A Cross-Sectional Perspective on WHO Collaboration

September, 2007
A Cross-Sectional Perspective on WHO Collaboration

September 2007
Nepal
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Introduction

Regional Director, Dr Samlee Plianbangchang is scheduled to visit Nepal from 11-14 September. The last visit he made was in July 2005. During June 2006, Regional Director planned to visit Nepal once again, but country political situation did not allow him to make it happen.

This is an opportune time for the Regional Director to visit the country. Firstly the country is now moving forward in a speedy momentum toward building a New Nepal through democratic means, secondly, the country has been offered to have a privilege in the first wave of the new health initiative, International Health Partnerships (IHP) and finally, the Regular Budget is in its final quarter of the period and the country office is engaging in its assessment of the work done which will be the springboard for the takeoff of the forthcoming biennium. This is the time the country office is expecting guidance from the Regional Director.

In this report to the Regional Director, A Cross-Sectional Perspective on WHO Collaboration, a short analysis of the political scenario and health situation is briefly presented together with highlights in programme management. The guidance given by the Regional Director was recalled and a brief report is presented. The country office is currently engaged in the programme assessment. DPM has visited recently to look into it and the first stage of the assessment report has already been submitted to the Regional Office. A conceptual framework for the second stage has been prepared and presented in this report. Concurrently, the report on status of leprosy elimination programme, progress on public health initiative and the work carried out on the International Health Partnership is also briefly presented. Finally graphic presentation on disease surveillance is also included.
## Tentative Programme for Regional Director’s Visit to Nepal

### 11-14 September 2007

<table>
<thead>
<tr>
<th><strong>Tuesday, 11 September 2007</strong></th>
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<tbody>
<tr>
<td>13.15</td>
<td>Arrival by flight 9W-262</td>
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<tr>
<td></td>
<td>Accommodation at Hotel Himalaya</td>
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<tr>
<td>16:00 – 16:30</td>
<td>Courtesy Call on Minister of Health &amp; Population</td>
</tr>
<tr>
<td></td>
<td>Hon’ble Mr Girirajmani Pokharel</td>
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<td>Ministry of Health &amp; Population</td>
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<tr>
<td>7:30</td>
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<tr>
<td>8:30</td>
<td>Courtesy Call on Rt. Hon’ble Prime Minister Mr Girija Prasad Koirala</td>
</tr>
<tr>
<td></td>
<td>PM’s Residence, Baluwatar</td>
</tr>
<tr>
<td>10:00</td>
<td>Courtesy Call on State Minister of Health &amp; Population Hon’ble Mrs Shashi Shrestha</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health &amp; Population</td>
</tr>
<tr>
<td>10:30</td>
<td>Meeting with Mr Ramchandra Man Singh Secretary, Ministry of Health &amp; Population Dr Nirakar Man Shrestha, Chief Specialist, Policy, Planning &amp; International Cooperation Division Dr Govinda Prasad Ojha, Director General, Department of Health Services</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health &amp; Population</td>
</tr>
<tr>
<td>12:00 - 13:00</td>
<td>LUNCH BREAK</td>
</tr>
<tr>
<td>14:00</td>
<td>Meeting with the Professional Staff</td>
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<tr>
<td></td>
<td>WR’s Office</td>
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<table>
<thead>
<tr>
<th><strong>Thursday, 13 September 2007</strong></th>
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</thead>
<tbody>
<tr>
<td>8:30</td>
<td>Pick-up from Hotel Himalaya</td>
</tr>
<tr>
<td>10:30 – 12:00</td>
<td>Visit to Institute of Medicine</td>
</tr>
<tr>
<td></td>
<td>IoM, Maharajgunj</td>
</tr>
<tr>
<td>12:00 – 13:00</td>
<td>LUNCH BREAK</td>
</tr>
<tr>
<td>14:00</td>
<td>Meeting with Mr Matthew G. Kahane, Resident Representative, UNDP</td>
</tr>
<tr>
<td></td>
<td>OCHA Office</td>
</tr>
</tbody>
</table>
The followings are the Dignitaries from the Government side, especially from the Ministry of Health:

Rt. Hon’ble Mr Girija Prasad Koirala
Prime Minister

H.E. Mrs Sahana Pradhan
Minister of Foreign Affairs

H.E. Dr Ram Sharan Mahat
Minister of Finance

H.E. Mrs Hisila Yami
Minister of Physical Planning and Works

H.E. Mr Girirajmani Pokharel
Minister of Health and Population

H.E. Mrs Shashi Shrestha
State Minister for Health and Population

Mr Ramchandra Man Singh
Secretary, Ministry of Health and Population
Tel:  4262590
Res.  5523393, 5541517

WHO Country Office for Nepal
Dr Nirakar Man Shrestha  
Chief, Policy Planning and International Cooperation Division,  
Ministry of Health and Population  
Tel: 4262862; Res. 4255970

Dr Govinda Prasad Ojha  
Director General, Department of Health Services, Ministry of Health and Population  
Tel: 4261436

Dr Mahesh Maskey  
Chairman, Nepal Health Research Council  
Tel: 4254220

The followings are Senior Officials from United Nations and its related specialized Agencies in Nepal:

Mr Matthew Kahane  
Humanitarian Coordinator and Resident Coordinator of the UN System’s Operational Activities for Development

Ms Junko Sazaki  
Representative, United Nations Population Fund (UNFPA)

Mr Wasim Zaman  
Country Director, UNFPA Country Support Team for Central and South Asia (UNFPA/CST)

Mr Richard F. Ragan  
Country Director, World Food Programme (WFP)

Mr Abraham Abraham  
Representative, United Nations High Commissioner for Refugees (UNHCR)

Ms Bui Thi Lan  
Representative, Food and Agriculture Organization (FAO)

Ms Gillian Mellsop  
Representative, United Nations Children's Fund (UNICEF)

Ms Frances Turner  
Deputy Regional Director, United Nations Children's Fund Regional Office for South Asia (UNICEF/ROSA)
Mr Shengie Li  
Country Director, International Labour Organization (ILO)

Ms Susan Goldmark  
Country Director, World Bank

Mr Alexander Pitt  
Resident Representative, International Monetary Fund (IMF)

Mr Paul J. Heytens  
Country Director, Asian Development Bank

Mr Donald B. Clark  
Mission Director, USAID

Mr Noriaki Niwa  
Resident Representative, Japan International Cooperation Agency (JICA)

Ms Bella Bird  
Head of Mission, Department for International Development (DFID)

**Facts about WHO Nepal**

Nepal became a member on 2 September 1953 by becoming party to the constitution, joining the South-East Asia Region. WHO supports in Nepal has been mostly in the following areas:

- Policy development and planning
- Health systems management
- HRH (Human Resources for Health Development)
- Prevention and control of communicable diseases, including Polio Eradication and Leprosy elimination
- Family and community health
- Sustainable development and healthy environments
- Health technology and pharmaceuticals
- Resource mobilization and building partnerships with development partners/other agencies
A Joint GON/WHO Coordination Mechanism was established since 1987. Its terms of reference and membership were modified in line with the changes in the Ministry of Health May 1989. The mechanism operates through two groups:

- The GOV/WHO Policy Group acts for promoting coordination. It addresses main issues, and provides guidance to the working group.
- The GON/WHO Working Group, guided by the Policy Group, addresses the operational issues, through monitor’s implementation of activities by various Programme Directors.
- Both groups are headed by the Secretary, Ministry of Health and Population.

Nepal is a least developed and resource constrained country with difficult terrains. Most of its health status indicators are relatively low. Resource inputs from External Development Partners and technical supports from WHO have contributed to the improvements of health services over the years. But, much more resources and supports are needed to achieve the health policy objectives and the millennium development goals related to health. In addition to resources, some managerial issues that need to be addressed are as follows:

- Analytical decision making including operational planning has yet to become an integral part of managerial systems across the various levels.
- The overall coordination among different programs and interventions its inadequate.
- There is need to improve cost-effectiveness, efficiency and timeliness of implementation as well as to improve sustainability of interventions.
- The process of decentralization and community empowerment is relatively slow which also need rigorous streamlining.
- It is necessary to further streamline accountability of health managers and care providers, based on selected performance indicators.
### Country Office:

<table>
<thead>
<tr>
<th>International LTS</th>
<th>International STE</th>
<th>National Professional Officer (NPO)</th>
<th>National LTS</th>
<th>National STE</th>
<th>National SSA</th>
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<tr>
<td>3</td>
<td>-</td>
<td>2</td>
<td>12</td>
<td>2</td>
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### Project Offices:

<table>
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<tr>
<th>International LTS</th>
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<th>National Professional Officer (NPO)</th>
<th>National LTS</th>
<th>National STE</th>
<th>National SSA</th>
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<td>5</td>
<td>-</td>
<td>4</td>
<td>27</td>
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### Project Office: Immunization Preventable Disease (IPD)

<table>
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<tr>
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<th>International STE</th>
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<th>National STE</th>
<th>National SSA</th>
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<td>1</td>
<td>1</td>
<td>–</td>
<td>3</td>
<td>53</td>
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### Total Staff in WHO Nepal:

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<th>International LTS</th>
<th>International STE</th>
<th>National Professional Officer (NPO)</th>
<th>National LTS</th>
<th>National STE</th>
<th>National SSA</th>
<th>Grand Total Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>6</td>
<td>3</td>
<td>16</td>
<td>32</td>
<td>55</td>
<td>122</td>
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</tbody>
</table>
Situation Analysis

Political Scenario

The country is heading for a new Nepal shaping up a democratic system. As is usual the case, the country is facing with several difficulties and occasionally hiccups of political and social turmoil. The present political challenge is to conduct the CA polls peacefully, fairly and successfully. To render efficient focus for the political parties, the Legislative Parliament prorogued since 22 August 2007.

On 18 August, UN Under-Secretary-General for Political Affairs B Lynn Pascoe arrived in Kathmandu for a two day visit. During his stay in Nepal, he met with the Prime Minister, major political party leaders, Chief Election Commissioner, civil society leaders as well as UN Country Team representatives. Mr. Pascoe affirmed that the security situation was conducive to hold the CA election and urged the political parties to support the process of creating a free, fair and transparent environment to conduct the election. Similar calls for the conduct of CA election as scheduled were received from the India, US and UK envoys in Nepal.

In Terai, during the third week of August, Janatantrik Terai Mukti Morcha (JTMM Jwala Singh) warned Civil Servants in the Terai districts not to participate in any preparations for Constituent Assembly (CA) election. Similarly, on 20 August, JTMM (Goit) announced in Sunsari District that it would boycott the CA election and launch a campaign to disrupt the planned election. On 3 September, the chairman of Madhesi Peoples Right Forum (MPRF) Upendra Yadav called on the Madhesi community to be united and make the CA election a success. On 4 September, a leader of the Madhesi Tigers (MT), one of the armed groups operating in Eastern and Central Terai region, said in Saptari District that the group was not against the Constituent Assembly (CA) elections slated for 22 November. He also reportedly stated that the MT would lay down arms and take part in the CA elections if the government agreed to a proportional electoral system.

However, the government began implementing the first phase of security plan for the CA election. By 20 August, the Armed Police Force (APF) teams had reportedly been dispatched to 156 electoral constituencies. Similarly, on 30 August the Home Minister announced a detailed security plan for supporting the CA election that
includes the deployment of 40,000 regular police as well as recruitment of additional 70,000 temporary regular police and additional 6000 APF. On 27 August, the VDC secretaries who had been on strike demanding security guarantees from the government suspended their strike in order to create conducive environment for the conduct of CA election.

Concurrently, different political groups continued to exert pressure on the government to fulfill certain demands prior to the conduct of CA election. On 17 August, representatives of Dalit organizations from the ruling political parties put forward 15-point demand to the Government that include reservation of 20 % seats of Constituent Assembly for Dalits, free education and giving of preference to Dalits in foreign employment and education. On 19 August, CPN-Maoist set 22-point precondition for ‘credible’ CA election and announced a series of protest programmes that the party intended to launch by mid September to demand that the country be declared a republic before the CA election. Other demands by the CPN-Maoist include formation of a commission of inquiry on disappeared persons, round table conference of all sections of the society including Janajatis and Madhesis, release of all political detainees, start of the process for integrating the People’s Liberation Army (PLA) within the Nepali Army by forming a special cabinet committee, withdrawal of Nepal Army from the royal palaces and nationalization of the properties of the King. Several political parties are reported to have criticized the CPN-Maoist’s planned programmes.

On 30 August, the MPRF and government reached a 22 point agreement. As per the agreement, the government will provide compensation to the families of all Madhesi activists killed during the Madhesi movement and free treatment to all injured in the movement. The government also agreed to withdraw cases against the Madhesi leaders and activists and further agreed to ensure representation of all Madhesi minority communities in all state functionaries. The government and the MPRF also agreed to a federal structure of the state with autonomy without affecting the national sovereignty and integrity. The boundaries and rights of such federal units within the state would be decided by the Constituent Assembly. The government also agreed to give national recognition to dress, language and culture of the Madhesi communities, sanction public holidays during Muslim festivals and formulate laws to protect people’s religious rights, recognition of local Madhesi languages for official communication, provide free education up to primary level to Madhesis, give preferential treatment to Madhesi in education and employment and provide land to the landless within the Madhesh region. The MPRF in return accepted participation
in a mixed electoral system during the forthcoming CA election called off all its planned strike programmes.

Apart from the progress in preparation for CA Poll, on 23 August, The cabinet announced that it had decided to nationalize the property belonging to the royal family and formed a five-member panel to nationalize the royal property inherited by the present king, including the property of late King Birendra and his family. The property covered by this decision reportedly includes 7 palaces and the land where they stand namely Narayanhiiti, Basantapur, Patan, Bhaktapur, Gorkha, Lamjung and Nuwakot. The panel stated that it would consider nationalizing 5 other palaces and forested land as well.

The second phase of registration and verification of CPN-Maoist combatants at Division 2 Cantonment site in Sindhuli District, Central Nepal was completed.

(Source: OCHA)
Health System Trend

Policy/Stewardship

The Nepal Living Standard Survey 1995/1996 had reported a poverty incidence of 42 percent, the tenth plans goal was set based on the end 2001/2002 estimate of poverty which was about 38 percent. The NLSS 2003/2004 reported a decline of poverty by 11 points from 42 to 31 percent. However, Urban rural disparities are still alarming 31 percent of rural poverty to 10 percent of urban poverty. There is also disparity across regions, lowest poverty incidence in the central region (27 percent) and highest poverty incidence in the Mid western region (45 percent). Among the population groups, poverty is higher in the “lower” castes and indigenous group.

Percentage of HH reporting less than adequate

<table>
<thead>
<tr>
<th></th>
<th>NLSS-I</th>
<th>NLSS-II</th>
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</thead>
<tbody>
<tr>
<td>Food consumption</td>
<td>50.9</td>
<td>31.2</td>
</tr>
<tr>
<td>Housing</td>
<td>64.1</td>
<td>40.6</td>
</tr>
<tr>
<td>Clothing</td>
<td>57.6</td>
<td>35.6</td>
</tr>
<tr>
<td>Health care</td>
<td>58.7</td>
<td>28.3</td>
</tr>
<tr>
<td>Schooling</td>
<td>45.4</td>
<td>21.4</td>
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<tr>
<td>Total income</td>
<td>72.6</td>
<td>67.0</td>
</tr>
<tr>
<td>Adult literacy, Total</td>
<td>35.6</td>
<td>48.0</td>
</tr>
<tr>
<td>(15+) F</td>
<td>19.4</td>
<td>33.8</td>
</tr>
<tr>
<td></td>
<td>53.5</td>
<td>64.5</td>
</tr>
<tr>
<td>NER in primary school</td>
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<td></td>
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<tr>
<td>Total</td>
<td>57.0</td>
<td>72.4</td>
</tr>
<tr>
<td>Female</td>
<td>46.0</td>
<td>66.9</td>
</tr>
<tr>
<td>Male</td>
<td>67.0</td>
<td>77.9</td>
</tr>
<tr>
<td>Children fully immunized</td>
<td>36.0</td>
<td>59.4</td>
</tr>
<tr>
<td>Access to electricity</td>
<td>14.1</td>
<td>37.2</td>
</tr>
<tr>
<td>Access to piped water</td>
<td>32.8</td>
<td>43.9</td>
</tr>
<tr>
<td>Access to toilet facility</td>
<td>21.6</td>
<td>38.7</td>
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</table>
Household access to facility within 30 minutes

<table>
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<tr>
<th>Facility Type</th>
<th>Access 30 mins Nepal</th>
<th>Access 30 mins PRSP</th>
<th>Access 30 mins Proportion</th>
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<tr>
<td>Primary school</td>
<td>88.4</td>
<td>91.4</td>
<td></td>
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<tr>
<td>Health post/hospital</td>
<td>44.8</td>
<td>61.8</td>
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<tr>
<td>Agriculture centre</td>
<td>24.5</td>
<td>31.9</td>
<td></td>
</tr>
<tr>
<td>Commercial banks</td>
<td>20.7</td>
<td>27.8</td>
<td></td>
</tr>
<tr>
<td>Paved road</td>
<td>24.2</td>
<td>37.2</td>
<td></td>
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<tr>
<td>Motorable road</td>
<td>58.0</td>
<td>67.6</td>
<td></td>
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</table>

(Source: PRSP progress report 2005)

The key challenges to the health system are:

- a. Find means of increasing overall (public and private) resources for health care.
- b. Ensure essential services (i.e., services which produce the greatest reduction in health burden) and the poorest people, receive the greatest share of public subsidies.
- c. Improve the efficiency and acceptability of publicly provided services.
- d. Improve the value (high quality at reasonable cost) of privately provided services.

Policy response to these challenges

Government policies have been consistent in confirming its commitment to equity and meeting the needs of the poor through the delivery of essential health services:

- A Poverty Reduction Strategy Paper (PRSP), based on the work of the Public Expenditure Review Commission, has been endorsed by the Government.
- The 1999 Local Self-Governance Act sets out a framework for decentralized delivery of health care.
- The Second Long Term Health Plan (SLTHP) 1997–2017 defines the responsibilities of the Government:
  - to ensure that an essential health care package is available to all regardless of ability to pay.
  - To ensure policies and strategies are in place for health needs that fall outside the essential package
  - to regulate the private health market/sector
- The SLTHP put special emphasis on improving the health status of the very poor and other vulnerable groups whose health needs often go unmet.
- The Medium-Term Expenditure Framework July 2002 categorized health budget in three prioritized health services and awarded first priority to Essential Health Care Services (EHCS).
• The Health Sector Strategy – Agenda for Change, 2002 sets out the agenda for health reform
• The Three Year Plan (2064/65 – 2066/67)

Financing trends
Composition of health expenditure in Nepal

Source: NHSP-IP

Approximately 14 percent of total health expenditures in Nepal are channeled through the Ministry of Health and an additional three percent is spent by other ministries (e.g., MoF, MoD, MoE), autonomous bodies (e.g., universities) and local bodies (DDC, VDC and municipalities). In addition, direct expenditures by external development partners account for another 13 percent of health expenditures.

These estimates of total health expenditure suggest that Nepal spends approximately NRs. 1,200 per capita (US $ 6.8 per-capita) on health expenditures. This statistic on per-capita expenditure, however, must be balanced against the fact that health spending is highly uneven across income groups with the majority of private expenditures coming largely from the few, relatively well off and spent primarily on curative and tertiary care.

Under the 10th Plan/PRSP, MoH is the line agency charged with implementing the NHSP-IP. Though private and other (non-MoH) public health expenditures complement the health sector strategy, the feasibility of NHSP-IP must be sized against resources available to MoH. Other public agencies (MoF, MoHA, MoD, MoESC) that provide health services may complement the NHSP objectives but do not play a direct role in implementing the strategy and are not accountable for any
of the NHSP goals. Consequently, this analysis examines public health financing for the health sector strategy only in terms of MoHP and does not account for expenditures from private contributions or other (non-MoH) public agencies.

**Government commitment to the health sector**

The Government has engaged with a new Three Year Health Plan with innovative approaches to address the popular people’s movement voices. The Three Year Plan emphasizes on the expression of the Interim Constitution "Free Basic Health Services to All". In the recent budget statement in the Legislative Parliament the Finance Minister expressed as:

Quote: “I have proposed to earmark Rs. 12 billion and 180 million in health sector. This figure is Rs. 2 billion and 870 million more as compared to the previous year. I hope, the proposed budget will contribute to the prompt and qualitative delivery of basic health services. The implementation of this budget, I hope, shall contribute to curb the population growth rate, reduce child and maternal mortality rate, improve the physical facilities in hospitals and hence to increase the average life expectancy.

The number of beds in hospitals shall be increased. Construction of hospitals and health centers shall be given continuity. Budgetary provision has been made to upgrade 25 sub health posts into health centers on the basis of population and geographical location. Concessions shall be made available to the students of community schools while providing medical services in government hospitals and primary health centers. Additional budget has been earmarked to improve the supply of medicines and equipments in the hospitals and health centers. Mandatory provision has been made to explicitly mention an indication “For free distribution and not for sale” in the external cover of the medicines that are meant for free distribution.

Integrated child disease management Programme will be implemented in 64 districts with additional 16 districts in 64 districts to reduce infant mortality rate. 10 million vitamin tablets and 80 million Iron Tablets will be distributed. School vaccines Programme will be implemented in 44 districts as well as administering Polio drops Programme will be continued.

Vaccines will be provided against encephalitis. Spraying medicines will be launched in a broader scale to control Kala-azar."
A Programme will be launched establishing a permanent fund in every village development committees to encourage women volunteers who are under the family planning and secured maternity Programme. Thirty five (concerning the eradication of Prolapse 25, ENT 5 and specialist 5) free mobile health camp will be launched. Nepal Medical Association and Non Governmental Organizations will be mobilized to operationalize the camp.

The policy taken by the Government of Nepal current year to send doctors, who have completed M.B.B.S. under the scholarship Programme of the Government of Nepal to provide their services in remote and rural area health centers, will be continued.” Unquote.

The following are graphic presentations in line with the proposed budget for health sector:
Situation Analysis

A Cross-Sectional Perspective on WHO Collaboration

During the recent Joint Annual Review 25 June – 1 July 2007 the Ministry of Health has agreed the following innovative actions to be taken up as an urgent matter.

- Integrated management of childhood illness (IMCI); from 48 districts to 60 districts.
- Maternity Incentive Scheme: from payment for the first two births per mother to all births.
- Community Drug Programme: from 32 districts to 48 districts

### Budget Analysis Output-wise NRs in billion

<table>
<thead>
<tr>
<th>Service</th>
<th>2006-07</th>
<th>2007-08</th>
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<tbody>
<tr>
<td>EHCS</td>
<td>11.524</td>
<td>71.93</td>
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<tr>
<td>Decentralization</td>
<td>0.474</td>
<td>2.98</td>
</tr>
<tr>
<td>Sector Management</td>
<td>0.512</td>
<td>2.28</td>
</tr>
<tr>
<td>Health Financing</td>
<td>0.141</td>
<td>1.35</td>
</tr>
<tr>
<td>Logistics/assets</td>
<td>1.368</td>
<td>8.80</td>
</tr>
<tr>
<td>HRD</td>
<td>0.194</td>
<td>1.22</td>
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<tr>
<td>Integrated HMIS</td>
<td>0.171</td>
<td>0.99</td>
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<tr>
<td>PPP (beyond EHCS)</td>
<td>0.051</td>
<td>0.32</td>
</tr>
<tr>
<td>Beyond EHCS</td>
<td>1.783</td>
<td>10.14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16.217</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
- Scale up provision of essential drugs
- Increase the production of skilled birth attendants (1000)
- Scale up new policy on user fees abolition. Currently 70% of facilities (district hospitals up to 25 beds and all primary health centers) have abolished in-patient care and emergency care for the poor and vulnerable. In 25 districts the abolition to be extended to outpatient care as well.
- Introduce telemedicine in 18 districts in collaboration with private hospitals.
- More budget directly allocated to district level current 13% to 25% in coming year.
- Scaling up of anti filarial mass drug campaign.
- Scale up interventions in addressing prolapse of uterus – treatment camps
- Scale up of nutritional interventions.

At the same time EDPs in health has also suggested messages for the MoF on means to improve development implementation in relation to move forward for aid effectiveness and speedy utilization of funding:

1. Improve the financial disbursement to districts: an important trigger in this is ensuring all district treasury offices submit their statements of expenditure on time.

2. Strengthen financial controls and audit capacity in the districts: an important step is approval by Cabinet of the pending amendments to the Local Bodies Financial and Administrative Rules.

3. Implement the recently promulgated Public Procurement Law based on international norms. Key next steps are approval by Cabinet of the Public Procurement Regulations and establishment of the Public Procurement Monitoring Office.

4. Direct that, at district and village level, local bodies comprised of all party representatives, will be formed to oversee development planning and implementation-carried out by the VDCs and DDCs. This will be an interim arrangement until local governments are formed.
5. Scale up performance related budgeting to DDCs: good practice includes: transparency in budget planning, being proactive in ensuring the development budget is disseminated in “user friendly” means and ensuring public auditing mechanisms are in place.

6. Enact a Civil Service Law which will improve the professionalism, and hence accountability, productivity and inclusiveness of the service at all levels of government. In the interim fully respect legislature with regard to the tenure of civil service postings (2 years).

7. Fill staff vacancies in local government bodies, particularly in DDCs and VDCs, to enhance implementation capacity. A package of incentives (both financial and non financial) needs to be offered to motivate civil servants to locate in remote settings and fulfill the tenure of their appointments.
**Floods and Landslides**

This year the monsoon rains arrived on 10 July and triggered severe landslides and localized flooding in some parts of the country. From 12 to 15 July, 26 people died due to landslides in remote Village Development Committees in Baglung and Bajura districts. Rescue teams faced difficulties reaching the remote locations, and displaced families and damaged water pipes remained public health priorities for days.

Mahottari district was affected by rains on 25 July and two days later incessant rains caused widespread flooding in the Terai belt. By 27 July Banke, Dhanusha, Siraha and Saptari districts had more than 1,000 displaced families each. At the time of writing, Nepal Red Cross Society (NRCS) assesses that the floods and landslides have caused at least 131 deaths, displaced more than 18,410 families and affected approximately 406,587 people in 44 districts (15 August).

A Central Disaster Relief Committee meeting took place on 27 July followed by a high-level meeting in the Ministry of Home Affairs (MoHA) on 28 July. Further coordination meetings were organized by OCHA, NRCS, DP-Net and WHO during subsequent days and supported by active email exchange among key responders.

The fact that this year’s floods and landslides in Nepal were linked to flooding in India and Bangladesh, create international media interest. Also the increased number...
of humanitarian agencies in the country contributes to prompt and plentiful response capacity. Although no Government appeals for international assistance were issued, the Ministry of Foreign Affairs requested foreign assistance during an appraisal to donors and diplomats.

Water logging posed a major challenge during the initial response and hindered access to the worst affected areas. In some districts in the Eastern and Central Region, access was further compromised by the unstable political and security situation. Bandhs and civil unrest made it difficult to conduct rapid assessments and deliver emergency relief. Since more attention is being given to districts in the Mid-West than in the Central and Eastern regions, unbalanced distribution of assistance has become an issue.

Despite these difficulties, relief and response operations were quickly mobilized by MoHA and NRCS in coordination with Chief District Officers and international and national stakeholders. Initial relief efforts focused on search and rescue, identifying emergency shelters, providing potable water, food supplies and nonfood items as well as ensuring access to health care.

Immediately after 27 July EDCD / DHS deployed three response teams to Biratnagar, Birgunj and Nepalgunj to provide public health guidance and epidemiological support to the DHOs / DPHOs and RRTs. EDCD also opened a hotline from 6 am till 6 pm to receive urgent health updates from the field.

At the end of July, MoHP formed a high-level committee for mitigation of health impacts of the floods and landslides. The high-level committee established six health teams comprising of a coordinator from MoHP / DHS, a medical doctor, a paramedic and a nursing staff, to coordinate field response and provide emergency medical care and public health guidance. From 1 August onwards, the teams were dispatched to the following locations:

- Janakpur covering Dhanusha, Mahottari and Sarlahi districts
- Birgunj covering Bara, Parsa and Rautahat districts
- Bhairahawa covering Rupandehi, Nawalparasi and Kapilvastu district
- Nepalgunj covering Banke, Bardia and Kailali districts
- Biratnagar covering Jhapa, Morang and Sunsari districts
- Lahan covering Siraha and Saptari districts
In addition, the National Health Education and Information Centre prepared health messages to be disseminated through mass media. Compared to previous years, the health response was impressive – perhaps because severe outbreaks of acute gastroenteritis had kept DHS / EDCD on high alert since the middle of May.

Public health interventions were clearly more important than medical care. Lack of medical doctors and medical teams have not been an issue. For this reason, WHO did not encourage international medical teams to begin operating in Nepal during the emergency. It appeared more appropriate to strengthen the national health system rather than substituting it.

Lack of emergency medicine was also not a priority, since DHS was in the process of distributing regular medical supplies to peripheral health facilities. Before the floods and landslides, EHA had pre-positioned two diarrhoeal kits at the regional medical stores in Nepalgunj and Biratnagar. On 3 August, WHO delivered additional emergency supplies to the five MoHP teams.

As in pre-emergencies, WHO continued to collaborate with EDCD during the flood response. EHA concentrated its initial efforts to work closely with WHO IPD and EDCD to establish an information management system based on multiple sources including rapid health assessments, disease surveillance data and media reports.

On 2 August, EHA called an EHNWG meeting to assist in assessing and coordinating health interventions.

Health issues in general and epidemics in particular were given a lot of attention from the beginning of the floods. Last year’s malaria outbreak in flooded VDCs in Banke district was widely regarded as an example of what should not happen again.

WHO acknowledges the heightened risk of increased mortality and morbidity in the coming weeks and months due to risks of outbreaks; most importantly respiratory infections, diarrhoeal diseases, vector-borne diseases and snakebites. Although an increased number of viral fever cases, acute respiratory infections, diarrhoeal diseases, eye and ear infections and skin diseases have been reported, they are below epidemic threshold. However, it is yet too early to write off the risk. The monsoon season is not over and endemic diseases continue to claim a heavy toll in remote districts.
Flood and Landslide Statistics

In order to maintain a perspective on the ongoing flood response, it is useful to contextualize this season’s statistics with historical records. Official data from the Ministry of Home Affairs provides the following picture of mortality and morbidity caused by floods and landslides during the past six Nepalese years (NRCS data from this year superimposed as of 15 August):

Mortality and Morbidity due to Floods and Landslides
Year 2058-2064 (2001-2007)

(Source: MoHA)
Apart from year 2059 (2002), the number of injured and deaths are relative small compared to other public health threats such as communicable diseases and road traffic accidents. Although the above data is not desegregated by flood and landslides, it is likely that most fatalities are caused by landslides rather than by flash floods.

NRCS is an equally important source of information since the society includes the number of displaced families, which remains a key public health indicator. Based on the last issued sitrep from past years, the following pattern of displaced and affected families emerge (2007-data included as of 15 August):

Number of Displaced Families due to floods and landslides 2002-2007

Even though the flooding is worse compared to the past two years it is not yet at the level of 2004. What the coming weeks have in store for us remains an open question...

It is worth keeping these numbers in mind when evaluating the international media interest in this year’s flooding in Nepal, which is being linked to similar scenarios in India and Bangladesh. Humanitarian needs, media interest and response commitment does not always correlate!
International Health Partnership

Since its inception, under the direct supervision of the Regional Office, the country office has engaged itself pro-actively in this endeavour of new initiative. At the country level DFID, WB and WHO are the three prime movers and jointly briefed the Ministry of Health and EDPs. While handing over to the Rt. Hon'ble Prime Minister, all three Agencies participated.

Based on the series of draft global concept note, WHO took the initiative and develop the Nepal Concept Note in close cooperation with the DFID and WB. Later a contribution from the Ministry of Health has also been obtained. The note is now at its version 4 and has been shared with UN Agencies and EDPs.

From this concept note attempts will be made to develop strategic papers on the following issues:

1. Skilled Birth Attendants – SBA.
2. Female Community Health Volunteers – FCHV.
3. Essential Health Care Services – EHCS.
4. Decentralization of Health System and its Management
5. Health Care Referral System.
6. Community Drug Programme – CDP.
7. Decentralized Health Management Information System – HMIS.
8. Abolition of User Fees.

The strategic papers will look into issues, constraints and challenges more closely and identify alternative ways and means for a better performance of the health care system. As of now, we have already drafted Decentralization of Health System and its Management, Health Care Referral System, Community Drug Programme and Decentralized Health Management Information System. Currently these drafts have been shared with Ministry of Health. These drafts are also presented in the annexure.

The following is the Nepal Concept note, version 4:

Rationale

This concept note provides an initial overview of the immediate health sector challenges in Nepal. This exercise attempts to understand the health service delivery barriers and prepare the way forward to introduce the new scheme started by the Health Access Initiative, geared to reduce child and maternal mortality and lessen the impact of the major killer diseases- AIDS, TB and Malaria.
International Health Partnership has selected Nepal as one of the seven countries to implement the first round of the programme. The objective of the initiative is to reduce child and maternal mortality, and to reduce the impact of the killer diseases AIDS, TB and malaria as part of the global effort to meet the millennium development goals (MDG 4, 5 & 6) in these areas. This will be achieved by increasing the numbers of people who have access to a health service that can deal with their major health problems. Given that infectious diseases, nutritional disorders and maternal and perinatal problems dominate the overall pattern of morbidity in Nepal, a proactive participation in this Partnership is quite pertinent.

The Concept Note will provide a situation analysis of the health sector in Nepal including a brief note on the health policies drafted by the Ministry of Health and Population (MoHP) and a description of the key components of the health care delivery system in Nepal, i.e. Essential Health Care Services package. It also introduces the mechanism in which the health stakeholders work with the government. The paper finally summarizes the identified areas of interventions to ensure universal access of EHCS and how it could be scaled up to achieve the expected health outcomes of the National Health Plan.

1. Situation Analysis

Nepal is a landlocked country, with a large proportion of the area being hills and mountains and 31% being under the poverty belt (the rural-urban disparities are still alarming: rural poverty is 35% compared to 10% in urban areas). Given this challenging situation, its way forward to achieve the health related Millennium Development Goals, cannot by any means be an easy formulae.

1.1 Health overview

Over the years, Nepal has made progress in raising the health status and living standards of the population in terms of life expectancy, total fertility rate, child immunization, adult literacy and access to health care. Yet, the country continues to be afflicted with the double burden: persistent problems of infectious diseases along with emerging epidemics and upward trends of lifestyle related noncommunicable diseases. HIV/AIDS is still primarily confined to vulnerable groups such as labour migrants, sex workers and intravenous drug users. HIV/AIDS is regarded to be in a stage of “concentrated epidemic” but has the potential to develop into a more generalized epidemic. Malaria is still a major public health problem.

The table below summarizes the progress made so far by Nepal in relation to the health related Millennium Development Goals (MDGs) against the targets the country
needs to reach by 2015. According to these indicators and the evaluation made in 2005 on the potential of each country to reach MDGs by the target year, further assistance is recommended for Nepal to meet the 5th and 6th development goals. Nevertheless, it must be noted that improvements have been made in important health areas during the last few years as indicated in the Nepal Demographic and Health Survey (NDHS), published in 2006.

The Maternal Mortality Rate (MMR) has fallen from an estimated 539/100,000 live-births in 1996 to 281/100,000 in 2006 which is still high and warrants concerted action to bring it down. The infant mortality rate decreased from 64.4/1000 live-births in 2001 to 48/1000 live-births in 2006. The perinatal mortality has recorded a slight improvement from 47/1000 pregnancies (2001) to 45/1000 pregnancies as of 2006.

Selected Millennium Development Goal Indicators, Nepal 2006

<table>
<thead>
<tr>
<th>Goal (MDG)</th>
<th>Indicator</th>
<th>2001</th>
<th>2006</th>
<th>2015 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Reduce Child Mortality</td>
<td>Under 5 mortality rate (per 1000 live births)</td>
<td>76</td>
<td>61</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Infant mortality rate (per 1000 live births)</td>
<td>64.4</td>
<td>48</td>
<td>34</td>
</tr>
<tr>
<td>5. Improve maternal health</td>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>539*</td>
<td>281</td>
<td>213 or 134</td>
</tr>
<tr>
<td></td>
<td>% of births attended by skilled birth attendant</td>
<td>13</td>
<td>18.7</td>
<td>60</td>
</tr>
<tr>
<td>6. Combat HIV/ AIDS, malaria and other disease</td>
<td>% of current users of contraception who are using condoms</td>
<td>NA</td>
<td>1.09</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Condom use at last high-risk sex</td>
<td>NA</td>
<td>71.2</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>% aged 15-24 with comprehensive knowledge of HIV/AIDS</td>
<td>NA</td>
<td>43.6 (males) and 27.6 (females)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Contraceptive prevalence rate</td>
<td>NA</td>
<td>44.2 (females)</td>
<td>--</td>
</tr>
</tbody>
</table>

* Source- NDHS 2006 & CBS (2007), Nepal
* refer to year 1996
A cross cutting health issue affecting the progress of the above mentioned indicators is the high malnutrition rates reported in the country. According to the NDHS (2006), almost half of children under 5 are stunted (too short for their age), 13% are wasted (too thin for their height) and 39% are underweight (weigh less for their age).

Malnutrition in Nepal varies ecologically. Stunting is more common in the mountain areas than in the Terai, but underweight and wasting are more common in the Terai area than in the mountain areas. Protein-Energy Malnutrition (PEM) in Nepal is caused by low weight at birth, which leads to an intergenerational cycle of malnutrition. Both macro and micro nutrients deficiencies are common in Nepal particularly among children and women, although some improvements in this regard had been recorded during the last five years. The percentage of children stunted fell by 8% (57% in 2001 to 49% in 2006). Underweight declined slightly (from 43% to 39%), and wasting arose from 11% in 2001 to 13% in 2006. National biannual vitamin A supplementation programme was introduced in all districts due to the high prevalence of worm infestation among children under 5.

Inequitable access to health care facilities is another major factor contributing to the increase of the disease burden in the country, where gender, age, caste, ethnic group, income and area of residence seem to unfortunately determine the health care accessed/received. Transport costs are a significant deterrent to the poor accessing health care in remote areas and the largest equity discrepancies relate to areas of residence. Furthermore, access to both public and private inpatient facilities vary considerably by income group with the wealthier having higher utilization of both public and private facilities.

**Mortality by area of residence (2006)**

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Infant Mortality</th>
<th>Under 5 Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>37</td>
<td>47</td>
</tr>
<tr>
<td>Rural</td>
<td>64</td>
<td>84</td>
</tr>
<tr>
<td>Mountains</td>
<td>99</td>
<td>128</td>
</tr>
<tr>
<td>Hills</td>
<td>47</td>
<td>62</td>
</tr>
<tr>
<td>Terai (Plains)</td>
<td>65</td>
<td>85</td>
</tr>
</tbody>
</table>

*Source: NDHS 2006*
It is estimated that health spending in Nepal (both public and private) is around US $14 (The commission on Macroeconomics on health recommends 23-34 dollars per capita spending for developing countries). The public spending on health is estimated to be 1.76 % of GDP. Government health expenditure has not increased substantially since 2000, both in terms of proportion and per capita (US $ 4.06).

Since restoration of the parliament and democracy in April 2006 after a decade long civil conflict, positive changes have taken place in the development sectors in Nepal. MoHP, under the new government, issued a 10 point guideline making health a fundamental human right of Nepali people. The Government of Nepal (GON) has started providing free health services to the poor, socially disadvantaged women and indigenous people, and it plans to expand these by promoting corporate social responsibility of the private sector.

1.2 Health Policy of the Government of Nepal

To provide an equitable, high quality health care system and to be in line with the poverty reduction strategy paper and MDGs, MoHP formulated the ‘Health Sector Strategy: An agenda for reform 2003’. This strategy outlines three programme outputs and five management outputs as it’s core focus during the five year period, starting from 2004. The programme outputs pay special emphasis on expanding the Essential Health Care Services (EHCS), decentralization of health management and providing cost effective quality services to consumers through the private sector and NGOs. The management outputs focus on coordination within the MoHP to support decentralization, sustainable development of health financing and resources, effective management of physical assets and procurements, develop better human resource policies and a comprehensive integrated management information system.

The operational guidelines to achieve the 8 outputs of the Health Sector Strategy are spelt out in the Nepal Health Sector Programme – Implementation Plan (NHSP-IP) and the Business Plan for Health Sector. Both these documents emphasize on increasing coverage and quality of the EHCS (more details given below).

Given the change in the current political context, A three year Interim Plan was developed by the MoHP in 2007. It aims to ‘bring about improvement in the health status of all Nepalese population with provision of equal opportunity for quality health care services to all through an effective and equitable health system….”. This includes programmes to operationalize the constitutional provision of “Free
Basic Health Services to all” starting with the poor and socially excluded living in 35 low HDI districts, marginalized groups like women, people living in geographically difficult regions where all health indicators are low and also include measures to mitigate the mental and physical problems for the conflict victims.

While the present context signifies hope for better health to its people, many are pessimistic that this may be limited to policies and strategies to be seen only in paper. In order for the GON and MoHP to make real commitment to increase access to health care to achieve the MDGs,

systematic technical assistance needs to be provided to address the key issues hampering scale up of health interventions.

1.3 Essential Health Care Services (EHCS)

The Sub Health Post (SHP), Health Post (HP), Primary Heath Care Centre (PHCC) and District Hospital are the foundation of the health care system of the country. They are also complemented by the household/family and community outreach services. Investment in proper health interventions at this level will result in very high health gains. With this in mind, Nepal’s health system introduced the EHCS (EHCS) Package at health facilities in district level and below.

At present the EHCS package includes a total of 20 interventions. These could be categorized broadly into the 4 following areas;

- Family planning, safe motherhood and neonatal
- Child health
- Communicable disease control
- Out-patient care

This strategy redirects the high cost – low impact interventions towards a more pro-poor strategy. As this intervention is critical to the health outcomes of the country, it is time to revisit the strategy and process, in terms of its conceptualization between the providers and stakeholders, appropriate and optimal skill-mix and infrastructure needs at each tier, enabling sensitive response to community needs inclusive of gender issues and political commitment at all level of administration, especially the local bodies.
2. Health Stakeholders in Nepal

Nepal’s health system works very closely with the External Development Partners (EDPs), which includes those agencies who have all signed a Statement of Intent to cooperate in a Sector-Wide Approach (SWAp). Health Sector Development Partners Forum, chaired by the MoHP, is another parallel mechanism for stakeholder collaboration. All partners act collectively within these two mechanisms and have regular biannual sessions which include a Joint Annual Review (JAR), i.e., the prospective one which seeks to reach broad agreement on the forthcoming year’s work plan and budget and the retrospective one which seeks to review the performance of the sector in the previous year.

This year, the MoHP proposed a steep increase in the budget over the previous fiscal year. Public resources in the proposed budget account for 47% and EDP resources 53%. EDPs regularly meet with the government counterparts to plan the health policy and determine implementation mechanisms. At the recent JAR, EDPs suggested the following areas as requiring attention for the health system to deliver the promised goods. They are; to ensure more than four in five (83 percent) Nepalese children age 12-23 months are fully immunized against the six major illnesses, expand Integrated Management Childhood Illnesses (IMCI) from the prevailing 48 districts to 60 districts, change maternity incentives scheme from payment of the first two births per mother to all births, expand provision of essential drugs, increase the production of skilled birth attendants to 1000, scale up the implementation of the new policy on user fees abolition to include outpatient care in 35 districts (at present 70 percent of the district hospitals with up to 25 beds and all primary health centres practice this policy for inpatient and emergency care), introduce telemedicine in selected districts in collaboration with private hospitals, increase allocated budget directly to district level from 13 percent to 25 percent in coming years and make provisions for scaling up anti filarial mass drug campaign, prolapsed-uterus treatment camps and nutritional interventions.

3. Health System Challenges

The new interim Three Year Health Plan is in line with the overall objective of International Health Partnership. Increasing the number of people who have access to health care services is enforced in Nepal through EHCS package, which is the primary focus in the Three Year Health Plan. It spells out a road map to meet the targets for EHCS expansion and may not be successful if the major bottlenecks within the health system are not systematically addressed.
WHO, as a lead International agency for health, suggest the following as priority areas to be strengthened to overcome the health system problems preventing scaling up for better health in Nepal.

**International Health Partnership in Nepal**

A bottom-up approach is advocated by WHO where community level health centres is strengthened to ensure that people from the lowest economic strata have access to basic health care. For peripheral level health facilities to function normally, a decentralized management system is imperative. Especially in a country, where geographical barriers prevent instant communication and access, VDC/district level decision making ability would be crucial. While the health facilities at rural level are being strengthened to meet demand, an active mechanism of disease surveillance culture among health personnel together with a management information system needs to be implemented to ensure regular monitoring and supervision. ‘Strength at
the Periphery’ will be best motto for Nepal to enhance equitable access to health care and also to enable to cope during the extra stretch the country faces with natural calamities every year.

3.1 Improved Functional Health Facilities at Periphery Level

Majority of Nepal’s population live in rural areas. For these people, SHP is the first contact point to access basic health services. It is the referral centre for volunteer cadre of trained traditional birth attendants (TTBAs) and Female Community Health Volunteers as well as venue for community based services. At the moment the government is upgrading these to the level of HP.

PHCC is the first referral point and it is the lowest health facility manned by a medical officer (doctor).

To ensure universal access to basic health care, peripheral level health care facilities need to be strengthened in terms of infrastructure (to continue the upgrade of SHP to HP), logistics (equipment and drugs to be available throughout the year) and human resources (all sanctioned posts to be filled and training to be provided to ensure the correct skill-mix). Regular monitoring and supervisions mechanisms need to be strengthened to identify gaps and address them immediately.

Distance and accessibility to this first level health facility should be equitable for all groups of population irrespective of their wealth, residence, caste and other socio-economic status. Since EHCS is meant to be delivered at district level and below, having functional first level health facilities play a key role in increasing the number of people who can access the health services.

3.2 Community Drug Programme

The main objective of the Community Drug Programme (CDP) is to increase the utilization and efficiency of health facilities so that its own financing together with the government contribution can meet total resources needed. The programme ensures availability of essential drugs at SHPs, HPs and PHCCs throughout the year, promotes community participation in management of health system and standardizes the prescription pattern. Since introduction of the programme, availability of essential drugs in the PHC outlets has improved. However, quality of care in terms of rational use of drugs, availability of the right drugs and trained health workers and auditing mechanism need further strengthening. The programme has so far being implemented
in 32 out of 75 districts of the country and planned to be extended to 48 districts. While extending to more districts, safety-nets should also be imparted for the underprivileged groups of people. Local bodies may also encourage and monitor full functioning of CDP management committee.

### 3.3 Decentralized Health Management

With regard to decentralization, currently more efforts are being made to hand over health care institutions to local bodies reflecting more in terms of devolution. From a health system perspective, more value may be added in decentralizing the services. This process requires definition of available health care services at each facility level, developing a dedicated health referral system with SOPs to avoid disconnection from the peripheries to the highest level.

Nepal, through the 1999 local Self-Governance Act and subsequent guidelines, has embarked on a multi-sectoral process of decentralization of government functions, including health services. Decentralization of peripheral health facilities will be designed to address those aspects of health facility management and services that are currently identified as problems amenable to local solutions, while at the same time avoiding large changes in programs that have successful models. GON hopes to achieve the following through this process of decentralized management of health facilities:

- Shifting some personnel management functions to local health committees may result in better staff accountability and increased ability to replace poorly performing staff.
- Adequate supplies of basic commodities and essential drugs. These issues are being addressed through logistics and physical assets management reforms.
- Proper maintenance of facility and equipment maintenance. Local management of facilities is expected to generate additional support for maintenance.

Presently Nepal lacks the human resources and management infrastructure to introduce autonomy rapidly. Preparation will involve training a cadre of hospital administrators and adoption of written guidelines for policies and procedures for autonomous hospitals.
To date, decentralization process is limited to 14 districts. However, it is felt that no real authority has been transferred to the district or village development committees from the central bodies. Furthermore decentralization has been difficult as most of the VDC secretariats have been displaced during the conflict.

Through decentralization, many bottlenecks with regard to logistics, procurement and human resources could be addressed as the local authorities would be responsible for the functioning of the health facilities.

### 3.4 Health Management Information System (HMIS)

One of the sector management outputs is a comprehensive and integrated management information system for the whole health sector designed and functional at all levels. Currently HMIS is being established in a phase-wise manner. This includes data on health finance, personnel, logistics, facilities, maintenance, performance, and impact at all levels. The attempt will also define service indicators and allow mapping, so that managers at all levels can execute informed decision in a timely manner. The system will also accommodate the HRD Information System (HRDIS).

However, there are several teething problems which have to date, limited HMIS to reach peripheral levels appropriately. Sensitivity of surveillance information through the established HMIS system needs improvement. Moreover comprehensive disaggregated data are not yet available. Especially in the endeavor to achieve the MDGs in the set time frame, disaggregate data is indispensable.

It is also an opportune time to explore the hospital information management system as this will address retention issues of manpower, shortage of essential drugs and equipment in terms of seasonal disease trends. A proactive feedback mechanism should be built-in and thereby encourage use of information both at the decision and operation levels. It may further need to identify different modes of data dissemination based on need and availability of resources. A periodic assessment of the system in terms of human, material and financial resources is essential to clear all impediments, side by side with degree of utilization and updating the mapping of target audience.

### 3.5 Human Resource Planning, Development and Management

There has been a tremendous progress in the production of human resources for health. Almost all types of health workers starting from specialists to grassroots
level health staff are produced inside the country. However, the qualitative aspect
of human resource planning, development and management need further attention
to achieve the health policy targets and health-related MDGs. Important strategic
issues related to decentralization of health services; public-private NGO partnerships;
development and implementation of pro-poor health interventions; mobilization of
additional resources; and strengthening health system’s responsiveness all rely on a
string public health workforce and their effective utilization.

There is an imbalance in the production of different categories of health professionals,
resulting in lack of appropriate skill-mix in many cases. The level of skills and
competencies of public health workforce particularly paramedics is below the
required standard. Coordination among the concerned ministries, universities and
institutions need further improvement.

The problem of human resource management with regard to deployment, retention,
utilization and accountability are major challenges. Streamlining of regulatory
framework to ensure accountability in health care needs facilitation. Hospital
administration remains a relatively neglected area due to paucity of
competent managerial staff. Assistance will be required to develop public
health workforce through short-term, in-country training to address priority health
problems at community level. The major challenge the country faces at present, in
terms of health sector human resources is that only 19% of child births are attended
by SBAs (MDG target is 60 by 2015). The current target is to have 1000 SBAs by the
end of 2007.

The SHP level health workers are responsible to deliver EHCS components to the
people at their door steps. Hence, the competency of these categories of health workers
is crucial to ensure the quality of EHCS is maintained. Systematic monitoring and
supervision has been a critical concern for the delivery of quality health care services
at peripheral outlets of Nepal. There are approximately 14,710 PHC/ORC and 16,099
EPI outreach clinics in Nepal. As such, the national health care delivery system is
highly dependent upon the functioning of a well manned SHP in the country.

3.6 Managerial Issues

Health sector is now engaged with output-based planning and budgeting. For more
meaningful and effective outcome, greater involvement of EDPs and Civil Societies
in the planning process is needed. In implementation, several constraints have been
highlighted in the logistics component, including procurement, distribution and
inventory management. Interventions in these areas may appropriately promote the speedy implementation of the proposed strategies. Intensifying sector coordination function at the ministerial level will also scale up the aid-effectiveness of the health sector.

To be able to meet targets set in the Implementation Plan, the EDPs have suggested the following to the Ministry of Finance on management of funds for the health sector; Improve the financial disbursement to districts, strengthen financial controls and audit capacity, implement the recently promulgated Public Procurement Law, plan and implement local bodies to be formed to oversee development, scale up performance related budgeting to District Development Committees (DDCs), enact a civil service law and fill staff vacancies in local government bodies.

3.7 Periodic Appraisal

Under the GON leadership, all partners will be collectively responsible for delivering national priorities as outlined in the health plans and providing financial and technical resources agreed. Currently Nepal practices a JAR mechanism, where biannual joint reviews are held between GON and EDP to discuss progress made and draw future plans for the health sector. There is a need to build on these existing review mechanisms of joint appraisal to develop progress measuring indicators and make collective commitment to support the National Plans. Simultaneously, attention should also be focused on analyzing individual programme areas in detail with regard to quality of implementation.

4. Way Forward

In this endeavour the Government and Partners will work together efficiently to improve health care and health outcomes adopting innovative process mechanisms with minimum change to the existing policies. The Government will lead the process and all partners will assist to tackle the challenges facing country’s health systems, particularly to have a sufficient trained and motivated health workforce, equipped with the necessary tools and medicines, appropriately placed and equitably distributed to carry out their duties. This initiative will build on and use the existing systems at country level for planning, coordination and management of the health sector. In this perspective, the national health policies and plans will be the basis for providing funding and thereby avoid introducing new plans or projects that are inconsistent with the national health plans.
The Government of Nepal and EDPs are mutually committed for the equity, quality, accessibility and efficiency of the health care system of the country. Keeping in line with the existing coordination mechanism, the government takes the lead with effective cooperation from all the EDPs, in executing this initiative. The strength of each of these respective partners will contribute to shape and enhance the strategies and approaches to address the shortages, bottlenecks, imbalances and inequities in the existing health care skills. The established code of conduct will help to build trust among all stakeholders which will allow action to be taken together in a transparent manner, maximizing the accountability. This process will thereby ensure aid-effectiveness and speedy aid-utilization through a flexible and efficient behaviour.

Action oriented strategic approaches are suggested to develop and strengthen critical areas, such as Skilled Birth Attendant (SBA), Female Community Health Worker (FCHW), essential health care services (EHCS), decentralized health management, health care referral system, community drug programme, decentralized health management information system (HMIS), abolition of user fees. WHO is committed to provide technical support in these endeavours to move the initiative forward.

5. Conclusion

Intervention in any health system is finally geared towards providing better health care to its people irrespective of their socio-economic and cultural status. With Nepal’s present constitution upholding the value of health care, by declaring it a basic human right, signifies the commitment of the government to ensure equitable access to health services for its people. Moving in this direction, many of the pro-poor strategies are being rigorously implemented and the expansion of the essential health care service package is one such crucial intervention. This opens a window for International Health Partnership to strengthen the process by addressing the health system challenges that have delayed the delivery of optimal health care to the nation.

Despite the 10 year long conflict, Nepal has reported improvement in the health indicators. The SWAp mechanism has been functioning and the external development partners have continuously supported the efforts of the government to reach its health outputs. The country definitely is moving in the right direction to achieve its millennium development targets.
Nevertheless, barriers in the functioning of peripheral level health facilities, slow process of decentralization in terms of decentralized health system and decentralized management, deficiencies in HMIS and insufficient skilled human resource develop, especially to gear up efforts to decrease maternal mortality are key areas that need immediate support and development. Interventions in these areas will ensure a functioning health system both at central and periphery level paying high dividends in terms of reduced child and maternal mortality as well as reduced burden of the killer diseases AIDS, TB and Malaria. Thus, the initiative will ensure Nepal’s commitment to achieving the millennium development goals.
Programme Management

Regional Director’s Guidance

The Regional Director during his visit to Nepal in July 2005 has provided valuable guidance and directions on ways to improve WHO work at country level in accordance with organization’s strategic orientation as well as in the context of national health sector priorities, issues and challenges. Several initiatives were taken by the WHO Country Office during present biennium to support the National Health Sector as directed by the Regional Director.

Diseases Control

During the biennium technical support was provided for strengthening and implementation of integrated disease surveillance through development of policy, legal framework and operational guidelines. WHO country office initiated activities for preparedness for Avian Influenza introduction in the country and for an influenza pandemic. The laboratory component of sentinel influenza surveillance was piloted as a priority Programme. During the biennium WHO supported the Ministry of Health to implement the International Health Regulation activities.

In order to eliminate neglected tropical diseases WHO has supported the health sector to initiate several activities. WHO continued to provide its technical support for enhancing national capacity to initiate Kala Azar elimination work and promoted them to work in close coordination with Bangladesh and India. REGIONAL DIRECTOR has reminded in his previous visit to continue keeping Nepal dengue free. However few cases were notified in 2006. This demanded intensive actions of WHO in ensuring that the country has the capacity to control it. National Alliance to control urban rabies was formulated to attend to activities to bring down the incidence of urban rabies cases. Nepal is at brink of elimination of leprosy and WHO continued to provide its assistance for this purpose.

With the support from WHO Country Office the Government has adopted STOP TB Strategy in line with the Global and Regional Strategy during 2006. WHO assisted in conducting first Tuberculin survey last year. Surveys were conducted for TB/HIV co-infections and also on Multi drug resistance.
HIV asserted WHO’s technical leadership role in core areas as agreed within the framework of the UN joint partnership and EDPs and to assist the MoHP in the scale up of the national programme through collaboration and coordination opportunities with national sectoral departments, ministries and NGOs.

Sporadic malaria outbreaks occurred in low endemic areas during 2006. Those outbreaks were timely investigated and responded promptly and controlled. ToT on clinical management of severe malaria was conducted during 2006 in collaboration with BPKIHS.

Technical Assistance of WHO was provided for the health ministry to handle activities under the areas of Non Communicable diseases including prevention of blindness and prevention of deafness. One of the key achievements made in this area was the preparedness of mental health legislation. The draft of the legislation is to be endorsed by the Ministry of health. Several awareness programs were conducted on this area of work during the biennium. Also initiated the NCD risk factor survey during 2007 and the activities are ongoing.

**Family and Community Health**

Evidence based guidelines for SBAs to deliver effective MNH care at the primary health care level was adopted with the assistance of WHO and those are being used as a reference manual in their day to day practice. WHO technical assistance provided to establish home visit based out reach programme, for follow up every pregnancy.

With WHO support IMCI Programme has been expanded to two additional districts during last biennium. Norms and standards related to adolescent friendly health services were developed and adopted.

**Determinants of Health**

Multi-sectoral approach has been adopted as a mean of coordination and intervention for promoting environmental health. Water safety plan piloted in two districts based on the WHO water quality guidelines. Community based arsenic mitigation response capacity in the terai districts was supported by WHO.

In the area of health promotion the main focused was on integrated approach in coordination with other partners. Community awareness building on health related issues were mainly approached through dissemination of IEC materials using different types of channels.
During the biennium several community Nutrition awareness programmes were supported by WHO. The training programmes were mainly on National strategy on IYCF, management of severe malnutrition and importance of iodized salt.

Ratification of FCTC for tobacco free initiative was completed during the biennium. Antitobacco legislation based on framework convention was drafted and forwarded to parliament for approval. Support provided for NGOs to conduct tobacco prevention and control activities at the community level in 3 districts.

Draft national action plan for injury prevention has been developed in the year 2007. Different kinds of advocacy materials on violence and injuries were developed and disseminated.

**Health Policies and Systems**

WHO has been supporting in improving management capacity of health officials at central, regional and district levels on different aspects of health care management. Orientation and advocacy programs for community management of health institutions were held in two districts.

WHO support to the training institutes was further strengthen to develop the country capacity to produce its own health manpower to feed both its public and private health systems. Similarly HRH Programme also coordinated with professional associations to motivate and with their support to ensure quality of education and training.

WHO provided technical support for updating national health accounts and to expand the community health insurance scheme to additional districts. Manuals, guidelines and information kits on community health insurance were revised during the biennium.

**Emergency Preparedness and Response**

EHA programme continue to support core areas namely health sector emergency plans, seismic assessment of health facilities, mass casualty management training and dissemination of best public health practices through publications and training. EHA programme also contributed effectively in the Public Health Initiative

Emphasis was on strengthening operational presence and addresses several aspects of disaster management including risk mitigation, emergency preparedness and crisis response.

*WHO Country Office for Nepal*


**Essential Medicines**

In order to deal with the changes and developments taken place in the pharmaceutical sector, The National drug policy was revised with the WHO support during 2007. Pharmacovigilance Programme was carried out with the target of establishing system of regular reporting of the adverse drug reactions. Computerized registration database was also updated during this biennium.

Development of good manufacturing guidelines and revision of essential drug list was the main outputs achieved under the traditional medicine sector.

**Country Cooperation Strategy (CCS)**

Regional Director emphasized the need to look into CCS as a tool for WHO work with the country. Second CCS (2006-2011) was developed in 2006, Started in 2005, side by side in preparing the 2006-2007 country plan. CCS is the main hub in Programme budget 2006-2007 assessment. The process of assessment started in July, the last quarter of the biennium.
DPM’s guidance for further improving the programmes

DPM, BFO and PDO has visited Nepal from 12-15 August 2007 related to review the programme implementation status and its assessment. During the process DPM has provided the following guidance and is being cooperated and observed in the programme management process. The guidance are:

- WCO, Nepal may also wish to review the PB 2008-2009 in consultation with concerned officials / Programme managers. Slight changes can be made till November, 2007 before Regional Director signs it for approval.

- More effort should put on the capacity building activities like trainings, seminars, expert group meetings and utilization to of research findings. These are generic activities which will go a long way and improve the overall capacity of the health professionals working at various levels of the country.

- The small expert group meeting could be conducted more frequently in the country to discuss issues of contemporary importance. The invitation could be extended to one or two experts from outside the country as appropriate.

- As there are many players in the field of health, WHO staff must be technically strong in their area of work. We should promote this through various means. The WCO is also currently doing this.

- The WCO should develop a simple and doable monitoring system for every Programme areas (already in place). WHO should provide technical support, health information system support and should share the data collecting formats for make it more simple and user friendly.

- When considering or refining activities for PB 2008 – 2009, we may consider putting simple, action oriented operational research activities for different programs areas. The results of these activities should be shared with health professionals at different level from the Ministry. A small, doable action oriented operation research can lead to improved Programme performance, logistic and administration. It will build up the analytical capacity of the concerned persons.

- Activities leading towards promotion of networking of institutions (Centres, Research Institutions, etc) in the Member Countries could be promoted. Networking between the institutions like NHRC, IOM and other institutions need to be further strengthened.
• WHO activities should be linked with the World Bank funded activities, the ADB funded activities, DFID funded activities etc. There should be more interaction between these agencies to avoid duplication of activities as well for efficient and effective use of WHO funds.

• WHO should build up analytical capacity of health workers at different levels especially at the PHC level. Effort should be made so that they can develop simple line graphs, bar diagrams, pie charts etc. They will realize the importance of data. SEARO can provide technical support to facilitate this move forward.

• WR Office website should be updated as much as possible. There should be sufficient data in the website and the information should be shared with the Ministry. There should be constant improving and updating of the information in the website.

• The WCO needs to have small group meetings with other UN agencies to decide on how to go about collectively especially in the context of upcoming International Health Partnership.

• The technical information received from the HQ and the SEARO in respective areas of work should be studied well by the WHO staff and disseminated to the respective Programme managers in the Ministry as soon as possible. Programme Managers should make sure that they are well versed with the technical information in the document before disseminating it to be able to answer the questions that might follow.

• The priority activities for PB 2008-09 should be aligned with the CCS document and it should be linked with country health policy documents and country health strategies.

• Whenever a SEARO staff visits the Country Office, WCO should make the most out of it. For example by asking him/her to give a talk in his area of his work so that they will be better prepared for the next visit by sitting and discussing the PB 2006- 2007 as well as PB 2008 - 2009.

• The reports of inter country meetings on various technical subjects should be studied and its recommendations should be followed up and implemented. There is no point of conducting another meeting without looking and following up on the recommendations made earlier.

• STC and STP assignments, reports are the reviewing of the assignment report is important and should be studied carefully by the WCO professional staff.
• The speeches delivered by Regional Director himself and those delivered by other people on behalf of Regional Director should be read by all. We have one yellow book and one green book for Regional Director's speeches. They are very clear cut, specific and can tremendously improve the technical knowledge and policy/strategy in a Programme technical area.

• SMO network of the Country Office should be used other purposes as well after approval from the Health Secretary. These health workers must be trained at the top notch-level in basic epidemiology. The trainings need not be of two years, two weeks FETP training for SMOs should suffice. SEARO already has a curriculum which could be shared with the Country Office so that there is a readily available epidemiologically thinking health workforce at grass root level for 2008 – 2009.

• Activities directed towards underserved/underprivileged population should be considered.
Public Health Initiatives at the BPKIHS

A Public Health Initiative sensitization workshop was conducted at BPKIHS in 3 – 4 March 2006 to develop a plan of action for the Implementation of South East Asia Public Health Initiative which aims at strengthening health as a major part of health systems development. The then State Health Minister inaugurated the programme and was attended by Hon'ble Health Secretary, DGHS, Senior Directors, Members of Medical Association, Health Professional Association and Senate Members attended the two days programme together with the Faculty Members of the University. Four groups were assigned to identify relevant training programs under this initiative. Based on the list of training courses suggested by four groups during the workshop, seven priority training programmes were identified and agreed upon during the final discussion held on 16 March 2006, to be conducted at BPKIHS as per the annexe calendar. The four groups came up with 21 programmes and identified most essential and urgent needs seven programmes.

Relevant activities conducted under each of these seven priority programmes are as follows:

1. **In-Service Competency Based SBA Training of ANMs**

BPKIHS has conducted one training Programme on “Training of trainers” on competency based SBA training of ANMs. The competency based ANM training modules have been developed. At present, BPKIHS is in the process of finalizing the course curriculum for the same. Further, Institutionalization and expansion of Maternal and Perinatal Death Reviews in zonal and medical college hospitals and strengthening of ongoing review process in the initial six implementing hospitals have been undertaken. During the biennium, the performance evaluation of ANMs on Midwifery competencies at selected health posts and study on performance of Eastern Region ANM Staff Nurses on maternal and neonatal health skills were conducted. However, though training activities have not taken place as scheduled due to lack of administrative and management personnel in the institution, TOT training has conducted.

2. **Clinical Management on Malaria**

Institution has conducted the training course on clinical management of Malaria as per the schedule. Guidelines for clinical management of malaria in vulnerable groups’ children and pregnant women were updated and health personnel were trained.
Case management was integrated with IMCI and MPS in 12 districts. ToT on clinical management of severe malaria was conducted during June 2006 in collaboration with BPKIHS and WHO provided technical support with 2 STCs from Mahidol University and Doctors and nurses were trained on clinical and laboratory diagnosis, Pathophysiology, pharmacology, signs and symptoms of severe malaria, management practices for severe and complicated malaria, management of malaria in pregnant women and children. Pre test and post test and course evaluation reveals the quality of training was excellent.

### 3. Disaster Management Training

Although it was planned to conduct two disaster management training sessions, the one scheduled for the month of March 2006 has not taken place. The Programme scheduled for September, 2006 was conducted as planned. Given the importance of first aid and safe referral, EHA supported NRCS community-based first aid trainings of peripheral health workers and reached out to ambulance drivers via the B.P. Koirala Institute of Health Sciences (BPKIHS). Collaboration with the most important health institution in the Eastern part of the country contributed significantly to strengthening mass casualty management in the three Eastern target zones. Based on BPKIHS’ skills and competencies, EHA supported important pre- and in-hospital training courses such as Hospital Preparedness for Emergencies (HOPE) and Primary Trauma Care training. (Guideline developed)

### 4. Outbreak Investigation Training

With the help of WHO advisor from field epidemiology programmes in Chennai, a Programme and a curriculum has been developed.

### 5. Environmental Health

Four day training programme on environmental health in Emergencies for district health officers from each region was conducted at BPKIHS.

### 6. Public Health Administration

The Curriculum for Public Health workforce and Training module on Public Health Management has been developed.

Two weeks refresher training on ICD 10 has been conducted in BPKIHS, Dharan in October 2006 for medical recorders of seven hospitals.
District Public Health Officers from selected districts were trained on Public Health management in a three days training session.

Two days training programme on Research Methodology was also conducted.

7. Field Epidemiology

Two staff members from BPKIHS visited Thailand and New Delhi for a training Programme on field epidemiology and surveillance and outbreak investigation and response. With the help of SEARO, they are in the process of organizing the training programmes in this area.

All the seven programmes identified as urgent needs were accomplished. The others, could not make it happen due to several reasons, after the new Government came into power.
### Short Public Health Training Calendar (BPKIHS)

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Duration</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In service competency based SBA training of ANMS</td>
<td>6 months</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Spill into 2007</td>
</tr>
<tr>
<td>2. Clinical Management on Malaria</td>
<td>1 week</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 batches 3 m block</td>
</tr>
<tr>
<td>3. Disaster Management Training</td>
<td>2 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Outbreak Investigation training</td>
<td>6 weeks</td>
<td></td>
<td></td>
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<tr>
<td>5. Environmental Health</td>
<td>1 month</td>
<td></td>
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<tr>
<td>6. Public Health Administration</td>
<td>2 months</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Field Epidemiology</td>
<td>2 months</td>
<td></td>
<td></td>
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</table>
Leprosy Elimination

1. Background

Nepal, a known leprosy endemic country, remains so even today and is one of the 4 countries in the world that have not achieved the goal of elimination of leprosy as a public health problem.

With an estimated number of 100,000 Leprosy cases, in the year 1966, leprosy control Programme using Dapsone mono therapy was started as a pilot project in Nepal. This project gradually expanded as a vertical Programme and remained so till 1987 when it was integrated into general health services. MDT was introduced for the first time in Nepal in the year 1982/83 in a few selected areas and hospitals. At this time, number of registered cases was 31537 giving a prevalence rate (PR) of 21 per 10,000 population. 62 of the 75 districts had a PR of >5 per 10,000 population, 10 districts had a PR varying between 1 to 5 per 10,000 population and only 3 districts had a PR was less than 1 per 10,000. Thereafter, there was a gradual and steady expansion of MDT services and by the year 1996, MDT coverage was extended to all the 75 districts of the country.

The first independent evaluation of the National Leprosy Control Programme was undertaken during January 1996, by a group of experts representing GoN, WHO and NGOs. The team had appreciated the performance of NLEP. Two rounds of Leprosy Elimination Campaigns were organized in the years 1999 and 2000.

To assess the performance and the progress towards elimination of leprosy in the country, Leprosy Elimination Monitoring exercises were conducted in 1999, 2003 and 2005. In addition, in 2005, Case validation Exercise was done through independent evaluators to find out the quality of diagnostic services provided at peripheral health facilities in Nepal. Case validation was repeated during 2007 to detect inappropriate diagnosis and delete them from the register. Case review activities are also being undertaken independently and periodically. Quarter yearly review meetings were held very regularly. IEC using electronic media (Radio & TV) is being carried out through out the year.

2. Leprosy Service Delivery

All the peripheral Health Facilities (HFs) numbering around 4190 (Health Posts, Sub Health Posts and Primary Health Centers) are providing services to leprosy
patients. All most all of the basic health staff numbering about 19445 have undergone
Comprehensive Leprosy Training (CLT) and a majority of them an additional Refresher
Leprosy Training (RLT) as well. Over the years, the National Leprosy Elimination
Programme (NLEP) had created a vast network of skilled manpower to deliver leprosy
services throughout the country. Deployment of this Human resource is quite
satisfactory and there is more than one trained staff at each HF in the country. In
addition, one staff member is designated as focal person to cater to the needs of
leprosy patients and the Programme alike. These HFs carry out leprosy diagnosis
and treatment services, patient counseling, contact examination, community health
education, focal case detection drives, treatment of minor complications and referral
services.

Over 90% of Female Community Health Volunteers have been provided with
orientation training and are participating in leprosy related community health
education activities and are identifying suspects and refer them to HFs for diagnosis
and treatment.

There is a good network of facilities that are providing secondary and tertiary general
health care in the country. By and large their participation is not much in leprosy
service delivery. The information regarding the participation of Private practitioners
in providing care to leprosy patients is very limited.

Secondary and tertiary care to needy leprosy patients are being provided by Referral
Centers managed by International and local NGO’s. In general, every medical and
surgical requirement of leprosy patients is being fully met from within the country.

Though not mandatory as per the guidelines, skin smear examinations are done
wherever facilities exist. The country has a laboratory run by INGO-The Leprosy
Mission (TLM) capable of undertaking advanced mycobacterial research work. It
has amongst others mouse foot pad and PCR facilities.

2.1 Managerial Support

District Leprosy & Tuberculosis assistant posted at each district is the first line manager
and is providing managerial and technical support to the staff working at HFs. District
Public Health Officers and Public Health Officers are the next level managers who
in addition to other responsibilities will also provide managerial support to NLEP.
At the regional level there is RTLA to assist the Programme.
There is a Leprosy Control Division located at the center headed by Director. It is mainly responsible for laying down the policy, deciding on the strategy of leprosy control and issuing periodically updated national guidelines for leprosy control activities in the country. It undertakes review of programme performance from time to time. LCD coordinates activities of all the supporting partners. It undertakes periodic review of the training curriculum for various categories of health workers providing leprosy services.

2.2 Supporting Partners

There are several partners (INGOs and NGOs) who provide human, material and financial support to Nepal’s Leprosy Elimination programme. They all function in accordance with the project agreements with HMG reviewed, revised and renewed from time to time. The major partners are The Leprosy Mission International, Sasakawa Memorial Health Foundation, Netherlands Leprosy Relief Association, International Nepal Foundation, Nepal Leprosy Fellowship and Nepal Leprosy Trust. The main sphere of support from these NGOs / INGOs is in training of basic health staff, IEC and providing curative services through referral centers and hospitals. In addition these partners provide technical and financial support to undertake focal active case detection drives and supervision in the field. Limited Social rehabilitation work for Persons affected by leprosy is being taken up by some of these INGOs / NGOs. Information available on these activities is sketchy.

World Health Organization is an important partner and stakeholder in leprosy control in Nepal. WHO has been providing technical support through one STP, and National and Regional Coordinators. To ensure free mobility of these technical personnel vehicles and drivers have been provided. It provides financially and technical support for supervisory visits, IEC activities, LEM & case validation exercises and quarterly review meetings.

3. Current Leprosy Situation

3.1. Prevalence

In the beginning of the year under report (15/7/06) the number of cases on the register was 4291 and by the end of the year (14/7/2007) this number has come down to 3786. There has been an 11% reduction in registered leprosy caseload. Accordingly the prevalence rate has come down from 1.65 to 1.45 per 10 000. As was the case earlier two third of these cases are from CDR & EDR. (fig 1)
Leprosy is highly focal and 80% of the cases are located in 23% of the land area (terai) of the country. In 42 districts the PR is less than one and in only 1 (Dhanusha) district it is over 3.

As shown in the figure none of the regions in Nepal have reached elimination levels.

3.2. New Case Detections

During the recently concluded (2006/07) fiscal year, 4317 new leprosy cases were detected and were put on MDT. Nearly one fourth (28.1%) of these new were female and 6.1% were children. Fifty five percent of these new cases were grouped as Multi Bacillary. Amongst these new cases 5.56% had already developed Gr II disabilities at the time of detection. The New Case detection rate for the year 2006/07 works out to be 1.65/10 000 population.

NCDR is highest in EDR (2 / 10 000) followed by CDR (1.86 / 10 000). WDR had reported a lowest (1.07) NCDR during 2006/07.
3.3. Disease Trends in Nepal

Trends observed with respect to indicators are summarized in the figure 5 above and the table 1 below.

<table>
<thead>
<tr>
<th>Table 1: Trends in selected few indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/03</td>
</tr>
<tr>
<td>New patients</td>
</tr>
<tr>
<td>RFT</td>
</tr>
<tr>
<td>Default</td>
</tr>
<tr>
<td>UT at the end</td>
</tr>
<tr>
<td>New child</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>NCDR</td>
</tr>
<tr>
<td>PR</td>
</tr>
<tr>
<td>MB %</td>
</tr>
<tr>
<td>Child %</td>
</tr>
<tr>
<td>Disab Gr II %</td>
</tr>
<tr>
<td>Female %</td>
</tr>
</tbody>
</table>

Both NCDR and PR have been declining during the last 5 years. MB % and child proportions are by and large stable. Reduction in female proportion and increase in DR GR II was seen during the year 2006/07.
4. Drug Supply

MDT stock position remained quite good throughout the year. The practice of supplying once in everything six month continued. There was no disruption in treatment of leprosy cases due to shortage of any type of MDT blister packs. Currently, sufficient stock of MDT is available at the national and district level to meet the needs. Apart from MDT supplied free of cost by WHO, the Nepal Government had purchased drugs to treat reactions and other supportive drugs needed for leprosy patients.

4.1. Treatment Compliance

Treatment compliance has been exceptionally good in Nepal. During the last 4 years treatment completion rates were over 90 % for both MB and PB cases. P D ratio is 0.88 during 2006/07.

5. Problems/Constraints and Action to be taken

The main obstacles and problems the NLEP is facing are summarized below in table 2.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Problem/Constraints</th>
<th>Action to be taken</th>
<th>Responsibility</th>
<th>Dead Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High PR (above elimination levels)</td>
<td>Minimize operational factors. Detect and delete inappropriate registered cases.</td>
<td>LCD/RD/DHO</td>
<td>2006/07</td>
</tr>
<tr>
<td>2</td>
<td>Recycling / Wrong diagnosis</td>
<td>Disseminate case validation &amp; LEM findings. Supervision.</td>
<td>DGHS/LCD/ RHD / DTLAs</td>
<td>Done</td>
</tr>
<tr>
<td>3</td>
<td>Lack of adequate motivation among peripheral level BHS workers.</td>
<td>More and effective supervisory visits. Reward good work</td>
<td>DHS / LCD / RHD</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4</td>
<td>Voluminous &amp; (duplication) parallel and underutilized MIS</td>
<td>Review, simplify and integrate to evolve a need based MIS.</td>
<td>LCD / RHD</td>
<td>2006 / 07</td>
</tr>
<tr>
<td>5</td>
<td>Low reliability of program data</td>
<td>Periodic Validation of data</td>
<td>LCD</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6</td>
<td>Underutilization of trained manpower</td>
<td>Review, develop and deploy Human Resources rationally.</td>
<td>LCD/RHD</td>
<td>2007</td>
</tr>
<tr>
<td>7</td>
<td>MDT services in low endemic areas</td>
<td>Centralize service delivery, Strengthen referral services</td>
<td>LCD / RHD</td>
<td>2006/2007</td>
</tr>
<tr>
<td>8</td>
<td>Post elimination disease surveillance</td>
<td>Establish sentinel surveillance system</td>
<td>LCD</td>
<td>2007</td>
</tr>
<tr>
<td>9</td>
<td>Poor quality laboratory services</td>
<td>Workshop for concerned lab technicians</td>
<td>LCD</td>
<td>2007</td>
</tr>
</tbody>
</table>
6. Future Focus

Achieving elimination will be the top priority of NLEP in coming few months. Validation exercises in the remaining 12 districts to detect inappropriate registration and deleting these cases that do not need treatment, perusal of records and review of data aggregation to reduce incorrect data entries, are expected to reduce the PR substantially. Coupled with the declining natural trend of the disease Nepal the country will be able to eliminate leprosy in few months.

Once leprosy is eliminated as a public health problem the attention will be drawn towards mopping up of the existing sub national high endemic foci. Highly focal area specific IEC, proactive cases detection drives and possibly chemoprophylaxis should the situation warrants will be able to bring down transmission in these pockets.

Sustaining quality services that are cost effective and accessible will continue to draw the attention of NLEP during next few years.

POID services are to be upgraded so as to include development of appropriate POAs and systematic implementation of these plans jointly with supporting partners so as to reach most of the patients affected in Nepal should be the next logical step of NLEP.

7. Summary

Nepal is one of the 4 countries in the world that has not yet achieved elimination of leprosy as a public health problem though the country has been reporting a steady decline both in PR and NCDR since the last 5/6 years. The current decline is not fast enough to reach elimination by the end of 2007. It has been observed that Operational factors such as Wrong diagnosis, wrong grouping, re registration have a significant role in inflating PR in Nepal. Individually their contributions appear small but collectively it becomes considerable. Case holding in Nepal is exceptionally good with the cure rates of over 91 % for MB and 94 % for PB cases. Endemicity of leprosy is mainly localized to Terai region accounting for

80 % of the cases under treatment and 82 % new cases detected. An effective cross referral system is in place. Programme is assisted by a good network of supporting partners. Concerted efforts are being made to minimize the operational factors and improve the quality of leprosy services in order to attain the goal of leprosy elimination as soon as possible.
Disease Surveillance

Every monsoon season, Nepal suffers from outbreaks of communicable diseases. This year, diarrhoeal diseases and cholera in particular have claimed a heavy toll on the population in remote VDCs in Rautahat and Kalikot districts as well as the Kathmandu Valley. The first and most severe outbreak occurred in Khin VDC in Kalikot district between 20 May and the last week of June. Because of the remote location (18 hours walk to the district headquarter), and health posts and sub-health posts with no staff and no medicine in the neighbourhood, the DHO was notified too late to prevent 39 deaths. Only on 15 June, a health team was dispatched from Manma District Hospital, which provided emergency medical care to 459 patients from 17 to 23 June. According to DHO, the main causes of the outbreak were malnutrition, scarcity of potable water, lack of health education and poverty. The incident sadly illustrates the importance of a functional peripheral health system, community-based disease surveillance, early warning, prompt control measures and health education.

New collaboration patterns between EDCD, MSF-Holland and WHO took place during outbreak investigations, since MSF transported stool samples from Khin VDC to the National Public Health Laboratory in Kathmandu for further investigation (7 out of 10 samples tested positive). During transfer in mountainous terrain without electricity, the cold chain was maintained by cooling samples with cold water. Several factors indicate that cholera is highly endemic in Kalikot district. Simultaneously with the outbreak, seven additional deaths (three in Chhapre, two in Dhaulaga and two in Thirpu) were reported from other VDCs. Recently, new cases have raised concern of a renewed outbreak in yet other locations. Irrespective of what the numbers may show, only preventive measures can contain and prevent future outbreaks. Health education is the key to change water and hygiene practices and thereby addressing the root cause of the problem.

From 19 to 24 June, Gairatar VDC in Rautahat district experienced another outbreak which was effectively controlled by DHO in collaboration with an epidemiologist from EDCD. At an early stage, stool as well as water samples confirmed the presence of the cholera bacteria. Effective treatment of patients with drip, ORS and antibiotics resulted in a low case fatality rate. Readmission of patients and cross infections were identified as common problems. In order to identify suitable solutions (e.g. complete full course of antibiotics and extensive hand-washing), these issues were further discussed with patients. Simultaneously, community interventions focussed on cleaning water tanks followed by chlorination of water three to four times a day.
Community volunteers were identified to motivate people to drink boiled water and cook food properly.

Meanwhile in the Kathmandu Valley, hospitals reported a high and increasing number of acute gastroenteritis and cholera cases. As of 25 July, 305 cases of confirmed cholera including five deaths were reported from Patan, Kanti, Bhaktapur and Teku Hospital as well as Nepal Medical College. Given the size of the population at risk, the outbreak in the Kathmandu Valley was of great concern for epidemiologists and public health experts. Since cholera outbreaks are usually associated with water supply, health officials investigated the water quality in the Kathmandu Valley. Official reports from the Nepal Water Supply Corporation (NWSC) revealed drastically decreasing water quality from April to July 2007. Whereas 28% of the examined water was undrinkable in April/May, the share had increased to 72% in June/July (see pie charts).

**E-EWARS (Enhanced Early Warning and Reporting System)**

(Source: EDCD/MoHP)

E-EWARS reports the epidemiological surveillance of priority immunization preventable diseases, vector borne diseases and other outbreak potential communicable diseases. The following map shows the mapping of the EWARS sentinel sites.
There are nine priority diseases currently being reported in E-EWARS. They are as follows:

1. Acute flaccid paralysis (AFP)
2. Measles
3. Neonatal tetanus
4. Malaria
5. Kala-azar
6. AES (+JE)
7. Acute Gastroenteritis (AGE) including Cholera
8. Dengue fever (DF/DHF/DSS)
9. Influenza-like Illness (ILI)
The above bar diagrams show the enhanced early warning and reporting system sentinel site-wise completeness and timeliness reporting status from epidemiological week 1 to 26, 2007. The completeness of reporting of enhanced early warning and reporting system for 29 districts is presented above in the second bar diagram.
A Cross-Sectional Perspective on WHO Collaboration

Cholera and Acute Gastro Enteritis outbreak - 2007
1st July Onwards

Acute Gastro Enteritis Cases - Epi. Week 34 (19 Aug - 25 August)

<table>
<thead>
<tr>
<th>Health Institution</th>
<th>26-Aug</th>
<th>27-Aug</th>
<th>28-Aug</th>
<th>29-Aug</th>
<th>30-Aug</th>
<th>31-Aug</th>
<th>1-Sep</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>17</td>
<td>16</td>
<td>17</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>Patan Hospital</td>
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<td>4</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
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<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Bhaktapur Hospital</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Nepal Medical College</td>
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<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
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<td>32</td>
<td>26</td>
<td>22</td>
<td>0</td>
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Daily Trend of Acute Gastro Enteritis Cases,
Epi Week 34, 2007

**Acute Gastro Enteritis Cases of Previous Weeks - Epi. Week 27-33**

<table>
<thead>
<tr>
<th>Health Institution</th>
<th>28</th>
<th>29</th>
<th>30</th>
<th>31</th>
<th>32</th>
<th>33</th>
<th>34</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teku Hospital</td>
<td>404</td>
<td>444</td>
<td>299</td>
<td>204</td>
<td>118</td>
<td>128</td>
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<tr>
<td>Patan Hospital</td>
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<td>200</td>
<td>141</td>
<td>78</td>
<td>68</td>
<td>43</td>
<td>51</td>
<td>715</td>
</tr>
<tr>
<td>Kanti Hospital</td>
<td>50</td>
<td>80</td>
<td>65</td>
<td>37</td>
<td>25</td>
<td>22</td>
<td>17</td>
<td>296</td>
</tr>
<tr>
<td>Bhaktapur Hospital</td>
<td>50</td>
<td>73</td>
<td>35</td>
<td>18</td>
<td>23</td>
<td>8</td>
<td>6</td>
<td>213</td>
</tr>
<tr>
<td>Nepal Medical College</td>
<td>NA</td>
<td>21</td>
<td>23</td>
<td>11</td>
<td>7</td>
<td>15</td>
<td>2</td>
<td>79</td>
</tr>
<tr>
<td>Total</td>
<td>638</td>
<td>818</td>
<td>663</td>
<td>348</td>
<td>241</td>
<td>216</td>
<td>163</td>
<td>2987</td>
</tr>
</tbody>
</table>

Total Acute Gastro Enteritis = 3766 (1st July Onwards)

Weekly Trend of Acute Gastro Enteritis Cases
Epi. Week 27 to 34, 2007

WHO Country Office for Nepal
A Cross-Sectional Perspective on WHO Collaboration

Cholera Cases This Week - Epi. Week 34

<table>
<thead>
<tr>
<th>Health Institution</th>
<th>26-Aug</th>
<th>27-Aug</th>
<th>28-Aug</th>
<th>29-Aug</th>
<th>30-Aug</th>
<th>31-Aug</th>
<th>1-Sep</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teku Hospital</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patan Hospital</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Kanti Hospital</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Bhaktapur Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nepal Medical College</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>1</td>
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<td>0</td>
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<td>0</td>
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</tr>
</tbody>
</table>

Daily Trend of Cholera Cases, Epi. Week 34, 2007

<table>
<thead>
<tr>
<th>Date</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/26/2007</td>
<td>4</td>
</tr>
<tr>
<td>8/27/2007</td>
<td>1</td>
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<tr>
<td>8/28/2007</td>
<td>0</td>
</tr>
<tr>
<td>8/29/2007</td>
<td>0</td>
</tr>
<tr>
<td>8/30/2007</td>
<td>0</td>
</tr>
<tr>
<td>8/31/2007</td>
<td>0</td>
</tr>
<tr>
<td>9/1/2007</td>
<td>0</td>
</tr>
</tbody>
</table>

Cholera Cases of Previous Weeks - Epi Week 27-33

<table>
<thead>
<tr>
<th>Health Institution</th>
<th>27</th>
<th>29</th>
<th>30</th>
<th>31</th>
<th>32</th>
<th>33</th>
<th>34</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teku Hospital</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Patan Hospital</td>
<td>33</td>
<td>56</td>
<td>23</td>
<td>25</td>
<td>9</td>
<td>12</td>
<td>9</td>
<td>167</td>
</tr>
<tr>
<td>Kanti Hospital</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Bhaktapur Hospital</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Nepal Medical College</td>
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<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>78</td>
<td>25</td>
<td>29</td>
<td>10</td>
<td>15</td>
<td>9</td>
<td>214</td>
</tr>
</tbody>
</table>

Total cases of Cholera = 303 (1st July Onwards)

Weekly Trend of Cholera Cases
Epi. Week 27 - 34, (1 July - 18 August 2007)
Altogether 218 cases of malaria have been reported by different sentinel sites in first half of the year. Of these cases, there were 97 p. vivax and 38 p. falciparum cases. The maximum number of cases was reported between the Epidemic weeks No 16 to 26. No deaths have been reported so far. Three years comparison (2005 - 2007) shows that till Epi Week 26, 2007 has recorded the most number of malaria cases.

WHO Country Office for Nepal
Altogether 395 cases of Kala-azar have been reported by different sentinel sites. Of these, 91 were confirmed by dipstick and 115 by Micro. The maximum amount of cases was reported between the Epidemic week No. 17 to 24. Total of 6 deaths have been reported so far. Three years comparison (2005 – 2007) show that till epidemiologic week 26, 2007 has recorded the most cases.

The surveillance of Dengue started in 2007 at the Enhanced EWARS sentinel sites. Since, January 3 cases have been recorded till date. 2 cases in BPKIHS, Dharan, both had travel history to India and 1 case in Shukraraj Tropical and Infectious Communicable Hospital, Teku, Kathmandu. This case had a travel history to Malaysia.

Although surveillance of Diarrhoeal disease has existed since years, the surveillance has been intensified from 2007 onwards. Total of 6955 cases have been reported of which 11 deaths were due to Acute Gastro Enteritis.
An active surveillance in 5 different hospitals has been taking place in the Kathmandu valley since 29 of June 2007. Total of 3766 cases of Acute Gastro Enteritis and 303 cases of Cholera have been reported since 1st of July 2007.

The surveillance of Cholera was included in the E-EWARS since 2007. Since, January 2007, 12 cases have been recorded as of 26th epidemic week.

Surveillance of Influenza Like Illness started from 2007. Since January till epidemiologic week 26, Total of 3281 cases and 17 deaths have been reported.

WHO Country Office for Nepal
Immunization & Vaccine Preventable Diseases

Routine Immunization Coverage Trend
1994-2007, Nepal

Source: MoH, DoHS, HMIS, Annual Report
WHO/IPD, Immunization Section

Immunization Coverage Surveys
Nepal, 1996-2006

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Total Number of Un-immunized Children against DPT3

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of un-immunized children</td>
<td>145,997</td>
<td>104,397</td>
<td>72,091</td>
<td>146,756</td>
<td>52,108</td>
<td>117,262</td>
</tr>
</tbody>
</table>

Effective Vaccine Store Management Assessment - 2003 and 2007

# Programme Management

WHO Country Office for Nepal
Present Cold Storage Capacity

Wild Polio Cases Nepal, 2005-2006

- Wild P1 Case 2006 = 2
- Wild P1 Cases 2005 = 4

Data as of 14 Sep 2006

WHO, Programme for Immunization Preventable Diseases (IPD)
Japanese Encephalitis

There have been a total of 632 cases of Acute Encephalitis Syndrome (AES) recorded from all 5 developmental regions as of week 32, of these 383 were males, 249 were females. There has been total death of 38 reported cases during this period. There has been 592 specimens collected for laboratory tests of which, 51 cases were confirmed using Anti JE IgM.

The number of JE cases is starting to rise. The month of August is when we see maximum number of cases. So far, there have been 51 lab-confirmed cases of JE cases in 2007. 25 cases were reported in just one week in the month of August. None of the cases documented in 2007 have reported being vaccinated against JE.
The following mapping shows the distribution of 632 cases as per the districts. The red dots in the map show the lab confirmed cases of Japanese encephalitis.
Implementation Status

The Monitoring and Evaluation Unit was established since November 2006 in the Country Office. Process monitoring has been a key instrument and an indispensable aspect of WHO Country Office in terms of ensuring a high level of performance. The Unit has been effectively monitoring all the WHO Collaborative activities from aspects of its implementation status and the quality of the product. Monitoring the whole sequential process is critical for the Country Office to ensure the programme implementation and delivery is in a timely manner.

Process monitoring in the Country Office provides systematic information about whether a Programme is going according to the workplan, is on schedule, the expected activities are being carried out in the manner they should be and resources being effectively utilized they were originally planned. The timely monitoring of these activities undertaking reflected how they are being conducted thus highlighting the quality of implementation. This is further strengthened by the weekly held Monday morning meetings where the details of these activities are brought into limelight.

All Programme areas in the workplan 2006 – 2007 have progressed effectively to achieve the expected implementation status in due course of the biennium and the entire process has been carefully monitored on a weekly basis. The detail steps of process monitoring have been described in the first stage assessment report.

In this report, five graphic presentations are included to depict the current implementation status:

1. Implementation status – in percentage – as of 6 September 2007
3. Liquidation status of individual AoW – as of 6 September 2007
5. Activities still in progress for year 2007

WHO Country Office for Nepal
A Cross-Sectional Perspective on WHO Collaboration

Implementation status – in percentage – as of 6 September 2007

### Liquidation status of individual AoW – as of 6 September 2007

<table>
<thead>
<tr>
<th>AoW</th>
<th>Allotted Budget</th>
<th>Obligation</th>
<th>Liquidation</th>
<th>Balance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>45,000</td>
<td>49,881</td>
<td>111</td>
<td>30,238</td>
<td>61</td>
</tr>
<tr>
<td>Gender Equity, Women and Health</td>
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<td>26,741</td>
<td>100</td>
<td>19,692</td>
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</tr>
<tr>
<td>Health and Environment</td>
<td>350,900</td>
<td>361,419</td>
<td>103</td>
<td>275,965</td>
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<td>Food Safety</td>
<td>39,700</td>
<td>39,632</td>
<td>100</td>
<td>31,162</td>
<td>79</td>
</tr>
<tr>
<td>Emergency Preparedness and Response</td>
<td>82,300</td>
<td>86,124</td>
<td>105</td>
<td>69,626</td>
<td>81</td>
</tr>
<tr>
<td>Making Pregnancy Safer</td>
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<td>322,808</td>
<td>100</td>
<td>265,088</td>
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<tr>
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<td>111,990</td>
<td>89</td>
<td>91,747</td>
<td>82</td>
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<td>Immunization &amp; Vaccine Development</td>
<td>237,800</td>
<td>238,847</td>
<td>100</td>
<td>201,095</td>
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<td>108,600</td>
<td>114,823</td>
<td>106</td>
<td>97,422</td>
<td>85</td>
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<tr>
<td>Mental Health and Substance Abuse</td>
<td>45,300</td>
<td>43,348</td>
<td>96</td>
<td>36,975</td>
<td>85</td>
</tr>
<tr>
<td>Malaria</td>
<td>109,400</td>
<td>110,344</td>
<td>101</td>
<td>98,093</td>
<td>87</td>
</tr>
<tr>
<td>Health System Policies and Service Delivery</td>
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<td>363,819</td>
<td>103</td>
<td>317,062</td>
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</tr>
<tr>
<td>Communicable Disease Surveillance</td>
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<td>96</td>
<td>174,930</td>
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</tr>
<tr>
<td>Violence, Injuries and Disabilities</td>
<td>17,600</td>
<td>17,241</td>
<td>98</td>
<td>15,241</td>
<td>88</td>
</tr>
<tr>
<td>Essential Medicine</td>
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<td>223,413</td>
<td>99</td>
<td>199,548</td>
<td>89</td>
</tr>
<tr>
<td>Human Resources for Health</td>
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<td>610,036</td>
<td>100</td>
<td>540,809</td>
<td>89</td>
</tr>
<tr>
<td>Non Communicable Diseases and Deafness, Blindness, &amp; Prog.</td>
<td>282,800</td>
<td>274,728</td>
<td>97</td>
<td>248,207</td>
<td>90</td>
</tr>
<tr>
<td>Leprosy &amp; Comm. Disease Prevention and Eradication and Control</td>
<td>306,600</td>
<td>298,369</td>
<td>97</td>
<td>269,991</td>
<td>90</td>
</tr>
<tr>
<td>Child and Adolescent Health and IMCI</td>
<td>178,900</td>
<td>171,250</td>
<td>96</td>
<td>158,647</td>
<td>91</td>
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<td>Health Promotion</td>
<td>86,900</td>
<td>86,727</td>
<td>100</td>
<td>78,727</td>
<td>91</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>234,200</td>
<td>230,815</td>
<td>99</td>
<td>218,706</td>
<td>95</td>
</tr>
<tr>
<td>Essential Health Technologist - Lab</td>
<td>90,400</td>
<td>88,357</td>
<td>98</td>
<td>85,517</td>
<td>97</td>
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<tr>
<td>Kmal - HELLIS</td>
<td>48,800</td>
<td>52,942</td>
<td>108</td>
<td>51,622</td>
<td>98</td>
</tr>
<tr>
<td>Communicable Disease Research</td>
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<td>97</td>
<td>43,750</td>
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<td>Health Information Evidence and Research Policy</td>
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<td>68,181</td>
<td>90</td>
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<td>Policy making for health in development</td>
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<td>109,309</td>
<td>99</td>
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<tr>
<td>Health Financing and Social Protection</td>
<td>23,500</td>
<td>22,606</td>
<td>96</td>
<td>22,606</td>
<td>100</td>
</tr>
</tbody>
</table>

Red: < 50% Liquidation
Yellow: > 50-75% Liquidation
Green: > 75% Liquidation

### Unliquidated obligation Pie diagram – as of 6 September 2007

[Diagram showing unliquidated obligations with different categories such as APW/DFC, S&E, FEL, TRV (staff), MCA, STE/SSA, STP, and GoE.]
### Activities still in progress for year 2007

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Partially Funded Activities - 2007</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No. of Activities</td>
</tr>
<tr>
<td>Child and Adolescent Health</td>
<td>1</td>
</tr>
<tr>
<td>Leprosy</td>
<td>3</td>
</tr>
<tr>
<td>Comm. Dis. Prev. Eradication &amp; Control</td>
<td>1</td>
</tr>
<tr>
<td>Epidemic Alert and Response (CSR)</td>
<td>3</td>
</tr>
<tr>
<td>Making Pregnancy Safer (MPS)</td>
<td>1</td>
</tr>
<tr>
<td>Health System Policies and Service Delivery</td>
<td>1</td>
</tr>
<tr>
<td>Human Resource for Health</td>
<td>6</td>
</tr>
<tr>
<td>Food Safety</td>
<td>1</td>
</tr>
<tr>
<td>Health and Environment</td>
<td>7</td>
</tr>
<tr>
<td>Nutrition</td>
<td>2</td>
</tr>
<tr>
<td>Tobacco</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

Total: $160,585 $110,639 $49,946
Programme Evaluation

The collaborative activities of the World Health Organization, at the country level adapted to more closely reflect the country needs. As the country is the centre of the WHO work in countries, the main emphasis is to trigger more effective action to improve health and decrease inequities in health outcomes and to reach the health related Millennium Development Goals. To address the needs effectively, the WHO presence at the country level adequately positioned with its competencies and skill and concurrently programmes at all level are working in a more coherent, responsive and mutually supportive way within the agreed broad framework of the Country Cooperation Strategies.

Within the Medium Term Strategic Plan, WHO Programme and Budget is structured on biennial basis. For the biennium 2006-2007, it is now in its last quarter of the plan period. Further to the built-in process of monitoring throughout the biennium, it is very critical to assess the contribution of WHO to national health development at this time. In assessing the collaborative works it is more important to specify more closely on WHO’s contribution in improving the planned national health outcomes. The outcome of the exercise will enable the Country Team to learn way to improve in monitoring performance of work in order to ensure transparency, accountability and efficient use of resources relevant to the expected national health outcomes.

The assessment takes place in two stages:

1. The first stage confines on the performance of the AoW and assess whether the work done reached to the planned targets both at the product and office specific expected result. The process starts at the activity level with a critical emphasis on quality of technical input and output. In the process both the technical and coverage gaps be identified and review that if those could be rectified within the remaining period of the biennium. A critical consideration is also reflected to the extent of maintaining the programme integrity and a balancing the approach in responding to emergence issues during the implementation. The whole assessment process takes place in a transparent manner first among the Country Team, then at the Regional level and again a business type meeting with the national colleagues.

2. The second stage of the assessment looks further on WHO’s contribution to national health outcome in line with the health sector implementation plan. At this level, the emphasis of the assessment to identify investments...
made during the biennium in terms of strengthening the national core health system, equitable access to health, global health security, determinants of health and accountability. Throughout the process, assessment of the extent of cooperative effort undertaken both within the UN Agencies and with other EDPs in search for comparative advantage will also be taken up inclusively.

During the current biennium 425 national participants have taken part in various meetings, workshops and conferences within and beyond the region with the total cost incurring till date to an amount of US$ 814,136.00. Country office staffs have participated in 71 meetings, seminars and workshops. The cost incurred for this is about US$ 160,000.00. Total cost incurred for nationals and WHO staffs in this biennium, as of 10 September 2007, for attending ICP meeting stands at US$ 974,136.00. This does not include technical backup staff visits from Regional and Headquarter. The amount of WHO resources spent on this component deserve to be assessed on how it has contributed to the national health outcomes.

The first stage has already been completed and reported to the Regional Office accordingly. For the second stage assessment, a conceptual framework has been developed.

**Second Stage Assessment Conceptual Framework**

**Process**

Nepal second CCS (2006-2011) was started developing in the later part of 2005 and finalized in the year 2006. The PB 2006-2007 preparation and CCS process took place side by side. The programme Budget followed the directions and strategies spelled out in the CCS. The second stage evaluation will be carried out within the strategies and expectation made in the second CCS. The second CCS embrace the outlines of the global health agenda and organization wide strategy in promoting health but also respond the challenges in the National Health Sector Programme so as to move forward the Second Long Term Health Plan through effectively contribute the expected national health outcomes.

The second stage assessment for the 2006-2007 biennial implementation will strictly confine within the premises of 2nd CCS complemented with Engaging for Health -
Eleventh General Programme of Work, and closely adhere to the national health policy, strategies and lan documentations (References). The above is the graphic presentation of the conceptual framework for the second stage assessment. The first stage was the desk work assessment starting from the process of activity level implantation, quality of activity output contributed to the expected product and then to the office specific expected result. In the second stage, the output of each activity will again verify and assess its own quality then to identify its utility and combination with others to the product level. The actual product will be reconciled with the expected product in case if it differs and assessed the outcome within the prevailing situation in terms of changes in epidemiological and political changes and financial constraints.

With the aim of providing an equitable, high quality health care system and to be in line with the poverty reduction strategy paper and MDGs, the Ministry of Health and Population (MoHP) formulated the ‘Health Sector Strategy: An agenda for reform 2003’. This strategy outlines three programme outputs and five management outputs as its’ core focus during the five year period, starting from 2004 (Nepal CCS Annex 3, page 41-42). The programme outputs pay special emphasis on expanding the Essential Health Care package, decentralization of health management and providing cost effective quality services to consumers through the private sector and NGOs. The management outputs focus on coordination within the MoHP to support decentralization, sustainable development of health financing and resources, effective management of physical assets and procurements, develop better human resource policies and a comprehensive integrated management information system. The alignment of WHO strategic agenda and directions with the national health sector

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programme – Implementation Plan is presented as Annex 4 in the Nepal CCS (page 43-46); and also with the rural water supply and sanitation sectoral strategic action plan: 2004 food act (page 47).

Given the change in the current political context, a three year Interim Plan was developed by the MoHP in 2007. The Three year Plan includes programmes to operationalize the constitutional provision of “Free Basic Health Services to all” starting with the poor and socially excluded living in 35 low HDI districts, marginalized groups, people living in geographically difficult regions where all health indicators are low and also include measures to mitigate the mental and physical problems for the conflict victims.

In implementing the strategic agenda it requires a clear consensus between the WHO and the Government on key issues, interventions and technical support so as to ensure the exponential affects on health outcomes. The assessment will then look into it to what extent WHO biennial programme products synergize for a positive impact on the health outcomes. At this level, in areas of working together with other partners, the assessment will also identify challenges in relating to coordinating, harmonizing aligning the efforts of all partners with the national strategies and priorities.

In these endeavours, it is also essential to recapitulate how WHO Core Functions been enacted in priority areas, highlighting the seven priority areas spelled out in the global agenda. The assessment started with individual Area of Work which will then be converging into the six strategic agenda identified in Nepal CCS: strengthening the health system, control and prevention of disease and disability, human resource development, child, adolescent and reproductive health, healthier environment and emergency preparedness and response., (Nepal CCS – page 21-27). The assessment will align and realize the stated strategic objectives and approaches with the way actual implementation has taken placed. The strength, weaknesses and opportunities and also tangible affects if any will be identified and at the same time locating the missing gaps under various constraints during the period. It is also essential to revisit through this assessment where the Country Team stands in terms of its performance - WHO core functions against the Six Strategic Priority Areas formulated for Nepal (Nepal CCS – Table 12, page 38). The assessment will also align closely with the Nepal’s MDG targets, the manner and the extent of WHO’s contribution to its progress.
Conclusion

The final outcome of the second stage assessment will provide the Country Office the extent of its contribution to the national health outcomes, investment made in strengthening the national core health system ensuring equitable access to health, the missing gaps and the needs for way to improve its result based management system and opportunities to work harmoniously together with other partners on the ground. The lesson learnt from this exercise will also be reflected positively not only for further improvement in its performance but also be a springboard in taking-off for the forthcoming biennium.

References

2. Business Plan for Health Sector (FY2006/07 – 2008/09)
3. Elements of Essential Health Care Services - 2000
5. Free Essential Health care Services for Poor and Destitute People – 2006.
7. Health Sector Strategy – an Agenda for Reform
8. Millennium Development Goals - 2006
9. National Drug Policy
11. National Health Policy, 1991, MoHP
12. National Health Sector Programme – Implementation Plan (NHSP-IP)
14. National Reproductive Health Strategy
17. Second Long Term Health Plan
Decentralization of Health System and its Management

Introduction

Decentralization in Health is pursued for a variety of reasons: technical, political and financial. On technical side, it is frequently recommended as a means to improve administrative and service delivery effectiveness. Politically decentralization usually seeks to increase local participation and autonomy, redistribute power, and reduce ethnic and/or regional tensions. On the financial side, decentralization is invoked as a means of increasing cost efficiency, giving local units a greater control on resources and revenues and sharpening the accountability.

It is generally accepted that decentralization is the most powerful driving force in improving the efficiency of health system performance, equity, narrowing the unmet demands of the community and its empowerment. It is essential to define properly the task to be decentralized in a stratified manner, roles and function of the management system, establishing appropriate laws and enforcement. Concurrently the authority and responsibility need to be clearly defined and respected by all level. The local bodies should ensure the process engaging in a holistic manner throughout the whole health sector not necessarily confined to public institutions. Process of de-concentration, delegation and devolution should be appropriately addressed in the context of the respective community.

Country Overview

The National Health Policy of 1991 laid out an extensive reorientation of health services, including commitment to extend primary health care to the rural population of Nepal. Commitment of HFA was strongly expressed in these changes. The administrative reform of 1992 created a dramatic restructuring of the government, including the MoHP. The intent was to render more effective and efficient services closer to the people. Decentralization was another feature of the reorganization emphasis given to regional and district health services. This was again followed with Long Term Health Plan (1997), and then the Ninth five-year plan (1997-2002) formulated policies, strategies and programmes based on decentralized concepts and approaches. Local Governance Act (1999) was intended for total decentralization.
Decentralization has been implemented, since then, in phases and now completed in 28 districts out of 75. Health facilities have been handed over to the local bodies. Out of 28, 14 districts are enjoying a block grant budget from the finance ministry. Whether there was any assessment taken place on performance based health outcomes in the decentralized districts could not be traced. However there are several information that could be gathered in many of the related studies.

As far as planning is concerned, health ministries prepared the guidelines for local units and units prepared the plans observing the bottom up approach but usually an incremental one than that of need based. Village development committees get five hundred thousand rupees, and out of which five percent has to be set aside for the health sector. Hospital boards are allowed to generate funds and free to plan within their resources. Hospital board can carry out the procurement by themselves. However the system suffered with a lengthy flow of government funds. First allocated in the MoHP budget and then transferred to the local bodies. Local bodies do not have a control over these funds and need to follow the central mandate. Recruitment of all levels is done by PSC. However MoHP make appointments of medical doctors, and other support staff for the Departments, Regions and Districts. All staff salary comes from central treasury and hospital boards are free to recruit and pay from resources generated locally. Though private sector has been encouraged, effective regulatory process are yet to be established. Country has committed to decentralized health services. The policy is limited by deficiency in defining task to be decentralized and its nonuniform technical competence at the local level and growing resistance from the centre to delegate authority and assign responsibility. Effective mechanism for interagency coordination at local level is yet to be established. The present decentralization process demands considerable changes in attitudes, values and norms at all levels among both providers and users.

Challenges

The health system’s performance in achieving the objectives of equity, efficiency, quality and functional soundness depends on the width of decision space of the local authority. The functional areas of finance, service autonomy, human resources, access rules and governmental rules have a very narrow decision space for the local authorities and are under much control of the centre. As the allocation of expenditure influence the equity and financial soundness, likewise it also affects the efficiency of performance and quality of services. So also that of decisions about organizational structure needs more choices for a particular local context. Human resources policy including hiring, firing and building competence are under strict
control of central regulation and hardly enable the local body to exercise flexibility, which concurrently discourage the productivity and quality incentives for the providers. Provision of a moderate level of decision space to local body in areas of financial, organizational design and flexibility in human resources will greatly increase in hospital autonomy and will drastically improve the performance.

Business as usual is a taboo for health sector reform. Reform actions are essential steps to be undertaken for a changed performance scenario. A directed change approach from the centre need to be discouraged in decentralized health system instead needs a wider decision space at the locality. A wide choices of economic and noneconomic incentives scheme, both for individual and institutions, need to be tested and established to rectify current issues of human resources retention at district level.

**Strategic Actions**

1. Strong and sustained political commitment is needed to delegate authority and stop encroaching on authority already delegated.

2. The capacity of local bodies needs to be appraised and provide necessary training programme so that all their execution are on informed decision.

3. The new role of various level of central authorities should also be redefined and restructured accordingly so as to avoid ambiguities in discharging of functions.


5. District health systems management needs to be strengthened. Structured training programmes in team building approach should be conducted in respective districts.

6. There is still lack of sufficient formal institutionalized analytical framework for systematically studying the achievement attained through the assessment of the performance based health outcomes for both preventive and curative components.

7. A task force should be established involving of all stakeholders for engaging in process monitoring, utility based research on district health system and introducing of new innovative choices for better health care performance in district.

8. Widen the decision space for the local bodies.
Conclusion

In a phase-wise manner, decentralization process is in progress. However, there are still several issues impeding to achieve improved equity, efficiency, quality, and financial soundness. Mismatch between authority and responsibility, capacity gaps, tension and conflicts among objectives, and tension between vertical and horizontal integration need further corrective actions to be undertaken. Political commitment and process dimension should also explore how to widen the decision space for the local authority.

References


4. PHR Plus, Decentralization and Health System Reform, No 1 – September 2002


## Matrix of Types of Administrative Decentralization and Functions

<table>
<thead>
<tr>
<th>Functions</th>
<th>Types of Administrative Decentralization</th>
<th>Deconcentration</th>
<th>Delegation</th>
<th>Devolution</th>
<th>Remarks</th>
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</thead>
<tbody>
<tr>
<td><strong>Planning Decentralization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy formulation</td>
<td></td>
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<tr>
<td>Programme / project design</td>
<td></td>
<td>√</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td><strong>Finance</strong></td>
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<td></td>
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</tr>
<tr>
<td>Revenue generation &amp; resources</td>
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<td></td>
<td></td>
<td></td>
<td>Partially Devolved</td>
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<td>Budgeting, revenue allocation</td>
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<tr>
<td>Expenditure management &amp; accounting</td>
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<td></td>
<td></td>
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<tr>
<td>Financial audit</td>
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</tr>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Central</td>
</tr>
<tr>
<td>Staffing (planning, hiring, firing, evaluation)</td>
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<td></td>
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<td></td>
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<tr>
<td>Salaries and benefits</td>
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<tr>
<td>Training</td>
<td></td>
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<td><strong>Service Delivery and Program/Project Implementation</strong></td>
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<td></td>
<td>Central</td>
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<tr>
<td>Defining Service Packages (primary care, tertiary care)</td>
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<td>Setting care norms, standards and regulations</td>
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<td>Targeting service delivery</td>
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<td>Monitoring &amp; oversight providers</td>
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<tr>
<td>User participation</td>
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<td>Locally</td>
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<tr>
<td>Managing insurance schemes</td>
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<td>Locally</td>
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<tr>
<td>contracting</td>
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<tr>
<td><strong>Operation Maintenance</strong></td>
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<tr>
<td>Drugs and supplies (ordering, payment, inventory)</td>
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<td>√</td>
<td></td>
<td>√</td>
<td>Partial</td>
</tr>
<tr>
<td>Vehicles and equipment</td>
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<td>Locally</td>
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<tr>
<td>Drugs and supplies (ordering, payment, inventory)</td>
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<td>Vehides and equipment</td>
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<tr>
<td>Facilities and infrastructure</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Information Management

| Health information system design | | |
| Data collection, processing, and analysis | | |
| Dissemination of information to various stakeholders | √ | |

### Financing

| Source of revenue | | |
| Expenditures | | |
| Income from fees | √ | √ |

### Service Organization

| Hospital Autonomy | √ | Partial, 50 hospitals have developmental boards |
| Insurance Plans | √ | Community health insurance in small scale |
| Payment mechanisms | | Oversight body exists |
| Contracts with private providers | | Patan hospital, Lamjung hospital, Eye hospital, 40% vasectomies done by NGOs |

### Human Resources

| Salaries | | |
| Contracts | | |
| Civil services | | |

### Access Rules

| 75 districts, 75 commission |

### Governance

| Local government | | |
| Facility board | √ | Hospital board |
| Health offices | | |
| Community participation | | Present |
Health Care Referral System

Introduction

Primary health care centers need to maintain a close relationship between all the levels of a health system. This linkage between primary health care services and first referral units upwards is crucial in providing health care for the people of any country. Continuous collaboration between health care personal at primary health care level and those of referral facilities is very essential. This kind of coordination not only will be beneficial for the patients but also it will build professional relationships between health care workers at the community level with health professionals at first referral facility.

Although a limited number of patients will develop life threatening complications, very few of these can be predicted. Therefore the system of referring any of the patients to the next referral centre needs to be improved. However, the first care referral centers need to be provided with essential equipments and facilities to handle any such complications of those referred patients. It also recognizes the importance of support and linkages with the household and community for safe care.

Referral system network need to start from the community upwards. In order to bring down mortalities and disabilities following any disease condition or accidental injuries, availability of an operational referral system is one of the prerequisites where it will help the patient to receive optimal Health care from the next level of referral care without delay. The referral system need to aim at connecting each patient through different levels of services and should assure at the appropriate level where he or she will receive optimal health care for any kind of illness.

When discussing about a referral system it does not mean only the forward referrals. Equal importance should be given to the back referrals as well. If the patients are treated at the first level referral centre they may be referred back to the original primary health care centre with the necessary follow-up advices. This will enhance the trust towards the primary care centers by the patients from the catchments areas. Effective referral requires clear communications to assure that the patient receives optimal care at each level of the system. This communication need to be on both directions, forward , describing the problem ascends at the lower level facility and backward, information back to the lower level facility describing the findings and the actions to be taken and the follow up needs. Introduction of a well planned referral care mechanism could contribute to overcome some of the short comings.
and to minimize the prevailing deficiencies which ultimately leads to provide health care services to the people on an equitable basis.

**Country Overview**

The National health policy was adopted in the year 1991 to bring about improvements in the health of the nation. The primary objective of the National Health Policy was to extend the PHC system to the rural population on an equitable basis. Decentralization and regionalization was one of the key area identified to be addressed through the National health Policy among different other important subjects.

Based on the National health policy the Government of Nepal has developed its Twenty year Long term plan (1997-2017) to guide health sector development for the improvement of health of the population. The vision of this long term plan is Health care system with equitable access and quality services to both rural and urban areas.

Health sector strategy; an agenda for reform and the National Health sector programme Implementation plan has been developed in light of the National Health Policy 1991 and the second long term health plan with priority issues to be tackled in the immediate future. One of the key reforms identified to be implemented is: Devolution of the entire health system with decentralization to local bodies.

In order to ensure decentralization system is functioning well, it is very necessary to combine the decentralization process with an effective referral system.

Findings of the recently published Demographic Health Survey has indicated various obstacles reasons faced by the women in accessing health care which prevent them from getting medical advice or treatment for themselves when they are sick. In that survey a random sample of women between 15-49 age group had been interviewed on their accessibility to health care. 86% of the respondents had at least one problem in accessing health care. 40.5% of the sample had reported that the distance to health care as a barrier. Reasons like not wanting to go alone, no provider available, no drugs available and security concerns, and the transport difficulties etc were the main reasons given by them. These issues were more visible among rural female community than that of among urban setting.

Further, the previous health survey (1995-1996) had found that 30% of the households take more than one hour in travel to reach a health post. Poorest 20% of the poor seem to have less access to the health post when compared to the rest.

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As of these findings it is noted that large number of the female community members are facing difficulties in accessing health care services even at the nearest health care station. In this scenario it is obvious that obtaining any special care is becoming a remote possibility for them.

Despite the access to health care being a major health services problem only minimal action has been taken to address this issue.

Besides the positive steps undertaken by the Health ministry to achieve the set goals and targets, there has been slow progress in implementing activities on decentralization. Accelerated implementation of the decentralization process is a must and need to be considered as an urgent need. Considering the geographical situation of Nepal and the status of the physical access to health care services, establishment of a effective functioning referral care system along with effective decentralized health care management is essential if it is to provide Essential health care services to its people on an equitable basis.

**Present Status of the Referral Mechanism**

Although there is some mechanism established for patient referrals by the Ministry of Health it is not functioning properly at present. Government has introduced a referral form where the health care personal at the primary care centers are expected to fill it and forward while transferring the patients. This mechanism may not function well because of the lack of other requirements for an efficient referral system.

In a study conducted on referral mechanism in Palpa district it was reported that although most government PHCs facilities are using the referral system, only a small number of patients reach the secondary care institution after referral. Even there most of the patient are coming from nearby centers. The study observes that the existing referral system does not greatly improved the access to secondary care for more remote, and probably for more needy communities.

**Future Directions**

While establishing well functioning and effective health care referral system there is some key factors to be considered:

1. Identification of types of services to be provided through each level of institutions

   This will enable to identify the level of care to be available at each level
institution. Whenever the patients need of higher level of care the patients needs to be transferred to upper level of institutions.

2. Development of referral protocols and referral cards

Present referral cards could be revised and amended. The referral cards need to be designed to facilitate communications in both directions. Development of the referral protocols will be much beneficial to health care personal at each level to follow a unified procedure while referring patients. This also will enable to prevent any unnecessary referrals

3. Streamline the referral procedures.

As the present system of referral mechanism is not functioning in an efficient way, the Ministry and the department of health need to revisit it and streamline the procedures. Developing a manual in-cooperating all the instructions and guidelines on referral mechanism will be beneficial.

4. Creating awareness among the health staff and the communities on the referral mechanism

While establishing a referral system, providers at all levels of health care system needs to be oriented and trained on functioning of the system. Further. The staff at each level needs to be thorough on recognizing the need of referral care with regard to each condition.

5. Provision of adequate resources based on the norms for each level of institutions

Availability of the services as for the identified norms at each level of care will generate the trust on the referral mechanism among the health care providers as well as among the people.

6. Establishment of proper communication mechanism between PHCs and other higher level referral centers.

Development of suitable communication facilities at each level of care will enable the system to be functional more effectively.

7. Identification of suitable transport mechanisms to transfer the patients in need for referral care.

Developing transport systems to transfer the patient to the higher level is also very essential. If the health care institutions do not own suitable vehicular arrangements with them, it is always better to identify the alternative mechanisms in transferring patients to higher level institutions at the earliest.
Decentralized Health Management Information System

Introduction

Before the Integration of all Health Programme in 1993, various vertical projects were using their own information system using separate recording and reporting formats. Programme specific recording / reporting resulted in Lack of standardization, duplication, more resources, unnecessary information collection etc. To address such issues Integrated Health Management System was established.

The comprehensive and integrated management information system for the whole health sector has been designed and is functional at all levels as well as quality assurance mechanism is in place for public and private sectors. Currently HMIS is being established in a phase-wise manner to cover the entire country. This includes financial, personnel, logistics, facilities, maintenance, performance, and impact data accessed to all levels. The attempt will also define service indicators and provide health mapping services. The key principle is to ensure that managers at all levels can execute informed decision in a timely manner.

To date there are several issues and challenges that is being faced by the unit in reaching to peripheral levels appropriately. It is also necessary to improve the sensitivity of surveillance information through the established HMIS system. Moreover, comprehensive disaggregated data are not yet available in the timely manner. This information will be very critical for equitable access to health system and also for effective allocations of resources. Especially in the endeavour to achieve the MDGs in the set time frame, disaggregate data is indispensable.

It is also an opportune time to start exploring the hospital information management system as this will answer many of the human and financial resource constraints at all levels. Retention issues of manpower, shortage of essential drugs and equipment in terms of seasonal disease trends are critical in health management especially in strengthening the peripheral health care system.

For an effective way of motivating data procedures and continuous growth of the system, a proactive feedback mechanism should be built-in and thereby encourage use of information both at the decision and operation levels. It may further need to identify different modes of data dissemination based on need and availability of resources. A periodic assessment of the system in terms of human, material and financial resources is essential to clear all impediments, side by side with degree of utilization and updating the mapping of target audience.
Current HMIS Situation

The HMIS was established with the following objectives:

1. To monitor the achievement, coverage, continuity and quality of health services.
2. To help assessing progress (evaluation) towards goals and targets of district health programmes.
3. To support the planning activities of all health programs.
4. To help senior managers develop appropriate health policy guidelines.
5. To provide access of data/information to MoHP, all departments, divisions and centers on time.
6. To support the planning, monitoring and evaluation (PME) management cycle of all health programmes.
Recording and Reporting Tools

Currently there are 37 recording and reporting tools being used by HIMS. Of these, there are 33 different kinds of forms and registers (HMIS 1-30 and 35-37) developed for data collection for Recording Tools. There are 4 kinds of reporting forms (HMIS 31-34) to be used by VHW/ MCHW, SHP, HP, PHCC, DHO and Hospitals for reporting purpose.

- 400+ variables are recorded in the system.
- More than 100+ indicators are being monitored regularly.

Various indicators currently being used by the HMIS for MDG 4, 5 & 6 has been attached as annex I

A process of bottom up planning to make use of HMIS data in planning process from community to National level has been implemented. HMIS is currently monitoring at National Level, a core project is being conducted on a monthly basis, a core programme on a bimonthly basis and all programmes on a quarterly basis. Monitoring at field level for all programmes is being conducted by using monitoring profiles and feedback processes.

A bottom up performance review process is done by conducting a National, Regional and District Review Workshop. Reviews are also done at HP, PHC and VDC Level. Data received at HMIS are reviewed manually before further processing. Erroneous / Inconsistent data are noted and notified back for correction. Internationally standardized coding is applied where necessary.

World Health Organization has trained the hospital medical recorders for ICD 10 since 2002-2003. In 2006-2007 WHO is supporting a pilot of “local area monitoring” at two districts (Lalitpur and Bhaktapur) to increase access and coverage of Essential health Care Services. In 2006-2007 WHO initiated NCD Info base in Shahid Gangalal Heart Center, Bhaktapur Cancer hospital and Patan hospital

Data Quality Improvement

The follow up meetings are being held and the feedback system (both manual & IT enabled) is in place. The Unit is currently facing lack of human resources to adequately monitor the data quality processes and supervision and monitoring is lacking at multiple levels. Data verification is being done but there are many areas at multiple levels that need to be improved.
Information Dissemination

Raw data that are generated monthly, trimester and annually at district, region and national level are being analyzed based on the set of indicators and reports are generated each trimester applying rates, ratios and percentages. Various EDPs have supported many districts in bring out comparative analysis reports which are generated periodically. Single integrated DoHS/Regional/District level Annual Report is being published yearly. There is a need to bring out disaggregated reports on a monthly or at least on a quarterly basis so that there is timely and appropriate action taken at all levels.

HMIS Intranet

HMIS Intranet is being hosted by HMIS to serve easy access to HMIS central data bank thus serving on demand dynamic access to raw data, analyzed reports, annual/monthly trend analysis reports & charts, feedback reports, online data entry/update and communication services etc. HMIS Intranet can be accessed using network connectivity with HMIS Server e.g. wired, wireless, dialup etc. Connectivity Status with Regions, Districts and others is currently being supported by dial up connection using telephone service.

Issues / Challenges

The HMIS is currently facing many Inconsistencies and incomplete reporting. There is a need to identify the inconsistencies in the system and streamline the information collection flow which is adequate, reliable and timely.

The system is also facing underreporting from hospitals particularly in central level and only few reporting is being done by the private sector. There is a need to support and strengthen the information flow from district and below to the central level.

Monthly monitoring sheets need to be updated in a timely manner for the indicators that has been set forth. An information need of the Programme requires to be updated to accommodate their changing needs.

Gender specific, marginalized group disaggregated data needs to be incorporated in the reporting system. Resources and logistics management is essential for the proper functioning of the system and needs to be adequately addressed.

A weak coordination and linkage between different information sources and systems,
e.g., service statistics and survey-based data, LMIS, FMIS & on HR and of other agencies (NGOs and private) needs to be supported and strengthened for better and timely delivery of the good quality data. Currently there is a need to foster the monitoring and upliftment of the data quality. The planning and decision making process needs to adequately use the data generated by the HMIS. There is a need to provide adequate resources to train employees for both basic as well as refresher courses including comprehensive computer training.

Health information is not being used for further action or decision making process; data generator does not get any incentive of reporting good / timely / quality data. The challenge is in making the reported data useful for the data generator. The meaning of data and the action needed to be taken at all levels especially for the front line to increase access and coverage of quality health service and for regional and central level for decision making process and policy direction is to be disseminated.

Different level of services requires different set of data. Front liners need individual follow up, sub district need institutional follow up, districts need subdistrict follow up. The challenge is how to “trim down” reports from the front line to the central level. Only limited and relevant data should be reported to the upper level. Outcome data should be obtained from surveys.

**Future Directions**

There is a need to establish linkages amongst various information systems:

- Health Management Information System (HMIS)
- Human Resource Management Information System (HURIC)
- Logistics Management Information System (LMIS)
- Financial Management Information System (FMIS)
- Drug Information Network (DIN) – DDA
- Surveys / Census

There is a need to develop standardized data exchange format for the wide use of the information system. (e.g. Infobase, Country Response Information System (CRIS), ChildInfo etc.) The following diagram shows the linkages that need to be established between various information systems.
Annex I:

**Major Indicators: Child Health**

**EPI:**
- i. Immunization Coverage
- ii. Drop out Rate
- iii. Wastage Rate

**Nutrition:**
- i. Coverage of Growth Monitoring 1st Visit
- ii. Average no. of visits
- iii. % Malnourished Children
- iv. % of pregnant women receiving Iron tablets
- v. % of postpartum mothers receiving Vitamin 'A'
- vi. Treatment of Vitamin 'A'

**ARI:**
- i. Incidence
- ii. % Pneumonia and severe pneumonia
- iii. Treatment by antibiotic and mortality

**CDD:**
- i. Incidence
- ii. % Dehydration and severe dehydration
- iii. Treated with IV fluid and mortality

(Source: HMIS)
**Major Indicators: Reproductive Health**

Safe motherhood:
- Coverage of ANC and PNC 1st Visit
- Average no. of ANC Visit
- % ANC 4 Visit
- Delivery conducted by health manpower
- Maternal Deaths

Family Planning:
- No. of new acceptors and current users
- CPR
- CYP
- Contraceptive distributions by method

FCHV:
- Mothers Group Orientations
- Contraceptive distributions
- Motivation to the clients

TBA:
- ANC visit
- PNC visit
- Delivery

**Major Indicators: Disease Control**

Malaria/ Kala-azar:
- Slide Positivity Rate
- Annual Parasite Incidence
- Clinical Malaria Incidence

Tuberculosis:
- Slide Collection
- Sputum Conversion
- Cure Rate

Leprosy:
- Prevalence Rate
- New Case Detection Rate
- Treatment Compliance Rate

AIDS/STD: Morbidity
- RTI
- STD
- HIV

Hospital Services:
- Mortality & Morbidity pattern of Indoor Services
- Average Length of Stay
- Bed Occupancy Rate
- OPD Service and Emergency
- Case Fatality Rate
Community Drug Programme

1. **Introduction**

Availability of year round supply of essential drugs in the peripheral level health facilities has been one of the major challenges for the efficient management of primary health care delivery system in Nepal. To improve the drug availability situation in the health facilities the Government of Nepal /Department of Health Services launched the Community Drug Programme (CDP) in 1995. Community Drug Programme aims at improving year round availability of drugs at service delivery points through introduction of user fee and active participation of communities in co-management of health facilities thereby making each health facilities self-reliant and supplementing government expenditures.

The objectives of CDP include:

- To ensure round the year availability of essential drugs and improve the quality of healthcare services at sub health posts, health posts, primary health care centers and district hospitals
- To promote standardized prescription pattern by health workers
- To promote community participation in the management of the health services

As reflected in the 10th five-year plan CDP has been identified as one of the priority (P1) programs of the Government of Nepal and targeted to expand in 35 new districts during the period 2002 – 2007. The second long term health plan (1997-2017) also has aimed to provide essential health services at the district to 90% of the population within 30 minutes travel time and health financing through community (CDP) with respect to the supply of essential drugs. The National Health Sector Programme-Implementation Plan (NSHP-IP 2004) has incorporated CDP as a component for the sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes. Government of Nepal has endorsed Policy on Drug Financing Scheme in 2001 in order to strengthen the CDP.

2. **Country Overview**

With per capita income estimated at US$ 294 (Central Bureau of Statistics 2005), Nepal remains world’s one of the least developed countries. With about 86 per cent of the population living in the rural areas, health post and sub-health post are the...
basic Primary Health Care units (PHC) for providing curative, preventive and promotive health services to largely rural population in Nepal. The main causes of death and disability are infectious and parasitic diseases, perinatal and reproductive ill health. Despite the government efforts, efficient management of PHC services is still a challenge to the country with assured and continual supply of essential drugs in these health posts being a major constraint. The government supplied drugs annually meet health post requirements for only 3-8 months of the year. One of the major indices of the performance of the primary healthcare delivery remains improved access to essential drugs. A rough estimate of 40% has been made regarding the availability of essential drugs at remote facilities. This has resulted to irrational drug use at service delivery points, inequity in drug dispensing and low utilization of rural public health facilities in Nepal. The lack of available drugs in health posts reduces visits by people who could benefit from other aspects of preventative health services.

The Community Drug Programme has been considered as a very important initiative for the support of the development of self-sustaining essential health care delivery system in Nepal. Implemented with the support of external development partners (EDPs) CDP helps to create a facilitating environment for decentralized health service delivery. Under the CDP the community health management committee will charge user fees for drugs and services, the ownership of funds thus raised will remain in community and is used for replenishment of drugs supply and management of health facilities. People have to pay a onetime users’ (or registration) fee, which is normally around NRs 2–5. Then, they must pay for medicines, which are discounted by at least 15 per cent from the retail price. There is also a mechanism for exempting the poorest from paying for medicines.

Strategies followed:

- Formation of committees at various levels (center, districts and VDCs) and establish their ownership to CDP
- Orientation to the District Drug Management Committee and Community Health Management Committee
- Training of health workers and store keepers about CDP
- Formation of Task Force to manage availability of drugs in health facilities
- Involvement of community for management /procurement of essential drugs at health facility level
A Cross-Sectional Perspective on WHO Collaboration

Annexure: Strategic Papers

WHO Country Office for Nepal

- Logistic support (cup board, calculator, form, formats and IEC materials)
- Coordination and mobilization with governmental organization, line agencies and CBOs at all levels/ and
- Periodic supervision, monitoring and evaluation of the Programme

Present Status of Community Drug Programme (CDP)

As of FY 2005-2006, CDP is functional in 30 out of 75 districts in Nepal, however the complete coverage is only about 33% in these districts. Coverage by ecological belt is the highest in plain (terai) 95%, followed by hill 56% and mountain only one fourth.

Initially UNICEF supported the CDP but now many other EDPs, namely, BNMT; CARE/Nepal; HSSP/GTZ; HHES, RHDP/SDC and Plan/Nepal have joined hands with the government to support this Programme in various districts. Some other EDPs like WHO; RPM Plus/MSH; NFHP and INRUD/Nepal are also supporting the various activities of the Programme.

Table No.1: Community Drugs Programme & Cost sharing Scheme Coverage

<table>
<thead>
<tr>
<th>Description</th>
<th>District</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Full CDP coverage districts</strong></td>
<td>Terhthum, Morang, Sunsari, Rautahat, Parsa, Chitawan, Kaski, Banke, Kailali Kanchanpur</td>
<td>10</td>
</tr>
<tr>
<td>CDP is functioning in all the health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Partially coverage CDP districts</strong></td>
<td>Solukhumbu, Udayapur, Siraha, Ilam, Dhankuta, Jhapa, Dolakha Ramechhap, Dhading, Kavre, ‡Bara, ‡Mahottari, Makwanpur, Baglung, Rupandehi, Surkhet, ‡Nawalparasi, Bardiya, ‡Dang, Doti</td>
<td>20</td>
</tr>
<tr>
<td>CDP partially covered &amp; stopped in some HF previously implemented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Other Cost Sharing Schemes</strong></td>
<td>Taplejung, Sankhuwasabha, Panchthar, Bhojpur and Khotang</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>35</td>
</tr>
</tbody>
</table>


WHO Country Office for Nepal
3. Issues and Challenges Identified in CDP Implementation

i. Availability

The government provides an annual indent supply of drugs once in a year in July/August. A study\(^2\) showed that 40% of government facility clients had to obtain some or all needed drugs from private pharmacies by November. Although findings show that the availability of essential drug is 82% in the CDP facilities while non-CDP facilities have only 65% but still CDP facilities fall short of the government mandate which states that at least 95% of ‘critical’ life saving drugs must be available year round in CDP facilities. The availability and stock-outs may be due to problems with drug supply, distribution and irrational prescribing.

ii. Drug Supply

Government supplies of essential drugs are not according to the requirement of the community. Most of the health institutions get nearly identical drugs regardless of local disease pattern, local service delivery capacity and size of population covered resulting in wastage or lacking of medicine. The procurement capacity remains weak and the frequency and rate of drug procurement at health facilities varies from one to another. Local capacity for redistribution of surplus drugs of health institutions appears to be suboptimal. The Essential Drug List is not updated frequently to accommodate all the needed drugs.

Steps to be taken: There should be the effective implementation of the Pull System in the CDP Programme. Pull System scale-up will help better address problems of non-availability of essential drugs at health facility level, thereby improving the quality of health services available. There should be proper mechanism of procurement and distribution of affordable and quality essential drug at district level.

iii. Rational Use of Drug

One of the key issues is rational use of drug in the CDP. For promoting rational use of drug, Government of Nepal has published Essential Drug List (EDL) and Standard Treatment Schedule (STS) for health post and sub-health posts. National List of Essential Drugs-Nepal (EDL) is the basis for the selection of medicines for health

\(^2\) SDC/RHDP CDP Action Research Report
facilities and is classified according to the level of health facilities. The CDP training manual also includes courses on rational use of drugs, STS and EDL. But rational use of drug still largely remains a question in CDP. Irrational use of drug may be traced to several causes like lack of availability and implementation of EDL and STS in most of the health facilities and inadequate awareness of health workers on rational use of drugs. It has been found that EDL and STS is not being followed strictly. When health facilities are directly responsible for procurement of drugs, the EDL is not always followed. The programme is managed by the people who have not received adequate orientation for the implementation of the programme. So they are demanding and purchasing medicines which are not included in the EDL and there are many irrational combinations wrongly preferred by the healthcare providers. In a survey done in one of the district (Morang) it was found that four out of every five cases were provided antibiotics.

Steps to be taken: The aim should be to increase the percentage of drugs prescribed from within the EDL, promotion and intensive training of rational use of drug to the health workers and the community and the availability of EDL and STS in all health facilities.

iv. Accessibility

There is lack of community awareness on CDP. In a study done in Dolakha and Ramechhap districts 75% of people interviewed were unaware of CDP, of the 25% who were aware information was obtained from the female community health volunteers (FCHV) and from individual price comparison.

Steps to be taken: Knowledge of CDP and participation in CDP management by local public is needed. One of the contributory factors behind few successful CDPs had been a strong community leadership supported by FCHV. FCHVs can play a vital role in CDP awareness generation, bridging community members with facilities and contributing towards sustainability. Promotion of the Programme via different media, development of information, education and communication (IEC) materials, capacity building of health facility staff and also FCHVs should be carried out to better promote the Programme.

v. Affordability and Exemption Management

One persistent failure in the scheme is the inability to workout exclusion criteria, whereby those unable to pay would not be charged. This effectively let the health
workers decide who could be charged and who could not be. There is lack of a well-designed exemption mechanisms and found to be provided haphazardly causing bias-ness. The CDP committee has been found to be unable to identify the real poor and disabled people. It has been found that there is a great difference on exemption rate among the districts. CDP facilities should provide drugs at 15% less than market value and free to the poor. However exemption policies and prices vary by facility and are not transparent. The challenge is to maintain both equity and quality of services in the CDP, which will allow affordable price setting and suitable exemption procedures (i.e. balancing sustainability of the Programme against the affordability of the community, particularly in rural areas).

Steps to be taken: Locally appropriate fee schedules (user charge) should be identified and implemented. An effective mechanism that includes guidelines and procedures should be developed and strictly followed by the health institutions to exempt the poor and marginalized people for e.g., BNMT proposed colour card system to exempt poor people. Criteria of exemption should be widening so that needy people can access health services. Local group poor identification exercise should be referenced, and assistance can be taken from FCHV and social workers engaged in community outreach.

vi. Management

There is information gap between different levels. Managers at central and the regional levels are not aware of the actual situation of money, purchase, payment and delays of the drugs in the distribution channel and the district authorities are not involved in drug planning and decision-making. All of the stakeholders are not being represented in district level CDP Management Committee. Inadequate planning skills and motivation of the health management committee at village development committee persists. There is lack of Programme monitoring and supervision at regional and district level. As per CDP directive, it is mandatory that the CDP has to be externally audited at the end of every fiscal year but the health facilities and management committee are facing problem in auditing.

Steps to be taken: There should be improved coordination between concerned governmental and external development partners in implementation of CDP. The role of district development committee and village development committee should be promoted by continuous facilitation to increase their active participation in planning and management of CDP. Supervision and monitoring mechanism of the CDP should be developed and implemented.
vii. Efficiency

Revolving Drug Fund (RDF) is not properly used. As per CDP directive, money from RDF cannot be used for other than essential drugs. As a result, many health facilities has significant amount of money accumulated in RDF.

Steps to be taken: Fund should not be idle. Proper fund flow guidelines need to be produced in central level in order to mobilize the fund efficiently and effectively in other health development activities.

4. Strategic Action

1. Decentralized planning to promote district level commitment and a feeling of programme ownership and responsibility for effective programme implementation.

2. Standardized implementation guidelines for proper CDP management.

3. Identify and implement locally appropriate fee schedules and exemption management and ensure adequate protection mechanisms for the poor and other target groups.

4. Promotion of rational use of drug.

5. Organize intensive initial training followed by periodic refresher training to promote rational drug prescribing, good dispensing practices and good store keeping practices to the health workers.

6. Ensuring availability of standard treatment schedules and essential drug list in all health facilities.

7. Develop proper mechanism of procurement and distribution of affordable and quality essential drug at district level.

8. Strengthening supervision and monitoring of the CDP.

9. Develop proper fund flow guidelines to mobilize the fund efficiently.

10. Develop and strengthen effective coordination among all CDP implementing partner.

11. Gradual expansion of CDP throughout the country. Focus should be more on maintaining existing CDPs and less on starting new ones. Expansion to more districts needs a careful examination of existing problems and suitable modification in strategies is required.
12. Ensure reliable supply of low cost essential drugs of good quality and assure drug quality throughout distribution channels with technical support of DDA.

13. Provide drug management training to ensure transparent accounting and management together with improved drug supply techniques.

14. Develop good administrative systems for financial management and supply management.

15. Promotion of the function of District Development Committee and Village Development Committee by continuous facilitation to increase their active participation in planning and management of CDP.

16. Increase awareness of CDP in the community via different means.

17. Promote CDP as a planned nationwide government Programme

5. Conclusion

There has been gradual expansion of CDP since 1995 and the availability of essential drug in the health facilities has been found to be improved after the implementation of the CDP. Development of a sustainable CDP would definitely improve the quality of health care services in health facilities at the community level however various operational issues such as exemption management, rational use of drug, access, orientation of community health management member, financial management and district empowerment are important issues that needs to be addressed at while its implementation.
Essential Health Care Services

Introduction

Health care service delivery is mostly carried out by the District Health System through a network of government-run Health Facilities such as SHPs, HPs, PHCs and DPHOs. Primary Health Care approach is universally adopted in Nepal. Resources that are available from all sources including developmental partners are not unlimited. There is always a need for minimizing costs. Through prioritization it is possible to reallocate resources from high cost-low impact interventions to low cost-high impact interventions. The process further facilitates defining roles of different partners and assists resource mobilization. Hence prioritization becomes essential.

Essential Health Care Services (EHCS) is a concept adopted in the second long-term plan consisting of a list of prioritized public health measures and curative services aimed at treating and preventing common diseases and injuries. These measures or services after a gradual expansion will be covering the entire population. EHCS are cost-effective, address most essential needs of the community. They are feasible, acceptable and practical. They are part of Primary Health Care approach followed everywhere including Nepal.

A workshop, organized in the year 1996, identified and enumerated major health problems of Nepal and came out with interventions to address these problems. Out of these identified interventions 20 were prioritized based on the pre-set criteria. They criteria were

- Intervention should address Nepal's principal health problem.
- Reflect various international commitments of NG.
- Cost effective, feasible & socially acceptable.
- Gender sensitive.
- Political commitment for the specified intervention.

A steering committee (SC) and also a Technical Working group (TWG) together collected additional information to define specific elements/components for each of the 20 prioritized interventions. The SC and TWG were guided then by the document "Standards/guidelines for primary level health institutions (1995)." Thus a draft package containing the elements/components of EHCS package to be provided at different levels in the country had emerged. That draft was further reviewed by a consultant and a final version was submitted to Government.

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EHCS covers 20 main interventions. Focal points for each of these interventions have been identified in the document. Elements / components for the above interventions are packaged to be delivered at 7 different levels. The levels are Household, Outreach, SHP, HP, PHC, District Hospital and DPHO.

The above list of interventions cover most of the prevalent ailments and are being implemented to a lesser or greater extent. However there exist some gaps in implementation and the outcome falls short of expectations. Instead of going into the shortcomings of the individual disease or programme specific interventions further description will largely be limited to the major obstacles observed at different levels of service delivery points. If these obstacles are overcome then the beneficial effects will be found across all specific interventions.

Issues and Challenges

1. Household Level

Ignorance and lack of awareness is the main obstacle coming in the way of members seeking help early. Poverty is the next most important factor that cases delays in seeking services. Community members have to spend money on travel and for services they get either at NG facilities or outside. Gender bias and other cultural beliefs and practices also delay the process of accessing health services.

2. Outreach Posts Level

There are 15532 EPI Outposts and 15248 PHC ORC Outposts. Persons manning these 30780 Out posts are by and large lack adequate skills and appropriate attitude. Awareness generation among community about various services that are available is one of the responsibilities. Motivating and facilitating utilization are the other responsibilities. These activities are being undertaken informally, while they interact with community members. Service utilization is excellent if the community is aware of the need and demand particular service. Immunization is a good example where community demands and the system delivers.

3. Sub Health Posts Level

This primary health care outlet is expected to provide preventive, promotive and curative services to the population. Some of the factors hindering utilization of these facilities are lack of punctuality, absence of staff from work place, poor
infrastructure, inadequate supplies, skill and attitudinal deficiency. Private practice and private business (pharmacy) often keeps staff away from SHP.

4. Health Posts Level

HPs have additional staff when compared to SHPs. Services of ANMs are available at this level. However the skill deficiency amongst ANMs in delivering Ante natal, Natal and Post natal services was found to be grossly inadequate in one of the studies conducted. Their ability in providing neonatal and infant care was much worse in comparison. Other obstacles enumerated under SHP could also be found at this level as well.

5. Primary Health Center Level

Services of a doctor are expected to be available at this level. But most of the posts of doctors remain vacant. To some extent this applies to the posts of Staff Nurse. Clinical laboratories are in place with a trained person manning them. However supplies are not regular. Safety procedures are not followed thus exposing patients and worker to risk. Some of the minor equipments are not available at some places. At some places equipments like Operation tables, X-ray plants remain unutilized.

6. District Hospitals

Over crowding, lack of hygiene and inadequate staff are the major obstacles found at district hospitals. Utilization of these facilities by and large is good.

Strategic Actions

1. Community Empowerment

Improve community awareness about the common ailments afflicting the people. Provide information about the availability of services at various levels. Utilize every means (formal / informal) of communication to educate community. Services of FCHVs should be utilized optimally for creating awareness amongst community members and also in enhancing utilization of various services offered at HFS by community members. Improve the quality of services at NG HFvs so as to make them more acceptable to the people. Install a quick effective mechanism to attend to the complaints of clients promptly.
2. Improve Compliance at Health Facilities

Monitor closely the opening and closing timings of the HFs. Ensure presence of staff at all times at HFs. Reduce the frequency of staff travel to attend meetings & trainings etc. that is not essential. More frequent supervisory visits from the district office will improve compliance. Delegate the authority to monitor compliance by staff to local authorities / community leaders.

3. Skill Enhancement

Undertake training need assessment of all category of the staff at HFs. Organize strictly task oriented training if need be. ANMs have to be trained so as to make them trained birth attendants and improve their skills in managing newborn's and infants health problems. Frequent visits from the technical supervisors and on the job training of the staff at the periphery should become the norm. SOPs have to be developed and disseminated covering locally prevalent common ailments.

4. Human Resource Deployment

Every effort should be taken to fill up the exiting vacant posts of Doctors and Nurses. Additional incentives to motivate people to join NG may have to be considered.

5. Supplies

Timely and adequate supply of essential drugs, laboratory consumables and other materials are to be ensured. Inventory of all heavy equipment remaining unutilized at various facilities is to be made. Reasons are to be ascertained for not using them. Remove or shift them to places where then can be put to use.

6. Incentives to Staff & Clients

Introduce incentive schemes so as to encourage better performance by staff.

All services at SHP, HP and PHCs could be provided free of cost to the clients so as to remove economic inaccessibility. If not all for economic reasons at least poor and marginalized groups have to be provided free treatment.
Skilled Birth Attendants

1. Rationale

The International Health Partnership (IHP) aims to strengthen and enhance the progress developing countries are making to reduce child mortality and improve maternal health (MDG 4 & 5 respectively). Nepal being one of the selected countries to implement this new initiative needs to develop a strategy to address some of the key areas that would indicate the country’s commitment and ensure the achievement of these MDGs. The table below summaries the key indicators for Nepal with regard to child mortality and maternal health;

Selected Millennium Development Goal Indicators, Nepal 2006

<table>
<thead>
<tr>
<th>Goal</th>
<th>Indicator</th>
<th>2001</th>
<th>2006</th>
<th>2015 (Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Reduce Child mortality</td>
<td>Under 5 mortality rate (per 1000 live births)</td>
<td>76</td>
<td>61</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Infant mortality rate (per 1000 live births)</td>
<td>64.4</td>
<td>48</td>
<td>34</td>
</tr>
<tr>
<td>5. Improve maternal health</td>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>539</td>
<td>281</td>
<td>213 or 134</td>
</tr>
<tr>
<td></td>
<td>% of births attended by skilled birth attendant</td>
<td>13</td>
<td>18.7</td>
<td>60</td>
</tr>
</tbody>
</table>

Reducing the high burden of unnecessary deaths due to pregnancy and childbirth calls for a combination of social, economic and health interventions, as well as changes in individual and family behaviour. However the key factor for success is the availability of skilled attendants at the community level with a referral back-up, providing emergency obstetric care and special care for newborns with problems, in a functioning health system. Therefore this paper spells out the direction for Nepal to both increase the quantity and quality of skilled birth attendants (SBAs) in an enabling environment with the aim of reducing neonatal and maternal mortality.

The high infant mortality indicated in the recent statistics have largely been attributed to the unacceptable neonatal mortality rate in the country, which is the third highest in the world. Similarly the issue of maternal mortality in Nepal was highlighted in the recent world disaster report as being a neglected crisis. Skilled attendants—people with midwifery skills, such as midwives and doctors and nurses who have
been trained to proficiency in the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and identify, manage or refer complications in the woman and newborn—are best placed to ensure the survival and safety of pregnant women and their infants.

Past experience has also shown that no country reduced its MMR to below 100 per 100,000 live births, without ensuring skilled care for a high proportion of births. The international consensus is that skilled care at every birth is the key to making childbirth safer for women and their newborns.

2. Country Overview

2.1 Neonatal and Maternal Mortality Causes

According to the 1998 Maternal Mortality and Morbidity Study, the major direct causes of maternal death in Nepal are postpartum haemorrhage (46%), obstructed labour (16%), pre/eclampsia (14%), sepsis (12%), abortion (5%), and antepartum haemorrhage (5%). It was found that 62% percent of the deaths occurred during the postpartum period. Hospital data suggest that the major causes of neonatal death in the country are birth asphyxia/trauma (most common), sepsis, low birth weight and premature birth, and hypothermia.

For a healthy pregnancy, safe delivery and a healthy child, a woman needs at least a minimum level of care during her pregnancy, at delivery and in the postpartum period, with timely recognition and treatment or referral of complications.

The recent Nepal Demographic and Health Survey (2006) shows that 81% of deliveries take place at home. 18% of births take place in a health facility: 13% are delivered in a public health facility, 4% in a non-government health facility and less than 1% in a private facility. These national figures vary according to geographical location of the delivery and the socio-economic status of the woman. For example, 48% of the children in urban areas are born in health facilities, compared with 14% in rural areas. Furthermore delivery in a health facility also varies according to ecological regions, where mountain areas report the lowest of 6% and the terai and hill areas reporting 17% and 21% respectively. Analysis of this data indicates a strong association between health facility delivery, mothers’ education and wealth quintile. Such disparities are visible in other indicators as well. Rural neonatal mortality ratio of 48.5 per 1,000 live births, compared with an urban ratio of 36.6 per 1,000 live births.
The fact that a large proportion of the deliveries are home based with only 5.6% of them being assisted by a SBA is a scenario that begs for immediate interventions. Obstetric care from a trained provider during delivery is recognised as critical for the reduction of maternal and neonatal mortality.

### 2.2 Skilled Birth Attendants

In the 1990s, Nepal invested in two types of health workers to be responsible for providing maternal/child health services and obstetric first aid at the village level-the Maternal and Child Health Workers (MCHW) and Auxiliary Nurse Midwives (ANM). Neither category of worker has successfully functioned as an SBA due to a number of factors, including: inadequate length of the midwifery component of the training; the training not being competency based; a lack of adequate clinical training and experience; professional and social isolation at post; and lack of support from the health system to enable MCHWs and ANMs to provide quality emergency obstetric and neonatal care, especially during life threatening complications.

WHO definition of skilled attendant is a health provider who has at least the minimum knowledge and skills to manage normal childbirth and provide basic (first line) emergency obstetric care.

In Nepal, less than 19% of births take place with the assistance of a SBA. The targets for SBAs set for the country are: 40 percent of all births to be assisted by an SBA by 2005, 50 percent by 2010, and 60 percent by 2015. This is an enormous challenge as currently as per the internationally accepted definition, only a limited number of health workers in Nepal qualify as SBAs. Furthermore, the inequity in access of SBAs depending on the area one lives and the economic status, are barriers to achieve the MDG indicators in this regard. 51% of deliveries in urban areas are attended by a SBA, compared to 14% of births in rural areas. Births in hill zone, central region, and especially central hill sub region are most likely to be attended by an SBA.

At present the government hopes to have 1000 trained SBAs by 2008. As an incentive, a Nepal Rs 300 payment is made to staff classified as trained health workers for attending deliveries either at home or in a facility.

### 3. Government Policies for Skilled Birth Attendants

To address the issue of SBAs, Nepal developed a National Policy on Skilled Birth
Attendants in 2006. Based on the WHO/ICM/FIGO definition of SBAs, Nepal has spelled out core competencies of SBAs for promoting safe motherhood. The SBA Policy is in concurrence with the Nepal Health Sector Programme-Implementation Plan 2004-2009, particularly with output one (prioritizing Essential Health Care Services) and output seven (Human Resource Development). According to the policy, the following are its specific objectives in order to ensure that sufficient numbers of SBAs are trained and deployed at primary health care levels with necessary support system.

- To strengthen referral services for safe motherhood and newborn care, particularly at the first referral level (district hospitals).
- To strengthen the pre-service and in-service SBA training institutions to ensure that all graduates will have the necessary skills as proposed.
- To strengthen supervision and support system to ensure that all SBAs are able to provide quality maternal and newborn health care according to the national standard and protocol.
- To develop regulating, accrediting and re-licensing systems for ensuring that all SBAs have the abilities and skills to practice in accordance with the core competencies proposed.

The strategies incorporated in the policy comprise of short term, medium term and long term measures for production of SBAs (annex-1). Other key elements of the policy are the production of SBAs as a part of HR management systems to address deployment, motivation and retention issues, introducing decentralized health management system to ensure equitable distribution of skilled attendants, ensure effective partnerships with other health workers including Female Community Health Volunteers (FCHVs) and develop capacity of professional councils for instituting a process of effective accreditation system in order to ensure quality of care.

Although the GON has been actively drawing out plans to reduce maternal mortality and improve newborn care abiding by the international recommendations of developing SBAs, it must noted that solutions to Nepal’s lost mothers and newborns could be as complex as the root causes itself. The strategies proposed and to be implemented may have little effect if the challenges are not addressed in a multifaceted manner, where simultaneous interventions are necessary.
4. Issues / Challenges to Increase Access to Skilled Birth Care

Broadly, the issues relating to SBAs include supply and demand related challenges as well as the poor enabling environment. While the supply of SBAs is crucial to ensure necessary services are provided for safe delivery and newborn care, demand for SBAs need to be encouraged to ensure these services are accessed actively. The mechanism of ensuring a good supply and demand for SBAs requires a conducive enabling environment.

4.1 Supply of SBAs - Quantity and Quality issues

- The GON health policies have projected the number of SBAs required for the country, under short term, medium term and long term. However, it has been noted that actual production of SBAs increases only by about 2-3% when a much higher rate of 6-7% per year increase is needed to meet the MDGs.

- The existing health care providers (ANMs and Staff Nurse) responsible to provide maternal and newborn care, do not have the required skills of SBAs.

- Low human resource retention and deployment in peripheral level health facilities need closer attention, especially when most births take place at home and geographical access proves to be a huge barrier.

- Quality of services have taken a toll due to increased pressure to include the expanding range of tasks to be performed at field level, thus overloading the curriculum; and increased class size, with the number of students exceeding the available case-load, resulting in production of nurse midwives with a lack of hands-on experience.

- As multi purpose workers, SBAs are often busy with other primary health care duties, preventing them from devoting sufficient time for providing appropriate maternal and newborn care,

- No appropriate career development schemes to ensure their retention in communities they serve.

- Rapid and ill planned scaling-up of the production of midwifery-trained health workers;
4.2 Demand for SBAs-geography, Social and Economic Barriers

- To increase the demand for SBAs at delivery, maternity incentive scheme has started offering cash payments to women to cover transportation to reach a health facility and in some selected districts making delivery services. However, finances is only one demand side barrier, others including low education level of women, customs and traditions, geographical constraints and ignorance. According to the NDHS 2006, 73% of women believed that it was necessary to give birth in a health facility, 17% mentioned that it was not customary, 10% said it costs too much and 9% said the health facility was too far to be accessed.

4.3 Enabling Environment- Health Systems Challenges

- Need to build effective leadership for maternal and neonatal health at district health system
- Lack essential equipment and supplies, and adequate supervision and effective back-up for referral services.
- No systematic linkage between primary health care services and the first referral unit which is crucial in the process of saving the mother and newborn.
- No special outreach services for the poor and disadvantaged groups.

5. Strategic Direction to Meet MDG Indicators for Skilled Birth Attendants

The strategic direction towards SBAs complements the proposed government policy. However certain areas proposed in the policy for SBAs need additional assistance to ensure Nepal is on the correct track to achieve both national and global targets for maternal and neonatal health care. The following areas are suggested as key fields to address the problems identified in section 4 above.

5.1 Addressing Supply Barriers

- Expand access to and utilization of skilled care at birth with special attention to the poor, the disadvantaged and under-served communities through a systematic out-reach services programme.
- Develop a long-term plan for human resources for safe motherhood in order to achieve universal skilled care at birth.
• Special attention to strengthen pre-service for ANMs and nurses at training institutions, as future SBAs and improve the status of midwifery as a profession.

5.2 Addressing Demand Barriers

• Strengthen involvement of women, families and communities to care for women and newborn in normal condition, birth preparedness and referring those with complications and problems. Also build confidence in and trust of skilled health workers.

• Greater attention to educating communities and working together with them to develop birth and emergency preparedness plans, including transport and communication systems.

• Forging strategic partnerships to achieve common goals with all actors and agencies including public and private sectors and NGOs at all levels including community level.

5.3.1 Addressing Barriers for an Enabling Environment

• Strengthen and increase investments at all levels of health system for achieving universal skilled care at birth.

• Ensure adequate financing for maternal and newborn health programmes at local/district levels to ensure that necessary activities, basic equipment and supplies for skilled care at birth both at primary health care and its referral back up are well covered.

• Strengthen management of resources at all levels to ensure that they are utilized in an effective and efficient manner in order to achieve universal skilled care at birth and to ensure quality of care.

• Strengthen an effective system for monitoring and evaluation coverage and quality of MNH services
A Cross-Sectional Perspective on WHO Collaboration

**Annex: 1** Diagrammatic presentation of recommended Short, Medium and Long Term plan (Source: Final MNH forum, 2006)

**Proposed strategy for SBAs at community level**

**Short Term**
Time Scale: Ongoing/Current

**Medium Term**

**Long term**
Time Scale: Planning/Preparatory phase-2005/06 Implementation phase-2006/07

**Recommendations:**
1. Continue ongoing MNH refresher to ANM and MCHW
2. PHN refresher for supervision and monitoring of MNH activities
3. Revision of curricula to include newborn care component

**Recommendations:**
1. Upgrade skills of ANMs:
   - One year midwifery training for ANMs with 3 years experience, to make them SBA
2. Restructure ANM course:
   - Total duration –2 years (6 months basic nursing and 18 months midwifery)
3. ANMs (upgraded and newly trained) will be posted at HP and SHP level. They will not be allowed to work at hospital level (public or private)

**Policy Recommendations:**
1. Policy decision to restructure ANM curriculum and training.
2. Policy decision on ANMs work regulation, job description and deployment.
3. New ANM posts, created according to the Strategic Plan for Human Resources for Health (2003-2017), will be filled with 2 years trained ANMs.

**Policy recommendations:**
1. Create new cadre of midwives (RM, BM, MM)
2. RM will be employed at district hospital and PHCC level
3. BM will be employed at midwifery training hospitals and birthing centers with the responsibilities as trainers/supervision and monitoring of district MNH activities and birthing center.

WHO Country Office for Nepal
Female Community Health Volunteers

1. Rationale

The Female Community Health Volunteer (FCHV) Programme IN Nepal was started in 1988 by the Ministry of Health and Population in order to improve community participation and to enhance the outreach of health services through local women working voluntarily. Initially the strategy proposed one FCHV per ward in rural areas. In the mid-1990s a “population based” strategy was adopted in 28 districts whereby additional FCHVs were recruited leading to a current total of nearly 50,000 FCHVs in Nepal and 97 % of them are in in the rural areas.

FCHVs play an important role in contributing to a variety of key public health programs, including family planning, maternal care, child health, vitamin A supplementation/de-worming and immunization coverage. They are the foundation of Nepal’s community-based primary health care system and are the key referral link between the health services and communities. Additionally FCHVs have made significant contributions to women’s leadership and empowerment at the Village Development Committee (VDC) level, and several active FCHVs are as VDC members.

Given that majority of health problems in Nepal, particularly in the rural communities, are related to the health of women and children coupled with a lack of human resources in the health sector, FCHVs will be a major contributory factor for Nepal to achieve its health related Millennium Goals (4, 5 and 6). Therefore, this paper summarizes the role of FCHVs, the government policy with regards to them and how the programme could be further strengthened to help the health sector utilise their skills to reach its targets.

The effective implementation of FCHV program depends largely on support provided by the community, the Health System, and the mass media.

2. Context of FCHVs in Nepal

Through their voluntary services, Female Community Health Volunteers (FCHVs) contribute extensively to the health and well being of their communities, in particular to the women and children in rural areas of Nepal. FCHVs are present in over 97% of rural wards in Nepal. Their median age is 38 years and 62% of them literate; 53% of FCHVs have been working for more than 10 years and the annual turnover is only about 4%. On average, the FCHVs were found to work for 5.1 work hours per week and 76% of them willing to increase the amount of time they spend working as FCHV in the future.

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The role of the FCHVs has been outlined as below;
- To act as voluntary health educators and promoters, community mobilizers, referral agents and community-based service providers in areas of health as per the trainings received.
- To promote the utilization of available health services and the adoption of preventive health practices among community members.
- To play a supportive role in linking the community with available PHC services and to continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level.

2.1 Coverage of Health Services by FCHVs

The graph below illustrates the FCHV workload by household covered and geographical zone.

![Graph showing FCHV workload by household covered and geographical zone.](source: USAID 2007)

Note: Data is from 47 districts (population-based districts are excluded). Only data based on 100+ FCHVs per category is shown.

Source: USAID 2007

The Nepal Demography and Health Survey (NDHS 2006) indicates that about 10% of children with ARI in CB-IMCI districts go to FCHVs compared with 19% of children
who go to government rural facilities. Only 13% of treatment FCHVs failed to treat any children over six months due to lack of medicines. Evidence from districts that have all treatment FCHVs is that 88% of FCHVs treat successfully if trained. Nationally, FCHVs see nearly one fifth of children with diarrhoea who go to any provider for treatment.

The 2006 NDHS survey found that 90% and 84% coverage for vitamin A and deworming, respectively. All doses are provided by FCHVs. They also play a major role in routine immunizations and Polio campaigns.

With regard to maternal and newborn care FCHVs provide counselling during pregnancy. Eighty five percent of women who see an FCHV during pregnancy also go for antenatal care. However advise on the use of skilled birth attendant was only mentioned by 30 percent of FCHVs and preparing for possibly emergencies by only 11% and 4% only for birth plan. Hence this area needs considerable support for strengthening community-based maternal and neonatal health programme.

The main source of information for FCHVs is their local health facility and training sessions. Mass media (especially radio) is an important secondary source of information for about half of FCHVs. Eighty-five percent of FCHVs report having support from mother’s groups and 68 percent report that these groups help them with their work. The overall levels of contact between FCHVs and the government health system and their continued training are good in most districts.

There are excellent prospects for the continued functioning of Nepal’s FCHVs and with well designed and supported programs, they may be able to expand their activities and impact.

2. Government Policies and Plans

A very comprehensive National FCHV Program Strategy has been prepared by the Ministry of Health in Nepal in 2003. The overall Goal of the FCHV program, according to the document, is to contribute to Nepal’s goal of reducing the total fertility rate and the under 5 mortality and maternal mortality rates by focusing on family planning, maternal/neonatal and child health, including the semi-annual Vitamin A supplementation program.

2.1 Features of the FCHV Programme Strategy

The program objectives listed below will help to reach the goal of the FCHV strategy.
• To develop at least one Female Community Health Volunteer in every ward nationwide, who is knowledgeable, trained and well supported health resource person through capacity building, distance education and supportive monitoring activities, which will reinforce each FCHV’s ability to fulfill her role as health educator, referral agent, community mobilizer and community-based service provider.

• To empower FCHVs with necessary skills and support (to empower rural women with basic health knowledge and skills) in order to increase utilization of available primary health care services and participation in community health development.

• To increase community awareness on the importance of the joint roles and responsibilities of FCHVs and Mothers Groups (MGs) through advocacy and health communication activities; and

• To strengthen community level ownership, management and long-term sustainability of the FCHV program in conjunction with the LGSA, through the establishment of local funds by local VDC and District Development Committee (DDC) authorities, and through active support and commitment from all levels of implementation, including health facilities (HFs), Health Facility Management Committees (HFMCs) and District Health Offices/District Public Health Offices (DHO/DPHOs).

2.2 Key Elements of Program Strategy

• The ward-based approach to be strengthened nationally and implemented as the primary approach of the FCHV program.

• At a minimum, at least one FCHV selected in each ward.

• Population-based approach may be expanded cautiously and implemented on the basis of clearly defined criteria in specific cases where DDCs, VDCs or municipalities demand program expansion or request an increased number of FCHVs.

• Emphasis will be given to strengthening support to all current FCHVs.

2.3 Three Year Plan and FCHVs

In addition to the is the FCHV strategy, the Three Year Plan (2008-2011) of the Ministry of Health, which sets the overall direction of the country’s health sector also include the following under the objective of providing equal opportunity for
health development to all with special emphasis to socially disadvantaged, poor, women and disabled people per the provision of “Basic Health as Human Right” in the Interim Constitution of Nepal in 2007.

- FCHV programme will be strengthened through the establishment of revolving fund of Rs. 50,000 at each VDC level. This fund will be to support and empower these women.
- FCHVs who are above 40 years old, and not working will be replaced from indigenous and disadvantaged communities.
- Links and mechanism will be established through FCHV to make funds available for enabling women to avail emergency obstetric service through FCHVs with the “saving and cooperative programme”.

3. Issues and Challenges

It is important to further promote this community volunteer scheme as it is one of the most successful programmes in the health system of Nepal. Strengthening it would ensure that the FCHVs will be able to support the health staff at peripheral level to provide good quality health care. Therefore following areas are suggested;

- Strengthen support by all concerned for effective implementation of the strategic directions and critical approaches of the national program as per revised FCHV programme strategy, 2003.
- Ensure strong health system support through an effective referral system and institutional establishment for orientation, training and retraining for the volunteer health workers.
- Population-based programme supported by key stakeholders to ensure effectiveness of work of the FCHVs. Most evidence suggests that programme coverage decreases rapidly with increased catchment population per FCHV. However, this effect is lessened when the programmes are of high profile (like the Vitamin A distribution).
- Support the distant learning program for FCHVs through mass media and by radio in particular.
- To utilise FCHVs to increase service coverage or underserved groups, but programs need to be designed with this end in mind.
- FCHVs have substantially better knowledge of HIV/AIDS than rural women, and somewhat better than rural men so they can be better utilized in HIV/AIDS prevention at village level.
• Innovative incentive programs designed / supported to sustain the motivation of the volunteers.

4. Strategic Action

FCHVs are able to support a variety of public health programs. They are the main provider for vitamin A and de-worming for children. They are an important contributor to family planning, maternal care, immunizations, care for sick children and other programs. Although FCHV programme function well in Nepal, it must be noted that the output level of FCHV activity depends on the degree of support of the community and the functioning of the health system. FCHVs will be able to achieve their goals only when other health workers sanctioned to the peripheral level facilities perform their assigned tasks. Although on average the FCHVs may work for about 5 hours a day, it is not possible for FCHVs to undertake work beyond their terms of reference due to lack of formal education and training.

The following areas have been identified as major issues which need to be improved to have a fully functioning FCHV programme. The programme has to be well designed to help achieve high coverage especially to include the poor and disadvantaged groups.

• There is a substantial backlog of new FCHVs who have not received basic training.

• FCHV performance is closely related to the availability of supplies and the support and motivation provided to them. Absence of these would result in low level of performance.

• Lack of medicinal supplies (ORS) prevented FCHVs from treating one fifth of the children who came for diarrhoea treatment, according to the latest Nepal Demography Health Survey.

• Evidence indicate that FCHVs need additional training on issues relating pregnancies, delivery and child health care to promote community-based maternal and newborn care.

• The main source of health information for FCHVs is from their training and their local health facility. Other medium of providing information should be explored to keep them regularly updated.

• 21% of FCHVs report having an endowment fund in their VDC, but only 17% has been used yet to support their activities.
ABOLITION OF USER FEES

1. Rationale

User fees for health care, charged at the point of access (also referred to as cost sharing, cost recovery or co-payment), are widespread around the developing world, despite mounting opposition to abolish them. Many studies have found them to be among the barriers to the use of health services, and have shown that they affect poor people more than others.

When most countries adopted this policy in the 1980s, it was argued that user fees would improve efficiency and equity in health service delivery by reducing frivolous demand, increase revenue, and quality and coverage, which encourage the use of cheaper healthcare options like primary healthcare posts rather than hospitals. However, there is conclusive evidence from research undertaken in the last 30 years that health fees are inequitable. They place the burden of care upon those least able to shoulder it – the poor and the sick.

The International Health Initiative, which at present is implemented in a few selected countries, focuses on assisting governments to overcome the obstacles to reach MDG 4, 5 and 6 as expected. The negative impact of the user fees is expected to act as a barrier to the MDGs and to the fulfilment of the right to healthcare. Therefore, this paper looks into an important area of healthcare, which has the potential to change the health seeking behaviours of the majority of people in Nepal and also ensure healthcare is provided equitably.

Research on user fees in low income countries show that they usually make the poor worse off economically, often prevents women and children from access healthcare, reduce the poor from using health services thereby elevating mortality, causes delay in people attending health facility and increase the use of unregulated private health services and traditional healers. Experiences in countries like Uganda and Burundi show a dramatic increase in the demand of healthcare when user fees were abolished.

Nepal seem to be following the footsteps of these countries, as recent media reports have indicated the government’s intention to provide free health care at peripheral level health facilities in the near future. Therefore, this paper encourages the commitment of the Ministry of Health on this endeavour and attempts to provide a strategic direction towards adopting a systematic approach to do so.
2. Country Overview

Nepal is ranked at 138 (of 177 countries) in the Human Development Index and has a gross national income of US $250 pr capita. Thirty percent of its 27 million people live below the national poverty line.

The country faced a decade of political unrest until very recently. However, recent political changes have paved the way towards multiparty democracy and the solution of the decade-long political conflict and violence.

Persisting gaps exist between the haves and the have-nots, despite the country promoting the principle of placing all its citizens, including the poorest and most vulnerable, at the centre of the development strategy.

Whilst there has been notable success in some areas of health service delivery in Nepal despite an unfavourable political and economic climate, health indicators remain low compared to other countries in the region.

2.1 Health Indicators

The health gaps between the poor and the rich are very wide. Women in the poorest quintile receive antenatal care three times less and professional attendance in deliveries 11 times less than women in the richest quintile. The percentage of underweight children is 5 times higher among the poorest quintile compared to the richest. The differences in infant and under-5 mortality rates between urban and rural areas and zones are also significant.

Infectious diseases and maternal, perinatal nutritional problems cause almost half of all deaths in the country and the DALYs lost due to ill health remain the highest in the region and are second to sub-Saharan Africa.

The country has a wide network of public health infrastructure; 70% of the population depends upon public facilities for modern health care as large parts of the country have few private medical clinics. Yet, due to distance and cost, only 50% of the poorest seek care when they are ill (versus 70% among the wealthier group)- the average treatment cost per illness episode is equal to one and a half month per capita consumption for the very poor.

Indicators relating to child health have seen vast improvements, especially in relation to immunisation. It must be noted that this is provided free. Neonatal mortality and
maternal mortality rates are still very high and if MDGs are to be met, a drastic change in health seeking behaviour is necessary. About 80% of the deliveries occur at home attended by untrained providers, and while the relatively better-off women seek prenatal care, women from the socially disadvantaged groups do not. Reaching households and increasing utilisation- especially among poor, women and marginalised groups remains a key challenge for the sector.

Good progress has been noted in infectious disease programmes like TB, leprosy and Malaria where cost to the patient has been subsidised to a very minimal and services are available at peripheral facilities. However, other diseases like Kala-azar which is seen among some of the very poor people, continues to unnecessarily burden many in Nepal mainly due to the high costs associated with treatment. For example, a cost calculation for the treatment for Kala-azar was estimated to be 890 NRS.

### 2.2 Health Financing

Health financing is one of the major issues. The total public spending on health is low (1.76% of GDP and 5.86% of the total national budget). The share of government health expenditure has not increased substantially since 2000, both in terms of proportion and per capita (US $ 4.06). Presently Nepal spends only about half the money (US $ 14 per capita) recommended by the Commission on Macroeconomics and Health (US $ 23-43 is recommended for developing countries) on each individual. And that too, according to the recent national health account data, household (out of pocket) expenditure is the biggest source of funding in Nepal; it accounts for 62 percent (which translates to about US $ 9) with the Government being the second biggest source of funding, accounting for 17 percent of the health expenditure followed by official donors (10%) and international not for profit agencies (11%).

According to a study done in 11 Asian countries on health care financing, it was noted that only Nepal’s charges for public-sector health care accounts for more than 40% of total out-of-pocket payments. In most of the other countries, the public sector share was 23–37% and in Bangladesh, Malaysia, and in Sri Lanka it was less than 10%. This scenario in an under developed country like Nepal with very low per capita income creates a risk of pushing many people into poverty because of catastrophic health expenditure in the absence of some risk pooling and pre-payment schemes. In general, better-off individuals can respond to health problems with the purchase of medicines etc; while the poorest of the poor cannot afford to divert resources from their very constrained budgets.

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Abolition of the userfees is therefore expected to increase the number of people who are at the moment prevented from using health care mainly due to its cost. The graph below illustrates the utilisation of health services by income group in Nepal if user charges were progressively removed.

Source: DFID presentation 2007

If the Government is to meet the outcomes stated in the Poverty Reduction Strategy, a paradigm shift is required in health sector expenditure. The existing challenges and gaps in the health sector provide rationale to introduce reform approaches in realization that business as usual cannot help to improve health system performance and to attain the outlined outcomes and goals.

3. Government Policies

Since April 2006, conflict had ended in Nepal and peace has prevailed. The Nepal government has initiated important policies such as providing free emergency and inpatient services to the poor people in District Hospitals. Furthermore, Government of Nepal has made political commitment for health of the people at the highest level by declaring ‘Basic Health a Human Right’ in the Interim Constitution of Nepal 2007 for the first time in the history of Nepal.

At present certain exemption programmes are in place to encourage vulnerable and marginalised groups to access health facilities.

The National Immunisation Programme delivers routine immunisation through fixed
facilities, outreach programmes and mobile teams free. All vaccines and immunisation related logistics are supplied to the private institutions free of cost. There is no cost sharing/recovery.

High financial costs are a key barrier to women accessing skilled birth attendance in Nepal, whether at home or at a health facility. Therefore the government has initiated a scheme to provide financial assistance to women seeking skilled delivery care to cover transportation cost.

A cash payment is being made to women presenting for delivery at any public health facility for their first or second child. In selected districts (low HDI) free services at public health facilities for both normal and complicated deliveries are proposed.

Diagnosis and treatment for infectious disease like Leprosy, Malaria and Tuberculosis are provided free, keeping with the international norms.

In the light of these developments, the Minister of Health proposes to provide free of cost medical services to people through health post and sub health post level. He has also indicated that the government will spend almost 70% of its health budget on the primary health care sector this year. District hospitals across the country will be providing medical services free of cost within the next few years.

4. Strategic Actions

While applauding the decision by the Government of Nepal to begin abolishing user fees in the near future, it is necessary to ensure that the process is systematic and able to manage the excess load of patients who may access the services. Abolishing user fees and providing a pro-poor service does not mean that the quality of the service should be compromised; a service for the poor does not mean it should be a ‘poor service’.

At the same time, it is necessary to understand that user fees are only part of the financial barriers preventing the people accessing healthcare. Efforts should be made in the future to plan strategies to initiate free universal access to essential health care where no hidden or related costs would deter people from getting the required treatment to live a healthily.

Following are the main suggestion made to plan abolishing user fees;

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4.1 Increase Funding

Removing user fees leads to a large increase in the use of health services, which could lead to drug shortages, staff difficulties, and falling quality. Funding therefore has to be increased to a level which not only compensates for the loss of fees from existing users, but also allows the system to cope with an influx of new users. Donor funding might help to do this, but should be used cautiously because it is unreliable. Instead, the money should come from general taxation.

4.2 Well-directed Funding

The increase in service use that follows fee removal is likely to be greatest in poorer areas, and so these areas will need the largest injections of new funding.

4.3 Decentralise and Strengthen Health Systems

Health systems at all levels, especially at district level need to be strengthened to manage the excess load of care seekers. Decentralisation of budgets and thereby empowering communities is essential to systematically abolish user fees. Strategies could include establishing locally controlled operational funds for small scale funding decisions.

4.4 Develop a Communications Strategy

Communication between senior managers and local level health workers is needed to elicit good ideas about how to implement the policy effectively, and to improve acceptance of it. Public information campaigns are also needed to ensure the general public knows about the change – otherwise health workers may continue to charge fees.