Annual Health Report

Health Section

Mahakulung Rural Municipality

2079/80(2022/2023)

Local Government
Mahakulung Rural Municipality
Office of the Rural Municipal Executive
HEALTH SECTIOMN
Bung, Solukhumbu
Koshi Province

स्थानीय सरकार

महाकुलुङ गाउँपालिका

गाउँ कार्यपालिकाको कार्यालय

बुङ, सोलुखुम्बु

स्थाः २०७३

कोशी प्रदेश, नेपाल

प.सं.२०८०/०८१
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शुभकामना

महाकुलुङ गाउँपालिकाका सबै नागरिकलाई उच्चतम गुणस्तरीय स्वास्थ्य सेवा उपलब्ध गराउनु स्थानीय तहको मुख्य जिम्मेवारी र प्रतिबद्धता रहेको छ। राष्ट्रिय स्वास्थ्य नीति, २०७६ र नेपाल स्वास्थ्य क्षेत्र रणनीतिक योजना २०२३-२०३०, स्थानीय स्वास्थ्य र सरसफाई ऐन, २०७५ ले अवलम्न गरेका स्वास्थ्य सेवाहरुलाई स्थानीय तहले सार्वजनिक निकाय र निजी क्षेत्रलगायत सबै सरोकारवालासँग हातेमालो गर्दै स्वास्थ्य क्षेत्रमा आमुल विकास गर्नका लागि गाउँपालिका प्रतिबद्ध छ। सङ्घीय व्यवस्था पछिको झण्डै एक दशकको अवधिमा धेरै चुनौतीहरूका बाबजुद पनि स्वास्थ्य क्षेत्रले धेरै उल्लेखनीय उपलब्धि गरेकोमा म खुशी छु । अहिलेसम्म प्राप्त स्वास्थ्यका नतिजाहरुमा सरकारी र गैरसरकारी सरोकारवाला दुवैको संयुक्त प्रयासको परिणाम हो । विगतका वर्षहरूमा जस्तै यस आर्थिक वर्ष २०७९/८० (२०२२/२०२३)मा महाकुलुङ गाउँपालिका स्वास्थ्य शाखाले पहिलो श्रृङखलाका रुपमा प्रकाशन गर्न लागेको **वार्षिक स्वास्थ्य प्रतिवेदन** सार्वजनिक गर्न पाउँदा मलाई खुशी लागेको छ। गत आर्थिक वर्षको प्रगति प्रतिवेदनले स्वास्थ्य सेवा वितरण प्रणालीका सबै अंगहरूको वार्षिक कार्यसम्पादन र स्वास्थ्य संस्थाले वार्षिकरुपमा सम्पन्न गरेका कार्यहरुको विस्तृत चित्रण प्रस्तुत गर्दछ। यस प्रतिबेदन स्वास्थ्य सेवाको उपयोगिता, विश्लेषणात्मक प्रवृत्ति र रोगका ढाँचाहरूको डेटाहरुको विवरणहरु समेत यस वार्षिक प्रतिवेदनले दिनेछ भन्ने विश्वास लिएको छु । यस प्रतिवेदनले रोगको बोझ, सेवाको उपयोग र स्वास्थ्य सेवाको पहुँचसँग सम्बन्धित अन्य डेटाहरुवाट र समयमै नीति, योजना निर्माण गर्नमा धेरै महत्त्वपूर्ण हुनेछ।

वार्षिक स्वास्थ्य प्रतिवेदन नीति निर्माताहरूका लागि, कार्यक्रमहरू तयार गर्नका लागि र स्वास्थ्य क्षेत्रमा संलग्न सबै सरोकारवालाहरूका लागि बहुमूल्य श्रोत हुनेछ भन्ने मेरो अपेक्षा छ। यस प्रतिवेदनले महाकुलुङ गाउँपालिकाको स्वास्थ्य सेवाको थप सुधारका लागि पनि धेरै सहयोगी हुने विश्वास लिएको छु। यस प्रतिवेदन तयार गर्नको लागि स्वास्थ्य शाखा प्रमुख र योगदानकर्ताहरूलाई मेरो हार्दिक धन्यवाद। म हाम्रा स्वास्थ्य विकास साझेदारहरूलाई गाउँपालिकामा स्वास्थ्य सेवा सुधार गर्न निरन्तर सहयोग गर्न र गर्नु भएकोमा धन्यवाद दिन चाहन्छु। धन्यवाद,

मिति २०८०।१०।२०

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सूर्य वहादुर कुलुङ राई

अध्यक्ष

महाकुलुङ गाउँपालिका

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<u>शुभकामना</u>

यसले हामीलाई स्वास्थ्य क्षेत्रको प्रगतिको विस्तृत सारांश सहितको आर्थिक वर्ष २०७९/८० (२०२२/२०२३) को वार्षिक स्वास्थ्य प्रतिवेदन सार्वजनिक गरेको देख्न पाउँदा निकै खुशी लागेको छ । प्रत्येक वर्ष स्वास्थ्य शाखाले आफ्ना धेरै कार्यक्रमहरू र गतिविधिहरू मार्फत स्वास्थ्य क्षेत्रले गरेको प्रगति र उपलब्धिहरूको सारांश प्रस्तुत गर्दछ। यो प्रतिवेदनले स्वास्थ्य क्षेत्रका सबै प्रमुख गतिविधि र उपलब्धिहरूको रूपमा काम गर्दछ। प्रतिवेदनले सार्वजनिक क्षेत्रका स्वास्थ्य संस्थाको कार्यसम्पादनको प्रतिवेदन मात्र नभई निजी क्षेत्रबाट प्रदान गरिने स्वास्थ्य सेवाको उपयोगको तथ्यांक पनि समावेश गरेको छ। स्वास्थ्य विकास साझेदारहरू र अन्य गैर-सरकारी संस्थाहरूको योगदान पनि प्रतिबिम्बित हुन्छ।

प्रतिवेदनले स्वास्थ्य क्षेत्रमा गत वर्ष प्रदान गरेको स्वास्थ्य सेवा र त्यसको उपयोगको आधिकारिक दस्तावेजको रूपमा काम गर्दछ। प्रभावकारी स्वास्थ्य व्यवस्थापनको लागि स्वास्थ्यको प्रतिबद्धता, स्वास्थ्य संस्थाका स्वास्थ्यकर्मि तथा कर्मचारीहरूसँगको सहकार्यमा यसको समर्पणले बलियो र उत्तरदायी स्वास्थ्य सेवा प्रणालीको लागि हाम्रो साझा दृष्टिकोणलाई प्रतिबिम्बित गर्दछ। स्वस्थ र सुरक्षित समाजको हाम्रो सामूहिक खोजमा सामना गरिएका चुनौतीहरू, र उपलब्धिहरू प्रतिवेदनमा उल्लिखित स्वास्थ्य सम्बन्धी गतिविधिहरू प्रभावकारी रूपमा व्यवस्थित र समुदायहरूको आवश्यकता अनुरूप हुने स्वास्थ्य सेवाको सुनिश्चित गर्न महत्त्वपूर्ण कदमहरूलाई जोड दिएको छ। यो प्रतिवेदन सबै तहका सरकारका लागि स्वास्थ्य क्षेत्रका समस्याहरू बुझ्न र आगामी वर्ष आ-आफ्ना क्षेत्रका जनतालाई उच्च गुणस्तरीय सेवा उपलब्ध गराउन योजना बनाउन सहायक हुनेछ । यस प्रतिवेदनले गाउँपालिकाको स्वास्थ्य सेवाको गुणस्तर सुधार गर्न नवप्रवर्तनका नयाँ क्षेत्रहरूमा सिक्ने र पहिचान गर्ने संघ संस्थाहरुका लागि अध्यान गर्ने अवसर प्रदान गर्नेछ।

हामीले हाँसिल गरेका स्वास्थ्य क्षेत्रका उपलब्धिहरु, स्वास्थ्य संस्थाहरुवाट सञ्चालन भएका स्वास्थ्य सेवाहरू स्वास्थ्य प्रणालीका विभिन्न वडाहरूमा काम गर्ने महिला सामुदायिक स्वास्थ्य स्वयंसेवीहरू लगायत सबै स्वास्थ्यकर्मीहरूको कडा परिश्रमको हामी प्रशंसा गर्दछौं। तिनीहरूको प्रयास बिना, यी उपलब्धिहरू सम्भव थिएनन्; नेपाली नागरिकको स्वास्थ्य अवस्था सुधार गरेकोमा उहाँहरु हार्दिक धन्यवादको पात्र हुनुहुन्छ ।

अन्तमा, म स्वास्थ्य शाखालाई हार्दिक धन्यवाद र बधाई दिन चाहन्छु।

मिति २०८०।१०।२०

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नविन कुमार गोले

प्रमुख प्रशासकीय अधिकृत

महाकुलुङ गाउँपालिका

स्थानीय सरकार

महाकुलुङ गाउँपालिका

गाउँ कार्यपालिकाको कार्यालय

बुङ, सोलुखुम्बु

स्थाः २०७३

कोशी प्रदेश, नेपाल

प.सं.२०८०/०८१

च.नं.

दुई शब्द

नेपालको संविधान २०७२ मा प्रत्येक नागरिकलाई राज्यबाट आधारभुत स्वास्थ्य सेवा निशुल्क प्राप्त हुने र आकस्मिक स्वास्थ्य सेवाबाट कसैलाई पनि बञ्चित नगरिने प्रत्याभूति गरेको छ। सबै नागरिकलाई स्वास्थ्य सेवामा समान पहुचको हक हुने छ भनि मौलिक हकमा ब्यबस्था गरिएको छ। संवैधानिक हकलाई कार्यान्वयन गर्नकालागि नेपाल सरकारले जनताको घरदैलो सम्म आधारभूत स्वास्थ्य सेवा प्रदान गर्दै आईरहेको ब्यहोरा सवैमा बिदितै छ।

आधारभूत स्वास्थ्य सेवा प्रदान गर्ने सन्दर्भमा महाकुलुङ गाउँपालिकाका सबै स्वास्थ्य सस्थाहरुबाट निशुल्क रुपमा सेवा प्रबाह हुदै आईरहेको हुदा आ. व. २०७९।८० मा प्रत्येक स्वास्थ्य संस्थाहरुले प्रवाह गरेको सेवा र जनताले पाएको सेवा सुबिधाहरुकाबारेमा समेत जनकारी राख्न र आगामि दिनमा अझ बढि सहज तरिकाबाट सेवा प्रदान गर्न सकियोस भन्ने उदेश्यले आ. व. २०७९।८० मा स्वास्थ्य संस्थाहरुले प्रवाह गरेको सेवाका बारेमा स्वास्थ्य संस्था स्तरिय र पालिका स्तरिय वार्षिक समिक्षा गोष्ठी समेतलाई हेर्दा यस गाउँपालिकाका नागरिकहरुले विगतमा कोभिड १९ महामारीको अबस्थामा पनि स्वास्थ्यकर्मिहरुबाट स्वास्थ्य संस्थामा सहज रुपमा सरल तरिकाबाट निशुल्क सेवा पाएको र नागरिकहरुको स्वास्थ्यमा समेत उल्लेखनिय सुधार भएको पाईएको छ। स्वास्थ्य सम्बन्धि गतिबिधिलाई जानकारी दिने उदेश्यले स्वास्थ्य सम्बन्धि गतिबिधिलाई समेटेर तयार पारिएको यो **बार्षिक प्रतिबेदन** पुस्तकले आ. व. २०७९/८० मा संचालित जनस्वास्थ्य कार्यक्रमका सम्पुर्ण तथ्याङकिय गतिबिधि ,निर्दिष्ट निति , कार्यबिधि र लक्ष्य का साथै कार्यक्रम संचालनको दौरानका चुनौति , अवसर र सुधारका बिषय संगसगैं आगामि आ .व. २०८०।८१ का लागि कार्यदिशा समेत स्पष्ट गर्दछ र हरेक नागरिकले पाउने सुचनाको हक लाई समेत प्रत्याभुति गरेको छ भन्ने अपेक्षा राखिएको छ।

अन्तमा, यो बार्षिक पुस्तिका तयार (सुचना संकलन तथा लेखन कार्यमा समेत) गर्न महत्वपुर्ण भुमिका खेल्नुहुने स्वास्थ्य कार्यालयका जनस्वास्थ्य अधिकृत श्री सौजन वावु सिक्देल र जनस्वास्थ्य अधिकृत श्री विकेश मल्लज्यू लाई बिषेश धन्यबाद दिदै यस कार्यमा सहयोग गर्नु हुने महाकुलुङ गाउँपालिकाका जनप्रतिनिधि, पालिकाका कर्मचारीहरु, स्वास्थ्य कार्यालय र स्वास्थ्य संस्थाका प्रमुखज्यूहरु तथा सम्पुर्ण स्वास्थ्यकर्मिहरु र अन्य सहयोगि साझेदार सस्थाहरुलाई समेत धन्यबाद ब्यक्त गर्दै निरन्तर सहयोगको अपेक्षा गर्दछु।

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हरी प्रसाद आचार्य

स्वास्थ्य शाखा प्रमुख

महाकुलुङ गाउँपालिका, बुङ, सोलुखुम्बु

TABLE OF CONTENTS

ABBREVIATIONS

AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ART	Anti Retro Viral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BC	Birthing Centre
BCC	Behavior Change Communication
BEOC	Basic Emergency Obstetric and Neonatal Care
BMI	Body Mass Index
BS	Bikram Sambat
CAC	Comprehensive Abortion Care
CBOs	Community Based Organizations
CB-IMCI	Community Based Integrated Management of Childhood Illnesses
CEOC	Comprehensive Emergency Obstetric Care
CHU	Community Health Unit
CMYP	Comprehensive Multiyear Immunization Plan
CMS	Central Medical Store
CPR	Contraceptive Prevalence Rate
DCC	District Coordination Committee
DOHS	Department of Health Services
EDP	External Development Partners
EHCS	Essential Health Care Service
EP	Expected Pregnancies
ELB	Expected Live Birth
FCHV	Female Community Health Volunteer
FP	Family Planning
FY	Fiscal Year
GESI	Gender Equality and Social Inclusion
GM	Growth Monitoring
GON	Government of Nepal
HCT	HIV Counseling and Testing
HD	Health Directorate
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HO	Health Office
HP	Health Post
HTC	Health Training Center
IDD	Iodine Deficiency Disorder
IEC	Information Education Communication
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
IUCD	Intra-Uterine Contraceptive Device
JE	Japanese Encephalitis

MDA	Mass Drug Administration
MDG	Millennium Development Goal
MDR	Multi Drug Resistance
MMR	Maternal Mortality Rate
MOHP	Ministry of Health and Population
MOSD	Ministry of Social Development
MRSD	Measles-Rubella Second Dose
MSNP	Multi Sector Nutrition Plan
MSS	Minimum Service Standard
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organization
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal Health Sector Program
NIP	National Immunization Program
PAC	Post Abortion Care
PEM	Protein Energy Malnutrition
PHC/ORC	Primary Health Care Outreach Clinics
PHCC	Primary Health Care Center
PHCRD	Primary Health Care Revitalization Division
PHLMC	Provincial Health Logistic Management Center
PNC	Post Natal Care
SHN	School Health Nurse
RED	Reaching Every District
TB	Tuberculosis
UHC	Urban Health Clinic
UNDP	United Nations Development Programs
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency Disorder
VHW	Village Health Worker
VPD	Vaccine Preventable Diseases
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1. BACKGROUND

Submission of annual progress report to higher authority is the fundamental part of HMIS and it is mandatory of Health Section (HS) Mahakulung. This report has been prepared after the completion of annual review meeting followed by Health post review meeting. It is the outcome of relevant information of annual performances of all the health programs and activities carried out during the FY 2079/80 through the network of health service outlets of Mahakulung. It also analyzes the annual trends of progress based on the major key program indicators and achievements against the target set with regard to the last three fiscal years i.e. 2077/78 to 2079/80. In addition, it highlights the problems/constraints identified while carrying out the activities in local level and suggests respective recommendations for relevent stakeholders.

This report includes information related to local health system, which can help in managing health programs. With the organization and leadership of local government, one day rural municipal level annual review workshop was conducted with full participation and involvement of HO staffs, elected officials, municipal health coordinator(s)/ sub-coordinator(s), health facilities incharges and I/NGOs. Session-wise conduction of workshop was carried out with the presentations, discussions and review, analysis and recommendations of each program. Indicators and municipals/health facilities with satisfactory progress, good practices were appreciated and those with low performances were provided ways forward for improvement in coming days.

This report covers the following areas:

- Overview of HS Solukhumbu, Mahakulung R.M.
- Highlights of Major guiding policies like: Constitutional provision in health, National Health Policy 2076, Public Health Service Act- 2075, Public Health Service Regultion -2077, 15th Periodic Plan, SDG and Population Policy
- Program specific information viz. background, targets, objectives, policies, strategies, analysis of service statistics
- Activities in terms of Annual target vs. Achievement
- Three Years Trend analysis of program- wise indicators
- Partners working with HS on various programs
- Program- specific issues, problems and constraints and recommendations.

1.2. NATIONAL POLICIES AND PLANS

१. राष्ट्रिय स्वास्थ्य नीति, २०७६

पृष्ठभूमि

नेपालको संविधानले आधारभूत स्वास्थ्य सेवालाई प्रत्येक नागरिकको मौलिकहकको रुपमा स्थापित गरेको छ । देश संघीय शासन प्रणालीमा गई सकेकोले संघीय संरचनाको वस्तुगत धरातलमा आधारित रही गुणस्तरिय स्वास्थ्य सेवालाई सबै नागरिकको सर्वसुलभ पहुँचमा पुऱ्याउनु राज्यको दायित्व हो । संविधान बमोजिम राज्यका संघ, प्रदेश र स्थानीय तहले सम्पादन गर्ने कार्यहरुको एकल तथा साझा अधिकार सूची, नेपाल सरकारका नीति तथा कार्यक्रमहरु, नेपालले विभिन्न समयमा गरेका अन्तर्राष्ट्रिय प्रतिबद्धताहरु एवं स्वास्थ्य सेवा भित्रका समस्या र चुनौतीहरु, उपलब्ध श्रोत साधन तथा प्रमाणलाई समेत आधार बनाई राष्ट्रिय स्वास्थ्य नीति, २०७६ तर्जुमा गरी जारी गरिएको छ ।

भावी सोच (Vision)

स्वस्थ तथा सुखी जीवन लक्षित सजग र सचेत नागरिक ।

ध्येय (Mission)

साधन श्रोतको अधिकतम एवं प्रभावकारी प्रयोग गरी सहकार्य र साझेदारी मार्फत नागरिकको स्वास्थ्य सम्बन्धी मौलिक अधिकार सुनिश्चित गर्ने ।

लक्ष्य (Goal)

संघीय संरचनामा सबै वर्गका नागिरकका लागि सामाजिक न्याय र सुशासनमा आधारित स्वास्थ्य प्रणालीको विकास र विस्तार गर्दै गुणस्तरीय स्वास्थ्य सेवाको पहुँच र उपभोग सुनिश्चित गर्ने ।

उद्धेश्यहरु (Objectives)

1. संविधान प्रदत स्वास्थ्य सम्बन्धी हक सबै नागरिकको उपभोग गर्न पाउने अवसर सिर्जना गर्नु ।
2. संघीय संरचना अनुसार सबै किसिमका स्वास्थ्य प्रणालीलाई विकास, विस्तार र सुधार गर्नु ।
3. सबै तहका स्वास्थ्य संस्थाहरुबाट प्रदान गरिने सेवाको गुणस्तरमा सुधार गर्दै सहज पहुँच सुनिश्चित गर्नु।
4. अति सिमान्तकृत वर्गलाई समेट्दै सामाजिक स्वास्थ्य सुरक्षा पद्धतिलाई सुदृढ गर्नु ।
5. सरकारी, गैरसरकारी तथा नीजि क्षेत्रसँग बहु क्षेत्रीय साझेदारी, सहकार्य तथा सामुदायिक सहभागितालाई प्रबर्धन गर्नु ।
6. नफा मुलक स्वास्थ्य क्षेत्रलाई सेवा मूलक स्वास्थ्य सेवामा रुपान्तरण गर्दै जानु।

नीतिहरु :

1. सबै तहका स्वास्थ्य संस्थाहरुबाट तोकिए बमोजिम निःशुल्क आधारभूत स्वास्थ्य सेवा सुनिश्चित गरिनेछ।
2. स्वास्थ्य बिमा मार्फत विशेषज्ञ सेवाको सुलभ पहुँच सुनिश्चित गरिनेछ ।
3. सबै नागरिकलाई आधारभूत आकस्मिक स्वास्थ्य सेवाको पहुँच सुनिश्चित गरिनेछ ।
4. स्वास्थ्य प्रणालीलाई संघीय संरचना अनुरुप संघ, प्रदेश र स्थानीय तहमा पुर्नसंरचना, सुधार एवं विकास तथा विस्तार गरिनेछ ।
5. स्वास्थ्यमा सर्वव्यापी पहुँच (Universal Health Coverage) को अवधारणा अनुरुप प्रवर्धनात्मक, प्रतिकारात्मक, उपचारात्मक, पुनस्थापनात्मक तथा प्रशामक सेवालाई एकिकृत रुपमा विकास तथा विस्तार गरिनेछ ।
6. स्वास्थ्य क्षेत्रमा सरकारी, नीतितथा गैर सरकारी क्षेत्र बीचको सहकार्य तथा साझेदारीलाई प्रवर्द्धन, व्यवस्थापन तथा नियमन गर्नुका साथै स्वास्थ्य शिक्षा, सेवा र अनुसन्धानका क्षेत्रमा नीजि, आन्तरिक तथा बाह्य लगानीलाई प्रोत्साहन एवं संरक्षण गरिनेछ ।

7. आयुर्वेद, प्राकृतिक चिकित्सक, योग तथा होमियोप्याथिक लगायतका चिकित्सा प्रणाली लाई एकीकृत रुपमा विकास र विस्तार गरिनेछ ।
8. स्वास्थ्य सेवालाई सर्वसुलभ, प्रभावकारी तथा गुणस्तरीय बनाउन जनसंख्या, भूगोल र संघीय संरचना अनुरुप सीप मिश्रित दक्ष स्वास्थ्य जनशक्तिको विकास तथा विस्तार गर्दै स्वास्थ्य सेवालाई व्यवस्थित गरिनेछ ।
9. सेवा प्रदायक व्यक्ति तथा संस्थाबाट प्रदान गरिने स्वास्थ्य सेवालाई प्रभावकारी, जवाफदेही र गुणस्तरीय बनाउन स्वास्थ्य व्यवसायी परिषद्हरुको संरचनाको विकास, विस्तार तथा सुधार गरिनेछ ।
10. गुणस्तरीय औषधी तथा प्रविधिजन्य स्वास्थ्य सामाग्रीको आन्तरिक उत्पादनलाई प्रोत्साहन गर्दै कुशल उत्पादन, आपूर्ति भण्डारण, वितरणलाई नियमन तथा प्रभावकारी व्यवस्थापन मार्फत पहुँच एवं समुचित प्रयोग सुनिश्चित गरिनेछ ।
11. सरुवा रोग, किटजन्य रोग, पशुपन्छीजन्य रोग, जलवायु परिवर्तन र अन्य रोग तथामहामारी नियन्त्रण लगायत विपद् व्यवस्थापन पूर्व तयारी तथा प्रतिकार्यको एकीकृत उपायहरु अवलम्बन गरिनेछ ।
12. नसर्ने रोगहरुको रोकथाम तथा नियन्त्रणका लागि व्यक्ति, परिवार समाज तथा सम्बन्धित निकायलाई जिम्मेवार बनाउँदै एकीकृत स्वास्थ्य प्रणालीको विकास तथा विस्तार गरिनेछ ।
13. पोषणको अवस्थालाई सुधार गर्न, मिसावटयुक्त तथा हानिकारक खाना लाई निरुत्साहित गर्दै गुणस्तरिय एवं स्वास्थ्यवर्धक खाद्यपदार्थको प्रवर्द्धन, उत्पादन, प्रयोग र पहुँचलाई विस्तार गरिनेछ ।
14. स्वास्थ्य अनुसन्धानलाई अन्तर्राष्ट्रिय मापदण्ड अनुरुप गुणस्तरिय बनाउँदै अनुसन्धानबाट प्राप्त प्रमाण र तथ्यहरुलाई नीति निर्माण, योजना तर्जुमा तथा स्वास्थ्य पद्धतिको विकासमा प्रभावकारी उपयोग गरिनेछ ।
15. स्वास्थ्य व्यवस्थापन सूचना प्रणालीलाई आधुनिकिकरण, गुणस्तरिय तथा प्रविधिमैत्री बनाई एकीकृत स्वास्थ्य सूचना प्रणालीको विकास गरिनेछ ।
16. स्वास्थ्य सम्बन्धी सूचनाको हकतथा सेवाग्राहीले उपचार सम्बन्धी जानकारी पाउने हकको प्रत्याभूति गरिनेछ ।
17. मानसिक स्वास्थ्य, मुख, आँखा, नाक कान घाँटी स्वास्थ्य सेवा लगायतका उपचार सेवालाई विकास र विस्तार गरिनेछ ।
18. अस्पताल लगायत सबै प्रकारका स्वास्थ्य संस्थाबाट प्रदान गरिने सेवाको गुणस्तर सुनिश्चित गरिनेछ ।
19. स्वास्थ्य क्षेत्रमा नीतिगत, संगठनात्मक तथा व्यवस्थापकीय संरचनामा समयानुकूल परिमार्जन तथा सुधार गर्दै सुशासन कायम गरिनेछ ।
20. जीवन पक्षको अवधारणा अनुरुप सुरक्षित मातृत्व, बाल स्वास्थ्य, किशोर किशोरी तथाप्रजनन स्वास्थ्य, प्रौढ तथा जेष्ठ नागरिक लगायतका सेवाको विकास तथा विस्तार गरिनेछ ।
21. स्वास्थ्य क्षेत्रको दिगो विकासका लागि आवश्यक वित्तियश्रोत तथा विशेष कोषको व्यवस्था गरिनेछ ।
22. बढ्दो शहरीकरण, आन्तरिक तथा बाह्य बसाईसराई जस्ता विषयहरुको समयानुकूल व्यवस्थापन गर्दै यसबाट हुने जनस्वास्थ्य सम्बन्धी समस्याहरुलाई समाधान गरिनेछ ।
23. जनसांख्यिक तथ्यांक व्यवस्थापन, अनुसन्धान तथा विशेषण गरी निर्णय प्रक्रिया तथा कार्यक्र मतर्जुमा सँग आबद्ध गरिनेछ।
24. प्रति जैविक प्रतिरोधलाई न्यूनिकरण गर्दै संक्रामक रोग नियन्त्रण तथा व्यवस्थापनका लागि एकद्धार स्वास्थ्य प्रद्धतिको विकास तथा विस्तार गरिनुका साथै वायु प्रदुषण, ध्वनि प्रदुषण, जल प्रदुषण लगायतका वातावरणीय प्रदुषणका साथै खाद्यान्न प्रदुषणलाई वैज्ञानिक ढँगले नियमनतथा नियन्त्रण गरिनेछ ।
25. आप्रवासन, प्रक्रियाबाट जनस्वास्थ्यमा उत्पन्न हुन सक्ने जोखिमलाई न्यूनिकरण गर्न तथा विदेशमा रहेका नेपाली नागरिकहरुको स्वास्थ्य सुरक्षाका लागि समुचित व्यवस्थापन गरिनेछ ।

२. नेपालको संविधान, २०७२ मा स्वास्थ्य

नेपालको संविधान २०७२ मा स्वास्थ्य सम्बन्धी नागरिक का मौलिकहक र कर्तव्य निम्नानुसार रहेका छन्।

धारा ३५.स्वास्थ्य सम्बन्धि हकहरु :

(१) प्रत्येक नागरिकलाई राज्यबाट आधारभूत स्वास्थ्य सेवा निःशुल्क प्राप्त गर्ने हक हुनेछ र कसैलाई पनि आकस्मिक स्वास्थ्य सेवाबाट वञ्चित गरिने छैन ।

(२) प्रत्येक व्यक्तिलाई आफ्नो स्वास्थ्य उपचारको सम्बन्धमा जानकारी पाउने हक हुनेछ ।

(३) प्रत्येक नागरिकलाई स्वास्थ्य सेवामा समान पहुँचको हक हुनेछ ।

(४) प्रत्येक नागरिक लाई स्वच्छ खानेपानी तथा सरसफाइमा पहुँचको हक हुनेछ। **यसका अतिरिक्त धारा ३८ को महिलाको हक अन्तर्गत उपधारा २ मा "प्रत्येक महिलालाई सुरक्षित मातृत्व र प्रजनन स्वास्थ्य सम्बन्धी हक हुनेछ ।"**भन्ने कुरा उल्लेख छ, त्यस्तै धारा ५१ मा उल्लेखित राज्यका नीतिहरू अर्न्तगत स्वास्थ्य सम्बन्धी देहायका नीतिहरू राज्यले अवलम्बन गर्नेछः-

(५) नागरिकलाई स्वस्थ बनाउन राज्यले जनस्वास्थ्यको क्षेत्रमा आवश्यक लगानी अभिवृद्धि गर्दै जाने,

(६) गुणस्तरीय स्वास्थ्य सेवामा सबैको सहज, सुलभ र समान पहुँच सुनिश्चित गर्ने,

(७) नेपालको परम्परागत चिकित्सा पद्धतिको रूपमा रहेको आयुर्वेदिक, प्राकृतिक चिकित्सा र होमियोपेथिक लगायत स्वास्थ्य पद्धतिको संरक्षण र प्रवर्धन गर्ने,

(८) स्वास्थ्य क्षेत्रमा राज्यको लगानी अभिवृद्धि गर्दै यस क्षेत्रमा भएको निजी लगानीलाई नियमन र व्यवस्थापन गरी सेवा मूलक बनाउने,

(९) स्वास्थ्य सेवालाई सर्वसुलभ र गुणस्तरीय बनाउन स्वास्थ्य अनुसन्धानमा जोड दिदै स्वास्थ्य संस्था र स्वास्थ्यकर्मीको संख्या वृद्धि गर्दै जाने,

(१०) नेपालको क्षमता र आवश्यकताका आधारमा जनसंख्या व्यवस्थापनका लागि परिवार नियोजनलाई प्रोत्साहित गर्दै मातृ शिशु मृत्युदर घटाई औसत आयु बढाउने ।

स्थानीय तहको स्वास्थ्य सम्बन्धि अधिकार तथा कार्य विस्तृतीकरण

अनुसूची	अधिकार सूचीको क्र.सं	संविधानको अधिकार सूचीकाविषयको विस्तृतीकरण
अनुसूची ८(९) आधारभूत स्वास्थ्य र सरसफाइ	९.१	आधारभूत स्वास्थ्य र सरसफाइ सम्बन्धी नीति, कानुन, मापदण्ड, योजना, कार्यान्वयन तथा नियमन
	९.२	आधारभूत स्वास्थ्य सेवा संचालन र प्रवर्द्धन
	९.३	अस्पताल र अन्य स्वास्थ्य संस्थाको स्थापना तथा सञ्चालन
	९.४	स्वास्थ्य सेवा सम्बन्धी भौतिक पूर्वाधार विकास तथा व्यवस्थापन
	९.५	स्वस्थ खानेपानी र खाद्यपदार्थको गुणस्तर एवं वायु तथा ध्वनि प्रदुषण नियन्त्रण
	९.६	सरसफाई सचेतना अभिवृद्धि र स्वास्थ्य जन्यफोहोर व्यवस्थापन
	९.७	स्वास्थ्य जन्य फोहरमैला संकलन, पुनर्उपयोग, प्रशोधन, विसर्जन, सेवा शुल्क निर्धारण र नियमन
	९.८	रक्त संचार सेवा, स्थानीय तथा शहरी स्वास्थ्य सेवा
	९.९	औषधी पसल सञ्चालन र नियमन

संविधान, अनुसूची ८(९) : आधारभूत स्वास्थ्य र सरसफाइ

संविधान, अनुसूची ९(३) : स्वास्थ्य

अनुसूची	अधिकार सूचीको क्र.सं	संविधानको अधिकार सूचीकाविषयको विस्तृतीकरण
अनुसूची ९(३) बाट स्वास्थ्य	३.१	राष्ट्रिय तथा प्रादेशिक लक्ष्य र मापदण्ड बमोजिम स्थानीय स्तरको लक्ष्य र गुणस्तर निर्धारण
	३.२	राष्ट्रिय र प्रादेशिक लक्ष्य र मापदण्ड अनुरुप जनरल अस्पताल र नर्सिङ होम, निदान केन्द्र र अन्य स्वास्थ्य संस्थाहरुको क्लिनिक दर्ता, सञ्चालन अनुमति र नियमन

	३.४	स्थानीय स्तरमा औषधी जन्य वनस्पति, जडिबुटी र अन्य औषधी जन्य वस्तुको उत्पादन, प्रशोधन र वितरण
	३.५	स्वास्थ्य बिमा लगायतका सामाजिक सुरक्षा कार्यक्रम व्यवस्थापन
	३.६	स्थानीय स्तरमा औषधी तथा अन्य मेडिकल उत्पादनहरुको न्यूनतम मूल्य निर्धारण तथा नियमन
	३.७	स्थानीय स्तरमा औषधीको उचित प्रयोग र सूक्ष्म जीवनिरोधक प्रतिरोध (Anti-microbial Resistance) न्यूनीकरण
	३.८	स्थानीय स्तरमा औषधी र स्वास्थ्य उपकरणको खरिद, भण्डारण र वितरण
	३.९	स्थानीय स्तरमा स्वास्थ्य सूचना प्रणली व्यवस्थापन

३. राष्ट्रिय जनसंख्यानीति, २०७१

राष्ट्रिय जनसंख्या नीतिको भावी सोच, ध्येय, लक्ष्य तथा उद्देश्यहरु :

राष्ट्रिय जनसंख्या नीतिको भावी सोच, ध्येय, लक्ष्यतथा उद्देश्यहरु देहाय बमोजिम रहेका छन् :

भावी सोच

हरेक नागरिकलाई गुणस्तरीय जीवनयापन गर्ने अवसरको वृद्धि भएको हुनेछ ।

ध्येय

जनसंख्या, वातावरण र विकास बीच सामञ्जस्य कायम गरी नागरिकलाई अधिकारमा आधारित जनसंख्या र विकासका एकीकृत सेवा प्रवाहको सुनिश्चितता गर्दै उत्पादशील र स्तरीय जीवनयापनको वातावरण बनाउने ।

लक्ष्य

१ जनसंख्याका सवालहरुलाई विकाससँग एकीकरण गर्दै सबै नागरिकको जीवनमा गुणस्तरीय सुधार ल्याउने, प्रजनन स्वास्थ्य तथा प्रजनन सम्बन्धी मौलिक अधिकारलाई सुनिश्चित गर्ने र जनसंख्या व्यवस्थापनमा लैगिक समानता तथा सामाजिक समावेशीकरणलाई प्रवर्धन गर्नु यस नीतिको लक्ष्य रहेको छ ।

२.सहश्राब्दी विकास लक्ष्य तथा दिगो विकास लक्ष्य समेतलाई ध्यानमा राखी यो नीति कार्यान्वयनमा आएपछि बीस वर्ष (वि.सं. २०९० वा सन् २०३४) भित्रमा नेपालले हासिल गर्न सक्ने लक्ष्य देहायानुसार निर्धारण गरिएको छ ।

तालिका नं १ : जनसंख्या सम्बन्धी सूचकहरुको आगामी २० वर्षका लक्ष्य

क्र.सं.	सूचक	लक्षित वर्ष (सन् 2014-2034)
१	कुलप्रजनन्दर (TFR), प्रतिमहिला	२.१
२	वार्षिक जनसंख्या वृद्धिदर, प्रतिशत	१.१
३	कोरा मृत्युदर (CDR), प्रतिहजार	५.०
४	शिशु मृत्युदर (IMR), प्रति हजार जीवित जन्म	२५.०
५	औसत आयु (वर्ष) दुवै	७५.०
	पुरुष	७४.०
	महिला	७६.०
६	घर परिवारको औसत आकार	२४.१
७	अनुपस्थित जनसंख्या, प्रतिशत	५.०
८	साक्षरता प्रतिशत (दस वर्ष माथिको जनसंख्या)	९५.०
९	परिवार नियोजन साधनमा पहुँच हुने सम्भाव्य दम्पती प्रतिशत	९०.०

क्र.सं.	सूचक	लक्षित वर्ष (सन् 2014-2034)
१०	शहरी जनसंख्या, प्रतिशत	६०.०

यस तालिकाको प्रमुख उद्देश्य देहाय बमोजिम रहेका छन् :

उद्देश्यहरु :

१ जनसंख्या र विकास बीच तादात्म्य कायम गरी जनसंख्या व्यवस्थापनलाई समग्र विकासको अभिन्न अंगका रुपमा विकास गर्ने,
२ यौन र प्रजनन स्वास्थ्य, परिवार नियोजनजस्ता सेवाहरुलाई अधिकारमुखी कार्यक्रमका रुपमा विकास गर्ने,
३ स्वस्थ जीवनयापन का लागि स्वास्थ्य सेवाप्रवाह लाई गुणस्तरीय बनाउने,
४ वाह्र तथा आन्तरीक बसाईसराई र सहरीकरणलाई व्यवस्थित गर्ने,
५ लैंगिक समानतातथा सामाजिक समावेशीकरणलाई विकासका सबै आयामहरुमा समाहित गर्ने,
६ जनसाङ्ख्यिक तथ्यांक व्यवस्थापन, अध्ययन, अनुसन्धान, सर्वेक्षण र विश्लेषण गर्ने कार्यलाई व्यवस्थित र प्रभावकारी बनाउने र
७ राष्ट्रिय उत्पादकत्व वृद्धिका लागि सक्रिय जनसंख्यालाई उत्पादनशील र उद्योगमुखी बनाउने ।

नीतिहरु :

१ जनसंख्या र विकास बीच तादात्म्य कायम गर्न जनसंख्या व्यवस्थापनलाई समग्र विकासको अभिन्न अंगका रुपमा लिदै सरोकारवाला निकायका बीचमा सम्पर्क र समन्वय स्थापित गरिने छ ।
२ यौन स्वास्थ्य, परिवार नियोजन र सुरक्षित गर्भपतन लगायतका प्रजनन स्वास्थ्य सेवालाई अधिकारमुखी कार्यक्रमका रुपमा विकास गरिने छ ।
३ स्वस्थ जीवन यापनका लागि उपयुक्त जीवनशैली एवं वातावरणको निर्माण गरिने छ ।
४ वाह्य तथा आन्तरकि वसाई सराई र सहरीकरणको प्रभावकारी व्यवस्थापन गरिने छ ।
५ लैगिक, यौनिक, भाषिक, आर्थिक, सामाजिक एवं क्षेत्रीय रुपमा पछि परेका समूह र शारीरिक, मानसिक तथा बौद्धिक रुपमा आपाङ्गता भएका व्यक्तिहरुलाई समावेशीकरण गर्दै जनसंख्या र विकासमा मुलप्रवाहीकरण गर्न नीति, कानुन तथा संस्थागत व्यवस्थामा सुधार गरिने छ ।
६ जनसंख्या क्षेत्रका नीति निर्माण, कार्यक्रम तर्जुमा, कार्यान्वयन, अनुगमन र मुल्यांकनका लागि संस्थागत संरचनाको सुदृढीकरण गरिने छ ।
७ जनसंख्या तथा विकास बीचको अन्तरसम्बन्धको सूचना प्रविधि समेतका उपयोगबाट अध्ययन, अनुसन्धान र विश्लेषण गरी नीतिनिर्माण र कार्यक्रम तर्जुमाका लागि सरोकारवाला निकायहरुलाई पृष्ठपोषण गरिने छ ।
८ विकास आयोजना र कार्यक्रम तर्जुमा गर्दा तिनको जनसाङ्ख्यिक प्रभावको समेत अध्ययन गरी तिनको उपयुक्तता पुष्टि गरेर मात्र कार्यक्रम कार्यान्वयन गरिने छ ।
९ जनसंख्याको लाभांश (Demogrphic Dividend) हुने हिस्सा र खास गरी युवा समूहलाई रोजगारमूलक कार्यमा उपयोग गरिने छ ।

४. पन्ध्रौ योजना(आर्थिक वर्ष :२०७६/७७-२०८०/८१)

पृष्ठभूमि

नेपालको संविधानले प्रत्येक नागरिकलाई राज्यबाट आधारभूत स्वास्थ्य सेवा निःशुल्क प्राप्तगर्ने मौलिक हकको व्यवस्था गरेको छ । देश विकासमा स्वस्थ र उत्पादनशील नागरिकको महत्त्वलाई दृष्टिगत गरी यस क्षेत्रमा लगानी वृद्धि मार्फत गुणस्तरीय तथा सर्वसुलभ स्वास्थ्य सेवामा समतामूलक पहुँच सुनिश्चित गर्नु राज्यको दायित्व हो । यसै सन्दर्भमा लोक कल्याणकारी राज्यको अवधारणा अनुरूप स्वास्थ्य क्षेत्रलाई नाफा मूलकबाट क्रमशः सेवामूलक क्षेत्रमा रूपान्तरण गर्दै लैजानु पर्ने आवश्यकता छ । संविधानको एकल तथा साझा अधिकार सूची अनुसार संघ, प्रदेश र स्थानीय तहलाई स्वास्थ्य सेवाको जिम्मेवारी दिँदै स्वास्थ्य नीति, मापदण्ड, गुणस्तर, अनुगमन,

परम्परागत उपचार सेवा र सरुवा रोग नियन्त्रण लगायतको कार्य संघको अधिकार भित्र राखिएको छ। यसको प्रभावकारी कार्यान्वयनको लागि अन्तर मन्त्रालय समन्वय तथा सहकार्य अपरिहार्य रहेको छ ।

स्वास्थ्य सेवामा कार्यान्वयन भएका विभिन्न कार्यक्रमको फलस्वरूप प्रतिहजार जीवित जन्ममा शिशु मृत्युदर३२, नवजात शिशु मृत्युदर २१ र पाँच वर्ष मुनिको बाल मृत्युदर ३९ तथा मातृ मृत्यु दर २३९ (प्रति लाख जीवित जन्ममा) मा झरेको छ भने कुल प्रजनन दर २.३ प्रति महिला रहेको छ । त्यसैगरी पाँच वर्ष मुनिका बालबालिकामा पुड्कोपना घटेर ३६ प्रतिशत रहेको छ । यस परिप्रेक्षमा नेपालले विभिन्न समयमा गरेको अन्तराष्ट्रिय प्रतिबद्धता, नेपालसरकारका विद्यमान नीति एवम स्वास्थ्य तथा पोषण क्षेत्रका प्रमुख समस्या, चुनौति तथा अवसरलाई समेत आधार बनाउँदै दिगो विकास लक्ष्य हासिल गर्ने राष्ट्रिय कार्य सूची रहेको छ । नागरिकलाई स्वस्थ बनाउन आधुनिक चिकित्सा, आयुर्वेदिक, प्राकृतिक, होमियोपेथिक चिकित्सा क्षेत्र, स्वास्थ्य सुशासन र अनुसन्धानमा लगानी बढाउन आवश्यक देखिएको छ । यस योजनामा स्वास्थ्य सेवालाई जनताको घरदैलोसम्मै पुर्याउन राज्यको नेतृत्वदायी र निजि तथा सहकारी क्षेत्रको परिपूरक भूमिका रहनेछ ।

सोच

स्वस्थ, उत्पादनशील, जिम्मेवार र सुखी नागरिक ।

लक्ष्य

सबै तहमा सबल स्वास्थ्य प्रणालीको विकास र विस्तार गर्दै जनस्तरमा गुणस्तरीय स्वास्थ्य सेवाको पहुँच सुनिश्चित गर्ने।

उद्देश्य

१. संघ, प्रदेश र स्थानीय तहमा सबै किसिमका स्वास्थ्य सेवाहरूको सन्तुलित विकास र विस्तार गर्नु ।
२. सर्व सुलभ र गुणस्तरीय स्वास्थ्य सेवाको लागि सरकारको उत्तरदायित्व र प्रभावकारी नियमन अभिवृद्धि गर्दै नाफा मूलक स्वास्थ्य क्षेत्रलाई सेवा मूलक क्षेत्रको रूपमा क्रमशः रूपान्तरण गर्नु ।
३. बहुक्षेत्रीय समन्वय तथा साझेदारी सहित स्वास्थ्य सेवामा नागरिकको पहुँच तथा उपभोग बढाई सेवा प्रदायक र सेवाग्राहीलाई थप जिम्मेवार बनाउदै स्वस्थ जिवनशैली प्रवद्धन गर्नु ।

<u>अपेक्षित उपलब्धि</u>

स्वस्थ, सबल र सक्रिय जीवन सहितको नेपालीको औसत आयु ७२ वर्ष पुगेको हुनेछ । प्रति लाख जीवित जन्म मातृ मृत्यु अनुपात ९९, प्रति हजार जीवित जन्ममा नवजात शिशु मृत्यु दर १४ र पाँच वर्ष मुनिको बाल मृत्युदर २४ मा झरेको हुनेछ । पाँच वर्ष मुनिका कम तौल भएका बालबालिका २७ बाट १५ प्रतिशत र पुड्कोपना भएका बालबालिका ३६ बाट २० प्रतिशतमा झरेको हुनेछ। नागरिकले आधारभूत स्वास्थ्य सेवा निःशुल्क प्राप्त गरेका हुनेछन्। स्वास्थ्य बिमामा आबद्ध भएको जनसङ्ख्या ६० प्रतिशत, स्वास्थ्य उपचारमा व्यक्तिगत खर्च घटेर ४० प्रतिशत, स्वास्थ्यमा सरकारी लगानी ८ प्रतिशत र ३० मिनेटको दूरीमा स्वास्थ्य संस्थामा पहुँच भएका घर-परिवार ८० प्रतिशत पुगेको हुनेछ । प्रोटोकल अनुसार कम्तिमा चार पटक गर्भवती जाँच गराउने महिला ८१ प्रतिशत, दक्ष स्वास्थ्यकर्मीको उपस्थितिमा जन्मिएका बालबालिका ७९ प्रतिशत र पूर्ण खोप पाउने बालबालिका ९५ प्रतिशत पुगेका हुनेछन् । मलेरिया, कालाजार र हात्तीपाइले रोग निवारण भएका हुनेछन्।

५. दिगो विकासको लक्ष्य (Sustainable Development Goals)

The Sustainable Development Goals (SDGs), officially known as Transforming our world: the 2030 Agenda for Sustainable Development is a set of seventeen aspirational "Global Goals" with 169 targets, between themSustainable Development Goal 3 is among the most specific SDGs with a number of clear, measurable targets. It is a direct result of the fact that Goal 3 can build on experiences with the Millennium Development Goals (MDGs), which had a very strong focus on health (MDGs 4, 5 and 6). In this regard in particular, it is unfortunate that some of the main lessons learnt from the MDGs have not been accounted for. Clear examples are Targets 3.1, 3.4 and 3.6, which focus on global reductions only. Global targets not

only risk masking significant variations in the starting conditions of countries but also risk being adopted at the national level, as experience with the MDGs has demonstrated. The Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) suggests repeatedly disaggregating data by geographic location (e.g. urban and rural) but also by age group, sex and income as data systems improve. Furthermore, a simple adoption of global targets at the national level is highly disadvantageous to countries with bad starting conditions (William Easterly's article "How the Millennium Development Goals Are Unfair to Africa" from 2009 is a prominent source in this regard).

The SDG3 is operationalized through nine targets and four suggestions for means of implementation. Most of the targets deal with health issues that are relevant for developing and developed countries alike. Most of the targets are very precise; the levels of ambition, however, vary considerably between the targets.

Targets:

Target 3.1: The target requires by 2030 to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births"

Target 3.2: The target requires by 2030 to "end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortalities to at least as low as 25 per 1,000 live births".

Target 3.3: The target requires by 2030 to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases".

Target 3.4: The target requires by 2030 to "reduce by one-third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing"

Target 3.5: The target requires to "strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol".

Target 3.6: The target requires by 2020 to "halve global deaths and injuries from road traffic accidents"

Target 3.7: The target requires by 2030 to "ensure universal access to sexual and reproductive health care services"

Target 3.8: The target requires to "achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all".

Target 3.9: The target requires by 2030 to "substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination".

From the above targets we can conclude that; the goal's focus on healthy lives and well-being, instead of the mere absence of disease or infirmity, is not sufficiently reflected in its operationalization. This could be mended if Targets 3.3 and 3.4–with their focus on specific communicable and non-communicable diseases –were to be measured by changes in the HALE indicator. The targets for the goal are, in general, precise in their formulation with a rather high level of ambition. Targets 3.1, 3.4 and 3.6, however, focus on global reductions only. Whereas the experience with the MDGs demonstrated that the compelling advantages of country comparisons contributed to the adoption of global goals at the national level, the 2030 Agenda foresees the requirements for national implementation plans that will reflect national circumstances and will prevent these targets from unfairly impacting those countries with bad starting conditions. We welcome the inclusion of Target 3.9 but anticipate the huge challenge of translating this target into a meaningful indicator. Finally, almost all means of implementation explicitly refer to developing countries only which goes against the aspired universal character of the 2030 Agenda. But, of course, it also highlights the need of poor countries to receive external support.

1.3. OVERVIEW OF MAHAKULUNG RURAL MUNICIPALITY

With the implementation of federal structure in Nepal, Mahakulung Rural Municipality is located in Koshi Province of Nepal, it is a Himalyan region divided in to Five Wards i.e. Ward 1: Bung, Ward 2: Pelmang, Ward 3: Chheskam, Ward 4: Tumau and Ward 5: Gudel. The Local level, with Bung as its headquarters, covers an area of 648.05 km² and has a population 11,847 according to census 2078. Peak Barunche (7129 m.), Mera Peak (6,476 m.) is located in the northern part, with in Makalu Barun National Park. The main ethnic groups in the mid-hills are the indigenous ethnic Kulung, Kirat Rai, and hill caste Chhetri, while Sherpas live in the high mountains. The Panch Pokhari and Arun valley Trail are popular hiking trail in the area.

The mahakulung Rural Municipality total area is 648.05 square kilometres. It is located between the latitudes of 27°37' and 27°62' north and the longitudes of 86°50' and 86°84' east.

This is a Sankhuwasabha in the east, Bhojpur in the south-east, Khotang and Sotang R.M in the, Mapya Dudhkoshi R.M in the west, and Khumbupasanglamu R.M in the north surround the Local Level.

Basic Demographic Information:

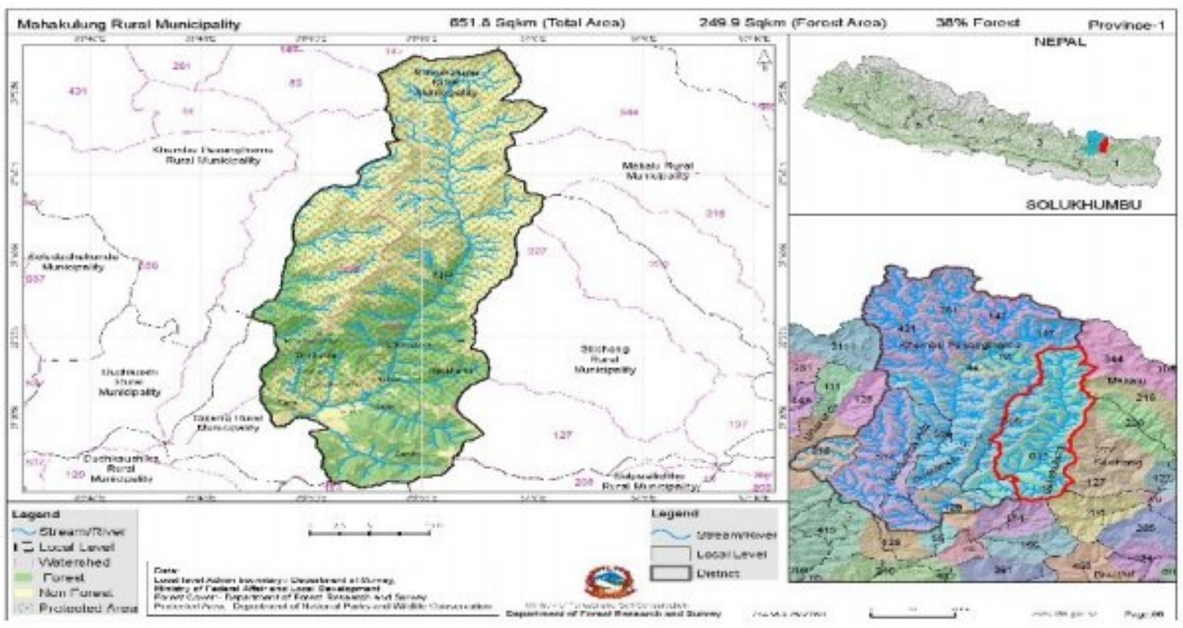
Indicators	**Number**	**Percentage**
Total Population	11,847	NA
Male	5,870	49.5%
Female	5,977	50.5%
Household number	2912	NA
Population Growth Rate	0.33	
Avarage Family Size	4.06	
Litetacy Rate	79.1%	Census 2078
Population Density (per Sq. KM)	18	
Sex Ratio	98.21	
Source: Census 2078		

Ward Level Basic Information

Ward Name	**Total Area (Sq. KM)**	**Households**	**Population (Census 2078)**		
			Total	**Male**	**Female**
Bung	19.54	766	3269	1639	1630
Pelmang	124.14	462	1970	969	1001
Chheskam	411.21	835	3277	1624	1653
Tumau	69.28	454	1808	894	914
Gudel	23.88	395	1523	744	779
Total	**648.05 km2**	**2912**	**11847**	**5870**	**5977**

Geographical and Political Information

Map of Mahakulung Rural Municipality



PALIKA BOUNDARIES

Altitude

Maximum:8848.86 meters

Minimum :600 meters

Climate: Upper tropical

East: Sankhuwasabha

West: Sotang and Mapya

North: Khumbu

South: Khotang and Sotang

Latitue:27°37' and 27°62'north

Longitude:86°50' and 86°84' east.

Temperature

Maximum : 30.7^0C

Minimum : 18^0C

Administrative and peripheral Information

Name of Office	Name of Head	Contact Number	Name of Health Coordinator	Contact Number	Website
District Coordination Committee	Krishna PSD Niraula	9860476799			ddcsolukhumbu.gov.np
Solududhkunda M	Namgel Gyaljen Sherpa	9841344690	Chamar Bd Magar	9842930716	solududhkundamun.gov.np
Thulung Dudhkoshi RM	Asim Rai	9851038291	Uddhab Dhungana	9852829000	dudhkaushikamun.gov.np
Necha Salyan RM	Dhanjan Rai	9844694281	Medghraj Kattel	9862815633	nechasalyanmun.gov.np
Mapya Dudhkoshi RM	Buddhi Kiran Rai	9851187116	Jitendra Yadav	9842897097	dudhkoshimun.gov.np

Mahakulung RM	Surya Kulung	9851099156	Hari Pd Aacharya	9842685397	mahakulungmun.gov.np
Sotang RM	Khil Raj Basnet	9851082017	ShreeDhowaj Rai	9841316174	sotangmun.gov.np
Likhu Pike RM	Mina Karki Basnet	9845252252	Gyanu Karki	9851215289	likhupikemun.gov.np
Khumbu Pasanglhamu RM	Mingma Chhiri Sherpa	9801842343	Arthimaya Tamang	9842939436	khumbupasanglhamumun.gov.np

जिल्ला स्थित कार्यालयहरु को विवरण

क्र.सं	कार्यालयको नाम र ठेगाना	मोबाइल नं.	कार्यालयको आधिकारिक फ्याक्स नं.	कार्यालयको आधिकारी इमेल ठेगाना
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३	जिल्ला समन्वय समिति		०३८-५२०१४४	ddcsolu@gmail.com
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५	अरिदमन गण ख गुल्म सल्लेरी	९८४१८१९३९५	०३८-५२०२००	bnaridaman@nepalarmy.mil.np
६	राष्ट्रिय अनुसन्धान जिल्ला कार्यालय	९८५१२२६६१५	०३८-५२०२४९	nidsolu2076@gmail.com
७	सशस्त्र प्रहरी बल, नेपाल आश्रित गुल्म सल्लेरी	९८५१२६०२५२	०३८-५२०१०१	solukhumbuapf2018@gmail.com
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९	इलाका प्रशासन कार्यालय, सोताङ	९८५२८३१७०७	०३८-४१००६५	aaosotang220@gmail.com
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११	कारागार कार्यालय, सोलुखुम्बु	९८५२८७४७७७	०३८-५२०२१९	solukhumbu.jailor@dopm.gov.np
१२	शमशेर गुल्म, नाम्चे	९८५२८२८०१०	०३८-५४०१२०	नभएको
१३	जिल्ला आयोजना कार्यान्वयन इकाई (शिक्षा), सल्लेरी	९८५२८२१२२९	०३८-५२०२४९	soludliu@gmail.com
१४	नापी कार्यालय, सल्लेरी	९८५२८३०३०८	०३८-५२०२३२	napisolu2075@gmail.com
१५	कोष तथा लेखा नियन्त्रक कार्यालय, सोलुखुम्बु	९८५२८५२१४०	०३८-५२०१४०	dtcosolu@gmail.com
१६	साल्ट ट्रेडिङ कर्पोरेशन लिमिटेड,	९८५२८२८०४०	नभएको	shyamsaha@gmail.com
१७	जिल्ला हुलाक कार्यालय, सोलुखुम्बु	९८५२८२२४२९	नभएको	postoffice.solukhumbu@gmail.com
१८	जिल्ला निर्वाचन कार्यालय	९८५२८२८०२१	०३८-५२०००३	ec.deo.solu@gmail.com

१९	शिक्षा विकास तथा समन्वय इकाई	९८५२८५१३३०	०३८-५२९३५८	soludeo@gmail.com
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२१	मालपोत कार्यालय, सोलुखुम्बु	९८५२८५१२९६	०३८-५२०१९६	ramchandrahtd@gmail.com or
२२	प्रधानमन्त्री कृषि आधुनिकिकरण परियोजना	९८५११४२९८१	०३८-५२०१३०	dadosolu@gmail.com
२३	याक आनुवांशिक श्रोत केन्द्र, स्याङवोचे	९८५२८२८०४१	०३८-५४०१२४	jeevalallamsal@gmail.com
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२५	नेपाल खाद्य तथा व्यापार कम्पनी,	९८५२९३६६९३	०३८-५२०१९०	snp.namche@gmail.com
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२९	नेपाल एयरलाइन्स, फाप्लु	९८५२८२८०३८	०३८-५२०१६७	
३०	डिभिजन वन कार्यालय, सोलुखुम्बु	९८५२८५१३३४	०३८-५२०१३४	dfosolukhumbu@gmail.com
३१	जिल्ला अस्पताल, फाप्लु	९८५२८८५१८८	०३८-५२०१८८	soluhsp78@gmail.com
३२	खानेपानी तथा सरसफाई सव डिभिजन कार्यालय	९८६२६८८९८४	०३८-५२०११०	wsssdosolukhumbu@gmail.com
३३	राष्ट्रिय वाणिज्य बैंक लि. सल्लेरी,	९८४२९०७२८५	०३८-५२०३५५	salleri@rbb.com.np
३४	कृषि विकास बैंक सल्लेरी	९८५१३१६१६६	०३८-५२०१०९	salleri.branch@adbl.gov.np
३५	जलश्रोत तथा सिचाई विकास सव डिभिजन कार्यालय	९८५२८५२११४	०३८-५२०११४	idsdsolukhumbu@gmail.com
३६	घरेलु तथा साना उद्योग कार्यालय	९८५२८५११०६	०३८-५२०१०६	csidbsolu71@gmail.com
३७	जिल्ला आयुर्वेद स्वास्थ्य केन्द्र	९८५२८२०२२५	०३८-५२००२५	madhurjeedhakal@gmail.com
३८	वागवानी केन्द्र, फाप्लु	९८५२८२०२१६	०३८-५२०११६	hrtphaplup1@gmail.com
३९	कृर्षिज्ञान केन्द्र,	९८५२८५११३०	०३८-५२०१३०	akcsolukhumbu@gmail.com
४०	स्वास्थ्य कार्यालय, फाप्लु	९८५२८५१३६०	०३८-५२०१८९	dho.solu@yahoo.com
४१	नेपाल विद्युत प्राधिकरण	९८५२६७२३२१		

1.4. HEALTH SECTION STRUCTURE AND SYSTEMS

The Local health system has been globally recognized as the core mechanism for the delivery of Primary Health Care Services. Essential Health Care Services are administratively and institutionally organized at Local level and offers the best possibility for optimization of critical factors viz; assess, quality, planning, supervision, monitoring, evaluation and the management of the personnel and other resources as well as inter and intra sectoral coordination.

Previously Local health system was run and function through the network of ministry of health and population and its constituent organization under federal government, now the pattern is shifted and its function are implementing through province government and Local government.

This chapter presents the findings related to the HS structure and systems which covers following areas: service delivery points, management system, health workforce, monitoring and evaluation system, IT and health information management and disaster management system.

Service Delivery Points	
Type of service delivery points	**Number**
PHCC/Basic Hospital	1
Health Posts	2
Basic Health Service Center	2
Community Health Unit	4
Urban Health Center	1
CEONC Site	0
BEONC Sites	0
Birthing Centers	3
PHC Out-Reach Clinic	11
Immunization Clinic	11
DOTS Sub/Center	3
MDR Sub center	0
ART Service Site	0
PMTCT Site	5
HTC Site	5
IUCD Service Sites	2
Implant Service Sites	3
Safe abortioin site	1
OTC	3
Microscopic Center	1
N. of FCHV	27
Health Mother Group	27
NGO/INGOs	6
No. of Ambulance	2

1.4.1. Service Delivery Points

As a whole, there are altogether 10 peripheral public health facilities representing all ward of Rural Municipality i.e. 1 MPH, 2 HPs, 2 Basic Health Service Center. Altogether 3 birthing centers in Palika, 11 PHC/ORCs and 11 Immunization Clinics. Now the trend of establishment of the Community Health Units (CHU)is increasing with the leadership of local government via unconditional budget plan. There are 4

CHU and 1 UHC. In this R.M. there are previous ward based FCHVs, so the total number of Female Community Health Volunteers (FCHVs) is 27 as well as 27 Health Mother's Group in Local Level. There is 2 IUCD and 3 implant service sites and have plan to listed and declared as availability of atleast five FP methods in all health facilities. There are three OTC site, 3 DOTS, 1 microscopic center all together in R.M. And six different national and international non-governmental organizations are working in health sector in the Mahakulung with the close coordination of Health Section, Mahakulung.

1.4.2. Management Systems

Meetings:

HS Mahakulung holds different meetings every month which includes- the monthly HS staff meeting and Monthly review meetings with the health post incharge of 5 Wards via physical meeting, training, orienatation or phone call regarding their reporting status.

In addition, with this health Section organized the different sorts of coordination meetings with relevant line agencies and stakeholders to build common consensus to promote and strengthen, to minimize the work duplicatioin and the quality health system throughout the Local Level.

All HFs have their own Health Facility Operational and Management Committee (HFOMC) lead by chairperson and their meeting used to be conduct routinely and as per need for the community levels quality health services.

1.4.3 Current Staffs Sanctioned Post of Health Section Mahakulung.

Current Staffs Sanctioned Post of Health Section (FY 2079/80)			
Position of staffs	**Sanctioned post**	**Status**	**Remarks**
Chief of Health Section (PHI)	1	1	Filled
Staff Nurse	1	1	Filled
Total	**2**	**2**	

TOR of Health Section, Mahakulung

1. Prepare policy, planning and implementation for better local health system
2. Managing and operating preventive, curative and promotive services
3. Storage and distribution plan of vaccine, essential drug, urgent medicine and equipments at quality manner under health service.
4. Facilitate and coordinate for the management of the public health disaster/epidemic and vector surveillance.
5. Facilitate and coordinate to conduct different public health campaigns.
6. Coordinate to Health Facility and service outlets and concern stakeholders.
7. Study and analysis of integrated health information, prepare plan and facilitate and prepare feedback to local Health institutions.
8. Coordinate and facilitate to improve access and utilization of quality health services
9. Regulate, Supervise, monitor, and quality improvement of government, non-government, and private and co-operatives health institutions.
10. Technical capacity building of the human resourses and organization

11. Coordinate, facilitate and implement of the province special health program and other regular public health programs (like: - tuberculosis, leprosy, family planning, lymphyatic filariasis, nutrition, measeals/rubella vaccination and other special program)
12. Promotion and management of environmental health, safe drinking water, sanitation and occupational health.
13. Population management related tasks
14. Implementation of activities provided by federal and province government
15. Multisectoral coordination and facilitation
16. Internal administration (Financial, Administration, and Management) related works.

1.4.4 Health workforce status in Mahakulung

Health Workforce Status	
Type of Health workforce	**Number**
Doctor (Medical Officer)	1
HA	4
AHW	12
Staff Nurse	3
ANM	11
SBA tained	9
RUSG Trained	3
Clinical Mentor	1
Lab Professionals	1
Pharmacy Professional	1
Radiogarpher	1
Office Helper	10
Dental Hygenist	1

Disaster Response Mechanism

Being the member of Disaster Management Committee (DMC), chaired by Chairperson of mahakulung rural municipality, Health Sector Mahakulung is playing active role as assigned in the area of disaster focusing on health. Furthermore, HS has its own Rapid Response Team (RRT) at Local level, which is actively mobilized if there is any outbreaks and epidemics. In addition, there is Community Rapid Response Team (CRRT) at all 5 ward levels which has member's representation from ward level elected persion's, agriculture, veterinary, forestry, school, and so on and is lead by public health supervisor. If there is any outbreak or epidemic, at first, CRRT is mobilized and if the condition is out of their control RRT at the Palika level is mobilized. Likewise, if the Palika level RRT is also unable to control the situation then Distric, province health emergency operation center, national health emergency operation center and EDCD is summoned for further action.

CHAPTER 2

FAMILY WELFAREPROGRAM

2.1. NATIONAL IMMUNIZATION PROGRAM

National Immunization Program (NIP) formerly Expanded Program on Immunization (EPI) was started in 2034 and is a priority1 program. It is one of the successful public health interventions of Ministry of Health and Populationand has achieved several milestones and contributed in reduction of morbidity, mortality and disability associated with vaccine preventable diseases.

NIP works closely with other divisions of Department of Health Services centres of Ministry of Health and Population and different partners supporting national immunization program. In the decade of vaccine 2011-2020 NIP has introduced several new and underutilized vaccines contributing towards achievement of Gobal vaccine Action Plan targets of introducing new and underutilized vaccine in routine immunization. Currently NIP has included several underused and new vaccines in program which provides vaccination against12vaccine preventable disesaes, antigen includes–BCG, DPTHepBHib (penta), Rota, fIPV, PCV, OPV (bOPV), Measles and Rubella (MR) and Japanese Encephalitis, Typhoid provided through 16,500 service delivery points in health facilities (fixed session), outreach sessions and mobile clinic (sessions).

National Immunization Program has cMYP 2017-2021 aligned with global, regional and national guidelines, policies and recommendation to guide the program for five years. All the activities outlined in cMYP have been costed as well as have developed strategies for implementation. NIP has a very good record to meet the eradication, elimination and control of vaccine preventable disease targets. Smallpox eradication has become the history, MNT elimination status is sustained from 2005, polio free status is maintained since 2010, measles elimination and rubella, congenital rubella syndrome control was targeted by 2019.

Since FY 2069/70, Nepal has initiated and implemented a unique initiative known as ‘‘Full Immunization Program’’. The program addresses issues of social inequity in immunization as every child regardless of social or geographical aspects within an administrative boundary are meant to be fully immunized under this program. Over the years, Nepal has witness's participation of all stakeholders at all levels to achieve full immunization. As the end of FY 075/76, 80 % of total local level declared FID and 58 out of 77 districts and now the all districts have been declared “Fully Immunuzed” and as continuation basic all district conducted program every year for "Fully Immunizaed" and Solukhumbu delared as FY 2075/76 "Fully Immunized"

Guiding Documents of National Immunization Program

There are several Global, Regional and National guiding documents for National Immunization Program. The main documents which have been taken in account and are incorporated in cMYP 2017-

21 areGlobal Vaccine Action Plan, SEARO Vaccine Action Plan, National Immunization Act 2072 and Nepal Health Sector Strategy.

Comprehensive Multi Year Plan of Action

The Comprehensive Multi Year Plan (cMYP) 2012-16 ended in 2016 and new cMYP 2017-21 is inplace which is also ended. The cMYP 2017-21 provides a plan for five years to achive immunization related goals of the country.

Vision

Nepal: a country free of vaccine-preventable diseases.

Mission

To provide every child and mother high-quality, safe and affordable vaccines and immunization services from the National Immunization Program in an equitable manner.

Goal

Reduction of morbidity, mortality and disability associated with vaccine preventable diseases.

Strategic Objectives

Objective 1: Reach every child for full immunization.

Objective 2: Accelerate, achieve and sustain vaccine preventable diseases control, elimination and eradication.

Objective 3: Strengthen immunization supply chain and vaccine management system for quality immunization services;

Objective 4: Ensure financial sustainability for immunization program;

Objective 5: Promote innovation, research and social mobilization activities to enhance best practices

Target Population

The target populations of the National Immunization Programme are:

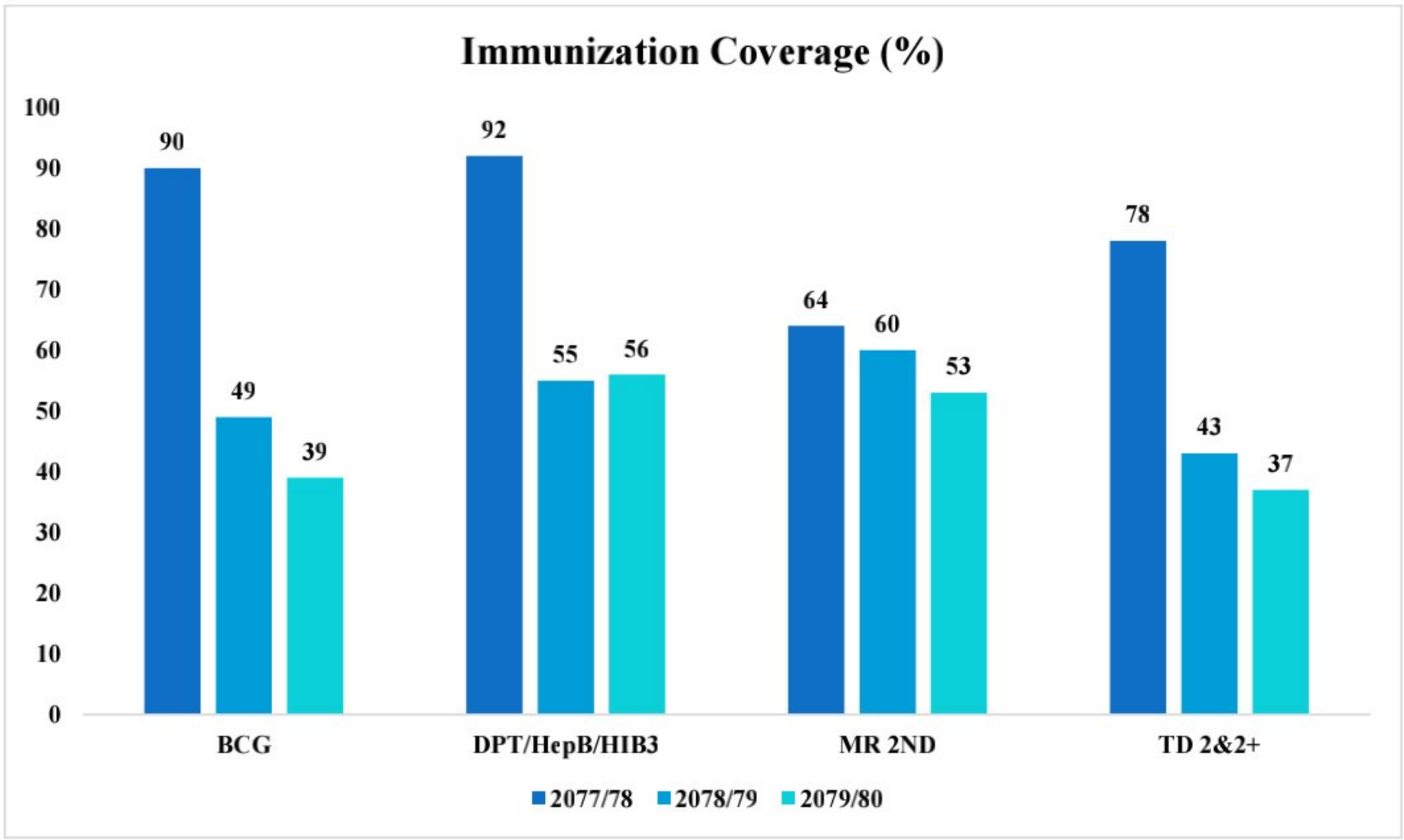
- Under 1-year children for BCG, DPT-HepB-Hib, OPV, fIPV, PCV and Measles/ Rubella1 (MR1) vaccine.
- Twelve months' children for JE
- 15 months' children for MRSD measles-rubella second dose (MRSD) and typhoid (TCV)Vaccine.
- Pregnant women for Tetanus Toxoid containing (Td) vaccine

Trends of Indicators of last three years

Immunization coverage:

Coverage of every vaccine is slightly decreasing in FY 2079/80 than FY 2078/79. BCG, Penta, MR 2nd and TD2 & 2+ coverage had been slightly decreasing than last fiscal year. However, the status seems good and near to equal as compared to the Distric level. Coverage fluctuation might has incurred

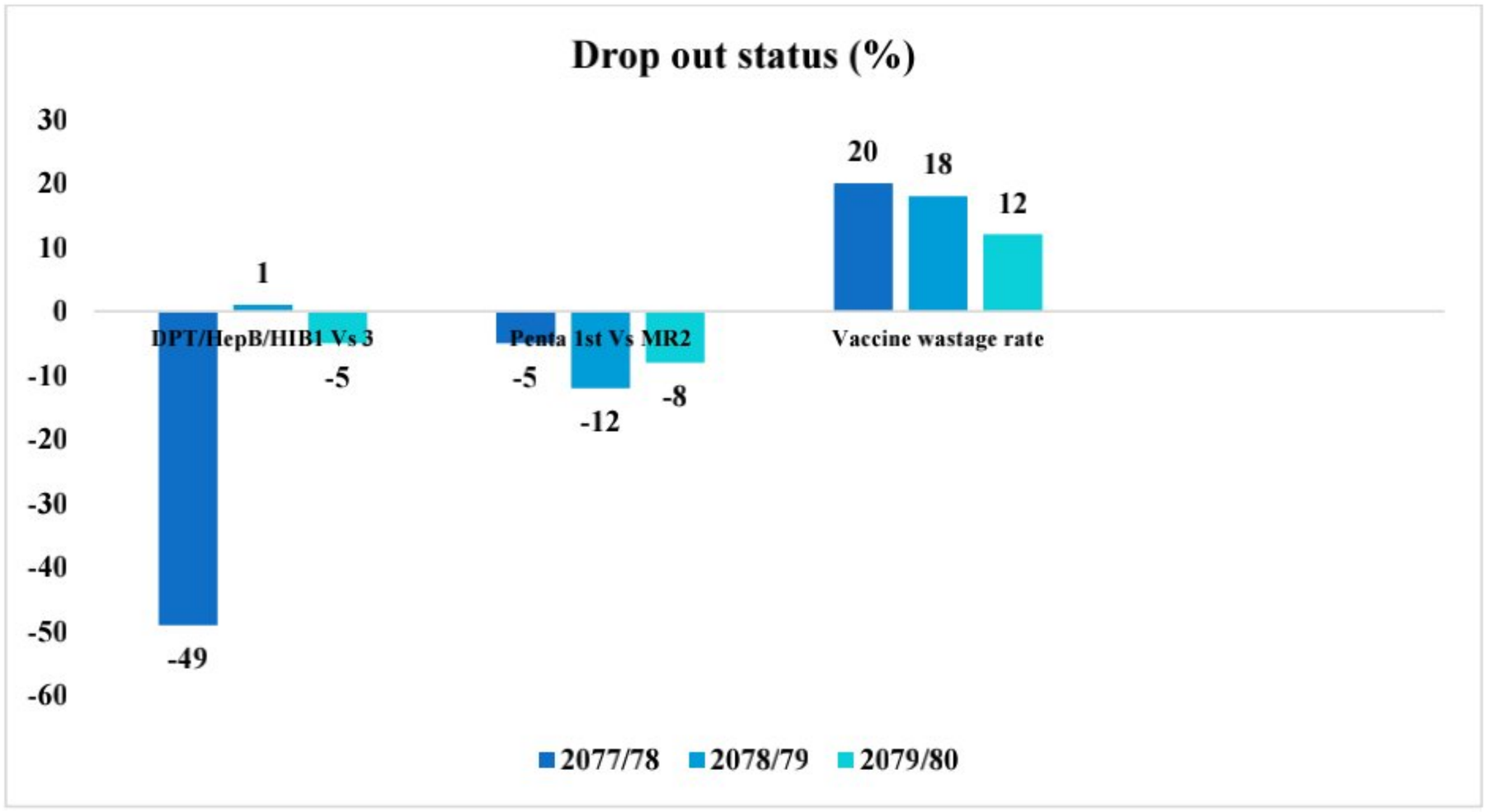
because of the changing dynamics in health system in this federal state, high mobility of people to urban areas but other major reason to this is also the high target set that is quite different to the actual target of under one population. As that actual basis, data survey from households Mahakulung R.M. has declared as a full immunization by the year 2079/80 with active participation of district as well as local stakeholders and local leaders.



Source: DHIS-II

Drop Out:

Less than 10 % drop out rate is expected to ensure good utilization of immunization services while, more than 10% and minus dropout rates signify that there could be problems with recording and reporting or because of the miscalculated denominators. DPT+HepB+Hib-1 vs. DPT+HepB+Hib-3 and Penta 1st Vs MR 2nd dropout rate is in minus status i.e. -5%, -12% and -8% respectively. However, it is still less than 10% since the last three Years for Penta 1st vs 3rd and Penta 1st Vs MR2nd at Mahakulung. Likewise, the wastage rate of all vaccine is also in a decreasing trend i.e 20%, 18% and 12%, which is best achievement.



Categorization of HFs Based on Access and Utilization of Immunization- FY 2079/80

National Immunization Program also evaluates the status of the accessibility and utilization of immunization services. HFs are categorized by CAT I to IVon the basis of DPT-HepB-Hib1 coverage and dropout rate of DPT-HepB-Hib1 VS DPT-hepB-Hib3 to know the accebility and utilization of immunization services respectively.

As mentioned in below, Mahakulung RM is in category III (i.e poor access and good utilization). Altough Gudel Health Post is in category II and other HF's of Mahakulung is in category IV

Category I(less Problem) High Coverage (≥90%) Low Drop-Out (<10%)	Category II(Problem) High Coverage (≥90%) High Drop-out (≥10%)	Category III (Problem) Low Coverage (<90%) Low Drop-out (<10%)	Category IV (Problem) Low Coverage (<90%) High Drop-out (≥10%)
	Gudel HP	Mahakulung RM	Chheskam HP Tumau BHS Pelmang BHS Bung Hospital
**All Ward have been declared as Full Immunized.*			

Major Activities Carried Out in FY 2079/80

1. Construction Immunization center buildings by local government
2. Round yearly management and supply of the vaccines to uninterrupted conduction of EPI sessions and clinics
3. Interaction on immunization with all elected bodies, all chief administrative officer and health facilities incharges for sustainability of full immunization and approval of the sustainability status.
4. Basic Immunization Training to health workers
5. Repair and maintenance of cold chain equipments and solar setup for cold chain room
6. Orientation on introduction of various phase of Covid-19 vaccine and Hygiene promotion alongwith, AEFI and its management to Health Workers including vaccinators
7. Conduction of Local level immunization coordination committee meeting quarterly
8. Orientation related to Immunization Act and regulation towards health workers and stakeholders.
9. Data verification and quality monitoring to low/poor immunization covarage sites.
11. Supportive monitoring and Suppervision at health facilities.
12. Declared Mahakulung R.M as "Fully Immunized"

Fully Immunized mahakulung Rural Municipality Declaration, Bung

Issues/ Recommendations

Issues	Recommendations	Responsibility
Program Duplication in district and at Local level.	Avoid the duplication of program	MoHP/DOHS/ Province MoH
Provision of compensation for field activities isn't uniform for all staffs	Provision of compensation for field activities should be provided equally for all staff.	MoHP, MoH, MoF
Inadequate budget for vaccine transportation	Allocate budget for vaccine transportation as per need	MoH, FWD, DoHS
Poor quality immunization data with under and overreporting	Strengthen supportive supervision lower levels and DQSA program	HF, HO, MoH, FWD

2.2 NUTRITION PROGRAM

Nutrition interventions are cost effective investments for socioeconomic development as they enhance human capital by improved productivity of the population. Hence, nutritional well-being is crucial for attaining many of the Sustainable Development Goals. In alignment with international and national declarations and national health policies, the Government of Nepal is committed to ensuring that its citizens have adequate food, health and nutrition. The Constitution (2015) ensures the right to food, health and nutrition to all citizens. Hunger and under-nutrition often result in the vicious cycle of malnutrition and infections that leads to poor cognitive and intellectual development, less productivity and compromised socioeconomic development. When combined with household food insecurity, frequent illnesses, inadequate dietary intake, poor hygiene, care and practices continue the cycle of intergenerational malnutrition.

Focus on Nutrition

Nutrition is a globally recognized development agenda. Since the year 2000, several global movements have advocated nutrition for development. The Scaling-Up-Nutrition (SUN) initiative calls for multi-sectoral action for improved nutrition during the first 1,000 days of life. The Government of Nepal as an early member of SUN adopted the Multi-sector Nutrition Plan (MSNP) in 2012 to reduce chronic nutrition. Recently, the UN General Assembly declared the 2016–2025 periods as the Decade of Action on Nutrition.

Policy Initiatives

The National Nutrition Policy and Strategy was officially endorsed in 2004 to address all forms of malnutrition including under-nutrition and over-nutrition. This policy provides the strategic and programmatic directions in the health sector while the MSNP provides a broader policy framework within and beyond the health sector under a Food and Nutrition Security Secretariat of the National Planning Commission that coordinates its implementation. The National Health Policy, 2071 highlights improved nutrition via the use and promotion of quality and nutritious foods generated locally to fight malnutrition.

Aligning with the SDG roadmap, MSN-II, National health Policy, National Health Sector Strategy Plan and current global initiatives, nutrition section Of FWD has developed national nutritional strategies and plans for improving maternal infant and young child nutrition assisted by experts from the Nutrition Technical Committee. Moreover, as recommended by the Nepal Nutrition Assessment and Gap Analysis (NAGA) and guided by MSNP, in 2012–2013 MoHP conducted an Organization and Management Survey towards establishing a National Nutrition Centre as an expert nutrition center under MoHP for nutrition specific intervention. **Goal**

The goal of the National Nutrition Programme is to achieve nutritional well-being of all people to maintain a healthy life (to contribute to the socioeconomic development of the country), through improved nutrition programme implementation in collaboration with other sectors.
The overall objective is to enhance nutritional well-being, reduce child and maternal mortality and contribute to equitable human development.

The specific objectives of the programme are as follows Mahakulung RM:

- To reduce protein-energy malnutrition in children under 5 years of age and women of reproductive age
- To improve maternal nutrition
- To reduce the prevalence of anaemia among adolescent girls, women and children
- To eliminate iodine deficiency disorders and vitamin A deficiency and sustain elimination
- To reduce the infestation of intestinal worms among children and pregnant women
- To reduce the prevalence of low birth weight
- To improve household food security to ensure that all people can have adequate access, availability and use of food needed for a healthy life
- To promote the practice of good dietary habits to improve the nutritional status of all people
- To prevent and control infectious diseases to improve nutritional status and reduce child mortality
- To control lifestyle related diseases including coronary disease, hypertension, tobacco related diseases, cancer and diabetes
- To improve the health and nutritional status of schoolchildren
- To reduce the critical risk of malnutrition and life during very difficult circumstances
- To strengthen the system for analyzing, monitoring and evaluating the nutrition situation
- Behavior changes communication and nutrition education at community levels
- To align health sector programmes on nutrition with the Multi-Sectoral Nutrition Initiative.

Current National Nutrition Strategies

Strategies

The following general strategies have been pursued to address the nutritional situation in Nepal:

- To reduce protein-energy malnutrition (PEM) in children less than five years of age and Reproductive aged Women to half of the 2000 level by the year 2017 through a multi-sectoral approach.
- Promote, facilitate and utilize communityparticipation and involvement for all nutritionactivities.
- Develop understanding and effective co-ordination between various concerned Sections, Divisions and Centres within the Department of Health Services.

- Maintain and strengthen co-ordination among other agencies involved in nutrition activities, i.e. the Ministries of Agriculture, Education, Local Development and the National PlanningCommission, as well as with EDPs, NGOs, INGOs and private sector.
- Decentralize authority to the region, district, Health Post, Sub Health Post and community forneeds assessment, planning, implementation, and monitoring.
- Conduct national advocacy and social mobilization campaigns; Integrate/incorporate activities (such as Expanded Program on Immunization, Integrated Management of Childhood Illness, Maternal and Family Health and other concern program, etc.) into nutrition plans.
- Develop a systematic approach for Monitoring and Evaluation of all nutrition program activities.
- Celebrate different events related to nutrition program like School Health and Nutrition Week (Jestha 1 to 7), Breast feeding week (August 1-7), Iodine month (February) to raise awarenessabout the importance of Nutrition.
- Implement School Health and Nutrition Program as per National Strategy.
- Growth monitoring will be used as a screening tool to assess the general malnutrition status of children under less than five years.

Major Achievements of Mahakulung Rural Municipality

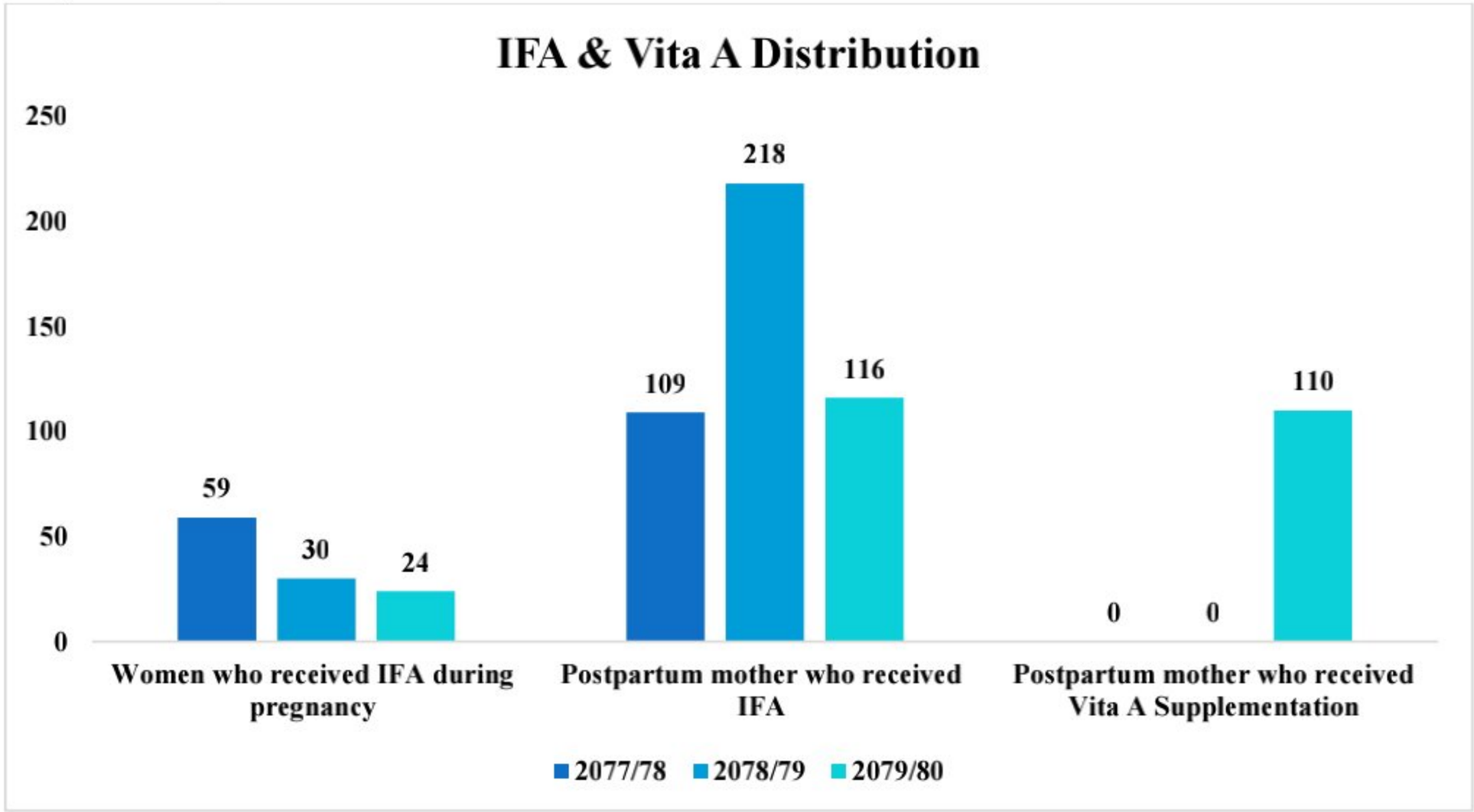
Indicators	Fiscal years		
	2077/78	2078/79	2079/80
% of children aged 0-23 months registered for growth monitoring	59	50	36
Average number of visits among children aged 0-23 months	11	14	17
% of children aged 0-6 months registered for growth monitoring, exclusively breastfed for the first six months	133	60	72

According to the nutrition program, growth of under 2 years' children should be monitored at least every month that is 24 times during 0-23 months. Children aged 0-23 months registered for growth monitoring is 36%, which is in a decreasing trend than last fiscal years. Similarly, the percentage of infants who fed exclusive breast feeding up to six months of age is in a increasing trend i.e 72%. Also, the Averege number of visits for growth monitoring is in a increasing trend i.e. 11%,14% and 17%.

Coverage of Iron, Folic Acid and Vitamin "A" Distribution as % of Expected Live Birth:

Since 1998, the MoHP has been providing iron foliate (IFA) at “no cost” to pregnant women and breastfeeding mothers through the HF, PHC/ORC and FCHVs as part of antenatal care (ANC) and

postnatal care (PNC) services. Pregnant women are provided with 180 tablets during antenatal visits and are advised to take one tablet a day. An additional 45 tablets are provided after childbirth to cover the post natal period.



Source: DHIS-II

As shown in bar diagram, IFA received during pregnancies period is in a decreasing trend than last fiscal year ie, 24 and postpaertunmother who received IFA is decreasing in FY 2079/2080 i.e 116 than previous FY. As per the policy of MOHP, every mother is supplied with a 'Vitamin A' capsule in the postpartum period. Health workers provide 'Vitamin A' capsule to mothers immediately after delivery. If the delivery is at home FCHVs provide Vitamin A at home. As mentioning it the indicator postpartum mother who received Vitamin A suppllemmentaion is 110 which is far better than last FY 2077/78.

Adolescents Girls Iron Folic Acid Supplementation

SHN Program has initiated weekly Iron Folic Acid (IFA) supplementation to the adolescent girls aged 10-19 years from FY 2072/73 aiming to prevent and control the high burden of Iron Deficiency Anemia among this particular group of population. This activity was piloted in Kathmandu, Dolakha, Khotang, Panchthar, Bhojpur, Saptari, Pyuthan and Kapilvastu districts in FY 2072/073. Now the program is scalingup upto additional 41 districts of Nepal and have plan to reach all 77 districts.

Under this component, almost all the adolescent girls aged 10-19 years are supplemented with weekly Iron Folic Acid biannually in Shrawan (Shrawan -Asoj) and Magh (Magh- Chaitra) rounds. In each round, they are provided with one IFA tablet every week for 13 weeks. So, each adolescent girl gets a total of 26 IFA tablets in a year.

Iron Folic Acid Consumption Period FY 2079/80 (Achievement Status)

S. N.	Age Group (Adolescent girl)	School/HF/FCHV
		Number of adolescent girls aged 10-19 years who received IFA
1	10-19 years	92

Source: Vertical reporting received from Hfs

Major Activities Carried Out in FY 2079/2080

- Biannual Distribution of Vitamin A and Albendazole tablet under 5 years children
- Celebration of breast-feeding promotion week, Nutrition Week and Iodine Month
- School Health and Nutrition Programs
- Adolescent Girls Iron Folic Acid Supplementation
- Regular supply and distribution of nutritional program commodities to HFs
- Supportive Supervision and Monitoring of nutrition related activities in the district
- Identification of 1000 Days HHs and monitored the status accordingly.
- Celebration of different Nutritional Importance Days
- Regular Monitoring and Supervision of nutritional programs
- IEC/BCC intervention through local media and publications.

Issues and Recommendations:

Issues	Recommendation	Responsibility
Poor recording and reporting of all nutritional indicators	-Onsite coaching to improve the recording and reporting -HMIS training to newly recruited HWs.	MoSD/HD/HO, HF
Less priorities on nutritional promotional activities by local level government	-Program and activities should be planned as stated in multisectrol nutritional plan and linkup with other governmental priorities	R/M
Unavailability of nutritional rehabilitation home in district	One nutritional rehabilitation home in each district need to be established.	MoHP/DoHS
Poor linkages in between theline agengies and stakeholders	Establish linkages to related stakeholder like agriculture, livestock and education sector etc. to quality improvement of nutritional status.	MoH/HD/HO

2.3. COMMUNITY BASED INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES (CB-IMNCI)

CB-IMNCI is an integration of CB-IMCI and CB-NCP Program that is being implemented across the country after the decision of MoHP on 2071/6/28 (October 14, 2015). This integrated package of childsurvival intervention addresses the major problem of sick new born such as birth asphyxia, bacterial infection, jaundice, hypothermia, low birth weight, counseling of breastfeeding. Among the age group of 2 months to 59 months' children, it addresses major childhood illnesses like pneumonia, diarrhea, malaria, measles and malnutrition in a holistic way.

In CB-IMNCI program, FCHVs are expected to carry out health promotional activities for maternal, newborn and child health and dispensing of essential commodities like distribution of iron, zinc, ORS, chlorohexidine and immediate referral in case of any danger signs appear among sick newborn and child. Health workers will counsel, and provided the health service like management of non-breathing cases, skin to skin contact and management of neonatal sepsis and common childhood illness. Also, program has provisioned the post-natal visits by trained health workers through primary health care outreach clinic. For treatment of possible severe bacterial infection (PSBI), treatment recommended is injection Gentamycine and inj. Ampicillin or oral Amoxicillin.

Goal:

Improve newborn and child survival and ensure healthy growth and development.

Targets of Nepal Health Sector Strategy (2015-2020)

- Reduction of Under-five mortality rate (per 1,000 live births) to 28 by 2020
- Reduction of Neonatal mortality rate (per 1,000 live births) to 17.5 by 2020

Targets of Nepal Every Newborn Action Plan (NENAP)

- Reduction of Neonatal mortality rate (per1000live births) to 11 by 2035
- Reduction of still births (per 1000 total births) to 13 by 2035

Objectives:

- To reduce neonatal morbidity and mortality by promoting essential newborncare services.
- To reduce neonatal morbidity and mortality by managing major causes of illness
- To reduce morbidity and mortality by managing major causes of illness among under 5 years children.

Strategies:

- Quality of care through system strengthening and referral services for specialized care
- Ensure universal access to health care services for new born and young infant
- Capacity building of frontline health workers and volunteers
- Increase service utilization through demand generation activities
- Promote decentralized and evidence-based planning and programming

Major Interventions

Newborn Specific Interventions

- Promotion of birth preparedness plan
- Promotion of essential newborn care practices and postnatal care to mothers and newborns Identification and management of non-breathing babies at birth
- Identification and management of preterm and low birth weight babies
- Management of sepsis among young infants (0-59 days) including diarrhea

Child Specific Interventions

- Case management of children aged between 2-59 months for 5 major childhood killer diseases (Pneumonia, Diarrhea, Malnutrition, Measles and Malaria)

Cross Cutting Interventions

- Behavior change communications for healthy pregnancy, safe delivery and promote personal hygiene and sanitation
- Improved knowledge related to Immunization and Nutrition and care of sick children
- Improved interpersonal communication skills of HWs and FCHVs

Major Indicators:

Indicators	Fiscal Year		
	2077/78	2078/79	2079/80
Incidence of ARI/1000 <5 Years Children	397	561	590
Incidence of Pneumonia among children under five years (HF & Outreach)	37	67	68
% of children U5 years with Pneumonia treated with antibiotics (Amoxicillin)	96	95	100
% of children under five years with diarrhea suffering from Severe dehydration	265	170	177
% of children under five years with diarrhea treated with zinc and ORS	100	99	100

Estimated number of children U-5 years:1449

Incidence of ARI/1000 <5 years' children has Increased in FY 2079/80 as compared to previous year. It is high ARI cases reported, it may be due to misclassification of cases. Incidence of pneumonia has also increased to 68 in FY 2079/80 as compared to 2078/2079. Likewise, Incidence of diarrhoea is in increasing i.e 177 than last FY 2078/2079. Both % of children U5 years with Pneumonia treated with antibiotics (Amoxicillin) and % of children under five years with diarrhea treated with zinc and ORS are 100% which is a best practice.

Major Activities Carried Out in FY 2079/80

- Six days district level TOT was conducted to HWs of all health facilities with the coordination to training sites.
- Onsite coaching to the peripheral level health workers through trained mentor.

- Regular supervision and monitoring of the program to enhance the quality recording and reporting.
- Orientation of the remote area guideline and its implementation toward health workers and FCHVs
- Regular supply of the CBIMNCI commodities to health facilities level and below.
- Follow up of the piloted program Equity and Access (*Samata and Pahunch*) and application of SAATH tools in community level.

Issues and Recommendations:

Issues	Recommendations	Responsibility
Inadequate Logistic supplies like job aids, treatment books, treatment cards, timers etc. from the central level	Provision of Regular supply	FWD, PHLMC
Poor recording and reporting as per guidelines	Maintain CB-IMCI register properly at HF, discuss with FCHV about recording and reporting as per guideline	HO, HF
Poor referral mechanism	Strengthen the referral mechanism	DoHS/HO/HF
CBIMNCI Un-train health workers in health facilities	Provision of training regularly	MoH/HTC

2.4. SAFE MOTHERHOOD AND NEWBORN HEALTH

The goal of the Natioanl Safe Motherhood Program is to reduce maternal and neonatal morbidity and and improve maternal and neonatal health through preventive and promotive activities and by addressing avoidable factors that cause death during pregnancy, childbirth and the post partum period. Global evidence shows that all pregnancies are at risk, and complications during pregnancy, delivery and the postnatal period are difficult to predict. Evidence suggests that three key delays are of critical importance to the outcomes of an obstetric emergency in Nepal: (i) delay in seeking care, (ii) delay in reaching care, and (iii) delay in receiving care.

To reduce the risks associated with pregnancy and childbirth and address these delays, three major strategies has adopted in Nepal:

- Promoting birth preparedness and complication readiness including awareness raising and improving the availability of funds, transport and blood supplies.
- Expansion of 24 hours birthing facilities alongside Aama Surakshya Programme promotes continuum of care from antenatal care (ANC) to post-natal care (PNC).

- Expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected health facilities in every district.

Since its initiation in 1997, the Safe Motherhood Program has made significant progress in terms ofthe development of policies and protocols as well as expansion in the role of service providers suchas staff nurses and ANMs in life saving skills. The policy on skilled birth attendants endorsed in 2006by MoHP specifically identifies the importance of skilled birth attendance at every birth andembodies the Government's commitment to training and deploying doctors and nurses/ANMs withthe required skills across the country. Similarly, endorsement of revised National Blood TransfusionPolicy 2006 is also a significant step towards ensuring the availability of safe blood supplies in theevent of an emergency.

HO Solukhumbu has been providing Safe Motherhood Services through all Health Facilities and PHC-ORCs. Solukhumbu hospitaland Sotang Primary Hospital has started CEONC service in the district as well as SolukhumbuHospital and One PHC, three basic hospitals, three commuhnity Hospitall are providing BEONC services effectively. Twenty-Seven HFs are performing as Birthing Centers. Services like CAC and PAC are provided from Solukhumbu Hospital.

Main strategies of the Safe Motherhood Programme

1. Promoting inter-sect oral coordination and collaboration at Federal, Provincial, districts and Locallevels to ensure commitment and action for promoting safe motherhood with a focus on poor andexcluded groups.
2. Strengthening and expanding delivery by skilled birth attendants and providing basic and comprehensive obstetric care services at all levels. Interventions include:
    - developing the infrastructure for delivery and emergency obstetric care;
    - standardizing basic maternity care and emergency obstetric care at appropriate levels of the health care system;
    - strengthening human resource management training and deployment of advanced skilledbirth attendant (ASBA), SBA, anesthesia assistant andcontracting short-term human resourcesfor expansion of services sites;
    - establishing a functional referral system with airlifting for emergency referrals from remoteareas, the provision of stretchers in Palika wards and emergency referral funds in all remotedistricts;
3. Strengthening community-based awareness on birth preparedness andcomplicationreadinessthrough FCHVs and increasing access to maternal health information and services.
4. Supporting activities that raise the status of women in society.
5. Promoting research on safe motherhood to contribute to improved planning, higher qualityservices and more cost-effective interventions.

Major Activities included in Safe Motherhood Program

1. Antenatal Care

Antenatal care services include:

- At least four antenatal check-ups: first at 4th month, second at 6th month, third at 8th month and fourth at 9th month of pregnancy;
- Monitor blood pressure, weight and fetal heart rate;
- Provide information, education and communication (IEC) and behavior change communication (BCC) for danger signs and care during pregnancy and timely referral to the appropriate health facilities;
- Birth preparedness and complication readiness (BPCR) for both normal and obstetric emergencies (delivery by skilled birth attendants, money, transportation and blood); Early detection and management of complications;
- Provision of tetanus diphtheria (TD) immunization, iron tablets, deworming tablets to all pregnant women and malaria prophylaxis where necessary.

Delivery Care

Delivery care services include:

- Skilled birth attendants at deliveries (either home based or facility-based);
- Early detection of complicated cases and management or referral after providing obstetric first aid by health worker to appropriate health facility where 24 hours emergency obstetric services are available;
- Obstetric first aid at home and/or HP/SHP if complications occur, using Emergency Obstetric Care Kit (EOC kit);
- Identification and management of complications during delivery and referral to appropriate health facility as and when needed;
- Registration of births and maternal and neonatal deaths.

2. Postnatal Care

Postnatal care services include:

- Three postnatal visits: First visit within 24 hours of delivery, second visit on the third day and third visit on seventh day after delivery;
- Identification and management of mother's and newborn in complications of postnatal period and referral to appropriate health facility as and when needed;
- Promotion of exclusive breastfeeding;
- Personal hygiene and nutrition education, post-natal vitamin A and iron supplementation for the mother;
- Immunization of newborns; and
- Post-natal family planning counseling and services.

3. Newborn Care

Newborn care includes:

Health education and behavior change communication on essential newborn care practices, Identification of neonatal danger signs and timely referral to the appropriate health facility.Delivery by

skilled birth attendant both at home and health facility, immediate newborn care (warmth, cleanliness, immediate breast feeding, cord care, eye care and immunization) and newborn resuscitation

4. NyanoJholaProgramme

The NyanoJholaProgramme was launched in 2070/71 to protect newborn from hypothermia andinfections and to increase the use of peripheral health facilities (birthing centers). Two sets of clothes (bhoto, daura, napkin and cap) for newborns and mothers, and one set of wrapper, mat for baby and gown for mother are provided for women who give birth at birthing centers and district hospitals. The programme was interrupted due to financial constraints, however MOHP allocated extra budget for due to popular demand.

5. Emergency Obstetric Care

Basic emergency obstetric care (BEOC) covers management of pregnancy complications by assistedvaginal delivery (vacuum or forceps), manual removal of placenta, removal of retained products ofabortion (manual vacuum aspiration), and administration of parental drugs (for postpartumhemorrhage, infection and pre-eclampsia/eclampsia), resuscitation of newborn and referral.Comprehensive emergency obstetric care (CEOC) includes surgery (caesarean section), anesthesiaand blood transfusion along with BEOC functions. Safe blood transfusion is an essential part of CEOC, and to support this, national blood transfusion policy was revised in 2006 and blood transfusion guideline developed.

6. Safe Abortion Services

Preventing unwanted pregnancies through a quality family planning services is a first step towards addressing women's reproductive health needs, and increasing access to safe abortion services hasbeen considered as a missed opportunity to prevent unwanted pregnancy, however, there is ad earth need to make this service available in order to prevent mortality and morbidity from unsafeabortion. A comprehensive approach needs to be integrated between three services, familyplanning, safe abortion and post abortion care. This means ensuring the availability ofcomprehensive abortion care (CAC) that refers termination of unwanted pregnancies through safetechnique with effective pain management, post procedure family planning information and serviceto ensure women are able to plan when to have children and avoid further unwanted pregnancies.

Only trained doctors or health workers can provide safe abortion services at the governmentapproved health facilities, with the consent of women by following the protocol.

Aama Programme Provision

a. For women delivering their babies in health institutions:

Transport incentive for institutional delivery: Cash payment to women immediately after institutional delivery (NPR 3,000 in mountains, NPR 2,000 in hills and NPR 1000 in Tarai districts).

Incentive for 4 ANC visits: A cash payment of NPR 800 to women on completion of four ANC visits at 4, 6, 8 and 9 months of pregnancy, institutional delivery and postnatal care.

Free institutional delivery services: A payment to health facilities for providing free delivery care. For a normal delivery health facility with less than 25 beds receive NPR 1,000 and health facilities with 25 or more beds receive NPR 1,500. For complicated deliveries health facilities receive NPR 3,000 and for C- sections (surgery) NPR 7,000. Ten types of complications (antepartum haemorrhage (APH) requiring blood transfusion, postpartum haemorrhage (PPH) requiring blood transfusion or manual removal of placenta (MRP) or exploration, severe pre-eclampsia, eclampsia, MRP for retained placenta, puerperal sepsis, instrumental delivery, and management of abortion complications requiring blood transfusion) and admission longer than 24 hours with IV antibiotics for sepsis are included as complicated deliveries. Anti-D administration for RH negative is reimbursed NPR 5,000. Laparotomies for perforation due to abortion, elective or emergency C-sections, laparotomy for ectopic pregnancies and ruptured uterus are reimbursed NPR 7,000 to both public and private facilities.

b. Incentives to health service provider:

For deliveries: A payment of NPR 300 to health workers for attending all types of deliveries ***to bearranged from health facility reimbursement amounts***.

Newborn Care Programme Provision

a. For sick newborns:

There are four different types of package (Package 0, Package A, B, and Package C) for sick newborns case management. Sick newborn care management cost is reimbursed to health facility. The cost of package of care include 0 Cost for Packages 0, and NPR 1000, NRP 2000 and NRP 5000 for package A, B and C respectively. Health facilities can claim a maximum of NPR 8,000 (packages A+B+C), depending on medicines, diagnostic and treatment services provided.

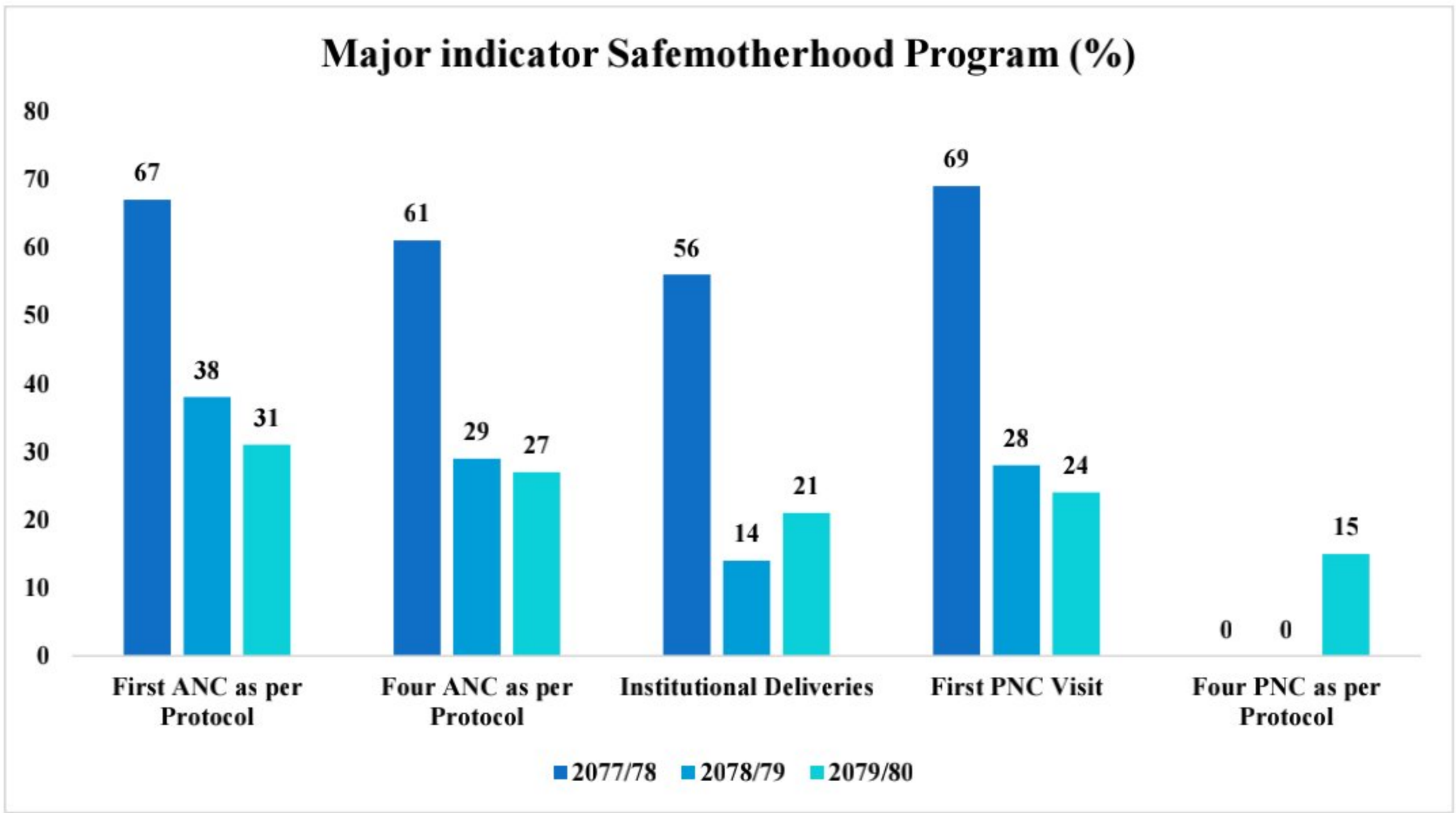
b. Incentives to health service provider: A payment of NPR 300 to health workers for providing all forms of packaged services ***to be arranged from health facility reimbursement amounts***.

Service Sites in Mahakulung Rural municipality

Service Sites	**Fiscal Year**
	2078/79
Number of CEOC Sites	0
Number of Functional BEOC Sites	0
Number of Birthing Centers	3

There is no CEOC and BEOC site in Mahakulung Rural Municipality. Where as, three HFs are performing as Birthing Centers.

Major Indicators of Safe Motherhood Program



ANC 1st visit as per protocol is 31% in FY 2079/80, which has decreased by 7% as compared to previous FY 2078/79. The ANC complete 4th visit has also decreased to 27% in FY 2079/80 as compared to previous FY. Institutional deliveries (deliveries by SBA and other than SBA) as percent of expected live birth is increased to 21% in this fiscal year 2079/80 compared to the last fiscal year. Four PNC as per protocol has increased to 15%, which was previously 0%.

Other indicators such as PNC 1st visit is decreased by 12% than last financial year i.e 39% and PNC complete visit as per protocol has also been decreased by 11% in this financial year i.e 34%.

Maternal and Neonatal death status

Indicators	Fiscal Year
	2079/80
No. of Maternal Death	0
No. of Neonatal Death	2

Furthermore, 0 maternal deaths were reported during the FY 2079/80. New born death reported is 2 in FY 2079/80 which is decreasing as compared to FY 2078/79 most of the death is reported on the way death during the referral time.

Major Activities carried out in 2079/80

- Equipment purchases and supply to birthing center for Quality Improvement
- SBA onsite coaching and mentoring
- VIA test, STI management camps, screening and ring pessary service camp for uterine prolapsed clients and timely referral for better management.
- Clinical update for nursing staffs (ANM and Staff Nurse)
- Supportive supervision and monitoring of the Program
- IEC/BCC Intervention and media advocacy
- Innitiation of full ANC visit and zero home delivery campaign
- Community awareness activities to quality utilization of birthing center and services.

Issues and Recommendations

Issues	Recommendations	Responsibility
Inadequate supply of logistics including power supply at Birthing Centers	Supply of adequate logistics (Equipments and Materials)	R/M
Inadequate Health workforce (ANMs) at Birthing centers	Ensure 24 hrs availability of adequate nursing staffs in the Birthing sites	R/M
Low coverage of ANC 4th visit as protocol	Strengthen defaulter tracing. Mobilize FCHVs, HFOMC, mothers' groups, and school students for awareness.	HF, HO, R/M
Very low complete PNCcoverage	-Raise the quality of ANC counseling services, focusing on continuum of care -Develop a special package to encourage timely first ANC visits. -Initiate PNC home visit in selected communities	HF, R/M
The inadequate use ofsome birthing centersandincreasing the numberof birthing centers, and increasing use of referral hospitals	-Upgrade strategically located birthing centers to providecomprehensive quality primary health care services andaimfor 'home delivery free' Wards -Run innovative programmes to encourage delivery atbirthingcentres	HF, R/M

2.5. Family Planning and Reproductive Health

Modern Family Planning (FP) refers to female sterilization (eg, minilap), male sterilization (eg no-scalpel vasectomy), intrauterine contraceptive device (IUCD), sub-dermal contraceptive implants (e.g. Jadelle), three monthly injectables (eg. Depo provera), the oral Pill (combined oral pills), condoms (male condom), lactational amenorrhea mothod (LAM), emergency contraceptive pill and standard days method (SDM).

The aim of the National Family Planning Programme is to ensure that individuals and couples can fulfill their reproductive needs by using appropriate family planning methods based on informed choices. To achieve this, GoN is committed to equitable and right based access to voluntary, quality FP services based on informed choice for all individuals and couples focusing more on hard to reach communities and underserved populations such as adolescents, migrants and other vulnerable or marginalized groups ensuring no one is left behind.

Family planning is a priority programme of the Government of Nepal. It is a component of the reproductive health package and essential health care services under the Nepal Health Sector Programme-2 (2010-2015), the National Family Planning Costed Implementation Plan (2015–2021), the Nepal Health Sector Strategy (2015-2020) and the government's commitments to Family Planning 2020.

Quality FP services are also provided through private and commercial outlets such as NGO run clinic/centre, private clinics, pharmacies, drug stores, hospitals including academic hospitals. FP services and commodities are made available by some social marketing (and limited social franchising) agencies.
FP services are part of essential health care services and are provided free in all public sector outlets.

Main Objective:
To improve the health status of all people through informed choice on accessing and utilizing client-centered quality voluntary FP services.

The specific objectives are as follows:

- To increase access to and the use of quality family planning services that are safe, effective and acceptable to individuals and couples. A special focus is on increasing access in rural and remote places and to poor, Dalit and other marginalized people with high unmet needs and to postpartum and post-abortion women, the wives of labor migrants and adolescents.
- To increase and sustain contraceptive use, and reduce unmet need for family planning, unintended pregnancies and contraception discontinuation.
- To create an enabling environment for increasing access to quality family planning services to men and women including adolescents.
- To increase the demand for family planning services by implementing strategic behavior change communication activities.

Policies and Strategic areas for FP

- Enabling environment: Strengthen the enabling environment for FP
- Demand generation: Increase health care seeking behavior among populations with high unmet need for modern contraception
- Service delivery: Enhance FP service delivery including commodities to respond to the needs of marginalized people, rural people, migrants, adolescents and other special groups
- Capacity building: Strengthen the capacity of service providers to expand FP service delivery
- Research and innovation: Strengthen the evidence base for programme implementation through research and innovation

Service Outlets of Family Planning Program

Indicators	Fiscal Year
	2079/80
Number of IUCD Sites	2
Number of Implant Sites	3

As shown in above table, number of Long Family Planning service sites for IUCD, implant some sites are not sufficient this is due to transfer of trained staffs from HFs.

Major Indicators:

Indicators	Fiscal Years		
	2077/78	2078/79	2079/80
CPR (unadjusted) among WRA	33	31	31
% modern contracetive among WRA	11	16	12

New acceptors are defined as the number of WRA who adopted any one FP method for the first time in their life. The use of family planning combodities like condom and Implant are in increasing trend and combodities like Depo, IUCD and Pills are in decreasing trend than last FY.

Major Activities carried out in FY 2079/80

- Provision of regular comprehensive FP service
- Provision of long-acting reversible services (LARCs)
- FP strengthening program through the use of decision-making tool (DMT) and WHO medical eligibility for contraceptive (MEC) wheel
- Micro planning for addressing unmet need of FP in all wards
- Interaction program on FP in marginalized communities
- Monitoring and Supervision of FP and RH programs.

Issues and Recommendations

Issues	Recommendations	Responsibility
Inadequate number of Implant and IUCD service sites	Expansion of Implant and IUCD service sites by providing training	HO, MOH, FWD, Local Government
Report Collection from private clinics not included in HMIS	Establish a system to collect report from private clinics in regular basis	HFs, Local Government, MoH
Low FP acceptors among post abortion and post partum women	Strengthen post abortion and post partum FP counseling	HO, HF
VSC service is limited to mobile camp only	Provide VSC service through district level Institution	FWD, HO, MoH
Seasonal demand of FP during festival (as theperiodicout-migrants return back to their home during festival time)	Prepare FCHVs to address the seasonaldemand of FP	HO, HF

2.6. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

National Adolescent Sexual and Reproductive Health is one of the priority programs of Family WelfareDivision (FWD), DepartmentofHealthServices.Nepal is one of the countries in South Asia developed andendorsed the first National Adolescent Health and Development (NAHD) Strategy in 2000. To addressthe needs of emerging issues of adolescents in the changing context, the NAHD strategy is revised in 2018 the main aim of revision of strategy was to address the problem face by the adolescent in Nepal. Adolescents aged 10 to 19 constitute 24% (6.4 million) of the population in Nepal. Nepal is 3rd highest country in child marriage though legal age at marriage is 20. Seventeen percent of girls aged 15-19 years are already mothers or pregnant with their first child. Only 15% of currently married adolescents use a modern method of contraceptives. The Adolescent Fertility Rate (AFR) is an increasing trend from 81 in 2011 to 88 in 2016 per 1,000 women of 15-19 years.

Vision:
To enable all adolescents to be healthy, happy, competent and responsible.

Mission:
Optimum use of the available methods and establishing strong bond between the concerned partiesand developing strategy with the view of securing the health and development of adolescents.

Goal: To promote the sexual and reproductive health of adolescents.

General Objectives

- By the year 2025, all adolescents will have positive life styles to enable them to lead healthy andproductive lives.

Specific Objectives

- To create safe, supportive and protective environment for all adolescents.
- To increase adolescents' access to scientifically sound and age appropriate information about their health and development
- To enhance life skills and improve the health status of adolescents
- To increase accessibility and utilization of adolescent friendly quality health and counseling services.

Targets:

- To make all health facilities as adolescent friendly as per the envision of National Health policy (2014) and NHSS (2016-2021),
- To ensure universal access to ASRH services, the Nepal Health Sector Strategy Implementation Plan (2016-2021) aims to:
  - -scale up Adolescent Friendly Service (AFS) to all health facilities;
  - -behavioral skill focused ASRH training to 5,000 Health Service Providers and
  - -more than 100 health facilities to be certified with quality AFS by 2021

The programme aims to reduce the adolescent fertility rate (AFR) by improving access to family planningservices and information.

Strategic Principles and Direction

- Participation and leaderships of adolescent
- Equality and equity
- Right with responsibility
- Strategies partnership
- Role of central, province and local government

The criteria of adolescent-friendly services (AFS) include the availability of trained staffs and information on adolescent sexual and reproductive health, the delivery of services in a confidential way, adolescentfriendly opening hours, the display of the AFS logo and including two adolescents as invitees to HFOMC meetings.

Implementation Status of ASRH Program in Mahakulung Rural Municipality

Initially, the rural municipality was identified for the ASRH programme in FY 2069/70. In the rural municipality, where listed as AFS site for the provision of quality Adolescent Friendly Health Services, which is the great innovation and achievement of of HS Mahakulung. To ensure quality and sustainability of ASRH program, now the HFs are going on the process of certification. From three health facilities were operating ASRH services throughout the rural municipality.

ASRH implementing site with in Rural Municipality

Name of health facilities for ASRH
Mahakulung Primary Hospital, Gudel HP Chheskam HP (Supotted by Action for Nepal)

Major Activities conducted in FY 2079/80

- Conduction of AFS orientation to health workers including nurses.
- Printed and distributed IEC/BCC booklets, posters and comics
- Distributed ASRH flip chart, adolescent job aids to AFS health facilities
- AFS site verification, pre-certification and certification program.
- School health orientation program to school teachers and Health post incharge
- Program orientation to local stakeholders including HFOMC members, FCHVs in program HFs.
- IEC Flex displayed with key message in program implemented HFs
- Community awareness activities through existing structures
- Conducted bi-annual ASRH review meetings at district level
- Supply of necessary logistics for AFS sites.
- Printed of required reporting tools and distribution to HFs
- Monitoring and supportive supervision of ASRH program

Issues and Recommendations

Issues	Recommendations	Responsibility
High prevalence of early marriage and teenage pregnancy	Intensify community awareness activities and effectively implement the law	R/M
Timing is not friendly for students to come in health facility for AFHS	Specify day and time for service to adolescents	HF, HFOMC, School, R/M
Lack of adequate space and facilities as per the ASRH guideline in most of the health facilities	More support for infrastructure to make HF adolescent friendly	FWD, HO, EDPs
Lack of adequately trained health staffs for adolescent and youth counseling	Provision of counselling training to HFs, preferably from both male and female gender	MoH, FWD, HO, EDPs
Lack of community awareness and importance on adolescent sexual and reproductive health	-Needed to expand ASRH program up to community level. -Orientation needed for guardian	HO, HF, EDPs
Newly Constructed HF Building have no Space for AFS Corner	Design of AFS room in newly constructed health facility building	MD/DUDBC

Recording and reporting is not still channelizing to HMIS/DHIS2	Incorporating ASRH reporting in DoHS HMIS/DHIS2

2.7. PRIMARY HEALTH CARE OUTREACH CLINIC

As envisaged in the last national health policy 1991, health facilities were extended up to villagelevel. However, utilization of services provided by health facilities, especially preventive andpromotive services, has been found to be limited because of limited accessibility. Therefore, it was felt that services should be expanded closer to the community. Thus, Primary HealthCare Outreach (PHC/ORC) services was initiated and established in 1994 (2051 BS).

The aim of PHC/ORC is to improve access to some basic health services including familyplanning and safe motherhood closer to rural households. These clinics are the extensiveservice sites of PHCCs,HPs and basic health service centers up to community level. The primary responsibility toconduct these clinics lies with ANMs, AHWs; Other staffs of HP/PHCCs help to conduct the PHC/ORC. FemaleCommunity Health Volunteers (FCHVs) and other local NGOs/CBOs support health workersto conduct the clinics and also support in recording/reporting and other support activities.

Based on the local needs PHC/ORCs are conducted every month at fixed locations of the ward son specific dates and time. The clinics are conducted within half an hour'swalkingdistance for the population residing in that area.

According to PHC/ORCstrategy, following services are provided from the clinic.

1. Safe Motherhood & Newborn Care

- Antenatal, postnatal, and newborn care
- Iron distribution
- Referral if danger signs identified

2. Family Planning

- DMPA, (Depo-Provera) pills and condom
- Monitoring of continuous users
- Education and counseling on FP methods and emergency contraception
- Counseling and referral for IUCD, implant and VSC service
- Tracing defaulter

3. Child Health

- Growth monitoring of under 3 years children
- Pneumonia/Diarrhoea treatment

4. Health Education and Counseling

- Family planning
- Maternal and newborn care
- Child health

- STI, HIV/AIDS
- Adolescents' sexual and reproductive health
- Others

5. First aid treatment

- Minor treatment and referral for complicated cases

Major Indicators of PHC/ORC Program

Indicators	Fiscal Years		
	2077/78	2078/79	2079/80
Health Facilities within Catchment Area-Outreach Clinics-Planned	71	103	85
Health Facilities within Catchment Area-Outreach Clinics-Conducted	34	45	25
Health Facilities within Catchment Area-Outreach Clinics-People Served	710	639	616

As shown in table above, PHC/ORC clinic conduction and people served are in decreasing trend it's because people are getting services from HF's FY 2079/2080 than FY 2078/80.

Issues and Recommendations:

Issues	Recommendations	Responsibility
Poor Infrastructure of PHC/ORC	-Strengthen PHC/ORC committee and select the proper place. -Local resource mobilization to strengthen PHC/ORC	HO, HF, HFOMC, women's group, R/M
Some of thePHC/ORCs not conductedeffectively	-Decide whether PHC/ORC clinics are at appropriate place of the community. -Ensure community participation andownership in PHC/ORC conduction as perlocal need.	HFOMC, HF, R/M
Inadequate human resource mobilization to conduct the clinics	-Send AHWs or ANMs as per the availability to every clinic.	HO, HF, HFOMC, R/M
Lack of field allowance toadditional staff mobilization	Endorse a policy to provide allowance for field staffs	FWD, DoHS, R/M

CHAPTER 3

EPIDEMIOLOGY AND DISEASE CONTROL

3.1. TUBERCULOSIS

Tuberculosis (TB) is a public health problem in Nepal that affects thousands of people each year and is one of the leading causes of death in the country. WHO estimates that around 42,000 (Incidence rate of 151 per 10, 00,000) people develop active TB every year in Nepal. Nearly fifty percentages of them are estimated to have infectious pulmonary disease.

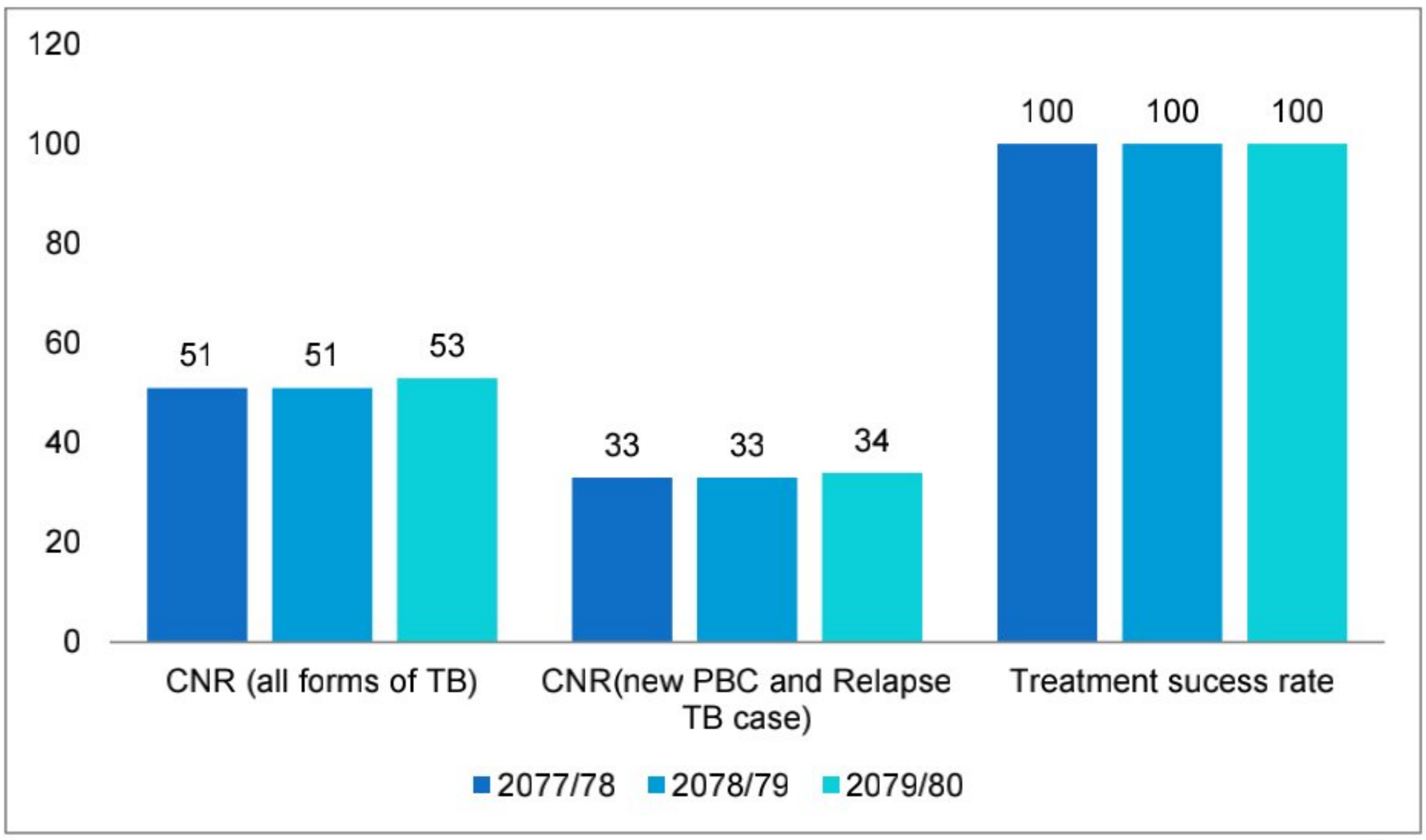
During last Fiscal Year, National Tuberculosis Programme (NTP) registered 32,043 all forms of TB cases, which includes 31,397 incident TB cases (new and relapse). Among all forms of incident TB cases (new and relapse) 18,106 (58%) were bacteriologicallyconfirmed (PBC) incident TB cases, 4,112 (13%) were pulmonary clinically diagnosed (PCD) incident TB cases and 9,179 (29%) were extra pulmonary incident TB cases reported during the reporting year. Out of total registered cases in NTP, there were 11,667 (37%) female and 20,330 (63%) male.

According to the latest WHO Global TB Report 2018, Tuberculosis Mortality rate was 23 per 100,000populations, which exclude HIV+TB. As per the Global TB report, 6000 to 7000 people are dying peryear from TB disease. However, TB death among registered TB patients was 3% (1,013 deaths) among 32,313 registered TB cases in FY 2074/75. TB mortality is high given that most deaths are preventable if people can access tuberculosis care for diagnosis and the correct treatment is provided. Nepal NTP hasadopted the global WHO's END TB Strategy as the TB control strategy of the country.

The Directly Observed Treatment, Short Course (DOTS) has been implemented throughout the country since April 2001. The NTP has coordinated with the public sector, private sector, local government, I/NGOs, social workers, educational institutions and other sectors to expand DOTS and sustain thegood progress achieved by the NTP. There are 4,382 DOTS treatment centres in Nepal and the NTPhas adopted the global End TB Strategy and the achievement of the SDGs as the country's TB controlstrategy.

Major Indicators of TB Control Program Mahakulung Rural Municipality

Case notification



Source:DHIS-II

Treatment outcomes

Mahakulung has achieved 100% treatment success rate in FY 2079/2080, which is constant as last FY 2078/79. As that for satisfactory result at least 90%, Treatment Success Rate is required.

Major activities carried out in FY 2079/80

- Celebration of World TB Day 2023

- Quarterly review meeting and cohort analysis workshop at each local level
- Orientation and quarterly review program related to TB/HIV co-infection and its referral
- Linkage of DOTS centres to microscopic centres through courier
- Conduction of Tuberculosis Preventive Therapy (TBPT) intervention as a component of TB program
- TB Modular training for health workers
- Nutrition allowance for TB relapse cases on treatment
- Regular supply of medicine and commodities including laboratory supplies
- IEC/BCC messages production and broadcasting via local medias
- Onsite coaching, Supportive Supervision and Monitoring to improve the recording reporting and other aspects

Issues and Recommendations:

Issues	Recommendations	Responsibility
Lack of trained laboratory staffs at new locally established laboratories	Basic TB microscopy and TB modular training to new staffs	HO, NTC
Low screening of presumptive TB cases from OPD resulting in low slide collection	-Regular sputum testing of the presumptive cases by HFs -Increment in sputum courier system for transporting slides and sputum from remote areas -Increment in contact tracing process from community level	HFs,HO, R/M, EDPs
Recording tools not completely updated	Regular update of TB recording tools. Ensure consistency with HMIS	HFs, HO, R/M
Lack of standard and functional microscopes at microscopic centers local laboratories	Provision of standard microscopes at local laboratories and maintenance of non- functional microscopes at old microscopic centres	NTC,HO, R/M
Lack of patient-friendly TB treatment services in some facilities	Expandcommunity-based DOTS programme	HO, NTC
Insufficient income generation programmefor needy TB patients and drug resistance TB patients and theirfamilies	Explore sustainable methods to financially support the patients and their families	HO, NTC, EDPs

3.2. LEPROSY

Vision: Leprosy free Nepal

Goal: End the consequences of leprosy including disability and stigma

Guiding principles

- Stewardship and system strengthening
- Expedite the elimination process in high prevalence districts
- Collaboration, coordination and partnership
- Community involvement
- Integration, equity and social inclusion
- Linkages with Universal Health Coverage and Sustainable Development Goals

Objectives:

- Achieve elimination status in all districts by 2020.
- Expand services for early detection of leprosy cases at health facility, especially in high prevalence districts through Enhancing selected diverse approaches (ISDT)
- Initiate Post-Exposure Leprosy Prophylaxis to family members and neighbors
- Achieve the surveillance performance indicators

Strategies

- Expand and enhance early case detection through selected diverse approaches (ISDT)
- Strive to achieve the surveillance performance indicators
- Modernize and intensify the service delivery pathways for ensuring quality services
- Heighten the collaboration and partnership for Leprosy-Free Nepal
- Enhance support mechanism for people infected and affected by lepr

Indicators Mahakulung

Indicators	Fiscal Years		
	2077/78	2078/79	2079/80
New Case Detection Rate/100000	0	0	0
Prevalence Rate/10,000	0	0	0
Disability Rate Grade 2 among New Cases	0	0	0

Nepal has declared itself with the Leprosy elimination status in January 2010 and since then has successfully sustained elimination at the national level. Similarly, Mahakulung has also declared and sustained the elimination status of leprosy (defined as: reducing the Prevalence <1 case/10,000 populations) till now. In this fiscal year 2079/80, the new case detection rate is 0 which is constant as previous year. Along with, prevalence rate is 0 in FY 2079/80 As analysing major indicator of leprosy from FY 2077/78-079/80 no one case diagnosed in Mahakulung.

Major activities carried out in FY 2079/80

- Regular supply of medicine and commodities
- IEC/BCC intervention and world leprosy day celebration
- Supportive supervision and monitoring of the program
- Conducted review program with district stakehder in reagrds leprosy well as disable management
- orientaion to health worker regarding

Issues and Recommendations

Issues	Recommendations	Responsibility
low level of diagnosis	Enhacing contract tracing and case investigation program	LG/HO

3.3. MALARIA

Malaria control project was first initiated in Nepal in 1954 with the support from USAID (then USOM). The objective of the project was to study malaria mainly in Terai belt of central Nepal. In 1958, national malaria eradication program was launched with the objective of eradicating malaria from the country within a stipulated time period. Due to various reasons the eradication concept was reverted to control program in 1978. Following the call of WHO to revamp the malaria control programs in 1998, Roll Back Malaria (RBM) initiative was launched to address the perennial problem of malaria in hard-core forests, foot hills, inner Terai and valley areas of the hills, where more than 70 percent of the total malaria cases of the country prevail. The high risk of acquiring the disease is attributed to the abundance of vector mosquitoes, mobile and vulnerable population, relative inaccessibility of the area, suitable temperature, environmental and socio-economic factors.

Malaria risk stratification 2019 was tailored to suit the changing epidemiology of malaria in the country and to ensure appropriate weightage is allotted to key determinants of malaria transmission as recommended by external malaria program review. Malaria data from last three years reveals that even within rural municipalities or municipalities, malaria is concentrated within some wards while other wards remain relatively free of malaria. In these settings, transmission is typically sufficiently low and spatially heterogenous to warrant a need for estimates of malaria risk at a community level, the wards. In order, to refine the risk stratification at the community level and thereby define the total population at risk of malaria; malaria risk micro-stratification was conducted at the wards level of rural municipality or municipalities.

Nepal's current **National Malaria Strategic Plan (NMSP, 2014–2025)** has the Aim, mission, goals and objectives as shown below:

The aim of NMSP is to attain "Malaria Free Nepal by 2026".

NMSP (2014-2025- Revised) are phased malaria elimination by province:

- Achieve Malaria Elimination (zero indigenous cases) throughout the country by 2022;
  -Province 1, Bagmati, Gandaki "get to zero indigenous case" by 2020
  -Province 2 and Lumbini "get to zero indigenous case" by 2021,
  -Province Karnali and sudurpashchim "get to zero indigenous case by 2022, and
- Sustain Malaria- free status and prevent re-introduction of malaria in province after getting to zero indigenous case.

Goal

In line with the WHO Global Technical Strategy for Malaria 2016-2030 (GTS) and the Asia Pacific Leaders Malaria Alliance Malaria Elimination Roadmap, the goals of NMSP 2014-2025 are:

- Achieve Malaria Elimination (zero indigenous case) throughout the country by 2022
- Sustain Malaria free status and prevent re- introduction of malaria

The specific objective of NMSP (2014-2015, Revised are as follows:

- Strengthen surveillance and strategic information on malaria for effective decision making
- Ensure effective coverage of vector control intervention in the targeted malaria risk areas.
- Enusre universal access to quality assured diagnosis and effective treatment of malaria.
- Devlop and sustain support from leadership and communities for malaria elimination
- Strengthen programmatic technical and managerial capacities for malaria elimination.

Malaria Control Program Mahakulung Rural Municipality:

Indicators	Fiscal Years		
	2077/78	2078/79	2079/80
Total malaria slide examination	0	1	3
Number of malaria cases	0	0	1
Number of kala-azar cases	0	0	0

Annual malaria slide examination rate has increased compared with the last fiscal year 2078/79. Likewise, incidence of annual parasitic incidence rate per 1000 risk population is zero and number of kala-azar case reported zero in Mahakulung.

Major Activities performed during FY 2079/80

- Sample collection of suspected malaria cases and test was done by rapid diagnostics test kits
- Case-based treatment and referral
- Celebrated World Malaria Day on 25 April.

Issues and Recommendations:

Issues	Recommendations	Responsibility

Low blood slide collection of suspected malaria cases	Regular blood slide collection of the suspected cases by HFs	R/M, HFs,HO
Lack of orientation of basic Malaria and Malaria Microscopy Training	Training or orientation need to plan for newly recruited health workers and laboratory personnel	MoH/HD/EDCD
Lacking in malaria case-based investigation	Orientation to local level health staffs and elected bodies to internalize the importance	MoH/HD/EDCD

3.4. HIV/AIDS AND STI

With the first case of HIV identification in 1988, Nepal started its policy response to the epidemic of HIV through its first National Policy on Acquired Immunity Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs) Control, 1995 (2052 BS). Taking the dynamic nature of the epidemic of HIV into consideration, Nepal revisited its first national policy on 1995 and endorsed the latest version: National Policy on Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs), 2011. With the National HIV Strategic Plan, Nepal has embarked on a Fast-Track approach towards ending the AIDS epidemic as a public health threat by 2030, through achieving the ambitious 95-95-95 targets by 2026. By 2026, 95% of all people living with HIV (PLHIV) will know their HIV status by 2020, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and by 2026, 95% of all people receiving antiretroviral therapy will have viral suppression.

National HIV Strategic Plan 2021-2026

National HIV Strategic Plan 2021-2026, the sixth national strategy with the aim of meeting the global goal of 95-95-95 by 2026. By 2026, 95% of all people living with HIV (PLHIV) will know their HIV status by 2020, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and by 2026, 95% of all people receiving antiretroviral therapy will have viral suppression.

Strategic Directions

Vision: Ending the AIDS epidemic as a public health threat in Nepal by 2030

Mission: To provide inclusive, equitable and accessibale services throuhout the HIV care continum.

Goals:

- To prevent new HIV infections
- To improve HIV related health outcome of PLHIV
- To reduce HIV related inqualities among PLHIV and KPs

Targets by 2026

1. Identify, 95% of the estimated PLHIV
2. Treat 95% of people diagnosed with HIV.
3. Attain viral load suppression for 95% of the PLHIV on ART
4. Reduce 90 % of new HIV infections (Baseline as of 2010)
5. Eliminate vertical transmission of HIV
6. Achieve case rate of congenital syplis of < 50 per 100000 live births

Priorities

1. Acclerating HIV prevention service among key populations
2. Expanding innovative and effective testing approaches
3. Elimination of vertical transmission and syphlis
4. Scaling up of HIV Sensitive social protection services to key and vulnerable population
5. Addressing human rights and gender in HIV resposes
6. Strengthening sffective, inclusive and accountable HIV governance

Major HIV Services in district:

- HIV testing services and STI management
- Community Based/Prevention of mother to child transmission
- HIV treatment, care and support services

In Mahakulung, 5 Community PMTCT sites are responsible for HIV/Testing and Counseling and Treatment.

HIV Co-infection indicators

Indicators	Fiscal Years		
	2077/78	2078/79	2079/80
% of pregnant women who tested for HIV at an ANC checkup	21%	27%	24%
HIV/AIDS-PMTCT-Counseling and Testing-Pregnancy-Tested	76	97	84
HIV/AIDS-PMTCT-Counseling and Testing-Pregnancy-Positive	0	0	0
HIV/AIDS-PMTCT-Counseling and Testing-Pregnancy-Counselled	76	97	84

Pregnant women who tested for HIV at an ANC checkup for this FY 2079/80 are 24% which is less checkup than last FY 2078/79 and same another coinfection HIV/AIDS-PMTCT-Counseling and Testing-Pregnancy-Tested for this FY is 84 in number which is less than last FY and the among that no positve diagnosed for HIV. Likewise, as the counselling part there was a 84 counselled for testing preganancy which is also lessthan last FY 2078/79

Major Activities done in FY 2079/80

- Establishing linkages and integration among HIV services and other health services for quality HIV prevention, treatment and monitoring of treatment adherence
- HIV Counseling and Testing Services (static and camp) and community-based testing services
- Roll out PMTCT training to remaining and newly recruited health workers
- District and Municipal level HIV program review meeting and data verification workshop
- World AIDS day and Condom Day celebration.
- Regular monitoring and supervision of the program and uninterrupted supply of commodities (Test kits, ARV medicine and others)

Issues and Recommendations:

Issues	Recommendations	Responsibility
Poor supply of STI and Opportunity Infections (OIs) medicines	Consistent supply of STI and OIs medicines	NCASC, Medical stores
Low HIV testing among key population like labor migrants and their spouses	Effective roll out of Community-led HIV Testing and Treatment Competence (CTTC) approach is needed	FCHVs, HFs, EDPs, HO
Fewer number of HTC sites	All PHC need to be listed as HTC site to increase the test numbers	NCASC
Inadequate financial support or other rehabilitation provisions for needy PLHA	Need of comprehensive rehabilitation programs/ services for PLHA	HO, EDPs, NCASC
Poor HIV/STI services recording and reporting in hospital setting especially in OPD	Proper linkages of OPD and laboratory services to HTC and ART services to improve quality recording and reporting	HO, Hospital, HF
CHBC services coverage is declining over time due to Limited support from donors.	Invest in such an essential service in Coordination with NGOs.	NCASC, EDPs

3.5 Non-Communicable Diseases and Mental Health

Background:

Non-Communicable diseases (NCD) are a leading cause of morbidity and premature mortality in the world. Globally, 15 million people die prematurely due to NCDs annually and over 85% of these deaths occur in low and middle-income countries. The World Health Organization has identified NCDs as a major public health problem. NCDs pose a challenge in achieving the Sustainable Development Goals 2030 of reducing the premature NCD related mortality by one third by 2030.

Multi-sectoral Action Plan for NCD

Nepal developed the first Multi-Sectoral Action Plan for prevention and control of non-communicabledisease 2014-2020 with targets and set of indicators. The action plan was the national guiding document for implementation of NCD related activities. The Action Plan defined targets, activities, roles and responsibilities of the MoHP and concerned line Ministries for the period of 2014-2020. There was a High-Level Committee (HLC) chaired by Chief Secretary, Prime Minister's Office, with Secretaries of 17 Line Ministries as members of the committee for policy level decision and integration of NCD related activities in line ministries' Annual Work Plan Budget (AWPB). The HLC has been key to providing policy direction related to NCDs and has assigned NCD focal point in Office of the Prime Minister and Council of Ministers (OPMCM) and key Line Ministries. Subsequently, National Health Policy 2019, Public Health Service Act 2018, Health Service Regulation 2020, NHSS IP (2016-2021), focused on prevention and control of NCDs. The National Health Account reports dedicated funds have been allocated to prevention and control of NCDs and its risk factors.

Multi-sectoral Action Plan for NCDs (2021-2025)

The MSAP II focuses on creating actions which are potentially implementable, have high health impact, politically and culturally acceptable and financially feasible in co-ordination across multiple sectors and multi-stakeholders. Sustainable Development Goals have provided a renewed impetus to accelerate progress in addressing NCDs, its risk factors and determinants. The goal 3 on ensuring healthy lives and promoting well-being for all includes target 3.4: "by 2030, reduce by one third premature mortality from NCDs. The 11 SDG targets (1,2,4,5,6, 7,8,10,11,12, 13) are linked with NCDs and call for integrated national response. If Nepal is to meet the SDG targets, investing in interventions to reduce the burden of NCDs and its risk factors will improve health and accelerate progress on many other SDGs. The Nepal NCDI Poverty Commission's an Equity Initiative to Address Non-communicable Diseases and Injuries National Report, 2018 reports NCD as health and societal inequity issue and need for more resources and strategic investment. Nepal has moved from unitary government system to federalism and is divided into 7 provinces and 753 local levels with federal, provincial and local government. Federalism in Nepal provides an unprecedented opportunity for strengthened governance to establish linkages across sectors, provide predictable and sustained resources including innovative financing mechanism and accountability to accelerate implementation of the action plan.

Strategic Approach for MSAP II

Vision

All people of Nepal enjoy the highest attainable status of health, well-being and quality of life at all age, free
of preventable NCDs and associated risk factors, avoidable disability and premature death.

Goal

Reduce the burden of NCDs in Nepal through "whole of government" and "whole of society" approach

Specific objectives

1. To raise priority accorded to the prevention and control of non-communicable diseases in the national agenda, policies and programs

2. To strengthen national capacity and governance to lead multi-sectoral action and partnership across sectors for the prevention and control of non communicable diseases
3. To reduce risk factors for non communicable diseases and address underlying social determinants across sectors
4. To strengthen health systems through provision of people-centric, comprehensive, integrated and equitable care for improved prevention and control of NCDs
5. To establish NCD surveillance, monitoring and evaluation system for evidence-based policies and programmes.

Targets

The overarching target is to reduce premature death from major NCDs by 25% by 2025 and by one third by
2030.

Major activities carried out in FY 2079/80

- PEN traning for health workers
- Advocacy to local level governents for allocation of sufficient budget for NCD related activities such as screening, case investigation and contract tracing and various of reserach
- Case finding/ diagnosed as well referral from passive case finding
- Regular supplies of commodotoes relating to NCDs
- IEC/BCC matreial provides to local level
- Free medicine to old people with chronic disease
- Two of our health workers are working inorder to provide health services to old people at their residence

CHAPTER 4

CURATIVE SERVICES

Government of Nepal is committed to improving the health status of rural and urban people by delivering high-quality health services throughout the country. The policy is aimed at providing prompt diagnosis and treatment, and referral of cases through the health network from community health facilities (PHCC/HP) to the specialized and central public hospitals. Curative Service is one of the important components of Health Care Delivery System in Nepal. Health Care Delivery Net-work is committed to provide Quality Service to improve the Health Status of people on Equity basis. The Policy regarding Curative Service in district is aimed at providing appropriate Diagnosis, Treatment and Referral Service throughout the Health Network from the PHC-Outreach Clinic to the District Hospital.

The overall objective curative services are to reduce morbidity, mortality by ensuring the early diagnosis of diseases and providing appropriate and prompt treatment. In Mahakulung Rural Municipality, curative service is provided through the PHC Out-reach Clinics, HPs, PHC and Basic Hospital. The private health institutions registered in HS are also the part of service providers in the district especially in outpatient services.

Curative service strategies

- To make curative health services available in an integrated way in rural areas through healthposts and PHCCs.
- To establish hospitals on the basis of population density and patient load with at least one hospital per district.