal Context, 2075', a guideline, defines the reporting mechanism and use of data at all three levels of government

SN	Heading	Agreed Actions	Current Status
			▪ Web-based dashboards for monitoring of progress on the NHSS RF indicators and equity in utilization of services using the routine and national level surveys (NDHS series and NHFS) have been developed and published on the MoHP website.
31	Effective use of evidence	▪ Determine data needs at different levels, ensure availability and use of quality assured information ▪ Enhance institutional capacity on operational research and routine surveillance ▪ Standardize data dissemination platforms at each level ▪ Institutionalize health facility based CRVS	▪ 'Monitoring and Evaluation in Federal Context, 2075', a guideline, addresses the data needs at all levels to report to the NHSS RF and SDGs. It also addresses the issues related to quality and use of the data. ▪ Web-based routine data quality assessment system and e-learning packages have been developed and published on the MoHP website. ▪ MoHP is coordinating with MoFAGA for strengthening of CRVS.
32	Fragmented surveillance system (disease control and public health interventions)	▪ Develop and implement integrated surveillance system for disease control ▪ Explore potentials for integrated public health surveillance mechanism	▪ Health facility registry with a unique ID to each facility has been developed. ▪ Integrated Health Information Management Section within the Management Division, DoHS, has initiated the process of integrating information systems including the public health surveillance systems.
Health infrastructure and equipment			
33	Inadequate storage capacity at province and local levels	▪ Construction of storage facilities in appropriate strategic location to address the need	▪ Store reconstruction budget allocated in federal level and Sudur Paschim Province.
34	Construction of health facilities, quality of work and sick projects	▪ Effective implementation of 'Integrated Health Infrastructure Development Plan' endorsed by Cabinet in 2074 ▪ Provide design and drawings to the provinces and local bodies ▪ Operationalize committees on Health Infrastructure Management at each level	▪ "Integrated health infrastructure development plan" disseminated. ▪ Yet to be operationalized and linked with HR and equipment
35	Timely completion of health facility construction and handover of health facilities to local government	▪ Develop a plan 'single door' for all new and existing health infrastructure related works in health ▪ Allocate adequate budget and complete all the on-going projects ▪ Review all 'sick projects' and address the needs ▪ Make joint monitoring and coordination at all levels functional	▪ Sufficient budget not received ▪ Sick project significantly reduced

SN	Heading	Agreed Actions	Current Status
		▪ Implement standard handover process	
36	Existence of Sub Health Posts in some districts	▪ Immediately upgrade all SHPs to HPs	▪ Sub health posts listed and upgrading process initiated
37	Lack of routine maintenance Plan/policy and management of health infrastructure and equipment	▪ Develop Physical Asset Management Policy (including maintenance) ▪ Operationalize the policy through a costed implementation strategy	▪ Technical working group formed and work initiated.
Financial management			
38	TABUCS Vs LMBIS	▪ Assess and explore possible compatibility features between these two data platforms in the federal structure ▪ Make appropriate decision on the use of a 'financial management system' – electronic platform	▪ Coordination and discussion initiated with MoF
39	Problem in budget release (development partners)	▪ Timely release of cash grant to FCGO.	▪ Coordination and follow up with FCGO is in progress
Health financing			
40	Challenges in providing free service to poor and needy patients	▪ Expand Social Service Units ▪ Develop practical criteria for identification of target group ▪ Provide sufficient budget for free care	▪ SSUs have been expanded from 32 to 37 ▪ OCMCs expanded from 44 to 55 ▪ Geriatric wards expanded from 8 to 12 hospitals
41	Identification of poor population for premium subsidy on health insurance	▪ Identify and define target population based on defined criteria ▪ Utilize allocated budget for premium subsidy	▪ Ultra-poor identified in 25 districts and 270,000 enrolled. ▪ Premium subsidized in 25 districts.
42	Scope and coverage of free basic health service and health insurance package	▪ Clearly define the packages of services covered by insurance and free basic health services ▪ Expand insurance service package in line with labor act	▪ Package defined and planned to update. ▪ Health insurance regulation is in the process of approval
Disaster preparedness and management			
43	▪ Preparedness for disaster mitigation in high risk zone ▪ Institutionalization of the lessons learned in the past	▪ Develop/Revise Disaster Risk Reduction (DRR) Plan based on vulnerability mapping at all levels ▪ Institutionalize emergency preparedness plan at Federal, Province and Local and make the plan fully operational ▪ Form a super specialized RRT at central and provincial level ▪ Establish Emergency Logistic Facilities in each province	▪ Pandemic Preparedness Plan is being prepared. ▪ Provincial level buffer stock, expert and academics pool are oriented. ▪ Interim guideline circulated for RRT formation and mobilization at provincial and local level. ▪ Fund allocated for RRT mobilization and orientation in province and local level ▪ For Super specialized RRT, Medical Colleges of different province were

SN	Heading	Agreed Actions	Current Status
		▪ Revise emergency procurement process ▪ Enhance Multi-sectoral collaboration (among government ministries, academic institutions, private sector, EDPs) ▪ Improve information management system during emergencies	coordinated for team preparation. ▪ Fund for emergency procurement allocated for each province and local level ▪ Malaria Disease Information System functional, Early Warning and Reporting System functional and planned for upgrade. ▪ Assigned team of people to contact for 24 hours for communication during emergencies. ▪ Regular situation updates and disseminate in emails, website.

1.3   Status of Aide Memoire

The JAR of FY 2016/17, conducted in January-February 2018, developed an aide memoire with a key action plan for the year and was jointly signed by the Secretary of Ministry of Health and Population and the Chairperson of the EDP's Forum. Table 1.2 shows the progress made towards the action points mentioned in the aide memoire.

Table 1.2: Achievement of 2018 Aide Memoire

SN	Heading	Agreed Actions	Current Status
1	Health in Federal Transition	A health transition plan will be developed by May 2018	Health transition plan was jointly developed, jointly agreed and approved by MoHP.
2	Basic Health Care Service	Basic Health Care Services will be defined by mid-July 2018	Basic Health Care Service package has been defined. The Public Health Service Act- 2075 has also defined with key elements of the basic health services included.
3	Annual Review	MoHP will organize a Joint Annual Review (JAR) in November following Provincial health review	It has been jointly agreed to hold the JAR on 17- 19 December 2018.
		The budget provision for the JAR to be included in the annual work planning and budgeting (AWPB)	Budget for the JAR has been allocated in the AWPB 2018/19.
4	Mid-Term Review Process	Terms of references (ToR) for the Mid-Term Review (MTR) of NHSS will be jointly developed by May 2018	ToR for the Mid-Term Review has been developed jointly.
		MTR of Nepal Health Sector Strategy (NHSS) report will	Task team has been formed and the process initiated for the review.

SN	Heading	Agreed Actions	Current Status
		be prepared by December 2018	9
5	Health Financing Strategy (HFS) for the health sector	Ministry of Health and Population will have a task force to develop a HFS by May 2018	A task force has been formed and ToR has been developed.
		Draft a technical paper on the HFS by March 2019	The task force is drafting the health financing strategy.
6	Human Resources for Health (HRH)	The HRH Strategic Roadmap will be updated by level by September 2018.	A draft of the HRH strategic roadmap has been developed focusing on human resources for health requirement. The MoHP is working on action plan of HRH strategic roadmap.
7	Procurement	A Joint Task Force on procurement will be formed by May 2018	The MoHP is working on the procurement issues continuously. A "Policy Forum" has been formed at the MoHP and the first meeting held to discuss the procurement issues. A technical working group has also been formed to address emerging policy issues including procurement. It is envisioned that this team will consult with stakeholders as relevant.
		The Task Force will develop an interim arrangement for procurement of drugs and medical goods by June 2018	A framework arrangement for procurement of medicines has been developed and agreed. It is in the phase of final discussion and endorsement by the Public Procurement Monitoring Office (PPMO).
8	Health Care Waste Management	Existing guidelines will be reviewed for development of regulations by August 2018	A pilot initiation has been undertaken in Sudur Paschim province for incineration and plastic management jointly by provincial government, GIZ, KfW, UNDP and WHO.

1. NHSS Results Framework

1.1   Overview of progress

The NHSS Results Framework defines major sectoral indicators and targets in accordance with the NHSS goal and outcomes. The Results Framework has 29 outcome level indicators to monitor the achievement of NHSS's nine outcomes. The NHSS has 2017 and 2020 targets for the indicators. Similarly, there are 56 output level indicators to monitor the 26 NHSS outputs with annual milestones and 2020 targets. The latest progress against each indicator of the NHSS Results Framework is available on the MoHP website (www.mohp.gov.np). This web-based application allows the compilation and analysis of indicators alongside the key interventions that contribute to achieving the outputs and outcomes.

Table 2.1 shows the ten goal level indicators with their baseline data and achievements against the defined milestones for 2018 and the targets for 2020.

Table 2.1: NHSS Results Framework goal level indicators

Code	Indicators	Baseline			Milestone	Achievement*		2020/21
		Data	Year	Source	2016/17	2018	Source	Target
G1	Maternal mortality ratio (per 100,000 live births)	190	2013	WHO	148	239	NDHS[2] 2016	125
G2	Under five mortality rate (per 1,000 live births)	38	2014	NMICS[3]	34	39	NDHS 2016	28
G3	Neonatal mortality rate (per 1,000 live births)	23	2014	NMICS	21	21	NDHS 2016	17.5
G4	Total fertility rate (births per 1,000 women aged 15–19 years)	2.3	2014	NMICS	2.2	2.3	NDHS 2016	2.1
G5	% of children under-5 years who are stunted	37.4	2014	NMICS	34	35	NNMSS 2016[4]	31
G6	% of women aged 15-49 years with body mass index less than 18.5	18.2	2011	NMICS	13	14.5	NNMSS 2016	12
G7	Lives lost due to road traffic accidents per 100,000 population	34	2013	Nepal Police	23	7.1	Police Mirror 2016; CBS[5] population projection 2016	17
G8	Suicide rate per	16.5	2014	Nepal	15	17.8	Police Mirror	14.5

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[2] Nepal Demographic and Health Survey.
[3] Nepal Multiple Indicator Cluster Survey.
[4] Nepal National Micronutrient Status Survey.
[5] Central Bureau of Statistics.

| Code | Indicators | Baseline | | | Milestone | Achievement* | | 2020/21 |
		Data	Year	Source	2016/17	2018	Source	Target
	100,000 population			Police			2016; CBS population projection 2016	
G9	Disability adjusted life years lost due to communicable, maternal and neonatal, non-communicable diseases, and injuries	8,319,695	2013	BoD, IHME[6]	7,487,726	9015320	GBD Study 2017	6,738,953
G10	Incidence of impoverishment due to out-of-pocket expenditure in health	NA	2011	NLSS[7]	20	NA	NLSS	Reduce by 20%
Refer to full NHSS Results Framework for means of verification of the targets and required data disaggregation								
Achievement against target- Green: 100%; Yellow: >50%; Red: <50%								

Improvement in overall health outcomes has been observed over last two decades. Table 2.2 presents the progress in key indicators. The maternal mortality ratio (MMR) (pregnancy-related mortality ratio) of 539 per 100,000 live births in 1996 has declined to 239 in 2016[8]. There has also been a large decline in child mortality over the last five years. The latest data from the Nepal Demographic Health Survey (NDHS) 2016 shows under-five mortality rate at 39 per 1,000 live births and neonatal mortality at 21 per 1,000 live births. Overall, the nutritional status of children (stunting) has improved. The percentage of children under five years who are stunted (% below -2SD[9]) has declined from 41% in 2011 to 36% in 2016.

Table 2.2: Progress in major health indicators

| SN | Indicator | Year | | | | |
		1996	2001	2006	2011	2016
1	Maternal Mortality Ratio (per 100,000 live birth) (NHSS RF[10] G1)	539	NA	281	NA	259
2	Under-five child mortality rate (per 1,000 live births) (NHSS RF G2)	118	91	61	54	39
3	Neonatal mortality rate (per 1,000 live births) (NHSS RF G3)	50	39	33	33	21
4	Children stunted (%)	48	51	49	41	36

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[6] Institute for Health Metrics and Evaluation
[7] Nepal Living Standards Survey
[8] The NDHS measures maternal mortality every ten years. NFHS 1996 and NDHS 2006 measured only pregnancy-related maternal deaths per 100,000 live births for the seven-year period before the survey whereas NDHS 2016 also estimated the maternal mortality ratio (239 per 100,000 live births). Figures in the table are of pregnancy related deaths.
[9] Standard Deviation
[10] Results Framework

SN	Indicator	Year				
		1996	2001	2006	2011	2016
	(NHSS RF G5)					
5	Fully immunized children (%) (NHSS RF OC3.2)	43	66	83	87	78
6	Institutional delivery (%) (NHSS RF OC3.3)	8	9	18	35	57
7	Demand satisfied for family planning (%) (NHSS RF OC 3.4)	47	59	66	64	69

*MMR has been measured using pregnancy related deaths except in 2016
NA- not available
Source: Data for 1996 from Nepal Health Facility Survey (NHFS), rest of the data from succeeding NDHS

There has been a large improvement in the proportion of women delivering at health institutions, increasing from 8% in 1996 to 57% in 2016. The percentage of children aged 12-23 months who had received all eight basic vaccinations has decreased from 87% in 2011 to 78% in 2016. The percentage of demand satisfied for family planning among currently married women has increased from 64% in 2011 to 69% in 2016. Although there has generally been progress at the national level, inequalities persist by geographic location and socio-economic groups.

An examination of tracer indicators using HMIS data of the past three years shows important trends at the national level. Furthermore, disaggregation of current data by provinces allows a critical appraisal of health system status post federalisation. Further details are provided in the annex, while key results are presented below:

- Increasing numbers of public hospitals are reporting to HMIS in the past three years. However, the situation is not the same when it comes to primary health care centres (PHCCs) and health posts (HPs). In recent years the reporting status (PHCCs and HPs) has declined to 98% from the previous high of 100% at the national level. Reporting from female community health volunteers (FCHVs) has also declined (72%) while that for non-public facilities is also low at 49%. Sudur Paschim province has the highest reporting rate at 100% for non-public facilities.
- In case of immunization status, BCG coverage has increased to 92% at the national level in the past three years, with highest coverage (100%) in Karnali province and the lowest coverage (73%) in Gandaki province. On the other hand, the coverage of DPT-HepB-Hib3 has dropped to 82% at the national level with highest rates in Karnali province at 93% and lowest in Gandaki province at 72%. The dropout rate has increased to 7.4% at the national level with highest rate in Province 2 (14%). The national target is to attain 90% full immunization by 2020 and 95% by 2030. However, there is a declining trend in cases of full immunization coverage at the national level. The coverage of 73% in 2073/74 has declined to 70% in 2074/75. Coverage was lowest in Province 3 (57%) and highest in Karnali Province (88%).
- Considering nutrition status, an increasing number of children aged 0-11 months are being registered for growth monitoring (rising from 78% in 2015/16 to 84% in 2017/18).

Registration for growth monitoring was highest in Karnali province at 126%[11] and lowest in Province 3 at 67% in 2017/18. In the past year, 59% of pregnant women received 180 tablets of Iron during pregnancy in Karnali province which is the highest among all provinces; the lowest rate was reported in Province 3 at 28%.

- Karnali Province reported the highest incidence of pneumonia among children under five years (per 1000) at 106 which is substantially higher than the incidence reported by Province 3 (40) – lowest among all provinces. Similarly, Gandaki Province reported the highest percentage of children under five with diarrhoea treated with oral rehydration solution (ORS) and zinc at 99% which is higher than the rate of 90% reported by Province 1 – lowest among all provinces.

- In safe motherhood, the percentage of pregnant women who attended four antenatal care (ANC) visits as per protocol, as well as institutional deliveries decreased from 53% and 55% to 50% and 54% respectively at the national level in the past year. Both indicators were lowest in Province 2 at 34% each. At the national level the target is to reach 70% coverage by 2020 and 90% coverage by 2030 for both of these indicators. Mothers who had three postnatal care (PNC) check-ups as per protocol has decreased in the past three years to 16% at the national level. It was highest in Sudur Paschim Province at 26% and lowest in Province 3 at 10%. At the national level the target is to reach 50% coverage by 2020 and 90% coverage by 2030.

- The contraceptive prevalence rate (CPR) has decreased from 43% to 41% at the national level in the past three years. It was highest in Province 2 at 48% and lowest in Gandaki Province at 33% in the past year.

- In case of Malaria programme, the percentage of PF among malaria positive cases was highest in Province 3 at 41%. Similarly, in case of Kala-azar, incidence per 10,000 populations at risk was highest in Karnali province at 0.23. The new case detection rate of leprosy per 100,000 populations was highest in Province 2 at 21.

Since the implementation of federalism, there has been a decline in key HMIS tracer indicators, which is a sign that there are serious threats to the progress made in the health sector in the past. It is vital to analyse province wise achievements and requirements first, followed by similar exercise for the local level, in order to design tailored interventions to sustain and go beyond the public health programme's achievements so far. This is also crucial in meeting the national and SDG targets.Table 2.3 presents the three years' trend on tracer indicators from different programmes and the 2017/18 achievement by the seven provinces using the HMIS data.

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[11] Percentages larger than hundred is the result of estimated target population (denominator) being smaller as compared the cases (numerator)

Table 2.3: Three years' trend on tracer indicators from different programmes and the 2017/18 achievement by the seven provinces

Color code for performance of province (2074/75)						
Equal to or above national average (2074/75)		Less than national average (2074/75)		Least among the 7 provinces (2074/75)		

Programme Indicators	National level			FY 2074/75 (2017/18) by Province							National Target	
	2072/73 (2015/16)	2073/74 (2016/17)	2074/75 (2017/18)	1	2	3	Gandaki	5	Karnali	Sudur Paschim	2020	2030
NUMBER OF HEALTH FACILITIES												
Public hospitals	111	123	125	18	13	33	15	20	12	14		
PHCCs	202	200	198	40	32	43	24	30	13	16		
HPs	3803	3808	3808	648	745	640	491	570	336	378		
Non-public facilities	1277	1715	1822	133	169	1163	100	168	46	43		
HEALTH FACILITIES & FCHVs REPORTING STATUS (%)												
Public facilities	na	96.8	95	95	95	95	95	95	95	95	100	100
Public hospitals	89	93	96	99	95	90	95	99	97	99	100	100
PHCCs	100	98	98	99	92	100	96	96	100	98	100	100
HPs	99	100	98	98	96	99	97	99	98	98	100	100
Non-public facilities	80	47	49	40	26	60	47	67	72	100	100	100
FCHVs	82	90	72	81	79	47	81	79	91	92	100	100
IMMUNIZATION STATUS (%)												
BCG coverage	87	91	92	90	104	84	73	98	106	87		
DPT-HepB-Hib3 coverage	82	86	82	82	87	73	72	87	93	83		
MR2 coverage (12-23 months)	na	57	66	69	58	57	70	79	73	70		
Fully Immunized children*	71	73	70	80	66	57	66	74	88	76	90	95
Dropout rate DPT-Hep B-Hib 1 vs 3 coverage	5.0	4.7	7.4	4.6	14	5	4	5	10.5	5	0	0
Pregnant women who received TD2 and TD2+	66	64	73	68	88	55	64	83	82	76		
NUTRITION STATUS (%)												
Children aged 0-11 months registered for growth monitoring	78	85	84	82	74	67	89	98	126	89	100	100
Underweight children among new GM visits (0-11m)	2.7	3.5	3.6	1.9	6.4	2.3	0.7	3.3	6.6	4.3		
Children aged 12-23 months registered for growth monitoring	47	54	56	50	57	42	67	59	86	57	100	100
Underweight children among new GM visits (12-23m)	4.2	5.7	5.7	3.5	9.2	2.4	1.5	5.4	10.3	7.6		
Pregnant women who received 180 tablets of Iron	49	44	45	37	46	28	58	57	59	51		
Postpartum mothers who received vitamin A supplements	51	72	66	60	83	45	53	72	87	72		

Programme Indicators	National level			FY 2074/75 (2017/18) by Province							National Target	
	2072/73 (2015/16)	2073/74 (2016/17)	2074/75 (2017/18)	1	2	3	Gandaki	5	Karnali	Sudur Paschim	2020	2030
CB-IMNCI STATUS												
Incidence of pneumonia among children U5 years (per 1000)	147	66	54	69	41	40	41	50	106	71		
% of children U5 years with Pneumonia treated with antibiotics	174	156	165	152	231	129	207	164	159	139		
% of children U5 years with Pneumonia treated with antibiotics (Amoxicillin)	na	na	102	92	127	99	126	98	85	100	100	100
Incidence of diarrhea per 1,000 under five years children	422	400	385	364	337	262	290	403	709	648		
% of children under 5 with diarrhea treated with ORS and zinc	87	92	95	90	97	94	99	95	96	98	100	100
SAFE MOTHERHOOD (%)												
Pregnant women who attended first ANC visit (any time)	97	102	103	105	94	110	94	108	117	93		
Pregnant women who attended four ANC visits as per protocol*	51	53	50	47	34	49	60	61	55	55	70	90
Institutional deliveries *	55	55	54	53	34	49	47	75	67	69	70	90
Deliveries conducted by skilled birth attendant*	54	52	52	52	35	49	47	70	56	60	70	90
Mothers who had three PNC check-ups as per protocol*	18	19	16	12	14	10	13	22	19	26	50	90
FAMILY PLANNING												
CPR-unadjusted*	43	43.6	40.6	43.0	47.9	36.7	33.2	40.9	35.5	39.5	56	60
CPR (Spacing methods)	20	21	18	20	9	20	15	25	20	23		
FEMALE COMMUNITY HEALTH VOLUNTEERS (FCHV)												
Number of FCHVs	51416	49101	48172	8818	6208	9012	5525	8602	4097	5910		
% of mothers' group meeting held	94	86	98	95	98	97	95	100	100	98	100	100
MALARIA AND KALA-AZAR												
Annual blood slide examination rate (ABER) per 100	0.84	0.79	1.3	0.56	0.5	0.5	0.6	1.6	1.2	4.6		
Annual parasite incidence (API) per 1,000 population at risk	0.07	0.08	0.08	0.01	0.02	0.02	0.03	0.07	0.3	0.3		
% of plasmodia falciparum (PF) among Malaria Positive case	16.3	13.1	7.1	20.8	6.1	40.7	25.0	12.1	0.5	4.1		

Programme Indicators	National level			FY 2074/75 (2017/18) by Province							National Target	
	2072/73 (2015/16)	2073/74 (2016/17)	2074/75 (2017/18)	1	2	3	Gandaki	5	Karnali	Sudur Paschim	2020	2030
Incidence of kala-azar per 10,000 population at risk	0.12	0.11	0.11	0.11	0.08	0.03	0.08	0.15	0.23	0.02		
TUBERCULOSIS												
Case notification rate (all forms of TB)/100,000 pop.	113	111	109	92	88	121	96	140	101	120		
Treatment success rate	90	91	87	85	85	88	90	90	93	85		
LEPROSY												
New case detection rate (NCDR) per 100,000 population	11	11	11	8	21	5	4	16	5	9		
Prevalence rate (PR) per 10,000	0.9	0.9	0.9	0.7	1.1	1	0.3	1.36	0.45	0.8		
HIV/AIDS and STI												
Number of new positive cases	2163	1781	2013	142	133	715	197	526	57	243		
CURATIVE SERVICES												
% of population utilizing outpatient (OPD) services	66	72	72	78	47	82	96	69	78	71		
Average length of stay at hospital	4	3	4	3	4	4	3	4	3	2		

Note: *NHSS RF and/or SDG indicators

1.2 Inequalities in progress of major health indicators

Complete continuum of care: Antenatal, delivery and postnatal care from health service providers including female community health volunteers (FCHVs)

The first point of contact with the health system for most pregnant women is their first ANC visit. This is an important entry point not just for maternal health but also for other programmes. A high coverage of ANC and repeated contacts between the woman and the health service offers many opportunities for providing evidence-based interventions likely to affect maternal, fetal, and neonatal health and survival[12]. In order to continuously retain women during antenatal, delivery and postnatal care within the continuum of service, it is important to ensure the quality of ANC service delivery particularly during the first visit.

Out of all women 15-49 years who had a live birth in the past five years preceding the NDHS 2016 survey, about four percent did not use any of the maternity care services, i.e., ANC, delivery care (DC), or PNC services. Of the total women, 23.9% utilized ANC services only, less than one percent used DC services (0.5%) or PNC (0.9%). This means that one out of four women who took ANC services, did not utilize DC and PNC services. This gap needs to be carefully considered. One out of 10 women (10.7%) utilized ANC and PNC services only

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[12] The Partnership for Maternal Newborn and Child Health. *Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa.* Cape Town : World Health Organization on behalf of The Partnership for Maternal Newborn and Child Health, 2006.

(excluding those who utilized all three – ANC, PNC and DC services). In other words, these women did not utilize DC services which is a missed opportunity that requires further intervention. Similarly, less than one percent (0.6%) utilized PNC and DC services only and 34.6% utilized ANC and DC services only. One out of four women (24.9%) utilized all three services. (Figure 2.1).
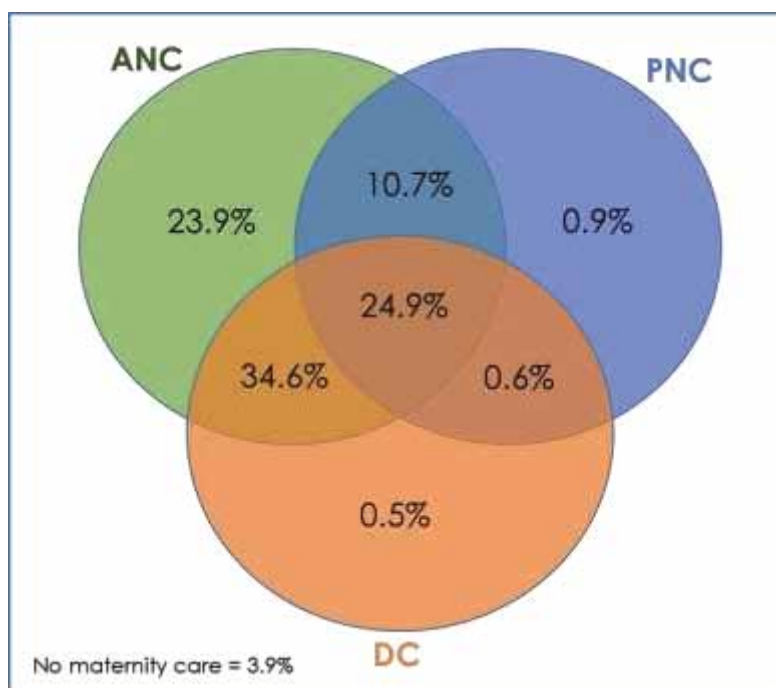

Figure 2.1. Venn diagram showing use of maternity care services
Weighted N=3998; ANC: Antenatal Care, PNC: Postnatal Care, DC: Delivery Care
Source: Further analysis of NDHS 2016 data

When considering provincial inequalities, in Province 6, more than one in ten women (11.1%) did not receive any maternal health services and only 12.9% women received all three services. This is the lowest scoring of all provinces. These figures indicate low enrolment and continuity in maternal health service utilization in Province 6. In Province 2, although 96% of women utilized one of the three maternal health services, only 12.6% of women utilized all three services. This gap shows the work that needs to be done in terms of increasing the number of women that utilize all available services. (Data not shown in figure)

Wealth quintile specific inequalities in institutional delivery
Trends in the total proportion of women utilizing services for delivering in a health facility show a minimal increase from 1996 to 2001 (Table 2.5). Thereafter, the increase is remarkable, from 9% in 2001 to 57% in 2016. Quintile specific estimates are also increasing but estimates are larger in fifth quintile (richest) compared to first quintile (poorest) showing greater utilisation

among the well off. Between 1996 and 2016, the absolute increase in utilisation per year was lowest in the first quintile at 32 percentage points, while it was highest in fourth quintile at 63 percentage points.

The absolute difference (Q5-Q1) in utilisation increased from 28 percentage points in 1996 to 67 percentage points in 2011; but then decreased to 56 percentage points in 2016 (Table 2.5). Although the absolute difference has increased overtime, estimates of relative difference (Q5/Q1) show decreasing disparity – the ratio of 17.2 in 1996 has decreased to 2.6 in 2016. It should be noted that these estimates are based only on richest vs poorest groups.

Categories	Institutional delivery					Absolute increase (percent points)
	1996	2001	2006	2011	2016	1996-2016
First quintile (poorest)	1.7	2.3	4.3	11.4	33.9	32.2
Second quintile	3.5	3.0	9.3	23.3	46.6	43.1
Third quintile	4.8	5.5	11.9	35.4	57.6	52.8
Fourth quintile	6.2	9.0	21.7	51.9	69.5	63.3
Fifth quintile (richest)	29.9	36.5	55.0	77.9	89.6	59.7
Total	7.6	9.1	17.7	35.3	57.4	49.8
Ratio of fifth to first quintile	17.2	15.6	12.7	6.8	2.6	
Difference in fifth and first quintile	28.2	34.2	50.7	66.5	55.6	
Concentration index[*]	0.551	0.558	0.481	0.349	0.186	

Table 2.5: Wealth quintile specific trends and estimates for institutional delivery in 1996, 2001, 2006, 2011 and 2016

Source: Further analysis – Data for 1996 from Nepal Health Facility Survey (NHFS), rest of the data from succeeding Nepal Demographic and Health Survey (NDHS)
[*]*The concentration index is expressed in a scale ranging from -1 to 1; a value of zero represents perfect equality, whereas a value of 1 to -1 indicates that only the richest or the poorest households bear the burden.*
Note: Data for 1996 are estimated three years preceding the survey; for other years, data are estimated five years preceding the survey

Unlike absolute and relative differences, the concentration index takes into account disparity across all wealth groups (Table 2.5). It decreased from 0.551 in 1996 to 0.186 in 2016. The positive values indicate that the utilisation of institutional deliveries is disproportionately concentrated in richer households. However, the values are decreasing overtime, which shows that inequality has declined over the years. A concentration index value of zero would mean the absence of inequality.

Caste-wise inequalities in major health outcomes

Nepal's population is diverse in caste/ethnicity. The national averages of health outcome indicators do not necessarily reflect the actual situation among these sub-groups of the population and there are wide variations in access to health services, utilization and health outcome. Among *Dalit*, nearly three out of every 50 children die before reaching their fifth birthday and about two in 50 children die before their first month of life. In other *terai* caste, only six out of 10 (64%) children received all eight basic vaccinations. Among children under five years, stunting (<-2SD) was higher in other *terai* caste (42%), *Dalit* (40%) and Muslim (38%) in comparison with *Newar* (27%). Nearly one third (31%) of Muslim women aged 15-49 years were thin (BMI[13]<18.5). Prevalence of anaemia in women age 15-49 was highest in other *terai* caste (56%) and Muslim (52%). Nationally, 57% of women delivered their baby in a health facility, this percentage is higher than the 45% of *Dalit* women who deliver at a facility. The total fertility rate was highest in Muslim (3.6), other *terai* caste (3.0) and *Dalit* (2.7), and lowest in *Newar* (1.6).

Table 2.6: Caste specific estimates for major health outcomes in 2016										
Caste group	Under 5 mortality rate (per 1,000 LB)	Neonatal mortality rate (per 1,000 LB)	Total fertility rate	% children <5 yrs. stunted (<-2SD)	% women 15-49 yrs. with BMI <18.5	% children fully immunized	% institutional delivery	% demand satisfied for family planning	% diarrheal diseases in children <5 yrs.	% anaemia in women 15-49 yrs.
Dalit	63	43	2.7	40	21.1	73.2	45.4	63.3	7.6	38.4
Janajati	42	24	2.1	32	12.4	82.9	57.9	70.8	6.7	39.7
Other *terai* caste	51	27	3.0	42	27.9	64.3	48.1	72.2	9.7	55.6
Muslim	47	25	3.6	38	31.4	68.1	51.6	52.9	11.2	51.8
Newar	33	9	1.6	27	9.4	88.7	74.6	73.8	12.2	26.4
Brahmin/Chhetri	39	23	2.0	35	15.2	87.3	68.4	68.7	5.6	36.5
National[*]	39	21	2.3	36	17.3	77.8	57.4	68.9	7.6	40.8

Source: Ministry of Health and Population [Nepal]: Mind the gap: Policy brief. Kathmandu, Nepal: Ministry of Health and Population; 2018.
[*]*Nepal Demographic and Health Survey 2016*

Inequalities in caesarean section rates in Nepal

Caesarean section (CS) is one of the most common surgeries performed in modern obstetrics to manage complicated deliveries. It can be life saving for both mother and child if medically indicated; otherwise it is risky. The NDHS shows an increasing trend in deliveries by CS (1% in 1996, 0.8% in 2001, 2.7% in 2006, 4.6% in 2011 and 9% in 2016). This rising trend is a major concern when the total percentage is broken down by different groups (see below) given WHO guidelines[14], and has implications both in terms of risk and resources. Additionally, it is important to track socioeconomic and geographic inequalities in use of CS service to measure progress towards maternal and child health targets.

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[13] Body Mass Index
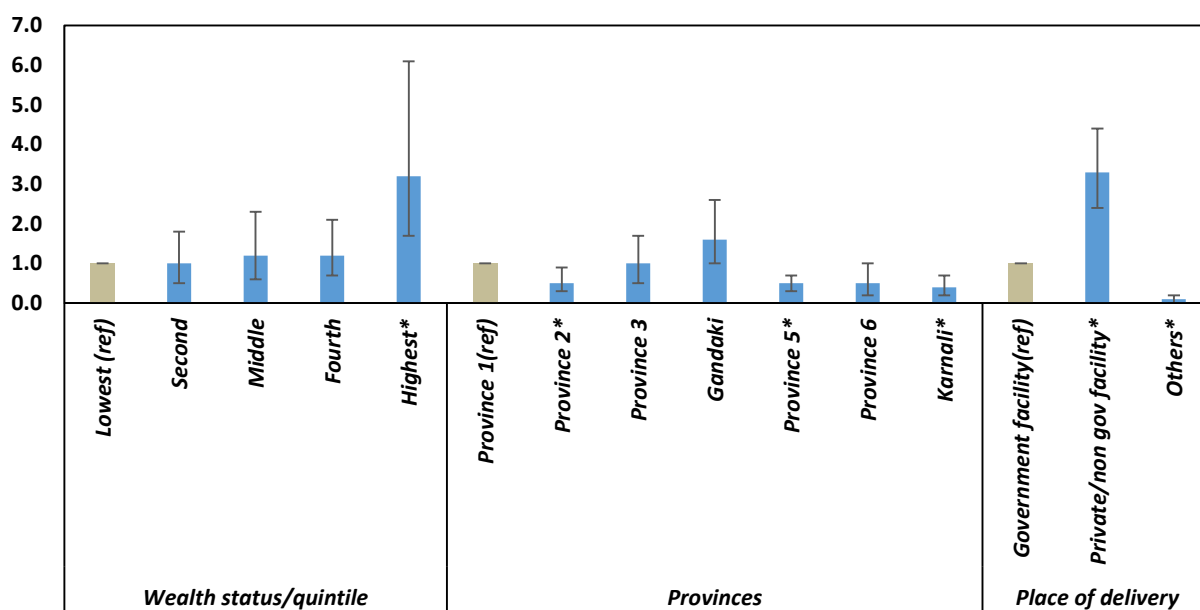[14] https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

Figure 2.2:Odds ratio of selected socio-economic characteristics of women for cesearan section delevery
(*p<0.05) (1=reference category)

The NDHS 2016 shows that CS deliveries were twice as prevalent in urban areas as compared to rural areas. CS deliveries comprised one in four (24%) births in women with higher education as compared to one in 20 (5%) in women with no education. The CS rate was considerably lower in the mountain region. Nearly 13% of women with four or more antenatal care visits undergo CS, which is three times higher than in women with no or less than four visits. The CS rate was higher in *Newar* compared to other caste groups. Compared to women in the lowest (poorest) wealth quintile, more women in the highest (richest) wealth quintile (28%) opted to undergo CS. The CS deliveries accounted for only two percent of total deliveries in Province 6, as compared to 17% each in Provinces 3 and 4. The CS rate was higher for deliveries in private facilities (35%) than in public institutions. Women in the highest wealth quintile; women in Provinces 2, 5 and Karnali (compared to Province 1); and women delivering in private health facilities (versus public) were significantly more likely to deliver via CS (Figure 2.2).

Status of nutrition related indicators

The recently disseminated Nepal National Micronutrient Status Survey (NNMSS) 2016 results shed light on the micronutrient status of the population, including specifically the status of vitamin A, iron, folic acid, iodine, zinc and the condition of anaemia. According to the survey results, among children aged 6-69 months, 35% were stunted, 4.2% were vitamin A deficient, 20.7% were zinc deficient, 27.6% were iron deficient; while the prevalence of iron deficiency anaemia was 10.6%. Similarly, the prevalence of anaemia was 19.1%. In terms of inequalities by ecological zones, stunting was highest in the mountain region (45.3%), vitamin A deficiency was highest in the *terai* region (7.3%), zinc deficiency was highest in the mountain region

(28.1%); while prevalence of iron deficiency (32.3%), iron deficiency anaemia (12.3%) and anaemia (23%) was highest in the *terai* region. Although three out of five (59.1%) households were food secure, seven percent were severely food insecure. In dietary diversity, 41.6% children aged 6-9 years received the minimum dietary diversity. Only 8.1% children 6-59 months participated in growth monitoring in the last month.

3. Progress against NHSS Outcome targets

3.1 Outcome 1: Rebuilt and Strengthened Health Systems: Infrastructure, Human Resources for Health, Procurement, and Supply Chain Management

The essential and interconnected health system components for smooth service delivery, namely infrastructure, human resources for health, and procurement and supply chain management are included in Outcome 1. Under this outcome, seven outputs and their key interventions were defined to rebuild and strengthen the health system that was massively affected by the devastating earthquake of April 2015.

3.1.1 Outcome 1.a Infrastructure

Background

Developing a comprehensive health infrastructure network across the country is central to the Government of Nepal's (GoN) LNOB goal and in line with the objective of UHC set out in the NHSS 2015-20. The commitment to eventually provide a suitable health facility in each of the local level demonstrates the intention to serve geographically distant areas as well as marginalised ethnic communities. This commitment has been given substance with the GoN's adoption of the Integrated Health Infrastructure Development Project (IHIDP).

Under the NHSS, there are three outputs in developing resilient infrastructure and a strong regulatory framework:
- Health infrastructure developed as per plan and standards – improved planning and construction standards, including seismic resilience.
- Damaged health facilities are rebuilt – continued reconstruction after the 2015 earthquake, incorporating Build Back Better principles.
- Improved management of health infrastructure – better guidelines and enhanced capacity to monitor, manage and develop facilities.

Major progress

Significant progress has been made during FY 2017/2018 and 2018/2019 to date. Key achievements are summarized below.

Nepal Health Infrastructure Development Standards (NHIDS) 2074 (2017) and IHIDP
- NHIDS frameworks are starting to be used in developing infrastructure and service delivery priorities at provincial level planning.

Health infrastructure information system (HIIS)

- HIIS has been used to develop a risk assessment of the physical location of all health facilities in the country. This will support provincial and municipal authorities to improve decision-making in fulfilling their new mandates and responsibilities for health infrastructure. This exercise has identified facilities at highest risk from environmental hazards.

Health facility reconstruction

- As of October 2018, 330 activities have been completed and 47 are still under construction. A summary of progress made is presented below in Table 3.1.

Table 3.1: Repair and reconstruction activities with External Development Partners

Districts	Total number of Activities	Completed	Ongoing	Type of Construction			Semi-Permanent & Shelter
				Permanent	Prefab	Repair/Retrofitting	
Bhaktapur	3	3	-	-	3	-	-
Dhading	49	46	3	2	34	13	-
Dolakha	46	43	3	1	38	5	2
Gorkha	56	55	1	1	37	3	15
Kathmandu	5	2	3	3	2	-	-
Kavrepalanchowk	39	24	15	8	30	1	-
Lalitpur	7	7	-		7	-	-
Makwanpur	11	8	3	3	8	-	-
Nuwakot	49	42	7	1	43	1	4
Okhaldhunga	7	7	-	-	7	-	-
Ramechhap	16	14	2	1	14	-	1
Rasuwa	18	17	1	1	13	3	1
Sindhupalchowk	62	58	4	3	31	6	22
Sindhuli	4	-	4	4	-	-	-
Solukhumbu	6	5	1	-	6	-	-
Grand Total	**378**	**332**	**46**	**28**	**273**	**32**	**45**

> *Note:*
> 1. *Solukhumbu belongs to the category of Earthquake Medium Affected District but manty health facilities were damaged*
> 2. *Minor repair works were carried out in 298 health facilities located in 31 had hit and affected districts in financial support from EU.*

In addition, health facilities were being reconstructed under GoN bilateral arrangements with international development agencies. Progress on these projects is set out in Table 3.2 below.

Table 3.2: Progress under agreements with bilateral agencies

Agency	Works description	Progress
JICA	Bir Hospital, Kathmandu	RCC Structure Completed, finishing and building services works are ongoing
	Paropakar Maternity and Women'ts Hospital, Kathmandu	Preparation for Final slab casting. Brick works and works for building services are ongoing.
KOICA	Nuwakot District Hospital	Preparing for Top floor RCC casting. Brick works in Ground floor is ongoing.
	Prefab structures at ten health posts	5 completed and handed over and 5 is under construction (over 90% completed)
KFW	Reconstruction of Rasuwa, Dolakha, Gorkha, and Ramechhap district hospitals	Preparation for tender
DFID	Health facilities in Sindhupalchok, Ramechhap, and Dolakha	Completed
USAID	Bahrabise PHCC	Completed
CHINA	Chautara and Manang hospitals	Preliminary design concept for Chautara has been finalized. Manang is still pending.

Retrofitting of Bhaktapur Hospital and Western Regional Hospital Pokhara

Over 2018, the MoHP has held a series of workshops and briefings to build commitment among major stakeholders, as well as explaining the main technical proposals and challenges.

Development of an integrated approach

- The patient-centered construction approach has been approved had has 4 key components: Seismic retrofitting (structural and non-structural elements, including relevant functional improvements).
- Decanting (including construction of a temporary decant facility for patients and hospital services).
- Logistics management of services and patient transfers.
- 'Green' retrofitting to maximise environmental benefits and improve sustainability (including implementation of a Zero Waste site policy, potential adaptive re-use of the decant facility, improved water management and energy efficiency).

To date the following activities have been completed or are in progress:
- Testing on site - destructive and non-destructive material testing and geo-technical investigations - have been completed at both hospitals.
- Seismic modelling for structural retrofitting, selection of design solutions and production of detailed drawings is complete.
- Identification of functional improvements with stakeholders and incorporation into building designs is complete.
- Design of decant facility is complete.
- Design of sanitary and electrical services is complete.

- Preparation of designs, estimates, and bidding documents have been prepared for the decant facility, seismic and functional interventions, sanitary and electrical services.

Independent external reviews

A recent independent review of retrofitting designs and details has approved the retrofitting designs and details, while an additional independent assessment (October 2018) team's briefings indicate that the approach has been approved and specialised materials tests will be applied to provide data to strengthen specific design interventions.

Gender Equality and Social Inclusion (GESI) in Health Infrastructure

Gender Equality and Social Inclusion (GESI) aspects in health infrastructure development are being strengthened and stakeholder coordination is ensuring adoption of GESI principles. A recent report on GESI compliance has been prepared relating to hospital retrofitting.

Capacity Enhancement Programme

Over the period January – October 2018, MoHP has conducted 10 capacity enhancement events, involving a total of 320 participants. These are:
- Orientation Training on Retrofitting and Tender Processes
- Training Needs Analysis for Construction Contractors and Professionals
- Multi-hazard Resilient Health Infrastructure Planning, Designing and Implementation
- e-Government Procurement training (two events)
- Orientation on Health Infrastructure Development (three events)
- Health Infrastructure Policy Development Workshop
- Training on Electrical and Sanitary Design for Health Infrastructure

Under the capacity enhancement programme, a set of detailed training modules and manuals is being prepared. These will cover the following areas:
- Retrofitting module and handbook
- Sanitary services module and handbook
- Electrical services module and handbook
- Heating, ventilation and air conditioning services module and handbook
- Waste management services module and handbook

Development of health infrastructure policy and standards

Earthquake performance appraisal and disaster risk reduction
- The MOHP's Health Emergency and Disaster Management Unit has adopted the Health Infrastructure Disaster Risk Reduction (DRR) report and has established a review committee to strengthen existing DRR documents and guidelines.

Infrastructure Capital Investment Policy and implementation of the Categorisation of Health facilities

- The MoHP has approved the plan to disseminate and support the implementation of the Infrastructure Capital Investment Policy to assist decision making at all levels of government.
- The categorisation of Health Facilities document is, being disseminated to central, provincial and local government structures as part of capacity enhancement events and interactions.

Challenges

While there has been substantial progress, a number of challenges are also seen:
- There is lack of clarity due to restructuring within the MoHP and Department of Urban Development and Building Construction (DUDBC) and also about the role of federal, provincial, or local government in developing the health infrastructure.
- Provincial and local governments are now seeking to take up their constitutional mandates for health infrastructure. As well as working out the parameters of these roles, the sub-national governments are hampered by lack of institutional memory, capacity constraints and critical staff shortages. Capital spending by provincial governments is reported by the Ministry of Finance as likely to be very low in the remainder of 2018.

Way Forward

- Continued close engagement of MoHP with DUDBC and provincial governments will be essential in supporting improvements in evidence-based decision-making, sustainable investments in health infrastructure and value-for-money in health infrastructure. Capacity enhancement, technical support and dissemination of information on standards and policies will be important in assisting provincial-level delivery.
- Internalization of NHIDS and allied policy documents within the MoHP and across the local level and provincial governments.
- Development of regular update mechanisms for the continual updating of the HIIS database to reflect the current state of infrastructure and other status relating to the health facilities.
- Execution of analysis for different contexts including repair, reconstruction and upgrading, disaster risk reduction, and climate change induced hazard mitigation for health facilities.

3.1.2 Outcome 1.b Human Resources for Health

Background

Quality health services rely on strengthening the production, deployment, and retention of skilled human resources as reflected in the following two outputs of NHSS regarding HRH:
- Improved availability of human resources at all levels with a focus on rural retention and enrolment.
- Improved medical and public health education and competency.

Availability of skilled health workforce at the service delivery point is very important in delivering quality health services. The NHSS recognises the importance of planning, producing, retaining, and developing skilled human resources to deliver affordable and effective health services. During this reporting period HRH data for NHSS indicator (OP1b1.1): improved staff availability at all levels with focus on rural retention and enrolment is to be updated.

The vacancy fulfilment rates (particularly for doctors in three provinces: 5, 6, and 7) as 44%, 45%, and 39% respectively (Annual Report of the Department of Health Services (DoHS), 2016/17) confirms that the majority of the positions remain vacant. In 2015/16, this figure was still lower (only 36%) (NHSS (2015-2020), indicating slight improvements but there is still a big challenge in retaining doctors particularly in rural parts of the country. On the other hand, data on the availability of nursing staff was found to be much better (99%) in province 7 compared to the other provinces, this could be related to the adequate local supply and effective recruitment process.

Major Progress

- Staff Adjustment Act (2074) was enacted on 15th October 2017.
- During this FY one new health academic institution (Rapti Academy of Health Sciences, Province 5) in Dang district was approved by GoN, making a total of four state owned academic institutions under the MoHP. These are the National Academy of Medical Sciences (NAMS) in Province 3, Pokhara Academy of Health Science in Province 4, Karnali Academy of Health Science (KAHS) in Karnali Province.
- A memorandum of understanding (MoU) was signed between MoHP and KAHS to support comprehensive emergency obstetric and neonatal care (CEONC) hospitals located in 9 districts with skills mix HRH (MDGP, AA, and OT nurse).
- Similarly, under the leadership of Nursing & Social security division a MoU was signed with the Council for Technical Education and Vocational Training (CTEVT) to develop proficiency certificate level (PCL) training within the midwifery curriculum.
- Developed deployment procedures to plan deployment of 189 specialists (MD/MS, MDGP and others) to be graduated during this FY from NAMS, Institute of Medicine (IoM) and B.P. Koirala Institute of Health (BPKIH) academic health institutions
- Drafted policy on nursing & midwifery service education program.
- Developed PCL in midwifery curriculum.

Challenges

- There is no HRH dedicated unit at MoHP for the purpose of projection, production, planning, education, and using data for HRH management
- As per constitutional provision, the Local Government (LG) is responsible for recruitment of staff on a contractual basis, but there are no standard guidelines on the recruitment process, which compromises the quality.

- Although HRH registry is in place, there is lack of consolidated data from all professional councils.
- HRH projections, gaps and HRH needs are yet to be completed as per the new structure including staffing.
- There is a mismatch of HRH production and actual needs (e.g. need more MDGPs for primary level hospitals vs. dentist super specialisation).
- Lack of HRH in new and crucial areas like Hospital Management.
- Retention of health care providers is a major challenge particularly in the remote areas. This is due to the absence of a transparent guideline for management of health workers across the health system (promotion, transfer, incentive packages)
- Accountability to provide 24 hour services in public hospital is low due to low salary in the public sector compelling doctors to undertake dual practices.
- Unregulated dual practice. (The Britain Nepal Medical Trust 2014: A Desk Review Report: Key Issues, Challenges, and Gaps in Human Resources for Health in Nepal and Recommendations to the MoHP and Development Partners for Action).
- Partnerships with academic health institutions to support HRH needs did not yield positive results due to lack of clarity on roles/responsibilities of academic health institutions and MoHP.
- During this FY, most of the CEONC hospitals received their budget to recruit staff locally on contractual basis directly from their respective provinces. However, few secondary level hospitals have yet to receive budget from their respective provinces.

Way Forward

- Establish effective partnership with public and private academic health institutions to address burning HRH needs, especially for the remote areas through clear partnership guidelines.
- Establishment of a dedicated HRH unit at MoHP.
- Implement appropriate deployment of 189 specialists as per needs identified by the referral hospitals.
- Capacity enhancement of provincial and local government to implement updated HRH Strategic Roadmap.
- Development of seven-year Midwifery education plans (2076-2082) on projections, production, recruitment, deployment, service protocols, and a retention plan.
- Revise in-service training programmes: Skilled Birth Attendant (SBA) Training Strategy.
- Strengthen the HURIC and promote digitalisation of HRH information.

3.1.3 Outcome 1.c Procurement and Supply Chain Management

Background

The NHSS envisions two outputs for reforming the procurement and logistics systems for capacity enhancement in supply chain management and the implementation of innovative approaches. These are:
- Improved procurement management
- Improved supply chain management

In public procurement, the public purse is involved. The principles of economy, efficiency, efficacy, competition, accountability, and transparency in procurement procedures lead towards Value for Money (VfM). In this regard, the MoHP is considering a strategic reform of procurement and supply chain management in order to provide quality health services.

A. Procurement Management Reform

Procurement management in the health sector consists of preparing, operating and monitoring the Procurement Improvement Plan (PIP), the Technical Specification Bank (TSB), Logistics Management Information System (LMIS), Inventory Management System (IMS), Annual Procurement Plan (APP), Master Procurement Plan (MPP), and the CAPP. These also need to be effectively implemented to ensure their timely delivery and the distribution of medical goods and equipment.

Major Progress

In the fiscal year 2016/17 and 2017/18, the MoHP has made good progress in improving the performance of procurement management. The following targets have been achieved:
- PIP for 2017-21 has been prepared and endorsed by MoHP in 2017/18.
- The formation of a nine member CAPP monitoring committee (CAPP-MC) under the chairmanship of the Director General (DG) of the DoHS, and the endorsement of the ToR of the CAPP-MC.
- The CAPP for medical goods and equipment and other services in 2016/17 has been made within the specified timeframe and federal level CAPP in MoHP initiated in 2017/18.
- The TSB was restructured in 2016/17 and systematized in the website of DoHS. The system is open to use for all stakeholders (now 300+ users are registered in the system) in 2017/18.
- The codification of drugs (108 Drugs) and equipment (1089 equipment) has been completed and uploaded in TSB in the website of DoHS in 2017/18.
- Two e-GP trainings in procurement were conducted at the central level; four provincial/local level training for capacity building in procurement conducted in 2017/18.
- Multi-year procurement is ongoing for specified medical items. It is planned to expand to other items in coming years as well.

- The Electronic Bidding System (e-GP-I) for the procurement of medical goods and equipment is increasingly well practiced. In 2017/18, 83% of all bids have been processed through e-GP.
- Standard Bid Documents (SBDs) for health sector procurement (3 SBDs including the Framework Agreement) have been drafted and sent for approval to Public Procurement Monitoring Office (PPMO).
- Two SOPs on procurement management and e-GP usage for provincial governments (PGs) and local governments (LGs) have been prepared and endorsed by DoHS and sent to all PGs and LGs for use in 2017/18.
- A Procurement Clinic concept paper has been prepared and endorsed by DoHS and 119 clinics have been held in DoHS for troubleshooting in procurement management during 2017/18. Grievances Handling Mechanism software has been initiated and installed in DoHS in 2017/18. Likewise, a drug disposal mechanism was drafted and executed by the Logistics Management Division (LMD) in 2017/18.
- Training session plans have been developed for PGs' and LGs' capacity building in procurement management in 2017/18.

The following table (1.c.1) summarises the overall procurement management function of last FY 2016/17 and FY 2017/18 in the DoHS.

Table 1.c.1: Analysis of CAPP with estimated budget (in million NPR)

SN	Division of DoHS	2016/17 CAPP Budget	2016/17 CAPP Actuals	2017/18 CAPP Plan & Budget	2017/18 CAPP Actual	2018/19 CAPP Plan
1	Logistic Management Division (LMD)	1285.87	1285.87	218.54	80.86	282.94
2	Child Health Division (CHD)	881.92	566.82	655.40	378.41	445.48
3	Family Health Division (FHD)	912.65	236.22	380.50	224.15	314.15
4	Epidemiology & Disease Control Division (EDCD)	161.32	160.28	378.09	309.24	306.35
5	Management Division	69.20	43.66	72.00	24.66	164.60
6	Primary Health Service Revitalisation Division (PHCRD)	814.23	606.38	1031.52	587.87	475.00
7	Leprosy Control Division (LCD)	-	-	4.5	0.99	3.5
	Total	**4125.19**	**2899.23**	**2728.55**	**1606.18**	**1992.02**

- **CAPP Execution:** In comparison to 2016/17, CAPP plan value of procurement in 2017/18 reduced by 66%. Mainly this was due to the amount devolved to the LGs which is around Nepalese Rupees (NPR) 1409 million. In result, actual procurement in 2017/18 also decreased by 55% in comparison with the value of 2016/17. Likewise, a total of 118

procurement proceedings with a CAPP value of NPR 2728.55 million have been processed in 2017/18. Of these, 67 contracts (79%) have succeeded with cost estimates of NPR 2156.34 Million.

- *Use of the TSB:* Since FY 2017/18, the TSB has been scientifically restructured and mandatorily used by the DoHS and its all divisions. All procurement of drugs (100%) has been using the technical specification of the TSB. At this moment more than 300+ individuals/institutions from local to federal level are using the TSB.

- *Changing Cost Estimation practices:* Endorsements of all final rates are made within the cost estimates and approved by the DoHS within the agreed CAPP timeframe. However, the CAPP plan value of costs estimated while preparing the annual workplan budget (NPR 2728.55 M) and the actual cost estimates (NPR 2156.34 M) used in procurement decisions are somehow different. In 2017/18 the DoHS organized a Supplier's Conference and raised this issue again. Although it was discussed, the DoHS could not get proper cooperation from suppliers and their respective professional organizations. As a result, the cost estimation practices in DoHS are not be very realistic and effective in the case of procurement of drugs.

- *Cost savings in procurement expenditures:* The LMD had used open bid competition as a prime method of procurement, and e-GP-I and II execution to standardize the procurement process in FY 2016/17 and 2017/18 As a result, when comparing with the cost estimates, there were savings of about 17% in FY 2016/17. Whereas In FY 2017/18 by standardizing the procurement process and e-GP-II execution, savings in procurement increased to the value of about 26% of cost estimates.

The following table summarizes the overall procurement expenditures of different divisions of the DoHS in 2016/17 and 2017/18, showing yearly saving through standardization of procurement process and implementation of e-GP in past two years of CAPP execution.

Table 1.c.2: Procurement Expenditure & Savings Analysis in 2016/17-2017/18 (in NPR Million)

SN	Division of DoHS	2016/17 Cost Estimates	2016/17 CAPP Actuals	Cost Savings in 2016/17	2017/18 CAPP Plan	2017/18 Cost Estimates	2017/18 CAPP Actuals	Cost Savings in 2017/18
1	LMD	1403.80	1285.87	117.93	218.54	104.26	80.86	23.40
2	CHD	943.74	819.17	124.57	655.40	550.52	378.41	172.11
3	FHD	730.51	655.51	75.00	368.50	221.67	224.15	-2.48
4	EDCD	197.87	160.28	37.59	378.09	348.19	309.24	38.95
5	MD	53.85	43.66	10.19	72.00	30.00	24.66	5.34
6	PHCRD	850.09	606.38	243.71	1031.52	900.70	587.87	312.83
7	LCD	-	-	-	4.5	1.0	0.99	0.01
	Total	**3427.47**	**2859.16**	**568.31 16.58%**	**2728.55**	**2156.34**	**1606.18**	**550.16 25.51%**

Source: Various Years CAPP plan of LMD/DoHS.

- ***Approval of SBD:*** DoHS is strictly using the SBDs prescribed by the PPMO in its procurement proceedings. SBDs are approved by DG along with technical specification and cost estimates before procurement proceedings start. Besides, the LMD drafted two sets of new SBDs specifically for the procurement of drugs and equipment, and one set of SBD for the Framework Agreement and sent them to PPMO for approval in 2016/17. One set of revised SBDs for the Framework Agreement were sent again to PPMO for approval in 2017/18 and discussion is on-going.

- ***Procurement Modality:*** The DoHS uses an open, competitive, and transparent modality for bidding. The open bid method is the most commonly used (for 84.57% of bids in 2016/17 and 81.36% in 2017/18) in the DoHS for the procurement of drugs, medical equipment, hospital devices, contraceptives, cold chain equipment, insecticides, and other health facilities. This method is also appropriate to the aims of achieving VfM within the health sector.

    The international competitive bidding (ICB) modality is decreasing (from 68.57% in 2016/17 to 48.31% in 2017/18). In contrast, national competitive bidding (NCB) is increasingly used (from 16% in 2016/17 to 33.05% in 2017/18). This is as a result of an incremental ceiling in public procurement authority (PPA)/public procurement regulation (PPR) amendments.

    The newly introduced modality of catalogue shopping which was seldom used (8% in 2016/17) has not been used at all in 2017/18. Sealed Quotations (5.14% in 2016/17 and 16.95% in 2017/18) are increasingly being used as a result of the increase of the financial ceiling in PPA/PPR amendments. Lastly, direct purchasing (2.29% in 2016/17 and 1.69% in 2017/18) seemed to be used only as an emergency procurement method in both years.

Table 1.c.3: Selection of procurement modality in FY 2016/17-2017/18

S.N.	Procurement Modality	No. of contracts in 2016/17	% 2016/17	No. of contracts in 2017/18	% 2017/18
1	Open Bid Method (ICB)	120	68.57	57	48.31
2	Open Bid Method (NCB)	28	16	39	33.05
3	Sealed Quotation Method (SQ)	9	5.14	20	16.95
4	Catalogue Shopping (CS)	14	8	0	0
5	Direct Purchase (DP)	4	2.29	2	1.69
	Total Contract	**175**	**100**	**118**	**100**

Source: Various Years CAPP plan of DoHS

- *Selection of procurement modality by procurement type:* Among all other procurement type's procurement of drugs (65.71% in 2016/17 and 72.03% in 2017/18) and procurement of equipment (21.71% in 2016/17 and 15.25% in 2017/18) is popular purchasing type in DoHS. Similarly, among all procurement civil works is (2.29% in 2016/17 and 3.39% in 2017/18), Office Supplies (5.14% in 2016/17 and 3.39% in 2017/18), Vehicle purchase (3.44% in 2016/17 and 4.25% in 2017/18) and Consulting Services (1.71% in 2016/17 and 1.69% in 2017/18) procurement proceedings are very small in the scenario.

Table 1.c.4: Selection of procurement modality in type of procurement in 2016/17

SN	Procurement Type Procurement Modality	Drugs	Equipment	Civil Works	Services	Office Supplies	Vehicles	Total	%
1	Open Bid Method (ICB)	103	14	-	-	-	3	**120**	**68.57**
2	Open Bid Method (NCB)	2	9	3	2	9	3	**28**	**16.00**
3	Sealed Quotation Method (SQ)	6	2	1	-	-	-	**9**	**5.14**
4	Catalogue Shopping (CS)	1	13	-	-	-	-	**14**	**8.00**
5	Direct Purchase (DP)	3	-	-	-	-	-	**3**	**1.71**
6	Other Method	-	-	-	1	-	-	**1**	**0.58**
	Total	**115**	**38**	**4**	**3**	**9**	**6**	**175**	**100**
	%	**65.71**	**21.71**	**2.29**	**1.71**	**5.14**	**3.44**	**-**	**-**

Source: CAPP-2016/17 of LMD/DoHS.

Due to the effect of the amendments of the PPA/PPR the number of ICB proceedings of drugs (103 contracts) in 2016/17 is reducing (55 contracts in 2017/18). Instead, there is a switch to the NCB proceedings (23 in 2017/18 as against 2 in 2016/17). This means there will be efficiency increments due to using national suppliers. This switch is seen to be due to both the amendment of PPA/PPR and the Suppliers Conference held in DoHS in 2017/18. In the same manner, ICB proceedings for medical equipment has reduced from 14 in 2016/17 to only 1 in 2017/18. This is as a result of reducing the AWPB for medical equipment in central level budget of 2017/18.

Table 1.c.5 Selection of procurement modality in type of procurement in 2017/18

SN	Procurement Type Procurement Modality	Drugs	Equipment	Civil Works	Services	Office Supplies	Vehicles	Total	% of Modality
1	Open Bid Method (ICB)	55	1	0	0	0	1	57	48.31
2	Open Bid Method (NCB)	23	9	3	1	1	2	39	33.05
3	Sealed Quotation Method (SQ)	5	8	1	1	3	2	20	16.95
4	Catalogue Shopping (CS)	0	0	0	0	0	0	0	0.00
5	Direct Purchase (DP)	2	0	0	0	0	0	2	1.69
6	Other Method	0	0	0	0	0	0	0	0.00
	Total	**85**	**18**	**4**	**2**	**4**	**5**	**118**	**100**
	% of Type of Procurement	**72.03**	**15.25**	**3.39**	**1.69**	**3.39**	**4.25**	**100**	**-**

Source: CAPP-2017/18 of LMD/DoHS.

LMD's encouragement of the open bid method for procurement of drugs and equipment has ensured openness, transparency, efficiency and competition. It is also one of the indications of increasing VfM of health facility expenditures of GoN.

- **Bid Publication and Public Bid Opening:** All the bids were processed in a transparent and non-discriminatory way, given the wide range of time periods (30 days for NCB and 45 days in ICB) for bid preparation and submission. Public bid opening (PBO) is held on the stipulated date and time as per the bidding document and a systematic practice of bid opening reporting (BOR) has been established.

- **Bid Evaluation and Approval:** Bid evaluation and approval standard time is maximum of 120 days as per PPA/PPR. All procurement of drugs and equipment had good timing of bid evaluation and approval in both years. All ICB bids in DoHS have been evaluated within the maximum period of 90 days of time and all NCB bids have been evaluated within the maximum period of 35 days. Although frequent changes of DG have occurred, putting effort into e-GP in 2017/18 has sharply reduced the time of bid evaluation and approval in DoHS. So, all procurement of drugs and equipment has improved to a good timing of bid evaluation and approval.

- **Information and communication technology (ICT) Initiatives in Solicitation of Bid:** The DoHS has been improving the use of ICT in bid proceedings since 2016/17. In 2016/17 e-GP was used for almost all bids (99.43%). This was an off-line bidding medium issued by PPMO which only went up to the bid submission. After that all other processes had to be completed manually. So that in 2017/18 LMD started the on-line e-GP-II which includes on-line bidding and built-in evaluation process and has been using it for almost all procurement bidding in the DoHS. Data for 2017/18 shows impressive improvements. Almost 83% of bids have been processed through e-GP and of the other 17% used manual methods of bidding. Among total proceedings, 59% of bids have been processed through on-line e-GP and 24% of bids through off-line e-GP procedures.

e-GP USAGE STATUS OF 2017-18

- Following Medium of bid have been used in this year:

e-GP I	389.99	24.28
e-GP II	939.76	58.51
Other	276.44	17.21
Total	1,606.18	100

- Average lead time for the total procurement proceedings is now reduced to 4 months of time.

Bidding Medium

276.44 , 17%
389.99 , 24%
939.76 , 59%

■ e-GP I ■ e-GP II ■ Other
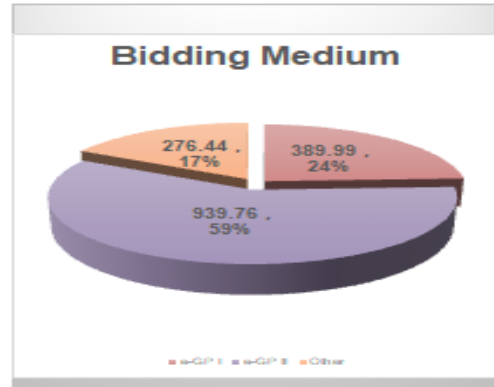
- In 2017/18 by applying e-GP-II in procurement management, the average lead time (ALT) for procurement has significantly improved. In 2016/17, ALT reported was 6 months whereas in 2017/18 by e-GP-II application has shortened to 4 months. Application of e-GP-II has also reduced the total average lead time to 4 months in 2017/18. In 2016/17 it was 6 months.

- ***Contract Management practices:*** The Contract Management Unit (CMU) has established Contract Management System (CMS) software within the DoHS. This is a tool for the execution and monitoring of active contracts.

- ***Procurement Clinics:*** Procurement Clinics are a troubleshooting approach applied in various cases of procurement occurred in all divisions of DoHS. Basically, it is an advisory function for decision makers. In 2017/18 there were 119 clinics formally operated and recorded within the DoHS.

- ***Grievance Handling Mechanism:*** Grievance Handling and Redressal Mechanism is an important phenomenon in procurement and supply chain management, however, it is seldom given very much importance within Nepal. In 2017/18 a concept paper on grievance handling and redressal mechanism was prepared and approved by DoHS. A third-party software developer was hired through competitive NCB method. An outline for software preparation was developed and approved by DoHS and handed over to the software company. Developers have completed the software and handed over to the DoHS in this fiscal year.

- ***Drug Disposal Management:*** In 2017/18, after the devastating earthquake in April 2015, DoHS received a variety of drugs and medical accessories from EDPs as bilateral/multilateral commodity grants. These were stored in various emergent places. In 2016/17 the remaining balance of drugs and consumables were ending their self-life and waiting for proper disposal as pharmaceutical waste. At the beginning of 2017/18

DoHS initiated a study to report on disposal of this waste. As a result it has been decided to send them for incineration at Cement Industries with the help of Ministry of Industry and MoHP.

- ***Monitoring Management through Committee approach:*** MoHP has formed a Public Financial Management (PFM) committee under the chairmanship of the Policy, Planning and International Cooperation Division (PPICD) chief and endorsed its TOR to monitor overall financial management matters including procurement and supply chain management. Similarly, in 2017/18 MoHP formed a CAPP-MC under the leadership of the DG of the DoHS and endorsed its TOR to monitor overall matters of procurement and supply chain management. Under these two broad central level committees, DoHS has formed and expanded the management of various technical committees by CAPP-MC in FY 2017/18.

B. Supply Chain Management Reform

Supply Chain management in the health sector consists of preparing, operating and monitoring the logistics and supply chain improvement activities indicated in the PIP, LMIS, e-LMIS, IMS, Warehouse Development and Management, Transportation Mechanism, and their effective implementation to ensure timely delivery and distribution of medical goods and equipment.

Major Progress

In the fiscal year 2016/17 and 2017/18, the MoHP has made good progress in improving the performance of logistics management. The following targets have been achieved:

- ***Forecasting and Quantifications***: DoHS generally used LMIS software for forecasting and quantification of drugs for coming year. Since 2015/16 this forecasting technique commonly used historical consumption data, morbidity, demographic data and program considerations to predict yearly need of procurement. The procuring entities prepared their forecasts based on data from the HMIS, LMIS, demographic health surveys, census data and other health related policy documents. Basically, LMIS software provides national and district level requirements of drugs as the basis for health commodity procurement planning and delivery schedules practices commonly used in DOHS.

- ***e-LMIS Initiatives:*** LMIS software is primarily based on district level data from 75 districts (two new districts have not been incorporated yet). District public health offices (DPHO) are responsible for collection and data entry into LMIS system on a quarterly basis. In this regard, 71 districts out of 77 are using online LMIS for quarterly district level data updating. e-LMIS software preparation and development has only recently been completed and implemented across the 22 district (5 districts off-line and 17 districts on-line). This is being treated as a program pilot.

- ***Pipeline Reporting and Monitoring:*** Drug status pipeline report of FY 2017/18 is produced through LMIS software and co-monitoring of drugs with EDP representatives at DoHS level. The stock status of 37 drugs is monitored quarterly basis out of 108 which are in Technical Specification Bank (TSB) whereas medical equipment, is not monitored through the system yet.

Challenges

- Poor system linkages between AWPB, TSB, LMIS and CAPP in preparing procurement proceedings and pre-bid information and planning systems mainly including Market analysis, TSB, Cost Estimation, SBDs preparation and APP/MPP approvals directly affects their timeliness.
- The limited capacity of the LMD to conduct market analysis, cost analysis, sourcing analysis, and Procurement Risk Analysis (PRA) for the procurement management system. Market analysis of drug rates, availability of drugs in local/Foreign market, MRP analysis are almost none in practice while making cost estimates in DoHS. So that cost estimation practices in DoHS could not be very realistic and effective in the case of procurement of drugs.
- The existing LMIS/e-LMIS is not comprehensive enough to inform the quantification and forecasting of drugs. Stock status of only 37 drugs is monitored in quarterly basis out of 108 FEDs whereas status of available equipment is not monitored through the system yet.
- The slow pace of standardising the procurement process due to lack of specific solicitations of bids and SBDs designed specifically for the health sector. Absence of health specific SBDs in e-GP system is hampering the procurement of medicine at all levels.
- Delays in procurement due to the lack of effective post-bid information systems, Procurement Audit System (PAS), Quality Assurance Plan (QAP), Risk Mitigation Plan (RMP) and Contract Management System (CMS).
- There is no function assigned to the federal government for the procurement of drugs. This may cause a big challenge in the near future.
- Warehousing facilities in the medical stores are traditional and do not have enough human resources and designed space for the adoption of good warehousing practices.
- Skilled workforces for the operation of e-GP, CAPP, TSB, LMIS, QAP, and Information Management System have not been developed and deployed yet at the federal, provincial, and local level. Similarly, institutional memory has been weakened due to rapid transfers of workforce involved in procurement and supply chain systems.
- Weak contract management capacity and practices have caused problems relating to liquidated damages charges, variations, extension of time, and non-timely delivery of drugs. Contract management capacity and its monitoring are also very weak.
- A weak Drug Disposal Management System is causing a pile-up of expired drugs in the CMS and PMS which are waiting for proper disposal.

- Procurement troubleshooting and a grievance handling system is not in place at Federal, Province or Local levels.
- Capacity building in the provinces and local government is crucial in the case of procurement of drugs. Although, MoHP has already designated health staffs at all levels, 'procurement' seems to be an "unknown task". Similarly, capacity building of Bidders and Suppliers needs to be rolled out immediately at those levels.
- Adequate monitoring of the CAPP is not in place for each type and modality of procurement in each department. DoHS has formed a CAPP Monitoring Committee, but Department of Drug Administration (DDA) and Department of Ayurved (DoA) have not established CAPP-MCs.
- MoHP and its procurement entities are currently undergoing audit observation due to non-compliance, mis-procurement, stock-outs and over-stocking.

Way Forward

- A separate chapter for the procurement of drugs including solicitation of bids along with SBDs, guidelines, and technical notes is required in the PPA/PPR.
- PFM and CAPP-MC to strengthen its monitoring functions to reduce audit observation in procurement.
- Development and endorsement of SOPs for the quantification, forecasting, and procurement of essential medicines and the disposal of expired drugs for PGs and LGs is essential.
- Strengthen pre-bid information and planning systems including market analysis, cost analysis, sourcing analysis and procurement risk analysis in procurement management.
- Develop a Framework Arrangement for the procurement of drugs at Federal and Provincial level immediately.
- Increase the use of ICT through the e-GP system; and incorporate health specific SBDs. Strengthen pre- and post-bid information systems such as the LMIS, PAS, and CMS.
- Professional and institutional capacity building at all levels of governance with systematic provisions to retain institutional memory when staff are transferred.
- Strengthen the supply chain management to ensure the timely availability of drugs and other medical supplies.
- Forecasting and quantification of drugs shall be made Federal, Province and Local requirements.
- Ensure a Quality Assurance Plan including Pre-Shipment Inspection at federal level and Post-delivery Inspection of Drugs at Province and Local level.
- Establishment of a Procurement Clinic for troubleshooting on Federal, Province and Local Governments procurement.
- Effective implementation of the Procurement Mechanism and culture to reduce interferences and irregularities at all level of Governments.

3.2 Outcome 2: Improved Quality of Care at Point-of-delivery

Background

Renewed focus on improving the quality of care at the point-of-delivery has been stressed by the NHSS through establishing minimum standards of service for primary, secondary, and tertiary level institutions. The existing policy frameworks strongly advocate for the establishment of 'quality assurance committees' to coordinate quality assurance and improvement efforts.
The main outputs under this outcome are as follows:
- Quality health services delivered as per standards and protocols
- Quality assurance system strengthened
- Improved infection prevention and health care waste management

Major Progress in FY 2017/18

- In line with the new organogram of MoHP in the federal context, the "Quality Assessment and Regulation Divisions" has been established.
- Public Health Service Act 2018 has been enacted, which lays the foundation for meaningful quality improvements in health.
- A Health Institution Quality Assurance Authority Act was drafted which provisions the establishment of an autonomous body for accreditation of private (including NGO) health institutions. The Public Health Act 2018 provisions institutional arrangements for accreditation.
- The Basic Health Care Package has been defined.
- A High-Level Steering Committee on Antimicrobial Resistance has been formed with representation from other sectors.
- Various guidelines and standards such as the Human Organ Transplantation Regulation (2073), Hospital Pharmacy Guidelines (2073), and a number of standards are currently being updated including the National Medical Standard for reproductive health and child health.
- A report on Quality of Care was published by the MD for the first time which aims to analyse quality of care based on the eight dimensions and document key progresses on quality of care.
- A total of 77 district and district level hospitals have implemented Minimum Service Standards for strengthening hospital management and improving scores achieved on availability and quality of services by these hospitals.
- The Minimum Service Standard for the Health Post, Primary, Secondary and Tertiary hospitals have been developed along with the implementation guideline. The documents are in the approval stage in MoHP.

Highlights of 2018/19

- The draft National Health Policy 2018 has included Quality of Health Care as an integral component.
- The Quality Assessment and Regulation Division of MoHP has initiated updating the guidelines for hospital establishment and upgrade.
- The draft National Action Plan for Anti-Microbial Resistance (AMR) is being finalised.
- The development of Standards Treatment Protocols has been initiated by the Curative Services Division (CSD), DoHS.
- The operational guideline for the implementation of the Basic Health Care Service is being initiated by CSD, DoHS.

Challenges

- Unclear governing structure on quality assurance across three levels of governance in the changed context.
- Overlapping roles of various divisions on quality of care leading to confusion and delay.
- Translating various standards/scores of various tools into indicators to measure quality of care.
- Linking performance of health institutions with quality of care and vice versa.
- Realising the "Institutional Mechanism" for accreditation as provisioned in the Public Health Act 2018.

Way Forward

- Prioritise development of regulation in line with the commitments of the Public Health Act 2018.
- Develop the operational guideline for the implementation of Basic Health Service Package.
- Develop and define the quality assurance structures at all three levels of governance.
- Finalise and approve the guideline for health institution establishment and upgrade.
- Bring the private hospitals under the licensing framework based on the updated guideline.
- Develop provision e-licensing submission for private health institutions based on the updated guideline.
- Finalise and approve the national action plan on AMR.
- Develop/update standard treatment protocols.
- Implement the minimum service standards for different levels of health facility to ensure quality of care at the point of delivery.
- Develop provision of consolidated indicators to monitor quality of care.
- Develop a legal framework for the regulation of drugs and laboratory services across each level of governance.

3.3 Outcome 3: Equitable Distribution and Utilisation of Health Services

Background

It is stated in the NHSS that the MoHP will sustain and improve upon the progress made towards reducing inequalities in health outcomes through the expansion of health services focusing on under-served, poor, and urban communities. The NHSS has equity as one of its four strategic approaches within its target for universal health coverage. The major identified health sector implications of financial, socio-cultural, geographical, and institutional barriers are reduced access to services. As a result, it is essential to improve equitable access to health services by all citizens. Equitable access to health services entails programme implementations that give priority to populations and areas who lack or have limited access to health services.

Two outputs under this outcome are as follows:
 • Improved access to health services, especially for unreached populations
 • Strengthened health service networks including the referral system

Major Progress in 2017/18

This section highlights achievements of the NHSS Results Framework (RF) indicators and changes in equity gaps from the baseline (2011 NDHS) to 2016 NDHS, focusing on provincial disparity, and achievement made during 2017/18 based on HMIS data and from programme implementation status.

 • The neonatal mortality rate (NMR) declined from 33 deaths per 1,000 live births to 21 deaths and the under-5 mortality rate declined from 58 per 1000 live births to 39 deaths from 2011 to 2016 with large provincial variations. Province 4 has the lowest rates both for NMR and under-5 mortality rate at 15 and 27 per 1000 LB respectively, while Province 7 has the highest rates of 41 and 69 deaths per 1000 LB respectively. Province 7 fares well in other health status of children including nutrition status, diarrheal and fever prevalence, and health service utilisation compares to national level, and thus it is important to identify reasons for high mortality in this Province.
 • Women from Provinces 2 and 6 had lowest timely antenatal first visit, four antenatal visits, which is the current protocol, and institutional delivery among all seven provinces. Coverage and compliance to 90 days Iron Folic acid also is lowest in Province 2 while prevalence of anaemia among married women of reproductive age is highest in Province 2.
 • While improvement in service utilization was observed during the last few years, HMIS data from 2017/18 shows a decline in service use (eg. ANC 4 and institutional delivery) especially in some Provinces. It is not yet clear whether the decline is due to declining functionality of service sites or due to incomplete reporting. Aama reporting from HMIS is incomplete from almost all districts (data downloaded on 6thNovember 2018).

- Of the total 31,020 estimated people living with HIV in Nepal about 53% (16,428 persons) received ART from 74 ART sites in 59 districts in 2017/18. Of the 330,460 people tested for HIV at 175 sites; 2,101 were tested positive. It is estimated that approximate 8% of people living with HIV are co-infected with TB. Fifty four percent of newly diagnosed TB patients were tested for HIV, as per the 2018 TB report. At the time of TB diagnosis 9,634 persons knew their HIV status (positive). This has increased from 6,307 in 2016/17. The number of TB patients under treatment with ART is 214 in 2017/18 which was 227 in 2015/16.
- Registered drug resistant TB patients increased from 1,093 in 2016/17 to 1,230 in 2017/18. Multi-drug resistant TB patients decreased from 266 to 246.
- Severely and moderately malnourished children treated under Integrated Management of Acute Malnutrition (IMAM) increased from 591 in 2016/17 to 2,938 children in 27 IMAM implemented districts in 2017/18
- Based on HMIS report, the following table shows that access to and utilisation of family planning (FP), immunization, measles, and institutional delivery by province.

Table 3.1: Overview of the coverage of selective services by province

	Province 1 (N=14)	Province 2 (N=8)	Province 3 (N=13)	Province 4 (N=11)	Province 5 (N=12)	Province 6 (N=10)	Province 7 (N=9)	Nepal (N=77)
Number of districts with measles coverage less than 80%*								
2016/17	3	1	9	8	4	0	2	27
2017/18	6	1	10	10	3	0	3	33
Number of districts with CPR less than 30%*								
2016/17	na	na	na	na	na	na	na	10 (N=75)
2017/18	4	0	1	2	2	5	0	14
Number of districts with institutional delivery less than 30%*								
2016/17	6	1	4	6	1	1	0	17
2017/18	4	3	4	6	2	0	0	17
Number of districts with institutional delivery less than 55%**								
2016/17	9	6	9	9	5	4	1	43
2017/18	9	6	9	9	6	2	0	41

*National programme low coverage cut-off point
**National average for 2017/18 fiscal year
Source: HMIS data (2016/17 and 2017/18) downloaded on 6th November 2018

Major Progress

- A draft of the basic healthcare services (BHCS) package was finalized. The pack includes emerging health care needs such as psychosocial counselling, mental health, geriatric health, oral health, non-communicable diseases (NCD), Ayurveda, and rehabilitative services.
- The social health insurance (SHI) programme has been implemented in 36 districts with about 1.5 million members enrolled.

- Total of 400 Urban Health Centres expanded and 24 Urban Health Promotion Centres established. A total of 450 Community Health Units were operationalized in strategic locations across 77 districts.
- Special newborn care services expanded across the country. There are now Special Newborn Care Units in 21 district hospitals and Neonatal Intensive Care Units in 11 referral hospitals.
- Micro-planning has been conducted to address high unmet need in FP in 58 districts. Visiting providers have been availed to provide long acting reversible FP methods in 60 municipalities of 20 remote districts.
- Provision of a roving auxiliary nurse midwife (ANM) to provide reproductive maternal, newborn and child health services to un-reached groups has been made in 40 municipalities of 20 districts.
- Micro-planning has been conducted for reaching children who have not received immunization in 55 districts. The equity and access programme for new born care has been conducted in two districts.
- The birth preparedness packaged intervention has been conducted in 48 districts.
- The nutrition rehabilitation home scheme has been implemented in 22 districts, the1000 golden day nutrition programme conducted in 30 districts (308 palikas), the school health and nutrition programme in 56 districts, integrated management of acute malnutrition (IMAM) in 27 districts and adolescents' Iron and Folic Acid supplementation in 10 districts.
- The expansion of birthing centres in rural and remote areas has been continued by local government, however the number could not be ascertained due to reporting problems.
- A total of 64,746 C-section were reported in 2017/18 compared to 61,642 in 2016/17 in HMIS.
- A total of 450 community health units (CHUs) were established in strategic locations and made operational across 75 districts.
- A total of eight hospitals[15] have been providing geriatric health services. MoHP has planned to establish 4 geriatric wards in referral hospitals in FY2018/19.
- The MoHP established social service units (SSUs) in 32 hospitals and has planned for an additional 5 in FY2018/19.
- Trainings on communication, psychosocial support, coordination and volunteerism were provided in 6 SSU-based at hospitals.
- A total of 21,820 persons benefited from the Deprived Citizen Treatment Fund in FY 2016/17 (beneficiaries by diseases category: Cancer-10608, Kidney- 4661, Heart – 4276, Sickle cell Anaemia- 1114, Spinal Injury – 539, Head Injury- 521, Parkinson -77, Alzheimer-24. Total expenses were 2.12 billon (2,115,618,907) NPR (Program Progress Report 2017/18)
- A "10-year action plan for disability prevention and rehabilitation" has been developed to support implementation of the National Policy and Plan of Action for Disability.

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[15] Patan Hospital, Kirtipur Aurvedic Hospital, Bhratpur Hospital, Western Regional Hospital, BPKIHS, Bheri Zonal Hospital, Seti Zonal Hospital and Lumbini Zonal Hospital

- The first national conference on disability was organized by LCD/MoHP in August 9-11, 2017 in Kathmandu.
- List of priority assistive devices for Nepal produced.
- National Conference on Post Hospital Care for Emergencies conducted.

Challenges

- Although the responsibility of delivering basic health services lies at the local level, the service package is yet to be realised through a legal framework.
- Improving access to health facilities remains a major challenge particularly in mountain and hill areas, mainly due to geographical barriers.
- Continued limited provision of C-section and surgical services in remote areas is mainly due to inadequacy of skilled human resources. There is a limited case load of procedures/surgeries in remote service sites, which gradually leads to skill loss of specialists and hence demotivates staff from staying at their remote posting.
- Retention of service providers in remote areas is still a serious challenge.
- Limited population and service coverage under the health insurance programme.
- Improving access to health facilities especially to poor, marginalized, gender-based violence (GBV) survivors and people with disability remains a major challenge particularly in mountain and hill areas, mainly due to geographical barriers.
- Retention of service providers in remote areas.
- Limited population and service coverage under the health insurance programme. The challenge is to increase the people's participation towards the program by enhancing trust through assurance of quality health service delivery and capacity building of health institutions. In addition, improved management of human resources including doctors in the service provider institutions, operation and management of pharmacy services in hospitals.
- Alignment between health insurance and other free health care programs.
- Complicated procedures to access the Deprived Citizens' Treatment Fund by the genuine poor.
- Limited availability of geriatric services due to a lack of skilled human resources and hospital-based facilities.
- Limited availability of disability friendly health services and capacity of service providers including inadequate assistive devices and infrastructure.
- Inadequate budget for SSUs considering the client load.
- Increasing trend of Leprosy prevalence rate even after Leprosy elimination.
- Inadequate budget and human resources for the Leprosy Control program.
- Incorporating the disability information into the HMIS, including birth defects and referral to higher level facilities for reconstructive surgeries.
- Insufficient numbers and skills of rehabilitation professionals.
- Absence of rehabilitation facilities and equipment and lack of integration into health systems.

Way Forward

- Endorsement of BCHS package with its regulation, development of the operational guideline and standard treatment protocol at the earliest opportunity.
- Expansion of health insurance to remaining all districts in this current fiscal year 2075/76. (2018/19).
- Alignment between health insurance and free health care programmes.
- Support to local government in health planning focusing on reaching un-reached and marginalized/vulnerable groups and for the referral mechanism in the federal context to reduce the journey barriers to accessing referral level (lifesaving) services.
- Implementation of GESI Strategy after approval from the Cabinet through the development implementation plan, establishment of a GESI institutional mechanism at all levels, and support to province and local levels for the roll out of GESI strategy.
- Improve governance and accountability of health services through local government taking increased responsibility for ensuring basic health care services.
- Ensure equitable availability and provision of basic health care services especially in rural and remote areas through the continued expansion of services at strategic locations.
- Expand coverage services and prioritise the subsidized enrolment of poor populations in the health insurance scheme.
- Advocate and display disaggregated service coverage at local councils and provincial levels to increase awareness among decision makers and service providers.
- Harmonise the health insurance service package with other schemes of social health protection such as basic health care, institutional delivery, and services provided through SSUs.
- Develop a geriatric health care strategy and guidelines for elderly friendly services in hospitals.
- Expand the establishment of rehabilitation units and disability centres.
- Develop new and innovative rehabilitation related training courses i.e. physical and rehabilitation medicine, occupational therapy, and mid-level health workers.
- The SSU model is now being scaled up to teaching private and community hospitals, to support them achieve their own social responsibility targets. The government also plans to take the model down to district hospitals.
- Revise the SSU guidelines in the changed context. Harmonise SSUs with social health insurance and other social health security schemes (information to and engagement with the public and one window entitlement). Roll out and support the use of the new SSU management information system (MIS) in all SSUs.
- Develop a geriatric health care strategy and guidelines for elderly friendly services in hospitals.
- Coordination with provincial and local government level and partners for the effective implementation of the "Policy, Strategy and 10 Years Action Plan on Disability Management".
- Ensure access of disabled people to health services through health insurance package.

- Development of National Guidelines on Disable Friendly Health Services and implement.
- Develop an induction package and integrated information pack and provider friendly materials based on national guidelines on disability friendly health services.
- New disability-friendly health facility designs will be followed for all new health facilities across the country (based on approved health infrastructure development standards 2017).
- Support establishment of new and innovative rehabilitation related training courses i.e. physical and rehabilitation medicine, occupational therapy, and mid-level health workers (multilevel/revisiting curriculum/sensitizing the National Health Training Centre)
- Revise the current HMIS as per the internationally comparable data standards to include disability data
- Intensify IEC activities to raise community awareness on early diagnosis and treatment, the prevention of disability, rehabilitation and social benefits.
- Build the capacity of health workers for early case detection, management and community based rehabilitation.
- Review the budgetary allocations for expansion of SSU, OCMC, Geriatric, Disability and Leprosy Control Program.
- Start the School Health Nurse program in all provinces.
- Regulate home based care by adopting the Act and guidelines related to home based care.
- Initiate a midwifery education program.

3.4 Outcome 4: Strengthened Decentralised Planning and Budgeting

Background

The NHSS has highlighted that there will be a renewed focus on a decentralised approach to health sector planning and budgeting with an aim to make the health system more accountable to the public and responsive to their needs. It also mentions that the centre will define national priorities, establish the necessary regulatory framework, monitor progress, and provide necessary technical and financial resources. Outcome 4 of the strategy has its single output as "strategic planning and institutional capacity strengthened at all levels".

Considering the unitary structure of governance, the NHSS had envisioned to make districts responsible for participatory planning, budgeting, and implementing their respective health plans. Federalism has instead provided a major impetus to decentralise planning and budgeting and each of three levels of governments have mandates to develop annual work plans and budgets and to implement their plans. Organisational structure has been revisited and restructured for the federal, provincial and local levels. While the structure of provincial health offices have been defined and are being established in some provinces, the District (Public) Health Offices have also been retained temporarily.

As the planning and budgeting happens in each of three levels, it is critical to ensure harmonisation of the annual work planning and budgeting process across three levels of the government so that a consistent and coherent plan can be developed. Similarly, the delivery of basic health services is a primary responsibility of the LGs while the federal and provincial governments have major roles in relation to setting the policy and regulatory framework, quality assurance, financing and management of hospital services.

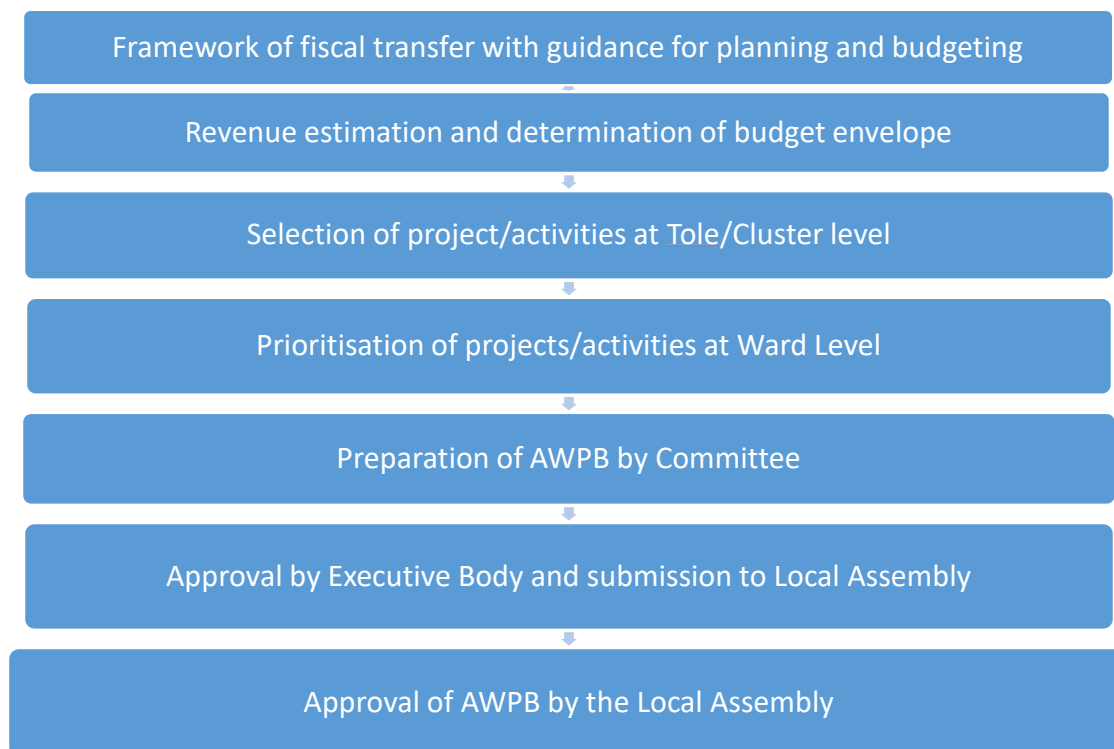**Major Progress in FY2017/18**

- The fiscal year 2017/18 has been a landmark towards decentralized planning and budgeting. As per the constitutional provision and the federal structure, the budget was provided to the local level in two components, namely: an equalisation grant and a conditional grant. In the past, the MoHP had initiated providing a block grant to districts to address specific needs at the district level as per their specific needs within the provided framework.
- The equalisation grant is unconditional by nature and can be used for administrative and developmental activities including for the health sector. The conditional grant is earmarked to specific sectors and should be spent as per the conditions provided. As per the allocation of the budget in 2017/18, the conditional grant is allocated mainly for the education, health, and agriculture sectors.
- MoHP developed a consolidated implementation guideline focusing on the activities assigned to the local level to facilitate/guide the implementation of health programmes at the local level

- Providing grants to the local level has provided an opportunity for integrated planning at the decentralised level. The volume of the equalisation and conditional grants allocated in 2017/18 is depicted in table 4.1 later in this section. On average, one local government received 200 million NPR in budget in the form of an equalisation grant while the volume of the conditional grant was 102.7 million NPR including 20 million NPR for the health sector.
- Of the total health sector budget, one third of the budget was allocated to the local level while the rest was distributed across central, regional, and district health offices
- Out of the total health budget allocated to the local level, almost two thirds was for administrative purposes which mainly includes staff salaries. The remainder is for programme activities including the procurement of medicines.
- Conditional grants were provided to the local level along with the detailed list of activities to be implemented.
- In the federal structure, crucial documents promulgated in 2017/18 in relation to the planning and budgeting. These are summarised below.

Local Government Operation Act- 2017: This Act defines the overall mandates of the LGs and their operational procedure. This also includes a section on 'planning and implementation' with the following key provisions.
- Local levels should prepare periodic and annual plans compatible with provincial and federal policies, targets, objectives, timeframes, and procedures
- Estimates of revenue, prioritisation of projects, an execution plan and monitoring and evaluation (M&E) plan should also be included while preparing the local level plan
- Provision of the Budget and Programme Formulation Committee (Deputy Mayor/Chief of the Municipality, sectoral members of Council, Chief Administrative Officer , Planning Head)
- Estimates of revenues and expenditure – the AWPB, to be presented in Local Assembly by *Ashad* 10 (approx. June 25)
- Endorsement of the AWPB by the Assembly by end of *Ashad* (mid-July) with necessary revisions
- Public Procurement at local level shall be as per the Federal Procurement Act
- The organisational structure of local levels should be defined based on the Organisation and Management (O&M) survey while considering local needs and context after the staff adjustment
- Considering the rights of LGs, sectoral ministries should review their organisational structure and make necessary arrangements for the handover of assets, liabilities, and budget to the local level within six months upon the endorsement of the Act

Figure 4.1 Seven step planning process at the Local Level

Framework of fiscal transfer with guidance for planning and budgeting
Revenue estimation and determination of budget envelope
Selection of project/activities at Tole/Cluster level
Prioritisation of projects/activities at Ward Level
Preparation of AWPB by Committee
Approval by Executive Body and submission to Local Assembly
Approval of AWPB by the Local Assembly

- **Inter-governmental Fiscal Management Act- 2017:** This Act defines the basis for the allocation of funds across the different governments and includes following key provisions regarding resource allocation among three levels of government:
  - Establishment of Federal Distributive Fund: Revenues from Value Added Tax and Excise Duty will be accumulated in this fund and distribution will be made to three levels of governments in the ratio of: 70 % to GoN; 15 % to 7 provinces; 15 % to 753 local level.
  - The **Inter-Governmental Fiscal Commission** to define the basis for distribution to provinces and local level and makes provisions for:
    - o Financial equalisation grant
    - o Special grant
    - o Conditional grant
    - o Matching grant
- Receiving foreign grants and loans is the mandate of the GoN

Highlights of FY2018/19

- The MoHP developed planning and budgeting guidelines for the local level to facilitate the evidence based planning process also in accordance to the federal and provincial level plan

- The annual work plan and budget for 2018/19 was developed as per the federal structure and summary of the financial equilisation and conditional grants allocated by the federal government to provinces and local level is depicted in the table below.

Table 4.1: Summary of the financial equilisation and conditional grant allocated by federal government

Description	Financial equilisation	Conditional	Total	Total (per unit)
Provinces Total	50,298.6	63,135.5	113,434.1	16,204.9
Local Level				
Metropolitan	2,663.0	4,054.2	6,717.2	1,119.5
Sub-metropolitan	3,559.8	4,479.2	8,039.0	730.8
Municipality	38,165.4	50,175.9	88,341.3	320.1
Rural municipality	40,819.3	51,136.3	91,955.6	199.9
Local Level Total	85,207.5	109,845.6	195,053.1	259.0

Note: Amount in million NPR.
Source: Compiled from MoF (Red Book) and AWPB for local level.

- Programme implementation guideline developed for local level and provincial level to facilitate the execution of the conditional health budget allocated to the respective levels.
- Programme implementation plan developed by MoHP along with a monitoring framework as per the template prescribed by the Office of the Prime Minister and Council of Ministers (OPMCM) which focuses on the areas highlighted in the annual policy and programmes.
- The health sector budget was also allocated to federal, provincial and local levels. Allocation of the health sector conditional grant to local level (18,152.7 million NPR) increased by 20% in FY 2018/19 as compared to the grant allocated in FY 2017/18. However, the volume of the equilisation grant to local level has reduced.
- The revenue transfer mechanism as provisioned in the constitution has come into effect from the FY 2018/19. As per this mechanism, funds accumulated in the federal distribution fund will be divided to federal (70%), provinces (15%) and local levels (15%).
- Provincial governments have also allocated equilisation and conditional grants to local level from the FY 2018/19.

Challenges

- Delay in the approval of the organizational structure and its functionality has affected the budget allocation. Particularly, the health budget for district level hospitals was allocated to the local level while those institutions have been provisioned under the provinces in organisational restructuring. Similarly, although DHOs still remain functional, their future role and adjustment is yet to be confirmed.
- There has been a certain level of mismatch in the allocation of the health budget to the LGs. However, the MoHP is coordinating with the Ministry of Finance (MoF) on the management of budgetary mismatch and inadequacy.
- Challenges remain to ensure rational allocation of the budget to provinces and the local level as per the actual availability of the human resources and other programmatic need.

- As planning and budgeting happens at three levels, and by not having a single platform for the planning and budgeting, it is a challenge to ensure horizontal and vertical harmonisation of planning and implementation of health sector programmes across the three layers of government.
- Ensuring timely implementation of the planned activities and utilisation of the allocated budget in the current federal structure remains a challenge as institutional structures are newly formed and organisational capacity remains limited as respective level.

Way Forward

- Develop a manual/platform for the planning and budgeting at the federal, provincial and local levels to ensure harmonised and coordinated planning and budgeting across three levels.
- Review and revise the e-AWPB planning framework to make it consistent with the line ministry budgetary information system (LMBIS) and in accordance with NHSS outcomes
- Closely engage with provinces to monitor progress, performance and challenges in planning and implementation.
- Continuously track the implementation challenges and successes at the provincial and local levels.
- Develop case studies and success stories and promote peer learning amongst provinces and local level.
- Coordinate with the National Resource and Fiscal Commission and MoF to develop a transparent mechanism for the rational allocation resources for the health sector across provinces and local level.

3.5 Outcome 5: Improved Sector Management and Governance

Background

The NHSS asserts that the restructuring process of the health sector will be aligned with the broader state restructuring agenda vis-a-vis federalism. Furthermore, it recognises aid effectiveness as an important facet of health governance through embracing the principles and priorities of the Development Cooperation Policy, 2014, for further strengthening sector wide approach (SWAp) arrangements. There are five outputs under this outcome as follows:

- The MoHP structure is responsive to health sector needs
- Improved governance and accountability
- Improved development cooperation and aid effectiveness
- Strengthened multi-sectoral coordination mechanisms
- Improved public financial management

Major Progress in FY2017/18

- Restructuring of health sector of three levels of governance in accordance with federalism approved and being implemented.
- Major roles and responsibilities of each restructured unit has been approved and implemented.
- A transitional plan of health sector has been developed jointly with partners and is under implementation.
- With the view of gaining an in-depth understanding on health service delivery at the local level (i.e. leadership, governance and accountability, service quality, planning and budgeting, and monitoring of health interventions, reaching the unreached) the MoHP is implementing the 'learning lab' approach in seven identified rural/urban municipalities, with at least one in each province. The MoHP is being supported by a number of EDPs to implement this concept and help generate evidence to strengthen health service delivery at the local level.
- The following Acts are enacted:
  - Health Insurance Act
  - Local Government Operation Act
  - Staff Adjustment Act
- Frequent interaction with the officials of provincial social development ministries and health directorates were held on the issues of health governance and implementation plans.
- Performance based financing approach has been adopted in the health sector through Disbursement Linked Indicators.
- Strengthened Public Financial Management (PFM) practices as follows:
  - Internal Control Guidelines revised and endorsed on 4th July, 2018. A total of 500 hundred copies of the guidelines were printed, published on FMoHP website, and distributed to concerned spending units.

- The financial monitoring report (FMR) templates revised & approved by MoHP on 16 May 2018 as the need of DLI.
- All FMR (3 trimesters) were submitted to EDPs on time as per the revised FMR templates.
- Submitted Audit Financial Statements of FY 2016/17 to the Office of the Auditor General (OAG) and its audit report certified by OAG on 25 June, 2018. The certified report forwarded to EDPs on 27 June, 2018. This is a significant improvement on last year, when the report was submitted on 06 September, 2017.
- Built monitoring system on the transaction accounting and budget control system (TABUCS) for internal audit functions. This is the first time the MoHP has prepared an internal audit functions report. The TABUCS has a feature to record the audit reviews reports.
- Financial management workshops were held in five regions (covering 7 provinces) to enhance capacity of the programme managers and finance officers in financial matters.
- The data of "percentage of audited spending unites responding to OAG's primary audit queries within 35 days" has met the disbursement linked indicators (DLI) target of 55.84%. (It is a one of the indicators of DLI), while last year the target was 44.97%.

- For measuring and improving data quality, the RDQA tool, (an online tool) is developed and is available for health workers and managers at various levels to monitor the quality of data produced by health facilities.

- A Health Facility Registry which captures brief information on each health facility belonging to both the public and private (non-government sector including) sectors across the country is prepared and uploaded on the MoHP web site. The registry features an interface that allows various information systems to connect to it, and keep their individual lists of health facilities up-to-date and synchronized with that of MoHP. The list of facilities in the registry can be viewed from http://nhfr.mohp.gov.np.

- A review of all existing health sector policies (22 in total) was made and it has provided the input for developing the new health policy.

- Under the leadership of OPMCM a five-year National Strategy and Action Plan for GBV and Gender Empowerment is prepared.

- Prepared the Ten Year National Policy and Action Plan for Disability.

- Social Audit implemented in 2,138 health facilities across 77 districts.

- The report of Nepal National Health Accounts 2009/10-2011/12 is finalised and published.

- The report of Nepal national micronutrient status survey is finalised and published.

- A number of meetings were held within the MoHP and its departments and with EDPs to update and discuss on various aspects of federalism pertaining to health services delivery.

- Prepared a concise implementation guideline on health programmes for province level and for local levels and uploaded on the MoHP website.

- Joint Consultative Meetings (JCM) are held as planned.

Highlights of FY2018/2019

- A draft of New National Health Policy is prepared.
- As per the provision of the Constitution, the Public Health Service Act (PHS Act) and the Safe Motherhood and Reproductive Health Act are enacted. The PHS Act has broadly defined the scope of basic health services, it has provision of health system and health service management, organ transplant, social, environmental and cultural determinants of health and management of emergency health services among others.
- The Health Sector Gender Equality and Social Inclusion Strategy is prepared and submitted to the Cabinet for approval. Similarly, guideline on Budget Markers for LNOB is drafted.
- A thematic vision paper of the health sector drafted for the 25 year vision paper under the leadership of National Planning Commission.
- A thematic approach paper on the health sector drafted for the 15th five-year periodic plan.
- The final draft of the guideline for Health Facility Operation and Management Committee of the local level health facilities is prepared.
- Although in current FY only NPR 4.18 billion is allocated for the health sector for the provincial governments in the form of conditional grants.
- Internal Control Guidelines updated and circulated to concerned entities within MoHP for feedback
- Conducted a comprehensive National Health Review of 2016/17 in Kathmandu, participated by all 75 districts and hospitals including tertiary and referral, academia, and development partners; this was the first national review of its kind in the federal context hence it was designed to allow discussions based on federal, provincial, and local health functions.
- Formed multi-sectoral steering committee (SC) and technical working group (TWG) for the revision of GESI strategy and developed framework for revision.
- The policy dialogue forums are initiated in the ministry. The forums are being organised on a monthly basis for stakeholders to discuss pertinent issues of the sector. A TWG is also formed to address the issues raised during the forums.
- Approval of the BHS package, costing of the package, formulation of the regulation of the recently enacted Acts and preparation of various guidelines based on the Acts and regulations are in the pipeline.
- The regulations to realise the Public Health Service Act are being developed.
- The guideline to effectively engage the private sector in health is being developed by MoHP.

Challenges

- Ensuring the delivery of BHCS across all local levels with effective harmonisation
- Costing the BHCS Pacakge.
- Limited capacity of local governments for managing devolved health functions.
- The health sector at the local level will have to compete with other sectoral priorities such as roads and infrastructure, among others. In the absence of a clear mechanism in health for the prioritisation and resource allocation with use of evidence at the local level, the health sector may suffer from a lack of resources and compromise service delivery.
- Ensuring a good balance between strengthening hospitals/facility based curative services and sustaining public health interventions at local levels. Indications at the local level show an increased focus on curative care which can be at the cost of public health interventions.
- Unclear engagement modality for development partners and other stakeholders such as private sector, NGOs/CBOs, and cooperatives for the provincial and local level.
- Finalising the complete governance structure of health at federal, province, and local governments (organisational structure, human resources, and horizontal and vertical linkages), including the immediate adjustment and mobilisation of health staff at various levels.
- Inclusion and implementation of GESI provisions in policies, programmes and guidelines requires further advocacy and influencing work.
- Developing a coordination and collaboration mechanism between ministries and different tiers of government (Federal, Provincial and Local levels) to address the complex issues that impact on access to and use of health services by women, the poor and other excluded groups.
- Lack of clarity on on-budget and off-budget reporting mechanisms in the changed context including expenditure reporting at the local level.
- There is confusion in particularly about the status of district health offices.
- Mismatch between some provision of AWPB of the FY 2018/19 and the status of district level hospitals.
- Retain the gain and adoption at provincial and local level achieved in GESI in health sector.
- Delay in adjustment of staffs at three layers of governance is creating problems.
- Revision of all the health sector Acts and regulations in spirit of the constitution within 3 months is a challenging task.

Way Forward

- Approval of the BHCS package and support the LGs to implement BHCS adequately.
- Clarity on the health governance structures of all levels with defined roles and responsibilities.
- Provide technical and managerial support to government leadership and respective health departments/units at province and local level for uninterrupted health service delivery.

- Work with Natural Resources and Fiscal Commission, MoF, and respective ministries to ensure financial accountability and reporting of health expenditure.
- Update TABUCS in the federal context and support for its effective implementation by concerned entities.
- Promote the use of available evidence to inform a local health plan so health service quality is improved and no-one is left behind.
- Make the transition to federalism well informed with lessons learned at the local level.
- Implement the learning lab concept under the operational research framework in federal context, design, implement, document, and scale up– in identified sites to strengthen health service delivery at the local level.
- Ensure GESI concerns are integrated into all newly formulated, revised, updated and amended policies, such as the new health policy, and the GBV national strategy and action plan.
- Implementation of GESI strategy including development of Implementation Plan and establishment of GESI institutional mechanism at all levels.
- Development of Gender Responsive Budget Guidelines and its implementation at all levels (Federal, Provincial and Local Levels).
- MoHP to continue integrating GESI into its annual workplans and budgets (AWPBs) and include adequate funding for GESI mainstreaming activities in forthcoming AWPBs.
- Continue implementing GESI integration in NHTC's induction and other training packages.
- Support the implementation of the HMIS indicators and promote the use of disaggregated data and evidence during planning, programming and monitoring at provincial and local level.

3.6 Outcome 6: Improved Sustainability of Healthcare Financing

Background

UHC is well placed in the National Health Policy (NHP) 2014, ensuring the provision of free BHS as a fundamental right of every citizen. The policy envisions providing access to quality health services (beyond BHS) in an affordable manner by ensuring financial protection in health. The policy aims to do this by gradually increasing the state's investment in the health sector, increasing per capita expenditure and reducing out of pocket expenditure (OOPE) through social health protection arrangements, including targeted subsidies.

The NHSS focuses on increasing investments in the health sector and social health protection mechanisms for the improved sustainability in healthcare financing. The following two outputs are the core function of the stated outcome:
- Strengthened health financing system
- Strengthened social health protection mechanisms

Major interventions proposed under this outcome particularly for 2017/18 include developing and introducing a resource allocation formula, enhancing the MoHP's capacity on performance based resource allocation, enhancing capacity for the institutionalisation of the National Health Accounts and the harmonisation of existing social health protection schemes, and the implementation of health insurance.

Major Progress in FY2017/18

- Government health expenditure as a percentage of the Gross Domestic Product (GDP) for FY 2017/18 is 1.9% compared to 1.8% in FY 2016/17. There has been a 0.5% increase compared to the baseline year and 0.3% increase compared to the NHSS target. The figure below provides an indication of the trend of government health spending as a percentage of the GDP. Over the years, government spending on health as a share of GDP is increasing, albeit marginally. In the figure below, the government spending on health includes the budget allocated to the MoHP, and other line ministries.

Figure 6.1 Trend on government health spending as a percentage of GDP (NPR Billion)
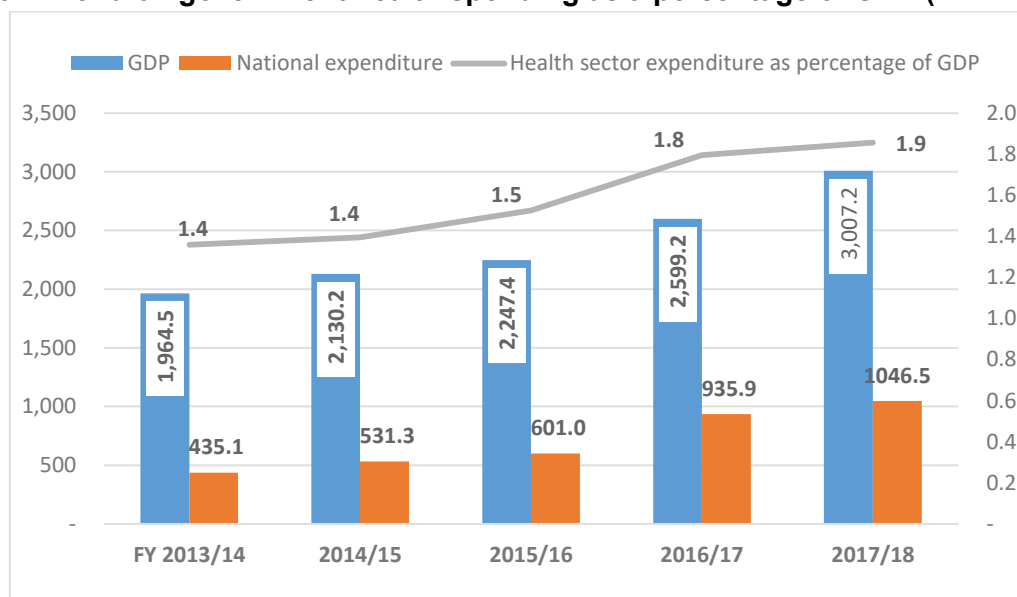
- The Chatham House report of 2014 recommended that countries should strive to spend 5% of their GDP on progressing towards UHC. There is a wide range of evidence and comparisons across countries that support the target of at least 5% or more of the GDP. The 2010 World Health Report stated that public spending of about 6% of the GDP on health will limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible. Government spending on health of more than 5% of the GDP is required to achieve a conservative target of 90% coverage of maternal and child health services. The same Chatham House report recommends low-income countries to spend USD 86 per capita to promote universal access to primary care services.

- The figure 6.2 below shows trends in per capita government spending on health. Between FY 2013/14 to FY 2017/18, the per capita government spending has gradually increased from NPR. 966 (USD 9.8) to NPR. 1,819 (USD 17.7) in real terms. However, during the same period, government spending on health increased very little from NPR. 373 (USD 3.8) to NPR. 551 (USD 5.4), in constant terms (base year fixed to FY 2000/1). This shows that Nepal is spending far behind the recommended amount to achieve universal access to primary care services.

Figure 6.2 Per capita government health spending
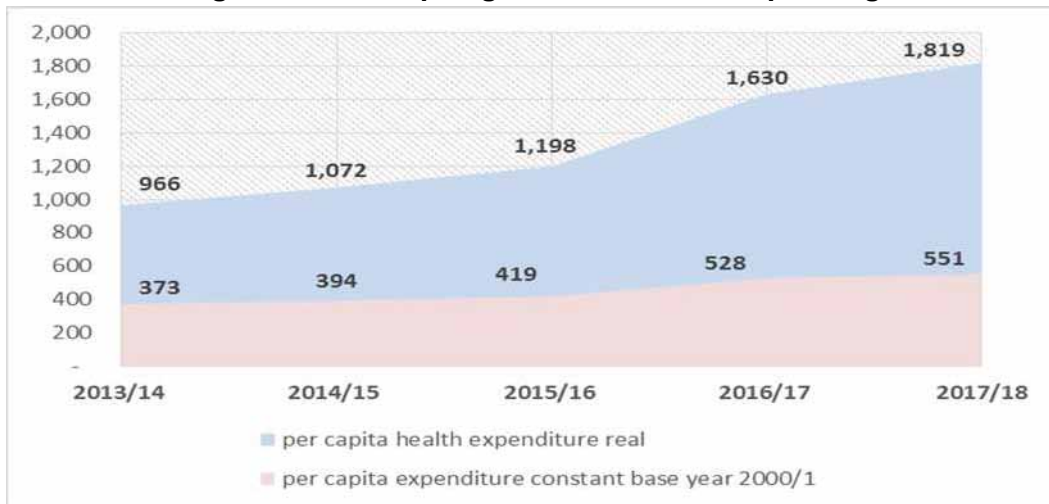
Source: BA FY 2017/18

- The figure 6.3 below shows trends in the health budget as a percentage of the national budget. The percentage of the health budget against the total government budget has decreased by 1.1% from 6.1% in FY 2013/14 to 5% in FY 2018/19 including the health budget allocated to the local and provincial level. In FY 2018/19, a NPR. 18.2 billion budget has been allocated to LG and NPR 4.2bn to the PGs in the form of conditional grant for health. The conditional health budget accounts for 40% of the total health budget. Evidence suggest that PGs and LGs have made additional allocation in health. Thus, actual government spending in health is anticipated to rise.

Figure 6.3: Health budget as a percentage of the national budget
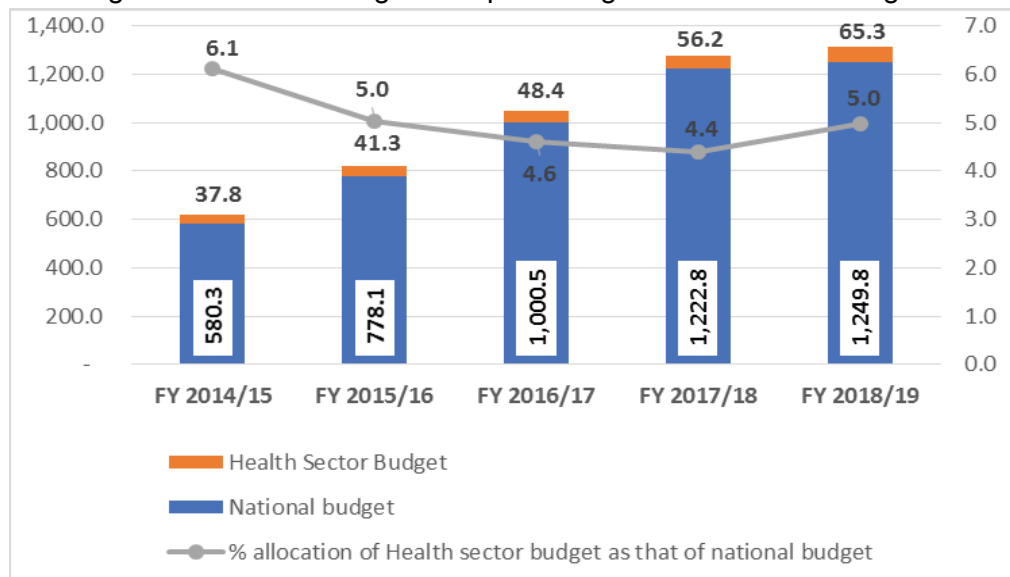
Source: BA 2017/18

- The GoN has rolled out several social protection schemes to reduce OOPE in health. The GoN had expanded the coverage of the health insurance programme in 36 districts by the end of 2017/18. The cumulative number of people enrolled in the SHI has increased to 1.1 million by the end of FY 2016/17 (and more than 1.3 million by the end of Nov 2018, which is 8.3 % of the catchment population in the implemented districts).

- The latest National Health Account (NHA) reports OOPE as a percent of current health expenditure (CHE) to be 55.44%, 59.44%, 60.05, and 63.53 for FY FY2015/16, FY2014/15, FY2013/14 and FY2012/13. This implies that OOPE as percent of CHE has been gradually decreasing over the years. Between FY2012/13 and FY2015/16 OOPE as a percent of CHE decreased by 8%. Major policy concern is demanded towards strengthening social health protection mechanisms in the country in order to achieve the NHSS target of 40% by 2020.

Challenges

- Slow rise in the government health spending in relation to government's commitment in achieving UHC and leaving no one behind.
- Out of pocket expenditure is still a dominant share of health care financing.
- Capturing health spending at all level of governments including resources for health beyond the conditional grant.
- Institutionalisation of the National Health Accounts to routinely monitor health expenditure including spending by PGs and LGs.
- A fragmented approach to the management of various social health protection schemes such as the free health care programme, free delivery, health insurance, and so on.
- Delays in the identification of the poor hampering for the inclusion of the poor and other targeted groups in health insurance through government subsidy.

Way forward

- Continue to advocate with the Natural Resources and Fiscal Commission and the MoF to increase government investment in the health sector to progress on universal health coverage and the agenda of leaving no one behind.
- Assess the root causes of low budget absorption and take action accordingly.
- Costing of basic health service package and its delivery.
- Support PGs and LGs for increased allocation and spending in health.
- Establish a mechanism to track budget allocation and spending for health at each level of government.
- Design and develop a health financing strategy that is applicable to all levels of government.
- Enrol the poor segment of the population in health insurance through government subsidy as envisioned in the recently promulgated Health Insurance Act (2017).
- Review indicators for gauging progress in various tiers of government as well as for comparison with global indicators.

3.7 Outcome 7: Improved Healthy Lifestyles and Environment

Background

NHSS has the view that creating a healthy environment and healthy lifestyle is central to the improvement of overall health status. For this purpose, innovative approaches for behavioural change are suggested for specific behaviours like smoking, alcohol consumption, health seeking behaviour, and obesity. The single output under this outcome is promotion of healthy behaviours and practices.

In Nepal, there is an absence of nationally representative data on prevalence of mental health problems. To cater the mental health needs in the long run, in collaboration with the MoHP few organizations implemented mental health and psychosocial programs through the existing health care system using the task-sharing approach. To spread the word about the service availability in the community and to ensure utilization of these services by the people in need, community members including Female Community Health Volunteers (FCHVs) were trained on detection and referral of people with mental health problems.

The MoHP revised essential drugs list (EDL). The revised EDL has added 6 new psychotropic medicines summing up to 13 in the free essential drug list. The MoHP developed a Standard Treatment Protocol (STP) for medical officers and primary health care workers based on the revised essential drug list and Mental Health Gap Action Programme (mhGAP) intervention guidelines. The National Health Training Center (NHTC) developed training modules and facilitators guides for both psychosocial interventions and detection and management of priority mental disorders using mhGAP intervention guides. Further, MoHP allocated budget for community mental health activities for the first time through red-book. In these processes, many partners including the DFID- Nepal Health Sector Support Programme III provided support to MoHP. Some of these initiatives and approaches have been successfully scaled up by the MoHP.

Major Progress in FY2017/18

- Established Mental Health Section at EDCD
- International mental health conference organized in February, under the theme of mental health promotion, prevention, treatment and rehabilitation
- International conference on child and adolescent mental health was organized in November, 2018.
- Development of the training manual based on the Standard Treatment Protocol for Prescribers and the Reference Manual and conducted TOT.
- Rehabilitated 63 mental health patients those were helpless with public private partnership modality.
- Mental health training in 6 different provinces and also conducted TOT at central level based on the newly developed training modules.

- IEC materials including radio program and disseminated through DPHOs, NGOs working in mental health.
- National mental health survey is ongoing. A pilot study in three districts has been completed and preparation for the national prevalence survey has been initiated.
- Development of the training modules for the child and adolescent mental health has been initiated.
- Established forty-four OCMCs in each of the forty-four districts by the end of 2017/18.
- Essential services and support required by GBV survivors in OCMC were provided to 10,700 individuals comprising of 92% women and 8% men) accessing services until January 2018 (since its establishment). A high percentage of women receiving services (39.8%) were victims of physical assault or domestic violence, while 29.8% had experienced sexual violence, 26.4   % had suffered extreme emotional/mental abuse and 4.% 'other types of violence (trafficking, witchcraft, child marriage, poisoning, attempted suicide)'.
- The "Basic Psychosocial Counselling Training" was provided to 53 OCMC/hospital staff from 23 OCMC based hospitals. Comprehensive psychosocial counselling training (6 months long) was provided to 14 OCMC staff from 14 OCMC districts.
- GBV clinical protocol rolled out in 14 hospitals of 14 districts. Completed a training of trainers (TOT) session entitled Health Response to GBV. Following the TOT, on-the-job training in all three training sites was conducted for medical officers and paramedics. The OCMCs of all three training sites reported 285 number of GBV cases.
- Finalized standard operating procedures prepared by NHTC on forensic (autopsy, age estimation, injury examination, anthropology identification, examination of GBV/sexual assault, torture examination) training guide and reference manual.
- The Package of Essential Non-communicable diseases (PEN) protocol is endorsed and operationalized and scaled up into additional six districts in 2017/18.
- TOT for PEN Programme conducted for 71 people; About 850 service providers trained on PEN package in eight districts.

Challenges

- Ensuring integrated one-door services to GBV survivors and the long-term rehabilitation of survivors.
- Poor reporting on road traffic accidents
- Inadequate referral provisions
- A low level of awareness on GBV, mental health, and psychosocial issues at community level

Way Forward

- Strengthening and scaling-up of 11 new OCMCs in 2018/19.
- Roll out of GBV Clinical Protocol in OCMC based hospitals and periphery.
- Development of non-communicable diseases and mental health related implementation strategy considering the federal structure.
- Develop online reporting system from OCMCs.
- Conduction of mental health training on standard treatment protocol in 14 different districts of 7 provinces.
- Conduction of psychosocial counselling training to staff nurses in OCMC based hospitals.
- Development and standardize psychosocial counselling training curricula.
- Incorporate NCD data management into the current HMIS training package.
- Strengthen integrated surveillance of communicable diseases and NCDs.
- Implement surveillance of road traffic accidents.

3.8 Outcome 8: Strengthened Management of Public Health Emergencies

Background

A roadmap is provided by the NHSS for improved preparedness and strengthened response to public health emergencies during humanitarian and public health emergencies. It directs towards revising protocols and guidelines for improved health sector emergency at the central and decentralized levels along with enhancement of institutional and human capacity for effective and timely response. The outputs of this outcome are:

- Public health emergencies and disaster preparedness improved, and
- Strengthened response to public health emergencies

In April 2015, Nepal experienced a humanitarian crisis due to devastating earthquake and its subsequent tremors. There are still after effects of this earthquake. The health sector response to earthquake was well recognized and applauded at national and internal level. However, the post-earthquake response nevertheless stretched the capacity of the health sector to its limit and also exposed some limitations of the health systems and capacity especially on emergency preparedness and disaster response.

Besides, outbreaks and endemics are being reported. Following table summarizes the situation of major diseases reported to EDCD (as of 20 Nov 2018, www.edcd.gov.np).

SN	Diseases	Districts affected	Number reported	Period
1	Scrub Typhus	58	773	1 Jan – 26 Oct 2018
2	Kala-azar	44	157	1 Jan – 26 Oct 2018
3	Dengue	27	104	1 Jan – 26 Oct 2018
4	Malaria	44	1050	1 Jan – 26 Oct 2018
5	Leptospirosis	7	10	1 Jan – 26 Oct 2018
6	Brucellosis	1	1	1 Jan – 26 Oct 2018
7	Chikungunya	1	1	1 Jan – 26 Oct 2018

Major progress in FY2017/18

- Restructuring of Epidemiology and Diseases Control Division
- A section for Non-Communicable Diseases (NCD) and mental health has been established
- Leprosy Control and Disability Management Section has also been brought under the EDCD.
- Discussions were held on the integration of diseases surveillance systems
- Central Health Emergency Operation Center (HEOC) is functional for effective health sector response to the flood and landslide.

- Provincial EOCs have also been established
- Effective response was provided to the outbreak of malaria in Mugu district (with 219 cases reported), which was considered a malaria free district in the past.
- Search and destroy activities were carried out for dengue reported districts
- Hospital Preparedness and Response Readiness strengthened including establishment of emergency medical logistics ware houses and finalization of contingency plans in an additional four hub hospitals- two each in provinces 5 & 7.
- Emergency Medical Deployment Teams formed in the six designated hub hospitals of Kathmandu valley.
- Valley wide simulation exercise conducted to test the emergency preparedness and response readiness of the Tribhuvan International Airport authorities; ambulance services providers; the six hub and satellite hospital networks and the coordination capacity of the national HEOC

Challenges

- Challenges in coordinating preparedness and response activities for Public Health emergencies between 3 tiers of government
- Lack of clarity in the roles and responsibilities of different authorities for management of Public Health emergencies.
- Funding gap to address the emergencies
- Poor state of stocking of drugs for emergencies
- Inadequate supply of essential medicines and prepositioning of supplies at strategic locations
- Delayed construction and restoration of damaged health facilities post-earthquake 2015.
- Timely reviewing/updating of 'contingency plan' including 'hospital emergency response plan' frequently as was felt during this year's flood response.
- Gaps in coordination and communication with public and private hospital.

Way Forward

- Enhance capacity and deployment procedures of Rapid Response Teams (RRTs) for effective team mobilization and initiation of first response/recovery activities at Palika level.
- Strengthening of effective information management by EDCD and coordination support between relevant line ministries and other stakeholders at all levels of government.
- Establish an emergency response fund at all levels of government and preposition of essential lifesaving drugs/medicines and supplies in strategic locations
- Support various hospitals for adequate preparedness during disasters.

- Strengthen the hub hospitals of the country and make the National Emergency Medical Deployment Teams and Epidemic Rapid Response Teams functional at respective levels;
- Establish HEOCS in the remaining four provinces;
- Develop a comprehensive integrated multi-year national capacity building plan for the management of emergencies and disasters.

3.9 Outcome 9: Improved Availability and Use of Evidence in Decision Making Processes at All Levels

Background

Increased access to and use of information through the use of ICT is a direction provided by NHSS. It also emphasises improved and interoperable routine information systems and prioritises surveys and research. Similarly, it strives for improved and integrated health sector reviews at various levels that feed into the planning process. Towards achieving universal health coverage and leaving no one behind, the NHSS and the SDGs emphasise monitoring and reducing the equity gap in the health outcomes of different population sub-groups.

The outputs linked to the stated outcome 9 are as follows:
- Integrated information management approach practiced,
- Survey, research and studies conducted in priority areas
- Improved health sector reviews with functional linkage to planning process

Major Progress in FY2017/18

Integrated information management
- This year the MoHP continued the expansion of electronic reporting of service data from health facilities. A total of 1200 public health facilities now submit the HMIS monthly reports electronically. As health posts and primary health care centres are now being managed by the local government, the MoHP is focusing on enhancing their capacities on health information management, including the use of the DHIS2 platform. This will allow for the continuous flow of data from the health facilities to the national HMIS system. The HMIS e-learning modules for the orientation of health workers, statisticians, computer operators and programme managers have been developed and are available on the MoHP website.
- A web-based Routine Data Quality Assessment (RDQA) tool has been developed to improve the quality of health facility based data reported mainly via health management information system (HMIS). Along with the assessment tool, an e-learning package to facilitate its use has been developed and is available on the MoHP website.
- Currently, patient-based data in health facilities are recorded on a paper-based system which cannot be readily analysed, used and shared for decision making. Using open source software technology, the MoHP has designed an electronic health record system – a digital collection and retrieval of a client's medical records - for hospitals, primary health care centres and health posts. It will contribute in building an efficient health information system and also help the local governments to keep track of the health status of their catchment population.
- The MoHP developed a guideline on Health Sector M&E in the federal context. This guideline defines the health sector M&E functions of the local, province and federal government; specifies the way forward and roles of different entities in meeting the data

gaps with specific reference to the NHSS Results Framework and Sustainable Development Goals - Goal 3.

- Keeping the idea of interoperability among various health information systems at the core, the MoHP has been developing the core components of the eHealth ecosystem. In the last year, MoHP developed the Health Facility Registry, a tool that keeps track of all health facilities within the country, public and private, as well as key information regarding the facility such as the services offered. At the same time, the registry features an interface that allows for various information systems to connect to it, and keep their individual lists of health facilities up-to-date and synchronized with the MoHP. The registry can be accessed from the MoHP website.
- Digital dashboard has been developed to monitor major health indicators including the NHSS Results Framework and health-related SDG indicators and are published in MoHP website. The dashboard uses data from NDHS, NHFS and HMIS.
- The MoHP has initiated a number of e-health initiatives like web-based grievance management system and file tracking system.

Survey, research and studies
- The Nepal National Micronutrient Status Survey 2016 was completed and the findings disseminated. Key findings of the survey include:
    - 35 percent of children 6-59 months suffer from stunting, 29 percent underweight and 11 percent wasting
    - One-third of the adolescent boys and adolescent girls aged 10-19 years (32 percent each) suffer from stunting.
    - Among non-pregnant women 15-49 years, 11 percent had short stature (shorter than 145 cm),
    - 15 percent were thin or underweight, 19 percent were overweight and five percent were obese.
    - The prevalence of risk of RBC folate deficiency was 16 percent among adolescent girls and 12 percent among non-pregnant women.
    - The median urinary iodine concentration among children 6-9 years was 314.1 µg/L.
- Further analysis of NHFS 2015 was completed and findings disseminated on the following topics:
    - Client Satisfaction and Quality of Curative Services for Sick Children in Nepal
    - Quality of Family Planning Services Delivery and Family Planning Client Satisfaction at Health Facilities in Nepal
    - Quality of Care and Client Satisfaction with Maternal Health Services in Nepal
    - Health Services Availability and Readiness in Seven Provinces of Nepal
- National health accounts covering the three-year period from 2009 -2012 have been prepared in 2017. These provide detailed and updated information regarding the health expenditure by source, financing agents, types of service providers, functions, and status of out-of-pocket expenditure in the country.
- The Nepal Health Research Council (NHRC) carried out a number of research studies in 2017/18. The reports of the research are available in NHRC website.

- MoHP in collaboration with NHRC has initiated the process of preparing a country report based on the global burden of disease (GBD) 2017 data. The key findings of the GBD 2017 estimates for Nepal include:

  - Females are expected to live longer (73.3 years) than male (68.7 years). Life expectancy for females increased from 59 to 70 years, and from 58 to 69 years for males, in the 27 years between 1990 and 2017. However, not all these additional years gained will be healthier ones. Females are expected to live only 62 years of healthy life, with men living only 60 years of healthy life for males.
  - A total of 182,751 deaths are estimated in Nepal for the year 2017. Non-Communicable Diseases (NCDs) are the leading cause of death – two third (66%) of deaths are due to NCDs, with an additional 9% due to Injuries. The remaining 25% are due to communicable, maternal, neonatal and nutritional (CMNN) diseases. Ischemic Heart Disease (20.6% of total deaths), Chronic Obstructive Pulmonary Diseases (COPD) (8.8% of total deaths), Stroke (8.6% of total deaths), Road Injuries (4.9% of total deaths), and Neonatal Disorders (4.8% of total deaths) were the top five causes of death in 2017. This reflects a similar, growing pattern world-wide with 73% of deaths due to NCDs, 8% due to Injuries, and 19% due to CMNN diseases in 2017.
  - Similarly, out of total (5,850,044) Years of Life Lost (YLLs) due to premature death, 49% are due to NCDs, 39% due to CMMN disease and remaining 12% due to injury. Top 5 causes of YLLs due to premature deaths are Neonatal Disorders (12.9% of total YLLs), Ischemic Heart Disease (11.3% of total YLLs), Lower Respiratory Infection (7.9% of total YLLs), COPD (5.5% of total YLLs) and Road Injuries (5.1% of total YLLs) and Stroke (5.6% of total YLLs). The leading causes of morbidity (Years of Life Lived with Disability – YLDs) are low back pain, headache disorders, COPD and depressive disorders.
  - Approximately, 59% of disease burden (Disability Adjusted Life Years – DALYs) in 2017 is due to NCDs, 31% due to CMMN diseases and 10% due to injury. Ischemic heart disease (7.5% of DALYs), COPD (5.3% of DALYs) and lower respiratory infection (5.1% of DALYs) are the top three health problems causing majority of disease burden (DALYs lost) in 2017.
  - GBD 2017 findings reveal that Child and Maternal Malnutrition (14.7% of total DALYs), Dietary Risks (10.7% of total DALYs), Tobacco (9.6% of total DALYs), High Systolic Blood Pressure (9.2% of total DALYs) and Air Pollution (9% of total DALYs) are the top five risk factors driving death and disability in Nepal.

  Ref: Global Burden of Disease Study 2017. Global Burden of Disease Study 2017 (GBD 2017) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2016. Available from: https://vizhub.healthdata.org/gbd-compare/

- With the objective of translating the evidence into action, the practice of developing policy briefs has been initiated analysing the secondary data available. The following briefs have been developed and published on the MoHP website:
  - An analysis of caste disaggregates from NDHS 2016 data to assess caste-wise inequalities in the achievement of major health outcome indicators.

- o Analysis of NHFS 2015 data to investigate the predictors of client satisfaction from antenatal care services;
- o Analysis of NDHS 2016 data examining socio-economic differentials in caesarean section rates in Nepal;
- o A brief highlighting the need for a process for engaging health academic institutions in each province to lead the implementation, strengthening and expansion of maternal and perinatal death surveillance and response system within the province;
- o Review of 22 health sector policies, as a part of a broader effort to ensure improved alignment of the country's legal provisions and policies with the spirit of the constitution.
- o Analysis of routine and survey data to identify inequities in maternal health service utilisation in Nepal.

Health sector reviews with functional linkages with the planning processes
- The MoHP prepared a guideline and tools for the health sector review at all three levels. The objective was to standardise the review process at the local and provincial level and link the review at the sub-national level with the federal level review and planning. The guidelines and tools were shared through the MoHP website. The guideline has been instrumental not only to standardise the review process but also in drawing lessons from the sub-national reviews feeding into the federal review and planning.
- The 'Health Sector M&E in Federal Context 2075' also defines the role and process of health sector review at each level of governance.

Challenges

- Limited availability of quality data to meet the health sector data needs at local, province, and federal levels
- Limited use of evidence based decision making at all levels
- Limited use of integrated information management leveraging the ICT at all levels to sustain the good practices and achievements of the health sector
- Slow progress in the institutionalisation and regularisation of national health accounting.

Way Forward

- Develop strategies, standard protocols, and guidelines for improved information management leveraging ICT.
- Effective implementation of the guideline 'Health Sector M&E in Federal Context, 2075.
- Implementation of 'Health Facility Registry' at all levels.
- Develop and operationalise the central standard data repository.
- Standardise, develop, strengthen, and institutionalise e-health initiatives at all levels.
- Institutionalization and regularization of producing national health accounts.

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CASE STUDY

Leadership Matters: Federalism in Action

Ajayameru Rural Municipality is located in Dadeldhura District of Sudur Pashim province of Nepal. It has total six wards with the population of 17,066.

In the past two years, many notable actions have been undertaken by the municipality towards improving well-being of people. The following are the remarkable innovations and programs of last fiscal year 2017/18. It is evident that health sector has been a priority area of Rural Municipality. In fiscal year 2017/18, around 4,500,000 NRs was allocated, which was increased by 40 percent (6,400,000 NRs) in fiscal year 2018/19.

- Health Act 2075 (2018) of the municipality has been unveiled.
- Rural municipality has six wards, and among five have a health posts. Two community health units (CHU) are established to reach the geographically hard to reach population and aiming for no-one-leave-behind.
- Basic lab services are now available from five health facilities. And from this year nebulizer services are also provided. Further, all health posts and one CHU have run the birthing centers services. Some basic equipment and few human resources are locally hired to provide these services 24/7.
- To increase the maternal and child health services, performance-based-incentive to the FCHVs has been in place. This has caused a positive competition among the FCHVs and also enhances the ANC visits. Similarly, incentive of mobile recharge to the ANM has started from this fiscal year. Also, to attract a regular ANC checkup; egg, washing soap, brush, toothpaste and iodized salt are provided to the pregnant women.
- Hygiene & sanitation is another challenge of Ajayameru, knowing this Rural Municipality has started a hand washing & nail cutting services at health facilities. In fiscal year 2017/18, more than one thousand (1078) people received these services.
- All health facilities are equipped with a computer and printer. Among five HPs, four have internet service.
- Further e-attendance and CCTVs have been installed in all health facilities.
- Monthly staff meeting and in-charge's meeting are regularized. As a result, various schemes are designed & implemented.