Government of Nepal

MINISTRY OF HEALTH AND POPULATION

SECOND LONG TERM HEALTH PLAN
1997-2017

Perspective Plan for Health Sector Development

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FOREWORD

Government of Nepal, Ministry of Health (MOH) is determined and committed to improve the existing health care system in order to provide equitable access to quality health care for all people. Towards that end, a Long-Term Health Plan has been developed and approved by the Ministry of health that addresses the health needs of all the people of Nepal.

A clear vision and strategy is a basic requirement for the development and successful implementation of plans and programmes. The Long-Term Health Plan provides a realistic and workable guidance (vision/strategy) to improve the management and organization of the public health sector and increases the efficiency and effectiveness of the health care system. It ensures the delivery of an integrated comprehensive health services that are available in an equitable manner to all the population. The Long-Term Health Plan provides guidance and support to private and NGO sectors, to Donor Organizations to direct the resources and expertise where it is most needed; and to formulate rational and realistic strategy to improve the health situation over the next 20 years.

A complex issue like health has to be addressed by a variety of different approaches/strategies, different organizations and institutions/actors. Public sector, private sector, NGOs, individuals and communities have to join hands in order to improve the health situation. Given scarce human, finance and physical resources, priorities are set and policies have been formulated which consider those resource constraints.

The Long Term Health Plan is not a static blue print but a dynamic rolling plan which allows for the development of successive periodic and annual health plans that would lead to improvement in the health status of the population; development of appropriate strategies, programmes and action plans that reflect the national health needs and priorities which are affordable and consistent with available resources; provide assistance and guidance to the public/private sectors (including NGOs) and donor partners; and establishment of co-ordination among public/private sectors, NGOs, and donor partners.

I appreciate the commendable job of the members of the Technical Working Group and other national and international experts who assisted in preparing this document. MOH is fully committed to implement this plan.

(Mr. Pradeep Nepal)
Minister of Health

PREFACE

Planning is an essential stage in the path of development. Failures in achieving the desired result are due in part of weak planning. In the past, plans were made on an ad-hoc basis. They were not developed in an objective, systematic and broad-based manner. They were often created without a clear goal in mind. They were not guided by a long-term vision. GoN Ministry of Health has felt the need of having a perspective health plan for the coming 20 years. Preparation of Second Long-Term Health Plan (SLTHP) is an attempt to fill this gap.

The perspective plan will guide health sector development, resulting in the improved health status of the population particularly those whose health needs often are not met – the most vulnerable groups, women and children, the rural population, the poor, the underprivileged and the marginalized. To meet these challenges, MOH will give priority to provide Essential Health care Services to all population.

SLTHP was prepared with a participatory approach following a rigorous exercise of information collection, analysis, discussion, dissemination of findings and conclusions in different occasions and settings. This document is the result of these exercise carried out over a two years period. Emphasis was given to ensure wider participation from all sectors - the public the private and NGO sectors including the key donor partners working in health and related field.

The SLTHP document is divided into four parts; Part I provides a Background and Situational Analysis: Part II sets the Goal, Objectives and Targets: Part III deals Policies for Achieving the Goal, Objectives and Targets and lastly the Part IV stresses the Implementation and Institutionalization process.

The SLTHP will be useful for preparing periodic and annual health plans, which will address the disparities in health status, assuring equitable access to quality health care services with full community participation and gender sensitivity. It will be used a resource document to guide GON in funding and to avail donor assistance in areas of greatest need, to avoid duplication and to assure effective use of public, private, NGO, community and donor resources.

Many national and international experts and colleagues from different organizations have contributed in this endeavor. They deserve special thanks and should be congratulated.

(B.R. Pokharel)
Secretary
Ministry of Health

ACKNOWLEDGEMENTS

In developing the Second Long Term Health Plan (SLTHP) a working group was established comprising of key representatives of the Ministry of Health, the National Planning Commission, the Private sector including NGOs and GoN's donor partners. To further broaden participation, a series of workshops were held to receive input and permit interactions between the policy makers, including the Ministers and Parliamentarians, planners, those responsible for program implementation along with professional bodies, NGOs and the donor community. Gaps in policy and program implementation were identified and future directions specified.

Dr. Kalyan Raj Pandey, the Director General of Department of Health Services and his team of Directors and other officials of Department of Health Services have been actively involved in the development of SLTHP since its inception. Dr. Pandey also served as the member of the Technical Working Group and coordinator of the Management Sub-Group. His cooperation and expertise was invaluable. Colleagues at the Ministry of Health and National Planning Commission are to be thanked for their involvement in the formulation of this plan.

Special mention must be made of Dr. Harry Feirman. Technical Officer of WHO, Dr. J.P. Steinmann. Team Leader of PHCP/GTZ and Dr. Tirtha Rana. Population and Health Specialist of the World Bank for their help and assistance in the preparation of this plan. Likewise, Mr. Ishwar Bahadur Shrestha, consultant for the Development of the Long-Term Health Plan and Mr. Ramji Dhakal, Health System Development Expert of PHCP/GTZ have contributed significantly in its preparation. I appreciate their hard work.

Similarly, the then Directors of Policy, Planning, Foreign Aid and Monitoring Division Dr. B.D. Chataut and Dr. Chhatra Amatya must be thanked for their initiation and continuation of the world work in this document to its present form. Likewise, all those who had been involved in one stage or another, be it in the form of participation in the workshops or attendance at the meetings (Annex 4: Participants of the Seminars, Workshops and Meetings) have provided invaluable inputs for which I would like to extend my warmest appreciation.

Many people and organizations have contributed to the formulation and development of this plan. I would like to acknowledge a debt of gratitude to them for their technical and financial assistance.

This plan will be highly useful to planners, policy makers, program managers, donors, NGOs/ INGOs, private providers and academicians. This document will be used as a *rolling resource document* to be reviewed periodically. The review process will be institutionalized in the MOH incorporation the changes and revisions as warranted.

(Dr. S.P. Bhattarai)
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CONTENTS

OVERVIEW OF THE SECOND LONG TERM HEALTH PLAN

1. General Background

A first Long Term Health Plan (1975 – 1990) was formulated with a calendar of operations for the Fifth, Sixth and Seventh Five Year Plans. The main emphasis was the provision of comprehensive basic health services to the majority of the rural population.

The National Health Policy (1991) established a policy framework to guide health sector development. The principle objective of the National Health Policy to upgrade the health standards of the majority of the rural population by strengthening the primary health care system, making effective health care services readily available at the local level. The National Health Policy elaborated specific policy objectives to address the following main areas:

(a) preventive and promotive health services;
(b) basic primary health services;
(c) curative health services;
(d) ayurvedic and other traditional health services;
(e) organization and management
(f) community participation in health services;
(g) human resources for health development;
(h) drug supply;
(i) resource mobilization in health services;
(j) health research;
(k) private, NGO health services and inter-sectoral coordination; and
(l) decentralization and regionalization.

GoN, Ministry of Health has felt the need of having a perspective health plan for the coming 20 years that would build upon the National Health Policy and guide health sector development in response to changing trends in the society. The perspective health plan will result in the improved health status of the population particularly those whose health needs often are not met:

- the most vulnerable groups,
- women and children,
- the rural population,
- the poor,
- The underprivileged and the marginalized.

The perspective plan would address disparities in health status, assuring equitable access to quality health care services with full community participation and gender sensitivity.

The perspective plan would be used to:

- Focus GoN, private sector, NGO funding and donor assistance on areas of greatest need;
- Avoid duplication; and

- Ensure effective use of public, private, NGOs, the community and donor resources.

It was recognized that in developing the Second Long Term Health Plan it is necessary to prioritize health sector needs given the scarce human, financial and physical resources available to the health sector.

It was further recognized that the Second Long Term Health Plan must offer a realistic, broad policy framework that takes into consideration those resource constraints.

2. Specific Purpose of the Second Long Term Health Plan

The specific purpose of the Second Long Term Health Plan is to provide a guiding framework to:

(a) Build successive periodic and annual health plans that would lead to improvement in the health status of the population. Recognizing there may be a need for adjusting the policies to accommodate changes in the health sector, the "Second Long Term Health Plan: is not a fixed blue print for the coming 20 years. Rather it is a resource document and rolling plan for the preparation of successive five-year development plans and annual implementation plans.

(b) Develop appropriate strategies, programs and action plans that:
- reflect the national health needs and priorities;
- are affordable; and
- consistent with available resources.

(c) Establish co-ordination among public, private and NGO sectors, and donor partners.

3. The Vision of Health and Development that Guided the Development of the Second Long Term Health Plan

A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by:

- self-reliance,
- full community participation,
- decentralization,
- gender sensitivity,
- effective and efficient management, and
- private and NGO sector participation (an appropriate public/NGO/private mix in the provision and financing of health services
- resulting in improved health status of the population.

Underpinning the development of coordinated quality health care services in rural and urban area is the continued adherence to the Primary Health Care Approach and the primary health care principles:

- Universal accessibility to available resources and services in order to provide adequate coverage of the most essential health needs of the population;
- Community and individual involvement and self-reliance;
- Inter-sectoral action for health; and

- Appropriate technology and cost-effectiveness, i.e., allocation of resources in such a manner as to yield the greatest benefits, with benefits measured by the extent to which health needs of the largest number of people can be met.

The principal health problems of the majority of the population including significant emerging and re-emerging diseases are to be met before the less common health problems are addressed (specific tertiary and specialized care for a minority of the population).

Therefore, GoN should give priority to:

- health promotion and prevention activities; and
- development and implementation or priority public health measures and essential clinical/curative services (including traditional and other systems of medicine) for the appropriate treatment of common diseases which are highly cost effective and address the most essential health needs of the population.

4. The Participatory Process For Developing the Second Long Term Health Plan

A working group was established comprised of key representatives of the Ministry of Health. The National Planning Commission, the private sector, NGOs and GoN's donor partners.

To further broaden participation, series of five workshops were held to:

- define the scope of the Second Long Term Health Plan;
- establish an approach and develop the plan of action for the plan's development;
- receive input and permit interactions between the policy makers, including the Ministers and Parliamentarians, planners, those responsible for program implementation, professional bodies, NGOs and the donor community.

Gaps in policy and programme implementation were identified and future directions specified. Detailed situational analyses were carried out with detailed studies commissioned to obtain necessary information when available data was not sufficient. Among the specific studies carried out were those which addressed:

- burden of disease;
- health services in Nepal;
- the role of private, NGOs and traditional sectors in health care delivery
- national health accounts and health financing;
- systems analysis of planning, personnel/HRH and financial management of public health services; and
- stakeholder analysis.

The burden of disease study provided a basis for prioritizing health intervention programmes to meet the health needs of the majority of the population. Significant problems were noted, constraints identified, policy issues/policy options were generated and prioritized.

Following the preparation of the draft document, a two day national meeting was held to review the draft. Representatives from Government of Nepal, NGOs the private sector,

the community and GoN's donor partners provided comments for improving the draft plan.

To gain further input, more than 100 copies of the draft document were distributed to Members of Parliament, interested individuals, professional organizations and councils, NGOs, past and present GoN officials for their comment. All comments received were reviewed and changes made in the draft document as warranted.

5. Key Findings from Participatory Process

(a) Nepal's demographic and disease profile indicated that:

- children between 0-4 years of age account for approximately one half of the total burden of disease.
- the leading causes of morbidity, mortality and disability in the 0-4 age group being perinatal conditions, acute respiratory infections, diarrhoea and measles.
- the higher burden of disease among females in 15-44 age group is primarily attributable to high maternal morbidity and mortality.
- estimate of the burden of disease for the year 2011 suggest that in the absence of effective interventions, infectious diseases, maternal and perinatal disorders and nutritional deficiencies would still predominate despite a declining trend.

(b) The total per capital expenditure on health (public, private, NGO and donor expenditures) is Rs. 538. Three fourths (Rs. 407) of total per capital expenditure on health are out-f-pocket expenditures.

(c) For the foreseeable future, Nepal will not have adequate financial and human resources to address all of the possible health care needs of the population.

(d) The health sector is not in a position to direct scarce human and financial resources to high cost-low impact interventions that make a small contribution to reduction morbidity and mortality rates without restriction its ability to provide for the most essential health needs of the population.

6. Targets for the period of the Second Long Term Health Plan

By the end of the Second Long Term Health Plan, the following targets will be achieved:

a) Infant Mortality Rate will be reduced to 34.4 per thousand live births from its present level of 74.7.

b) Under five mortality rate will be reduced to 62.5 per thousand from its present level of 118;

c) Total Fertility rate will be reduced to 3.05 from its present level of 4.58;

d) Life expectancy in years will be increased to 68.7 from its present level of 56.1;

e) Crude birth rate will be reduced to 26.6 per thousand from its present level of 35.4;

f) Crude death rate will be reduced to 6 per thousand from its present level of 11.5;

g) Maternal Mortality Ratio will be reduced to 250 per hundred thousand births from its present level of 475;

h) Contraceptive Prevalence Rate will be increased to 58.2 percent from its present level of 30.1;

i) Percentage of deliveries attended by trained personnel will be increased to 95% from its present level of 31.5;

j) Percentage of newborns weighing less than 2500 grams will be reduced to 12 percent;
k) Essential Health Care Services at the District will be available to 90 percent of the population living within 30 minutes travel time.

7. Principle Policies to be Pursued in the Second Long Term Health Plan

a) Based on the demographic and disease profile "Essential Health Care Services at the District (including Ayurvedic and Other Systems of Medicine)" are proposed. These are a group of highly cost effective public health measures and essential curative services for the appropriate treatment of common diseases and injuries.
b) The "Essential Health Care Services at the District" will:
   - address the essential health needs of the population at the district level and below years.
   - help meet the targets for the Second Long Term Health Plan through the next twenty years.
c) To effectively implement the Essential Health Care Services and meet the most essential health needs of the population the health sector must:
   - redirect resources from high-cost low-impact interventions to those that could substantially reduce morbidity, mortality and disability without increasing expenditures.
   - address the issues which limit the effective utilization of scare human and financial resources; and
   - adopt alternative financing mechanisms which see to :
   - mobilize non-governmental funds to support health care and
   - increase the public-private mix in terms of financing and provision of services.
d) Within this context, the Second Long Term Health Plan defines the Essential Health Care services, and identifies the key issues and policies necessary for:
   - ensuring that the health care system provides care that effective in producing positive health outcomes and in which the community is satisfied that their needs are being met;
   - improving the efficiency and effectiveness of the health care system;
   - improving inter-and intra-sectoral coordination and providing the necessary conditions and support for effective decentralization.
   - over coming management and organizational constraints to effective public health sector service delivery;
   - ensuring the appropriate numbers, types and distribution of technically competent and socially responsible health personnel are available to provide quality health care to all the people of Nepal, particularly those living in rural areas;
   - providing the requisite data, analysis and interpretation necessary for informed decision-making;
   - addressing the changing trends of communicable and non-communicable diseases and emerging health issues; and

- regularly updating the Second Long Term Health Plan as pert of a rolling resource document process including providing input into development of approach papers for the successive five year development plans.

PART I

Background
&
Situational Analysis

CHAPTER 1

The Health Sector and National Development

A. Country Profile

B. Health Policy Context

c. The Vision of Health and Development

A. Country Profile

Nepal is a landlocked country surrounded by India and China. Geographically, it can be divided into three distinct belts – the mountains in the north, the hills in the middle and the narrow plain of the terai to the south. The predominance of rugged mountainous areas has made the development of transport and communications extremely difficult. Even today a large part of the country remains inaccessible by modern transport and communications; essential goods and information can not reach remote areas in a timely manner. The most remote and poorest districts have an additional burden. They have to depend on outside economics, paying two to three times more for essential goods. The costs of medicines and other basic necessities are often beyond the means of the poor in remote regions.

Nepal is a land of diversity with marked multi-ethnic characteristics. Approximately 55% of the population comprises indigenous Nepal speakers. Nepal has a social system characterized by the centrality of the family with factors such as caste and religion having significant impact on the lives of the people.

Administratively, Nepal is divided into 5 development regions, 14 Zones, 75 districts, 58 municipalities, 3912 Village Development Committees (VDC) and nearly 36,000 wards. The i*laka* is an administrative service level between the district and the VDC; there are 9 i*lakas* per district. At the district level, each of the departmental or ministry offices oversees the plans and programs for that sector. The role of Chief District Officer is to maintain law and order whereas the Local Development Committee (DDC). The District Health Officer is responsible for all health activities of the district including the organization and management of district hospital, PHCs, HPs and SHPs.

District Development Committees are responsible for the political and economic development of their respective districts. The District Development Act of 1992 empowers the DDC to function as an integrated development institution in line with the national decentralization policy. Further, Municipalities and Village Development Act of 1992 delegate development authority to the respective municipalities and villages.

Nepal's economic development has been severely constrained by geographic, topological and socio-cultural factors including; it’s landlocked position, limited natural resources, rapid population growth, heavy dependence on traditional agriculture and an increasing reliance on foreign assistance. A high though declining rate of population growth has exerted heavy pressure on the country's limited natural resources, resulting in deforestation, soil erosion and pollution of water sources.

The rapid rate of urbanization during the past two decades has created unprecedented pressure on Kathmandu and a number of cities in the Terai. Apart from the obvious health issues, the main problems are inadequate infrastructure and services, increase in slum and squatter settlements, a decline in the quality of the environment and social conflicts due to overcrowding.

Mortality and morbidity rates especially among women and children are alarmingly high. Acute preventable childhood diseases, complications of child birth, nutritional disorders and endemic diseases such as malaria, tuberculosis, leprosy, STDs, rabies, vector borne diseases continue to prevail at a high rate. Determinants of such conditions are associated with pervasive poverty, low literacy rates, poor mass education, rough

terrain and difficult communication, low levels of hygiene and sanitary facilities, and limited availability of safe drinking water. These problems are further exacerbated by under-utilization of resources; shortages of adequately-trained personnel; under developed infrastructure; poor public sector management and weak intra-and inter-sectoral co-ordination.

B. Health Policy Context

The principal instruments of health policy that established the framework for health sector development is "The New National Health Policy (1991)" and the health section of the "Eighth Five Year Plan (1992-1997). Based on the policy framework established in these documents, programmes, specific policy statements, goals, objective and service targets have been derived that have guided Ministry of Health activities.

The principal objective of the "National Health Policy" is to upgrade the health standards of the majority of the rural population by strengthening the primary health care system, making effective health care services readily available at the local level. That is extending basic primary health services to the village level and providing the rural population with the benefits of modern medical facilities and trained health care provider. Specifically, the "National Health Policy" addresses the following main areas with a number of specific policy objectives noted, including:

Preventive and Promotive health Services – Priority is given to programmes which directly help reduce infant and child mortality rates, and those which enable persons and communities to live healthy lives. Services are to be provided in an integrated manner through sub-health posts at the local level.

Basic Primary Health Services – Infrastructure will be developed for improving service delivery in health and population programmes. Sub-health posts will be established in each Village Development Committee (VDC) area. Moreover, a Primary Health Care Centre will be constructed in each of the 205 electoral constituencies or an existing health post upgraded to a PHC Centre. The PHC Centre will have a medical doctor and containing three beds – one for delivery and two for emergency.

Curative Health Services – Hospital expansion will be undertaken on the basis of population density and patient loads with development of district, zonal, regional and central level hospitals, Supplementing the hospitals, mobile teams will be organized to provide specialist services to the remote areas. A referral system will be developed for providing services of well-equipped hospitals to the rural population.

Ayurvedic and other Traditional Health Services – The Ayurvedic system will be gradually developed.

Organization and Management – The organizational and managerial aspects of health services delivery will be improved at the central, regional and district level. This will include the integration of the district level hospital and public health offices into the District Health Office. There will be a focus on technical and administrative supervision and follow-up. Descriptions of services available at the different levels of health facilities, costs of services and lists of free services will be made available to the public. Finally, an effective logistics system for medical supplies, drugs and equipment will be developed.

Community Participation – Community involvement will be sought at each level of the health care system. Local women volunteers, trained TBA and local leaders will be mobilized to participate in health and population programmes at the ward level. Physical facilities are to be provided by the community to establish SHP.

Human Resources for Health Development – Capable human resources for health will be developed with arrangements made for training of HRH in foreign countries as warranted. Training centers under MOH will be strengthened. Reforms in transfer, promotion and career development procedures will be implemented with appropriate incentives provided to motivate physicians and other health personnel to work in rural and remote areas.

Private, Non-Governmental Health Services and Inter-sectoral Coordination – MOH will coordinate activities with the private sector, NGOs and the non-medical sectors of GoN.

Decentralization and Regionalization – Decentralization and regionalization processes will be strengthened with peripheral units being made more autonomous. Local level planning (micro-planning procedures for primary health plans at the village level) and management of curative and promotive services shall be supported.

Blood Transfusion Services –The Nepal Red Cross Society will be authorized to conduct all programmes related to blood transfusion. The practice of buying, selling and depositing blood will be prohibited.

The Health Section of the "Eighth Five Year Plan (1992-1997)"

Building on the objectives and policies incorporated in the "National Health Policy," and attempting to address the basic deficiencies in the health sector, the health section of the "Eighth Five Year plan" established specific objectives, policies and targets for health and population activities directed towards the overall goal of HFA.

The "Eighth Five Year Plan" identifies four specific objectives:

- To improve the general health conditions of the population to provide the healthy manpower necessary for the country's development.
- To extend basic and primary health services to the villages to improve the health status of the rural population.
- To extend maternal and child health, and family planning services at the local level to make population control programmes more effective; and
- To develop specialized health services to provide quality health services throughout the country.

To facilitate achievement of these objectives, a series of policies were noted in the "Eighth Five year Plan" which has guided the health sector activities:

Preventive and Promotive Health Services

- Emphasis given to developing activities and inter-regional co-ordination for the promotion of maternal and child health.
- Implementation of programmes to control micronutrient deficiencies (anemia, vitamin A and iodine deficiency) in order to improve the nutritional status of women and children.

- Traditional healers to be provided appropriate training in health, nutrition and family planning and will be used in health education activities at the local level.
- Public awareness of the adverse affects of smoking, drinking alcohol and drug abuse.

Basic Health Services

- Extension of health services to all Village Development Committees through the establishment of primary health care centers, health posts and sub-health posts in a phased manner (sub-health posts are to be established at the VDC level through community participation). Basic health services will be provided through these institutions employing an integrated approach.
- Integration of family planning and MCH services with basic primary health services. Temporary and permanent family planning services will be made available according to the preference of the clients. Priority shall be given to the concept of birth spacing and the use of temporary birth control measures.
- Revision and implementation of drug policies and regulations in order to ensure a regular supply of quality pharmaceuticals.

Curative Health Services

- District, zonal, regional and central level hospitals will be developed with central hospitals as the providers of specialized services.
- A referral system shall be a central element in the provision of curative services. The referral system shall include co-ordination between primary health care centers and district, zonal, regional and central level hospitals.
- The private sector will be encouraged to provide specialized and general curative health services.
- Rehabilitation programmes to be provided for the crippled and disabled.

Ayurvedic and other Traditional Health Services

- Phased development and strengthening of the Ayurvedic system including strengthening of existing institutions; human resources development; drug production: and research. Encouragement will be provided to other traditional health systems such as Unani, Homeopathy and naturopathy.

Organization and Management

- Strengthening management capability of health institutions at all level, including village level.

Human Resources for Health Development

- The institute of Medicine and other training institutions will be extended and strengthened to produce additional required health personnel for the various health institutions and service oriented programmes.

Drug Supply

- Drug policies and regulations will be revised and necessary training provided for drug importers and shopkeepers to ensure a continuous supply of quality drugs.
- Encouragement will be given for private sector participation in essential drug production.

Decentralization and Regionalization

- Regional Health Directorates and District Health Offices will be provided personnel and delegated the authority for the administration, management and supervision of health services.

Community Participation in Health Services

- Local bodies will be encouraged to manage health institutions and service.

Private, Non-Governmental Health Services and Inter-sectoral Co-ordination

- Private sector and foreign investment in health sector development will be encouraged with emphasis on the private sector for provision of specialized and general curative services.

C. The Vision of Health and Development

In developing the Second Long Term Health Plan, Government of Nepal has been guided by the belief that health is a human right and by a vision of a health system in which there is:

- equitable access to coordinated quality health care services in rural and urban areas; and
- health services are characterized by self-reliance, full community participation, decentralization, gender sensitivity, and effective and efficient management, resulting in improved health status of the population.

In translating the general concept of equity into an operational definition to effectively guide implementation of GoNs vision for health sector development. GON embraces the view that: equity be envisaged as the distribution of benefits according to "demonstrable need", rather than on the basis of political or socio-economic status or privilege. What is significant about this perspective is that it enables the health sector to focus on disparities in health status rather than simply equality of inputs. The guiding principle for assuring equity becomes:

- services be provided at rates proportional and appropriate to the existing need for care; and
- the needy and underprivileged will not be deprived of needed services because of inability to pay ("safety-net").

To achieve equity in health, the concept of access assumes a central role. The purpose of increased access is to assure that all people but particularly those whose health needs often are not being met, are able to use services at rates proportional and appropriate to their need for care (the most vulnerable groups: women and children; the rural population; the poor; the disadvantaged and marginalized). Thus the individual dimensions of access which affect a person's ability to make use of the health system

will be addressed in health sector development – geographic/physical access, economic access, social/culture access, and organizational access.

To assure that the principal health problems of the majority of the population including significant emerging and re-emerging diseases are met before the less common health problems are addressed. **GoN will give priority to health promotion and prevention activities and development and implementation of a "Essential Health Care Services".** "Essential Health Care Services" are priority public health measures and essential curative services (including traditional and other systems of medicine) that GoN will ensure is available to the total population. The "Essential health Care Services" is highly cost effective and addresses the most essential health needs of the population. After ensuring access and adequate coverage of the most important health needs of the population, the "Essential Health Care Services" may be broadened to include additional public health and curative services, and later the provision of tertiary and specialized services.

Underpinning the development of coordinated quality health care services in rural and urban areas is the continued adherence to the Primary Health care approach and principle:

a. Universal accessibility to available resources and services in order to provide adequate coverage of the most essential health needs of the population;
b. Community and individual involvement and self-reliance.
c. Inter-sectoral action for health; and
d. Appropriate technology and cost-effectiveness, i.e., allocation of resources in such a manner as to yield the greatest benefits, with benefits measured by the extent to which health needs of the largest number of people can be met.

Central to the vision of health and development which had guided the preparation of the Second Long Term Plan is the recognition that;

- self-reliance;
- gender sensitivity in health programmes;
- full-community participation;
- private sector participation (an appropriate role for the private and NGO sectors in the provision and financing of health services); and
- decentralization

are characteristics essential to the health system.

Within this context, it is recognized that the ultimate responsibility for health development lies with the communities themselves (community members, local health workers, VDCs, DDCs and technical personnel). The effectiveness and sustainability of health development activities depends in part on; the commitment of the public, private and NGO sectors; district, regional and central level personnel whom can influence the achievement of health development objectives; and support of the decentralization process.

Full community participation is recognized as an essential characteristic of an effective efficient and sustainable health system; community participation is not viewed as simply compliance to programme activities nor the mere provision of resources. Rather, community participation includes the community in decision-making at various levels

through its representatives and organizations. Within the context of full community participation, central, regional and district level personnel are expected to fulfill a supportive role in assisting and enabling the community to carry out their responsibilities.

Nepal is not devoid of human and financial resources that can contribute to developing and strengthening the health system. While Nepal can expect support and assistance from INGOs, multi-and bilateral donors and other agencies, such resources are envisaged as supplements to resources that Nepal can mobilize nationally and locally.

GON continues to look towards community resource mobilization efforts to assist in financing the expanding health care network in Nepal. GON will undertake the development and implementation of policies and strategies for further encouraging the private sector to assume an expanded role in the provision and financing of health services. Recognizing that Nepal has experienced success in addressing various aspects of health development, it is necessary and appropriate that the knowledge gained and lessons learned be applied nationwide and locally in pursing health sector development.

CHAPTER 2

Situation Analysis

A. Population, Health and Disease

B. Health Services Delivery System – Public, NGO, Private and Traditional Sectors.

C. Human Resource for Health – Planning and Development.

D. Health Care Financing and Expenditure.

E. Inter & Intra-sectoral Coordination & Decentralization.

F. Management and Organizational Issues in the Public Sector.

G. Quality Assurance in Health Service.

H. Population, Health and Disease

i. Population

Several demographic, health and family planning surveys were undertaken at national level to estimate the population parameters of the country. Correct estimates of fertility, mortality and migration are essential for making valid population projections, which are necessary for health policy, and planning. The dilemma is that adequate information on fertility; mortality and migration are not available. To overcome these constraints, various indirect methods of estimation were applied to arrive at the best estimates of population parameters.

Fertility

Fertility has gradually declined as evidenced in various surveys. The Crude Birth Rate (CBR), which was 45.5 per 1000 in 1976, dropped to 41.6 in 1991.

Table 1: Trends in Crude Birth Rates (1976-1991)

Year	CBR	Source
1976	45.5	Nepal Fertility Survey, 1977
1981	44.0	Central Bureau of Statistics. Tathynka Gatibidhi, 1988
1986/87	40.7	Demographic Sample Survey, 1987
1991	41.6	Central Bureau of Statistics, 1995

Indirect methods of estimation suggested that a Total Fertility Rate (TFR) of 5.6 (CBS 1995) seems quite plausible and consistent with the reported Contraceptive Prevalence Rate (CPR) of 28.5% (NFHS 1996). The Age Specific Fertility Rate (ASFR) has been projected after making the necessary adjustments for underreporting of births. The projected trend in ASFRs and TFRs are presented in Table 2 which indicates that the TFR is projected to decrease from the 5.6 in 1991 to 4.98 in 1996, 4.43 in 2001 and 3.50 in 2011.

Table 2: Trends in Age Specific Fertility Rates and TFR (1991-2011)

Year/Age Group	15-19	20-24	25-29	30-34	35-39	40-44	45-49	TFR
1991	0.095	0.286	0.272	0.212	0.151	0.077	0.028	5.60
1996	0.088	0.236	0.248	0.208	0.141	0.062	0.013	4.98
2001	0.079	0.219	0.235	0.182	0.116	0.016	0.009	4.43
2006	0.070	0.204	0.223	0.159	0.093	0.034	0.005	3.94
2011	0.059	0.182	0.209	0.140	0.077	0.029	0.004	3.50

Mortality and Life Expectancy: The Crude Death Rate (CDR) which was 22.2 in 1976 declined to 13.3 in 1991 (Table 3).

Table 3: Trends in Crude Death Rates (1976 – 1991)

Year	CDR	Source
1976	22.2	Demographic Sample Survey, 1997
1986-87	16.1	Demographic Sample Survey, 1987
1991	13.3	Central Bureau of Statistics, 1994

As indicated in Table 4 the Infant Mortality Rate (IMR) has declined steadily over the years 1976 through 1991.

Table 4: Trends in Infant Mortality Rates (1976-1991)

Year	IMR	Source
1976	152	Nepal Fertility Survey, 1977
1981	117	New Era, 1986
1986/87	107	Demographic Sample Survey, 1987
1991	97	Population Census, 1991

The gain in life expectancy during these two decades would be about 8 years. The estimates suggest that in 1991, life expectancy at birth was 55.0 years for males and 53.5 years for females (Shrestha, 1995). Using the Cole and Demeny Model Life Tables (West) and the life expectancy at birth for males would increase from its 1991 level of 55 years by 0.4 percent per calendar year through 2001 and thereafter by 0.3 years per year up to 2011. For females, the life expectancy at birth would increase from its 1991 level of 53.5 years by 0.5 years, by 0.5 percent per calendar year up to 2001 and by 0.4 per year up to 2011.

Migration

Precise information on external migration is difficult to obtain. The assumption used for internal migration was, its net effect on size and structure of population would be negligible on a national scale.

Population Projections

Applying fertility, mortality and migration assumptions to 1991 Census population of Nepal, future population projections were made for a period of 20 years using the Component Method. The component method follows a cohort of people of the same age throughout its lifetime according to its exposure to mortality, fertility, and migration. The projections were made for various age groups and by sexes (Table 5 a-c)

Table 5 (a): Projected Population Trends in Nepal, Males

Age Groups											
Year	**0-4**		**5-14**		**15-44**		**45-49**		**60+**		**Total**
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
1991	164087	17.45	2613525	26.93	3902670	40.21	940511	9.69	555495	57.2	9706382
1996	1839649	16.55	3070198	27.61	4546621	40.89	1045358	9.40	616676	5.55	11118596
2001	1887232	15.02	3421863	27.24	5384972	42.86	1180028	9.39	688752	5.48	1252942
2006	1957061	13.98	3628637	25.91	6359882	45.42	1336278	9.54	721183	5.15	14003113 6
2011	2031853	12.78	3759150	23.65	7430801	46.75	1797860	11.31	874984	5.50	15894742

Table 5 (b): Projected Population Trends in Nepal, Females

Age Groups						
Year	**0-4**	**5-14**	**15-44**	**45-49**	**60+**	**Total**

	No.	%	No.	%	No.	%	No.	%	No.	%	
1991	15573797	16.4	2421508	25.34	4143483	43.36	880648	9.21	5373392	5.62	9556922
1996	1727997	15.92	2805305	25.85	4693277	43.24	1030128	9.49	596033	5.49	10852835
2001	1777499	14.58	3159434	25.92	53753444.11	44.11	1203780	9.87	672500	5.52	12189441
2006	1847977	13.66	3381093	25	6177967	45.68	1388542	10.27	728246	5.38	13523920
2011	1923229	12.8	3519420	23.42	7031881	46.79	1625942	10.82	927100	6.17	15027666

Table 5 (c) : Projected Population Trends in Nepal, Both Sexes

Age Groups											
Year	0-4		5-14		15-44		45-49		60+		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
1991	3267884	33.92	5035033	52.26	8046153	83.56	1821159	18.90	1092887	11.35	19263305
1996	3567646	32.4	5875503	53.46	9239898	84.14	2075486	18.89	1212709	11.04	21971431
2001	3664731	29.60	6581297	53.16	10761506	86.9	2383508	19.27	1361152	11.00	24750383
2006	3805038	27.04	7009730	50.91	12537849	91.10	2724820	19.81	1449429	10.54	27527055
2011	3955082	25.58	7278570	47.07	14462682	93.57	3423802	10.81	1802084	11.67	30922408

The growth of male and female populations is presented along with trends selected maternal indicators in Table 6. The table indicates that under assumptions of declining fertility and mortality, the population is expected to grow at an average annual rate of 2.7% during 1991-96, 2.4% during 1996-2001, 2.2% during 2001-06 and 2.1% during 2006-11. Although the size of the population would increase, the growth rate of the population would undergo a significant reduction during 1991-2011.

Table 6: Changes in Male Female Population with Maternal Indicators

Year	Total Population	Growth Rate	No. of Annual Births	Growth Rate	GFR	% of Births in 20-34 Age Group
1991	18491097	2.66	75991	0.1	173.1	73.0
1996	21126636	2.41	774366	0.4	156.1	73.0
2001	23832106	2.23	790219	0.6	139.1	74.0
2006	27738096	2.07	814087	0.5	124.1	76.0
2011	29542892	-	833044	-	111.6	78.0

Based on the relative sizes of the sub-national population and their time-trends, the future size and structure of population by urban/rural, ecological zones and regions were estimated.

Table 7: Number of Reproductive Age Women, the Under-Fives and the Elderly in 1991 and 2011.

	Reproductive age women 15-49			Children aged < 5			Elderly Population 65 +		
Area	1991	2011	Ratio	1991	2011	Ratio	1991	2011	Ratio
Nepal	4373382	7464691	171	3135966	3836429	122	655515	1093640	167
Urban	424245	1424476	336	126748	576119	143	54406	179819	331
Rural	3946137	6040215	153	2899218	3260238	112	601109	913821	150
Ecological Zones									
Mountain	340045	537604	158	250187	283801	113	52181	81080	155
Hill	2020392	3398845	168	1438916	1694972	118	325494	527923	160
Administrative Regions									
EDR	1057490	1224458	166	721462	866189	120	156682	257152	164
CDR	1456198	2456607	169	1003221	123818	124	224936	379849	169
WDR	901190	1578122	175	646202	777058	120	165816	274150	165
MWDR	562942	957306	170	450635	556950	124	59990	100906	168
FWDR	395561	716932	181	314444	392413	125	48092	81583	170

(Source: Sub national population projections Nepal 1991-2011, CBS, 1994

i. Policy Implications for Population

1. The results suggest that Nepal's population is expected to grow at an average annual rate of 2.7% during 1991-1996, 2.4% during 2001-2006 and 2.1% during 2006-2011. Even at this rate the population of the country would double every 25 years. Thus population programmes with focus on fertility regulation need to be given priority.
2. The proportion of women of reproductive age participating in reproduction (GFR) would decrease from 17.6% in 1991 to 11.2% in 2011. However, such decrease in reproductive prevalence needs to be associated with a corresponding increase in contraceptive use Reproductive services should increasingly focus on improved contraceptive use.
3. The declining GFR implies the demand for maternal and infant care services would decline in relation to other reproductive health services. Since a decrease in reproductive participation should be accompanied by an increase in contraceptive practice, there is the need for a different mix of services, rather than a reduction in services provided to women of reproductive age.
4. Based on the relative sized of the urban and rural populations, the need for reproductive health services appears in urban areas will increase by three-folds by the year 2011. There will be a wide variation in need for childcare services in rural versus urban areas over the coming twenty-year period.
5. The size and geographic distribution of the under-five population is a critical consideration in allocating resources for child survival. In the light of the steep

projected increase the urban under-five population, greater focus should be given to child survival programmes in urban areas.

6. With the projected gradual increase in elderly population there is an increasing need to focus on degenerative and non-communicable diseases in the next century.

ii. Communicable and Non-communicable Diseases

a. Communicable Diseases

The discovery of vaccines and antibiotics has led to the belief that infectious and communicable diseases would no longer be public health problems. Unfortunately such expectations have not been realized. Today infectious diseases remain the leading cause of death, especially in the developing world. The spectrum of infectious diseases is rapidly changing in conjunction with socio economic and ecological changes. In recent years new diseases are emerging as a threat to public health in many developing parts of the world.

Emerging diseases are defined as those whose incidence in humans has increased in the past two decades or whose incidence threatens to increase in the near future. RE-emergence is the reappearance of known diseases after a significant decline in its incidence.

Some infectious diseases such as malaria, visceral leishmaniasis (Kala-azar) and tuberculosis, which were under control or on the verge of elimination, are re-emerging as significant health problems in Nepal. Malaria was nearly eradicated during early 1970s, Kala-azar was still unknown in many of the districts were it is presently a problem. The control of these diseases was due mainly to wide spread spraying and an effective surveillance and treatment mechanism.

At present the malaria program is functioning in 65 districts; malaria is a problem in 50 of those districts. Kala-azar has been detected in 9 districts; however, increased surveillance may reveal additional districts in which Kala-azar is a problem.

Encephalitis has been observed in Nepal since 1978 and continues to be a public health problem. It occurs mainly in the southern part of the country, which is hot, humid, and has significant areas of stagnant water. During 1994, 1995 and the first ten months of 1996, 384, 681 and 873 cases of encephalitis were reported.

Meningococcal meningitis has the potential for major outbreaks if not diagnosed and treated early. It is reported in nearly 60 districts. It is not possible to identity the type of meningitis as the necessary laboratory facilities are unavailable in most districts (treatment is provided on the basis of clinical diagnosed).

The goals of the expanded program of immunization (EPI) are to immunize: at least 90% of children less then one year of age against the EPI target diseases by the year 2000 (diphtheria, pertusis, tetanus, tuberculosis, poliomyelitis and measles); and 90% of women of reproductive age against tetanus. All countries in the South East Asia Region including Nepal have intensified their efforts to control the targeted EPI diseases.

Tuberculosis is a significant public health problem. The disease is reported to be prevalent in 40% of the Nepalese population. Though TB occurs in nearly all age

groups, the greatest burden in terms of morbidity and mortality is concentrated in adults aged 15-59 years.

Polio, measles and neonatal tetanus are still reported in Nepal. The number of polio cases has been drastically reduced in the last years. Neonatal tetanus and measles are still highly prevalent; 392 and 7.663 cases respectively were reported during 1995/96.

Viral hepatitis is wide spread, occurring mainly in urban areas due to over crowding, poor sanitation and inadequate supplies of clean water. The prevalence of hepatitis B infection and its resulting diseases, such as chronic hepatitis, cirrhosis and hepatocellular carcinoma, is a significant problem for Nepal.

For the prevention and control of these communicable diseases, GoN has adopted and implemented the following strategies:

Malaria – Early diagnosis and prompt treatment; affordable and sustainable vector control; prevention and control of epidemics; and continuous program assessment through strengthening HMIS, program management and operational research.

Kala-azar – Reduction of Kala-azar mortality through improved and strengthened disease management in hospitals; reduction in morbidity by means of early referral through peripheral health institutions; timely diagnosis and treatment; and a reduction in transmission through vector control and provision of free Kala-azar drugs to patients.

Japanese Encephalitis – Identification of epidemic prone areas and preparedness by early recognition and identification of JE in peripheral health services; early diagnosis and timely management of the disease; anti vector measures (fogging/ULV spraying) in epidemic foci; developing the necessary nursing care in hospitals.

Tuberculosis –Directly Observed Short Course Therapy (DOTS) for all patients taking Short Course Chemotherapy (SCC). All activities and services are to be implemented through the existing infrastructure of the Ministry of Health; training and supervision of basic staff at all levels is to be gradually expanded to cover all districts. NGOs and bilateral aid agencies will work as "counterparts" to the regional health directorates, achievement of the short term objective of 70% case finding and 85% cure rate by 1999.

HIV/AIDS – IEC, further strengthening of STD clinical management; ensuring safe blood transfusion; strengthening STD/HIV and AIDS surveillance; caring for and supporting people living with HIV/AIDS; supporting NGOs that provide care to HIV/AIDS patients; and establishment of a national focal point for HIV/AIDS (National Center for AIDS and STD Control, MOH).

b. Non-Communicable Diseases

A public health approach is necessary for the effective control of the non-communicable diseases. Such an approach would have the following components:

- measures to reduce risk factors common to some or most of them, like tobacco use, lack of physical activity, excessive consumption of alcohol and poor dietary habits; behaviors and life style, environmental and occupational hazard;
- identification and screening of high risk groups;
- early diagnosis and where necessary, long term treatment or long term follow up; and
- increased coverage by the involvement of the PHC infrastructure and communities.

Mental Health – Though specific data is unavailable for Nepal, the prevalence of severe mental disorders globally is approximately 5 per 1000 population. Within Nepal the mental hospital is till mainly custodial, with minimal community outreach services. A substantial segment of the mentally ill population is treated through the general medical outpatient departments of general hospitals.

Oral Health – Dental caries are the most common oral health problem world wide. Other common diseases are periodontal diseases including inflammation of the tissues surrounding the teeth. For both, the associated risk factors are increased sugar intake, presence of plaque, tobacco smoking, chewing pan, and excessive consumption of alcohol.

Hearing Impaired – Deafness and hearing impairments are common problems in Nepal population though the data is sketchy and inconsistent. The main cause of hearing impairments is chronic supporative otitis media.

Blindness – Cataract and trachoma are the major cause of visual impairment and blindness. It is estimated that of nearly 0.8% of the population suffer from total blindness. Among the totally blind 72% are the results of cataract. Because of the strong association between cataract and ageing, a ten-year increase in the average life span is likely to double the prevalence of cataracts. Trachoma accounts for approximately 2.4% of total blindness. In addition of cataract and trachoma a high risk of blindness is linked to malnutrition. Vitamin A deficiency especially in conjunction with acute infections such as measles, diarrhea diseases and respiratory tract infections need attention. Age related conditions such as glaucoma, diabetic retinopathy and macular degeneration are also emerging as major challenges for prevention of blindness.

Cardiovascular Diseases – Specific date on cardiovascular and cerebro-vascular diseases (coronary heart disease, hypertension etc.) in Nepal is lacking. However, these diseases have emerged as major contributors to morbidity and mortality in the region. Smoking is one of the main causes of cardiovascular disease and respiratory ailments. Other behavioral risk factors for cardiovascular disease are diet, and heavy alcohol consumption.

Diabetes and Hypertension – Diabetes mellitus is a chronic, non-communicable disease that is largely irreversible. Diabetes mellitus is associated with urbanization, changing life styles and nutrition habits. In recent years there has been growing concern that diabetes mellitus is becoming more common, mainly in urbanized cities particularly among people in the middle age groups.

Malignancies – The estimated morbidity and mortality rates for cancer are not available. It is a widely held belief that cancer is primarily a diseases industrialized countries occurring late in life as a consequence of affluent life style, and thus should not be given priority in developing countries. However, there are valid reasons why the prevention of cancer deserves attention. Several important cancers (stomach, liver) occur most often in poorer countries. With the changes in the age-structure the importance of cancer has increased. Once an individual is past the hurdle of childhood disease, cancer looms as one of the three leading causes of death. Finally, increasing tobacco usage virtually ensures that an epidemic of lung cancer will occur in many developing countries. In addressing malignancies, the focus must be on prevention activities. WHO estimates that a prevention programme can reduce cancer cases by one-third. Undue reliance treatment strategies, which often involve the use of, sophisticated and expensive techniques and facilities, can result in inequitable selection of patients, rapid depletion of scarce resources and a shift in emphasis away from much more appropriate and affordable prevention activities.

Problems of Elderly – As the population grows older, health services will need to address the changing patterns of disease and disability. Chronic conditions will be more prevalent, with a higher prevalence of physical disability, visual impairment, hearing problems etc.

The implications of an aging population are considerable, not only in items of the elderly themselves, but on all sectors of society. A wide range of issues needs of be addressed, including the family, community and government's role in the provision of care.

Policy Issues/Policy Implications for Communicable and Non-Communicable Diseases

As the population grows older, health services will need to address the changing patterns of disease and disability. Chronic conditions will be more prevalent, with a higher prevalence of physical disability, visual impairment, hearing problems etc.

The implications of an aging population are considerable, not only in items of the elderly themselves, but on all sectors of society. A wide range of issues needs of be addressed, including the family, community and government's role in the provision of care.

1. There is a need to address the changing trends of communicable and non-communicable diseases within the context of the "Essential Health Care Services at the District". Addressing the changing trends of communicable and non-communicable diseases through the "Essential Health Care Services" approach

is linked to the recognition that the resources available to the health sector through GON and its donor partners are inadequate to address all of the possible health care needs of the population. Given the situation, there is a need to redirect resources from high cost-low impact interventions to those that could substantially reduce the burden of disease (morbidity/mortality) without increasing expenditures. Further it is necessary to assure that highest priority interventions (vis-à-vis burden of disease and cost effectiveness) are not neglected in terms of financial and technical resources (see Chapter 4 "Policies Regarding Essential Health Care at the District" and Chapter 5 "Policies Regarding Essential Health Care Beyond the district").

2. There is a need to establish an epidemiological surveillance system, including effective IEC measures, laboratory back up for early detection, confirmation of diagnosis and antibiotic sensitivity. Rather than developing a new surveillance system, the emphasis is on the strengthening of the early existing infrastructure.
3. There is the need for the development of rapid response teams that can quickly respond to disease outbreaks and a reliable reporting system.
4. There is the need for the development of standard protocols for diagnosis and treatment of diabetes, hypertension and cardiovascular disease,
5. There is the need for a concerted effort to reduce the prevalence of smoking. The anti-smoking campaign should include community education-schools, work places, and media. Regulation needs to be developed and enforced to restrict smoking in public places.
6. There is a need for operations research to improve the efficiency and effectiveness of cataract care.
7. There is a need for an effective primary oral health programme directed towards preventions and care which should combine with other health services or school health activities.
8. There is a need for training HRH in geriatrics and having geriatric treatment facilities.

iii. Burden of Disease

The Burden of Disease Concept

An estimate of relative burden caused by different diseases constitutes a vital tool for planning, financing and evaluation health services. Till 1993 most assessments of the relative planning, financing were essentially based on number of deaths caused. Disabilities did not receive much attention. To address this constraint, a collaborative effort was undertaken by the World Bank and WHO to assess the Global Burden of Disease using Disability Adjusted Life years (DALYs). The components of this indicator include "Potential Years of Life Lost" as a result of death at a given age and "Years of Life Lived with Disability". The latter is made comparable of death by using appropriate disability weights depending on the severity of illness.

Overview of Burden of Disease Methodology as Applied in Nepal

The estimates of Nepal's burden of disease have been made for the year 1996 based on population protections for 1996 derived from 1991 CBS census date. The Coale and Demeny Model life table has a close resemblance to Nepal's age structure and mortality pattern, was used to estimate age and sex specific mortality rates.

The major constraint in estimating Nepal's disease burden was lack of reliable information on the causes of death. To provide the necessary information, data from United Missions to Nepal (UMN) hospitals was used. Though hospital data does not necessarily reflect the community situation, a review of the five year mortality data from UMN hospitals and its comparison with the age and sex specific mortality patterns indicate that it is fairly representative. The exception is an underestimation of mortality due to diarrhoea and acute respiratory infections. Appropriate adjustments to the UMN hospital data have been made using epidemiological estimates from available community based data for ARI, diarrhoea, vaccine preventable diseases and tuberculosis. GON Programme data with adjustments for under-coverage constituted input for vector borne diseases such as Kala-azar, malaria and HIV. In the absence of Nepal specific data on non-communicable diseases, estimates for rural India were used ("Global Burden of Disease Study").

Results of Burden of Diseases Study

1. The study estimated that approximately 7.68 million DALYs were lost during the year 1996. Premature mortality was responsible for more than two third of the DALYs lost, a trend commonly observed in many developing countries.
2. The diseases were classified in to three broad categories: Group I which includes pre-transition disorders such as infectious diseases, maternal and perinatal disorders, and nutritional deficiencies; Group II which includes degenerative and non-communicable disease; and Group III comprising injuries and accidents. The estimates indicate that the Group I disorders are responsible for more than two thirds of the disease burden (65%) in Nepal. Group II disorders contributed to about a fifth of the estimated burden (23%), and Group III, injuries and accidents contributed the remaining (9%).
3. When compared to developing countries, the present estimates for Nepal indicate that its current burden of disease is quite high, especially, for pre-transition disorders.

DALYs lost per 1000 population in selected developing countries

Disease Group	Country			
	China	India	Nepal	Sub Saharan Africa
Group I	45	175	239	409
Group II	103	138	80	111
Group III	30	31	30	54
All	178	344	349	574

Source: Global Burden of Disease Study 1991

4. Children between 0-4 years of age contributed to approximately one half of the total burden of disease followed by those in the 15-44 age group which were responsible for a quarter of DALYs estimated to be lost.

DALYs lost/1000 population by age, sex and major cause groups						
Age Group	Group I		Group II		Group III	
	Male	Female	Male	Female	Male	Female
0-4	874	1086	72	83	30	38
5-17	71	88	16	19	31	39
15—44	89	128	59	65	29	30
45-59	96	85	196	165	22	19
62 +	101	79	355	351	28	22

5. The higher burden of disease among females, especially in younger age groups suggests ender bias against female children. The higher burden among females in 15-44 age groups was essentially due to high maternal morbidity and mortality.
6. The leading causes of DALYs lost in the 0-4 age group includes perinatal conditions, acute respiratory infections, diarrhoea and measles.
7. In case of adult males (15-44 years) tuberculosis, accidental falls, ARI and motor vehicle accidents were the leading causes contributing the burden of diseases for that age group. For females in the same age group the burden of disease was attributed to maternal disorders, tuberculosis, burns and major affective disorders.
8. The burden attributed to diseases influenced by life styles (smoking, drinking etc.) such as ischaemic heart disease, cirrhosis and alcohol dependency were greater among males than females.
9. Injuries and accidents were estimated to contribute 9% of the total burden of disease. However, this is believed to be an under estimate as reliable data for injuries and accidents is not available.
10. Estimates of the burden of disease for the year 2011 suggest that in the absence of effective interventions, the Group I disorders – despite an evident declining trend- would still predominate with a corresponding increase in the burden contributed by Group II disorders.

Policy Implications for Addressing Burden of Disease

1. Considering the high burden contributed by pre-school children there is strong need for specific focus on interventions aimed at child survival.
2. The high burden caused by diseases strongly influenced by environment like ARI and diarrhoea emphasizes the need to ensure improved domestic environment and better access to safe drinking water and sanitary disposal of excreta.
3. The high burden due to maternal and perinatal disorders emphasizes the need for effective reproductive health programmes, especially in the remote areas.
4. Interventions aimed at improving the status of women in society are needed to address the neglect of female children.

5. The high burden due to preventable communicable diseases like TB, Kala-azar and HIV requires that emphasis be placed on improving the operational efficiency of on-going intervention programmes and enhancement of community awareness through effective IEC strategies.
6. Interventions aimed at modifying life styles such as smoking, drinking etc. need to be considered.
7. Mechanisms for the collection and analysis of reliable vital statistics and epidemiological data should be developed and implemented.

I. Health Service Delivery System-Public, NGO, Private and Traditional Sectors

Historical Perspective of the Health Service Delivery Systems

Nepal has a long history of traditional medical practice with faith healers and Ayurvedic practitioners playing a dominant role in the provision of health care. With the coming of missionaries during the period of the Malla regime, modern medicine was introduced in Nepal. Bir Hospital, the first modern hospital was established in 1890 A.D. signaling the beginnings of a gradual growth of modern medicine in Nepal. In 1933, the Department of Health Services (DHS) was established. It soon assumed the responsibilities for carrying-out the promotion, regulation and management of hospitals, government run traditional Ayurvedic dispensaries, an Ayurved school and a unit for the production of Ayurvedic medicine. Beginning in the late 1950's vertical programs and projects were established largely with aid of foreign assistance to provide various health services, e.g. Malaria Eradication Programme (1985), Small-pox Eradication Programme (1967), FP/MCH Project (1968), TB & Leprosy Control the Integrated Community Health Service Development Project (ICHSDP) was established in 1978 to provide integrated comprehensive health services nationwide.

In line with GoN's decentralization policy, the Ministry of Health went through a major structure change in 1987. Regional Health Services Directorates (RHD) were established in each of the five regions and the Department of health Services abolished. A further restructuring of MOH occurred in 1993 with the reintroduction of the DHS into the organogram with responsibility to implement, monitor and supervise preventive, promotive, rehabilitative and curative health programs through its divisions and centres, RHDs and District Health Offices (DHO). The Divisions and Centres are responsible for; target setting for the specific programs in consultation with RHDs and DHOs; preparing operational plans and programs; and supporting health facilities. At the regional level the RHDs are responsible for planning, supervision, monitoring and training.

Policy-making and formulation of annual, five-year and long-term plans including donor co-ordination continued to be the responsibility of MOH with relevant inputs from the DHS. A separate department for Ayurveda had been established within the Ministry of Health with the responsibility for the development and promotion of traditional systems of medicine practiced in Nepal including Ayurveda, Homeopathy, Naturopathy and Unani.

The curative services are provided through central hospitals and hospitals at regional, zonal and district levels, and through PHCs, HPs and SHP at the sub-district level. District Health Offices are responsible for preventive promotive and curative services. The Ayurvedic dispensaries, Aushadhalayas and hospitals also deliver health services in the Ayurvedic sector. Similarly, Homeopahtic and Unani medical services are delivered through central hospitals and dispensaries located in Kathmandu,

The Ministries of Education, Defense and Home also provide curative services through the teaching hospitals and hospitals for service personnel.

NGO Sector

There has been a tremendous growth in the number of NGOs following the restoration of multiparty democracy in 1990. It is estimated that about 24,000 NGOs are currently operating in Nepal. NGOs are either registered with the Social Welfare Council or directly with the District Administration Offices where they operate. Out of the total number of NGOs registered with the Social welfare Council 6% are estimated to be involved in the health sector. There are 43 NGOs involved in health activities directly or indirectly in partnership with the local NGOs. Among NGOs/INGOs, there are those offering single and multi-specialty services. The range of services provided by NGOs/INGOs includes preventive, promotive, curative and rehabilitative services. There are NGOs/INGOs with a particular focus on tuberculosis, leprosy, family planning, provision of immunization services, eye care, health education, awareness and advocacy programmes.

The geographical distribution of NGOs involved in the health sector is highly skewed. There is a relatively high concentration in Central, Eastern and Western Regions and very low presence in Mid-Western and Far-Western Regions. Even in regions with a large presence of NGOs, their programmes are confined to accessible areas.

Private Sector

With the development and wide spread practice of modern medicine, the private medical sector has grown rapidly. Initially doctors practiced on an individual basis; the group practice concept has slowly emerged leading to the establishment of the private health service institutions such as nursing homes and polyclinics. The past five to six years have witnessed substantial growth in private sector health facilities; a result of Government of Nepal adopting policies to encourage private sector involvement in development. At present there are a total of 9 private hospitals, 49 private nursing homes and over 2,000 private clinics operating throughout the country (hospitals differ from nursing homes in that they are required to provide "emergency services"). Several private medical colleges with teaching hospitals have been established. The majority of private health facilities are located in Kathmandu Valley.

Traditional Sector

Traditional medicine has been widely practiced in Nepal from time immemorial. The varying systems of traditional medicine provide a wide range of preventive, promotive, curative and rehabilitative services. Ayurved emphasizes disease prevention. Within the government sector there is a central Ayurved hospital (50 beds) located in Kathmandu, one 15-bed zonal hospital in Dang, 172 dispensaries in 55 districts and a central unit for the manufacture of Ayurvedic drugs. A total of approximately 500 Ayurvedic personnel work in these institutions. In addition, there is an Ayurveda Campus under Tribhuvan University for the training of middle and higher level Ayurvedic personnel.

There are various private sector institutions providing Ayurvedic treatment in Nepal. Though many of the private Ayurvedic practitioners are attached to public institutions/dispensaries, a number provide services only through their private clinics.

Homeopathy, introduced into Nepal in the 1920's is a therapeutic natural healing system of medicine. There is one six-bed homeopathy hospital located in Lalitpur. The hospital provides both in-door and outpatient services. There are approximately 10 professional NGOs providing homeopathic services in various parts of the Country. There are approximately 100 homeopathy clinics and 500 homeopathy practitioners working in the private sector.

The Unani system of medicine includes preventive, promotive and curative services. There is practiced in selected areas of the country. There are 10-12 dispensaries of Tibetan medicine at Bouddha, Kathmandu; these dispensaries sell Tibetan drugs but do not have facilities for treating patients.

Naturopathy treats sickness and disease thorough naturally occurring substances such as water, mud, sun, air and prescribing physical exercise, diet and fasting for prevention of diseases. The emergence of Naturopathy on an institutionalized basis is relatively new in Nepal.

In addition to the above systems of traditional medicine are faith healers. Normally local persons, they tend to reflect local customs and beliefs and often are the "principal health care providers" in the village. Faith healers deal with physical and mental ailments by prayers, sacred axioms, amulets, mysticism etc. It is estimated that there are 400,000 faith healers in Nepal.

iv. Preventive and Community Health Services

Background

Government of Nepal's is committed to the principles of preventive and community health services as embodied in the primary health care approach of the "Health For All Strategies" through the district health system.

The district health system is a self-contained segment of the national health system comprising a well-defined population living within a clearly defined administrative and geographic area. It includes all institutions and individuals providing health care in the district. The district health system takes in to account the following principles; equitable access; effectiveness; decentralization; community involvement and self-reliance. The district health system includes four dimensions:

- Community involvement and inter-sectoral coordination.
- functional infrastructure – information, management (planning, financing and budgeting), human resources planning and development, logistics, facilities and research;
- Levels of service delivery – family and home, community health activities, first health facility, first referral level hospital/district hospital, district health office; and
- Primary health care elements – appropriate treatment of common diseases, provision of essential drugs, control of communicable diseases, immunization, reproductive health, water and sanitation, food and nutrition, health education.

At the district level and below, the District Health Office is responsible for the provision of preventive and community health services through an array of primary health centres, health post, sub-health posts and outreach programmes. At the primary health center and health post level, the preventive and community health services are incorporated in package of essential health care services including curative services. At the sub-health post and peripheral levels the focus is on the provision of preventive and promotive health measures.

Primary health centres provide the eight elements of primary health care (appropriate treatment of common diseases, provision of essential drugs, control of communicable diseases, immunization, reproductive health, water and sanitation, food and nutrition, health education). They are to be established in each of the 205 electoral constituencies. The PHC is led by a medical doctor with the additional support of other staff and is equipped with one maternity and two emergency beds.

Below the level of the PHC there is no provision for medical doctors. The health posts are staffed by one health assistant, two auxiliary health workers, two auxiliary nurse midwives and one village health worker. Health posts provide curative, preventive and promotive services including treatment of common diseases and injuries. Sub-health posts are the peripheral institution of the health care delivery system. They are to be established in each Village Development Committees. The SHP staffed by one auxiliary health worker, one village health worker and one maternal and child health worker. SHPs provide simple curative, promotive and preventive health services. Outreach programmes operate at the ward level thorough the use of Village Health Workers (VHW) and Female Community Health Volunteer (FCHV)

The private sector (the nursing homes, private hospitals, clinics and private practitioners) is concentrated in urban centres. It provides very little preventive and

promotive services. In contrast to the private sector, NGOs offer a wide array of preventive and community health service including; safe motherhood; family planning; child survival; leprosy; tuberculosis; prevention and control of diseases; prevention of deafness and blindness; eye care; support for drinking water and sanitation etc. NGOs have demonstrated their capabilities for effective organization of outreach services in the periphery.

Traditional systems of medicine (Ayurved, Homeopathy, Naturopathy, and Unani) also provide preventive and promotive health services.

Significant Problems

1. The number and location of community level facilities (sub-health post, health posts, primary health centres) are based on administrative areas, which do not adequately reflect need. The uniform staffing patterns by level of facility are not adjusted to account for variations in service population.
2. There is a shortage of adequately trained health personnel especially technical staff. There are extensive vacancies in sub-health posts, health posts, primary health centres including unfilled posts and posts that are filled but unmanned (see Chapter 2 F Management and Organizational Issues in the Public Sector, and Chapter 7 Policies for planning, Development and Management of Human Resources for Health).
3. Essential components of preventive health services for each level of care are not available or not carried out as defined. The nature and scope of the preventive services provided are dependent on the motivation of the individual providers.
4. There is an absence of an effective and efficient referral system linking community health services to higher levels of care for modern and traditional systems of medicine (public, NGO and private sector).
5. Tertiary care facilities often are providing primary care services; an inappropriate use of financial, technical and human resources.
6. The functional relationship between different levels are not clearly defined, e.g. DHO with PHC, PHC with HP/SHP, HP with SHP.
7. There is a lack of effective supervision and monitoring mechanisms especially at community level facilities.
8. Most peripheral level health facilities at the district level have not been able to deliver minimum services as outlined in the PHC Package.
9. There is a lack of a sense of "community ownership" of health services as the community (VDC/DDC) is not oriented to their role in the management of PHC or HPs or SHPs.
10. Clear strategies and operational guidelines are lacking to ensure effective community participation in preventive and community health service activities.
11. For lack of financial incentives, volunteer community health workers (e.g. FCHV, etc.) are not providing the expected level of service.

12. There is a lack of specific policies, strategies and plans to encourage NGO and private sector participation in the delivery of preventive and community health services.
13. An effective mechanism to coordinate GON, NGO/INGO and private sector preventive and community health service activities is absent.

Policy Issues/Implications for Preventive and Community Health Services

1. There is a need to assure that preventive and community health services are implemented that address the principal health problems of the majority of the population including significant emerging and re-emerging diseases. Less common health problems requiring tertiary and specialized care for the minority should be addressed only after preventive and community health services are provided (see Chapter-4 "Policies Regarding Essential Health Care at the District").
2. There is a need to consolidate the Primary Health Care initiatives taken to date. These include the development and maintenance of fully operational health infrastructures at the community level following the PHC principles of equity, self-reliance, full community participation, decentralization, gender sensitivity, and effective and efficient management.
3. There is a need to define the role of public, private and NGO sectors in the provision of preventive and community health services for modern and traditional systems of medicine. Further, there is the need to develop the necessary mechanisms to encourage and facilitate the public, private and NGO sectors in effectively carrying out their defined roles (see Chapter-4 "Policies Regarding Essential Health Care at the District").
4. There is a need for establishing clear functional relationships, lines of authority and responsibility between different levels, e.g. DHO with PHC, PHC with HP/SHP, HP with SHP.
5. There is a need to develop strategies and operational guidelines to ensure effective community participation in the planning, implementation, monitoring and supervision of preventive and community health services. Effective community participation is viewed as the means of generating the necessary sense of "community ownership" of health services.
6. There is a need to provide financial incentives to community level health volunteers (e.g. FCVs etc).
7. INGOs/NGOs should be encouraged to undertake preventive and community health services activities in the most needy and remote parts of the country.
8. There is a need to ensure co-ordination and collaboration between multi-and bilateral donors. INGOs and the government/public sector (e.g. MOH, DDCs, VDCs, etc.) to achieve national goals and objectives for preventive and community health services. Multi-and bilateral donors, INGOs and the government/public sector should be encouraged to work in partnership with national and local NGOs, adopting an institutional capacity building approach.

9. There is a need to develop and implement a need-based methodology for planning community health facilities (number and location) that takes account of INGO/NGO facilities. The need-based approach should replace the current administrative area approach. An appropriate unit to carry-out facilities planning needs to be designated within Department of Health Services and provided the necessary skilled personnel for the task.
10. There is a need to adjust uniform staffing patterns for sub-health post, health post, and primary health centre to account for variations in service populations (see Chapter 7 Policies for Planning, Development and Management of Human Resources for Health).
11. There is a need to develop feasible and appropriate mechanisms for the effective supervision and monitoring of public, private and NGO community level facilities. These mechanisms will ensure that the essential components of preventive health services for each level of care are carried out as defined (see Chapter 2 F Management and Organizational Issues in the Public).
12. There is a need to develop feasible and appropriate mechanisms to ensure an effective referral system for modern and traditional sector. The referral system will link community health services to higher levels of care making use of public, private and NGO providers.
13. There is a need to encourage the use to faith healers to refer persons to the district health system and to provide basic preventive and promotive health service.

v. Curative and Rehabilitative Services

Background

The provision of curative health services is focused on providing appropriate diagnosis, treatment and referral services from the sub-health post to the specialized hospital. At the community level, facilities such as the sub-health posts and health posts focus on the provision of essential health services including the treatment for common diseases and injuries. The primary health center provides a somewhat higher level of curative services and also attends referral cases from the community level.

District hospitals are first level referral hospitals that offer in-patient (15-25 beds) and outpatient care. At present there are 65 district hospitals; health centre located at the district headquarters serve the 10 districts without such facilities. Gradually, these 10 health centre will be upgraded to district hospitals. Zonal hospitals (50 to 150 beds) and regional hospitals 150 to 250 beds) are supposed to function as second level referral hospitals, However, zonal hospitals often are unable to carryout their referral responsibilities due to shortages in staffing, supplies and equipment, and inadequate facilities. There are 9 zonal and one regional hospital.

At the tertiary level, the government operates one national and five specialized hospitals. Bir Hospital, the national hospital, was established in 1890 A.D. It has 350

beds, providing OPD, In-patient and emergency services including specialized services for patients with cardiac, renal and neurological problems. The specialized hospitals include Kanti Children's Hospital-150 beds; Maternity Hospital – 200 beds; the Infectious Diseases Hospital – 150 beds and the Mental Hospital – 50 beds. Additional specialized hospitals are being established including the B.P. Koirala Memorial Cancer Hospital, and Ganga Lal National Heart Center etc. There are two teaching hospitals, Tribhuvan Unversity Teaching Hospital in Kathmandu with 400 beds and the B.P. Koirala Institute of Health Sciences in Dharan with 200 beds. Finally, the government provides hospitals for military and police personnel, the Millitary Hospital under the Ministry of Defense – 250 beds, and the Police Hospital run by the Ministry of Home 250 beds.

While government hospitals have been described in terms of numbers of beds, it should be emphasized that traditional indicators such as total numbers of beds and bed to population ratios have little or no significance. Government hospitals are neither staffed nor equipped on the basis of their bed compliments particularly those at the district level. Consequently hospital bed indicators do not adequately reflect availability or access of services, neither the quality nor quantity of services provided. Hospital bed indicators may in fact provide a distorted view of the care available at such institutions.

The curative services rendered by NGOs range from basic curative services to specialized medical care including: tuberculosis, leprosy, safe motherhood, child survival, family planning and eye care services as well as the provision of essential drugs. The community generally perceives these services as being of higher quality that offered by the public sector. In providing these services the NGOs operate a broad range of health facilities including hospitals. The source of funding for NGOs is largely derived from foreign donors.

Turning to the private sector, there are in excess of 2,000 private clinics, 9 private hospitals and 49 private cursing homes in Nepal. Kathmandu based hospitals and nursing homes offer a wide range of curative services, from basic to specialized care including; ambulatory services, obstetrics/gynecology, oncology, plastic surgery to neuro-surgery and ENT. Private sector facilities outside of Kathmandu provide a more limited range of clinical services.

As discussed in the section of the traditional sector, the Ayurved, Homeopathy and Unani systems of medicine provide curative services through government, NGO and private sector providers with their own systems of health facilities.

Significant Problems

1. Essential components of curative services at each level of care are not available or not carried out as defined. The nature and scope of the curative services including specialized services at the district and zonal hospitals are dependent

on the motivation of the individual providers; and availability of supplies, equipment and facilities.

2. There is a lack of co-ordination in the provision of curative, rehabilitative and preventive public health services.
3. The resources available to district hospitals often bear no relation to the size of the facilities service population (clinical, technical and administrative staff: medical supplies, equipment and facilities).
4. There is a shortage of adequately trained health personnel especially technical staff. There are extensive staff vacancies in hospitals with unfilled posts and posts that are filled but unmanned (see Chapter 2 F Management and Organizational Issues in the Public Sector, and Chapter 7 Policies for Planning Development and Management of Human Resources for Health).
5. The quality of services provided at health facilities often does not meet established standards of care.
6. The relationship between the districts, zonal, regional and central level hospitals are not clear. The absence of a clear relationship hinders the establishment of effective and efficient referral system linking curative services at the community level to higher levels of care for modern and traditional systems of medicine (public, NGO and private sectors).
7. Tertiary care services and facilities often are established without the necessary feasibility studies. Generally, little consideration is given to the present and future costs of the services/facilities nor the level of benefits that these services/facilities can reasonably be expected to provide relation to Nepal's morbidity/mortality rates. The impact on the system's ability to provide basic services to the broader population (preventive and community health services) often is neglected.
8. There is a lack of specific policies, strategies and plans to encourage the proper growth and development of curative aspects of traditional systems of medicine.
9. There is a lack of specific policies, strategies and plans to encourage NGO participation in the delivery of curative service.
10. There is a lack of an effective mechanism to coordinate GON, NGO/INGO and private sector curative services for the modern and traditional systems of medicine.

Policy Issues/Policy Implications for Curative and Rehabilitative Services

1. There is a need for co-ordination in the provision of curative, rehabilitative and preventive/public health services.
2. There is a need to explore the feasibility of additional approaches for the provision of curative and specialized services in difficult and remote areas that will compliment the facility based service delivery system.
3. There is the need to develop and implement a need-based hospital planning mechanism to replace the current administrative area approach. The need-based methodology should take into account (a) the needs of the service area population in determining hospital staffing patterns, supplies, equipment, and

facilities requirements, (b) existing government, INGO, NGO and private sector facilities. An appropriate unit carryout hospital planning needs to be designated within Department of Health Services and provided the necessary skilled personnel for the task.

4. There is a need to develop commitment at the highest levels for making decisions related to the establishment of tertiary care services and facilities on the basis of well designed and appropriately implemented feasibility studies. At a minimum, the feasibility studies should address considerations of the present and future costs of the services/facilities and the opportunity costs in terms of human and financial resources. The studies should consider the financial drain on the health sector; and the level of benefits that these services/facilities can reasonably be expected to provide in relation to Nepal's morbidity/mortality rates.
5. There is a need for the establishment of effective quality assurance mechanisms for public, private and NGO sectors that take into account the clients and providers' perspectives (see Chapter 11 "Policies for Ensuring Quality Assurance in Health Services").
6. There is need to develop specific policies, strategies and plans to encourage INGO/NGO to undertake the provision of curative and rehabilitative services in the most needy and remote parts of the country.
7. There is a need to develop specific policies, strategies and plans to encourage the proper growth and development of curative and rehabilitative aspects of traditional systems of medicine.
8. There is a need to define the relationship between district, zonal, regional and central hospitals in the provision of curative including specialized services (public, NGO and private sector hospitals). Further, there is the need to develop the necessary mechanisms to encourage and facilitate the public, private and NGO sectors in effectively carrying out their defined roles (see Chapter 4 "Policies Regarding Essential Health Care Services at the District, " and Chapter 5 "Policies Regarding Essential Health Beyond the District").
9. There is the need to develop a feasible and appropriate mechanism to assure an effective referral system linking curative services to higher levels of care for modern and traditional systems of medicine that makes use of public, private and NGO providers.
10. There is a need to adjust staffing patterns at district and zonal hospitals to account for variations in the service area population and to provide the curative including specialized services as defined in the "Essential Health Care Services" (see Chapter 4.5 and 7).

vi. Ancillary Services and Information, Education and Communication

Background

a. Laboratory and Other Investigative Services

Laboratory services are provided through an extensive network of laboratory facilities extending from the health post to central levels. The laboratory network includes 68 primary health center and health post laboratories, 58 district

laboratories, 10 zonal laboratories and one regional referral laboratory – the Western Regional Health Laboratory in Pokhara. These laboratories are supplemented by central level laboratory facilities provided by Bir Hospital, Kanti Children's Hospital, Maternity Hospital and the National Tuberculosis Centre. At the apex of the laboratory network is the National Public Health Laboratory (NPHL), the central and specialized referral laboratory for the country. The major responsibilities of NPHL are to provide referral laboratory services; improve quality control in all health laboratory services; and train mid-level personnel in laboratory services.

Besides laboratory services, other public sector diagnostic and investigative services are provided by hospital facilities. Private sector diagnostic centre offer limited laboratory and investigative services; they tend to be concentrated around hospitals and nursing homes. Most private sector diagnostic centre are poorly staffed and equipped. It should be noted that Kathmandu has seen the introduction of a number of highly sophisticated private sector diagnostic services. The number and distribution of private sector diagnostic centre is difficult to estimate, as there is no system for their registration.

b. Pharmacies and Free Standing Drug Stores

The distribution of drugs to public sector facilities is the responsibility of the Ministry of Health through its Regional Medical Stores (see Chapter 2 F, section on Logistics Management). Supplementing the drug supply that is provided by GON are drugs made available through the rapidly increasing number of private sector pharmacies. It has been estimated that there are approximately 8014 retail pharmacies, 1315 drug wholesalers, and 1086 drug importers operating in Nepal. Both the public and private sectors are engaged in the local manufacture of drugs. There are two public sector drug manufactures- Royal Drugs Ltd. and Singhdurbar Baidyakhana - and 26 private pharmaceutical companies that produce nearly 200 different types of drugs.

c. Blood Transfusion Services

Nepal Red Cross Society is exclusively responsible for organizing and operating the blood transfusion program in Nepal. NRCS operates 45 blood transfusion centres in different district supplemented by 14 emergency blood transfusion centres in remote areas of the country to meet emergency needs. All blood is donated by voluntary donors and not by professional donors who receive money for providing blood. All blood is tested for HIV hepatitis and syphilis.

d. Information, Education and Communication

The focal point for IEC activities in the Ministry of Health is the National Health Education. Information and Communication Centre (NHEICC). It is responsible for developing appropriate and cost-effective mass media health education

messages in collaboration with other divisions of the Department of Health Services. Among the strategies adopted by NHEICC is the promotion of IEC activities in government and NGO health facilities at all levels and dissemination of information through health and other development workers.

Significant Problems

1. The role of the public, NGO and private sectors in the provision of laboratory and diagnostic services is ill defined.
2. The laboratory services provided by public, private and NGO sectors are often of poor quality.
3. Necessary laboratory equipment at public sector health facilities is often lacking or in disrepair. There is a lack of basic repair and maintenance knowledge among laboratory technicians (see Chapter 2 F section on Logistics Management).
4. The supply of drugs at the health facility level is inadequate with the annual provision of essential drugs sufficient for 3-5 months, the uniform content and quality of drugs provided to health facilities are not adjusted to account for variations in service population. As a consequence, there is a tendency for health providers to dispense drugs in small quantities irrespective of patient's actual need in order to extend the facility's drug supply. The result is irrational drug use, especially in terms of antibiotics where the recommended course of treatment is replaced by and adequate course of treatment due to the small quantity of drugs dispensed. Once the drug supply is depleted, the patient load decreases, thereby reducing the utilization of preventive and promotive health services provided at the health facility.
5. The role of the public, NGO and private sectors in the provision of pharmacy services and in assuring an adequate and continuous supply of drugs is ill defined.
6. Untrained personnel often staff private pharmacies. This leads to poor dispensing practices and irrational drug use.
7. There is insufficient drug manufacturing capacity for the production of traditional medicines.
8. Most district hospitals lack blood bank services. There is difficult in obtaining blood donors when transfusions are required.
9. IEC efforts are over centralized. There is no mechanism to ensure standard IEC messages.

Policy Options/Policy Implications for Ancillary Services and IEC

1. There is a need to define the role of public, NGO and private sectors in the provision of laboratory and diagnostic services. It is necessary to develop mechanisms to encourage and facilitate the public; NGO and private sector to effectively carryout their defined roles.

2. There is a need to develop and provide training in "good laboratory practices". The necessary rules, regulation and enforcement mechanisms need to be established for ensuring public. NGO and private sector facilitate maintain "good laboratory practices."
3. There is a need to assure the availability of required laboratory equipment at public sector health facilities. Laboratory technicians must have the skill and knowledge to undertake basic repairs and regular maintenance of laboratory equipment (see Chapter 2 F selection on Logistics Management).
4. There is a need to develop and implement feasible and appropriate alternative financing schemes that will assure a continuous and uninterrupted supply of affordable essential drugs of acceptable quality at the district and below (e.g. community drug programmes, introduction of user fees, etc.) The alternative financing schemes must support rational drug use.
5. There is a need to define the role of the public, NGO and private sectors in the provision of pharmacy services. In defining the public-NGO-private mix the availability of an adequate and continuous supply of affordable drugs must be assured. Further, it is necessary to develop mechanisms to encouraged and facilitate the public, NGO and private sectors in effectively carrying out their defined roles.
6. There is a need to assure that persons working in private pharmacies/drug retailers are trained in the rational use of drugs and proper dispensing practices. Monitoring and inspection of the private pharmacies/drug retailers must occur on a regular basis.
7. There is a need to increase the production medicinal plants and manufacture of pharmaceutical products used in traditional systems of medicine.
8. There is a need to develop blood-banking services in district hospitals.
9. There is a need to decentralize IEC efforts assuring greater local orientation and standardized IEC messages.

J. Human Resources for Health-Planning and Development

Background

The need for a national policy on planning and development of Human Resource in Health (HRH) has been recognized. Such policies are viewed as a means to ensure the appropriate numbers, types and distribution of technically competent and socially responsible health personnel are available to provide health personnel are available to provide health care to all the people of Nepal, particularly those living in rural areas. Within this context, a series of HRH planning exercises and policy development activities have been undertaken.

At the start of Fifth Development Plan period, public sector requirements for sixteen selected categories of health personnel were projected for three five-year periods

1975-80, 1980-85 and 1985-90. A further planning exercise focusing on the public sector was carried out in 1980, which for the first time recommended the establishment of a full time human resources planning secretariat. However, such recommendations were not acted upon. In 1982 an interim report warned that the significant shortfall in all categories of HRH would continue to the end of 1990. In 1986, detailed health personnel planning exercise was undertaken examining HRH supply and demand, including NGO requirements. The exercise identified deficiencies in almost all categories of health personnel and recommended improvements in HRH management practices.

In 1993, the first "Master Plan for the Development and Utilization of Human Resource for Health in Nepal" was completed. Based on an assessment of the then current situation, the "Master Plan" projected HRH requirements through 1997 for the health sector including public, NGO and private service providers. The "Master Plan" identified regional imbalances in the numbers and types of available health personnel with some areas suffering more severe shortages than others. The "Master Plan" provided recommendations to address HRH management and developmental issues. A revised version of the HRH "Master Plan" was developed in 1995 focusing on the public sector excluding the military and police. It addressed HRH need, which was defined on the basis of sanctioned posts. The revised "Master Plan" provided detailed recommendations and an action plan for planning and management of HRH taking into account the changing government policy towards the role of the public, private and NGO sectors in the health.

With the adoption of the National Health Policy (1991) and the Eighth Five Year Development Plan (1992-1997) specific national policies and plans for HRH were outlined, these include:

- Capable manpower required for various facilities will be developed in a planned manner;
- Necessary cooperation will be extended for institutional development to raise the capacity of the main organization producing health personnel (Institute of Medicine-IOM, Council for Technical Education and Vocational Training CTEVT, and training centers under MOH); and
- Necessary arrangement will be made for training in foreign countries in order to produce those categories of personnel, which cannot be produced in the country.
-

The Eighth Five-Year Plan also highlighted two specific areas of human resource production:

- The capability of training institutions including IOM will be expanded to produce additional personnel in a planned manner; and
- The public and private sector will be mobilized to produce high-level health personnel (graduate and post-graduate) in Nepal. Basic and mid level health personnel (semi-skilled and para professional) will be trained in the country with some specially and super specially personnel trained overseas in recognized institutions.

There are a series of central level bodies responsible for HRH planning including:

- High Level Manpower Development Committee – chaired by the National Planning Commission focusing on all higher-level education.
- MRH Steering Committee – a multi sectoral committee chaired by the Ministry of Health.
- Basic, mid and high level sub committees – these sub-committees function under the auspices of the HRH Steering Committee.
- Postgraduate Medical Education Co-ordination Committee – comprised of representatives of Ministry of Health and Tribhuvan University – IOM.
- National Fellowship Committee – Ministry of Health with representatives from the World Health Organization.
- Committee for Medical College at the Ministry of Education – a multi-sectoral committee.
- Tribhuvan University – IOM, Kathmandu University.

Significant Problems

1. HRH planning is a centralized process focused on the public sector (excluding police and military) with minimal input from lower levels and consequently limited sensitivity to local needs. HRH planning is not linked to the overall health-planning framework.
2. HRH requirements are determined by staffing norms and numbers of sanctioned posts. Neither approach accurately reflects actual need.
3. The supply of health personnel does not correspond to need. There is a persistent mismatch between the skills personnel have taught and those required for the positions they fill.
4. Limited resources are often used to produce categories of qualified personnel for which there is limited use. Cadres of personnel are trained without due consideration to their cost effectiveness.
5. The capacity for training mid-level health personnel insufficient. There is the potential for acute shortage in staff nurses and other Para professionals; the result of a decision by universities to shift away from undergraduate and non-credit training programmes (e.g. CMA, AHW, ANM, HA, etc.) in order to focus on graduate and post-graduate level training.
6. There is a lack of effective co-ordination, consultation and collaboration among the numerous committees and individual ministries, organizations and agencies involved in planning, production and use of HRH. This problems extends to the Ministry of Health and its various divisions and centers from the central to periphery levels; the National Planning Commission; the Ministry of Education; Universities; NGOs; the private sector; donor, etc.
7. The trend to concentrate private training institutions in urban areas and in the Terai is increasing, exacerbating the existing regional imbalances and further reducing the training opportunities available to rural population particularly those in hill and mountain areas.

8. The quality of training and the essential infrastructure necessary to impart adequate levels of skills is uncertain, especially with regards to private sector training institutions.
9. There is an unplanned/uncoordinated growth of public and private medical schools and the establishment of new degree or training programmes within existing institutions. The new medical schools, new degree and training programmes often are established without consideration of the health sector's HRH requirements and often expect government support. They do not conform to standards, criteria and guidelines established by GoN. Moreover, they distort the priority given to "Primary health Care" by diverting limited human, financial and material resources necessary for assuring availability of essential health care services. Similarly, they limit the quality of graduates produced by existing institutions and programmes, and threaten their sustainability.
10. In-service and continuing education continues to employ a vertical program approach, resulting in health workers frequently out-of-station attending programmatic training.
11. In-service training is not linked to career advancement opportunities. There are no mechanisms for in-service "training blocks" which over a number of years would lead to career advancement for basic level health workers. Under the current system, basic level health workers retire in the post of recruitment.
12. Equal opportunities for continuing and higher education is lacking especially for persons serving in rural areas. This is particularly the case when it involves study in foreign countries.

Significant Constraints

1. Frequent policy changes affecting health personnel are introduced without assessing their impact on HRH planning and development.
2. There is no effective mechanism for HRH planning within the Health Institutions and manpower Development Division (HIMDD) of DHS, the responsible unit within the Ministry of Health.
3. Assessment of need for health personnel is not adequately based on the skill requirements of the position, job analysis, nor adequate consideration of the morbidity patterns of the specific locations in which personnel are to serve. Moreover, assessment of need does not address service demands of the locations nor attrition rates.
4. HIMDDs human resources information system (HuRDIS) is not effectively linked to training and deployment of health personnel.
5. The responsibilities and authorities of HIMDD and the Ministry of Health’s National Health Training Centre are not clearly defined in relation to planning and development of HRH, Co-ordination between HIMDD and NHTC is limited.
6. The NHTC and Regional Training Centers are carrying out pre-service training of VHW, AHW, MCHW and community workers (e.g. FCHVs and TBAs) which adversely affects their ability to fulfill their mandate to provide in-service training.

7. NHTC lacks adequate numbers of trainers in those disciplines for which it is mandated to provide in-serving training.
8. CTEVT and its affiliated institutions have sole responsibility to meet the requirements for training of basic and mid-level para professionals. However, their limited training capacity restricts their ability to address the potential shortage of staff nurses and other para professionals.
9. GON standards, criteria and guidelines for the establishment and operation of medical schools and institutions for the training of health personnel do not address issues of HRH needs, regional/geographic balance, feasibility, and sustainability, Nor do they address the financial and human resources implications for existing health sector priorities, or their affect on existing medical schools and training institutions. Moreover, there is an absence of legal provisions to enforce compliance with the standards, criteria and guidelines that do exist. There is lack of inter-sectoral co-ordination for enforcement of quality standards.
10. Information on continuing and higher education opportunities is not disseminated in a timely manner particularly to health personnel serving in rural areas. Moreover, there is a lack of transparency in the selection process especially when it involves study or observation visits in foreign countries.

Policy Issues/Policy Implications for HRH – Planning and Development

1. There is a need for the decentralization of HRH planning, broadening its focus to include the INGO/NGO and private sectors. HRH planning must maximize input from lower levels and increase sensitivity to local needs. HRH planning should be linked to the overall health-planning framework.
2. There is a need for development of human resources projections for clinical, technical and support personnel for the health sector as a whole (i.e. government including police and military INGO/NGO; and private sector). Further, there is a need to replace the "sanctioned post" methodology for HRH projects with a methodology that more accurately reflects need.
3. There is a need to link production of clinical, technical and supportive health personnel to their projected need, rather than the capacity of the training institutions.
4. There is a need to establish effective co-ordination, consultation and collaboration among the various ministries, organizations and agencies involved in supply and use of HRH.
5. There is a need for the Ministry of Health to focus on continuing education and in-service training employing an integrated programmatic and management approach.
6. There is a need to establish in-service "training blocks" that will serve as a tool for career advancement for basic health workers (e.g. VHW to AHW, MCHW to ANM etc.). Under such an arrangement having successfully completed to the next higher level of qualifications.
7. There is a need for the development of standards and criteria, and the creation/implementation of compliance mechanisms for the establishment and

operation of public and private medical schools and institutions for the training of health personnel.

8. There is a need to place public and private institutions which train clinical, technical and/or support personnel under accreditation schemes to be monitored by the concerned professional bodies (e.g. Nepal Medical Council, Nepal Nursing Council-Health Professional Council, etc). The accreditation schemes should require periodic reaccreditations that at a minimum focuses on: the nature and quality of the instructional curricula, training staff and facilities: and adequacy of practical field training sites. The accreditation schemes also should address competency based enrollment; gender equity in enrollment; reservations for individuals from remote areas who meet entrance requirements; and preparation of reports for annual audits.
9. The need to subsidize the cost of pre-service education for training of basic and mid level health personnel to ensure regional/geographic balance for candidates of remote areas and gender equity in enrollment.

K. Health Care Financing and Expenditures

1. Analysis of Health Care Expenditure

Magnitude of Health Care Expenditure by Source

There are several internal and external sources that provide funding for the development and operation of the health sector. Internal funding sources include GON, private companies and individual households. External sources consist of multilateral and bilateral donors, and INGOs, External sources also include the expenditures of national NGOs that depend upon external donors for funding.

The total health expenditure in 1994/95 amounted to Rs. 10.95 billion (US$ 195 million). This is equivalent to 5.3 percent of GDP (ADB; 1997), a higher percentage than Bangladesh (3.2%) and Pakistan (3.4%) and slightly less than India (6.0%)

Table 1 : Level of Total Health Expenditure by Source (1994/95)

Expenditure	Internal Source							External Source				Total Internal and External
	Private Sector			Public Sector Ministry of								
	Private Sector	Private Cos.	Total	Health	Education	Defense	Home	Total	Donors	INGOs	NGOs	
Millions Rs.	8102.1	176.5	8276.6	1079.4	1.0	52.1	28.4	1160.9	1360.7	101.3	43.0	10944.6
Percent	74.04	8.68	407.20	53.1	0.04	2.56	1.40	57.11	66.93	4.98	2.12	538.4

Source: ADB, National Accounts Analysis and Social Sector Reform in Nepal. A Report for the Education and Health Sector Assistance Strategy Study, November 14, 1994.

Private sector (non-public funding sources) accounts for the highest share of total health expenditures (75.6%) followed by donors (12.4%) and GON (10.6%). Within

the private sector, household expenditures are (74%). Within the public sector, over 90 percent of health expenditures are through the Ministry of Health. The remaining expenditures are through the Ministry of Defense (Army Hospital), the Ministry of Home (Police Hospital), and Ministry of Education (Tribhuvan University, Institute of Medicine).

The per capita expenditure on health in FY 1994/95 was Rs. 538.35 (US$ 11). This compares to a per capita expenditure of US$ 7 for Bangladesh, US$ 21 for India, and US$ 12 for Pakistan. Total per capita expenditure in Nepal is, internal sources accounted for US$ 9.5 and external sources US $ 1.5.

ii. Level and Trends of Public Sector Health Expenditure

Health Expenditures vis-à-vis National Budget and GDP

MOH expenditures (including donor assistance) over the past five years increased four fold from Rs. 918.1 million in 1991/92 to Rs. 3457.9 million in 1996/97 with an annual growth rate of 30.3 percent (Table 2). In real terms, the annual growth rate in MOH expenditures was 21 percent. MOH expenditures as a percentage of the national budget increased to nearly 6 percent in 1996/97 from 3.47 percent in 1991/92.

As a percent of GDP, public sector health expenditures reached 1.26 percent in 1996/97 in comparison to 0.63 percent in 1992/92. Nevertheless, health expenditures remain far below the expenditure levels for education and local development (Table 2).

Table 2: Trends of Health Expenditure Growth vis-à-vis other Social Sector

Fiscal Year	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	Annual Growth Rate (%) 1991/92-199/97
A. Public Expenditure	26418.2	30897.7	33597.4	39060.0	46681.2	57565.6	16.8
Current Price Real	26418.2	27986.6	28330.7	30887.2	34385.1	402266.9	8.8
B. Health Expenditure	918.1	1061.0	1065.6	1495.6	2178.7	3457.6	30.3
Current Price Real	918.1	961.0	898.0	11825.6	1595.2	2418.8	21.0
C. Social Sector as % of A	20.99	27.94	21.84	25.81	29.91	23.50	-
Health	3.47	3.43	3.17	3.82	4.67	5.99	-
Education	10.85	13.43	12.75	12.97	14.20	12.41	-
Water Supply	5.10	5.90	2.90	2.80	2.80	4.00	-
Local Development	1.57	2.15	3.02	6.22	8.24	7.10	-
D. Social Sector: % of GDP	3.78	4.65	3.82	4.77	5.86	6.2	-
Health	0.63	0.64	0.55	0.71	0.90	1.26	-
Education	1.97	2.51	2.44	2.41	2.76	2.63	-
Water Supply	0.90	1.10	0.50	0.50	0.60	0.80	-
Local Development	0.28	0.40	0.53	1.15	1.60	1.51	-

Source: Economic Survey, Various Issue, GoN/Ministry of Finance

Regular Vs. Development Expenditure

In line with the allocation of national budget, the health budget allocation is divided into regular and development budgets. The distinction between the regular and development budget is made on the basis of "non-productive" and "productive" components. Accordingly, the majority of administrative costs including salaries, allowances, rent, fuel, repair and maintenance etc. are covered under the regular budget. The development budget constitutes the expenses that support development projects and programmes. Expenditures for health facility construction, training, research etc are classified as development expenditures. Any project, program, or activities supported through external funding sources are treated as development expenditures.

In conformity with the objectives of the economic reform program, there is a need to maintain regular health sector expenditure within a certain limit. The growth rate for regular expenditures in the health sector (16%) remained considerably lower than the national average (25%) during the 1991/92-1994/95 period.

Development expenditures have increased by 61 percent during the 1991/92-1994/95 period from Rs. 507 million to Rs. 858 (an average increase of 19 percent per year).

Table 3: Trends in Regular versus Development Expenditures

Particulars	1991/92	1992/93	1993/94	1994/95	Average Annual Growth Rate (%)
Total Expenditure	26418.2	30897.7	33597.4	39060.0	13.9
Regular	9905.4	11484.1	12409.2	16265.1	24.8
Development	16512.8	19413.6	21188.2	19794.9	6.3
Development expenditure as % of total expenditure	62.5	62.8	63.1	50.7	-
Total Health Expenditure	918.1	1061.10	1065.6	1495.6	17.7
Regular	410.9	460.8	505.1	637.1	15.7
Development	507.2	600.2	560.5	858.5	19.2
Development expenditure as % of total health expenditure	55.2	56.6	52.6	57.4	-
Health Expenditures (% of total	3.5	3.4	3.2	3.8	-
expenditure)	4.1	4.0	4.1	3.3	-
Regular	3.1	5.1	2.6	4.3	-
Development					

Source: Economic Survey, Budget Speech and red Book, Various Issues, GON/Ministry of finance

Recurrent and Capital Expenditure

During the period 1991/92-1994-95, recurrent expenditures as a percentage of total health expenditure grew marginally from 92.4 percent to 95.3 percent. Personnel costs (salaries and wages) decreased from 53 percent of total health expenditure in 1991/92 to 39 percent in 1994/95 (Table 4). Expenditures for operations and maintenance remained at 1.0 percent during this period. The low level of expenditure

for operations and maintenance indicates that it has restricted to take full advantage of the already existing established health facilities. Although, expenditure for drugs and medical supplies has increased three fold, there still remains critical shortage of medical supplies at all health institutions.

Turning to capital expenditures, construction and medical equipment are the major components receiving the largest shares. Comparing 1991/92 and 1994/95 expenditure levels construction increased by approximately 34 percent while medical equipment expenditures decline by approximately 7 percent. Further analysis shows expenditures for primary health care construction activities declined sharply (93 percent) from Rs. 11.4 million in 1991/92 to Rs. 0.8 million in 1994/95 (Table 4). This situation might be explained by the fact that almost all the PHCs and HP construction by the communities themselves, additional expenditures from the government is not required.

Table 5: Level of Expenditure in Tertiary, Secondary and General Hospitals (FY 1994/95)

Expenditure for	Rs. In millions	Percentage
Tertiary Hospitals	112.6	7.5
Secondary Hospitals	47.2	3.2
General Hospitals (District Hospital)	66.2	4.4
Sub total	226.0	15.1
Other Non-hospital Expenditures	1273.0	84.9
Total MOH Expenditures	1499.0	100.0

Source: GON/Ministry of Finance, Department of Health Services

Tertiary, secondary and general hospital expenditures accounted for 15.1 percent of total health expenditure in 1994/95 (Table 5). The five tertiary-level hospitals (Bir Hospital, Maternity Hospital, Kanti Children's Hospital, Teku Hospital, and B.P. Koirala Memorial Cancer Hospital) accounted for 7.5% of total health expenditures. The nine secondary level hospitals (Patan Hospital, Western Regional Hospital, Pokhara and eight zonal Hospitals) accounting for 3.2% of total health expenditures with the 61 district level general hospitals accounting for 4.4% total health expenditures.

The expenditures levels noted above do not reflect total expenditures of these hospitals. Health institutions at all levels fund some portion of their operational (purchase of medicine, stationery, repair and maintenance etc.) and capital expenditures (for construction, purchasing medical equipment, etc.) out of revenue generated through service charges. However, the magnitude of these expenditures is not known.

iii. Sources of Health Care Financing in the Public Sector

Internal Sources

Government expenditures for health are derived from internal and external sources. The budget for regular expenditures is entirely met by international revenue, raised through direct and indirect taxes, non-tax revenues and domestic loans. After

meeting the government's regular expenditures, the revenue surplus in utilized to meet development expenditures.

Notwithstanding the fact that a large proportion of health development expenditures is being met through internal resources, the health sector's claim on revenue surpluses has remained relatively smaller. The ratio of internal funding to revenue surplus has increased form 4.0 percent in 1993/94 to 8.3 percent in 1994/95, nevertheless it is still below 1992/93 levels (Table 6)

Table 6: Trends of Internal Funding to Development Expenditure in Health Sector

Particulars	1991/92	1992/93	1993/94	1994/95
Revenue Surplus	3607.3	3664.3	7171.6	5310.1
Internal Funding to Development Programs	325.2	333.9	333.7	442.3
Percent of Internal Fund to Revenue Surplus	9.0	9.1	4.7	8.3

Source: GON/Ministry of Finance, Economic Survey, 1995/56

External Source

Nepal's Eighth Plan (1992-97) expected 65 percent of the planned outlay to be financed through foreign aid contributions. During the first three year of the plan period (1992/93) and 1994/95), Nepal received Rs. 33.103.6 million in foreign aid. This amounted to approximately 56.8 percent of the total development expenditures. The overall aid flow to Nepal increased from Rs. 7800.4 million in 1991/92 to Rs. 12.310.9 million in 1944/95 (Table 8). For the health sector foreign aid increased from Rs 182.0 million in 1991/92 to Rs. 416.2 million in 1994/95. Despite the large increase, foreign aid to the health sector as a percentage of total foreign aid has remained relatively small and has changed only marginally over the years.

The percentage of total health expenditures funded through foreign aid is relatively high, 19.8% in 1991/92 increasing to 27.6% in 1994/95. The role of foreign aid in supporting the development budget is remarkable even more significant, 35.9 percent in 1991/92 increasing to 78.5 percent in 1994/95 (Table 7)

Table 7: Trends of Total Foreign Aid Growth vis-à-vis Health Sector Aid

Particulars	1991/92	1992/93	1993/94	1994/95	Annual Growth Rate
Total Foreign Aid in Million Rs.	7800.4	9235.6	11557.2	12310.9	16.4
Foreign Aid in Health in Million Rs. As a percent of Total Foreign Aid	182.0 2.3	266.3 2.9	226.8 2.0	416.2 3.4	31.7 2.6
Health Development Budget in Million Rs. Percent of Health Development Budget Funded Through Foreign Aid	507.2 35.9	600.8 44.3	560.5 40.5	858.5 48.5	- -

Source: GoN/Ministry of Finance Economic Survey, 1995/56.

Funding for primary health care activities is highly dependent on external sources, with donor partners providing 58.47 percent of the total expenditures for primary health services (Table *). Funding for TBA programmes is almost entirely provided by donors. Similarly, external assistance in nutrition, Goiter/Cretinism, and FCHV programmes exceeds 900 percent.

Table 8: Aid Dependency in Primary and Non-Primary Health Care Services (1994/95)

Type of Health Cares	In Thousand Rs.			Percent		
	GON	Donor	Total	GON	Donor	Total
Primary Health Care	235860	332070	567939	41.53	58.47	100.0
Non-Primary Health Care	134580	42204	176784	76.13	23.87	100.0
Total	370440	374283	744273	49.74	56.26	100.0

iv. Household Health Expenditure

Household expenditures are the largest source of health care financing in Nepal. These expenditures include the payment made by the households for the services provide by government health care facilities, mobile clinics, community based services, private nursing homes, private doctors, pharmacies, INGO/NGO facilities, traditional practitioners etc. (Table 9). According to the Central Bureau of Statistics (CBS) Living Standards Measurement Survey, household expenditures for health in 1944/95 amounted to Rs. 8.102 million or approximately six percent of total household expenditures. This represents an increase from approximately four percent since 1984.

Table 9: Annual Household Expenditure on Health by Uses: 1994-1995

Exp entiture	GON Care				Private Care				INGO NGO	Tradi tional	Grand Total
	Hospitals	Clinics	Mobile Camp	Total	Pharm acies	Home Visits	Other Private	Total			
MI.Rs.	2.225.01	2.448.44	104.71	4.778.21	540.44	119.78	2.176.46	2.836.69	68.61	418.6	8.102.11
Percent	27.46	30.22	1.29	58.97	6.67	01.48	26.86	35.01	0.85	05.17	100

Source: ADB, National Accounts Analysis and Social Sector Reforms in Nepal. A Report for the Education and Health Sector Assistance Strategy Study, November 14, 1994.

v. Household Expenditures for Private Health Services

In many countries, consumer demand for health care has outstripped the ability of the public sector to provide services. With respect to both quantity and quality, consumers have turned to the private sector. This has occurred in countries at all levels of development, as austerity in government economic policy has led to longer waiting times, shortage of essential drugs and supplies, and deterioration of building and health facilities. It has also occurred, for different reasons, in some newly industrializing countries, such as Thailand, where rapid income growth has been experienced.

The share of health services provided by the private-for-profit sector in Nepal is substantial. With the incentive given under the economic reform programmes, the size of private health sector in Nepal has significantly increased since the mid-1980s. In recent years the private health care providers have been an important component of Nepal's urban health care delivery system. The private sector includes private practitioners both trained and untrained as well as government personnel who provide services after hours in their own clinic.

The information presented is derived from a study of the role of the private sector in health conducted in 1996/1997 by PHCP/GTZ.

Private Nursing Homes: Private sector participation in the nursing home sector started with the establishment of two nursing homes in 1985. The number of registered private nursing homes reached 61 in 1996 out of that number only 26 nursing homes are functional at present. Most of the nursing homes have inpatient facilities including diagnostic services like X-ray, pathological laboratories, ECG, USG endoscopy etc. Doctor-bed ratio and other para medical staff ratios seem to be quite high. An estimated four to five thousand people a day receive outpatient services from private nursing homes.

Only 20 out of the 29 nursing homes surveyed provided financial information, which indicates a total of Rs. 37.67 million spent on private nursing home care in 1994/95. This is an average of Rs. 1.88 million per private nursing home. Applying the per nursing home average to all operating nursing homes, the total amount spent for private nursing home services is approximately Rs. 54.5 million.

Private Diagnostic Centres: There are substantial number of private diagnostic centres providing X-ray, pathology, ECG, USG, endoscopy and other diagnostic services. Out of 30 diagnostic centers surveyed, seven did not furnish financial information. The information provided by the remaining 21 diagnostic center revealed a total Rs. 7.44 million spent for private diagnostic services, an average of 323.47 thousand per diagnostic center. Applying the per diagnostic center average to all private diagnostic centres, the total amount spent for private diagnostic service is approximately Rs. 9.70 million.

Pathological Laboratories: Information on private pathological laboratories does not reflect the true picture of the amount spent for such services. Out of the 30 pathological laboratories surveyed, nine did not provide financial information. The 21 private pathological laboratories that did provide information indicated total expenditures of Rs. 4.72 million for laboratory services in 1994/95. This averages Rs. 224.59 thousand per laboratory. Applying the per laboratory average to all private pathological laboratories, the total amount spent for private pathological laboratory services nationally is approximately Rs. 6.29 million.

In summary, the combined expenditure figure for private-for-profit nursing homes, diagnostic and a pathological laboratory service in 1994/95 is estimated to be Rs. 70.5 million.

vi. NGO Sector Health Expenditures

The non-governmental organizations health expenditures encompass local and international NGOs, mission organizations, voluntary associations. The information presented is derived from a study of NGOs and INGOs conducted in 1996/1997 by PHCP/GTZ.

International NGOs: Information on 18 of 28 the INGOs operating in Nepal indicates expenditures of approximately Rs. 386 million for million for health and health related activities in 1994/45. Of the 18 INGOs, 10 are working in primary health care activities including child survival, family planning, reproductive health services, AIDS and STD Control programmes, eye care etc.

Among INGOs, the United Mission to Nepal (UMN) has the largest health programme with expenditures of approximately Rs. 177.7 million in 1994/95 accounting for 46 percent of the total INGO expenditures in health. UMN is involved in community health care, provision of hospitals based services and TB control.

National NGOs: A study of 32 NGOs indicates expenditures of approximately Rs. 284.67 million for health and health related activities in 1994/95. Among the NGOs surveyed the Nepal Red Cross Society (NRCS) was the largest with expenditures of approximately Rs. 14.32 million of health education and health care activities. The Family planning Association of Nepal (FPAN) was the second largest with expenditures of Rs. 72.19 million. NGO involvement in the provision of eye care services including the rehabilitation of the blind is significant with expenditures of approximately Rs. 13.90 million. Though there is an absence of detailed date, it is generally acknowledged a large percentage of the major national NGOs are dependent on external (international) source of funding.

Significant Problems

1. The ministry of Health does not have sufficient knowledge of a large proportion of the foreign assistance that flows to the health sector. It is not aware of the extent to which direct donor assistance occurs "outside" the Ministry.
2. Ministry of Health limits its focus to resources that are channeled through it, little emphasis is given to resources which flow to the health sector "outside" the Ministry.
3. Funding for the Ministry of Health as a percentage of GDP and the national budget remains inadequate in comparison to other social sectors particularly education and local development. The health sector's share of the revenue surplus has remained modest in comparison to other social sectors.
4. The policy regarding loan assistance for the health sector is neither clearly defined nor consistent. The position of the National Planning commission and Ministry of Finance frequently changes regarding the health sector's use of grant assistance rather then loans.

5. The distinction between recurrent and capital expenditures in the health sector is ambiguous. Information on central and district level expenditures is not transparent, making it difficult to analyze the efficiency of the Ministry of Health. Similarly, the distinction between primary and non-primary health care for financing and budgetary purposes is misleading, (e.g. district hospitals are included under primary health care though many of their activities are directed to the provision of secondary care.)

Policy Issues/Policy Implications for Health Care Financing and Expenditures

1. There is a need for the Ministry of Health to be apprised of all funds flowing into the health sector and to take account of these resources in formulation health sector plans and programs. Towards that end it is necessary to regularly update the national health accounts (NHA) prepared by the Asian Development Bank. The NHA should be used as input for increasing the efficiency of health sector allocations and as a tool for monitoring and evaluation of the effects of health reform.
2. There is a need to increase the health sectors share of national budget in line with the 20/20 initiative. (The 20/20 initiative at least 20 percent of development aid from donors and 20 percent of developing country governments' spending be devoted to basic social services; health, family planning, nutrition, education and water and sanitation). Further, there is a need to develop alternative financing mechanisms, which seek to mobilize non-governmental funds to support health development.
3. There is a need to define the role of NGO and private sectors in the financing of health services (see Chapter 4 "Essential Health Care at the District" and Chapter 5 "Essential Health Care Beyond the District).
4. There is a need to clearly define GoN policy towards the use of loan instruments to support health sector development.
5. There is a need to clearly distinguish between recurrent and capital expenditures: clarify the definition of primary and non-primary health for financial and budgetary purposes: and make information on central and district level expenditures more transparent.
6. There is a need to provide supplementary inputs for medical supplies, medical equipment, operation and maintenance costs etc. in order to make spending on personnel cost more effective.
7. There is the need for an inter-sectoral coordinating body with access to information on health expenditures for all ministries, INGOs/NGOs and the private sector. The coordination body should be chaired by the Ministry of Health with representatives from government, INGOs/NGOs and the private sector.

vii. The Role of the Public, Private and NGO Sectors in Financing and Provision of Health Services

Government policy on the role of the public, private and NGO sectors in the financing and provision of health care services focused on three principle areas. These include

privatization; the use of community financing schemes particularly with respect to the supply of essential drugs; and income generation at public facilities.

Beginning with the Seventh Five-Year Plan, GoN has recognized, supported and encouraged private sector involvement in the provision of health services and training of human resources. This has been accomplished through a combination of "Passive and "Active" privatization policies. In pursuing privatization policies, GoN has not relinquished its regulatory role.

In terms of "passive privatization" GoN has provided a tolerant regulatory environment allowing market forces to encourage private investors to enter the health care sector. That is the public's demand for a higher quality and broader range of health services than are available generally in the public sector. GoN policy permits the private sector to extend health services through the establishment of hospitals, health units, nursing homes, laboratories and diagnostic facilities etc. GoN policy also permits private sector involvement in the training of medical and paramedical personnel without financial liability to GoN. Private medical schools and training institutions may be operated after having obtained the necessary permission from GoN. They are subject to minimum prescribed standards. NGOs and associations are similarly permitted and encouraged to provide health services under the prescribed policies of GoN.

In addition to allowing the existing market forces to encourage private sector involvement in the provision of health care. GoN is pursuing an active privatization policy. The government provides import duty waivers for the purchase of goods necessary for the operation of private health facilities e.g. medical equipment, ambulances, etc. The government also makes available public facilities to private sector training institutions for training of students.

Since mid-1980s, under the combination of passive and active privatization policies, private nursing homes in Nepal have witnessed extraordinary growth, providing important health services in selected urban area. As of 1996 there were 58 registered nursing homes of which 26 are in operation. Available information on 18 nursing homes indicates that their investment in 1992/93 amounted to Rs. 3.8 million, averaging Rs. 0.2 million per nursing home. Indicative of the positive climate for nursing home development, nursing home investment is estimated to have increased to Rs. 4.83 million in 1993/94. This represents 0.5 percent of the total resources available to the health sector in 1993/94.

The second area of emphasis in defining the appropriate role of public, private and NGO sectors is community-financing schemes. The emphasis on community financing schemes is linked to GoN’s focus on the expansion of basic health services to the rural masses as a mean of attaining the goal of "Health for All by the Year 2000." As part of that strategy, GoN is establishing sub-health posts in each village development committee. In implementing that strategy, GoN recognized that a regular and adequate

supply of essential drugs thorough out the year is necessary for meeting the health needs of the community. However, the government also recognized that budget constraints would not permit it to meet the increasing demand for drugs. Thus the necessity to institute alternative funding mechanisms for assuring drug supply, within this context GoN has encouraged and supported the development of drug cost-sharing and cost recovery schemes undertaken in collaboration with its INGO/NGO and donor partners; including but not limited to:

1. Cost sharing – *British-Nepal Medical Trusts Cost Sharing Drug Scheme* where all patients attending either a health post or hospital would be required to pay a token registration fee and per-item charges for essential drugs. The patient is entitled to a full course of treatment, including inpatient treatment if needed. The BMNT scheme covers 33 health posts in four districts).
2. Cost-recovery – GoN/WHO *Community Drug Supply Scheme* recovers some of the costs for essential drugs through a token registration fee. GoN/WHO scheme covers 122 health posts in eighteen districts; *Family Planning Association of Nepal Drug Revolving Fund* is functioning in 1.000 VDC in 33 districts.
3. The use of local merchants to provide drugs – British-Nepal Medical Trusts Hill Drug Scheme where "Kirana Pasal" shopkeepers who principally sell food and dry goods in a village are on contract with BNMT Drugs Project. The shopkeepers buy selected basic drugs from BNMT and to sell them at the shop at fixed prices with a set profit (12.5% in 1993). The Hill Drug Scheme covers approximately 30 small retail shops in seven districts; and
4. Health Insurance – *Lalitpur Medical Insurance Schemes* initiated by the United Mission to Nepal in which subscribing households' pay a premium established by a community health committee. The premiums are different for different health posts. The insured households are entitled to free services with provision of whatever drugs are appropriate for an unlimited number of visits during the year. Patients referred to the Patan Hospital with referral paper and insurance card are taken to a special registration and to an appropriate doctor. There is a reduction in the OPD bill, the necessary drugs are provided free. The insurance scheme covers five health posts in one district.

The third area of emphasis in defining the appropriate role for public, private and NGO sectors is income generation at public facilities. Within this context GoN provides annual lump sum grants to zonal and central level hospitals. The hospitals operate with hospital development boards established under the Development ACT 2013. These hospitals are authorized to establish service fees and maintain revenues thus generated for use at the boards' discretion.

Though limited in scope, Nepal is experiencing the establishment of health cooperatives, which may offer an alternative means of providing health care services.

Policy Issue/Policy Implications for the Role of Public, Private and NGO Sectors

1. There is a need to establish base line data addressing government health budgets, private health expenditures, cost sharing and the extent of public, private and NGO participation in the health sector at the district level. Using these data policies for

defining and implementing the role public, private and NGO sectors in the provision of health care can be developed (active and passive privatization).

2. There is a need explore the feasibility of contracts between government and non-government entities including NGOs and private providers. Among the type of arrangements that should be studied are arrangements for private practice at government facilities; establishing private wings in government hospital; contraction with NGOs for provision of service and/or attachment of NGO staff to work in government facilities. Feasibility studies also should be considered for contracting with private-for-profit clinics, private-nursing homes and hill shopkeepers (provision of drugs); and contracting of non-medical services (security, cleaning and maintenance, laundry etc.) Contracts between the VDCs, which will be responsible for basic health services and others, e.g. NGOs, private sector etc. should also be explored (see Chapter 4 "Essential Health Care at the District" and Chapter 5 "Essential Health Care Beyond the District").

L. Inter-Intra-Sectoral Co-ordination and Decentralization

i. Inter and Intra-sectoral Co-ordination

Background

Health development requires a multi-sectoral approach with effective coordination among government agencies, private sector, NGOs, INGOs, and donor partners. The National Health Policy 1991, Eighth Five-Year Plan (1992-97) emphasized active co-ordination as one of the policy guidelines for health sector development, The formation of committees has facilitated the active participation and co-ordination at the national level include committees for safe-motherhood, AIDS, polio eradication; and nutrition. The efforts of these inter-sectoral co-ordination committees have produced national plans of action for safe-motherhood, AIDS/STD, and nutrition. Supplementing the national co-ordination committees, are meeting among MOH, bi-and multi-lateral donors, NGOs, INGOs, and universities. The inclusions of the private sector in inter and an intra-sectoral co-ordination mechanism is limited, though they do on occasion participate in MOH workshops and consultation meetings.

Social Sector and Population Sub-committees have been established for the purpose in accordance with the new District Development Act - 1991. The Sub-Committees are responsible for co-coordinating health activities within the district including the formulation of annual health plans for submission to the MOH

Significant Problems

1. There is a widely held perception that health should only be the concern of MOH.
2. Health is viewed in isolation, sectoral ministries, bi and multi-lateral donors rarely consider the impact of their activities on health or the affect of health and health interventions on other sectors.

3. There is a lack of adequate policy guidelines and strategies for co-ordination of policy issues and mechanisms for assuring appropriate and effective policy analysis.
4. There is no effective mechanism to assure co-ordination at central, regional, district and local levels between health and other related ministries specially housing and physical planning including water/sanitation; education; agriculture; and local development.
5. There are no mechanisms to enforce effective co-ordination among ministries, private sector, NGOs, INGOs, bi and multi-lateral donors.
6. The existing formal co-ordination committees are not functional.
7. Mechanisms are lacking for the dissemination of information on policies and plans among ministries which impact health development.
8. The necessary rules and regulations are absent for the effective implementation of the District Development Act and Village Development Act.
9. Lack of specific strategies to implement the policies of National Health Policy 1991 and Eight Five-Year Plan on participation of private sector and NGOs.
10. Lack of a unit in MOH and DHS with responsibility to co-ordinate NGO and private sector involvement.

Policy Issues/Policy Implications for Inter and Intra Sectoral Co-ordination

1. The perception that health only is the concern of the MOH needs to be changed. It is necessary for sectoral ministries, bi-and multi-lateral donors to consider the impact of their activities on health and the effect on health interventions on other sectors.
2. There is a need to develop mechanism to ensure ministries and their donor partners effectively co-ordinate among themselves and with other sectors.
3. There is a need for the development of policy guidelines and strategies for co-ordination of policy issues. An effective mechanism for health policy analysis is necessary.
4. There is the need to identify/establish units within MOH at all levels with the responsibility to co-ordinate NGO and private sector involvement in health development. It is necessary to provide the units with the required human and financial resources to fulfill their responsibilities.
5. There is the need to develop a mechanism to disseminate information on policies, plans, and programmes among ministries, NGOs, private sector and donor partners.

ii. Decentralization

Background

GoN has been moving towards decentralization for nearly three decades with several attempts made to ensure full decentralization at the local level. Following the restoration of democracy GoN adopted new legislation, which authorized local level elected institutions (the district, municipalities, and the VDCs) to manage development programs including health. Among these acts were the District

Development Committee Act 1992, municipality act-1992 and village development committee act-1992. This legislation devolves essential health programmes to lower levels of government. The programmes devolved to the VDCs and municipalities include environmental sanitation, prevention and control of communicable diseases and epidemics; health education, record keeping of vital statistics and rabies control. In addition municipalities also are responsible for food hygiene, primary health care to the urban population and arrangement of ambulance services.

The DDC Act states that all district level development activities performed by the district through government and semi-government offices will be assessed by the DDC and submitted to the district assembly for approval. After approval the programs will be launched, directed, supervised, monitored, and evaluated by the DDC.
The District Development Committee by-laws mandate four committees to develop and supervise district level development planning. As one of the four committees, the Health and Social Committee is responsible for health among its other sectoral responsibilities. The committee prepares plans and submits them to the District Development Program Co-ordination Committee (DDPCC). The DDC Chairperson chairs the DDPCC; its members include members of the four sub-committees and heads of the district line agencies. The DDPCC reviews the plans and forwards them to DDC for approval.

The DDC then instructs the appropriate departments to prepare the plan and submit it to the District Assembly. The District Assembly approves the individual plans and informs the concerned offices about any changes or alternations in the proposed plan. The plans are then forwarded to the central level line ministries.

Significant Problems

1. The main constraint to effective decentralization is the excessive centralization of power. There is an ambivalence or unwillingness on the part of the central level bureaucracy to delegate authority to local institutions. This reluctance is not unique to MOH but is common throughout government.
2. Actions taken at the district level and below often do not comply with the provisions or spirit of the District Development Committee Ac, Village Development Committee Act or Municipality Act.
3. Local authorities have not received adequate orientation regarding decentralization policies and plans. As a consequence, they are uncertain of their roles and responsibilities and in many instances are reluctant to take decisions.
4. Institutional capacity at the district level and below is inadequate to fulfill its role as mandated under the decentralization.

Policy Issues/Policy Implications for Decentralization

(See also Chapter 2 F Management and Organizational Issues in the Public Sector and Chapter 10 Policies for Health Management and Organization in the Public Sector)

1. The existing Health and Social Committee at the district level should be strengthened through the addition of representatives from NGOs and the private sector.
2. There is a need to develop long-term plans for the decentralization of primary health services at the district level ensuring a sequenced devolution of services up to the VDC level.
3. There is a need to ensure that DPHO provides the necessary support for the village based primary and preventive health care system.
4. The authority to manage additional district budgets for decentralized health programmes should be vested in the DDC and its newly expanded Health and Social Committee.
5. A system of programme budgeting needs to be developed at the district level to manage the new village based health system.
6. The DDC and VDC should develop their capacities to evaluate the effectiveness of their programmes so that they can plan and negotiate for their budgets accordingly.
7. Districts should develop a plan for local support and resource generation. The plan could include the allocation of district resources to the VDC and SHP level and include support for local resource mobilization schemes. It is critical that money raised through local resource generation be kept at the local level and used to improve the quality of care.

M. Management and Organizational Issues in the Public Health Sector

i. Strategic and Operational Planning

Background

Long Term Planning – Long term planning for the health sector is currently focused on the development of a twenty-year prospective plan. The plan is prepared by the Ministry of Health in collaboration with a broad range partners in health and related sectors, and submitted to the National Planning Commission for approval and necessary action. Based on the policy framework established in the twenty-year prospective plan, the five-year plans are developed. Programme specific policy statements, goals, objective and service targets are derived from these plans that guide Ministry of Health activities.

Short Term Planning – Five-year plans are prepared by the National Planning Commission in collaboration with the sectoral ministries. The Ministry of Health formulates policy and issues directives in accordance with the National Planning Commission guidelines and containing relevant specific targets are set by the Department of Health Services. In December the Ministry of Health request the Regional Health Directorates to prepare their plans and budget based on the policy and issues directives and targets. The Regional Health Directorates in turn ask the

District Development Committees which requests the yearly programme from the District Health Officers. By the end of January the District Health Offices submit the annual programme and budget to the Ministry of Health through the Regional Health Directorates. Between February and March the Ministry of Health analyses these proposals, completing discussions with the districts in March and with the Ministry of finance by April. Following a detailed review, the National Planning Commission finalizes the proposal. In June the Ministry of Finance presents the budget plans with a starting date of July to Parliament.

Ad-hoc Planning – Despite the existence of a formalized short-term and annual planning process, various divisions, departments and centers independently produce their own plans.

Significant Problems at Central Level

1. The planning process is centralized. All major policy decisions regarding planning including establishment of targets are taken at central level based on central level budget, capacity and priorities.
2. The preparation of plans is generally behind schedule at each stage of the planning process.
3. With the exception of some routine statistics, the data that flows from the district to the region and to central level generally is not used in the planning process. The routine statistics often are sent to the centres even though the districts note inaccuracies.
4. Quite often the final annual plan is prepared at the central level before the arrival of the proposed plans from the districts.
5. Plans at all levels are not need based. Previous year's targets are used or are adjusted according to the population growth rate or by an addition of a 10% increase. The central level adds 10% to previous year's plan to adjust for recurrent activities.
6. District proposals are not returned to the region or districts for revision, though occasionally clarifications are requested from district managers or departmental heads.
7. Inter-and intra-sectoral co-ordination in planning is weak. This is particularly true of co-ordination between the private sector, NGOs, and local authorities, as well as between different units of Ministry of Health (e.g. the HRH Master Plan and National Health Training Centre Master Plan, both dealing with planning for personnel in the health sector are developed separately).
8. Gender sensitivity is not systematically embodied in planning policies.
9. High level politicians often are not aware of the key health issues and strategies adopted for addressing health sector concern.

Significant Problems at Regional Level

1. Actual planning generally is not done at the regional level. The regions usually limit themselves to consolidation the individual district plans, making superficial changes and then forwarding the plans to central level.
2. Regional Health Directorates are often bypassed with District Health Officers sending their plans directly to the central level or Department of Health Services.

Significant Problems at District Level and Below

1. There is limited continuity in the planning process from one year to the next.
2. There are no mechanisms to guarantee community representation in the planning process according to the caste, class and gender. Mechanisms are lacking to receive fee back from services users regarding quality, quantity and appropriateness of service provided.
3. NGO and private sector needs are not considered in the annual planning process though they have an increasingly significant role in the district.
4. The District Development Committee's approved plans are not accepted in their original form by higher authorities at the center.

Constraints in Addressing the Significant Problems of Strategic and Operational Planning Central Level

1. GON has reserved for the central government wide-ranging discretionary powers, which effectively limit decentralization even after the adoption of three local government acts (District Development Committee Act, Village Development Committee Act, and Municipality Act, 1992). The centralized planning process is a reflection of this situation.
2. The central level does not have an effective, standardized planning system. It lacks sufficient numbers of trained personnel to synthesize and undertake an ongoing review of the 75 district plans.

Regional Level

1. Regional Health Directorates have planning responsibilities but neither authority nor capability in term of adequate manpower, skills etc.
2. Concerned section-heads in the regions do not have training in planning methodologies.

District Level and Below

1. Resources and skills to support the planning process are limited at the district level, a situation further exacerbated by the frequent transfer and deputation of staff.
2. There is an absence of delay in the receipt of planning guidance from central level.
3. Planning meetings only are held with the sub-committee of the DDC for Health and Social Services. Consultations with the community health workers (e.g. FCHV and VHW) and the community as to their felt needs has not been part of

the planning process. Training and orientation of the community and community health workers prior to programme implementation is lacking.
4. Fee back is not provided on information collected at district level and below.

Policy Issues/Policy Implications for Strategic and Operational Training

Central Level

1. High level politicians and government officials need to be aware of the health planning process and national commitments relevant to the health sector.
2. There is a need to incorporate the principles and procedures of decentralization into the planning mechanism. The necessary authorities need to be delegated to lower levels. Plans produced at lower levels within their delegated authority need to be acknowledged and accepted.
3. There is a need to strengthen strategic and operational planning skills at central level.
4. There is a need to match resource needs and allocations.
5. There is a need for timely distribution of planning guidance from central to lower levels.
6. There is a need for inter and intra-sectoral co-ordination in the planning process including planning within the Ministry of Health. NGO and private sectors need to be included in the planning process.
7. There is a need for a mechanism to assure full and meaningful community participation in the planning process.
8. The need to integrate gender sensitivity into the planning process.

Regional Level

1. There is a need to identify clear policies regarding the planning authorities and responsibilities of the Regions.
2. There is a need to grant Regions the required financial and human resources necessary for fulfilling their planning responsibilities.

District and Below

1. There is a need to devolve the necessary authority, financial and human resources to the districts in order that they can effectively carryout their planning responsibilities. Districts should be permitted to establish their own targets within national guidelines.
2. The need to develop and implement mechanisms for the active participation of the relevant committees, sub-district staff, community health workers, and the community participation in the planning process. These mechanisms should include representatives from the NGO and private sectors and ensure appropriate caste, class and gender representation.
3. There is a need to ensure that there is a single, functioning district level coordinating body in all districts.

4. There is a need to train and keep staff with planning skills in place and ensure compliance with existing policies and regulations regarding transfers and deputation.
5. There is a need to employ simplified reporting and planning mechanisms with uncomplicated formats.

ii. Financial Management

Background

Financial management involves central, regional and district levels. At the central level the National Development Council working through the National Planning Commission establishes overall sectoral priorities and allocation of funds. The Ministry of Finance (MOF) arranges release of budget including allocation of donor's funds. It authorizes the Ministry of Health to spend the budget in the approved programmes under prevailing financial rules of GON. Based on the authorization received from the MOF, the Secretary, MOH authorizes the Director General of Department of Health Services (DHS) to spend the budget on approved programmes, notifying the Financial Comptroller General's Office of the same. The Financial Comptroller General's Office is responsible for regulating spending procedures, releases budget through its District Treasury and comptroller's Office and performs final audits. The DHS forwards the programme and authorized the Regional Health Directorates and District Health Offices to make expenditures.

At the beginning of the fiscal year the District Treasury and comptroller's Office release the equivalent of $1/6^{th}$ of the previous year's expenditures to the respective offices down to the District Health Office Level. The funding is meant to cover recurrent expenditures including administrative expenses. It is viewed as a first installment against future reimbursements. For special programmes such as family planning and EPI, the DHS retains some portion of programmes budget, which is later disbursed upon the receipt of specific request from the District Health Office.

At the regional level, the Regional Health Directorate supervises expenditure procedures of the offices below it. At the district level, the District Health Office is responsible for all matters related to disbursement of funds by the district hospital and other facilities. Health posts and sub-health posts do not actually handle cash; rather their programmes are run with materials received from the DHO. The District Health Office distributes the targets and release budget to individual facilities within the district. At the end of each month the District Health Office is require to prepare a statement of monthly expenditures and request reimbursement from the District Treasury and Comptroller's Office. The District Treasury and Comptroller's Office in addition to releasing funds are expected to perform internal auditing on a monthly basis.

Significant Problems at Central Level

Financing

1. The overall size of the health sector budget is inadequate to meet health sector needs.
2. Grants and loans provided by the donor community often do not accurately reflect GoN’s health sector plans;
3. Donor funding is not effectively coordinated. Disbursement procedures are not uniform.

4. Existing cost-sharing and cost-recovery schemes, particularly community drug programmes and cost recovery schemes in Central and Zonal hospitals are hampered by the absence of appropriate policies and guidelines (e.g. fee exclusion policies, spending limit etc.)

Budgeting

1. The budget process is centralized. It neither supports the concepts of decentralization and "bottom-up planning" adopted by Government of Nepal nor reflects costing and expenditures by programme.
2. There is excessive reliance on incremental budgeting that is developing new budgets based on a percentage increase over the previous year's budget. Budgetary approaches are neglected that link budget to changing goals, objectives and priorities, programme performance, need or programme requirements etc. (e.g. programme budgeting, performance based budgeting zero based budgeting etc.)
3. The real costs of programmes and their correlation with impact on service delivery and health status are not known.
4. Integrated programme budgets do not exist even though programmes are meant to be integrated at eh implementation level.
5. Local revenues generated for use by the health sector are not taken into account in annual budget preparations.
6. An excessive portion of the development budget (in excess of 50%) is retained at the central level.
7. Budgets (with plans) prepared by District Health Office generally are not used by the planning Division of the DHS in annual budget preparation.

Accounting

1. There are extensive delays in submitting statements of accounts and expenses particularly in relation to donor funded projects.
2. "Direct funds" from donors to the Ministry of Health often are not reported nor accounted for.
3. The accounting function is centralized and reflects a vertical programme approach despite integration in service delivery.

Auditing

1. There are excessive delays in clearing the Ministry of Health's continuously increasing audit objections, thus threatening budget releases.

Significant Problems at Regional Level

1. Regional Health directorates are supposed to exercise financial control and supervision. In practice they have no role in financial management.

Significant Problems at District Level and Below

Financing

1. Financing to cover a portion of recurrent and capital cost are available from local sources including District and Village Development Committees. However such potential sources of financial are not pursued by the Ministry of Health.
2. In determining fee structures, ability and willingness to pay often is not considered.

Budgeting

4. Budgetary practices at the district level and below do not support the concept of decentralization and "bottom-up planning" adopted by Government of Nepal. There is no clear mechanism for matching local perceived needs and budget constraints.
2. There is excessive reliance on incremental budgeting to exclusion of other budgetary approaches that support and accommodate; changing health sector goals, objective and priorities for the district level and below; programme performance etc.
3. The development budget is fragmented at the district level. A District Health Office typically handles 5 to 10 development budgets for specific programmes. The multiple budgets often lead to duplication funds for some purposes and insufficient fund for others.
4. Service delivery units are expanded without assurance of the necessary financial resources for staffing, operations, and maintenance.

Accounting

1. There are extensive delays in submission of statements of accountants and expenses. Which are necessary of reimbursement of expenditures and this is particularly serious problem in terms of donor project.

Auditing

1. Health committees have authority to approve health expenditures; however they often have little understanding of financial procedures and regulations. The lack of understanding increases the potential for irregularities and misappropriation of funds.
2. The District Treasury Office does not audit on a monthly basis as prescribed.
3. Auditing focuses on determining whether required documents have been completed regularly. Performance auditing which has been accepted in principle is not carried out.

Constraints in Addressing the Significant Problems of Financial Management

Financing

1. The role of the private, INGO/NGO donor and public sectors in health care financing are not well defined. Health sector financing provided by private and NGO sectors, some INGOs and donors are not considered in public finance and budgeting exercises.
2. There is no specific vision, long term goals and objectives or intermediate strategies for either developing alternative financing mechanisms or adapting appropriate existing, cost-sharing/cost recovery schemes for nationwide implementation.

Budgeting

1. There is a shortage of adequately trained personnel with the appropriate knowledge and skills required to implement alternative budgetary approaches such as performance or programmer budgeting, zero-based budgeting etc. The necessary data for such alternative budgetary approaches is similarly lacking (e.g. performance data, programmer costing/unit costing etc.)

Accounting

1. The health sector lacks sufficient numbers of adequately trained finance/accounting staff to effectively carry out the accounting function or cope with the multiple accounting requirements of donors. The shortage of such personnel is particularly server at the district level.
2. Staffing patterns for accounting staff are not related to workload, which has had a negative effect in high workload district.
3. Uniform accounting and reporting systems developed do not meet both donor and GON requirements.
4. The accounting system has not been computerized at any level.

Auditing

1. There is a lack of trained auditors in the health sector particularly at district level.
2. A specific chart of accounts for health sector programmers, facilities and institutions is lacking. Categories necessary to account for health-related expenditures differ from other sectors, nonetheless auditors demean that the standard categories of accounts be followed.

Policy Issue/Policy Implications for Financial Management Central Level

Financing

1. The health budget should be increased.
2. There is need for a clear definition of the roles of the private, INGO, NGO bi-and multilateral donors, and public sector in health care financing. Similarly there is a need for effective mechanisms to assure non-government funding actively supports GoN's health sector plans and priorities.
3. There is a need to include health sector financing provided by private, INGOs, NGOs, bi-and multilateral donors in public finance and budgeting exercises.
4. There is a need to develop uniform disbursement procedures across donors.
5. There is a need for a comprehensive and unified vision, goals and objectives, specific strategies and policy guidelines for implementing alternative financing mechanisms. This includes adapting appropriate existing, cost-sharing/cost recovery schemes for nationwide implementation.

Budgeting

1. There is a need to incorporate the principles and procedures of decentralization and "bottom-up budgeting" into the budget process. The necessary authorities should be delegated to lower levels. Budgets produced at lower levels, which are in compliance with budget ceilings and central level budget guidelines should be acknowledged and accepted.
2. There is a need to shift from a budgeting approach that solely relies on incremental budgeting, to one that makes greater use of methods that link budget with goals, objectives and priorities, performance, outcomes etc. (e.g. programme budgeting, performance budgeting, zero based budgeting).
3. There is a need for budgetary policies and practices that more effectively encourage and support integrated program implementation at the local level.

4. There is a need to revise disbursement policies to allow a greater percentage of the development budget to be allocated to regional, district level and below.
5. There is a need to include locally generated funds (cost-sharing, cost-recovery schemes, monies provided by local NGOs etc) in the decentralized budgetary process.
6. There is a need to calculate real programme costs to allow for rational budgeting exercises under the decentralized budgeting system.

Accounting

1. There is a need to increase the numbers of trained of finance/accounting personnel within the health sector, particularly within the Ministry of Health. It is necessary to ensure that they possess the necessary knowledge and skills to fulfill their job responsibilities.
2. There is a need to develop a specific chart(s) of accounts for the health sector (programmers, facilities and institutions).
3. There is a need to make GoN and donors accounting and reporting systems less burden some.
4. There is need to develop of systematic recording and accounting systems for Ministry of Health "directly funded" donor contributions.
5. There is a need to integrate the system of vertical programmer accounting.

Auditing

1. There is a need to immediately clear existing audit objections and address future audit objections as issued.
2. There is a need to provide trained auditor for the health sector who are skilled and knowledgeable in health sector accounting practices.

Regional Level

1. There is a need to define clearly the Regional Health Directorate's role and responsibilities for financial management, providing the necessary authority and resources as warranted.

District Level and Below

Financing

1. There is a need to pursue local sources of financing to augment central level funding of health services (e.g. District and Village Development Committees).
2. There is a need to consider ability and willingness to pay in establishing fee structures in cost sharing/cost-recovery schemes.

Budgeting

1. There is a need for a decentralized budget process that encourages and supports "bottom-up-planning" at the district level and below.
2. Reliance on incremental budgeting should be reduced. Greater use should be made of budgetary approaches that support and accommodate changing health sector goals, objective and priorities for the district level and below; programme performance etc.
3. There is a need for an integrated budget to support integrated programme implementation at district level and below. The integrated budget should incorporate presently fragmented development budgets.
4. There is a need to assure the necessary financial resources for staffing, operations, and maintenance as a prerequisite for expansion of service delivery units.

5. There is a need to include in annual plans developed by the planning Division of the DHS, budgets prepared by District Health Offices, which conform to MOH budget guidelines.

Accounting

1. There is a need to increase flexibility in of disbursement of funds.
2. There is a need for adequate numbers of trained accounting staff skilled and knowledgeable regarding the specific chart(s) of accounts for the health sector programmes, facilities and institutions.

Accounting

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2. There is a need for adequate numbers of trained accounting staff skilled and knowledgeable regarding the specific chart(s) of accounts for the health sector programmers, facilitates and institutions.

Auditing

1. There is a need to enhance the Health Committee's understanding of financial procedures and regulations.
2. There is a need for trained auditors skilled and knowledgeable in term of health sector accounting systems, financial procedures and regulations.
3. There is a need for the District Treasury Office to perform audits on a more regular basis, preferable monthly.

Iii Logistic Management

Background

The Ministry of Health's logistic activities are managed at the central level by the logistics Management Division. Department of Health Services (LMD); at the regional level by the Regional Health Directorate and the Regional Medical Stores; and at the district level by the District Health Office.

The transit warehouse in Pathlaiya receives programme supplies; equipment, instruments and machinery shipped overland are received by the transit warehouse in Pathlaiya. Materials arriving by air in Kathmandu are received in the Teku warehouse. From these warehouses, the materials are distributed to the regions or districts, as needed using private or MOH carriers. District Health Office (DHO) arranges transport from the district to peripheral levels.

Annual indent supplies are delivered either to regions for repacking and forwarding to the districts, or directly to the districts depending on where the procurement was done. Once in the districts, the DHO arranges onward transportation to the health facilities.

A programme fro strengthening the logistics system was initiated in 1994. Since then, a logistics management information system (LMIS) has been implemented in 75 districts; 1800 stores have been cleaned, reorganized and equipped; and 3,900 MOH personnel have been trained in LMIS and store management. Procurement strengthening activities are underway, essential drug procurement has been

decentralized to 30 districts, a national distribution team is being put in place, and an inventory control system is being implemented.

Significant Problems at Central Level

Procurement

1. Needs are difficult to quantify – Procurement plans do not always reflects actual need due to a lack of information from GoN and NGO facilities, Furthermore, resources are allocated on an institutional rather than on a population or demand basis.
2. Lengthy procurement process – GoN's cumbersome tendering rules and regulations, insufficient numbers of adequately trained personnel at LMD, and a lack of documentation on the procurement process result in a prolonged procurement process. Developing tenders and evaluating bids is time consuming because of a lack of product specifications and the absence of criteria for evaluating bids. Further complications arise from ill-defined quality assurance procedures.
3. Procurement is not well planned – Poor communication and co-ordination between the Logistics Management Division and other division results in LMD being unable to procure supplies according to programme requirements.

Distribution

1. Distribution requirements are not well planned due to a lack of inventory management procedures, lack of information on current stock and utilization rates, and lack of co-ordination among LMD, other divisions, and donors that procure supplies for ministry programs.
2. The Minister of Health, which is required to provide vaccine and contraceptives to NGOs, does not include these needs in the LMD projections.
3. Transportation is not always available when needed. There is a lack of communication between LMD and other divisions, the lack of authority to requisition vehicles when needed and poor performance by contract carriers.
4. Storage space is not adequate given current procurement and distribution practices.
5. Some unusable goods are difficult to dispose of due to complex regulations.

Logistics Managements Information System (LMIS)

1. The LMIS is not institutionalized in LMD due to the lack of personnel and resources. LMIS is operated with the support of a local NGO.
2. LMIS dates are not being used routinely for planning, monitoring and evaluation at the central and peripheral levels.

Significant Problems at Regional Level

Distribution

Regional Medical Store (RMS) has difficulty in carrying out their functions in a timely manner due to:

1. The lengthy process of obtaining resources from the Regional Health Directorate; the RMS do no have their own budget allocation.
2. The prolonged delivery time of indent drugs and the protracted period of time require repacking indent items.
3. The lack of space in some regional stores for storage and repacking.

Repair and Maintenance

Vehicles and equipment cannot be repaired quickly due to:

1. The protracted process obtaining budget and authorization from the Regional Health Directorate for such activities.

Supervision and Monitoring

1. The lack of budget for supervision and monitoring at RMS makes regular visits to lower level facilities problematical.

Significant problems at District Level and below

1. Supplies cannot always be delivered in time due to a lack or the uncertainty of availability of transport.
2. Stock outs and overstocks exist due to inadequate procurement planning, lack of an inventory control system and insufficient resources to satisfy demand.
3. Stores are not always well managed due to a lack of supervision and the absence or transfer of trained personnel.
4. Districts lack the skills and resources to manage all their logistics activities.
5. Storage space and conditions are not always adequate due to lack of resources, use of rented facilities, and lack of supervision.
6. Complex regulations make disposing of expired and unusable items difficult.

Constraints in Addressing the Significant Problems of Logistics Management

1. There is a lack of clearly identified transportation budgets at all levels of the distribution system.
2. There is a lack of adequately trained personnel at all levels.
3. Frequent transfers of trained personnel at all levels.
4. GON regulations make procurement a complicated and time-consuming process.
5. There is a lack of authority and the necessary resources to carry out key LMD responsibilities such as operation of the LMIS.
6. Regional Medical Stores lack resources and budgetary authority to carry out their logistics management responsibilities.
7. There are restrictions on the payment of commercial rates for transportation by GoN.
8. GoN daily allowance rates for supervision are inadequate.
9. There is a lack of clear lines of authority between Regional Medical Stores and LMD.
10. Regulatory complexity makes it difficult to dispose of damaged, expired, and out-of-service items.

Policy Issues/Policy Implications for Logistics Management

1. There is a need for the development and implementation of a needs-based supply system which takes into account the district level essential drug procurement system and the vaccine and contraceptive needs of NGOs.
2. There is a need to modify procurement regulations and the pre-qualification system for manufactures and suppliers to allow more flexibility and faster contracting arrangements.
3. There is a need to develop appropriate bidding documents and technical specifications for medical supplied and equipment.
4. There is a need to decentralization procurement authority to lower levels.

5. There is a need to create a new logistics cadre with a well-defined career ladder to minimize the impact of transfers and to reduce the loss of expertise from the logistics system.
6. There is a need to provide LMD greater operational control over the resources needed to carry out its responsibilities (personnel, vehicles, etc.)
7. There is a need to create a separate budget line within LMD for transportation.
8. There is a need to create an LMIS sections in LMD with adequate number of trained staff and resources to carry out those functions.
9. There is a need to streamline auction, disposal, and write-off procedures for damaged, expired, and out-of-service items.
10. There is need to convert LMD to a "Centre" with an autonomous accounting system.

iv. Health Facilities Maintenance and Development

Background

Importing equipment at regular intervals has become a regular phenomenon necessitated by the absence of an established system for repair and maintenance. Though the Logistics Management Division (LMD) is responsible for repair and maintenance of buildings, machinery, equipment and medical instruments, it has been severely limited in carrying out these responsibilities.

Significant Problems

1. Most of the Primary Health Centres were upgraded from existing health post. Consequently the physical facilities and layouts are inadequate to meet GoN guidelines.
2. Most of the health posts are located in sites much smaller than required for their proper functioning.
3. Most of the Village Development Committees were not provided clear instructions and guidelines regarding the space requirements and physical layout of the sub-health posts. As a consequence the sub-health posts were established in facilities with inadequate space.
4. Except for newly built facilities most of the existing health facilities lack basic amenities such as water supply and latrines.
5. The lack of policies, guidelines and procedures for repair and maintenance of physical facilities, machinery, medical instruments and equipment (preventive maintenance) results in ad-hoc crisis management practices.
6. The lack of comprehensive policies or guidelines for procurement or receipt of donated of equipment results in an inventory comprising a wide variety of makes and models of equipment. This makes it difficult to initiate a planned repair and maintenance system.
7. Spare parts rarely accompany equipment provided by donors. Much of this equipment is therefore discarded after a short period of use due to unavailability of spare parts.
8. A monitoring system to provide information for efficient equipment management including repair and maintenance requirements is needed.
9. There is lack of a separate budget for repair of equipment and the consolidated budget for equipment repair and repair and maintenance of other items such as vehicles, physical facilities, etc. does not provide sufficient funds for repair of equipment.
10. The Department of Health Services lacks qualified personnel and infrastructure for repair and maintenance.
11. The centralized approach to repair and maintenance (preventive maintenance) issues hinder peripheral institution from developing local potential. There is an acute shortage of adequately trained repair and maintenance personnel at the district hospital.
12. There is a lack of co-ordination among agencies involved in repair and maintenance (preventive maintenance) activities.

Policy Issues/Policy Implications for Health Facilities Maintenance and Development

1. There is a need to assure that instructions and guidelines regarding the space needs and physical layout of the primary health centers and sub-health posts are provided to VDCs prior to the sub-health posts establishment and upgrading of health posts to primary health centers.

2. There is a need to assure that existing health facilities have basic amenities such as water supply and latrines.
3. There is a need to formulate and implement a comprehensive plan, policies and guidelines in relation to equipment management.
4. There is a need for better co-ordination between public, private and NGO sectors in the area of repair and maintenance.
5. There is a need to ensure the availability of necessary personnel and infrastructure for repair and maintenance.
6. There is a need to formulate policies and guidelines for the procurement and donation of goods taking into consideration the use of appropriate and affordable technology.
7. There is need to ensure that donors comply with Department of Health Services standards concerning equipment specifications, spare parts and funding for spare parts.
8. There is a need to develop and implement an equipment management information system, which includes information on repair and maintenance requirements.
9. There is a need to separate the budget for repair and maintenance of medical equipment from the general repair and maintenance budget.
10. There is a need to establish a system for back-up services.

v. Human Resources Management

Background

The need of national policy and planning for human resource management in health has been long recognized. The main thrust of National Health Policy related to human resource management is to strengthen and make more effective health services currently provided and expand those services to the village level through proper management of appropriate human resources.

Significant Problems at Central Level

1. There are shortage of technical personnel and support staff.
2. The rules and regulations regarding placement, transfers, and deputation of staff are not strictly adhered to
3. There is a mismatch between staff responsibilities and competencies.
4. Central staff does not provide adequate supportive supervision for staff at the periphery.
5. There is a lack of incentives and an absence of career ladders and career management plans for various categories of staff.
6. There is an excessive amount of training, with only tenuous linkages to staff development and capacity building

Significant Problems at Regional Level

1. Regional Health Directorates lack the authority to undertake human resources management-related tasks for which they are responsible.
2. Regional Health Directorates suffer from vacant post, under-staffing and staff without the appropriate skills necessary for their positions.
3. Regional Health Directorates do not provide adequate supportive supervision for staff at the district level and below.

Significant Problems at District Level and Below

1. There is a constant shortage of adequately trained and motivated health personnel at all levels (unfilled posts and posts that are filled but unmanned).
2. There is a mismatch between staff responsibilities and competencies.
3. The rules and regulations regarding placement, transfers, and deputation of staff are not strictly adhered to.
4. There are fewer opportunities for academic training, and no scope for attachment to larger hospitals. There is less access to information, poor opportunities for private practice, inadequate school facilities for children and inadequate housing. Staff often suffers from personal and professional isolation.
5. Staff at the periphery does not receive adequate supportive supervision from District Health Offices.

Constraints in Addressing the Significant Problems of Human Resources Management

1. There is difficulty in resisting external pressure, which does not permit adherence to existing policy and rules regarding transfer and deputation. Commitment at the highest levels for a strict implementation of the relevant rules and regulations is not always present.
2. The lack of a performance oriented reward and punishment system and the absence of a supportive system of supervision, monitoring and feedback contributes to an attitude of negligence. This situation creates a major obstacle to staff development and job satisfaction.
3. Salaries and allowances are inadequate.
4. There is a widespread and pervasive belief that training is an incentive to compensate for low salaries and allowances rather than a means of staff development and capacity building.
5. Central level control of all aspects of human resources management leaves the regions and districts without the necessary authority to maintain their personnel in place.
6. Projections of human resources requirements are based on sanctioned posts and limited to Ministry of Health. The continued and expanding involvement of NGOs and the private sector in health services delivery is not taken into account in making HRH projections.
7. Production of health personnel is largely a supply-led phenomenon where course type, content and intake are determined by the capacity of the training institution. Consequently there is a mismatch between the health personnel requirements and the available supply.
8. There is a lack of co-ordination between the Ministry of Health and other ministries responsible for personnel matters which are further complicated by excessive and inflexible regulations and long bureaucratic delays.

Policy Issue/Policy Implications for Human Resources Management

1. There is a need to develop commitment at the highest levels for the strict implementation of existing policies, rules and regulations governing appointment, placement, deputation and transfer.
2. There needs to be strict adherence to the rules contained in the Civil Service Regulations and Health Acts. Staff selection and retention should be undertaken in transparent manner.
3. There is a need to introduce a performance based incentive system (rewards and punishments).

4. Difficult area posting need to be made more attractive to health personnel by providing proper working conditions, schooling, housing, facilities, monetary and career benefits etc.
5. There is a need for clear job descriptions for all levels of technical and support staff, based on standards and guidelines for the types of institutions in which they serve.
6. There is a need for an integrated system for supportive supervision of technical and support personnel at central, regional and district levels and below.
7. There is a need to explore the possibility of delegating additional authority to the Regional Health Directorates for recruitment and discharge/removal of staff.
8. There is a need to explore the possibility of giving the relevant health committees a broader role and greater authority for human resources management including supervision, performance appraisal, assessment of personnel requirements, etc.
9. There is the need to explore the possibility of legalizing the private practice of paramedical staff for the provision of certain services (e.g. ANMs, AHWs and HAs). Private practice by paramedical staff is an unacknowledged reality; legalization with appropriate oversight will begin to ensure a minimum level of quality for services which are a community necessity.
10. There is a need to establish close co-ordination between the Ministry of Health and other ministries responsible for personnel, simplify rules and regulations and decrease bureaucratic delays.

vi Supervision, Monitoring and Evaluation

Background

Supervision, monitoring and evaluation are essential activities for assuring an effective and efficient health care delivery system. The system for supervision, monitoring and evaluation extends from the ward or community level to the central Ministry of Health level. At the ward or community level the Ministry of Health has established Ward Health Committees and Mothers Group wherever health volunteers have been recruited. Monitoring and evaluation is the responsibility of Ward Health Committee and Mothers Group. Moving to the village level, the Village Development Committees are responsible for planning, implementing and reviewing all local development programmes including those in health. The Health Post in-charge is responsible for the monitoring and evaluation of health services provided at the health post.

At the district level, the District Development Committees chaired by the Chief District Officer undertakes reviews of the progress achieved in development activities including health. Day-to-day monitoring of health activities is the responsibility of the District Health Officer who maintains operational control of programme activities. Turning to the zonal level, there is no unit directly responsible for monitoring and evaluation; rather zonal health institutions are monitored by the Regional Health Directorates. At the regional level the five Regional Health Directorates are responsible for monitoring and evaluation of the health activities in their development regions.

At the central level the Policy, Planning and Foreign Aid and Monitoring Division (PP & FAM), MOH is responsible for the overall supervision, monitoring and evaluation of Ministry of Health policies and programs. To assist PP & FAM in carrying out its monitoring and evaluation function and provide the necessary information for programme monitoring an Integrated Health Management Information System (HMIS), Human Resource Development Information System (HuRDIS) and Logistics Management Information System (LMIS) have been established within the Department of Health Services. Supplementing the on going supervision, monitoring and evaluation activities, the Ministry undertakes four-monthly reviews of all projects and programmes, and bimonthly reviews of projects designated as priority projects by the National Planning Commission (the bimonthly reviews are undertaken in the presence of a representative from the Planning Commission).

Significant Problems

1. There is a lack of supportive supervision. Supervision is generally confined to observation and is usually perceived as a "fault-finding mission". The motivational role of supervision is insufficiently recognized and seldom practiced.
2. Personnel with supervisory responsibilities at all levels generally lack the appropriate managerial and technical skills to identify and solve problems.
3. The operational definitions of management and technical supervision-what should be looked at – are unclear, supervision indicators are poorly defined, and there are no supervisory log-books. The absence of these supervisory tools and the necessary guidance discourages the service providers from performing their supervisory functions.
4. The centralized nature of authority and decision-making at all levels does not support nor encourage a sense of responsibility among supervisors.
5. There is no unit at central level to support, encourage and carry out supportive, integrated supervision.
6. The daily allowance is inadequate which undermines all supervisory activities.
7. The responsibilities of the Ward Health Committees are not well defined. It is not clear who supervises the Ward Health Committees. Moreover their co-ordination with the "Mothers Group" is weak.
8. The accountability of the Village Development Committees and Health Post Development Committees is limited in matters of supervision and monitoring.
9. Though monitoring and evaluation of health posts and Village Health Workers are the responsibility of the District Health Office, it lacks of a strong monitoring and evaluation unit.
10. Monitoring and evaluation units at the regional level are weak due in part to a lack of adequately trained personnel.
11. The unit attached to Policy, Planning and Foreign Aid and Monitoring Division of MOH responsible for monitoring, evaluation information management is inadequately staffed and thus unable to effectively carry out its responsibilities.

Policy Option/Policy Implications for Supervision, Monitoring and Evaluation

1. There is a need to clearly define and differentiate between management and technical supervision.
2. There is a need to enhance the technical and managerial knowledge and skills necessary for supervisory to carry out integrated supportive supervision.

3. There is a need to develop appropriate supervisory tools and provide the necessary guidelines to promote and strengthen integrated supportive supervision.
4. There is a need to introduce performance appraisal linked to positive and negative incentives into the national supervision system (rewards such as promotion, awards, grades in the pay scale, training opportunities etc. or, if necessary, disciplinary action including demotion or freezing of pay scale etc).
5. There is the need to delegate the appropriate and necessary authority, financial and human resources to the different supervisory levels to carry out integrated supportive supervision (central level divisions, Regional Directorates and District Health Offices).
6. There is a need to clearly define the supervisory responsibilities of the Ward Health Committees, establish to whom the Ward Health Committee is responsible and strengthen co-ordination between the Committee and the "Mother Group".
7. There is a need to strengthen the accountability of the Village Development Committees and Health Post Development Committees.
8. There is a need to allocate adequate funds in MoH's annual budget ("Red Book") for performing all supervision activities and to ensure proper utilization of the supervision funds.
9. There is a need to increase daily allowance for supervision or identity alternative sources of compensation for carrying out supervision,
10. There is a need to establish a unit at the central level to coordinate supervision
11. A strong unit for monitoring, evaluation and supervision needs to be established at the district level and integrated into the "District Health System" with the authority, financial and human resources necessary to carry out its responsibilities.

vii. Information Management

Background

Health information management used to be the domain of the Epidemiology Section of MOH and the various vertical programmes. Occasional publication of health statistics by the Epidemiology Section constituted the major elements of information management. When MOH was reorganized in 1993, a core Management Information Section was established under PFAD, DHS. Within this initiative, the vertical statistics sections of previous project programme division were, in theory, abolished. The hundred plus recording and reporting forms in use was reduced to approximately thirty-four.

Currently, a number of health information systems are being developed and are in use in various areas of the health sector, some of them are as follows:

Health Management Information System (HMIS) – Between November 1995 and July 1996, approximately 15,000 health workers were trained in record keeping and the use of information. Computer analysis is being established in the MIS section of PFAD. A system of monthly, trimester and annual reports has been implemented to give feedback to division managers. With this system there has been an increase in the reporting rate from the periphery. DHS undertakes a national and regional performance review using data produced by the HMIS.

Hospital Based Information System (HoBIS) – The existing hospital based information system is being updated to collect, analyze and report more precision hospital morbidity and mortality data.

Human Resources Development Information System (HuRDIS) – HuRDIS is being developed in the Health Institution and Manpower Development Division (HIMDD) of the DHS. The system will provide information on the HRH situation of each health facility, qualifications, and profession career details of all health personnel in the country (public, private and NGO sectors). The information is currently available on-line to those undertaking the planning of human resources, recruitment, placement, promotion and training.

Logistic Management Information System (LMIS) – The Logistics Management Division of the DHS has recently established a LMIS for providing information concerning the logistics and inventory situation of each health facility in the country.

Financing Information – Tri masterly budget disbursement and expenditure records are maintained in the Finance Section, DHS. There is currently no system for disseminating this information. There is no system for donors to provide standardized information on their financial inputs.

Demographic and epidemiological Information – In addition to a ten-year national population census carried out by the CBS/NPC, a demographic and health survey (Nepal Fertility, Family Planning and Health Survey) is undertaken every five years by the Family Health Division, DHS. Early warning systems to allow for the early detection of outbreaks of communicable diseases and sentinel surveillance systems for vitals statistics are being developed.

Reports for Planning Monitoring and Evaluation – The Policy, Planning, Foreign Aid and Monitoring Division of the MOH is responsible for ministry-level monitoring and evaluation of health and population activities. The division periodically published a "Health Information Bulletin" to disseminate summary information on the health sector. In addition annual reports are produced by the Department of Health Services, and specific programme such as Tuberculosis, Leprosy, Malaria, Family Health etc. In general these reports are prepared on an ad hoc basic not having been institutionalized.

Significant Problems

1. Most of the time, planning and management decisions are taken without relevant information.
2. Significant gaps remain in information including but not limited to: health status, management supports services, data on quality of health services, etc. for public, private and NGO sectors.
3. In those areas where data is available excessive amounts are collected which is not analyzed.
4. Data is often non-reliable and inconsistent.
5. Date collection and analysis continues to be undertaken by a number of separate government and non-government organizations whose actions are not coordinated.
6. Reporting is often delayed and incomplete.

7. The current information systems are difficult to sustain given the available level of GON financial and human resources.
8. Short-Term approaches to information system development have been adopted.

Constraints in Addressing Significant Problems in Information Management

1. The culture does not support the use of information-based decision-making.
2. There is a lack of motivation to collect and use information appropriately.
3. Information systems are scattered among various units in the Ministry of Health and other health and health related organizations. These systems generally do not capture all essential types of data particularly information generated by pilot projects and studies.
4. Donor reporting requirements place excessive and conflicting data demands on the information system.
5. There are shortage of personnel, equipment, and financial resources essential for information collection, analysis and use.

Policy Issues/Policy Implications for Information Management

1. There is a need to improve the motivation to collect analyses and use information appropriately.
2. There is a need to integrate existing information to ensure the availability of reliable and consistent information essential for decision-making.
3. There is a need to develop and implement a mechanism to make health sector information available to all potential users.
4. There is need to provide essential personnel, equipment and financial resources for the development and operation of the integrated information system.
5. There is a need to institutionalize the integrated information system.

viii. Organizational Design

Background

The Ministry of Health has undergone a series of reorganizations and restructuring. Beginning in the late 1950s health services in Nepal were largely provided through vertical programmes and projects under Department of Health Services (DHS). The programmes were principally funded through foreign assistance. Reliance on vertical programmes continued until 1978. In that year the provision of integrated comprehensive health care services nationwide was attempted with the establishment of the Integrated Community Health Services Development Project (ICHSDP).

The Ministry of Health went through a major structural change in 1987 with the abolishment of the Department of Health Services-first established in 1933 – and establishment of a Regional Health Service Directorate (RHSD) in each of the country's five development regions. In 1993, the Ministry of Health underwent further restructuring with a reintroduction of the Department of Health Services in the organogram.

Based on the current "Organizational Structure (1993)", the General Administration Division in the Ministry of Health is responsible. "To study regularly the organization structure, manpower work procedure of the ministry and all agencies under the ministry" However, a review of the 1993 reorganization and that currently underway

indicates that the efforts a review of the organizational structure was not part of a regular ongoing process but done on ad hoc basis.

Significant Problems

1. The Ministry of Health organogram is based on staffing patterns that can not be met with presently available personnel or those that can realistically expected to be made available.
2. Highly centralized decision-making and limited delegation of authority lead to excessive work pressure at the center. This further exacerbates inadequate staffing levels inherent in the organogram.
3. The current organizational arrangement fosters overlapping of roles and responsibilities at all levels as it does not clearly define responsibility for functions such as planning, staff deployment, monitoring, supervision etc.
4. The present organizational structure does not support decentralization in terms of decision-making, financing, planning and management.
5. Responsibilities allocated to the regional level are very extensive. However, the regions do not have the corresponding and requisite authority nor are the regions described in legislation concerning decentralization.
6. The requirement of accountability at the district level has led to the centralization of decision-making authority in the District Health Office.
7. The organogram does not clearly define the relationship between curative and preventive services, especially at the district level (leadership, authority, and responsibility).
8. The process of restructuring is unsystematic, Reorganizations are undertaken without (a) an appropriate, well defined and systematic assessment of the Ministry of Health's goals, tasks, functions and organizational environment; and thus the lack of a clear agreement on what should be restructured and the extent of change required; and (b) a realistic assessment of the personnel that could reasonably be expected to be made available to staff the revised structure.
9. Reorganizations and studies to reorganize the Ministry of Health occur without providing sufficient time to allow the effects of previous reorganization efforts to be seen. As there is a usually significant gap in filling the posts sanctioned in the revised organogram, it is difficult to adequately assess the effectiveness of the revise organizational structure. That is, it is difficult to establish whether problems arise due to deficiencies in the organizational structure, inadequate staffing etc.
10. The MOH lack sufficient numbers of qualified personnel experienced organizational design. There is a lack of criteria concerning the individuals who are to be involved in the reorganization efforts.

Policy Issues/Policy Implications for Organizational Design

1. The personnel necessary to staff the Ministry of Health's organ gram need to be obtained and provided the necessary training to effectively carry out their roles and responsibilities (see Chapter 2 Human Resources for Health – Planning and Development).
2. There is a need to create regular mechanisms for assuring effective workflow, communications and co-ordination between the Ministry of Health and Department of Health Services as well as between related divisions and centres.
3. There is the need to clearly define at all levels the specific roles and responsibilities for functions such as planning, staff deployment, monitoring, supervision etc.

4. There is a need to clarify the role and function of the regional tier. Accordingly it is necessary to provide them the requisite authority, technical and financial resources; and develop capacity to carryout their responsibilities.
5. There is a need to review the organizational structure to ensure that it support and encourages decentralization in terms of decision-making, financing, planning and management.
6. There is a need to clarify the composition, roles and responsibilities of the health management committee (e.g. hospital development board, district health development board, health post helping committees etc.). The committees should involve public, NGO and private sectors. The committees should be provided the requisite authority, and training to permit them to effectively carryout their responsibilities.
7. There is the need to reverse the trend to centralize decision-making authority in the District Health Office and to change organizational norms so that they encourage and support delegation authority and teamwork.
8. There is a need to refrain from undertaking "ad hoc" or precipitous revisions in the Ministry of Health organogram. That is without providing sufficient time to allow the effects of previous reorganizations to be seen. Reorganizations efforts need to be undertaken with a clear understanding of what should be redesigned and the extent of change required based on (a) systematic assessments of Ministry of Health's goals, task, functions and organizational environment; and (b) a realistic assessment of the personnel that could be reasonably expected to be made available to staff the revised structure.

G. Quality Assurance in Health Care

Background

The National Health Policy (1991) has provided both the impetus and direction for the development of quality assurance (QA) mechanisms through its emphasis on the provision of effective, accessible and equitable health care. The establishment in 1993 of the Inspection and Quality control (I & C) section within the Health Institutions and Manpower Development Division was an important step towards developing QA within the Ministry of Health. I & QC was given the responsibility to develop mechanisms for improving quality in various health institutions and by various levels of health personnel. Its main achievement has been the development of standards and operational guidelines for GON and private health related institutions including primary care institutions, hospital, nursing homes, and diagnostic centers. However, there has been little development of the mechanisms and tools needed to apply and enforce these standards.

Other progress in QA has happened in piece-meal manner in different parts of the health services. Some of the main developments are as follows.

- A quality of care (QOC) program including a QOC centre has been established for FP services.
- Universities. CTEVT and other institutions have developed QA tools for monitoring quality of training health personnel.
- Some services have established standards of care specific to Nepal, e.g. FP/safe-motherhood and TB.
- Standards have been established for quality of public and private diagnostic services.
- Standards have been established for quality of drugs supplied to the health sector.

Most of the efforts undertaken are the area of standard setting. However QA has not yet happened in many instances because effective monitoring and enforcement systems have yet to be established. This partly reflects wider human resource management problems relating to work performance. Accountability and effective supervision.

Significant Problems

An analysis of QOC in Nepal indicates that the problems lie less with the individual care providers than with weakness in the wider health system within which they work. Deficiencies in health institutions physical facilities, management and support systems are the main barriers to provision of good qualities care. Personnel management systems, which are crucial in QA, are a particular problem because of the organizational culture, which does not place a high value on performance.

1. There are deficiencies in the organization of the health sector including: Centralized authority in the Ministry of Health, a lack of Co-ordination among divisions of MOH and between central and peripheral institutions and a lack co-ordination among MOH, other Ministries, training institutions, private service providers. NGOs and communities. Vertical programmes are target driven rather than quality oriented.
2. There are deficiencies in monitoring and supervision systems. Supervision and monitoring are initiative reporting and information systems are inadequate. There are no established roles for community and local government in development and management of health facilities and services skills to implement QA lacking and a lack of regulation of the private sector.
3. There are deficiencies in human resource management and deployment including insufficient, insufficient and poor quality training (pre-service and in-service).
4. Physical facilities are inadequate, that is health facilities often lack basic amenities (water and sanitation) and necessary equipment.
5. There are deficiencies in logistics management including an ineffective logistics system for drugs and equipment.
6. Financial resources for the health sector are inadequate.

Constraints in addressing the significant problems of Quality Assurance

1. There is no clear policy for QA in the public, private or NGO sectors; this constrains the development of an effective and coordinated approach to QA throughout the health system.
2. The legal framework for implementing QA. Especially in the private sector is weal or absent.
3. The commitment needed to make QA systems work is lacking. Traditionally there has not been a strong performance ethic. Good quality care is not a priority of service of QA in other countries, are not applicable to the Nepal context (growth in litigation. Contracting out of government health services, privatization of public health services. Strong consumer pressure etc.)
4. Traditional ways of working are barriers to QA. Especially among health managers. Health professionals and donors, they do not clearly understand the concepts of QA and many are uncertain of its importance. They also have concerns about the uncertain costs and lack of resources available to improve quality. Health processionals may feel that their autonomy and competence is threatened and therefore resent what is perceived as interference. They have

concerns about implications for employment prospects if efficiency increases, and may view QA as simply a way of containing costs.

5. The supply of well-trained personnel, appropriate placement, incentives to perform. Discipline and accountability are especially important for QA but are areas of particular weakness in Nepal.
6. Pre-and in-service training programmes do not emphasis quality of care.
7. Mechanisms for effective co-ordination among divisions, centres and programmes within the ministry of Health, and between the Ministry of Health, other ministries. INGO, NGO and the private sector that are necessary for QA are weak.
8. Centralization of Health service management limits the development of Local QA initiatives, including those, which entail community participation.
9. The costs of implementing QA systems and improving quality are not known; given the structural weaknesses in Nepal with ill-equipped and understaffed facilities these costs may be considerable. The may not be affordable even if cost-effective.

Policy Issues/Policy Implications for Quality Assurance

1. There is a need for a quality assurance policy that includes a working definition of quality of care that is appropriate in the Nepal context. There must be a real commitment at the highest level to improving quality of care at all levels of the health sector.
2. There is a need to develop a realistic. Cost-effective. Quality assurance strategy. The strategy must be directed towards providing high quality “Essential Health Care” at the district level involving public and private sectors. The strategy should emphasize: responsiveness to the felt needs and concerns of service users the development and use of normative or minimum standards that include a client dimension and establishment of a process of continuous quality improvement.
3. The process of strategy development should be designed to build widespread support and commitment throughout the health system. It should emphasis consultation teamwork and the involvement of health professionals and other care providers in the development of appropriate QA strategies and tools.
4. There is a need to institutionalize the quality assurance system in public, private and NGO sectors. The QA system should be integrated with existing management structures and new initiatives to strengthen health services. Duplication of Supervision and monitoring functions should be avoided and implementation costs minimized. In particular, mechanisms for effective intra-and inter-sectoral co-ordination need to be established.
5. There is a need to increase awareness and understanding of quality of care and QA and the advantages and benefits they offer. Further it is necessary to promote a quality culture in which all persons working in the health sector become committed to performing to a high standard and are willing to be accountable. Information and communication need to be provided to the public regarding rights and responsibilities in terms of QOC.
6. Appropriate tools and techniques for QA need to be developed, which involve the public, can be adapted to local situations, and comply with established cost constraints.
7. There is a need to make the quality assurance system responsive to the felt needs and concerns of service users. The QA system must elicit their views and employ quality standards that include a client dimension.

8. There is a need to develop and effectively implement appropriate QA regulations, especially for private and NGO sectors.

Part II

Goals, Objectives and Targets
of the Second Long Term Health Plan

Chapter 3

Goals, Objectives and Targets
Of the Second Long Term Health Plan

A. Goal

B. Objectives

C. Targets

A. Goal

The health status of the Nepalese Population will be improved through the health care system, which provides equitable access to quality health care for all people.

B. Objectives.

1. To improve the health status of the population particularly those. Whose health's needs often are not met the most vulnerable group, women and children. The rural population. The poor the underprivileged and the marginalized population.
2. To extend essential health care services (highly cost effective public health measure and essential curative services for the appropriate treatment of common diseases and injuries) to all districts.
3. To provide the appropriate numbers, types and distribution of technically competent and socially responsible health personnel necessary for the provision of quality health care throughout the country. [Particularly in under-served areas.
4. To improve the management and organization of the public health sector and increase the efficiency and effectiveness of the health care system.
5. To develop the appropriate roles for the public, NGO and private sectors in the provision and financing of health services.
6. To improve inter and intra-sectoral coordination and to provide the necessary conditions and support for effective decentralization with full community participation.

C. Targets

	Indicator	Status/Target	
		2002	2017
1.	IMR/1000 live-births	61.5	34.4
2.	U5 MR/1000	102.3	62.5
3.	TFR	4.2	3.05
4.	Life Expectancy (in Years)	59.7	68.7
5.	CBR/1000	33.1	26.6
6.	CDR/1000	9.6	6.0
7.	MMR/100000 births	400	250
8.	CPR %	36.6	58.2
9.	% of Delivery Attended By Trained Personnel	50	95
10.	% of Pregnant Women Attending a Minimum of 4 Antenatal Visits.	50	80
11.	% of Iron-deficiency Anemia Among Pregnant Women	40	15
12.	% of women 15-44 receiving TT2	60	90
13.	% of new-born weighing less than 2500 grams	23	12
14.	Essential Health Care services will be available to x% of population living within 30 minutes travel time at the district level and below	70	90
15.	% of facilities with essential drugs available	100	100
16.	% of facilities equipped with full staff to deliver essential health care services	100	100
17.	Total health expenditure as % of total expenditure	7	10

Part III

Policies for Achieving the Goals, Objectives and Targets of the Second Long Term Health Plan

Chapter 4

Policies Regarding Essential Health Care Services (Including Ayurvedic and Other Systems of Medicine) at the District and Below

Background

“Essential Health Care Services at the District Level Below " are priority public health measures and essential curative services for the treatment of common illnesses and injuries (including Ayurved and other systems of medicine) that GON will ensure is available to the total population. These services address the most essential health needs of the population and are highly cost effective. After ensuring health care services “may be broadened to include additional public health and curative services.

"Essential Health Care Services" is part of the Primary Health Care Approach and Supports the four basic PHC principles:

A Universal accessibility to available resources and services in order to provide adequate coverage of the most essential health needs of the population.

B. Community and individual involvement and self- reliance.

C. Inter-sectoral action for health and

D. Appropriate technology and cost-effectiveness i.e. allocation of resources in a manner that yields the greatest benefits. With benefits measured by the extent to which the health needs of the largest number of people can be met.

The rationale for providing "Essential Health Care Services" is linked to the recognition that the resources available to the health sector through GON and its donor partner are inadequate to address all of the possible health care needs of the population. Moreover, redirect resources from high cost-low impact interventions to those that could substantially reduce the burden of disease (morbidity mortality) without increasing expenditures. Further it is necessary to assure that resources are rationally used and that the highest priority interventions (vis-à-vis burden of disease and cost effectiveness) are not neglected in terms of financial and technical resources. Finally an explicit definition of services to be funded by GON helps to; better estimate the need for external assistance and focuses the use of donor resources defines the role of private and NGO sectors and focuses attention of GON on its own responsibilities and capacities.

The Choice to develop integrated services rather than a list of individual services was governed by an attempt to minimize the total cost of the services provided by exploiting the shared use of resources. Separate “Essential Health Care Services “that are to be made available to the districts were developed for the modern system of medicine and for traditional and other systems of medicine. This was done to recognize and accommodate the distinctive approaches to provision of health care, the diverse delivery mechanisms and differing preferences of the population. Recognizing these differences, the forms in which the modern and traditional services are presented differ. The development of separate groupings of "Essential health Care Services” for the modern system of medicine and for traditional and other system health care system that have been proven safe and effective.

In determining the services to be provided in “Essential Health Care" it was felt that the main interventions should.

- Address Nepal's principal health problems including significant emerging and re-emerging diseases:
- reflect various international commitment made by GoN (e.g., World summit for Children and its Mid-decade Goals; Fourth Women's Conference-Beijing; Universal Childhood Immunization; Polio Eradication; Universal Iodization of Salt; Elimination of Leprosy etc.)
- be cost-effective (ratio of cost of providing intervention to health gain) and be operationally feasible, that is (a) the required infrastructure and technical resources

(manpower, materials) should be available; (b_ be affordable at present and in the future; (c) reflect participation of key stakeholders and their choices by programme, geographic area, and duration; (d) operational barriers should be identified and he necessary, alternative implementation strategies developed that are capable of overcoming those barriers (accessibility, logistics, seasonal migrations etc.); (e) delivery mechanisms should be sensitive to and accommodate the socio-cultural setting; (f) the role of other sectors should be recognized; and (g) there should be a political commitment for the main intervention

- be gender sensitive.

The identification of "Essential Health Care Services" using the above criteria was done through a national workshop held in 1996. Participating in the workshop were Members of Parliament: representatives from the National planning Commission; departments and divisions of the Ministry of Health; training institutions such as the Institute of Medicine; Councils; professional associations; practitioners of traditional and other systems of medicine; NGOs, INGOs, and bi-and multilateral donors. In identifying "Essential Health Care Services" Nepal's major health problems were noted (se Chapter 3 Burden of Disease Analysis) and main interventions for addressing them identified. The interventions were the prioritized based on the previously noted criteria.

The specific "Essential Health Care Services" for the modern system of medicine, Ayurveda, Homeopathy, Unani, and Naturopathy are noted below:

Content of "Essential Health Care Services" for the Modern System of Medicine

Main	Health Problems Addressed
Appropriate Treatment of Common Disease and injuries	Common Diseases and Injuries
Reproductive Health Services	Maternal, Perinatal
EPI+Hepatitis B Vaccine	Diphtheria, Pertussis, TB, Measles, Polio, Neonatal Tetanus, Hepatitis B
Condom Promotion and Distribution	STD, HIV, Hepatitis B, Cervical Cancer
Leprosy Control	Leprosy
Tuberculosis Control	TB
Integrated management of Childhood Illness (IMCI)	Diarrhoeal Disease, Acute Respiratory Infection, Protein-Energy Malnutrition

Table Continue

Main Interventions	**Health Problems Addressed**
Nutritional Supplementation, Enrichment, Nutrition Education and Rehabilitation	Protein-Energy Malnutrition, Iodine, Deficiency Disorders, Vitamin A deficiency, Anaemia, Cardiovascular Disease. Diabetes. Rickets. Perinatal Mortality, Maternal Morbidity, Diarrhoea Disease. ARI
Prevention and Control of Blindness	Cataracts, Glaucoma, Peteryfium, Refractive Error and other preventable Eye Infections.
Environmental Sanitation	Diarrhoea Disease, Acute Respiratory Infection, Intestinal Helminthes, Vector Borne Diseases, Malnutrition.
School Health Service	Diarrhoea Disease, Helminthes, Oral Health. HIV, STDs. Malaria, Eye and Hearing Problems, Substance Abuse, Basic Trauma Care.
Vector Borne Disease Control	Malaria, Leishmaniasis, Japanese

	Encephalitis
Oral Health Services	Oral Health
Prevention of Deafness	Hearing Problems
Substance Abuse including Tobacco and Alcohol Control	Cancers, Chronic Respiratory Disease, Traffic Accidents
Mental Health Services	Mental Health Problems
Accident Prevention and Rehabilitation	Post Trauma Disabilities
Community Based Rehabilitation	Leprosy, Congenital Disabilities, Post Trauma Disabilities, Blindness
Occupational Health	Chronic Respiratory Disease, Accidents, Cancer, Eye and skin Diseases, Hearing Loss
Emergency Preparedness and Management	Natural and Man-made disasters

The "Essential health care Services" will be made available at district level and below in a manner that is gender sensitive and ensures the needy and underprivileged population will not be deprived of essential health care services because of inability to pay ("safety-net). For each of the main interventions, the specific components and necessary support services to be provided as those levels will be defined. That is. The specific components to be provided in the community, at health post, health centre, PHC. And district hospital. After ensuring adequate coverage of the most important health needs of the population. The "Essential Health Care Services" may be broadened to include additional public health and clinical services.

Content of "Essential Health Care Services" for Ayurveda Services

Peripheral Ayurveda Dispensary - Local medicinal herbs for the management of common ailments. - Simple Ayurveda preparations (locally prepared from level medicinal herbs). - Simple Ayurveda procedures in the management of common diseases. - Identify and help in the cultivation of locally available medicinal herbs.
District Level Ayurvedic Health Centres - Ayurveda services as above. - Ayurveda formulations (prepared at the district level) - Specialized Ayurveda procedures, that is basic procedures of "pancha karma"
Ayurvedic Regional Level Hospitals - Provision of indoor services. - Rural pharmacy services. - Herbarium and herbal gardens. - Specialized Ayurvedic Services, aspects of "pancha karma" not provided at district level.
Central Ayurveda Hospitals - Comprehensive specialized Ayurveda services in all eight branches of Ayurveda. - Complete procedures of "pancha karma" and kshara sutra"

Content of "Essential Health Care Services" for Homeopathic Services

Central Homeopathic Hospitals (Specialized Services) - Acute and Chronic Respiratory Disease

- Diarrhoeal Disease
- Jaundice
- Warts (Laryngeal Papilloma)
- Diabetes Mellitus
- Chronic Skin Diseases
- STDs
- Cataract
- Diseases of the Digestive System
- Gall Bladder and Kidney Stones

Content of "Essential Health Care Services" for Unani Medical Services

Unani Dispensary

- Diseases of Digestive System
- Jaundice
- Asthma
- Insomnia
- Allergy
- Piles
- Neurological disorder
- Menstrual disorder
- Skin
- Fever
- Gastric

Content of "Essential Health Care Service" for Naturopathy

Naturopathy Clinics:

- **Sinusitis**
- **Allergy and Skin Disease**
- **Back pain**
- **Indigestion**
- **Gastric**
- **Menstrual Disorders**
- **Asthma**
- **Bronchitis**
- **Hysteria**
- **Lucorrhoea**
- **Diabetes Mellitus**

The Role of the Public Sector, NGOs and INGOs and Private Sector in Funding and Delivery of the " Essential Health Care" including the "Essential Health Care" for Traditional and Other Systems of Medicine"

The estimated cost of the standard "Essential Health Care Services" is approximately US $12 to US $17 per capita (World Bank 1993). GON expenditures on health including resources provided by its donor partners were estimated to be US $ 4 PER CAPUTA IN FISCAL YEAR 1994/95 (See Chapter 2 D). GON resources are inadequate to ensure that the total population has access to the (Essential Health Care". Consequently, GON initially will focus on the public health aspects of the essential health care services and promote NGO and private sector expenditure on selected public health measure and services for the treatment of common diseases and injuries.

Policies/ Strategies for Implementing the" Essential Health Care Services"

1. The highest priority will be given to ensuring the provision of " Essential Health Care " (i.e. priority public health measures and essential curative services based on the guiding principles of PHC) before GON and donor resources are diverted to the provision of tertiary and super-specialty services.
2. In delivering the " Essential Health Care Services at the District level and Below" the government will:
    - Rely on community participation: and
    - Emphasize broad national coverage focusing on providing selected elements of all public health and curative intervention in all 75 districts (e.g. elements of the reproductive health, integrated management of childhood illness, etc).

3. GON will gradually expand the number of elements in each of the main intervention available in the districts in a phased manner and improved the quality of the intervention provided.
4. Private and NGO sector will be encouraged to provide selected public health and essential clinical services included in" "Essential Health Care Services".
5. GON will encourage its donor partner to assume responsibility for assisting in the implementation of"Essential Health Care Services" in specific district.
6. GON will ensure pre-service education and in-service training for physicians, basic and mid-level health personal for the modern and traditional systems of medicine. The training will give adequate attention to the components of"Essential Health Care Services".

Chapter 5

Polices Regarding Health Care Services Beyond the District

Background

The resources presently available to the health sector are inadequate to address all possible health care needs of the population. Given this situation His Majesty's Government has adopted the concept of "Essential Health Care Services" that is priority public health measures and essential curative services for the treatment of common diseases and injuries which are cost effective, address the most essential health needs of the population and be made available to all the population-

Recognizing that,

- the use of scarce resources to address one set of health problems means giving up the opportunity to use them to address a different set of health problems; and
- providing benefits in one programme area means forgoing them in another.

Government of Nepal at present is not in a position to direct resources to health Interventions beyond those included in the "Essential Health Care Services" without prejudicing its ability to provide for the most essential health needs of the population. That is, GoN is not able to direct scarce human and financial resources to high cost-low impact interventions that make a small contribution to reducing morbidity and mortality rates.

Government of Nepal will first ensure the majority of elements of each of the main "Essential Health Care" interventions are available on the persons in all 75 districts. GoN will then begin to address cost-effective intervention for health problems that are less common through perhaps severe, or the individual health loss is negligible. The funding and provision of "Health Care Services Beyond the District" requires that:

- the population will have to pay for such services. However a "safety net" will be maintained to ensure the needy and underprivileged population will not be deprived of necessary health care services because of their inability to pay; and
- the private sector will be expected to play a major role in funding and delivery of such services.

Policy/Strategies for implementing "Health Care Services Beyond the District"

1. In moving beyond the "Essential Health Care Services" emphasis will be on developing integrated service rather than providing individuals services in order to minimize the total cost of services provided by exploiting the shared use of resources and reduce the cost to patients of obtaining services.
2. In defining health care services "Beyond the District," consideration shall be given to the following criteria:
   - services should employ appropriate technology;
   - services should be cost effective and operationally feasible; and
   - the cost of providing the services (personnel, physical infrastructure, supplies and equipment etc.) should be affordable at present and in the future without placing excessive human resources demands and financial strains on the health sector. Similarly the cost of providing services should not prejudice the health sector's ability to provide priority public health and essential services for the treatments of common diseases and injuries.

3. After making available the main public health and essential curative interventions as defined in the "Essential Health Cares Services" in all 75 districts, GON will
   - finance other services included in the "Essential Health Care Services Beyond the district" and
   - provide financial incentives to the private sector for such purposes
4. In the gradual introduction of "Health Care Services Beyond the District", the highest priority will be given to assuring that support for the "Essential Health Care Services" is not neglected in terms of financial and technical resources. GONON will not discourage its donor partners, the private and NGO sectors from providing services included in "Health Care Services beyond the District" until selected public health and essential curative services included in the "Essential Health Care Services" are made available in all 75 districts.

Chapter 6

Policies Regarding the Health Service Delivery System (Public NGO and Private Sectors including Modern, Ayurveda and Other Systems of Medicine)

A. Policies Regarding the Provision of Preventive and Community Health Services

B. Policies Regarding the Provision of Curative and Rehabilitative Services.

C. Policies Regarding the Provision of Ancillary Services.

A. Policies Regarding the Provision of Preventive and community Health Services

1. Preventive and community health services will be made available to the majority of the population before additional tertiary and specialized care services are provided (see Chapter 4" Policies Regarding Essential Health Care Services-Modern Ayurveda and Other Systems of Medicine-at the District Level and Below").Such services should support the primary health care approach; be gender sensitive; and meet the needs of disadvantaged and vulnerable groups.
2. The role of public, private and NGO sectors in the provision of preventive and community health services will be defined for modern, Ayurveda and other systems of medicine. The necessary mechanisms will be developed to encourage and facilitate these sectors to effectively carry out their defined roles (see chapter 4).
3. Strategies and operational guidelines will be developed to ensure effective community participation and gender sensitivity in the planning, implementation, monitoring and supervision of preventive and community health services.
4. Alternative community financing mechanisms to provide incentives to community health workers (e.g. FCHVs, TBAs etc) will be explored.
5. Mechanisms for co-ordination and collaboration among multi- and bilateral donors, INGOs and the public sector will be developed to achieve national goals and objectives for preventive and community health services.
6. A feasible and appropriate mechanism for the planning of community health facilities will be developed and implemented. The planning mechanism will replace the administrative area approach with a need- based methodology. An appropriate unit within Department of Health Services will be designated and provided the necessary skilled personnel to carry out health facilities planning.
7. A mechanism will be developed to ensure an appropriate and effective referral system for modern and traditional systems of medicine. The referral system will link community health services to higher levels of care making use of public, private and NGO providers.
8. The use of traditional and faith healers to refer persons to the district health system and to provide basic preventive and promotive health service will be expired.

B. Policies Regarding the Provision of Curative and Rehabilitative Services

1. Essential curative services for the treatment of common diseases and injuries that are gender sensitive and meet the needs of disadvantaged groups shall be made available to the majority if the population before delivering specialized curative services which address less common health problems affecting the minority of the population.
2. The role of public, private and NGO sectors in the provision of curative and rehabilitative services that support the primary health care approach will be defined for modern and traditional systems of medicine. Necessary mechanisms shall be

developed to encourage and facilitate these sectors to effectively carrying out their defined roles.

3. The feasibility of additional approaches for the provision of curative and rehabilitative services including specialized services in difficult and remote areas will be examined. Such approaches will compliment the facility based service delivery system.
4. A feasible and appropriate hospital planning mechanism will be developed and implemented replacing the administrative area approach with a need based methodology. An appropriate unit within DHS will be designated and provided the necessary skilled personnel to carryout the hospital planning function.
5. Decision- making related to the establishment of tertiary care services and facilities will be based on well-designed and appropriately implemented feasibility studies that at a minimum address:

   - Consideration of the present and future costs of the services/facilities will be based on well designed and appropriately implemented feasibility studies that a minimum address:
   - The opportunity costs in terms if human and financial resources:
   - The financial drain on the health sector: and
   - The level of benefits that these services/facilities can reasonably be expected to provide in relation to Nepal‘s morbidity/mortality rates.
6. Effective quality assurance mechanisms for public, private and NGO sectors will be developed and implemented (see chapter 11 Policies for Ensuring Quality Assurance in Health Services).
7. Appropriate and feasible mechanisms will be developed to ensure an effective referral system for modern and traditional systems of medicine. The referral mechanism will link curative services to higher levels of care making use of public, private and NGO providers.

C. Policies Regarding the Provision of Ancillary Services

1. The role of public, NGO and private sectors in the provision of laboratory and diagnostic series will be defined and the necessary mechanisms developed to encourage and facilitate these sectors to effectively carryout their defined roles.
2. Feasible and appropriate financing schemes will be developed and implemented that will assure a continuous and uninterrupted supply of affordable essential drugs of acceptable quality at the district level and below (community drug programmes, user fees etc). Such schemes will support the rational drug use. The roles of the public, private and NGO sectors in the provision of pharmacy services will be defined and the necessary mechanics developed to encourage and facilitate these sectors to effectively carryout their defined roles.
3. Persons working in private pharmacies/drug retailers will be trained in the rational use of drugs and proper dispensing practices.
4. The production of medicinal plants and manufacture of pharmaceutical products used in traditional medicine will be increased.
6. Blood banking services in district hospitals will be developed.

Chapter 7

Policies for Planning, Development and Management of Human Resources for Health

A. Policies on Human Resources Planning and Development

B. Policies on Human Resources Management

A. Policies on Human Resources Planning and Development

1. The highest priority will be given to decentralizing HRH planning within the broad national guidelines of the "HRH Master Plan".
2. The scope of the "HRH Master Plan" will be gradually broadened to include the INGO. NGO and private sectors. The "Master Plan" will maximize input from lower levels, increase sensitivity to local needs, and effectively link HRH planning to the overall health-planning framework.
3. For the immediate future, the type and number of personnel needed for health services delivery through the Ministry of Health will be based on "1996 HRH Master Plan". GoN will gradually shift its focus from planning for the Ministry of Health, to planning for the HRH requirements of the health sector as a whole. Ministry of Health will replace the "sanctioned post" base methodology with a "service target" approach, which specifies the level of services that should be provided. The targets established by the Second Long Term Health Plan (Chapter 3 Section C), national targets adopted by individual MOH programmes and GoN bilateral and multilateral commitments shall be used. In employing the "service target" approach to project HRH requirements, a combination of "workload based projections," "population ratios for community based health workers adjusted for geographic area" and "standard staffing patterns adjusted for geographic area" will be used.
4. Periodic assessments of the need to supply of health personnel will be undertaken with the co-ordination and collaboration of the various sectoral and inter-sectoral committees, individual ministries, organization and professional bodies involved in planning, production and use of HRH.
5. Production of clinical, technical and supportive health personnel for all systems of medicine will be based on their projected need, rather than the capacity of the training institutions.
6. Norm, standards and criteria to assure quality education and training of health personnel will be developed for all systems of medicine. The requisite compliance mechanisms will be established placing public and private institutions which rain clinical, technical and/or and support personnel under accreditation schemes with periodic reaccredidation. Compliance is to be monitored by the concerned professional councils.
7. Standards, criteria and the requisite compliance mechanisms governing establishment and operation of public and private medical schools, and institutions for the training of health personnel will be developed for the systems of medicine. At a minimum, the standards and criteria will address issues of:
   - health sector priorities and needs;
   - regional/geographic balance;
   - gender equity in enrollment;
   - reservations for individuals from remote areas who meet entrance requirements;
   - feasibility;
   - sustainability;
   - financial and human resource implications for existing health sector priorities; and
   - their effect on existing medical schools and training institutions.

The necessary legal provisions for effective operation of the compliance mechanisms will be developed.

8. To ensure regional/geographic balance for candidates from remote areas and secure gender equity in enrollment, subsidies will be provided to cover pre-service education costs for training of basic and mid level health personnel.
9. The Ministry of Health will terminate its involvement in pre-service training, refocusing its efforts on in-service training, refresher courses and continuing education. MoH will employ integrated training and a distance learning approach for all levels of health personnel.
10. In-service "training blocks" that give adequate scope for career advancement will be established, especially for basic level health workers (MCHW, ANM, AHW/VHW).

B. Policies on Human Resources Management

1 There will be strict adherence to the rules and regulations regarding recruitment, selection, placement, transfers and deputation of staff. In undertaking transfer and deputation provision should be made for overlapping of staff for orientation and briefing purposes.

2 Clear and explicit job descriptions based on standards and guidelines by type of institution will be developed and implemented for all levels of technical and support staff within the Ministry of Health.

3 A transparent performance based and result oriented incentive system will be developed and implemented. The incentive system will have positive and negative incentives that also addresses the "push and pull factors" for filling remote postings (i.e. those factors that compel and attract or encourage personnel to take up remote postings).

4 A system for integrated supportive supervision of technical and support personnel at central, regional and district level and below will be developed and implemented.

5 The responsibility, necessary authority and resources for human resource management-related tasks will be devolved to the Regional Directorates, District Health Offices and the relevant health committees. The broader role of the health committees at a minimum will include supervision of sub-health post, health post and primary health care centre personnel (performance will be a strengthening of HRH management capacity at those levels.

6 Private practice of paramedical staff (e.g. ANMs, AHWs and HAs) will be legalized for the provision of certain services. As the practice of paramedical staff is an unacknowledged reality, legalization will begin to ensure a minimum level of quality for services. Mechanisms for appropriate oversight of paramedical staff practice will be developed and implemented.

7 Effective co-ordination between the Ministry of Health and other ministries responsible for personnel will be encouraged actively. Provisions in the "Health Service Act" and Ministry of Health regulations governing recruitment, selection, placement, transfers, and deputation shall be simplified and bureaucratic delays affecting HRH management reduced.

Chapter 8

Policies Governing Health Care Financing and Expenditures

Health Care Financing & Expenditures

1. A mechanism will be developed to assure that the Ministry of Health is aware of all funds flowing into the health sector; taking account of these resources the Ministry of Health will formulate health sector plans and programs.
2. The national health accounts (NHA) will be institutionalized and updated on a regular basis. The NHA will be used as an input for increasing the efficiency of health sector allocations and as a tool for monitoring and evaluating the effects of health reform.
3. The health sectors share of national budget will be gradually increased in line with the 20/20 initiative.
4. Base line data addressing government health budgets, private health expenditures and cost sharing, and the contribution of public. Private and NGO sectors at the district level will be collected. Using this information, policies concerning the role of public, private and NGOs sectors can be developed (e.g. tolerant regulatory environment: encouragement of private sector investment: privatization; import duty waivers; making government facilities available to private training institutions etc).
5. The highest priority will be given to develop alternative financing mechanisms, which seek to mobilize community funds to support health development including
    - Cost sharing
    - Health cooperatives
    - Health insurance

6. The feasibility of alternative delivery mechanisms that make use of the public, private and NGO sectors wide explored. The alternative delivery mechanisms will maintain a “safety net” to ensure the needy and underprivileged populations are not deprived of necessary health care services because of their inability to pay. Among the alternative delivery mechanisms to be explored are:
    - contracts between government and non- government entities including NGOs, private providers, and health insurance schemes
    - establishing private wings in government hospital facilities –e.g. arranging for private practice at government facilities:
    - contracting with NGOs for provision of services and /or attachment of NGO staff to work in government facilities:
    - contracting with private-for- profit clinics, private-nursing homes; contracting with hill shopkeepers(provision of drugs).
    - Contracting for non-medical services (security, cleaning, and maintenance, laundry etc).
    - Contracts between the VDC’s which will be responsible for essential health services and others –e.g. NGOs: private sector .etc;
    - Health insurance ;and
    - Health cooperative.

7. A clear distinction will be made between recurrent and capital expenditures. The definition of primary and non- primary health service for financial and budgetary purposes will be made more transparent.

8. An inter-sectoral coordinating body chaired by the Ministry of Health with representatives from government. INGOs, NGOs and private sectors will be established. The coordinating body will have access to information on health expenditures of all ministries, INGOs, NGOs and private sector.

Chapter 9

Policies on Inter & Intra-sectoral Coordination & Decentralization

A. Policies on Inter and Intra –Sectoral Coordination

B. Policies on Decentralization

A. Policies on Inter and Intra Sect oral Co-ordination

1 The highest priority will be given to change the perception and belief that health is only the concern of the MOH Sectoral ministries, bi- and multi- lateral donors will be encouraged to consider the impact of their activities on health, and the effect health interventions on other sectors.

2. Positive and negative incentives will be adopted to encourage ministries and their donor partners to co-ordinate among themselves and with other sectors.

3. Policy guidelines and strategies will be developed for co-ordination of policy issues. A unit for health policy analysis will be developed within the MoH with the necessary staff and resources to effectively carry out their responsibilities

4. Units within MoH at all levels (central, regional, and district) will be identified/established to co-ordinate NGO and private sector involvement in health development. These units will be provided the required human and financial resources to fulfill their responsibilities.

5. Mechanisms will be developed to disseminate information on policies, plans and programmes among ministries, NGOs and private sector and donor partners which impact on health development.

B. Policies on decentralization

1. Strengthening of the existing Health and Social Welfare Committee at the district level will be strengthened.

2. Membership of the committee should be as per the Decentralization Act. However, additional citizen members should be included on the invitation of the Committee to ensure wider public participation and greater public support for the new system.

3. A district level long –term plan for the decentralization of primary health services will be developed. The plan will provide for a sequenced devolution of services up to the VDC level.

4. The DPHO will provide necessary support to enable the Village Health Development Committee to carryout their roles and responsibilities in the village based primary health system.

5. District budget for decentralized health programmes will be vested in the DDC and its Health and Social Committees (e.g. District Health Development Board)

6. District level programme budgeting will be developed to manage the new village based health system.

7. The capacity of the DDC and VDC will be developed in order that they are able to evaluate the effectiveness of their programmes and negotiate for their budgets accordingly.

8. The DDC and VDC will develop plans for local support and resource generation. Such plans may include the allocation of district resources to the VDC and SHP level and include support for local resource mobilization schemes. The monies raised through local resource generation are to be kept at the local level and used to improve the quality of care (e.g. Village Health Development Board).

Chapter 10

Policies for Health Management in the Public Sector

A. Policies on Strategic and Operational Planning
B. Policies on Financial Management
C. Policies on Logistics Management
D. Policies on Health Facilities Maintenance and Development
E. Policies on Supervision, Monitoring and Evaluation
F. Policies on Information Management
G. Policies on Organization Design

A. Policies on Strategic and Operational Planning

1. The principles and procedures of decentralization will be incorporated into the planning mechanism. The necessary authorities will be clearly defined and delegated to regional and district levels and below. The plans produced at the various levels within their delegated authority and which confirm to national policies and guidelines will be accepted. The necessary financial and human resources will be provided to regional, district levels and below to carryout their planning responsibilities.
2. Strategic and operational planning skills at central, regional and district levels and below will be developed and maintained.
3. The highest priority will be given to ensure inter and intra sectoral co- ordination in the planning process including planning within the Ministry of Health NGO and private sectors.
4. Mechanisms will be developed to ensure the active participation of the Health Management Committees, sub-district staff, community health workers, and community in the planning process including representatives from the NGO and private sectors .Appropriate representation of women and socio-economic group in health sector planning will be ensured.
5. The highest priority will be given to ensure that there is a single, functioning district level coordinating body in all districts (e.g. District Health Development Board)

Ongoing orientation programmes will be established to make high levels politicians and government officials aware of the health planning process and national commitments relevant to the health planning process and national commitments relevant to the health sector.

B. Policies on Financial management

General

1. The Regional Health Directorate's role and responsibilities for financial management will be defined with the necessary authority and resources provided.

Financing

1. The roles of in the INGO, NGO, bilateral and multilateral donors and public sector in health care financing will be clearly defined.
2. Effective mechanisms will be developed to ensure non-government funding actively supports the GoN's health sector plans and priorities.
3. Health sector financing provided by private INGOs, NGOs, bilateral and multilateral donors will be included in public finance and budgeting exercises.
4. A comprehensive unified vision, goals and objectives, specific strategies and policy guidelines will be established for implementing alternative financing mechanisms. This includes the introduction of ability and willingness to pay as a basic criterion in establishing fee structures in cost sharing /cost-recovery scheme. Existing, cost-sharing/cost recovery schemes will be adapted for nationwide implementation as appropriate.
5. Local sources of financing including District and Village Development Committees will be pursed to augment central level funding of health services.

Budgeting

1. The principles and procedures of decentralization and “bottom-up budgeting” will be incorporated into the budget process. The necessary authorities shall be delegated to lower levels. Budgets prepared by District Health Office which are compliance with budget ceilings and budgetary, guidelines produced at central level will be included in the annual plans developed by the Planning Division, of DHS.
2. Integrated budgeting at the district level and below will be established. The integrated budget will include presently fragment development budgets and locally generated funds (cost sharing, cost-recovery schemes, money provided by local NGOs etc.)
3. Reliance on incremental budgeting will be reduced, making greater use of budgetary approaches that link budget with goals, objectives and priorities, performance, outcomes etc. (e.g. Programme budgeting, performance budgeting, zero based budgeting)

Accounting

1. Specific charts of accounts for the health programmer’s facilities and institutions will be developed.
2. The highest priority will be afforded to making the GoN and donors accounting and reporting systems less burdensome.
3. The numbers of trained finance /accounting personnel within the health sector, particularly within the Ministry of Health will be increased. Efforts will be undertaken to ensure they possess the necessary knowledge and skills to fulfill their job responsibilities.

Auditing

1. The Health Management Committee understands of financial procedures and regulations will be enhanced.
2. Auditors will be trained to work in the health sector. Efforts will be undertaken to ensure they possess the necessary knowledge and skills of health sector accounting systems, financial procedures and regulations to fulfill their job responsibilities.

C. Policies on logistics Management

1. The national and districts ability to plan, implement, monitor and supervise routine procurement and distribution activities will be strengthened. Logistics management responsibilities at each level in the supply system will be defined. Co-ordination among Logistics Management Division, other divisions, and donor partners will be strengthened.
2. A needs-based supply system will be developed which takes into account the district levels essential drug procurement system and the vaccine and contraceptive needs including that of NGOs. To facilitate distribution of supplies a separate budget line within LMD for transportation will be established.
3. Decentralization of the procurement process will be continued for appropriate categories of supplies. Streamlined procurement processes will be implemented with modified procurement regulations, a pre-qualification system for manufactures and suppliers and appropriate bidding documents and technical specifications for medical supplies and equipment will be implemented. An improved procurement and distribution planning and monitoring mechanisms at the national level will be developed.
4. The use of logistics Management Information System data for decision-making at all levels will be encouraged. An LMIS section in LMD will be created with adequate numbers of trained staff and resources to carry out those functions.
5. Adequate logistics personnel (a logistics cadre) and resources will be provided at each level to carry out logistics responsibilities. The logistic staff will be provided a well-defined career ladder and given the skills and tools (operations manuals) needed to carry out their logistics responsibilities.
6. Inventory and quality control procedures will be developed and implemented nationwide that will ensure that products reaching clients are safe and effective. Auction, disposal, and write-off procedures for damaged, expired and out-of-service items will be streamlined.
7. The logistics Management Division will be converted into a “centre” with greater operational control over the resources needed to carry out its responsibilities (personnel, vehicles, etc) including an autonomous accounting system.

D. On Health Facilities Maintenance and Development

1. The highest priority will be given to assuring that instructions and guidelines regarding the space need s and physical layout of the primary health centre and sub–health posts are provided to VDCs prior to the sub–health posts establishment and upgrading of health posts to primary health centre.
2. Existing health facilities will be provided basic amenities such as water supply and latrines.
3. A comprehensive plan, policies and guidelines in relation to equipment management will be formulated and implemented.

4. A repair and maintenance policy strategy will be developed and implemented covering vehicles, equipment, instruments, and machinery and physical facilities at all levels in the system.
5. The necessary personnel and infrastructure for repair and maintenance shall be provided. Co-ordination between public, private and NGO sectors in the area of repair and maintenance shall be strengthened.
6. A separate budget for repair and maintenance of medical equipment will be established.
7. An equipment management information system, which includes information on repair and maintenance requirements will be developed and implemented.
8. Policies and guidelines for the procurement and donation of goods taking into consideration the use of appropriate and affordable technology will be implemented.
9. A mechanism will be developed to ensure that donors comply with Department of Health Service's standards concerning equipment specifications, spare parts and funding for spare parts.

E. Policies on Supervision, Monitoring and Evaluation

1. The process and content of management and technical supervision will be defined. Supervisors will be provided the technical and managerial knowledge and skills, supervisory tools and necessary guidelines to carryout integrated supportive supervision.
2. The highest priority will be given to incorporate performance appraisals into the national supervision system. Performance appraisals will be linked to positive and negative incentives (rewards such as promotion, awards, grades in the pay scale, training opportunities etc. or if necessary, disciplinary, action including demotion or freezing of pay scale etc.)
3. The appropriate and necessary authority on financial and human resources will be given to the different supervisory levels to carry out integrated supportive supervision (central level divisions, Regional Health Directorates and District Health Offices).
4. A strong unit for supervision, monitoring and evaluation will be established at the district level and integrated to the “District Health System”. The unit will be provided the authority on financial and human resources necessary to carryout its responsibilities.
5. A system of supervisors meetings covering the village to the district levels will be developed .The supervisors meetings to be held at least once a month will present and discuss the problems observed during the supervision visits and find the local solutions. Only those problems that can not be solved locally will be referred to the higher level.
6. Supervisory responsibilities of the Ward Health Committees will be defined and co-ordination between the Committee and the “Mothers Group” strengthened.
7. Adequate funds will be allocated in the budget (“Red Block”) for all supervision activities. The level of funding will reflect an increase in the daily allowance for supervision.

f. Policies on Information Management

1. The highest priority will be given to improve motivation for the accurate collection analysis and appropriate use of information.
2. Components of the information system covering management support services, and quality of care for public, private and NGO sectors will be developed (see Chapter 11 Quality assurance in Health Services).
3. Essential personnel, equipment and financial resources necessary for the development and operation of the integrated information system will be provided.
4. Existing information systems will be integrated and institutionalized in a phased manner.
5. A mechanism will be developed for making health sector information available to potential users on a regular basis.

G. Policies on Organizational Design

1. The highest priority will be given to ensure the personnel necessary to staff the Ministry of Health's Organogram are obtained and provided the necessary training to effectively carry out their roles and responsibilities.
2. A mechanism will be developed for assuring effective workflow, communications and co-ordination between Ministry of Health and Development of Health Services as well as between related division and centre.
3. The specific roles and responsibilities for functions such as planning, staff deployment, monitoring, supervision etc will be defined at all levels.
4. The role and function of the regional tier will be clarified and provided the necessary authority, technical and financial resources. The required regional capacity to carryout its responsibilities will be developed.
5. The organization structure will be reviewed and revised as warranted to ensure that it supports and encourages decentralization in terms of decision-making, financing, planning and management.
6. The composition, roles and responsibilities of the health, management committees will be clarified (e.g. Hospital development board, district health development board, health post helping committees etc.).The committees will include public NGO and private sectors. The committees will be provided the necessary training to permit them to effectively carryout their responsibilities.
7. Revisions in the Ministry of Health organogram will be undertaken in a systematic manner providing sufficient time to allow the effects of previous reorganizations to be seen. Reorganization efforts will be undertaken with clear understanding of what should be redesigned and the extent of change required. Reorganization will be based on: (a) a systematic assessments of the Ministry of Health's goals, task, functions, structures and organization environment; and (b) a realistic assessment of the personnel reasonably expected to be available to staff the revised structure.

Chapter 11

Policies for Ensuring Quality Assurance in Health Care

Quality Assurance in Health Care

Minimum Standards Approach - All health care inputs and processes should at least be of a minimally acceptable level. The minimum standards approach aims to ensure that health facilities, training institutions, trained health personnel, and health care providers all attain explicit minimum quality standards**.** This approach is directed at improving quality at the lowest end of the spectrum.

Continuous Quality Improvement (CQI) Approach - The CQI approach is less concerned with achieving a particular standard (in some instances even a minimum standard may be unattainable) than with establishing a quality improvement process that is the health system regardless of the actual level of quality. It is particularly useful when quality has not been explicitly defined and for local problem solving approaches to improving quality.

Policies for Ensuring Quality Assurance in Health Care

1. A policy for Quality Assurance will be developed that provides clear direction and authority for development of an effective QA system in the public, INGO, NGO and private sectors. The QA policy will emphasis improving quality of services provided at the peripheral level where most primary health care takes place (SHP, HP, PHC Centre and district hospital).QA programmes will address the complete process of care in public, INGO and NGO and private health facilities (i.e. prevention, screening, diagnosis, treatment, patient advice and follow- up).QA programmes will also aim to improve the structures and systems and will be implemented with minimal extra costs.
2. A Quality Assurance Unit (QAU) will be established as the focal point for QA in the Ministry of Health. The QAU will have the overall responsibility for development, implementation, and co-ordination of QA programmes. The specific functions of the QAU shall include:
   (a) Establishing and maintaining effective intra- and inter-sectoral co-ordination for QA.
   (b) Establishing linkages with external organizations for technical support, training, access to information materials, and planning collaborative work.
   (c) Establishing a QA resource centre in the MOH;
   (d) Providing or arranging for training in QA;
   (e) Assisting in the development of an IEC programme for QA;
   (f) Developing and adapting QA tools and techniques;
   (g) Conducting and coordinating research in QA;
   (h) Developing a charter of patients health care rights and responsibilities;
   (i) Co-coordinating QA programmes implemented in different services and institutions;
   (j) Supervising, monitoring and evaluating quality of care(QOC);

(k) Collaborating with professional groups in setting standards for QOC.
(l) collaborating with training institutions in development of QA in training of health personnel;
(m) setting and monitoring standards and make recommendations for licensing or registration of private health related institutions and programmes; and
(n) initiating the developing of legislation for effective regulation of QOC.

3. The highest priority will be give to establish a quality culture in the health services.
4. IEC programmes for health sector managers, health care providers and the community will be developed and implemented with the aim of building a "quality culture". At a minimum the IEC programmes will inform politicians, health managers, professionals and the public of the cost and impact of poor quality and the importance of improving QOC. The programmes will publicize and inform patients of their rights and responsibilities in utilization of health care at different levels and types of health institutions. Finally, the programmes will encourage and support the inclusion of quality of care in health education at schools.

5. A regional QA committee will be established at each Regional Health Directorate. It will be responsible for QA at district level and supervision of district QA committees and hospital QA programmes.
6. A district QA committee will be established at each District Health Office. It will be responsible for QA at all sub-district health facilities.
7. All government primary care facilities (sub-health posts, health posts, primary health care centre) will meet minimum standards set by the MOH for physical infrastructure, amenities, equipment, instruments, and staffing levels. Facilities will be assessed annually by the District Health Office. The finding will be analyzed by the QAU, which will provide fee back to DHO, makes recommendations for action and disseminate findings to relevant sections f MOH.
8. All private health care institutions (private nursing homes, hospitals, and clinics) will meet minimum standards and norms for licensure and operations set by the MOH. The QAU will assess institutions and approve for licensing if standards are met.
9. All NGOs (e.g. INGOs, NGOs, local NGOs, community-based organizations etc.) operating in the health sector will meet quality standards set by the MOH. The AU will establish criteria for registration of NGO health programmes and will recommend approval for establishment and registration of NGOs, which meet quality criteria.
10. Each service (e.g. MCH, CDD/ARI, EPI, FP, SM, TB, Leprosy, AIDS/STD etc.) will establish a quality assurance programme with established standards and guidelines for care appropriate to Nepal context.
11. All government primary care facilities will have a locally managed system for improving quality of care. The facility's Health Management Committee will meet regularly to identify and discuss local problems affecting quality of care and to propose and implement solutions. In reviewing quality of care the client perspective of quality will be emphasized (e.g. condition of facilities, presence of staff availability of drugs, attitude of staff etc.). The District QA Committee will supervise quality of technical care.
12. National quality of care indicators will be developed and utilized to monitor hospital performance. Selected indicators will be identified which can be measured using routinely collected data (e.g. Maternal mortality, post-operative infection rates, bad occupancy rates etc.).The performance of individual hospitals will be compared with set

standards for these indicators. Specific hospitals will be identified for quality improvement interventions.

13. An accreditation system with minimum standards for physical infrastructure, amenities (e.g. Water, sanitation etc.) equipment, instruments, and staffing levels will be established for district hospitals. The standards to be used in accreditation will be set by Ministry of Health's Quality Assurance Unit.
14. Regional Health Directorate will undertake an annual assessment of district hospitals .The findings shall be analyzed by QAU which will provide feedback, make recommendations for action and disseminate findings to relevant sectors of MOH. Those facilities, which achieve standards, will be awarded accreditation.
15. All districts, zonal, regional and specialized hospitals will have quality assurance programmes that include a Quality Assurance committee will be multi-disciplinary in nature. Representing both clinical and local quality problems, and implement appropriate remedial action with available resources. The Quality Assurance Committee will identify and analyze local quality problems, and implement appropriate remedial action with available resources. The Quality Assurance Unit of Ministry of Health or Regional QA Committees will supervise the work of the Hospital QA Committees. In supporting the QA Programme medical, nursing and clinical audits will be institutionalized as a key technique will be established as part of routine hospital procedures (case references, mortality reviews, infection control procedures, clinical protocols, standard drug lists etc).
16. The Department of Drug Administration will establish a programme to regulate and control the production, marketing, distribution, export-import, storage, and utilization of drugs. As part of the programme, the National Quality Control Laboratory (NQCL) and National Drugs Research Laboratory (NDRL) will monitor quality of drugs manufactured by national producers. The capacity of the NDRL will be increased to improve quality control of imported drugs. Moreover, the NQCL will develop in guidelines for quality control laboratories in the drug by private wholesale and retail pharmacies will be strengthened. Finally, pharmacy assistants will be trained in dispensing of drugs; the National List of Essential Drugs will be revised regularly; and standard treatment guidelines will be further developed and promoted.
17. A programme will be established to ensure the delivery of high quality "Essential Health Care" services by traditional systems of medicine (Ayurveda, Homeopathy, Unani, Naturopathy etc.) The Department of Ayurved and units responsible for other systems of traditional medicine will develop a QA system in co-ordination with the Ministry's Quality Assurance Unit. For each system of traditional medicine, standard guidelines will be developed for production of ingredients, preparation of formulations, and procedures used in the treatment of diseases. These guidelines will be prepared in collaboration with the relevant professional associations. The use of treatments of proven effectiveness, especially those which are part of the "Essential Health Care", will be promoted. Quality assurance and accreditation systems for training institutions for traditional medical practitioners will be established. The quality of care at institutions providing traditional medical services will be monitored and supervised by the Ministry of Health.

Chapter 12

Policies on Essential National Health Research

Background

Nepal is confronting a changing health scenario characterized in part by a demographic transition, changes in the health environment and the “multiple burden of disease”. The old problems of communicable disease still pose a significant challenge, while there is an emergence of lifestyle related non-communicable diseases.

To respond to the changing health scenario, achieve the vision of health and development that guides the Second Long Term Health Plan and meet the Plan’s targets. It may be necessary to reorient the health system, change health policies, the organization and administration of health services, financing and budgeting and the selection and application of appropriate technologies. To determine the most appropriate approaches for realizing such change, those involved in health sector development require appropriate, accurate and detailed information. Unfortunately, such information is often lacking, inadequate, or unreliable. The result too often is inappropriate decisions with the undesirable consequences corrected through a painful process of trial and error without an assessment of what led to those consequences; and the potential for repeating such mistakes.

As the World Health Assembly has noted all health policies should be based on valid scientific evidence. In addition to the data routinely available in health information systems, many decision- making situations require additional detailed data that is provided through specifically designed health research studies. Essential National Health Research (ENHR) provides the requisite data, analysis and interpretation necessary for informed decision-making through:

- the participation of all concerned and involved in health care development(e.g. politicians, policy-makers .planners ,other decision-makers, health and health related professionals and the community):and
- a broad inclusive view of health research as an instrument of development.

The need for ENHR lies in its contribution to improving the decision making process all levels (central, regional, district and below).ENHR provides the necessary research base to: allow for an limited resources: improve health policy and management: foster innovation; and provide a foundation for a stronger developing country voice in setting regional and international health priorities.

ENHR can be characterized as having a national and sub- national focus. That is, ENHR pursues research priorities and a research agenda to solve health sector needs at al levels with networking for information exchange and transfer of appropriate technology. ENHR includes various types of research and may employ different methodologies simultaneously. It linkages between research, policy and action, based on informed decision making; and gives priority to the disadvantaged and vulnerable groups.

Critical Areas for the Development of ENHR

1. Consensus and National Commitment Building for ENHR

   It is necessary to raise awareness among those involved in health sector development of the importance of ENHR as a tool in health planning, programme management and health policy development. Consensus building must occur among the Ministry of Health, TU, Institute of Medicine, BPKHIS, the Nepal Medical, Paramedical and Nursing Associations and other relevant professional associations, NGOs and the various representatives of the community –District and Village Development Committees etc. Such consensus is required to create the necessary supportive environment for health research at all levels of the health care system. Similarly, a commitment from the national health programme planners and implementers must be generated. As part of the consensus and commitment building process, it will be necessary to "bridge the gap" between:

   - the researchers and the users of health services research; and
   - the research scientists from academic institutions-a group which places greater emphasis on the philosophy and methodology of scientific research and the "new breed of investigators"-the programme managers, deliverers of health care and the community who are more pragmatic and more concerned with utility of research findings for making rational operational decisions.

2. Institutional Strengthening

   To date, whatever has been accomplished in health research in Nepal mainly is attributable to the interest and commitment of the individual researchers. The contribution of the individual researcher not withstanding, the continued encouragement and sustainability of health research requires a strong institutional presence at central, regional, zonal and district levels. Such a presence can provide the necessary leadership, identify needs, provide support, help networking and co-ordinate participatory health research activities. At the central level one of the institutions is the Nepal Health Research Council, the national focal point for health research and a focal point for ENHR in Nepal.

   In developing focal points for ENHR, there is a need for institutional strengthening efforts. At a minimum these should focus on expanding existing infrastructure (administrative and library facilities, data processing facilities). Training and upgrading the professional staff's research skills and providing direct support for research.

3. Building Research Capacity

   The focus of research capacity building is the development of a critical mass of individuals with the appropriate research skills to conduct participatory health research. This requires a systematic and sustained effort to train members of the community, health and health related personnel, programme managers, policy-makers and academic researchers. It also requires that support be provided while they gain experience in using the skills acquired during training. Across these

categories is the “young researchers”, who demonstrate a basic level of research competence, but who have not yet accomplished researches.

In training members of the community and health services personnel the focus should be on providing the knowledge and basic skills to identify, plan and carry out simple research projects at the community or operational level. Training for health service managers would include the basic skills taught to members of the community and health personnel. The training would develop management skills that use research findings in problem solving. For other decision-makers, the emphasis would be on assessing/evaluating, interpreting and understanding research findings and using such findings for decision-making. For young researchers, the focus should be on supporting research studies as a practical learning mechanism to develop and improve their research skills.

With academic and establish researchers the emphasis should be on promoting inter disciplinary research and developing skills in participatory research activities involving health personnel and health services managers. Underpinning these capacity building activities is the introduction of health research skills into the curriculum of institutions such as IOM and into the basic, post basic, and in-service training of health personnel.

4. Creating Awareness and Demand for ENHR Activities

   ENHR is acknowledged to be a valuable management tool for effective decision-making at all levels of the health system. However, it is rarely used in the policy or decision-making process. To counter the negative and indifferent attitudes of decision-makers, managers, health professionals and the community towards health research, efforts must be focused on increasing their knowledge of the potential uses of ENHR for informed decision-making. These efforts should be supplemented by providing training in the use of research findings for decision-making and in the broad dissemination of research findings.

5. Promotion and Advocacy of ENHR

   Resources available for research are limited. The effective promotion and advocacy of ENHR requires researchers to focus on areas that have been identified as priorities and for which solutions can be found through health research. The researchers must be made are of the need to adopt a participatory approach interacting with the community, managers and policy makers in the research process. They must recognize the frequent need to adopt a multi-disciplinary approach. Finally, in ENHR at all levels of the health system, the establishments of peripheral research centre in co-ordination with Regional Health Directorates become a valuable tool.

6. Research Priorities and Research Agenda

   Research priorities and a national research agenda are essential for focusing resources on those problems, issues and concerns affecting health sector development. The development of research priorities and a research agenda should flow from national health policies and priorities for which there is insufficient information for appropriate decision-making. It should be based on specific criteria

that recognize the magnitude of the problem or issue; the probability of finding solutions and the feasibility of their application; as well as the availability of persons, facilities and funds to carry out the research. The research priorities and research agenda also should be guided by the level of ongoing research to solve the problems, the benefits that would accrue from applying the results; and the potential usefulness of the results in solving other problems.

Policies for implementing Essential National Health Research

1. Active encouragement will be given to forging a consensus and developing a national commitment to ENHR among those involved in health sector development (e.g. politicians, policy makers, planners, programme managers, health and health related professional and the community)
2. Efforts will be undertaken to create awareness and demand ENHR, promote a health research culture within health and health related sectors, education and training institutions and emphasize the uses of research for informed decision-making.
3. Research priorities and a national research agenda will be developed that will serve as the basis for the allocation of resources for health –research by the government, private sector, NGO, INGO and the donor community. At a minimum he following areas should be addressed:
    - the influence of other sectors on health outcomes and the role the health sector can play in advocating and guiding non-health sector activities that influence health.
    - Planning and management of service delivery, priority setting, allocation of pubic resources and health needs assessments.
    - Health care financing including user fees, equity and the effectiveness of exemption mechanisms.
    - Incentives as they influence demand and supply for health services.
    - Public, private and NGO sector roles in financing and provision of health care including regulation and incentive setting, integrating private practice by public sector physicians.
    - Health behavior research directed at understanding factors affecting appropriate utilization of health services and facilities.
    - Educational research directed at employing new/revised educational technologies for change in health behaviors:
    - Human resources policy and employment structures in the public, private and NGO sectors:
    - Quality assurance and monitoring systems;
    - Environment health research;
    - Research on traditional medicine;
    - Emerging and re-emerging diseases; and
    - Substances abuse.

4. The private sector, NGOs, INGO’s and the donor community will be encouraged to assist GON in supporting institutional strengthening and the development of a

critical mass of individuals able to undertake ENHR at different levels of the health care system.

5. Mechanisms for maintaining ethical, scientific and technical standards in health research shall be developed and supported.
6. The development of networking arrangements among individuals and organizations/institutions undertaking research will be encouraged. The networking arrangements will promote the dissemination and exchange of information on ENHR concepts and methods, research methodologies and techniques, ongoing and completed research projects etc.
7. The development of bibliographic database and publication of health research journals research shall be promoted especially for operational level.
8. Funding will be encouraged from GON, health institutions, private sector. NGOs, INGOs and the donor community to support ENHR that address established research priorities and issue included in the national research agenda.

Chapter 13

Policies on Changing Trends of Communicable and Non- communicable Diseases

Changing Trends in Diseases

1. Changing trends of communicable and non-communicable diseases will be addressed within the context of the “ Essential Health Care”(see chapter 4”Essential Health Care at the District” and Chapter 5”Essential Health Care Beyond the District”)
2. An epidemiological surveillance system, including effective IEC measures, laboratory back-up for the early detection and confirmation of diagnoses and antibiotic sensitivity will be enhanced. Emphasis is on the strengthening of the early existing infrastructures rather than developing a new surveillance system.
3. A rapid response team that can quickly respond to any disease outbreak and reliable reporting system will be developed.
4. Standard protocols for diagnosis of diabetes mellitus will be developed. The focus will be made on primary and secondary cases only.
5. A concerted effort will be made to reduce the prevalence of smoking with emphasis on community education-schools, work places media. Regulations will be developed and enforced to restrict smoking in public places.
6. Operation research will be carried out for improving the efficiency and effectiveness of cataract care.
7. A primary oral health programme directed towards prevention and care will be developed and implemented .The programme will be combined with other health services or school health activities.

Chapter 14

Emerging Health Issues

Emerging Health & Related Issues

In addressing the health problems and issues the SLTHP has not dealt in depth with the following emerging health issues. These issues should be addressed in formulating the Five Yearly Development Plans.

1. Environmental health and sanitation air pollution
   - water supply
   - solid waste disposal and sewage system
   - excreta disposal
   - food safety and food hygiene
   - housing, ventilation, lighting, roofing etc.
   - work place

3. Occupational health:
   - occupational safety
   - health and hygiene
   - sound pollution
   - legislation

4. Urban health:
   - population pressure
   - 'healthy cities' initiative including services provided through municipalities and towns.

5. School health:
   - health and nutrition
   - personal hygiene
   - school environment
   - torture and child abuse

6. Medico-legal issues
   - client's right
   - quality of care
   - substance abuse

7. HIV/AIDS and STDs
   - migration
   - poverty
   - gender
   - girl-trafficking
   - STDs problems
   - community based care for HIV

8. Accidents and injuries
   - road traffic and accident
   - falls and injuries
   - agricultural accident, use of pesticides
   - industrial accident
   - poisoning

8. Problems of the elderly
    - homeless
    - expansion of geriatric services

9. Care for the disabled
    - blindness
    - hearing impaired
    - polio

10. Centre of excellence
    - training institutes
    - trauma centre
    - cancer hospital
    -infertility centre
    -cardiovascular diseases
    - oral health
    - centre for communicable diseases
    -other specialties
11. Health systems decentralization
    - Cost-recovery
    - Devolution of power
    - Managerial efficiency

PART IV

Implementation and Institutionalization of the Second Long Term Health Plan

Chapter 15

Action Plan for Implementation of SLTHP

1. Implementation Strategy for Second Long Term Health Plan

The implementation of a long-term requires commitment from the government, NGOs and the private sector to the vision, goals, and objectives contained in the plan. It also requires that reasonable predictions be made of human and financial resources that will be required to the health sector. Without such commitments the implementation of a perspective health plan is not possible.

Recognizing that there may be a need for adjusting the policies to accommodate changes in the health sector, the "Second Long Term Health Plan" is not perceived as a fixed blue print for the coming 20 years, rather it is viewed as a resource document and rolling plan for the preparation of successive five- year development plans and annual implementation plans. The SLTHP should be reviewed every three years and linked to on-going evaluations.

2. General Strategies to be Pursued in Successive Five Year Development Plans

The general strategies to be pursued in the successive five-year development plans provide the framework for implementing the specific policies for achieving the vision, goals, objectives and targets of the SLTHP. The general strategies noted below do not replace the specific policies earlier stated in Part III of the SLTHP.

a. 9th Five Year Plan 1997-2002

- Provision of essential health care services at the district with special reference to health promotion/health prevention activities, infectious diseases, nutrition promotion reproductive and child health services.
- An operational primary care network in terms of infrastructure, manpower, management, supplies and drugs.
- Strengthened TB, Kala-azar and Malaria control programmes.
- Integrated delivery of services, integrated training, supervision and monitoring.
- Development of referral care in a phased manner.
- Development of standard drug treatment, schedules, service norms, and quality assurance mechanisms at all levels, in public, NGO and private sectors.
- Establishment of units for management of trauma and burns at district hospitals
- Strengthening the District Health System.
- Decentralized management through local government and community participation.
- Advocacy for emerging diseases especially HIV/AIDS, tobacco, Alcohol and Substance abuse.
- Active involvement of private, NGO in financing and delivery of health services.
- Development and implementation of alternative financing schemes.
- Development and integration of traditional systems of medicine.

- Essential National Health Systems Research.
- Plan for geriatric care services.

b. 10th Five Year Plan 2002-2007

-consolidation of basic and primary health care services
- Focus on HIV/AIDS and Non-Communicable Diseases
- Fully developed referral care hospitals
- Computerized MIS linked to districts.
- Basic urban health services
- Quality of hospital services
- Development of laboratory and diagnostic centers
- Regulation of private sector – service and training
- Well institutionalized cost-recovery systems
- Increased role of traditional systems of medicine to manage chronic and non-communicable disease
- Expand geriatric care services.

c. 11th Five Year Plan 2007-2012

- More active participation of Private sector in health care delivery
- Substantial cost-recovery
- Control of non-communicable diseases and emerging diseases like HIV/AIDS
- Centers for Excellence in tertiary care
- Fully functional geriatric care facilities

d. 12th Five Year Plan 2013-2017

- Increased participation of Private sector and NGO sectors in health care delivery
- Full cost-recovery and health insurance scheme
- Establishment of centre for excellencies in cardiovascular disease, trauma centre, infertility clinics
- Urban basic health services
- Expansion of geriatric care facilities

3. Institutionalization of the Second Long Term Health Plan

- Ministry of Health, Policy, Planning, Foreign Aid and Monitoring Division will act as the focal point for co-ordination and institutionalization of the LTHP including the "Plan's" periodic revision.
- All donor and foreign aid assistance to the health sector will be based on the specific needs and priorities set forth in the Five Yearly Blocks of Second Long Term Health Plan (9th Plan, 10th Plan, 11th Plan and 12th Plan). Projections of human, material and financial resource and investment plans will be made in developing the detailed content of the Five-Year Plans.
- Co-ordination and collaboration between multi-and bilateral donors, NGOs, INGOs and the government/public sector will be enhanced o achieve national goals and objectives of health sector development.

- Issues raised in the Mid-terms Reviews of the Five Year Development Plan will be addressed while reviewing and updating the 20 years prospective SLTHP.
- National Planning Commission while developing the five-year development plan will critically review SLTHP and will adhere to the issues raised therein.
- Policy units in the National Planning Commission, Ministry of Health and Department of Health Services will be the key actors in reviewing the SLTHP. The available staff and resource needs to be backed up by technical inputs and expertise to do a rigorous policy analysis.

Appendices

1. List of Abbreviations and Acronyms

2. Organogram

3. Members of Technical Working Group

4. List of Personnel Involved in the Development of SLTHP Document

5. Bibliography

Appendix-1

List of abbreviation and Acronyms

ADB	Asian Development Bank
AHW	Auxiliary Health Worker
AIDS	Acquired Immuno -Deficiency Syndrome
ANM	Assistant Nurse Midwife
ARI	Acute Respiratory Infection
ASFR	Acute Respiratory Infection
CBO	Community Based Organization
CBR	Crude Birth Rate
CDO	Chief District Officer
CDR	Crude Death Rate
CHV	Community Health Volunteer
CMA	Community Medicine Auxiliary
CPR	Contraceptive Prevalence Rate
CTEVT	Council for Technical Education and Vocational Training
DALY	Disability Adjusted Life Years
DDA	Department of Drug Administration
DDC	District Development Committee
DHO	District Health Office
DHS	District of Health Services
DOA	Department of Ayurved
DOT	Directly Observed Therapy
DWSS	Department of Water Supply and Sanitation
ENHR	Essential National Health Research
EPI	Expanded Program of Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
FPAN	Family Planning Association of Nepal
GO	Governmental Organization
GoN	Government of Nepal
HA	Health Assistant
HIMDD	Health Institutions and Manpower Development Division
HIV	Human Immuno- Deficiency Virus
HMIS	Health management Information System
HOBIS	Hospital Based Information System
HP	Health Post
HRH	Human Resources for Health
HURDIS	Human Resource Development Information System
IDD	Iodine Deficiency Disorder
IEC	Information Education and Communication

IMR	Infant Mortality Rate
IOM	Institute of Medicine
JE	Japanese Encephalitis
LMD	Logistics Management Division, DHS
LMIS	Logistics Management information System
LNGO	Local NGO
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MOE	Ministry of Education
MOH	Ministry of Health
NAC	Nepal Ayurvedic Council
NGO	Non-government Organization
NHEICC	National Health Education, Information and Communicable Centre
NHP	National Health Policy
NHRC	Nepal Health Research Council
NHTC	National Health Training Council
NMC	Nepal Medical Council
NNC	Nepal Nursing Council
NNGO	National NGO
NPC	National Planning Commission
NPHL	National Public Health
OPD	Outpatient Department
PFAD	Planning and Foreign Aid Division, DHS
PHC	Primary Health Care/Primary Health Care Centre
PPFAMD	Policy, Planning, Foreign Aid and Monitoring Division, MOH
QA	Quality Assurance
QOC	Quality of Care
RHD	Regional Health Services Directorate
RMS	Regional Medical Store
RTC	Regional Training Centre
SAHW	Senior Auxiliary Health Worker
SHP	Sub- Health Post
STD	Sexually Transmitted Diseases
SWC	Social Welfare Council
TB	Tuberculosis
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
VBD	Vector Borne Diseases
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

Appendix 3

Technical Working Group

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Appendix 4

Participants of the Seminar, Workshops and Meetings

(November 1995-December 1997)

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1. Adhikari Ram Chandra (Mr.), Member of Parliament, House of Representative
2. Baral Guru (Mr.) Member of Parliament, House of Representative
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8. Sharma Dhurba S. (Dr.) Member of Parliament, House of Representative
9. Uprety Shankar (Dr.) Member of Parliament, House of Representative
10. Yadav Suresh C. Das (Mr.), Asst. Minister for Health, MoH

2. National Planning Commission

1. Baidya Bal Gopal (Dr.)	Member	National Planning Commission
2. Chapagain Devendra (Dr.)	Member	National Planning Commission
3. Mathema Padma (Mrs.)	Under Secretary	National Planning Commission
4. Pyakuryal Kailash (Prof.)	Ex. Member NPC	National Planning Commission
5. Singh Shri Bhagwan (Mr.)	Joint Secretary	National Planning Commission

3. MOH/DHS

1. Acharya Hari Nath (Dr.)	Director	Planning Division, DHS
2. Acharya Shesh Raj (Dr.)	Medical Superintendent,	Nardevi Ayurved Hospital
3. Amatya Chattra (Dr.)	Chief	PPFA & MD, MOH
4. Aryal Prakash (Dr.)	Director	National Center for AIDS & STD Control,Teku
5. Aryal Som Nath (Dr.)	Specialist Secretary	MOH
6. Bajracharya Ghan M. (Dr.)	Director	National Public Health Laboratory
7. Bam Dirgha Singh (Dr.)	Director	National Tuberculosis Centre
8. Bhandari Bhim Shanker (Mr.)		Joint Secretary, MoH
9. Bharati Pushkal (Dr.)	Director	PIU
10. Bhattarai D.D. (Dr.)	Director	Dept. of Drug Administration
11. Bhattarai Shyam P. (Dr.)	Director	NHEICC

12. Bista M.B. (Dr.)	Director	Child Health Division, DHS
13. Chalise Damodar Sharma (Mr.),	Director,	Department of Ayurved
14. Chataut B. D. (Dr.)	Chief	PPFAD, MoH
15. Duwadi T. P (Dr.)	Medical Officer	Department of Ayurved
16. Gautam Balaram (Mr.)	Section Officer	Planning Division, MoH
17. Gyawali Devendra (Mr.)	Statistical Officer	MOH
18. Jha Shiva Shankar (Dr.)	Regional Director	Central Health Directorate
19. K.C. Kedar Narsingh (Dr.)	Advisor	MoH
20. K.C. Vijaya (Ms.)	Specialist Secretary	MOH
21. Karki Benu BDr. (Dr.)	Director	Epidemiology/Disease Control Division, DHS
22. Karki K.B. Singh (Dr.)	Director	Logistics Management Division, DHS
23. Khadka Rishi (Mr.)	Section Officer	Personnel Section, DHS
24. Khanal N.P. (Dr.)	DHO	Dhading
25. Khatri I.B. (Dr.)	Consultant	MoH
26. Manandhar Durga P (Dr.)	Special Secretary	MOH
27. Marasini B.R. (Dr.)	DHO	Kavre
28. Neupane R. Chandra (Mr.)	Under Secretary	Planning Division, MOH
29. Ojha Ghana Nath (Mr.)	Secretary	Ministry of Health
30. Pandey Kalyan Raj (Dr.)	Director General	DHS
31. Pant P. P. (Ms.)	Director	NHTC
32. Parajuli K.P. (Dr.)	Director	Department of Ayurved
33. Pathak Laxmi Raj (Dr.)	Director	Family Health Division, DHS
34. Paudel Sri Ram (Mr.)	Secretary of Health	MOH
35. Pradhan Yasho Bardhan (Dr.)	Director	HIMDD, DHS
36. Rajbhandari Renu (Dr.)	Medical Officer	MOH
37. Rana N. B. (Dr.)	Coordinator	MD Program PGMECC
38. Raya Bhanu Bhakta (Mr.)	Chief	CRHD
39. Rayamajhi S. B. (Mr.)	Chief	Finance Section, DHS
40. Sharma Shiv Bhakta (Mr.)	Joint Secretary	MOH
41. Sheik Asfaq (Dr.)	Director	Department of Drug Administration
42. Shrestha Badri Lal (Dr.)	Director General	DHS
43. Shrestha Hira (Dr.)	Joint Secretary	MoH

44.	Shrestha Jeeb Krishna (Mr.)		DHS
45.	Shrestha Jyoti (Mr.)	Under Secretary	MoH
46.	Shrestha Parbati (Dr.)	Under Secretary	Planning Division, MoH
47.	Sthapit Nanda Man (Mr.)	Training Officer	NHEICC
48.	Thapa B. B. (Mr.)	Senior Pharmacist	Department of Drug Administration
49.	Thapa Manodari (Mrs.)	Senior Nurse	MOH
50.	Tuladhar Sanu (Ms.)	Senior Nurse	MOH
51.	Udas D.R. (Mr.)	Computer Programmer	Planning Division, MoH
52.		Regional Director	Central Region
53.		Regional Director	Eastern Region
54.		Regional Director	Western Region
55.		Regional Director	Mid-Western Region
56.		Regional Director	Far Western Region
57.		DHO	Bhaktapur
58.		DHO	Lalitpura
59.		DHO	Kathmandu
4.	**Hospitals**		
1.	Dahal Madhav (Dr.)	Director	Bir Hospital
2.	Dhital Saroj (Dr.)	Director	Model Hospital
3.	Dhungana S. (Dr.)	Member Secretary	Shahid Ganga Lal National Heart Centre
4.	Khan Sabbir (Dr.)	Senior Medical Officer	Homeopathy Hospital, Patan
5.	Koirala Govind (Dr.)	Member Secretary	Shahid Ganga Lal National Heart Centre
6.	Malla D. S. (Dr.)	Senior Consultant	Maternity Hospital
7.	Osti Bidur (Dr.)	Member – Secretary	B.P. Koirala Memorial Cancer Hospital
8.	Sharma G. (Dr.)	Director	TUTH
9.	Shrestha Ram Kanta (Dr.)	Director	Dhulikhel Hospital
10.	Singh D. M. (Dr.)	Director	Mental Hospital
11.	Upadhyaya S. (Dr.)	Director	Maternity Hospital
12.	Vaidya V.N. (Dr.)	Consultant	Sukra Raj Tropical & Infectious Disease Hospital
13.		Director	Birendra Police Hospital
14.		Director	Army Hospital
5.	**Councils and Professional Bodies**		
1.	Ban Laxmi Raman (Mr.)	Chairman	Nepal Public Health Association
2.	Baral Manindra R. (Dr.)	President	Nepal Medical Council

3.	Basnet Kunti (Ms.)	Chairperson	Nepal Nursing Association
4.	Basnet Praya (Dr.)	Member Secretary	Social Welfare Council
5.	Bhurtel Shyam Krishna (Dr.)	General Secretary	DDC Association
6.	Das Uma Devi (Dr.)	Chairperson	Nepal Nursing Council
7.	Gajurel Govinda (Dr.)	Director	CTEVT
8.	Gautam Shyam Bhai (Mr.)	Chairman	Nepal Paramedical Association
9.	Joshi Bhoj Raj (Dr.)	President	Nepal Medical Council
10.	Karki Surya Bahadur (Mr.)	Coordinator	Naturopathy Council
11.	Rai Bishnu (Ms.)	President	Nepal Nursing Association
12.	Rijal Bhola (Dr.)	Vice President	Nursing Home Association
13.	Shah Dev Narayan (Dr.)	Acting President	Nepal Medical Association
14.	Sharma Anjani K. (Dr.)	President	Nursing Home Association
15.	Sharma Bijaya Kumar (Dr.)	Chairman	Nepal Medical Association
16.	Shrestha M. P. (Prof. Dr.)	Chairman	Nepal Health Research Council
17.	Subedi Chandra (Ms.)	Member-Secretary	Social Welfare Council
18.	Upreti Ram P (Dr.)	Member Secretary	Nepal Health Research Council

6. University and Medical College

1.	Acharya Gopal (Dr.)	Director	Dept. of Medical Education, TUTH
2.	Adhikari Ramesh Kanta (Dr.)		Professor, IOM, Tribhuvan University
3.	Adhikary S. M. (Mr.)	Registrar	Kathmandu University
4.	Bhatta Bhim Dev (Dr.)	Professor	Dept. of Public Administration, TUTH
5.	Dixit Hemang (Dr.)	Director	Health Learning Materials Centre
6.	Dixit Sundar Mani (Dr.)	Director	B.P. Koirala Institute of Health Sciences
7.	Gartaulla Ritu P. (Dr.)	Lecturer	Tribhuvan University
8.	Karmacharya Puran C. (Dr.)	Dean	Institute of Medicine
9.	Koirala Shekhar (Dr.)	Rector	BPKIHS
10.	Mishra Chaitanya (Dr.)	Professor	Dept. of Sociology, Tribhuvan U
11.	Nagra (Prof.)	Dean	Manipal Medical College
12.	Pant Chet Raj (Dr.)		Institute of Community Health
13.	Pant Devendra Singh (Dr.)	Lecturer	Medical Education Department, IOM
14.	Pradhan S.B.S. (Dr.)	Campus Chief	Ayurved Campus
15.	Pradhananga Yogendra (Dr.)		Reader, Institute of Medicine
16.	Prasai Bhisma Raj (Dr.)	Advisor	Nepalganj Medical College
17.	Shrestha Bimala (Dr.)	Professor	Institute of Medicine
18.	Singh Indira (Dr.)	Professor	Tribhuvan University
19.	Singh L. M. (Dr.)	Professor	Ayurved Campus
20.	Tuladha S. (Ms.)	Professor	CERID
21.	Upadhyay Madan P. (Prof. Dr.)		Professor/Director Institute of Medicine/BPKIHS, Dharan

7. Other Ministers

1.	Ghimire Madhav (Mr.)	Jjoint secretary	Ministry of Finance
2.	Nepal Khem Raj (Mr.)	Joint secretary	Ministry of Population & Environment

3.	Pokharel Rebati Raman (Mr.)	Secretary	MoH
4.	Pyakurel Dinesh (Mr.)	Director General	Department of Water Supply & Sewerage
5.	Regmi Khem Raj (Mr.)	Secretary	MoH
6.	Shrestha Sundar Man (Mr.)	Under Secretary	Ministry of Finance
7.	Singh Narsingh Narayan (Dr.)		Joint Secretary Ministry of Local Development

8. Ex GoN Personnel/Officials

1.	Das Gauri S.L. (Dr.)	Ex-Director General	DHS
2.	Pandey Badri Raj (Dr.)	Ex-Director	DHS
3.	Pandey Devendra Raj (Mr.)	Ex-Minister	
4.	Prasad Laxmi Narayan (Dr.)		Consultant ENT surgeon
5.	Shah Narayan Keshari (Dr.)		Ex-Officer WHO
6.	Shrestha Bihari Krishna (Mr.)		Free Lance Consultant

9. NGOs and Others

1.	Acharya Meena (Dr.)	Director	HDS
2.	Bhadra /Rajendra (Dr.)		BP Memorial Health Foundation
3.	Bhattarai Anil (Mr.)	Journalist	
4.	Dhakhwa Dev Ranta (Mr.)	Secretary-General Nepal	Red Cross Society
5.	Dhungel Chandra (Mr.)		CDP, Surkhet
6.	Ghimire Jagadish (Mr.)	Chairman	Tamakoshi Sewa Samity
7.	Karki Arjun (Mr)		NGO Federation
8.	Karki Roshan (Ms.)		Ama Milan Kendra
9.	Karki Y.B. (Dr.)	Director – General	FPAN
10.	Mulmi S.L. (Mr.)	Executive Director	RECPHEC
11.	Neupane Ram Krishna (Mr.)	Director General Nepal	Family Planning Association
12.	Onta Sharad (Dr.)		RECPHEC
13.	Pradhan Peden (Dr.)		PHECT
14.	Pyakurel Sushil (Mr.)		INSEC
15.	Sahi Sama (Ms.)	Naturopath	
16.	Shrestha Janak Das (Mr.)	Free Lancer	
17.	Shrestha Kapil (Mr.)		HURON
18.	Tuladha P. R. (Mr.)		Forum for Protection of Human Rights
19.	Upadhyay P. (Mr.)		WICOM
20.	Vaidya T. M. (Dr.)		Director Nepal Fertility Care Centre
21.	Executive	Director	New Era

10. INGOs/Bilateral Agencies

1.	AL-Nahi Q. (Dr.)	Nutrition & Health Specialist	UNICEF
2.	Alok Swatantra (Mr.)	Resident Representative	UNFPA
3.	Bhattarai Anjali (Mr.)	Project Officer	UNDP
4.	Bista Ramesh (Mr.)	Information Management Expert	GTZ/PHCP

5.	Bondurant Tony (Dr.)	Project Manager	ODA/ERPHCP
6.	Brisott M. (Dr.)	Project Manager	SDC, Ekantakuna
7.	Burki Albert (Mr.)		SDC
8.	Campbell Bruce (Mr.)	Program Specialist	UNFPA
9.	Chaulagain C. (Mr.)	Consultant	UNFPA
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11.	de Witt Vincett (Dr.)	Consultant	ADB
12.	Dhakal Ramji (Mr.)	Health System Development Expert	GTZ/PHCP
13.	Drexler Antony (Dr.)	Team Leader	Social Sector Review Team, ADB
14.	Durvasula R. (Dr.)	Consultant	World Bank
15.	Feirman Harry (Dr.)	consultant	WHO
16.	Gayars Othello (Dr.)	Consultant	World Bank
17.	Ghimire Raghu (Mr.)	Human Resources Expert	FTZ/PHCP
18.	Gingerich Molly (Ms.)	Chief, Health FP	USAID
19.	Glenn Post (Dr.)	Chief, Health & FP	USAID
20.	Gopal Benu (Mr.)	Consultant	UNDP
21.	Gould Bill (Dr.)	Health Director	UMN
22.	Gurung Dambar		Health Care Project US
23.	Gurung Hem (Mr.)		NORAD
24.	Gurrung Satish (Mr.)	Logistics Management Exert	GTZ/PHCP
25.	Hamlet Neil (Dr.)		INF
26.	Harding Richard (Dr.)	Director	UMN/CHDP
27.	Herringshaw V. (Ms.)	Consultant	ODA/ERPHCP
28.	Islam Md S. (Dr.)	Consultant	WHO
29.	Jayawickramarajah P.T. (Dr.)		Medical Educator WHO
30.	Jimba Masammisa (Dr.)	Expert	JICA
31.	Johnsen Jon Kristain (Mr.)	Director	Redd Barna
32.	Khadka Madhav (Mr.)	Programme Coordinator	JICA
33.	Kudo Mikako (Ms.)	Deputy Director	JICA
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35.	LeMaster J (Dr.)	Ag Health Service Director	UMN
36.	Leslie Keith (Mr.)	Director	SCF (USA)
37.	Lavitt Martha (Dr.)	Director	Redd -Barna
38.	Long Carroll (Ms.)	Resident Reprehensive	UNDP
39.	Mac Donald Maria (Dr.)	Consultant	World Bank
40.	Mackay Bruce (Mr.)	Second Secretary	British Embassy
41.	Manandhar P. K. (Mrs.)	Advisor	USIAD
42.	Manandhar Vijaya (Dr.)	National Operations Off.	WHO
43.	Mc Connel Claudia (Ms.)	Director	SCF (UK)
44.	O'del Daniel (Mr.)	Resident Representative	UNICEF
45.	Ono Yukari (Ms.)	Assistant Representative	JICA
46.	Pigott William (Dr.)	WR	WHO
47.	Pradhan Birendra (Mr.)	Director	ADRA

48. Presern Carole (Ms.)	Health Advisor	DIFD, British Embassy
49. Puri Sarveshwar (Dr.)	National Prog. Officer	WHO
50. Rai Chanda (Ms.)	Project Director	SCF/UK
51. Rajbhandari Nabina (Ms.)	Consultant	ADB
52. Ramana G.N.V. (Dr.)	Consultant	World Bank
53. Rana Tirtha (Dr.)	Pop. & Health Specialist	World Bank
54. Sarma R.S.S. (Dr.)	Consultant	World Bank
55. Seikh s. Raheem (Dr.)	Director	UNFPA/CST
56. Sekharan C.S. (Mr.)	Project Director	HDP
57. Shah Arjun (Mr.)	Health Economist	PHCP/GTZ
58. Shah Marshuk Ali (Mr.)	Res. Representative	ADB
59. Shrama Mahesh (Mr.)		BMNT
60. Shrestha B. R. (Mr.)	Consultant	UNICEF/ROSA
61. Shrestha I. B. (Mr.)	Consultant	PHCP/GTZ and World Bank
62. Shrestha S. L.		Lutheran World Service
63. Singh Ramesh (Mr.)	Country Director	Action Aid
64. Steinmann J. P. (Dr.)	Team Leader	PHCP/GTZ
65. Stevens David P.N. (Mr.)	Asst. Director	UMN
66. Stuart McNab	Representative	UNICEF
67. Suryarachchi Para (Mr.)	Act. Res. Rep.	World Bank
68. Swatantra Alok (Mr.)	Resident Representative	UNFPA
69. Thapa D.B. (Mr.)	Health Management Specialist	ODA/ERPHCP
70. Thapa Kamala (Ms.)		Mary Stoppes International
71. Thapa Munu (Ms.)	Lecturer	IOM
72. Thapa S. (Dr.)		FHI
73. Tiwari S. R. (Prof.)	Consultant	World Bank
74. Tumbull Aleda (Ms.)		ADB
75. Weakliam David (Dr.)	Medical Officer	UMN
76.	Representative	CARE – Nepal
77.	Country Director	SCF (Japan)
78.	Representative	SNV – Nepal
79.	Country Director	CARITAS
80.	Country Director	Asia Foundation

Note: The designations of the participants refer to their positions at the time of their participation.

Appendix 5

Bibliography

Adhikari R.K. 1991; *Trends in the Nutritional Status in Nepal since 1975.*

Administrative Staff College of India; *Report on Beneficiary Social Assessments Secondary Health Systems Expansion*

Aldeman & Lavy V; *Household responses to public health services: cost and Quality Tradeoffs, The World Bank Research Observes, vol II No. I, 1986*

Almas A., *Status of Health of Nepal*

Associated Pharmatech Consultancy (P) Ltd. 1993; *Nepal Pharmaceutical Guide; 1993*

Bahn M.K. WHO et al; *Disciplinary Epidemiology of Persistent Diarrhea among Young Children in Rural Northern India;1967*

Barnum H.N. et al *Cost Effectiveness of an immunization Program in Indonesia*

Basu R.N. *Measles Vaccine-Feasibility, Efficiency and Complication Rates in Multi-Centric Study.*

Central Bureau of Statistics *The analysis of the 1991 population census.*

Central Bureau of Statistics *Vital Rates from Demographic Samples Survey 1986/87* Statistical, 1988, Bulletin

Central Bureau of Statistics *Population of Projection for Nepal 1991-2011.*

1991

Central Bureau of Statistics *Sub-National Population Projection Nepal 1991-2011*

1994

Central Bureau of Statistics *Population Monograph of Nepal,* 1995

Centre for Human Ecological *Study on Traditional Systems of Health Care in Nepal: A Review for the* Studies, 1996

Development of the Long Term Health Plan (1997-2011)

Centre for Policy Studies, 1997, *A Study of INGOs and NGOs in Health Sector. A Report submitted to PHCP/GTZ.*

Chataut B.D. 1995 *The Health Policy Context for Health Sector Development* Paper Presented at The First Workshop on Long Term Health Plan Development

Chowdhury M. 1995 *Provider's Perspective,* Paper Presented at the First Workshop on Long Term Health Plan Development MOH, Kathmandu

Coll X. 1995 *Health System Development Issues*. Paper Presented at the First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Dhakal R. 1995 *User's Satisfaction with Health Care Services: An Assessment Undertaken in Namibia*. Master's Thesis, University of Hidelberg, Germany.

Dhakal R. 1996 *Beneficiary Assessment:* Paper Presented at The Interim Review Meeting on Long Term Health Plan Development, MOH, Kathmandu

Dixit H. and Maskey B.K. 1995 *Medical Education in Nepal*. Nepal Medical Council/Nepal Medical Association, Kathmandu

Durvasula R.S. 1995 *Unit Cost Analysis.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Durvasula R.S. 1996 *Unit Cost Profiles of Health Facilities.* Paper Presented at The Interim Review Meeting on Long Term Health Plan Development.

Duwadi T.P. 1995 *Ayurved System of Medicine in Nepal*. Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Gautam M. & Shrestha B. 1994 *Health Sector Review Nepal*

Gurung S. 1992 *Cost Effectiveness of Health Manpower Development at IOMTU,* Kathmandu

Gurung S. and Devkota U.N. *Field Trip Report to Siraha*.

Halbwachs H. and Gurung S. *Maintaining Health Care Facilities and Equipment in Nepal*.

Holm J., *Our Enemy: The Tubercle Bacillus,* International Tuberculosis Digest, (IUATLD Special Publication)

HURDEC. 1996 *System Analysis of Planning Personnel/HRH and Financial Management of Public Sector Health Services in Nepal,* Report Submitted to Eastern Region, Primary Health Care Project.

ICOMP 1996 *Management Needs Assessment for Population and Family Planning Program in Nepal Vol. 1 & 2*

Institute of Health, Development *Role of Private Sector in Health (A Study of Selected* Research, 1996 *Health Institutions and Individuals)*

Judith Justice, 1989 *Policies, Plans and People*

Lergerghe W. Van and Later *The Role of Hospitals in the District, Delivering or Supporting Primary*

Y. 1993 *Health Care, 1993*

Lob-Levyt *Global Burden of Disease Estimates*

Lohani S.P. & Shrestha S.P. *Financial Plan on Population & Health*

1983

Maeda A. 1995 *Health Financing in Global Context*. Paper Presented at The First Workshop on Long Term Health Plan Development MOH, Kathmandu

Martiens J. et al. 1993 *Diarrhoeal Disease*. Disease Control Priorities in Developing Countries (ed Jamison D.. et al). The World Bank/Oxford University Press.

Mathema P. 1995, *Review of Current Health Expenditure Resource Allocation and Trends*.Paper Presented at The First Workshop on Long Term Health Plan,Development, MOH, Kathmandu

Measham A. 1995, *Comparative View of Health Policy*. Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Measham A. 1995, *Nutrition and Morbidity Linkage*. Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Ministry of Finance, 1995 *Annual Budget Speech FY* 1995-96

Ministry of Finance, 1995 *Economic Survey FY* 1994-95

Ministry of Finance, 1996 *Economic Survey FY* 1995/96

Ministry of Health, Protocol of Community Drug Programme

Ministry of Health, *Atlas of Population Distribution and Health Facilities with Regional/District FP/MCH Profiles*. Department of Health Services/UNFPA

Ministry of Health 1986 *Long Term Health Plan 2032* (in Nepali)

Ministry of Health 1987 C*ountry Health Profile, 1988*

Ministry of Health 1991 *National Health Policy 1991.*

Ministry of Health 1992 *Department of Health Services. Annual Report 2051/52.*Kathmandu

Ministry of Health 1992 *Health Information Bulletin.*

Ministry of Health 1992 *Health Information Bulletin*, Kathmandu

Ministry of Health 1993 *Gastroenteritis, Encephalitis, Meningitis and Kala-azar:* An Epidemiological Review.

Ministry of Health 1993 *Health Section of Eighth Plan (1992-1997)*

Ministry of Health 1993 *Hepatitis and Enteric Fever: An Epidemiological Review*

Ministry of Health 1993 *Organization Structure of the Ministry of Health*

Ministry of Health 1993 *Staffing Norms: Ministry of Health Organogram, 1993*

Ministry of Health 1994 *Drug Bulletin of Nepal.*

Ministry of Health 1994 *Resource Allocation. Plan Formulation and Implementation in the Health Sector, Working Documents, Vol. I, II, & III.*

Ministry of Health 1994 *Guidelines for Establishing Nursing Homes in Nepal, 1994*

Ministry of Health 1994 *Standard Guidelines for Primary Level Health Institutions, 195*

Ministry of Health 1995 *An Overview of the Health /Situation in Dhading and Siraha District* Primary Health Care Project/GTZ

Ministry of Health 1995 *General Profile of STD in Nepal Country Report.*

Ministry of Health 1995 *HMIS Approved Forms and Guidelines*

Ministry of Health 1995 *Plan Formulation, Implementation and Evaluation in the Health Sector*

Ministry of Health 1995 *Human Resources for Health: Master Plan 2052 Department of Health Services/ERPHCP*

Ministry of Health 1996 *Nepal Family Health Survey Preliminary Report.*

Ministry of Health/National Planning Commission, 1992 *National Programme of Action of Children and Development for the 1990s.*

Ministry of Health/SDC, 1990 *Primary Health Care/Mother Child Health/Family Planning Project in Dolakha, Ramchhap, Sidhuli districts, Project Document,* Swiss Development Corporation.

Ministry of Health, *Acute Respiratory Infections (ARI) among Children in Nepal. May-August*

Health/UNICEF, 1994 *1994*

Ministry of Health/WHO 1995 *Anaemia in Pregnant Women in Nepal: Strategies to improve compliance with Iron Supplement.*

Ministry of Health/WHO, 1987 *Basic Information/Indicators to Support Implementation of Basis Minimum Needs and Health for All by 2000 Strategies, Nepal, 1987.*

Ministry of Health/WHO, 1993, *Seminar on Health Economics & Health Care Financing*

Ministry of Health/WHO, 1995, *Analysis of Health Economics & Nepa,. Health Economics Task Force, Shrestha B.R. & Shrestha S.P. (eds). Kathmandu.*

Ministry of Health/WHO, 1993 *Second Seminar on Health Economics and health Care Financing, 1991*

Ministry of Health/World Bank, *Proceedings of the Seminar ion Dissemination of Finding of Operations* ,1995

Research on Family Health Service Delivery in rural Nepal.

Ministry of Health/World Bank, 1994 *Family Health Service Delivery in Three Rural Areas of Nepal – Lessons Learned from the process of Implementation of the National Health Policy, 1991*

Ministry of Health/World Bank, 1995 *proceeding of the Seminar on Dissemination of Findings of Operations*

Research on Family Health Services Delivery in Rural Nepal, Dec, 1995

Ministry of Law and Justice, F*inancial Rules and Regulation, 2052,* 1994

Ministry of Health, 1994 *HURDIS Planning Workshop Report*. Department of Health

Services/PHCP/GTZ, April 1994

Ministry of Health, 1996 *Proceedings of the First Workshop (February 27-28, 1996). Working Group Meeting (February 29-March 1, 1996) and The Second Workshop (March 6, 1996) on Long Term Health Plan Development.* MOH/The World Bank/WHO/GTZ, Kathmandu.

Ministry of Health 1996 *Proceedings of the Interim Review Meeting (June 27-28, 1996) on Long Term Health Plan Development.* MOH/WB/WHO/GTZ, Kathmandu

Ministry of Health 1996 *Proceedings of Workshop on Basic Health Care Package including Beyond the Basic Health Care for the Long Term Health Plan Development (August 26-27, 1996).* MOH, Kathmandu

National Planning Commission/UNICEF: *Children and Women of Nepal. A Situational Analysis 1992*

Nepal Administrative Staff College, 1995, *Management Audit of Ministry of Health,*

Nepal Medical Association, 1994 *Doctor's Directory, 1994*

Nepal Medical Council, 1996 *Medical Register, 1996*

Neupane R.K. 1995 *Role of NGO's in Health Care: Retrospect and Prospect*. Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

ODA, 1995 *ANM Study Report.*

Pandey K.R. 1995 *Public Health Services in Nepal: Distribution and Operational Status.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Pandey K.R., 1996 *Public Health /Sector Management/Organization Issues,* Paper Presented at the Interim Review Meeting on Long Term Health Plan Development,MOH, Kathmandu

Pandey M.R. et al *Domestic Smoke Pollution and ARI in Rural Community of the Hill Region of Nepa,.* Environment International.

Pant R.D., 1995 *The Flow of Funds in Nepal.*

PHCP/GTZ, 1994 *Orientation Workshop on PHCP Conducted in Dhading District Health Office.*

PHCP/GTZ, 1995 *Investigating District Health System – Participatory Rural Appraisal-II.*

PHCP/GTZ, 1995 *Primary Health Care Perception at Grassroots Level on Health in Dhading and Siraha District*

PHCP/GTZ, 1995 *Project Planning Workshop Report* Department of Health Services/PHCP/GTZ.

Ramana G.N.V, 1995 *Morbidity and Mortality Profile.* Paper Presented at the First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Rana T. 1995 *Policy, Planning Development and Utilization of Manpower in Health,* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Rijal B. 1995 *Role of Private Sector in Health Care.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Bangladesh Yesterday, Today and Tomorrow

SAARC, 1993 *Nepal Country Paper, SAARC Ministerial Conference on Women and Family Health 21-23 November, 1993*

SCF (UK), 1992 *Sustaabilityin the Health Sector*

Sharma H.R. & Devkota U.N. *An Overview of the Health Situation in Dhading and Siraha Districts* 1995

Sharma R.S.S. 1995 *Epidemiological and Demographic Situation.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Sheik A. 1995 *Sustainable Drug Supply Plan in the Community Health Care.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Shrestha B.R. 1995 *Analysis of Health Financing. Paper Presented at the First Workshop on Long Term Health Plan Development, MOH, Kathmandu*

Shrestha I. and Shrestha M.P. *Multidisciplinary and Multi professional Participation in Health System* 1996

Research: For better and informed Decision. Paper Presented at The Interim Review Meeting on Long Term Health Plan Development, MOH, Kathmandu

Shrestha I.B. 1979 *Health Personnel Training in Nepal.* Journal of Institute of Medicine, I, 155-72

Shrestha I.B. 1996 *User's Survey.* Paper Presented at The Interim Review Meeting on Long Term Health Plan Development, MOH, Kathmandu

Shrestha M.P. 1996 *Status of Health Services Research in Nepal.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

Singh H. 1990 *Re-structuring of Health Services and Nepal, Situational Analysis.*

Steinmann J.P. and Dhakal R. *Beneficiary Assessment of Health Care Services.* Paper Presented at the First 1995, Workshop on Long Term Health Plan Development, MOH, Kathmandu

Steinmann J.P. et al. 1995 *Planning for Community Health in Dhading District. At which level can it be Done ?*

Styblo K. *The Relationship between the Risk of Tuberculosis Infections. Book of the International Union against Tuberculosis.*

Tiwari S.R. 1995 *Physical Status of Health Institutions in Nepal: Implication to Policy Planners.* Paper Presented at The First Workshop on Long Term Health Plan Development, MOH, Kathmandu

UNDP, 1994 *Development Cooperation Report, Nepal 1994*

United Nations, 1980 *Population of Nepal.* Country Monograph Series No. 6, ESCAP, Bangkok.

Valley Research Group, 1995 *Health Status and Health Care Delivery Indicators: A Survey of Districts*

Valley Research Group, 1995 *Unit Cost Study of Primary Health Care*

WHO, 1988 *The Challenge of Implementation, District Health Systems for Primary Health Care, 1988*

World Bank, *Social Sector Strategy Review, Nepal,* Population and Health Vol III. 1989.