Progress of the Health and Population Sector, 2019/20

NATIONAL JOINT ANNUAL REVIEW REPORT – 2020 (2077 BS)

Government of Nepal
Ministry of Health and Population
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Abbreviations

2019-nCoV	Novel Coronavirus
4ANC	Four ANC visits
AA	Anaesthesia Assistant
AFIC	Adolescent-friendly Information Centre
AFS	Adolescent-friendly Services
AIDS	Acquired Immunodeficiency Syndrome
AGO	Auditor General's Office
AMC	Annual Maintenance Cost
AMR	Antimicrobial Resistance
AMRMSC	Antimicrobial Resistance Multisectoral Steering Committee
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APP	Annual Procurement Plan
ARI	Acute Respiratory Infection
ART	Antiretroviral Treatment
ASBA	Advanced Skilled Birth Attendant
ASRH	Adolescent Sexual and Reproductive Health
AWPB	Annual Work Plan and Budget
BA	Budget Analysis
BC	Birthing Centre
BCG	Bacillus Calmette-Guérin
BEONC	Basic Emergency Obstetric and Neonatal Care
BHS	Basic Health Services
BS	Bikram Sambat
CAPP	Consolidated Annual Procurement Plan
CAPP-MC	Consolidated Annual Procurement Plan Monitoring Committee
CB-IMNCI	Community-based Integrated Management of Neonatal and Childhood Illnesses
CBO	Community-based Organisation
CBS	Central Bureau of Statistics
CBS	Central Bureau of Statistics
CCMC	Committee for COVID-19 Crisis Management
CDC	Centre for Disease Control
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHE	Current Health Expenditure
CICT	Contact Investigation and Contact Tracing
CLPIU	Central-level Project Implementation Unit
CMNN	Communicable, Maternal, Neonatal and Nutritional
CMS	Contract Management System
COVID-19	Coronavirus Disease 2019
CPR	Contraceptive Prevalence Rate
CSD	Curative Services Division
CTEVT	Council for Technical Education and Vocational Training
DALY	Disability-adjusted Life Year
DDF	District Development Fund
DG	Director General
DHIS2	District Health Information Software 2
DHO	District Health Office
DLI	Disbursement Linked Indicator

DMPA	Depot Medroxyprogesterone Acetate
DoAA	Department of Ayurveda and Alternative Medicine
DoDA	Department of Drug Administration
DoHS	Department of Health Services
DOT	Directly Observed Treatment
DP	Direct Procurement
DPHO	District Public Health Office
DPR	Detailed Project Report
DPT-HepB-Hib	Diphtheria Pertussis Tetanus - Hepatitis B and Haemophilus Influenzae Type B
DRR	Disaster Risk Reduction
DRTB	Drug-resistant Tuberculosis
DSS	Disaster Surveillance System
DTG	Dolutegravir
DUDBC	Department of Urban Development and Building Construction
e-CAPP	electronic Consolidated Annual Procurement Plan
ECG	Electrocardiograph
ECMC	Epidemic Control and Monitoring Committee
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partner
e-GP	electronic Government Procurement
EHR	Electronic Health Record
e-LMIS	electronic Logistics Management Information System
EMDT	Emergency Medical Deployment Team
EPI	Expanded Programme on Immunization
e-TSB	electronic Technical Specification Bank
EWARS	Early Warning Reporting System
F-CAPP	Federal Consolidated Annual Procurement Plan
FCGO	Financial Comptroller General Office
FCHV	Female Community Health Volunteer
FDA	Food and Drug Administration
FED	Free Essential Drugs
FMIP	Financial Management Improvement Plan
FMR	Financial Management Report
FP	Family Planning
FWD	Family Welfare Division
FY	Fiscal Year
GBD	Global Burden of Disease
GBV	Gender Based Violence
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GHRM	Grievance-handling and Redressal Mechanism
GHSC-PSM	Global Health Supply Chain Programme – Procurement Supply Management
GIS	Geographic Information System
GLASS	Global Antimicrobial Resistance Surveillance System
GM	Growth Monitoring
GoN	Government of Nepal
HEOC	Health Emergency Operation Centre
HFOMC	Health Facility Operation and Management Committee
HIIS	Health Infrastructure Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

HP	Health Post
HRH	Human Resources for Health
ICB	International Competitive Bidding
ICS	Incident Command System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IHIDP	Integrated Health Infrastructure Development Programme
IHIMS	Integrated Health Information Management Section
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
iHRIS	Integrated Human Resource Information System
IMS	Inventory Management System
IMU	Information Management Unit
INGO	International Non-governmental Organisation
IP	Implementation Plan
IPC	Infection Prevention and Control
IUCD	Intrauterine Contraceptive Device
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JICA	Japan International Corporation Agency
KfW	German Development Bank
KOICA	Korean International Cooperation Agency
LARC	Long-acting Reversible Contraception
LG	Local Government
LL	Learning Lab
LMBIS	Line Ministry Budgetary Information System
LMIS	Logistics Management Information System
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MA	Market Analysis
mCPR	Modern Contraceptive Prevalence Rate
MD	Management Division
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MoF	Ministry of Finance
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MoPIT	Ministry of Physical Infrastructure and Transport
MoSD	Ministry of Social Development
MPDSR	Maternal Perinatal Death Surveillance and Response
MPP	Master Procurement Plan
MR	Measles and Rubella
MSS	Minimum Service Standards
MToT	Master Training of Trainers
MTR	Mid-term Review
NA	Not Available
NAP	National Action Plan
NBoD	Nepal Burden of Disease
NCASC	National Centre for AIDS and STD Control

NCB	National Competitive Bidding
NCD	Non-communicable Disease
NCDR	New Case Detection Rate
NDHS	Nepal Demographic and Health Survey
NFHS	Nepal Family Health Survey
NGO	Non-governmental Organisation
NHA	National Health Accounts
NHFS	Nepal Health Facility Survey
NHIDS	National Health Infrastructure Development Standards
NHP	National Health Policy
NHRC	Nepal Health Research Council
NHSPPSF	Nepal Health Sector Public Procurement Strategic Framework
NHSS	Nepal Health Sector Strategy (2015–2020)
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NJAR	National Joint Annual Review
NLSS	Nepal Living Standards Survey
NMC	Nepal Medical Council
NMICS	Nepal Multiple Indicator Cluster Survey
NMS	National Medical Standard
NPC	National Planning Commission
NPHC	Nepal Population and Housing Census
NPHL	National Public Health Laboratory
NPR	Nepalese Rupees
NRA	National Reconstruction Authority
NTP	National Tuberculosis Programme
OAG	Office of the Auditor General
OC	Outcome
OCAT	Organisational Capacity Assessment Tool
OCMC	One-stop Crisis Management Centre
OCP	Oral Contraceptive Pill
ODK	Open Data Kit
OOPE	Out-of-pocket Expenditure
OP	Output
OPD	Outpatient Department
OPMCM	Office of the Prime Minister and Council of Ministers
ORS	Oral Rehydration Solution
OST	Opioid Substitution Therapy
PCAS	Procurement Compliance Audit System
PCR	Polymerase Chain Reaction
PDI	Post-delivery Inspection
PE	Procuring Entity
PEFA	Public Expenditure and Financial Accountability
PEN	Package of Essential Non-Communicable Diseases
PF	Plasmodium Falciparum
PFM	Public Financial Management
PFMSF	Public Financial Management Strategic Framework
PG	Provincial Government
PHCC	Primary Health Care Centre
PHD	Provincial Health Directorate
PHLMC	Provincial Health Logistics Management Centre

PHS	Public Health Service
PHTC	Provincial Health Training Centre
PIP	Procurement Improvement Plan
PLMO	Provincial Logistics Management Office
PNC	Postnatal Care
PPA	Public Procurement Act
PPE	Personal Protective Equipment
PPM	Public-private Mix
PPMO	Public Procurement Monitoring Office
PPR	Public Procurement Regulations
PPSF	Public Procurement Strategic Framework
PSI	Pre-shipment Inspection
PWID	People Who Inject Drugs
QAP	Quality Assurance Plan
QI	Quality Improvement
RDQA	Routine Data Quality Assessment
RDT	Rapid Diagnostic Test
RF	Results Framework
RFQ	Request for Quotation
RH	Reproductive Health
RHIS	Routine Health Information System
RHSC	Reproductive Health Sub-cluster
RMP	Risk Mitigation Plan
RNA	Ribonucleic Acid
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SARI	Severe Acute Respiratory Infection
SAS	Safe Abortion Services
SBA	Skilled Birth Attendant
SBD	Standard Bidding Document
SCM	Supply Chain Management
SDG	Sustainable Development Goal
SFD	Saudi Fund for Development
SHN	School Health Nurse
SMNH	Safe Motherhood and Newborn Health
SMS	Store Management System
S-NCB	Short-notice National Competitive Bidding
SNCU	Special Newborn Care Unit
SNG	Sub-national Government
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SSU	Social Service Unit
STI	Sexually Transmitted Infection
STP	Standard Treatment Protocol
SuTRA	Sub-national Treasury Regulatory Application
SWAp	Sector-wide Approach
TABUC S	Transaction Accounting and Budget Control System
TB	Tuberculosis
TIMS	Training Information Management System
ToR	Terms of Reference
ToT	Training of Trainers
TSB	Technical Specification Bank

TWG	Technical Working Group
U5	Under Five Years Old
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
USG	Ultrasonography
VfM	Value for Money
VSP	Visiting Service Provider
VTM	Viral Transport Medium
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WISN	Workload Indicators and Staffing Norms
YLD	Year Lived with Disability
YLL	Year of Life Lost

Executive Summary

In 2015, the Ministry of Health and Population (MoHP) developed the Nepal Health Sector Strategy (2015–2020) (NHSS) to guide the design, management and implementation of health sector programme for the next five years. However, considering the Coronavirus Disease 2019 (COVID-19) pandemic and the sectoral priority required to manage the response, a one-year extension of the NHSS has been approved, retaining it as the sectoral strategy until July 2022. 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 is to "Ensure citizen's fundamental right 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 major progress in the health sector in the Fiscal Year (FY) 2019/20, key highlights of activities in FY 2020/21 against the NHSS outcomes, along with existing challenges, and the ways forward.

The NHSS was developed while Nepal was in a unitary system of governance. However, as the country has adopted federalism, multiple changes have been made to the governance system, which have implications for the implementation of the NHSS. Following the recommendations of the Mid-term Review (MTR) of the NHSS, some of the indicators defined in the NHSS Results Framework (RF) were found to have less significance in the context of federalism and were considered to be removed for progress monitoring purposes.

In response to the COVID-19 pandemic, different policy and legal frameworks, strategic plans, standards, protocols and guidelines have been developed. The MoHP priority remains the prevention of transmission, treatment of infected people and control of COVID-19. Different measures, such as lockdown and other restrictive orders, were enforced and entry-point management, quarantine management, isolation and case management, case investigation and contract tracing and timely treatment for infected people and resumption of essential services remained high priorities for the MoHP.

Major factors that have impacted on the NHSS at the national level, in the current context, are:
- Three levels of governance: federal, provincial, and local
- Functional assignments, which define the responsibilities of the federal, provincial, and local levels
- Distribution of financial resources across federal, provincial and local governments
- Adjustment and posting of staff to their respective working areas
- Various activities that were necessary to align with the new governance structure by the MoHP.
- Impact of emerging pandemic – COVID-19 on the health sector.

Major Achievements

MoHP carried out various activities in FY 2019/20. The majority of activities continued programmes previously carried out as per the NHSS (2016-2021) while new and adapted

activities were introduced in the Annual Work Plan and Budget (AWPB) process to comply with the requirements of federalism. As a result, various programmes and activities were rearranged across federal, provincial and local governments.

The major achievements of progress in FY 2019/20 are summarised below:

- The National Health Policy, 2076 (2019) has been endorsed by the Cabinet of Ministers. The policy includes 25 policy statements, each with multiple strategies.
- The Cabinet of Ministers has endorsed the Public Health Service Regulations 2020, the Safe Motherhood and Reproductive Health Rights Regulations 2020 and the Health Insurance Regulation 2019.
- Health human resources have been deputed as per the federal structure of governance.
- An adequate response to the COVID-19 pandemic has been provided.
- Health services are offered from health facilities despite the challenges posed by COVID-19 Pandemic.
- Gender-responsive Budget Guidelines for the health sector was developed and approved.
- Prepared the final draft of National Strategic Plan for 2021–2026 (National Tuberculosis Programme) has been prepared.
- Pre-bid and post-bid information systems, including Market Analysis (MA), electronic Technical Specification Bank (e-TSB) strengthening, electronic Logistics Management Information System (e-LMIS) reforms, Grievance-handling and Redressal Mechanism (GHRM) installation and online electronic Consolidated Annual Procurement Plan (e-CAPP) modules in the Transaction Accounting and Budget Control System (TABUCS) have been endorsed and implemented.
- As agreed in the NJAR 2019, the concept of transforming the Procurement Improvement Plan (PIP) into an umbrella strategic document on procurement and Supply Chain Management (SCM) is being progressed by drafting the Nepal Health Sector Public Procurement Strategic Framework (NHSPPSF).
- Updating of the Financial Management Improvement Plan FMIP into the Public Financial Management Strategic Framework (PFMSF) has been completed and the PFMSF is in the process of being endorsed.
- Two sets of Standard Operating Procedures (SOPs) for procurement and electronic Government Procurement (e-GP) have been endorsed in FY 2018/19 and their implementation continues across the three levels of government.
- Emergency Procurement Guidelines have been drafted and are now in the course of endorsement by MoHP.
- Standardisation of the procurement process through new Standard Bid Documents (SBDs) and e-GP-II implementation in the bidding process has been improved and put into practice. This electronic bidding system, executed as e-GP in FY 2019/20, has increased the proportion of procurement carried out electronically to the highest recorded level: 98 per cent of CAPP value, compared to 83 per cent in e-GP for FY 2017/18.
- Audit queries against total audit amount have been reduced from 7.01 per cent (in FY 2016/17) to 4.77 per cent (in FY 2017/18). However, this figure increased to 6.73 per cent (in FY 2018/19).
- Charts of activities have been prepared and are ready to be used in TABUCS.Key highlights of achievements in FY 2020/21 (until November 2020) are summarised below:

- Five district hospitals have been upgraded to 25-bed hospitals, while all remaining district hospitals have been upgraded to 50-bed hospitals. Provincial hospitals are being upgraded to have 200 beds and hospitals under the federal government are being upgraded to have 500 beds.
- As per the Government of Nepal's (GoN's) policy of 'one municipality-one hospital', budget has been sent to 396 local levels to establish 5-, 10- and 15-bed basic health care hospitals. Foundation stones for more than 300 hospitals were laid down on a single day (November 30, 2020).
- Establishment of a 300-bed communicable diseases control hospital at federal level, and similar 50-bed hospitals in each province, has been initiated.
- The work for establishing 10 trauma centres is ongoing (5 million Nepalese Rupees (NPR) has been allocated to each hospital), and free emergency services are being provided from 14 public sector hospitals.
- Extensive and unprecedented response actions are being undertaken to mitigate the effects of COVID-19.
- The Programme Implementation Guideline for FY 2020/21 (for the programme of provincial- and local-level activities) was prepared and made public through the MoHP website.
- About 3.3 million people in total have enrolled in the health insurance scheme, which is being implemented in 60 districts and 471 local levels.
- The MA of Pharmaceutical Products in Nepal was designed, and accompanying survey completed, by October 2019. The final report was distributed in FY 2019/20 to all stakeholders.
- In response to COVID-19, technical specifications of equipment to be installed in the e-TSB have been prepared.
- The Federal CAPP (FCAPP) was prepared and endorsed in FY 2018/19 and implementation progress is being monitored by the Public Financial Management (PFM) Committee of MoHP and CAPP Monitoring Committee of DoHS. Online preparation of the federal e-CAPP was initiated in FY 2018/19 and the executed e-CAPP for FY 2019/20 captures 97 per cent of the total procurement budget of the MoHP.
- The Internal Control Guidelines have been drafted as the New Financial Procedures and Fiscal Accountability Act, 2076 (2019) and Financial Comptroller General Office (FCGO) directives.
- The FMIP has been updated as the Nepal Health Sector Financial Management Strategic Framework, to guide financial management procedures. The framework was endorsed by the Minister of MoHP (on 2077.04.04/19 July 2020) and has been printed and disseminated; its implementation continues across federal-level entities.
- The Financial Management Reports (FMRs) for each trimester of FY 2019/20 were submitted on time. Improved internal control through internal and final audit clearance was evidenced in the Audit Status Report prepared in August 2020, which was disseminated to External Development Partners (EDPs).
- Provincial reviews of the health sector in all seven provinces have been completed.
- MoHP secured funding from the Global Environment Facility to implement the project entitled Building Resilience of Health Systems in Asian Least Developed Countries to Climate Change.

- Seven additional One-stop Crisis Management Centres (OCMCs) have been established in the first quarter of 2077/78 (2020/21), which makes a total of 77 OCMC sites in 74 districts. Similarly, six Social Service Units (SSUs) were established in the first quarter of 2077/78 in referral and district-level hospitals; the total number of SSUs has gone up to 44.
- Geriatric health services are available in 24 hospitals as of the first quarter of 2077/78.
- Health Emergency Operations Centres (HEOCs) are functional in each of the seven provinces, cluster coordination mechanisms activated, and different guidelines/SOPs developed which,played a crucial role in the management of the COVID-19 response.
- Reconstruction of the structures of 15 Health Posts (HPs) damaged by the earthquake has been completed by National Reconstruction Authority (NRA).
- An Annual Report on Population for FY 2018/19 has been produced, highlighting major progress in this sub-sector.

1. Introduction

1.1 Background

The Nepal Health Sector Strategy (NHSS) was developed in 2015 to outline the key priorities that should guide the health sector over a five-year period. The NHSS aims to progressively expand both health packages and services, while at the same time assuring the quality of care being delivered, making services affordable, and covering the population in need – in particular the vulnerable and poorest of Nepal.
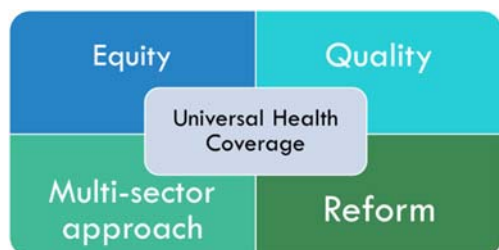
The NHSS focuses on achieving Universal Health Coverage (UHC) and has four strategic areas: equitable access, high-quality health services, health systems reform, and a multisectoral approach. These four areas are delivered through nine outcomes and 28 outputs. In accordance with the NHSS, the Ministry of Health and Population (MoHP) has developed an Implementation Plan (IP), which provides a broad list of interventions to be implemented in the five-year period. Early in 2020, the MoHP started internal consultation to initiate the development of a sectoral strategy for the next phase. However, the increasing number of Coronavirus Disease 2019 (COVID-19) cases in the country and other associated challenges demanded that priorities be shifted exclusively to management of the COVID-19 response and ensuring delivery of routine health services. Accordingly, MoHP and External Development Partners (EDPs) mutually agreed to extend the implementation period of NHSS by one year until July 2022 so that MoHP and supporting partners could prioritise COVID-19 response management as per the contextual need.

A Joint Annual Review (JAR) has been held every year since 2004 in accordance with the Nepal Health Sector Strategy: An Agenda for Reform (2004). The JAR is jointly organised by the MoHP and EDPs to review annual progress and harmonise support in the health sector. At the JAR meeting, the achievements of the last Fiscal Year (FY) are reviewed and strategic action points to prioritise for the coming FY are identified. As the JAR meeting is a joint event to review the whole health sector, support from EDPs and the contribution of the private and other non-governmental sector are also discussed. Further, this event also serves as the platform for the review of the population sector as this is an important thematic area of the MoHP. An "aide memoire", is agreed at the end of the JAR summarising strategic action points to be prioritised in the year ahead. The JAR and National Annual Review, which used to take place separately, have been organised as a single combined event since 2018. FY 2019/20[1] is the fourth implementation year of the NHSS (2015–2020); the National Joint Annual Review (NJAR) will take place from 10 to 14 December 2020.

This report focuses on overall progress in the health and population sector and is intended to contribute to informed discussion and decision making in the annual NJAR event. The report is organised as per the outcomes, outputs and interventions as defined in the NHSS and its IP and major progress towards achieving the stated goals and objectives. Major achievements during FY

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[1] Mapping between Nepali Calendar Years and Gregorian Years for the last five years is provided in Annex1

2019/20, highlights of FY 2020/21, existing challenges, and ways forward are captured in this report. The report also presents progress made against NHSS indicators as defined in the Results Framework (RF).

While the country is making progress towards federalism, the COVID-19 pandemic has deeply affected the economy in diverse ways, including the overall management of the health sector and its functionality. Various policy and legal provisions as well as guidelines and protocols have been developed and are being implemented in line with the federal structure and in response to COVID-19. Restructuring is progressing to comply with the Constitution of Nepal, 2015. The following overarching actions have been taken towards the implementation of federalism and in the current context of COVID-19:

- In light of the COVID-19 pandemic, policies and programmes for FY 2020/21 propose organisational reform of the health sector to strengthen health system capacity. Accordingly, MoHP has initiated the process of organisational reform; some of the overarching reforms planned include:
  o Establishment of a Centre for Disease Control (CDC), which can potentially be an apex body to oversee the management and control of communicable and Non-communicable Diseases (NCDs).
  o Establishment of a National Food and Drugs Administration Authority for the integrated management of food- and drug-related affairs, which are currently regulated by two different entities (i.e. one under MoHP and the second under the Ministry of Agriculture).
  o Establishment of a National Authority for the Accreditation of Health Institutions.
  o Introduce a common umbrella Act to manage health academies.
- The adjustment of staff to better fit the new organisational structure has been completed, although there are some challenges in ensuring that staff remain in the filled posts, which MoHP is addressing. Existing gaps have been managed through contract-based staff.
- In accordance with constitutional provisions, four different types of grants (fiscal equalisation, conditional, special and matching) and revenue transfer mechanisms have been used to distribute financial resources across federal, provincial and local levels. Provinces have also channelled equalisation and conditional grants to local levels.
- Provincial Annual Reviews of the health sector for FY 2019/20 have been conducted in all seven provinces.

Nepal has embraced international commitments towards meeting the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) and is continuing to expedite activities. The Government of Nepal (GoN) has also endorsed the 15th five-year periodic plan (2076/77–2080/81 Bikram Sambat (BS)) for the overall development of the nation, which also includes sectoral goals and strategies.

1.2 Status of Aide Memoire
The NJAR of FY 2018/19 was held on 4–6 December 2019 in Kathmandu. The third day of the NJAR was a business meeting between the MohP and EDPs. The meeting concluded with the development of an Aide Memoire, which identified certain strategic areas to be prioritised in the

next FY and was jointly signed by the Secretary of MoHP and the Chairperson of the EDP Forum. Table 1 shows progress made towards the action points of the Aide Memoire.

Table 1: Progress on the action points of 2019 Aide Memoire

Agreed Actions	Current Status
• MoHP will implement a mechanism to fulfil human resource gap • Jointly review progress on regular basis	• Staff adjustment has been completed. Out of a total of 26612 Human Resources for Health (HRH), 2,237 have been deputed to federal, 2,313 to province and 22,062 to local level: 8.4%, 8.7% and 82.9% respectively. • Few of the grievance management in relation to staff adjustment is on hold now due to the COVID 19 situation. It will be resumed once the situation is stable
• Assess capacity development need, develop and implement an integrated capacity development package for province and local level	• Different training/orientation packages have been developed and orientation are being conducted virtually, focused on COVID-19: case management and critical care, infection prevention, Contact Investigation and Contact Tracing (CICT), Water, Sanitation and Hygiene (WASH), emergency medical deployment team, etc,
• Develop a central database to incorporate the details of health workers in the country	• A committee consisting of all the professional councils has been formed and activated. • iHRIS has been customised for Nepal; initial piloting will be done through Pharmacy and Ayurvedic Councils •
• Public Health Service Regulations endorsed	• Public Health Service Regulations have been endorsed by the Cabinet of Ministers
• Jointly work on reducing numbers of line items in health-related conditional grants	• Number of activity heads for the local level in the FY 2020/21 Annual Work Plan and Budget (AWPB) has been reduced compared to last year
• Provide guidelines for conditional grants at the same time as budget	• Guidelines developed and uploaded onto the MoHP website on time
• Establish monitoring and assessment mechanism of Basic Health Services Package (BHSP)	• Discussion held with provinces and identified Local Governments (LGs) to further strengthen routine information systems (Health Management Information System (HMIS), Logistics Management Information System (LMIS)) and surveys to capture BHSP
• Develop and disseminate guidelines/ policy for the types of drugs procured and their supply chain	• Public Procurement Strategic Framework (PPSF) prepared and approved by MoHP
• Assess the need for framework contracting and endorse	• MoHP has conducted a Market Analysis (MA) of Pharmaceuticals in Nepal to find the degree of variation of pricing and quality in procurement of different levels of governments

• Assure the quality of drugs post shipment/in delivery	• All specifications of medicines revised, and new specifications of medicines and surgical consumables added. These specifications will be the reference for quality evaluation. Draft version of guideline for Pre-shipment Inspection (PSI) and Post-delivery Inspection (PDI) with quality assurance mechanism is prepared • An interim supply chain guideline for COVID-19 response items has also been prepared and distributed to provinces
• Discuss and settle issues related to the electronic Logistics Management Information System (e-LMIS)	• Completed
• Formulate Terms of Reference (TOR) and form Technical Working Group (TWG) to develop next Health Sector Strategy	• Steering Committee (35 members, with EDP chair and WHO); and Technical Working Group-TWG (17 members, four from EDPs) formed on 16 March 2020 • Concept note prepared
• Submit next Health Sector Strategy to the Cabinet of Ministers for endorsement	• Strategy development process delayed due to the COVID-19 pandemic, and current strategy has been extended for one more year (until 15 July 2022)
• EDPs to communicate options of financial and technical assistance modalities in the health sector	• Completed
• Ensure regular hands on support to spending units (on HMIS, SUTRA, Transaction Accounting and Budget Control System (TABUCS), PLMBIS, Health System Registry and other information systems)	• The Cabinet of Ministers has made a decision in Asar last year to use the national information system. Accordingly, all 753 local and seven Provincial Governments (PGs) use HMIS platform for reporting • In the last FY overall HMIS reporting was 84% whereas reporting from public HFs was 98%. However, total on time reporting was 41% whereas on time reporting from public HFs was 53% • Regular hands-on support is being provided for improving HMIS reporting • PPMD is supporting the provinces for updating the Health Facility Registry (HFR). The HFR includes the details of 8002 HFs (https://nhfr.mohp.gov.np) • Chart of activity model in TABUCS is linked to SUTRA. Using SUTRA, LGs can now analyse the health budget expenditure
• Ensure online reporting from 2,000 HFs and implement Routine Data Quality Assessment (RDQA) in 100 HFs	• As of 14 June 2020, 1,109 HFs have reported online and 300 HFs have implemented the RDQA using online and offline platforms
• Develop EHR (Electronic Health Record) standards and software	• The draft EHR guidelines prepared are in the process of further consultation with experts
• Align Ayurvedic Management Information System with HMIS	• Ayurvedic Management Information System in District Health Information Software 2 (DHIS2) platform to align with the HMIS is ongoing

• Establish and operationalise Health Emergency Operation Centre (HEOC) in all provinces	• HEOCs are established in all seven provinces and are functional
• Finalise Standard Operating Procedures (SOPs) of HOC and HEOC	• Completed
• Develop and pilot disaster information management system to provide real-time data	• Weekly Early Warning Reporting System (EWARS) reporting has been upgraded to daily reporting of Severe Acute Respiratory Infection (SARI) and COVID-19 suspected cases from sentinel sites • e-LMIS has been updated to include COVID-19-related supplies • Health Declaration Form and Self-quarantine Forms to be used at the point of entry in Tribhuvan International Airport and other ground crossings have been digitised. • Development of OSCAR Digital Platform as a Decision Making Aid is under implementation.
• Convene high-level stakeholders meeting to assess and develop action plan to achieve SDGs	• MoHP has initiated consultation with programme divisions and centres to assess performance against SDGs and other tracer indicators and to explore way forward for improvement. However, the process has been delayed by the COVID-19 pandemic
• Support to address equity gap, reach the unreached and change pattern of burden of diseases	• Further analysis of survey/routine data has been performed to explore the equity gap in service utilisation
• Align technical assistance with MoHP priorities	• Alignment with GoN's eight prioritised programmes, as stated in the 15th periodic plan continues. Focus areas are: Health Facility (HF) and health service expansion; health insurance; safe motherhood and Reproductive Health (RH); immunisation and nutrition; and integrated disease prevention and control.
• Align EDP support with GoN's annual policies and programmes and implement jointly by giving them high priority	• As stated in GoN policies and programmes for FY 2020/21, the first priority is to make Nepal COVID-19-free • EDPs are providing support in this context to the GoN

2. NHSS Results Framework

2.1 Background

The NHSS RF defines major health sector indicators and targets in accordance with the NHSS goal and outcomes. The RF has 10 goal-level indicators, 29 outcome-level indicators and 56 output-level indicators. Progress against each indicator of the NHSS RF is available on the MoHP website (www.nhssrf.mohp.gov.np). This section of the report highlights progress in the 10 goal-level indicators and selected outcome-level and output-level indicators.

2.2 Overview of Progress

Improvement in overall health outcomes has been witnessed over the last two decades (Table 2.2.1). The Maternal Mortality Ratio (MMR) (pregnancy-related mortality ratio) of 539 per 100,000 live births in 1996 had declined to 239 in 2016[1]. The under-five mortality rate had declined from 118 per 1,000 live births in 1996 to 28 per 1,000 live births in 2019[2]. Similarly, the neonatal mortality rate had declined from 50 per 1,000 live births in 1996 to 16 per 1,000 live births in 2019[2]. Overall, the nutritional status of children (stunting) has improved. The percentage of children under five years old (U5) who are stunted (% below -2 standard deviations) has declined from 41% in 2011 to 31.5% in 2019[2].

Table 2.2.1: Progress in major health indicators

Indicator	Year				
	1996	2001	2006	2011	2019
MMR (per 100,000 live birth) (NHSS RF[2] G1)	539	NA	281	NA	239
Under-five child mortality rate (per 1,000 live births) (NHSS RF G2)	118	91	61	54	28**
Neonatal mortality rate (per 1,000 live births) (NHSS RF G3)	50	39	33	33	16**
Children stunted (%) (NHSS RF G5)	48	51	49	41	31.5**
Fully immunised children (%) (NHSS RF OC3.2)	43	66	83	87	78
Institutional Delivery (ID) (%) (NHSS RF OC3.3)	8	9	18	35	77.5**
Demand satisfied for Family Planning (FP) (%) (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 Family Health Survey (NFHS), 2001–2016, Nepal Demographic and Health Survey (NDHS)
** Nepal Multiple Indicator Cluster Survey (NMICS) 2019

There has been a large improvement in the proportion of women delivering at a Health Facility (HF), increasing from 8 per cent in 1996 to 78 per cent in 2019[2]. The percentage of demand satisfied for FP among currently married women has improved from 64 per cent in 2011 to 69 per

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[2] MoH/Nepal, New Era/Nepal, & ICF. NDHS 2011 and 2016

cent in 2016[3]. The proportion of children aged 12–23 months who had received all eight basic vaccinations had increased from 47 per cent in 1996 to 87 per cent in 2011 but this had reduced to 78 per cent in 2016[1]. Although there has mostly been progress across many of the indicators, inequalities persist by geographic location and socioeconomic groups.

The UHC service coverage index for Nepal was estimated to be 52 per cent in 2010 and has increased to 59 per cent in 2019[2]. In 2019, 10.7 per cent of people spent more than 10 per cent of their household's total expenditure on health care, while access to essential medicines is at 72 per cent. Table 2.2 shows progress against the ten NHSS goal-level indicators with achievements in 2020 against the targets.

Table 2.2.2: Progress against the NHSS RF goal-level Indicators

| Code | Indicators | Baseline | | | Achievement | | 2020 |
		Data	Year	Source	2020	Source	Target
G1	Maternal mortality ratio (per 100,000 live births)	190	2013	WHO	239	NDHS, 2016	125
G2	Under-five mortality rate (per 1,000 live births)	38	2014	NMICS[2]	28	NMICS, 2019	28
G3	Neonatal mortality rate (per 1,000 live births)	23	2014	NMICS	16	NMICS, 2019	17.5
G4	Total fertility rate (births per 1,000 women aged 15–19 years)	2.3	2014	NMICS	2.0	NMICS, 2019	2.1
G5	% of children under 5 years who are stunted	37.4	2014	NMICS	31.5	NMICS, 2019	31
G6	% of women aged 15–49 years with body mass index less than 18.5	18.2	2011	NMICS	17.3	NDHS, 2016	12
G7	Lives lost due to road traffic accidents per 100,000 population	34	2013	Nepal Police	9.5	Nepal Police, 2075/76	17
G8	Suicide rate per 100,000 population	16.5	2014	Nepal Police	19	Nepal Police, 2019	14.5
G9	Disability-adjusted life years lost due to communicable, maternal and neonatal, Non-communicable Diseases (NCDs), and injuries	8,319,695	2013	NBoD, IHME[4]	9,015,320	Nepal Burden of Disease, 2017	6,738,953
G10	Incidence of impoverishment due to out-of-pocket expenditure in health	NA	2011	NLSS[5]	NA		Reduce by 20%

WHO: World Health Organization   NBoD: Nepal Burden of Disease Study

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[4] Institute for Health Metrics and Evaluation
[5] Nepal Living Standards Survey, Central Bureau of Statistics

Table 2.2.3: Progress against selected NHSS RF outcome-level indicators

Code	Indicators	Baseline			Achievement		2020/21
		Data	Year	Source	2019/20	Source	Target
OC 1.4	% of HFs with no stockout of tracer drugs	70	2013/14	LMIS	1.5[6]	Survey Report[7]	95
OC 2.1	% of HFs meeting minimum standards of quality of care at point of delivery	0.7	2015	Nepal Health Facility Survey (NHFS)	--	Information not available	90
OC 3.1	% of children fully immunised	70	2015/16	HMIS	64.5	HMIS 2019/20	>90
OC 3.3	% ID	55	2015/16	HMIS	65.5	HMIS 2019/20	70
OC 4.1	% of MoHP's [district] budget disbursed as block grant	NA	2015	Budget Analysis	39.6% of budget to SNG	Budget Analysis 2017/18	5% incre-ment
OC 5.1	Budget absorption rate (% expenditure of budget)	75.1	2013/14	FMR	80.4	Budget Analysis 2018/19	95
OC 6.1	Government health expenditure as % of Gross Domestic Product (GDP)	1.4	2013/14	Budget Analysis	1.9	Budget Analysis 2018/19	2
OC 7.1	Prevalence of diarrhoeal diseases among children under five years (%)	12 (422)	2014 (2015/16)	NMICS (HMIS)	NA (336)	Population based data not available. (HMIS)	10
OC 8.1	Case fatality rate per 1,000 reported cases due to public health emergencies	7.0	2013	Disaster Surveillance System (DSS)	NA	DSS 2018/19	NA
OC 9.2	Children below one year whose births are registered (%)	32.8	2014	BMICS	56	CRVS/ MoFAGA	41

As per the recommendations from the Mid-term Review (MTR) of the NHSS, the MoHP has removed the indicators listed below from the NHSS RF in alignment with the federal context.

Code	Indicator
OC4.1	% of MoHP's district budget disbursed as block grant
OC4.2	Proportion of District Development Fund (DDF) allocated for health

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[6] Physical count of the available quantity of all tracer drugs/commodity (including two formularies of Paracetamol) in the store was done by data collectors on the day of visit to the health facilities. Physical counts of drugs/commodity available in health facility' store was done and counts in facility's dispensary and respective delivery units (e.g.Maternity ward, emergency ward, vaccination ward, ART center, DOTS center etc.) were not done as this did not fall under the scope of this study. Out of 275 health facilities, only 1.5% (four health facilities) of health facilities (0.5% of health posts, 1.9% of PHCC and 7.1% of hospitals) had all 18 tracer drugs/commodity (except Oxytocin as it was assessed in birthing centres only) including two formularies of Paracetamol and 71.6% of health facilities had oxytocin available on the day of visit. None of the health facilities in province 1, 2, 3 and 4 had all 18 drugs/commodity, and availability was highest in province 7 (5.9%) in comparison to province 5 (2%) and 6 (2.1%).

[7] Preliminary findings of the survey on factors contributing to the stockout of essential medicines in government facilities in Nepal in 2019, which captured data from 275 HFs out of 21 districts of seven provinces

Code	Indicator
OP4.1.1	Number of districts (District Health Offices (DHOs) and District Public Health Offices (DPHOs)) submitting DDC approved annual plan to the Department of Health Services (DoHS) on specified time by development region
OP4.1.3	% of flexible budget provided to districts (DPHOs/DHOs) in total district programme budget
OP5.4.1	% of districts with functional District Health Coordination Committee
OP6.1.3	% of districts receiving budget based on identified needs and output criteria
OP8.1.1	Number of districts with health emergency response plan
OP9.1.2	Number of districts with functional integrated disease surveillance system

Progress on Tracer Indicators by Programme

Table 2.2.5 presents progress on tracer indicators from different programmes across three years and by the seven provinces using HMIS data.

Table 2.2.5: Tracer indicators for different programmes, 2016–2020 and achievement by province

Programme Indicators	National level			FY 2076/77 (2019/20) by Province							National Target	
	2074/75 (2017/18)	2075/76 (2018/19)	2076/77 (2019/20)	1	2	Bagmati	Gandaki	Lumbini	Karnali	Sudur Pashchim	2020	2030
Number of health facilities												
Public hospitals	123	125	136	22	14	31	15	21	19	14		
Primary Health Care Centres (PHCCs)	200	198	196	40	32	41	23	30	14	16		
Health Posts (HPs)	3,808	3,808	3,798	644	744	642	490	569	333	376		
Non-public facilities	1,715	1,822	2,098	130	192	1,407	97	173	60	39		
Total	5,846	5,953	6,228	836	982	2,121	625	793	426	445		
Reporting status by type of facility (%)												
Public facilities	95	98.68	100	100	100	100	100	99.7	100	100	100	100
Public hospitals	96	89	83.5	84.4	100	59.6	100	88.8	100	97.8	100	100
PHCCs	98	99.2	100	100	100	100	100	100	100	100	100	100
HPs	98	99.5	100	100	99.9	100	99.8	100	100	99.9	100	100
Non-public facilities	49	36.59	52.5	83.6	49.4	43.6	100	75.7	92.3	75.9	100	100
Female Community Health Volunteers (FCHVs)	95	98.68	100	100	100	100	100	99.7	100	100	100	100
Immunisation status (%)												
Bacillus Calmette-Guérin (BCG) vaccine coverage	92	90.9	85.9	82	97.8	81.8	66	92	92.7	80.7		
Diphtheria Pertussis Tetanus - Hepatitis B and Haemophilus Influenzae Type B (DPT-HepB-Hib) 3 vaccine coverage	82	86.4	77.8	74.1	90.8	68.4	68.6	80.5	88.5	75.2		
Measles and Rubella (MR2) vaccine coverage (12–23 months)	66	72.8	70.6	71.9	66.4	61.1	74.9	80.3	77.6	74.5		
Fully immunised children*	70	67.9	64.5	63.3	65.8	54.2	61.1	71	73.9	71.9	90	95
Dropout rate, DPT-Hep B-Hib 1 vs 3 coverage	7.4	4.3	8.9	6.9	14.4	5.9	3.7	9.5	8.5	6.8	0	0
Pregnant women who received TD2 and TD2+	73	64.3	59.3	51.7	80	45.2	47	63.6	64.9	60.4		
Nutrition status (%)												
Children aged 0–11 months registered for Growth Monitoring (GM)	84	84.4	76.9	71.9	73.7	66.5	84	83.2	106.7	78.8	100	100
Underweight children among new GM visits (0-11m)	3.6	2.9	2.5	1.3	4.3	1.5	0.7	2.5	4.1	2.7		
Children aged 12–23 months registered for GM	56	56.8	53.6	47.1	58	43.1	67.1	53.1	77.5	52.8	100	100
Underweight children among new GM visits (12-23m)	5.7	4.5	3.4	1.5	5.2	1.4	1.2	3.6	6.4	4.6		
Pregnant women who received 180 tablets of Iron	45	50.6	43.9	33.3	45.7	28.7	46.7	52.5	58.5	64.3		

Programme Indicators	National level			FY 2076/77 (2019/20) by Province							National Target	
	2074/75 (2017/18)	2075/76 (2018/19)	2076/77 (2019/20)	1	2	Bagmati	Gandaki	Lumbini	Karnali	Sudur Pashchim	2020	2030
Postpartum mothers who received vitamin A supplements	66	64.5	57.3	47.1	74.8	40.7	40	59.2	85.7	69.3		
Community-based Integrated Management of Neonatal and Childhood Illnesses (CB-IMNCI) status												
Incidence of pneumonia among children U5 (per 1,000)	54	50.3	42.8	51.3	30.8	29.9	26.7	43.1	98.9	61.3		
% of children U5 with pneumonia treated with antibiotics	165	176.3	156.1	171.3	240.3	133.9	161.9	138.2	105.5	138.5		
Incidence of diarrhoea among children U5 per (1,000)	385	375.2	336.1	318.2	330.2	215.3	243.8	339.5	627.2	538		
% of children U5 with diarrhoea treated with Oral Rehydration Solution (ORS) and zinc	95	95.5	95.5	93	92.1	93.8	99.9	100.5	95.8	96.7	100	100
Safe motherhood (%)												
Pregnant women who attended first Antenatal Care (ANC) visit (any time)	103	110.2	106.9	107.9	122.3	107.4	86.5	99.5	130	90.1		
Pregnant women who attended four ANC visits as per protocol*	50	56.2	52.6	56.5	40	48.9	54.5	60.5	65.6	56.1	70	90
Institutional deliveries*	54	63.2	65.5	63.1	53.6	67.8	46.5	81.4	77.5	71.1	70	90
Deliveries conducted by Skilled Birth Attendant (SBA)*	52	59.6	62.3	61.7	51.8	66.5	45.9	78.5	62.7	62.5	70	90
Mothers who had three Postnatal Care (PNC) check-ups as per protocol*	16	16.4	18.8	15.4	13	16.9	13.2	21.7	36.1	38.6	50	90
FP												
Contraceptive Prevalence Rate (CPR) – unadjusted*	40.6	40.9	38	40.3	44.4	32.1	33.4	37.7	37.1	39.5	56	60
FCHVs												
Number of FCHVs	48172	50200	49413	8601	7466	8685	5760	8702	4233	5966		
% of mothers' group meetings held	98	95.2	90.7	105.7	90.6	89.5	83.1	85.7	86.2	89	100	100
Malaria												
% of Plasmodia Falciparum (PF) among malaria-positive cases	7.1	5.4	9.0	26.7	15.6	32.4	8.7	6.4	5.9	6.6		
Tuberculosis (TB)												
Case notification rate (all forms of TB)/100,000 pop.	100.3	100.1	92.6	78.6	91.6	101.4	77.3	111.8	68.8	93.9		
Treatment success rate	88	83	90.4	90.8	91.5	87.5	92.6	92.9	88.8	90		
Leprosy												
New Case Detection Rate (NCDR)/100,000 pop.	11.0	10.9	6.0	5.8	9.5	2.9	2.8	9.4	3.1	4.0		
HIV/AIDS and Sexually Transmitted Infections (STIs)												
Number of new positive cases	2013	2365	2656	246	399	1027	183	485	30	286		
Curative services												
% of pop. using Outpatient Department (OPD) services	73.6	78	83	91	64	84	105	87	98	75		
Average length of stay at hospital	4	3.7	3.4	2.8	1.2	3.9	3.7	4.8	2.3	2.2		
Note: *NHSS RF and/or SDG indicators												

Immunisation: There is a declining trend in full immunisation coverage nationally, from 70 per cent in FY 2017/18 to 64.5 per cent in FY 2019/20. Coverage was lowest in Province 3 (55.2%) and highest in Karnali Province (71.9%). BCG coverage is at 89.5 per cent at the national level, with highest coverage (97.8%) in Province 2 and lowest coverage (66%) in Gandaki Province. The coverage of DPT-HepB-Hib3 has decreased to 77.8 per cent at the national level, with highest rates in Province 2 at 90.8 per cent and lowest in Bagmati Province at 68.4 per cent. The dropout rate has increased to 8.9 per cent at the national level with highest dropout rate in Province 2 (14.4%). Although, a WHO-UNICEF estimates of National Immunization Coverage (WUENIC) which are published annually are also available, however, as WUENIC series does not give full immunization coverage but only single antigen estimates, so HMIS data and NDHS 2016 findings are used..

Nutrition: The proportion of children aged 0–11 months being registered for growth monitoring has decreased nationally to 76.9 per cent (FY 2019/20) from 84.4 per cent in FY 2018/19 and was highest in Karnali Province at 106.7 per cent[8] and lowest in Bagmati Province at 66.5 per cent. The prevalence of underweight children (0–11 months) among new growth monitoring visits has fallen to 2.5 per cent but is still high in Province 2 (4.3%). The proportion of pregnant women receiving 180 iron tables has decreased from 50.6 per cent in FY 2018/19 to 43.9 at the national level, with highest levels in Sudurpashchim Province at 64.3 per cent and the lowest rate reported in Bagmati Province at 28.7 per cent.

CB-IMNCI: Karnali Province reported the highest incidence of pneumonia among children under five, which is substantially higher than the incidence reported by Bagmati Province, which had the lowest incidence among all provinces. The highest percentage of children under five with diarrhoea treated with oral rehydration solution and zinc was found to be in Lumbini Province at 100.5 per cent while the lowest rate was in Province 2 at 92.1 per cent.

Safe motherhood: The percentage of pregnant women who attended Four ANC visits (4ANC) as per protocol has decreased at the national level from 56 per cent to 52 per cent. However, institutional deliveries have increased from 63 per cent to 65 per cent. Attendance at 4ANC was lowest in Province 2 (40%) and ID lowest in Gandaki Province (46%).

FP and FCHVs: The CPR has decreased from 41 per cent to 38 per cent at the national level over the past two years. It was highest in Province 2 at 44 per cent and lowest in Bagmati Province at 34 per cent. The number of FCHVs has increased in recent years and the proportion of FCHVs holding mothers' groups is 95 per cent.

Malaria, TB, Leprosy, HIV/AIDs: The percentage of PF among malaria-positive cases (9%) has increased at the national level; the highest rate was in Bagmati Province, at 32 per cent. The NCDR of leprosy per 100,000 population has decreased marginally at the national level (6%) and was highest in Province 2 (9.5%). The detection of new HIV-positive cases has increased over the past two years with the highest number found in Bagmati Province (1,027).

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[8] Percentages larger than one hundred is the result of estimated target population (denominator) being smaller than the number of cases (numerator)

HMIS reporting status: Reporting from the public sector predominates each month; non-public sector reporting to HMIS is still lower.

Health Facilities (HFs) must enter monthly service statistics in the national HMIS database by the 15th day of the following month. Figure 2.1 shows that reporting status improved in FY 2076/77 as compared to 2075. Consistent reporting of 98 per cent and above from public HFs was observed from the month of Shrawan 2076 to Asar 2077. Reporting was lowest in Bhadra 2077 (90.6%). Reporting is highest with consistency of 98.6 in the month Bhadra, Mangsir and Push 2076. On-time reporting from public HFs is better that of non-public HFs across the FY. Highest reporting from non-public HFs (61.6%) was found in the month of Kartik 2076. The key issue remains with timely reporting in HMIS.

Figure 2.1 Monthly HMIS Reporting Status, 2018/19 and 19/20
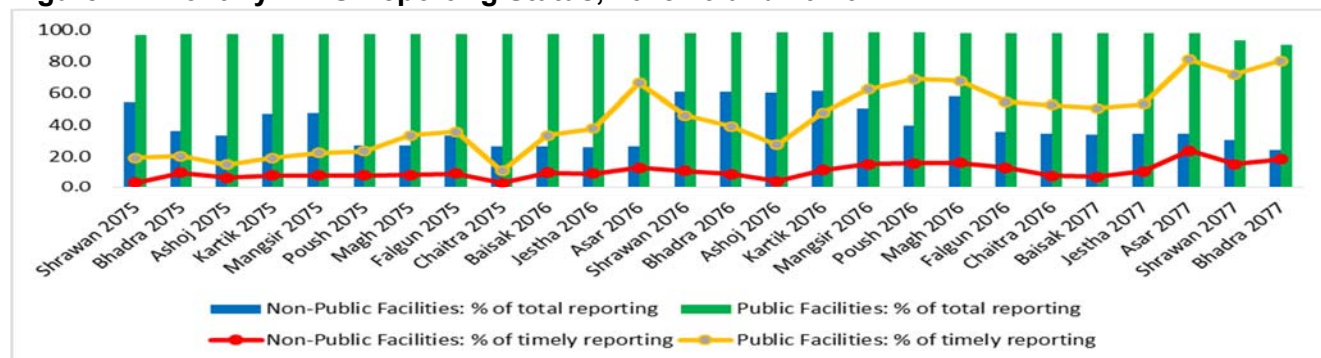
2.3 Regular Programme Reviews

The MoHP used to organise National Annual Reviews and JARs as two separate events. In the past three years these events have been combined into a National Joint Annual Review (NJAR). The key objectives of the NJAR 2019/20 are to:

- Jointly review the annual progress of the NHSS;
- Review COVID-19 pandemic preparedness and response at all levels of government;
- Ensure that all stakeholders have a shared understanding on achievement, problems and challenges in the sector;
- Identify the strategic priority areas based on existing problems and challenges that need to be addressed in the changing context;
- Agree on the strategic actions to be included in the next year's AWPB.

2.4 Equity Analysis of Key Health Indicators

Equity gap in essential health service utilisation: This section analyses the average equity gap across three indicators (CPR; percentage of ID; and percentage of children with pneumonia treated with antibiotics)[9] from 2016/17 to 2019/20 using HMIS data.

CPR

The average CPR of the bottom 10 and top 10 districts has gradually decreased over the past four years. The absolute differences in CPR (equity gap) between the top 10 and bottom 10 districts were observed to be 36.0, 29.5, 26.0 and 24.7 percentage points in FYs 2016/17, 2017/18, 2018/19 and 2019/20 respectively (Table 2.4.1). The annual change in the CPR equity gap showed an improvement across FYs 2016/17–2019/20: FY 2016/17–FY 2017/18, 18.1 per cent; FY 2017/18–2018/19, 11.9 per cent; and FY 2018/19–2019/20, 5.0 per cent (Table 2.4.1). The figure of 5.0% in FY 2019/20 exceeded the target for improvement of the equity gap from Year Three, which was three per cent.

Table 2.4.1: Trends in equity in essential health service utilisation

	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20
Contraceptive Prevalence Rate (CPR)				
Average CPR of top 10 districts (%)	62.0	54.7	52.6	50.9
Average CPR of bottom 10 districts (%)	26.0	25.2	26.6	26.2
Percentage-point difference between top and bottom average	36.0	29.5	26.0	24.7
% difference between top and bottom average	58.1	53.9	49.4	48.5
Annual change in percentage-point difference between top and bottom average (%)	-	18.1	11.9	5.0
ID				
Average % ID of top 10 districts	87.9	88.7	95.6	94.9
Average % ID of bottom 10 districts	18.3	19.1	20.9	21.6
Percentage-point difference between top and bottom average	69.6	69.6	74.7	73.3
% difference between top and bottom average	79.2	78.5	78.1	77.2
Annual change in percentage-point difference between top and bottom average (%)	-	0.0	-7.3	1.9

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[9] Contraceptive prevalence rate; % of ID; and % of children with pneumonia treated with antibiotics are the Disbursement-linked Indicators (DLIs)

Pneumonia cases treated with antibiotics/Acute Respiratory Infection (ARI)				
Average % of top 10 districts on ARI	68.8	48.4	38.2	30.7
Average % of bottom 10 districts on ARI	24.2	9.8	8.3	6.4
Percentage-point difference between top and bottom average	44.6	38.6	29.9	24.3
% difference between top and bottom average	64.8	79.8	78.3	79.2
Annual change in percentage-point difference between top and bottom average (%)	-	13.5	22.5	18.7

Morang, Saptari and Parsa Districts remained in the top 10 districts with the highest CPR throughout the four FYs, while Kavre, Mustang and Palpa also remained in the top 10 districts for the baseline year (2016/17) and FY 2019/20 (Table 2.4.2). Arghakhanchi and Udayapur Districts continuously fell in the bottom 10 districts throughout the four FYs, while Terhathum and Gulmi also fell in the bottom 10 districts in the baseline year and FY 2019/20.

Table 2.4.2: CPR by district

Districts	2016/17	2017/18	2018/19	2019/20	Districts	2016/17	2017/18	2018/19	2019/20
MORANG	62.6	56.0	51.4	53.2	SANKHUWASABHA	26.8	28.3	30.1	32.6
SAPTARI	59.8	57.4	49.8	46.8	TERHATHUM	27.7	29.8	28.0	25.4
SIRAHA	62.9	48.0	46.1	43.9	UDAYAPUR	25.5	26.6	28.8	28.6
RAUTAHAT	58.3	42.8	40.2	39.5	PARBAT	24.5	30.0	30.8	32.3
PARSA	69.4	70.7	66.8	67.0	GULMI	26.4	39.3	28.7	28.6
LALITPUR	55.2	51.0	42.1	46.0	ARGHAKHANCHI	24.6	26.3	26.4	25.0
KAVREPALANCHOK	56.9	52.1	45.3	48.3	MUGU	26.2	23.5	24.1	29.7
MAKWANPUR	56.2	49.1	45.8	43.2	RUKUM WEST	23.2	26.9	28.7	32.2
MUSTANG	75.6	45.7	48.9	50.7	BAJHANG	27.9	33.4	31.6	33.1
PALPA	63.2	46.5	48.3	48.3	DARCHULA	27.7	37.2	37.6	40.0
Note: Green highlighted districts are top 10 and yellow highlighted districts are bottom 10 districts									

ID

Overall, the average uptake of ID for the bottom 10 districts was found to have grown from FY 2016/17 to FY 2019/20. A similar pattern was shown for the top 10 districts from FY 2016/17 to FY 2018/19; however, the FY 2019/20 average decreased by 0.7 percentage points compared to FY 2018/19. The absolute differences in ID (equity gap) between the top and bottom 10 districts were found to be 69.6, 69.6, 74.7 and 73.3 percentage points in FYs 2016/17, 2017/18, 2018/19 and 2019/20 respectively. The annual change in the percentage-point difference was 0.0 per cent

for FYs 2016/17–2017/18, -7.3 per cent for FYs 2017/18–2018/19, and 1.9 per cent for FYs 2018/19–2019/20. The average uptake of ID for the bottom 10 districts gradually increased over the past four FYs and an improvement in the equity gap of about two per cent was observed in FY 2019/2; the target was a three per cent improvement on the Year Three figure (Table 2.4.1).

Parsa, Kaski, Palpa, Rupandehi, Banke and Surkhet Districts remained in the top 10 districts throughout the four FYs and Chitwan was in the top 10 districts in both the baseline year (2016/17) and FY 2019/20. Ilam, Bhaktapur, Mustang and Tanahu Districts fell in the bottom 10 districts throughout the four FYs and Dhankuta and Manang also fell in the bottom 10 districts in both the baseline year and FY 2019/20 (Table 2.4.3).

Table 2.4.3: ID

Districts	2016/17	2017/18	2018/19	2019/20	Districts	2016/17	2017/18	2018/19	2019/20
JHAPA	75.5	78.7	81.3	70.1	KHOTANG	22.0	32.8	37.2	39.1
SUNSARI	78.7	25.3	83.6	73.4	DHANKUTA	17.7	25.9	21.7	21.3
PARSA	82.6	84.9	109.5	124.6	ILAM	19.1	21.3	16.7	21.8
CHITAWAN	97.7	29.9	113.6	118.5	DHANUSA	6.2	6.9	74.5	62.4
KASKI	110.5	112.3	116.3	110.4	SINDHUPALCHOK	23.9	19.1	27.2	27.4
PALPA	84.4	90.8	96.6	94.5	BHAKTAPUR	23.9	22.7	26.7	22.1
RUPANDEHI	105.6	127.9	117.4	130.6	MANANG	9.2	24.8	8.3	9.4
BANKE	121.2	135.2	160.4	156.1	MUSTANG	21.9	19.8	22.3	27.0
HUMLA	79.1	60.9	86.4	79.9	TANAHU	21.2	20.7	18.2	20.0
SURKHET	80.7	86.3	92.2	95.8	KAPILBASTU	18.0	37.7	50.8	50.4
Note: Green highlighted districts are top 10 and yellow highlighted districts are bottom 10 districts									

Pneumonia cases treated with antibiotics (ARI)

The averages of both the top 10 and the bottom 10 districts were found to be in decreasing trend across the four FYs. The absolute differences in ARI (equity gap) between the top and bottom 10 districts were found to be 44.6, 38.6, 29.9 and 24.3 percentage points in FYs 2016/17, 2017/18, 2018/19 and 2019/20 respectively (Table 2.4.1). The annual change in the percentage-point difference was 13.5 per cent from FY 2016/17 to FY 2017/18, 22.5 per cent from FY 2017/18 to FY 2018/19 and 18.7 per cent from FY 2018/19 to FY 2019/20. Although the average of both the top 10 and the bottom 10 districts decreased from FY 2016/17 to 2019/20, the annual equity gap was always higher than 10 per cent. The analysis shows that an improvement in the equity gap

of about 19 per cent was observed in FY 2019/20; the target was a three per cent improvement on the Year Three figure (Table 2.4.1).

Mugu remained in the top 10 districts in both the baseline year (2016/17) and FY 2019/20 (Table 2.4.4). Kaski and Syangja Districts fell in the bottom 10 districts throughout the four FYs and Kathmandu and Kavre also fell in the bottom 10 districts in both the baseline year and FY 2019/20 (Table 2.4.4)

Table 2.4.4: Pneumonia treated with antibiotics (ARI)

Districts	2016/17	2017/18	2018.19	2019.20	Districts	2016.17	2017.18	2018.19	2019.20
KHOTANG	76.3	21.4	20.6	21.6	PARSA	29.5	67.2	26.1	16.6
CHITAWAN	57.9	26.5	16.6	11.7	KATHMANDU	22.8	12.2	7.7	5.6
MUSTANG	108.5	46.1	10.6	11.1	LALITPUR	24.0	11.1	9.5	12.9
KAPILBASTU	73.1	33.1	21.7	18.0	KAVREPALANCHOK	29.8	12.2	8.3	7.2
DANG	58.9	28.6	16.4	14.3	RAMECHHAP	28.3	8.2	12.4	8.2
DOLPA	67.7	43.4	60.7	21.2	KASKI	17.9	8.6	7.2	4.6
MUGU	64.0	42.2	45.9	32.1	LAMJUNG	26.4	18.3	10.6	14.2
KALIKOT	57.6	19.9	22.9	16.2	SYANGJA	23.7	9.5	6.7	7.0
JAJARKOT	67.6	43.2	20.4	22.7	RUPANDEHI	57.6	18.8	11.4	9.0
RUKUM WEST	64.9	40.4	17.5	16.8	DAILEKH	28.8	31.1	21.1	13.9
Note: Green highlighted districts are top 10 and yellow highlighted districts are bottom 10 districts									

3. NHSS Outcome-wise Progress Status

3.1 Outcome 1: Rebuild and Strengthen Health Systems: Infrastructure, HRH, Procurement, and Supply Chain Management

Three key components are defined under outcome 1 of the NHSS for achieving efficient and effective service delivery: Health Infrastructure (HI), HRH, and procurement and Supply Chain Management (SCM). This section highlights progress made in these areas, and the progress in building back better after the destruction of the 2015 earthquake.

Outcome 1a Infrastructure

Background
The MoHP continues to improve the HF network across the country, guided by the NHSS requirement to build earthquake-resilient infrastructure, adopt upgraded standards and improve practices in regular maintenance and inventory management. The MoHP has been working in coordination with provincial and local governments to promote good practices and to ensure a harmonised approach to health-related infrastructure. It has continued to use information from the Health Infrastructure Information System (HIIS) to encourage a rational and efficient HI network at sub-national level while at the same time supporting the GoN's goal to Leave No One Behind (LNOB) by locating HFs in areas that cover ethnically and geographically marginalised communities. As per the policy of GoN, Basic Health Care Centres are being established in all wards where that currently lack a HF. Sub-national governments have been orientated and encouraged to implement maintenance and management plans for HI, to continue their effectiveness and extend their life span.

Major progress
Significant progress has been made in FY 2019/20 and further in FY 2020/21. Major achievements are summarised below under different thematic areas.

Nepal Health Infrastructure Development Standards (NHIDS) 2074 (2017) and Integrated Health Infrastructure Development Programme (IHIDP)

- NHIDS and IHIDP have laid out categorisation, delineation and investment plans for HI development, which are being implemented through all levels of government.
- The MoHP has been guiding HI development through different agencies at all levels by issuing standard designs, guidelines for design and construction and monitoring frameworks. Further, the technical team in MoHP is supporting local and provincial governments to prepare architectural and engineering designs and estimates as per the prevailing standards and guidelines. Such constructions are funded by provincial and local budgets and are in the process of implementation.
  - o Mustang Hospital, Gandaki Province
  - o Dailekh Hospital, Karnali Province

- o Dolpa Hospital, Karnali Province
- o Humla Hospital, Karnali Province
- o Rukum Hospital, Karnali Province
- o Salyan Hospital, Karnali Province
- o Budhanilkantha City Hospital, Budhanilkantha Municipality, Bagmati Province.
- This FY (2077/78, 2020/21) MoHP selected, budgeted and authorised different municipalities to upgrade certain HFs to primary hospitals. This upgrade consists of the construction of 52 five-bed primary hospitals (PH B3 type), 105 10-bed hospitals (PH B2 type) and 107 15-bed hospitals (PH B1 type). MoHP also planned, budgeted and sent authorisation to initiate the construction of three tertiary-level hospitals (Bharatpur, Koshi and Narayani) and one academic hospital (Pokhara Academy of Health Sciences) for the expansion of 50-bed emergency units.
- The standard design for each type was developed/updated as per the prevailing standards (NHIDS 2017 and the Minimum Service Standards (MSS)) and was adopted for the planning and implementation of the upgrading of HFs. The upgrading works include the upgrading of HPs and PHCCs in line with the categorisation of HFs developed under the NHIDS. A framework for the preparation of detailed project reports and monitoring of the construction of all these projects has been developed by the MoHP and circulated to respective municipalities, Ministries of Social Development (MoSDs) and hospital authorities for compliance.

Ongoing Post-Gorkha-Earthquake 2015 Reconstruction
- Reconstruction work (prefab construction, shelter construction and permanent construction) performed by Non-governmental Organisations (NGOs) and International Non-governmental Organisations (NGOs) has been completed, in accordance with the tripartite Memorandum of Understanding (MoU).
- Reconstruction of HFs (permanent construction) is being carried out by the National Reconstruction Authority (NRA) Central-level Project Implementation Unit (CLPIU). The CLPIU is running a total of 456 health building reconstruction projects. Among them, 285 projects are funded by the GoN, 24 projects are funded through the Saudi Fund for Development (SFD) from the Kingdom of Saudi Arabia and 147 projects are funded through Indian Grant Assistance from the Government of India. The progress status of these projects is given in Tables 3.1.1a, 3.1.1b and 3.1.1c.

Table 3.1.1a Progress status of HI reconstruction by NRA-CLPIU through GoN funds

HI types	Completed	Ongoing	DPR preparation	Total
HPs	15	80	151	246
Primary hospitals	0	3	26	29
Ayurveda Ausadhalaya	0	3	6	9
Buildings in Health Science Academies	0	1	0	1
Total	**15**	**87**	**183**	**285**

Table 3.1.1b Progress status of HI reconstruction by NRA-CLPIU through SFD

HI types	Completed	Ongoing	DPR preparation	Total
HPs	0	11	11	22
Primary hospitals	0	2	0	2
Total		**13**	**11**	**24**

Table 3.1.1c Progress status of HI reconstruction by NRA-CLPIU through Indian Grant

HI types	Completed	Ongoing	DPR preparation	Total
HPs	0	0	111	111
Primary hospitals	0	0	18	18
Ayurveda Ausadhalaya	0	0	18	18
Total	**0**	**0**	**147**	**147**

- The GoN also has in place a set of bilateral arrangements with EDPs for HF reconstruction. These projects are being implemented by the partners themselves and their progress is set out in Table 3.1.2.

Table 3.1.2: Progress of ongoing projects under agreements with bilateral agencies

Agency	Works description	Progress
KOICA	Nuwakot District Hospital	Construction complete and handed over
	Prefab structures at 10 HPs	Construction complete and handed over
KfW	FC Recovery Phase - 1: Reconstruction of Jiri Hospital, Gorkha hospital and Ramechhap Hospitals	Construction work ongoing
	FC Recovery Phase - 2: Reconstruction of Rasuwa Hospital, Jhaukhel HP, Salang Primary Hospital, Dhading, Sankhu Primary Hospital, Kathmandu	Design phase
	Decongestion of Paropakar Maternity and Women's Hospital by establishing satellites in the peripherals	Feasibility stage
CHINA	Chautara and Manang hospitals	Chautara Hospital reconstruction work is ongoing. Reconstruction work at Manang Hospital is in the planning stage.
USAID	NRES Nepal Reconstruction Engineering Services: Construction of 4 HFs: Belghari PHCC, Kapilakot PHCC, Mahendrajhyadi PHCC, Mahadevsthan HP in Sindhuli District and Sukaura HP and Kankada HP in Makawanpur district.	Construction work ongoing

KOICA: Korean International Cooperation Agency   KfW: German Development Bank

Regular construction programme for HFs

The MoHP collaborates with the Department of Urban Development and Building Construction (DUDBC) as its delivery entity in the construction, extension and refurbishment of HFs. Since FY

2015/16, there has been a general improvement in the number of projects completed, while the number of 'sick' projects (projects that have been stalled or halted, for example, owing to technical or contractual problems) has decreased. As shown in Table 3.3, MoHP authorised DUDBC to implement 557 projects in FY 2019/20. Of these projects, 255 have been completed and the contractors were fully paid, while 52 projects are complete but payments are outstanding. There are 291 live projects carried over from previous years, and three new projects commissioned in FY 2019 /20. A total of 11 projects were either dropped or terminated over the same period. Progress status of these projects is given in Table 3.1.3.

Table 3.1.3: Progress status of ongoing HI construction works as of July 2020

Progress Status	Ongoing (Carried over from previous years) before 2019/20
Work completed and full payment made to the contractor	255
Work completed but full payment pending	52
Work up to finishing, electrification, sanitation	110
Work up to RCC in fourth floor/roofing	2
Work up to RCC in third floor/roofing	8
Work up to RCC in second floor/roofing	52
Work up to RCC in first floor/roofing	27
Work up to foundation/DPC level	2
Work ordered	5
Tender called	4
Design and cost estimate	26
Total	**543**
Projects dropped	10
Projects terminated	1

Note: Projects terminated: Projects that have been contracted then ended due to unresolvable issues.
Projects dropped: Projects originally planned but later withdrawn as they were found to be unfeasible.

Health Infrastructure Information System (HIIS)

- HIIS has been a useful tool for evidence-based planning and is being upgraded into an online portal for HI information and to allow data to be updated. HIIS was also used for analysis and mapping of potential government-owned HFs for COVID-19 response across Nepal.

Development of HI policy and standards

- **Repair and maintenance guidelines and action plan:** This is the policy document prepared by MoHP to address issues regarding HI repair and maintenance. It intends to enable governments to maintain the existing HI in terms of sustainability, safety and efficiency in smooth service delivery. It also set up the mechanism and methodology for both regular and emergency repair and maintenance, maintaining statistics on deterioration and efforts in repair and maintenance. This will enable government agencies to prepare budget plans and maintain monitoring reports.

- **Land acquisition and relocation policy:** MoHP has drafted a policy on land acquisition and relocation to provide guidelines to federal, provincial and local governments. The guidelines will help governments to provide high-quality and equitable health care services by acquiring appropriate land: sites must be accessible, in location with a large population (catchment area) and suitable for construction of multi-hazard-resilient HI, built as per the existing standards and codes. The policy draft has been sent to federal government for review.

Capacity Enhancement

Over the period from July 2019 to November 2020, the MoHP conducted various capacity enhancement events on HI, involving a total of 464 participants. See Table 3.1.4 below for details.

Table 3.1.4: HI capacity enhancement events, July 2019 – November 2020

Capacity Enhancement Event	No of Participants
Province 2: orientations on HI development	202
Skills for retrofitting in masonry buildings	17
HI policy development training	20
In-service training for HI specialists	16
Orientation on retrofitting for contractors	8
Orientation to construction workers at Bhaktapur Hospital on health and safety at the construction site, Gender Equity and Social Inclusion (GESI) and Gender-based Violence (GBV)	28
Orientation to construction contractors (District and Province members of the Federation of Contractors' Associations of Nepal) on WRH Pokhara main retrofitting design and bidding document at Pokhara	23
Total participants	**464**

Retrofitting of Bhaktapur Hospital and Western Regional Hospital Pokhara

The retrofitting of the Western Regional Hospital (WRH) in Pokhara and the Bhaktapur Hospital is a flagship activity in the MoHP HI programme. As well as strengthening and rehabilitating HI at two significant hospitals, this activity will provide a replicable experience that can be applied to HFs across the country. It implements a fourfold integrated approach, involving:

- Seismic retrofitting (structural and non-structural elements, as well as rehabilitation of relevant functional service areas)
- Construction of a temporary multi-purpose decanting facility
- Decanting transfer of hospital services and patients
- A 'green' retrofitting package to maximise environmental benefits and improve sustainability (including implementation of a zero waste site policy, potential adaptive re-use of the decanting facility, improved water management and energy efficiency).

This is a patient-centred construction process, involving close cooperation with the DUDBC Health Buildings Division. Progress is set out in Table 3.1.5.

Table 3.1.5: Retrofitting Bhaktapur Hospital and WRH Pokhara

Activity	Progress
WRH decanting block	Completed and handed over
Bhaktapur decanting block	Completed and handed over
WRH main retrofitting works	Construction work ongoing
Bhaktapur main retrofitting works	Bid evaluation in progress
WRH decanting services tender	Ready for tendering
Bhaktapur decanting services tender	Ready for tendering
WRH 'green' retrofitting package	Planning phase
Bhaktapur 'green' retrofitting package	Planning phase

COVID-19 Response

In response to the COVID-19 pandemic, MoHP has been putting its efforts into HI to treat infected patients and prevent the spread of the disease. Major activities undertaken by the MoHP include:

- Assessment of existing HI with the potential to be repurposed into COVID-19 treatment centres was performed using HIIS. Typical repurposing plans have also been developed with mapping of potential facilities using Geographic Information System (GIS) mapping.
- The decanting blocks constructed in Bhaktapur Hospital and Western Regional Hospital, Pokhara under the UKaid retrofitting support programme were repurposed to COVID-19 treatment facilities after the declaration of the COVID-19 pandemic.
- Further, 50-bed infectious disease hospitals in six provinces were also planned and budgeted in FY 2077/78; in Bagmati Province, an infectious disease department in Bharatpur Hospital has been planned and budgeted. Type designs for these structures have been prepared and funds have been provisioned and sent to the respective governments, which are proceeding with the implementation of these projects.
- Type designs for a 300-bed infectious disease hospital have also been prepared; this is in the planning process, before being initiated for construction.
- In line with supporting the control of COVID-19, MoHP has planned and budgeted the construction of Health Help Desk facilities to screen people arriving and departing from different border entry and exit points by land in Nepal. Detailed designs, including bills of quantities and cost estimates, were prepared and sent to respective local authorities for construction.
- A COVID-19 scanning, examination and emergency facility has also been planned at Tribhuvan International Airport: draft designs for the proposed facility have been developed and are in the process of agreement with the concerned airport authorities.

Other undertakings

- **Provincial Medical Store (PMS)**: MoHP has planned and budgeted for the construction of PMSs in all provinces. Design documents have been prepared. Construction work will start this year.

- **Upgrading the National Public Health Laboratory (NPHL) to National Diagnostic Centre:** In order to fulfil the GoN's vision to develop the NPHL as Centre of Excellence in Diagnostic Services, the master plan for infrastructure development has been prepared.

Challenges

The HI sector has seen major progress during 2019/20 in terms of the quantity, quality and geographical coverage of HFs. However, significant challenges remain:

- Funds for HI development have been sent by the MoHP to provincial and local governments for operational and capital expenditure. However, weak absorptive capacity is a challenge, especially in the context of COVID-19. With newly formed institutional arrangements and a scarcity of skilled staff, respective governments have to plan and implement these projects.
- Detailed information on the type and condition of HI for selected districts is available; however, there are significant gaps in coverage elsewhere, which hampers planning and implementation. Comprehensive updated data on HI is available only for 37 districts in Nepal.

Way Forward

The following activities are planned for the continued improvement of HI planning, development and maintenance:

- Continue to work closely with DUDBC and provincial and local governments to improve planning and decision making for HI. There will be continued orientation and support for the adoption of NHIDS, IHIDP, Disaster Risk Reduction (DRR) and other relevant infrastructure-related policies and standards at the sub-national level, involving close engagement and information sessions with provincial and local governments.
- Continue investment in capacity enhancement for improving technical skills at the federal and sub-national level, targeting managerial and technical staff.
- Carry out infrastructure risk analysis, with the development and incorporation of a multi-hazard resilience perspective.
- Further strengthening evidence-based decision making through improved HIIS data and analysis and wider geographical coverage.
- Continuously monitor the implementation progress and take timely actions to speed up planning and construction works and hence enhance budgetary absorption as per the plan.

Outcome 1.b HRH

Background

The NHSS recognises that a key component of high-quality health services relies on strengthening the production, deployment and retention of skilled human resources. This NHSS outcome will be delivered through the following outputs: improved availability of human resources at all levels, with a focus on rural retention and enrolment, and improved medical and public health education and competency. As a result of the restructuring of health governance, staff adjustment is progressing. Of the 31,591 permanent positions in the MoHP, approximately 4,000 are vacant.

Major Progress

- The HRH strategy 2030 has been prepared and is in the process of consultation and final review. It has been refined in line with recent acts and regulations. The process of consultation has been completed with officials from federal and provincial government as well professional councils and associations.
- Workload Indicators and Staffing Norms (WISN) piloting has been started in HPs and PHCCs in six districts from Provinces 3 and 4.
- iHRIS software, to develop and manage an integrated HRH database, has been implemented through two professional councils (Nepal Pharmacy Council and Nepal Ayurvedic Medical Council) with the plan to extend to other remaining professional councils.
- Considering the prolonged challenges faced in fulfilling the need for HRH, the MoHP has developed and endorsed procedures to hire staff on a contract basis.
- Adjustment had been carried out for nearly 27,500 staff in the health sector as per the Staff Adjustment Act (2074) by October 2019. Those members of staff were adjusted across the three levels of government and into different entities. Placement of staff was performed after staff adjustment. Table 3.1b.1 shows numbers of staff placed across federal, provincial and local levels.
- Developed certificate level midwifery bridging course for nurses providing maternity services.
- The National Academy of Medical Sciences (NAMS) and the Kathmandu University (KU) were accredited for Bachelor level midwifery programmes in 2919 and 2020 respectively, and 15 midwives graduated in 2020

Table 3.1b.1: Number of staff placed across federal, provincial and local levels by category

Category (Level)	Federal	Provincial	Local	Total	Total (%)
4	7	95	9,618	9,720	36.5
5	572	664	7,441	8,677	32.6
6	657	879	4,520	6,056	22.8
7	219	275	342	836	3.1
8	386	283	136	805	3.0
9	122	43	2	167	0.6
10	182	54	3	239	0.9
11	89	20	0	109	0.4
Chief specialist	3	0	0	3	0.0
Total	2,237	2,313	22,062	26,612	100.0
Percentage (%)	8.4	8.7	82.9	100.0	-

Source: MoHP, 2020

As presented in the table, nearly 83% of staff were placed at the local level. This is mainly because of the large number of HFs (particularly HPs and PHCCs) operational at the local level as well staffing in municipal offices. The remaining staff were adjusted to federal (8.4%) and provincial (8.7%) levels almost equally.

In terms of categories of adjusted health sector staff, more than one-third were 4th-level staff followed by 5th- (32.6%) and 6th-level (22.8%) staff: these three categories of staff comprised 92 percent of health personnel. Beyond these three categories, a relatively large number of staff were of 10th level (0.9%).

Challenges
- Although the staff adjustment process has been completed, there are still vacant sanctioned posts that must be fulfilled to ensure the delivery of high-quality services.
- Local Governments (LG) are responsible for recruiting staff on a contractual basis, but there are challenges in ensuring quality in the absence of tailored standards and guidelines, particularly as per the requirements of the local levels.
- As a result of following the criteria of staff adjustment, there is an oversupply of staff in urban areas, whereas in rural and mountain areas there is a short supply of HRH.
- HRH projections, gaps and needs are not yet complete as per the new federal structure.
- Mismatch between the production and actual needs of HRH still remains a major challenge.
- Sanctioned posts are limited and fulfilment of HRH in some specialities, such as hospital managers and biomedical engineers, is problematic.
- Partnerships with academic health institutions to support HRH needs have not yet yielded significant results and there is a lack of clarity on roles and responsibilities.

Way Forward

- Strengthen the HRH unit in the MoHP to carry forward HRH-related activities.
- Endorse the HRH Strategic Road Map 2030 after necessary updates and accordingly plan its implementation.
- Restructure and reorganise health institutions in light of lessons from COVID-19.
- Reform and restructure existing professional councils in light of the federal context and strengthen their regulatory capacity.
- Mobilise human resources developed through government scholarship strategically to address priorities.
- Management of HRH in the context of implementation of the Basic Health Services Package (BHSP) in line with public health service regulations.

Outcome 1.c Procurement and SCM

Background

The MoHP aims to implement new and innovative approaches to reform procurement and SCM systems. In the health sector, procurement and SCM are interdependent activities that contribute to ensuring the delivery of high-quality health services. The principles of economy, efficiency, efficacy, competition, accountability and transparency are paramount in both procurement procedures and logistics management, leading to Value for Money (VfM) in health expenditure. In this regard, MoHP realises the importance of strengthening the procurement and supply chain cycle through the development, endorsement and implementation of the Procurement Improvement Plan (PIP, 2017–2021). Moreover, MoHP is in the process of endorsing the Public Procurement Strategic Framework (PPSF, 2022–2026) as a policy document for all tiers of Nepalese health service delivery. This framework will provide strategic policy guidelines for all spheres of health governance in Nepal. Under this comprehensive strategic plan, MoHP is planning to implement the following five policy reform agendas:

(i)   Pre-bid information system strengthening, such as MA, Technical Specification Bank (TSB) and LMIS improvement;

(ii)   Efficient procurement and logistics planning, through consolidation of different planning tools;

(iii)   Standardisation of procurement and logistics management processes by executing e-GP system with health-friendly Standard Bidding Documents (SBDs) and e-LMIS;

(iv)   Enhancing contract management and capacity building programme at all spheres of health governance; and

(v)   Strengthening post-bid evaluation system for procurement and supply chain, such as Risk Analysis, Procurement Compliance System, Quality Assurance Plan, etc.

A. Procurement Management Reform

Procurement management in the health sector consists of preparing, executing and monitoring the PIP, TSB, LMIS, Inventory Management System (IMS), Annual Procurement Plan (APP), Master Procurement Plan (MPP), Consolidated Annual Procurement Plan (CAPP); their effective implementation is required to ensure the timely delivery and distribution of medical goods and equipment. Since FY 2014/15, MoHP has been monitoring and evaluating the compilation and consolidation of APPs through its departments. Table 3.1c.1 depicts the scenario of consolidation developments process through the years in MoHP and its departments.

Table 3.1c.1: CAPP budget, plan and actuals (in NPR Million)

SN	Fiscal Year	Total Budget	Procurement Budget	CAPP	CAPP Actuals	% of CAPP Value on Procurement Budget
1	2014/15	33,517.1	1,410.85	1,405.37	513.22	99.61
2	2015/16	36,729.5	2,159.01	2,102.33	1,321.01	97.37
3	2016/17	39,122.3	4,125.19	2,899.23	1,723.91	70.28

4	2017/18	24,420.2	2,728.55	2,156.34	1,606.18	79.03
5	2018/19	34,082.2	6,300.00	5,944.83	5,590.29	94.36
6	2019/20	42,670.8	5,692.43	5,433.48	4,420.28*	97.19
7	2020/21**	60,678.8	6,400.00	6,321.32	0	99.00

* Expenditure Figures in this year are taken from the output of e-CAPP module of TABUCS retrieved from *http://tabucs.gov.np/e-capp*. This also includes COVID-19 response expenses by federal Procuring Entities (PEs)
**Figures in this FY are only planned figures entered into h*ttp://tabucs.gov.np/e-capp*
Source: Various years' fiscal statements from DoHS, MoHP and CAPPs. Figures for FY 2020/21 are taken from the output of the e-CAPP module of TABUCS retrieved from *http://tabucs.gov.np/e-capp*

The formal CAPP was introduced in FY 2017/18, covering only 79 per cent of procurement in the health sector. In FY 2018/19, a Federal CAPP (F-CAPP) was introduced, covering 94 per cent of procurement; in FY 2019/20, around 97 per cent of the procurement budget is planned to be processed through online F-CAPP procedures. Assuming FY 2017/18 as a baseline date, CAPP execution has been improving over the last three years (Table 3.1c.1). Table 3.1c.2 shows F-CAPP procurement management differentiated by MoHP departments and health institutions. In FY 2020/21, 99 per cent of the procurement budget is entered into the online electronic Consolidated Annual Procurement Plan (e-CAPP) module of TABUCS and major improvements have been shown in procurement planning management under MoHP. Table 3.1c.2 further analyses and summarises the overall federal procurement management function of the last three FYs under the MoHP.

Table 3.1c.2: Three years of F-CAPP development process, FY 2018/19–2020/21

Group of Pes	FY 2020/21 Procurement Budget and F-CAPP (NPR million)	FY 2019/20 Procurement Budget and F-CAPP (NPR million)	FY 2018/19 Procurement Budget and F-CAPP (NPR million)
MoHP and hospitals	1,566.1	1,029.8	1,084.6
DoHS and programmes	2,665.6	2,536.1	1,992.0
Department of Drug Administration (DoDA) and programmes	408.0	81.5	79.0
Department of Ayurveda and Alternative Medicine (DoAA) and programmes	499.8	6.3	11.6
Boards and Academies	1,998.9	1,779.7	2,827.3
Grand total	**6,321.3**	**5,433.4**	**5,994.5**
% of procurement budget	10.42	12.73	17.4
Number of Pes	49/49	47/48	28/41
Compilation of APPs	Online	Online/offline	Offline/manual

Source: MoHP CAPP reports of three FYs, generated through: *http:/:www.tabucs.gov.np/summary_reports*

F-CAPP Execution: FY 2019/20 is the second year of federal-level CAPP execution as per procurement budget allocation. Out of NPR 42.67 billion of allocation, the federal procurement budget was NPR 5.69 billion (13.1% of total health budget), under which NPR 5.43 billion (12.7% of total health budget and 97% of federal procurement budget) was planned as per F-CAPP and executed over this year. Out of 48 PEs, 47 (98%) participated in the F-CAPP planning process

by using both online and offline methods of F-CAPP preparation. Table 3.1c.3 summarises the overall federal procurement management function in FY 2019/20 under the MoHP.

Table 3.1c.3: Federal CAPP budget, plan and actuals of FY 2019/20 (in NPR Million)

Description	Total Budget	Procure-ment Budget and Initial CAPP	Revised CAPP Plan	Civil Works	Medical Goods	Consul-ting Services	Other Serv-ices	CAPP Value Actual
MoHP and federal hospitals	22,654.5	1,029.8	1,029.8	208.5	809.0	12.3	0	1029.8
DoHS and programmes	9,322.0	2,795.1	2,536.1	44.1	2,426.9	29.9	35.2	2,161.3
DoDA and programmes	190.6	81.5	81.5	11.2	60.3	10.0	0	9.6
DoAA and programmes	156.2	6.3	6.3	6.3	0	0	0	0.00
Board and Academies	10,347.6	1,779.7	1,779.7	678.0	1,066.2	26.5	9.0	1,219.6
Total	42,670.9	5,692.4	5,433.4	948.1	4,362.4	78.7	44.2	4,420.3
Composition of procurement budget (%)	**100**	**13.10**	**12.73**	**17.45**	**80.29**	**1.45**	**0.8**	**81.35**

Source: Federal Budget and procurement Budget taken from Red Book, 2018/19; F-CAPP, 2018/19 and CAPP Status, 2018/19 taken from National Planning Commission (NPC) Form No.2; CAPP Monitoring Report of MoHP. CAPP Value actual figures are taken from http:/:www.tabucs.gov.np/summary_reports

In FY 2019/20, 81 per cent of the F-CAPP value (NPR 4.42 billion out of NPR 5.43 billion) was absorbed as procurement expenditure. Planned procurement expenditure includes the procurement categories of civil works (17.5%), medical goods (80.3%), consulting services (1.5%) and other services (0.8%).

EDPs' mid-term observations on the implementation of F-CAPP over two years from FY 2018/19 showed that CAPP procedures were effectively applied as an updated management tool in the procurement management of MoHP.[10]

COVID-19 Response: After the WHO declared the COVID-19 outbreak a pandemic, GoN formed a high-level COVID-19 Crisis Management Committee (CCMC) to address the situation. Under the policy guidance of the CCMC, MoHP commenced item identification, forecasting and quantification of essential logistics for COVID-19 response and management. Various EDPs, including WHO, British Embassy Kathmandu and the United States Agency for International Development (USAID), provided technical assistance in the development of technical specifications amongst other support. Some unplanned expenditure against F-CAPP, in the form of emergency procurement, was also necessary for the COVID-19 response. The Management Division (MD) of the DoHS prepared an immediate needs-based procurement plan and initiated the procurement process under the emergency procurement provisions of the Public Procurement

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[10] A Report on Biannual Assessment of CAPP Implementation Process for FY 2018/19, Ukaid, September 2019

Act (PPA)/Public Procurement Regulations (PPR). Table 3.1c.4 lists emergency procurement by MD/DoHS for the COVID-19 response in the last trimester of FY 2019/20.

Table 3.1c.4: Emergency procurement for COVID-19 response in FY 2019/20

S.N.	Procurement of Medical Goods and Logistics	Cost Estimate (NPR)	Contract Amount (NPR)	Method of Procurement	Remarks
1	Thermal scanner and infrared non-touch hand thermometer	15051000.00	6,396,430.54	RFQ	
2	Essential logistics for novel coronavirus management	15051000.00	7,222,962.00	RFQ	
3	Essential logistics	280000000.00	276,549,430.00	RFQ	Cancelled
4	Intensive Care Unit (ICU) equipment	48474700.00	37,267,225.80	RFQ	
5	General bed and accessories for isolation ward	51415000.00	35,482,000.00	RFQ	
6	Hand Sanitiser	1044000.00	1,152,600.00	DP	
7	Gum boots for Personal Protective Equipment (PPE)	2320000.00	1,999,139.50	DP	
8	PPE items	402297145.72	338,051,630.55	S-NCB	
9	Laboratory items	56488706.00	45,216,950.00	S-NCB	
10	Different items for control and prevention	58507919.60	27,461,373.00	S-NCB	
11	Rapid Diagnostic Test (RDT) kit	115418000.00	63,873,250.00	RFQ	
12	Drugs	75000000.00	45,418,140.00	S-NCB	
13	Reverse Transcription Polymerase Chain Reaction (RT-PCR), Ribonucleic acid (RNA) and Viral Transport Medium (VTM)	102039101.04	311,089,000.00	S-NCB	
14	RDT kit	102039101.04	77,536,560.20	DP	
15	ICU consumables	78050000.00	29,496,479.50	S-NCB	
16	Automated RNA extraction machine and RNA extraction kit	252500000.00	146,822,030.00	S-NCB	
17	RDT kit	9600000.00	94,500,000.00	DP	
	Total NPR Value	**1,667,137,673.40**	**1,547,569,201.09**		

Source: Annual CAPP Report, 2019/20 of MD/DoHS
DP: Direct Procurement   *RFQ: Request for Quotation*
S-NCB: Short-notice National Competitive Bidding

e-CAPP Initiation: In FY 2018/19, monitoring of F-CAPP had some shortcomings: its offline feature led to limited participation. Accordingly, an online e-CAPP module under TABUCS has been piloted and an orientation and initial training to MoHP officials was conducted in FY 2018/19. FY 2019/20 is the second year of federal-level CAPP execution and the first year of online data entry into the e-CAPP module of TABUCS at federal level – a rapid innovative reform in CAPP.

In FY 2019/20, the federal health budget was NPR 42.67 billion. Out of this, the federal procurement budget was NPR 5.59 billion (13%), under which NPR 5.43 billion (97% of procurement budget) was planned as online F-CAPP and executed over this year. DoHS and

programmes make up 47 per cent of the CAPP against the procurement budget, boards and academies make up 33 per cent and MoHP and central hospitals 19 per cent. Full coverage of the 47 PEs under MoHP has been incorporated into the system in an online basis.

According to the online CAPP for FY 2020/21, out of a total budget of NPR 60.68 billion, almost NPR 6.32 billion (10.4%) is for federal health sector procurement, which is divided among the following institutions/programmes: 42 per cent for DoHS and its programmes, 31 per cent for boards and academies, 25 per cent for MoHP and central hospitals and one per cent for each of the DoAA and the DoDA and their programmes (Figure 3.1c.1). This sum does not include fiscal transfers and grants to hospitals at all Sub-national Government (SNG) levels and/or the civil works budget for hospital infrastructure development through DUDBC of the Ministry of Physical Infrastructure and Transport (MoPIT).

Figure 3.1c.1: Procurement Budget by Institutional Programme, FY 2020/21
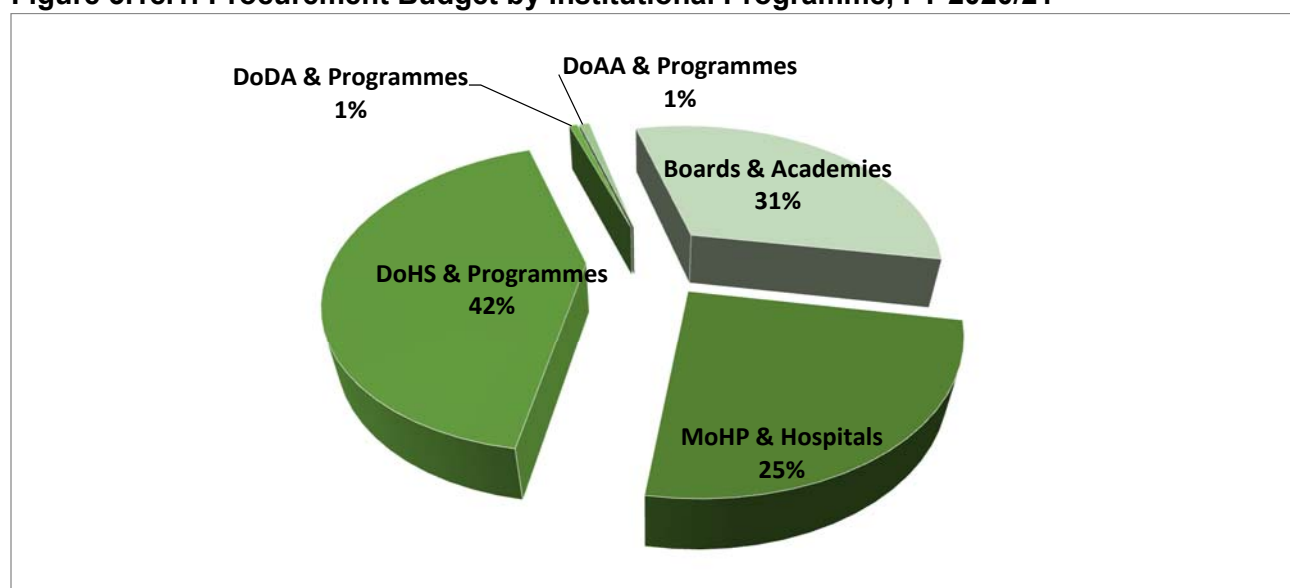
It should be noted that fiscal transfers and hospital grants and the NPR 14.4 billion for DUDBC/MoPIT have a high chance of being allocated for procurement; if these are counted as part of the total health sector procurement amount, the proportion rises to more than 60 per cent of the CAPP. The Federal DoHS is the largest buyer of medical goods and equipment among PEs under the MoHP. Procurement of medical goods and equipment consumes almost 72 per cent of the total procurement budget apportioned, while civil works consumes 17 per cent, consulting services 10 per cent with the remaining 1 per cent for other services.

Functional Status of Equipment in Hospitals: MD has maintained the functional status of equipment under the scope of the DoHS through regular monitoring. The functional status of sixteen different intermediate forms of equipment in 94 (mostly provincial-level) hospitals, disaggregated by province, is presented in Table 3.1.c.5 below. Overall, 82.3 per cent of equipment was found to be functional (range: 51.8%–92.2%). The type of item with the lowest functional status was ventilator (51.8%), which is used in intensive care, while that with the highest

functional status was dental X-ray (92.2%). Variation in the functional status across provinces is relatively low: the highest and the lowest overall functional status were in Sudurpashchim Province (92.6%) and Province 1 (76.9%) respectively.

Table 3.1c.5: Functional status of equipment in hospitals by equipment type and province

SN	Name of Equipment	Description	Number of Equipment by Provinces							Total	
			1	2	3	Gandaki	5	Karnali	Sudur Paschim	Total (No.)	Functional (%)
1	Vital Sign Monitor	Total	83	68	134	97	119	59	71	631	
		Functional	65	57	107	82	90	47	70	518	82.1
2	Oxygen concentrator	Total	95	47	51	54	69	70	51	437	
		Functional	78	41	46	42	61	58	51	377	86.3
3	Warmer, infant	Total	60	69	54	50	74	36	54	397	
		Functional	51	60	49	38	55	31	53	337	84.9
4	Microscope, binocular	Total	48	30	30	57	53	36	40	294	
		Functional	35	24	27	54	51	36	38	265	90.1
5	Electrocardiograph (ECG)	Total	57	25	42	43	46	35	29	277	
		Functional	37	19	34	36	39	29	25	219	79.1
6	Analyser, biochemistry	Total	38	16	29	27	49	26	28	213	
		Functional	25	13	26	16	43	23	26	172	80.8
7	USG Machine	Total	34	15	24	26	35	23	23	180	
		Functional	25	10	22	20	31	19	20	147	81.7
8	Phototherapy unit	Total	30	20	25	29	33	12	12	161	
		Functional	27	14	25	27	30	12	11	146	90.7
9	Electrosurgical unit	Total	34	13	18	20	30	21	21	157	
		Functional	29	11	17	20	28	18	20	143	91.1
10	Incubator, laboratory	Total	28	15	15	23	18	13	16	128	
		Functional	19	10	12	13	15	10	15	94	73.4
11	Anaesthesia apparatus	Total	11	9	13	9	16	5	11	74	
		Functional	6	7	11	6	13	4	9	56	75.7
12	Defibrillator	Total	3	2	6	9	8	5	4	37	
		Functional	2	1	5	8	6	5	3	30	81.1
13	Endoscopy	Total	5	7	5	8	8	5	1	39	
		Functional	3	6	4	6	8	3	1	31	79.5
14	Ventilator, intensive care	Total	5	6	14	17	25	9	9	85	
		Functional	5	5	5	8	8	7	6	44	51.8
15	X-Ray, dental	Total	12	5	9	7	8	5	5	51	
		Functional	11	5	9	5	8	4	5	47	92.2
16	X-Ray	Total	33	25	29	29	38	26	29	209	
		Functional	25	13	24	23	25	17	21	148	70.8
	Total	Total	576	372	498	505	629	386	404	3,370	
		Functional (No.)	443	296	423	404	511	323	374	2,774	82.3
		Functional (%)	76.9	79.6	84.9	80.0	81.2	83.7	92.6	82.3	

Source: Management Division, Department of Health Services.
Note: this table mainly depicts the picture before COVID-19; there are many changes in the COVID-19 context.

Major Progress

During the reform period of FY 2017/18 to 2019/20, the MoHP has made impressive progress in improving the performance of procurement management. The following targets have been achieved:

- *Procurement Improvement Plan:* PIP 2017–21 has been prepared and endorsed by MoHP; a nine-member CAPP Monitoring Committee (CAPP-MC) has been formed under

the chairmanship of the Director General (DG) of the DoHS and the Terms of Reference (ToR) of the CAPP-MC was endorsed in FY 2017/18. Since then, 12 consecutive trimestral monitoring meetings have been held in the period up to FY 2019/20.

- *Federal Procurement Planning and Consolidation:* Until FY 2017/18, DoHS and its divisions prepared the departmental CAPP within the specified timeframe. In FY 2018/19. F-CAPP was initiated and executed by MoHP for the first time; later, MoHP designed and piloted the online CAPP under TABUCS and an orientation training was held for MoHP and DoHS officials. Since FY 2019/20 the e-CAPP module in TABUCS has been operational for procurement planning and monitoring.

- *NHSPPSF Initiative:* After devolution, all health sector system transfers to SNGs were completed by FY 2018/19. However, the 2018 National Annual Review developed the concept of transforming the PIP into the NHSPPSF, an umbrella strategic policy document on procurement and SCM. The PIP was reviewed to cover all spheres of health governance and developed into the NHSPPSF for overall health sector reform. In FY 2019/20, this took the form of the PPSF and is under discussion for endorsement by the MoHP taskforce. It is planned that this framework will have strategic policy guidelines applicable to all spheres of health governance in Nepal.

- *TSB:* The TSB was restructured and systematised on the DoHS website in FY 2017/18 and is open to use for all stakeholders. Over 300 system users were registered in FY 2017/18; at the time of writing, over 700 users are registered to access the system, with over 17,000 technical specifications downloaded in FY 2018/19. The codification of drugs (108 drugs) and equipment (1,089 types of equipment) was completed and uploaded onto the TSB in FY 2017/18; in FY 2018/19, the specifications were updated to include 121 drugs and 1,109 types of equipment and the TSB was in use by SNGs. In FY 2019/20, the TSB was again updated and restructured in order to respond to the COVID-19 pandemic.

- *Procurement Process Standardisation:* In FY 2017/18, electronic Government Procurement (e-GP) was executed through the electronic bidding system, with 83 per cent of bids processed. In FY 2018/19 and FY 2019/20 the proportion of CAPP value processed through e-GP increased to 98 per cent and 99 per cent, respectively. Similarly, Standard Bidding Documents (SBDs) for health sector procurement (three SBDs, including the framework agreement) were drafted and sent for approval to the Public Procurement Monitoring Office (PPMO) in FY 2017/18; several follow-up and discussion meetings with PPMO were conducted by MoHP in FY 2018/19 in an effort to gain approval.

- *Technical Support:* In FY 2017/18, two sets of SOP, on procurement management and e-GP operation for SNG levels, were prepared, endorsed and distributed for implementation; technical support through the Third Nepal Health Sector Support Programme (NHSSP-3) continued in FY 2018/19. Procurement clinics were held 119 times in FY 2017/18, with 205 clinics, including 19 provincial support clinics, taking place in FY 2018/19. In FY

2018/19 and FY 2019/20, technical support was provided to all provinces: as several procurement clinics were held in response to official demands received by MD/DoHS.

- *Capacity Enhancement:* In 2017/18, two trainings on e-GP were conducted at the central level, while four provincial-/local-level trainings for capacity building in procurement were held. Training session plans were developed for capacity building of SNGs in procurement management. In FY 2018/19, the Logistic and Procurement Management Training Manual was reviewed. SNG-level capacity enhancement programmes were conducted in all provinces in FY 2018/19 and FY 2019/20: topics included forecasting and quantification (7), procurement planning (7), e-GP operation (7) and Training of Trainers (ToT).

- *Procurement Modality:* The MoHP is using an open, competitive and transparent mode of bidding as its prime method. The open bid method is the most popular and commonly used method among PEs for the procurement of drugs, medical equipment, hospital devices, contraceptives, cold chain equipment, insecticides and HI facilities. Openness, transparency, and competition in procurement fulfil one of the parameters for increasing VfM of GoN health sector expenditure.

- *Bid Evaluation and Approval:* The standard time allowed for bid evaluation and approval as per the PPA/PPR is a maximum of 120 days. All procurement of drugs and equipment in both years took place within the legal timeframe for bid evaluation and approval. In DoHS, all International Competitive Bidding (ICB) bids are evaluated within a period of 90 days and all National Competitive Bidding (NCB) bids are evaluated within a period of 35 days.

- *ICT Usage in Grievance-handling:* The Grievance-handling and Redressal Mechanism (GHRM) is an important element in procurement and SCM; however, it is not given very much importance in our context. In FY 2017/18, a concept paper on the Information-and-Communication-Technology- (ICT-) based GHRM was endorsed by DoHS on behalf of MoHP and system software was developed, approved and executed in FY 2018/19. This software is installed in MD/DoHS; in FY 2018/19, 37+ grievances were handled by the system.

- *Monitoring Management through committee approach:* MoHP formed the Public Financial Management (PFM) Committee under the chairmanship of the Policy, Planning and Monitoring Division (PPMD) Chief and endorsed its ToR to monitor overall financial management matters, including procurement and SCM. In 2017/18, MoHP formed the CAPP-MC under the leadership of DG of the DoHS and endorsed its ToR to monitor overall matters of procurement and SCM. Under these two broad central-level committees, DoHS has formed and expanded the various technical committees governed by CAPP-MC since FY 2017/18. From FY 2018/19 to the end of FY 2019/20, the PFM Committee has been monitoring the function of the CAPP-MC on behalf of MoHP.

B. SCM Reform

SCM in the health sector consists of preparing, operating and monitoring logistics needs in the PIP using the LMIS, e-LMIS and IMS. It involves warehouse development and management and transportation to ensure the timely distribution of medical goods and equipment. Under this comprehensive system, the DoHS/MoHP is implementing the following reform packages on logistics and SCM:

1. Enhancing strategy and planning with effective Monitoring and Evaluation (M&E) functions;
2. Improving forecasting and quantification techniques;
3. Standardisation of warehousing and inventory management;
4. Enhancing management information system practices through e-LMIS; and
5. Promoting capacity development programmes in all forms of government.

LMIS collects data from 77 districts and data is entered into LMIS on a quarterly basis. To date, 71 out of 77 districts have been reporting information in this way. In FY 2016/17, e-LMIS was introduced and in FY 2017/18, 22 districts (five districts offline and 17 districts online) were piloting the system.

In FY 2018/19, e-LMIS was implemented at six central stores, two PMSs, 22 HO stores (Provinces 5 and 6), 4 LGs and 23 HFs in Bardiya and Surkhet Districts. As a result, LMIS reporting rates of over 90 per cent and over 80 per cent have been achieved in the e-LMIS-implemented provinces of Province 5 and Karnali Pradesh, respectively. Data from all HFs is reported quarterly and made available nationally in the form of a dashboard and reports through use of e-LMIS software. Work is in progress to make LMIS data entry possible at the SNG level and capacity is being built, starting with health directorates and Provincial Health Logistics Management Centres (PHLMCs) at the provincial level, health offices at the district level and municipality health sections at the local level. So far, 371 LGs have been trained on e-LMIS data entry. Likewise, e-LMIS implementation in the remaining PHLMCs, hospitals, health offices, and LGs is also in planning.

Major Progress
In the period from FY 2017/18 to FY 2019/20, MoHP and DoHS has made good progress in improving the performance of the SCM system. The following targets have been achieved:

- *Forecasting and Quantification:* DoHS generally used LMIS software for forecasting and quantification of drugs for the coming year. This forecasting technique commonly used historical consumption data, morbidity, demographic data and programme considerations to predict yearly procurement needs. PEs prepared their forecasts based on data from the HMIS, LMIS, demographic health surveys, census data and other health-related policy documents. LMIS software provides national, provincial, district and local-level requirements as the basis for health commodity procurement planning and delivery schedules as commonly practised.

- *e-LMIS Initiatives:* LMIS software is primarily based on district- level data from 77 districts. Until all local levels are live on e-LMIS, DHOs make LMIS enter data on the e-LMIS platform based on the information provided quarterly by respective HFs through the local levels. e-LMIS implementation is a major system for logistics information management and is currently live at the local level.

- *Pipeline Reporting and Monitoring:* Drug status pipeline reports are produced from live e-LMIS at the national and provincial level. The status thus reported is verified and co-monitored with stakeholders and partners for regular intervention so as to ensure uninterrupted stock status at all levels. The stock status of 37 of the 121 Free Essential Drugs (FEDs) is monitored on a quarterly basis, whereas requirements for medical equipment and the status of available equipment are not as yet monitored through the system.

- *SCM governance:* The SCM Governance forum has been made functional at national and provincial level. This is a comprehensive mechanism for sorting out all SCM issues and challenges. A similar mechanism is required at sub-provincial and local level so that there will be integrated logistics in place, giving value for expended resources through avoidance of any duplication in efforts and wastage. One notable outcome so far of this governance system is the expansion of a live system for reporting health commodities status and use of the cold chain storage system in an integrated manner.

- *Rollout of the e-LMIS System:* In FY 2018/19, the MD/DoHS carried out capacity building programmes for SNGs and e-LMIS was implemented in 57 sites, including:

    - Two central stores
    - Four central sub-stores
    - Two PHLMCs (Butwal and Nepalgunj)
    - 22 districts in Provinces 5 and 6
    - Four local levels and 23 HFs in Bardiya and Surkhet Districts.

    In FY 2019/20, in coordination with the DoHS, this system was also rolled out in four new local levels (Learning Lab (LL) sites) with support from USAID/Global Health Supply Chain Programme – Procurement Supply Management (GHSC-PSM) and Ukaid/NHSSP. MD/DoHS assessed e-LMIS operational sites, including all levels of the supply chain (i.e. Central Medical Stores, PMSs, districts, LGs and SDPs) and covering all types of e-LMIS modules (i.e. online, offline and mobile modules of e-LMIS). For e-LMIS Phase II implementation, MD/DoHS is to scale up e-LMIS throughout the country. including all 753 SNGs. USAID/GHSC-PSM developed an e-LMIS scale-up plan to roll out the e-LMIS transactional module to five PMSs and 55 district stores and the reporting module to 753 SNGs. As per this plan, the required usernames and passwords have been made ready for distribution. To support the e-LMIS scale-up, a local vendor was selected in FY 2018/19 to roll out e-LMIS.

- *Ensure master data management and interoperability within NHSS:* The MD/DoHS has developed a shared dashboard that includes key indicators, such as HFs' reporting percentage and growth patterns, expiring/expired commodity situations country-wide, and stock availability status. They are regularly reviewed by concerned authorities for appropriate decisions based on the data. Analysis reports were regularly circulated to the districts and relevant stakeholders to resolve any identified issues.

- *Review of LMIS reporting system:* With new federal structures in place, it was unclear how information across the supply chain levels would be handled and as a result there was a gap in the LMIS reporting rate. The GHSC-PSM and MD/DoHS has focused on these areas, which resulted in an improvement in the LMIS reporting rate: the reporting rate for FY 2018/19 was only 30 per cent, whereas the reporting rate for FY 2019/20 increased more than twofold to 68 per cent. The quarterly average reporting rate of FY 2018/19 was 65 per cent, whereas in FY 2019/20, it increased to 78 per cent.

- *National supply chain policy:* The MD/DoHS organised a consultative meeting with provincial MoSD officials to discuss health commodities specification, FASP, procurement, LMIS and human resources. This activity was pursued through interaction with Directors of Provincial Health Directorates (PHDs) and PHLMCs and LG officials.

- *Capacity Building and Technical Support:* A critical mass of people at SNG level has been developed. Comprehensive training on procurement and SCM was conducted, participants certified and Viber groups created for exchanging knowhow and success stories.

- *Enhancing warehouse and inventory management:* In FY 2018/19, 500 posters promoting basic warehouse good storage practices were distributed and a catalogue of health commodities developed to support better practices in stores. The Epidemiology and Disease Control Division (EDCD) store physical stock count has been completed and the EDCD store is part of e-LMIS alongside five divisions and centres, two PMSs, 22 district stores, four LGs and 23 HFs. A draft warehouse management guideline has been developed and is under review. MD has sent racks, material handling and safety equipment to five PMSs.

- *Data governance and online IMS support:* USAID/GHSC-PSM will reconcile e-LMIS master data against the HF codes issued by the new Health Registry. Online IMS support is performed optimally through Intellisoft. As per the new regulatory requirements on AGO forms, the Intellisoft team has developed and incorporated changes into the online IMS, made available for users for their daily operations.

Challenges
- Poor system linkages between AWPB, TSB, LMIS and CAPP in preparing procurement proceedings and pre-bid information and planning systems, e.g. MA, TSB, cost estimation, SBD preparation and APP/MPP approvals, directly affects their timeliness.

- Capacity to conduct analysis on market, cost, source and risk for the procurement management system is limited. MA of drugs, availability of drugs in local/foreign markets, and price analysis are in practice almost non-existent when approving cost estimates. Cost estimation practices are therefore not very realistic or effective, especially in the case of procurement of drugs.
- The existing LMIS/e-LMIS is not comprehensive enough to inform the quantification and forecasting of drugs to cover all SNG and federal requirements. The stock status of only 37 of 121 FEDs is monitored on a quarterly basis and the status of available equipment is not yet monitored through the system.
- The pace of standardising the procurement process is slow as solicitations of bids and SBDs designed specifically for the health sector are lacking. The absence of health-specific SBDs in the e-GP system is also hampering the procurement of medicine in all spheres of government. Evaluation of procurement systems is delayed by the lack of post-bid information systems, such as the Procurement Compliance Audit System (PCAS), Contract Management System (CMS), Quality Assurance Plans (QAPs) and Risk Mitigation Plans (RMPs).
- There is no function assigned to the federal government for the procurement of essential drugs, which might cause a significant challenge in the near future: this has been shown to be crucial in the COVID-19 response efforts. Likewise, warehousing facilities in the PMSs are traditional and do not have the human resources and designed spaces for the adoption of good warehousing practices.
- Skilled workforces for the operation of e-GP, e-CAPP, electronic Technical Specification Bank (e-TSB), e-LMIS and IMS are yet to be developed and deployed in all spheres of government. Similarly, institutional memory has been weakened by rapid transfers of staff involved in procurement and supply chain systems.
- Weak contract management capacity and practices have caused issues 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: CAPP-MC has been reporting through manual preparation of Excel spreadsheets from individual active contract files.
- Capacity building at SNG level is critical in the case of procurement of drugs. However, MoHP has already designated health staff who lack procurement expertise and knowledge to all levels: procurement seems to be an "unknown task" to them. Similarly, capacity building of bidders and suppliers at SNG level is another issue to be resolved immediately.
- Monitoring of the CAPP is not yet robust for each type and modality of procurement. DoHS has formed the CAPP-MC to monitor the procurement cycle, but similar structures for DoDA and DoAA are yet to be established and their capacity to monitor the procurement cycle needs to strengthened. MoHP and its PEs currently have relatively high audit observations, mainly originating from non-compliance and mis-procurement, which also lead to stockouts and over-stocking of commodities.
- The stockout of key commodities was also observed in FY 2019/20. The e-LMIS provides information on the status of selected medicines in HFs across the country. Table 3.1c.6 summarises stockout levels on a quarterly basis.

Table 3.1c.6: Percentage of facilities reporting stockout of selected items in 2019/20

Item Name	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
Depot Medroxyprogesterone Acetate (DMPA) – injectable	9.6	7.5	7.7	9.2	8.5
Condom	10	9.7	8.9	12.2	10.2
Oral Contraceptive Pills (OCPs)	14.1	11.0	11.4	16.7	13.3
Oxytocin	31.5	22	23.1	21.7	24.6
ORS	0.0	4.6	6.4	10.6	7.7
Amoxycillin 500 mg caps	15.3	12.8	11.5	16.1	13.9
Paracetamol	6.6	4.2	3.4	5.1	4.8

Source: e-LMIS

Way Forward

- *Separate provisions for medical goods procurement:* Specific provisions for the procurement of medical goods are required in the PPA/PPR. This will lead to health-friendly procurement practices in the health sector. Amendments of the PPA/PPR shall focus on framework agreements, commodity contracts and G-2-G (Government to Government) arrangements for health sector use. Further, the PPMO needs to develop and endorse health-friendly SBDs and SOP for emergency procurement, quantification, forecasting, and the disposal of expired drugs at both federal and SNG level.

- *Enhance Committee approach of Monitoring:* Focus on PFM and CAPP-MC to strengthen its monitoring functions to reduce audit observations in procurement and SCM at all levels. ICT-based monitoring functions should also be initiated at SNG level.

- *System development and standardisation:* Pre-bid information and planning systems should be strengthened, including MA, cost analysis, sourcing analysis and risk analysis in procurement and SCM. In the post-bid stage, enhance the use e-GP, e-LMIS, e-CAPP; and incorporate health-sector-friendly SBDs into the e-GP system. The Procurement Clinic function should be institutionalised to give troubleshooting and technical support for SNG-level procurement. The LL approach currently being implemented shall be strengthened as a focal hub for SNG-level technical support.

- *Quality Assurance:* Ensure delivery of the Quality Assurance Plan (QAP), including PSI of drugs at the federal level and PDI of drugs at all levels of health governance.

- *Strategic planning:* Strengthen: strategic planning skills; data-driven planning and decision making at various procurement and SCM levels; capacity building; quantification and supply planning; forecast accuracy; stock status analysis; and develop and capacitate a Provincial Task Force. PPSF shall provide a policy guideline for this purpose.

- *Capacity building:* Capacity building of institutions and personnel is required at both federal and SNG level. A programme of competency-based in-service training, supportive

supervision and mentorship is needed to improve SCM performance at SNG level. Professional and institutional capacity building at all levels of health governance with systematic provisions to retain institutional memory is necessary.

- *Institutionalisation of epidemic response:* Epidemic crises are almost common in Nepal each year. The MoHP therefore needs to formulate permanent institutional arrangements.
-
- *Focusing the Learning Lab (LL) sites:* e-LMIS was established in four of the LL sites, which has contributed to planning and SCM at the respective levels. Additional sites will be supported as per local needs and capacity will be enhanced in priority areas. The procurement clinic function needs to be institutionalised for troubleshooting and technical support in SNG-level procurement. LL sites will be equipped with a procurement clinic tool for SNG-level technical support and capacity building to generate insights for further strengthening.

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

Background

Improving quality of care at the point-of-delivery is a priority for NHSS and is delivered under three outputs:

- High-quality health services delivered as per standards and protocols
- Quality assurance system strengthened
- Improved infection prevention and health care waste management.

Both the NHSS and the 2019 National Health Policy (NHP) prioritise quality of care and have proposed to have regulations to accredit health institutions and quality assurance mechanisms for allopathic and Ayurvedic medicines, supplies, lab services and medical equipment. Progress has been made in the first output by initiating the implementation of the MSSs for HPs and primary-, secondary-, and tertiary-level hospitals. Moreover, in the policy and programme for FY 2020/21, activities directly related to the regulation of quality in the provision of health services are planned: the establishment of a National Authority for the Accreditation of Health Institutions and the introduction of a common umbrella Act to manage health academies.

Major Progress in FY 2019/20

- A Health Institution Quality Assurance Authority Act was drafted to establish an autonomous body for accreditation of private (including NGO) health institutions and Quality Assurance Guidelines have been prepared.
- Various divisions/centres of MoHP and DoHS are developing/revising national strategies and plans for improving quality of care provided at service delivery points: the Nursing and Midwifery Strategy and Plan of Actions (2020–30): in progress with costing action plans; SBA/Skilled Health Personnel Strategy (2020– 25) and Training Strategy (2020–25): in progress, to be implemented as transition towards replacing national workforce with professional midwives; and a National Health Care Quality Improvement Strategy.
- The National Action Plan (NAP) for Antimicrobial Resistance (AMR) has been finalised and approved by the National Technical Working Committee. The plan has been prepared in Nepali and in English and will be further reviewed, to be approved by the AMR Multisectoral Steering Committee (AMRMSC). The Protocol for Laboratory-based Surveillance of AMR in Clinical Bacterial Isolates in Nepal has been developed and national AMR surveillance data has been reported in the WHO-Global Antimicrobial Resistance Surveillance System (GLASS).
- Various divisions of DoHS/MoHP are developing/revising national standards, new protocols and guidelines to align with the new Federal organogram. Documents endorsed include: Multiyear Procurement Plan of Immunisation Syringes; National Medical Standard (NMS) for Reproductive Health (RH), Volume 1 (2020); RH Clinical Protocol 2076 (2019) for Medical Officers, Staff Nurses, Auxiliary Nurse Midwives (ANMs) and Paramedics; Public-private Mix (PPM) Guideline; Guidelines for Tuberculosis Treatment and Referral Management; Guideline on Drug-resistant TB (DRTB) Community-based Directly Observed Treatment (DOT); National Guideline on

DRTB Management (2019); and Basic Health Service Establishment and Management Programme Guide for Local Levels (2019); and Leprosy Control Programme Management Interim Standard (2077). Some are in the final drafting stage, including: NMS Volume 3; STP for Basic Health Services (BHS) and Operational Guidelines; Hospital Risk Management Standard; Health Training Management Guideline and Quality Improvement (QI) tools.

- Training materials and manual revised/developed on: Burn Care and Management, Road Traffic Accident and Safety, Occupational Health and Safety, Menstrual Hygiene Management, Basic Physiotherapy, Minimum Initial Service Package (MISP), Spinal Cord Injury, AMR Prevention and Psychosocial Counselling.
- Various trainings and orientations have been conducted to ensure provision of high-quality health services, including: advanced SBA (10 providers), rural ultrasound (44 providers), paediatric nursing care (11 providers), Diploma in Biomedical Equipment Engineering (10 persons), medico-legal training (30 persons), operation theatre technique and management (24 nurses), Special Newborn Care Unit (SNCU) level II (34 providers), ICU/critical care (20 providers), cervical cancer (VIA/cold coagulation) (20 providers), climate change and health impacts (44 persons), Health Facility Operation and Management Committee (HFOMC) (more than 2300 persons), clinical training skills (45 persons), Infection Prevention and Control (IPC) (45 persons), Anaesthesia Assistant (AA) (10 persons), palliative care (32 persons), mental health training (40 persons), Package of Essential Non-Communicable Diseases (PEN) (80 persons) and GBV (16 persons), Maternal Perinatal Death Surveillance and Response (MPDSR) orientation (10 districts and 16 hospitals), clinical mentors (30 mentors), birth preparedness and misoprostol (health workers and FCHVs) and SBA (273 nurses). More training on SBA, Adolescent Sexual and Reproductive Health (ASRH), Intrauterine Contraceptive Devices (IUCDs), IMPLATS and COFP are being conducted at Provincial Health Training Centres (PHTCs).
- Four new training sites have been made operational, specialising in the following: MSS Biratnagar, CAC; Kohalpur Medical College, SBA; Surkhet Provincial Hospital, MLP, vasectomy, implants, IUCDs and SBA; and Karnali Academy of Health Sciences, SBA, implant and IUCDs.
- Follow-up enhancement of trained staff conducted with 88 SBAs, 43 MLP and 9 OTTM.
- Training Information Management System (TIMS) installed and onsite training completed in all seven provinces.
- During FY 2019/20, 247 clinical mentors and partners' staff provided on-site clinical mentoring to 3,700 Maternal and Newborn Health (MNH) service providers. Clinical mentors also supported hospitals and Birthing Centres (BCs)/Basic Obstetric and Neonatal Care (BEONC) sites for self-assessment and planning for service readiness using QI tools during clinical coaching visits to HFs and hospitals. Clinical mentors using Open Data Kit (ODK) mobile applications report quality updates from Comprehensive Emergency Obstetric and Neonatal Care (CEONC) hospitals.
- MSS for HPs are now available in Nepali. Implementation and monitoring of MSS has been completed at 219 of 753 municipalities. Use of a virtual approach is being considered in the context of COVID-19.
- Measles outbreak and outbreak response effectively completed.

- National TB Prevalence Survey finalised.

Highlights of FY 2020/21
- GoN has approved the Public Health Service Regulations, 2077 (2020), published in the Nepal Gazette on 21 September 2020 to implement the Public Health Service Act, 2075 (2018).
    - The Public Health Service Regulation defines the BHSP and outlines the institutional arrangements for licensing and the emergency health care package. The Public Health Service Regulation, 2077 (2020) has further specified HF management standards and conditions for the provision or revocation of institutional licenses at federal-, provincial- and local-level health institutions.
    - BHS were also costed and necessary adjustments were made in the service package in light of ensuring cost-effective services from frontline HFs, financing feasibility and political vision during the process of its approval and endorsement.
    - The final draft of National Strategy Plan (TB) for 2021–2026 has to be endorsed. In light of the COVID-19 pandemic, implementation guidelines were developed for various programmes and services to ensure the provision of services with preventive measures.
- Introduction of Vitamin K programme within MNH services from current FY is planned from provincial level.
- Prepared the draft of National Health Training Strategy.
- A draft of procedures for accreditation of health training has also been prepared.
- Draft manuals for the Organisational Capacity Assessment Tool (OCAT) have been prepared for local and provincial levels.

Challenges
- Delayed or limited implementation of major quality-improvement interventions, such as MSS at HP/PHCC level and on-site clinical coaching, because of COVID-19.
- Practice of analysing routine data to measure quality of care is yet to be institutionalised.
- Fluctuating functionality of CEONC and BC services affecting service uptake.
- Certain programmes did not receive due priority during the COVID-19 pandemic, posing risks for the future: e.g. lack of dedicated focal person for TB at local and provincial levels.
- Roles of federal, provincial and local levels in the procurement of essential medicines and commodities are not yet very clear, which sometimes create stockouts and overstocks.
- Staff turnover is affecting multiple areas of the health system: there are problems in MPDSR online reporting from the local level and challenges in ensuring effective communication between local and federal levels for necessary guidance and backstopping
- Improving and maintaining high-quality health services remains a major challenge in mountain and hill areas, mainly due to geographical barriers.
- The quality assurance framework at health institutions for health service delivery is still weak and need to be strengthened.
- Less focus on data-driven quality assurance mechanisms to improve service delivery

- Developing key indicators in order to monitor the implementation of standards is challenging
- Systematic coordination mechanism with provinces and local levels for training management and quality control
- Limited institutional capacity of PHTCs to reach the respective institutions and local levels.
- Limited coverage of MPDSR and incomplete data to monitor maternal death
- Lack of information on functionality of the EmONC facilities

Way Forward
- Finalise and endorse STP and operational guidelines for the implementation of BHSP and carry out necessary orientation to local levels and health workers.
- Finalise national Quality of Care Strategy and Implementation Guidelines, ensuring that planning is based on performance of HFs and needs.
- Develop and define quality assurance structures at all three levels of government. Alignment between health insurance and the free health care programme is to be strengthened.
- Implement MSS at all levels and develop a reporting and monitoring mechanism to link with annual planning.
- Strengthen legal framework for the regulation of drugs and laboratory services across each level of government.
- Strengthen the regulations as well as facilitation for the smooth operation of private hospitals as per the licensing framework and develop e-licensing submission for private health institutions.
- In accordance with the Safe Motherhood and Newborn Health (SMNH) Road Map developed by the MoHP, continue to have policy dialogue, discussion, planning, budgeting and programing to enhance ownership of the of the proposed strategy and plan by provincial and local level to maintain and improve the quality of essential health care services.
- Enhance capacity of local levels on planning and implementation of quality improvement interventions and reaching hard-to-reach communities.
- Training Needs Assessment for systematising and institutionalising needs-based trainings.
- Coordinate with universities and the Council for Technical Education and Vocational Training (CTEVT) to incorporate national programme requirements in the pre-service curriculum.
- Standardise and strengthen training sites to ensure adequacy of training aids, such as audio-visual equipment, laptops, desktops, anatomical models, furniture/fixers and simulation-based education equipment, establishing model clinical training sites in each province.
- Build capacity of clinical trainers to place core groups of "pool trainers" and improve their inventory management.
- Enhance coordination, collaboration and partnership between programme divisions, other federal entities, PGs, EDPs and United Nations (UN) Agencies to achieve high-quality health training management and implementation.

- Implement MSS at HP/PHCC level and develop a reporting and monitoring mechanism to link with annual planning.
- Scale –up and strengthening of MPDSR system
- Focus on functionality and quality of existing CEONC sites instead of quantitative expansion of new sites.

3.3 Outcome 3: Equitable Distribution and Utilisation of Health Services

Background

The NHSS states that the MoHP will sustain and improve progress made towards reducing inequalities in health outcomes through the expansion of health services, focusing on the under-served, the poor and urban communities. The NHSS has equity as one of its four strategic approaches to achieve UHC. The major implications of financial, sociocultural, geographical and institutional barriers reduce access to services. Equitable access to health services requires the development of activities that give priority to populations and areas who lack or have limited access to health services, including those suffering from COVID-19 infection. There are two outputs under this outcome:

- Improved access to health services, especially for unreached populations
- Strengthened health service networks, including the referral system.

The COVID-19 pandemic and response measures such as the nationwide lockdown affected the continuous delivery and utilisation of routine health services. The situation, however, has gradually been improving after the development of new guidelines within the context of the COVID-19 pandemic, which facilitated provision of services with preventive measures.

Major Progress

- The number of service delivery sites has increased, ensuring access to essential health care services, especially for remote and rural communities. Service delivery sites include the following: 620 community health units, 613 urban health centres, BCs or BEONC sites operating at HPs/PHCCs and 92 CEONC sites in 72 districts.
- In total, about 3.3 million people have enrolled in the health insurance scheme, which is being implemented in 471 local levels of 60 districts.
- Based on the NMS and SMNH Road Map 2030 and various guidelines, DoHS is implementing interventions for hard-to-reach communities: full immunisation of 58 districts (December 2019); PNC home visit programme (98 Palikas); visiting service providers (36 Palikas); roving ANC (54 Palikas); Adolescent-friendly Services (AFS), provided through 1,331 AFS sites and 297 Adolescent-friendly Information Centres (AFICs) in schools.
- At the time of writing, there are One-stop Crisis Management Centres (OCMCs) in 77 hospitals located in 74 districts. At the end of 2018/19, there were only 55 OCMCs in 54 districts. The MoHP intends to complete the establishment of OCMCs across the country in FY 2020/21. The functionality of OCMCs was better in general hospitals than elsewhere: 88 per cent of general hospitals provided services without interruption as compared to 78 per cent of COVID-19 hospitals.
- Similarly, Social Service Units (SSUs) have been established in 44 hospitals; geriatric care is available in 24 hospitals.
- The Family Welfare Division (FWD)/DoHS, with financial and technical support from UKaid has carried out a number of programme activities in various parts of the country. The overall progress of the programme is over 90 per cent.

- The FWD, with the support of the United Nations Population Fund (UNFPA) is scaling up FP/Expanded Programme on Immunization (EPI) integration activities in two districts (Baitadi and Udayapur).
- The following activities were also carried out by FWD with support from UNFPA:
  o FP/RH orientation was provided to elected representatives, health coordinators and government officials at the local level: 139 elected representatives and LG officials were oriented on FP and sexual and reproductive health and rights.
  o Mobilising Visiting Service Providers (VSPs); Long-acting Reversible Contraception (LARC) services were provided to 3,560 women.
  o Forty healthcare providers received competency-based training on the provision of ASRH services.
  o A total of 3,198 women and 1,986 men from excluded and marginalised communities (Dalit, Muslim, and Janajati) were provided with FP information and messaging.
  o The Social and Financial Skills Package (Rupantaran Programme) was rolled out in five districts through 48 peer educators and 22 social mobilisers (youth champions) selected from local communities. They were responsible for demand generation for RH/FP services among adolescents and young people and reached 1,245 adolescent girls with training activities.
  o Two RH-related sets of guidelines have been developed, The Pelvic Organ Prolapse Guideline and the Cervical Cancer Guideline; both are being finalised.
- A FP Sustainability Road Map (2021-2030) is being developed; in light of the new sector strategy, 2030 agenda and the Family Planning Costed Implementation Plan (FP CIP) 2015-2020, coming to an end.
- is being developed
- A fully functional modern district hospital has been built with KOICA support in remote Mugu district.

Humanitarian response and assistance, including COVID-19 crisis (FY 2019/20–2020/21)

- The Health Cluster, Reproductive Health Sub-cluster (RHSC), and Emergency Nutrition Cluster were active and held regular meetings at provincial and federal level. Participation from Provincial Health Directorates in central-level RHSC meetings has provided cross-learning.
- Seventy-three laboratories were established for COVID-19 testing by GoN and the private sector across seven provinces.
- Over 15,000 health workers were oriented on the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Interim Guideline; orientation was led by FWD/DoHS and supported by selected supporting partners. Follow-up showed that health workers had fairly good knowledge, except on danger signs, PPE needs per day, Safe Abortion Services (SAS) provision and improved IPC practices after COVID-19/RMNCAH Interim Guideline orientation.

- Supporting partners supported GoN (different levels) with COVID-19-related Information, Education and Communication (IEC) materials, including risk communication messages, PPE, hotline services and essential commodities, kits and supplies.
- The Health Cluster, Nutrition Cluster and RH Sub-cluster are monitoring availability and continuity of high-quality essential health services delivery and essential commodities, including food supplements. These include ad hoc monitoring of RMNCAH services by phone calls, weekly monitoring of MNH services, monitoring of children with malnutrition, weekly monitoring of maternal and perinatal deaths, monitoring of essential commodities, assessment of RMNCAH service utilisation and HF readiness during the COVID-19 crisis and the impact of the COVID-19 pandemic on functionality and utilisation of RMNCAH services by clients in public sector HFs.
- The status of increased maternal death during COVID-19 (MPDSR) was reviewed by an expert panel under the RH Sub-cluster. It recommended strengthening MPDSR, referral linkages and capacity enhancement of obstetric providers. Knowledge enhancement of health care providers (obstetric care) at selected referral-level hospitals on some direct obstetric causes of maternal death has been initiated.
- During lockdown, the following services were also made available:
  - Medicine for TB treatment was provided at home
  - Iron tablets were supplied for three months to all pregnant women
  - People Who Inject Drugs (PWID) received Opioid Substitution Therapy (OST) at home
  - Prevention of mother-to-child transmission continued
  - Home delivery ensured uninterrupted ART.
- The National Centre for AIDS and STD Control (NCASC) introduced Dolutegravir (DTG) as the first-line drug for all in May 2020.
- Monitoring and assessment of service delivery status was performed; key findings are:
  - During COVID-19 lockdown, there was an initial decrease in Sexual and Reproductive Health (SRH) service uptake but the health system managed to recover and continue essential SRH services at most HFs. Regular immunisation/vaccination services for children were halted during the first month of lockdown (Chaitra) at the majority of HFs (51%); service availability and provision improved from May 2020 and almost all services were provided as expected, except the following:
    - Less than 40 per cent of HFs prepared for screening clients, taking into account staff safety and maintaining physical distancing in the context of the COVID-19 pandemic.
    - There was insufficient PPE available at point-of-care facilities: about 40 per cent of health workers provided services without PPE and limited numbers of health workers used teleconsultations for RMNCAH services.
    - Most COVID-19 hospitals (80%) and nearly three-quarters of other hospitals had adequate availability of all five types of PPE but availability of PPE at PHCCs, HPs and urban health centres is low.
    - Excepting hospitals, the majority of peripheral HFs were unable to provide delivery incentives at the time of discharge.

- Human resource gaps (both technical and non-technical) and health workforce overstretch (including leadership/management) were observed during the COVID-19 crisis; these issues were exacerbated by the pandemic.
- There were anecdotal reports that abortion, including unsafe abortion, increased, especially during lockdown; women and couples showed a lack of knowledge about abortion laws and services.
- Relatively high maternal and perinatal deaths were observed during the COVID-19 pandemic.

Challenges
- Geographical barriers need to be addressed to improve access to HFs, especially in maintaining CEONC services in remote and difficult areas.
- Limited population coverage under the health insurance programme.
- Trained staff, including Advanced Skilled Birth Attendants (ASBAs) and AAs, continue to be placed in HFs that do not have CEONC services and/or surgery, resulting in discontinuing services at remote/difficult areas. Access to essential health services has been affected by the COVID-19 crisis, especially for hard-to-reach and vulnerable groups.
- Limited availability of geriatric services and disability-friendly health services and capacity of service providers to adapt services accordingly.
- Both the continuation and utilisation of SRH services, including FP and maternal health, remain low in the COVID-19 context because of fears around virus transmission – for both providers and clients – and restricted mobility.
- In the absence of HF-level information in the e-LMIS, the real-time stock situation of FP/RH commodities is not available.
- Strong policy provisions, disability-related health strategies and technical guidelines have been introduced. However, implementation is below expected levels and hindering access to essential health services and rehabilitation. The response of the health service to prepare for COVID-19 cases among people with severe and complete disabilities is almost negligible.
- Numbers of maternal and infant deaths reportedly increased during the COVID-19 crisis, compared to the previous year.

Way Forward
- Ensure implementation and provision of BHSP as per Public Health Regulation.
- Ensure equitable availability and provision of BHS, especially in rural and remote areas, through the continued expansion of services at strategic locations. Prohibit unregulated expansion of services sites (including CEONC) in easy-access areas of the country as this has resulted in difficulty in maintaining services in remote areas.
- Expand health insurance to all remaining districts and prioritise the enrolment of the poor in the health insurance scheme.
- Update the RMNCAH Interim Guideline, make the RMNCAH Interim Guidelines available at all HFs, continue information and knowledge updates on RMNCAH, promote self-care health services with links to the health system, and promote digital technology for health service delivery follow-up.

- Ensure adequate supplies of PPE and provision of orientation training to health providers stationed at peripheral HFs on the use of PPE.
- Scale up programmes for reaching hard-to-reach communities, such as AFS, VSPs, Roving Auxiliary Nurse Midwives (RANMs), PNC home visits.
- Implement of National Guideline on Disability-inclusive Health Services.
- Harmonise the services and benefits available in the BHSP, health insurance and other free health care programmes (SSUs, Deprived Citizens Fund, Aama Programme etc.).
- Implement GESI Strategy, establish GESI institutional mechanism and continue to support provinces and local levels for the roll-out of the GESI Strategy. Strategically support LG in health planning, focusing on reaching unreached and marginalised/vulnerable groups.
- Prioritise budgetary allocations for expansion of SSUs, OCMCs, geriatric and disability services, the Leprosy Control Program and mental-health-related programmes.
- Development of Universal Health Coverage implementation framework and its implementation.

3.4 Outcome 4: Strengthened Decentralised Planning and Budgeting

Background

The NHSS highlighted the need to 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 more responsive to their needs. It identifies that the centre will define national priorities, establish the necessary regulatory framework, monitor progress and provide necessary technical and financial resources. Outcome 4 of NHSS has one single output: "strategic planning and institutional capacity strengthened at all levels".

With the promulgation of the Constitution of Nepal, 2015, federalism has provided a major impetus to decentralised planning and budgeting. Each of three levels of governments has a mandate to operationalise their policies and strategies and to develop an AWPB. The local levels started developing their own AWPBs in FY 2017/18 and hence 2019/20 is the third FY after the federal restructuring. The MoHP organisational structure and health service delivery system was revised for the federal, provincial and local levels and staff adjustments have taken place. At the province level, the MoSD, PHDs, Provincial Logistics Management Offices (PLMOs) and PHTCs have been established. DHOs have been established in each of the 77 districts under the PHDs and previously existing DPHOs have been dissolved. FY 2019/20 also marks a new achievement towards federal reform, with human resources adjusted to the respective levels.

Local-level AWPBs are a joint reflection of the planning and budgeting done at the federal, provincial and respective local levels. The provision of fiscal transfers has also come into practice, with federal and provincial levels providing grants to local levels. In this context, it is critical to ensure harmonisation of the AWPB process across the three levels of government so that a consistent and coherent plan can be developed for overall effectiveness in the health sector. As per the Constitution, federal government presents its AWPB by 15 Jestha (end of May); similarly, provinces present their AWPB by the end of Jestha (mid-June); and finally, local levels present their AWPB by 10 Ashad (25 June). The Constitution has mandated the local level in the provision of BHS, which are to be delivered free of charge. Nevertheless, the federal government has the mandate to define the scope and standards for BHS. Provinces have also been supporting local levels in the provision of health services.

Major Progress in FY 2019/20

- FY 2019/20 is the second FY after the provision of revenue distribution came into effect, which marked greater resources being available for local levels in a flexible manner. AWPBs were presented by each level of government on time.
- Sources of revenue for local levels included revenue transfer and grants from federal and provincial levels as well as tax and non-tax revenue from LGs (just like federal and provincial governments). Similarly, sources of revenue for provinces include revenue transfer and grants from the federal level as well as tax and non-tax revenue from the respective PGs.
- Among the different components of the fiscal transfer from federal to sub-national level, conditional grants constitute the bulk of the resources, particularly at the local level: 46 per

cent of the fiscal transfer is for programmes conditioned by the federal level. The two other major components of the fiscal transfer are revenue transfer and equalisation grants, which are unconditional by nature, and jointly comprise 62 per cent of provincial and 52 percent of local-level revenue. This implies that local levels have less flexibility, relatively, in terms of programme planning and implementation. Composition of the intergovernmental fiscal transfer for provincial and local levels is presented in Figure 3.4.1 below.

Figure 3.4.1: Composition of Intergovernmental Fiscal Transfer for Provincial and Local Levels, FY 2018/19
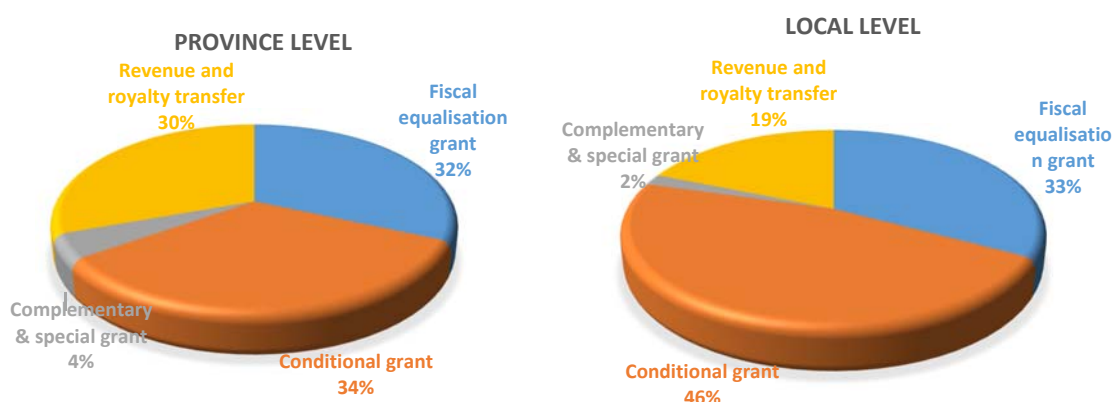
Source: Ministry of Finance (MoF), 2020: Economic Survey 2019/20

- The share of own-source revenue in the total revenue base of local levels was 7.8 per cent in 2018/19, which is lower than that of provinces (10.9 in 2018/19)[11]. However, local levels spent 24 per cent of total general government expenditure, while provinces spent 10 per cent. This indicates that local levels primarily rely on the fiscal transfer for their developmental works with a substantial share of conditional grants.
- Revenue transfers and equalisation grants are unconditional by nature and are to be used for administrative and developmental activities, including different sectoral areas such as health and education. Conditional grants are earmarked to specific programmes and activities and are to be spent as per the conditions provided. Conditions are mainly provided in terms of operational procedures, as defined in the respective guidelines and instructions provided by the concerned line ministry and sectoral agency. The share of the conditional grant that local levels have been receiving is dominated by the social sector, particularly the education and health sectors. In FY 2020/21, education and health sector conditional grants respectively comprised 68.8 per cent and 15.8 per cent of the total conditional grants provisioned by the federal government to local levels.

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[11] Devkota, KL (2020), Intergovernmental Fiscal Transfers in a Federal Nepal, International Center for Public Policy Working Paper 20-17 November 2020.

- The volume of the equalisation and conditional grants allocated in 2019/20 is depicted in Table 3.4.1. For FY 2019/20, an average of NPR 284.0 million was provisioned per local level in the form of equalisation (NPR 119.5 million) and conditional grants (NPR 164.5 million). The values of conditional grants provisioned from federal to provincial and local levels for health were NPR 4,878.5 million and NPR 21,229.7 million, respectively: this comes to NPR 696.9 million per province and NPR 28.2 million per local level, on average.
- Similarly, the values of per province equalisation grants and conditional grants from the federal level for FY 2019/20 were NPR 7,899.8 million and NPR 6,363.7 million, respectively. A summary of equalisation and conditional grants for provinces and local levels is presented in Table 3.4.1.

Table 3.4.1: Summary of the financial equalisation and conditional grants provisioned by federal government, FY 2019/20 (million NPR)

Description	Financial equalisation	Conditional	Total grant	
			Total	Average (per government unit)
Provinces total	55,298.6	44,545.8	99,844.4	14,263.5
Metropolitan	3,131.2	4,620.2	7,751.4	1,291.9
Sub-metropolitan	3,484.1	4,511.1	7,995.2	726.8
Municipality	39,779.6	55,510.3	95,289.9	345.3
Rural municipality	43,552.1	59,232.5	102,784.6	223.4
Local-level total	89,947.0	123,874.1	213,821.1	284.0

Source: Compiled from MoF (Red Book) and AWPB for local level

- On top of the conditional and equalisation grants, NPR 20 billion was provisioned by the federal government under complementary and special grants for FY 2019/20 to be provided to provinces and local levels to address additional needs at provincial and local levels.
- As in previous years, MoHP developed implementation guidelines for provinces and local levels to facilitate the implementation of health programmes as provisioned through the conditional grants. Such implementation guidelines provide operational procedures for the execution of programme activities planned with conditional grants.
- The provision of grants and own-source revenue of the provinces and local levels has provided an opportunity for integrated planning at the sub-national level. A seven-step planning process defined for local levels bridges the top-down fiscal transfer and planning framework provided by federal and provincial levels with the bottom-up planning process adopted by local levels, starting from the local community.
- The establishment of HFs continued at the local level to ensure that Basic Health Service Centres (BHSCs) are set up at ward level in accordance with the National Health Policy. BHSCs were planned to be established in wards without HFs; budgetary provisions were made to the respective local levels in FY 2019/20.

- With the support of EDPs, MoHP has channelled technical support to provincial and local levels. MoHP continues to implement the LL approach in seven LG areas (one from each province) to closely monitor and document challenges and successes.
- Following the federal restructuring, organisational reform and staff adjustment were accomplished in FY 2019/20. The amount of conditional grant provisioned from federal to provincial and local levels for health was respectively NPR 4,878.5 million and NPR 21,229.7 million; this comes to NPR 696.9 million per province and NPR 28.2 million per local level, on average.
- A comparative scenario of federal grants (equalisation and conditional grants) to selected local levels (LL sites) for FY 2018/19 and FY 2019/20 is presented in Table 3.4.2; this shows that the flow of grants is not uniform across local levels. Pokhara Metropolitan City is exceptional among the sites selected in receiving reduced grant under both equalisation and conditional grants in FY 2019/20 compared to FY 2018/19. Among the selected sites, the highest percentage increase (45.9%) in the federal grant was observed for Kharpunath Rural Municipality; this figure is dominated by the substantial increase in the conditional grant component. This indicates that the basis for resource allocation is being adjusted to their needs and revenue-generating capacity, which are the two major components that define the equalisation and conditional grants to local levels.

Table 3.4.2: Overall pattern of the federal grant to selected local levels

Amount in million NPR

S.N	Municipality	Equalisation Grant			Conditional Grant			Total		
		2018/19	2019/20	Change in %	2018/19	2019/20	Change in %	2018/19	2019/20	% change
1	Itahari Sub-Metropolitan City	283.1	316.6	11.8	303.6	341.0	12.3	586.7	657.6	12.1
2	Dhangadhimai Municipality	136.7	141.9	3.8	129.1	155.4	20.4	265.8	297.3	11.9
3	Madhyapur Thimi Municipality	213.3	217.9	2.2	150.5	161.7	7.4	363.8	379.6	4.3
4	Pokhara Metropolitan City	614.4	600.2	(2.3)	1,204.2	1,172.7	(2.6)	1,818.6	1,772.9	(2.5)
5	Yasodhara Rural Municipality	120.8	123.2	2.0	101.4	136.2	34.3	222.2	259.4	16.7
6	Kharpunath Rural Municipality	60.0	68.1	13.5	110.8	181.1	63.4	170.8	249.2	45.9
7	Ajaymeru Rural Municipality	68.2	78.5	15.1	167.5	190.8	13.9	235.7	269.3	14.3

Source: Compiled and analysed based on data from *Inter-governmental Fiscal Transfer*, 2018 and 2019, MoF.

- The COVID-19 pandemic, along with the nationwide lockdown imposed as a response measure, affected programme implementation towards the last quarter of the FY. Moreover, considering the impact of COVID-19 on economic activity, and hence revenue collection, the MoF, towards the end of the third quarter of FY 2019/20, issued a notice to suspend the spending of budget under 14 line items. These included capacity strengthening and programme budget, which affected implementation of programme activities towards the end

of the FY. Based on the information from local levels connected to the Sub-national Treasury Regulatory Application (SuTRA), 29 per cent of their annual budget had been spent in the first eight months of the FY, which indicates high pressure for budget absorption towards the end of the FY[12].

- The vision paper for 2030 (15th Periodic Plan) was developed under the leadership of the NPC; MoHP contributed in preparing for the health and population sector.

Highlights of FY 2020/21

- Public Health Service Regulations were endorsed by the Cabinet of Ministers in September 2020. These regulations include the long-awaited BHSP, giving clarity on the core mandates of local levels in relation to the provision of health services. Towards ensuring the delivery of BHS, local levels have also introduced different initiatives based on local contexts. A case study on mobilising Pregnant Mother Groups and FCHVs towards achieving the Zero Home Delivery Initiative is presented in Annex 3.

- As per the national policy of establishing a hospital in every local level, MoHP has identified 264 local levels in which to initiate the construction of a municipal hospital with five, 10 or 15 beds. Accordingly, budget of 7 million, 8.5 million and 10 million NPR has been released from the MoF to the respective local levels to begin construction works as per the standards defined by the MoHP.

- In light of the COVID-19 pandemic, MoHP directed local levels without hospital facilities to establish temporary five-bed hospitals, with the particular aim of allowing local management of COVID-19 patients. For this purpose, local levels were also provided with 1 million NPR.

- Despite a reduction in the overall national budget in FY 2020/21, the health sector was prioritised in the budgetary allocation, given the COVID-19 context. Health sector conditional grants for local levels were also higher than in previous years.

- Planning and budgeting for FY 2020/21 was carried out amidst the COVID-19 pandemic and during lockdown measures, which affected the usual planning process, particularly wider stakeholder consultation. As per the Intergovernmental Fiscal Transfer Act, local levels should present the annual budget (estimates of revenue and expenditure) for the next FY by 10 Ashad (25 June). However, the Ministry of Federal Affairs and General Administration (MoFAGA) database indicates that a relatively large number of local levels were not able to present their budget on time. Figure 3.4.2 presents the budget approval status of local levels as of 23 July 23 2020 (8 Shrawan, 2077). Even after the start of the new FY, 29 per cent of local levels were reported not to have presented their annual budget, based on the reporting status of local levels. This information should, however, be taken only as an indication of the situation: some local levels that had presented their budget on time were categorised as not having presented their budget because related information was not reported to the MoFAGA on time.

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[12] Ministry of Finance (2020), Economic Survey of 2019/20.

Figure 3.4.2: Delays in the Presentation of the Annual Budget by Local Levels

स्थानीय तहको आर्थिक वर्ष ०७७/७८ बजेट अपडेट

बजेट पेश भएका स्थानीय तह: ५३३   बजेट पेश नभएका स्थानीय तह: २२०

प्रदेश	जम्मा स्थानीय तह	बजेट पेश भएका स्थानीय तह	बजेट पेश नभएका स्थानीय तह	बजेट पेश भएका स्थानीय तह%	बजेट पेश नभएका स्थानीय तह%	बिस्तृतमा
प्रदेश नं. १	१३७	१०३	३४	७५.२%	२४.८%	
प्रदेश नं. २	१३६	५८	७८	४२.६%	५७.४%	
बागमती प्रदेश	११९	९२	२७	७७.३%	२२.७%	
गण्डकी प्रदेश	८५	६५	२०	७६.५%	२३.५%	
प्रदेश नं. ५	१०९	९७	१२	८९%	११%	
कर्णाली प्रदेश	७९	६१	१८	७७.२%	२२.८%	
सुदूरपश्चिम प्रदेश	८८	५७	३१	६४.८%	३५.२%	
जम्मा	७५३	५३३	२२०	७०.७८%	२९.२२%	

* यस मन्त्रालयको पोर्टल मार्फत सम्बन्धित स्थानीय तहले प्रविष्टि गरेको विवरणको आधारमा तयार पारिएको ।

Showing 1 to 7 of 7 entries | Takes 0.19 seconds to render

Source: MOFAGA website, accessed on 23 July, 2020

- The National Health Training Centre (NHTC), with support from NHSSP and based on implementation experience from selected local levels, has developed a framework for the assessment and strengthening of organisational capacity of the health sector, particularly at the local level. This could be used as a reference to strengthen organisational capacity to deliver high-quality BHS.
- Local levels played an active role in prevention and control measures in response to COVID-19 in accordance with the framework and guidance provided by the federal level. The role of local levels included: awareness raising, management of entry points, quarantine management, sample collection and facilitation for lab tests as per the national protocol; isolation management of confirmed cases; and case investigation and contract tracing. Based on the LL sites, it was also found that local levels prioritised the management of COVID-19 response activities as reflected in the budget allocated from internal resources on top of the budget provisioned from the federal level.

Challenges
- Along with the endorsement of the Public Health Service Regulations, the BHSP has been approved. The challenge is therefore to complete the establishment of HFs in each ward and hospitals in each local level and to ensure the availability of high-quality BHS across the country.
- Local levels have been using SuTRA[13] as a platform for the planning, budgeting and accounting of expenditure. However, challenges remain to effectively connect all local

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[13] SuTRA is a planning, budgeting and accounting software developed under the leadership of Public Expenditure and Financial Accountability (PEFA) Secretariat, based on a decision by the MoF. It is a web-based system developed for

levels through SuTRA to enable the routine monitoring of implementation progress and also of the health sector.

- Some local levels have initiated organisational and management surveys to reform their organisational structure along with the positions of human resources as per the local needs. In relation to this, the federal government may need to set standards and benchmarks to harmonise staffing patterns and address the differential needs across local levels.
- The challenge lies in ensuring horizontal and vertical harmonisation in the planning and implementation of health sector programmes across three levels of government. The COVID-19 pandemic added further challenges to the planning process in FY 2020/21 as well as enduring challenges for implementation.

Way Forward

- Ensure the timely implementation of planned activities and utilisation of allocated budget, particularly given the current context of COVID-19 and limitations in organisational capacity at the local level.
- Accelerate the process for establishing HFs at local levels and prioritise their smooth functionality to deliver the BHSP. Use of the MSS-based assessment can serve as the benchmark to strengthen existing HFs across local levels, which could contribute towards enhancing the quality of health services
- Create a platform to enable interaction across three levels to ensure harmonised and coordinated planning and address any issues as they emerge. SuTRA could be used as an effective tool to link sectoral ministries with provinces and local levels in relation to planning, budgeting and expenditure tracking from the federal level.
- Continue to develop case studies, document success stories and promote a cross and peer learning approach to strengthening delivery of health services at the local level.
- Develop a framework for the enhancement of organisational capacity in crucial areas of the health system to effectively manage and operationalise health sector functions at the respective levels. A framework for the assessment and strengthening of institutional capacity at local levels drafted by the NHTC could be considered for this purpose.

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facilitating and implementing a structured financial management procedure for SNG. SUTRA has two broader separate applications for provinces and local levels. The local-level application is available for all LGs and the provincial application is available for PGs. This system will provide financial information at the sub-national level to the National Natural Resource and Fiscal Commission, MoF and Financial Comptroller General Office for their purposes. Website: https://sutra.fcgo.gov.np/

3.5 Outcome 5: Improved Sector Management and Governance

Background

The NHSS states that the restructuring process of the health sector will be aligned with the broader state restructuring agenda with regards to 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 multisectoral coordination mechanisms
- Improved PFM.

Major Progress in FY 2019/20 and 2020/21

Alongside the implementation of new political and governance structures, the health sector has almost completed the transition to full federalisation. However, orienting the new structures to the spirit of federalism continues. Managing transition with ministerial stewardship and adequate and timely technical and managerial guidance to SNGs remains vital to the MoHP. The Public Health Service (PHS) Act, 2018 and the Safe Motherhood and Reproductive Health Rights (SMRHR) Act, 2018 set historic landmarks towards securing health as a fundamental right of the citizen as provisioned in the Constitution. In order to materialise these constitutional and legal provisions, the long-awaited BHSP was endorsed in FY 2020/21 together with the PHS and SMRHR Regulations.

As per the spirit of the Constitution, GoN has also formulated and issued a new NHP, 2076 (2019). With the gradual deployment of officials in line with the new federal structure, the MoHP has provided timely guidance on the AWPB process; rationalised the health budget under the conditional grant; progressively institutionalised sector coordination functions; initiated the policy dialogue platform, including the knowledge café; and formed and/or revitalised TWGs in a number of areas. Structurally, SNGs require competencies and skills in a range of areas to deliver their responsibilities in the health sector, which is being addressed by the MoHP and needs to be prioritised as a long-term investment.

In order to address the prolonged challenge of shortages in HRH, the MoHP developed a procedure to hire staff on a contract basis. Since the last quarter of FY 2019/20, the country has been facing the unprecedented challenge of COVID-19: the full attention of the health sector has been limited in managing the COVID-19 pandemic. In this context, the country has developed its capacity in real-time Polymerase Chain Reaction (PCR) testing from zero to 25,000 tests per day. About 45 guidelines related to COVID-19 have also been developed and are being implemented. However, the challenge still remains as infection is reported in a large number of districts and the death toll continues to rise.

Policies, Acts, Guidelines and Structure

- NHP, 2019 has been endorsed by the GoN.
- The overall structure of the MoHP has been reorganised as per the federal structure under federalism. As per the new provision, there are three departments, seven centres, 22 hospitals, including academies, eight councils, the health insurance board and hospital development committees.
- To address the changed needs of the sector, the process of establishing CDC Nepal, Food and Drug Administration (FDA), and the Health Accreditation Authority has already begun. These reforms were proposed in the policy and programme for 2020/21.
- The PHS Regulations, 2020 and the Safe Motherhood and Reproductive Health Rights Regulations have been enacted.
- The Health Insurance Regulation has been approved and has been in implementation since 2019.
- The PHS Regulations define BHS along with other regulatory provisions for management of health services across different levels.
- The National Medical Education Regulation 2077 (2020) has been approved.
- Guidelines on Public-private Partnership in the Health Sector, 2076 (2020) have been developed and endorsed by the GoN.
- A number of formation orders *'Gathan Adesh'* have been approved, particularly in relation to COVID-19 response management.
- Considering COVID-19 challenges and needs, the budget and programme to establish a temporary five-bed hospital has been sent to 649 local levels (where there is no hospital).
- In addition to this, as per the GoN's policy of 'one municipality-one hospital', budget has been sent to 396 local levels to establish five-, 10- and 15-bed basic health care hospitals. Foundation stones for more than 300 of these hospitals were laid on a single day (November 30 2020).
- Five district hospitals (Manang, Mustang, Humla, Dolpa and Rukum East) have been upgraded to 25-bed hospitals; all remaining district hospitals have been upgraded to 50-bed hospitals. Provincial hospitals are being upgraded to 200 beds and hospitals under the federal government are being upgraded to 500 beds. The upgradation and establishment of new hospitals are expected to add more than 5,000 and 7,000 beds, respectively; in total, more than 12,000 beds will be added to the system.
- Establishment of a 300-bed communicable diseases control hospital at federal level, and similar 50-bed hospitals in each province has been initiated.
- The work for establishing 10 trauma centres continues: NPR 5 million has been dispatched to each hospital. Free emergency services are being provided from 14 public sector hospitals and a procedure has been developed and endorsed in this regard.
- An integrated ambulance service has been initiated and is in operation.
- A number of health-related Acts have been amended through the '*Kehi Nepal Ain samsodhan garne sambandhi Ain'* (an Act to amend certain Nepalese Acts).
- The following guidelines have been prepared and endorsed:
  - A guideline for treatment of health care workers working in the risk zone of communicable diseases

- o A procedural document to link the treatment cost of chronic diseases with health insurance
  - o Trauma service operation procedure
  - o A guideline for integrated ambulances with pre-hospital services
  - o A guideline for operation of extended hospital service programmes
  - o A procedural document on telemedicine, which is in the process of endorsement.
- The revised GESI Strategy has been resubmitted for approval.
- The Gender-responsive Budget Guidelines for the Health Sector have been developed and approved.
- Guidelines on Leaving No One Behind Budget Markers have been developed and submitted for approval.
- The Strategy on Prevention of Sex-selective Abortion has been developed and sent to the Cabinet of Ministers for approval.
- Under the leadership of the Office of the Prime Minister and Council of Ministers (OPMCM) a five-year National Strategy and Action Plan for GBV and Gender Empowerment has been prepared.
- Health Sector Social Accountability Federal Directives, including Model Social Auditing Operational Guidelines for the Local Level, have been developed and approved under the leadership of the Curative Services Division (CSD). The Interim Guidelines for OCMCs, SSUs, Geriatric Services, Services for People with Disability and GBV Prevention and Response in Quarantine During Lockdown and the COVID-19 Pandemic were developed and approved.

Disbursement-linked Indicator (DLI) Achievements
- The target "65 per cent of audited spending units responding to OAG's [Office of the Auditor General's] primary audit queries within 35 days" was met, with 97 per cent achievement.
- The target "90 per cent of MoHP's annual spending captured by TABUCS" was met, with 90 per cent achievement.

PFM
- The Internal Control Guidelines have been drafted as the New Financial Procedures and Fiscal Accountability Act, 2076 (2019) and Financial Comptroller General Office (FCGO) directives. They will be finalised in 2021.
- The Financial Management Improvement Plan (FMIP) has been updated as the Nepal Health Sector Financial Management Strategic Framework, to guide financial management procedures. This document was endorsed by the GoN (Hon. Minister level) on19 July 2020; it has been printed and disseminated and its implementation continues across federal-level entities.
- Procurement Strategic Framework: The PIP has been updated as the Nepal Health Sector Public Procurement Strategic Framework (NHSPPSF), which is yet to be approved.

- Changes in OAG's forms and formats: GoN changed the financial recording and reporting forms and formats in FY 2018/19; MoHP updated these forms and formats in TABUCS in FY 2019/20.
- Chart of Activities: The revised chart of activities has been prepared and included in TABUCS, which will help to consolidate all health sector activities in the system.
- Linkage between TABUCS and LMBIS: All approved activities of the Line Ministry Budgetary Information System (LMBIS) can be uploaded in TABUCS, which forms the basis of budget execution.
- Financial Management Reports: All FMRs (three trimesters) were submitted to EDPs on time as per the revised FMR templates. The draft of the third and final FMR for FY 2019/20 has been prepared and was submitted to EDPs on 28 August 2020; it is currently in the process of being reviewed by EDPs.
- Audited financial statements: The audited financial statements of FY 2018/19 have been submitted to the OAG; the audit report was certified by the OAG on 10 June 2020. The certified report was forwarded to EDPs on 16 June 2020.
- Internal audit and final audit: MoHP has improved internal control through internal and final audit clearance, as evidenced in the Audit Status Report of August 2020, disseminated to EDPs. Internal audit and final audit data are recorded on TABUCS.
- Capacity enhancement: Financial management workshops were held in two groups in February and March 2020 at Dhulikhel and Saurahawa (Chitawan) to enhance the capacity of programme managers and finance officers in financial management. Forty people were trained on PFM and 18 account staff from MoHP participated in TABUCS training.
- The 'Mero Swasthya Mero Jimmewari' App was developed to promote health by making every individual more sensitive to and responsible for their own health.

Other activities
- With the view of gaining an in-depth understanding of health service delivery at the local level (i.e. leadership, governance and accountability, service quality, planning and budgeting, monitoring of health interventions and reaching the unreached) the MoHP continues to implement the 'learning lab' approach in seven rural/urban municipalities, one in each province, with technical support from UKaid/NHSSP.
- For measuring and improving data quality, the online RDQA tool has been developed and is in the process of implementation at various levels to monitor the quality of data produced by HFs.
- A Health Facility Registry that captures brief information on each HF across the country, both public and private (including the non-government sector) has been prepared and uploaded onto the MoHP website. The registry features an interface that allows various information systems to connect to it and keep their individual lists of HFs up to date and synchronised with that of MoHP. The list of facilities in the registry can be viewed at http://nhfr.mohp.gov.np.
- The MSS are being implemented: an orientation about MSS implementation has been provided to all provinces, and monitoring of implementation of MSS in federal-level hospitals is progressing.

- The report of the Nepal National Micronutrient Status Survey has been finalised and published.
- The External Joint Monitoring Review Mission of the National Tuberculosis Programme (NTP) has submitted its mission report. Moreover, the National TB Prevalence Survey has been completed.
- Guidelines for TB Treatment and Referral Management and the Guidelines of DRTB Community-based DOT Programme have been drafted and endorsed.
- The number of OCMCs in the country has increased to 77, distributed across 74 districts. The Guidelines for HFOMCs have been endorsed and are being implemented.
- Two Joint Consultative Meetings (JCMs) were held as planned. Similarly, the NJAR (of FY 2018/19) was held in December 2019.

Challenges
- Ensuring the delivery of BHS as per the recently endorsed package of services across all local levels with limited LG capacity for managing devolved health functions.
- Ensuring a good balance between strengthening hospitals/facility-based curative services and sustaining public health interventions at local levels remains a challenge. However, lessons can be drawn from the COVID-19 pandemic and the strategies adopted for response management. For FY 2020/21, the health sector was prioritised across each of the three levels, as reflected in policy, programmes and budgetary allocations.
- There is yet to be clarity on the effective engagement of EDPs and other stakeholders, such as the private sector, NGOs/Community-based Organisations (CBOs) and cooperatives, for provincial and local levels.
- 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.
- Insufficient training programmes and budget to implement TABUCS at province level: there are still no activities provisioned for the Annual Maintenance Cost (AMC) of supporting TABUCS.
- Maintain gains made in GESI in the health sector at federal, provincial and local levels.

Way Forward
- Provide technical and managerial support to government leadership and respective health departments/units at province and local level for uninterrupted health service delivery.
- Support LGs to ensure the effective implementation of BHS as per the PHS Regulations.
- Expand the number of MoHP local learning sites (a UKaid supported programme)
- Work with Natural Resources and Fiscal Commission, MoF, and respective ministries to ensure financial accountability and reporting of health expenditure.
- Build the capacity of the federal staff to implement TABUCS in respective entities.
- Finalise and implement the Internal Control Guidelines in light of "Internal Control System Directives, 2019" (FCGO) and new Financial Procedural and Accountability Act, 2019.

- Proper implementation of the Public Financial Management Strategic Framework (PFMSF) for the overall improvement of financial management.
- Continue to prioritise clearing audit queries and hence reduce irregularities.
- Enhance capacity of programme managers and finance officers in financial management.
- Enhance patient safety and quality assurance of services by developing the required strategy or road map.
- Develop contract management system and Store Management System (SMS) as additional models in TABUCS.
- Promote the use of disaggregated data (from GESI and social inclusion perspective) and evidence during planning, programming and monitoring at provincial and local levels.
- Integration of GESI concerns into all policies, strategies and action plans to be formulated and revised.
- Implement GESI strategy, including development and operationalisation of IP.
- Implement of Gender-responsive Budget Guidelines at federal, provincial and local levels.
- Develop and implement GESI Strategy at provincial and local levels.
- Expand OCMC services in districts where they are not currently available.

3.6 Outcome 6: Improved Sustainability of Healthcare Financing

Background

Nepal's commitment towards UHC is well reflected in the health policy of 2019 which ensures the provision of free BHS as a fundamental right of every citizen. The policy envisions providing access to high-quality health services (beyond BHS) in an affordable manner by ensuring financial protection in health. The GoN 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.

For improved sustainability in healthcare financing, the NHSS focuses on increasing investment in the health sector and social health protection mechanisms as reflected in the two outputs listed below:
- Strengthened health financing system
- Strengthened social health protection mechanisms.

Major interventions proposed under this outcome 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 (NHA) and the harmonisation of existing social health protection schemes; and the implementation of health insurance.

Major Progress

- Government health expenditure as a percentage of the Gross Domestic Product (GDP) for FY 2019/20 is two per cent: this constitutes a 0.6 percentage-point increase compared to the NHSS baseline year (1.4% for FY 2014/15). Figure 3.6.1 provides an indication of the trend of government health spending as a percentage of GDP. Over the years, government spending on health as a share of GDP has been increasing, albeit marginally. In Figure 3.6.1, government spending on health includes budget allocated to the MoHP and other line ministries and health budget from provincial and local government.

Figure 3.6.1 Trend on Government Health Spending as a Percentage of GDP (NPR Billion)
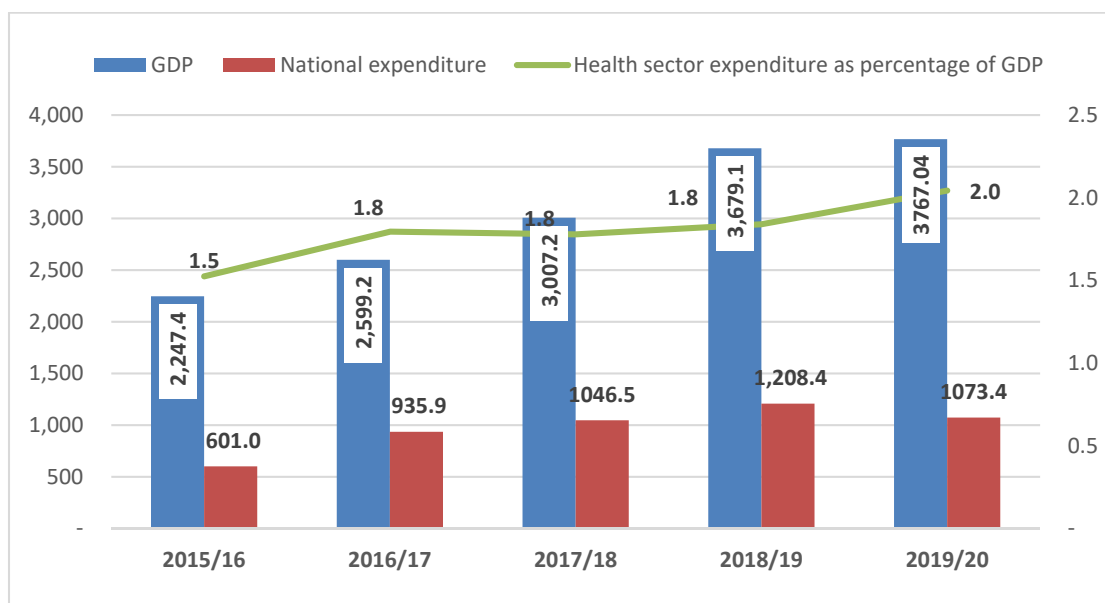
Source: Budget Analysis (BA) FY 2020/21

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

- Figure 3.6.2 below shows trends in per capita government spending on health. Between FY 2015/16 and FY 2019/20, per capita government spending has gradually increased from NPR 1,198 (USD 11.3) to NPR 2,601 (USD 20.2) in real terms. However, during the same period, government spending on health increased very little, from NPR 419 (USD 4) to NPR 704 (USD 6), 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 3.6.2 Per Capita Government Health Spending (NPR)

- Figure 3.6.3 shows trends in the health sector budget as a percentage of the national budget. The percentage of the health budget against the total government budget is in increasing trend. Compared to FY 2019/20, there is 3.1 percentage-point increase in the health sector budget for FY 2020/21. The NHSS sets the target of allocating almost nine per cent of the national budget to the health sector. This implies that health sector allocation is close to the NHSS target. In FY 2020/21, NPR. 25.4 billion has been allocated to LGs and NPR 4.6bn to PGs in the form of conditional grant for health; NPR 60.7bn remains with MoHP and rest is allocated to other line ministries. Evidence suggests that PGs and LGs have made additional allocations in health from different revenue sources. Thus, the actual health budget as a percentage of national budget is anticipated to rise

Figure 3.6.3 Health Budget as a Percentage of the National Budget
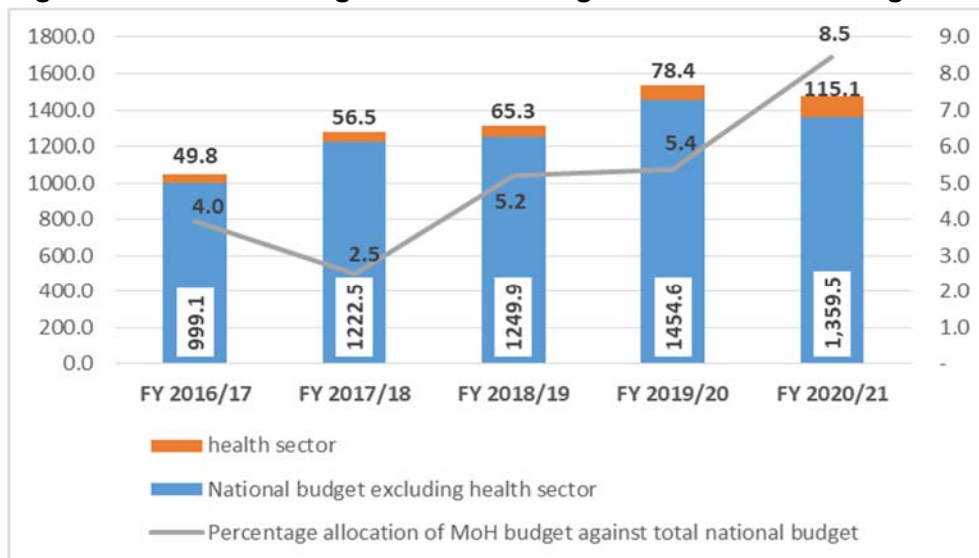
- The GoN has rolled out several social protection schemes to reduce OOPE in health. The GoN has expanded coverage of the Health Insurance Programme in 60 districts. So far, about 3.3 million people have enrolled in the health insurance scheme, which was being implemented in 471 local levels in FY 2018/19. The Social Health Insurance Regulations were enacted in accordance to the Health Insurance Act.

- The latest NHA reports OOPE as proportion of Current Health Expenditure (CHE) to be 55.4 per cent, 59.4 per cent, 60.1 per cent, and 63.5 per cent for FY 2015/16, FY 2014/15, FY 2013/14 and FY 2012/13 respectively. This implies that OOPE as a percentage of CHE has been gradually decreasing over the years. Between FY 2012/13 and FY 2015/16, OOPE as a percent of CHE decreased by eight percentage points. Major policy concern must be directed towards strengthening social health protection mechanisms in the country in order to achieve the NHSS target of 40 per cent by 2020.

Challenges

- Slow rise in government health spending in relation to GoN's commitment to LNOB and achieve UHC.
- OOPE retaining a dominant share of health care financing.
- Capturing health spending at all level of government, including resources for health beyond the conditional grant.
- Institutionalisation of the NHA to routinely monitor health expenditure, including at sub-national level.
- 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 inclusion of the poor and other targeted groups in health insurance through government subsidy.

Way Forward

- Revise the existing Health Sector Strategy with indicators for gauging progress in various tiers of government as well as for comparison with global indicators.
- Consult and advocate with the Natural Resources and Fiscal Commission and the MoF to increase government investment in the health sector to progress towards Universal Health Coverage and the agenda of LNOB.
- Assess the root causes of low budget absorption in the health sector, including the capital budget, and take action accordingly.
- Support PGs and LGs for increased investment and absorption of the allocated budget in the health sector.
- Establish a mechanism to track and consolidate budget allocation and spending for health at each level of government
- Design and develop a Health Financing Strategy that can streamline financing sources and their management in the health sector, covering all levels of government.

- Enrol the poor in health insurance through government subsidy as envisioned in the recently promulgated Health Insurance Act (2017) and its Regulations.

3.7 Outcome 7: Improved Healthy Lifestyles and Environment

Background

GoN intends to create a healthy environment and inspire healthy lifestyles, which are central to the improvement of overall health status. For this purpose, NHSS suggests innovative approaches to behavioural change for specific behaviours like smoking, alcohol consumption, health-seeking behaviour and obesity. The single output for this outcome is the promotion of healthy behaviours and practices.

Major Progress

- The Mental Health Section is established and functional at the EDCD as per the new organogram of the MoHP.
- The National Mental Health Strategy and Action Plan have been developed, and is in the process of approval.
- Training modules have been developed, based on the STP for Prescribers, and central-level ToT has been conducted, scaling up in 25 districts across the seven provinces. Training modules for child and adolescent mental health have been initiated.
- Trainings were conducted for PEN in collaboration with NHTC and provinces.
- MoHP secured funding from the Global Environment Facility to implement a project titled 'Building Resilience of Health Systems in Asian Least Developed Countries to Climate Change' with support from WHO.
- *Nagarik Aarogya* (Health Citizen) *Programme* conducted throughout the country (in all provinces and local levels), promoting active lifestyle through yoga and meditation sessions and a healthy diet.
- Initiated School Yoga and Ayurveda Health Programme in various local levels.
- Established open gym centres in three selected areas.
- Developed and implemented Ayurveda and Alternative Medicine Guidelines of Preventive Measures and Management Protocol for COVID-19 in Nepal.
- Consultation with School Health Nurses (SHNs) conducted towards developing resource materials on RH.
- A training module is being developed to enhance the skills of SHNs in addressing issues of adolescents and RH.
- Development of training package for Occupational Health Safety continues.
- OCMC Operational Guidelines and SSU Operational Guidelines have been implemented as per the revision in FY 2018/19.
- The number of functional OCMCs in the country has been increased from 54 at the end of FY 2018/19 to 77, located in 74 districts.
- SSUs have been established in 44 hospitals and geriatric care services have begun in 24 hospitals.
- An in-depth review of the scale-up, functionality and utilisation of OCMCs, including barriers to access, has been conducted: findings will help develop a road map for strengthening OCMCs. A case study was conducted on 'Access to OCMC Multisectoral Services during COVID-19 Lockdown', which is enclosed in Annex 1.

- In the period immediately following the onset of COVID-19 and the subsequent lockdowns, it was anticipated that there would be an increased risk of GBV and family violence. OCMCs across the country were advised to remain on high alert to respond to the situation in coordination with partners, especially the police and safe homes.
- Medico-legal Service Guidelines were approved by the Cabinet of Ministers.
- The GBV Clinical Protocol was revised and approved. GBV and Basic Psychosocial Counselling Training was provided to 95 OCMC staff from 68 OCMC hospitals.
- A much-awaited Senior Citizen Survey, commissioned in 2014, has finally come out.
- The GBV Referral Directory was developed and approved for OCMCs and GBV survivors.
- Various messages on prevention of COVID-19 were broadcast, telecast and promoted on social media, including communications for differently abled people.
- Different sets of IEC materials were produced and distributed to all provinces and local levels.
- Printed materials in Braille were produced for orientation and counselling on COVID-19.
- Different infographics developed by WHO were translated into Nepali and disseminated through various digital platforms.
- Posters and radio messages were developed and broadcast, focusing on RH, safe motherhood, FP, immunisation, etc. in relation to COVID-19.
- Multi-sectoral Action Plan for NCD (2021-2025) under development process

Challenges

- In light of COVID-19, access to services might have been limited.
- Monitoring of air quality, food quality and hygiene and water quality remains poor.
- Preparedness to combat the repercussions of climate change remains weak.
- Inadequate funding allocation for Health Promotion and Education.
- Limited demand-generating activities, focusing on hard-to-reach areas.

Way Forward
- Address mental health needs and the needs of those with NCDs in the context of COVID-19.
- Address issues faced by older people in the context of COVID-19.
- Promote traditional medicines for cost-effective management of health problems and to maintain good health.
- Expand public places to promote an active lifestyle and fitness centres for physical activity within the community setting.
- Strengthen the capacity of SHNs to promote healthy lifestyles and a healthy environment within schools.
- Strengthen integrated surveillance of communicable diseases and NCDs.
- Implement surveillance of road traffic accidents in coordination with concerned stakeholders.

- Strengthen and scale up OCMCs and SSUs in additional sites. Further, develop an online recording and reporting system for OCMCs, SSUs and geriatric services.
- Conduct ToT on GBV Clinical Protocol and roll it out in OCMC-based hospitals
- Conduct psychosocial counselling training to staff nurses in OCMC-based hospitals.
- Conduct GBV medico-legal training in all provinces, covering 77 districts.
- Implement National Disability-inclusive Health Service Guidelines.

3.8 Outcome 8: Strengthened Management of Public Health Emergencies

Background

The NHSS provides a road map for improved preparedness and strengthened response to public health emergencies during humanitarian and public health crises. It prioritises revising protocols and guidelines for improved management of health sector emergencies at both central and decentralised levels and recommends the enhancement of institutional and human capacity for effective and timely response. The outputs of this outcome are:

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

COVID-19, which was first reported from Wuhan, China, in December 2019, has affected all the countries of the world, including Nepal. The first case of COVID-19 in Nepal was reported on 23 January 2020. Until the end of February, there were no reports of further infection. However, in the second week of March, the number of infections started to rise. MoHP and its various organisational units has been working on managing the response to COVID-19 alongside other sectoral ministries and central-level entities. The role of provinces and local levels has been instrumental in response management, while public and private health institutions and associated health workers and other front-line workers have been working untiringly towards the prevention, treatment, management and control of COVID-19.

Nepal is prone to natural calamities, including recurrence of floods and landslides almost every year. This invites challenges to the health sector. Outbreaks of various diseases are also reported from time to time. In 2015, Nepal experienced a humanitarian crisis due to the devastating earthquake and its subsequent tremors. The health sector response to the earthquake was well recognised and applauded at national and international level. However, the post-earthquake response nevertheless stretched the capacity of the health sector to its limit and also exposed certain limitations in health systems and capacity, especially regarding emergency preparedness and disaster response.

Major progress in FY 2019/20

- To address potential outbreaks and epidemics, as well as disasters, Health Emergency Operation Centres (HEOCs) have been established and are operational in all seven provinces.
- Timely actions were taken to address disease outbreaks reported in FY 2019/20, which include:
  - Diarrhoea outbreak in Parshuram Municipality of Dadeldhura District reported in August 2019. One case was diagnosed as cholera. Outbreak adequately managed.
  - Outbreak of influenza was reported from Jugal Municipality of Sindhupalchok District in January 2020.
  - Measles outbreaks were reported during the lockdown period. However, the outbreaks were managed adequately.

- o Kala-azar has been reported from mountainous districts (such as Dolpa, Humla and Mugu) of Karnali Province.
- Dengue is also posing a challange to health system over the years.
- Certain hospitals have been designated as COVID-19 hospitals to address the need for providing health services to people infected with COVID-19.
- A total of 73 laboratories, both public and private, have been established across the country to identify COVID-19 cases.
- Supplies, including equipment for ICUs, such as ventilators, were provided.
- Effective support was provided in response to the outbreak of dengue.
- An additional four hub hospitals (two in Province 5 and two in Sudurpashchim Province) were established, which included setting up medical logistics warehouses and finalising contingency plans.
- Emergency Medical Deployment Teams were formed in the existing six designated hub hospitals in the Kathmandu valley.
- A kala-azar tracking system at treatment sites is planned for the current FY and has started in Province 1.
- The EWARS system is now operational in all 77 districts and is based on the DHIS2 platform.
- As a part of the Post-disaster Health Services Recovery Programme, the construction of the Trishuli (Nuwakot) District Hospital has been completed, with KOICA support. The hospital is currently being used as a COVID-19 treatment hospital.

Challenges
- Diverse challenges posed by COVID-19, particularly in ensuring smooth delivery of essential health services.
- Lack of clarity in the roles and responsibilities of different authorities for the management of public health emergencies.
- Funding gap and limited institutional capacity to address emergency status.
- Inadequate supply of essential medicines and prepositioning of supplies at strategic locations.
- Regular reviews of 'hospital emergency response and contingency plans' could not take place.
- Gaps in coordination and communication with and between public and private hospitals.

Way Forward
- Continue the mitigation effort for COVID-19, especially Contact Investigation and Contact Tracing (CICT).
- Continue managing quarantine and isolation centres more effectively, based on lessons from the past.
- Plan for introducing vaccines against COVID-19 when these are available in the market.
- Continue to develop the capacity and deployment procedures of Rapid Response Teams at local levels and in hub hospitals in order to ensure an effective first response.

- Strengthen EDCD information management and its role in coordinating support between relevant line ministries and other stakeholders at all levels of government.
- 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

The NHSS focuses on better access to and use of information with ICT. It also emphasises improved and interoperable routine information systems and prioritises surveys and research. Similarly, it strives for upgraded and integrated health sector reviews at various levels that feed into the planning process. Towards achieving UHC and LNOB, the NHSS and SDGs place an emphasis on 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 practised
- Survey, research and studies conducted in priority areas
- Improved health sector reviews with functional linkage to planning process.

Major Progress

Integrated Health Information Management

In alignment with the NHSS and the spirit of the 15th Periodic Plan, the Integrated Health Information Management Section (IHIMS) under the MD has initiated integration of Routine Health Information Systems (RHISs), such as HMIS, LMIS and HIIS. The section has prepared a National IHIMS Road Map (2020–2030) for the integration of different RHISs. The proposed e-Health architecture framework and the road map will further strengthen planning, coordination and implementation of the proposed architecture blueprint among all stakeholders, particularly government and implementing partners at all levels.

The IHIMS Section has completed an assessment of the RHISs, which has identified their strengths and the areas to improve for their better functionality and integration.

e-LMIS has now been configured to cater for the needs of COVID-19 logistics data management and reporting. e-LMIS roll-out has been scaled up from 58 e-LMIS sites to 446 new e-LMIS sites during the period from September to November 2020.

Table 3.9.1: The status of e-LMIS roll-out, 2018–2020

Year	e-LMIS Sites	
2018	58 sites	• 2 PHLMCs in Lumbini and Karnali Provinces, 22 Health Offices, 4 LLGs, 23 SDPs
2019	e-LMIS reporting modules implemented at 77 Health Offices	• LMIS reporting aggregation moved to HOs instead of central level • New features added on e-LMIS to improve easy and flexible usage of the system for users, along with Ma Le Pa • Room roll-out approach tested in LLGs of Banke and Bardiya for cost-effectiveness, timeliness and ease of management

Year	e-LMIS Sites	
2020	173 e-LMIS sites configured to support COVID-19 commodity inventory management	• PHLMCs, HOs, COVID-19 hospitals, laboratories and Medical Colleges
	446 new e-LMIS sites September– 24 November, 2020	• GoN moved e-LMIS implementation responsibility to IHMIS • Strong engagement with PGs, HOs and LLGs • All LLGs of Gandaki, Sudurpashchim, Bagmati and Lumbini Provinces covered; Province 2 ongoing • All LLGs (753 in all provinces) expected to be completed

The e-LMIS was implemented in two central stores, three PMSs, 33 hospitals and one national laboratory in less than one month.

Table 3.9.2: e-LMIS roll-out, 2020

e-LMIS roll-out in 2020		
Provinces	**# of Districts**	**# of LLG**
Sudurpashchim	9	88
Gandaki	11	85
Bagmati	12	107
Lumbini	10	93
Total	**42**	**373**

IHMIS is coordinating e-LMIS roll-out activities. In year 2020, e-LMIS has been rolled out in 373 LGs from 42 districts. The e-LMIS has also been expanded in 55 Health Offices, 60 hospitals, 12 medical colleges and seven provincial public health laboratories.

Continuous follow-up and coordination with PHLMCs resulted in a LMIS reporting rate of 95 per cent, the highest reporting rate ever, by the end of FY 2076/77. LMIS reports from more than 4,000 SDPs are recorded on quarterly basis. All COVID-19 commodities are recorded in e-LMIS. All central data for COVID-19 lab commodities from NPHL and regional labs are in e-LMIS. Roll-out of e-LMIS is expected to be completed in all provinces by December 2020. Likewise, the recording and reporting tools of OCMCs and SSUs are being digitised in the DHIS2 platform and linked with the HMIS.

The Health Facility Registry, a tool that keeps track of all HFs within the country, public and private, and also provides information on which services are offered, has been updated. The registry has an interface that allows other information systems to connect to it in order to keep their individual lists of HFs up to date and synchronised with the MoHP. The registry can be accessed from the MoHP website.

The MoHP continues to expand the electronic reporting of service data from HFs. In FY 2020/21, 1,400 public HFs submitted HMIS monthly reports electronically. As HPs and PHCCs are now being managed by LGs, the MoHP is focusing on enhancing their capacities on health information management, including the use of the DHIS2 platform. All 753 LGs reported HF-based service statistics electronically to the national database (HMIS). This has been a milestone for the continuous flow of data from LGs to the national HMIS system. The HMIS e-learning modules for the orientation of health workers, statisticians, computer operators and programme managers have been updated and are available on the DoHS website (www.dohs.gov.np).

The web-based RDQA tool and the e-learning package have been updated, incorporating feedback from users; they are available on the MoHP website (www.rdqa.mohp.gov.np).Twenty-six HFs were reported to have completed the RDQA this year.

The web-based digital dashboards hosted at the MoHP website that help monitor major health indicators, including the NHSS RF and health-related SDG indicators, have been updated.

MoHP has established an Information Management Unit (IMU) to establish, strengthen and operationalise an integrated information management system for better informed decisions and monitoring of the health sector response to the COVID-19 pandemic. The unit coordinates and manages information related to different domains, such as: logistics, human resources, case investigation, contact tracing, laboratory, hospitals, quarantine, isolation centres, health desks at points of entry, communication and continuation of regular services. The unit consists of a skill-mixed team of statisticians, demographers, epidemiologists, health workers, ICT experts and public health professionals. This unit assists the Incident Command System (ICS) operations and other entities of the MoHP by providing analysed information on a regular basis. The IMU will also be expanded to sub-national level and will continue after the COVID-19 pandemic for effective and integrated health information management in any future disaster or emergency. The unit has established a daily report of the case management status from COVID-19-designated hospitals. This system has been very effective in monitoring and managing the case load and reimbursing COVID-19 case management costs to the hospitals.

MPDSR
The plan to expand the facility-based MPDSR system from 77 hospitals in FY 2018/19 to an additional 16 hospitals in FY 2019/20, and to expand the community-based MDSR system from 11 districts to an additional seven (Taplejung, Rautahat, Nuwakot, Myagdi, Palpa, Dailekh and Bajhang) in FY 2019/20, could not take place because of the COVID-19 pandemic. As the routine MPDSR system has been affected by COVID-19, the FWD has developed a system in ODK for monitoring of maternal and neonatal deaths occurring at HFs during the COVID-19 pandemic.

EWARS
EWARS is a hospital-based sentinel surveillance system where the sentinel sites (hospitals) send weekly reports (including zero reports) on six epidemic-prone, vector-borne, water- and food-borne diseases in order to detect outbreaks. EWARS started in 1997 with eight sentinel sites and expanded to 24 sites in 1998, 26 sites in 2002, 28 sites in 2003, 40 sites in 2008, 82 sites in 2016 and 118 sites in 2020. EWARS sentinel sites are now reporting in the DHIS2 platform, which has

contributed to building better linkages with the HMIS. The weekly reporting EWARS has now been upgraded to report SARI cases on a daily basis; this facilitates monitoring of SARI cases so that they can be tested with RT-PCR for COVID-19 as per the National Testing Guidelines. There has been a sharp decline in the number of SARI cases reported in 2020 compared to those reported in 2019 and 2018. Figure 3.9.1 shows that from the 17th epidemiological week of the year 2020, a smaller number of SARI cases have been reported compared to the same epidemiological weeks of the years 2019 and 2018.

Figure 3.9.1: SARI Cases Reported, by Epidemiological Week (2018–2020)
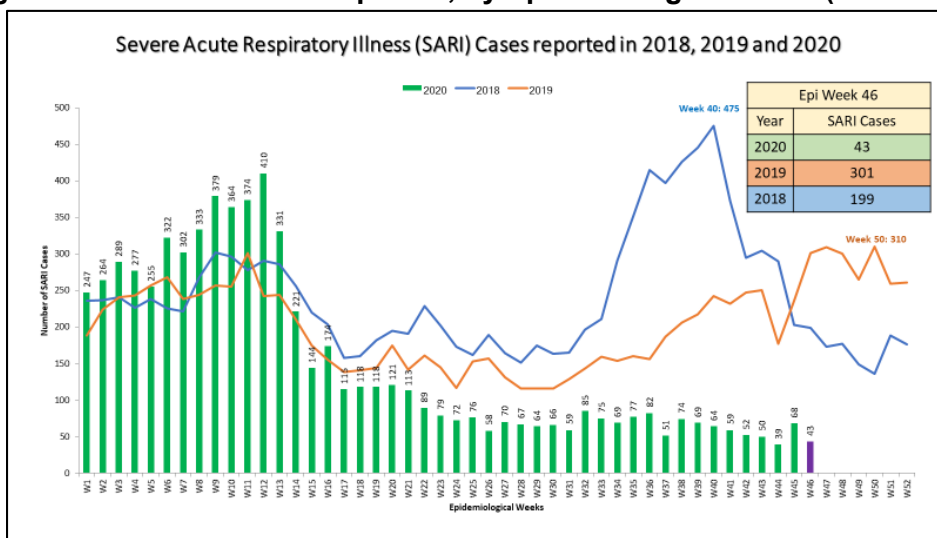
A total of 12,553 SARI cases were reported in 2018 and 10,542 cases in 2019 (January–December). There were 11,554 cases until the 46th week in 2018 and 8,890 cases during the same period in the year 2019, whereas a total of 6,928 cases had been reported by the 46th week of 2020. Figure 3.9.1 shows the trend of SARI cases reported in 2018, 2019 and 2020 by the epidemiological week. The 2020 data in the figure reflects the data available to date, and these numbers could be different going forward. The SARI cases reported through EWARS need further analysis by sites and the reporting period.

Survey, Research and Studies

The first **NHFS** was performed in 2015; the second was planned for early 2020, with data collection from February to May 2020, but the preparatory work, such as questionnaire finalisation and selection of the implementation agency, was delayed because of the COVID-19 pandemic. By September 2020, the selection of the survey implementing partner and the finalisation of the tools had been completed and the Master Training of Trainers (MToT) was in progress.

Similarly, the sixth series of the **NDHS** is planned for FY 2020/21. MoHP has initiated preliminary consultation with relevant stakeholders and the questionnaire development process is in progress. The selection of the survey implementation partner has also been completed.

The sixth series of the **NMICS, 2019,** conducted by the Central Bureau of Statistics (CBS) from May to November 2019, has been completed. The key findings of the survey released in 2019 and the full report are expected by the end of 2020. NMICS 2019 provides data from an equity perspective by indicating disparities by sex, province, location, education, household wealth and other characteristics. The NMICS 2019 is a national survey of 12,800 households; 14,805 women aged 15–49, 5,501 men aged 15–49, 6,658 mothers/caretakers of children U5, and 7,792 mothers/caretakers of children 5–17 years were interviewed. In addition, water quality testing for E. coli and arsenic was performed in 2,536 households.

The **National TB Prevalence Survey (2018–2019),** the first of its kind in Nepal, was completed in 2020. The survey was based on a nationally representative sample, covering 55 districts. The survey has provided exact information on burden of disease and health seeking behaviour among TB patients. It reflects the true epidemiology of TB, monitors ongoing programme impact and collects relevant data on incidence and prevalence.

Maternal Mortality Study following the Census 2078: For the first time in its history, MoHP is planning to conduct a maternal mortality study following the Census. The forthcoming 12th series of the Nepal Population and Housing Census (NPHC) will take place from Jestha 25 to Asar 08, 2078 (8 to 22 June 2021). The 11th series of the NPHC in 2011 had for the first time given a national estimate of the pregnancy-related mortality ratio (480 per 100,000 live births) but did not deal with the causes of maternal deaths. The proposed maternal mortality study following NPHC 2021 aims to identify programmatically useful information to inform investment and interventions directed towards improvement of maternal health in Nepal. The specific objectives of this study include:

- o To increase the evidence base available on maternal mortality in Nepal to generate estimates of current levels of maternal mortality at national and sub-national levels, for the first time in Nepal.
- o To gain a better understanding of why women are dying during pregnancy, childbirth and the postpartum period, and the social and clinical determinants.
- o To provide information to policy makers and programme managers at the national and sub-national levels to identify and plan targeted interventions that are successful in reducing maternal mortality and morbidity.

The Nepal Burden of Disease (NBoD) 2019 Study: The NBoD 2017 study was conducted under the leadership of the Nepal Health Research Council (NHRC) and the report was published in April 2019. With the Global Burden of Disease (GBD) 2019 estimates released in October 2020, this summary provides a picture of the NBoD 2019 around Disability-adjusted Life Years (DALYs), Years Lived with Disabilities (YLDs), Years of Life Lost (YLLs), and risk factors attributing death and disability.

The study covers the disease burden quantified as DALYs. These are broadly categorised into DALYs due to Communicable, Maternal, Neonatal and Nutritional (CMNN) diseases, NCDs and injuries.

GBD 2019 estimates for Nepal revealed a major shift in disease burden and cause of. In 2019, 71.1 per cent of all deaths were caused by NCDs, 21.1 per cent of deaths by CMNN diseases and the remaining 7.8 per cent by injuries. NCDs have emerged as leading causes of deaths in both males (70.8%) and females (71.5%). Approximately 61.2 per cent of total DALYs are attributed to NCDs, 29.3 per cent to CMNN diseases and 9.6 per cent to injuries. Out of the total YLDs in 2019, 74.9 per cent were due to NCDs, 17.6 per cent due to CMNN diseases and the remaining 7.5 per cent due to injuries. Cardiovascular diseases (24.0%), chronic respiratory diseases (21.1%) and neoplasm (11.2%) were the top three causes of death in 2019. Among risk factors, behavioural risk factors, environmental/occupational risk factors and metabolic risk factors attribute 38.1 per cent, 31.2 per cent and 22.9 per cent of total deaths, respectively. Air pollution has emerged as the single leading cause of death, attributing 21.8 per cent of total deaths, followed by tobacco (19.4%) and high systolic blood pressure (12.8%). As per GBD 2019 estimates, the average life expectancy of a Nepalese citizen is 71.1 years. The life expectancy in males is 69.2 years, while it is 73.0 years in females. A Nepalese born in 2019 can expect to live 62.2 years of healthy life compared to 50.4 years for those born in 1990.

With the evidently growing pattern of a double burden of NCDs and CMNN diseases, there is an arduous challenge for the health system to rightfully address with urgency the rapidly growing burden due to NCDs and injuries without deprioritising interventions on reducing the burden due to CMNN diseases.

Further Analysis of Routine Data on Maternal Health and FP
A further analysis, titled "Determinants of Maternal Health and Family Planning Service Coverage in Nepal: Modelling of Routine Data" was carried out under the leadership of IHIMS, MD, DoHS, MoHP. The analysis intended to identify the determinants of coverage of maternal health and FP services in Nepal, utilising service coverage data from the HMIS for five years, from FY 2014/15 to FY 2018/19, and district characteristics data from 'the Population Atlas of Nepal, 2014'.

A composite coverage index was formed to access maternal health services, combining the coverage of first ANC visit, four ANC visits, ID, and PNC visit within 24 hours, giving equal weight to each of them. Similarly, modern CPR (mCPR) was used for assessing FP services.

Key findings:
- This analysis showed that districts with a higher proportion of female household heads had higher coverage of ID.
- Out of 77 districts, 31 had higher than average (60% as an aggregate of five years analysed in this study) and 30 districts had lower than average composite coverage of maternal health services. Gandaki Province, Province 2, and Bagmati Province had 27 per cent, 26 per cent and 15 per cent lower composite coverage of maternal health services, respectively, than districts in Province 1.
- The mCPR of 21 districts was above the national average value (39% as an aggregate of five years analysed in this study) while the other 37 districts had below the average value.

This analysis revealed HDI, province and predominant caste of the district as the key determinants of mCPR. With one-unit increase in HDI of the district, the mCPR of the district increased by almost three per cent. Compared to districts with Brahmin as the predominant caste, districts with Gurung, Magar and Tharu as predominant caste had 32 per cent, 26 per cent and 18 per cent higher mCPR. Conversely, compared to districts with Brahmin as predominant caste, districts with Rai, Chhetri, Limbu and Newar as predominant caste had 29 per cent, 28 per cent, 27 per cent and 21 per cent lower mCPR. Similarly, compared to districts in Province 1, Gandaki Province, Lumbini Province and Bagmati Province had almost 37 per cent, 18 per cent and 12 per cent lower prevalence of mCPR.

- A significant variation was found in composite coverage of maternal health services as well as FP services. Out of 77 districts, the number with less than the average value of composite coverage of maternal health services and mCPR was 30 and 37, respectively. The current federal structure allows for an extra opportunity for tailored targeted interventions in districts with low coverage of maternal health services and FP services.

- NHRC has conducted a number of research projects/studies in FY 2018/19; the key findings are summarised below:
  - o NHRC approved 805 and 500 research projects respectively in 2019 and 2020.
  - o NHRC has plans to conduct the following studies in the coming months of FY 2020/21:
    - ▪ A study on effectiveness of traditional (Ayurveda) health services to promote health
    - ▪ National survey on mental health
    - ▪ Studies on burden of diseases in Nepal and tropical diseases
    - ▪ Studies on pharmacovigilance and AMR in Nepal
    - ▪ Study on outbreak investigation of infectious diseases
    - ▪ Operational research on integrated disease surveillance in Nepal
    - ▪ An interventional study on the prevention and control of NCDs and their risk factors
    - ▪ A study on the prevention and control of cancer in Nepal (including population-based cancer registry)
    - ▪ A study on diagnosis, control and prevention of sickle cell anaemia and thalassaemia in Nepal
    - ▪ A study on neonatal and child health in Nepal
    - ▪ A survey of HIV-infected migrants in Nepal
    - ▪ Studies on COVID-19 (including clinical trials, epidemiology, policy, laboratory, diagnostics, mental health, public health measures, social science aspects: 25 in total as of 30 November 2020)
    - ▪ Additional research is also planned, with support from WHO, in different areas, such as NCDs, air pollution, UHC and the effects of the COVID-19 pandemic on provision and utilisation of selected services.

In the current FY, GoN has increased the budget for the health research by 110 per cent.

Health Sector Reviews with Functional Linkage to Planning Process

The periodic performance reviews, at both national and sub-national levels, have been contributing to monitoring the sector performance under the NHSS. MoHP, together with EDPs, have been streamlining these reviews and improving their alignment with the priorities of the NHSS and the 15th Periodic Plan. The AWPB has been a useful instrument to translate strategy into action by linking resources to achievements. The AWPB provides a comprehensive set of activities needed to achieve the output, outcome and ultimately the goal of the NHSS.

Figure 3.9.2: Journey from Policy to Activity Level
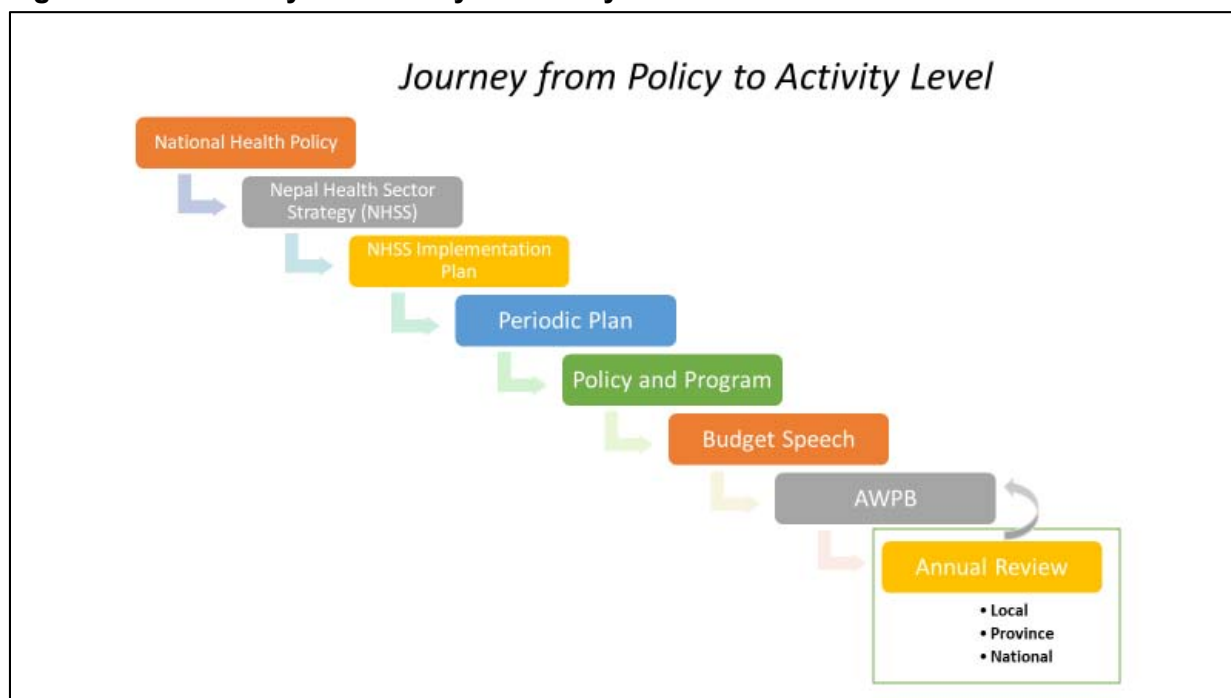
Way Forward
- Ensure compliance of timely reporting from HFs on monthly basis.
- Digitise HMIS recording registers to facilitate on-time reporting, improving data quality and use of data at the point of data generation.
- Standardise the M&E orientation package for induction training to different health cadres and roll out.
- Digitise and integrate Ayurveda Information Management System with the national database.
- Ensure functional and reliable data sources for all NHSS and SDG indicators.
- 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.
- Institutionalise and regularise production of NHA.

4. National Response on COVID-19 Pandemic: Health Sector Perspective

Background

In December 2019, a cluster of patients with pneumonia of unknown aetiology was linked to a seafood wholesale market in Wuhan, China[14]. After three weeks of the reported cases in China, Nepal also reported its first case of coronavirus infection on 23 January 2020[15]. After a pause of two months, infection cases were increasing in Nepal. The Emergency Committee on the Novel Coronavirus (2019-nCoV) under the International Health Regulations (IHR, 2005) was reconvened on 30 January 2020. WHO declared the outbreak to be a Public Health Emergency of International Concern[16]. After WHO declared COVID-19 as a pandemic on 11 March 2020, many countries started various preventive and control measures, including Nepal. As a preventive measure, a countrywide lockdown came into effect on 24 March 2020 with shutdown of schools, closing of border movements, suspension of all international flights, imposing quarantines on those returning to Nepal from abroad and lockdowns for the general population. The nationwide lockdown ended on 21 July 2020. However, provincial, district and local governments continued to impose lockdowns at provincial/district/local level following a surge in infections and rising deaths from COVID-19.

As of 27 November 2020, **more than 61 million cumulative cases** of COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) have been reported, including **1.4 million deaths[17].** Nepal has been categorised as one of the high-risk countries considering its limited infrastructure, response capacity and resources to stop the spread of COVID-19.

To respond to the growing number of infections, the GoN, has formed a Corona Crisis Management Centre (CCMC) under the leadership of the Deputy Prime Minister and the ICS has been activated and mobilised at the MoHP. All pillars of the COVID-19 response have been activated, including surveillance, rapid response teams and case investigation; point of entry, national laboratories, IPC; case management; operation support and logistics; and primary and RH care.

Figure 4.1 maps the reported number of infected persons (cumulative) by district over the 10 months up to the end of November 2020. As of 27 November 2020, the most affected part of the country is Province 3, followed by Province 2. A high burden of cases is observed in Kathmandu valley as compared with other parts of the country.

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[14]   Brief   Report: A   Novel   Coronavirus   from   Patients   with   Pneumonia   in   China,   2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7092803/
[15]   Ministry   of   Health   and   Population   Nepal.   SitRep#1_28-01-2020   -   Google   Drive. https://drive.google.com/drive/folders/1SQz5zoNNwYGi_wBeHxnU6sYs261fg1Tx
[16] World Health Organization. Novel Coronavirus (2019-nCoV) Situation Report – 11 https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200131-sitrep-11-ncov.pdf?sfvrsn=de7c0f7_4
[17] European Center for Disease Control and Prevention. COVID-19 pandemic. *European Centre for Disease Prevention and Control* https://www.ecdc.europa.eu/en/covid-19-pandemic

Fig.4.1 Reported number of COVID 19 infected persons (cumulative) by districts (up to Nov 27, 2020)

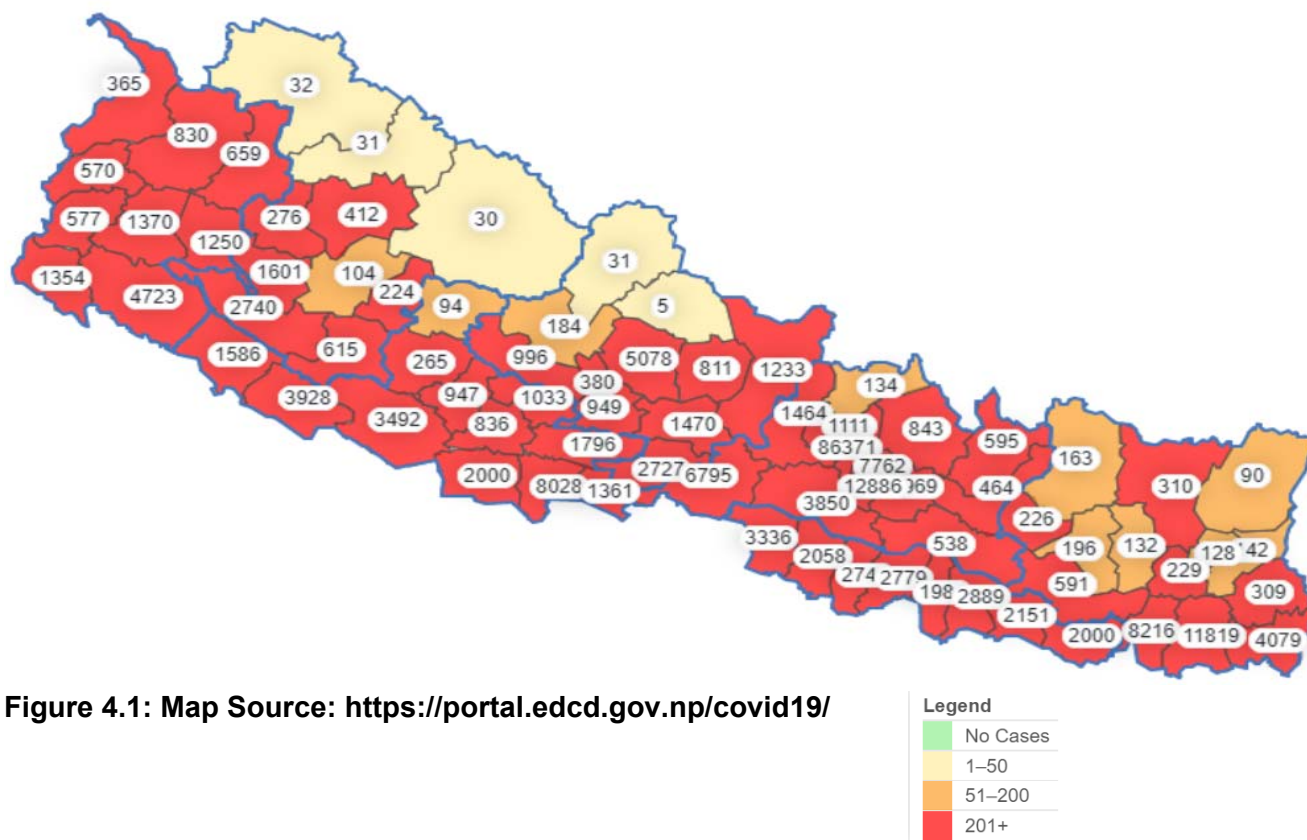**Figure 4.1: Map Source: https://portal.edcd.gov.np/covid19/**

Legend
- No Cases
- 1–50
- 51–200
- 201+

Datelines

- High-level Committee for COVID-19 Crisis Management was established under the coordination of the Deputy Prime Minister and Defence Minister (18 Falgun 2076/1 March 2020).
- Implementation of lockdown (Banda-bandi) to reduce the possible transmission of COVID-19) (11 Chait 2076/24 April 2020 onwards).
- Restriction of inward movement through all border points (9 Chait 2076/22 March 2020).
- Decision to establish Corona Crisis Management Centre (CCMC) (16 Chait 2076/29 March 2020).
- Standards for Quarantine Implementation endorsed (16 Chait 2076/29 March 2020).
- Decision to implement antibody-based test and to carry PCR tests to confirm infection (22 Chait 2076/4 April 2020).
- Grants were provided to hospitals for treatment of COVID-19, and provisions for allowance for health workers is also ensured.
- Protocol to manage dead bodies of COVID-19 cases endorsed (12 Jesth 2077/25 May 2020).
- COVID-19 case investigation and contact tracing team mobilisation and management guidelines endorsed (28 Jestha 2077/10 June 2020).

- Interim Guidelines for RMNCAH Services in COVID-19 Pandemic endorsed (23 Baisakh 2077/5 May 2020).

Major Responses of MoHP to COVID-19 Crisis

- The MOHP activated the Health Cluster, RHSC, and Emergency Nutrition Cluster; these clusters held regular meetings at provincial and federal level.
- Various policies, plans and guidelines were developed for preventing transmission and providing services for COVID-19 infection and for ensuring continuity of high-quality essential health services:
  - Interim Protocol for Pooled PCR for COVID-19
  - Interim Guidelines for SARS-CoV-2 PCR Laboratories in National Public Health Laboratory Network
  - RMNCAH Interim Guideline (Baisakh 2077/April 2020)
  - IPC when COVID-19 is suspected (Chaitra 2076/March 2020)
  - Interim Clinical Guidance for Care of Patients with COVID-19 in Health Care Settings (Chaitra 2076/ March 2020)
  - PPE Use Guideline
  - Pocket Book for IPC Measures for COVID-19 in the Healthcare Setting (Jesth 2077/May 2020)
  - Public Health Standards for Management of Quarantine (Jesth 2077/May 2020)
  - COVID-19 Cases Isolation Management Guidelines (Jesth 2077/May 2020),
  - Environmental Cleaning and Disinfection Guideline in COVID-19 (Asad 2077/June 2020)
  - SOP for Cleaning and Decontamination of Ambulances used in COVID-19
  - Health Care Waste Management in the Context of COVID-19 Emergency (Interim Guidance) (Saun 2077/July 2020)
  - Frontline Health and Other Workers Management Guideline (2077/2020)
  - Ayurveda and Alternative Medicine Guidelines of Preventive Measures and Management Protocol for COVID-19 in Nepal
  - Interim Guideline (Baisakh 2077/April 2020), Health Sector Emergency Response Plan, COVID-19 Pandemic (Jesth 2077/May 2020)
  - Interim Guidance for Health-related Rehabilitation and Physiotherapy of Person with COVID-19 in Acute Care Settings (Asad 2077/June 2020)
  - Interim Guideline for Dental Practices During COVID-19 Global Emergency in Nepal (Asad 2077 June 2020)
  - SOP for Case Investigation and Contact Tracing of COVID-19 (Chait 2076/March 2020)
  - Interim Clinical Guidance for Care of Patients with COVID-19 in Healthcare Settings, Nepal Medical Council (NMC) (Baisakh 2077/April 2020)
  - Interim Guidance for Management of Essential TB Services during COVID-19 Pandemic (Chait 2076/March 2020)
  - Guideline on Airlifting of COVID-19 patients, 2077 (Ashoj 2077/October 2020)

- o COVID-19 Emergency Medical Deployment Team (EMDT) Mobilisation Guidelines (Jesth 2077/May 2020)
    - o HEOC/MoHP and EDCD regularly made COVID-19 epidemiological/Situation Updates.
- Airing of COVID-19 related health Public Service Announcements through radio and television channels, printing and distribution of leaflets/brochures in various local languages/dialects, targeting diverse groups of people, including people with disabilities.
- Establishment of 76 medical laboratories for COVID-19 testing across all seven provinces.
- More than 15,000 health workers were oriented on the RMNCAH Interim Guideline.
- Dissemination of COVID-19-related IEC materials, including risk communication messages, PPE, hotline services and essential commodities, kits, and supplies.
- Regular monitoring of availability and continuity of high-quality essential health services and essential commodities, including food supplements, through phone calls, weekly monitoring of MNH services, monitoring of children with malnutrition, and weekly monitoring of maternal and perinatal deaths.
- An assessment of RMNCAH for service utilisation and HF readiness during the COVID-19 crisis was carried out: Impact of COVID-19 Pandemic on Functionality and Utilisation of RMNCAH Services by Clients in Public Sector HFs of Nepal.

Expansion on RT-PCR Laboratories

Testing for COVID-19 started in laboratories in Nepal on 27 January 2020, through the NPHL. As of 27 November 2020, a total of 58,587 RT-PCR tests per 1000,000 population had been performed in Nepal, with a cumulative positivity rate of 13.4 per cent (Table 4.1). As there was a gradual increment in positive cases and people in quarantine, expansion was rapid in the following months. As of 27 November 2020, there are 77 RT-PCR labs (44 public sector and 33 private sector) providing COVID-19 testing services in Nepal and reporting to the MoHP. Figure 4.2 depicts the time series of the establishment of the labs in response to the need for COVID-19 testing.
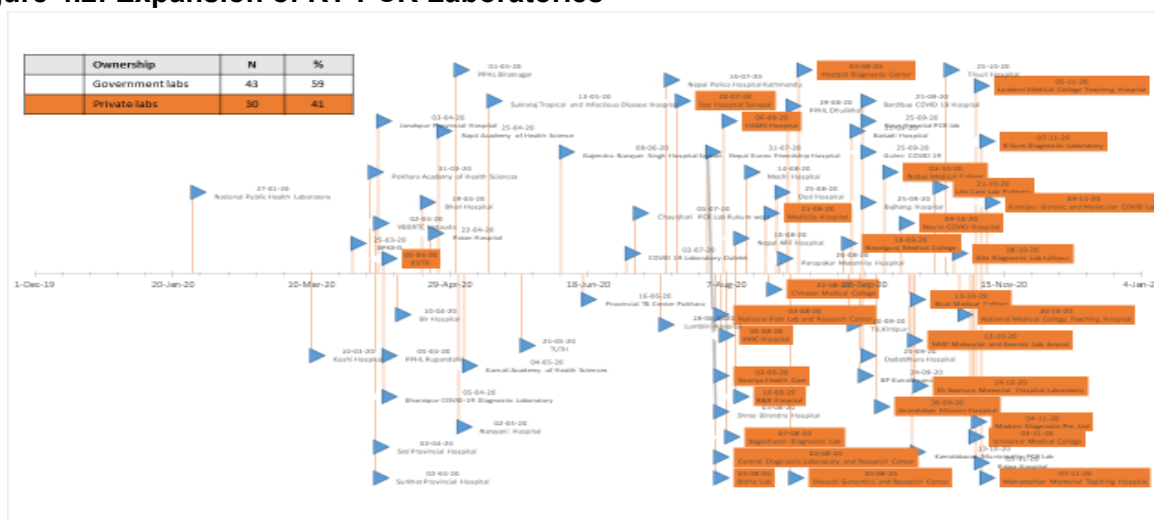
Figure 4.2: Expansion of RT-PCR Laboratories

Table 4.1 Milestones on RT-PCR Test

Highest positivity rate (%)	34.8	10 Kartik	5,006 tests with 1,741 positive cases
2nd highest positivity rate (%)	28.6	21 Kartik	10,153 tests with 2,909 positive cases
3rd highest positivity rate (%)	28.5	5 Kartik	20,118 tests with 5,743 positive cases
Highest number of RT-PCR tests	20,118	5 Kartik	5,743 positive cases with 28.5% positivity rate
2nd highest number of RT-PCR tests	19,320	24 Ashoj	5,008 positive cases with 25.9% positivity rate
Highest number of positive cases	5,743	5 Kartik	20,118 tests with 28.5% positivity rate
2nd highest number of positive cases	5,008	24 Ashoj	19,320 tests with 25.9% positivity rate
Highest number of districts reporting new cases	71	30 Ashoj and 17 Kartik	92.2% of districts
New RT-PCR tests	10,460	12 Mangsir	1,703 positive cases with 16.3% positivity rate
Total RT-PCR tests	1,710,460	As of 12 Mangsir	229,343 positive cases; positivity rate: 13.4%
Cumulative positivity rate (%)	13.4	As of 12 Mangsir	1,710,460 tests, with 229,343 positive cases
RT-PCR tests per 100,000 population	58,587	As of 12 Mangsir	
Total RT-PCR testing laboratories	77	As of 12 Mangsir	44 Public (57%); 33 Private (43%)

Affected Population

As of 27 November 2020, a total of 229,343 persons had tested positive for COVID 19. Of them 210,671 (91.9%) have recovered; a total of 1,435 persons died (0.6%). Of the total active cases (17,937), 2.1 per cent (354) were in ICU and 0.3 per cent (54) on ventilators.

Table 4.2: Highlights of COVID-19

RT-PCR Tests	Total Cases	Positivity Rate (%)	Active Cases	Recovered Cases	Death	People in Quarantine
1,710,460	228,343	13.4	17,237 (7.52%)	210,671 (91.86%)	1,435 (0.63%)	601
[10,460]	[1,703]	[16.3]		[1,236]	[23]	

Total [new cases in the last 24 hours]

Management of Active Cases				
Hospital / Institutional Isolation	ICU	Ventilator	ICU + Ventilator	Home Isolation
6,293	354	54	408	10,944
36.5%	2.1%	0.3%	2.4%	63.5%

The affected age and sex groups are shown the graph below (Fig 4.3). The prevalence of COVID-19 is highest in the age group 20 to 59 years, which makes up 80.7 per cent of the total cases (229,343), followed by 60 years and above (9.4%) and 0 to 19 years (9.2%). Females account for 34.3 per cent of the total cases, and males 65.7 per cent. Younger age groups in both sexes are less likely to be affected than older age groups.

Figure 4.3: Population Pyramid of COVID-19 Cases
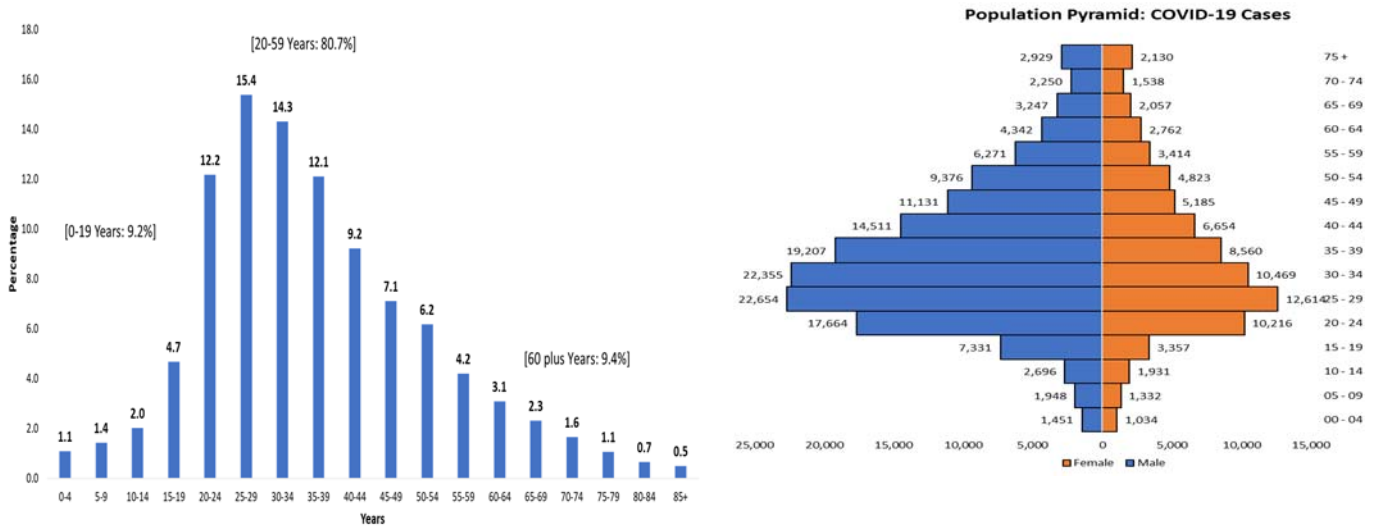
Mortality

As of 27 November 2020, the case fatality rate of COVID-19 was 0.6 per cent. Out of the total (1,435) deaths, 69 per cent were male and 31 per cent female. Age-specific mortality rates were found to be highest in the age group 85 and above (8.45%) followed by 80–84 (7.5%), 75–79 (5.9%) and 70–73 (4.9%). The lowest death rate was observed in the age group 10 to 14 years (0.02%). The highest number of deaths was reported on the month of Kartik (487) and the number of deaths is found to have the incremental trend in seven months to November 2020.

Figure 4.4 Death Distribution of COVID-19
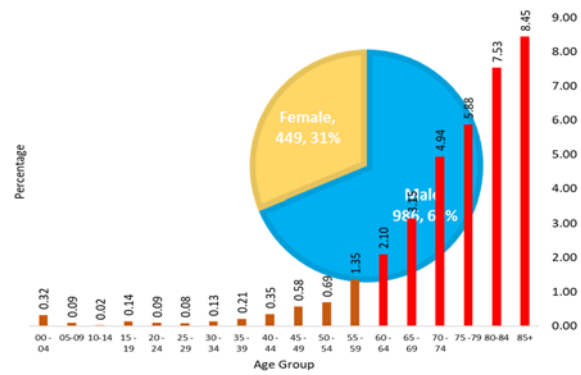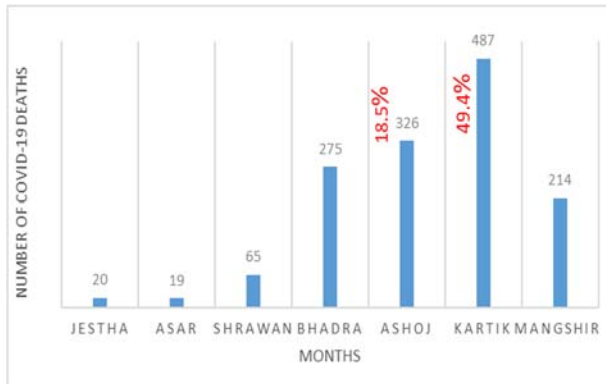
Initial Effect of COVID-19 on RMNCAH Services

The initial effect of COVID-19 on RMNCAH programmes has been determined by comparing the service utilisation status during the COVID-19 pandemic with the same period in the previous FY using HMIS data. A polynomial distributed auto regression model was used to analyse the service utilisation pattern. Among the indicators on Immunisation, DPT 3 was taken in consideration for examination. Uptake of DPT 3 immunisation was lower for the months of Falgun and Chaitra 2076 than for earlier months at both national and provincial level (see Figure 4.5 (a)). Unlike the previous month, from Jestha 2077 onwards, service utilisation began to recover and continued to do so for the following months of FY 2077.

Similarly, 4ANC attendance and ID were taken in account for the analysis of the initial effects of COVID-19 on the Safe Motherhood Programme. Figure 4.5 (b) examines the service utilisation pattern of 4ANC visits. A national decrease was observed in 4ANC attendance for FY 2076/77 compared to FY 2075/76, for the initial period of the COVID-19 outbreak. Province 1, Province 2 and Gandaki and Lumbini Provinces reported a decline in 4ANC visits in FY 2076/77 as compared to FY 2075/76. Karnali and Sudurpashchim Provinces, however, reported improved 4ANC attendance, despite the COVID-19 pandemic. ID declined nationally in the initial months following the onset of the COVID-19 pandemic; this was observed in all provinces except Karnali Province Fig 4.5 (c)

Figure 4.5 (a) Polynomial Distributed Auto Regression of DPT 3 immunisation, FY 2075/76 and FY 2076/77
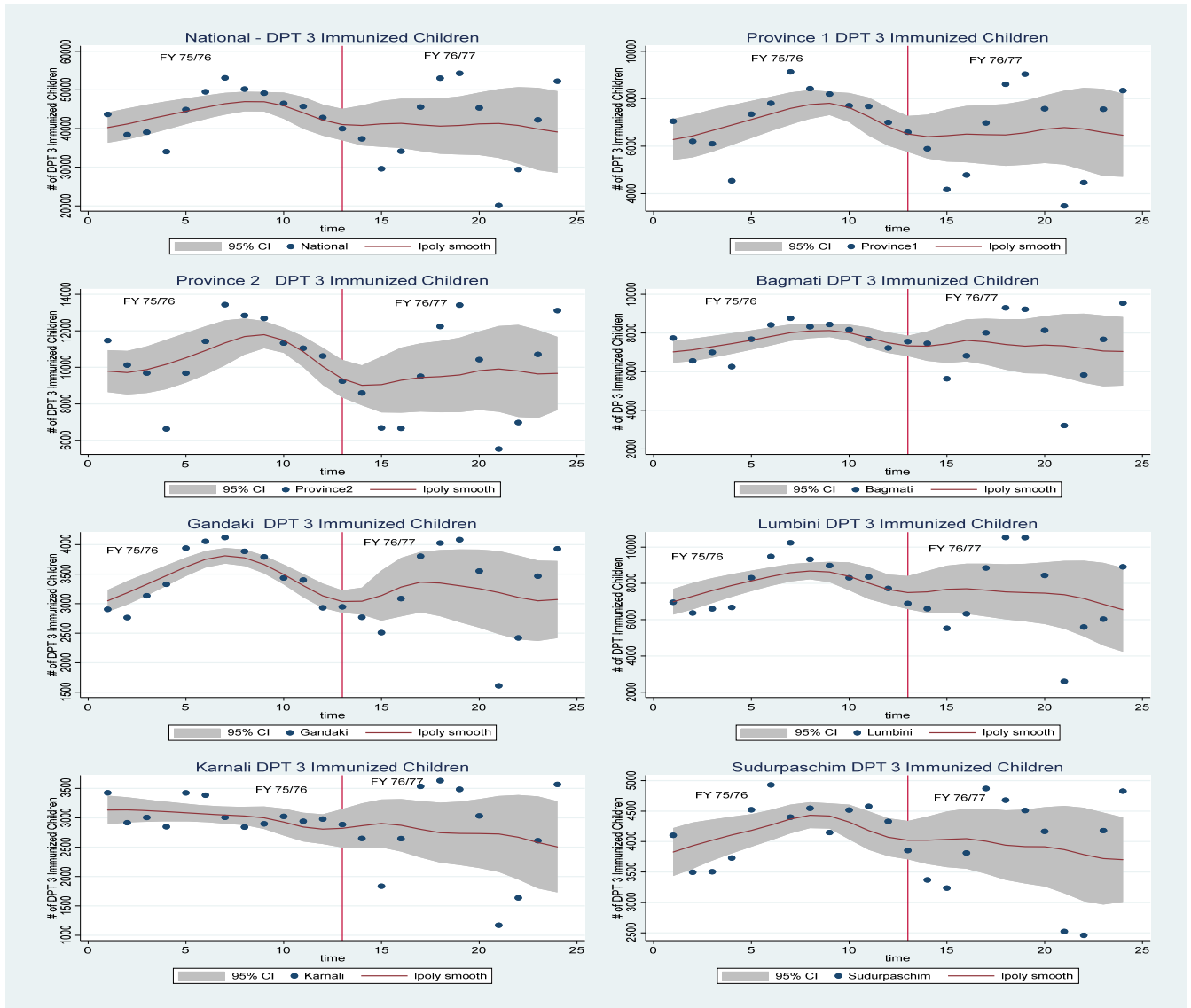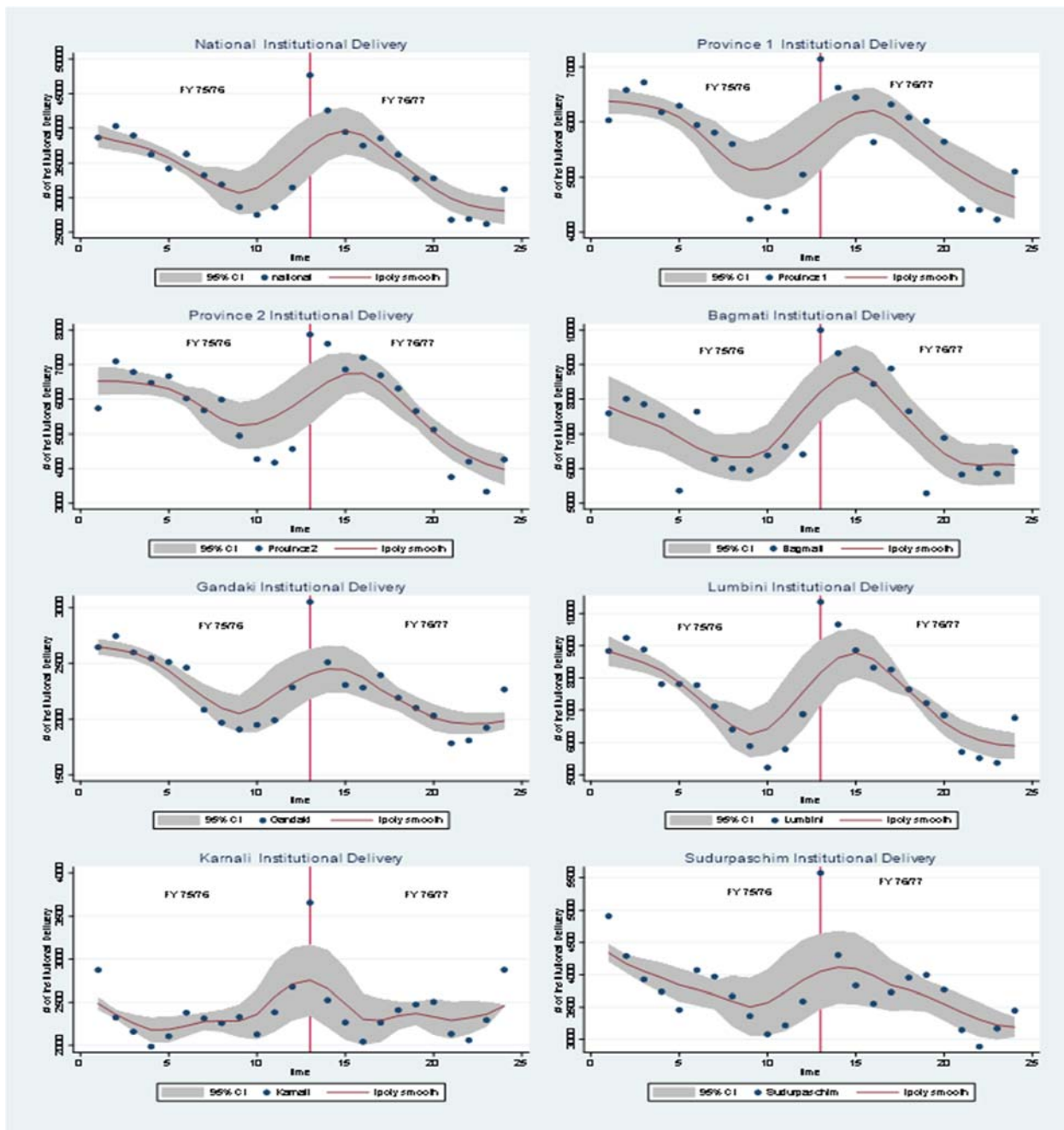

Note: In the above figure:
         5 denotes Bhadra 2076.
         10 denotes Magh 2076
         15 denotes Asar 2077
         20 denotes Mangsir 2077

Figure 4.5 (b) Polynomial Distributed Auto Regression of Four ANC visits as per protocol, FY 2075/76 and FY 2076/77
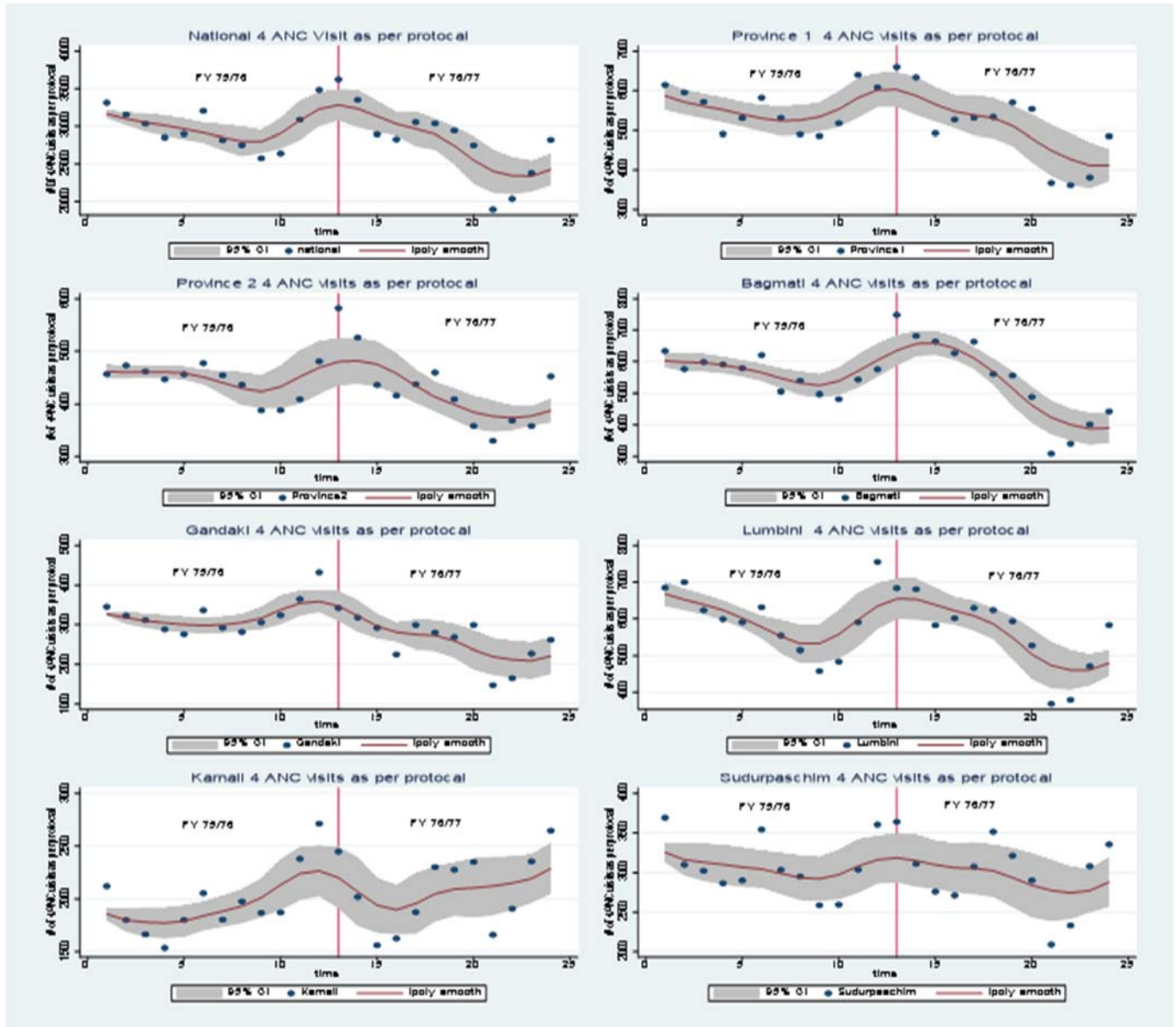
Note: In the above figure:
         5 denotes Bhadra 2076.
         10 denotes Magh 2076
         15 denotes Asar 2077
         20 denotes Mangsir 2077

Figure 4.5: Polynomial Distributed Auto Regression of ID as per protocol, FY 2075/76 and FY 2076/77

Note: *In the above figure*
   5 denotes Bhadra 2076.
   10 denotes Magh 2076
   15 denotes Asar 2077
   20 denotes Mangsir 2077

Infrastructure

In response to the COVID-19 situation, MoHP has been putting its efforts into arranging health infrastructures to treat infected patients and to prevent the spread of the disease:

- MoHP assessed the existing HI for suitability to be repurposed into COVID-19 treatment centres. Newly constructed PHCCs were selected for this purpose. The decanting blocks in Bhaktapur Hospital and Western Regional Hospital, Pokhara, constructed under the retrofitting programme, were immediately repurposed and used for COVID-19 treatment.
- MoHP planned, budgeted and authorised the expansion of 50-bed emergency units in three tertiary-level hospitals and one academic hospital in different provinces. Further, 50-bed infectious disease hospitals have also been planned in six provinces and an infectious disease department has been planned in Bharatpur Hospital in Bagmati Province.
- Designs for 300-bed infectious disease hospitals and 500-bed quarantine facilities have been prepared.
- To prevent the spread of COVID-19 from entry points, MoHP designed a well-equipped Health Help Desk, which has been established to screen people entering and leaving at these entry points. Such facilities were planned for 20 entry points on the southern border (with India), with one in Tribhuvan International Airport.
- All HEOs are functional at federal and provincial level.

Annexes

Annex 1: Mapping between Nepali Fiscal Years and the corresponding Gregorian Years

Nepali Fiscal Years	Corresponding Gregorian Years
2060/61	2003/04
2061/63	2004/05
2062/63	2005/06
2063/64	2006/07
2064/65	2007/08
2065/66	2008/09
2066/67	2009/10
2067/68	2010/11
2068/69	2011/12
2069/70	2012/13
2070/71	2013/14
2071/72	2014/15
2072/73	2015/16
2073/74	2016/17
2074/75	2017/18
2075/76	2018/19
2076/77	2019/20
2077/78	2020/21
2078/79	2021/22
2079/80	2022/23
2080/81	2023/24

Annex 2: Mobilizing Pregnant Mother Groups and Female Community Health Volunteers: A synergy towards Zero Home Delivery Initiative

A Case Study of Kharpunath Rural Municipality, Humla[18]

Introduction

The National Female Community Health Volunteer (FCHV) Program was established in 1988 under the then Public Health Division of the Ministry of Health (MoH) of Nepal. The National FCHV Program was designed to enhance Nepal's primary health care network through community participation and expanded outreach by local women working voluntarily[19]. Aligned with this, National Health Policy (1991) has also envisioned the participation of the community mothers and volunteers in facilitating the implementation of health service functions at community level. After federalisation, the implementation of BHS, including the implementation of community health program, is primarily the responsibility of local level (LL).

Based on the evolving needs at the community level as well as the responsibilities of the FCHVs as guided by the FCHV Guidelines (2019), some of the local level have prioritized in the appointing relatively young, energetic, educated and motivated volunteers to manage the community health program. Kharpunath Rural Municipality (KRM) is one of such municipality which recently in April-May, 2020 reformed the FCHV program. As part of the restructuring of FCHV programme, a total of 36 new FCHVs were selected and mobilized by Pregnant Mothers Groups (PMGs) to implement the community health program effectively. The expected outcome of the restructuring of FCHV program is to strengthen the community health programme particularly to contribute in 'Zero Home Delivery" initiative by improving the institutional birth rate in KRM.

The "Pregnant Mother Groups": leading "Zero Home Delivery" initiative

The implementation of FCHV program is complemented and to a certain extent guided by the groups of community based local pregnant women and mothers named as "Pregnant Mother Groups" (PMG). PMG is formed based on the peer mobilisation approach and participated by mainly pregnant women of reproductive age who could facilitate the promotion of safer motherhood practices during pregnancy and childbirth. The role of PMG was aligned with National FCHV Program Strategy (First Revision, 2076)[20] and their main responsibilities include selection, mobilisation, monitoring and guidance and support in capacity enhancement of FCHVs; conduct participatory discussion with FCHVs and municipal health workers and ensure reporting of FCHV program activities to HFs and municipal health division and sections.

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[18] Khapunath is one of the learning site of MoHP, with the implementation support by UKaid.

[19] *National FCHV Program Revised Strategy, 2002, Government of Nepal*

[20] *National FCHV Program Strategy (First Revision,2076), MoHP, DoHS, Nursing and Social Welfare Division,2019*

According to the report from monthly meeting of HF incharges held in July-Aug, during the fiscal year (FY) 2019/20, a total of 35 pregnant women delivered births in their own home without assistance from health workers and Skilled Birth Attendants. This indicatives possible risks of maternal and neonatal health problems. Although mothers and children are primary beneficiaries of the safe motherhood program but they were not able to effectively benefit from the available service in most of the rural and remote areas of the municipality.

Different interventions related to safe motherhood were found to have been poorly implemented at most of the communities of KRM where there was limited participation of mothers in activity planning and monitoring. The traditionally established mothers group and FCHV and their work did not ensure the participation of pregnant women from that community during the community meetings. So far, the pregnant women and post-partum mothers were also missing care such as four- ANC visits as per the protocol and thereby even did not prioritise for institutional births at HFs and three-PNC visits. In this scenario, the role of PMG was considered to be crucial to promote access to routine health services particularly on safe motherhood program, immunisation and nutrition program. Accordingly, KRM decided to establish PMG and support for their regular meetings at community level aiming to ensure ID for all and to enhance the effectiveness of other community-based programmes. A total of 15 PMGs were formed across five wards of KRM (Table 1).

Ward No.	Population (CBS, 2011)	Number of PMG formed	Population per PMG	Name of Cluster/community
1	1575	3	525	Peush, Lali and Gopka
2	842	2	421	Thali and Seradil
3	1060	2	530	Raya and Kaaranga
4	1045	4	261	Maajha, Chhipra, Nalla and Lekh

5	1489	4	372	Taakla, Kharpel gaon, Yanchu and Durpa
Total	6011	15	400	

For the effectiveness and uniformity of implementation of the PMG meeting, the health section has developed implementation guidelines. Likewise, the KRM authority has allocated resources/budget for the tea and snacks to all the meeting participants for ongoing FY.

The Initiative: "Zero Home Delivery"

Zero home delivery is an important initiative undertaken at the local level in accordance to the strategic objective of strengthening maternal and child health program and promoting ID for the ultimate goal of reducing the maternal and neonatal deaths. Many of the LL have been putting their efforts to make the initiative successful through various program development and implementation strategies. KRM has also prioritised this initiative for last three consecutive FYs to achieve the target and recently reformed the Mothers Group and FCHV team. The overarching objective of the "Zero Home Delivery" initiative is to achieve 100 per cent ID discouraging home delivery. The specific objectives are:

- To identify and list out and collect basic information of pregnant women and lactating mothers of the community,
- To conduct health education and orientation session on monthly basis,
- To contact and follow up of pregnant women to ensure receiving of four ANC as per protocol and,
- Encourage them to conduct ID from the nearest HFs, three PNC services and to adopt the appropriate post-partum Family Planning ((PPFP) methods.

The road to "Zero Home Delivery" Initiative is depicted in the given flowchart.

Role of FCHVs
- The concerned FCHV collect information of pregnant women

Flowchart:

Selection of FCHVs based on the Revised FCHV Guideline

↓

Collection of information on Pregnant and post-partum mothers by FCHV

↓

Formation of PMG at ward level

↓

PMG meeting for Role Division of PMG, FCHVs, HF Incharges, HF staff

↓

Series of Orientations on "Zero Home Delivery" Initiative at Ward level

↓

Monthly PMG meeting with HF staff for review, discussion, way forward; and reporting

↓

Regular Supervision, Monitoring, guidance by FCHV/HF/Health Section

↓

HFs send cards to Pregnant Women inviting for ID by HF
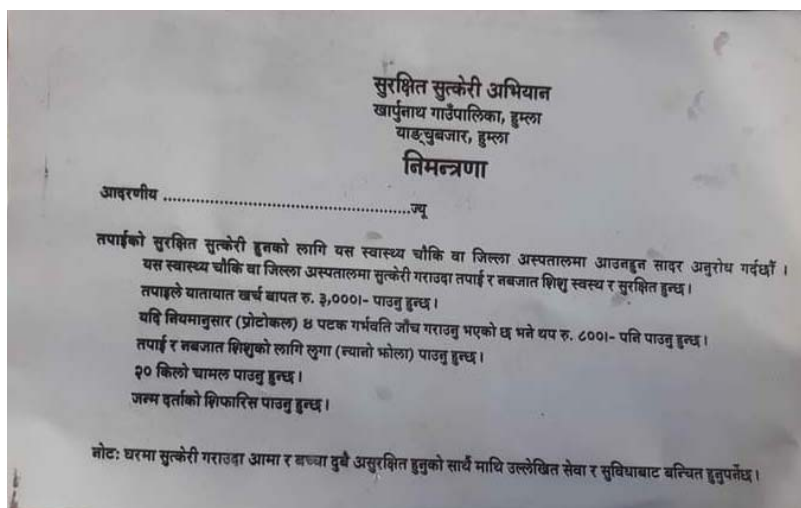
↓

Vision: Zero Home Delivery

including lactating mother (belonging *Sunaula* 1000 *din*) and inform them to participate at PMG meeting.

- FCHVs arrange and fix date, venue, time and inform target group to participate in the meeting and also manage snacks as per the provided norms.
- Conduct meeting around 1-2 hours, keep meeting minutes including registration of participants, topics covered in health education/orientation session and any other decision made during the meeting.
- List out pregnant women of the community with basic information and report to the concerned HFs.
- FCHVs will be in touch with the target women and encourage to access 4 ANC, 3 PNC as per the protocol, perform ID and FP services and facilitate with necessary support.
- Participate in monthly meeting to be held at respective HFs and report what the progress were including the major activities carried out during the reporting month.

Role of HF staff

- Facilitate FCHVs to conduct PMG meeting in their catchment areas on regular basis.
- Provide and ensure logistic supply (register, banner, snacks and format) as needed for PMG.
- Keep update with basic information of the pregnant women including contact number in order to ensure the use of ANC, PNC, ID and PPFP services on timely manner.
- Invite to pregnant women by sending invitation card for performing ID at the HFs. See the invitation card enclosed.
- Collect and compile FCHVs report in regular basis.

सुरक्षित सुत्केरी अभियान
खार्पुनाथ गाउँपालिका, हुम्ला
याङ्चुबजार, हुम्ला

निमन्त्रणा

आदरणीय ....ज्यू

तपाईंको सुरक्षित सुत्केरी हुनको लागि यस स्वास्थ्य चौकि वा जिल्ला अस्पतालमा आउनुहुन सादर अनुरोध गर्दछौं ।
यस स्वास्थ्य चौकि वा जिल्ला अस्पतालमा सुत्केरी गराउदा तपाई र नवजात शिशु स्वस्थ र सुरक्षित हुन्छ ।
तपाइलले यातायात खर्च बापत रु. ३,०००।- पाउनु हुन्छ ।
यदि नियमानुसार (प्रोटोकल) ४ पटक गर्भवति जाँच गराउनु भएको छ भने थप रु. ८००।- पनि पाउनु हुन्छ ।
तपाई र नवजात शिशुको लागि लुगा (न्यानो भोला) पाउनु हुन्छ ।
२० किलो चामल पाउनु हुन्छ ।
जन्म दर्ताको शिफारिस पाउनु हुन्छ ।

नोटः घरमा सुत्केरी गराउदा आमा र बच्चा दुबै असुरक्षित हुनुको सार्थ माथि उल्लेखित सेवा र सुविधाबाट बन्चित हुनुपर्नेछ ।

Role of health section of the Rural Municipality

- Provide and ensure necessary supplies of logistics e.g. register, banner, snacks and format as per need.
- Conduct monitoring of PMG meetings and birthing centers regularly, and provide feedback as relevant.
- Collect, compile and analyze the data/report and provide necessary feedback to HF for the improvement.

Key Messages

Pregnant women and lactating mother (belonging to golden 1000 days) are the one primary category of target groups from the perspective of health service delivery at the local level. Also,

maternal and new born care are included in the package of basic health serviced endorsed by the Government of Nepal. Despite various efforts by governmental and non-governmental agencies, target groups were still leaving behind to access HFs for ANC and PNC services as per the protocol, ID and adopting appropriate FP measures in most of the rural communities. In September 2020, around 60 pregnant and lactating mothers participated in five PMG meetings organised at their respective wards. It is envisioned by KRM that all pregnant women and lactating mother would continue participating in the routine PMG meetings which could be instrumental in achieving 100 per cent coverage of ANC, PNC, ID along with improvement in utilisation of FP services. Its impact has already been seen at the community level and the members of PMG feel proud that they have been contributing towards improving the health of the people in the community. Thus, strengthening the role of PMG and FCHV can be pivotal towards "Zero Home Delivery" initiative making it a successful intervention for improvement of the community health program especially at rural areas such as KRM.

Annex 3: Access to OCMC Multisectoral Services during COVID-19 Lockdown:
A Case Study[21]

Introduction

The global COVID-19 pandemic has led to rising levels of gender-based violence across the globe[22]. Women and girls and vulnerable populations more broadly, have been the hardest hit by the direct and indirect effects of the pandemic which has exacerbated existing inequalities, and pushed millions deeper into poverty.

In Nepal, national lockdown introduced to reduce transmission led to the closure of schools, markets and workplaces, stopped travel and use of public and private transport, and impacted access to and use of basic services. Ashish KC et al (2020) found that institutional deliveries dropped by more than half, neonatal mortality increased and the quality of health care declined in nine hospitals after the introduction of lockdown[23]. The return of thousands of labour migrants from the region, international restrictions on travel and slump in tourism have decimated remittance earnings and the country's major economic sectors. Against this backcloth, the risk of increased gender-based violence in Nepal, as seen across the world, was anticipated and has been reported in various media and by key informants. This report picks up this line of inquiry and explores how access to, and use of One Stop Crisis Management Centres (OCMC) was affected by the COVID-19 lockdown.

Methodology

The rapid case study uses OCMC records of registered clients from 15 January to 14 June, 2020. Data was drawn from 58 functioning OCMCs from across all provinces. The OCMC data was arranged into periods covering pre-lockdown and early lockdown. The pre-lockdown period includes the two months from 15 January to 13 March (Nepali months Magh and Falgun). The early lockdown period covers the three months from 14 March to 14 June (Nepali months of Chaitra, Baisakh and Jestha). Average monthly numbers of users were calculated for the pre-lockdown and early lockdown period respectively for comparison.

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[21] OCMC, one of the MoHP's priority programme, supported by UKaid.

[22] UN Women. 2020. COVID-19 and violence against women and girls: addressing the shadow pandemic. https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-COVID-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006. UN Women. 2020. Impact of COVID-19 on violence against women and girls and service provision: UN Women rapid assessment and findings. https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/impact-of-COVID-19-on-violence-against-women-and-girls-and-service-provision-en.pdf?la=en&vs=0

[23] Ashish KC, Rejina Gurung, Mary V Kinney, Avinash K Sunny, Md Moinuddin, Omkar Basnet, Prajwal Paudel, Pratiksha Bhattarai, Kalpana Subedi, Mahendra Prasad Shrestha, Joy E Lawn, Mats Målqvist. August 10, 2020. Effect of the COVID-19 pandemic response on intrapartum care, stillbirth, and neonatal mortality outcomes in Nepal: a prospective observational study. The Lancet Global Health. https://doi.org/10.1016/S2214-109X(20)30345-4
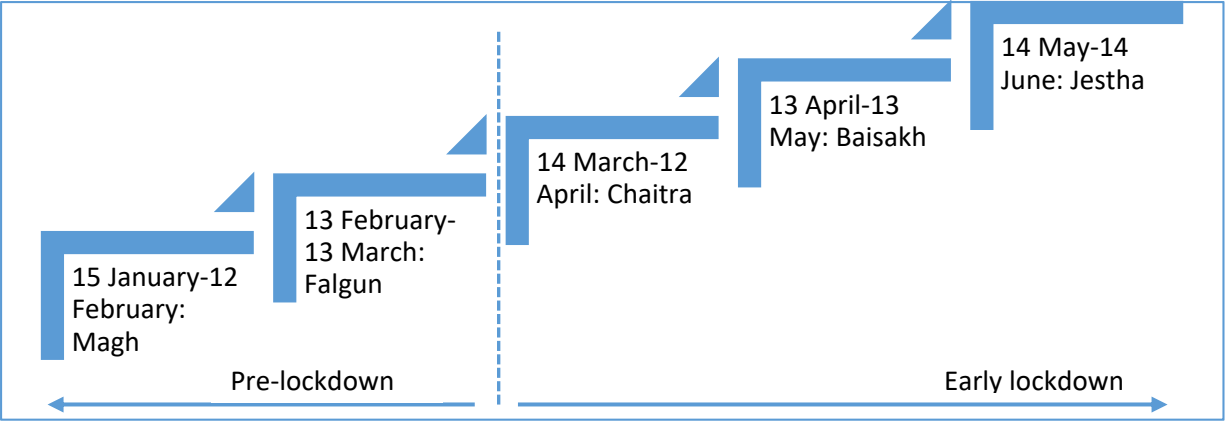
Figure 1: Pre-lockdown and early lockdown periods used in this rapid case study

Secondly, the study included a small number of key informant interviews with OCMC in-charge at six referral hospitals. This qualitative data provides local interpretation of the factors contributing to utilisation of the OCMC service during lockdown.

Figure 2: Key informant interviews at selected hospitals

Province	District	Hospital with OCMC
1	Morang	Koshi Hospital
2	Saptari	Sagarmatha Hospital
4	Kaski	Pokhara Health Sciences Institute
5	Rupendehi	Lumbini
6	Surkhet	Surkhet Provincial Hospital
7	Kailali	Seti Provincial Hospital

Use of OCMC services pre-lockdown and early lockdown
Total number of OCMC cases

There were 1411 cases in total registered at the 58 OCMCs in the pre-lockdown period from 15 January to 13 March, 2020. In comparison there were 1516 cases in total registered at the 58 OCMCs in the early lockdown period of 14 March to 14 June 2020.

The average monthly number of clients in early lockdown was 505.3. In comparison, the average monthly number of clients in the pre-lockdown period was 705.5. This is a significant drop in the number of clients at a time when the risk factors for gender-based violence had increased, and as will be further discussed below, appears to reflect the reduced access to services during lockdown.

The vast majority of clients were female. The percentage of female clients in the pre-lockdown period was 94.7 per cent and in the early lockdown period, 93.7 per cent. No cases were registered of third gender persons.

Type of violence:

94

Figures 3 and 4 show the distribution of cases by type of violence in the pre-lockdown and early lockdown periods. In both periods, physical assault was the most frequent form of violence, making up 30 per cent and 32 per cent of cases respectively. The second most frequent form of violence was rape, this made up 19 per cent of cases in pre-lockdown and increased to 25 per cent in the early lockdown period. In total physical assault, rape and sexual assault were 67 per cent of all cases pre-lockdown and 73 per cent in early lockdown; the increase resulting from the larger number of rape cases. The proportion of other types of violence remained largely similar in both time periods with the exception of 'denial of resources and opportunities' which fell from 6 per cent to 3 per cent.

The Ministry of Health and Population and NHSSP (2019) study on survivor perspectives on the nature, risks and response to gender-based violence reported how it is only when violence is severe and injuries require medical attention that medical help is sought. Moreover, that decision itself is often made by neighbours, family and the police, rather than the survivor herself[24]. In the lockdown context where women and girls are likely to face increased family scrutiny and control, less social interaction outside the household and increasing economic insecurity, it is understandable that barriers to accessing help for GBV would have increased, and therefore those clients that access services are increasingly those with serious injuries needing medical attention.
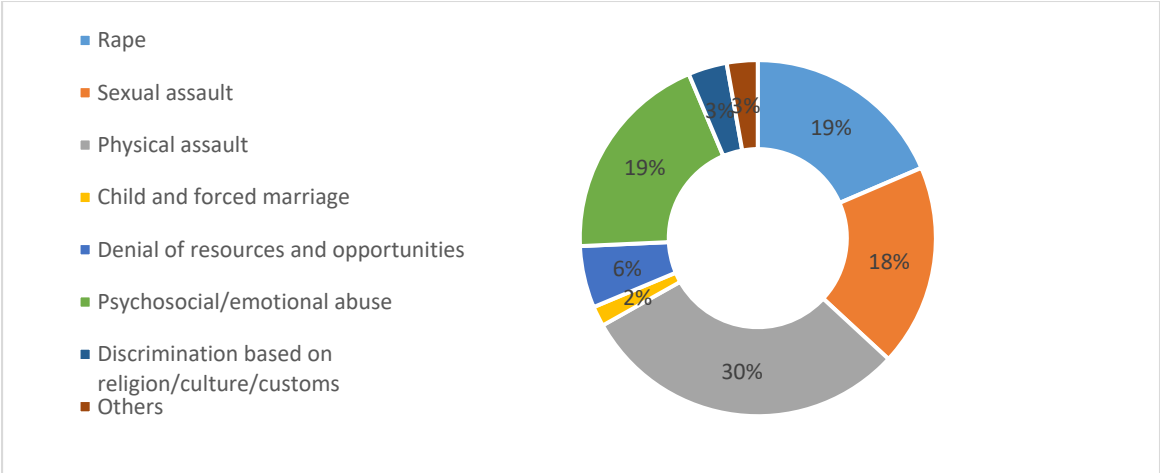
Figure 3: Average monthly number of clients by type of violence, pre-lockdown

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[24] Ministry of Health and Population and NHSSP. 2019. Survivor perspectives on the nature, risks and response to gender-based violence in Nepal and the implications for One Stop Crisis Management Centres.
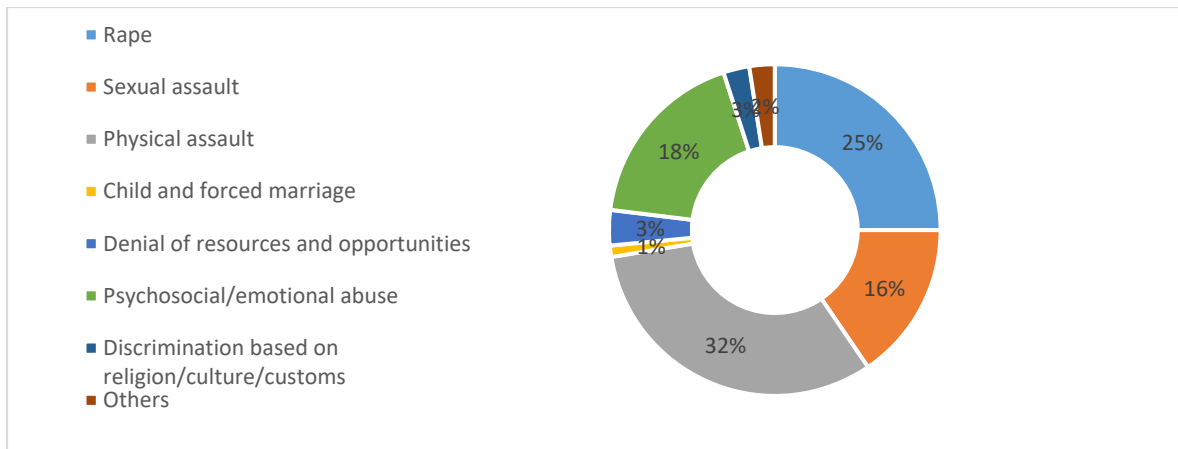
Figure 4: Average monthly number of clients by type of violence, early lockdown period

Age of survivors

Figure 3 below shows the age-wise breakdown of survivors in the pre-lockdown and early lockdown period based on monthly average number of clients. The data shows that violence against women and girls continues throughout the life cycle with the highest number of survivors in the 19-49 age group in both periods. The proportion of survivors 18 years and under increased from 30 per cent pre-lockdown to 37 per cent in early lockdown. For comparison, in the year 2018/19 (Nepali year 2075/76), the proportion of OCMC clients 18 years and under for all 44 reporting OCMCs was 31.7 per cent[25].

The high proportion of gender-based violence cases involving girls 18 years and under is extremely disturbing and has been found in other OCMC related studies. Further analysis is required to identify the types of violence experienced by girls accessing OCMC services during early lockdown but this is likely to have been for serious injuries. The additional vulnerability of girls locked at home during COVID-19 imposed restrictions is cause for serious concern and action of government and civil society.

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[25] Ministry of Health and Population OCMC records.
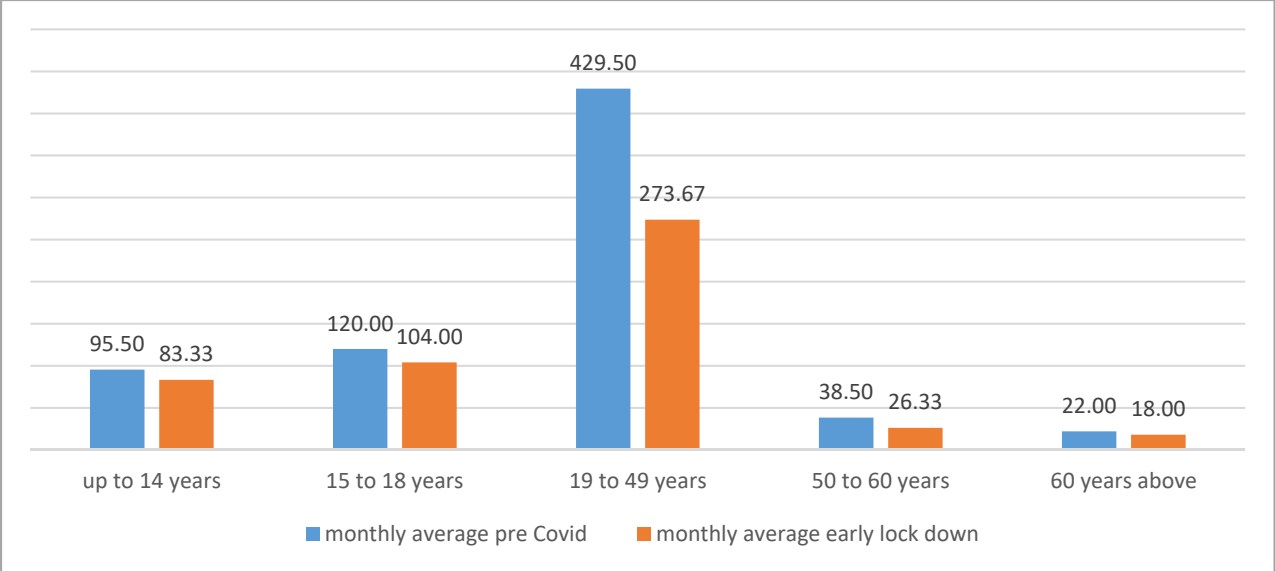
Figure 5: Monthly average number of OCMC cases by age group, pre-lockdown and early lockdown periods

Caste and ethnicity

In both periods, clients of Janajati, Dalit and Brahmin/Chhetri backgrounds made up the majority of clients. The proportion of clients from these caste and ethnic groups increased between pre-lockdown and early lockdown. In contrast, the proportion of Madhesi clients declined from 16 per cent to 11 per cent and the proportion of Muslim clients dropped from 10 per cent to 5 per cent between pre-lockdown and the early lockdown period.
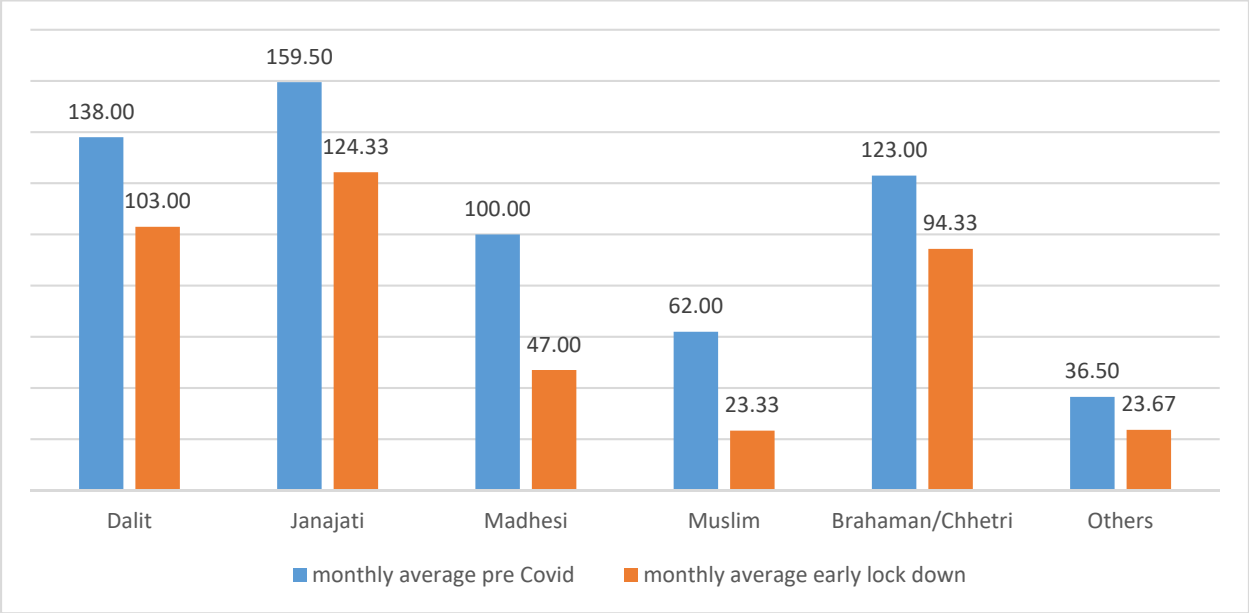
Figure 6: Monthly average number of clients by caste/ethnicity, pre-lockdown and early lockdown periods

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Persons with disabilities

For the very first time, data on 'differently abled persons' was recorded in the OCMC system in 2020. The average monthly number of clients with disabilities pre-lockdown was 17.5 clients and in early lockdown, the number was 14.3. Early studies of the impact of lockdown on persons with disability show the significant impact on access to drugs and supplies, information and other services. The number of clients with disabilities reporting to OCMCs is relatively small and further research is needed to better understand the challenges this particularly disadvantaged group face in accessing GBV services.
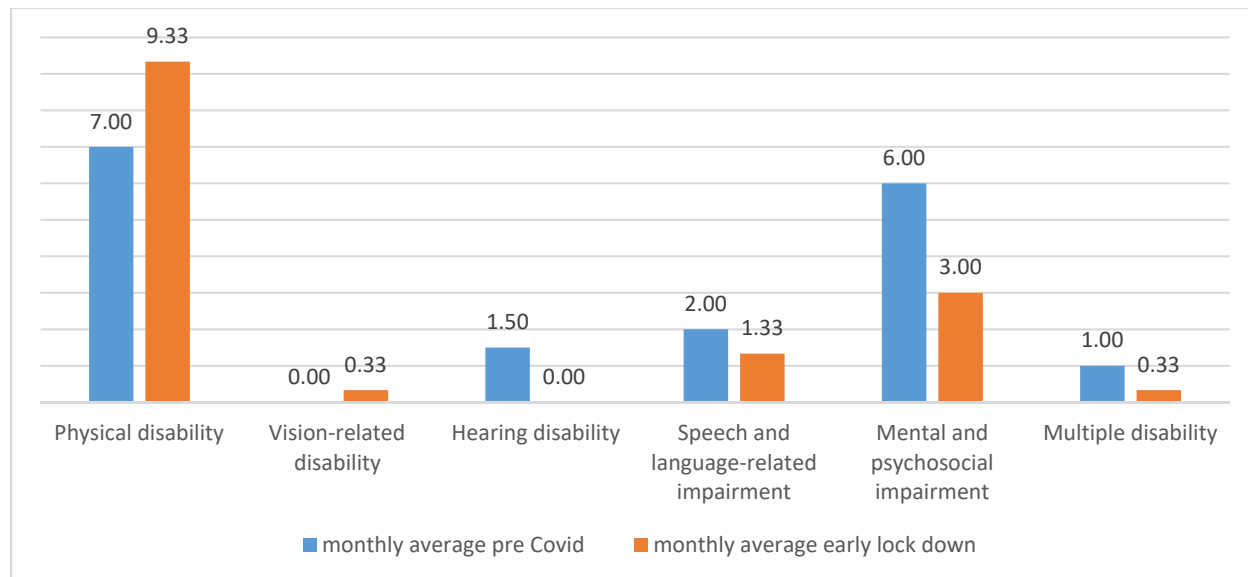
Figure 7: Monthly average number of OCMC clients with disabilities, pre-lockdown and early lockdown period

Client referral to OCMCs

Recent studies have found that the police are the most common source of referral of clients to OCMCs[26]. Figures 8 and 9 show that the police continue to be the main source of referral. The percentage of clients referred to OCMCs by the police increased slightly, from 48 per cent of clients to 51 per cent of clients from pre-lockdown to early lockdown. The percentage of clients that referred themselves increased from 14 per cent to 18 per cent, and the percentage of clients referred by relatives increased from 8 per cent to 13 per cent from pre-lockdown to early lockdown. In contrast the percentage of clients referred from a HF or hospital dropped from 13 per cent to 6 per cent. This likely reflects the reduced access to and use of health services during lockdown generally, which meant that health providers were not seeing the same volume of gender-based violence survivors because they were not attending HFs. The fact that a number of OCMC based hospitals became designated COVID-19 hospitals, may have to some extent created additional barriers for survivors to seek help.

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[26] Ministry of Health and Population and NHSSP. 2020. Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres.
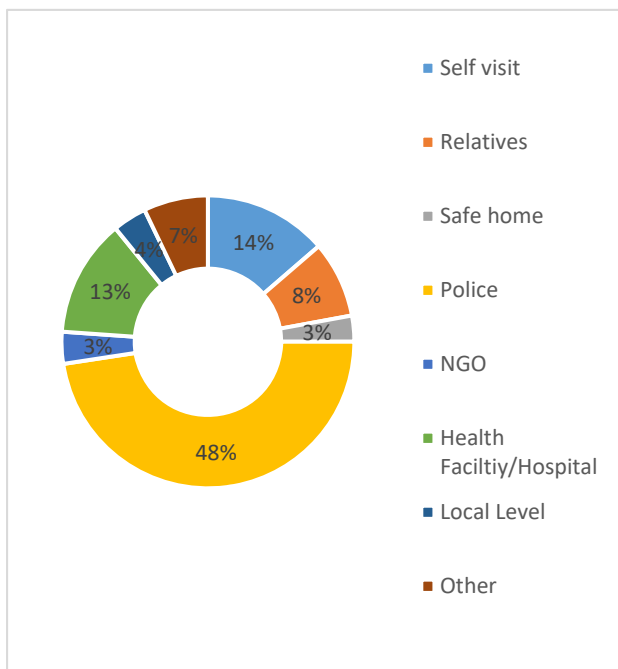
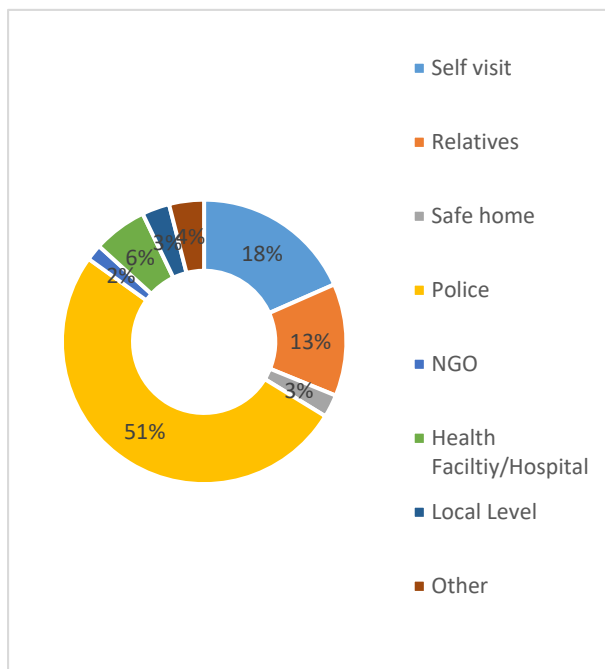**Figure 9: Source of referral to OCMC, pre-lockdown monthly average**

Figure 8: Source of referral to OCMC, early lockdown monthly average

Referral from OCMCs

Data from OCMCs during the case study period, shows that the percentage of clients referred from the OCMC to home increased from 51 per cent to 55 per cent; the percentage referred from the OCMC to the police dropped from 35 per cent to 32 per cent; the percentage referred to safe homes dropped from 5 per cent to 4 per cent; and the percentage referred to rehabilitation centres stayed at 2 per cent. While the changes appear small in scale, behind these numbers sit reports from OCMC staff that COVID-19 was further increasing the challenge of finding shelter for survivors as safe homes introduced quarantine rules and were afraid to accept new clients.

The increasing lack of shelters and rehabilitation centres linked to changes in the mandate and role of the Federal Ministry of Women, Children and Senior Citizens, and the impact this is having on the care and support provided to survivors was reported earlier this year by the Ministry of Health and Population and NHSSP[27]. Survivor reports have also highlighted how survivors are frequently returned from OCMCs to the same family that inflicted violence because of social norms and lack of viable alternatives, and that violence is often repeated[28]. COVID-19 and lockdown restrictions are likely to further complicate the availability of safe shelters for survivors.

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[27] Ministry of Health and Population and NHSSP. 2020. Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres.

[28] Ministry of Health and Population and NHSSP. 2019. Survivor perspectives on the nature, risks and response to gender-based violence in Nepal and the implications for One Stop Crisis Management Centres.
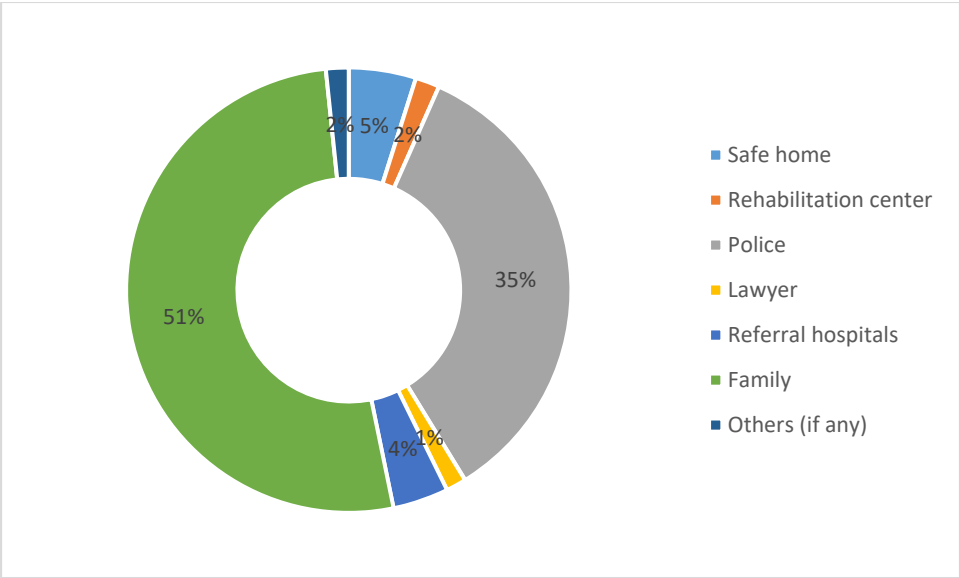
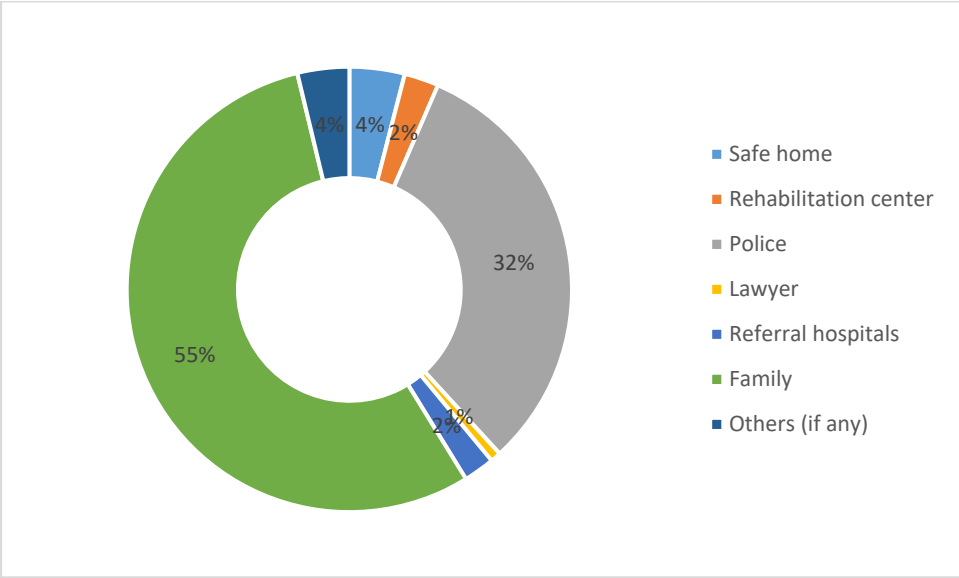Figure 10: Referral of clients from OCMCs, pre-lockdown monthly average

Figure 11: Referral of clients from OCMCs, early lockdown monthly average

Key informant perspectives

OCMC key informants were interviewed to collect their reflections on how and why demand for OCMC services had changed during lockdown. Figure 12 shows the number of cases per month under study at each of the six referral hospitals were OCMC staff were interviewed. While the pattern of use varied by hospital, the general pattern is of a decline in the number of cases at the beginning of lockdown in Chaitra in all six hospitals. This downward trend continued for four out of the six hospitals (Koshi, Lumbini, Surkhet and Seti) in the month of Baisak. In Kaski and Sagarmatha Hospitals the number of cases increased in Baisak.
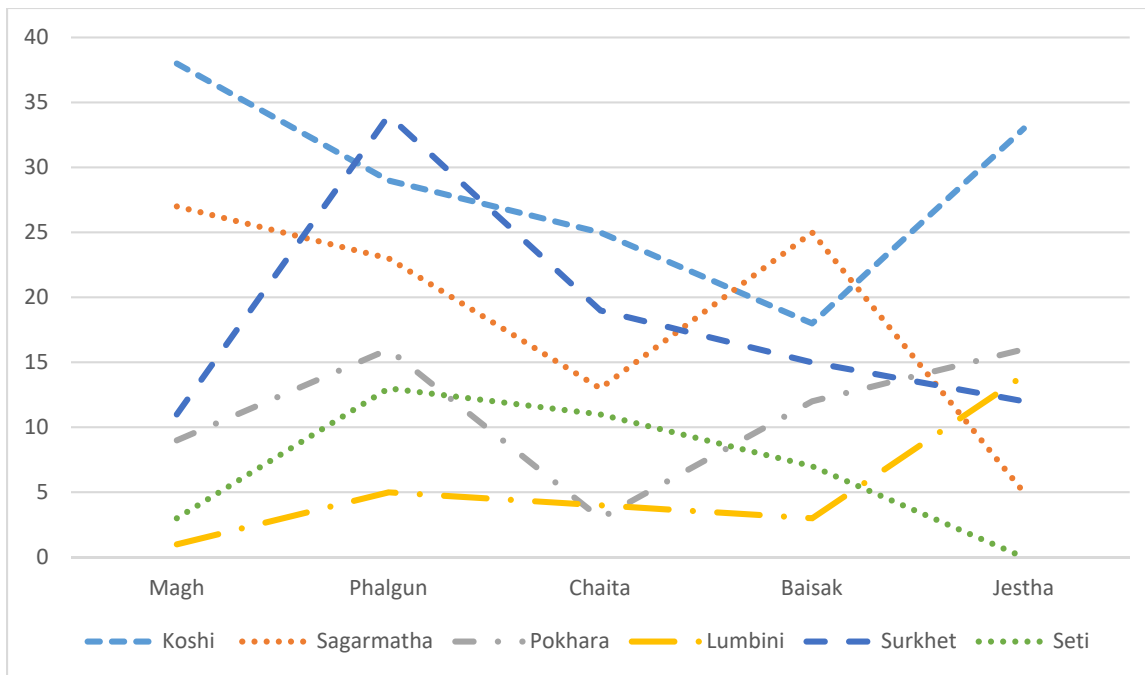
Figure 12: Number of OCMC clients per month for six selected referral hospitals

Key points from the interviews are presented below.

Increased gender-based violence but decline in clients at OCMCs

Respondents from all six OCMCs reported an increase in domestic violence due to lockdown, and the increasing financial pressure on families and social isolation. However, the lockdown conditions, fear of COVID-19 and the non-availability of transport meant that mainly, only those severe cases of violence which were also reported to the police, were accessing OCMCs. For these clients, a police vehicle or hospital ambulance was despatched to transport the victim.

Increased number of child abuse and rape

The respondent from Pokhara Health Sciences Hospital felt that most of the cases attending the OCMC during lockdown were girls under 18 years. Cases of family abuse of children under 10 had also been treated, as well as victims that had been trafficked from other districts to Pokhara, and three cases of rape that had involved the intoxication of the victims.

Increased number of attempted suicides

Sagarmatha Hospital noted that there was an increase in the number of attempted suicides after lockdown, and felt this was linked to social and economic pressure, family disputes and unemployment. The OCMC provided telephone counselling to clients who could not get to the hospital because of lack of transport.

Good coordination with the hospital authority and police

OCMC respondents from all six of the hospitals reported good coordination with the hospital management and police. The Sagarmatha respondent highlighted the provision of personal protective equipment to the OCMC by the hospital management, and the transport and supplies for medico-legal tests provided by the police for rape cases.

In contrast to the support of police and hospital authorities, Surkhet Hospial OCMC felt that the survivor's neighbours and community didn't want to be involved with the case or the police.

Safe home
Fear of COVID-19 and the need to protect existing safe home residents, plus the chronic shortage of safe homes per se, made it difficult to access safe homes during lockdown. Koshi, Pokhara and Seti hospitals all flagged that safe homes were only accepting clients after they had tested negative for COVID-19 and had received the PCR report. Gaps in access to testing and delays in getting results, made this problematic. At Koshi Hospital, an agreement was reached with the safe home to accept new residents prior to the test result but this was not so in other sites.

In the case of Sagarmatha Hospital, which has no safe home or shelter in the municipality where it is located (Rajbiraj Municipality), the OCMC faced great difficulty to support clients in need of emergency shelter during lockdown.

Recommendations
The rising incidence of gender-based violence triggered by the COVID-19 pandemic and lockdown restrictions has amplified the barriers to accessing OCMC services. Women's and girl's lack of agency to seek help and lack of awareness of the services provided by OCMCs is a major hindrance.

In the short term, multi-media campaigns including television, radio and social media, are needed to raise awareness of women's and girl's rights, the illegality of gender-based violence, the harm to the individual, family and society, and how and where victims and perpetrators can seek help. Online conferences and workshops are also a way to target young people. Secondly, a solution for providing accessible safe homes is needed. In the short-term, the approach used by the Morang Safe Home could be considered at other sites to overcome the problem of how to house survivors as they wait for COVID-19 test results. Where safe homes lack the physical space for safe quarantine of new clients, temporary quarantine accommodation may need to be sourced by the local authority. More systemically, access to safe homes for all survivors and OCMCs needs increasing to avoid returning survivors to violent settings where they are at risk of continuing abuse.

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