Progress of Health and Population Sector

2023/24 (2080/81)

NATIONAL JOINT ANNUAL REVIEW REPORT

Government of Nepal
Ministry of Health and Population
Ramshahpath, Kathmandu
Nepal

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November 2024

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PREFACE

The Nepal Health Sector Strategic Plan (NHSSP) 2023-2030 represents a collaborative commitment between the Government of Nepal (GoN) and Health Development Partners (HDP). This plan serves as a framework for a sector-wide approach, translating constitutional health provisions into actionable steps and striving for Universal Health Coverage in alignment with the SDGs. Led by the Ministry of Health and Population (MoHP), HDPs share accountability for the implementation, monitoring, and achievement of NHSSP outcomes. Health ministries at the provincial level and municipal health offices, in collaboration with federal entities and HDPs, are driving NHSSP implementation locally. Funding primarily comes from government budgets and contributions from HDPs.

Sector performance is tracked through the NHSSP results framework, supplemented by mid-term and annual performance reviews at federal, provincial, and local levels. Since 2018, the National Annual Review (NAR) and the Joint Annual Review (JAR) have been combined into the National Joint Annual Review (NJAR), providing a platform for MoHP and HDPs to assess annual progress, share lessons, set priorities, and coordinate efforts toward achieving the agreed results.

As Fiscal Year 2080/81 (2023/24) marks the first review of the NHSSP 2023-2030, this report begins by drawing key insights from the implementation of the previous NHSS 2015-20 with extension 2023. It highlights the alignment between the 16th Periodic Plan and the NHSSP while assessing progress in the health sector during 2080/81 against the NHSSP's five strategic objectives and 14 outcomes. Additionally, the report outlines strategic priorities for the upcoming Annual Work Plan and Budget (AWPB) and provides a robust evidence base for discussions at the National Joint Annual Review (NJAR), 2081 (2024).

This report has been prepared with input from program divisions and centers across the three departments, as well as health development partners and other stakeholders. The Ministry of Health and Population (MoHP) appreciates their contributions and extends gratitude to the WHO Country Office Nepal for their generous support in preparation of this report. Finally, the MoHP urges all provincial and local governments, health development partners, and stakeholders to strengthen collaborative efforts in translating the principles of the Constitution and the NHSSP into actionable steps to enhance health outcomes for all citizens.

Ministry of Health and Population

Acronyms

AEFI	Adverse Events Following Immunization
AHMIS	Aayurveda Health Management Information System
AI	Artificial Intelligence
AMR	Anti-Microbial Resistance
AWPB	Annual Work Plan and Budget
BCC	Behavior Change Communication
BHS	Basic Health Services
BMid	Bachelor's in Midwifery
CAPP	Consolidated Annual Procurement Plan
CHU	Community Health Unit
CMNN	Communicable, Maternal, Neonatal, and Nutritional
CRVS	Civil Registration and Vital Statistics
CSD	Curative Service Division
DDA	Department of Drug Administration
DoAAM	Department of Ayurveda and Alternative Medicine
DoHS	Department of Health Services
DoNIDCR	Department of National ID and Civil Registration
DPR	Detail Project Report
EDCD	Epidemiology and Disease Control Division
e-GP	Electronic Government Portal
EHR	Electronic Health Record
EMR	Electronic Medical Record
EVM	Electronic Vaccine Management
EWARS	Early Warning, Alert and Reporting System
FB-IMNCI	Facility Based Integrated Management of Neonatal and Childhood Illnesses
FCHV	Female Community Health Volunteer
FWD	Family Welfare Division
G2G	Government-to-Government
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HALE	Healthy Life Expectancy

HDI	Human Development Index
HDP	Health Development Partners
HEOC	Health Emergency Operation Center
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HR	Human Resource
HRH	Human Resources for Health
HWMIS	Health Workforce Management Information System
ICT	Information Communication Technology
IHME	Institute for Health Metrics and Evaluation
JFA	Joint Financing Arrangement
KAHS	Karnali Academy of Health Sciences
KUSMS	Kathmandu University School of Medical Sciences
LMIS	Logistics Management Information System
MD	Management Division
MDSR	Maternal Death Surveillance and Response
MEC	Medical Education Commission
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
MPDSR	Maternal and Perinatal Death Surveillance and Response
MSS	Minimums Service Standards
MToT	Master Training of Trainers
NAMS	National Academy of Medical Sciences
NCASC	National Center for AIDS and STD Control
NCDs	Non-Communicable Diseases
NDHS	Nepal Demographic and Health Survey
NFHS	Nepal Family Health Survey
NHA	National Health Accounts
NHEICC	National Health Education, Information and Communication Center
NHFR	Nepal Health Facility Registry

NHFS	Nepal Health Facility Survey
NHRC	Nepal Health Research Council
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Strategic Plan
NJAR	National Joint Annual Review
NMR	Neonatal Mortality Ratio
NQHSP	Nepal Quality Health Systems Program
NSO	National Statistics Office
O&M	Organizational and Management
OCMC	One-Stop Crisis Management Center
OOP	Out-Of-Pocket
PNC	Post Natal Care
PPMD	Policy, Planning and Monitoring Division
RF	Results Framework
RRT	Rapid Response Team
RTA	Road Traffic Accident
SBA	Skilled Birth Attendants
SDG	Sustainable Development Goals
SNCU	Special Newborn Care Unit
SoP	Standard Operating Procedure
SWAp	Sector Wide Approach
TA	Technical Assistance
TFR	Total Fertility Rate
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
UHC	Urban Health Center
VPD	Vaccine Preventable Diseases

Executive summary

The Nepal Health Sector Strategic Plan (NHSSP) 2023-2030, a joint commitment of the Government of Nepal and Health Development Partners (HDP), provides a framework for a sector wide approach and a roadmap towards achieving Universal Health Coverage in alignment with the SDG. The National Joint Annual Review (NJAR) covering support from HDPs and the contribution of the private and other non-governmental sectors serves as a common platform for MoHP, HDPs and other stakeholders to review annual progress, draw lessons, agree priorities for subsequent years and harmonize efforts for achieving NHSSP results.

As Fiscal Year 2080/81 (2023/24) marks the first annual review of the Nepal Health Sector Strategic Plan (NHSSP) 2023-2030, this report presents key insights from the implementation of the previous NHSS 2015-20 with extension 2023. It examines the alignment between the 16th Periodic Plan and the NHSSP, assessing progress in the health sector during 2080/81 against the NHSSP's five strategic objectives and 14 outcomes. The report also outlines strategic priorities for the upcoming Annual Work Plan and Budget (AWPB) and provides a solid evidence base for discussions at the NJAR 2081 (2024).

The NHSSP draws on lessons learned from the implementation of previous sectoral strategies, particularly the NHSS. The NHSS highlighted the need to transition from earthquake-resistant structures to multi-hazard, climate-resilient, and environmentally friendly health infrastructure using green technology. Establishing health facilities based on geography, population and disease burden would help optimize the limited resources. To meet the growing demand for health professionals, maintaining a comprehensive health workforce database and improving training and retention systems is essential. Reforming procurement to prioritize domestic production and enhancing regulatory frameworks will ensure consistent supply. Improving healthcare quality requires effective coordination among government levels and robust public-private partnerships. Stakeholders must view health spending as an investment, commit to increasing funding, and harmonize external assistance with local needs. Additionally, integrating social security for free basic services, promoting healthy lifestyles, strengthening emergency preparedness, and assessing cost-effectiveness of public health interventions are vital for future priorities.

The NHSSP (2079/80-2087/88) was developed nearly two years prior to the 16th Plan (2081/82-2085/86) and has laid the groundwork for health priorities in the latter. Formulating 13 transformative strategies, the 16th Periodic Plan builds upon and is aligned with the strategic objectives, outcomes, and outputs of the NHSSP. A review of the progress on health priorities outlined in Policy and Program 2080/81 reveals that of the 193 activities identified, 68 percent have been successfully completed, 18 percent are still in progress, and 14 percent could not be implemented.

The section below highlights key progress made in FY 2023/24 (2080/81) and the key priority interventions for the upcoming year(s), by the NHSSP's five strategic objectives (SO) and the 14 outcomes (OC).

<table>
<tr><th>Key progress of FY 2023/24</th><th>Key priority interventions for the upcoming year(s)</th></tr>
<tr><td colspan="2">SO1: Enhance efficiency and responsiveness of health system</td></tr>
<tr><td colspan="2">OC1: Skill-mixed human resources for health produced and mobilized</td></tr>
<tr><td>• Currently, medical education in Nepal offers 14 bachelor's degree programs, 53 master's degree programs, and 15 DM/MCh programs.
• MBBS curriculum has been launched through the Academy of Health Sciences to develop skilled personnel using internal resources from government hospitals with over 300 beds.
• Midwifery education has been institutionalized.
• Health Workforce Management Information System (HWMIS) and Procedure for the Nepal Health Workforce Management Information System (NHWMIS), 2081 have been developed.
• MoHP has been demanding and advocating for additional incentives for health workers assigned to the remote areas for their retention.
• 'One Doctor - One Health Facility' program is being implemented.
• NHTC, in collaboration with program divisions, centers, and HDPs, has conducted several training sessions and orientations to enhance the skills of health workers.
• MoHP, in collaboration with the National Federation of Nepalese Transport Entrepreneurs, has managed to provide free transportation to FCHVs during their duty travel.</td><td>• Periodic review of the medical education curriculum in collaboration with universities, academia and MEC to meet the country's needs.
• Assess the demand for new health professionals in the changing context and coordinate with academic institutions and relevant councils for their production.
• Update human resource records and enhance HR information systems for interoperability with major health information systems
• Conduct organizational and management surveys of health institutions and establish a system for regular reviews of organizational structures to guide HR recruitment and deployment
• Ensure multi-disciplinary medical teams are available at all basic hospitals.
• Employ bachelor's degree holders in health sciences at local levels for effective health program management.
• Provide financial and other incentives to health professionals for retaining them, particularly in remote areas.</td></tr>
<tr><td colspan="2">OC2: Evidence-and equity-based planning</td></tr>
<tr><td>• MoHP has reviewed the data sources for each indicator in the RF, focusing on quality and identifying gaps, and outlined key actions needed to address these issues.
• In the month of Asar 2081, two-thirds (65.7%) of health facilities submitted e-report to the HMIS independently, while 18.5% submitted e-report through their parent organizations (Palikas)
• Standard and Interoperability Lab (SIL-Nepal) has been established and is now operational
• Electronic medical record (EMR) system has been prioritized by all three levels of government
• Several research, assessments, surveys, studies and reviews have been conducted to support evidence-based planning and decision making.</td><td>• Expand electronic health records system in public and private hospitals promoting interoperability.
• Develop medicine information management system to manage information related to production, import, consumption, quality and regulation of medicine, medicinal and diagnostic products.
• Promote a gradual use of artificial intelligence in healthcare, such as in diagnostics and treatment
• Initiate next series of the Nepal Health Facility Survey (NHFS) 2025 and plan for the Nepal Demographic and Health Survey (NDHS) 2026 are in the process of planning</td></tr>
<tr><td colspan="2">OC3: Safe and people friendly health infrastructures</td></tr>
<tr><td>• By end of FY 2080/81, construction of 413 Basic Hospitals has been completed.
• Hospitals at both provincial and federal levels are being strengthened to function as referral centers, offering specialized and super-specialty services.</td><td>• Accelerate the construction of health facilities with a regular maintenance mechanism.
• Revise and standardize the Health Infrastructure Information System (HIIS) for better planning and maintenance.</td></tr>
</table>

Key progress of FY 2023/24	Key priority interventions for the upcoming year(s)
• To ensure consistency in the naming of public health facilities run by local governments, the MoHP has standardized the naming process.	• Update building standards for health facilities to ensure they are multi-hazard resistant, climate-resilient, and user-friendly.
OC4: Ensured uninterrupted availability of quality medicine and supplies	
• Fair Price Fixation Regulation and Guidelines for Technological Medical Equipment have been prepared and are currently in the endorsement process. • As per the DDA registry, there are 170 domestic, and 578 international medicines producers registered in Nepal. Of the total 19,254 drugs (brand) registered with DDA, 11,667 are domestic and 8,087 are international. There are 29,609 registered pharmacies across the country, and there are 6,396 pharmacy entrepreneurs, 8,740 pharmacy assistants, and 2,539 pharmacists. • Over 100 local manufacturers have been trained in Good Laboratory Practice (GLP) and current Good Manufacturing Practice (cGMP). • To improve quality of locally manufactured ayurveda medicines, ayurveda medicine manufacturers have been trained in GMP and documentation preparation as per WHO GMP requirements. • The MoHP is working to upgrade Singhadurbar Baidhyakhana to produce at least 20 types of essential Ayurvedic medicines, increasing from the current 13, with a development committee established to facilitate this expansion.	• Promote and enhance domestic production of quality essential medicines, diagnostics, and biomedical equipment. • Review and update regulations for the licensing, production, import, and export of pharmaceuticals. • Regulate pricing and pharmacovigilance of medicines to safeguard public health. • Expand and standardize cold chain and storage capacities for vaccines and medical products. • Maintain a consistent buffer stock of medicines and supplies with effective storage and distribution practices. • Strengthen procurement and supply chain management using existing platforms like e-GP, e-LMIS, e-CAPP, and TSB.
OC5: Improved governance, leadership and accountability	
• To facilitate the effective implementation of the NHSSP, the MoHP has formulated several Acts, Regulations, Guidelines and Workplans. • MoHP has reactivated the high-level Public Health Committee provisioned in the Public Health Service Act 2075. • Several discussion sessions have been organized for strengthening coordination and collaboration among different spheres of government and stakeholders. • MoHP is collaborating with local governments for targeted efforts to strengthen their capacity to institutionalize social audits as a tool for fostering local accountability systems and laying the groundwork for strategic social accountability approaches.	• Institutionalize robust social accountability mechanisms such as social audits and public hearings. • Ensure transparency by disseminating information and data through diverse platforms. • Promote ethical practices and rational use of medicines and services through targeted Behavior Change Communication (BCC). • Strengthen public financial management with regular fiduciary risk assessments and proactive gap addressing.
OC6: Public health emergencies managed effectively	
• Emergency responses were made to various alerts and outbreaks. This included case investigation and contact tracing of identified Mpox patients, and response to the earthquake in Jajarkot district and other notified outbreaks (Cholera, food poisoning, Respiratory illness in Mugu district).	• Build institutional capacity for managing disasters and public health emergencies. • Improve the integrated public health surveillance system for the prediction, early detection, verification, and notification of diseases and potential public health threats.

Key progress of FY 2023/24	Key priority interventions for the upcoming year(s)
• National Pandemic Preparedness and Response plan revised incorporating lessons learned from COVID-19 response and latest WHO guidelines. • MoHP, with support from WHO, carried out a post-earthquake joint operational review of the response on February 20-21, 2024. • Several training, orientations, and workshops have been organized to strengthen health emergency preparedness. • Laboratory capacity for detection of emerging and re-emerging pathogens has been strengthened.	• Strengthen the public health laboratory network, incorporating biosafety, biosecurity measures, and a quality assurance system. • Develop manual (adaptation of WHO toolkit) for antimicrobial stewardship program in healthcare facilities. • Scaling up of laboratory capacity to perform culture sensitivity test to 50 bed hospitals. • Build institutional capacity of hospitals to implement antimicrobial stewardship program
SO2: Address wider determinants of health	
OC7: Reduced adverse effects of wider determinants on health	
• MoHP activated the multi-sectoral Public Health Committee at the federal level and formed eight sub-committees, outlining their structures/composition, roles, and responsibilities. • NHEICC has oriented journalists in Bagmati and Madhesh provinces emphasizing the importance of suicide prevention. • A comprehensive training curriculum has been developed for healthcare workers on Brief Tobacco Intervention, focusing on quitting tobacco and providing effective counseling and treatment.	• Operationalize the multi-sectoral Public Health Committee and its federal sub-committees while enhancing collaboration at provincial and local levels. • Mitigate the public health impacts of climate change by implementing relevant standards and adaptation plans. • Integrate Gender Equality and Social Inclusion (GESI) across the sector. • Institutionalize the "One Health" approach and "Health in All Policies". • Collaborate with stakeholders to improve standards for food, air, water, and housing.
OC8: Citizens responsible for their own, family and community health	
• National Health Education, Information and Communication Centre (NHEICC) has produced and disseminated several health awareness materials. • MoHP has been advocating and coordinating with stakeholders for a mandatory health course in high school education.	• Strengthen regulatory measures to control tobacco use, substance abuse, and the harmful consumption of alcohol. • Implement healthy cities initiatives. • Establish a behavioral risk factor surveillance system. • Ensure mandatory health education in school curricula.
SO3: Promote sustainable financing and social protection in health	
OC9: Improved public investment in health sector	
• The volume of health sector budget has increased more than five-folds, from NPR 23.8 billion in FY 2011/12 to NPR 122.8 billion in FY 2021/22 and declined to 86 billion in 2023/24. • In recent years, provincial and local governments have received an increasing share of the health sector budget, while the federal MoHP's share has been gradually declining. • MoHP has been enhancing collaboration and health representation in legal and policy forums. • As per the Federal, Provincial, and Local Level (Coordination and Interrelationships) Act, 2077 MoHP held its first joint meeting with health ministers from all seven provinces along with local government representatives.	• Implement results-based management. • Monitor health sector expenditures through budget analysis, Public Expenditure Tracking, and National Health Accounts. • Effectively implement the TA framework with periodic reviews to adapt to changing contexts. • Align technical and financial assistance from all partners, including I/NGOs, with the NHSSP to promote harmonization.

Key progress of FY 2023/24	Key priority interventions for the upcoming year(s)
OC10: Improved social protection in health	
• A monitoring framework for BHS has been developed and endorsed • The health insurance program is currently functioning across all 77 districts of Nepal, encompassing all 753 local levels. • Population coverage has risen from 25% in FY 2022/23 to 28% in FY 2023/24, while household coverage has grown from 33% to 39% during the same period. The Health Insurance Strategic Roadmap (HISR) was developed and endorsed with the aim of providing health insurance for all to enhance citizens' health status.	• Implement the BHS monitoring framework effectively. • Reform the insurance scheme for universal enrollment and coverage of specialized health services. • Use a positive discrimination approach to ensure social health protection for underserved populations. • Streamline current social health protection schemes. • Track out-of-pocket healthcare expenditures to guide financial protection design.
SO4: Promote equitable access to quality health services	
OC11: Quality of health services improved	
• A national-level review of the MSS across all health facilities has been completed with input from representatives of all provinces, leading to the development of an action plan to guide future initiatives. • Health service rates at selected federal hospitals have been assessed to provide policy guidance on standardizing these rates. • The National Action Plan on Antimicrobial Resistance (2024-2028) has been developed and rolled out. • Koshi and Bagmati provinces have initiated liquid-waste management initiatives in selected hospitals. • Facility based maternal and perinatal death surveillance and response (MPDSR) system is implemented in 122 hospitals across 52 districts. • Several standards, guidelines, manuals have been developed for improving quality of care.	• Establish a national accreditation body for quality assurance and accreditation. • Develop and strengthen a system for safe and timely disposal of pharmaceutical, diagnostic, and health care wastes and chemicals of public health concern. • Develop institutional linkages among federal, provincial, and local level public health facilities for coordinated health service system and referral. • Promote using generic prescription and the use of listed essential medicines. • Institutionalize clinical audit system to improve quality of care by making it interactive. • Develop mechanisms to monitor client satisfaction and address the identified issues in a timely manner.
OC12: Reduced inequity in health services	
• An equity analysis of the utilization of child, maternal, and reproductive health services across provinces indicates that Madhesh Province performed the worst in 9 out of the 19 selected tracer indicators when compared to the national average. • Study has revealed low institutional delivery among socioeconomically and geographically disadvantaged groups, low continuum of care and wide equity gaps among intersectional groups. • Approximately 10,000 adolescent girls aged 14 have received two doses of the HPV vaccine, providing protection against cervical cancer. • Cancer treatment services have been expanded to all seven provinces.	• Implement a life course and continuum of care approach to streamline and ensure coverage of health services. • Enhance interventions aimed at controlling, eliminating, and eradicating identified, emerging, and re-emerging diseases while addressing cross-border health issues. • Implement a targeted tax on trans fats and sugar-sweetened beverages, using the revenue to fund public health campaigns, food subsidies, and initiatives to improve access to nutritious foods in underserved communities. • Expand the coverage of Ayurveda, Naturopathy, Homeopathy, Unani, Acupuncture, Sowa-rigpa, Amchi, and other medical systems in a coordinated manner.

Key progress of FY 2023/24	Key priority interventions for the upcoming year(s)
• An agreement has been made between Bhaktapur Cancer Hospital and B.P. Koirala Memorial Cancer Hospital to manage laboratory tests not available at their facilities via the National Public Health Laboratory. • MoHP has expanded two-shifts out-patient-services in federal hospitals. • MoHP has arranged for free treatment to burn patients in need due to poverty from at least one hospital in each province. • One stop crisis management centers, social service units and geriatric health services have been strengthened and expanded.	• Strengthen in-country diagnostic capabilities, particularly in laboratory and radiology facilities. • Expand digital health initiatives, including EMR and telemedicine, in alignment with the Digital Nepal Framework. • Establish satellite clinics from hospitals to target underserved and hard-to-reach areas. • Strengthen and expand psychosocial counseling services and One-Stop Crisis Management Centers (OCMCs). • Ensure gender equality and social inclusion (GESI) responsive planning, budgeting, and health service delivery.
SO5: Manage population and migration	
OC13: Maximized demographic dividend and managed demographic transitions in development process	
• The MoHP has formed a steering committee, chaired by the secretary, and a technical committee, led by the chief of the Population Management Division, to revise the National Population Policy 2071. The steering committee has also established thematic subcommittees that are currently reviewing and updating the policy. • Coordination with Ministry of Home Affairs, Department of National ID and Civil Registration (DoNIDCR) has helped in integrating Civil Registration and Vital Statistics (CRVS) system with health facilities to ensure an updated database on births and deaths. • MoHP is collaborating with stakeholders to establish a comprehensive population information management system.	• Establish and operationalize population information management system for up-to-date population profiling including migration, to facilitate decision-making at all levels. • Strengthen the Civil Registration and Vital Statistics (CRVS) system and enhance the linkage with health facilities for updated database on births and deaths. • Promote youth for development concept and prioritize women and girls in economy. • Prioritize and design activities tailoring to the minority groups and contribute to their health, education, and income-generating opportunities. • Link the secondary education system with employment. • Develop appropriate structures at all levels for population and migration management.
OC14: Systematic migration and planned settlement practiced	
• The federal-level multi-sectoral Public Health Committee, chaired by the health minister, has established a subcommittee focused on Population, Labor Migration, and Health. Its focus areas include maximizing the benefits of the population dividend, creating job opportunities for youth, reviewing current laws and policies, mitigating the negative health impacts of foreign employment, and addressing other relevant tasks assigned by the ministry.	• Establish a supportive environment that leverages the skills and expertise of returning migrants. • Enhance the attractiveness of villages in strategic locations. • Encourage the village stay initiative (smart village settlement) by creating a conducive environment through tax exemptions, subsidies for education and health, insurance support, and the expansion of basic facilities. • Provide social protection services for migrant workers through diplomatic channels.

01 Introduction

The Nepal Health Sector Strategic Plan (NHSSP) 2023-2030 represents a collaborative effort between the Government of Nepal (GoN) and Health Development Partners (HDP), establishing a framework for a comprehensive sector-wide approach aimed at achieving Universal Health Coverage in line with the Sustainable Development Goals (SDGs). The National Joint Annual Review (NJAR), which encompasses support from HDPs and contributions from private and non-governmental sectors, provides a shared platform for the Ministry of Health and Population (MoHP), HDPs, and other stakeholders to review annual progress, share insights, set future priorities, and coordinate efforts toward the NHSSP's objectives.

As Fiscal Year 2080/81 (2023/24) marks the inaugural annual review of the NHSSP 2023-2030, this report highlights key findings from the implementation of the previous NHSS 2015-20 with extension 2023. It assesses the alignment between the 16th Periodic Plan and the NHSSP, measuring progress in the health sector for 2080/81 against the NHSSP's five strategic objectives and 14 outcomes. Additionally, the report outlines strategic priorities for the upcoming Annual Work Plan and Budget (AWPB) and serves as a foundational resource for discussions at NJAR 2081 (2024).

1.1 Key takeaways from the NHSS 2015-20 with extension 2023

Building on earlier plans and strategies, including the Long-Term Health Plans (1975-1995 and 1997-2017), and the Health Sector Strategy (2004), the Nepal Health Sector Programs (2004-2009 and 2010-2015), Nepal successfully implemented the Nepal Health Sector Strategy NHSS 2015-20 with extension 2023. Additionally, national health policies were introduced in 1991, 2014, and 2019. The NHSS implementation witnessed the structural reforms in health systems and governance following the introduction of the new constitution in 2015, the earthquake 2015 and 2019 and the COVID-19 Pandemic 2020-2023. Under the leadership of the Ministry of Health and Population (MoHP), provincial and local governments, NGOs, and health development partners (HDPs) together were jointly responsible for developing, implementing, monitoring the performance, and achieving the results of the NHSS.

The promulgation of the Constitution in 2015, the Public Health Service Act in 2018, and the Public Health Service Regulations in 2020 established the legal and regulatory framework essential for the effective implementation of the NHSS. Defining Basic Health Services (BHS) under public health service regulations has supported the delivery of BHS in alignment with constitutional mandates, although many challenges remain at the local implementation level. The implementation of the NHSS has provided valuable insights across all nine outcome areas.

The NHSS underscored the need to transition from focusing solely on earthquake-resistant structures to developing health infrastructure that is multi-hazard resistant, climate-resilient, and environmentally friendly by incorporating green technology. The blanket policy to establish at least one basic hospital with capacities of 5, 10, or 15 beds in each Palika, and a community health unit (CHU) or urban health center (UHC) in each ward of a Palika regardless of population size has impacted the quality-of-service delivery due to insufficient human resources, equipment, and other essentials. To effectively meet the growing demand for health professionals at all levels, it's crucial to maintain an active and comprehensive health workforce database to monitor and manage the health workforce across the country. This requires a strong system for projecting, producing, distributing, and retaining healthcare workers. Additionally, reforming procurement and supply chain management requires strengthening domestic production of medicines, diagnostics, and health products. It is also essential to improve regulatory mechanisms to meet international standards, ensuring quality and consistent supply at service delivery points across all 753 local levels.

The implementation of NHSS has also shown that enhancing healthcare quality requires the establishment of a comprehensive regulatory framework and an independent quality assurance and accreditation body. Institutions must be equipped to effectively implement policies aimed at delivering equitable health service to all, leaving no one behind. Effective coordination among three spheres of the government and public-private partnerships are essential for better planning and budgeting. There is a growing recognition among stakeholders to view health spending as a long-term investment in human capital and to commit to increasing public funding. It is important to harmonize technical assistance of HDPs with local needs, integrate social security schemes to ensure free BHS and sustainable healthcare financing. Additionally, promoting healthy lifestyles through various channels such as social accountability in the health sector and multi-sectoral interventions can help address social determinants like school education, nutrition, sustainable organic agriculture, and water, sanitation and hygiene. Strengthening institutional capacity for emergency prevention and building a resilient health system is vital for coping with various shocks including earthquakes, pandemics and the effects of climate change. This effort should also include preparedness and response measures, as well as leveraging modern technologies to enhance system interoperability and efficiency. Additionally, further assessing the cost-effectiveness of public health interventions through the cost of curative health care services in health facilities will help guide future priorities.

1.2 Scope of the report

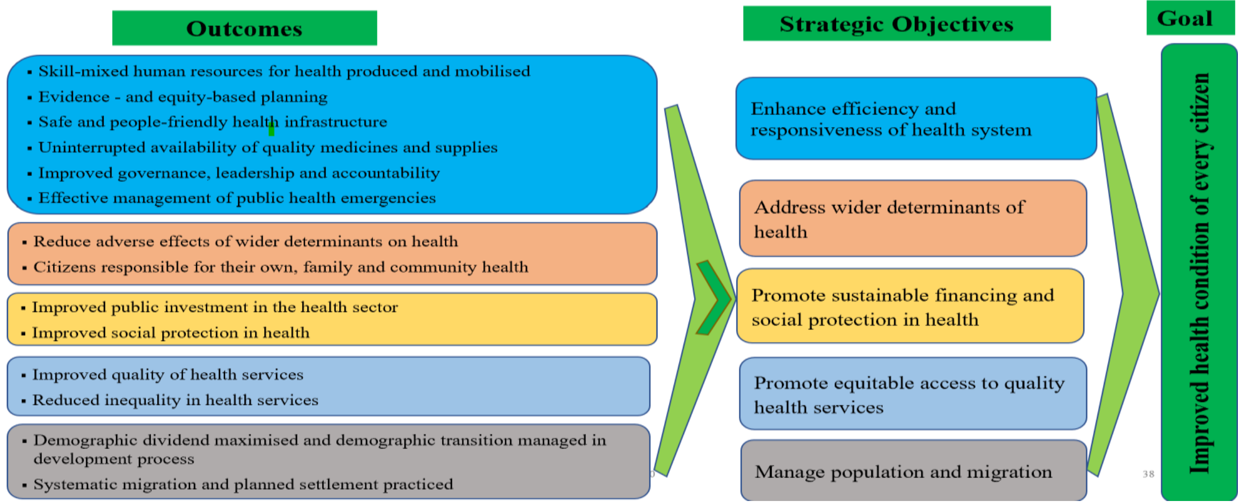
As the Nepali Fiscal Year (FY) 2080/81 (2023/24) marks the first review year of the Nepal Health Sector Strategic Plan (NHSSP), 2023-2030, this report draws key insights from the implementation of the previous Nepal Health Sector Strategy (NHSS) 2015-2023. Briefly highlighting the alignment between the 16th Periodic Plan and the NHSSP, this report, primarily, reviews the progress made in the health sector during FY 2080/81 (2023/24) against the NHSSP five strategic objectives and 14 outcomes. Based on the review, it outlines strategic priorities for the forthcoming Annual Work Plan and Budget (AWPB) (2025/26). Furthermore, this report provides a strong evidence base to support discussions at the National Joint Annual Review (NJAR) of the health sector in 2081 (2024).

1.3 Overview of the NHSSP 2023-2030

Building on the lessons from previous plans and strategies as well as takeaways from the NHSS, the NHSSP 2023-30 is the first national sectoral strategic plan developed post-federalism. This plan is designed to address key health issues and ensure citizens' constitutional right to free basic health services while working towards universal health coverage (UHC). It prioritizes strengthening a Sector Wide Approach (SWAp) in health and through aligning domestic and international resources across the three spheres of Government of Nepal (GoN) - federal, provincial, and local – to effectively deliver NHSSP. The legal and policy frameworks established during the NHSS period have created a strong foundation for financing health services delivery, strengthening systems, and enhancing partnerships for health in federalized Nepal.

At the federal level, the NHSSP serves as the foundation for establishing policies, setting standards and developing strategic plans, including AWPB, ensuring that national priorities towards achieving health sector SDGs by 2030. It provides a health system perspective that applies to all health services and directs planning and implementation of program-specific activities. Additionally, the NHSSP offers a cohesive framework for health development partners (HDPs) to align their support, thereby improving overall aid effectiveness in the health sector. The NHSSP outlines five major strategic objectives aimed at enhancing the health of every citizen, with 14 outcomes and 29 outputs to achieve the goal (Annex 1). Figure 1.1 presents goal, five strategic objectives and 14 outcomes of the NHSSP (2023-2030).

Figure 1.1: NHSSP goal, strategic objectives and outcomes



Like previous sector strategies, the GoN and HDPs jointly developed the NHSSP and its results framework (RF), sharing responsibility for implementation and monitoring to achieve the established goals.

1.4 NHSSP 2023-2030 alignment with the 16th periodic plan

The NHSSP (2079/80-2087/88) was developed almost two years ahead of the 16th Period Plan (2081/82-2085/86) of the GoN. The NHSSP has provided a foundation for formulating the health priorities in the 16th Plan. The 16th Plan builds upon and advances the objectives and priorities established by the NHSSP. The 16th plan has formulated 13 transformative strategic directions for the health sector, which are fully aligned with the strategic objectives, outcomes and outputs of the NHSSP, which are discussed under Section 3 below. Table 1.1 presents the key highlights of the 16th periodic plan.

Table 1.1: Health related transformative strategies and the strategic interventions of the 16th periodic plan

SN	Transformative strategies	Strategic interventions
1	Free delivery of BHS	• Increase public investment in health sector. • Increase domestic financing to BHS based on population, geography and disease burden, and federal and provincial governments to provide financial and technical assistance to local governments for delivery of free BHS • Adopt milestones-based system for AWPB implementation. • Apply effective regulation and taxation on unhealthy products like tobacco, alcohol and sugar-sweetened beverages. • Reinvigorate community health systems like health mothers' groups, female community health volunteers (FCHVs), community health workers to enhance access to health services and improve referral systems.
2	Ensuring universal access to quality health services	• Improve equitable access to quality health services – promotive, preventive, curative, rehabilitative, and palliative care. • Reduce out of pocket expenditure on health by improving access to cost-efficient quality health services. • Manage health infrastructure and human resources based on population, geography, disease burden and social context. • Build health human resources for health system based on need, demand, supply and utilization. • Implement one-health worker one-health facility concept • Implement a compulsory health course in high schools in collaboration with education sector stakeholders.

Table 1.1: Health related transformative strategies and the strategic interventions of the 16th periodic plan		
SN	**Transformative strategies**	**Strategic interventions**
3	Strengthening health insurance system through its restructuring	• Review act, regulations, policy, guidelines, and institutional structures of current health insurance. • Provide specialized, super-specialized and emergency cost-efficient health services through the national health insurance program. • Integrate all social health protection schemes to avoid duplication. • Review the health insurance premium based on cost-efficiency and effectiveness and adopt the benefit package accordingly. • Expand the coverage of health insurance to all citizens, including formal and informal sectors. • Promote research on health insurance.
4	Ultra-modernization and technological advancement of overall health system	• Leverage advanced technologies like artificial intelligence (AI), digital health, telemedicine, robotic technology to enhance health services and operational efficiency. • Explore alternatives.
5	Developing quality, reliable, and integrated health system	• Adapt integrated health system by strengthening and expanding modern, Ayurvedic, naturopathy and other alternative health systems. • Establish a referral hospital in each province. • Upgrade district hospitals to provide routine secondary health and a minimum set of specialized health care services.
6	Promoting health tourism	• Promote international level health tourism in collaboration with public, private and community sector stakeholders
7	Implementation of multisectoral and multidimensional concepts	• Control non-communicable diseases (NCDs) through coordination, collaboration, co-financing and joint accountability among all levels, entities, and sectors. • Prevent and control emerging and re-emerging health issues, including malnutrition. • Develop resilient health system to address climate change induced health problems. • Institutionalize 'one-health policy' to address anti-microbial resistance (AMR), zoonotic diseases, and geriatric health issues.
8	Maximizing population dividend	• Integrate and mainstream population education across all levels and sectors to effectively manage demographic transitions and migration within the development process. • Implement innovative strategies for population management to optimize the benefits of the demographic dividend.
9	Developing evidence-based health management system	• Acknowledge the broader social and economic determinants of health and develop evidence-based national policies, strategies, plans, and programs for effective implementation. • Develop public health facilities as centers for knowledge exchange and community service. • Institutionalize partnerships for research, studies and innovations involving all sectors and levels.
10	Self-reliance on production of medicines, medical supplies, and vaccines	• Promote self-reliance in the production of medicines, medical supplies, and vaccines through coordinated efforts and partnerships among all government and non-government stakeholders in the pharmaceutical sector. • Regulate pharmaceutical market.

Table 1.1: Health related transformative strategies and the strategic interventions of the 16th periodic plan		
SN	**Transformative strategies**	**Strategic interventions**
11	Ensuring governance and social justice in health sector	• Ensure transparency and good governance to promote social justice across all public, private, and other health facilities by enhancing institutional structures and building the leadership capacity of the mechanisms responsible for regulation, monitoring, and quality control. • Foster community engagement and accountability in planning, monitoring, and evaluation activities. • Strengthen the mechanisms for the registration, regulation, and monitoring of the production, supply, and distribution of medicines, equipment, and medical supplies.
12	Increase investment for strengthening health system	• Ensure the public invest in health as per the international standards and national commitments. • Increase the financial space in partnership with private and cooperatives as well as HDPs. • Strengthen health financing by fostering accountability and transparency in investments through effective leadership.
13	Review and reform the existing health programs	• Evaluate and revamp traditional programs that have not delivered satisfactory outcomes and discontinue those that are no longer relevant.

02 Progress overview

2.1 Progress on key action points from Policy and Program - health, 2023/24 (2080/81) and Budget Speech 2080/81

The Policy and Program of FY 2080/81 prioritises strengthening of primary hospitals to provide all basic health services; expansion of diagnosis and primary treatment of breast cancer, uterine prolapse and cancer services; operating medical colleges at their full capacity to fulfil the human resource requirements in various medical fields for the next five years; upgrading Department of Drugs Administration into Food, Drugs and Health Technology Department, and managing production of all 98 types of medicines listed under the BHS package; reforming Singhdurbar Baidhyakhana and Jadibuti Prasodhan Kendra; upgrading all federal hospitals into teaching hospitals; revising the National Population Policy; and reforming health insurance program. Table 2.1 summarizes the progress of key action points from the Policy and Program, and Budget Speech of FY 2080/81. Overall, of the 193 activities outlined in the Policy and Program, 68 percent were successfully completed, 18 percent were underway, and 14 percent were not initiated by the end of FY 2080/81 (Figure 2.1).

Figure 2.1: Progress status of Policy and Program 2080/81

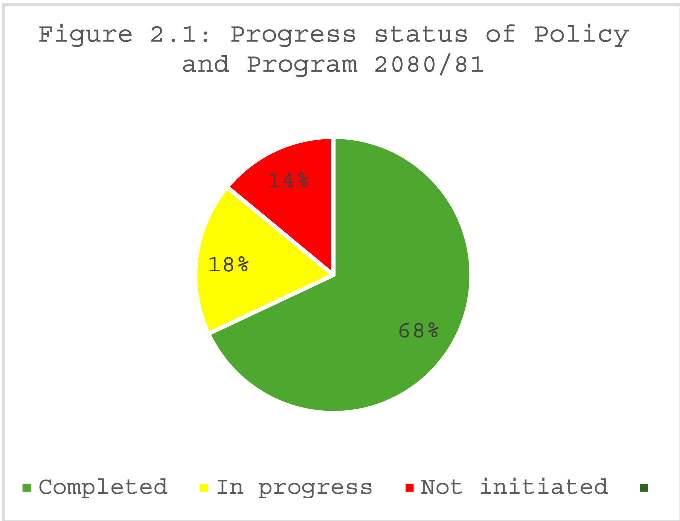


Table 2.1: Progress status of key action points from the Policy and Program and Budget Speech 2080/81

Key action points from Policy and Program 2080/81	Key action points from Budget Speech 2080/81	Progress status
Basic health services (BHS)		
• Equip primary hospitals with one MDGP, one obstetrician/ gynecologist, at least three medical officers, adequate nurses, diagnostic facilities with laboratory, ambulance with oxygen supply to provide all basic health services. • Provide higher education opportunities for a doctor who serves at primary hospital.	Prioritize establishing basic hospitals at strategic locations to benefit larger population. Budget (NRP 8 billion) allocated for ongoing 322 basic hospital construction projects, and NPR 820 million allocated for medical equipment in 100 hospitals to be completed next year.	• A committee chaired by the Additional Health Secretary is currently revising the existing organogram. • The Medical Education Commission Act is currently being revised following a high-level agreement. • Detailed Project Reports (DPR) for 462 Basic hospitals have been completed. • Construction is currently underway at 413 facilities, while 27 facilities have been completed.
Coverage and quality of health services		

Table 2.1: Progress status of key action points from the Policy and Program and Budget Speech 2080/81

Key action points from Policy and Program 2080/81	Key action points from Budget Speech 2080/81	Progress status
• Ensure 'one doctor/ health worker - one health institution' [Ek chikitsak ek aspatal] and make mandatory provision of running OPD services from 8am to 8pm in public hospitals. • Develop the necessary infrastructure, technology, and human resources to upgrade at least one provincial hospital in each province to a super specialty hospital capable of performing heart surgeries and diagnosing cancer. • Establish one air ambulance service in each of the two districts in Sudurpaschim and Karnali provinces, as well as in remote areas. Develop a coordinated national ambulance service supported by a centralized database system. • Manage diagnosis and treatment of autism at health facilities • Expand rapid diagnosis and primary treatment of breast cancer and uterine prolapse as a special program across the country. • Initiate maternal and neonatal care special programs at local levels with high neonatal and maternal mortality. • Expand infertility care services in federal hospitals in all seven provinces. • Strengthen and expand geriatric health services in hospitals	• NPR 240 million has been allocated to implement the "one doctor-one hospital" policy across all federal hospitals. • Manage kidney transplantation and infertility treatment services at all federal hospitals. • Strengthen National Trauma Centre and expand primary trauma care centre at Lamki in Kailali, Saljhandi in Rupandehi, Vardghat in Nawalparasi west, Gaidakot in Nawalpur, Bhiman in Sindhuli, and Belkhu in Dhading in collaboration with the nearby public hospital. • Strengthen and expand geriatric health services in hospitals	• Hospitals have been communicated to implement the program. • Dadeldhura, Pyuthan, Gorkha, Nuwakot hospitals have extend OPD from 8am to 8pm • A special committee has identified Seti hospital, Surkhet hospital and Narayani hospital to be upgraded into super specialty hospital performing heart surgeries and diagnosing cancer, work in progress. • Software and mobile application have been developed for the National Ambulance Service with integrated database, and 52 percent of the ambulances have been enrolled in the system. • Geriatric health services have been launched in the provincial hospitals of Mahakali, Surkhet, Bhaktapur, Hetauda, Janakpur, and Bardibas following orientation sessions for health workers. • A work plan has been developed to address high maternal and neonatal mortality rates reported in local levels of Banke and Kapilvastu districts. • Federal level monitored MSS at 119 hospitals. • Infertility management unit has been established at Lumbini, Surkhet and Narayani hospitals. • Mahakali provincial hospital, Surkhet provincial hospital, Bhaktapur hospital, Hetauda hospital, Janakpur hospital and Bardibas hospital have been oriented on geriatric health services standards, and the hospitals have started the services

Table 2.1: Progress status of key action points from the Policy and Program and Budget Speech 2080/81

Key action points from Policy and Program 2080/81	Key action points from Budget Speech 2080/81	Progress status
Medical/health education		
• Operate medical colleges at their full capacity. Assess the human resource requirements in various medical fields for the next five years and develop customized education and training programs accordingly.	• Formulate integrated health science academy Act and upgrade all federal hospitals into teaching hospitals equipped with super speciality facilities.	• The HRH projection has been completed, and the Medical Education Commission has been requested to ensure the production of the necessary human resources accordingly.
Medicines and medical supplies		
• Upgrade Department of Drugs Administration into Food, Drugs and Health Technology Department, manage production of all 98 types of medicines listed under the BHS package, and provide financial and other support for domestic production of drugs and medical equipment		• A list of medicines and medical supplies included in the BHS package produced in the country has been compiled.
Aayurveda and alternative medicines		
• Reform Singhdurbar Baidhyakhana and Jadibuti Prasodhan Kendra to promote production and availability of Aayurveda medicines	• Promote alternative treatment services like Aayurveda, homeopathy, Unani, Acupuncture, Aamchi and naturopathy. Budget has been allocated for completion of Rastriya Aayurved Panchakarma Yog Sewa Kendra in Budanilkantha, Kathmandu.	• Situation analysis of Singhdurbar Baidhyakhana has been completed, preparation for its O&M survey is in progress.
Population management		
• Revise the National Population Policy to maximize the benefits of the current demographic dividend and avert future labor shortages.		• The MoHP has formed a steering committee, led by the secretary, and a technical committee, chaired by the chief of the Population Management Division, to revise the National Population Policy 2071. The steering committee has set up thematic sub-committees that are reviewing and updating the policy.

2.2 Progress on NJAR 2023 (2080) action points

The National Joint Annual Review (NJAR) 2080 (2023) was held on 7-8 Mangsir 2080 (23-24 November 2023). NJAR 2023 identified key action points across six broad themes/areas to be prioritized in the policy, program, and AWPB for FY 2081/82. These action points, listed below, played a significant role in shaping the priorities for the fiscal year. The progress on these priority interventions has been discussed in Section 3 below.

Action points from NJAR 2080 (2023)

a. Service delivery

- Develop BHS delivery mechanism in alignment with the constitutional, legal and policy provisions
- Accelerate O&M survey, HR post creation, fulfillment, mobilization, retention
- Accelerate MSS roll out improving transparency and accountability at the local level and address the gaps identified
- Integrated planning for infrastructure, HR, equipment, supplies, commodities (no duplications)
- Promote ICT in service delivery
- Last mile extra efforts on near elimination diseases
- Strengthen surveillance on emerging and reemerging public health threats
- Sustaining and maintaining public health gains
- Mainstreaming Ayurveda and alternative medicine

b. Health financing

- Increase public financing in line with the National Health Financing Strategy 2080-90.
- Harmonize health security schemes leveraging ICT
- Streamline the duplications in social health measures

c. Digitalization

- Standardization, integration, and expansion of EMR system
- Review eHMIS in Gandaki province, explore feasibility and scaling up
- Hospitals to ensure compliance to service and financial reporting and MoHP to facilitate
- Digitalization of Councils

d. Provincial initiatives

- Coordination with local levels to provide free BHS from all levels of hospitals including federal hospitals
- Flexible pool of skilled health workforce (esp. for specialized and specialist services) to be used by provinces
- Focus on mobilizing the available resources to achieve the SDG targets as a part of effective localization of SDGs
- Evidence led need-based establishment/upgrade of health facilities
- Improve coordination and collaboration among three spheres of government

e. Academies and councils

- Assign focal point at MoHP to coordinate and facilitate in addressing issues related to academies
- HRH projection-based production and motivation for retention mechanism
- Review and revisit legal provisions incorporating federal context
- Strengthening research capacity of the academics
- Collaboration with the academies for mutual academic benefits (like HR exchange/knowledge/skills sharing)
- Technical/specialist service support to districts/provinces as per the legal provisions
- Satellite clinics and telemedicine in collaboration with Curative services Divisions

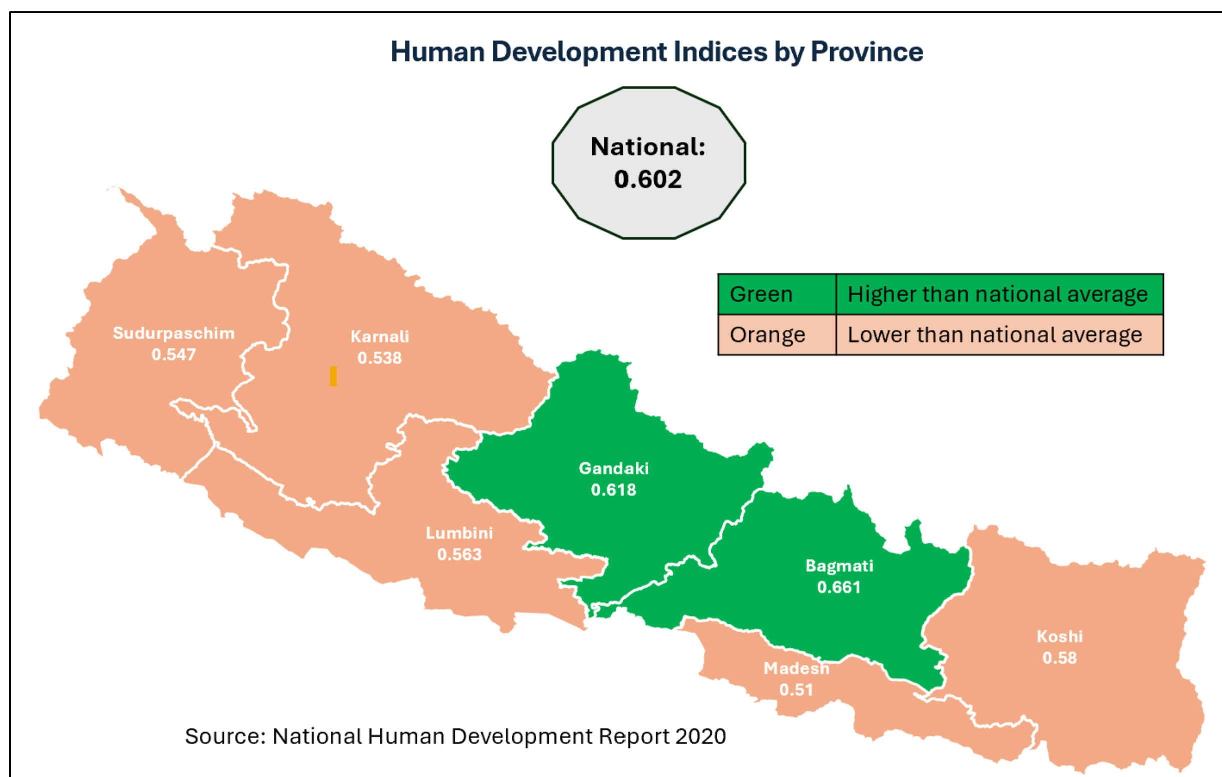
f. Joint priorities

- Health financing & fiscal space as per health financing strategy
- PHC as foundation of UHC
- Leveraging federalism: Fostering health sector in federal context
- Fostering collaboration (locally tailored TA)
- Implementation of Health Sector Strategic Plan as a mean to achieve Health related SDGs
- Strengthened co-responsibility, co-investment and co-ownership, multi-sectoral approach: health beyond the health sector

2.3 Highlights on progress against NHSSP RF goal level indicators

Human Development Index: The Human Development Index (HDI) is a composite measure that evaluates average performance across three fundamental aspects of human development: health, education, and living standards. The health component of the HDI is indicated by life expectancy at birth, a statistical estimate of the average number of years a newborn is expected to live, given current age-specific mortality rates. The NHSSP aims to raise the HDI of Nepal from 0.602 in 2019 to 0.62 in 2025, 0.65 in 2027 and 0.68 in 2030. The Nepal Human Development Report 2020, published by the National Planning Commission highlights provincial disparities in HDI. Bagmati ranks highest at 0.661, while Madhesh has the lowest score at 0.51. Bagmati, Gandaki and Sudurpaschim provinces scored above the national average of 0.602, whereas the other four provinces fell below this average (Figure 2.2).

Figure 2.2: Human development indices by province



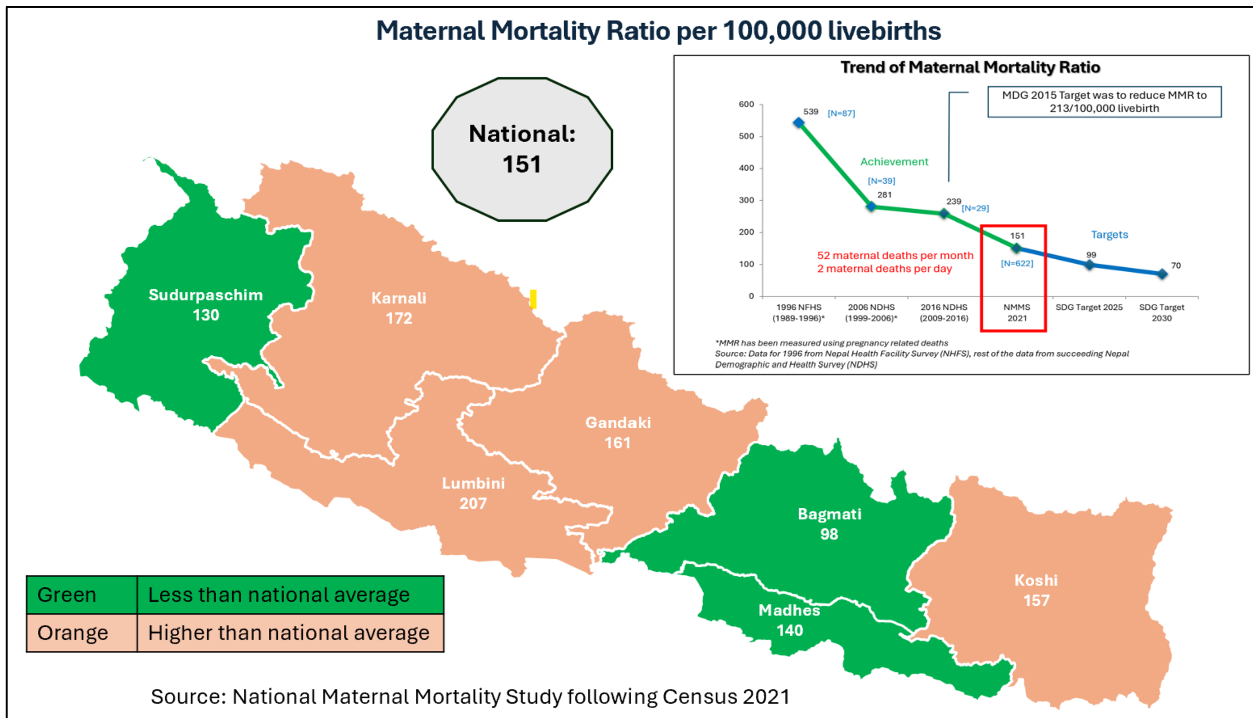
Healthy life expectancy: While life expectancy measures the number of years a person is expected to live, healthy life expectancy (HALE) assesses the quality of health experienced by people. HALE represents the average number of years an individual is expected to live in good health, considering current age-specific health conditions and mortality rates[1]. According to Global Health Observatory Data of 2021, estimated healthy life expectancy at birth is 61.5 years. HALE of females (60.7 years) males (59.8 years), produced based on the Global Burden of Disease study conducted by IHME, estimated the healthy life expectancy at 61.5 years, which is approximately 10 years lower than life expectancy, and an increase of 11.1 years from 1990. HALE of females (62.2 years) was slightly higher than that of males (60.9 years) in 2019. The NHSSP aims to elevate the healthy life expectancy from 61.5 years in 2019 to 65.8 years by 2025, 68.8 years by 2027 and 70.8 years by 2030.

Maternal mortality: Maternal mortality ratio (MMR), expressed as the ratio of number of maternal deaths per 100,000 livebirths, reflects not only the capacity of health systems in preventing and managing complications during pregnancy and childbirth but also the social, economic and environmental conditions affecting mothers and their communities, including overall development of a country. The Sustainable Development Goals (SDGs) aim to lower the global maternal mortality ratio to below 70 per 100,000 live births by 2030, ensuring that no country has an MMR exceeding 140 per 100,000 live

[1] Wang H, Abbas KM, Abbasifard M, Abbasi-Kangevari M, Abbastabar H, Abd-Allah F, et al. Global age-sex-specific fertility, mortality, healthy life expectancy (HALE), and population estimates in 204 countries and territories, 1950–2019: a comprehensive demographic analysis for the Global Burden of Disease Study 2019. The Lancet. 2020;396(10258):1160-203.

births. Nepal is dedicated to achieving this objective and has prioritized maternal health as a key development focus. Nepal's MMR is estimated at 151 per 100,000 live births[2]. The ratios are higher in Lumbini and Karnali provinces, at 207 and 172 per 100,000 live births, respectively, while Bagmati province has the lowest ratio at 98 per 100,000 live births (Figure 2.3). Nearly half of the deaths (47 percent) were reported in the Lumbini and Madhesh provinces. Most maternal deaths occurred in the postpartum period (61 percent), while thirty-three percent occurred during pregnancy and six percent during delivery. One in ten maternal deaths was among adolescent mothers. Most of the deaths (57 percent) occurred in health facilities, whereas 26 percent occurred at home.

Figure 2.3: Maternal mortality ratio by province



The Nepal Demographic and Health Survey (NDHS) estimates the pregnancy-related death ratio using the sisterhood method. Previous measures of the maternal mortality ratio (MMR) were provided by the Nepal Family Health Survey (NFHS) in 1996, NDHS in 2006, and NDHS in 2016. Typically, MMR is measured in every alternate DHS series. However, the MMR estimates from NDHS have wide confidence intervals and reflect long-term rates, which limits the potential for trend analysis. The health facility and community-based maternal death surveillance and response (MDSR) system is also operational in Nepal. However, due to incomplete national coverage of the MPDSR system and challenges with cause-of-death assignment, MDSR data does not accurately represent maternal mortality ratio (MMR) measurements.

In 2021, the MoHP and the National Statistics Office (NS0), in collaboration with HDPs, carried out a maternal mortality study following the 2021 Census. This was the first study in Nepal to measure the maternal mortality ratio (MMR) at both national and sub-national levels, including by province and ecological regions—mountain, hills, and terai—and to investigate the causes of maternal deaths using population census data.

Civil registration and vital statistics (CRVS), along with complete coverage and medical certification of cause of death, are the preferred data sources for measuring MMR. However, low coverage, under-reporting, and limitations in the classification of causes of death in CRVS hinder accurate MMR estimation in Nepal.

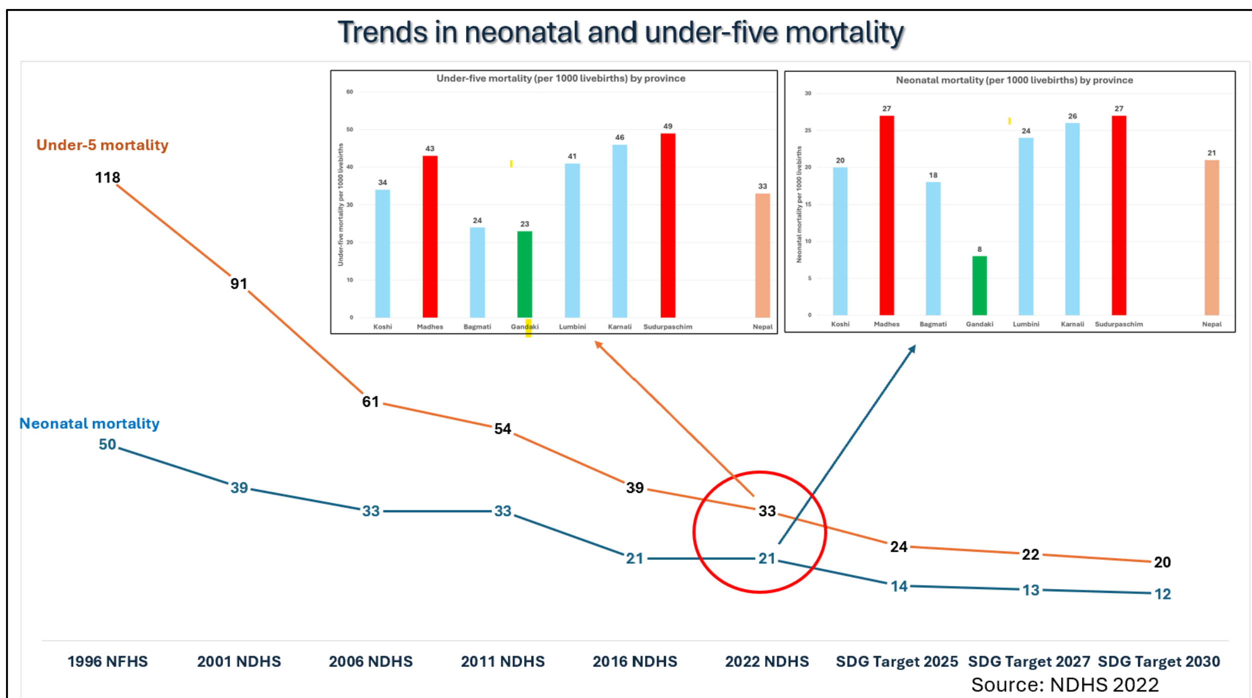
Neonatal and under-five mortality: In simpler terms, neonatal mortality rate (NMR) is probability of dying within the first 28 days of life and under-five mortality rate (U5MR) is the probability of dying between birth and the fifth birthday. Studies have indicated that higher coverage of health services does not always correlate with improved health outcomes.

[2] MoHP, NSO. (2022). National Population and Housing Census 2021: Nepal Maternal Mortality Study 2021. Kathmandu: Ministry of Health and Population. National Statistics Office.

For example, while the institutional delivery rate rose from 64% in 2016 to 79% in 2022, the neonatal mortality rate, which was 21 per 1,000 live births in 2016, remained unchanged through 2022. The NHSSP aims to reduce the NMR from 21 per 1,000 live births in 2016 to 12 per 1,000 live births by 2030, and to reduce U5MR from 33 per 1,000 live births in 2016 to 20 per 1,000 live births by 2030.

Nepal has made progress in reducing the NMR and under-five mortality for past two decades. While U5MR has monotonically declined, the NMR has virtually stalled in between 2006 and 2011, and 2016 and 2022. The country has observed a stagnant NMR of 21 since 2016. U5MR have dropped from 39 in 2016 to 33 in 2022 (Figure 2.4).

Figure 2.4: Trends in neonatal and under five mortality



There is moderate disparity in U5MR between provinces, with the highest U5MR at 49 per 1000 livebirths in Sudhurpaschim province and the lowest U5MR at 23 per 1000 livebirths in Gandaki province.

Highlighting the widened equity gaps of NMR among socioeconomically disadvantaged and privileged groups, a recent study on trends and determinants of neonatal mortality and service readiness and availability for newborn care in Nepal reveals the following:

- In 2022, the NMR on the first day of birth decreased compared to 2016.
- From 2016 to 2021, there was a paradox where the NMR remained stagnant, despite an increase in the utilization of maternal and neonatal services.
- Higher NMR is observed among mothers with little or no education and those who marry at an early age.
- A positive association exists between SBA-assisted deliveries and postnatal care (PNC) for newborns and lower NMR.
- There is a positive association between women's decision-making power and lower NMR.
- Overall, health facility service readiness has improved since 2015; however, disparities remain among provinces, types of health facilities, and ecological regions.

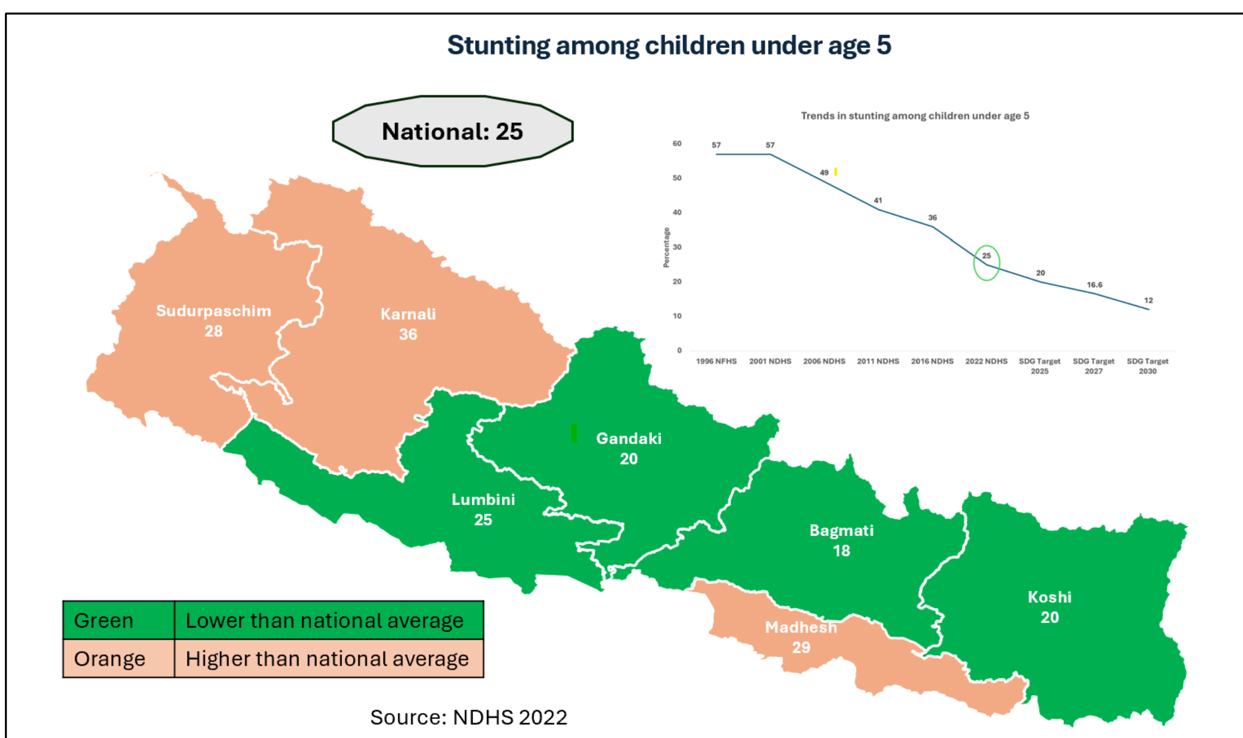
Stunting among children under 5 years of age: Stunting (height-for-age) in children captures the broad effects of chronic malnutrition. Prevalence of stunting among children under five years of age is defined as the percentage of children under age 5 whose height-for-age is two or more standard deviations below the median height-for-age of a reference

[3] Pokhrel, K. N., R. Khatri R., G. Pradhan, T. R. Thapa, T. Pullum, and F. Greenwell. 2024. Trends and Determinants of Neonatal Mortality and Service Readiness and Availability for Newborn Care in Nepal. DHS Further Analysis Reports No. 151. Rockville, Maryland, USA: ICF.

population. The NHSSP aims to reduce the percentage of stunted children under 5 years of age from 25 in 2019 to 20 in 2025, 16.6 in 2027 and 12 in 2030.

In the past five years, child nutrition in Nepal has seen significant advancements. The prevalence of stunting among children under age 5 decreased markedly between 1996 and 2022, from 57% to 25%, respectively. The proportion of children who are stunted is highest in Karnali Province (36%) and Madhesh Province (29%) and lowest in Bagmati Province (18%) (Figure 2.5). A recent study analyzing the factors behind this improvement identified birth weight, maternal BMI, and effective water treatment methods as key predictors for reducing child stunting, wasting, and underweight[4]. Conversely, larger family sizes and older child ages were identified as common risk factors for increased stunting, wasting, and underweight. Furthermore, the factors affecting stunting, wasting, underweight, and anemia varied across provinces, highlighting the complexity of addressing malnutrition.

Figure 2.5: Stunting among children under age 5, by province



Mortality between 30 and 70 years of age from Cardiovascular disease, Cancer, Diabetes or Chronic respiratory disease (per 100,000 population):

In line with the global shift in the disease paradigm, Nepal has experienced a transition in disease patterns, moving from a high burden of infectious diseases to a lower burden, while simultaneously facing an increasing burden of non-communicable diseases (NCDs). In 1990, communicable, maternal, neonatal, and nutritional (CMNN) diseases were the leading causes of death in Nepal, accounting for approximately two out of every three deaths (63.6%). During the same period, NCDs were responsible for nearly one-third of total deaths (29.9%). However, by 2015, this trend had reversed, with NCDs emerging as the primary cause of death (63.2%), while CMNN diseases accounted for less than a third of total deaths (26.8%). By 2040, NCDs will be the leading cause of deaths in Nepal, with metabolic risk factors being the leading risk factors[5].

Mortality between 30 and 70 years of age from Cardiovascular disease, Cancer, Diabetes or Chronic respiratory disease (per 100,000 population), measures the proportion of deaths due to these specific non-communicable diseases (NCDs) within the 30 to 70 age range. By focusing on the 30 to 70 age group, the indicator provides valuable insights into the burden

[4] Tiwari, I., Acharya, K., Paudel, Y. R., Sapkota, B. P., & Kafle, R. B. (2020). Planning of births and childhood undernutrition in Nepal: evidence from a 2016 national survey. BMC Public Health, 20, 1–13

[5] Pandey AR, Chalise B, Shrestha N, Ojha B, Maskey J, Sharma D, et al. (2020) Mortality and risk factors of disease in Nepal: Trend and projections from 1990 to 2040. PLoS ONE 15(12): e0243055. https://doi.org/10.1371/journal. pone.0243055.

of disease and the effectiveness of health systems in reducing mortality from these conditions. The NHSSP RF utilizes the baseline figure (2.8 per 100,000 population) for this indicator from the Nepal Burden of Disease Report 2019, produced by the Nepal Health Research Council (NHRC)[6], which is based on the Global Burden of Disease study conducted by the Institute for Health Metrics and Evaluation (IHME). The NHSSP aims to reduce this to 2.15 by 2025, 2.10 by 2027 and 1.96 per 100,000 population by 2030. The IHMIE has recently published the GBD 2021 report.[7] However, the most recent estimates for mortality rates from cardiovascular disease, cancer, diabetes, or chronic respiratory disease (per 100,000 population) for individuals aged 30 to 70 in Nepal are still awaiting analysis based on the GBD 2021 dataset.

Suicide mortality rate: The suicide mortality rate, expressed per 100,000 population, serves as a critical indicator of mental health disorders reflecting the prevalence of mental health disorders and the effectiveness of preventive measures. This rate not only highlights the tragic loss of life but also underscores the far-reaching impacts on families, communities, and society. In recent years, the need for updated statistics has become increasingly urgent as mental health issues gain recognition as significant public health challenges. The NHSSP aims to reduce suicide mortality rate from 23.4 in 2021[8] to 7.8 in 2025, 6.2 in 2027 and 4.7 by 2030. The National Population and Housing Census 2021 estimates the suicide mortality rate at 18 per 100,000 live births (Figure 2.6). Koshi Province recorded the highest rate at 24, while Madhesh had the lowest, with 10 deaths per 100,000 population. The Census also revealed that an average of 14 people commit suicide each day in Nepal (Table 2.2).

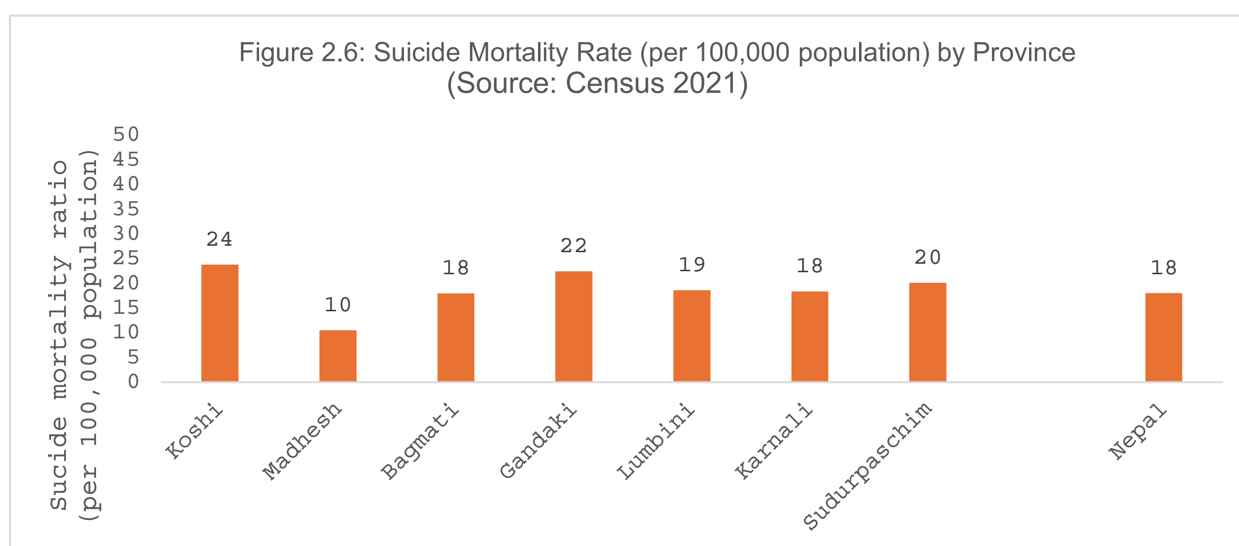


Table 2.2: Suicide mortality rate and suicide deaths per day, by province

	Total population	Suicide death	Suicide mortality rate	Suicide death per day
Koshi	4,961,412	1179	23.8	3
Madhesh	6,114,600	640	10.5	2
Bagmati	6,116,866	1097	17.9	3
Gandaki	2,466,427	553	22.4	2
Lumbini	5,122,078	951	18.6	3
Karnali	1,688,412	310	18.4	1
Sudurpaschim	2,694,783	541	20.1	1
Nepal	29,164,578	5271	18.1	14

Source: National Population and Housing Census 2021, Housing and Household Dynamics in Nepal, Thematic Report II (Page 129, Table 61)

[6] Nepal Health Research Council (NHRC), Ministry of Health and Population (MoHP), Monitoring Evaluation and Operational Research (MEOR), Institute for Health Metrics and Evaluation (IHME). Nepal Burden of Disease 2019. Kathmandu, Nepal: NHRC, MoHP, MEOR, and IHME; 2021.
[7] http://ghdx.healthdata.org/gbd-2021.
[8] Nepal Police Mirror 2021

Life lost due to road traffic accidents (per 100,000 population): Road traffic accidents are a significant public health concern, contributing to a substantial loss of life and injury worldwide. In Nepal, the rising number of vehicles, combined with inadequate road infrastructure and safety measures, has led to an alarming increase in fatalities and serious injuries from road traffic accidents. Each life lost not only represents a tragic personal loss but also has profound implications for families, communities, and the nation's overall development. The NHSSP aims to reduce the RTA mortality rate from 9.5 per 100,000 population in 2019[9] to 7.45 in 2025, 6.20 in 2027 and 4.96 by 2030. The National Population and Housing Census 2021 estimates the RTA mortality rate at 13 per 100,000 live births (Figure 2.6). Lumbini Province recorded the highest RTA mortality rate at 14.4 per 100,000 population, while Karnali had the lowest, with 10.4 deaths per 100,000 population. The Census also revealed that an average of 13 people die from RTA each day in Nepal (Table 2.3).

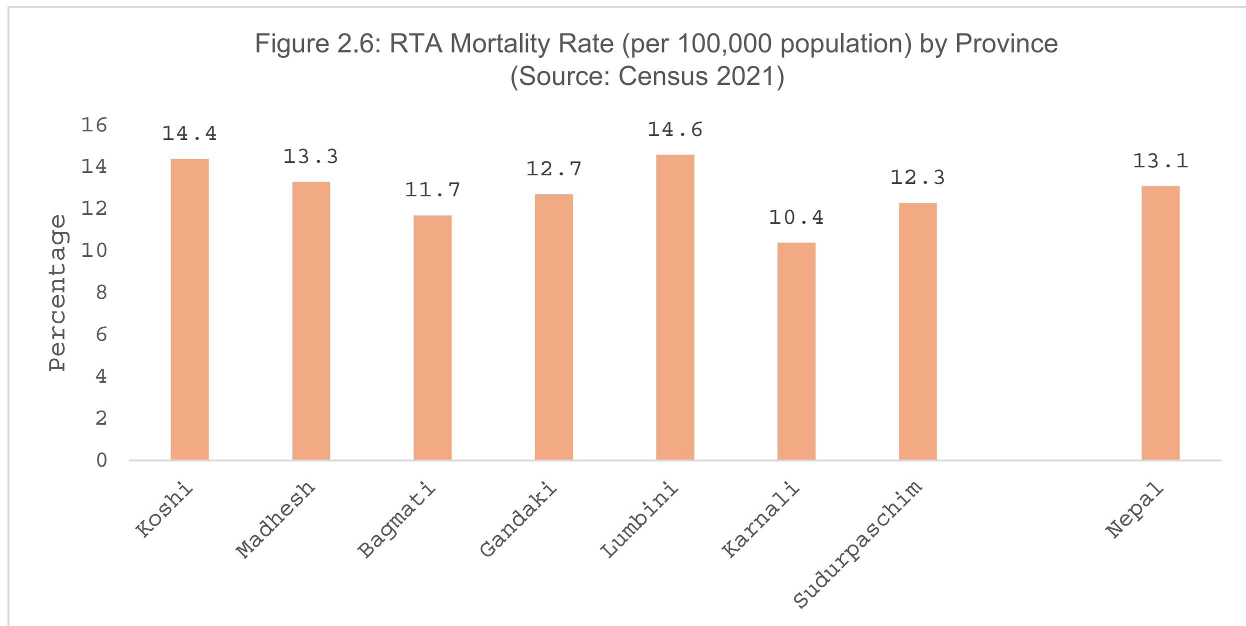


Table 2.3: RTA mortality rate and RTA deaths per day, by province

	Total population	RTA death	RTA mortality rate	RTA death per day
Nepal	29,164,578	3807	13.1	10
Koshi	4,961,412	715	14.4	2
Madhesh	6,114,600	813	13.3	2
Bagmati	6,116,866	713	11.7	2
Gandaki	2,466,427	314	12.7	1
Lumbini	5,122,078	746	14.6	2
Karnali	1,688,412	175	10.4	0
Sudurpaschim	2,694,783	331	12.3	1

Source: National Population and Housing Census 2021, Housing and Household Dynamics in Nepal, Thematic Report II (Page 129, Table 61)

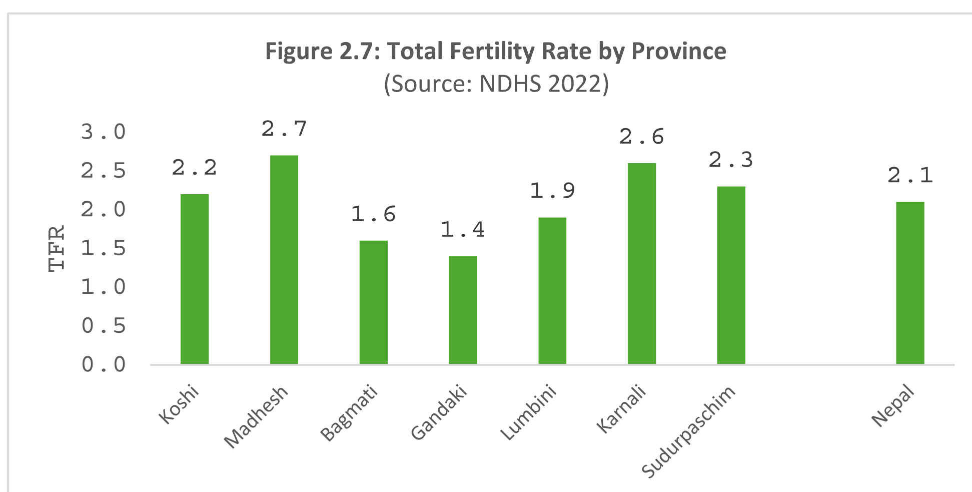
The NCDs risk factors STEPS survey 2019 highlighted alcohol consumption as a significant contributor to road traffic accidents and injuries. Almost half (48%) of adults had encountered messages discouraging alcohol consumption, while 19% had seen advertisements promoting alcohol, and 22% had attended social events where they were exposed to alcohol advertising or offered free drinks. The government has implemented strategies to reduce public access to alcohol products and to raise awareness through social mobilization programs. Strengthening anti-alcohol campaigns could further contribute to achieving and maintaining a quicker decline in alcohol consumption.

[9] Nepal Police Mirror 2021

Incidence of impoverishment due to OOP expenditure in health: High out-of-pocket (OOP) expenses and opportunity costs, such as wage loss, create financial barriers to healthcare, pushing many into poverty. High OOP can drive households into impoverishment, i.e. potentially push people below poverty lines. Recognizing the need to address these financial challenges to reduce inequity in health service utilization, the Government of Nepal has introduced various social health protection schemes over the past two decades. However, despite these efforts, financial barriers and inequities in healthcare access and outcomes persist. The NHSSP aims to reduce the incidence of impoverishment due to OOP expenditure from 1.7 in 2015/16 to 1 in 2025, 0.6 in 2027 and 0 by 2030.

In 2023, the Ministry of Health and Population released the eighth round of National Health Accounts, covering the fiscal years 2018/19 and 2019/20. These reports estimate healthcare expenditures within Nepal's health system. In the fiscal years 2018/19 and 2019/20, estimated out-of-pocket expenditures accounted for 57.9% and 54.2% of current healthcare expenditures, which is the primary funding source in Nepal's health system. As Nepal is dedicated to achieving Universal Health Coverage (UHC), minimizing OOP spending on healthcare is a key national priority. It is essential to implement efforts aimed at reducing dependence on direct OOP payments for healthcare and to establish a systematic and reliable system for monitoring progress.

Total fertility rate: Nepal has transitioned from having a high total fertility rate (TFR) to having a replacement level of fertility. It was measured at 4.6 per woman in Nepal in 1996, which declined to 2.1 per woman in 2022. The NHSSP aims to sustain this to 2030. A recent study has revealed that contraceptive use and husband–wife separation, among other indices, had the highest share of contribution to the current replacement level of fertility in Nepal[10]. Madhesh province reported the highest fertility rate at 2.7, while Gandaki the lowest rate at 1.4 (Figure 2.7).



[10] Dulal, K. P., R. Khatri, R. B. Kafle, K. Aryal, C. Khanal, and K. Bietsch. 2024. Factors Associated with Stagnation in Modern Contraception Use, Declining Fertility Rates, and Increasing Abortion and Use of Traditional Methods, Nepal DHS Surveys 2016–2022. DHS Further Analysis Reports No. 155. Rockville, Maryland, USA: ICF

Table 2.4 summarizes the progress on the NHSSP RF goal level 11 indicators.

Table 2.4: Progress on the NHSSP RF goal level 11 indicators

	Indicators	Baselines	Sources	2024 Status	Sources	2025 Milestones	2027 Milestones	2030 Targets
IM1	Human Development Index	0.602	NHDR 2020	0.602	NHDR 2020	0.62	0.65	0.68
IM2	Healthy Life expectancy	61.5	NBoD 2019	61.5	NBoD 2019	65.8	68.8	70.8
IM3	Maternal mortality ratio	151	Census 2021	151	Census 2021	99	85	70
IM4	Neonatal mortality rate	21	NDHS 2022	21	NDHS 2022	14	13	12
IM5	Under-five mortality rate	33	NDHS 2022	33	NDHS 2022	24	22	20
IM6	Prevalence of stunting among children under 5 years of age	25	NMICS 2019	25	NDHS 2022	20	16.6	12
IM7	Mortality between 30 and 70 years of age from Cardiovascular disease, Cancer, Diabetes or Chronic respiratory disease	2.8	NBoD 2019	2.8	NBoD 2019	2.15	2.10	1.96
IM8	Suicide mortality ratio	23.4	Nepal Police 2021	18.1	Census 2021	7.8	6.2	4.7
IM9	Life lost due to road traffic accidents	9.5	Nepal Police 2021	13.1	Census 2021	7.45	6.20	4.96
IM10	Incidence of impoverishment due to OOP expenditure in health	1.7	NHA 2019	1.7	NHA 2019	1	0.6	0
IM11	Total fertility rate	2.1	NDHS 2022	2.1	NDHS 2022	2.1	2.1	2.1

03 Progress by NHSSP strategic objectives and outcomes

This section highlights the progress on NHSSP, and 16th plan priority interventions followed by details on key initiatives at federal and provincial level, and the AWPB priorities for the next fiscal year – 2081/82. The sub-headings are outlined based on the NHSSP strategic objectives followed by outcomes.

3.1 Efficiency and responsiveness of health system

This objective focuses on creating an efficient and accountable health system that meets people's needs. The outcomes focus on enhancing human resource management, evidence-based planning, safe health infrastructure, consistent access to quality medicines, improved governance, and effective management of public health emergencies, creating synergies and complementarity between public and private sector.

3.1.1 Production and mobilization of skill-mixed human resources for health

To achieve the expected outcome of producing and mobilizing skill-mixed human resources for health (HRH) tailored to local contexts, the NHSSP outlines two outputs: **output 1**: Competent human resources for health produced based on projection; and **output 2**: Human resources for health mobilized effectively. According to Global Strategy on Human Resources for Health: Workforce 2030, countries should have a minimum of 4.45 human resources for health per 1,000 population. However, in 2020, Nepal had only 1.94 HRH per 1,000 population. Recognizing the importance of both availability in the labor market and employment status coupled with equitable distribution of skilled HRH, the GoN aims to reach the target HRH threshold by 2030[11]. The National Strategy on Human Resources for Health (2020/21-2029/30) outlines the projected health workforce needs until 2030 and serves as the guiding document for HRH management.

The Medical Education Commission (MEC), established under the National Medical Education Act 2075, is tasked with developing medical education to meet the country's needs and regulating it in an integrated and efficient manner. The Act defines medical education as the education of all disciplines and levels pertaining to health professions (Health Professional Education). Currently, medical education in Nepal offers 14 bachelor's degree programs, 53 master's degree programs, and 15 DM/MCh programs[12].

To address the increasing demand for healthcare professionals at federal, provincial, and local levels, the MoHP has introduced a policy and program to launch the MBBS curriculum through Academy of Health Sciences. This initiative aims to develop skilled manpower using MoHP internal resources in government hospitals with over 300 beds. MBBS education will commence at the Pokhara Academy of Health Sciences and the Rapti Academy of Health Sciences, with plans to start MBBS studies at the Madhesh Academy of Health Sciences this year. The policy will also be extended to additional hospitals.

In response to the high stillbirth rate, maternal mortality, and rising Caesarean section rates, along with the growing acknowledgment of the crucial role that trained midwives play in improving maternal and neonatal health outcomes, Nepal endorsed a new cadre of professional midwives in 2016 as part of its long-term strategy to enhance the health of mothers and infants in the country. Most maternity services in the country were – and still are – provided by nurses and auxiliary nurse midwives who learn basic midwifery skills as part of their pre-service training. Many of them also completed the skilled birth attendant training to become certified skilled birth attendants (SBA). However, they do

[11] National HRH Strategy 2022
[12] https://mec.gov.np/

not always have the competencies and depth of experience needed to manage challenging obstetric situations on their own[13]. Professional midwives have the competencies needed to manage normal pregnancies and deliveries – and to detect potentially life-threatening complications which require emergency intervention. In 2016 Nepal's first Bachelor's in Midwifery (BMid) course: a competency-based education program aligned to international standards, was launched at the Kathmandu University School of Medical Sciences (KUSMS). Programs at National Academy of Medical Sciences (NAMS) and at the Karnali Academy of Health Sciences (KAHS) followed in 2017 and 2018, respectively. By 2021, and the annual intake for new entrants had reached 70 students[14].

The Nepal Safe Motherhood and Newborn Health Road Map 2030 envisions the establishment of midwife-led birthing units in hospitals that handle more than 300 births per month. Staffing these units will necessitate a significantly larger number of professional midwives than can be produced through the BMid courses alone soon. To fill this gap, the three-year PCL Midwifery course has been designed and implemented adhering to internationally recognized standards while considering the local context. This course is open to both current auxiliary nurse midwives and new entrants, including recent high school graduates[15].

To develop and manage the health workforce in Nepal, the MoHP has established the Health Workforce Management Information System (HWMIS). In accordance with Clause 64 of the Public Health Service Act 2075, it has also developed and endorsed the "Procedure for the Nepal Health Workforce Management Information System (NHWMIS), 2081.

Not all sanctioned posts in public health facilities are filled, resulting in shortage of critical health workers at service delivery points. The proportion of MoHP sanctioned posts of doctors, nurses, and paramedics in public health facilities has improved slightly, rising from 71.3% in 2015 (NHFS 2015) to 73.4% in 2022 (NHFS 2022). The NHSSP aims to achieve 95% coverage by 2025 and 100% by 2027. The NHSSP aims to produce 95% of the projected annual health workforce by 2025, and to ensure that 85% of local levels have at least one medical officer by the same year. To track these indicators, a functional monitoring system needs to be established and maintained.

Retention of specialized health workers in remote areas has been a serios problem in Nepal, adversely affecting service delivery. Recognizing this challenge, the MoHP has been demanding and advocating for additional incentives for health workers assigned to the remote areas[16]. In line with the government's priority initiatives for effective human resource mobilization and management, the MoHP has decided to implement the 'One Doctor - One Health Facility' program[17] at Bir Hospital, Kanti Children's Hospital, National Trauma Center, and Paropakar Maternity Hospital. This decision aligns with the 'Operational Guidelines for One Health Worker/Doctor-One Health Facility Program 2077' and the 'Operational Guidelines for Extended Hospital Services Program 2077.' The MoHP is collaborating closely with hospitals to ensure successful implementation of the program. A close monitoring of the program is necessary, along with plans to expand it nationwide while adapting it to local contexts. Establishment of motivational and regulatory measures, such as performance-based contracts, could contribute to ensuring continuous service delivery at designated facilities.

To develop skilled human resources for delivering quality health services, the National Health Training Center (NHTC), in collaboration with program divisions and centers and HDPs, has implemented several training/orientation initiatives during FY 2080/81. These efforts are anticipated to elevate service quality, leading to greater client satisfaction and improved health outcomes. Some of the key initiatives include:

- 25 school nurses from Bagmati province were oriented on eye, ear, nose, throat, and oral health.
- 35 pharmacy officers working in hospitals were oriented on pharmacy management
- 35 public health workers were oriented on clinical audit

[13] In 2022, 80% of women were attended by skilled birth attendants (SBAs) (doctor, nurse or auxiliary nurse midwife) with wide inequalities between the poorest (67%) and wealthiest (97%) quintiles. A total of 41% of births were attended by nurse/auxiliary nurse midwife (NDHS 2022).
[14] https://health.bmz.de/stories/midwifery-education-in-nepal-training-the-first-generation-of-professional-midwives/
[15] Council for Technical Education and Vocational Training (CTEVT), Curriculum Development Division, Curriculum: Proficiency Certificate Level in Midwifery (Three-year program), CTEVT, 2018
[16] Health secretary's briefing to the Parliamentary sub-committee on health and education.
[17] 'One doctor, one health facility program' means that each healthcare worker is assigned exclusively to a single facility, promoting continuity of care, enhancing community health management, and optimizing resource utilization. It emphasizes the importance of dedicated, stable staffing for improving the quality and accessibility of healthcare

- 34 hospital managers and health workers of private hospitals were oriented on the standards of managing hospital and the MSS
- 42 doctors working in federal level hospitals including hospitals run by academy of health sciences, teaching hospitals, private hospitals were trained on standard treatment protocol of emergency services in Nepalgunj and Kathmandu
- 26 health workers in Kalikot district were oriented on the standard treatment protocol of BHS
- 30 health workers in Janakpur were oriented on MSS of health posts and its software application
- 25 scholarship doctors were oriented on national health systems
- Training on AEFI, Vaccine safety, VPD surveillance for pediatricians, medical officers and health workers
- Training on Facility Based Integrated Management of Childhood Illnesses (FB-IMNCI) for hospital level medical officers, nurses and paramedics
- Orientation on MPDSR for hospital and district teams
- Whole site orientations for doctors and nurses on post-pregnancy family planning of three referral hospitals and refresher training on post-partum IUCD for SBA trained nurses of 15 high volume delivery sites
- Training on RMNCAH program management for one batch of officers of federal, provincial and local levels
- Training on comprehensive newborn care for medical officers of level II hospitals
- Training on management of severe acute malnutrition (two batches of MToT) for doctors and nurses working in inpatient treatment center
- Orientation on storage management of nutrition commodities for nutrition focal persons and store focal persons from all provinces and health offices
- Orientation on HPV DNA screening of cervical cancer in 14 local levels of 8 districts
- Training of Trainers (ToT) on prevention and response to outbreaks and other public health events for rapid response team members (125 health workers)
- Training on HIV testing & counselling for ART counsellors
- Training on clinical management of HIV/AIDS for medical officers and ART counsellors
- Orientation on healthcare waste management and WASH for 159 health workers from private hospitals in Nepalgunj, Chitwan and Pokhara
- Orientation on healthcare waste management for more than 470 participants from 10 hospitals
- Orientation on HMIS (DHIS-2) for staff from federal and provincial hospitals
- Orientation on suicide prevention for journalists in Bagmati and Madhesh provinces
- Orientation on SAFER initiatives for district level stakeholders in Sudurpashchim and Bagmati provinces
- Orientation on SAFER initiatives for health workers in seven metropolitan and sub-metropolitan cities
- Orientation on standard treatment protocols of emergency health services to provinces
- Integrated training package for environmental health, climate change, HCWM and WASH in health care facility
- Service provider training on PEN in Kavrepalanchowk, Manang and Palpa districts.
- One day Orientation on NORAD project conducted in Ilam (Province 1), Parsa (Madhesh Pradesh), Kavrepalanchowk (Bagmati), Manang (Gandaki), Palpa (Lumbini), Kailali and Kanchanpur (Sudurpaschim). Around 25-30 participants attended in each province.
- Common competencies for MBBS Program identified to strengthen preservice training on mental health in Nepal
- Province level training on AEFI, vaccine safety and VPD surveillance to pediatricians, medical officers and stakeholders in all seven provinces.
- South-South learning exchange (SSLE) with Sri Lanka on Postpartum Family Planning (PPFP) and Establishment of demonstration site at Civil Services hospital for PPFP services
- Orientation on prevention and response on sexual exploitation, abuse and harassment
- ToT on WASHFIT to Gandaki, Lumbini and Madhesh provinces
- ToT and training on PEN to service providers
- Leadership training on NCDs for MoHP officials (29 MoHP senior officials and WHO Nepal NCD team participated in the first series and 26 officials in the second)
- Training program for WHO's Communication for Behavioral Impact (COMBI) with special focus on noncommunicable diseases (NCDs) (5 days training for 32 participants)
- ToT on Primary Care Rehab Package
- TB lab review and capacity building to reach universal DST and to adopt oral DR TB regimen (rGLC mission)
- Federal level MToT and province level ToT on Typhoid Conjugate Vaccine (TCV) introduction in national immunization program.

- Training on Integrated Care of Older People (ICOPE) based geriatric care to medical officers, nursing staff and health care professionals
- Training on implementation of developed SoPs on laboratory quality documents
- Training on Good Manufacturing Practice for ayurveda medicines to ayurveda manufacturers
- Training for Ayurveda medicine manufacturers on documentation preparation as per GMP requirements
- Training on Pharmacovigilance and vigiflow software use to the members of Pharmacovigilance program to improve adverse drug reaction (ADR) reporting
- Basic training on medical oxygen system
- ToT of the Advanced IPC LRP (Core components of infection prevention and control programs at the national and acute health care facility level)
- Acute respiratory distress syndrome training in 7 provinces
- Training on molecular diagnosis of anthrax and Nipah
- Ambulance Drivers Training
- ToT on basic emergency care and emergency care toolkit
- Biosafety and Risk Assessment Refresher and Practical Training of Trainers
- Biosafety Cabinet Certification Training and Basic Accreditation
- MCCOD for mortality reporting along with ICD-11 coding for medical officer and medical recorders
- Training on climate resilient water safety plan (CR-WSP), followed by onsite audit at one site
- ToT on Social Accountability in Health Sector Guidelines 2020 provided to 24 health officers of Sudurpaschim, Lumbini and Karnali provinces; and trained 60 district managers and NGOs of Sudurpaschim province.

Besides these, the NHTC has undertaken some special initiatives, which include:

- 5 new training materials developed, and 6 existing training materials revised.
- National Health Training Strategy has been drafted.
- In the fiscal year 2080/81, 14,121 health workers received skill-based training through the national health system, with 589 health workers trained specifically by the NHTC.
- For the first time, the NHTC provided international-level training on Basic Operation and Maintenance of Medical Oxygen Systems to 7 Bhutanese participants.
- The field epidemiology training was provided to 122 field epidemiologists from 57 districts.
- 336 health workers have received training on Hemodialysis. The BMET unit repaired and maintained 70 biomedical devices and machines.
- Safe abortion training has been conducted as part of the educational programs at 11 medical colleges.

Free transportation for FCHVs

The Female Community Health Volunteer (FCHV) program in Nepal was launched in 1988, initially starting in 27 districts and expanding to all districts by 1995. Currently, there are over 52,000 FCHVs nationwide, who have played a crucial role in reducing child and maternal mortality rates. The FCHV program is well established as a vital component of Nepal's public health system. In recognition of their contributions to improving health outcomes, especially for mothers and children, the MoHP has reached an agreement with the National Federation of Nepalese Transport Entrepreneurs, an umbrella organization of transport entrepreneurs across the country, to provide free transportation for FCHVs during their duty travel, effective from 15 Kartik 2081 (31 October 2024). The MoHP hopes this gesture will motivate FCHVs and is committed to offering additional benefits in the future.

An agreement between the MoHP and the National Federation of Nepalese Transport Entrepreneurs to offer free transportation for FCVHs during their duty travel

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Periodic review of the medical education curriculum in collaboration with universities, academia and MEC aligning with international standards to better address the country's needs.
- Assess the demand for new health professionals in the changing context and coordinate with academic institutions and relevant councils for their production.
- Update human resource records and enhance HR information systems for interoperability with major health information systems
- Conduct organizational and management surveys of health institutions and establish a system for regular reviews of organizational structures to guide HR recruitment and deployment
- Ensure multi-disciplinary medical teams are available at all basic hospitals.
- Employ bachelor's degree holders in health sciences at local levels for effective health program management.
- Provide financial and other incentives to health professionals for retaining them, particularly in remote areas.

3.1.2 Evidence- and equity-based planning

The NHSSP focuses on strengthening the overall process of evidence generation and data management leveraging modern technologies with a particular focus on their use at three levels of government. The NHSSP outcome of 'evidence-and equity-based planning' is realized through two outputs. **Output 1** focuses on generating, analysing, and utilizing evidence at all levels by leveraging technology; while **Output 2** promotes high-quality health research in priority areas.

Digitalization has played a crucial role in enhancing the collection, processing, analysis, and use of data in the health sector. This process has facilitated systematic monitoring of progress toward the 16th Plan, NHSSP, the SDGs, and various programs. With support from GIZ, the Standard and Interoperability Lab (SIL-Nepal) has been established and is now operational at MoHP, aiding in the development of standards and promoting interoperability among different routine management information systems. In the month of Asar 2081, two-thirds (65.7%) of health facilities submitted e-report to the HMIS independently, while 18.5% submitted e-report through their parent organizations (*Palikas*). Some provinces and local levels have initiated 'eHMIS', i.e., digitizing HMIS recording and reporting tools. For example, 637 out of 1,000 public facilities in Gandaki province have initiated the eHMIS, with plans to expand its implementation across all public health facilities in the province. Some facilities in other provinces have also begun using eHMIS. However, there is a pressing need to standardize these systems to enhance interoperability, enabling effective data sharing.

Similarly, the electronic medical record (EMR) system has been prioritized by all three levels of government. Gandaki Province has implemented EMR in all 12 of its provincial hospitals and is focused on further strengthening and institutionalizing the system. However, not all facilities are adopting the system at the same pace. Additionally, the province is working on building interoperability among these systems to transition towards a comprehensive electronic health record (EHR) system.

At the federal level, the Integrated Health Information Management Section (IHIMS) within the Management Division, DoHS, prioritized the following initiatives in the fiscal year 2080/81:

- Integrated review of routine MISs: HMIS, LMIS/eLMIS, IMU, HIIS
- Implementation of the activities prioritized in the HMIS roadmap
- Data verification and validation
- Expansion of the 'Dashboard Program' in local levels of all seven provinces
- Capacity enhancement of health-related GIS in collaboration with Survey Department, Meteorological Department and other stakeholders
- Mainstreaming of data related to post-mortem at hospitals
- Capacity building on research and analysis using HMIS data
- Inter-province observational and exchange visit of medical recorders and statisticians
- Operation, assessment and follow-up of ICD 11 program to strengthen medical record system
- Strengthening of medical record system, including operation of electronic medical record (EMR) system at federal, private and other hospitals

- Revision of and orientation on Guidelines on Standard and Interoperability of software (both existing and in development) related to health data
- Development of guidelines for catchment population mapping survey
- Legacy data migration
- Development of an integrated monitoring and supervision checklist for overseeing local levels and health facilities at all levels
- Standard Operating Procedure for Electronic Medical Record (EMR) and Telemedicine has been drafted.
- Development of strategy for national health data sharing and security
- Improving recording and reporting of data related to non-communicable diseases, mental health and injuries
- Expansion of online reporting of HMIS, eLMIS and HIIS from health facilities

Besides these, Disease Surveillance and Research Section under EDCD has conducted several activities promoting generation, processing, analysis and use of data. Some of the key activities include:

- Review of the EWARS program accomplished in all provinces except Koshi and Karnali provinces.
- A Standard Operating Procedure (SOP) has been developed for RDT-based cholera surveillance, and the surveillance has been initiated.
- Monitoring of SORMAS implemented in Gandaki and Sudurpaschim provinces has improved use of SORMAS platform. Server installation and networking between emergency, inpatient and OPD departments completed in four piloting sites hospitals.
- A list of 52 prioritized diseases prepared through a consultative process. The list is endorsed by the cabinet and published in the Gazette.

In 2023, the MoHP, with support from WHO, conducted nationally representative survey to measure access to assistive technology in Nepal[18]. The survey has generated evidence regarding utilization and unmet need of assistive technology in Nepal. It has highlighted the disparities in access to assistive technology across different geographic and demographic distributions. The survey has revealed that there is a high need for AT, but demand is low, and supply is even lower in Nepal. These evidence are crucial for the policy makers and program managers to devise and implement assistive technology related policies and programs aimed at increasing access to assistive technology.

The Nepal Demographic and Health Survey (NDHS) and the Nepal Health Facility Survey (NHFS), conducted with support from USAID in every five years, are key sources of information that enable international, national, and sub-national comparisons of health sector data in Nepal. The upcoming NHFS, the third in its series, is scheduled for 2025, while the NDHS, the seventh in its series, is planned for 2026. The main report presents descriptive findings and trends. While generally sufficient, the final report falls short in addressing the 'why' behind the data. Further analysis aims to answer these critical questions, essential for reshaping key policies and programs. Building on prior practices, the MoHP, in collaboration with USAID and with technical assistance from USAID Learning for Development Project and DHS Program, conducted analysis of the 2022 NDHS across 11 topics within three thematic areas in 2023/24. The areas and topics of the further analysis are listed below, and the reports are available at https://lnkd.in/ggW_QC3R.

Child health:

1. Trends and determinants of neonatal mortality rates in Nepal
2. Vaccination coverage and factors behind increasing rate of no immunization
3. Effective coverage of sick child-care services and its relationship with under five mortalities
4. Prevalence and care-seeking for diarrhea and fever among children under five years old

Maternal and reproductive health:

5. Equity analysis of maternal health services in Nepal: Trends and determinants
6. Trends and determinants of adolescent pregnancy and unmet need for family planning
7. Factors associated with stagnation in modern contraception use, declining fertility rates and increasing abortion and traditional methods

[18] Paudel KP, Gyanwali P, Dahal S, Bista B, Baskota R, Das CL, Marasini RP, Baral RP, Napit P, Shrestha N, Aryal UR, Koirala P, Marahatta K, Pokhrel S, Shrestha A, Dhimal M (2023). Measuring access to Assistive Technology in Nepal: A Country Report. Kathmandu: Epidemiology and Disease Control Division, Department of Health Services, Ministry of Health and Population, Nepal Health Research Council and World Health Organization, Nepal.

General health:

8. Baseline of Basic Health Service
9. Forms and determinants of violence perpetrated by intimate partners and other perpetrators
10. Factors associated with increased blood pressure
11. Contributors to Nepal's significant improvement in key nutrition outcomes

The NHSSP focuses on promoting health research in priority areas linked with the evidence-based decision-making process. Prioritizing research and surveys have been one of the key initiatives at all levels. Gandaki province has initiated a collaborative approach of prioritizing health research in the province. The process began with a comprehensive review of national and provincial level policy and strategic documents, alongside ongoing research activities in the province. Consultations with experts helped to identify needs from program managers, which helped in synthesizing and identifying thematic priorities. Inputs from participants of the provincial review meeting were also considered in prioritization process. Following this, the feasibility of implementation will be reviewed and assessed. Collaborative implementation will then be carried out, leading to the execution of research, followed by follow-up and dissemination of findings. The province has a plan to implement the prioritized research in different modalities: some by itself, some through the provision of early career grants to academia and students, and some others through development partners and other stakeholders. The province has a plan to organize provincial health conference to enhance research capacities among health professionals.

Studies, research, surveys and assessments conducted in the FY 2080/81 include:

- Utility and effectiveness of health education materials related to family planning, Aama Surakshya, and newborn care (NHEICC).
- Measuring access to assistive technology in Nepal: A country report (EDCD)
- Investment case for mental health Nepal (draft)
- VPD surveillance to sustain and enhance the sensitivity of VPD surveillance at all sub-national levels. More than 1550 VPD surveillance sites exist in the country and functional weekly reporting units (884) exist in more than two-thirds (79%) of municipalities.
- Environmental surveillance for poliovirus (Koshi and Madhesh provinces and five permanent sites of Kathmandu Valley)
- Vulnerability and adaptation assessment of climate sensitive diseases and health risks in Nepal
- Baseline assessment of GHG emissions from health sector operations in Nepal
- Auditing of climate resilient water safety plans (CR-WSP) in Nepal
- Household Energy Assessment Rapid Tool (HEART) Country report
- Situation assessment of rehabilitation systems in Nepal
- Rapid Assistive Technology Assessment survey
- Assessment of Ear and Hearing Care in Nepal
- LF Coverage Evaluation Survey
- Review of Kala-azar management among treating hospitals
- DR TB survey
- Integrated external review of Vector Borne Disease Programs (Malaria, Kala-azar, Lymphatic Filariasis and Dengue - This comprehensive review highlighted significant gaps in strengthening elimination-oriented interventions in Nepal, emphasizing the imperative need for strategic reform in policy, intervention approaches and HR structures. The review has contributed to development and updating of disease-specific national strategic plans and country roadmaps, aligning efforts to strategically shift from control-oriented to elimination-focused landscape.
- External review of National TB Program. This comprehensive review illuminated significant gaps in enhancing multi-sectoral engagement and private sector partnerships, emphasizing the need for improved resource mobilization for TB with enhanced local accountability. This review has contributed to updating the National Strategic Plan for ending TB and formulating M&E and operational plans for its implementation aiming for renewed efforts in TB control in Nepal.
- Independent monitoring of routine immunization and TCV campaign. More than 46000 thousand children monitored during the TCV campaign. The children were also assessed for routine MR doses. The under-immunized children were referred to the nearest health facility for completion of vaccination as per the national immunization schedule.

- Post Campaign coverage survey for TCV
- Data quality and risk assessment of VPDs (quarterly)
- Rapid appraisal of the current situation of local pharmaceutical manufacturing and drug pricing mechanism.
- Entomological survey of major VBDs
- Situational analysis on forecasting, procurement, and supply chain management of drugs and equipment for safe abortion service and Emergency Contraceptive Pills (ECPs)

National level population and health facility-based surveys planned for the upcoming year(s) include:

- Nepal Health Facility Survey (NHFS) (2025)
- National Female Community Health Volunteer Survey (2025)
- Neonatal Death Verbal Autopsy to Ascertain Causes of Death (2025)
- National Micronutrient Survey (2025)
- Nepal Multiple Indicator Cluster Survey (NMICS) (2025)
- Nepal Demographic and Health Survey (NDHS) (2026)

To monitor the health sector's performance on a periodic basis, the NHSSP includes a Results Framework (RF) that defines a set of indicators at impact, outcome, and output levels. The RF utilizes data from various sources like routine information systems (HMIS, LMIS, CRVS, EWARS), periodic national surveys (NDHS, NHFS, NMICS), and health system reports like FMR and NHA. The RF includes an indicator matrix specifying baseline value and data source, year specific targets, level of disaggregation and means of verification for each indicator. The NHSSP RF features a total of 111 indicators: 11 for monitoring goal, 33 for tracking 15 outcomes, and 67 for monitoring 29 outputs (Table 3.1). However, several indicators lack defined data sources, while some existing sources need improvement to meet data requirements and enhance quality.

Table 3.1: Distribution of indicators across goal, strategic objectives, outcomes, and outputs of NHSSP RF

	Outcomes		Outputs		Total indicators
	Statements	Indicators	Statements	Indicators	
Goal					11
Strategic objective 1	6	12	14	28	40
Strategic objective 2	2	8	3	7	15
Strategic objective 3	2	5	5	7	12
Strategic objective 4	2	4	4	19	23
Strategic objective 5	2	4	3	6	10
Total	15	33	29	67	111

MoHP, as agreed in the Joint Financing Arrangement (JFA) in 2023, in collaboration with HDPs, has reviewed the data sources for each indicator in the RF, focusing on quality and identifying gaps, and outlined key actions needed to address these issues. This document, tailored to the local context, defines each indicator with rationale, assesses the data systems associated with them - focusing on quality and identifying gaps - and recommends specific actions for enhancing existing data systems and developing new ones as needed. It also designates the entity primarily responsible for ensuring the generation and reporting of the data.

The review of the NHSSP RF reveals that some indicators lack established data sources, and others require upgrades to their current data sources. Although routine information systems connect health facilities with all levels of government, there are indicators for which no mechanism exists for local levels to provide annual updates. Furthermore, while HMIS generally updates data monthly, certain indicators require annual reporting, for which no system is currently available. Table 3.2 below lists the indicators in the NHSSP RF for which new data sources need to be established to meet data requirements.

Table 3.2: Indicators for which new data source need to be establishedt	
Indicator code	**Indicator**
Outcome level indicators	
OC1.2.1	Overall score of health information system performance index (%)
OC1.2.2	Number of impact assessments done in priority public health programs and fed to AWPB/Plan
OC 1.4.1	Percentage of domestic production of tracer medicines in their total supply
OC 2.1.2	Percentage of antibiotic resistant among culture and sensitivity tests
Output level indicators	
OP1.3.1 (c)	Number of local levels with storage facilities for drugs and medical supplies
OP1.5.2 (a)	Number of local level conducting social audit and / or public hearing focusing on health
OP1.6.1 (a)	Number of local level allocating budget for health emergency preparedness and response
OP2.1.1 (a)	Integrated surveillance mechanism for selected determinants established and functional at all levels
OP2.2.1 (a)	Percentage of people served through Yoga services
OP2.2.1 (b)	Number of Nagarik Aarogya groups formed
OP3.2.3 (a)	Percentage of social protection programs streamlined with national health insurance scheme
OP4.1.1 (c)	Percentage of registered laboratories performing culture and sensitivity test
OP5.1.2 (b)	Number of local levels implementing set of packages for healthy lifestyle
OP5.2.1 (a)	Percentage of migrants receiving pre departure session including on health
OP5.2.1 (b)	Percentage of local levels initiating planned settlement

Table 3.3 categorizes the indicators by the type of action needed to address data gaps.

Table 3.3: Indicators that need specific action to meet the data requirements	
Indicator code	**Indicator**
Action: Create an online integrated system to enable local levels to update specific information annually	
OP1.3.1 (c)	Number of local levels with storage facilities for drugs and medical supplies
OP1.5.2 (a)	Number of local level conducting social audit and / or public hearing focusing on health
OP1.6.1 (a)	Number of local level allocating budget for health emergency preparedness and response
OP2.1.1 (a)	Integrated surveillance mechanism for selected determinants established and functional at all levels
OP2.1.1 (b)	Percentage of secondary schools (public) with health workers
OP2.2.1 (a)	Percentage of people served through Yoga services
OP2.2.1 (b)	Number of Nagarik Aarogya groups formed
OP5.1.2 (b)	Number of local levels implementing set of packages for healthy lifestyle
OP5.2.1 (b)	Percentage of local levels initiating planned settlement
Action: Develop an online integrated system to enable health facilities to report annually on indicators that fall outside the scope of existing routine MISs, such as HMIS and LMIS	
OP1.5.3 (b)	Number of federal and provincial hospitals conducting clinical audit
OP1.6.1 (b)	Number of hub hospitals with updated hospital emergency preparedness and response plan

Table 3.3: Indicators that need specific action to meet the data requirements	
Indicator code	**Indicator**
Action: Conduct a deeper analysis of the secondary data	
IM7	Mortality between 30 and 70 years of age from cardiovascular disease, cancer, diabetes or chronic respiratory disease [BoD]
IM10	Incidence of impoverishment due to OOP expenditure in health [NHA]
OC 1.6.1	International Health Regulations (IHR) average capacity score [SPAR]
OC 2.1.4	Proportion of year lived with disability due to mental disorders [BoD]
OC 3.2.1	UHC services coverage index of essential health services (Percent)
OP4.1.2 (e)	Percentage of PLHIV on ART with viral load suppressed among PLHIV on ART
Action: Enhance the existing MISs to meet data requirements more effectively	
OP1.2.1 (b)	Number of hospitals operating electronic medical record system as per MoHP standards [NHFR]
OP1.6.2 (a)	Percentage of public health emergency events notified timely [EWARS]
OP1.6.2 (b)	Percentage of public health emergencies responded by rapid response teams within 24 hours of notification [EWARS]
OP2.2.1 (a)	Percentage of people served through Yoga services [AHMIS]

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Develop medicine information management system to manage information related to production, import, consumption, quality and regulation of medicine, medicinal and diagnostic products.
- Expand electronic health records system in public and private health facilities promoting interoperability.
- Expand online reporting mechanism in all health facilities and create a public interface to enable easy access to data
- Establish and functionalize health intelligence system utilizing data from health information systems, routine surveillance, surveys, research, global evidence and alerts to create scientific evidence for health policy decision making at municipal, provincial and federal levels
- Promote a gradual use of artificial intelligence in healthcare, such as in diagnostics and treatment
- Strengthen regulation of health research in priority areas to promote quality of care
- Promote studies and research in collaboration with national and international universities and research institutions to generate data and evidence in addressing existing inequalities
- Develop a mechanism to synthesize policy recommendations from health research and promote their utilization
- Successfully execute the national-level surveys planned for the upcoming year(s).

3.1.3 Safe and people friendly health infrastructures

Building on the lessons learned from previous health sector strategies, the NHSSP emphasizes the development of multi-hazard-resistant, climate-resilient, and environmentally sustainable infrastructure through the integration of green technology. While the benefits of incorporating green technology into health infrastructure are widely recognized, challenges related to finance, technical expertise, logistics, and social acceptance can hinder its implementation, particularly in rural and resource-limited settings. To address these obstacles, a collaborative approach involving governments, NGOs, local communities, and the private sector is crucial, along with the creation of tailored policies and incentive mechanisms to foster sustainable infrastructure in underserved areas.

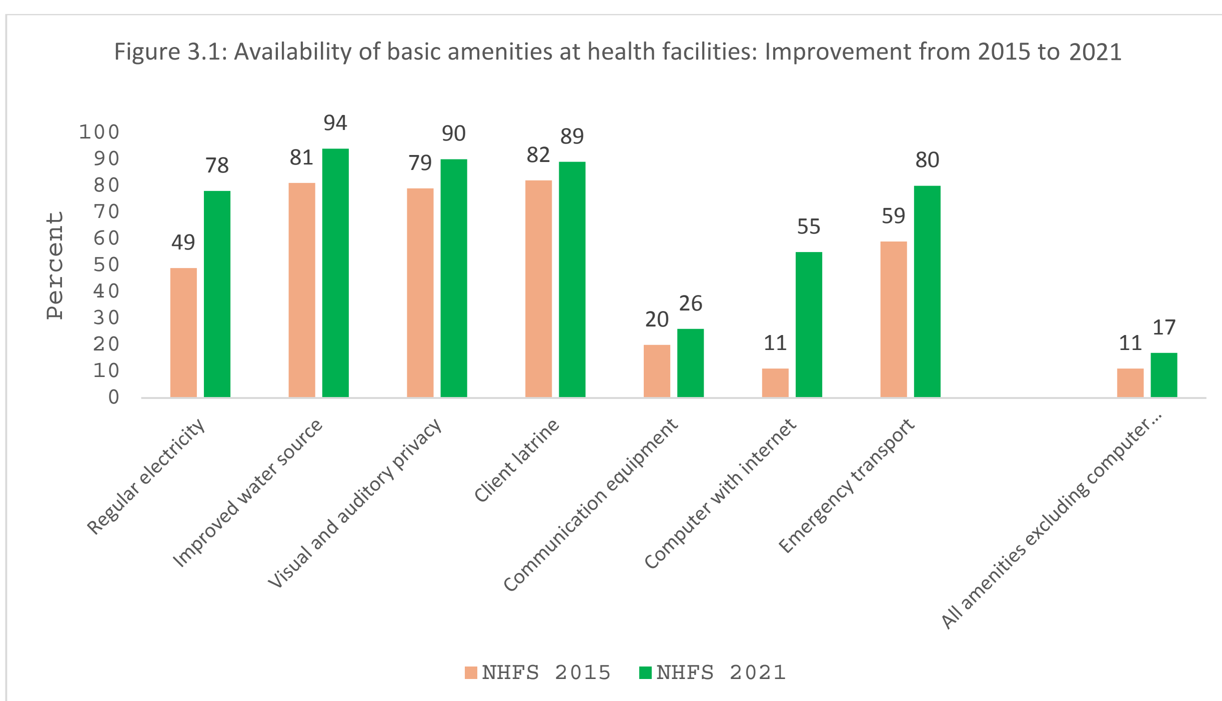
The NHSSP aims to achieve outcome of safe and people friendly health infrastructures through two outputs: **Output 1** focuses on strengthening of physical infrastructure of health institutions, while **Output 2** emphasizes equipping health facilities with bio-medical and other equipment, ensuring they are regularly repaired and maintained.

To enhance the readiness of health facilities for delivering improved quality of services, the MoHP has updated Minimum Service Standards (MSS). In line with the national policy to establish Basic Hospitals at each local level and Basic Health Service Centers at the ward level, construction is currently underway to enhance access to basic health services. By end of FY 2080/81, construction of 413 Basic Hospitals has been completed. Hospitals at both provincial and federal levels are being strengthened to function as referral centers, offering specialized and super-specialty services. Furthermore, routine, and periodic repairs and maintenance of health facility buildings are prioritized, along with ensuring the availability of preventive and curative medical equipment-including IT equipment, generators, ambulances, fire-fighting tools, and diagnostic and treatment devices.

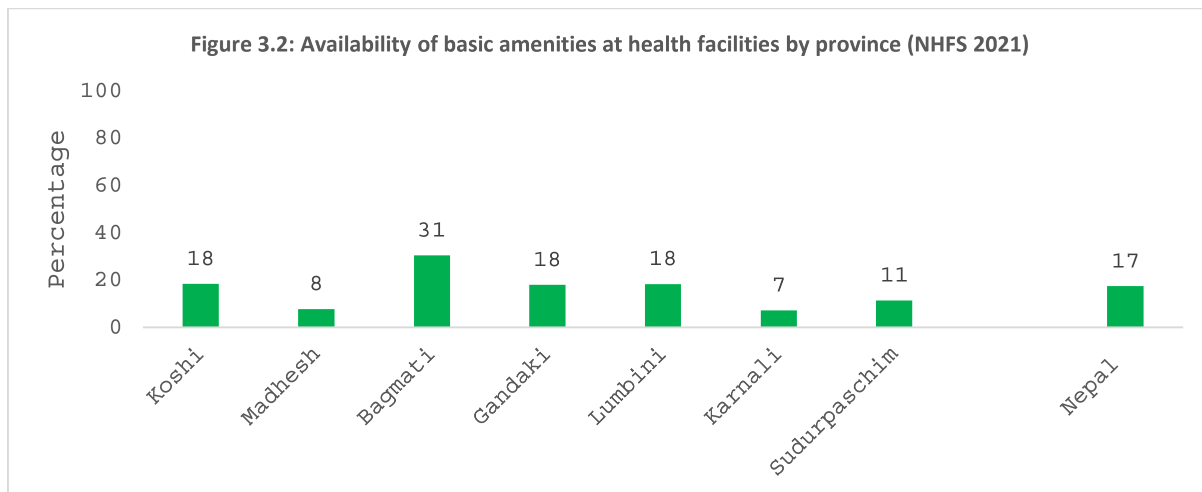
At the federal level, this year, the MD under the DoHS concentrated on several key initiatives: continuing the construction of the Central Vaccine Store, equipping the newly built Central Medical Store in Kathmandu, maintenance of the Central Medical Store in Pathlaiya, and maintaining and repairing buildings within the DoHS complex, including the Central Cold Store in Kathmandu. Additionally, Bir Hospital in Kathmandu has established and begun providing services in Burn Ward.

Equipping health facilities with essential amenities, including reliable electricity, improved water sources, visual and auditory privacy, client latrines, communication equipment, computers with Internet access, and emergency transport, is crucial for delivering quality services and motivating clients to utilize health facilities. The evidence indicates only a modest increase in the percentage of facilities providing six of the seven amenities (excluding a computer with Internet access) considered essential for client services, rising from 11% in 2015 to 17% in 2021 (Box 3.1, Figure 3.1) (NHFS 2015 and NHFS 2021).

Box 3.1: Basic amenities at health facilities
Regular electricity: Facility is connected to a central power grid, experienced no power interruptions longer than 2 hours during normal working hours in the week before the survey, has a functioning generator with fuel available on the survey day, or has backup solar power. Improved water source: Piped water, bottled water, or alternative sources such as public taps, standpipes, tube wells, boreholes, protected dug wells, protected springs, or rainwater, with the outlet located within 500 meters. Visual and auditory privacy: A private or screened-off space in the outpatient area allows for normal conversations without being seen or heard by others. Client latrine: A functioning flush or pour-flush toilet, a ventilated improved pit latrine, or a composting toilet. Communication equipment: The facility has a functioning landline telephone, a facility-owned cellular phone, a supported private cellular phone, or a functioning radio. Computer with internet: A functioning computer with uninterrupted Internet access for more than 2 hours during normal working hours, or it has Internet access via a cellular phone. Emergency transport: A functioning ambulance or emergency transport vehicle stationed on-site with fuel available on the survey day, or it has access to an ambulance from another facility.



In Bagmati province, over 31% of facilities possess all the basic amenities, compared to less than 10% in Madhesh (8%) and Karnali (7%) (Figure 3.2). The highest percentage of facilities with all six basic amenities is found in private hospitals (87%) and federal/provincial hospitals (82%), while basic health care centers have the lowest percentage at just 9% (NHFS 2021).



The Physical Infrastructure Section of the Management Division, DoHS, prioritized eight initiatives for FY 2080/81. These initiatives include monitoring and following up on program implementation, as well as infrastructure development and planning activities at both the provincial and local levels. Additionally, there is a focus on identifying materials to be purchased and distributed through the DoHS, alongside managing stickers for updating tools and equipment in hospitals nationwide. The Inventory Management System is being updated. Proper management of biomedical equipment is prioritized, including the preparation and printing of facilitation guidelines for unused health equipment, as well as providing orientation and follow-up for technicians. Furthermore, there is a continuous effort to update and follow up on information from health institutions within the health information management system and to upgrade software related to this system. Monitoring, reviewing, and planning activities are also being conducted for programs aimed at enhancing information systems such as HMIS and HIIS. It has completed updating infrastructure related information of facilities in 24 districts in the health infrastructure information system (HIIS).

Standardizing the names of public health facilities

To ensure consistency in the naming of public health facilities run by local governments, the MoHP has standardized the naming process. The following criteria have been set for naming these facilities: The 5, 10, and 15-bed hospitals operated by local governments, along with the primary health care centers and health posts upgraded in FY 2076/77, FY 2077/78, and FY 2078/79, will be designated as: ….(name of local government) Basic Hospital, ….(location), ….(district). Sample: Sunkoshi Basic Hospital, Ratamata, Sindhuli.

Likewise, primary health care centers, health posts and basic health service centers will be designated as: Basic Health Service Center, ……. (location), …….. (name of local government), Ward No. ….., ……. (district). Sample: Basic Health Service Center, Charkune, Vyas Nagarpalika, Ward No. 1, Tanahu.

The MoHP has also decided to conduct an Organizational and Management (O&M) survey of Basic Health Service Centers and 5, 10, and 15-bed hospitals operated by local governments, using the existing sample organogram developed by the ministry.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Expedite the construction of green and resilient health facility infrastructures at local, provincial, and federal levels, ensuring regular maintenance.
- Revise and standardize the Health Infrastructure Information System (HIIS) for effective infrastructure planning and maintenance.

- Based on the learning of COVID-19 pandemic and land acquisition challenges, update the health facility building standards for establishing multi-hazard resistant, climate-resilient, environment and user-friendly health infrastructure.
- Set up and manage biomedical equipment repair and maintenance centers at both the federal and provincial levels.

3.1.4 Uninterrupted availability of quality medicine and supplies

The federal, provincial and local governments are responsible for ensuring uninterrupted availability of quality medicines and supplies at the service delivery points. Despite the observed progress, the procurement and supply chain management system require further enhancements. For this, the NHSSP outlines two outputs, Output 1: Domestic production of medicines, diagnostics and health products promoted and regulated; and Output 2: Procurement and supply chain management of medicines and supplies strengthened.

Government of Nepal has the policy to promote and regulate domestic production of medicines and medical supplies. Department of Drugs Administration (DDA), within the MoHP, is responsible for regulation of medicines. The MoHP is dedicated to enhancing the DDA to reach WHO maturity level 3, as outlined in the WHO Global Benchmarking Tool (GBT) for National Drug Regulatory Agencies (NRAs). As per the DDA registry, there are 170 domestic, and 578 international medicines producers registered in Nepal. Of the total 19,254 drugs (brand) registered with DDA, 11,667 are domestic and 8,087 are international. A total of 190 companies import drugs. There are 29,609 registered pharmacies across the country, and there are 6,396 pharmacy entrepreneurs, 8,740 pharmacy assistants, and 2,539 pharmacists (Table 3.4).

Table 3.4: Pharmaceuticals in Nepal	
Medicine producers	748
Domestic	170
International	578
Drugs (brands) registered	19,254
Domestic	11,667
International	8,087
Importers	190
Registered pharmacies	29,609
Pharmacy entrepreneurs	6,396
Pharmacy assistants	8,740
Pharmacists	2,539

Capacity building of local medicine manufacturers: To facilitate local production of quality medicines, DDA conducted training workshops to over 100 local manufacturers on Good Laboratory Practice (GLP) and current Good Manufacturing Practice (cGMP). To improve quality of locally manufactured ayurveda medicines, DDA conducted training to ayurveda medicine manufacturers on GMP and documentation preparation as per WHO GMP requirements.

In FY 2080/81, DDA has the total budget of NPR 140,558,000 (one hundred forty million, five hundred fifty-eight thousand rupees) while DDA raised the revenue of NPR 118,305,518 (one hundred eighteen million, three hundred five thousand, five hundred eighteen rupees) the same year.

Table 3.5 summarizes key achievement of DDA in the FY 2080/81.

Table 3.5: Key achievements of DDA in FY 2080/81

Key activities	Unit	Annual target	Achievement	
			No.	%
Supervision of medicines industries	No.	111	81	73.0
Supervision of pharmacies	No.	2800	3100	111
Sample testing of medicines	-	-	226	-
Low quality medicines	No.	-	39	-
Supervision of laboratory of Nepali medicines industries	No.	30	26	86.7
Approval for licencing new production	No.	-	847	-
Renewal of production licencing	No.	-	8504	-
Recommendation for establishment of new industry	No.	-	11	-

Table 3.5: Key achievements of DDA in FY 2080/81				
Key activities	**Unit**	**Annual target**	**Achievement**	
			No.	**%**
Design approval of medicine industry	No.	-	16	-
Registration of new medicines (foreign)	No.	-	354	-
Registration of new foreign company	No.	-	17	-
Registration of new pharmacy	No.	-	2,418	-
Renewal of pharmacy	No.	-	13,846	-
Reactivation of pharmacy	No.	-	1,084	-
Renewal of pharmacy entrepreneurship card	No.	-	1,055	-
Cancellation of pharmacy	No.	-	1,245	-
Suspension of pharmacy	No.	-	301	-
Vaccine lot release	No.	-	25	-
Medicine recall	No.	-	27	-
Source: DDA records				

A shortage of human resources has been a major challenge for the effective operation of the DDA. Revision of the Drugs Act and Regulations, and alignment of the DDA's organizational structure with its federal functions are key for enhancing the DDA's operational effectiveness. Conducting an organizational and management (O&M) survey will provide valuable insights, and establishing the DDA and National Drugs Laboratory structures at the provincial level will further strengthen the system. The MoHP is advocating for an increase in human resources, and as a proactive measure, a temporary solution has been implemented to recruit staff under scholarship contracts, effectively responding to the growing demand for personnel.

With increasing recognition that out-of-pocket expenses for medicines significantly contribute to high OOP costs in Nepal, drug price adjustment presents an opportunity for the DDA to enhance its regulatory efforts. By responding to fluctuations in the international market with appropriate price adjustments, the DDA can enhance its effectiveness. A draft of the Fair Price Fixation Regulation 2080 has been prepared and is currently in the endorsement process with the ministry, paving the way for positive changes ahead.

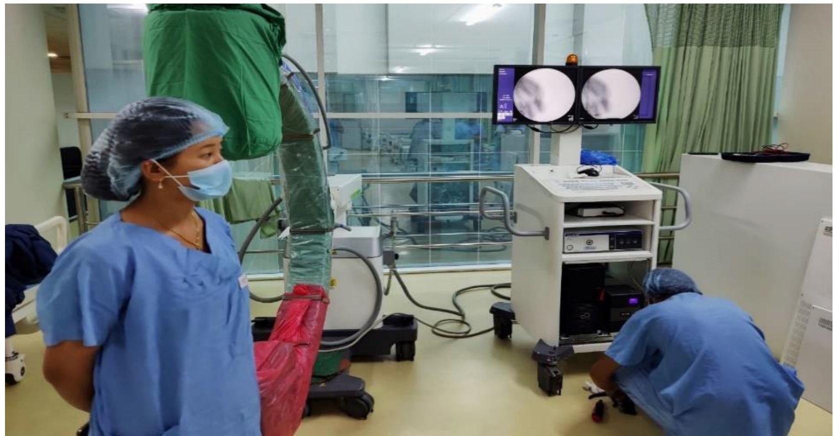
The DDA is working towards enhancing its capacity for the effective regulation of medical equipment. It has developed the 'Guidelines for Technological Medical Equipment, which is in the process of endorsement. To address the serious shortage of appropriate human resources for its effective implementation, the budget for FY 2081/82 has provisions for the regulation of technological medical equipment program.

The DDA is also overseeing the dispensing of medications according to prescriptions from authorized personnel through on-site visits and public awareness campaigns. However, a shortage of human resources has presented challenges for effective implementation. An integrated approach is needed to regulate prescribers, distributors, and pharmacists. Additionally, the DDA needs to regulate the supply of medicines through open borders, online pharmacies, advertisements, and clinical trials, ensuring close collaboration with stakeholders.

The MoHP plans to enhance Singhadurbar Baidhyakhana to produce at least 20 types of essential Ayurvedic medicines. At present, the hospital manufactures 13 types of these medicines. A development committee has been established to facilitate the production of additional medicines.

Collaboration with the National Innovation Center

Repair and maintenance of medical equipment at public hospitals is a serious concern. The MoHP has signed a memorandum of understanding (MoU) with the National Innovation Center, led by Dr. Mahabir Pun, to repair, maintain and operate medical equipment in federally run hospitals. Under this MoU, biomedical engineers from the Center have successfully completed maintenance of medical equipment at Bir Hospital in Kathmandu. Aiming to leverage local skills, optimize resources, and enhance efficiency, the MoHP plans to gradually repair unused medical equipment from other hospitals using domestic resources to provide effective services to the public. The MoHP looks forward to continued support from the Center and beyond in this initiative.



Biomedical engineers from National Innovation Center repairing medical equipment at Bir Hospital.
PC: National Innovation Center

At the federal level, Logistics Management Section within the Management Division, DoHS, is responsible for procurement and distribution of medicines, equipment and medical supplies. In FY 2080/81, Logistics Management Section carried out several initiatives to streamline the procurement and supply chain management of medicines and medical supplies across the country. Some of the key initiatives listed in the AWPB for FY 2080/81 include:

- Orientation at the federal and provincial levels on pre-shipment and post-delivery inspection related to the procurement of medicines, equipment, and medical supplies, as well as coordination meetings and follow-up on supply management with the provinces.
- Deployment of refrigerator technicians for on-site coaching to enhance preventive maintenance in the management of quality vaccines and cold chain systems.
- Capacity-building program on electronic vaccine management (EVM) for focal persons of health institutions that have received cold chain equipment.
- Technical assistance from USAID for the digitization process, including the management of old and new files related to procurement.
- Update of Specification Bank and File tracking system.
- Quality testing of tenders, advertisements, notices, and procured medicines and medical supplies.
- Periodic review of the DoHS, tender evaluations, preparation of the integrated annual procurement plan, and meetings of technical evaluation sub-committee, procurement plan monitoring committee, and other various meetings.
- Interaction with stakeholders (staff from Airport, Cargo handlers).
- Preparation of checklists for preventive maintenance of vaccines and cold rooms, along with coordinated discussions on vaccine supply chain management.
- Breakdown maintenance of cold chain equipment.
- Orientation on installation and management of temperature monitoring system.
- Revision, printing, and distribution of guidelines, procedures, and specifications related to cold chain management.
- Technical assistance for temperature monitoring studies and temperature mapping.
- Emergency management for vaccine handling and management at the airport and central vaccine store.
- Transportation of medicines, vaccines, and vaccine-related materials, tools and equipment, and family planning supplies from the federal level to the provincial and local levels, including packaging, repackaging, and loading and unloading activities.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Foster and expand domestic production of quality essential medicines, diagnostics, and biomedical equipment.
- Enhance the DDA to achieve Maturity Level 3, according to the WHO Global Bench Marking Tool for NRAs.
- Promote research and development of medicinal plants, minerals, and other raw materials for patenting, processing, and the production of Ayurvedic medicines and other products.
- Review and update regulatory provisions concerning the licensing, production, import, and export of pharmaceutical products and supplies.
- Regulate the pricing and monitor the pharmacovigilance of medicines and medicinal products to protect public health.
- Enhance the procurement system to ensure the quality of medicines and timely purchases.
- Standardize processes for quantification, forecasting, and procurement of medicines and supplies.
- Ensure a coordinated, timely, and demand-driven procurement and supply chain for quality assured medicines and medical products across all three levels.
- Expand and standardize cold chain and quality storage capacities at all levels for vaccines, medicines, and medical products.
- Maintain a regular buffer stock of medicines and supplies, along with effective storage and distribution practices at all levels.
- Strengthen the capacity for procurement and supply chain management using existing platforms such as e-GP, e-LMIS, e-CAPP, and TSB.
- Prioritize the procurement of standard domestic medicines, diagnostics, and health products.

3.1.5 Governance, leadership, and accountability

The NHSSP identifies governance, leadership, and accountability as essential for sustaining and expanding progress, as well as for implementing necessary reforms in the health sector. To achieve these, the NHSSP outlines four outputs:

Output 1: Governance and leadership performance improved at all levels
Output 2: Citizen engagement platforms enhanced and institutionalized
Output 3: Ethical health practice and rational use of services promoted
Output 4: Improved public financial management

There are well established legal frameworks and instruments like Acts, Regulations, Guidelines, and Standards to translate the policy and legal provisions into practice. To facilitate the effective implementation of the NHSSP, the MoHP has formulated the following Acts, Regulations, Guidelines and Workplans in the fiscal year 2080/81:

- Nepal Health Sector Strategic Plan (2079/80-2087/88)
- Nepal Health Financing Strategy 2080-2090 and the NHFS Implementation Plan
- Sixteenth Periodic Plan (2081/82-2085/86), including health sector plan
- 126 infectious diseases have been listed and 52 diseases prioritized for implementation of Public Health Service Act, 2075, Clause 49.
- National Cancer Prevention and Control Strategy, 2081
- Health Sector Gender Equality and Social Inclusion Strategy, 2080
- Guidelines for Infertility Management Services, 2080
- Guidelines for screening of uterine prolapse through HPV DNA method
- Basic Health Service Monitoring Framework 2080
- Revision of uterine prolapse prevention and treatment procedure
- Nepal Health Facility Registry Procedure, 2081
- Procedure for Nepal Health Workforce Management Information System (NHWMIS), 2081
- Dengue prevention and control workplan 2081
- Fistula roadmap, 2081
- Framework and Standard Operating Procedure for maternal mental health and intrapartum care, 2081
- Health National Adaptation Plan (2023-30)
- National Health Sector Guiding Framework on Early Childhood Development (2080)

Strengthening social accountability

Social accountability is a strategy for enhancing public accountability through citizen and non-state actor involvement. Social accountability in the health sector aims to improve health service quality, empower communities, strengthen governance, and achieve better health outcomes. The MoHP introduced social audits in 2009 as a tool to enhance service responsiveness, particularly for the poor, women, and marginalized populations. Social audits enable citizens to monitor health service quality and facility performance, fostering collaboration between community members and health staff to identify and address gaps. The process involves analyzing health records, assessing facility standards, evaluating resource allocation, and gathering user perceptions. Findings are presented to the Health Facility Operation and Management Committee (HFOMC) and health staff, leading to the development of an action plan. This plan is then validated and discussed in a public meeting, resulting in revisions. Progress is monitored through annual follow-up visits.

Social audits have been expanded to all 77 districts. The MoHP is collaborating with local governments for targeted efforts to strengthen their capacity to institutionalize social audits as a tool for fostering local accountability systems and laying the groundwork for strategic social accountability approaches. This includes integrating the social audit process into the planning and budgeting cycle, ensuring that the social audit action plan guides local resource allocation decisions, including human resources. Additionally, MoHP is linking the action plan to local supervision and monitoring processes to enable local governments to oversee and support the actions agreed upon through the social audit process.

Other initiatives

For strengthening a functional coordination mechanism among three levels of government to achieve broader health targets by promoting policy and program coherence, as outlined in the NHSSP, the MoHP reactivated the high-level Public Health Committee provisioned in the Public Health Service Act 2075.

The NHSSP emphasizes consumer education, monitoring the use of medicines and services, and regulating prescription and dispensing practices. Additionally, it focuses on promoting community involvement in planning, monitoring, and evaluation through various entities for enhancing accountability within the system.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

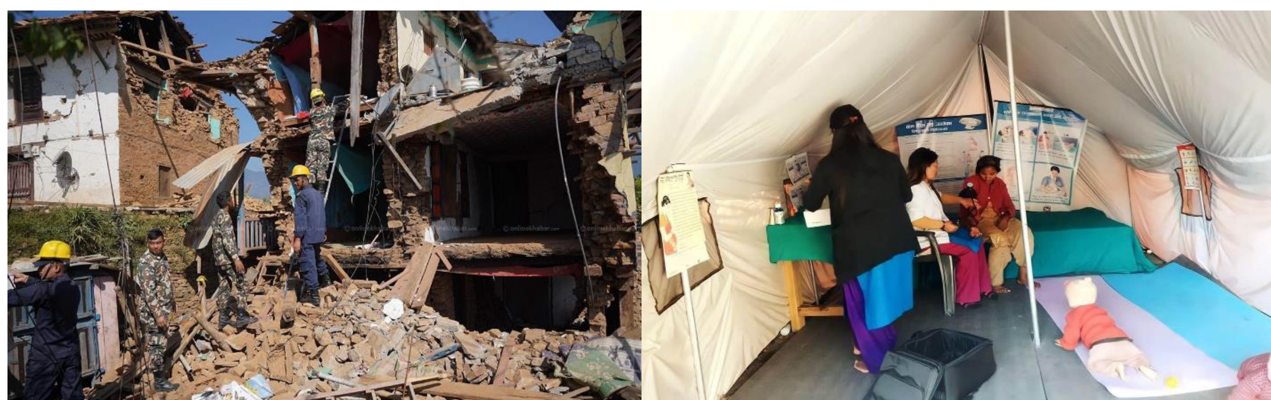
- Facilitate and regulate the process to guarantee minimum wages for health professionals employed in the private sector
- Institutionalize and functionalize social accountability mechanisms, such as social audits, public hearings, community scorecard etc.
- Disseminate information and data to the public through multiple platforms to promote transparency and informed decision making.
- Improve insurance literacy amongst citizens.
- Develop and implement clinical audit of diagnostic, curative services, and medicine with respect to its rational prescription, sale and referral.
- Strengthen ethical practices and the rational use of medicines, diagnostics, and services through Behavior Change Communication (BCC) and other strategies among health care workers and public.
- Develop standards for regulating information and advertisement about health services and products
- Strengthen public financial management practices by conducting periodic fiduciary risk assessment and addressing the gaps
- Enhance the absorptive capacity of the health system for timely execution of planned activities and budget
- Develop and implement the financial management improvement plan at all levels

3.1.6 Public health emergencies

Natural disasters and outbreaks of communicable diseases lead to a heightened demand for emergency health care services. The NHSSP acknowledges the urgent need to transform health structures and systems to enhance their resilience, ensuring a timely response during emergencies and the ability to meet increased health care demands while

maintaining essential health services. The NHSSP aims to effectively manage public health emergencies by focusing on two outputs: Output 1 emphasizes strengthening preparedness for such emergencies, while Output 2 targets timely and effective responses. To address these outputs, Health Emergency Operation Centers (HEOCs) are operational at the federal level and in each of the seven provinces. Rapid Response Teams (RRTs) have been established at the local level, and Medical Deployment Teams are available in selected hospitals. Epidemiology and Outbreak Management Section within EDCD works in close collaboration with the HEOC at the federal and provincial levels. Additionally, an Early Warning, Alert and Reporting System (EWARS) is functioning in all 77 districts to monitor and respond to disease outbreaks promptly.

On November 3, 2023, a 6.4 magnitude earthquake struck Jajarkot district in Karnali province, causing over 300 aftershocks, resulting in 154 deaths, around 1,000 injuries, and displacing more than 10,000 people, with damage to over 62,000 households. Despite the relatively low magnitude, weak infrastructure and the early hour of the quake exacerbated the destruction. In response, drawing lessons from the 2015 Gorkha earthquake, teams from the MoHP, along with local and provincial governments, were mobilized quickly to provide healthcare services. Coordination among federal, provincial and local authorities was established, enabling effective disease surveillance and communication on hygiene for displaced communities. Karnali province activated its incident command system, conducted timely disease surveillance, and communicated hygiene practices to displaced communities, preventing further fatalities and potential outbreaks. The Epidemiology and Disease Control Division (EDCD) led daily reporting of inpatient and outpatient cases, active syndromic surveillance, and stockpiling of essential medical supplies. Strengthened hospital networks facilitated



Jajarkot earthquake: Damage and the immediate health response

a referral system that reduced the need for patients to be transferred to provincial hospitals and tertiary facilities in Kathmandu. Lessons from the 2015 earthquake prompted early immunization campaigns to avert potential outbreaks. Municipalities supported hospitals, ensuring smooth health service delivery in temporary setups, and lab services remained operational. Support from health development partners, particularly WHO, was crucial in the response.

On February 20-21, 2024, the MoHP, with support from WHO, conducted a joint operational review of the response to the Jajarkot earthquake. This evaluation focused on leadership, coordination, emergency operations, and the continuity of health services. The review recognized key successes, including the swift deployment of response teams, prompt action from governments at all levels, effective health interventions that stabilized the overall health situation and prevented disease outbreaks in affected areas, and the resilience of healthcare workers in addressing the immediate health needs of the impacted population. However, it also identified logistical challenges, communication gaps, and resource strains as areas needing improvement. The review emphasized the importance of having a dedicated emergency budget and maintaining buffer stocks of medical supplies for future preparedness. The review enabled the MoHP to identify necessary actions and refine future preparedness plans through discussions.

Some of the key initiatives carried out in the FY 2080/81 include:

- Emergency responses were made to various alerts and outbreaks. This included case investigation and contact tracing of identified Mpox patients, and response to the earthquake in Jajarkot district and other notified outbreaks (Cholera, food poisoning, Respiratory illness in Mugu district). Verification of generated alerts has helped in

prevention and containment of different outbreaks. Media monitoring and Call center (1115) activities are ongoing for outbreak and public health detection.

- National Pandemic Preparedness and Response plan revised incorporating lessons learned from COVID-19 response and latest WHO guidelines.
- Mapping and risk categorization of health hazards conducted in Gandaki, Sudurpaschim and Koshi provinces with multi-sectoral involvement. This has helped in planning, prevention, and response to health hazards.
- ToT on Rapid Response Team (RRT) conducted at provincial level in Lumbini, Madhesh, Koshi and Bagmati using RRT training implementation package in fiscal year 2080/81. Provincial level facilitators were created with the aim to conduct subsequent training to rapid response teams at local levels.
- Risk Communication and Community Engagement (RCCE) orientation was conducted in Sudurpaschim, Karnali and Lumbini Province with the aim to sensitize local health workers and media personnel.
- Federal level Rapid Response Committees (RRC) meeting held to discuss current public health challenges and preparedness to detected outbreaks.
- Strengthened Nepal's resilient response in preparedness by end-to-end integration and expansion of integrated lab-based surveillance for wider respiratory pathogens i.e. influenza, SARS-CoV-2 and RSV
- Trained and certified 23 professionals in Infectious Substance Shippers Training (ISST), accredited by ICAO and IATA, significantly improving the safe handling and transportation of infectious substances, crucial to preventing cross-border disease spread and supporting coordinated global health responses.
- Bolstered laboratory capacity for detection of emerging and re-emerging pathogens:
  - Upgraded lab infrastructure with BSL Class III cabinet, thus strengthening biosafety measures.
  - Implemented a Biosafety Cabinet Certification and Basic Accreditation Program, certifying nine professionals to close critical gaps in biosafety standards, bolstering the country's capacity to maintain secure laboratory environments.
- National Essential In-vitro Diagnostic List (NEIDL) - endorsed in Feb-2024
- Nepal launched its National Essential In-vitro Diagnostics List and became the third country globally to do so, aiming to improve access to essential diagnostics nationwide.
- National Guideline on (1) Alert and response framework, and (2) Sample Collection and Transportation During Acute Public Health Events (awaiting endorsement)
- Workshops and Hands-on Training on the Hospital Safety Index Plus (HSI+) app for Hub and satellite Hospitals, Provincial Health Ministries, Health Directorates, and Partner Organizations. The workshops focused on application orientation and training for recording electronic data and digital management of Hospital Disaster Preparedness and Response Plans (HDPRP).
- Orientation program on health facility assessment using the Health Resources and Services Availability Monitoring System (HeRAMS) was conducted to monitor health service availability and resources at facilities, identify gaps, and design targeted interventions in response to the aftermath of the Jajarkot earthquake.
- Orientation program on data visualization was conducted successfully, assembling health officials, statistical officers, and medical recorders from across Gandaki Province. The program provided comprehensive training on data fundamentals, principles of effective epidemiological data visualization, and advanced analytical techniques for diverse datasets.
- Surveillance Outbreak Response Management and Analysis System (SORMAS) User Training was conducted for municipal health authorities and RRT focal persons in Gandaki and Sudurpashchim provinces to enhance outbreak management and improve data collection and analysis during adverse health events.
- The IHR-PVS National Bridging Workshop (global One Health flagship program) was held on 19-21 March 2024 with the importance of One Health approach in addressing emerging infectious diseases, zoonoses, AMR, food safety, and environmental health.
- A multidisciplinary workshop on "One Health" was held at Sudurpaschim Province on 29th and 30th May 2024 to foster collaboration among one health stakeholders to address emerging health threats. The workshop brought together over 45 diverse stakeholders from federal, provincial, and local level which included representatives from public health, animal health, environment, food and agriculture, academia, security forces and partners such as FAO and USAID.
- Dissemination of National Infection Prevention Control (IPC) guideline and orientation on IPC manual at 4 provinces – Gandaki, Lumbini, Karnali and Sudurpaschim Province.

- Three batches of 2-days training on Management of ARDS was conducted at Kathmandu, Biratnagar and Janakpur.
- Development, finalization and piloting of "Advanced Infection Prevention and Control Learning Resource Package" (32 participants)
- Two-days' workshop on "Infection Prevention and Control (IPC) Activities Evaluation – case Study" supported by WHO, Country Readiness Strengthening (CRS), Infection Prevention and Control (IPC) from the WHO HQ in collaboration with London School of Hygiene and Tropical Medicine (LHSTM).
- Capacity Building Workshop for Health Care Associated Infections Point Prevalence Survey Activity (15-17 August 2023)
- SoP for Healthcare Associated Infection (HAI) surveillance has been developed & piloted at two tertiary level hospitals
- National IPC strategy finalized (endorsement awaiting).
- Three temporary Rehabilitation Facility setup has been established in Karnali Province to ensure the continuity of post injury rehabilitation services post-earthquake in west Nepal.
- Cross-sectoral stakeholders' workshops was organized at provincial level in three provinces, Lumbini (28 July 2023), Karnali (28 August 2023) and Sudurpaschim (8 August 2023) to regularize and strengthen the cross-sectoral information sharing during disasters and public health emergencies.
- Cross Sectoral Stakeholders Tabletop exercise conducted in Lumbini - 3 June 2024 Karnali - 14 May 2024 and Sudurpashchim- 8 May 2024 to improve coordination for health response during disasters and public health emergencies.
- The Two-day (8 and 9 Oct 2023) "National workshop on collaboration (between public health, Nepal Army, Nepal Police and Armed Police Force) to strengthen health emergency preparedness" was held in Kathmandu under the chair of Additional Secretary Ministry of Health of Population, guardianship of Hon'ble Health Minister, MoHP, Secretary Ministry of Defense, Secretary Ministry of Agriculture and Livestock development, DG DOHS, Joint Secretary of Ministry of Home Affairs, Director General of medical services, Army Medical Core, Chief Nepal Police Hospital, Secretary of Provincial Government, Directors of Provincial Directorate, Directors of Hub Hospitals, Experts from all three security agencies, Experts from MoHP and DoHS.
- Development of HDPRP of satellite hospital through HSI+ application at Lumbini, Karnali and Sudurpaschim Provinces.
- Ambulance drivers training conducted in Lumbini (22 Sep 2023 - 23 Sep 2023) and Karnali Province (27 Sep 2023 - 30 Sep 2023). ToT Ambulance Driver Training conducted in Lumbini Province (21-23 Aug 2024).
- A "Health Cluster Training" was conducted from 14 to 18 August 2023, with participation from Division Chiefs of the MoHP, Directors of Provincial Health Directorates, Focal Points from Provincial Health Emergency Operations Centers (PHEOCs), as well as representatives from the Nepal Red Cross Society, UNICEF, and WHO. Organized by the MoHP with technical and financial support from WHO Nepal, the training featured experts from WHO HQ and WHO SEARO, marking the first-ever "Global Health Cluster Training" held at the national level.
- Six batches of Hospital Preparedness for Emergencies (HOPE) were conducted; 2 batch each in Lumbini, Karnali and Sudurpaschim province

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Develop a health emergency plan at both the national and provincial levels, regularly updating it and conducting periodic simulation exercises.
- Revise and enhance the hospital emergency preparedness and response plan, ensuring it is well-integrated with hospital safety, pre-hospital care, and post-hospital care.
- Improve the integrated public health surveillance system for the prediction, early detection, verification, and notification of diseases and potential public health threats.
- Build institutional capacity for managing disasters and public health emergencies.
- Strengthen the public health laboratory network, incorporating biosafety, biosecurity measures, and a quality assurance system.
- Operationalize and strengthen the hub and satellite hospital network, including an institutionalized referral system.
- Develop and endorse the National guideline on antimicrobial stewardship program for healthcare facilities in Nepal.

- Develop and endorse implementation manual (adaptation of WHO toolkit) for antimicrobial stewardship program in healthcare facilities.
- Develop learning resource package on AMR for healthcare professionals.
- Scale up laboratory capacity to perform culture sensitivity tests to 50 bed hospitals.
- Build institutional capacity of hospitals to implement antimicrobial stewardship program

3.2 Wider determinants of health

The goal of mitigating the adverse effects of broader social and economic determinants on health emphasizes the need for a multi-sectoral framework and collaboration within the health sector. These determinants include policy and legal factors, structural issues, health system elements, educational status, economic status, social and community influences, and individual factors. These are often aggravated by climate change and other environmental factors – in particular air quality, water and food quantity and quality, waste and sewage treatment and disposal. In Nepal, the impact of these determinants on the changing burden of disease is increasingly evident, with non-communicable diseases becoming the leading causes of premature death, along with rising fatalities from suicide and road traffic accidents. The NHSSP aims to address wider determinants of health through reducing adverse effects of wider determinants on health and encouraging citizens to be responsible for their own, family and community health.

3.2.1 Reduction of adverse effects of wider determinants on health

To mitigate the negative impacts of broader determinants on health, the NHSSP outlines two outputs: **Output 1** focuses on developing and reforming the institutional and policy frameworks related to these determinants, while **Output 2** emphasizes the establishment of institutional mechanisms to facilitate multi-sectoral collaboration. Some of the concrete efforts initiated to reduce adverse effects of wider determinants on health include, advocating for health in all policies, multi-sector nutrition plan, and multi-sector plan of action to prevent and control NCDs.

The Public Health Service Act 2018 envisions multi-sectoral Public Health Committee at the federal level, as an institutional arrangement to address wider determinants of health. The committee's primary role is to address the comprehensive social determinants of health that impact human well-being and to make policy recommendations for incorporating public health issues into policies and programs. The committee is led by minister for health and population, and the members comprise member of NPC; one person nominated by the GoN from among the Vice-chancellors of Academies of Health and Sciences; secretaries of ministries related to industries, finance, agriculture, drinking water and sanitation, home affairs, physical infrastructure and transport, women, children and elderly citizens, forest and environment, education, labor, employment and social security, and health. Other members include chief specialist of ministry of health, one chairperson nominated from among the councils related to health, one person nominated by the chairperson from among health experts, two persons including one woman nominated by the chairperson from among the directors of private health institutions, one person nominated by the chairperson from among the office bearers of the organizations/ institutions related to the consumers' welfare protection. The Chief of PPMD, MoHP serves as member secretary of the committee.

The MoHP activated the committee at the federal level by organizing its meeting on 2081/05/27. As the Act has provision for formation of sub-committees as necessary, the Committee has formed the following eight sub-committees, outlining their structures/composition, roles, and responsibilities:

1. Epidemic, Health Security, and Emergency Management Subcommittee
2. Mental Health, Substance Abuse, and Addiction Control Subcommittee
3. Nutrition, Food Security, and Poison Control Subcommittee
4. Climate Adaptation, Environment, Water Supply, and Sanitation Subcommittee
5. Road Accident Reduction and Pre-Hospital Management Subcommittee
6. Medicine and Technological Health Supplies Management Subcommittee
7. Medicinal Plant Development and Sustainable Use Subcommittee
8. Population, Labor Migration, and Health Subcommittee

The NHEICC has accomplished several initiatives like orientation sessions for journalists in Bagmati and Madhesh provinces emphasizing the importance of suicide prevention. Concurrently, district-level programs were held in Sudurpashchim and Bagmati provinces to raise awareness about the SAFER Initiative, aimed at regulating alcohol consumption. Efforts to combat tobacco-related issues included collaboration with government agencies to prohibit the import and use of e-cigarettes. A comprehensive training curriculum was developed for healthcare workers on Brief Tobacco Intervention, focusing on quitting tobacco and providing effective counseling and treatment. Additionally, orientation sessions were conducted for healthcare workers in seven metropolitan and sub-metropolitan cities to enhance their skills in implementing these interventions.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Continue to operationalize the multi-sectoral Public Health Committee and its federal sub-committees, while expanding collaborative mechanisms at provincial and local levels.
- Address the public health impacts of climate change by implementing relevant standards and adaptation plans.
- Integrate Gender Equality and Social Inclusion (GESI) concepts throughout the sector, including initiatives to prevent and respond to gender-based violence.
- Institutionalize the "One Health" approach and "Health in All Policies" by fostering collaboration across government and society.
- Implementation of Health National Adaptation Plan towards building climate resilient and sustainable low carbon health system.
- Finalization of the updated national drinking water quality surveillance guidelines and enhancement of surveillance activities at both national and sub-national levels.
- Promote health activities in health facilities, schools, workplaces, and other environments.
- Establish a system to assess and address the public health impacts of development projects, industries, and businesses.
- Collaborate with stakeholders to monitor and enhance standards for food, air, water, and housing.
- Advocacy program to improve the collection, transportation, treatment, and disposal of wastewater, solid waste, industrial waste, healthcare waste, and household waste for minimizing associated health risks.
- Regulate the use of insecticides and pesticides to minimize public health risks in partnership with relevant stakeholders

3.2.2 Citizens responsible for their own, family and community health

The NHSSP seeks to empower responsible citizens to take charge of their own health, as well as that of their families and communities, by encouraging them to adopt healthier lifestyle behaviors. The National Health Education, Information and Communication Centre (NHEICC) is the focal unit at federal level for raising health education in citizens. The Centre develops and disseminates various health awareness materials in different themes. In FY 2080/81, it produced health awareness materials in the following areas:

- Measles and Rubella vaccination campaign
- IPV vaccination campaign against Polio
- Cervical cancer screening and management
- Epidemic and disease prevention
- Vector-borne diseases
- Non-communicable diseases
- Postpartum family planning, safe motherhood, reproductive health, obstetric fistula, uterine prolapse
- Basic health and social security
- Impact of smoking and tobacco products on health
- Adolescent reproductive health
- Production of messages in various languages in local context, including disability-friendly content

Advocating for a mandatory health course in high school education

Education and health are deeply interconnected. Health education provides individuals with the knowledge and skills necessary to make informed health choices. Improved health not only boosts academic performance but also lays a

strong foundation for economic and social prosperity. Health literacy among citizens generally refers to the ability to access, process, and comprehend essential health information and services needed for informed decision-making. This includes skills such as understanding health-related materials, comprehending the constitutional rights related to health, effectively communicating with healthcare providers, and navigating the healthcare system. High levels of health literacy empower individuals to manage their health, interpret medical instructions, critically evaluate health information, and advocate for their own healthcare needs. A cross-sectional study involving 426 respondents with hypertension, diabetes mellitus, or chronic obstructive pulmonary disease from a tertiary care hospital and primary care clinics revealed that 19% had marginal health literacy, while 54% demonstrated inadequate health literacy[19]. Health literacy, therefore, has a pivotal role in prevention of diseases and health hazards, adherence to treatment, self-care, and better use of health care.

The Constitution of Nepal recognizes education and health as fundamental rights, guaranteeing compulsory free education up to grade 8 and free education through grade 12, as well as access to free basic health services and emergency care. These constitutional provisions suggest that incorporating a mandatory health course into the high school curriculum is a cost-effective way to improve health literacy among students, who can then serve as change agents in their communities. However, health education is currently offered as an optional subject in high schools. A review by the NHEICC found that the health content in the mandatory "Social Studies and Life Skills Education" course is insufficient, with only 12% of grade 10 students and 16% of grade 12 students choosing health as an elective in 2078. The National Population and Housing Census 2021 revealed that only 4.4% of the population aged 15 and older had completed 10+2 education focused on health or medical studies. These statistics indicate a significant gap in basic health literacy among students and the wider population. To address this issue, the Government of Nepal's 16th Periodic Plan has proposed a strategic initiative to introduce a mandatory health course in high school education, in collaboration with stakeholders in the education sector.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Promote social and behavioral change communication to encourage healthy lifestyles, self-care, and the use of essential services.
- Raise awareness and strengthen regulatory measures to control tobacco use, substance abuse, and the harmful consumption of alcohol.
- Implement healthy cities initiatives by designating ample public spaces for recreational and healthy activities, including parks, jogging paths, cycling lanes, and community fitness centers for yoga and other exercises.
- Design and implement targeted interventions to combat harmful social and cultural practices, such as Chhaupadi, and early or adolescent marriage and pregnancy.
- Establish a behavioral risk factor surveillance system to gather evidence on health risk behaviors and promote preventive health practices.
- Maintain collaboration with education sector stakeholders to ensure mandatory health education in school curricula, support initiatives like "one school, one health worker," and promote healthy schools through yoga and meditation programs.
- Institutionalize a system for ensuring compliance with and regulation of public health standards.

3.3 Sustainable financing and social protection in health

The NHSSP aims to develop stronger and more comprehensive strategic interventions to boost public investment in the health sector and reduce the financial burden of accessing healthcare services. To achieve this through improvement in public investment and social protection in health sector.

[19] Abha Shrestha, et.al., Health Literacy and Knowledge of Chronic Diseases in Nepal

3.3.1 Public investment in health sector

Increased public investment and the institutionalization of alternative funding mechanisms are crucial for advancing universal health coverage. With low public financing, individuals face high out-of-pocket (OOP) expenses for health services. As Nepal graduates from LDC status, available grants for the health sector may decline, making it harder to secure adequate funding. For public investment in health sector, the NHSSP outlines two outputs: Output 1 emphasizes on increasing domestic financing and efficiency, and Output 2 focuses on improving management of development cooperation in health sector.

It is estimated that a minimum investment of US$ 86 per capita is necessary to ensure access to priority health services in resource poor countries[20]. However, in Nepal, the per capita public investment from domestic sources in health is only US$17.3[21] in the FY 2019/20. To address this gap, the MoHP has developed a comprehensive National Health Financing Strategy, 2023-2030, aimed at mobilizing adequate funds for the health sector. Recently, the MoHP developed and approved the NHFS implementation plan to translate the strategy's working policies into time-bound activities, monitor and evaluate their execution, and ensure their incorporation into annual budgets and programs based on cost estimates. The NHSSP emphasizes increasing public investments, enhancing resource mobilization from other sources, and pooling resources for better financial protection in health (Results based management). While the health sector has gained priority at policy level, the allocated budget remains largely insufficient to tackle the growing health challenges.

A trend analysis of national budget and health budget reveals that the volume of the health sector budget has increased more than five-folds, from NPR 23.8 billion in FY 2011/12 to NPR 122.8 billion in FY 2021/22 and declined to 86 billion in 2023/24. Up to FY 2019/20, the share of the health sector against the national budget remained slightly below or above 5%, had peaked at 7.5% in 2021/22, during response to COVID-19, and has come down to less than 5% (4.9%) in 2022/23, and even lower (4.7%) in 2024/25 (Figure 3.3).

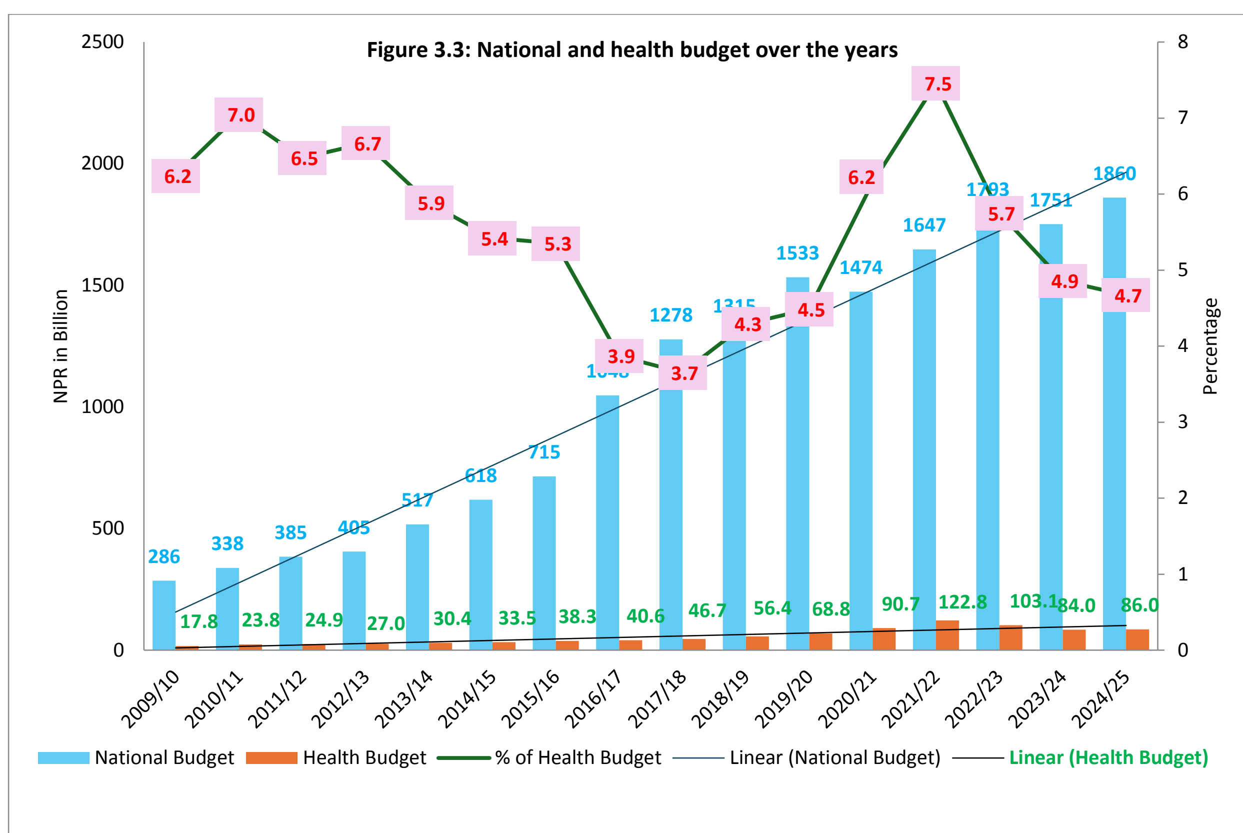
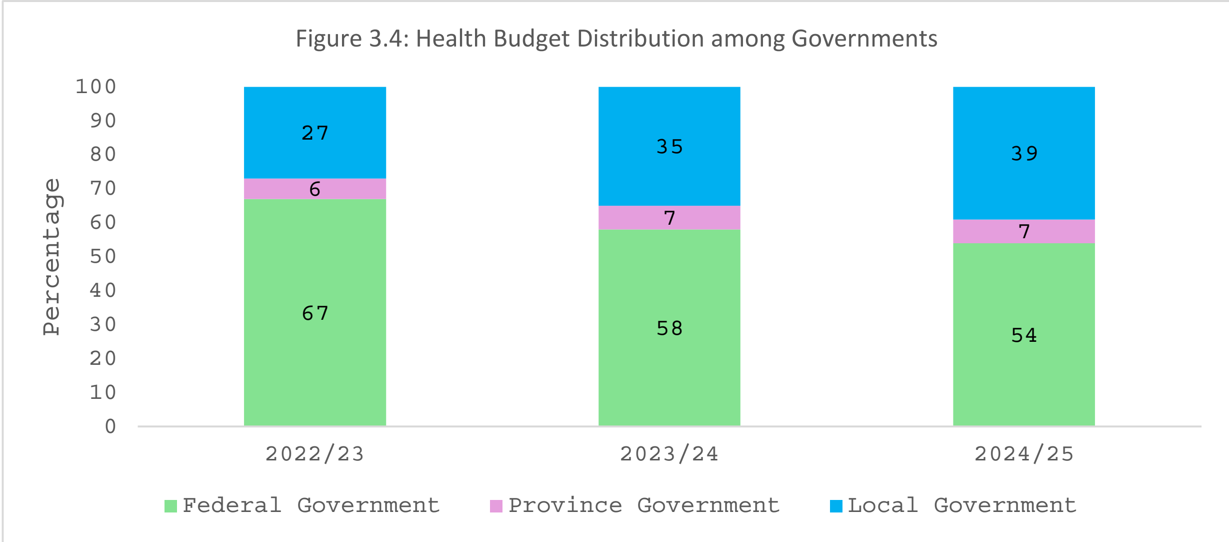


Figure 3.3: National and health budget over the years

[20] Trygve Ottersen, et.al., Towards a coherent global framework for health financing: Recommendations and recent developments, Health Economics, Policy and Law (23 March 2017)

[21] MoHP, Nepal National Health Accounts, Government of Nepal, MoHP (2077)

In recent years, provincial and local governments have been receiving an increasing portion of the health sector budget. While the federal MoHP has historically accounted for the largest share, this share has been declining over time. An analysis of the budget from the last three years shows a decrease in the federal MoHP's allocation, dropping from 67% in 2022 to 58% in 2023/24, and 54% in 2024/25 (Figure 3.4). Likewise, the budget share for local governments has risen from 27% in 2022/23 to 39% in 2024/25, and the share for provincial governments has increased from 6% in 2022/23 to 7% in 2024/25.



Enhancing collaboration and health representation in legal and policy forums

Recognizing the critical need for a shared understanding among lawmakers and policymakers across all three spheres of government regarding sustainable financing and social protection, the MoHP and its entities have actively engaged in advocacy meetings. These efforts aim to effectively translate the constitutional mandate of providing free basic health services to citizens and achieving universal health coverage. To achieve this, senior officials from the MoHP, led by the minister, have engaged in discussions with federal parliamentary sub-committees, as well as with political and bureaucratic leaders from provincial and local governments. Program divisions and centers have also held advocacy meetings with provincial and local authorities on a range of issues. These initiatives also included orientation on specific issues like Brief Tobacco Interventions, and safe motherhood initiatives.

The Federal, Provincial, and Local Level (Coordination and Interrelationships) Act, 2077, establishes distinct mechanisms to institutionalize the relationships between three levels of government and to address any potential differences that may arise. In accordance with the Act, the MoHP held its first joint meeting on 6th Bhadra 2081, bringing together health ministers from all seven provinces along with local government representatives. The aim of this meeting was to enhance inter-governmental collaboration and eliminate redundancy in health planning and programming. The meeting concluded with the following decisions:

Federal, Provincial and local level (Coordination and Interrelationship) Act, 2020 health subjective committee meeting

- Collaborate to eliminate redundancy in plans and programs
- Identify tier-specific issues and formulate plans to address them
- Collaborate to manage healthcare personnel, including doctors
- Conduct O&M surveys of 5, 10, and 15-bed hospitals that have completed their physical infrastructure but are not yet operational
- Implement integrated rapid response measures for controlling cholera and dengue outbreaks
- Collaborate for the prevention and control of non-communicable diseases
- Implement social health security programs in an integrated manner.

Other such initiatives include:

- The MoHP team, led by the Hon Minister, engaged in discussions with the Education and Health Committee of the House of Representatives.
- Family Welfare Division of the DoHS conducted an advocacy meeting with the honorable members of this committee to address key health and education issues.
- Curative Service Division, DoHS held policy dialogue with the elected leaders of local governments and journalists in Dhangadi, Kailali, Sudurpaschim province.
- National Dialogue on Health Sector in Nepal organized as the joint venture of Ministry of Health and Population, National Planning Commission, and WHO
- Policy Dialogue on Universal Health Coverage in Provinces organized in all seven provinces on role of provinces for effective delivery of basic health services and emergency health services with efficient investment.
- Interaction program with province, local government and stakeholders of Lumbini, Karnali and Sudurpachhim provinces to discuss on drug regulatory systems, specific issues around AMR, rational use of medicines, pharmacovigilance and improving access to quality medicines.
- Workshop for collaboration between public health and security agencies for strengthening health emergencies preparedness.

Development cooperation in health sector

Since its introduction in 2004, the sector-wide approach (SWAp) in Nepal's health sector has been essential in aligning foreign aid with government policies and objectives. Financial assistance (FA) has been the main aid modality within the SWAp, supported by a balanced provision of technical assistance (TA), which represents a significant portion of foreign funding for health. The Foreign Aid Policy 2002 emphasizes the importance of TA in building domestic institutional capacity, transferring expertise, and utilizing human resources effectively, while discouraging loans for TA. This assistance has evolved contextually and expanded to sub-national levels to align with federal structures. The NHSSP incorporates the sector-wide approach (SWAp) as a key partnership model, ensuring joint accountability for both the government and development partners in implementing and assessing the NHSSP.

In January 2024, the GoN and HDPs agreed to the Joint Financing Arrangement (JFA), 2023, to support the implementation of the NHSSP 2023-2030. The JFA involves partner signatories, including both pooling partners, who collectively contribute to a pooled fund, and non-pooling partners, who earmark their contributions for specific components of the NHSSP, such as technical support and on-budget or off-budget contributions. The JFA signatories, which comprise the GoN and the partner signatories, have agreed to 63 action points. The JFA signatories include Ministry of Finance (MoF), MoHP, and Ministry of Federal Affairs and General Administration (MoFAGA) from GoN (Table 3.6). Pooling partners consist of the Foreign Commonwealth and Development Office (FCDO)/British Embassy Kathmandu, GAVI, the Vaccine Alliance, United Nations Population Fund (UNFPA), World Bank (WB), and Asian Development Bank (ADB). Non-pooling partners include the United States Agency for International Development (USAID), German Development Cooperation/The Deutsche Gessellschaft fur Inaternationale Zusammenarbeit (GIZ), German Development Cooperation (GDC/KFW), Korea International Cooperation Agency (KOICA), Japan International Cooperation Agency (JICA), United Nations Children Fund (UNICEF), World Health Organization (WHO), International Office of Migration (IoM) and UNAIDS (Table 3.6).

Table 3.6: Joint Financing Arrangement (JFA) 2023 Signatories

Government of Nepal	N	
	Pooling partners	Non-pooling partners
Ministry of Finance (MoF)	FCDO	USAID
	Gavi, the Vaccine alliance	GDC/KfW
Ministry of Health and Population (MoHP)	UNFPA	GDC/GIZ
	WB	KOICA
Ministry of Federal Affairs and General Administration (MoFAGA)	ADB	JICA
		UNICEF
		WHO
		IOM
		UNAIDS

Recognizing the need to harmonize various forms of technical assistance (TA) in the health sector, the JFA 2023 seeks to collaboratively establish a framework for providing pooled, need-based TA to effectively implement the NHSSP across all three levels of government. The MoHP has developed a TA framework aimed at enhancing the capacity and resilience of national health systems to effectively implement the NHSSP and address both current and emerging health challenges. This framework, shaped by insights gained from two decades of TA mobilization within the SWAp and refined through extensive consultations with government entities and health development partners, is a strategic and adaptable document designed to respond to evolving needs.

GoN and HDP share in health budget

From FY 2015/16 to FY 2019/20, HDPs contributed between 20% and 28% to the GoN's budget (Figure 3.5). In FY 2020/21, the contribution jumped to 63%, mainly in response to COVID-19. However, this share subsequently fell to 54% the following year, and further decreased to 29% in FY 2023/24 and 28% in FY 2024/25.

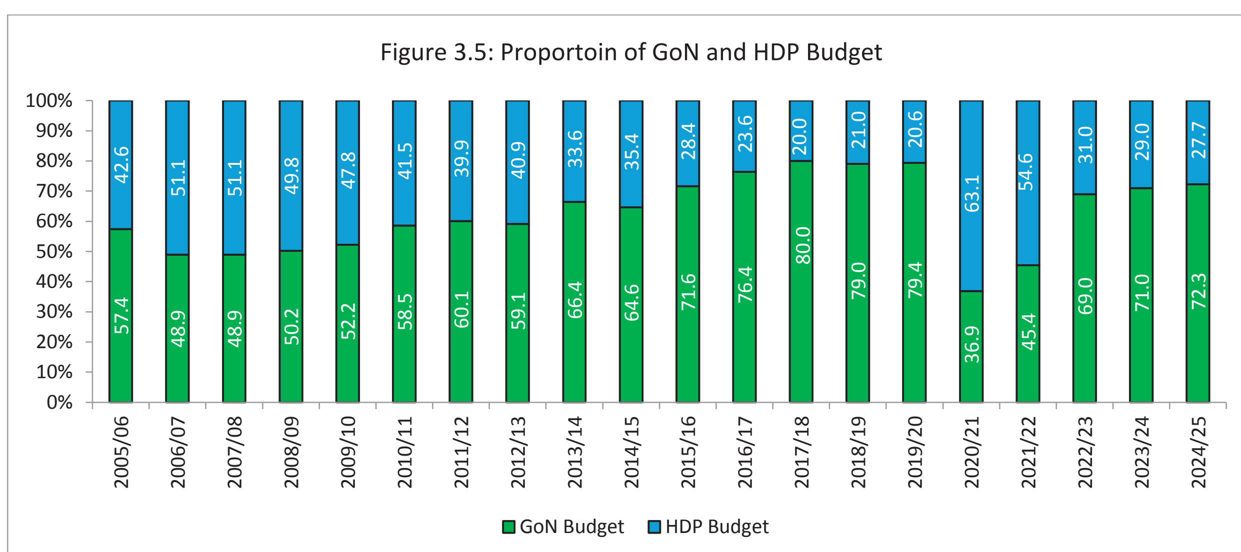
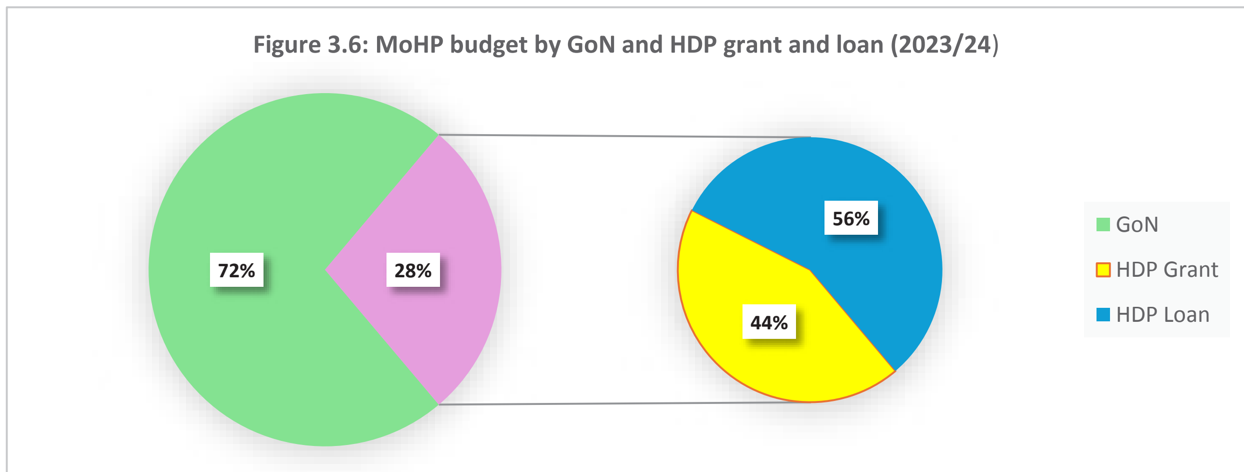


Figure 3.5: Proportoin of GoN and HDP Budget

In FY 2023/24, the distribution of HDP budgetary support to the GoN indicated that 56% of the total support came in the form of loans, with the remaining 44% provided as grants (Figure 3.6).

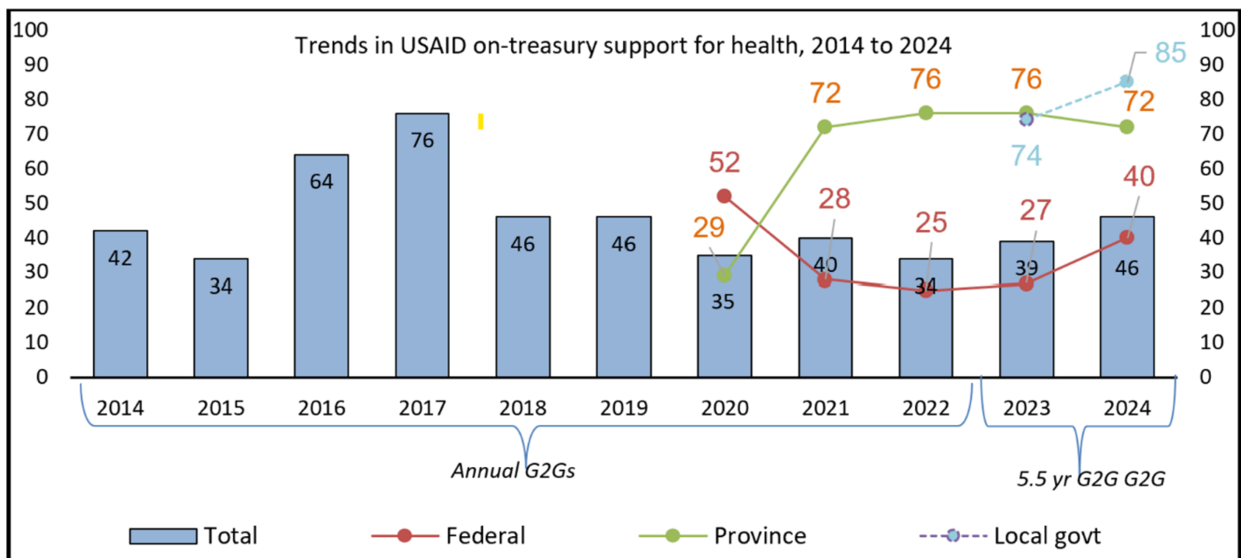


Some HDP initiatives

USADI: Government-to-Government (G2G) support to increase access to quality health services

USAID's Health Direct Financing Project -- G2G support -- is a 5.5-year (March 2023 to October 2028) US$ 25 million agreement between the GoN and the USAID. The MoHP and USAID co-designed the project with the Karnali Province Ministry of Social Development (MoSD), and three local governments of Karnali Province: Gurans, Birendranagar, and Bheri Ganga municipalities, with a goal to improve health outcomes by increasing access to and quality of health services and strengthening health systems capacity for equitable, accountable, and resilient health services. Through G2G, USAID has been providing "on-budget" "on-treasury" support to the MoHP since the 1990s. At present, cost reimbursement modality is used. In FY 2023 and FY 2024, the G2G budget was US$ 4 million, and US$ 4.75 million respectively, and the absorption rate has been 39% and 46% in aggregate. Absorption rate at the sub-national level has been significantly higher.

Figure 3.7: Trends in USAID on-treasury support for health, 2014 to 2024.



Health G2G support has demonstrated the true spirit of federalism particularly by strengthening the capacity of local governments and facilitating coordination among the three tiers of the government. Health G2G has gained popularity in the three target municipalities because it gives them a leading role in designing, planning, and executing health initiatives according to local needs. The target municipalities used an evidence-based seven-step planning process for developing G2G activities. Providing direct funding to the municipalities is found very effective in targeting and tailoring interventions to the hard-to-reach populations. It has contributed to increasing access and improving the quality of health services.

G2G Innovative approaches in FY 2080/81: "Hello Pregnant Mother" telephone program of Birendranagar Municipality aims to improve regular antenatal checkups, blood tests, video x-rays, urine and other necessary tests, vaccinations, nutrition and hygiene, pregnancy danger signs, birth preparedness, and other health services to pregnant women and mothers. Health workers' phone reminders helped improve antenatal service coverage, increase institutional births, and improve growth monitoring for children. The rural ultrasonogram (RUSG) service for pregnant women is expanded through G2G funds in all three municipalities targeting the hard-to-reach areas. Support included buying new RUSG equipment, training health workers for using the equipment, managing proper transport, and mobilizing the trained medical officers in the field, which has significantly improved the service quality. In Gurans out-reach services are provided to Raute, the nomadic tribes of Nepal. 137 (75 women and 62 men) Rautes are living in Gurans, who do not come to health facilities for health services. Community-based services are strengthened. For example, Bheri Ganga Municipality creatively mobilizes community nurses and school nurses to reach more children and adolescents for health education, physical examinations, and referral services.

Health G2G has enabled the municipalities and the MoSD to plan, budget, and organize different training for health workers and the municipality health team, which otherwise would have been difficult to manage from the regular GoN funds. G2G through co-creation, program review meeting and joint field trips has provided unique platforms for the three tiers of government to come together to plan, discuss, and manage resources, which has helped deep-dive analysis of the local context and develop need-based programs for the municipalities. G2G support has contributed to strengthening their institutions and delivery. They see this support as a strong foundation for strengthening federalism in the health sector. G2G support has contributed to improving the information management system at the municipal level (e.g. Health Dashboard in Birendranagar municipality), helping evidence-based decision making and more targeted health programming. Through G2G, the municipalities have also conducted social audits for accountability and good governance practices.

G2G will be expanded to seven new municipalities: Khatyad Rural Municipality (Mugu), Tatopani Rural Municipality (Jumla), Pachal Jharana Rural Municipality (Kalikot), Aathbis Municipality (Dailekh), Nalagad Municipality (Jajarkot), Sani Bheri Rural Municipality (Rukum West), Siddha Kumakh Rural Municipality (Salyan) and in Gandaki Province Ministry of Health in FY 2082/83.

World Health Organization

In 2023, the WHO has formulated a Country Cooperation Strategy (CCS) to support the GoN in implementation of NHSSP. Nepal-WHO Country Office. The Nepal–WHO Country Cooperation Strategy (CCS) 2023–2027, in alignment with the NHSSP 2023-2030, focuses on the four strategic priorities :

- Strengthening the federal health system by focusing on primary care and capacity-building to achieve universal health coverage and serve vulnerable populations.
- Enhancing national capacity to manage health security threats through an all-hazard approach and resilient health systems at all levels.
- Leveraging data, research, and digital technologies to inform health planning, innovation, and service delivery monitoring.
- Improving health outcomes by addressing determinants through multisectoral collaboration and effective partnerships.

For successful implementation of the CCS, WHO has committed to providing quality technical assistance tailored to the local context. Priority interventions will focus on enhancing primary health care as a cornerstone for achieving universal health coverage, addressing broader health determinants, enhancing institutional capacity for managing health emergencies while prioritizing gender equity and human rights in all technical support.[22]

[22] Country Cooperation Strategy 2023–2027: Nepal. New Delhi: World Health Organization, Regional Office for South-East Asia; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Foreign Commonwealth and Development Office (FCDO), British Embassy Kathmandu

The UK Foreign, Commonwealth & Development Office (FCDO), supporting the portfolio of the British Embassy Kathmandu (BEK) in Nepal through the Nepal Health Sector Program III (NHSP3), has been delivering support for eight years (July 2016 through December 2024) for the implementation of the Nepal Health Sector Strategic Plans, 2015/16-2022/23 and 2023/24-2030/31. This includes bespoke support for the retrofitting and rehabilitation of two public hospitals in areas affected by the 2015 earthquake and at risk of future earthquakes. Over the next seven years, BEK will support a new initiative, Samartha ('Empowered'): Enhancing gender and human development outcomes through systems strengthening, which aims to assist local, provincial, and federal governments in translating constitutional mandates into people-centered policies and service delivery; improve the allocation and use of intergovernmental transfers to expand and enhance the delivery of essential social services; and increase accountability and citizen participation, particularly among women and marginalized groups, in the planning and oversight of social services.

German Development Cooperation/The Deutsche Gessellschaft fur Inaternationale Zusammenarbeit (GIZ)

The German Development Cooperation/The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), through its Support to the Health Sector Strategy (S2HSS) from 2021 to 2024, has been assisting the Ministry of Health and Population (MoHP) in the following areas:

- Social health protection: improving core processes of the Health Insurance Board (HIB) and the Social Security Fund (SSF)
- Subnational health management: strengthening health management capacities of subnational governments in five municipalities (Bidur, Nilkantha, Nepalgunj, Dhangadi and Godawari) and Sudurpaschhim Province, and improving healthcare waste management and infection prevention & hygiene in 13 hospitals
- Integrated health information systems: improving access to digital data and information for health sector management and improving the interoperability of various systems.
- Reproductive health: institutionalization of selected approaches for the improvement of reproductive health services, which includes institutionalizing midwifery profession, training of birth attendants and menstrual health services

World Bank

The World Bank has been supporting Nepal in its endeavor to reform the health sector for the past several decades. The COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSP) aimed to prevent, detect and respond to the threat posed by COVID-19 and to strengthen national systems for public health preparedness in Nepal became effective in April 2020 and successfully closed in July 2024. The US$122 million CERHSP project has contributed robustly to Nepal's strategy for testing, tracing and treatment of COVID-19 cases throughout the pandemic with support towards (1) Supplies: Timely procurement and deployment of RT-PCR and Antigen RDT kits, viral transport media, PPE, consumables, ICU beds, equipment and drugs, oxygen concentrators and generation plants, etc. (2) Vaccines: Four million doses of Moderna vaccines procured under the COVAX cost share option were supplied to Nepal and deployed for adolescent populations 12-17 years of age. Reimbursement of US$8 million equivalent for domestically procured Covishield vaccines. (3) Health Care Waste Management: Procurement and deployment of 200 autoclaves at Primary Healthcare Centers, and Provincial level hospitals based on demand. Includes procurement and distribution of needle cutters, trolleys for transportation of waste and puncture proof bins were also procured and distributed. (4) Community Engagement and Risk Communication through strengthening of call centers.

Recognizing the importance of tackling the second-generation challenges in Nepal's healthcare sector, an additional US$103.84 million for the Nepal Quality Health Systems Program (NQHSP) is effective since January 2024 and will run until July 2028. Through a US$100 million IDA Credit and a US$3.84 million Health Emergency Preparedness and Response grant, the NQHSP will support three critical reform agendas envisaged by the GoN/MoHP on its journey toward Universal Health Coverage: (i) improving readiness of healthcare delivery system and quality of care, (ii) improving health insurance coverage and effectiveness, and (iii) enhancing health emergency preparedness and response capacity. The NHQSP is a result-based financing and is being implemented in Federal Level, Koshi and Gandaki Provinces and

Local Levels therein.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Strengthen the mechanism for resource allocation based on performance and need (adopt results-based management).
- Monitor health sector expenditures through budget analysis, Public Expenditure Tracking, and National Health Accounts (NHA).
- Implement the TA framework effectively, ensuring periodic reviews to adapt to changing context.
- Align the technical and financial assistance provided by all partners, including I/NGOs, with the NHSSP, and promote partner harmonization.
- Update information on health programs implemented with financial and technical support from development partners and I/NGOs, while continuing periodic reviews.

3.3.2 Social protection in health

Recognizing the significant out-of-pocket (OOP) expenses associated with accessing healthcare, the NHSSP has prioritized addressing financial hardships by providing social protection to citizens. It emphasizes on harmonizing the existing fragmented social health financing schemes. The NHSSP aspires to achieve this through three outputs:

Output 1: Free basic health services ensured in urban and rural settings,

Output 2: Reformed health insurance system, and

Output 3: Streamlined social health protection schemes

Basic health services

Basic Health Services (BHS) represents a minimum set of healthcare services that the government commits to providing free of charge to all citizens, irrespective of their demographic, geographic, or socioeconomic background. By making free BHS more accessible to communities, the national health system aims to achieve UHC and meet health-related Sustainable Development Goals. With funding and technical support from federal and provincial governments, delivery of BHS is an exclusive function of local governments. There are legal and policy frameworks, programmatic guidelines, and institutional mechanisms in place to translate constitutional mandates into actions. A further analysis of NHFS 2021 and NDHS 2022 data reveals that the availability of BHS varies among different tiers of designated health facilities, with federal and provincial facilities providing more services than local ones and the services have not been fully implemented both on supply and demand sides[23]. While there are opportunities for improvement in health facility readiness, with ongoing efforts to enhance basic amenities, equipment, infection control items, medicines, and human resources, the quality of care is being positively addressed. Some individuals may still need to make out-of-pocket payments to access BHS at public and private facilities. There is a structured framework for the free distribution of 98 types of medicines for BHS, and efforts continue to ensure that more public facilities can provide this complete list. Further analysis revealed that less than one percent of facilities reported having all 20 tracer drugs available, highlighting a significant opportunity for growth and improvement.

The BHS standard treatment protocol has been developed and rolled out across the country. To facilitate the effective implementation, BHS operational guidelines has been developed. The Basic and Emergency Service Management Section of the Curative Service Division (CSD) within DoHS has been proactively monitoring and supporting the implementation of Basic Health Services (BHS) at the local level. This year, the CSD organized an interactive program with journalists to discuss basic and emergency health services, which has effectively informed them about the legal, policy, institutional, and practical aspects of BHS, enabling them to communicate this information to a wider audience. Additionally, 26 health facilities were assessed to evaluate the availability and utilization of basic and emergency health services, including the 98 free medicines.

[23] Poudel, P., R. Khatri, L. Bhatt, P. Thapa, R. K. Mishra, S. Tuladhar, and E. Panahi. 2024. Baseline Status of Basic Health Service Delivery, 2022 Nepal DHS and 2021 Nepal HFS. DHS Further Analysis Reports No. 157. Rockville, Maryland, USA: ICF; and Kathmandu, Nepal: MoHP.

A monitoring framework for BHS has been developed and endorsed. It is essential to expedite its implementation as detailed in the framework. This year, a national level discussion program was held on 'the status and prospects of BHS' featuring a wide range of stakeholders from both federal and provincial levels. Curative Service Division has also prepared technical specification of 98 BHS free medicines which is in the process of endorsement.

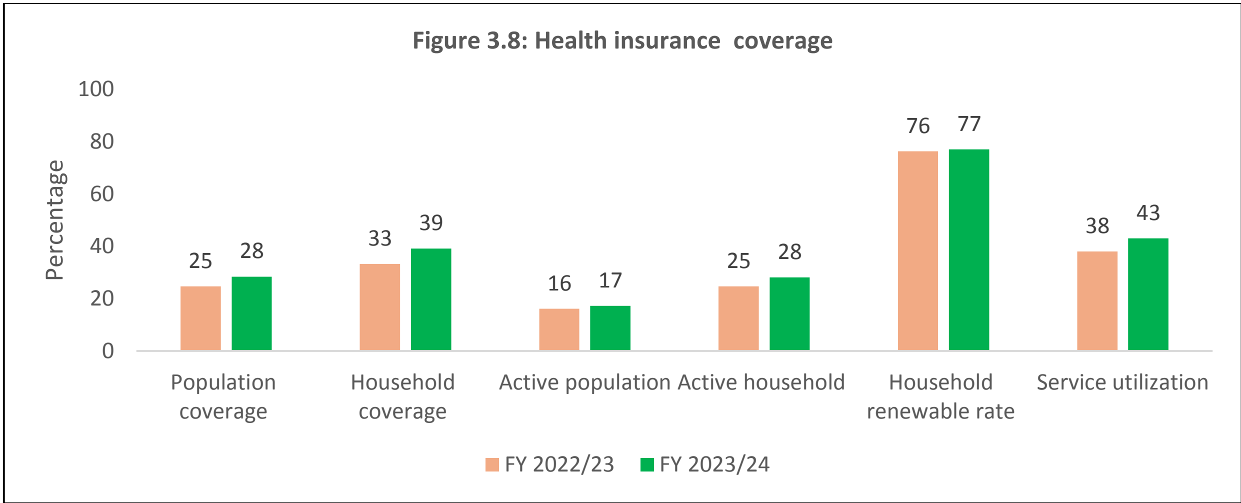
Orientation sessions on standard treatment protocols for Basic Health Services and emergency health services were conducted for healthcare workers across the provinces. Additionally, policy dialogues on basic health services for universal health coverage took place in Sudurpaschim province and at the national level, involving a diverse range of stakeholders to enhance effective and efficient service delivery and investment.

Health insurance system

The national health insurance is an effective mechanism to facilitate achieving SDG by 2030. The Health Insurance Board (HIB) is the purchaser of health services, and health facilities under the MoHP are the providers. Despite having the legal, policy and institutional framework in place the national health insurance program (NHIP) faces challenges of low enrollment and high dropout rates, hindering progress towards this goal. There are provincial, geographical and socio-economic variances in enrollment to the health insurance program. Evidence demonstrates a positive association between health insurance and healthcare utilization, with insured individuals exhibiting a higher likelihood of visiting health facilities and reporting fewer access-related issues. People with higher levels of education and greater wealth were significantly more likely to enroll in health insurance than those with basic education and middle-level wealth, respectively[24]. Beneficiaries encountered issues with compromised quality of care or a lack of services when needed, leading to high drop-out rates and reduced interest in renewing their premiums[25].

The health insurance program is currently functioning across all 77 districts of Nepal, encompassing all 753 local levels. Population coverage has risen from 25% in FY 2022/23 to 28% in FY 2023/24, while household coverage has grown from 33% to 39% during the same period (Figure 3.8). There has been a slight increase in both the active population and active households over the last fiscal year. The household renewal rate has also seen a modest rise, from 76% in FY 2022/23 to 77% in FY 2023/24. Notably, service utilization has improved from 38% in FY 2022/23 to 43% in FY 2023/24. This year, the Health Insurance Board (HIB) introduced a cost-sharing model, requiring insured individuals—except for certain targeted groups—to pay 10% of the total cost in government health facilities and 20 % in private health facilities.

Figure 3.8: Health insurance coverage



The Health Insurance Strategic Roadmap (HISR) was developed and endorsed with the aim of providing health insurance for all to enhance citizens' health status. The HISR's objectives focus on strengthening governance, increasing citizen participation, enhancing financial protection, fostering sustainable partnerships, and improving demand management, information systems, and monitoring mechanisms.

[24] Acharya D, Sharma S, Bietsch K (2024) Enrollment and associated factors of the national health insurance program of Nepal: Further analysis of the Nepal Demographic and Health Survey 2022. PLoS ONE 19(10): e0310324. https:// doi.org/10.1371/journal.pone.0310324

[25] Geha N. Khanal1†, Bishal Bharadwaj2,3, Nijan Upadhyay4, Tulasi Bhattarai3, Minakshi Dahal5 and Resham B. Khatri (2023) Evaluation of the National Health Insurance Program of Nepal: are political promises translated into actions? Health Research Policy and Systems. (2023) 21:7. https://doi.org/10.1186/s12961-022-00952-w

In addition to BHS and HI, various financing schemes are available, such as safe motherhood incentives, free newborn care, vertical disease control programs, social security provisions, chronic disease support programs, free hospital beds, One-Stop Crisis Management Centers (OCMC), geriatric care, and cardiac care, among others. Streamlining and ultimately merging these social health protection schemes would enhance user experience and support the national goal of achieving UHC. For this, there is an urgent need to identify the barriers that prevent households from participating in the health insurance program to enhance its usage.

Digitalizing claims and reimbursement processes, endorsing the HIB's organizational structure, recruiting staff, and developing a robust information management system can enhance program efficiency. Additionally, expanding benefit packages and establishing tripartite agreements for health facility accreditation would improve service delivery and ensure high-quality healthcare. Additionally, the provision of compulsory enrolment in the program, whether working in formal or informal sectors, and health services beyond BHS packages could balance the demand and supply of services, including trust building between providers and patients. Implementing school-based and community-based awareness campaigns could effectively educate the public, fostering better understanding, participation, and renewal of insurance coverage. Areas with high non-enrollment rates should be prioritized for targeted interventions.

Nepal's social health protection schemes aim to reduce financial barriers and OOP expenses by expanding access to essential healthcare services. While these programs have made progress, challenges persist, including geographical disparities, limited-service coverage, and sustainability concerns. Many households still face high medical costs for specialized care, medications, and advanced treatments not fully covered by existing schemes. Despite progress, out-of-pocket spending continues to be significant, underscoring the need for broader coverage, more integrated implementation, and expanded access to ensure healthcare is genuinely affordable and accessible to all Nepali citizens.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Ensure free BHS is available at all designated health facilities, with a focus on underserved and hard-to-reach areas.
- Effectively implement the BHS monitoring framework.
- Reform the insurance scheme to cover specialized health services beyond basic health services.
- Mandate universal enrollment in health insurance as outlined in current laws to promote sustainable financial protection.
- Identify barriers to enrolling in and renewing insurance policies and adjust implementation strategies accordingly.
- Adopt a positive discrimination approach to ensure social health protection for underserved populations.
- Update the benefit package and premium amounts based on evidence and lessons learned from implementation.
- Enhance organizational capacity for effective health insurance implementation by ensuring adequate human resources.
- Streamline existing social health protection schemes.
- Continuously track and evaluate out-of-pocket healthcare expenditures to inform the design of financial protection mechanisms.

3.4 Equitable access to quality health services

This objective of the NHSSP continues prioritizing promoting equitable access to quality health services with renewed focus. The objective is achieved through improved quality of health services and addressing the drivers of inequities in health services.

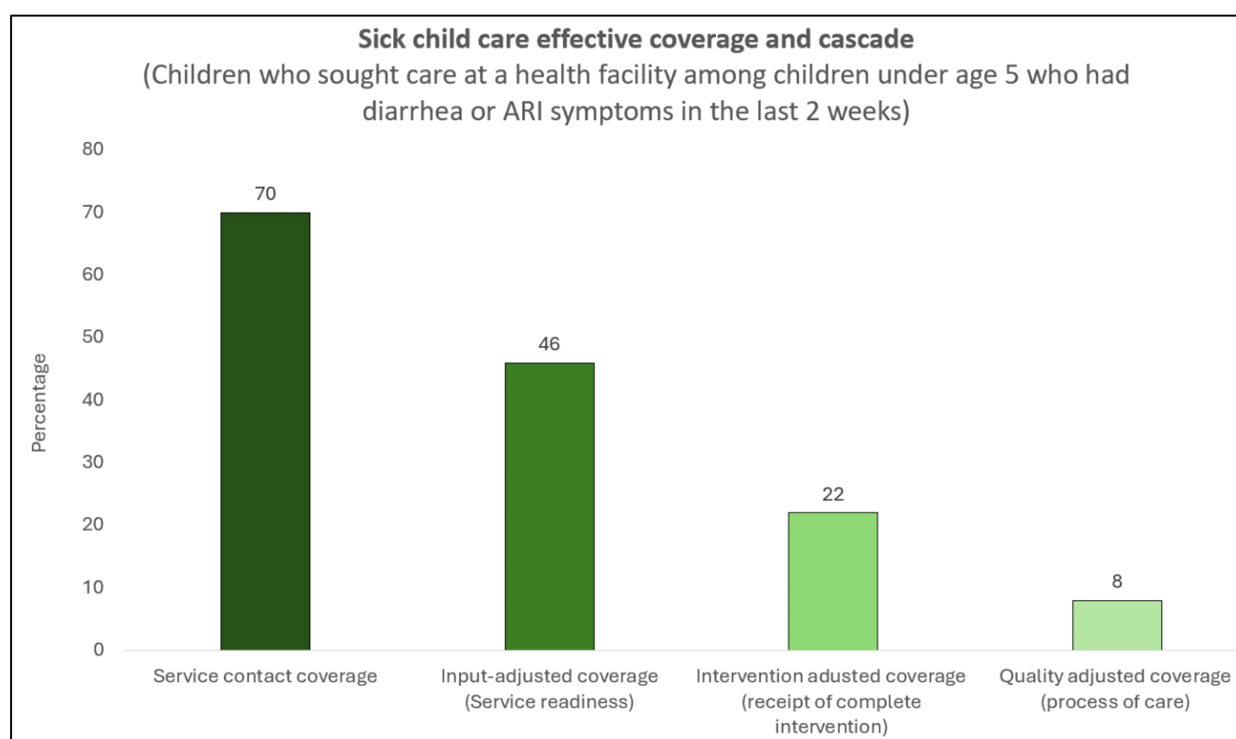
3.4.1 Quality of health services

A comprehensive set of standards, guidelines, and program-specific protocols has established the framework for governing the quality of healthcare services. The Public Health Service Act, 2018 includes provisions for regulating healthcare quality, and the MoHP has implemented minimum service standards (MSS) for health facilities at all levels. However, initiatives to enhance access to quality health services remain fragmented and have not achieved the desired quality standards at service delivery points. Furthermore, the current data within existing systems is insufficient for effective monitoring of healthcare quality. To improve the quality of health services, the NHSSP has outlined two outputs:

Output 1 aims to strengthen the quality assurance mechanisms for health services, while Output 2 focuses on enhancing the quality of care at the point of delivery.

Analysis of the effective coverage cascade revealed that 92% of sick children under 5 who seek care at health facilities in Nepal do not receive quality care[26]. Service-contact coverage, which measures the proportion of sick children who have contacted a health facility, stood at 70%. Input-adjusted coverage, accounting for facility readiness, was 46%, while intervention-adjusted coverage, which considers whether children received the complete intervention, was only 22%. Quality-adjusted coverage, reflecting adherence to the recommended care processes by providers, was just 8% (Figure 3.9). The study also indicated that around 65% of facilities were equipped to offer sick childcare services, with approximately 34% of providers following the recommended care processes. Notably, children with diarrhea who were attended by a provider trained in integrated management of neonatal and childhood illness (IMNCI) within the last 24 months were significantly more likely to receive the complete intervention compared to those seen by untrained providers.

Figure 3.9: Sick childcare effective coverage and cascade



Elevating MSS implementation

Minimum Service Standard (MSS) tools have been developed to assess and help improve service readiness across various levels of health facilities, from health posts to super-specialized hospitals. The implementation of MSS is managed by different levels of government: local governments oversee MSS at local health facilities, provincial governments manage it at provincial facilities, and federal government handles it at federal facilities. However, the federal government provides supportive supervision to both provincial and local governments, while provincial governments offer similar support to local levels. The MSS implementation process utilizes the AWPB in accordance with relevant guidelines.

In FY 2080/81, the Curative Service Division of the DoHS identified resource persons for the Minimum Service Standards (MSS) across all levels of health facilities, pinpointed implementation gaps, and assisted provincial and local governments in their application. Resource persons have been mobilized to meet the needs of various organizations. A national-level review of the MSS across all health facilities has been completed with participation from representatives of all provinces.

[26] Acharya, K., R. Church, K. Paudel, T. R. Thapa, and A. Gautam. 2024. Effective Coverage of Sick Child Care Services and Relationship with Under-5 Mortality Across Seven Provinces, 2022 Nepal DHS and 2021 Nepal HFS. DHS Further Analysis Reports No. 148. Rockville, Maryland, USA: ICF; Kathmandu, Nepal: USAID Learning for Development; and Kathmandu, Nepal: MoHP.

The review of MSS implementation suggests that, although there hasn't been a significant increase in overall service quality standards, qualitative findings clearly demonstrate several positive benefits resulting from its application. The review resulted in the development of an action plan to guide future initiatives.

The Curative Service Division developed referral guidelines to ensure effective and efficient management of referral cases, promoting continuity of care. Additionally, the division assessed service rates at selected federal hospitals to provide policy guidance on standardizing these rates.

Combating antimicrobial resistance

Antimicrobial resistance (AMR) is a significant global public health challenge and is ranked among the top ten threats to humanity by the World Health Organization. Several policy documents from the GoN, including the National Health Policy, the Sixteenth Five-Year Plan, the National Animal Health Policy 2078, the Nepal Health Sector Strategic Plan 2023-2030, have recognized AMR as a critical public health issue and emphasized the urgent need for action. Recognizing the importance of multisectoral action to address AMR, the Quality Standards and Regulation Division, MoHP formulated a National Action Plan on Antimicrobial Resistance (2024-2028) in 2024, which was endorsed by the Cabinet in February 2024. Implementation of the National Action Plan is underway, spearheaded by the focal agencies designated for each strategic pillar of the plan. The NHEICC has been developing and distributing fact sheets, flyers, infographics, pamphlets, and videos on antimicrobial resistance (AMR) to raise awareness among stakeholders, including the public.

The NPHL has been conducting surveillance of AMR among priority bacterial pathogens, while the DDA monitors antimicrobial consumption. The MoHP has developed a National Antimicrobial Treatment Guideline to promote rational prescribing practices. Additionally, the MoHP has initiated point prevalence surveys on antimicrobial use in selected hospitals. Other specific initiatives undertaken in FY 2023/24 include:

- Consultation workshop on Tracking Antimicrobial Resistance Country Self-Assessment Survey (June 5, 2024)
- Training on Antimicrobial Consumption and a workshop on optimizing antimicrobial use in Nepal (July 2024)
- Training on AMR bacteriology, including fastidious and newly identified pathogens in the Global Antimicrobial Resistance and Use Surveillance System (June 2024)
- Completed implementation and dissemination of findings from the One Health ESBL E. coli Tricycle Project in Nepal (December 2023)
- Laboratory clinician interaction workshops to promote diagnostic stewardship in addressing AMR were conducted at ten hospitals in Nepal from June to December 2023.

Healthcare waste management

The National Healthcare Waste Management Standards and Operating Procedures 2020 primarily focus on solid waste management, with liquid waste management receiving comparatively less attention in terms of implementation (NJAR 2023). However, some provinces - Koshi and Bagmati provinces - have initiated liquid-waste management initiatives in selected hospitals. The learning from these hospitals needs to be shared, lessons drawn and scaled up across the country tailoring to the local context. The Management Division, with support from GIZ, has conducted a study to help develop standardized testing parameters for liquid waste in healthcare facilities across Nepal. The study sampled liquid waste from eight healthcare facilities representing diverse geographical regions—hills, mountains, and Terai. The findings from this study will serve as the foundation for creating a comprehensive guideline on liquid waste management practices in Nepal's healthcare facilities.

Strengthening and scaling up MPDSR system

Hospital and district-level staff have been oriented on the facility-based Maternal and Perinatal Death Surveillance and Response (MPDSR) system, which is currently being implemented in 122 hospitals across 52 districts. Additionally, the Anti-Shock Garment Program has been introduced in 42 district hospitals, aiming for management of hemorrhage to reduce maternal mortality deaths.

Development of standards, guidelines, manuals for improving quality of care

Several standards, guidelines, manuals, and training packages have been developed to support enhance the health system by improving quality of care. Some of these instruments include:

Standards and protocols

- Standards for Skin Care Services
- Cost Standardization of Health Care Services at Public Hospitals (In Progress)
- Dental Lab and Dental Clinic Operation Standards (In Progress)
- Technical Specification of 98 BHS Free Medicines (Draft)
- Standard Treatment Protocol for the Management of Alcohol and Substance Use Disorder (Draft)
- National Standards and Operational Plan on Assistive Products
- SoP for Integrated Vector Surveillance 2023
- Lifesaving Emergency Medicines and Orphan Medicines List
- Standard Operating Procedures (Sops) on Laboratory Quality
- Standard Operating Procedure for Deployment of Emergency Medical Teams (Draft)
- National Drinking Water Quality Standards and Implementation and Monitoring
- Protocol for Implementation Research on Hypertension Care

Guidelines

- National Implementation Guidelines for Intrapartum Care and Labor Care (Draft)
- Guidelines for Breastfeeding Corner Establishment and Operation
- Guidelines for Nutrition Corner Establishment and Operation
- Guidelines for Nutrition Model Local Level
- Guideline for Establishment and Operation of Travel Clinic (Draft)
- Death Audit Guidelines for Audit of Deaths that Take Place at Health Facilities (Draft)
- National Referral Guidelines (Draft)
- Newborn Hearing Screening Guideline (Draft)
- Eye, Nose, Ear and Oral Health Screening Guideline
- National Guidelines for Coordination among Humanitarian Health Partners to Prepare and Respond to Disaster and Public Health Emergencies Following Cluster Approach (Draft)
- Media Guideline on Responsible Reporting on Suicide
- Guidance for Municipalities on Planning and Organization of Community Mental Health and Wellbeing Program (Draft)
- Facilitators Guideline On "Routine Immunization Strengthening and Health Workers Training on Immunization-2023
- Operational Guidelines on Hygiene Promotion Through Routine Immunization
- Vaccination Campaign (MR And TCV) Guidelines in Earthquake Affected Districts – 2023/24
- Revision of National Guidelines on DR-TB Management, 2023
- National Guidelines on Diagnosis, Management and Prevention of Scrub Typhus in Nepal 2022/23
- Antenatal and Postnatal Continuum of Care Guidelines
- CPD Guideline for Nursing Professional
- Good Manufacturing Practice (GMP) Guideline on Ayurveda Medicines
- National Antimicrobial Treatment Guidelines (Revised)
- IPC National Guidelines
- Guidelines for Setting Up Healthcare Simulation Lab
- A Practical Guide for Improving Quality of Care through Water, Sanitation and Hygiene in Health Care Facilities

Training, orientation & resource packages, tools, manuals

- SNCU Orientation Package 2080 - Mentor's & Mentee's Guide
- Revision of Training Packages on Mental Health
- Training Package for School Nurses
- Training Curriculum to Enhance the Technical and Managerial Capacity of Pesticide Inspectors
- Clinical Specimen Collection and Transportation Manual (Draft)

- IPC National Implementation Manual
- Strategic Tool for Assessing Risk (STAR) Report (Draft)
- Training Manual on Climate Change and Health at Local Level
- One Day Orientation Package and 5-Day's Training Package on Integration of Simulation for SRHR Components in Pre-Service Medical, Nursing and Midwifery Education
- Advanced IPC Learning Resource Package
- Primary Care Package of Rehabilitation Services
- Health Workers Reference Book on National Immunization Program, 2023

Plans, Strategies, Frameworks, Roadmaps

- Integrated Action Plan of Electronic Medical Record (EMR) and Telemedicine (Draft)
- Patient Safety Action Plan 2022-2030 (Draft)
- Basic Health Service Monitoring Framework
- Costed Roadmap for WASH in Health Care Facility (Draft)
- National Eye Health Strategy Developed (Endorsement Under Process)
- National Cancer Control Strategy (Draft)
- National Oral Health Strategy (Draft)
- Suicide Registry (Draft)
- Program Implementation Framework on Maternal Mental Health
- National Strategy on Ear Health and Hearing Care
- National Rehabilitation Strategy (Draft)
- Plan of Action for Nationwide Measles Rubella Campaign 2024
- Implementation Plan for Human Papillomavirus (HPV) Vaccine Multi-Age Cohort Vaccination and National Scale Up of Routine Immunization 2024
- Polio Transition Plan (2023-2030)
- National Leprosy Strategy and Action Plan (2021-25)
- Revision of National Strategic Plan to End Tuberculosis 2021/22-2025/26
- Transitional Plan for DR TB Regimen, December 2023
- National Strategic Plan for HIV 2021/22-2025/26
- Costed National Strategic Plan for Viral Hepatitis (B &C) 2023-2030
- Framework for Health Sector on Early Childhood Development
- National Health Financing Strategy – Implementation Plan
- Health Insurance Strategic Roadmap 2014 - 2030 (Draft)
- Revision of National Drug Policy
- Costed National Action Plan on AMR (NAP-AMR)
- Policy Brief on AMR
- Alert and Response Framework
- Multi-Hazard Health Contingency Plan, Karnali Province
- Earthquake Response Plan of Lumbini and Sudurpaschim Province (Draft)
- Monsoon Preparedness and Response Plan
- Jajarkot Earthquake Joint Recovery Plan
- National Adaptation Plan (NAP) and Health National Adaptation Plan (H-NAP)
- Training Manual on Climate Resilient Water Safety Plan (CR-WSP) for Health Professionals
- Multisectoral Action Plan for The Prevention and Control of NCDs (2021 -2025)
- National Strategic Action Plan on Addressing Health Impacts of Air Pollution
- National SRHR Social Behavior Change Communication Strategy 2022-2026
- Costed Roadmap for Hand Hygiene for All (Draft)
- Revision of Birth Defect Surveillance, Prevention and Management – National Implementation Plan 2025-2030

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Establish a national accreditation body for quality assurance and accreditation.

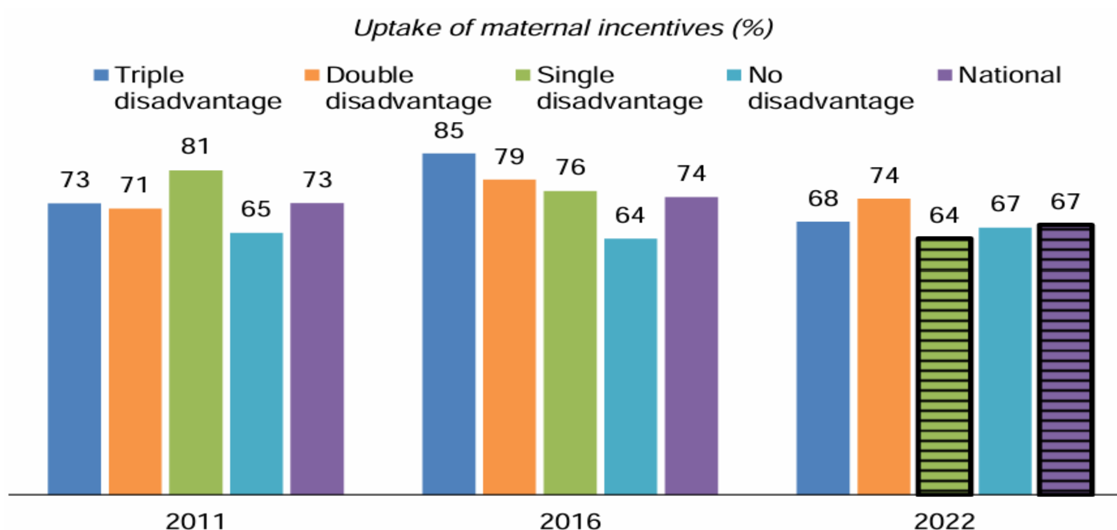
- Establish a mechanism for monitoring indicators and data system for measuring progress on health care quality.
- Routinely monitor service standards in all public and private facilities and strengthen quality improvement structures and interventions.
- Develop and strengthen a system for safe and timely disposal of pharmaceutical, diagnostic, and health care wastes and chemicals of public health concern.
- Develop and implement pre-and in-service training manuals consolidating all the existing standards for each level of care.
- Develop institutional linkages among federal, provincial, and local level public health facilities for coordinated health service system and referral.
- Promote using generic prescription and the use of listed essential medicines.
- Institutionalize clinical audit system to improve quality of care by making it interactive.
- Develop mechanisms to monitor client satisfaction and address the identified issues in a timely manner.

3.4.2 Equity in quality health services

The NHSSP aspires to achieve equity in quality health services through two outputs. Output 1 emphasizes improving access to quality health services, and Output 2 on addressing the drivers of inequities in health services.

The uptake of maternity incentives decreased so significantly among women with a single disadvantage that this group went from having the highest uptake in 2011 to having the lowest uptake in 2022[27] (Figure 3.10). There were no statistically significant changes in the uptake of maternity incentives among women with other marginalization statuses[28]. The study has also revealed low institutional delivery among socioeconomically and geographically disadvantaged groups, low continuum of care and wide equity gaps among intersectional groups.

Figure 3.10: Trends in uptake of maternity incentives among women who gave birth in health facilities, by marginalization status



Source: Khatri, R, et.al., (2024).
Note: Each bar with horizontal lines indicates a statistically significant change from 2016 to 2022. Each bar with a solid outline indicates a statistically significant change from 2011 to 2022.

An equity analysis of the utilization of child, maternal, and reproductive health services across provinces indicates that Madhesh Province performed the worst in 9 out of the 19 selected tracer indicators when compared to the national average (Table 3.7). In contrast, Gandaki province excelled in 9 of the 19 indicators.

[27] Khatri, R., K. P. Dulal, K. Timelsena, M. Tamrakar, R. Rosenberg, and S. Tuladhar. 2024. Equity Analysis of Maternal Health Services in Nepal: Trends and Determinants, 2011–2022 Nepal DHS Surveys. DHS Further Analysis Reports No. 152. Rockville, Maryland, USA: ICF; and Kathmandu, Nepal: MoHP.
[28] The study defines the multiple marginalization status based on intersections of ethnicity (advantaged and disadvantaged), education (literate and illiterate), and wealth status (rich and poor). PID: Poor, illiterate, and disadvantaged ethnicity; PIA: Poor, illiterate, and advantaged ethnicity; PLD: Poor, literate, and disadvantaged ethnicity; RID: Rich, illiterate, and disadvantaged ethnicity; PLA: Poor, literate, and advantaged ethnicity; RIA: Rich, illiterate, and advantaged ethnicity; RLD: Rich, literate, and disadvantaged ethnicity; and RLA: Rich, literate, and advantaged ethnicity.

Table 3.7: Equity in utilization of child, maternal and reproductive health services

Color code: Green = Best performance among the 7 provinces, Red = Worst performance among the 7 provinces.

Indicator	Koshi	Madhesh	Bagmati	Gandaki	Lumbini	Karnali	Sudurpaschim	Nepal
Neonatal mortality	20	27	18	8	24	26	27	21
Infant mortality	28	38	21	19	34	36	40	28
Under-five mortality	34	43	24	23	41	46	49	33
Fully vaccinated children (%)	81	67	83	93	85	84	89	80
No vaccination (%)	5.6	4.0	9.3	0.0	3.4	5.6	2.2	4.4
Prevalence of diarrhea (%)	11	10	13	8	10	10	9	10
Sought treatment (%)	49	57	59	49	65	56	63	57
Treated in public facility (%)	35	16	26	44	13	66	40	27
Stunting in children (%)	20	29	18	20	25	36	28	25
Wasting in children (%)	4	10	5	4	16	4	5	8
Under-weight in children (%)	13	27	11	18	23	18	14	19
Anemia in children (%)	34	51	43	31	49	40	45	43
Adolescence marriage (20-24 yrs)	53	76	35	40	48	65	56	54
Adolescence childbearing (20-24 yrs)	35	54	22	24	28	46	35	36
Institutional delivery *	82	65	94	88	84	79	89	81
mCPR (currently married, 15-19 yrs)	20	4	20	22	21	17	17	14
Unmet need for FP (15-19 yrs)	25	33	22	25	35	37	35	31
Met need for FP (15-19 yrs)	46	13	39	31	32	30	36	28
Induced abortion	7	4	12	17	11	16	11	10

* Delivery at HFs among women aged 15–49 years who had a live birth one year prior to the survey.

Source: NDHS 2022

Key activities carried out in FY 2080/81 for improving access to quality health services include:

Vaccination

Approximately 10,000 adolescent girls aged 14 have received two doses of the HPV vaccine, providing protection against cervical cancer. Additionally, over 6,317,000 children under 15 have been vaccinated with one dose of the MR vaccine, safeguarding them from measles and rubella. More than 1.4 million children have also received one dose of IPV, protecting them from poliomyelitis. Furthermore, pediatricians, medical officers, and health workers from all seven provinces have been trained on Adverse Events Following Immunization (AEFI), vaccine safety, and Vaccine-Preventable Disease (VPD) surveillance, enhancing timely reporting and accurate classification of AEFI cases.

Child health

Hospital-level health workers have been trained in Facility-Based Integrated Management of Neonatal and Childhood Illnesses (FB-IMNCI), which has enhanced child treatment and improved the referral mechanisms. The SNCU Orientation Package 2080, comprising a Mentor's and Mentee's Guide, has been developed and approved, with orientation sessions conducted for most of the Level II hospitals across the country. This four-day package strengthens the capacity of staff in Special Newborn Care Units (SNCUs), maternity wards, post-natal wards, and emergency wards, enabling them to effectively manage and refer small and sick newborns. SNCU mentors have been established in five provinces, excluding Sudurpaschim and Gandaki. Additionally, the revision of the Newborn Birth Defect Surveillance, Prevention, and Management – National Implementation Plan 2025-2030 has been finalized in English, and the Nepali translation is currently in progress for endorsement. Similarly, the national health sector guiding framework on Early Childhood Development (2080) has been endorsed. Furthermore, A review of the Mother Baby Friendly Hospital Initiative (MBFH) was conducted to enhance maternal and child health services in 15 hospitals. Heating systems have been installed in postnatal wards of hospitals located in hilly and mountainous regions.

Family planning and reproductive health

The Family Planning Costed Implementation Plan (FP-CIP) for 2024-2030 has been prepared and is currently undergoing the approval process. The plan enhances family planning options by introducing Synapses and Emergency Contraceptive Pills (ECP) in health facilities, with Synapses distributed in 20 districts and ECP available nationwide. Data verification related to family planning at the hospital level has been completed in five federal and provincial hospitals. A total of 1,599 health facilities have been declared as Adolescent Friendly Health Facilities across federal, provincial, and local levels.

The guidelines for managing pelvic organ prolapse have been revised and finalized for use, along with new guidelines for cervical cancer screening using HPV DNA techniques. Stakeholder have been oriented, making them ready for implementation. Cervical cancer screenings using HPV DNA and VIA have been initiated in seven provincial and 20 local health facilities, with significant numbers of screenings conducted: 55,311 for HPV DNA, 163,739 for VIA, and 40,409 PAP smears.

Furthermore, an orientation and capacity development program for infertility management guidelines has been implemented in two hospitals to support infertility services. Disability-friendly reproductive health services have also been established, with coordination and capacity-building efforts underway in four provincial hospitals to ensure accessible care.

Nutrition

Guidelines for the establishment and operation of breastfeeding and nutrition corners, as well as a Nutrition Model for local levels, have been developed and printed for distribution to provinces. Training sessions for doctors and nurses at Inpatient Treatment Centers focusing on severe acute malnutrition management have been completed, with two batches of Master Training of Trainers (MToT) and onsite coaching conducted in 10 hospitals. This initiative has facilitated the establishment and functioning of inpatient treatment centers. Additionally, orientation sessions on the storage management of nutrition commodities have been held for nutrition and store focal persons from all provinces and health offices, enhancing the management of these resources. Planning for the National Micronutrient Survey 2025 has progressed, with a successful planning meeting involving participants from US CDC Atlanta, UNICEF, USAID, and various universities, leading to the development and finalization of the survey protocol. Advocacy efforts for the Breast Milk Substitution (Sales, Distribution,

Control) Act 2049 have also been completed in federal and provincial hospitals, raising awareness among hospital and pharmacy staff.

Leprosy control and disability management

A total of 10 dermatologists, 25 medical officers, and 23 paramedics have received training in leprosy case management, enabling them to enhance active case detection and management of leprosy cases. A basic training package on leprosy has also been developed to orient health workers. In Kapilvastu district, 60 Female Community Health Volunteers (FCHVs) and 60 paramedics were trained on Active Case Detection (ACD) and Leprosy Post-Exposure Prophylaxis (LPEP). Out of 6,130 contacts of 264 leprosy index cases screened, 5,102 eligible contacts received a single dose of rifampicin, leading to the identification of 14 new leprosy cases among 95 suspected cases, with none presenting grade 2 disability. The National Rehabilitation Strategy 2024-2030 has been drafted based on a Delphi survey, outlining the roles of various stakeholders in delivering rehabilitation services. Additionally, a Disability Management and Rehabilitation (DMR) training package has been created and endorsed for health workers in basic health facilities, facilitating the integration of rehabilitation services and improving medical officers' skills in managing disabilities. A comprehensive training package for assistive products has been developed with stakeholder consultation, and 21 mentors from all provinces have been trained to lead provincial-level training. This initiative is essential for incorporating assistive devices into health facilities for persons with disabilities, the elderly, and other vulnerable populations. Furthermore, low-cost interventions were implemented in three municipalities with high road injury rates, raising awareness about road safety policies and educating school children on safe practices.

NCD and mental health

The National Cancer Control Strategy 2024-2030 has been approved, outlining comprehensive interventions for cancer prevention and control. Additionally, four batches of MDGPs, psychiatrists, medical officers, psychologists, and specialists in maternal and child health have been trained in Child and Adolescent Mental Health (CAMH). A policy dialogue on non-communicable diseases (NCDs) and mental health was conducted in six districts, involving stakeholders from all three tiers of government. This initiative fostered collaboration to develop a strategy for combating NCDs and mental health issues. Furthermore, a guideline has been created to establish 'Role Model Palika on Mental Health,' assisting local governments in identifying and implementing mental health activities tailored to their specific needs.

NTDs and vector borne disease

The LF MDA Campaign has been successfully conducted in seven endemic districts, protecting a total of 5,000,000 people from lymphatic filariasis infection. Additionally, a Dengue Prevention and Control action plan has been formulated and implemented across all levels of government, leading to a reduction in dengue morbidity and mortality compared to the previous year. Integrated vector surveillance has also been carried out in seven sentinel sites nationwide, providing critical baseline data for the prevention and control of vector-borne diseases.

Zoonotic and other communicable diseases

Fourteen new snakebite treatment centers have been established, significantly improving the management of snakebite envenoming. To prevent rabies, a mass dog vaccination campaign was organized in Mandandeupur and Mahabharat Rural Municipalities, engaging the community. Additionally, an IHR-PVS Bridging Workshop was conducted to address future zoonotic disease threats. A self-assessment of the 15 core capacities for state party annual reporting (SPAR) was carried out enabling timely reporting and evaluation of capacities. Furthermore, onsite coaching and mentoring have been provided in selected areas of Koshi, Lumbini, and Madhesh Provinces to enhance healthcare workers' skills in snakebite management.

Expansion of cancer treatment services in all seven provinces

With the endorsement of National Cancer Control Strategy, 2024-2030 and the accompanying action plan for expanding cancer services, the MoHP has set a strategic plan to improve access to cancer treatment for patients throughout all seven provinces. As per the plan, BP Koirala Memorial Cancer Hospital (Chitwan) will extend its services to Surkhet Provincial Hospital (Karnali province), Seti Provincial Hospital (Sudurpashchim province), and Pokhara University of Health Sciences (Gandaki province). Meanwhile, Bhaktapur Cancer Hospital will expand its reach to Koshi Hospital in Biratnagar (Koshi province) and Narayani Hospital in Birgunj (Madhesh province). Bhaktapur Cancer Hospital (Bhaktapur) and BP

Koirala Cancer Hospital (Chitwan) in Bagmati province, and Sushil Koirala Prakhar Cancer Hospital (Nepalgunj), in Lumbini province, are already providing the services. BP Koirala Memorial Cancer Hospital (Chitwan, Bagmati province) and Pokhara Institute of Health Sciences (Pokhara, Gandaki province) have already established a partnership to provide extended cancer treatment services. This strategic initiative will ensure comprehensive cancer care throughout the seven provinces.

Additionally, an agreement has been established between the Bhaktapur Cancer Hospital in Bhaktapur and B.P. Koirala Memorial Cancer Hospital in Bharatpur to manage laboratory tests that cannot be conducted at their facilities through the National Public Health Laboratory. This service will gradually be available for all public cancer hospitals. Furthermore, the laboratory will assist in upgrading the standards of these hospitals' laboratories. The MoHP anticipates that this initiative will help lessen the inconvenience and expenses associated with cancer testing for the public.

OPD in two shifts

The MoHP has announced the implementation of two-shift outpatient services (OPD) in all federal hospitals. Currently, Bir Hospital, Sukraraj Tropical and Infectious Disease Hospital, Bhaktapur Cancer Hospital, Bharatpur Hospital, National Trauma Center, Narayani Hospital, and Kanti Children Hospital are operating OPD in two shifts. This initiative will be expanded to include all other federal hospitals.

Expansion of treatment to burn patients

The Cabinet Meeting of the Government of Nepal, held on 02 Kartik 2081, has resolved to provide free treatment to burn patients in need due to poverty from at least one hospital in each province, as outlined below. This marks a significant step towards ensuring that no burn patient is denied treatment because of financial constraints.
Koshi: BP Koirala Institute of Health Sciences, Dharan
Madhesh: Narayani Hospital, Birgunj
Bagmati: Kirtipur Burn Hospital, Kirtipur and Bir Hospital, Kathmandu
Gandaki: Pokhara Academy of Health Sciences, Pokhara
Lumbini: Bheri Hospital, Nepalgunj
Karnali: Surkhet Provincial Hospital, Surkhet
Sudurpaschim: Seti Provincial Hospital, Dhangadi

Similarly, Geta Hospital has begun offering inpatient services with a capacity of 30 beds.

Strengthening OCMC

Nepal is among the few countries globally that adopts a health response integrating support services within hospitals and training health workers to identify and refer victims of gender-based violence (GBV). Recognizing that health workers are frequently the first responders to the GBV survivors, the GoN has established hospital-based 'one-stop crisis management center (OCMC)', across all districts. Currently there are 92 hospitals running OCMCs: 16 federal hospitals, 69 provincial hospitals, and 7 basic hospitals. Sixty-three districts have at least one hospital running OCMC, and fourteen of the 77 districts have more than one OCMCs. In FY 2080/81, a total of 12,978 victims received services from 79 OCMCs, comprising 95% females and 5% males.

The team at the one stop crisis management center – staff nurse Punam Rawat, counsellor Radha Paudel and police officer Sabita Thapa – listens to a patient (Credit: Bunu Dhungana)
Photo source: https://www.bbc.com/future/article/20181023-nepals-plans-to-save-womens-lives

The NDHS 2022 data indicates that 23% of women in Nepal aged 15–49 have experienced physical violence since the age of 15, while 8% have faced sexual violence. Among women who have been pregnant, 6% experienced violence during their pregnancy. Additionally, 27% of women have encountered physical, sexual, or emotional violence from their current or most recent husband or intimate partner. Only 28% of women who have experienced any form of physical or sexual violence sought help to address it.

A further analysis of NDHS 2022 data shows that disadvantaged ethnic groups, particularly Madheshi and Muslim women, face higher risks of violence against women (VAW), including both intimate partner violence (IPV) and non-partner violence[29]. Madheshi and Muslim women are at increased risk for both intimate partner violence (IPV) and non-partner violence, while Dalit women face higher IPV risks. Older women are more likely to experience IPV than younger women, and education protects against IPV but not non-partner violence. Working women are more vulnerable to sexual violence by non-partners, while owning a mobile phone reduces the risk of non-partner physical violence. Exposure to paternal violence against mothers raises the likelihood of violence from both intimate and non-partners. Female household heads and lower household wealth increase vulnerability to non-partner violence, while characteristics like unemployment, alcohol use, and controlling behavior in partners heighten IPV risks. Provincial disparities show the highest rates of physical and sexual violence in Madhesh, with rural women at greater risk of non-partner sexual violence. The normalization of VAW is linked to increased physical violence risk, whereas access to mass media offers protection against emotional violence from partners. Women facing healthcare access barriers are at higher risk of violence than those without such barriers.

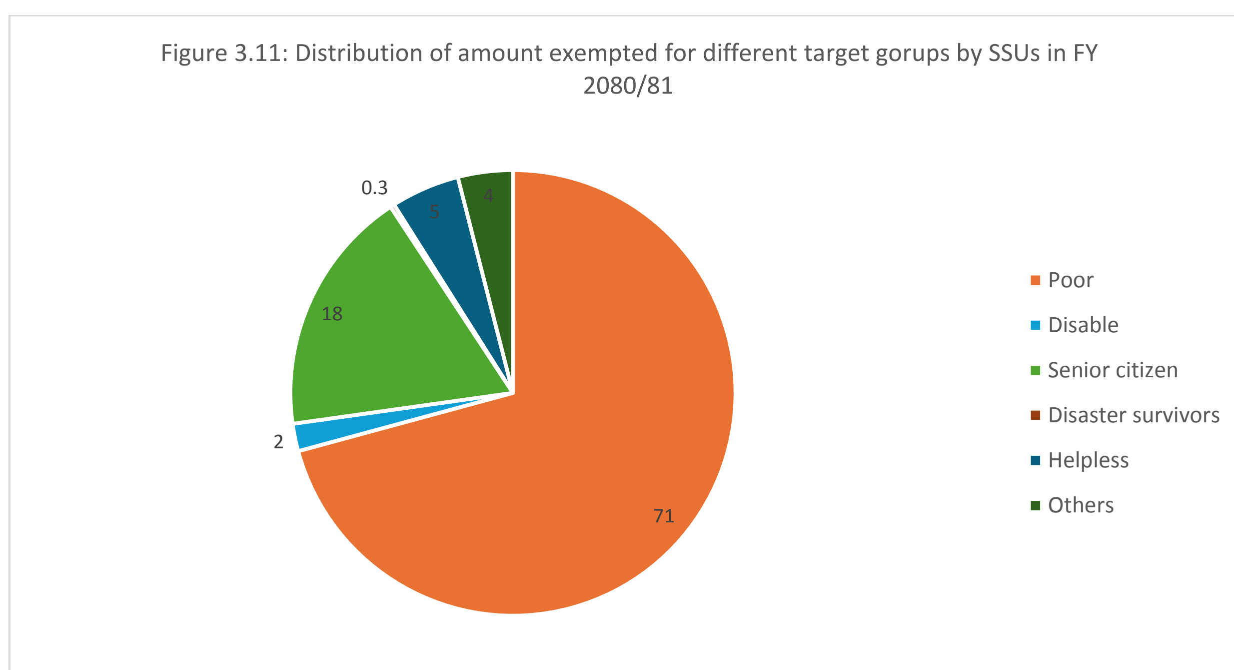
Continued efforts are necessary to train frontline health workers across all levels of health facilities and school nurses to recognize violence, provide timely psychosocial support, and establish stronger referral mechanisms. MoHP is collaborating with the education sector to revise the school curriculum to incorporate gender, violence, and healthy relationships in more detail.

[29] Dhital, R., R. Khatri R, S. Paudel, L.Y. Sherpa, and J. Edmeades. 2024. Determinants of Violence Against Women Perpetrated by Intimate Partners and Non-partners, 2022 Nepal DHS. DHS Further Analysis Reports No. 154. Rockville, Maryland, USA: ICF; Kathmandu, Nepal: USAID Learning for Development; and Kathmandu, Nepal: MoHP.

Strengthening social service unit (SSU)

In 2012, Social Service Units (SSUs) were established in five public sector referral hospitals to deliver free and subsidized services to vulnerable populations, including the poor, destitute, survivors of gender-based violence (GBV), people with disabilities (PWD), senior citizens, Female Community Health Volunteers, disaster victims, families of martyrs, and individuals from highly vulnerable indigenous groups. The SSUs serve as a gateway at federal, provincial, governmental, private, community, and teaching hospitals, facilitating access to these services for the targeted patients. Additionally, the HMIS platform is being implemented across all SSUs to digitalize recording and reporting processes.

The MoHP provides conditional grants to support the operation of SSUs. Since 2019/20, some provincial ministries have begun offering additional grants to SSUs within their jurisdictions. Additionally, certain hospitals allocate portions of their internal income to support SSUs, following the operational guidelines. There are a total of 94 SSUs nationwide, with 18 located in federal hospitals, 71 in provincial hospitals, and 5 in local hospitals. In FY 2080/81, 90,446 beneficiaries accessed services from 79 SSUs, consisting of 51% females and 49% males. During that same year, NRP 19,670,8791 was exempted for the targeted groups. Over two-thirds (71%) of SSU beneficiaries were identified as poor, nearly one-fifth (18%) were senior citizens, and 5% were classified as helpless (Figure 3.11).



The SSU is gradually becoming a central hub for all targeted programs within hospitals, playing a crucial role in coordinating, harmonizing, and facilitating access to various social security programs and services. The MoHP is focused on strengthening and expanding SSUs to all hospitals while ensuring the harmonized delivery of social protection policies and programs through the SSUs. This includes developing integrated social service guidelines that encompass all social health security programs and services, such as health insurance, the deprived citizens treatment fund, emergency health services, neonatal care, and geriatric healthcare. Additionally, efforts are underway to enhance the capacity of SSU staff and facilitators.

Expansion of geriatric health services

Nepal has experienced a significant demographic shift, with a growing proportion of older individuals in the population. The National Population and Housing Census 2021 indicates that the percentage of people aged 60 and above increased from 8.13% in 2011 to 10.21% in 2021. This change is attributed to improved healthcare services, which have raised life expectancy from 55 years in 1990 to about 70 years in 2020, along with declining birth rates and the migration of younger Nepalis abroad. The traditional family support systems are strained due to the migration of younger family members, leading many older individuals to face social isolation and inadequate care.

The rising number of seniors requires improved geriatric care services, such as specialized clinics and trained healthcare professionals. Additionally, traditional family support systems are strained due to the migration of younger members, leaving many older individuals socially isolated and without adequate care. The National Geriatric Health Strategy 2021–2030 aims to improve the health and well-being of senior citizens by providing comprehensive services and promoting healthy aging by fostering a multisectoral collaboration. It addresses the rising prevalence of chronic conditions and multimorbidity among elder citizens, highlighting the need for tailored healthcare interventions. As a result, geriatric services have been extended to 64 hospitals comprising 18 federal, 46 provincial and 3 local level hospitals. In FY 2080/81, 49,257 clients received geriatric services from 48 hospitals. Of these, 51% were females.

The MoHP is prioritizing the integration of geriatric health issues into the national health system, ensuring that policies and programs are tailored to the needs of older citizens. Key priorities include improving access to quality health services, promoting social health insurance, and strengthening family and community support systems. Efforts are being made to incorporate geriatric health into the national framework, enhance the capacity of health facilities, and ensure inclusive, gender-equitable services. The MoHP is also coordinating with all stakeholders to foster a supportive environment for healthy aging.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Implement a life course and continuum of care approach to streamline and ensure coverage for newborn and childcare, immunization, nutrition, sexual and reproductive health (including adolescent health, family planning, sub-fertility, safe motherhood, safe abortion, and morbidity management), as well as geriatric services.
- Effectively implement a targeted tax on trans fats and sugar-sweetened beverages and use the revenue generated from these taxes to fund public health campaigns, subsidies for healthier foods, and initiatives to improve access to nutritious foods in underserved communities.
- Enhance interventions aimed at controlling, eliminating, and eradicating identified, emerging, and re-emerging diseases while addressing cross-border health issues.
- Expand the coverage of Ayurveda, Naturopathy, Homeopathy, Unani, Acupuncture, Sowa-rigpa, Amchi, and other medical systems in a coordinated manner.
- Strengthen in-country diagnostic capabilities, particularly in laboratory and radiology facilities.
- Increase the capacity of public health facilities to offer a broader range of services, including eye care, ENT, oral health, and medico-legal services.
- Expand digital health initiatives, including EMR and telemedicine, in alignment with the Digital Nepal Framework.
- Design and implement targeted interventions for underserved populations to ensure that no one is left behind (LNOB).
- Establish satellite clinics from hospitals to target underserved and hard-to-reach areas.
- Strengthen and expand psychosocial counseling services and One-Stop Crisis Management Centers (OCMCs).
- Ensure gender equality and social inclusion (GESI) including gender-responsive planning, budgeting of health service delivery at local, provincial and federal levels.

3.5 Population and migration

Over the years, Nepal has encountered both internal and external migration, a demographic transition characterized by an increasing aging population, and underutilization of the demographic dividend. The NHSSP seeks to enhance life expectancy at birth, effectively manage migration and urbanization, and leverage the demographic dividend for development. To achieve these objectives, it emphasizes on maximizing demographic dividend and managed demographic transitions in development process and practicing systematic migration and planned settlement.

3.5.1 Maximizing demographic dividend and managing demographic transitions

For maximizing demographic dividend and managing demographic transitions, the NHSSP sets two outputs: Output 1 deals with strengthening population information management system and research; and Output 2 with creating enabling environment for demographic dividend and transition management.

The Constitution of Nepal guarantees that every child shall have the right to name and birth registration along with his/her identity. The National ID and Civil Registration Act, 2020 and its subsequent Regulation, 2021 set the legal framework for notification, verification, registration, and certification of vital events. MoHP is collaborating with the Ministry of Home Affairs, Department of National ID and Civil Registration (DoNIDCR) for strengthening of the Civil Registration and Vital Statistics (CRVS) system. The DoNIDCR manages the Vital Event Registration and Social Protection Management Information System (VERSP-MIS) for the centralized online civil registration. MoHP manages the Birth Registration Management Information System and Death Registration Management Information System for birth and death notification. Coordination with DoNIDCR has helped in integrating CRVS with health facilities to ensure an updated database on births and deaths.

To effectively manage population and migration, a comprehensive population information management system is needed. This gives real-time profiling, including migration data, and facilitates decision-making at all levels. MoHP is collaborating with stakeholders to establish a system that gathers information on both internal and external migration at the local level.

The MoHP is actively promoting and advocating for youth development, with a focus on prioritizing women and girls in economic activities. Local governments are establishing recreational centers, parks, libraries, yoga centers, and community learning facilities to support diverse age groups, including both youth and the elderly, enhancing their physical, mental, and spiritual well-being. However, there is a need to tailor these initiatives to better address the specific needs of minority groups, thereby improving their health, education, and income-generating opportunities. Additionally, connecting the secondary education system with employment opportunities will foster collaboration for skill development. Overall, local governments have played a crucial role in fostering positive progress toward establishing effective structures at all levels for managing population and migration.

The MoHP has established a steering committee, chaired by the secretary, and a technical committee, led by the chief of the Population Management Division, to revise the National Population Policy 2071. The steering committee has created thematic sub-committees, which are currently reviewing and updating the existing policy.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Establish and operationalize population information management system for up-to-date population profiling including migration, to facilitate decision-making at all levels
- Strengthen the Civil Registration and Vital Statistics (CRVS) system and enhance the linkage with health facilities for updated database on births and deaths.
- Promote income-generating activities at all levels ensuring gender equity.
- Promote youth for development concept and prioritize women and girls in economy.
- Promote physical, mental, and spiritual well-being of the elderly population through the provision of recreation centers, libraries, Yoga centers, community learning and skill exchange centers.
- Prioritize and design activities tailoring to the minority groups and contribute to their health, education, and income-generating opportunities.
- Link the secondary education system with employment to increase collaboration for skill enhancement.
- Develop appropriate structures at all levels for population and migration management.

3.5.2 Systematic migration and planned settlement

The NHSSP promotes safe migration and planned settlement. To promote organized settlement in both rural and urban areas, collaboration and coordination with relevant government and non-governmental organizations are essential. The federal-level multi-sectoral Public Health Committee, chaired by the health minister, has established a subcommittee focused on Population, Labor Migration, and Health (See Section 3.2.1). This subcommittee is responsible for analyzing evidence and assisting the main committee in developing suitable policies, strategies, programs, and activities to effectively manage population and migration. Its areas of focus include optimizing the benefits of the population dividend, creating job opportunities for youth, reviewing existing laws and policies, mitigating the negative health impacts of foreign employment, and addressing any other relevant tasks assigned by the ministry.

Creating a supportive environment that harnesses the skills and expertise of returning migrants involves developing a human resources management database to categorize these skills effectively. Additionally, enhancing the appeal of villages in strategic locations can be achieved through vulnerability mapping to identify key development areas. Encouraging the village stay initiative, or smart village settlement, requires creating a conducive environment that includes tax exemptions, education and health subsidies, insurance support, and the expansion of basic facilities. Furthermore, providing social protection services for migrant workers through diplomatic channels and strengthening mechanisms for managing health check-ups before departure and upon arrival are vital steps in this process.

Priorities for the next AWPB

Key initiatives to be included in the upcoming AWPB, as prioritized in the NHSSP and the 16th plan, comprise:

- Establish a supportive environment that leverages the skills and expertise of returning migrants by developing a human resources management database that categorizes these skills.
- Enhance the attractiveness of villages in strategic locations by conducting vulnerability mapping to identify key areas for development.
- Encourage the village stay initiative (smart village settlement) by creating a conducive environment through tax exemptions, subsidies for education and health, insurance support, and the expansion of basic facilities.
- Provide social protection services for migrant workers through diplomatic channels.
- Strengthen mechanisms for regulating and managing health check-ups before departure and upon arrival.

Annexes

Annex 1: NHSSP 2023-2030 Results Framework

Nepal Health Sector Strategic Plan (NHSSP) 2023 – 2030						
Code	**Output**	**Code**	**Outcome**	**Code**	**Strategic Objective**	**Goal**
OP1.1.1	Competent human resources for health produced based on projections	OC1.1	Skill-mixed human resources for health produced and mobilized	OBJ1	Enhance efficiency and responsiveness of health system	Improved health status of every citizen
OP1.1.2	Human resources for health mobilized effectively					
OP1.2.1	Evidence generated, analysed and used at all levels leveraging technology	OC1.2	Evidence- and equity-based planning			
OP1.2.2	Promoted high-quality health research in priority areas					
OP1.3.1	Physical infrastructure of health institutions strengthened	OC1.3	Safe and people friendly health infrastructures			
OP1.3.2	Health facilities equipped with bio-medical and other equipment, and regularly repaired and maintained					
OP1.4.1	Domestic production of medicines, diagnostic and health products promoted and regulated	OC1.4	Ensured uninterrupted availability of quality medicine and supplies			
OP1.4.2	Procurement and supply chain management of medicines and supplies strengthened					
OP1.5.1	Governance and leadership performance improved at all levels	OC1.5	Improved governance, leadership and accountability			
OP1.5.2	Citizen engagement platforms enhanced and institutionalized					
OP1.5.3	Ethical health practice and rational use of services promoted					
OP1.5.4	Improved public financial management					
OP1.6.1	Strengthened preparedness for public health emergencies	OC1.6	Public health emergencies managed effectively			
OP1.6.1	Public health emergencies responded effectively and timely					
OP2.1.1	Institutional and policy arrangements governing wider determinants developed and/or reformed	OC2.1	Reduced adverse effects of wider determinants on health	OBJ2	Address wider determinants of health	
OP2.1.2	Operationalized multi-sectoral collaboration by establishing institutional mechanism					
OP2.2.1	Modified behaviour of citizens for a healthier lifestyle	OC2.2	Citizens responsible for their own, family and community health			

Nepal Health Sector Strategic Plan (NHSSP) 2023 – 2030						
Code	**Output**	**Code**	**Outcome**	**Code**	**Strategic Objective**	**Goal**
OP3.1.1	Increased domestic financing and efficiency in health sector	OC3.1	Improved public investment in health sector	OBJ3	Promote sustainable financing and social protection in health	
OP3.1.2	Improved management of development cooperation in health sector					
OP3.2.1	Free basic health services ensured in urban and rural settings	OC3.2	Improved social protection in health			
OP3.2.2	Reformed health insurance system					
OP3.2.3	Streamlined social health protection schemes					
OP4.1.1	Quality assurance mechanism for health services strengthened	OC4.1	Quality of health services improved	OBJ4	Promote equitable access to quality health services	
OP4.1.2	Quality of care improved at the point of delivery					
OP4.2.1	Improved access to quality health services	OC4.2	Reduced inequity in health services			
OP4.2.2	Drivers of inequities in health services addressed					
OP5.1.1	Strengthened population information management system and research	OC5.1	Maximized demographic dividend and managed demographic transitions in development process	OBJ5	Manage population and migration	
OP5.1.2	Enabling environment created for demographic dividend and transition management					
OP5.2.1	Safe migration and planned settlement promoted	OC5.2	Systematic migration and planned settlement practiced			

Annex 2: Alignment of Nepali Fiscal Years with Gregorian Calendar Years

Nepali Fiscal Years	Gregorian Calendar Years	Nepali Fiscal Years	Gregorian Calendar Years
2060/61	2003/04	2073/74	2016/17
2061/62	2004/05	2074/75	2017/18
2062/63	2005/06	2075/76	2018/19
2063/64	2006/07	2076/77	2019/20
2064/65	2007/08	2077/78	2020/21
2065/66	2008/09	2078/79	2021/22
2066/67	2009/10	2079/80	2022/23
2067/68	2010/11	2080/81	2023/24
2068/69	2011/12	2081/82	2024/25
2069/70	2012/13	2082/83	2025/26
2070/71	2013/14	2083/84	2026/27
2071/72	2014/15	2084/85	2027/28
2072/73	2015/16	2085/86	2028/29
		2086/87	2029/30

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