

Progress of the Health Sector

REPORT FOR JOINT ANNUAL REVIEW 2018



Government of Nepal
Ministry of Health
Kathmandu
2018

Contents

Abbreviations	III
Executive Summary	VII
1 Introduction	1
1.1 Background	1
1.2 Status of Aide Memoire	2
2 NHSS Results Framework.....	5
2.1 Overview of progress	5
2.2 Progress against outcome and output level indicators	7
3 Outcome 1: Rebuilt and Strengthened Health Systems: Infrastructure, Human Resources for Health, Procurement, and Supply Chain Management	10
3.1 Outcome 1.a: Infrastructure.....	10
3.2 Outcome 1.b- Human Resources for Health	17
3.3 Outcome 1.c Procurement and Supply Chain Management.....	20
4 Outcome 2: Improved Quality of Care at Point-of-delivery	25
5 Outcome 3: Equitable Distribution and Utilisation of Health Services.....	28
6 Outcome 4: Strengthened Decentralized Planning and Budgeting	34
7 Outcome 5: Improved Sector Management and Governance	39
8 Outcome 6: Improved Sustainability of Healthcare Financing.....	43
9 Outcome 7: Improved Healthy Lifestyles and Environment.....	47
10 Outcome 8: Strengthened Management of Public Health Emergencies.....	50
11 Outcome 9: Improved Availability and Use of Evidence in Decision Making Processes at All Levels	54
References.....	57

List of Table

Table 1: Achievement of 2017 Aide Memoire points	2
Table 2: NHSS Results Framework goal level indicators	5
Table 3: Progress against MoU for repair and reconstruction through different EDPs.....	12
Table 4 : Progress against agreement with bilateral agencies.....	13
Table 5: Status of health facilities of 17 earthquake affected districts	14
Table 6: Health facilities without basic services (electricity, water supply, and road access)	14
Table 7: Progress status of ongoing health infrastructure construction.....	16
Table 8 Analysis of CAPP with estimated budget (in million NPR)	21
Table 9 Procurement expenditure analysis (in million NPR)	21
Table 10 Selection of procurement type and modality in FY 2016/17	22
Table 11 Selection of procurement modality by type of procurement	22
Table 12 Overview of the coverage of selective services	30
Table 13 Progress made on disability related activities.....	31
Table 14 Budget allocated to Local Governments in 2017/18	35
Table 15 Types of sporadic small scale outbreaks responded	50

List of Figure

Figure 1: Maternal mortality ratio	6
Figure 2: Institutional deliveries, Nepal, 1996 to 2030 (NHSS RF: OC3.3).....	8
Figure 3: Institutional deliveries by wealth quintiles, Nepal, 1996 to 2016	8
Figure 4: Fully immunized children, Nepal, 1996 to 2016.....	9
Figure 5: Fully immunized children by wealth quintiles, Nepal, 1996 to 2016.....	9
Figure 6: Demand satisfied for family planning, Nepal, 1996 to 2016.....	9
Figure 7: Demand satisfied for family planning by wealth quintiles, Nepal, 1996 to 2016.....	9
Figure 8: Concept for integrated health infrastructure development: infrastructure, human resources, and equipment.....	11
Figure 9 Composition of health budget allocated to Local Governments	36
Figure 10 Seven step planning process at the Local Level	37
Figure 11 Trend on government health spending as a percentage of GDP	44
Figure 12 Per capita government health spending.....	45
Figure 13 Health budget as a percentage of the national budget.....	45

Abbreviations

AIN	Association of INGOs in Nepal
AMR	Anti-Microbial Resistance
APP	Annual Procurement Plan
AWPB	Annual Workplan and Budget
BHS	Basic Health Services
BOR	Bid Opening Report
CAPP	Consolidated Annual Procurement Plans
CEO	Chief Executive Officer
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	Child Health Division
CHE	Current Health Expenditure
CHU	Community Health Unit
CLPIU	Central Level Project Implementation Unit
CMS	Contract Management System
CMSt	Central Medical Store
CSD	Curative Services Division
CSO	Civil Society Organisations
DDA	Department of Drug Administration
DFID	Department for International Development
DDG	Deputy Director General
DG	Director General
DHO	District Health Office
DoHS	Department of Health Services
DPHO	District Public Health Office
DUDBC	Department of Urban Development and Building Construction
eAWPB	Electronic AWPB
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partners
ENC	Emergency Nutrition Cluster
EWARS	Early Warning and Reporting System
FCGO	Financial Comptroller General's Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMIS	Financial Management Information System
FP	Family Planning
FY	Financial Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GIS	Geographic Information System
GoN	Government of Nepal

HEOC	Health Emergency Operation Centre
HIIS	Health Infrastructure Information System
HIQAA	Health Institutions Quality Assurance Authority
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resource for Health
ICB	International Competitive Bidding
ICT	Information and Communication Technology
IEC	Information, Education, and Communication
IFB	Invitation for Bid
IMNCI	Integrated Management of Childhood Illness
INGO	International Non-governmental Organisation
IP	Implementation Plan
JAR	Joint Annual Review
JICA	Japan International Corporation Agency
KfW	German Development Bank
KOICA	Korea International Cooperation Agency
LCD	Leprosy Control Division
LG	Local Government
LMBIS	Line Ministry Budgetary Information System
LMD	Logistics Management Division
LMIS	Logistics Management Information System
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MD	Management Division
mhGAP	Mental Health Gap Action Programme
MIS	Management Information System
MMR	Maternal mortality ratio
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoGA	Ministry of General Administration
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoUD	Ministry of Urban Development
MoWCSW	Ministry of Women, children and Social Welfare
MPDSR	Maternal and Perinatal Death Surveillance and Response
MPP	Master Procurement Plan
MRDT	Medical Response Deployment Team
MSS	Minimum service standards
NA	Not available
NCB	National Competitive Bidding
NDHS	Nepal Demographic and Health Survey
NHIDS	Nepal Health Infrastructure Development Standard 2074

NHFS	Nepal Health Facility Survey
NHP	National Health Policy
NHRC	Nepal Health Research Council
NHSP	Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy (2015-2020)
NHSS-IP	Nepal Health Sector Strategy Implementation Plan
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NMICS	Nepal Multiple Indicator Cluster Survey
NPC	National Planning Commission
NPHL	National Public Health Laboratory
NPR	Nepalese Rupees
NRH	Nutrition Rehabilitation Home
O&M	Organisation and Management
OAG	Office of the Auditor General
OC	Outcome
OCMC	One-Stop Crisis Management Centres
OOP	Out-of-pocket
OOPE	Out of Pocket Expenditure
OPMCM	Office of the Prime Minister and Council of Ministers
PAS	Procurement Audit System
PFM	Public Financial Management
PHAMED	Public Health Administration Monitoring and Evaluation Division
PHCC	Primary Health Care Centre
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PPMO	Public Procurement Monitoring Office
PRA	Procurement Risk Analysis
QAP	Quality Assurance Plan
RDQA	Routine Data Quality Assurance
RF	Results Framework
RHCC	Reproductive Health Coordinating Committee
RMP	Risk Mitigation Plan
RRT	Rapid Response Team
SA	Social Audit
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SHI	Social Health Insurance
SHP	Sub-Health Post
SHSDC	Social Health Security Development Board
SOP	Standard Operating Procedures
SSU	Social Service Units
SWAp	Sector-Wide Approach

TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
TB	Tuberculosis
TIMS	Training Management Information System
ToR	Terms of Reference
TSB	Technical Specification Bank
TWG	Technical Working Group
UrbHC	Urban Health Clinic
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States' Dollar
VDC	Village Development Committee
VAT	Value Added Tax
VfM	Value for Money
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Executive Summary

The Ministry of Health (MoH), Government of Nepal (GoN), developed the Nepal Health Sector Strategy (NHSS) in 2015 to guide the health sector for the five year period considering the unitary system of government. The NHSS has nine outcomes measured through 29 outcome level indicators and 26 outputs with 56 corresponding output level indicators. This annual report intended for Joint Annual Review (JAR) summarises the activities carried out in FY 2016/17 under the nine outcomes and provides highlights of FY 2017/18 along with existing challenges and the way forward.

Federalism has brought tremendous changes to Nepal which will have implications concerning the implementation of the NHSS in the coming years. The constitution has defined the governance structure and functions mandating the local levels to deliver the package of basic health services. The development of standards and policies, management of hospitals, regulation of medicines, addressing the outbreaks and disasters, and international cooperation will remain with the federal and provincial governments. The federal government will also play a supporting role in enhancing the capacity of local and provincial government.

The fundamental changes at the national level which have impacted the implementation of the NHSS were:

- Restructuring of the government at three levels: federal, provincial, and local
- Functional analysis and assignments which define the responsibilities of the federal, provincial, and local levels
- Allocation of the health budget to local governments, amounting about 36% of the total health budget

In order to progress with federalism, various transitional activities are being executed by the MoH; the following are the major ones:

- Establishment of a Federalism Implementation Unit at the MoH
- Deputation of health workers to the Local Governments
- Drafting of the governance structure for the health sector and submitting it to the Ministry of General Administration (MoGA)
- Handing over of local health facilities to local level government

Major achievements in 2016/17

- Drafting of the National Health Act
- Drafting of the Health Institution Quality Assurance Authority Act (HIQAA)
- Endorsement of the eHealth Strategy 2017-2020
- Formation of Project Coordination Unit for post-earthquake reconstruction of health facilities
- Development of the Nepal Health Infrastructure Development Standards 2074 (2017)
- Of the 367 units of health facilities selected for repair and reconstruction, 276 have been completed
- Codification of drugs and equipment and restructuring of the Technical Specification Bank
- Endorsement of National Strategy on Reaching the Unreached
- Geriatric services available in eight referral hospitals
- Revitalisation of Nepal Drugs Limited
- Revision of Financial Management Improvement Plan
- Initiation of risk-based post marketing surveillance of medicines
- Development of guidelines for establishing hospitals up to 25 beds
- Implementation of social audit in 1752 health facilities across 70 districts
- Updating of the guidelines for disaster and epidemic management

Highlights of 2017/18

- Promulgation of Social Health Insurance Act
- MoH drafted the New National Health Policy and submitted to the Cabinet for approval
- Stocktaking of various documents (standards, protocols and guidelines) for updating in federal context
- Procurement Improvement Plan (PIP) for FY 2016/17-2020/21 is prepared and proposed for endorsement
- Handing over of health facilities (HP, PHCC, CHU, UHC and Ayurvedic Clinics) to Local Governments
- Dissemination of the Nepal Demographic and Health Survey 2016
- Expansion of health insurance in 25 districts with Health insurance coverage increased to around 5% of the catchment population
- Annual Performance Review by DoHS conducted with changed modality focusing on federal structure
- Reorganisation of the reporting system considering the role of the local government

The vision of the NHSS “*All Nepali citizens have productive and quality lives with highest level of physical, mental, social, and emotional health*” and the mission “*Ensure citizen’s fundamental rights to stay healthy by utilising available resources optimally and through strategic cooperation between service providers, service users, and other stakeholders*” continue to remain valid in the changed context. The four strategic directions for Universal Health Coverage (UHC) are equally important, however, these need to be incorporated into various tiers of government for effectiveness. As the NHSS remains the key document for the health sector, it will be followed. However, necessary adjustments to the NHSS’s implementation plan could be made to suit to the changed context. Similarly, some of the priority activities for the MoH are as follows:

- Establish health as a priority for the local governments and ensure the continuation of health services
- Capacity development of provincial and local governments to implement various health activities
- Develop various standards and legal framework in health as mandated by the Constitution
- Institutionalise the quality assurance mechanism in health
- Work with natural resources and fiscal commission and other ministries to ensure adequate financial allocation and accountability, including the expansion of the Transaction Accounting and Budget Control System (TABUCS)
- Develop engagement modality in health for development partners and other stakeholders in the federal context
- Preposition essential lifesaving medicines and supplies in strategic locations to address outbreaks and disasters

1 Introduction

1.1 Background

The Ministry of Health (MoH) of Nepal developed the Nepal Health Sector Strategy (NHSS) in 2015 to guide the country for the following five years in the health sector. The NHSS has an overall thrust of universal health coverage with four strategic areas of direction: equitable access, quality health services, health systems reform, and a multi-sectoral approach. The strategy explicitly states its ambition for the progressive expansion of health packages and services with continuous improvement in quality of care being delivered, making these services more affordable, and covering the larger population in need- especially the vulnerable and poor. Towards this end, the NHSS has defined nine outcomes and 28 outputs which encapsulate the different components of the health system. In accordance with the NHSS, the MoH has developed an Implementation Plan which provides a broad list of interventions to be implemented in the five year period.



A Joint Annual Review (JAR) has been held every year since the implementation of the Nepal Health Sector Strategy (2004). This review is jointly organised by the MoH and the External Development Partners (EDPs) to support the health sector. At the JAR meeting, the achievements of the last fiscal year are reviewed and major action points are identified for the next fiscal year. During the JAR, support from donors and other EDPs is also discussed. This is also supplemented by the signing of an “aide memoire”, which directs more specific action points for the topics agreed on by the representatives at the JAR meeting. The fiscal year (FY) 2016/17 was the first implementation year of the NHSS, 2015-2020 plan. The report is thus developed in light of the proposed interventions by the NHSS and in its Implementation Plan (IP) towards achieving the stated goals, objectives, and targets of the NHSS. Accordingly, major achievements made during FY 2016/17, highlights of FY 2017/18, existing challenges, and the way forward are captured in this report. The report also presents progress made against NHSS indicators as defined in the results framework.

Nepal has made a big transition towards federalism. Accordingly, elections for the three tiers (Federal, Provincial, and Local) have taken place, many previous laws and procedures have been changed, and budget allocation will be entirely changed in the future to comply with the spirit of the Constitution. The following actions have been taken to transition towards federalism:

- The functional analysis and assignments endorsed by the government which define functions at the federal, provincial, and local level
- Allocation of health budget to local governments, amounting about 36% of the total health budget
- Handing over of health facilities to Local Governments (LGs)
- Deputation of health workers to the LGs

- Reporting system in the health sector reorganised considering the role of LGs
- Governance structure for the health sector prepared as per the federal structure and submitted to the MoGA
- Annual Reviews of the health sector conducted as per the federal structure (local, provincial, and federal)
- Orientation package for LGs (elected members and health workers) developed for their capacity development in the changed context

The Sustainable Development Goals (SDG) emphasise achieving UHC by “ensuring that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of *sufficient quality* to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”. The World Health Organization (WHO) also recommends that improvement in the quality of health care be entry point for health system strengthening, and ultimately for achieving enhanced health of the population.

Amongst the numerous international commitments to improve the quality of health care, the GoN, through its Constitutional mandate of 2015, reaffirmed its commitment to providing quality health care to all. The JAR of 2017 agreed on some key actions which were reflected in the aide memoire, jointly signed by the Secretary of Health and the Chairperson of the EDP Forum. The following table shows the progress made towards the action points mentioned in the aide memoire.

1.2 Status of Aide Memoire

Table 1: Achievement of 2017 Aide Memoire points

S.N.	Agreed Actions	Current Status
1	A combined National Annual Review (NAR) and JAR process will be held by first half of November each year and the MoH will announce the dates at least one month prior to the review to all participants	Considering the federal context and with the objective of the national review feeding to the planning of next fiscal year, unlike previous years, the provincial and national review NAR took place in September 2017. However, the JAR could not take place due to elections at various levels during the last quarter of 2017.
2	The MoH will undertake rigorous stakeholder consultations and finalise the draft of the acts (Public Health Act and Social Health Insurance Act) by the end of October 2017	The Social Health Insurance Act has been enacted. The National Health Act has been drafted and sent to the Ministry of Law and Justice for further processing.
3	Public Health Administration Monitoring and Evaluation Division (PHAMED) in coordination with WHO, USAID, UNFPA, UNICEF, and DFID/NHSSP will develop a ten year survey plan by July 2017.	The process has been initiated and discussions were held. Outlines are prepared. However, bearing in mind the data needs of the three governance structures and the health related SDGs (15 year period) the MoH is preparing the overall health sector Monitoring and Evaluation (M&E) plan including the survey plan for 2030.
4	The MoH in consultation with its departments, centres, and divisions will	Discussions were held in this respect. However, keeping in view the changed context, further

S.N.	Agreed Actions	Current Status
	identify technical assistance (TA) needs and request the partners for support by September 15, 2017.	discussions are needed for adjusting to various tiers of government.
5	Development Partners will provide their TA commitments in the Combined Annual Review (CAR) process in November of each year.	As the CAR did not take place (see SN 1 above) it is expected that development partners will provide their TA commitments in the JAR meeting (Jan 2018), EDPs have provided their Technical and Financial Assistance to the MoH for the next three years.
6	The MoH will endorse the eHealth strategy by the end of July 2017.	The eHealth Strategy has been endorsed. The document is available on the MoH's website (www.mohp.gov.np).
7	PHAMED will identify the budget for implementation of the strategy for the next AWPB FY 2017/18	The budget for the implementation of strategy has been identified and a total of NRS ten million has been allocated.
8	The Human Resource and Financial Management Division (HRFMD) at the MoH, with the assistance from DFID/NHSSP, will customise the eAWPB in TABUCS for alignment with NHSS-IP and NHSS-RF (results framework) by November 15, 2017.	Customisation of the eAWPB with TABUCS has been completed. Now, the MoH can produce brief budget analysis on this basis. However, it needs updating in changed context.
9	The MoH, in coordination with the relevant stakeholders, will develop a transition plan for the Federal Health Structure by December 30, 2017.	The proposed structure of the MoH has been submitted to the Office of the Prime Minister and Council of Ministers (OPMCM) and the High Level Committee for restructuring. In the Ministry, a "Federal Implementation Unit" has been created and is operational. An orientation package for the local levels has also been developed.
10	The MoH and the Ministry of Federal Affairs and Local Development (MoFALD) with support from USAID/H4L will identify the issues and scope of the collaborative framework and implementation in the federal context by July 2017.	Due to the changed context (the formation of LGs and their legal mandates), revisiting the present situation is important.
11	The Logistics Management Division (LMD) to review and update the 16 point procurement plan, identify gaps, and institutionalise the plans by ensuring adequate budget for next FY in AWPB 2017/18 and subsequent FYs.	Considering the 16 point plan, the MoH has taken a step forward and developed the Procurement Improvement Plan (PIP) which was endorsed in December 2017.
12	The MoH with support from the WHO and other relevant partners will facilitate the Department of Drug Administration (DDA) to fund and initiate construction and equipping of Bio-safety Level (BSL) III laboratory within National Medical Laboratory (NML) to enhance capacity to test Biological and bio-therapeutic products, by July 2019.	Budget has been allocated for the construction of the Laboratory for NML. There is a three year plan for construction and FY 2017/18 will be the first year for implementation.

S.N.	Agreed Actions	Current Status
13	The DDA, with support from WHO and other partners, will develop risk-based post marketing surveillance tools (including Inspector's Handbook) to improve the quality of medicines in the Nepalese market, by July 2018.	The DDA has prepared the necessary tools for this purpose and there is a plan to train the inspectors within this fiscal year.
14	The MoH/ Social Health Security Development Board (SHSDC) together with relevant EDPs will commit to continuing dialogue on interim approaches to ensure poor people's access to social health security schemes.	SHSDC has initiated enrolling the ultra-poor through government subsidy in the health insurance program in 13 districts where identification of the poor is done.
15	The MoH/SHSDC together with potential development partners will develop and execute a plan to improve quality of care in public health facilities.	A draft of Health Institution Quality Assurance Authority Act has been prepared and sent to the Ministry of Law and Justice for input.
16	The MoH/Management Division (MD) with United Nations Population Fund (UNFPA) and DFID/NHSSP will ensure incorporation and use of gender equality and social inclusion (GESI) checklist and/or provide guidance for analysis of existing evidence in the AWPB guiding framework	Developed GESI checklist based on MoH's GESI framework and Sectorial Perspectives on Gender and Social Inclusion Monograph (Volume II), joint publication of the WB, UKaid and ADB. Based on the same, MoH has been scaling up GESI targeted interventions and the revision of GESI strategy is proposed.
17	The MoH, with relevant development partners, will work together to accelerate the pace and quality of reconstruction of health facilities.	Reconstruction of earthquake damaged health facilities is ongoing. 544 health facilities are enrolled for reconstruction retrofitting.
18	The MoH will take forward the proposed Central Level Project Implementation Unit (CLPIU) for post-earthquake and non-earthquake health reconstruction for better coordination and collaboration with partners based on established guidelines.	CLPIU, renamed the Project Coordination Unit (PCU) has been formed, staffed, and is functional. It is closely working with NRA, Ministry of Urban Development (MoUD), the Department of Urban Development and Building Construction (DUDBC), and international partners.

The next section of the report focuses on the result framework of the NHSS in which encompasses progress against goals, outcomes, and output level indicators. The rest of the sections of the report are in accordance to the NHSS outcomes and capture progress, challenges, and the way forward specific to those outcome areas.

2 NHSS Results Framework

2.1 Overview of progress

This section presents highlights of the progress against some tracer indicators. The latest results/progress against each indicator of the NHSS Results Framework is available on the MoH's website (www.mohp.gov.np). This web-based application also includes a graph of the trend data with a focus on equity between different population sub-groups, the metadata related to the indicators, and the NHSS output specific key interventions defined in the NHSS-IP by each MoH agency. This application allows the compilation and analysis of indicators alongside the key interventions that contribute to achieving the outputs and outcomes.

Table 9.2 shows the ten goal level indicators with their baseline data and achievements against the defined milestones for 2017 and the targets for 2020.

Table 2: NHSS Results Framework goal level indicators

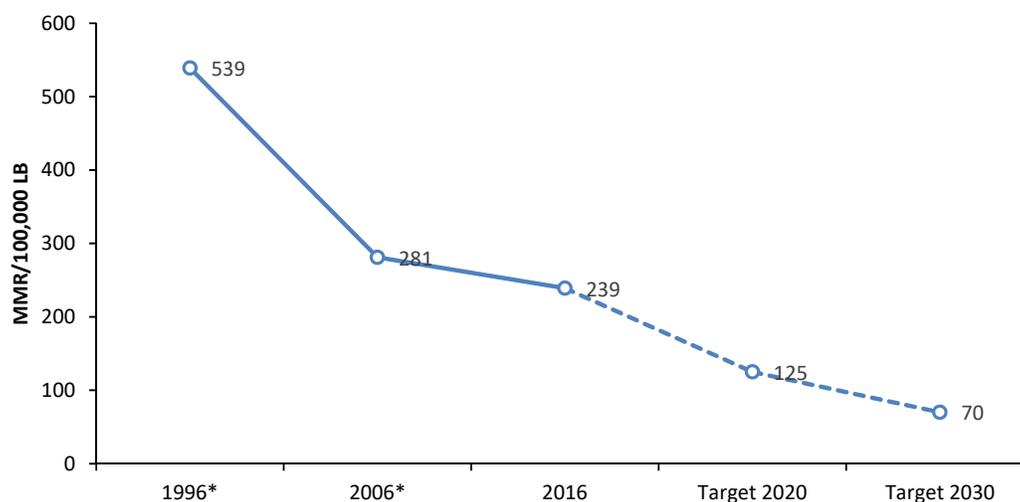
Code	Indicators	Baseline			2016/17			2020/21
		Data	Year	Source	Target	Achievement*	Source	Target
G1	Maternal mortality ratio (per 100,000 live births)	190	2013	WHO	148	239	NDHS 2016	125
G2	Under five mortality rate (per 1,000 live births)	38	2014	NMICS	34	39	NDHS 2016	28
G3	Neonatal mortality rate (per 1,000 live births)	23	2014	NMICS	21	21	NDHS 2016	17.5
G4	Total fertility rate (births per 1,000 women aged 15-19 years)	2.3	2014	NMICS	2.2	2.3	NDHS 2016	2.1
G5	% of children under-5 years who are stunted	37.4	2014	NMICS	34	35.8	NDHS 2016	31
G6	% of women aged 15-49 years with body mass index less than 18.5	18.2	2011	NMICS	13	17.3	NDHS 2016	12
G7	Lives lost due to road traffic accidents per 100,000 population	34	2013	Nepal Police	23	7.1	Police Mirror 2016; CBS population projection 2016	17
G8	Suicide rate per 100,000 population	16.5	2014	Nepal Police	15	17.8	Police Mirror 2016; CBS population projection 2016	14.5

Code	Indicators	Baseline			2016/17			2020/21
		Data	Year	Source	Target	Achievement*	Source	Target
G9	Disability adjusted life years lost due to communicable, maternal and neonatal, non-communicable diseases, and injuries	8,319,695	2013	BoD, IHME	7,487,726	9,228,540	GBD Study 2016	6,738,953
G10	Incidence of impoverishment due to out-of-pocket expenditure in health	na	2011	NLSS	20	na	NLSS	Reduce by 20%

Refer to full NHSS Results Framework for means of verification of the targets and required data disaggregation

**Achievement against target- Green: 100%; Yellow: >50%; Red: <50%*

The health sector in Nepal has witnessed an improvement in overall health outcomes of the people over last two decades. The Maternal Mortality Ratio (MMR) of 539 per 100,000 live births in 1996 has declined to 239 in 2016¹ (Figure 1.1). However, this is far behind the 2017 target of reaching 148. Nepal aims to reduce the MMR further to 125 by 2020 and 70 by 2030, in line with the SDG global targets. Realising the importance of having a reliable source of data to estimate the MMR, the MoH has been giving priority to strengthening and expanding the maternal and perinatal death surveillance and response system (MPDSR).



*MMR has been measured using pregnancy related deaths

Source: Data for 1996 from Nepal Health Facility Survey (NHFS), rest of the data from succeeding Nepal Demographic and Health Survey (NDHS)

Figure 1: Maternal mortality ratio

¹ The NDHS measures maternal mortality rate (MMR) every ten years. NFHS 1996 and NDHS 2006 measured pregnancy-related deaths per 100,000 live births for the seven year period before the survey whereas NDHS 2016 also monitors the maternal mortality ratio.

There has been a large decline in child mortality over the last five years. The latest data from the Nepal Demographic Health Survey (NDHS) 2016 shows under-five mortality rate at 39 per 1,000 live births and neonatal mortality at 21 per 1,000 live births. The under-five mortality rate has increased slightly compared to the 2014 figure of 38 per 1,000 live births. However, it should be noted that 2014 measurements are from the Nepal Multiple Indicator Cluster Survey (NMICS) while the rest of the figures are from the NDHS. The NHSS targets are to reduce under-five mortality to 34 per 1,000 live births by 2017 and 28 per 1,000 live births by 2020 and to reduce neonatal mortality to 21 per 1,000 live births by 2017 and to 17.5 per 1,000 live births by 2020.

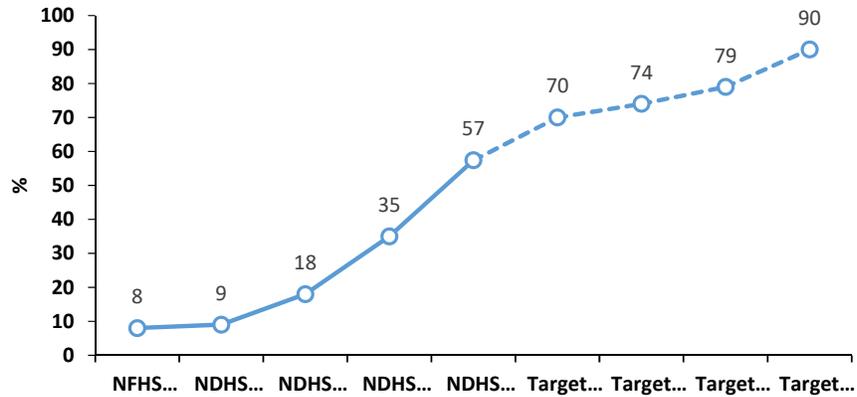
The under-five mortality rate (U5MR) at the national level in 2016 (NDHS) compared to 2014 (NMICS) and the gap between the highest and the lowest quintile population sub-groups has increased. Both U5MR and NMR increased among the poorest quintile from 54 and 29 deaths per 1000 live births in 2014 to 62 and 36 in 2016 (NDHS) respectively. Similarly, both U5MR (32 to 49) and NMR (21 to 28) increased in the Terai.

Overall, the nutritional status of children (stunting) has improved. The percentage of children under five years who are stunted (% below -2SD) has declined from 40.5% in 2011 (NDHS) to 37.4% in 2014 (NMICS) and to 35.8% in 2016 (NDHS). However, these data should be interpreted cautiously as 2014 measurements are from the NMICS while the rest of the figures are from the NDHS. The equity gap in the nutritional status of children (stunting) between the highest and lowest quintiles declined from 39.5% in 2014 to 32.7% points in 2016, however, the gap is still unacceptably high. Stunting has slightly increased among children of mountain and Terai areas and declined amongst children of hill areas, resulting in increased gaps between hilly areas and mountain/Terai from 11% to 14.5% points in the same period.

2.2 Progress against outcome and output level indicators

The Results Framework has 29 outcome level indicators to monitor the achievement of NHSS's nine outcomes. The NHSS has 2017 and 2020 targets for these indicators. This section presents progress of some of the outcome level indicators in 2016/17. Indicator-wise progress is available in <http://www.mohp.gov.np/content/statistics>.

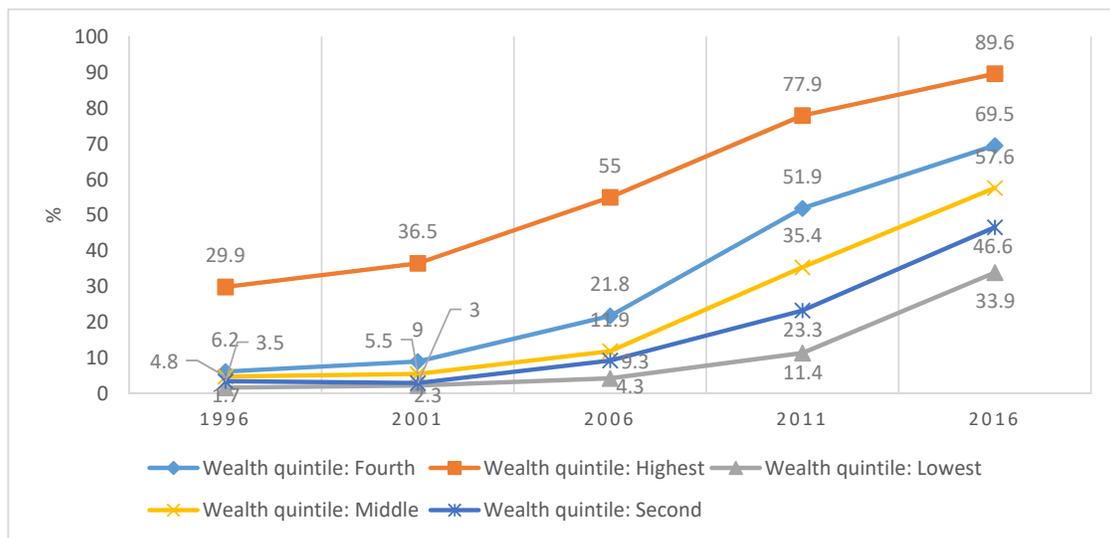
Institutional delivery: There has been large improvement in the proportion of women delivering at health institutions (Figure 9.2). The proportion of women delivering at health institutions increased from 8% in 1996 (NFHS) to 57% in 2016 (NDHS). However, there is a wide variation between different population sub-groups with only 34% of lowest quintile women delivering in health facilities compared to 90% of highest quintile women (NDHS 2016) (Figure 9.3). The Health Management Information System (HMIS), 2016/17, also reports 56% of women delivering in health facilities. NHSS's target is to reach 70% by 2020 with the focus on reducing the equity gap between sub-groups.



Source: Data for 1996 from NHFS, rest of the data from succeeding NDHS

Figure 2: Institutional deliveries, Nepal, 1996 to 2030 (NHSS RF: OC3.3)

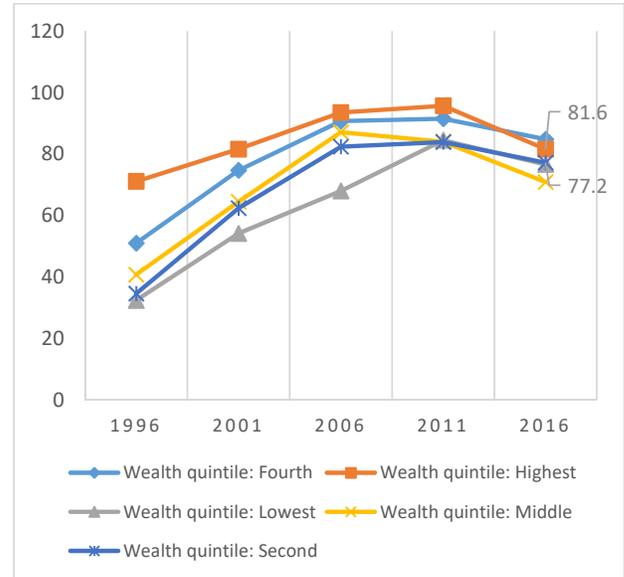
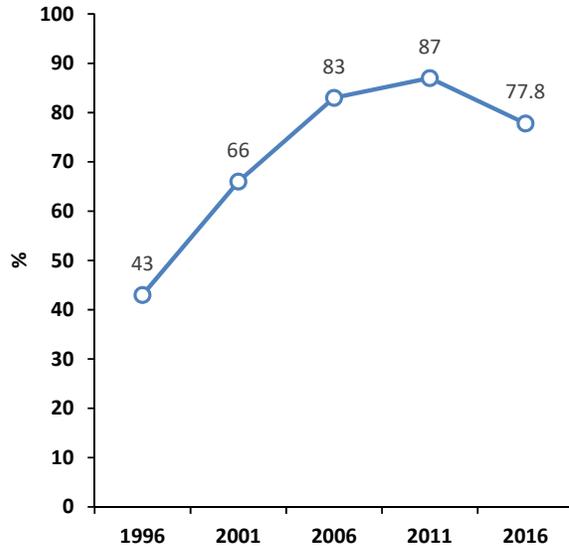
Although the equity gap in institutional delivery has decreased from 63% in 2014 to 56% in 2016 between the highest and lowest quintile, it is still unacceptably high (Figure 3). Institutional deliveries increased in mountain (32% to 42%) and hilly districts (55% to 61%) but declined in Terai districts (59% to 57%). The institutional delivery rate is the lowest in province numbers 2 and 6.



Source: Data for 1996 from NHFS, rest of the data from succeeding NDHS

Figure 3: Institutional deliveries by wealth quintiles, Nepal, 1996 to 2016

Fully immunisation: The percentage of children aged 12-23 months who had received all eight basic vaccinations has decreased from 87% in 2011 to 78% in 2016 (Figure 9.4). The equity gap has reduced from 11.2 in 2011 to 4.4 percentage points in 2016 (Figure 9.5).

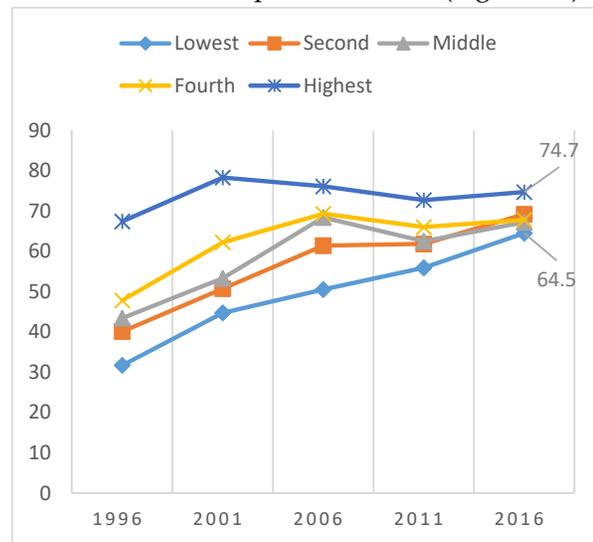
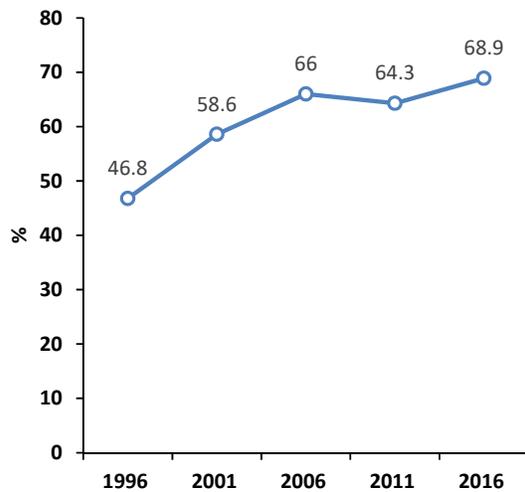


Source: Data for 1996 from NHFS, rest of the data from succeeding NDHS

Figure 4: Fully immunized children, Nepal, 1996 to 2016

Figure 5: Fully immunized children by wealth quintiles, Nepal, 1996 to 2016

Demand satisfied for family planning: The percentage of demand satisfied for family planning among currently married women has increased from 64.3% in 2011 to 68.9% in 2016 (Figure 1.6). The equity gap has reduced from 16.8 in 2011 to 10.2 percent in 2016 (Figure 1.7).



Source: Data for 1996 from NHFS, rest of the data from succeeding NDHS

Figure 6: Demand satisfied for family planning, Nepal, 1996 to 2016

Figure 7: Demand satisfied for family planning by wealth quintiles, Nepal, 1996 to 2016

There are 56 output level indicators to monitor the 26 NHSS outputs with annual milestones and 2020 targets. Indicator-wise progress is available in <http://www.mo hp.gov.np/content/statistics>.

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

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

3.1 Outcome 1.a: Infrastructure

Background

The NHSS states to develop a master plan to guide the building of earthquake resilient infrastructures, revising standards, managing inventories, and routine maintenance. There are three outputs under this sub-heading as follows:

- Health infrastructure developed as per plan and standards
- Damaged health facilities are rebuilt
- Improved management of health infrastructure

Adequate and appropriate infrastructure with good management has been a priority for the MoH since NHSP 1 and the priority continues with more emphasis on multi hazard resilient health infrastructure and an integrated approach to health infrastructure development in the context of the current federal structure of the nation. In this way, the MoH has already initiated the process of institutionalising evidence based planning for the construction, operation, and maintenance of health infrastructure in the federal context. It concentrates on facilitating the development of health facilities that will withstand future environmental shocks and natural disasters, and encourages the maintenance and management of such improvements to continue their effectiveness and economic value.

Appropriate and clear policies, strategies, plans, standards, and guidelines have been developed, updated, and used and further updating and upgrading has been initiated to develop multi hazard resilient health infrastructure. While the MoH obviously has the prime responsibility for developing policy and regulations for health infrastructure, the DUDBC is a significant partner and key delivery agent for the development and maintenance of health facilities. Therefore, the MoH will consult and work closely with the DUDBC in implementing its health infrastructure development initiatives.

The reconstruction, retrofitting, repair, and maintenance of health facilities damaged by the 2015 earthquake is also a priority of the GoN during the NHSS period. Learning from the experience of the earthquake, the MoH is also committed to adopting policies and practices that are more suitable to develop multi hazard resilient health infrastructure and also adopting principle of preventive measures through retrofitting of health infrastructure and

preparing a multi-hazard disaster response plan during NHSP3. Hospitals and health facilities are critical elements of the state’s emergency and recovery response to earthquakes and other disasters. Hospitals and health facility buildings not only have to protect occupants and medical staff, they need to remain functional in the post-disaster context to provide healthcare to casualties and act as a focus for humanitarian activities.

Major Progress

Development of Nepal Health Infrastructure Development Standards 2074 (2017)

- The MoH has adopted the Nepal Health Infrastructure Development Standard 2074 (NHIDS), which details the provision of all three components of the health infrastructure framework- physical infrastructure, human resources, and equipment. The Cabinet has already endorsed this document.
- The NHIDS forms the basis for rational planning for establishing and upgrading of health institutions on the basis of such factors as accessibility, catchment population, geography, availability of suitable land, condition of existing or nearby facilities and morbidity statistics and thereby, reducing haphazard construction of new or upgrading of existing facilities. An important departure from the past, this standard classifies health institutions according to health services, as opposed to number of beds (see

Figure Classification of Health Facilities and Development of Standard Designs

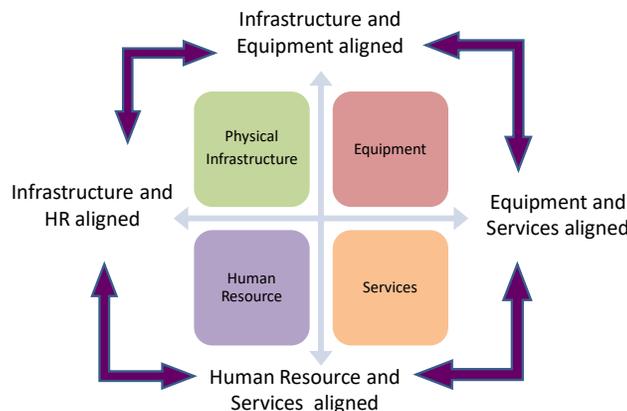


Figure 8: Concept for integrated health infrastructure development: infrastructure, human resources, and equipment

- To complement the NHIDS, health institutions have been classified into five levels based on a minimum set of health services:
 1. Community level (Health Posts or Community Health Units)
 2. Primary Hospitals
 3. Secondary Hospitals
 4. Tertiary Hospitals

5. Academic or Super-specialty hospitals

- Catchment population and geography (accessibility, linkage analysis, and transportation) form the basis for assigning the number of beds and identifying the required number of health workers. Standard drawings for each type of health institution have been developed to facilitate the delivery of quality health services.
- Using the Geographic Information System (GIS) component of the Health Infrastructure Information System (HIIS), the required level of service and existing condition of each facility in each new local authority was analysed against the new standards and projected service levels. Combined with current reconstruction and rehabilitation works (where appropriate), standard designs for different levels of health facility, and capital cost estimates for each facility were estimated to produce a seven year construction programme, named the Integrated Health Infrastructure Development Project (IHIDP). All of the above information was amalgamated to give a dataset for each of the seven new provinces.
- The MoH's IHIDP sets out a seven-year programme to meet the new standards and improved coverage required for the health infrastructure network under the federal system. While this programme proposes a pre-specified list of services for each level of health facility, the situation at each facility and at each level of government needs to be analysed.

Reconstruction and Recovery Activities

Progress in construction of health facilities through EDPs

- A total of 367 repair and reconstruction activities worth about 7.5 billion NPR was signed off by the GoN and EDPs. Out of the total, 276 have been completed and 91 are still under construction. A summary of progress made is presented below in Table 1.

Table 3: Progress against MoU for repair and reconstruction through different EDPs

Districts	Total number of MoUs	Completed	Ongoing	Type of Construction			Semi-Permanent & Shelter
				Permanent	Prefab	Repair/Retrofitting	
Bhaktapur	3	3		0	3	0	0
Dhading	49	41	8	2	34	13	0
Dolakha	46	36	10	1	38	5	2
Gorkha	56	52	4	1	37	3	15
Kathmandu	5	2	3	3	2	0	0
Kavrepalanchowk	37	13	24	5	30	2	0
Lalitpur	7	7		0	7	0	0
Makwanpur	9	7	2	1	8	0	0
Nuwakot	48	34	14	1	42	1	4
Okhaldhunga	7	3	4	0	7	0	0

Ramechhap	16	10	6	1	14	0	1
Rasuwa	18	17	1	1	13	3	1
Sindhupalchowk	60	49	11	2	31	5	22
Sindhuli	0	0	0	0	0	0	0
Solukhumbu	6	2	4	0	6	0	0
Grand Total	367	276	91	18	272	32	45

Note:

1. Solukhumbu belongs to the category of Earthquake Medium Affected District but many health facilities were damaged
2. Sindhuli despite being within the hard hit district was not selected by any EDPs for any reconstruction/recovery activity

Table 4 : Progress against agreement with bilateral agencies

Agency	Work description	Progress
JICA	Bir Hospital, Paropakar Maternity Hospital, and Ampipal Hospital	Construction underway in Bir Hospital and Paropakar Maternity Hospital (to be finished by February 2019), Design for Ampipal hospital ongoing.
KOICA	Nuwakot District Hospital and prefab structures at ten health posts	Ongoing
KFW	Reconstruction of Rasuwa, Dolakha, Gorkha, and Ramechhap district hospitals	Ongoing
DFID	Health facilities in Sindhupalchok, Ramechhap, and Dolakha	Completed Repair / Retrofitting and Prefab construction
USAID	Bahrabise PHCC	Ongoing
CHINA	Chautara and Manang hospitals	Preparatory survey completed

Damage Assessment of Health facilities

- The information collected as a part of the Post Disaster Need Assessment (PDNA) was deemed not enough to plan for the reconstruction/repair/rehabilitation of the health facilities in the affected districts. This is because detailed engineering information was required to plan the next steps for infrastructure support, which would mean that each facility would need to be visited and assessed by a trained technical person. Such a Detailed Engineering Assessment for 14 severely affected districts was executed in 2015. A similar type of intervention was deemed necessary to prepare a plan for reconstruction activities for 17 medium affected districts. A detailed engineering assessment of 17 districts with the technical and financial support of the NHSSP was initiated from December 1 2016 to February 1 2017. GIZ also supported the process with its technical and logistics support. The data of this assessment has been uploaded into the web-based system which can be accessed from the link www.nhsp.org.np
- The major findings of the assessment are presented in the table below. A separate document with analysis is also being prepared with support from the NHSSP, which will be very important to the MoH for considering health facilities to be reconstructed or

retrofitted in 17 medium affected districts as a preventive measure against the next possible disaster.

Table 5: Status of health facilities of 17 earthquake affected districts

S.N	Description	Number of Building Blocks
1	Health Facilities that do not own land/building	116
2	Building blocks of health facilities that need reconstruction	358
3	Building blocks of Health facilities that need retrofitting	533
4	Building blocks of Health facilities that need to be repaired	97
5	Building blocks that were not damaged during the earthquake but do not comply with seismic standards and are vulnerable for the next major earthquake in the area (high intensity as in the 14 district)	621
	Total	1725

Table 6: Health facilities without basic services (electricity, water supply, and road access)

Districts	Without Electricity Connection	Without water supply system	Without roads connection	Without basic services (electricity, water supply, and road access)
Arghakhanchi	3	4	0	0
Baglung	1	5	12	0
Bhojpur	46	6	7	1
Chitawan	6	3	3	0
Dhankuta	3	4	0	0
Gulmi	13	13	3	2
Kaski	0	3	4	0
Khotang	36	15	26	4
Lamjung	13	12	19	3
Myagdi	7	1	11	0
Nawalparasi	11	10	0	0
Palpa	26	15	1	0
Parbat	4	6	4	1
Sankhuwasabha	13	2	20	1
Solukhumbu	13	5	22	2
Syangja	9	11	1	0
Tanahu	7	7	6	1
Grand Total	211	122	139	15

Formation of Project Coordination Unit (PCU)

- The MoH has established a PCU for reconstruction and recovery work. Its staff members have been oriented on health infrastructure development process and exposure has been provided to different health facility sites. With the limited size of technical staff members

and limited support from other agencies, the PCU has not been able to achieve the envisaged speed for the reconstruction work.

Retrofitting of two Major Hospital

- As planned in the AWPB, the MoH is moving forward for the retrofitting of two major hospitals with technical and financial support from DFID. The MoH selected the two hospitals based on agreed prioritisation criteria. The technical viability of the retrofitting, its values for money and other technicalities involved in the process is yet to be confirmed, this process of conformity will be led by the DUDBC in conjunction with the MoH's Infrastructure Development Technical Team supporting the retrofitting process. As for the technical part, so far different types of testing (destructive and non-destructive material testing and geo-technical investigation) have been completed and building assessments were also conducted with technical support from the NHSSP together with DUDBC and PCU (MoH) personnel as part of capacity enhancement technical support. A retrofitting dissemination and sharing programme was also organised in Pokhara and Kathmandu.
- Site surveys have been conducted, drawings of all the existing blocks have been prepared, and a consultation has been carried out with the stakeholders on functional retrofitting requirements and solutions. Bidding designs, estimates, and bidding documents have been prepared for the decanting strategy. The strategy for equipment decanting and the reinstallation process is also under study. The retrofitting involves three types of interventions, which are as follows:
 - Structural Retrofitting
 - Non-structural Retrofitting
 - Functional retrofitting
- Following a rigorous and systematic review process, the Western Regional Hospital (Pokhara) and Bhaktapur District Hospital (Bhaktapur) were selected in a joint session with the MoH, DUDBC, and DFID for retrofitting and rehabilitation works. The selection was formally confirmed and recorded in an agreement made between the MoH and DFID for retrofitting and rehabilitation works.

Regular Construction Activity

Progress in Construction through the DUDBC

- Improvement in the completion rate of building construction of health facilities through the DUDBC relative to earlier years has been observed. While in the year 2015/26, out of 676 projects 131 were completed, in the year 2016/17 out of 704 projects, 228 have been completed (Table 5). In addition, the number of sick projects are reducing in large numbers. The reduction of sick projects has, in part, been achieved by continuous follow-ups by the DUDBC with initiating actions and penalties against the contractors delaying work or non-complying with the standard working procedures and specifications. However, the DUDBC still needs to make more follow-ups on sick projects that have been

ongoing for many years. Priority must be given to scrutinising the issues of individual projects to resolve them as soon as possible.

Table 7: Progress status of ongoing health infrastructure construction

Progress Status	Carried over the previous years before 2016/17	Works planned in fiscal year 2016/17
Work Completed	228	-
Work up to Finishing, Electrification, Sanitation	166	1
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	54	1
Work up to RCC in First Floor/Roofing	66	3
Work up to Sill Level/Wall of Third Floor	1	7
Work up to Sill Level/Wall of Second Floor	45	1
Work up to Sill Level/Wall of First Floor	46	1
Work up to Foundation/DPC Level	35	73
Work Ordered	23	200
Tender Called	5	34
Design and Cost Estimate	25	27
	704	348
Total of Ongoing and new Projects	1052	

Note: The status of the projects that have been authorised by the MoH to the DUDBC for the fiscal year 2017/18 (2074/75) has not been reported since the authorisation this year was delayed significantly due to different unavoidable circumstances. A total 258 projects have been authorised this fiscal year to the DUDBC.

Development of policy/standard and capacity enhancement

- One of the priority of MoH is to develop the policy/ standards on health infrastructure and to implement the capacity enhancement activities for the development of multi-hazard resilient health infrastructure. In this context, gaps are identified on existing policy/standards on health infrastructure. Under the programme and with support from DFID, the MoH has initiated the process of developing standards on Health Infrastructure Seismic Retrofitting Standards in conjunction with the DUDBC. The process will be led by the DUDBC with support from the NHSSP. A national level workshop with national and international experts was recently organised to decide on a way forward to get the standards prepared that meet international standards.
- The MoH, with support from the NHSSP, also prepared the Earthquake Performance Appraisal Report, which elaborates an overview of Disaster Risk Reduction (DRR) activities and policies concerning the MoH. In addition, the Climate Change and Health Infrastructures Framework, a road map document, was also prepared.

- The MoH has conducted a Training Needs Assessment (TNA) with support given by the NHSSP to the MoH, DUDBC, and other private stakeholder officials and representatives for building an enabling environment for the development of multi-hazard resilient health infrastructure. A list of essential training needs for the health infrastructure development sector has also been formalised. The Health infrastructure Policy Development Workshop as routed by the TNA was completed recently in November 2017 participated in by major stakeholders.

Major Challenges

- No systematic mechanism to retain institutional memory when concerned staff are transferred
- Institutional structure and functions of the MoH and DUDBC remain uncertain in the federal context
- The capacity and willingness of the LGs to adopt standard practices for infrastructure and adhere to quality compliance
- Incomplete HIIS database (updated for 31 districts only) causing difficulty in assessing the vulnerability of all the health facilities spread across the nation, including its impact on preparing realistic disaster response plan (mitigation and preparedness)
- No clarity on the role of federal, provincial, or local government in developing the health infrastructure

Way Forward

- Orientation to stakeholders at the local level on the Health Infrastructure development process, existing codes, standards, by-laws, and other relevant policies
- Preparing the MoH for direct involvement at the local level with regard to health facility construction as the roles and responsibilities of the DUDBC in the federal context are not clear
- Development of regular update mechanisms for the continual updating of the HIIS database to reflect the current state of infrastructure and other statuses relating to the health facilities of Nepal
- Execution of analysis for different contexts including repair, reconstruction and upgrading, disaster risk reduction, and climate change induced hazard mitigation for health facilities

3.2 Outcome 1.b- Human Resources for Health

Background

To gear up for the delivery of quality health services, focus is given to strengthening the production, deployment, and retention of human resources as reflected in the following two outputs of NHSS regarding HRH:

- Improved availability of human resources at all levels with a focus on rural retention and enrolment

- Improved medical and public health education and competency

Delivering quality health services requires the availability of a skilled health workforce. The National Health Policy 2014 and NHSS recognise the importance of planning, producing, retaining, and developing skilled human resources to deliver affordable and effective health services.

The management of HRH in Nepal is informed by policies and principles of public service management: the Nepal Civil Service Act 1992, Nepal Civil Service Regulations 1993, Nepal Health Service Act 1997, Nepal Health Service Regulations 1999, Health Worker and Health Institution Security Act 2010, and the Health Worker and Health Institution Security Regulations 2012. The recent Staff Adjustment Act has added a new dimension to this context.

Major Progress

The annual report of the DoHS for 2016/17 has highlighted the vacancy fulfilment rates (particularly for doctors in three provinces: 5, 6, and 7) as 44%, 45%, and 39% respectively compared to 2015/16 data that revealed that the availability of medical officers at the hospitals was only 36% (NHSS (2015-2020) OP1b1.1), indicating slight improvements but still a big challenge in retaining doctors particularly in rural parts of the country. On the other hand, data on the availability of nursing staff was found to be much better (99%) in province 7 compared to the other provinces, this could be related to the adequate local supply and effective recruitment process.

Regarding the availability of the health workforce in Nepal, the WHO global strategy for Nepal estimated needs of approximately six per 1,000 population factoring in all cadres (one medical doctor, two nursing staff, and three paramedics). In 2016, Nepal's health workforce availability (173,376) was estimated at 4.45 doctors (Professional Councils, HR registry data collected in 2017), nurses/midwives and paramedics, substantial progress against the values reported in 2012 captured total of 54,177 health workers employed in Nepal by the DoHS and in private hospitals, which illustrated a density of only 0.7 doctors and nursing workforce per 1000 population (NHSSP 2013: HRH assessment 2012 in Human Resources for Health Nepal Country Profile). The final draft of a Human Resources for Health Strategic Roadmap is being prepared with the support from the WHO this FY. A total of 5,417 Human resources for health were trained in FY 2016/17 by the National Health Training Centre (NHTC) (NHTC annual report 2073/74) as follows:

- Doctors- 1,000
- Nurses- 3,620
- Public Health Officers and other health professionals- 797

The NHTC maintains a record of all approved trainings undertaken by health workers within the government system (TIMS). The NHTC completed around 90% of their 072/073 training work plan.

Challenges

- Long process for recruitment; it usually takes about one year from the phase of deciding how many vacancies there are to the deployment process
- Retention of health workers remains a challenge, often due to a lack of a motivational packages (financial-non financial) for remote areas
- High prevalence of unregulated dual practice (The Britain Nepal Medical Trust [BNMT] 2014: A Desk Review Report: Key Issues, Challenges, and Gaps in Human Resources for Health in Nepal and Recommendations to the MoH and Development Partners for Action).
- Performance and productivity poorly matched with career opportunities and other benefits
- Unacceptable levels of absenteeism of skilled health care providers (Human Resources for Health Strategic Plan 2011-2015 final draft) mainly due to long duration of deputation (*Kaaj* and study leave), too many and too frequent in-service training programmes without proper linkages amongst them
- During this FY, the majority of the Comprehensive emergency obstetric and neonatal care (CEONC) hospitals are facing an acute shortage of skilled human resources particularly due to delays in local contracting by the municipal Palikas (Routine monitoring findings FHD/NHSSP).

Way Forward

- A fast recruitment process is expected once the provincial/local recruitment process is in place. The centre should play a stimulating role in fulfilling the existing vacant posts.
- Capacity development of provincial and local government to implement the HRH Strategic Roadmap
- Strengthen partnerships with academic health institutions and Council for Technical Education and Vocational Training to support HRH needs, particularly in rural and remote areas
- Develop a deployment strategy for MBBS and specialised doctors (MD, MS) graduated with government scholarship
- Develop an HRH retention strategy and guidelines (financial and non-financial package)
- Develop procedures for task-shifting
- Revise in-service training programmes in order to minimise absenteeism:
 - Implement e-Health Strategy for continuous health and medical education
 - Integrate all relevant short courses and harmonise training programmes
 - Scale up blended learning training approach and on the job training (OJT)
 - Initiate partnerships with professional councils to establish an accredited continuous professional development (CPD) systems in Nepal for systematic process of re-licensing
 - Produce distance-learning materials for health workers

3.3 Outcome 1.c Procurement and Supply Chain Management

Background

This sub-outcome of the NHSS envisions reforming the procurement and logistics systems for capacity enhancement in supply chain management and the implementation of innovative approaches. It has two outputs:

- Improved procurement system
- Improved supply chain management

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

Procurement management in the health sector consists of preparing and operating the Technical Specification Bank (TSB), Logistics Management Information System (LMIS), Inventory Management System (IMS), Annual Procurement Plan (APP), Master Procurement Plan (MPP), and the Consolidated Annual Procurement Plan (CAPP) and their effective implementation to ensure their timely delivery and the distribution of medical goods and equipment.

Major Progress

In the fiscal year 2016/17, the MoH has made good progress in improving the performance of procurement management. The following targets have been achieved:

- The formation of a nine member CAPP monitoring committee (CAPP-MC) under the chairmanship of the Director General (DG) of the DoHS, and the endorsement of the terms of reference (ToR) of the CAPP-MC
- The CAPP for medical goods and equipment and other services has been made within the specified timeframe
- The TSB was restructured
- The codification of drugs (108 Drugs) and equipment (1089 equipment) has been completed and uploaded in Logistics Management Division's (LMD's) website
- Two e-GP trainings in procurement were conducted at the central level
- Multi-year procurement is ongoing for specified medical items and is planned to expand to other items in coming years as well
- The Electronic Bidding System (e-GP-I) for the procurement of medical goods and equipment is well practiced and now progressing towards to electronic government procurement (e-GP-II) execution (3 bids) as well
- Standard Bidding Documents (SBDs) for health sector procurement (2 SBDs) have been drafted and sent for approval to Public Procurement Monitoring Office (PPMO)

The following tables summarise the overall procurement management function of last FY 2016/17 and FY 2017/18 in the DoHS.

Table 8 Analysis of CAPP with estimated budget (in million NPR)

SN	Division of DoHS	2016/17 CAPP Budget	2016/17 CAPP Actuals	2017/18 CAPP Budget	2017/18 CAPP Plan
1	Logistic Management Division (LMD)	1285.87	1285.87	165.00	162.05
2	Child Health Division (CHD)	881.92	566.82	500.00	472.19
3	Family Health Division (FHD)	912.65	236.22	380.00	368.54
4	Epidemiology & Disease Control Division (EDCD)	161.32	160.28	375.00	371.79
5	Management Division	69.20	43.66	70.00	68.52
6	Primary Health Service Revitalisation Division (PHCRD)	814.23	606.38	945.00	942.65
	Total	4125.19	2899.23	2435.00	2385.73

- **Use of the TSB:** Since FY 2017/18, the TSB have been scientifically restructured and mandatorily used by the DoHS and its all divisions.
- **Changing Cost Estimation practices:** Endorsements of all final rates are made within the cost estimates and approved by the DG of the DoHS within the agreed CAPP timeframe.
- **Cost savings in procurement expenditures:** In FY 2016/17, the total budget for procurement remains NPR 4201.98 million and out of this budget and programme, NPR 3427.47 is estimated as a procurement cost of the drugs and equipment. Whereas the LMD using open bid competition, the actual bid value remains NPR 2859.16 only and thus NPR 568.31 cost savings in procurement occurred. Compared to cost estimates, there have been savings of about 17%.

Table 9 Procurement expenditure analysis (in million NPR)

SN	Division of DoHS	2016/17 Budget	2016/17 Cost Estimates	2016/17 CAPP Actuals	Cost Savings
1	Logistic Management Division (LMD)	1415.40	1403.80	1285.87	117.93
2	Child Health Division (CHD)	881.92	943.74	819.17	124.57
3	Family Health Division (FHD)	912.65	730.51	655.51	75.00
4	EDCD	161.30	197.87	160.28	37.59
5	Management Division	69.20	53.85	43.66	10.19

6	Primary Health Service Revitalisation Division (PHCRD)	814.20	850.09	606.38	243.71
	Total	4201.98	3427.47	2859.16	568.31 16.58%

- **Approval of Bidding Documents:** The LMD has drafted two sets of SBDs for the procurement of drugs and equipment and has sent them to PPMO for approval.
- **Procurement Type and Modality:** The LMD/DoHS is using open, competitive, and transparent modality of bidding in practice. The open bid method is the most commonly used method (85.15%) in the DoHS for the procurement of drugs, medical equipment, hospital devices, contraceptives, cold chain equipment, insecticides, and other health facilities.

Table 10 Selection of procurement type and modality in FY 2016/17

S N	Procurement Type	Goods	Works	Consulting Services	Non-Consulting Services	Total no. of Contracts	% of modality used	% of total modality
	Procurement Modality							
1	Open Bid Method (ICB)	116	-	-	-	116	66.29	85.15
2	Open Bid Method (NCB)	28	3	2	-	33	18.86	
3	Sealed Quotation Method (SQ)	8	1	-	-	9	5.14	12.57
4	Catalogue Shopping (CS)	13	-	-	-	13	7.43	
5	Direct Purchase (DP)	3	-	-	-	3	1.71	1.71
6	Other Method	-	-	-	1	1	0.57	0.57
	Total	168	4	2	1	175	100	100
	Type of Procurement	96%	2.29%	1.14%	0.57%	175	100	100

As seen in the table above open bid method was most commonly used method (84.57%) for the procurement of drugs and equipment in FY 2016/17 which indicates towards openness, transparency, and competition in procurement is one of the indications of increasing VfM of health facility expenditures of the GoN.

Table 11 Selection of procurement modality by type of procurement

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

- **Bid Publication (IFB) and Public Bid Opening:** Almost all bids have been processed in a transparent and non-discriminatory way, given the wide range of time periods (30 days for NCB and 45 days in ICB) for bid preparation and submission in FY 2016/17.
- **Bid Evaluation and Approval:** All procurement of drugs and equipment had good timing of bid evaluation and approval in FY 2016/17. All ICB bids in the LMD are evaluated within the maximum period of 90 days of time and all NCB bids are evaluated within the maximum period of 35 days.
- **Contract Management practices:** The LMD has established a separate unit for contract management functions.

Challenges

- Poor linkages between technical specifications of drugs and equipment in preparing SBDs
- The existing LMIS is not comprehensive enough to inform the quantification and forecasting of drugs
- The limited capacity of the LMD to conduct market analysis, cost analysis, sourcing analysis, and Procurement Risk Analysis (PRA) for the procurement management system
- The slow pace of standardising the procurement process due to a lack of specific solicitations of bids and SBDs designed for the health sector
- Despite pre-bid information systems like the TSB and the LMIS, current practices on pre-bid information systems (TSB, LMIS, IMS, contract management) being in place, their implementation has not been very effective

- Delays in procurement due to the lack of effective post-bid information systems (Specific Procurement Audit System [PAS], Quality Assurance Plan [QAP], Risk Mitigation Plan [RMP] and Contract Management System [CMS])
- There is no function assigned to the federal government for the procurement of drugs in the functional assignments which might cause a big challenge in the future.
- Warehousing facilities in the medical stores are traditional and do not have enough human resources and designed space for the adoption of good warehousing practices
- Weak contract management capacity and practices have caused issues relating to liquidated damages charges, variations, extension of time, and non-timely delivery of drugs
- A weak Drug Disposal Management System is causing a pile-up of expired drugs in the CMS and RMS which are waiting for proper disposal

Way Forward

- Develop standard operating procedures (SOP) for the quantification, forecasting, and procurement of essential medicines and the disposal of expired drugs
- Increase the use of Information and Communication Technology through e-bidding and the e-GP system
- Strengthen pre- and post-bid information systems such as the LMIS, PAS, and CMS
- Professional and institutional capacity building with systematic provisions to retain institutional memory when staff are transferred
- Strengthen the supply chain management to ensure the timely availability of drugs and other medical supplies
- Establishment of a Procurement Clinic for strategic actions for troubleshooting
- Effective implementation of the Procurement Framework and culture to reduce interferences and irregularities

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

Background

The NHSS stresses a renewed focus on improving the quality of care at the point-of-delivery by establishing minimum standards of care for primary, secondary, and tertiary level institutions. The existing policy frameworks strongly advocate for the establishment of 'quality assurance committees' to coordinate quality assurance and improvement efforts.

The main outputs under this outcome are as follows:

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

Major Progress in FY 2016/17

- A draft National Health Act has been prepared and shared with relevant ministries for feedback, which will lay the foundation for the meaningful quality improvement in health.
- Similarly, the Health Institution Quality Assurance Authority (HIQAA) Act has been drafted which provisions the establishment of an autonomous body for accreditation of private (including NGO) health institutions. The HIQAA has been submitted to the Ministry of Law and Justice for comments.
- Various guidelines and standards such as the Human Organ Transplantation Regulation (2073), Hospital Pharmacy Guidelines (2073), and a number of standards are currently being updated including the National Medical Standard for reproductive health and child health.
- The National Action Plan for Anti-Microbial Resistance (AMR) was drafted by the NPHL and has been submitted to the MoH for approval.
- The National Policy of AMR has been drafted and submitted to the MoH for approval.
- A few innovative approaches were implemented at different levels of health institutions- Regional/Sub-regional/Zonal/District level hospitals, the PHCC and Health Posts (HPs)- to improve quality of care at service delivery points and trainings:
 - A total of 75 district and district level hospitals have implemented Minimum Service Standards for strengthening hospital management and improving scores achieved on availability and quality of services by these hospitals.
 - A follow up of trained staff was conducted for health workers trained by the NHTC including Skilled Birth Attendants (SBAs), anaesthesia assistants, BNMTs and OT management.
 - The FHD followed up the MSS implementation with self-assessment tools for maternity care services followed by action planning to improve readiness and show their readiness with a traffic light scoring system, and the on-site coaching/mentoring of SBA in ten district hospitals.
 - On-site coaching and mentoring of MNH staff was also provided to nurses/ANMs with the support of various partners.

- Training site quality improvement for family planning and IMNCI was carried out using quality improvement modules by N/RHTC and CHD.

Highlights of 2017/18

- The MD has taken stock of all the existing standards, protocol, and guidelines to identify the need to update them in the changed federal context. The compiled list (e-copy) of the documents will be made available on the MoH website to allow for ease of access to the documents by local governments.
- The report on Quality of Care is being produced by the MD for the first time which aims to analyse quality of care based on the eight dimensions and document key progresses on quality of care. The report will be available in early 2018.
- The Minimum Service Standards for the PHCC is being developed.
- The MoH is coordinating with DPHOs and RHDs for consolidating the list of private hospitals.
- Guidelines for establishing a hospital with up to 25 beds were developed by the Federalism Implementation Unit of the MoH and sent to local levels as the responsibility of licensing is now devolved to the local level.
- The National Health Training Centre has developed an orientation package to locally elected representatives and health staff which emphasises quality of care as an important aspect of health care.
- Improving quality of care is the major thrust of the draft National Health Policy 2074 and also explicitly has policy statements to combat AMR and strengthen the public private partnership.
- The Drug Policy 2074 has been drafted by the DDA.

Challenges

- The oversight and steering structures e.g. committees for quality improvement have limited resources to perform quality improvement activities
- Poor coordination mechanisms among and between the different structures for quality assurance and improvement initiatives
- The continuation of the existing committees, mostly district and hospital based, which currently have been support from partners/projects is a concern in the federal context
- Poor linkages and a lack of clarity of roles between the current quality governance structures and various autonomous entities like the Social Health Security Committee and the NHRC
- A limited practice of analysing routinely collected data to measure quality of care and utilising it for improvement
- Limited capacity to oversee the quality of health care and to steer quality assurance mechanisms at the local level
- Unclear reporting linkages of different levels of government and their linkage with autonomous and regulatory entities

Way Forward

- Facilitate the endorsement of the HIQAA Act and National Health Act to ensure quality of care
- Review and institutionalise the quality improvement and assurance governance structures in the federal context
- Bringing all private hospitals under a licensing framework including e-licensing submission for private health institutions
- Make the health institution quality assurance and improvement information public as evidence suggests that publicly releasing performance data stimulates quality improvement activity at the hospital level
- Incorporate quality improvement processes and indicators in routine monitoring systems
- Develop minimum service standards for different levels of health facility to ensure quality of care at the point of delivery
- Develop a legal framework for the regulation of drugs and laboratory services across each level of government

5 Outcome 3: Equitable Distribution and Utilisation of Health Services

Background

The NHSS states that the MoH will sustain and improve upon the progress made towards reducing inequalities in health outcomes through the expansion of health services focusing on under-served, poor, and urban communities. The NHSS considered equity as one of its four strategic approaches within its target for the universal health coverage and identified major health sector implications of financial, socio-cultural, geographical, and institutional barriers hampering service access and aims for improved equitable access of health services by all citizens. Equitable access to health services entails programme implementations that give priorities to populations and areas who lack or have limited access to health services.

There are two outputs under this outcome as follows:

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

Major Progress in 2016/17

This section highlights achievements of the NHSS Results Framework (RF) indicators and changes in equity gaps from the baseline (2011 NDHS or 2014 NMICS) to 2016 NDHS. The NHSS RF baseline data for U5MR, NMR, stunting, diarrhoea prevalence, institutional delivery, and C-section rate are from the 2014 NMICS. The baseline for anaemia is from the 2011 NDHS.

- The prevalence of anaemia among women aged 15-49 declined among women from the poorest quintile but increased among women from the richest quintile resulting in a reversed equity gap between the richest and poorest quintiles from 3.3% in 2011 to -3.7% in 2016. However, anaemia increased among women in mountain (27% to 35.4%) and Terai (42% to 52%) districts resulting in an increased geographical equity gap between hilly areas and mountain/Terai areas from 15% to 23%.
- Anaemia increased among children aged six to 59 months from 46% in 2011 to 53% in 2016. It increased by 10% among children residing in mountain (48% to 57%) and Terai (50% to 60%) areas.
- Prevalence of diarrhoea declined amongst all quintiles as well as in all geographical regions. The decline of prevalence was highest amongst children of the poorest quintile (15.4% to 5.9%) and children in mountain areas (from 14.7% to 5.2%), resulting in reversed equity gaps from 7.5% points to -1.4% points between richest and poorest quintile and from 3% points to -3.5% points between Terai and mountain children from 2014 to 2016.
- The C-section rate at population level among the poorest quintile increased from 2014 to 2016 from 1% to 2.4%, but this is still lower than the WHO's optimum rate of 5-10% (WHO 2015) to effectively save mothers and newborns' lives. A very low C-section rate at 2.2% was also observed in province number 6. The increasing C-section rate

among the richest quintile at 28% is a national public health concern as this procedure comes with higher mortality and morbidity risks for mothers.

- Time taken to reach a health facility for institutional deliveries was reduced- the proportion of women reaching a health facility for an institutional delivery within 60 minutes increased from 45% in 2011 to 74% in 2016. Major improvement was observed among women from the Terai (45% to 87%), the richest quintile (64% to 90%), and poorest quintile from 38% to 60%. However, little improvement observed for women from mountain areas with an increase from 50% to 58% and hilly areas from 56% to 66%.
- The implementation of the social health insurance programme in 15 districts by expanding it in 12 additional districts in 2016/17
- A draft of the basic healthcare package developed by including emerging health care needs including psychosocial counselling, mental health, geriatric health, oral health, standard NCD package, Ayurveda, and rehabilitative services.

National policy, strategy, plan, and programme implementation for reaching the unreached (Data from annual report 2015/16 and preliminary analysis of HMIS 2016/17)

- The MoH endorsed the National Strategy on Reaching the Unreached: a strategy for reducing health and nutrition inequities and contributing towards UHC (2015-2030). The documents identified different strategies for addressing inequities related to geographical, poverty, ability, and identity barriers.
- The MoH endorsed the “Remote Areas Guidelines for IMNCI (2015)”.
- The CHD started implementation of the IMNCI in selected remote districts accordingly.
- A draft of the basic health service package was prepared.
- The number of Urban Health Centres was expanded and Urban Health Promotion Centres were established.
- 450 CHUs were established and made operational across 75 districts.
- The CHU guidelines were updated.
- Specific targeted interventions such as Family Planning (FP) micro-planning (in 25 poor performing districts), visiting providers for long acting reversible FP methods (in 18 remote districts), and immunisation micro-planning for poor performing VDCs and “fully immunised VDCs” approaches resulted in improved access and use of FP and immunisation services in these districts.
- Nutrition specific interventions were implemented across Nepal through multisector, Suaahara, and 1000 golden day nutrition programmes in 62 districts in 2016/17.
- The expansion of birthing centres in rural and remote areas continued with 5.8% increase in mountain districts, 4.8% in hilly districts, 1.6% in Terai districts, and an increase of 4.2% in Province number 2 from 2015/16 to 2016/17.
- The MoH established community health units in strategic locations where the community’s access to existing health facilities is compromised by distance. By 2016/17 a total of 248 CHUs were established: 52 in mountain districts, 147 in Hill, and 49 in Terai districts.

- Of the total 39,397 estimated people living with HIV in Nepal (MoH 2016) about 28% (11,089 persons) received ART from 65 ART sites in 59 districts in 2016/17. Of the 211,800 people tested for HIV at 263 sites, 2,116 tested positive.
- It is estimated that approximate 8% of HIV are co-infected with TB and 4.5% of people with TB had HIV positive tested in Nepal (annual report NTC 2015/16). 54% of newly diagnosed TB patients were tested for HIV in 2016/17, an improvement from 32% in 2015/16. Number of TB patients under treatment with ART was 416 in 2016/17, an increase from 142 in 2015/16.
- Registered drug resistant TB patients declined from 1,485 in 2015/16 to 1,093 in 2016/17. However, multi-drug resistant TB patients increased from 234 to 266.
- The following table shows that access to and utilisation of FP and immunisation (measles) improved mostly in mountain and Terai districts from 2015/16 to 2016/17. However, availability (provision) of institutional delivery and C-section services at districts improved only in hilly districts from 2015/16 to 2016/17, but no improvement was observed in Mountain and Terai districts.

Table 12 Overview of the coverage of selective services

	Mountain districts (N=16)	Hill districts (N=39)	Terai districts (N=20)	Nepal (N=75)
Number of districts with measles coverage rate less than 80%*				
2015/16	8	17	12	37
2016/17	4	17	5	26
Number of districts with CPR less than 30%*				
2015/16	4	9	0	13
2016/17	3	7	0	10
Number of districts with institutional delivery rate less than 30%*				
2015/16	5	13	3	21
2016/17	4	10	2	16
Number of districts with institutional delivery rate less than 55%**				
2015/16	11	28	8	47
2016/17	12	25	10	47
Number of districts with non-functional C-section services (1-12 months)				
2015/16	11	16	6	33
2016/17	11	15	6	32

*National programme low coverage cut-off point

**National average for 2015/16 fiscal year

Source: Annual report (2015/16) and HMIS 2016/17 (preliminary analysis)

- A total of eight hospitals have been providing geriatric health services with 50% discount in listed services for senior citizens.
- The MoH established SSUs in eight additional hospitals, which make up a 16 hospitals with SSU by the end of 2016/17. A total of 77,702 individuals received services through SSU in 2016/17 which comprised of 46.7% poor, 41.9% senior citizen, 4.6% people with

disability, 4.20% helpless, 0.7% gender based violence (GBV) survivors, and other targeted groups (SSU Annual Review, 2017).

- More than NRS 63 million has been collected as member contributions in the Social Health Insurance Program (SHIP). By the end (15 July 2017), 22,228 members from among 228,113 insured populations had already utilised health services. For the provision of these services, more than 18 million Nepali rupees have been reimbursed to the service provider health institutions (Social Health Insurance Program: Annual Progress Report, 2016/17).
- A total of 17,771 persons benefited from the Deprived Citizen Treatment Fund in FY 2016/17 (beneficiaries by diseases category: Kidney- 4611, Cardiac - 8643, Heart - 3342, Sickle cell Anaemia- 600, Spinal Injury - 182, Head Injury- 67, Parkinson -17, Alzheimer- 9. Total expenses were 1.33 billion NPR (Program Progress Report 2016/17)
- The Ten Year Action Plan on Disability prevention and rehabilitation 2073-2083 was endorsed

Table 13 Progress made on disability related activities

Major activities	Target	Achievement	
		No.	in %
Preventive and curative services on eye and ENT at apex centre and community level	190,000	99,435	52.3
Medical rehabilitation, treatment, referral, surgeries for persons affected by leprosy and Persons with disability	493	463	93.9
Social Consultation /Follow-up (Home visit, CBR-C, RRC visit) with disabled children	7,261	6,265	86.3
Static outreach clinic for eye screening and treatment	30,000	30,102	100.3
Provided holistic rehabilitation services to people with spinal cord injury	200	272	136.0
Parent and Child /Teachers Training /Health professionals for autism	185	213	115.1
Fabrication and Delivery of Assistive Devices	2,080	1,580	76.0
Assistive device (wheelchairs, tricycle, elbow crutches, walker, white cane, toilet chair etc.) children included	2,000	2,621	131.1
Skill trainings provided for self-employment to PWDs	260	350	134.6
Seed money for PWD to start income generation	80	115	143.8
Hostel construction for children with disabilities		6	
Orientation on disability to newly elected local bodies, district stakeholders, health facility staff, and HFOMC members in Kapilvastu, Sindhupalchowk	315	245	77.8

Highlights of FY 2017/18

- The Social Service Unit was established in 16 additional hospitals with priority given to those districts where social health insurance has been implemented.

- Implementation of the Social Health Insurance (SHI) programme started in an additional ten districts in FY 2017/18 covering a total of 25 districts as of January 2018. The SHSDC has a plan to expand in an additional 14 districts by the end of current fiscal year.
- The “ultra-poor”, as identified by the GoN, are currently (as of January 2018) being enrolled in the SHI programme through government subsidies in 13 districts where the identification of the poor has been accomplished.
- Along with the expansion of the districts, over 400,000 people have been enrolled in the SHI programme which is 5 % of the catchment population of the implemented districts.
- The PHCRD has planned for 16 new Urban Health Centres for the current fiscal year to provide free care services to the urban poor and marginalised population.

Challenges

- Although the responsibility of delivering basic health services lies with the local level, the service package is yet to be defined through a legal framework.
- While institutional delivery has increased in general, access to C-section (live saving services) is still limited making it difficult to ensure effective emergency obstetric care.
- Limited provision of C-section and surgical services in remote areas mainly due to inadequacy of skilled human resources.
- Improving access to health facilities remains a major challenge particularly in mountain and hill areas, mainly due to geographical barriers.
- Retention of service providers in remote areas.
- Limited case load of procedures/surgeries in remote service sites, which gradually leads to skill loss of specialists and hence demotivates staff from staying at their remote posting.
- Limited population and service coverage under the health insurance programme.
- Alignment between health insurance and free health care program.
- Complicated procedure to access the Deprived Citizens’ Treatment Fund by the genuine poor.
- Limited availability of geriatric services due to a lack of skilled human resources and hospital-based facilities.
- Limited availability of disability friendly health services.

Way Forward

- Effectively implement National Strategy on Reaching the Unreached: a strategy based on the local context to minimise equity gaps
- Improve governance and accountability of health services through LG responsible for ensuring basic health care services
- Strengthen the referral mechanism in the federal context to reduce the journey barriers to accessing referral level (live saving) services

- Review and revise Aama guidelines for incentives (transport subsidy) for referral of obstetric emergencies from lower to higher level health facilities
- Ensure equitable availability and provision of basic health care services especially in rural and remote areas through the continued expansion of services at strategic locations
- Expand coverage services and prioritise the enrolment of poor population in a subsidised manner in the health insurance scheme
- Advocate and display disaggregated service coverage at local councils and provincial levels for decision makers and service providers
- Revise the SSU guidelines in the changed context
- Harmonise the health insurance service package with other schemes of social health protection such as basic health care, institutional delivery, and services provided through SSUs
- Develop a geriatric health care strategy and guidelines for elderly friendly services in hospitals
- Develop guidelines for disabled friendly and geriatric services
- Expand the establishment of rehabilitation units and disability centre
- Develop new and innovative rehabilitation related training courses i.e. physical and rehabilitation medicine, occupational therapy, and mid-level health workers

6 Outcome 4: Strengthened Decentralized Planning and Budgeting

Background

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

Considering the unitary structure of the governance, the NHSS had envisioned to make districts responsible for participatory planning, budgeting, and implementing their respective health plans. Federalism has in fact provided a major impetus to decentralise planning and budgeting. However, in the federal structure, local levels have greater responsibility for service delivery while the roles of the district health offices are yet to be clarified. Moreover, in accordance to the constitutional mandate and functions of the federal, provincial and local level, the institutional structure for health sector is being defined and finalised.

As per the federal structure of governance, planning, and budgeting will happen at three levels: federal, provincial and local levels. However, it is critical to ensure harmonisation of the planning and budgeting across three levels of the government so that a consistent and coherent plan can be developed. Similarly, the delivery of basic health services is a primary responsibility of the LGs while the federal and provincial may have critical roles in terms of quality assurance and financing.

Major Progress in 2016/17

- Capacity on planning and budgeting functions particularly with focus on LMBIS and eAWPB was enhanced by conducting training to the planning officers of the 35 MoH entities in annual planning and budgeting process in FY 2016/17
- Training provided to accountants and account officers working at district level officers on TABUCS in six batches covering around 120 participants
- The MoH developed planning and budgeting guidelines applicable to all planning entities under the MoH
- The share of district level budget was slightly higher (48%) in 2016/17 as compared to 2015/16 (46%)
- Planning and budgeting for 2017/18 was done based on the federal structure and hence health sector budget was allocated to federal, regional, district, and local level
- The conditional grant for hospitals and PHCCs was continued
- A block grant was provided to six districts with NPR 1.2 million to 1.8 million under the Collaborative Framework

Highlights of 2017/18

- In the past, the MoH had initiated providing a block grant to districts to address specific needs at the district level as per their specific needs within the provided framework. However, as per the constitutional provision and the federal structure, the budget has been provided to the local level in two components, namely: an equalisation grant and a conditional grant.
- The equalisation grant is unconditional by nature and hence can be used for administrative and developmental activities while the conditional grant is earmarked to specific sector which should be spent as per the conditions provided. As per the allocation of the budget in 2017/18, the conditional grant is mainly for the education, health, and agriculture sector.
- The provision of providing grants to the local level has provided an opportunity for integrated planning at the decentralised level. The volume of the equalisation and conditional grants allocated in 2017/18 is depicted in the table below. On average, one local government received 200 million NPR in budget in the form of an equalisation grant while the volume of the conditional grant was 102.7 million NPR including 20 million NPR for the health sector.

Table 14 Budget allocated to Local Governments in 2017/18

Amount in million NPR

Local level	Equalisation grant		Conditional grant	
	Min	Max	Min	Max
Rural municipality	100	390	12	172
(Urban) Municipality	150	430	39	313
Sub-metropolitan city	400	630	148	310
Metropolitan city	560	1240	281	784
Average budget per local government	199.8		102.7 (out of which health is 20)	

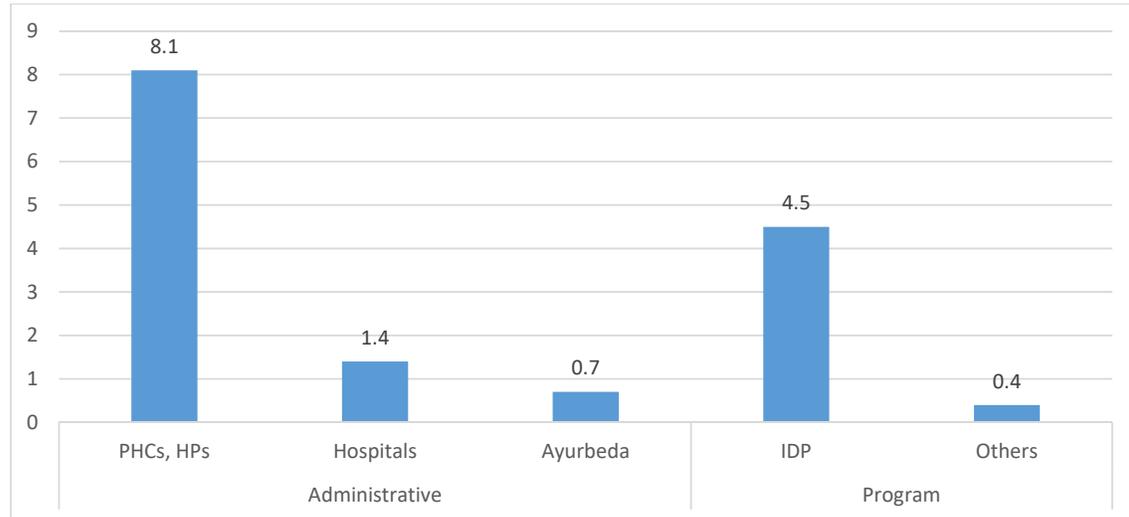
Note: This is based on initial allocation to 744 LGs which was later reallocated to 753 LGs.

Source: Compiled from MoF (Budget Speech) and AWPB for local level

- Of the total health sector budget, one third of the budget is allocated to the local level while the rest is distributed across central, regional, and district health offices. Details of the budget allocation is shown in health financing theme. Conditional grants were provided to the local level along with the detailed list of activities to be implemented.
- Out of the total health budget allocated to the local level, almost two thirds is for administrative purposes which mainly include staff salaries and the remainder is for programme activities including the procurement of medicines.

Figure 9 Composition of health budget allocated to Local Governments

Amount in billion NPR



Source: MoH (Health Budget allocation to local level, 2017/18)

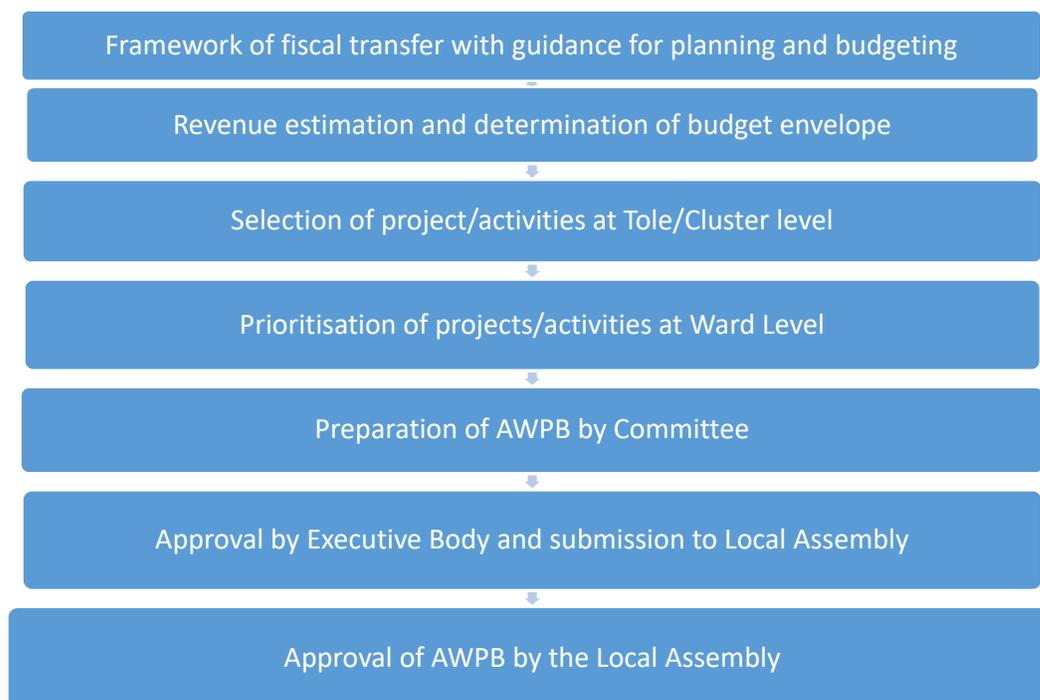
- Implementation Guidelines have been developed by the programme divisions and circulated to the districts for implementation. Similarly, a consolidated guideline was developed by the MoH focusing on the activities assigned to the local level to facilitate/guide the implementation of health programmes at the local level.
- In the federal structure, crucial documents regarding the planning and budgeting are summarised below.

Local Level Operation Act- 2017: This Act defines overall mandates of the LGs and their operational procedure. This also includes a section on 'planning and implementation' with the following key provisions.

- Local levels should prepare periodic and annual plans compatible with provincial and federal policies, targets, objectives, timeframes, and procedures
- Estimates of revenue, prioritisation of projects, an execution plan and M&E plan should also be included while preparing the local level plan
- Provision of the Budget and Programme Formulation Committee (Deputy Mayor/Chief of the Municipality, sectoral members of Council, Chief Administrative Officer (CAO), Planning head)
- Estimates of revenues and expenditure (AWPB) to be presented in Local Assembly by *Ashad* 10 (approx. June 25)
- Endorsement of the AWPB by the Assembly by end of *Ashad* (mid-July) with necessary revisions
- Public Procurement at local level shall be as per the Federal Procurement Act
- The organisational structure of local levels should be defined based on the Organisation and Management (O&M) survey while considering local needs and context after the staff adjustment

- Considering the rights of LGs, sectoral ministries should review their organisational structure and make necessary arrangements for the handover of assets, liabilities, and budget to the local level within six months upon the endorsement of the Act

Figure 10 Seven step planning process at the Local Level



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

Challenges

- The institutional structure has not been approved and accordingly the roles of different levels in terms of health sector planning and budgeting are still not very clear, in particular the role of the District Health Offices (DHOs).
- There has been a certain level of mismatch in the allocation of the health budget to the LGs. Challenges remain for ensuring the rational allocation of the budget to provinces and the local level as per the actual need
- As planning will be carried out at three levels, there is a challenge to ensure horizontal and vertical harmonisation of planning and implementation of health sector activities across the three layers of government
- Ensuring the timely implementation of the planned activities and utilisation of the allocated budget in the current federal structure as there is a new institutional set up and limited capacity at the local level

Way Forward

- Develop a comprehensive manual to guide the planning and budgeting at the local and provincial level in accordance to the guidelines from the MoF and MoFALD
- Review and revise the e-AWPB planning framework to make it consistent with LMBIS and in accordance with NHSS outcomes
- Continuously track the implementation challenges and successes at the local level
- Closely engage with provinces and monitor progress and performance in the health sector at different levels
- Develop case studies and success stories in planning and budgeting at the local level and disseminate learning
- Coordinate with the National Resource and Fiscal Commission and MoF to develop a robust mechanism for the rational allocation resources for the health sector across provinces and at the local level

7 Outcome 5: Improved Sector Management and Governance

Background

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

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

Major Progress in 2016/17

- Initiated health sector restructuring in accordance with federalism
- Functional analysis and assignments of federal, province, and LGs has been endorsed by the government
- Revised Health Infrastructure Standards and developed a costed Integrated Health Infrastructure Project, endorsed by the government
- Deputation of human resources in all local governments (Palika level)- the deputed staff consists of two, three, four, and five health workers of different grades to the Rural Municipal, Municipal, Sub-Metropolitan, and the Metropolitan levels respectively
- Prepared the induction package for elected local representatives and provided orientation in provinces 3, 4, and 6 in coordination with MoFALD
- With the view of gaining an in-depth understanding on health service delivery at the local level (i.e. leadership, governance and accountability, service quality, planning and budgeting, and monitoring of health interventions, reaching the unreached) the MoH has identified 'learning lab sites'², with at least one in each province. The MoH will be supported by a number of EDPs to implement this concept and help generate evidence to strengthen health service delivery at the local level.
- Drafted National Health Act and shared with relevant ministries for their feedback
- Drafted Partnership Policy in Health which is yet to be endorsed by the government
- Revitalised Nepal Drugs Limited which has now initiated the production of few drugs
- A draft report on Citizen Engagement has been prepared and electronic dashboards have been established for ensuring right to information
- Performance based financing approach has been adopted in the health sector through Disbursement Linked Indicators
- Strengthened Public Financial Management (PFM) practices as follows:

² The local level approach focuses on enhancing the capacity of local governments for evidence-based planning and budgeting and delivery of quality health services, which will ultimately contribute to make the local health system more resilient.

- Developed Internal Audit Improvement Plan (IAIP) in consultation with FCGO and revised Financial Management Improvement Plan (FMIP)
- Audit queries cleared as per the government target and noticeably reduced audit queries against audited amount. Almost half (46.03%) of audit queries amounting NRS 2.09 billion had been cleared at the end of FY 2016/17; updated audit queries records in TABUCS
- Financial management workshops were held in five development regions to enhance capacity of the programme managers and finance officers in financial matters
- Submitted Audit Financial Statements of FY 2015/16 to OAG on May, 2017 and its audit report certified by OAG on 06 September, 2017
- Periodic meetings of PFM Committee were held and meetings of the Audit Committee were also held for expediting settlement of audit observations
- GESI technical working groups (TWGs) have been formed in all districts and GESI focal persons nominated in all Regional Health Directorates (RHDs) and all DHOs and DPHOs.
- Conducted orientation on GESI strategy and its framework to Medical Superintendent and health workers from 25 hospitals and orientation on overall GESI/LNOB perspectives was held with the MoH, DoHS, divisions, and centres
- Provided technical inputs to draft the five year National Strategy and Action Plan for GBV and Gender Empowerment and the Ten Year National Policy and Action Plan for Disability
- Revised Social Audit Guidelines and implemented social audit across 70 districts in 1752 health facilities
- Prepared health profiles of all municipalities and sent them to their respective district; the profile provides detailed information on human resources and physical assets of each health facility at Palika level
- A number of meetings were held within the MoH and its departments and with EDPs to update and discuss on various aspects of federalism pertaining to health services delivery.
- Prepared a concise guideline on health programmes for local level for and uploaded on the MoH website.
- Terms of Reference of the health partners' forum, "Health Sector Development Partners Forum", were endorsed and a meeting of the forum was held on December 19, 2016, participated in by various partners working in the health sector including academia, private sector, and civil society, etc. The meeting was chaired by the Health Minister.
- Conducted Joint Coordination Meeting (JCM) in June 2017 and discussed the budget related issues in light of federalism

Highlights of 2017/2018

- New National Health Policy (2017) drafted and submitted to the cabinet for approval

- A governance structure of the health sector (at three levels of governance) was prepared and endorsed by the MoH. The governance structure at federal level was discussed with the high level administrative restructuring committee stationed in MoGA.
- Formed Federalism Implementation Unit (FIU) in the MoH to provide strategic guidance and support to rollout health functions in the federal context
- Handed over health facilities (PHCs, HPs, CHUs, and *Aayurveda Aushadhalaya*) to respective local governments (753)
- Budget allocated to 753 local government including for the fiscal year 2017/2018 including conditional grant for health
- Internal Control Guidelines updated and circulated to concerned entities within MoH for feedback
- Conducted a comprehensive National Health Review in Kathmandu, participated by all 75 districts and hospitals including tertiary and referral, academia, and development partners; this was the first national review of its kind in the federal context hence it was designed to allow discussions based on federal, provincial, and local health functions
- Prepared a brief guideline for registration, licensing, and renewal of privately owned health institutions for local level and sent to the local levels
- Formed multi-sectoral steering committee (SC) and TWG for the revision of GESI strategy and developed framework for revision
- Health Insurance Act promulgated
- Local Government Operation Act promulgated
- Staff Adjustment Act promulgated

Challenges

- Defining Basic Health Service, considering the constitutional provisions and costing the Basic Health Services (BHS) for fund allocation
- Limited capacity of local governments for managing devolved health functions
- Health sector at the local level will have to compete with other sectoral priorities such as road and infrastructure, among others. In the absence a clear mechanism in health for the prioritisation and resource allocation with use of evidence at the local level, the health sector may suffer from a lack of resources and compromise service delivery.
- Ensuring a good balance between strengthening hospitals/facility based curative services and sustaining public health interventions at local levels; early indication at the local level shows an increased focused on curative care which can be at the cost of public health interventions
- Unclear engagement modality for development partners and other stakeholders such as private sector, NGOs/CBOs, and cooperatives for the provincial and local level
- Finalising the complete governance structure of health at federal, province, and local governments (organisational structure, human resources, and horizontal and vertical linkages), including the immediate adjustment and mobilisation of health staff at various levels
- Unclear on-budget and off-budget reporting mechanisms in the changed context including expenditure reporting at the local level

Way Forward

- Define BHS and support the LGs to implement BHS adequately
- Proactive engagement of the MoH in finalising health governance structures at all levels with defined roles and responsibilities
- Provide technical and managerial support to government leadership and respective health departments/units at province and local level for uninterrupted health service delivery
- Develop and share various tools and guidelines to facilitate developing the AWPB at the each level of government
- Work with Natural Resources and Fiscal Commission, MoF, and respective ministries to ensure financial accountability and reporting of health expenditure
- Update TABUCS in the federal context and support for its effective implementation by concerned entities
- Promote the use of available evidence to inform a local health plan so health service quality is improved and no-one is left behind
- Make the transition to federalism well informed with lessons learned at the local level
- Implement learning the lab concept under the operational research framework in federal context, design, implement, document, and scale up- in identified sites to strengthen health service delivery at the local level

8 Outcome 6: Improved Sustainability of Healthcare Financing

Background

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

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

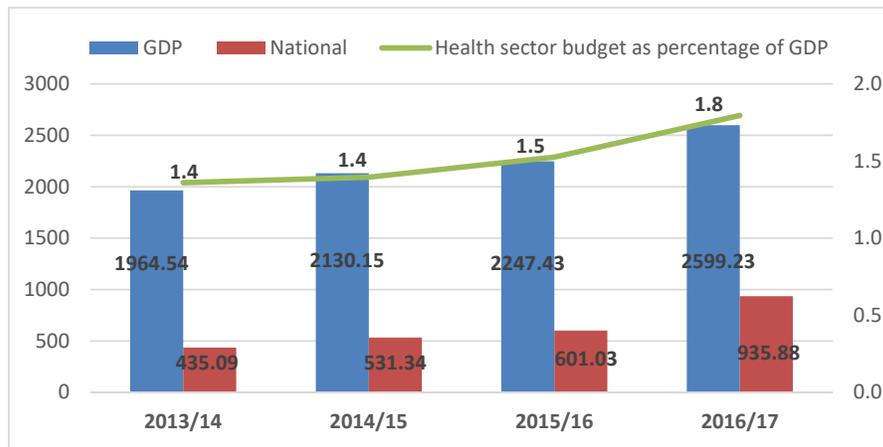
- Strengthened health financing system
- Strengthened social health protection mechanisms

Major interventions proposed under this outcome particularly for 2016/17 include developing and introducing a resource allocation formula, enhancing the MoH's capacity on performance based resource allocation, enhancing capacity for the institutionalisation of the National Health Accounts and the harmonisation of existing social health protection schemes, and the implementation of health insurance.

Major Progress

- Government health expenditure as a percentage of the Gross Domestic Product (GDP) for FY 2016/17 is 1.8%. There has been a 0.4% increase compared to the baseline year and 0.2% increase compared to the NHSS target. The figure below provides an indication of the trend of government health spending as a percentage of the GDP. Over the years, government spending on health as a share of GDP is increasing, albeit marginally. In the figure below, the government spending on health includes the budget allocated to the MoH, and other line ministries.

Figure 11 Trend on government health spending as a percentage of GDP

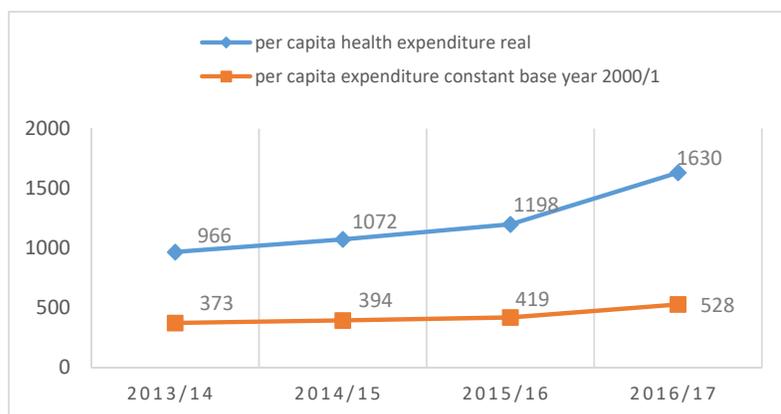


Source: BA FY2017/18

Note: GDP in NPR million, National Budget in NPR

- The Chatham House report of 2014 recommended that countries should strive to spend 5% of their GDP for progressing towards Universal Health Coverage (UHC). There is a wide range of evidence and comparisons across countries that support the target of at least 5% or more of the GDP. The 2010 World Health Report stated that public spending of about 6% of the GDP on health will limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible. Government spending on health of more than 5% of the GDP is required to achieve a conservative target of 90% coverage of maternal and child health services. The same Chatham House report recommends low-income countries to spend USD 86 per capita to promote universal access to primary care services.
- The figure below shows trends in per capita government spending on health. Between FY 2013/14 to FY 2016/17, the per capita government spending has gradually increased from NPR. 966 (USD 9.8) to NPR. 1,630 (USD 15.4) in real terms. However, during the same period, government spending on health increased very little from NPR. 373 (USD 3.8) to NPR. 578 (USD 5), 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.

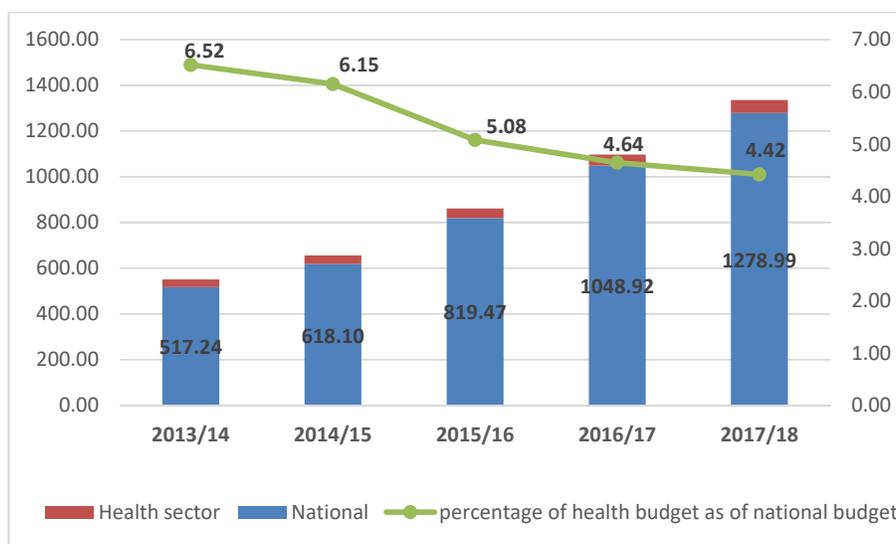
Figure 12 Per capita government health spending



Source: BA FY 2017/18

- The figure below shows trends in the health budget as a percentage of the national budget. The percentage of the health budget against the total government budget has decreased by 1.7% from 6.1% in FY 2013/14 to 4.4% in FY 2017/18 including the health budget allocated to the local level. In FY 2017/18, a NPR. A 15.08 billion budget has been allocated to LG in the form of conditional grants for health. The share of the conditional health budget accounts for 6.7% of the total centrally allocated budget to the LGs.

Figure 13 Health budget as a percentage of the national budget



Source: BA 2017/18

- The GoN has rolled out several social protection schemes to reduce OOPE in health. The GoN had expanded the coverage of the health insurance programme in 15 districts by the end of 2016/17. Furthermore, in 2017/18, insurance programme has been expanded in seven more districts. The number of people enrolled by the SHSDC in insurance programmes has increased to 3.08% in FY 2016/17. Along with the

expansion of the districts, over 400,000 people have been enrolled in the insurance programme which is 5 % of the catchment population in the implemented districts. In 2017, the Social Health Insurance Act was promulgated which makes a mandatory provision for enrolment in health insurance.

- Nevertheless, the share of OOPE in current health expenditure (CHE) is relatively high at 60% for 2015 as per the WHO estimates³. The latest National Health Account (NHA) data available in-country is for FY 2011/12 which suggests OOPE as percent of CHE is 56% which matches to the WHO estimates. This implies that OOPE as percent of CHE has increased by 4% from 2011 to 2015 which is a major policy concern towards strengthening social health protection mechanisms in the country.

Challenges

- The decreasing trend of health expenditure in relation to the total government budget
- The increasing share of out of pocket expenditure for health
- 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.
- The institutionalisation of the National Health Accounts to routinely monitor health expenditure
- Delays in the identification of the poor hampering for the inclusion of the poor and other targeted groups in health insurance through government subsidy

Way forward

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

³ OOPE as of current health expenditure obtained from
<http://apps.who.int/nha/database/ViewData/Indicators/en>

9 Outcome 7: Improved Healthy Lifestyles and Environment

Background

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

The data shows that mental health related problems are escalating in Nepal. A recent study conducted with population affected by 2015 earthquake found elevated rates of depression (34.3%), anxiety (33.8%), PTSD (5.3%), and alcohol use disorder (20.4%) (Kane et al., 2017). Similarly, a study conducted in Chitwan district reported that more than 90% of people with depression and alcohol use disorders have received no treatment in the past one year (Luitel et al., 2017).

Major Progress in 2016/17

- Established twenty-nine OCMCs in each of the twenty-nine districts by the end of 2016/17 and plan is to establish sixteen more in 2017/18; each OCMC aims to provide an integrated package of services for survivors of GBV through a 'one-door' system
- The "Basic Psychosocial Counselling Training" was provided to health workers from 26 OCMC based hospitals
- Essential services required by GBV survivors in OCMC were provided to 8,664 individuals comprising of 8,030 (92.7%) women and 634 (7.3%) men) accessing services until May 2017 (since its establishment). A high percentage of women receiving services (37.40%) were victims of physical assault or domestic violence, while 29.10% had experienced sexual violence, 29.50% had suffered extreme emotional/mental abuse and 4.00% 'other types of violence' (OCMC Annual Review, 2017)
- Basic Psychosocial Counseling Training provided to 36 OCMC and hospital staff in two batches from 26 OCMC based hospitals
- Forensic training provided to 63 medical officers from PHC, district, zonal and regional hospitals
- GBV clinical protocol rolled out in 18 hospitals
- Draft of standard operating procedures prepared by NHTC on forensic (autopsy, age estimation, injury examination, anthropology identification, examination of GBV/sexual assault, torture examination) training guide and reference manual.
- The PEN protocol is endorsed
- The Ministry of Education has made a policy decision to acquire the services of nursing staff in every school
- Mothers' Groups are engaged in various activities including WASH. The Pregnant Women's Group was formed and discussions on various topics were initiated.
- The revised mental health policy submitted for inter-ministerial feedback

- The PEN package was piloted in two districts in the year 2016/17 and expanded into eight more districts in 2017/18.
- The PHCRD organised a central level workshop for the effective promotion and expansion of the PEN Programme. The workshop brought people from different sectors and disciplines together to develop a training package for health workers on the PEN package. The Training Package consists of a Training Manual, Reference Materials, and Trainer's Guide.
- About 50 stakeholder and 45 journalists were oriented on PEN in both pilot districts
- TOT for PEN Programme conducted for 71 people; About 850 service providers trained on PEN package in eight districts.
- Developed and disseminated IEC/BCC materials like posters on Healthy Lifestyle i.e. Smoking, Alcohol, Physical Activities, and Food Habits
- Water quality surveillance standard developed by EDCCD is being implemented
- Successfully piloted the PEN Programme in Kailali and Ilam with expansion to eight more districts
- Training on HEARTS tool provided to coach team in Kailali and Ilam
- Developed and endorsed the Health National Adaptation Plan (H-NAP) on climate change for Nepal
- Organised national conference on disability
- Integration of mental health into primary care as guided by WHO Mental Health Gap Action Programme (mhGAP)
 - Revised Standard Treatment Protocol (STP) for mental health
 - Five more new generation drugs related to mental health have been added in free drug list
 - Developed a training curricula based on revised STP and globally used mhGAP IG, version: 2 by the National Health Training Centre.
 - Prepared standard and curricula for psycho-social counselling.
 - In the post-earthquake scenario, more than 500 Health workers were trained and more than 7,000 people received mental health and psychosocial support from various programmes.
 - A five day basic mental health training in Okhaldhunga was completed. Furthermore, health workers received a five day basic and three day refresher training on mental health in the project districts.
 - Conducted 153 events for orientation on mental health at the local level to FCHVs, traditional healers and other target groups
 - Developed and mobilised psychosocial counsellors in nine districts for individual and group counselling to migrant workers and their families

Highlights of 2017/18

- Developed the community based mental health care packages
- OCMC national review program conducted
- Total of 29 Urban Health Promotion Centres (UHPCs) are being established including 11 in Kathmandu

Challenges

- Limited harmonisation of activities for NCDs at the local level including surveillance
- Limited training on water quality surveillance
- Poor reporting on road traffic accidents
- Limited preparation of standards for air, water, and food quality
- Inadequate referral provisions for people with severe GBV and mental health problems
- A low level of awareness on GBV, mental health, and psychosocial issues at community level
- Not enough allocation of budget as per the costed PEN implementation plan
- Lack of linkage of PEN with other programmes like Aama or SHI

Way Forward

- Implement community based mental health care package to mainstream mental health services at the local level
- Revisit the multi-sectoral NCD plan taking into consideration the changed federal context
- Incorporate NCD data management into the current HMIS training package
- Strengthen integrated surveillance of communicable diseases and NCDs
- Strengthening and scaling-up of OCMCs
- Implement surveillance of road traffic accidents
- Implement the health national adaptation plan to climate change and incorporate it in the overall national adaptation plan

10 Outcome 8: Strengthened Management of Public Health Emergencies

Background

The NHSS, through this outcome, provides a clear road map towards improved preparedness and strengthened responses to public health emergencies during humanitarian and public health emergencies. It directs towards revising protocols and guidelines for improved health sector emergency at the central and decentralised levels along with the enhancement of institutional and human capacity for an effective and timely response. The outputs under this outcome are as follows:

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

Nepal witnessed a humanitarian crisis due to the devastating earthquake in April, 2015. The health sector response to the earthquake was applauded and commended at a national and internal level. However, the post-earthquake response stretched the capacity of the health sector to its limit and also exposed some limitations of the health systems and capacity, especially on emergency preparedness and disaster response.

Table 15 Types of sporadic small scale outbreaks responded

S.N	Outbreaks	Districts
1	Seasonal Influenza	Gorkha, Rukum, Mugu, Palpa, Syangja
2	Dengue	Rupendehi, Sarlahi, Dhading, Mahottari
3	Leptospirosis	Morang
4	Chikungunya	Chitawan, Syangja, Bhaktapur
5	Viral fever	Mugu
6	Malaria	Dhanusha, Mugu, Bajura
7	Kalazar	Sarlahi
8	Diarrheal disease/ cholera	Saptari, Parsa, Lalitpur, Kapilvastu
9	Food Borne	Nuwakot
10	Mushroom poisoning	Palpa

Major Progress in 2016/17

- The Epidemiology and Disease Control Division updated the guidelines for disaster and epidemic management
- The RRT training package and RRT guideline revised
- The EDCCD procured RRT deployment kits

- The MoH endorsed Nepal's Post-earthquake communications plan- this plan aims to communicate health risks with communities directly affected by the earthquake in 14 priority districts

Highlights of FY 2017/18

- Highway RRT guideline is in the process of development
- The MoH activated the Central Health Emergency Operation Centre (HEOC) for effective health sector response to floods and landslides.
- A national conference for rapid response teams, the first of its kind, was held in Kathmandu from December 19 to 20, 2017 with a thematic slogan of "towards reliable and resourced teams for rapid response to Public Health Emergencies"

Challenges

- Limited budget to timely address the emergency situation
- Inadequate supply of essential medicines and prepositioning of supplies at strategic locations
- Delayed construction and restoration of damaged health facilities post-earthquake 2015
- Shortage of dignity kits and nutritious food to meet the caseload of affected pregnant and lactating women
- Gaps in coordination and communication with Public and Private Hospitals during emergencies

Way Forward

- Prepositioning, in a ready to use state, essential lifesaving drugs/medicines and supplies in strategic locations
- Enhance capacity of humanitarian aid workers including FCHVs on disaster preparedness, response, and drills through training/orientations
- Strengthening of effective information management through the Early Warning Reporting System and coordination support between relevant ministries
- Establish an emergency response fund at all levels and preposition of essential lifesaving drugs/medicines and supplies in strategic locations
- Support the hub hospitals for adequate preparedness during disasters and form a medical response deployment team (MRDT) at all hub hospitals
- Enhance the capacity and deployment procedures of RRTs for effective team mobilisation and initiation of the first response/recovery activities
- Establish an operational Incident Command System (ICS) at institutions for emergencies

The Case of Flooding, August 2017

The three-day heavy rainfall in the second week of August 2017 caused significant floods in the Terai region and several landslides in hill areas, impacting lives, livelihoods, and infrastructure in 35 of the 77 districts. The flood led to the inundation of about 80% of the land in the Terai region.

According to the Ministry of Home Affairs (MoHA), 161 people lost their lives, 46 were injured, and 29 people are missing. An Initial Rapid Assessment (IRA) conducted in 28 districts found almost 65,000 houses destroyed and 400,000 people displaced by flooding. The flood and inundation caused heavy loss of housing, health, education, agriculture, livestock, irrigation, transport, water and sanitation, and energy sectors, and the total cost for recovery is estimated to be US \$697 million according to the government's Post Flood Recovery Needs Assessment (PFRNA 2017).

The floods destroyed or damaged critical infrastructure including schools and health posts. It also destroyed 64,000 hectares of standing crops and food stocks in the ten worst affected districts and leading to compromises on the livelihoods and food security. Nearly 100 health facilities were damaged or partially damaged disrupting the already stressed health service delivery. Flood- and landslide- affected people were at a heightened risk of contracting leptospirosis, dengue, diarrhoea, acute respiratory infections, fungal infections, and hepatitis owing to disruptions in the health sector and the impacts on WASH networks and facilities.

A successful response to the 2017 flood was possible through the effective engagement of all health cluster partners and other clusters including academia, private hospitals, and professional bodies at different levels. Below are some key initiatives:

- A Central Coordination Committee under the chairpersonship of the Secretary, MoH and an Operation Committee/Disaster Management Committee under the chairpersonship of the Deputy Director General (DDG), DoHS, was formed.
- The MoH formed five Central RRTs and deployed them in the affected 22 districts.
- The EDCD established a central information management unit and a hotline was established (Hotline: 01-4100187 and 01-4262268) to facilitate response activities. All 36 affected districts reported to the EDCD.
- A total of 2,940 health workers (1,932 government health workers, 857 private, and 151 agency health workers) were mobilised in flood and landslide affected districts.
- Supporting partners contributed significantly to crisis management by supplying logistics and kits.
- Newly elected representatives of the urban and rural municipality and their staff supported the flood response
- A detailed report of the event was prepared by the EDCD which will be a source of information for humanitarian assistance in future.

Challenges

- Supply of essential medicines at times of crisis
- Prepositioning of supplies at strategic locations
- There was a funding gap for immediate flood response
- Delayed progress on reconstruction and restoration of damaged health facilities

The Case of Dengue Outbreak in Dhading

More than 75 reported fever cases of Dengue were reported in Dhading district over three months from Bhadra to Kartik 2074 (Mid- August to Mid November 2017). Laboratory diagnosis (RDT) confirmed the diagnosis at Dhading Hospital. The index case came from Hetauda, Makwanpur District. Other cases had a history of frequent travel to Dhading Besi (Nilkantha Municipality).

An urgent meeting was held between Mayor of Nilkantha municipality, CDO, Chief of Nepal Police and Armed Police, and the media. An orientation programme was held for health workers, uniformed personnel, and local community leaders who would be directly engaged in the search and destroy response. They were provided with needed logistics. Search and destroy interventions were carried out in 2,061 households of the most affected pockets of Nilkantha Municipality. A total of 778 households had larvae positive for the *Aedes Aegypti* mosquito. A three kilometers radius around Dhading Besi was part of the “search and destroy” mission. The Dengue outbreak came under control with a timely and effective outbreak response.

This outbreak taught the following lessons:

- Year round RDT for Dengue diagnosis must be available at hospitals. This will also reduce chances of over treatment.
- Community and other key stakeholder engagement is a must.
- Establish emergency/outbreak response funds for immediate mobilisation of RRTs.

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

Background

The NHSS foresees increased access to and use of information through the use of ICT. It emphasises improved and interoperable routine information systems and prioritises surveys and research. Similarly, it strives for improved and integrated health sector reviews at various levels that feed into the planning process. Towards achieving universal health coverage and leaving no one behind, the NHSS and the SDGs emphasise monitoring and reducing the equity gap in the health outcomes of different population sub-groups. The outputs for achieving this outcome are:

- Integrated information management approach practiced,
- Survey, research and studies conducted in priority areas
- Improved health sector reviews with functional linkage to planning process

Major Progress

Integrated information management

- The MoH developed and endorsed the National e-Health Strategy in 2017. The strategy strives for cost-effectiveness and secure use of information and communications technologies for population, health clients, health workers, and public health managers and policy makers. The MoH is in the process of finalising the eHealth roadmap drafted in July 2017.
- Similarly, the MoH has initiated the process of developing a unified coding system of health facilities. Each health facility gets a unique code which identifies each individual facility irrespective of its ownership, type, and location. The unified coding system will be a milestone to move towards data exchange across various information systems and making them interoperable.
- The MoH has also initiated the process of developing a web-based health facility registry which will include a master inventory list of all health facilities in Nepal with unique identification code, location, type, level, and service information that can be used by the GoN and the public. Gradually, this system will be upgraded to include the e-registration and licensing of health facilities.
- The MoH has also initiated a number of e-health initiatives such as the standardisation of the e-attendance system and the development of a web-based grievance management system.
- The development of the health sector M&E plan is currently underway. The plan will: (a) define the M&E functions of the local, provincial, and federal government based on the functional analysis endorsed by the Cabinet in 2017; (b) map out the health sector data needs to monitor the NHSS RF and health related SDG indicators and ensure timely availability of the data either through routine systems or surveys or other means as appropriate; and (c) develop a survey plan with reference to the NHSS RF and the SDGs.

- Progress on the NHSS RF indicators, key results from the national level surveys (NDHS and NHFS), and HMIS are shared through dashboards hosted at interactive web-portal on the MoH's website (www.moh.gov.np). The MoH has a plan to share the progress on SDGs and Disbursement Linked Indicators (DLIs) in the same portal.
- The MoH, in close collaboration with the National Planning Commission, developed the national health sector SDGs indicators, milestones, and targets in line with the global framework.
- The HMIS in DHIS2 platform has been updated to incorporate the latest federal structure.
- Electronic reporting of service statistics from health facilities has expanded to more than 600 facilities across the country.
- During the flood in 2017, the DoHS /MoH effectively managed information from the flood affected 36 districts in real time. This helped in assessment of the situation and identification of needs to deliver an effective and efficient health sector response. The daily situation update reports including final comprehensive report are available at www.edcd.gov.np.

Survey, research and studies

- The Nepal Demographic and Health Survey (NDHS) 2016 was completed and the findings disseminated.
- Further analysis of 2015 Nepal Health Facility Survey (NHFS) is being carried out on the following topics:
 - Integrated Management of Neonatal and Childhood Illnesses (IMNCI)
 - Maternal health
 - Family planning
 - Quality of care
 - Status of service readiness and availability by province
- The MoH produced a report of national health accounts covering three year period from 2009 -2012 in 2017. It provides detailed and updated information regarding the health expenditure by source, financing agents, types of service providers, functions, and status of out-of-pocket expenditure in the country.
- The Nepal Health Research Council (NHRC) carried out a number of researches in 2016/17. The reports of the researches are available at <<http://nhrc.gov.np/publication-category/reports/>>

Health sector reviews with functional linkage to planning process

- The national annual review of 2016/17 was aligned with the federal structures in line with the changed context of transition to federalism. Service statistics and other issues were analysed and presented by province.
- The annual report of the Department of Health Services for the year 2016/17 will reflect the provincial status.

Challenges

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

Way Forward

- Develop strategies, standard protocols, and guidelines for improved information management leveraging ICT
- Develop health sector M&E and survey plan in the federal context
- Develop and operationalise the central standard data repository
- Standardise, develop, strengthen, and institutionalise e-health initiatives at all levels
- Institutionalisation and regularisation of producing national health accounts

References

- Campbell O and Graham WJ (2006). Strategies for reducing maternal mortality: getting on with what works. *The Lancet* 2006; 368: 1284-99.
- EDCD (2017) EWARS Weekly Bulletin 2017 week 32, 2017, EDCD, DoHS, MoH
- EDCD (2017). Comprehensive Health Sector Report, EDCD, DoHS, MoH.
- EDCD (2017). Summary Reports of flood in Bardiya District, EDCD, DoHS, MoH.
- GoN (2017). Nepal GESI Guideline for Identifying and prioritising vulnerable and marginalised populations for humanitarian response, recovery, preparedness and disaster risk reduction, August 2017.
- GoN, DFID, WFP (2017). Nepal food security monitoring system. A report on food security impact of 2017 flood in Terai, 2017.
- Holmes W and Kennedy E (2010). Reaching Emergency Obstetric Care: Overcoming the 'Second Delay'. *Compass Briefing Paper*. Melbourne: Burnet Institute.
- Kane, J. C., Luitel, N. P., Jordans, M. J., Kohrt, B. A., Weissbecker, I., & Tol, W. A. (2017). Mental health and psychosocial problems in the aftermath of the Nepal earthquakes: findings from a representative cluster sample survey. *Epidemiology and Psychiatric Sciences*, 1-10. doi:10.1017/s2045796016001104.
- Luitel, N. P., Jordans, M. J., Sapkota, R. P., Tol, W. A., Kohrt, B. A., Thapa, S. B., Sharma, B. (2013). Conflict and mental health: a cross-sectional epidemiological study in Nepal. *Society of Psychiatry and Epidemiology*, 48(2), 183-193. doi:10.1007/s00127-012-0539-0
- Luitel, N. P., Subba, P., & Jordans, M. (2017). Development, evaluation and scale up of a mental health care plan (MHCP) in Nepal. Paper presented at the Third National Summit of Health and Population Scientists in Nepal, Kathmandu.
- MoF (2016). Estimates of budget and expenditure, various years, MoF
- MoH (2010). Health Sector Gender Equality and Social Inclusion (GESI) Strategy, 2010. Kathmandu: Ministry of Health and Population.
- MoH (2011). Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming across the Ministry of Health and Population 2011. Kathmandu: Ministry of Health and Population.
- MoH (2013). Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector. Kathmandu: Ministry of Health and Population.
- MoH (2015). Nepal Health Sector Strategy (2015-2020). Kathmandu: Ministry of Health and Population.
- MoH (2015). Social Service Unit Implementation Guidelines (revised) 2015. Kathmandu: Ministry of Health and Population.
- MoH (2016). Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual (revised) 2016. Kathmandu: Ministry of Health and Population.
- MoH (2016). National HIV Strategic Plan 2016-21, MoH
- MoH (2017). Annual Progress Review and Future Direction of One-stop Crisis Management Centres, Social Service Units and geriatric services. June 2017.
- MoH (2017). Annual work plan and budget for 2017/18. MoF
- MoH (2017). Case Study, Performance of Hospital-Based One Stop Crisis Management Centres (OCMC). Kathmandu: MoH.

- NHT (2016). National Tuberculosis Programme: Annual Report (2015/16).
- NPC (2017). Nepal Flood 2017: Post-Flood Recovery Assessment (PFRNA), November 2017
- OPMCM (2012). National Strategy and Action Plan for Gender Empowerment and to End Gender Based Violence (2012/13 to 2016/17). Kathmandu: Office of the Prime Minister and Council of Ministers.
- PHCRD and NHSSP (2014 and 2015). Process Evaluation of Social Auditing in Ilam, Jhapa, Rupandehi and Palpa Districts. Kathmandu: Primary Health Care Revitalisation Division and NHSSP.
- Suvedi, B., Pradhan, A., Barnett, S., Puri, M., Rai, S., Poudel, P. Hulton, L. (2009). Nepal Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu, Nepal: Family Health division, Department of Health Services, Ministry of Health, Government of Nepal.
- Tol, W. A., Kohrt, B. A., Jordans, M. J., Thapa, S. B., Pettigrew, J., Upadhaya, N., & de Jong, J. T. (2010). Political violence and mental health: a multi-disciplinary review of the literature on Nepal. *Soc Sci Med*, 70(1), 35-44. doi:10.1016/j.socscimed.2009.09.037
- TPO Nepal (2017). Integration of Mental Health and Psychosocial Support Services in Primary Health Care Facilities and Community Settings in the Post- Earthquake Context in Nepal. Kathmandu: Transcultural Psychosocial Organization (TPO) Nepal
- WHO (2015) WHO Statement on Caesarean Section Rate. WHO/RHR/15.02
- WHO (2010). mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialised Health Settings: Mental Health Gap Action Programme (mhGAP). Geneva: World Health Organization.