WHO Country Cooperation Strategy 2006-2011

Nepal

World Health Organization
Country Office for Nepal
Kathmandu

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List of abbreviations and acronyms

AEFI	Adverse Events Following Immunization
ART	Anti Retroviral Therapy
AusAID	Australian Agency for International Development
CAP	Consolidated Appeal Process
CCA	Common Country Assessment
CCM	Country Coordination Mechanism
DALY	Disability Adjusted Life Years
DFID	Department for International Development
DHO	District Health Office
DHS	District Health System
DoHS	Department of Health Services
EDP	External Development Partners
EHA	Emergency and Humanitarian Action
EHCS	Essential Health Care Services
GFATM	Global Funds for AIDS, Tuberculosis and Malaria
GTZ/KfW	Deutsche Gesellschaft für Technische Zusammenarbeit/ Kreditanstalt für Wiederaufbau (German Development Cooperation)
HDI	Human Development Index
HRH	Human Resource for Health
IDS	Integrated Diseases Surveillance
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illness
IPD	Immunization Preventable Diseases
JAR	Joint Annual Review
JICA	Japanese International Cooperation Agency
HSRS	Health Sector Reform Strategy
MDG	Millennium Development Goals

MDGP	Medical Doctor in General Practice
MOHP	Ministry Of Health and Populations
MOSS	Minimum Operations Security Standard
MMR	Maternal Mortality Ratio
MPS	Making Pregnancy Safer
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Disease
NDHS	Nepal Demographic and Health Survey
NER	Net Enrollment Ratio
NGO	Non Governmental Organization
NHDR	Nepal Human Development Report
NHSP-IP	Nepal Health Sector Programme Implementation Plan
NOO	National Operation Officer
NLSS	Nepal Living Standard Survey
NPO	National Program officer
OPD	Out Patients Department
PPP	Public and Private Partnership
PRSP	Poverty Reduction Strategy Paper
SAARC	South Asia Association for Regional Coordination
SBA	Skilled Birth Attendant
SDC	Swiss Agency for Development and Cooperation
SEAR	South East Asia Region
SSA	Special Service Agreement
SLTHP	Second Long Term Health Plan
STC	Short Term Consultant
STP	Short Term Professional
SWAp	Sector Wide Approach
UNS	United Nations System
UNDAF	United Nations Development Assistance Framework
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
WB	The World Bank

Preface

The collaborative activities of the World Health Organization in the South-East Asia Region are aimed to improve the health status of the population in the Member States. To achieve this objective, WHO works closely with the Ministry of Health and other health development partners in the respective Member States. Considering WHO's limited resources in terms of funding and staff, there is a need for a thorough analysis and discussion of how WHO can maximize its contribution to health in each Member State.

The South-East Asia Region was the first WHO Region to promote Country Cooperation Strategies (CCS) as a process to identify how best the Organization could support health development in our Member States. Over the past six years, all 11 Member States in the Region have prepared their CCS. In the case of Nepal, the previous CCS covered the period 2002-2005. Since it was prepared, many changes have taken place in Nepal, both in terms of the health situation, the government's own health development efforts and those of key partners. Keeping these changes in mind, WHO has developed a new CCS for the country covering the period, 2006-2011.

An analysis of the current health situation and the likely scenario up to 2011 has formed the basis for the priorities outlined in this CCS. We appreciate the inputs and suggestions from the Ministry of Health and Population, other health-related ministries, key health experts and our partners in health development in the country. This consultative process helped to ensure that WHO's inputs provide the maximum support to health development efforts in Nepal.

To help achieve the objectives of this CCS, we recognize the importance of a strong WHO Country Office to work closely with key counterparts keeping in mind local conditions. Nonetheless, the commitment to the work of the CCS is from the entire Organization. The staff of the Regional Office will use the CCS in determining country priorities and in supporting collaborative activities in Nepal. Furthermore, we will also work together, as necessary, with WHO headquarters to strengthen these efforts.

I would like to thank all those who were involved in developing this CCS, which has the full commitment of the Regional Office. Our joint efforts, over the next six years, should be aimed at achieving the maximum health benefits for the people of Nepal.

December 2006

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

Foreword

The first Country Cooperation Strategy document of Nepal was published in the year 2000 and during last two biennia the WHO has developed its programs of work according to the priorities identified over there.

Along with the demographic and epidemiological transition of the country the health sector of Nepal facing new challenges in providing health care services to the people. Some of the health care challenges continued to exist over the years. It is the time to revisit and revise the Country Cooperation Strategy of the WHO in Nepal for us to align our programs in order to assist the Government to address those new challenges.

The Ministry of Health and Population of Nepal has developed National Health Sector Program- Implementation Plan (NHSP-IP) to cover the period of 2004-2009. The key focus of the NHSP-IP is to strengthen the Essential Health Care Services program (EHCS) at all levels of care with the ultimate objective of improving the health status of the people of Nepal.

This second Country Cooperation Strategy has prioritized the approaches of the WHO under six major areas and will closely align with the vision of the Essential Health care services provision. This has been developed following comprehensive review of the health situation of the country. Wide range of consultations with different stakeholders and partners of health development were taken place in identifying the priority areas of work for WHO.

It is my pleasure to present this document to the Government of Nepal and to our development partners. WHO will continue to provide its maximum assistance towards the Health development work of Nepal.

December 2006

Dr. Kan Tun
WHO Representative, Nepal

Executive summary

The WHO Country Cooperation Strategy (CCS), a medium-term framework for WHO cooperation with the Government of Nepal, has been developed keeping in mind the need to balance between the country priorities and WHO priorities as outlined in WHO's 11th General Programme of Work and the Medium Term Strategic Plan. This CCS has been prepared through a series of consultation and dialogue with major stakeholders including health sector policy makers and planners, health professionals and programme managers, members of academia, external development partners and agencies. The WHO Country Office led the process and the Regional Office and WHO Headquarters contributed to it.

WHO's collaborative work in Nepal during the period of 2006-2011 would be based on the strategic agenda and objectives identified in the CCS which have been developed keeping in mind the national health sector needs, MDGs and the comparative advantage of WHO. However, the CCS, being a dynamic document, is subject to periodic adjustments according to the country situation and priority health needs.

Nepal, one of the least developed countries, has faced in a decade of political unrest until very recently. The conflict, which started in 1996 with the Maoist insurgency, took a heavy toll of peoples' lives and significantly hampered the country's economic development. However, recent political changes have paved the way towards multiparty democracy and the solution of the decade-long political conflict and violence.

Nepal has made some progress over the years in raising the health status, particularly through expansion of immunization for vaccine-preventable diseases and priority disease interventions. However, much remains to be done. DALYs lost due to ill health remain the highest in the Region and are second to sub-Saharan Africa. Major communicable diseases still persist and are a major public health problem. At the same time, diseases related to life style and risk factors (e.g. diabetes, hypertension, CVD, cancer etc.) are increasing. Population growth remains high compared to the other countries in the Region. About two-thirds of the population is under 15 years of age, and the number of people 60 years and above is also increasing. Thus, the country is going through demographic and epidemiological transitions.

Despite the emphasis on equity and social justice in the national health policy, health gaps between the rich and the poor, and between urban and rural areas are wide. The disparities in access, service utilization and health status are marked. The deeply-rooted discriminatory practices based on ethno-caste system or patriarchal structure affect the poor and the marginalized in every sphere, including access to and utilization of health services.

The Nepal Health Sector Programme Implementation Plan (NHSP-IP) emphasizes the essential services package but resources are skewed towards tertiary care. While production of health care providers is increasing, quality is a cause for concern. The health sector is heavily dependent on external resources. At the same time, people spend a significant amount of money on health care from their pocket. The private sector is growing without much regulation and supervision from the Ministry of Health.

Notwithstanding the above challenges, the country has numerous opportunities to improve the health status of its population. Political stability is seen on the horizon. The health and development policies and strategies are in place. Initiatives for elimination of discriminatory practices have been well established and are being enforced. Nepal has a fairly good health infrastructure in public and private sectors. Production of health workers in terms of numbers is generally sufficient. There is a commitment to increase resources, both internally, and from external development partners.

Considering the above political, social and health development challenges and opportunities, the strategic agenda of this CCS has identified six priority components. These are: strengthening health system; control and prevention of disease and disability; human resource development; child, adolescent and reproductive health; healthier environment; and emergency preparedness and response. Each of the components has a number of strategic objectives and strategic approaches, which are aligned with NHSP-IP outputs relevant to WHO.

The key areas identified are: equitable health care financing; increased access of the underprivileged to services; integrated disease surveillance; prevention and control of communicable and chronic diseases; rationalization of human resource development and management; reduction of maternal and neonatal mortality; promotion of healthier physical environment; and health system capacity building for emergency preparedness and response. Emphasis is also placed on facilitating the process of decentralization of health services, and supporting development of a strategy for effective public/private/NGO collaboration. Support for mobilizing additional resources for the health sector and to better harmonize its work with those of other UN agencies and external development partners will also be considered. Cross-cutting issues such as health equity, health as a human right, people's empowerment and the health system's responsiveness to people's needs will be the overarching principles for WHO in Nepal while implementing its strategic agenda.

Implementing the strategic agenda requires a clear consensus between WHO and the government on key issues, interventions and technical support. WHO has, at present, well set and well equipped staff with skills and competencies in the country office. However, it will review its existing skills and competencies to effectively implement the strategic agenda with a stronger and more competent, cohesive and dynamic team. Continued support from the Regional Office and Headquarters is important for achieving the agenda and objectives identified in the CCS.

1 Introduction

The WHO Country Cooperation Strategy (CCS), a medium-term framework for WHO cooperation with the Government of Nepal, has been designed to represent a balance between the country priorities and the WHO priorities as outlined in WHO's 11th General Programme of Work and the Medium Term Strategic Plan. The strategic agenda of the CCS aims to guide WHO's collaborative work in supporting the country's health systems development during 2006-2011. It identifies priority areas and issues for WHO's technical support for increasing effective cooperation with national authorities and development partners; and for promoting coordination of strategic inputs in the health sector, aiming at achieving better health outcomes for the population.

A fairly comprehensive policy framework for health and overall socio-economic development of Nepal is in place:

- The second long-term health plan (SLTHP) 1997-2017, provides a road map for developing "a health system in which there is equitable access to coordinated, quality health care services in rural and urban areas, characterized by: self-reliance; full community participation; decentralization; gender sensitivity; effective and efficient management; and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population" (SLTHP1999).
- The Poverty Reduction Strategy Paper (PRSP) 2002-2007, as well as the Tenth Development Plan of the government, emphasizes improvement in access to social and economic services in rural areas and greater socio-economic inclusion of the poor and the disadvantaged groups. The government, accordingly, developed the Health Sector Strategy: An Agenda for Reform (HSRS) in 2004, which aims at achieving the health-related MDGs with improved health outcomes for the poor and those living in remote areas so as to contribute to poverty reduction.
- The Nepal Health Sector Programme-Implementation Plan (NHSP-IP) 2004-2009, has been designed for implementing the health sector reform strategy for reducing maternal, infant and under-five mortality and total fertility rates; increasing contraceptive prevalence rate; skilled birth attendance; immunization of children; knowledge about HIV transmission; and an increased proportion of budget for health. This plan has been developed in consultation with all stakeholders through a sector-wide approach (SWAP).

- Within the UN system, Nepal's second Common Country Assessment (CCA) presently in the process of development will have been completed by end-2006. This document (in draft form) provides an overview of development issues facing the country and prioritizes action for the United Nations System (UNS). The MDG targets dealt with in the CCA pertain to income and human poverty; hunger; primary education; gender equality and women's empowerment; under-5 mortality; reproductive and maternal health; HIV/AIDS; malaria and TB; environment; disaster preparedness; water and sanitation; and human rights and governance. The preparation of United Nations Development Assistance Framework (UNDAF) will follow the completion of the CCA.

It is in keeping with the above policy background that this CCS has been prepared for improving WHO's performance in Nepal's health development in the context of increased cooperation with national authorities and partners. Priority health sector issues and challenges were examined from different perspectives. WHO's strategic directions, its core functions and their implications were analyzed in the context of the country's health sector priorities. All this was done in a participatory, interactive process of consultation and dialogue with major stakeholders from the government, UN agencies, development partners, academia and WHO staff from the Regional Office, Headquarters and the country office.

Country health and development challenges 2

The major health and development challenges facing the country are: its unique location in three ecological zones (mountains, hills and plains); its socio-cultural and ethnic diversity; socio-economic exclusions; slow economic growth; unemployment and poverty; disparities in access to basic services and opportunities; political instability, decade-long conflict and violence. Despite many challenges, the country has made some progress in overall socio-economic development. Table 1 presents an overview of the health and development situation.

The MDG targets related to extreme poverty, child mortality, tuberculosis and access to safe drinking water are likely to be achieved, whereas the goal related to universal primary education and the target related to HIV/AIDS are unlikely to be achieved. Only two MDGs, on universal primary education and child mortality reduction, have been assessed to have a strong supportive environment (Annex 1). According to the National Planning Commission, there is an estimated total financial gap of US dollar 7.6 billion for the period 2005-2015 for achieving the MDGs (Nepal Millennium Development Goals Progress Report 2005).

2.1 Demography

Nepal is a land-locked country of about 27 million people in an area of 147 181 square kilometers. Despite an increase in the contraceptive prevalence rate (41%), the population is growing at a rate of 2.25%, which is relatively higher compared to other countries in the Region. About one fourth of women of reproductive age do not have access to contraceptives as there is a 28% unmet need. While Nepal's population is still young (about two third are under 15 years of age), the number of people aged 60 years and above is also increasing. Hence, the country is in the middle of its demographic transition.

2.2 Economy

Nepal is one of the least developed countries with GDP per capita of only US$ 294. While about 80% of the population depends on agriculture for livelihood, the share of the agriculture sector in GDP is only 40%. Tourism, one of the main sources of income in the past, has been affected adversely due to civil conflict and violence. During this conflict, a significant proportion of the productive labour force left the country in search of jobs. Remittance from foreign employment has been the major income source for Nepal

(US$ 920 million in 2004/05 compare to US$ 203 million in 1995/96). Small-scale industry, tourism and foreign aid are the other main components of the economy.

The benefits of macro-economic policy change have been limited primarily to the urban business community. This has resulted in weak macro-micro linkages for reducing poverty and empowering the poor and the disadvantaged groups. Other challenges include: low factor productivity and low resource availability; low domestic savings; declining public and private sector investments; low absorption capacity; a weak financial sector and regulatory oversight; and inefficient public enterprises. Nepal has been a member of the World Trade Organization since 2003, but is yet to benefit from membership.

2.3 Poverty and human development

The population living below the national poverty line has declined from 42% (1990-1995) to 31% (2003-2004). However, the rural-urban disparities are still alarming: rural poverty is 35% compared to 10% in urban areas. There is a striking disparity in the incidence of poverty in different regions. The table below shows human poverty index in different regions in 2001.

Region	Human poverty index
Eastern	37.1
Central	39.7
Western	36.7
Mid-western	46.3
Far-western	45.9
Nepal	39.6

Source: Nepal Human Development Report 2004

The Nepal Living Standard Survey (NLSS) reported major improvements in living standards and access to basic services in terms of income, food consumption, housing, health care, schooling and household access to electricity, piped water and toilet facility. However, the gaps between the poor and the rich, both in rural and urban areas with regard to health status and services, are wide (Tables 2 and 3).

The Human Development Index has improved considerably over the years from 0.296 in 1975 to 0.526 in 2003. Again, there are wide variations across the districts, ranging from 0.652 (Kathmandu) to 0.381 in Dailekh (Table 4). Development outcomes have varied inequitably, manifesting themselves in gender, caste, ethnic and geographic disparities. The Tenth Plan cannot reduce poverty significantly without systematic efforts and harmonizing the fundamental components of empowerment: economic empowerment, political empowerment and social empowerment (Table 5).

2.4 Education

Over the years, there has been a notable improvement in the education sector, particularly among the population aged 15 years and among girls. The proportion of

girls completing primary education increased from 46 % in 1995-1996 to 66.9 % in 2003-2004 (Nepal Living Standard Survey, 2004). In addition, there has been some progress in gender equality over the years, but still gender disparity exists in primary and secondary education (ratios of girls to boys at primary and secondary levels are 0.86 and 0.82 respectively). As evidenced by many studies globally, the education of girls is one of the main factors for improving the health status of mothers and children. Hence, Nepal needs to strive further to reduce gender disparity in education.

2.5 Nutrition

Malnutrition among children, adolescents and women is still a serious public health problem. About half of under-five children are affected by stunting. The proportion of underweight children is around 48%. Of them, 10% suffer from acute malnutrition and 13% by a combination of stunting, vitamin A deficiency and iron deficiency. It is believed that one of the main causes for malnutrition is the high prevalence of worm infestation, which is very high in rural areas (74% as per a survey conducted in three districts). Similarly, the prevalence of iron deficiency anaemia is equally high (46% among adolescent girls, 78% among preschool children and 75% among pregnant women). Continuation of exclusive breast feeding beyond six months, without any complementary feeding is another cause of malnutrition among infants and children. The situation of Vitamin A deficiency disorders has improved over the years but it is still a public health problem, as indicated by the prevalence of night blindness among pregnant women and women of reproductive age (6% and 4.7% respectively). The initiative by the Ministry of Health on the micronutrient intensification programme, with the focus on iron supplementation during pregnancy and postpartum, is continuing but the desired outcomes are awaited.

2.6 Food security

While food production has improved with a marginal surplus reported since 2000, food availability remains uneven. Some of the hill and mountain regions have been vulnerable to food insecurity. Of the 75 districts, 41 are categorized as food deficit. Only 40% of the rural households produce enough food to meet their year-round needs. Gender preference in intra-household food access makes women vulnerable to hunger. In addition, continuous population growth of 2.25% puts an extra strain on self-sufficiency of production and distribution of food.

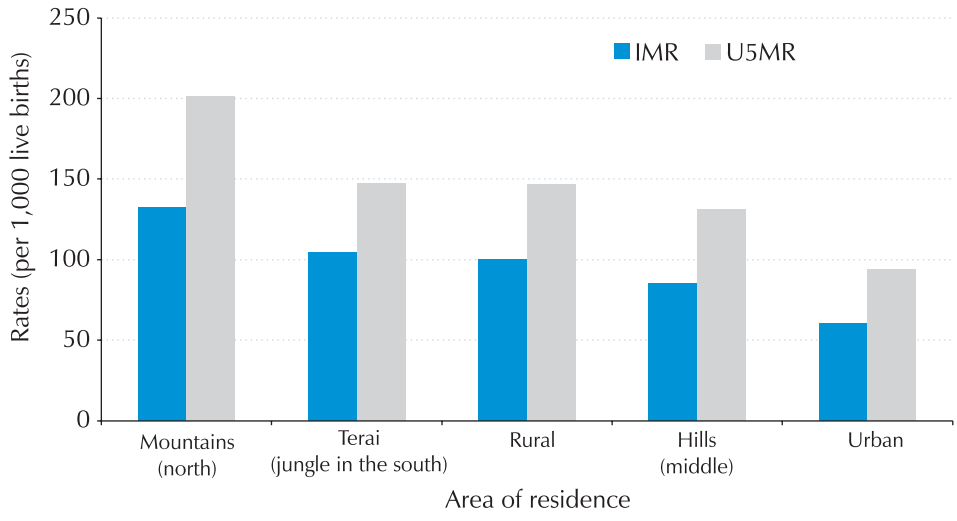
2.7 Social and health inequity

Persisting gaps exist between the haves and the have-nots, despite the country promoting the principle of placing all its citizens, including the poorest and most vulnerable, at the centre of the development strategy. Discriminatory practices rooted in its ethno-caste system have dominated every sphere, including health. Discrimination based on

the patriarchal structure deprives the majority of women of their dignity, self-respect and puts them in a disadvantageous position in access to and utilization of basic services. The historic exclusion of some indigenous minorities undermines their culture as well as livelihood. Though all forms of discrimination against Dalits (socio-economically backward caste) are prohibited, untouchability continues in practice.

The health gaps between the poor and the rich are very wide. Women in the poorest quintile receive antenatal care three times less and professional attendance in deliveries 11 times less than women in the richest quintile. The percentage of underweight children is 5 times higher among the poorest quintile compared to the richest. Immunization coverage of children under two receiving all vaccinations is less than half that of the rich children (Table 6). The differences in infant and under-5 mortality rates between urban and rural areas and zones are also significant as shown in the Figure below and Table 7.

Figure 1: Infant and under-5 mortality rates by area of residence, Nepal 2001



Source: Nepal Health Sector Strategy, June 2002

2.8 The conflict

Until very recently, Nepal had been passing through a period of political unrest, insurgency and violence. Following the people's upsurge in April 2006, the process for multiparty democracy is on the way. As per the joint request of the government and the Maoists, the UN has agreed to assist the peace process up to observing the Constituent Assembly election.

The conflict, started in 1996 with the Maoist insurgency, took a heavy toll. The rural people suffered the brunt of the conflict. Tens of thousands of people fled the

conflict-affected areas. Estimates suggest that up to 200, 000 people had been internally displaced. While the programmes of immunization, polio eradication, measles mass campaigns, vitamin A supplementation, de-worming and family planning services were allowed to continue, other health services, including supervision and monitoring, were hampered due to staff absences in the health centres and lack of equipment and supplies. It is believed that many of those who were internally displaced suffered psychological and mental stress.

2.9 Vulnerability to disasters

Nepal is a highly disaster-prone country. Several types of natural hazards like floods, landslides and drought affect different geographical zones annually with a varying degree of damage to the health infrastructure and people's health. Fires and epidemics occur during the dry and wet seasons respectively. Nepal, in particular Kathmandu, is vulnerable to earthquakes, but the preparedness for such a disaster is lacking. Hospitals are not earthquake-proof. The 1934 Great Bihar Earthquake epitomizes the worst case scenario for the country in the future. In the 1988 earthquake that hit the eastern and central regions, a lot of people died because of poorly designed buildings. The major flood disaster in 1993 as well as the flooding in 2002, and 2004 serve as reminders of the long-term consequences and developmental implications of natural disasters. Moreover, avian influenza poses a similar level of threat as in other Asian countries, and Nepal is on serious alert.

2.10 Governance and public sector reforms

The government has taken various measures to tackle issues which make the civil service efficient, responsive and accountable. Some of the measures include: establishment of governance reform units at key ministries, reorganization of some government agencies into autonomous organizations, preparation of a governance road map; and amendment of the Civil Service Act. However, much remains to be done for effective, efficient and transparent bureaucracy and fair representation of women and other marginalized groups. Decentralization is a key element of public sector reform. The decentralization efforts are constrained because of the absence of elected authorities, and lack of awareness of and understanding about the complex process of decentralization itself.

2.11 Epidemiology and disease burden

Over the years, Nepal has made progress in raising the health status and living standards of the population in terms of life expectancy, total fertility rate, child immunization, adult literacy and access to health care. Yet, the country continues to be afflicted with the double burden: persistent problems of infectious diseases along with emerging epidemics and upward trends of lifestyle related noncommunicable diseases. HIV/AIDS

is still primarily confined to vulnerable groups such as labour migrants, sex workers and intravenous drug users. HIV/AIDS is regarded to be in a stage of "concentrated epidemic" but has the potential to develop into a more generalized epidemic. Malaria is still a major public health problem. The incidence of selected diseases and conditions, and coverage of services are shown in Table 8.

The maternal mortality rate is very high, estimated at 740 and 539 per 100 000 live births as per the World Health Report 2005 and the Nepal MDG Progress Report 2005 respectively. The infant mortality rate is 61 per 1000 live births, two-thirds of which is accounted for by neonatal mortality. The major underlying causes are: gender discrimination, very low level of skilled birth attendance, socio-cultural beliefs and practices, maternal malnutrition and lack of awareness among the family and community about the importance of availing skilled care in case of pregnancy complications. Addressing all these is a major challenge for improving maternal and newborn health.

Reliable information on the lifestyle and risk factors-related diseases, particularly the prevalence of diabetes, hypertension, CVD and cancer is not available, but there are indications of the upward trends. A survey in Kathmandu city (2003) among the 25-54 years age group found that 74% of male respondents and 91% of female respondents were "physically inactive"; 27% of men and 42% of women were over weight; and the proportions with hypertension risk factors ranged from higher than normal to grade 3 hypertension were 39% among the male and 30% among the female population. Injuries and accidents, substance abuse and tobacco use are causes of great concern. The government signed the Framework Convention on Tobacco Control (FCTC) in December 2003. This has been ratified by the parliament in August 2006. Meanwhile, some administrative measures in keeping with the FCTC provisions have been in place.

Except in Sub-Saharan Africa, DALYs lost is the highest in Nepal - 363 per thousand people compared to 178 in China and 344 in India. Of the DALYs lost, 68.5% is due to the Group 1 diseases (infectious and parasitic diseases, acute respiratory infections, perinatal conditions and nutritional problems). This proportion is also highest compared to China (25.3%) and India (50.9%) as shown in Table 9. It is estimated that in 2011, DALYs lost due to Group 1 diseases would be 61.4 million, based on the projected population of 29.5 million (Table 10).

While information on private sector provision and utilization of health services are not available, it is estimated to be growing, mostly in urban areas. A significant number of people visit public health facilities. A total of 9.55 million outpatients (38% of the total population) were treated in the government health facilities in 2004-2005. The top ten OPD diseases were: skin diseases; ARI; diarrhoeal diseases; intestinal worms; pyrexia of unknown origin; gastritis; ear infection; sore eye and complaints; chronic bronchitis and dental problems, accounting for 28% of the total morbidity. Of the total hospital discharges, female patients accounted for 66% as against 34% males. Of the

total female patients, 77% were in the age group of 15-49 years, the corresponding figure for males was 38%. This disproportionately high percentage is perhaps due to the reproductive health problems of women.

2.12 Health policy orientations and priorities

A fairly comprehensive framework of health policies now in place include: the National Health Policy 1991; the Second Long Term Health Plan (SLTHP: 1997-2017); The Tenth Plan (Poverty Reduction Strategy Paper) 2002-2007; the Medium Term Expenditure Framework (MTEF, 2003); and the Nepal Health Sector Programme – Implementation Plan (NHSP-IP, 2004-2009).

The *National Health Policy 1991 aims at* extending the primary health care system to the rural population through health infrastructure development, community participation, multi-sectoral coordination, mobilizing local resources, decentralized planning and management. To take the policy forward, the Second Long Term Health Plan (1997-2017) has focused on improving the health status of women and children, the rural population, the poor, the underprivileged, and the marginalized. The plan has spelled out the need for redirecting resources from high-cost, low-impact interventions to low-cost, high-impact essential health care services (EHCS), while improving effectiveness and efficiency. EHCS is a package of services meant to be available for all. The list of such services is at Annex 2.

The *Medium Term Expenditure Framework has adjusted* priorities, based upon disease burden, equity consideration and pro-poor orientation. The *NHSP-IP* has developed a roadmap with eight outputs based on the Tenth Plan which can be summarized as: prioritized EHCS; decentralized health management; private and NGO sector development; sector management; financing and resource allocation; management of physical assets; human resource development; integrated management information system and quality assurance policy. The details of the outputs are given in Annex 3. Despite these clear and important long and medium-term policy and strategies, implementation has not been satisfactory.

2.13 Decentralization of health services

Within the overall decentralization framework of the Government, MOHP initiated community management of health facilities in 2003, with three actions: a) management of sub-health posts by local committees; b) verification of attendance of staff at sub-health posts by the VDCs before issuing pay cheques to them; and c) arrangement of compulsory public notice in the sub-health posts regarding the range of services, fees, and opening hours to be verified by VDCs and DHO. Over 1400 health facilities including health posts and primary health care centres were handed over to local committees by 2004/05, in 28 districts.

Community management of health facilities was found to have some advantages. These include: increased ownership by local communities; enhanced monitoring; quicker decision-making; greater transparency; and improved financial management in some districts. Issues such as handing over health facilities to community management in a systematic manner consistent with the main policy principles including equity in access and affordability of the poor, quality of care, managerial accountability, and people's empowerment are still to be dealt with. In addition, the absence of local elected bodies hampered the reform process.

2.14 Health financing

Health financing is one of the major issues. The total public spending on health is considered to be low (1.76% of GDP and 5.86% of the total national budget). The share of government health expenditure has not increased substantially since 2000, both in terms of proportion and per capita (US $ 4.06). Information on fiscal space is not available but the absorptive capacity of the public sector is relatively weak. In addition, the share of external resources in the public health budget has been over 30% over the years; most of which goes for essential health services (more than 90%). While a shift of resources to essential health services has been clearly outlined in the national health plan and MTEF, the Government continues to spend disproportionately on nonessential services.

More than half of the total health spending is from out-of-pocket source. In such a scenario, a country like Nepal, with very low per capita income runs the risk of pushing many people into poverty because of catastrophic health expenditure in the absence of some risk pooling and pre-payment schemes.

The Ministry of Health accounts for about two-thirds (70%) of the total government spending on health, followed by the Ministry of Finance (14%) and the Ministry of Education and Sports (10%). The development expenditure for the social sectors: (education, health, drinking water and local development) as a percentage of total development expenditure has grown over the years as shown below.

Social and health sectors development expendture as percentage of total development expenditure

Year	Social sector	Health sector
2001/2002	36.6	6.0
2002/2003	42.0	5.6
2004/2005	47.4	9.6

Source: Tenth Plan – Second Progress Report

2.15 Human resource

Human resource for health is a critical component to provide quality health services. A good number of medical graduates and other categories are being produced every year, but issues such as poor quality of education and imbalance of production of different categories of health professionals persist, resulting in lack of appropriate skill-mix in many cases. Production of HR is entrusted to the MOH and MOE, but coordination among the concerned ministries, universities and institutions is weak. The issue of human resource management with regard to deployment, retention, utilization and accountability is another challenge.

2.16 Summary of health challenges and opportunities

Slow economic growth, poverty and socio-economic exclusion, disparities in access to basic services and opportunities, poor governance, public sector inefficiency, lack of systems' responsiveness to people's legitimate demands, and gender inequality are the major cross-cutting issues impacting health of the population. Some major health sector challenges to be tackled are:

Health system including HRH

- Wide ranging health inequities persist between the rich and the poor, urban and rural areas and different ethnic groups. The challenge is how to design cost-effective interventions and reach the target groups who are still unreached because of socio-economic barriers and difficult geographical terrain.
- The present financing is far from fair, adversely affecting the poor. In the absence of risk pooling or pre-payment schemes, the general population, especially the poor, are vulnerable to be drawn further into poverty.
- There is lack of coordination between the public and private sectors with regard to service provisions, human resource quality and accountability. There is a pressing need to frame an appropriate regulatory framework for the private health institutions and facilities to ensure their compliance with the policy principles related to fair pricing, quality of care, and health equity for the poor.
- Responsiveness of the health care system in terms of coverage, quality of care and provider's accountability is weak. Quality assurance systems are not virtually in place.
- Presently, there are fragmented efforts to address the multi-sectoral determinants of health. The public health system's capacity and strategic management competencies are inadequate to meet this challenge. There is an urgent need to strategically focus and coordinate interventions of different sectors to achieve better health outcomes through effective coordination and synchronization of multi-sectoral interventions to address the socio-economic and environmental determinants of health.

- Human resource planning and development are not presently aligned enough with the health sector needs and priorities, resulting in an imbalance of production and sub-optimal skill-mix. Moreover, HRH management issues are yet to be effectively addressed in collaboration with major stakeholders.

Disease control, environmental and emergency health

- Though some communicable diseases have declining trends, effective control of endemic tropical diseases has been elusive, affecting mainly the rural poor. Malaria persists as a public health problem. Rabies, lymphatic filariasis, kala-azar and Japanese encephalitis still account for avoidable morbidity and deaths.
- Emerging disease threats and epidemics exist such as avian influenza and HIV/AIDS is a cause of great concern. There is presently no integrated disease surveillance encompassing communicable as well as noncommunicable diseases and their risk factors.
- People's access to improved water supply has increased but the quality of drinking water remains uncertain in many cases. The coverage of households with basic sanitation remains very low particularly in rural areas.
- Nepal's vulnerability to natural disasters including high magnitude earthquakes and frequent occurrences of floods and landslides result in serious health consequences due to the health sector's weak capacity for emergency preparedness and response.

Maternal and reproductive health

- Skilled care at birth is presently available only for 13% of deliveries. Building effective partnerships and mobilization of additional resources for training a sufficient number of skilled birth attendants to rapidly reduce maternal and newborn mortality is a formidable challenge.
- The prevalence of malnutrition among pregnant women and children is very high. Developing integrated approaches and cost-effective interventions is an urgent need to address nutritional deficiencies in collaboration with other partners.

However, there are also opportunities that could be utilized in making further progress. As stated earlier, a fairly comprehensive framework of policies and strategies is in place. There exists a countrywide network of health facilities and institutions. The health workforce in the public sector is quite large. International donors and agencies are interested in supporting the government efforts in health development. In addition, a large number of NGOs and civil society, many organizations at the grassroot level, are functioning. Recent political developments are perceived as promising for overall socio-economic advancement including health.

Development assistance 3

3.1 Development aid and partners

Development assistance is a significant component of government financing. There has been consistent foreign aid flow over the years. Overall, foreign aid has seen upward trend. In 1998-99, Rs 161.89 billion was received as foreign aid, Rs 43.37 billion (26.8%) as grant and the balance Rs 118.52 billion (73.2%) as loan. In 2003-04, the total foreign aid received was Rs 189.12 billion, about 17% more compared to the amount in 1998-99. Of the total, 60% was grant and the balance 40% was loan. The health sector received Rs 7.61 billion (4.7% of the total) in 1998-99 and Rs 5.07 billion (2.7% of the total) in 2003-04. Of the total amount received, 53% and 98% were grants respectively in the above mentioned two fiscal years.

Foreign aid disbursement was lower than the foreign aid commitment. In 2003-2004, the commitment was Rs 237.38 billion of which 80% was received, compared to 88% of the commitment in 1998-99 (Public Economic Survey 2004/05). The need for development aid, in particular for the health sector, is well appreciated by international agencies and donors. However, the flow of aid depends on programme implementation and the political situation. Recent positive developments in the political process are looked upon as conducive to receiving and utilizing foreign aid in keeping with the policy priorities.

There are many partners working for the health sector and other development initiatives. The main donor agencies are: the World Bank, DFID, USAID, GTZ, KFW, the Asian Development Bank, JICA, AUS Aid and SDC. There are 137 international NGOs and thousands of NGOs. Many of them are working in health. The UN agencies collaborating with the government in health and related fields are: UNDP, UNICEF, UNFPA, UNAIDS, World Food Programme, FAO, ILO and WHO. GFATM/CCM has approved proposals in the programme areas of HIV/AIDS (US$ 10.37 million). Malaria (US$ 7.64 million) and Tuberculosis (US$ 10.13 million). An overview of the donor support in priority health programmes is presented in Table 11.

3.2 Coordination mechanism

A collaborative framework is in place for coordination of development assistance and partnerships. The Poverty Reduction Strategy Paper (PRSP), United Nations Development Assistance Framework (UNDAF) and Consolidated Appeal Process (CAP)

are there at macro level. There are 10 thematic groups in the United Nations System. These are on: Agriculture; Disaster preparedness; Education; Energy and power; Gender and development; Good governance and public sector; Health and population; Macroeconomic and financial management; private sector and trade; Natural resources management and environment; and Transport. A sector-wide approach has been agreed upon to provide support in the health sector. It is for the first time that a business plan for the health sector (2006/07 – 2008/09) has been prepared in 2005. This is based on the objectives of the Second Long Term Health Plan and is designed to implement the Health Sector Strategy: An Agenda for Reform.

In addition to the above, a statement of intent to guide the partnership in the health sector has been signed by the Ministry of Health and 11 external development partners including WHO. The principles of partnership include: harmonization of donor support, developing and maintaining a climate of transparency and accountability, working together to build consensus on necessary actions and prioritized spending framework – all this being aimed at ensuring that all the assistance by the partners will be fully consistent with the Health Sector Strategy – An Agenda for Reform. The implementation mechanism of the partnership includes: A formal health sector development forum and a Joint Annual Review (JAR). The forum is scheduled to meet quarterly and the review is carried out twice a year jointly by the MoHP and development partners. These two mechanisms serve the purpose of common monitoring. But, these meetings are not always taking place as planned and overall coordination between the MoHP and EDPs needs strengthening.

There is an agreement between the South Asia Association for Regional Cooperation (SAARC) and WHO for cooperation in health. The memorandum of understanding between SAARC and WHO signed in 2000 aims at enhancing collaboration between WHO and the SAARC TB centre in Kathmandu, and other institutions in South Asia; and promotion of research for enhancing technical cooperation and human resource development. Health and population activities is one of the components of the Regional Integrated Programme of Action (RIPA). The SAARC forum facilitates regional cooperation among its Member countries. A memorandum of understanding for kala-azar elimination has been signed between Bangladesh, India and Nepal.

3.3 Consolidated appeal process (CAP)

In 2005, a CAP was undertaken for the first time and a humanitarian appeal prepared and launched. The health component of the CAP had 10 proposals by various agencies to address current humanitarian gaps not covered by planned development interventions, particularly the needs of the most vulnerable, conflict-affected populations as well as the building of in-country emergency disaster response capacity. Of the 10 proposals, only WHO's proposal received SIDA funding amounting to US$ 500,000. The expected results of the WHO CAP programme include: humanitarian crisis

monitoring and rapid assessments of public health priorities; conceptualized and field-tested; best public health practices in emergencies identified; functional rapid response teams in place; mass casualty management and triage system in place; risk reduction and mitigation measures initiated.

3.4 Key challenges and opportunities

Working together in partnership provides opportunities for better understanding of different issues, sharing of information, exchange of opinions and views - all these facilitate addressing the identified issues and problems, thereby contributing to capacity building at different levels of the system. But, it also poses a number of challenges, particularly in coordinating, harmonizing and aligning the efforts of everyone with the national strategies and priorities.

There has been some improvement in coordination and absorption of development assistance over the years. The existing coordination mechanism is well defined and well accepted by all concerned. However, development partners need to make concerted efforts to support the Government to further strengthen the capacity of the Ministry of Health and Population to meet the requirements of timely implementation of agreed upon activities. The problem of capacity was further compounded by the conflict and the political instability that had adverse impacts not only on field activities but also on higher level decision making.

The EDP group comprising UN agencies and donors who are signatories to the statement of intent mentioned earlier meets once a month. The chairmanship as well as the co-chairmanship of the group rotates annually among the members. WHO plays a key role in promoting coordination between EDPs and with the government in respect of health issues and agreed upon interventions.

4 Current WHO cooperation

WHO, in its collaborative work with the government, is guided by its four strategic orientations in providing support and technical assistance for selected national priorities. The strategic orientations are: integrating health and human development in public policies; ensuring equitable access to health services; promoting and protecting health; and preventing and controlling specific health problems. WHO has successfully articulated its consistent, ethical and evidence-based advocacy and policy positions.

The WHO's support to the priority programme areas is from both the regular budget and voluntary contribution. The size of the regular budget in the last three biennia exclusively for programme activities has been around US$ 6 million for each biennium. Resource mobilization from other sources for ensuring adequate funding support to priority interventions on pressing health challenges is a function of increasing importance for WHO .

The WHO current cooperation (2006-2007) for different areas of work under four domains involves an amount of US$ 14.42 million: $ 7.27 million for essential health interventions in disease control, MCH and emergency health; $ 2.87 million for health policies, systems and products including HRH, essential health technologies and medicines; $ 1.36 million for environment, food safety, nutrition, tobacco, research and gender equity; and $ 2.92 million for enabling programme delivery and WHO's core presence.

The main emphasis of support has been on improving health systems planning and strategic management for promoting health equity, health outcomes and system's response to people's needs. With this end in view, support has been provided for human resource development; strengthening district health systems; epidemiological surveillance, disease prevention; and reproductive health. WHO has been giving substantial assistance for surveillance of vaccine-preventable diseases including poliomyelitis, measles and Japanese encephalitis. Other priority areas are: blood safety; promoting healthy life styles; and reducing risk factors to human health that arise from environmental and behavioral causes.

In addition to the WHO Representative, there are 14 international professional staff in the WHO country office including six short-term professionals and one Administrative and Programme Officer. The WHO programme for immunization preventable diseases (IPD) has 62 staff members including two expatriate professionals

and one national professional officer and one administrative and programme officer. Presently, there are 21 national operations officers, 15 for IPD and the remaining six for other programme areas. The provision for general staff is 18. There are 81 staff under Special Services Agreement (SSA) including 59 for IPD. Of them, 31 SSA holders are stationed in the field. The leprosy and HIV/AIDS programmes are supported by short-term consultants as and when needed. Among the international professional staff, 10 are males and four are females. There is only one female among 22 national professional staff (20 NOOs + 2 NPO). Of the existing general staff, only two are females.

The WHO country office is located in the UN House. WHO is in compliance with the minimum operating security standards (MOSS) in respect of its office, most of the office vehicles, and other items. There is a regular support from the Regional Office and from WHO Headquarters in terms of visits and participation in meetings on different health issues. The WHO country team and concerned government officials participate regularly in the activities of the Regional Office and Headquarters. The IPD programme has a separate office in the vicinity of the UN House, and is also MOSS compliant.

The work of WHO as a specialized agency in health is well appreciated by the government, UN agencies and development partners. There have been improved policy inputs in the national health plans and notable progress in sector management. Norms and standards are now available in most of the national program areas. However, the pace of translating the national policies into cost-effective interventions has been slow. There is a need for WHO to sharpen its focus on selectively few strategic interventions for achieving better health outcomes particularly with regard to the issues of health equity, integrated disease surveillance, prevention and control of chronic diseases, management of human resource for health; and sustainability of the system interventions to make progressive improvements in the years ahead.

5 WHO policy framework

5.1 Global challenges in health

The General Programme of Work (GPW) is the highest policy document of WHO. The 11th GPW (2006-2015) sets out the direction for international public health for the period of 2006 through 2015. The document notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain, as described in the following four gaps:

Gaps in social justice: Clearly, poverty is a key factor that impedes access to quality health services. In some countries the life expectancy of the poor is 20 years lower than other privileged members of society. Poor health and poverty form a vicious cycle. Other factors that reduce access to services are discrimination by ethnicity or gender, and women's health which is often not adequately addressed.

Gaps in responsibility: Health problems today are no longer merely the responsibility of those working on health, but require positive action by those outside the health sector. International conflicts and national crises often lead to the disruption of social services which include health care. Globalization and decisions made regarding international trade have a direct impact on health, especially in pharmaceuticals and the movement of health professionals. In many countries Ministries of Health often do not have the capacity to adequately influence important causes of ill-health outside the health sector.

Gaps in implementation: Very often the technology to implement cost-effective interventions to improve health is available. But these are not implemented because of shortage of funds, lack of human resources or the absence of an effective health system. Available resources may often be allocated to high-cost curative services and favor urban areas, leaving inexpensive and effective interventions in rural and remote areas neglected.

Gaps in knowledge: Global advances in science and technology have improved the effectiveness and efficiency of medical services and the prevention and treatment of diseases. However, information about these advances is often not available in many countries. Also, the lack of information about health conditions, and existing rigidities in many countries have in turn made it difficult to formulate and manage effective health policies and interventions. Even operational research for those most in need of health services is generally not done, thereby reducing the efficiency of key programmes.

Global health agenda

In order to reduce these gaps over the coming ten years, the 11th GPW outlines a global health agenda consisting of seven priority areas:

- Investing in health to reduce poverty
- Building individual and global health security
- Promoting universal coverage, gender equality, and health-related human rights
- Tackling the determinants of health
- Strengthening health systems and equitable access
- Harnessing knowledge, science and technology
- Strengthening governance, leadership and accountability

The global health agenda is meant for everyone working in the field of health development. WHO will contribute to this agenda by concentrating on its core functions, which have been built on the comparative advantages of the Organization. In accordance with the global health agenda and WHO's core functions, the Organization has set the following priorities:

(1) Providing support to countries in moving to universal coverage with effective public health interventions

(2) Strengthening global health security

(3) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health

(4) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health

(5) Strengthening WHO's leadership at global and regional levels and supporting the work of governments at the country level.

WHO will pursue these priorities through its Medium-term Strategic Plan (2008-2013) and the biennium budget of the Organization. The Director General of WHO has clearly put a major focus on the work of the Organization at the country level. The Regional Offices and Headquarters have been directed to emphasize support for country work and implement these priorities in Member States, especially where the health needs are greatest.

5.2 Regional policy framework

The South-East Asia Region (SEAR) has the second highest population among the six WHO regions and carries the greatest burden of disease. While there has been significant economic development in recent years, the problems of poverty and poor health persist. Many countries have faced health emergencies in the last decade and the threat of

WHO's core functions

- Providing leadership on matters critical to health and engaging in partnershipswhere joint action is needed;
- Shaping the research agenda and stimulating the generation, translation anddissemination of valuable knowledge;
- Setting norms and standards, and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change, and building sustainable institutional capacity;
- Monitoring the health situation and assessing health trends.

disease outbreaks is ever-present. At the same time, noncommunicable diseases have become an increasingly important cause of morbidity and mortality. Therefore, the global policy framework of WHO is appropriate for countries of the Region, with special attention given on strengthening their capacity to support public health interventions.

The South-East Asia Region has always placed a strong emphasis on its work in Member States. Of the total budget provided to the Region, 75% is allocated for countries, the highest in any WHO Region. The WHO Regional Director recently increased the delegation of authority to country offices to enable them to plan and implement programmes with a higher degree of independence and to be more accountable for their work. At the same time, he has emphasized that the Regional Office staff should give the highest priority to support the work in these countries.

Strategic agenda 6

This agenda has been prepared for the next six years keeping in view: the health sector issues and challenges outlined in Chapter 2; the unfinished agenda, for the last CCS (2002-2005) that is still relevant, MOHP priority interventions that require WHO technical support consistent with the Organization's core functions that is still relevant; WHO's comparative advantage; and support by other development partners to the health sector. There will be a strategic shift in the work of WHO. Six components identified as WHO's strategic agenda are:

- Strengthening health system;
- Control and prevention of disease and disability;
- Human resource development;
- Child, adolescent and reproductive health;
- Healthier environment; and
- Emergency preparedness and response.

WHO's technical assistance and support in these programme areas will be designed and provided in keeping with its core functions. An indication of the extent of their linkage with WHO's core functions is in Table 12. These components of the strategic agenda have been aligned with the National Health Sector Programme-Implementation Plan (Annex 4). Strategic approaches identified in each of the six components indicate priorities where WHO will focus its efforts to support the government in achieving its national objectives. These priorities will be undertaken in collaboration with major stakeholders, including the external development partners. WHO will play its role in keeping with its comparative advantage and six core functions in the context of the overall strategic framework of the Organization.

6.1 Strengthening the health system

Rationale

In spite of enhanced capacity in policy planning and strategic management, the main challenges ahead are: effectively reducing health inequities through cost effective interventions, multi-sectoral coordination and fair financing; systematically involving private and NGO sectors; promoting decentralization of health services aiming at community empowerment; and enhancing the health system's responsiveness in respect

of quality of care, and managerial accountability. All these are of crucial importance to achieving the health sector policy outcomes.

- Support equity in health and increased access to services particularly for the underprivileged population and vulnerable groups through promoting partnerships, key stakeholders coordination, evidence-based and integrated policy approach.
- Promote equitable, adequate and sustainable health care financing.
- Support the ongoing process for decentralization of health services in a systematic manner and community health promotion initiatives.

Strategic approaches

- Support the streamlining of public-private partnerships: regulatory framework; contracting systems; monitoring performance, and promote evidence-based policies to empower civil society engagement in developing equitable access.
- Strengthen multi-sectoral coordination and build capacity for an integrated approach to health development, involving the Ministry of Housing and Public Works, the Ministry of Agriculture and the Ministry of Local Development in environmental health interventions; and the Ministry of Education in Human Resource Development; and the Ministry of Finance, the National Planning Commission and the Ministry of Social Welfare in sector development.
- Promote synergy with key stakeholders and external development partners in ongoing health sector reform initiatives and sector-wide management
- Support revision of the national drug (medicines) policy and the development of systems that integrate essential drug supplies into the essential health care services
- Provide support to finalize the National Strategy for Health Sector Information System, and support national institutions in the collection of disaggregated data to help track progress and in measuring achievements of national policies and plans, including MDGs
- Analyze the present financing mechanism with regard to equity and burden of paying for health services, support alternative financing and capacity building to use National Health Accounts information for programme planning and management
- Bring global evidence to advocate for government policies in line with WHO positions on out-of-pocket payments, user fees and pre-payment and risk pooling systems of health financing
- Support the development of a health sector policy on decentralization, including community management of health facilities and show evidence-based experience on decentralization from other countries

- Support district health systems development: including decentralized management, essential drug systems, surveillance, capacity of public health workforce, and systemic linkages with other levels.

6.2 Control and prevention of disease and disability

Rationale

The incidence of endemic tropical diseases are still major public health problems affecting mostly the poor in rural areas. Drug-resistant malaria is an emerging problem. HIV infection is in a phase of "concentrated epidemic". Emerging disease threats and potential epidemics such as avian influenza are ever present. While WHO Immunization Preventable Diseases (IPD) has assisted the government to develop surveillance for vaccine-preventable diseases such as Japanese encephalitis and poliomyelitis, an integrated disease surveillance system is yet to be in place. Also, there is an urgent need to develop HRH competencies and facilities required for effective compliance with the provisions of the International Health Regulation. A national NCD prevention policy and strategy is being developed. Presently, community-based data are not available to plan evidence-based interventions.

Strategic objectives

- Provide support for the development of integrated disease surveillance (IDS) and NCD risk factors surveillance systems including unhealthy lifestyles.
- Support immunization activities and the introduction of new and underutilized vaccines that will lead to eradication, elimination, or control of polio, measles mortality, neonatal tetanus, Japanese encephalitis, rotavirus, and other immunization-preventable diseases.
- Support capacity building of public health workforce and programme interventions for effectively addressing priority communicable diseases including malaria, tuberculosis and HIV/AIDS, and elimination of leprosy, kala-azar and lymphatic filariasis,

Strategic approaches

- Support the quality assurance of DOTS expansion and the national strategy for MDR TB and HIV/AIDs
- Strengthen the systems for ART, laboratory services, VCT and support the integration of HIV/AIDS prevention and care with health services
- Continue support to programme management for leprosy elimination, quality assurance of leprosy surveillance, and capacity building at district level for effective implementation of the kala-azar elimination plan

- Develop the policy, legal framework, operational guidelines and support capacity building and public health laboratory network for integrated disease surveillance including compliance with the International Health Regulations (2005)
- Strengthen malaria control through evidence-based diagnosis, treatment, and district vector control, and promote compliance with the standard treatment protocol and carry out systematic monitoring of malaria drug resistance as per the revised national treatment policy
- Support implementation of the national policies and strategic plans for NCDs by developing community-based approaches for healthy lifestyles and promoting community involvement, and facilitate the review and revision of legislation pertaining to mental health
- Develop mechanisms for broad-based partnerships and a surveillance system for tobacco control in line with FCTC
- Support the development of recording and reporting systems on violence, injuries and disabilities and advocate for adequate cross-government policy responses.

6.3 Human resource development

Rationale

A number of medical graduates and other categories are being produced every year in Nepal. However, there is an imbalance in the production of different categories of health professionals, resulting in lack of appropriate skill-mix in many cases. In some cases, the level of skills and competencies of the health workforce is below what is required for discharging their functions. Coordination among the concerned ministries, universities and institutions needs much improvement. The issue of human resource management with regard to deployment, retention, utilization and accountability is a major challenge. Hospital administration remains a relatively neglected area due to the paucity of competent managerial staff. The strategic HRH plan now in place is not adequately aligned with the policy priorities and requirements of health care delivery systems. Moreover, most of the existing human resource management practices are not conducive to optimal performance.

Strategic objectives

- Support mainstreaming the development of HRH in accordance with the health sector policy priorities and issues
- Provide catalytic support to strengthen the national capacity for training HRH in keeping with the policy and programme interventions

Strategic approaches

- Assess human resources in the country's health system, covering the current HR situation, needs analysis and production policies, so as to inform national policies and plans.
- Review the existing human resource development strategy in collaboration with major stakeholders
- Assist in developing the public health workforce through competency-based training to deliver the prioritized essential health care services
- Review and strengthen the accreditation system for medical, nursing and paramedical education
- Facilitate the streamlining of the regulatory framework to ensure performance and accountability.

6.4 Child, adolescent and reproductive health

Rationale

The health of adolescents, who comprise 23% of the population, has not received due attention until recently. This group is most vulnerable to HIV/AIDS. Half of the country's 50,000 injecting drug users are 16-25 years old. More than 50% of women aged 20-24 are married by 18 years and 14% by 15 years. About one-fourth of births to adolescents are unplanned, 22% mistimed and 1% unwanted. The unmet need for family planning among adolescents is higher than the national average of 28%.

Under-5 and infant mortality rates are still very high; 76 and 61 per 1000 live births respectively. MMR of Nepal is the highest in the South-East Asia Region, 740 per 100,000 live births as per the National Demography Health Survey 2001. More than 4000 women die every year due to pregnancy-related causes. The proportion of deliveries conducted by health personnel continues to be very low, only 13% in 2003/2004 (DHS Annual Report 2003/2004). The major challenge is how to ensure that all women and newborns are provided with a continuum of care throughout pregnancy, childbirth and the post-partum period, by skilled birth attendants (SBAs).

Strategic objectives

- Promote reproductive, maternal and child health, focusing on interventions in underprivileged areas.
- Promote evidence-based interventions for addressing adolescent health problems including substance abuse, risk of HIV/AIDS, unsafe sex and unhealthy lifestyles.

Strategic approaches

- Support the strengthening of partnerships and resource mobilization efforts for scaling up the implementation of the package of essential maternal and neonatal health services.
- Support the training of SBAs by updating the in-service and pre-service training curricula for developing the core competencies.
- Support the development of quality assurance (audit) systems for maternal and neonatal health care services.
- Provide an evidence-based guidance for integration of newborn health care into the safe motherhood programme and advocate public-private-partnership for expansion of IMCI interventions in underprivileged areas.
- Provide an evidence base for developing cost-effective interventions for addressing adolescent health problems by creating an enabling environment and by integrating services in the health care delivery system.
- Build effective partnerships for resource mobilization and improved coverage to address nutritional deficiencies.

6.5 Healthier environment

Rationale

The major problems in the field of environment are: inadequate safe water supply; low sanitation coverage and poor hygiene practices, particularly in rural areas; poor waste management practices; high prevalence of ambient and indoor air pollution; and inadequate public awareness about exposure to hazardous or chemical substances. Arsenic contamination of tubewell water in the Terai areas and microbial contamination of surface water are two major challenges to human health.

Strategic objectives

- Promote suitable and cost-effective technological options for improving environmental health.
- Review the Food Act (2003) and support changes in health, hygiene and sanitation behaviour.

Strategic approaches

- Assist in dissemination and uptake of national water quality standards in line with WHO guidelines.
- Support and monitor the introduction of cost-effective, safe water and sanitation improvement measures in district plans

- Develop and implement arsenic contamination mitigation measures together with other partners
- Advocate for updating the national policy related to the environment in collaboration with partners
- Review the food safety and nutrition promotion measures in keeping with the Codex Alimentarius
- Build networks and partnerships on environmental health issues

6.6 Emergency preparedness and response

Rationale

Nepal is highly vulnerable to natural disasters, particularly high magnitude earthquake. The decade-long violent civil conflict has affected the delivery of basic public health and medical services to the population. Emergency preparedness and response is not adequately addressed in MoHP policies and planning. Further, there is a scarcity of financial resources, limited capacity and expertise in this area of utmost priority.

Health sector emergency planning, seismic assessments of hospitals, mass casualty management training and identification of best public health practices are being carried out under this programme. It is important to continue these efforts as well as introduce new field-based and humanitarian interventions in response to complex and natural disasters. An expansion of the programme is expected in future.

Strategic objectives

- Support health sector capacity building to mitigate the health effects of natural and man-made disasters.

Strategic approaches

- Advocate for adequate human resources in the area of health sector emergency preparedness
- Promote integration of health emergency preparedness and response as a cross-cutting issue
- Support health sector emergency planning, monitoring and response, including mass casualty programmes, and hospital mitigation
- Build partnerships for more effective planning, coordination and response.

7 Implementing the strategic agenda

The Mission members and the country team had jointly initiated a process for identifying the implications of the strategic agenda for WHO's work. Subsequently, a review was carried out by WHO country office technical staff to assess available capacities and required competencies for implementing the CCS strategic agenda. The following assessments are based on the above-mentioned review.

7.1 Shift in priorities

The CCS agenda requires a shift in priorities in the work of WHO at the country level. Emergency and humanitarian action, reproductive health and HIV/AIDS are three priority areas that need more technical support and focus from WHO. EHA is of crucial importance because of the country's high vulnerability to natural and man-made disasters. But emergency preparedness and response capacity of the health sector is very weak. On the other hand, the WHO country office lacks competency to provide leadership and coordination in capacity building in the concerned government departments.

Maternal and child mortality in Nepal is among the highest in the world. Any notable improvement in the people's health status requires accelerated reduction in maternal and newborn mortality rates. A number of external development partners are involved in reproductive health interventions. What is lacking, however, is strong technical support and coordination in child, adolescent and reproductive health. The WHO country office does not have the required competency to play its leadership role in terms of providing strong technical support and coordination in this programme area.

HIV/AIDS, presently in the phase of a 'concentrated epidemic', has serious epidemic potential because of a large number of Nepalese sex workers in different cities of India, intravenous drug users, migrant workers and a large open border with India. WHO is expected and required to play a more active role in providing technical support and promoting coordination among key stakeholders. This requires augmenting technical staff support on a regular basis.

In addition to the above-mentioned three areas, it will be necessary to continue support in other areas of work. The country office will need to have options for contracting STCs and STPs as and when required in such programme areas as

tuberculosis, malaria, leprosy elimination, IPD, laboratory services, health systems development , decentralization, health economics and communication/media relations.

7.2 Staff adjustments and positions

The WHO Country Office will critically review the current post descriptions, keeping in view the competency requirement for achieving the CCS strategic agenda. Based on this, post descriptions in some cases would be changed, aiming at ensuring shared responsibilities to better cover the CCS priorities. Moreover, a review of current capacities and required competencies will be jointly carried out by the WHO Country Office and the Regional Office to identify staff adjustments and positions to align them with the new priorities.

7.3 Staff training and orientation

Steps will be taken for building stronger, more competent, more cohesive and dynamic teams to more effectively address cross-cutting issues relevant to the CCS agenda. Issue-specific, task-oriented interactions among the staff on a regular basis are a way forward in this direction. More specifically, reorientation of staff on health system and evolving issues; training in environmental health epidemiology and disease burden as tools for advocacy; and reorientation/training for country office staff in cross-cutting issues impacting health would be necessary.

7.4 Technical support from the Regional Office and Headquarters

Continued support from the Regional Office and WHO Headquarters is important for achieving the outcomes targeted in the CCS. Additional technical support would be necessary in:

- Health systems development: review, reform and reorientation, based on cross-country evidence
- Decentralization of health services in a sustainable manner
- Health economics as a strategy for programme development and service delivery
- Harmonization and alignment, including donor coordination and partnerships
- Broad health and development issues such as social determinants, equity, human rights, and gender
- Enhancing skills in key stakeholders' coordination with regard to cost-effective interventions and resource allocation;
- Public health laboratory strengthening;

- Advocacy and promotion of evidence-based interventions for NCD and related risk factors;
- Promoting action-oriented research in policy and human resource development; and
- Technical assistance for Global Management System (GSM), knowledge management and information technology.

7.5 Implementation of the strategic agenda through WHO results-based management system

The strategic agenda of this CCS will be implemented through the strategic objectives of the Medium Term Strategic Plan (MTSP) 2008-2013 and related biennial programme budgets. During the preparation of the workplans in related biennial budgets, the priorities identified in the CCS will be reflected in the relevant strategic objectives of the MTSP and PBs, and joint planning which will ensure consistency with WHO priorities and strategies and programmes.

7.6 Resource mobilization

Additional resources for the country office and the Government will have to be mobilized to effectively implement the strategic agenda identified in this CCS. The WHO country office with support from the Regional Office and HQ will develop its country office capacity on resource mobilization. In addition, it will take a pro-active role in developing project proposals for the country office and in supporting the Government in developing proposals for mobilizing additional resources. The next two programmes will make sufficient provisions for short-term expertise to ensure timely and high quality technical assistance on issues arising from the changing context.

Table 1: *Health and development indicators of Nepal at a glance*

Indicator	Value
Total population (2005)[1]	27 133 000
% of total population under 15 (2005)[1]	39
Women of reproductive age (15-49 years) in million (2003)	6.1
Average population growth rate (2000-2005), %	2.2
Population distribution % rural (2005)[1]	84.0
Life expectancy at birth in years (2004)[2]	61
Under-5 mortality rate per 1000 live births (2004)[2]	76
Maternal mortality ratio per 100 000 live births (2005)[3]	415
Infant mortality rate per 1000 live births (2005)[8]	61
Total fertility rate per woman in reproductive age group (2004)[2]	3.6
Total expenditure on health as % of GDP (2004)[4]	5.4
General government expenditure on health as % of total government expenditure (2004)[4]	9.1
Human Development Index (2003)[5]	0.526
Human Development Index Rank, out of 177 countries (2003)[5]	136
Gross National Income (GNI) per capita US$ (2004)[6]	250
Population living below national poverty line % (1990-2002)[5]	42.0
Adult (15+) literacy rate (%) (2000-2004)[7]	48.6
Adult male (15+) literacy rate (%) (2000-2004)[7]	62.7
Adult female (15+) literacy rate (%) (2000-2004)[7]	34.9
% population with access to improved drinking water source (2002)[5]	84
% population with improved access to sanitation (2002)[5]	27

Sources:
[1]United Nations Population Division
[2]World Health Report 2006
[3]Nepal MDG Progress Report 2005
[4]WHO data on National Health Accounts
[5]Human Development Report 2005
[6]World Development Indicators 2005 (World Bank)
[7]UNESCO Institute for Statistics
[8]Nepal millennium Development Goal Progress Report 2005

Table 2: *The poverty gap in health status and services*

Health status	1996		2001	
	Poorest	Richest	Poorest	Richest
Infant Mortality Rate (IMR per 1000 live births)	96.3	63.9	85.5	53.2
Under-five Mortality Rate (U5MR per 1000 live births)	156.3	82.7	129.9	67.7
Underweight <2z score	59	31.8	32.7	24.6
Health services: Immunization coverage (%) (all)	32.4	71.1	54.2	81.6
Medical treatment Diarrhea prevalence in U5 age category (%)	32.2	20.7	41.8	64.3
Seen medically (%)	9.5	18.3	15	21.8
Antenatal care % (more than 2 visits)	16.6	57.4	NA	NA
Antenatal care % (more than 3 visits) to a medically trained person	NA	NA	13.3	62.4
Delivery by Health Workers %	2.9	33.7	3.6	45.1

Source: HNP 1996,2001
Note: Poorest–lowest 20% quintile consumption category
Richest–highest 20% quintile consumption category

Table 3: *The Urban-Rural gap in health status and services*

Health status	1996			2001		
	Urban rich	Rural poorest	Rural richest	Urban rich	Rural poorest	Rural richest
Infant Mortality Rate (IMR per 1000 live births)	–	96.5	71.7	39.4	84.8	62.1
Under-five Mortality Rate (U5MR per 1000 live births)	–	156.8	90.5	50.1	129.4	79.3
Underweight (<2z score)	19.8	53.3	31.2	23.4	32.7	25.4
Health services: Immunization (all) (%)	75.8	32.3	69	78.2	54	83.3
Medical treatment Diarrhea prevalence (%)	20	32.3	21	65.1	41.6	63.8
seen medically (%)	14.2	9.6	20	26.2	15.1	19.5
Delivery by Health Workers (%)	71.7	16.6	51.2	60.2	3.5	36.7

Source: Health Nutrition and Population, World Bank Analysis 1996, 2001

Table 4: *Human Development Index of 10 poor and 10 well off districts (Data refers to 2001)*

Poor districts	Life expectancy at birth (yrs)	Adult literacy %	Mean years schooling	GDP per capita (PPP US$)	Human develop-ment index (HDI)	Ratio to national HDI	HDI rank
Udayapur	68.03	47.3	2.30	975	0.488	103.5	21
Siraha	63.38	34.8	2.06	880	0.427	90.5	51
Rautahat	63.51	28.1	1.64	871	0.409	86.7	56
Rasuwa	54.75	25.4	1.56	1802	0.394	83.6	62
Arghakhachi	62.54	47.7	2.95	1130	0.471	100.0	33
Kapilbastu	62.53	35.8	2.00	1121	0.437	92.8	47
Pyuthan	61.69	37.8	2.15	754	0.416	88.3	53
Dailekh	55.83	39.9	1.95	679	0.381	80.8	66
Dadeldhura	56.62	43.4	2.40	1321	0.434	0.92	49
Doti	58.39	35.4	1.68	945	0.402	85.2	60
Well off districts							
Kathmandu	69.53	73.5	5.94	3438	0.652	138.2	1
Bhaktapur	71.33	64.0	4.41	1862	0.595	126.2	2
Kaski	70.76	66.8	4.40	1707	0.593	125.8	3
Lalitpur	67.10	66.9	5.07	2059	0.588	124.8	4
Rupandehi	68.27	62.2	3.01	1358	0.546	115.8	5
Kavrepalacnchok	69.33	56.1	2.60	1572	0.543	115.3	6
Syangja	67.71	57.5	3.47	1333	0.535	113.5	7
Morang	67.28	52.3	3.35	1617	0.531	112.6	8
Tanahu	68.79	54.4	2.98	1188	0.524	111.1	9
Terhathum	67.78	54.0	3.40	1246	0.523	111.0	10
Nepal	**60.98**	**48.6**	**2.75**	**1310**	**0.471**	**100.00**	

Source: Nepal Human Development Report, 2004

Table 5: *Empowerments and human poverty index in urban rural areas and regions (Data refers to 2001)*

	Economic empowerment		Social empowerment		GDI		Human poverty index	
	Value	Ratio to national index	Value	Ratio to national index	Value	Ratio to national index	Value	Ratio to national index
Nepal	0.337	100	0.406	100	0.452	100	39.6	100
Urban	0.518	154	0.334	82	0.562	124	25.2	64
Rural	0.034	90	0.481	118	0.430	95	42.0	106
Mountain	0.236	70	0.346	85	0.363	80	49.8	126
Hills	0.310	92	0.322	79	0.498	110	38.8	98
Terai	0.392	116	0.412	101	0.450	100	39.6	100

Source: Nepal Human Development Report, 2004

Table 6: *People in income quintile for selected health indicators*

Health indicators	Poorest 20%	2nd quintile	3rd quintile	4th quintile	Richest 20%
Attended delivery (%)	2.9	5.2	6.4	9.1	33.7
Ante Natal Care (%)	21.5	34.7	35.6	43.5	66.5
Immunization coverage[1] (%)	32.4	34.6	40.8	51.0	71.1
Severe malnutrition[2] (%)	20.1	19.6	17.6	14.1	4.4
Total Fertility Rate[3] (per woman)	6.2	5.0	4.7	4.4	2.9
Use of modern contraceptives (%)	15.7	21.2	23.2	26.6	44.9

[1] % of children under 2 years of age receiving all vaccinations
[2] % of underweight children under 5 years of age
[3] women of reproductive age group

Table 7: *Infant and child mortality rate by area of residence (Data refers to 2001)*

Area of residence	IMR	Under-5 mortality rate
Urban	60.4	93.6
Rural	100.2	147.0
Mountains (north)	132.3	201.0
Hills (middle)	85.5	131.3
Terai (jungle in the south)	104.3	147.3

Source: Nepal Health Sector Strategy, 2003

Table 8: *Incidences of selected diseases and health service coverage*

Programme areas	2002/03	2003/04	2004/05
A. Control of diarrhoeal diseases			
1. Incidence of diarrhea per 1000 under 5 children	200	222	219
2. Percentage of some (mild to moderate) dehydration among total new cases	41.4	40.3	37.8
3. Percentage of severe dehydration among total new cases	3	3	2
4. Diarrheal deaths per 1000 child population	0.04	0.05	0.07
5. Case fatality rate per 100 diarrheal cases	0.02	0.025	0.031
B. Nutrition			
6. Growth monitoring coverage as percentage of <3 children, new visits	51	55	54
7. Proportion of malnourished children (weight/age – new visits)	14	12	11
C. Acute respiratory infection			
8. Reported incidence per 1000 >5 children, new visits	289	344	360
9. Annual reported incidence of pneumonia (mild-severe) per 1000 among <5 children – new visits	117	131	128
10. Proportion of severe pneumonia among new visits	3.3	2.5	2.1
E. Expanded programme of immunization			
11. BCG coverage	97	96	92
12. DPT-3 coverage	86	90	80
13. Polio-3 coverage	84	90	83
14. Hepatitis B-3	–	–	56
15. Measles coverage	80	85	79
F. Malaria control			
16. Annual Blood slide examination rate per 100 population in malarious areas	0.8	0.8	0.7
17. Slide positivity rate (SPR) %	8.1	4.3	3.4
G. Kala-azar			
18. Cases per 100,000 population in area at risk (12 districts)	24.6	17.9	26.4
H. Japanese encephalitis			
19. Rate per 100,000 population in 24 affected districts	–	5.27	–
I. HIV/AIDS			
20. Percentage of HIV in tuberculosis patient	–	2.4	–
21. No. of cases reported (2003)	–	3,312	–
22. No of cases estimated	–	61,000	–
23. Children 0-5 yrs living with HIV	–	940	–
J. Tuberculosis			
24. Case detection rate (%)	71	71	70
25. New sputum +ve	14,348	–	–
26. Treatment success rate on DOTS (%)	90	88	88
27. Sputum conversion rate (%)	85	86	86

Programme areas	2002/03	2003/04	2004/05
K. Leprosy			
28. New case detection rate per 10,000 population	3.24	2.84	2.41
29. New prevalence rate per 10,000 population	3.04	2.41	2.00
30. Disability rate grade 2 among new cases (%)	3.95	9.48	4.41
L. Safe motherhood and reproductive health			
31. Antenatal first visits as percentage of expected pregnancies	53	66	69
32. ANC four visits among 1st visit	36.8	43.6	44.1
33. Average No. of ANC visits per pregnant women	1.8	2.1	2.1
34. Deliveries conducted by health workers as percentage of expected pregnancies	16.1	18.3	20.2
35. Deliveries conducted by TBAs as percentage of expected pregnancies	8.4	11.3	10.3
36. PNC first visits as percentage of expected pregnancies	18.8	28.3	30.4
37. Contraceptive prevalence rate (adjusted)	37.8	40.2	41.3
M. Curative services			
38. Total OPD new visits	9,567,761	9,800,451	9,552,307
39. Total OPD new visits as percentage of total population	38.6	40.0	38.1

Source: Annual Review DoHS 2003,2004,2005

Table 9: *International comparison of DALYs lost per 1,000 people*

Disease group	China		India		Nepal		Sub-Saharan Africa	
	Number	%	Number	%	Number	%	Number	%
Group I	45	25.3	175	50.9	248	68.5	409	71.3
Group II	103	57.8	138	40.1	83	22.8	111	19.3
Group III	30	16.9	31	9.0	32	8.7	54	9.4
Total	178	100.0	344	100.0	363	100.0	574	100.0

Source: Nepal Operational Issues and Prioritization of Resources in the Health Sector (World Bank), June 2000
Note: Figures for China, India and Sub-Saharan Africa are from World Bank (1993); figures for Nepal were estimated.

Table 10: *Current and projected diseases burden estimates for Nepal, 1996 and 2011*

Item	1996	2011
Estimated DALYs lost (millions)	7.7	7.2
Percent of DALYs lost		
– Children under 5	51.0	40.0
– Contributed by Group I	68.5	61.4
– Contributed by Group II	22.8	28.6
– Contributed by Group III	8.7	10.0
Population (millions)	21.1	29.5

Source: Nepal Operational Issues and Prioritization of Resources in the Health Sector (World Bank), June 2000
Note: World Bank sector team estimates

Table 11: *Donor support in priority health programme, Nepal 2006*

Donor	Reproductive health			Child health	Nutrition	Infectious diseases			
	Family planning	Adolescent health	Maternal/ neo-natal			HIV/AIDS	Malaria	TB	Other
USAID	nation-wide social marketing	nation-wide social marketing	nation-wide social marketing	27 districts	nation-wide social marketing: vit A	30 districts	two districts (RTI)	–	–
JICA	–	–	–	–	three districts	–	–	–	voluntary services in 3 districts
Swiss Develop-ment Coopera-tion	two districts	two districts	two districts	–	–	–	–	–	health awareness raising in 3 districts
GTZ/KfW	8 districts	9 districts	9 districts	5 districts	5 districts	8 districts	–	–	health system strength-ening & maintenance, construction of health facilities
Unicef	–	–	4 districts	15 districts	–	15 districts	–	–	–
UNFPA	42 districts	integrated population RH in six districts	45 districts	16 districts	–	–	–	–	VSC in 54 districts, PHC ORC nationwide. Support to ANM refreshing training with EOC kit
DfID	–	–	17 districts	–	–	–	–	–	support MOHP by pooled funds
WHO	–	three districts	–	immuni-zation nation-wide	–	–	six districts	DOTS nation-wide	4 districts strength-ening health systems

Wordbank: Pooled fund support to MOHP
Source: External development Partners, Nepal 2006

Table 12: *Priority areas of CCS 2006-2011 vis-à-vis WHO's core functions*

Priority areas	WHO's Core Functions					
	Policy and advocacy positions	Managing information	Technical and policy support	Partnerships	Norms and standards	Technologies, tools and guidelines
Strengthening health system	+	+ +	+ + +	+ + +	+ + +	+ + +
Control and prevention of diseases and disabilities	+ +	+ + +	+ + +	+ +	+ +	+ +
Human resource development	+ + +	+ +	+ +	+ + +	+ + +	+ +
Child, adolescent and reproductive health	+ +	+ +	+ + +	+ + +	+	+
Healthier environment	+ +	+ +	+ + +	+ + +	+ +	+ +
Emergency preparedness and response	+ +	+ +	+ +	+ + +	+ + +	+ +

Annex 1

Nepal's progress towards the MDGs: status at a glance

Goals	Will development goal be reached				Status of supportive environment			
1 A. Extreme poverty Halve the proportion of people living below the national poverty line by 2015	**Likely**	Potentially	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak
1 B. Hunger Halve the proportion of people who suffer from hunger between 1990 and 2015	Likely	**Potentially**	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak
2. Universal primary education Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	Likely	Potentially	**Unlikely**	Lack of data	**Strong**	Fair	Weak but improving	Weak
3. Gender and equality Achieve equal access for boys and girls to primary and secondary education by 2005 and to all levels of education no later than 2015	Likely	**Potentially**	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak
4. Child mortality Reduce under-five mortality by two-thirds by 2015	**Likely**	Potentially	Unlikely	Lack of data	**Strong**	Fair	Weak but improving	Weak
5. Maternal health Reduce maternal mortality ration by three-quarters by 2015	Likely	**Potentially**	Unlikely	Lack of data	Strong	Fair	**Weak but improving**	Weak
6 A. HIV/AIDS Halt and reverse the spread of HIV/AIDS by 2015	Likely	Potentially	**Unlikely**	Lack of data	Strong	Fair	**Weak but improving**	Weak
6 B. Malaria and other major diseases Halt and reverse the incidence of malaria and other diseases by 2015	Likely	**Potentially**	Unlikely	Lack of data	Strong	Fair	**Weak but improving**	Weak
6 C. Tuberculosis Halt and reverse the incidence of tuberculosis by 2015	**Likely**	Potentially	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak
7 A. Environmental sustainability Reverse loss of environmental resources	Likely	**Potentially**	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak
7 B. Access to safe drinking water Halve the proportion of people without access to safe drinking water	**Likely**	Potentially	Unlikely	Lack of data	Strong	**Fair**	Weak but improving	Weak

Source: Nepal MDG Progress Report 2005

Annex 2

Essential health care services

Main interventions*	Health problems addressed
Appropriate treatment of common diseases and Injuries	Common Diseases and Injuries
Reproductive health	Maternal and Peri-natal
The expanded programme on immunization (EPI) and Hepatitis B Vaccine	Diphtheria, Pertusis, TB, Measles, Polio, Neonatal Tetanus, Hepatitis B
Condom promotion and distribution	STD/HIV, Hepatitis B, Cervical Cancer
Leprosy control	Leprosy
Tuberculosis control	Tuberculosis
Integrated Management of Childhood Illness (IMCI)	Diarrhoeal Disease, Acute Respiratory Infection (ARI), Protein Energy Malnutrition (PEM)
Nutritional supplementation, enrichment, nutrition education and rehabilitation	PEM, Iodine Deficiency Disorders, Vitamin A Deficiency, Anaemia, Cardiovascular Disease Prevention, Diabetes, Rickets, Perinatal Mortality, Maternal Morbidity, Diarrhoeal Disease, ARI
Prevention and control of blindness	Cataracts, Glaucoma, Pterygium, Refractive Error, and other Preventable Eye Infection
Environmental sanitation	Diarrhoeal Disease, Acute Respiratory Infection, Intestinal Helminthes, Vector Borne Diseases, Malnutrition
School health services	Diarrhoeal Disease, helminthes, Oral Health, HIV, STDs, Malaria, Eye and Hearing Problems, Substance Abuse, Basic Trauma Care
Vector-borne disease control	Malaria, Leishmaniasis, Japanese Encephalitis
Oral health services	Oral Health
Prevention of deafness	Hearing Problems
Substance abuse, including tobacco and alcohol control	Cancers, Chronic Respiratory Disease, Traffic Accidents
Mental health services	Mental Health Problems
Accident prevention and rehabilitation	Post-Trauma Disabilities
Community-based rehabilitation	Leprosy, Congenital Disabilities, Post-Trauma Disabilities, Blindness
Occupational health	Chronic Respiratory Disease, Accident, Cancers, Eye and Skin Diseases, Hearing Loss
Emergency preparedness and management	Natural and Man-made disasters

*Main Interventions are listed in priority order

Annex 3

Outputs of Nepal's health sector programme – implementation plan 2004-2009

Output one:

- Costing of and resource allocation for EHCS
- Redefine institutional arrangements for delivering EHCS
- Develop systems for priority access for poor and vulnerable groups
- Strengthen outpatient services
- Enhance Behaviour Change Communication (BCC) activities

***Output two:* Decentralized health management**

- Introduce local management of Sub-Health Posts
- Create hospital autonomy and initiate resource mobilization

***Output three:* Private and NGO sectors developed**

- Establish district-level health coordinating committees
- Establish sub-committees or workgroups for specific programme areas to coordinate the work of government, donor and I/NGO groups
- Up-date inventory of Private/NGO/Public agencies involved in the health sector, by district
- Define an appropriate Public/Private/NGO/ mix for each district
- Set quality standards and regulatory mechanisms for private and NGO sector service delivery

***Output four:* Sector management**

- Strengthen joint MoH/Donor annual planning, programming, budgeting and monitoring cycle
- Strengthen ongoing MoH/Donor programmatic collaboration
- Strengthen Sector Management at the central level
- Strengthen regional and district management
- Capacity building at central and district levels
- Assess institutional and organizational arrangements systematically
- Re-define roles and responsibilities throughout the health system

Output five: Financing and resource allocation

- Identify health sector priorities and re-allocate resources to those services
- Explore alternative financing arrangements, such as community health insurance.
- Develop national guidelines for user-free practices and other payments in public facilities
- Strengthen drug financing mechanisms to support increased and equitable availability of essential drugs

Output six: Management of physical assets

- Improve product selection and quality
- Strengthen the commodity distribution system
- Expand and strengthen the drug financing mechanism
- Implement National Drug Policy in relation to essential drugs
- Strengthen the Logistics Management Information System (LMIS)
- Strengthen disaster relief commodities management
- Establish quality and safety policies and system

Output seven: Human resource development

- Locate HRD unit in an appropriate MoH structure and reform it
- Improve the personnel management system effectively
- Improve co-ordination and quality of in-service training
- Provide training in newly-identified areas of training needs
- Improve co-ordination between the Ministry of Education (MoE), MoH and Council for Technical Education and Vocational Training (CTEVT) (for pre-service education)

Output eight: Integrated MIS and QA Policy

- Develop and establish an Integrated Management Information System
- Establish and implement the Quality Assurance (QA) Policy

Annex 4

Alignment of WHO strategic agenda/directions with the national health sector programme – implementation plan (NHSP-IP)

NHSP-IP strategic objectives/outputs	WHO strategic direction	WHO strategic approaches
Output 1: EHCS Sub-output: 2: Reduce maternal and newborn mortality	Child, Adolescent and Reproductive Health	• strengthening partnerships • support to training of SBAs • Support development of QA (audit) systems for maternal and neonatal health care services • Provide evidence-based guidance for integration of newborn health care into SM programme
Output 1: EHCS Sub-output: 3: Infant and child mortality	Child, Adolescent and Reproductive Health	• Support the expansion of IMCI interventions in under-priviledged areas • Advocate for the development of public-private partnerships for newborn and infant care
Output 1: EHCS Sub-output: 4: Vaccine preventable diseases	Control and prevention of disease and disabilities	• Improved coverage with routine vaccines • Introduce new vaccines • Strengthen AEFI surveillance • Strengthen and sustain the IPD programme
Output 1: EHCS Sub-output: 5: Nutritional deficiencies	Child, Adolescent and Reproductive Health	• Support improved coverage of the micro-nutrient programme • Strengthen the community nutrition programme • Build effective partnerships for resource mobilization and improved coverage
Output 1: EHCS Sub-output: 6: Tuberculosis	Control and prevention of disease and disabilities	• Support the QA of DOTS expansion and national strategy for MDR TB and HIV/AIDS
Output 1: EHCS Sub-output: 7: Leprosy	Control and prevention of disease and disabilities	• Continued support to programme management for leprosy elimination • Support quality assurance of leprosy surveillance
Output 1: EHCS Sub-output: 8: HIV/AIDs	Control and prevention of disease and disabilities	• Support development of the national strategic plan and district level work–plans • Strengthen systems for ART, laboratory services and VCT • Support integration of HIV/AIDS prevention and care with health services

NHSP-IP strategic objectives/outputs	WHO strategic direction	WHO strategic approaches
Output 1: EHCS Sub-output: 9: emerging and re-emerging diseases	Control and prevention of disease and disabilities	• Develop the policy, legal framework and operational guidelines for integrated disease surveillance • Build HR capacity for disease surveillance and response and capacity to comply with the International Health Regulations • Strengthen the mechanisms to establish a public health laboratory network • Strengthen national surveillance including cross-border issues
Output 1: EHCS Sub-output: 10: Health sector capacity to mitigate health effects of disasters	Emergency preparedness and response	• Advocate for adequate HR in the area of health sector emergency preparedness • Promote integration of health emergency preparedness and response as a cross-cutting issue • Support health sector emergency planning, monitoring and response, including mass casualty programmes, and hospital mitigation • Build partnerships for more effective planning, coordination and response
Output 1: EHCS Sub-output: 11: Vector-Borne Diseases	Control and prevention of disease and disabilities	• Enhance capacity at district level to run kala-azar elimination plan • Strengthen malaria control through evidence-based diagnosis & treatment, district vector control, community-based communication and behaviour change. • Promote compliance with standard treatment protocol and carry out systematic monitoring of malaria drug resistance linked to the revised national treatment policy
Output 1: EHCS Sub-output: 13: Promoting healthy behaviour	Control and prevention of disease and disabilities	• Develop community-based approaches for healthy lifestyles and promote the involvement of the community in health promotion and disease control • Facilitate the review and revision of mental health legislation • Develop mechanisms for broad-based partnerships and a surveillance system for tobacco control so as to comply with the Framework Convention for Tobacco Control • Support implementation of the national policies and strategic plans for NCDs • Support development of recording and reporting systems on violence, injuries and disabilities and advocate for adequate multisectoral policy responses.

NHSP-IP strategic objectives/outputs	WHO strategic direction	WHO strategic approaches
Output 2: Decentralized management of health facilities 1: Strategic plan for devolution of health service	Strengthening health systems	• Support the development of a health sector policy on decentralization • Show evidence for decentralization, based on experience from other countries • Support district health systems development: including decentralized management, essential drug systems, surveillance, capacity of public health workforce, and systemic linkages with other levels; • Support strengthening of community involvement in management of peripheral health facilities and health promotion initiatives
Output 3: Private sector and NGOs 1: Coordinating body	Strengthening health systems	• Support the streamlining of public-private partnerships: regulatory framework; contracting systems; monitoring performance.
Output 3: Private sector and NGOs 2: Strategic plan	Strengthening health systems	• Promote evidence-based policies to empower civil society engagement in developing equitable access
Output 4: Coordinated sector management: 1: Cross-cutting sector management	Strengthening health systems	• Strengthen multi-sectoral coordination and build capacity for an integrated approach to health development – Env. health: MoH& PW, MoA, MoLD – HR: MoE – Sector development: MoF, NPC, MoSW • Promote synergy with key stakeholders and external development partners in ongoing health sector reform initiatives and sector-wide management
Output 5: Health Financing and resource allocation: 5: Alternative financing and safety net arrangements	Strengthening health systems	• Analysis of the present financing mechanism with regard to equity and burden of paying for health services and support alternative financing in a phased manner • Support building and institutionalize the capacity to use National Health Accounts information for programme planning and management
Output 5: Health Financing and resource allocation: 6 & 7: User fees and social and community health insurance	Strengthening health systems	• Bring global evidence to advocate for government policies in line with WHO positions on out-of-pocket payments, user fees and pre-payment and risk pooling systems of health financing

NHSP-IP strategic objectives/outputs	WHO strategic direction	WHO strategic approaches
Output 6: Physical assets, procurement, distribution and rational use of drugs: 4: National drug policy	Health systems strengthening	• Support revision of the national drug (medicines) policy
Output 6: Physical assets, procurement, distribution and rational use of drugs: 6: A responsive and effective logistics and management system		• Support the development of systems that integrate essential drug supplies into the ECHS
Output 7: Human resource development: 2: HR plan and systems	Human resource development	• Assessment of human resources in the country's health system, covering current HR situation, needs analysis and production policies, so as to inform national policies and plans • Review existing HR strategy in collaboration with major stakeholders • Facilitate the streamlining of the regulatory framework to ensure performance and accountability
Output 7: Human resource development: 6: Training, coordination and quality	Human resource development	• Assist developing public health workforce through competency based training to deliver the EHCS
Output 7: Human resource development: 7: Integrated network for appraisal and accreditation	Human resource development	• Review and strengthen the accreditation system for medical, nursing and paramedical education
Output 8: Comprehensive and integrated management information system 1: Strengthened HMIS and related IT	Health systems strengthening	• Provide support to finalize the National Strategy for Health Sector Information System • Support national institutions in the collection of disagregated data to help track progress and in measuring achievements of national policies and plans, including MDGs

Alignment of WHO strategic agenda/directions
Rural water supply and sanitation sectoral strategic action plan: 2004
Food act

GOV strategic objectives/outputs	WHO strategic direction	WHO strategic approaches
Suitable and cost-effective technological options	Environmental Health	• Assist in dissemination and uptake of national water quality standards in line with WHO guidelines • Support and monitor the introduction of cost-effective safe water sanitation improvement measures in district plans
Changes in health, hygiene and sanitation behaviour		• Develop and implement arsenic contamination mitigation measures together with other partners
	Environmental Health	• Advocate for the update of national policy (to clarify) in collaboration with partners • Codex Alimentarius (to be clarified) • Building networks and partnerships on environmental health issues

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