Annual Health Report

2078/79 (2021/22)

Health Directorate
Koshi Province

Health Directorate, Koshi Province, Annual Health Report 2078/79 (2021/22)

Province Government

Ministry of Health

Koshi Province, Biratnagar

MESSAGE

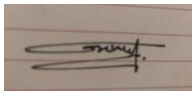
It gives me a great pleasure to know that the Health Directorate, Dhankuta has been publishing compressive Annual Report regularly after conducting series of performance review workshops at various levels. The Government of Province, Ministry of Health, is committed to ensure that every citizen of the province recognizes health as a fundamental right as guaranteed by the constitution. To attain universal health coverage, the ministry is committed to implement the core principles of federal, provincial, and local levels health policies, as well as the national health sector strategy, periodic plans, and other policy documents. The MoH has initiated and implemented several programs to ensure the quality of basic and emergency health care services to citizen and achieved tremendous outcome as reflected in this progress report.

It is crucial that periodical program review is an important responsibility for the institutions to analyzeand comprehend program success, explore pertinent issues, set an evidence-based approaches for thecoming years. The statistics presented in this report reflects the annual performance of all the parts of the health caredelivery system, including achievements and innovations, bottlenecks, and potential future action points. By addressing the gaps and priorities identified in this report, I can guarantee on behalf of the ministry that a significant investment will be made to reinforce the province's high-quality health care system.

The Ministry of Health is also committed to collaborating with all the stakeholders including health care experts, universities, schools, development partners and civil societies along with governmental bodies to achieve our holistic goal "Making our Health Services Quality and Accessible for the wider positive impact" I hope there port will be very important and fruitful to all the planners, readers, citizens, staffs, and any concerning personalities. Further, the report expects the positive response and comments from all the concerns that will help to the ministry for more improvements of the health sector for the future planning process.

To conclude, I would like to extend my sincere thanks to Province Health Directorate and all who are involved in the preparation and publication of this annual report.

Thank You.



Honorable Minister Nirmala Limbu
Ministry of Health
Koshi Province, Biratnagar, Nepal

मन्त्री

Province Government

Ministry of Health

Koshi Province, Biratnagar

PREFACE

I am pleased to know that the Provincial Health Directorate is bringing out the Annual report 2078/79 and I am confident that this comprehensive document based on the annual performance of all components ofhealth system and the reviews done in local and Provincial level will guide Health Professionals and Policy makers to bring further improvement in Health Services in Koshi Province. The report reflects annual performance of all the components of health system as well as their reviews conducted at local provincial levels. This progress report not only reviews the past performance but also aims to guide arobust and evidence-based planning at all levels. I believe that the information provided in this report play an important role in planning and implementing evidence-based program in the changing context of health.

This annual report is a comprehensive document that includes all the initiatives of the Ministry of Health as well as those of its institutions, local governments, international development partners and non-governmental organizations. Each section of the report outlines background, status of the major indicators, new initiatives, issues, and constraints and suggests way forwards for the effective delivery of health services in coming years.

I know that there is still much to achieve and much to give to the citizens of this province, but I also fully believe that our focused effort will help achieve it all in the very near future. I am pleased to share that the Koshi Province has made several remarkable accomplishments in health sector that helped to meet the goal soutlined infederal and provincial policy papers. This report will provide the status of the priority indicators listed in the periodic plans, NHSS-IP, and Sustainable Development Goals to comprehend theachievementsmade sofar.

Finally, I extend my gratitude and congratulations to the Director of Health Directorate and his team,especially annual report preparation committee and other concerned personnel for their contributionstothe report's formulation and finalizations.

Thank You

सचिव

Dr. Anuj Bhattachan
Health Secretary

PROVINCE GOVERNMENT
Ministry of Health
Health Directorate
Koshi Province, Dhankuta, Nepal

ACKNOWLEDGEMENT

I am delighted to publish this Annual Health Report 2078/79 (2021-2022) of the Koshi Province based on routine HMIS information obtained from 14 districts of this province. I strongly believe that this report will be helpful inguiding planners, managers, service providers and academia for better planning and implementation of healthprogramsthereby, increasingaccess tobasichealthservices toeach personof theprovince. The report also covers theprogress of activities performed by private health institutions and External Development Partners(EDPS).

To achieve universal health coverage, the Health Directorate of the Mo His dedicated to translating the aspiration of the Constitution of Nepal, National Health Policy 2076, Nepal Health Sector Strategy, and other health related plans and policies. SDG indicators are progressing positively in the province, and we must sustain and made further progress to cross the target in comingyears. This Annual Health Report 2021/2022(AD) compiles and summarizes the performance of all promotive, preventive, and curative health services implemented by the public health institutions, private for profit and non-profit health institutions working in the partnership with public health institutions in Koshi Province. In addition to this, it also provides information regarding targets versus achievements of the major health indicators along with budget allocation and actual expenditure.

I sincerely appreciate the Hon'ble Minister, Nirmala Limbu, Ministry of Health, for her inspiring leadership and guidance. I also want to express my gratitude to Dr. Anuj Bhattachan, Secretary of the Ministry of Health, for his leadership and support in advancing the healthcare delivery system of the province. I am grateful to our health workers across all the districts and municipalities within the province that have been working day and night, all year round to provide quality health services at our facilities. My appreciational so goes to Female Community Health Volunteers for their efforts in promoting of health activities and raising public awareness incommunity levels. Further more, I take this opportunity to thank various external development partners, non-governmental organizations, and the private sector for their important contributions in advancing the health sector performance of this province.

Finally, I appreciate the annual report development team of the Health Directorate, other provincial level entities and EDPs for their meticulous effort to bring out this report. I hope, this report will be a useful document for all the institutions involved in developing, implementing, and evaluating evidence-based programs and strengthening health services to improve the health status of all citizens in this province.

निर्देशक

Mr Gyan Bahadur Basnet

Director

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List of Abbreviation

ABER	Annual Blood Examination Rate
AES	Acute Encephalitic Syndrome
AFP	Acute Flaccid Paralysis
AHW	Auxiliary Health Worker
AI	Avian Influenza
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Managemet of Third Stage of Labour
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APD	Acid Peptic Disease
API	Annual Parasite Incidence
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
ASBA	Advance Skilled Birth Attendant
BCC	Behavior Change Communication
BCG	Bacillus Calmette and Guerin
BEOC	Basic Emergency Obstetric Care
BPKIHS	Bisheshore Prasad Koirala Institute of Health Science
C/S	Caesarean Section
CA/CO	Computer Assistant/Computer Officer
CAC	Comprehensive Abortion Care
CAC	Comprehensive Abortion Care
CARE	Co-operative For Assistance & Relief Everywhere
CBIMCI	Community Based Integrated Management of Childhood Illness
CBNCP	Community Based Neonatal Care Programme
CBO	Community Based Organization
CBOs	Community Based Organizations
CBR	Community Based Rehabilitation
CBS	Central Bureau of Statistics
CDD	Control of Diarrhoeal Diseases
CDP	Community Drug Programme
CEOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CHD	Child Health Division
CHW	Community Health Worker
CLT	Comprehensive Leprosy Training
CMI	Clinical Malaria Incidence
CoFP	Comprehensive Family Planning
COPD	Chronic Obstructive Pulmonary Disease
CPR	Contraceptive Prevalence Rate
CRS	Contraceptive Retail Sales
CYP	Couple Years Protection

DACC	District AIDS Coordination Committee
DDA	Department of Drugs Administration
DDC	District Development Committee
DHMC	District Health Management Committee
DHMGN	District Health Mothers Group Network
DHO	District Health Office
DoHS	Department of Health Services
DOTS	Directly Observed Treatment Short Course
DPHO	District Public Health Office
DPT	Diphtheria, Pertussis and Tetanus
DQSA	Data Quality Self-Assessment
DR	Drug Resistant
DTLA	District Tuberculosis and Leprosy Assistant
DTOT	District Training of Trainers
E/RMS	Eastern/Regional Medical Store
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partners
EDPs	External Development Partners
EDPT	Early Diagnosis and Prompt Treatment
EHCS	Essential health care services
ENT	Ear Nose Throat
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ERHD	Eastern Regional Health Directorate
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FM	Frequency Modulation
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSWs	Female Sex Workers
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEM	Global Empowerment Measure
GESI	Gender equality and social inclusion
GM	Growth Monitoring
GoN	Government of Nepal
HA	Health Assistant
HDB	Hospital Development Board
HDI	Human Development Index
HE	Health Education
HepB	Hepatitis B

HFOMC	Health Facility Operation Management Committee
HFs	Health Facilities
HI	Health Institution
Hib	Haemophilus Influenza B
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HRDC	Hospital Based Rehabilitation and Development Center
HRH	Human Resources for Health
HSR	Health Sector Reform
HSSP	Health Sector Support Programme
HWs	Health Workers
ICU	Intensive Care Unit
IDD	Iodine Deficiency Disorder
IDU	Injection Drug User
IEC	Information, Education and Communication
IMR	Infant Mortality rate
INF	International Nepal Fellowship
INGO	International Non-Governmental Organization
IP	Infection Prevention
IPD	Immunization Preventable Diseases
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant & Young Child Feeding
JE	Japanese Encephalitis
Km	Kilometer
Lab. Asst.	Laboratory Assistant
LBI	Local Bacterial Infection
LCD	Leprosy Control Division
LDC	Least Developed Countries
LEC	Leprosy Elimination Campaign
LMD	Logistic Management Division
LMIS	Logistic Management Information System
LWF	Lutheran World Federation
M&E	Monitoring and Evaluation
MA	Medical Abortion
MARP	Most At Risk Population
MB	Multi-Bacilli
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MCs	Microscopy Centers
MD	Management Division
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDT	Multi Drug Therapy
MMR	Maternal Mortality Ratio

MNH	Maternal Neonatal Health
MNT	Maternal Neonatal Tetanus
MO	Medical Officer
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MRA/MRO	Medical Record Assistant/Medical Record Officer
MSS	Minimum Service Standards
MWRA	Married Women of Reproductive Age
NACC	National AIDS Co-ordination Committee
NCASC	National Center of AIDS and STD Control
NDHS	Nepal Demographic Health Survey
NFCC	Nepal Fertility Care Center
NGOs	Non-Governmental Organizations
NHEICC	National Health Education Information and Communication Center
NHSP	Nepal Health Sector Support Program
NHTC	National Health Training Center
NID	National Immunization Day
NIP	National Immunization Programme
NLR	Netherlands Leprosy Relief
NMR	Neonatal Mortality Ratio
NRCS	Nepal Red Cross Society
NSMP	Nepal Safer Motherhood Project
NT	Neonatal Tetanus
NTC	National Tuberculosis Center
ODA	Official Development Assistance
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORC	Outreach Clinic
ORS	Oral Rehydration Solution, Oral Rehydration Salts
ORT	Oral Rehydration Treatment
OT	Operation Theater
PAC	Post Abortion Care
PB	Pauci-Bacilli
PEM	Protein-Energy Malnutrition
PF	Plasmodium Falciparum
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHC-ORC	Primary Health Care-Outreach Clinic
PHCRD	Primary Health Care Revitalization Division
PHN	Public Health Nurse
PHO/PHA	Public Health Officer/Public Health Administrator
PME	Planning, Monitoring and Evaluation
PMTCT	Prevention of Mother to Child

	Transmission
PNC	Post Natal Care
PO	Planning Officer
PR	Prevalence Rate
PR	Principal Recipient
PSBI	Possible Severe Bacterial Infection
PV	Plasmodium Vivax
RDT	Rapid Diagnostic Test
RED	Reaching Every District
RH	Reproductive Health
RHCC	Regional Health Co-ordination Committee
RHCT	Regional Health Co-ordination Team
RHD	Regional Health Directorate
RHTC	Regional Health Training Center
SA/SO	Statistical Assistant/Statistical Officer
SBA	Skilled Birth Attendant
SCF	Save the Children Fund
SDC	Swiss Development Cooperation
SDIP	Safe Motherhood Delivery Incentive Programme
SHP	Sub Health Post
SLTHP	Second Long-term Health Plan
SM	Safe Motherhood
SMNHLTP	Safe Motherhood and Neonatal Health Long Term Plan
SN	Staff Nurse
SPR	Slide Positivity Rate
Sq	Square
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWC	Social Welfare Council
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TNA	Training Need Assessment
TO	Training Officer
TOT	Training of Trainers
TT	Tetanus Toxoid
UMN	United Mission to Nepal
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USI	Universal Salt Iodization
VACC	Village AIDS CO-ordination Committee
VAD	Vitamin A Deficiency
VBD	Vector Borne Diseases
VCA	Vector Control Assistant
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
VHW	Village Health Worker
VPD	Vaccine Preventable Diseases
VSC	Voluntary Surgical Contraceptive
WHO	World Health Organization

EXECUTIVE SUMMARY

Province Health Directorate is the major technical and administrative unit of health under Ministry of Health in the Province. Health Directorate ensures proper delivery of promotive, preventive, and curative health services through different health institutions in the province and assist Ministry of Health in planning, designing, monitoring and implementation of different health related activites.

This Annual Report of Province Health Directorate (PHD) for the FY 2078/79 (2021/22) reflects the performances of different programs and compare with the progress made over the preceeding three years of overall provincial health programs.

This report was prepared by a technical team of PHD considering all the information coming from different sources. Moreover, the report was verified by the representatives from different hospitals, Health Offices, PHD and supporting partners. Therefore, it is hoped that this comprehensive and analytical report will be a useful document for MoHP, MoH,MoSD, DoHS, PHD, Health Office, Hospitals, Ayurveda, Palika, health planners, researchers and academic institutions, students, supporting partners, interested organizations and individuals.

It consists of different chapters and sections. Every chapter includes background, major activities carried out in FY 2078/79, analysis of achievements, interpretation and discussion of key findings, conclusion, major issues, problems, constraints, and actions to be taken.

Data used in this report were generated, compiled, and verified both at periphery and district level. In addition, data are based on district level annual performance review meetings in all 14 districts and a province level review meeting. The primary data source of this report is Integrated Health Information Management System (IHIMS). In addition, reports were also sought from I/NGOs and Private Health Institutions working in the province.

National Immunization Program (NIP):
The immunization coverage of all antigens in the regular NIP program in 2078/79 has increased as compared to last fiscal year. BCG coverage has increased to 94% from 79% and has not met the national target > 90%. The coverage of DPT-Hep B-Hib 3, JE and MR2 have increased in this fiscal year as compared to previous fiscal year from 79% to 89%, 80% to 89% and 77% to 87% respectively. Dropout rate is below 10% in all the 14 districts. All the 14 districts have been declared full immunization districts till FY 2078/79 except for the province declaration as fully immunized.

Nutrition:
There has been increase in growth monitoring coverage from 62% in 2077/78 to 78% in 2078/79. Average number of visitshas remained constant to 3.4 since last two fiscal year. From FY 2077/78 to 2078/79 Exclusive breast feeding among children registered for growth monitoring has slightly increased from 19% to 28% but it is very low compared to national achievement. Pregnant women receiving iron/folic acid has increased than previous year from 36% to 48%. Postpartum mothers who received Iron tablet and Vitamin A has increased to 32% from 24% in this fiscal year.

CB-IMNCI:
The Incidence of diarrheal cases per 1,000 under five populations has increased to310 in 2078/79 from 298 in 2077/78. The diarrheal cases treated with zinc and ORS is 89%. The incidence of ARI among under 5 children has increased from 549/1000 to 666/1000 this year. The pneumonia cases treated with antibiotics is 103% which has decreased in comparison to previous year.

Safe motherhood
At least one ANC visit has increased to 128% in FY 2078/79 from 102% in FY 2077/78. ANC four visit as per protocol has increased from 53% in FY 2077/78 to 69% in FY 2078/79. Institutional delivery has increased to 72% in comparison to previous FY. Three PNC visit as per protocol has increased to 37% from 22% in FY 2078/79.

Family Planning and safe abortion
The Contraceptive Prevalence Rate (CPR) of the province is 44.9%, which has increased slightly in comparison to previous fiscal year i.e 45.0%. New acceptor of family planning methods among MWRA has remained constant at 10% in this fiscal year. The common choice of method mix new spacing contraceptive method is Depo-Provera followed by pills. There is increasing trend of CAC and PAC service users while short term post abortion contraceptive user has increased from 83.2 to 83.5 in comparison to previous year.

Adolescent and Reproductive Health
18.4% adolescent had 1st ANC visit as per protocol among total ANC visitor and 12.7% were adolescent among pregnant women who had their ANC 4 visit as per protocol.
Female Community Health Volunteer (FCHV)

In FY 2078/79, FCHV distributed 734715 condoms, 101622 pills cycle and 63860 iron tablets. FCHV treated 87694 diarrheal cases with zinc and ORS. 159889 ARI cases were also treated by FCHV in this fiscal year.

Tuberculosis
The case finding rate of tuberculosis has increased to 89% in FY 2078/79 from 72% in FY 2077/78. Jhapa, Morang, Sunsari and Udayapur had higher case finding rate as compared to other district. The treatment success rate has increased from 90% to 91% in this fiscal year. MDR cases have increased to 103 in FY 078/79 from 79 in FY 077/78.

Leprosy
In this fiscal year 2078/79, new case detection rate was 7 per 10,000 populations in Province 1. Highest numbers of cases were detected in Morang whereas no new cases were detected in Panchthar, Khotang, Ilam and Sankhuwasabha.

Malaria
As per the reported cases from the health facilities, total number of cases reported on FY 078/79 was 5 which shows increasing trend as compared to previous fiscal year. 4 cases were reported from Morang whereas 1 case was reported from Jhapa.

Kala-azar
Kala-azar cases showed increasing trend compared to last fiscal year i.e from 45 to 47 cases. The highest number of Kala-azar cases reported from Sunsari is 32.

Dengue
The number of reported dengue case has increased to 123 in FY 2078/79 in comparison to previous year which was 25. During FY 2078/79, dengue cases were reported from 9 districts. The majority of cases have been reported from Sankhuwasabha that is 73.

HIV/AIDS & STD
The total number of 322395 persons were screened for HIV and among them 343 cases were found HIV reactive in the year 078/79. The total cumulative numbers of 2082 PLHIV were receiving Anti-retroviral therapy till the end of the year.

Zoonoses
Dog bite cases in province 1 is in increasing trend. It has increased from 4993 in FY 2077/78 to 6739in FY 2078/79. Poisonous snake bites were less in comparison to non-poisonous snake bites. Poisonous snake bites reported in the FY 2078/079 was 196.

Curative services
Taplejung Hospital stood out with highest MSS score of 81% among 17 hospitals in FY 2078/79. Bed occupancy rate was highest in Academic Hospital and Lowest in Primary level hospital. Among the different OPD morbidities reported in hospitals, gastritis remainsthe highest with 5.2% followed by Upper Respiratory Tract Infection (URTI) Cases with 5%.

Ayurveda and alternative medicine services

The total number of OPD patients in FY 2078/79 has increased to 137542 from 124621 in FY 2077/78. More number of service users were found attracted towards Nagarik Aarogya program and Healthy Lifestyle Services which has been beneficial for prevention and management of non communicable disease.

HEALTH SERVICES COVERAGE FACT SHEET

Fiscal Year 2076/077 to 2078/079 (2019/2020 - 2021/2022)

INDICATORS		2076/77	2077/78	2078/79
1. REPORTING STATUS (%)				
1.1	Hospital	100	100	100
1.2	Primary Health Centre	100	100	100
1.3	Health Post	99	100	100
1.4	Non-Public Health Institutions	55	57	100
2. IMMUNIZATION COVERAGE (%)				
2.1	BCG	82	79	94
2.2	DPT-Hep B-Hib 3	74	79	89
2.3	JE	77	80	89
2.4	Measles Rubella 2	72	77	87
2.5	Td-2 and Td2+	52	49	68
3. NUTRITION				
3.1	Growth monitoring coverage as percentage of <5 children new visits	59	62	78
3.2	Average number of visits among children aged 0-23 months registered for growth monitoring	3.1	3.4	3.4
3.3	Proportion of underweight (Weight/Age) children among new visits	1.4	1.2	1.8
3.4	Percentage of pregnant women receiving Iron tablets	33	36	48
3.5	Percentage of postpartum mothers receiving Iron tablets	24	24	32
3.6	Percentage of postpartum mothers receiving Vitamin A	49	48	57
4. CBIMNCI				
4.1	Incidence of ARI per 1,000 <5 children	655	549	666
4.2	Incidence of pneumonia per 1,000 <5 children	51	32	63
4.3	Incidence of diarrhea per 1,000 <5 children	329	298	310
5. SAFE MOTHERHOOD (%)				
5.1	Antenatal first visits as percentage of expected pregnancy	108	102	128
5.2	Antenatal 4 visit as per protocol	57	53	69
5.3	Institutional delivery as percentage of expected live births	63	60	72
5.4	PNC first visit as percentage of expected live births	16	22	37
6. FAMILY PLANNING (%)				
6.1	Contraceptives Prevalence Rate (CPR)	40	45.0	44.9
6.2	New Acceptors total spacing method (as percentage of MWRA)	10	10	10
7. VECTOR BORNE DISEASES				
7.1	No. of Malaria cases	15	3	4
7.2	No. of Kalazar cases	65	45	47
7.3	No. of Dengue cases	851	25	123
8. TUBERCULOSIS				
8.1	Case Notification rate	78	72	89
8.2	Treatment Success rate	89	90	91
8.3	No. of DR cases	73	79	103
9. LEPROSY				
9.1	New Case Detection Rate (NCDR)/10,000 population	7	6.9	7
9.2	Prevalence Rate (PR)/10,000 population	1.21	0.73	0.69
10. ZOONOSES				
10.1	Dog Bite	6229	4993	6739
10.2	Poisonous Snakebite	124	286	196
10.3	Non-poisonous Snakebite	581	2376	1292

PART 1 – INTRODUCTION OF PROVINCE

1.1 Background

The newly carved out Koshi Province under the federal system is one of the seven provinces in the country. It has 14 districts spread from Mount Everest, the highest mountain in the world, to one of the greenest districts in Ilam and downward to Koshi Tappu, the serene wetland known for its wildlife reserve. Besides these natural wonders, this province has people from different ethnicities, making it an amalgamation of diverse culture and language. It is the easternmost of the seven provinces established by the new constitution of Nepal which was adopted on 20 September 2015. The province covers an area of 25,905 km2, about 17.5% of the country's total area. With the industrial city of Biratnagar as its headquarters, the province covers other major eastern towns including Birtamod, Birat Chowk, Damak, Dharan, Itahari, Triyuga and Mechinagar and includes several mountains including the Everest, Kanchanjunga, and Ama Dablam. Koshi – the largest river of the nation, circumvents the province's western boundary. According to the 2021 Nepal census, there are around 5 million people in the province, with a population density of 190 per square kilometre. As per the 2011 Nepal census the province had around 4.5 million people.

1.2 Geography

Koshi Province lies between 860 1′ & 880 3′ East longitude and 280 2′ & 260 3′ North latitude. It has an area of 25,905sq.km out of which 17.16% land is covered by forest. It is bordered by India in the east and south and Bagmati Province and Madesh Province in the west, while big mountains towards China segregate the north side. Two major points of topographic importance lies in the province – Kechana Kawal (Jhapa) 67m above sea level in south-eastern Terai and Mt. Sagarmatha 8,848 m, the highest peak in the world located at Solukhumbu in north-eastern Himalayas. Topographically, the province can be divided into four main regions starting from the North, viz. 1) The Himalayan Region and Inner Himalayas, 2) The Sub-Himalayas or the mountainous region, 3) The valley basin, Dun, or Inner Terai, and 4) The Low plain region – Terai. he Himalayan region, comprising 40.29% of the province land surface, is sparsely inhabited. The highest peaks of the Himalayas like Sagarmatha (29028ft. /8848m), Kanchenjunga (28,208 ft./8,586m), Lhotse (27,809 ft./ 8,516m), Yalungkang (8,505m), Makalu (8463m), Choyu (8201m) lie along the northern border. here are many river basins and gentle slopes as well. Chure, Mahabharat, many basins, tars, and valleys form the Terai region. Between the Churia and Mahabharat, a low land of inner Terai exists. The Koshi river flows through theregion with its seventributaries; Indrawati, Likhu, Tamur, DudhKosi, Arun, Tamakoshi and Bhote Koshi (Sunkoshi). Tundra vegetables, coniferous forests, deciduous monsoon forests, and sub-tropical evergreen woods are vegetations found here. Sub-tropical, temperate, sub-temperate, and alpine and tundra types of climates are found here.

1.3 Political and Administrative Division

As per the New constitution formulated on 2015, Nepal is a federal republic comprising 7 provinces. Among the seven provinces, Koshi Province is also one province. The province has 137 municipalities that includes 1 metropolitan city (Biratnagar), 2 sub metropolitan cities (Itahari and Dharan), 46 Municipalities and 88 Rural Municipalities.Adhering to the first-past-the-post voting system issued by the Constituency Delimitation Commission, the province hosts 28 parliamentary seats and 56 provincial seats. Also, there are 27 proportional representation seats on the province. District wise details as per political and administrative division is mentioned on table below:

Table 1: Province Political and Administrative Division

S. N	Districts	Total Local Level	Metropolitan City/Sub-Metropolitan	Municipality	Rural Municipality	Total wards	Constituency Seats	
							Parliamentary	Provincial
1	Taplejung	9	0	1	8	61	1	2
2	Sankhwasabha	10	0	5	5	76	1	2
3	Solukhumbu	8	0	1	7	52	1	2

4	Okhaldhunga	8	0	1	7	75	1	2
5	Khotang	10	0	2	8	79	1	2
6	Bhojpur	9	0	2	7	81	1	2
7	Dhankuta	7	0	3	4	60	1	2
8	Terhathum	6	0	2	4	43	1	2
9	Paanchthar	8	0	1	7	60	1	2
10	Ilam	10	0	4	6	81	2	4
11	Jhapa	15	0	8	7	131	5	10
12	Morang	17	1	8	8	159	6	12
13	Sunsari	12	2	4	6	124	4	8
14	Udayapur	8	0	4	4	75	2	4
	Province 1	137	3	46	88	1157	28	56

1.4 Population and Area

Total population of Koshi Province (according to 2021 Nepal census) is 4,972,021 and population density is 192 per square Km. Percentage of population is increased by 9.34 % as compared to 2011 census with yearly increment of 0.8 %. Female comprises 52% (2,546,755) and male comprised (24,25,266) of the total population. There are 1,20,39,30 households in province 1 and average family member number is 4.13. 37.68 % of total population resides in rural areas while 62.32 % lives in urban area. Three districts Sunsari, Morang and Jhapa with high number of populations is situated on Koshi Province. The province covers an area of 25,905 km^2

Table 2: District wise Population and Area

S. N	Districts	Total Area (KM^2)	Female Population	Male Population	Total Population	Population Density
1	Taplejung	3,646	59835	60524	120359	33
2	Sankhwasabha	3,480	78991	80055	159046	46
3	Solukhumbu	3,312	52139	52629	104768	32
4	Okhaldhunga	1,074	71592	69322	140914	131
5	Khotang	1,591	88819	86521	175340	110
6	Bhojpur	1,507	80540	78451	158991	106
7	Dhankuta	0,892	76750	73234	149984	168
8	Terhathum	0,679	45334	43791	89125	131
9	Paanchthar	1,241	87386	87033	174419	141
10	Ilam	1,703	140991	139574	280565	165
11	Jhapa	1,606	516594	477496	994090	619
12	Morang	1,855	589659	557527	1147186	618
13	Sunsari	1,257	480386	454075	934461	743
14	Udayapur	2,063	177739	165034	342773	166
	Province 1	25,905	25,46,755	24,25,266	49,72,021	192

1.5 Organizational Structure of Provincial Health Institutions and its entities

Health Services system of Koshi Province is led by Ministry of Health situated in Biratnagar. As per the structure there are Health Directorate, Health Training Centre, Provincial Health Logistics and Management Centre, Provincial Public Health Laboratory, Infectious Diseases, and Intensive Treatment Centre in Provincial level. Similarly, there are one Provincial Hospital, one provincial level Ayurveda Hospital, 13 district hospitals, 14 Health Offices and 14 District Ayurved Health Centre. Detail organogram of each institution is described on figure below:

Figure 1: Organogram of Ministry of Health

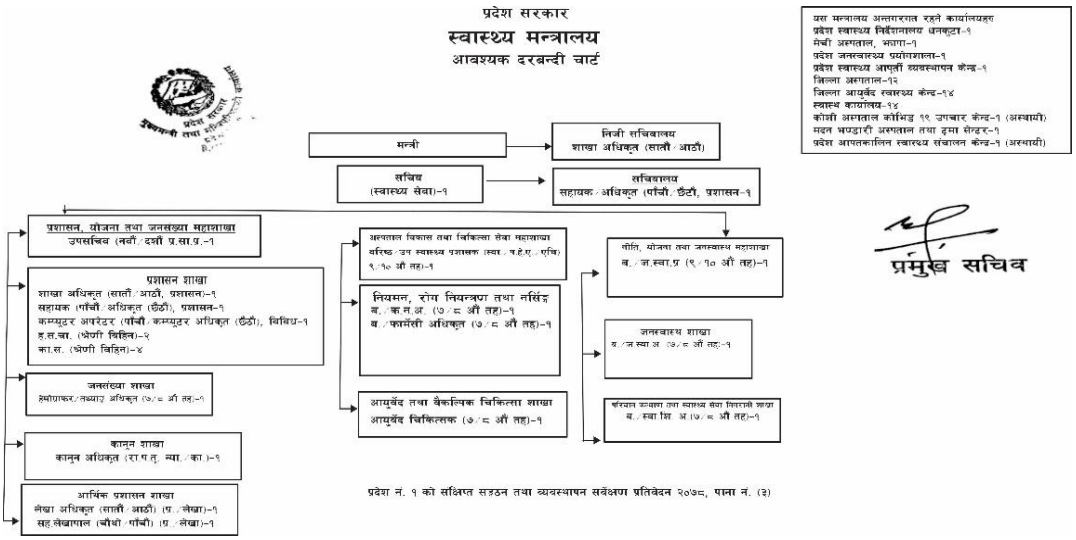
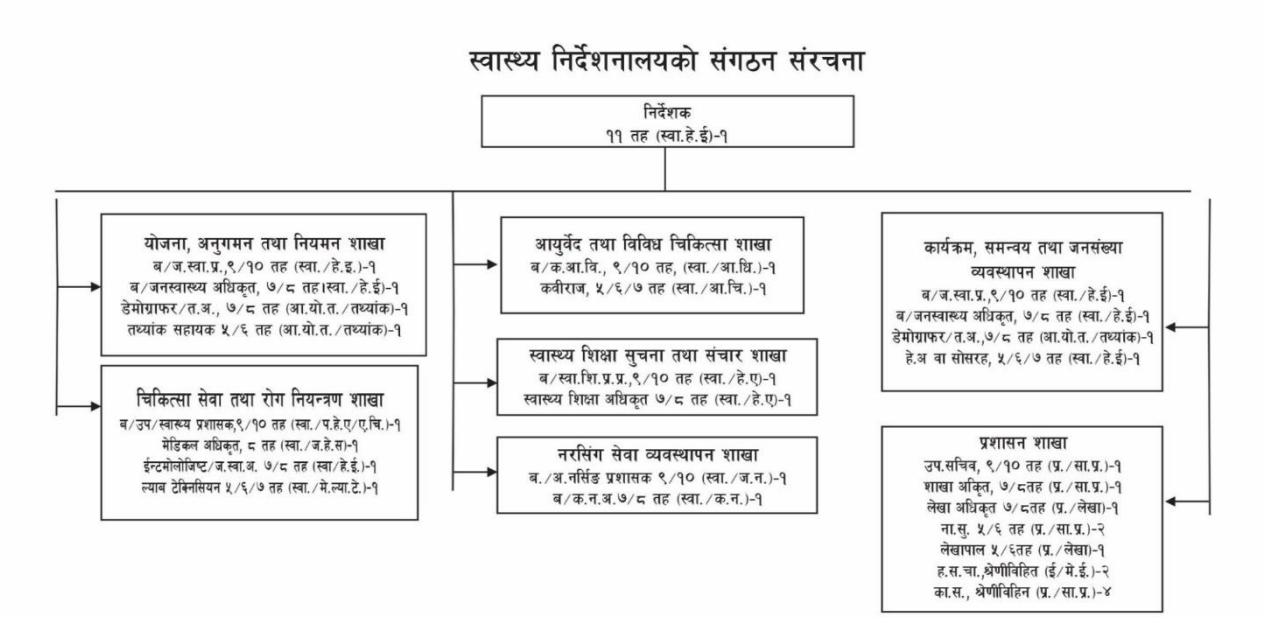


Figure 2: Organogram of Health Directorate



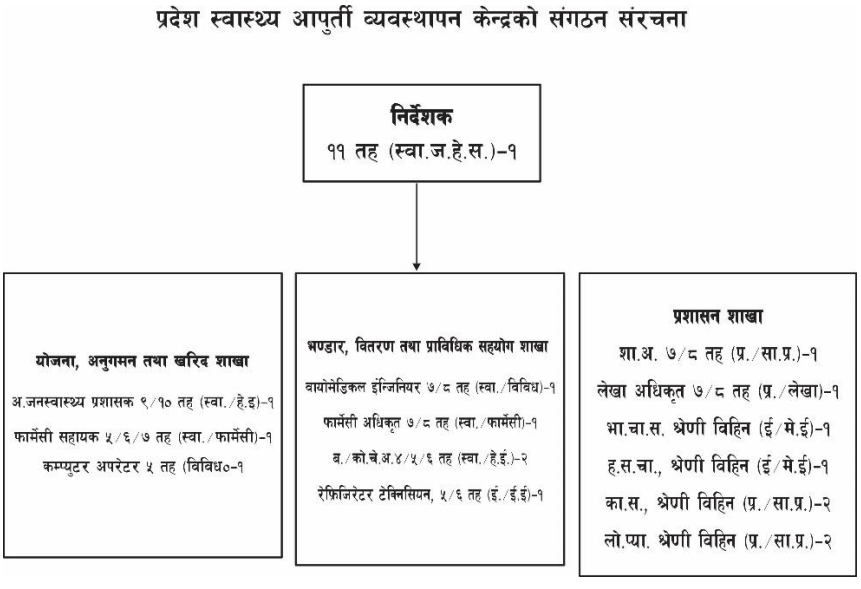


Figure 4: Organogram of Province Health Training Center

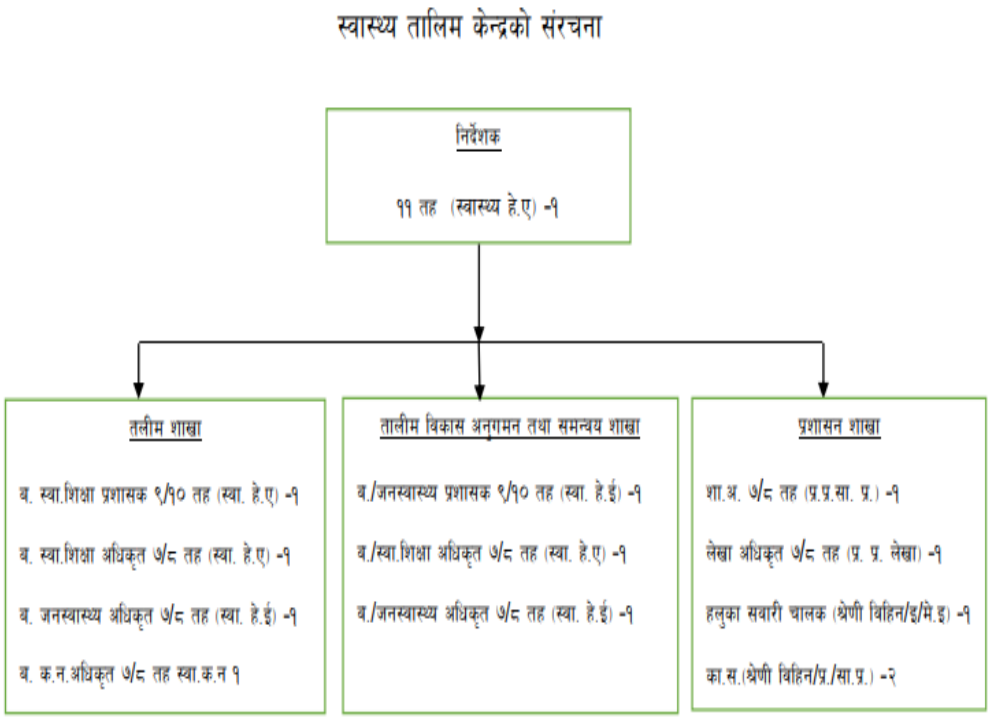


Figure 5: Organogram of Province Public Health Laboratory

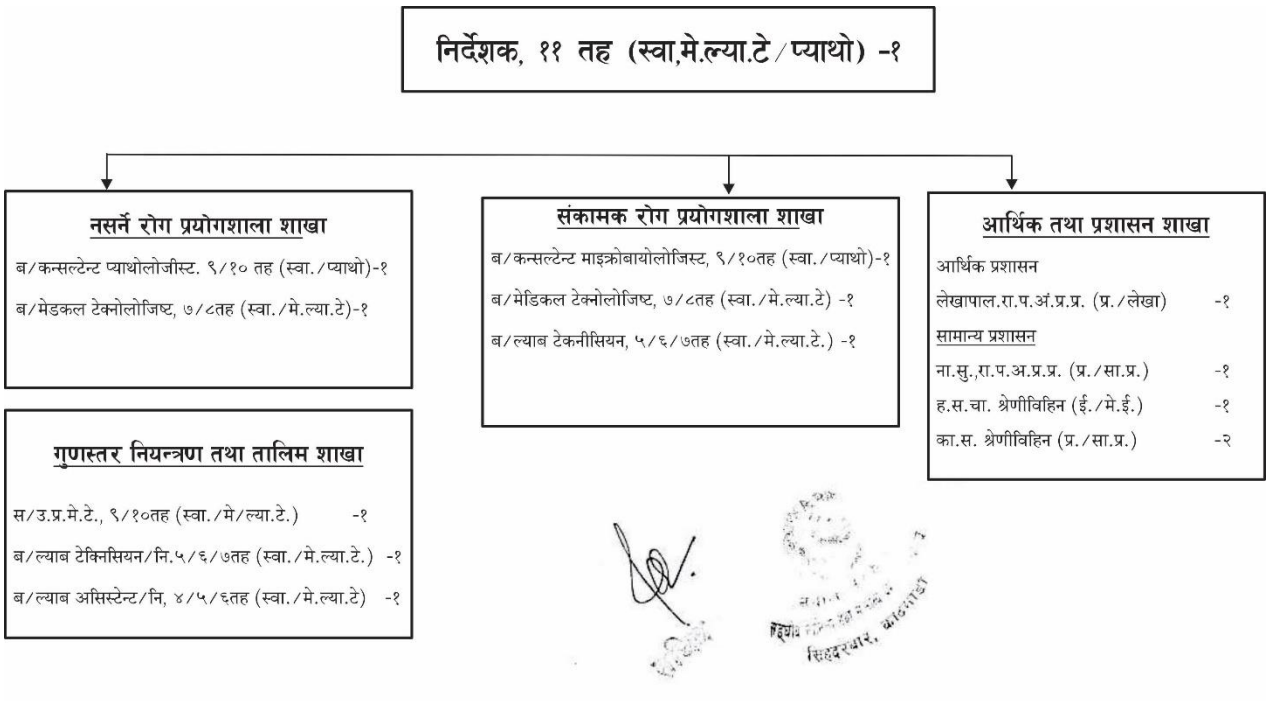


Figure 6: Organogram of Ilam, Morang, Jhapa and Sunsari Health Office

क्र.सं.	पद	श्रेणी/तह	सेवा	समुह	दरबन्दी
१	ब/जनस्वास्थ्य प्रशासक	५/१० तह	स्वा.से.	हे.इ	१
२	जनस्वास्थ्य अधिकृत वा सो सरह	७/६ तह	स्वा.से.	हे.इ	१
३	तथ्याङ्क अधिकृत	७/८ तह	आ.यो.त.	तथ्याङ्क	१
४	हे.अ. वा सो सरह	५/६/७ तह	स्वा.से.	हे.इ	३
५	प.हे.न.	५/६/७ तह	स्वा.से.	क.न.	१
६	ल्याब टेक्निसियन	५/६/७ तह	स्वा.से.	मे.ल्या.टे.	१
७	कोड चेन	४/५/६ तह	प्रशासन	हे.इ	१
८	अधिकृत	६ तह	प्रशासन	लेखा	१
९	अधिकृत	६ तह	प्रशासन	सा.प्र.	१
१०	का.स.	श्रेणीविहिन	प्रशासन	सा.प्र.	२
११	ह.स.चा.	श्रेणीविहिन	ईन्जि	मे.ई	१
	जम्मा				१४

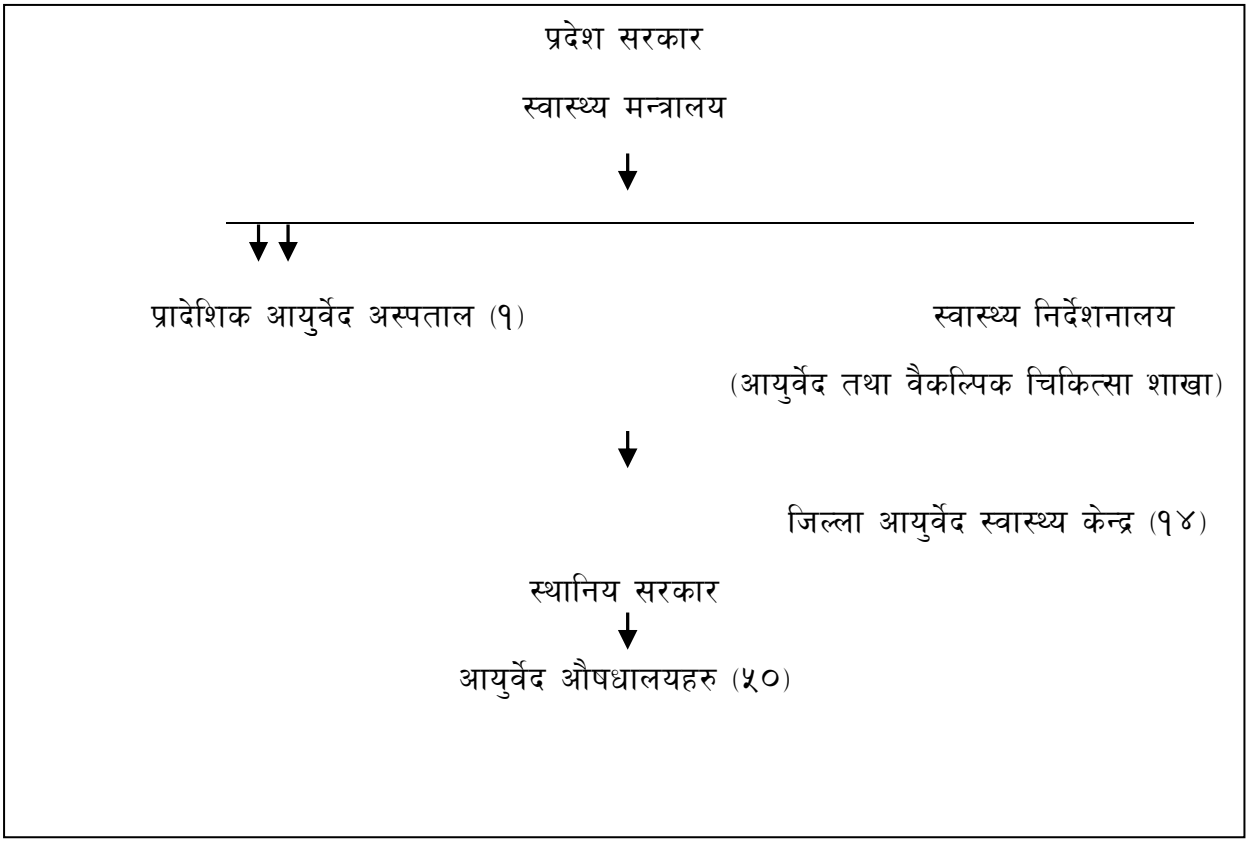
Figure 7: Organogram of Dhankuta, Udayapur, Paanchthar, Okhaldhunga, Sankhwasabha, Khotang and Bhojpur Health Offices

क्र.सं.	पद	श्रेणी/तह	सेवा	समुह	दरबन्दी
१	ब/जनस्वास्थ्य प्रशासक	७/८ तह	स्वा.से.	हे.इ	१
२	हे.अ. वा सो सरह	५/६/७ तह	स्वा.से.	हे.इ	२
३	प.हे.न.	५/६/७ तह	स्वा.से.	क.न.	१
४	ल्याब टेक्निसियन	५/६/७ तह	स्वा.से.	मे.ल्या.टे	१
५	कोड चेन असिटेन्ट	४/५/६ तह	स्वा.से.	हे.इ	१
६	लेखा सहायक	५ तह	प्रशासन	लेखा	१
७	सहायक	५ तह	प्रशासन	सा.प्र.	१
८	तथ्याङ्क सहायक	५/६ तह	आ.यो.त	तथ्याङ्क	१
९	का.स.	श्रेणीविहिन	प्रशासन	सा.प्र.	२
१०	ह.स.चा.	श्रेणीविहिन	ईन्जि	मे.ई	१
	जम्मा				१२

Figure 8: Organogram of Tehrathum, Solukhumbu and Taplejung Health Offices

क्र.सं.	पद	श्रेणी/तह	सेवा	समुह	दरबन्दी
१	ब/जनस्वास्थ्य प्रशासक	७/८ तह	स्वा.से.	हे.इ	१
२	हे.अ. वा सो सरह	५/६/७ तह	स्वा.से.	हे.इ	१
३	प.हे.न.	५/६/७ तह	स्वा.से.	क.न.	१
४	ल्याब टेक्निसियन	५/६/७ तह	स्वा.से.	मे.ल्या.टे	१
५	कोड चेन असिटेन्ट	४/५/६ तह	स्वा.से.	हे.इ	१
६	लेखा सहायक	५ तह	प्रशासन	लेखा	१
७	सहायक	५ तह	प्रशासन	सा.प्र.	१
८	तथ्याङ्क सहायक	५/६ तह	आ.यो.त	तथ्याङ्क	१
९	का.स.	श्रेणीविहिन	प्रशासन	सा.प्र.	२
१०	ह.स.चा.	श्रेणीविहिन	ईन्जि	मे.ई	१
	जम्मा				११

Figure 9: Organizational structure of Ayurveda Institutions



1.6 Health Facilities as per District Level

Table 3: Information of Health facilities in district

Districts	Government Hospital	PHC	Health Post	CHU	UHC	BHC	Private HF
Taplejung	1	2	51	21	2	7	3
Sankhwasabha	3	3	33	36	15	34	3
Solukhumbu	1	5	29	17	2	16	0
Okhaldhunga	2	1	54	20	3	8	2
Khotang	1	2	74	4	5	2	0
Bhojpur	1	3	66	5	1	11	3
Dhankuta	1	2	35	11	7	10	9
Terhathum	3	2	26	11	2	8	0
Paanchthar	1	2	40	10	2	16	3
Ilam	3	4	42	9	3	29	18
Jhapa	6	4	42	5	18	61	19
Morang	3	5	56	3	7	86	36
Sunsari	6	3	48	9	7	47	14
Udayapur	2	1	43	3	15	14	6
Total	34	39	639	164	89	349	116

Overall, there are 34 government hospitals in Province 1 including provincial, district and municipal hospitals. There are one government owned medical college (BPKIHS) and two private medical colleges (Nobel and Birat), 39 PHCCs, 639 Health Post, 164 Community Health Unit, 89 Urban Health Care Center and 349 Basic Health Service Centers. 116 private health facilities are providing health services in Province 1.

1.7 Health Servicesites as per District Level

Table 4: Information on different health services

Districts	PHC-ORC	EPI	FCHV	Birthing Center	CEONC	BEONC	DOTS Center	Gene Expert Machine	Safe Abortion Sites	OTC
Taplejung	171	171	855	29	1	2	54	1	1	20
Sankhwasabha	90	198	327	38	1	4	39	0	18	13
Solukhumbu	79	111	310	27	2	7	32	0	9	13
Okhaldhunga	171	173	690	44	1	1	57	0	17	14
Khotang	229	240	898	59	1	1	79	1	1	10
Bhojpur	195	195	567	47	1	3	81	1	9	15
Dhankuta	118	153	343	21	1	3	38	1	12	8
Terhathum	67	127	407	12	1	5	32	0	15	6
Paanchthar	150	211	394	34	1	2	43	0	13	17
Ilam	185	214	1012	27	1	5	56	1	22	18
Jhapa	144	268	568	19	2	3	42	3	7	18
Morang	297	333	729	17	1	5	71	1	25	6
Sunsari	165	273	1190	28	2	0	58	1	33	19
Udayapur	170	250	450	39	2	1	79	1	13	9
Total	2231	2917	8740	441	18	42	761	11	195	186

1.8 Ayurveda Institutions

Table 5: Information on Ayurveda Institutions

S. N	Institutions	Number	Remarks
1	Provincial Ayurveda Hospital	1	Kamal RM, Jhapa
2	District Ayurveda Health Centre	14	In each district
3	Ayurveda Aushadalaya	50	In local level
4	Nagarik Aarogya Sewa Kendra	53	
5	Lifestyle Management Program	1	Rabi PHCC, Paanchthar

PART 2– FAMILY HEALTH PROGRAM

2.1 IMMUNIZATION

2.1.1 National Immunization Program (NIP)

Background

National Immunization Program (NIP) of Nepal (Expanded Program on Immunization) was started in 2034BS and is a priority 1 program. It is one of the successful public health programs of Ministry of Healthand Population, and has achieved several milestones contributing to reduction in morbidity and mortalityassociated with vaccine preventable diseases.

National Immunization Program works closely with other divisions of Department of Health Services andnational centres of Ministry of Health and Population, and different partners, including WHO and UNICEF,supporting the National Immunization Program. In the Decade of the Vaccines (2011 – 2020), NationalImmunization Program has introduced several new and underutilized vaccines contributing towardsachievement of Global Vaccine Action Plan targets of introducing new and underutilized vaccines in routineimmunization. Currently, the program provides vaccination against 12 vaccine-preventable diseases. As peromprehensive Multi-Year Plan for Immunization (cMYPI) 2017 - 2021, several other vaccines, includingTyphoid Conjugated Vaccine (TCV) and Human Papilloma Virus Vaccine (HPV) are planned for introductionin Nepal. Preparatory works for Typhoid Conjugated Vaccine (TCV) campaign and its introduction in routineimmunization in fiscal year 2078-79 (2021-2022) is underway and the campaign is planned for later half ofthe next fiscal year. Currently, Immunization services are delivered through almost 16,000 service deliverypoints in health facilities (fixed sessions), outreach sessions, and mobile clinics.

National Immunization Program has cMYP 2017 - 2021 aligned with global, regional and national guidelines,policies and recommendations to guide the program for five years. All activities outlined in the cMYPI arecosted and has strategies for implementation.

Nepal is the first country in the South East Asia Region to have Immunization Act, thus supporting andstrengthening the National Immunization Program. Immunization Act 2072 was published in the OfficialGazette on 26 January 2016. Based on the Act, Nepal has Immunization Regulation 2074, which was publishedin the Official Gazette on 6 August 2018. The Immunization Act of Nepal has recognized immunization as aright of all children. In line with this, provinces of Nepal also have developed its own provincial ImmunizationAct.

Since FY 2069/70 (2012/2013), Nepal has initiated and implemented a unique initiative known as ‘fullimmunization program’. This program addresses issues of social inequity in immunization as every childregardless of social or geographical aspect within an administrative boundary are meant to be fullyimmunized under this program. Over the years, Nepal has witnessed participation of all stakeholders at alllevels to achieve full immunization. As of end of FY 2077/78, 63 out of 77 districts have been declared ‘fullyimmunized’. Gandaki Province has declared their province as fully immunized province.

National Immunization Program has a very good track record of meeting the targets for control, eliminationand eradication of vaccine preventable diseases. Smallpox has now become history due to eradication in2034 BS (1977 AD). Maternal and neonatal tetanus (MNT) was eliminated in 2005 and the elimination statushas been sustained since then. The last case of polio in Nepal was in 2010, and along with other countriesof the South East Asia Region, Nepal was certified polio free in 2014. This status has been maintained sincethen. Nepal is one of the first countries in the world to introduce JE vaccine in routine immunization. In2016, Japanese Encephalitis (JE vaccine), which initially was given only in 31 endemic Terai districts, wasscaled up all over the country, thus, further contributing towards control of Japanese encephalitis in Nepal.

In August 2018, Nepal was certified as having achieved control of rubella and congenital rubella syndrome.This certification is two years ahead of the regional target year of 2020 and one year ahead of the nationaltarget of 2019. In July 2019, Nepal was certified of having achieved hepatitis B control among childrenthrough immunization as the prevalence of the disease (sero-prevalence of HBsAg) dropped to less than< 1% (0.13% only) among 5-6-year-old children. With this, Nepal became one of the first four

countries(along with Bangladesh, Bhutan, and Thailand) in the WHO South-East Asia Region to control hepatitis Bamong children. Overall, the National Immunization Program is considered as the main contributor towardsdecline of infant and child mortality (Source: Nepal and the Millennium Development Goals, Final StatusReport 2000-2015, National Planning Commission), and has contributed significantly in achieving MDG Goal4 of reducing child mortality. Though measles burden has been reduced by > 95% compared to 2003, the national target of achieving measles elimination by 2019 has not been met. In September 2019, membercountries of WHO South-East Asia Region, including Nepal, have resolved to eliminate both measles andrubella by 2023 to prevent deaths and disabilities caused by these highly infectious childhood killer diseases.Measles, which is one of the most infectious diseases, will require very high coverages (> 95%) with boththe first and second routine immunization doses of measles-rubella (MR) vaccine in every community,municipality, district, province, and nationally. To quickly close the immunity gap to measles (and rubella),MoHP conducted nation-wide MR campaign in the month of Falgun and Chaitra 2076 extended till Ashad2077 in two phases, including polio campaign (with bOPV) in 19 selected districts of Terai. Even during theCOVID-19 pandemic situation in the second half of FY 2076/77, Nepal was able to complete its nation-widevaccination campaign, as well as introduce Rota vaccine in the National Immunization Program.

National Immunization Program produces evidence on burden of vaccine preventable diseases and impactof vaccine introduction. The Immunization Preventable Disease programme (WHO-IPD) of the World HealthOrganization, Nepal provides technical assistance to Ministry of Health and Population for nation-widesurveillance systems for acute flaccid paralysis (for polio), measles and rubella, neonatal tetanus, and acuteencephalitis syndrome (for Japanese encephalitis). Further, with support of WHO-IPD, sentinel surveillanceof selected vaccine preventable diseases (invasive bacterial diseases, rotavirus, and congenital rubellasyndrome) is conducted in collaboration with academia and research institutes. National Immunization Program with the support of WHO-IPD works with various immunization and vaccinepreventable diseases surveillance committees and task forces which function as advisory and qualitymonitoring bodies of the program. The committees include National Immunization Committee, NationalImmunization Advisory Committee, National AEFI Investigation Committee, Inter-Agency CoordinationCommittee on Immunization, National Certification Committee for Polio Eradication, National Verification
Committee for Measles and Rubella/CRS Elimination, National Task Force for Laboratory Containment ofPolio, Expert Review Committee for Polio, Polio Legacy Committee, etc. Since 2018, concurrent immunizationsupervision and monitoring has been conducted through program staff, partners, Surveillance MedicalOfficers (SMO) network, independent monitors, and immunization and VPD committee members at subnationallevels including assessment at communities producing real-time data for real-time action.

2.1.2 Guiding Documents of National Immunization Program

There are several global, regional and national guiding documents for the National Immunization Program.The main documents which have been taken in account and incorporated in cMYPI 2017 - 21 are GlobalVaccine Action Plan, South East Asia Regional Vaccine Action Plan, National Immunization Act 2072,Immunization Regulation 2074 and Nepal Health Sector Strategy, and periodic recommendations fromSEAR-ITAG (South-East Asia Region Immunization Technical Advisory Group) and polio and measles rubellacertification committees.

NATIONAL IMMUNIZATION SCHEDULE

Table 6: National Immunization Schedule

SN	Type of Vaccine	Number of Doses	Schedule
1	BCG	1	At birth or on first contact with health institution
2	OPV	3	6, 10, and 14 weeks of age
3	DPT-Hep B-Hib	3	6, 10, and 14 weeks of age
4	Rotavirus Vaccine	2	6 and 10 weeks of age
5	fIPV	1	6 and 14 weeks of age
6	PCV	3	6, 10 weeks and 9 months of age
7	Measles-Rubella	3	First dose at 9 months and second dose at 15 months ofage
8	JE	1	12 months of age
9	Td	2	Pregnant women: 2 doses of Td one month apart in firstpregnancy, and 1 dose in each subsequent pregnancy

2.1.3Major Activities

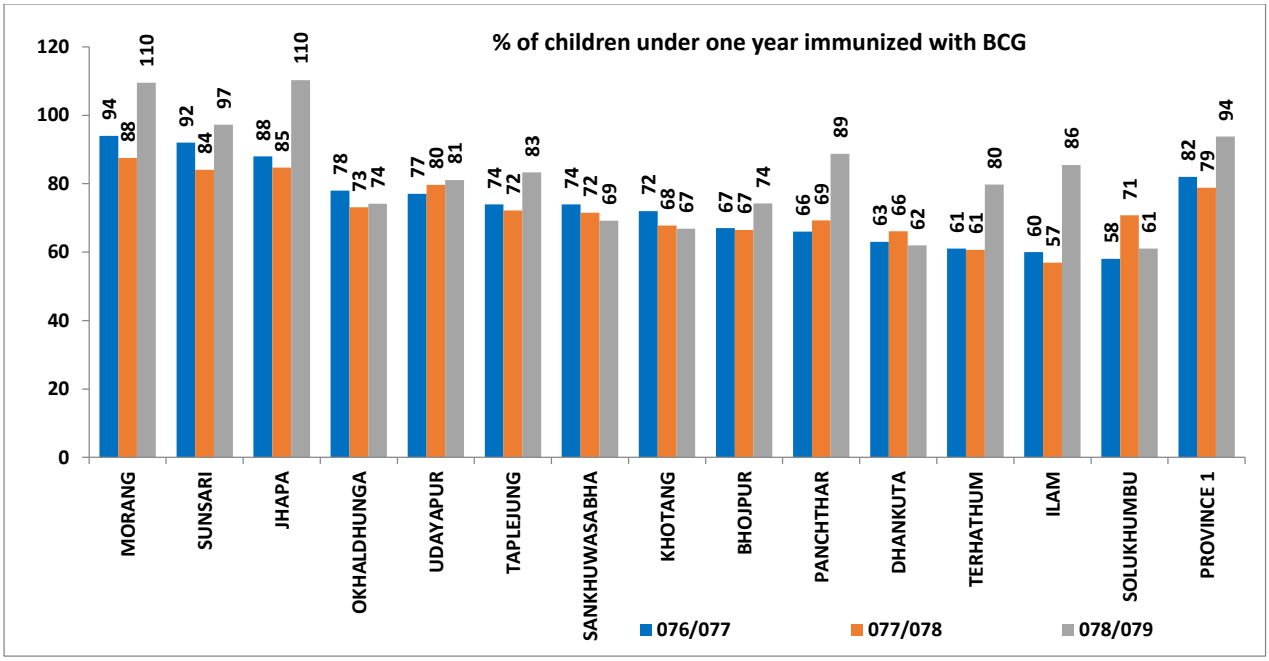
The planned sets of activities were identical in all districts. The following were the major activities carried out during FY 2078/79:

- Provision of routine immunization services delivery either through fixed sites or outreach sessions: 3-5 session/month/VDC(Previous) as per micro plan, conducted Reaching Every District (RED) micro planning in districts
- Hygiene promotion integration and continuation in National Immunization Program
- Celebrated "Immunization Month" and “National Immunization Day”
- Training provided to health workers in the province
- Repair of cold chain equipments
- Vaccine and supplies (Icepacks, syringes, vaccine carriers& safety boxes) transportation
- Conducted joint supervision and monitoring in poor performing districts
- Conducted review of immunization services
- Continued integrated VPDs surveillance (AFP, Measles, NT, AES, pneumonia for AI and Hib), measles case-based surveillance expanded, outbreaks of suspected measles investigated and responded followed by lab confirmation, done by WHO.
- Conducted independent routine immunization monitoring in all districts
- Immunization data verification, validation and monitoring for sustainability of municipality for Full Immunization Declaration program
- Continued AEFI investigation in routine immunization and COVID-19 vaccination campaign
- Outbreak response Immunization conducted for MR outbreaks at four outbreak sites
- Review, supervision and monitoring of NIP along with hygiene promotion program at immunization clinics

BCG coverage

Trend of BCG coverage has increased from 79 in FY 077/078 to 94 in FY 078/079 and have met the national target.Morang and Jhapa has the highest coverage i.e 110 and Solukhumbhu has the lowest coverage(61) followed by Dhankuta(62).

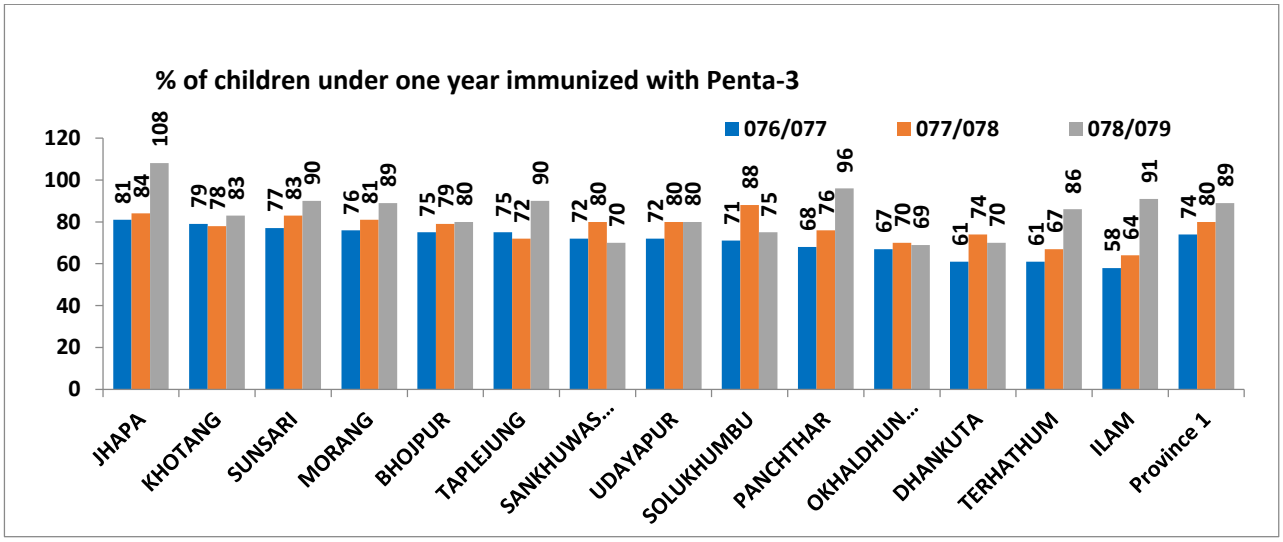
Figure 10: Percentage of BCG Coverage



DPT-Hib-HepB-3 coverage

Penta-3 coverage has increased as compared to previous fiscal year. Districts like Jhapa, Sunsari, Taplejung, Panchthar and Ilam has 90% coverage as Okhaldhunga has lowest coverage and Jhapa has the highest coverage in this fiscal year.

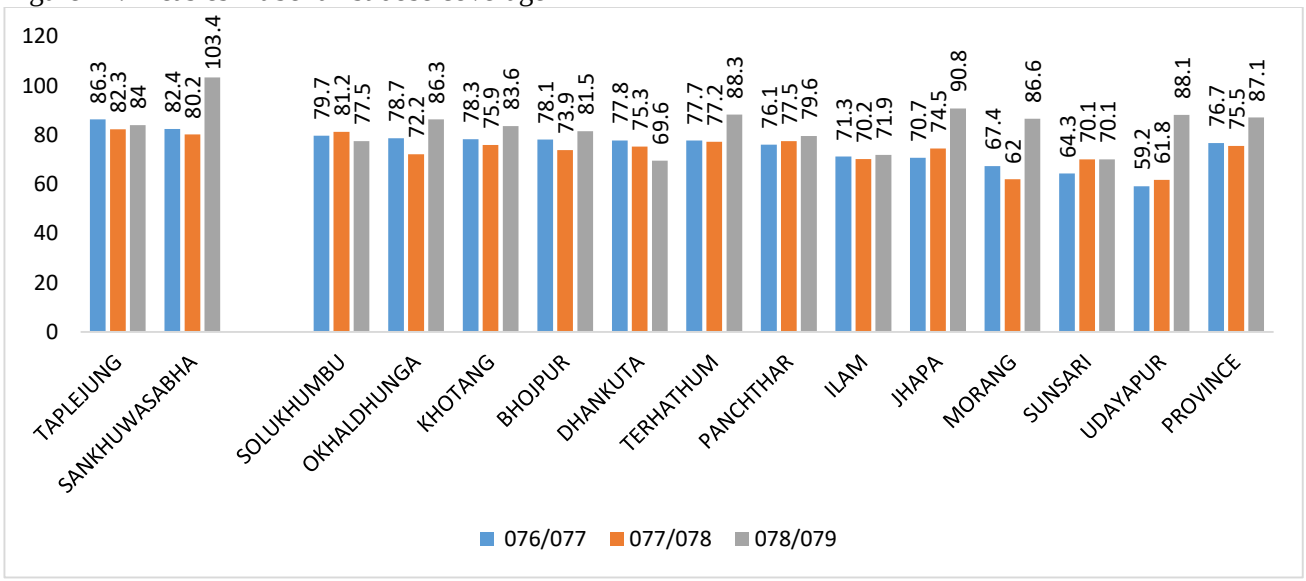
Figure 11:DPT-Hib-HepB-3 coverage



Measles-Rubella 1st dose coverage

Measles-Rubella 1st dose coverage has incerased than previous fiscal year from 75.5% to 87.1%. Sankhuwasabha and Jhapa has more than 90% coverage. The coverage of Solukhumbu and Dhankuta has decreased from 81.2% and 75.3% to 77.5% and 69.6% reapectively.

Figure 12: Measles-Rubella 1st dose coverage



Measles-Rubella 2nddose coverage

Measles-Rubella 2nd dose coverage has increased than previous year. Sankhuwasabha has the highest coverage whereas Solukhumbu has lowest coverage.

Figure 13: Measles-Rubella 2nd dose coverage

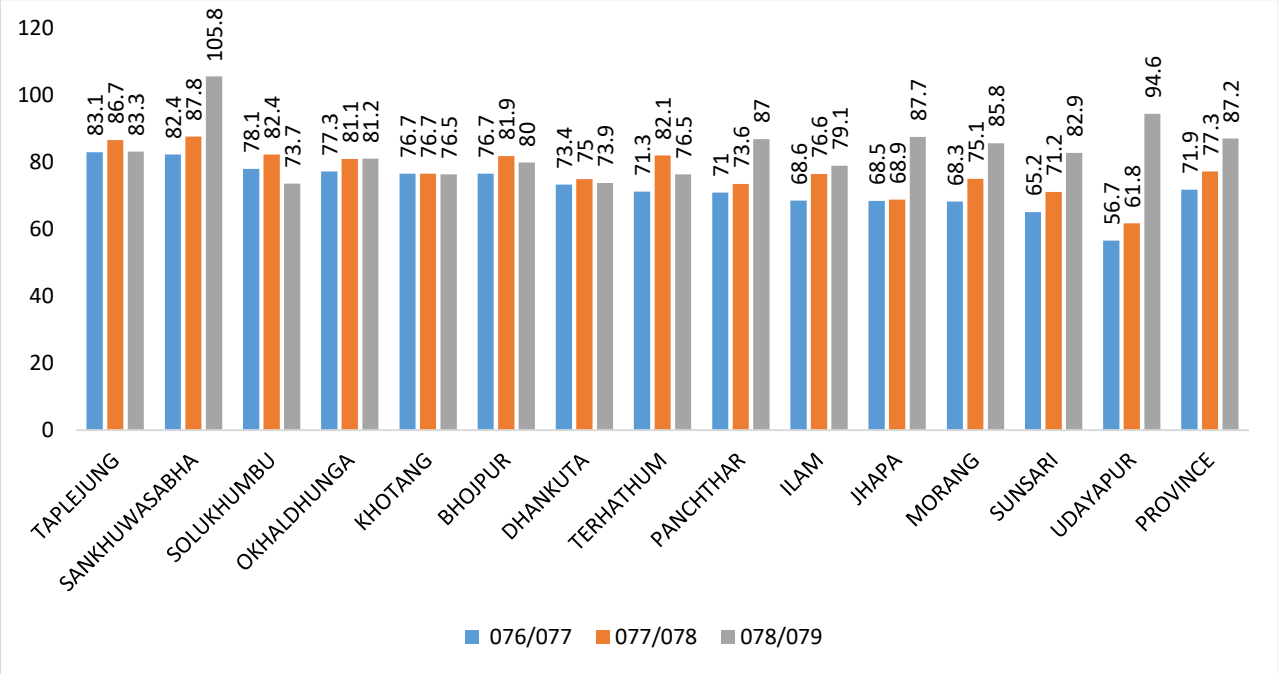


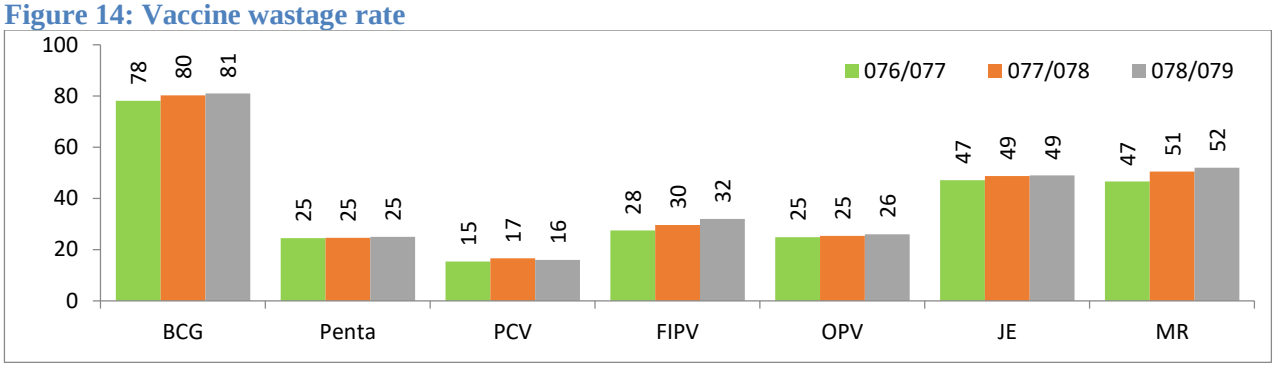
Table 7: Target and achievement by antigens

Vaccine	Target	Achievement	% Achieved
BCG	84823	79753	94
DPT-HepB-Hib-1st	84823	78555	93
DPT-HepB-Hib-2nd	84823	77081	91
DPT-HepB-Hib-3rd	84823	75721	89
OPV-1st	84823	78363	92
OPV-2nd	84823	76696	90
OPV-3rd	84823	75651	89
FIPV-1st	84823	77630	92
FIPV-2nd	84823	75257	89
PCV-1st	84823	78956	93
PCV-2nd	84823	77197	91
PCV-3rd	84823	75103	89
Rota 1st	84823	77964	92
Rota 2nd	84823	74912	88
Measles/Rubella-9-11 Months	84823	73856	87
Measles/Rubella-12-23 Months	84937	74037	87
JE	84937	75161	88
TD(Pregnant Women)-2	99910	44296	44
TD(Pregnant Women)-2+	99910	23256	23

Vaccine Wastage

Vaccine wastage seems increasing for all vaccines except PCV. Almost all vaccine wastage rates are higher than recommended level.

Figure 14: Vaccine wastage rate



Access and Utilization of Immunization Services

Evaluation of access of immunization services are based on third dose of DPT-HepB-Hib coverage (>80% as good access), while utilization of immunization services is evaluated against drop-out rate Penta 1 against Penta 3 (<10% drop-out as good utilization). Districts are categorized and prioritized in 4 groups based on "access" and "utilization" of DPT-HepB-Hib vaccine.

Category 1 includes districts with high coverage (>80%) and low drop-out (<10%) and are considered as districts with good access and utilization, category 2 includes districts with high coverage (>80%) and high drop-out (>10%) and are considered as districts with good access but poor utilization, category 3 includes districts with low coverage (<80%) and low drop-out (<10%) and are considered as districts with poor access and good utilization and category 4 includes districts with low coverage (<80%) and high drop-out (>10%) and are considered as districts with poor access and poor utilization.

Table 8: Access and Utilization of Immunization Services

Category 1 (Penta 3 coverage >80 %, Penta 1 VS Penta 3 Drop out <10%): Terhathum, Panchthar, Jhapa, Illam, Taplejung, Sunsari, Udaypur, Bhojpur and Morang 9	Category 2 (Penta 3 coverage >80 %, Penta 1 VS Penta 3 Drop out >=10%): Khotang, Solukhumbu, Sankhuwasabha and Dhankuta 5
Category 3 (Penta 3 coverage <=80 %, Penta 1 VS Penta 3 Drop out <10%): 0	Category 4 (Penta 3 Coverage <=80%, Penta 1 VS Penta 3 Drop out >=10%): 0

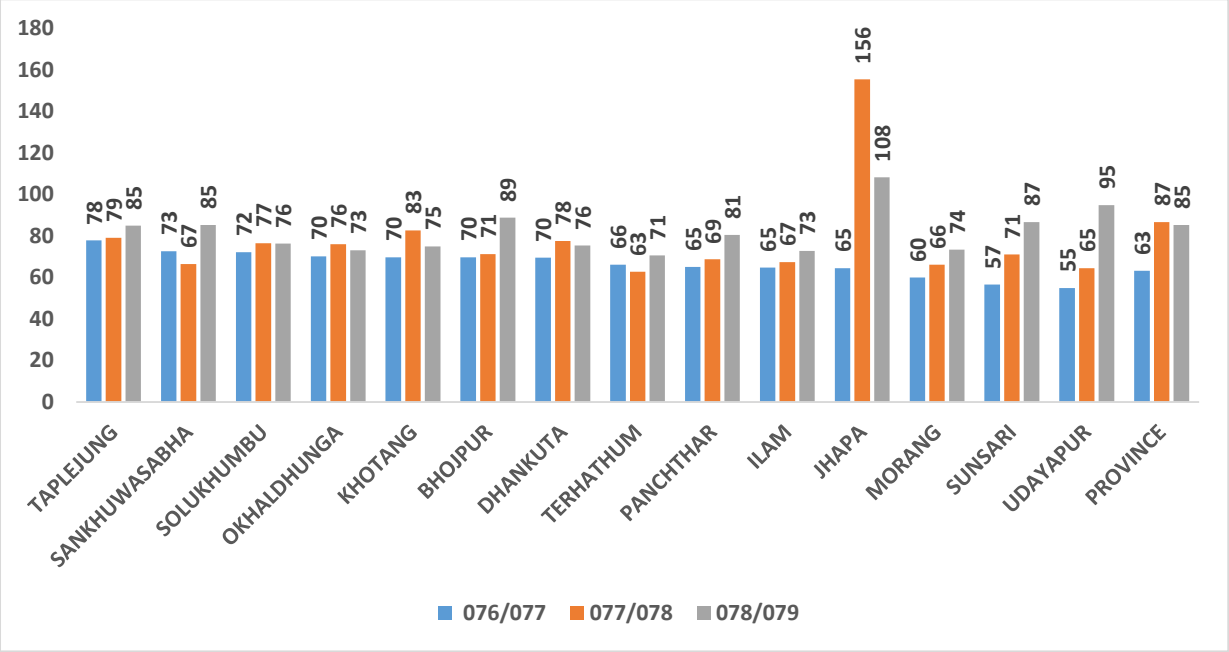
Full Immunization Declaration status of districts

Out of 14 districts, all the districts of Province 1 have been declared as full immunization. On the other hand Province is yet to be declared as fully immunized Province.

Percentage of children fully immunized as per immunization schedule

Percentage of children fully immunized as per immunization schedule has been decreased from 87 to 85 in this fiscal year.

Figure 15Percentage of children fully immunized as per immunization schedule



Issues and Recommendation

Issues	Recommendation	Responsible
Low immunization coverage	Actual target should be identified from census by palika Reporting and recording errors should be corrected. Effective EPI Microplanning, implementation, and monitoring Strengthen routine immunization as well as full immunization campaign	Health Facility, Palika, Health Office, Province
Not proper physical infrastructure at palika level to maintain vaccine cold chain	Vaccine supply centre should be established at palika level	Palika, Health Office, Province, Management division
Vaccine distribution	Timely supply of commodities related to immunization	Health Office, Province, Management Division
Lack of HR to conduct EPI clinic after Samayojan	Vacant post should be fulfilled by palika, province through contract	Palika and Province
Vaccine Management at Palika Level	Assign cold chain manager for each Palika	Palika
Data management of COVID-19 vaccination campaign	Proper planning and management of safe vaccination sessions, timely data entry in DHIS2	Palika and Province
Supportive supervision and monitoring	Develop supervision and monitoring through digital tracking system	Palika, Health Office, Province

2.2 Nutrition Program

2.2.1 Background

Nutrition is a basic component of human life and is essential for people of all age groups. Pregnantwomen, lactating mothers, adolescents and children have particular nutritional requirements andrequirespecial attention. The effect on the body due to an imbalance in our food intake compared to our actualnutritional requirements is called malnutrition. The term malnutrition encompasses undernutrition as wellas overweight and obesity. The various forms of undernutrition are stunting, underweight, wasting andmicronutrient deficiencies. Factors such as healthcare, food security, education, consumption of purifiedwater, hygiene, sanitation, access to resources and empowerment play a major role in the development ofmalnutrition.

Malnutrition has devastating consequences: it slows economic growth and perpetuates poverty through direct losses in productivity from poor physical status and indirect losses from poor cognitive function and increased health costs. Hunger and undernutrition often result in the vicious cycle of malnutrition and infections that leads to poor physical, cognitive and intellectual development, reduced productivity and compromised socioeconomic development. The term malnutrition covers a range of short and longtermconditions that result in physiological impairment caused by lack of or excess of nutrients in thebody. Malnutrition includes both undernutrition and overnutrition. Under-nutrition includes wasting andnutritional oedema (Acute Malnutrition), stunting (Chronic Malnutrition), intrauterine growth restrictionleading to low birth weight, and micronutrient deficiencies. These conditions may be experienced overa scale of severity and are usually classified into moderate and severe forms. They may occur in isolationwithin an individual or in combination.

The Nutrition Section of the Family Welfare Division (FWD), Department of Health Services (DoHS), Ministryof Health and Population (MoHP) is responsible for the implementation and regulation of all the nutritionspecific interventions throughout the country. The ultimate goal of the National Nutrition Program is "toachieve the well-being of all people in order to maintain a healthy life and to be able to contribute tothe socio-economic development of the country, through the implementation of the nutrition program incollaboration with all relevant sectors." Nutrition interventions are cost effective, high quality and essentialinvestments which contribute towards the achievement of many of the Sustainable Development GoalsSDGs). Without adequate and sustained investments in nutrition, the SDGs will not be realized. Our goal to"End hunger, achieve food security and improved nutrition and promote sustainable agriculture" is stated inthe SDGs and at least 12 of the 17 SDGs contain indicators that are highly relevant to nutrition.

Focus on nutrition — The Government of Nepal (GoN) is committed to ensuring that all its citizens haveaccess to adequate nutritious food, healthcare and other social services that impact nutrition outcomes.The Constitution of Nepal (2015) ensures the right to food, health and nutrition for all citizens. Nutrition isa globally recognized development agenda. Since 2000, several global movements have advocated on theimportance of nutrition for development. In 2012 the World Health Assembly Resolution 65.6 endorsed acomprehensive implementation plan on maternal, infant and young child nutrition, which specified a set ofglobal nutrition targets to be achieved by 2025 (as compared to the NDHS 2011 baseline levels):

1. Achieve a 40% reduction in the number of children under-5 who are stunted.
2. Achieve a 50% reduction of anaemia in women of reproductive age.
3. Achieve a 30% reduction in low birth weight; ensure that there is no increase in childhood overweight.
4. Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%.
5. Reduce and maintain childhood wasting to less than 5%.

The Scaling-Up-Nutrition (SUN) initiative calls for multi-sectoral actions for improved nutrition during thefirst 1,000 days of life and the Road Map for Scaling-Up-Nutrition (SUN) was released in September 2010."Nepal was the fifth country to join the SUN Movement on the 5th of May 2011 as an early riser, it adoptedthe Multi-sector Nutrition Plan in 2012 with a 10-year vision (2013-2022) and five-year plans (2013-2018)to reduce chronic undernutrition with a focus on children in their first 1,000 days of life. Similarly, on April2016, the United Nations General Assembly agreed on a resolution proclaiming the UN Decade of Action onNutrition from 2016 to 2025 with an aim "to provide a clearly-defined time-bound operational frameworkthat works within existing structures and available resources to implement the commitments made at theSecond International Conference on Nutrition and the 2030 Agenda for Sustainable Development."

Policy initiatives — The National Nutrition Strategy was officially unveiled in 2077 (2020) and it aims toaddress all forms of malnutrition by implementing nutrition specific and sensitive interventions throughthe health sector and provide strategic and programmatic direction for nutrition interventions in Nepalthrough the health sector. Similarly, Multi-sector Nutrition Plan (MSNP-II 2018-2022) which is a broadernational policy framework for nutrition, within and beyond the health sector, coordinated by the NationalPlanning Commission (NPC), provides national policy guidance for nutrition specific and nutrition sensitiveinterventions as well as creating an enabling environment for nutrition interventions throughout the country.The National Health Policy, 2076 (2019) focuses on improving nutrition through the effective promotion ofquality, nutritious foods produced locally. A Nutrition Technical Committee

(NUTEC) led by the Director ofthe Family Welfare Division was established in 2011. NUTEC comprised of technical experts from relevantGovernment Ministries and Departments, UN Agencies and Development Partners. It provides technicalguidance for nutrition specific and sensitive interventions through multisector coordination and a jointdecision-making process.

In alignment with the SDG roadmap (2015-2030), National Nutrition Strategy 2020 (2077), the FifteenthPeriodic Plan (2019/20-2023/24), the National Multi-Sector Nutrition Plan (MSNP-II), National HealthPolicies, the National Health Sector Strategic Plan (NHSSP – III) and the National Agriculture DevelopmentStrategy (ADS), the Nutrition Section of the Family Welfare Division has developed national nutritionstrategies and plans for improving maternal, infant and young child nutrition assisted by nutrition experts,relevant agencies and members of the Nutrition Technical Committee. Moreover, as recommended by theNepal Nutrition Assessment and Gap Analysis (NAGA 2009/2010) and guided by the MSNP, MoHP conductedan Organization and Management Survey in 2012–2013,towards establishing a National Nutrition Centre asan apex body under the Ministry of Health and Population for all nutrition specific interventions.

2.2.2Objectives of National Nutrition Program

The overall objective of the national nutrition program is to enhance nutritional well-being, contribute toreduce child and maternal mortality and enable equitable human development. The National Nutritiontrategy 2077 adopted the following fundamental principles and approaches:a) nutrition plan andactivities as per the federal structure; b) gender equality and social inclusion; c) expansion of programto unreached groups and communities; d) transparency, responsibility and accountability; e) good governance; f) evidence-based nutrition service; g) private sector engagement; h) mobilization of local resources; i) community participation.According to the National Nutrition Strategy 2077, the specific objectives of the national nutrition programare as follows:

1. Improve the nutritional status of infant, young children, adolescent girls and women by increasingaccess to nutrition specific and nutrition sensitive services.
2. Improve the quality of nutrition specific and nutrition sensitive interventions and build capacity of theservice providers.
3. Increase the demand of nutrition specific and nutrition sensitive interventions through public awareness,promote good nutrition behaviors and inhibit harmful behaviors.
4. Timely expansion of nutrition services.As per the MICS 2019 data, information on key nutrition indicators is illustrated on table below:

Targets

Sustainable Development Goal

Goal 2 — End hunger, achieve food security and improved nutrition and promote sustainable agriculture

- By 2030, end hunger and ensure access by all people, the poor and people invulnerable situations, including infants, to safe, nutritious, and sufficient food all year round.
- By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.
- By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists, and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment.

Current Global Nutrition Targets

Global Nutrition Target by 2025 (World Health Assembly [WHA])

- Reduce the global number of children under five who are stunted by 40 percent
- Reduce anemia in women of reproductive age by 50 percent
- Reduce low birth weight by 30 percent
- No increase in childhood overweight
- Increase the rate of exclusive breastfeeding in the first six months up to at least 50 percent

- Reduce and maintain childhood wasting to less than 5 percent.

2.2.3 Major Activities

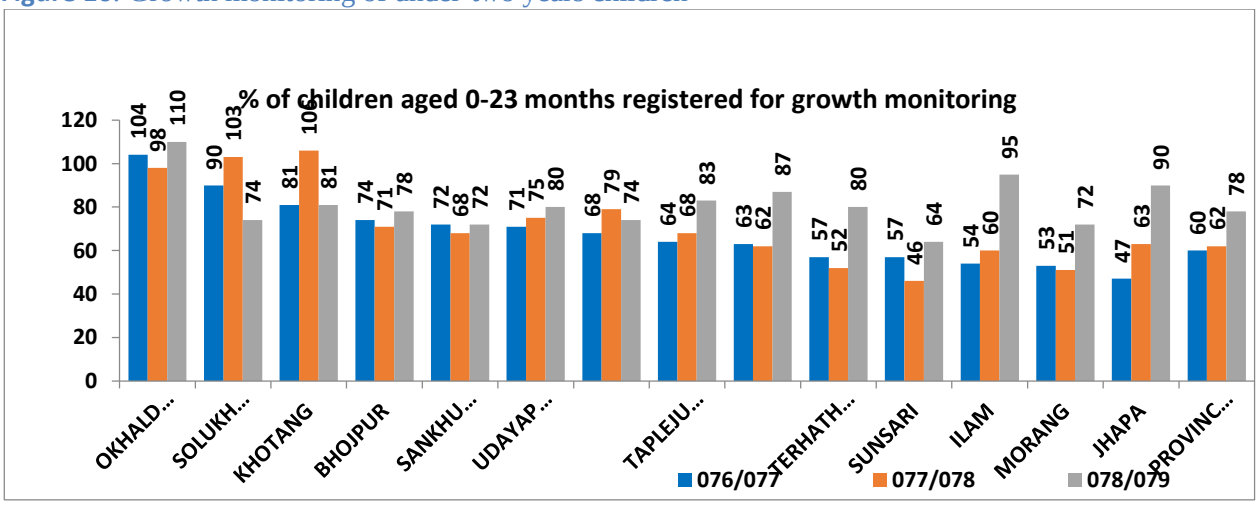
The following were the major activities carried out during FY 2078/79:

- Nutrition Review Meeting in all local level and provincial level
- CNSI training to health worker and FCHV
- Establishment/strengthening of OTC's
- MNP distribution linked with IYCF
- Growth monitoring of under two years children
- Mass Vitamin A distribution & de-worming program for under five children
- Celebration of breast-feeding week
- Advocacy of IDD month
- Celebration of school/nutrition week
- Iron tablets distribution to pregnant women and adolescents
- Albendazole distribution to pregnant women and children
- Supervision and monitoring of Nutrition Program
- Implementation of MSNP
- Establishment and regular conduction of NRH
- Publication of Nutrition related IEC materials
- Establishment of Nutrition corner in health facilities and Breastfeeding corner
- Regular distribution of Nutrition related forms/format and other commoditiesAnalysis of achievement
- Nutritional related HMIS tools printing and distribution
- Airing of Nutrition related massages through radio

Growth Monitoring

The percentage of growth monitoring of under two years children in the year 2078/79 has been increased from 62% to 78% as compared to the year 2077/078. In this year, Okhaldhunga has the highest growth monitoring while Sunsari has lowest.

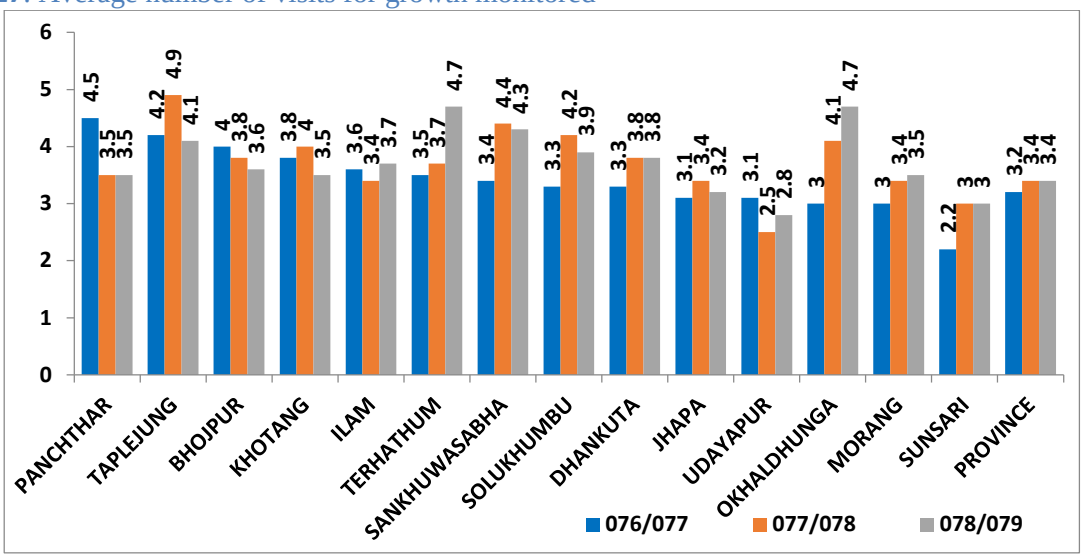
Figure 16: Growth monitoring of under-two years children



Average number of visits for growth monitored

The average number of visits for growth monitored has been stagnat to 3.4 in FY 077/078 and FY 078/079, with the highest number of visits in Terthathum and Okhaldhunga, and lowest number of visits in Udayapur. The number of visits is very less as compared to the total number of visit (24 times) to be conducted of a children within two year.

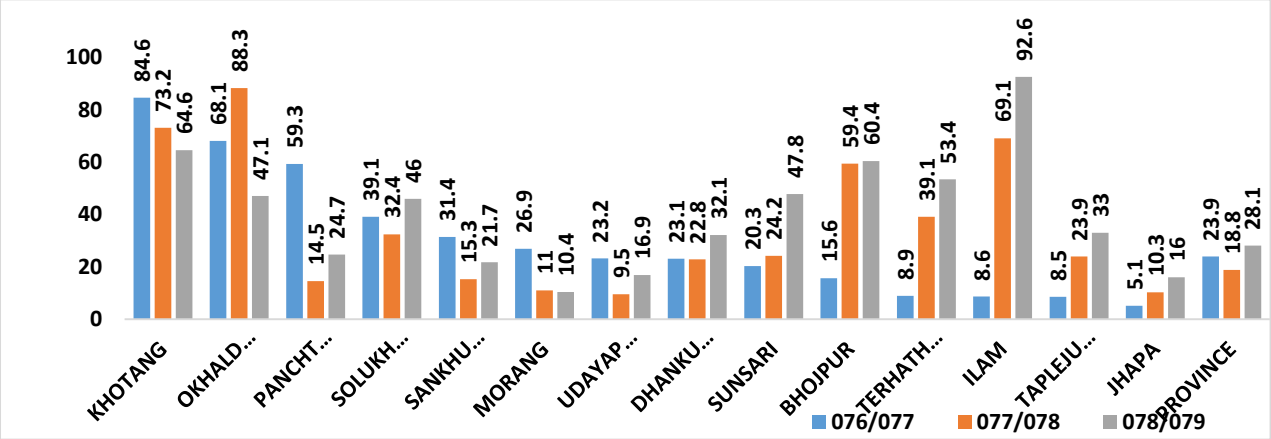
Figure 17: Average number of visits for growth monitored



Exclusive Breastfeeding (among growth monitored)

Exclusive Breastfeeding among growth monitored children has increased in this fiscal year i.e., 28.1. Among the growth monitored children, highest percentage of exclusive breastfeed was found in Ilam district i.e., 92.6% and Jhapa being the lowest with only 16%. Progress in this indicator is in declining phase comparing with the data of MICS 2019. As per MICS 2019 data percentage of infants under 6 months of age who are exclusively breastfed in Province 1 was 60.6 % and 62.1 % in National. SDG has set the target of 90% to be achieved by 2030.

Figure 18: Exclusive Breastfeeding (among growth monitored)



Issues and Recommendation

Issues	Recommendation	Responsible
Low growth monitoring coverage	• New policy and strategy should be developed to strengthen growth monitoring program	Province, Health Office, Palika, MoHP/Nutrition section
Low notification of malnourished children and its management	• Strengthen growth monitoring system and screening/identification of malnourished children. • Establishment of at least one OTC center at each Health facility, developing owing strategy • Regular conduction of NRH	Province, Health Office, Palika, Health facilities
Timely Recording/Reporting	• Regular follow-up and RDQA in health facilities. • Develop mechanism of quality assurance and regular onsite coaching	Province, Health Office, Palika, MoHP/Nutrition section

2.3 Community Based-Integrated Management of Neonatal and Childhood Illness (CB-IMNCI)

2.3.1 Background

Chronological development: Integrated Management of Neonatal and Childhood Illness (IMNCI)

Child survival intervention In Nepal began in 1983 with the initiation of Control of Diarrhoeal Disease (CDD)Program and Acute Respiratory Infection (ARI) Control Program in 1987. For the management of ARI Casesfrom household level and to maximize ARI related services, referral model and treatment model at thecommunity level were piloted. An evaluation of this intervention in 1997 revealed that treatment modelwas more effective and popular in the community than referral model. In 1997/98, ARI intervention wascombined with CDD and named as CB-AC program. One year later two more components, nutrition andimmunization were also incorporated in the CBAC program. IMCI program was piloted in Mahottari districtand was extended to the community level as well. Finally, the government decided to merge the CBAC intoIMCI in 1999 and named it as Community-Based Integrated Management of Childhood Illness (CB-IMCI) asboth of the program targeted same population with involvement of similar Health Service Providers. CBIMCImainly focused in five major childhood diseases; pneumonia, diarrhoea, malaria, measles, and malnutrition.The strategies adopted in IMCI were improving knowledge and case management skills of health serviceproviders, overall health systems strengthening and improving community and household level carepractices. After successful piloting of low osmolar ORS and Zinc supplementation, it was incorporated in CBIMCIprogram in 2005. Nationwide implementation of CB-IMCI was completed in 2009 and revised in 2012incorporating important new interventions.

Community-Based Integrated Management of New-born and Childhood Illnesses (CB-IMNCI)

CB-IMNCI is an integration of CB-IMCI and CB-NCP Program as per the decision of MoHP on 2071/6/28(October 14, 2015). This integrated package of child-health intervention addresses the major problemsof sick newborn such as birth asphyxia, bacterial infection, jaundice, hypothermia, and low birth weight.The program aims to address major childhood illnesses like Pneumonia, Diarrhoea, Malaria, Measlesand Malnutrition among under 5 year's children in a holistic way. Since 2016, CB-IMNCI program is beingimplemented in 77 districts of the country.

In CB-IMNCI program, FCHVs carry out health promotional activities for maternal, new-born and child healthand provide essential commodities like distribution of iron, zinc, ORS, chlorhexidinewhich do not requireassessment and diagnostic skills, and immediate referral in case of any danger signs that appear among sicknew-borns and children. Health service providers counsel and provide health services like management ofnon-breathing cases, low birth weight babies, common childhood illnesses, and management of neonatalsepsis. Also, the program has provisioned for the post-natal visits by trained health service providers throughprimary health care outreach clinic.

The program has envisioned for Child Health & Immunization Services Section (CHISS), Family WelfareDivision with overall responsibility of planning, management and quality assurance and monitoring oftheCB-IMNCI program. The CHISS has been focusing continuously onmonitoring, supportive supervision, onsitecoaching to enhance the clinical skill among service providers, and Routine Data Quality Assessment (RDQA)tostrengthen the CB-IMNCI program. The program aims to reach the unreached population and communitiesthrough implementation of equity and access program (EAP).

Goal

Improve New-born child survival and ensure healthy growth and development.

Targets

Target for reduction of NMR, U-5MR & Stillbirths by NHSS, NENAP, SDGs

Objectives:

- To reduce neonatal morbidity and mortality by promoting essential New-born care services & managing major causes of illness
- To reduce childhood morbidity and mortality by managing major causes of illness among under 5yearsof age children

Strategies

- Quality of care through system strengthening and referral services for specialized care
- Ensure universal access to health care services for New-born and under 5 years of age children
- Capacity building of healthservice providers and FCHVs
- Increase service utilization through demand generation activities

Major Activities

Major activities carried out in the FY 2078/79 include the following:

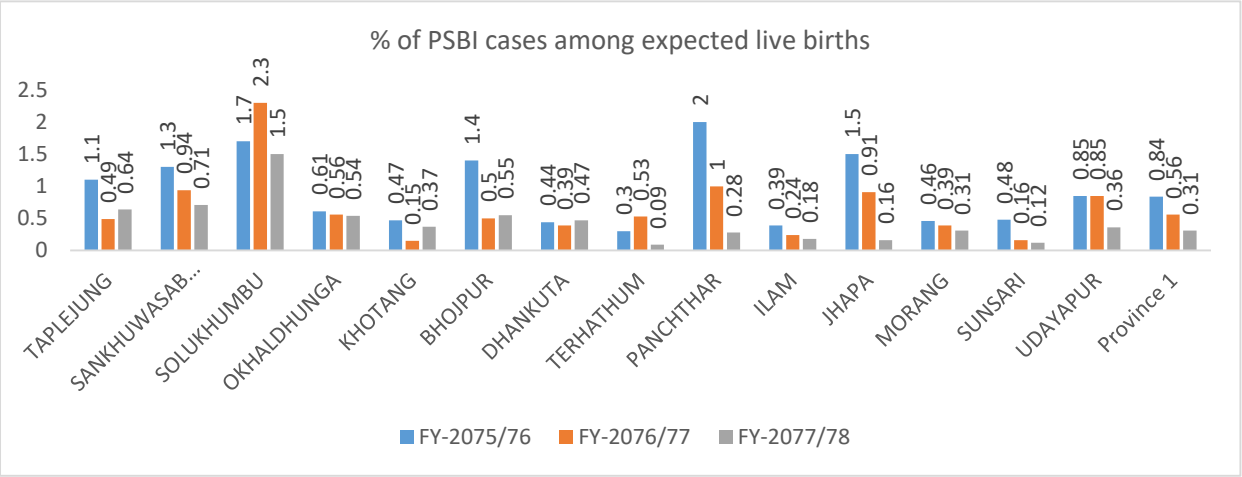
- Management of under-five sick children through health facilities and community health workers and FCHVs.
- Various equipment and Medicines for IMNCI programs (ORS, Zinc, Amoxicillin, Gentamycin, and Chlorohexidine gel) procured at provincial level.
- Provision of budget for Free Newborn Care Services in provincial, district and local level hospitals.
- CB-IMCNI training to health workers and FCHV.
- Development of CBIMNCI coach in district and local level.
- CB-IMNCI onsite coaching in health facilities.
- Incorporation of equity and access approach in CBIMNCI program.
- Monitoring and Supervision of CBIMNCI program.

Analysis of achievement

Possible Severe Bacterial Infection (PSBI)

PSBI cases have decreased than previous year. PSBI cases were highest in Solukhumbu i.e., 1.5% and lowest in Terhathum i.e., 0.09% this year.

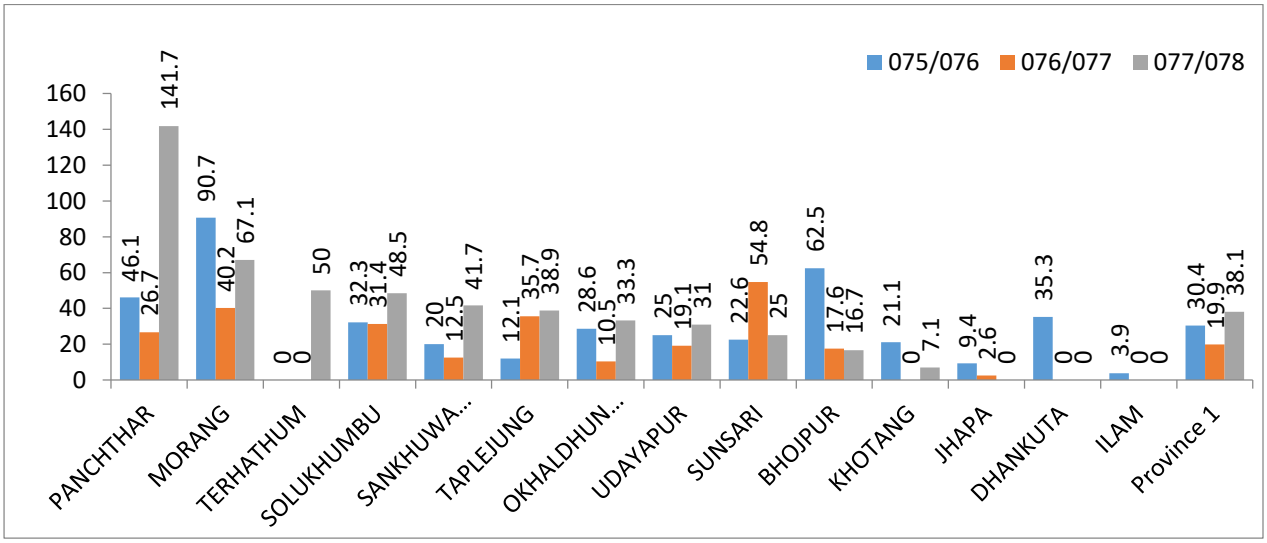
Figure 19:Percentage of PSBI cases among expected live birth



Treatment of PSBI case with complete dose of Gentamycin

Use of complete dose of Gentamycin for treatment of PSBI case is in increasing trend in majority of the districts and overall, in province. Jhapa, Dhankuta and Illam had zero Gentamycin coverage.

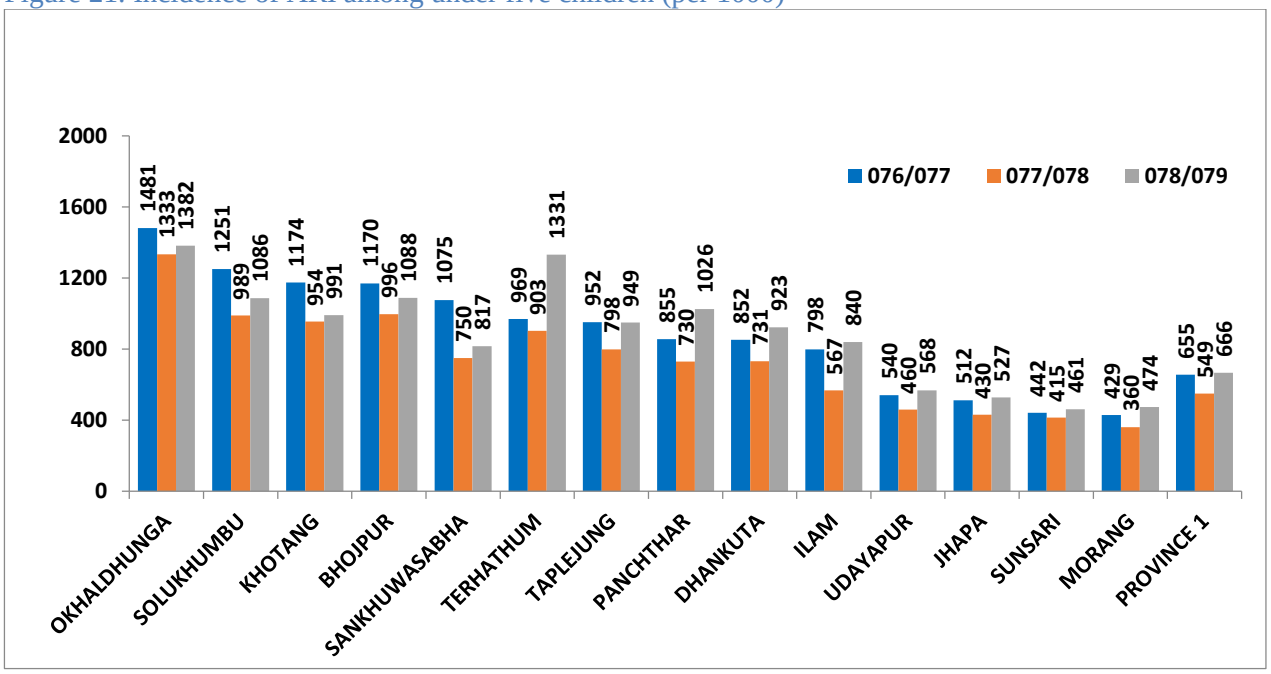
Figure 20:Percentage of PSBI Cases treated with complete dose of Gentamycin



Incidence of ARI

ARI incidence has increased than previous year. Morang (474 per 1000), Sunsari (461 per 1000) and Jhapa (527 per 1000) had lower incidence of ARI as compared to another district.

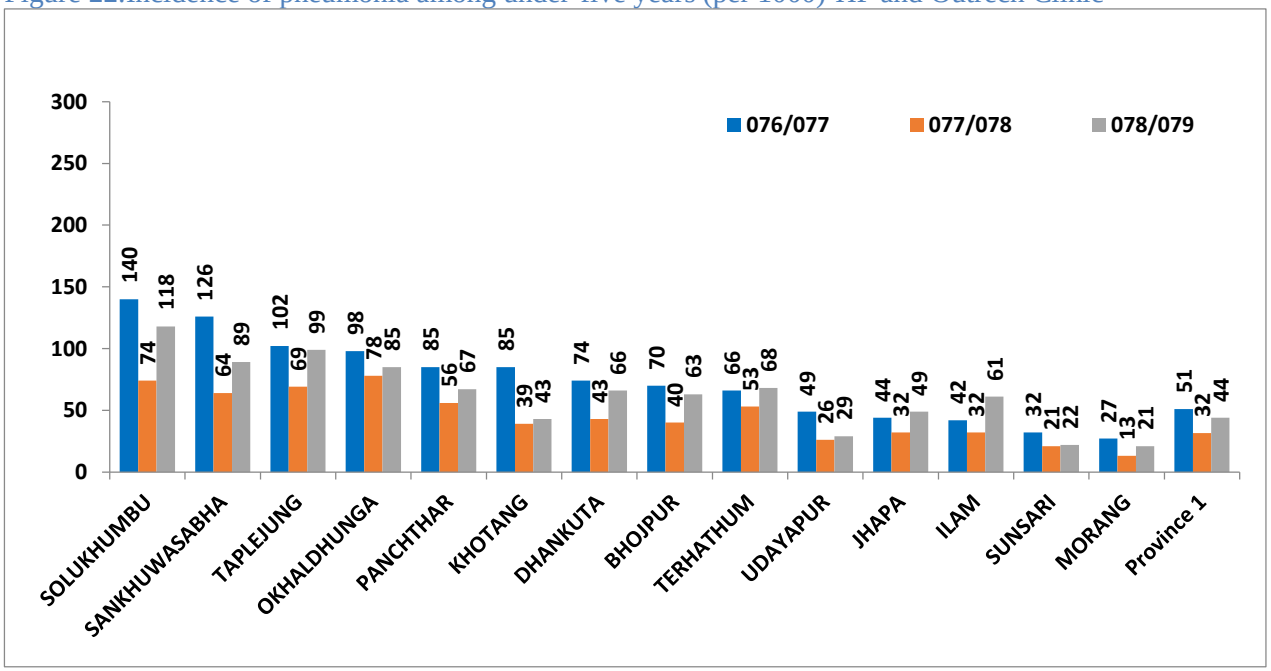
Figure 21: Incidence of ARI among under five children (per 1000)



Incidence of pneumonia (HF and Outreach clinic)

Incidence of pneumonia has increased than previous year.Solukhumbu had highest incidence of pneumonia i.e.,118 per 1000 followed by Taplejung (99 per 1000) U5 children. Morang had lowest incidence of pneumonia i.e., 21 per 1000 as compared to other districts.

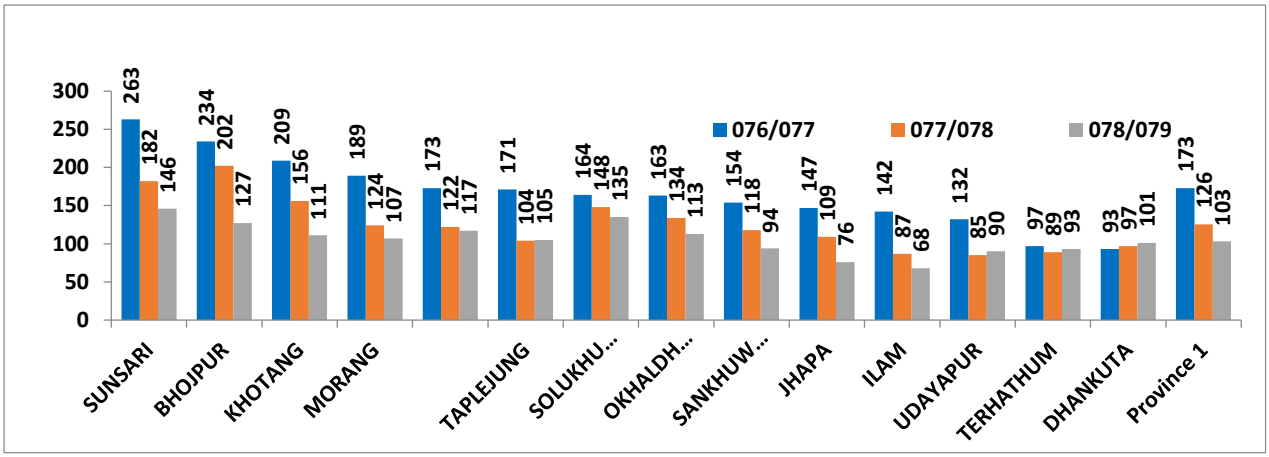
Figure 22:Incidence of pneumonia among under-five years (per 1000)-HF and Outrech Clinic



Pneumonia cases treated with antibiotics (amoxicillin)

Treatment of pneumonia cases with antibiotics has decreased from 173% in FY 2076/77 to 126% in FY 2077/78 and to 103% in 078/079. Sunsari had the highest percentage i.e., 146 % for Pneumonia cases treated with antibiotics whereas Ilam had the lowest i.e. 68 %.

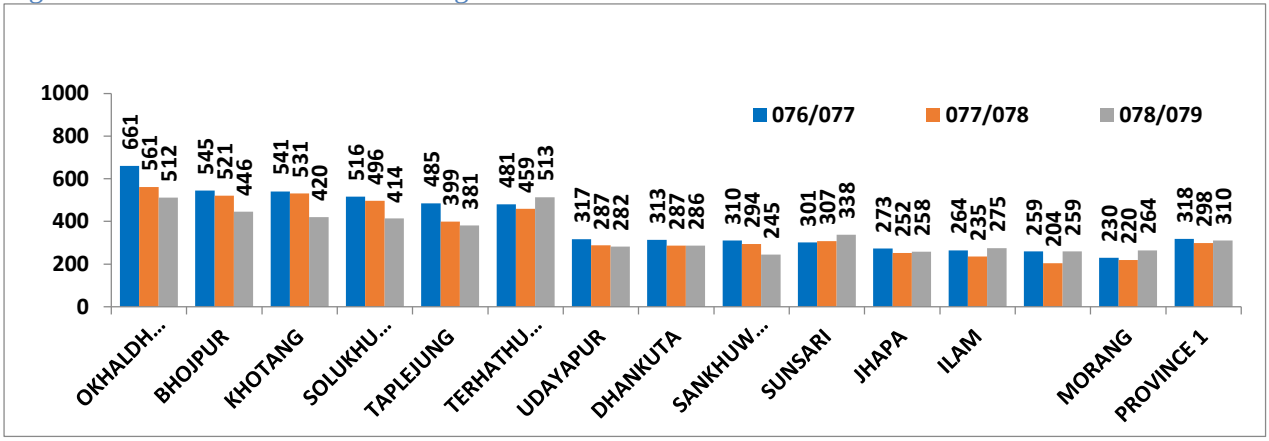
Figure 23:Percentage of Pneumonia cases treated with antibiotics



Incidence of diarrhea

Diarrheal incidence has slightly increased than previous year. Okhaldhunda has the highest incidence rate i.e., 512 per 1000 whereas Sankhuwasabha has lowest incidence of diarrhea this year i.e., 245 per 1000.

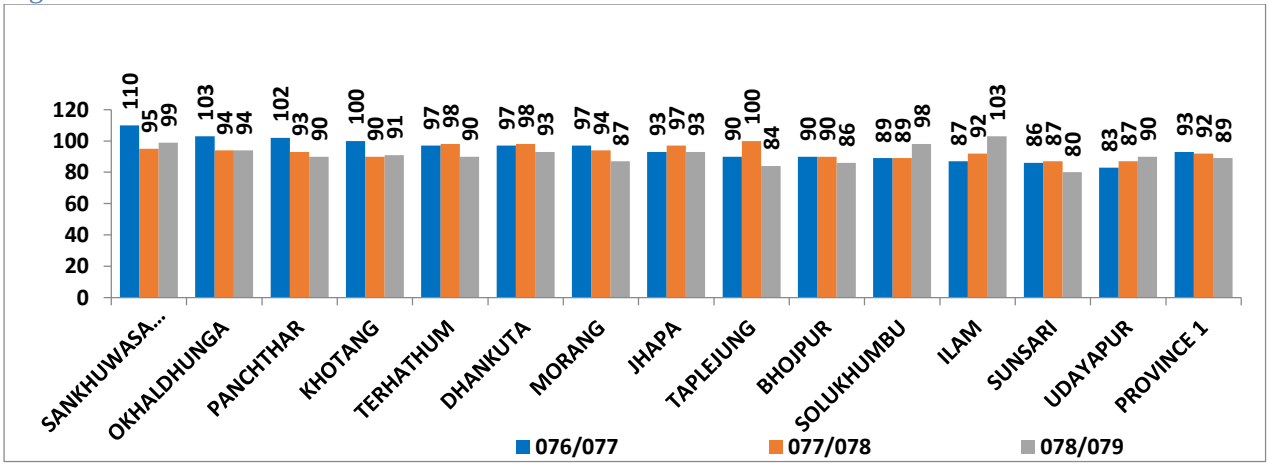
Figure 24: Incidence of diarrhea among under five children



Diarrhea cases treated with zinc and ORS

Treatment of diarrhea with zinc and ORS has decreased from 92% to 89%. Ilam has 103% use of zinc and ORS whereas Taplejung and Sunsari has lowest use of it for treatment of diarrheal cases. This is also on increasing trend as per the MICS 2019 data as it was reported 30 % on Province 1 and 28.9 % on National figure.

Figure 25:Diarrhea cases treated with zinc and ORS



Issues and Recommendation

Issues	Recommendation	Responsible
No defined focal person to conduct IMNCI program at district and to facilitate at palika	Manage focal person to conduct IMNCI program at district and to facilitate at palika	Province, Health Office
No timely supply and adequate of IMNCI related commodities, ICE materials for awareness raising program	Timely and adequate supply of commodities, IEC materials	Province, Health office, NHEICC
Use of antibiotics for no pneumonia cases	Strictly follow CBIMNCI protocol	Province, Health office, Palika
Low use of Gentamycin for treatment of PSBI cases	Strictly follow CBIMNCI protocol	Province, Health office, Palika

2.4. Safe motherhood

Background

The goal of the National Safe Motherhood Programme is to reduce maternal and neonatal morbidity and mortality and improve maternal and neonatal health through preventive and promotive activities and by addressing avoidable factors that cause death during pregnancy, childbirth, and the postpartum period. Evidence suggests that three delays are important factors for maternal and newborn morbidity and mortality in Nepal (delays in seeking care, reaching care and receiving care). The following major strategies have been adopted to reduce risks during pregnancy and childbirth and address factors associated with mortality and morbidity:

- Promoting birth preparedness and complication readiness including awareness raising and improving preparedness for funds, transport, and blood transfusion.
- Expansion of 24 hours birthing facilities alongside Aama Suraksha Programme promotes antenatal check-ups and institutional delivery.
- The expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected health facilities in all districts.

The Safe Motherhood Programme initiated in 1997 has made significant progress with formulation of safe motherhood policy in 1998. Service coverage has grown along with the development of policies, programmes and protocols. The policy on skilled birth attendants (2006) highlights the importance of skilled birth attendance (SBA) at all births and embodies the government's commitment to train and deploy doctors, nurses and ANMs with the required skills across the country. Introduction of Aama programme to ensure free service and encourage women for institutional delivery has improved access to institutional deliveries and emergency obstetric care services. The endorsement of the revised National Blood Transfusion Policy (2006) was another significant step for ensuring the availability of safe blood supplies for emergency cases. The Nepal Health Sector Strategy (NHSS) identifies equity and quality of care gaps as areas of concern for achieving the maternal health sustainable development goal (SDG) target, and gives guidance for improving quality of care, equitable distribution of health services and utilization and universal health coverage with better financing mechanism to reduce financial hardship and out of pocket expenditure for ill health.

Major Activities

The planned activities in safe motherhood and newborn health are similar in all districts within the region. Some district might have additional activities and programs mostly supported by the non-government sectors. Some major activities undertaken in FY 2078/79 were as follows:

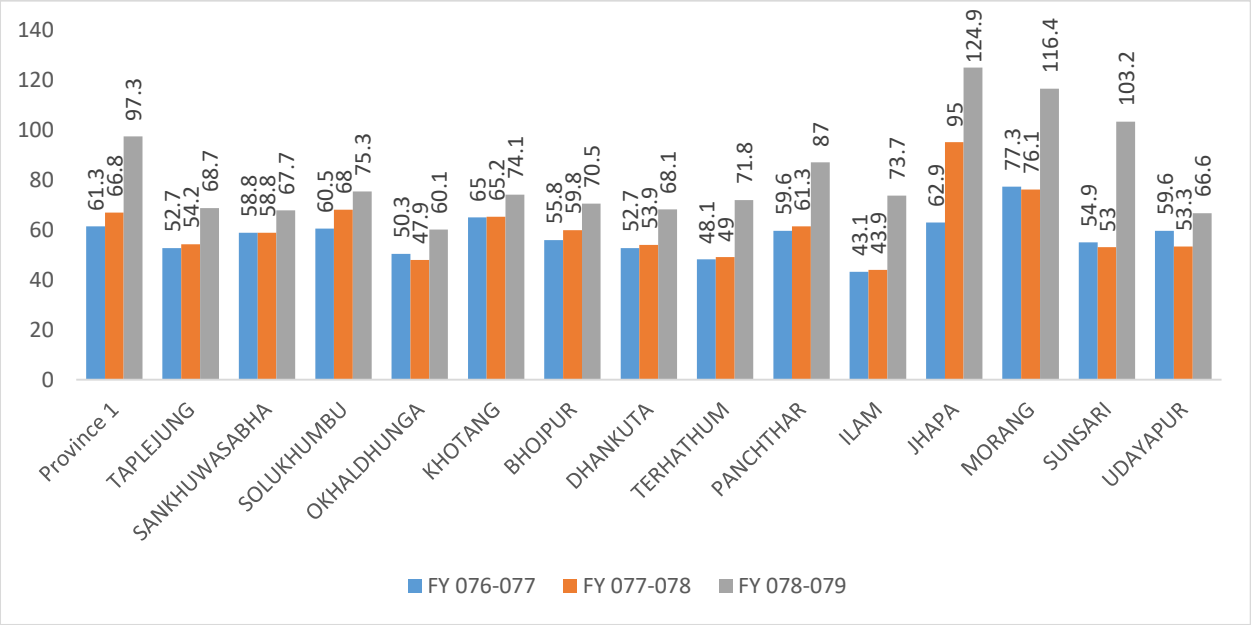
- Continuation of AamaSurakchhya and Antenatal Incentive Program
- Continuation Antenatal, natal, and postnatal care
- Maternal & Neonatal Health Update- clinical update training provided to ANMs, and Staff Nurses based on the standard SBA training package (participants were trained on the use of partographs, active management of third stage of labor (AMTSL) for prevention of PPH including conduction of normal labor, management of PPH, use of magnesium sulphate (MgSO4) for severe pre/eclampsia and neonatal resuscitation)

- On-site coaching and mentoring to improve quality of care and upgrade competencies of the skilled attendants
- Screening and surgical management of uterine prolapse
- Recruitment of ANMs on local contract to support 24-hour delivery services in birthing center
- Strengthening of birthing centers and B/CEOC sites for promoting institutional deliveries and management of emergency obstetric complications
- Formation and regulations of Provincial Reproductive Health Technical Working Group
- Continuation of Grahmin Aama Program in 3 districts (Ilam, Sunsari, Sankhuwasabha)
- Scale up of Grahmin Aama Program in new six districts(Terhathum, Bhojpur, Khotang, Udaypur, Morang,Taplejung)

Analysis of achievement

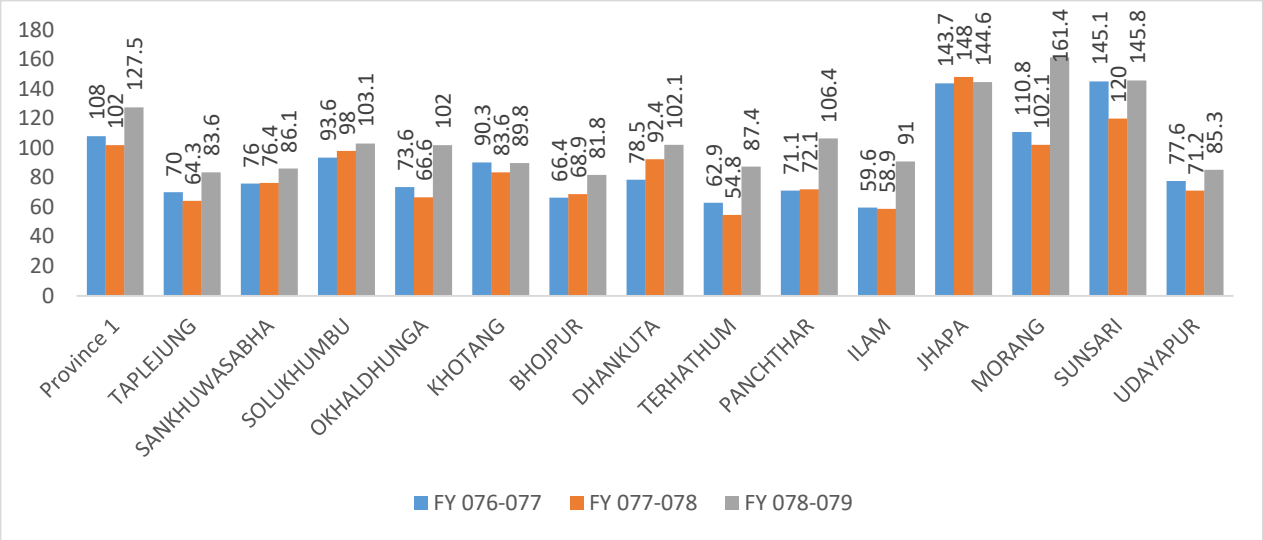
Percentage of pregnant women who had First ANC checkup as protocol was highest in Jhapa and lowest in Okhaldhunga. As compared to previous fiscal year, slight increment of first ANC checkup visit in this year.

Figure 26 Percentage of pregnant women who had First ANC checkup as protocol



Percentage of pregnant women who had at least one ANC checkup:
Percentage ofpregnant women who hadat least one ANC visit is more than expected in province 1. In this fiscal year, Sunsari and Morang had more than expected ANC 1st visit while it was lowest in Bhojpur.

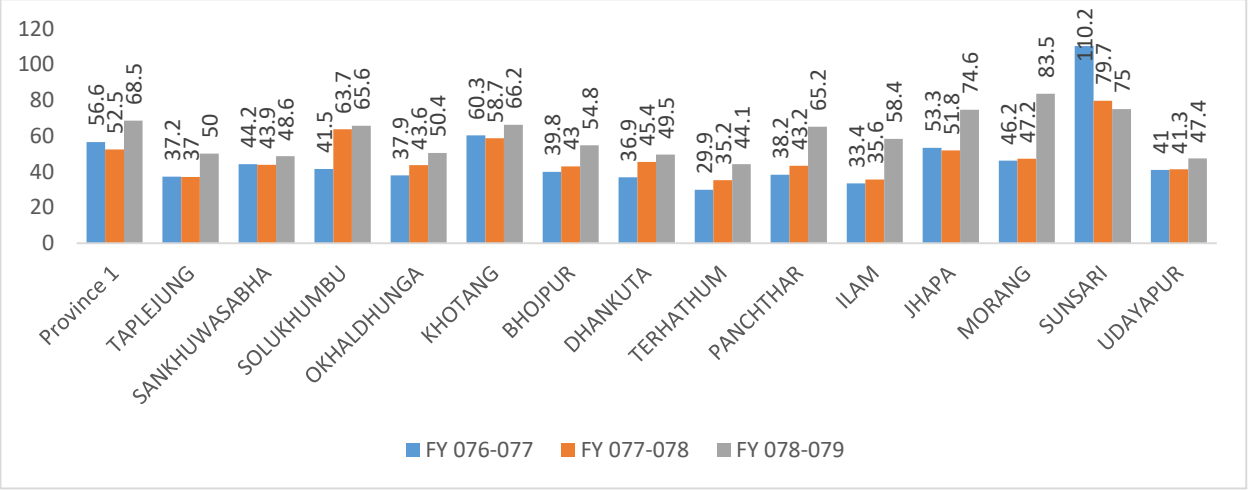
Figure 27 Percentage of pregnant women who had at least one ANC checkup



ANC 4 visit (as per protocol):

Four ANC visit as per protocol has increased from 53 to 68.5. Udaypur and Terathum has the lowest coverage of 4 ANC visit this year. Except Sunsari, all other district has increased four ANC visit as compared to previous year.

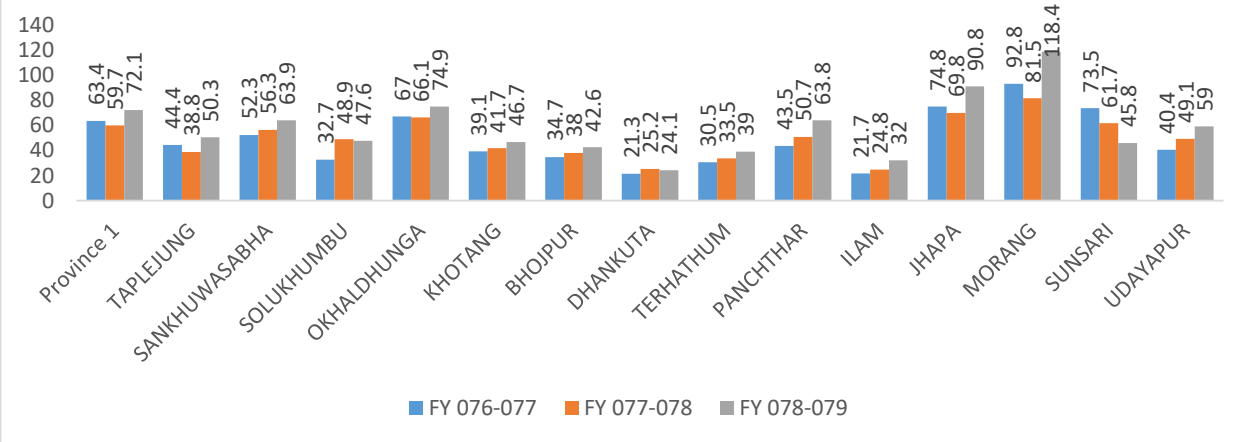
Figure 28 Percentage of pregnant women who had four ANC checkups as per protocol



Institutional delivery

Morang (118.4%), Jhapa (90.8%) and Okhaldhunga (74.9%) had higher institutional deliveries while Illam (32%) and Dhankuta (24.1%) have lower institutional deliveries this year.

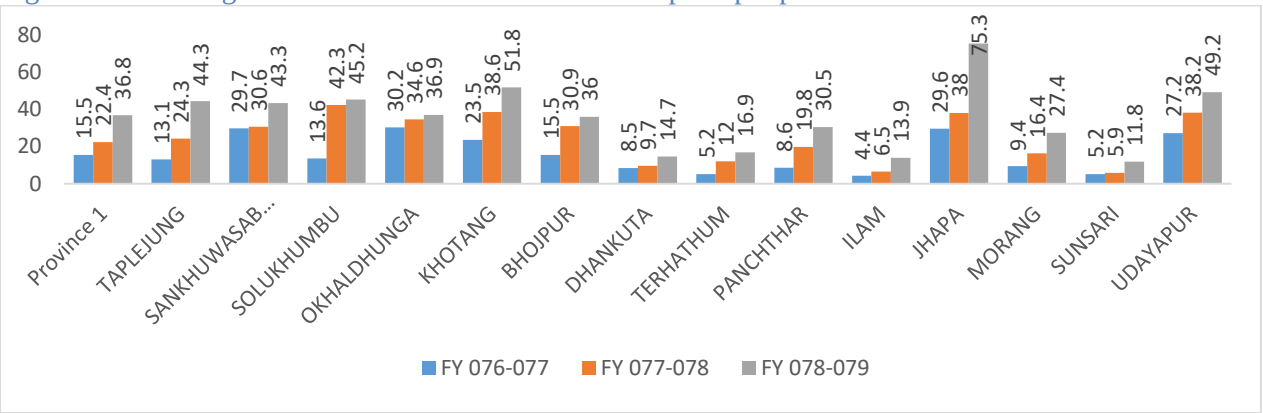
Figure 29 Percentage of institutional deliveries



PNC 3 visit (as per protocol):

PNC visit is lower in Province 1 but it has increased than previous year. In this fiscal year, Jhapa had 75.3% coverage which was the highest 3 PNC coverage while Sunsari i.e., 11.8% had the lowest coverage.

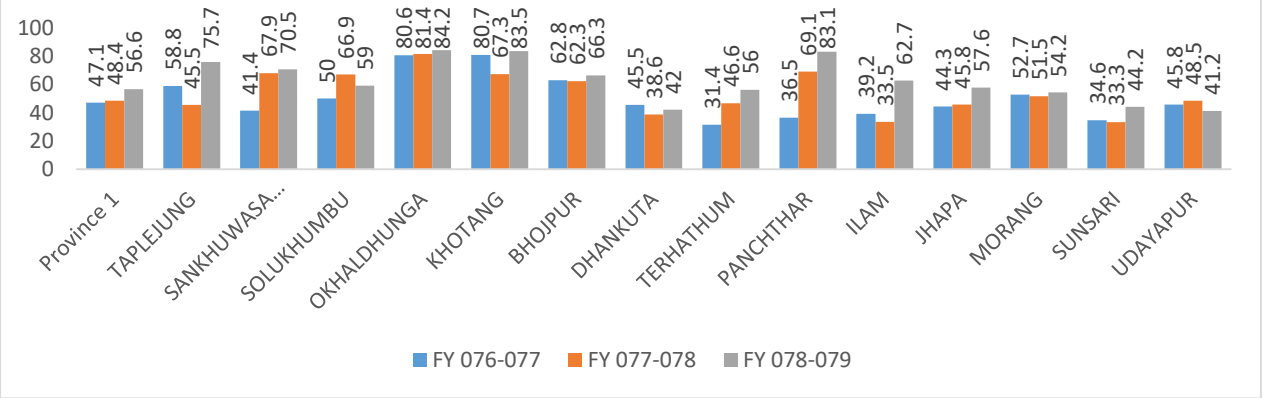
Figure 30 Percentage of women who had 3 PNC check-ups as per protocol



Postpartum Vitamin A supplementation

Postpartum vitamin A supplementation has slightly increased than previous year. Okhaldhunga had highest coverage i.e., 84.2% while Udaypur (41.2%) had lowest coverage of postpartum vitamin A supplementation in this fiscal year.

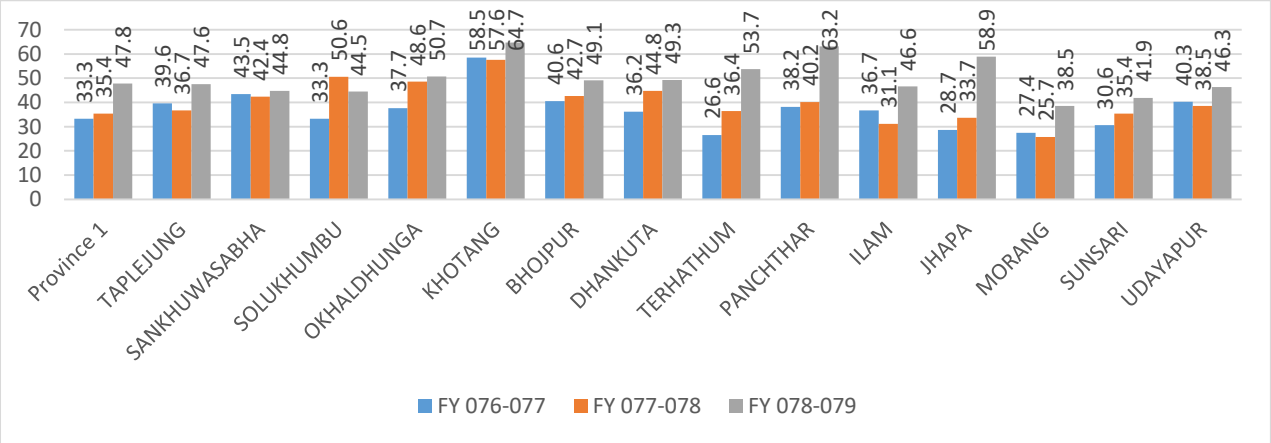
Figure 31 Percentage of postpartum women who received Vitamin A supplementation



Iron Folic Acid (IFA) supplementation: During pregnancy

IFA supplementation during pregnancy has increased than previous year except Solukhumbu . In this fiscal year, Khotang has the highest coverage with 64.7% while Morang had lowest coverage i.e., 38.5% of IFA supplementation during pregnancy.

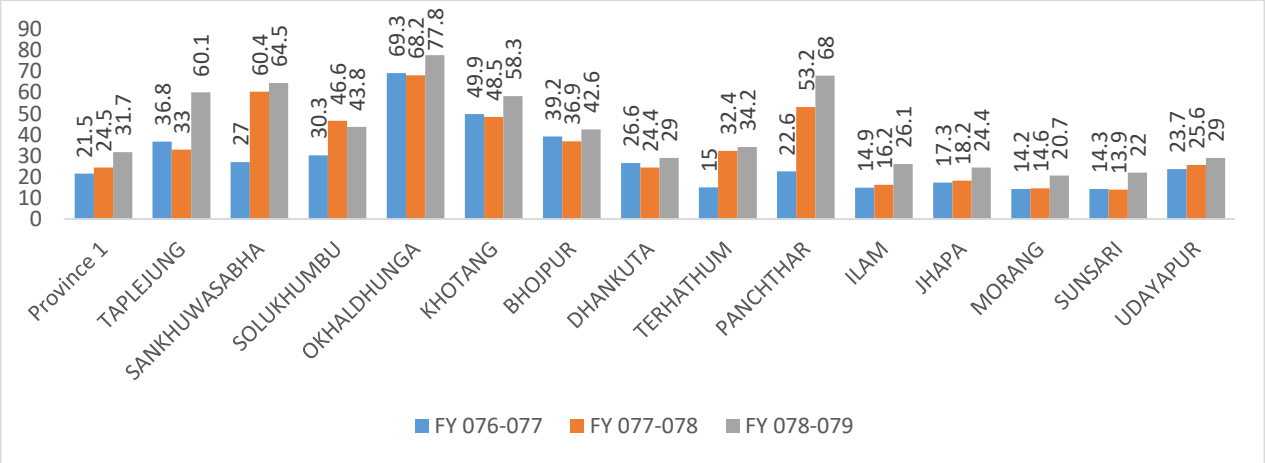
Figure 32 Percentage of women who received 180 days supply of Iron Folic Acid during pregnancy



Iron Folic Acid (IFA) supplementation: During postpartum

IFA supplementation during postpartum has increased as compared to previous fiscal year. Okhaldhunga (77.8%) and Panchthar (68%) had higher coverage while Morang (20.7%) and Sunsari (22%) had lower coverage of IFA supplementation during postpartum in this fiscal year.

Figure 33 Percentage of postpartum women who received a 45 days supply of IFA



Issues and Recommendation

Issues	Recommendation	Responsible
Low ANC 4 visit	• Actual target should be identified by census by palika • Upgrade current health institution to reproductive health friendly Uniformity of recording and reporting tools in private and public institution. • Proper counseling from health service provider	Health Facility, Palika, Health Office, Province
Low institutional delivery	• Establishment of new well equipped birthing centers • Upgrade current health institution to reproductive health friendly SBA training with some extra incentive to health worker, proper counseling from health service provider, and Increase access to transportation/ambulance service.	Health Facility, Palika, Health Office, Province
Low PNC coverage	• Family, community, political leaders should be aware on PNC services and its importance, Management of Roving ANM in the catchment area, Proper counseling from health service provider	Palika, Health Facility, Health Office, province
Inadequate human resource and skill service provider/staff turnover	• Recruitment HR on contract basis. • Need based training should be conducted.	Palika, Health Facility, Health Office, province
Non-recorded Pre conceptional care	• Encouragement to client • Mandatory registration system	Health facilities level
Insufficient supply of commodities/ equipments	• Timely procurement and well-established supply chain management	Palika, Health Facility, Health Office, province

2.5 Family Planning

Background:

Family planning (FP) refers to a conscious effort by a couple to limit or space the number of children through use of contraceptive methods. Modern methods include female sterilization (e.g., minilap), male sterilization (e.g., no-scalpel vasectomy), intrauterine contraceptive device (IUCD), implants (e.g., Jadelle), injectables (e.g., Depo Provera), the pill (combined oral pills), condoms (male condom), lactational amenorrhea method (LAM) and standard day's method (SDM).

The main aim of the National Family Planning Programme is to ensure that individuals and couples can fulfill their reproductive needs by using appropriate FP methods voluntarily based on informed choices. To achieve this, the Government of Nepal (GoN) is committed to equitable and right based access to

voluntary, quality FP services based on informed choice for all individuals and couples, including adolescents and youth, those living in rural areas, migrants and other vulnerable or marginalized groups ensuring no one is left behind.

GoN also commits to strengthen policies and strategies related FP within the new federal context, mobilize resources, improve enabling environment to engage effectively with external development partners and supporting partners, promote public-private partnerships, and involve non-health sectors. National and international commitments will be respected and implemented (such as NHSSIP 20152020, Costed Implementation Plan 2015-2020 and FP2020 etc.).

From program perspective, Province 1 Government through its subsidiary (Public Health Division, MOH, HD,, and municipalities) will ensure access to and utilization of quality FP services through improved contraceptive use especially among hard to reach, marginalized, disadvantaged and vulnerable groups and areas, broaden the access to range of modern contraceptives method mix including long acting reversible contraceptives such as IUCD and implant from service delivery points, reduce contraceptive discontinuation, scale up successful innovative evidence informed FP service delivery and demand generation interventions.

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

Target of Family Planning

Selected FP goals and indicators to ensure universal access to sexual and reproductive health-care services, including for FP/SRH programme are as follows: (Data source: NDHS, 2016)

Table 9: Target of Family Planning indicators

Indicators	Status on Province 1	National status	SDG Indicators		
			2022	2025	2030
Contraceptive prevalence rate (CPR) (modern methods) (%)	40.9	46.7	53	56	60
Total Fertility Rate (TFR) (births per women aged 15-49 years)	2	2	2.1	2.1	2.1

Objectives of Family Planning Program:
The overall objective of Nepal's FP programme is to improve the health status of all people through informed choice on accessing and using voluntary FP. The specific objectives are as follows:

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

Target Group:
All the individuals along with couples and Youth, residents of rural, immigrants and any other vulnerable and marginalized group are the Target groups of this program.

Major activities conducted in 2078/2079

- Service: Permanent Family Planning service to Male and Female, 5 types of Temporary Family Planning Method, and Emergency Contraception

- Counseling Service
- IUCD and Implant Training
- Supply of FP Commodities and instruments
- Enforcement of Post Abortion Family Planning

Achievements

Table 10: Contraceptive Prevalence Rates

Organization unit / Period	076/077	077/078	078/079
Province 1	43.7	45.0	44.9
1. TAPLEJUNG	24	30	27
2. SANKHUWASABHA	26	32	36
3. SOLUKHUMBU	30	34	37
4. OKHALDHUNGA	48	49	60
5. KHOTANG	23	27	36
6. BHOJPUR	30	35	38
7. DHANKUTA	45	42	45
8. TEHRATHUM	30	32	41
9. PANCHTHAR	31	32	39
10. ILAM	31	30	28
11. JHAPA	76	74	68
12.MORANG	64	66	61
13. SUNSARI	18	19	19
14. UDAYAPUR	19	20	23

Figure 34: New users by FP methods

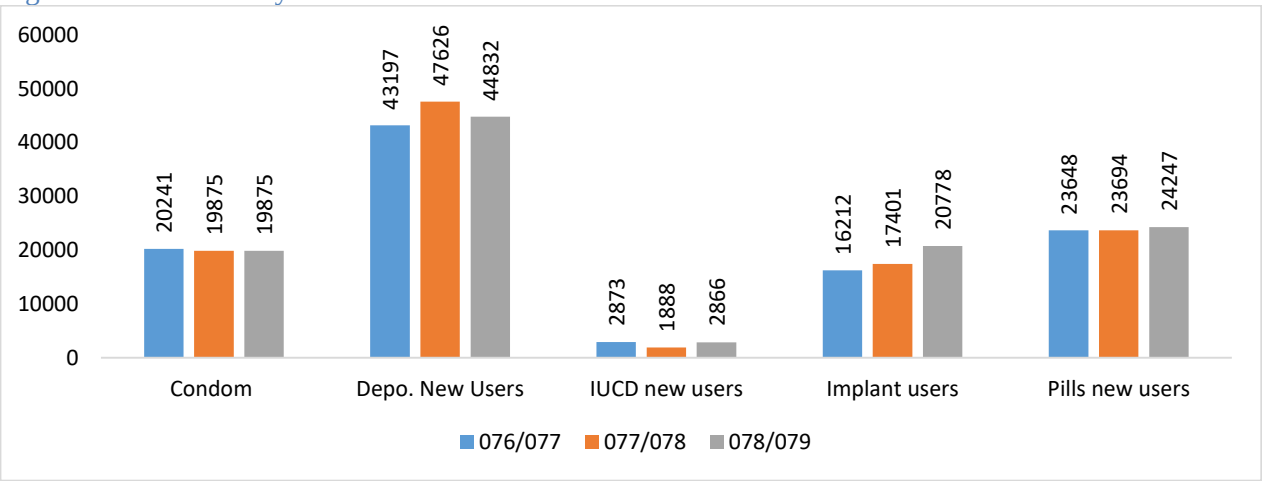
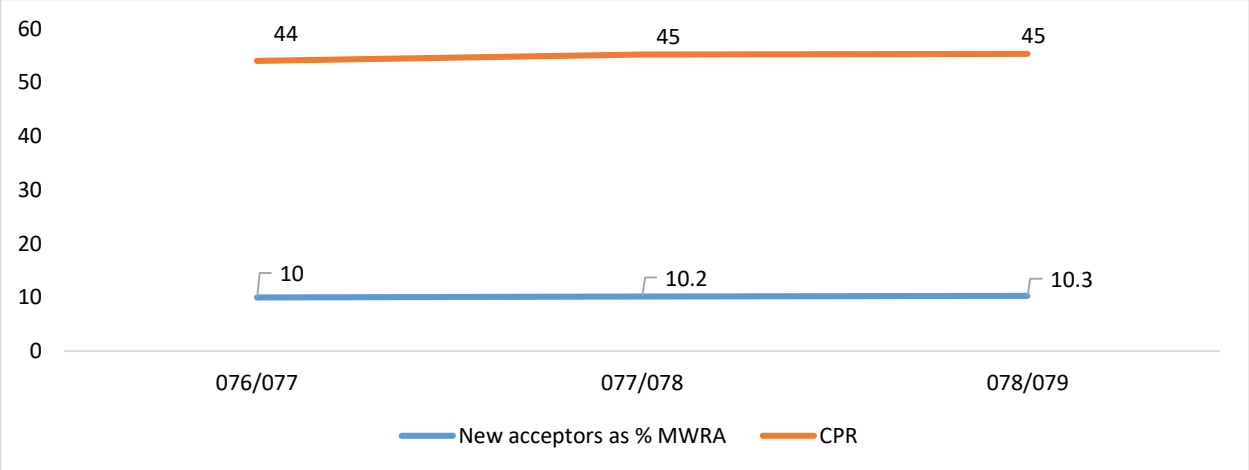


Figure 35:CPR and New acceptor



According to the above diagram CPR has increased from 44% in 076/077 to 45% in 077/078 and remained constant in FY 078/079. To achieve the Sustainable Development Goal Family Planning program should be conducted in planned way and need to take reference of Non-Government Organization and public sector data, strengthen HMIS recording and reporting system and channelize all in the mainstream of HMIS.

Among the new Modern Contraceptive users, in comparison to previous three consecutive years the use of IUCD, Implant and Pills had increased. The upcoming program should focus on making availability of all five kinds of contraception in all the Health Facility. However, Community Awareness campaign is a must to fulfill the demand of users and decrease the unmet need.

Challenges:

- Stock Out of Pills and Implant in Health facilities
- Unavailability of IUCD and Implant insertion set
- Low competency and confidence for LARC among SBA trained
- Unavailability all 5 types of FP commodities in all the Health Facilities
- Lack of IEC/BCC materials related to Family Planning in Health facilities

Issues and recommendation

Issues	Action needs to be taken	Responsible	Coordination
Recording, Reporting from Private Institutions	• Make all Compulsive for Reporting	Federal, Provincial and Local Government	Health Office and HD
Limited health facilities providing five contraceptives methods	• Availability of 5 types of FP methods in all the HF	Federal, Provincial and Local Government	Health Office and HD
Contraceptive discontinuation	• Implement FP micro-planning in low contraceptive • prevalence wards/municipalities along conduction of mobile outreach and satellite clinics focusing on LARC • Mobilize FCHVs for community awareness on LARC		
Limited number of FP training sites	• Strengthen and expansion of FP training sites.	Federal, Provincial and Local Government	Health Office and HD

2.6 Adolescent Sexual and Reproductive Health

Background

National Adolescent Sexual and Reproductive Health is one of the priority programs. Nepal is one of the countries in South Asia developed and endorsed the first National Adolescent Health and Development (NAHD) Strategy in 2000.To address the needs of emerging issues of adolescents in the changing context, the NAHD strategy is revised in 2018 the main aim of revision of strategy was to address the problem face by the adolescent in Nepal. Adolescents aged 10 to 19 constitute 24% (6.4 million) of the population in Nepal. Nepal is 3rd highest country in child marriage though legal age at marriage is 20. Seventeen percent of girls aged 15-19 years are already mothers or pregnant with their first child. Only 15% of currently married adolescents use a modern method of contraceptives. The Adolescent Fertility Rate (AFR) is an increasing trend from 81 in 2011 to 88 in 2016 per 1,000 women of 15-19 years. The target of SDG is to reduce the adolescent fertility rate to 30 per 1000. Adolescent friendly SRH services are provided through 12 certified AFS (Adolescent Friendly Service) sites in Province 1.

Vision:

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

Mission:

Maximum use of the available methods and establishing strong bond between the concerned parties and developing strategy with the view of securing the health and development of adolescents.

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

General Objective

By the year 2025, all adolescents will have positive lifestyles to enable them to lead healthy and productive lives.

Specific Objectives

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

Targets:

- To make all health facilities as adolescent friendly as per the envision of National Health policy (2014) and NHSS (2016-2021)

- To ensure universal access to ASRH services, the Nepal Health Sector Strategy Implementation Plan (2016-2021) aims to: scale up Adolescent Friendly Service (AFS) to all health facilities; behavioral skill focused ASRH training to 5,000 Health Service Providers and more than 100 health facilities to be certified with quality AFS by 2021The programme aims to reduce the adolescent fertility rate (AFR) by improving access to family planning services and information.
- To support district health managers to operationalize the strategy.

An implementation guideline on Adolescent Sexual and Reproductive Health (ASRH) was developed in 2007 and piloted in 26 public health facilities of 5 districts (Bardiya, Surkhet, Dailekh, Jumla, Baitadi) National Health Sector Program (NHSP)-IP-II (2010 to 2015) set a target of expanding 1000 public health facilities for provision of Adolescent Friendly Service (AFS) and revised the National ASRH Programme Implementation Guideline accordingly and is implementing from 2011.

As per recommendations of the ASRH barrier study entitled "Assessing supply side constraints affecting the quality of adolescent friendly services (AFS) and the barriers for service utilization" carried out in 2014 under leadership of FWD or interventions were implemented in BS.2072 (2015) as part of system strengthening (capacity building, certification for quality delivery of AFS in friendly manner) and awareness raising interventions among adolescents and key stakeholders. Over the period ASRH training package was revised as per national standards; establish and strengthen ASRH clinical training sites within RH comprehensive training sites and additional 2 training sites in Bharatpur Hospital and Koshi Zonal Hospital were established. Different training materials, quality improvement tools were developed and printed which were subsequently distributed in different districts for strengthening health system.

Strategic Principles and Direction

- Participation and leaderships of adolescent
- Equality and Equity
- Right with responsibility
- Strategic Partnerships
- Role of central, province and local government

Achievement

Table 11: New users of Family Planning Temporary Methods among Adolescents

Unit	Percentage of -Pills-New Users <20 yrs	Percentage of Depo-New Users <20 yrs	Percentage of IUCD-New Users <20 yrs	Percentage of Implant-New Users <20 yrs	Proportion of Temporary FP Method-New Users <20 yrs
PROVINCE	27.0	60.3	0.5	12.2	6.6
TAPLEJUNG	24.9	61.3	0.8	13.0	9.0
SANKHUWASABHA	9.4	64.8	0.7	25.1	11.0
SOLUKHUMBU	21.1	75.9	0.0	3.1	5.3
OKHALDHUNGA	17.1	77.6	0.0	5.3	5.5
KHOTANG	21.6	67.2	0.0	11.2	12.0
BHOJPUR	17.1	60.3	0.6	22.0	14.7
DHANKUTA	24.1	71.8	0.5	3.6	7.1
TERHATHUM	16.2	68.8	0.0	14.9	8.6
PANCHTHAR	27.0	65.5	0.2	7.4	11.1
ILAM	43.7	48.4	0.2	7.7	7.4
JHAPA	37.9	51.5	0.5	10.0	4.5
MORANG	39.3	48.1	1.1	11.5	5.1
SUNSARI	30.4	58.4	0.8	10.4	2.7
UDAYAPUR	21.9	66.1	0.0	12.0	6.0

Table 12: Proportion of adolescent ANC among total ANC visits

Unit	Proportion of ANC 1st visit <20 any time	Proportion of ANC 1st visit <20 per protocol	Proportion of 4 ANC visit <20 per protocol
PROVINCE	13.2	11.3	10.3
TAPLEJUNG	17.7	19.6	15.8
SANKHUWASABHA	36.1	30.1	26.0
SOLUKHUMBU	25.6	23.4	21.8
OKHALDHUNGA	13.1	14.3	11.2
KHOTANG	20.7	22.0	13.9
BHOJPUR	25.5	23.1	15.7
DHANKUTA	18.3	16.3	12.4
TERHATHUM	12.7	12.1	12.3
PANCHTHAR	21.0	22.2	18.9
ILAM	8.4	7.3	5.2
JHAPA	19.5	19.2	16.3
MORANG	13.2	11.3	10.3
SUNSARI	17.7	19.6	15.8
UDAYAPUR	36.1	30.1	26.0

Table 13 Proportion of adolescent safe abortion service users among total safe abortion service

Unit	% of <20 yrs. women received SAS		
	076/77	077/78	078/79
PROVINCE	7.3	8.3	5.8
TAPLEJUNG	5.9	12	11.3
SANKHUWASABHA	8.7	8.7	7.2
SOLUKHUMBU	8.4	6.3	25.5
OKHALDHUNGA	15.7	7.9	1.4
KHOTANG	8.5	8.6	9.3
BHOJPUR	10.1	8.5	10.2
DHANKUTA	8.3	6.8	4.5
TERHATHUM	6.7	8	6.8
PANCHTHAR	13.6	19.6	7.9
ILAM	11	16.3	9
JHAPA	2.1	4.6	4.5
MORANG	7.4	2.5	4.8
SUNSARI	5.5	6.8	3.5
UDAYAPUR	5.8	7.1	2.9

Issues and Recommendation

Issues	Recommendation	Responsible
Lack of privacy and confidentiality of health services from health facility	• Maintain proper privacy and confidentiality of health services seek by adolescent	Health Facility, Palika, Health Office, Province, FWD
Inadequate links with other programs (family planning, safe motherhood, HIV)	• Advocate for the functional integration of ASRH issues and services in other thematic areas/programs	Health Facility, Palika, Health Office, Province, FWD
Inadequate IEC/BCC materials	• Ensure the supply of ASRH related IEC/BCC materials to health facilities	Palika, Health Office, Province, NHEICC

2.7 Safe Abortion Program:

Background

With respect to the reproductive rights of women, it is the right of the woman herself to decide whether to conceive or not to conceive, and whether to have children after conception. Thus, it's right for women to conduct abortion relying under the law and periphery. To assure this right in National Safe abortion Policy 2060 article 2.3 it is written under the section of women rights that “The right of a woman to continue or

not to abort a certain pregnancy under existing law shall be guaranteed." Nepal Constitution in 2072 has also guaranteed that every Woman's Reproductive right will be taken as a fundamental right.

To ensure the reproductive health rights of Nepali women, there is a provision for abortions under the 9th Amendment Bill of the country, as the Ministry of Health and Population has adopted a policy of continuously expanding and developing safe abortion services.

Safe abortion service means the services provided by the listed health worker in the health care institution approved by the listed health worker, with the consent of the carrying woman. After the implementation of the Safe Abortion Services Procedure 2 and the National Policy on Safe Abortion, this service is being operated by issuing a working guide. Currently, the program is operating in accordance with the Safe Abortion Services Program Procedure Directive 2. By conducting such programs, women in the service will be able to reach out to remote and marginalized areas and communities, expanding their services in difficult, marginalized, vulnerable and at-risk groups and areas, such as social disadvantage and transnational renewal.

The program is being implemented by implementing the Safe Abortion Service Extension Strategy and Operational Guidelines 2066 used by pharmaceuticals to provide access to safe abortion services to women in rural and remote areas. Sub-section 5.1.1 of this directory states that health workers working at various levels of health institutions at the community level should be provided with abortion training using medicines.

The "Safe Motherhood and Reproductive Health Rights Act 2075 and Safe Motherhood and Reproductive Health and Rights Regulation 2077" has clearly clarified the legal provisions, privacy and sanction of safe abortion.

In line with the objective of the National Health Policy 2, to provide basic healthcare services as a fundamental right of all citizens, arrangements have been made by the Government of Nepal to provide safe abortion services to government health institutions.

Goal

Increasing access to safe abortion services and quality service delivery is key to minimizing maternal mortality and morbidity.

Objectives:

- Provide clear information about national policies, existing legal provisions and policy guidance regarding safe abortion.
- To extend the quality of free abortion services to the women by extending free safe abortion services to the women even in the local government.
- Management of severe complications and treatment of incomplete abortion.
- Conduct a vigilance program to eliminate the stigma and disadvantages associated with abortion.

Target group

Women and adolescents of reproductive age are directly involved in this targeted group of services. Indirectly, people of all age groups belong to the target group of the program, because if women do not have access to safe abortion services at the desired time, it will have a negative impact on the family and socially.

Services and Programs:

- Training related to Safe Abortion (MA, MVA/CAC, 2nd Tri)
- Extension of service center
- COPE (Client-oriented, provider-efficient) Process for Quality Improvement
- Post Abortion Family Planning and LARC service

Safe abortion procedures

FWD has defined the four key components of comprehensive abortion care as:

- Pre and post counseling on safe abortion methods and post-abortion contraceptive methods.
- Termination of pregnancies as per the national protocol.
- Diagnosis and treatment of existing reproductive tract infections; and
- Provide contraceptive methods as per informed choice and follow-up for post-abortion complication management.

Achievement
Safe abortion sites (HF) and services.

Table 14: Safe abortion sites (HF) and services

Unit	Service Sites			Abortion complications			CAC Services			PAC services		
	Gov.	Non-Gov	Total	76/77	77/78	78/79	76/77	77/78	78/79	76/77	77/78	78/79
PROVINCE 1	195	41	236	463	172	902	15957	15405	15911	1829	1634	1909
1.TAPLEJUNG	1	0	1	5	1	1	373	283	354	59	38	61
2.SANKHUWASABHA	18	1	19	10	16	31	1170	1119	1090	90	106	121
3.SOLUKHUMBU	9	0	9	0	0	2	167	175	251	3	16	29
4.OKHALDHUNGA	17	0	17	96	0	93	89	63	72	94	92	104
5.KHOTANG	1	0	1	9	1	4	259	245	321	2	6	13
6.BHOJPUR	9	1	10	0	1	2	158	177	157	17	53	65
7.DHANKUTA	12	2	14	3	5	1	649	468	552	14	11	5
8.TERHATHUM	15	0	15	3	1	1	729	742	606	7	5	14
9.PANCHTHAR	13	0	13	44	3	17	1366	1409	1005	44	18	25
10.ILAM	22	4	26	92	3	80	1721	1587	1637	102	97	79
11.JHAPA	7	12	19	105	16	118	2057	2141	2915	729	483	411
12.MORANG	25	7	32	68	4	492	2819	2883	2287	506	378	590
13.SUNSARI	33	8	41	2	121	1	4038	4080	4107	121	2790	304
14.UDAYAPUR	13	6	19	26	0	59	362	533	557	41	52	88

Figure 36:CAC service

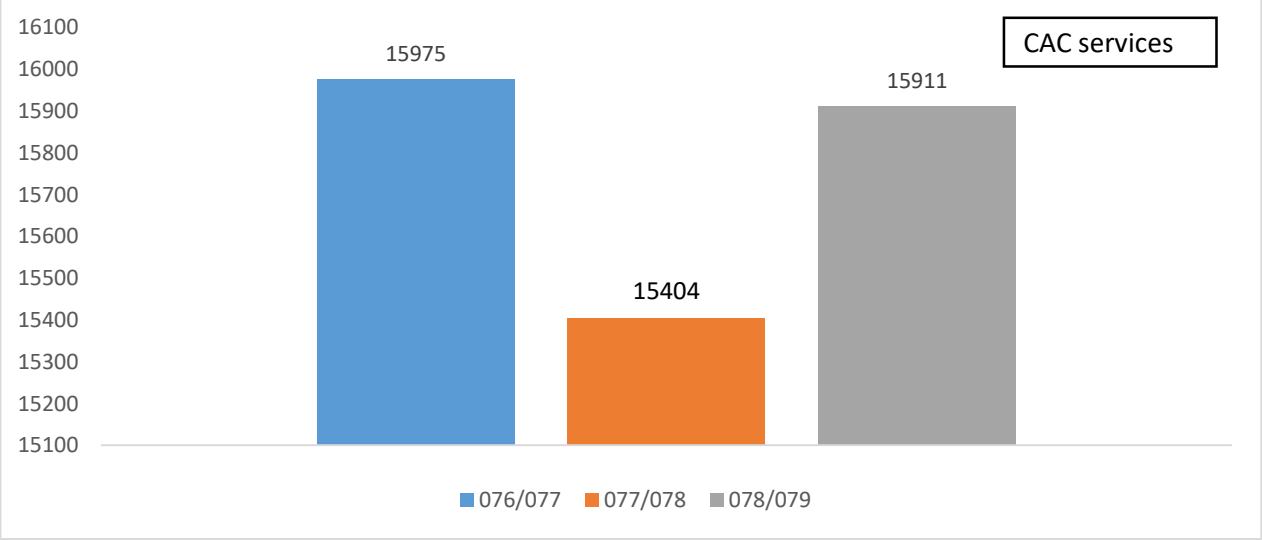


Figure 37: PAC service

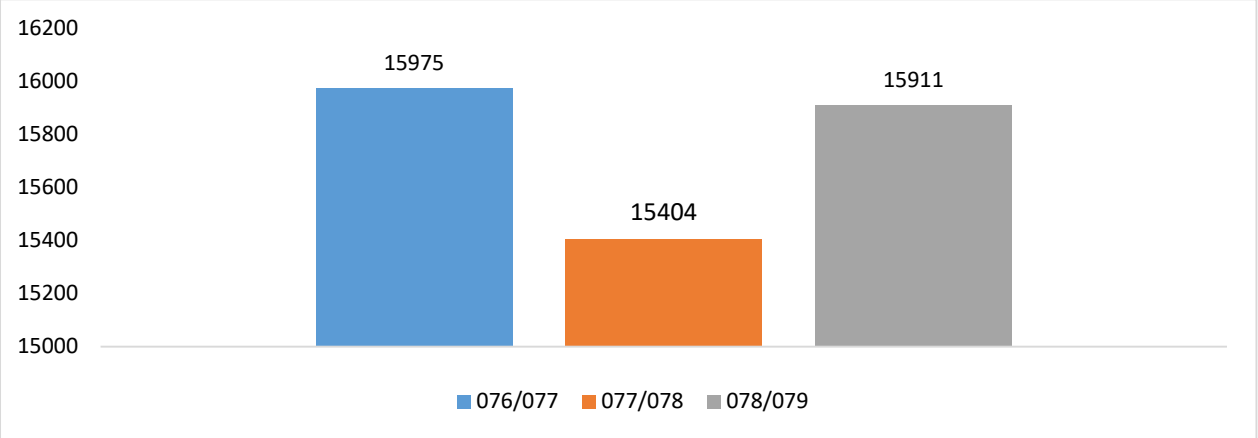
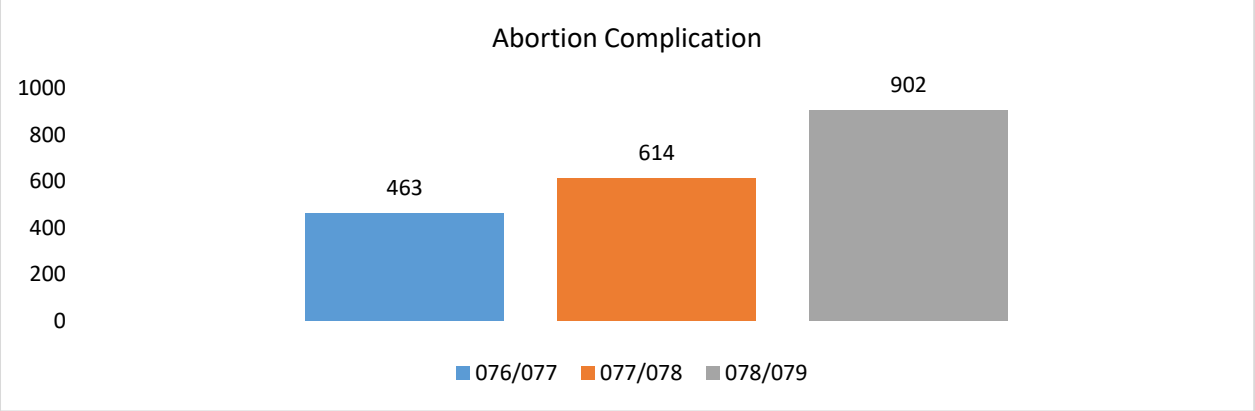


Figure 38: Abortion complications



Based on available data, CAC services, PAC services have increased in FY 2078/79 in comparison to FY 2077/78. The act of Safe motherhood and Reproductive Health Rights has helped to promote safe abortion service up to community level. It creates enabling environment for the Medical Abortion.

If we compare to other district of Province one, Okhaldhunga, Solukhumbu, Khotang, Bhojpur,and Taplejung has low number of safe abortion service. From this result we can assume that there is still illegal abortion. Thus, there is need to expand safe abortion service as well must focused on Quality Improvement. Number of complication management after abortion has been increased on FY 2078/79 as compared to FY 2077/78. Morang,Jhapa, Okhaldhunga and Ilam have the high number of abortions complication. One of the reasons behind this was many of the women must walk up to Pharmacy for the abortion. Likewise, client from Hilly district may travel to other districts for respective service. Thus, number of respective services was high. Women under 20 years have also access for respective service on all districts.

Status of Post Abortion Contraception Acceptance

Table 15: Post Abortion Contraception Acceptance

Data/ OU	Percentage of clients received post abortion contraceptives Short Term			Percentage of clients received LARC		
	076 /77	077 /78	078 /79	076 /77	077/78	078/79
1 Province 1	80.8	83.2	83.5	13.8	14.3	14.5
1. Taplejung	101.6	102.5	93.5	34.6	28.3	11
2. Sankhuwasabha	88	90	95.2	21.6	23.3	18
3. Solukhumbu	82.6	71.4	80.1	14.4	13.7	15.9
4. Okhaldhunga	32.6	47.6	23.6	2.2	0	4.2
5. Khotang	94.6	87.8	90.7	18.9	24.9	15.9
6. Bhojpur	36.7	33.9	21	0.63	3.4	3.2
7. Dhankuta	93.2	98.5	93.7	10.8	6	6.2
8. Terhathum	97.8	92.6	78.4	20.6	20.2	10.7

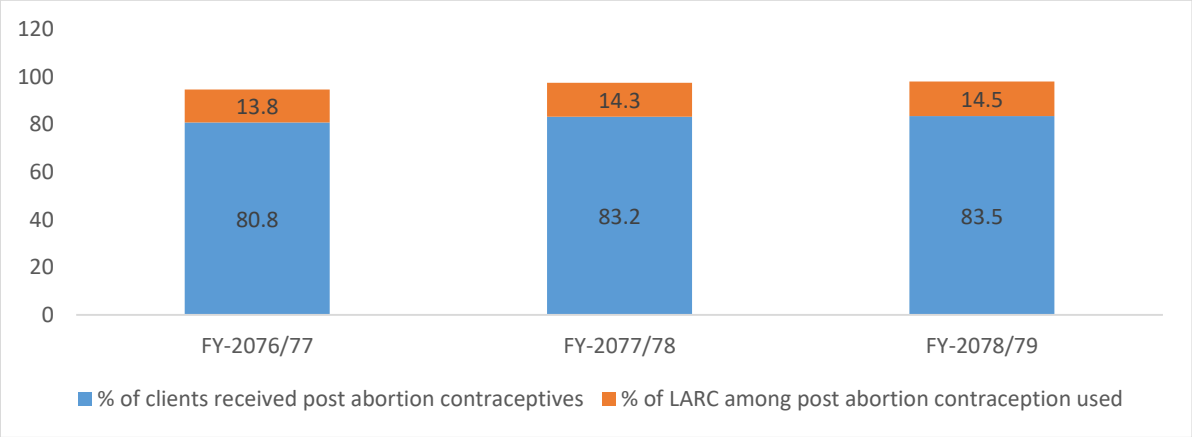
Data/ OU	Percentage of clients received post abortion contraceptives Short Term			Percentage of clients received LARC		
	076 /77	077 /78	078 /79	076 /77	077/78	078/79
9. Panchthar	74.9	65.7	83.9	8.6	9.6	10
10. Ilam	79.5	83	88.2	19.9	18.1	17.9
11. Jhapa	62	78.9	78.3	8.3	11.2	14.5
12. Morang	72	87.6	77.7	12.2	14.9	17.9
13. Sunsari	91.1	82.8	86.4	12.2	13.2	14.9
14. Udayapur	89.5	101.3	88.7	14.4	6.6	6.8

Above information shows that percentage of client receiving post abortion contraceptives has increased to 83.5% in 078/79 as compared previous year 077/78.

A woman can become pregnant after the 8th day of abortion. Thus, service provider must counsel the client for family planning service after safe abortion. Therefore, due to given reason it is more important for a woman. Long term family planning methods has been increased by 0.2 percentage as compared to previous year in Province one. If we analyze the service trend of short-term family planning methods, there was increaseby 0.3 percentage in comparison to previous fiscal year.

Overall post abortion family planning contraception acceptance was 83.5 percentage. If we analyze the district wise service status, Okhaldhunga and Bhojpur has low long-term family planning service acceptance and was high in Taplejung, Sankhuwasabha, Dhankuta and Khotang,as compared to another. Data reflects that, there is necessity of Safe Abortion related intensive program to increase the post abortion contraception acceptor on respective districts.

Figure 39:Percentage of post abortion contraception acceptance



Major Innovations

- In Terathum District, campaign for "Zero Unsafe Abortion District in Province 1" was initiated with support from Ipas Nepal. Some of the Palika has expanded safe abortion service, community awareness program and quality service as per need.
- Increase on access of safe abortion service up to community level through Health Post.
- Start to supply Safe Abortion Drug to listed Health Facility from Hospital Pharmacy.

Strength

- Free safe abortion service program was implemented in effective way.
- Myth regarding the abortion was decreased among the community.
- Local government has started to take the ownership on program.
- Increase in number of Long-term family planning service after the abortion.
- Program was effective with support from IPAS Nepal, Family Planning Association, MSI and PSI Nepal.

Challenges

- Increasing trend of Unsafe abortion
- Number of Safe abortion service was low in 6 districts (Taplejung, Solukhumbu, Okhaldhunga, Khotang, Bhojpur and Udayapur) as compared to other districts.
- Availability of drug on Pharmacy and other illegal service center.
- Transfer out of trained human resource from the service center
- Poor supply chain management of MA drugs
- Limited Safe Abortion Service Site.

Issues and recommendation

Issues	**Action needs to be taken**	**Action plan for FY 2079/80**	**Responsible**	**Coordination**
Lack of Human Resource	SAS (CAC/MA/2nd tri) training	Provide training based on need identification	Palika/ Province/ Center	Training Center
Insufficient number of Service Center	Increase number of service center and ensure availability of service as well assure confidentiality	At least one MA service center at each Palika and assure availability of MVA service (within 12 weeks) at Hospitals.	Palika/ Provence/ Center	EDPs/HO
Illegal uses of Drugs from illegal service sites	Regular monitoring of Pharmacy and private clinic. Regular supply of drug to Service center.	Compulsory Quarterly Monitoring	DDA/HO/ DAO	Palika/DDA
Sites non-Functional	Manage the trained Human Resources in Service Sites	Identify the service stoppage sites and manage trained human resource	Palika/ Province	Health Office EDPs
Myth on respective issues	Aware about women's right	Identification of Local Supportive partners and conduct awareness and advocacy campaigns	Palika	Health office/Supportive Organization

PART 3 – EPIDEMIOLOGY AND DISEASE CONTROL

3.1. Malaria

Background

Nepal's malaria control programme began in 1954, mainly in the Tarai belt of central Nepal with supportfrom the United States. In 1958, the National Malaria Eradication Programme was initiated and in 1978the concept reverted to a control programme. In 1998, the Roll Back Malaria (RBM) initiative was launchedfor control in hard-core forests, foothills, inner Tarai and Hill River valleys, which accounted for more than70 percent of malaria cases in Nepal. Malaria has a greater risk in areas with an abundance of vectormosquitoes, amongst mobile and vulnerable populations, in relatively inaccessible areas, and during timesof certain temperatures.

Malaria risk stratification 2077/78 (2021) was conducted to develop program intervention to suit thechanging epidemiology of malaria in the country. Appropriate weightage was allocated to key determinantsof malaria transmission as recommended by external malaria program review. Malaria data from last fiveyears reveals that even within Rural Municipalities or Municipalities, malaria is concentrated within somewards while other wards remain relatively free of malaria. In order, to refine the risk stratification at thecommunity level and thereby define the total population at risk of malaria; malaria risk micro- stratificationwas conducted at the wards level of Rural Municipality or Municipalities.

The methodology used recent malaria burden data supplemented by information on the spatial distributionof key determinants of transmission risk including climate, ecology, and the presence or abundance of keyvector species and vulnerability in terms of human population movement. The method was based on 2012and 2016 micro-stratification study, and it was recommended by Epidemiology and Disease Control Division(EDCD) and Malaria Technical Working Group (TWG). EDCD provided the overall oversight of the study.

Nepal's National Malaria Strategic Plan (NMSP, 2014–2025)

National Malaria Strategic Plan (NMSP 2014 – 2025**)** which was developed in 2013 with pre-eliminationfocus was updated in 2021 based on the WHO Global Technical Strategy for malaria elimination 2016 –2030 and framework for malaria elimination, federalization of the health system, disease epidemiologyand midterm malaria program review-2017.Nepal is also part of the global E-2025 countries with aim toattain **"Malaria Elimination in Nepal by 2025".**

Vision: Malaria Elimination in Nepal by 2025.

Mission: Ensure universal access to quality assured malaria services for prevention, diagnosis, treatmentand prompt response in outbreak.

Goal: Reduce the indigenous malaria cases to zero by 2022 and sustain thereafter.
Sustain zero malaria mortality.

Objectives:

To ensure proportional and equitable access to quality assured diagnosis and treatment in health facilitiesas per federal structure and implement effective preventive measures to achieve malaria elimination.The updated NMSP (2014-2025) will attain the elimination goals through the implementation of followingfive strategies:

• Strengthen surveillance and information system on malaria for effective decision making.
• Ensure effective coverage of vector control interventions in malaria risk areas to reduce transmission.
• Ensure universal access to quality assured diagnosis and effective treatment for malaria.
• Ensure government committed leadership and engage community for malaria elimination.
• Strengthen technical and managerial capacities towards malaria elimination.

Services and Interventions:

- Early diagnosis and prompt effective treatment
- Case based surveillance
- Foci investigation
- Transmission Reduction: entomology and vector control
- Advocacy and Behavior Change Communication
- Human resource and capacity building

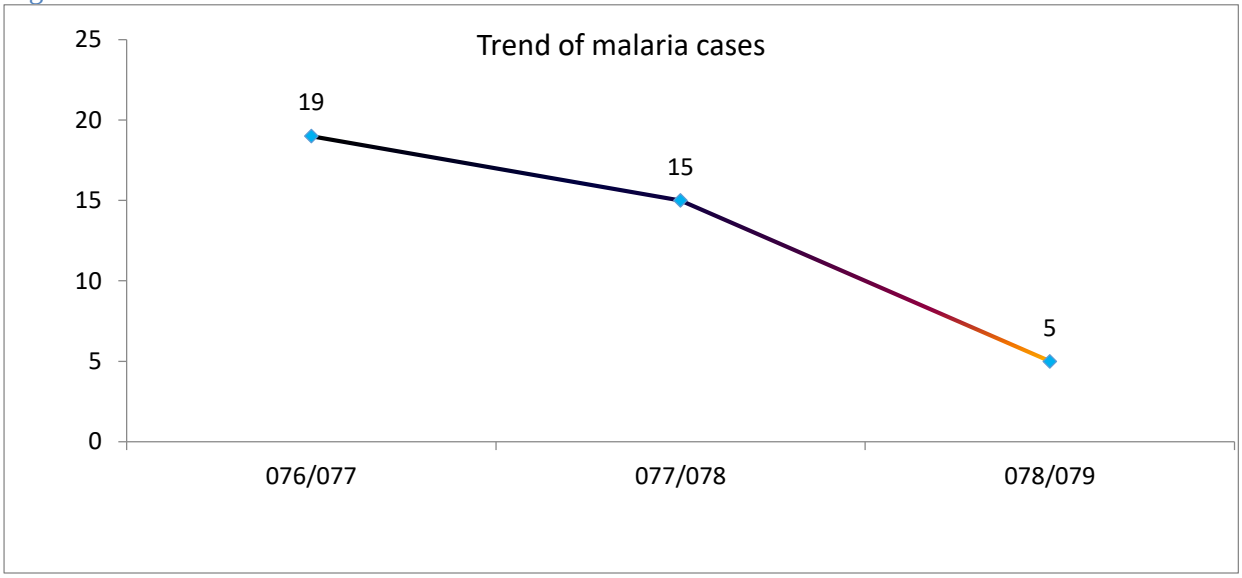
- Malaria logistics supply
- Research and surveys

Major activities accomplished in FY 2078-79:

- Case Base investigation of all reported positive cases of Province1
- HMIS orientation for Public and Private health facilities of selected districts
- District and Province level virtual orientation on malaria program focusing to increase testing at community level
- Orientation/Training on malaria case management
- Implemented Advocacy, social mobilization & Behavior Change Communication program
- Intensified Care Detection program for Malaria elimination
- Orientation on malaria treatment protocol to health personnel
- Integrated vector surveillance program conducted in 5 districts

Analysis of Achievements

Figure 40:Trend of Malaria Cases



As per the reported cases from the health facilities, total number of cases reported on FY 078/79 was 5. Among which 4 cases were from Morang which was Plasmodium Vivax-Imported and 1 case was from Jhapa which was Plasmodium Falciparum-Imported.

Above data indicates that the malaria cases were in decreasing trend in comparison with previous FY.

Issues and recommendations

Issues	Action to be taken	Responsibilities
Private hospitals are not reporting Malaria cases in time.	Need to supervise regularly for the monthly report from private health institutions	Palikas and health office
Lacking commitment from all level and Coordination between HF and palikas D/PHOs is minimal.	Needed commitment from all responsible authority	All responsible authority
Timely and correct HMIS recording and reporting of public & private health institution need to be followed (timely and complete recording and reporting).	Timely recording and reporting from responsible authority	All responsible authority of health facilities

3.2 **Kalazar**

Background

Kala-azar is a vector-borne disease caused by the parasite *Leishmania donovani*, which is transmitted bythe bite of female sandfly *Phlebotomus argentipes*. The disease is characterized by fever of more than twoweeks with splenomegaly, anaemia, and progressive weight loss and sometimes darkening of the skin. Inendemic areas, children and young adults are the principal victims. The disease is fatal if not treated ontime.

Kala-azar is slated for elimination as a public health problem in the South-East Asia Region.Elimination ofKala-azar is defined as achieving annual incidence of less than 1 case of kala-azar in 10,000 population atthe implementation unit i.e. district level in Nepal, sub-district (block) in India and upa zilla in Bangladesh.The government of Nepal is committed to the WHO regional strategy to eliminate Kala-azar and signatoryto the memorandum of understanding (MoU) on strengthening collaboration in the regional eliminationefforts along with Bangladesh and India that was formalized during the side meeting on the occasion ofWorld Health Assembly held in May 2005. This MoU was renewed in 2014 with inclusion of Bhutan andThailand. In 2005, EDCD formulated a National Plan for Elimination of Kala-azar in Nepal. The National Planwas revised in 2010 as a National Strategic Guideline on Kala-azar Elimination in Nepal which recommendedrK39 as a rapid diagnostic test kit and miltefosine as the first line treatment of Kala-azar. The 2010 guidelinewas updated in 2014 to introduce liposomal amphotericin B and combination therapy in the nationaltreatment guideline. The 2014 National Guideline was again updated in 2019 which recommended singledose liposomal amphotericin B as the first line treatment for primary kala-azar.

Goal, objectives and strategies

Goal

- The goal of kala-azar elimination program is to contribute to mitigation of poverty in kala-azar endemic districts of Nepal by reducing the morbidity and mortality of the disease and assisting in the development of equitable health systems.

Target

- Reduce the incidence of kala-azar to less than 1 case per 10,000 populations at district level.

Objectives

- Reduce the incidence of kala-azar in endemic communities with special emphasis on poor, vulnerableand unreached populations.
- Reduce case fatality rates from kala-azar to ZERO.
- Detect and treat Post-Kala-azar Dermal Leishmaniasis (PKDL) to reduce the parasite reservoir.
- Prevent and manage Kala-azar HIV–TB co-infections.

Strategies

Based on the regional strategy proposed by the South East Asia Kala-azar Technical Advisory group (RTAG)and the adjustments proposed by the Nepal expert group, Government of Nepal, MoHP has adopted thefollowing strategies for the elimination of Kala-azar.

- Early diagnosis and complete treatment
- Integrated vector management
- Effective disease and vector surveillance
- Social mobilization and partnerships
- Improve programme management
- Clinical and implementation research

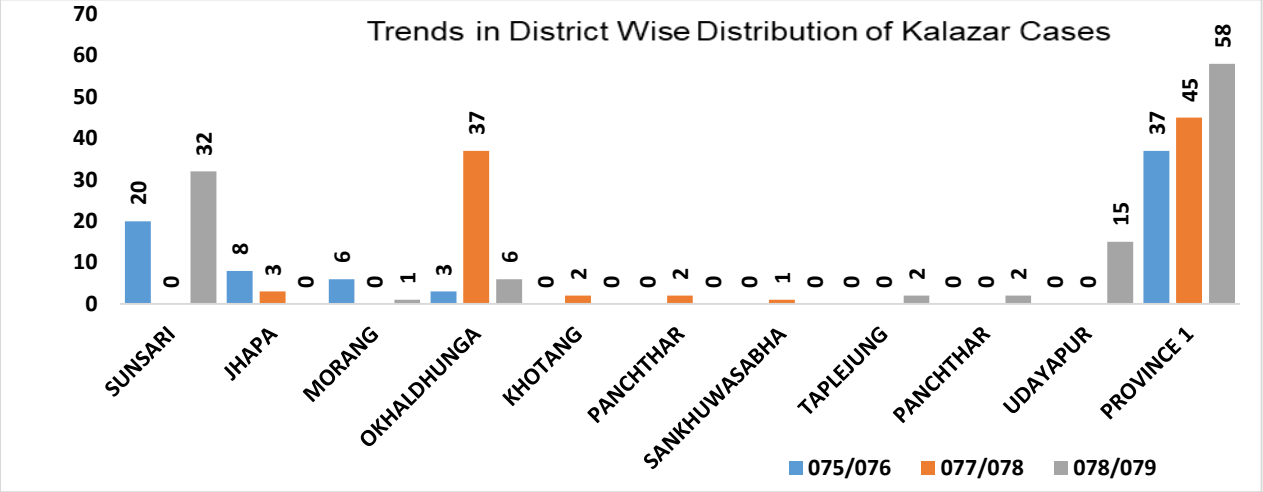
Over the last decade, there have been significant advances in the diagnosis and treatment of kala-azar.
Nepal’s national programme made the rK39, dipstick test kit (a rapid and easily applicable serological test)available up to PHCC level in affected districts. Likewise, drugs for kala-azar such as liposomal amphotericinB, miltefosine and paromomycin are made available to all the kala-azar treatment centres. Kala-azardiagnostics and drugs are provided free of costs to the patients by EDCD.
Major Activities:

- Case detection and treatment,
- Indoor Residual Spraying (IRS) was carried out in prioritised Kala-azar affected areas
- Continuation of treatment through Amphotericine B and Miltefosine
- Case based investigation of all positive reported cases
- Conducted IEC and BCC activities in the Kala-azar endemic districts.

Analysis of achievements

In the Province 1 Kalazar cases shows increasing trend than previous year. A total of 58 Kalazar cases were reported in the province with majority of cases being reported from Udayapur district. Sunsari does not have any reported cases in this fiscal year.

Figure 41:Kalazar cases



Issues and recommendations

Issues	Action to be taken	Responsibility
Low Patients compliance for the treatment of kala-azar	Training/orientations to the relevant health workers& Public awareness activities in community, increase incentive for the treatment.	EDCD, HD, Health Office and Palika
Inadequate integrated vector management and case base surveillance	Promote integrated vector management and case base surveillance in high-risk areas	EDCD, HD, Health Office and Palika
Inadequate awareness aboutdisease among the communities.	Dissemination of educational message to public, public health professionals and policy makers related to kala-azar.	NHEICC, HD and Palikas
Lack of proper distribution of travel allowance and additional treatment fair for patient	Strict policy should be developed by central level	EDCD and Province

3.3 Lymphatic Filariasis

Background

Lymphatic Filariasis (LF), commonly known as elephantiasis is one of the mosquito borne parasitic disease.It's a painful and highly disfiguring neglected tropical disease often associated with areas that havepoor sanitation and housing quality. The infection may be acquired during childhood whereas its visiblemanifestations may occur later in life, causing temporary or permanent disability, pain and social stigma.The infection transmitted by different species of mosquitoes (Culex, Anopheles & Aedes) is caused by athread like filarial worms (nematodes). In majority of the cases (90%), the infection is caused by WuchereriaBancrofti and remainder by Brugia Species (Brugia Malayi & Brugia Timori).Adult worms reside in the lymphatic vessels interrupting the normal function of the lymphatic system.The worms have life span of about 6–8 years and produce millions of microfilariae (immature larvae) thatcirculate in the blood. Mosquitoes are infected with microfilariae by consuming blood when biting an infectedpeople. Microfilariae mature into infective larvae stage within the mosquito. When infected mosquitoesbite people, mature parasite larvae are deposited on the skin from where they can enter the body. Thelarvae then migrate to the lymphatic vessels where they develop into adult worms, thus continuing a cycleof transmission.The number of infected persons, the micro filarial density in the blood of infected persons, vector mosquito'sdensity, and characteristics of the vector and frequencies of human-vector contact are the major factorsaffecting transmission of LF in a community. Filarial infection can cause a variety of clinical manifestations,including lymphoedema of the limbs, genital disease (hydrocele, chylocele) and recurrent acute attacks,which are extremely painful and are accompanied by fever. The vast majority of infected people areasymptomatic, but virtually all of them have subclinical lymphatic damage. It takes years to

manifest chronicand disfiguring conditions. These conditions lead to mental, social and financial losses contributing to socialstigma and poverty.

Lymphatic Filariasis Elimination Programme of Nepal

The World Health Assembly (WHA) of 1997 passed a resolution (50.29) to eliminate LF as a public healthproblem and in response to this, WHO established a Global Programme to Eliminate LF (GPELF) in 2000 witha goal to eliminate LF as public health problem by 2020.As per global commitment for GPELF, LF mapping were done in 2001, 2005/2006 and remapping in 2012 byusing ICT which discovered that 61 out of than 75 districts of Nepal were endemic for LF. Almost 25 million
people living in these districts are considered to be at risk of getting LF. This indicates that quite a significantnumber of people are estimated to be living with symptomatic and asymptomatic infections which cateras source of infection to others. Treating all potential reservoirs of infection kills the parasites (both adultand microfilaria) present in the population which in turn reduces the sources of infection and hence, thetransmission can be lowered significantly and LF can be eliminated as a public health problem.

To address the challenges, Government of Nepal has also set a goal and national targets through effectiveimplementation of WHO recommended strategies to eliminate LF by 2020. Due to failing the TAS and pre TASin some districts the LF elimination year of Nepal is now shifted to 2030 to align with WHO NTD roadmap.Annual mass drug administration (MDA) of single doses of Albendazole plus Diethyalcarbamazine (DEC) isimplemented in endemic districts, treating the entire at-risk population.

Goal

Elimination of Lymphatic Filariasis from Nepal by the year 2030 as a public health problem by reducing thelevel of the disease in population to a point where transmission no longer occurs

Objectives:

• To interrupt the transmission of lymphatic Filariasis
• To reduce and prevent morbidity
• To provide de-worming benefit using Albendazole to endemic communities
• To reduce mosquito vectors through application of suitable and available vector control measures (Integrated Vector Management)

Targets:

• To cover with MDA in all endemic districts by 2014
• To eliminate lymphatic filariasis as a public health problem by the year 2030 by reducing the microfilaria rate to below 1 percent (OR Antigenemia less than 2 %).

Indicators

• Prevalence of disease is the primary indicator to be used for identification and stratification of endemic areas.
• Prevalence of infection is the secondary indicator which can be used for identification of endemic areas.
• Coverage of distribution of drug and compliance of intake are important indicators for process evaluation.

Strategies

• **Interruption of transmission by Mass Drug Administration (MDA)** – Initially using two drug regimens,
Diethyalcarbamazine (DEC) and Albendazole, yearly campaign for six years. Now, using three drug regimens, Ivermectin, DEC and Albendazole yearly for 2-3 years in newly endemic and Transmission Assessment Survey failure districts.
• **Morbidity management and Disability Prevention (MMDP)** – Morbidity management by self-care and
with support using intensive but simple, effective, and local hygiene techniques.

Major activities in 2078/79

- MDA program conducted in Morang and Jhapa district.
- Free hydrocele surgeries conducted in specific hospitals.
- Public awareness program conducted by Province, District and Palikas.

3.4 Dengue

Background

Dengue is a vector-borne disease that is transmitted by mosquitoes (*Aedes aegypti* and *Aedes albopictus*) andoccurs in most of the districts of Nepal. WHO (2009) classified dengue as i) Dengue without warning signs, ii)Dengue with warning signs, iii) Severe Dengue. The first dengue case was reported from Chitwan district in aforeigner. The earliest cases were detected in 2005. Since 2010, dengue epidemics have continued to affectlowland districts as well as mid-hill areas. This trend of increased magnitude has continued with number ofoutbreaks reported each year in many districts- Chitwan, Jhapa, Parsa (2012-2013), Jhapa, Chitwan (2016),Rupandehi, Jhapa, Mahottari (2017), Kaski (2018) and Sunsari, Kaski, Chitwan (2019).

The mostly affected districts are Kanchanpur, Kailali, Banke, Bardiya, Dang, Kapilbastu, Rupandehi, Parsa,Chitwan, Kaski, Rautahat, Sarlahi, Saptari and Jhapa, reflecting the spread of the disease throughout theTerai plains from west to east. In 2011, 79 confirmed cases were reported from 15 districts with the highestnumber in Chitwan (55). During 2012 -15, the dengue cases still continued to be reported from severaldistricts but the number fluctuated between the years. In 2019, we experienced the outbreak at Sunsari(Dharan), Chitwan (Bharatpur) and Kaski (Pokhara) and since then the number of cases were in increasingtrend till the start of 2020.*Aedes aegypti* (the mosquito-vector) was identified in five peri-urban areas of the Terai (Kailali, Dang,Chitwan, Parsa and Jhapa) during entomological surveillance conducted by EDCD during 2006–2010,indicating the local transmission of dengue. However, recent study carried out by VBDRTC has shown thatboth the vector mosquitoes responsible for transmitting the disease in Nepal.

Studies carried out in collaboration with the Walter Reed/AFRIMS Research Unit (WARUN) in 2006 by EDCDand the National Public Health Laboratory (NPHL) found that all four sub-types of the Dengue viruses (DEN-1, DEN-2, DEN-3 and DEN-4) were circulating in Nepal. Details of Nepal's Dengue Control Programme aregiven in Box

Goal, Objectives and Strategy of Dengue Control Programme
Nepal's Dengue Control Programme

Goal — To reduce the morbidity and mortality due to dengue fever, dengue haemorrhagic fever (DHF) and dengue shock syndrome (DSS).

Objectives:

• To develop an integrated vector management (IVM) approach for prevention and control.
• To develop capacity on diagnosis and case management of dengue fever, DHF and DSS.
• To intensify health education and IEC activities.
• To strengthen the surveillance system for prediction, early detection, preparedness and early response to dengue outbreaks.

Strategies:

• Early case detection, diagnosis, management and reporting of dengue fever
• Regular monitoring of dengue fever surveillance through the EWARS
• Mosquito vector surveillance in municipalities
• The integrated vector control approach where a combination of several approaches are directedtowards containment and source reduction

Major Activities

- Trained physicians, nurses, paramedics and laboratory technicians on dengue case detection, diagnosis, management and reporting.
- Supplied rapid diagnostic test kits (IgM).
- Dengue case monitoring.
- Search and destruction of dengue vector larvae (*A. aegypti*)
- Developed and disseminated health education messages.
- Fogging conducted in affected districts.

Achievement

Table 16: Dengue Cases

District	2076/077	2077/078	2078/079
Jhapa	117	0	4
Morang	257	0	8
Sunsari	115	0	5
Bhojpur	1	0	0
Udaypur	15	0	5
Dhankuta	5	0	0
Ilam	10	0	1
Taplejung	2	0	1
Sankhuwasabha	5	5	73
Panchthar	7	0	0
Khotang	0	0	12
Okhaldhunga	3	0	14
Terhathum	1	0	0
Province	538	5	123

The number of reported dengue case has increased than previous fiscal year in FY 2078/79. During FY 2078/79, Dengue cases were reported from 9 districts. Most cases have been reported from Sankhuwasabha followed by Okhaldhunga and Khotang.

Issues and recommendations

S. N	ISSUES	ACTION TO BE TAKEN	RESPONSIBILITIES
1	Vector Control	Vector surveillance and Integrated Vector management	EDCD/VBTRTC/ HD/HO
2	Involevement of stakeholders in vector search and destroy	Coordinate with municipalities for search and destroy programs	HD/ HO/ Palika

3.5 TB Program

Background

TB burden in Nepal (prevalence and incidence) is higher than previously estimated. As per the National Tuberculosis Prevalence Survey 2017/18, the TB prevalence rate is 416/100,000 which is 1.8 times higher than previously estimated by WHO, and revised incidence rate is 245/100,000 which is 1.6 times higher than previously estimated. The mortality rates associated with TB were also re-estimated to be 3.1 times higher than previous estimation while TB drug resistance is 1.6 times higher than the previous estimation. Hence, Nepal has been enlisted in WHO bulletin as a country having high resistance towards TB drugs Worldwide,

The tuberculosis control program at the province is guided by the national policies and strategies. The province has coordinated with different public & private sectors, local government bodies, I/NGOs, social workers to expand DOTS, establish/reactivate DOTS committee and increase social mobilization at various levels. A good teamwork has been established in the province between the public and private sectors to sustain the results achieved by NTP at the provincial level. DOTS by community volunteers, I/NGOs and CBOs has been found effective in terai, hill and mountain districts of the region. Besides the government health institutions, the major partners in implementing DOTS program in the province are private and social sectors.

Vision

- TB free Nepal

Goals

- Nepal has set a goal to decrease incidence rate from 238 in 2020/21 to 181 per 100,000 population by 2025/26; decrease mortality rate from 58 in 2020/21 to 23 per 100,000 by 2020/21; end TB epidemic by 2035; eliminate TB by 2050; and reduce the catastrophic cost to zero.

Objectives

1. To build and strengthen political commitment, sustainability, and patient-friendly health system to end TB.
2. To ensure the identification of TB, diagnosis, quality treatment and prevention.

Services and Interventions:

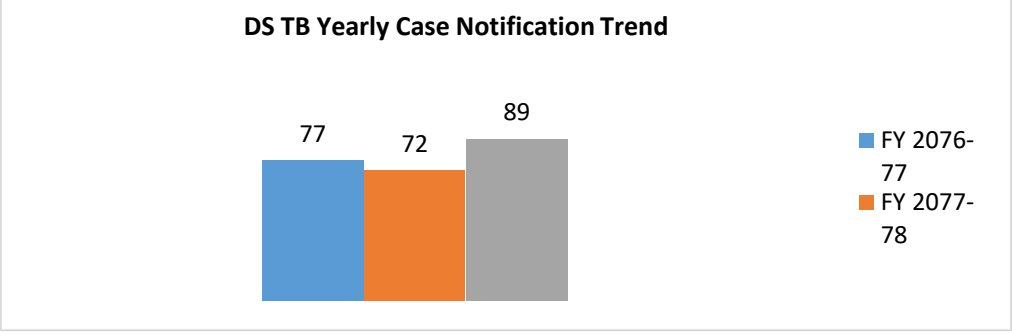
- DOTS services
- Childhood TB diagnosis and Management
- DR TB diagnosis and Management
- Laboratory Services including GeneXpert and Culture
- Public Private Mix
- Community System Strengthening
- Trainings and capacity development

Major Activities

- Carried out *half yearly* review meetings
- Conducted TB coordination meetings with different stakeholders and partners.
- Celebrated World TB Day with different IEC/BCC and advocacy activities.
- Carried out TB/HIV sensitization meetings.
- Conducted TB modular/refresher and lab modular/refresher training to the health workers and Lab assistants.
- Carried out review meetings for TB/HIV and drug resistance.
- Strengthening of microscopic centers, DOTS centers and sub-centers was done as needed.
- IEC/BCC activities were carried out at various levels.
- Provided DOTS to all patients in accordance to the treatment policies.
- Promoted early diagnosis of people with infectious pulmonary TB by sputum smear examination.
- Continued a system of quality control of sputum smear examination.
- Provided continuous drugs supply to all treatment centers including systems for storage, distribution, monitoring and quality control of drugs.
- Maintained a standard system for recording and reporting.
- Provided continuous training and supervision for all staff involved in TB control program.
- Conducted a coordination meeting with private sectors, non-government organizations and External Development Partners so as to strengthen the referral mechanism from private sectors.
- Cohort Workshop
- Training to HWs on eTB Register
- Strengthen of DR centers and sub centers.
- Expansion of Genexpert sites at Taplejung, Khotang and Bhojpur
- Regular supportive Supervision and monitoring

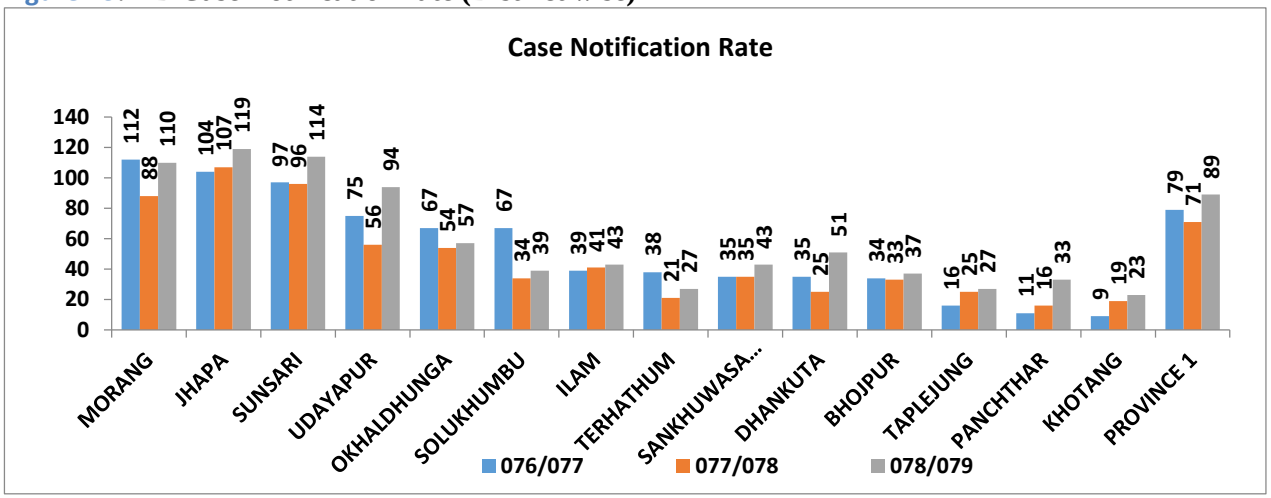
Analysis of achievements

Figure 42: Trend of TB case notification, FY 2076/077 to 078/79



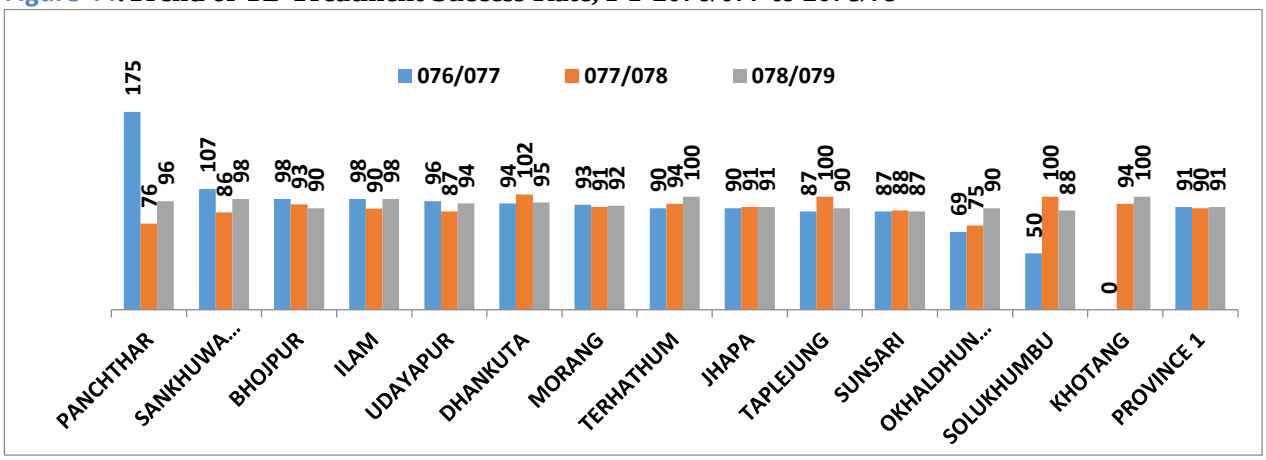
The above figure displays the trend of 3 year cases notification and as compared to the previous year, the notification increased by 18% .

Figure 43: TB Case Notification rate (District wise)



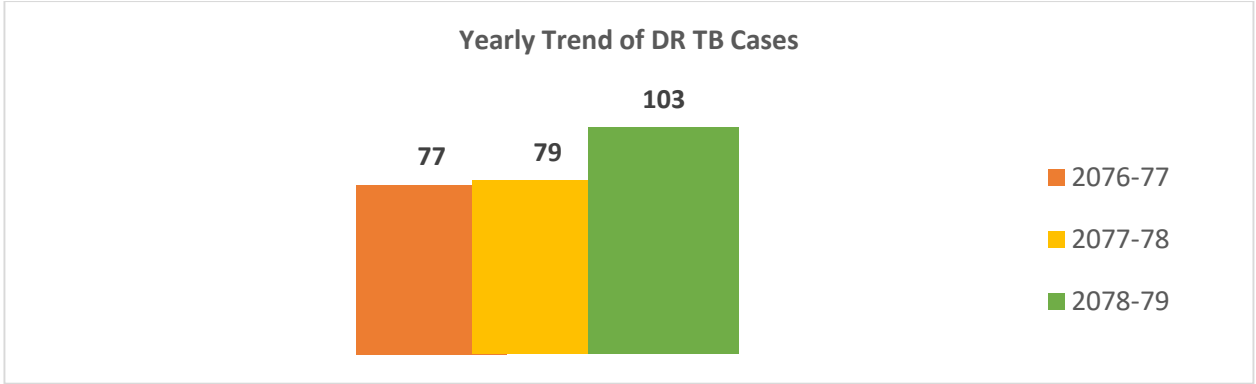
The above Figure displays the fluctuating trend of case notification rate of TB in the Province. The figure shows the highest number in Jhapa whereas lowest in Khotang. The case notifications in the Terai districts is maximum. Udayapur have highest case notification as compared to other hilly region. The case notification rate of the region has increased to 89 in 2078/079 in comparison to 2077/078.

Figure 44:Trend of TB Treatment Success Rate, FY 2076/077 to 2078/79



The above figure shows trend of treatment success rate in TB have been 91, 90 and 91 at Provincial level in FY 2076/77, 077/078 and 078/079 respectively. TB treatment success rate is 100% for two districts (Khotang and Terhathum).

Figure 45: Trend of DR TB cases, FY 2076/77 to 078/79



The above Figure shows the trend of DR cases in over last three years period. There has been increment in the number of DR cases; as compared to previous year the cases increased from 79 to 103.

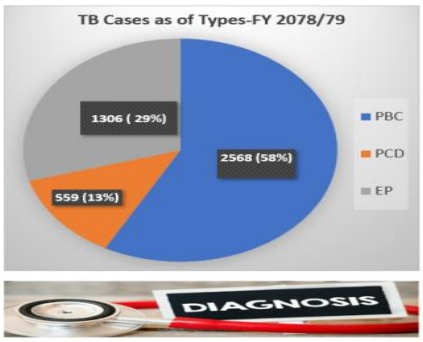
Table 17: Service Mapping of Province1

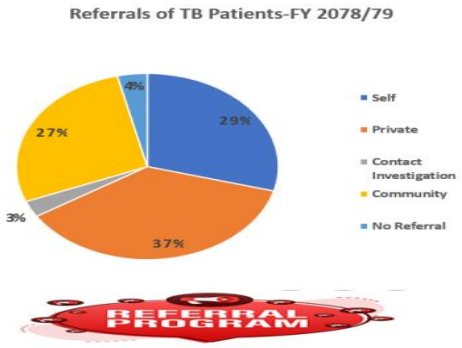
DOTS Center	925
MDR Treatment Center	3
MDR Sub Center	18
DR Hostel	1
Microscopy Center	102
Genexpert sites	13
TB Free Palika (Running Program)	4 (Mechinagar, Chaubisey, Ithari and Kerabari)

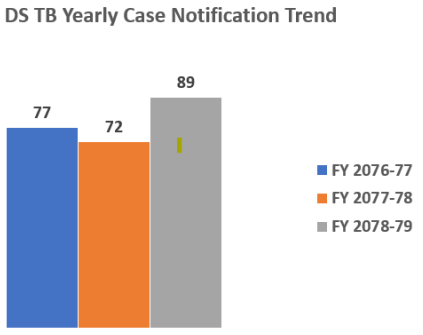
Table 18: Issues and recommendations

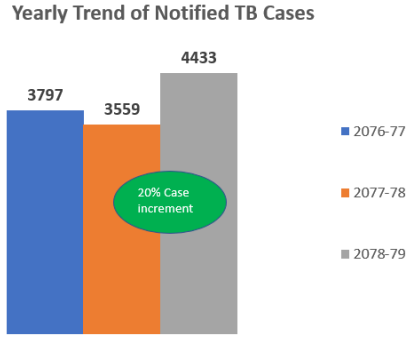
Issues	Actions to be taken	Responsibility
Low Case finding Rate	Strengthen referral mechanism between Private& Public sector and encourage following NTP Policies by Private sectors. Referral of Presumptive TB cases as low OPD referral is noticed Promote research activities Increase functionality of Microscopic Centre.	NTC/HD/ Hos
Enhance DR hostel capacity	NTC and Province to support NATA for the expansion	NTC/MoH and HD
Expansion of Genexpert sites	Exapansion of Genexpert machine to Panchtar, Solu,Sankhuwasabha and Terathum	NTCC/PHD
Recording and Reporting	Regular feedback and follow up for 100% timely recording and reporting. Support for data cleaning and quality reporting	PHD/District/Palika
Untimely Drug demand	Should adopt practice of timely drug demand on quarterly basis and district should ensure timely drug demand from respective HFs and Palika	PDH/PHLMC/Districts and Palika

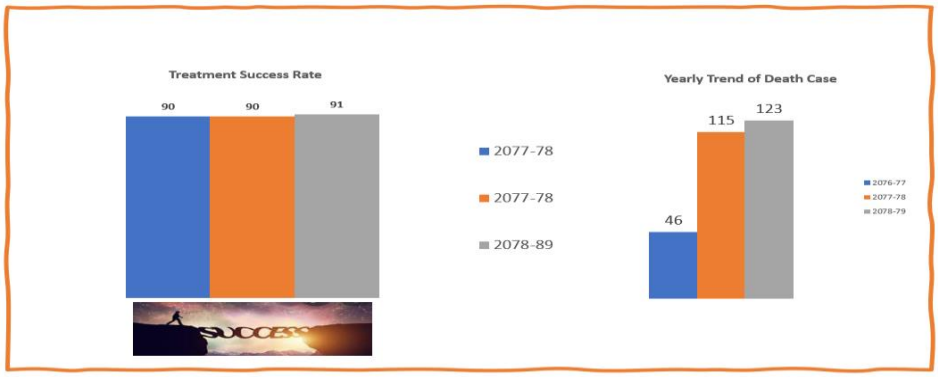
TB Program on Glance:











3.6 Leprosy Control Program

The establishment of the Khokana Leprosarium in the nineteenth century was the beginning of organizedleprosy preventive services in Nepal. With an estimated number of 100,000 Leprosy cases, in the year 1966,leprosy control program using dapsone mono therapy was started as a pilot project in Nepal. This projectgradually expanded as a vertical program and remained so till 1987 when it was integrated into generalhealth services. Multi drug therapy (MDT) was introduced for the first time in Nepal in the FY 1982/83 inselected areas and hospitals. By that time number of registered cases had come down to 31,537 (PrevalenceRate of 21 per 10,000). Number of districts then with a prevalence rate (PR) of over 5 was 62 and in onlythree districts the PR was less than 1 per 10,000. There was a gradual and steady expansion of MDT servicesand by the year 1996 MDT coverage was extended to all the 75 districts of the country. Being a membercountry of WHO, Nepal is committed to the elimination of leprosy as a public health problem in line with theglobal program and is an active member of the global alliance for elimination of leprosy a six-year plan wasdeveloped in 1995 for strengthening the program. Accordingly, as per that plan, an estimation of leprosyprevalence was done and all basic health staff (BHS) were provided training in Leprosy. Health Educationwas intensified to improve community awareness and to facilitate case detection. The first independentevaluation of the National Leprosy Control Program (NLMP) was undertaken during January (7th to 26th)1996, by a group of experts representing His Majesty Government (HMG), World Health Organization(WHO) and National Government Organizations (NGOs). Two rounds of Leprosy Elimination Campaignswere organized in the years 1999 and 2000.

Evolution and milestones of leprosy control programme in Nepal
Year Landmarks

- 1960 Leprosy survey by Government of Nepal in collaboration with WHO
- 1966 Pilot project to control leprosy launched with Dapsone monotherapy
- 1982 Introduction of multi-drug therapy (MDT) in leprosy control programme
- 1987 Integration of vertical leprosy control programme into general basic health services
- 1991 National leprosy elimination goal set
- 1995 Focal persons (TB and leprosy assistants [TLAs]) appointed for districts and regions
- 1996 All 75 districts were brought into MDT programme
- 1999/2000–2001/02 Two rounds of National Leprosy Elimination Campaign (NLEC) implemented
- 2008 Intensive efforts made for achieving elimination at the national level
- 2009 and 2010 Leprosy elimination achieved and declared at the national level
- 2011 National Leprosy Strategy (2011–2015)
- 2012-2013 Elimination sustained at national level and national guidelines, 2013 (2070) revised
- 2013-2014 Mid-term evaluation of implementation of National Leprosy Strategy (2011-2015)
- 2014-2015 Ministry of Health designated LCD as the Disability Focal Unit
- 2017 Policy, Strategy and 10 Years Action Plan on Disability Management (Prevention, Treatment and Rehabilitation)
- 2073-2082 developed and disseminated Goal, objectives, strategies and targets of the leprosy control programme

Goal, objectives, strategies and targets of the leprosy control programme

The National Leprosy Elimination Program of Nepal has outlined the following vision, goals, objectives andtargets as stated in National Leprosy Strategy of Nepal (2021-2025):

Vision: Leprosy free Nepal

Goal: Elimination of leprosy (interruption of transmission of leprosy) at the sub-national level (municipality)(interruption of transmission is defined as zero new autochthonous child leprosy cases for consecutive fiveyears at the municipality level)

Objectives

1. To eliminate leprosy at the sub-national level (province, district, local level).
2. To strengthen clinical case management at district and municipal levels and improve referral system.
3. To enhance capacity building through training of health staff particularly at the peripheral healthfacilities.
4. To enhance prevention of leprosy.
5. Reduction of stigma and discrimination.
6. To strengthen leprosy surveillance system and regular monitoring, supervision, and periodicevaluationat all level.
7. To strengthen partnerships among different stakeholders.
8. To strengthen management of leprosy complications like reactions and disability prevention and rehabilitation.
9. To coordinate with neighbouring states of India in management, reporting and referral of cases from border areas.
10. To promote research and innovations.

Table 19: Milestones of National Leprosy Control Program

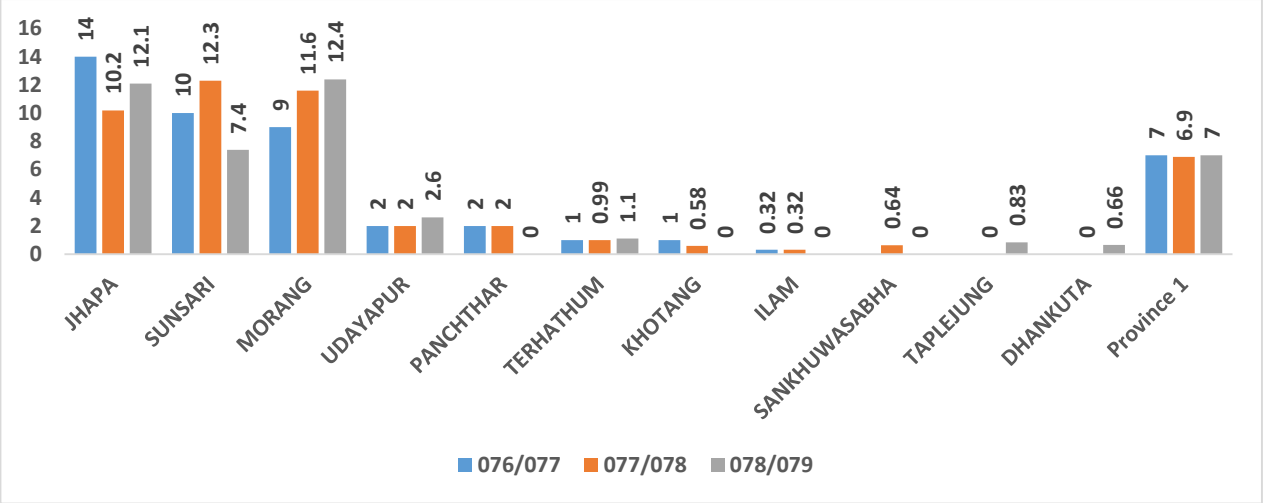
1960	Leprosy survey in collaboration with WHO.
1966	Pilot Project to control leprosy launched with Dapsone Monotherapy
1982	Introduced MDT
1987	Integration of vertical leprosy control programme with the general basic health services
1995	Focal Persons – DTLA, RTLA appointed
1996	Independent evaluation of National LCP
1999-2001	National Leprosy Elimination Campaign (2 Rounds)
2010	Leprosy elimination declared from Nepal
2013-2014	Mid Term Evaluation of implementation of National Leprosy Strategy 2011-2015
2015	Disability Focal Unit, LPEP piloting in three districts of Nepal
2017	National Leprosy Strategy 2016-2020 introduced

Major Activities

The major activities under leprosy control program carried out in all districts of province are mostly similar but more focus was given to high endemic districts. The following activities (including activities done by the supporting partners) were carried during the reporting period:

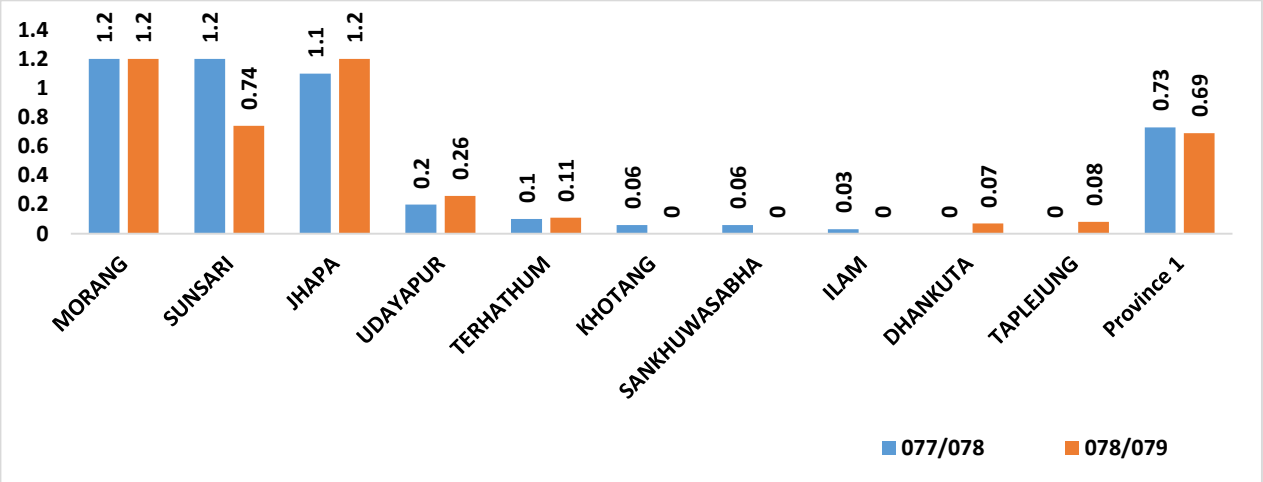
- Case detection and treatment.
- LPEP (Leprosy Post Exposure Prophylaxis) for early detection and prevention to risk populations
- Conducted review meetings on quarterly basis.
- Celebrated World Leprosy Day with different IEC/BCC & advocacy related activities.
- Basic and refresher training to the health workers.
- Management of reaction and other complications
- Carried out regular IEC/BCC activities including school & community health education activities
- Conducted program monitoring and follow up workshops at different levels
- Contact examination, skin camps
- Case validation & updating of records
- Self-care & self-help group formation and activities carried out at community level
- Income generation programs for Leprosy-affected and people with disability.
- Carried out activities to mainstream leprosy disabilities to general disabilities
- Analysis of achievements

Figure 46**: New case detection rate of Leprosy**



In the fiscal year 2078/079, new case detection rate of leprosy was highest in Morang i.e. 12.4 cases per 10,000 population. Panchthar, Khotang, Ilam and Sankhuwasabha had no new cases.

Figure 47: Prevalence of Leprosy



Prevalence of leprosy has decreased in comparison to previous fiscal year.It was 0.73 in FY 077/078 and in 078/079 it counts 0.69.

Table 20: Issues and recommendations

Problems	**Action for FY 2078/79**	**Responsible**
PR > 1 in some districts	Early diagnosis and treatment	District, Province, Local level
Late detection of cases	Active case finding (household and neighbor contact screening)	District, Province, Local level
Continue cases reporting	Regular SDR – PEP interventions	District, Province, local level
Impairment management of persons affected	Strengthen referal mechanism: -Complication management -Reaction management -Rehabilitation	District, Province, local level
Function of POID centres	orientation to BHs staff , BlT Training, complications management training etc	Federal, District, Province, local level

3.7 HIV/AIDS program

Background

With the first case of HIV identification in 1988, Nepal started its policy response to the epidemic of HIV through its firstNational Policy on Acquired Immunity Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs) Control, 1995 (2052 BS). Taking the dynamic nature of the epidemic of HIV into consideration, Nepal revisited its first national policy on 1995 and endorsed the latest version: National Policy on Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs), 2011. A new National HIV Strategic Plan 2016-2021 is recently launched to achieve ambitious global goals of 90-90-90.By 2020, 90% of all people living with HIV (PLHIV) will know their HIV status by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy,andby 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

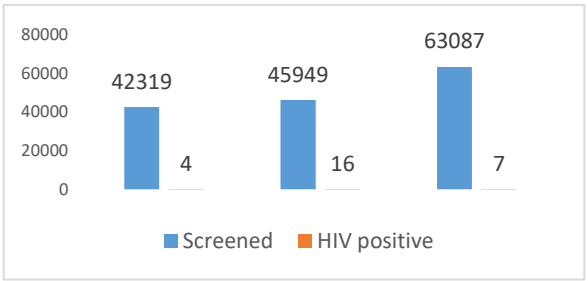
Overview of the Epidemic

Starting from a 'low level epidemic' over the period of time HIV infection in Nepal evolved itself to become a 'concentrated epidemic' among key populations (KPs), notably with People who Inject Drugs (PWID), female sex workers (FSW), Men who have Sex with Men (MSM) and Transgender (TG) People in Nepal. A review of the latest epidemiological data, however, indicates that the epidemic transmission of HIV has halted in Nepal. The trend of new infections is evidently taking a descending trajectory, reaching its peak during 2001-2002.The epidemic that peaked in 2000 with almost 8,000 new cases in a calendar year has declined to 942 in 2016 (reduced by 88%). In 2016, 96.4% of the total infection was distributed among the population having agegroup 15 years and above. The estimate indicates that among total infections are distributedamong PWIDs (4%), MSWs(6%), MSM and TG (7%), FSWs (1%) and Client of FSWs (7%). These apart, low-risk males including MLM account for 38%,andlow-risk females account for 37% of the remaining infections.The estimated number of annual AIDS deaths of all ages is estimated to be around 1,771 for 2016. Civil societies have also played pivotal roles inthe national response. Civil societies, through empowerment of KPs, have been playing instrumental roles in prevention, treatment, care and support as well as bringing about changes in legal and policy environment through advocacy.External development partners equally support the national response to HIV in Nepal by providing a substantial amount of resources required for combating HIV.The Global Fund, bilateral agencies, namely Global Fund for AIDS, TB and Malaria (GFATM), United States Agency for International Development (USAID), United Nations Children's Fund (UNICEF),AIDS Health Care Foundation (AHF) are the external sources that are contributing to the national HIV response.

Major activities:

The following were the major activities undertaken under HIV/AIDS & STDs control program in FY 2078/79:

1. **PMTC Services:**
   Total 63087 females were screened for HIV during ANC, labour/delivery and puerpenium during FY 78/79 which is higher compared to previous fiscal years i.e. 42319 in FY 76/77 and 45949 in FY 77/78. Among all the reactive cases identified, 7 were confimed HIV case in FY 78/79 who got enrolled for ART services as well.



2. **HIV Testing and Counseling Services:**
   There is total 16 government HTC sites and 3 non governmental HTC sites where the HIV reactive cases reported from Province 1 are confirmed for HIV status. Total 32395 tests were conducted at HTC centers in FY 078/79 where 343 cases were confirmed for their HIV status.
3. **ART services:**
   Anti-Retroviral Treatment services are provided through Total 2082 PLHIV are currently on ART at 10 different ART sites of Province 1.
4. **OST services:**
   Opoid Substituition Therapy (OST) services is a harm reduction program targeted to People Who Inject Drugs (PWID) for prevention from possible HIV infection. Currently there are 208 PWID on OST who are recevieing services from Koshi Hospital (107 clients) and Mechi Hospital (101 clients).

Analysis of achievement:

A total of 32395 persons were screened for HIV and among them 343 cases were found HIV reactive in the year 078/79.

Figure 48: HIV testing Vs. HIV positive yield

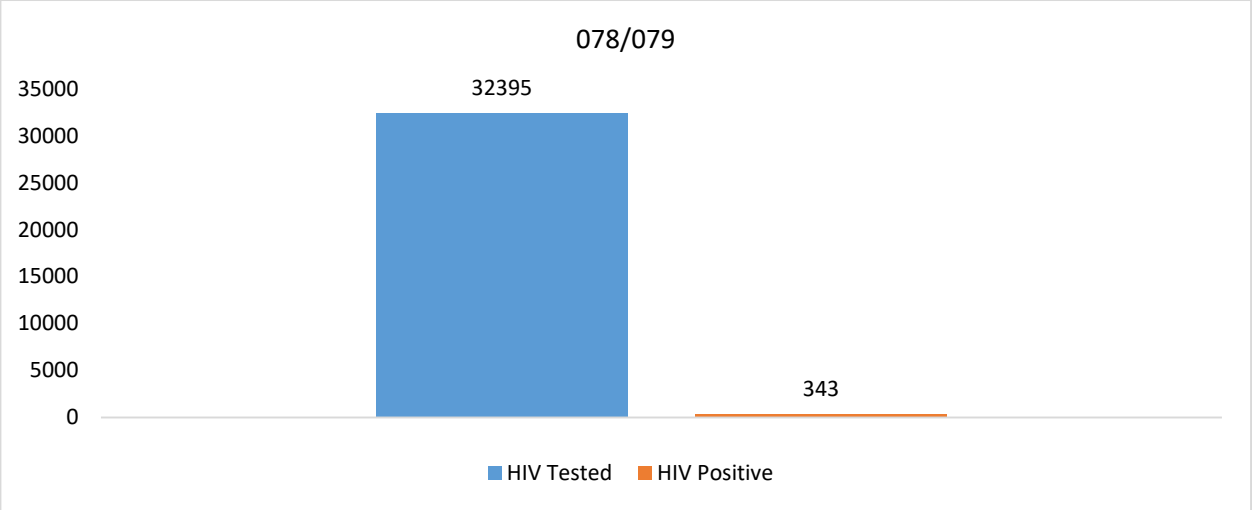


Figure 49 District wise HIV testing Vs. HIV positive yield for FY-2078/79

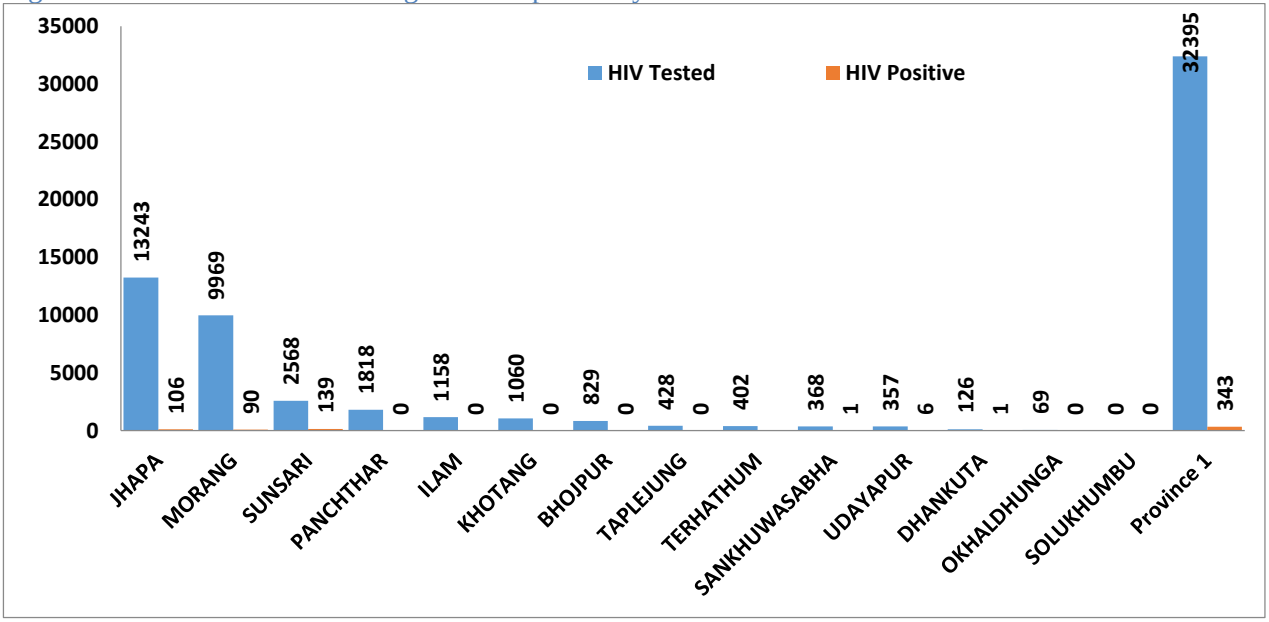


Table 21: Issues/problems, constraints, and action to be taken:

S. N	ISSUES	ACTION TO BE TAKEN	RESPONSIBILITIES
1	HIV Testing data from Private sectors not mainstreaming in provincial data system	Enhance private sectors involvement in reporting	NCSASC /PHD /HMIS section
2	Some hilly/mountain districts hospitals are not expanded for ART services (Bhojpur, Terrhathum, Taplegunj, Khotang)	Expansion of ART sites in respective districts	NCASC /PHD
3	No timely demand of test kits through bi-monthly requisition from Palikas to districts and districts to province so that there is Inadequate supply of test kits	Need timely reporting of bi-monthly requisition to Province	Palika's/Districts
4.	Insufficient Chase buffer for CB-PMTCT services as supply of chase buffer is insufficient compared to the numbers of test kits.	Need to supply enough chase buffer for all service sites.	NCASC
5.	Lack of trained manpower in hospitals (non-ART sites) for HIV counseling, proper recording and reporting.	Need to plan for capacity building targeting the HIV counselors and lab personnel.	NCASC/PHD
6.	OST clients to be travelled long distance to receive daily OST doses.	Need expansion of OST site	NCASC/PHD

3.8 Zoonoses

Background

Priority zoonotic diseases in Nepal are Brucellosis, Leptospirosis, Hydatidosis, Cysticercosis, Toxoplasmosis etc. Our public health activities are focused to poisonous snake bitesand dog bites. The HD has been working for public health in coordination and collaboration with governmental livestock sector, public and other non-governmental sectors.

Goals:

- No people die of rabies or poisonous snake bites due to the unavailability of anti-rabies vaccine (ARV) or anti-snake venom serum (ASVS) or timely health care services.
- To prevent, control and manage outbreaks and epidemics of zoonosis.

Objectives:

- To strengthen the response and capacity of health care service providers for preventing and controlling zoonoses.
- To improve coordination among and between stakeholders for preventing and controlling zoonoses.
- To enhance the judicious use of ARV and ASVS in health facilities.
- To reduce the burden of zoonotic diseases (especially rabies and other priority zoonoses through public awareness programs.
- To provide cell culture ARV as a post-exposure treatment to all victims bitten by suspicious rabid animals.
- To reduce the mortality rate in humans by providing ASVS and ARV.
- To train health workers on snake bite management and the effective use of ARV and immunoglobulins.
- To reduce the number of rabid and other suspicious animal bites.

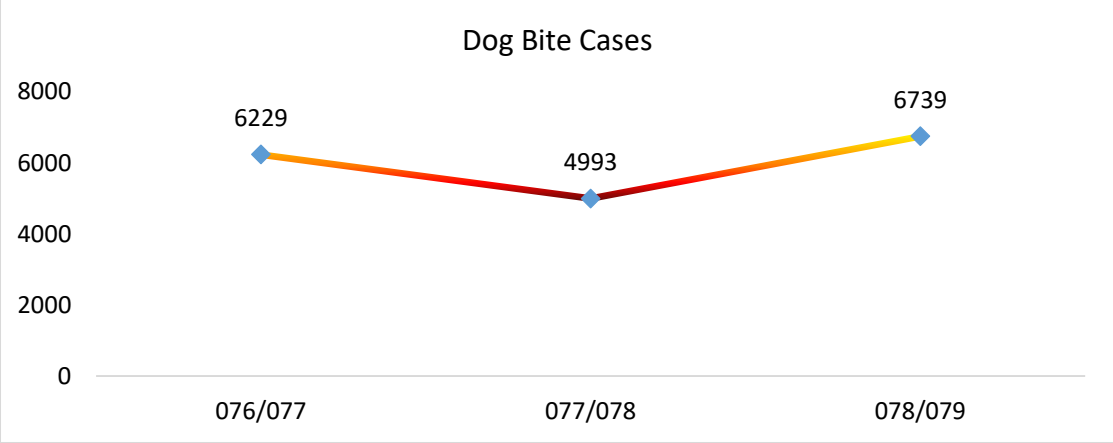
Rabies

Rabies is primarily a disease of warm-blooded animals like Dogs, Jackals, Wolfs, Mongoose wildcats etc. Rabies cases are almost all fatal, but it is 100% preventable by vaccination, awareness about human and animal interaction. Most of the affected are children. It has been assumed that almost half of Nepal's populations are at high risk and a quarter at moderate risk of rabies. It is estimated that around 30,000 cases in pets and more than 100 human rabies cases occur each year with the highest risk are in the Terai. Latent infections have been reported in dogs and cats. Very few patients take rabies immune globulin (post-exposure prophylaxis). Almost all of human cases (99%) of rabies are result of dog bites. Vaccinating 70% of dogs break rabies transmission cycle in an area at risk.

Dog bite

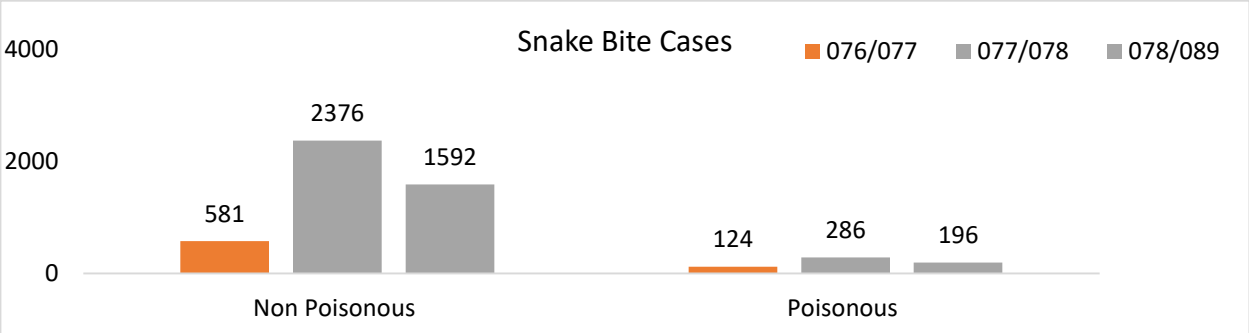
Dog bite cases in Province 1 is fluctuated, there is increase in number of dog bite cases in this FY 2078/079 to 6739 from 4993in FY 2077/078 where in 2076/077 there was 6229reported dog bite cases.

Figure 50Dog bite cases



Snakebite:
Snake bites are the major problem in the Terai districts of Province 1. Many death cases are reported every year due to snake bites. Poisonous snake bites — Twenty-one of the 79 species of snakes found in Nepal are poisonous (11 pit viper species, 5 krait species, 3 cobra species and 1 each coral and Russel's viper species).

Figure 51:Snake bite cases



Poisonous bites are less in comparison to non-poisonous bites but there has been decrease in poisonous bites to 196 in this FY 2078/079. Likewise,non-poisonous snake bites has been decreased in this FY from 2376 to 1592.

Table 22:Issues and recommendations

Issues	Actions to be taken	Responsibility
Proper awareness about animal bites	Collaborate with different local stakeholders	HD/HO/Palika
Training and Availability of ARV in all health care facilities	Provide regular supply and service at least to PHC level	HD/HO/Palika/ PHLMC
No sufficient & timely supply of anti-snake venom (ASV)	Adequate stock needs to be maintained in high-risk areas School awareness program to be conducted in the high-risk areas	EDCD

3.9 Non-Communicable Diseases and Mental Health

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

Table 23: NCDs and shared modifiable risk factors

NCD	Tobacco Use	Unhealthy diet	Physical inactivity	Harmful use of alcohol	Air pollution
Cardiovascular disease	✓	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓	
Cancer	✓	✓	✓	✓	✓
Chronic respiratory disease	✓				✓
Mental Disorders	✓		✓	✓	

The Burden of Non-Communicable diseases has been steadily rising in Nepal. The premature mortality due to NCDs has risen from 51% in 2010 to 71% in 2019. The proportional mortality of NCDs is ever increasing. CVD is responsible for 30% deaths, cancer 9%, diabetes 4%, chronic respiratory disease 10% and other NCDs 13%. Increasing life expectancy, demographic and epidemiological transition, rampant urbanization and change in the lifestyle all account to this rising burden of non-communicable diseases. The increasing disease burden is associated with decreasing quality of life, increase in DALYs and catastrophic health expenditures. A four-year analysis of National Health Accounts reported highest

healthcare spending was on NCDs at NPR37.73 billion. Out of Pocket expenditure by disease and health conditions was highest for NCDs with 31% OOP (National Health Accounts 2012/13 – 2015/16).

Multi-sectoral Action Plan for NCD

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

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

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

Strategic Approach for MSAP II

Vision

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

Goal

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

Specific objectives

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

Targets

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

Table 24: National Monitoring Framework for NCDs

Targets/Outcomes	Indicators	Data Source	Frequency of collection	National Target 2025	Current status
1. Premature mortality and morbidity			Baseline 2010		
1.1 25% relative reduction in the overall premature mortality from cardiovascular disease, cancer, diabetes or chronic respiratory diseases	Indicator 1: Unconditional probability of dying between ages of 30 and 70 from cardiovascular disease, cancer, diabetes or chronic respiratory diseases	CRVS	Base line 23.8 (2010) End line in 2025	17.9	21.8 (2016)
2. Behavioural Risk Factor					
2.1 At least 10% reduction in the harmful use of Alcohol (heavy episodic drinking)	Indicator 2: Age-standardized prevalence of heavy episodic drinking among adolescents and adults	Adolescent or school health survey, NCD STEPS Survey 2013	Base line 10.6 (2013) End line in 2025	9.5	21.8 (2019)
2.2 10% relative reduction in prevalence of in sufficient physical activities	Indicator 3: Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily	NCD STEPS survey 2013	Base line 3.5 (2013) End line in 2024	3.2	7.4 (2019)
2.3 30% relative reduction in prevalence of current tobacco use in persons aged over 15 years	Indicator 4: Prevalence of current tobacco use among adolescents. Indicator 5: Age Standardized prevalence of current tobacco use among persons aged 18+ years	NCD STEPS survey 2013	Baseline: 30.8 (2013) End Line in 2024	21.6	28.9 (2019)

Nepal PEN program

The Package of Essential Non-Communicable Diseases Program was developed on a risk-based approach to be implemented in a low resource setting in the Primary Health Care model. The Nepal PEN protocol I, II and concept note was developed and endorsed in June, 2016 and the program started in two pilot districts (Ilam and Kailali) on October, 2016. In addition, Nepal PEN protocol III and IV was endorsed and the program was scaled-up in the 8 districts (Palpa, Myagdi, Baglung, Achham, Bardiya, Surkhet, Makwanpur and Rautahat) for Fiscal Year 2073/74. This fiscal year, 2077/78, the PEN program has been expanded to all the 77 Districts of the Country. This issection has been conducting regular Monitoring and supervision on the Program Districts.

Mental Health

The Strategy for Mental Health was launched on the last fiscal year. This year, the piloting and endorsement of Module 5 was done on two Provinces (Karnali and Sudurpaschim). The revision of the Module 2 package to separate them into 2 trainings (for Medical Officers and other paramedics) is also being done. The Child and Adolescent Mental Health Training for Medical Officers, Paediatricians and General Practitioner was conducted in Lumbini, Karnali and Sudurpaschim Province this year and will be conducted in the remaining 4 Provinces in the coming year.

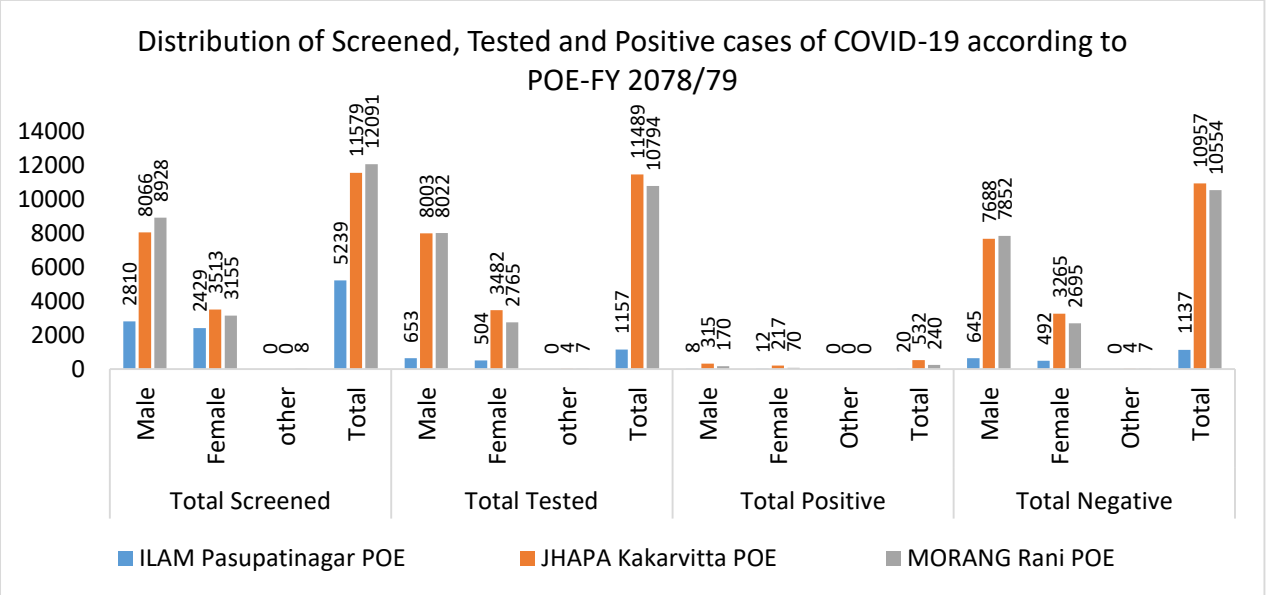
WHO Special Initiative for Mental Health (SIMH)

The WHO Special Initiative for Mental Health was proposed to achieve Universal Health Coverage in Mental Health. Nepal has been enrolled as 7th country on this initiative. Financial support was received from the Government of Norway/NORAD. A rapid situation assessment of mental health systems in Nepal by the University of Washington has been complete. A multi-year log frame-implementation plan has been developed in collaboration with wide range of stakeholders. The piloting of this initiative will be done in 14 Districts of the country; two from each Province. In province 1, this initiaves haves been piloted in Bhojpur and Panchthar districts.

3.10 Covid-19

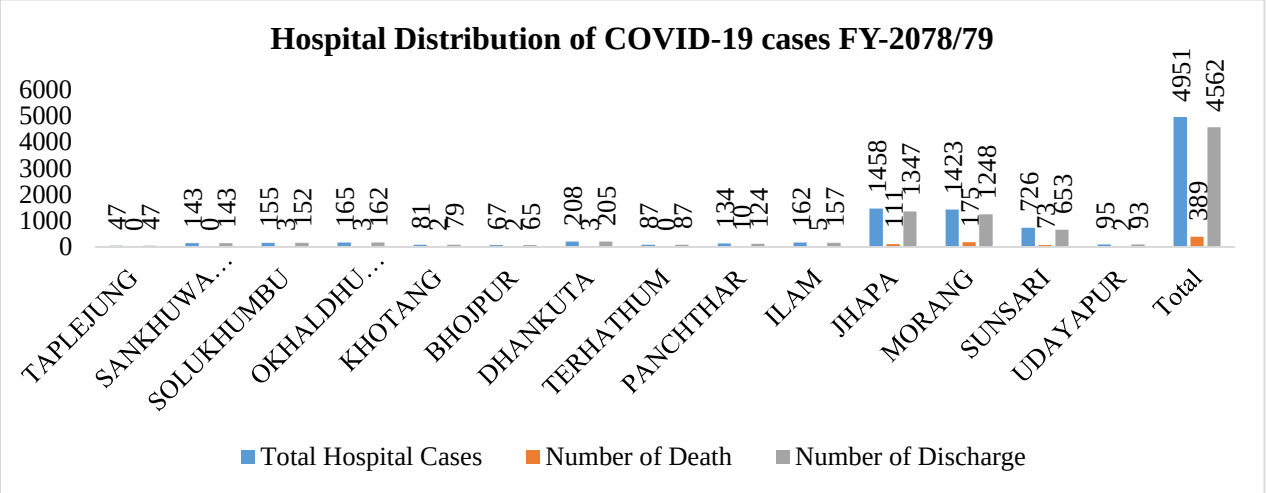
This section describes the epidemiological analysis of COVID 19 in the Province since the report of the confirmed cases of Corona Virus Disease 2019 (COVID 2020) till the end of the fiscal year 2079/80. The novel corona virus outbreak was first reported by the Chinese authorities to the World Health Organization on 31st December and Public Health Emergency of International Concern was declared on 30 January 2020 and a global pandemic on 11 March 2020 by WHO. In Nepal the first COVID-19 case was detected on 20th January 2020.There were no reported COVID 19 cases in the Province 1 till the month of April. From the Month of May almost all districts started reporting cases.

COVID-19 management in PoE



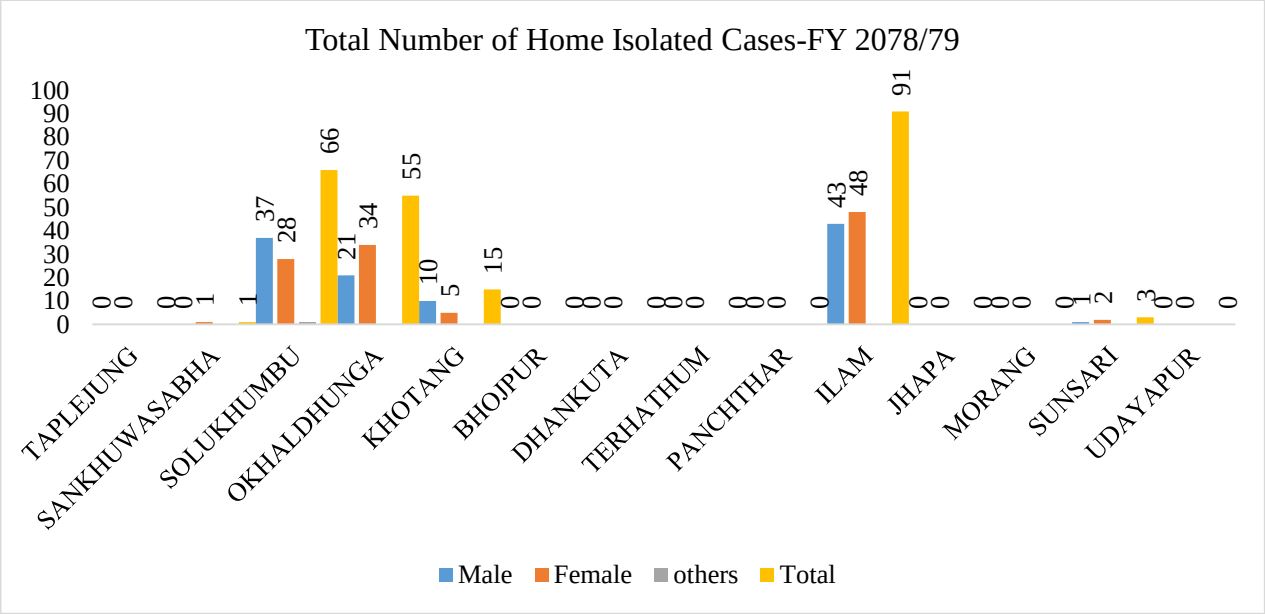
Among the COVID-19 cases screened and tested in major three point of entry of Province 1, highest number of cases were screened and tested on Kakarvitta PoE.

Hospital Distribution of Covid-19 Cases



Hospitals of Jhapa district accounted the greatest number of hospital cases and discharges, whereas Morang district accounted for the highest death cases i.e. 175, among hospitals in districts of Province 1 during the reporting period.

Home Isolation Cases



Highest number of COVID 19 cases managed in home isolation was reported from Ilam district whereas eight districts did not report any home isolated cases during the period.

Time Distribution

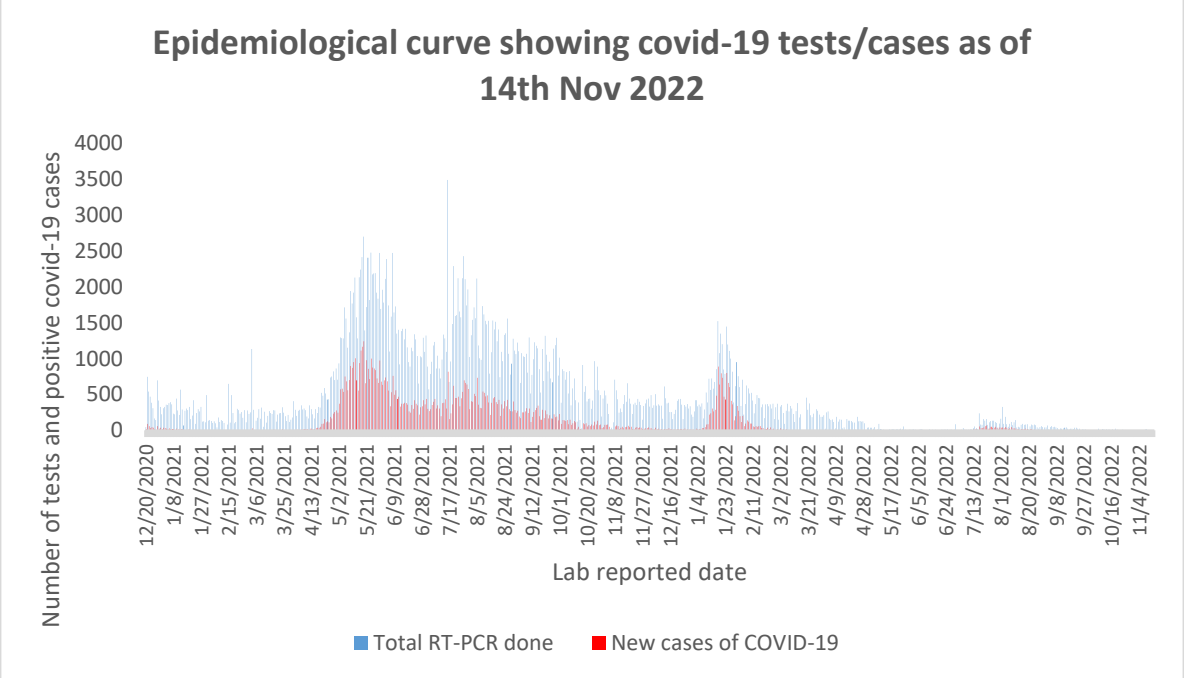
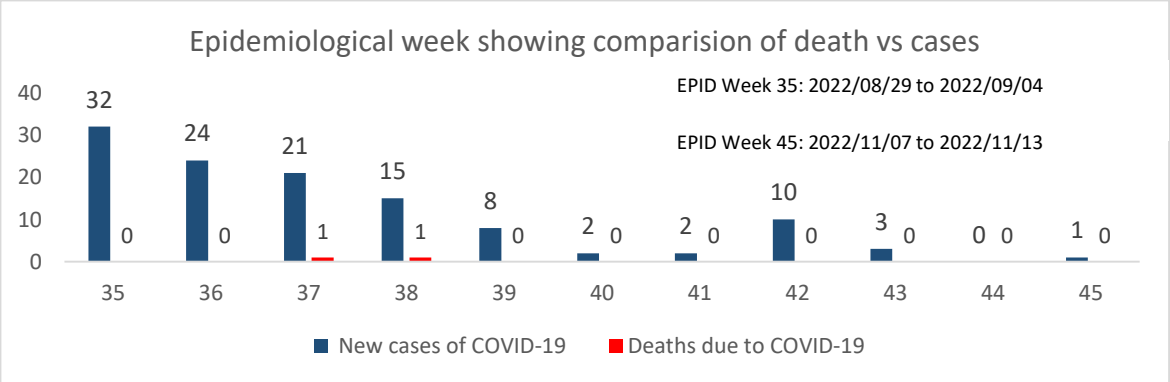
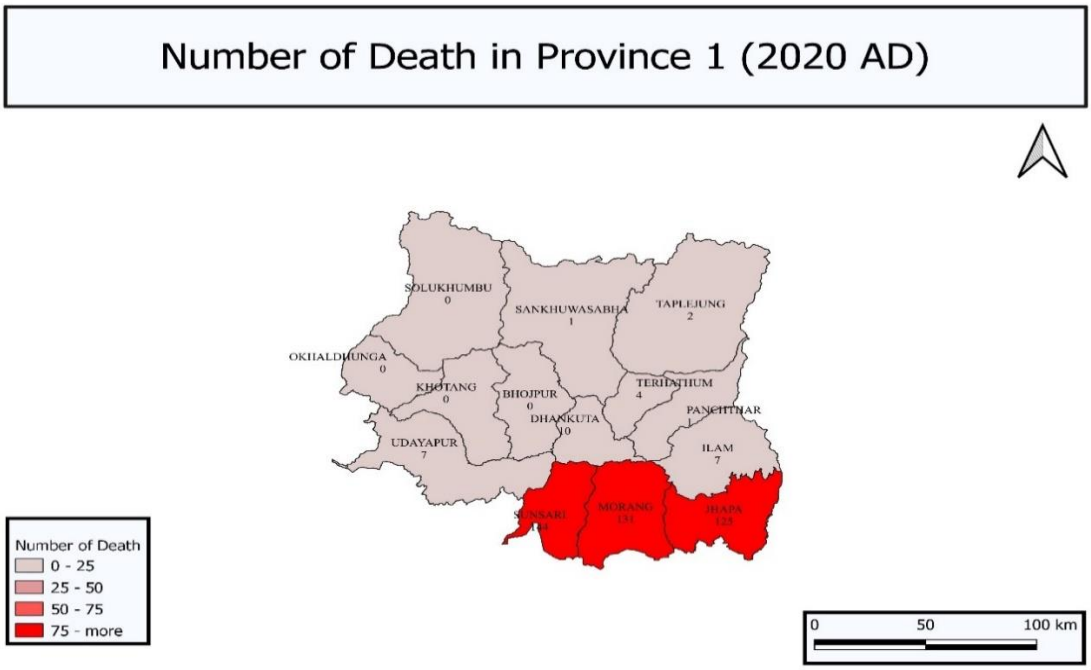
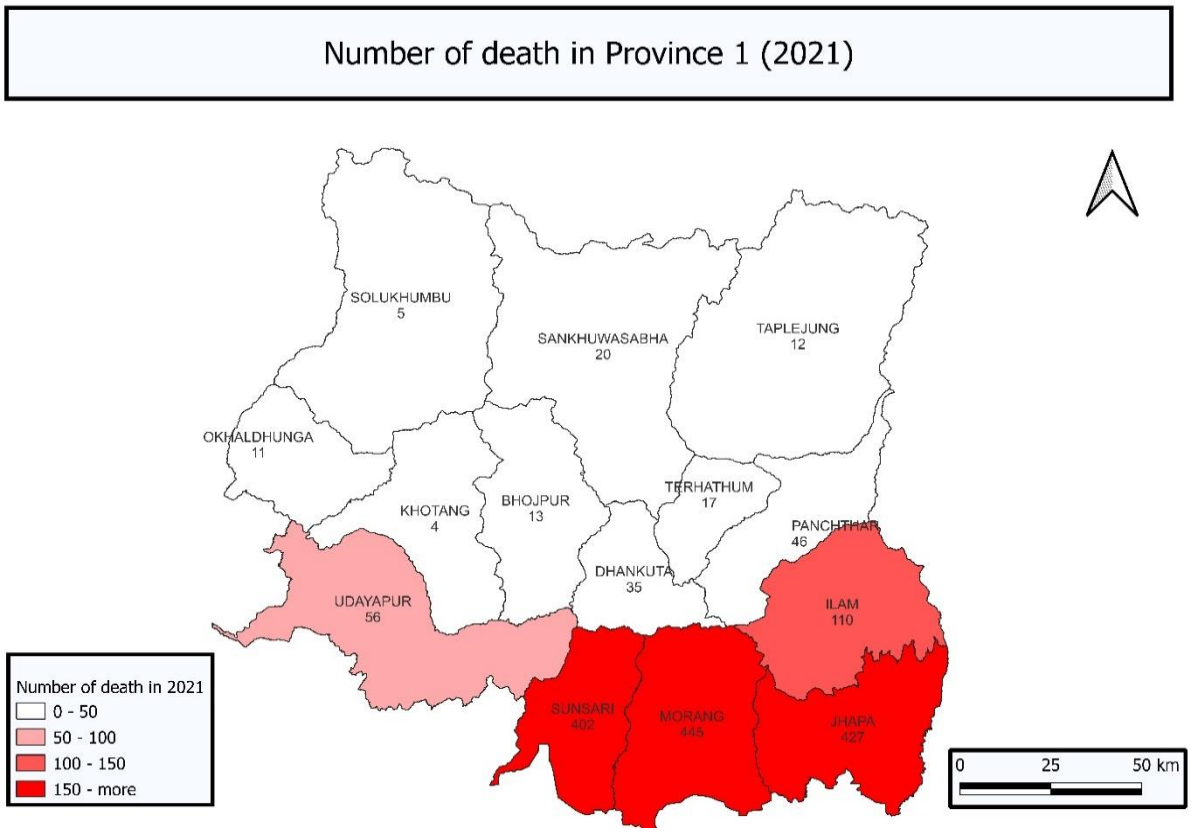


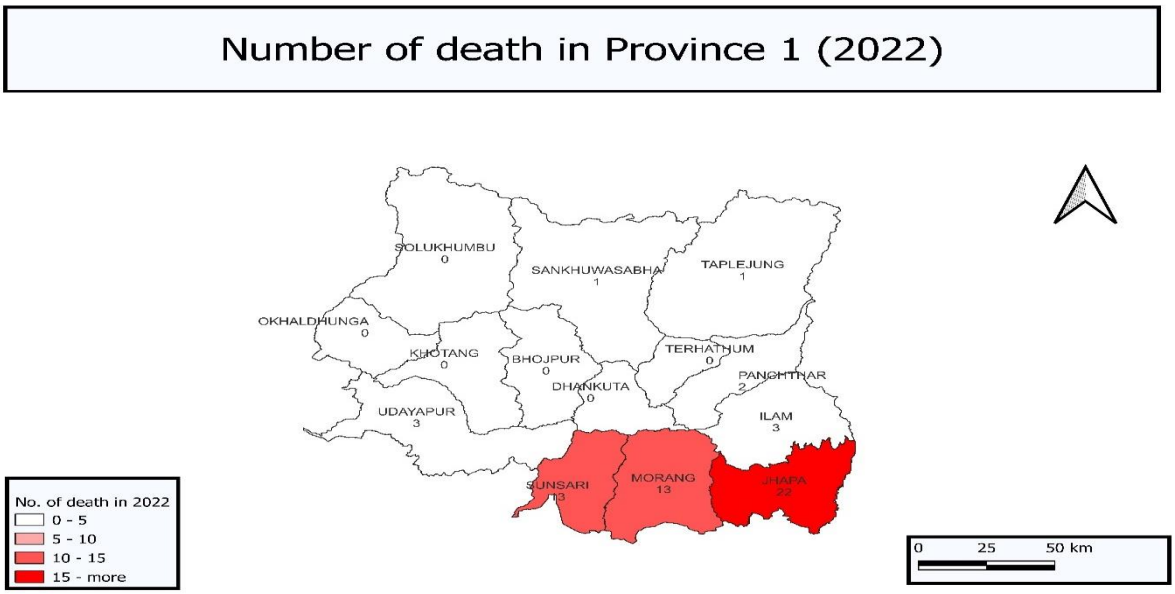
Figure1: Epidemiological curve showing covid-19 cases till date 14th Nov 2022, the cases were in increasing rate in 1st and 2nd wave



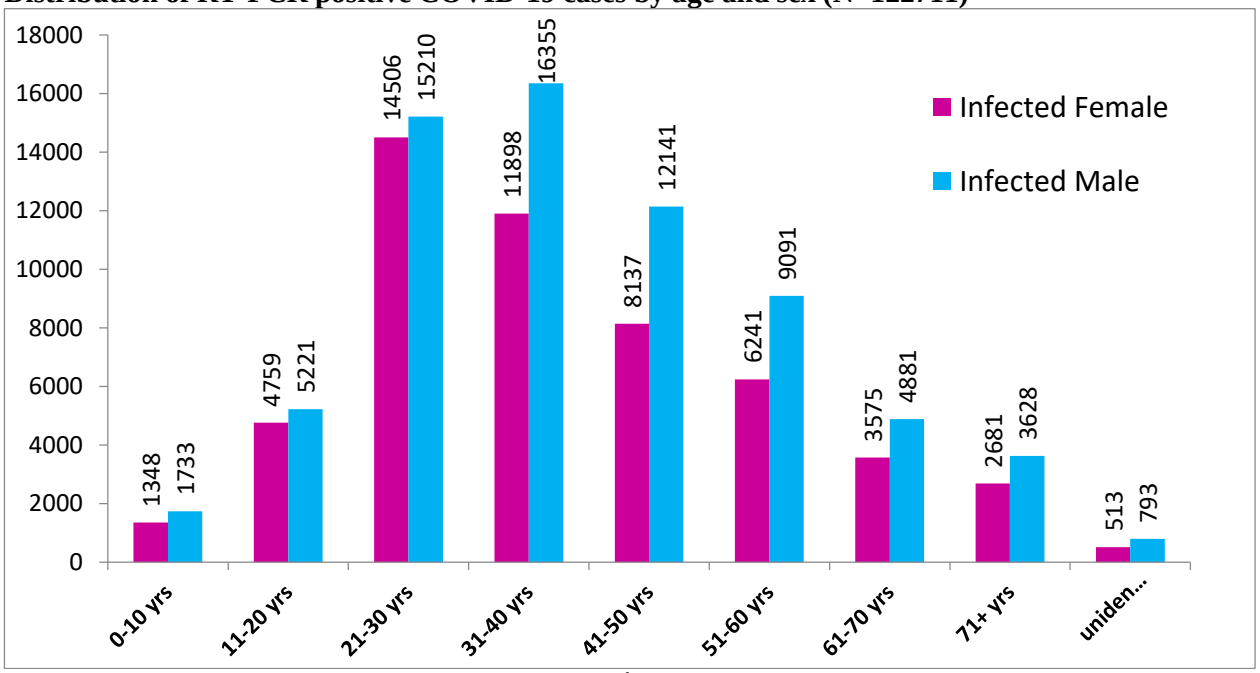
Death case analysis of Covid-19 cases



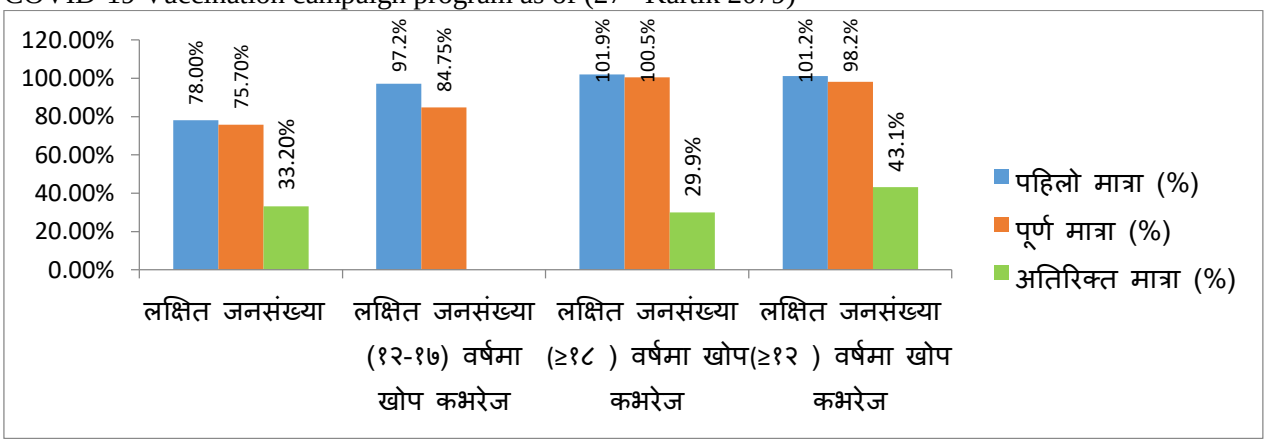




Distribution of RT-PCR positive COVID-19 cases by age and sex (N=122711)



COVID-19 Vaccination campaign program as of (27th Kartik 2079)



जिल्ला	लक्षितजनसंख्या			लक्षितजनसंख्या (१२-१७) वर्षमाखोपकभरेज		लक्षितजनसंख्या (≥१८) वर्षमाखोपकभरेज			लक्षितजनसंख्या (≥१२) वर्षमाखोपकभरेज		
	पहिलो मात्रा (%)	पूर्णमात्रा (%)	अतिरिक्त मात्रा (%)	पहिलो मात्रा (%)	पूर्ण मात्रा (%)	पहिलो मात्रा (%)	पूर्ण मात्रा (%)	अतिरिक्त मात्रा (%)	पहिलो मात्रा (%)	पूर्ण मात्रा (%)	अतिरिक्त मात्रा (%)
ताप्लेजुंग	77.6	79.7	15.3	75.7	55.44	95.1	101.5	18.8	92.3	94.8	18.2
संखुवासभा	77.0	82.0	42.9	107.1	97.94	101.3	110.6	66.1	102.2	108.7	56.9
सोलुखुम्बु	88.7	78.1	22.7	104.1	99.61	120.2	104.4	34.5	117.8	103.7	30.1
ओखलढुङ्गा	79.7	80.8	34.5	91.7	88.33	96.5	98.7	42.5	95.8	97.2	41.5
खोटाङ्ग	69.3	65.1	27.2	103.3	83.79	89.8	86.6	35.0	91.7	86.2	36.0
भोजपुर	71.3	79.6	42.5	103.2	93.44	94.1	108.8	60.4	95.5	106.5	56.9
धनकुटा	68.8	75.2	47.2	86.4	68.38	76.7	88.3	47.6	78.1	85.4	53.6
तेह्रथुम	76.3	74.5	35.5	82.0	69.19	88.4	88.2	45.2	87.5	85.4	40.7
पाँचथर	73.8	72.9	26.1	85.5	79.86	84.3	84.1	32.6	84.5	83.4	29.8
इलाम	79.4	69.6	25.7	80.4	68.09	94.2	83.0	31.7	92.2	80.8	29.8
झापा	79.6	86.7	44.1	107.8	109.88	110.3	121.3	40.1	109.9	119.7	60.9
मोरङ्ग	83.6	71.7	40.5	95.2	81.89	115.9	99.3	17.3	112.8	96.7	54.7
सुनसरी	72.2	74.1	19.3	90.1	72.96	95.6	101.5	16.8	94.8	97.3	25.3
उदयपुर	79.5	64.6	21.9	122.6	83.95	94.3	79.3	26.1	98.4	80.0	27.1
प्रदेश १ जम्मा	78.0	75.7	33.2	97.2	84.75	101.9	100.5	29.9	101.2	98.2	43.1

श्रोत: HMIS-DHIS2/ FWD

PART 4 – NURSING AND SOCIAL SECURITY

4.1 Female Community Health Volunteer (FCHV)

Background

The FCHVs act as a bridge between the government health services and community. They are the foundation of Nepal's community-based primary health care system and have made significant contributions to women's leadership and empowerment at the VDC level. Additionally, FCHVs play an important role in contributing to a variety of key public health programs, including family planning, maternal & newborn care, vitamin A supplementation/ de worming and immunization coverage. There is a total of 8697 FCHVs working in Province 1. The overall FCHVs program in the region is guided by the national policy and strategies i.e., revised FCHVs program strategy (2010) which provides strategic directions and critical approaches to ensure a strengthened regional and national program.

They are the frontline health resources who are supposed to provide necessary information and services on health and healthy behavior of mothers and community people for the promotion of safe motherhood, child health, family planning, and other community-based health services with the support of the trained health workers working at the below district level health facilities. FCHVs are selected by the Mothers Group for health in each ward with the support from other community leaders. They are provided training on basic primary health components.

The role of the FCHVs has been outlined as below-

- To act as voluntary health educators and promoters, community mobilizer, referral agents and community-based service providers in areas of health as per the trainings received.
- To promote the utilization of available health services and the adoption of preventive health practices among community members.
- To play a supportive role in linking the community with available PHC services and to continue to play an important role related to family planning, maternal/neonatal health, child health and selected infectious diseases at the community level.

Goal

The goal of FCHV program is to improve the health of local community people by promoting public health measures of health promotion and disease prevention. This includes imparting knowledge and skills for empowering women, increasing awareness on health-related issues and involving local institutions in promoting health care.

Objectives

FCHV program has the following objectives:

- Mobilize a pool of motivated volunteers to connect health programmes with communities and to provide community-based health services,
- Activate women to tackle common health problems by imparting relevant knowledge and skills;
- Increase community participation in improving health,
- Develop FCHVs as health motivators and
- Increase the demand of health care services among community people.

Major Activities

The major activities carried out under the FCHVs programme are mostly identical in all districts within the region. The following major activities were undertaken under the FCHVs programme during the reporting period:

- Celebration of FCHVs day
- Conducted FCHVs bi-annual program review
- Conducted FCHVs fund utilization training to VDC level fund management committee members in the selected districts.
- Provided reward for voluntary retirement to FCHVs through establishment of fund at district level with allocation of budget from MoSD.
- Basic and refresher training for old and new FCHVs was done respectively,
- Conducted Health Mothers Group meetings & its revitalization program.
- Mobilization of FCHVs in national campaigns- Vitamin A, de-worming, polio vaccination and newborn care including Chlorhexidine Navi Care Programmatic
- Dress allowance distributed to all FCHVs.

Analysis of Achievement

Table 25: District wise achievement of FCHVs

Unit	No. of Condoms Pieces Distribution	Pills Cycles Distribution	Pregnant Women given Iron Tablets	2-59 Months-Treated with ORS & Zinc	2-59 Months-Total cases ARI
Province 1	734715	101622	63860	87694	159889
TAPLEJUNG	16529	996	712	2590	5499
SANKHUWASABHA	15420	2132	704	2286	5847
SOLUKHUMBU	6242	1487	716	2275	3496
OKHALDHUNGA	19603	2564	781	5158	12002
KHOTANG	40329	4303	1644	4816	9489
BHOJPUR	39203	7624	2129	4304	9055
DHANKUTA	17892	5208	605	3014	6604
TERHATHUM	23299	1305	112	2951	5673
PANCHTHAR	46721	6206	1661	2065	9159
ILAM	57428	7828	1099	4701	9863
JHAPA	135600	23761	14938	13328	22710
MORANG	129421	17237	18182	17467	29077
SUNSARI	137718	12953	16647	16646	21248
UDAYAPUR	49310	8018	3930	6093	10167

Table 26:Issues and recommendations

Issues	Action to be taken	Responsibility
Low utilization of FCHV Fund	Strictly implementing guidelines and audit FCHV fund every year	FWD
Inadequate incentive and encouragement	Needs policy revision-Health mothers group meetings need to carry out on every month and provision of incentives for meeting. Explore for provision of Palika grant, linking with Saving and Credit activities- needs coordination between MoHP and MoFLD	FWD, MoHP, MoFLD
FCHV are not interested in farewell program	Rethink the farewell package Implement revised FCHV strategy (1st amendment 2076)	FWD

4.2 School Health Nurse Programme:

Introduction

A healthy child represents a healthy family, society, community and nation itself. So, the health of a child is very important. All of the health-related casual factors can be prevented through behavioural change. With this view school health nurse programme is being implemented in Province 1 community schools. The programme is led by nurses who provide promotive, preventive and curative health services. This aims to improve the health of school children, which is directly or indirectly associated with their physical and cognitive development, learning and academic performance.

The programme was initially launched in 14 districts of Province 1 with 14 School Health Nurses on fiscal year 2075\76 which turned out to be effective. Thus, the programme was expanded and further 131 schools were selected and over all 145 School Health Nurses have been working under this programme.

Objectives

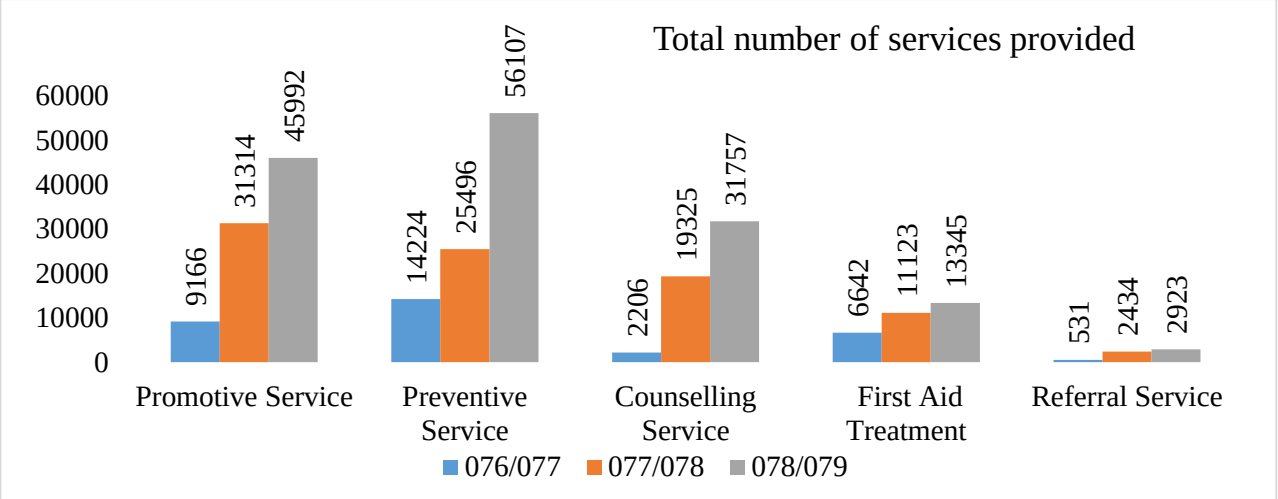
- To provide promotive, preventive and curative health services in school.
- To provide awareness about nutrition, personal hygiene and sanitation.
- To discourage junk food and encourage nutritious diet.
- To help promote health through counselling and screening services in different health issues such as sexual and reproductive health, mental health, oral and eye care.
- To encourage family and community to adopt healthy life style through different health programme.
- To conduct awareness programme involving students themselves regarding communicable and non –communicable diseases.

- To run other several programme related to school health.

Table 27: Total number of community schools in 14 districts of Province 1

Name of Districts	Number of Schools
Taplejung	9
Sankhuwasabha	10
Solukhumbu	8
Okhaldhunga	8
Khotang	10
Bhojpur	9
Dhankuta	7
Terathum	6
Panchthar	8
Illam	10
Jhapa	17
Morang	19
Sunsari	15
Udaypur	9

Figure 52: School Health Nurse Program



Major activities:
Major activities School Health Nurses are being provided are:

1. Promotive: Initiative and awareness regarding drug abuse, healthy lifestyles, personal hygiene and sanitation, nutritious diet, safe drinking water, menstrual hygiene, gender equality and equity, waste management, communicable and non-communicable diseases. Encouraging learning through child to child health programme. General health assessment.
2. Preventive: Immunization, Deworming, Iron and folic acid distribution, oral rehydration solutions.
3. Curative: First aid management like simple dressing, oral analgesics for pain (headache, stomach ache, dysmennorhea), fever management etc.
4. Counselling: pubertal changes, sexual and reproductive health, menstrual health.
5. Referral services: referral of deep cut injury, large open wound, adverse effect of immunization.

Additional activities
Additional activities that School Health Nurses are being provided are as follows:

- Provided nursing care to those who have been admitted in Covid ward of Koshi Covid Aspatal during Covid-19 pandemic
- Participated in Covid-19 vaccination programme
- Participated in Filariasis mass drug administration programme in different districts

Table 28: Implementation of School Health Nurse Program in Province 1

S.N	District	Local Level	School Name	Start Year
1	Morang	Ratuwamai Municipality	Saraswati Ma.Vi	2076
2	Morang	Biratnagar Metropolitan.	Satyanarayan Ma.Vi	2076
3	Morang	Dhanpalthan R.M	Sarada Ma.Vi	2076
4	Morang	Urlabari Municipality	Radhika Ma.Vi	2076
5	Morang	Biratnagar Metropolitan.	Mills Ma.Vi	2076
6	Morang	Kerabari R.M	Macchindra Ma.Vi	2076
7	Morang	Sunbarsi Municipality	Mangalsingh Ma.Vi	2076
8	Morang	Pathari Sanischare Municipality	Panchayat Ma.Vi	2076
9	Morang	Budiganga R.M	Naragram Ma.Vi	2076
10	Morang	Katahari R.M	Janapriya Ma.Vi	2076
11	Morang	Biratnagar Metropolitan.	Pokhariya Ma.Vi	2075
12	Morang	Sundarharaicha Municipality	Sukuna Ma.Vi	2076
13	Morang	Kanepokhari R.M	Janasewa Ma.Vi	2077
14	Morang	Letang Municipality	Santi Bhagwati Ma.Vi	2077
15	Morang	Miklajung R.M	Kalika Samudayik Ma.Vi	2077
16	Morang	Belbari R.M	Bhagwati Ma.Vi	2077
17	Morang	Jahada R.M	Durga Ma.Vi	2077
18	Morang	Gramthan R.M	Saraswati Ma.Vi	2076
19	Morang	Rangeli Municipality	Public Ma.Vi	2077
20	Sunsari	Barhakshetra Municipality	Saraswati Ma.Vi	2076
21	Sunsari	Dharan Sub-Metropolitan	Saraswati Ma.Vi	2076
22	Sunsari	Duhabi Municipality	Saraswati Ma.Vi	2076
23	Sunsari	Inaruwa Municipality	Sarada Ma.Vi	2076
24	Sunsari	Itahari Sub-Metropolitan	Sarada Ma.Vi	2076
25	Sunsari	Itahari Sub-Metropolitan	Rastrya Ma.Vi	2076
26	Sunsari	Harinagara R.M	Balkrishna Ma.Vi	2076
27	Sunsari	Barhakshetra Municipality	Basantaritu Ma.Vi	2076
28	Sunsari	Inaruwa Municipality	Bal Mandir Ma.Vi	2075
29	Sunsari	Ramdhuni Municipality	Adarsha Ma.Vi	2077
30	Sunsari	Bhokhara R.M	sarada Ma.vi	2077
31	Sunsari	Barju R.M	Shree Ma.Vi	2077
32	Sunsari	Debanjung R.M	Amarsingh Ma.Vi	2077
33	Sunsari	Gadi R.M	Shree Ma.Vi	2077
34	Sunsari	Koshi R.M	Rastrya Ma.Vi	2077
35	Jhapa	Damak Municipality	Himalaya Ma.Vi	2076
36	Jhapa	Haldibari R.M	Haldibari Ma.Vi	2076
37	Jhapa	Mechinagar Municipality	Sahid Dasrath Ma.Vi	2076
38	Jhapa	Birtamod Municipality	Devi Ma.Vi	2075
39	Jhapa	Birtamod Municipality	Durga Ma.Vi	2076
40	Jhapa	Gauradha Municipality	Janta Ma.Vi	2076
41	Jhapa	Arjundhara Municipality	Janta Ma.Vi	2076
42	Jhapa	Kankai Municipality	Kankai Ma.Vi	2076
43	Jhapa	Mechinagar Municipality	Dhulabari Ma.Vi	2076
44	Jhapa	Sivasatakshi Municipality	Rastrya Ramaniya Ma.Vi	2076
45	Jhapa	Kanchankabal R.M	Laxmi Ma.Vi	2076
46	Jhapa	Bhadrapur Municipality	Birendra Ma.Vi	2077
47	Jhapa	Budhasanti R.M	Budha Adarsha Ma.Vi	2077
48	Jhapa	Barhadashi R.M	Pasupati Ma.Vi	2077
49	Jhapa	Jhapa R.M	Janta Ma.Vi	2077
50	Jhapa	Gaurijung R.M	Gaurijung Ma.Vi	2077
51	Jhapa	Kamal R.M	Mangalmaya Ma.Vi	2077
52	Taplejung	Mikwakhola R.M	Sawa Ma.Vi	2076
53	Taplejung	Phungling Municipality	Bhanujan Ma.Vi	2076

S.N	District	Local Level	School Name	Start Year
54	Taplejung	Pathibhara Yanwarak R.M	Thechambu Ma.Vi	2075
55	Taplejung	Sirijangha R.M	Sinam Ma.Vi	2077
56	Taplejung	Sidingwa R.M	Nilgiri Ma.Vi	2077
57	Taplejung	Maiwakhola R.M	Nayayani Ma.Vi	2077
58	Taplejung	Meringden R.M	Tribhuwan Ma.Vi	2077
59	Taplejung	Phaktanglung R.M	Siwa Ma.Vi	2077
60	Taplejung	Aathrai Tribeni R.M	Saraswati Namuna Ma.Vi	2077
61	Sankhuwasabha	Chainpur Municipality	Saraswati Ma.Vi	2075
62	Sankhuwasabha	Makalu R.M	Himalaya Ma.Vi	2076
63	Sankhuwasabha	Madi Municipality	Madi Ma.Vi	2076
64	Sankhuwasabha	Khadbari Municipality	Himalaya Ma.Vi	2077
65	Sankhuwasabha	Silichong R.M	Kalikaka Ma.Vi	2077
66	Sankhuwasabha	Sabhapokhari R.M	Janajyoti Ma.Vi	2077
67	Sankhuwasabha	Bhotkhola R.M	Arunadaya Ma.Vi	2077
68	Sankhuwasabha	Pachkhappan Municipality	Bana Ma.Vi	2077
69	Sankhuwasabha	Dharmadevi Municipality	Rameshor Ma.Vi	2077
70	Sankhuwasabha	Chichila R.M	Dharmadevi Ma.Vi	2077
71	Solukhumbu	Solududhkunda Municipality	Janajagriti Ma.Vi	2075
72	Solukhumbu	Mahakulung R.M	Gudel Ma.Vi	2077
73	Solukhumbu	Mapya Dudhkoshi R.M	Sagarmatha Ma.Vi	2077
74	Solukhumbu	Likhu Pike R.M	Budha Ma.Vi	2077
75	Solukhumbu	Sotang R.M	Birendra Jyoti Ma.Vi	2076
76	Solukhumbu	Nechha Salyan R.M	Kedar ma.Vi	2077
77	Solukhumbu	Thulung Dudhkoshi R.M	Janakalyan Ma.Vi	2077
78	Solukhumbu	Khumbu Pasanglahmu R.M	Khumjung Ma.Vi	2077
79	Bhojpur	Tyamkemaiyum R.M	Timbba Ma.Vi	2075
80	Bhojpur	Salpasilichho R.M	Birendra Ma.Vi	2076
81	Bhojpur	Bhojpur Municipality	Yasodhara Ma.Vi	2076
82	Bhojpur	Ramprasad Rai R.M	Singheshwori Ma.Vi	2077
83	Bhojpur	Pauwadungma R.M	Panchakanya Ma.Vi	2077
84	Bhojpur	Aamchok R.M	Sikxya Xyamakanya Ma.Vi	2077
85	Bhojpur	Arun R.M	Mahendrodaya ma.Vi	2077
86	Bhojpur	Sadananda Municipality	Sarada Ma.Vi	2077
87	Bhojpur	Hatuwagadi R.M	Sagarmatha Ma.Vi	2077
88	Dhankuta	Mahalaxmi Municipality	Arunadaya Ma.Vi	2075
89	Dhankuta	Dhankuta Municipality	Hile Ma.Vi	2077
90	Dhankuta	Pakhribash Municipality	Annapurna Ma.Vi	2076
91	Dhankuta	Sahidbhumi R.M	Chintang Ma.Vi	2076
92	Dhankuta	Sagurigadi R.M	Ramnabami Ma.Vi	2077
93	Dhankuta	Chatthar Jorpati R.M	Saraswati Ma.Vi	2077
94	Dhankuta	Chubise R.M	Punya Ma.Vi	2077
95	Udaypur	Triyuga Municipality	Balmandir Ma.Vi	2075
96	Udaypur	Katari Municipality	Janta Ma.Vi	2076
97	Udaypur	Chudandigadi Municipality	Jyoti Ma.Vi	2076
98	Udaypur	Triyuga Municipality	Triyuga Ma.Vi	2076
99	Udaypur	Udaypurgadi R.M	Dhuwajan Ma.Vi	2076
100	Udaypur	Limchungbung R.M	Mahendra Ma.Vi	2077
101	Udaypur	Rautamai R.M	Shree Ma.Vi	2077
102	Udaypur	Belka R.M	Saptakausika MaVi	2077
103	Udaypur	Tapli R.M	Shree Ma.Vi	2077
104	Okhaldhunga	Likhu R.M	Janajyoti Ma.Vi	2075
105	Okhaldhunga	Champadevi R.M	Golmadevi Ma.Vi	2076
106	Okhaldhunga	Sidhicharan Municipality	Rumjatar Ma.Vi	2076
107	Okhaldhunga	Sunkoshi R.M	Kutunje Ma.Vi	2077
108	Okhaldhunga	Molung R.M	Saraswati Ma.Vi	2077

S.N	District	Local Level	School Name	Start Year
109	Okhaldhunga	Manebhanjyang R.M	Harkapur Ma.Vi	2077
110	Okhaldhunga	Chisankhugadi R.M	Saraswati Ma.Vi	2077
111	Okhaldhunga	Khijiidemba R.M	Kundali Ma.Vi	2077
112	Khotang	Kepilasgadi R.M	Rastrya Ma.Vi	2075
113	Khotang	Diktel Rupakot Municipality	Saraswati Ma.Vi	2076
114	Khotang	Khotehang R.M	Simpani Ma.Vi	2077
115	Khotang	Jantedhunga R.M	Chisapani Ma.Vi	2076
116	Khotang	Halesi Tuwachung Municipality	Saraswati Ma.Vi	2077
117	Khotang	Rababesi R.M	Dharapani Ma.Vi	2077
118	Khotang	Barhapokhari R.M	Sankheswori Ma.Vi	2077
119	Khotang	Aiselukharka R.M	Tribhuwan Ma.Vi	2077
120	Khotang	Diprung Chuichuma R.M	Mahendrodaya ma.Vi	2077
121	Khotang	Sakela R.M	Sakela Ma.Vi	2077
122	Terhathum	Athrai R.M	Pokhari Ma.Vi	2076
123	Terhathum	Laligurash Municipality	Basanta Ma.Vi	2075
124	Terhathum	Myanglung Municipality	Kalika Ma.Vi	2077
125	Terhathum	Menchhayayem R.M	Gaukhuri Ma.Vi	2077
126	Terhathum	Chathhar R.M	Saraswati Ma.Vi	2076
127	Terhathum	Phedap R.M	Ishibu Ma.Vi	2077
128	Panchthar	Tumwewa R.M	Indreni Ma.Vi	2076
129	Panchthar	Yangwarak R.M	Ganesh Ma.Vi	2075
130	Panchthar	Kummayak R.M	Prithivi Ma.Vi	2076
131	Panchthar	Hilihang R.M	Singhapur Pasupati Ma.Vi	2077
132	Panchthar	Miklajung R.M	Durga Ma.Vi	2077
133	Panchthar	Phidim Municipality	Phidim Ma.Vi	2077
134	Panchthar	Phalelung R.M	Kalika Ma.Vi	2077
135	Panchthar	Phalgunanda R.M	Jayanarayan Adharsha Ma.Vi	2077
136	Illam	Mai Jogmai R.M	Amarkalyan Ma.Vi	2076
137	Illam	Mai Municipality	Kankai Ma.Vi	2076
138	Illam	Chulachuli R.M	Janata Ma.Vi	2076
139	Illam	Deumai Municipality	Bhanubhakta Ma.Vi	2076
140	Illam	Rong R.M	Saraswati Ma.Vi	2077
141	Illam	Phakphokthum R.M	Singhadevi Ma.Vi	2077
142	Illam	Suryodaya Municipality	Janak Ma.vi	2077
143	Illam	Sandakpur R.M	Saraswati Ma.Vi	2077
144	Illam	Mangsebung R.M	Chisapani Ma.Vi	2077
145	Illam	Illam Municipality	Adarsha Ma.Vi	2075

PART 5 – CURATIVE SERVICES

Background:

The Government of Nepal is committed to improving the health status of rural and urban people by delivering high quality services. The policy aims to provide prompt diagnosis and treatment, and to refer cases from PHCCs and health posts to hospitals.

In December 2006 the Government began providing essential health care services (Emergency and inpatient services) free of charge to destitute, poor, disabled, senior citizens, FCHVs, victims of gender violence and others in up to 25 bedded hospitals and PHCCs and for all citizens at health posts in October 2007. The constitution of Nepal, 2015 ensures that every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services. Provincial Government ensures the delivery of health services to the people through Tertiary, Secondary and Primary Hospitals.

In line with the Sustainable Development Goal 3: Ensure healthy lives and promote well-beings for all at all ages, Nepal aims to achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

Table 29: HEALTH SERVICE SITES

Types	Number	Remarks
Primary Hospital (Palika level)	27	
Provincial Hospital/ Secondary A Hospital	14	District Hospital, Trauma center
Tertiary Level Hospital	1	Koshi Hospital
Teaching Hospitals	2	Nobel/Birat Medical college
Academy	1	BPKIHS
Private/ Other General Hospital	100	

5.1 MAJOR ACTIVITIES AND ACHIEVEMENTS IN THE FISCAL YEAR 2078/079

Curative health services were provided through all levels of hospitals including INGO and NGO operated hospitals, private hospitals, teaching hospitals and nursing homes. Analysis of major achievements is done on various areas as mentioned below:

Minimum Service Standards for Hospitals

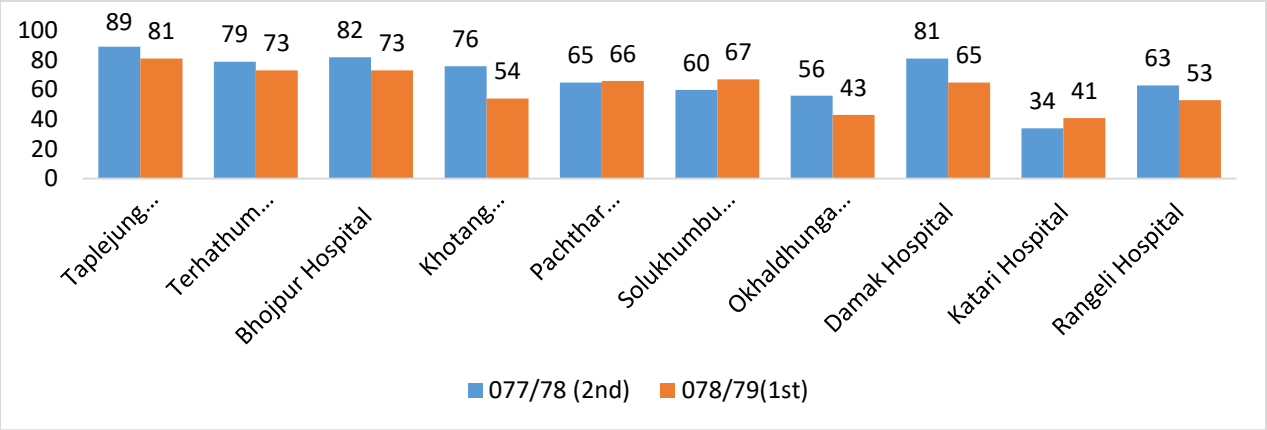
Minimum Service Standards (MSS) for hospitals is the service readiness and availability of tool for optimal requirement of the hospitals to provide minimum services that are expected from them. This tool entails for preparation of service provision and elements of service utilization that are deterministic towards functionality of hospital to enable working environment for providers and provide resources for quality health service provision. MSS for hospitals reflect the optimally needed minimum criteria for services to be provide but is not an "ideal" list of the maximum standards. There are all together 5 sets of MSS Tools including Health Post MSS (Basic Health Care Centre), Primary Hospital MSS (5,10,15 Beds Hospital), Secondary A Level (25-50 Bed General Hospital), Secondary B Level (100-300 Bed General Hospital) and Tertiary Level (Specialized Hospital). The revised MSS tool has been organized in three major sections: Governance and Management (20% Weightage), Clinical Service Management (40% Weightage) and Hospital Support Service Management (20% Weightage). It has been prepared in the form of checklist that thrives for the preparedness and utilization that are fundamental to establish services towards quality. The total standards and Score that is used to measure the Service Standard varies according to the respective tools. This MSS Score for hospitals measures the existing situation and enables to identify the gap areas that are to be addressed through the development of the actions plan that demands both technical and financial inputs and managerial commitments.

Table 30: MSS Tools Implemented Hospitals

MSS Tools	Name of Hospitals	Ownership
Primary Level Hospital MSS Tools	Rangeli Hospital, Morang, Damak Hospital, Jhapa Katari Hospital, Udaypur	Local Government Hospitals
Primary Level Hospital MSS Tools	District Hospital, Taplejung, Panchthar, Terhathum, Dhankuta, Bhojpur, Khotang, Okhaldhunga, Solukhumbhu	Provincial Hospitals
Secondary A Level Hospitals	District Hospital, Sunsari, Udaypur, Ilam,	Provincial Hospital

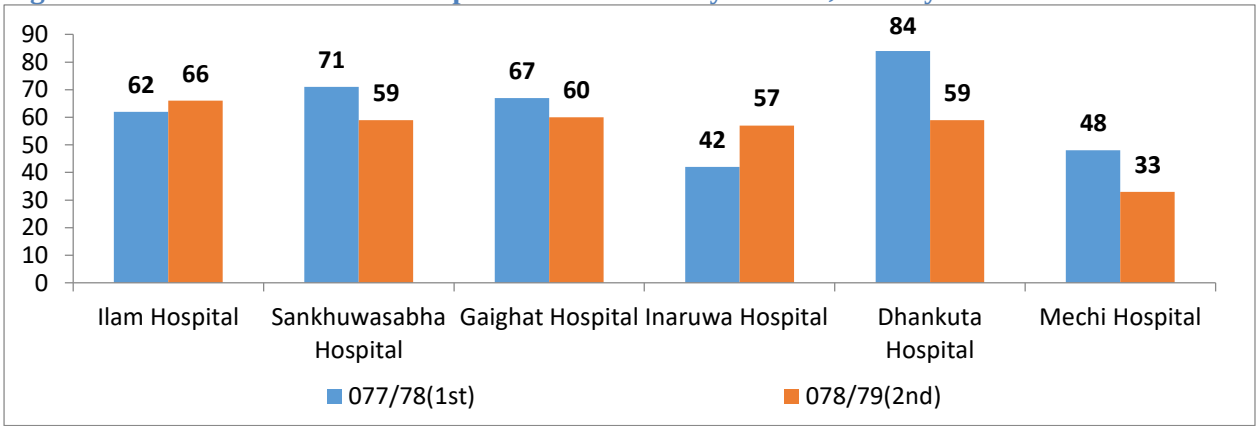
MSS Tools	Name of Hospitals	Ownership
MSS Tools	Sankhuwasabha, Madan Bhandari Hospital & Trauma Center, Morang	
Tertiary Level Hospital MSS Tools	Koshi Hospital, Biratnagar, Morang BPKIHS, Dharan	Federal Hospital

Figure 53: MSS Score Trend of Hospitals used Primary Level Hospital Tools, Fiscal Year 2077/078 2078/079



MSS score trend shows majority of score in decreasing trend, this is due to low number of HR. Among the Primary Hospital MSS tools, Taplejung hospital has highest MSS score i.e., 81% which is followed by Bhojpur Hospital and Terahthum Hospital. Katari Hospital has lowest MSS score i.e., 41%.

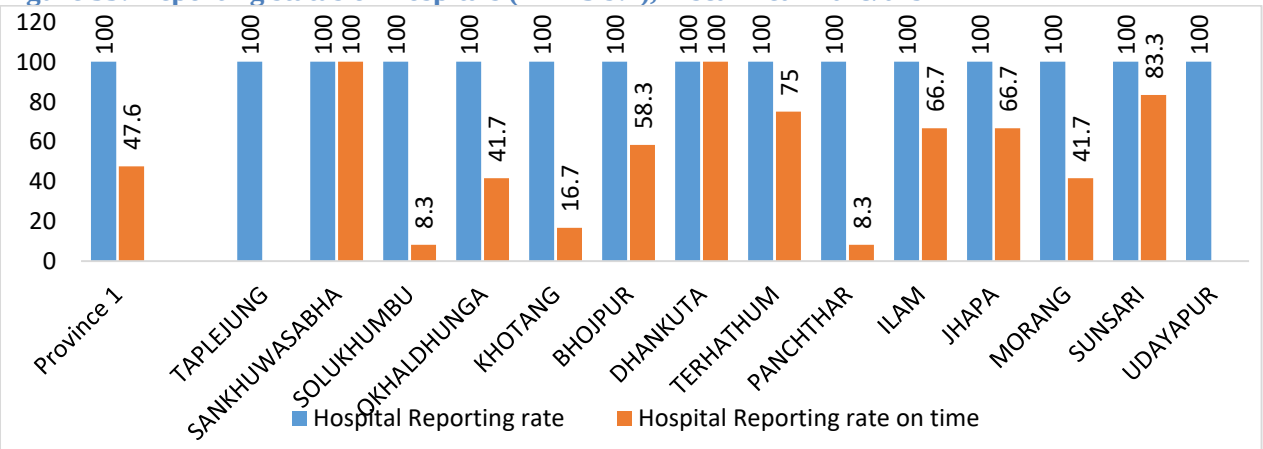
Figure 54: MSS Score Trend of Hospitals used Secondary A Level, Fiscal year 2077/078 & 2078/079



Due to less HR, score is in decreasing trend. Ilam Hospital has highest MSS score of 66% which is followed by Gaighat Hospital 60%. Mechi Hospital has only 33% MSS score.

Reporting Situation

Figure 55: Reporting status of Hospitals (HMIS 9.4), Fiscal Year 2078/079

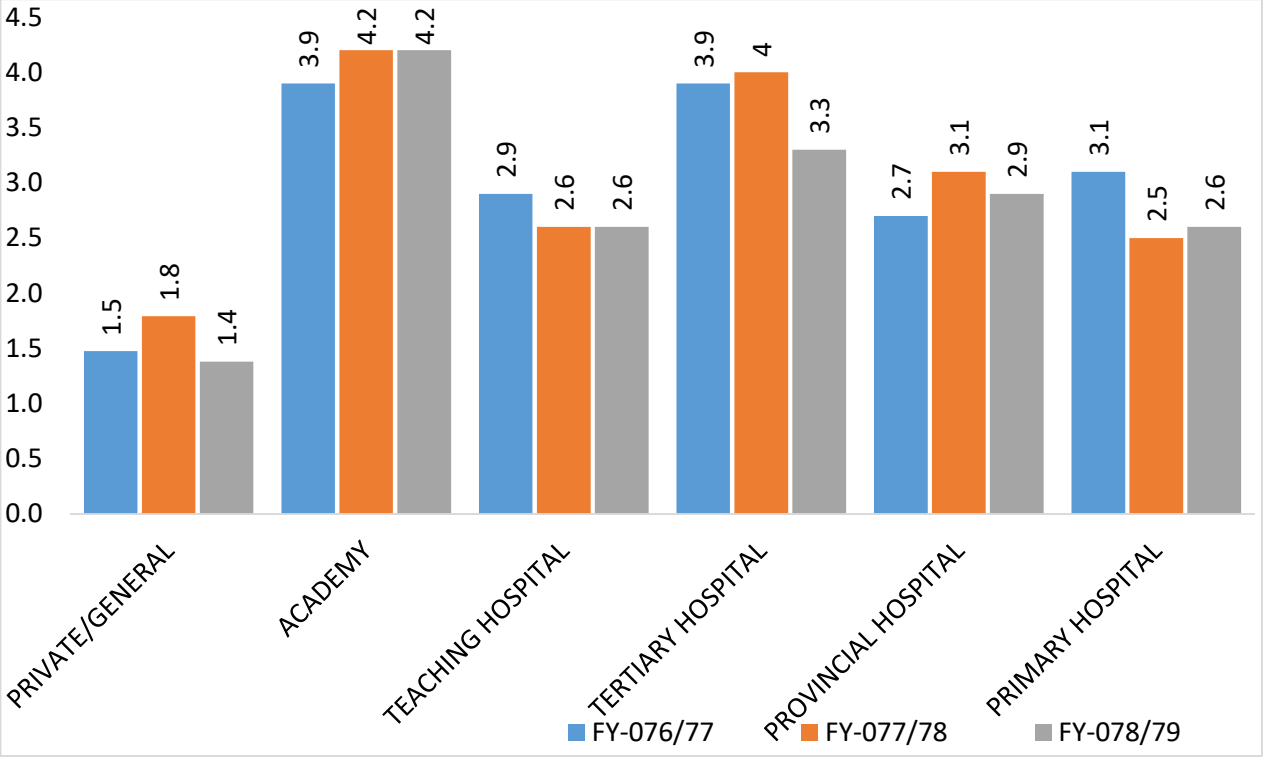


All the Government Hospitals and teaching hospitals in Province 1 reported in HMIS 9.4. More than 1/4thof the Private/Other General Hospitals did not report in HMIS 9.4. Efficacy of the plan and policies for quality health services depends upon the accuracy of information available. Hence, there is high need for formulation of strategies for encouraging the non-reporting hospitals to report in HMIS 9.4.

5.2 Inpatient Services

According to last 3 fiscal years trend shows decrease in average length of stay in ProvincialHospital, Tertiary level Hospital, Private/General Hospital. While increase in average length of stay in Primary Hospital. Similarly, neutral in Academy and Teaching Hospital.

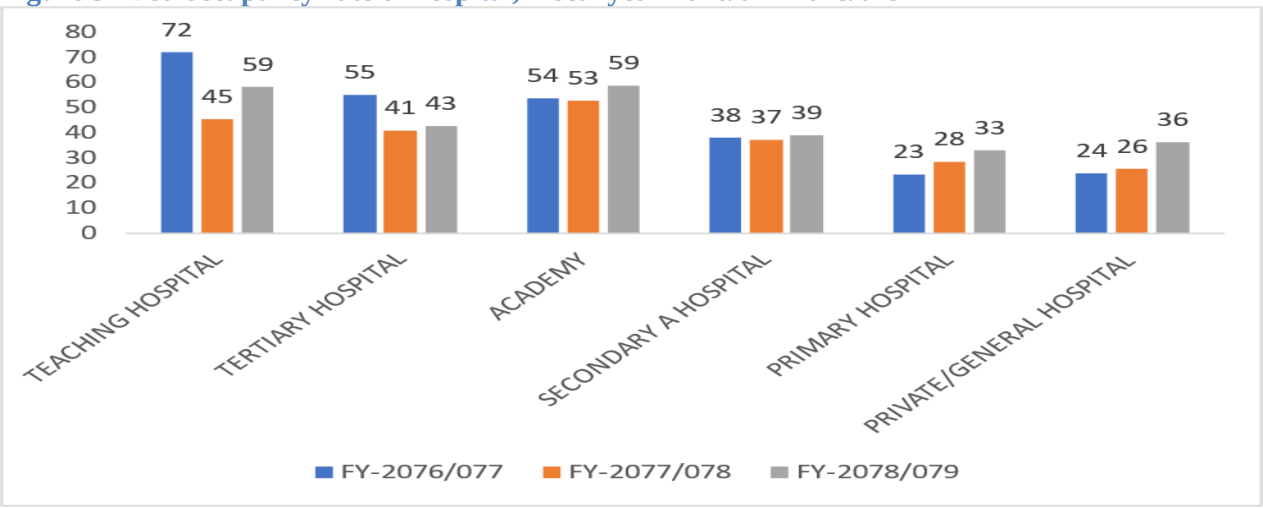
Figure 56 Average length of stay in hospital, Fiscal Year 2076/077-2078/079



Bed Occupancy Rate

Bed occupancy rate trend shows increased in Secondary hospitals and private/general hospital. while bed occupancy rate trend shows decrease in other hospital.

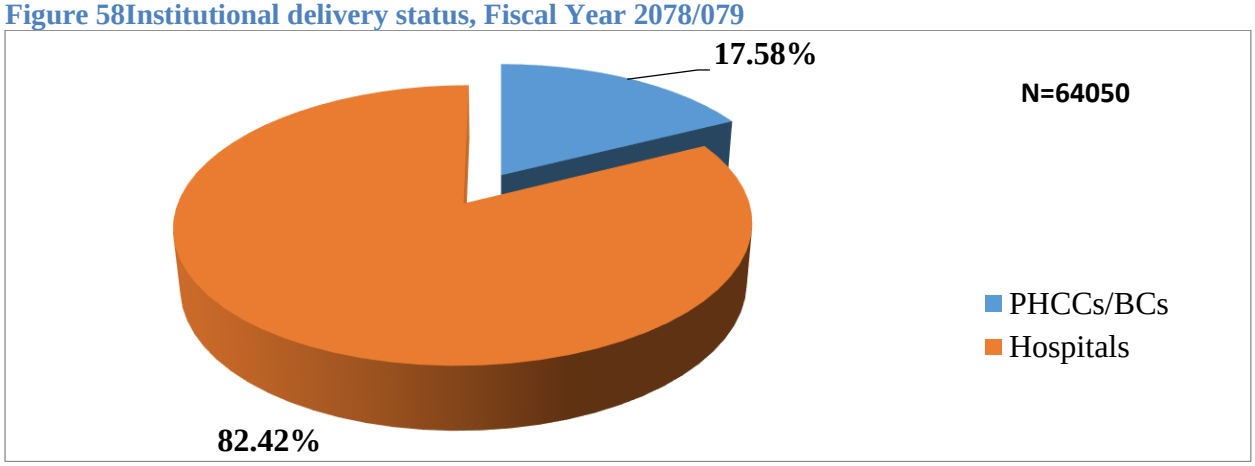
Figure 57 Bed occupancy rate of hospital, Fiscal year 2076/077-2078/079



Among the bed occupancy rate of hospital, in 3 years data we can identify the increasing trend comparing to previous year in all types of hospital.

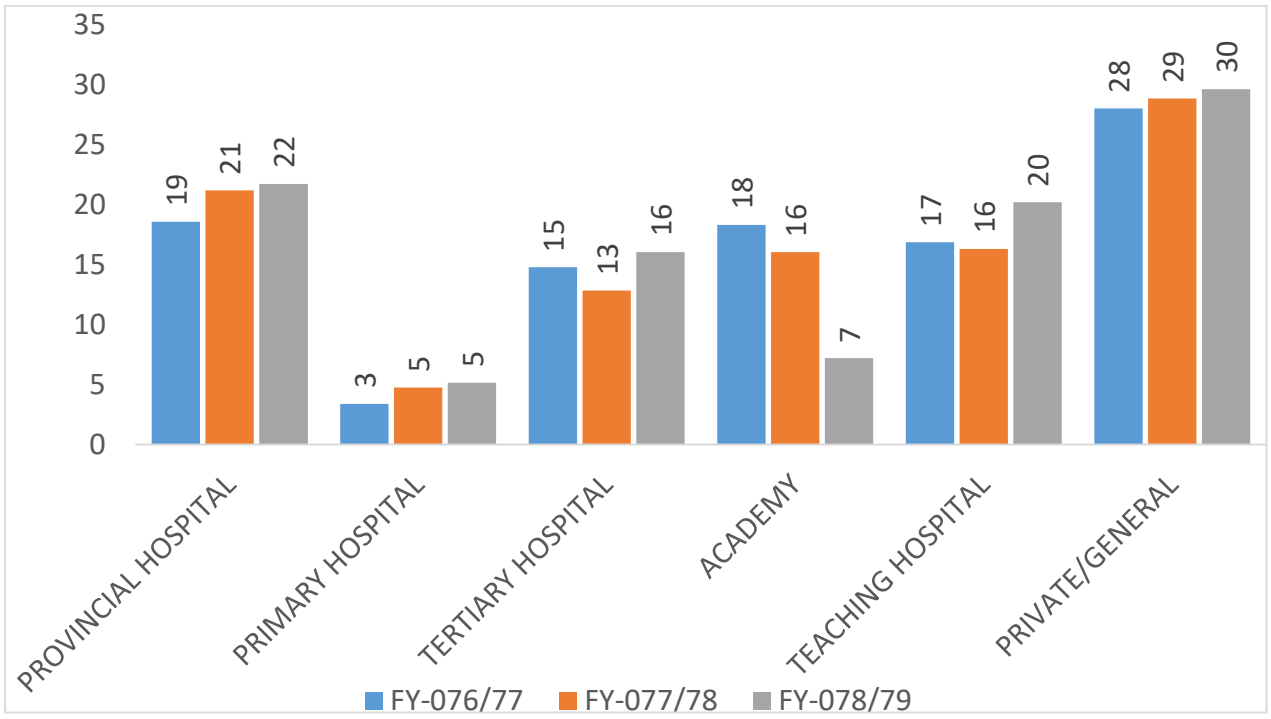
5.3 Maternity Services Indicators

Figure 58Institutional delivery status, Fiscal Year 2078/079



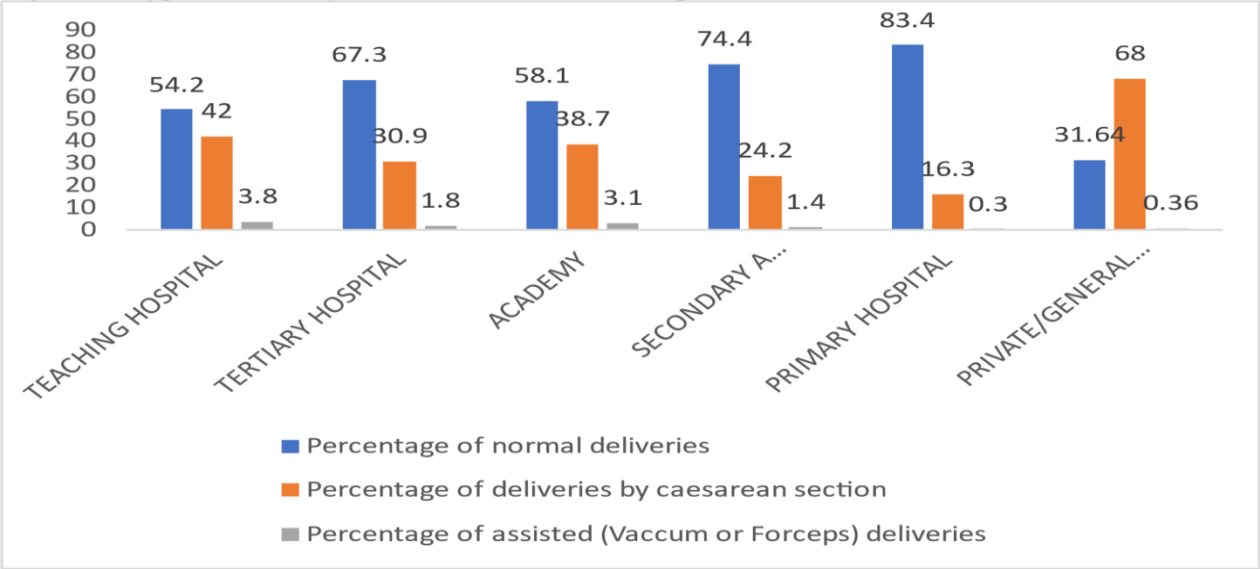
Among the total institutional delivery in Province 1, majority (82.42%) of the institutional delivery occurred in hospitals while only 17.58% occurred in PHCCs/BCs. This data shows the need for strategical planning not just increasing the number of birthing centres. Birthing centres should be established only in the places where there is no/limited access to other birthing facilities. Moreover, there is need for strengthening and well equipping the existing birthing centres that is functioning well.

Figure 59 Institutional delivery status in different hospitals, Fiscal Year 2078/079



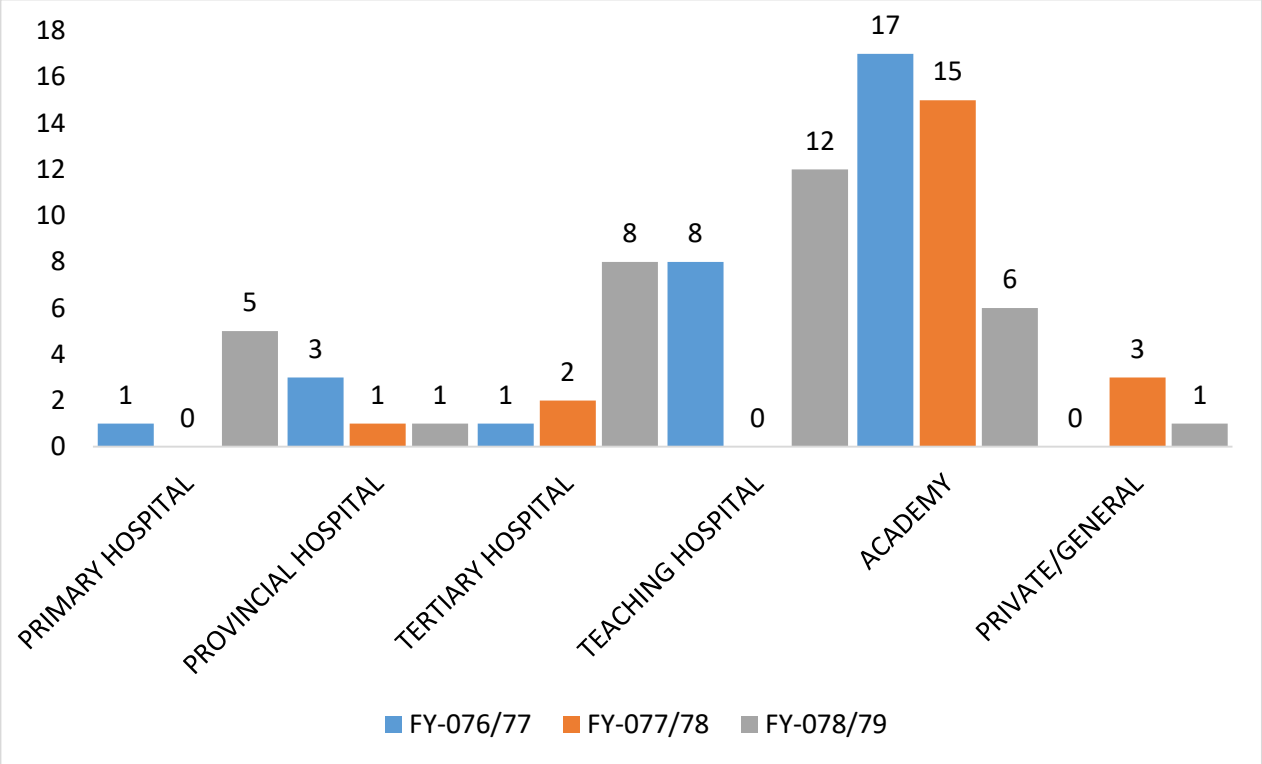
Among the institutional deliveries in hospitals, highest number of deliveries occurred in Private/General hospital i.e. 30% followed by provincial hospitals i.e., 22% while Primary hospitals has only 5%. Other hospitals have similar in number of deliveries. Low number of deliveries occurred in district level hospitals which could be due to interruption/lack of CEONC services and increased consumer demand for specialty services. Hence there is need for strengthening delivery service and continuity of CEONC services in district level hospitals.

Figure 60 Types of delivery conducted in different hospitals, Fiscal Year 2078/079



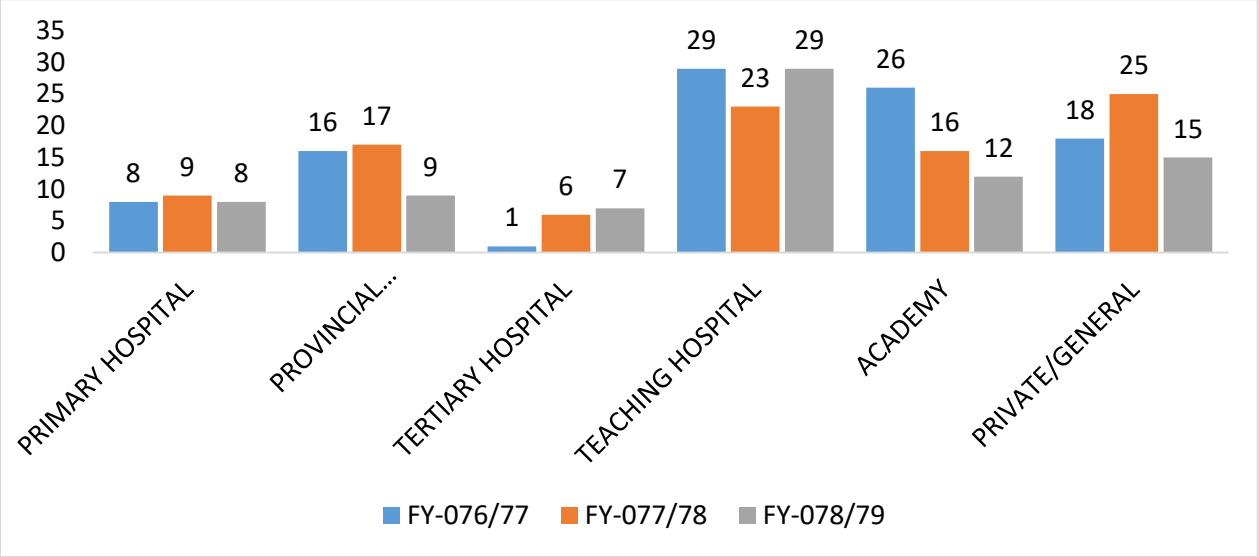
Among the different level of hospitals in Province 1, percentage of normal deliveries is higher than Caesarean section in government hospitals, teaching hospitals and academy. Percentage of Caesarean section is high in Private/General Hospital. According to WHO, C/S rate needs to between 5-10%, C/S rate of >10% does not reduce maternal mortality rate and >15% increases maternal mortality rate. Globally also the C/S rate is 21.1% which is higher than the recommended rate of WHO.

Figure 61 Maternal death trend in different hospitals, Fiscal Year 2076-77/2077-78/2078-79



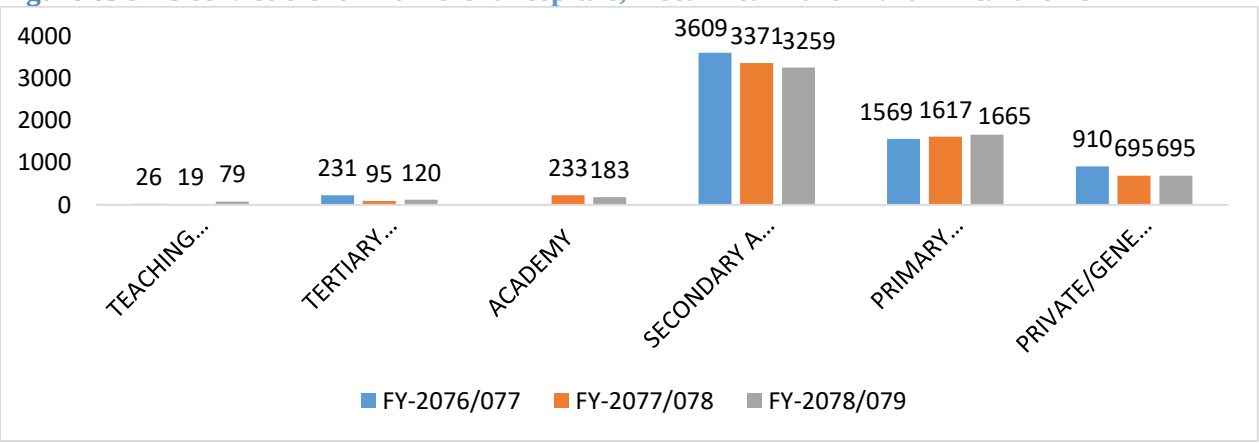
Last two fiscal years data shows the number of maternal death high in Academy Hospital and the number of maternal deaths has increased as compared to previous fiscal year. Maternal deaths could be high in teaching hospital due to high referrals and complicated cases being received. In this fiscal year, Maternal Death is low in academy comparision to teaching hospital. Primary hospital has increased from zero to five in this fiscal year.

Figure 62 Neonatal death trend in different hospitals, Fiscal Year 2076-77/2077-78/2078-79



Last two fiscal years data shows the number of neonatal death high in teaching hospital followed by Private/General hospital and Academy; however, the number is decreasing compared to previous fiscal year in all hospital except Tertiary Hospital. The decreasing trend of Neonatal death in hospital could be due to improvement and expansion of services.

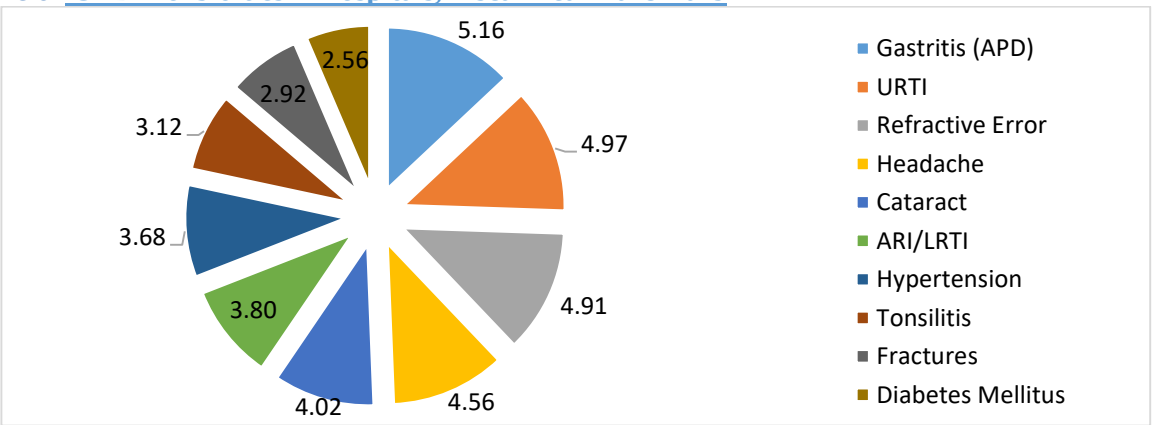
Figure 63CAC service trend in different hospitals, Fiscal Year 2076-77/2077-78/2078-79



Last two fiscal years data shows the number of CAC service high in Secondary A level hospital which is followed by Primary hospital. The number of CAC services has increasing in Primary hospital, Tertiary hospital and Teaching Hospital; however, decreasing in academy. This could be the expansion and strengthening the CAC services.

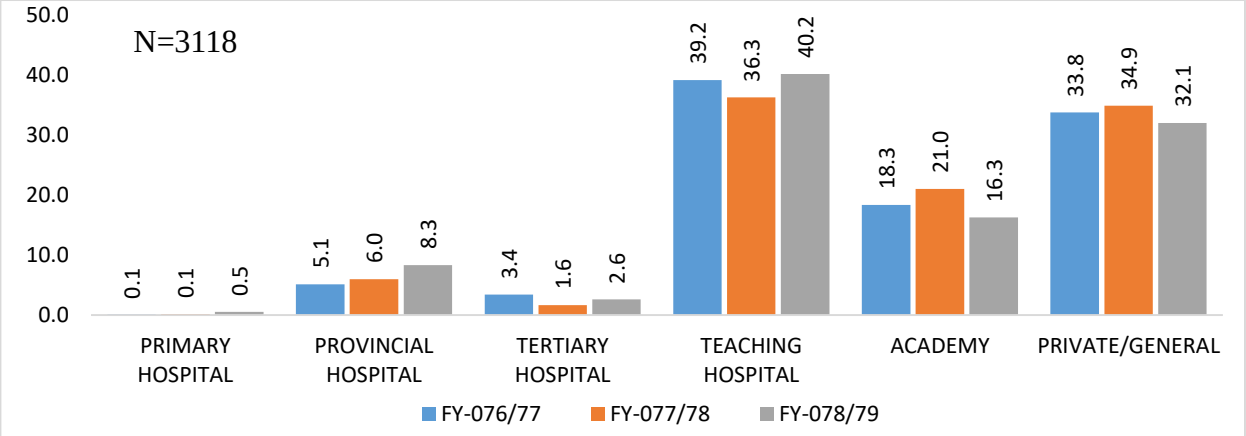
5.4 Morbidity & Mortality Indicator

Figure 64 OPD morbidities in hospitals, Fiscal Year 2078-2079



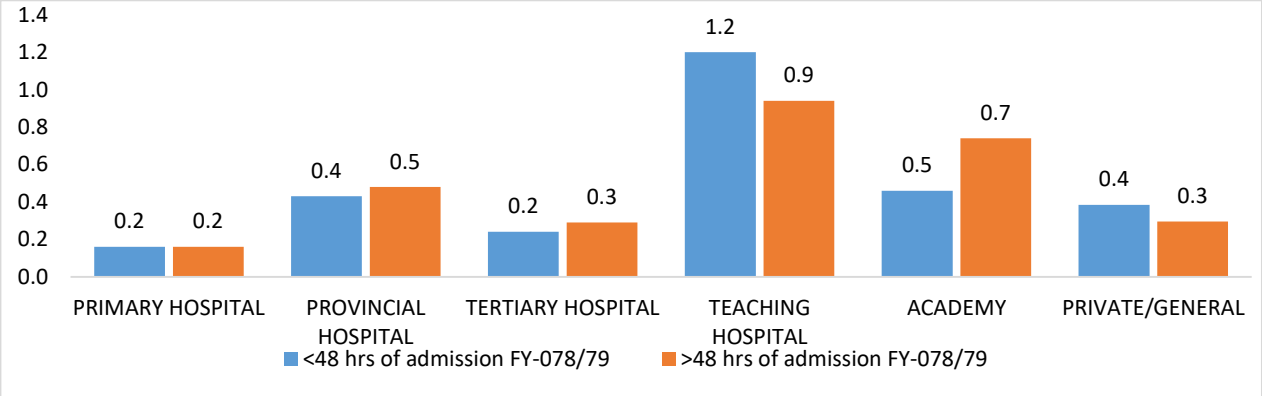
Among the different OPD morbidities reported in hospitals, gastritis remains highest with 5.16% followed by URTI with 4.97%. The number of gastritis could go high than the above data as many hospitals have not reported the OPD morbidities in HMIS.

Figure 65 Total hospital death in different hospitals, Fiscal Year 2078/079



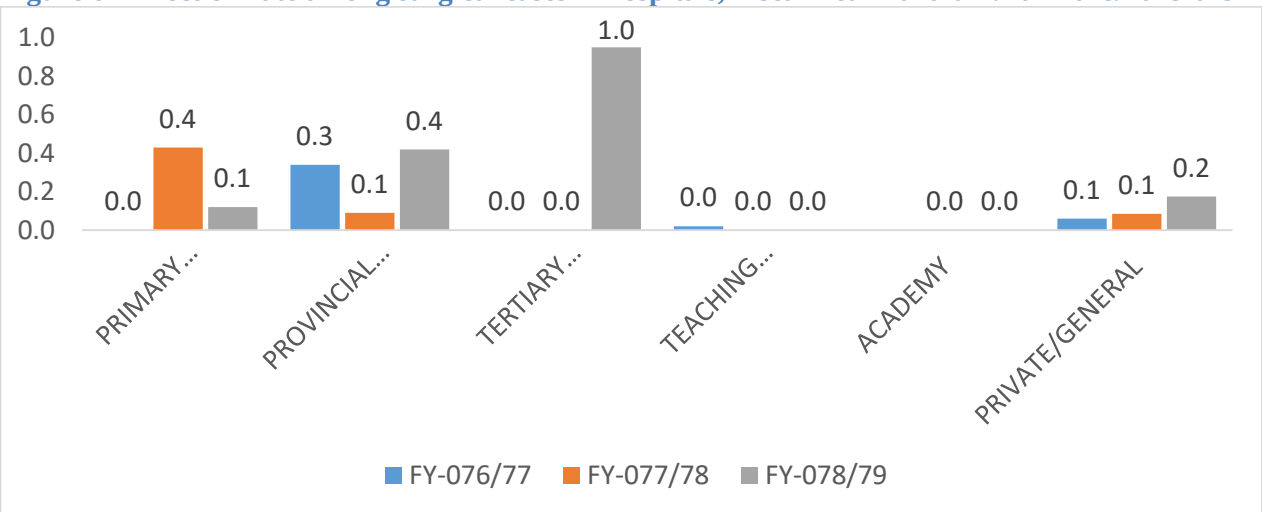
Among the total deaths in hospitals, the highest number of death i.e., 40.2% of the death occurred in teaching hospital followed by private/other general hospital with 32.1%. Referral of complicated cases and high flow of cases could be the reason for highest number of deaths occurring in teaching hospital. More than one third (32.1%) of death occurring in private/other general hospitals calls for the need of monitoring the causes of death and quality of service provided by these hospitals.

Figure 66 Hospital Deaths with respect to duration of admission, Fiscal Year 2078-2079



Hospital deaths seem equal within 48 hours of admission and after 48 hours of admission in primary hospitals. The deaths rate has high in teaching hospital and academy as these centers are referral centers.

Figure 67 Infection rate among surgical cases in hospitals, Fiscal Year 2076-077/2077-078/2078-079



Among the different levels of hospital, Tertiary hospital has the highest rate of infection among surgical cases followed by Provincial hospital and Private/General Hospital. Infection rate among surgical cases shows zero in teaching and academy, this should be monitored for the reporting and recording. Quality of service and infection prevention measures needs to be monitored for decreasing the rate of infections occurring.

5.5 Emergency Readiness

Table 31 Bed availability for Critical Care Management in Hospital

S.N.	HOSPITAL	ICU BEDS	Ventilators	Oxygen Plant
1	Mechi Hospital	3	3	Yes
2	Koshi COVD-19 Hospital	21	20	Yes
3	Koshi Hospital	0	0	Yes
4	BPKIHS	15	12	Yes
5	Nobel Medical College	82	29	Yes
6	Birat Medical College	7	2	Yes
7	Inaruwa Hospital	0	0	Yes
8	Tehrathum Hospital	0	1	Yes
9	Solukhubhu Hospital	0	0	Yes
10	Illam Hospital	0	1	Yes
11	Udaypur Hospital	0	0	Yes
12	Other Private Hospital	64	29	Yes
	Total	**192**	**97**	

Availability of Ambulance in Districts

S.N	Districts	Government	Non-Government	Private
1	Ilaam	5	14	1
2	Udayapur	17	17	11
3	Okhaldhunga	4	4	0
4	Khotang	1	9	1
5	Jhapa	5	122	2
6	Taplejung	9	14	0
7	Terhathum	8	4	0
8	Dhankuta	9	13	2
9	Paanchthar	3	17	1
10	Bhojpur	6	4	0
11	Morang	11	104	29
12	Sankhwasabha	12	3	2
13	Sunsari	10	62	1
14	Solukhumbu	10	0	0
	Total	110	387	50

Status of Health care waste management in Hospitals

S.N	Hospital	Separate Waste Management Plant	Autoclaving of contaminated Waste
1	Provincial Hospital	Yes	Yes
2	Madan Bhandari	Yes	No
3	Udayapur	Yes	No
4	Ilam	Yes	Yes
5	Sunsari	Yes	No
6	Dhankuta	Yes	Yes
7	Terhathum	No	No
8	Bhojpur	Yes	No
9	Sankhwasabha	No	No
10	Taplejung	Yes	Yes
11	Panchthar	Yes	Yes
12	Okhaldhunga	No	No
13	Solukhumbu	Yes	No
14	Khotang	No	No

Table 32: Issues and recommendations

S.no.	Issues/Constraints	Action to be taken
1	Insufficient skill-mix human resource for effective service delivery	For fulfillment of sanction post, government should have to take high priority for loksewa.
2	Cesarean section delivery rate is high in private hospitals	
3	Weak referral mechanism	
4	Despite the availability of ICU setup, lack of trained personnel for its operation	For operating ICU, training and HR should be hired immediately otherwise all the ICU setup will get damaged soon.
5	Incomplete and poor data quality of hospital service delivery	Strenghthening the quality of recording and reporting. EHR should be initiated by all kind of hospital.

PART 6–AYURVEDA AND ALTERNATIVE HEALTH SERVICES

6.1 Background:

Ayurveda, providing health services from the very dawn of civilization, is a complete and holistic medical system. Ayurveda provides all the knowledge needed for the healthy life and helps to preserve and promote the health; prevent and cure the diseases. Though Ayurveda has the long history, it lacks behind in the present context. At present, there are 2 Ayurveda Hospitals, 64 District Ayurveda Health Centers, and 305 Ayurveda dispensaries. Among the 753 local government, only 311 provides the Ayurveda service whereas in 422 local level we still need to extend the Ayurveda Health Service. The Department of Ayurveda and Alternative Medicine, at the Federal level, must be responsible for the expansion, strengthening and development of Ayurveda and Alternative Medicine across the country.

Ayurveda has been mentioned as the Fundamental health right of all the Nepalese. So, every local level should provide the Ayurveda Service for the promotion of health and prevention and treatment of diseases. It should be expanded in all the local levels. In the present Federal system of Nepal, there is Ayurveda and Alternative Medicine Section in both the Ministry of Social Development and Directorate of Health in every Province. Province 1 is trying to expand and strengthen Ayurveda and Alternative Medical services through various efforts. There are 3 Ayurveda dispensaries (then Zonal Ayurveda dispensary), 11 District Ayurveda Health Centers, 50 Ayurveda dispensaries and Ayurveda Service from 1 PHC in Province 1. Among the 137 local levels of Province 1, only 44 of them have provided Ayurveda Service and 93 of them still lacks Ayurveda Service. Ministry of Social Development has upgraded 4 of the district level Ayurveda Institutions (Morang, Jhapa, Ilam and Udaypur) and expanded the health service in 3 of the district level Ayurveda Institutions (Dhankuta, Sankhuwasabha and Okhaldhunga).

Ayurveda medicine is popular in all spheres because of its efficacy, availability, safety and affordability. More than seventy five percent of the population used traditional medicine mainly based on Ayurveda medicine. (Legal status WHO 2001)

This report is prepared based on report provided from the Ayurveda Institution of Province 1, FY 2075/076 to FY 2077/078 report, Ayurveda Health Management Information System and Provincial Annual Health Review. It has carefully analyzed the status of Provincial Ayurveda Institutions, Ayurveda service extension, staff details and the programs of Ayurveda. At the same time tries to provide the suggestion and recommendation to solve the problems and challenges of Ayurveda.

Goal:

Its goal is to preserve and promote the health of the public and to free the diseased person from disease by expanding Ayurveda and alternative medicine services along with modern medical practices by empowering basic health services to achieve the goals of sustainable development.

Objectives:The objectives of Ayurveda and Alternative Medicine are as follows:

- To provide fundamental Ayurveda and Alternative Health Services to the local people as mentioned in constitution.
- To reduce the Non communicable diseases.
- To provide Panchakarma service for the promotion of health.
- To provide the Ksharsutra service.
- To help the people to adopt healthy lifestyles through healthy living programs.
- To spread awareness about Ayurveda for the Healthy society.
- To provide maternal health care programs as priority.
- To carry out senior citizen health programs effectively.
- To start homeopathy and other alternative medical services.

Target group:

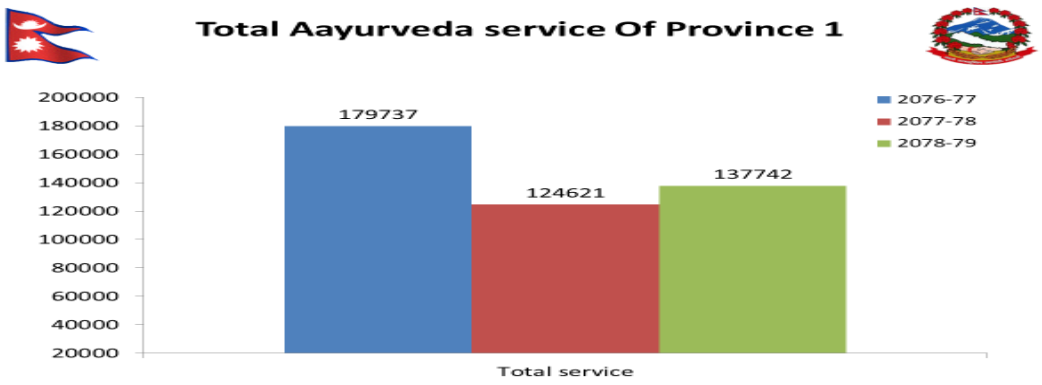
Patients and healthy people, from infants to old age throughout the province

Main Ayurveda Services and Program in Province 1:

- OPD Service.
- Panchakarma (Purakarma) service.
- Distribution of galactoguge medicine to breastfeeding mothers.
- Senior citizen health promotion service.
- Outreach clinic and non-communicable disease program.
- Healthy living program.
- School Ayurveda Health and Yoga Education Program.
- Herbs and Herbal introducing program to the locals.

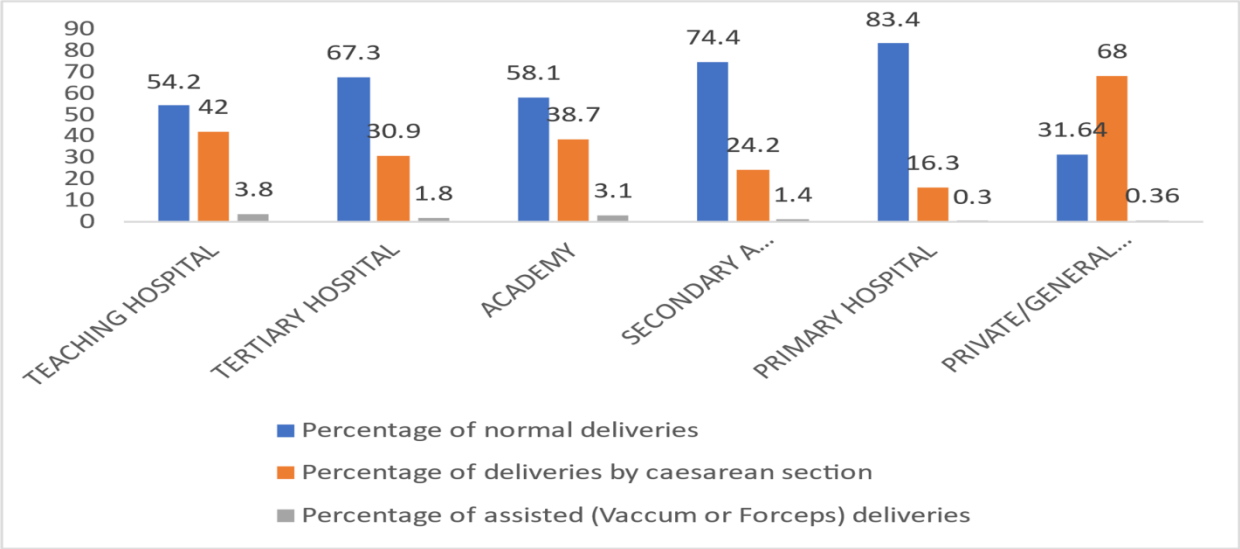
- National and International Yoga Day; National Health Day and Dhanvantri Jayanti.
- Free Ayurveda Health Camps and Yoga Camps

Figure 68: Total Aayurveda Service Of Province 1



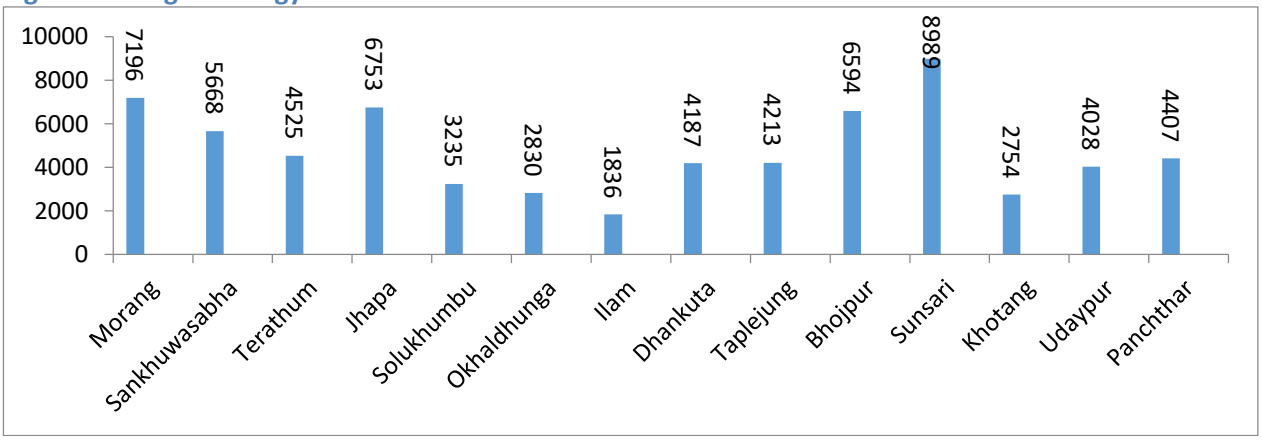
While comparing all the services of three financial years provided by Ayurveda health institutions under the province government, it was found that 179,737 clients took the service in 076/77 and the number was decreased on 077/078 due to the interruption of services on Covid epidemic but the trends have been increased again at 078/79.

Figure 69: Percentage of Deliveries



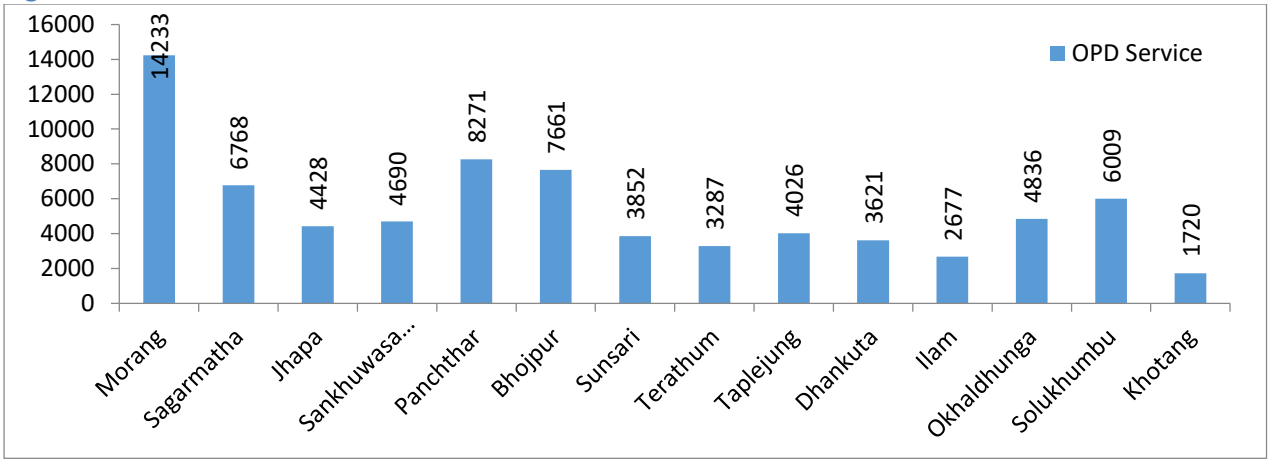
While analyzing and comparing the top 10 major diseases that came to Ayurveda institutions in 14 districts on FY 078/079, it has been found that acid bile patients were the most common and nose, ear and throat patients were the least. Among the 30 diseases listed on AMIS, only the common ten diseases were analyzed.

Figure 70: Nagrik Aarogya Sewa



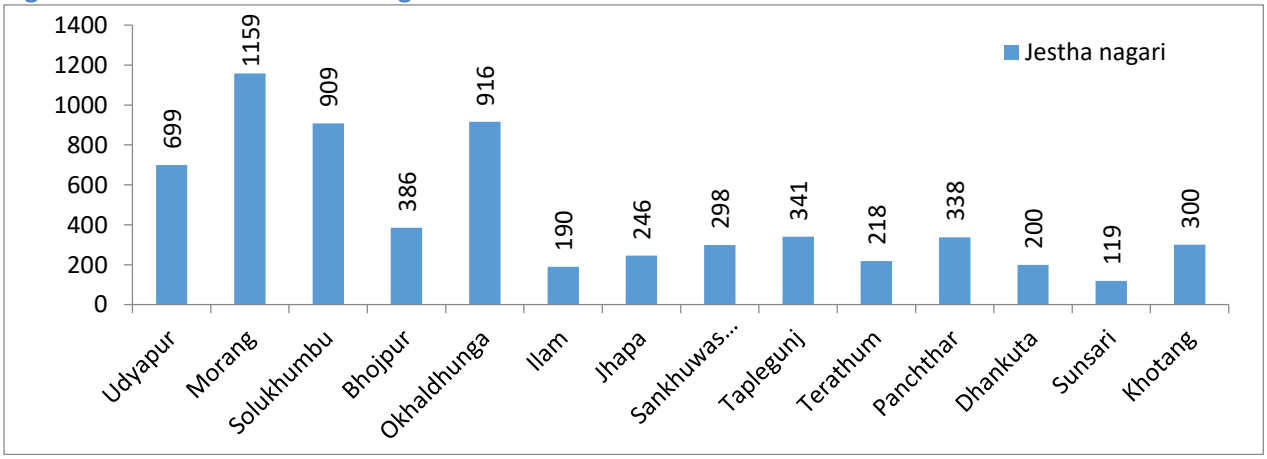
Nagarik Aarogya Centers have been established at 53 places of province 1 from federal conditional budget with an objective to fulfill the purpose of Ayurveda medicine to protect and enhance the health of citizen in community level and eliminate the diseases of patients with basic slogan of My Health, My Responsibility. Analyzing the various services provided by these centers, the highest number of service users were found in Sunsari and lowest in Ilam district.

Figure 71: District wise OPD Service FY 2078.79



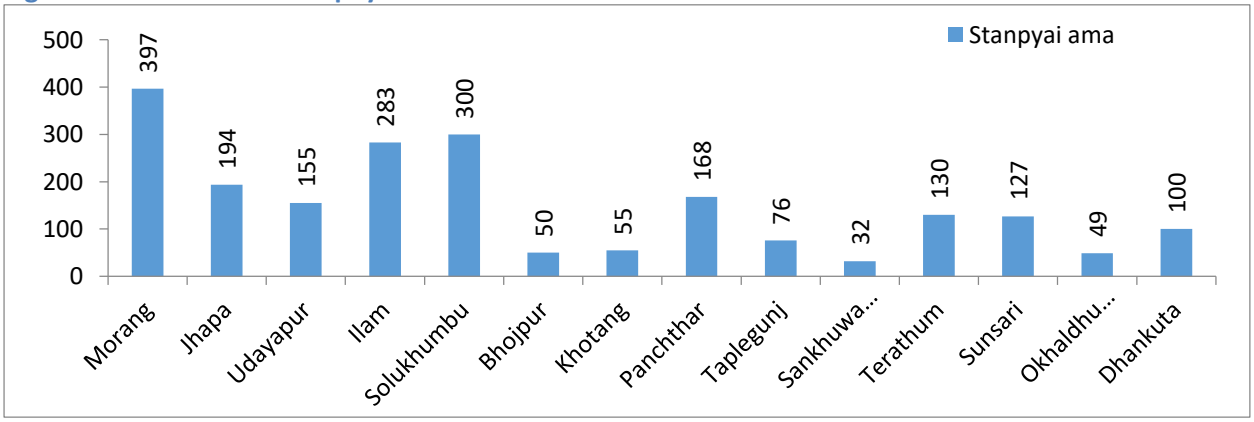
The number of patients who came to the OPD for treatment at the District Ayurveda Health Center in FY 078/79 was found highest in Morang due to the upgradation of the hospital with extended services whereas Ayurveda Health Center Khotang has seen low number of clients.

Figure 72: District Wise Jesthanagarik Service



Analyzing the details of the beneficiaries who came to the district Ayurveda health centers under the province for senior citizen health promotion service program, highest number was observed at Morang and least on Khotang. This program regularly distributes aswagandha and amalaki powder with objective for the protection and promotion of the health of senior citizens over 65 years old.

Figure 73: Districtwise Stanpayi aama Service



While analysing the data of the districts where Satavari Churna and Zwano Churna are regularly distributed as part of the milk-enhancing herbal medicine distribution program for lactating mothers, the highest number was found on Morang and the lowest in Sankhwasabha. This program is conducted with an objective to protect the health and nutrition status of pregnant lactating mothers and new-born babies and to protect them from malnutrition.

Figure 74: District wise Purbakarma Service

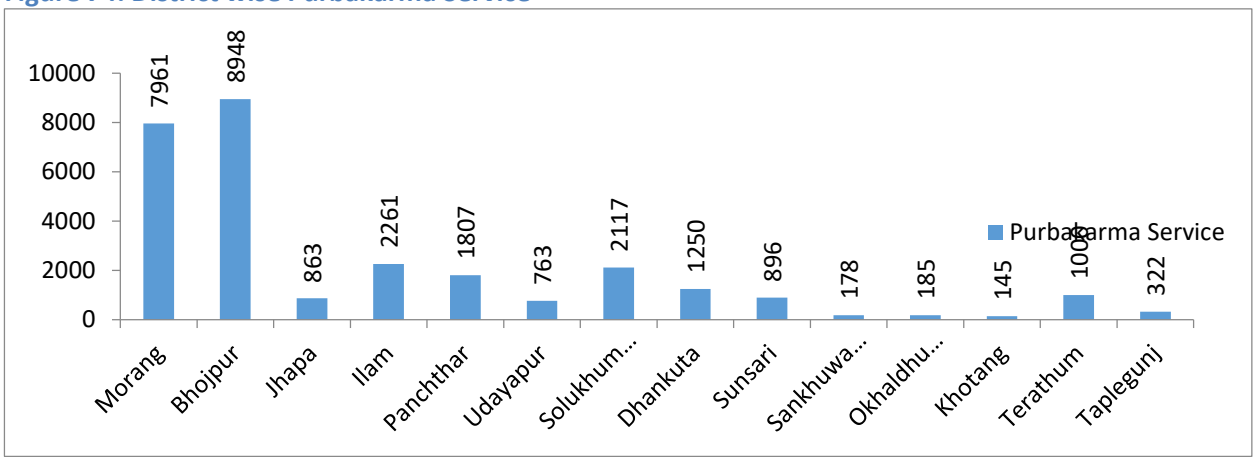
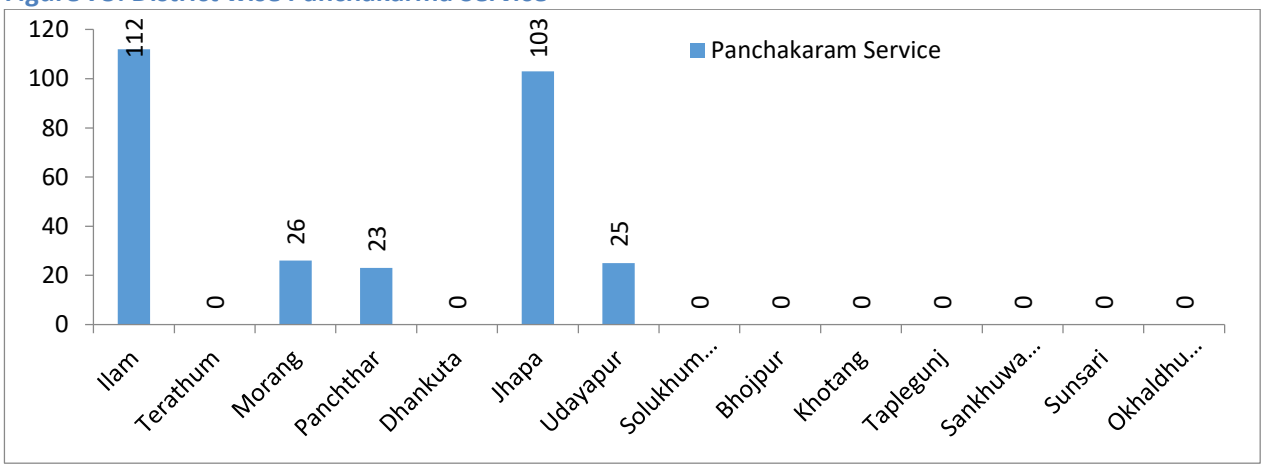
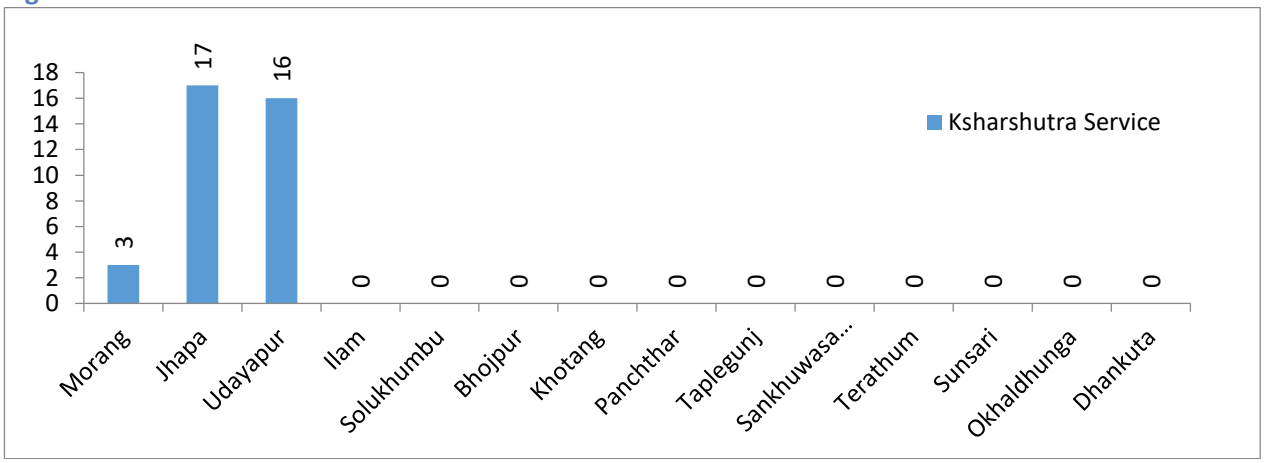


Figure 75: District wise Panchakarma Service



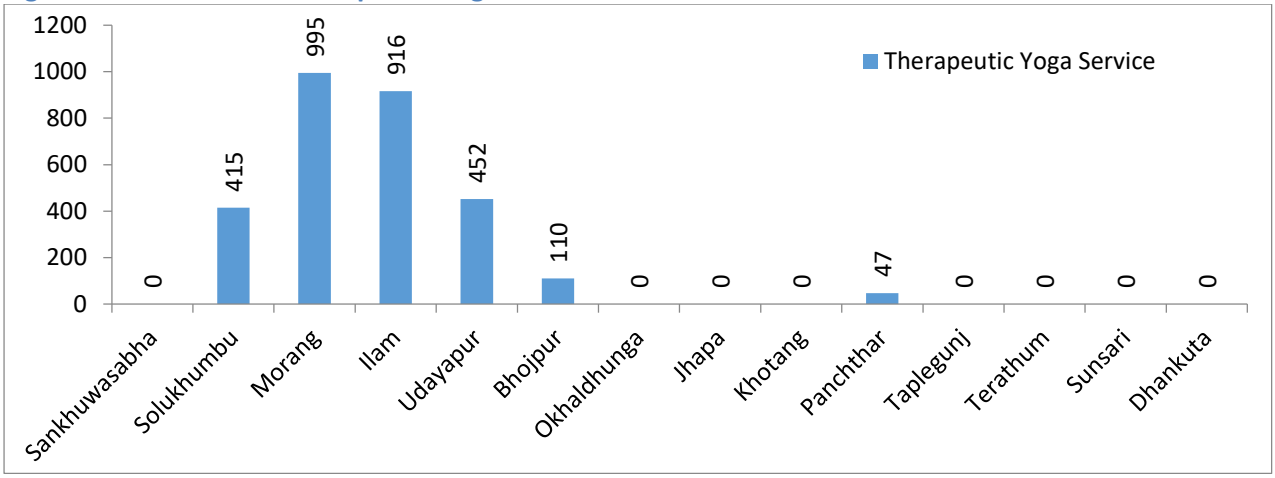
While analysing the details of the clients who received various types of Ayurvedic medicine and panchakarma therapy without the use of food for various chronic diseases, the number of people who received purbakarma services was highest in Bhojpur and less in Khotang, while the number of people who received panchakarma services was the highest in Ilam and the least in Udaipur. In addition, in some districts, services have not been functional due to lack of service management and manpower.

Figure 76: District wise Ksharshutra Service



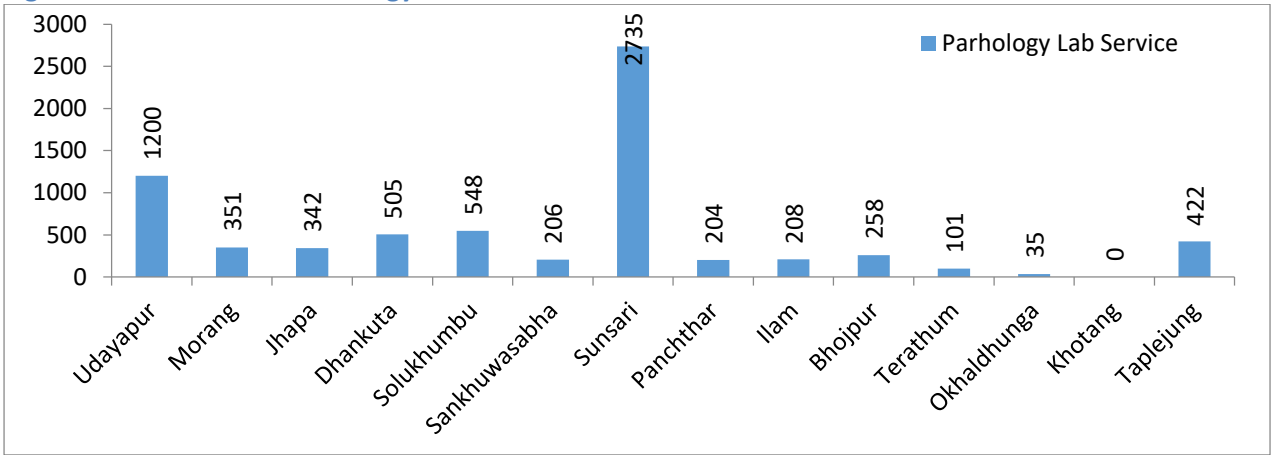
According to the technology of treating piles and fistula by tying it with a thread (Ksharasutra) prepared without operation, the greatest number of clients were found in Jhapa and less in Morang. This service has not been managed in most of the districts.

Figure 77: District wise Therapeutic Yoga Service



For the management and treatment of various types of non-communicable diseases, program has been launched to provide regular therapeutic yoga services from all districts. Analysing the data of this program, it is seen that the most clients of the program were in Morang and least in Panchthar and in some districts this service was not provided regularly.

Figure 78: District Wise Pathology Lab Service



From the budget received from federal conditional budget, laboratory services have been established and operated in all 14 district Ayurveda health centres. Analysing the number of clients who have been provided laboratory services, it has been seen that the highest number is in Sunsari and the lowest is in Okhaldhunga. Besides, laboratory services in Khotang district were only started the end of FY 078/79, the service could not be provided.

From the federal conditional budget, only one primary health centre in Province No. 1, Ravi Panchthar, is conducting an integrated lifestyle management program. In FY 078/079, a total of 1476 clients took various services.

Major Issues and Challenges

- Lack of manpower as per the approved position, which has hampered in effective service delivery.
- Insufficient management of medicines and other logistics due to low budget allocation
- Due to the lack of clarity regarding the management of the regulatory body, some of the services which are operated in both public and private levels are not efficient and effective.
- Assessment for ayurveda programs is not being conducted as the indicators are not defined yet.

Strengths

- Completion and handover of provincial Ayurveda Hospital
- Own land and structure of Ayurveda Centres in district level.

- Since there is specialized Ayurveda manpower available in this province, it will be easy for regular functioning the hospital.
- Due to the effectiveness of both curative and health promotion services, people are getting attracted towards Ayurveda services.

Findings from Monitoring visits:

- Most of the Nagarik Aarogya Centres established on province is providing the services related to OPD, Panchakarma rather than promotional related services.
- Most of the ayurveda institutions in local level are not conducting the programs as per the approved guideline and budget and even the coordination with local bodies is poor.
- Coordination mechanism should be established with district ayurveda health centres for effective implementation of Nagarik Aarogya related activities.
- Effective services are not being provided in some districts due to lack of manpower, infrastructures, and logistics.

Way Forward

- Update of all ayurveda related services and programs on AMIS.
- Development of Nagarik Aaroyga Centres as permanent health facility to deliver ayurveda curative services.
- Establishment of at least one ayurveda institutions in each local level.
- Development and Implementation of MSS tools in Ayurveda Hospital

PART 7–PROGRESS OF PROVINCIAL/FEDERALLEVEL ENTITIES

7.1. Health Training Center

Introduction

Established in 2076 BS, Health Training Center, Province No. 1, the then Eastern Regional Health Training Center (Health Training Center) situated in Devrebash, Dhankuta has been coordinating all training activities according to the annual calander of MoHP and MoH , Province No.1.. The overall goal of Health Training Center is to coordinate and accomplish the allotted programs from the National Health Training Center (NHTC) and MoH, Province No. 1 to develop a training system which can respond to the requirement of all categories of health workers and enable them to deliver primary health care according to the National Health Policy.

The health training center infrastructure constitute of an office block, three training halls in a single building, a lady's hostel with capacity for 32 lady's participants and a gent's hostel with capacity for 32. The entire premise stands in an area of 39 ropanis of land.

The Ministry of Health and Population has a network of training institutions throughout the country designed to meet national, provincial, and local health training needs. The provincial training centers support, guide and regulate training activities conducted by central level, local level and those conducted by NGOs and/or INGOS. In addition, the Training Center itself conducts skill-oriented trainings such as SBA, Implant, IUCD, MLP, CAC, and trainings intending behavior modification such as CoFP and Counseling, ASRH, PEN, etc.

Goal of Health Training Center:

Expand, accelerate, and improve the quality of the national health training programs in order to increase the covers and quality and broaden the scope of services provided at various levels of heath care delivery system in Province No. 1 of Nepal.

Specific Objectives:

- Increase the quality of service of health care service providers
- Increase awareness and knowledge of people on health issues and the ability of health facility staffs by providing trainings, as per the national and regional health training programs
- Increase positive attitudes of community people towards health care providing trainings to the service providers
- Increase access to information and technology in health programs for the people
- Plan, coordinate, implement and evaluate health training programs
- Coordinate with the Health Directorate, supporting partner agencies and HOs to conduct health related trainings
- Avail technical support and guidance to local level training programs
- Enable health care providers to demonstrate skills in providing health services through BCC approach

Gaps and Recommendations:

- Training related research works could have been carried out by provincial training centers as a variety of health personnel are available throughout the fiscal year as trainees.
- Specific instructions, guidelines, directions, and norms, if been extended at the beginning of the FY could facilitate in early planning and coordination for training activities.
- Continuous communication and discussions regarding upcoming training programs between the line ministry, Health Directorate and the training center could obviously lead to Quality Training Practices.
- Training materials should be printed at a time within the province to fulfill the need of provincial and local level health training activities.
- Adequate IT equipments (Printers, Laptops, etc) should be available to conduct trainings.
- There must be program for recurrent and systematic mechanism of coordination between PHTC, MoSD and Health Directorate (non-personal) in terms of participant selection, curriculum revision, need identification and accreditation of training sites as per local needs.
- PHTC must be informed of trainings being conducted by health offices, directorate, and partner organizations. All trainings should be maintained in TIMS records
- Multiple disciplines of health sector within the province need to be coordinated to establish a one door mechanism of Health Training activities
- Trainings should be considered as one's asset for promotion. But it should only be provided according to the real need and should follow the principle of equity. Participant selection should be standardized and should be made transparent. Set of criteria should be formulated for participant selection
- Local level health training needs vary a lot. Seldom do they not align with the overall national health needs. So, they would be demanding trainings on sectors which the central government is unaware of. It must be addressed.
- Traditional training package approach is sometimes loads of undesired information to the participants. So, existing training packages need to be either fragmented and delivered or revised to be cadre specific. This eventually would provide with business to peripheral health facilities as well and motivate the health workers for better performance.
- Thus, existing training sites underscoring in terms of QAA should be strengthened and newer sites need to be explored.
- Post training performance must be followed up. HWs participating in specific trainings need to be posted in relevant departments. It should be assured by the liable authorities.
- PHTC and training sites need to be coordinated in every instance when the central sections/departments revise their policies, guidelines, curriculum, etc.
- Training norms should be revised (automated) according to the market price elevation/variation
- Post training f/u should be strict. It should monitor the actual performance of the trainee after training. There should be a marked improvement in respective health indicators due to their receiving the training.
- Trainings should not be considered as personal benefit (stipend). It should only be provided as if the service providers are indicative of receiving training.
- It is the right time we could start something better:
- There should be no allowance for participants taking part in the trainings. Moreover, all trainings must be started to be made residential and no extra allowances be provided to the participants.
- Integration of sectors beyond health in health training and public awareness should be considered (eg. PTC, BLS, Training on CICT to Police/Army, etc.)
- Timely conduction of a greater number of Training of Trainers needs to be considered.
- TIMS needs to be revised in terms of access to Province and Local Level.
- Inter province trainers' observation visits and trainers' exchange programs should be carried out.

7.2 Provinical Public Health Laboratory

Provincial Public health Laboratory (PPHL) is a government-based laboratory under the wing of Ministry of Health. It is directly linked with different levels of government and non-government laboratories in Province 1. It was established in 1stAshadh, 2076 B.S. Some of the major functions of PPHL are networking, licensing, monitoring, supervision, capacity strengthening, conducting research activities and quality control of the laboratories located in Province 1.

AIMS:

To upgrade laboratory services (diagnostic and public health related) all over the province.

OBJECTIVE:

- To prepare laboratory rules and policies.
- To provide license for registration of laboratories.
- To establish province laboratory as a reference laboratory.
- To conduct external quality assurance system in all heath laboratories [Govt. and Non govt.]
- To conduct capacity building training programs for the technical personnel [Govt. and Non govt.]
- To strengthen overall capacity of health laboratory services in all health institutions through supervision and monitoring.
- To conduct the surveillance programs and help investigate the epidemics, emerging and re-emerging disease outbreaks.
- To integrate the INGO/NGO laboratory services under the PPHL.
- To help upgrade physical facilities of laboratories.

Location:

Currently, under the support and supervision of Save the Children, physical infrastructure for PPHL has been constructed near Center for Infectious Disease and Critical Care Hospital (Koshi COVID Hospital), Biratnagar. The foundation ceremony was held on 30th Mangsir, 2077 B.S on behalf of presence of chief guest Hon. Sher Dhan Rai, Chief Minister of Province 1.The building is in stage of getting furnished and instrument installation has also begun.

Newly constructed building of PPHL-1

MAJOR ACTIVITES:

- RT-PCR test for COVID-19
- Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-COv-02). It was declared as pandemic on 11th March 2020.

Test for COVID-19:

Gold standard test for COVID-19 is PCR (Polymerase Chain reaction) that detects genetic material of the virus. Other test/ methods available is Rapid Antigen test. Antibody tests are also available that is being used for seroprevalence surveys.

Progress of PPHL for testing COVID-19:

At the initial stage of COVID-19 pandemic, National Public Health Laboratory (NPHL) was the only laboratory of the country to perform PCR Test. Later, B.P Koirala Institute of Health Sciences (BPKIHS) in Dharan and Koshi Hospital at Biratnagar were upgraded for COVID-19 PCR testing where molecular testing was already available. PPHL also started its own Covid -19 PCR testing facility in the building provided by Veterinary laboratory in Biratnagar.

This pandemic was new to all and resources all around the world were scarce. Our country was also facing this crisis as well. Being a public health laboratory, PPHL had to manage this issue as well. At the beginning we provided various government and non-government institutions with Viral transport media (VTM) and swab sticks for sample collection. Training on sample collection, preservation, and transport along with donning and doffing of PPE was also provided to various laboratory staff of both government and non-government institutions. After establishing our PCR testing facility, PPHL also increased the testing capacity by adding one more PCR machine and automated extraction machine and many more accessories. The staff at PPHL worked day and night to provide continuous uninterrupted service for patients not just from Biratnagar but from all over Province 1 by networking with district hospitals, health offices and municipalities. It was grim situation for our country, so every staff supported with extra working hours without any holidays.

In addition to running our won PCR laboratory, PPHL also helped to establish PCR laboratories at 3 different sites in province 1 namely Mechi hospital Bhadrapur, District Hospital Dhankuta and Kotihom PCR laboratory at Jhapa. Logistic and technical support is still being provided to all the aforementioned sites.

Sample collection:
PCR laboratory has been providing sample collection facilities since the start of its establishment. Currently, for sample collection, patients registeration and collection begins at 11:00 am.
PCR Testing:
PPHL is well equipped with advanced molecular laboratory and has qualified and trained staffs. Nucleic acid extraction is performed by both manual and automated methods. At the beginning, PCR Testing was done by POCT device (USTAR biotechnologies) but now this technology has been discontinued as we have equipped the laboratory with higher versions of thermocycler.
Report dispatch:

- Samples received by PPHL PCR laboratory are tested and reported within 24 hours of receipt.
- Reports are now dispatched through SMS alert. One can get hardcopy of their reports from PPHL PCR laboratory or they can even get it printed through the online link sent to their mobiles via SMS alerts.
- After testing, the compiled excels reports are sent to respective referring sites and to the authorities at the central and provincial covid reporting government agencies.

Data of service provided from 2078.04.01 to 2079.03.31:

Total PCR tests For FY 2078/79	
Total Tests	25944
Total Positives	8340
Total Negatives	16117
Repeat Positives	1487

Koshi COVID Hospital Laboratory:
PPHL had started laboratory services in Koshi-COVID hospital premises since its establishment. Along with technical assistance, we also provide all equipment and reagents for the tests. Our laboratory provides all routine tests including some important investigation for Covid-19 ICU patients. Laboratory services is being provided 24 hours. The sample for follow up PCR testing of admitted patients is also collected by our laboratory staff and sent to PPHL PCR laboratory.
Logistic support to various institutions of Province 1:
COVID-19 pandemic had created a worldwide shortage for various products like Viral transport media (VTM), masks, sanitizer and even reagents and consumables utilized in PCR. Thus, PPHL acted as a bridge between the central and provincial government and ensured uninterrupted supply of such necessities to any government and non-government laboratories and institutions that needed assistance.
M. Tuberculosis Lab Activities:
Introduction:
Laboratory diagnosis of active tuberculosis cases by sputum smear microscopy is a critical element of DOTS – to the extent that the quality of the tuberculosis laboratory service has a major influence on the success of the tuberculosis control program. It follows that tuberculosis control will be most effective (and efficient) in countries that have a network of laboratories providing a reliable service within the framework of the National Tuberculosis Program. A reliable laboratory service is one that is cost-efficient and provides results that are consistently accurate. These demands can be met only through commitment to quality assurance. A key component of quality assurance for tuberculosis microscopy services is "External Quality Assessment" – the process by which the performance of a routine diagnostic service is monitored by a more competent laboratory such as PPHL, province 1.
Currently there are 90 microscopy centers delivering sputum microscopy examination in province 1. Majority of the microscopy centers are established within government health facilities. Some are established in non-government organization as well as in the private sector. All microscopy centers send the examined sputum smear slides to PPHL according to Lot Quality assurance sampling system (LQAS).
There are 12 GeneXpert machine running under supervision of PPHL located at NATA Morang Biratnagar, Nobel Medical College Biratnagar, Inaruwa Hospital Sunsari, BPKIHS Dharan, Dhankuta Hospital, Madan Bhandari Hospital and Trauma Center Mangalbare Morang, Damak Hospital Jhapa, Dhulabari PHC Jhapa, Mechi Hospital Jhapa, Ilam Hospital, Gaighat Hospital and Okhaldhunga Community Hospital.
Function of PPHL TB QCL:

- Capacity building of Laboratory staffs in province.
- Reagents and logistics supply
- Onsite coaching to lab staffs

- Rechecking of sputum smear slides and provide feedback.
- Recording/Reporting

Performed Activities 2078/2079:

S.N	SUMMARY REPORT	NUMBER
1	NO. OF MICROSCOPY CENTERS	92
2	PARTICIPATED MICROSCOPY CENTERS IN QUALITY ASSURANCE PROGRAM IN 2078-79	92
3	LOGISTIC SUPPLY:ZIEHL NEELSEN STAIN SOLUTION	750 LITERS
4	THREE GROUPS OF TB LQAS TRAINING WAS ORGANIZED	30 PARTICIPANTS
5	2 TB MODULAR MICROSCOPY TRAINING WAS ORGANIZED	26 PARTICIPANTS

Liquid Based Cytology

Cervical cancer is the 4th most common cancer of women and constitutes 6.5% of the total cases of cancer in the female population around the world. In Nepal, it is much higher at 19.4%. Effective primary (HPV vaccination) and secondary prevention approaches (screening for and treating precancerous lesions) helps to prevent most of the cervical cancer cases. As long as it is diagnosed early and managed effectively, cervical cancer has good prognosis. Even on late stages, it can still be managed effectively with appropriate treatment.

In our country, diagnosing cervical cancer is a much bigger problem considering the local and cultural views of women, the complex topography of the country hindering patients from actively reaching out health facilities and lack of resources. While health services around the world are upgrading their screening method to liquid-based cytology (LBC) and DNA testing for the causative agent Human papilloma virus (HPV), our health facilities are still struggling to provide conventional papanicoulau (Pap) smear test to women residing at remote areas.

Thus, PPHL planned this program with Health ministry where we would use the LBC technology to help screen women at hilly and remote areas of province 1 where conventional pap smear was not available. Dhankuta, Udayapur, Bhojpur and Ilam were selected. Staffs were trained regarding sample collection, storage and transport of the LBC container. Sample were then processed by trained personnel in PPHL and reported by pathologist.

Total number of patients served was 202.

Logistic support to various institutions of Province 1:

Various laboratory logistics was supplied by PPHL to different laboratories in Province-1, logistics included Covid-19 PCR reagents and accessories, TB microscopy reagents and accessories. In recent surge of dengue cases PPHL-1 supplied Dengue detection kits to different laboratories.

Laboratory registration:

Till date, PPHL has 31 laboratories registered under its C grade category.

Training and Orientation programs:

Since its establishment, PPHL has been conducting regular training and orientation programs related to various topics such as COVID-19, Tuberculosis LQAS, Biosafety and biosecurity,malaria microscopy,capacity building etc.

Data from 2078-04-01 to 2079-03-31:

S. No	Topic	Participants
1.	Malaria basic microscopy training,two batches	20
2.	TB LQAS Training,3 batches	30
3.	TB Modular microscopy training	26
4.	Capacity building training	25

7.3. Provincial Health Logistic Management Center (PHLMC)

Provincial Health Logistic Management Center (PHLMC) is a health logistic supply and management wing of Ministry of Health.. It was established with the purpose of regular supply of health commodities in the province level. It is situated in Biratnagar, Province-1.

Key Distribution Activities performed:

- Quarterly basis and as demand: distribution of essential medicine, program items and surgical items to District Health Offices and Ditrict Health Hospitals; Aaurvedic medicines are also distributed to Aayurved Aausadhalayas of province 1.
- Monthly Basis: Distribution of vaccines and commodities related to immunization program to health offices and Rabbies Vaccines to hospitals of province- 1, including Siraha and Saptari districts of province- 2.

- As per demand: Distribution of essential medicine, programmed items and other commodities to health offices and health facilities.
- Covid-19 related commodities are distributed as per the list mentioned by Ministry of Social Development and as per the demand and need of health offices, hospital LLGs.
- We also distributed the Covid-19 vaccines.
- Coordinated with different provincial ministries, stakeholder, and active UN agencies/NGOS/INGOs for support on need and maintaining supply chain of medical items and equipment.
- Annual procurement plan prepared.

Other Activities Performed:

- 20-80 temperature is maintained for oxytocin.
- eLMS have been rolled out in all LLGs.
- Activated Supply Chain Management Working Group (SCMWG) at provincial level.
- Quantification for Forecasting is organized.
- Basic and Logistic Procurement training is provided at district level.
- Regular supply of Covid-19 related medical supplies are maintained to Kashi Covid Hospital, Biratnagar.

Warehouse Status:

- PHLCMC has been performing proper distribution mechanism with all records of dispatched and received.
- Well-equipped storage area with sufficient racks and pallets.
- Monthly physical count and stock verification is performed.
- PHLCMC has its own 3 well equipped cold rooms with enough storage space and well temperature monitoring system.
- PHLCMC has roll out the eLMIS Inventory Management. All transactions are done through eLMIS.
- PHLCMC has 4 storage rooms and equipped with 6 A/C with capacity of 2 Mt each, especially for hormonals contraceptives and temperature sensitive medicines.

Challenges:

- No sufficient storage spaces.
- Lack of manpower as per sanctioned posts.(Darbandhi teries).
- No proper guidelines for procurement to LLGs, districts level and provincial levels.
- Lack of computer and furniture's to employees.
- Not enough budget for transportation receiving lower budget than previous FY.
- The capacity development of HR should be done who are in logistics management in province, districts and LLGs.
- The districts and LLGs are not able to forecast and quantify the commodities as their needs.

Measures to be addressed to mitigate the challenges:

- Informed and requested to relevant ministries to provision budget ceiling as per need of PHLMC
- Requested to deploy the employees as per need.
- Enough budget is requested for transportation.
- Guided at LLGs level for quantification and forecasting the medical commodities.
- Requested to increase the capacity of warehouse.
- Provision to release the allocated annual budget.
- Guideline is to be made to minimize the duplication in procurement of commodities at all level of procurement process.

1.1 YEARLY STATUS OF FP PROGRAM, PHLMC Biratnagar

SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	Condom	Pcs	5870000	4486000	396000	1720800	1763500	1612600
2	Depo Provera	Set	370600	363600	320000	279000	415000	371400
3	Pills	Cycle	402624	402624	187200	187200	260200	252442
4	IUD CuT	Set	3100	3100	4000	3800	6900	6600
5	Implant	Set	13400	12500	19600	12000	27900	13000

1.2 YEARLY STATUS OF CDD/ARI/NUTRITION PROGRAM, PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	ORS	Pkts	703565	622465	1057600	929300	753015	539508
2	Zinc Sulphate	Tab	1492200	1492200	1600000	1450000	702075	40000
3	Ferrous Sulphate	Tab	25066500	23980800	21690000	12707300	16277400	9953300
4	Vitamin A	Cap	1566000	1562000	1230500	1155900	1339100	1237000
5	Albendazole	Tab	1412000	1403000	5798900	5781848	1235452	1000352
1.3 YEARLY STATUS OF ASV/ARV PROGRAM, PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	Polyvalent ASV	Vial	9335	7195	5060	4260	4110	3465
1.4 YEARLY STATUS OF MALARIA PROGRAM, PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	Chloroquine 150 mg	Tab	2000	2000			9500	9500
2	Primaquine 7.5 mg	Tab	5000	5000			105000	21000
1.5 3 YEARLY STATUS OF T B PROGRAM, PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	HR(75+150)mg	Tab.	2836224	2218944	866880	1347744	1347528	1347528
2	HR Child	Tab.	139454	124250	20160	33516	97860	91452
3	HRZ Child	Tab.	81812	71000	20160	28620	55860	50232
4	HRE	Tab.	322560	288960	134400	162624	897792	856096
5	HRZE	Tab.	1840736	1418592	822528	995592	322328	322328
6	Ethambutol 400 mg	Tab.	6500	5560	0	0	1080	1080
7	Pyrazinamide 400 mg	Tab.	0	0	0	0	21500	14400
8	Isoniazid 100 mg	Tab.	11600	11600	0	0	592704	579264
9	Rifampicin 150mg	Cap.	9500	7700	0	0	9200	9150
10	Streptomycin Inj	Vial	39790	34190	6000	10600	600	560
11	Glass Slide	Pcs.	86000	85000	0	0	61500	57250
12	Sputum Container	Pcs.	82400	43600	50000	43800	59800	54000
1.6 3 YEARLY STATUS OF Leprosy PROGRAM, PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Total Received	Total Issued	Total Received	Total Issued	Total Received	Total Issued
1	MB Combi Adult	Strip	9732	6080	1728	3904	5844	5369
2	MB Combi Child	Strip	488	308	60	222	294	108
3	PB Combi Adult	Strip	3196	2224	42	1002	1356	1290
4	PB Combi Child	Strip	330	246	66	138	126	120

1.7 3 YEARLY STATUS OF EPI PROGRAM, PHLMC Biratnagar					
SN	Items	Unit	FY 2076/77	FY 2077/78	FY 2078/79
			Total Supply	Total Supply	Total Supply
1	BCG 20 Dose	Vial/Ampule	35700	36300	9000
2	BCG Diluents	Ampule	35700	36300	9000
3	DPT,HepB,Hib- 10	Vial	48552	51090	5470
4	Polio- 10 Dose	Vial	54000	45700	5600
5	Polio Droper	Piece	54000	45700	5600
6	Measles/Rubella -10	Vial	47950	46998	8350
7	Measles/Rubella Dil	Ampule	47950	46998	8350
8	TD- 10 Dose	Vial	34500	32550	5550
9	JE- 5 Dose	Vial	44900	44200	3500
10	JE Diluents	Vial	44900	44200	3500
11	PCV- 4Dose	Vial	216600	50900	12900

1.7 3 YEARLY STATUS OF EPI PROGRAM, PHLMC Biratnagar					
	Items	Unit	FY 2076/77	FY 2077/78	FY 2078/79
12	FIPV	Vial	0	87800	1452
13	Rota	Tub	0	0	33200
14	AD syringe 0.1 ml	Piece	0	58189	14500
15	AD syringe 0.05 ml	Piece	0	253600	22700
16	AD syringe 0.5 ml	Piece	148500	145100	472000
17	Syringe 2 ml	Piece	1304000	253600	19500
18	Syringe 5 ml	Piece	69100	145100	0
19	Safety Box	Piece	105800	964500	3900
20	ARV vaccine	Vial/Ampule	15250	51900	12700

1.8 3 YEARLY STATUS OF Covid-19 Commodity PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Received	Issued	Received	Issued	Received	Issued
1	Antigen Kit Covid-19	Pieces	0	0	0	0	199450	194897
2	Biohazard bag (COVID 19)	Pieces	0	0	685	585	54235	51145
3	Chloroquine 250 mg Tablet (COVID-19)	Tablet	0	0	5000	2000	5000	3700
4	Cidex (glutaraldehyde) 5 litre (COVID-19)	Jar	0	0	5	5	5	5
5	Cotton Mask (COVID-19)	Pieces	0	0	1000	1000	1000	1000
6	Dead Body Bag	Pieces	0	0	98	20	1379	956
7	Disposable Cap (COVID 19)	Pieces	0	0	17700	17057	44400	40464
8	Disposable Gown (COVID-19)	Pieces	0	0	23680	22405	68460	68295
9	Disposable protective clothing (Cover all)	Pieces	0	0	21875	20450	27625	27425
10	Electric Needle Destroyer	Pieces	0	0	2	2	2	2
11	Examination (loose) Gloves COVID-19	Pair	0	0	241824	233502	484824	429998
12	Face Mask (COVID 19)	Pieces	0	0	1325	1200	15125	15125
13	Face Shield (COVID 19)	Pieces	0	0	8021	6854	105131	75491
14	Goggles polycarbonate (Reusable)	Pieces	0	0	4245	4095	10500	6945
15	Gown for reusable (COVID-19)	Pieces	0	0	25	0	1700	908
16	Gown Set (COVID-19)	Pieces	0	0	19846	7937	81046	54722
17	Gum Boot (COVID-19)	Pair	0	0	1253	883	5783	5694
18	Hand Sanitizer 100 ml (COVID-19)	Jar	0	0	1055	968	1055	1005
19	Hand Sanitizer 10L	Jar	0	0	135	134	135	135
20	Hand Sanitizer 500 ml	Jar	0	0	4442	2794	4712	4712
21	Hand Sanitizer 1000 ML	Jar	0	0	0	0	1800	1575
22	Heavy duty gloves (COVID-19)	Pair	0	0	450	21	450	168
23	Hydroxychloroquine 200 mg (COVID-19)	Jar	0	0	10000	250	10000	1250
24	Hygiene Kit	Pieces	0	0	0	0	50	0
25	Infrared Thermometer Piece COVID-19	Pieces	0	0	1578	755	2449	1788
26	Liquid handwash	Jar	0	0	42	42	5800	42
27	Mask (COVID-19)	Pieces	0	0	180110	36130	2058270	1498115
28	N95 Mask (COVID-19)	Pieces	0	0	20027	14406	261057	139754
29	Oxygen Cylinder 40 L	Pieces	0	0	0	0	500	465
30	Oxygen Cylinder 46 L	Pieces	0	0	0	0	200	200
31	Oxygen Cylinder 50L	Pieces	0	0	0	0	125	25
32	Oxygen Concentrator 5 ltr	Pieces	0	0	0	0	30	30
33	Oxygen Cylinder 8 ltr	Pieces	0	0	0	0	110	5
34	Oxygen Cylinder 10 Ltr	Pieces	0	0	0	0	263	95
35	Pulse Oxymeter	Pieces	0	0	0	0	840	468
36	PPE- Personal Protective Equipment Set (COVID-19)	Pieces	0	0	854	759	4467	1934
37	PPE Set for Ground (COVID-19)	Pieces	0	0	100	100	100	100
38	PPE set for reusable (COVID-19)	Pieces	0	0	75	32	175	83
39	Pressure Sprayer 5 ltr COVID-19	Pieces	0	0	5	4	5	5
40	Rapid Diagnostics Test Kit for COVID	Pieces	0	0	10560	9080	10560	9797
41	Real time PCR Machine (COVID-19)	Pieces	0	0	2	2	0	0
42	Real Time RT-PCR Kits for SARS Cov-2(COVID-19)	Pieces	0	0	10000	5220	10000	10000
43	Rectified Spirit 5 ltr Jar (COVID-19)	Jar	0	0	0	0	10	10

1.8 3 YEARLY STATUS OF Covid-19 Commodity PHLMC Biratnagar								
SN	Items	Unit	FY 2076/77		FY 2077/78		FY 2078/79	
			Received	Issued	Received	Issued	Received	Issued
44	Safety Goggles (COVID-19)	Pieces	0	0	12709	11626	47259	29965
45	Shoe Cover (COVID 19)	Pair	0	0	5101	3967	41501	36627
46	Sodium Hypochlorite 5 Liter Solution (COVID-19)	Pieces	0	0	44	25	144	130
47	Sprayer Pump	Pieces	0	0	3	3	3	3
48	Surgical Cap	Pieces	0	0	3933	3933	9933	4233
49	Surgical Gloves COVID-19	Pair	0	0	40599	30299	54099	54099
50	Surgical Mask (COVID 19)	Pieces	0	0	359895	359700	481895	480170
51	Swab Stick (Piece)	Pieces	0	0	26000	22400	26000	26000
52	T piece	Pieces	0	0	0	0	600	600
53	Viral Transport Medium (VTM) - COVID-19	Pieces	0	0	23000	16750	69350	64498
54	Waste Paper	Pieces	0	0	25	25	25	25

7.4 Provinical Health Insurance Board

१. परिचय

स्वास्थ्य बीमा स्वास्थ्य सेवाको खर्चलाई परिवारले धान्न सक्ने अवस्थामा ल्याउने र स्वास्थ्य समस्याका कारणले हुन सक्ने आर्थिक जोखिमलाई न्यूनिकरण गर्ने कार्यक्रम हो । यो स्वास्थ्य सेवामा सबैको पहुँच सुनिश्चित गर्ने हृत सामाजिक साझेदारीको अवधारणा हो । यसमा व्यक्ति, समुदाय र सरकारको प्रत्यक्ष सहभागिता हुने गर्दछ । यसले स्वास्थ्य सेवा उपयोगका क्रममा अनियोजित रुपमा भइरहेको व्यक्तिगत खर्चलाई व्यवस्थित गर्दै उपलव्ध स्रोतको प्रभावकारी, दक्ष तथा जिम्मेवार व्यवस्थापन गर्न मद्दत गर्दछ । यसले गुणस्तरीय स्वास्थ्य सेवा उपभोगलाई वकालत गर्दछ ।

नेपालको संविधानमा मौलिक हकको रुपमा रहेको स्वास्थ्य सम्बन्धि हक (धारा ३५) मा "प्रत्येक नागरिकलाई स्वास्थ्य सेवाको सहज पहुँचको हक हुनेछ" भन्ने व्यवस्था गरेको छ र गुणस्तरीय एवं सर्वसुलभ स्वास्थ्य सेवामा नागरिकको सहज पहुँच सुनिश्चित गर्दै उपचार खर्चमा नागरिकको वित्तीय सुरक्षा प्रदान गर्ने उद्देश्यले नेपालको संविधानको धारा ५१ (ज) को १५ मा "नागरिकको स्वास्थ्य बीमा सुनिश्चित गर्दै स्वास्थ्य उपचारमा पहुँचको व्यवस्था मिलाउने" उल्लख गरेको छ । राष्ट्रिय स्वास्थ्य नीति, २०७१ र राष्ट्रिय स्वास्थ्य बीमा नीति, २०७१ ले स्वास्थ्य बीमालाई कार्यान्वयनमा ल्याउने नीति अनुसार सामाजिक स्वास्थ्य सुरक्षा विकास समिति गठन आदेश, २०७१ बमोजिम नेपाल सरकारले आ.व.२०७२।०७३ देखि स्वास्थ्य बीमा कार्यक्रम कैलाली, बाग्लुङ्ग र इलामबाट शुरु गरेको थियो। स्वास्थ्य बीमा कार्यक्रम हाल नेपालमा ७७ जिल्लामा र प्रदेश नं. १ का १४ वटै जिल्लामा विस्तार भईसकेको छ । गुणस्तरीय स्वास्थ्य सेवा प्राप्त गर्ने नागरिकको अधिकारको संरक्षण गर्न, स्वास्थ्य बीमाद्वारा पूर्व भुक्तानीको माध्यमबाट बीमितको आर्थिक जोखिम न्यूनीकरण गर्न तथा स्वास्थ्य सेवा प्रदायकको दक्षता र जवाफदेहीता अभिवृद्धि गरी स्वास्थ्य सेवामा आम नागरिकको सहज पहुँच सुनिश्चित गर्ने सम्बन्धमा आवश्यक व्यवस्था गर्न वाञ्छनीय भएकोले स्वास्थ्य बीमा सम्वन्धी **स्वास्थ्य बीमा ऐन, २०७४ र स्वास्थ्य बीमा नियमावली, २०७५** पनि पारीत भएर कार्यन्वयनमा आइसकेको छ ।

२. दीर्घकालीन सोच

आम नेपाली जनताको समग्र स्वास्थ्य स्थितिमा सुधार गर्नु ।

३. स्वास्थ्य बीमा कार्यक्रमको उद्देश्य

- गुणस्तरीय स्वास्थ्य सेवाको पहुँच र उपयोगमा सुधार ल्याई स्वास्थ्य बीमाको आधारमा सबैका लागी स्वास्थ्य सेवा सुनिश्चित गर्नु
- स्वास्थ्य सेवाका लागि पूर्व भुक्तानि प्राप्त गरि जोखिम न्युनीकरणको व्यवस्था गरेर सर्वसाधारणका लागि थप बित्तिय संरक्षण प्रदान गर्ने
- स्वास्थ्य सेवा प्रवाहका क्रममा सेवाको गुणस्तर प्रभावकारिता दक्षता र जवाफदेहितामा सुधार ल्याउनु

४. स्वास्थ्य बीमा कार्यक्रमको फाइदा तथा महत्व

स्वास्थ्य बीमा कार्यक्रम योगदानमा आधारित कार्यक्रम हो । यस कार्यक्रमले कम जोखिममा रहेकाले बढि जोखिममा रहेकालाई सहयोग (स्वास्थ्य जोखिम), भएकाले नभएकाहरुलाई सहयोग (आर्थिक र समानताको आदान प्रदान) उत्पादनमुलक उमेरकाले आश्रित तथा अनुत्पादनमुलक उमेरकालाई सहयोग (उमेर र सामाजिक दायित्व) प्रदान गर्ने गर्दछ ।

स्वास्थ्य बीमा कार्यक्रमले राज्यकोलागि

स्वास्थ्य सेवा प्रदान गर्न अतिरिक्त श्रोत परिचालन गर्न सहयोग गर्ने, समग्र स्वास्थ सेवा प्रणालीको सुधार, प्रेषण प्रणाली व्यवस्थित हुने तथा स्वास्थ्य सेवामा हुने राज्यको व्यय भार कम गर्ने कार्यमा महत्वपुर्ण भूमिका छ ।

सेवा प्रदायक संस्थाकोलागि

स्वास्थ्य संस्थामा श्रोतसाधन पर्याप्त व्यवस्था हुने, भौतिक पुर्वाधारको विस्तार गरी स्वास्थ्य संस्था सुदृढीकरण हुने तथा सेवा प्रदान गरिएको आधारमा भुक्तानी हुने हुँदा स्वास्थ्य संस्था सुदृढीकरण भई गुणस्तरीय स्वास्थ्य सेवा प्रदान गर्न सहज हुने गर्दछ ।

व्यक्ति तथा परिवारकोलागि

आर्थिक अभावको कारण स्वास्थ्य उपचारबाट बञ्चित हुने अवस्थाको अन्त्य हुने, सुषुप्त अवस्थामा रहेका रोगहरूको समयमै पहिचान हुने, तत्काल उपचारको लागि ऋण खोज्नु पर्ने अवस्थाको अन्त्य हुने, स्वास्थ्य उपचारकै कारणले निम्तिन सक्ने गरीबीलाई रोक्ने कार्यमा महत्वपुर्ण भूमिका रहेको हुन्छ ।

५. कार्यक्रममा सहभागिताका लागि दर्ता प्रक्रिया

यस कार्यक्रममा दर्ता गर्न स्थानीय वडाबाट छनौट भई आएका दर्ता सहयोगी रहनेछन् । दर्ता सहयोगीहरु घरदैलोमै गई बीमा कार्यक्रममा दर्ता गराउने छन् । सदस्यता दर्ताका समयमा आफ्नो फोटो भएको परिचयपत्र (नागरिकता, सवारी अनुमति पत्र वा अन्य परिचय खुल्ने) दर्ता सहयोगीहरुलाई देखाउनु पर्दछ । नाबालिकको हकमा भने निजको जन्म दर्ताको प्रमाण पत्र वा अभिवावक वा संरक्षकको परिचय खुल्ने प्रमाण पत्र देखाउनु पर्ने हुन्छ । दर्ता फाराम भर्ने वेलामा सेवा लिने पहिलो स्वास्थ्य संस्था रोज्नु पर्ने हुन्छ । नेपाल सरकारले उपलब्ध गराएको परिचय पत्रको आधारमा योगदान रकम अति गरिव, अति अशक्त अपागं, कुष्ठरोगी, :म्च त्य, ज्क्ष्ख रोगीको परिवारको योगदान रकममा १०० प्रतिशत छुट र महिला स्वास्थ्य स्वयंसेविकाको परिवारको ५० प्रतिशत योगदान रकममा छुट प्रदान गर्ने व्यवस्था छ । कार्यक्रममा सहभागि परिवारका सबै सदस्यहरुले छुट्टाछुट्टै परिचय पत्र पाउँदछन् । प्रत्येक सदस्यहरुले सेवा लिन जाँदा आफ्नो परिचय पत्र अनिवार्य लिएर जानु पर्दछ । सदस्यता प्रत्येक बर्ष नवीकरण गर्नु पर्नेछ ।

६. कार्यक्रमको सदस्यता दर्ता र सेवा सुरु हुने समय

यस कार्यक्रममा जुनसुकै समयमा सदस्य बन्न सकिन्छ तर सेवा प्राप्त गर्न तोकिएको समय सम्म कुर्नुपर्ने हुन्छ ।

कार्यक्रमको सदस्यता दर्ता चक्र	सेवा क्रियाशील हुने मिति
वैशाख, जेष्ठ र असार	भदौ १ गते
साउन, भदौ र असोज	मंसिर १ गते
कार्तिक, मंसिर र पुस	फागुन १ गते
माघ, फागुन र चैत्र	जेठ १ गते

नोटः सदस्यता क्रियाशील अविध कार्यक्रममा सदस्य बनेको मितिबाट नभई सेवा क्रियाशिल भएको मिति बाट १ बर्षको हुनेछ ।

७. कार्यक्रममा सहभागि हुन लाग्ने योगदान रकम र सुविधा थैली

- ५ जना सम्मको परिवारले बार्षिक रुपमा प्रति परिवार रु ३५००। तिर्नु पर्दछ ।
- परिवारमा ५ जना भन्दा बढि सदस्य भए, प्रति थप सदस्यको रु ७०० का दरले थप रकम तिर्नु पर्छ ।
- ५ जना सम्मको परिवारले दैनिक १० रुपैया जम्मा गर्दा एक बर्षको लागि तिर्नु पर्ने रकम जम्मा हुन्छ ।
- ५ जना सम्मको परिवारले आवश्यक पर्दा वार्षिक रु १,००,००० (एक लाख) सम्मको स्वास्थ्य सेवा उपभोग गर्न सक्नेछन् ।
- ५ जना भन्दा बढि सदस्य भएको अवस्थामा प्रति सदस्य रु २०००० (विस हजार) सुविधा थैलिमा थपिनेछ, यसको अधिकतम सिमा रु २,००,००० दुई लाख) हुनेछ ।

८. कार्यक्रमबाट पाइने सुविधा (द्यभलभाष्त एबअपबनभ) सम्बन्धी व्यवस्था

नेपाल सरकारबाट निशुल्क उपलब्ध गराइएको सम्पूर्ण स्वास्थ्य सुविधाहरु यथावत रहनेछन् । यस बाहेक सदस्यले तोकिएका सेवा प्रदायक संस्थाहरुबाट निम्न प्रकारका स्वास्थ्य सेवाहरु प्राप्त गर्नेछन् ।

- बहिरङ्ग, आकस्मिक तथा अन्तरङ्गमा नपरेका तर स्वास्थ्य संस्थामा उपलब्ध सबै सेवा)
- कक्षबाट प्राप्त गरिने सेवाहरु ।कार्यकमले तोकेका निदानात्मक सेवाहरु Lab Test, ECG, ECHO, USG, MRI, CT Scan र परिक्षण सेवाहरु ११३३ प्रकारका औषधीहरु (सो मध्ये निःशुल्क औषधी समेत)
- रु १००० सम्मका चश्मा, रु. ५,००० सम्मका स्वास्थ्य सम्वन्धी सहायक यन्त्रहरु

९. कार्यक्रमबाट उपलब्ध नहुने सेवा सुविधाहरु

तोकिएको मूल्य भन्दा बढी रकमका चस्मा, श्रवणयन्त्र लगायतका स्वास्थ्य सम्बन्धी सहायक यन्त्र, प्लाष्टिक सर्जरी, कृत्रिम गर्भाधान सेवा, महँगा खालको दाँतको उपचार तथा तोकिए बमोजिमका अन्य सेवा ।

१०. स्वास्थ्य सेवा उपभोग प्रकृया

स्वास्थ्य उपचारको सिलसिलामा बहिरङ्ग सेवा लिनु पर्दा कार्यक्रमको सदस्यता लिने वेलामा आफै रोजेको प्राथमिक स्वास्थ केन्द्र वा अस्पतालबाट लिनुपर्नेछ । आकस्मिक स्वास्थ्य सेवा सूचिकृत जुनसुकै स्वास्थ्य संस्थाबाट पनि लिन

पाइने छ । सदस्यले स्वास्थ्य सेवाको उपयोग गर्दा सम्बन्धित स्वास्थ्य संस्थामा उपलब्ध सेवाहरु मात्र पाउने छन् । सदस्य आफैले रोजेको पहिलो स्वास्थ्य संस्थामा उपचार सम्भव नभएमा वा चिकित्सकले प्रेषण गरेमा माथिल्लो तहको सूचिकृत अस्पताल वा विशिष्टकृत वा अति विशिष्टकृत अस्पतालहरुबाट पनि स्वास्थ्य सेवा पाउने व्यवस्था छ । स्वास्थ्य बीमा कार्यक्रमका सदस्यहरुलाई सेवा प्रदान गर्दा सेवा प्रदायक संस्थाको नियमानुसार सेवा प्रदान गरिनेछ ।

११. प्रदेश नं. १ मा स्वास्थ्य बीमा

नेपाल सरकारद्धारा सञ्चालित स्वास्थ्य बीमा कार्यक्रम प्रदेश नं. का १४ वटै जिल्लामा शुरुवात भईसकेको छ । यहाँको स्वास्थ्यका र आर्थिक सुचकहरु सुधार गर्नकोलागि स्वास्थ्य बीमा कार्यक्रम एउटा महत्वपुर्ण आधार स्तम्भ हो । स्वास्थ्य बीमा कार्यक्रम यस प्रदेशमा प्रभावकारी वनाउनकालागि प्रदेश सरकार र स्थानीय सरकारको महत्वपुर्ण भूमिका रहन्छ । यस प्रदेशमा रहेका स्वास्थ्य सेवा प्रवाह गर्ने स्वास्थ्य संस्थाहरुलाई सक्षम वनाएर गुणस्तरीय स्वास्थ्य उपचारमा सवैको पहुँच उपलव्ध हुने अवसर सिर्जना गराउनुपर्छ ।

१२. प्रदेश नं १ मा स्वास्थ्य बीमा कार्यक्रम जिल्ला विस्तारको चरण

क. स.	जिल्लाको नाम	मिति	क. स.	जिल्लाको नाम	मिति
१	इलाम	२०७३।०३।१५	८	मोरङ्ग	२०७६।०५।१५
२	झापा	२०७४।०६।२५	९	ओखलढुगां	२०७६।०६।०८
३	सुनसरी	२०७४।०६।२५	१०	तेह्रथुम	२०७६।१२।०२
४	सोलुखुम्वु	२०७४।०६।२५	११	धनकुटा	२०७७।०३।१०
५	भोजपुर	२०७४।०९।२४	१२	उदयपुर	२०७७।०८।२७
६	खोटागं	२०७४।०९।२४	१३	पाँचथर	२०७७।१०।०२
७	संखुवासभा	२०७६।०१।१९	१४	ताप्लेजुङ	२०७७।१२।२५

१३. प्रदेश नं १ मा स्वास्थ्य बीमा कार्यक्रममा दर्ता भएका विमित सदस्यहरुको जिल्लागत विवरण

क्र.स	जिल्ला	जम्मा जनसंख्या	जम्मा सदस्य	प्रतिशत	विमित परिवार
१	मोरङ्ग	११,४७,१८३	४,३९,१०३	३८	१,२०,४९५
२	सुनसरी	९,३४,४६१	४,४२,४८२	४७	१,२०,१८४
३	झापा	९,९४,०९०	६,१०,८५२	६१	१,५८,४६०
४	इलाम	२,८०,५६५	१,३१,१९९	४७	३८,६६९
५	पाँचथर	१,७४,४१९	२३,९११	१४	८,६०२
६	ताप्लेजुङ	१,२०,३५९	१३,२२५	११	४,८११
७	धनकुटा	१,४९,९८४	३०,६७४	२०	९,०६७
८	तेह्रथुम	८९,१२५	१३,५१३	१५	४,५०१
९	भोजपुर	१,५८,९९१	३५,०९२	२२	१२,०३४
१०	खोटागं	१,७५,३४०	५०,३५०	२९	२१,०५८
११	संखुवासभा	१,५९,०४६	३२,८१५	२१	११,४१४
१२	सोलुखुम्वु	१,०४,७६८	९,७२६	९	५,५४४
१३	ओखलढुगां	१,४०,९१४	३९,५७७	२८	२५,२२९
१४	उदयपुर	३,४२,७७३	४५,६५३	१३	१७,२०४
	जम्मा	**४९,७२,०२१**	**१९,१८,१७२**	**३९**	**५,५७,२७२**

१४. प्रदेश नं. १ मा आ.व. अनुसार बीमित सदस्यको प्रतिशतको तुलनात्मक विवरण

क. स.	आर्थिक वर्ष	बीमित सदस्य	बीमित प्रतिशत	बीमित परिवार
१	आ. व. २०७६।०७७	६,२३,५६३	१४	५७,७५३
२	आ. व. २०७७।०७८	१५,११,९१४	३४	३,६३,५९४
३	आ. व. २०७८।०७९	१९,१८,१७२	३९	५,५७,२७२

१५. प्रदेश नं. १ मा स्वास्थ्य बीमा कार्यक्रममा संकलित योगदान रकम

क. स.	आर्थिक वर्ष	संकलित योगदान रकम	सेवा प्रदायक संस्थाहरुलाइ गरीएको दावि भुक्तानी रकम
१	आ. व. २०७६।०७७	६६,२४,४०,१२४।०	१,४४,८६,५९,०१८।२४
२	आ. व. २०७७।०७८	७०,२७,०९,०१३।०	२,०२,५५,४८०६२।९६
३	आ. व. २०७८।०७९	९७,००,८१,१३०।०	३,९२,५२,८६,७२७।९१
आ.व. २०७८।०७९ सम्म कुल जम्मा		२,३३,५२,३०,२६७।०	७,३९,९४,९३,८०९।११

१६. स्वास्थ्य बीमा बोर्ड प्रदेश नं. १ अर्न्तगत रहेका सेवा प्रदायक संस्थाहरुको जिल्लागत विवरण

सि.नं	जिल्लाको नाम	सरकारी	सामुदायिक	नीजि	जम्मा
१	मोरङ्ग	१४	१	९	२४
२	सुनसरी	९	०	१	१०
३	झापा	१०	१	१२	२३
४	इलाम	७	०	०	७
५	पाचथर	३	०	०	३
६	ताप्लेजुङ	४	०	०	४
७	धनकुटा	३	०	०	३
८	तेह्रथुम	५	०	०	५
९	भोजपुर	४	०	०	४
१०	खोटागं	३	०	१	४
११	संखुवासभा	६	०	०	६
१२	सोलुखुम्वु	४	१	०	५
१३	ओखलढुगां	२	१	०	३
१४	उदयपुर	४	०	०	४
जम्मा		**७८**	**४**	**२३**	**१०५**

१७. स्वास्थ्य बीमा बोर्ड प्रदेश नं. १ अर्न्तगत भए गरेका कार्यकलापहरुको विवरण

स्वास्थ्य बीमा बोर्ड प्रदेश नं. १ अर्न्तगतका १४ वटै जिल्लाहरुमा स्वास्थ्य बीमा कार्यक्रम विस्तार भएको, प्रदेश नं. १ सभाका माननिय सदस्यहरुलाई अभिमुखिकरण,सरोकारवालाहरु वीच स्वास्थ्य बीमा सम्वन्धि अभिमुखिकरण, सेवा प्रदायक संस्थासँग संझौता, दर्ता सहयोगी छनौट, तालिम तथा पुर्नताजकी तालिम, स्वास्थ्य बीमा दर्ता शुभारम्भ, अर्ध बार्षिक समिक्षा तथा बार्षिक समिक्षा कार्यक्रम, स्वास्थ्य सेवा प्रदायकहरुको लागि अभिमूखिकरण कार्यक्रम, स्थानीय तहका जनप्रतिनीधि तथा कर्मचारीहरुलाई अभिमूखिकरण, स्वास्थ्य सेवालाई प्रभावकारी वनाउन आवश्यक समन्वय तथा स्वास्थ्य सेवा प्रवाहको अनुगमन लगायतका कार्यक्रमहरु सञ्चालन भएका छन् ।

१८. समस्या तथा चुनौतीहरु

- जनताको विश्वास जित्न, सदस्यता दर्ता विस्तार गर्ने र नविकरण दर घट्नु,
- Formal Sector र बैदेशिक रोजगारमा जाने परिवारलाई समेट्न नसकिएको,
- कार्यक्रमको सम्बन्धमा व्यापक प्रचार प्रसार गर्न नसकिएको
- हेल्थ पोष्टलाई सेवाको पहिलो बिन्दु बनाउन नसकिएको,
- गुणस्तरीय स्वास्थ्य सेवाको सुनिश्चितता गर्न नसकिएको,
- UHC मा राज्यको लगानी न्यून, आपूर्ति व्यवस्था, जनशक्ति व्यवस्था, फार्मेसी व्यवस्था जस्ता समस्या

१९. समाधानका उपायहरु

- प्रदेश सरकार र स्थानीय सरकारको समेत सहयोग र सक्रियतामा सदस्यता दर्ता विस्तार
- गुणस्तरीय स्वास्थ्य सेवाको सुनिश्चितता
- कर्मचारी र मानव संशाधन व्यवस्थापन संगठन तथा व्यवस्थापन
- सेवा प्रदायक संस्थामा जनशक्ति, भौतिक पूर्वाधार, उपकरण व्यवस्थापन
- अनिवार्य सदस्यताको प्रावधान सहित स्वास्थ्य बीमा ऐन निर्माण भइसकेको
- UHC मा राज्यको लगानी बढाउन पहल गर्ने,

7.5 Provincial Health Emergency Operation Centre (PHEOC), Province 1

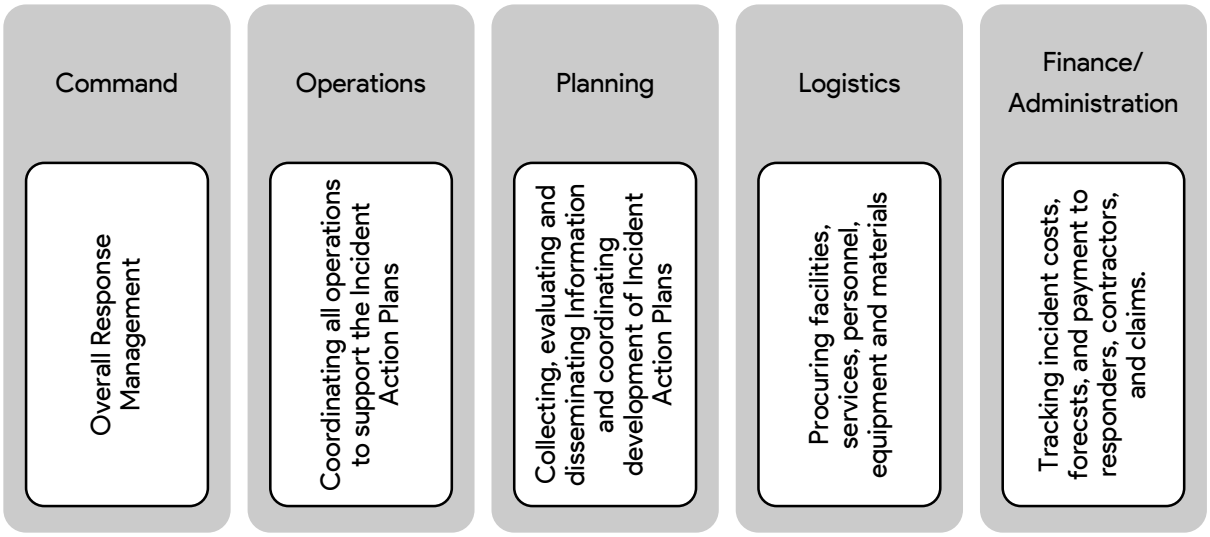
Provincial Health Emergency Operation Centre (PHEOC) is the command center for Ministry of Health and Population (MoHP) under Provincial Health Directorate (PHD). Curative Service & Disease Control Division of PHD works as a liaison for the planning and administrative procedures of PHEOC. PHEOC is the dedicated unit with its own dedicated HR and carried out activities during public health emergencies and disasters. PHEOC is the coordination hub with the roles and functions similar and complementary to the HEOC of the federal level. Its prime role is to mitigate and manage the adverse impacts of disasters and public health emergencies at the provincial level.

Major Functions of PHEOC

The five major functions of PHEOC encompass Command, Operations, Planning, Logistics, and Finance/Administration at the provincial level. PHEOC has direct linkage with HEOC and municipal health emergency operation center, unit, or focal points at different levels.

Establishment of PHEOC in Province 1:

Provincial Health Emergency Center (PHEOC) was established and handed over formally to the MOSD,



Province 1 on 25th March 2021.It is located within the premises of the Koshi Hospital, Biratnagar. In the manner of HEOC, PHEOC will also be a command center of the province in case of any health emergencies and/or disasters. It will host necessary resources and data for effective coordination (within the province including district level local level, and with the federal level).

PHEOC discharges key mandates of commanding and coordinating with different higher-level authorities at the Provincial level for the development of Incident Action Plans; facilitates and manages resources and responsibilities; and build the capacities of HR for emergency preparedness and readiness to deal with disasters and public health emergencies. It coordinates all operations with different bodies to support the Incident Action Plans, including facilitating services, deployment of EMDT.

Box 1: Bodies for Coordination

- Federal ministries
- Provincial Ministries
- Provincial Departments
- HEOC/DEOC/LHEOC
- Internal (committees, teams)
- Provincial hospitals
- Hub and satellite hospitals
- Medical Colleges
- District Hospitals
- International bodies/EDPs
- Health and Nutrition clusters
- NGOs

It maintains operational linkages between health sector multi-hazard preparedness and response mechanisms and the existing and emerging institutions/mechanisms at the provincial level.

While PHEOC facilitates the implementation of policies, strategies, guidelines, and SOPs at the provincial level, it develops and updates operational plans, action plans, planning tools, databases, etc. for multi-hazard health sector emergency risk assessment, risk mitigation, preparedness, and response readiness during the non-emergency settings. PHEOC focuses on establishment and strengthening of hub and satellite hospital networks, formation, and capacity building of EMDTs, stockpiling of emergency medical logistics, etc.

PHEOC gets activated at the time of disaster and public health emergency and will work as a command center for PHD to provide proper direction to the concerned stakeholders for effective response to disasters and public health emergencies and coordinates all the activities. Through PHD, it coordinates all the health and nutrition clusters.

PHEOC also works as the central communication body. It collects information regarding health issues during disasters and public health emergencies at the provincial level, evaluates and disseminates correct facts and status of emergencies to various bodies, including to the public. In coordination with different

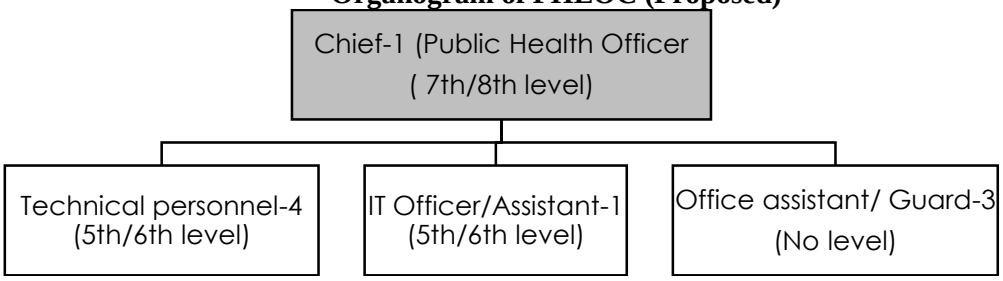
bodies, PHEOC also maintains 3Ws (Who, what, Where) and 4Ws (Who, what, Where, When) matrices to minimize gaps and overlaps during humanitarian/ emergency response through PHD.

After the response period, PHEOC through PHD undertakes after-action reviews; facilitates and documents learnings; updates plan, strategies, and tools; and coordinates and monitors the implementation of recovery interventions.

Organizational Structure

The proposed organization structure of PHEOC has its own structure within Provincial Health Directorate/PHD under Curative Service & Disease Control Division to plan and execute the response for public health emergencies and disasters at the provincial level (Annex-I).

Organogram of PHEOC (Proposed)



**Provincial authority can add some personnel (temporary & permanent) on need basis.*

Human resources are the part and parcel of PHEOC to run the health disaster management and risk reduction in the province through the vertical, horizontal, and diagonal coordination among various stakeholders. There is no sanctioned post in PHEOC so following permanent position will be approved by concerned authority to run the PHEOC:

Proposed staffing pattern of PHEOC:

Post	Level	Number	Remarks
Chief	Public Health Officer (7^{th}/8^{th} level)	1	Proposed
Technical personnel	5^{th}/6^{th} level	4	Proposed
IT Officer/Assistant	5^{th}/6^{th} level	1	Proposed
Office assistant/Guard/Driver	No level	3	Proposed
Total		**9**	

** MOHP/Mosd can add some temporary personnel based on requirement and approval.*
** The PHEOC act as the Secretariat of Incident Command System,*
#MoHP/MoSD/PHD can mobilize 2 guards from general security.
The Director of PHD leads as the first authorized person and the Chief of Curative Health & Disease Control Division from Mosd leads as the second authorized person.

Major Objectives of PHEOC

- To coordinate for preparedness and response against disaster and public health emergency among different concerned stakeholders at the province level.
- To prepare and update health related acts, regulations, operational plans, and action plans for preparedness against disaster and public health emergency, response, and rehabilitation at the province level in accordance with the federal documents; and,
- Under the guidance of steering committee, lead technical issues related to disaster and public health emergency.
  Form sub-committees as per need, such as Planning & Information management
  Material development, Communication, Logistic management, Public Health-RRT
  Hub satellite-EMDT, Admin/Finance-HR, Finance & Community care
- Planning& Information management
- Material development
- Communication
- Logistic management
- Public Health-RRT
- Hub satellite-EMDT
- Admin/Finance-HR, Finance
- Community care

Major Achievement in year 2022

Target for year 2023

One Door Covid-19 Reporting system

Coordination center for Health emergencies and Disasters

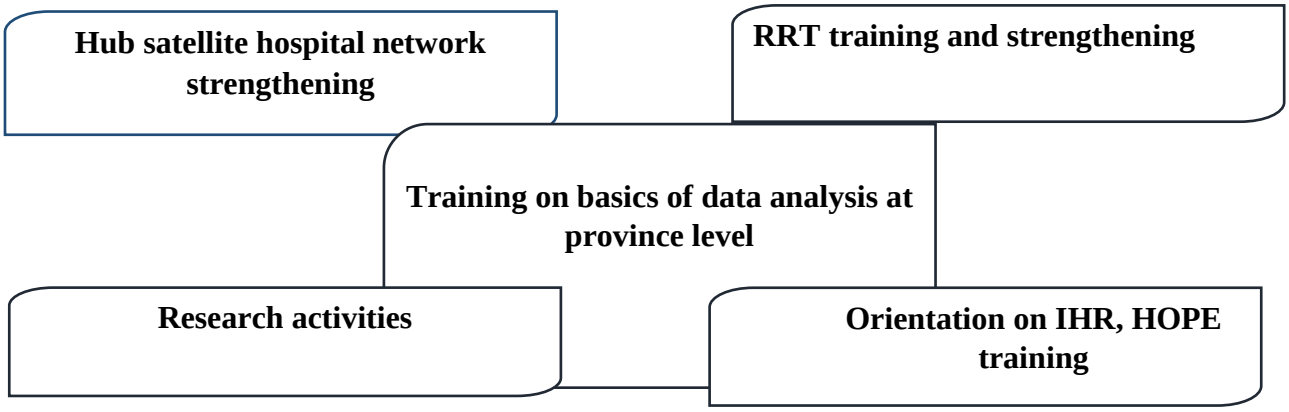
Technical support and capacity building training activities

Establishment of Ambulance Dispatch center (support from C-19 Global fund and save the children)

Joint monitoring with government entities during outbreak or emergencies

Information dissemination of IEC materials,guidelines, media content, health information, Rumor Verification

Advocacy, coordination, and support in transportation of samples (C-19, Dengue) from different parts to NPHL through PPHL



7.6 Department of Drug Administration (DDA), Provincial Office, Biratnagar

औषधि व्यवस्था बिभाग, शाखा कार्यालय, विराटनगरको संगठन

सांगठनिक ढाँचा र दरबन्दि विवरण

सि.न.	पदनाम	स्वीकृत दरबन्दी	पदपूर्ति	रिक्त	रिक्त प्रतिशत
प्राविधिक					
१.	औ.व्य./ब.औ.व्य.(नवौं/दशौं)	१		१ रिक्त	
२.	फा.अ.(सातौं/आठौं)	२	१ पदपूर्ति	१ रिक्त	
३.	फा.सु.(पाचौं/छैठौं)	२	१ पदपूर्ति	१ रिक्त	
प्रशासनिक					
४.	ना.सु.(रा.प.अनं.प्रथम)	१	पदपूर्ति		
५.	स.ले.पा.(रा.प.अनं.द्वितीय)	१	पदपूर्ति		
६.	ह.स.चा.(श्रेणी विहिन)	१		रिक्त	
७.	कार्यालयसहयोगी (श्रेणी विहिन)	१		रिक्त	
करार					
८.	फा.अ.(सातौं)		१ जना		
९.	फा.सु.(पाचौं)		२ जना		
१०.	ह.स.चा.(श्रेणी विहिन)		१ जना		
११.	कार्यालय सहयोगि (श्रेणी विहिन)		१ जना		
१२.	हेल्प डेस्क (श्रेणी विहिन)		१ जना		
१३.	सुरक्षा गार्ड (श्रेणी विहिन)		१ जना		
जम्मा:			**९**	**३**	

प्रगती विवरण

लक्ष्य तोकिएको र नतोकिएको सेवाहरुको विवरण

१ फार्मेसी सम्बन्धि कार्यहरु

१.१	नयाँ फार्मेसी दर्ता	थोक	खुद्रा		जम्मा
			Community	Hospital	
१.१.१	एलोप्याथिक	२९	२८५	११	३२५
१.१.२	भेटेरिनरी	१	११	-	१२
१.१.३	आयुर्वेदिक	-	३६	-	३६
१.१.४	होमियोप्याथिक	-	४	-	४
१.१.५	यूनानी	-	-	-	-
जम्मा		३०	३३६	११	**३७७**
१.२	फार्मेसी नविकरण	२८६	२५९४	२३	२९०३
१.३	फार्मेसी रद्ध	१४	१५२	-	१६६
१.४	प्रमाणपत्र (अनुसूची ९) मा संशोधन	५२	३५७	४	४१३
१.५	व्यवसायी प्रमाणपत्र प्रदान		नयाँ	नविकरण	
	जम्मा		९	१६२	

२	निरीक्षण सम्बन्धि कार्यहरु					
२.१	फार्मेसी निरिक्षण	मासिक लक्ष्य	थोक	खुद्रा		जम्मा
				Community	Hospital	
२.१.१.	एलोप्याथिक	४२	३३	५५२	४१	६२६
२.१.२.	भेटेरिनरी		-	१९	-	१९
२.१.३	आयुर्वेदिक		-	८	-	८
२.१.४	होमियोप्याथिक/युनानी		-	४	-	४
जम्मा			३३	५८३	४१	**६५७**

लक्ष्य		बार्षिक	यस महिनासम्म	हालसम्मको प्रगती	वार्षिक प्रगती प्रतिशत
		५००.०	५००	**६५७**	**१३१.४०%**
२.२	फार्मेसी निरीक्षण सम्बन्धि कैफियत	कैफियत फार्मेसीको संख्या			कैफियत संख्या
		थोक	खुद्रा		
			Community	Hospital	
२.२.१	दर्तानभएका फार्मेसी	-	६९	५	७४
२.२.२	ब्यवसायी/फर्माशिष्टअनुपस्थित	९	२११	११	**२३१**
२.२.२.१.	फर्माशिष्ट	-	५	-	५
२.२.२.२.	सहायकफर्माशिष्ट	१	४०	३	४४
२.२.२.३.	व्यवसायी	६	१७६	-	१८२
२.२.३	दर्तानभएका औषधि प्राप्त फार्मेसी	-	२५	-	२५
२.२.४	लागू तथा मनोद्विपक औषधिको रेकर्ड नराखेको	2	१२३	१०	१३५
२.२.५	उचित तापक्रममा भ्याक्सिन सञ्चय नगरेको	-	३२	२	३४
२.२.६	म्याद नाघेका औषधि सञ्चय गरेको	१	११	-	१२
२.२.७	निःशुल्क वितरण गर्नु पर्ने औषधि सञ्चय गरेको	-	-	-	-
२.२.८	Physician Sample संचय गरेको	-	११	-	११
	जम्मा	-			
३.	नमुनासंकलन	PMS	निरीक्षण	अन्य	जम्मा
३.१	संकलितनमुना संख्या	९०	२२	३	११५
३.२	विश्लेषणकालागि पठाएको संख्या	९०	२२	३	११५
४.	फार्मेसी कारबाही	थोक	खुद्रा		जम्मा
			Community	Hospital	
४.१	निलम्बन	१	३१	-	३२

४.२	मुद्दाको विवरण र संख्याः				१९
५	उद्योगनिरिक्षण	WHO GMP	National GMP	Regular	जम्मा
५.१.	एलोप्याथिक	-	-	१	१
५.२.	भेटेरिनरी	-	-	-	-
५.३.	आयुर्वेदिक	-	-	१	१
६	उजुरी	अ.दु.अ.आ.	स्थानीय प्रशासन	व्यक्ति/अन्य	जम्मा
६.१.	प्राप्त उजुरी	-	१	३५	३६
६.२	फर्स्यौट	-	१	२१	२२
७.	यस आर्थिक वर्षकोराजश्व संकलन	११३७३८६५	एक करोड तेह्र लाख तिरहत्तरहजार आठ सय पैंसठी मात्र ।		
	२०७८/७९ सम्मको धरौटी संकलन	११६०६१२	एघार लाख साठी हजार छ सय बाह्र मात्र ।		
	बेरुजु	नभएको			

बजेट तर्फ

पुँजिगत

ख.शि.न	खर्च संकेत	बार्षिक बजेट	जम्मा खर्च	खर्च प्रतिशत
३११६१	रंगरोगन तथा झ्याल ढोका मर्मत	४०००००	३९७२९०	९९.३२
३११२१	मोटर सयिकल र स्कुटर खरिद	५५००००	५४८८००	९९.७८
३११२२	शाखा कार्यालयहरुको लागि कार्यालय उपकरण (कम्पुटर, फोटोकपी मेशिन, जेनेरेटर, रेफ्रिजेरेटर, हिटर, एसी, सिसि क्यामेरा) आदी खरिद	५०००००	५०००००	१००
३११५९	गार्ड टहरा निर्माण	२०००००	१९६९०६	९८.४५
३११२३	फर्निचर तथा फिक्सचर	५०००००	४९८७२८	९९.७५
	जम्मा	**२१५०००० **	**२१४१७२४**	**९९.६०**

चालू तर्फ

ख.शि.न	खर्च संकेत	बार्षिक बजेट	जम्मा खर्च	खर्च प्रतिशत
२११११	पारिश्रमिक कर्मचारी	४९५८०००	२१४७७८०	४३.३२
२११२१	पोशाक	८००००	५००००	६२.५०
२११२२	थुनुवाको राशन सिदा	५००००	४९९५०	९९.९०
२११३२	महंगी भत्ता	१६८०००	९६०००	५७.१४
२११३४	मुल्यांकन समितिको बैठक भत्ता	४१०००	०	०
२११३९	पाले पहरा भत्ता	६३०००	३१४२५	४९.८८
२१२१२	उपदान कोष खर्च	१०००००	०	०
२१२१३	योगदानमा आधारित बिमा कोष खर्च	४४०००	१८०००	४०.९१
२२१११	पानि तथा बिजुलि	१४७०००	१४७०००	१००
२२११२	संचार महसुल	१३८०००	१३६६८१	९९.०४
२२२१२	ईन्धन	४६६०००	४६६०००	१००
२२२१३	सवारी साधन मर्मत	४६००००	४५९९९९	९९.९९
२२२१४	बिमा तथा नविकरण	४५०००	४३५३५	९६.७४
२२२२१	संचालन तथा मर्मत संभार	५४०००	५३९४०	९९.८९

ख.शि.न	खर्च संकेत	बार्षिक बजेट	जम्मा खर्च	खर्च प्रतिशत
२२३११	कार्यालय संचालन खर्च	४१००००	४१००००	१००
२२३१४	ईन्धन अन्य प्रयोजन	८७०००	८७०००	१००
२२३१५	पत्रपत्रिका छपाई तथा अन्य प्रयोजन	१८००००	१५५५०९	८६.३९
२२४१३	करार कर्मचारीका लागि पोशाक	२००००	२००००	१००
२२४१३	करार कर्मचारीको लागि चाडबाड खर्च	४१०००	४१०००	१००
२२४१३	हलुका सवारी साधन चालक, कार्यालय सहयोगी स्वीपर करार	४८२०००	४८२०००	१००
२२४१३	हेल्प डेस्क तथा सुरक्षा गार्ड सेवा करार	४९४०००	३९३६८०	९९.९४
२२४१३	निरिक्षण कार्यक्रमको लागि निरिक्षक करार सेवा	१०८२०००	१०८१६१०	९९.९६
२२५१२	सिप विकास तथा जनचेतना तालिम गोष्ठी	४८००००	४८००००	१००
२२६११	अनुगमन तथा निरिक्षण मुल्यांकन	८०७०००	६८२८३८	८४.६१
२२६१२	भ्रमण खर्च	४२०००	४२०००	१००
२२७११	विविध खर्च	६५०००	६५०००	१००
२७२१३	औषधि खरिद	३०००००	२३३४८७	७७.८३
	जम्मा	**१,१५,०४,०००/**	**८१,७४,४३४/**	**७१.०६/**

<u>औषधि व्यवस्था बिभागको वेबसाईटहरु:</u>

- यस कार्यालयको वेबसाईट-https://www.dda.gov.np/
- यस कार्यालयको इमेल ठेगाना-ddabiratnagar4@gmail.com, biratnagar@dda.gov.np
- यस कार्यालयको फसबूक पेज–DDABiratnagar

<u>कार्यालय प्रमुख र सूचना अधिकारीको नाम र पद:</u>

- कार्यालय प्रमुखको नाम: **टेकेन्द्र मिश्र**, **फार्मेसी अधिकृत**-९८५२०६१०१०
- सूचना अधिकारीको नाम:**दिपेन्द्र खड्का**, **फार्मेसी सुपरभाइजर**-९८५२०८१०३२

PART 8 - SUPPORTING PROGRAMS

8.1. Health Education, Information and Communication

Background

The health education and communication units in the Province Health Directorate works to meet the increasing demand for health education services by implementing IEC activities utilizing various media and methods according to the needs of the local people in the province. Local media and languages are used in the district for dissemination health messages so that people can understand health messages clearly in their local context.

The general objective of IEC for health is to raise the health awareness of the people as a mean to promote improved health status and to prevent disease through the efforts of the people themselves and through full utilization of available resources. The specific objectives of the programs are to:

- Increase awareness and knowledge of the people on health issues
- Increase positive attitudes towards health care
- Increase healthy behavior
- Increase participation of the people in the health intervention programs at all levels of health services
- Increase access to new information and technology on the health programs for the people
- Promote environment health and hygiene
- Control the tobacco and Non-Communicable Diseases (NCDs)

Major Activities

- Radio program airing from FM
- Orientation to journalist and stakeholders on health
- Production of health materials
- Distribution of health education materials in HFs
- School health programme
- Awareness campaign on prevention and control of COVID 19.
- Program on Environmental / occupational health and hygiene
- Community health promotion campaign
- Award to FCHVs and encourage FCHVs to promote health education
- Supervision and Monitoring of IEC activities
- Awareness program on control of epidemics
- Orientation for control of smoking and non-communicable diseases in Health education program

8.2 Integrated Health Information Management System (IHMIS)

Manages health service information from community to the DoHS level. This system provides the basic information for planning, monitoring and evaluation of the health system at all levels.

Major functions of the Integrated Health Information Management System:

- Facilitate MoHP to develop national level policies, plans, regulation, guidelines, standards and protocols related to integrated information system.
- Timely update and making information digital friendly for effective management and health information.
- Develop, expand and institutionalize existing health sector information system such as HMIS, LMIS, HIIS etc as an integrated information system.
- Identification and revision of sector wise health indication for national level health information. Develop periodic and annual health reports and disseminate the funding based on rigorous analysis and existing health information.
- Facilitate for capacity building and health personnel for institutionalization of integrated information system at different level.
- Coordination and cooperation with provincial and local level government for health-related information management system development and implementation.
- Facilitate division of DoHS for developing annual work plan and budget.
- Prepare and document monthly, trimester and annual progress and various activities conducting by divisions under DoHS and need based reporting to MoHP.
- Provide support to MoHP on behalf of DoHS for development of overall plan. Improve online data entry mechanisms in all districts and hospitals and gradually extend online data entry to below districts level health facilities.
- Online data entry mechanism will be established in provinces and local levels.

- Establish a uniform and continuous reporting system from government and non-government health service providers so that all health services provided by government and non-government providers are reported and published.
- Verify, process and analyze collected data and operate a databank. Provide feedback on achievements, coverage, continuity and quality of health services to programme divisions and centers, RHDs, hospitals, DHOs and DPHOs.
- Databased feedback will be provided to provinces. Disseminate health information through efficient methods and technologies.
- Improve the information management system using modern information technology. Update HMIS tools as per the needs of program divisions and centers.
- Update geo-information of health facilities. Provide HMIS and DHIS 2 tracking as per needed.

History of IHIMS

1958: Reporting system for malaria eradication program and initiation of program specific reporting
1993: Integrated Health Management Information System (HMIS) all vertical reporting system integrated
1997: Logistic Management Information System (LMIS) used in all 75 districts
2004: First Telemedicine system introduced
2006: Health sector information system (HSIS) endorsed integrated information management conceptualization
2012: Transaction Accounting and Budget Control System (TABUCS) started
2013: World Health Resolution (WHA) resolution on standardized and interoperability and Health facility wise online entry in HMIS
2016: HMIS migrated to District Health Information System (DHIS2) platform
2017: National eHealth strategy endorsed and HMIS expands eReporting from health facilities
2018:

- Health facility registry completed and Health workforce registry initiated
- Launch of digital Nepal framework 2018, WHA 71.1 digital health
- Beginning of Electronic Logistic Management Information System (eLMIS) on the support of Global Health Supply Chain Program-Procurement supply management (GHSC-PSM)

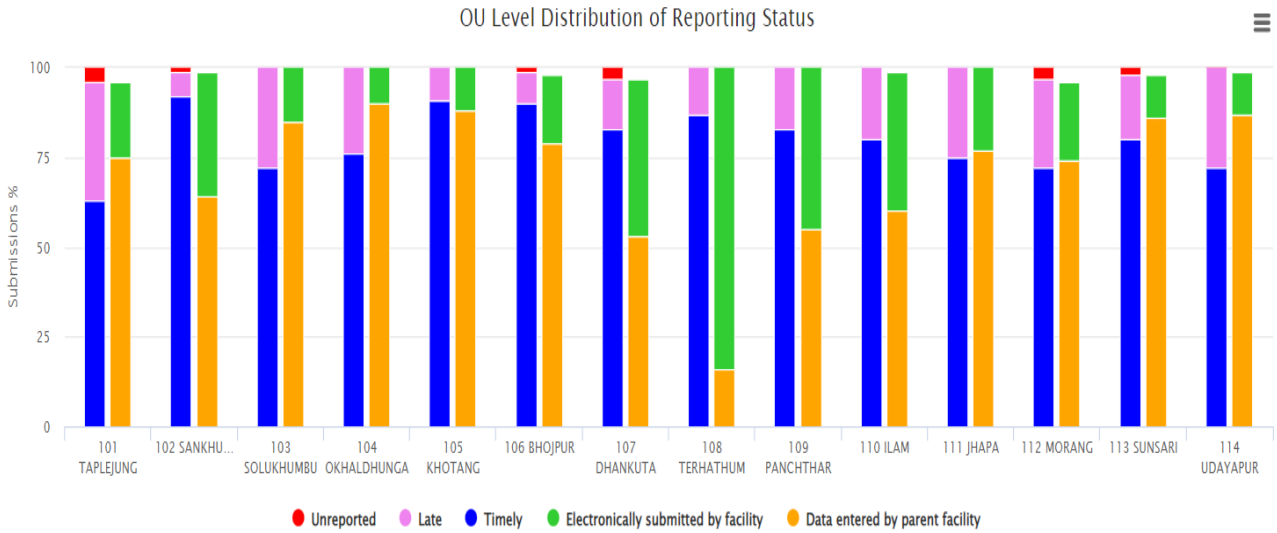
2019:

- HMIS turned into Integrated Health Information Management System (IHIMS) section
- Establishment of Information Management Unit (IMU) under ICS/HEOC and management of necessary resources to operationalize (secretary level decision:2077/02/27)

2020: IHIMS roadmap drafted
2022: IHIMS roadmap approved by ministerial level (2078/03/24)

DHIS2:

Reporting status



- The above bar diagram shows the reporting status of Province 1. Where Red color indicates the Closed health facilities in DHIS-2.
- Among 14 districts Terhathum District has highest no. of self-reporting health facility (84%) and Okhaldhunga has the lowest (10%) self-reporting in DHIS-2.

DHIS-2 implementation status:

Health Facility	FY-2077/78	FY-2079/80	Total newly Registered HFs in DHIS-2
Primary Hospital	4	28	24
BHSC	253	359	106
UHC	95	99	4
CHU	103	136	33

EHR and EMR implementation status:

- EHR datacenter/ server implemented in 2 hospitals of Province 1, PHD, NITC (National Information Technology Center)
- EMR- Fully implemented in 7 Hospitals and partially implemented in all other hospitals of Province 1.

Information Management Unit (IMU) Nepal Application:

Background:

- On 31 December 2019, a novel coronavirus, SARS-CoV-2 was identified in Wuhan, China.
- The first confirmed COVID-19 case in Nepal was reported on 23 January 2020.
- Incident Command System under MOHP, realized information management is one of the prime pillars of effective response.
- Information Management Unit (IMU) was established at the Health Emergency Operation Centre (HEOC) under the ICS/MoHP.

History:

- Establishment of IMU under ICS/HEOC and Management of necessary resources operationalize (Secretary level decision: 2077-02-27 BS)
- Formation of Different teams with dedicated members and their ToR to operationalize different functions of IMU as per concept note (Secretary level decision: 2077-05-23 BS)
- Nominated Mr. Anil Thapa (Chief of IHIMS) as chief of IMU with even additional scope of work to manage COVID-19 vaccination reports (Secretary level decision: 2077-12-3 BS)

Concept and Objective of IMU:

- Concept: Health Sector Emergency Response Plan 2020 COVID-19 Pandemic, 4.5 Monitoring, Evaluation and Reporting(A) "An information management unit with a dedicated team and adequate resources will be established under the Incident Command System (HEOC). The composition and number of the team will be assessed by HEOC based on the situation (level).
- Objective: Effective management of the information related to COVID-19 pandemic, assist the ICS operation, other ICS teams and entities of the MOHP by providing analyzed information on a regular basis to help them in information decision making to control the pandemic.

Introduction to IMU Nepal Application:

- MoHP recognized the Hamro Survey app developed by Amakomaya, later modified as IMU Nepal app with technical support from WHO.
- IMU Nepal app is an online national digital platform for case registration, recording, reporting and monitoring COVID-19 cases.

In the IMU system, the different organization types according to LLGs in respective districts are:

- PCR Lab only
- PCR and Antigen test
- Antigen test only
- Hospital with COVID- 19 Lab
- Hospital without COVID- 19 Lab
- Home Isolation and CICT
- Institution Isolation
- Point of Entry

Objectives of IMU Nepal Application:

- Real time identification, management and reporting of COVID 19 positive cases.
- To provide information about the epidemiological distribution of positive cases and support in case management and CICT.
- To provide real time raw data for concerned divisions (EDCD) for planning and policy-making.
- To support in COVID-19 surveillance system.

Modules in IMU:

- PCR laboratory module- 10 laboratories have been registered in IMU Nepal Application for regular recording and reporting of PCR test conducted and number of Positive and negative cases.
- COVID-19 case management module-7 Hospitals with COVID-19 laboratory and 43 hospitals without COVID-19 laboratory have been registered in IMU Nepal application.
- Community module- All 137 LLGs.
- CICT Module- All 137 LLGs.
- PoE Module- 3 PoEs (Rani PoE, Kakarbhitta PoE and Pashupatinagar PoE) have been registered in IMU Nepal Application for regular recording and reporting of Screening, Antigen testing and number of positive and negative cases of COVID-19.
- Vaccination Module- All 137 LLGs. are responsible for QR code verification of COVID-19 vaccination.

Role of stakeholders in IMU:

Case Origin/Data origin/Case Management

❖ **Palika**

-To register the suspected case and swab collection

-To monitor health status of case in home isolation or institutional isolation

❖ **Hospital/Isolation**

-To register the suspected case, swab collection, swab test (If lab facility is available)

-To monitor health status of case in home isolation or institutional isolation and case manage

❖ **Laboratory**

-To register the suspected case and swab collection, lab test

Case Monitor/report produce/facilitate to use IMU

❖ **EDCD**

-To monitor case in community (isolation/home)/hospital/lab/PoEs by using IMU update aggregated case data to MoHP, produce report, facilitate palika/hospital/isolation and lab by using IMU

-Facilitate Hospital/lab/palikas to use IMU

❖ **NPHL**

-Directly support to labs on using IMU. Solve the technical problem with closed coordination of IMU technical team

❖ **Curative Division**

-Directly support to hospital on using IMU. Solve the technical problem with closed coordination of IMU technical team

❖ **HEOC**

-Directly support to palika/hospital/isolation/labs on using IMU. Solve the technical problem with closed coordination of IMU technical team

❖ **FWD**

-Directly support to COVID vaccination centers on using IMU. Solve the technical problem with closed coordination of IMU technical team

❖ **IMU/IHIMS**

-Develop and strengthen the IMU system, server and Data Management, develop system and data standardization, data security, training and technical support to EDCD, NPHL, Curative division and HEOC, National/Geo based data analysis, provide support in field, share data as per the defined protocol to designated agency.

Activities Carried out to improve Data quality:

- RDQA- Health Directorate carried out RDQA in 11 Health Facilities, Health Office and LLGs are also involved in conducting RDQA in Health Facilities.
- Monthly meeting-3 Virtual meeting via Zoom regarding data quality.

- Half yearly review and budget planning workshop has been organized by Health Directorate, Dhankuta.
- Annual Review has been organized by Health Directorate, Dhankuta.
- Data verification
- Continuous phone follows up
- Data quality- continuous feedback via Email and Phone calls
- Orientation meeting for revised DHIS2/LMIS/IMU monthly reporting via Zoom which was organized by PHD and participants were from IHIMS section-MD, PHLMC, Health offices, LLGs and Health facilities
- Continuous feedback through messenger group and email
- Messenger group has been created to discuss the issues and challenges facing while using DHIS-2 and IMU.

Issues and Challenges:

- Lack of trained human resources in DHIS-2, IMU.
- Inadequate HR in health facilities.
- Internet problem in some Palikas and Health facilities of Mountain/Hilly Districts.
- Although frequent follow up, negligence of Palika on timely and complete reporting of DHIS2/IMU.
- In some palikas and health facilities there are lack of laptop and desktop, in some laptop and desktops require maintenance.
- Difficulty in getting report from Private health facilities, need to discuss to solve the issue regarding private health facility reporting in DHIS-2.
- DHIS-2 system unreachable is also one of the problems, because frequent system unreachable problem is causing difficulty in on time DHIS-2 reporting.
- In some palikas and health facilities revised HMIS forms and format yet to reach.
- Difference in printed HMIS recording and reporting tools and data entry in DHIS-2, which cause confusion.
- Need of IMU training: as there are changes in IMU software, responsible human resources are not capable to use updated version of IMU software smoothly.
- Poor coordination between health offices and LLGs.

8.3 Logistics Management Information System (LMIS)

Logistic Management Information System comprises collection and analysis of quarterly (three monthly) LMIS reports from all of the health facilities across the country; preparation, reporting and dissemination of information to:

- Forecast annual requirements of commodities for public health program including family planning,
- maternal, neonatal and child health, HIV and AIDS commodities, vaccines, and Essential Drugs;
- Help to ensure demand and supply of drugs, vaccines, contraceptives, essential medical and cold chain supplies at all levels;

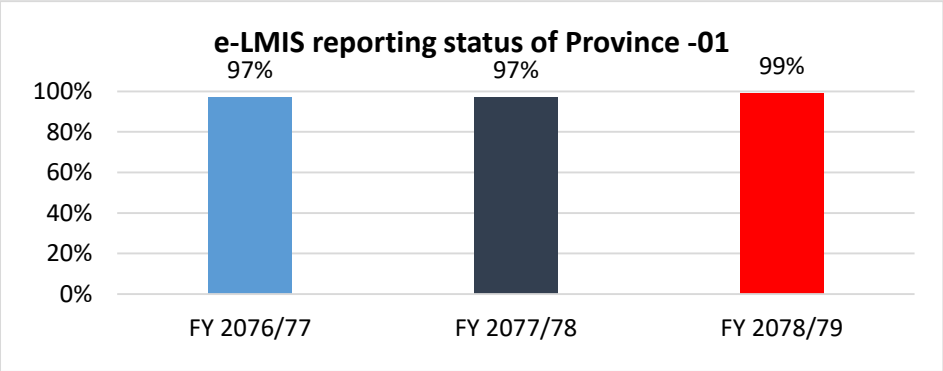
• Quarterly monitor the national pipeline and stock level of key health commodities.

The major activities conducted by eLMIS unit of provincial health directorate in FY 2078/79:

- Conducted eLMIS orientation program in Solukhumbu, Dhankuta, Taplejung, Okhaldhuga, Morang, Bhojpur and Sankhuwasabha districts
- Conducted refresher eLMIS training to all the districts in Biratnagar
- Onsite coaching to local levels and hospitals
- Oriented and trained health workers for monthly eLMIS reporting
- Initiation of eLMIS reporting from Service Delivery Points (SDPs)
- Distribution of eLMIS report user ID and password to SDPs by coordinating with Management Division, Teku, Kathmandu
- Created a social media group encompassing all the health workers from local levels, districts, province and central.
- Follow up and provided necessary feedback through emails, phone calls and other online mediums
- Conducted monthly meetings for strengthening and improving data quality in eLMIS
- Provided technical support via zoom, any-desk and other online mediums
- Coordination with IHIMS, PHLMC, districts and local levels consistently for complete, accurate, relevant and timely eLMIS data

Provincial eLMIS Reporting Status, FY 2078/79:

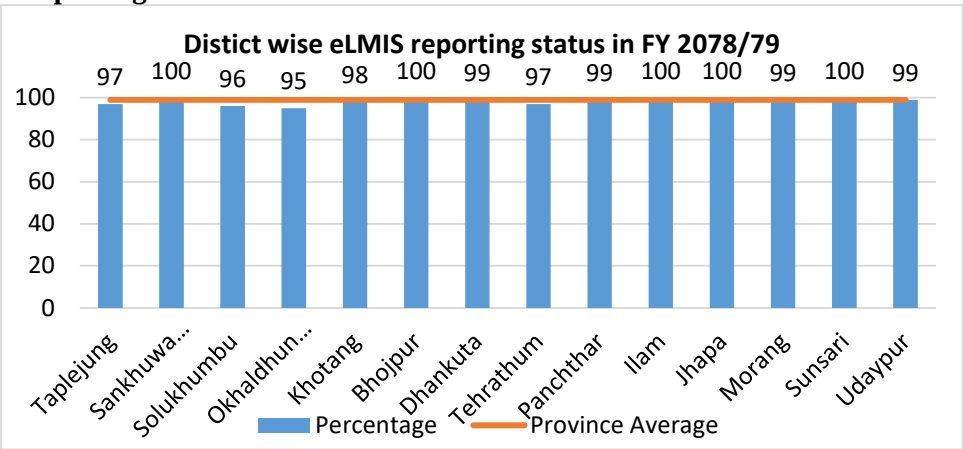
Figure 79: Province-01 eLMIS reporting status



After successful implementation of eLMIS at all local level governments in FY 2077/78, LMIS reporting status has been gradually improved (99%) in FY 2078/79 compared to FY 2076/77 and FY 2077/78.

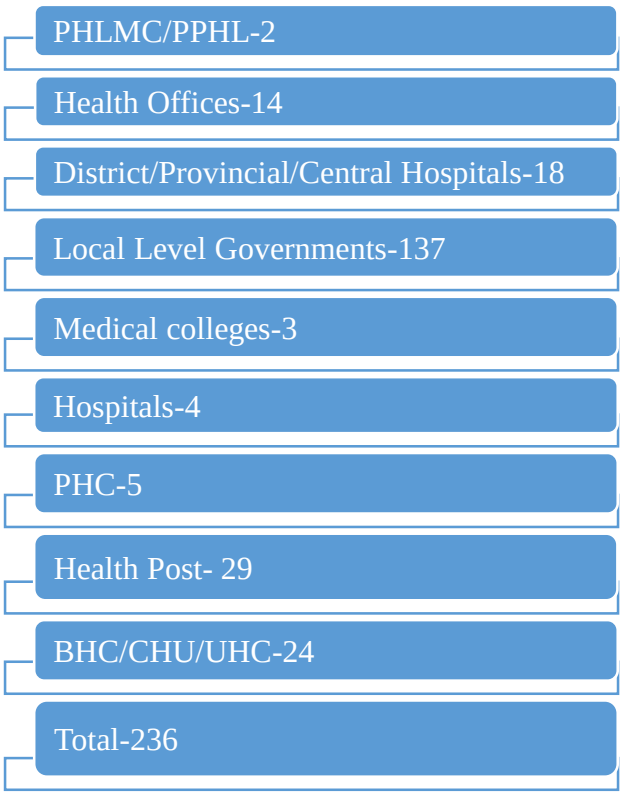
Figure 80:District wise Reporting Status

In fiscal Year 2078/79, Okhaldhunga, Solukhumbu, Taplejung, Tehrathum and Khotang have LMIS reporting lower than province average (99%).



eLMIS Implemented Sites:

Figure 81: Number of eLMIS implemented sites in FY 2078/79



In FY 2077/78 eLMIS was implemented up to Local level governments and in FY 2078/79 eLMIS has been implemented up to sixty-two service delivery points. The total number of eLMIS implemented sites till the end of FY 2078/79 have reached two hundred thirty-six.

Issues and Challenges:

- Inadequate human resources in health facilities
- Internet problem in some Palikas and Health facilities of Mountain/Hilly Districts
- Although frequent follow up, negligence of Palika on timely and complete reporting of eLMIS
- In some palikas and health facilities there are lack of laptop and desktop, in some laptop and desktops require maintenance
- Difficulty in getting report from Private health facilities, need to discuss to solve the issue regarding private health facility reporting
- Poor coordination between health offices and LLGs

PART 9 - SUPPORTING PARTNERS

Summary of External Development Partners in Province 1

Name of Organization	Contact Person	Cell number	Program area / theme	Geographical coverage/Districts
BNMT	Gyanendra Shrestha	4436434/ 4428240	Ensure equitable access to quality health services (TB Case Finding project-5 District)	Udayapur, Sunsari, Morang, Jhapa & Ilam
FHI 360 Nepal (EPIC Project)	Salina Joshi	9851097118	HIV prevention, treatment, care, and support services for key populations and PLHIV in Ilam, Jhapa, Morang and Sunsari districts	Ilam, Jhapa, Morang and Sunsari
Chemonics International	Sailendra Patel	9851140260	Supply chain Management / health system strengthening.	All district of Province 1
Helen Keller International (HKI-Suaahara-II)	Subhash Gautam, Province Coordinator	9801248602	Suaahara-II is an integrated nutrition program intended to improve the nutritonal status of women and children in Nepal. Its major components are - household nutritional & WASH behaviour change communication, Health system strengthening, Homestead food production and marketing (diversed agriculture) and strengthened local governance.	Solukhumbhu, Bhojpur, Sankhuwasabha, Panchthar and Taplejung
Ipas Nepal	Popular Gentle	01-4420787	Sexual and reproductive health and rights through enhanced access to and use of safe abortion and contraceptive care.	sankhuwasabha, Terhathum, Ilam, Sunsari
Karuna Foundation	Yogendra Giri	9852021562	Prevention of avoidable childhood disability and rehabilitation of person with disability, Maternal and child health, Cervical Cancer screening and Management, WASH and Holistic Development	Ilam,Pachthar,Dhankuta, Morang and Sunsari
Marie Stopes	KP Upadhyaya Sr. Advisor	4439642 4419371	Health (SRHR)	Sunsari, Morang, Jhapa, Khotang, Bhojpur, Sankhuwasabha, Udaypur and Terahthum
Netherlands Leprosy Relief (NLR), Nepal	Nand Lal Banstola	9842032513	Leprosy control & prevention; Disability prevention and management (I2C), Disabilities Inclusive development (DID), comprehensive WASH, Organizational strengthening, Inclusive development (ID)	Leprosy control program coverage - all districts of province 1 & province 7; DID and Model Village coverage - Selected urban/rural Municipalities of Province 1 & 7
Nick Simons Institute	Sushma Lama	9843561333	Hospital Management (District), Rural Staff support, Support in MSS	All 14 districts
NHSSP (Nepal Heath-Sector Support Project III)	Bandana Neupane	9841824965	Nepal Health System Strengthenning Support Program	Sunsari (Itahari Sub-Metropolitan city)
One Heart	Nilesh Kumar	9841196741	Maternal neonatal and Child	Mostly focused on all the

Name of Organization	Contact Person	Cell number	Program area / theme	Geographical coverage/Districts
World-wide	Pravana		Health: Demand generation of MNCH services, Capacity building (SBA and ASBA training, Rural RUSG training, Onsite coaching and mentoring, MNH Update) Service site strengthening (equipment support and birthing center renovation, Hospital/HF quality improvement process)	birthing centers of 9 districts of province 1 (Taplejung, Pachthar, Ilam, Terathum, Shankhuwasabha, Bhojpur, Khotang, Okheldhunga and Sholukhumbu). BPP/Miso training and follow up, and other activities covers all the HF of the districts.
PSI-Nepal	Sudip Devkota	9856043401	Family planning and Safe Abortion	Jhapa, Morang, Sunsari, Udayapur
Save the children Global Fund / Biratnagar	Haribol Bajagain	9804005737	TB, Malaria & HIV AIDS (Case identification, treatment / Care & Support), system strengthening	Province 1
WaterAid Nepal	Shyam Bhandari	9841051628	Hygiene Promotion through Routine Immunization, Technical Support to Immunization section to integrate hygiene in routine immunization	Nationwide/All 14 districts of Province - I
World Vision International	Mohan Dangi	9802806996	Health & child Protection	Udayapur, Mornag
WHO- IPD, Biratnagar Field Office	Dr. Saru Devkota/ Sanoj Kumar Poudel	9852020068/ 9852035517	Vaccine Preventable Disease Surveillance (Polio, Measles, Japanese Encephalitis and Neonatal Tetanus), Routine Immunization and SIAs(Supplementary immunization Activities)	Sunsari , Morang ,Udhaypur, Okhladhunga, Khotnag and Solukhumbhu
WHO- IPD, Damak Filed Office	Dr. Karishama Gurung	9852024591	Vaccine Preventable Disease Surveillance (Polio, Measles, Japanese Encephalitis and Neonatal Tetanus), Routine Immunization and SIAs(Supplementary immunization Activities)	Jhapa, Illam, Panchataar, Taplejung, Dhankuta , Bhokpur, Terathum and Sankhuwashabha
WHO-Health System	Krishna Kumar Deo	9818806191 deok@who.int	Support to MoSD for evidence-based health system, policy, and planning.	MoH
WHO - PHEOC	Dr Sagar Poudel	986663508	Support in different areas of health sector preparedness and response readiness such as hub and satellite hospitals network coordination, prepositioning and replenishment of emergency medical logistics, risk assessment, human resources management etc.	Province 1
FAIRMED	Dambar Singh Gurung	9851073712	Neglected Tropical Diseases, Maternal and Neonatal Health, GESI, Disability, WASH and Nexus As cross cutting	Jhapa, Morang and Sunsari
Plan International Nepal, Janakpur	Mihir Kumar Jha		Child protection, ECD, gender & social inclusion, Household Economic Security (young women	9 Rural/Municipalities of Sunsari Dharan, Barahachetra, Ramdhuni, Inaruwa, Duhabi, Dewangunj, Harinagara, Gadi,

Name of Organization	Contact Person	Cell number	Program area / theme	Geographical coverage/Districts
			empowerment), Disaster Risk management, Sponsorship program	Barju.
PHECT Nepal	Kailash Khaki Shrestha		Disability care and support	
MSNP	Sanjeev Ghising	9849083418	Multi-sectoral Nutrition	137 Palika of Province 1
WFP	Arpan Dhakal	9852049935	Mother and Child Health and Nutrition Programme, technical support for implementation of Nutrition interventions of Province, BFSP distribution during emergencies	Jhapa, Morang and Sunsari

स्वास्थ्य क्षेत्रमा कार्यरत साझेदार सस्था, प्रदेश १
आर्थिक बर्ष २०७७/७८ (१६ जुलाइ २०२० देखि १५ जुलाइ २०२१) को विवरण

१. **सेभ द चिल्ड्रेन, ग्लोवल फण्ड**

संस्थाको नाम	सेभ द चिल्ड्रेन, ग्लोवल फण्ड
सम्पर्क व्यक्ती र सम्पर्क नम्बर	हरिबोल बजगाई, बरिष्ठ कार्यक्रम प्रवन्धक ग्लोवल फण्ड, सम्पर्क नम्बर: ९८४००१६०७५
विषयगत कार्यक्षेत्र	क्षयरोग, एच आई भी एडस तथा औलो रोग
भौगोलिक कार्यक्षेत्र	प्रदेश १
सञ्चालित परियोजनाको नाम र परियोजना अवधि	क्षयरोग, एच आई भी एडस तथा औलो रोग पहिचान, नियन्त्रण, उपचार र सहयोग परियोजना । १६ मार्च २०२१ देखि ३१ जुलाई २०२४ सम्म
परियोजना सञ्चालन प्रकृया	क्षयरोग, एच आई भी एडस तथा औलो (मलेरिया) का विरामीको पहिचान तथा उपचार गर्ने उदेश्यहरु पुरा गर्न नेपाल सरकारको स्वास्थ्य मन्त्रालय संगको सहकार्यमा तीन तहका सरकार अन्तर्गतका स्वास्थ्य सेवा प्रदायकहरुलाई सहयोग । साथै रोगको निदान र उपचारका लागि उपचार सेवा केन्द्रमा पहुच अभिबृद्धि र संक्रमण रोकथामका लागि जोखिममा रहेका समुदाय संग कार्यरत सस्था संस्था तथा जोखिममा रहेका व्यक्तीहरुले नेतृत्व गरिरहेका नेपाली संस्थाहरुसंग सहकार्य र साझेदारी ।
परियोजनाको बार्षिक उपलब्धि	मलेरिया ● १२ ओटा मलेरिया केसको अनुसन्धान र उपचार ● इटा उद्योगहरुमा मलेरियाको सवेक्षण । ● अरुण नदीका माथिल्ला उपत्यकाहरुमा सामुदायीक परीक्षण ● मलेरिया कार्यक्रमको अवधिक योजनाका लागि परामर्श वैठक सम्पन्न । एचआइभी एडस ● ३०५३ जना लागु पदार्थ सेवनकर्तालाइ एचआइभी सचेतना, १९२० जनाको एचआइभी परीक्षण, ५ जनामा एचआइभी निदानमा सहयोग र १२४५५३ कण्डमको वितरण ● ९३५ जना एच आइ भी संक्रमितहरुलाई घर तथा समुदायमा आधारित हेरचाह र सेवा प्रदान गर्न सहयोग । ५५२ जनालाई सामुदायीक हेरचाह केन्द्रवाट आवसीय उपचार सेवा प्रदान गरिएको । ● ९८ जना एचआइभी संक्रमित बाल बालिकालाई मासिक रु १००० (एक हजार) नगद सहायता कार्यक्रममा आवद्ध गरी सहायता प्रदान गरिएको र प्रदेश बाट समेत सोही वराबरको सहायता थप गर्नको लागि पहल गरिएको । ● एचआइभी परिक्षण र उपचारका लागि अवश्यक जाँच तथा उपचार सामाग्री वितरणमा प्रदेश आपुर्ति केन्द्र संग सहकार्य गरिएको ।

	क्षयरोग • २४२ डट्स सेन्टरहरुलाई खकार ढुवानी सेवामा आवद्ध गरिएको • १२०१ क्षयरोगीको निदान गरियो • ७४ बाल बालिकामा क्षयरोग निदान गरियो । • १७७ जना क्षयरोगीको निदान नीजि स्वास्थ्य सेवा प्रदायक मार्फत सम्पन्न । • १४६ जना क्षयरोगको जोखिममा रहेका ५ बर्ष मुनीका बाल बालिकालाई क्षयरोग निरोध थेरापी सेवामा आवद्ध गरिएको र २४७ जना बालबालिकाले थेरापी सेवा पुरा गरेको । • जिन सपर्ट सेवा विस्तारमा सहयोग । • खकार परीक्षणको गुणस्तर मापन प्रणाली मा सहयोग • हरेक क्षयारोगीको एच आइ भी परीक्षणमा पहल गरिएको
बजेट र खर्च विवरण	साझेदार मर्फत विनियोजित बजेट: ३,०३,९०,००० (तीन करोड, तीन लाख, नब्बे हजार)
आगामी प्राथमिकताहरु	• सर्वेषणले अनुमान गरेका तर निदान र उपचारमा पुग्न नसकेका तथा जोखिममा रहेका वा संक्रमित व्यक्तीको जाँच र उपचारमा सेवा अभिबृद्धि गर्ने • नीजि स्वास्थ्य सेवा प्रदायकहरुमा भएका निदान र उपचारका तथ्याकहरु नेपाल सरकारको रिपोर्टिङ्ग प्रणालीमा प्रविष्ठ गर्ने । • स्वास्थ सामाग्री आपुर्ति व्यवस्थापनलाई सघाउने • राज्यले निर्दिष्ठ गरेको लक्ष तथा रणनीति हरुलाई हाँसील गर्न, स्थानीय तहसंग सहकार्य गर्ने

साझेदार संस्था, कार्यक्षेत्र, सम्पर्क व्यक्ती र सम्पर्क नम्बर

प्रदेश १

साझेदार सस्थाको नाम	परियोजना विषय	कार्य क्षेत्र	सम्पर्क व्यक्ती	सम्पर्क नम्बर
बागमती सेवा समाज नेपाल (BWSN)	क्षयरोग निदान, नियन्त्रण र उपचार	इलाम, झापा, मोरङ्ग, सुनसरी उदयपुर,	अनिल देव, प्रदेश टीम लिडर	9852035638 anil.deo@bwsn.org.np
नाटा मोरङ्ग	डी आर विरामीलाई आवसीय सेवा	विराटनगर	ध्रुव उराउ	9852029926 drtlo1966@gmail.com
रिचमण्ड फेलोसिप मोरङ्ग	लागु औषध सेवन कर्ता लक्षित, एचआइभी एड्स सचेतना, असुरक्षित व्यवहार परिवर्तन तथा एचआइभी परीक्षण र उपचार प्रेषण	इलाम, झापा, मोरङ्ग, सुनसरी उदयपुर,	संजिव चापागाई, परियोजना व्यवस्थापक	9852024927 rfm.pwid@gmail.com
राष्ट्रिय एच.आई.भी. तथा एड्स महासंघ(NAP+N)	एच आइ भी संक्रमितको उपचार, हेरचाह र सहयोग	संखुवासभा, इलाम, झापा, मोरङ्ग, सुनसरी, उदयपुर	सन्तोश शाह	9849131440 santosh.napn@gmail.com
Nepal Health Society (NHS)	जेलमा रहेका व्यक्तीहरुलाइ एचआइभी सम्बन्धि सचेतना र परीक्षण सेवा	झापा, मोरङ्ग, सुनसरी	पुनम श्रेष्ठ	9841567807 nepalhealths@gmail.com
Recovering Nepal (RN)	Catalytic Fund - एच आइ भी संक्रमितिलाई समाजमा हुने गरेको भेदभाव, लान्छना हटाउदै, अधिकारको सुनिस्चितता र सेवा सवलिकरणमा पैरवी गर्ने ।	संखुवासभा, उदयपुर, सुनसरी, मोरङ्ग, झापा	अभिशेक थापा	9817389288 bikkitakka007@gmail.com
National Federation of Women Living with HIV (NFWLHA)			अल्सन चौधरी	9807 020 898 / 9862 430 811 nfwlha.province1@gmail.com

नोट: कार्यक्रमको आवश्यकता र श्रोतको उपलब्धताका आधारमा आगामी दिनमा परियोजना र साझेदार थप वा परिवर्तन हुन सक्ने छन ।

२. हेलेन केलर इन्टरनेसनल (सुआहारा दोश्रो चरण कार्यक्रम)

संस्थाको नाम	हेलेन केलर इन्टरनेसनल (सुआहारा दोश्रो चरण कार्यक्रम)
सम्पर्क व्यक्ति र सम्पर्क नम्बर	सुभाष गौतम, (वरिष्ठ प्रदेश संयोजक, प्रदेश नं. १) सुआहारा कार्यक्रम सव-अफिस, फिदिम, पाँचथर कार्यालय फोन : ०२४-५२१०२१, मोवाईल :९८०१२४८६०२
विषयगत कार्यक्षेत्र	एकीकृत पोषण
भौगोलिक कार्यक्षेत्र	प्रदेश १ अन्तरगतका सोलुखुम्बु, भोजपुर, संखुवासभा, पाँचथर र ताप्लेजुङ जिल्लाहरु

सञ्चालित परियोजनाको नाम र परियोजना अवधि	Suaahara II (Good Nutrition) Program अप्रिल २०१६ देखि मार्च २०२३
परियोजना सञ्चालन प्रकृया	सुआहारा परियोजना नेपाल सरकार र सम्बद्ध सरकारी निकाय, निजी तथा पोषणसँग सम्बद्ध अन्य परियोजनाहरूतथा सरोकारवालाहरूको समन्वयमा सञ्चालन गरिन्छ ।यो परियोजना मूख्यत: किशोरिकिशोरी, गर्भवती महिला, सुत्केरी महिला र दुई वर्ष मुनिका बालबालिकाको स्वास्थ्य तथा पोषणको अवस्थामा सुधार गर्नमा केन्द्रित छ । यसका साथै किशोर-किशोरीको स्वास्थ्य तथा पोषणसम्बन्धी सेवाहरूको विस्तार गर्नमा पनि नेपाल सरकारलाई सहयोग गर्दछ । सुआहारा- दोस्रो परियोजनाले नेपालको बहुक्षेत्रीय पोषण योजनाले निर्धारण गरेका पोषणसम्बन्धी लक्ष्यहरू हासिल गर्न योगदान पुऱ्याउँछ ।यस परियोजनाका कार्यक्रमहरूमा बहुक्षेत्रीय अवधारणाको आधारमा सञ्चालन गरिन्छन् जसमा स्वास्थ्य, कृषि, पशुपन्छी, महिला सशक्तीकरण, शिक्षा, खानेपानी तथा सरसफाइ क्षेत्रहरूलाई समेटिएको हुन्छ । साथै लैङ्गिक समानता, सामाजिक समावेशीकरण, व्यवहार परिवर्तन र असल शासनका सिद्धान्तहरूलाई पनि यस परियोजनाले ध्यान दिएको छ ।
स्थानिय साझेदार सस्था भएमा तीनकोनाम र सम्पर्क नम्बर	1. Bhojpur district - Health, Education, Human Right, Local Development, Drinking Water and Environment Nepal (HEEHURLDE Nepal) Tel : 029-420641 Email : heehurlde55@gmail.com 2. Sankhuwasabha district - Shilichong Club Social Development Center (SCSDC) Tel : 029-561106 Email : scsdcssava@gmail.com 3. Solukhumbu district - Young Star Club (YSC) Tel : 038-520212 Email : ysc.suaahara@gmail.com 4. Panchthar district - Nepal Janauddhara Association (NJA) Tel : 024-520061 Email : nepaljanauddhar@gmail.com 5. Taplejung district- Environment Conservation and Development Forum (ECDF) Tel : 024-460940 Email : ecdftaplejung@gmail.com
परियोजनाको बार्षिक उपलब्धि आ व २०७८/७९	स्वास्थ्य तथा पोषणका नियमित क्रियाकलापहरु अन्तर्गत वार्षिक प्रगति ● स्वास्थ्य आमा समुहको बैठकलाई अझै प्रभावकारी बनाउन र १००० दिनका आमा र परिवारका निर्यणकर्तालाई स्थानीयस्तरमा पाइने खानेकुराहरु प्रयोग गरि बच्चाको लागि थप पोषिलो खाना बनाउन, खुवाउन र सरसफाईमा ध्यान पुर्याउन सिकाउने उद्धेश्यले सुआहारा दोस्रो कार्यक्रम लागु भएका पाँच जिल्लाहरुका स्वास्थ्य आमा समुहमा जम्मा ६०४ वटा पोषिलो खाना प्रदर्शनी सम्पन्न भएको, जसबाट ८६४१ जना हजार दिनका आमा तथा परिवारका सदस्यहरु लाभान्वित भएका थिए । ● १००० दिनभित्र पर्ने विभिन्न अवस्थामा महिला र बच्चाको स्वास्थ्य र पोषणको लागि अपनाउनुपर्ने सहि व्यवहारहरुलाई प्रोत्साहन गर्न स्वास्थ्य आमा समुहको बैठकमा १००० दिनको आमा र परिवारका सदस्यहरुको उपस्थितिमा जीवनका महत्वपुर्ण अवसरहरु मनाउने गरिएको थियो । यस आर्थिक वर्षमा कुल ४१०४ वटा जीवनका महत्वपुर्ण अवसरहरु मनाइएको थियो जसमा २४२७१ जना हजार दिनका आमा तथा परिवारका सदस्यहरुको उपस्थिति रहेको थियो । ● स्वास्थ्यकर्मीहरुको क्षमता बिकास एवं सुदृढीकरणका लागि स्थानीय स्वास्थ्य संस्थाहरुमा ऋद्य(क्षल्ऋक्ष, क्ष८, :क्ष्ऋल का स्थलगत अनुशिक्षण एवं चम्त८ क्रियाकलापहरु ७५ वटा स्वास्थ्य संस्थाहरुमा सम्पन्न भई ५०४ जना स्वास्थ्यकर्मीहरु लाभान्वित भएका थिए । ● गुणस्तरीय पोषण तथा स्वास्थ्यका लागि आफ्नै पहल ९क्व्ज्० तथा समुदाय स्वास्थ्य प्राप्ताइक बोर्ड ९ऋज्क्व० सम्बन्धि अभिमुखीकरणका ८ वटा क्रियाकलापहरुमा स्वास्थ्य संस्था व्यवस्थापन समिति पदाधिकारी, स्वास्थ्यकर्मी, महिला स्वास्थ्य स्वयंसेविका तथा समुदायका २४२ जनाको सहभागिता रहेको थियो । ● नवजात शिशु तथा बाल रोगहरुको एकीकृत व्यवस्थापन कार्यक्रम अन्तर्गत स्वास्थ्यसंस्थाहरुमा स्थलगत अनुशिक्षणका लागि प्रशिक्षक तयार गर्न सञ्चालन गरिएका दुईवटा जिल्लास्तरीय कार्यशाला एवं ८ वटा स्वास्थ्य संस्थामा स्थलगत अनुशिक्षणका लागि सहजीकरण तथा प्रविधिक सहयोग गरिएको थियो भने ८ वटा स्थानीय तहमा पोषण समीक्षाका क्रममा सहजीकरण सहयोग उपलब्ध गराईएको थियो । ● विद्यालय स्वास्थ्य एवं पोषण क्रियाकलाप अन्तर्गत १६ वटा स्थानीय तहमा किशोरीहरुलाई आईरन चक्की खुवाउने कार्यक्रमका लागि अभिमुखीकरण कार्यशाला सम्पन्न गरिएको थियो । ● राष्ट्रिय भिटामिन ए कार्यक्रमलाई प्रभावकारी बनाउन प्रचारप्रसार, स्थलगत सहयोग तथा सुरक्षित कार्यक्रम सञ्चालनका लागि ५ वटै जिल्लाका सबै महिला स्वास्थ्य स्वयंसेविकाहरुलाई सर्जिकल मास्क र स्यानिटाईजर उपलब्ध गराईएको थियो । ● शीघ्र कुपोषण बहिरंग उपचार केन्द्रहरुमा उपचाररत बालबालिकाहरुका अभिभावकहरुलाई नियमित फलोअप तथा परामर्श गरिने गरेको छ । ● घरायसी खाद्य उत्पादन प्रवर्द्धनका लागि ग्रामीण नमूना कृषकहरु तथा तरकारी एवं कुखुरापालन श्रोत व्यक्तिहरुको क्षमता बिकासमा सहयोग, अभिमुखीकरण, तालीम प्रदान गरिएको तथा बीउबिजन एवं कृषि सामग्रीहरु वितरण गरिएको थियो । ● पोषण तथा स्वास्थ्य कार्यक्रमहरुको दिगोपना सुनिश्चितताका लागि १३ वटा स्थानीय तहमा जनप्रतिनिधिहरु एवं पालिकाका विषयगत कर्मचारीहरुको सहभागितामा दुईदिने कार्यशाला गोष्ठी एवं समन्वय बैठकहरु सम्पन्न भई पोषण स्वास्थ्य सुधारका लागि नगर/गाउँपालिकाका प्राथमिक क्रियाकलाहरु तय गरी प्रतिवद्धता निर्माण गरिएको थियो ।

	• अत्यावश्यक पोषण तथा स्वास्थ्य व्यवहारहरु एवं सेवाको माग वृद्धिका लागि हजार दिने महिला, परिवारका सदस्य एवं महिला स्वास्थ्य स्वयंसेविकाहरुलाई ११४५०९ वटा मोवाईल शन्देशहरु पठाईएको थियो । • १५ वटा एफएमहरुबाट रेडियो कार्यक्रम भन्छिन् आमा तथा स्वास्थ्य तथा पोषणसम्बन्धी रेडियो सन्देशहरु प्रसारण गरिएको थियो । • समुदायका घरधुरीमा कोभिड १९ का लक्षणहरु तथा बच्चका लागि अपनाउनुपर्ने सावधानीहरुका बिषयमा टेलिफोनमार्फत् परामर्श गरिएको । लक्षण देखिएकाहरुलाई परीक्षणका लागि परामर्श गर्ने तथा उनीहरुबारे स्थानीय निकायलाई जानकारी गराउने गरिएको । • महामारीका समयमा अपनाउनुपर्ने अत्यावश्यक स्वास्थ्य एवं पोषण व्यवहारहरु तथा सेवाको उपलब्धताबारे हजार दिने आमाहरुलाई ३०४०९ पटक फोन परामर्श गरिएको साथै घरधुरी भ्रमण गरी १३७६४ आमाहरुलाई परामर्श गरिएको । • स्वास्थ्य संस्थाहरुमा अत्यावश्यक सेवा तथा सामग्रीहरुको उपलब्धताबारे नियमित सुचना संकलन एवं छलफल गरी अत्यावश्यक सेवा सुचारु गर्न तथा सामग्रीहरु उपलब्ध गराउन स्वास्थ्य कार्यालय, पालिका एवं स्वास्थ्य संस्था तथा सम्बन्धित सरोकारवालाहरुसँग समन्वय गरिएको, • रेडियो कार्यक्रम तथा जिंगलहरुमार्फत कोभिड १९ बाट बच्ने उपायहरुबारे प्रचारप्रसार ।
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु	• घरधुरी एवं आमा समुह स्तरमा एकीकृत पोषण, स्वास्थ्य एवं सरसफाई व्यवहार परिवर्तन सञ्चार तथा क्षमता विकास क्रियाकलापहरु, • आमा समुहमा पोषिलो खाना प्रदर्शनी एवं जीवनका महत्वपूर्ण अवसरहरु मनाउने क्रियाकलापहरु, • स्वास्थ्यकर्मीहरुको क्षमता बिकासका लागि स्थलगत अनुशिक्षण तथा तालिमपश्चात्का अनुगमन क्रियाकलापहरु, • मध्यम कुपोषित बालबालिकालाई सुपोषित र स्वस्थ बनाउन परिवारका सदस्यहरुलाई प्रोत्साहित गर्ने घरधुरी केन्द्रित क्रियाकलापहरु, • शीघ्र कुपोषण बहिरंग उपचार केन्द्रहरुमा उपचाररत बालबालिकाहरुका अभिभावकहरुलाई नियमित फलोअप तथा परामर्श, • वृहत पोषण विशेष कार्यक्रम सम्बन्धि प्रशिक्षक प्रशिक्षण तालिम साथै उक्त तालिम पालिका र समुदायस्तरमा संचालन गर्न प्राविधिक सहयोग, • विद्यालय स्वास्थ्य तथा पोषण सेवाहरुलाई प्रभावकारीता र दिगोपनासम्बन्धि स्वास्थ्य, शिक्षा र स्थानीय तहमा जनप्रतिनिधिहरु विच समिक्षा गोष्ठी, • सुचना तथा सञ्चार माध्यमहरुको प्रयोग, १५ वटा एफएमहरुबाट रेडियो कार्यक्रम भन्छिन् आमा तथा स्वास्थ्य, पोषण र कोभिडबाट सुरक्षा सम्बन्धी रेडियो सन्देशहरु प्रसारण, • कोभिड १९ जोखिम सञ्चार एवं सामुदायिक संलग्नता अभियानसँग सम्बन्धित क्रियाकलापहरु, • महामारीका समयमा अपनाउनुपर्ने अत्यावश्यक स्वास्थ्य एवं पोषण व्यवहारहरु तथा सेवाको उपलब्धताबारे हजार दिने आमाहरुलाई घरभेट, फोन एवं मोवाईल सन्देशमार्फत् परामश • गुणस्तरीय पोषण तथा स्वास्थ्यका लागि आफ्नै पहल ९क्व्ज्० तथा समुदाय स्वास्थ्य प्राप्ताइ्क बोर्ड ९ऋज्क्व्० सम्बन्धि अभिमुखीकरण एवं समुदायस्तरीय सहभागितामूलक क्रियाकलापहरु, • घरायसी खाद्य उत्पादन प्रवर्द्धन, ग्रामीण नमूना कृषकहरु तथा तरकारी एवं कुखुरापालन श्रोत व्यक्तिहरुको क्षमता बिकास सहयोग एवं विविध प्रकारका तरकारीको वीउ वितरण क्रियाकलापहरु, • नगर/गाउँपालिकाहरुका कृषि एवं पशुसेवा कर्मचारीहरुलाई पोषण संवेदनशील कृषि तालीम, • पोषण तथा स्वास्थ्य कार्यक्रमहरुको दिगोपना सुनिश्चितताका लागि स्थानीय तहमा जनप्रतिनिधिहरु एवं पालिकाका बिषयगत कर्मचारीहरुको सहभागितामा दुईदिने कार्यशाला गोष्ठी तथा कार्ययोजना निर्माण गर्ने कार्यक्रम ।

३. UN-Migration Agency, International Organization for Migration (IOM)

सस्थाको नाम(Name of Organization)	UN-Migration Agency, International Organization for Migration (IOM)
सम्पर्क व्यक्ती र सम्पर्क नम्बरcontact Person, contact Number)	Dr. Vasil Gazdadziev; 9801004508
विषयगत कार्यक्षेत्र(Working area)	IOM, Nepal
भौगोलिक कार्यक्षेत्र (Geographical area)	Province 1
सञ्चालित परियोजनाको नाम र परियोजना अवधि Programe Name, and duration)	Migration Health Program for refugees and immigrants, TB DOTS program for the migrants and refugee.
परियोजना सञ्चालन प्रकृया(Program implementation method)	-Health Assessment, Vaccination and TB DOTS implementation -Support in Covid-19 response -Support in TB Control program
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर(Local	Ministry of Health and Population (MoHP)-Kathmandu, Provincial Health

Partner and their contact Number)	Department-Province-1, District Health Office-Jhapa, Damak Municipality-Damak and Nepal Anti Tuberculosis Association (NATA)- Biratnagar National Tuberculosis Control Center (NTCC), Bhaktapur Nepal Nepal Red cross society, Nepal
परियोजनाको वार्षिक उपलब्धि(Achievement of program)	• Strengthening the capacity of government of Nepal for migrant sensitive preparedness and response towards COVID-19: project: With the funding from the Government of Japan, IOM Nepal supported the Government of Nepal, Ministry of Health and Population (MoHP) in prevention, mitigation, and response efforts to control the transmission and mitigate the negative impact of the society and reduce huge strain on the health care system due to COVID-19 from 13 March 2020- 31 January 2021. IOM worked on four pillars; Pillar 1: Coordination and Partnership, Pillar 2: Risk Communication and Community Engagement, Pillar 3: Surveillance and Pillar 4: Point of entry. Population mobility and public health risk mapping from August-October 2020 in Mechinagar, Suryodaya and Biratnagar for Province 1. • IOM donated 4,000 sets of non-food items (NFIs), each consisting of one mosquito net, 120 ml sanitizer and one face mask in August - October 2020. The sets were distributed to holding, isolation and quarantine centers in Jhapa, Morang and Sunsari districts of Province 1. • Handwashing station Installed in Kakardvitta POE in June 2020. • Various IPC material provided to Damak and Mechinagar municipality in August 2020. • Orientation to frontline health workers and border officials deployed at the ground crossing points (GCP) of Nepal (May-August 2021). Out of 10 GCP, 3 was in province 1(Ilam, Jhapa and Biratnagar) • IOM Nepal has been successfully conducting the health assessment process for the refugees and migrants since 2007. • IOM has played a vital role in screening TB cases and providing treatment under TB DOT program for the same among the refugee and migrant's population. Vaccination has also been an integral part of IOM health assessment program which has successfully vaccinated more than 100,000 refugees to prevent from vaccine preventable diseases
बजेट र खर्च विवरण Budget & expense)	Not applicable
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु (Future priorities)	• IOM will continue the health assessment process with the aim to screen more refugees and migrants and help in timely detection and treatment of the tuberculosis (TB) case through CXR and sputum analysis. • "Advancing the global health security agenda through strengthening capacities for rapid response to humanitarian and public health". In coordination with MoHP and FWD to make vaccines available at the GCP /Port of entry for the returnee migrants and other migrants, the program is being planned for Province 1(Kakarbhitta) • "Effective case management by strengthening Isolation centers and Ground Crossing Points (GCPs) management for Rapid Response and Preparedness against COVID-19" intends to implement a twofold COVID-19 response to address the gaps and needs identified through the assessment. The project aims to strengthen the capacities of one GCPs and isolation centers through supporting the Governments of Province 1. The screening and testing at GCPs help reduce the spread of COVID-19 by early detection and provides an opportunity to educate returnee migrant and their families about COVID-19 and ways to remain safe.

	• TB Reach: Operational Research: To address the gaps in enhanced and facility led screening of TB suspects, operational research and introduction of artificial intelligence technology for CXR screening at Nobel Medical College, Biratnagar.

४. फेयर मेड फाउण्डेशन, नेपाल

सस्थाको नाम	फेयर मेड फाउण्डेशन, नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	डम्बरसिंह गुरुङ्ग, टिम लिडर ९८५१०७३७१२
विषयगत कार्यक्षेत्र	Neglected Tropical Diseases, Maternal and Neonatal Health, WASH and Disability Prevention
भौगोलिक कार्यक्षेत्र	सुनसरी, मोरङ्ग र झापा
सञ्चालित परियोजनाको नाम र परियोजना अवधि	विश्वास परियोजना BISWAS Project (Building Trust and Confidence Among NTD affected People) ४ बर्ष (सन २०२१ देखी २०२५)
परियोजना सञ्चालन प्रकृया	स्थानीय स्तरमा रहेका स्वास्थ्य आमा समूह, महिला स्वास्थ्य स्वयं सेविका, स्वास्थ्य संस्थाहरु, गाउं तथा नगरपालिका, जिल्ला स्थित स्वास्थ्य कार्यालय,अस्पताल, प्रदेश स्वास्थ्य तालिम केन्द्र, प्रदेश स्वास्थ्य निर्देशनालय र प्रदेश सरकार संगको समन्वय, सहभागिता र साझेदारितामा कार्यक्रमको प्रतिफल लक्षित समुदाय सम्म पुग्ने गरी काम गर्ने । समुदायमा स्वास्थ्य सेवा र विकासका हिसावले पछाडि पारिएका वर्गलाई समेट्नका लागि "कोही पनि नछुटुन" (Leave No One Behind- LNOB) भन्ने अवधारणाबाट काम गर्ने ।
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	साहारा नेपालस् झापा र मोरङ्ग फोन नं ०२३ ५४३४०८ सेभ द अर्थस् सुनसरी फोन नं ०२५ ५६२२५६ करुणा फाउण्डेशन, नेपालस् अपाङ्गताको क्षेत्रमा रणनैतिक साझेदार संस्था (झापा, मोरङ्ग र सुनसरी) फोन नं ०२५ ५८८८०२
परियोजनाको बार्षिक उपलब्धि	फेयरमेड फाउण्डेशन नेपालले यो प्रदेशमा गत २०२१ को मध्यबाट मात्रै आफ्नो कार्यालय स्थापना गरेर काम गर्न शुरु गरेको ।
बजेट र खर्च विवरण	
आगामी बर्ष आ व २०७९/८० का प्राथमिकताहरु	NTDs, MNH / Disability prevention को विषयमा महिला स्वास्थ्य स्वयंसेविका लगायत समुदाय स्तर सम्मै जनचेतना अभिवृद्धी गर्ने, ल्म्क का बारेमा प्रदेश स्तरको तालिम म्यानुअलको विकास गर्ने, सबै स्वास्थ्यकर्मीहरु र महिला स्वास्थ्य स्वयंसेविकाहरु लाई समेत तालिम दिई ति रोगहरुको समयमै पहिचान, निदान र प्रभावकारी उपचार कार्यमा सहयोग पु(याउने, स्थानीय सरकार, प्रदेश सरकार र अन्य सहयोगी संस्थाहरु संगको साझेदारितामा आवश्यक तालिम, उपकरण जस्ता कुराहरुमा सहयोग गरी ल्म्क को उपचार केन्द्र स्थापना र नियमित सञ्चालनमा पहल गर्ने । आमा र नवजात शिसु स्वास्थ्यका सुधारका लागि MNH Update जस्ता तालिमहरु प्रदान गरी नर्सिङ्ग कर्मचारीहरुको क्षमता अभिबृद्धी गर्ने, २४ घण्टे सुत्केरी सेवा केन्द्रहरुको सुद्धृढीकरणका लागि आवश्यक तालिम, औजार जस्ता कुराहरुमा आवश्यक सहयोग गर्ने । स्थानीय निकायहरु संग निरन्तर समन्वय, छलफल र अर्न्तक्रियाका माध्यमद्धारा पछाडि परिएका समुहको स्वास्थ्य तथा स्थानिय निकायबाट प्रदान गरिने सेवामा पहुच बृद्धी र स्वास्थ्य क्षेत्रमा नियमित बजेट विनियोजनका लागि पैरवी गर्ने । साथै स्थानिय स्वास्थ्य संस्था संचालन तथा व्यवस्थापन समितिको क्षमता अभिबृद्धी र सुद्धृढिकरण गर्नका साथै स्वास्थ्य संस्थाहरु बट गरिने रेकर्डिङ्ग रिपोर्टिमा सुधारका लागि आवश्य सहयोग गर्ने ।

५. प्लान ईन्टरनेशनल

सस्थाको नाम	प्लान ईन्टरनेशनल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	मिहिर कुमार झा
विषयगत कार्यक्षेत्र	प्रारम्भिक बालविकास
भौगोलिक कार्यक्षेत्र	जिल्ला (सुनसरीगढी गाउँपालिका, दुहबी नगरपालिका, रामधुनी नगरपालिका
सञ्चालित परियोजनाको नाम र परियोजना अवधि	बालबालिकाको सपना परियोजना (२०७७ साउन देखि २०७९ अषाढ)
परियोजना सञ्चालन प्रकृया	यो परियोजना स्थानीय गैर सरकारी संस्थाको सहकार्यमा संचालन गरिएको छ ।
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	ग्रामीण समाज उत्थान केन्द्र ईनरुवा सनसरी सम्पर्क व्यक्ति (तिलक राई (९८०४०४६४०६)
परियोजनाको बार्षिक उपलब्धि	• पलिका स्तरीय योजना तर्जुमा गोष्ठी • बाल अनुकुल स्याहार तथा प्रारम्भिक उत्प्रेरणाको लागि अभिभावक शिक्षा सम्बन्धी स्वास्थ्यकर्मी, महिला स्वास्थ्य स्वंयसेविका तथा सामाजिक परिचालकहरुलाई तालिम • महिला स्वास्थ्य स्वंयसेविकाद्वारा समुदायमा अभिभावक शिक्षा सत्र संचालन • सामुहिक संबाद समबन्धी स्वास्थ्यकर्मी तथा सहजकर्ताहरुलाई तालिम • समुदाय स्तरमा सामुहिक संबाद संचालन • महिला स्वास्थ्य स्वंयसेविका तथा सामाजिक परिचालकद्वारा घरभेट कार्यक्रम

	• कोभिड (१९ प्रतिकार्यको लागि स्वास्थ्य सामाग्री सहयोग
बजेट र खर्च विवरण	खर्च (रु ७९७४४३०.००
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु	• पालिका स्तरीय योजना तर्जुमा गोष्ठी • बाल अनुकुल स्याहार तथा प्रारम्भिक उत्प्रेरणाको लागि अभिभावक शिÔा समबन्धी स्वास्थ्यकर्मी, महिला स्वास्थ्य स्वंयसेविका तथा सामाजिक परिचालकहरुलाई तालिम • महिला स्वास्थ्य स्वंयसेविकाद्वारा समुदायमा अभिभावक शिक्षा सत्र संचालन • सामुहिक संवाद समबन्धी स्वास्थ्यकर्मी तथा सहजकर्ताहरुलाई तालिम • समुदाय स्तरमा सामुहिक संवाद संचालन • महिला स्वास्थ्य स्वंयसेविका तथा सामाजिक परिचालकद्वारा घरभेट कार्यक्रम • कोभिड (१९ प्रतिकार्यको लागि स्वास्थ्य सामाग्री सहयोग • कोभिड (१९ विरुद्दको खोप कार्यक्रममा सहयोग

६. पपुलेसन सर्भिसेज इन्टरनेसलन नेपाल (पि.एस.आई.नेपाल)

सस्थाको नाम	पपुलेसन सर्भिसेज इन्टरनेसलन नेपाल (पि.एस.आई.नेपाल)
सम्पर्क व्यक्ती र सम्पर्क नम्बर	सुदिप देवकोटा, ९८५६०४३४०१
विषयगत कार्यक्षेत्र	परिवारयोजनारसुरक्षितगर्भपतन
भौगोलिक कार्यक्षेत्र	निजि क्षेत्र तर्फ :–झापा, मोरङ्ग, सुनसरी र उदयपुर सरकारी क्षेत्र तर्फ :– धनकुटा र झापा
सञ्चालित परियोजनाको नाम र परियोजना अवधि	परियोजना :– महिला स्वास्थ्य परियोजना परियोजना अवधि निजि क्षेत्र तर्फ :–सन् २०२० देखि २०२२ सम्म सरकारी क्षेत्र तर्फ :– सन् २०२१
परियोजना सञ्चालन प्रकृया	स्थानिय साझेदार संस्था मार्फत कार्यक्रमको कार्यन्वयन
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	स्थानिय साझेदार संस्था :– हुरुण्डेक उदयपुर सम्पर्क व्यक्ति :– अनिल थापा
परियोजनाको बार्षिक उपलब्धि	• आधारभुतआयु. सी. डी. , इम्पलान्टरसुरक्षितगर्भपतनसेवासम्बन्धि (MedicalAbortion)तालिमप्रदान गरिपरिवारयोजनाकासाधनआयु. सी. डी. रइम्पलान्टतथा सुरक्षित गर्भपतनको सेवाको विस्तार । (निजि तथा सरकारी स्वास्थ्य संस्थाहरुवाट) • औषधीको प्रयोगद्वारा गरिने गर्भपतनबारे जोखिम न्यूनीकरणसम्बन्धी अभिमुखिकरण • व्यवहार परिवर्तन सञ्चारका गतिविधिहरु ○ अन्तरव्यक्ति सञ्चार ○ समुदायस्तरका चेतना अभिवृद्धि कार्यक्रम
बजेट र खर्च विवरण	१,३४,६६,८२४ (कार्यक्रम बजेट सन् २०२१ को लागि – स्थानिय साझेदार संस्था अन्तरगत)
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु	• आई.यू.सी.डी.र इम्प्लान्ट सेवा सम्बन्धी तालीम प्रदान • सुरक्षित गर्भपतन सेवा सम्बन्धी तालीम प्रदान • सेवा सुचारु गर्दा आवश्यक पर्ने औजार, उपकरण, औषधी लगायतका समाग्रीहरुको व्यवस्थापन • स्वास्थ्य संस्था र सेवा प्रदायकलाई सुचिकृत (सुरक्षित गर्भपतन सेवाको लागि) गर्नको लागि सहजिकरण • सेवा प्रदायकहरुलाई कार्यस्थलमा कोचिङ्गको व्यवस्था तथा गुणस्तर निर्धारण सम्बन्धि लेखापरिक्षण • औषधीको प्रयोगद्वारा गरिने गर्भपतनबारे जोखिम न्यूनीकरणसम्बन्धी अभिमुखिकरण • व्यवहार परिवर्तन सञ्चारका गतिविधिहरु – अन्तरव्यक्ति सञ्चार,समुदायस्तरका चेतना अभिवृद्धि कार्यक्रम

७. नेपाल परिवार नियोजन संघ, मोरंग शाखा, विराटनगर

सस्थाको नाम	नेपाल परिवार नियोजन संघ, मोरंग शाखा, विराटनगर
सम्पर्क व्यक्ती र सम्पर्क नम्बर	शंकर प्र. दाहाल ,मो. नं. ९८४२१५९०४४
विषयगत कार्यक्षेत्र	यौन तथा प्रजनन स्वास्थ्य सेवा
भौगोलिक कार्यक्षेत्र	मोरंग जिल्लाका ग्रामथान गाउपालिका,सुन्दरहरैचा नगरपालिका,वेलवारी नगरपालिका, तथा विराटनगर महानगरपालिका अन्तर्गतका विभिन्न वडाहरु
सञ्चालित परियोजनाको नाम र परियोजना अवधि	एकिकृत यौन तथा प्रजनन स्वास्थ्य सेवा, परियोजना अवधि : निरन्तर
परियोजना सञ्चालन प्रकृया	ने. प. नि. संघ केन्द्रीय कार्यालय व्दारा स्वीकृत कार्यक्रम तथा वजेटका आधारमा शाखाव्दारा कार्यान्वयन गरिने ।
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	

परियोजनाको वार्षिक उपलब्धि	११३१९० यौन तथा प्रजनन स्वास्थ्य सेवा
बजेट र खर्च विवरण	२४७०१९३।
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु	यौन तथा प्रजनन स्वास्थ्य अधिकार को उपभोग प्रति जनमत निमाण सेवाको पहुचमा वृद्धि गर्ने स्थानिय स्तरमा सहयोग र समन्वय विस्तार गर्ने

८.संयुक्त राष्ट्रसंघिय विश्व खाध्य कार्यक्रम

सस्थाको नाम	संयुक्त राष्ट्रसंघिय विश्व खाध्य कार्यक्रम
सम्पर्क व्यक्ती र सम्पर्क नम्बर	अर्पण ढकाल : ९८५२०४९९३५
विषयगत कार्यक्षेत्र	मातृ,बाल स्वास्थ्य पोषण, खाध्य सुरक्षा, खाध्य सहायता, आपतकालिन अवस्थामा प्रतिकार्य तथा पुर्नलाभ सहयोग
भौगोलिक कार्यक्षेत्र	प्रदेश नं १
सञ्चालित परियोजनाको नाम र परियोजना अवधि	• प्रदेशको पोषण,कृषि, खाध्य सुरक्षा लगायतका क्षेत्रमा प्राविधिक सहयोग • आमा तथा बालबालिका स्वास्थ्य तथा पोषण परियोजना • आपतकालिन अवस्थामा पोषिलो खाना वितरण
परियोजना सञ्चालन प्रकृया	सम्बन्धित मन्त्रालय तथा सरकारी निकायको समन्वयमा कार्यक्रम संचालन भईरहेको
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	
परियोजनाको वार्षिक उपलब्धि	• स्वास्थ्य निर्देशानलय मार्फत प्रदेशको पोषण कार्यक्रममा प्राविधिक सहायताको लागी जनशक्ति सहयोग • मोरङ, झापा र सुनसरीमा मातृ तथा बाल स्वास्थ्य पोषण परियोजनाको सुरुवात आपतकालिन अवस्थामा गर्भवती, सुत्केरी र बालबालिकाको पोषण अवस्था सुधार गर्न सुनसरीमा पोषिलो खाना वितरण
बजेट र खर्च विवरण	
आगामी वर्ष आ व २०७९/८० का प्राथमिकताहरु	• मोरङ, झापा र सुनसरीमा मातृ तथा बाल स्वास्थ्य पोषण परियोजनाको निरन्तरता • स्वास्थ्य निर्देशानलय मार्फत प्रदेशको पोषण कार्यक्रममा प्राविधिक सहायताको लागी जनशक्ति सहयोगको निरन्तरता • आपतकालिन अवस्थामा गर्भवती, सुत्केरी र बालबालिकाको पोषण अवस्था सुधार गर्न पोषिलो खानाको वितरण कार्यक्रमको निरन्तरता

९.करुणा फाउन्डेसन नेपाल

सस्थाको नाम	करूणा फाउण्डेशन नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	योगेन्द्र गिरी, सह निर्देशक (९८५२०२१५६२) कमल कोइराला, वरिष्ठ कार्यक्रम व्यवस्थापक ९९८५११४०४१६०
विषयगत कार्यक्षेत्र	मातृ शिशु स्वास्थ्य, अपाङ्गता रोकथाम तथा अपाङ्गता भएका व्यक्तिहरूको समुदायमा आधारित पुनर्स्थापना
भौगोलिक कार्यक्षेत्र	मोरङ, सुनसरी, धनकुटा, इलाम, पाँचथर, भोजपुर र संखुवासभा जिल्लाका ६९ स्थानीयतहहरू
सञ्चालित परियोजनाको नाम र परियोजना अवधि	अपाङ्गता रोकथाम तथा पुनर्स्थापना कार्यक्रम (२०७६ देखि २०८०)
परियोजना सञ्चालन प्रकृया	अपाङ्गता रोकथाम तथा पुनर्स्थापना कार्यक्रम प्रदेश सरकार, सामाजिक विकास मन्त्रालय, सम्बन्धित स्थानीय तहहरू र करूणा फाउण्डेसन नेपालको त्रिपक्षिय लागत साझेदारी तथा स्थानीय तहहरूको नेत्रित्वमा सञ्चालित कार्यक्रम हो । प्रदेश सरकार सामाजिक विकास मन्त्रालयवाट स्वीकृत कार्यक्रमको कार्यान्वयन स्थानीय तहहरूले गर्ने र सो का लागि आवश्यक प्राविधिक सहयोग करूणा फाउण्डेसन नेपालले प्रदान गर्ने गर्दछ । यसका अलावा अपाङ्गता भएका व्यक्तिहरूको अधिकार स्थापित गराउने कार्यमा राष्ट्रिय अपाङ्ग महासंघले समेत प्राविधिक सहयोग पुर्याउने व्यवस्था रहेको छ । कार्यक्रमका ती मुख्य पक्षहरू मध्ये अपाङ्गता रोकथाम (मातृ शिशु स्वास्थ्य प्रवर्दन) अन्तर्गतका कृयाकलापहरू स्थानीय स्वास्थ्य संस्था मार्फत र अपाङ्गता भएका व्यक्तिहरूको समुदायमा आधारित पुनर्स्थापना र सामुदायिक सेवा प्रदायकहरूको सुध्रिढिकरण अन्तर्गतका कृयाकलापहरू पालिकामा रहेको सामाजिक विकास महा/शाखा मार्फत समुदायमा आधारित पुनर्स्थापना सहजकर्ताहरूद्वारा सञ्चाल नगर्ने व्यवस्था रहेको छ ।
स्थानिय साझेदार संस्था भएमा तीनको नाम र सम्पर्क नम्बर	मोरङ, सुनसरी, धनकुटा, इलाम, पाँचथर, भोजपुर र संखुवासभा जिल्लाका ६९ स्थानियतहहरू
परियोजनाको वार्षिक उपलब्धि	• एम हेल्थ कार्यक्रम संचालनका लागि ४० वटा पालिकाहरुका ५४४ स्वास्थ्यकर्मीहरु र ती पालिकाहरुमा रहेका २०४ वटा स्वास्थ्य संस्थाहरुमा कार्यरत २०२७ महिला स्वास्थ्य स्वयंसेविकाहरुलाई तालिम प्रदानगरी एम हेल्थ कार्यक्रम

संचालनमा आएको । आ.व.२०७७/०७८ को अन्त्य सम्ममा ८१७१ जना गर्भवती महिलाहरु एम हेल्थ कार्यक्रममा दर्ता भएको । त्यसैगरी १९ वटा स्वास्थ्य संस्थामा एम हेल्थ कार्यक्रमको समिक्षा भइसकेको ।

- जन्मजात हुने अपाङ्गता रोकथामका लागि गर्भ पुर्वदम्पत्तीले तीन महिना र गर्भधारण पश्चात गर्भवती महिलाले तीन महिना खानुपर्ने फोलिक एसिड चक्कीका सम्बन्धमा १५४० स्वास्थ्यकर्मीहरुलाई अभिमुखिकरण गरे पश्चात हाल सम्म ६२३ दम्पत्ती र ४३२९ गर्भवती महिलाहरुले फोलिक एसिड चक्की सेवन गरेको ।
- बच्चामा जन्मजात हुने अपाङ्गता शिघ्र पहिचानका लागि ६६८ जना स्वास्थ्यकर्मीहरुलाई तालिम प्रदान गरे पश्चात हालसम्म ४३६२ नवजात शिशुहरुको स्वास्थ्यकर्मीहरुले जन्मजात हुने अपाङ्गता भएको नभएको यकिन गर्न स्वास्थ्य परीक्षण गरेको । जसमध्ये ३६ जना बालबालिकाहरुमा जन्मजात अपाङ्गता देखिएको र ती नवजात शिशुहरुलाई तुरुन्तै विशिष्टि कृत स्वास्थ्य उपचारका लागि प्रेषण गरिएको । गत आ.व.मा ९ जनाले उपचार पाएको ।
- आ.व.२०७७/०७८को अन्त्य सम्ममा ५७ वटा पालिकाहरुले पोर्टेबल अल्ट्रासाउण्ड मशिन खरिद गरी २५८८ गर्भवती महिलाहरुलाई सो सेवा प्रदान गरेको ।
- एउटा पालिकामा कम्तिमा एउटा प्रसुती केन्द्र नेपाल सरकार स्वास्थ्य तथा जनसंख्या मन्त्रालयको मापदण्ड अनुसार बनाई गुणस्तरीय प्रसुती सेवा दिने उद्देश्य राखिएकोमा आ.व.२०७७/०७८को अन्त्य सम्ममा ४७ वटा प्रसुती केन्द्रहरु सुदृढीकरण भईसकेको ।
- कोभिड १९ को प्रतिकुलताको वावजुद पोषण तथा प्रजननस्वास्थ्यका विषयमा क्रमस ८४९ र ४२ वटा अभिमुखिकरण कार्यक्रमहरु संचालन गरी ७५८६ जना सुनौला हजार दिनका आमाहरू तथा ६०८ जना किशोरकिशोरीहरुलाई शिक्षा प्रदान गरियो ।
- आ.व. २०७७/०७८ मा ८५ वटा विद्यालयका १८ वर्ष मुनिका ८८०८ विद्यार्थिहरुको आँखा , पोषण ,कान एवं बौद्धिक क्षमता सम्बन्धी कुनै प्रकारको जटिलता भए नभएको जाँच गरीयो । जस मध्य ९८७ बालबालिकामा केही समस्या देखिएकोमा ६०८ लाई तत्कालै उपचार प्रदान गरियो ।
- सर्वेक्षणबाट पत्ता लागेका अपाङ्गता भएका व्यक्तिहरुको प्रारम्भिक अवस्थाको मुल्याङ्कन गरी पुनर्स्थापनाका लागि लक्ष्य र योजना निर्माण गर्न तथा आवश्यक पुनर्स्थापना सेवा दिन ३६९ वडाहरुमा अपाङ्गता जाँच शिविर आयोजना गरियो । शिविरबाट २८९४४, जना अपाङ्गता भएका व्यक्तिहरुको वर्तमान अवस्थाको जाँचगरी पुनर्स्थापना लक्ष्य र योजना बनाउन प्रारम्भ गर्नुका साथै पुनर्स्थापनाका सेवाहरु समेत प्रदान गर्न थालिएको छ ।
- आ.व. २०७७/०७८ मा २५०३ जना अपाङ्गता भएका व्यक्तिहरुलाई चाहिने सहायक सामग्री खरिद गरी ५२० लाई प्रदान गरिएको, २०७ जना अपाङ्गता भएका व्यक्तिहरुलाई पोषण सहयोग तथा ४७ जना अपाङ्गता भएका व्यक्तिहरुलाई उपचार सेवा प्रदान गरियो।
- यसै आ.व. मा २५९ जना अपाङ्गता भएका बालबालिकाहरुलाई विद्यालय भर्ना गराउनुका साथै २३ जना विद्यालय जान नसक्ने अपाङ्गता भएका बालबालिकाहरुलाई घरमा नै अनौपचारीक शिक्षा प्रदान गरियो । त्यसै गरी समावेशी शिक्षा सम्बन्धी १४ वटा तालिमहरु संचालन गरेर ४८१ जनाशिक्षक तथा विद्यालय व्यवस्थापन समितिका सदस्यहरुलाई अभिमूखिकरण गरियो ।
- अपाङ्गता रोकथाम तथा पुनर्स्थापना कार्यक्रमका सम्बन्धमा पालिका तहमा रहेका सवै सरोकारवालाहरुलाई जानकारी प्रदान गर्ने उद्देश्यले विभिन्न पालिकाहरुमा ३३ वटा कार्यक्रमहरु सम्पन्न गरी १०२९ जना व्यक्तिहरुलाई कार्यक्रमका विषयमा अभिमुखिकरण गर्ने काम सम्पन्न भयो ।
- आ.व.२०७७/०७८ को अन्त्य सम्ममा ५८ वटापालिकाहरुले २२७ जना समुदायमा आधारीत पुनर्स्थापना सहजकर्ताहरु नियुक्त गरीसकेकोमा आ.व. २०७७/०७८ अन्त्य सम्ममा ९६ जना सहजकर्ताहरुले ४५ दिनेतालिमको) जम्मा अवधी ९० दिनको आधार (हुने भुत तालिम प्राप्त गरिसकेको अवस्था छ भने बाँकी रहेका सहजकर्ताहरुलाई आ.व. २०७७/०७८ मा ९० दिनको तालिम र ४५ दिनको तालिम लिई सकेका सहजकर्ताहरुलाई बाँकी ४५ दिनको तालिम प्रदान गरिनेछ ।

कोरोना प्रति कार्यमा सहयोग

कोरोना महामारीको पहिलो लहरमा सरकारलाइ कोरोना रोकथामनियन्त्रण , र उपचारमा सहयोग स्वरूप अपाङ्गता रोकथाम तथा पुनर्स्थापना कार्यक्रम कोभिड १९ को दोश्रो लहरका कारण सृजना भएको कठिन परिस्थिती सँग लड्नका लागि विभीन्न साझेदार संस्थाहरुबाट श्रोत जुटाएर संघिय सरकार प्रदेश , सरकारप .रदेशन्ं १ र विभिन्न अस्पताला तथा संघ संस्थाहरुलाई Oxygen Concentrator लगायत विभिन्न स्वास्थ्य सामाग्रीहरु उपलब्ध गराएर सहयोग पुर्याउने काम सम्पन्न काम भयो । यस अवधीमा प्रदेशनं १ . मा उपलव्ध गराइएका सामाग्रीहरुको विवरण देहाय अनुसार रहेकोछ ।

क्र.सं.	सामाग्रीकोनाम	सामाग्री प्राप्त गर्नेको नाम
१.	**अक्सिजन कन्सन्ट्रेटर** मुख्यमन्त्री तथा मन्त्री परिषदको कार्यालय मार्फत वितरण (गरिएको	जिल्ला अस्पताल सुनसरी – ३ जिल्ला अस्पताल धनकुटा ३ जिल्ला अस्पताल भोजपुर ३ जिल्ला अस्पताल संखुवासभा ३

			जिल्ला अस्पताल इलाम ३ जिल्ला अस्पताल पाँचथर ३ जिल्ला अस्पताल खोटाङ्ग २ विराटनगर महानगरपालिका १० प्रदेश कोभिड अस्पताल विराटनगर १०
		२	एन्टिजिनकिट	जिल्ला अस्पताल धनकुटा १६०पिस जिल्ला अस्पताल भोजपुर १६०पिस जिल्ला अस्पताल संखुवासभा १६०पिस जिल्ला अस्पताल इलाम (पालिकासहित) ९००पिस
		३	पिसेट .इ.पि.	जिल्ला अस्पतालहरू धनकुटा १० सेट जिल्ला अस्पतालहरू इलाम १०पिस विराटनगर महानगरपालिका ५० पिस
		४	खाद्यान्नसामाग्री ,नुन ,तेल ,दाल ,चामल) (आलु	विराटनगरमा ३१ जना ट्राइसाइकल प्रयोग कर्ताहरू सामाजिक विकास मन्त्रालयको अनुरोध तथा राष्ट्रिय अपाङ्ग महासंघ प्रदेश १ सँगको समन्वयमा प्रदान गरिएको
		५	अक्सिजनकनेक्टर	सभा पोखरी गाउँपालिका संखुवासभा

यसका अतिरीक्त कोरोनाको महामारीका विच अपाङ्गता भएका व्यक्तिहरूलाई यसवाट वच्ने उपायहरूलागि , हालेमा सम्पर्क गर्नुपर्ने व्यक्तिको विवरण लगायत कोरोना र यसवाट वच्ने उपायबारे जान्नैपर्ने कुराहरू जानकारी गराउनका लागि टेलि काउन्सिलिङ्ग सेवा समेत प्रदान गरिएको थियो । यस अवधीमा समुदायमा आधारित पुनर्स्थापना सहजकर्ताहरू मार्फत १८६७१ जना अपाङ्गता भएका व्यक्ति वा निजका परिवारलाई टेलि काउन्सिलिङ्ग मार्फत परामर्श सेवा उपलब्ध गराइयो । यस अवधिमा ७८ जना कोरोना संक्रमित अपाङ्गता भएका व्यक्तिहरू र १३१ जना परिवारका सदस्यहरूलाई परामर्श सेवा उपलब्ध गराइएको थियो । कोरोनाको दोस्रो लहरका अवधिमा चार जना अपाङ्गता भएका व्यक्तिहरूको कोरोना संक्रमणका कारण मृत्यु वरण गर्न पुगे ।

त्यसै गरी संखुवासभा जिल्लाको पाँच खपन नगरपालिकाकी एक कोरोना संक्रमित गर्भवती महिलाको उपचारमा समेत सहजिकरण गरिएको थियो । केहि दिनको अस्पताल वसाइ पश्चात नीज गर्भवती महिलाले कोशी अस्पताल विराटनगरमा स्वस्थ्य शिशुलाई जन्म दिइन् ।

बजेट र खर्च विवरण	आ०७८/२०७७ .व.को योजनाःरू ५९६,७२५,२०३ खर्चःरू३३४,५३०,१९१
आगामी वर्ष आ व २०७९८० का प्राथमिकताहरु	**SBA** तालिम **RUSG** तालिम दम्पती महिला) र हरुका (पुरुष लागि फोलिक एसिड चक्की वितरण मोवाइलमा आधारित शुभकामना कार्यक्रम*(प्रोटोकलअनुसारको गर्भजांच, संस्थागत प्रसुती तथा सुत्केरी जांचलाई प्रोत्साहान गर्ने)* जन्मजात अपाङ्गता पहिचानका लागि नवजातशिशुको जाँच तथा रेकर्ड विद्यालय स्वास्थ्य परिक्षणका लागि स्वास्थ्यकर्मी प्रशिक्षक प्रशिक्षण तालिम विद्यालयमा स्वास्थ्य परिक्षण गरी विकास हुनसक्ने अपाङ्गता रोकथाम गर्ने शिविर सुनौला हजार दिनका आमाहरुका लागि पोषण सम्बन्धी शिक्षा किशोरकिशोरीलाई– प्रजनन स्वास्थ्य र अपाङ्गता रोकथाम सम्बन्धी शिक्षा अपाङ्गता भएका व्यक्तिहरूको स्वास्थो पचारमा सहयोग अपाङ्गता भएका व्यक्तिहरूको लागि सहायक सामाग्री प्रदान अपाङ्गता भएका बालबालिकाहरुलाई पोषण सहयोग पूर्ण अशक्त र अति अशक्त अपाङ्गता भएका व्यक्तिका स्वाहेरचाहका लागि अभिभावक वा हेरचाह गर्नेलाई सिप प्रदान फिजीयो थेरापी केन्द्र स्थापना र संचालन आदी ।

१०. एन. एल. आर. नेपाल

सस्थाको नाम	एन. एल. आर. नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	नन्द लाल बास्तोला ९८४२०३२५१३
विषयगत कार्यक्षेत्र	कुष्ठरोग रोकथाम कार्यक्रम कुष्ठरोग नियन्त्रण कार्यक्रम अपांगता समावेसी विकास कार्यक्रम
भौगोलिक कार्यक्षेत्र	कुष्ठरोग रोकथाम कार्यक्रम (प्रदेश न. १ का सम्पुर्ण स्थानिय तहहरु) कुष्ठरोग नियन्त्रण कार्यक्रम (प्रदेश न. १ का सम्पुर्ण स्थानिय तहहरु)

	अपांगता समावेसी बिकास कार्यक्रम (याङवरक गा.पा. पांचथर, कचनकवल गा.पा., बुद्धशान्ती गा. पा., कन्काई न. पा, कमल गा.पा झापा, लेटाङ न. पा., कानेपोखरी गा.पा. मोरङ, बेलका न.पा. उदयपुर)
सञ्चालित परियोजनाको नाम र परियोजना अवधि	"Support to Leprosy control, Disabilities Management and Inclusions in Nepal"
परियोजना सञ्चालन प्रकृया	साझेदारी (नेपाल सरकार तथा राष्ट्रीय गैर सरकारी संस्था संग)
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	राष्ट्रीय अपांग महासंघ प्रदेश न. १ बिराटनगर Email : province1@nfdn.org.np ०२१ ५१७४२२
बजेट र खर्च विवरण	बजेट २४१४१७६१ खर्च २१४९२८२४
आगामी प्राथमिकताहरु	संचालित कार्यक्रमहरुको निरन्तरता

११. Chemonics International

सस्थाको नाम	Chemonics International, Lazimpat Kathmandu Nepal
सम्पर्क व्यक्ती र सम्पर्क नम्बर	Shailendra Kumar Patel Provincial Supply Chain Coordinator 9851140260
विषयगत कार्यक्षेत्र	Supply Chain Management Health System Strengthening Warehouse Management Inventory Management (eLMIS)
भौगोलिक कार्यक्षेत्र	PHLMC, District Hospitals, Health Offices, LLGs, SDPs of Province 1
सञ्चालित परियोजनाको नाम र परियोजना अवधि	Global Health Supply Chain Management- Procure Supply Management Project (GHSC-PSM/USAID) 2016 to 2023 AD.
परियोजना सञ्चालन प्रकृया	Technical Support to government
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	
परियोजनाको बार्षिक उपलब्धि	- eLMIS rollout and implementation of 137 LLGs of province 1. - Store rearrangement and supportive supervision to14 district health Offices - Technical support to PHLMC on forecasting and quantification workshop - Technical Support to PHLMC for SCMWG (Supply Chain Management Working group) meeting - Technical Support to PHLMC for warehouse management and inventory management - Technical Support to PHLMC for BLT training - Technical support to eLMIS functionalization - Completed eLMIS user training of health offices of province 1.
बजेट र खर्च विवरण	
आगामी बर्ष आ व २०७९८० का प्राथमिकताहरु	Capacity building in supply chain Management - Basic Logistics Training (BLT) for LLGs health coordinator and store focal person of all LLGs of province 1. - Logistics and Supply chain orientation for Mayor and chief administrative officers. MIS Activities - eLMIS scale- up and implementation to service delivery point. - Technical support for eLMIS functionalization. Coordination and Collaboration - Quarterly Supply chain management working group meeting - Technical support to improve health commodities procurement at province and LLGs level to minimizing duplication, stock out and overstock (Workshop)

१२.एफएचआई ३६० नेपाल

संस्थाको नाम	एफएचआई ३६० नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	भगवान श्रेष्ठ, कन्ट्री डाइरेक्टर, ०१४४३७१७३
विषयगत कार्यक्षेत्र	एचआईभी र एड्स तथा यौनरोग रोकथाम, उपचार तथा हेरचाह र सहयोग कन्ट्री ग्रान्ट नेपाल मार्फत)

भौगोलिक कार्यक्षेत्र	इपिक नेपाल : इलाम, झापा, मोरङ्ग र सुनसरी जिल्ला फ्लेमिङ्ग फण्ड कन्ट्री ग्रान्ट नेपाल : कोशी अस्पताल विराटनगर र बि.पी. कोइराला स्वास्थ्य विज्ञान प्रतिष्ठान, धरान	
सञ्चालित परियोजनाको नाम र परियोजना अवधि	• पेपफार तथा यूएसएआइडी को सहयोगमा संचालित इपिक नेपाल परियोजना (अक्टोबर २०२०– सेप्टेम्बर २०२२) • संयुक्त अधिराज्य सरकारको डिपार्टमेन्ट अफ हेल्थ एण्ड सोसियल केयर को आर्थिक सहयोग तथा मट म्याकडोनाल्डको व्यवस्थापन सहयोगमा संचालित फ्लेमिङ्ग फण्ड कन्ट्री ग्रान्ट नेपाल (अगस्ट २०१८– फेब्रुअरी २०२२)	
परियोजना सञ्चालन प्रकृया	• इपिक नेपाल परियोजनाले साझेदार संस्थाहरु मार्फत एचआइभि तथा यौनरोगको रोकथाम, उपचार र हेरचाह सम्बन्धि कार्यक्रमहरु संचालन गर्दछ । यस परियोजनाको मुख्य लक्षित समूदायहरुमा महिला यौनकर्मीहरु, महिला यौनकर्मीका ग्राहकहरु, पुरुष समलिङ्गीहरु, पुरुष यौनकर्मीहरु, तेस्रोलिङ्गीहरु, एचआईभीको जोखिममा भएका लक्षित समुदाय र एचआईभी संक्रमित व्यक्तिहरु हुन् । • नेपाल सरकार स्वास्थ्य तथा जनसंख्या मन्त्रालय, कृषि तथा पशुपन्छी मन्त्रालय, खाद्य प्रविधि तथा गुणस्तर नियन्त्रण बिभाग, औषधि व्यवस्था बिभाग, वातावरण बिभाग, राष्ट्रिय जनस्वास्थ्य प्रयोगशाला, केन्द्रिय पशू चिकित्सा प्रयोगशाला संग समन्वय गरि यस परियोजना ले एक स्वास्थ्य (वान हेल्थ) प्रणाली लाइ सुदृढ गर्ने, तथा प्रयोगशालाहरुमा एन्टीमाइक्रोबियल रेसिस्टेण्ट तथा एन्टीमाइक्रोबियलको प्रयोगको निगरानीलाई सुदृढ र दिगो बनाउने उद्धेश्य रहेको छ ।	
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	इपिक नेपाल १. आम्दा नेपाल, प्रोजेक्ट जिल्ला : इलाम, झापा, मोरङ्ग, सुनसरी ठेगाना तथा सम्पर्क : इटहरी, सुनसरी, फोन : ०२५-५८६९५१ । रोहित कुमार उराव, प्रोजेक्ट कोअर्डिनेटर, इपिक नेपाल प्रोजेक्ट विर्तामोड, झापा, फोन :०२३-५३०१४०, २. लिड नेपाल, प्रोजेक्ट जिल्ला : झापा ठेगाना तथा सम्पर्क : दमक, बेलडाङ्गी रोड, झापा, फोन : ०२३-५८५३१९ । नुमा लिम्बु (चन्चला), प्रोजेक्ट कोअर्डिनेटर, इपिक नेपाल प्रोजेक्ट ३. परिवर्तनशील समाज, प्रोजेक्ट जिल्ला : मोरङ्ग ठेगाना तथा सम्पर्क : कलेज रोड, बिराटनगर, मोरङ्ग, फोन : ०२१-५२६०७१ । मुस्कान श्रेष्ठ, प्रोजेक्ट कोअर्डिनेटर, इपिक नेपाल प्रोजेक्ट ४. मानव कल्याण समाज, प्रोजेक्ट जिल्ला : सुनसरी ठेगाना तथा सम्पर्क : बि.पि चोक, इटहरी, सुनसरी, फोन : ०२५-५८६७३० । देवनारायण चौधरी, प्रोजेक्ट कोअर्डिनेटर, इपिक नेपाल प्रोजेक्ट	
परियोजनाको बार्षिक उपलब्धि	इपिक नेपाल एचआईभी रोकथाम तथा नियन्त्रणको लागि लक्षित वर्ग भेटिएको संख्या	४,३५२
	नयाँ एचआईभी रोकथाम तथा नियन्त्रणको लागि एचआईभी जाँच गरेको संख्या	१,९०९
	नयाँ एचआईभी पोजिटिभ पत्ता लागेको संख्या :	१५५
	नयाँ एआरटी शुरु गरेको संख्या	२१२
	यौनराग निदान र उपचार सम्बन्धी जाँच सेवा लिएको संख्या	३७८
	समुदायमा एचआईभी हेरचाह तथा सहयोग सेवा लिएको संख्या	१,१३३
	कण्डम वितरण गरेको संख्या	३८३,४१६
	ल्युब्रिकान्ट वितरण गरेको संख्या	१४०,५१२
परियोजनाको बार्षिक उपलब्धि	फ्लेमिङ्ग फण्ड कन्ट्री ग्रान्ट नेपाल • प्रयोगशालाका भौतिक पुर्वधारहरुको मागहरु मूल्याङ्कन गरि पुनर्निर्माण सुरु गरिएको । • प्रयोगशालासंग सम्बन्धित रिएजेन्ट तथा अन्य सामानहरुको खरिद प्रक्रिया सुरु गरिएको । • सेन्टिनेल साइट प्रयोगशालामा कार्यरत जनशक्तिहरुको क्षमता अभिवृद्धी, अनसाइट कोचिङ्ग, मेण्टरिङ्ग तथा सिपमा आधारित तालिमहरु प्रदान गरिएको । • राष्ट्रिय जनस्वास्थ प्रयोगशाला तथा अन्य प्रयोगशालाहरुको गुणस्तरमा सुधार गर्न सहयोग गरिएको । • प्रयोगशाला सम्बन्धित सामग्रीहरुको खरिद तथा आपूर्तिलाइ सुदृढ बनाइएको । • एन्टीमाइक्रोयिबल रेसिस्टेण्ट सेन्टिनेल प्रयोगशालाहरुमा एन्टीमाइक्रोयिबल रेसिस्टेण्ट युनिटको स्थापना गरि रेसिस्टेण्ट निगरानी कार्य संचालन गराइएको ।	

	• एन्टीमाइक्रोयिवल रेसिस्टेण्ट तथ्यांक रेकर्ड तथा रेपोर्टिङ्ग कार्य मा प्राविधिक सहयोग गरिएको । • तथ्यांक विश्लेषण गरि तथ्यांक विश्लेषण बाट प्राप्त नतिजा हरुलाइ तथा ग्लोबल एन्टीमाइक्रोबियल रेसिस्टेण्ट निगरानी प्रणालीमा प्रकाशित गरिएको ।	
बजेट र खर्च विवरण	इपिक नेपाल बजेट : ४८,६९६,७४९.८८ खर्च : ४२,६८८,२८८.०० फ्लेमिङ्ग फण्ड कन्ट्री ग्रान्ट नेपाल बजेट : रु २२२,९९८,२०४ (नेपाल भरिको लागि जम्मा) खर्च : रु ६१,८४७,०२० (नेपाल भरिको जम्मा)	
आगामी वर्ष आ व २०७९८० का प्राथमिकताहरु	इपिक नेपाल : • एचआईभी र यौनरोग संक्रमण (एसटीआई) रोकथाम शिक्षा, अफलाईन र अनलाइन प्लेटफर्महरू मार्फत रेफरल र फलोअप, र कन्डम तथा लुब प्रवर्धन र वितरण • एचआईभी परीक्षण र परामर्श (एचटीसी) सेवाहरू र अर्ली इन्फ्यान्ट डाइग्नोसिस पसेवाहरू • यौनरोग परीक्षण र उपचार सेवा • एन्टिरिट्रोभाइरल थेरापी (एआरटी) र भाइरल लोड परीक्षण सेवाहरूको लागि प्रेषण र फलोअप • एआरटी निरन्तरताका लागि सहयोग र शिक्षा • प्रि एक्सपोजर प्रोफाइल्याक्सिस (प्रेप)सम्बन्धि सेवा • एचआईभी सम्बन्धित लान्छना र भेदभाव न्यूनिकरण • क्षमता बिकास • एआरटी र भाइरल लोड जाँच केन्द्रहरुलाई सहयोग • एआरटी वितरण सेवा फ्लेमिङ्ग फण्ड कन्ट्री ग्रान्ट नेपाल : • बिभिन्न क्षेत्र हरु (मानव स्वास्थ,पशुपन्छी प्रयोगशाला, खाद्य प्रबिधि) मा प्राबिधिक कार्य समिति गठन गर्न सहयोग गर्ने ।प्रयोगशालासंग सम्बन्धित रिएजेन्ट तथा अन्य सामानहरु को खरिद प्रक्रिया सुरु गर्ने । • स्वास्थ तथा जनसंख्या मन्त्रालय, खाद्य प्रबिधि तथा गुण नियन्त्रण बिभाग, औषधि व्यवस्था बिभाग, र अन्य सर्भिलेन्स साइटहरुलाइ एन्टी माइक्रोबियल रेसिस्टेण्ट निगरानी कार्य संचालन गर्न आवस्यक सूचना प्रबिधि सामाग्री हस्तान्तरण गर्ने । • कुखुराहरुमा एन्टी माइक्रोबियल रेसिस्टेण्ट निगरानी तथा माइक्रोबियल प्रयोगको लागि नमुना संकलन तथा परिक्षणका लागि प्रयोगशाला सामाग्री उपलब्ध गर्ने । • औषधि व्यवस्था बिभाग लाइ माइक्रोयिवल उपयोग सर्भिलेन्सको लागि आवस्यक सफ्टवेर को भ्यलिडेसन कार्य पुरा गरि सफ्टवेर लाइ पूर्ण संचालनमा ल्याउने प्रक्रिया सुरुवात गर्ने । • उच्चस्तरिय बहुक्षेत्रीय समिति, राष्ट्रिय प्राबिधिक कार्य समिति र प्राबिधिक कार्य समुहलाइ आवस्यक सहयोग गर्ने । • एन्टीमाइक्रोबियल नीति, रणनीतिहरु, प्रोटोकल, मार्गदर्शनहरुको विकास तथा आवस्यक संसोधन गराउने । • सेन्टिनेल साइट प्रयोगशाला मा कार्यरत जनशक्तिहरुको क्षमता अभिवृद्धी, अनसाइट कोचिङ्ग, मेण्टरिङ्ग तथा सिपमा आधारित तालिमहरु प्रदान गराउने । • राष्ट्रिय जनस्वास्थ प्रयोगशाला तथा अन्य प्रयोगशालाहरुको गुणस्तरमा सुधार गर्न सहयोग गर्ने । • प्रयोगशाला सम्बन्धित सामग्रीहरुको खरिद तथा आपुर्ती लाइ सुदृढ गराउने । • एन्टीमाइक्रोयिवल रेसिस्टेण्ट तथ्यांक रेकर्ड तथा रिपोर्टिङ्ग कार्यमा प्राविधिक सहयोग गर्ने । • तथ्यांक विश्लेषण गरि तथ्यांक विश्लेषण बाट प्राप्त नतिजा हरुलाइ तथा ग्लोबल एन्टीमाइक्रोबियल रेसिस्टेण्ट निगरानी प्रणालीमा प्रकाशित गर्ने ।	

१३. वाटरएड नेपाल

सस्थाको नाम	वाटरएड नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	नामस् धिरेन्द्र भुजेल, प्रोजेक्ट म्यानेजर फोन न. स् ९८४१८६१२८५ इमेल: dhirendrabhujel@wateraid.org
विषयगतकार्यक्षेत्र	१.नियमितखोप सेवामा सरसफाई प्रबर्द्धनको लागी स्वास्थ्यकर्मीको क्षमता अभिवृद्धि गर्ने २. संघिय तथाप्रदेश स्तरमाखोप कार्यक्रममा सरसफाई प्रबर्द्धनको प्याकेज समायोजनको लागिप्राविधिक सहयोग
भौगोलिककार्यक्षेत्र	१.नियमितखोप सेवाप्रदनागर्ने बाह्यतथा संस्थागत सबै खोप केन्द्रहरु
सञ्चालित परियोजनाको नाम र परियोजनाअवधि	Hygiene Promotion through RoutineImmunization (नियमितखोप सेवामार्फत सरसफाई प्रबर्द्धन कार्यक्रम)
परियोजना सञ्चालनप्रकृया	खोप दिने स्वास्थ्यकर्मी मार्फत सम्पूर्ण खोप केन्द्रमाखोप सेसन शुरु हुनु पूर्व सरसफाई प्रबर्द्धन प्याकेजको प्रयोग गरी बच्चालाई खोप लगाउनलिएर आएकाआमातथाअभिभावकहरुलाई सरसफाई प्रबर्द्धनको सेसन संचालनगर्ने गरिएको ।
स्थानिय साझेदार सस्थाभएमातीनको नाम	कोहीनभएको, नेपाल सरकारको अगुवाईमा कार्यक्रम संचालन भईरहेको

र सम्पर्क नम्बर	
परियोजनाको वार्षिक उपलब्धि	१. प्रदेश नं १ का सम्पूर्ण जिल्लाहरुमा रोटा खोपको शरुवातसँगै नियमितखोप सेवाकार्यक्रममा सरसफाई प्रबर्द्धन कार्यक्रम संचालनको लागी ३५२५ जना स्वास्थ्यकर्मीको सरसफाई प्रबर्द्धन प्याकेजमाक्षमता अभिवृद्धि २. प्रदेश १ का १३७पलिकामार्फत २,८५७खोप केन्द्रमानियमितखोप मार्फत सरसफाई प्रबर्द्धनको सेसन संचालनको लागि२,५५६ सरसफाई प्रबर्द्धन प्याकेज, ३,३३२ कार्यक्रमनिर्देशिकातथाकार्यक्रमव्याज, १०८,४७१ आमा तथा अभिभावकको लागि ऐना र नमुना परिवारको ड्याङ्गलर वितरण
बजेट र खर्च विवरण	जम्मा बजेट : ३,८४०,२४०।- जम्माखर्च :३,८४०,२४०।- (स्वास्थ्य कार्यलय मार्फत खर्च) रु ८,८६१,२४८ बस्तुगत सहयोग (सरसफाई प्रबर्द्धन सामाग्री वितरण)
आगामी प्राथमिकताहरु	आ.व. २०७७७८ मा नेपाल सरकार, परिवार कल्याण महाशाखा, बाल स्वास्थय तथा खोप सेवाशाखा मार्फत कार्यक्रमलाई निरन्तरता दिने छ भने वाटरएडको प्राविधिक सहयोग स्वास्थ्य निर्देशनालयमा रहनेछ। कोभिड(१९ रोग, रोकथाम तथा नियन्त्रणको लागि व्यवहार परिवर्तनका सामाग्रीतथा सुरक्षाका सामाग्रीहरु वितरण

१४.विराट नेपाल मेडिकल ट्रष्ट-वि एन एम टि नेपाल)

सस्थाको नाम	विराट नेपाल मेडिकल ट्रष्ट-वि एन एम टि नेपाल) प्रादेशिक कार्यालय: विराटनगर १५ जनपथ टोल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	ज्ञानेन्द्र श्रेष्ठ, कार्याक्रम प्रवन्धक ९८५२०२३९१९, ०२१ ४७०६०८
विषयगतकार्यक्षेत्र	स्वास्थ्य, क्षयरोग नियन्त्रण कार्याक्रम, आपतकालिन रेसपोन्स
भौगोलिककार्यक्षेत्र	ईलाम, मोरङ्ग, उदयपुर, झापा, र सुनसरी
सञ्चालित परियोजनाको नाम र परियोजनाअवधि	• क्षयरोग नियन्त्रण कार्याक्रम • आपतकालिन रेसपोन्स (कोभिड १९)
परियोजना सञ्चालनप्रकृया	साझेदारीतामा आधारीत प्रकृया
स्थानिय साझेदार सस्थाभएमातीनको नाम र सम्पर्क नम्बर	छैन।
परियोजनाको वार्षिक उपलब्धि	• During the reporting period all total **118 (M= 70, F=38)** health workers were participated at the onsite coaching /trainingon SR guideline and ACF modality • Organized training on Active Case Finding at Hot Spot area to local volunteer **134** (**M=57,F=77**) and mobilized for door to door screening of TB presumptive, during this reporting period able to visited 21580 house hold and identified 2652 TB presumptive cases and diagnosed 45 new cases. • Regular coordination, sharing meeting and reporting to PHD, HO, TB Focal persons, Health Coordinators, and others concerns stakeholders. • Conducted two ACF screening camp at prison at Morang and Sunsari district. • Total crosschecked of sputum smears slides during reporting period was 1806. Among those 1708 smears was Negative of microscopy centres and 98 smears was positive. • Total 0.1% smears was false negative and 6% smears was false positive and rate of agreement was 99% of province 1 Total 1306 litters of reagents solution of Carbol fuchsin, 0.1% methylene blue and 25% of Sulfuric Acid was supplied to 14 districts of province 1. • Organized one group of TB microscopy refresher training for 10 participants. • 29 microscopy centres were visited and conducted on site coaching during this period. • Front line Health Workers of forty Health Facilities of Morang district had got medical material (Hand sanitizer, Examination mask, and gloves) which help them to prevent them self and community people from COVID-19 infection. • All total 111 most vulnerable families (Affected by COVID-19, Tuberculosis Patients, leprosy, HIV patients with low socio-economic status people) received food and sanitation materials which help them to fulfil their basic need and survive them self in this crisis. • Community awareness about COVID-19 through local radio by broadcasting jingle related to COVID- 19 prevention and to flow government rules and regulation. • As per request of Koshi Hospital, Recruited one paramedical staff (HA) for

	support at Koshi COVID hospital from 1st June to October 2021 • Procured necessary PPE items and distributed to Koshi COVID Hospital and other Health Facilities of Morang for infection control with the coordination of Health Office, Morang. Total budget consumption is Rs 1700000.00 • Support to identify no of TB presumptive cases 16988 among them 1296 were new cases and all are enrolled in nearby DOTS centre for the treatment.

बजेट र खर्च विवरण

Intervention	Plan	Expenditure
TB care and prevention	18,846,831	11,538,442.50
MDR-TB	4,847,325	3,622,155.77
Program management	8,959,268	7,284,330.64
Covid-19	1,469,750	924,926.50
Total	**34,123,173**	**23,369,855**

आगामी बर्ष आ व २०७९८० का प्राथमिकताहरु	○ Epidemic Intelligence: Understanding how economic migrant waves drive SARS-CoV2 epidemic seeding and community transmission events in the South Asian context- Bheri Hospital- Nepalgunj , Koshi Hospital- Biratnagar and Teku Hospital- Kathmandu ○ The Impact of the COVID-19 Pandemic on Tuberculosis Service Delivery in Nepal: TB READY ○ Addressing the social determinants and consequences of tuberculosis in Nepal (ASCOT) –Morang district

१५. मेरी स्टोप्स् ईन्टरनेशनल, नेपाल

सस्थाको नाम	मेरी स्टोप्स् ईन्टरनेशनल, नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	के.पि. उपाध्याय, ९८५१०७०२०८
विषयगत कार्यक्षेत्र	प्रजनन स्वास्थ्य
भौगोलिक कार्यक्षेत्र	काठमाण्डौ, ललितपुर, काभ्रे, रामेछाप, दोलखा, सिन्धुली, चितवन तथा धादिङ्ग
सञ्चालित परियोजनाको नाम र परियोजना अवधि	नेपालमा यौन तथा प्रजनन स्वास्थ्यसम्बन्धी आवश्यकताहरूको सम्बोधन -AESRH_
परियोजना सञ्चालन प्रकृया	परिवार कल्याण महाशाखाको स्वीकृतमा स्थानिय पाकिाहरु संग समन्वय गरि कार्यक्रम संचालन भएको ।
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	सुनौलो परिवार नेपाल
परियोजनाको बार्षिक उपलब्धि	
बजेट र खर्च विवरण	
आगामी प्राथमिकताहरु	स्थायी तथा अस्थायी परिवार नियोजन सेवा, सुरक्षित गर्भपतन सेवा, तथा अन्य प्रजनन् स्वास्थ्य सेवा लामो अवधिको प.नि. तालिम, सुरक्षित गर्भपतन तालिम, भि.आई.ए तालिम

१६. आईपास नेपाल

सस्थाको नाम	आईपास नेपाल
सम्पर्क व्यक्ती र सम्पर्क नम्बर	पपुलर जेन्टल, राष्ट्रिय निर्देशक ०१४४२०७८७, पारस प्रसाद फुयाल, सिनियर एड्भाइजर ९८५११६५४१३ ।
विषयगत कार्यक्षेत्र	यौन तथा प्रजनन् स्वास्थ्य र सुरक्षित गर्भपतन
भौगोलिक कार्यक्षेत्र	प्रदेश १ अन्तरगतका इलाम, सुनसरी, तेह्रथुम र संखुवासभा जिल्ला अन्तरगतका ३६ वटा स्थानिय तह, सुरक्षित गर्भपतन सेवा प्रदान गर्न सूचिकृत स्वास्थ्य संस्था तथा अस्पतालहरु
सञ्चालित परियोजनाको नाम र परियोजना अवधि	Enhancing the Ability of Women to Obtain Comprehensive Abortion Care and Prevent Unwanted Pregnancy (FY 2018-2020)
परियोजना सञ्चालन प्रकृया	नेपाल सरकार स्वास्थ्य तथा जनसंख्या मन्त्रालयको विद्यमान स्वास्थ्य प्रणाली, स्वास्थ्य संस्थाहरु र सेवा प्रदायक एंव अन्य जनशक्तिहरुको कार्य क्षमता अभिवृद्धि गरी सुरक्षित गर्भपतन सेवालाई महिला एंव किशोरीहरुको प्रजनन स्वास्थ्य अधिकारको रुपमा अङ्किार गराई सेवाको पहुँच सर्वसुलभ र पहुँच योग्य बनाउन स्थानिय तह, प्रदेश सरकार र गैर सरकारी संस्थाहरु सगं समन्वय र सहकार्य गरि कार्यक्रम कार्यान्वयन गरिएको ।
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	स्थानिय साझेदार संस्थाहरुस् फेकोफन तेह्रथुम, सम्वृद्ध तेह्रथुमका लागि अभियान, सोडेक संखुवासभा ।
परियोजनाको बार्षिक उपलब्धि	यस संस्थाले सुरक्षित गर्भपतन सेवाकोलागि स्वास्थ्य तालिम केन्द्र संगको समन्वयमा आवश्यक प्रशिक्षकहरु तयार गर्न र तालिमको व्यवस्थापन, सेवाको पहुँच ग्रामिण क्षेत्रसम्म पुऱ्याउन र गुणस्तरीय सेवाको लागि ६६ वटा संस्थाहरुमा आवश्यक औषधि, औजार उपकरण, सामान्य भौतिक पुनसंरचना सहयोग, लगभग ४५०० जना महिलाहरुलाई प्रत्यक्ष रुपमा सुरक्षित गर्भपतन सेवा र सो को ८५ प्रतिसतलाई उक्त सेवा पश्चातको परिवार नियोजन सेवा उपलब्ध गराउन सहयोग, कायक्षेत्रमा रहेका ३६ वटा पालिकाहरु संग अभिमुखिकरण र कार्यक्रम अन्तरक्रिया तथा व्यवस्थापन समितीहरु संग गुणस्तर सुधारका लागि बैठक तथा

	कार्ययोजना बनाई सूधार प्रकृयामा सहयोग एवं विभिन्न अध्ययन र अनुसन्धानहरु गर्न, तथा समुदायमा आधारित चेतनामूलक कार्यक्रमहरु आदि संचालन गर्न सहयोग गरेको छ। १३ हप्ता वा सो भन्दा माथिको गर्भपतनका लागि प्रदेशमा भएका अस्पतालहरुमा सेवा सुरुवात तथा सुदृढीकरणमा सहयोग गरेको छ। साथै आइपास नेपालले यो सेवालाई प्रजनन स्वास्थ्य सेवाको एउटा अभिन्न अङ्गको रुपमा स्थापित गराउन र महिला तथा किशोरीहरुको सुरक्षित गर्भपतन सम्बन्धि अधिकार परिपूर्ती गर्न विभिन्न तहमा आफ्नो साझेदारी संस्थाहरुसंग हातेमालो गरी निरन्तर चेतनामूलक तथा पैरवीवकालत गर्दै आइरहेको छ, जसमा स्थानिय तहको क्षमता अभिवृद्धी भएको र यस कार्यक्रमलाई अफनत्व ग्रहण गरेको पाईएको छ।
बजेट र खर्च विवरण	प्रदेश १ का जिल्लाहरुमा रु. १०,०९०,९९८ बजेट खर्च भएको छ। जुन प्रस्तावित बजेटको १०० प्रतिसत हो।
आगामी प्राथमिकताहरु	आईपासले प्रदेश सरकार र स्थानिय तह संग सहकार्य गर्दै यौन तथा प्रजनन् स्वास्थ्य, सुरक्षित गर्भपतन र परिवार नियोजन सेवामा महिला र किशोरीहरुको निर्णय क्षमता बढाउने, सेवाको पहुंच तथा उपयोगीतामा वृद्धि गरी नेपाल सरकार स्वास्थ्य तथा जनसंख्या मन्त्रालयले लिएको दिगो विकास सम्बन्धी लक्ष्य हांसिल गर्न सहयोग पुऱ्याउने छ। कार्यक्रम सीमान्तकृत वर्ग र ग्रामिण क्षेत्रहरुलाई विशेष प्राथमिकता दिई संचालन गर्नमा जोड दिइने छ साथै स्थानिय तह संग साझदारीतामा लैङ्गिक हिसाँ रोकथाम तथा प्रतिकार्य सम्बन्धि कार्यक्रममा समेत केहि जिल्लामा परियोजना संचालन गरिने छ।

१७. निक साईमन्स इन्स्टीच्युट

संस्थाको नाम :	निक साईमन्स इन्स्टिच्यूट , ललितपुर महानगरपालिका(२, ललितपुर
सम्पर्क व्यक्ती र सम्पर्क नम्बर	डा. अनिल बहादुर श्रेष्ठ, कार्यकारी निर्देशक ९७७(१५४५१९७८
विषयगत कार्यक्षेत्र :	१. उपचारात्मक सेवा सहयोग कार्यक्रम २. अस्पताल सुदृढिकरण कार्यक्रम ३. तालिम कार्यक्रम
भौगोलिक कार्यक्षेत्र :	१. उपचारात्मक सेवा सहयोग कार्यक्रम अन्तर्गत रङ्गेली- मोरङ्ग, दमक-झापा, मंगलवारे- मोरङ्ग, कटारी-उदयपुर, भोजपुर, गाईघाट-उदयपुर, ताप्लेजुङ्ग, तेह्रथुम, संखुवासभा र खोटाङ्ग अस्पताल २. तालिम कार्यक्रम अन्तर्गत प्रदेशमा रहेका तालिम केन्द्रहरु ३. अस्पताल सुदृढिकरण कार्यक्रम अन्तर्गत धनकुटा, गाईघाट- उदयपुर, इलाम, इनरुवा(सुनसरी, खोटाङ्ग, ताप्लेजुङ्ग, तेह्रथुम, संखुवासभा, पाँचथर, फाप्लु(सोलुखुम्बु, रङ्गेली- मोरङ्ग, दमक- झापा, मंगलवारे- मोरङ्ग, कटारी-उदयपुर, भोजपुर, रुम्जाटार- ओखलढुङ्गा, मेची- झापा अस्पताल
परियोजनाको नाम र परियोजनाको अवधि:	ग्रामिण स्वास्थ्य सहयोग परियोजना (आ.व. २०७७।७८)
परियोजना सञ्चालन प्रकृया	समाज कल्याण परिषद, दाता र संस्था बीच त्रिपक्षीय परियोजना सम्झौता गरे पश्चात् सम्बन्धित प्रदेश र अस्पतालहरुसँग बेग्ला- बेग्लै सम्झौता गरी कार्यक्रम सञ्चालन गर्ने
स्थानिय साझेदार सस्था भएमा तीनको नाम र सम्पर्क नम्बर	स्थानिय साझेदार संस्था नरहेको

परियोजनाका वार्षिक उपलब्धि:

१. उपचारात्मक सेवा सहयोग कार्यक्रम अन्तर्गत १० वटा सरकारी अस्पतालहरुमा आवश्यक जनशक्ति तथा उपकरण सहयोग गरि अस्पतालबाटै आधारभूत तथा आकस्मिक शल्यचिकित्सा सेवाको निरन्तरतामा सहयोग

२.अस्पताल सुदृढिकरण कार्यक्रम अन्तर्गत तीन वटा स्थानिग तहका अस्पतालहरुमा न्यूनतम सेवा मापदण्ड कार्यान्वयनमा आर्थिक तथा प्राबिधिक सहयोग गर्नुका साथै १७ वटा अस्पतालहरुलाई ल्क्ष्य न्चबलत प्रदान गरिएको र :क्क क्षउझिभलतबतष्यल ग्लष्त स्थापना गर्न आर्थिक सहयोग।

३. अस्पतालमा कार्यरत स्वास्थ्यकर्मचारीहरुको लागि आवश्यक क्यब, ीए, ब्क्यब, इत्त, भ्क्रक्रत, एभ्क्र, ब्ब्क्र लगायतका तालिमको ब्यवस्था गरिनुका साथै तालिम केन्द्रहरुलाई आवश्यक प्राबिधिक सहयोग

४.कोभिड १९ प्रतिकार्यमा अक्सिजन कन्सनट्रेटर , थर्मलगन, पी.पी. सेट लगायतका सामाग्रीहरु सहयोग वित्तीय तथा भौतिक प्रगति : प्रदेश नं. १ मा आ.ब. २०७७।७८ को वित्तीय स्थिति निम्नानुसार रहेको देखिन्छ।

कार्यक्रमहरु	खर्च (आ.ब. २०७७।७८)
१. तालिम	६,६२६,७४८.२२
२. उपचारात्मक सेवा सहयोग कार्यक्रम	४३,६३७,१२४.०६
३. अस्पताल सुदृढीकरण कार्यक्रम	६,९३०,८३०.१२
जम्मा	५७,१९४,७०२.४

Part 10 **Contributors to the annual report**

Mr. Gyan Bahadur Basnet	Director	Health Directorate
Mr. Udesh Shrestha	Immunization Officer	Health Directorate

Mrs. Priyanka Khatiwada	Public Health Officer	Health Directorate
Mr. Mukunda Dahal	Statistical Officer	Health Directorate
Ms. Tara Devi Subedi	Public Health Inspector	Health Directorate
Mr. Tulsi Prashad Guragain	T.B/ Leprosy Supervisor	Health Directorate
Mr. Sanjay Adhikari	Lab Technician Officer	Health Directorate
Mr. Dilip Singh	Lab Technician	Health Directorate
Mr. Khagendra Paudel	Senior Kabiraj	Health Directorate
Mr. Roshan Pokhrel	Account Officer	Health Directorate
Mr. Anil Pradhan	Public Health Inspector	Health Directorate
Mr. Surya Pokhrel	Officer	Health Directorate
Mr. Surendra Bajimaya	Officer	Health Directorate
Mr. Nabin Kishor Rai	Typist Na. Su	Health Directorate
Ms. Bivechana Chaulagain	Public Health Officer	Health Directorate
Mr. Srijat Dahal	MSS Implementation Officer	Health Directorate
Ms. Anamika Sharma	School Health Nurse Co-ordinator	Health Directorate
Mr. Arpan Dhakal	Nutrition Officer	Health Directorate/WFP
Mr. Shyam Bhandari	Quality Monitoring Officer	Health Directorate/WaterAid
Mr. Anil Kumar Deo	Province SRHR Officer	Health Directorate/WHO
Mr. Krishna Kumar Deo	Provincial Health Officer	WHO
Ms. Sabina Chaudhary	Data Focal Officer	Health Directorate
Ms. Dixita Lama	Pharmacy Officer	Health Directorate
Mr. Rup Narayan Yadav	I.T. Officer	Health Directorate
Ms. Saranga Tamang	eLMIS Officer	Health Directorate

ANNEX I: Event Report of Provincial Annaul Health Review Workshop

Name of event: Provincial Annual Review Workshop
Date of event: 2079/06/07-2079/06/09
Location of event: Kanchenjunga Party Palace, Biratnagar
Organized by: Provincial Health Directorate, Dhankuta

Introduction:
With the aim of discussing the overall situation of health services and identifying the main issues and including them in the upcoming quarterly/half-yearly/annual action plan, the health office and hospitals have been adopting a certain method of half-yearly and annual program review. The basic purpose of the half-yearly and annual review is to analyze the state of progress, the situation that needs to be improved, and the learning from the health facilities to the health office level as targeted and identification of key issues and included them in the next quarterly/annual action plan. In this review, there is a review of women, poor and disadvantaged consumers in the use of health services. What is the condition of the period, why are they not able to come/go to that service and what will be the role of the relevant agencies and stakeholders in diagnosing the reason and to discuss and decides necessary.

Day: First

1. **Registration: (8:00-9:00 am)**
2. **Program inaugurations:**

The Inauguration session was hosted by Mr. Mukunda Dahal, Statistical officer of PHD. The session was chaired by Mr. Gyan Bahadur Basnet, Director of PHD. The chief guest of the meeting was Mr. Jayram Yadav, Health Minister of province1. Dr. Anuj Bhatttachan, Secretary of Health ministry was the special guest of the meeting. Dr. Dipendra Raman Singh Director of DoHS Joined the meeting from zoom as guest.
Phadindra Khatri, Public health Lab, Jayabendera Yadav, Superintendent of Koshi hospital, Sagar prasai health section chief of Provincial Health Ministry, Dr. Suresh Meheta, Health Planning Section chief of Provincial health Ministry, Dibakar sapkota, chedilal Yadav, Bharat Shah from Logistic management division Chief, Ashok kumar shah, Haribol Bhattrai from AFIM, Shree Lal from Journalist association were invited in Dash as guest.
Mr Mukunda Dahal also thanked the District Hospital and Health office, Private hospitals, UN-agencies, WHO, EDPs and requested to have a seat in their own place.
Then khada and a batch was provided for the guests and the program started playing the national Anthem. The program was inaugurated pouring water in plant of Tulsi.
Introduction: All guest and participants provided their introduction with name, job position and working place
Objectives of Program was presented by Mr. Gyan Bahadur Basnet, Director of H.D. Dhankuta

He started presentation by saying these three days program will give road map on the basis of which commitment can be made for another Fiscal Year and he shared the objectives of annual review program which are:

- To discuss and share experiences with each other about innovative programs including annual health programs conducted at the local level, district level and state level.
- Prioritized the major health problems and challenges identified at the local level and district level so that they are addressed in the next plan.
- Activities completed in Fiscal Year 2078/79 and the activities, freeze budget activities, learnings, main achievements, problems and challenges based on indicators will be critically reviewed and included in the detailed annual report.

Presentation from IHIMS-DoHS by Mr. Diwakar Sapkota (Statistical officer):
He presented on the behalf of IHIMS, DoHS, he shared the IHIMS slogan of FY 2079/80 that is "***Provide standardised & Quality data to all".*** He presented activities done in IHIMS which are as follows:

Activities done in HMIS

- Approval of IHIMS's Roadmap, 2022-2030
- Comprehensive Revision of R/R tools, Monitoring sheets, guidelines and Indicator booklet
- MTOT & ToT on Revised HMIS tools and DHIS2 update up to LLG levels
- Upgrade of DHIS2 from 2.30 to 2.36 version
- Dashboard program in 17 LLGs from UNICEF support
- 5 years trend analysis by major Indicators and Programs up to LLG level to use in planning
- Recruitment of Data focal persons in IHIMS and Provinces (8 persons-UNICEF)
- Introduced ICD 11-MToT and ToT in several batches (Supported from WHO)
- Micro-teaching and On-site Coaching in different hospitals
- Data verification & validation for LLG & HFs
- Orientation of DHIS2 for health workers in jail
- Inter country observation tour of MROs for best experience sharing
- Printing of HMIS tools for Federal Hospitals
- Projection/Forecasting of target population up to ward level
- Preparation and distribution of DoHS-Annual Report 2077/78
- Training/Orientation of QGIS using HMIS data for Provincial & HO level officers.

Activities done in e/LMIS

- Revised LMIS tools as per demand from Centers and Divisions.
- Incorporate the COVID related commodities
- Printing and distribution of new LMIS tools (supported by GHSC-PSM)
- Forecasting & Quantification FY2079/80
- Training, microteaching and on-site visit on e/LMIS as per need
- Gradual expansion of eLMIS in SDPs as per integration policy.
- Recruitment of eLMIS coordinators in IHIMS and Provinces (8 persons-GF)
- Process for settling issues raised between PAMS and eLMIS
- Server management and Data Security in MD/GIDC/Provinces
- Establishment of linkage among e/LMIS, HMIS and other information systems.

Activities done in IMU

- Fully implementation of IMU (Lab, Hospital, CICT, Antigen, PoE, QR-Code linking to DHIS2)
- Full digitization of CoVID-19 vaccine data (8 LLGs) & review meeting with the stakeholders
- Training/orientation on IMU up to LLGs,Labs,Hospitals and PoEs
- Establishment of Reimbursement system of Covid designated hospitals with close monitoring system
- Regular reporting about Covid related information to concerned authorities
- Storage of Covid related Data in GIDC/IHIMS
- Time series CoVID-19 related data analysis and sharing with Higher authorities

Future Plan of Section/Unit

- Online recording and Registration system from all HFs (Starting from some HFs)
- Online reporting from 4000 HFs (up to December) and cent percent from all HFs in this FY.
- Mapping of all HFs, those reporting in IHIMS.
- Strong and lively updated and revised DHIS2 system
- High level Data security maintained in the National Health Central Server System.
- Regular data sharing and feedback mechanism (Data management committee at all levels)
- Prepare the data sharing policy and SOP of IHIMS
- Prepare the IP with costed for approved IHIMS's Roadmap
- Authorize IHIMS section as the Digitalization and AI Focal Implementation Unit
- Integration model (Health Infrastructure, HF registry and other sub-systems and Trackers
- Focus on EMR/EHR in all Federal and Provincial hospitals
- Improvement of Provincial level capacity in the areas of data quality
- Meta Data Analysis
- Preparing of Data quality booklet (Support from IPD-WHO) & Indicator compendium
- Fund rising program for sustain of IHIMS (IHIMS kosh)-selling the data/Report (Capacity Building, Hardware/Software etc.)

Virtually Participated guests: Dr. Dipendra raman Singh (DG, DoHS)

Best wishes speech (Oprning Remarks)

Virtual speech: National Health Training Centre- Mr. Yadu Chandra Ghimire

He said that many programs are going well but, in some indicators, we are below the national average and in some we are above too. He was happy for the improvement of the hospital activities. Many programs have been done and will be continued in future, in coordination with Central and Province for improving and strengthening Province health indicators. He gave best wishes to all participants and said from the three days annual review program may we recognize all the flaws, how they can be solved from and who is responsible for that. Lastly, he thanks all the health workers for their efforts and gave best wishes.

Ministry of Health Province 1, Secretary, Dr. Anuj Bhattachan

He said that he is happy to meet all the health employees from all districts of province 1, and thanked the Province Health Directorate team for organizing the grant annual review. He says there are things that all the health workers should think about it. Like, who are we? We are health employees, there are our certain responsibilities, and our own importance. Health safety is shown time and again from the history. We are responsible to direct the way of Health in the future. All the health workers in different geographics should know the importance of health and their responsibility to perform their activities. He said that he is proud to be in health sector and has a relation to province 1. He has spent his academics in Province1 and is happy to work for province 1. He requested all the Health Office Chief for proper utilization and management of information technology. He also said that Major problems in Province 1 is the lack of human resources approximately 40%, these are many challenges and questions that have come into the scene. In this fiscal year, political expectations, promises given to the public to fulfil the sanction post by Loksewa Ayog. He said that timely reporting is a topic to think about, but the covid19 double dose has increased the public confidence and all these are possible due to the health workers. In some districts, development is in red color, so coordination should be done with LLG. Despite all these things, dengue is now emerging as an epidemic, He shares the happiness by saying that he received information-district heads are working closely with LLG to prevent it. At last, he wishes for the success of the three days annual review program.

Speech by Chief Guardian, Health minister, MoHP1, Mr. Jay ram Yadav, Health

He gave thanks to all the health institutions who have put their efforts to strengthen the health sector of province 1 and he believes that the 3 days program will be successful. He added that due to development of technology, we were able to communicate through zoom, receive data-based information, and all these are the things we should consider. He believes that there have been some improvements after the formation of the Provincial government after the development of the health ministry, if development is not done in a good way, there will be criticism, and challenges but if done with good performance the division will show a good demonstration. No matter how many democrats there are, we must stay in discipline for the progress of all LLGs, districts, province, and government. With proper coordination, we will surely reach certain decisions and get fruitful results. He said that among all health ministers of provinces, the health ministry of Province one has low spending on programs and last year approximately 54% possible activities also did not complete. Not only the Secretary and Health minister is responsible for this, all health employees will be equally responsible. He draws all attention to timely reporting and key indicators. He said that he has not got any advice or suggestions from any health office chiefs and he asked if he should take this in a good way or bad way? He again focused on serious issues of reporting, as per the presentation, coordinating with the Health Coordinators of municipalities and Rural Municipality. He has also received the information that the respect and coordination that should be shown to district chiefs is lacking. He expects if full immunization will be completed before mangsir during his work leadership.

Now, he shares the things that has been done after he has been the health minister-For huge vacant post of HR- Loksewa amendment bill for opening vacancies, has allowed LLGs to run 15 bedded hospitals, has increased beds number in district hospitals, eg Mechi hospital as 200 bed as Provincial hospital, Tehrathum, Bhojpur, Panchthar has been upgraded to 50 bed hospital from the cabinet. Koshi covid hospital which has been developed, still has 2 covid patients with proper ventilation and tools. The name of koshi covid hospital has changed to Centre for infectious disease and critical care (CIDCC). Many employees want to stay in Jhapa, Moarng, Sunsari, so that incentive provision of hilly regions has increased. Contract guidelines have been approved, ambulances of kha categories have been distributed. Ambulance tracking system (GPS) work is ongoing with the help of Save the Children and is at the final stage. He shared that the Provincial Health Laboratory is in its final stage and going to be open soon and also mentioned that soon Building will be established for PHLMC. He also shared Critical state of provincial health training center that he observed during his visit and said that budget has been allocated for renovation of PHTC. He also suggests preparing and staying aware for prevention of epidemics in

festival occasions. Lastly, he gave his best wishes for the success of the 3 days program and ending session.

Closing speech of informal Session by Director of Health Directorate Dhankuta, Mr. Gyan Bahadur Basnet

He greeted all the participants of the annual review program. He said that the live broadcasting of the annual review program helped to participate virtually also. He also mentioned about the coordination that should be maintained with the MoHP1 and Health Directorate by all the health workers in districts and LLG. He said that this is the time to discuss the important agenda, all the activities that have been done during the previous Fiscal year and make a workplan for betterment of health activities in next Fiscal Year. He also thanked the whole management team for such a wonderful of IT friendly management like in abroad. He said that he is worried about the low health indicators of Province 1 and suggested that it can be improved by the coordination of Health teams of Province 1. Lastly, he wishes Happy Birthday to Minister of Health Mr. Jayram Yadav and he closed the informal session by thanking all participants and speakers.

Technical Session

Presentation of Pharmacy Officer, Bharat Shah from Provincial Health Logistic Management Centre:

He stated that he had worked in the related fields earlier and used to distribute medicines after the procurement. He expressed his sadness regarding the insufficient medicine stock due to which the distribution process gets affected and the situation hasn't changed for a long period of time.

His presentation majorly focuses on the main activities of PHLMC, commodities forecast, supply and total expenditures of supply to 16 districts out of which 14 districts are of province 1 and 2 of them are Siraha and Saptari. He mentioned the distribution of COVID-19 vaccine to different districts and stated that all the vaccines were utilized effectively but Astrazeneca and Covishield expired. Likewise, 2 Ice Line Refrigerators and 1 deep freeze will be supplied in each district health office and 2 health facilities will also receive 1 Ice Line Refrigerator and 1 deep freeze each with the aid of UNICEF. He also mentioned the received and supply status of medicines and equipment on different public health programs such as; malaria and kala azar program, leprosy/TB program, etc. and the distribution of Ambulance/Mortuary Van to Mechi hospital, Madan Bhandari Hospital, Inaruwa hospital and Udayapur hospital. Some of the major challenges seen in logistic management division are enlisted below:

- Insufficient storage space
- Lack of human resources
- No proper procurement guidelines
- Lack of fuel budget for generator and vehicle
- Computers and laptops not available for all the employees
- No systematic process of demand and supply between province, districts and local level governments
- Capacity development needed for the HR in province, district and LLG who are responsible for logistic management
- Difficulties in disposal of expired and damaged commodities

Along with these challenges, he presents a possible solution to overcome them such as land allocation for the storage area, management of HR, procurement guidelines, central bidding local purchasing, allocation of budget for the essential drugs as per quantification and forecasting to minimize stock out, conduction of workshop to facilitate procurement among three types of government and rate fixation, and Implementation of eLMIS to health facility level.

Presentation by Mr. Binod Thapa, Provincial Public Health Laboratory:

He explained about the main plan and activities of PPHL in previous FY 2078/79. The major training provided by PPHL were TB basic microscopic training, Refresher and LQS training, 1-month basic malaria microscopy training and capacity development training to lab health workers from rural mother health programs implemented in eight districts. He added that till now 31 labs have registered in PPHL and Samples that come from health facilities under the provincial government are also regularly tested. He said that in FY 2078/079 total 25944 COVID 19 tests were done of which 8340 were positive cases. According to his presentation there are 14 gene xpert centres and recently 2 centers have been added which are soon going to be operated. He said that there is no budget for HIV related programs in FY 078/079 in PPHL. He said that recently 10 samples from Mechinagar Municipality were tested for cholera but thankfully all samples were negative. He also addresses the problems, challenges and suggestions of PPHL which are as follows:

- Most of the district hospitals have well facilitated labs and enough manpower but still microbiology service has not started due to lack of skill-based training.

- Due to lack of budget for reagents, chemicals and instruments required in governmental lab centres, PPHL is unable to address the requisition from those lab centres.
- Due to lack of sanctioned post and insufficient human manpower PPHL is facing difficulties to run different programs
- The Government of Nepal has committed to develop PPHL as a centre of excellence and reference lab but the allocated budget is not enough for that.
- Cartridge and reagents those required in gene xpert centres should be provided through PPHL.
- TB and Malaria QA/QC slides must be sent trimester wise to PPHL through Lab supervisors of the health office.

Presentation by Mr. Udesh Shrestha, Immunisation Officer, Health Directorate, Dhankuta:

His presentation explained that vaccine coverage is near 100% in terai region and less in hilly regions and penta-3 coverage should be above 95% but coverage in province 1 is only 89%. He said that better performance has been seen in TCV campaigns but not so good performance in regular vaccination programs. He mentioned that province-1 has low (3.4) times the average number of visits in growth monitoring. He said that nowadays vector borne diseases like malaria, kala azar, and dengue have been increasing in Hilly regions also.

The major key issues he mentioned are

- Under and over reporting in DHIS2, eLMIS and EWARS which is hindering in data analysis,
- Improper documentation of work has created the question in our work,
- Cold chain problems like vaccine, syringe shortages have hampered in the service delivery,
- Low exclusive breastfeeding, low complementary feeding has created problem in indicators of nutritional status.

Presentation by Bivechana Chaulagain, Public Health Officer, Health Directorate, Dhankuta:

Her presentation overview of health service status of the Hospitals of province 1 where she mentioned the key issues like

- lack of HR, high CS delivery rate, weak referral mechanism
- incomplete and poor data quality which are creating the problems in an effective service delivery

she also said that she has hope that these issues will be properly discussed in coming presentations and discussions.

Discussions

Ramesh Barakoti, Chief of HO Jhapa

- There are approximately 60-70 medicines to be provided to local level governments by the province, so it would be helpful if those medicines are provided sufficiently and LLG won't have to buy it - **Mr. Bharat Shah** addressed this query by saying that there are lists of medicines which are categorized for procurement and the medicines will be distributed as per that guidelines and stock.
- The vaccine should be transported through special carriers but as seen practically those were carried by normal vehicles, thus, he requests Province Logistic Centre to transport such medicines and commodities by their own vehicle and allocate the budget accordingly- **Mr. Bharat Shah, PHLMC** addressed these queries by saying that the vehicles with commodities are sent to respective health offices. However, he accepts that the supply in medicine was delayed for 1-2 months due to some reasons.
- There is huge demand of TB microscopic training, so it should be prioritized on the basis of available budget- **Mr. Binod Thapa, PPHL** addresses this query by saying that, at first there should be coordination between health offices and LLG and with the aid of Save The Children, the training will be conducted.
- Regarding quality control, it's said to take data from each lab in a three months period but is it possible in the case of Leprosy as that of TB? **Mr. Binod Thapa, PPHL** states that there are no activities carried out for leprosy from PPHL.
- Is it possible to distribute MNH cards to those hospitals who conduct Safe Motherhood Program? - It is addressed as; only samples for MNH cards could be provided.
- It's said that EMR was conducted successfully in two hospitals and why has it been a challenge to conduct the same in other hospitals that have all the resources?

Kumar Dhakal, Save the Children

- An epidemic, Malaria is said to end by 2030- there are many ongoing tests conducted by private hospitals but they have not come into reporting even after huge follow up, there is not any data to interpolate with the private cases, so what improvements can be made to strengthen the reporting from private sectors?

- Likewise, there are more than 10 thousand private cases of HIV testing but are not presented in DHIS2. How can we bring them effectively into the DHIS2 system?

Dambar Singh Gurung, Fairmed

- Glad that the presentation ways are upgraded than the previous years
- Why are CS cases increasing in the private sector? - It is addressed as: many complicated cases are referred to Private hospitals, and for the safety of newborn and mother, CS cases are increased in private sectors.

Panchthar

- Thankful for the decision of 50 bed hospital
- Received the ambulance but not suitable for hilly regions. It would be better if an ambulance as per the geography was sent to such places. Also, a huge amount of diesel/petrol was consumed- Mr. Bharat Shah, PHLMC said; if that problem existed in one ambulance or all the ambulances, a technical person should be called for discussion of these issues.

Mrs. Bijaya Rai, Taplejung Hospital

- She asked about the data entry date for timely reporting and raised her queries if that was the first 15 days of the month or first week of the month. In addition, she says that the reporting has always been done regularly in the last fiscal years and doubts the data which showed zero reporting percentage of Taplejung hospital.
- Later, Mr. Mukunda Dahal explained the issues that Taplejung hospital has not entered any data of Magh month and asked her to verify data entry date in DHIS2.

Mr. Punya Prasad Sigdel, Khotang

- He raises his queries about the data difference of MR2 and Full immunisation in DHIS2.
- Private technician was sent for repairing and maintenance of the refrigerator and the budget to be allocated for such activities.
- Supply of vaccine in time in hilly and mountainous regions.
- Lack of room for school health nurse and availability of equipment and instruments but they are not into use and are in the critical state
- Lack of HR (Computer Operator)

Presentation from Health office Jhapa (Mr. Ramesh Barakoti, HO Chief)

Mr. Ramesh Barakoti who has recently transferred to Jhapa district as a Chief of health office gave a presentation about the overall status of public health aspect of the Jhapa district. He addressed that key issues in recording and reporting are delay in report entry by private health facilities, delay supply of HMIS tools and system error in DHIS2 server. He said that in Jhapa district the number of safe abortion site is not enough there is only 7 government sites for abortion. He also addressed that the number of FCHVs in Jhapa district should be 660 but there are only 568 FCHVs. He said that the human resources in Jhapa districts are fulfilled according to the sanction post. He said that the email id and website of every health office in province 1 should be linked under the Ministry of Health. He also addresses the problems, challenges and suggestions of Health Office Jhapa which are as follows:

- Delay Report Entry by Private Health office, supply chain of HMIS tools as well as server error during reporting in DHIS-2.
- Low coverage of vaccine, IFA program in adolescence and OTC center is not functioning
- In IMNCI program there is low service coverage and poor data quality
- Low coverage of institutional delivery in peripheral birthing center
- Continue knowledge and skill update at least 2 hour per month for FCHVs
- There is also low testing of malaria, kala-azar so compulsory testing of malaria should be done in fever cases.
- Low TB case notification as well as treatment success rate is not 100% there is also high burden of Dr TB so active case detection and awareness, counselling should be done to patients.
- There is low case reporting and underdiagnosed case of NCDs and Mental health so training to health worker is needed

Discussion:

- **Mr. Krishna Deo, WHO**, asked about the way forwards for low status growth monitoring and Mr. Ramesh Barakoti said that there should an enabling environment for growth monitoring like enough Human resources for recording and reporting and proper functioning instrument for growth monitoring and he presented his ideas: the growth monitoring can be strengthened if awareness programs regarding nutrition could be conducted in different grassroot level by coordinating with LLG.

Closing session of first day: Secretary of MoHP, Dr. Anuj Bhattachan states that the presentationwas overall good and more improvements could be made in the coming future. He also focused towards the participants and said- 1. Are we going to remain in our same state? 2. Are we going to be confused more? Or 3. Are we going to improve and strengthen? Through this, he prioritized making the work plan and expects all the health facilities to act accordingly. Apart from this, for the upcoming presentations, he expects not only the problems but also the actions that are done to solve those issues should be presented and gives his greetings for the successful completion of three days Provincial Annual Review Workshop.

SECOND DAY

Presentation from Health office Ilam(Mr. Aaditya Shakya, HO Chief)

He majorly focuses on the issues and recommendations which are as follows:

- Low immunisation coverage in some LLG and was recommended to reach difficult areas, then search and conduct immunisation programs for full immunisation.
- Lack of HR (Cold chain assistant) and therefore, the quality of vaccine was questioned and was recommended to sanction the post from MoH. Also, the lack of HR in DOTS centres.
- Less use of balvita due to compromise in quality
- Lack of manpower due to which 4 safe abortion center is not in function
- Lack of AFI corner in many school
- Use of antibiotic in no pneumonia case
- Insufficient buffer for HIV- it was suggested that a single buffer is present in 2 kit and therefore should be used accordingly to avoid the shortage of buffer
- 6 suicidal attempts were recorded in a week and hence, life skill modification class should be arranged in the school as well as psychosocial counselling can help reduce such cases
- Insufficient budget allocation in information channel
- Low ANC, PNC visit due to lack of trained manpower and awareness
- Lack of training and insufficient reporting tools due to which reporting pillar was weak

Presentation from Health office Ilam Hospital (Dr. Prabhu Sah)

He presented the general overview of the hospital and discussed the major activities performed by the hospital. He shared about the low institutional deliveries and all MSS status was achieved except the mock drill. He also shared the major achievements such as manufacturing of oxygen implant, construction of waste management building, use of autoclave for infectious waste, construction of maternity waiting building, freeze in mortuary room. Triage system was developed for emergency readiness. Along with this, he reflected on some of the problems such as lack of space, huge patients in insurance and thought 14 nurses were available for the service but it was still not enough.

Presentation from Health office Taplejung (Mr. Yograj Ghimire)

He recently took the responsibilities of Health Office Taplejung from Bhadra 12. Just after his arrival, paid the bill of vehicles (which was 4.5 lakhs) from the budget allocated to repair and maintenance of vehicles and some dues are still left. He shared some of his problems which are enlisted below:

- NCD and mental health programs are not yet started but the training was given so will start in near future.
- Top ten morbidity cases from DHIS2 were not satisfactory in real case scenarios due to improper diagnosis from paramedics.
- Lack of HR and only one permanent staff in Aathrai tribeni, and 2 in Dhungesaghu out of which one works in insurance which makes difficult to accomplish tasks such as timely reporting

Presentation from Taplejung Hospital (Mrs Bijaya Rai)

She shared an overview of the Taplejung hospital and she said that there is enough availability of equipment required in the hospital and she also mentioned that they are planning to upgrade an old ambulance into a vehicle for dead body transportation. She said that the hospital was approved only for 15 beds but they are running a 38-bed hospital by coordinating with the committee. She addressed the problems like institutional delivery has decreased. In Taplejung hospital there is HepB vaccination program for every staff in the hospital and all staff collaborate to decontaminate the hospital on a weekly basis. She raised her queries about complicated delivery data entry in DHIS2. She mainly focused on issues and challenges like lack of trained human resources, lack of infrastructure and reimbursement of Insurance.

Presentation from Panchthar Health Office (Mr. Tej bahadur Tumbapo)

He said that there are twelve sanctioned posts for Human resource of which six posts are vacant. Due to lack of skilled manpower Panchthar has low reporting status and due to some problems in DHIS2

vaccination report has not entered. He also gave the example of Phidim Municipality where ward chairpersons are not aware about health programs which is hindering the conduction health programs.

Presentation from Panchthar Hopsitall (Medical officer, Narayan Joshi)

He presented the general overview of the hospitals and their financial statements. Then, he discussed the major activities that were carried in the hospital. About human resources, he explained that though there was a presence of pediatricians, the number of neonatal cases was 6, due to delay in visit. From shrawan, the bed was upgraded to 40 beds but 10 ICU are not in operation and also, the ambulances are not sufficient to provide optimum service. Likewise, regarding waste management, the building has been constructed but has not been utilized yet. Not only this, he also stated that though 5 lakhs budget has been allocated for logistics and medicine, that was still not enough because of the flow of patients from other districts and also, he asked for the supervision of Province about the new building that has been constructed but not furnished properly. Apart from this, he discusses some of the major achievements during FY078/79, like purchasing of DR machine, CR machine, after the allotment of budget from the province, and completion of ONM survey for 50 bed hospital, has an orthopedic doctor after coordinating with the development committee.

Presentation from Tehrathum Health Office (Phadindra Thapa, Health Office Chief)

He gave the overview of the Tehrathum health office. Then, he said that in laligurans Aathrai municipality PHC has updated the hospital but the health office was not informed about that. He mentioned that Tehrathum district has been declared as safe abortion district two years ago and there are 15 abortion centres. About immunisation, he said that immunisation coverage has increased and dropout rate has decreased and due to frequent turnover of the contract trained health workers there is. He also mentioned an issue that there is only one SBA in an entire district.

Presentation from Terhathum Hospital (Dr. Pankaj Gupta, District Hospital)

He said that the hospital has been approved for a 15-bed hospital but due to high patient flow the hospital is running a 52-bed hospital. He mainly focuses on issues and challenges like lack of adequate Human resources (lack of medical recorder has hindered in the timely reporting and reporting), he also said that in previous fiscal year budget was allocated for separate health care waste management building renovation but couldn't utilised it, he also said that due to inadequate space in mortuary there is a problem in managing more than one dead body at a time. He also mentioned that they are planning to establish a paid Hospital pharmacy in near future. Some way forwards he mentioned are establishment of Drug and Therapeutic Committee and follow its guidelines to start paid pharmacy, Screen cervical cancer patients through rural health camp on monthly basis, Collaborate with BPKIHS for compulsory rotatory internship with our center throughout the year and have already started optional cashless QR code service at counter and same service is under process in pharmacy.

Discussion:

- **Mr. Sagar Prasain from MoHP1** addresses the queries about constant ambulance fare by saying that there is an ambulance committee in the province where districts with problems can submit the letter for increasing ambulance fare. He also addressed the queries from Terhathum about upgrade of PHC into hospital by saying that Nepal government has given authority to LLG for upgrading PHC to hospital and also suggested establishing a paid pharmacy in Terhathum hospital as soon as possible.
- **Mr. Diwakar Sapkota from DoHS,** added that while upgrading health service centers, LLG should inform District, Province and Central so that data sets can be updated in DHIS2 as well. He also stated data quality can be improved, if it is discussed in the monthly meeting of LLG.
- **Mr. Ramesh Barakoti, health office chief of Jhapa** raised a question about vacant posts of FCHVs after retirement of old ones which was addressed by Prof. Dr. Goma Devi Niroula. She said that by conducting meetings among the health coordinator and Mothers group in LLG they can recruit new FCHVs and should inform the central government as well. She also addressed the queries from Ramesh Barakoti about availability of continuous education booklets for FCHVs all over the country by saying

it is available in websites and for hard copy they are searching for financially supporting organizations.

- **Mrs. Kesu Kafle from PTHC,** gave suggestions about a common problem in lack of trained manpower in a safe motherhood program. She said there are problems like inadequate budget for training and high turnover of contract staff in hilly and mountain regions which can be solved by recruitment of permanent staff and training them. In addition, she said that nursing staff can be trained by developing the training package and mobilizing them to high patient flow hospitals like Koshi hospital for practice for a certain period of time.
- **Mr. Sagar Prasain from MoHP1** said that there is a slogan "one LLG, one birthing centre" but there are no specific guidelines for birthing centre which has created the confusion in province and LLG as well and he added that in some birthing centres there is no SBA and where there is SBA there is no birthing centre. Prof, Dr. Goma devi Niroula addressed these queries by saying that there is a guideline of birthing centres on the website and for trained human resources O and M survey has been going on and also suggested for integrated training of SBA and Family planning package.

Presentation from Sankhuwasabha Health office (Narad Subedi, Health office chief)

He said that there are issues in recording and reporting like unexplained variation in service data, Electronic medical record (EMR) partially functional and Problem in DHIS2 server. About immunisation, he said that some LLGs have not prepared micro planning for immunisation, sanitation programs also have not been implemented in all immunisation centres so there is a need for proper coordination between District and LLG. He added that due to nonfunctional ITC in hospitals, treatment of Severe malnutrition has not been provided that can be solved by recruitment of Specialised human resources in district hospitals. He mentioned that there is a high home delivery rate and low ANC visit according to protocol which creates risk in maternal and child health so that they have planned to conduct an awareness program in the community by coordinating with LLG. He also said that there is a vacant post of school health nurse that should be fulfilled soon.

Presentation from Sankhuwasabha Hospital (Nirmika Rai, District Hospital)

She presented the major achievements which are extension of ICU/NICU/HDU, Physiotherapy, Specialised service, Lap service, and has started EHR, Orthosurgery service and delivery waiting room. Some issues and challenges she mentioned are old and insufficient infrastructure, improper waste management, difficulties in patient transportation, lack of human resources and also problems in reimbursement of insurance payment. Furthermore, she presented some ways forward like management of HR and equipment for the extension of dialysis service, procurement of CT scan machine, Washing Machine, Mortuary Machine and Autoclave machine. And at last, she said that health insurance for all staff in Hospital will be done by the hospital committee.

Presentation from Bhojpur Health office (Suman Tiwari, Health office chief)

According to him some key issues in recording reporting in bhojpur district are vacant post of statistical assistant, frequent turnover of contract staff, untimely distribution of HMIS tools, Lack of enough training to health workers about revised HMIS tools. He also presented problems in immunisation that are low coverage and high dropout so that tracing is needed for making further plans on immunisation. There is inadequate skilled human resources for specific programs like CB IMNCI, Safe motherhood, NCDs and mental health programs. At last, he mentioned some innovative activities which are in Pauwadungma Rural Municipality door to door growth monitoring program that has been started, Rural USG program has extended, Distribution of Laptop/printer in health facilities.

Presentation from Bhojpur Hospital (Dr. Milan Rai, District Hospital)

He presented some major achievements of bhojpur hospital which are 90% completion of ICU and oxygen plant installation, construction of well managed mortuary building with deep freeze, start of psychiatric consultation service, establishment of breast-feeding corner, Geriatric patient friendly service system, Nursing quarter is under construction and recruitment of MDGP under NSI. Then, he majorly focused on some issues and challenges HR management, sanctioned post in hospital is only for 15 beds but currently they are running 37 bed hospital which has created problem in retention of manpower with government scale salary. He presented some major ways forward for strengthening of hospital service which are the start of Advanced USG service, provision of ICU service with at least two ventilators, extension of SNCU service and Geriatric ward and start of TRIAGE system.

Discussion

Mr. Om Prakash Yadav form MoHP1, asked queries about health care waste management that a large budget (around 11 crore) had allocated for waste management in previous fiscal year but still proper

management of health care waste has not been done so he gave his suggestion for proper planning for HCWM in upcoming days. Likewise, even with implementation of IMNCI program still indicator is same state so everyone should focus on that program.
Mr. Bharat Sah from PHLMC addressed the problem of low quality balvitta by saying that if any problem arises in medicines those can be returned and replaced by coordinating with PHLMC.
Mrs. Bijaya Rai from Taplejung hospital asked how electricity voltage can be managed for an oxygen plant since it requires high voltage to operate.
From Dhankuta health office asked to NSSD that those FCHVs who are already retired also comes to claim for incentives and he asked for clearance of incentive claim time period of FCHVs after retirement and Prof. Dr. Goma devi Niroula addressed this query by saying educated FCHVs can be mobilized and for that in collaboration with NSSD and NHRC, FCHV national survey is ongoing.
Dr. Suresh Mehta from Morang Health Office said that increasing the number of stillbirths can be prevented by effective use of partograph.

Presentation from Koshi Hospital (Dr. Laxmi narayan Yadav)

He presented the overview of the Koshi hospital and mainly focused on the major priority issues for hospital strengthen to achieve expected result are Preparation of Master Plan, Healthcare waste management system, Extension of ICU, Strengthening of NICU, Strengthening of EYE, ENT, Dental & Laboratory, Physical Infrastructure inadequate and improper, Due to COVID 19 Infection difficulty in service delivery, Lack of Human resource for PCR Lab running, COVID Ward, Difficulty in salary distribution for hospital committee staff, Drainage management, Further strengthening of electricity, and Cleaning and maintenance of waste management. According to his presentation some major achievements of hospital are Maintenance of cleanliness of maternity ward - all the hidden and dumped junks were cleaned, Regular Tuesday and Friday cleaning of the hospital territory by all support staffs, Putting dustbins with stand in hospital compound, Maintenance of power house and establishment of all board, panels with new ones, Upgrading of electric capacity with replacement of 500 mA of transformer, and Deep boring installation for water supply.

PANEL DISCUSSION:

Strengthening public health Services and hospital services

Background

Health Directorate of Province 1 organized annual health review from 23-25 September 2022 in Biratnagar. Two panel discussions were held as the parts of annual health review proceedings on 2nd and 3rd days of review.

The general objective of the panel discussion was to share experiences, lessons learnt, challenges and way forward in strengthening public health and hospital services in the context of federalized health system.

Specific objective of discussions was: (a) to identify current situation of public health services and discuss major challenges of health service delivery in federal structure and three tier of government. (b)to identify role and efforts of provincial government in quality and effective delivery of health services. (c) to make recommendation on the way forwards for strengthening public health and hospital services

<u>Panel discussion on strengthening public health services of province</u>

Date: 24 September, 2022

Moderator: Kailash Khaki Shrestha, Public Health Expert/ Media Person

Panelists:

1. Mr. Gyan Bahadur Basnet, Director, Health Directorate, Province 1
2. Dr. Goma Devi Neurala, Director, Nursing and Social Security Division, DOHS, MOHP
3. Dr. Suresh Mehata, Chief, policy, planning and public health division, Province 1
4. Yog Raj Ghimere, Chief, Health Office, Taplejung, Province 1.

Proceeding:

Panel discussion on strengthening public health service was chaired by Mr. Gyan Bahadur Basnet. After welcome and introduction of panelists, moderator of the discussion, Mr. Kailash Khaki Shrestha highlighted function and formation of public health service delivery units after the country moved into federal structure. He iterated the constitutional mandates that delivery of health service remains concurrent

responsibility of all three tier of government. He flagged up the agenda of discussion and individual panelist expressed opinions, experience, and recommendation on given issue. In between the discussion and at end of panelist view, participants raised the pertaining questions to the respective panelist.

Major issues and discussions

Current public health delivery status and challenges

- According to constitution, health service is mandate of all the three tiers of government. Delivery of basic health service lies under local government whereas basic health service delivery remains under mandate of both province and federal government.
- There is poor chain of command between province and local level in terms of health service administration and management. Even effective implementation of vaccine programs sometimes suffers due to lack of coordination and authority issues. Performance appraisal of local level health worker might be a tool for chain of command, whatsoever it lies under the authority of local level administrator.
- There is lack of administrative and managerial linkage between health office at district and health section of local level resulting into derailed monitoring and backstopping of local level public health programs. Often, health section chief of local level wonder role of health office.
- Local level authorities are more focussed on physical and hardware activities leaving public health service program in lower priority.
- Shortage of health human resources owing to more than 30-year-old sanction posts and around 40 percent vacant positions have impaired delivery of public health services.
- Curative services get priorities after federalism
- Ministry of Health and Province Health Directorate have to extend their role to maintain quality of health service delivery at Local level

Ensuring the effective delivery of Health services

- School health program is the good initiation from provincial government
- Social security fund can be provided from allocated hospital, but in reality needy people are not getting benefits from this scheme.
- FCHVs program is directly linked with preventive and promotive services.
- Senior citizen Program should be implemented effectively in government hospital

Ministry of Health's plan to manage health human resource and health services

- Human resource management is major challenges. Province government has endorsed service contract guideline that ratifies recruitment of health human resource on need and contract basis.
- Province public service commission is in process of recruiting health human resource in the near days ahead.
- Province government has initiated organization and management survey.
- To put a couple of examples of public health service strengthening; Ministry of Health has implemented Rural Mother support program under the special grant and mobilized female community health volunteers in non-communicable disease prevention and management.

Key recommendation

- Establish functional linkage between health office and local level health authorities by addressing issues at policy level
- Explore the modes to establish linkage and coherence between province and local level health authorities such as monthly meeting, various meeting platform, onsite coaching and backstopping and establish those channels through policy and legal arrangement.
- It is recommended to carry out organization and management survey of health sector soon, sanction and fulfil vacant position as per new standards.

Presentation from APHIN (Dr. Shankar Adhikari)

He said that private hospitals have covered 65% of total hospitals in province -01 and they are working in collaboration with the government. He expressed his sadness about differentiation done by the government towards private hospitals. He gave a statement "no one has provided health service without cost". He said that 20% contribution should be made by citizens in health insurance so that adverse use of health services can be minimized. He added that in governments short course training should be provided to health workers from private hospitals as well without TADA and should involve the private in policy making also. He said that the private sector also has the problem of human resource crisis and he also said that encouragement should be given to normal delivery rather than caesarean section.

Presentation from BPKIHS, Dharan (Dr. Ashok kumar Rai)

He presented the major achievements of hospital which are New 256 Slice CT scan is in operation, New fully automated Biochemistry Analyzer is installed in Central lab, two additional Ultrasound machines are

installed in Radiology Department, Hospital Pharmacy is running successfully at four different locations of the Hospital, New 20 Bedded Dialysis unit (including 2 bed Seropositive) is established and providing services successfully, New Television sets have been installed in GOPD, Central Lab, Radiology and Dental College for information videos regarding hospital services, Expansion of 30 bed ICU/CCU and one CTVS OT is completed and will be operational shortly after recruitment of human resources, Expansion of oxygen & vacuum pipeline outlet points in various wards, Using Web API Technology for Claim management in Swasthya Bima, 100 bedded COVID-19 Hospital is in running successfully and, Extension of Emergency building with 27 bedded setups for emergency service.

He also focuses on some issues and challenges of hospital that are Existing infrastructure is insufficient to meet the recent increase in patient flow, Existing equipment and hospital items are more than 15 years old and needs to be replaced, Due to change in government policy and lack of autonomous decision, major income from academic programs is significantly decreased, Challenges in management of Nepal government Insurance Program, Patients flow increased significantly, Irregularity in payment- Delayed and less valuation of service, Discrepancy in Service charge and Investigation rate is causing significant loss., Challenges in running Superspecialist department, Faculties recruitment and retention, Financial, academic and logistic issues, Retention of existing working faculties and, Total strength of ICU beds to be increased as per WHO guidelines.

Some way forwards he presented are 400 bedded dedicated MCH (Maternal & Child Hospital) hospital building construction is about 65% completed, 200 bedded cardiac Centre DPR ready but Budget allocation awaited, 200 bedded oncology Centre DPR ready but Budget allocation awaited, 50 bedded ICU setup is in final process, Dedicated pharmacy building (~90% complete), Make hospital paperless by installing integrated health management information system (Electronic medical record and health system), Dedicated Hospital Pharmacy for Dental Hospital, Expansion of Laboratory & Radiology Services, Expansion of Emergency & ICU Services, Establishment of Trauma Centre, Up gradation of Deemed University to University, Procurement of equipment like MRI Machine, Advanced Biomedical Waste Management System, New Air Condition Plan, New High-Capacity Electrical Generator System, Fluoroscopy Machine, Integrated Modular Biochemistry and Immunoassay Auto analyzer, High end Ultrasound Machine and, Immunofluorescence Microscope

After presentation Token of love was given to the Director of NSSD, Dr. Goma devi Niroulaby the hand of MOH P1 secretary, Mr. Anuj Bhattachan

Some words form Director of NSSD, Dr. Goma devi Niroula before she leaves the workshop:

She thanked all presenters and said that she has learned a lot from those presentations. She added that health services should be provided according to the disease pattern of that place, she also said that preventive and promotive health services should be in major priority. She suggested in the way forward of BPKIHS to start kidney transplant service and sero positive diagnosis. She said the burden of rapidly growing NCD should be focused on by health workers and a balance between preventive and curative services should be made. She suggested that proper planning should be made and work accordingly on the basis of results from discussions of a three days' workshop. She ended her speech by giving best wishes for successful completion of a 3 days annual health review.

Discussions:

Ramesh Barakoti, Chief of Health office Jhapa

- Even with HR production from three medical colleges still health services have not been provided sufficiently- answered by BPKIHS, even with production of HR they still don't have sufficient human resources in hospital so they request the Nepal government to retain those produced HR in hospital for at least two years.
- He also raised his queries about the large number of CS in BPKIHS- answered by BPKIHS, because of referral complicated cases from other health facilities, and some patients have intention of doing CS.

Srijat Dahal, Health directorate Dhankuta

- He asked why health workers from private hospitals are getting low incentives even though they are high in profit. Answered by APHIN- private has more burden than profit.

Yograj Ghimire, Chief of Health office Tpalejung

- He asked BPKIHS about what type of manpower they have mobilized in an ambulance? Answered by BPKIHS- they have mobilized HA who have got BMET training of BMET and can do all activities properly.

Director of health directorate, Mr. Gyan Bahadur Basnet closed the second day session and he expects to bring workplan from all hospitals and health offices by tomorrow.

Third Day:

Presentation from Udaypur Health office (Mr. Umesh Luitel, Statistical officer)

He gave overview of Udaypur districts and presented some issues and challenges of Udaypur Health office which are data shows low coverage of vaccine even though all children are vaccinated, inadequate equipments for growth monitoring, OTC service is not running effectively, PNC visit is decreasing, reporting of family planning service was not properly done by private sectors and supply of inadequate buffer as compare to test kit of HIV. He shared some major achievements like in the Safe Motherhood program they distributed chicken to pregnant women and for the effectiveness of the vaccine program in Udaypur district they distributed snacks to all the children who visit the vaccine center.

Presentation from Udaypur Hospital (Gyanendra kumar Jha)

He presented some major issues of Udaypur Hospital which is inadequate building structure for providing service, oxygen plant with filling buster so there is problem in providing GA and treating patient properly in ICU, ambulance expenses couldn't be managed by hospital and there is lack of blood bank and CT scan service. He said some way forward like to start SNCU and extend the maternity ward.

Presentation from Khotang Health office (Jivan chaulagain,Program officer)

According to his presentation the major issues and challenges of khotang health office are untimely and inadequate availability of vaccines, less importance has given to sanctioned post of health facilities as the population of khotang has increased than previously, lack of RDT kit, medicines and other equipment for test of Dengue, scrub Typhus, Kala azar, Tuberculosis and HIV, lack of medicines for safe abortion, lack of training for online recording and reporting in some health facilities, lack of monitoring, supervision and evaluation of programs, problem in procurement and transportation of medicines. Some way forwards he presented to strengthen health service of khotang districts are Regular review, follow-up, supervision and monitoring of health programs from elected representatives and chief of municipalities, budget should be allocated for procurement of drugs regarding mental health, monthly, quarterly and annual reviews should be done for progress of health indicators, expansion of birthing centers in remaining health facilities as well, timely distribution of medicines, vaccines and health commodities from central and province.

Presentation from Khotang Hospital (Dr. Nitu Lama, District Hospital):

She shared some major achievements which are as follows:

- Procurement of Ambulance Completed.
- Oxygen Plant, Mortuary fridge,Vehicle parking Area Setup Completed.
- Lab Test Added (Amylase/ Calcium/ Troponin I)
- E-attendance started
- Patient waiting hall completed
- Hematology coulter counter
- Procurement of ICU equipment and instruments

She presented some issues and challenges which are Sanctioned post unfulfilled, Old and dilapidated infrastructures, Issue of new 50 bedded hospital (lack of Space for emergency and inpatient management), Lack of Residential quarter, Waste management and disposal and Inadequate supply of free drugs

She also presented some ways forwards to strengthen the hospital are Fulfilment of sanctioned posts, Renovation and constructions of infrastructures, Adequate and timely supplies of logistics, and Microbiology Lab service expansion.

Presentation from Okhaldhunga Health office (Mr. Shiv Kumar Yadav)

He gave overview of okhaldhunga districts and presented major issues and challenges of Health Office which is low coverage Growth Monitoring visit of under 2yrs children so that malnourished children cannot be identified, lower achievement on pregnant women receiving 180 tablets, error on recording and reporting of Pneumonia case which was treated by antibiotics, there is gap between 1st ANC visit and 4th visit as protocol and treatment rate of TB is not satisfactory.

Presentation from Rumjatar Hospital Okhaldhunga (Dr Jiwan Narayan Mandal)

He presentedmajor achievement of Rumjatar Hospital as:

- Digital x ray services have started
- Ambulance service id added
- ICU with 2 ventilator, HVAC system setup and oxygen plant and pipeline setup was completed

- New hospital building handover

He also said some issues and challenges are inadequate human resources, the setup of NICU/Major OT/ICU is completed but not functioning, there is difficulty in maintenance of medical equipment and inadequate quarters for nursing staff and paramedics of the hospital. He mentioned some ways forward like recruitment of human resources like MDGP, anesthesia assistant, internal medicine, pediatrician to start OT service, NICU and ICU services and recruitment of vacant posts like administration and accountant for proper functioning of hospitals.

Presentation from Solukhumbu Health office (Mr. Shibham Thakur)

He presented issues, challenges and recommendation of Health Office which is:

- Poor Recording and Reporting for that onsite coaching can be provided to improve it.
- Low achievement in booster dose can be improved by household survey and awareness programs.
- Provision of regular supply for inadequate logistic supplies like job aids, treatment books, cards etc.
- Ensure 24hrs availability of SBA staff for inadequate SBA.
- Expands and manages an inadequate number of Implants and IUCD service sites and health workers.
- Poor knowledge of revised HMIS tools so provision of training and onsite coaching should be done.
- Ageing and low education status of FCHVs so needed to appoint educated females for FCHVs.

He also mentioned some supportive activities carried out in FY 2078/79 like training of revised HMIS, DHIS-2, CBIMNCI, TB Modular, FCHV basic and refresher etc, Health education, information and communication in Covid-19 management and typhoid champaign, training in E-LMIS, Procurement supply chain management, Family planning program and awareness program through LLG.

Presentation from Phaplu Hospital Solukhumbu (Dr. Pradip Adhikari)

He presented the Hospital Overview and said some major achievement of hospital like provided health service from newly constructed hospital building, setup of 2 ventilator with 3 ICU bed, continuity of CEONC services, functioning of newly constructed oxygen plant and successfully preventing, treating and tracing Covid-19 and dengue cases. He also focused on issues and challenges like sanctioned post in hospital is only for 15 beds but currently they are running 50 bed hospital which has created problem in management of human resources, there is no budget allocated for dental consultant so patient are facing deprived from dental service, no budget allocated for Telemedicine, Dot's Program, Electronic Health Record and Waste management and ART centre was not established. He also mentioned some way forward which is Continuing essential services and use of information technology and telemedicine program if budget is allocated from MoHP1.

Presentation from Sunsari Health office (Mr. Sagar Prasain, Health office Chief)

He said that 34% of the population of Sunsari district has vaccinated booster dose of covid 19, vaccine coverage is around 90 to 100% but has a high dropout rate. He added that to manage dengue cases they have made plans by coordinating with all LLGs. He also shared some key issues which are poor timely reporting, insufficient HR, low immunization coverage, lack of proper infrastructure to maintain vaccine cold chain, lack of HR at EPI clinic, haphazard use of antibiotics, low use of gentamicin, lack of enough health commodities, declined 4 ANC visit, institutional delivery, establishment of birthing center but not as per standard, insufficient budget for basic and refresher training of FCHVs, no activities of ARSH program and NCD/NTD screening program are neglected. Some key innovations he shared are recruitment and mobilization of two ANM at Ventabari POE in own budget of health office which is now supported by EPIC Nepal, has done household survey of second and booster dose covid 19 vaccination, they were working to declare Sunsari as a full immunization district since last 8 years and has succeed on that in Previous Fiscal year.

Presentation from Inaruwa Hospital (Dr. Debraj Ghimire, District Hospital):

He shared some major achievements which are as follows:

- Replacement of wage health workers/staffs with contract health workers
- Oxygen plant setup completed
- Procurement of equipment needed for ICU/SNCU/NICU
- Completion of building renovation for health care waste management and also procurement of autoclave for managing health care waste
- Procurement of washing machine with Dryer
- Has implemented token system to reduce problem of crowd in registration
- Has started video x-ray service from radiologist and orthopedic service in the collaboration of Hospital and management committee

- Has started eco and endoscopy service, general surgery and laparoscopic surgery service, thyroid, vitamin b12, vitamin D and gene xpert service

Some priority issues for hospital strengthen to achieve expected result are as follows:

- Coordination for fulfilment of sanctioned post
- Coordination with concerned authorities for expansion of specialist service and buildings construction
- Recruitment of contract human manpower for starting ICU service as soon as possible
- Expansion of physiotherapy, social service unit and geriatric service

Discussion:

- **Mrs. Astha Thapa (MoHP1) asked**
    - to Khotang hospital about NRH activities and also asked to clarify about Challenges in health care waste management- answered that NRH is under operation but patients do not visit the NRH and he said that he has requested a coordination team and LLGs for referral of patients for NRH service.
    - To Diwakar Sapkota about difficulties in autoclave setup and how they are managing now?
    - To the health office Solukhumbu about the new building handover- answered that coordination has been made with CDO and will handover after Tihar.
    - To Okhaldhunga health office, why is institutional delivery higher than the first ANC visit? - answered that there is a private hospital nearby where patients visit for ANC visits but come to government health facilities for delivery. That's why Institutional delivery is higher than the first ANC visit.
- **Mr. Aditya Sakhya from Ilam health office** asked to Mr. Sagar Prasain from Sunsari health office for adjustment of target population for TB case notification rate in Hilly regions- he answered that target population was not determined in previous Fiscal Year but they should have kept target population by determining themselves and in this FY target population has given already.
- **Mr. Ramesh Barakoti from Jhapa health office**
    - asked to Inaruwa hospital how cost of Lab test can minimize in government hospital as it is almost equal to private hospital
    - Admired Sunsari health office for innovative activities like Household survey of covid 19 second dose vaccination and HR mobilization in POE
    - Suggested that human resources that are produced from medical colleges of Sunsari and Morang could be utilized in hilly regions of province one via use of telemedicine.

- **Mr. Gokul Bhandari from Dhankuta Health office** asked Mr. Sagar Prasain from Sunsari health office how they are managing the budget for monthly meetings? - he answered that they do not take TADA for monthly meetings and meetings are conducted by every LLGs turnwise with provision of snacks on the own budget of LLGs.
- **Mr. Damber Singh Gurung from Fairmed** asked the Okhaldhunga health office how they are coordinating with LLGs to act against increasing numbers of Kalazar in Okhaldhunga and if they need any support from EDPs?
- **EDPs** asked the PHD/MoH that there are huge vacant posts of permanent staff in the health sector and how they are planning to fulfil those posts?
- **Mr. Sushil Basnet from NSI** asked PHLMC on which basis they are sending logistics to district hospitals as they are not using already available instruments and also asked hospitals what is the plan for training of ICU service to health workers as they are expanding ICU set up without manpower?
- **Mr. Anil Deo from PHD/WHO** asked to udayapur hospital that they are charging rs. 3000 as a cost of painless abortion service and asked to clarify what does painless abortion service means?
- **Mr. Bharat sah from PHLMC** addresses the complaint from Khotang about damaged Balvitta distribution from previous session that none of the districts has complained about Balvitta in PHLMC till now. And, he also addressed that because of only one biomedical engineer in PHLMC they couldn't send technical support for equipment maintenance on time. In addition, he said that he wants to get information about the situation of IFA distribution in school health programs as PHLMC has an overstock of IFA.

- **Mr. Binod Thapa from PPHL** said that they could not provide cartridges of Gene-xpert to Khotang and Bhojpur because they have not got orientation on that subject yet.
- **Mr. Sambhu Sah from PHLMC addressed**
    - the complains about Ambulance from previous sessions. He said that it takes time to adjust in new vehicles. The provided ambulance has many good features with best equipment and instruments inside and he also said that new ambulances should be used for critical cases only rather than in general cases. He also said that if this is the problem of all district's discussion will be made with technicians.
    - About balvitta, he said that there was a problem in distributed one batch of balvitta which was send from central and some gap in balvitta was created while returning that damaged batch
    - He also addressed the problem in maintenance of equipment saying that one biomedical engineer is not enough to reach everywhere so they can also hire human resources from outside when biomedical engineers could not reach on time. He also added that they have requested MoH for the contract of one biomedical engineer.
    - He said that Iron folic acid consumption is low in province one and has overstock in PHLMC and it should be distributed adolescents' girls via help of school health nurse
    - He said that test kits are sent to districts from PHLMC but districts do not distribute them to concerned places and he requests that they be sent on time.

Wrap up of discussion by Director of PHD, Mr. Gyan bahadur Basnet:

He said that all presentations and discussions were fruitful and thanked all presentations. He added that he has noticed hub formation plan in Udayapur, problem in operation of oxygen plant in Khotang, field screening for NRH in Okhaldhunga, well-furnished building of Solukhumbu which was in very critical state when he visited before, innovative activities of sunsari like covid 19 vaccine survey, monthly meetings, he also admired Dr. Debraj of Itahari hospital on his contribution and dedication towards hospital. At last, he asked about poor results in health care waste management even though a huge budget was allocated via his poem.

Presentation by Mr. Dipendra Khadka, Act. Chief, Department of Drug Administration, Biratnagar

The major points he shared are as follows:

- Five vacant posts in DDA
- 31 pharmacies are suspended, lawsuit has filed against 19 pharmacy and 24 pharmacies has shut down in province-01 from DDA of Biratnagar

Some issues and challenges of DDA he presented are:

- Lack of human resources
- Problem of nutraceuticals
- Regulation of medical devices and equipment
- Operation of pharmacy with clinical registration
- Lack of custody to keep the defendant safely
- There no Provincial DDA and NML in province one yet

Discussion:

Mr. Aditya Sakhya from the Ilam health office asked if it is propaganda of private pharmacies that they say medicines from their pharmacies are of better quality? And also asked about GMP certification and quality test of medicines after distribution to different health facilities. - Mr. Dipendra Khadka answered that GMP certification is not necessary for all medicines and after 2 years establishment of industry can apply for GMP certification but which is not mandatory.

Mr. Umesh Luitel from Udayapur health office suggested coordinating with Health offices for supervision of Insurance medicines.

Dr. Mukti Acharya from Nobel Hospital express his anger in price difference of vitamins with same composition and why DDA is not aware of that. - Mr. Dipendra Khadka replied that the price difference in vitamins is because of nutraceuticals that are supplied from the Department of Food Technology and Quality Control and they seize those products if they are found in any pharmacy. And also added that doctors are also prescribing those products which is wrong in practice. He said that if any pharmacy sales physician sample license will be seized.

Mr. Ramesh Barakoti from health office Jhapa said that it would be better if we could see a list of GMP certified drugs with name of company on the website and also raised queries about renewal of pharmacy and also asked for orientation to health offices and health sections for operationalization of pharmacy. He also asked how DDA is acting to stop import of unregistered medicines from foreign countries. He also asked if they are monitoring and supervising availability of free medicines in health facilities.

Mr. Dipendra Khadka said that to be frank while supervising pharmacies they find mistakes and actions against rules and those pharmacies have been sealed also. They don't have a problem coordinating with the health office for supervision and observation but in some places relatives or self-health workers are running pharmacies and acting against rules and guidelines. He said that they will try to coordinate with health offices from now on.

Panel discussion:

Panel Discussion on Strengthening Hospital Services

Moderator: Kailash Khaki Shrestha

Panelists:

1. Dr. Tanka P. Barakoti, Medical Superintendent, Provincial Hospital, Bhadrapur
2. Mr. Gyan Bahadur Basnet, Director, Health Directorate, Province 1
3. Dr Shankar Adhikari, Chair, Association of private health institution in Nepal(APHIN), Province 1
4. Dr. Khageshwor Gelal, Representative, Department of health services, MoHP
5. Mr. Sagar Parsai, Chief, Hospital Development and curative service division, MoH, province 1

Discussion Points and issues

Major challenges of Hospital sector:

- Inadequate human resource, space, medical equipment remains unused, more than 30 years old sanction post,
- Growing competition to establish hospitals at local level, there is expectation with province and federal government for establishment cost, local level should bear management cost
- Covid 19 pandemic has been impetus for hospital sector development (establishment of NICU equipment, infrastructure development oxygen supply, etc)
- Hospital pharmacy should be operated as per guideline

Quality of hospital services

- Action Plan needed to extend MSS in government and private hospital
- Service users are hesitated to enjoy free health service from private hospitals
- Low reporting from private hospital; training on reporting required
- Motivation allowance to be rendered to medical doctors of Sunsari, Morang, Jhapa also as there is high pressure of service users.
- Payment of health insurance is not done on time
- Health insurance reach to target(poor) population is not adequate
- Scholarship contract holders should also be equally addressed in terms of allowance and benefit

Key recommendation

- Hospital sector improvement plan is required should be addressed by provincial policy and budget
- Province government should conduct organization and management survey and recruit in vacant position as soon as possible to overcome human resource issues in hospital sector.
- Private hospital should report in time. Health directorate or health office should orient private hospital staff in this regard.
- Minimum service standards (MSS) are be extended and oriented to private hospital also.
- An arrangement of relevant training is to be made for private hospitals
- Private hospitals should clearly communicate about the provisions for earmarked free service to poor citizens.

After Launch Break: Program was hosted by Mr. Khagendra Poudel, from PHD, Dhankuta

Presentation from Provincial Health Training Centre (PHTC) (Mrs. Kesu Kafle, Nursing Officer)

She gave the overview of PHTC and mentioned the training sites which are Koshi Hospital, BPKIHS, Amda Hospital, Family Planning Centre Itahari, Family Planning Centre Charali, Nobel Hospital and Mechi Hospital. She shared some Innovative activities like training of RH Morbidity Screening which has already started in Dhankuta Districts, Extension of training sites (RUSG, SBA, IUCD/Implant) and training has been ongoing with the financial support and coordination of LLG.

She also mentioned major issues and challenges which are:

- Inadequate Human Resources according to sanction Post
- Problem in adjusting a large number of participants because of limited training hall space.
- Problem in water supply.
- Budget allocated by the Provincial government cannot meet all aspects of training and lacks guidelines for conducting virtual meetings.
- Turnover of trained Human Resources.
- Unclear guidelines for implementation of program.
- Lack of budget allocation for new training package

- Due to strict program guidelines and lack of coordination there is a problem in conducting programs.

Presentation from Nobel Medical College Teaching Hospital Pvt. Ltd. (Dr Mukti Acharya)

He started presentation with the overview of hospital and its services, he shared some achievements of hospital which is they provided the service like Renal Transplant, IVF, Open Heart Surgery (successfully completed 100 cases), Rheumatology, Hepatology, Gastroenterology,EP lab and awarded with highest tax payer. He also mentioned major priority issues for hospital strengthening to achieve expected results like Hassle free services, training to nursing, paramedical staff for quality care to patients, 100 bedded cancer specialty unit and addition of more subspeciality/superspecialist services.

Presentation from Birat Medical College & Teaching Hospital (Mr. Niraj Shrestha)

He presented the services and facilities of the Hospital and mentioned the programs running under Nepal government in Birat Hospital like Health insurance program, Safe Motherhood program, National Immunization Program, Treatment of Deprived Citizen Program and Social security fund. He also shared major issues of the Treatment of Deprived Citizen program which is lack of awareness about this program in LLG and community people, problem in attendance of patients due to nonfunctioning of biometric and lack of hemodialysis training for staff.

Presentation from Provincial Insurance Board (Mr. Arjun Pandit)

He said that the health insurance program was initiated from Ilam district, from around 19.7 lakh population of province 1 insurance has 59% coverage and Jhapa has highest (47%) coverage. He added that around 70% of the insured population has taken insurance services. Furthermore, he said that renewal rate is 75% and mostly renewal is done from Jhapa and Sunsari and has low renewal rate in Hilly regions. He explained that there are a total 105 insurance services providing health facilities of which 80 belong to the government. Insurance service has been stopped in five health facilities. Till now 3 billion, 92 crore and 52 lakh insurance money has been reimbursed to health facilities that are providing insurance service. He said that only a few local levels have formed an insurance management committee as per guidelines and the province also has not formed a provincial insurance coverage committee and said that he will soon work on that.

Some important information he shared are:

- Eye hospitals should provide insurance service to patients from outside of districts only after taking referral slips
- Insurance identity has been activated
- Should banned re-write, overwrite, and double write and over prescribe in prescriptions
- Has sent letter for claim bill and referral of patients
- Avoid zero billing and hand bill will not be approved from now on
- Each hospital should ensure availability of medicines in their own pharmacies
- Untimely reimbursement of claim bill is because of inadequate human resource and large amount of daily claim bills

Some issues he shared are: Lack of advocacy of insurance, number of health insurance service providing health facilities are not enough, lack of quality services

Presentation from UNM MDT Okhaldhunga (Mr. Roshan Kharel, Hospital director)

He said that the hospital is running with the patients' revenue. Dental caries also falls inside the top 10 diseases. And he mainly focused on the issues and challenges like

- Retention of senior doctors
- Registration of hospital for 100 beds
- Challenges in insurance claim
- Has been facing burden of vector borne diseases as well

Presentation from Nick Simons Institute (Mr. Sushil Basnet)

He presented the Programs Areas of NSI which are Training, Curative Service Support Program (CSSP), Hospital Strengthening Program (HSP) and Research /advocacy. He also shared training programs done on FY 2078/079 like Advance Skilled Birth Attendant Training (ASBA), SBA,Operation Theatre Technique Management (OTTM), Mid-Level Practicum Training (MLP). Primary Emergency Care Training (MLP), Primary emergency Care training (PEC) and CTS training.

He mentioned some major issues and challenges of NSI which are:

- Lack of skilled Human Resources at hospitals to start services such as ICU,SNCU
- Problem in equipment maintenance at hospital
- Training gap at hospital
- Unequal distribution of resources by Federal, Province and Local government.

Presentation from EDPs (Mr. Damber Gurung FAIRMED)
He presented all EDPs working in Province 1 with their Thematic and Geographical area. He shared contributions of EDPs like:

- Health system strengthening-Policy, standard development, technical assistance, ELMIS, disease tracker, service site expansion/scale up
- Monitoring of routine program, RDAQ and disease surveillance
- Support in disease prevention, promotion, curative and Rehabilitation services
- Physical Infrastructure support-small scale/large scale
- Logistic support, supply chain management
- Technical support, comprehensive monitoring
- HR support-Province/District/LLG
- Support in capacity building of health workers, FCHVs, HFOMC
- Support in planning and implementation of health programs, health emergency, epidemic management, disaster response and disease control
- Support for R&R tools forecasting, printing, supply, survey and research.
- DHIS2 reporting follow up, data correction and management

He also mentioned major challenges which are as follows:

- Geographical difficulties/Infrastructure/Poor health care waste management practice
- Open border (High chance of pandemic diseases, difficulties in disease control
- Lack of trained HR as per of Sanction position
- Readiness of health facilities to provide services, less practice of action plan and its follow up for proper implementation
- Urbanization/Control of Vector Borne diseases/Illicit drugs use
- Emerging/re-emerging of epidemic/endemic diseases
- Achieving SDG goals (MMR, NMR, Elimination of NTDs)
- Streamline private sectors in national reporting system, Data quality
- Commodities/drug supply chain management
- Inadequate-untimely supply of Recording & Reporting tools
- Increasing cases of NCDs and Mental Health

Welcome of Chief of district coordination committee Mr. Ajambar Rai

Discussions of previous presentations:
Mr. Anil Deo from PHD/WHO said to Nobel hospital that Nobel hospital is one of the most expensive hospitals of Nepal. Why do they take charges haphazardly for services such as Rs.600 for x-ray which normal rate is Rs 300-400 and Rs. 15000 for CT-scan which normal rate is Rs. 8000 in other hospitals.

- **Dr. Mukti Acharya from Nobel hospital** answered that they will discuss minimization of service rates in next work revision and he also informed that Nobel is one of the hospitals that has given free health services more than government has recommended and also added that they are planning to start Nobel University soon.
- **Mr. Anil Deo** also said that in eye hospital normally they charge rs.1200 for checkup but charges Rs. 3000 for insured
- He also raised queries that if people from Madesh Province can get insurance service from province one if their working place has changed than previously.
    - **Answered by Mr. Arjun Pandit**: yes, they can change their first priority place for taking insurance service after sending letter to Bima Board

Mr. Ramesh Barakoti from Health office Jhapa, HO chief asked questions which are as follows:

- **To Keshu Kafle (PHTC),** suggested for online orientation of IUCD and implant

Answer- there is no budget for online orientation and it has been discussed with secretory of MoHP1.

- **Tej bahadur Tumbafu (Panchthar Health office):** Awareness about insurance is still lacking in the most of communities and he asked that either the insurer will go door to door to spread awareness or that the people of the community will go to the insurer?

Answered- Mr. Arjun Pandit, from Insurance board said that insurer must do household visit to spread awareness in the community. He added that insurer is not actively working and that issue should be raised in discussions.

Mr. Sambhu Sah, Director of PHLMC, suggested to Insurance board to add essential medicine list in Insurance so that burden of 1100/1200 medicines of insurance can be reduced and efficacy, affordability, availability and effectivity also can be ensured.

Mr. Jayavendra Yadav Director of PPHL addressed some queries which are as follows:

- In his opinion, concept of training should be changed that health workers should not expect for separate training always, some trainings can be provided in an integrated manner from similar programs
- Skilled based training can be provided by provincial lab but budget for training should be managed by health facilities themselves.
- Lab technicians from health offices should act as ambassador for coordinating with higher and lower organizations
- Miuse of the technology is also one of the prevalent problems and those technologies should be used in right place.

Mr. Narad subedi from Sankhuwasabha health office asked to EDPs that why supporting partners are only there where facilities are available? Why not in hilly and rural areas?

Answered by Dambar singh Gurung from Fairmed- he said that project is finalized on the basis of need analysis of that particular area and they try to avoid duplication. So, it is not true that they are only in comfort places.

After discussions Mr. Gyan bahadur Basnet, Director of PHD thanked all presenters and participants and he aslo asked for submission of workplan from all districts.

Mr. Mukund Dahal, statistical officer from PHD presented the commitments for future activities on the basis of three days presentations and discussions, which are as follows:

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१. प्रदेश तथा स्थानिय तहको स्वास्थ्य संस्था तथा कार्यालयहरुमा रिक्त रहेको जनशक्तिको व्यवस्थापन र दरबन्दी सर्वेक्षण लाई मुख्य प्राथमिकतामा राखी आवश्यक प्रक्रियाको लागि सम्बन्धीत निकायमा समन्वय गरिनेछ ।
२. प्रदेशमा कुपोषणको दरलाई न्युनिकरण गर्न कुपोषित बच्चाहरुको समयमै पहिचान र उपचारका साथै बहिरंग उपचार केन्द्र र पोषण पुर्नस्थापना गृहको स्थापना, सुदृढिकरण र निरन्तर संचालनमा जोड दिईनेछ ।
३. पुर्ण खोप सुनिश्चितता, सरसफाई प्रर्वदन र दिगोपनालाई निरन्तरता दिदै प्रदेशलाई पुर्ण खोप सुनिश्चितता प्रदेश घोषणा गरिनेछ ।
४. न्युनतम सेवा मापदण्ड कार्यक्रममा देखिएका सुधार गर्नुपर्ने पक्षहरुलाई आवश्यक कार्ययोजना तथा बजेट निर्धारण गरि कार्यन्वयन गरिनेछ ।
५. सम्पुर्ण संस्थाहरुबाट गुणस्तरिय तथ्याकंहरु विभिन्न सुचना प्रणालीहरु मार्फत समयमै र पुर्णरुपमा प्रविष्ट गरिने दर ९० प्रतिशत भन्दा माथि पुरयाईनेछ ।
६. क्षयरोगको केश पहिचान दरलाई वृद्धि गर्दै क्षयरोग मुक्त पालिकाको अभियानलाई निरन्तरता र विस्तार गरिनेछ ।
७. स्वास्थ्य संस्थाजन्य फोहोर व्यवस्थापनलाई अस्पताल सुदृढिकरणको लागि प्राथमिकतामा राखि यो सम्बन्धी समस्याहरु समाधान गरिनेछ ।
८. सुरक्षित गर्भपतन सेवा प्रदायक स्वास्थ्य संस्थाहरुबाट नियमित गुणस्तरिय सुरक्षित गर्भपतन सेवा प्रदान गर्ने व्यवस्था मिलाउने ।
९. गुणस्तरिय जनस्वास्थ्य कार्यक्रमहरुको पहुँच दुर्गम तथा ग्रामिण क्षेत्रमा रहेका गरिब, पिछडिएका सिमान्तकृत समुदायमा पुरयाउन जिल्लास्तर बाट सुक्ष्म योजना निर्माण गरि कार्यन्वयन गरिनेछ ।
१०. महामरी रोगको समय अनुकुल पहिचान तथा व्यवस्थापनको लागि आवश्यक प्रतिकार्य योजना तथा संयन्त्रको निर्माण गरिनेछ ।
११. बर्थिङ सेन्टरलाई थप सुदृढिकरण गर्दै स्वास्थ्यकर्मिहरुलाई आवश्यक तालिमको व्यवस्थापन गरि गुणस्तरिय सेवालाई वृद्धि गरिनेछ ।
१२. नसर्ने तथा मानसिक रोग सम्बन्धि रोकथाम तथा उपचार कार्यक्रमको विस्तार गरिनेछ ।
१३. सन्तानको योजना बनाएका दम्पतीहरुमा फोलिक एसिडको प्रयोग दर बढाउने र जन्मजात हुने अपाङ्गता न्युनिकरण गरिनेछ ।
१४. प्रदेशको समग्र स्वास्थ्य सुधारका लागि साझेदार तथा सरोकारवालाहरुसंगको समन्वय र सहकार्यलाई सुदृढ र प्रभावकारी बनाउने ।
१५. प्रदेश जनस्वास्थ्य प्रयोगशाला मार्फत प्रदेश र स्वास्थ्य कार्यालय संग समन्वय गरी पालिका मातहतका सबै किसिमका प्रयोगशालाको गुणस्तर मापदण्ड निर्धारण र नियमन गर्ने र External Quality Assurance प्रणालीमा आवद्ध गरी certified गर्ने कार्यलाई निरन्तरता दिईनेछ ।

१६. प्रदेश जनस्वास्थ्य प्रयोगशाला लाई प्रदेशभर कै साधन स्रोत सम्पन्न, रिफ्रेन्स ल्याबको रुपमा स्थापना गरिनेछ । साथै सर्ने तथा नसर्ने रोगहरुको परिक्षणको दायरा बढाउँदै सो सम्बन्धी तालिमका व्यवस्थापन गरिनेछ ।
१७. सर्ने, किटजन्य, यौनजन्य तथा माहामरी जन्य रोगहरुको नियन्त्रण, निवारण तथा उन्मूलनको लागि स्थानीय तहको सहकार्यमा योजना वनाइ कार्यान्वयन गरिनेछ ।
१८. स्वास्थ्यकर्मिहरुको निरन्तर क्षमता अभिवृद्धिलाई निरन्तरता दिदै विभिन्न सरोकारावालाहरुको सहकार्यमा एकिकृत तालिमका एकिकृत प्याकेजहरु तयार गरिनेछ ।
१९. आवश्यकताको आधारमा स्वास्थ्य संग सम्बन्धित सामग्रीहरु, औषधी, औजार, उपकरणको नियमित प्रक्षेपण गरि समयमै खरिद तथा वितरण गरिनेछ । साथै औषधी तथा औषधीजन्य सामग्रीको जिन्सी व्यवस्थापन, अभिलेख व्यवस्थापन लाई दुरुस्त बनाउन सेवा प्रदायक तहसम्म eLMIS लाई विस्तार तथा व्यवस्थित गरिनेछ ।
२०. प्रदेशमा रहेका एम्बुलेन्सहरुलाई प्रादेशिक प्रेषण केन्द्र मार्फत संचालन र व्यवस्थित बनाउदै लगिनेछ ।
२१. स्वास्थ्यको समस्याको पहिचान गरि सो अनुसारको कार्ययोजना बनाई स्थानिय तह संग समन्वय गरेर कार्यन्वयन गरिनेछ ।
२२. मेडिकल कलेज, एकेडेमी संग समन्वय गरी दुर्गम जिल्लामा विशेषज्ञ सेवाको पहुँच पुरयाईनेछ ।
२३. अस्पताल तथा स्वास्थ्य कार्यालयमा रहेका Biomedical Equipment को मर्मत सभ्भारको Biomedical Equipment Workshop स्थापना गर्दै स्वास्थ्य संस्थाहरुको भवन निर्माण तथा मर्मतलाई समेत प्राथमिकतामा राखिनेछ ।
२४. संयुक्त सुपरिवेक्षण गरी पहिचान गरिएका समस्याहरुलाई प्राथमिकरण गरी कार्यन्वयन गरिनेछ ।
२५. प्रदेश स्वास्थ्य आर्पुती केन्द्रको भवन निर्माण तथा भण्डारण वितरण कार्यलाई व्यवस्थिा बनाउन क्षमता अभिवृद्धिलाई निरन्तरता दिईनेछ ।
२६. स्वास्थ्य बिमाको दायरालाई वृद्धि गर्दै ५० प्रतिशत पुरयाईनेछ ।
२७. नियमित खोप कार्यक्रमहरुको अनलाईन प्रणालीबाट दर्ता गर्ने व्यवस्थाको लागि आवश्यक प्रयासहरु गरिनेछ ।
२७. विधालय स्वास्थ्य तथा पोषण कार्यक्रम अन्तर्गत किशोरीहरुलाई आईरन फोलिक एसिड वितरण कार्यक्रमलाई निरन्तरता र विस्तार गर्दै लगिनेछ ।
२८. स्थानिय तह संग समन्वय र सहकार्य गरि स्वास्थ्यका कार्यक्रमलाई गुणस्तरिय ढंगबाट संचालन गर्न जिल्लास्तरमा प्रत्येक महिना मासिक बैठक संचालन गरिनेछ ।
२९. स्वास्थ्यको प्राथमिक विषयमा अध्ययन, अनुसन्धान गरी अल्पकालिन तथा दीर्घकालिन योजना तर्जुमा गरिनेछ ।
३०. बिकास साझेदार संस्थाहरुले प्रदेशस्तरका सम्बन्धीत कार्यलय र स्थानिय तह संग समन्वय गरि कार्यक्रम संचालन गरिनेछ ।

Speech by Mr. Anuj Bhattachan, Secretory of MoHP1:

He congratulates PHD for successful completion of the annual review and he said that this is the best annual review among all because all concerned authorities presented their activities, achievements, issues and challenges and on the basis of which commitment has been made. Then, he said that activities are ongoing in some points of commitment and some are in the process and he also suggest that new innovative actions are required in upcoming days. He also suggests to focus on quality health services, and activities based on workplan. He said that curative services from hospital are not satisfactory as allocated budget. In addition, he said that for the fulfillment of vacant post, has bring bill of Loksewa and soon vacancy will be open. Financial irregularities should be placed in first priority of workplan and He also suggest for effective supervision and monitoring from MOHP1 and PHD team.

Token of love was given to Secretary of MoHP1, Mr. Anuj Bhattachan by Mr. Gyan bahadur Basnet

Evaluation Criteria Details:

Group	Indicator	Weight
Reporting status (Timely)	Reporting status	2
	Immunization	2
	Safe Motherhood	2
Immunization	Immunization Categories	4
IMNCI	Percentage of pneumonia among ARI cases	2
	Percentage of severe dehydration among Diarrhoeal cases	2
Nutrition	Average number of visits among children aged 0-23 months registered for growth monitoring[a]	2
	Percentage of children aged 0-23 months registered for growth monitoring	2

Group	Hospital Indicator	Weight
Service Indicator	01-2 Hospital Summary Dataset Reporting rate on time	4
	01-3 Hospital Indoor Services Dataset Reporting rate on time	4
	02-1 Immunization Dataset Reporting rate on time	4
	06 Safe Motherhood Program Reporting rate on time	4
	Average number of laboratory tests per day	4
	Average number of radiographic images per day	4
	Bed occupancy rate	4
	eLMIS Operational	2
MSS	MSS 2079	10
	MSS 2078	10
	Total	50
Safe Motherhood	Percentage of pregnant women who had First ANC checkup as protocal	2
	Percentage of institutional deliveries	2
	Percentage of women who had 3 PNC check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery)	2
Family Planning	CPR	2
	FP Methods New acceptor among as % of MWRA	2
TB	TB - Case notification rate	2
	TB - Treatment Success Rate (New and Relapse)	2
OPD	% of OPD New Visits among total population	2
Community	Average no. of People Served FCHV (reporting Period)	2
	Average no. of People Served ORC (Per Clinic)	2
	Percentage of Mother groups meeting held	2
Malaria Control Program (2)	% Annual blood examination rate collected and examined (slide collection/total popn*100)	2
HIV/AIDS and STI control program (2)	% Of pregnant women who tested for HIV at ANC checkup	2
ELMIS	Quarterly Reporting Rate	२
	Operational Status	2
Covid 19 Vaccination		2
Presentation, Performance and Coordination	नविनप्रयास (Innovative program)	5
	वित्तियप्रगति (%)	5
	Template Completeness	5
	वेरुजु	5
	Provincial Secretaty Evaluation	5
	Provincial Director Evaluation	5
	Annual report	10
	Flex	5
	Remoteness (5)	5

Rank of hospital: The table below shows the rank of District hospitals on the basis of evaluation criteria above. Sankhuwasabha hospital was ranked first.

Organization	Total	RANK
Sankhuwasabha Hospital	**63.16**	**1**
Ilam Hospital_ Ilam	**60.92**	**2**
District Hospital_ Dhankuta	**60.69**	**3**
District Hospital_ Terhathum	52.16	4
Taplejung Hospital	52.08	5
District Hospital Khotang	50.60	6
District Hospital_ Panchathar	49.90	7
District Hospital_ Bhojpur	48.88	8

Organization	Total	RANK
Madan Bhandari Hospital & Trauma Center_Morang	44.52	9
Mechi Zonal Hospital_ Jhapa	41.91	10
District Hospital Solukhumbu	39.69	11
Rumjatar Hospital Okhaldhunga	34.30	12
Inaruwa Hospital_ Sunsari	34.00	13
District Hospital_ Udayapur	28.48	14

Result of Health offices: The table below shows the rank of Health Offices on the basis of evaluation criteria above. Morang Health Offices was ranked first.

Organization	Total	RANK

Organization	Total	RANK
112 Morang	**68.67**	**1**
105 Khotang	**68.30**	**2**
102 Sankhuwasabha	**67.63**	**3**
108 Terhathum	66.97	4
111 Jhapa	66.89	5
109 Panchthar	66.78	6
104 Okhaldhunga	66.57	7

Organization	Total	RANK
110 Ilam	65.88	8
103 Solukhumbu	65.00	9
114 Udayapur	62.38	10
107 Dhankuta	61.49	11
106 Bhojpur	59.30	12
113 Sunsari	57.75	13
101 Taplejung	57.15	14

Speech on the behalf of all district hospitals from Sankhuwasabha Hospital (Mrs. Nirmika Rai)

She expressed her happiness on coming first in rank of work evaluation and she said that it was only possible with the efforts of all team members. She said that there is more work to be done to improve health indicators. At last, she said that teamwork is most important of all.

Speech on the behalf of all health offices from Khotang Health office (Chief of health office, Mr. Punya Prasad Sigdel)

He congratulated all team members of khotang district for securing second place among all health offices and also said that they will try to secure first rank in next Fiscal year. He thanked the PHD team for organizing a grand annual review program and said that they will work according to the finalizedcommitments.

Speech by Secretary of DCC, Morang, Mr. Ajambar Rai:

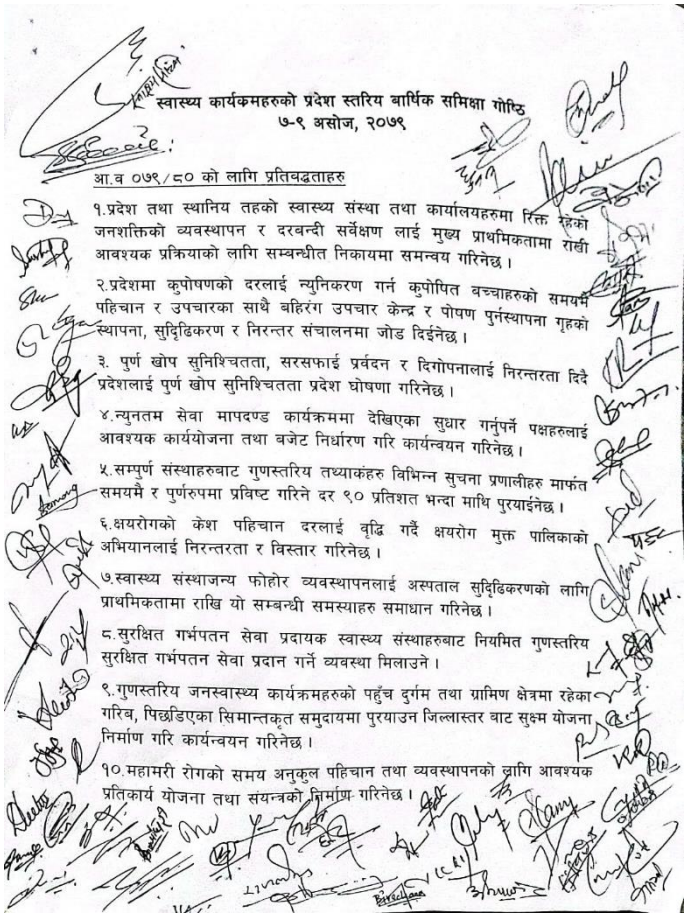
He said that review is the way of evaluating already done activities. He added that low indicators in some places might be because of lack of enough resources but still trying is the best thing itself.

Closing speech by Health minister of province-01, Mr, Jayram Yadav

He congratulates entire PHD team for successful completion of the Annual review workshop and he said that management workshop was 10 times better than expected. He mainly focused on the subjects like effective mobilization of FCHVs other than Morang district also, coordination of EDPs with all levels, effective suicide prevention programs. He also talks about need of health facility in the area Pathivara Temple of Taplejung which cannot proceed directly from Ministry but will manage by coordinating with Local level. He also gives his best wishes for coming festival Dashain and Tihar.

Three days Provincial Annual Review Workshop was closed with the distribution of Token of love to the Chief guest and other guests.

Annex II: Commitments Picture



स्वास्थ्य कार्यक्रमहरुको प्रदेश स्तरिय बार्षिक समिक्षा गोष्ठि
७-९ असोज, २०७९

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१.प्रदेश तथा स्थानिय तहको स्वास्थ्य संस्था तथा कार्यालयहरुमा रिक्त रहेको जनशक्तिको व्यवस्थापन र दरवन्दी सर्वेक्षण लाई मुख्य प्राथमिकतामा राखी आवश्यक प्रक्रियाको लागि सम्बन्धीत निकायमा समन्वय गरिनेछ।

२.प्रदेशमा कुपोषणको दरलाई न्युनिकरण गर्न कुपोषित बच्चाहरुको समयमै पहिचान र उपचारका साथै बहिरंग उपचार केन्द्र र पोषण पुर्नस्थापना गृहको स्थापना, सुदृढिकरण र निरन्तर संचालनमा जोड दिईनेछ।

३. पुर्ण खोप सुनिश्चितता, सरसफाई प्रर्वदन र दिगोपनालाई निरन्तरता दिदै प्रदेशलाई पुर्ण खोप सुनिश्चितता प्रदेश घोषणा गरिनेछ।

४.न्युनतम सेवा मापदण्ड कार्यक्रममा देखिएका सुधार गर्नुपर्ने पक्षहरुलाई आवश्यक कार्ययोजना तथा बजेट निर्धारण गरि कार्यन्वयन गरिनेछ।

५.सम्पुर्ण संस्थाहरुबाट गुणस्तरिय तथ्यांकहरु विभिन्न सुचना प्रणालीहरु मार्फत समयमै र पुर्णरुपमा प्रविष्ट गरिने दर ९० प्रतिशत भन्दा माथि पुर्याईनेछ।

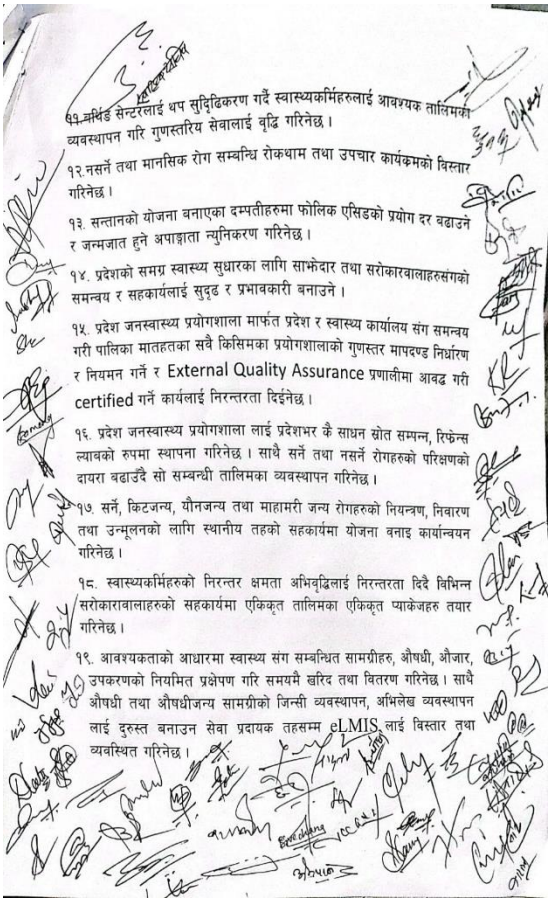
६.क्षयरोगको केश पहिचान दरलाई वृद्धि गर्दै क्षयरोग मुक्त पालिकाको अभियानलाई निरन्तरता र विस्तार गरिनेछ।

७.स्वास्थ्य संस्थाजन्य फोहोर व्यवस्थापनलाई अस्पताल सुदृढिकरणको लागि प्राथमिकतामा राखि यो सम्बन्धी समस्याहरु समाधान गरिनेछ।

८.सुरक्षित गर्भपतन सेवा प्रदायक स्वास्थ्य संस्थाहरुबाट नियमित गुणस्तरिय सुरक्षित गर्भपतन सेवा प्रदान गर्ने व्यवस्था मिलाउने।

९.गुणस्तरिय जनस्वास्थ्य कार्यक्रमहरुको पहुँच दुर्गम तथा ग्रामिण क्षेत्रमा रहेका गरिब, पिछडिएका सिमान्तकृत समुदायमा पुर्याउन जिल्लास्तर बाट सुक्ष्म योजना निर्माण गरि कार्यन्वयन गरिनेछ।

१०.महामरी रोगको समय अनुकुल पहिचान तथा व्यवस्थापनको लागि आवश्यक प्रतिकार्य योजना तथा संयन्त्रको निर्माण गरिनेछ।



११.सबै सेन्टरलाई थप सुदृढिकरण गर्दै स्वास्थ्यकर्मिहरुलाई आवश्यक तालिमको व्यवस्थापन गरि गुणस्तरिय सेवालाई वृद्धि गरिनेछ।

१२.नसर्ने तथा मानसिक रोग सम्बन्धि रोकथाम तथा उपचार कार्यक्रमको विस्तार गरिनेछ।

१३. सन्तानको योजना बनाएका दम्पतीहरुमा फोलिक एसिडको प्रयोग दर बढाउने र जन्मजात हुने अपाङ्गता न्युनिकरण गरिनेछ।

१४. प्रदेशको समग्र स्वास्थ्य सुधारका लागि साझेदार तथा सरोकारवालाहरुसंगको समन्वय र सहकार्यलाई सुदृढ र प्रभावकारी बनाउने।

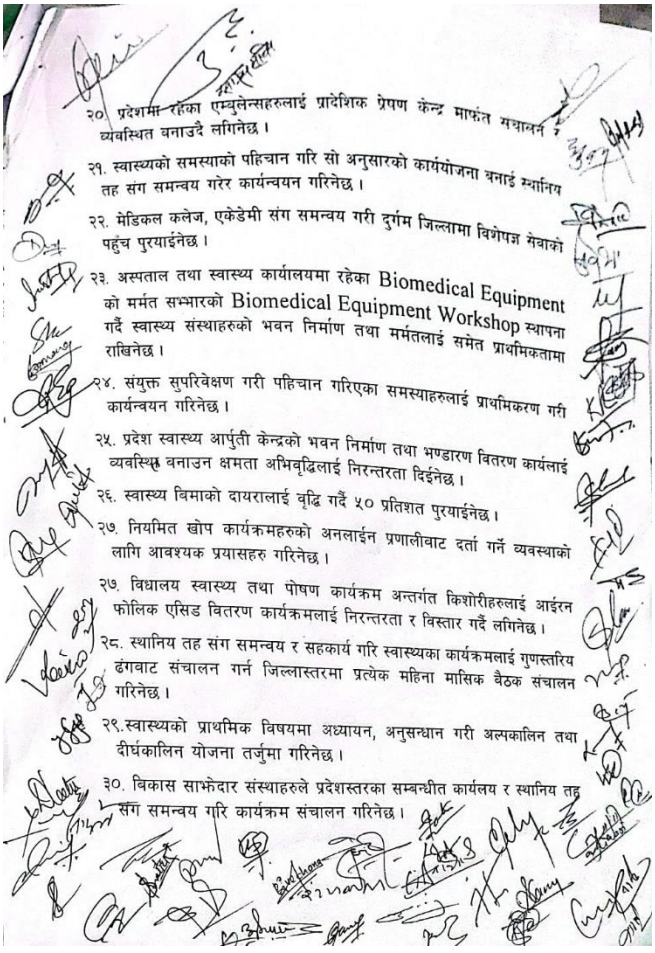
१५. प्रदेश जनस्वास्थ्य प्रयोगशाला मार्फत प्रदेश र स्वास्थ्य कार्यालय संग समन्वय गरी पालिका मातहतका सबै किसिमका प्रयोगशालाको गुणस्तर मापदण्ड निर्धारण र नियमन गर्ने र External Quality Assurance प्रणालीमा आवद्ध गरी certified गर्ने कार्यलाई निरन्तरता दिईनेछ।

१६. प्रदेश जनस्वास्थ्य प्रयोगशाला लाई प्रदेशभर कै साधन स्रोत सम्पन्न, रिफेन्स ल्याबको रुपमा स्थापना गरिनेछ। साथै सर्ने तथा नसर्ने रोगहरुको परिक्षणको दायरा बढाउँदै सो सम्बन्धी तालिमका व्यवस्थापन गरिनेछ।

१७. सर्ने, किटजन्य, यौनजन्य तथा माहामरी जन्य रोगहरुको नियन्त्रण, निवारण तथा उन्मूलनको लागि स्थानीय तहको सहकार्यमा योजना बनाइ कार्यान्वयन गरिनेछ।

१८. स्वास्थ्यकर्मिहरुको निरन्तर क्षमता अभिवृद्धिलाई निरन्तरता दिदै विभिन्न सरोकारावालाहरुको सहकार्यमा एकिकृत तालिमका एकिकृत प्याकेजहरु तयार गरिनेछ।

१९. आवश्यकताको आधारमा स्वास्थ्य संग सम्बन्धित सामग्रीहरु, औषधी, औजार, उपकरणको नियमित प्रक्षेपण गरि समयमै खरिद तथा वितरण गरिनेछ। साथै औषधी तथा औषधीजन्य सामग्रीको जिन्सी व्यवस्थापन, अभिलेख व्यवस्थापन लाई दुरुस्त बनाउन सेवा प्रदायक तहसम्म eLMIS लाई विस्तार तथा व्यवस्थित गरिनेछ।



२०. प्रदेशमा रहेका एम्बुलेन्सहरुलाई प्रादेशिक प्रेषण केन्द्र मार्फत सञ्चालन व्यवस्थित बनाउदै लगिनेछ।

२१. स्वास्थ्यको समस्याको पहिचान गरि सो अनुसारको कार्ययोजना बनाई स्थानिय तह संग समन्वय गरेर कार्यन्वयन गरिनेछ।

२२. मेडिकल कलेज, एकेडेमी संग समन्वय गरी दुर्गम जिल्लामा विशेषज्ञ सेवाको पहुंच पुर्याईनेछ।

२३. अस्पताल तथा स्वास्थ्य कार्यालयमा रहेका Biomedical Equipment को मर्मत सम्भारको Biomedical Equipment Workshop स्थापना गर्दै स्वास्थ्य संस्थाहरुको भवन निर्माण तथा मर्मतलाई समेत प्राथमिकतामा राखिनेछ।

२४. संयुक्त सुपरिवेक्षण गरी पहिचान गरिएका समस्याहरुलाई प्राथमिकरण गरी कार्यन्वयन गरिनेछ।

२५. प्रदेश स्वास्थ्य आर्पुती केन्द्रको भवन निर्माण तथा भण्डारण वितरण कार्यलाई व्यवस्थित बनाउन क्षमता अभिवृद्धिलाई निरन्तरता दिईनेछ।

२६. स्वास्थ्य विमाको दायरालाई वृद्धि गर्दै ५० प्रतिशत पुर्याईनेछ।

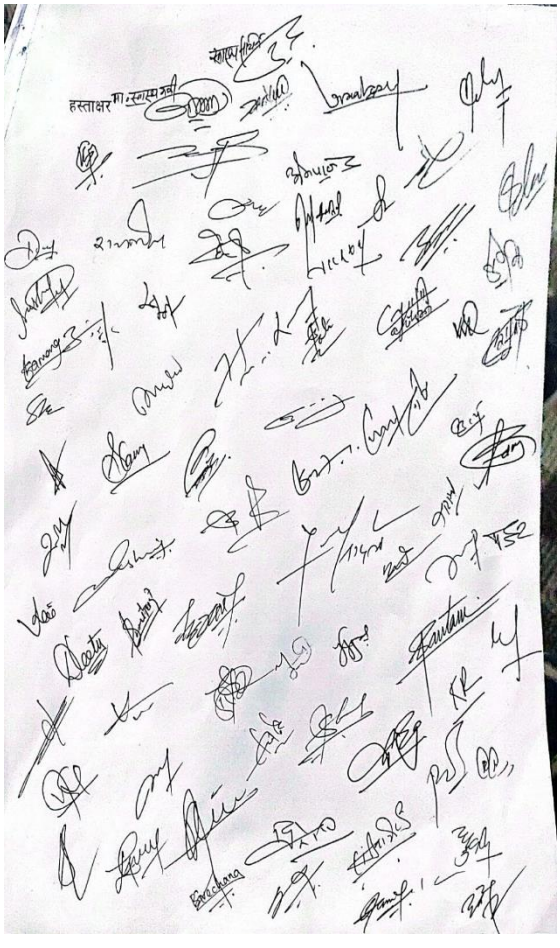
२७. नियमित खोप कार्यक्रमहरुको अनलाईन प्रणालीवाट दर्ता गर्ने व्यवस्थाको लागि आवश्यक प्रयासहरु गरिनेछ।

२७. विद्यालय स्वास्थ्य तथा पोषण कार्यक्रम अन्तर्गत किशोरीहरुलाई आईरन फोलिक एसिड वितरण कार्यक्रमलाई निरन्तरता र विस्तार गर्दै लगिनेछ।

२८. स्थानिय तह संग समन्वय र सहकार्य गरि स्वास्थ्यका कार्यक्रमलाई गुणस्तरिय ढंगवाट संचालन गर्न जिल्लास्तरमा प्रत्येक महिना मासिक बैठक संचालन गरिनेछ।

२९.स्वास्थ्यको प्राथमिक विषयमा अध्ययन, अनुसन्धान गरी अल्पकालिन तथा दीर्घकालिन योजना तर्जुमा गरिनेछ।

३०. विकास साझेदार संस्थाहरुले प्रदेशस्तरका सम्बन्धीत कार्यलय र स्थानिय तह संग समन्वय गरि कार्यक्रम संचालन गरिनेछ।



हस्ताक्षर

Annex III : Major Innovations

1.Bhojpur

- Implementation of Home-Based Growth Monitoring program in Pauadungma RM.
- Expansion of Rural USG program
- Distribution of Computer/Laptops in Health facilities for reporting mechanism
- Development of different physical infrastructures from local level.

2. Ilam

- Commitment from all local levels for sustainability of full immunization
- Production and development of brochure and IEC materials including the information of immunization schedule, immunization related diseases and importance.
- Production and development of flex and treatment protocol for Newborn care.
- Free ambulance services provided by local level.
- Expansion of eLMIS system up to health facilities level.
- Conduction of clinic for elderly citizens.
- Encouragement program launched for FCHV and Lactating women.

3. Morang

- Conduction of Community Based NCDs (HTN & Diabetes) identification Program.
- Conduction of Community Based active screening for identification of malnourished cases (SAM & MAM)
- Strengthening Birthing Centers in terms of service availability, acceptability, accessibility, and quality

4. Sankhawasabha

- Printing and distribution of 2600 Mothers and Child Health Booklet
- Referral of six complicated cases during pregnant, labour, and lactating period through President Air rescue program.
- Ensured sustainability of full immunization in all local level.
- Registrations and renewal of private health institutions from Health Office.
- Establish of system in district hospital to inform the nursing staff of local level for PNC services.
- Continued to provide one pager information through email to schools regarding the messages for school health education during different day celebration.

5. Sunsari

- Establishment of health Desk at Bhantabari POE
- Conduction of Survey on COVID 19 Vaccination in Harinagar and Bhokraha RM
- Declaration of Full Immunization District on 2079/03/31
- Daily reporting, Monthly meeting with Health coordinator of local level
- Measurement of MSS score and updated of all Health facilities.

6. Panchthar

- Covid -19 fully immunization palika declaration above 18 years population in Yangbarak Rural Municipality

7. Solukhumbu

- One Health facilities one RUSG program implemented on Likhupikhe RM.
- Digital X-ray services provided on Likhupikhe RM
  Distribution of calcium, soap and cash for encouragement to pregnant and lactating women in Mahakulung RM
- Declaration of Nutrition and adolescent friendly health facilities in Mahakulung RM
- Provision and availability of oxygen cylinder, concentrator, nebulizer, pulse oximeter and other necessary equipment's in all health facilities of Solu Dhudkunda RM.

Annex IV: Human Resources Information

Table 34: Human Resources Information of Provincial Health Directorate

S.N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Director (Chief PHA)	11th	1	0	1	0	0
2	Senior /Public Health Administrator	9/10th	2	1	1	0	0
3	Senior /Health Administrator	9/10th	1	0	1	0	0
4	Consultant Ayurveda Physician	9/10	1	0	1	0	0
5	Senior/Health Education Administrator	9/10	1	0	1	0	0
6	Senior/Hospital Nursing Administrator	9/10	1	0	1	0	0
7	Under Secretary	9/10	1	0	1	0	0
8	Senior/Public Health Officer	7/8	3	1	2	1	0
9	Demographer/Statistics Officer	7/8	2	0	2	0	0
10	Medical Officer	8	1	0	1	0	0
11.	Senior/Community Nursing Officer	7/8	1	0	1	1	0
12	Senior/Health Education Officer	7/8	1	0	1	0	0
13	Health Assistant/Supervisor	5/6/7	2	2	0	0	2
14	Lab Technician	5/6/7	1	1	0	0	1
15	Kabiraj	5/6/7	1	1	0	0	0
16	Statistics Assistant	5/6	1	1	0	0	0
17	Section Officer	7/8	1	0	1	0	0
18	Account Officer	7/8	1	0	1	0	0
19	Admin Officer	5/6	2	2	0	0	0
20	Account Assistant	5/6	1	1	0	0	0
21	Typist/NASU	5/6	0	0	0	0	2
22	IT officer	7	0	0	0	1	0
23	MSS Implementation Officer	7	0	0	0	1	0
24	Pharmacy Officer	7	0	0	0	1	0
25	Light Vehicle Driver	0	2	1	0	1	0
26	Office Assistant	0	4	3	0	2	0
	Total		32	14	16	8	5

Table 35: Human Resources Information of Province Health Training Centre

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Director	11th	1	0	1	0	0
2	Senior /Health Education Administrator	9/10th	1	1	0	0	0
3	Senior/Public Health Administrator	9/10	1	0	1	0	0
4	Senior/Public Health Officer	7/8	2	0	2	0	0
5	Senior/ Health Education Officer	7/8	2	0	2	0	0
6	Community Nursing Officer	7	1	1	0	0	0
7	Section Officer	7/8	1	0	1	0	0
8	Account Officer	7/8	1	0	1	0	0
9	Public Health Inspector	6/7	0	0	0	0	2
10	IT Assistant	5	0	0	0	1	
11	Warden	0	0	0	0	1	0
12	Light Vehicle Driver	0	1	1	0	0	0
13	Office Assistant	0	2	2	0	1	0
	Total		13	5	8	3	2

Table 36: Human Resource Information of Provincial Health Logistics and Management Centre

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Director	11th	1	0	1	0	0
2	Senior /Public Health Administrator	9/10th	1	0	1	0	0
3	Bio-Medical Engineer	7/8	1	0	1	1	0
4	Pharmacy Officer	7/8	1	1	0	0	0
5	Section Officer	7/8	1	0	1	0	0
6	Account Officer	7	1	1	0	0	0
7	Pharmacy Assistant	5/6/7	1	1	0	0	0
8	Computer Operator	5	1	0	1	0	0
9	Cold Chain Officer	4/5/6	2	2	0	0	0
10	Refrigerator Technician	5/6	1	1	0	0	0
11	Heavy Vehicle Driver	0	1	0	1	0	0
12	Light Vehicle Driver	0	1	1	0	0	0

13	Office Assistant	0	2	1	1	0	0
14	Loader Packer	0	2	0	2	0	0
	Total		17	8	9	1	0

Table 37: Human Resources Information of Provincial Public Health Laboratory

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Director	11th	1	1	0	0	0
2	Senior /Consultant Pathologist	9/10th	1	0	1	0	0
3	Senior/Consultant Microbiologist	9/10	1	0	1	0	0
4	Under Chief Medical Technologist	9/10	1	0	1	0	0
5	Senior /Medical Technologist	7/8	2	2	0	0	0
6	Senior/Lab Technician	5/6/7	2	2	0	0	0
7	Senior/Lab Assistant	4/5/6	1	1	0	0	0
8	Admin Assistant	5/6	1	1	0	0	0
9	Account Assistant	5/6	1	1	0	0	0
12	Light Vehicle Driver	0	1	0	0	1	0
13	Office Assistant	0	2	1	0	1	0
	Total		14	9	3	2	0

Human Resources at Health Offices

Table 33: Human Resources Information at Health Office Morang

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Administrator	9/10	1	1	0	0	0
2	Public Health Officer	7/8	1	0	1	0	0
3	Statistics Officer	6/7/8	1	1	0	0	0
4	Health Assistant/Supervisor	5/6/7	3	3	0	0	4
5	Public Health Nurse	5/6/7	1	1	0	0	0
6	Lab Technician	5/6/7	1	1	0	0	0
7	Cold Chain	4/5/6	1	1	0	0	0
8	Admin Officer	6	1	1	0	0	0
9	Account Officer	6	1	1	0	0	0
10	Light Vehicle Driver	0	1	1	0	0	0
11	Office Assistant	0	2	1	0	1	3
	Total		14	12	1	1	7

Table 34: Human Resources Information at Health Office Sunsari

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Administrator	9/10	1	1	0	0	0
2	Public Health Officer	7/8	1	0	1	1	0
3	Statistics Officer	7/8	1	0	0	0	0
4	Health Assistant/Supervisor	5/6/7	3	3	0	0	0
5	Public Health Nurse	5/6/7	1	1	0	0	0
6	Lab Technician	5/6/7	1	0	1	0	1
7	Cold Chain	4/5/6	1	1	0	0	0
8	Admin Officer	6	1	1	0	0	0
9	Account Officer	6	1	1	0	0	0
10	Light Vehicle Driver	0	1	1	0	0	0
11	Office Assistant	0	2	1	0	1	0
	Total		14	10	2	2	1

Table 35: Human Resources Information at Health Office Jhapa

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Administrator	9/10	1	0	1	0	0
2	Public Health Officer	7/8	1	1	0	0	0
3	Statistics Officer	7/8	1	1	0	0	0
4	Health Assistant/Supervisor	5/6/7	3	3	0	0	0
5	Public Health Nurse	5/6/7	1	0	1	0	0
6	Lab Technician	5/6/7	1	1	0	0	0
7	Cold Chain	4/5/6	1	1	0	0	0
8	Admin Officer	6	1	1	0	0	0
9	Account Officer	6	1	1	0	0	0
10	Light Vehicle Driver	0	1	0	0	1	0
11	Office Assistant	0	2	2	0	0	0
	Total		14	11	2	1	0

Table 36: Human Resources Information at Health Office Ilam

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Administrator	9/10	1	0	1	0	0
2	Public Health Officer	7/8	1	1	0	0	0
3	Statistics Officer	7/8	1	0	1	0	0
4	Health Assistant/Supervisor	5/6/7	3	3	0	0	1
5	Public Health Nurse	5/6/7	1	0	0	0	1
6	Lab Technician	5/6/7	1	1	0	0	0
7	Cold Chain	4/5/6	1	1	0	0	0
8	Admin Officer	6	1	1	0	0	0
9	Account Officer	6	1	1	0	0	0
10	Light Vehicle Driver	0	1	1	0	0	0
11	Office Assistant	0	2	0	0	2	0
	Total		14	9	1	2	2

Table 37: Human Resources Information at Health Office Dhankuta

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	2
3	Public Health Nurse	5/6/7	1	1	0	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	1	0	0	0
7	Assistant Finance	5	1	1	0	0	0
8	Statistics Assistant	5/6	1	1	0	0	0
9	Light Vehicle Driver	0	1	1	0	0	0
10	Office Assistant	0	2	1	0	1	0
	Total		12	10	1	1	2

Table 38: Human Resources Information at Health Office Udayapur

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	1	0	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	0
3	Public Health Nurse	5/6/7	1	1	0	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	1	0	0	0
7	Assistant Finance	5	1	1	0	0	0
8	Statistics Assistant	5/6	1	1	0	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	1	0	1	0
	Total		12	10	0	2	0

Table 39: Human Resources Information at Health Office Paanchthar

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	2
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	0	1	0	0
6	Admin Assistant	5	1	0	1	0	0
7	Assistant Finance	5	1	1	0	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Computer Assistant	5	0	0	0	1	0
10	Office Assistant	0	2	2	0	0	0
	Total		12	6	5	2	2

Table 40: Human Resources Information at Health Office Sankhwasabha

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	1
3	Public Health Nurse	5/6/7	1	1	0	0	1
4	Lab Technician	5/6/7	1	1	0	0	0

5	Cold Chain Assistant	4/5/6	1	0	1	1	0
6	Admin Assistant	5	1	0	1	0	0
7	Assistant Finance	5	1	1	0	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	0	0	2	0
	Total		12	5	3	4	2

Table 41: Human Resources Information at Health Office Okhaldhunga

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	0
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	0	1	0	0
7	Assistant Finance	5	1	0	1	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	1	0	1	0
	Total		12	5	5	2	0

Table 42: Human Resources Information at Health Office Khotang

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	0
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	1	0	0	0
7	Assistant Finance	5	1	1	0	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	1	0	1	0
	Total		12	7	3	2	0

Table 43: Human Resources Information at Health Office Bhojpur

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	2	2	0	0	1
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	0	1	0	0
6	Admin Assistant	5	1	1	0	0	0
7	Assistant Finance	5	1	0	1	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	0	0	2	0
	Total		12	4	5	3	1

Table 44: Human Resources Information at Health Office Tehrathum

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	1	1	0	0	0
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	0	1	0	1
7	Assistant Finance	5	1	0	1	0	0
8	Statistics Assistant	5/6	1	1	0	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	0	0	2	1
	Total		11	4	4	3	2

Table 45: Human Resources Information at Health Office Solukhumbu

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	0	1	0	0
2	Health Assistant/Supervisor	5/6/7	1	1	0	0	0
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	1	0	0	0
6	Admin Assistant	5	1	1	0	0	0
7	Assistant Finance	5	1	0	1	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	1	0	1	0
	Total		11	5	4	2	0

Table 46: Human Resources Information at Health Office Taplejung

S. N	Designation	Level	Sanctioned Post	Fulfilled	Vacant	Contract	Others
1	Senior/Public Health Officer	7/8	1	1	0	0	0
2	Health Assistant/Supervisor	5/6/7	1	1	0	0	0
3	Public Health Nurse	5/6/7	1	0	1	0	0
4	Lab Technician	5/6/7	1	1	0	0	0
5	Cold Chain Assistant	4/5/6	1	0	1	0	0
6	Admin Assistant	5	1	0	1	0	0
7	Assistant Finance	5	1	0	1	0	0
8	Statistics Assistant	5/6	1	0	1	0	0
9	Light Vehicle Driver	0	1	0	0	1	0
10	Office Assistant	0	2	1	0	1	0
	Total		11	4	5	2	0

Human Resources Information at Provincial and District Hospital

Table 47: Human Resources Information at Mechi Provincial Hospital, Jhapa

Designation	Approved Sanctioned Post				Other's sources /Contract
	Post	Fulfilled		Vacant	
		Permanent	Contract		
Chief Medical Superintendent	1	0	0	1	0
Chief Consultant Physician	1	0	0	1	0
Chief Consultant Pediatrician	1	1	0	0	0
Chief Consultant Obs and Gynae	1	1	0	1	1
Consultant Obs and Gynae	2	1	0	1	1
Consultant Pediatrician	2	0	0	2	1
Consultant Physician	2	1	0	1	1
Consultant Pathologist	1	1	0	0	1
Consultant Anesthesiologist	1	0	0	1	4
Consultant Dermatologist	1	1	0	0	0
Consultant ENT Surgeon	1	0	0	1	1
Consultant Psychiatric	1	0	0	1	0
Consultant Surgeon	2	1	0	1	1
Consultant Medical Generalogist	1	0	0	1	1
Consultant Orthopedics	1	0	0	1	2
Consultant Radiologist	1	1	0	0	0
Consultant Dental Surgeon	1	0	0	1	1
Hospital Nursing Administrator	1	0	0	1	0
Medical Officer	6	4	0	2	4
Dental Surgeon	1	1	0	0	1
Medical Technologist	1	0	0	1	0
Nursing Officer	1	1	0	0	1
Section Officer	1	1	0	0	0
Account Officer	1	1	0	0	0
Nayab Subba	1	1	0	0	0
Medical Recorder Assistant	1	1	0	0	1
Lab Technician	1	1	0	0	1
Radiographer Supervisor	1	1	0	0	2
Staff Nurse	18	14	0	4	10

Housekeeper Assistant	1	0	0	1	0
Health Assistant	1	1	0	0	1
Dark Room Assistant	1	1	0	0	1
ANM	4	3	0	1	3
AHW	5	3	0	2	5
Account Assistant	1	0	0	1	1
Lab Assistant	1	0	0	1	0
Light Vehicle driver	1	0	0	0	2
Bio-Medical Engineer	0	0	0	0	1
Office Assistant	33	4	0	5	49
Homeopathy Doctor	0	0	0	0	1
Homeopathy assistant	0	0	0	0	1
Anesthesia assistant	0	0	0	0	1
security Guard	0	0	0	0	14
Khardar	0	0	0	0	2
Computer Assistant	0	0	0	0	3
Total	103	45	0	54	194

Table 48: Human Resources Information at Madan Bhandari Hospital and Trauma Center, Morang

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant Doctor	1	0	1	11	1	0	1
Medical Officer	2	2	0	1	2	0	2
Nursing Staff	8	8	0	0	10	0	2
Paramedic	5	5	0	0	7	0	0
Lab	2	2	0	0	5	1	0
Radiographer	1	0	1	0	1	0	1
Pharmacy	0	0	0	0	1	0	0
Administration	1	1	0	0	0	0	0
Accounts	1	1	0	0	0	0	0
Computer Operator	0	0	0	0	7	0	0
Office Assistant	6	0	6	0	7	0	0
Cleaner	0	0	0	0	11	0	0
Total	27	19	8	12	52	1	6

Table 49: Human Resources Information at District Hospital Sunsari

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant Doctor	9	0	9	4	2	0	0
Medical Officer	5	2	3	0	0	1	0
Matron/MLT/Physio/Manager	3	1	2	0	0	0	1
Nursing Staff	6	6	0	0	0	0	5
Paramedic	5	3	2	0	2	2	0
Lab	4	4	0	0	3	0	0
Others	10	7	3	0	7	0	0
ANM/AHW	5	5	0	0	5	0	0
Computer Operators	1	0	1	0	6	0	0
Office Assistant	11	3	8	0	1	8	1
Cleaner	0	0	0	0	0	4	0
Security Guard	0	0	0	0	4	0	0
Total	59	32	29	4	30	15	7

Table 50: Human Resources Information at District Hospital Dhankuta

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Medical Superintendent	1	0	1	1	0	0	0
Medical Officer	2	2	0	3	0	0	0
Medical Recorder	1	1	0	0	0	0	0
Nursing Staff	6	5	1	0	0	0	10
Paramedic	3	3	0	0	4	0	3
Dental Surgeon	0	0	0	2	0	0	0
Lab	2	2	0	0	1	0	4
Radiographer	2	2	0	0	1	0	0
Admin	2	1	1	0	0	0	0

Pharmacy Officer	0	0	0	0	0	0	1
Computer Assistant	0	0	0	0	4	0	0
Office Assistant	11	2	9	0	10	0	10
Light Vehicle Driver	0	0	0	0	1	0	1
Total	30	17	13	6	21	0	29

Table 51: Human Resources Information at District Hospital Bhojpur

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1	0	0	0	1
Medical Officer	2	0	2	1	1	0	1
Dental Surgeon	0	0	0	2	0	0	0
Nursing Staff	6	2	4	1	0	1	4
Paramedic	3	0	3	0	0	0	4
Lab	2	2	0	0	0	0	1
Radiographer	2	1	1	0	0	0	1
Admin	2	1	1	0	0	0	0
Pharmacy Officer	0	0	0	0	1	1	0
Administration	1	0	1	0	0	0	0
Bio-Medical Technician	0	0	0	0	0	0	1
Account	0	0	0	0	0	0	0
Medical Recorder	1	1	0	0	0	0	0
Computer Operator	0	0	0	0	1	1	0
Driver	0	0	0	0	0	1	0
Office Assistant	11	4	7	0	3	9	1
Security Guard	0	0	0	0	1	0	0
Total	31	11	20	4	7	13	14

Table 52: Human Resources Information at District Hospital Paanchthar

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	1	0	1	1	0	0
Medical Officer	2	0	2	1	1	0	0
Dental Surgeon	0	0	0	1	0	0	0
Staff Nurse	4	3	1	0	0	7	0
Health Assistant	1	1	0	0	0	3	3
ANM	2	2	0	0	1	1	0
AHW	2	0	2	0	2	0	0
Lab	2	1	1	0	1	3	0
Radiographer	2	2	0	0	1	3	0
Medical Recorder	1	1	0	0	0	0	0
Anesthesia Assistant	1	0	1	0	0	1	0
Pharmacy Assistant	0	0	0	0	2	1	0
Admin	3	0	3	0	0	0	0
Driver	0	0	0	0	1	1	0
Office Assistant	11	4	7	0	6	12	0
Total	32	15	17	4	15	29	14

Table 53: Human Resources Information at District Hospital Terhathum

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1	1	0	0	0
Medical Officer	1	1	0	3	0	1	1
Dental Surgeon	0	1	0	0	0	0	1
Staff Nurse	3	2	1	0	2	0	1
Health Assistant	1	0	1	0	1	1	1
ANM	2	2	0	0	1	3	0
AHW	2	0	2	0	1	3	0
Lab	1	0	1	0	4	1	0
Radiographer	1	1	0	0	0	1	0
Computer Operator	0	0	0	0	3	0	0
Office Assistant	9	0	9	0	1	10	0
Total	21	8	13	4	13	20	4

Table 54: Human Resources Information at District Hospital Sankhwasabha

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant Doctor	9	0	9	2	3	0	0
Medical Officer	4	0	4	2	0	1	0
Dental Surgeon	1	0	1	1	1	0	0
Physiotherapist	1	0	1	0	1	0	0
Medical Lab Technologist	1	1	0	0	0	0	0
Nursing Officer	1	1	0	0	0	0	0
Admin	2	1	1	0	0	0	0
Account assistant	1	0	1	0	0	0	0
Lab Technician/assistant	4	2	2	0	4	1	0
Medical Recorder	1	1	0	0	0	0	0
Staff Nurse	6	3	3	0	5	10	0
Health Assistant	5	1	4	0	1	5	0
Pharmacy Assistant	1	1	0	0	3	2	0
Radiographer	1	0	1	0	0	1	0
Dental Hygienist	1	0	1	0	0	0	0
Bio-Medical Technician	1	0	1	0	1	0	0
ANM	5	3	2	0	5	0	0
Anesthesia assistant	1	0	1	0	1	0	0
Computer Operator	1	0	1	0	0	0	0
Computer Technician	0	0	0	0	1	0	0
Facilitator	0	0	0	0	0	3	0
Electrician	0	0	0	0	1	0	0
X-ray Assistant	0	0	0	0	1	0	0
Light Vehicle driver	1	0	0	0	1	1	0
Security Guard	0	0	0	0	3	0	0
Office Assistant	11	3	0	0	7	13	0
Total	59	17	42	5	45	38	0

Table 55: Human Resources Information at District Hospital Solukhumbu

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1		0	0	1
Medical Officer	1	0	1	2	1	0	0
Staff Nurse	2	2	0	0	0	1	5
Health Assistant	1	0	1	0	1	1	1
ANM	2	2	0	0	1	1	0
AHW	3	0	3	0	1	3	0
Lab	1	0	1	0	1	1	0
Radiographer/Dark room	1	0	1	0	0	1	0
Admin	1	0	1	0	0	0	0
Office Assistant	6	1	5	0	1	5	3
Total	19	5	14	2	6	13	10

Table 56: Human Resources Information at District Hospital Ilam

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Medical Officer/Consultant	14	1	13	4	1	3	0
Physiotherapist	1	0	1	0	0	0	0
Nursing Officer	1	1	0	1	0	0	1
Medical Lab Technologist	1	0	1	0	0	1	0
Hospital Manager	0	0	0	0	0	1	0
Health Assistant	5	2	3	0	0	6	0
Staff Nurse	6	6	0	0	0	7	1
Radiographer/Dark room	1	0	1	0	1	2	0
Lab Technician/Assistant	4	3	1	0	1	3	0
AHW	0	1	0	0	6	0	0
ANM	5	1	4	0	2	0	0
Admin	3	2	1	0	0	0	0
Medical Recorder	1	1	0	0	0	0	0

Others(Pharmacy, Biomedical, Anesthesia, Dental assistant)	5	2	3	0	2	3	0
Support Staff, Driver, Helper	12	3	9	0	12	16	0
Counter Assistant	0	0	0	0	4	0	0
Total	59	25	36	5	29	42	0

Table 57: Human Resources Information at District Hospital Khotang

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1	1	0	0	0
Medical Officer	2	2	0	3	0	0	0
Nursing Staff	6	2	4	0	7	5	0
Paramedics	3	0	3	0	3	2	0
Anesthesia Assistant	1	0	1	0	1	0	0
Lab Staff	2	1	1	0	1	1	0
Radiographer/Dark room	2	1	1	0	1	0	0
Medical Recorder	1	0	1	0	1	0	0
Admin	2	1	1	0	0	0	0
Account	1	0	1	0	0	0	0
Driver	0	0	0	0	2	0	0
Total	21	7	14	4	16	8	0

Table 58: Human Resources Information at District Hospital Taplejung

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1	1	0	0	1
Medical Officer	1	0	1	1	0	0	1
Nursing Staff	3	1	2	0	0	3	1
Health Assistant	1	0	1	0	0	1	0
Admin	1	0	1	0	0	0	0
Medical Lab Technologist	0	0	0	0	0	1	0
Radiographer/Dark room	1	0	1	0	1	1	0
Bio-Medical Technician	0	0	0	0	0	0	1
Lab Technician/Assistant	1	0	1	0	2	1	0
ANM	2	2	0	0	1	1	0
AHW	1	0	1	0	1	1	0
Anesthesia Assistant	0	0	0	0	0	0	1
Computer Operator	0	0	0	0	4	0	0
Office Assistant	9	5	4	0	5	6	0
Total	21	8	14	2	14	15	5

Table 59: Human Resources Information at District Hospital Okhaldhunga

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Consultant	1	0	1	0	0	0	0
Medical Officer	2	1	1	4	0	2	0
Staff Nurse	4	1	3	0	0	0	0
Health Assistant	1	1	0	0	0	0	0
Admin	2	0	2	0	0	0	0
Lab Technician/ Assistant	2	1	1	0	0	1	0
Radiographer/Dark room	2	2	0	0	0	0	0
Medical Recorder	1	0	1	0	0	0	0
ANM	2	2	0	0	7	2	0
AHW	2	1	1	0	0	3	2
Office Assistant	11	2	9	0	0	9	4
Total	30	11	19	4	0	22	8

Table 60: Human Resources Information at District Hospital Udayapur

Designation	Approved sanction post			Contract			
	Post	Fulfilled	Vacant	Scholarship	Hospital Committee	Province	Others
Chief Medical Superintendent	1	0	1	0	0	0	0
Consultant	9	1	8	5	0	0	0
Medical Officer	4	2	2	3	0	0	2
Dental Surgeon	2	0	0	2	0	0	1
Physiotherapist	1	0	0	0	0	0	0
Nursing Staff	12	4	8	1	0	0	2
Lab Staff	5	4	1	0	0	0	1
Radiographer/Dark room	1	0	0	0	0	0	0
Medical Recorder	1	1	0	0	0	0	0
Health Assistant	5	0	5	0	0	0	3
AHW	2	1	1	0	0	3	2
Pharmacy Supervisor	1	1	0	0	0	0	0
Bio-Medical Technician	1	0	1	0	0	0	0
Anesthesia Assistant	1	1	0	0	0	0	0
Admin	3	1	2	0	0	0	0
Account Assistant	1	1	0	0	0	0	0
Driver, Office Assistant	12	1	11	0	0	0	11
Total	59	16	43	11	0	0	20

Human Resources information at Ayurveda Institutions

Table 61: Human Resources Information as per sanctioned post at Provincial Ayurveda Institutions

S. N	Designation	Sanctioned Position			Remarks
		Total	Fulfilled	Vacant	
1	Senior Ayurveda Consultant	1	0	0	Health Directorate
2	Ayurveda Physician	1	1	0	Ministry of Health
3	Ayurveda Physician	14	11	3	District Ayurveda Health Center
4	Kabiraj	15	11	4	District Ayurveda Health Center
5	Baidya	25	13	12	District Ayurveda Health Center
6	Account Assistant	14	6	8	District Ayurveda Health Center
7	Medicine Maker	14	14	0	District Ayurveda Health Center
8	Office Assistant	14	14	0	
	Total	98	70	28	

Table 62: Human Resources Information fulfilled from Contract at Provincial Ayurveda Institutions

S. N	Designation	Contract Staff		Remarks
		No	Districts	
1	Ayurveda Physician	7	Paachthar, Ilam, Jhapa, Morang, Okhaldhunga	3 from scholarship
2	Homeopathic Physician	3	Morang, Mechi	
3	Physiotherapist	1	Jhapa	
4	Homeopathic Assistant	1	Morang	
5	Acupuncture Assistant	1	Morang	
6	Lab Technician	14	All districts	

7	Staff Nurse	4	Ilam, Jhapa, Morang, Udayapur	
8	Panchakarma Therapy Assistant	4	Ilam, Morang	
9	ANM	2	Ilam, Morang	
10	Vaidya	3	Ilam, Morang, Udayapur	
11	Abhyangkarta	28	All 14 districts	
12	Office Assistant	8	Ilam, Morang, Jhapa	

Table 63: Human Resources Information at "Nagarik Aarogya Sewa Kendra"

S. N	Total Number of Nagarik Aarogya Sewa Kendra	Position	Total Number
1	53	Baidya	53
		Support Staff	53

Summary of Human Resources situation at different institutions

Table 64: Summary of Human resources at Provincial Level Institutions and Health Offices

S. N	Designation	Level	Sanctioned Position			Institutions
			Total	Fulfilled	Vacant	
1	Secretary	11th	1	1	O	Ministry of Health
2	Director	11th	4	1	3	PHD, PHTC, PPHL, PHLMC
3	Senior /Public Health Administrator	9/10	9	3	6	PHD, PHTC, PHLMC, HO
4	Senior/Health Administrator	9/10	2	0	2	MoH, PHD
5	Senior/Health Education Administrator	9/10	2	1	1	PHD, PHTC
6	Senior/Hospital Nursing Administrator	9/10	1	0	1	PHD
7	Senior/Consultant Pathologist	9/10	1	0	1	PPHL
8	Senior/Consultant Microbiologist	9/10	1	0	1	PPHL
9	Sub Chief Medical Technologist	9/10	1	0	1	PPHL
10	Under Secretary	9/10	2	0	2	MoH, PHD
11	Senior/Public Health Officer	7/8	20	5	15	MoH, PHD, PHTC, HO
12	Senior/Health Education Officer	7/8	4	0	4	MoH, PHD, PHTC
13	Senior/Community Nursing Officer	7/8	3	1	2	MoH, PHD, PHTC
14	Demographer	7/8	3	0	3	MoH, PHD
15	Pharmacy Officer	7/8	2	1	1	MoH, PHLMC
16	Medical Lab Technologist	7/8	2	1	1	PPHL
17	Section Officer	7/8	5	3	2	MoH, PHD, PHTC, PPHL
18	Account Officer	7/8	4	2	2	MoH, PHD, PHTC, PPHL
19	Law Officer	7/8	1	0	1	MoH
20	HA or Supervisor	5/6/7	31	31	0	PHD, HO
21	Lab Technician	5/6/7	17	17	0	PHD, HO, PPHL
22	Lab Assistant	4/5/6	1	1	0	PPHL
23	Bio-Medical Engineer	7/8	1	0	1	PHLMC
24	Public Health Nurse	5/6/7	14	7	7	HO
25	Cold Chain	4/5/6	16	12	4	HO, PHLMC
26	Statistics Assistant	5/6	15	6	9	PHD, HO
27	Admin	5/6	19	12	7	
28	Account Assistant	5/6	17	12	5	
29	Pharmacy Assistant	5/6	1	1	0	PHLMC
30	Refrigerator Technician	5/6	1	1	0	PHLMC
31	Computer Operator	5/6	2	1	1	MoH, PHLMC
32	Heavy Vehicle Driver	0	1	1	0	PHLMC
33	Loader Packer	0	2	2	0	PHLMC
34	Light Vehicle Driver	0	21	21	0	MoH, PHD, PHLMC, PHTC, PPHL, HO
35	Office Assistant	0	42	42	0	MoH, PHD, PHLMC, PHTC, PPHL, HO
	Total		269	186	83	

Table 65: Summary of Human resources at Provincial and district Level Hospitals

S. N	Institutions	Number	Sanctioned Position			Remarks
			Total	Fulfilled	Vacant	
1	Province and District Hospitals	14	571	236	335	

Table 66: Contact details of Health Directorate

S.N	Name	Designation	Contact No.	Email ID
1	Gyan Bahadur Basnet	Act. Director	9852070508	basnetgyan23@gmail.com
2	Priyanka Khatiwada	Public Health Officer		priyankakhatiwada.gov@gmail.com
3	Udesh Shrestha	Immunization Officer	9852047878	udeshbhp@gmail.com
4	Tulsi Guragain	TB/Leprosy Officer		tguragai1967@gmail.com
5	Mukunda Dahal	Statistics Officer	9852077005	dahalm@gmail.com
6	Tara Subedi	Public Health Inspector	9852051774	
7	Anil Pradhan	Public Health Inspector	9807004579	anilpradhan2032@gmail.com
8	Tulasa Adhikari	Hospital Nursing Inspector	9851061025	Tadhikari2@gmail.com
9	Khagendra Paudel	Senior Kabiraj Inspector	9861101018	Khagendrailam37@gmail.com
10	Dilip Singh	Lab Technician	9869812829	singhdilip239@gmail.com
11	Sanjay Adhikari	Lab Technician		
12	Surendra Bajimaya	Officer (Admin)	9852060670	bajimayasurendra39@gmail.com
13	Surya Pokhrel	Officer (Admin)	9842040444	suryapokharel2030@gmail.com
14	Roshan Pokhrel	Account Officer	9849126536	iamroshankp@gmail.com
15	Bivechana Chaulagain	Public Health Officer	9844416723	cbivechana@gmail.com
16	Anamika Sharma	School Nurse Coordinator	9843589617	animasharma@gmail.com
17	Ronina Dangal	Nursing Officer		roninad41@gmail.com
18	Rup Narayan Yadav	IT officer	9852077022	It.hdd.p1@gmail.com
19	Dikshika Lama	Pharmacy Officer		Dikshulama.dl@gmail.com
20	Srijat Dahal	MSS implementation officer	9852073755	srijatdahal@gmail.com
21	Saranga Tamang	eLMIS coordinator		tamangsaranga@gmail.com
22	Bijay Adhikari	Statistics coordinator		Adhikari.bijaya9@gmail.com
23	Sabina Chaudhary	Data focal Officer	9848646184	sabinachaudhary111@gmail.com
24	Nabin Rai	Ta.Nasu	9842347939	nabinrai1980@gmail.com

Table 67: Contact details of Health Office

S.N	Health Office	Name	Designation	Contact No.	Email ID
1	Taplejung	Yograj Ghimire	Chief	9842667659	taplejungpho@gmail.com
2	Paanchthar	Tej Bahadur Tumbahamfo	Acting Chief	9852681355	dho.panchthar@yahoo.com
3	Ilam	Aditya Shakya	Acting Chief	9849598097	dphoilam@gmail.com
4	Jhapa	Ramesh Barakoti	Acting Chief	9852682199	dphojhapa@gmail.com
5	Morang	Dr.Suresh Mehta	Chief	9842036595	dpho.morang@gmail.com
6	Sunsari	Sagar Prasain	Chief	9852035707	dhosunsari@gmail.com
7	Dhankuta	Gokul Bhandari	Acting Chief	9852055934	dhodhankuta999@gmail.com
8	Tehrathum	Fadindra Thapa	Acting Chief	9842160839	dhothm@gmail.com
9	Bhojpur	Suman Tiwari	Acting Chief	9852070235	dhobhojpur10@gmail.com
10	Sankhuwasabha	Narad Subedi	Acting Chief	9852033060	dhosankhuwasabha@gmail.com
11	Udayapur	Brij Kumar Das	Chief	9852032519	dhoudayapur@gmail.com
12	Khotang	Punya Sigdel	Acting Chief	9852888800	dho.khotang@gmail.com
13	Okhaldhunga	Ahmed Mansuri	Acting Chief	9842941143	info.dhor@gmail.com
14	Solukhumbu	Shiwan Thakur	Acting Chief	9842077159	dhosolukhumbu189@gmail.com

Table 68: Contact details of Hospitals

S.N	Hospital	Name	Designation	Contact No.	Email ID
1	Sankhuwasabha	Dr. Pranam Paneru	Acting Chief	9852032188	sankhuwasabha.hosp@gmail.com
2	Bhojpur	Dr. Shivaji Rijal	Acting Chief	9852052188	hospitalbhp@gmail.com
3	Terhthum	Dr. Pankaj Gupta	Acting Chief	9852060188	dhterhathum@gmail.com
4	Dhankuta	Dr. Amitabh Thakur	Acting Chief	9852061639	dhankutahospital7@gmail.com
5	Taplejung	Bijaya Rai	Acting Chief Chief	9852660189	dht.taplejung@gmail.com
6	Panchthar	Dr Buddhi Bdr Thapa	Chief	9852684188	panchtharhospital@gmail.com

7	Ilam	Dr Prabhu Shah	Acting Chief	9849824635	ilamhospital@gmail.com
8	Okhaldhunga	Dr. Jeeb Narayan Mandal	Acting Chief	9852844437/9841315379	rumjatarhospital@gmail.com
9	Solukhumbu	Sani Sherpa	Acting Chief	9862689891	soluhsp78@gmail.com
10	Khotang	Dr. Pradip Pariyar	Acting Chief	9852849576	dho.khotang@gmail.com
11	Madan Bhandari	Dr. Ravi Kr. Shah	Acting Chief	9810096568	mangalbarehospitalmorang@gmail.com
12	Inaruwa	Dr. Devraj Ghimire	Acting Chief	9860777066	districthospitalsunsari756@gmail.com
13	Udaypur	Dr. Gyanendra Jha	Acting Chief	9862845046	udp700@gmail.com
14	Provincial Hospital	Dr Tanka Psd Barakoti	Chief	9852671615	mechi.zonalhospital@yahoo.com

Table 69: Contact details of Ayruveda Institutions

S.N	Ayurveda Institutions	Name	Designation	Contact No.	Email ID
1	Taplejung	Dr. Gambir Jha	Chief	9852660509	ayurvedtpj@gmail.com
2	Paanchthar	Bijay Jha	Chief	9852621027	dahcpanchthar@gmail.com
3	Ilam	Dr. Bijay Shrestha	Chief	9852640178	mechiayurvedilam@gmail.com
4	Jhapa	Dr. Anil Kumar Yadav	Chief	9852655025	dahcjhapa@gmail.com
5	Morang	Dr. Kenin Rai	Chief	9852035835	dahcmorang@gmail.com
6	Sunsari	Dr Sanjiv Kumar Yadav	Chief	9843363774	dahcsunsari@gmail.com
7	Terhathum	Amarendra Pandit	Acting Chief	9852044217	dachterahthum@gmail.com
8	Dhankuta	Dr. Surya Narayan Mehta	Chief	9852080117	koshiayudhankuta@gmail.com
9	Sankhwasabha	Dr. Ram Prabodh Chaudhary	Chief	9852038811	dahcsankhuwasabha@gmail.com
10	Bhojpur	Manoj Pandit	Acting Chief	9852062038	dahcbhopur038@gmail.com
11	Khotang	Dr. Umesh Kumar Pandit	Chief	036-420392	dahckhotang@gmail.com
12	Solukhumbu	Keshav Dhungana	Acting Chief	9852828024	dahcsolukhumbu@gmail.com
13	Okhaldhunga	Dr. Sarita Bajgain	Chief	9852041150	dahcokhaldhunga@gmail.com
14	Udayapur	Dr. Saroj Bishal	Chief	9852835489	sagarmathaayu@gmail.com