Nepal Health Sector Programme-2
IMPLEMENTATION PLAN

2010-2015

Government of Nepal

Ministry of Health and Population (MoHP)

PREFACE

EXECUTIVE SUMMARY

The Second Nepal Health Sector Programme (NHSP-2) is a national guiding document for the health sector and contributes directly to meeting the health-related Millennium Development Goals (MDGs) 1 (partly), 4, 5 and 6. It also offers a strong foundation to scale up existing elements of Essential Health Care Services (EHCS) and allows for a few new elements. Within NHSP-2, the EHCS package was expanded to better address Nepal's health care needs; some additional programmes were added, including programmes on mental health, oral health, environmental health, community-based newborn care, and a community-based nutrition care and support programme. In addition, a Non-communicable Disease (NCD) control component was included to address changes in demographics and diseases. A few new strategic directions have been included across the programmes, for example Public-private Partnerships (PPPs), governance and accountability, inter-sectoral coordination and collaboration, and sustainability.

This NHSP-2 Implementation Plan (IP) has been prepared to ensure that the objectives, strategies, and major activities planned in NHSP-2 are implemented smoothly in the given timeframe. The NHSP-2 IP is divided into three parts.

Part one describes the vision, mission, strategies, and implementation, along with the challenges, to ensure that NHSP-2 policies, strategies and programmes are translated into the Annual Work Plan and Budget (AWPB).

Part two covers the EHCS components, including the goals, objectives, strategies, monitoring indicators, challenges, and responsible officers for each programme included in NHSP-2. In addition, it incorporates NCDs, environmental health, the Community-based Newborn Care Programme (CB-NCP), and the Community-based Nutrition Programme. Part two of this NHSP-2 IP thus discusses the following:

Immunisation Programme: The Immunisation IP 2012-2016 guides the AWPB programme for the next five years to achieve the immunisation-related goals the Government of Nepal (GoN) has expressed in various policy documents, in the MDGs and World Health Assembly (WHA) resolutions, and in different national and international fora. The objectives, strategies, and activities set forth in the plan provide the framework required to meet the goal of reducing infant and child mortality and morbidity associated with Vaccine-preventable Diseases (VPDs).

Integrated Management of Childhood Illness (IMCI) and the Newborn Care Programme (NCP): The Integrated Management of Childhood Illness, through the progressive implementation and improvement of the Community-based IMCI (CB-IMCI) Programme, contributes to the reduction in deaths due to the major illnesses that cause 70% of child mortality globally. The major illnesses addressed by CB-IMCI are: Acute Respiratory Infections (ARIs), diarrhoeal diseases, malaria, measles, malnutrition, and other common childhood illnesses. The challenge will be to incorporate the community-based elements of the NCP into the CB-IMCI and Safe Motherhood (SM) Programmes.

Nutrition Programme: The Nutrition Programme has established the vision of all Nepalese citizens enjoying adequate nutrition, food safety, and food security for adequate physical, mental, and social

growth, and development and survival. This is designed to improve the overall nutritional status of children, women of childbearing age, pregnant women, and people of all ages. A Community-based Nutrition Programme has been planned; it is to be progressively introduced, starting from the wards with the highest incidence of malnutrition. The IP is therefore designed to implement both NHSP-2 and the Multi-sectoral Nutrition Plan (MSNP). The strategies and activities are embedded under the strategic directions of NHSP-2 and the MSNP.

SM Programme: The GoN is committed to continue offering free delivery services at hospitals, Primary Health Care Centres (PHCCs), Health Posts (HPs) and selected Sub-Health Posts (SHPs), and selected non-government facilities. Transport and provider incentives will continue to be paid for women delivering with a Skilled Birth Attendant (SBA) or in a facility.

Family Planning (FP) Programme: The unmet need for FP among certain groups of individuals and couples, such as adolescents, residents of rural and hilly areas, the eastern development region, and the western hills, poor communities, and, unexpectedly, among educated groups, is a challenge for the FP programme. To address these gaps, the Ministry of Health and Population/Family Health Division (MoHP/FHD) has recently developed a new FP Strategy 2068 that focuses on increasing access to quality FP services in rural and marginalised communities, and on implementing focused FP programmes to fulfil the needs of special groups like post-partum mothers, post-abortion clients, migrants, and adolescents.

Adolescent Sexual and Reproductive Health (ASRH) Programme: The Reproductive Health Strategy and Plan states that ASRH is a major component of reproductive health. GoN developed the National Adolescent Health and Development (NAHD) Strategy in 2000, has included ASRH in the EHCS package, and in 2007 produced the "Implementation Guidelines on ASRH" for district health managers. The ASRH Programme has at its core the introduction of Adolescent-friendly Services (AFS) and aims for the establishment of 1,000 AFS centres by 2015, as outlined in NHSP-2. The Programme will improve existing clinical services in the areas of safe abortion, FP, maternal and child health care, and HIV and Sexually Transmitted Infection (STI) prevention and treatment with a view of making these services more accessible to adolescents.

Female Community Health Volunteer (FCHV) Programme: The goal of the FCHV programme is to support the national objectives of health through community involvement in public health activities, imparting knowledge and skills for the empowerment of women, increasing awareness on health-related issues, and involving local institutions in promoting health care. This will stimulate the health and healthy behaviour of mothers and community people for the advancement of SM, Child Health, FP, and other community-based health services with the support of health personnel from the SHPs, HPs and PHCCs.

Free Health Care Programme: To safeguard every citizen's right to basic health care, the MoHP declared free health care in 2007, targeting poor, vulnerable, and marginalised people in order to increase their access to and utilisation of health care services. During NHSP-2, EHCS in district hospitals are planned to be made free to all.

***Urban Health Care Programme*:** Only a few government-run urban PHCs, HPs or SHPs are found in urban centres. A few municipalities have established urban health clinics but they cannot meet the growing demand for health care. Lack of coordination and collaboration between the MoHP, Ministry of Local Development (MoLD), and the municipalities is the major hurdle to be overcome. The Three-year

Interim Plan and NHSP-2 give special emphasis to the Urban Health Programme. Thus, this NHSP-2 IP focuses on improving the health status of urban residents, particularly the poor, the marginalised, and women and children.

***Malaria Control Programme*:** The following on-going interventions will continue as the strategies to eliminate the malaria by 2026: vector control with Long-lasting Insecticidal Bed Nets (LLINs) and/or Indoor Residual Spraying (IRS) with synthetic pyrethroid insecticides; parasitological diagnosis with microscopy or Rapid Diagnostic Tests (RDTs); timely treatment of P. falciparum cases with Artemisinine Combination Therapy (ACT) plus primaquine and P. vivax cases with chloroquine (three days) and primaquine (14 days); and early detection and response to malaria outbreaks within a week.

Kala-azar Elimination Programme: The Epidemiology and Disease Control Division (EDCD) has revised the diagnosis and treatment of Kala-azar in Nepal, and the rK39 test kit has been introduced and accepted as a diagnostic test along with Miltefosine as the first-line treatment for Kala-azar.

Lymphatic Filariasis (LF) Elimination Programme: EDCD has formulated a National Action Plan (2003-2015) for the elimination of LF in Nepal by establishing a National Task Force under the Chairmanship of the Director-General (DG), Department of Health Services (DoHS), and by adopting the two pillars of LF elimination strategy: transmission control and disability prevention and management.

Dengue Control Programme: Dengue Haemorrhagic Fever (DHF), a potentially lethal disease, was first recognised in the 1950s during the dengue epidemic in Philippines and Thailand; today DHF also affects Nepal and is a leading cause of childhood deaths. No specific treatment for dengue has been found, but appropriate medical care frequently saves the lives of patients with the more serious DHF. GoN has thus adopted early case detection, diagnosis, case management, and reporting of DHF.

Leprosy Control Programme: The major strategies to control leprosy during this period include: early case detection and prompt treatment of cases, enabling all general Health Facilities (HFs) to diagnose and treat leprosy; ensuring a high Multidrug Therapy (MDT) treatment completion rate; preventing and limiting disability by early diagnosis and correct treatment; reducing stigma through information and education; and advocacy by achieving community empowerment through partnership between media and the community.

Public Health Laboratory Services: Public health laboratory services include providing diagnostic services along with public health activities such as surveillance, research, and regulation, etc. as a part of the Nepalese health system. Every decade new and emerging diseases with epidemic and pandemic potential are appearing. Diagnosing these new diseases often requires the latest sophisticated technology in rapid diagnosis and reporting within 24 hours. The programme goal here is to support physicians and patients by offering quality laboratory diagnostic services.

HIV/AIDS and STI Control Programme: The overall goal of this Programme is to achieve universal access to HIV prevention, treatment, care and support, and includes halving by 2016 the incidence of HIV, when compared to 2010 (including reduction of new HIV infections in children by 90% compared with a 2010 baseline); and by 2016, reducing AIDS-related deaths by 25% when compared to 2010.

National Tuberculosis Programme (NTP): NTP policies are in accord with the National Health Plan, the WHO Stop TB Strategy and the Global Plan to Stop TB (2006-2015). The Stop TB Strategy sets

out the steps NTP and its partners need to take for TB control in Nepal. The Strategy is based on experience gained over the past decade and on continuing consultations with stakeholders at the global, regional, national and local levels.

NCD Control Programme: Tobacco- and alcohol-related illnesses, mental illness, aging-related health problems, and road traffic accidents and injuries are the major areas of NCD and lifestyle-related health issues. NHSP-2 is focused on reducing mortality and disability, and addressing morbidity, by encouraging healthier lifestyles and managing the problems at early stages.

Programme on Mental Health and Neurological Disorders: Nepal has made significant progress formulating a Mental Health Policy (1996.) However, implementation has been inadequate and needs to be strengthened. The overall objective of the Programme is increase access to and utilisation of basic mental health services by all, including the excluded and needy.

Oral Health Care Programme: The overall objective is focused on increasing the access and utilisation of basic oral health services that will reduce the morbidity and disability caused by oral health problems.

Curative Health Services Programme: The exemption provision has increased access to and utilisation of health care services. Regarding catastrophic illnesses, a guideline has been prepared for reimbursing the catastrophic costs to the poor and destitute. The guideline covers catastrophic spending for five diseases: kidney disease, cancer, heart disease, Alzheimer's, and Parkinson's. This programme aims to reduce mortality and disability, and will address the morbidity of the general population.

Ayurvedic and Alternative Medicine: New Ayurvedic health services are planned, to be established in different parts of the country, in both the Government and non-state sectors. This will increase access to and utilisation of the Ayurvedic system of medicine and will contribute towards improving the health status of Nepalese citizens.

Health Education and Communication Programme: Health education and communication is a priority of the GoN and is focused on creating demand and increasing the utilisation of EHCS through the dissemination of messages using appropriate multiple channels of communication. As stated in NHSP-2, health education and communication is a priority for EHCS programmes, such as Maternal and Child Health (MCH), adolescent health, communicable and non-communicable diseases, tobacco control, emergency and disaster preparedness (including pandemic influenza), and Gender Equality and Social Inclusion (GESI).

Environmental Health and Hygiene (EHH) Programme: Water-, Sanitation- and Hygiene- (WASH-) associated diseases, including skin diseases, ARIs, and diarrhoeal diseases, are the top three preventable diseases among infants and children; ARI and diarrhoeal diseases remain the leading causes of child deaths. In order to promote hygiene and sanitation practices, the EHH Programme aims to improve water quality through water quality surveillance and monitoring.

Part three of this document explains health system strengthening, which includes the following:

Health Governance*:* The NHSP-2 IP plans to improve Financial Management and accounting practices through networking and establishing a mechanism to reduce irregularities. Effective fund

management, including fund tracking, is planned in order to develop a responsive and accountable health system.

Human Resource (HR) Development: The inequitable distribution of HR remains a problem, with retention of medical doctors and nurses as a major concern. As mentioned in NHSP-2, all remaining SHPs will be gradually upgraded to HPs. Posts for Health Assistants (HAs) and Auxiliary Nurse Midwives (ANMs) will be added in HPs. Thus, ensuring the deputation of staff to additional training and orientation so that Maternal and Child Health Workers (MCHWs) can upgrade to ANM is a major focus for this period.

GESI: The GESI strategy has been fully adopted based on the framework of strengthening gender-responsive budgeting. Although the Electronic Annual Work Plan and Budget (e-AWPB) analyses the budget by gender-responsive categories, a need remains to revisit programmes for robust estimation. This will improve health care utilisation and health outcomes, particularly of poor and excluded groups.

Health Financing: The expanded prevention effort proposed under NHSP-2 will help slow the growth of the NCD burden, but will not prevent the continued growth of demand for curative services of an increasingly complex and expensive nature. A plan has been made for introducing a social health protection scheme for catastrophic illness that will develop a responsive and fair financing system that moves towards universal coverage to enhance social health protection and equity in health.

State and Non-State Partnerships: The non-state sector has contributed to meeting the goals of NHSP-1 in almost all areas, notably TB control, expanding contraceptive use, controlling HIV/AIDS, eye care, and WASH promotion. The overall objective of the NHSP-2 IP approach is to increase the role of the non-state sector in service delivery, using the skills, expertise, and capital of the non-state sector in public service delivery and health system development.

Procurement and Supply: Major contributing factors to quality health care delivery include the supply of various commodities (medicines, instruments, equipment, furniture, and other supplies), and physical infrastructure (peripheral facilities, hospital, laboratories, etc.). In the NHSP-2 IP procurement and supply are focused on ensuring an efficient, effective, transparent and accountable, and value for money procurement system in the health sector.

Physical Facilities and Maintenance: Delivering ECHS requires substantial investment in new construction, as well as refurbishing and upgrading existing facilities. At the same time, repair and maintenance of existing facilities will be a regular activity. So, the overall objective is to develop infrastructure for the expansion of service delivery, and to upgrade the HFs for comprehensive care.

Monitoring and Evaluation (M&E): The success or failure of any programme largely depends upon the M&E function. Therefore, responding to Output 8 – "Develop and Implement an Integrated and Comprehensive Health Information System for the Health Sector" – of NHSP IP-2, MoHP endorsed a Health Sector Information System (HSIS) Strategy. The overall goal of M&E is to improve the health sector M&E system.

Sector–wide Approach (SWAp) and Health Sector Reform: Increased use of GoN systems is not an end in itself, but is intended to be a route towards improving aid effectiveness, improving coordination, and reducing costs, by gradually replacing the multiplicity of External Development Partner (EDP) systems for planning, budgeting, implementing, reporting, and accounting for aid with a

single set of procedures that all partners use. Thus, to establish efficient and effective common procedures and to increase harmonisation and alignment, the SWAp will be continued for health sector reform.

Finally, the result matrix for NHSP-2 (2010-2015) and the proposed budget (2010/11-2015/16) are presented in the Annexes.

Limitations of NHSP-2 IP: The following are the major limitations of this document:

1. This NHSP-2 IP is based within the frame and programmes mentioned in NHSP-2, and
2. Some of the targets have already been achieved before the endorsement of this NHSP-2 IP.

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LIST OF ABBREVIATIONS

AA	Anaesthetic Assistant
ACSM	Advocacy, Communication and Social Mobilisation
ACT	Artemisinin Combination Therapy
AFP	Acute Flaccid Paralysis
AFR	Adolescent Fertility Rate
AFS	Adolescent Friendly Services
AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ALB	Albendazole
ANC	Antenatal Clinic
ANM	Assistant Nurse Midwife
APH	Association of Private Hospitals
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
AWPB	Annual Work Plan and Budget
BCC	Behavior Change Communication
BEOC	Basic Emergency Obstetric Care
BPKIHS	B.P. Koirala Institute of Health Sciences
CEOC	Comprehensive Emergency Obstetric Care
BMI	Body Mass Index
BMLT	Bachelor of Medical Laboratory Technology
BTS	Blood Transfusion Service
BTSC	Blood Transfusion Service Centre
C4D	Communication for Development Network
CABA	Children Affected by AIDS
CAC	Comprehensive Abortion Care
CB-IMCI	Community Based Integrated Management of Childhood Illness
CB-NCP	Community Based Newborn Care Programme
CBOs	Community Based Organisations
CBS	Central Bureau of Statistics
CCF	Country Coordination Forum
CDC Atlanta	Centers for Disease Control and Prevention
CDD	Control of Diarrhoeal Diseases
CDR	Case Detection Rate
CEOC	Comprehensive Emergency Obstetric Care
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CFR	Case Fatality Rate
CHD	Child Health Division
CHW	Community Health Worker
CMA	Community Medicine Auxiliary
CMAM	Community Management of Acute Malnutrition
CME	Continuing Medical Education
CMLT	Certificate in Medical Laboratory Technology
CPR	Contraceptive Prevalence Rate
CRS	Contraceptive Retail Store Company

CRS	Congenital Rubella Syndrome
CS	Caesarean Section
CTEVT	Council for Technical Education and Vocational Training
D(P)HO	District (Public) Health Office
DACCs	District AIDS Coordination Committee
DALY	Disability Adjusted Life Year
DDA	Department of Drug Administration
DDC	District Development Committee
DEOs	District Education Offices
DF	Dengue Fever
DG	Director General
DG II	Grade II Disability
DGO	Diploma in Gynaecology and Obstetrics
DH	District Hospital
DHF	Dengue Haemorrhagic Fever
DHO	District Health Office
DIN	Drug Information Network
DoA	Department of Ayurveda
DoHS	Department of Health Services
DoT	Department of Transport
DOTS	Directly Observed Treatment Short Course
DSS	Dengue Shock Syndrome
DUDBC	Department of Urban Development and Building Construction
DWSHCC	District Water Sanitation and Hygiene Coordination Committee
DWSS	Department of Water Supply and Sewerage
EAP	Equity and Access Programme
e-AWPB	electronic Annual Work Plan and Budget
EBF	Exclusive Breast Feeding
ECD	Early Childhood Development
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partner
EHCS	Essential Health Care Service
EHH	Environmental Health and Hygiene
EHHS	Environmental Health Hygiene and Sanitation
ELF	Elimination of Lymphatic Filariasis
ENT	Ear Nose and Throat
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
EQAS	External Quality Assessment Scheme
EWARS	Early Warning and Reporting System
FCHV	Female Community Health Volunteer
FCTC	Framework Convention on Tobacco Control
FHD	Family Health Division
FIDU	Female Injecting Drug Users
FM	Financial Management
FMIS	Financial Management Information System
FP	Family Planning
FP/MCH	Family Planning/Maternal and Child Health

FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GBV	Gender-based Violence
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIS	Geographical Information System
GIVS	Global Immunisation Vision and Strategy
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GM	Growth Monitoring
GMP	Growth Monitoring Promotion
GO	Government Organisation
GoN	Government of Nepal
HA	Health Assistant
HCWM	Health Care Waste Management
HDI	Human Development Index
HEFU	Health Economics and Financing Unit
HF	Health Facility
HFMS	Health Facility Mapping Survey
HFOMC	Health Facility Operation and Management Committee
HHS	Household Survey
HIIS	Health Infrastructure Information System
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HP	Health Post
HR	Human Resources
HRH	Human Resources for Health
HRDC	Hospital and Rehabilitation Centre for Disabled Children
HSIS	Health Sector Information System
HSR	Health Service Reform
HSRU	Health Sector Reform Unit
HTC	HIV Testing and Counselling
HuRIS	Human Resource Information System
HW	Health Worker
IBBS	Integrated Bio-behavioural Survey
ICD	International Classification of Disease
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IFPSC	Institutionalised Family Planning Service Centres
IHP	International Health Partnership
IHR	International Health Regulation
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate

INF	International Nepal Fellowship
INGO	International Non-Governmental Organisation
IOM	Institute of Medicine
IP	Implementation Plan
Ipas	International Pregnancy Advisory Services
IPC	Interpersonal Communication
IPR	Intellectual Property Rights
IRS	Indoor Residual Spraying
ISTC	International Standards for Tuberculosis Care
ITI	International Trachoma Initiative
IUCD	Intrauterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JAR	Joint Annual Review
JE	Japanese Encephalitis
JHU	Johns Hopkins University, USA
JICA	Japan International Cooperation Agency
KAP	Knowledge Attitude Practice
KOICA	Korean International Cooperation and Agency
KTM	Kathmandu
LAKH	Local Ayurveda Kits for Health
LCD	Leprosy Control Division
LF	Lymphatic Filariasis
LHGSP	Local Health Governance Support Programme
LIS	Laboratory Information System
LLIN	Long Lasting Insecticidal Bed Nets
LMD	Logistic Management Division
LMIS	Logistic Management Information System
LMN	Leprosy Mission Nepal
M&E	Monitoring and Evaluation
MA	Medical Abortion
MAM	Management of Acute Malnutrition
MBBS	Bachelor in Medicine and Bachelor in Surgery
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MD	Management Division
MDA	Mass Drug Administration
MDG	Millennium Development Goal
MDGP	Doctor of Medicine General Practitioner
MDR TB	Multi Drug Resistant Tuberculosis
MDT	Multi Drug Therapy
MGH	Mothers Group for Health
MI	Micronutrient Initiative
MIP	Micronutrient Initiative Powder
MIS	Management Information System
MIYCN	Maternal, Infant and Young Child Nutrition
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health

MNP	Maternal and Neonatal Programme
MO	Medical Officer
MoAD	Ministry of Agriculture and Development
MoD	Ministry of Defence
MoE	Ministry of Education
MoEST	Ministry of Environment, Science and Technology
MoF	Ministry of Finance
MoGA	Ministry of General Administration
MoHA	Ministry of Home Affairs
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoLJ	Ministry of Law and Justice
MoIC	Ministry of Information and Communication
MoUD	Ministry of Urban Development
MoWC&SW	Ministry of Women, Children and Social Welfare
MPDR	Maternal and Perinatal Death Review
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MSNP	Multi-Sectoral Nutritional Plan
MSW	Male Sex Workers
MTEF	Medium Term Expenditure Framework
MTOT	Master Training of Trainers
MUAC	Mid Upper Arm Circumference
MVA	Manual Vacuum Aspiration
NA	Not Available
Na & K	Sodium and Potassium
NAHD	National Adolescent Health and Development
NAMS	National Academy for Medical Science
NCASC	National Centre for AIDS and STI Control
NCD	Non-Communicable Disease
NCDR	New Case Detection Rate
NCP	Newborn Care Programme
NDHS	Nepal Demographic Health Survey
NEPAS	Nepal Pediatric Society
NEQAS	National External Quality Assessment Scheme
NFE	Non-Formal Education
NFCC	Nepal Fertility Care Centre
NFHP	Nepal Family Health Programme
NGO	Non-Governmental Organisation
NHA	National Health Account
NHEICC	National Health Education Information and Communication Centre
NHSP-1	Nepal Health Sector Programme-1
NHSP-2	Nepal Health Sector Programme-2
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NID	National Immunisation Day
NIP	National Immunisation Programme
NLEC	National Leprosy Elimination Campaign

NLR	Netherlands Leprosy Relief
NLSS	Nepal Living Standard Survey
NLT	Nepal Leprosy Trust
NMSS	National Micronutrient Status Survey
NNC	National Nutrition Centre
NNT	Neonatal Tetanus
NPC	National Planning Commission
NPHL	National Public Health Laboratory
NPR/NRs	Nepalese Rupees
NRCS	Nepal Red Cross Society
NRHs	Nutrition Rehabilitation Homes
NSI	Nick Simon Institute
NSV	Non-surgical Vasectomy
NTAG-M	National Technical Advisory Group for Malaria
NTC	National Tuberculosis Centre
NTP	National Tuberculosis Programme
NUTEC	Nutrition Technical Committee
O&M	Organisation and Management
OBB	Output Based Budgeting
OCM	One-stop Crisis Management
OCMC	One-stop Crisis Management Centre
ODF	Open Defecation Free
OP	Out Patient
OPD	Out Patient Department
OPMCM	Office of the Prime Minister and the Council of Ministers
OPV	Oral Polio Vaccine
ORC	Outreach Clinic
ORS	Oral Rehydration Salts
OST	Oral Substitution Therapy
OT	Operating Theatre
PAC	Post Abortion Care
PAHS	Patan Academy of Health Science
PAL	Practical Approach to Lung Health
PCR	Polymerase Chain Reaction
PER	Public Expenditure Review
PHAM&ED	Public Health Administration Monitoring and Evaluation Division
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCRD	Primary Health Care Revitalisation Division
PHCW	Primary Health Care Worker
PHN	Public Health Nurse
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPA	Public Procurement Act
PPH	Post-partum Haemorrhage
PPICD	Policy Planning and International Cooperation Division
PPM	Public-Private Mix
PPMO	Public Procurement Monitoring Office

PPP	Public-Private Partnership
PR	Prevalence Rate
PSA	Public Service Announcement
PSI	Population Services International
PWID	People Who Inject Drugs
QA	Quality Assurance
QoC	Quality of Care
RBM	Roll Back Malaria
RD	Regional Director
RDQA	Routine Data Quality Assessment
RDT	Rapid Diagnostic Test
RECPHEC	Resource Centre for Primary Health Care
RED	Reach Every District
ReSoMal	Rehydration Solution for Malnutrition
RF	Results Framework
RH	Reproductive Health
RHCCs	Reproductive Health Coordination Committees
RHD	Regional Health Directorate
RI	Routine Immunisation
RMS	Regional Medical Store
RRT	Rapid Response Team
RTI	Research Triangle Institute
RUTFs	Ready-to-Use Therapeutic Foods
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Save the Children
SCF	Save the Children Fund
SDC	Swiss Development Cooperation
SEARO	South East Asia Regional Office of WHO
SHN	School Health Nutrition
SHP	Sub Health Post
SIAs	Supplementary Immunisation Activities
SM	Safe Motherhood
SMNH	Safe Motherhood and Neonatal Health
SMNHLTP	Safe Motherhood and Neonatal Health Long Term Plan
SN	Staff Nurse
SOP	Standard Operating Procedure
SPN	Sunaulo Pariwar Nepal
SRH	Sexual and Reproductive Health
SRP	School Resource Person
SSU	Social Service Unit
STC	Salt Trading Corporation
STI	Sexually Transmitted Infection
STS	Service Tracking Survey
SUN	Scaling Up Nutrition
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis

TFR	Total Fertility Rate
TOR	Terms of Reference
TMIS	Training Management Information System
TT	Tetanus Toxoid
Tufts	Tufts University, USA
TWG	Technical Working Group
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UP	Uterine Prolapse
USAID	United States Agency for International Development
USD	US Dollars
USG	Ultra Sonogram
VAD	Vitamin A Deficiency
VBD	Vector-Borne Disease
VBDRTC	Vector-Borne Diseases Research and Training Centre
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
VDPV	Vaccine-derived Poliovirus
VHW	Village Health Worker
VPD	Vaccine-preventable Disease
VSC	Voluntary Surgical Contraception
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organisation
WHO-GMP	World Health Organisation-Growth Monitoring Programme
XDR-TB	Extreme Drug Resistant Tuberculosis
ZH	Zonal Hospital

Part One: Introduction

1.1 Introduction

The Government of Nepal (GoN) is committed to bringing about tangible changes in access to and utilisation of Essential Health Care Services (EHCS), thereby improving the health status of the Nepalese population through the health sector development process. The aim of the health sector reform envisaged in 2003 was to develop an equitable, high quality health care system for Nepal. The Millennium Development Goals (MDGs), the Health Sector Strategy: An Agenda for Reform 2003, and the First Nepal Health Sector Programme Implementation Plan (NHSP-1 IP) (2004-2009) provided the basis for developing the Second Nepal Health Sector Programme (NHSP-2) (2010-2015). The best practices and the lessons learned in the course of practising the Sector-wide Approach (SWAp) were capitalised upon and used in developing NHSP-2. A shared vision, agreed priorities, and a joint financial arrangement advanced partnerships and developed mutual accountability between the Ministry of Health and Population (MoHP) and the External Development Partners (EDPs).

NHSP-2 has been built upon the foundation of NHSP-1, the Health Sector Strategy, and the Three-year Interim Plan. During NHSP-2, the EHCS package was expanded to address Nepal's health care needs. Some new EHCS programmes were added, such as mental health, oral health, environmental health, community-based newborn care, and community-based nutrition care and support. In addition, a Non-communicable Disease (NCD) control component has been included in EHCS to address demographics and disease transition. A few new strategic directions have been included across the programmes, including, for example, Public-private Partnerships (PPPs), governance and accountability, inter-sectoral coordination and collaboration, and sustainability.

Various new activities are required to achieve the programme objectives. Although impressive progress was made during the first one and a half years of NHSP-2 in extending the coverage of essential services, access and utilisation are far from universal. Considerable numbers of people remain uncovered by some of the most cost-effective life-saving interventions, e.g. the Community-based Newborn Care Programme (CB-NCP). Consensus has been reached that the new EHCS elements will not be promoted at the cost of existing programmes. Evaluating the resources available and the costs of the new programmes to be piloted and of the aspects of existing programmes that are planned to be scaled up needs more work. Moreover, certain ambiguity and difficulties occur when translating NHSP-2 into the Annual Work Plan and Budget (AWPB) without an IP. The NHSP-2 IP helps make health institutions and their officials accountable, facilitates prioritising activities, guides programme managers in programme and activity planning for five years, and ultimately contributes to achieving the results defined in NHSP-2.

Purpose of the NHSP-2 IP

To ensure that the objectives, strategies and major activities stated in NHSP-2 are implemented smoothly in the given timeframe.

Methods
The NHSP-2 IP was developed through wide consultation with the respective programme directors, programme managers, and health system related in-charges. A series of interactive meetings and a workshop coordinated by MoHP's Policy, Planning and International Cooperation Division (PPICD) and technically supported by two national consultants were organised to develop the NHSP-2 IP. The NHSP-2 IP represents the operational guideline for achieving the visions, goals, and objectives set out in the NHSP-2. All the strategies and major activities outlined in NHSP-2 were translated to the respective programmes. Quick programmatic and thematic gap analyses were performed to plan additional activities to cover the identified gaps. The strategic and multi-year plans of the respective programme divisions helped to embed the activities under the strategies established by NHSP-2. Considering the high demand for additional activities and the limited resources available in the health sector, the NHSP-2 IP proposes only key activities.

1.2 Vision, Mission, Strategies and Implementation

The NHSP-2 IP includes the vision, value statement, strategic directions, issues, and challenges from the official NHSP-2 document.

Health Sector Vision Statement
The MoHP vision for the health sector is to improve the health and nutritional status of the Nepalese population and to provide an equal opportunity for all to receive quality health care services affordably or free of charge, thereby contributing to poverty alleviation.

Mission Statement
The MoHP will promote the health of Nepal's people by facilitating access to and utilisation of essential health care and other health services, emphasising services to women, children, the poor and excluded, and changing the dangerous lifestyles and behaviour of the Most-at-risk Populations (MARPs) through Behaviour Change Communication (BCC) interventions.

Value Statement
The MoHP believes in:

- Equitable and quality health care services
- Patient-/client-centred health services
- A rights-based approach to health planning and programming
- Culture- and conflict-sensitive health services
- Gender-sensitive and socially inclusive health services.

Strategic Directions
To achieve the three objectives of NHSP-2, MoHP will embrace the following key directions:

- Poverty reduction
- The agenda to achieve the health MDGs by 2015
- Free EHCS to patients/clients and the protection of families against catastrophic health care expenditures
- Gender Equality and Social Inclusion (GESI)
- Access to facilities and the removal of barriers to access and use
- Human Resource (HR) development
- Modern contraception and safe abortion

- Disaster management and disease outbreak control
- Eradication, elimination, and control of selected Vaccine-preventable Diseases (VPDs)
- Institutionalising health sector reform
- SWAp for improved aid effectiveness
- EDP harmonisation and the International Health Partnership (IHP)
- Improved Financial Management (FM)
- Inter-sectoral coordination, especially with the Ministry of Local Development (MoLD) and the Ministry of Education (MoE)
- Local governance: devolution of authority
- Health system strengthening, especially through Monitoring and Evaluation (M&E).

To increase access to and use of EHCS and achieve the health MDGs by 2015, MoHP will implement a number of major strategies and activities, and measure progress made towards targets by outcome indicators. These strategies will be implemented to achieve several outcomes as measured by reduced mortality rates (including reduced neonatal, infant and under-five mortality rates), the Maternal Mortality Ratio (MMR) and the Total Fertility Rate (TFR). Data related to intermediate indicators, as well as the outcome indicators, will be disaggregated by gender, caste/ethnicity, wealth and region.

Issues and Challenges

Political instability, exacerbated by the economic crisis, rising food prices, constant power outages, street demonstrations, and a general lack of law and order, constitutes a major challenge (and a constant recent backdrop) to the health sector's efforts. This situation is likely to continue for the foreseeable future. Major accomplishments have been seen in a short time, but much remains to be done for Nepal to achieve its health sector goals and the MDGs.

Without partnering with the Non-governmental Organisation (NGO) community, the GoN alone cannot reach remote rural communities to deliver more basic health services, especially to the poor and excluded. The failure to deploy and retain health care providers, particularly doctors and nurses in remote areas, persists and will continue to damage the quality of care at Primary Health Care Centres (PHCCs) and district hospitals. Posting teams at district hospitals for Comprehensive Emergency Obstetric Care (CEOC) must be pursued if Nepal is to continue reducing maternal mortality. Logistic management, especially procuring quality drugs at bulk pricing and distributing these to facilities based on nationwide consumption, must be improved to reduce stock-outs of essential drugs. Maintaining and procuring equipment for district hospitals is another high priority. New schemes are underway to solve both problems.

Access to health care facilities continues to be a problem in rural areas, especially for the most disadvantaged. The facilities are too few in number and often not built at locations easily accessible for those who need care the most. New construction is costly and time-consuming. Building standards need to be established. While some evidence indicates that local management of Health Facilities (HFs) is improving health care, the local bodies have little capacity to govern and manage. Minimum standards must be developed and local committees oriented. Supervision by District Health Offices (DHOs) will become more critical to delivery, as will monitoring of pro-poor programmes. Improved access to health care, improved quality of health care services, and lessened disparities in utilisation of health services will continue to pose challenges. Public funds will be increasingly consumed by the burden of NCDs, injuries, and

violence, as well as by funding for expanding prevention, care, and treatment for the populations most at risk of HIV infection.

Implementation Plan

The NHSP-2 IP will work towards achieving the following three objectives set out in the NHSP-2 Results Framework (RF):

- To increase access to and utilisation of quality EHCS
- To reduce harmful cultural practices and cultural and economic barriers to accessing health care services in partnership with non-state actors
- To improve the health system to achieve universal coverage of EHCS.

Phased Implementation

The EHCS package needs to be expanded to address disease and demographic transitions. The first phase of implementation will include planning and implementing the existing components of the EHCS programme by incorporating all resources available (GoN, EDPs, and International Non-governmental Organisations (INGOs)). In addition, the planning and design of new EHCS components will be completed. The second phase will include piloting the new elements of EHCS and their gradual scaling up.

Sequencing implementation is complex and requires careful planning to determine which groups of activities must be completed before the next set of activities can begin (dependent activities), and which can be pursued independently. Sequencing begins with design and planning, piloting, evaluation, and rollout or scaling up of activities. Activities related to implementation, monitoring, and strengthening await key activities such as preparing frameworks, mechanisms, schemes, and guidelines. They not only direct other activities but also facilitate their implementation. In planning activities, efforts were made to ensure the right mix of reform and routine activities. Some activities have been transferred directly from NHSP-2 and others are embedded under the set strategies. Some activities are expensive and others are relatively less so. The types of activities in the NHSP-2 IP include:

- Continuation of existing activities
- Strengthening or restructuring of existing activities
- Entirely new actions/activities.

Prioritising Programmes and Activities

The MoHP, National Planning Commission (NPC) and the Ministry of Finance (MoF) jointly prioritise health care programmes by using certain set criteria. The programmes are classified into P1, P2 and P3 as per the Medium-term Expenditure Framework (MTEF). However, prioritising activities falls under the remit of programme divisions and centres, where virtually no effort is made to prioritise at the activity level. The common tendency is to plan the ongoing strategies and activities as before, adding a few additional activities considering the importance and availability of resources. Each component of the health care programme has a ceiling for the upcoming AWPB and, despite a growing demand to add additional activities, lack of resources does not permit this. Therefore, prioritising activities is necessary to balance high demand for additional activities and the limited resources available. During the NHSP-2 period, the programme divisions and centres will prioritise activities in consultation with technical or thematic (sub-)committees to maximise the outputs. Priority will be given to low-cost- and high-output-related activities.

Coordination

1. At the central level, EDPs will participate in consultative meeting on AWPB formulation, health sector development partners meetings, and sectoral-level joint planning and joint review meetings. At the sub-sectoral level, joint technical committees or thematic committees (comprised of government officials and EDP representatives) will coordinate the design, planning and implementation of the programmes.

2. At the district level, programme-specific coordination committees have been formed to coordinate the activities of state and non-state sectors, for example Reproductive Health Coordination Committees (RHCCs), District AIDS Coordination Committee (DACCs), District Water, Sanitation and Hygiene Coordination Committees (DWASHCCs) etc. In the case of innovations and pilot programmes, agreements will be made between the MoHP and EDPs and then reflected in the AWPB.

3. Multi-sectoral coordination mechanisms will be implemented in HIV/AIDS, nutrition, WASH, infrastructure development, curative services, academic and training institutions etc., at both the central and the district levels to avoid duplication and to maximize synergies.

1.3 Description of Programmes and Services for the NHSP-2 IP

Essential Health Care Services

The three objectives set out in the RF are:

- To increase access to and utilisation of quality EHCS
- To reduce harmful cultural practices and cultural and economic barriers to accessing health care services in partnership with non-state actors
- To improve the health system to achieve universal coverage of EHCS.

The GoN assumes responsibility for ensuring that these three objectives are met for the defined EHCS package since universal coverage will not be achieved if left to the market. EHCS include services that the market will not provide sufficiently because the costs cannot be recovered by charging for them (such as public health campaigns), or because benefits are broader than to the individual directly receiving the service (such as immunisation). It also includes some services that are only profitable for the private sector to provide at prices many people cannot afford. The services included in the package are those that are the most cost-effective – those that have the biggest potential impact in reducing mortality per rupee spent.

The focus of the three objectives is on extending and sustaining EHCS coverage. Although impressive progress was made in extending the coverage of essential services during the NHSP-1 IP, access and utilisation are far from universal, and a significant though shrinking share of the population is still not covered by some of the most effective life-saving interventions. The task of NHSP-2 is therefore to continue to increase the proportion of the population benefiting from the existing EHCS package of services, with a particular focus on all women receiving reproductive health services, and the poor and excluded gaining access to essential services and utilising the same services as do wealthier and more advantaged households.

Supply-side constraints to the delivery of quality EHCS must be overcome, especially by planning how best to reach those populations that have previously not had good access to services.

Services need to be brought closer to more remote communities and rendered more results-focused and accountable to the population; necessary drugs and supplies and sufficiently trained and motivated staff must be available, and services rendered more results-focused and accountable to the population. Demand-side constraints to the utilisation of available services should be reduced. This partly involves reducing the cost barrier to accessing services through extending free EHCS, and through support to help meet transport and other costs for accessing services. It also involves action against other factors that prevent people from using services, including improving knowledge, and helping empower women and socially excluded groups to demand the services which the interim constitution assures them the right to receive.

Pressures to expand the range of services offered within the EHCS package are inevitable. Given the limited availability of financial and human resources, however, additions to the EHCS package come at significant opportunity cost, with the addition of a new service implying that fewer resources are available to extend coverage of the existing package of interventions of proven worth. At this stage, the resources available and the precise costs of some aspects of the programmes that are planned to be scaled up or added remain to be estimated. The approach taken will continue to be an incremental one, based on available resources, evidence from international experience, and careful piloting within Nepal.

Although the main priority is to continue to extend the coverage of services defined in the existing EHCS package, reconsidering and amending the package of services in light of the changing burden of disease and of the GoN's policy priorities is also necessary. This is a continuous process, and the EHCS package in 2009 was already significantly different from that defined in the NHSP-1 IP.

During NHSP-2, the MoHP will add to the existing EHCS package several services that are needed to further address reproductive and child health problems, and communicable and non-communicable diseases, and to improve the health status of Nepal's citizens, especially the poor and excluded. Medical safe abortion, and prevention and treatment of uterine prolapse will be added to reproductive health services. Community-based newborn care and significantly expanded nutrition care will be added to the Child Health Programme. Community-based mental health services and health education and behaviour change services will be added to address the growing burden of NCDs. Promotive and preventive eye and oral health education will be provided in schools and, together with other ministries, hygiene and sanitation will be promoted. All essential services are provided free of charge to reduce financial barriers to access and utilisation, especially for the poor and excluded.

Essential Health Care Services Package for NHSP-2
(New programmes and services in italics)

Programme	Service	Status	Implementation Modality
1. Reproductive Health	1.1 Family planning	Scaling up	Partnerships with the Family Planning Association of Nepal (FPAN), Marie Stopes International (MSI), Contraceptive Retail Store company (CRS), Population Services International (PSI), Nepal Fertility Care Centre (NFCC) and others
	1.2 Safe Motherhood (SM), including newborn care (free institutional deliveries nationwide for all)	Scaling up	Expanding to medical colleges and private hospitals
	1.3 Medical safe abortion	*Piloting and scaling up*	*Partnerships with I/NGOs (MSI, FPAN and others) and private clinics and hospitals*
	1.4 Prevention and repair of uterine prolapse	*Piloting and scaling up*	*Partnerships with medical colleges and private hospitals*
2. Child Health	2.1 Expanded programme on immunisation 2.2 Community-based Integrated Management of Childhood Illness (CB-IMCI) 2.3 Nutrition 2.3.1 Growth monitoring and counselling 2.3.2 Iron supplementation 2.3.3 Vitamin A supplementation 2.3.4 Iodine supplementation 2.3.5 De-worming	Scaling up Maintaining Scaling up Scaling up Maintaining Maintaining Maintaining Maintaining	Government
	2.4 Community-based newborn care (emerging as a separate component) *2.5 Expanded nutritional care and support (added to community-based nutrition care, community nutrition rehabilitation with institutional care, and School Nutrition Programme)*	*Piloting and scaling up* *Piloting and scaling up*	*Partnerships with local governments and inter-sectoral coordination (schools)*

Programme	Service	Status	Implementation Modality
3. Communicable Disease Control	3.1 Malaria control 3.2 Kala-azar control 3.4 Japanese Encephalitis (JE) control 3.5 Prevention and treatment of snakebites and rabies control 3.6 Tuberculosis control 3.7 Leprosy control 3.8 HIV/AIDS/STI control	Scaling up Elimination Maintaining Maintaining Maintaining Elimination Scaling up	Government Partnerships with International Nepal Fellowship (INF) and other INGOs Partnerships with INGOs
4. NCD Control	*4.1 Community-based Mental Health Programme** *4.2 Health promotion for NCD control*	*Piloting and scaling up*	*Partnerships with local governments and Community-based Organisations (CBOs)*
5. Oral Health	*5.1 Promotive and preventive oral health care*	*Piloting and scaling up*	*Partnerships with schools and private clinics and hospitals*
6. Eye Care	6.1 Promotive and preventive 6.2 Examination, correction and surgery	Scaling up	Partnerships with Nepal Netra Jyoti Sangh (NNJS) and Tilganga Eye Hospital
	6.2 Trachoma (SAFE Programme)	Scaling up	Partnerships with NNJS, Department of Water Supply and Sewerage (DWSS) and International Trachoma Initiative (ITI)
7. Rehabilitation of the Disabled	*7.1 Promotive and preventive* *7.2 Rehabilitation, surgery and therapy*	*Piloting and scaling up*	*Partnerships with* Hospital and Rehabilitation Centre for Disabled Children (HRDC *and Khagendrad Nawa Jeevan Kendra*
8. Environmental Health	*8.1 Promotive and preventive (water, air quality, sanitation, hygiene, waste disposal, etc.)*	*Piloting and scaling up*	*Inter-sectoral partnerships*
9. Curative Care	9. 1 Outpatient care at district facilities	Increasing access and use	Partnerships with local governments, NGOs and medical colleges

** Including Gender-based Violence (GBV) Services*
Source: NHSP-2, MoHP, 2010.

Strategies to Achieve the Objectives

This section details actions and activities under NHSP-2. Implementation of these activities will collectively result in achieving the NHSP-2 objectives. The programme activities fall into three types:

1. Entirely new actions/activities
2. Strengthening or restructuring existing activities
3. Continuing existing activities.

Objective 1:
To increase access to and utilisation of quality EHCS.

The following EHCS components will be implemented to achieve the above objectives. The detailed IP includes the following programmes:

- Reproductive Health (FP, SM, including newborn care and medical safe abortion, prevention and repair of uterine prolapse)
- Child Health (expanded programme on immunisation and CB-IMCI including community-based newborn care and nutrition)
- Communicable Disease Control (Malaria, Kala-azar, JE, TB, Leprosy, HIV/AIDS/STIs)
- NCD Control (Community-based Mental Health Programme, health promotion)
- Oral Health
- Eye Care (partnerships – providing grants)
- Rehabilitation of the Disabled (partnerships – providing grants)
- Environmental Health (partnerships – providing grants).

Objective 2:
To reduce harmful cultural practices and cultural and economic barriers to accessing health care services in partnership with non-state actors.

The following programmes explicitly, and all other programmes indirectly, contribute to achieving the above objectives:

- Information Education and Communication Programme
- National Free Health Care Programme
- GESI Mainstreaming Programme
- Health Financing.

Objective 3:
To improve the health system to achieve universal coverage of EHCS.

The following health-system-related components will be implemented to achieve the objectives:

- State and non-state partnerships
- Promoting the SWAp
- Addressing the transition to federalism
- Strengthening local health governance and FM
- Human Resources for Health (HRH)
- Health financing
- Procurement and distribution
- Mainstreaming GESI
- Physical facilities, investment and maintenance
- Research and M&E.

The EHCS package developed in NHSP-2 will be delivered through the static and mobile clinics of health institutions located at district and lower levels. In the case of the SM component, services will be delivered irrespective of level. IPs for the following programmes and services have been prepared to achieve the objective of increasing access to and utilisation of quality EHCS. NHSP-2 includes the following nine programmes under the EHCS package:

1. Reproductive Health
2. Child Health
3. Communicable Disease Control
4. NCD Control
5. Oral Health
6. Eye Care
7. Rehabilitation of the Disabled
8. Environmental Health
9. Curative Care

Part Two: Programmes (Essential Health Care Services)

2.1 Immunisation Programme

1. Introduction

The Immunisation Programme is a priority programme of the GoN. It has helped reduce the mortality and morbidity of children and mothers from VPDs and thus contributes to achieving MDGs 4 and 5. Through its policy documents the GoN has emphasised reaching poor and marginalised populations with equitable immunisation services. Vaccines have been available in the market for decades, and the GoN intends to provide all available means to reduce morbidity and mortality.

The Immunisation IP 2012-2016 guides the AWPB for the next five years to achieve the immunisation-related goals the GoN has expressed in various policy documents, in the MDGs and World Health Assembly (WHA) resolutions, and in different national and international fora. The plan also takes into consideration the Global Immunisation Vision and Strategy (GIVS) 2005 and the Global Vaccine Action Plan 2012.

The objectives, strategies and activities set forth in the IP provide the framework required to meet the goal of "reducing infant and child mortality and morbidity associated with vaccine-preventable diseases." Furthermore, this plan addresses new challenges and expands the previous plan by providing guidelines for the introduction of new vaccines, for the eradication, elimination and control of targeted Vaccine Preventable Diseases (VPDs), and for the strengthening of routine immunisation.

2. Goal and Objectives

Goal

To reduce the child mortality, morbidity, and disability associated with VPDs.

Objectives

1) Achieve and maintain at least 90% vaccination coverage for all antigens both at national and district levels by 2016
2) Enhance the HR capacity for immunisation management
3) Ensure access to vaccines of assured quality and with appropriate waste disposal
4) Achieve and maintain polio-free status
5) Maintain maternal and neonatal tetanus elimination status
6) Achieve measles elimination status by 2016
7) Accelerate control of VPDs through the introduction of new and underutilised vaccines
8) Expand Vaccine Preventable Disease (VPD) surveillance
9) Continue to expand immunisation beyond infancy.

3. Major Strategies

- Increase access to vaccination services
- Strengthen the HR for immunisation
- Strengthen communication and social mobilisation

- Strengthen immunisation services in the municipalities
- Strengthen monitoring and facilitative supervision
- Strengthen the vaccine management system
- Strengthen the cold chain systems at all levels
- Achieve and maintain immunity levels to stop the transmission of polio
- Respond adequately and timely to outbreaks of polio with the appropriate vaccine
- Achieve and maintain certification standard Acute Flaccid Paralysis (AFP) surveillance at the district level
- Develop post eradication strategic guidelines
- Introduce new and under-used vaccines (rubella, pneumococcal, typhoid, cholera, rota) based on the disease burden and financial sustainability
- Continue to expand immunisation beyond infancy.

4. Indicators and Targets

Health Outcome	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Infant Mortality Rate (IMR) (per 1,000 live births)	46	43.2	40.4	37.6	34.8	32
Under-five Mortality Rate (per 1,000 live births)	54	50.8	47.6	44.4	41.2	38
DPT3	>80% in 30 dist.	90 % in 30 districts	90 % in 50 districts	90 % in 60 districts	90 % in 75 districts	90 % in 75 districts
All antigens	>80% in 20 dist.	90% in 20 districts	90% in 30 districts	90% in 50 districts	90% in 65 districts	90% in 75 districts

5. Major Challenges and Issues

- Achieving 90% coverage for all antigens and maintaining their quality
- Ensuring the availability of vaccines
- Maintaining the cold chain
- Filling vacant posts of vaccinators (Village Health Workers (VHWs))
- Reducing the dropout rate (BCG vs. measles – 9.85% in 2010/11)
- Reducing vaccine wastage rate (BCG: 78%, DPT/Heb and Hib: 8.6%, measles: 64%, JE: 29%, and TT: 32% in 2010/11)
- Improving the immunisation structure in municipalities (8 + 40 municipalities)
- Strengthening surveillance and monitoring
- Expanding immunisation beyond infancy.

Accountable Officer: Director, Child Health Division (CHD), Department of Health Services (DoHS)

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increase access to vaccination	Revise micro-planning guidelines	Expanded Programme of Immunisation (EPI) section	World Health Organization (WHO), United Nations Children's Fund (UNICEF)		X				
	Review micro-planning (district)	EPI section	WHO, UNICEF		30 districts	60 districts	75 districts	75 districts	75 districts
	Develop a strategy for integration of immunisation with other child health programmes	EPI section	WHO, UNICEF		X	X			
	Prepare and implement the periodic intensification of the Routine Immunisation (RI) plan	EPI section	WHO, UNICEF	X	X	X	X	X	X
	Conduct two rounds of National Immunisation Day (NID)	EPI section	UNICEF, WHO		X	X	X		
	Conduct micro-planning in municipalities	EPI section			X	X			X
	Conduct an integrated child health review meeting	CHD			X	X	X	X	X
Reach unreached groups	Develop and implement an action plan to reach unreached groups	EPI section			X	X	X	X	X
Enhance HR capacity	Revise training material	EPI section	WHO, UNICEF	X			X		
	Conduct Mid-level Managers training (persons)	EPI section	WHO, UNICEF		20	20	20	20	20
	Conduct refresher training for vaccinators (districts)	EPI section	WHO, UNICEF				30	35	30

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Train basic-level staff to operate, repair, implement, and maintain the cold chain	EPI section	WHO, UNICEF		100	100	50		
Strengthen communication and social mobilisation	Develop innovative district-specific social mobilisation plans	EPI section		X	X	X	X	X	X
	Revise the strategy and policy for conducting NID	EPI section	WHO, UNICEF, National Health Education Information and Communication Centre (NHIECC)	X	X	X	X	X	X
	Review, finalise and implement RI BCC strategy					X			
	Initiate a continuous mass media communications campaign	EPI section		X	X	X	X	X	X
Strengthen immunisation services in the municipalities	Implement an immunisation policy and guidelines for the municipalities				X	X	X	X	X
Strengthen supportive supervision and monitoring	Conduct a minimum of two joint (government and partners) supervisory visits from the central office to low-performing districts, three from the region to HFs, and at least one joint visit from district headquarters to all Village Development Committees (VDCs) and sessions in a year using the tools	EPI section	Primary Health Care Revitalisation Division (PHCRD), UNICEF, WHO		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Strengthen the vaccine management system	Assess the forecasting, procurement, storage and distribution of vaccines and the related logistics	Logistics Management Division (LMD)	CHD, WHO, UNICEF	X		X		X	
	Introduce/adopt and implement strategic guidelines on the cold chain and vaccine management system	LMD	CHD, UNICEF WHO	X	X	X	X	X	X
	Monitor implementation Standard Operating Procedures (SOPs) on vaccine management at all levels	LMD	CHD, UNICEF WHO		X	X	X	X	X
	Provide tool kits for maintenance to staff	LMD	CHD, UNICEF WHO		X	X			
	Dispose of medical waste according to the guidelines	EPI section	UNICEF, WHO		X	X	X		
Strengthen the cold chain system at all levels	Procure cold chain equipment and spare parts, and replace old equipment as per the replacement plan	LMD	CHD, UNICEF WHO		X	X	X	X	X
	Procure generators, solar freezers, and hybrid systems for districts with poor electricity supply	LMD	CHD, UNICEF WHO		X	X	X	X	X
Achieve and maintain immunity levels to stop transmission	Introduce Oral Polio Vaccine (OPV) birth dose in CB-NCP districts	EPI section	UNICEF, WHO		X	X	X	X	X
Respond adequately and promptly to	Conduct mop-up campaigns with Vaccine-derived Polio Virus (VDPV) in the appropriate type of vaccine	EPI section	UNICEF, WHO		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
outbreaks of polio	Conduct cross border activities during Supplementary Immunisation Activities **(**SIAs)	EPI section	Epidemiology and Disease Control Division (EDCD), UNICEF, WHO		X	X	X	X	X
Achieve and maintain certificate standard surveillance	Intensify AFP surveillance activities in each district to meet certification standards	EPI section	UNICEF, WHO	X	X	X	X	X	X
	Implement a laboratory containment plan with review	National Public Health Laboratory (NPHL)	WHO		X	X	X	X	X
Develop and implement post-eradication strategies	Develop and implement post-eradication strategies for polio	EPI section	UNICEF, WHO				X	X	X
Achieve and maintain 80% coverage of TT2+	Integrate and implement tetanus toxoid (TT or Td) in the BCG immunisation strategy against Tuberculosis	EPI section	UNICEF, WHO		X	X	X	X	X
	Develop and implement policy on TT five doses	EPI section	Family Health Division (FHD), UNICEF, WHO		X	X	X	X	X
	Conduct two rounds of TT campaign (districts in numbers)	EPI section	UNICEF, WHO		10	10	10	10	
Achieve and sustain the immunity level for measles	Develop guidelines for measles elimination	EPI section	UNICEF, WHO, FHD		X				
	Provide a second opportunity for measles vaccine	EPI section	MoHP, UNICEF, WHO			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Conduct a follow up Measles and Rubella campaign targeting children from nine months to under five years of age	EPI section	UNICEF, WHO			X	X		X
	Introduce a second dose of measles vaccine in RI	EPI section	UNICEF, WHO						X
Investigate all suspected measles outbreaks	Investigate all suspected measles outbreaks and follow up with appropriate response	EPI section	EDCD, UNICEF, WHO		X	X	X	X	X
Introduction of new and under-used vaccines in National Immunisation Programme (NIP)	Introduce the rubella vaccine (as MR) in routine immunisation	EPI section	UNICEF, WHO			X			
	Introduce pneumococcal vaccine in RI	EPI section	UNICEF, WHO						X
Expand VPD surveillance	Conduct integrated surveillance of AFP, measles, Neonatal Tetanus (NNT) and JE	EPI section	UNICEF, WHO		X	X	X	X	X
	Initiate surveillance for Congenital Rubella Syndrome (CRS)/Rubella	EPI section	UNICEF, WHO			X	X	X	X
	Conduct sentinel surveillance for typhoid and cholera	EPI section	UNICEF, WHO		X	X	X	X	X
	Continue sentinel surveillance sites for pneumo and rota surveillance	EPI section	UNICEF, WHO		X	X	X	X	X
	Continue to provide support for NPHL (test kits, reagents, additional staff and other support)	EPI section	NPHL		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Control of JE, CRS/Rubella and other VPDs	Continue to conduct JE campaigns in high risk districts (districts in number)	EPI section	UNICEF, WHO		5	5			
Expand school-based immunisation	Expand school-based TT immunisation among 1-8 grade students (districts)	EPI section	UNICEF, WHO		2	2	2	3	4

2.2 Integrated Management of Childhood Illness and Newborn Care Programme

1. Introduction

IMCI, through the progressive implementation and improvement of the CB-IMCI Programme, will contribute to the reduction in deaths due to the major illnesses that cause 70% of child mortality globally. The major illnesses addressed by CB-IMCI are acute respiratory infections, diarrhoeal diseases, malaria, measles, malnutrition, and other common childhood illnesses. At the community level, CB-IMCI is more focused on diarrhoea and pneumonia management and treatment by Community Health Workers (CHWs). The Programme expects that the poor and excluded groups will benefit from interventions as they have higher rates of illnesses and less access to care at facilities. CB-IMCI is also expected to improve community-based and facility-based management of pneumonia, diarrhoea, malnutrition, malaria, measles and neonatal care.

Early research showed that IMCI case management training does improve quality of care (as evidenced by more thorough assessment and more accurate treatment, with carers more likely to receive key messages). However, training alone was insufficient to achieve gains in child survival without health system strengthening measures. Based on 20 years of experience with Female Community Health Volunteers (FCHVs), Nepal leads the world in early identification and case-based management of childhood disease at the community level. This has resulted in significant gains in child survival in both diarrhoea and Acute Respiratory Infection (ARI); results from the evaluation of the CB-NCP on the equivalent impact on newborns are eagerly awaited.

The challenge will be to incorporate the community-based elements of the NCP in the CB-IMCI and SM Programmes. From the present level covering neonates it will be difficult to reduce under-five mortality to the desired level by 2015. The CB-NCP started in 15 districts in 2008; it expanded to 10 further districts in 2010 and to an additional 15 districts in 2011. The Nepal Demographic Health Survey (NDHS) 2011 shows a slowing of progress of health child services in the last five years. The under-five mortality rate has decreased from 61 per 1,000 live births in 2006 to 54 in 2011. The neonatal mortality rate has remained stagnant (33 per 1,000 live births) over the last five years. Deaths amongst newborns account for 33 of every 54 childhood deaths. The CB-NCP is being scaled up and an evaluation is expected in 2012. Given the need to make rapid progress in newborn survival, the expansion of CB-NCP to achieve coverage in all 75 districts should remain a top priority.

Therefore, NHSP-2 has focused on the following:

- Maintaining programme quality by training new entrants (health workers and FCHVs), conducting refresher training, providing intensive supervision, monitoring, and periodic programme reviews
- Developing PPPs for implementing the CB-IMCI programme
- Incorporating CB-IMCI protocols into the pre-service curriculum of health workers
- Integrating tested CB-NCP interventions with CB-IMCI and SM after evaluation of CB-NCP programmes in piloted districts
- Revitalising the programme in low-performing districts.

2. Goal and Objectives

Goal

To reduce death, illness, and disability, and to promote improved growth and development in newborns and children under five years of age.

Objectives

1. To complete the expansion phase of the CB-NCP

2. To reach the unreached (poor and excluded, newborns)
3. To improve the quality of CB-IMCI
4. To increase the coverage of CB-IMCI
5. To broaden the components of CB-IMCI.

3. Major Strategies

Improving Health Workers' Skills

- Ensure that all facility-based staff provide high-quality management of childhood illness
- Integrate the post-natal case management skills training of the CB-NCP into CB-IMCI training
- Ensure that all CHWs, including FCHVs, commence treatment and refer sick children where appropriate
- Ensure the inclusion of CB-IMCI in the curriculum of pre-service medical and paramedical schools.

Improving the Health System

- Build capacity for CB-IMCI programme management at all levels, especially district and regional levels
- Strengthen logistic management of IMCI/NCP commodities
- Strengthen CB-IMCI/NCP in urban areas
- Strengthen the referral system for CB-IMCI/NCP
- Engage the private health sector in CB-IMCI/NCP
- Improve the monitoring and supportive supervision system
- Undertake operational research for CB-IMCI/NCP
- Ensure inter-sectoral and divisional collaboration for efficient programme management and delivery.

Improving Family and Community Practices

- Reach disadvantaged and hard-to-reach communities through participatory community groups
- Encourage changes in key family and community practices through community mobilisation and communication strategies
- Engage in local resource mobilisation to strengthen CB-IMCI/NCP at the local level.

4. Indicators and Targets

Health Outcome	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Under-five Mortality Rate (per 1,000 live births)	46	43.2	40.4	37.6	34.8	32
IMR (per 1,000 live births)	54	50.8	47.6	44.4	41.2	38
Neonatal Mortality Rate (per 1,000 live births)	33	30	27	24	20	16
% of children with symptoms of ARI treated with antibiotics	30	35	40	44	47	50
% of diarrhoea cases among children under five treated with zinc	7	15	25	30	35	40

(and Oral Rehydration Salts (ORS))						

5. Major Challenges and Issues

- Continuum of care to achieve MDG 4
- Integrating tested CB-NCP interventions with CB-IMCI and SM
- Scaling up CB-NCP to the remaining districts
- Quality maintenance
- Reaching the unreached
- Increasing resources for CB-IMCI.

Accountable Officer: Director, CHD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Ensure all facility-based staff provide high-quality management of childhood illness	Provision of IMCI training to newly recruited Medical Officers (MOs)/health workers (five/district/year) with VDCs to hire health workers (c.20/district/year)	IMCI section	Nepal Health Sector Support Programme (NHSSP), training providers, Nepal Pediatric Society (NEPAS)			X	X	X	X
	Regional five-year contracting process to supply one IMCI training/district including clinical skills component	IMCI section	NHSSP, training providers, NEPAS			X	X	X	X
	Revision of IMCI training	IMCI section	National Health Training Centre (NHTC)						
	Revised CB-IMCI (2) protocol to be phased in to replace CB-IMCI (1) to districts (once CB-NCP is fully established in that district)	IMCI section	NEPAS				CB-IMCI (2) for CB-NCP districts		
	Referral-level management of sick newborn/child training for district hospital doctors and nursing staff (districts)	IMCI section	Curative Division		Adapt Training Package		10	20	25

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Introduce peer review of case management through CME (Continuing Medical Education) programme at HF level with district support	IMCI section	Health Management Information System (HMIS)				Piloting		
Integrate the post-natal case management skills training of the CB-NCP programme into CB-IMCI training	Rationalise FCHV training organisation	IMCI section	NHTC		X				
	Prepare Revised Training for CHWs (FCHVs, Maternal and Child Health Workers (MCHWs), VHWs) with Revised CB-IMCI protocol*and field testing	IMCI section	NHTC		X	X			
	Develop indicators of newborn care	IMCI section	HMIS	X					
Ensure that all CHWs, including FCHVs, commence treatment and refer sick children where appropriate	Training to newly recruited FCHVs in CB-IMCI (c. 60/district/year allowing for turnover) three batches/district	IMCI section	NHTC/EDPs		X				
	Replace new recruit training with revised format to include case management for 0-2 month olds in all districts where CB-NCP is fully established	IMCI section	NHTC			X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Refresher training for FCHVs to include new components as revisions are agreed (piggy back onto CB-NCP expansion)	IMCI section			X	X			
Inclusion of CB-IMCI in the curriculum of pre-service medical and paramedical schools	Review of pre-service curricula of paramedical school (co-opt representative of Council for Technical Education and Vocational Training (CTEVT) into IMCI technical working group)	IMCI section	CHD, WHO, UNICEF		X				
	Provide CB-IMCI training to faculty/junior doctors/clinical staff of medical colleges and institutes	IMCI section	CHD, WHO, UNICEF			X	X		
	Provide CB-IMCI training to faculty and clinical staff of paramedical colleges and institutes	IMCI section	CTEVT			X	X	X	
Capacity building for CB-IMCI/NCP programme management at all levels, especially at district and regional levels	Broaden the mandate of the CB-NCP secretariat to CB-IMCI and CB-NCP secretariat for logistics, information, training management, and monitoring and supervision	IMCI section				X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Strengthen the CB-IMCI/NCP secretariat in terms of technical capacity at the centre	IMCI section				X	X		
	Establish the CB-IMCI/NCP secretariat support team at regional and district levels	IMCI section				X	X		
	Micro-planning for strengthening CB-IMCI/NCP at regional, district, municipality and below district levels	IMCI section				X	X	X	X
	Capacity building for CB-IMCI/NCP focal persons (district and region: c. 100)	IMCI section				X	X	X	X
Strengthen logistic management of CB-IMCI/NCP commodities	Develop a system of procurement of commodities for community, HF and referral centres as per the multi-year procurement plan	IMCI section	LMD, Regional Medical Store (RMS)		X	X	X	X	X
	Strengthen the supply chain system for CB-IMCI/NCP commodities at regional, district, HF and community levels	IMCI section	LMD, RMS		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Strengthen the supply chain system for CB-IMCI/NCP commodities in the municipalities	IMCI section	CHD, LMD, RMS, PHCRD		X	X	X	X	X
	Logistics management orientation to DHO chiefs, store in-charges, and finance and HF in-charges	IMCI section			X	X	X	X	X
Strengthen CB-IMCI/NCP in urban areas	Liaise with metro and sub-metro municipalities to establish the training needs for staff working in Maternal and Child Health (MCH) Clinics	IMCI section	PHCRD/ municipalities			X			
	Liaise with the PHCRD regarding joint plan for revitalisation of urban CB-IMCI/NCP	IMCI section	PHCRD/ municipalities			X			
	Provide CB-IMCI/NCP training for appropriate MCH staff, including urban FCHVs	IMCI section	PHCRD/ municipalities			X	X	X	X
	Build partnerships with urban NGOs working in child-related fields	IMCI section	PHCRD/ municipalities			X	X		
Strengthen referral system for CB-IMCI/NCP	Map a district-level referral system for each facility to include travel time, and the availability of transport (e.g. district ambulance)	IMCI section	HMIS		X				

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Prepare and conduct district and zonal level advanced clinical training for the management of serious childhood illness (referral IMCI) and newborns	IMCI section	Curative Division		X	X	X	X	
Strengthen referral system for CB-IMCI/NCP	Develop a monitoring and information management system for referral case management of under-five-year-old children and newborns, both outpatients and in-patients, for piloting and expansion	IMCI section	HMIS			X	X	X	
Engagement of private health sector in CB-IMCI/NCP	Conduct a mapping of pharmacies, chemists, and private sector providers in districts, municipalities and VDCs	IMCI section	UNICEF/PSI				X		
	Screen pharmacies, private sector providers in districts, municipalities and VDCs for eligibility for training	IMCI section	UNICEF/PSI				X	X	
	Provide training and orientation on CB-IMCI and CB-NCP	IMCI section	UNICEF/PSI				X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Certify private sector providers to provide child and newborn services	IMCI section	UNICEF/PSI				X	X	X
	Develop an orientation and continuous medical education package for pharmacies and private sector providers	IMCI section	UNICEF/WHO/ NHSSP			X	X	X	X
	Develop a system of distribution of CB-IMCI and newborn commodities through retailers	IMCI section	PSI					X	X
Improved monitoring and supportive supervision system	Review the monitoring tool for CB-IMCI/NCP using HMIS data at district levels (based on assessment)	IMCI section	HMIS		X				
	Identify the gaps in the CB-NCP monitoring system and tools	IMCI section	HMIS			X			
	Develop a set of integrated monitoring tools for CB-IMCI and CB-NCP	IMCI section	HMIS			X			
	Use monitoring tools to determine district performance	IMCI section	HMIS			X	X	X	X
	Support IMCI focal persons to apply monitoring tools to	IMCI section	HMIS			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	district data to better understand local performance								
	Review the performance change in CB-IMCI/NCP of HFs at both the VDC and municipality levels during regular quarterly meetings	IMCI section	HMIS			X	X	X	X
	Strengthen the district supervision system using a checklist approach for routine district supervisor visits, to include IMCI monitoring at HF level	IMCI section	HMIS			X	X	X	X
	Conduct annual performance review monitoring meetings with focal persons at regional, district, municipality and below district levels focusing on low-coverage interventions	IMCI section	HMIS		X	X	X	X	X
Improved monitoring and supportive supervision system	Develop the system of private sector reporting to local HF and DHO	IMCI section	HMIS		X	X	X	X	X
	Undertake monitoring and supervision of the private sector on the quality of care for children and newborns	IMCI section	HMIS				X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Operational research for CB-IMCI/NCP	Collaborate with the Clinical and NGO research sectors, including Kanti Children's Hospital, the Maternity Hospital and NPHL in setting a Child Health Research Agenda	IMCI section	Curative Division/Nepal Health Research Council (NHRC)			X	X		
	Commission an infectious disease research team to determine the continuing efficacy of co-trimoxazole treatment for community-acquired pneumonia in zero to five-year-old children	IMCI section	EDCD/NHRC			X	X		
	Conduct operational research on programme management of low-coverage or under-utilised interventions	IMCI section	NHRC/ research firms		X		X		X
	Determine the perception of users regarding IMCI services	IMCI section	NHRC/ research firms			X		X	
	Undertake a Knowledge, Attitude and Practice (KAP) study on private providers	IMCI section							
Inter-sectoral and divisional collaboration	Broaden the existing performance-based incentive scheme of CB-NCP for FCHVs to add on	IMCI section	FHD/EDCD/ PHCRD /partners		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	the activities of EDCD, FHD and PHCRD								
	Hold regular joint meetings among FHD, ECDC, PHCRD and CHD for efficient programme management and delivery through FCHVs	IMCI section	FHD/EDCD/ PHCRD/partners		X	X	X	X	X
Reach the disadvantaged and hard-to-reach communities	Training of FCHVs/CHWs to identify hard-to-reach communities, and in actions for reaching them (tools and a training package must be developed and included in the revised CB-IMCI package)	IMCI section					X		
	Map FCHVs' ethnicity by VDC, and have the district focal persons analyse and advise on selective recruitment	IMCI section					X		
	In urban areas, provide capacity building of local organisations working in urban slums and poor communities on IMCI/NCP	IMCI section				X	X	X	X
	Focus urban recruitment of FCHVs in hard-to-reach communities	IMCI section	PHCRD/ municipalities			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Encourage changes in key family and community practices through participatory community groups and communication strategies	Provide Interpersonal Communication (IPC) and group facilitation skills training for community health workers at all levels – FCHVs, VHWs and Health Workers (HWs) (develop a module and integrate it in ongoing and basic training)	IMCI section	NHEICC		X	X	X	X	X
	Use proven community mobilisation methods (e.g. pregnant mothers' groups) but with a focus on zero to five-year-olds' health and development	IMCI section	NHEICC			X	X	X	X
	Make IMCI a standing agenda item for the FHD FCHV subcommittee	IMCI section				X			
	Develop an early child development policy with MoE colleagues	IMCI section				X			
	Undertake two-way mass communication	IMCI section				X	X	X	X
Local resource mobilisation to strengthen IMCI/NCP at the local level	Integrate the IMCI/NCP message in the non-formal education (NFE) curriculum, School Health Nutrition (SHN) activities, and existing parenting and Early Child	IMCI section	District Development Committee (DDC)/VDCs/ municipalities				X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Development (ECD) modules								
	Localise IMCI/NCP BCC messages, especially by using local FM radio and other innovative approaches	IMCI section	DDC/VDCs/ municipalities				X	X	X
	Train district-level stakeholders (DHOs) in micro-planning and implement an IMCI/NCP BCC plan to address district gaps (e.g. religious leaders, health exhibitions, etc.) and link to the Maternal, Neonatal and Child Health (MNCH) communication strategy	IMCI section	DDC/VDCs/ municipalities			X	X	X	X

2.3 Nutrition Programme

1. Introduction

Nepal has made significant progress in reducing micronutrient deficiency over the past decade, and is one of the very few countries in the world that is on track to meet the micronutrient-related goals of the 1990 World Fit for Children. This progress can mainly be attributed to sustained and consistent programmes of semi-annual vitamin A supplementation and deworming distribution to pre-schoolers, which cover more than 90% of children. The percentage of households consuming adequately iodised salt has risen to 80%. The prevalence of anaemia among children under five years of age was reduced by more than one-third between 1998 and 2011, while during the same period a reduction by almost half was noted in anaemia among reproductive-aged women. However, not much reduction was found in the prevalence of anaemia in children between 2006 and 2011 (NDHS 2011). Progress in reducing general malnutrition among children and women has remained slow. The prevalence of stunting, underweight and wasting has been reduced to 41% and 29% respectively in 2011 from 47% and 53% in 2001. The status of wasting has remained stagnant. Maternal malnutrition, especially chronic energy deficiency and micronutrient deficiencies, is also still an important challenge in Nepal. NDHS 2011 shows that the prevalence of thinness (Body Mass Index (BMI) $<18.5kg/m^2$) among reproductive age women is 18.2%, and the prevalence of obesity/overweight ($BMI>25kg/m^2$) is 13.5%.

To address micro- as well as macronutrient deficiency in women and children, the GoN has highly prioritised improving the nutritional status of the Nepalese people through the involvement of multi-sectoral stakeholders from the government and non-government sectors. Likewise, the MoHP has aligned its ongoing interventions and activities to match the approved and costed Multi-sectoral Nutrition Plan (MSNP) to improve the nutritional status of children aged under five, adolescent girls, and pregnant and breastfeeding women. The Nutrition Section under the CHD has been working to review, revise and develop strategies for different priority programmes that will be scaled up in a phase-wise manner in all districts.

During the NHSP-2 IP, MoHP is committed to expanding priority programmes under the leadership and management of the CHD. The focus of the interventions is to break the intergenerational cycle of malnutrition by prioritising the critical 1,000 days from pregnancy to a child's second birthday, considering this as a long-term investment for the future, with generational payoffs.

Evaluation of the Community Management of Acute Malnutrition (CMAM) pilot programme in five districts in terms of reducing mortality due to severe acute malnutrition (0.46%) and identifying the highest recovery rate (90%) compared to the Sphere standard (The Sphere Handbook: *Humanitarian Charter and Minimum Standards in Humanitarian Response*, The Sphere Project) provided a strong basis for further scale-up of the programme. The GoN will be scaling up the CMAM programme in six additional districts in 2012, and progressively to other districts, in order to address severe acute malnutrition using Ready-to-use Therapeutic Foods (RUTFs). In addition, Nutrition Rehabilitation Homes (NRHs) have gradually been established in 11 zonal, sub-regional and regional hospitals. NRHs have also been established in two district-level hospitals and will be further extended to five more zonal and sub-regional hospitals. Furthermore, components of Water, Sanitation and Hygiene (WASH), comprehensive child care

including ECD, CB-IMCI and Infant and Young Child Feeding (IYCF) will be integrated into CMAM and NRH activities.

Orientation training to CHWs, volunteers, and Mothers' Groups for Health (MGHs) will be conducted to strengthen the Iron Folic Acid (IFA) supplementation of pregnant and breastfeeding women to improve coverage and compliance. Zinc treatment will also be strengthened. New interventions such as newborn vitamin A dosing, and Maternal and Neonatal Programme (MNP) supplementation linked with IYCF community promotion will be initiated at scale. Additional funding will be leveraged through the SWAp to sustain vitamin A distribution and salt iodisation and to intensify IYCF promotion.

Action to address the broader impact of poverty and food insecurity on malnutrition requires inter-ministerial cooperation, and MoHP may not be the lead ministry. Inter-ministerial collaboration will be strengthened to increase awareness of under-nutrition as well as to utilise non-health structures and programmes to promote good nutrition and appropriate care practices. For example, under the framework of the joint MoHP and MoE School Health and Nutrition Strategy, schoolchildren can be mobilised as community advocates promoting good nutrition. At present, various community organisations, such as forest user groups and those carrying out credit and saving activities, exist in most districts and can provide a useful platform to promote nutrition at the community level.

The government is reviewing the case for introducing food supplementation for malnourished children and pregnant and lactating mothers on a larger scale. This would be a significantly more expensive intervention. Piloting is needed in order to identify the form of assistance that would have the biggest impact, and how best to deliver it. Options range from developing cash transfer or voucher programmes to directly providing food supplements. Decisions are needed on the extent to which the programme should be targeted, how targeting should be done, and how to effect a durable improvement in household food security without creating long-term dependence on food subsidies. Various options exist regarding the type of conditions that should be attached to the additional assistance to households, and this is an area where MoHP might have a more direct interest. Since malnutrition is linked to poor feeding practices rather than simply a lack of food, there is a good case for linking the programme to the Community-based Nutrition Programme, in order to ensure that food or financial support is linked to improved knowledge on how to protect children from malnutrition. EDPs have indicated that significant additional funding could be available for an expanded nutrition programme. Partners will be involved in developing the programme. There would be merit in piloting several alternative models, and scaling up those that appear to be most promising in addressing the problem.

Recently, the health sector has taken the lead in enhancing the country's capacity for emergency preparedness and providing a nutrition response in the case of humanitarian crisis. District-based capacity for emergency preparedness and response on nutrition will be enhanced and implemented.

This IP is prepared to implement NHSP-2 and the MSNP. The strategies and activities are embedded under the strategic directions of NHSP-2 and the MSNP.

2. Goal

To achieve the nutritional wellbeing of all the people in Nepal so they can maintain a healthy life and contribute to the country's socioeconomic development, through implementation of an improved nutrition programme in collaboration with the relevant sectors.

Nutrition-specific MDGs

The following Nutrition-specific Goals are to be achieved by the end of 2015 (MDGs):

- Reduce sub-clinical Vitamin A Deficiency (VAD) to 7%
- Reduce anaemia in pregnant women to 43%; reduce anaemia in all women to 42%
- Reduce anaemia in children to 43%
- Increase consumption of adequately iodised salt (≥ 15 PPM) at household level to 88%
- Reduce prevalence of night blindness in pregnant women to 1%
- Reduce prevalence of underweight in <5 years children to 27%
- Reduce prevalence of stunting in <5 years children to 28%
- Reduce prevalence of wasting in <5 years children to 5%
- Increase exclusive breastfeeding in <6 months children to 88%
- Reduce prevalence of thinness (BMI 18.5 – below 25) in women to 15%
- Reduce worm infestation rate in children (pre-school) to less than 10%.

3. General Objective

To enhance child and maternal mortality through nutritional interventions.

Specific Objectives

- Reduce general under-nutrition among children and women, i.e. stunting, underweight, wasting, low BMI
- Reduce Iron Deficiency Anaemia (IDA) among children under five with a focus on under-two-year-old children, and pregnant and lactating women
- Maintain and sustain Iodine Deficiency Disorder (IDD) and VAD control activities
- Improve maternal nutrition
- Align with multi-sectoral nutrition initiatives
- Improve nutrition-related BCC
- Improve M&E for nutrition-related programmes/activities.

4. Major Strategies

- Protect, promote and support optimal feeding practices of children
- Promotion of growth monitoring and counselling
- Prevention and control of IDA among children, adolescent girls, and pregnant and breastfeeding women
- Maintaining and sustaining achievements made in programmes for prevention and control of micronutrient deficiency disorders, e.g. IDD, VAD disorders
- Control of intestinal parasitic infections
- Gradual expansion of the School Health and Nutrition activities
- Communication for changing dietary practices to improve maternal and child nutrition practices and care
- Management of acute malnutrition though facility- and community-based approaches
- Improvement of adolescent and maternal nutrition

- Alignment of the heath sector nutrition plans, policies and activities with multi-sectoral and global nutrition initiatives
- Institutional strengthening and capacity building for an effective nutrition programme
- Strengthen community participation to reach the unreached populations
- Strengthen preparedness and response capacity to address nutrition in humanitarian crises
- Establishment of an effective Nutrition Surveillance System, M&E, and research.

5. Indicators and Targets

Impact Indicators	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Under-five Mortality Rate (per 1,000 live births)	46	43.2	40.4	37.6	34.8	32
IMR (per 1,000 live births)	54	50.8	47.6	44.4	41.2	38
Neonatal Mortality Rate (per 1,000 live births)	33	30	27	24	20	16
% prevalence of stunting among under-five-year-old children	41	38.6	36.2	33.8	31.4	29
% of low birth weight babies	32	30.6	29.2	27.8	26.4	25
Outcome Indicators						
% of women with chronic energy deficiency (measured as mean BMI)	21.4	20.1	18.8	16.6	16.3	15
% prevalence of underweight among under-five-year-old children	29	27.2	25.4	23.6	21.8	20
% prevalence of wasting among under-five-year-old children	11	9.8	8.6	7.4	6.2	5
Output Indicators						
% of women who took deworming medicine during pregnancy	55.1	60	65	70	75	80
% of women who took iron tablets or syrup during the pregnancy of their last birth	79.5	81.6	83.7	85.8	87.9	90
Vitamin A distribution as % of children 6-59 months old	90.4	91	92	93	94	95
Postpartum vitamin A coverage		40				
% of severe acute malnourished children with access to therapeutic feeding services		90	90	90	90	90
% of 6-23-month-old children with access to the multiple Micronutrient Powder (MIP) supplementation		60	70	75	80	80

6. Major Challenges and Issues

- Slow scale-up and low coverage of evidence-based and cost-effective interventions, e.g. IYCF, CMAM, and multiple MIP supplementation
- Institutional strengthening for nutrition and capacity building of HWs at all levels including management capacity at the central level
- Reducing inequities in nutritional outcomes
- Weak monitoring and supervision at all levels with poor use of available data
- Maintaining and sustaining progress attained in micronutrient deficiency disorders
- Changing the behaviour of the people to promote consumption of local indigenous food, diet diversity, and nutrition-rich food, for improved nutrition outcomes for women and children
- Sustained and predictable financing for scaling up priority programmes
- Sluggish procurement process for commodities and services
- Identification of the impact/outcome of interventions such as targeted food supplementation and cash grants

Accountable Officer: Director, CHD, DoHS

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Protect, promote and support optimal feeding practices of children	Develop IYCF strategy	Nutrition Section, CHD	UNICEF, United States Agency for International Development (USAID), United Nations World Food Programme (WFP), Save the Children (SC)		X				
	Develop IYCF training manuals, guidelines and Information, Education and Communication (IEC) materials	Nutrition Section, CHD	UNICEF, USAID, WFP, SC		X				
	Provide training on IYCF counselling to HWs, community volunteers and Mothers' Groups for Health (MGHs)	Nutrition Section, CHD	UNICEF, USAID, WFP, SC		X	X	X	X	X
	Procure consultancy services to provide training	LMD	Nutrition Section, CHD		X				
	Print and distribute training manuals, guidelines and IEC materials	Nutrition Section, CHD	UNICEF, USAID, WFP, SC		X	X	X	X	X
	Celebrate breastfeeding week (1-7 August)	Nutrition Section, CHD	UNICEF, USAID, SC		X	X	X	X	X
Promotion of Growth Monitoring (GM) and counselling	Revise GM guideline as per the new WHO GM standard	Nutrition Section, CHD	UNICEF, SC		X				
	Develop community-based Growth Monitoring Promotion (GMP) guidelines	Nutrition Section, CHD	UNICEF, SC		X				

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Conduct operational feasibility research of new GM charts in four districts up to the community level	Nutrition Section, CHD	UNICEF, SC		X	X			
	Undertake national scale-up of a new GM chart based on the findings of the operational feasibility study	Nutrition Section, CHD	UNICEF, SC			X	X	X	X
	Print and distribute training manuals, guidelines and IEC materials	LMD; Nutrition Section, CHD	UNICEF, SC, USAID		X	X	X	X	X
	Provide orientation on the new GM chart and guidelines to CHWs and volunteers	Nutrition Section, CHD	UNICEF, SC, USAID		X	X	X	X	X
	Procure and distribute the Salter Scale, Mid Upper Arm Circumference (MUAC) and equipment for measuring height/length	Nutrition Section, CHD	UNICEF			X	X	X	X
Prevention and control of anaemia among children, adolescent girls, pregnant and breastfeeding women	IFA supplementation to pregnant and breastfeeding women	Nutrition Section, CHD	UNICEF, USAID, Micronutrient Initiative, SC		X	X	X	X	X
	Pilot weekly IFA supplementation to adolescent girls	Nutrition Section, CHD	UNICEF, SC			X			
	Procurement and distribution of IFA tablets and MIPs	LMD; Nutrition Section, CHD	UNICEF, WFP, MI, USAID		X	X	X	X	X
	Scaling-up of MIP supplementation to children aged 6-23 months, linked with IYCF community promotion	Nutrition Section, CHD	UNICEF		X	X	X	X	X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Refresher orientation of IFA intensification programme to CHWs, volunteers and MGHs	Nutrition Section, CHD	MI			X	X	X	X
Maintaining and sustaining achievements made in prevention and control of micronutrient deficiency disorders, e.g. IDD and VAD	Promotion of household consumption of adequately iodised salt through targeted awareness campaigns such as social marketing of "two children logo" packet salt	Nutrition Section, CHD	UNICEF, USAID, MI		X	X	X	X	X
	Celebration of "February" as "Iodine Month" nationwide for increased household consumption of adequately iodised salt	Nutrition Section, CHD	UNICEF, MI		X	X	X	X	X
	Ensure the availability and accessibility of iodised salt through close collaboration with the Salt Trading Corporation (STC)	Nutrition Section, CHD	UNICEF, STC		X	X	X	X	X
	Semi-annual supplementation (Baisakh and Kartik) of vitamin A to children aged 6-59 months	Nutrition Section, CHD	UNICEF, USAID		X	X	X	X	X
	Postpartum vitamin A supplementation, treatment in cases of prolonged diarrhoea, measles, xerophthalmia and Severe Acute Malnutrition (SAM)	Nutrition Section, CHD	UNICEF, USAID		X	X	X	X	X
	Procurement and distribution of vitamin A capsules	LMD; Nutrition Section, CHD	UNICEF, USAID, MI		X	X	X	X	X
Control of Intestinal Parasitic	Semi-annual distribution of a single dose of deworming tablet (e.g. Albendazole) to children 12-59	Nutrition Section, CHD	UNICEF, USAID		X	X	X	X	X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Infections	months old, along with mass vitamin A supplementation								
	Bi-annual distribution of a single dose of deworming tablet (e.g. Albendazole) to school children (grade 1-10)	Nutrition Section, CHD	UNICEF, USAID, Department of Education (DoE)		X	X	X	X	X
	Distribution of a single dose of deworming tablet (e.g. Albendazole) to pregnant women after completion of first trimester	Nutrition Section, CHD	UNICEF, USAID		X	X	X	X	X
	Procurement and distribution of deworming tablet (e.g. Albendazole)	LMD	Nutrition Section, CHD		X	X	X	X	X
Gradual expansion of SHN activities	Phase-wise scaling up of SHN activities in districts	Nutrition Section, CHD	UNICEF, DoE, SC, Centro Cooperazione Sviluppo Onlus (CCS Italia)		X	X	X	X	X
	Orientation training on SHN to HWs, School Resource Persons (SRPs), school supervisors and schoolteachers to improve use of SHN services (first aid kit box, deworming, IFA and physical check-ups) and health and nutrition behaviour	Nutrition Section, CHD	UNICEF, DoE, SC, CCS Italia		X	X	X	X	X
	Procurement and distribution of first aid kit box to schools	LMD	Nutrition Section, CHD, MoE		X	X	X	X	X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Improve adolescent and maternal nutrition	Develop "Health Sector Strategy for Addressing Maternal Under-nutrition"	Nutrition Section, CHD	UNICEF, USAID, Helen Keller International (HKI), WFP			X			
	Develop and pilot a package for improving adolescent and maternal nutrition based on the strategy	Nutrition Section, CHD	UNICEF, USAID, HKI, WFP				X		
	Evaluate the piloted package in terms of its cost-effectiveness and scalability	Nutrition Section, CHD	UNICEF, USAID, HKI, WFP					X	
Commun-ication for changing dietary practices for improved maternal and child nutrition practices and care	Develop a detailed communication framework for maternal infant and young child nutrition based on the strategies for IYCF, Maternal Nutrition and existing MNCH communication	Nutrition Section, CHD	UNICEF, USAID, SC, HKI, WFP			X			
	Develop, pre-test, and finalise harmonised communication materials and tools	Nutrition Section, CHD	UNICEF, USAID, SC, HKI, WFP				X		
	Print IEC materials related to the nutrition programme	Nutrition Section, CHD	UNICEF, USAID, SC, HKI, WFP					X	X
	Develop and disseminate messages about the consumption of an adequate diversified diet through the promotion of locally available food rich in iron and vitamin A with improved care and practices for Maternal, Infant and Young Child Nutrition (MIYCN)	Nutrition Section, CHD	UNICEF, USAID, SC, HKI, WFP						X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Management of acute malnutrition through facility- and community-based approaches	Phase-wise scaling up of CMAM and training to district, CHWs, volunteers and MGHs	Nutrition Section, CHD	UNICEF, WFP, SC, Partners		X	X	X	X	X
	Establish and strengthen hospital-based rehabilitation and NRHs for SAM cases	Nutrition Section, CHD	UNICEF, Partners		X	X	X	X	
	Integrate NRH, WASH, ECD and IYCF activities into CMAM programme components	Nutrition Section, CHD	UNICEF, WFP, ACF, SC, NYF			X	X	X	
	Formulate national Management of Acute Malnutrition (MAM) guidelines and integrate with CMAM to develop an integrated training package	Nutrition Section, CHD	WFP, UNICEF, Patan Academy of Health Sciences (PAHS), ACF, NYF		X				
	Procurement and distribution of RUTFs, formula milk (F-75), Rehydration Solution for Malnutrition (ReSoMal) and essential drugs and commodities	LMD; Nutrition Section, CHD	UNICEF, ACF, SC		X	X	X	X	X
Align health sector nutrition plan, policies and activities with multi-sectoral and global nutrition initiatives	Active participation in global Scaling Up Nutrition (SUN) Movement, Reach Every District (RED) and multi-sectoral nutrition initiatives	NPC; CHD	UNICEF		X	X	X	X	
	Align health sector nutrition activities with the NPC's MSNP	NPC	CHD, UNICEF, WFP, USAID, SC, WHO			X	X	X	
	Review and revise the Nutrition Policy and Strategy 2004	Nutrition Section, CHD	UNICEF, WFP, USAID, SC, WHO			X			

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Formulate a multi-year costed health sector nutrition plan in accordance with the revised Nutrition Policy and Strategy	Nutrition Section, CHD	UNICEF, WFP, USAID, SC, WHO			X			
	Build capacity and strengthen the district- and village-level Multi-Sectoral Nutrition and Food Security Steering Committee	NPC	CHD, UNICEF, WFP, USAID, SC, WHO			X	X	X	
	Finalise and disseminate national food-based dietary guidelines	Nutrition Section, CHD	Department of Food Technology and Quality Control (DFTQC), UNICEF, WHO			X			
Institutional strengthening and capacity building for effective nutrition programme	Design and conduct an Organisation and Management (O&M) assessment for establishing a National Nutrition Centre (NNC)	Nutrition Section, CHD	NHSSP			X			
	Review and revise health sector institutional arrangements at all levels in line with existing health policy and the NNC	Nutrition Section, CHD	NHSSP			X	X		
	Approve and establish the organisational structure of the NNC	Nutrition Section, CHD	NHSSP				X		
	Fill the allotted positions according to the NNC's approved organisational structure	Nutrition Section, CHD	NHSSP				X	X	
	Formulate a capacity development plan based on the O&M assessment and the NNC organisational	Nutrition Section, CHD	NHSSP					X	

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	structure								
	Review and revise various existing nutrition training materials and curricula (pre-service and in-service)	Nutrition Section, CHD	UNICEF, WHO, WFP, SC, USAID				X		
	Based on findings of the curriculum review of health cadres and a capacity needs assessment, integrate essential nutrition components (IYCF, CMAM, adolescent girls and pregnant and breastfeeding women) in pre- and in-service training curricula	Nutrition Section, CHD	UNICEF, WHO, WFP, SC, USAID					X	
	Network and link with key international/national vocational and academic institutions for improved nutrition programme advocacy, technical support, and knowledge and experience sharing	Nutrition Section, CHD	UNICEF, WHO, WFP, SC, USAID, Tufts, Johns Hopkins University (JHU)			X	X	X	X
	Review the existing job descriptions of health personnel in line with the revised Nutrition Policy and Strategy and MSNP	Nutrition Section, CHD	NHSSP			X			
	Procure essential office equipment for the nutrition programme	LMD; Nutrition Section, CHD	UNICEF, WFP, USAID, SC		X	X	X	X	X
	Strengthen the Nutrition Technical Committee (NUTEC)	Nutrition Section, CHD	UNICEF, WFP, USAID, SC		X	X	X	X	X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Procure consultancy services to recruit for the national-level programme coordinators i.e. SHN, MCHC and Nutrition; transport of nutrition-programme-related commodities to programme districts	LMD; Nutrition Section, CHD				X	X	X	X
Strengthen community participation to reach the unreached populations	Map the district to identify the underserved, unreached, and disadvantaged populations	Nutrition Section, CHD	NPC, UNICEF, WFP			X			
	Develop and implement a plan based on the mapping	Nutrition Section, CHD	NPC, UNICEF, WFP				X		
	Revitalise and mobilise MGHs and Primary Health Care (PHC)/Outreach Clinic (ORC) for improved nutrition, dietary intake, care and practices	Nutrition Section, CHD	NPC, UNICEF, WFP				X	X	X
Strengthen preparedness and response capacity to address nutrition in humanitarian crises	Finalise and disseminate the Nutrition Cluster Contingency Plan for earthquake and flood scenarios	Nutrition Section, CHD	UNICEF, Nepal Red Cross Society (NRCS), WFP, WHO, USAID, SC, HKI, partners			X			
	Build capacity of HWs and stakeholders at all levels as per the contingency plan	Nutrition Section, CHD	UNICEF, NRCS, WFP, WHO, USAID, SC, NYF, ACF				X	X	X
	Procure and preposition essential drugs and commodities in identified places	UNICEF, WHO	CHD, NRCS, WFP, USAID, SC, partners			X	X	X	X

Major Strategies	Major Activities	Responsibilities	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop and implement a guideline for IYCF in emergencies	Nutrition Section, CHD	UNICEF, WHO, WFP, USAID			X			
Establish effective Nutrition Surveillance System, M&E, and research	Follow up and monitor: IYCF, GMP, MIP, IFA supplementation, IDD and VAD prevention and control programme, CMAM and NRH programmes	Nutrition Section, CHD	UNICEF, USAID, WFP, WHO, SC, HKI, partners		X	X	X	X	X
	Conduct the second National Micro-nutrient Status Survey (NMSS)	Nutrition Section, CHD	UNICEF, USAID, Centers for Disease Control and Prevention (CDC Atlanta), WFP			X	X		
	Establish a Nutrition Surveillance System in selected areas/regions	Nutrition Section, CHD	UNICEF, WHO, Tufts, JHU, WFP, HKI			X	X	X	X
	Strengthen and build capacity training on nutrition surveillance and nutritional information systems for different levels of HWs	Nutrition Section, CHD	UNICEF, WHO, Tufts, JHU, WFP, HKI				X	X	X
	Develop and integrate the M&E framework to ensure effective programme implementation	Nutrition Section, CHD	UNICEF, WFP, WHO, USAID, SC, HKI, partners				X		

2.4 Safe Motherhood Programme

1. Introduction

Global evidence shows that all pregnancies involve risk, and complications during pregnancy, delivery, and the postnatal period are difficult to predict. Experience also shows that three key delays are of critical importance to the outcomes of an obstetric emergency: (1) delay in seeking care, (2) delay in reaching care, and (3) delay in receiving care. To reduce the risks associated with pregnancy and childbirth, the SM Programme has made significant progress in terms of developing policies and protocols as well as expanding the role of service providers such as staff nurses and Auxiliary Nurse Midwives (ANMs) in life-saving skills. The Policy on Skilled Birth Attendants (SBAs), endorsed in 2006 by MoHP, specifically identifies the importance of skilled birth attendance at every birth and embodies GoN's commitment to training and deploying doctors and nurses/ANMs with the required skills across the country.

The revised SM and Neonatal Health Long-term Plan (SMNHLTP) 2006-2017 includes the following: recognition of the importance of addressing neonatal health as an integral part of SM programming; the policy for SBAs; health sector reform initiatives; legalisation of abortion and the integration of safe abortion services under the SM umbrella; addressing the increasing problem of mother-to-child transmission of HIV/AIDS; and recognition of the importance of equity and access efforts to ensure that the neediest women can access the services they need.

The current low level of care at childbirth, including care for women with complications, must improve in order for the MMR to decline further. GoN will continue to offer free delivery services at hospitals, PHCCs, Health Posts (HPs) and selected Sub-Health Posts (SHPs), and selected non-government facilities. Transport and provider incentives will continue to be paid for women delivering with an SBA or in a facility. The incentive to SBAs for home delivery has been reduced to ensure that there is no disincentive to institutional delivery.

The IP has been prepared by embedding the activities under the following strategies and measures included in NHSP-2:

- Further strengthening the community-based support organised through FCHVs, including mothers' groups and birth planning. Particular stress will be placed on identifying danger signs, strengthening the referral links, and reducing the immediate financial constraints that inhibit women from travelling to a facility by encouraging mothers to save funds for transport in preparation for the birth, and establishing or expanding the emergency funds that FCHVs manage on behalf of the community. These funds are quite distinct from the FCHV revolving fund, although one possible use for expanded FCHV revolving funds could be for loans to meet the up-front costs of reaching a facility, given the delays that have been experienced in payment of the transport allowance extended to women delivering in a HF.
- Training of SBAs will be expanded in line with the National In-Service Training Strategy for SBAs, which estimated that achieving MDG 5 would require 60% of births to be attended by an SBA. To achieve this target, 4,573 SBAs will be needed by 2012, and 7,000 by 2012, allowing for attrition. The MoHP will provide some kind of SBA training and/or orientation to approximately 5,000 nurses and doctors by that date, and will ensure their proper placement in relation to need. The precise form of training will depend on an assessment of current skills against the competencies defined in the training strategy.
- To encourage increased institutional delivery, investment in Basic Emergency Obstetric Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC) will continue towards national coverage. This investment will be planned alongside training and deployment of the necessary staff teams to ensure that facilities can be brought into operation. When NGO or private facilities with the capacity to provide CEOC are available in locations where there are currently

no public facilities able to do so, consideration will be given to negotiating a PPP to secure the required CEOC coverage through a contract with the non-government facility.

- An additional 1,000 SHPs will be upgraded to HPs with the addition of birthing units.
- In areas with poor physical access to facilities, community-based administration of misoprostol will be implemented as a supplement to reduce the risk of Post-partum Haemorrhage (PPH).
- Based on the Blood Policy, 1991 (Revised in 2006) and the Strategic Plan (2009-2013), coordination among existing blood centres will be strengthened and expanded, HR skills will be strengthened, and quality will be ensured through an accreditation process by NPHL/NRCS, in addition to other interventions.

2. Goal

To improve maternal and neonatal health and survival, especially of the poor and excluded.

3. Objective

Increased healthy practices and utilisation of quality maternal and neonatal health services, especially by the poor and excluded.

4. Major Strategies

1. Strengthening and expansion of maternal and newborn health care services to improve coverage and quality of services
    - Strengthening and expansion of Comprehensive Emergency Obstetric and Neonatal Care (CEONC) services
    - Strengthening and expansion of birthing centres at PHCC, HP and SHP levels
    - Expansion of safe surgical and Medical Abortion (MA) services
    - Expansion of *Adolescent Sexual and Reproductive Health (*ASRH) Programme (1,000 HFs)
    - Screening for uterine prolapse through Reproductive Health (RH) camps
    - Management of uterine prolapse in static (hospitals) and mobile settings
    - Revise/develop (as required) and implement RH and SM-related guidelines and protocols
    - Develop a mechanism for quality monitoring
    - Strengthening the referral system, including Emergency Obstetric Care (EOC) referral funds for remote districts
    - Other RH services (fistula, cancer screening).

2. Enhancing the capacity of service providers and managers at different levels (Advanced Skilled Birth Attendants (ASBAs), SBAs, Public Health Nurses (PHNs) to provide various services, such as Intrauterine Contraceptive Devices (IUCDs), implants, Ultrasonogram (USG), medical/surgical abortion, etc.
    - Local recruitment of HR to provide CEONC and birthing centre services
    - Advocate and implement development of service providers for CEONC (Doctor of Medicine General Practitioner (MDGP), Diploma in Gynaecology and Obstetrics (DGO), Anaesthetic Assistant (AA))
    - Strengthen and expand the community Maternal and Neonatal Health (MNH) Programme including community mobilisation and the FCHV Programme
        - Prevention of PPH through misoprostol especially in remote areas
        - Equity and Access Programme (EAP) through PHCRD
    - Promoting BCC
    - Coping with excess demand for institutional delivery
    - Fostering PPPs
    - Strengthening the Aama Programme and integration with the incentive for four Antenatal Clinic (ANC) visits
    - Fostering coordination and collaboration

- Research and M&E to improve quality and service delivery
- Strategies to improve governance and accountability and to mainstream GESI.

5. Indicators and Targets

Health Outcome and Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
MMR (maternal deaths per 100,000 live births)	170 (UN estimate)	229	229	192	160	134
Neonatal Mortality Rate (neonatal deaths per 1,000 live births)	33 (NDHS 2011)	30	28	23	19	16
Obstetric case fatality rate (%)	<1	<1	<1	<1	<1	<1
% of HPs providing delivery service	79 (Annual Report 2010/11)	85 (current)	>80	>80	>80	>80
% of PHCCs providing BEOC service, including Comprehensive Abortion Care (CAC)	53.6 (Annual Report 2010/11)	>50	>50	>50	60	70
% of districts with at least one facility providing all CEONC services	57.3 (Annual report 2010/11)	60	64	68	72	76
% of women with knowledge about the abortion sites	19 (NDHS 2006)	58.8 (NDHS 2011)	25	35	40	50
% of women having had an abortion who experienced complications	14 (2009)	12	11	10	8	7
% of safe abortion (surgical and medical) sites with long-acting FP service		>80	>85	>90	>90	>90
% of deliveries assisted by SBAs	18.7 (NDHS 2006)	36 (NDHS 2011)	38	40	54	60
% of births which are institutional deliveries	18 (NDHS 2006)	35 (NDHS 2011)	36	37	38	40
% of pregnant women completing at least four ANC visits during pregnancy	35.2 (2008 Health Management Information System (HMIS))	57 (NDHS 2011)	60	65	72	80
% EOC need met	31 (2008/9 HMIS)	34	35	43	47	49
% of births delivered by Caesarean Section (CS)	3.6 (2008/9 HMIS)	4.6 (NDHS 2011)	4.0	4.3	4.4	4.5

6. Major Challenges and Issues

- Shortage of service providers at both hospitals (especially CS providers) and peripheral levels
- Single- (fiscal-) year contracts for HR and services

- Problems in continuity of service delivery owing to frequent transfer of staff
- Low level of awareness of mothers regarding transport incentives (70% in 2010)
- Insufficient number of ASBAs and SBAs (4,543 SBAs needed by 2012, 7,000 by 2015)
- Weak monitoring of the Aama programme (institutional delivery) including the private sector
- Ensuring quality services
- Expanding Aama programme and quality monitoring in private hospitals
- Coping with excess demand for institutional delivery at tertiary level
- Low utilisation of lower-level health facilities for childbirth
- Institutionalising the management of uterine prolapse

Accountable Officer: Director, FHD, DOHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Strengthen and expand maternal and newborn health care services to improve coverage and quality of care	Strengthening and expansion of CEONC services	SM Section	Partners		X	X	X	X	X
	Strengthening and expansion of birthing centres at HP and SHP levels	SM Section	Partners		X	X	X	X	X
	Expansion of surgical and medical safe abortion services a) Surgical and medical services (integrated in hospitals and PHCCs) b) Expansion of MA only in phase-wise manner in HPs with SBAs	SM Section	Inter-national Pregnancy Advisory Services (Ipas) and partners	Surgical scaled up in 75 districts MA piloted in 6 districts 10 districts	Monitoring Integrated MA in 75 districts 6 districts	Monitoring 5 districts	Monitoring 4 districts	Monitoring X	Monitoring X
	Expansion of the ASRH Programme (1,000 HFs)	Family Planning (FP) Section	GIZ and partners		X	X	X	X	X
	Revise/develop (as required) and implement RH-/SM-related guidelines and protocols	FP/SM Section	Partners		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop mechanisms for quality monitoring	FP/SM Section	Partners		X	X	X	X	X
	Strengthening the referral system including the EOC referral fund for remote districts				X	X	X	X	X
	Screening for uterine prolapse through RH camps	Uterine Prolapse (UP) Section	United Nations Population Fund (UNFPA), WHO			X	X	X	X
	Management of uterine prolapse in static (hospitals) and mobile settings	UP Section	UNFPA, WHO	X	X	X	X	X	X
	Initiate other RH services (fistula, cancer screening)	FHD	Partners			X	X	X	X
Enhance the capacity of service providers and managers at different levels	ASBA training (target for two per site including attrition)	SM Section; NHTC	Partners	30	40	40	40	40	40
	SBA training	SM Section; NHTC	Partners	1,000	1,000	1,000	1,000	1,000	1,000
	IUCD training (in PHCCs and HPs, including upgraded SHPs)	FP/SM Section; NHTC	Partners	304 (status)	402	402	402	402	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Implant training (in PHCCs and HPs, including upgraded SHPs)	FP/SM Section; NHTC	Partners	168 (status)	431	431	431	431	
	USG training	SM Section; NHTC	Partners		X	X	X	X	X
	PHN capacity building	SM Section	Partners		X	X	X	X	X
	Operating Theatre (OT) management training (target for three per site)	SM Section; NHTC	Partners		X	X	X	X	X
	Medical/surgical abortion training	SM Section; NHTC	Ipas/ Partners: Medical (HP and PHCC); Surgical (Manual Vacuum Aspiration (MVA)	145 300	X 116 300	X 93 300	X 89 300	X X 300	X X 300
	Develop capacity of region- and district-level on SM, FP and ASRH including GESI mainstreaming	SM Section	Ipas/ partners			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Local recruitment of HR for CEONC and birthing centre services	CEONC fund for districts	SM Section	Partners	24	26	28	30	30	30
	ANM Staff Nurse (SN)				900 50	1,200 60	1,400 70	1,500 70	1,500 70
	Recruitment of supervisors for monitoring of SM Programme (six persons)	Demography Section	Finance Section		6	6	6	6	6
Advocate and implement the development of CEONC service providers	MDGP	FHD	Nick Simon Institute (NSI)						
	DGO training	FHD	National Academy for Medical Science (NAMS)		10	12	15	15	15
	AA Training	FHD/NHTC	NAMS			15	15	15	15
Strengthen and expand the community-based MNH Programme including FCHV community mobilisation	Prevention of PPH through misoprostol, especially in remote areas of districts	FHD	Partners		23	25	28	30	30
	Birth Preparedness Plan implementation	FHD	Partners		X	X	X	X	X
	Implement EAP through PHCRD in districts				20	20	25	30	35

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	RH referral by FCHVs in districts		Ipas	10	6	5	4	X	X
Promote BCC	Develop messages on SM and newborn care	SM Section	NHEICC/ NGOs	X	X				
	Air messages on SM, newborn care services, and the transport incentive to mothers	SM Section	NHEICC/ NGOs Ipas	10	6	5	4	X	X
	Implement information/ awareness/advocacy campaigns for youth and adolescents	FP Section	NHEICC, UNFPA, WHO, UNICEF, INGOs, Ipas	10	6	5	4		
	BCC focusing on husbands, mothers-in-law, and decision makers	SM Section	NHEICC/ partners	X	X	X	X	X	X
	Air messages on management of uterus prolapse	UP section	NHEICC	X	X	X	X	X	X
Cope with excess demand for institutional delivery	Develop a coping strategy for excess demand for institutional delivery	SM Section	NHSSP and partners	X	X				
	Establish large birthing centres at referral hospitals	SM Section	NHSSP and partners		X	X	X	X	
	Promote local-level planning for excess demand for institutional delivery	SM Section	NHSSP and partners		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Build a referral system to discourage bypassing	SM Section	NHSSP, UNICEF and partners			X	X	X	X
Promote PPPs	Implement PPP for CEONC services, Aama, uterine prolapse, safe abortion services	All Sections	SM partners, Ipas	10	6	5	4	X	X
Strengthen the Aama programme and integrate with the incentive for four ANC visits	Integrate 4 ANC visits with the Aama programme	Director	NHSSP/ WHO/ UNFPA		X				
Foster coordination and collaboration at central and district levels	RHCC and sub-committee meetings (districts)	Director	All partners, Ipas	10	6	5	4	X	X
	RH planning and review meetings	Director	All partners	X	X	X	X	X	X
	Regular monitoring	Demography Section	UNFPA, WHO, UNICEF, INGOs, Ipas	X	X	X	X	X	X
Research and M&E to improve quality and service delivery	Integration of EOC and Aama monitoring in HMIS	Demography Section	SM partners	X	X	X	X	X	X
	Rapid assessment of Aama Surakchha Programme by NGOs/private organisations	Demography Section	SM partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Recruitment of supervisors for monitoring SM programme (six persons)	Demography Section	Finance Section	X	X	X	X	X	X
	Study on GBV, trends, level, protection against, and the impact on FP and SM	Demography Section	Population Division			X		X	
	Monitoring and supervision of the RH Programme	Demography Section	Ipas/ partners	X	X	X	X	X	X
	Data analysis and report writing of maternal mortality sentinel districts	Demography Section	Partners	X	X	X	X	X	X
	Internet service, web hosting and updating	Demography Section	Partners	X	X	X	X	X	X
	Evaluation of ASRH and UP programmes	Demography Section			X UP		X ASRH		
	Conduct a feasibility study on the appropriateness of misoprostol for treatment of incomplete abortion in the Nepal context		Ipas		X				
	Evaluation of nurses as CAC service providers		Ipas	X		X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Evaluation of SBA-trained ANMs as MA service providers		Ipas		X				
	Post Abortion Care (PAC) monitoring		Ipas		X	X	X		
	RH planning and review meetings	FHD	Ipas/ All partners	X	X	X	X	X	X

2.5 Family Planning Programme

1. Introduction

The main aim of the FP Programme is to improve the health status of mothers and children and to improve the overall quality of family life by fulfilling the FP needs of individuals and couples throughout Nepal. To address the aim of the FP Programme, MoHP has committed to provide quality FP services to all individuals and couples through the health service network, including hospitals, PHCCs, HPs, SHPs, PHC/ORCs and mobile Voluntary Surgical Contraception (VSC) services. In addition, FP services are available through NGOs, private clinics, and social marketing initiatives; FCHVs also provide information, distribute condoms, and re-supply oral pills. Various BCC approaches are being implemented at different levels to make individuals and couples aware of the importance of FP, healthy timing and spacing for pregnancy, the concept of a well-planned family, and contraceptive methods.

FP has been proven to reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of high-risk births. It also helps reduce child mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development and protect the environment. International studies have repeatedly confirmed that FP is one of the most cost-effective of all health services. Investing in FP can result in large savings to the health and education sector and help countries to achieve development goals. Thus, attention to FP has recently been increasing worldwide.

Nepal has achieved significant progress in reducing the TFR, and the adolescent fertility rate, increasing knowledge about FP methods and birth intervals. The Contraceptive Prevalence Rate (CPR) and method mix have improved. However, the CPR has stalled within the last five years (2006-2011). Progress on fertility and FP is uneven. A high unmet need for FP remains among certain groups such as adolescents, residents of rural and hilly areas, the eastern development region, and the western hills, poor communities, and, unexpectedly, among educated groups. The last decade has seen a high rate of out-migration, especially among men of reproductive age.

To address these gaps, MoHP/FHD has recently developed the new FP Strategy 2068. The current strategy focuses on increasing access of quality FP services in rural and marginalised communities. It implements a focused FP programme to fulfil the needs of special groups like post-partum mothers, post-abortion clients, migrants, and adolescents. In addition, the strategy works to integrate FP into other health services like MCH and HIV/AIDS.

2. Goal

To improve the health status of mothers and children and improve the overall quality of life of the entire family through increasing the accessibility, availability and utilisation of quality FP services for individuals and couples.

3. Objectives

- To increase access and use of quality FP services that are safe, effective and acceptable to individuals and couples. Special focus will be given to increase access to those regions where rural, poor, Dalit, other marginalised people and groups with high unmet needs live.

- To create an enabling environment for increasing access to quality FP services for men and women.
- To increase the demand for FP services by conducting various BCC activities.

4. Major Strategies

- Emphasise the provision of quality FP services, including the ability of men and women residing anywhere in Nepal to make an informed choice based on facts and comprehensive information
- FP services will be made available through government, private, NGO and social marketing initiatives. The role of the private sector in providing FP services will be encouraged
- Establish FP as a reproductive right of men and women
- Increase access to and availability of FP services
- Enhance the effective integration of FP with other health services
- Implement various activities to develop the capacity of service providers and managers
- Establish an effective logistic management system to ensure the regular availability of FP services
- Initiate various innovative approaches to engage men in FP services
- Implement various BCC activities to enhance the general public's decision-making capacity to accept FP methods based on facts and knowledge
- Implement focused programmes to fulfil the FP needs of special groups and communities living in areas of high unmet need
- Promote BCC by using multiple channels
- Train care providers
- Continue micro-planning in low CPR districts
- Increase the availability of five methods (condoms, Pills, Depo-provera, IUCD, implants) in all service centres
- Integrate FP services with health care and non-health services
- Reduce the barriers to clients in accessing services
- Promote PPPs
- Target FP to educated and better-off groups
- Fostering coordination and collaboration.

5. Indicators and Targets

Indicators and Outputs	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
TFR	3	2.9	2.8	2.7	2.6	2.5
CPR (%)	48	50	52	54	56	67
% unmet need for contraception (15-19)	27	25	20	20	19	18
VSC	63,000	70,000	70,000	70,000	70,000	70,000
IUCD	23,000	44,800	58,000	64,000	70,500	77,000
Implant	28,000	60,000	63,000	66,000	73,000	80,000
No. of districts providing regular VSC services	21	30	45	55	70	70
No. of PHC/HPs providing	422	600	900	1,200	1,200	1,500

IUCD services						
No. of PHC/HPs providing implant services	318	500	900	1,200	1,200	1,500

6. Major Challenges and Issues

- Stagnant CPR over the last five years
- Unequal use of FP between urban and rural, rich and poor, tarai and mountain regions, and among various ethnic groups
- Need to fulfil the FP needs of special groups: adolescents, the poor, rural and mountainous communities, post-partum and post-abortion women, spouses of migrants
- Integration of FP services with other health services such as immunisation, MCH, HIV/AIDS and general health services
- High percentage of women with husbands away from home.

Accountable Officer: Director, FHD, DOHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Promote BCC through multiple channels	Airing messages on delayed marriage, birth spacing, and a well-planned family norm	FP Section: FHD	NHEICC	X	X	X	X	X	
	Developing and implementing a BCC framework targeting educated and better-off people	FP Section	NHEICC		X	X	X	X	
Improve the Quality of Care (QoC)	Strengthening counselling, infection prevention, and management of side effects and complications	FP Section	Partners		X	X	X	X	
	Providing training on QoC	FP Section	Partners			X	X	X	X
	Recanalisation after vasectomy	FP Section	Partners			X	X	X	
	Complication management	FP Section	Partners			X	X	X	X
	Forecasting of requirements for contraceptives and logistic supplies	FP Section	LMD, partners		X	X	X	X	X
Increase the availability of five FP methods in all service centres	Procurement and supply of contraceptives	FP Section	LMD, partners		X	X	X	X	
	Conducting regular year-round mobile VSC outreach services	FP Section	FPAN, MSI/ Sunaulo Pariwar Nepal (SPN)		X	X	X	X	X
	Providing recanalisation services in selected hospitals	FP Section	Curative Division		X	X	X	X	X
	Continuing the post-partum FP service	FP Section	Partners		X	X	X	X	
Continue micro-planning in low-CPR	Expanding IUCD/implantation services to PHCs and HPs	FP Section	Partners		X	X	X	X	X
	Promoting wider use of Health	FP Section	HMIS		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
districts; Target FP to educated and better-off people	Management Information Systems (HMISs) in low-CPR districts								
	Conducting micro-planning in low-CPR districts	FP Section	CHD		X	X	X	X	
	Developing and implementing a special programme of FP for educated groups	FP Section	Partners		X	X	X	X	X
	Distribution of better-quality contraceptives through campuses, shopping malls, department stores	FP Section		X	X	X	X	X	X
Integrate FP- and population-related services	Integrating FP services with safe abortion care, post-partum care, Ayurvedic care and EPI clinics	FP Section	MoHP	X	X	X	X		
	Strengthening Institutionalised FP Service Centres (IFPSCs)	FP Section	Hospitals		X		X		X
	Introducing VSC services in district hospitals and PHCCs (year-round)	FP Section				X	X	X	
	Implementing population-related activities	Population Division			X	X	X	X	X
	Integrating population- and FP-related activities	Population Division					X	X	X
	Developing and implementing a population management plan	Population Division			X	X	X	X	X
	Enhancing multi-sectoral coordination of population-related programmes	Population Division			X	X	X	X	X
Train care providers	Training service providers on IUCD, implant, Non-surgical Vasectomy (NSV) and minilaparotomy	FP Section	NHTC		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Institutionalising policy/operational guidelines and clinical protocols	FP Section			X	X	X	X	
Reduce the barriers to clients	Introducing FP in the school curriculum	FP Section	CDC Atlanta, MoE		X	X			X
	Supporting the development of 1,000 "youth-friendly centres"	FP Section			200	200	200	200	200
Foster coordination	Coordinating the FP programme and activities through RHCC networks, including the Family Planning Sub-Committee meetings	FP Section	RHCC	X	X	X	X	X	X
Promote PPP	Developing a state and non-state partnership framework for FP service delivery (focusing on I/NGOs)	FP Section	RHCC		X	X			
	Developing a PPP modality to run the Family Welfare Centre (Chetrapati)	FP Section	RHCC		X	X			
Monitor FP services	Conducting periodic policy reviews through national RH Steering Committee meetings	FP Section	HMIS		X	X	X	X	X
	Conducting district, regional and national reviews of the FP Programme (RH review)	FP Section	HMIS	X	X	X	X	X	X
	Providing intensive monitoring and facilitative supervision in low-CPR districts	FP Section			X	X	X	X	X

2.6 Adolescent Sexual and Reproductive Health Programme

1. Introduction

Improving the Sexual and Reproductive Health (SRH) of adolescents through the health sector has been of strategic importance for more than a decade; most recently this has received programmatic attention from the FHD. The NDHS surveys show a positive trend over the past two decades regarding marriage patterns and maternity during adolescence. The mean age at marriage of girls has increased from 16.4 years in 1996 to 17.8 years in 2001, and the percentage of adolescent girls aged 15-19 who are already married has declined from 44% in 2006 to 29% in 2011. This has resulted in a decline of the percentage of adolescents who have begun childbearing, from 24% in 1996 to 17% in 2011. Nevertheless, reducing the age of marriage and motherhood during adolescence remains a crucial issue, requiring a sustained and multi-sectoral approach. The extremely low CPR among currently-married adolescent girls (only 14.4% in 2011) and the equally high (40%) unmet need for contraception in this age group also reflect this.

MoHP in 1998 issued the RH Strategy and Plan, which clearly states that ASRH is a major component of RH. Subsequently, in order to meet this strategic objective, FHD developed the National Adolescent Health and Development (NAHD) Strategy in 2000, included ASRH in the EHCS package, and in 2007 produced the "Implementation Guidelines on ASRH" for district health managers.

In 2010, FHD finalised the National ASRH Programme as a health sector response to addressing adolescents' RH needs. This programme has at its core the introduction of Adolescent-friendly Services (AFS) and aims for the establishment of 1,000 AFS centres by 2015 as outlined in NHSP-2. The programme will improve existing clinical services in the fields of safe abortion, FP, maternal and child health care, and HIV and STI prevention and treatment, with a view of making them more accessible to adolescents. The programme will be scaled up by FHD with the support of EDPs throughout the country. The ASRH Programme essentially consists of:

- Upgrading 13 PHC facilities (SHPs, HPs, PHCCs and district hospitals) per district to offer AFS, and creating demand for the services in the communities
- Equipping HFs with basic equipment to provide private and confidential services to adolescents
- Providing HWs with a job aid on ASRH, a counselling flipchart on ASRH, and IEC materials (eight booklets) developed by NHEICC
- Involving adolescents in the decision making of respective HFs' Health Facility Operation and Management Committees (HFOMCs) for adolescent issues
- Providing appropriate SRH services to adolescents (FP, HIV and STI services, abortion) and recording service utilisation.

The ASRH programme includes orientations outlining the respective responsibilities and tasks in terms of management, service provision, and demand creation for the following key implementing stakeholders:

- District health managers
- District key actors (RHCC)
- HFOMCs
- Health care providers.

ASRH has so far been a sub-component of the "Health Communication Strategy for Family Planning, Maternal and Child Health" (2005-2009), but will be given more specific strategic attention in the ASRH Communication Strategy to be developed by NHEICC. This will emphasise the new programmatic focus that FHD has given to this health issue and will provide more specific guidance for communication to address the knowledge gaps of adolescents, to increase service demand, and to sensitise parents,

households, and communities in order to provide a supportive environment for adolescents to lead a healthy life.

At the end of 2015, evidence on the effectiveness of the ASRH Programme in terms of the utilisation of health services by adolescents, their satisfaction with these services, and their knowledge, attitudes and practice regarding SRH will be available from an impact evaluation conducted by FHD with approval from NHRC.

2. Goal

To promote the SRH of adolescents.

3. Objectives

- To increase the availability of and access to information about adolescent health and to provide opportunities to build the skills of adolescents, service providers and educators.
- To increase the accessibility and utilisation of health and counselling services for adolescents.

4. Major Strategies

- Scaling up the national ASRH Programme to introduce AFS in the remaining districts
- Promoting BCC, targeting adolescents and their social environments
- Capacity building
- Increase cooperation with MoE to improve comprehensive sexuality education.

5. Indicators and Targets

Health Outcome and Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Adolescent Fertility Rate (AFR) (per 1,000)	98 (NDHS 2006)	90	85	82	80	70
% unmet need for contraception (15-19)	34.7 (NDHS 2006)	30	27	25	22	20
Number of health facilities offering AFS	-	100	200	200	200	300

6. Major Challenges and Issues

- Changing cultural and social reasons for early marriage and childbearing
- Reducing cultural and social barriers for unmarried adolescent girls to access contraception and safe abortion services
- Ensuring access to AFS for marginalised adolescent girls and boys.

Accountable Officer: Director, FHD, DOHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Scaling up the ASRH Programme	Implement the ASRH Programme in 1,000 HFs in 75 districts	ASRH Section	GIZ, UNICEF, UNFPA, WHO	X	X	X	X	X	X
	Link the ASRH Programme with the ASRH component of the local population management programme (peer education)	ASRH Section	Population Division	X	X	X	X		
	Supervision of existing AFS	ASRH Section	GIZ, UNFPA, UNICEF, WHO, INGOs	X	X	X	X	X	X
	Demand creation for AFS	ASRH Section	GIZ, UNICEF, UNFPA	X	X	X	X	X	X
Promoting BCC	Develop an ASRH Communication Strategy and IP	ASRH Section	NHEICC/ GIZ, UNFPA, UNICEF, WHO, INGOs	X	X				
	Develop a mass media campaign with key messages on ASRH, targeting adolescents and their social environment	ASRH Section	NHEICC/ GIZ, UNFPA, UNICEF, WHO, INGOs			X	X	X	X
	Implement an ASRH mass media campaign	ASRH Section	NHEICC/ GIZ, UNFPA, UNICEF, WHO, INGOs	X	X	X	X	X	X
	Assess and design interventions based on using modern technologies for reaching adolescents	ASRH Section	NHEICC		X	X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Capacity building	Orientation on the ASRH Programme for district managers	ASRH Section	GIZ, UNFPA, UNICEF, WHO, INGOs	X	X	X	X		
	Orientation on the ASRH Programme for district stakeholders	ASRH Section	DHOs	X	X	X	X		
	Orientation on the ASRH Programme for HFOMCs	ASRH Section	DHOs	X	X	X	X		
	Orientation on the ASRH Programme for service providers	ASRH Section	DHOs	X	X	X	X		
Research and M&E	Regular monitoring of district reports	ASRH Section	UNFPA, WHO, UNICEF, INGO	X	X	X	X	X	X
	Conduct impact evaluation of the ASRH programme	ASRH Section	GIZ	X		X	X		

2.7 Female Community Health Volunteers Programme

1. Introduction

Recognising the importance of women's participation in promoting health, GoN initiated the FCHV Programme in Fiscal Year (FY) 2045/46 (1988/1989) in 27 districts, and in a phased manner has expanded to all of Nepal's 75 districts. Initially, the approach was to select one FCHV per ward regardless of the population size. In 1993 a population-based approach was introduced in 28 selected districts. At present there are 48,489 FCHVs actively working in VDCs all over the country.

The FCHVs' major role is to improve the health and healthy behaviour of mothers and community members by promoting SM, child health, FP, and other community-based health services with the support of health personnel from the SHPs, HPs, and PHCCs. As well as motivating and educating, the FCHVs re-supply pills and distribute condoms, ORS packets and vitamin A capsules. They treat pneumonia cases and refer more complicated cases to health institutions. They also distribute iron tablets to pregnant women in districts with Iron Intensification Programmes. Various policies, strategies, and guidelines have been developed to strengthen the programme.

FCHVs provide their services voluntarily, thus their performance depends on the support they receive. MGHs are responsible for the selection and removal of FCHVs, and also for supporting FCHVs in their work. Interested women from marginalised, oppressed, and backward communities will be promoted to become MGH members. Generally, every VDC ward will have at least one FCHV, and when selecting new FCHVs priority will be given to women from Dalit, Janajati and marginalised communities.

The success of the FCHV Programme has resulted in more responsibilities being given to FCHVs. This trend raises the issue of how to continue to motivate what remains a cadre of volunteers. Arguably, the commitment to voluntary community service is what makes the FCHVs so effective, and the same level of results would not be achieved if delivered by an equivalent force of poorly paid public employees. Training and recognition of the importance of their work are strong motivating forces for many. A balance should be struck between compensating the women for the real financial and time costs they incur in carrying out their duties, and not losing the spirit of voluntary service. FCHVs do receive a flat per diem rate for their participation in vitamin A distribution, and are paid for their attendance at biannual two-day review meetings and for participation in training/orientation. The CB-NCP proposes to pay a lump sum to FCHVs based on their individual performance in delivering newborn care services.

A further incentive introduced in 2007/08 is the establishment of a fund in each VDC which the FCHVs can use in order to support income generation activities. Each VDC is provided with 50,000 Nepalese Rupees (NRs) as seed money to establish the FCHV fund. In addition, every year NRs 10,000 will be added to this amount. Moreover, local government and partners can add any amount of money to this fund. A survey of the funds' use will also be conducted to find the most effective uses.

2. Goal

To support the goal of health through community involvement in public health activities, including imparting knowledge and skills for women's empowerment, increasing awareness on health-related issues and involving local institutions in promoting health care.

3. Objectives

- To inspire women to tackle common health problems by imparting relevant knowledge and skills

- To prepare a pool of self-motivated volunteers as focal persons for bridging health programmes and the community
- To prepare a pool of volunteers to provide service for community-based health programmes
- To increase the participation of communities in health improvement
- To develop FCHVs as health motivators
- To increase the utilisation of health care services through demand creation.

4. Major Strategies

- Creating demand
- Providing training
- Offering primary care
- Strengthening the FCHV Programme.

5. Indicators

Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Number of FCHVs who will have been recruited and deployed in mountain regions and remote districts	-	100	200	300	400	200

6. Major Challenges and Issues

- Increased expectation of FCHVs
- Trade unionism
- Overloaded FCHVs
- Coordination
- Effective utilisation of the FCHV fund
- Supportive supervision and monitoring
- Lack of replacements for ageing population of FCHVs.

Accountable Officer: Director, FHD, DOHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Advocacy	FCHV Day Celebration (all VDCs)	FCHV Section	Partners	X	X	X	X	X	X
Training	Provide guidelines to MGHs to select FCHVs from poor and excluded groups and to provide them training	MGHs, HFOMC	Partners		X	X	X	X	X
	Conduct two-day training for the VDC-level FCHV fund management committee	FCHV Section	Partners	X	X	X	X	X	X
Review and monitoring	Organise the FCHV Biannual Review Meeting (all VDCs)	FCHV Section	Partners	X	X	X	X	X	X
	Organise Biannual Review Meeting of Sub Health Post In-charges at district and Ilaka levels	FCHV Section	Partners	X	X	X	X	X	X
Contribution to FCHV fund	Reward for voluntary retirement	FCHV Section	Partners	X	X	X	X	X	X
	Add FCHV fund (NRs 10,000)	FCHV Section	Partners	X	X	X	X	X	X
Revitalisation	Orient to MGHs	FCHV Section	Partners	X	X	X	X	X	X
	Revitalise FCHVs and MGHs	FCHV Section	Partners	X	X	X	X	X	X
	Assess the performance of FCHVs after revitalisation								
Research/ study	National FCHV survey (quantitative)	FCHV Section	Partners		X	X	X		
	Service-seeking behaviour of people and their perceptions of FCHVs (in remote area of Nepal)	FCHV Section	Partners		X	X	X		
	FCHV fund utilisation	FCHV Section	Partners		X	X	X		

2.8 Free Health Care Programme

1. Introduction

The Interim Constitution of Nepal (2007) specifies "free basic health care" as a fundamental right of every citizen (article 16.2). To safeguard every citizen's right to basic health care, the MoHP declared free health care in 2007. The free health care policy of the GoN targets poor, vulnerable, and marginalised people to increase their access to and utilisation of health care services. The policy also declared free essential health care to all at HPs, SHPs and PHCCs across the country. In order to materialise the constitutional commitment (Interim Constitution, 2007) of the fundamental right of basic free health care, the MoHP introduced a policy of providing "Free Health Care Services" to the population in a phased manner to enhance access to EHCS for every citizen on an equal footing, with special consideration being given to providing a safety net for the poor, ultra-poor, destitute, disabled, senior citizens, and FCHVs. During NHSP-1, free EHCS were initially designed for the poor and excluded, but later EHCS became free of charge for all at district facilities, except for district hospitals, where free EHCS continued to be targeted, although 40 essential drugs were free to all.

The evolution of free health care is as follows:

- On December 15, 2006 (2063-8-29), the GoN made emergency and inpatient services free of charge to ultra-poor, poor, destitute, and elderly people, people living with disabilities, and FCHVs, at district hospitals and PHCCs. Outpatient (OP) services were also made free to the targeted groups in low- Human Development Index (HDI) districts from FY 2064/65 (2007) onward.
- On October 7, 2007 (2064-6-21) the GoN declared EHCS free of charge to everyone at all HPs and SHPs. The policy was implemented in mid-January 2008.
- On November 16, 2008 (2065-10-1), the GoN declared EHCS free of charge to all at PHCCs.
- On January 15, 2009 (2065-10-1), the GoN declared OP services, inpatient services and emergency services free of charge to the targeted groups in hospitals of 25 or fewer beds, as well as listing all medicines as free. For non-targeted groups, 20 listed drugs were made available free of charge.

In addition, as a safety net, under the MoHP free care is provided to poor patients in central, regional and zonal hospitals. The MoHP has prepared guidelines providing some relief to the poor and destitute by reimbursing them for a certain amount of costs for catastrophic illness. The guidelines cover catastrophic spending for five diseases: kidney disease, cancer, heart disease, Alzheimer's and Parkinson's. Each patient receives the equivalent of NRs 50,000.00 annually. Patients identified as poor by district committees have direct access to the accredited treatment centres, with their costs being reimbursed by the MoHP. Free care is provided to the poor and destitute, and free dialysis is provided for citizens above 75 years of age. Patients below 14 or above 75 years of age will receive free operations for heart disease in the Shahid Gangalal National Heart Centre.

During NHSP-2, EHCS in district hospitals is planned to be made free to all. As was the case with the earlier extension of free services, this should result in a substantial increase in utilisation of district hospital services, but this will happen only if quality is maintained and, if possible, improved. At present, district hospitals rely on user fees for a quarter of their revenues. Moreover, user fees finance expenditures that government revenues at present do not. They pay for contract staff where an established public servant is not available, they pay for some performance incentives to staff, and they finance maintenance and additional drugs and supplies. They also help to cover problems caused by delayed or interrupted disbursement of government funds. Some revenues will continue to be collected for services outside the definition of EHCS, but they will be significantly reduced. Maintaining the quality of services offered at district hospitals, and increasing their volume in response to increased demand caused by abolition of fees, will thus require that lost fee revenue is replaced with increased government

funding. The increased government funds will need to be both timely and flexible as to how they can be used. These policies contribute to mitigating the financial barriers to seeking care, provide relief to poor families, promote the utilisation of EHCS, and, ultimately, contribute to improving the health of the population.

2. Goals

- To reduce out-of-pocket spending on health care, particularly of the poor, marginalised and vulnerable groups
- To reduce the disability rate, and address morbidity, especially of poor, marginalised and vulnerable people, by securing the right of citizens to basic health services.

3. Objectives

- To ensure the citizens' constitutional right to basic health care services
- To increase access to and utilisation of EHCS, especially by poor and marginalised groups.

4. Major Strategies

- Increasing awareness of free care through effective and localised health communication
- Strengthening free care
- Increasing allocative efficiency
- Improving the quality of care
- Institutional development
- Promoting the role of local government in free care.

5. Indicators and Targets

Health Outcome and Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Under-five Mortality Rate (per 1,000 live births)	54	50.8	47.6	44.4	41.2	38
% of people with disability	3.6	3.5	3.4	3.3	3.2	3
% of total cost paid by patient for obtaining health services	53	52	51.5	51	50	49
% of households aware of free care	60	66	72	78	84	90
% of households that received free care at the district level and below	29	45	60	70	80	90
% of district facilities that will have no stock-outs of tracer drugs/commodities for more than one month per year by 2015	70	75	80	85	90	90

6. Major Challenges and Issues

- Increasing awareness of free care (60% of the population is aware of free care)
- Ensuring the retention of care providers at service centres
- Maintaining the quality of care
- Reducing stock-outs of essential drugs at the facility level
- Expanding the list of free essential drugs
- Monitoring free care
- Classifying poor and non-poor patients in district hospitals
- Moving from case-based to population-based budget allocations for free care.

Accountable Officer: Director, PHCRD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increasing awareness of free care	With NHEICC, develop a communication framework on free care	NHEICC	PHCRD/ EDPs			X			
	Develop and spread additional messages on free care through print media, especially to women, the poor and excluded	NHEICC	PHCRD/ EDPs			X	X	X	X
	Develop IEC materials (electronic) on free care	NHEICC	PHCRD/ EDPs		X	X			
	Airing free-care-related messages through FM radio and television	NHEICC	PHCRD/ EDPs		X	X	X	X	X
	Localise free-care-related messages in local languages with local contexts	NHEICC	PHCRD/ EDPs						
	Integrate free-care-related messages in non-health interventions such as forest users' groups, women's empowerment, formal education and local-development-related programmes	NHEICC	PHCRD/ EDPs		X	X	X	X	
	Promote free care through FCHVs, schoolteachers, students, and local stakeholders	PHCRD	NHEICC		-	X	X	X	X
Expanding universal free care in district hospitals	Study the strategic and financial implications of free care	PHCRD	PPICD, NHSSP		X	X			
	Assess the marginal and total costs for expanding free care	PHCRD	PPICD, NHSSP			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop a framework to replenish the loss of user fees	PHCRD	PPICD, NHSSP			X			
	Generate evidence to inform policy makers	PHCRD	PPICD, NHSSP			X			
Strengthening free care	Replenish the registration fees of DHOs, PHCCs, HPs and SHPs (grants)	PHCRD	Finance Section		X	X	X	X	X
	Provide institutional grants on the basis of OP/inpatient and emergency visits/morbidity/ population	PHCRD	Finance Section		X	X	X	X	X
	Develop procurement plan with forecasting of the drug	PHCRD	LMD			X			
	Ensure timely procurement and supply of listed essential drugs for free care	PHCRD	LMD; Finance Section		X	X	X	X	X
	Provide additional care providers on a contract basis	PHCRD	Personnel Section; DoHS		X	X	X	X	X
	Orient care providers on free care	PHCRD	NHTC			X	X	X	X
	Train focal persons on the operation of software and websites	PHCRD	HMIS			X	X		
	Train the storekeeper on medicine store management	PHCRD	LMD			X	X		
	Maintain coordination and collaboration through stakeholder meetings	PHCRD	Department of Drug Administra-tion (DDA)			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increasing allocative efficiency	Revise resource allocation criteria for free care	PHCRD	Health Economics and Financing Unit (HEFU), GIZ			X			
	Use allocation criteria for funding	PHCRD	HEFU			X	X	X	X
Improving the quality of care	Periodically expand the list of essential drugs for free care	PHCRD	DDA			X	X	X	X
	Introduce a QoC package as a performance evaluation of HFs (provide a standardised system of infection prevention)	PHCRD	Manage-ment Division (MD)/EDPs				X	X	X
	Ensure the regular presence of service providers in all HFs throughout the year.	PHCRD	DoHS/MoHP						
	Provide at least basic physical and infrastructure facilities, including equipment and instruments in each HF	DoHS/MoHP	MD/PHCRD/ EDPs			X	X	X	X
Institutional development	Expand and strengthen the role of the monitoring committee	PHCRD	MD		X				
	Ensure year-round drug availability in public health facilities as per free care drug list	PHCRD	LMD			X	X	X	X
	Strengthen and make functional monitoring mechanisms within PHCRD	PHCRD	MD			X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Strengthen the free care management support units and cells at PHCRD, Regional Health Directorate (RHD), and DHOs	PHCRD	EDPs		X	X	X	X	X
Promote the role of local government in the provision of free care	Orient the members of local government bodies and stakeholders on free care and their supporting roles	PHCRD	MoLD/DDC VDC Federation		X	X	X	X	X
	Develop a framework for the joint funding and monitoring of free care	PHCRD	MoLD/DDC VDC Federation		X				
	Prepare and agree to the joint funding modalities (centre, provincial, and district governments) for free care	PHCRD	MoLD/DDC VDC Federation		X				
Monitoring of free care	Revise and update the free care monitoring framework	PHCRD	HMIS		X				
	Develop software and websites on free health care	PHCRD	HMIS		X				
	Promote web-based monitoring of free care	PHCRD	HMIS		X	X	X	X	X
	Conduct an intensive review workshop on free care (quarterly, half-yearly and yearly) at least up to the district level.	PHCRD	HMIS		X	X	X	X	X
	Conduct social audits of free care together with other health programmes	PHCRD	HMIS/Civil society/ NGOs		X	X	X	X	X
	Undertake periodic monitoring of free care, through visits and long-distance communication	PHCRD	HMIS		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Conduct internal assessments of free care through mobilising independent consultants	PHCRD	HMIS		X		X		X
	Undertake periodic evaluation of free care; connect with Household Survey (HHS) and other surveys as appropriate	PHCRD	Independent firms			X			X
Social mobilisation and empowerment for increased service utilisation by unreached communities	Review and refine existing equity and access implementation modalities and programmes	PHCRD	EDPs and MoHP		X	X	X		
	Roll out EAP in additional districts	PHCRD	EDPs and MoHP	X	X	X	X	X	X
	Identify and address the socio-cultural barriers of specific target groups through EAP	MoHP/PHCRD	MoHP/EDPs		X	X	X	X	X
	Undertake capacity building of health managers and health service providers on GESI	PHCRD and the Population Division	All divisions		X	X	X	X	X
	Strengthen the GESI technical group based at DoHS	PHCRD and the Population Division	All divisions		X	X	X	X	X

2.9 Urban Health Care Programme

1. Introduction

Nepal's population reached 26,620,809 in the year 2011, with the population growth rate decreasing from 2.25% in 2001 to 1.4% per annum in 2011. The urban population constituted about 17% of Nepal's total population in 2011, compared to 14% in 2001, revealing a massive urban increase. The sex ratio in urban areas (92) is lower than in rural areas (104). Among the urban areas, the Kathmandu Metropolitan City has the largest population (1,006,656), followed by Pokhara, Lalitpur and Biratnagar Municipalities. Dhulikhel Municipality has the lowest urban population (16,406) followed by Dasharathchand, Bhadrapur and Ilam Municipalities (CBS, 2011). Migration is very high in Nepal, with almost half of the migrants moving within the country. Most migrants move from rural to urban areas in search of jobs and in pursuit of education. They are at greater risk of contracting HIV/AIDS and STIs and increase pressure on public services and utilities.

Migration brings significant demographic shifts to a society and carries socioeconomic implications in urban areas. Poor people may not be able to afford housing, drinking water, and a power supply, and so may stay in temporary shelters on riverbanks. These unplanned settlements, and the mobility of the urban poor, have caused the health care delivery system difficulties in addressing this population's needs. The urban poor are prone to illness owing to poor housing, unsafe drinking water, and unhealthy life styles. They are more exposed to risk factors, including a polluted environment. Urban residents are more likely to have improper food habits and unhealthy life styles, with higher prevalence of smoking, alcoholism, and the consumption of junk food.

Very few government run HPs or SHPs, and no FCHVs are functional in urban areas. A few municipalities have established urban health clinics but they have been unable to cater to the growing demand for health care. Coordination and collaboration between the MoHP, MoLD, and municipalities is lacking. The health of the urban poor has drawn the attention of the policy makers. The Three-year Interim Plan and NHSP-2 give special emphasis to the Urban Health Care Programme.

2. Goal

To improve the health status of the urban population, particularly the poor, marginalised, women, and children.

3. Objectives

To increase the access to and utilisation of quality basic health care services in urban areas, particularly by the poor, marginalised, women, and children.

4. Major Strategies

- Increasing access to basic health services, especially by poor and excluded (urban slum dwellers)
- Integrating urban health into local development plans and programmes
- Multi-sectoral coordination and collaboration, including partnerships
- Developing the capacity of the municipalities and urban health sections of PHCRD
- Improving QoC
- Scaling up urban health care services, especially in locations where urban slum dwellers live
- Conducting operational research and studies
- M&E.

5. Major Challenges and Issues

- Fostering coordination and collaboration
- Low coverage of immunisation in urban areas
- Low use of contraceptives among the educated population
- High levels of pollution
- Ensuring basic health care as a fundamental right of the urban poor and excluded.

Accountable Officer: Director, PHCRD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Provision of Urban Health Policy and structural framework	Develop Urban Health Policy framework	MoHP/MoLD	EDPs		X	X			
	Develop and implement Urban Health Strategy	PHCRD with MoLD	EDPs			X			
	Rapid assessment of existing urban health activities with activities modified accordingly	PHCRD with MoLD	EDPs				X		
Increasing access to basic health services	Data collection on urban health	PHCRD/ Municipalities	HMIS/MD/ Municipalities	X	X	X	X	X	X
	Estimate target population, including mobile population, by programme	PHCRD/ Municipalities	HMIS/MD		X	X	X	X	X
	Conduct needs assessment of urban poor	PHCRD/ Municipalities	HMIS/MD		X	X			
	Conduct stakeholder analysis	PHCRD/ Municipalities	HMIS/MD			X			
	Design and disseminate messages related to urban health clinics and available services through multimedia	PHCRD with Municipalities	NHEICC			X	X	X	X
	Strengthen referral mechanism to specialised hospitals from urban health clinics	PHCRD with Municipalities	MoHP/MoLD			X	X	X	X
	Develop and implement special social mobilisation initiatives for urban slums	PHCRD with Municipalities	MoHP/MoLD				X	X	X
	Support equipping FCHVs	PHCRD/ Municipalities	LMD			X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Developing the capacity of municipalities	Support preparing Urban Health Plans for municipalities, including setting priorities	PHCRD/ Municipalities	MoLD/ Municipal Federation			X	X	X	X
	Support municipalities to establish and strengthen urban health units	PHCRD/ Municipalities	LMD			X	X	X	X
	Provide urban health care service grants	PHCRD	MoLD		X	X	X	X	X
	Develop and print a training manual for care providers on urban health care	PHCRD/ Municipalities	LMD			X	X	X	X
	Develop and print a training manual for FCHVs on urban health care	PHCRD/ Municipalities	NHTC		X	X	X	X	X
	Conduct basic and refresher training to urban FCHVs	PHCRD/ Municipalities	NHTC		X	X	X	X	X
	Develop and introduce mechanisms to engage FCHVs with urban poor and excluded communities, especially with urban slum dwellers	PHCRD/ Municipalities	Other divisions of DOHS			X	X	X	X
	Hire HR for urban health clinics	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Train and orient health care providers on urban health care	PHCRD	MoHP/MoLD		X	X	X	X	X
	Establish and promote FCHV funds	PHCRD/ Municipalities	MoHP/MoLD			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Developing the capacity of municipalities	Observe FCHV Day	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Develop/revise/expand urban health care package to include ayurvedic, and other alternative medicine	PHCRD/ Municipalities	MoHP/MoLD			X		X	
Improving QoC	Provide basic physical facilities and medical instruments to urban health clinics	PHCRD/ Municipalities	LMD		X	X	X	X	X
	Support municipalities to organise (mobile) free care services in urban slums	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Support municipalities to deliver Reproductive Health Services from service centres	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Support municipalities to deliver HIV/AIDS-related services from service centres	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Support municipalities to organise specialised care clinics	PHCRD/ Municipalities	MoHP/MoLD		X	X	X	X	X
	Develop Memorandum of Understanding (MoU) with care provider hospitals to offer free care to poor and excluded groups	PHCRD/ Municipalities	MoHP/MoLD			X	X	X	X
	Prepare a framework for exemption of user fees to urban poor, including a reimbursement mechanism	PHCRD/ Municipalities	MoHP/MoLD			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Scale up Urban Health Programme to other (new) municipalities	PHCRD/ Municipalities	Finance Section			X	X	X	X
Expansion and extension of Urban Health Programme	Review the function of existing urban health clinics	PHCRD/ Municipalities	MoHP/EDPs			X			
	Expand the number of health clinics and promotional initiatives to other parts of existing municipalities, focusing on urban slums	PHCRD/ Municipalities	MoHP/MLD			X	X	X	X
	Conduct assessment of air, water and noise pollution	PHCRD/ Municipalities	MoHP/EDPs			X	X	X	X
Promoting research and studies	Conduct assessment on QoC provided by private institutions	PHCRD/ Municipalities	MoHP/EDPs			X	X	X	X
	Conduct a situation analysis/stocktaking report on NCDs	PHCRD/ Municipalities	MoHP			X	X	X	X
	Provide support to develop and implement integrated municipality plans	PHCRD/ Municipalities	MoHP/EDPs			X	X	X	X
Integrating urban health into local development	Conduct an Inter-ministerial Committee meeting	Inter-ministerial Committee	PHCRD		X	X	X	X	X
Inter-sectoral coordination and	Conduct a Management Committee meeting	PHCRD	MoLD		X	X	X	X	X
	Develop funding modalities for	PHCRD/MoLD	MoLD		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
collaboration and partnership	the Urban Health Programme								
	Develop a MoU between the MoHP and MoLD on urban health	PHCRD	MoLD		X	X	X	X	X
	Establish and promote FCHV funds	PHCRD	MoLD		X	X	X	X	X
	Coordinate with WASH, accident prevention, and infrastructure development programmes	MoLD	PHCRD/ MoLD		X	X	X	X	X
	Prepare a monitoring framework for the Urban Health Programme	PHCRD	MoLD		X	X	X	X	X
M&E	Monitor air, water, and noise pollution	Inter-ministerial Committee	MoLD		X	X	X	X	X
	Monitor QoC	PHCRD/ Municipalities	MoLD		X	X	X	X	X
	Undertake national, regional, and district reviews	PHCRD	MoLD		X	X	X	X	X
	Undertake regular monitoring of quality of instant and prepared foods	PHCRD	MoLD		X	X	X	X	X
	Review FCHV programme	PHCRD	MoLD		X	X	X	X	X
	Undertake external evaluation of Urban Health Programme (process in 2013 and Impact in 2015)	PHCRD	MoLD				X		X

2.10 Malaria Control Programme

1. Introduction

In 1958, the malaria eradication programme, the first national public health programme in Nepal, was launched with the objective of eradicating malaria from Nepal within a limited time period. For various reasons, the eradication concept became a control programme in 1978. Following the call of WHO to revamp the malaria control programmes in 1998, the Roll Back Malaria (RBM) initiative was launched to address the perennial problem of malaria in heavily forested, foot hills, the inner tarai and valley areas of the hills, where more than 70% of the total malaria cases of the country occur. Since 2004, interventions have been carried out in high-risk areas, covering a population of 5.98 million with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). From 2011/12 to 2015/16, similar interventions are being extended to moderate-risk areas, affecting a population of 8.24 million, again supported by the GFATM. In addition, Nepal has low-risk areas with a population of 6.12 million, and malaria-free areas with a population of 2.13 million, where malarial control activities will be carried out with funding from the regular government budget and without EDP support. This is based on the provisional stratification of malaria endemic areas of the country in 2010.

Currently, malaria control activities are carried out in 65 districts at risk of malaria. The GFATM supports malaria control programmes in 31 high endemic districts and 18 moderate districts. The strategy has shifted from control to pre-elimination. The programme is divided into two implementation phases: the time between 2011 (July) and 2013 (July) will be pre-elimination phase I (preparatory phase), and August 2013 to July 2017 will be pre-elimination phase 2. Preparatory phase activities include: update of stratification of Nepal's malaria endemic areas, i.e. micro-stratification; preparation of national guidelines for the elimination of malaria; assessment of HR and their capacity; recruitment of additional staff; and training and reorientation of the programme to implement elimination activities. During this phase, special attention will be given to developing and enhancing the entomological capacity at the central and regional levels.

The ongoing interventions include: vector control with Long-lasting Insecticidal Bed Nets (LLIN) and/or Indoor Residual Spraying (IRS) with synthetic pyrethroid insecticides; parasitological diagnosis with microscopy or Rapid Diagnostic Test (RDT); timely treatment of P. falciparum cases with Artemisinine Combination Therapy (ACT) plus primaquine, and of P. vivax cases with chloroquine (three days) and primaquine (14 days); and early detection and response to malaria outbreaks within a week.

2. Goal

To eliminate malaria by the year 2026.

3. Objective

To completely interrupt the malaria transmission and reduce the incidence of locally contracted malaria in Nepal to zero by 2026.

4. Major Strategies

- Vector control and personal protection
- Early diagnosis and appropriate treatment
- Malaria surveillance and epidemic preparedness

- BCC
- Programme management
- Pre-elimination intensification.

5. Indicators and Targets

Health Outcome and Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Malaria annual parasite incidence (per 1,000)	0.15	0.15	0.14	0.14	0.13	0.12
At least 90% of households with at least one LLIN per two residents in all high-risk districts and areas by 2015	-	90%	90%	90%	90%	90%
At least 80% of children under five years old who slept under a LLIN the previous night	70%	80%	80%	80%	80%	80%

6. Major Challenges and Issues

- Low coverage of blood slide collection and examination
- Inadequate training and orientation to staff on the Malaria Programme
- Less effective spraying activities
- Reaching the pre-elimination stage of malaria
- Lack of coordination and collaboration.

Accountable Officer: Director, EDCD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Vector control and personal protection	Conduct two rounds of routine IRS	Disease Control Section	LMD	X	X	X	X	X	X
Early diagnosis and appropriate treatment	LLINs will be provided free of charge to all people living in high-risk areas	Disease Control Section	GFATM/PSI	X	X	X	X	X	X
	Provide diagnostic services for malaria (slide collection and examination)	Disease Control Section	LMD	X	X	X	X	X	X
	Perform RDTs	Disease Control Section		X	X	X	X	X	X
	Support to develop a referral laboratory network	Disease Control Section	NPHL	X	X	X	X	X	X
	Provide ACT	Disease Control Section	WHO	X	X	X	X	X	X
Malaria surveillance and epidemic preparedness	Establish and maintain a malaria outbreak early warning system in selected public health facilities	Disease Control Section	Partners	X	X	X	X	X	X
	Establish and maintain an integrated surveillance system	Disease Control Section	Partners		X	X	X	X	X
	Provide technical and operational linkages between EDCD and epidemic-prone districts	Disease Control Section	Partners					X	X
	Conduct focal IRS in the wards	Disease Control Section	Partners	X	X	X	X	X	X
	Conduct RDT-based active case detection in the outbreak ward(s) and in all adjacent wards	Disease Control Section	Partners	X	X	X	X	X	X
	Perform RDT-based active case detection in the outbreak ward(s)	Disease Control Section	Partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
BCC	Develop and produce BCC materials	Disease Control Section	Partners	X		X		X	
	Air/print messages on malaria control during special events (malaria day) and establish high-level advocacy	Disease Control Section	Partners	X	X	X	X	X	X
	Promote interpersonal communication on malaria	Disease Control Section	Partners	X	X	X	X	X	X
Programme management	Provide technical and management training through central- and district-level staff	Disease Control Section	Partners	X	X	X	X	X	X
	Hold Technical Working Group (TWG) meetings	Disease Control Section	Partners	X	X	X	X	X	X
	Prepare/revise technical guidelines: guidelines on case management, vector control, epidemic preparedness and control, monitoring drug and insecticide resistance	Disease Control Section	Partners	X	X			X	X
	Hold National Technical Advisory Group for Malaria (NTAG-M) meetings	Disease Control Section	Partners	X	X	X	X	X	X
	Promote community participation and partnership	Disease Control Section	Partners	X	X	X	X	X	X
Pre-elimination intensification	Draft/adapt and implement International Health Regulations (IHR)	Legal Section	WHO			X			
	Prepare structure, tools and mechanisms for the implementation of IHR	EDCD	WHO			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Conduct micro-stratification	Disease Control Section	Partners		X				
	Conduct weekly reporting including zero reporting and epidemiological/entomological investigation of cases/foci	Disease Control Section	Partners			X	X	X	X
	Prepare and implement national guidelines for elimination of malaria	Disease Control Section	Partners		X	X	X	X	X
	Assess HR and their capacity	Disease Control Section	WHO/ partners			X			
	Recruit additional staff to implement elimination activities	Disease Control Section	WHO/ partners			X	X	X	X
	Train and reorient staff on elimination of malaria	Disease Control Section	partners			X	X		
	Enhance entomological capacity	Disease Control Section	WHO/ partners		X	X			
	Establish and maintain integrated surveillance system (policy, guidelines, and tools)	Disease Control Section	WHO/ partners		X	X	X	X	X

2.11 Kala-azar Elimination Programme

1. Introduction

Kala-azar is a vector-borne disease caused by the parasite *Leishmania donovani, which is* transmitted by the sand fly, *Phlebotomus argentipes.* The disease is characterised by fever for more than two weeks with splenomegaly, anaemia, progressive weight loss and sometimes darkening of the skin. In the endemic areas, children and young adults are its principal victims. The disease is fatal if not treated promptly. Kala-azar has emerged as a health problem in recent years, but over the last decade, some significant advances have been made both in its diagnosis and treatment. A rapid and easy applicable serological test, the rK39 dipstick test, has been demonstrated to have high sensitivity and specificity in validity studies conducted on the Indian subcontinent. For the first time, an oral drug – Miltefosine – has proven to be efficacious in drug trials and has been registered for use in treating Kala-azar.

GoN has accepted the regional strategy of eliminating Kala-azar, and with India and Bangladesh is a signatory to the MoU that was formalised during the May 2005 WHA on Kala-azar elimination, with the target of eliminating the disease by 2015. In 2005, the EDCD of DoHS formulated a three-phase National Plan for the Elimination of Kala-azar: Preparatory Phase: 2005-2008, Attack Phase: 2008-2015, and Consolidation Phase: 2015 onwards. There are six expected outputs of the plan. One of the outputs is to develop a functional network that provides diagnosis and case management with special outreach to the poorest of the poor.

EDCD has revised the diagnosis and treatment of Kala-azar in Nepal. The rK39 test kit has been accepted and introduced as a diagnostic test and Miltefosine as a first-line treatment. This strategy was tested in Saptari district in 2007 as a pilot programme, and Saptari has served as a demonstration district for all the other endemic areas.

2. Goal

To contribute to improving the health status of vulnerable groups and at-risk populations living in Kala-azar endemic areas of Nepal through the elimination of Kala-azar by 2015, so that it is no longer a public health problem.

3. Objective

To reduce the annual incidence of Kala-azar to less than 1 per 10,000 people in every district by 2015 (elimination target).

4. Major Strategies

- Improve programme management
- Early diagnosis and complete treatment (introducing new technology)
- Integrated vector management
- Expand the elimination activities
- Effective disease surveillance and vector surveillance
- Social mobilisation and partnerships
- Clinical implementation and operational research.

5. Indicators and Targets

Outcome	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Case fatality rate (%)	0.50	0.40	0.30	0.25	0.20	0.1
Incidence of Kala-azar (per 10,000 population)	0.95	0.90	0.85	0.80	0.75	0.70

6. Major Challenges and Issues

- Shortage of staff for outbreak investigation and control
- Delayed response due to unavailability of staff
- Incomplete reporting
- Staff overwhelmed by control activities
- Delayed or non-existent care seeking.

Accountable Officer: Director, EDCD , DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Early diagnosis and complete treatment	Develop a functional network that provides diagnosis and case management	Disease Control	Hospitals	X	X	X	X	X	X
	Continue treatment (Miltefosine)	Disease Control	Hospitals	X	X	X	X	X	X
Training	Provide training to health workers and laboratory personnel on rK-39 dipstick diagnosis of Kala-azar	Disease Control	Vector-borne Diseases Research and Training Centre (VBDRTC)	X	X	X	X	X	X
	Provide training to DHOs, MOs, Public Health Officers and other health personnel on Kala-azar and other Vector-borne Diseases (VBDs)	Disease Control	VBDRTC	X	X	X	X	X	X
Expanding elimination activities	Expand the elimination activities	Disease Control	VBDRTC/ partners		X	X	X	X	
Integrated vector management	Conduct two rounds of selective IRS (included in malaria control)	Disease Control	Districts	X	X	X	X	X	X
Effective disease surveillance and vector surveillance	Conduct integrated disease surveillance and vector surveillance (as included in malaria control)	Disease Control	Partners	X	X	X	X	X	X
Social mobilisation and partnerships	Promote social mobilisation and partnerships	Disease Control	Partners	X	X	X	X	X	X
Clinical implementation	Undertake implementation and operational research	Disease Control	VBDRTC B.P. Koirala	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
and operational research			Institute of Health Sciences (BPKIHS)						
Assessment	Conduct internal and external assessment of Kala-azar elimination	Disease Control	HMIS/ partners		X			X	

2.12 Lymphatic Filariasis Elimination Programme

1. Introduction

Nepal is endemic for three of the target neglected tropical diseases for which chemotherapy is available: lymphatic filariasis (LF), soil-transmitted helminthiasis, and trachoma. Recent mapping exercises indicate that there are a number of districts, particularly in the tarai region, where these diseases are co-endemic. LF is a public health problem in Nepal. The disease is a major cause of morbidity, primarily hydrocele and lymphoedema of legs, and impedes socio-economic development in many areas of Nepal where it is endemic. The disease is prevalent in rural and slum areas, predominantly affecting the poorer sections of the community. LF mapping completed in 2005 by using the Immunochromatography Card Test (ICT) revealed that 60 of Nepal's districts are endemic for LF. The disease has been detected in different topographical areas ranging in altitude from 300 feet above sea level in the tarai plains ecological zone to 5,800 feet above sea level in high hill areas. More LF cases are seen in the tarai than in the hills.

Elimination of LF (ELF) means that LF would cease to be a public health problem, defined as when the number of microfilaria carriers is less than 1% and the children born after initiation of ELF are free from circulating antigenaemia. Absence of antigenaemia among children is considered as evidence for the absence of transmission and new infection. Nepal is a signatory to the WHA resolution to eliminate LF by 2020. The GoN is fully committed to eliminate the disease within the stipulated time, with support from EDPs (NHSP-2 IP (2010-15)). The EDCD under the DoHS has formulated a Plan of Action (2003-2015) for the elimination of LF in Nepal by establishing a Task Force under the Chairmanship of the Director-General (DG), DoHS.

2. Goal

To eliminate LF from Nepal by the year 2020 and reduce the disease to such a level that transmission within Nepal will be stopped.

3. Objectives

- To interrupt the transmission of LF
- To reduce and prevent morbidity
- To provide de-worming by giving Albendazole (ALB) to endemic communities, especially to children
- To reduce mosquito vectors through application of suitable and available vector control measures (integrated vector control management).

4. Major Strategies

- The national target has been to eliminate LF as a public health problem in Nepal by the year 2015 by reducing the level of the disease in the population to a point where transmission no longer occurs. The objectives are to reduce and eliminate transmission of LF by Mass Drug Administration (MDA), and to reduce and prevent morbidity in affected persons.
- The twin pillars of the ELF strategy are:
  1. Transmission control: The strategy of interruption of disease transmission is based on MDA to prevent the occurrence of new infection and disease by administration of annual single dose of Diethylcarbamazine (DEC) + ALB once a year for four to six years.
  2. Disability prevention and management: For those individuals who already have the disease, provide home-based management and limb hygiene for lymphoedema and surgical correction for hydrocele.

5. Major Challenges and Issues

- Increasing coverage (in 19 additional districts)
- Mobilising resources (budget and logistic support)
- Addressing morbidity meticulously
- MDA
- Social mobilisation and mass campaigns.
- Increasing public awareness about the disease
- Increasing the coverage of MDA in urban communities.

Accountable Officer: Director, EDCD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transmission control	Mapping and disease burden estimation	EDCD	World Health Organisation / Research Triangle Institute (WHO/RTI)	X	X	X	X	X	X
	Rapid assessment through questionnaire	EDCD	WHO/RTI	X	X	X	X	X	X
	Direct physical examination	EDCD	WHO/RTI	X	X	X	X	X	X
	Detection of microfilariae in the blood	EDCD	WHO/RTI	X	X	X	X	X	X
	ICT card tests	EDCD	WHO/RTI	X	X	X	X	X	X
	Endemicity mapping of LF	EDCD	WHO/RTI	X	X	X	X	X	X
	Staging and phasing of the programme	EDCD	WHO/RTI	X	X	X	X	X	X
	MDA	EDCD	WHO/RTI	X	X	X	X	X	X
Disability prevention and management	Surgical management of hydrocele due to lymphatic filariasis	EDCD	WHO/RTI	X	X	X	X	X	X
Social mobilisation	Social mobilisation and campaign	EDCD	WHO/RTI	X	X	X	X	X	X
Monitoring and surveillance	M&E	EDCD	WHO/RTI	X	X	X	X	X	X
	Microfilaria baseline survey and sentinel surveillance	EDCD	WHO/RTI	X	X	X	X	X	X
	Staff training	EDCD	WHO/RTI	X	X	X	X	X	X
	Transmission assessment surveys	EDCD	WHO/RTI	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Post-MDA surveillance (WHO draft recommendations 2010)	EDCD	WHO/RTI	X	X	X	X	X	X

2.13 Dengue Control Programme

1. Introduction

Dengue Fever (DF) is a very important mosquito-borne viral disease and a major international public health concern. Aedes (Stegomyia) Aegypti (Ae. Aegypti) and Aedes (Stegomyia) Albopictus (Ae. Albopictus) are the two major vectors of dengue. DF is a usually self-limiting disease found in tropical and sub-tropical regions around the world, predominantly in urban and semi-urban areas. Dengue Haemorrhagic Fever (DHF), a potentially lethal form of disease, was first recognised in the 1950s during a dengue epidemic in the Philippines and Thailand, but today DHF affects most Asian countries and is a leading cause of childhood deaths. There is no specific treatment for dengue, but appropriate medical care frequently saves the lives of patients with the more serious DHF. The most effective way to prevent dengue virus transmission is to combat the disease-carrying mosquitoes.

Nepal's first case of DF was reported in 2004 in Chitwan district. During September-October 2006, following a dengue epidemic in India, hospitals in the central and western tarai and also a hospital in Kathmandu reported 32 laboratory-confirmed dengue cases. Most of these cases were indigenous. Sporadic clinical cases were reported between 2007 and 2009. However, in 2010, a dengue epidemic occurred in several locations in lowland districts as well as in some hilly areas. According to EDCD, 4,529 suspected cases, 917 serologically-confirmed cases, and five deaths were reported by the end of December. This was the highest recorded morbidity caused by the dengue virus in Nepal to date. The 2010 dengue epidemic highlights the first expansion of DF/DHF to Nepal's hilly regions, whereas only classic DF caused by multiple serotypes had been reported previously.

2. Goal

To reduce the morbidity and mortality owing to DF/DHF to a level where dengue will no longer present a public health problem.

3. Objectives

- To develop an integrated vector control approach for prevention and control
- To develop capacity on diagnosis and case management of DF, DHF, Dengue Shock Syndrome (DSS) and chickengunya
- To intensify health education/IEC activities
- To strengthen the surveillance system for prediction, early case detection, preparedness and early response to dengue outbreaks.

4. Major Strategies

- Early case detection, diagnosis, case management and reporting of DF, DHF, DSS and chickengunya
- Regular case-based surveillance of DF, DHF, DSS and chickengunya through the Early Warning and Reporting System (EWARS)
- Mosquito vector surveillance in concerned municipalities
- An integrated vector control approach that combines several approaches directed towards container management and source reduction
- BCC
- Operational research
- Integrated vector management.

5. Major Challenges and Issues

- Outbreak control
- Increasing capacity on diagnosis and case management
- Diagnosis, case management.

Accountable Officer: Director, EDCD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Early case detection, diagnosis, case management	Provide training on early case detection, diagnosis, case management	Disease Control	Partners	X	X	X	X	X	X
	Strengthen laboratory facilities/diagnostic support	Disease Control	Partners	X	X	X	X	X	X
Integrated vector management	Develop and maintain vector control management guidelines	Disease Control	Partners	X	X	X	X	X	X
	Undertake integrated vector management (cross reference with malaria control)	Disease Control	Partners	X	X	X	X	X	X
Outbreak control	Provide rapid response during outbreaks and conduct an Ae. Aegypti larva survey and control the Ae. Aegypti larva (search and destroy)	Disease Control	Partners	X	X	X	X	X	X
Surveillance	Dengue case and vector surveillance	Disease Control	Partners	X	X	X	X	X	X
BCC	Provide health education through electronic, print and interpersonal communication	Disease Control	Partners	X	X	X	X	X	X
Operational research	Conduct operational research	Disease Control	Partners	X	X	X	X	X	X

2.14 Leprosy Control Programme

1. Introduction

Nepal eliminated leprosy as a public health problem, defined as a Prevalence Rate (PR) of <1 case per 10,000 population, in December 2009. The DoHS acknowledged this achievement as one of the health sector's major success stories of the past decades. Since then Nepal has consistently sustained the elimination status with a PR of <1 case per 10,000 population, and efforts are underway to further reduce the disease burden and achieve universal elimination. Although significant progress has been made in reducing the national-level disease burden, sustaining the achievement and further reducing the disease burden through delivering quality leprosy services still remain as major challenges.

After meeting the elimination target, the national strategy was formulated to "Sustain Quality Leprosy Services and Further Reduce the Disease Burden due to Leprosy in Nepal: 2011-2015 (2068/69-2072/73)" based on the "Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy: 2011-2015" and the updated Operational Guideline laid down by WHO.

The main principles of leprosy control are based on early detection of new cases and their timely and complete treatment with Multidrug Therapy (MDT) through integrated health services. The emphasis is on sustaining the provisions for quality patient care that are equitably distributed, affordable and easily accessible.

Milestones

Following are the notable milestones of Nepal's leprosy control programme:

- 1960 - Leprosy survey performed in collaboration with WHO
- 1966 - Pilot Project established to control leprosy with dapsone monotherapy
- 1982 - Introduced MDT in the leprosy control programme
- 1987 - Integrated leprosy control within the general basic health services
- 1996 - MDT coverage reached all 75 districts
- 1999 - National Leprosy Elimination Campaign (NLEC) carried out in 27 districts
- 2001 - NLEC carried out in 17 districts
- 2009 - Leprosy elimination declared on 2066/10/5 (December 2009)
- 2010 onwards - Sustained elimination at the national level with a PR <1 case/10,000 population
- 2011 - National strategy formulated to "Sustain Quality Leprosy Services and Further Reduce the Disease Burden due to Leprosy in Nepal: 2068/69 - 2072/73"
- More than 80% of the leprosy burden is found in tarai districts.

2. Goal for 2015

To further reduce the disease burden due to leprosy in comparison to the 2010 level.

3. Objectives

- To further reduce the disease burden due to leprosy
- To improve and sustain the quality of leprosy services in an integrated manner
- To rehabilitate people affected by leprosy
- To increase awareness and reduce the stigma related to leprosy.

4. Major Strategies

The new national strategy has envisioned delivering leprosy services through the following ten strategic methods:

1. Early new case detection and their timely and complete management

2. Provide quality leprosy services in an integrated manner by qualified health workers
3. Prevent leprosy associated impairment and disability
4. Rehabilitate people affected by leprosy, including medical and community-based rehabilitation
5. Reduce stigma and discrimination through advocacy, social mobilisation, and IEC activities, while addressing GESI issues
6. Strengthen referral centres for management of complications
7. Promote meaningful involvement of people affected by leprosy in leprosy services, while addressing human rights issues
8. Promote and conduct operational research/studies
9. Conduct monitoring and supportive supervision, including onsite coaching, surveillance, and evaluation to ensure and strengthen quality leprosy services
10. Strengthen partnership, co-operation and coordination with local government, EDPs, civil society, and community-based organisations.

5. Targets

The programme has set the following national-level targets (in comparison to the 2010 level):

- To reduce the New Case Detection Rate (NCDR) by 25% by the end of 2015
- To reduce the PR by 35% by the end of 2015
- To reduce Grade II Disability (DG II) amongst newly detected cases by 35% by 2015.

6. Indicators

Indicators and Targets	Year						
	2009/10*	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Population by HMIS	27,495,585	27,999,405	28,480,814	27,248,474	27,629,953	28,016,772	28,409,007
Patients being treated	2,104	2,210					1,367
PR (%)	0.77	0.79					0.45
New cases	3,157	3,142					2,368
NCDR (%)	1.15	1.12					0.79
DG II among new cases	86						56
DG II proportion (%)	2.72						2.36

** Baseline data*

7. Major Challenges and Issues

- Limited resources
- Trained HR and their retention
- Rehabilitation of people affected by leprosy
- Mainstreaming leprosy-related charity approach services
- Increase in numbers of endemic districts as compared to the base year
- Declining attention to leprosy programmes especially at highly endemic districts.
- Validation of reported new cases
- Sustaining quality services
- Sustaining effective surveillance, monitoring and supervision
- Community-based and medical rehabilitation including local participation
- Further reducing stigma and discrimination with a focus on marginalised and unreached populations
- Sustain elimination at the national level
- Achieve elimination at the district level (universal achievement).

Accountable Officer: Director, Leprosy Control Division (LCD), DoHS

Major Strategies	Major activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Early case detection and timely and complete management	Case detection, free treatment with MDT, and management of complications	LCD/ Regional Health Directorate	Netherlands Leprosy Relief (NLR)/ Leprosy Mission Nepal (LMN)/ Nepal Leprosy Trust (NLT)/ INF	X	X	X	X	X	X
Capacity building for quality integrated service delivery in the health system	Provide comprehensive leprosy training for HWs	LCD/RHD	NLR/LMN/ NLT/INF/ BIKASH[1]	X	X	X	X	X	X
	Provide refresher training to HWs and managers' training	LCD/RHD	NLR/LMN/ NLT/INF/ BIKASH	X	X	X	X	X	X
	Training of MOs	LCD/RHD	LMN/INF/ NLR	X	X	X	X	X	X
	Orientation to volunteers and CBOs	LCD/RHD	Partners	X	X	X	X	X	X
Prevention of disability due to leprosy	Formation of self-care/self-help groups	LCD/RHD	Partners	X	X	X	X	X	X
	Provide supportive materials and devices	LCD/RHD	Partners	X	X	X	X	X	X

[1] BIKASH: an NGO – Building in Knowledge, Attitude and Skills for Health

Major Strategies	Major activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Prevention of disability due to leprosy	Early detection and management of complications at HF level	LCD/RHD	Partners	X	X	X	X	X	X
Medical, physical and social rehabilitation of people affected by leprosy	Surgical correction of physical disabilities	LCD/RHD	NLM/NLT/ INF	X	X	X	X	X	X
	Income generation programmes	LCD/RHD	Partners	X	X	X	X	X	X
	Provide social rehabilitation	LCD/RHD	Partners	X	X	X	X	X	X
	Provide vocational training	LCD/RHD	Partners			X	X	X	X
IEC and social mobilisation activities to raise awareness and reduce stigma	Produce and distribute posters, leaflets, brochures, bulletins and annual reports	LCD/NHIECC	Partners	X	X	X	X	X	X
	Use electronic and non-electronic media	LCD/NHIECC	Partners	X	X	X	X	X	X
	Celebrate World Leprosy Day	LCD/RHD/ districts	Partners	X	X	X	X	X	X
	Conduct school health education programmes	MoHP/LCD/ DoHS/RHD/ districts	NLR/ Partners	X	X	X	X	X	X
Strengthen leprosy referral centres for complication management	Expand speciality services in central and regional hospitals	MOHP/DoHS/ LCD/RHD	Partners	X	X	X	X	X	X
Involvement of people affected	Increase meaningful involvement of people	LCD/RHD/ Districts	Partners/ network	X	X	X	X	X	X

Major Strategies	Major activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
by leprosy in leprosy services	affected by leprosy in programme planning and services, motivation, and vocational training								
Research and studies	Conduct operational research and studies	LCD/RHD	Partners/ WHO	X	X	X	X	X	X
Programme monitoring	Organise review meetings/monitoring workshops	LCD/RHD	Partners	X	X	X	X	X	X
	Conduct technical supervision	LCD/RHD	Partners	X	X	X	X	X	X
	Conduct on-site coaching	LCD/RHD	Partners/ WHO			X	X	X	X
	Conduct case validation and data verification	LCD/RHD	Partners/ WHO	X	X	X	X	X	X
	Conduct surveillance	LCD/RHD/ HF/districts	Partners			X	X	X	X
Partnership	Strengthen partnership, collaboration, and coordination among various organisations including local governments	MoHP/LCD/ RHD	Partners/ NGOs/ INGOs/ MoLD/ local bodies	X	X	X	X	X	X

2.15 Health Laboratory Services

1. Introduction

The National Public Health Laboratory (NPHL) has a mandate to serve as the national reference laboratory for public health activities. Routine and specialised diagnosis services and laboratory-based surveillance of diseases of public health importance are performed with quality assurance under the network of health laboratories.

Nepal's health care system includes laboratories involved in diagnostic services and laboratories involved in public health activities (surveillance, research, regulatory). At present almost half of these laboratories are functioning under the MoHP's direct government health care management system at central, regional, zonal, district, and local HP levels, while the remainder are functioning under private management at hospital, poly clinic, and diagnostic centre levels. The health laboratory service has been expanded to the periphery, with eight central hospital-based, three regional-based, two sub-regional-based, 11 zonal-hospital-based, 66 district-hospital-based and 204 PHCC-based laboratories operating directly under the MoHP, a few under the Ministry of Home Affairs (MoHA), Ministry of Defence (MoD) and Ministry of Education (MoE), and more than 1,000 private laboratories.

IHR 2005 has identified health laboratory service as one of the eight core capacities; Nepal as a signatory country needs to develop the core capacities to the required level as directed by the guidelines. Nepal has no specific legislation for registration, renewal, quality monitoring, and accreditation procedures for health laboratories. MoHP has nominated the NPHL as the national nodal/coordinating laboratory for health care laboratories in Nepal. Every decade new and emerging diseases appear, with epidemic and pandemic potential. New disease diagnosis often requires the latest sophisticated technology in rapid diagnosis and reporting within 24 hours. This is part of government's commitment towards IHR 2005. Every few years huge outbreaks of established but dangerous pathogens occur in different and difficult parts of Nepal, taking the lives of underprivileged groups.

2. Goal

To support physicians and patients by offering quality laboratory diagnostic services.

3. General Objective

To strengthen the capacity of public health laboratories at all levels.

Specific Objectives

1. To prepare policy, guidelines, and an overall framework for capacity building
2. To develop NPHL as a nodal institute and national influenza centre
3. To strengthen laboratory procedures and communications between different levels and also to strengthen the laboratory system.

4. Major Strategies

Laboratory Service

- Expand basic health laboratory services down to the HP level
- Develop health laboratory legislation
- Develop and implement a Laboratory Information System (LIS)

- Develop HR for laboratory services through scholarship programmes (priority will be given to women, Dalits, Janajatis, Madheshis and other socially excluded groups)
- Assure laboratory quality
- Improve monitoring and supervision
- Upgrade laboratory physical facilities and the level of services
- Strengthen service centres (National Influenza Centre, Virological Lab, Biosafety Level (BSL) 3 Lab)
- Strengthen infection control.

Blood Transfusion Services (BTS)

- Establish a National Blood Centre
- Strengthen BTS with the provision of component facilities down to the zonal level
- Advocate for awareness raising and motivation for blood donations
- Establish new Blood Transfusion Service Centres (BTSCs), giving priority to remote and disease-burdened areas.

5. Indicators and Targets

Coverage and Output	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
No. of laboratory services established at HP level (priority will be given to remote HPs with birthing centres, and low-HF areas)			10	50	50	50
No. of regional laboratories established			1	1	1	2
No. of zonal hospitals with the facility for bacteriological, culturing, and sensitivity services			5	7	6	-
No. of electrolyte (Na & K) services in zonal hospital laboratories			5	6	3	4
No. of district hospitals with the facility for bacteriological, culturing and sensitivity services			15	20	20	13
No. of district hospitals with semi-automatic analysers			20	20	20	8
No. of labs participating in the National External			300	Continuous	Continuous	Continuous

Coverage and Output	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Quality Assessment Scheme (NEQAS) programme						
No. of lab personnel receiving qualification upgrades			17	Continuous	Continuous	Continuous
No. of districts with BTSC			5	Continuous	Continuous	Each district will have at least one BTSC
Laboratories established at HP level			10	50	50	50
Laboratories established at regional level			1	1	1	2
Bacteriological, culturing, and sensitivity services expanded in zonal hospital laboratories			All zonal hospitals	All zonal hospitals	All zonal hospitals	All zonal hospitals
Expansion of electrolyte (Na & K) services in zonal hospital laboratories			5	6		
Expansion of bacteriological service			15 districts	20 districts	20 districts	13 districts
Expansion of semi-automatic analyser service			20 districts	20 districts	20 districts	8 districts
National laboratories operation and management guidelines will be developed			X			
Laboratory policy will be developed			X			
Highly advanced biosafety lab will be established for diagnosis of highly infectious diseases			At NPHL	Continuous	Continuous	Continuous
NIC will be upgraded with facilities for other respiratory viruses			At NPHL	Continuous	Continuous	Continuous

Coverage and Output	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
(Real Time Polymerase Chain Reaction (PCR) and viral culture)						
Registration and licensing of health laboratories				Continuous	Continuous	Continuous
All districts will have a BTSC			5 districts	15 districts	20 districts	23 districts
Registration and licensing of BTSC				Continuous	Continuous	Continuous

6. Major Challenges and Issues

- Establishing BSL 2-plus lab, molecular biology and viral isolation facility
- Upgrading NPHL
- Ensuring logistics and supplies
- Establishing LIS
- Communicating laboratory requirements and test results
- Providing evidence for physicians and patients for decision making
- Finding focal persons for training at district level
- Needs assessment and curriculum development for training for new components of EHCS

Accountable Officer: Director, NPHL, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Expansion of laboratory services	Establish basic health laboratory at HPs	NPHL	NHSSP/WHO/ Nepal Family Health Programme (NFHP)			X	X	X	X
	Establish/strengthen regional-level health laboratories	NPHL	NHSSP/WHO/ NFHP			X	X	X	X
	Expand bacteriological laboratory services in zonal hospital	NPHL	NHSSP/WHO/ NFHP			X			
	Expand electrolyte (Na & K) services in all zonal hospitals	NPHL	NHSSP/WHO/ NFHP			X			
	Expand bacteriological services at district hospitals	NPHL	NHSSP/WHO/ NFHP			X	X	X	
Developing health laboratory legislation	Prepare framework for health laboratory legislation	NPHL	NHSSP/WHO/ NFHP			X			
	Develop laboratory operation and management framework	NPHL	NHSSP/WHO/ NFHP			X			
Developing and integrating LIS	Develop and implement LIS (software)	NPHL	HMIS/NHSSP/ WHO/NFHP			X			
	Provide training on LIS	NPHL	HMIS/NHSSP/ WHO/NFHP				X	X	
Developing HR for laboratory services	Provide scholarships for Doctor of Medicine in Pathology, Masters in Medical Laboratory Technology, Masters in	NPHL	NHSSP/WHO/ HR Section, MoHP			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Medical Laboratory, and Certificate in Medical Laboratory Programmes								
Assuring quality	NEQAS, External Quality Assessment Scheme (EQAS), Proficiency Testing Panel preparation and dispatch to public and private labs	NPHL	Hospitals			X	X	X	X
Improving monitoring and supervision	Facilitative supervision and monitoring	NPHL		X	X	X	X	X	X
Upgrading physical facilities and level of services	Renovate/upgrade physical facilities at all levels	NPHL	MD			X	X	X	X
	Upgrade NPHL as national reference lab for blood transfusion services	NPHL	MOHP			X			
	Functioning of BSL 2-plus lab	NPHL	WHO			X			
Strengthening service centres	Maintain national Influenza centre	NPHL	MOHP/WHO			X	X	X	X
Infection control programme	Developing guidelines on infection control	NPHL	WHO			X			
	Train laboratory staff on infection control	NPHL	WHO			X	X	X	X
	Train in proper disposal of waste (waste management)	NPHL	WHO			X	X	X	X
Support blood donation	Support awareness and blood donations to achieve 100% non-remunerated blood (especially focusing on	NPHL	MOHP/NRCS/ Blood Donors Association			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	women, marginalised people and those from remote areas who are not interested in donating)								

2.16 HIV and STI Prevention and Control Programme

1. Introduction

Since the first HIV case was reported in 1988, Nepal's HIV epidemic has matured from a low-level to a concentrated epidemic among key higher-risk populations, such as People Who Inject Drugs (PWID), Men who have Sex with Men (MSM), and Female Sex Workers (FSWs). HIV prevalence is consistently more than 5% among PWID and less than 1% among pregnant women in urban areas: Nepal's HIV epidemic is characterised as concentrated rather than generalised. More than 80% of infected people acquired the infection through sexual transmission. In 2011, it was estimated that Nepal had nearly 50,200 People Living With HIV (PLHIV)[2], about 0.3% of the adult population between 15 and 49 years of age.

Most HIV cases have been among male labour migrants (29.5%) who travel to areas in India with high HIV prevalence. Clients of sex workers in Nepal and male labour migrants (particularly to areas in India with high HIV prevalence where they often visit sex workers) act as a bridging population transmitting the HIV infection to low-risk populations. Surveillance data in Nepal during the last five years indicate a decreasing HIV prevalence among adults (15-49 years) and key populations (mainly PWID, FSWs and clients of FSWs). This achievement is mainly attributed to targeted preventive interventions conducted for the key population groups. However, sustaining the prevention interventions with quality, coverage, and effectiveness is the key challenge.

The current National HIV/AIDS Strategy, 2011-2016[3] has prioritised a national response that aims to (i) reduce new HIV infections by 50%, with the goal to reduce new HIV infections among children by 90%, and (ii) reduce HIV-related deaths by 25% by 2016, compared with the 2010 base line. These strategic goals are built upon the goal of reaching universal access to HIV prevention both among key higher-risk populations and among the general population, and providing treatment, care, and support to HIV-infected and affected populations according to the following strategic directions:

- Optimising HIV prevention
- Providing treatment, care, and support
- Implementing cross-cutting strategies such as strengthening health and community systems, strengthening strategic information for evidence-based planning and programming, and providing legal support, human rights, and social protection.

The previous strategy of 2006-2011[4] had aimed to contribute directly to MDG 6: "To halt and begin to reverse the spread of HIV by 2015"; it was designed to be in line with the universal access target (of 80% in most of the interventions) of prevention of HIV among key higher-risk populations.

Review of the previous strategy has identified considerable gaps in the following areas: reaching migrant workers in India and their spouses with prevention interventions; rates of utilisation of HIV Counselling and Testing (HCT) and Prevention of Mother-to-child Transmission (PMTCT)

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[2] National Centre for AIDS and STI Control (NCASC) (2012) National Estimates of HIV Infections, 2011, March, 2012.

[3] NCASC (2011) National HIV/AIDS Strategy, 2011-2016, Kathmandu Nepal, December, 2011.

[4] NCASC (2007) National HIV/AIDS Strategy, 2006-2011, Kathmandu Nepal.

services; policy in the initiation of Antiretroviral Treatment (ART); HIV mainstreaming in other sectoral development plans; coordination for effective planning and programming in the field; civil society capacities; combatting discrimination against PLHIV, sex workers and transgender persons; and sustainable and independent funding for the HIV response.

Therefore, the NHSP-2 IP has undertaken to address the major challenges, issues, and concerns through the following:

- Increasing the effectiveness of HIV and STI prevention and control interventions at the local level (district and below)
- Fostering coordination and cooperation between government, donors, NGOs, and communities, including PLHIV
- Sustaining the quality and effectiveness of targeted prevention interventions, and improving coverage
- Expanding comprehensive PMTCT services to reach more children, girls, women, and men
- Scaling up of care and support services for PLHIV and affected populations
- Managing QoC of interventions for improved programme outcomes
- Improving the predictability of funds and exploring the resources
- Correcting the uneven distribution of care and support programmes between districts and regions
- Strengthening M&E systems.

2. Vision

Nepal will become a place where new HIV infections are rare and when they do occur, every infected person will have access to high-quality, life-extending care without any discrimination.

3. Goals

To achieve universal access to HIV prevention, treatment, care and support.
Specific goals are:

1) Halve the incidence of HIV by 2016 compared to 2010 (including reduction of new HIV infections in children by 90% compared with a 2010 baseline)
2) Reduce HIV-related deaths by 25% by 2016, compared with a 2010 baseline.

4. Objectives

To meet Goal 1, the following objectives are set:

1) Reduce sexual transmission of HIV
2) Reduce HIV transmission through the injecting of drugs
3) Reduce vertical (mother-to-child) transmission of HIV
4) Maintain low levels of blood-borne transmission of HIV
5) Create an enabling environment for HIV prevention.

To meet Goal 2, the following objectives are set:

1) Provide prophylaxis for opportunistic infections among PLHIV
2) Provide ART for eligible adults and children living with HIV
3) Provide treatment for co-infection among adults and children living with HIV
4) Provide care and support services to PLHIV according to their needs
5) Reduce the HIV-related impacts among PLHIV.

5. Major Strategies

- Optimising HIV prevention
- Provision of HIV treatment care and support
- Cross-cutting strategies.

6. Indicators

Impact Indicators	Baseline (2010)	Target by 2016
1. HIV prevalence in the population aged 15-24 years	0.12% (2010) (NCASC, 2011)	0.06%
2. Percentage of adults and children with HIV known to be on treatment 12, 24 and 36 months after initiation of ART	89% - 12 months (2010) 84% - 24 months (2010) 70% - 36 months (2010)	At least 93% - 12 months At least 90% - 24 months At least 85% - 36 months

The key outcome-level indicators and targets are:

Outcome 1.1 Reduce sexual transmission of HIV

	Outcome Indicators [a, b]	Baseline (2010)	Target by 2016
1.1.1	% of Most-at-risk Populations (MARPs) (sex workers – female and male – and male labour migrants aged 15-49 years) who are HIV-infected	• FSWs = 1.7 (2011) • MSWs = 5.2 (2009) • MSM = 3.8 (2009) • Labour migrants (15-49) = 4.5	• FSWs = 1.0 • MSWs = 2.5 • MSM = 2.0 • Labour migrants (15-49) = 0.5
1.1.2	% of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	• FSWs = 30 (2011) • MSM = 64 (2009) • Labour migrants (15-49) = 18.1	• FSWs = 60 • MSM = 80 • Labour migrants (15-49) = 50
1.1.3	% of men reporting the use of a condom the last time they had anal sex with a male partner	75 (2009)	>80
1.1.4	% of FSWs and Male Sex Workers (MSWs) reporting the use of a condom with their most recent client	• FSWs: 83 (2011) • MSWs: 87 (2009)	>85
1.1.5	% of migrants aged 15-49 reporting the use of a condom the last time they had sex with a non-regular sexual partner	53	>80
	% of MARPs who had received an HIV test in the last 12 months and know their results	• FSWs = 54.7 (2011) • MSWs = 65.2 (2009) • MSM = 42 (2009) • Labour migrants (15-49) = 13.8 (2010)	• FSWs = 80 • MSWs = 80 • MSM = 80 • Labour migrants (15-49) = 80

Notes: a: The baseline and targets referred to Kathmandu valley cluster of Integrated Bio-behavioural Survey (IBBS), used as proxy

b: The baseline and targets referred to mid-and far-western cluster of IBBS, used as proxy

Outcome 1.2: Reduction of HIV infection through the injecting of drugs

	Outcome Indicators *	**Baseline (2010)**	**Target by 2016**
1.2.1	% of PWID who are HIV-infected	6.3 (2011)	3
1.2.2	% of PWID who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	64 (2011)	80
1.2.3	% of PWID reporting the use of sterile injecting equipment the last time they injected	95 (2011)	>95
1.2.4	% of PWID who received an HIV test in the last 12 months and who know their results	21.4 (2011)	80
1.2.5	% of PWID currently on Oral Substitution Therapy (OST) who have been on OST continuously for the past 12 months	NA	80

*Note: * The baseline and targets referred to Kathmandu valley cluster of IBBS, used as proxy*

Outcome 1.3: Reduction of vertical (mother-to-child) transmission of HIV

	Impact/Outcome Indicators	**Baseline (2010)**	**Target by 2016**
1.3.1	Eliminate new HIV infections in children: reduce new HIV infections in children by 90% (compared with a 2010 baseline)	NA	90%
1.3.2	% of infants born to-HIV infected mothers who are HIV-infected	NA	12
1.3.3	% of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission of HIV	8.3	80
1.3.4	% of infants born to HIV-infected women receiving a virological test for HIV within two months of birth	1.7	100

Outcome 1.4: Maintenance of low level of blood-borne transmission of HIV

	Outcome Indicators	**Baseline (2010)**	**Target by 2016**
1.4.1	% of HFs providing HIV services with post-exposure prophylaxis available	NA	100
1.4.2	% of donated blood units screened for HIV in a quality assured manner*	38 (2009)	100

**Quality assured manner is defined as the blood units screened for HIV included in EQAS*

Outcome 1.5: Creation of enabling environment in HIV Prevention

	Outcome Indicators	**Baseline (2010)**	**Target by 2016**
1.5.1	% of HWs aged 15-49 years, both women and men, expressing an accepting attitude towards PLHIV	NA	>90%

Outcome 2.1: PLHIV received prophylaxis for opportunistic infection, treatment, and other common co-infections treatment according to national guidelines

Outcome Indicators		Baseline (2010)	Target by 2016
2.1.1	% of people enrolled in HIV care and treatment who received cotrimoxazole prophylaxis in the last 12 months	NA	80%
2.1.2	% of PLHIV (both adults and children) currently enrolled in HIV care receiving prophylaxis against opportunistic infection	NA	80%

Outcome 2.2: Adults and children living with HIV and eligible for ART who are receiving it.

	Outcome Indicators	Baseline (2010)	Target by 2016
2.2.1	% of eligible adults and children currently receiving ART	27% (2010)	80%
2.2.2	% of people starting ART who picked up all the prescribed antiretroviral drugs on time	NA	80%

Outcome 2.3: Adults and children with HIV-associated co-infections who received treatment for co-infection management

Outcome Indicators		Baseline (2010)	Target by 2016
2.3.1	Number (and %) of adults and children enrolled in HIV care who had their TB status assessed and recorded during their last visit (among all adults and children enrolled in HIV care in the reporting period)	NA	22,500 (80%)
2.3.2	% of estimated HIV-positive incident TB cases who received treatment for both TB and HIV	NA	80%
2.3.3	% of adults and children newly enrolled in HIV care who will start treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period	NA	80%

Accountable Officer: Director, NCASC

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Optimising HIV prevention	Reduce sexual transmission of HIV: condom programming, BCC, IEC, peer education	NCASC	GFATM, multi-bilateral partners, USAID	X	X	X	X	X	X
	Provide comprehensive prevention interventions among key populations such as PWID, MSM, FSWs, labour migrants, and their spouses	NCASC	GFATM, multi-bilateral partners, USAID	X	X	X	X	X	X
	Provide HCT	NCASC	GFATM, multi-bilateral partners, USAID	X	X	X	X	X	X
	Protect against HIV infection among PWID through safe syringe and needle exchanges with a special emphasis on creating an enabling environment for female injecting drug users	NCASC	GFATM, multi-bilateral partners	X	X	X	X	X	X
	Provide diagnosis and management of STIs	NCASC	GFATM, USAID, WHO	X	X	X	X	X	X
	Prevent mother-to-child transmission of HIV, with a special emphasis on attracting the poorest and excluded women to PMTCT services by providing them with incentives such as nutritional packages	NCASC	GFATM, UNICEF, WHO, UNFPA	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Optimising HIV prevention	Prevent HIV transmission in health care settings	NCASC	GFATM	X	X	X	X	X	X
	Ensure blood safety	NCASC, NRCS, NPHL	GFATM, WHO	X	X	X	X	X	X
	Prevent HIV transmission in close settings such as prisons and work places	NCASC	GFATM	X	X	X	X	X	X
	Prevent HIV among youth and adolescents at risk	NCASC	GFATM, UNICEF, UNFPA	X	X	X	X	X	X
Provision of HIV treatment, care, and support	Optimise HIV treatment and care of adult and children – scale up ART services	NCASC	GFATM, WHO	X	X	X	X	X	X
	Manage HIV-associated co-infections (TB treatment for PLHIV)	NCASC, National Tuberculosis Centre (NTC)	GFATM, WHO	X	X	X	X	X	X
	Provide community- and home-based care for PLHIV	NCASC	GFATM, USAID, partners	X	X	X	X	X	X
	Support CABA	NCASC, Ministry of Women, Children and Social Welfare (MoWC&SW)	GFATM, UNICEF	X	X	X	X	X	X
	Establish social protection, addressing the poorest and excluded girls and women, infected and affected spouses, and children of migrant workers	NCASC	GFATM	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Promote health system strengthening – service delivery, health information, HR development, procurement and supply chain management, financing of HIV response, and leadership and governance	NCASC, LMD	GFATM, USAID, NHSSP	X	X	X	X	X	X
Cross-cutting strategies	Health system strengthening - provision of integrated service delivery including logistics and reporting systems, improving the quality of services including quality logistics of drugs and commodities, and capacity building of the health workforce	NCASC, LMD	GFATM, USAID	X	X	X	X	X	X
	Community system strengthening – strengthening networks, human rights, social entitlement, M&E	NCASC	GFATM, multi-bilateral partners	X	X	X	X	X	X
	HIV surveillance – case reporting, Integrated Bio-behavioural Survey , size estimation, epidemic analysis and modelling, including HIV drug resistance surveillance	NCASC	GFATM, multi-bilateral partners, NGOs	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Undertake operational research to improve quality, coverage and effectiveness of interventions	NCASC	GFATM, WHO	X	X	X	X	X	X
	Undertake M&E of interventions and programmes	NCASC	GFATM	X	X	X	X	X	X
	Reduce stigma and discrimination among key populations and PLHIV	NCASC	GFATM, hospitals, NGOs	X	X	X	X	X	X
	Provide legal support, legal reforms and human rights	NCASC	GFATM, multi-bilateral partners, I/NGOs	X	X	X	X	X	X
	Address sexual and gender-based violence	NCASC	GFATM, multi-bilateral partners, I/NGOs	X	X	X	X	X	X

2.17 National Tuberculosis Programme

1. Introduction

The National Tuberculosis Programme (NTP) is an approach within the national health system for control of Tuberculosis (TB). NTP has specific policies, plans and activities to achieve its goals, objectives and targets. NTP is countrywide, continuous and permanent, and fully integrated within the general health services. NTP policies are in accordance with the national health plan, the WHO Stop TB Strategy and the Global Plan to Stop TB (2006-2015). The Stop TB Strategy sets out the steps NTP and its partners need to take for TB control in Nepal. The strategy is based on experience gained over the past decade and on continuing consultations with stakeholders at the global, regional, national and local levels.

2. Vision

Nepal free of TB.

3. Goal

To reduce the mortality, morbidity and transmission of TB until it is no longer a public health problem in Nepal.

4. Objectives

- Achieve universal access to high-quality diagnosis and patient-centred treatment
- Reduce the human suffering and socioeconomic burden associated with TB
- Protect poor and vulnerable populations from TB, TB/HIV and Multidrug-resistant TB (MDR-TB)
- Support development of new tools and enable their timely and effective use.

5. Targets

MDG6, Target 8: halt by 2015 and begin to reverse the incidence...

Target linked to the MDGs and endorsed by the Stop TB Partnership:

- By 2005: detect at least 70% of new sputum-smear-positive TB cases and cure at least 85% of these cases
- By 2015: reduce the prevalence of and deaths due to TB by 50% relative to 1990
- By 2050: eliminate TB as public health problem (<1 case per million population).

Components of the Stop TB strategy

1. Pursue high-quality Directly Observed Treatment Short Course (DOTS) expansion and enhancement
   - Political commitment with increased and sustained financing
   - Case detection through quality assured bacteriology
   - Standardised treatment with supervision and patient support
   - An effective drug supply and management system
   - M&E system and impact measurement.

2. Address TB/HIV, MDR-TB and other challenges
   - Implement collaborative TB/HIV activities
   - Prevent and control MDR-TB
   - Address prisoners, refugees and other high-risk groups and special situations.

3. Contribute to health system strengthening
   - Actively participate in efforts to improve system-wide policy, HR, financing, management, service delivery and information system.

4. Engage all care providers
    - Public-Public, and Public-Private Mix (PPM) approaches
    - International Standards for Tuberculosis Care (ISTC).

5. Empower people and communities with TB
    - Advocacy, communication and social mobilisation
    - Community participation in TB care
    - Adoption of Patient's Charter for Tuberculosis Care.

6. Enable and promote research
    - Programme-based operational research.

The NTP Stop TB Strategy is in line with the Global Plan to Stop TB (2006–2015) developed by the Stop TB Partnership. With this strategy NTP aims to achieve the MDG and Stop TB Partnership targets for TB control and eliminate this disease. Therefore, the IP 2012-2016 provides a plan for the next five years to achieve the immunisation-related goals the Government of Nepal (GoN) has expressed in various policy documents, in the MDGs and World Health Assembly (WHA) resolutions, and in different national and international fora.

Millennium Development Goals and Stop TB Strategy
The MDGs require halving the 1990 TB prevalence and mortality rates by 2015. In 1990, the TB incidence rate was 243/100,000, prevalence rate 621/100,000, and mortality rate 51/100,000.[5] Hence by 2015, the targets should be: an incidence rate of 121.5/100,000, prevalence rate of 310.5/100,000 and mortality rate of 25.5/100,000.

6. Major Strategies

- Pursue high-quality DOTS expansion and enhancement
- Address TB/HIV, MDR-TB and other challenges
- Contribute to health system strengthening
- Engage all care providers
- Empower people and communities with TB
- Enable and promote research.

7. Indicators and Targets
The number of deaths in this period will be reduced by 75% to 24,770, saving about 70,222 lives according to the National Strategic Plan Stop TB Strategy of 2010 - 2015.

Health Outcome and Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Case Detection Rate (CDR) (new smear positive) (%)	78	80	81	82	82	82
Treatment success rate (%)	90	90	90	90	90	90

8. Major Challenges and Issues

1. Inability to increase the national CDR beyond 70%
2. Access to and utilisation of health services in rugged areas
3. Lack of a sustainable national reference laboratory within NTP, and decentralised culture facilities for MDR-TB detection

[5] Source: Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report, 2007.

4. Health system weak owing to the following:
    - Inadequate diagnosis and treatment of respiratory illnesses
    - Lack of required infection control measures with special focus on the MDR-TB management sites
    - No specialised respiratory service in Kathmandu
5. HIV/AIDS epidemic's influence on TB control
6. MDR-TB default rates due to patients needing to be away from families and jobs for 24 months
7. Inadequate IEC materials to meet specific target groups
8. Lack of coordination of TB diagnosis and treatment by the private sector, resulting in low CDR and the possible development of MDR TB
9. Insufficient research to determine the causes of gender inequity in TB registrations, the effectiveness of community-based DOTS in Nepal, etc.
10. Lack of electronic data management for DOTS, MDR-TB management programmes, and logistics management, and follow-up on internal and cross-border migration
11. Programme sustainability at risk due to limited programme financing through GoN resources and insufficient HR to implement the expanded scope of work after adopting the Stop TB Strategy, particularly for specialised programmes such as MDR-TB treatment, TB/HIV collaboration, Practical Approach to Lung Health (PAL), Advocacy, Communication and Social Mobilisation (ACSM) and PPM.

Accountable Officer: Director, NTC

Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Free treatment for TB patients	NTC	WHO, Partners	32,731	33,809	34,468	35,128	35,357	35,500
Expand reach of diagnostic facilities	NTC	GFATM, Partners	21	21	27	28	28	28
Case detection (%)	NTC		78	80	81	82	82	82
No. of Sputum Positive Cases (increasing CFR)	NTC		16,365	16,904	17,234	17,564	17,679	
No. of total new TB cases (pulmonary and extrapulmonary)	NTC		32,731	33,809	34,468	35,128	35,357	
No. of Cat 2 @ 15% of new Sputum Positive Cases	NTC		2,455	2,536	2,585	2,635	2,652	
Total estimated first-line TB cases	NTC	GFATM, Partners	35,186	36,344	37,053	37,763	38,009	
Estimated MDR-TB cases	NTC	GFATM, Partners	300	300	300	300	300	300
Total detected TB cases	NTC	GFATM, Partners	35,486	36,644	37,353	38,0633	38,309	
Intensified case finding among specific groups	NTC	GFATM, Partners	X	X	X	X	X	
Chest camps	NTC	GFATM, Partners	15	20	25	30	35	
Revision of NTP policy and guidelines	NTC	GFATM, Partners			X			
Treatment services (DOTS) expansion	NTC	GFATM, Partners	21	21	27	28	28	
Drug procurement and supply	NTC	GFATM, Partners	X	X	X	X	X	X
HR development (training and retention)	NTC	GFATM, Partners	X	X	X	X	X	X

Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Expand partnerships with (I/NGOs) and private organisations	NTC	GFATM, Partners	X	X	X	X	X	X
Improve the quality and coverage of TB microscopy programme	NTC	GFATM, Partners	X	X	X	X	X	X
Build and expand national laboratory capacity at the regional level for cultures and DST (number)	NTC	GFATM, Partners			2	1		
Provide monitoring and supervision of TB laboratories	NTC	GFATM, Partners	X	X	X	X	X	X
Provide support to I/NGOs operating QC Laboratories	NTC	GFATM, Partners	X	X	X	X	X	X
Adapt a comprehensive and systematic approach to managing patients with respiratory symptoms	NTC	GFATM, Partners	X					
Expand PAL (in districts)	NTC	GFATM, Partners	5	5	5	5	4	
Develop a National Infection Control Strategy and guidelines	NTC	GFATM, Partners						X
Develop MDR Infection control and staff safety mechanism	NTC	WHO, GFATM, Partners						X
Establish a 100-bedded respiratory hospital	NTC	GFATM, Partners			X	X		
Expand TB/HIV collaboration	NTC	WHO, GFATM, Partners	5	5	5	5	5	
Revise operational guidelines, training manuals, and IEC materials	NTC	GFATM, Partners		X				
Conduct surveillance and operational research on HIV prevalence in TB patients, carry out a sentinel sites survey	NTC	WHO, GFATM, Partners		X		X		X

Major Activities		Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Establish Voluntary Counselling and Testing (VCT)/ART sites in DOTS centres		NTC	WHO, GFATM, Partners		3	3	3	3	3
Establish DOTS sites in VCT/ART centres					10	10	10	10	10
Provide care and support to TB/HIV co-infected cases in VCT/ART sites in DOTS		NTC	GFATM, Partners	X	X	X	X	X	X
Build and implement a two-way referral system between TB and HIV				X	X	X	X	X	X
Provide joint supervision and M&E of TB/HIV activities		NTC	WHO, GFATM, Partners	X	X	X	X	X	X
Expand MDR-TB management	Centre	NTC	WHO, GFATM, EDPs	11	13	15	17	19	20
	Sub-centre			39	44	48	52	56	60
Manage MDR-TB					300	300	300	300	300
Extreme Drug-resistant TB (XDR-TB) management plan and targets (10 cases)		NTC	WHO, GFATM, Partners	10	10	10	10	10	10
PPM in urban areas		NTC	GFATM, Partners	10	5	5	5	5	5
ACSM		NTC	GFATM, Partners	X	X	X	X	X	X
Operational Research		NTC	Nuffield Centre for International Health and	X	X	X	X	X	X

Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
		Development (University of Leeds, UK), GFATM, Partners						

2.18 Non-Communicable Diseases Control Programme

1. Introduction

WHO estimates that NCDs account for 39% of Disability-adjusted Life Years (DALYs) lost, and for 44% of deaths. About half of the deaths are from cardio-vascular diseases, 18% relate to cancers, 10% to respiratory diseases, and 7.5% to digestive diseases. Neuro-psychiatric conditions account for 28% of DALYs lost to NCDs, cardio-vascular diseases for 20%, sense organ diseases for 13%, and respiratory and digestive diseases about 7.5% each. Injuries account for a further 11% of deaths and 12% of DALYs, with around half of the injuries caused by violence or war; road traffic accidents are the other major cause.

NCDs were not part of the EHCS package during NHSP-1. They are relatively expensive to treat, and it remains unaffordable to offer comprehensive free services during NHSP-2. However, in response to the rising importance of NCDs and injuries in the burden of disease, NHSP-2 will expand prevention activities aimed at reducing the burden of NCDs by encouraging healthier lifestyles. Measures will include:

- BCC via multiple channels, aimed at encouraging a better diet, more exercise, reduced smoking and alcohol consumption, and safer driving, including the wearing of seatbelts and helmets
- Advocacy for implementation and enforcement of tobacco and alcohol controls and legal requirements to wear seatbelts and helmets
- Strengthening the capacity of health facilities located close to highways and to the sites of frequent traffic accidents to handle injuries from road traffic accidents.

Mental health problems are clearly widespread, and may be associated with the legacy of conflict and with the very high rates of violence and suicide. What can be achieved with the available resources is less clear. Before committing to a major expansion of mental health services, one or more scalable pilots will be implemented. The initial approach will focus on giving basic mental health training to HWs in pilot districts, beginning to cover mental health issues in health education programmes, and on integrating mental health within PHC, following guidance issued by WHO.

The elderly benefit from free services, and appear to make use of health services in proportion to their share in the population, though less than their higher incidence of health problems would predict. The first step to addressing this potential inequality will be a study of the issue, to identify the extent to which the health service meets the needs of this group, as preparation for considering what further measures might be appropriate and feasible.

2. Goal

To reduce mortality and disability, and to address morbidity by encouraging healthier lifestyles and managing NCDs at early stages

3. Objectives

- To reduce the prevalence of tobacco use
- To prevent and control accidents and injuries
- To reduce the prevalence of mental disorders
- To prevent and manage the health care problems of the elderly.

4. Major Strategies

- New programme development
- Piloting new programmes

- BCC
- Expansion of care and support activities for NCDs
- Partnerships
- Collaboration and coordination.

5. Indicators and Targets

Indicators and Targets	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Prevalence of tobacco use among men (%)	29.8	27	24	22.5	21.5	20
Prevalence of tobacco use among women (%)	15.4	14	13	12	11	10
% reduction of prevalence of mental disorders		1	1	1	1	1
% reduction of premature death from cardio-vascular diseases, cancer, diabetes, and chronic respiratory diseases		1	1	1	1	1
% reduction in prevalence of diabetes		0.5	0.5	0.5	0.5	1
% reduction in fat intake		0.5	0.5	0.5	0.5	1
Halt in prevalence of obesity		Rural 0.25 Urban 0.5	Rural 0.25 Urban 0.5	Rural 0.25 Urban 0.5	Rural 0.25 Urban 0.5	Rural 0.5 Urban 1
% reduction in physical inactivity		0.5	0.5	0.5	0.5	0.5
% reduction in prevalence of high cholesterol level		1	1	1	1	1
% reduction in raised blood pressure		1	1	1	1	1
% reduction in salt intake		2	2	2	2	2
% reduction in tobacco smoking		2	2	2	2	2
% distribution of drug therapy to prevent heart attack		1	1	1	1	1
% availability of essential NCD medicines		0.25	0.25	0.25	0.25	0.25
% of women 30-49 years screened for cervical cancer		4	4	4	4	4

6. Major Challenges and Issues

- Programme development
- Piloting
- Training
- Establishing new services.

Accountable Officer: Chair, Non-Communicable Disease Control Committee, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reducing the prevalence of tobacco use	Implement Tobacco Control Act								
Law enforcement	Formulate a Tobacco Control (regulatory) Act	NHEICC	Partners		X				
BCC	Enhance capacity of NHEICC and law enforcement agencies	NHEICC	Partners		X	X	X	X	X
	Ban advertising, promotion, and sponsorship of tobacco products and companies	NHEICC	Partners			X	X	X	X
	Expand the coverage of non-smoking areas	NHEICC	Partners			X	X	X	
	BCC, considering the practices of different social groups	NHEICC	Partners	X	X	X	X	X	X
	Increase tax on tobacco products	NHEICC	Partners	X	X	X	X	X	X
	Packaging and labelling of tobacco products	NHEICC	Partners		X	X	X	X	X
	Tobacco use cessation	NHEICC	Partners			X	X	X	X
	Develop a supply reduction strategy	NHEICC	Partners				X		
Prevention and control of accidents and injuries	Define the roles and implement activities for prevention and management of accidents and injuries	Curative Division	MoHA, Traffic Police, NHEICC, media			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop and implement a joint plan of action to prevent accidents and injuries	Curative Division	MoHA, Traffic Police, Department of Transport (DoT), media			X	X	X	X
	Organise a coordination meeting on the prevention and handling of accidents and injuries	Curative Division	MoHA, Traffic Police, National Trauma Centre, Association of Private Hospitals (APH), DoT			X	X	X	X
Training	Provide training to health and non-health workers to handle injury and accident cases in a responsive manner	Curative Division	MoHA, National Trauma Centre, NHTC, DoT, APH			X	X	X	X
Monitoring	Support traffic police to monitor the incidence of accidents, deaths, and severe injuries due to driving under the influence of alcohol	Curative Division	MoHA, National Trauma Centre, NPHL, I/NGOs			X	X	X	X
Mental health Reduce the incidence and prevalence of mental disorders	Conduct needs assessment on mental health in a disaggregated manner	Curative Division	MD, Institute of Medicine, psychiatric hospitals, I/NGOs		X				

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Programme development	Develop/adapt a mental health programme with relevant components	Curative Division	PPICD, IOM, psychiatric hospitals, I/NGOs			X			
	Prepare a mechanism including indicators, the frequency of monitoring, and tools	Curative Division	PPICD, MD, IOM, psychiatric hospitals, I/NGOs		X	X			
Service provision	Develop and implement a full pilot plan with cost estimates based on needs assessment	MD	IOM, psychiatric hospitals, I/NGOs		X	X	X		
Expansion of services	Expansion of mental health service with backup and follow up	Curative Division	MD, IOM, psychiatric hospitals, I/NGOs		X	X	X	X	X
Research and M&E	Include operational research to test the models	MD	IOM, psychiatric hospitals, I/NGOs			X	X		
	Process and impact evaluation of pilot programmes among different social groups	MD	IOM, psychiatric hospitals, I/NGOs			X		X	
Partnerships	Develop a modality of partnerships with I/NGOs, hospitals, and medical colleges	Curative Division	MD, M&E Division, IOM, psychiatric hospitals, I/NGOs,			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
			media						
Elderly care Study and research	Study on the inequality in health care utilisation by the elderly by sex, location, and social group	Curative Division/ PHCRD	MoWC&SW, Elderly Homes, I/NGOs			X			
Programme development	Identify the health care needs of elderly by sex and social group	Curative Division/ PHCRD	MoWC&SW, Elderly Homes, I/NGOs			X			
	Develop and implement a programme for the elderly as required for different income and social groups	Curative Division/ PHCRD	MoWC&SW, Elderly Homes, NHEICC			X			
Monitoring	Develop a monitoring mechanism and GESI-responsive guidelines					X			
Partnerships	Develop a partnership modality for an elderly care programme	Curative Division	MoWC&SW, Elderly Homes, NHEICC, I/NGOs, media			X			

2.19 Programme on Mental Health and Neurological Disorders

1. Introduction

Mental health conditions constitute five out of the total top ten conditions that cause lost DALYs in developing countries. It is estimated that depression will top the list in 2020. Between 25 and 30% of patients coming to seek help at any health delivery point come because of underlying mental health problems. Suicide is reported as the second most common cause of maternal mortality in Nepal, and can be easily attributed to undiagnosed and untreated depression. Although Nepal has made significant progress formulating a Mental Health Policy (1996), implementation has been inadequate and needs to be strengthened.

Ongoing programmes that require strengthening include the following:

- Mental health services will be strengthened as more districts are chosen for the implementation and introduction of HP-level mental health services
- Health Assistants (HAs) and Auxiliary Health Workers (AHWs) (paramedics) at HPs and counsellors at hospitals will be trained in mental health care. FCHVs will be trained in case detection and referral
- Psychiatrists will be posted at least to the level of zonal hospitals to ensure the availability of specialist care and a referral point for community-level workers
- The availability of basic psychotropic and anti-epileptic medication will be ensured at the HP level.

2. Goal

To reduce the morbidity and disability caused by mental health problems.

3. Objective

To increase the access to and utilisation of basic mental health services to all, including the poor and excluded.

4. Major Strategies

- Programme development
- Institutional development
- Training
- Partnership with Government Organisations (GOs), INGOs/CBOs and academia
- Expansion of services, especially to areas where mental health problems are reported.

5. Major Challenges and Issues

- Limited information regarding mental health problems
- Programme refinement for mental health care
- Developing indicators and a monitoring framework
- Financing a mental health programme
- PPPs
- Institutional development
- Lack of skilled HR.

Accountable Officer: Director, MD

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Policy decision	Creation of a Mental Health Unit	MD	NCD Committee/ MoHP			X			
Programme development	Develop and revise the training manual of paramedics (HAs, Senior AHWs/Community Medicine Auxiliaries (CMAs))	MD	Curative Division		X		X		
	Develop and revise the training package for doctors with a Bachelor in Medicine and Bachelor in Surgery (MBBS) degree	MD	Curative Division			X		X	
	Develop a training package for FCHVs	MD	Curative Division			X			
	Develop a training manual for counsellors	NHTC	MD			X			
Training	Provide training to paramedics of new districts	MD	Curative Division		X	X	X	X	X
	Provide training to FCHVs of new districts	MD	Partners		X	X	X	X	X
	Provide post-training follow-up for doctors and paramedics	MD	Partners		X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Training of counsellors	MD	NHTC				X	X	X
Partnership	Develop and implement a collaborative programme with medical colleges, GOs, I/NGOs, CBOs and academia	MD	Private hospitals			X	X	X	X
M&E	Develop a monitoring mechanism	MD	HMIS			X	X	X	X
Service expansion	Survey/study	MD	PHCRD				X		
	Design and implement a programme based on the survey findings	MD	PHCRD					X	X

2.20 Oral Health Care Programme

1. Introduction

Oral health conditions are estimated by WHO to account for 0.6% of DALYs lost in Nepal, and account for 3% of Outpatient Department (OPD) visits recorded in DoHS's 2007-08 Annual Report. More than 57% of Nepalese children at six years of age and 69% of adults above the age of 50 suffer from untreated dental caries affecting more than three teeth. Untreated dental caries is the most prevalent childhood disease in Nepal – more prevalent than malnutrition (53%) and vitamin deficiency (58%). Nepal ranks among the top 15 countries in the world where periodontal disease in the age group of 35-44 years is prevalent. However, GoN has made significant progress formulating an Oral Health Policy (2004) and has an Oral Health Strategic Plan. It also has advocated for fluoridation of toothpastes that are produced in Nepal.

Ongoing programmes that need to be strengthened include the following:

- Dental surgeons or dental assistants will be recruited and posted at selected district hospitals to train staff at HPs and PHCCs in basic dental/oral check-ups. Mobile dental camps will work in communities in collaboration with medical and dental colleges
- Primary Health Care Workers (PHCWs) will be trained on basic oral health care, including extraction and simple fillings
- Dental surgeons will be posted at district hospitals where facilities are available throughout the country helping ensure the availability of oral health services
- Teachers, schoolchildren, FCHVs and HWs will be trained on oral-health-related subjects to promote good oral health.
- Brushing programme will be promoted at schools.

2. Goal

To reduce the morbidity and disability caused by oral health problems.

3. Objective

To increase access to and utilisation of basic oral health services.

4. Major Strategies

- Programme development
- Institutional development
- Training
- Partnership
- Piloting
- Expansion of services
- Strengthening M&E.

5. Indicators and Targets

Outcome	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Prevalence of dental caries at age six years (%)	57	54	50	46	42	40

Prevalence of dental caries (caries in three or more teeth) at age 50 (%)	69	66	62	58	54	50

6. Major Challenges and Issues

- Programme development for basic oral care
- Developing indicators and monitoring framework
- Financing oral health programme
- PPPs
- Institutional development.

Accountable Officer: Director, MD

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Programme development	Assess oral health needs	MD	Curative Division	X	X				
	Prioritise oral health care services	MD	Curative Division		X				
	Develop or adapt an oral care package for District Hospital, PHCC, HP/SHP levels	MD	Curative Division		X				
Training	Plan service provision for oral health	MD	Curative Division		X				
	Offer oral health care	MD	Partners		X	X	X	X	X
	Train HWs on oral health	MD	Partners		X	X	X		
Institutional development	Orient teachers, schoolchildren, FCHVs, and HWs on oral health	MD	Partners		X	X	X		
	Conduct an O&M survey for adding dental surgeons at selected DHs and dental assistants in PHCCs	MD	Administrative Division, MoGA		X				
	Create posts and recruit dental surgeons at selected DHs	Curative Division	MoGA				X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Partnership	Develop and implement a collaborative programme with medical and dental colleges	MD	Private hospitals			X	X		
Piloting	Develop a pilot plan of oral health (DH, PHCCs and HPs)	MD	Partners			X			
Expansion of services	Offer oral health services	MD	Partners			X	X	X	X
	Organise oral health camps in communities	MD	Private hospitals			X	X	X	X
	Organise a brushing campaign for a year	MD	Private hospitals			X	X	X	X
M&E	Develop a monitoring mechanism	MD	HMIS			X	X	X	X
	Carry out process and impact evaluation					X			X

2.21 Curative Health Services

1. Introduction
GoN facilities provided curative services to 60% of the population in 2007-8, 45% if only new contacts are included. Over 85% of patient contacts were through HPs, SHPs and outreach clinics, about 10% through PHCCs, and the remaining 5% or so via hospitals. A 35% increase in new outpatient contacts was seen in 2007-8 following the introduction of free services at HPs and SHPs, and targeted free services at PHCCs and district hospitals for some population groups in low-HDI districts. The main reasons for low and delayed utilisation of health services are distance and cost, with qualitative factors such as the non-availability of drugs and staff playing a role through raising the risk of incurring significant costs for uncertain benefits. The strategy is therefore to bring services closer to the population, especially to the poor and excluded, to make them more affordable, and to ensure that they meet minimum standards of quality and availability.

Roughly half of all outpatient visits for acute illness among both children and adults are to private providers (NDHS 2006 and Nepal Living Standard Survey (NLSS) 2004). Private providers include private pharmacies (some of which are owned by GoN health staff) that provide diagnostic services as well as drugs. Nearly two-thirds of households taking a sick child to a pharmacy report that the child was examined (NDHS 2006). In some areas a two-tier system of access to public-sector health staff is found. Those willing to pay to see staff in their private pharmacies will be given a more thorough examination and access to diagnostics not available from the government.

Guidelines on exemption have been developed as a safety net in the referral hospital to increase access to and utilisation of health care services. This provision has also been made for poor and excluded group in tertiary care hospitals. Regarding catastrophic illness, a guideline has been prepared for reimbursing the catastrophic costs to the poor and destitute. The guideline covers catastrophic spending for five diseases: kidney disease, cancer, heart disease, Alzheimer's and Parkinson's. Patients whom district committees determine to be poor have direct access to the identified treatment centres and their cost is reimbursed by the MoHP. Patients below 14 or above 75 years of age will receive selected services in few centres.

2. Goal
To reduce mortality and disability, and to address the morbidity of the general population.

3. Objective
To increase access to and utilisation of curative health services, including by women, the poor and excluded.

4. Major Strategies
- Increase physical access to health facilities
- Upgrade all SHPs to HPs and add birthing units, giving priority to locations with easy access for poor and excluded women
- Declare district hospitals free to all
- Strengthen district hospitals
- Establish an accreditation system
- Expand universal free outpatient, inpatient and emergency care to district hospitals
- Expand specialised services to selected district hospitals (obstetric care, paediatric care, basic surgical care with anaesthesia, eye care, oral health and mental health care)
- Provide more allocations to district hospitals
- Develop a referral policy

- Contract out ancillary services.

5. Major Challenges and Issues

- Expansion of universal free care to district hospitals
- High demand for the reimbursement of treatment cost
- Ensuring the availability of HWs and drugs
- De-motivated care providers
- Identifying the poor to receive free services.

Accountable Officers: Chief, Curative Division, MoHP; Director, MD; Director, PHCRD

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increase physical access to health facilities	Increase and provide new investment in HPs and SHPs	MD		X	X	X	X	X	X
	Develop an incentive policy and package for care providers in remote areas	Curative Division	MD, PPICD			X			
	Develop the infrastructure to ensure the privacy of women patients	MD	Department of Urban Development and Building Construct-ion (DUDBC)	X	X	X	X	X	
Upgrade all SHPs to HPs and add birthing units	Upgrade SHPs to HPs and add birthing units, giving priority to locations with easy access for poor and excluded women	MD	PPICD	500	500	500	500	500	
	Develop criteria for upgrading HPs to PHCCs and PHCCs to rural hospitals, ensuring GESI-related criteria	MD	PPICD		X	X	X	X	X
	Develop a guideline for upgrading HPs to PHCCs and PHCCs to community/rural hospitals, ensuring GESI-related criteria	MD	PPICD			X	X		
	Upgrade HPs to PHCCs and establish one PHCC per 50,000 population (c. 40 based on new municipalities)	MD	PPICD			10	10	10	10

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Upgrade PHCCs to rural/community hospitals (10 based on demand) considering unreached groups and areas	MD	PPICD		2	2	2	2	2
Expand specialised care at district hospitals	Expand specialised care in selected district hospitals	Curative Division	Finance Section, PPICD		X	X	X	X	
Provide exemption for the poor and excluded	Prepare exemption criteria and process for the poor and excluded at referral and central-level hospitals	Curative Division	Finance Section, Hospitals			X			
Strengthen district hospitals	Implement a plan for strengthening district hospital management	Curative Division	PPICD			X	X	X	X
	Conduct an O&M survey to add specialised care at DH	MD	HR, FM			X			
	Create positions for MDGPs, paediatricians, obstetricians, anaesthetists/Anaesthetic Assistants (AAs), dental surgeons/dental assistants, physiotherapists/ physiotherapy assistants, optometrist or ophthalmic assistants	Personnel Administration MoHP	Curative Division				X		
	Strengthen the capacity of district hospitals to manage One-stop Crisis Management Centres (OCMCs) where applicable	Population Division	Curative Division, LMD, NHTC		X	X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Expand universal free care at DHs	Prepare for making EHCS at district hospitals free to all	PHCRD	PPICD			X			
Provide greater discretion to DH	Provide block grants to district hospitals	PHCRD	Finance Section			X	X	X	X
	Provide clearer targets with disaggregation and performance indicators to district hospitals	PHCRD	PPICD			X	X	X	X
Upgrade health facilities	Upgrade selected PHCCs to community/rural hospitals (as per need)	MD			X	X	X	X	
	Upgrade numbers of hospitals beds (from 15-20) to 25-50 beds	MD			X	X	X	X	X
Treatment support to the poor	Revise the guidelines for reimbursement of treatment costs for the poor and excluded	Curative Division	Finance Section			X			
Increase access to specialised care in remote areas	Organise health camps with specialised care (surgical, medical, Obstetrics and Gynaecology, ENT etc.)	PHCRD/ Curative Division	Hospitals	X	X	X	X	X	X
Enhancing QoC	Develop a mechanism for hospital accreditation (policy/legal, structure, para-legal, tools)	Curative Division	PPICD, EDPs and partners		X	X			
	Plan and implement for waste management	Curative Division	Hospitals (private and public), partners			X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Provide training to nurses on QoC and leadership development including GESI	MD	Nursing Council, Medical Council, National Health Traders Council		X	X			
	Develop nursing standards for hospital care	Curative Division	Partners						
	Monitor the quality of private and public hospitals	Curative Division/Public Health Administration M&E Division (PHAM&ED)/ MoHP	Hospitals	X	X	X	X	X	X
Contracting out	Prepare and implement a framework for contracting out ancillary services such as cleaning and laundry	Personnel Administration	Curative Division, Hospitals			X	X	X	X
Sectoral and cross-sectoral coordination	Establish a multi-sectoral coordination committee	Curative Division	PPICD			X			

2.22 Ayurvedic and Alternative Medicine

1. Introduction

Ayurveda is Nepal's indigenous treatment system. According to the National Ayurveda Health Policy, 2052 BS, GoN is to establish new Ayurvedic health services and equip them well in proportion to population density, public demand and participation. Ayurvedic health services will be established in different parts of the country, not only in the government sector but also in the non-state sector.

The top ten diseases identified for Ayurvedic systems are: Amlapitta (gastritis), Udara roga (abdominal disease), Swas Vikar (respiratory disease), Vatavyadhi (Vataja disease), Bal rog (paediatric diseases), Stri rog (gynaecological diseases), Karna, Nasa, Mukha, Danta and Kantha roga (ENT, oral, and dental diseases), Jwar (fever), Vrana (wounds, abscesses) and Atisar/Grahani (constipation, diarrhoeal disease).

The Ayurvedic system of medicine will be promoted as the National System of Medicine.

2. Goals

- To contribute towards improving the health status of Nepalese citizens
- To ensure the optimum utilisation of local herbal resources to strengthen the national economy.

3. Objective

To increase access to and utilisation of the Ayurvedic system of medicine.

4. Major Strategies

- Increasing awareness of the Ayurvedic system of medicine
- Expanding the Ayurvedic system of medicine
- Piloting integration of Ayurvedic services
- Promoting evidence based practice
- Improving the quality of Ayurvedic services
- Developing HR for Ayurvedic services
- Enhancing M&E of Ayurvedic services
- Developing infrastructure for Ayurveda-related institutions
- Developing Ayurvedic specialist services in Ayurvedic institutions
- Review of the Ayurveda Health Policy 2052.

5. Major Challenges and Issues

- Promoting Ayurvedic services
- Expanding Ayurvedic services at the grassroots level
- Developing HR for Ayurvedic services
- Developing a research and M&E system
- Ensuring the availability of Ayurvedic drugs
- Developing Ayurvedic institutions and expanding their coverage
- Expanding the Ayurvedic specialties (Panchakarma, Kshar sutra and Yoga)
- Piloting the integration of Ayurvedic services
- Reviewing the Ayurveda Health Policy 2052 and other policy issues
- Promoting herbal resources for economic growth
- Developing a Data Bank of Ayurvedic and traditional medical resources with their Intellectual Property Rights (IPR).

Accountable Officer: D-G, Department of Ayurveda (DoA) , MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increasing awareness of the Ayurvedic system	Develop and implement a BCC strategy on Ayurveda	DoA	NHEICC	X	X	X	X	X	X
Expanding Ayurvedic services	Continue treatments with special focus on the top ten diseases	DoA		X	X	X	X	X	X
	Develop model herb farms to encourage herbal production	DoA		X	X	X	X	X	X
	Establish one regional hospital	DoA	PPICD		X	X			
	Establish 19 Ayurvedic Aushadhalayas	DoA	PPICD			6	6	7	
	Produce, collect, and promote locally available herbs	DoA		X	X	X	X	X	X
	Continue the Senior Citizen Rasayana Programme (no. of persons)	DoA		3,750	4,500	5,250	6,000	6,750	7,500
	Introduce Local Ayurveda Kits for Health (LAKH) Programme	DoA				X	X		
	Continue the Lactating Mother Programme (no. of persons)	DoA		7,500	8,250	9,000	10,500	11,250	12,000
	Continue the Ayurveda School Health Programme	DoA		X	X	X	X	X	X
Improving the quality of services	Establish and operate an Ayurvedic Medicine Examination Committee and Laboratory	DoA			X	X	X	X	X
	Develop Naradevi Ayurveda Hospital (central hospital) as a specialised Ayurvedic medical service centre	DoA				X			
	Develop a quality assurance mechanism for Ayurvedic drug manufacturing	DoA	DDA			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reviewing the Ayurveda Health Policy 2052	Create a high-level committee to review the Ayurveda Health Policy	DoA		X					
Integrating Ayurvedic services	Pilot integration of Ayurvedic services with alternative and allopathic medicine through Ayurvedic service centres	DoA			X	X			
Promoting evidence-based practice	Establish a National Ayurvedic Research and Training Centre	DoA			X				
	Prepare an Ayurveda research strategy with prioritised research activities	DoA				X			
	Prepare an inventory of indigenous knowledge and skills	DoA				X	X		
	Produce a peer-reviewed journal of Nepal's Ayurvedic practice	DoA				X			
Developing HR for Ayurvedic services	Produce postgraduates specialising in Ayurveda from the National Ayurveda Academy and other institutions	National Ayurveda Academy	MoHP				X	X	X
	Provide refresher training to service providers	DoA		X	X	X	X	X	X
	Provide management training to officer level service providers	DoA		X	X	X	X	X	
	Increase opportunities for specialised Ayurvedic education	DoA			X				
Enhancing M&E	Revise and improve the Ayurveda monitoring mechanism	DoA			X				
	Develop a data bank of Ayurvedic and alternative medicine with IPR					X			
	Conduct process and impact evaluation of the LAKH, Lactating	DoA				X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Mother, and Ayurveda School Health Programmes								
Enhancing local economy through herbal medicine	Provide herbal cultivation training for local farmers	DoA				X			
Developing infrastructure for Ayurveda-related institutions	Prepare/revise an infrastructure development plan for the DoA and its institutions	DoA				X			X
Developing a data bank of Ayurvedic and traditional medical resources with IPR	Prepare the infrastructure for a data bank of Ayurvedic and traditional medical resources in the DoA	DoA				X			
Promoting other alternative medicines	Promote the use of the naturopathy, Unani, Amchi and homeopathy systems of medicine	DoA		X	X	X	X	X	X

2.23 Health Education and Communication Programme

1. Introduction

Health education and communication are a priority of the MoHP, and are designed to create demand and increase the utilisation of EHCS through the dissemination of messages using appropriate multiple channels of communication to support the achievement of programme goals and objectives. As health education and communication are cross-cutting in all health programmes, they aim to increase knowledge and improve behaviour regarding key health issues of all castes and ethnic groups, and disadvantaged and hard-to-reach populations. Health education and communication also aim to create demand for quality EHCS, thereby improving access, creating public trust in health services, and ultimately encouraging people to utilise the existing health services, as well as mitigating public panic and responding to communication needs during emergency situations.

The Health Education and Communication Programme designs and implements advocacy, social mobilisation and IEC/BCC programmes for desired behaviour changes of individuals and communities. Strategic plans are developed and adopted while implementing different IEC/BCC programmes at the national, regional, district and community levels, following the principles of decentralisation.

As stated in NHSP-2, health education and communication will prioritise certain focused EHCS programmes, such as MCH, adolescent health, communicable and Non-communicable Diseases, tobacco control, GESI, occupational and environmental health, and emergency and disaster preparedness, including pandemic influenza.

2. Goal

To contribute to attaining the national health programme goals and objectives by providing support for all national health services and programmes.

3. Objectives

- To increase knowledge, improve skills and promote desired behaviour change on EHCS and beyond
- To create a demand for quality EHCS among all castes and ethnic groups, and disadvantaged and hard-to-reach populations
- To advocate for required resources (human and financial) and capacity development for effective communication programmes and interventions to achieve the NSHP-2 goals
- To increase access to new information and technology on health programmes
- To raise awareness among the public on communicable and Non-communicable Diseases and to encourage all to seek preventive measures
- To intensify and strengthen action against tobacco use, both smoked and smokeless, excessive use of alcohol, unhealthy diets, and physical inactivity
- To mitigate public panic and respond to communication needs during emergency situations.

4. Major Strategies

NHEICC plans and proposes needs-based IEC/BCC programmes every year at the national, regional, district and community levels to achieve national health goals. The Health Education And Communication Units in the DHOs are empowered to run health education and promotion activities by implementing needs-based IEC/BCC programme activities using local media. They should also consider the districts' social and cultural contexts so that the messages, materials and activities reach their target

audiences and encourage health-seeking and healthy behaviour. The NHSP-2 IP for health education and communication includes the following major actions:

- Mutually reinforcing approaches of ACSM, BCC, and IEC linked to service availability of EHCS and beyond
- Advocacy activities carried out to gain support for EHCS, occupational and environmental health, and tobacco control, and for political and social commitment, as well as resources for implementing the programme
- Social mobilisation of local-level resources, mobilisation of HR in existing networks as well as support for FCHVs and HWs
- Informing people about EHCS, social issues and service availability, and promoting positive behaviour
- Disseminating and reinforcing messages through mass media, community-based media and IPC
- Catering to specific gender needs and to the needs of the poor, socially excluded, and disadvantaged communities, and making efforts to produce and disseminate messages and materials in local languages and for different socio-cultural contexts
- Promotion of health as a right, especially in the context of Nepal's political restructuring and decentralisation
- Strengthening institutional capacity, and in hospital settings providing appropriate health education and communication programmes at all levels
- Coordination with other ministries and academic institutions to ensure in-service and pre-service training specifically on health education
- Multi-sectoral collaboration to implement communication programmes
- Ensuring that the impact of communication interventions is captured by the HMIS and that additional resources are available for periodic surveys.

The strategies and activities in this IP are set under the overall strategic directions of NHSP-2 and the strategies of the services and programmes, as this is a supporting programme for health programmes and services. Similarly, this plan has been prepared following two major national communication strategies approved by MoHP to move forward and achieve the NHSP-2 health education and communication goal, objectives and major strategies. The two approved major communication strategies are:

- National Communication Strategy for MNCH, 2012-16
- National Communication Strategy for ASRH, 2012-16.

In addition to these two strategies, an updated national communication strategy for other priority programmes of EHCS and beyond will guide all health education and communication activities at all levels. Health education and communication activities will be coordinated to minimise duplication and maintain the uniformity, consistency and effectiveness of health messages through NHEICC. These strategies have been developed considering the GESI perspective, with a special focus on the poor and excluded, and will be continued as such.

5. Indicators

- % increase in knowledge on key health promotion and disease prevention issues among intended audiences
- % increase in utilisation of EHCS among intended audiences
- % of people practising key health behaviours to prevent disease and promote health
- % increase in funds for key health issues and health communication programmes

- Increase in qualified HR for health education and communication
- The number of people trained in health education and communication
- Strengthened system of health education and communication/BCC down to the VDC level.

Indicators and Targets

Coverage	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Prevalence of tobacco use among men (%)	29.8	27	24	22.5	21.5	20
Prevalence of tobacco use among women (%)	15.4	14	13	12	11	10

6. Major Challenges and Issues

- Less priority is given in practice to the health education and communication required for health promotion
- Insufficient dedicated HR for health education and communication
- Need to strengthen the institutional capacity of MoHP, NHEICC, RHDs, and DHOs on health education and communication
- Inadequate capacity and technical skills of staff involved in health education and communication at different levels
- Weak mechanisms and resource constraints for research and quality M&E of health education and communication programmes
- Inadequate focus on in-service and pre-service training for health education and communication
- Less priority given to IPC through FCHVs and other health volunteers, MGHs and other community groups, and CBO/NGOs
- Insufficient attention given to the production and delivery of messages and materials according to the local context
- Inadequate PPPs
- The one-door system through NHIECC is not always followed to ensure the quality and consistency of messages and to maximise the effectiveness of resources
- Unequal access to information among the population
- Inadequate focus on targeted health education programmes, including the localisation of IEC/BCC materials, to cater to specific gender needs and to the needs of socially excluded and marginalised groups
- Inadequate supportive service delivery mechanisms in place in conjunction with health education and BCC efforts.

Accountable Officer: Director, NHEICC

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Advocacy activities carried out to gain support for Safe Motherhood and Neonatal Health (SMNH), FP, ASRH, IMCI, EPI, nutrition, free health care, oral and eye health, as well as promotion of GESI. Providing information on TB, leprosy, HIV/STIs, VBD and neglected tropical disease prevention and beyond, and promoting political and social commitment, as well as allocating resources for programme implementation	Advocacy meetings, orientations, workshops with policy makers, planners, professional organisations, influential people and media	NHEICC	Partners	X	X	X	X	X	X
	Develop, produce and disseminate advocacy toolkit	NHEICC	Partners	X	X	X	X	X	X
	Organise press meetings involving all sectors of media people	NHEICC	Partners	X	X	X	X	X	X
	Develop, produce and distribute media kits	NHEICC	Partners	X	X	X	X	X	X
	Undertake advocacy/ awareness campaigns for promoting health issues, particularly focusing on decision makers	NHEICC	Partners	X	X	X	X	X	X
	Make a proposal to MoHP for the required and trained manpower at the centre and in	NHEICC	Partners	X	X	X	X	X	X
	Celebrate health days, weeks, and months for raising awareness and advocating on the issues	NHEICC	Partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Social mobilisation of resources at the local level, mobilisation of HR of existing networks as well as support for FCHVs and HWs for SMNH, FP, ASRH, IMCI, EPI, nutrition, free health care, oral and eye health, as well as promotion of GESI. Providing information on TB, leprosy, HIV/STIs, VBD and neglected tropical disease prevention and beyond	Hold planning meetings at central, regional and district levels involving related stakeholders	NHEICC	Partners	X	X	X	X	X	
	Develop, produce and distribute toolkits for social mobilisation	NHEICC	Partners	X	X	X	X	X	
	Identification and formulation of social mobilisation networks at different level of health services	NHEICC	Partners	X	X	X	X	X	
	Organise social mobilisation events, including mass gathering, rallies, and communication events, and inter-school or group competitions to promote EHCS	NHEICC	Partners	X	X	X	X	X	
	Mobilise large networks of HWs, volunteers and other existing networks and groups (particularly MGHs) to reach hard-to-reach families	NHEICC	Partners	X	X	X	X	X	
	Organise funfair activities at the community level to promote health messages and materials	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Informing people about SMNH, FP, ASRH, IMCI, EPI, nutrition, free health care, oral and eye health, as well as promotion of GESI. Providing information on TB, leprosy, HIV/STIs, VBDs and neglected tropical diseases, and a discussion of social issues, service availability and the promotion of positive behaviors	Conduct media and IPC activities for informing women and families on dangers signs and harmful practices as well as healthy practices	NHEICC	Partners	X	X	X	X	X	
	Prepare and implement specific IEC/BCC plans to reach hard-to-reach and migrant families who may not be aware of EHCS	NHEICC	Partners	X	X	X	X	X	
	Conduct media and IPC IEC/BCC activities focusing on women, children, adolescents, youths and men to provide comprehensive and correct information and knowledge to target audiences	NHEICC	Partners	X	X	X	X	X	
	Research on knowledge, practices and behavior of specific groups and social issues	NHEICC	Partners	X	X	X	X	X	
	Provide orientation on health rights to service providers and communities	NHEICC	Partners	X	X	X	X	X	
	Develop and pre-position messages and materials for all media	NHEICC	Partners	X	X	X	X	X	
	Support the dissemination of health messages and materials, and promote IEC activity during epidemics and disasters	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Disseminating and reinforcing messages through mass media, community-based media and IPC on SMNH, FP, ASRH, IMCI, EPI, nutrition, free health care, oral and eye health, as well as promotion of GESI. Providing information on TB, leprosy, HIV/STIs, VBD and neglected tropical disease prevention and beyond	Develop and disseminate service-friendly messages and materials	NHEICC	Partners	X	X	X	X	X	
	Engage media in order to improve health-seeking behavior of people	NHEICC	Partners	X	X	X	X	X	
	Disseminate messages through new media, using mobiles or PC games	NHEICC	Partners	X	X	X	X	X	
	Develop, produce and distribute print materials i.e. flip wall charts, posters, pamphlets, booklets	NHEICC	Partners	X	X	X	X	X	
	Conduct exhibitions on health issues and messages and materials on important days and occasions	NHEICC	Partners	X	X	X	X	X	
	Launch campaigns by celebrities or key influential leaders and goodwill ambassadors, making announcements through mass media and megaphones	NHEICC	Partners	X	X	X	X	X	
	Disseminate messages at rallies, fairs, *haat bazaars, melas*, religious ceremonies, processions, public meetings	NHEICC	Partners	X	X	X	X	X	
	Provide orientation on IPC skills to EHCS service providers	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Undertake advocacy/awareness campaigns to promote health issues, particularly focusing on adolescents, youths, mothers, husbands and mothers-in-law	NHEICC	Partners	X	X	X	X	X	
	Organise sensitisation programmes for women, community people, local leaders, teachers, journalists, health workers and FCHVs	NHEICC	Partners	X	X	X	X	X	
	Organise interaction programmes for journalists, women, community people, local leaders, teachers, adolescents and youth	NHEICC	Partners	X	X	X	X	X	
	Organise orientation on programmes for FCHVs, MGHs, HWs and social mobilisers	NHEICC	Partners	X	X	X	X	X	
	Conduct mass media campaigns: develop, produce and disseminate messages and materials through radio, television, Frequency Modulated (FM) radio, newspapers and print media to promote EHCS programmes	NHEICC	Partners	X	X	X	X	X	
	Promote service sites through mass and other communication media	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Use locally available means of information and local cultural performances to disseminate health messages								
Catering to specific gender needs and the needs of the poor, socially excluded and disadvantaged communities	Make efforts to produce and disseminate messages and materials in local languages and for different socio-cultural contexts	NHEICC	Partners	X	X	X	X	X	
	Promote health as a right, especially based on the policy documents available	NHEICC	Partners	X	X	X	X	X	
	Develop gender-friendly messages and materials and disseminate them	NHEICC	Partners	X	X	X	X	X	
	Conduct IEC/BCC activities to discourage GBV	NHEICC	Partners	X	X	X	X	X	
Strengthening institutional capacity in health and in hospital settings to provide appropriate health education and communication programmes at all levels	Conduct regular technical staff, intra-divisional, EDP and INGO meetings at the central level	NHEICC	Partners	X	X	X	X	X	
	Conduct National IEC/BCC Coordination and Technical Committee meetings to implement a one-door system of IEC/BCC programmes in order to maintain uniformity and appropriate and consistent health messages	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Hold annual regional IEC/BCC review and orientation meetings	NHEICC	Partners	X	X	X	X	X	
	Conduct IPC/BCC skill enhancement, orientation and training for district-level IEC/BCC focal persons and other HWs and volunteers on a yearly basis	NHEICC	Partners	X	X	X	X	X	
	Involve and orient central and district IEC/BCC focal persons, building their capacity to design, introduce and implement evidence-based tools, materials and programmes	NHEICC	Partners	X	X	X	X	X	
	NHEICC staff to make regular monitoring visits in the region, in the districts and at community level	NHEICC	Partners	X	X	X	X	X	
	Prepare and manage well-documented reports and materials in print or e-copy for health professionals and students	NHEICC	Partners	X	X	X	X	X	
	Provide necessary communication equipment, materials and other logistics at NHEICC, in the regions and	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	districts and below, and in hospitals								
	Develop guidelines for health education and communication programmes	NHEICC	Partners	X	X	X	X	X	
	Develop, review, revise and implement national communication strategies and plans for EHCS	NHEICC	Partners	X	X	X	X	X	
Coordination with other ministries and academic institutions to ensure in-service and pre-service training specifically on health education for EHCS and beyond	Hold Technical Committee meetings with stakeholders, including academics								
	Hold meetings with academics for orientation and training on health education and communication	NHEICC	Partners	X	X	X	X	X	
	Orient academics and public health and other students on IEC/BCC programmes	NHEICC	Partners	X	X	X	X	X	
	Hold meetings to coordinate with MoE, DoE, the Ministry of Urban Development (MoUD), DWSS, MoLD, the Ministry of Information and Communications (MoIC), the	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Ministry of Agriculture Development (MoAD), MoWC&SW, MoEST, local bodies and other concerned government, non-government, EDPs and UN organisations to develop and disseminate health messages								
Multi-sectoral collaboration to implement communication programmes. ensure that the impact of the communication interventions is captured by the HMIS, and that additional resources are available for periodic surveys	Conduct periodic research on BCC	NHEICC	Partners	X	X	X	X	X	
	Conduct assessments of needs-based IEC/BCC messages, methods and channels	NHEICC	Partners	X	X	X	X	X	
	Review, revise and pretest IEC/BCC messages and materials	NHEICC	Partners	X	X	X	X	X	
	Update the NHEICC's HMIS form in coordination with the HMIS sections	NHEICC	Partners	X	X	X	X	X	
	Conduct meetings and workshops for multi-sectoral collaboration in health communication	NHEICC	Partners	X	X	X	X	X	
	Promote PPPs in health education and communication and engage private partners in health promotion	NHEICC	Partners	X	X	X	X	X	
	Conduct gap identification exercises	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Establishing National Resource Centre for proper management and dissemination of IEC/BCC materials	Digitise all IEC/BCC materials and documents for reference, reprint and reproduction	NHEICC	Partners	X	X	X	X	X	
	Develop and implement an efficient annual IEC/BCC materials distribution plan								
Strengthening of School Health Education Programme involving students and teachers in and out of schools for EHCS and beyond	Conduct School Health Programmes targeting adolescents and their parents	NHEICC	Partners	X	X	X	X	X	
	Develop or link with tailor-made community-level programmes to reach out-of-school adolescents, marginalised communities, migrants, sexual minorities, and most-at-risk adolescents about AFS	NHEICC	Partners	X	X	X	X	X	
	Coordinate with MoE and the Curriculum Development Centre to incorporate health content into textbooks and resource materials	NHEICC	Partners	X	X	X	X	X	
	Orient school teachers on the school health education programme and its contents	NHEICC	Partners	X	X	X	X	X	
Mobilisation of FCHVs and other influential persons of the community	Conduct orientation to FCHVs to discuss harmful and unhealthy socio-cultural practices with communities	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
to support implementation of community health education and communication activities for EHCS and beyond	Conduct orientation programmes for FCHVs and other influential persons to enhance skills on IPC	NHEICC	Partners	X	X	X	X	X	
	Organise a FCHV promotion programme to promote the Health Education Programme at the community level	NHEICC	Partners	X	X	X	X	X	
	Develop, produce, and provide IEC/BCC materials and toolkits for FCHVs to update health information	NHEICC	Partners	X	X	X	X	X	
Promoting interventions on tobacco control, reduction of harmful use of alcohol, promotion of a healthy diet and physical activity to reduce the burden of NCDs, i.e. cancer, cardio-vascular diseases, diabetes	Tobacco control: develop and implement a tobacco control plan in line with the WHO Framework Convention on Tobacco Control (FCTC), implement strategy of MPOWER[6], and South East Asia Regional Office (SEARO) regional strategies	NHEICC	Partners, WHO	X	X	X	X	X	
	Undertake capacity enhancement and law enforcement on tobacco use restrictions	NHEICC	Partners, WHO	X	X	X	X	X	
and chronic respiratory	Ban advertising, promotion and sponsorship	NHEICC	Partners, WHO	X	X	X	X	X	

[6] MPOWER: M – Monitor prevention, P – Protect people, O – Offer help to quit, W – Warn about dangers, E – Enforce bans, R – Raise tax

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
diseases	Protect people from tobacco smoke by expanding the coverage of non-smoking areas	NHEICC	Partners, WHO	X	X	X	X	X	
	Undertake BCC and social mobilisation	NHEICC	Partners, WHO	X	X	X	X	X	
	Increase tax on tobacco products	NHEICC	Partners, WHO	X	X	X	X	X	
	Control packaging and labeling of tobacco products	NHEICC	Partners, WHO	X	X	X	X	X	
	Promote the cessation of tobacco use	NHEICC	Partners, WHO	X	X	X	X	X	
	Develop a supply reduction strategy	NHEICC	Partners, WHO	X	X	X	X	X	
	Undertake surveillance and research	NHEICC	Partners, WHO	X	X	X	X	X	
	Counter tobacco industry interference	NHEICC	Partners, WHO	X	X	X	X	X	
	Networking and coordination	NHEICC	Partners, WHO	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Reduce the harmful use of alcohol, promote a healthy diet and physical activity by developing and implementing a plan in line with the WHO Global Strategy for Diet, Physical Activity and Health; and the Global Strategy to Reduce the Harmful Use of Alcohol, as well as the SEARO regional strategies	NHEICC	Partners, WHO	X	X	X	X	X	
	Harmful use of alcohol: restrict access to retail alcohol, enforce restrictions and bans on alcohol advertising, raise taxes on alcohol	NHEICC	Partners	X	X	X	X	X	
	Unhealthy diet: reduce salt intake, replace trans-fats with polyunsaturated fats, promote public awareness about diet	NHEICC	Partners	X	X	X	X	X	
	Physical inactivity: promote the importance of physical activity through different mechanisms including the mass media	NHEICC	Partners	X	X	X	X	X	
Strengthening advocacy, social mobilisation, and IEC/BCC	Conduct activities for finding out evidence for advocacy, social mobilisation, and IEC/BCC intervention	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
interventions for the prevention for NCDs, cancer, cardio-vascular diseases, diabetes, and chronic respiratory diseases	Develop and implement plans for advocacy, social mobilisation and IEC/BCC intervention	NHEICC	Partners	X	X	X	X	X	
	Coordinate and collaborate with other sectors for the prevention of NCDs	NHEICC	Partners	X	X	X	X	X	
	Hold meetings of the IEC/BCC Technical Committee on NCDs	NHEICC	Partners	X	X	X	X	X	
	Develop, produce and disseminate NCD prevention and control messages through mass media, IPC, and social media	NHEICC	Partners	X	X	X	X	X	
	Conduct interaction programmes at community level	NHEICC	Partners	X	X	X	X	X	
	Mobilise media for the prevention of NCDs	NHEICC	Partners	X	X	X	X	X	
	Orient professional organisations on the prevention of NCDs	NHEICC	Partners	X	X	X	X	X	
	Conduct IEC/BCC activities about other risk factors for NCD prevention and control	NHEICC	Partners	X	X	X	X	X	
Promoting mental health in collaboration with	Develop and implement a mental health promotion plan in line with WHO strategies in	NHEICC	Partners	X	X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
relevant sectors	coordination with relevant agencies								
Raising awareness about road safety and the prevention of accidents	Develop and Implement a plan for the promotion of road safety and prevention of accidents in coordination with the relevant agencies	NHEICC	Partners	X	X	X	X	X	

2.24 Environmental Health

1. Introduction

Available epidemiological findings suggest that the provision of safe water, sanitation and hygiene are still in a critical state in Nepal. WASH-associated diseases, including skin diseases, ARI, and diarrhoeal diseases, are the top three leading preventable diseases among infants and children, and ARI and diarrhoeal diseases remain the leading causes of child deaths. Evidence also shows the role of poor hygiene, leading to the burden of malnutrition and VBDs.

Sanitation and hygiene are poor in many parts of Nepal, especially in rural areas. Outbreaks of diarrhoea and cholera still occur in different parts of the country. Many of these problems could be solved by raising awareness and promoting desired behaviours and hygiene practices, particularly hand washing. There is a growing need to focus on health education and BCC to prevent and respond to newly emerging diseases like human and pandemic flu, as well as NCDs and occurrences of epidemics such as diarrhoea and cholera. Environmental Health and Hygiene (EHH) thus must be improved through health sector interventions to prevent WASH-associated diseases.

The EHH Programme aims to improve water quality through water quality surveillance and monitoring, to promote hygiene and sanitation practices and to manage solid, liquid, and health care wastes effectively.

Chemical safety, air pollution, climate change, and occupational hazards are also issues in the present context which will be addressed by MoHP through its EHH Programmes.

2. Goal

To reduce health risks by improving Environmental Health, Hygiene and Sanitation (EHHS) conditions in Nepal.

3. Objectives

- Promote the critical time of hand washing with soap and water as a priority health programme
- Mainstream hand washing with soap and water into EHHS programming
- Promote EHH practices at the individual household, community and institutional levels, considering the GESI perspective
- Promote safe and healthy individual, domestic and community behaviour through proper management of household and health care waste, the prevention of indoor air pollution and the prevention of chemical, environmental, and occupational hazards
- Promote hygienic food and safe water handling and preservation
- Minimise the risks related to climate change and disasters by promoting safe practices
- Strengthen knowledge management through research- and information-related development activities
- Establish and implement water quality surveillance through the MoHP system.

4. Major Strategies

- Promote hygiene and sanitation through the existing institutional infrastructure

- Promote hygiene and sanitation in conjunction with other EHCS to mainstream hygiene and sanitation promotion. Adopt key performance indicators for behaviour change towards improved hygiene practices
- In partnership with related agencies, establish a water quality surveillance system and promote the use of safe water
- MoHP, MoE and partners will promote use of cleaner fuels for cooking such as biogas, along with improved cook stoves and improved ventilation in cooking areas
- Further develop specific standards on Health Care Waste Management (HCWM) and for the disposal of various categories of health care waste such as needles, mercury, infectious waste, liquid water, etc.
- Enhance the HR capacity to enforce and monitor the implementation of medical waste management to the required standard
- Establish a knowledge network with academia and practitioners on health promotion and behaviour change interventions related to climate change, and operationalise a public health response team to address the effects of climate change and disasters
- Collaborate with other ministries and NGOs, and take steps towards preventing the harmful effects of environmental hazards, particularly in urban areas where large numbers of people are exposed every day.

5. Indicators and Targets

Major Outcome	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of households with soap and water at a hand washing station inside or within 10 paces of latrines	13	25	37	45	53	55
% of households using water treated with appropriate methods		17.6				50
% of health institutions with toilets/water facilities						80
% of households with improved toilet facilities with flush		38.2				60
% health institutions adopting proper HCWM practices		10	20	30	40	50

6. Major Challenges and Issues

- Multi-sectoral coordination and harmonisation of strategy and operational plans
- Access to and utilisation of services with regard to geography and GESI
- EHHS are not perceived as equally important by many development partners and civil society
- Poor housing and its relationship to communicable disease
- Emerging and re-emerging of diseases over the years
- Inappropriate waste management by local authorities
- Current norms, values and cultural practices with adverse effects on human health
- Industrialisation, migration and urbanisation, as well as increased numbers of automobiles and vehicles
- Natural degradation and disasters, climate change, air pollution
- High levels of poverty in meeting basic sanitation services.

Accountable Officer: Director, NHEICC, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Promote hygiene and sanitation through the existing institutional infrastructure	Coordinate and hold regular meetings/discussions of the Technical Committee on EHHS	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Develop and implement a WASH strategy for the health sector which will be a basis to implement the WASH-related activities mentioned in NHSP-2	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Orient and mobilise schoolteachers on environmental health and climate change to reach people at household level, promote sanitation, and control vectors and vermin	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Launch, introduce and activate the hand washing programme at national and district levels	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	NHEICC, UNICEF, media and private sector to orient the national team on hand washing	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	DWASHCC Orientation And Activation Programme to promote waste management,	NHEICC	MoUD, UNICEF, WHO,	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	hand washing and oral hygiene		WaterAid, partners						
	Hand washing and communication training for district-level trainers	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Exposure and programme support visits on hand washing	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Regular programme meetings of DWASHCC on hand washing and safe water	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Develop and implement solid and liquid waste management guidelines in coordination with concerned bodies and authorities for all sectors	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Develop and implement food hygiene guidelines in coordination with concerned bodies and authorities for all sectors	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	NGO training of trainers along with District (Public) Health Offices (D(P)HOs), District	NHEICC	MoUD, UNICEF, WHO,	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Education Offices (DEOs), and WASH on hand washing		WaterAid, partners						
	Facilitators' and supervisors' training promoting waste management, hand washing and oral hygiene	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Education sector's resource person orientation promoting waste management, hand washing and oral hygiene	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Implement school-based hand washing programmes in all schools and train peer educators in schools to promote proper waste management, hand washing and oral hygiene	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	FCHVs to educate mothers of children under five in VDCs to promote proper waste management, hand washing and oral hygiene	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Implement community interaction programmes on the importance of hand washing with soap and water; adapt and promote proper waste management and oral hygiene	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Provide household events and demo stalls for mothers (MGHs) in each VDC and distribute IEC materials on hand washing	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Street theatre and flash mob in communities and *haat bazaars*, and distribution of collateral materials on hand washing at the community level	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Monitoring and supervision by NGOs in all programme VDCs on hand washing and other hygiene issues	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Promotion of proper waste management in both municipal and rural areas	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Conduct regular Technical Committee meetings to strengthen inter-sectoral collaboration between WASH, Education, and Health Programmes to support Open-defecation-free (ODF) VDCs to integrate GESI into all programmes and activities	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Integrate sanitation into the "Fit for School" Programme and allocate programme budget to conduct school- and community-level programmes in the district	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Promote and ensure the use of clean and hygienic toilet facilities in the ministry, divisions, centres, directorates and HFs	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Provide a yearly award for clean and hygienic toilet facilities in health institutions and schools	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Design, develop, produce and disseminate mass media materials	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Establish partnerships with private manufacturers and companies to promote separate toilets for boys and girls in schools and cost-effective toilet-building options in communities to cater for the needs of poor and unreached populations	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Mobilise FCHVs and service providers as role models in hard-to-reach and vulnerable communities to promote toilet construction	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Support ODF events and activation programmes in districts, municipalities and VDCs to reach poor, vulnerable and marginalised populations	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Implement school-based sanitation promotion programmes in schools through the regular programme budget and mobilise students in vulnerable communities	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Implement community interaction in partnership with the private sector to promote toilet building in hard-to-reach and vulnerable communities	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
Promote hygiene and sanitation in conjunction with other EHCS to mainstream the promotion of hygiene and	Develop surveillance tools for predicting epidemics, vectors and helminthes infections in coordination with EDCD and promote local technology and preventive and protective measures for vector control	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
sanitation, and adopt key performance	Carry out regular information sharing, monitoring and review of all sector activities to	NHEICC	MoUD, UNICEF, WHO,	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
indicators for behaviour change towards improved hygiene practices	promote coordination, collaboration and partnerships at all levels		WaterAid, partners						
	Develop and implement an advocacy and BCC plan of EHH	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Design, develop, produce and disseminate mass media Public Service Announcements (PSAs) and print materials	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Produce and install signage and hoarding boards in districts; organise a wall-painting event during the programme period	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Disseminate messages through radio, television, Frequency Modulated (FM) radio, and newspapers at national and district levels	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Conduct orientation training for people in the districts, involving at least one staff member from each HF	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Ensure adequate sanitation facilities and promote hygiene in all health institutions	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Promote personal, domestic, and environmental hygiene through different health promotion programmes	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Integrate hygiene and sanitation promotion through different health programmes such as IMCI, health promotion, HIV/AIDS, training, SM etc.	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Conduct regional-level Communication for Development Network (C4D) exercises (workshops) to harmonise the communication plan with the district context	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Conduct periodic formative research on EHH	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Provide orientation on hygiene to FCHVs	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
Establish a water quality surveillance system and promote the use of safe water in partnership with related agencies	Promote inter-ministerial and multi-sectoral coordination to ensure the public health safety of water facilities at the national, regional, district, and VDC levels, focusing on poor, vulnerable and hard-to-reach populations	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Coordinate water quality and safety measures, develop guidelines and promote the use of safe water	NHEICC	MoUD, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Provide district-level orientation and activation programmes for media and stakeholders in coordination with DWASHCC to ensure that the district plan includes water schemes to reach poor, vulnerable, and marginalised populations	NHEICC	MoUD, WHO, UNICEF, EDPs, partners	X	X	X	X	X	X
	Orient FCHVs and community service providers on the prevention of waterborne diseases; disseminate	NHEICC	MoUD, WHO, UNICEF, EDPs,	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	messages through MGHs, EPI, and outreach clinics, especially in areas where people are poor and vulnerable		partners						
	Design, develop, produce and disseminate messages and materials on water quality and safety measures	NHEICC	MoUD, WHO, UNICEF, EDPs, partners	X	X	X	X	X	X
	Develop a School Health Education Programme on water quality and safety for use in child-to-parent and child-to-community approaches	NHEICC	MoUD, WHO, UNICEF, EDPs, partners	X	X	X	X	X	X
	Promote safe drinking water or the treatment of water at the household level through Community Health Education and FCHV Programmes	NHEICC	MoUD, WHO, UNICEF, EDPs, partners	X	X	X	X	X	X
	Coordinate with NPHL and other sectors, particularly DWSS, for water quality monitoring	NHEICC	MoUD, WHO, UNICEF, EDPs, partners	X	X	X	X	X	X
Promote the use of cleaner fuels, such as biogas for cooking, along with improved cook stoves and improved	Develop and implement national standards on protection from the hazards and risks of air pollution, especially among poor, vulnerable and marginalised populations	NHEICC	MoEST, MoE, MoUD, WHO, EDPs, partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
ventilation in cooking areas, in coordination with different ministries and MoE and other partners	Monitor air pollution and air quality and disseminate the findings for further programme development and implementation	NHEICC	MD, NPHL, partners		X	X	X	X	
	Conduct awareness activities to promote pollution-free cooking practices and technology	NHEICC	MoEST, MoE, MoUD, WHO, EDPs, partners	X	X	X	X	X	X
Establish further specific standards on HCWM and for the disposal of various categories of health care waste such as needles, mercury, infectious waste, liquid water, etc.	Develop an implementation strategy and action plan on chemical safety, focusing on the elimination of mercury in health care, the elimination of lead in paint, and the management of arsenic in food and water	NHEICC	MoEST, MD, WHO, EDPs, partners	X	X	X	X	X	X
	Promote proper HCWM practices at health institutions	NHEICC	MoEST, MD, WHO, EDPs, partners	X	X	X	X	X	X
Enhance MoHP capacity, including HR capacity, to enforce and monitor implementation of medical waste	Develop and implement proper medical waste management standards jointly with stakeholders	NHEICC	MoEST, MD, WHO, EDPs, partners	X	X	X	X	X	X
	Coordinate with MD and other relevant agencies to build capacity on medical waste	NHEICC	MoEST, MD, WHO, EDPs,	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
management to the proper standard	management		partners						
	Promote implementing and enforcing medical waste management standards	NHEICC	MoEST, MD, WHO, EDPs, partners	X	X	X	X	X	X
Establish a knowledge network with academics and practitioners on health promotion and behaviour change interventions, and climate change. Operationalise a public health response team to address the effects of climate change and disasters	Facilitate national working groups, NGOs, civil society and experts to develop and implement coordinated mitigation and adaptation plans for climate change and health	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Integrate surveillance for an early warning and risk communication plan to contain the spread of diseases as per IHR	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Develop national capacity to undertake studies on the health implications of climate change	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Develop and disseminate messages through the Internet as well as through print materials	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Develop and implement adaptation plans for climate change and health in line with the WHO SEARO regional strategy	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Conduct a vulnerability study on the impact of climate change on health	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Develop and produce media materials based on the vulnerability assessment	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Support and strengthen community-based neighbourhood support/watch schemes and other empowering measures through stakeholders' orientation and activation events at the community level	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Implement community interaction programmes to adopt local measures to minimise climate risks	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
	Provide orientation the Rapid Response Team (RRT) on climate change	NHEICC	MoEST, UNICEF, WHO, WaterAid, partners	X	X	X	X	X	X
	Promote construction of eco-friendly/green and climate-proof “cooler” urban layouts	NHEICC	MoEST, WHO, other EDPs	X	X	X	X	X	X
Collaborate with other ministries and NGOs, and	Develop and implement occupational health standards jointly with stakeholders	NHEICC	EDPs, other partners	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
take steps to prevent the harmful effects of occupational health hazards, particularly in urban areas where large numbers of people are exposed every day	Coordinate and collaborate with other relevant agencies	NHEICC	EDPs, other partners	X	X	X	X	X	X
	Formulate regulations and implement the prevention of occupational health hazards	NHEICC	EDPs, other partners	X	X	X	X	X	X
	Promote occupational hygiene	NHEICC	EDPs, other partners	X	X	X	X	X	X

PART THREE: HEALTH SYSTEM STRENGTHENING

The WHO defines health systems as "all the organisations, institutions, and resources that are devoted to producing health actions." This definition includes the full range of players engaged in providing and financing health services including the public, non-profit, and for-profit private sectors, as well as international and bilateral donors, foundations and voluntary organisations involved in funding or implementing health activities. Health systems encompass all levels: central, regional, district, community, and household. Health sector projects engage with all levels and elements of the health system and frequently encounter constraints that limit their effectiveness. The *World Health Report 2000* (WHO 2000) identifies the four key functions of the health system as: (1) stewardship (often referred to as *governance* or *oversight*), (2) financing, (3) human and physical resources, and (4) the organisation and management of service delivery.

NHSP-2 includes the following building blocks of the health system:

1. Health governance
2. Human resources for health
3. Gender and social inclusion
4. Health financing
5. State and non-state partnerships
6. Procurement and supply
7. Physical facilities and maintenance
8. Monitoring and evaluation
9. Sector Wide Approach and Health Sector Reform

The detailed implementation plans are given under the following sub headings.

3.1 Health Governance

1. Introduction

The government must play the role of a steward since it spends revenues that people pay through taxes and social insurance, and makes many of the regulations that govern the operation of health services in other private and voluntary transactions (WHO 2000). Government exercises its stewardship function by developing, implementing and enforcing policies that affect the health system functions. WHO has recommended that one of the primary roles of a Ministry of Health is to develop health sector policy, with the aims of improving health system performance and promoting people's health (WHO 2000).

New constitutional provisions will require a re-definition of roles, responsibilities, powers and structures of the MoHP and its departments and Regional Directorates, and a remodelling of roles throughout the health system. The intention is to bring power and service provision nearer to the people or to the lowest level of government. In Nepal's health sector, the MoHP needs to prepare for transitioning the health system. Managing health systems under a federal structure requires serious dialogue and continuous consultation with stakeholders because of the serious implications for the existing institutional framework, referral system, research and training, HR management, and delivery of health services at different levels. Lessons from current decentralisation- and restructuring-related initiatives will need to be redefined in the context of federalism. Recently, the MoHP prepared a plan for a smooth transition that has been integrated into this document.

Work has been done to establish a functional downward accountability mechanism. For example, programme directors are made accountable for programme planning and implementation, and they must report progress against the Governance and Accountability Plan (GAAP). However, programme managers (section heads) are not so accountable for the performance of their programmes. Although a local health governance pilot programme has been developed and piloted in a few districts, it is moving at a snail's pace, with the stakeholders in half the piloted districts still not oriented on issues of local health governance and fund management.

Gaps were found in the capacity building of local government units and in strengthening collaboration among local-level institutions. A training package was developed for the HFOMC and HWs, but training has been provided to only half of the planned districts. A formula was developed to provide grants to the district level and below, but it has not been used. The budget allocated for the districts could not be used due to the lack of a joint village health development plan. Budget was allocated to the districts as capital grants, and they thus had difficulty using the funds for recurrent costs. In many cases, the authority for hiring staff is limited to DHOs and not provided to local HFOMCs. Regarding FM, gaps have been observed in establishing and maintaining computerised systems of accounting with networking, establishing mechanisms to reduce irregularities, and for effective fund management including fund tracking.

2. Goal

To develop a responsive and accountable health system.

3. Objectives

- To develop transparency in the health system
- To develop an accountability mechanism in health system service delivery
- To address the implications of federalism.

4. Major Strategies

- Functional downward accountability
- Transparency
- Promoting GESI
- Strengthening linkages between bottom-up and top-down planning
- Effective fund management
- Coping with the implications of federalism
- Allocation of health institutions, health workforce and financial resources between the central and provincial levels.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of actions identified in the GAAP that will have been implemented	90	90	90	90	90	90
% of district facilities that will have been subjected to social audits	0	10	15	19	22	25
% of the MoHP budget spent	83	84	84.5	85	85.5	86

6. Major Challenges and Issues

- Adequate allocation of health institutions and HRH
- Addressing the implications of federalism
- Capacity building of local government units
- Strengthening collaboration among local-level institutions
- Developing and using computerised accounting system
- Effective fund management
- Reducing irregularities.

Accountable Officers: D-G, DoHS; Chief, HR and FM Divisions, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Establish a functional downward accountability mechanism	Prepare and implement a downward accountability plan	Health Sector Reform Unit (HSRU)	NHSSP/GIZ/ WHO	X					
	Develop and implement guidelines for an integrated social audit	PHCRD	NHSSP/GIZ/ WHO		X	X	X	X	X
	Adapt and implement the GAAP at district and lower levels	PHCRD	NHSSP/GIZ/ WHO			X	X	X	X
	Update financial regulations for hospitals	Finance Section				X			
	Health Facility Operation and Management Committees to recruit health workers	Personnel Administration				X	X	X	X
Promoting transparency	Develop and update a computerised system of accounting linking with the Financial Management Information System (FMIS)	Finance Section				X	X	X	X
	Develop software for fund tracking and update it monthly	Finance Section				X	X	X	X
	Update health-related websites	HSRU		X	X	X	X	X	X
	Document the lessons learned on Local Health Governance Support Programme (LHGSP)	HSRU	NHSSP/GIZ/ WHO			X			
Promoting GESI	Review and revise HFOMCs to make them more inclusive	MD/PHCRD	NHSSP			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop a guideline for increasing the participation of women, the poor, and excluded in health care management	MD/PHCRD	NHSSP			X			
Strengthening linkages between bottom-up and top-down planning	Adapt AWPB formulation guidelines (MoF) with top-down and bottom-up linkages	Finance section/MoHP				X			
	Coordinate with NPC and MoF for building linkages in planning	Planning				X			
Capacity development	Structural and functional analysis of health system	HSRU	Staff College						
	Develop and implement a training package for HFOMC members, HWs, and other stakeholders	NHTC	MD		X				
	Develop and implement a capacity development package for local offices	NHTC				X			
Effective fund management	Update financial regulations for hospitals	Finance Section, MoHP	Curative Division, MoHP			X			
	Form and activate the Audit Committee	Finance Section, MoHP				X	X	X	X
	Develop and implement the FM Improvement Plan 2	HR and FM Divisions				X	X	X	X
Prepare for health system administration in	Develop transitional plan for service delivery between all levels	HR and FM Divisions	GIZ, other partners			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
a federal structure	Assign functions, HR, and financial resources in a federal structure to all relevant levels from federal to local	HR and FM Divisions	GIZ, other partners			X			

Note: Health systems as a whole are the mandate of MoHP; thus, the Secretary of MoHP is responsible for the entire range of activities. However, authorities are delegated to various officials in the respective departments, centres, and divisions that are reflected in the table above.

3.2 Human Resources for Health

1. Introduction

Nepal's health policy and strategy documents over the past several decades repeatedly identify issues regarding the deployment and retention of health sector staff as a major problem facing Nepal. The health sector constitutes about one-quarter of the public sector's total personnel. The HR Development Strategic Plan of 2003 must be revisited in the context of the health-related MDGs, free health care, health system development, and the above-mentioned transition. A new projection of HR by categories and sub-categories is imperative to support service delivery.

The market has supplied sufficient HR for health. However, a shortage of critical HR for service delivery still exists. For example, 7,000 trained SBAs are needed, but the current supply is only 1,000; 90 MDGPs are needed but only 34 are available. Shortages of other clinical and non-clinical HR are chronic. These include anaesthetists/AAs, psychiatrists, radiologists, radiographers, physiotherapists/physiotherapy assistants, optometric technicians/ophthalmic assistants, and dental assistants. In addition, there is a shortage of HR related to health systems management: procurement specialists, health legislation experts, epidemiologists, health economists, and health governance experts. The inequitable distribution of HR remains a problem. Out of a national stock of 8,118 medical doctors, 1,062 work in sanctioned government posts and about 300 are working in government posts under the MoHP's scholarship programme. Two-thirds are in the Kathmandu valley or in other cities. Overall, the national stock of medical doctors in some of the key specialities related to the health MDGs appears to be sufficient. For example, the Medical Council in March 2009 registered 182 specialists in obstetrics and gynaecology, and 139 paediatricians. The problem is one of poor distribution of doctors and specialists nationwide.

The retention of medical doctors and nurses remains a major concern. Evidence on the average length of stay of care providers is lacking. Health facility surveys showed that only 64-80% of posted medical doctors were available at the time of the surveys. The availability of nurses was 68-81% and of paramedics, 81-92%.[7] The situation is worse in the most remote districts. Productivity is also a continuing challenge. Paramedics at HPs and SHPs conduct as few six clinical consultations per day (HMIS, 2006/07), which is low even when considering their involvement in both preventive and curative services. Daily output per physician varies between the ecological regions.

Training activities can be broadly classified into two types: in-service training and international training. The process of including Dalits and other excluded groups in the health care workforce will be initiated during NHSP-2. An additional ANM from Dalits and/or other excluded groups will be provided to HPs in underserved areas and trained as Rahat (welfare workers). A total of 1,000 ANMs will be provided as Rahat (200 per year) during the planned period. Similarly, MGHs will be facilitated to select FCHVs from among Dalits and other excluded groups, who will then be trained.

As mentioned in NHSP-2, all remaining SHPs will be gradually upgraded to HPs. Posts for an HA and an ANM will be added in HPs. Additional training and orientation will be provided to MCHWs to upgrade to ANMs.

2. Goal

To reduce mortality and disability and effectively address morbidity by producing and distributing HR across the country.

3. Objectives

- To supply HWs for labour markets

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[7]RTI International (December 2009). *Assessing Implementation of Nepal's Free Health Care Policy: Third Trimester Health Facility Survey Report*. Research Triangle Park, NC, USA.

- To ensure the equitable distribution of HWs
- To improve the performance of HWs
- To coordinate HR planning and management.

4. Major Strategies

- Improve HR planning
- Improve the attractiveness of jobs in remote areas to retain HWs
- Ensure basic and pre-service training
- Implement compulsory service to improve rural health service provision
- Use NGOs and private health providers
- Provide staff with leadership and clear direction
- Strengthen the skills/capacity of HWs
- Reduce staff absences
- Ensure appropriate structure systems, and capacity development
- Provide effective coordination.

Operational strategies

- Developing teaching and learning materials
- Offering training
- Improving the quality of training
- Strengthening training institutions
- Enhancing the capacity of training institutions
- Promoting PPPs
- Improving monitoring and supervision
- Conducting operations research
- Increasing SBA training sites.

5. Indicators and Targets

Indicator	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
% of posts at PHCCs and district hospitals filled by doctors and staff nurses	NA	85	86.5	88	90	90
% of hospitals with at least one obstetrician/ gynaecologist, one anaesthesiologist, six staff nurses and blood service workers	NA		60	70	75	80
Number of SBAs trained	1,500	1,500	2,000	1,000	1,000	1,000

6. Major Challenges and Issues

- Uneven distribution of HR
- Deployment and retention of care providers in remote areas
- Low productivity of care providers
- Low incentives to care providers
- Lack of skill mix among care providers and trainers
- Vertical approaches and fragmented training.

Accountable Officers: Chief, HR and FM Division, MoHP; Director, NHTC, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Improve HR planning in the health sector	Strengthen the Human Resource Information System (HuRIS) and Training Management Information System (TMIS) and use the information in HR planning	HR and FM Divisions	M&E, NHTC, HMIS	X	X	X	X	X	
	Develop an HR development strategy	HR and FM Divisions			X				
	Medium- and long-term forecasting of HR needs	HR and FM Divisions	HR and FM Divisions		X				
Make jobs in remote areas more attractive in order to retain HWs	Conduct a bottleneck study on training and utilisation	HR and FM Divisions	NHRC	X					
	Assess, develop, and implement an incentive scheme to retain care providers in remote areas. Develop a GESI perspective retention scheme	HR and FM Divisions	FM and GESI Unit		X	X	X	X	X
	Develop and implement multi-year service contract guidelines	HR and FM Divisions	LMD			X	X	X	X
Ensure basic and pre-service training	Coordinate with academic institutions for accreditation	HR and FM Divisions	Curative Division		X	X	X	X	X
Implement compulsory service provision	Review and develop a compulsory service framework for HWs	HR and FM Divisions	Curative Division				X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
to improve rural service delivery									
Use NGOs and private health providers	Prepare and expand a PPP modality	HR and FM Divisions	NGO Coordination Section			X			
Provide staff with leadership and clear direction	Design and implement a leadership development training programme	NHTC	HR and FM Divisions/ Staff College			X	X	X	X
Strengthen the skills and capacity of HWs	Provide in-service training to HWs	NHTC	Partners	X	X	X	X	X	X
Reduce staff absences	Develop and implement absence management mechanisms	HR and FM Divisions	Partners		X	X	X	X	X
Ensure appropriate structure, system and capacity development	Review the existing structure, system and capacity from a GESI perspective	HR and FM Divisions				X	X	X	X
	Prepare the restructuring required for federalism	HR and FM Divisions				X	X		
Effective coordination	Strengthen the Country Coordination Forum (CCF)	HR and FM Divisions			X	X	X	X	X
Operational-level activities developed by NHTC									
Assessing training needs	Determine the training requirements of health workers through research/assessments	NHTC	INGOs	X	X	X			
Developing teaching/learning materials	Prepare training materials	NHTC	INGOs	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Offering training	International and national in-service training programme management and implementation (Basic, refresher, upgrading, and specialised training and orientation programmes)								
	1. Health institution management training	NHTC	INGOs	-	X	X	X	X	X
	2. GBV training	NHTC	INGOs	-	-	X	X	X	X
	3. GESI and GBV training	NHTC	INGOs	-	-	X	X	X	X
	4. SBA training	NHTC	INGOs	1,500	3,000	5,000	6,000	7,000	7,000
	5. FP training	NHTC	INGOs	X	X	X	X	X	X
	6. BCC training	NHTC	INGOs	X	X	X	X	X	X
	7. Safe abortion training	NHTC	INGOs	X	X	X	X	X	X
	8. OT management training	NHTC	INGOs	X	X	X	X	X	X
	9. Management training	NHTC	INGOs	X	X	X	X	X	X
	10. HFMC management etc. training	NHTC	INGOs	X	X	X	X	X	X
	11. Upgrading training			X	X	X	X		
	12. Training to biomedical technicians			X	X				
	13. Clearing the backlog of training for newly-appointed FCHVs								
	14. Post-training follow-up					X	X	X	X
Improving the quality of training	Certification and accreditation	NHTC	INGOs	X	X	X	X	X	X
	Upgrade TMIS	NHTC							
	Training quality assessment	NHTC	HR Section, MoHP			X		X	
Making the health workforce	Train 1,000 ANMs from Dalit and/or other	NHTC		200	200	200	200	200	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
inclusive	excluded groups								
	Train FCHVs from poor and excluded groups			X	X	X	X	X	
Institutional development	Conduct preparatory work for establishing a National Health Training Academy (O&M survey, planning, financial and strategic implications, structural and functional analysis of training)	NHTC	MoHP/ MoGA/MoF		X				
	Establish a semi-autonomous National Health Training Academy	MoHP	MoHP/ MoGA/MoF			X			
Enhancing the capacity of training Institutions	Review the capacity of training centres in the context of developing HR resources for DoHS, DDA and DoA				X				
	Review training and capacity-building packages		MoHP		X				
	Prepare quality trainers for training with the right mix of skills (abroad/in-country)	MoHP	WHO, UNFPA, UNICEF, NHSSP, NFHP			X	X	X	
	Enhance the capacity of regional training centres (for training, equipping and networking)	NHTC				X	X	X	
	Develop the capacity of district-level training units	NHTC	INGOs/ private			X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	(for training, equipping, and networking)		institutions						
	Increase SBA training sites with quality maintenance	NHTC	INGOs/ private institutions			X	X		
	Provide block grants to district-level offices to provide training based on their perceived needs	PPICD, MoHP	Finance Section, MoHP			X	X	X	X
Integrating training programmes	Prepare a framework for integrating training	HR section, MoHP	Programme divisions/ DOA, DDA			X			
	Integrate training	HR section, MoHP	Programme divisions/ DOA, DDA				X	X	X
Promoting PPPs	Explore the possibility of PPP in training programmes	NHTC	INGOs/ private institutions						
	Organise physiotherapy training and other related skill development initiatives through PPP	NHTC	INGOs/ private institutions				X	X	
Improving monitoring and supervision	Supervise, monitor, follow-up, and evaluate the training activities	NHTC		X	X	X	X	X	X
Operational research	Conduct operational research on the effectiveness of the training	NHTC		X	X	X	X	X	X

3.3 Gender Equality and Social Inclusion

1. Introduction

The health sector has responded positively to the national mandate[8] of inclusion through its pro-poor and pro-women programmes. Since 2007, the GoN's initiatives of pro-poor targeted free health care policies, coupled with the Aama programme for maternity services, have seen considerable success. NHSP-2 includes a specific objective of addressing the barriers of the poor and the excluded, incorporates disaggregated evidence on health outcomes, and embraces the GESI strategy for the health sector. GESI indicators are part of NHSP-2's GAAP. A National Action Plan on GBV, coordinated by the Office of the Prime Minister and the Council of Ministers and with commitments from 11 ministries, including MoHP, was implemented in November 2010.

Although disparities in access to and use of EHCS between the poor/excluded and wealthier/advantaged social groups have significantly declined over the years, financial and cultural barriers remain. Unless NHSP-2 programmes and services directly address structural social issues, geographic-, gender- and caste-/ethnicity-based discrimination, and the stigma associated with HIV/AIDS, leprosy, disability and sexual orientation, these barriers will not be overcome.

In the MoHP GESI Strategy for the Health Sector, three objectives and eight strategies highlight the need to develop and implement programmes and services that address the barriers to access and utilisation by women, the poor, and the excluded. MoHP has fully adopted the strategy. (See the detailed strategy framework of NHSP-2 or see the *Health Sector GESI Strategy*, Government of Nepal, Ministry of Health and Population, 2010, for further information.)

Recent evidence (NDHS 2011) indicates the progress made in improving the health outcomes of different groups: TFR has come down to 2.6, use of modern contraceptive methods has increased by 66% in the past 15 years, and neo-natal mortality has been reduced to 33 deaths per 1,000 live births. But disparities still exist: the proportion of pregnant women attending antenatal care visits is 88% in urban areas but only 55% in rural areas; 50.2% of children in the tarai are underweight, while the national average is 38.6%. These issues need to be addressed. Efforts have been made to strengthen gender-responsive budgeting according to the guidelines of the MoF: the e-AWPB analyses the budget by gender-responsive categories. However, there is a need to revisit programmes for robust categorisation. Additionally, GESI-responsive budgeting practice must be initiated. Other areas of improvement include: the creation of mechanisms for institutionalising GESI (creating institutional structures responsible for providing technical support, dedicating time for GESI-related work); systematic inclusion of GESI in policies and plans; defining the roles of MoHP/DoHS and D/PHOs in implementing the GESI strategy; mainstreaming GESI into programmes and their guidelines; piloting of the GBV programme;

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[8] Interim Constitution: Section 3: Fundamental rights: Article 13 states: No one will be discriminated against on the basis of religion, caste, ethnicity, gender or language (p. 4); affirmative actions can be taken for women, Dalits, Adibasi Janajatis, Madheshis, and socially or culturally discriminated groups (p. 5). The Three Year Plan has also prioritised the inclusion of persons with disability, women, Dalits, Adibasi Janajatis, Madheshis, Muslims and people who live in backward regions.

improving the care-seeking behaviour of the poor and excluded; and ensuring access to services for all, including women, the poor, and excluded.

2. Goal and Objectives

GESI is included in the mission, strategic direction, objectives, outputs and indicators of NHSP-2. Objective 1 of NHSP-2 demands disaggregated indicators and has set disaggregated targets. Objective 2 is clearly focused on addressing the cultural and economic barriers facing women, the poor, and excluded in order to enhance these groups' access to and use of health services.

3. Major Strategies

- Mainstreaming GESI into policies and programmes
- Institutionalising GESI into health systems and practices
- Promoting an inclusive and GESI-competent health work force
- Promoting state/non-state partnerships for GESI
- Maintaining equity in delivering health care services
- Addressing the social, cultural and economic barriers faced by the unreached
- Addressing the health needs of GBV survivors
- Empowering women, the poor, and excluded so they can access health services
- Improving the care-seeking behaviour of women, the poor, and excluded
- Enabling GESI-related evidence-based M&E.

4. Indicators and Targets

Outcome Indicators	Baseline/Year	Target		
		2010/11	2013	2015
CPR (modern methods) for the poor (lowest and second-lowest wealth quintiles) and excluded castes (%)	Poor: 35.5 Dalit: 44 Janajati: 47 Muslim: 17 (2006 for all)	Poor: 43 Dalit: 52 Janajati: 55 Muslim: 25	Poor: 46 Dalit: 55 Janajati: 58 Muslim: 28	Poor: 49 Dalit: 58 Janajati: 61 Muslim: 31
% of women who are poor (lowest and second-lowest wealth quintiles)/from excluded castes (Dalit) who took iron tablets or syrup during their last pregnancy	Poor: 44.9 (2006); 76.7 (rural, 2009) Hill Dalits: 78 (rural, 2009) Tarai Dalits: 90 (rural, 2009)	Poor: 77 Dalit: 82	Poor: 81 Dalit: 85	Poor: 85 Dalit: 88
% of deliveries attended by SBAs for the lowest and second-lowest wealth quintiles and excluded castes (Dalits)	Poor: 7.5 Dalit: 11 Janajati: 14 Muslim: 13 Other Tarai Madheshi: 13 (2006 for all)	Poor: 20.3 Dalit: 23 Janajati: 25 Muslim: 24 Other Tarai Madheshi: 24	Poor: 25.3 Dalit: 27 Janajati: 30 Muslim: 29 Other Tarai Madheshi: 29	Poor: 30 Dalit: 32 Janajati: 35 Muslim: 34 Other Tarai Madheshi: 34

Outcome Indicators	Baseline/Year	Target		
		2010/11	2013	2015
% utilisation of EHCS (OP, inpatient, especially deliveries and emergency) by targeted groups and disadvantaged castes and ethnicities, proportionate to their populations (as % of highest)	Poor: 62 (2006); 57 (rural districts, 2009) Dalits: 14 (OP) 17.1 (inpatient) 16.7 (emergency) (2008)	90	90	90
% of clients among targeted groups, disadvantaged castes and ethnicities who are satisfied with their health care at district facilities	68.4 (2008) (based on availability of range of services)	68	74	80
% use of available community-based emergency funds in districts with EAPs by the poor and socially excluded groups		19	30	50
Number of districts providing services for GBV		Three districts	Thirteen districts	Strengthening existing districts and expanding into four additional districts

5. Major Challenges and Issues

- Mainstreaming GESI in policy, planning, programming, budgeting and disaggregated monitoring systems, processes, and formats
- Establishing and strengthening institutional modalities with specific responsibility for GESI mainstreaming
- Skills and competencies of health service providers to provide GESI-responsive services
- Low access to and poor quality of health care services (including frequent absenteeism of health care providers) for women, the poor, and excluded
- Changing the care-seeking behaviour of women, the poor, and excluded, and sustaining demand-side programmes like the EAP
- Empowering women, the poor, and excluded
- Need for a multi-sectoral approach to address the cultural, social, and religious determinants that impact the health of women, the poor, and excluded
- Addressing GBV and providing health services to GBV survivors.

Accountable Officer: Chief, Population Division, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Mainstreaming GESI in the health sector	Develop GESI operational guidelines for the health sector	Population Division and PPICD	All divisions and centres of MoHP and DoHS			X			
	Review and revise selected policies from GESI perspectives	Population Division and PPICD	PPICD and concerned divisions and centres		X	X	X	X	X
	Ensure GESI integration in new policies, strategies and guidelines	PPICD	Population Division and concerned divisions and centres		X	X	X	X	X
	Review national programmes (e.g. kala-azar, nutrition) from a GESI perspective and address GESI integration	PHCRD	All concerned divisions and centres of DoHS		X	X	X		
	Include GESI related activities in all programmes of MoHP	PPICD	PHCRD and Population Division		X	X	X	X	X
	Mainstream GESI in the annual programme guidelines of divisions and centres	PPICD	PHCRD and all concerned divisions and centres			X	X	X	X
Institutionalising GESI in the health sector	Develop a MoHP approved concept note for mainstreaming GESI in the health sector	Population Division	PPICD		X				
	Form a GESI Steering Committee at MoHP and a GESI TWG at DoHS, RHD and district level	Population Division	PHCRD, RHDs and D/PHOs		X	X			

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Strengthen and make functional GESI TWGs and Focal Persons at all levels (DoHS, RHD and DHO)	Population Division and PHCRD	RHDs and D/PHOs		X	X	X		
	Strengthen the capacity of the HFOMC to address GESI- and governance-related issues	MD	DHOs			X	X	X	X
Inclusive and GESI-competent HR (cross reference HR, SM)	Strengthen the capacity of the health workforce to work in a GESI-responsive manner (orientation, training, on-the-job coaching, mentoring)	Population Division and PHCRD	RHDs and DHOs		X	X	X	X	X
	Support the implementation of HR Strategy to promote diversity in the health work force	HR Division	Personnel Administration and DoHS			X	X		
	Select, train and deploy ANMs from among Dalit and other disadvantaged groups (*rahat*)	NHTC and FHD	PHCRD and D/PHOs	200	200	200	200	200	
	Facilitate MGHs to select FCHVs from among Dalits and excluded groups	FHD	D/PHOs and programme divisions			X	X	X	X
Review training curricula of health sector and GESI integration	Review and revise selected training curricula from a GESI perspectives	NHTC	Concerned divisions and centres			X			
	Strengthen the capacity of NHTC on GESI integration in training programmes	NHTC	Population Division			X	X	X	
Improve the care-seeking behaviour of women, the poor	Develop and implement context-specific IEC materials targeting issues constraining health outcomes of women, the	NHEICC	PHCRD and other programme divisions			X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
and excluded	poor, and excluded								
	Air messages on community radio in local languages about addressing structural GESI-related issues and on health services in general	NHEICC	PHCRD, concerned programme divisions, centres and D/PHOs		X	X	X	X	X
Empower women, the poor, and excluded	Develop and implement targeted programmes to empower the target groups to claim their rights (promoting equity and access)	PHCRD	PPICD		X	X	X	X	X
	Develop and make functional GoN's and NGOs' multi-year partnership model to promote equity and access	PHCRD	Concerned divisions and centres of DoHS		X	X			
	Promote active participation of women, the poor, and excluded in social audit programmes	PHCRD	D/PHOs		X	X	X	X	
Maintain and promote equitable universal health coverage for the delivery of health care services	Establish HFs in underserved areas	MD	GESI TWGs			X	X	X	
	Mainstream GESI into initiatives and programmes of other divisions (e.g. of CHD, FHD, MD)	PHCRD	Programme divisions		X	X	X	X	X
	Conduct operational research as required to identify good practices	PHCRD and Population Division	PPICD and EDPs				X		X
	Develop and implement health-sector-specific gender-responsive budgeting guidelines	PPICD	Finance Section, Population			X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
			Division and EDPs						
	Identify and address socioeconomic and cultural barriers of specific target groups	Population Division	Concerned divisions			X	X	X	
	Review and revise the HFOMC guidelines to make them more inclusive and governance-responsive	MD and Curative Division	PPICD, Population Division and NHTC			X			
	Strengthen the capacity of the HFOMC from GESI and governance perspectives	NHTC	MD			X	X	X	X
Addressing GBV	Develop OCMC Implementation Guidelines and revise based on review and assessment	Population Division			X	X	X		
	Pilot hospital-based OCMC in seven districts and roll out to additional districts	Population Division	RHD		X	X	X		
	Provide capacity strengthening of OCMCs on providing services (treatment, psychosocial counseling, and coordination) to make them effective and functional	Population Division	RHD		X	X	X	X	X
	Develop screening and referral protocols for GBV cases and a user's guide on GBV	Population Division	UNFPA			X			
	Develop unified guidelines for addressing GBV (MoHP, MoLD, MoWC&SW, MoHA and Ministry	Population Division	MoWC&SW and the Office of the Prime				X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	of Law and Justice (MoLJ))		Minister and the Council of Ministers (OPMCM)						
Establish and strengthen a Social Service Unit (SSU) at central, regional and zonal hospitals	Conduct a study of existing practices of social services in central, regional and zonal hospitals	Population Division	PPICD, MD, and Curative Division			X			
	Establish and strengthen SSUs as a pilot	Population Division	PPICD, MD and RHD			X			
	Assess the piloting of SSUs, revise guidelines and roll out in additional hospitals	Population Division	PPICD and MD				X	X	X
Promote accountability	Conduct social audits up to the level of selected district hospitals and peripheral HFs in selected districts	PHCRD	D/PHO and HFOMC		X	X	X	X	
Gender audit in health sector	Develop a Gender Audit Framework and Terms of Reference (TOR) for the audit	Population Division	UNFPA and PPICD		X				
	Conduct a gender audit of MoHP	Population Division	UNFPA and PPICD			X	X		
Supervision and M&E	Revise the existing supervision checklist and methods from GESI and governance perspectives	M&E Division	MD			X	X		
	Develop monitoring tools and checklists for service delivery from GESI perspectives	M&E Division	MD			X			
	Data management disaggregation by	M&E Division	MD		X	X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	caste/ethnicity and wealth quintiles								
	Integrate GESI-related variables in health financing, the Service Tracking Survey and the HHS	PPICD	Population Division			X	X	X	X

3.4 Health Financing

1. Introduction

Health financing is the centre of the health system, contributing to health sector reform and system development. Government financing of EHCS has gradually expanded beyond the free provision of FP and MCH services to include a broader range of preventive and curative services free of charge or highly subsidised. The abolition of user fees at district-level peripheral facilities has led to a major increase in demand and a narrowing of inequity in the utilisation of services. Further planned expansion to district hospitals of free-of-charge universal care should lead to additional increases in utilisation by the poor and excluded. Although NHSP-2 presents a strong rationale for the modest extension of free-to-user services, the MoHP recognises that it will face increasingly difficult choices as to which curative services it can finance, and how to allocate limited budget funds. Already, 80% of outpatient contacts are for NCDs and injuries. The expanded prevention efforts proposed under NHSP-2 should help slow the growth in the burden of NCDs, but will not prevent continued growth in demand for curative services of an increasingly complex and expensive nature.

Government already provides some financial support for certain types of tertiary care and for those facing catastrophic health costs. Demands will inevitably increase on the limited funding available and will raise difficult choices about how to provide some social protection to those facing catastrophic illness, while ensuring that the increased spending on expensive curative care does not come at the cost of less than adequate funding for the core programmes that have delivered substantial improvements in health outcomes in recent years. The MoHP will need to continue developing partnerships with non-state actors with other resources to expand curative services.

Expenditure in health remains low, at 5.3% of Gross Domestic Product (GDP) in 2006. Per capita health expenditure stood at 18.09 US Dollars (USD) compared to USD 65 in Bhutan, USD 44 in Sri Lanka, USD 29 in India, and USD 19 in Afghanistan (WHO 2008). The composition of total health expenditure is 44% public expenditure, with the remaining 56% coming from private sources. The GoN share stands at 24% (USD 4.28) of the total health expenditure, while external partners contribute the remaining 21% (USD 3.75). More than 55% (USD 9.00) of the total health expenditure is financed through out-of-pocket expenditure by households at the time of service. There is scope for introducing a social health protection scheme for catastrophic illness. Some studies have been done regarding introduction of social health insurance; however, they are still inadequate to inform the policy, mechanism, and tools.

2. Goal

To develop a responsive and fair financing system to move towards universal coverage.

3. Objectives

- To increase allocative and technical efficiency in the health sector
- To enhance equity in the distribution of resources
- To develop a social health protection strategy in health sector.

4. Major Strategies

- Developing policies and strategies for health financing
- Enhancing technical efficiency
- Enhancing equity
- Splitting the roles of purchasers and providers
- Developing and implementing social health protection
- Capacity development.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of the MoHP budget spent	83	83.5	84	84.5	85.5	86
% of the budget of local bodies allocated to the health sector (borrowed from MoLD)	10	10	10	10	10	10
% of the budget allocated to EHCS	75	75	75	75	75	75
Health Financing Strategy		Health Financing Strategy developed	Health Financing Strategy implemented			

6. Major Challenges and Issues

- High out-of-pocket expenditure (56% of total health expenditure)
- Low fiscal space
- Low level of efficiency
- Equitable distribution of resources
- Fragmented health programme/activities
- Inadequate alternative health financing schemes.

Accountable Officer: Chief, PPICD, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Developing policies and strategies for health financing	Collect more evidence to inform Health Financing Strategy	HEFU	Health Financing TWG	X					
	Prepare background papers to inform Health Financing Strategy	HEFU	PPICD		X				
	Develop a draft of Health Financing Strategy	PPICD	HEFU, Health Financing TWG		X				
Enhancing technical efficiency	Develop and implement resource allocation criteria				X	X	X	X	X
	Develop guidelines for Output-based Budgeting (OBB)	Finance Section	PPICD	X					
	Implement OBB	Finance Section	PPICD	X					
	Monitor cost information during programme review	Finance Section	PPICD		X	X	X	X	X
	Provide OBB training to programme officers	Finance Section	NHTC	X	X				
	Coordinate with NPC, MoF and MoLD for providing block grants to DHOs/hospitals	Finance Section	MLD, NPC	X	X				
Enhancing equity	Assess the equity analysis/ benefit incidence analysis	HEFU	PPICD		X			X	
Splitting the roles of purchasers and providers	Conduct a study on the implications of splitting the roles of purchasers and providers	PPICD	Partners		X				

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Prepare an institutional and legal framework for splitting the roles of purchasers and providers	PPICD	Partners		X	X			
	Develop an institutional framework for purchasing agencies	PPICD	Partners		X				
	Develop a coping strategy for splitting the roles of purchasers and providers	HEFU/Finance Section, MoHP	Partners			X			
Develop and implement social health protection/social health insurance	Generate additional evidence for social health protection	HEFU	Partners		X				
	Develop a policy on social health protection	PPICD	Partners		X				
	Develop and pilot a social protection scheme for the formal sector not covered by other schemes	HEFU	Partners			X			
	Develop a policy on social health insurance	HEFU	Partners		X				
	Design, plan, and pilot social health insurance	HEFU	Partners			X			
Capacity development	Develop and implement a capacity development package for strategic purchasing of health services	HEFU	Partners			X	X		

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	Develop the capacity of HEFU (through training and networking)	PPICD	Partners	X		X		X	

3.5 State and Non-State Partnerships

1. Introduction

The non-state sector has contributed to meeting the goals of NHSP-1 in almost all areas, notably TB control, expanding contraceptive use, controlling HIV/AIDS, eye care, and WASH promotion. Although immunisation services are mainly provided through government facilities, the for-profit private-sector and NGO clinics also provide immunisation. The private sector provides immunisation services mainly in urban areas through hospital clinics, nursing homes, and NGOs. GoN supplies vaccines, related logistics and technical assistance, including monitoring and supervision to ensure uniform quality service. NGOs provide 44% of male and female VSC, with Sunaulo Pariwar Nepal (SPN) accounting for 75% of NGO-provided VSC. The private sector is also involved in the social marketing of contraceptives.

Apart from private pharmacies, the private for-profit sector is primarily involved in medical education and tertiary care in urban areas, catering to the better-off. The sector now produces almost 90% of MBBS-level doctors in Nepal, and a similar share of staff nurses. In 2005-6, the private health sector had two-thirds of hospital beds, 13,400 compared to 6,796 government hospital beds. It also operates over three times more health laboratories (1,000) than the Government (277) (DoHS, 2008). By reducing the need for Nepalese to go abroad for medical education or for specialist care, the sector is estimated to save Nepal more than NRs 500 million per year in foreign exchange (Rijal, 2008).

The private health sector also contributes through taxes and employs around 20,000 people in private health facilities (Rijal, 2008). Regulation of the sector has been minimal, and major differences are found in the quality of the services offered and the prices charged for similar services (Resource Centre for Primary Health Care (RECPHEC), 2005). Utilisation of private-sector facilities is very low, especially in medical colleges where students need patients to study.

Nepal has also developed a private pharmaceutical industry that meets around 32% of total domestic consumption and is worth NRP 9,719.3 million. Sixteen companies have WHO Good Manufacturing Practice certification for drug production. The private sector produces almost all domestic drugs.

Formal contractual relationships with non-state organisations to deliver services have mainly been financed by EDPs outside GoN budget procedures, although they work closely in support of government programmes. A number of more formal partnerships have been made between GoN and non-state providers, although these have not developed to the extent envisaged when NHSP-1 was approved. The partnerships include the following:

- Partnerships with NGOs to deliver health services at district and sub-district level – Lamjung Community Hospital (the contracting-out model for PPP), and Bayalpata Hospital, Achham
- Partnerships with district-level local governments and local communities (Jiri District Hospital)
- Partnerships with private hospitals and medical colleges in prevention and treatment of uterine prolapse.

2. Goal

To bring resources from non-state actors to fill the resource gap in the health sector.

3. Objectives

- To use the skills, expertise and capital of the non-state sector in public service delivery and health system development

- To increase the role of the non-state sector in service delivery.

4. Major Strategies

- Enhancing technical efficiency
- Enhancing equity
- Splitting the roles of purchaser and provider
- Developing and implementing social health protection
- Capacity development.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Develop, adapt and implement state/non-state and community partnership models			X	X	X	

6. Major Challenges and Issues

- Unclear policy on PPP
- Quality assurance
- Coordination
- Scaling-up of successful practices and expanding credible specialised services
- Monitoring.

Accountable Officer: Chief, HSRU, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Formulate policy and strategy	Collect evidence to inform policy makers on PPP	HSRU	Partners		X				
	Formulate a sectoral PPP policy	HSRU	Partners			X			
Develop PPP models	Develop hybrid models of PPP	HSRU	Partners			X			
Quality assurance/ accreditation	Develop a quality assessment mechanism including policy, legal framework and tools, both for state and non-state institutions	HSRU	Partners			X			X
	Document case studies on PPP	HSRU	Partners		X				
Expand specialised credible services	Build PPP arrangements with private medical colleges to expand the specialised care in districts	Curative Division	Partners		X		X		X
Scale up successful practices	Prepare and implement the scaling-up plan (PPP arrangements)	HSRU	Partners			X	X	X	X
Reactivate the PPP forum	Reactivate the PPP forum	HSRU	Partners			X	X	X	X
Monitoring	Collect and analyse the inputs, the public and private service utilisation dates	HMIS	Partners			X	X	X	X

3.6 Procurement and Supply

1. Introduction

Procurement has received considerable attention from policy makers and EDPs in recent years. MoHP reviews at all levels the supply of drugs, equipment, facilities and their quality or condition. Obviously, major contributing factors to quality health care delivery include the supply of various commodities (medicines, instruments, equipment, furniture, and other supplies), physical infrastructure (peripheral facilities, hospital, laboratories, etc.) and consulting services as part of a capacity enhancement and research programme.

In order to correct procurement-related anomalies that have existed in Nepal for decades and have delayed the development process, GoN enacted a Public Procurement Act (PPA) in 2007 that addresses the procurement of commodities, public works and services. Under MoHP, commodities are procured by the DoHS, RHDs, and D/PHOs. The responsibilities of constructing physical facilities, including repair and maintenance work costing NPR 1,000,000 or more, have been handed over to DUDBC. Offices under the MoHP carry out procurements costing less than that amount. Regarding services, major consultancies are procured from the central level, and hiring of temporary staff is carried out locally. Health commodities are distributed from the central store (and Regional Directorates) to the regional medical stores, and then to the district stores, which dispatch them to the service delivery points.

2. Goal

To ensure an efficient, effective, transparent and accountable, and value-for-money procurement system in the health sector.

3. Objectives

- To develop the capacity of procurement-related staff
- To advance the procurement process
- To increase the efficiency gains
- To ensure the quality of medical and other products
- To promote transparency and honesty in the bidding process.

4. Major Strategies

- Revised procurement-related policies
- Consolidated procurement planning
- Enhance capacity, Quality Assurance (QA)
- Enhance efficiency gains
- Promote transparency
- Coordination with other divisions and centres
- Train procurement professionals within the civil service.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of HFs without stock-outs of tracer drugs	90	90	90	90	90	100

6. Major Challenges and Issues

- Developing procurement as a speciality in the civil service
- Fair competitive bidding
- Multi-year contracts
- Transparency
- Efficiency gains
- Revising procurement related laws/bylaws
- Capacity development
- Consolidated procurement planning.

Accountable Officer: Director, LMD, DoHS

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Revised procurement-related policies and guidelines	Supporting legislation to develop procurement as a speciality	Legal Section	Public Procurement Monitoring Office (PPMO)		X				
	Revise MoHP procurement policy and guidelines	LMD	PPMO/PPICD			X			
	Revise logistics management policy and guidelines	LMD	PPMO		X				
	Amend the Drug Act and give the Nepal Drug Research Laboratory independent status	DDA	Partners, GIZ	X	X				
	Prepare guidelines for the public-private mix for supply and delivery of essential drugs	LMD	PPMO			X			
Advance procurement	Develop criteria to HFs	DUDBC	MD		X				
	Conduct a needs assessment for equipment and instruments	LMD/MD	Partners		X	X	X	X	X
	Carry out forecasting of drugs and other commodities	LMD/MD	Partners		X	X	X	X	X
	Develop a specification bank or link with a specification bank	LMD	Partners		X	X			
	Conduct a market survey	LMD	Partners	X	X	X	X	X	X
	Prepare standard bidding documents (international/national competitive bidding**)**	LMD	Partners	X	X	X	X	X	X
Integrate procurement plans	Prepare consolidated annual procurement plans (consolidated goods, public works, services for the entire ministry regardless of financing source)	LMD	All divisions and entities	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Capacity development	Provide training for strengthening of procurement capacity at central and district levels Increase numbers of LMD staff	LMD	NHTC	X	X	X	X	X	X
	Engage procurement support for NHSP-2 implementation	LMD	Partners	X	X	X	X	X	X
	Provide training to the staff (Procurement Unit) on procurement	LMD	LMD	X	X	X	X	X	X
	Support district offices on procurement	LMD			X	X	X	X	X
QA	Develop a sound QA system including pre- and post-shipment review at central and district levels to monitor the quality of procured drugs	LMD	DDA		X				
	Develop local capacity at district level to comply with QA	LMD	DDA		X				
Increasing efficiency gains	Adopt multi-year framework contracting for essential drugs, commodities, equipment, and services	LMD	PPMO	X		X		X	
	Assess the multi-year service contract to document efficiency gains	LMD	PPMO		X				
	Introduce e-procurement	LMD	PPMO		X	X	X	X	X
Promote transparency	Make the annual procurement plan available on the website to all interested parties at cost price six months before the beginning of the FY	LMD	MoHP	X	X	X	X	X	X
Foster coordination	Conduct coordination meetings with			X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	other divisions/centres and EDPs to avoid duplication, and obtain the benefit of economies of scale								

3.7 Physical Facilities and Maintenance

1. Introduction

In the context of expanding EHCS coverage to meet the needs of all citizens, particularly the poor and excluded, functional health infrastructure is needed to provide an enabling environment to deliver quality health services. Therefore, delivering ECHS requires substantial investment in both new construction and the refurbishing and upgrading of existing facilities. At the same time, repair and maintenance of existing facilities will be a regular activity. The key areas of concern during NHSP-2 include the following:

- Strengthening, institutionalising and decentralising the existing Health Infrastructure Information System (HIIS)
- Developing standard designs and guidelines that help increase quality, accountability, and transparency
- Ensuring a sufficient number of appropriately located facilities
- Implementing a predictable and timely financing, budgeting, and resource allocation mechanism
- Ensuring repair and maintenance of existing facilities through more rational budgeting using HIIS
- Promoting community participation and enhancing local ownership of public facilities.

2. Goal

To support providing quality health services through quality infrastructure.

3. Objectives

- To develop infrastructure for the expansion of service delivery
- To upgrade HFs for comprehensive care.

4. Major Strategies

- Increasing access to HFs
- Institutionalising/capacity development
- Increasing access to HFs, particularly by the poor, vulnerable, and marginalised
- Improving repair and maintenance
- Increasing community participation.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of SHPs that have sufficient space as per MoHP standards	30	40	60	70	80	80

6. Major Challenges and Issues

- Institutionalising HIIS
- Maintaining quality, accountability, and transparency
- High demand for infrastructure development and limited budget
- Construction on inappropriate donated land
- Preventive maintenance
- Community participation.

Accountable Officers: Director, MD; D-G, DUDBC

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Increasing access to HFs	Construct HFs as per the service expansion plan (DHs, PHCCs, HPs/SHPs)	DUDBC	MD	X	X	X	X	X	
	Construct CEOC units in major district hospitals	DUDBC	MD	X	X	X	X	X	
	Add birthing centres in HPs and PHCCs where required	MD		X	X	X	X	X	
Institutionalising/ capacity development	Develop upgrading criteria for HPs, PHCCs, and district hospitals	MD	NHSSP		X				
	Develop standard designs for HFs (SHPs, HPs, PHCCs and DHs)	DUDBC	MD	X					
	Prepare infrastructure development guidelines for construction and maintenance work	MD	DUDBC			X			
	Develop and implement standard construction guidelines	DUDBC	MD			X			
	Train technicians on standard construction	DUDBC	MD/GIZ/ NHSSP			X	X	X	
	Train and use HIIS for planning and monitoring	MD	DUDBC			X	X	X	
Increasing access to HFs, particularly by the poor, vulnerable, and marginalised	Establish HFs focusing on communities where poor and marginalised people live	MD	DUDBC		X	X	X	X	

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Improving repair and maintenance of HFs	Develop repair and maintenance related guidelines	MD	DUDBC		X				
Increasing community participation	Develop a guideline for community participation for the construction and maintenance of HFs	MD	DUDBC		X				X

3.8 Monitoring and Evaluation

1. Introduction

M&E to measure success, failure, or deviation at different phases of programme implementation is an integral part of any programme or plan. The success or failure of any programme largely depends upon the M&E function. The following must be in place for an effective M&E mechanism: reliable data collection mechanisms, including strong data QA and validation mechanisms; adequate capacity of the M&E system, including sufficient organisational arrangements; adequate resources (human, financial, and physical); good information architecture; and linkages and networking.

At present, the MoHP relies on sources such as the HMIS, NDHS, Living Standard Measurement Survey, STS, HHS, and other similar studies. Responding to Output 8, "Develop and Implement an Integrated and Comprehensive Health Information System for the Health Sector", of the NHSP-2 IP, MoHP endorsed a Health Sector Information System (HSIS) Strategy. HSIS was thus initiated as a pilot in three selected districts of Nepal in 2009. Two separate information systems are still being used. The existence of two parallel recording and reporting systems is creating confusion among the stakeholders and still remains inconclusive.

Data quality is a major concern in routine information systems. Linkage between the different information systems remains a challenge. These include the following: HMIS, Logistics Management Information System (LMIS), HuRIS, Financial Management Information System (FMIS), Ayurveda Information System (AIS), Drug Information Network (DIN), Health Infrastructure Information System (HIIS) and the private sector.

2. Goal

To improve the health sector M&E system.

3. Objectives

To strengthen the health sector M&E system and mechanism for effective M&E of NHSP-2.

- To support evidence-based planning and decision making processes
- To develop policy and legal frameworks (acts, policy, and guidelines etc.) by the end of July 2013
- To revise and develop standard health information recording and reporting tools by the end of 2013
- To establish functional linkages between different information systems and databases by developing uniform standard codes by the end of 2015
- To develop an effective data QA and validation mechanism by the end of 2013
- To monitor the goals, objectives, outcomes, and outputs of NHSP-2 at each level
- To align non-routine information collection mechanisms with the M&E framework of NHSP-2
- To develop institutional capacity at the central, regional, and district levels
- To share information with health sector stakeholders.

4. Major Strategies

- Develop policy, legal frameworks, and guidelines covering recording, reporting, data management, analysis, and use issues for effective implementation
- Strengthen institutional capacity at all levels
- Have a data QA mechanism in place
- Facilitate the development of a programme-specific M&E plan, framework, and guidelines at the regional level
- Establish an effective and evidence-based review mechanism linked with planning and management

- Develop linkages between the different data sources and levels
- Ensure that timely, complete, and updated data/information are available from all data sources
- Strengthen the information infrastructure down to the HFs
- Conduct an analysis and review from the GESI perspective
- Develop linkages between supervision data and findings with the decision making process and HR capacity development.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of timely and complete data on annually reportable M&E framework indicators reported before the end of December of the following year			100	100	100	100
% of health information systems using uniform standard codes			Develop	100	100	100
% of tertiary and secondary hospitals (both public and private) implementing International Classification of Disease (ICD) 10 and reporting coded information to the health information system			65	75	100	100
% of HFs (public and private) reporting to the national health information system (by type or level)			-	80	100	100
No. of M&E policy and legal frameworks (act, policy, guidelines etc.) developed			-	3	-	-
No. of standard recording and reporting tools developed by revising existing tools			1	-	-	-
No. of data quality assessments performed	Centre		1	1	1	1
	Region		5	5	5	5
	District		75	75	75	75
No. of HHSs conducted			1	-	1	-
No. of STSs conducted			1	1	1	1
No. of mid-term reviews performed			-	1	-	-
No. of NDHSs conducted			-	-	-	1

6. Major Challenges and Issues

At present, the following major challenges exist in the area of health sector M&E:

- Lack of policy and guidelines
- Weak institutional capacity
- Weak data QA and assurance mechanisms
- Fragmented M&E plan and approaches, lack of a comprehensive M&E plan
- Limited data analysis and use practice
- Lack of clarity on roles, responsibilities, and organisational arrangements
- Lack of appropriate organisational arrangements and clarity on institutional homes
- No formal linkages between different data sources
- Lack of an information infrastructure plan
- Inadequate resources for M&E.

Accountable Officer: Chief, PHAM&ED, MoHP[9]

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
Strengthen M&E plan of the National Health Strategy/MNCH	Development of a comprehensive health sector M&E policy, plan, and guidelines	PHAM&ED/MoHP			X			
	Regular meetings (one per month)	PHAM&ED/MoHP			X	X	X	X
	Routine Data Quality Assessment (RDQA) tools and guideline development	HMIS			X			
	RDQA by MoHP and RHD	PHAM&ED/MoHP	HMIS			X	X	X
	Develop an annual calendar for production and sharing of reports (calendar preparation workshop with concerned stakeholders)	PHAM&ED/MoHP	HMIS			X	X	X
	Production and sharing of the	PHAM&ED/MoHP	HMIS			X	X	X

[9] *This M&E plan does not cover programme specific monitoring and evaluation, such as M&E of HIV/AIDS, Malaria, TB etc.*

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	reports including annual report							
	Establish wireless networking between MoHP and the DoHS central server	PHAM&ED/MoHP	HMIS			X	X	X
	Internet provision for all public hospitals and D(P)HOs	PHAM&ED/MoHP	HMIS			X	X	X
	Revisit the organisational structure (O&M Survey) at all levels for M&E	PHAM&ED/MoHP					X	
Strengthen monitoring of results	Strengthen the routine information system to provide information for results-based monitoring (covering integration, uniform code, and other routine system strengthening activities for HuRIS, LMIS, HMIS etc.)	PHAM&ED/MoHP, HEFU	Divisions, centres, DoHS, MoHP			X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	Print tools	PHAM&ED/MoHP, HEFU				X	X	X
	Conduct the annual STS	PHAM&ED/MoHP	PPICD, NHSSP			X	X	X
	Complete the Health Facility Mapping Survey (HFMS) through use of the Geographical Information System (GIS)	HMIS	NHSSP			X	X	X
	Update HFMS database	HMIS	NHSSP			X	X	X
	Conduct NDHS, HHS, STS		USAID, NHSSP			X	X	X
	HR recruitment and deployment (M&E, Management Information System (MIS) etc.)	PHAM&ED/MoHP	Partners			X	X	X
	Training on statistical analysis (basic, seven days, one batch per year, 15 persons)	HMIS				X	X	X
	M&E training (70 persons, eight days)	HMIS				X	X	X
	Training on statistical analysis	HMIS				X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	(advanced, 10 days, one batch per year, 10 persons)							
	Develop reporting tools and guidelines for the private sector	HMIS	NHSSP			X		
	Training/orientation	HMIS				X	X	X
Strengthen institutional capacity	Develop an ICD 10 training group and institutionalise within NHTC	PHAM&ED/MoHP	HMIS			X	X	X
	Develop the institutional capacity of NHTC to conduct data management, analysis and report writing training	HMIS	NHTC				X	
Develop a digital health strategy	Develop the Health Policy	PPICD				X	X	
	Establish a national health data repository at MoHP (including necessary hardware)	PHAM&ED/MoHP	HMIS, Population Division/MoHP			X	X	X
	Assess and prepare system design and plan for electronic	HMIS	Partners				X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	health recording systems for public health centres							
	Strengthen ICD 10 at primary-, secondary-, and tertiary-level public and private hospitals	HMIS				X	X	X
Strengthen registration	Support for strengthening vital registration system (piloting FCHV mobilisation in 10 districts)	Population Division/MoHP	MoLD, Partners			X	X	X
Institute Maternal and Perinatal Death Reviews (MPDRs) and QoC assessments	Strengthen the MPDR system	FHD	Partners			X	X	X
Resource tracking through National Health Account (NHA) and institute sub-accounts for MNCH	Institutionalise and strengthen NHA, sub-accounts and Public Expenditure Review (PER)	HEFU	CBS			X		X
Carry out reviews and action	Strengthen national-, regional-,	MD	RHD, DPHO			X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	and district-level reviews							
	Regional level (two times a year, three days)	MD	RHD, DPHO					
	District level (two times a year, four days)	MD	RHD, DPHO			X	X	X
	Independent evaluation of the major health programmes	PHAM&ED/MoHP	Partners			X	X	X
	Data analysis and use of information from the GESI perspective at district and community levels	Population Division/MoHP, PHAM&ED/MoHP	HMIS			X	X	X
	Social analysis and action at HFs to improve service delivery for socially excluded groups	PHAM&ED/MoHP, Population Division/MoHP	HMIS			X	X	X
	Regular supervision and monitoring of major health programmes at all levels	MD	Divisions and centres			X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2011/2012	2012/13	2013/14	2014/15	2015/16
	Analysis and review of the activities in line with the NHSP-2 M&E framework output and outcome (desk review)	PHAM&ED/MoHP	Population Division, HMIS and partners		X	X	X	X
Advocacy and outreach	High-level advocacy and monitoring with parliamentarians, policy makers and decision makers	PHAM&ED/MoHP				X	X	X

3.9 Sector-wide Approach and Health Sector Reform

1. Introduction

The Paris Declaration on Aid Effectiveness 2005 and the Accra Agenda for Action 2008 shared the following major objectives: to focus all external assistance on common objectives, and to deliver the assistance through harmonised approaches aligned with those of government. Increased use of government systems is not an end in itself, but is intended to be a route towards improving aid effectiveness, improving coordination and reducing costs by gradually replacing the multiplicity of EDP systems for planning, budgeting, implementing, reporting, and accounting for aid with a single set of procedures that all partners use. Achieving the potential benefits of increased harmonisation and alignment depends on ensuring that the common procedures are efficient and effective, and are seen to be so.

During NHSP-1, considerable progress was made in improving the effectiveness of GoN procedures in the health sector:

- Since 2004 MoHP has moved towards a SWAp
- Budget implementation has steadily improved, with an increased focus on overcoming bottlenecks through approaches including more realistic budgets, earlier fund release, and more delegation. The improvement has been reflected in a higher volume of services being delivered, made possible partly by improved availability of essential supplies and operating budgets
- Lessons learned and best practices of the SWAp will be capitalised upon and used in the continuing implementation of the SWAp
- Since 2004-5, the separate district-level projects for FP/MCH, Control of Diarrhoeal Disease (CDD) and ARI, nutrition, EPI, construction, and supervision have been merged into a single integrated District Development Programme. Before the merger of the projects and the integration of supervision and reporting, each of the 75 districts had to maintain separate accounts on each project; a total of 13,500 reports were required each year. The merger of programme and budget heads has saved time and resources. Efforts are on-going to further reduce the number of budget headings, and hence the transaction costs. The integration has been deeper than a simple change in reporting: merging CDD and ARI into IMCI has resulted in a successful, cost-effective, and integrated approach to child health care.

Development partners have begun to respond by working in alignment with GoN procedures. In 2004, GoN and EDPs in the health sector signed a joint statement of intent on health, envisaging joint planning, joint programming and joint performance reviews. Since that time, nine joint reviews have been held, two each year. One in December is mainly backward-looking, reviewing performance during the previous year, but it also aims to inform the coming budget and annual plan preparation by providing indications of future funding for the coming budget year. A second review, normally in May, focuses more on discussion of the AWPB for the coming year.

Currently, aid flow in Nepal is done in three ways:

- Pooling of funds for sector budget support by five agencies
- Non-pooling but specific programme support
- Project approach by some agencies (the Japan International Cooperation Agency (JICA), the Swiss Development Cooperation (SDC), and the Korean International Cooperation Agency (KOICA)).

2. Goal
To enhance aid effectiveness in the health sector.

3. Objectives
- Fostering coordination between EDPs and MoHP
- Reducing transaction costs
- Developing mutual accountability between MoHP and EDPs.

4. Major Strategies
- More balanced partnerships
- Reducing transaction costs
- Fostering coordination, especially with INGOs
- Improving aid predictability
- Reducing the number of budget headings.

5. Indicators and Targets

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
No. of budget headings reduced	5	-	-	5	-	-

6. Major Challenges and Issues
- Reducing transaction costs
- Aligning EDPs' planning cycles
- MoHP providing strong direction
- Coordination of technical assistance
- Strengthening SWAp management capacity.

Accountable Officer: Chief, HSRU, MoHP

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reducing transaction costs	Assess the feasibility of merging the budget headings	HSRU	EDPs	X					
	Coordinate with MoF and NPC and reduce budget headings	HSRU	EDPs		X				
Promoting mutual accountability	Develop/adapt a framework for mutual accountability	HSRU	EDPs		X				
	Submit EDPs' performance assessments					X			
	Provide the AWPB to EDPs a week before the joint planning meeting			X	X	X	X	X	X
Harmonisation	Merge the two joint reviews (GoN and EDPs)	HSRU	EDPs			X			
	Submit background reports for the joint review	HSRU	EDPs	X	X	X	X	X	X
	Organise consultative meetings with EDPs			X	X	X	X	X	X
Promoting predictability of EDP support	Prepare a budgetary plan with medium-term indications of EDP support (for two/three years)	HSRU	EDPs	X	X	X	X	X	X
	Monitor indications of support			X	X	X	X	X	X
	Provide financing assumptions to EDPs based on adjusting the budget	HSRU	EDPs	X	X	X	X	X	X

Major Strategies	Major Activities	Responsibility	Supporting Agencies	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	year indications								
	Increase the frequency of communication between MoHP and EDPs	HSRU	EDPs	X	X	X	X	X	X
Coordinating TA	Prepare a joint TA arrangement	HSRU	EDPs			X			
	Study the feasibility of pooling TA	HSRU	EDPs			X			
	Organise a Joint Annual Review (JAR)	HSRU	EDPs	X	X	X	X	X	X
	Organise a joint annual planning meeting	HSRU	EDPs	X	X	X	X	X	X
	Organise consultative meetings	HSRU	EDPs	X	X	X	X	X	X

Annex 1: Result Matrix for NHSP 2 (2010-2015)

MDG/Impact Indicator	Achievement					Baseline / Year	Target			Means of Verification	Remarks/Assumptions/Risks
	1991	1996	2001	2006	2009[10]		2010-11	2013	2015		
MMR (per 100,000 live births)	539	539	415	281	229[11]	250	250	192	134	DHS 2011 and 2016[12]	Needs innovative programmes and resources at the community level, and high-quality services available to remote, underprivileged, and underserved populations
TFR	5.3	4.6	4.1	3.1	2.9[13]	3.0	3.0	2.75	2.5	DHS 2011 and 2016	Assumes a continuous linear decline
Adolescent Fertility Rate (15-19 years) (per 1,000 women)	NA	127	110	98	NA	98	NA	85	70	DHS 2011 and 2016	
CPR (modern methods) (%)	24	26.0	35	44	45.1[14]	48	48	52	67	DHS 2011 and 2016	Assumes a continuous linear decline; data source for verification – DHS 2011 and 2016. Year-round availability of FP commodities at service delivery sites. GoN budgets adequate each year to procure FP commodities
Under-five Mortality Rate (per 1,000 live births)	158	118.3	91	61	50[15]	55	55	47	38	DHS 2011 and 2016	Assumes a continuous exponential decline; data source for verification – DHS 2011 and 2016
Infant Mortality Rate (per 1,000 live births)	106	78.5	64	48	41[16]	44	44	38	32	DHS 2011 and 2016	Assumes a continuous exponential decline; data source for verification – DHS 2011 and 2016
Neonatal Mortality Rate (per 1,000 live births)		49.9	43	33	20[17]	30	30	23	16	DHS 2011 and 2016	More than half of infant deaths are neonatal so this is a focus of the programme
% of underweight children		49.2	48.3	38.6	39.7[18]	34	34	32	29	DHS 2011 and 2016	Weight-for-age < 2 standard deviations from mean

[10] *Achievements for 2009 should not be construed as trends. The sources are not necessarily nationally representative and the estimates may not be significantly different from 2006 estimates.*
[11] *Estimate from Suvedi, Bal Krishna, et al. Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu, Nepal. Family Health Division, Department of Health Services, Ministry of Health and Population, Government of Nepal.*
[12] *NDHS scheduled for 2016 but requested to be conducted early so report is available 2015.*
[13] *Estimate from Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Mid-term Survey for NFHP 2, New ERA, September 30, 2009.*
[14] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[15] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[16] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[17] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[18] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*

MDG/Impact Indicator	Achievement					Baseline / Year	Target			Means of Verification	Remarks/Assumptions/Risks
	1991	1996	2001	2006	2009[10]		2010-11	2013	2015		
HIV prevalence among those aged 15-49 years[19] (%)	NA	NA	NA	NA	NA	0.49[20]	Halt and reverse trend (0.39 in 2010-11 and 0.30 in 2015)			To be determined	HIV prevalence is currently (2009) concentrated among PWID (20.7%), MSM (3.8%), FSWs in Kathmandu (KTM) (2.2%); migrant workers in Western region (1.4%), migrants in Far Western region (0.8%), and wives of migrants (3.3%)
TB case detection and success rates (%)	NA	48 79	70 89	65 89	71[21] 88[22]	75 89	75 89	80 90	85 90	HMIS	MDG 6 target: Prevalence and death rates associated with TB. TB success rate was 88% in 2009. It should be at least maintained through 2015
Malaria annual parasite incidence (per 1,000)	NA	0.54	0.40	0.28	NA		Halt and reverse trend			HMIS	MDG 6 target: Prevalence and death rates associated with malaria

Specific Objective 1: Increase access to and utilisation of quality EHCS						
Outcome Indicator	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010-11	**2013**	**2015**		
% of children under 12 months of age immunised against DPT 3 (PENTA) and measles (or fully immunised as per HMIS scale up) – disaggregated by all wealth quintiles and castes/ethnicities	83 fully immunised (2006) 89 (rural districts, 2009)[23]	85%	85%	85%	HMIS and NDHS in 2011 and 2016	% of fully immunised children should be above herd immunity regardless of wealth, caste, or ethnicity
CPR (modern methods – disaggregated by method, age, caste/ethnicity, wealth and region) (%)	44 (2006) 45.1 (rural districts, 2009)	45%	52%	55%	HMIS and NDHS in 2011 and 2016	55.5% for women 15-49 living with husbands; 22.5% if husbands away (2009) rural
% of women who took iron tablets or syrup during the pregnancy of their last birth	59.3 (2006) 81.3 (rural districts, 2009)	82%	86%	90%	NDHS in 2011 and 2016	
% of deliveries performed by SBAs – disaggregated by all wealth quintiles and castes/ethnicities	18.7 (2006) 25 (2008/9) 28.8 (NFHP 2009 survey)		40%	60%	HMIS and NDHS in 2011 and 2016	Interventions targeted to poorest and excluded are necessary to reduce disparities
% of institutional deliveries – disaggregated by all wealth quintiles and castes/ethnicities	18 (2006)	27%	35%	40%	NDHS in 2011 and 2016	Wide disparities persist for ANC between wealth quintiles and castes/ethnicities

[19]The Ministry recognises the MDG 6 target of halting and reversing the trend of HIV prevalence among pregnant women aged 15-24 years. However, a data source is not yet available.
[20]NCASC 2010 and UNAIDS April 2010 database.
[21]2008
[22]2008
[23]All targets are national but evidence from 2009 survey of 40 rural districts is not.

% of EOC need met	31 (2008/09)		43%	49%	HMIS and NDHS in 2011 and 2016	HMIS
% of CS rate	2.7 (2006) 3.6 (2008/09)	4.0%	4.3%	4.5%	HMIS	HMIS 2008/09 report from 26 districts
Obstetric case fatality rate (%)		<1%	<1%	<1%	HMIS	
% knowledge of safe abortion sites	19 (2006)		35%	50%	Annual household surveys	97,378 women received safe abortions in 2007/08 at 202 listed sites
% knowledge of safe abortion legalisation	50 (2006)		60%	75%	Annual household surveys	
Abortion complications (%)	14 (2009)	14%	10%	7%		
% of women 15-49 with comprehensive knowledge about AIDS	19.9 (2006)	24%	32%	40%	NDHS 2011 and 2016	
% of children with symptoms of ARI treated with antibiotics	25.1 (2006) 29.2 (rural districts, 2009)	30%	40%	50%	NDHS 2011 and 2016	
% of underweight children under five years of age	38.6 (2006) 39.7 (2009)	39%	34%	29%	NDHS 2011 and 2016	45.5% stunted (height-for-age < 2 standard deviations from mean); will also be reported by NDHS
% of low birth weight (or small) babies	33 (2006)	32%	27%	25%	NDHS 2011 and 2016	
% of children exclusively breastfed in the first six months	30.6 (2006) aged four/five months 24.8 (rural districts, 2009)	35%	48%	60%	NDHS 2011 and 2016	
% of pregnant women completing at least four ANC visits during pregnancy	27.7 (2006) 35.2 (2008)	45%	65%	80%	HMIS and NDHS 2011 and 2016	
% vitamin A coverage maintained for children aged 6-59 months	90 (2009)	90%	90%	90%	HMIS	Consistently almost universal
% of diarrhoea cases among children under five treated with zinc (and ORS)	67.6 ORS + zinc (2007/08) 45.6 ORS 6.6% zinc (rural districts, 2009	7%	25%	40%	NDHS 2011 and 2016	Combined reporting in HMIS (2007/08). NDHS reports treatment with ORS and zinc separately
% coverage of PWID, MSM, and FSW populations with prevention services	Programme coverage: FSWs (KTM): 40.8 (IBBS 2008) MSM (KTM): 75.3 (IBBS 2009) MSWs (KTM): 77.3 (IBBS 2009) PWID (KTM): 56.9 (IBBS 2009)	PWID: 76 MSM: 54 FSW: 65		PWID: 80 MSM: 60 FSWs: 70	UNAIDS-supported surveys	HIV Prevalence: PWID (KTM) – 20.7% (IBBS 2009) MSM (KTM) – 3.8% (IBBS 2009) MSWs (KTM) – 5.2% (IBBS 2009) FSWs (KTM) – 2.2% (IBBS 2008) Migrants, Western region – 1.4% (IBBS 2008) Migrants, Far Western region – 0.8% (IBBS 2008) Wives of migrants, Far Western region – 3.3%

	Migrants, West/Far West: 6.9 (IBBS 2008)					(IBBS 2008)
% of households with soap and water at a hand washing station inside or within 10 paces of latrines	N/A	13%	37%	53%	MICS, NDHS 2011 and 2016	This indicator is now accepted globally as the most feasible proxy indicator to measure hand washing practices by observation

Specific Objective 2: Reduce harmful cultural practices and cultural and economic barriers to accessing health care services in partnership with non-state actors						
Outcome Indicators	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/11	**2013**	**2015**		
CPR (modern methods) for the poor (lowest and second wealth quintiles) and excluded castes (%)	Poor: 35.5 Dalit: 44 Janajati: 47 Muslim: 17 (2006)	Poor: 43 Dalit: 52 Janajati: 55 Muslim: 25	Poor: 46 Dalit: 55 Janajati: 58 Muslim: 28	Poor: 49 Dalit: 58 Janajati: 61 Muslim: 31	NDHS in 2011 and 2016 and HMIS for poor	
% of women who took iron tablets or syrup during the pregnancy of their last birth for women who are poor (lowest and second-lowest wealth quintiles) and excluded caste (Dalit)	Poor: 44.9 (2006); 76.7 (rural districts 2009) Hill Dalit: 78 Tarai Dalit: 90 (rural districts 2009)	Poor: 77 Dalit: 82	Poor: 81 Dalit: 85	Poor: 85 Dalit: 88	NDHS in 2011 and 2016 and HMIS for poor	
% of deliveries by SBAs for lowest and second-lowest wealth quintiles and excluded caste (Dalits), by 2015	Poor: 7.5 Dalit: 11 Janajati: 14 Muslim: 13 Other Tarai Madheshi: 13 (2006)	Poor: 20.3 Dalit: 23 Janajati: 25 Muslim: 24 Other Tarai Madheshi: 24	Poor: 25.3 Dalit: 27 Janajati: 30 Muslim: 29 Other Tarai Madheshi: 29	Poor:30 Dalit: 32 Janajati: 35 Muslim: 34 Other Tarai Madheshi: 34	NDHS in 2011 and 2016 and HMIS for poor	

Specific Objective 2: Reduce harmful cultural practices and cultural and economic barriers to accessing health care services in partnership with non-state actors						
Outcome Indicators	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/11	**2013**	**2015**		
% utilisation of EHCS (OP, inpatient, especially deliveries, and emergency) by targeted groups, and disadvantaged castes and ethnicities at least proportionate to their populations, by 2015	Poor: 62 (2006); 57 (rural districts 2009) Dalit: 14% (OP), 17.1 (inpatient) and 16.7 (emergency) (2008); 16.7 (of population in sample districts)	90	90	90	HMIS	90% of highest quintile or 90% of population proportion. Targeted groups: based on children under five for whom treatment was sought for fever. Dalits: selected MCH services at district HFs. District HF surveys report Dalits using services proportionate to their population
% of clients satisfied with their health care at district facilities among targeted groups, and disadvantaged castes and ethnicities by 2015	68.4 (2008) based on availability of range of services	68	74	80	Annual district HF surveys	
% use of available community-based emergency funds by the poor and socially excluded groups (in districts with EAP)		19	30	50	Annual HF surveys	
No. of cases recorded and treated related to GBV in HFs	Treatment provided but no recording available	Systems and training materials developed and piloted in three districts	Pilot evaluated and system rolled out in 20 districts	Scaled up intervention nationwide	Annual district HF surveys	

Specific Objective 3: To improve health systems to achieve universal coverage of essential health care services						
Outcome Indicators	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/11	**2013**	**2015**		
% availability of post-abortion FP services in HFs	50 (2006)	NA	60	80	HMIS	
% of hospitals that have at least two obstetricians/gynaecologists, two anaesthesiologists, 10 staff nurses and blood service, including VSC		NA	60	80	HMIS, HuRIS and programme surveys	
% of PHCCs that provide BEOC, including SAC and at least five FP methods	1 BEOC site; 46 under construction; 15 planned next year (2007/08)	23	50	70	HMIS and programme surveys	HMIS annual report 2007/08
% of health posts that operate 24/7, including delivery services, and provide at least 5 FP methods		45	60	70	HMIS	
% availability at district facilities of zinc supplementation for treatment of diarrhoea cases					HMIS	
% of households with at least one LLIN per two residents in all high-risk districts and areas by 2015	95 (in 13 high-risk districts, to be extended to areas in additional 18 districts)		90	90	Programme surveys	Programme is expanding to new high-risk areas in 18 new districts. Nets effective for two years.
% of children under five who slept under LLIN the previous night	61.2 (in 13 high-risk districts)	70	80	80	Programme surveys	The target for 2015 set by MoHP is 90%, which is the same as for one net per two residents in HHs. 80% is more realistic for use by children under five
% of the MoHP budget is spent by 2015	70.16 (FY 2004/5), 75.74 (FY 2005/6), 80.61 (FY 2006/7), and 81.37 (FY 2007/08)	83	84.5	86	e-AWPB	Reported by e-AWPB
% of the MoHP budget has been allocated to EHCS by 2015	72.1 (FY 2008/09), 75.4 (FY 2009/10)	75	75	75	e-AWPB	EHCS budget should be maintained at 75%
% of posts for doctors and staff nurses at PHCCs and district hospitals filled	89 (HPs and SHPs), 82 (DHs and PHCCs) (2008-09)	85	88	90	Annual district HF surveys	Reported by latest trimester district HF survey
One health facility per 3,000-5,000 population: one HP (with two SBAs) per 5,000 population; PHCC (with four SBAs) per 50,000 population; and one district hospital bed per 5,000 population		NA		Nation-wide	HMIS, administrative record	New policy

% of SHPs that have sufficient space as per MoHP standard (need baseline)				80	To be determined	
% of DFs which will have no stock-outs of tracer drugs/commodities for more than one month per year by 2015		70	80	90	Annual district HF surveys	Delayed budget approval caused massive stock-outs at district facilities in 2009
No. of additional FCHVs recruited and deployed in the mountain region and remote districts	48,514 (2007/08)	50,000	52,000	53,514	HMIS and HuRIS	5,000 additional FCHVs by 2015 plus 2,000 replaced (attrition)
% of actions identified in the GAAP implemented		90	90	90		
% of district facilities subjected to social audits	None to date	0	15	25	Annual district HF surveys	
A comprehensive health care finance strategy will be approved by 2012					MoHP and MoF approval	
5,000 SBAs by 2012 and 7,000 by 2015		1,134	5,000	7,000	HMIS and HuRIS	

Annex 2: Proposed Budget for NHSP-2 (2010-2015) - NPR IN 100,000

Chapter	Programme	2010/11	2011/12	2012/13	2013/14	2014/15	Total
2.1	Immunisation	15896	15640	11821	12842	14363	**70562**
2.2	IMCI+ CBNCP	1400	1520	3388	3681	4117	**14105**
2.3	Nutrition	1400	1541	9191	9985	11167	**33284**
2.4	SM	18045	20133	22719	24682	27604	**113183**
2.5	FP	4400	4734	5263	5718	6395	**26509**
2.6	ASRH	Included in Chapters 2.4 and 2.5 (above)					
2.7	FCHV	3700	4011	4228	4593	5137	**21669**
2.8	Free Care	12832	12753	13963	14004	15767	**69319**
2.9	Urban Health	1453	1695	335	1529	1606	**6618**
2.10	Malaria Control	1600	1741	1575	1711	1914	**8541**
2.11	Kala-azar Control	500	529	283	307	344	**1963**
2.12	LF Control	2000	2135	3661	3977	4448	**16222**
2.13	Dengue Control	Included in Chapters 2.10, 2.11 and 2.12 (above)					
2.14	Leprosy Control	282	294	325	375	600	**1876**
2.15	Laboratory Services	450	915	1526	1755	1262	**5908**
2.16	HIV & STI Control	2930	6600	6892	7926	9115	**33463**
2.17	TB Control	6917	10720	11186	12153	13592	**54568**
2.18	NCDs	14426	13744	15591	15256	15793	**74810**
2.19	Mental Health	Included in Chapter 2.18 (above)					
2.20	Oral Health	85	93	98	108	119	**503**
2.21	Curative Services	Included in Chapter 2.18 (above)					
2.22	Ayurveda and	5020	5290	6529	6944	7491	**31274**
2.23	NHEICC	1401	1763	2623	2937	3288	**12012**
2.24	Environmental	Included in Chapter 2.23 (above)					
3.1-3.5	Health System	41528	46720	55237	57986	60868	**262339**
3.6	Procurement and	58587	47397	50869	57835	69482	**284170**
3.7	Physical Facilities	1960	1641	1903	2186	2511	**10201**
3.8	M&E and Research	13065	15306	15556	17833	20471	**82231**
3.9	SWAp & HSR	Included in Chapters 2.1 – 3.5 and 3.8 (above)					
	Beyond EHCS	3118	18185	32919	61201	88003	**203426**
	Total	208300	235100	277300	327000	385600	**1433300**

Note 1: Health System Strengthening includes the following chapters: Health Governance, Human Resources for Health, GESI, Health Financing and State/Non-state Partnerships.

Note 2: Beyond ECHS incorporates whatever is not reflected in the budget.