# Annual Health Report
# 2076/77

Province Government

Ministry of Social Development

**Health Directorate**

Gandaki Province

Pokhara, Nepal

Province Government

# Ministry of Social Development
## Pokhara, Nepal

**Phone: 061-467914**

Date: 2077/11/15

# Greeting

Health is one of the most important sectors for human development. Unless the people become healthy, they never contribute to the nation and the province as well. Gandaki Province has understood this true-fact and has tried to manage this sector as better as possible from its initial phase.

Ministry of Social Development always wants to share its any activities and the experiences among the people through a report. The report is trying to submit all the health-based annual activities in details so that the people in the Gandaki Province will also aware on their health sector.

I hope the report 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.

Finally, I would like to thank to the secretary of the ministry, health director of the provincial health directorate, chiefs of the health divisions of the ministry and all the staffs of the ministry and health directorate who always engaged to implement the programs/activities and prepared the report.

Thank you!

.....

Nar Devi Pun Magar
Minister

Province Government

# Ministry of Social Development
## Pokhara, Nepal

**Phone: 061-467914**

Date: 2077/11/15

# Greeting

I am pleased to know that the Provincial Health Directorate is bringing out the Annual report 2076/77 and I would like to thank everyone who are directly or indirectly involved in preparation and completion of this report. This is a result of hard work and dedication of everyone involve in the Health system.

I am confident that this comprehensive document based on the annual performance of all components of health 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 Gandaki Province.

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.
Finally, I extend my sincerest thanks to the Health Directorate and everyone else involved in making this report and I look forward to a better health for all.

.....
Binod Bahadur Kunwar
Secretary
Ministry of Social Development

**Province Government**
**Ministry of Social Development**
**Health Directorate**
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# Preface

Iam delighted to publish this Annual Health Report 2076/77 (2019-2020) of the Gandaki Province based on routine HMIS information obtained from 11 districts of this province. I strongly believe that this report will be helpful in guiding planners, managers, service providers and academia for better planning and implementation of health programs thereby, increasing access to basic health services to each person of the province.

This Annual Health Report 2019/2020 (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 Gandaki Province. This report is organized in eight sections. Section I describes bio-physical and socio-economic condition of Gandaki province and section II explains performance on Family Welfare Program with special focus on Child Health and Family Health. Similarly, section III is about Epidemiology and Disease Control Program. In section IV Nursing Program is looked into, and section V on Curative Health Services Program. Further, section VI focuses on supporting program and section VII delves upon other department programs such as Ayurveda and Health Insurance lastly the section VIII discusses on Supporting Partners.

I would like to express my heart-felt gratitude to Honorable Minister Ms. Nar Devi Pun Magar and Secretary Ministry of Social Development, Gandaki Province for her valuable suggestions and guidance to the province directorate. I express my sincere thanks to respected Social Development Secretary Dilli Ram Sharma, I am very much optimistic that they will provide continuous support and guidance to implement the recommendations pertaining to this report. My sincere thanks go to my colleagues and staffs of this province for making their honest efforts in delivering healthcare services. Most importantly, I extend my appreciation to all the health workers and FCHVs for delivering quality health services to the people of this province. I hope they will make similar support in the future focusing on hard-to-reach area and people, particularly the socially excluded and the marginalized groups. I highly appreciate my colleagues at the HD, PHTC, RTC, PMS, Regional and Zonal Hospitals, HOs, district hospitals and local level at grassroots who have contributed a lot in preparing this report.

I would also like to acknowledge the contribution made by our valued partners including UNICEF, WHO–MOSD, WHO-IPD, WHO-PHEOCC, IPAS, Save the Children, SUAAHARA, Water Aid Nepal NSI, FPAN, FHI 360, INF, Marie Stopes, AHF, NauloGhumti, Kopila Nepal, private medical colleges/hospitals and other local partners for their support in health service delivery through various programs in this province.

Last but definitely not the least, my special thanks go to chiefs of Mr Shambhu Jnawali Policy, Law, Criteria Planning and Public health Division and Dr Ram Bahadur KC Hospital Development and Medical Service Division of Ministry of Social Development. Similarly, I would like to thanks, Mr. Tikaram Sharma, Mr. Dibakar Sharma and Mr. Rishi Ram Poudel (Statistics Officers) and all program focal persons in HD, Gandaki Province who have invested their precious time in this report.

2077Falgun (February 2021)

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**Dr Binod Bindu Sharma**
Director

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# ACRONYMS

| | |
|---|---|
| ABER | Annual Blood Examination Rate |
| AEFI | Adverse Event Following Immunization |
| AFI | Annual Falciparum Incidence |
| AFP | Acute Flaccid Paralysis |
| AHW | Auxiliary Health Worker |
| AIDS | Acquired Immuno-deficiency Syndrome |
| AIDSCAP | AIDS Control and Prevention |
| ANC | Antenatal Care |
| ANM | Auxiliary Nurse Midwife |
| API | Annual Parasite Incidence |
| ARI | Acute Respiratory Infection |
| ART | Anti-Retroviral Treatment |
| BCC | Behaviour Change Communication |
| BCG | Bacille Calmette-Guerin |
| BEOC | Basic Emergency Obstetric Care |
| BTC | Blood Transfusion Centre |
| BTS | Blood Transfusion Service |
| CAC | Comprehensive Abortion Care |
| CB-IMNCI | Community-based Integrated Management of Neonatal & Childhood Illness |
| CB-NCP | Community-Based New-born Care Program |
| CBS | Central Bureau of Statistics |
| CCA | Cold Chain Assistant |
| CDD | Control of Diarrhoeal Diseases |
| CDP | Community Drug Program |
| CEOC | Comprehensive Emergency Obstetric Care |
| CEONC | Comprehensive Emergency Obsteric and Neonatal care |
| CFR | Case Fatality Rate |
| CHD | Child Health Division |
| CHW | Community Health Worker |
| CPR | Contraceptive Prevalence Rate |
| CYP | Couple Years of Protection |
| DACC | District AIDS Co-ordination Committee |
| DDMC | District Development Management Committee |
| DHIS | District Health Information System |
| DoHS | Department of Health Services |
| DOTS | Directly Observed Treatment, Short Course |
| EDCD | Epidemiology and Disease Control Division |
| EDP | External Development Partner |
| EPI | Expanded Program on Immunization |

| | |
|---|---|
| FCHV | Female Community Health Volunteer |
| FHD | Family Health Division |
| FHI | Family Health International |
| FP | Family Planning |
| FPAN | Family Planning Association of Nepal |
| FY | Fiscal Year |
| HA | Health Assistant |
| HD | Health Division |
| HIV | Human Immuno-deficiency Virus |
| HMIS | Health Management Information System |
| HO | Health Office(r) |
| HP | Health Post |
| HPI | Health Post In-charge |
| IDUs | Intravenous Drug Users |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illness |
| IMR | Infant Mortality Rate |
| INF | International Nepal Fellowship |
| INGO | International Non-governmental Organization |
| IPD | Immunization Preventable Diseases |
| IUCD | Intra-uterine Contraceptive Device |
| JE | Japanese Encephalitis |
| LA | Lab Assistant |
| LCD | Leprosy Control Division |
| LMD | Logistics Management Division |
| LMIS | Logistics Management Information System |
| M&E | Monitoring and Evaluation |
| MB | Multi-bacilli |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MDT | Multi-drug Therapy |
| MMR | Maternal Mortality Rate |
| MoHP | Ministry of Health and Population |
| MSM | Men having Sex with Men |
| MDT | Multi-drug Therapy |
| NCASC | National Centre for AIDS and STD Control |
| NGO | Non-Governmental Organization |
| NHEICC | National Health Education, Information and Communication Centre |
| NHTC | National Health Training Centre |
| NID | National Immunization Day |
| NIP | National Immunization Program |

| | |
|---|---|
| NPHL | National Public Health Laboratory |
| NTC | National Tuberculosis Centre |
| NTP | National Tuberculosis Program |
| OPD | Out-Patient Department |
| OPV | Oral Polio Vaccine |
| ORC | Outreach Clinic |
| ORS | Oral Rehydration Solution, Oral Rehydration Salts |
| PAC | Post Abortion Care |
| PB | Pauci Bacilli |
| PCD | Passive Case Detection |
| PF | Plasmodium Falciparum |
| PHC | Primary Health Care |
| PHCC | Primary Health Care Centre |
| PHN | Public Health Nurse |
| PHO | Public Health Officer |
| PLHIV | People Living with HIV |
| PME | Planning, Monitoring and Evaluation |
| PMTCT | Prevention of mother to child transmission |
| PNC | Postnatal Care |
| PR | Prevalence Rate |
| PSBI | Possible Sever Bacterial Infection |
| PSI | Population Services International |
| RH | Reproductive Health |
| RTC | Regional Training Centre |
| SM | Safe Motherhood |
| SN | Staff Nurse |
| SPR | Slide Positivity Rate |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infections |
| STI/STD | Sexually Transmitted Infection/Disease |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid |
| VBD | Vector-Borne Disease |
| VPD | Vaccine Preventable Diseases |
| VSC | Voluntary Surgical Contraception |
| WHO | World Health Organization |

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# EXECUTIVE SUMMARY

Annual Health Report 2076/77 compiles and summarizes the performance of all promotive, preventive, curative and rehabilitative health services implemented by all public health, private profit and non-profit health institutions working in partnership with public health institutions in Gandaki Province. This report is 24th consecutive report of its kind for the Health Directorate but as for the Provincial report, it is the second. This report will help to understand the physical and financial performance of the districts, the situation of basic health indicators in the Province and it also provides the information for further analysis and road map for planning. Report therefore holds significant importance in understanding the provincial health system and its performance.

This Annual Health Report has six objectives: I. to assess the performance of the districts on implementation of planned activities; II. to assess and compare the financial and physical progress made by the districts; III. to assess and compare the trends in major health indicators in the province; IV. to identify weak areas and help the planners and policy makers to focus on programs with weak areas; V. to provide information on performance of provincial health system to the planners, policy makers, programmers, managers, service providers, researchers, academia, stakeholders and general population; VI. to help the planners for better planning using the information present in this health report.

Target audience of this report are policy makers, health planners, program managers, service providers, provincial, health authorities and community level leaders and policy makers, external development partners, INGOs, NGOs, CBOs, University teachers and students, researchers, academies, social workers and general people who have interest on health system.

Several steps have been taken to prepare this report. First, a review meeting was held at local levels. Then, the district level annual performance review meeting was held in all 11 districts and from the meeting; the data generated from the HMIS were critically analyzed. The data were interpreted during presentations and discussions and were further analyzed and interpreted in this report. Sources of information for this report are health management information systems (HMIS) managed by DHIS-2 software, disease surveillance reports, sentinel reports, M&E trip reports.

The performance in the Child Health program has almost always been constant during the review period from 2074/75 to 2076/77. Immunization coverage fluctuated over 3 year's period. DPT, HepB, Hib III coverages slightly increased from 72 percent in 2074/75 to 74 percent in FY 2075/76 and reached to 69 percent in FY 2076/77. Similarly, Measles Rubella-1st also increased from 71 percent in 2074/75 to 74 percent in FY 2075/76 and slightly decreased to 70 % in FY 2076/77. Percentage of BCG immunized is also decreased in last three years with 73% in 2074/75, 72% in 2075/76 and 66 % in 2076/77. Similarly, Percentage of JE immunized is also slightly decreased from 83% in 2074/75 to 80% in 2075/76 reached to 78% in 2076/77. Rota vaccine along with hygiene promotion through routine immunization ToT was happened in Gandaki Province in 7 February 2020.

HMIS report indicated that the nutritional status of children is fair in the province. The trend of registered growth monitoring percentages (0-11 months) is also in fluctuating trend and it has reached to 84% in 2076/77 from 89% in 2074/75. The rate of diarrheal disease incidence among under five years children is decreasing trend, with 302 in 2074/75, 270 in 2075/76 and 249 per 1000 under five children in 2076/77.

Safe motherhood program is not satisfactory in Gandaki Province. ANC first visit has increased from 94% in FY 2074/75 to 105% in 2075/76 and then decreased to 87% in FY 2076/77. Also, the overall four ANC visits as protocol is in fluctuating trend in the province. It has slightly increased from 60% in

2074/075 to 67% in 2075/076 and dramatically decreased to 55% in 2076/077. Percentage of delivery assisted by SBA is almost same, which was 47% in both F/Y 2074/75 and 2075/76 and reached to 46% in 2076/77. Institutional delivery is also almost same with 47% in 2074/75, 48% in 2075/77 and 47% in 2076/77. The PNC first visit was 46% in FY 2074/75 and increased to 47 % in FY 2075/76 and again reached 46 % in FY 2076/77. CPR is only 33 percent in FY 2076/77, whereas it was 46% in F/Y 2075/66. The proportion of adolescent receiving abortion service is slightly fluctuating. However, it's improved in FY 2076/77 compared to previous FY. The percentage was 7 in 2073/74, 11 in 2075/76 and reached 7 in 2076/77.

Most of the preventable diseases like malaria, tuberculosis, leprosy and HIV/AIDS have been under control in this province during FY 2076/77. Corona virus (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was declared pandemic on 11th March 2019 by WHO. The outbreak was first identified in Wuhan city, Hubei, China, in December 2019. As of 19 February 2021, more than 110 million cases of COVID-19 have been reported in 192 countries and territories, resulting in more than 2.43 million deaths. Number of Kala-azar cases also fluctuated in last three FY. Which was 3 in 2074/75, 0 in 2075/76 and 5 in 2076/77. All forms of TB case notification rate were 88 per lakh population in FY 2074/75, similarly, 89 and 77 per lakh population in FY 2075/76 and 2076/77 respectively. TB treatment success rate with 90 percent was achieved in FY 2076/77. The registered prevalence rate of Leprosy for this province in FY 2076/77 was 0.39 per 10,000 populations. New Leprosy case detection rate is 3.66 per 100,000 populations in the province for FY 2076/77. Data shows that general population of the province is not vulnerable to STI and HIV/AIDS. Though there are some high-risk groups of people in the province. In FY 2076/77, in total 57523 mothers were counseled, 41934 were tested and 10 were found HIV positive. The number of operation conducted for Lymphatic Filariasis/Hydrocele in last three years are 80, 58 and 22 in 2074/75, 2075/76 and 2076/77 respectively.

There are a total 5667 FCHVs in Gandaki Province among them 2695 are in urban areas and 2972 are in rural areas. The average number of people served by PHC-ORC clinics is in fluctuating trend over the last three years and it reached to 19 per clinics in 2076/77, 18 per clinics in 2074/75 and 20 per clinic in FY2075/76.

The percentage of new OPD visits in FY 2076/77 was >100 among whole population in the Province which was constant in both FY 2075/76 and 2076/77. Upper Respiratory Tract infection was the first cause of morbidity which was 7 percent followed by Gastritis which was 7 percent in FY 2076/77. The trends of hospital bed turnover were increasing in this province, which was 105 percent in 2076/77 as compared to 89 percent in 2074/75. The maternal death during the last three fiscal years in this province was significantly decreased. It has reached 8 in FY 2076/77 from 22 in 2074/75 and 10 in 2075/76.

Supporting Programs has ten components. Among them the achievement of the financial expenditure was about more than 50%. DHIS-2 reporting status in last three consecutive years was significantly increased, which was 94 percent, 97 percent and 100 percent in FY 2074/75, 2075/76 and 2076/77 respectively. Overall logistic management was fair in FY 2076/77 despite stock out of some commodities in few districts. Construction and renovation of health office buildings, hospitals, PHCCs and HPs went well in 2076/77 in this Province. Planning activities have completed in scheduled time and integrated supervision and monitoring completed by HD as planned. Human resources management was challenging during previous years in the province.

The others two components are: Department of Ayurveda and Alternative Medicine and Health Insurance. Top three diseases of Ayurveda in this province are Vatvyadi, Amalpitta and Skin Diseases.

In this Province Health Insurance program was implemented in 9 districts (Baglung, Kaski, Myagdi, Gorkha, Tanahu, Syangja, Parbat, Lamjung and Nawalparasi East). Out of eleven districts in province in nine districts where HI program has been launched, Population of 4,66,725 and total families of 1,59,138 are covered under HI program (except Lamjunj and Nawalparasi East district). Of the insured population 219,525 are male, 246681 are female and 45 are others. Of the total population of 19,15,675 in 7 districts (except Lamjung and Nawalparasi East launched newly) 40% were benefited from health insurance program.

Coordination and partnership include internal and external coordination. Coordination with external development partners, non-governmental international organizations, national non-governmental organizations, local NGOs, medical college and teaching hospitals, private and community hospitals and nursing homes and polyclinics has been strengthened gradually. Internal coordination also has been strengthened gradually as the PHD initiated regular internal coordination meetings, monthly review of service statistics of the district and immediate feedback to the districts, preparation of M&E trip reports including sending them back to respective districts for program improvement, minuting of meeting decisions and follow up on their implementation. Although reporting status of service-related data needs to be improved gradually.

## Health Service Coverage Fact Sheet from FY 2074/75 to 2076/77

| SN | Indicators | 074/75 | 075/76 | 076/77 |
|---|---|---|---|---|
| **REPORTING STATUS** | | | | |
| 1 | Public Institutions | 94.3 | 96.8 | 100 |
| 2 | Public Hospital | 90.5 | 92 | 100 |
| 3 | PHC/ORC | 95.8 | 96 | 80 |
| **FAMILY WELFARE (Child health, Family health)** | | | | |
| 6 | DPT/HepB/Hib III Coverage | 71.9 | 73.9 | 68.6 |
| 7 | Measles Rubella Coverage (IInd) | 70.2 | 76.6 | 74.9 |
| 8 | Percentage of pregnant women received TD2+ | 23.7 | 22.2 | 21.6 |
| 9 | Drop Out Rate (DPT, HepB, Hib I vs III) | 3.8 | 1.6 | 3.7 |
| 11 | % of children $u_5$ year with diarrhea treated with tab zinc/ORS | 98.7 | 97.3 | 100 |
| 12 | Postpartum Mother Receiving Vitamin A (%) | 52.8 | 46 | 40 |
| 13 | percentage of severe pneumonia among new cases | 0.2 | 0.19 | 0.07 |
| 14 | Percentage of $u_5$ year children with diarrhea suffering from severagede-hydration | 0.19 | 0.33 | 0.11 |
| 15 | % of ANC 1st Visit as protocol | 68.3 | 70.7 | 60 |
| 16 | % of 4th ANC Visit as protocol | 60.1 | 66.9 | 54.5 |
| 17 | Delivery Conducted by SBA as % of Expected Live Births | 46.8 | 47 | 45.9 |
| 18 | % of Institutional Delivery Among Expected Live Births | 47.1 | 47.8 | 46.5 |
| 19 | PNC 1st Visit as % of Expected Live Birth | 46 | 46.5 | 46 |
| 20 | CPR as % of MWRA | 36 | 35 | 33 |
| 21 | % FP methods new acceptor among MWRA | 10.6 | 10 | 9.5 |
| **PHC ORC** | | | | |
| 22 | % of PHC_ORC Conducted | 96 | 96 | 80 |
| 23 | Average People Served /PHC_ORC | 18 | 19 | 18.8 |
| **EPIDEMIOLOGY AND DISEASES CONTROL** | | | | |
| 24 | Malaria positive cases | 36 | 32 | 23 |
| 25 | Malaria: % of PF Among Total Positive Cases | 25 | 17.2 | 8.7 |
| 26 | TB Case Notification Rate | 91.5 | 95 | 77 |
| 27 | TB Treatment Success Rate | 88.3 | 94.1 | 90 |
| **LEPROSY CONTROL PROGRAM** | | | | |
| 28 | Leprosy New Case Detection Rate /10000 | 3.9 | 2.5 | 3.6 |
| 29 | Registered Prevalence Rate /10000 | 0.31 | 0.32 | 0.39 |
| 30 | HIV Counselling (Persons) | 61332 | 67141 | 57523 |
| 31 | New HIV Positive Cases | 34 | 9 | 10 |
| **CURATIVE SERVICES** | | | | |
| 32 | Total New OPD Visits as % of Total Population | 98 | 98 | 100 |

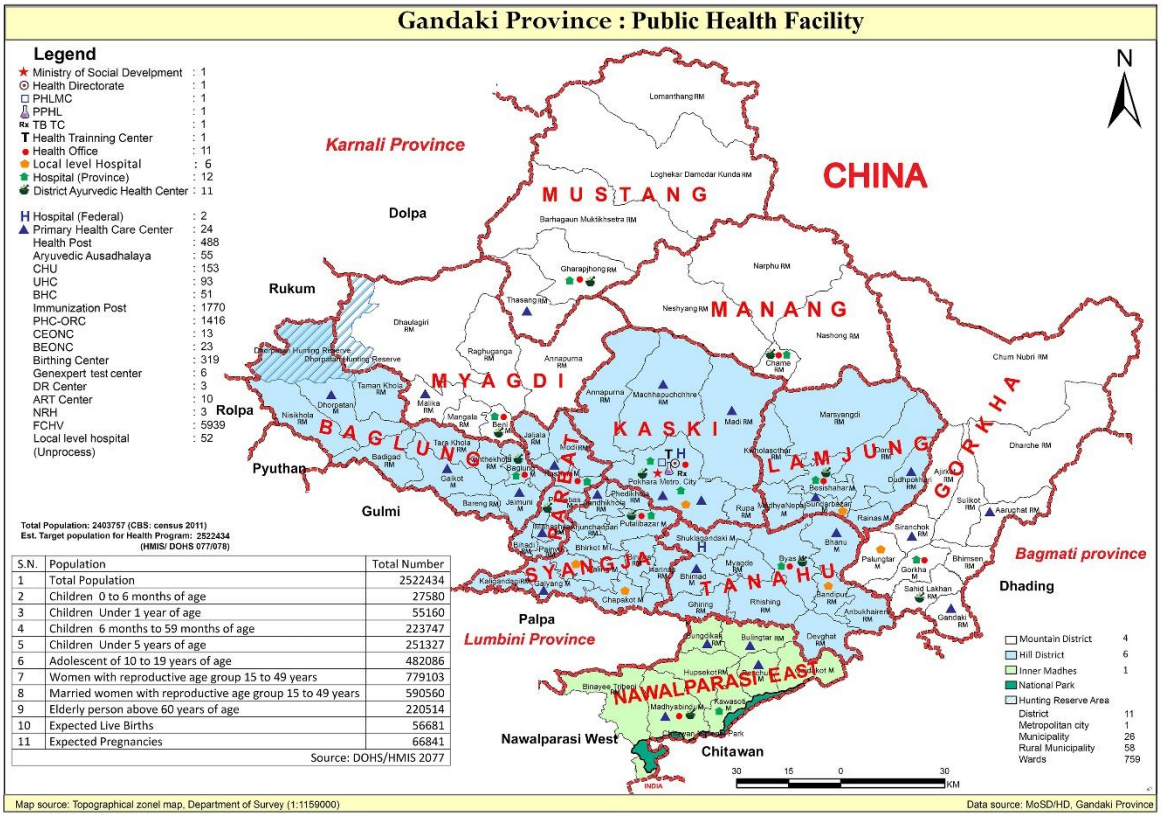
# Section 1

# INTRODUCTION

## 1.1Background

Gandaki Province lies in the mid region of Nepal with three Provinces to its west and three provinces to its East. Gandaki province is fourth biggest province according to its land size (21,504 sq. km). It has eleven districts out of which three districts (Mustang, Manang and Gorkha) lies in the northern part bordering China and one district (Nawalparasi East) lies in the southern part bordering India. Myagdi and Baglung lies in the western, Parbat and Syangja in the southern part, Tanahun and Lamjung in the Eastern part and Kaski, which is also the capital of the Province is in the center. This province has a total of 85 local levels including one metropolitan city, 26 municipalities and 58 rural municipalities.

**Figure 1.1 Geography and Administrative divisions of Gandaki Province**




## 1.2 Climate and vegetation

Gandaki province has a great deal of variation in climate. Normally five climatic zones are found in the province based on altitude: the subtropical zone below 1,200 meters; the cool temperate zone between 1,200 to 2,400 meters; the cold zone between 2,400 to 3,600 meters and the subarctic climatic zone between 3,600 to 4,400 meters; and the arctic zone above 4,400 meters in altitude.

Subtropical climate exists in one district Nawalparasi East. Outside the district however, the climate of other districts is completely different than that of Nawalparasi East. The remarkable differences in climatic conditions are primarily related to the enormous change of altitude within a short north-

south distance. The presence of the east-west-trending Himalayan massifs to the north and the monsoonal alteration of wet and dry seasons also greatly contribute to local variations in climate. Annual rainfall pattern is also affected by the altitude. Generally, up to about 3,000 meters, total annual rainfall increase as the altitude increases; thereafter, total annual rainfall diminishes with increasing altitude and latitude. Gandaki province receives about 1,000 millimeters of rain per year. Although there are variations in rainfall pattern Lumle in Kaski district receives (highest) rainfall about 6000 millimeters per year whereas the Jomsom in Mustang district receives (lowest rainfall) which less than 200 millimeters per year. Most of the rainfall occurs in summer monsoon months (June-August) and the season is wet. The autumn season (September-November) is mild, winter season (January-March) is cold and spring season (April-May) is dry and dusty. The vegetation pattern follows rainfall and temperature. Sub-tropical evergreen forest is found in Nawalparasi East (the south), deciduous forest in the hills and conifer forest in the mountain.

### 1.3 Main rivers

Gandaki Province is drained by Kaligandaki river and its six tributaries including Seti, Madi, Marsyangdi, Daraundi, Budhigandaki and Trishuli. Most of these rivers originate from the Himalaya in the north and flow to the south crossing the southern border to India. These rivers are used for drinking water and irrigation to some extent.

### 1.4 Inland lakes

Numbers of lakes are located in this province. Perhaps Province has highest number of inland lakes in the country. They are the source of entertainment and tourist attraction beside these, they are also used for hydropower, irrigation, drinking water and boating facilities. Major lakes in the province are: Phewatal, Begnastal, Rupatal, Khastetal, Maidital, Gudetal and Dipang in Kaski, Tilichotal in Manang, Panchasetal in Syangja, Kalchumantal in Gorkha, Jalpatal in Baglung, Kharibarahatal in Parbat.

### 1.5 Historical place and tourist area

There are some historical and tourist areas in the province. They provide historical information and attract tourists from different countries for recreation and study. Major historical area and tourist centers are: Gorkha Durbar (Gorkha), Ghandruk, Annapurna (Kaski), Bandipur (Tanahun), Upper Mustang, Dorbarahi, Chhabdibarahi (Tanahun), Tribenidham (Nawalpur).

### 1.6 Religious place

The province has number of religious places. Domestic and international toursits visit these marvelous places every year. Some of the well-known religious places in this province are: Muktinath or Muktichhetra, Kagbeni, Lomanthang (Mustang), Manakamana (Gorkha), Devghat, Byasgufa (Tanahun), Bindabasini, Bhadrakali and Talbrahiv (Kaski).

### 1.7 Hydro-electricity generation

The province has ten major hydro power plants with different hydropower generation capacity. A total of 320512 KW hydroelectricity power is generated in the province. Major plants are: Pokhara (Phewatal) 1088 KW, Marsyangdi Tanahun 69000 KW, Pokhara (Seti) 1500 KW, Andikhola Syangja 5100 KW, Modi Khola Parbat 14800 KW, Kaligandaki A (Syangja) 144000 KW, Madhya Marsyangdi (Lamjung) 69000 KW.

### 1.8 Transportation

Out of 11 districts in the province, Manang and Mustang are still not linked with topped road but they are connected with graveled road. Other 9 districts are linked with black topped road. One district Nawalparasi East is linked with Mahendra highway. Tanahun and Kaski district are linked with Prithvi highway. Syangja and Kaski are linked by Siddartha highway. Tanahun and Lamjung are linked with Bhanu Bhakta Marga, Tanahun and Gorkha are linked with Amar Singh Marga, Kaski, Parbat and Baglung are linked with Thirbam Marga, Myagdi and Mustang are linked with Bhupi Sherchan Marga. There are six airports (Pokhara, Humde Manang, Mustang, Balewa Baglung, Dhorpatan Baglung and Palungtar Gorkha) but the airport of Baglung and Gorkha are not functioning. Only one cable car service in Nepal lies in this province, which links Manakamana and Prithvi Highway. Another cable car also had been settled over Kaligandaki River in Kushma -Parbat, which links Kusma- Parbat with Balewa- Baglung.

### 1.9 Religion and language

The province has great cultural, ethnic, linguistic and religious diversity. Majority of people in this province believe in Hinduism followed by Buddhism, Islam and Christianity. Majority of people in the northern mountain districts follow Buddhism. People in the middle mountain districts have mix of Hinduism and Buddhism while southern Terai district have Hinduism and Islam. People following Christian religion are found in scattered forms in the middle mountain and inner-Terai district. Nepali is the common language among people whereas several other local languages such as Gurung, Magar, Thakali, Tharu and Abadhi are also spoken by the people. There is good social harmony among these religious beliefs, faiths and languages in the province.

### 1.10 Major festivals

People in this province celebrate various festivals. The Mother's Day is one of the widely celebrated festivals that falls on the first month of Baisakh (April/May), of the Nepali Year. It is also called Mata Tirtha Aunsi as it falls on a new moon night. Buddha Jayanti is another important festival. This day is celebrated to mark the birthday of the Lord Buddha which dates back in about 545 BC. It falls on Jestha Purnima (Full moon night-May/June). Janai Purnima or Rakshya Bandhan, is the festival of sacred thread which is celebrated by Hindu people. On this day every Hindu ties a sacred thread on the wrist. Dashain is the biggest festival which is the most auspicious festival among the Nepalese people celebrated by most of the Nepalese caste and creed throughout the province. Fifteen days of celebration occurs during the bright lunar fortnight ending on the day of the full moon in September or early October. Another great festival is the Tihar, the festival of lights which is one of the popular festivals among people. Loshar is also an important festival of Gurung and Thakali people in the province. This festival is celebrated as the beginning of New Year of their calendar. Id

and Moharam are greatest festivals of Muslim people while the Christmas is the biggest festival of people following Christian religion.

### 1.11 Population

Census report 2011 shows a total population 24,03,757 in Gandaki province which is 9.07% of total population (26,494,504) of Nepal. The inter census (2001-2011) annual population growth rate of this province is 0.75%, average household size is 4.16 and population density is 110 per sq. kilometer. However, the total estimated population in (HMIS projection) for this fiscal year 2075/076 was 2500044. According to census 2011 the annual population growth rate of three districts is positive and other eightdistricts have negative. The highest population lies in Kaski district (492098) and lowest lies in Manang (6527) district. Kaski has highest annual population growth rate. This indicates that population movement of this province towards Pokhara which is also the province headquarter.

**Table 1.1: Population in Gandaki Province**

| S.N. | District | Population | Population | Difference | Annual | Number | Avg. size of | population |
|---|---|---|---|---|---|---|---|---|
| | | All | Male | Female | Gr. Rate | Household | Household | density |
| 1 | Baglung | 268613 | 117997 | 150616 | -0.01 | 61522 | 4.37 | 151 |
| 2 | Gorkha | 271061 | 121041 | 150020 | -0.061 | 66506 | 4.08 | 75 |
| 3 | Kaski | 492098 | 236385 | 255713 | 2.57 | 125673 | 3.92 | 244 |
| 4 | Lamjung | 167724 | 75913 | 91811 | -0.55 | 42079 | 3.99 | 99 |
| 5 | Manang | 6538 | 3661 | 2877 | -3.83 | 1480 | 4.42 | 3 |
| 6 | Mustang | 13452 | 7093 | 6359 | -1.08 | 3354 | 4.01 | 4 |
| 7 | Myagdi | 113641 | 51395 | 62246 | -0.07 | 27762 | 4.09 | 49 |
| 8 | Nawalpur | 311604 | 142779 | 168825 | 1.34 | 66934 | 4.66 | 234 |
| 9 | Parbat | 146590 | 65301 | 81289 | -0.74 | 35719 | 4.10 | 297 |
| 10 | Syangja | 289148 | 125833 | 163315 | -0.93 | 68881 | 4.20 | 248 |
| 11 | Tanahun | 323288 | 143410 | 179878 | 0.25 | 78309 | 4.13 | 209 |
| | **Provincial** | **2403757** | **1090808** | **1312949** | **0.75** | **578219** | **4.17** | **110** |

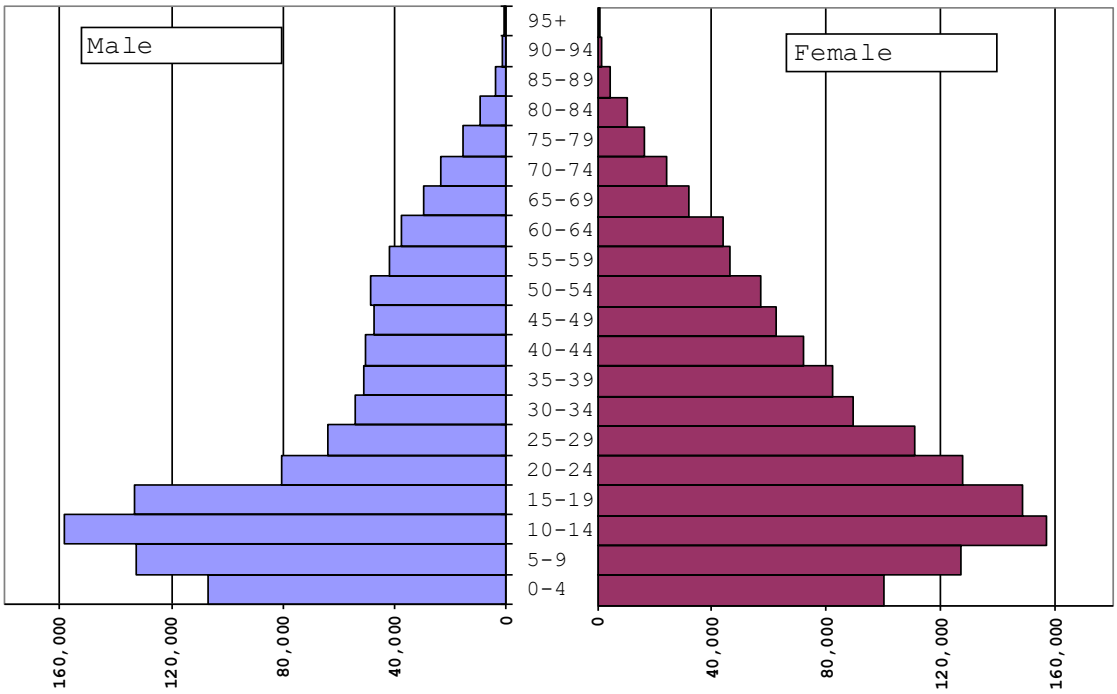
Source: CBS Report, 2011 `

**Table 1.2: Population of Gandaki Province by Age Group**

| Age group | Total | Male | Female |
|---|---|---|---|
| 0-4 | 206710 | 106677 | 100033 |
| 5-9 | 259731 | 132505 | 127226 |
| 10-14 | 314819 | 158243 | 156576 |
| 15-19 | 281450 | 133141 | 148309 |
| 20-24 | 208217 | 80411 | 127806 |
| 25-29 | 174413 | 63781 | 110632 |
| 30-34 | 143309 | 54017 | 89292 |
| 35-39 | 133543 | 51419 | 82124 |
| 40-44 | 122281 | 50374 | 71907 |
| 45-49 | 110218 | 47609 | 62609 |
| 50-54 | 105657 | 48872 | 56785 |
| 55-59 | 88211 | 42128 | 46083 |
| 60-64 | 81649 | 37461 | 44188 |
| 65-69 | 61605 | 29620 | 31985 |
| 70-74 | 47567 | 23472 | 24095 |
| 75-79 | 32389 | 15837 | 16552 |
| 80-84 | 19729 | 9454 | 10275 |
| 85-89 | 8329 | 4059 | 4270 |
| 90-94 | 2888 | 1293 | 1595 |
| 95+ | 1042 | 364 | 678 |
| All age total | 2403757 | 1090737 | 1313020 |

**Source:** CBS Population Census Report,2011

**Figure: 1.2 Population Pyramid of Gandaki Province**




**Source:** CBS Population Census Report,2011

The population pyramid of this province shows population of age group 10-14 has highest (314819) than other age group. The population of age group 5-9 and 0-4 is decreasing. The population structure shows working age population and young people are highly increasing with lower age

group and then decreasing in higher age group. Also, in general all age group the female population is higher than male population.

**Population Distribution by Ethnicity**

According to National Population and Housing census 2068, 126 casts are listed in Nepal, but in accordance to ethnicity the province's population are distributed as Brahmin, Chhetri, Gurung, Kami, Newar, Sarki, Damai, Tamang and Tharu. Among these, 21.4% are Brahmin, 18.8% are Magar, Chhetri 13.3%, Gurung 11.4%, Kami 8.7% Newar 4.3% and Sarki are 4.1%. These casts cover 82% of total population of province.

**Table1.3: Caste wise Population of Gandaki Province**

| Name of caste | Population | Percent |
|---|---|---|
| Brahimin | 514839 | 21.4 |
| Magar | 452590 | 18.8 |
| Chhetri | 320749 | 13.3 |
| Gurung | 273944 | 11.4 |
| Kami | 208985 | 8.7 |
| Newar | 102585 | 4.3 |
| Sarki | 98274 | 4.1 |
| Damai | 92731 | 3.9 |
| Tamang | 50139 | 2.1 |
| Tharu | 41159 | 1.7 |
| Others | 247027 | 10.3 |
| **Total** | **2403022** | **100** |

***Population distribution by religion***

Most of the people of this province are Hindu, where 82.9% are Hindu and 13.6% are Buddhist. Hindu and Buddhist cover 96.58% of total population.

**Table 1.4: Population by religion**

| Religion | Population | percentage |
|---|---|---|
| Hindu | 1992106 | 82.9 |
| Buddist | 328733 | 13.7 |
| Christian | 37487 | 1.6 |
| Islam | 18503 | 0.8 |
| Bone | 12015 | 0.5 |
| Prokriti | 6488 | 0.3 |
| Other (not mention) | 7690 | 0.3 |
| **Total** | **2403022** | **100** |

**1.12 Economic situation**

Farming is the main occuoations for older generation peoples who grows rice, maize, millet, barley wheat and vegetables. At low altitudes including southern inner-Terai district, agriculture is the principal means of subsistence, while at higher altitudes agro-pastoralism and hotel business along the tourist routes are main economic activity. Many households maintain chickens and goats across the province. However, few families own more than a small number of cows, buffalo, goat, sheep, yaks because the mountainous topography does not provide grazing land for large herd size.

Foreign employment is the main occupation of young generation in the province particularly in the hill districts. Joining the British army was main occupation of young people particularly in Gurung and Magar community of the province. Recruitment of young people in British army decreased gradually after the Second World War as the British Empire squeezed to Europe due to independence of colonial nations. Since then, new area of foreign employment emerged to young people of the province. Since the independence of India in 1947, joining Indian army also became a lucrative destination for foreign employment. In addition, opening of labor market in Gulf countries, Malaysia, Singapore, South Korea and other East and South East Asian Countries for Nepalese young people since 1990, out migration of people in the province in search of job opportunity has been increasing.

Tourism is another important source of employment and income in the Province. Pokhara and Annapurna Circuit for Trekking lies in this province which is the main center for foreign tourist attraction. Pokhara alone has more than 3500 hotels and restaurants targeted to foreign and local tourists. In addition, there are several hotels and restaurants along the Annapurna circuit. Similarly, this province has famous religious place Muktinath the Hindu temple. Many Hindu and Buddhist pilgrims from South Asia as well as East and South East Asia visit these religious places. The tourism industry has sparked the commercial production of crafts and souvenirs and created a number of service positions. This sector absorbs a significant chuck of population in hotel and restaurant management, tourists guide and pottering to tourist along the trekking routes.

In addition to foreign employment and tourism, there are small scale service centers and a few government offices in province which are the main source of off-farm employment within the Province. This service sector absorbs small segment of active labor force.

*Educational Status:* Literacy Rate of Gandaki Province is 70.9. The net enrollment rate of primary level is 98.9 and basic level enrolment is 92.6, secondary level the enrolment rate is 40.6 which show the educational indicators are more improved than in the province in compared to national level. Secondary level teacher student ratio is 26 students per teacher. In this Province highest literacy rate is district in Kaski (82.4) and low literacy rate is in Lamjung (66.4). In Gandaki province total institutional school are 16.1 % and community school are 83.9%.

## 1.13 National health policy and plan

The National Health Policy 2076 is launched with the principle aim of upgrading the health standards of majority of the rural population by extending basic primary health services up to the village level and to provide the opportunity to the rural people to enable them to obtain the benefits of modern health facilities by making services accessible to them. This document focuses on policies to the function of the Department of Health Services in a view to understand and appreciate the goals, objectives, targets and other aspects related to the National Health Policy to combat the health problems and obtain the sustainable achievements in province.

### 1.14 Provincial health service delivery system

Provincial health system comprises all health organizations, institutions, and resources that are intended to produce health actions whose primary objective is to promote, restore and maintain

good health of people in the province. There is a Health Directorate, one Regional Hospital, one Tuberculosis Center, one Health Training Center, one Logistics health Management Center, one Province Public Health Laboratory in the Gandaki Province. Similarly, one Zonal Hospital, 10 District Hospitals and one community hospital one other hospital (Matrri sisu Miteri), Eleven Health Offices, one 50 beded Infectious and Communicable disease hospitals and Seven 15 beded hospitals at local levels. Twenty-five PHC, 62 UHC, 82 CHU, 487 HPs 2 zonal Ayurvedhalaya, 9 district Ayurveda centres 55 Ayurbeda Ausadhalayas ,5939 FCHVs, 319 Birthing centre, 13 BEONCs are in the province. In addition, there are two private medical college and teaching hospitals in the Province.

**Figure1.3: Provincial health Institutions**

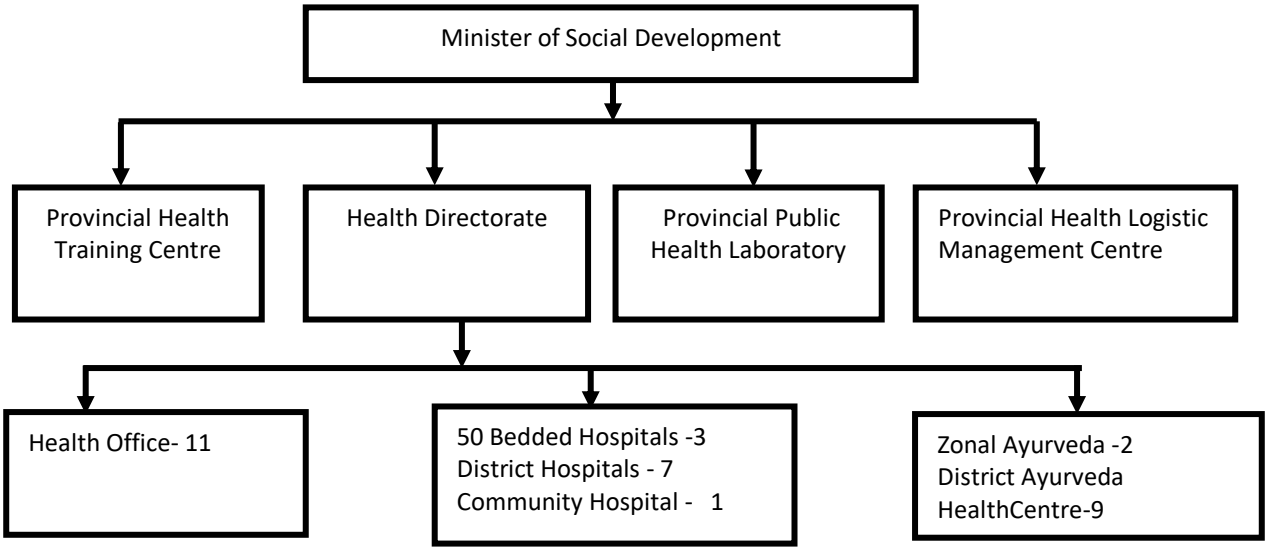
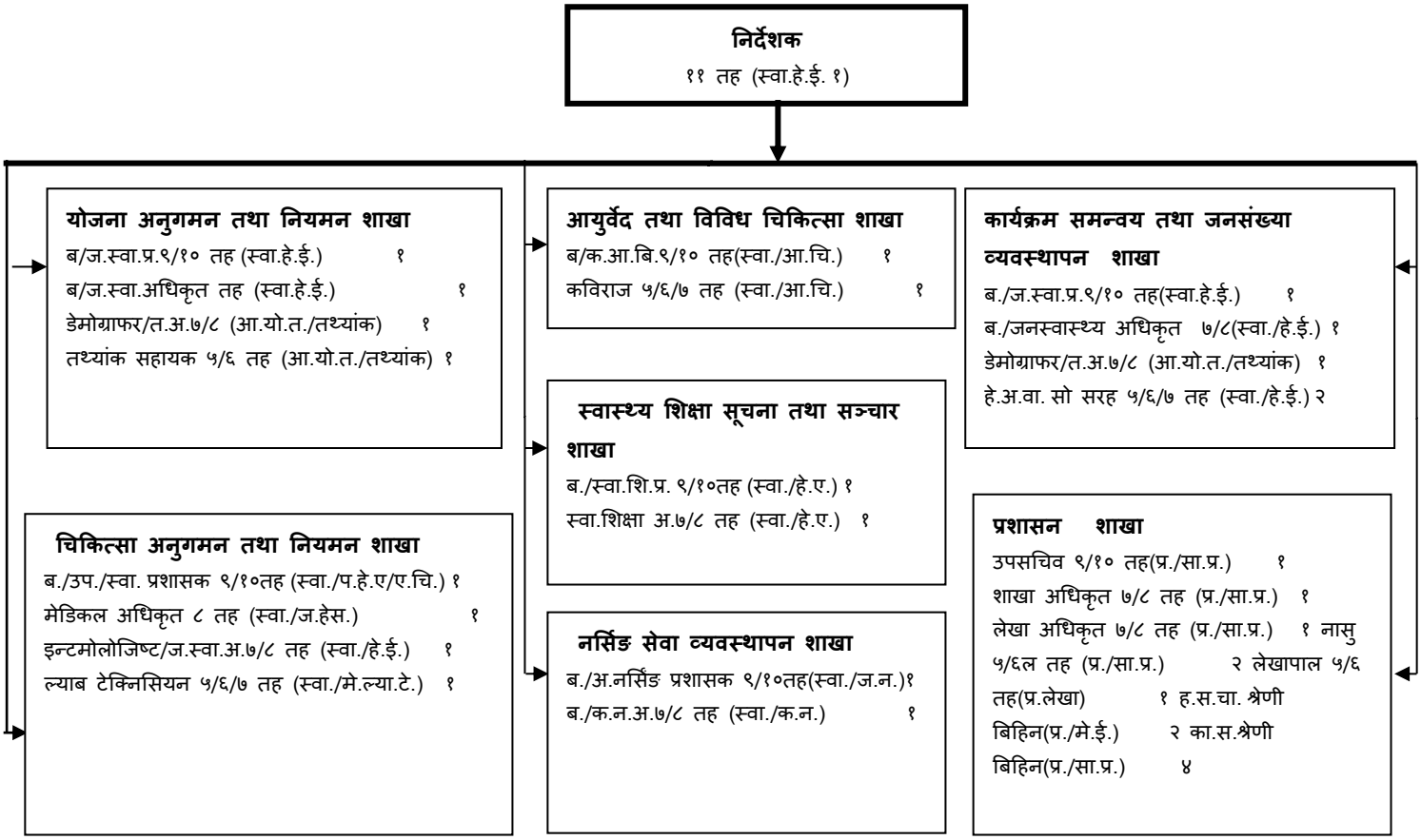



**Figure 1.5 Organogram of health directorate**



### 1.15 Role and responsibility of health directorate

The Constitution of Nepal 2072 endorsed health as basic fundamental right of people. Thus, health is the basic right of people by law. Primary health care services are provided according to the proclamation of the Alma Ata Declaration. Thus, health directorate has mainly the following objectives to serve people according to the spirit of the government and the people:

- To bring the preventive, curative and promotional health services up to the door steps of people
- Monitoring and supervision of health services

**Health Directorate working area**

Health Directorate is given the responsibility of monitoring, evaluation and quality control of

- Allopathic medicine
- Alternative and Ayurvedic medicine
- All health services and activities conducted by public and private sector health institutions

**Major activities of Health Directorate**

- Develop annual work plan according to the policy and directions of MOHP& Ministry of Social Development.
- Assist to implement National policy, provincial health policy by analyzing the available health services in the province.
- Develop the provincial level program taking into consideration the district level program and report to the central authority
- Conduct necessary monitoring and supervision of district level program and provide feedback.
- Collect and compile monthly progress report of the health program from all district (public) health offices
- Follow up of the districts which do not send monthly progress
- Consult and coordinate with all private and non-governmental organizations in the province and provide support to them.
- Monitoring and supervision of existing programs in the province.
- Develop working relations with NGOs/INGOs and coordinate with department of health services if formal agreements are to be made with the former.
- Identify basic and refresher training needs to various level of health workers in the province and consult with relevant training centers for the arrangements of the training.
- Prepare budget estimates in coordination with the health offices Hospitals, Ayurveda centres regarding the construction and repair of physical facilities
- Maintain personal records of the staff within the province, manage staff transfer in the province in accordance with the existing policy of MoHP and Ministry of Social Development.
- Manage leave applications of all Health Office Hospitals and Ayurved Centers heads within the province (except for special leaves and study leaves)
- Recommend for scholarships/foreign tours/observation tours etc. using the criteria set by MOHP

- Monitor and control the financial transaction in the district level as per need. Enforce the implementation of audit report and take action to those who do not clear their advances and financial irregularities as per the existing financial rules or recommend to the centre for necessary action.
- Print and distribute the forms provided by Policies to district Health Offices, Hospitals and Ayurveda Centers.
- Similarly, if non- officer level staff(administrative) positions remain vacant or new positions are created and if Public Service Commission transfers the authority, promote qualified staff to these vacant positions
- Provide administrative leadership to all health offices under the provincial health directorate.

**Key health program supported and supervised by Health Directorate**

- National Immunization Program (BCG, DPT/Hep B/Hib, Polio, Measles, JE, TT, etc.)
- National Nutrition Program (Growth monitoring, Infant and Young Child Feeding, Deworming, Vitamin A distribution, Iron supplementation, Iodine supplementation)
- IMNCI (ARI, Diarrheal Disease)
- Safe Motherhood (ANC, Delivery Service, PNC, CAC, PAC)
- Family Planning programs/services.
- Prolapse screening and surgery
- Adolescent Sexual and Reproductive health
- Elderly population health services
- Gender based violence
- Sub fertility management
- New born care
- Population Program
- FCHVs management
- PHC-ORC services
- Tuberculosis control program
- Leprosy elimination programes
- Malaria control program
- Kalazaar elimination program
- Japanese Encephalitis control
- HIV /AIDS/STI program
- Animal bites and Rabies Control
- Epidemic Outbreak and Disaster Management
- Capacity enhancement to staffs
- Health Education program
- Special Health/Mobile health service
- Private Hospitals/Nursing Home/NGO regulation
- Mental Health Program
- Health Promotion for Non-Communicable Diseases program
- Curative Service

**Table 1.5 Service Sites/Points of Province**

| S.N. | Details | Number | S.N. | Details | Number |
|---|---|---|---|---|---|
| 1 | Hospital | 16 | 15 | PMTCT Centre | 410 |
| 2 | PHCC | 24 | 16 | IUCD | 157 |
| 3 | Helth post | 487 | 17 | IMPLANT | 189 |
| 4 | Zonal Ayurved | 2 | 18 | Birthing Centre | 319 |
| 5 | District Ayurved | 9 | 19 | BEONC | 30 |
| 6 | Ayu.Ausadhalaya | 55 | 20 | CEONC | 18 |
| 7 | UHC | 62 | 21 | DR Centre | 3 |
| 8 | CHU | 82 | 22 | DR Sub centre | 6 |
| 9 | PHC-ORC | 1375 | 23 | DR home | 1 |
| 10 | EPI Clinic | 1787 | 24 | Gene-Xport Centre | 4 |
| 11 | FCHV | 5863 | 25 | CD4 Centre | 3 |
| 12 | Medical Abortion Centre | 119 | 26 | ART Centre | 10 |
| 13 | CAC | 42 | 27 | HTC | 10 |
| 14 | TB Microspic | 50 | 28 | NRH | 3 |

Health directorate provides technical assistance to districts to implement above mentioned programs by a team of staffs as mentioned. According to the constitution the role of health directorate is to provide health service within the province under ministry of social development. Health Directorate coordinate with local level to provide service in technical support in the local level with training, health camp, and other capacity enhances program.

### 1.16 Importance of this Annual Health Report

This Annual Health Report compiles and summarizes the performance of all promotive, preventive and curative health services implemented by all public health institutions, private for profit and non-profit health institutions working in partnership with public health institutions in Gandaki province catchment area over the year. This report helps to understand the physical and financial performance of the districts over the years, situation of basic health indicators in the province and helps to further analysis and planning. Therefore, this report has significant importance to understand the provincial health system and its performance.

This report analyses the performance and achievements of Health Directorate in the fiscal year 2075/76 BS. It mainly deals with the program specific policies, goal, objectives, strategies, major activities and achievement. It also presents the problems/issues/constraints raised by different wings of HD and stakeholders and recommendation for actions to be taken in order to improve performance and targets for the next fiscal year.

In addition, this report also provides information on contributions from other departments, partners and stakeholders, contemporary issues in the health sector as well as progress status of major programs implemented through HD, HOs Hospitals and Ayurveda centers.

### 1.17 Objectives of this report

This annual health report has six objectives as follows:

- To assess the performance of the districts on implementation of planned activities
- To assess and compare the financial and physical progress made by the districts
- To assess the trend of health indicators in the province.
- To identify weak area and help the planners and policy makers to focus on weaker program.
- To provide information on performance of provincial health system to the planners, policy makers, programmers, managers, service providers, researchers, academia, stakeholders and general population
- To help planner for better planning using the information pertaining in this report

### 1.18 Target audience of report

Major target audience of this report are policy makers, health planners, program managers, provincial, district and community level policy political leaders and policy makers, service providers, external development partners, INGO, NGO and CBO, university teacher and student, researcher, academia, foreign visitors, stakeholders, social workers and general people who have interest.

### 1.19 Process Adopted to Prepare this Report

Several steps had been taken for preparation of this Annual report. Local level review meetings were completed at first then district level annual review meeting was conducted where the problems and issues of health system were discussed. Then finally, provincial level annual performance review meeting was conducted in pokhara.

The provincial review meeting was attended by the Health Directorate, on recommendation of MoHP, Divisions of DoHS, Ministry of Social Development, in the presence of Health office, Hospitals,

Ayurveda Centers, and representatives from External Development Partners and NGOs/INGOs at each level. During the review meeting at Province policy guidelines of each program with achieved health indicator were presented, discussed and analyzed. Raw data extracted from HMIS (or DHIS-2) were carefully and critically analyzed and interpreted.
The provincial annual performance review meeting has:

- Reviewed the status of health indicators and achievement against the set target for the FY 2076/77 with respect to released budget and expenditure
- Compared trend of service coverage of the FY 2076/77 with previous two successive fiscal years and analyze the fact
- Reviewed the status of implementation of recommendation made by the previous provincialannual performance review meting
- Identified management issues/problems/constraints in implementing the program andsuggested recommendations and specific strategy and actions plans to address those issues
- Facilitated the process of generating specific strategies for low coverage districts to boost up their coverage and moderating on specific action plan to scale up the level of achievement and highlight the best performing districts to be replicated to achieve most advantageous results
- Interaction among Districts/Province/Department of Health Services/Ministry of Health and Populationand External Development Partners (EDPs)

Based on analysis, discussion and recommendation made in this annual provincial performance review meeting the data are further analyzed, interpreted and this report is prepared.

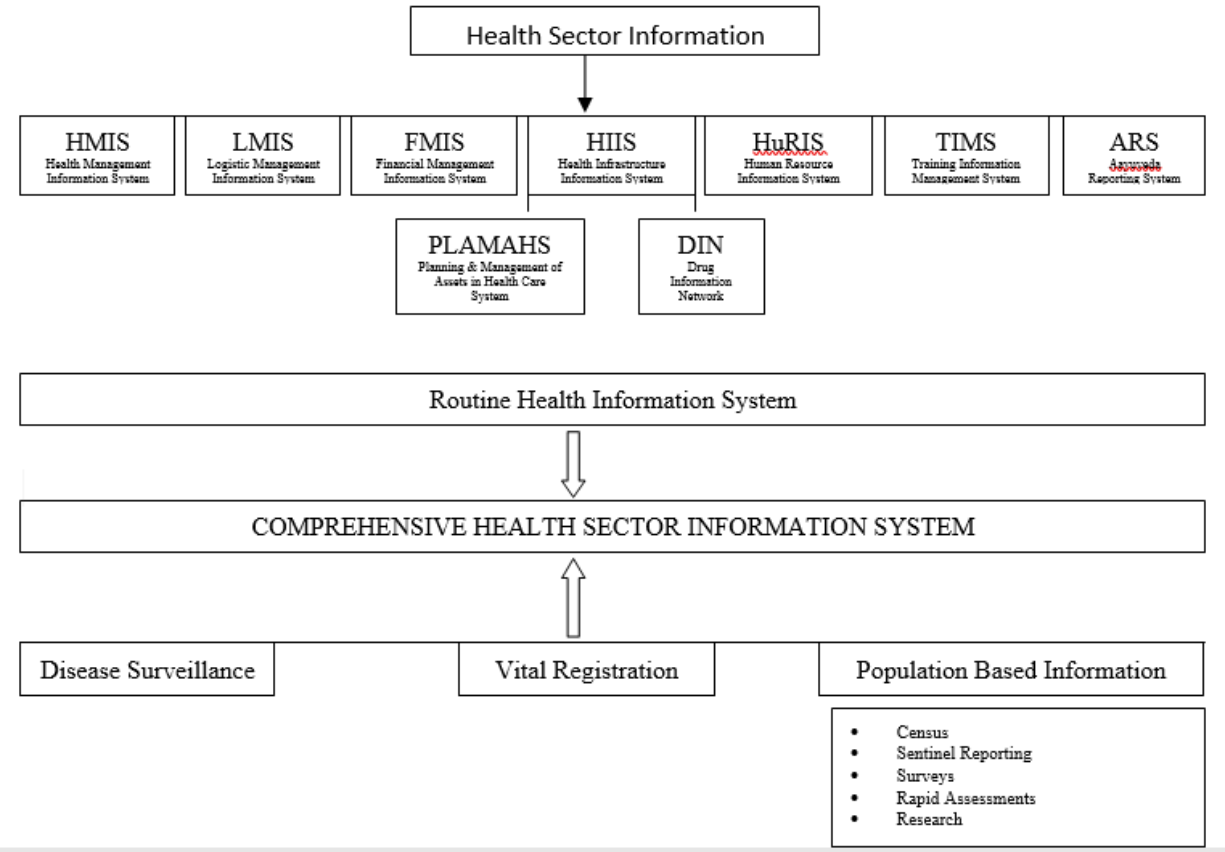
### 1.20 Data collection and reporting process

FCHVs are volunteers who provide Health services in the community and maintain record at pictorial HMIS 4.2 FCHV register; this collects data from the FCHV registers and their outreach services. Health Post, PHC, compiles HMIS 9.3 and report to local level on monthly basis for the entry in DHIS-2. In addition, the District Hospital, Provincial and National level hospitals and including other public and non-public hospitals submit HMIS 9.4. Hospital based data entry by themselves. HO, District hospitals and other hospitals prepare annual reports base on received data as entered in the HMIS software. Health Directorate monitors and supervises public health programs; ensure timely data entry from local level and hospitals to the DHIS-2 software regularly. Participate in district and other reviews and perform provincial review based on analyzed data received from the designated web-based software. The internet access is restricted and needs a password to access the HMIS data.

### 1.21 Sources of information of this report

Sources of information of this report include health management information systems (HMIS), disease surveillance, vital registration, census, sentinel reporting, surveys, rapid assessments, and research (Figure 1.4). The MIS within the health sector include the Health Management Information System (HMIS); Logistical Management Information System (LMIS); Financial Management Information System (FMIS); Health Infrastructure Information System (HIIS); Planning and Management of Assets in Health Care System (PLAMAHS); Human Resource Information System (HuRIS); Training Information Management System (TIMS); Ayurveda Reporting System (ARS); and Drug Information Network (DIN).

***Figure 1.5: Sources of Health Sector Information***




**1.22 SDGs and indicators:**

**SDG Goals**

1. No poverty
2. Zero hunger
3. Good health and well being
4. Quality education
5. Gender equality
6. Clean water and sanitation
7. Affordable and clean energy
8. Decent work and economic growth
9. Industry innovation and infrastructure
10. Reduce inequalities
11. Sustainable cities and communities
12. Responsible consumption and production
13. Climate action
14. Life below water
15. Life and land
16. Peace justice and strong institutions
17. Partnerships for the goals

**SDG Targets:**

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming toreduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.

3.8 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.

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

3.10a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.

3.10b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

3.10c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

3.10d Strengthen the capacity of all countries, in developing countries, for early warning, risk reduction and management of national and global health risks.

# Section 2

# FAMILY WELFARE

## 2.1 Child Health Program

### Background

The government of Nepal, Ministry of Health& Population has given high priority to Child Health Program. This contains three programs including National Immunization Program, Nutrition Program and CB-IMCI Program. Immunization is considered as one of the most cost- effective Public health interventions. The Government of Nepal, MOHP as well as the Ministry of Social Development Gandaki Province is committed to reduce morbidity and mortality from vaccine preventable diseases, nutritional problems and other child related diseases.

The National Immunization Program (NIP) is a priority 1 (P1) program of the Government of Nepal. Launched as the Expanded Program on Immunization in 2034 BS (1977/78), the National Immunization Program has met several milestones, including Millennium Development Goal 4 (MDG 4) on reducing under-5 mortality. Eleven antigens are provided through the national program to eligible infants, children and mothers through more than 16,000 outreach sessions, including in geographically and economically hard-to-reach and marginalized communities. The initiative of Reaching Every Child and declaring VDCs, municipalities and districts as fully covered was initiated in 2012 to search for and vaccinate never reached and dropout children. Till date, 58 districts have been declared fully immunized. Gandaki Province was declared first fully immunized province of Nepal in 2075 Bhadra 13.

Japanese encephalitis mass vaccination has been conducted in 44 non-JE introduced districts. Now onwards all 77 districts have introduced JE vaccine in routine immunization. A successful Human Papilloma Virus (HPV) vaccine demonstration project was implemented in Kaski and Chitwan during the same period. The Comprehensive Multi-Year Plan of Action (CMYPOA for 2012–16) ended in 2016 and the new Comprehensive Multi-Year Plan (CMYP, 2017-2021) has been prepared.

Ministry of Health and Population (MOHP), the Child Health and Immunization Section of Family Welfare Division (FWD), has now introduced Rotavirus vaccine (RVV) in routine childhood immunization programme to combat against diarrheal diseases in the National Immunization Programme (NIP) of Nepal on 2 July 2020. With this new vaccine introduction, all children in Nepal would now be protected against 12 vaccine preventable diseases. All infants will get RVV in Nepal against Rotavirus diarrhea along with messages to mothers on hygiene promotion practices. Similarly, in Gandaki Province Rota vaccine along with hygiene promotion integration was successfully introduces during of COVID-19 pandemic on 7 February 2020.

NIP under Child Health Division has a lead role in all immunization related activities at the National level. Similarly, Logistic Management Division play meaningful role in NIP for supplying vaccine and NIP related logistics. At the provincial level, Health Directorate acts as a facilitator between the Central, Gandaki Province Ministry and the District levels and monitors the achievement within the province to improve the NIP. It is the responsibility of the Health Office to ensure that a successful immunization program is implemented at the district and below level. Primary Health Care Centers and Health Posts implement immunization programs in their respective catchment areas by extending the NIP clinics following their micro-plan.

On the basis of HMIS data, NIP monitors the coverage of each antigen, drop out against DPT-HepB-Hib1 vs. DPT-HepB-Hib3, DPT-HepB-Hib1 vs. MR1 and BCG vs. MR and vaccine wastage at all levels and sends monthly feedback to the area of concern. Thus, the information received are analyzed at different levels and used for corrective actions. In addition to HMIS, surveillance information on vaccine preventable diseases (AFP, Measles-like illnesses, MNT and AES) is reported through integrated Vaccine Preventable Diseases (VPD) surveillance system supported by WHO/IPD as well. In surveillance, data are collected through zero reporting, monthly reporting and the sentinel sites. Similarly, any outbreak of vaccine preventable diseases is reported through both the HMIS and integrated surveillance network. Achieving and sustaining high coverage of all vaccines in all the districts is the motto of NIP. The decreasing and sometimes fluctuating immunization coverage trend in previous few years has become a concern for all. At present, the immunization coverage of all antigens is decreased but over 80% which is still satisfactory. It means that immunization coverage achieved the national standard.

### 2.1.1 National Immunization Program

#### Goal, Objectives, Target and Strategy -NIP

The goal of NIP is to reduce child mortality, morbidity and disability associated with vaccine preventable diseases.

The strategic objectives of NIP (2017-2021)

- Reach every child for full immunization;
- Accelerate, achieve and sustain vaccine preventable disease control, elimination and eradication;
- Strengthen immunization supply chain and vaccine management system for quality immunization services;
- Ensure financial sustainability for immunization program;
- Promote innovation, research and social mobilization activities to enhance best practices

#### Targets Groups

- All infants (under one year) for BCG, DPT-HepB-Hib, OPV, fIPV, PCV and MR vaccine
- All pregnant women for Td vaccine
- All children age 12-23 month for JE
- MR second doses in 15 months children

#### Strategies

The strategies to achieve the above-mentioned objectives are as follow:

- Increase access and utilization of immunization implementation micro-plan
- Enhance Human resources capacity for immunization management
- Strengthen monitoring system, social mobilization and advocacy activities
- Strengthen immunization services in municipalities
- Achieve and maintain certification standard AFP surveillance
- Strengthen surveillance system
- Introduction of new and underused vaccines
- Consider of booster dose of currently used antigens based on evidence
- Strengthen and expand laboratory support for surveillance

**Supplementary immunization activities**

Polio eradication is a priority program of the government of Nepal. Nepal is one of the signatories of the polio eradication initiative. Nepal is conducting NIDs since FY 2053/54 except 2061/62 (2005) and 2069/70 (2012). In 2061/62 (Technical Consultative Group, 2005) recommended that Nepal need not to continue with NID. In addition to NID, Nepal has been conducting outbreak response immunization activities in response to each detected wild polio case as per national guidelines but now it has been changed with no need of ORI at any AFP case. AFP surveillance meets the globally recommended targets. Besides NIDs, the GoN conducted the Measles catch-up campaign one time and follow up campaign before but in 2069/70, MR campaign was successfully finished in this province, the targeted population was under fifteen children for catch-up and under-five for follow up campaign. Similarly, in F/Y 2072/73, Nepal conducted MR follow-up and JE campaign was successfully conducted. From the F/Y 2073/74, JE vaccine was introduced on a routine basis. Similarly, routine base Rota Vaccine Immunization has been introduced from F/Y 2077/78

**Performance in Child Health Program**

Performance in child health program is analyzed by major indicators set in national policy in following sections.

**Performance in National Immunization Program**

Performance in immunization program is analyzed based on HMIS data downloaded from DHIS-2 software.

**2.1.1.1 National Immunizaion Program Conducted**

In Gandaki Province for FY 2076/77 for each month 1,740 Immunization clinics were targeted. The percentage of NIP clinic conducted in F/Y 2074/75 and 2075/76 remains the same which is 97% whereas, it is decreased in F/Y 2076/77 which is 90% only. In F/Y 2076/77 only Myagdi, Lamjung, Tanahun, Syangja and Baglung districts have crossed the 90%. (Table 2.1).

**Table 2.1: NIP Clinics Conducted**

| Districts | Targeted NIP clinic in a month | percentage of NIP clinic conducted in 2074/75 | percentage of NIP clinic conducted in 2075/76 | percentage of NIP clinic conducted in 2076/77 |
|---|---|---|---|---|
| Gorkha | 227 | 93 | 91 | 88 |
| Manang | 15 | 94 | 85 | 89 |
| Mustang | 24 | 87 | 85 | 81 |
| Myagdi | 114 | 96 | 98 | 92 |
| Kaski | 222 | 96 | 96 | 88 |
| Lamjung | 201 | 100 | 100 | 91 |
| Tanahun | 227 | 97 | 99 | 91 |
| Nawalparasi East | 134 | 99 | 100 | 93 |
| Syangja | 242 | 95 | 98 | 93 |
| Parbat | 175 | 95 | 99 | 88 |
| Baglung | 159 | 99 | 100 | 92 |
| **Gandaki Province** | 1740 | 97 | 97 | 90 |

***Source: HMIS/DHIS-2***

#### 2.1.1.2 BCG Vaccine Coverage

BCG coverage shows a decreasing trend in Gandaki Province. The coverage was 73%, 72% and 66% in last 3 fiscal years respectively. The highest coverage is in Kaski (90%) while the lowest coverage is in Manang (16%) in F/Y 2076/77. Although the province is declared fully immunized, except for three districts, all show a decreasing trend in BCG coverage.

**Table 2.2: BCG vaccine Coverage (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 67 | 68 | 60 |
| Manang | 27 | 14 | 17 |
| Mustang | 44 | 58 | 43 |
| Myagdi | 82 | 73 | 68 |
| Kaski | 101 | 103 | 90 |
| Lamjung | 71 | 60 | 60 |
| Tanahun | 58 | 52 | 48 |
| Nawalparasi East | 63 | 70 | 68 |
| Syangja | 60 | 58 | 60 |
| Parbat | 59 | 54 | 50 |
| Baglung | 78 | 74 | 64 |
| **Gandaki Province** | **73** | **72** | **66** |

***Source: HMIS/DHIS-2***

### 2.1.1.3 DPTHepB Hib III Vaccine Coverge

The objective of NIP is to cover every child by all antigens by 2021. In a given target, none of district has crossed the 80% Penta III coverage in this fiscal year. In three years, DPTHepB Hib III coverage has fluctuation trend however, it has decreased by 5% as compared to last year (2075/076). (Table 2.3).

**Table 2.3: DPTHepBHib III VaccineCoverage (%)**

| **Districts/FY** | **2074/75** | **2075/76** | **2076/77** |
|---|---|---|---|
| Gorkha | 75 | 80 | 74 |
| Manang | 43 | 48 | 38 |
| Mustang | 67 | 62 | 58 |
| Myagdi | 82 | 76 | 72 |
| Kaski | 71 | 73 | 64 |
| Lamjung | 75 | 68 | 63 |
| Tanahun | 69 | 69 | 62 |
| Nawalparasi East | 64 | 80 | 77 |
| Syangja | 77 | 73 | 75 |
| Parbat | 70 | 70 | 65 |
| Baglung | 76 | 77 | 69 |
| **Gandaki Province** | **72** | **74** | **69** |

***Source: HMIS/DHIS-2***

### 2.1.1.4 PCV3 Vaccine Coverage

The total average coverage of PCV3 vaccine in the Gandaki province is 70% in FY 2076/77. The coverage in this F/Y 2076/77 is decreased by 4% compared to last F/Y 2075/76. The range for the coverage is from 32% (in Manang) to 80% (in Nawalparasi East) in the current year.

**Table 2.4: PCV3 Vaccine coverage (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 72 | 77 | 74 |
| Manang | 42 | 46 | 32 |
| Mustang | 69 | 65 | 55 |
| Myagdi | 80 | 81 | 71 |
| Kaski | 72 | 74 | 65 |
| Lamjung | 74 | 71 | 66 |
| Tanahun | 68 | 68 | 64 |
| Nawalparasi East | 65 | 79 | 80 |
| Syangja | 75 | 70 | 74 |
| Parbat | 66 | 70 | 64 |
| Baglung | 77 | 76 | 71 |
| **Gandaki Province** | **71** | **74** | **70** |

***Source: HMIS/DHIS-2***

### 2.1.1.5 Measles/ Rubella Vaccine Coverage (%)

MR vaccine both first and second dose coverage is in fluctuating trend over the last three years period. In the last three years, MR-I was 71, 74 and 70 in this province, whereas MR-II was 70, 77 and 75 in 2074/75, 2075/76 and 2076/77 respectively.

**Table 2.5: Measles Rubella vaccine coverage (in %)**

| Districts/FY | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| | Measles/Rubella 1 | Measles/Rubella 2 | Measles/Rubella 1 | Measles/Rubella 2 | Measles/Rubella 1 | Measles/Rubella 2 |
| Gorkha | 73 | 76 | 76 | 81 | 75 | 85 |
| Manang | 43 | 45 | 48 | 29 | 31 | 25 |
| Mustang | 72 | 53 | 71 | 64 | 64 | 60 |
| Myagdi | 82 | 77 | 82 | 83 | 71 | 78 |
| Kaski | 71 | 66 | 74 | 72 | 65 | 64 |
| Lamjung | 74 | 68 | 70 | 76 | 65 | 71 |
| Tanahun | 67 | 66 | 68 | 73 | 64 | 73 |
| Nawalparasi East | 65 | 68 | 80 | 85 | 80 | 88 |
| Syangja | 75 | 77 | 70 | 77 | 75 | 80 |
| Parbat | 66 | 68 | 70 | 74 | 64 | 69 |
| Baglung | 77 | 78 | 77 | 80 | 72 | 77 |
| **Gandaki Province** | **71** | **70** | **74** | **77** | **70** | **75** |

***Source: HMIS/DHIS-2***

### 2.1.1.6 Japanese Encephalitis Vaccine Coverage percentage

The total provincial JE coverage of F/Y 2076/077 has a fluctuation trend over the three years. It has decreased slightly in FY 2076/077, in comparison to FY 2075/076. Comparatively, Gorkha, Nawalparasi East, Syangja and Baglung have high JE coverage (more than 80%) but the other seven districts have coverage lower than 80%. The Nawalparasi East has the highest coverage (90%) and the Manang district has the lowest coverage (25%) of JE vaccination in FY 2076/077.

**Table 2.6: Japanese Encephalitis vaccine coverage (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 87 | 83 | 87 |
| Manang | 45 | 32 | 25 |
| Mustang | 76 | 59 | 61 |
| Myagdi | 94 | 90 | 78 |
| Kaski | 78 | 76 | 69 |
| Lamjung | 81 | 81 | 73 |
| Tanahun | 78 | 74 | 71 |
| Nawalparasi East | 82 | 89 | 90 |
| Syangja | 90 | 80 | 82 |
| Parbat | 82 | 79 | 71 |
| Baglung | 94 | 85 | 84 |
| **Gandaki Province** | 83 | 80 | 78 |

***Source: HMIS/DHIS-2***

### 2.1.1.7 Fully Immunized Children

Gandaki province is declared as a fully immunized province on 2075/05/13 but the percentage of children fully immunized as per the NIP schedule is only 61 in 2076/77, which is same as the F/Y 2075/76.

**Table 2.7: Fully immunized children covarage as per NIP schedule (in %)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 69 | 66 | 75 |
| Manang | 61 | 47 | 42 |
| Mustang | 60 | 53 | 61 |
| Myagdi | 76 | 76 | 61 |
| Kaski | 42 | 45 | 43 |
| Lamjung | 75 | 70 | 64 |
| Tanahun | 55 | 52 | 60 |
| Nawalparasi East | 66 | 75 | 77 |
| Syangja | 70 | 66 | 67 |
| Parbat | 55 | 56 | 60 |
| Baglung | 111 | 69 | 60 |
| **Gandaki Province** | **66** | **61** | **61** |

***Source: HMIS/DHIS-2***

### 2.1.1.8 Access and utilization of Immunization services

All 11 districts are in category 3rd in F/Y 2076/77, at Gandaki Province.

**Table 2.8: Districts categorized based on DPT-HepB-Hib1 coverage and DPT-HepB-Hib1 vs DPT-HepB-Hib3 dropout rate**

| Category 1 (No Problem) High coverage (>80%) Low dropout (<10%) | Category 2 (Problem) High coverage (>80%) High dropout (>10%) | Category 3 (Problem) Low coverage (<80%) Low dropout (<10%) | Category 4 (Problem) Low coverage (<80%) High dropout (>10%) |
|---|---|---|---|
| | | **Gorkha, Parbat Syangja Tanahun Kaski, Lamjung, Nawalparasi East, Myagdi, Mustang, Manang** | |

**Note: Based on 80% DPT-HepB-Hib1 coverage and dropout of DPT-HepB-Hib1 vs DPT-HepB-Hib3 as of 10%**

### 2.1.1.9 Dropout Rate

The dropout rates for different vaccines are below 5% in the province in FY 2076/077. However, the dropout rates vary from -88.2 to -4.2 for the dropout of BCG vs Measles.

**Table 2.9: Dropout rate BCG vs Measles I % & Dropout rate DPT Hep B Hib I vs III %**

| Districts/FY | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| | Drop out BCG vs Measles | Drop out DPT-HepB-Hib 1 vs 3 | Drop out BCG vs Measles | Drop out DPT-HepB-Hib 1 vs 3 | Drop out BCG vs Measles | Drop out DPT-HepB-Hib 1 vs 3 |
| Gorkha | -9.1 | 0.61 | -10.5 | -0.55 | -24.5 | 3.1 |
| Manang | -62.1 | -4.4 | -240 | -59.4 | -88.2 | -21.9 |
| Mustang | -64.4 | -14.4 | -23.3 | -5.9 | -49.5 | 0 |
| Myagdi | -0.19 | 4.3 | -12.6 | 1.7 | -4.2 | 4.6 |
| Kaski | 29.6 | 2 | 27.8 | -0.23 | 27.3 | 3.6 |
| Lamjung | -4.2 | 1.7 | -17.1 | 1.8 | -8.5 | 6.1 |
| Tanahun | -16 | 4.1 | -30 | 1.8 | -33.3 | 5 |
| Nawalparasi East | -4.2 | 4.8 | -14 | 2.6 | -17.4 | 4.2 |
| Syangja | -24.5 | 5.1 | -22 | 6.1 | -24.3 | 2.7 |
| Parbat | -11.9 | 6.9 | -29 | 1.3 | -29.3 | 0.96 |
| Baglung | 1.7 | 6.8 | -4.6 | 5 | -12.5 | 3.2 |
| **Gandaki Province** | 2.5 | 3.8 | -2.9 | 2 | -6 | 3.7 |

***Source: HMIS/DHIS-2***

### 2.1.1.10 Vaccine Wastage

Table 2.10 shows the district wise wastage rate of vaccine used in NIP in the fiscal year 2076/077. The wastage rate of all antigens is more than the national acceptable level. Status of this province and national acceptable level of different antigen are as follows: BCG; 85% (50), Penta; 31% (15), OPV; 32% (15), PCV; 19% (5), MR; 56% (30), JE; 53% (15) and TD; 43% (15). The reason behind the high vaccine wastage rate of DPT-HepB-Hib, OPV and TD could be due to remote geographical areas where multi-dose vial policy cannot be practiced. In the case of BCG, MR, IPV and JE , high because MR and BCG vials contain a higher number of doses than the number of target groups of children. the session size is small but the presentation of BCG and MR vial is big. Similarly, in the case of JE vaccine, it should be discarded within 1 hour of dilution.

**Table 2.10: Vaccine wastage rate**

| Vaccine wastage rate in 2076/077 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Districts** | **BCG** | **DPT-Hep B-Hib** | **Measles/Rubella** | **PCV** | **Polio (OPV)** | **Polio (FIPV)** | **JE** | **TD** |
| Gorkha | 89 | 32 | 62 | 21 | 33 | 41 | 59 | 48 |
| Manang | 94 | 83 | 84 | 63 | 82 | 71 | 64 | 82 |
| Mustang | 94 | 73 | 80 | 49 | 73 | 68 | 75 | 84 |
| Myagdi | 88 | 38 | 65 | 25 | 39 | 41 | 60 | 56 |
| Kaski | 72 | 18 | 43 | 11 | 19 | 26 | 40 | 11 |
| Lamjung | 86 | 41 | 66 | 21 | 42 | 43 | 60 | 57 |
| Tanahun | 89 | 38 | 61 | 27 | 38 | 43 | 61 | 52 |
| Nawalparasi East | 80 | 19 | 39 | 11 | 19 | 23 | 41 | 29 |
| Syangja | 88 | 35 | 62 | 19 | 35 | 37 | 58 | 43 |
| Parbat | 91 | 42 | 66 | 24 | 44 | 43 | 62 | 62 |
| Baglung | 85 | 33 | 52 | 21 | 33 | 33 | 51 | 45 |
| Gandaki Province | 85 | 31 | 56 | 19 | 32 | 35 | 53 | 43 |

**Source: DHIS-2**

### 2.1.1.11 Some Innovative Works Initiated by the Health Directorate

- Declaration of "Fully Immunized Province"
- Partnership with local governments to resolve the issues of human resources and financial sustainability
- Onsite coaching and strong feedback system
- Reaching every child – micro-planning and local contract of vaccinators
- Supportive supervision and monitoring to NIP clinics

**Table 2.11 Gap analysis in Child Health**

| *Performance Gaps* | *Causes/ Reasons* | *Recommended Actions for improvements* | **Responsible** |
|---|---|---|---|
| • Low performance in targeted activities | • Weak local level Work Plan | • Prepare timeline work plan and follow accordingly<br>• Strictly follow up and technical support from higher authorities | • Local Level<br>• Province |
| • Decreased immunization coverage | • Target population not matched | • Revisit target population<br>• Conduct and validate household surveys every year and publish | • Local Level |
| • Error in data (re-cording & reporting) | • Lack of trainings | • Onsite coaching on recording reporting<br>• Supervision on service delivery outlets<br>• DQSA<br>• Training t new staff | • Local Level<br>• Province |

### 2.1.2 Nutrition Program

**Background**

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

**Malnutrition in Nepal**

The high rate of child under-nutrition in Nepal remains a major problem despite a steady decline in recent years. Maternal malnutrition is also a problem with 18.2 percent of mothers suffering chronic energy deficiency alongside the increasing trend of overweight mothers. Although Nepal's efforts in micronutrient supplementation such as the National Vitamin A Program have been globally recognized as a successful program, nutritional anemia remains a serious public health issue among women and children. Thirty six percent of children under age 5 are stunted (short for their age), 10% are wasted (thin for their height), 27% are underweight (thin for their age), and 1% are overweight (heavy for their height) according to NDHS 2016.). More than half (53%) of the children age 6-59 months and 41% of women reproductive age are anemic (NDHS 2016).

**Goal**

The overall goal of the national nutrition program is to achieve the nutritional well-being of all people to maintain a healthy life to contribute to the socio-economic development of the country through improved nutrition program implementation in collaboration with relevant sectors.

**Objectives**

**General objective**

The general objective of the national nutrition program is to enhance nutritional well-being, reduce child and maternal mortality, and contribute towards equitable human development.

**Specific objectives**

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

**Strategies**

- Control of Protein Energy Malnutrition (PEM)
- Control of Iron Deficiency Anemia
- De-worming
- Control of Iodine Deficiency Disorder
- Control of Vitamin A Deficiency (VAD)
- Control of Low Birthweight
- Promotion of Household Food Security
- Improve dietary practices
- Infectious Diseases Prevention and Control
- School Health and Nutrition program

- Integrated Management of Acute Malnutrition
- Nutrition in Emergency
- Control of Lifestyle Related Diseases

**Nutrition Targets and Current Status:**

Nepal has developed its nutrition targets to achieve by 2030 which is based on the SDG and nutrition targets set by the Global Health Assembly for nutrition. The status of provincial and national indicators along with the targets of MSNP 2022, World Health Assembly 2025, and Sustainable Development Goal 2030 are shown in the table below:

**Table 2.12: Nutrition Targets and Current Status**

| Indicators | Gandaki Province Status | National Status | Targets | | |
|---|---|---|---|---|---|
| | | | MSNP II 2022 | WHA 2025 | SDG 2030 |
| Prevalence of stunting among under 5 years children | 23 | 31.5 | 28 | 24 | 15 |
| Prevalence of wasting among under 5-year-old children | 8 | 12 | 7 | <5 | 4 |
| Prevalence of underweight among under 5-year-old children | 15 | 24.3 | 20 | 15 | 10 |
| Prevalence of low birth weight | 10* | 12.3* | 10 | ≤1.4 | ≤1.4 |
| % of children under 6 months with exclusive breastfeeding | 58.4 | 62.1 | 80 | 85 | 90 |
| % of children aged 6-23 months having a minimum acceptable diet | 40 | 31 | 60 | 70 | 80 |
| Anaemia among children aged 6-59 months | 46* | 53* | 28 | 20 | <15 |
| Anaemia among WRA (15-49 years) | 28* | 41* | 24 | 20 | <15 |
| % of women (WRA) with chronic energy deficiency (measured as body mass index <18.5 kg/m2) | 8.1* | 17* | 12 | 8 | <5 |
| % of overweight and obese women of reproductive age (WRA) | 31.6* | 22* | 18 | 15 | <12 |

***Source: NMICS 2019; *NDHS 2016***

**Nutrition Programmes:**

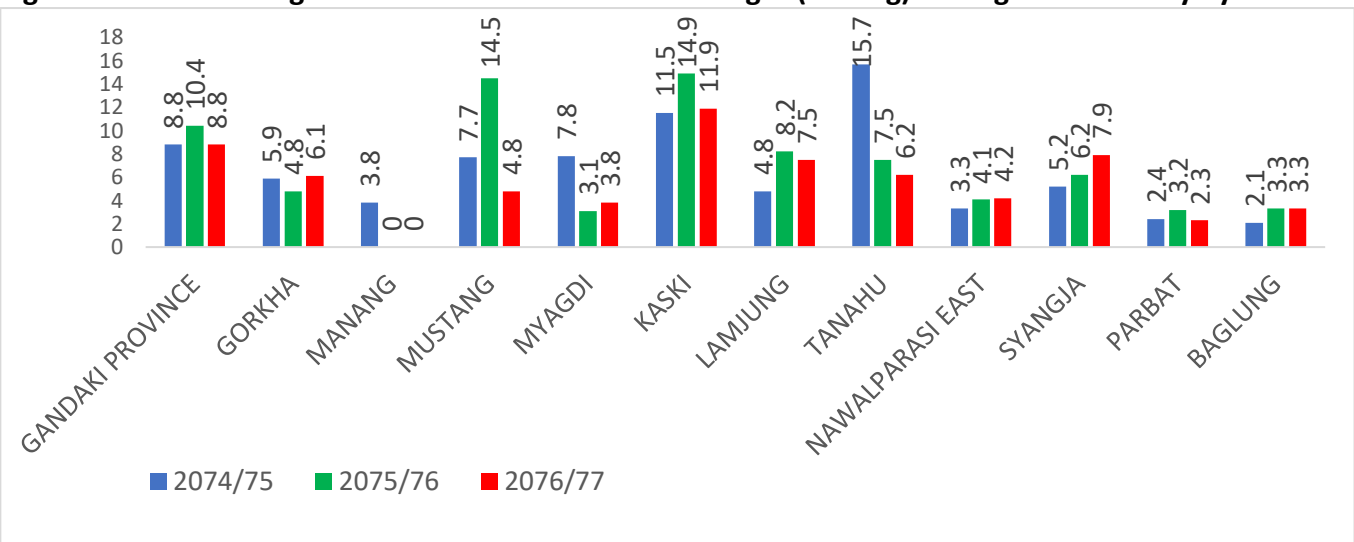
Beneath the broader umbrella of MSNP the following Nutrition Specific programmes are being implemented in Gandaki Province:

- Growth Monitoring and Promotion
- Infant and Young Child Feeding
- Integrated Management of Acute Malnutrition
- Prevention and Control of iron deficiency anemia
- Biannual Vitamin A Distribution to children aged 0-59 months
- Biannual Deworming Tablet Distribution to children aged 12-59 months
- Home Fortification of Complementary Food with Multiple Micronutrient Powder
- (MNP)/Baal-Vita
- Iron Folic Supplementation to the Adolescent Girls
- School Health and Nutrition Programme
- Promotion of Iodized Salt
- Nutrition in Emergency.

## Growth Monitoring and Promotion

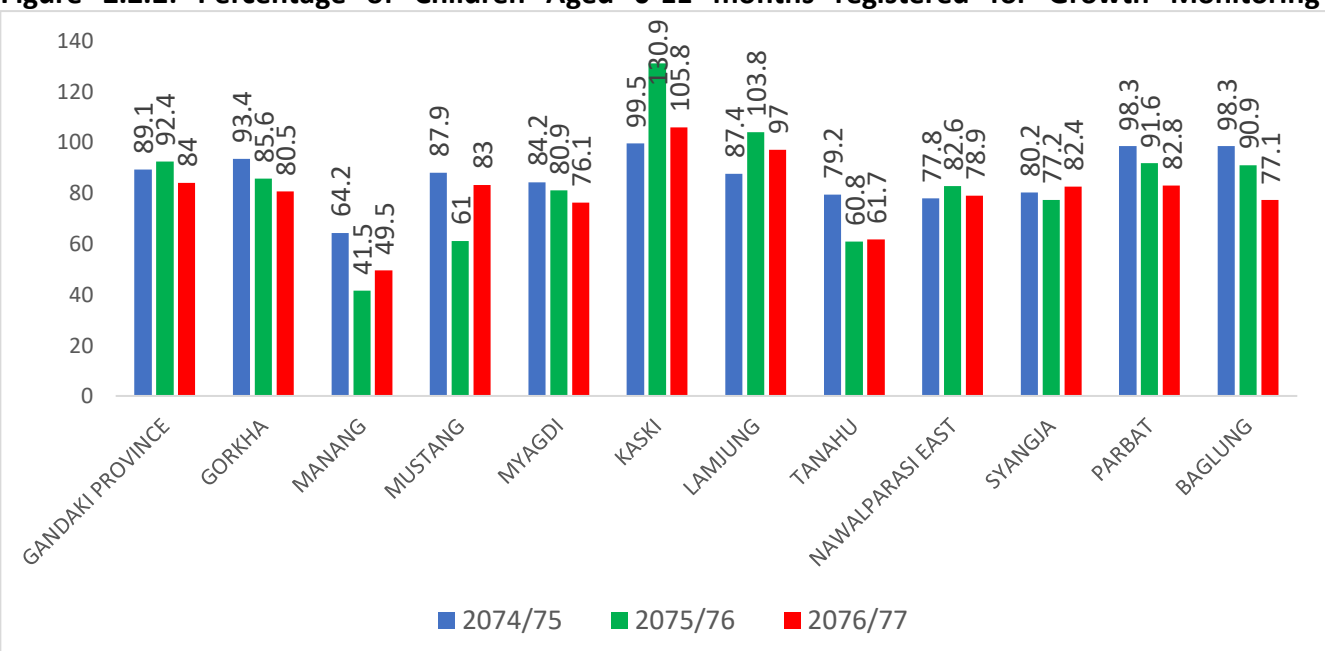
Regular growth monitoring of children <2 years of age supports the prevention and control of protein-energy malnutrition and also provides an opportunity to take necessary preventive and curative arrangements. The monthly growth monitoring is conducted by the health workers at all public health facilities using the growth monitoring card that is based on WHO's child growth standards. This platform is used for measuring the growth of children and to provide essential nutrition counseling to the mothers/caregiver of the children depending on their growth status.

**Figure 2.2.1: Percentage of newborns with low birth weight (<2.5 kg) among total delivery by HWs**




In FY 2076/77, the overall percentage of newborns with low birth weight (<2.5 kg) in the Province level has decreased to 8.8% from 10.4% in comparison to FY 2075/76. The highest rate is in Kaski (11.9%) which is higher than the provincial average. Likewise, no low birth rate has been reported in Manang (0%), followed by Parbat (2.3%) and Baglung (3.3). (Figure 2.2.1)

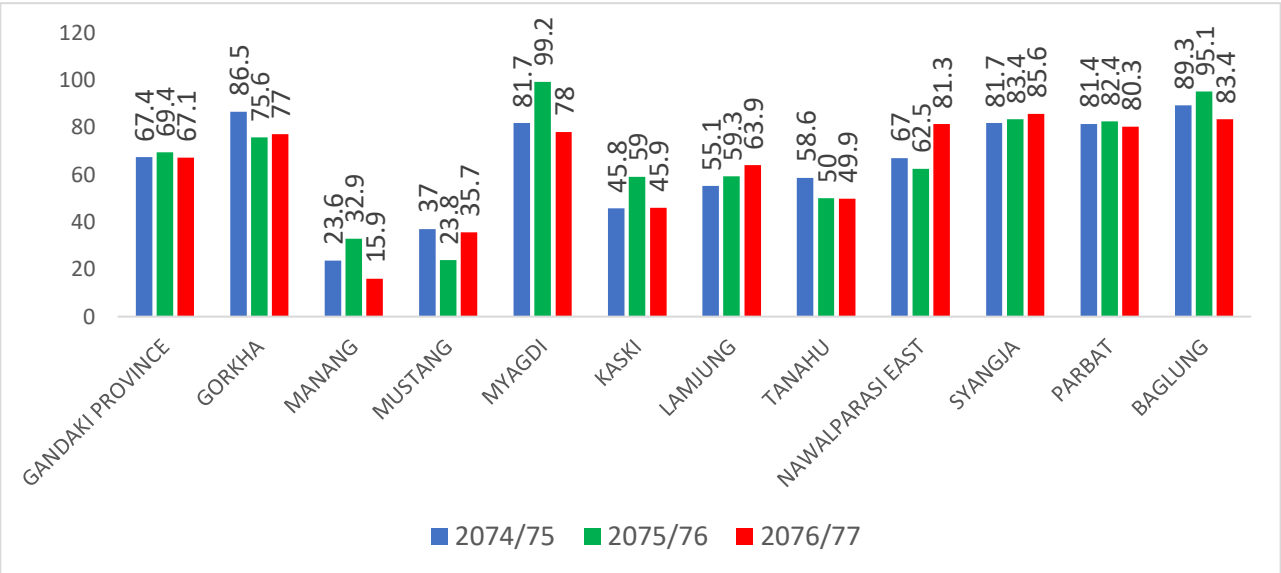
**Figure 2.2.2: Percentage of Children Aged 0-11 months registered for Growth Monitoring**




The registration for growth monitoring among the children aged 0-11 months has declined from 92 percent in FY 2075/76 to 84 percent in FY 2076/77. As shown in figure 2.2.2 this trend is evident across 7 districts except for Manang, Mustang, Tanahun, and Syangja. Kaski has the highest coverage (130.9%)

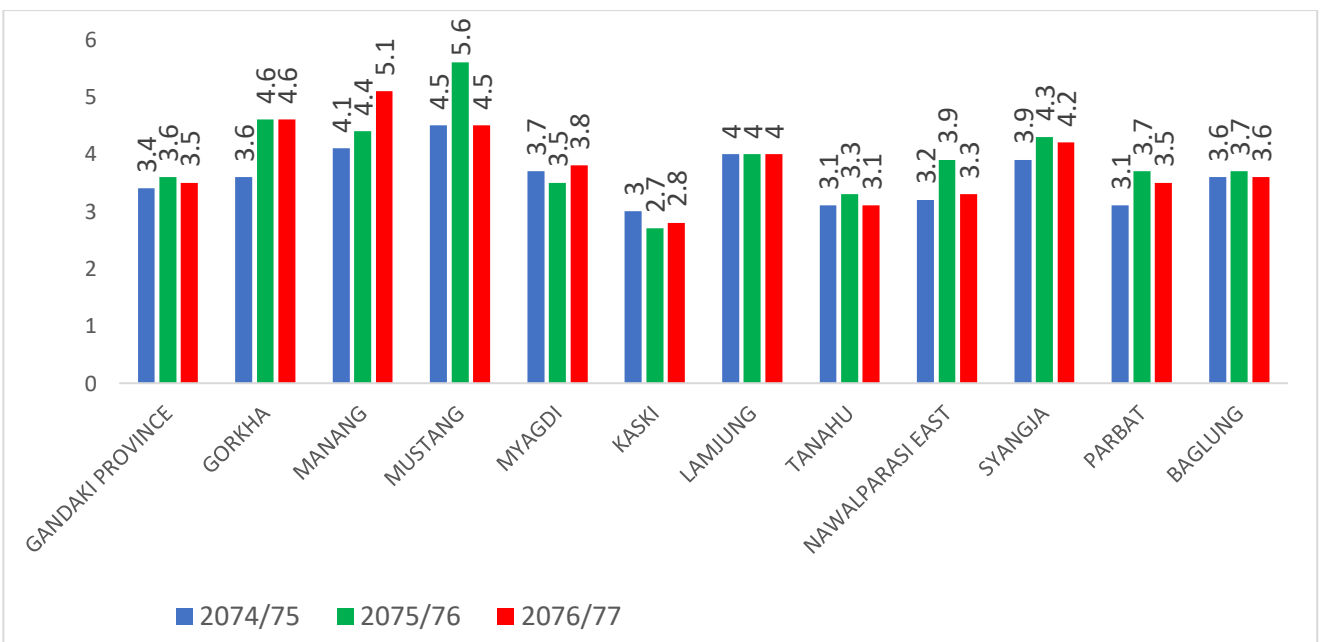
and Mustang has the lowest coverage (49.5%). The overall coverage for growth monitoring registration of the target children in 8 districts namely Gorkha, Mustang, Myagdi, Tanahu, Nawalparasi-East, Syangja, Parbat and Baglung is lower than the provincial average.

**Figure 2.2.3: Percentage of children aged 12-23 months registered for growth monitoring**




As observed in the trend of the growth monitoring registration for the children aged 0-11 months, the same for the children aged 12-23 months is also declining with a provincial average of 67.1%. As reflected in figure 2.2.3 the highest proportion of the children registered for growth monitoring among this age group is 85. 6% in Syangja and the lowest is 15.9% in Manang. The coverage for growth monitoring registration of the children aged 12-23 months is lower than the provincial average in Mustang, Kaski, Lamjung, and Tanahun.

**Figure 2.2.4: Average number of visits for Growth Monitoring among children aged 0-23 months**




A very minimal decline has been observed in the average number of visits for growth monitoring among children aged 0-23 months. The average visit was 3.6 in FY 2075/76 and 3.5 in FY 2076/77 out of the total of 24 recommended visits (figure 2.2.4). It is not very surprising since the registration of the children aged 0-11 months and 12-23 months for growth monitoring is considerably low (figures

2.2.2 and 2.2.3). The findings in figures 2.2.2-2.2.4 show that even though the children are registered for growth monitoring, the continuousness of measuring their growth every month has not been complied with as per the recommendations.

**Figure 2.2.5: Percentage of Children Aged 0-23 months, registered for Growth Monitoring (new) who were underweight.**

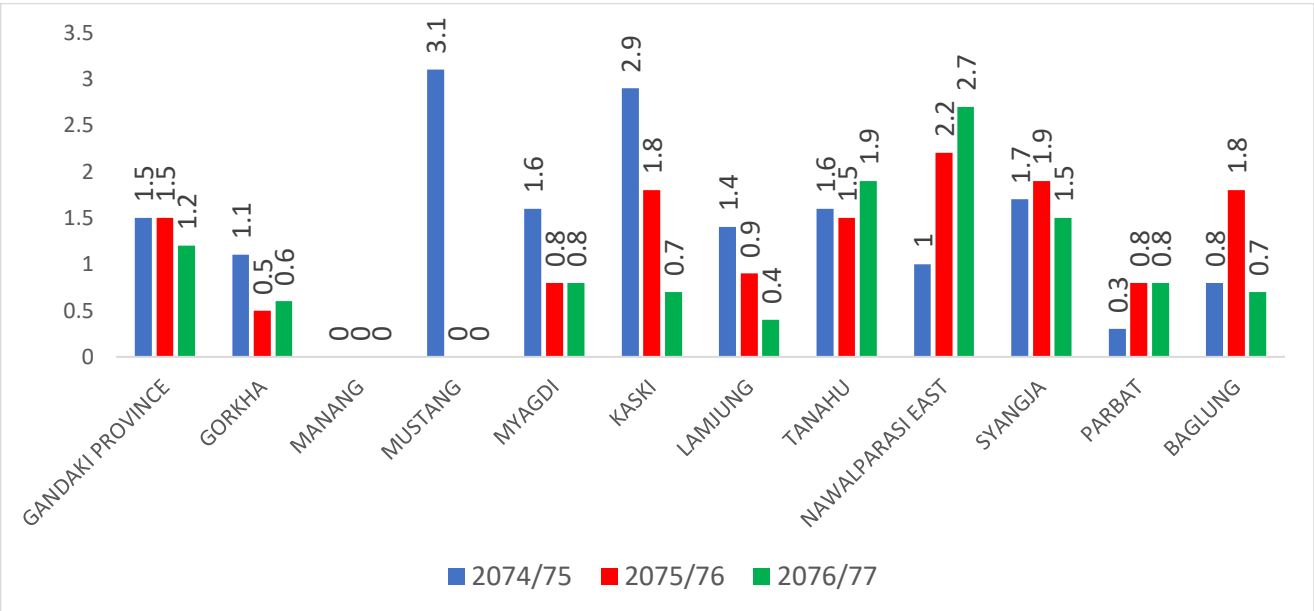



Figure 2.2.5 shows the underweight among the children aged 0-23 months with the new registration. The prevalence of underweight at the province level has declined from 1.5 percent to 1.2 percent from FY 075/076 to 076/077. However, inconsistency is detected in Gorkha, Tanahu, and Nawalparasi-East. The underweight prevalence among the target children has increased in these three districts, whereas the underweight prevalence among the target children is stagnant in Myagdi and Parbat. For the rest of the districts, the progress is changeable in the last three years. Nawalparasi-East has the highest prevalence at 2.7 percent which is, greater than the provincial average, while Manang and Mustang have 0 prevalence followed by Lamjung at 0.4 percent.

**Infant and Young Child Feeding**

Infant and young child feeding (IYCF) practices have been identified crucial for the appropriate child survival, growth, and development. Its components are exclusive breastfeeding up to six months and timely initiation of appropriate complementary feeding at the age of six months with continued breastfeeding up to two years of age or beyond. The Ministry of Health and Population has prioritized the IYCF strategy and incorporated it into the National Nutrition Program and has scaled up in all 77 districts from 2072/73.

**Figure 2.2.6: Percent of children aged 0-6 months registered for growth monitoring and were exclusively breastfed for the first 6 months.**

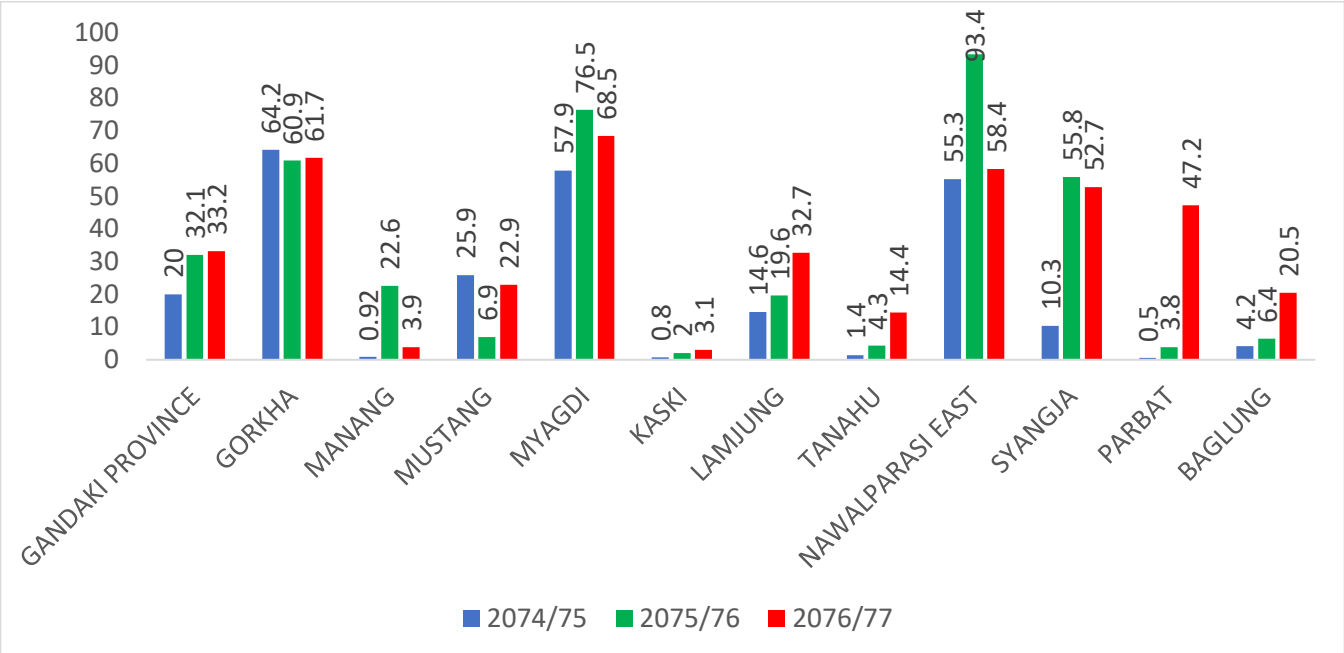



Figure 2.2.6 shows that only one-third (33.2%) of children aged 0-6 months registered for growth monitoring were exclusively breastfed in FY 2076/77 with a nominal increment of 1.1% from FY 2075/76 (32.1%). The proportion of infants receiving exclusive breastfeeding has been inconsistent across the districts. Myagdi has the highest proportion at 68.5%, greater than the provincial average despite the reductions while Kaski has the lowest at 3.1%. The proportion of exclusive breastfeeding among the target children has increased in Gorkha, Mustang, Kaski, Lamjung, Tanahu, Parbat, and Baglung. However, Manang, Myagdi, Nawalparasi-east, and Syangja observed a decline. Six out of 11 districts (Manang, Mustang, Kaski, Lamjung, Tanahu, and Baglung) have the proportion of exclusively breastfed children lower than the provincial average.

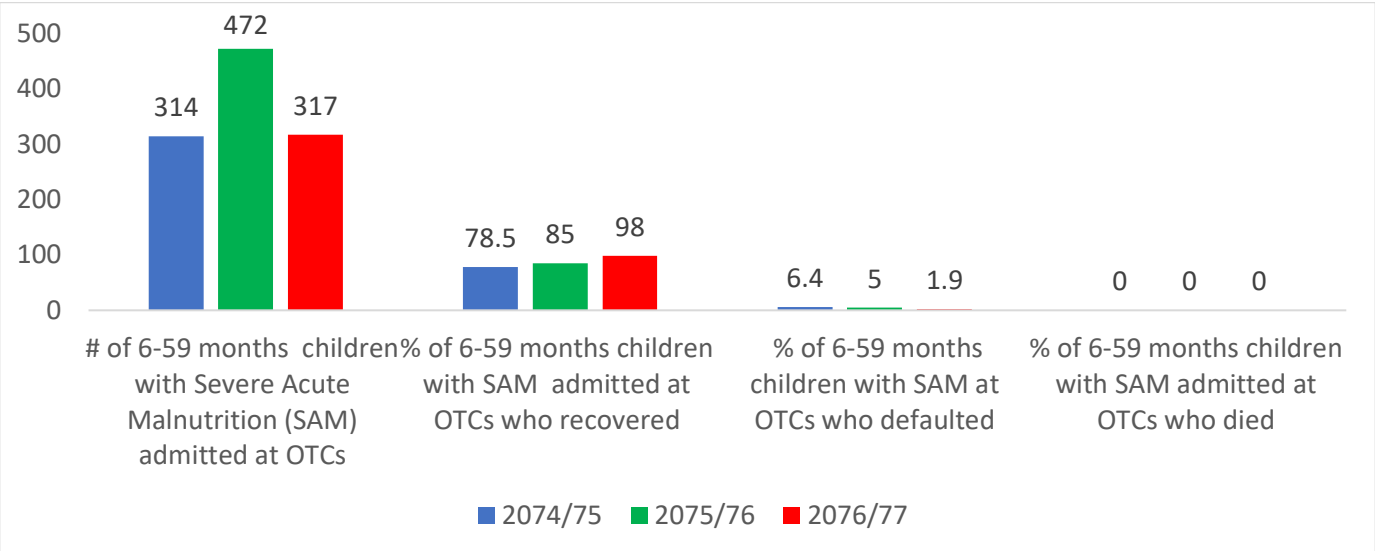
**Integrated Management of Acute Malnutrition**

The Integrated Management of Acute Malnutrition (IMAM) Programme caters to the management/treatment of Severe Acute Malnutrition (SAM) in children aged 0-59 months via inpatient and outpatient services. SAM cases with medical complications are provided services at Inpatient Treatment and Care Center (ITC) previously named as Stabilization Center (SC) at the hospitals in the program districts. Likewise, SAM cases without medical complications are provided services in the Outpatient Treatment and Care Center (OTC), established in the selected health facilities at the community level. The SAM among children under five years of age is provided Ready-to-use-Therapeutic Food by trained health workers along with other services as required. This program also provides nutrition counseling to mothers and caregivers for better maternal, infant, and young child nutrition (MIYCN). One of the aims of the IMAM programme is to integrate nutrition support across the health, early childhood development, WASH, and social protection sectors for the sustained rehabilitation of cases through supportive follow-up.

Five (Nawalparasi-East, Gorkha, Parbat, Myagdi, and Baglung) out of eleven districts are implementing this program, the provincial trend for the last 3 years is reflected in figure 2.2.7. The total number of SAM admission has declined by 33% in comparison to FY 2075/76. Though the admission rate has decreased a positive increment can be observed in the case of the recovery, defaulter, and death rate.

Among the SAM children admitted 98% recovered, 1.9 % defaulted, and no deaths reporting with meets the SPHERE standards for SAM Management (i.e., Recovery Rate >75%, Defaulter Rate <15%, and Death Rate < 5%).

**Figure 2.2.7: Three years trend of Integrated Management of Acute Malnutrition management**




## Nutrition Rehabilitation Homes

One of the major components of the IMAM programme is Nutrition Rehabilitation Home (NRH), this component reinstates good health among SAM cases among children under five years of age and also provides thorough nutrition education and counseling to the mothers/caretakers of the children admitted in the NRH. There are three NRH in Gandaki Province: 1) Pokhara Academy of Health Science, Pokhara; 2) Dhaulagiri Hospital, Baglung; and 3) Parbat Hospital, Kusma.

As shown in table 2.2.1. The number of admissions has reduced by almost 40 percent in comparison to last FY. A total of 187 cases of SAM were admitted during FY 2076/077 in three NRHs, in Pokhara Academy of Health Science, Dhaulagiri Hospital, and Parbat Hospital. Among the admitted SAM cases 99.46% recovered and 1.6 cases defaulted whereas no deaths were reported which is as per the SPHERE standards.

**Table 2.13: Trend of SAM case admission in NRH**

| FY/Indicators | Name of NRH | Number of <5 children with SAM admitted at nutrition rehabilitation homes (NRHs) | % of <5 children with SAM admitted at NRHs with SAM who recovered | % of <5 children with SAM at NRHs with SAM who defaulted | % of <5 children with SAM at NRHs with SAM who died |
|---|---|---|---|---|---|
| 2074/75 | Baglung and Kaski | 234 | 93.5 | 7.5 | 0 |
| 2075/76 | Baglung, Parbat and Kaski | 305 | 98 | 2 | 0 |
| 2076/77 | Baglung, Parbat and Kaski | 187 | 99.46 | 1.6 | 0 |

**Prevention and Control of iron deficiency anemia**

Since 1998 the Ministry of Health and Population has been providing iron-folic acid (IFA) supplementation to pregnant and post-partum women to reduce maternal anemia. As per the protocol 60 mg, elemental iron, and 400 micrograms of folic acid are provided to pregnant women for 225 days from their second trimester till 45 days postpartum. Intending to improve coverage and access in 2003 MoHP initiated the intensification of the Maternal and Neonatal Micronutrient Programme (IMNMP) and modified the distribution mechanism of IFA via FCHVs at the community level. Though the coverage was improved due to the IMNMP however the compliance of taking 180 tablets during pregnancy and 45 tablets post-partum still is an issue.

**Figure 2.2.8: Coverage of 180 IFA distributions to the pregnant women by districts for the last three years.**

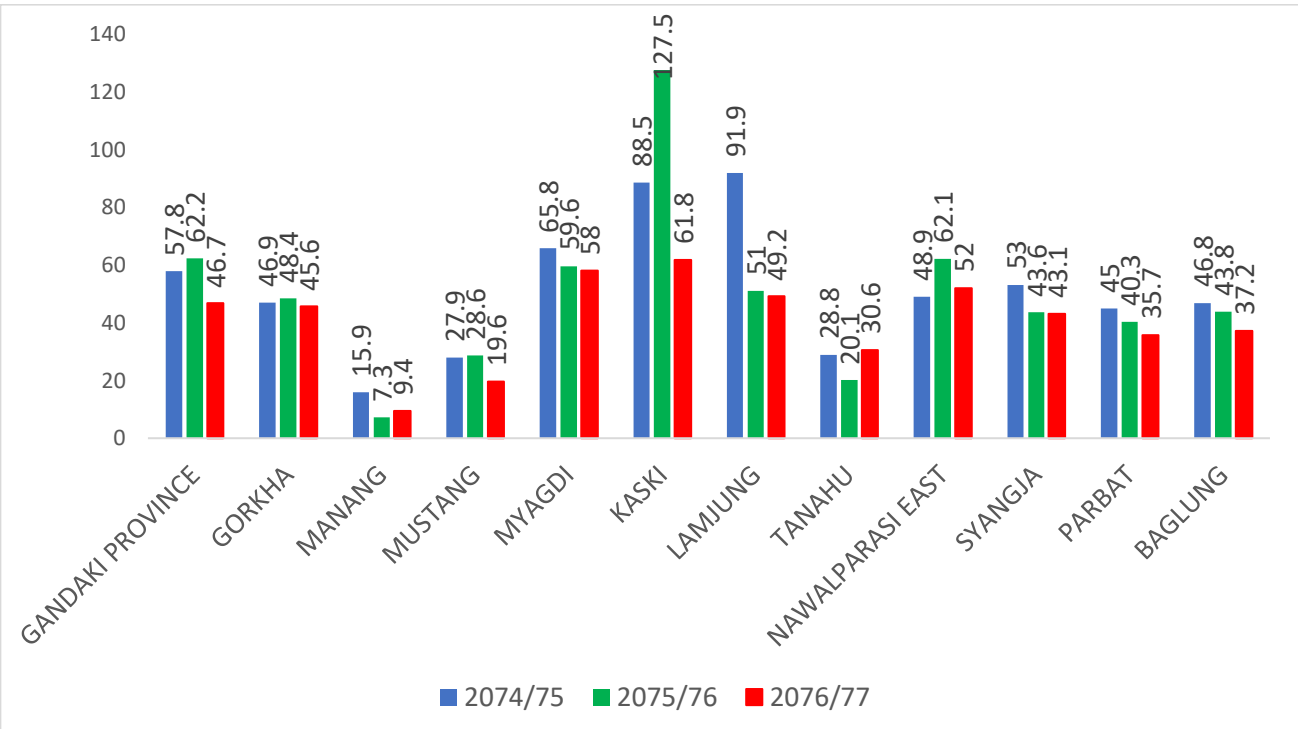


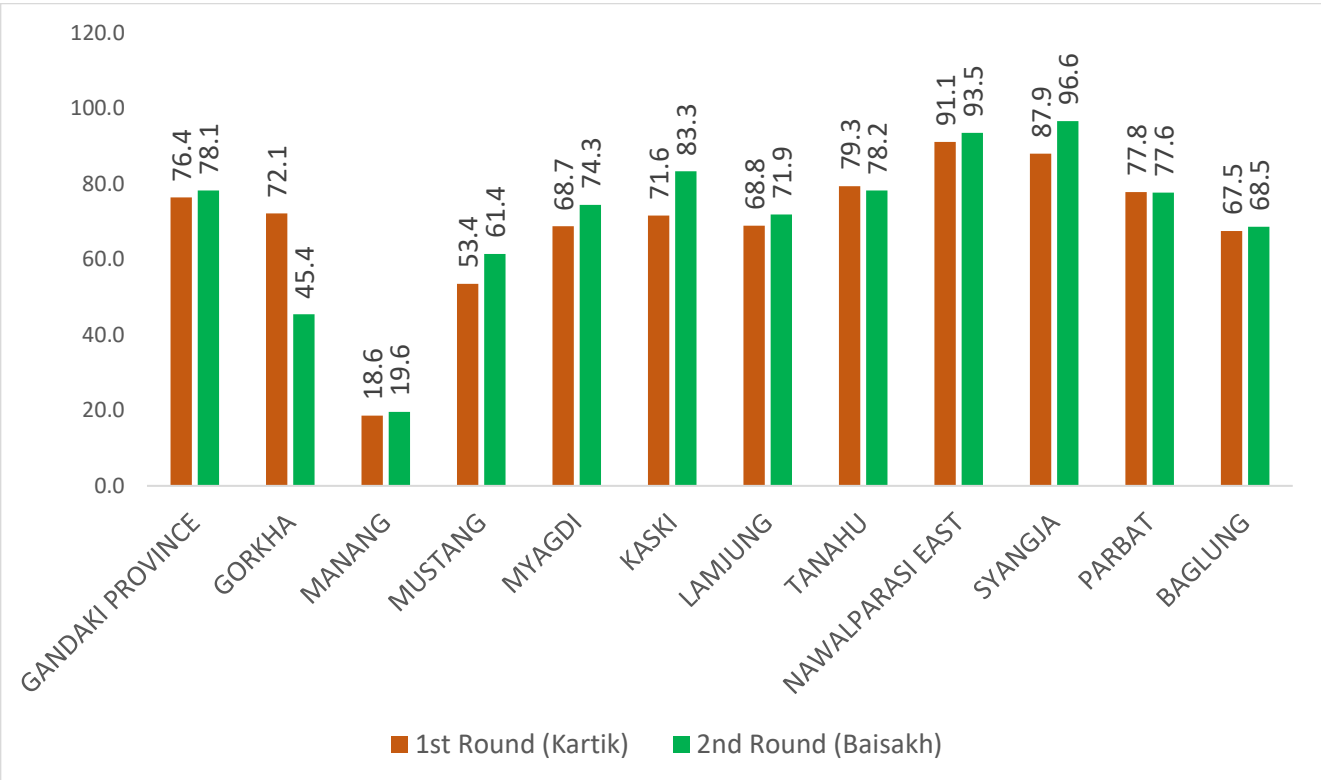

Figure 2.2.8 shows the coverage of iron-folic acid for 180 days among pregnant women. It is observed that the coverage has declined from 62.2 in FY 2075/76 to 46.7 in FY 2076/77. More than 50 percent of pregnant women have not received the supplementation for the recommended 180 days. The highest proportions of the pregnant women receiving the recommended doses are noticed in Kaski (61.8%) although it has reduced from 127.5% in FY 2075/76. Likewise, the lowest coverage is observed in Manang at 9.4%. Seven out of 11 districts (Gorkha, Manang, Mustang, Tanahu, Syangja, Parbat and Baglung) having coverage lower than the provincial average is alarming and needs more effort to ensure that the coverage and compliance are improved throughout the province.

**Prevention and Control of Vitamin A Deficiency Disorders**

Since 1993 the government of Nepal introduced the National Vitamin A Program to prevent and control vitamin A deficiency disorders among children aged 6-59 months and reduce child morbidity and mortality owing to its adverse effects. The Vitamin program has been recognized as a public health success globally. Vitamin A is provided by FCHV to the target children through a mass campaign twice a year in Baisakh and Kartik.

The progress on biannual Vitamin A supplementation is presented by the 1st Round (Kartik 2076) and 2nd Round (Asad 2077) in figure 2.2.9. The overall provincial achievement is above 75 percent with the highest coverage at around 96.6 percent in Syangja for the 2nd round showcasing an increment of 8.7%. An increment of coverage is observed in the 2nd round in 10 districts except for Gorkha, where the coverage has declined by 26.7%. The lowest coverage is seen Manang in both rounds at 18.6% and 19.6% respectively.

**Figure 2.2.9: Coverage of vitamin A supplementation to children aged 6-59 months by distribution round for FY 2076/77.**

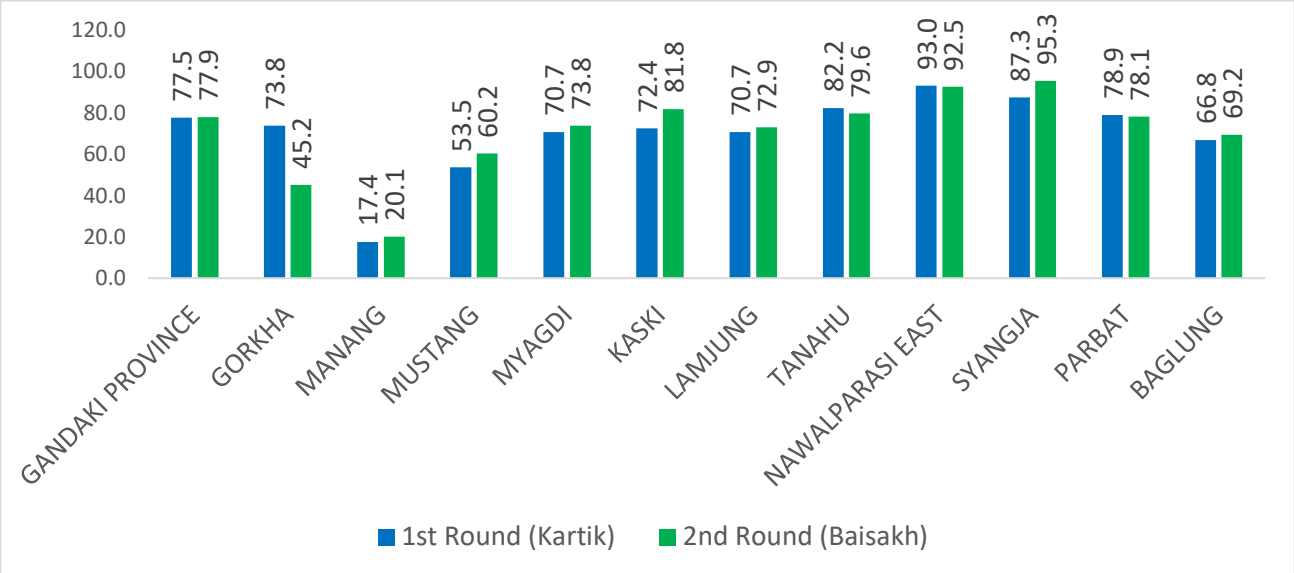



**Biannual Deworming Tablet Distribution to children aged 12-59 months**

With an aim to control parasitic infestation and reduce childhood anemia among under-five year children, the Biannual Deworming Tablet distribution initiative was started in some districts by the MoHP in 2000 which was later scaled-up nationwide in 2010. This activity was integrated with the biannual Vitamin A supplementation for children aged 6-59 months as the vitamin A supplementation coverage is 90 percent.

As shown in figure 2.2.10, the overall provincial coverage of deworming tablet distribution is approximately 77 in both first (Kartik) second round (Baisakh). The trend of increment between the first and second round of deworming is similar to the vitamin A coverage as shown in figure 2.2.9. The highest coverage is observed in Syangja at 95 % whereas Manang has the lowest coverage at 20%. Six districts (Gorkha, Manang, Mustang, Myagdi, Lamjung, and Baglung) have coverage lower than the provincial average whereas the remaining five districts have a higher coverage. It is observed that there has been a steep decline by almost 29% in the coverage of the second round in Syangja which is a major concern.

**Figure 2.2.10: Coverage of Deworming Tablets Distribution to the Children aged 12-59 months**




**Home Fortification of Complementary Food with Multiple Micronutrient Powder (MNP)/Baal-Vita**

Multiple Micronutrient Powder (MNP) named Baal-vita was introduced for the home-based fortification of complementary food by MoHP in 2012 with an objective to reduce the extremely high prevalence of anemia among under 5 years children. MNP distribution is linked with the Infant and Young Child Feeding (IYCF) program along with counseling on timely initiation of appropriate complementary feeding. A total of 180 sachets is recommended for a child during the age of 6-23 months in 3 cycles with a gap of 4 months in between each cycle, i.e., a child receives Baal-Vita for 2 consecutive months (60 sachets @ 1 sachet /day) then there will be a 4 months gap and again will receive for 2 months (60 sachets), and so on. Mothers and caregivers are provided counseling/education by FCHVs/HWs on the appropriate technique to mix Baal-vita with complementary food of the children to enrich the micronutrient contents of the child's diet. As of FY 2076/77, only four districts (one-third) have implemented this intervention in Gandaki province.

As shown in figures 2.2.11 and 2.2.12, the coverage of this home-fortification is not satisfactory with a provincial average coverage of at least one cycle of MNP at 17.5 percent, which has plunged from 27 percent in comparison to the last FY. Likewise, the compliance is also bothersome with only 3.5 percent of the target children receiving all 3 cycles (180 sachets) of Baal-Vita. Gorkha has observed relatively better coverage both in terms of receiving at least 60 sachets of MNP (52.7%, highest) and compliance (16.3%, the highest) in FY 2076/77. The overall provincial coverage has declined except in Baglung where there is an increment of almost 21%. The coverage in Nawalparsai East has faced a steep decline from 120% to 52.7%, similarly, Syangja has also shown a decline of 20% in comparison to last FY. Though the coverage of Nawlaparasi East has declined, surprisingly, the compliance is at 12.8%. The compliance of Baglung is at 1.2% whereas Syangja is shown nil.

**Figure 2.2.11: Percentage of Children Aged 6-23 months receiving at least one cycle (60 Sachets) of Baal Vita (MNP)**

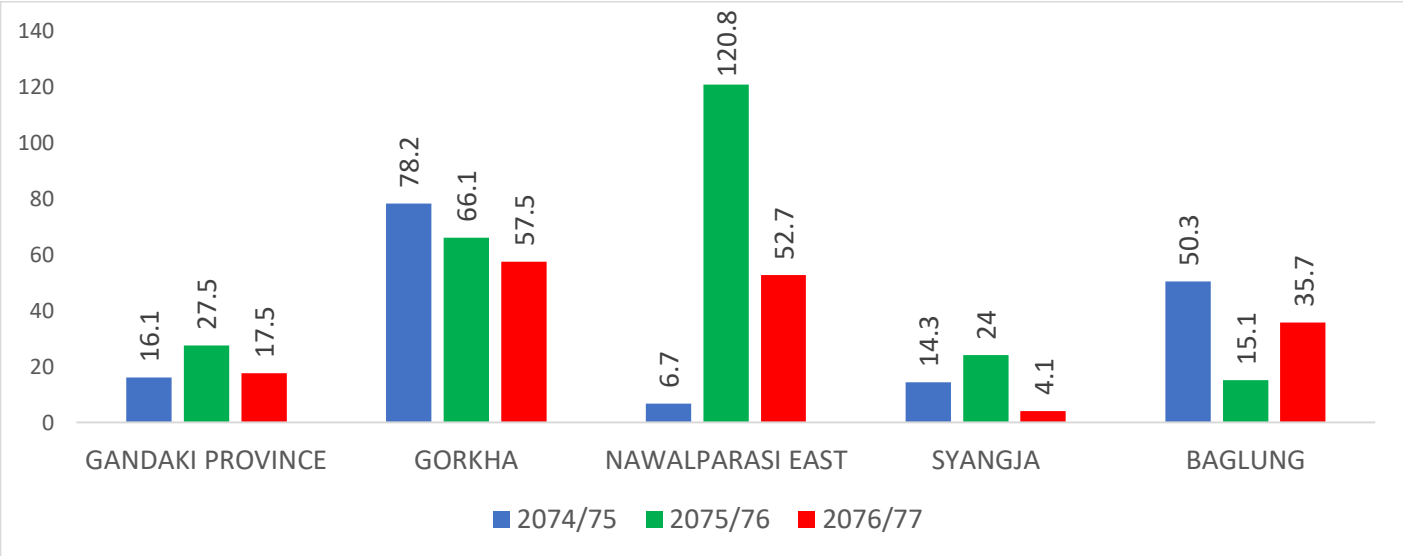
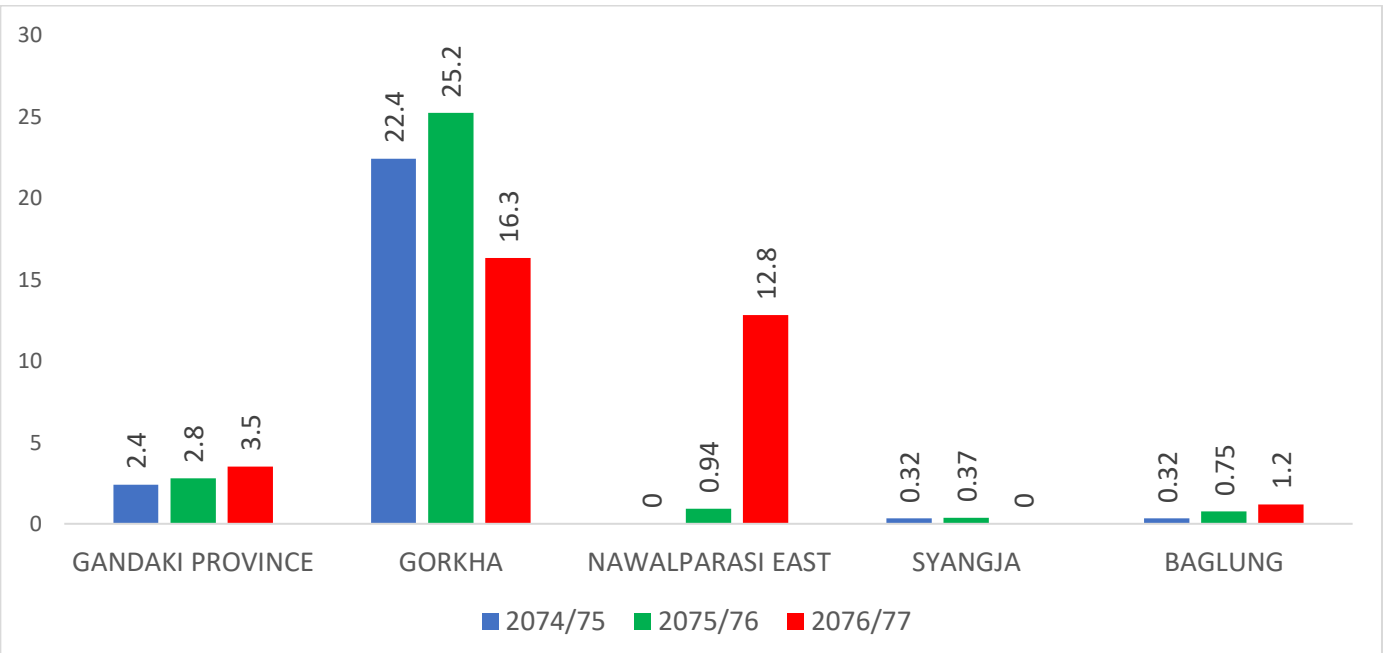



**Figure 2.2.12: Percentage of Children Aged 6-23 months receiving Recommended 3 Cycles of (180 Sachets) Baal Vita (MNP)**




**Iron Folic Supplementation to the Adolescent Girls**

In FY 2072/73 MoHP launched this initiative in collaboration with the Ministry of Education under the School Health and Nutrition Program (SHN) intending to prevent and control anemia among 10-19 years adolescent girls. The intervention was launched from 7 districts and by 2075/76 it was scaled up in 42 districts. In Gandaki Province, only two districts (Nawalparasi East and Manag) have rolled-out this intervention. This programme provides weekly iron-folic acid supplementation to adolescent girls aged 10-19 years in two rounds (Shrawan-Asoj and Magh-Chaitra). The recommended dose of the supplementation for each round is 13 iron-folic acids tablets each week, i.e., one tablet per week. So, each adolescent girl receives 26 iron-folic acid tablets per year. Even though the indicators for this

programme are incorporated in the DHIS 2 under Nutrition Program, the progress recording and reporting are yet to be mainstreamed in the routine online reporting system.
As the COVID-19 Pandemic forced the closure of all schools the IFA distribution was disrupted thus the data/information is not available. An interim guideline is required from the FWD-Nutrition section for the uninterrupted implementation of this programme even during emergencies/pandemics.

**Nutrition in Emergency (NiE):**

In addition to the regular nutrition programmes the MoHP also provides vital services to address nutrition-related issues during emergencies (such as earthquakes, floods, drought, conflicts, pandemics). Under the leadership of the FWD-Nutrition section, the Provincial nutrition cluster lead by Health Directorate with support from UNICEF (co-lead-Nutrition Cluster) and other members provides services/support to protect the nutrition status of under 5 children, pregnant and lactating women (PLW) as they are the most at-risk group during any emergency.
Five pillars of NiE are:

- Promotion, protection, and support to breastfeeding of infants and young children aged 0-23 months.
- Promotion of proper complementary feeding to infants and young children aged 6-23 months.
- Management of Moderate Acute Malnutrition (MAM) among the children aged 6-59 months and among PLW through targeted supplementary feeding.
- Management of Severe Acute Malnutrition (SAM) among the children aged 6-59 months through therapeutic feeding.
- Intensification of micronutrient supplementation for children and women including MNP and Vit A for children aged 6-59 months, IFA for pregnant and postnatal women.

**Small scale emergency response FY 2076/77:**

Through the COVID-19 pandemic the provincial health directorate with the guidance of MoHP (FWD-Nutrition section) started the subsequent interventions with nutrition cluster members support to protect the nutrition status of infants, young children, and pregnant and lactating women:

- Formation and activation of the provincial health and nutrition (H&N) cluster.
- Regulation the Health and & Nutrition (H&N) cluster meeting for regular sharing of key updates and challenges and exploring the avenues for collaboration.
- Finalization of H&N cluster TOR and initiate the endorsement from the Ministry of Social Development.
- PPE (Mask and Sanitizer) distributed to FCHV and HWs during Vit A Campaign.
- 18,054 kg super cereal distributed to 3009 beneficiaries (6–23-month children, PLW) in two palikas of Gorkha (Sahid Lakhan and Gandaki Rural Municipality).
- Broadcasting of radio PSA on comprehensive nutrition message in COVID-19 context via 19 local FM stations.
- 71,976 PLW reached with SMS service on IYCF related messages.
- 293,363 Telephone counseling services provided to HH with under 2 children and PLW.
- IEC/BCC material distributed to quarantine, isolation centers, and health facilities.
- IPC training provided to health workers.

- Contactless hand washing and sanitizer vending pumps installed in COVID-19 dedicated hospitals and isolation centers.
- Weekly/fortnightly updates and sharing of nutrition-related data.

**Issues/Challenges and way forwards:**

The Provincial review meeting of 2076/77 identified Issues/Challenges and way forwards as listed in the table below:

**Table 2.14 Problems, Constraints, and Actions to be taken at Provincial Level**

| Issues/ Challenges | Way forwards | Responsibility |
|---|---|---|
| COVID-19 Pandemic halted most of the Public health and nutrition interventions as reflected in almost all indicators | Gradual resumption of regular programmes with safety measures in place. | HD, HO, and Palikas |
| Non-functionality of many OTC in Gorkha and Myagdi, Likewise Inadequate number of OTCs in Baglung. | Revitalization of OTC and establish additional OTCs. | HD, HO, and Palikas |
| Low coverage of growth monitoring (0-23 months) and other nutrition-related services due to COVID-19 Pandemic. | Strengthen GM with safety measures in place. | HD, HO, and Palikas |
| NRHs are not well equipped as per the standards as well as a declining trend in cases. | Strengthen and well equipments NRHs. Initiate community outreach campaign by NRH in coordination with HO and Palikas | HD, NRH, HO, and Palikas |
| Patchy programme: Slow scaling up of evidence-based and cost-effective interventions of IYCF, IMAM, MSNP, IYCFMNP, SHNP (no complete CSNI package). | Roll out of complete CNSI package in all 11 districts. | FWD- Nutrition section, HD, Nutrition cluster partners |
| The functionality of the weekly Iron Folic Acid Supplement for adolescent programme (Vertical reporting). | Integrate adolescent WIFAS indicators in DHIS-2 reporting system. | FWD- Nutrition section |
| Priority is not given to food hygiene, a balanced diet, and food sanitation practice. Role of Socio-cultural determinants e.g. Early pregnancy, food consumption practice, increasing junk food consumption. | Scale-up MSNP programme as a framework for both nutrition-sensitive and nutrition-specific interventions with massive awareness on food practice, food sanitation, food security etc. | NPC, MoFAGA, FWD- Nutrition section, HD, Nutrition cluster partners, Palikas |
| Alarmingly low coverage and compliance of MNP (Baal vita) | Strengthen Bal vita programme by linking with IYCF and wider demand creation activities, | HD, Nutrition cluster partners, Palika |

### 2.1.3 Performance in CB-IMNCI Program

There are mainly five diseases under CB-IMCI. This program manages acute respiratory tract infection, diarrheal diseases, Measles, Malaria and Malnutrition.

The problem was not improved in Neonatal death due to Infection, asphyxia, Low Birth weight, Hypothermia. So, CB-NCP program merged with CB-IMCI and named as CB-IMNCI. At starting period FCHVs were used in this program but neonatal death did not reduce, so Health Facilities base program launched and neonatal death is reducing progressively.

#### 2.1.3.1 Percentage of PSBI among new registered cases

The three years trend of PSBI among new registered cases among 0-2 months of infants of this province is fluctuating (table 2.14)**.** The percent of PSBI among new registered cases are 6, 5.1 and 5.4 respectively in 2074/75, 2075/76 and 2076/77.

**Table 2.15 Percentage of PSBI among new registered cases (0-2months of infant)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 7 | 6 | 10.2 |
| Manang | 14.3 | 14.3 | 0 |
| Mustang | 25 | 0 | 0 |
| Myagdi | 6.9 | 5.7 | 2.3 |
| Kaski | 2.5 | 1.7 | 1.6 |
| Lamjung | 11.9 | 5.2 | 11.9 |
| Tanahun | 5.2 | 7.1 | 5.9 |
| Nawalparasi East | 8.7 | 9.6 | 5.9 |
| Syangja | 3.3 | 1.5 | 4.2 |
| Parbat | 2.7 | 2.6 | 3 |
| Baglung | 8.1 | 8.2 | 9 |
| **Gandaki Province** | 6 | 5.1 | 5.4 |

***Source: HMIS/DHIS-2***

#### 2.1.3.2 Percentage of Severe Pneumonia or Very Severe disease among total cases

The trend of proportion of severe or very severe pneumonia is on decreasing in last three fiscal years at this province. This was 0.2, 0.19 and 0.07 in 2074/75, 2075/76 and 2076/77 respectively.

**Table 2.16: Percentage of Severe Pneumonia among new cases**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 0.45 | 0.33 | 0.1 |
| Manang | 0.41 | 0.29 | 0 |
| Mustang | 0.2 | 0.16 | 0.3 |
| Myagdi | 0.13 | 0.13 | 0.13 |
| Kaski | 0.02 | 0.18 | 0.07 |
| Lamjung | 0.1 | 0.57 | 0.04 |
| Tanahun | 0.03 | 0.09 | 0.12 |
| Nawalparasi East | 0.13 | 0.04 | 0.07 |
| Syangja | 0.17 | 0.03 | 0.06 |
| Parbat | 0.07 | 0.03 | 0.07 |
| Baglung | 0.42 | 0.26 | 0.03 |
| **Gandaki Province** | 0.2 | 0.19 | 0.07 |

***Source: DHIS-2***

### 2.1.3.3 Incidence of Diarrheal Disease

The average incidence rate of Diarrheal Disease in this province has on fluctuating trend over the three years period.

**Table2.17: Incidence of Diarrheal Disease Under 5 years**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 446 | 371 | 349 |
| Manang | 500 | 435 | 419 |
| Mustang | 444 | 381 | 302 |
| Myagdi | 483 | 442 | 378 |
| Kaski | 202 | 201 | 176 |
| Lamjung | 369 | 318 | 300 |
| Tanahun | 220 | 207 | 178 |
| Nawalparasi East | 185 | 219 | 187 |
| Syangja | 282 | 246 | 252 |
| Parbat | 335 | 325 | 287 |
| Baglung | 489 | 410 | 366 |
| **Gandaki Province** | 302 | 277 | 249 |

***Source: DHIS-2***

Diarrheal cases incidence is decreasing in last three years at this province but the percent of severe dehydration has increased nominally in from 0.19 to 0.33 in F/Y 2075/76 from previous F/Y. This figure has decreased in F/Y 2076/77 and reached 0.11. Among the 11 districts of the province the Manang, Mustang, Myagdi, Nawalparasi East and Parbat districts have not any case of severe dehydration in F/Y 2076/77.

**Table 2.18: Percentage of severe dehydration among under 5 years Children**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 0.17 | 0.26 | 0.09 |
| Manang | 1.1 | 0 | 0 |
| Mustang | 0.31 | 0 | 0 |
| Myagdi | 0.22 | 0.1 | 0 |
| Kaski | 0.51 | 0.06 | 0.07 |
| Lamjung | 0.26 | 0.43 | 0.09 |
| Tanahun | 0.23 | 0.43 | 0.11 |
| Nawalparasi East | 0.06 | 0.21 | 0 |
| Syangja | 0.16 | 0.17 | 0.18 |
| Parbat | 0.33 | 0.17 | 0 |
| Baglung | 0.05 | 0.81 | 0.32 |
| **Gandaki Province** | 0.19 | 0.33 | 0.11 |

***Source: HMIS/DHIS-2***

The total children who presented with diarrhea, 100% were treated with ORS and Zinc tablet. This figure has slightly decreased than previous fiscal year.

**Table 2.19: percentage of diarrhea under 5 years children treated with ORS and Zinc**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 101 | 98 | 105 |
| Manang | 98 | 83 | 127 |
| Mustang | 87 | 78 | 100 |
| Myagdi | 102 | 100 | 90 |
| Kaski | 95 | 97 | 96 |
| Lamjung | 99 | 97 | 104 |
| Tanahun | 101 | 102 | 101 |
| Nawalparasi East | 101 | 92 | 95 |
| Syangja | 97 | 98 | 98 |
| Parbat | 97 | 98 | 101 |
| Baglung | 98 | 97 | 104 |
| **Gandaki Province** | 99 | 97 | 100 |

***Source: HMIS/DHIS-2***

### 2.1.3.6 Incidence of Acute Respiratory Infection (ARI) per 1,000 children of under five years

The figure of ARI incidence of per 1000 children of under five years in last three years is near about 600. This rate was slightly increased from 574 to 610 in 2074/745to 2075/76. But, in 2076/77this rate has decreased and reached at 563.

**Table 2.20: Incidence of Acute Respiratory Infection (ARI) per 1,000 children of under five years**

| **Districts/FY** | **2074/75** | **2075/76** | **2076/77** |
|---|---|---|---|
| Gorkha | 803 | 801 | 754 |
| Manang | 725 | 518 | 626 |
| Mustang | 1176 | 3168 | 835 |
| Myagdi | 664 | 762 | 803 |
| Kaski | 373 | 402 | 356 |
| Lamjung | 659 | 676 | 626 |
| Tanahun | 348 | 390 | 340 |
| Nawalparasi East | 349 | 418 | 436 |
| Syangja | 655 | 715 | 745 |
| Parbat | 985 | 965 | 857 |
| Baglung | 902 | 874 | 793 |
| **Gandaki Province** | 574 | 610 | 563 |

*Source HMIS/DHIS-2*

### 2.1.3.7 Percentage of PSBI Cases Treated with first and Complete dose of Gentamycin

Both Percentages of Possible Severe Bacterial Infection (PSBI) cases treated with the first dose of gentamycin and PSBI cases received complete dose of Gentamycin is in fluctuating trend within this province in last three years.

**Table 2.21: Percentage of PSBI Cases Treated with first and Complete dose of Gentamycin**

| Districts/FY | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| | % of PSBI Cases treated with first dose of Gentamycin | % of PSBI cases received complete dose of Gentamicin | % of PSBI Cases treated with first dose of Gentamycin | % of PSBI cases received complete dose of Gentamicin | % of PSBI Cases treated with first dose of Gentamycin | % of PSBI cases received complete dose of Gentamicin |
| Gorkha | 10 | 20 | 26 | 17 | 56 | 42 |
| Manang | 0 | 0 | 0 | 0 | | |
| Mustang | 25 | 0 | | | | |
| Myagdi | 79 | 14 | 0 | 0 | 133 | 167 |
| Kaski | 38 | 0 | 21 | 0 | 0 | 8 |
| Lamjung | 47 | 0 | 58 | 0 | 55 | 10 |
| Tanahun | 13 | 7 | 13 | 0 | 40 | 0 |
| Nawalparasi East | 19 | 12 | 7 | 7 | 32 | 12 |
| Syangja | 39 | 0 | 20 | 0 | 8 | 0 |
| Parbat | 50 | 0 | 0 | 0 | 33 | 33 |
| Baglung | 32 | 32 | 34 | 5 | 26 | 11 |
| **Gandaki Province** | 28 | 14 | 21 | 7 | 39 | 21 |

***Source HMIS/DHIS-2***

### 2.1.3.8 Percentage of new born applied chlorhexidine (CHX) gel immediately among reported live birth

The Percentage of new born applied CHX gel immediately among reported live birth in the last three years is fluctuating. This was slightly decreased in 2075/76 and reached 87 from 91. However, this percentage has slightly increased to 90 in 2076/77.

**Table 2.22Percentage of new born applied chlorhexidine (CHX) gel**

| **Districts/FY** | **2074/75** | **2075/76** | **2076/77** |
|---|---|---|---|
| Gorkha | 97 | 99 | 97 |
| Manang | 100 | 79 | 13088 |
| Mustang | 67 | 64 | 90 |
| Myagdi | 95 | 96 | 97 |
| Kaski | 84 | 71 | 71 |
| Lamjung | 75 | 97 | 97 |
| Tanahun | 97 | 93 | 95 |
| Nawalparasi East | 98 | 97 | 92 |
| Syangja | 92 | 100 | 89 |
| Parbat | 90 | 98 | 94 |
| Baglung | 114 | 122 | 127 |
| Gandaki Province | 91 | 87 | 90 |

***Source HMIS/DHIS-2***

## 2.2 Family Health

Family Health Program has three major program components including safe motherhood & neonatal health, family planning and adolescent sexual & reproductive health.

### 2.2.1 Safe Motherhood Program

The Safe Motherhood Program is the major one to reduce maternal and neonatal mortality by addressing the high rates of mortality and morbidity caused by the complications of pregnancy and childbirth. Experience also showed that the avoidance of the three delays: (i) delay in seeking care, (ii) delay in reaching care, and (iii) delay in receiving the care was imperative to achieve the stipulated goal of reducing the maternal mortality ratio in Nepal.

To reduce the risks associated with pregnancy and childbirth and address the above-mentioned delays, three major strategies have been adopted in Nepal:

- Promoting birth preparedness and complication readiness including awareness raising and improving the availability of funds, transport and blood supplies
- Encouraging women for institutional delivery
- Expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected public health facilities in every district

In order to ensure focused and coordinated efforts among the various stakeholders involved in safe motherhood and neonatal health program, government and non-government, national and international, the national Safe motherhood Plan (2002-2017) has been revised, to involve a wide range of partners and stakeholders. The revised Safe Motherhood and Neonatal Health Long Term Plan (SMNHLTP 2006- 2017) include recent developments in these areas which were not adequately covered in the original plan.

The revised plan recognizes the importance of addressing neonatal health as an integral part of safe motherhood program; the policy for skilled birth attendants; health sector reform initiatives; legalization of abortion and the integration of safe abortion services under the safe motherhood umbrella; addressing the increasing problem of mother to child transmission of HIV/AIDS; and recognition of the importance of equity and access efforts to ensure that most needy women can access the health services as per their need. The SMNHLTP identifies the following goal, purposes and outputs.

**Goal**

Improved maternal and neonatal health and survival, especially of the poor and disadvantaged group. The key indicators for the goal are:

- A reduction in the maternal mortality ratio from the current 281 per 100,000 live births to 70 per 100,000 by 2030 according to SDG.
- Reduce preventable deaths of new born and children to less than 1 percent according to SDG.
- Increase the CPR (modern methods) to 75percent
- Increase institutional deliveries to 90 percent

**Purpose**

Increased healthy practices and utilization of quality maternal and neonatal health services, especially by the poor and disadvantaged group, delivered by a well-managed health sector.

**Outputs**

- Eight outputs are specified in the plan, each with individual indicators.
- Equity and access
- Service delivery
- Public private partnership
- Decentralization
- Human resource development: Skilled birth attendant strategy
- Information management
- Physical assets and procurement
- Finance

**Strategies**

Safe Motherhood goals and objectives are to be achieved through the implementation of the following strategies:

- Promoting inter-sectoral collaboration by ensuring access for and commitments to Reproductive health, including safe motherhood at the central, provincial, district, local level and community levels focusing poor and excluded groups;
- Strengthening and expanding delivery by skilled birth attendants, basic and comprehensive obstetric care services (including family planning) at all levels.
- Supporting activities that raise the status of women in society
- Promoting research on safe motherhood to contribute to improved planning, higher quality services, and more cost-effective interventions

### 2.2.1.1 Service Facilities (Birthing Centers, BEOC and CEONC)

Extension of Birthing Centre seems to be required for the good coverage of institutional delivery. There is the total number of 319 birthing centers, 29 BEOC sites and 14 CEONC sites in which Manang and Mustang districts have no CEONC sites.

**Table 2.23: Services facilities**

| Districts | Services facilities in 2076/77 | | |
|---|---|---|---|
| | Birthing Centers | BEOC Sites | CEONC Sites |
| Gorkha | 51 | 3 | 2 |
| Manang | 7 | 1 | 0 |
| Mustang | 10 | 2 | 0 |
| Myagdi | 27 | 2 | 1 |
| Kaski | 26 | 4 | 4 |
| Lamjung | 35 | 3 | 1 |
| Tanahun | 36 | 3 | 1 |
| Nawalparasi East | 15 | 4 | 1 |
| Syangja | 28 | 4 | 1 |
| Parbat | 31 | 1 | 1 |
| Baglung | 53 | 2 | 2 |
| **Gandaki Province** | **319** | **29** | **14** |

### 2.2.1.2 TD-2 Coverage

TD-2 coverage is in decreasing trend in last three years. There was 30 percent coverage in 2074/2075, which decreased to 29 percent in 2075/2076 and 25 percent in 2076/2077. All the districts within the province have low achievement and not so variation on the districts.

**Table 2.24: TD-2 Coverage**

| Districts | Percentage of pregnant women who received TD2 | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 35 | 35 | 31 |
| Manang | 22 | 12 | 19 |
| Mustang | 17 | 21 | 18 |
| Myagdi | 30 | 25 | 23 |
| Kaski | 38 | 35 | 25 |
| Lamjung | 28 | 25 | 24 |
| Tanahun | 26 | 22 | 23 |
| Nawalparasi East | 28 | 36 | 30 |
| Syangja | 26 | 26 | 27 |
| Parbat | 25 | 22 | 17 |
| Baglung | 31 | 29 | 23 |
| **Gandaki Province** | **30** | **29** | **25** |

***Source HMIS/DHIS-2***

### 2.2.1.3 TD-2+ Coverage

TD-2+ coverage is in decreasing trend in last three years. There was 24 percent coverage in 2074/2075, which decreased 22 percent in 2075/2076 and stable in 22 percent in 2076/2077. Out of eleven districts, Kaski achieved highest and Manang achieved lowest percentage of TD-2+ in this province.

**Table: 2.25: TD-2+ Coverage**

| Districts | Percentage of pregnant women who received TD2+ | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 18 | 17 | 19 |
| Manang | 19 | 5 | 6 |
| Mustang | 19 | 22 | 10 |
| Kaski | 37 | 37 | 34 |
| Myagdi | 21 | 14 | 15 |
| Lamjung | 23 | 22 | 23 |
| Tanahun | 21 | 17 | 15 |
| Nawalparasi East | 21 | 30 | 28 |
| Syangja | 29 | 26 | 29 |
| Parbat | 28 | 24 | 23 |
| Baglung | 29 | 30 | 26 |
| **Gandaki Province** | **24** | **22** | **22** |

***Source: DHIS-2, 2076/77***

### 2.2.1.4: ANC first visit coverage

Overall Provincial coverage of at least one ANC 1st visit for health check-up as percentage of expected live birth has increased from 94% in 2074/75 to 105% in FY 2075/76. But in this FY 2076/77 the coverage is decreased to 87%. Furthermore, there is high variation within the districts of this province in the coverage of ANC 1st visit 31 % (Manang) to 128 % (Kaski). It seems that there is a need to implement and improve community mobilization activities for improving the health seeking behavior of pregnant women in the province. The province needs to further strengthen the quality of care, counselling, IEC and health education in hard-to-reach area and population.

**Table 2.26: Percentage of women who had at least one ANC checkup**

| Districts | Percentage of pregnant women who had at least one ANC checkup | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 78 | 71 | 77 |
| Manang | 72 | 45 | 31 |
| Mustang | 62 | 68 | 57 |
| Myagdi | 85 | 78 | 71 |
| Kaski | 161 | 194 | 128 |
| Lamjung | 86 | 79 | 85 |
| Tanahun | 58 | 78 | 60 |
| Nawalparasi East | 70 | 91 | 81 |
| Syangja | 95 | 95 | 94 |
| Parbat | 58 | 53 | 61 |
| Baglung | 84 | 81 | 72 |
| **Gandaki Province** | **94** | **105** | **87** |

***Source: DHIS-2, 2076/77***

### 2.2.1.5 Four ANC check-ups as per protocol (4th, 6th, 8th and 9th months) and delivered in a health facility)

Overall, four ANC visit as a protocol has a fluctuating trend in the province. It has slightly increased from 60% in 2074/075 to 67% in 2075/076 and decreased to 55% in 2076/077 which is not satisfactory. Only Myagdi and Syngja districts have slightly increased the four ANC visit as protocol. There was nearly constant in two districts; Gorkha and Lamjung whereas rest of the seven districts have decreasing trends. Counseling in the community to pregnant women to complete all 4 ANC check-up should be increased.

**Table 2.27: Percentage of women who had four ANC check-ups as protocol**

| Districts | Percentage of pregnant women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th month) | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 45 | 46 | 46 |
| Manang | 16 | 6 | 9 |
| Mustang | 26 | 22 | 17 |
| Myagdi | 65 | 57 | 59 |
| Kaski | 116 | 146 | 96 |
| Lamjung | 57 | 50 | 50 |
| Tanahun | 28 | 29 | 27 |
| Nawalparasi East | 49 | 62 | 53 |
| Syangja | 50 | 41 | 43 |
| Parbat | 43 | 40 | 36 |
| Baglung | 47 | 46 | 42 |
| **Gandaki Province** | **60** | **67** | **55** |

***Source: DHIS-2, 2076/77***

### 2.2.1.6 Pregnant mother receiving IFA Tablets

A postpartum woman should take iron and folic acid for 45 days after the delivery to prevent from anemia. It seems to slightly increasing and decreasing in the last three years. There is 27% in FY 74/75 it is increased to 28% in FY 75/76 and slightly decreased to 26% in FY 2076/77.

**Table: 2.28 Percentage of Pregnant mother receiving IFA Tablets**

| Districts | Percentage of postpartum women who received a 45-day supply of IFA | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 43 | 40 | 28 |
| Manang | 22 | 5 | 8 |
| Mustang | 28 | 23 | 26 |
| Myagdi | 38 | 57 | 57 |
| Kaski | 13 | 27 | 14 |
| Lamjung | 47 | 38 | 42 |
| Tanahun | 19 | 11 | 21 |
| Nawalparasi East | 24 | 26 | 20 |
| Syangja | 33 | 23 | 35 |
| Parbat | 26 | 29 | 26 |
| Baglung | 30 | 30 | 29 |
| Gandaki Province | **27** | **28** | **26** |

***Source: DHIS-2, 2076/77***

### 2.2.1.7 Postpartum mothers receiving vitamin A supplement

The percentage of postpartum women who received Vitamin A supplementation is in decreasing trend in the past 3 years. As the table reveals, the percentage is decreasing from 53 percent to 46 percent and again to 40 percent in FY 74/75, 75/76 and 76/77 respectively. It can be predicted that the mother

who had institutional delivery only had vitamin A supplementation only. This should be given to the mother who had home delivery too.

**Table: 2.29 Percentage of postpartum women who received Vitamin A Suppliment**

| Districts | Percentage of postpartum women who received Vitamin A supplementation | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 57 | 52 | 50 |
| Manang | 26 | 11 | 36 |
| Mustang | 33 | 38 | 29 |
| Myagdi | 51 | 66 | 63 |
| Kaski | 76 | 65 | 36 |
| Lamjung | 51 | 40 | 45 |
| Tanahun | 31 | 17 | 26 |
| Nawalparasi East | 36 | 44 | 42 |
| Syangja | 69 | 40 | 45 |
| Parbat | 37 | 39 | 33 |
| Baglung | 50 | 48 | 41 |
| Gandaki Province | **53** | **46** | **40** |

***Source: DHIS-2, 2076/77***

### 2.2.1.8 Deliveries conducted by Health workers

Table shows the percentage of births attended by a health worker other than SBA is 1 in the last three fiscal years. It is encouraged that the delivery should be conducted by the health workers who are trained with skilled birth attendant. Therefore, this data may be low due to the conduction of delivery by SBA trained health personnel.

**Table: 2.30 deliveries conducted by health workers**

| Districts | Percentage of births attended by a health worker other than SBA | | |
|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 2 | 7 | 3 |
| Manang | 2 | 1 | 3 |
| Mustang | 2 | 1 | 0 |
| Myagdi | 5 | 3 | 3 |
| Kaski | 0 | 0 | 0 |
| Lamjung | 1 | 0 | 0 |
| Tanahun | 1 | 0 | 0 |
| Nawalparasi East | 1 | 0 | 0 |
| Syangja | 0 | 0 | 1 |
| Parbat | 0 | 0 | 0 |
| Baglung | 2 | 1 | 2 |
| **Gandaki Province** | **1** | **1** | **1** |

***Source: DHIS-2, 2076/77***

### 2.2.1.9 Institutional Delivery

Institutional delivery in the province seems nearly constant in these last three years. Institutional delivery, as percentage of expected live births, was 47% in 2074/075 increased to 48% percent in 2075/76 and slightly decreased again to 47% in 2076/77. As we compare, The Kaski district has the highest percentage of institutional delivery. This may due to the referral centers like Pokhara Academy of Health Science, Gandaki Medical College and Manipal Teaching Hospitals are situated in the Kaski districts where the pregnant women from other districts of the province also come for delivery.
The percentage is less in Manang district i.e., only 9% which may be due to the geographical difficulties in reaching the health services during the time of delivery.

**Table 2.31: Percentages Institutional Delivery**

| Districts F/Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 38 | 34 | 27 |
| Manang | 25 | 8 | 9 |
| Mustang | 20 | 22 | 27 |
| Myagdi | 57 | 52 | 54 |
| Kaski | 112 | 116 | 110 |
| Lamjung | 43 | 37 | 40 |
| Tanahun | 21 | 18 | 20 |
| Nawalparasi East | 15 | 20 | 18 |
| Syangja | 22 | 24 | 26 |
| Parbat | 27 | 26 | 23 |
| Baglung | 42 | 43 | 44 |
| Gandaki Province | **47** | **48** | **47** |

***Source: DHIS-2, 2076/77***

### 2.2.1.10 Delivery conducted by SBA

The delivery assisted by SBA is in constant trend but it is not satisfactory. Lots of effort is required here to meet SDG Target i.e., 90%. This reflects that SBA training is required to all health staffs involved in delivery at every health facility and there must be SBA Trained personnel at every birthing center.
There is a slightly increasing trend on delivery conducted by SBA. Districts like Kaski have already achieved SDG goals but other districts had not meet SDG goal. Topography and difficulty to reach in health facilities in hill and mountain districts and non-functional birthing centers may be the reasons for low performance in few districts.

**Table: 2.32 Delivery conducted by SBA**

| Districts F/Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 38 | 29 | 25 |
| Manang | 23 | 7 | 7 |
| Mustang | 20 | 22 | 28 |
| Myagdi | 56 | 51 | 52 |
| Kaski | 112 | 116 | 110 |
| Lamjung | 42 | 37 | 40 |
| Tanahun | 20 | 18 | 20 |
| Nawalparasi East | 15 | 20 | 18 |
| Syangja | 22 | 23 | 25 |
| Parbat | 27 | 26 | 23 |
| Baglung | 42 | 42 | 43 |
| Gandaki Province | **47** | **47** | **46** |

***Source: DHIS-2, 2076/77***

### 2.2.1.11 Deliveries by Caesarean section

The percentage of deliveries by caesarean section (22%) also seems to be in increasing trend. It is highest in Kaski district i.e., is 38% where as Lamjung district is 11% where as Myagdi, Syangja and Baglung districts have 6 % and all other remaining districts have the percentage of caesarean section less than 5%. This may be due to the referral of complicated cases like breech presentation, oligohydramnios, fetal distress etc. to the hospitals in Kaski.

**Table 2.33: Percentage of deliveries by caesarean section**

| Districts F/Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 4 | 4 | 1 |
| Manang | 0 | 0 | 0 |
| Mustang | 0 | 0 | 0 |
| Myagdi | 6 | 5 | 6 |
| Kaski | 34 | 35 | 38 |
| Lamjung | 11 | 8 | 11 |
| Tanahun | 1 | 0 | 1 |
| Nawalparasi East | 0 | 0 | 0 |
| Syangja | 1 | 2 | 6 |
| Parbat | 2 | 1 | 3 |
| Baglung | 3 | 3 | 6 |
| Gandaki Province | **19** | **19** | **22** |

***Source: DHIS-2, 2076/77***

### 2.2.1.12 PNC First visit

There is no problem with institutional delivery because the woman is admitted for few days the in-health center only, but the cases which had home delivery should visit the health institution in first 24 hours of delivery for the confirmation of complete expulsion of product of conception as PNC 1$^{st}$ visit as per protocol. The percentage of postpartum women who received a PNC check-up within 24 hours of delivery has increased slightly 46% to 47% from FY 74/75 and in FY 75/76 but decreased to 46%

again in 76/77. It is less than 50% live births which are to be increased in order to prevent maternal and neonatal mortality.

**Table: 2.34 Percentage of postpartum women who received a PNC check-up within 24 hours of delivery**

| Districts F/Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 40 | 36 | 27 |
| Manang | 22 | 7 | 7 |
| Mustang | 23 | 22 | 28 |
| Myagdi | 58 | 53 | 54 |
| Kaski | 110 | 110 | 110 |
| Lamjung | 45 | 36 | 39 |
| Tanahun | 20 | 18 | 20 |
| Nawalparasi East | 15 | 20 | 19 |
| Syangja | 23 | 23 | 26 |
| Parbat | 27 | 26 | 23 |
| Baglung | 33 | 42 | 42 |
| **Gandaki Province** | **46** | **47** | **46** |

***Source: DHIS-2, 2076/77***

### 2.2.1.13 PNC Third visit

Postpartum mother should have three postnatal check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery) in to prevent and manage the postpartum complications. This data (13%) seems to be very low and nearly constant in these three years.

**Table 2.35: Percentage of postpartum women who had 3 PNC check-ups as per protocol**

| Districts F/Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 19 | 20 | 18 |
| Manang | 20 | 5 | 5 |
| Mustang | 13 | 18 | 24 |
| Myagdi | 21 | 17 | 23 |
| Kaski | 17 | 17 | 17 |
| Lamjung | 15 | 13 | 13 |
| Tanahun | 8 | 10 | 10 |
| Nawalparasi East | 7 | 9 | 10 |
| Syangja | 13 | 14 | 10 |
| Parbat | 9 | 11 | 12 |
| Baglung | 10 | 10 | 11 |
| **Gandaki Province** | **13** | **13** | **13** |

***Source: DHIS-2, 2076/77***

### 2.2.1.14 Met need of obstetric complication Management (15% of expected live births)

Met need of obstetric complication Management was stable i.e., 8 percent in FY 74/75 and in FY 75/76 but is decreased to 7% in FY 2076/77.

**Table 2.36 Met need of obstetric complication Management**

| Districts F/ Y | 2074/ 075 | 2075/ 076 | 2076/ 077 |
|---|---|---|---|
| Gorkha | 4 | 2 | 2 |
| Manang | 0 | 0 | 0 |
| Mustang | 1 | 1 | 1 |
| Myagdi | 4 | 2 | 2 |
| Kaski | 31 | 29 | 19 |
| Lamjung | 3 | 11 | 16 |
| Tanahun | 1 | 2 | 2 |
| Nawalparasi East | 2 | 3 | 3 |
| Syangja | 2 | 2 | 2 |
| Parbat | 0 | 0 | 1 |
| Baglung | 2 | 2 | 2 |
| **Gandaki Province** | **8** | **8** | **7** |

***Source: DHIS-2, 2076/77***

### 2.2.1.15 Status of Aama Suraksha Program Implementation

As we see the trend of the percentage of women receiving ANC incentives is in increasing order in FY 2076/77 i.e., 108% which shows that many of the women had 4 ANC checkups according to protocol and almost 81% of them had maternity incentives.

**Table 2.37 Status of Aama Suraksha Program implementation**

| Districts | % of women receiving ANC incentives | | | % of women receiving maternity incentives | | |
|---|---|---|---|---|---|---|
| | 2074/ 075 | 2075/ 076 | 2076/ 077 | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 95 | 95 | 96 | 97 | 98 | 99 |
| Manang | 25 | 100 | 474 | 33 | 100 | 107 |
| Mustang | 100 | 86 | 1 | 78 | 95 | 1 |
| Myagdi | 85 | 89 | 52 | 99 | 100 | 41 |
| Kaski | 90 | 40 | 94 | 99 | 49 | 83 |
| Lamjung | 94 | 31 | 100 | 94 | 65 | 100 |
| Tanahun | 100 | 98 | 100 | 99 | 96 | 96 |
| Nawalparasi East | 78 | 75 | 87 | 98 | 90 | 99 |
| Syangja | 100 | 99 | 88 | 100 | 100 | 100 |
| Parbat | 99 | 98 | 100 | 100 | 100 | 100 |
| Baglung | 90 | 94 | 97 | 99 | 98 | 100 |
| **Gandaki Province** | **93** | **72** | **108** | **99** | **68** | **81** |

***Source: DHIS-2, 2076/77***

### 3.2.2 Family Planning

The main thrust of the National Family Planning Program is to expand and sustain good quality of family planning services to people in the community through the health service network such as hospitals, primary health care centers (PHCC), health posts (HP), primary health care outreach clinics (PHC/ORC), mobile voluntary surgical contraception (VSC) camps and satellite clinics. The policy also aims to encourage public private partnership. Female Community Health Volunteers (FCHVs) will be mobilized to promote condom distribution and re-supply of oral pills. Awareness on FP will be

increased through various IEC/BCC intervention as well as active involvement of FCHVs and Mothers Groups as envisaged by the revised national strategy for female community health volunteers' program and family planning policy.

In this regard, family planning services are designed to provide a constellation of contraceptive methods/services that reduce fertility, enhance maternal and neonatal health, child survival and contribute to bringing about a balance in population growth and socio-economic development, resulting in an environment that will help the Nepalese people improve their quality of life. Informed choice of the clients is a basic strategy in demand generation and delivery of family planning services.

**Objectives**

Within the context of reproductive health, the main objectives of the Family Planning Program are to assist individuals and couples to:

- Space and/or limit their children
- Prevent unwanted pregnancies
- Improve their overall reproductive health

**Targets**

Periodic and long-term targets for the Family Planning Program have been established as follows:

- Contraceptive Prevalence Rate (CPR): to increase the Contraceptive Prevalence Rate (CPR) from 48 percent in 2006 to 57 percent by the end of 3 Year Interim Plan Period (2013), 67 percent by 2015 (MDG) and 75 percent by 2030 (SDG).

- Family Planning Continuing Users: recognizing the importance of spacing of births, the Family Planning Program placed greater emphasis on promoting long-acting temporary methods of contraception and this effort is continued in the last 3 Years Interim plan. More specifically, the long-term objective is to reduce the share of permanent sterilization in overall family planning methods use. However, the expected number of VSC cases need to be increased in order to meet the unmet demand of those who desire to limit the births.

**Strategies**

The Family Planning Program aims to provide a constellation on contraceptive services throughout the country. The strategy to achieve the family planning goals includes the following elements:

- Annual review of policy through national RH steering committee meetings
- Co-ordination through RH co-ordination committee half yearly meetings
- Institutionalization of policy/operational guidelines and clinical protocols to ensure maximum coverage and quality of family planning services
- Increasing the knowledge and understanding of the benefits of delayed marriage, birth spacing, and a well-planned family norm across the country through integrated RH/ FP/IEC/BCC activities
- Increasing accessibility and availability of FP services through a combination of static, outreach/satellite and referral services
- Establish FP service as a part of hospital service
- Strengthen and institutionalize Family Planning Service Centre (IFPSC)
- Expanding regular year-round and mobile VSC outreach services

- Expanding IUCD/Implant services to PHCC and HP, with special emphasis on thorough counseling and follow-up services
- Linking FP program with essential Health Care Service
- Providing non-clinical methods (condoms, pills, and injectable) through static and outreach services
- Training of service providers in collaboration with NHTC
- Improving the quality of care in accordance with the National Medical Standards for contraceptive services, with special attention on counseling, infection prevention and management of side effects and complications
- Providing re-canalization services in selected hospitals
- Establishing post-partum FP services in institutions with a significant caseload of deliveries;
- Integrating family planning services with post abortion care and safe abortion care in a phased manner
- Identifying national requirements and ensuring adequate procurement of contraceptives and logistic supplies
- Ensuring effective financial management of FP program
- Strengthening Health Management Information Systems (HMIS) for better management of RH programs including family planning program
- Utilizing health systems research more effectively to guide policy and planning decisions
- Ensuring effective monitoring and supervision of FP programs
- Increasing free access to condom by having condom boxes at all health institutions and
- Re-supplying pills and distributing condom through FCHVs.

### 2.2.2.1: FP method wise (modern contraceptives) new acceptors

The modern contraceptive new acceptor in this year is shown in the table. Most of the users are the user of condom and Depo-Provera. The new acceptor of Depo-Provera is highest in the districts like Gorkha, Kaski, Tanahun etc. Similarly, the new acceptor of Condom is highest in Kaski, Gorkha and Baglung. Kaski has 2189 Pills new users which is the highest among the districts. Implant new users are highest in Kaski, Tanahun & Gorkha. Similarly, IUCD new acceptor are highest in Kaski.

**Table 2.38: FP method wise (modern contraceptives) new acceptors**

| Districts | 2076/ 2077 | | | | |
|---|---|---|---|---|---|
| | Condom users(qty/150) | Pills New Users Total | Depo New Users Total | IUCD New Users Total | Implant New Users Total |
| Gorkha | 2090 | 1570 | 3103 | 73 | 868 |
| Manang | 111 | 37 | 58 | 10 | 45 |
| Mustang | 179 | 98 | 168 | 3 | 79 |
| Myagdi | 1029 | 640 | 1654 | 73 | 659 |
| Kaski | 2894 | 2189 | 2721 | 452 | 1253 |
| Lamjung | 1526 | 569 | 1086 | 204 | 344 |
| Tanahun | 1427 | 1620 | 2475 | 338 | 972 |
| Nawalparasi East | 1289 | 1718 | 2217 | 143 | 568 |
| Syangja | 1935 | 1195 | 1392 | 88 | 602 |
| Parbat | 1403 | 805 | 1155 | 150 | 631 |
| Baglung | 2189 | 1417 | 2095 | 65 | 758 |
| **Gandaki Province** | **16072** | **11858** | **18124** | **1599** | **6779** |

***Source: DHIS-2, 2076/77***

### 3.2.2.2 Percentage of new acceptors (all methods)

Regarding the percentage of new acceptors of all family planning methods, the trend in these three years is decreasing from 11% to 10% and constant in 10% (FY 074/75, 075/76 and 076/77 respectively).

**Table 2.39: Percentage of new acceptors (all methods)**

| Data | FP Methods New acceptor among as % of WRA | | |
|---|---|---|---|
| Districts | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 14 | 12 | 14 |
| Manang | 27 | 28 | 24 |
| Mustang | 27 | 21 | 22 |
| Myagdi | 18 | 16 | 16 |
| Kaski | 9 | 9 | 8 |
| Lamjung | 12 | 10 | 10 |
| Tanahun | 9 | 9 | 8 |
| Nawalparasi East | 7 | 8 | 7 |
| Syangja | 10 | 8 | 9 |
| Parbat | 11 | 11 | 12 |
| Baglung | 11 | 11 | 10 |
| **Gandaki Province** | **11** | **10** | **10** |

***Source: DHIS-2, 2076/77***

### 2.2.2.3 Contraceptive Prevalence Rate (CPR as percentage of WRA)

CPR is only 33 percent in this year. In spite of many efforts made by the Nepal government and the support of various NGOs and INGOs CPR is still low in this province. More efforts have to be done to meet the target of SDG i.e CPR 75 percent by 2030.

**Table 2.40: Contraceptive Prevalence Rate (CPR as percentage of WRA)**

| **Period** | **Current users Asar 2077** | | | | **2076/2077** | **2076/77** |
|---|---|---|---|---|---|---|
| District | Depo-Current User | IUCD-Current User | Implant-Current User | Pills-Current User | Condom-CYP | CPR |
| Gorkha | 4580 | 477 | 4983 | 1755 | 186 | 42 |
| Manang | 96 | 10 | 147 | 53 | 10 | 52 |
| Mustang | 213 | 12 | 230 | 77 | 19 | 50 |
| Myagdi | 1667 | 1333 | 3272 | 584 | 87 | 45 |
| Kaski | 1942 | 6739 | 7260 | 1641 | 242 | 34 |
| Lamjung | 1550 | 1032 | 1630 | 799 | 138 | 33 |
| Tanahun | 2041 | 3182 | 4495 | 1252 | 131 | 28 |
| Nawalparasi East | 2046 | 1817 | 1907 | 1828 | 118 | 31 |
| Syangja | 1579 | 1103 | 2309 | 1811 | 163 | 32 |
| Parbat | 1214 | 780 | 2627 | 821 | 148 | 31 |
| Baglung | 2206 | 1095 | 3669 | 1527 | 176 | 28 |
| **Gandaki Province** | 19134 | 17580 | 32529 | 12148 | 1416 | 33 |

***Source: DHIS-2, 2076/77***

### 2.2.3 Adolescent Sexual and Reproductive Health

More than a quarter of the world's population is between the ages of 10 and 24, with 86% living in less developing countries. These young people are tomorrow's parents. The reproductive and sexual health decisions they make today will affect the health and wellbeing of their communities and of their countries for decades to come.

Adolescent sexual and reproductive health refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion.

About 22% (6.38 million) of Nepal's 28.5 million population (government projection for 2016) are adolescents aged 10–19 years. The legal age of marriage in Nepal is 20 years. Despite that, 49% of women aged 20–49 years were married by the age of 18 and 16% aged 15-49 were married by the age of 15, according to the *Nepal Multiple Indicator Cluster Survey 2014 (NMICS 2014)*.

#### 2.2.3.1 Family Planning method used by adolescent

Adolescents seem to be using family planning methods in which the user of Depo-Provera is highest whereas the user of IUCD is the lowest in this fiscal year.

**Table 2.41: Family Planning method used by adolescent**

| Period | 2076/2077 | | | |
|---|---|---|---|---|
| Districts | Family Planning Program-Temporary FP Method-Pills-New Users <20 Years | Family Planning Program-Temporary FP Method-Depo-New Users <20 Years | Family Planning Program-Temporary FP Method-IUCD-New Users <20 Years | Family Planning Program-Temporary FP Method-Implant-New Users <20 Years |
| Gorkha | 119 | 267 | 5 | 46 |
| Manang | 0 | 2 | 0 | 1 |
| Mustang | 8 | 3 | 0 | 6 |
| Myagdi | 26 | 126 | 2 | 38 |
| Kaski | 193 | 278 | 11 | 64 |
| Lamjung | 45 | 101 | 7 | 21 |
| Tanahun | 125 | 194 | 5 | 68 |
| Nawalparasi East | 137 | 217 | 4 | 47 |
| Syangja | 53 | 84 | 4 | 28 |
| Parbat | 44 | 93 | 1 | 19 |
| Baglung | 92 | 179 | 0 | 19 |
| **Gandaki Province** | 842 | 1544 | 39 | 357 |

***Source: DHIS-2, 2076/77***

#### 2.2.3.2 Proportion of adolescent getting ANC check-up as protocol

In total 13% adolescent received four ANC check-up as protocol in Gandaki province. The lowest percentage (5%) of adolescent ANC check-up as protocol in Gandaki province was in mustang district

**Table 2.42: Proportion of adolescent getting ANC check-up as protocol**

| 2076/77 | | | |
|---|---|---|---|
| Organization unit / Data | Four ANC Checkup as Protocol< 20 Years | Four ANC Checkup as Protocol ≥ 20 Years | Proportion of Four ANC Checkup<20 |
| Gorkha | 372 | 2305 | 14 |
| Manang | 1 | 9 | 10 |
| Mustang | 2 | 37 | 5 |
| Myagdi | 208 | 1277 | 14 |
| Kaski | 1255 | 10685 | 11 |
| Lamjung | 222 | 1736 | 11 |
| Tanahun | 347 | 1838 | 16 |
| Nawalparasi East | 615 | 3688 | 14 |
| Syangja | 312 | 2268 | 12 |
| Parbat | 127 | 1122 | 10 |
| Baglung | 451 | 2345 | 16 |
| **Gandaki Province** | 3912 | 27310 | 13 |

***Source: DHIS-2, 2076/77***

### 2.2.3.3 Proportion of Adolescent (<20 years) receiving abortion service

Adolescent proportion receiving abortion service compare to last fiscal year is in decreasing trend. In this fiscal year, the proportion of adolescent receiving abortion service proportion is 7% in the provience. Kaski district had 10% which is the highest among the 11 districts. In Manang and Mustang districts the achievement is zero.

**Table 2.43 Proportion of Adolescent (<20 years) receiving abortion service**

| Data | Proportion of <20 years women receiving abortion service | | |
|---|---|---|---|
| Districts | 2074/ 075 | 2075/ 076 | 2076/ 077 |
| Gorkha | 5 | 12 | 8 |
| Manang | | | |
| Mustang | 0 | 0 | |
| Myagdi | 7 | 7 | 7 |
| Kaski | 7 | 17 | 10 |
| Lamjung | 15 | 6 | 8 |
| Tanahun | 7 | 8 | 6 |
| Nawalparasi East | 6 | 8 | 5 |
| Syangja | 7 | 10 | 7 |
| Parbat | 13 | 8 | 5 |
| Baglung | 6 | 5 | 8 |
| Gandaki Province | 7 | 11 | 7 |

***Source: DHIS-2, 2076/77***

### Problems and Issues in Family Health Program

Following problems and issues have been identified during district review meetings in Family Health Program.

**Issues and Recommendations in Safe Motherhood Program**

| Key Issues | Recommendation | Responsibility |
|---|---|---|
| Budget for birthing centre, BEOC, and CEOC site is minimal | • Enough budget should be allocated for purchasing equipment and furniture for these sites | MoHP/DoHs/ MoSD |
| Misuse of Medical Abortion | • Monitor private facilities<br>• Control the illegal trade of MA drugs | HO/FHD |
| Low 4th ANC visit | • Visit mother group meeting regularly by technical staffs<br>• Awareness Program | HO/FHD |
| Low Institutional delivery | • Expanding birthing centers and ensuring well equipped centers with sufficient staffs<br>• Provide sufficient SBA training to staffs<br>• Encourage and bring the potential private sector in govt. scheme of free delivery care | FHD |
| Lack of SBA training | • There are still many health institutions where no staffs are SBA trained which can decline institutional delivery and increase maternal and neonatal mortality. So, each health institution must have atleast one SBA trained staff | FHD |

**Issues and Recommendation in Family Planning Program**

| Key issues | Recommendation | Responsible |
|---|---|---|
| Low CPR | • Categorize low CPR district & micro plan<br>• Streamline reports from private and non-government sector<br>• Increase focus in Long term family planning service expansion<br>• Promote FP as a development agenda<br>• HR Development of FP service acceleration | FHD<br>HO/FHD |
| Target setting is not realistic | • Target is adjusted by center | FHD |
| Doctors not available for VSC | • MoHP and DoHS should take an initiative | FHD |
| Lack of Family Planning Training such as implant, IUCD, vasectomy etc | • Training must be conducted in such a way that at least one staff in every health institution will be trained and services can be run effectively there. | FHD |

# Section 3

# EPIDEMIOLOGY AND DISEASE CONTROL

## 3.1 Malaria

### Background

In 1954, Malaria control program was initiated in Southern Terai belt of central Nepal as Malaria control project named Insect Borne Disease Control (IBDC) supported by USAID (then USOM) in Nepal. In 1958, national Malaria eradication program, the first national public health program in the country was launched with the objective of eradicating Malaria from the country within a limited period. Due to various reasons, the eradication concept was reverted to control program in 1978. Following the call of WHO to revamp the Malaria Control Program in 1998, Roll Back Malaria (RBM) initiative was launched to address the perennial problem of Malaria in hard-core forested, foothills, inner Terai and valley areas of the hills, where more than 70 percent of the total Malaria cases of the country prevail. The high risk of getting the disease is attributed to the abundance of vector mosquitoes, mobile and vulnerable population, relative inaccessibility of the area, suitable temperature, environmental and socio-economic factors. The Global Fund has been continuously supporting Malaria control program in the risk areas since 2004.

The 2018 micro-stratification has categorized high, moderate and low-risk wards for Malaria. The result identified 49 high-risk wards with no wards in Gandaki province while among 151 moderate risk wards and one ward falls under Gandaki province.

**National Malaria Strategic Plan (NMSP) 2014-2025, Revised**
**Vision:** Malaria-free Nepal by 2025 AD.

National Malaria Strategic Plan (2014-2025, Revised) are phased as following for malaria elimination:

- Achieve Malaria Elimination (zero indigenous cases) throughout the country by 2022;
    - Province 1, Bagmati & Gandaki “get to zero indigenous case” by 2020,
    - Province 2 & 5 “get to zero indigenous case” by 2021,
    - Province Karnali & 7 “get to zero indigenous case” by 2022, and
- Sustain malaria – free status and prevent re-introduction of malaria in provinces after getting to zero indigenous case.

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

- Achieve Malaria Elimination (zero indigenous cases) throughout the country by 2022; and

- Sustain Malaria – free status and prevent re-introduction of Malaria.

**The specific objectives of NMSP (2014-2025, Revised) are as follows:**

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

**Major activities conducted during FY 2076/77**

In addition to the regular annual Malaria program activities and interventions, following are the major activities carried out during this fiscal year:

- Case-based surveillance, including web-based recording and reporting system for the districts.
- Oriented private health facilities on Malaria
- Celebrated World Malaria Day
- Conducted detailed case-based investigation around positive index cases
- Conducted provincial level annual review meeting

**Malaria Blood Slide Collection and Examination**

A total of 596 slides from active case detection and 4621 slides from passive case detection was collected and examined in FY 2076/77 in the province. The trend of slides collection is on decreasing trend. However, slides collected from ACD are more in number in FY 2076/77 compared to FY 2075/76. Comparatively, Kaski and Nawalparasi East have a greater number of slide collections for examination.

**Table 3.1.1: Malaria blood slide collection and examination**

| F/Y | F/Y 2074/75 | | F/Y 2075/76 | | F/Y 2076/77 | |
|---|---|---|---|---|---|---|
| Districts | ACD | PCD | ACD | PCD | ACD | PCD |
| Gorkha | 459 | 293 | 9 | 195 | 3 | 131 |
| Kaski | 107 | 2121 | 148 | 3011 | 90 | 1882 |
| Lamjung | 14 | 321 | 0 | 483 | 6 | 371 |
| Manang | 0 | 0 | 0 | 0 | 0 | 0 |
| Mustang | 0 | 0 | 0 | 0 | 0 | 0 |
| Myagdi | 0 | 0 | 0 | 82 | 0 | 67 |
| Nawalparasi East | 176 | 2631 | 195 | 2314 | 387 | 1823 |
| Parbat | 2 | 0 | 1 | 58 | 0 | 68 |
| Syangja | 0 | 157 | 0 | 121 | 1 | 177 |
| Tanahu | 1 | 330 | 0 | 72 | 92 | 97 |
| Baglung | 22 | 0 | 1 | 4 | 17 | 5 |
| Province | 781 | 5853 | 354 | 6340 | 596 | 4621 |

Source: HMIS/DHIS2

**Case Detection**

A total of 23 cases of malaria were reported in F/Y 2076/77 with the highest number reported in Nawalparasi East. Three districts (Myagdi, Mustang and Manang) showed no cases of Malaria. The case detection is observed in a decreasing trend in the last three fiscal years.

**Table: 3.1.2 Trend of Malaria cases detection**

| Districts/F/Y | F/Y 2074/75 | F/Y 2075/76 | F/Y 2076/77 |
|---|---|---|---|
| Gorkha | 1 | 1 | 1 |
| Kaski | 16 | 5 | 4 |
| Lamjung | 0 | 0 | 1 |
| Manang | 0 | 0 | 0 |
| Mustang | 0 | 0 | 0 |
| Myagdi | 0 | 0 | 0 |
| Nawalparasi East | 18 | 13 | 11 |
| Parbat | 0 | 3 | 1 |
| Syangja | 1 | 6 | 3 |
| Tanahu | 0 | 1 | 1 |
| Baglung | 0 | 3 | 1 |
| Total | 36 | 32 | 23 |

Source: HMIS/DHIS2

All cases reported in the province were imported cases of Malaria. No indigenous cases were reported in the last consecutive fiscal years.

**Table 3.1.3: Malaria cases detection by types**

| Cases | F/Y 2074/75 | F/Y 2075/76 | F/Y 2076/77 |
|---|---|---|---|
| Indigenous | 12 | 0 | 0 |
| Imported | 24 | 32 | 23 |

Source: HMIS/DHIS2

**Issues and Recommendation**

| Issues | Recommendations | Responsibility |
|---|---|---|
| Low coverage of testing of Malaria | Timely supply of commodities (RDT) | EDCD/HD/HO/Local Level |
| Irregular supply of Malaria drug and commodities | Onsite coaching to service providers at local health facilities | |
| Quality of Malaria testing (RDT and testing competencies of service providers) | Orientation/training/onsite coaching | |
| Poor monitoring and supervision up to health facility level | | |
| Missing to report service delivery at private health facilities | Follow up and onsite coach to private service providers for reporting | |

### 3.2 Kala-azar

**Background**

Kala-azar is a vector-borne disease caused by the parasite Leishmania donovani. It is transmitted by the bite of female sandfly Phlebotomutagenizes. The National Plan was revised in 2010 as a National Strategic Guideline on Kala-azar elimination in Nepal. The guideline was updated in 2014 and further revised in 2019. The recent guideline has recommended single dose liposomal amphotericin B as the first line treatment for primary kala-azar.

**Goal, objectives, and strategies**

**Goal:** To contribute to the 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, vulnerable and 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**

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

**Trend of Kala-azar Cases**

In the year 2076/77, a total 5 cases of kala-azar were reported in the province while no cases were reported in FY 2075/76. Among 5 cases of kala-azar, 4 were reported from Syangja while 1 was reported in Tanahun district.

**Table 3.2.1 Trend of Kala-azar Cases**

| Province | FY 2074/75 | FY 2075/76 | FY 2076/77 |
|---|---|---|---|
| Gandaki Province | 3 | 0 | 5 |

Source: HMIS/DHIS2

**Major activities in FY 2076/77**

The major activities for Kala-azar elimination program in Gandaki Province are as follows:

- Case based surveillance
- Transportation allowance to the cases identified

**Issues and Recommendation**

| Issues | Recommendations | Responsibility |
|---|---|---|
| Disease awareness among the service providers and in the communities | IEC/BCC activities; Orientation and Trainings | EDCD/HD/HO/Local Level |
| Case notification in hilly areas | Cover all districts of the province for kala-azar elimination interventions. | |

**3.3 Tuberculosis**

**Background**

Tuberculosis (TB) is a major public health problem in Nepal. According to WHO, every year, 42,000 people develop active TB. Of whom it is estimated that 20,000 have infectious pulmonary disease. The recent estimates of tuberculosis burden of Nepal resulted from National Prevalence Survey, 2019 AD is 69000 incident (245 per lakh population) cases and 117, 000 prevalent (416 per lakh population) TB cases. The incidence is 1.3 times and prevalence are 1.4 times higher than the WHO estimates. NTP has adopted the global WHO's END TB Strategy in the context of UN Sustainable Development Goals (SDGs) in 2016 AD. In line with END TB strategy, NTP has formulated five-year National Strategic Plan

(2016-2021) to accelerate the progress in declining TB incidence along with improvement in mortality and morbidity indicators. A focus is on joint efforts from all sectors – public, private, and civil society organizations towards ending TB.

National Tuberculosis Program (NTP) registered a total of 1941 TB cases in Gandaki Province and a total of 32 DR TB cases. Kaski and Nawalparasi East contribute 48% of the total notified TB cases. Out of which, 1902 (98%) were all forms of the incident (new and relapse) TB cases and 70% were pulmonary TB cases. Childhood TB is 4% of all notified TB cases, 60% were tested for HIV and treatment success rate is maintained at 90%.

There are 579 DOTS centers, 3 DR TB centers, 10 DR TB sub-centers including 1 DR TB home, 6 GeneXpert centers and 60 laboratory facilities working as a microscopic center in NTP.

**National Strategic Plan (2016-2021)**

**Vision**

TB Free Nepal

**Goal**

To decrease the TB incidence rate by 20% by the year 2021 as compared to 2015 and increase case notification by a cumulative total of 20,000 from July 2016 to July 2021, compared to the year 2015.

**Objectives**

**Objective 1:** Increase case notification through improved health facility-based diagnosis; increase diagnosis among children (from 6% at baseline to 10% of total cases by 2021); examination of household contacts and expanded diagnosis among vulnerable groups within the health service.

**Objective 2:** Maintain the treatment success rate at 90% patients (all forms of TB) through to 2021

**Objective 3:** Provide DR diagnostic services for 50% of persons with presumptive DR TB by 2018 and100% by 2021; successfully treat at least 75 % of the diagnosed DR patients

**Objective 4:** Further expand case finding by engaging providers for TB care from the public sector (beyond MoH), medical colleges, NGO sector, and private sector through results-based financing (PPM) schemes, with formal engagements (signed MoUs) to notify TB cases.

**Objective 5:** Strengthen community systems for management, advocacy, support, and rights for Patients to create an enabling environment to detect & manage TB cases in 60% of all districts by 2018 and 100% by 2021.

**Objective 6**: Contribute to health system strengthening through HR management and capacity development, financial management, infrastructures, procurements, and supply management in TB.

**Objective 7:** Develop a comprehensive TB surveillance, monitoring and evaluation system

**Objectives 8:** To develop a plan for the continuation of NTP services in the event of natural disaster or public health emergency.

**Major Activities in Fiscal Year 2076/77**

- Conducted trimester TB cohort review workshop for monitoring and evaluation of TB program
- Provide and ensure quality DOTS services to all TB patients
- Regular supply of TB drugs and required lab reagents and other consumables
- Strengthen DR TB tracking and laboratory system at all DR TB and GX centers
- Implementation of case finding interventions in Kaski, Tanahun, Nawalparasi East and Syangja through sub recipients of Global Fund Grant.
- Provided trainings, onsite coaching to health facility staffs.
- Collaborate with PMTCT program to improve TB/HIV testing

**TB Case notification**

The Case notification rate (CNR) of all forms of TB in the province is 77/100000 population, whereas case notification rate for incident TB cases is 76/100000 population. A total of 1947 TB cases are notified, of which 1902 (98%) are incident cases. There are 1370 (70%) pulmonary TB cases among the total notified cases. Out of pulmonary TB cases, 1089 (79%) are bacteriologically confirmed cases.

The trend of case notification has been decreased in FY 2076/77 compared to last fiscal years. The decrease in case notification in this fiscal year is observed in all districts except Mustang, Lamjung and Kaski. Syangja, Nawalparasi East and Tanahun share the highest percentage of decrease in case notification. The assumed reason for the decrease might be the interruption in OPD services and laboratory services during COVID 19 lockdown.

**Table 3.3.1: Case notification Rate of TB by districts per lakh population**

| F/Y / Districts | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 85 | 74 | 73 |
| Manang | 16 | 31 | 0 |
| Mustang | 17 | 25 | 69 |
| Myagdi | 39 | 58 | 43 |
| Kaski | 92 | 78 | 84 |
| Lamjung | 82 | 66 | 68 |
| Tanahun | 83 | 100 | 72 |
| Nawalparasi East | 143 | 151 | 124 |
| Syangja | 81 | 104 | 79 |
| Parbat | 61 | 50 | 45 |
| Baglung | 65 | 71 | 51 |
| **Gandaki Province** | **88** | **89** | **77** |

Source: IHIMS/HD

## Treatment Outcome

Treatment outcome in TB is measured with the sum of cured and treatment completed which is defined as treatment success. The province has maintained the treatment success rate at 90% in FY 2076/77. Except Parbat and Tanahun, all districts managed to maintain the treatment success rate at above 90% in the province.

**Table 3.3.2 Percentage of TB Treatment Success Rate by districts**

| F/Y / Districts | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 92 | 98 | 97 |
| Manang | 0 | 0 | 100 |
| Mustang | 0 | 0 | 100 |
| Myagdi | 82 | 83 | 100 |
| Kaski | 93 | 95 | 92 |
| Lamjung | 95 | 92 | 92 |
| Tanahun | 80 | 88 | 74 |
| Nawalparasi East | 85 | 96 | 91 |
| Syangja | 87 | 100 | 96 |
| Parbat | 83 | 91 | 87 |
| Baglung | 100 | 100 | 97 |
| **Gandaki Province** | **88** | **94** | **90** |

Source: HMIS/HD

**Drug-Resistant Tuberculosis (DR TB)**

Drug Resistant Tuberculosis (DR TB) is a major challenge for NTP. Early detection of DR TB and its management requires the huge investment of financial as well as skilled human resources. There is a huge gap in DR TB case notification with the estimated cases. Increasing no. of DR TB cases among new TB cases is an indication of continuous transmission in the community. According to Drug Resistance Survey (DRS), 2011, the burden of drug resistant TB cases is 2.2% among new TB and 15.4% among retreatment TB cases. With these estimates, in the year 2076/77, there are an estimated of 70 DR TB cases in the province. However, a total of 32 DR TB patients are notified in the province with a huge gap of 38 cases for notification.

**DR TB case notification**

There is no improvement in DR TB case notification in the province. In FY 2076/77, a total of 32 DR TB patients are notified for the treatment enrollment.

**Table 3.3.3 Number of DR TB case notification**

| Total no. of DR TB cases notified | DR TB cases notified | | |
|---|---|---|---|
| | FY 2074/75 | FY 2075/76 | FY 2076/77 |
| Gandaki Province | 29 | 36 | 32 |

Source: HD/DHIS 2

**DR TB treatment outcome**

In Gandaki province the **DR TB** treatment success rate is 72% in FY 2076/77 which is a raise from previous years; 71% and 60% in FY 2075/76 and 2074/75 respectivey.

**Issues/challenges and recommendations**

| **Issues** | **Recommendation** |
|---|---|
| Data inconsistency and incompleteness in IHIMS, DR TB tracking and laboratory system at all DR and GX sites | Onsite coaching to the reporting units. |
| | eTB roll out to the local level |
| | Strengthen DR TB tracking and laboratory system at all DR and GX sites |
| | Training and orientation (Data management and TB basic modular) |
| TB QC management | Assessment of labs established at local level |
| | Ensure regular and complete participation of MCs in QC |
| | Supportive monitoring, supervision, and onsite coaching to the microscopic centers |
| | Basic lab modular and LQAS training |
| Strengthening coordination and communication among province, district, and local level | Manage PME workshop at the district level |
| | Regular follow up and supportive visit |
| | Coordination meetings |

### 3.4 Leprosy Elimination Programme

**Background**

Leprosy has been recognized as a public health problem since time immemorial and efforts were made to combat it in all earnestness. For ages, leprosy has been a disease of serious health problem for the people and the government of Nepal. Activities to control leprosy in an organized and planned manner were initiated only from 1960 onwards. Considering the seriousness of the problem, the vertical leprosy program was integrated in the general health services in 1987. Multi-drug Therapy (MDT) service was gradually expanded and by 1996, MDT coverage had extended to all districts. Multi drug therapy has been introduced in all districts of the Province too.

**Vision, Goal and Strategy**

**Vision:** Leprosy free Nepal

**Goal:** End the consequences of leprosy including disability and stigma

**National Leprosy Strategy 2016-2020**

WHO has launched the "*Global Leprosy Strategy 2016–2020: Accelerating towards a leprosy-free World*" – which aims to reinvigorate efforts for leprosy control and to avoid disabilities, especially among children affected by the disease in endemic countries with three pillars and components. Similarly, Nepal has launched National Leprosy Strategy 2016-2020 in 2017 with following strategies and targets:

**Guiding principles**

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

**Objectives:**

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

**Strategies:**

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

The major achievements of the province in Leprosy Control Program are analyzed briefly in following by district and provincial average.

**Case Detection**

In the year 2076/77, a total of 92 leprosy cases were registered in the province. Of which 88 are new multi-bacillary (MB) and 4 are pauci-bacillary (PB) cases. The new case detection rate is 3.66 per 100000 populations in the province. Tanahun and Nawalparasi show the highest number of leprosy cases.

**Table 3.4.1: Total number of leprosy cases by districts**

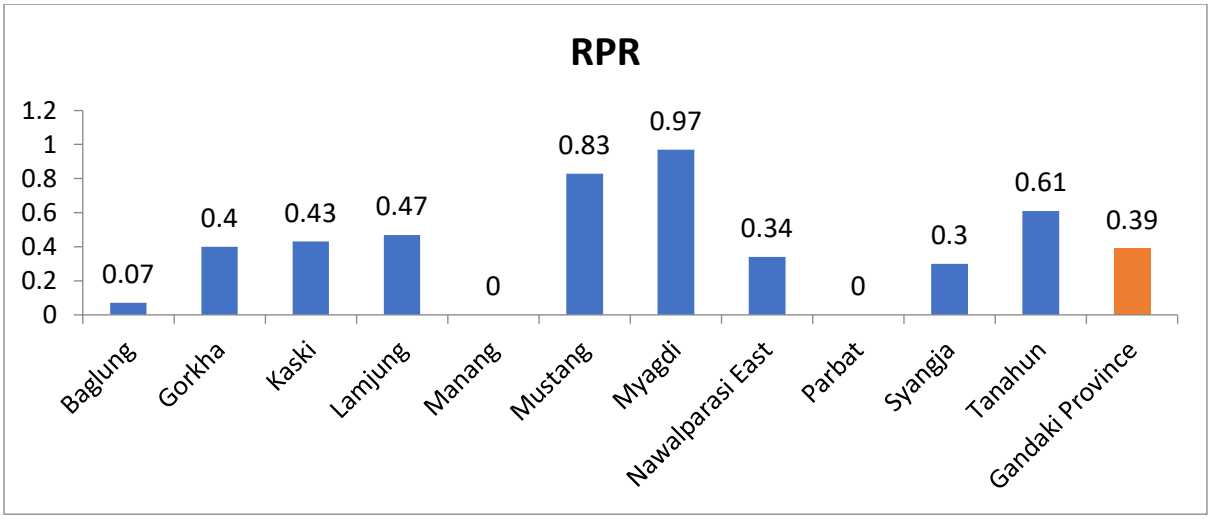
| F/Y | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| **Districts** | New MB | New PB | New MB | New PB | New MB | New PB |
| Gorkha | 1 | - | 3 | 2 | 4 | - |
| Manang | - | - | - | - | - | - |
| Mustang | - | - | - | - | 1 | - |
| Myagdi | 5 | - | 3 | - | 10 | - |
| Kaski | 23 | 2 | 25 | 1 | 27 | - |
| Lamjung | 2 | 1 | - | - | 9 | - |
| Tanahun | 6 | - | 1 | - | 15 | - |
| Nawalparasi East | 20 | 20 | 15 | 9 | 10 | 4 |
| Syangja | 11 | 1 | 1 | - | 9 | - |
| Parbat | 2 | - | - | 1 | - | - |
| Baglung | 1 | 1 | 1 | - | 3 | - |
| **Gandaki Province** | **71** | **25** | **49** | **13** | **88** | **4** |
| **Total** | **96** | | **62** | | **92** | |

**Source: HD**

**Registered Prevalence:**

The registered prevalence rate (RPR) of the province for the year 2076/77 was 0.39 per 10000 population. RPR is seen highest in Myagdi district with 0.97 per 10000 population while Manang and Parbat showed zero RPR. Moreover, all districts in the province have RPR less than 1.

**Figure 3.1: Registered prevalence rate of Leprosy by districts**




**Source: HD**

A total of 100 leprosy cases were on treatment in the year 2076/77. The three-year trend shows increasing number of leprosy cases with the highest number of cases in Kaski and Tanahu districts.

**Table 3.4.2: Registered prevalence of leprosy cases by districts**

| F/Y | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| Districts | MB | PB | MB | PB | MB | PB |
| Gorkha | 2 | - | 2 | 0 | 10 | - |
| Manang | - | - | - | - | - | - |
| Mustang | - | - | - | - | 1 | - |
| Myagdi | 2 | - | 8 | - | 10 | - |
| Kaski | 24 | 2 | 26 | 1 | 25 | - |
| Lamjung | 1 | - | 0 | 0 | 8 | - |
| Tanahun | 6 | - | 2 | - | 21 | - |
| Nawalparasi East | 14 | 9 | 23 | 3 | 12 | - |
| Syangja | 17 | - | 12 | 0 | 10 | - |
| Parbat | 1 | - | - | - | - | - |
| Baglung | - | - | 2 | - | 3 | - |
| **Province** | **67** | **11** | **75** | **4** | **100** | - |
| **Total** | **78** | | **79** | | **100** | |

**Source: HD**

**Issues and Recommendations**

| Issues | Recommendation |
|---|---|
| Prevalent self-stigma resulting hesitation for patients to get treatment services from nearby health facilities | Awareness/IEC/BCC activities |
| No testing services for skit slit smear in district hospitals | Initiate testing services |
| Disability TB cases still exist. Delay diagnosis | |
| Inadequate training to health workers | Manage adequate training |
| Error in recording and reporting | Onsite coaching |
| Poor monitoring of contact tracing | Supervised contact tracing process |

### 3.5 HIV /AIDS& STI Control Programme

**Background**

National HIV strategic plan (2016-2021) has adopted global goals of 90-90-90 in HIV AIDS control program. The goals aimed at achieving 90% of the PLHIV will know their HIV status by 2020, 90% of all people with diagnosed HIV infection will receive sustained anti-retroviral therapy (ART) and 90% of all people receiving ART will have viral suppression.

**Performance in HIV and AIDS Control Programme**

HIV/ AIDS and sexually transmitted diseases (STDs) are emerging as a major threat evolving from a low-level epidemic to a concentrated epidemic. Their multiple effects have so far been minimal in the province, but their potential impact is immense. The Government is committed to prevent and control HIV/AIDS& STDs in Nepal with multi- sectorial approaches from both government and non- government sectors. Major achievements of the HIV and AIDS control program in the province are as following.

**HIV Testing and Counseling (HTC) Services**

HIV testing and counseling (HTC) offers an important entry point for prevention, care, and support. It is an essential component of comprehensive HIV and AIDS program. HIV testing and counseling services are provided free of cost to the most at-risk populations, including general population from all over the province according to the National HTC guideline. Number of people counseled in HTC is on increasing trend throughout the years. A total of 10203 were counseled and 183 were diagnosed with HIV positive.

**Table 3.5.1: Number of HIV Testing and Counseling (HTC)**

| Details | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| # of people examined | 9506 | 9986 | 10203 |
| # of people with New HIV +ve | 197 | 196 | 183 |

***Source: HMIS/HD***

**HIV Prevention of mother to child transmission (PMTCT) Services**

A total of 57523 ANC mothers were counseled in FY 2076/77. Among them, 41934 were tested and 10 were found positive. A slight decrease in counseling has been observed in this fiscal year compared to the last consecutive fiscal years.

**Table 3.5.2: Services statistics in PMTCT**

| Details | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Number of Counselled | 61332 | 67141 | 57523 |
| Number of Test | 48481 | 49437 | 41934 |
| Number of Positive | 34 | 9 | 10 |

***Source: HMIS/HD***

**Anti-retroviral therapy (ART) Services**

A total of 2425 PLHIV are currently on ART in FY 2076/77. The trend shows that the number is in increasing. Proper counseling and care in ART services have resulted in the retention of large no. of PLHIV on ART throughout the year.

**Table 3.5.3: Total number ART cases**

| Details | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Number of PLHIV on ART | 1262 | 2163 | 2425 |

***Source: HMIS/HD***

**Issues and recommendation in HIV AIDS control Programme**

| **Issues** | **Recommendation** |
|---|---|
| Irregular regular supply of Determine test kits resulting low PMTCT tests | Improve the supply system of test kits cascading the responsibility to the province from the center |
| No testing and treatment services for STIs in district hospitals and PHCs due to the interrupted supply of STI medicines | Manage supply of STI medicines |
| Inadequate training and capacity building activities of the health workers | Onsite coaching, training, and orientation |
| No supply of confirmatory test kits in HTC sites since a long period of time | Manage the supply of confirmatory test kits in HTC sites |

### 3.6 Dengue

#### Background

The first dengue case was reported on August 1st, 2019 from Fewa City Hospital Pokhara. Series of meetings were held with all stakeholders (each provided support during the response), search and destroy and community orientations were done in all places, RDT test kits were provided, daily recording and reporting from PHEOC was carried out and awareness actions including flyer distributions, radio jingles and loudspeaker message dissemination were done. The initiation of response was from ward no.8 of Pokhara Metro city and gradually it was expanded to all wards of Pokhara Metropolitan city. The major players in the response of Dengue prevention and control were: EDCD, Ministry of Social Development, Health Directorate, Health Offices, Pokhara Municipality, local level political leaders, Government Hospitals, Private and Teaching Hospitals, Media, FCHVs, ward volunteers and all community peoples. Since the first case of Dengue in the province, a total of 2679 cases were reported. More number of Dengue cases was reported in 2019 compared to 2020. In the year 2020, a total of 29 Dengue cases were reported in 2020.

**Table 3.6.1: Trend of Dengue cases reported in the Province**

| Districts/FY | 2019 | 2020 | Total |
|---|---|---|---|
| GORKHA | 2 | 0 | 2 |
| MANANG | 0 | 0 | 0 |
| MUSTANG | 0 | 0 | 0 |
| MYAGDI | 11 | 12 | 23 |
| KASKI | 2575 | 15 | 2590 |
| LAMJUNG | 3 | 0 | 3 |
| TANAHU | 21 | 0 | 21 |
| NAWALPARASI EAST | 22 | 1 | 23 |
| SYANGJA | 4 | 0 | 4 |
| PARBAT | 2 | 0 | 2 |
| BAGLUNG | 10 | 1 | 11 |
| **Gandaki Province** | **2650** | **29** | **2679** |

Source: EWARS/HD

#### Issues and Recommendation

The following are the major issues and recommendations in Dengue Control Programme:

| Issues | Recommendations | Responsible |
|---|---|---|
| Financial constrains | Adequate budget should be managed | MoHP/MoSD |
| Quality of test kits | RDT test kits only use WHO prequalified and price | MoSD/HD/Pokhara |
| Preparedness plan | Prepare annual preparedness plan of Dengue | MoSD/HD/Pokhara |

### 3.7 Lymphatic Filariasis Elimination Programme

**Background:**

The World Health Assembly (WHA) of 1997 passed a resolution (50.29) to eliminate LF as a public health problem and in response to this, WHO established a Global Programme to eliminate LF (GPELF) in 2000 with a goal to eliminate LF as a public health problem by 2020.

As per global commitment for GPELF, LF mapping was done in 2001, 2005/2006 and remapping in 2012 by using ICT which discovered that 61 out of 75 districts of Nepal were endemic for LF. Almost 25 million people living in these districts are at risk of getting LF. This indicates that quite a significant number of people are estimated to be living with symptomatic and asymptomatic infections which cater as source of infection to others. Treating all potential reservoirs of infection kills the parasites (both adult and microfilaria) present in the populations which in turn reduce the sources of infection and hence, the transmission can be lowered significantly and LF can be eliminated as a public health problem.

To address these challenges, Government of Nepal has also set a goal and national targets through effective implementation of WHO recommended strategies to eliminate LF by 2020. Annual mass drug administration (MDA) of single doses of Albendazole plus Diethylcarbamazine (DEC) is implemented in endemic districts, treating the entire at-risk population. MDA should be continued for 5 years or more to fully interrupt transmission of infection. Nepal implements 6 rounds of MDA which is somewhat distinct from strategy being followed by other endemic countries where 5 rounds are taken as complete round (No extra rounds after passing Pre TAS). The goals, National objectives, targets, indicators, and strategies of LF Elimination Program.

**Goal, Objectives, strategies, and targets**

**Goal –** The people of Nepal no longer suffer from lymphatic filariasis

**Objectives:**

- To eliminate lymphatic filariasis as a public health problem by 2020
- To interrupt the transmission of lymphatic filariasis
- To reduce and prevent morbidity
- To provide deworming through albendazole to endemic communities especially to children.
- To reduce mosquito vectors by the application of suitable available vector control measures (Integrated Vector Management).

**Strategies:**

- Interrupt transmission by yearly mass drug administration using two drug regimens (diethylcarbamazine citrate and albendazole) for six years.
- Morbidity management by self-care and support using intensive simple, effective, and local hygienic techniques.

**Targets:**

- To scale up MDA to all endemic districts by 2014

- Achieve <1% prevalence (microfilaremia rate) in endemic districts after six years of MDA by 2018.

**Major Activities in FY 2076/77**

**Mass Drug Administration (MDA)**

The endemic districts for LF in Gandaki province are Baglung, Parbat and Lamjung among 11 districts. The MDA achievement is highest in Baglung and accordingly in Lamjung and Parbat in FY 2076/77. The MDA achievement trends in those districts are as follows:

**Table 3.7.1 Trend of Mass Drug Administration (MDA) achievement in districts**

| Hospitals/Health Facilities | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Baglung | 80.1% | 79.8% | 87.5% |
| Lamjung | 85.1% | 69.6% | 72.3% |
| Parbat | 73.0% | 71.0% | 61.0% |

Source: Health Office

**Hospital wise Hydrocele operation in the province**

The trend of number of Hydrocele operation in three FY at Gandaki province is decreasing. The number has reached 22 in FY 2076/77 from 58 in FY 2075/76 and 80 in FY 2074/75.

**Table 3.7.2 Hospital wise Hydrocele operation**

| SN | Name of the Hospital | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|---|
| 1 | Gorkha Hospital | 0 | 0 | 0 |
| 2 | Lamjung Hospital | 18 | 18 | 0 |
| 3 | Damauli Hospital | 0 | 0 | 1 |
| 4 | Syangja Hospital | 0 | 0 | 0 |
| 5 | Madya Bindu Hospital | 0 | 0 | 0 |
| 6 | Myagdi | 0 | 0 | 2 |
| 7 | Parbat | 2 | 0 | 5 |
| 8 | Dhaulagiri Hospital | 11 | 12 | 14 |
| **9** | Western Regional Hospital (PAHS) | 49 | 28 | NA |
| Total | | 80 | 58 | 22 |

Source: Health Office

**Major Issues/Challenges and Recommendation**

| Issues | Recommendations |
|---|---|
| As per TAS (Transmission Assessment Survey), it has been observed that the transmission chain was not interrupted. Continued transmission cycle | Awarness about transmission chain |
| Poor monitoring of drug compliance | Drug administration should be supervised |
| Integrated vector control has not been done | Conduct integrated vector control |

### 3.8 COVID19

**Background**

Coronavirus (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was declared pandemic on 11th March 2019 by WHO. The outbreak was first identified in Wuhan city, Hubei, China, in December 2019. As of 19 February 2021, more than 110 million cases of COVID-19 have been reported in 192 countries and territories, resulting in more than 2.43 million deaths.

Common symptoms for this disease include fever, cough, shortness of breath, loss of smell, loss of taste and body malaise. Complications may include pneumonia and acute respiratory distress syndrome. The time from exposure to onset of symptoms is typically around five days but may range from two to fourteen days. Primary treatment is symptomatic and supportive therapy. Vaccines are now available, and some countries have even started the vaccinations including Nepal.

Recommended preventive measures include hand washing, covering one's mouth when coughing (masks/handkerchiefs/bent elbow), maintaining distance from other people, and monitoring and self-isolation. Authorities worldwide have responded by implementing travel restrictions, quarantines, curfews, workplace hazard controls, and facility closures.

As news of confirmed case in Nepal was reported, Gandaki Province was already into planning and preparing for the response. There were, however, numerous challenges for the Province including lack of Provincial laboratories with biosafety for running PCR tests, human resources/expertise and districts were found to be lacking ICU beds, ventilators, and oxygen plants.

The Provincial Health Emergency Operation Center (PHEOC) geared up for the preparedness and response as soon as the news of the spread of COVID-19 was out. The central WHO team was communicated, materials and content on the disease were gathered and coordination and communication were initiated at all levels.

The PHEOC is located within the premises of the Provincial Health Directorate and its major role contains facilitation of preparedness and response during health emergencies, data and information repository including verification and dissemination, technical support in planning, orientation and trainings and supporting the Districts in any health-related adverse events.

The PHEOC is primarily operated by Health Directorate personnel and is supported by WHO personnel. The following are the Human Resource components in the PHEOC

| | Team members | Remarks |
|---|---|---|
| Government personnel | 1 PHEOC focal person, 1 IT staff and 1 Communication assistant | 1 Medical Officer post is vacant. |
| WHO personnel | 1 Field Medical Officer (FMO), 1 Information Management Assistant (IMA), 2 Covid Surveillance Associates (CSA) | The CSAs were specifically recruited for COVID-19 pandemic |

**TIMELINE:**

Nepal saw the first COVID-19 confirmed case on 23 January. A nation-wide lockdown was implemented on 24 March as few more cases were reported. The first COVID-19 case in Gandaki Province was confirmed on March 28 from Baglung District, a 22-year-old female who had travelled from Belgium. The Province focused its efforts on planning, prevention, and preparation.

After a few weeks of first case, cases were also reported from Nawalparasi – East, Lamjung and Syangja and by 20th June 2020 the COVID-19 case was present in all the Districts of the Province.

The first COVID-19 death in Gandaki Province was declared on 8th June 2020 and that of 60 Years male from Waling Syangja.

PHEOC communicated with the respective Districts and maintained the line lists of the reported cases. The line lists were disseminated to all respective stakeholders and authorities regularly.

**RESPONSE:**

On March 5, 2020, the Provincial government formed a high-level committee to prevent and control the spread of COVID-19 under the leadership of Chief Minister. The government was able to allocate Rs 33 Crore as an emergency fund and 22 Crore and 50 Lakhs as relief fund with contributions of a month's salary from government ministers. It also increased the allowances for health workers working at the front line of hospitals by 50–100%.

Pokhara Academy of Health Sciences, GP Koirala Hospital Tanahun and Baglung Zonal Hospital was the designated primary hospital for the treatment of COVID-19; isolation wards, makeshift hospitals and quarantine centers were established. Initially, National Public Health Laboratory (NPHL) in Kathmandu was the only laboratory capable of testing for the disease. PCR testing capable laboratory was later established in the Province on 18 June 2020.

**HOSPITALS:**

1414 Isolation beds were allocated for COVID-19 patients. Before the pandemic, there were no ICU beds in the Districts. During the response phase, a total of 29 ICU beds and 25 Ventilators were added.

A meeting of the high-level coordination committee for prevention and control of COVID-19 on 17 March decided to add 115 ICU and 1,000 isolation beds in the Kathmandu Valley. It also instructed the provincial governments to set up a total of 120 ICU beds. On 20 March, the Health Ministry decided to halt non-urgent health check-ups and surgeries until 12 April in hospitals in the Kathmandu Valley with 50 or more beds. On 21 March, the Health Ministry informed that private hospitals with more than 100 beds would not be allowed to refer patients to other hospitals; they were required to treat suspected patients, wait for test results and provide free treatment if the disease were confirmed.

Team members from the PHEOC were involved in the development of guidelines and protocols, its orientation and training, assessment of the Hospitals. PHEOC also maintained the complete repository of the resources of the Hospitals (including Human resource, contact details and available equipment).

Sample collection of the first suspected case in the Province was carried out by the member in PHEOC. The patient was admitted in Fishtail Hospital however the report was negative.

**QUARANTINES:**

In the initial phase, quarantine centers were established in the Province with the help of local levels. A total of 477 quarantine sites were established that could accommodate up to 8798 people. The quarantine was meant for the people arriving inside the Province from other Districts/Countries. After

the completion of quarantine stay PCR tests would be done and those with negative results would be allowed to go home. If they had Positive results, they would be escorted to isolation hospitals/centers. During the peak influx of people, total of 1337 numbers were quarantined at one point.

PHEOC team members were involved in the preparation of guidelines and protocols for the Quarantine sites, assessment of the site itself and those who were placed in the Quarantine site. Sample collection for the first suspected death from the Quarantine site was extracted by PHEOC team member with PPHL team.

**TESTING:**

The first case was confirmed by testing done in Hong Kong as NPHL did not have the reagents required for testing. The first tests inside Nepal were conducted at the bio-safety level-2 labs of the National Public Health Laboratory on 27 January. Gandaki Province established the PCR testing laboratory on 18 March 2020. Reagents sufficient for 200 tests were provided from the Federal Government and then province started to purchase its own reagent. A total of 4 Laboratories were set up in the Province including Provincial Public Health Laboratory, Pokhara Academy of Health Science, Lifecare Diagnostics and Madhyabindu Hospital.

20000 Rapid Diagnostic Test (RDT) kits were also provided to the Province by the Federal Government. Total of 3552 tests were conducted with the RDT. These kits were widely used in quarantines.

Additional 10,000 Antigen test kits were also provided by the Federal Government. However, the test could not gather momentum due to various issues like retest after positive results, the positive cases could not claim from the insurance companies and negative test result would not be sufficient to travel outside Nepal.

PHEOC team members were involved in development of guidelines and protocols for the laboratory test and its orientation and training. PHEOC further supported the PPHL by coordinating and communicating with District Hospitals and Health Offices.

**HEALTH DESKS:**

The domestic airport in Pokhara did not have large scale infrared scanners and was therefore help desk was set up on February 1st with manual thermal scanners. The passengers with fever were requested to visit PAHS. The Districts also set up its health desks in strategic locations. On 29$^{th}$ March 2020 the Province also launched a central help desk and a toll-free 24-hour hotline named “Hello Doctor” stationed in Provincial Health Emergency Operation Center.

PHEOC team members developed the guideline and protocol for Health Desks and also provided orientation and training for those who were designated at the Health Desks. PHEOC also helped procure the items necessary for the setup of health desk including assessment of health desk once it was established.

**TRAVEL RESTRICTIONS:**

Nepal announced suspension of visa-on-arrival service for nationals of five countries badly affected by COVID-19 – China, South Korea, Japan, Italy and Iran and also declared two-week mandatory self- and home-quarantines for everyone visiting Nepal.

Gandaki Province also closed its borders to all non-emergency and non-essential transportations from 24 March 2020.

The PHEOC team also coordinated with Pokhara International Regional Airport and discussed on issues and challenges of the workers and establishment of Health Desk as per the International Health Regulation.

**LOCK DOWN:**

On 19 March, the government declared suspension of all classes and postponement of all academic examinations including the Secondary Education Examination. All government services and private offices except those providing essential services were closed. The House of Representatives meeting was postponed. The National Assembly was suspended indefinitely. A full-bench meeting of the Supreme Court presided over by the Chief Justice decided to halt all non-urgent proceedings in courts across the country.

Gandaki Province declared an indefinite lock-down effective from 23March Along with the country-wide lockdown that came into effect on 24 March.

**PUBLIC AWARENESS:**

Various mediums were used to promote public awareness. Press meets/ briefs/social media/placards and IEC materials/radio and televisions. Total 86 Media were used for this purpose.
PHEOC team members helped create messages for the awareness and dissemination of the messages via social media (Facebook, Viber, websites etc.) Content for daily press briefing was created by PHEOC team members and broadcasted from PHEOC.

**COORDINATION RESPONSE*:***

Health Cluster was activated when Pandemic was declared. A Joint effort from different stakeholders played vital role in preparation and response. The stakeholders included MoSD, HD, PPHL, PHTC, PHLMC, Hospitals, Health Offices, Municipality health teams, local level chiefs, NGOs/INGOs

Several Committees were formed which includes:

1. High-level Directorate Committee in the leadership of Chief Minister
2. Coordination Committee led by Economic affairs and planning Minister
3. Returnee Management Committee led by Minister of Physical infrastructure development
4. Logistic Management Committee led by Minister of Industry Tourism Forest and environment
5. Emergency Fund Management Committee led by Social Development Minister

Beside these 10 subjective committees were also formed for COVID 19 response and Management.

PHEOC team members supported in preparing the content for the coordination meetings (at all level i.e., Federal, Provincial, District and Local level), conducting and facilitation of the coordination meetings (those that were held inside the Health Directorate) and in updating and maintaining all the line lists of the stakeholders and authorities of the Province.

**CONTROVERSIES:**

The first death case projected the prominent social taboo towards the disease and the affected people when the burial of the dead body was carried out. The public were not comfortable in burial of the dead bodies in their respective areas.

**IMPACT:**

Along with daily wage laborers and education, Tourism was also one of the hard-hit sectors (Nepal had declared 2020 as the Visit Nepal Year). However, every other sector was affected to some extent, travels and tours, construction business, airlines, imports/exports, food produce, farms were badly affected.

The positive impact was that due to reduced travel and closures of heavy industry, there was a decrease in air pollution and carbon emissions.

**SOCIAL LIFE:**

In the beginning of March, the government urged the general public to avoid large gatherings. On 18 March, the government shut down all cinema halls, gymnasiums, museums and cultural centers, and banned gatherings of more than 25 people in public spaces including at places of worship.

The PHEOC however was functional every day (including Saturdays) throughout the pandemic continuing its roles and responsibilities.

**SHORTAGES AND BLACK MARKETING:**

By the month of February, there was already a shortage of face masks and Hand rub Sanitizers, as people hurried to buy them. This was a domino effect from the ongoing global shortages.

Some PPEs were supported by the Federal Government, NGO/INGOs and some were procured by the PHLMC.

The Market Monitoring and regulatory committee also visited the market to assess the price of medical commodities. Some were found to be selling the items beyond the limit/norms and immediate action were carried out including sealing of those outlets and penalizing them.

**ESSENTIAL DRUGS:**

No disruption of essential drugs was noted in the Province and the PHLMC had sufficient stock throughout the pandemic.

**MISINFORMATION:**

There was few misinformation shared on social media/online sites causing public fear.

PHEOC focal person verified and followed up with information which were not authentic and true. Where possible, the individuals were personally contacted via PHEOC and were requested to remove any messages that were not true.

**VACCINATION:**

Vaccine was provided to the Province by the federal Government and was initiated on January 27, 2021.

The PHEOC team collected and updated daily information on COVID-19 vaccination. Till date first phase have been completed. Also place mapping of trainings, cases, deaths, vaccinations, number of tests vs number of positive cases, home isolation and quarantine etc is conducted.

**Coronavirus (COVID-19) Rapid Response and Disease Control Details**

**Quarantine**

Table 3.8.1 shows that a total of 34 quarantine centres having 845 bed capacities exist in the provience.

Table: 3.8.1 **Districtwise details of quarantine centre, bed capacity and people in quarantine**

| District | Quarantine Centre | Bed capacity |
|---|---|---|
| **Mustang** | 2 | 12 |
| **Manang** | 0 | 0 |
| **Myagdi** | 0 | 0 |
| **Parbat** | 0 | 0 |
| **Gorkha** | 5 | 186 |
| **Lamjung** | 7 | 73 |
| **Tanahun** | 8 | 202 |
| **Kaski** | 0 | 0 |
| **Baglung** | 0 | 0 |
| **Syangja** | 12 | 372 |
| **Nawalparasi East** | 0 | 0 |
| **Total** | 34 | 845 |

Table 3.8.2 shows a total of 21335 people stayed in quarantine in the provience in FY 2076/77, of the people staying in the quarantine, 14653 were people with travel history of India

Table: 3.8.2 **District wise details of people in quarantine with travel history**

| District wise details of people in quarantine with travel history | | | | |
|---|---|---|---|---|
| **District** | People in quarantine with travel history – India | People in quarantine with travel history - Other country | People in quarantine with travel history – within Nepal | Total people in quarantine |
| **Mustang** | 7 | 7 | 7 | 18 |
| **Manang** | 1 | 6 | 6 | 17 |
| **Myagdi** | 255 | 426 | 426 | 694 |
| **Parbat** | 1011 | 368 | 368 | 1437 |
| **Gorkha** | 775 | 458 | 458 | 1274 |
| **Lamjung** | 456 | 452 | 452 | 938 |
| **Tanahun** | 3028 | 959 | 1319 | 3399 |
| **Kaski** | 1413 | 1570 | 1570 | 3067 |
| **Baglung** | 2826 | 730 | 777 | 3588 |
| **Syangja** | 2368 | 825 | 825 | 3273 |
| **Nawalparasi East** | 2513 | 1019 | 1019 | 3630 |
| **Total** | 14653 | 6820 | 7227 | 21335 |
| Source: Health Directorate, Gandaki February 14, 2021 | | | | |

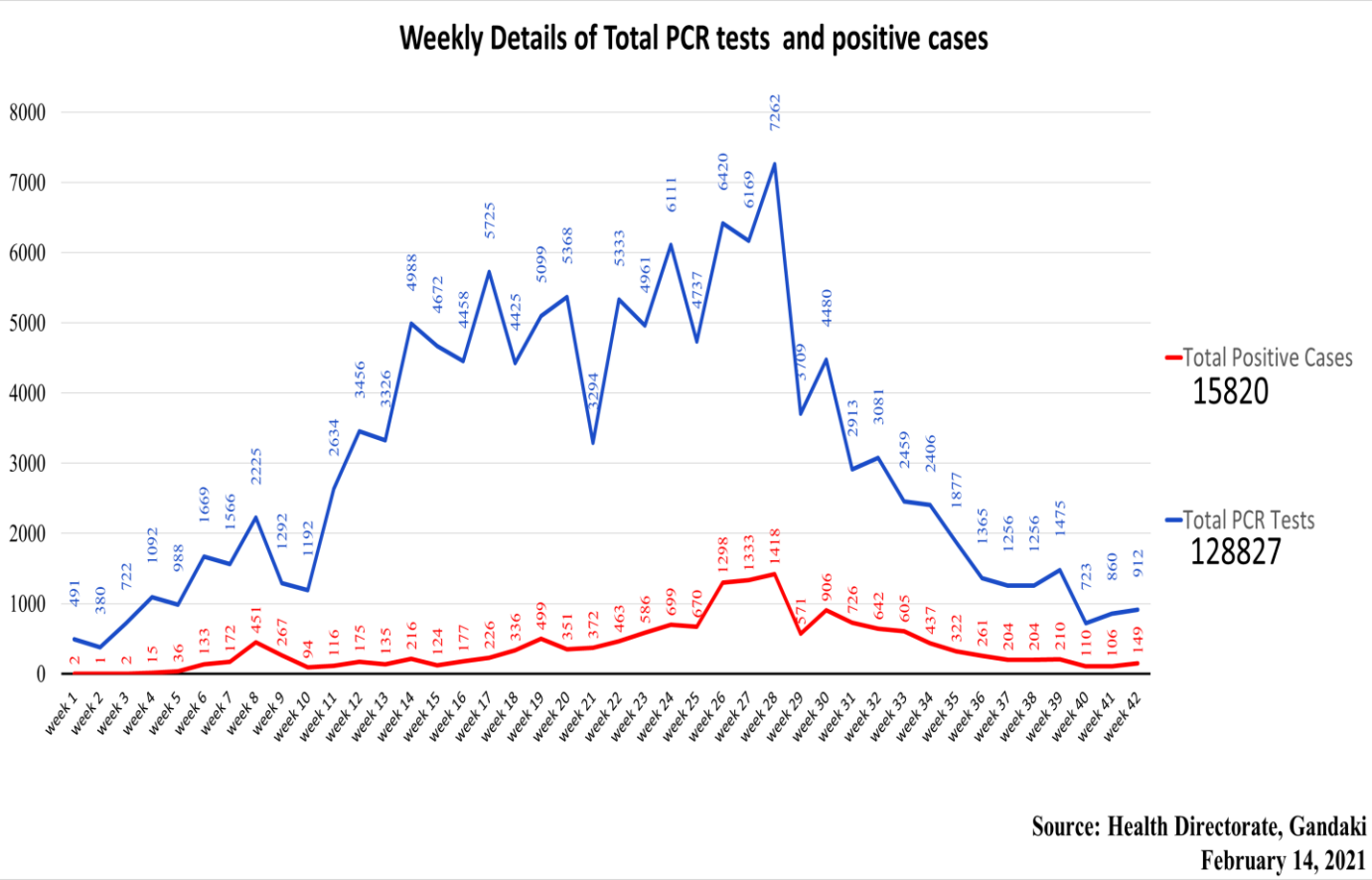
**PCR Testing**

Gandaki Province established the PCR testing laboratory for Covid-19 on 18 March 2020. Since then, a total of 128827 PCR tests were conducted of wich 15820 positive cases were identified till February 14, 2021. The highest number of COVID-19 cases (1014) was observed in kaski District.

**Table: 3.8.3 Districtwise PCR test details**

| District | Total PCR Tests | PCR Positive | Positive Female | Positive Male |
|---|---|---|---|---|
| **Mustang** | 432 | 32 | 9 | 23 |
| **Manang** | 362 | 20 | 7 | 13 |
| **Myagdi** | 2891 | 242 | 65 | 177 |
| **Parbat** | 5572 | 377 | 85 | 292 |
| **Gorkha** | 11186 | 845 | 261 | 584 |
| **Lamjung** | 9488 | 909 | 273 | 636 |
| **Tanahun** | 13869 | 1472 | 429 | 1043 |
| **Kaski** | 45789 | 7647 | 2866 | 4781 |
| **Baglung** | 12076 | 1014 | 213 | 801 |
| **Syangja** | 11154 | 832 | 185 | 647 |
| **Nawalparasi East** | 16008 | 2430 | 802 | 1628 |
| **Total** | 128827 | 15820 | 5195 | 10625 |

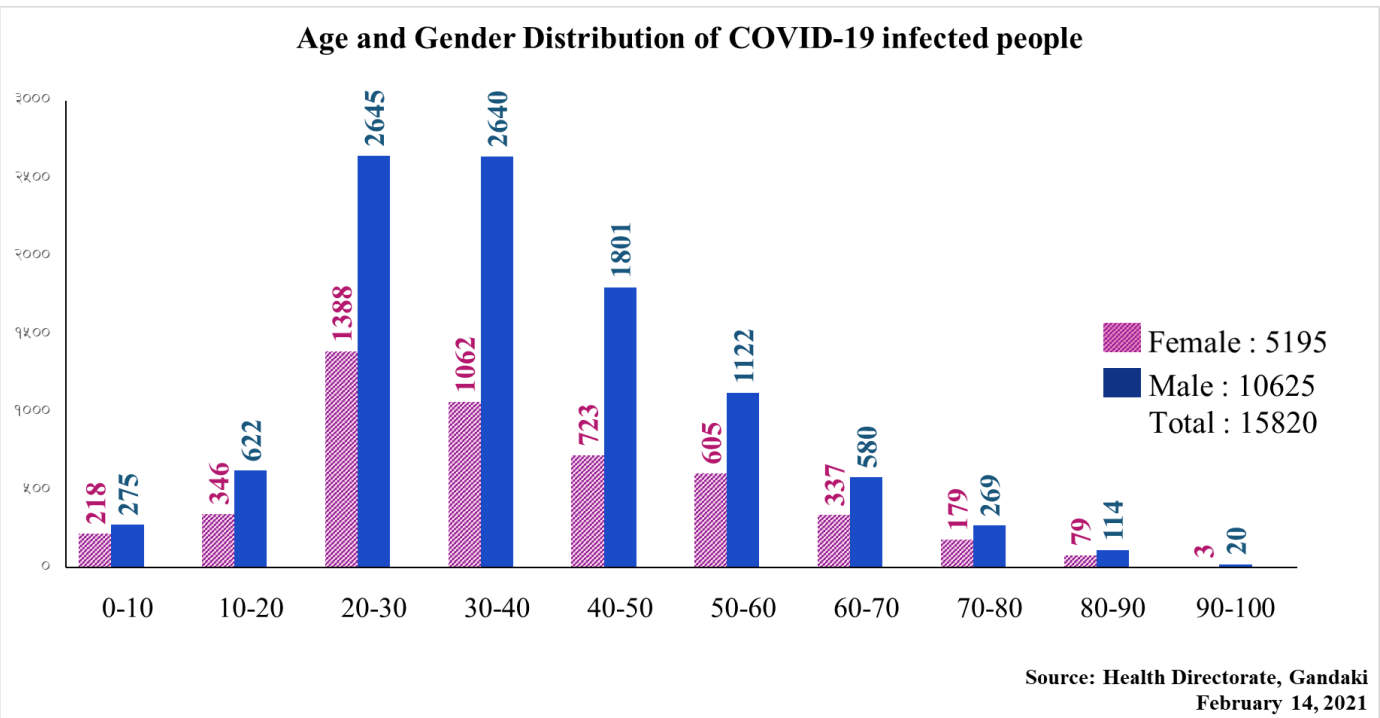
**Figure 3.2 Details of PCR test and Positive case**




Age and Gender Distribution of COVID-19 Infected People

Of the 15820 COVID-19 Infected People till February 14, 2021 in the Gandaki Province 10625 were male. The infected people were more of the active age group that is 20-30 and 30-40years this might be becaue of greater mobility of this age group people.

**Figure 3.3 Age and Gender Distribution of COVID-19 Positive case**



**Districtwise Isolation Centres and Bed capacity**

In the province there is a total of fifty isolation centers having an isolation bed capicity of 1613. The procivence is continuously working to strengthen its capacity for preparedness and fight back COVID-19 Pandamic.

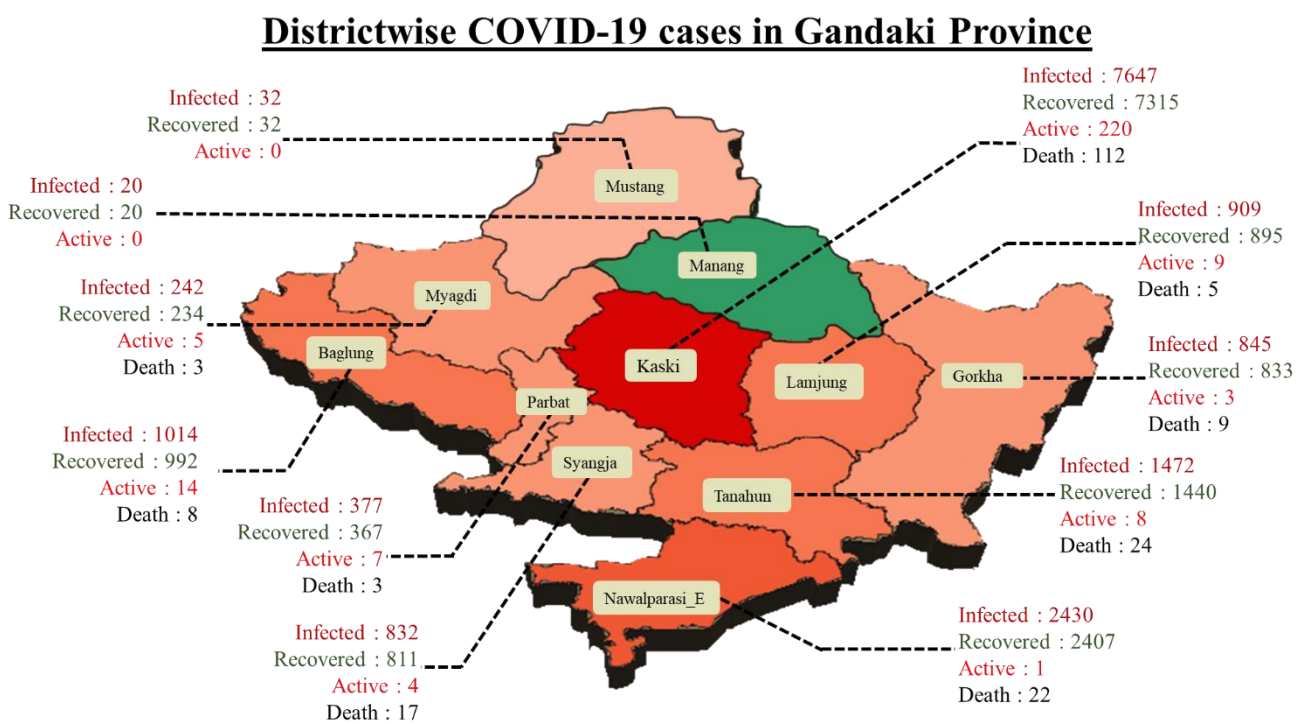
**Table: 3.8.4 Details of Districtwise Isolation Centres and Bed capacity**

| District | Isolation Centers | Isolation Bed |
|---|---|---|
| Mustang | 3 | 18 |
| Manang | 1 | 7 |
| Myagdi | 1 | 20 |
| Parbat | 3 | 110 |
| Gorkha | 4 | 52 |
| Lamjung | 3 | 239 |
| Tanahun | 7 | 158 |
| Kaski | 4 | 110 |
| Baglung | 12 | 374 |
| Syangja | 10 | 229 |
| Nawalparasi East | 2 | 296 |
| Total | 50 | 1613 |

**Details of Districtwise COVID-19 Cases in in gandaki province**

Till febuary 14, 2021 of the total 15820 caseses of COVID-19, 15346 were recovered and 203 people lost their life due to COVID-19.

**Figure: 3.4 District wise status of COVID-19 Cases in in gandaki province**



**ISSUES/CHALLENGES AND SUGGESTIONS:**

| S.N. | Issues and challenges | Suggestions |
|---|---|---|
| 1 | Unclear roles and responsibilities, especially for large scale health disasters | Roles and responsibilities at each level has to be clearly designated and officially documented |
| 2 | Hospitals were not adequately prepared (lack of PPE, Isolation wards, IPC protocols etc.) | Regular drills and training have to be implemented, resources should be mapped and updated, and its repository should be shared with respective stakeholders |
| 3 | Inadequate and delayed fund release | Enough fund for health emergency should be allocated with uncomplicated mechanism of fund release. Funds allocated for emergency should not freeze and a minimum limit should always be maintained every year. |
| 4 | Human resource | Human resource should be fulfilled at all levels including adequate trainings and orientations |
| 5 | Communication and coordination | Uniform communication is yet to be achieved. All levels should be strengthened via orientations and trainings. |

# Section 4

# NURSING

Nursing Section is responsible for delivery of quality health services through capacity development of nurses and enhancing professionalism including planning coordination supervision monitoring and facilitation for various aspects of nursing midwifery, school health and community health nursing services. Additional responsibilities like, the supervision and monitoring of Geriatric and Gender Based Violence (OCMC) related programs/activities, supervision of social health security program, the development and revision of FCHVs and other health related social mobilizer's policy, strategy, standard, protocol and guideline are undertaken by this section**.**

### 4.1 Female Community Health Volunteers (FCHV)

The Female Community Health Volunteer Program was initiated in 2045/46 BS with the objective of increasing involvement of rural women in promoting primary health care services focusing on FP/MCH. Initial approach was to select one FCHV per ward regardless of the population size. The major role of the FCHV is to promote health and healthy behavior of mothers and community people for the promotion of safe motherhood, child health, family planning, and other basic health services with the support of health personnel from the HPs, and PHCCs. Alongside the motivation and education, the FCHVs re-supply pills and distribute condoms, ORS packets and vitamin A capsules; and in IMNCI program implemented districts, they also treat pneumonia cases and refer complicated cases to health institution. Similarly, they also distribute iron tablets to pregnant women in districts with Iron Intensification programs.

**Objectives**

The objectives of the Female Community Health Volunteer Program are:

- To develop self-help mechanism among rural women by providing basic healthcare knowledge with special focus on maternal and child health care.
- To enhance community involvement in primary health care through mobilization of local women and resources.
- To promote community participation for the best utilization of available maternal health.

Overall performance in FCHV program is improving gradually over the years in the province. The FCHV mainly are involved in distribution of condom and re-supply of oral contraceptive pills and iron distribution, supporting EPI clinics and PHC/ORC, motivation and refer for VSC and spacing methods, motivation to pregnant women for ANC, PNC and safe delivery services, health education for nutrition, ARI, CDD and other community-based health education and services, Vitamin A distribution and support in measles campaign program and implementation of CB-IMNCI program at community level.

#### 4.1.1 Total number of FCHVs in rural and urban areas

There are 5667 FCHVs actively working in Gandaki Province among them 2695 are working in urban area and 2972 are working in rural area.

**Table 4.1: Total numbers of FCHVs in rural and urban areas**

| Districts | No. of FCHV in Urban | No. of FCHV in Rural | Total FCHVs |
|---|---|---|---|
| Gorkha | 130 | 487 | 617 |
| Manang | 0 | 108 | 108 |
| Mustang | 0 | 108 | 108 |
| Myagdi | 74 | 298 | 372 |
| Kaski | 643 | 394 | 1037 |
| Lamjung | 377 | 260 | 637 |
| Tanahun | 282 | 177 | 459 |
| Nawalparasi East | 190 | 126 | 316 |
| Syangja | 306 | 295 | 601 |
| Parbat | 197 | 303 | 500 |
| Baglung | 496 | 416 | 912 |
| **Gandaki Province** | **2695** | **2972** | **5667** |

*Source: DHIS-2, 2076/77*



### 4.1.2 Number of Pills cycle Distributed by FCHVs

Number of pills cycle Distributed by FCHVs is in decreasing trend past three years and has been decreased to 53518 this year.

**Table 4.2: Number of Pills cycle Distributed by FCHVs**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 7456 | 6316 | 6365 |
| Manang | 36 | 80 | 55 |
| Mustang | 179 | 131 | 70 |
| Myagdi | 3467 | 2944 | 3022 |
| Kaski | 8934 | 8332 | 7310 |
| Lamjung | 3948 | 3744 | 3711 |
| Tanahun | 6045 | 5693 | 5017 |
| Nawalparasi East | 7281 | 8973 | 7778 |
| Syangja | 8538 | 8133 | 8615 |
| Parbat | 4282 | 3898 | 3765 |
| Baglung | 9208 | 8007 | 7810 |
| **Gandaki Province** | **59374** | **56251** | **53518** |

***Source: DHIS-2, 2076/77***

### 4.1.3 Reporting Status of FCHV

The reporting status of FCHV throughout the province is comparatively in the same trend. No districts have reporting status 100%. On the average percentage of reporting Status (FCHV) by districts have from 72-99%.

**Table 4.3: Reporting Status by FCHV (in percentage)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 96 | 95 | 94 |
| Manang | 81 | 82 | 77 |
| Mustang | 77 | 72 | 77 |
| Myagdi | 96 | 97 | 97 |
| Kaski | 89 | 95 | 95 |
| Lamjung | 96 | 97 | 93 |
| Tanahun | 95 | 95 | 94 |
| Nawalparasi East | 99 | 99 | 98 |
| Syangja | 98 | 86 | 98 |
| Parbat | 95 | 94 | 97 |
| Baglung | 95 | 95 | 91 |
| **Gandaki Province** | **94 %** | **94 %** | **94 %** |

***Source: DHIS-2, 2076/77***

### Counseling and Referral

Counseling, as an important activity which helps the clients to make informed choice regarding appropriate family planning method, was made available to all potential clients. Health workers, Female Community Health Volunteers and partners were actively involved in counseling in all 11 districts. People requesting for FP services other than condoms and pills were referred to CHUs, HP, PHC or nearby health facilities, outreach clinics, mobile and static camps. Furthermore, PHC-ORC refer Norplant cases, IUCD and VSC clients to HPs, PHCCs or hospitals and mobile camps as appropriate.

### 4.2 Social security

According to “The Social Security Act, 2075 (2018)”, the following Nepali citizens shall have the right to get the social security allowance: (a) Senior citizens, (b) Indigent, (c) Incapacitated and helpless persons, (d) Helpless single women, (e) Citizens with disabilities, (f) Children, (g) Citizens unable to take care themselves.

Bipanna Nagarik Kosh was started after the mass movement of 2062 BS. As country is recovering from a decade long armed conflict, this Kosh was established to provide some financial relief to people from difficult and expensive diseases. Cardiovascular diseases, Cancer, Renal failure, Alzheimer's disease, Parkinson's disease, Head and Spinal injury, Sickle Cell Anaemia and Stroke are covered under this program.

### 4.3 Primary Health Care /Outreach Clinics (PHC/ORC)

Primary Health Care Outreach clinic (PHC-ORC) program was established in 1994 (2051 BS) with an aim to improve access to some basic health services including family planning and safe motherhood services for rural households. PHC-ORC clinics are the extension of HPs at the community level. ANMs/ AHWs provide basic PHC services (FP and ANC services/Health Education/ Minor Treatment) to a pre-arranged place close to communities (two to five catchment areas per VDC) on a predetermined day once in a month. The PHC Outreach Strategy has been revised recently. According to the revision, objective and strategies of PHC-ORC are as follows:

#### 4.3.1 Services Provided By PHC/ORC

**Safe Motherhood & New-born Care**

- Provision of antenatal, postnatal, and new-born care
- Iron distribution
- Referral if danger signs identified

**Family Planning**

- Provision of pills and condom
- Monitoring of continuing users
- Education and counseling on FP methods and emergency contraception
- Counseling and referral for IUCD, Implant and VSC service
- Tracing defaulter

**Child Health**

- Growth monitoring of under 2 children
- Pneumonia treatment
- Diarrhea treatment

**Health Education and Counseling**

- Family Planning
- Maternal and New-born Care
- Child Health
- STI, HIV/AIDS
- Adolescents' reproductive health
- Others

### 4.3.2 Performance in Primary Health Care /Outreach Clinics (PHC/ORC)

Reporting status, percentage of PHC/ORC conducted, average number of people serviced by PHC/ORC clinics, growth monitoring in PHC/ORC is analyzed briefly in following section.

**Reporting Status of PHC/ORC Clinics**

The reporting status of PHC/ORC has decreased in the last fiscal year 2076/77 and reached to 80%. This was same in previous last two years with 96%.

**Table 4.4: Reporting Status of PHC/ORC Clinics (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 96 | 94 | 79 |
| Manang | 86 | 94 | 100 |
| Mustang | 81 | 87 | 79 |
| Myagdi | 94 | 96 | 87 |
| Kaski | 94 | 97 | 73 |
| Lamjung | 100 | 98 | 80 |
| Tanahun | 95 | 95 | 81 |
| Nawalparasi East | 97 | 99 | 76 |
| Syangja | 95 | 94 | 85 |
| Parbat | 95 | 95 | 79 |
| Baglung | 98 | 99 | 79 |
| **Gandaki Province** | **96** | **96** | **80** |

***Source: DHIS-2, 206/77***

**Average Number of People Served by PHC/ORC Clinics**

The average number of people served by PHC/ORC clinics is in fluctuating trend over the last three years. This figure is 19 in fiscal year 2076/77, where it was 18 and 20 in F/Y 2074/75 and 2075/76 respectively.

**Table 4.5: Average Number of People Served by PHC/ORC Clinics**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 35 | 36 | 33 |
| Manang | 2 | 2 | 2 |
| Mustang | 4 | 6 | 4 |
| Myagdi | 12 | 13 | 13 |
| Kaski | 19 | 19 | 18 |
| Lamjung | 12 | 12 | 12 |
| Tanahun | 15 | 16 | 16 |
| Nawalparasi East | 38 | 49 | 48 |
| Syangja | 17 | 18 | 19 |
| Parbat | 13 | 14 | 12 |
| Baglung | 16 | 16 | 15 |
| **Gandaki Province** | **18** | **20** | **19** |

**Issues and Recommendations in PHC/ORC**

| Topic | Issues | Action to be taken | Responsibility |
|---|---|---|---|
| Functionality of PHC/ORC | Irregular PHC/ ORC. | • Instruct strictly to PHCC/HP/ by HO to conduct regular PHC/ORC<br>• Effective supervision and monitoring to be done | HO and in-charge of respective health institution |
| | PHCORC clinics are not running effectively | • Field incentive to field staff - for AHW and ANM<br>• Effective supervision and monitoring to be done | HO and in-charge of respective health institution |

**Issues and Recommendations in FCHV Program**

| Topic | Issues/bottlenecks | Action to be taken | Responsibility |
|---|---|---|---|
| FCHV mobilization for counselling and service delivery | Not enough incentive for FCHV<br>Low movement of FCHV in counselling and service delivery | •Providing incentive to FCHVs according to number of clients.<br>•Best performance award should be managed. | HO, FHD |
| | Denial by old age FCHV to retire after 60 years | •Compulsory retirement after 60 years of age.<br>Lucrative Retirement Incentive Package<br>• Replace with other young members fromtheir family as incentive.<br>• Replace with community ANMs | HO, FHD |

## Section 5

# CURATIVE SERVICES

**Background:**

Government of Nepal is committed to improving the health status of rural and urban people by delivering high-quality health services throughout the country. The policy is aimed at providing prompt diagnosis and treatment and referral of cases through the health network from community health facilities to the specialized and central public hospital. Likewise, diagnostic service and referral mechanism at different levels has been established to support early and correct diagnosis of the problem.

**Vision**

The vision is to contribute in improving the health status of Nepali population, especially of the poor and excluded. It will support the nation to poverty reduction through provision of equitable and accessible health care services.

**Goal**

To reduce morbidity and mortality; especially of poor, marginalized and vulnerable people by ensuring the rights of citizens to quality essential health services.

**Objectives**

- Increased access to and utilization of quality essential health care services by ensuring availability of essential drug in both urban and rural health facilities throughout the year
- To provide qualitative essential health care services to the municipal population through urban health clinic
- Minimizing economic, cultural and geographical barriers
- Carryout urban and environmental health program.
- Define basic health care package

**Strategies**

- To make curative health services available in an integrated way in rural areas through health posts and PHCCs.
- To establish hospitals on the basis of population density and patient load with at least one hospital per district.
- To establish local and provincial level hospitals to provide specialized services related to pediatrics, gynecology, general surgery, general medicine, eye care, dermatology, orthopedics and psychiatry.
- To equip central hospitals with sophisticated diagnostic and other facilities to provide specialized and super-specialty services. Specialist curative care services will be extended to remote areas, as and when required, through mobile teams.
- To extend referral systems to provide rural people with access to services from modern well-equipped hospitals.
- To strengthen diagnostic services such as laboratories and X-ray services at hospitals.
- To extend service provision through more outreach clinics and by considering the relocation of existing facilities.

**Major Activities**

Curative health service was provided through the existing health facilities through outpatient emergency and inpatient services including free health services as well. In-patient services were provided by different level of hospital including INGOs/NGOs, private medical college hospitals nursing homes and private hospital.

### 5.1.1 Percentage of population utilizing outpatient (OPD) services

The percentage of population encompassing new OPD visits is 106 % of total population during FY 2075/76 and 2076/77 which has increased from 98 percent of the total population in FY 2074/75. Thus, the volume of new OPD visits has been increased in comparison to 2074/75. District wise OPD visits also fluctuated over the last three fiscal years. It was 71% (Nawalparasi East) and 222% (Mustang) in F/Y 2076/77. However, the new OPD visits might be increased due to repeatedly recording of the old patients who visit the health facility coming for follow-up so further data verification and test is required for correct data.

**Table 5.1: District wise new OPD visit among total population in percentage**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 117 | 112 | 136 |
| Manang | 166 | 149 | 173 |
| Mustang | 197 | 222 | 208 |
| Myagdi | 128 | 119 | 101 |
| Kaski | 146 | 151 | 115 |
| Lamjung | 135 | 146 | 136 |
| Tanahun | 52 | 61 | 89 |
| Nawalparasi East | 41 | 67 | 71 |
| Syangja | 85 | 90 | 111 |
| Parbat | 104 | 109 | 108 |
| Baglung | 80 | 91 | 92 |
| **Gandaki Province** | **98** | **106** | **106** |

***Source: HMIS/DHIS-2***

### 5.1.2 Sex ratio of OPD services

The sex ratio of new OPD visits (number of male OPD visits in per 100 female OPD visits) in in this province is 76. Manang has highest OPD visit which is 108 and followed by Mustang with 95. Other districts of this province have less than 100 OPD visit sex ratio**.**

**Table 5.2: OPD patient distribution by Sex ratio**

| Districts | Total New OPD Visits Female in 2076/77 | Total New OPD Visits Male in 2076/77 | Total New OPD Visits in 2076/77 | Sex Ratio |
|---|---|---|---|---|
| Gorkha | 195566 | 141151 | 336717 | 72 |
| Manang | 5262 | 5678 | 10940 | 108 |
| Mustang | 12391 | 11714 | 24105 | 95 |
| Myagdi | 63570 | 48754 | 112324 | 77 |
| Kaski | 366445 | 304920 | 671365 | 83 |
| Lamjung | 132690 | 101288 | 233978 | 76 |
| Tanahun | 177287 | 130437 | 307724 | 74 |
| Nawalparasi East | 140215 | 108278 | 248493 | 77 |
| Syangja | 162076 | 118704 | 280780 | 73 |
| Parbat | 92569 | 68170 | 160739 | 74 |
| Baglung | 154496 | 106760 | 261256 | 69 |
| **Gandaki Province** | **1502567** | **1145854** | **2648421** | **76** |

***Source: HMIS/DHIS-2***

### 5.1.3 Top Ten Diseases

The rank order of top six cause of morbidity is constant compare to last year. Upper respiratory tract infection is the first cause of morbidity (7%) where gastritis (7. %) is the second highest cause of morbidity in this province. Falls/injuries/fractures, headache, lower respiratory tract, hypertension is 3rd to 6th common cause of morbidity respectively. Fungal infection and Skin diseases are new entry top ten diseases in F/Y 2076/77 at Gandaki province with rank 8 and ten respectively. Similarly, muscular pain and acute tonsilitis are the top 7 and top 9 causes of morbidity at this province.

**Table 5.3: Top Ten ranking diseases among new OPD case (%)**

| Rank | Causes of Morbidity | % new OPD cases (FY 2076/77) | Last year rank (FY2075/76) |
|---|---|---|---|
| 1 | Upper respiratory tract infection (URTI) cases | 7 | 1 |
| 2 | Gastritis (APD) | 7 | 2 |
| 3 | Falls/injuries/fractures | 6 | 3 |
| 4 | Headache | 6 | 4 |
| 5 | Lower respiratory tract infection (LRTI) cases | 5 | 5 |
| 6 | Hypertension | 4 | 6 |
| 7 | Muscular pain | 3 | 9 |
| 8 | Fungal infection | 3 | 12 |
| 9 | Acute tonsillitis cases | 3 | 7 |
| 10 | Skin diseases | 2 | 22 |

***Source: HMIS/DHIS-2***

### 5.1.4 Hospital bed turnover

The hospital bed turnover is in increasing trend in this province. This figure has reached 105 in 2076/77, whereas it was 89 and 90 in FY 2074/75 and 2075/76 respectively. There is great variation among the districts in last three F/Y. In 2076/77, Manang has highest 690 and Myagdi has lowest 63.

**Table 5.4: Hospital bed turnover rate**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 99 | 114 | 132 |
| Manang | 459 | 1253 | 690 |
| Mustang | 270 | 414 | 184 |
| Myagdi | 59 | 64 | 63 |
| Kaski | 88 | 85 | 100 |
| Lamjung | 54 | 61 | 119 |
| Tanahun | 96 | 140 | 129 |
| Nawalparasi East | 141 | 161 | 130 |
| Syangja | 531 | 238 | 266 |
| Parbat | 88 | 119 | 165 |
| Baglung | 78 | 122 | 114 |
| **Gandaki Province** | **89** | **90** | **105** |

***Source: HMIS/DHIS-2***

### 5.1.5 Hospital Death

Number of hospital deaths per year in 2074/75, 2075/76, 2076/77 is 1299, 1045 and 1249 respectively, this shows there is slightly fluctuating trend during last three years. There is high death in Kaski district and lowest (no hospital death) inManang and Parbat districts in FY 2076/77.

**Table 5.5: Number of Hospital Deaths**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 17 | 8 | 12 |
| Manang | 0 | 0 | 0 |
| Mustang | 0 | 0 | 1 |
| Myagdi | 2 | 3 | 6 |
| Kaski | 1251 | 1009 | 1197 |
| Lamjung | 13 | 6 | 9 |
| Tanahun | 5 | 5 | 7 |
| Nawalparasi East | 0 | 3 | 5 |
| Syangja | 0 | 1 | 5 |
| Parbat | 1 | 2 | 0 |
| Baglung | 10 | 8 | 7 |
| **Gandaki Province** | **1299** | **1045** | **1249** |

### 5.1.6 Average length of stay in Hospital

The average length of stay in Hospitals at this province is in increasing trend. In last three years, 2074/75, 2075/76 and 2076/77 this figure is 3.1, 3.6 and 3.7 days per patient respectively. There is high average length of stay in Kaski (4) and low in Manang (1.4) district in FY 2076/77

**Table 5.6: Average length of stay in Hospital days**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 2.7 | 3 | 2.6 |
| Manang | 1.4 | 1.4 | 1.4 |
| Mustang | 2.1 | 3.8 | 3 |
| Myagdi | 2.2 | 3.5 | 2.4 |
| Kaski | 3.3 | 3.7 | 4 |
| Lamjung | 0.12 | 2.5 | 2.2 |
| Tanahun | 3.1 | 3.9 | 2.6 |
| Nawalparasi East | 3.7 | 2.8 | 1.6 |
| Syangja | 0.88 | 0.02 | 2.5 |
| Parbat | 3 | 2.3 | 2.4 |
| Baglung | 2.1 | 2.5 | 3 |
| **Gandaki Province** | **3.1** | **3.6** | **3.7** |

### 5.1.7 Bed occupancy rate

The bed occupancy rate in Gandaki province shows slightly fluctuating trend in the three consecutive fiscal years. In F/Y 2074/74, 2075/76 and 2076/77 this rate is 41, 43 and 42 respectively. There is high bed occupancy rate in Kaski (47) and Myagdi (47) and low in Manang in FY 2076/77.

**Table 5.7: Bed occupancy rate in percentages**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 28 | 31 | 24 |
| Manang | 4 | 2 | 3 |
| Mustang | 10 | 10 | 21 |
| Myagdi | 46 | 45 | 47 |
| Kaski | 45 | 48 | 47 |
| Lamjung | 3 | 46 | 23 |
| Tanahun | 38 | 32 | 28 |
| Nawalparasi East | 26 | 18 | 17 |
| Syangja | 3 | 0 | 9 |
| Parbat | 30 | 21 | 17 |
| Baglung | 32 | 23 | 30 |
| **Gandaki Province** | **41** | **43** | **42** |

### 5.1.8 Maternal and Neonatal Death in Hospitals

The table below shows that the trend of reported number of maternal death and neonatal death are fluctuating over the three years period. However, in comparison with last fiscal year, the number of maternal deaths has decreased but number of neonatal deaths is increased in FY 2076/77.

**Table 5.8: Number of Maternal and Neonatal Death in Hospitals in number**

| Districts/FY | 2074/75 | | 2075/76 | | 2076/77 | |
|---|---|---|---|---|---|---|
| | Total Maternal Deaths | Total Neonatal Deaths | Total Maternal Deaths | Total Neonatal Deaths | Total Maternal Deaths | Total Neonatal Deaths |
| Gorkha | 2 | 18 | 1 | 11 | 1 | 11 |
| Manang | | | 0 | 0 | 0 | 0 |
| Mustang | 1 | 0 | 0 | 0 | 0 | 1 |
| Myagdi | 1 | 8 | 0 | 10 | 1 | 21 |
| Kaski | 14 | 53 | 7 | 30 | 2 | 68 |
| Lamjung | 1 | 22 | 0 | 0 | 0 | 5 |
| Tanahun | 0 | 7 | 0 | 4 | 0 | 4 |
| Nawalparasi East | 0 | 2 | 0 | 31 | 1 | 13 |
| Syangja | 1 | 15 | 2 | 6 | 1 | 3 |
| Parbat | 0 | 6 | 0 | 4 | 1 | 1 |
| Baglung | 2 | 12 | 0 | 14 | 1 | 10 |
| **Gandaki Province** | **22** | **143** | **10** | **110** | **8** | **137** |

# Section 6

# SUPPORTING PROGRAMS

**Background**

In management support functions there are various components, Capacity building (training), logistic management, financial management, physical infrastructure and renovation support function, planning, supervision, monitoring, review, evaluation, health management information system (HMIS), human resource management are some key supportive components in health program throughout the province.

**6. 1 Policy Setting**

A multi-sectoral approach has been adapted for the development and implementation of various health programs by the province government to strengthen all areas that would lead to improvement of the health services especially to the vulnerable groups. This includes health related and non-health related activities carried out from the province as well as from peripheral health facilities aimed to improve health services.

**6.2 Health Management Information System (HMIS)**

HMIS includes the systematic collection, presentation, analysis and interpretation of service statistics from the service delivery outlets. The information is being regularly used in policy formulation, planning, monitoring of service delivery and evaluation of outputs.

HMIS has been revised periodically to enable recording and reporting of more detailed, program-wise information. It aims to meet needs of all programs and integrate vertical reporting systems of programs, disaggregate selected indicators by caste and ethnicity, make tools more user friendly, improve data quality, improve use of HMIS data at different levels for monitoring and planning process.

**National Objectives**

The main objective of HMIS is to manage the health information system throughout the province. The specific objectives can be pointed out as follows:

- To collect and manage the health service delivery information from all levels of service delivery institutions
- To verify, process, analyze the collected data and draw inferences
- To provide feedbacks on achievements, coverage, continuity and quality of health services to all hospitals and health offices
- To provide necessary information for plan and policy formulation
- To disseminate health information through efficient methods and technologies
- To publish a comprehensive Annual report of Health Directorate and Districts
- To develop competent human resource for Health information management system
- To conduct Provincial performance review of health programs and district as well local level reviews
- To review the information management system and recommend for modification the tools, techniques and methodologies
- To establish integrated Health Information System.

### 6.3 Planning, Supervision, Monitoring, Follow-up and Evaluation

Monitoring and supervision are essential activities for better planning and evaluation of the program and health activities for delivering effective health services. The planning of all activities conducted by Health Directorate was done and monitoring sheet was prepared for monthly monitoring of all activities in the district on the basis of which timely feed-back was provided to the concerned districts for better service delivery. Likewise, the written instruction and guidelines were sent to the districts forbetter health care delivery as well as to coordinate the local level for data entry and its management. The following mentioned activities have been carried out for planning, supervision, monitoring and evaluation of Health Program during the FY 076/77. Technical support has given to local level staff with data entry training software (DHIS-2).

### 6.4 Financial Management

The major function and responsibilities of the finance section of the Health Directorate is to ensure and maintain the budgetary disciplines of the HD, support the districts for timely submission of the monthly financial reports to the HD and emphasize to reduce irregularities of the health office and hospitals.

**Objectives**

- To ensure the salaries, other expenses and timely purchase of official goods supplies.
- To support financial aspects of various health activities.
- To follow the act and regulations related to financial management and regularize district level activities accordingly
- To regularize and reduce irregular expenses
- To support the supply of the drugs and other related materials up to the service outlets throughout the province by ensuring transportation budget in time

### 6.5 Human Resource Management

Human resources and personnel administration play a vital role in the implementation of the health care delivery mechanism at all levels of the health institutions. The under mentioned tables summarized the staff situation of HD, Health Offices and Hospitals as well as Ayurveda health centers within the province. Still, complete settlement of health staff has not been due to adjustment process. This causes staff gap and not uniformly distribution of health staffs in the public health sector. The data reveals that many key posts are still vacant in HD as well as in districts too which has negative effect on the service delivery and the health programs.

Among the input resource management human resource is the most important as it provides the services and manage as well as controls all the others. The acquiring, orientation, retention and compensation of staffs are the main functions of human resource management.

**Human Resource in the province**

Out of 698 sanctioned posts, 384 posts have been fulfilled in F/Y 2076/77. This shows that about 44% posts are vacant. Currently, Ministry of Social Development has been fulfilling various posts on contract basis.

**Table 6.1: Human Resource Status**

| Categories | Posts Sanctioned | Post Fulfilled | Post vacant | Post vacant (%) |
|---|---|---|---|---|
| Public Health / Health Education Administer Officer | 38 | 18 | 20 | 53 |
| Specialist/Medical Doctor | 78 | 35 | 43 | 55 |
| Statistician | 21 | 15 | 6 | 29 |
| Paramedics | 97 | 67 | 30 | 31 |
| Nursing Staff | 108 | 81 | 27 | 25 |
| Lab Staff | 50 | 37 | 13 | 26 |
| Administrative Staff | 61 | 42 | 19 | 31 |
| Pharmacy | 6 | 2 | 4 | 67 |
| Ayurveda Staff | 45 | 39 | 6 | 13 |
| Other | 181 | 48 | 133 | 73 |
| **Total** | **685** | **384** | **301** | **44** |

### 6.6 Construction and Renovation

Ministry of Health and population regularly conducts the activities of construction and renovation collaborating with Urban Development and Building Construction Department, to provide the qualitative health services to the people, the infrastructures also should be qualitative according to the policy of the government. Thus, construction and renovation of physical infrastructure is one of the major activities of health service.

### 6.7 Capacity building

The Health care system should be competent in providing services to the people but still need to be improved to the proficient level so that it could meet the international quality. Skilled human resource for health is the main component to meet its standard. MoHP and Ministry of Social Development Ministry has given priority for the development of competent human resource through various training activities. The national health training system caters to the need of MoHP/DoHS and MoSD for developing trained human resource towards an improved health service delivery to the needy population of the country. National Health Training Centre (NHTC) and Provincial Health Training Centre (PHTC)are the center for the capacity building of the health workers in the country as well as province. They provide training through different training sites.

**Objectives**

- Assess training requirements of Health workers and prepare training plans based on the program's requirements.
- Plan, implement and train health workers as demanded by programs.
- Support HOs in organizing/implementing, evaluating training program to be executed
- Conduct basic, refresher or in-service training for the provincial level.

**Strategies**

- Production of grass root level health manpower is done at provincial health training center under residential setting.

- For developing job competency, all the trainers are exposed in the community for qualitative and practical training.

### 6.8 Health Education Information and Communication

The Ministry of Health and Population specifies that one of the main reasons for the low health status of the people is the lack of public health awareness, therefore health education must be provided in an effective manner from central to rural areas. Information education and communication (IEC) is an important part to raise awareness about public health.

**Objectives**

- To develop positive attitude towards health through effective IEC interventions at the national down to the community level.
- To promote participation of the people at all level in the health program by increasing information education and communication on health.
- To develop audiovisual materials and cultural media in support of motivation campaign and passing specific information to clients at community levels.
- To utilize mass media, NGOs, INGOs and local people for promoting public awareness on health.
- To mobilize the community through IEC for utilization of existing health institutions. The overall objective of the program is to change the behavior of people.

**Targets**

The overall goal of the information, education and communication (IEC) for health is to raise the health awareness of the people as a means to promote health status and to prevent the disease through the efforts of the people themselves and through full utilization of available resources.

**Strategies**

- Promotion of IEC activities with special focus to rural and hard to reach communities with the help of different Government and non-Government health agencies.
- Dissemination of information, education and communication on health-related issues through mass media.
- Use of individual groups and mass media in health information and communication.

**Program achievement of Gandaki province in FY 2076/77**

Though due to Covid-19 Pandemic multiple planned health programs were affected in F/Y 2076/77, Health Directorate has conducted many health education and promotion programs in Gandaki Province for improvement of better health in last fiscal year. Health Communication is one of the effective and low-cost interventions to change the behavior of people. All Health Offices have been conducting different types of Behavior Change Communication Programs. NHEICC is the apex institution for BCC Program in Nepal

- Interaction program for media persons.
- Covid-19 related press release and video conferencing.
- Publication of IEC materials and distributed to local health facilities.
- Web Page published.
- Message through local radio/FM program
- Message through local television program

- Message through local online publication.
- Local newspaper publication.
- Program on environmental health and occupational health at community level.
- Emergency and hazard control program
- Celebration of national days
- Hoarding Board display.
- Tobacco control & NCD control program.
- Established IEC corner
- Supervision of health education program at different levels.

### 6.9 Financial achievement

The Financial achievements of Health offices in the fiscal year 2076/77 and Health Directorate is more than 50% though it is not satisfactory. Due to Covid-19 Pandemic, financial achievement was not satisfactory in this Fiscal Year.Nonetheless, financial achievement of hospitals at this province in 2076/77 is comparatively satisfactory compare to health offices.

**Fig 6.1: Hospitals financial achievement**

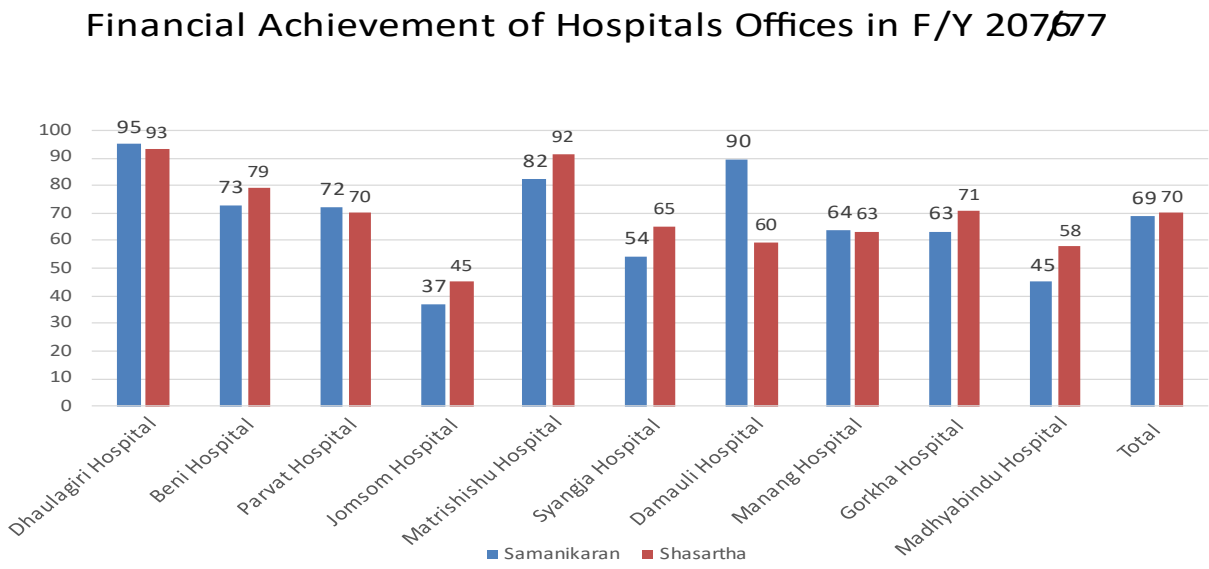
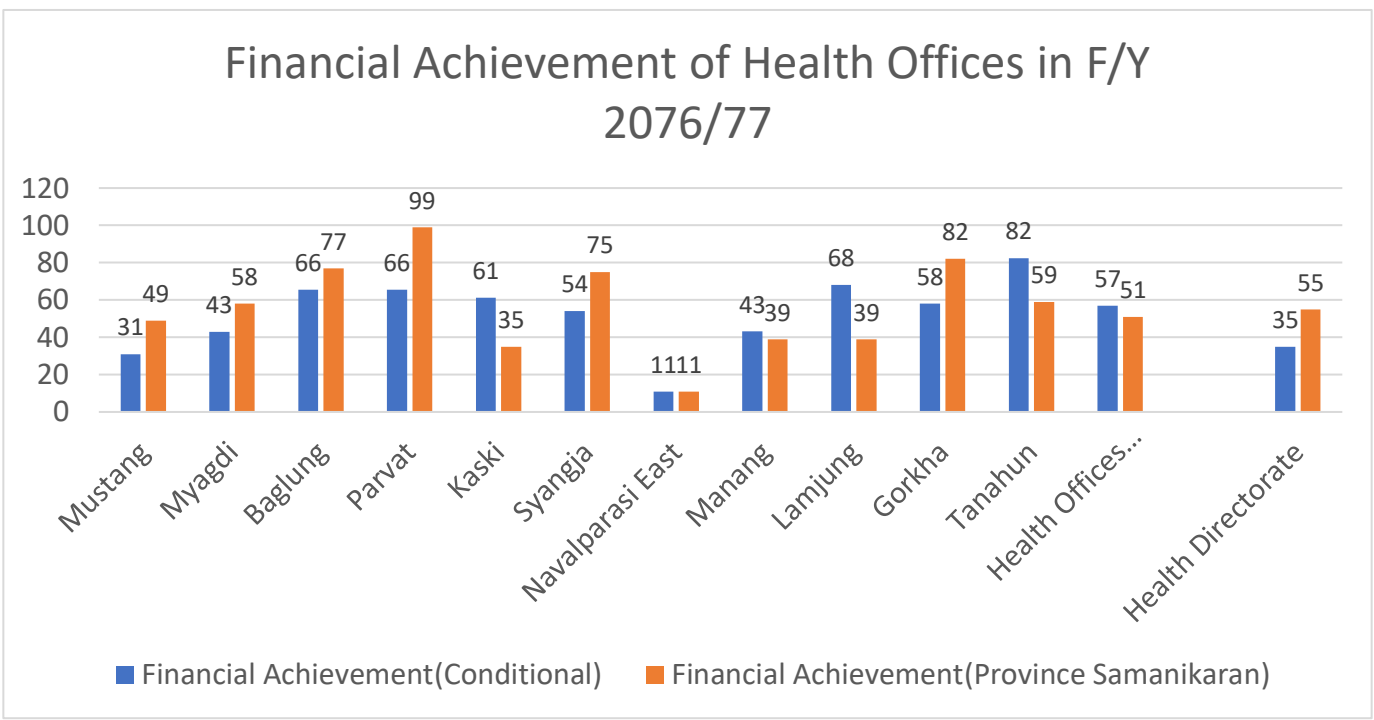



**Fig 6.2: Financial achievement of Health Offices and Health Directorates**



### 6.10 Reporting status

Reporting to the DHIS-2 software is a regular process carried out from Local level and other health institutions. The reporting status from the district is 100 percent but the timely reporting should be maintained. Nonetheless, reporting status in last three years in Gandaki Province is progressing from 94%, 97% to 100% in 2074/75, 2075/76 and 2076/77 respectively.

**Table 6.2: Reporting status of local level health institutions (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 97 | 91 | 100 |
| Manang | 86 | 96 | 94 |
| Mustang | 94 | 92 | 100 |
| Myagdi | 100 | 100 | 100 |
| Kaski | 99 | 96 | 100 |
| Lamjung | 82 | 97 | 100 |
| Tanahun | 92 | 99 | 100 |
| Nawalparasi East | 80 | 96 | 100 |
| Syangja | 100 | 93 | 100 |
| Parbat | 98 | 100 | 100 |
| Baglung | 100 | 100 | 100 |
| **Gandaki Province** | **94** | **97** | **100** |

#### 6.10.1Reporting Status (PHC/ORC)

The reporting status of PHC/ORC in the fiscal year 2076/077 is 80 % in average. This is gradually decreased than last two F/Y which was 96% in each year.

**Table 6.3: Reporting Status of PHC/ORC (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 96 | 94 | 79 |
| Manang | 86 | 94 | 100 |
| Mustang | 81 | 87 | 79 |
| Myagdi | 94 | 96 | 87 |
| Kaski | 94 | 97 | 73 |
| Lamjung | 100 | 98 | 80 |
| Tanahun | 95 | 95 | 81 |
| Nawalparasi East | 97 | 99 | 76 |
| Syangja | 95 | 94 | 85 |
| Parbat | 95 | 95 | 79 |
| Baglung | 98 | 99 | 79 |
| **Gandaki Province** | **96** | **96** | **80** |

#### Hospital Reporting status in the province

The hospital reporting status within the province in FY 2076/77 is 100% in average which is dramatically increased as compared to FY 2075/76 (72%), even though timely and complete reporting status of hospitals should be increased.

**Table 6.4: Reporting status of Hospitals (%)**

| Districts/FY | 2074/75 | 2075/76 | 2076/77 |
|---|---|---|---|
| Gorkha | 75 | 48 | 100 |
| Manang | 100 | 83 | 100 |
| Mustang | 100 | 100 | 100 |
| Myagdi | 100 | 100 | 100 |
| Kaski | 92 | 93 | 100 |
| Lamjung | 18 | 85 | 100 |
| Tanahun | 17 | 38 | 100 |
| Nawalparasi East | 14 | 60 | 83 |
| Syangja | 98 | 70 | 100 |
| Parbat | 79 | 50 | 100 |
| Baglung | 100 | 80 | 100 |
| **Gandaki Province** | **58** | **72** | **100** |

**Constraints and Recommendation**

| Key Issues | Recommendation | Responsibility |
|---|---|---|
| Logistic Supply not as per need (PUSH approach) is predominant all levels | Adopt both demand and supply systems across all levels | MD, DoHS/ PLMD/H0/Local Level |
| Untimely supply of drug and other logistics | Timely supply of logistics | MD/PMS/HD/H0/Local Level |
| Private sector reporting is not satisfactory so the district sevice statistics may not be the real picture | Streamline the private sector reporting by engaging and Partnership building with private sector | MoSD/HD/HO/ Local Level |
| Weak districts level work plan of targeted Activities | Prepare work plan in time and let me know it in all levels | MoSD/HD/HO/ Local Level |
| Weak planning practice | Empower province and District and Local Level for planning process | DoHS/MOSD/HD/ HO/Local Level |
| Inactive health management committee | Activate them | HO/Local level |
| Irregular functioning of software | Use the soft ware and report as required<br>Make user friendly software<br>Empower province on technology | MD, DoHS/HD/ Local Level |
| Lack of proper software for human resource management in district and province | Develop web-based software and update regulary | M o H / D o H S / MOSD/HD/ Local Level |

# Section 7

# AYURVED AND ALTERNATIVE MEDICINES

### 7.1 Background

Life in Ayurveda is conceived as the union of body, senses, mind and soul. The living man is a conglomeration of three humors (Vata, Pitta &Kapha), seven basic tissues (Rasa, Rakta, Mansa, Meda, Asthi, Majja & Shukra) and the waste products of the body i.e., Mala, Mutra and Sweda. Thus, the total body matrix comprises of the humors, the tissues and the waste products of the body. The growth and decay of this body matrix and its constituents revolve around food which gets processed into humors, tissues and wastes. Ingestion, digestion, absorption, assimilation and metabolism of food have interplay in health and disease which are significantly affected by psychological mechanisms as well as by bio- fire (Agni).

According to Ayurveda all objects in the universe including human body are composed of five basic elements (Panchamahabhutas) namely, earth, water, fire, air and vacuum (ether). There is a balanced condensation of these elements in different proportions to suit the needs and requirements of different structures and functions of the body matrix and its parts. The growth and development of the body matrix depends on its nutrition, i.e., on food. The food, in turn, is composed of the above five elements, which replenish or nourish the like elements of the body after the action of bio-fire (Agni). The tissues of the body are the structural entities whereas humors are physiological entities, derived from different permutations and combinations of Panchamahabhutas. Health or sickness depends on the presence or absence of a balanced state of the total body matrix including the balance between its different constituents. Both the intrinsic and extrinsic factors can cause disturbance in the natural equilibrium giving rise to diseases. This loss of equilibrium can happen by dietary indiscrimination, undesirable habits and non-observance of rules of healthy living. Seasonal abnormalities, improper exercise or erratic application of sense organs and incompatible actions of the body and mind can also result in creating disturbance of the existing normal balance. The treatment consists of restoring the balance of disturbed body-mind matrix by following proper diet, correcting life-routine and behavior, administration of drugs and resorting to preventive Panchakarma and Rasayanatherapy in Ayurveda diagnosis and treatment of disease is always individual to each patient. The physician takes a careful note of the patient's internal physiological characteristics and mental dispositions. He also studies other factors such as the affected bodily tissues, humors, the site at which the disease is located, patient’s resistance and vitality, his daily routine, dietary habits, the clinical conditions, condition of digestion and details of personal, social, economic and environmental situation of the patient. The diagnosis also involves the following examinations: General physical examination: Pulse, Urine, faeces, tongue and eyes, skin and ear, Auditory, and Tactile physiology.

The treatment approach in the Ayurveda system is holistic and individualized having Preventive, Curative, Mitigative, Recuperative and rehabilitative aspects. The principal objectives of Ayurveda are maintenance and promotion of health, prevention of disease and cure of sickness. Treatment of the disease consists in avoiding causative factors responsible for disequilibrium of the body matrix or of any of its constituent parts through the use of Panchakarma procedures,

medicines, suitable diet, activity and regimen for restoring the balance and strengthening the body mechanisms to prevent or minimize re-occurrence of the disease. Normally treatment measures involve use of medicines, specific diet and prescribed activity routine. These three measures are used in two ways. In one approach of treatment the three measures antagonize the disease by counteracting the etiological factors and various manifestations of the disease. In the second approach the same three measures of medicine, diet and activity are targeted to exert effects similar to the etiological factors and manifestations of the disease process. These two types of therapeutic approaches are respectively known as Vipreeta and Vipreetarthkari Chikitsa**.** For successful administration of a treatment four things are essential. These are physician, medicaments, nursing personnel and patient.

The physician comes first in order of importance. He must possess technical skill, scientific knowledge, purity and human understanding. The physician should use his knowledge with humility, wisdom and in the service of humanity. Next in importance comes food and drugs. These are supposed to be of high quality; wide application, grown and prepared following approved procedures and should be available adequately. The third component of every successful treatment is the role of nursing personnel who should have good knowledge of nursing, must know the skills and be affectionate, sympathetic, intelligent, neat & clean and resourceful. The fourth component is the patient himself who should be cooperative and obedient to follow instructions of the physician, able to describe ailments and ready to provide all that may be needed for treatment.

Ayurveda has developed a very vivid analytical description of the stages and events that take place since the causative factors commence to operate till the final manifestation of disease. This gives this system an additional advantage of knowing that possible onset of disease much before the latent symptoms become apparent. This enhances the preventive role of this system of medicine by making it possible to take proper and effective steps in advance, to arrest further progress in pathogenesis or to take suitable therapeutic measures to curb the disease in its earliest stage of onset.

The treatment of disease can broadly be classified as; Shodhana therapy (Purification Treatment) , Shamana therapy (Palliative Treatment) ,PathyaVyavastha (Prescription of diet and activity) , NidanParivarjan (Avoidance of disease causing and aggravating factors) Satvavajaya (Psychotherapy) ,Rasayana therapy (use of immuno-modulators and rejuvenation medicines). In Ayurveda, regulation of diet as therapy has great importance. This is because it considers human body as the product of food. An individual's mental and spiritual development as well as his temperament is influenced by the quality of food consumed by him. Food in human body is transformed first into chyle or Rasa and then successive processes involve its conversion into blood, muscle, fat, bone, bone-marrow, reproductive elements and Oja. Thus, food is basic to all the metabolic transformations and life activities. Deficiency of nutrients in food and improper transformation of food lead to a variety of disease condition.

Department of Ayurveda (DoA) primarily manages the delivery of Ayurveda services and promotes healthy lifestyles through its network facilities all across the country. The Department of Ayurveda, one of the three departments of the Ministry of Health (MoH) and is responsible for programming,

management of information, and supervision, monitoring and evaluation of the Ayurveda Service program.

Ayurveda is an ancient medical system and indigenous to Nepal with deep roots. The sources of Ayurveda medicine are medicinal herbs, minerals and animal products. The system works through simple and therapeutic measures along with promotive, preventive, curative and rehabilitative health of people. Ayurveda health services are being delivered through two Ayurveda Hospitals, 14 Zonal Ayurveda Dispensaries, 61 District Ayurveda Health Centers and 305 Ayurveda dispensaries across the country. The Ayurveda and Alternative Medicine unit in the Ministry of Health (MoH) is responsible for formulating policies and guidelines for Ayurveda and other traditional medical system.

Various national and international policies have highlighted the importance of Ayurveda services in primary health care and for prevention of NCDs. The Constitution of Nepal has emphasized on prevention and promotion of health traditional Ayurveda medicines along with naturopathy and homeopathy. The National Health Policy (2014) and National Urban Health policy (2015) has called for expansion of Ayurveda services for the National Ayurveda Health Policy (1995)

The fourteenth plan approach paper (2016/17-2018/19) of government of Nepal has guided the government to better preserve, manage and utilize the herbs available in the country. More specifically, it says: 1) suitable structure will be developed and extended for effective implementation of Ayurveda system; 2) Ayurveda production will be increased along with monitoring malpractices in the the name of Ayurveda and herbs and 3) Ayurveda, Homeopathy, Unani and other complementary medical systems will be preserved and developed with long-term planning.

### 7.1.1 Objectives

- To expand and develop functional, physical Ayurveda health infrastructure;
- To improve quality control mechanism for Ayurveda health services throughout the country;
- To develop and manage the required human resources;
- To mobilize the adequate resources for medicinal plants;
- To promote community participation in the management of the health facility & utilization of local herbs;
- To procure, store and distribute the Ayurveda medicine & other allied materials;
- To promote health status & sustainable development of Ayurveda system using locally available medicinal plants;
- To promote positive attitudes towards health care & awareness of health issues;

### 7.1.2 Strategies

- Provide preventive, promotive& curative health services in the rural areas;
- Establishment & development of Ayurveda institutions;
- Strengthen & expand the Ayurveda health services;
- Develop skilled manpower required for various health facilities;
- Strengthening of monitoring & supervision activities;
- Development of information, education & communication center in the Department;

- Develop Inter sectoral co-ordination with Ministry of Education, Forestry, local development sector & other NGO's & INGO's;
- Establishment of regional Ayurveda Hospitals & Ayurveda Dispensaries;
- Strengthening & expansion of research & training center of international level;
- National & International level training for the capacity buildup of its human resources

### 7.1.3 Gandaki Province Ayurveda Health Facilities

There are two zonal Ayurveda Dispensaries, 9 district Ayurveda health centers and 55 Ayurveda dispensaries in public sector. Among 85 local levels, the coverage of Ayurveda health Institutions is 47. Thirty-six local levels are out of coverage of Ayurveda health facilities. Ayurveda lifestyle coaching and Poorvakarma Service are started as pilot project in Bhedavari PHC from FY 2075/76. There are five private hospitals, 111 private clinic and pharmacy counters, 6 Ayurveda Manufacturing Companies (only three in operation). Naturopathy hospital and clinic, Homeopathy, Acupuncture and Amchi clinics are in operation in this province.

### 7.1.4 Ayurveda Health Workforce

The population of Gandaki Province is 2380749(2.380 million: CBS). The ratios between population and Ayurveda institution are as follows: Population per District Ayurveda Health Centers: 0.216 million; andPopulation per Ayurveda Dispensaries: 0.0361million. Total sanctioned posts for Ayurveda in this province are 85. The coverage of Ayurveda health Facility in 48 local level with 55 Ayurveda Health Facilities has 220 sanctioned posts includingKaviraj, Vaidhya, Peon and Aushadhi Kutuwa in each facility. Thus, the total work force under Ayurveda is 307 including 2 working in Bhedabari PHC in contract.

*Ayurveda lifestyle coaching and Panchakarma services started as pilot project by recruiting and placing human resource in contract basis since FY 2075/76 and the same is continue in running fiscal year.

### 7.1.5 Major Activities

**Province level**

- Publication of IEC material on Ayurveda and Yoga Knowledge
- Specialty Health Camp (Ayurveda and Yoga)
- Organization management, Poorvakarma and Panchakarma Training
- Ayurveda lifestyle coaching and Panchakarma Program in Bhedabari PHC
- Procurement and supply of Ayurveda Medicines
- Celebration of National Ayurveda Day/ DhanawantariJayanti2075
- Publication of Provincial Ayurveda and alternative medicine Profile
- Feasibility study of provincial Herbal Production &processing center
- Training materials (Facilitators Guide, Reference Book and Participants Handbook of Yoga, Panchakarma, Ksharasutra and accupunture Training) for Ayurveda Physicians, Kaviraj and Vaidhya.

**District level**

- OPD Service
- Senior Citizen Program (Distribution of Ashwagandha Powder and Dasmool Tel
- Lactating mother program (Distribution of Shatavari Powder)
- Poorvakarma & Panchakarma Program
- Life style modification and Yoga Program
- School Ayurveda and Yoga Program
- Introductory program on locally available Medicinal Plants for local people manufacturing of Power medicine in Rural Pharmacy
- Ayurveda health camps outreach Ayurveda Clinic and Urban Ayurveda Clinic in free of cost
- Ksharasura for Anorectal Diseases and other minor surgical Procedures
- Acupuncture service

### 7.1.6 Analysis of Achievement

**Figure 7.1: Total patients utilizing Ayurvedic Health Services**

**Service Statistics**

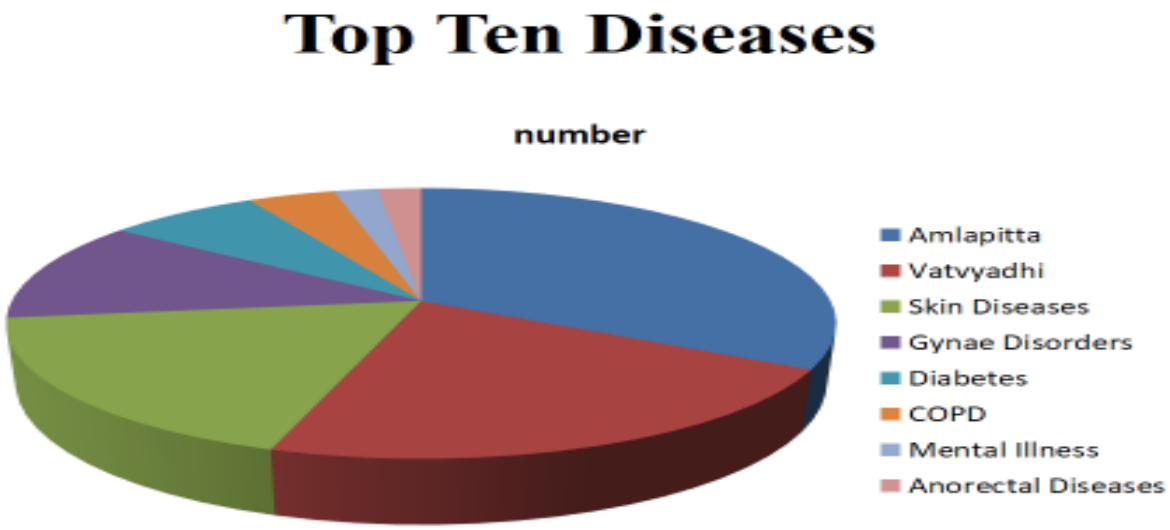
| SN | District | Total Patients |
|---|---|---|
| 1 | Navalparasi | 32,329 |
| 2 | Gorkha | 15,685 |
| 3 | Lamjung | 20000 |
| 4 | Manang | 1911 |
| 5 | Tanahu | 40,279 |
| 6 | Kaski | 15316 |
| 7 | Syangja | 30127 |
| 8 | Parvat | 14924 |
| 9 | Baglung | 8558 |
| 10 | Myagdi | 4446 |
| 11 | Mustang | 3677 |
| | Total | 197605 |

**Figure 7.2: Distribution of patients according to type of serrvice received**

**Program- Wise Data**

| S.N. | Program | Number |
|---|---|---|
| 1 | OPD service | 142051 |
| 2 | Lactating mothers | 2776 |
| 3 | Senior citizens | 8082 |
| 4 | Poorvakarma/ Panchakarma | 6603 |
| 5 | Swastha Jeevan Program | 2600 |
| 6 | Outreach Clinics | 10223 |
| 7 | COVID-19 | 884 |
| | Total | 173179 |

**Figure. 7.3: Top ten Morbidity Data of Ayurveda Health Facilities**




### 7.1.7 SWOT Analysis of Ayurvedic Health Service Program

**Strengths**

- Preventive and Promotive health Services
- Use of locally available herbs for common ailments
- Prevention of Non communicable Chronic Diseases
- Spiritual therapies
- Locally available Natural Medicines
- Ayurveda Food Technologies (Traditional Nepali recipes)
- Ayurveda lifestyles (दिनचर्या, रात्रीचर्या, ऋतुचर्या, सदवृत, ऋतुशोधन, आचाररसायन, आहारविहार, आहारसंस्कार, विरूद्धआहार, रसायनसेवनआदि)

**Weakness**

- Lack of amalgamation of Ayurveda lifestyles including diet, exercise and other preventive &promotive Ayurveda procedures in National& Provincial Health Programs
- Lack of public awareness on importance of traditional medical in preventive and promotive health care
- Lack of specialized & skilled Ayurveda Workforce
- Lack of opportunity in need-based capacity buildup program for Ayurveda Health Workforce
- Low motivation in Ayurveda Health Workforce
- Inadequate Academic institutions for development of specialty and skilled Ayurveda Human Resource
- No programs for Preservation & Promotion of Medicinal Herbs
- lack of policies and guidelines on Good cultivation, collection, storage, transport of medicinal Plants
- External dependency in Ayurveda Medicines
- External dependency in production of specialist Ayurveda Human Resources

**Opportunity**

- Establishment of Academic institutions for specialized Ayurveda Human Resource Development
- Establishment of Herbal Production & processing center for sustainable use of medicinal plants available in this province
- Poverty alleviation and income generation from Medicinal Plants
- Strengthening preventive and promotive health care services by incorporating Ayurveda lifestyles and medical procedures in provincial health policies&programs
- Establishment of Ayurveda Spiritual therapy centers for prevention and treatment of mental illness
- Conservation of traditional and ethnic medical knowledge as the intellectual property of the country
- Promotion of Ayurveda Tourism utilizing Ayurveda Panchakarma, Yoga, Spiritual Therapies, Traditional Nepali recipes by Establishment of Tourist Retreat Center
- Preservation & Promotion of food practices of different ethnic communities
- Promotion of Nepali way of living and socio-cultural behavior (मातृदेवोभवः ,पितृदेवोभवः , अतिथिदेवोभवः ,वसुबधैवकुटुम्बकम्)

**Threats**

- Retention of Competent and motivated Ayurveda Health workforce
- Ayurveda health facility infrastructure
- Rapid urbanization
- Demolition of natural resources
- Contamination & pollution of air, soil, water and entire natural phenomena
- Climate change and its effect on different species valuable medicinal plants

**Problems and Constraints**

| Problems/Constraints | Actions to be taken | Responsibility |
|---|---|---|
| No Provincial Ayurveda Hospital | • Establishment of Provincial Ayurveda Hospital | MoSD/OCMCM |
| No Provincial Ayurveda Health Directorate | • Establishment Provincial Ayurveda Health Directorate in new provincial organization and management Survey | MoSD/ OCMCM |
| no policies and plans for Ayurveda sector | • Short-term, Mid-term and long term Plans to be formulated | MoSD/ OCMCM |
| Lack of specialist Ayurveda Human Resources | • Scholarship for Specialist Ayurveda Human Resources production, recruitment & placement | MoSD/ OCMCM |
| Poor storage & dispensing Practices in Ayurveda health Facilities. | • Provide good furniture & dispensing<br>• materials<br>• Training on storage & Good dispensing Practice. | MoSD/ OCMCM |
| Lack of inter-sectoral co-ordination. | • Co-ordination with related ministries,<br>• NGO's &INGO's | MoSD/OCMCM |

| | | |
|---|---|---|
| Lack of community awareness on Ayurveda lifestyle and Ayurveda medical procedures | • Incorporation of Ayurveda Medical knowledge in provincial health policy<br>• Ayurveda Health Education at Community Level | MoSD/OCMCM/Local level |
| Lack of Capacity build up programs for Ayurveda health work force | • policy, plan and Budget allocation for Ayurveda Training Programs<br>• Design short term, mid term and longterm capacity buildup program for Ayurveda health work force | MoSDO/CMCM |
| Lack of appropriate Recording & Reporting system. | • Development and Implementation of Ayurveda Information Management System(AHIMS)<br>• Allocation of adequate budget for AHMIS.<br>• Training on AHIMS For Ayurveda Personnel | MoSD/OCMCM/Local level |
| No documentation and protection of Provincial ethno-medical knowledge | • Policy formulattion on protection of intellectual property right of traditional knowledge holders and practitioner<br>• Development of Traditional knowledge digital library | MoSD/ OCMCM |
| No provincial herbal data Bank | • Guide local government to prepare herbal data bank of each local level & compile in province level<br>• develop policy and plan to develop provincial herbal data bank | MoSD OCMCM |
| No Indoor service District Ayurveda health Centers | • IPD Services to be extended in all 11 DAHCs<br>• Develop adequate infrastructure<br>• Recruit adequate human Resource | MoSD OCMCM |
| No Ayurveda specialty center in Province | • Organization and Management Survey<br>• Recruitment and Placement of Specialized Ayurveda Human in different Ayurveda Specialties | MoSD OCMCM |
| No coverage of Ayurveda health facilities at all local levels | • Establishment of New Ayurveda health facilities in local levels out of coverage | MoSD OCMCM |
| No provincial Ayurveda manufacturing unit | • Establishment of Ayurveda manufacturing, quality control and research units | MoSD OCMCM |
| No MSS in Ayurveda Health Facilities | • Minimum Service Standard for all level Ayurveda Health Facilities | MoSD OCMCM |
| No Standard treatment Guidelines | • standard treatment Protocol for Curative Ayurveda Services to be developed | MoSD OCMCM |
| No Ayurveda Human Resource in Health Training center and heath logistic management center of Province | • Organization and Management Survey<br>• recruitment and placement of Ayurveda Human resource in Respective centers | MoSD OCMCM |

## 7.2 Health Insurance

### Introduction

Health Insurance Board (HIB) is a social protection program of the Government of Nepal that aims to enable its citizens to access quality health care services without placing a financial burden on them. The households, communities and government are directly involved in this program. Health Insurance program helps prevent people from falling into poverty due to health care costs i.e., catastrophic expenditure due to accidents or disease by combining prepayment and risk pooling with mutual support. This program also advocates towards quality health services. This program attempts to address barriers in health service utilization and ensure equity and access of poor and disadvantaged groups as a means to achieve Universal Health Coverage.

### 7.2.1 Main Objective

- To ensure Universal Health Coverage by increasing access to, and utilization of necessary quality health services.

### Specific objectives

- To increase the financial protection of the public by promoting pre-payment and risk pooling in the health sector;
- To mobilize financial resources in an equitable manner; and
- To improve the effectiveness, efficiency, accountability and quality of care in the delivery of health care services.

### 7.2.2 Strategic Goal and Responsibilities

### Strategies

- Increasing participation of communities towards health insurance program by providing special protection to the poor and marginalized and
- Extending coordination and cooperation with government and non-government service provider health institutions for gradual expansion of health insurance program throughout the country.

### 7.2.3 Present status of Health Insurance Program in Gandaki province

Initially to Introduce Health Insurance Program in Nepal i.e., the Vison of National Health policy 2071, National Health Insurance policy 2071, a Social Health Security Development committee (गठनआदेश२०७१) and Social Health security program (standard operation procedure) regulation 2072 was brought and under its provision on FY 2072/73 Baglung, Kailali and Illam were the three districts where Health Insurance Program was launched as pilot program. On FY 2073/74 HI (Health Insurance) program was launched on 4 more districts (Kaski, Myagdi, Tanahun and Gorkha) of Gandaki province. With certification of Health Insurance Act 2074, by Honorable President Bidhya devi Bhandari, the plan of expansion of HI program throughout the country on FY 2074/75 and 2075/76 Syangja and Parbat are two district where HI program was launched respectively on Gandaki province and most recently on FY 2077/78 Lamjung and East Nawalpur are the two recent

districts where HI program was launched also by the end of 2077/78 Manang and Mustang are the two district where HI program will be launched on Gandaki province. A health insurance board provincial office has established on 2074 BS in Pokhara capital city of Gandaki province and a district HI office are there in each district.

**Table 7.1: Insurance launched and service start date at Gandaki Province**

| SN | District | Launched date | Service start Date |
|---|---|---|---|
| 1 | Baglung | 2073 Ashad 15 | 2073 Bhadra 1 |
| 2 | Pokhara | 2073 Poush 12 | 2073 falgun 1 |
| 3 | Myagdi | 2073 Poush 13 | 2073 falgun 1 |
| 4 | Tanahun | 2074 Ashad 01 | 2074 Bhadra 1 |
| 5 | Gorkha | 2074 Ashad 15 | 2074 Bhadra 1 |
| 6 | Syangja | 2075 Falgun 05 | 2076 Jestha 1 |
| 7 | Parbat | 2076 Falgun 05 | 2077 Jestha 1 |
| 8 | Lamjung | 2077 Poush 29 | 2078 Jestha 1 |
| 9 | Nawalparasi East | 2077 falgun 09 | 2078 Jestha 1 |
| 10 | Manang | By the end of fy 2077/78 | - |
| 11 | Mustang | By the end of fy 2077/78 | - |

In 9 districts where HI program have already been launched, population of 466,725 and total 159,138 families are covered (except Lamjung and Nawalparasi East district). About 219,525 males, 246681 females and 45 other genders have been insured under HI program.

**Table 7.2: Health Insurance service sites in Gandaki Province**

| SN | Health facility Names | District |
|---|---|---|
| 1 | Pokhara Academy of Health Science (PAHS)(WRH) | Kaski |
| 2 | Himalayan Eye Hospital | Kaski |
| 3 | Manipal teaching hospital | Kaski |
| 4 | Gandaki medical collage | Kaski |
| 5 | Matrisishumiteri hospital | Kaski |
| 6 | Shishuwa hospital | Kaski |
| 7 | Bhedawari PHC | Kaski |
| 8 | Armala PHC | Kaski |
| 9 | Urban health care promotional center | Kaski |
| 10 | Kristi PHC | Kaski |
| 11 | Thumsikot PHC | Kaski |
| 12 | Paschimanchal community hospital | Kaski |
| 13 | Dhaulagiri zonal hospital | Baglung |
| 14 | Burtibang PHC | Baglung |
| 15 | Galkot PHC | Baglung |
| 16 | Kushmishera PHC | Baglung |
| 17 | Damauli Hospital | Tanahun |
| 18 | Bandiput Hospital | Tanahun |

| | | |
|---|---|---|
| 19 | GP koirala NCR | Tanahun |
| 20 | Purandihi PHC | Tanahun |
| 21 | Bhimad PHC | Tanahun |
| 22 | Sundarbazar hospital | Lamjung |
| 23 | District hospital Lamjung | Lamjung |
| 24 | Gauda PHC | Lamjung |
| 25 | Chandreswor PHC | Lamjung |
| 26 | Benihsospital | Myagdi |
| 27 | Darbang PHC | Myagdi |
| 28 | District hospital Gorkha | Gorkha |
| 29 | Aappipal hospital | Gorkha |
| 30 | Aaruchanaute PHC | Gorkha |
| 31 | Jaubari PHC | Gorkha |
| 32 | Makaisingh PHC | Gorkha |
| 33 | District hospital syangja | Syangja |
| 34 | Chapakot hospital | Syangja |
| 35 | Malunga PHC | Syangja |
| 36 | Panchamul PHC | Syangja |
| 37 | Garahun primary hospital | Syangja |
| 38 | GalyangMunucipal hospital | Syangja |
| 39 | Walaing Hospital Pvt Ltd | Syangja |
| 40 | District Hospital Parbat | Parbat |
| 41 | Lunkhu PHC | Parbat |
| 42 | Thulipokhari PHC | Parbat |
| 43 | Madhyebindu Hospital | East Nawalpur |
| 44 | Gaidakot hospital | East Nawalpur |
| 45 | Bunglingtar PHC | East Nawalpur |
| 46 | Dedhgaun PHC | East Nawalpur |
| 47 | Chormara PHC | East Nawalpur |
| 48 | Dumkauli PHC | East Nawalpur |

**Table 7.3: Insurer/ Insured details district wise**

| Districts | Total population | Insurance holder house hold | Insurance benefitted population | Insurance benefitted percentage |
|---|---|---|---|---|
| Baglung | 268613 | 21432 | 65537 | 24 |
| Kaski | 492098 | 49870 | 161796 | 33 |
| Myagdi | 113641 | 8119 | 22239 | 20 |
| Tanahun | 323288 | 27451 | 82170 | 25 |
| Gorkha | 271061 | 22280 | 59036 | 22 |
| Syangja | 289148 | 25742 | 66060 | 23 |
| Parbat | 157826 | 4244 | 9887 | 6 |
| **Total** | **1915675** | **159138** | **466725** | **24** |

Total of 61701 senior citizens and 9295 targeted families have been enrolled under HI program on free basis.

**Table 7.4: Targeted Groups under HI program in Gandaki Province**

| District | Senior Ctzn | Ultra-poor family | Null Disability family | HIV affected family | MDR TB family | Leprosy affected family |
|---|---|---|---|---|---|---|
| Baglung | 8647 | 2687 | 205 | 73 | - | - |
| Gorkha | 9002 | 1731 | 305 | 78 | 1 | 4 |
| Kaski | 16764 | Not surveyed | 550 | 375 | - | 6 |
| Myagdi | 3804 | Not surveyed | 67 | 18 | 1 | - |
| Parbat | 1031 | Not surveyed | 39 | 2 | - | - |
| Syangja | 12135 | Not surveyed | 315 | 107 | - | 3 |
| Tanahun | 10318 | 2474 | 225 | 26 | 1 | 2 |
| Total | 61701 | 6892 | 1706 | 679 | 3 | 15 |

**Table 7.5: HI service utilization data**

| Districts | Male | Female | Others | Total |
|---|---|---|---|---|
| Baglung | 12951 | 10253 | 8 | 23212 |
| Gorkha | 11269 | 8895 | 6 | 20170 |
| Kaski | 43168 | 34179 | 1 | 77348 |
| Myagdi | 5909 | 4494 | 0 | 10403 |
| Parbat | 395 | 337 | 0 | 732 |
| Syangja | 11247 | 8854 | 3 | 20104 |
| Tanahun | 18289 | 14328 | 0 | 32617 |
| **Total** | **103228** | **81340** | **18** | **184586** |

**Table 7.6: Premium collection details (Till month of Mangsir 2077)**

| District | Total Collected premium amount (in NRs) |
|---|---|
| Baglung | 51568335 |
| Kaski | 184669610 |
| Myagdi | 23380715 |
| Tanahun | 69488655 |
| Gorkha | 44702385 |
| Syangja | 49093945 |
| Parbat | 5100500 |
| **Total** | **428004145** |

**Table 7.7: Details of Enrollment Assistants currently providing services in ward level in HI district**

| District | Enrollment assistant details |
|---|---|
| Baglung | 87 |
| Kaski | 118 |
| Myagdi | 45 |
| Tanahun | 94 |
| Gorkha | 102 |
| Syangja | 97 |
| Parbat | 61 |
| Lamjung | 74 |
| Nawalpur | 90 |
| **Total** | **768** |

### 7.2.4 Activities in the Province

- A Provincial level HI co-ordination committee has been formed.

**Activities undertaken to increase enrollment**:

- Encouraging EAs to perform the enrollment more actively
- Coordination with local levels to release budget for marginalized groups and FCHVs
- Coordination with local levels to allow help desks in ward offices for enrollment assistants
- Coordination with elderly homes, child care centers, district jail office, social organizations
- Help desks for EAs on hospitals on various period to time.
- Flex print of HI information and EA contact list on hospital

**Activities undertaken to improve service quality**

- Communication with focal persons of all service providers.
- Regular visits and follow ups of service sites
- Immediate complainants hearing of insures
- Making local levels more accountable for the service availability and quality provided by PHCs

### 7.2.5 Challenges faced

- Uncompromisable insurer’s satisfactory level
- Service provider's incapability or not having enough of them
- Topography
- Logistics
- Covid-19 issues

### 7.2.6 Upcoming plans

- Target for FY 2077/ 78: 50-60% coverage of population

**Strategies to meet the enrolment target**

- Empower EAs with good logistics
- Awareness about HI program in the community through different means, i.e. schools, media sources, elderly homes, child welfare centers
- Co-operation with local levels and various social organizations to promote HI program and encourage funding's for the coverage of marginalized groups within the local level or perspective area
- Formation of local level HI program coordination committee
- Coordination for Families of overseas worker to be enrolled in HI program
- Orientation to all stake holders within district (i.e., local level, service providers)

# Section 8

# SUPPORTING PARTNERS

### 8.1 Background

External Development Partners (EDPs), National and International Non-governmental Organizations (I/NGOs) play an important role in bridging the gap and helping the government in health system strengthening and providing quality health services. The role of EDPs including I/NGOs in delivering health services has been well recognized and accepted in different plans and policies of Nepal including NHSP-II. They have been playing an important role in Gandaki Province in health system strengthening and providing quality health services. They have been contributing in their respective areas in the prevention, promotion and curative aspects of health care mechanism in district and down to the community level.

Partnerships seek to more closely align with Nepal Government efforts increasing collaboration and communication between the EDPs and the government contributing in their respective areas in the prevention, promotion and curative aspects of health care mechanism in district and down to the community level. They have been taking a significant responsibility in this Province for health system strengthening and providing quality health services.

**Objectives**

The overall objectives of developing partnership and coordination with EDPs and I/NGOs are to supplement and complement the health care system in a view to uplift the status of the health of the common people throughout the province. The EDPs and I/NGOs are especially concentrated to the areas of health in which they are mainly concerned. Collectively, working in these areas will serve to support the achievement of national targets and ensure health care system in a view to uplift the status of health of the community people throughout this Gandaki Province with greater sustainability over time.

**Major Partners (EDPs and I/NGOs*)***

Partner organizations working in health sector within the Gandaki Province are here categorized into two groups; viz. multilateral, bilateral and INGOs/NGOs working in two or more districts and Working within a district. The following table provides brief information of the partners who have been supporting in health services in Gandaki Provincefrom various aspects.

**Major INGO/NGOs working in Gandaki Province are**:

WHO, Save the Children, INF, IPAS, NSI, FPAN, CSG, LDCH, MSI, Nepal Red Cross Society, GNI, JANTRA, PSI, SUAAHARA, WaterAid Nepal, AHF, and so on.

The draft of NGO/INGOs working in Gandaki Province based on this year data (FY 076/77) are as follows:

| EDPS | Working Districts | Working Areas |
|---|---|---|
| WHO-IPD | PHD and all 11 districts | IPD surveillance |
| WHO-WHE | PHD and all 11 districts | Health Emergency Preparedness and Response |
| WHO-MoSD | MoSD, Gandaki | Technical Support for development of Health Policy, Planning, Program and monitoring |
| Save the children | All 11 districts | Support on TB, HIV and Malaria |
| International Nepal Fellowship (INF), Nepal | 7 Districts (Kaski, Gorkha, Lamjung, Tanahun, Myagdi, Parbat) | Disability, Leprosy, Ear, Spinal Cord Injury, Palliative care, Cerebral palsy, Disaster Management, CBR |
| IPAS Nepal | 5 Districts (Nawalparasi East, Myagdi, Parbat, Gorkha, Syangja) | Safe Abortion/ Family Planning |
| Nick Simons Institute (NSI) | 9 Districts (Myagdi, Tanahun, Parbat, Mustang, Syangja, Kaski, Gorkha, Lamjung, Manang) | Hospital Support, Taining |
| Family Planning Association Nepal (FPAN) | 4 Districts (Nawalparasi East, Kaski, Tanahun and Baglung) | Family Planning, Safe abortion, Safe delivery, STI, ASHR and SM |
| Community Support Group (CSG) | 4 Districts (Parbat, Kaski, Tanahun and Syangja) | HIV/AIDS (prevention (IDUs) and careand support program (PLHIV) |
| Naulo Ghumti Nepal | 2 Districts (Kaski and Tanahun) | HIV/AIDS, Durgs (rehabilitation center and hrm reduction), FP |
| Sunaulo Parivar Nepal (SPN)/ Marie stopes International | 9 Districts (Except Mustang and Manang) | Safe abotion and family planning |
| Population Services International (PSI) | 3 Districts (Kaski, Nawalparasi East and Tanahun | Family Planning and medical abortion |
| Nepal Red Cross Society | 9 Districts | Blood Bank |
| Good Neighbors International (GNI) | 4 Districts (Kaski, Gorkha, Parbat and Myagdi) | Health System Strengthening |
| Nepal CRS company | 9 Districts (Except Mustang and Manang) | FP contractives marketing |
| Gateway Foundation Nepal | 3 Districts (Kaski, Lamjung and Tanahun) | Treatment and rehabilitation to DUs and IDUs |
| Japan Nepal Health and Tuberculosis Association (JANTRA) | 4 Districts (Kaski, Syangja Nawalparasi East and Tanahun | Tuberculosis |
| Kopila Nepal | 9 Districts (Except Mustang and Manang) | Mental Health |
| AHF | 2 Districts (Kaski, Baglung) | HIV AIDS |
| SUAAHARA | 6 Districts (Syangja, Gorkha, Baglung, Lamjung, Myagdi, Nawalparasi) | Nutrition |
| WaterAid Nepal | PHD and all 11 Districts | Hygiene Promotion through Routine Immuniztion |

***NGO/INGOs working within single District***

| SN | Districts | Name of Project/I/NGOs | Working Areas |
|---|---|---|---|
| 1 | Baglung | Medic Mobile | MCH |
| | | Dhaulagiri Positive Group (DPG) | HIV Care and Support |
| | | Fairmed Foundation | Maternal and Neonatal Health |
| 2 | Gorkha | CAN Nepal | Public health |
| | | Arambha Nepal Gorkha | HIV Care and Support |
| | | PHD Group | Safe Abortion |
| | | Shree GHAP community | HALO, PHCORC support, WASH |
| | | KOSHISH | Mental Health |
| 3 | Kaski | NetrajyotiSangh | Eye Service |
| | | Kidasha | Access to Health Services |
| 4 | Lamjung | HDCS | Quality healthcare, education and community development |
| | | Dhading Plus (DP) | HIV Care and Support |
| | | Koshis Nepal | Mental Health |
| | | Nepal Red-cross Society | Disability |
| 5 | Manang | Community Eye Care Center (Affiliated with Tilganga Eye Hospital)<br>Himalayan Family Health Care ACAP | Minor Eye treatment, Eye surgery camp Primary health care<br>Camps, Free Health |
| 6 | Myagdi | Nirnaya | Prevention of HIV & HCV |
| | | Himalayan Group | Oral Health |
| 7 | Nawalpur | Lumbini Plus | HIV Care and Support |
| | | Action Against Hunger (ACF) | Nutrition, Health System |
| 8 | Parbat | Atmanirvar Bikas Manch | RH awareness |
| | | NESDO Nepal | RH awareness |
| | | SEED Nepal | RH awareness |
| 9 | Tanahun | Asian Forum | Health Checkup and Awareness |
| | | KIDS | FP Long-Acting contraception |
| | | Koshis Nepal | Mental Health |
| | | World Neighbor | Reproductive Health |
| 10 | Syangja | The Asia Foundation | Health Governance |
| | | SankalpaSahayogSamuha | HIV Care and Support |
| | | Blue Diamond Society | STI/HIV prevention among MSM |

**Source: PHD/Health Office**

## 7.2 Major EDPs, NGOs and INGOs and Their Areas of Support in Gandaki Province

### 1. World Health Organization (WHO), Program for Immunization Preventable Diseases, Nepal

**Background**

In 1998 through the collaboration between the MoHP and WHO, Polio Eradication Nepal (PEN) was established for Acute Flaccid Paralysis (AFP) surveillance as part of Global Polio Eradication Initiatives. In 2003, Measles and Neonatal Tetanus (NNT) was integrated into AFP surveillance system. Similarly, surveillance of Acute Encephalitis Syndrome (AES) for Japanese encephalitis (JE) was integrated in 2004 for VPDs surveillance.

In 2005, PEN changed its name to the Program for Immunization Preventable Diseases (IPD) to reflect its expanded activities of VPDs surveillance. These activities are performed in close collaboration with the Family Welfare Division (FWD), Epidemiology and Diseases Control Division (EDCD), and National Public Health Laboratory (NPHL) under the Department of Health Services of Ministry of Health and Population.

**Area of Specialization in Health Sector**

- Provide technical assistance to the Government of Nepal's endeavor to strengthen the surveillance of Acute Flaccid Paralysis (AFP for polio) and VPDs (Measles, Neonatal tetanus and Acute Encephalitis Syndrome for JE).
- Provide technical support to GoN to achieve the goal of reducing morbidity, mortality and disability due to vaccine preventable diseases by strengthening National Immunization Program.
- Provide technical assistance in National Immunization Campaigns (NID, SNID, Moping-up, JE &MSL/Rubella Campaign)

**Target groups**

AFP surveillance: Under 15 age Group
Measles and AES Surveillance: All age Group
Neonatal Tetanus: Neonatal age Group

**IPD's Core Activities**

- Surveillance of Vaccine Preventable Diseases (AFP, Measles, AES &Neonatal Tetanus)
- Support for routine and supplementary immunization activities
- Technical assistance for VPD surveillance and Measles/Rubella Outbreaks investigation
- Support in policy formulation and strategy development for the National Immunization Program (NIP) Publication and dissemination of VPD surveillance information and guidelines Social mobilization for VPDs Surveillance
- Technical support to DoHS/CHD for surveillance and laboratory diagnosis of VPDs Networking for VPD surveillance and specimen's shipment

**Geographical Coverage**

WHO Nepal-IPD currently has covered all 77 districts. In Gandaki Province, there are 2 Surveillance Medical Officers (SMOs) working through Field Office located in Pokhara.

## 2. WHO Health Emergency Program

### Provincial Health Emergency Operation Center (PHEOC)

**Core Activities**

- Provide technical assistance to the Govt. of Nepal in Health Emergencies
- Overall coordination, facilitation, direction and management during any health-related emergencies and disaster.
- To operate as a secretariat of Provincial Health Directorate during health emergencies and Disaster in the province

**Working Districts**

- Gandaki Province at present are covered by one Field Medical Officer (FMO) and one Information Management Assistant (IMA).
- Field Office is in Health Directorate – Provincial Health Emergency Operation Center.

**Major Contribution**

- Provide technical support in outbreak verification and response.
- Data repository of all health facilities (government and private) and health partners.
- Strengthen EWARS, AMR and Influenza sentinel sites.
- Hospital Disaster Preparedness and Response Plan Created.
- HUB and Satellite Network Strengthening.

### WHO/MOSD

The MOHP/WHO has appointed a Provincial Health Officer at the MOSD, Pokhara, Gandaki province from the August 2019 for the technical support, specially to assistance for the development of the health policy, planning, implementation and monitoring of the health programs.

**Major Contribution**

| Key Area | Major Activity |
|---|---|
| Coordination | • Support to develop partners mapping of Gandaki Province<br>• Participate and provide technical support for the prevention of Dengue Outbreak |
| HMIS/ M&E | • Assist in developing a brief Health Profile of the Gandaki Province<br>• Technical support for preparation of provincial Annual Health Review meeting of the province and Report Writing |
| Governance | • Technical assistance to develop the Provincial Health Policy |
| Others | • Develop the draft of the Guideline for the contract of the Health Worker, Gandaki province.<br>• Internal meeting to prepare guidelines for the committee required to develop provincial Public Health Act |

### 3. Save the Children

**Background:**

Save the Children is the leading independent organization for children. Save the Children save children's lives; fight for their rights; help them fulfill their potential. Save the Children work together, with our partners from civil societies and government, to inspire breakthroughs in the way the world treats children and to achieve immediate and lasting change in their lives.

**Save the Children's overall goals in Nepal are:**

- To bring quality and cost-effective solutions and results for the rights of children at scale.
- To advocate for policy change and child centered institutional reforms at the national level and its effective implementation at the local level.

**Save the Children is supporting on TB, HIV and Malaria program through Global Fund funding as being the sole PR of Global Fund.**

It covers three disease control programs

**HIV/AIDS prevention and care and support program:**

Technical support in all 11 districts of the Province, where as in 9 districts there is direct support through SRs and SDPs on harm reduction, care and support, treatment CABA cash transfer, PMTCT training, monitoring, logistics management, Support on ART service etc.

**Malaria control program:**

Distance technical support is provided in all 11 districts through Province and Health Offices, whereas intensive support is provided in two districts (Nawalparasi & Kaski) through intervention activities (Case based surveillance, LLIN distribution through local SR, orientation program at community level.) Malaria Disease Information System (MDIS) etc.

**Tuberculosis Program:**

Technical and financial support is provided in all 11 districts of the province through government service delivery points and D/PHOs.

### 4. International Nepal Fellowship (INF), Nepal

International Nepal Fellowship (INF), Nepal is a Christian non-government organization that has been serving in Nepal for past 6.5 decades. This organization serves in health and development sectors for the holistic development of poor, marginalized, deprived, disadvantaged, displaced, disabled, poverty stricken and unreached communities. Recently, the services of the organization have been restructured into two sectors, clinical and community services.

INF Nepal is a value-based organization that is working to fulfil the following vision, mission and strategy. The vision, mission, strategy and goal statements have recently been revised by the decision of INF Nepal board.

**Vision:**

"Life in all its fullness for Nepal's poor and disadvantaged people"

**Mission:**

INF is a Christian organization existing to serve people of Nepal particularly the poor and disadvantaged people and communities in their holistic development by demonstrating God's love and concern"

**Strategy:**

INF Nepal works to bring sustainable improvement in the health and development of individuals and communities, primarily through direct implementation along with partnerships with government and community organizations, including churches.

**Goal:**

The goal of the organization is "sustainable improvement in the health and quality of life of the people of Nepal, particularly the disadvantaged, by contributing to the fulfillment of the Sustainable Development Goals (SDGs) and the Poverty Reduction Strategy Paper (PRSP)"

**Green Pastures Hospital**

INF's Green Pastures Hospital established in 1957 currently with 100 beds serves poor and marginalized people of Western Nepal by providing medical and community-based rehabilitation services. It is a tertiary referral Centre for leprosy, rehabilitation of spinal cord injury and other patients with disability.

**Objective:**

Sustainable improvement in the health and quality of life of the people of Nepal, particularly the disadvantaged, by contributing to the fulfillment of the Sustainable Development Goals and the Poverty Reduction Strategy Paper.

**Areas of specialization in health sector:**

- Leprosy and Dermatology
- Orthopedics and Spine Disorders and Injuries
- Ear and hearing disability
- Cerebral Palsy focused for pediatrics
- Palliative Care
- Physio Therapy
- Occupational Therapy
- Speech and Language Therapy
- Prosthetics and Orthotics
- Provision of appropriate Wheel Chairs, provision of hearing aids, audiology tests
- and mobility devices
- Pastoral and psycho social counselling

**Target groups:**

People living with leprosy, SCI, Ear diseases and disabilities.

**Geographical coverage:**

Kaski, Gorkha, Lamjung, Tanahun, Baglung, Myagdi, Parbat

**5. Nick Simons Institute (NSI)**

**Background:**

Nick Simons Institute is a Nepal-based organization established in 2006. Its mission is to innovate solutions in rural healthcare –through training and hospital support– and to advocate for their scale up with the government of Nepal.

**NSI works according to the following principles:**

- Collaborate closely with the Nepal government – the main rural healthcare provider.
- Select strategic training cadres – which involves 'task-shifting' from traditional medical roles.

- Extend beyond training – to include workplace support and advocacy.
- Innovate – based on a growing body of research in the Nepalese context.

**Programs:**

- Hospital Support Program which includes Rural Staff Support program, Rural Staff Support Partnership Program and Hospital Management Strengthening Program)
- Training: In service clinical trainings to rural health care workers such as ASBA, SBA, MLP, OTTM, AAC, DBEE etc.
- Advocacy and Research
- Rural Communities who directly receive the health care services from government hospitals
- Rural Health Care Workers
- Rural Staff Support Program- Myagdi
- Rural Staff Support Partnership Program- Syangja, Damauli, Bandipur and MatrishishuMiteri Hospital
- Hospital Management Strengthening Program: Bandipur Hospital, Chapakot Hospital, Damauli Hospital, Gorkha Hospital, Manang Hospital, Matrishishu Hospital, Mustang Hospital, Parbat Hospital, Sisuwa Hospital Kaski, Sundar Bajar, Lamjung Hospital and Syangja Hospital.

**6. USAID/Suaahara-II Program**

**Background:**

The USAID Suaahara II "Good Nutrition" program aims to improve the nutritional status of women and children in 42 districts of Nepal. This will be achieved through partnerships with the Government of Nepal (GoN), private sector entities, and other USAID-funded initiatives. USAID's Suaahara II program is a five-year integrated nutrition program, designed in consultation with the GoN and other stakeholders to contribute towards achieving the goals set by Nepal's Multi-Sector Nutrition Plan. Suaahara II is dedicated to improving the health and nutrition of mothers and their children in the 1000 days' period from conception until a child reaches 24 months of age. This period is recognized as a crucial timeframe during which nutritional interventions have optimal impact on child growth and development. Suaahara II will also engage husbands, mothers-in-law, and adolescents to expand health and nutrition knowledge and services to the remaining gaps. In particular, the program will address anemia, reproductive health, menstrual hygiene, food diversity, health service utilization and social attitudes towards delayed marriage and pregnancy. Suaahara II builds upon the work done in Suaahara I with 1000-day mothers, using an integrated cross-sectoral approach. Suaahara II will cover all households in 42 of the 77 districts of Nepal. The program is led by Helen Keller International (HKI) and managed with CARE Nepal, FHI 360, Equal Access, Environment and Public Health Organization, Nepali Technical Assistance Group, Vijaya Development Resource Centre. In Gandaki Province, Suaahara-II program has been implementing by local partner NGOs since June 2016 to onwards in six program districts as below:

| SN | Program Districts | Implementing Local Partner NGOs |
|---|---|---|
| 1. | Syangja | DIYALO Syangja |
| 2. | Gorkha | System Development Service Center (SDSC), Gorkha |
| 3. | Lamjung | Rural Community Development Center (RCDC) Nepal |
| 4. | Baglung | Gaja Yuba Club (GYC), Baglung |
| 5. | Myagdi | MILAN Myagdi |
| 6. | Nawalpur | Backward Eradication Society (BES), Nepal |

**7. Population Service International (PSI) Nepal**

**Background:**

PSI is a global non-profit organization focused on the encouragement of healthy behavior and affordability of health products. PSI works in over 50 countries in the areas of family planning, Malaria, HIV, diarrhea, pneumonia and sanitation. PSI works with both private and public sector to enable vulnerable populations to lead healthier lives by increasing access to affordable products and services. PSI/Nepal began operations in early 2002 and has been partnering with government of Nepal, the private sector and local and international organizations in the area of nationally defined health priorities to create health solutions that are built to last. Its current portfolio includes family planning, safe abortion, adolescent sexual and reproductive health, and hygiene and sanitation programs in support to Government of Nepal's efforts.

PSI/Nepal has been implementing the Women's Health Project (WHP) since 2009 with an objective to increase access to and use of long-term family planning (FP) methods, especially IUCDs and safe abortion services through public and private sector. Currently, PSI/Nepal is implementing WHP-Phase

4 through six local implementing partners in 30 districts engaging with more than 200 private sector health facilities. The network facilities are providing family planning and safe abortion services focusing on informed choice and service quality. PSI/Nepal has been generating demand for FP services through multi-media channels including interpersonal communication (IPC). PSI/Nepal has a network of community mobilizers *(Didis)* who conduct household level IPC sessions on FP and refers prospective FP clients to the franchise network. Apart from the clinical training for service providers and IPC training to mobilizers, PSI/Nepal also has a robust Coaching and Mentoring system in place to support service delivery in private and public sector.

**Coverage (Districts and Palikas):**

| District | Municipalities |
|---|---|
| Kaski | Pokhara Metropolitan Municipality |
| Tanahu | Aabukhaireni, Bhanu, Byas, Shuklagandaki |
| Nawalparasi East | Devchuli, Gaidakot, Kawasoti, Madhyabindu, BinayTriveni Rural Municipality |

In the private sector, PSI/Nepal had contracted with around 23 Private Health Facilities in three district District (Kaski, Tanahu & Nawalaparasi East) of GandakiProvince, offering a wide range of family planning and safe abortion services implementing through Local Partner Kapilbastu Integrated Development Services (KIDS). These private network Health facilities are branded as OK Pariwar Swastha Sewa.

**8. IPASNepal**

**Background:**

Ipas is a non-profit organization that works globally to improve the sexual and reproductive health of women and girls by enhancing their access to and use of safe abortion and contraceptive care. We seek to eliminate unsafe abortion and the resulting deaths and injuries. We strive to foster a legal, policy and social environment supportive of women's right to make their own sexual and reproductive health decisions freely and safely.

Ipas started to work in Nepal since 2002, when abortion was legalized. Ipas Nepal has been registered with the Social Welfare Council in 2008 and continuously providing support in the country. Ipas Nepal is providing support to expand access to quality safe abortion service (SAS), to develop skilled human resources like ANMs, obs/gyn by providing specialized training on SAS, to support in developing policies, protocols and guidelines around SAS, to improve and strengthen health facilities for quality services: hospitals, primary health care centers, health posts, to establish SAS training centers and to generate manage and disseminate data on SAS. Ipas Nepal closely works with MoHP, Department of Health service (DoHS) and different divisions and centers such as Family Health Division (FHD), National Health Training Centre (NHTC), Management Division (MD), Logistic Management Division (LMD), National Health Education, Information and Communication Centre (NHEICC) and concerned Health Offices. Ipas is also coordinating and engaging with provincial and local level government to strengthen and improve quality SAS in the province and local level.

**Mission:**
Women and girls have improved sexual and reproductive health and rights through enhanced access to and use of safe abortion and contraceptive care.

**Geographical coverage in Gandaki Province:** Gorkha, Nawalparasi East, Syangja, Parbat, Myagdi. **Intervention districts (FP program in excluded and vulnerable community)**
Nawalparasi (Also feasibility and acceptability study of family planning device Sayana Press)

**Major Support Areas:**

- Comprehensive Abortion Care
- Post Abortion Care
- Post abortion family planning
- Support in policy guideline, protocols and advocacy for Safe Abortion
- Training (MA and 2nd trim abortion)
- Post training programmatic support and clinical mentoring
- Quality Improvement
- Stigma Reduction and SBCC
- Research/studies/data collection/monitoring

**9. Naulo Ghumti Nepal**
**Background:**
In response to the emerging problem of drug use & HIV transmission, Naulo Ghumti Nepal emerged as a project under INF (International Nepal Fellowship) in 1995 and was registered in District Administration Office as an independent NGO in 2002 by handing over its management to the elected Executive Committee.
Naulo Ghumti Nepal is a non-profitable and non-governmental organisation [NGO] working in various districts across the country. It is registered in Kaski District Administration Office. It is affiliated with SWC and also approved by Drug Control Division under Ministry of Home Affairs. It has a very good linkage and coordination with Nepal government agencies and civil society organizations at national, regional and district level.

**Objectives:**

- Carry out the services like community awareness, counselling & blood testing, STI clinic, treatment and rehabilitation, care & support, capacity building and advocacy for policy level changes for the prevention and control of drug, HIV and AIDS.
- Enhance peace and democracy, norms & values by ensuring the basic human rights, inclusion, good governance and eliminating all forms of discrimination including gender.
- Contribute in developing skillful human resources needed for the development of country by providing the opportunity of education for all as well as giving a meaningful and practical education system.
- Increase access to water, sanitation, hygiene and other basic health services and develop capacity and relevant mechanism for disaster risk reduction, epidemic and any kind of health hazards.
- Promote livelihood opportunities, basically focused to poor and marginalized community.
- Use Gender & Social Inclusion Approach and capacitate local development actors and community as well.

**Areas of specialization in health sector:**

HIV Prevention, Care & Support, Community and Home-Based Care (CHBC) service, Family Planning (FP), Drugs Rehabilitation for male and female, Health, Livelihood, Sanitation, community development, Education, Local governance.
**Target groups:** Female Sex Workers (FSWs), Clients of FSWs (CFSWs), Men who have Sex with Men (MSM), Male Sex Worker (MSW), Transgender People (TG), People living with HIV (PLHIV), People Who Inject Drugs (Male and Female), Students, General Community People, Youths.
Linkages across the continuum of HIV services for key populations affected by HIV (HIV Care, support and treatment services among key populations and PLHIV in Kaski District)
**Life of the Project:** October 2016-September 30, 2020 (LINKAGES Nepal Project)
**Geographical coverage:** Kaski and Tanahun.

**Major Achievements of the Project (*October 2018 – September2019*)**

Name of Supporting Agencies/Donors: PEPFAR and USAID Issues,
Challenges and Lesson learned:

- Difficult to enroll on ART those diagnosed as HIV positive clients as they wish to deny their HIV status and have no willingness to visit ART sites for ART.
- Difficult to follow up of PLHIV clients from Clinic.
- Easy and supportive service received from ART site/AHF/Social Care Unit to start ART and financial support for laboratory testing to start ART.

Counseling, Treatment and Rehabilitation Program
Funding Partner: Good Neighbor International (GNI)

**10. AIDS Healthcare Foundation (AHF) Nepal**

Name of INGO: **AIDS Healthcare Foundation (AHF) Nepal**
Name of Project: **Increasing access to treatment, care and prevention services by PLHIV in NepalWorking Areas in Gandaki Province**

- Western Regional Hospital, Pokhara (2015, April)
- Dhaulagiri Zonal Hospital, Baglung (2017, Nov)

**Project Duration: Five Years (2017-2022)**

**Aim of the project:**
Assisting government of Nepal in meeting sustainable development goal (SDG) through scaling up and delivering quality HIV treatment and care services from ART clinics

**Objective of the project:**

- To improve and expand prevention, testing and linkage services targeting high risk populations in the communities
- To increase access to quality treatment and care services from project supported ART sites
- To strengthen coordination, networking and advocacy for quality ART services

Target groups: People Living with HIV (PLHIV)

**11. Human Development and Community Services (HDCS)**

**Background:**

Human Development and Community Services (HDCS) is non-profit, non political, ecumenical non-governmental organization working in three main sectors of Health, Education and Community Development. Established in 1991, HDCS started by providing management and capacity building trainings to schools, hospitals and community-based organizations. Its aim is to uplift the health and educational status of the disadvantaged communities in Nepal. Currently, it is active across various districts in Nepal, especially the rural districts by providing services through hospitals, health camps, public health programs, schools, teacher training programs, enabling children to access education, educational day care centers (for children with physical and mental disabilities) and on child and women rights through its own FM radio stations. HDCS has also been active in conducting some baseline, mid-term and end-line surveys and studies. Currently HDCS is operating following projects in Nepal:

**Project Name:**

- Lamjung District Community Hospital (LDCH)
- Chaurjahari Hospital Rukum (CHR)
- Gunjman Hospital Chitwan (GHC)
- Public Health Program (PHP) in maternal, newborn, nutrition and mental health
- Asha Bal BikashSewa (ABBS) – A day care center for children with special needs
- Kathmandu International Study Centre (KISC)
- A teacher training program (EQUIP)
- Community Radio Initiative Nepal (CoRIN)

**Vision, Mission and Values**

**Vision**: To be living witnesses of God's love.

**Mission**: Spiritual, social and economic transformation of the disadvantaged, marginalized andunderprivileged communities through health, education and community development

**Values:** Righteousness, Honesty and Service

**Goal:** To increase access to, and use of quality healthcare, education and community development tothe poor and underprivileged without discrimination and with dignity and respect in seven provinces of Nepal.

**12.KOPILA-Nepal**

**Background:**

KN is a non-profit making social organization established in 2001 by self-motivated social worker friends and registered with the District Administration Office, Kaski. Since the inception, KOPILA-Nepal has been working with the most marginalized women and children for their right to education, livelihood / income generation, mental health / psychosocial wellbeing and civil and political rights of women, girls and people with disability including Mental Health Problem. It is working in nine districts of Gandaki Province (Western Nepal).

**Vision**: We envision a society in which the rights of all people are realized, and their basic needs are met.

**Mission:** KOPILA-Nepal strives to ensure that the most marginalized people in our working areas enjoy their fundamental human rights and psychosocial well being. We emphasize on eliminating social disparities of all kinds. We work with local and national government; non-governmental organizations; and funding partners to realize our goals and to bring about structural changes needed to achieve social justice and equity for all.

**Goal:** To improve quality of life of women, children and people with psychosocial problem by buildingtheir own capacity and maximizing local resources.

**Networking and Coordination**

1. National Mental Health Network and Global Mental Health Network
2. NGO Federation- President of Gandaki Province
3. Women Human Rights Defender's Network
4. Resource group for Violence Against Women, Kaski
5. Community Based Rehabilitation Network Nepal
6. Working in close relation with concern government and non-government organization such as women and child development office, district /regional education office, district development committee, district child welfare board, district/regional health office, district/regional police office, bar association, legal advisory committee LAC and others.

**13. ACTION CONTRE LA FAIM (ACF)**

Created in 1979, Action Against Hunger | ACTION CONTRE LA FAIM (ACF) is an International Non-Governmental organization (INGO) fighting against hunger in the world. Its mission is to save lives eradicating hunger through the prevention, detection, and treatment of malnutrition, during and after emergency situations caused by conflicts and natural disasters. It is a major player in the fight against hunger in the world. Structured as an international network, the organization provides a coordinated response in nearly 50 countries. Its priority is to have effective actions in the fields and testify about vulnerable population. Since the reasons for hunger are many, its response is multi-sectoral based on solid expertise. The seven field of expertise are:

1) Nutrition and health
2) Food security and resources of existence
3) Mental health, care practices, gender and protection
4) Water, sanitation and hygiene
5) Advocacy
6) Research
7) Risk and disaster management

ACF's first project in Nepal started in 2005, during armed conflict (1996-2006), with an overall objective

to support the conflict-affected population in remote areas. Nutrition based interventions were gradually included following further assessments that had highlighted alarming undernutrition rates in Nepal as a whole. ACF is working in Province 4 since April 2017.

### Areas of specialization in health sector

1) Nutrition
2) Health System Strengthening (Diagnosis to Planning around all 6 building blocks of the health system)

### Working area in Gandaki province and objective

All Palikas of Nawalparasi East of Bardaghat Susta (Nawalpur) of Gandaki Province

The objective is to contribute towards the reduction of undernutrition related morbidity and mortality of children aged under 5 years with acute malnutrition.

### Target groups

Children under 5 years and their mothers/caretakers

**14. Community Action Nepal**

**Background:**

Community Action Nepal was established with the aim of helping the nation in its development by helping people to develop their society and encouraging them towards a better future in terms of better Health and better Education.

**Objective:** Remote and rural community of our project area will have support to improved healthfacilities by supporting the Government Health Program in the remote areas

**Target Population**-: Total Population of Tsumnubri Rural Municipality.

**15. FAIRMED Foundation Nepal**

**Background:**

FAIRMED foundation, is a Swiss Organization, with its HQ in Bern, Switzerland. FAIRMED is dedicated TO ensure health for the poorest. FAIRMED works with the marginalized community, individuals affected by Neglected Tropical Diseases (NTD), mother and child in Africa and Asia to ensure their access to essential health care services.

FAIRMED has been working in Nepal as an INGO with the affiliation to Social Welfare Council since the year 2012. However, the organization is regulated through its Country Office since 2015. At present, FAIRMED Foundation Nepal is active in 5 districts. FAIRMED implemented maternal and neonatal health project in Kapilvastu until 2018. After the change in the global strategy of the organization FAIRMED is continuing its program with maternal health but with Neglected Tropical Diseases as an entry point in Kapilvastu, Rupandehi, Nawalparasi West, and Sindhupalchowk. Whereas, in Baglung FAIRMED Nepal has a primary focus on maternal and neonatal health. However, is also carrying out the interventions in the sector of Neglected Tropical Diseases.

**Vision:** Nobody should have to suffer or die from a curable disease. We want all people to have equal access to prevention and affordable health care of appropriate quality, and to be able to live in a healthy environment that is characterized by fairness.

**Target Group:** Those who are the farest behind affected directly or indirectly by a NTD – can take different forms from a country to another but include indigenous people, refugees, physically or social excluded.

FAIRMED has been working for long periods in regions and districts. It will continue supporting those communities but will reflect on exit strategies where relevant.
Decisions on future targeted beneficiaries will rely on socio-economic and epidemiologic data, to identify the the people under poverty and their specific needs.

**Program in Gandaki Province**
**Rural Health Improvement Project (RHIP)**
FAIRMED implement the first phase of Rural Health Improvement Project (RHIP) in three remote municipalities (Dhorpatan Municipality, Nishikhola Rural Municipality, Tamankhola Rural Municipality) of Baglung from July 2018 to June 2019 with a goal to Improve health condition of the targeted communities. With the results observed from the first phase of the project, the donor has funded for the second phase of the project. The second phase of the project will be in the six municipalities: *Dhorpatan Municipality, Nishikhola Rural Municipality, Tamankhola Rural municipality, Galkot Rural Municipality, Badigadh Rural Municipality, and partial interventions in Bareng Rural Municipality*ofthe district. The new phase of RHIP will follow up on the previous activities/achievement with some new activities as per the experience of implementing the first phase, recent needs and priorities of Municipalities, and learning from other districts. The major objectives of the project are:

- Basic health infrastructure and capacity of human resources are strengthened to deliver quality services in 52 HFs in targeted municipalities
- Nine targeted municipalities and 52 HFs are enabled for better planning and execution of health programs which addresses the health care needs of the population
- Improved access to basic health care services has contributed to increase 80% of service utilization among the targeted communities particularly the pregnant, lactating mothers, people affected by NTDs, and persons with disabilities through awareness raising and community mobilization.

**16.WaterAid Nepal**
**Background:**
Water Aid has been supporting the Government of Nepal's development endeavors, particularly in implementing programmes on water, sanitation and hygiene since the 1980s. As part of its continued support, it collaborated with the Ministry of Health and Population, Department of Health Services, Family Welfare Division to integrate hygiene in routine immunization at national scale. The nationwide integration decision was taken from the learning and success of a pilot intervention in Bardiya, Nawalparasi, Myagdi and Jajarkot districts between 2014- 2017.
In line with the global recommendation "*Vaccine introduction for enteric vaccines (Rota virus, typhoid, cholera) should be one component of an integral child health programme to* ***decrease morbidity and mortality from diarrhoeal disease, including safe water, hygiene, sanitation, nutrition and IMCI",*** Nepal Committee for Immunisation Practice, 2012 concluded that **this approach should be implemented in Nepal while introducing any enteric vaccine.**
The government of Nepal in partnership with WaterAid then decided to integrate hygiene at a nationwide scale through the routine immunization together at the time of Rotavirus vaccine introduction from July 2020.

**Areas of working**

- Hygiene promotion through routine immunization

**Target Groups:** Mother or guardians of children under age 15 months

**Progress so far from FY 2076/77**

- Provincial Training of Trainers (PToT) on hygiene promotion completed with 61 participants from Province Health Directorate, District chief, immunization focal person and partners working in the WASH and immunization sector in Gandaki.
- Supported to integrate hygiene in Rota vaccine training and trained 3189 HWs in district level and below training at 11 districts of Gandaki Province.
- 1950 set of hygiene promotion package along with 2600 program guideline and badges were distributed to conduct the hygiene promotion session from more than 1763 immunization clinics
- Total 11584 take home materials (mirror & dangler) were supported to health office to distribute the mothers participating hygiene promotion session
- Integrate the COVID preventive measures in hygiene promotion package and trained HWs during hygiene promotion training.
- 1282 COVID message flip chart and 57900 COVID preventive measures sticker were supplied to 85 local level of Gandaki province through Health Office
- 6600 pieces of surgical mask has been supported through Management Division for the HWs to conduct the immunization and hygiene promotion session during the COVID-19 pandemic.
- Mid-level consultants have been deputed at PHD since mid of June to support hygiene integration and expediate COVID preventive measures at district and below level

**17.Kidasha**
**Background:**

Kidasha is a UK-registered social development organisation which has been working in partnership with Social Welfare Council of Government of Nepal since 1997. Kidasha's country office is based in Pokhara, Nepal. Kidasha works to reduce the causes and impact of entrenched poverty and social exclusion, stopping exploitation and violence against children in Nepal.

A significant part of our work is focused on improving the physical and emotional wellbeing of children and adolescents living in urban poverty and increasing their access to health services – initially through the establishment of Asha Clinic in 2000. Kidasha has already worked in partnership with two Urban Health Centres (UHC) to increase the accessibility of services for adolescents.

**Areas of Specialization in Health Sector:**

- Quality Improvement in the UHCs
- Capacity development
- Behavior change communication

**Target Groups: Children and adolescents**

Geographical Coverage: Pokhara Metropolitan City, Kaski in Gandaki Province and Butwal Sub-Metropolitan City, Rupandehi in Province 5.

Name of Supporting Agencies/Donors: DFID, MANAN Hong Kong and Kidasha UK.

**18. Marie Stopes International**
**Background**:

Marie Stopes International is a global organization with 11,000 team members working in 37 countries to deliver our mission. Starting from one single clinic in London, our organization has grown from one clinic in central London to become one of the world's largest providers of high quality, affordable contraception and safe abortion services. Over the last 40 years, we have touched the lives of more than 120 million women and girls, giving them the power to take control of their futures. But we know that there is much more to do, today there are 214 million women who want to use contraception but can't and that number continues to grow.

Sunaulo Parivar Nepal (SPN), a local implementing partner of Marie Stopes International in Nepal, is a well-established NGO which is delivering Family Planning and Sexual Reproductive Health services through-out Nepal via different service delivery channels: centers, outreach, and Marie Stopes (MS) Ladies

- FP Services
- SA Services
- Training for FP and SA services
- Services through static centers, Outreach and MS Ladies
- Contact center

**19.Nepal CRS Company**

**Background:**

CRS was initiated as a USAID-funded social marketing activity in Nepal on 1978. Introduced as a pilot project in coordination with the Ministry of Health and Population (MOHP), its prime mission was and is to strengthen the Nepal government's national family planning and primary health care programs. The project aimed to do so by enhancing the knowledge and awareness on family planning methods and creating demand by dispensing contraceptive products via retail and medical shop. However, in 1983 following a government resolution prohibiting NGOs from selling donated products through commercial distribution, CRS registered as a "non-profit private limited company" under the Nepal Company Act of 1965. This unique status permitted CRS tax-free status as well as the ability to sell USAID and other donor-donated products.

The Corporate Advisory Board of CRS (Advisory Board) includes six members, including the Managing Director. The other five members must represent four different entities: NGOs, the government, professional associations, and the private sector. CRS is owned by 13 shareholders with the MOHP controlling 25 percent of the share. Individuals occupying certain position in the Department of Health Services are automatically granted seats in the Advisory Board.

Nepal has moved into provincial system and supply of health commodities have become a challenge as commodity procurements are now handled by state government. Likewise, quality is another challenging area where there is a KAP gap in proper counseling as well as infection prevention. With these challenges in hand CRS will complement and supplement GoN to fulfill these gaps in mainly four areas:

1. Family Planning (FP)
2. Maternal and Child Health (MCH)
3. Sexual and Reproductive Health Rights (SRHR)
4. Health and Hygiene

**Current Project and Programs**

**Ghar Ghar Maa Swasthya (GGMS) Project**

CRS is currently working under the GGMS project supported by USAID. USAID's GGMS project seeks to improve the health of disadvantaged populations in Nepal by improving accessibility and availability of health goods and services, especially in hard-to-reach rural areas, through the use of social marketing and social franchising techniques. The project activities center on social marketing of CRS condoms, oral contraceptives, ORS and injectable. In addition, GGMS supports CRS efforts to become a more efficient and sustainable organization. The project period will end in April 2020.

The GGMS Program aligns with the following GoN policies, guidelines and standards:

- GGMS will align with the new National Health Sector Strategy (NHSS, 2015-2020) which envisions "equitable service utilization, strengthening service delivery and demand generation to underserved populations, including the urban poor" as a core principle.
- GGMS will support the new National HIV and AIDS Strategy 2016- 2020, by providing products and services for the most-at-risk segments of the population (sex workers and their clients in hot zones, Men who have Sex with Men (MSM), migrant workers and families in hill areas, etc.)
- GGMS supports the National Health Communication Strategy for Family Planning, Maternal and Child Health by implementing and partnering with others to implement behavior change communication (BCC). GGMS follows this strategy by using the recommended three mutually reinforcing approaches of advocacy, social mobilization, and BCC deliverables.

**Sales & distribution of FP, MCH and Health Products for the FY 2075/76**

CYP Calculation matrix by Crs – In condom total unit / 120 unit = 1 CYP, in pills total unit / 15 cycle = 1 CYP, in Sangini total vial / 4 vial = 1 CYP and in ECP total cycle / 20 cycle = 1 CYP

**Remote Area Initiative Program**

In the year of 2018, upon graduation of RAI phase I and assessment of its effective impact in other districts, CRS expanded RAI program in Tanahu district at Gandaki Province.

**Activities of RAI in Province 4 in Tanahu District for the FY 2075/76 as below**

CRS in order to share and make aware of RAI program conducted meeting with District Project Advisory Committee (DPAC) to inform on RAI Program, its components, working areas along with monitoring and evaluation plans. Besides the sharing of RAI program this meeting also seeks to obtain the concurrence and support for implementing the program from local governments. As such CRS have already received the concurrence letter from all programs implementing Palikas.

**Working Areas**: Health Goverance-Policy Support

**Covarage**: Syangja-Waling Municipality

**Major Activities carried out in this fiscal year**:

Policy Support in formulating the Municipal Health Act, Municipal Health Rules, and Pharmacy Guidelines, health procurement

**20. World Neighbors**

**Background:**

World Neighbors (WN) is a nonprofit, international development organization striving to eliminate hunger, poverty, and disease in the most deprived rural villages in Asia, Africa, and Latin America. WN invests in people and their communities by training and inspiring them to create their own life changing solutions through programs in sustainable agriculture, rural livelihood, natural resources management, water, sanitation and hygiene, community and reproductive health, and environmental protection.

**Mission**: World Neighbors inspires people and strengthening communities to find lasting solutionto hunger, poverty, and disease and to promote a healthy environment. Working district in province 4: Tanahu

Municipality /Rural Municipality: Devghat Rural Municipality, Ward Number 1,5

# Annexes

## ANNEX-I

### Estimated Target Population of Gandaki Province in 2076/77

| Districts | Total Population | Exp. Live Births | 00 - 11 Months | 02 - 11 Months | 12 - 23 Months | 00 - 23 Months | 06 - 23 Months | 00 - 35 Months | 00 - 59 Months | 06 - 59 Months | 12 - 59 Months | 00 - 14 Years | Total: 10-19 Years | Male: 10-19 Years | Female: 10-19 Years | Female: 15-44 Years | WRA 15-49 Years | MWRA 15-49 Years | Expected Pregnancy | 60 & + Years |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gorkha | 247845 | 5764 | 5590 | 5406 | 4879 | 10469 | 7674 | 15327 | 24917 | 22122 | 19327 | 71548 | 48868 | 22787 | 26081 | 70768 | 77812 | 58981 | 6797 | 21451 |
| Manang | 6330 | 106 | 103 | 100 | 137 | 240 | 189 | 377 | 649 | 598 | 546 | 1865 | 1268 | 789 | 479 | 1298 | 1427 | 1082 | 125 | 546 |
| Mustang | 11587 | 230 | 223 | 216 | 241 | 464 | 353 | 704 | 1178 | 1067 | 955 | 3380 | 2302 | 1262 | 1040 | 2822 | 3103 | 2352 | 271 | 1001 |
| Myagdi | 111082 | 2523 | 2447 | 2366 | 2205 | 4652 | 3429 | 6849 | 11187 | 9964 | 8740 | 32123 | 21929 | 10514 | 11415 | 30975 | 34058 | 25816 | 2975 | 9611 |
| Kaski | 581962 | 12388 | 12149 | 11746 | 11799 | 23948 | 17871 | 35695 | 58881 | 52804 | 46732 | 168971 | 115291 | 59237 | 56054 | 152097 | 167234 | 126763 | 14610 | 50327 |
| Lamjung | 171739 | 3938 | 3819 | 3693 | 3398 | 7217 | 5308 | 10601 | 17283 | 15374 | 13464 | 49627 | 33889 | 16068 | 17821 | 48354 | 53166 | 40300 | 4644 | 14859 |
| Tanahu | 345297 | 8103 | 7858 | 7599 | 6773 | 14631 | 10702 | 21376 | 34690 | 30761 | 26832 | 99621 | 68048 | 31381 | 36667 | 99491 | 109393 | 82920 | 9555 | 29886 |
| Nawalparasi East | 350820 | 8140 | 7894 | 7633 | 6819 | 14713 | 10766 | 21467 | 34764 | 30817 | 26870 | 101313 | 71118 | 34411 | 36707 | 99623 | 109646 | 83112 | 9599 | 31082 |
| Syangja | 253089 | 5980 | 5799 | 5608 | 4952 | 10751 | 7852 | 15682 | 25414 | 22515 | 19615 | 72983 | 49858 | 22798 | 27060 | 73423 | 80731 | 61194 | 7052 | 21907 |
| Parbat | 148392 | 3438 | 3334 | 3224 | 2926 | 6260 | 4593 | 9173 | 14923 | 13256 | 11589 | 42847 | 29265 | 13707 | 15558 | 42214 | 46415 | 35183 | 4054 | 12842 |
| Baglung | 282993 | 6669 | 6467 | 6254 | 5542 | 12009 | 8776 | 17527 | 28421 | 25188 | 21954 | 81621 | 55758 | 25583 | 30175 | 81878 | 90027 | 68240 | 7864 | 24493 |
| Gandaki Province | 2511136 | 57279 | 55683 | 53845 | 49671 | 105354 | 77513 | 154778 | 252307 | 224466 | 196624 | 725899 | 497594 | 238537 | 259057 | 702943 | 773012 | 585943 | 67546 | 218005 |

## Annex- II
## Free Essential Drugs from FY 2075/76

| S.N. | Name of drugs | Forms | Strength | Group (Disease Coverage) | Dist Hosp | PHC | HP |
|---|---|---|---|---|---|---|---|
| 1. | Lignocaine | Ing 30ml | 1%with/without adrenaline,2%w/v | Local Anaesthesia | Yes | Yes | Yes |
| 2. | Paracetamol | Injection 2ml | 150 mg/ml | NSAID | Y | Y | N |
| | | Tablet | 500 mg | | Y | Y | Y |
| | | Syrup 60 ml | 125mg/5ml | | Y | Y | Y |
| 3. | Aspirin | Tablet | 75/150/300mg | NSAID, Cardiac | Y | N | N |
| 4. | Ibuprofen | Tablet | 400 mg | NSAID | Y | Y | Y |
| 5. | Diclofenac | Injn | 25mg/ml,3ml | NSAID | Y | Y | N |
| 6. | Indomethacin | Tab | 25mg,50mg | NSAID | Y | Y | N |
| 7. | Chlorpheniramine | Tab | 4mg | Antihistamine | Y | Y | Y |
| 8. | Pheniramine | Inj 2ml | 22.75mg/ml | Antihistamine | Y | Y | Y |
| 9. | Cetrizine HCL | tab, susp | 10mg,5mg/5ml | Antihistamine | Y | Y | N |
| 10. | Metronidazole | Infusion | 500mg/100ml | Antiprotozoal | Y | Y | N |
| | | Tablet | 400mg | | Y | Y | Y |
| | | Syrup 60ml | 200mg/5ml | | Y | Y | Y |
| 11. | Tinidazole | Tablet | 500mg | Antiprotozoal | Y | Y | N |
| 12. | Amoxycilin | Tablet | 125DT,250mgD | Antibiotic | Y | Y | Y |
| | | Cap | 500mg | | Y | Y | Y |
| 13. | Gentamycin | Inj | 500mg/ml | Antibiotic | Y | Y | Y |
| 14. | Ciprofloxacin | Eye/ear Drop 5ml | 0.3% w/v | Antibiotic | Y | Y | Y |
| | | Tablet | 250mg&500mg | | Y | Y | Y |
| | | Infusion | 200mg/100ml | | Y | Y | N |
| 15. | Chlormphenicol | applicap | 1% | Antibiotic | Y | Y | N |
| | | Caps | 250mg&500mg | | Y | Y | N |
| 16. | Ceftrixone | Inj | 1g | Antibiotic | Y | N | N |
| 17. | Sulfamethoxazole+Tri-methoprim | Tablet | 120DT,480 and 960 mg | Antibacterial | Y | Y | Y |
| 18. | Doxycycline | Caps | 100mg | Antibiotic | Y | Y | Y |
| 19. | Azithromycin | Tab | 250mg,500mg | Antibiotic | Y | Y | |
| 20. | Cloxacillin | Tab/Cap | 125/250/500mg | Antibiotic | Y | Y | |
| 21. | Neomycin skin | Oint | 15g | Ext antibiotic | Y | Y | |
| 22. | Fluconazole | tab/oin | 150mg/15gm | Anti-fungal | Y | Y | |
| 23. | Acyclovir | tab/oin | 200mg/5gm | Anti-viral | Y | N | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 24. | Ferrous Sulphate | Tablet | 5mg | Anaemia | Y | Y | Y |
| 25. | Folic acid | Tablet | 5mg | Anaemia | Y | Y | Y |
| 26. | Vitamin B Complex | Capsule | Therapeutic dose | Vit. supplement | Y | Y | Y |
| 27. | Compound solution of sodium lactate | infusion,500ml | Ringer's Lactate | Electrolyte imbalance | Y | Y | Y |
| 28. | Sodium chloride | infusion,500ml | Normal saline | ion substitution | Y | Y | Y |
| 29. | Dextrose sol | infusion | 5%w/v500ml | Glucose substitution | Y | Y | Y |
| 30. | Hydrochlorothiazide | Tablet | 25 mg | Diuretic, antihyper-tensive | Y | N | |
| 31. | Atenolol | Tablet | 50 mg | Antihypertensive | Y | Y | |
| 32 | Albendazole | Tablet | 400mg | Anthelmentic | Y | Y | Y |
| 33. | Calamine | Lotion,30ml | 15%w/v | Allergy, sunburn | Y | Y | Y |
| 34. | Gamma benzene hexa-chloride | Lotion100ml | 1% w/v | scabies | Y | Y | Y |
| 35. | Povidone Iodine | Liquid 500ml | 5% w/v | Antiseptics | Y | Y | Y |
| 36. | Aluminium hydrox-ide+Mag hydroxide | Tablet | 250mg+250mg | Antacid | Y | Y | y |
| 37. | Ranitidine | inj,2ml | 25mg/ml | ulcer healing | Y | Y | |
| | | Tablet | 150mg | | Y | Y | |
| 38. | Atropine | inj | 0.6mg/ml | Antispasmodic, Anti poisonous | Y | Y | |
| 39. | Hyoscine butylbromide | Inj'n | 20mg/ml | Antispasmoic | Y | Y | N |
| | | Tablet | 10mg,20mg | | Y | y | Y |
| 40. | Rehydration sol'n (ORS)/ ltr | Liquid | WHO formula Sa-chet/Ltr | Rehydration | Y | Y | Y |
| 41. | Clove oil | Liquid | 5ml | Dental pain | Y | Y | Y |
| 42. | Metachlopromide | Tablet | 10mg | Antiemetic | Y | Y | Y |
| 43. | Promethazine Hydro-chloride | Tablet | 25mg | Antiemetic | Y | Y | Y |
| 44. | Charcol activated | Powder | 10mg/sachet | Anti poisoning | Y | Y | Y |
| 45. | Benzoic Acid+ Salicylic acid | Ointment, tube,30g | 6%+3%w/w | Eczema | Y | Y | Y |
| 46. | Frusemide | Tablet | 40mg | Diuretics | Y | Y | Y |
| | | inj'n 2ml | 10mg/ml | | Y | Y | Y |
| 47. | Amlodipine | Tablet | 5mg | Antihypertensive | Y | N | N |
| 48. | Dexamethasone | inj'n2ml | 4mg/ml | steroid | Y | Y | Y |
| 49. | salbutamol | Tablet | 4mg | Bronchodilator | Y | Y | Y |
| 50. | Aminophylline | Tablet | 100mg | Bronchitis, Asthma | Y | Y | N |
| 51. | Prednisolone | Tablet | 10mg,5mg | Oral corticosteroid | Y | Y | N |
| 52. | Parlidoxim sodium | Inj'n | 500mg | Anti-toxic (antidote for OP) | Y | Y | N |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 53. | Phenobarbitone | Tablet | 60 mg | Anti-epilepticus | Y | N | N |
| 54. | Alprazolam | Tablet | 0.25mg | Benzodiazepin | Y | Y | N |
| 55. | Chlorpromazine | Tablet | 100mg | Psychotic drug | Y | N | N |
| 56. | Amitryptiline | Tablet | 10mg,25mg | Mental stimulant | Y | N | N |
| 57. | Hydrocortisone | Powder for inj'n | 100mg/vial with WFI | corticosteroid (Bron-chodilator, allergy) | Y | Y | N |
| 58. | Metformin | Tablet | 500mg | Anti-diabetic | Y | Y | |
| 59. | Adrenaline | Inj'n | 1:1000 | Anaphylactic shock | Y | Y | |
| 60. | Digoxin | Tablet | 0.25mg | Cardiac glycoside | Y | | |
| 61. | Silver Sulphadizine | Cream,25g | 1%w/w | Antiseptic specially for burn | Y | Y | |
| 62. | Clotrimazole | skin C | 1%w/w | Antifungal | Y | Y | |
| | | Pessary tab | 100mg | | Y | Y | |
| 63. | Diazepam | Inj'n | 5mg per 2ml | Tranquilizer | Y | Y | |
| 64. | Gention violet | 2%sol | 10ml | Antiseptic | Y | Y | |
| 65. | Allopurinol | Tablet | 500mg | Anti-gout | Y | No | N |
| 66. | Tetracycline | Caps | 250/500mg | Broad spectrum antibiotic | Y | Y | |
| 67. | Carbamazepine | Tabs | 200mg,400mg | Anti-epileptic | Y | | |
| 68. | Acetazolamide | Tabs | 250mg | For high altitude | Y | Y | |
| 69. | Oxymetazoline | nasal drop | 0.1%,5ml | Nasal decongestant | Y | Y | |
| 70. | Levothyroxin | Tablet | 100mcg | Antithyroid | Y | | |

## Annex: III

# Selected Indicators used in Public Health System in Nepal

## 1. Safe Motherhood

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **A** | **ANTEPARTUM** | | | | |
| 1.1 | % of pregnant women who had at least one ANC checkup | Number of pregnant women who had at least one ANC checkup | Estimated number of live Births | 100 | **Age:**<20 yrs, ≥20 years |
| 1.2 | % of pregnant women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th month) | Number of pregnant women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th month) | Estimated number of live Births | 100 | |
| 1.3 | % of women who received a 180 day supply of iron folic acid during pregnancy | Number of women who received a 180-day supply of iron folic acid during Pregnancy | Estimated number of live Births | 100 | **Area:** Urban, rural |
| 1.4 | % of pregnant women who received Td2 | Number Of pregnant women who received Td2 | Estimated number of live Births | 100 | |
| 1.5 | % of pregnant women | Number Of pregnant | Estimated | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | who received Td2+ | women who received Td2+ | number of live births | | |
| 1.6 | % of pregnant women who received anthelmintics | Number of pregnant women who received anthelmintics | Estimated number of live births | 100 | |
| **B** | **DELIVERY** | | | | |
| 1.7 | % of institutional deliveries | Number of deliveries conducted in health facilities | Estimated number of live births | 100 | **Sector:** Govt., non-Govt. institutions<br>**Level of facility:** Higher level hospitals, district hospitals, PHCCs, HPs<br>**Type of facility:** CEONC, BEONC, BC, Aama program implementing facility<br>**Caste/Ethnicity**<br>**Area:** Urban, rural |
| 1.8 | % of births attended by a skilled birth attendant (SBA) | Number of deliveries conducted by a skilled birth attendant (SBA) | Estimated number of live births | 100 | **Sector:** Govt., non-Govt.<br>**Place:** Institution, home<br>**Area:** Urban, rural |
| 1.9 | % of births attended by a health worker other than SBA | Number of deliveries conducted by a health worker other than SBA | Estimated number of live births | 100 | **Sector:** Govt. non-Govt. institutions<br>**Type of facility:** CEONC, BEONC, BC |
| 1.10 | % of women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th months) and delivered in a health facility | Number of women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th months) and delivered in a health facility | Estimated nrsumber of live birth | 100 | **Sector:** Govt., non-Govt. institutions<br>**Type of facility:** CEONC, BEONC, BC, Aama program implementing facility |
| 1.11 | % of normal deliveries | Number of normal deliveries | Number of reported deliveries | 100 | **Sector:** Govt., not Govt.<br>**Level of facility:** Higher level hospitals, district hospitals, PHCC, HP<br>**Type of facility:** CEONC, BEONC, BC |
| 1.12 | % of assisted (vacuum or forceps) deliveries | Number of assisted deliveries | Number of reported deliveries | 100 | **Sector:** Govt., non-Govt. institutions<br>**Level of facility:** Higher level hospitals, district hospitals, PHCC, HP<br>**Type:** CEONC, BEONC, BC |
| 1.13 | % of deliveries by caesarean section | Number of caesarean section deliveries | Number of reported deliveries | 100 | **Sector:** Govt. non-Govt institutions<br>**Type:** Higher level government hospitals, district hospitals |
| **C** | **POSTPARTUM** | | | | |
| 1.14 | % of postpartum women who received a PNC checkup within 24 hours of delivery | Number of postpartum women who received a PNC checkup within 24 hours of delivery | Estimated number of live births | 100 | |
| 1.15 | % of women who had three postnatal check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery) | Number of postpartum women who received three PNC checkups as per protocol (within 24 hours, on 3rd day and 7th day) | Estimated number of live births | 100 | |
| 1.16 | % of postpartum | Number of postpartum | Estimated | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | women who received a 45 day supply of iron folic acid (IFA) | women who received a 45 day supply of IFA | number of live births | | |
| 1.17 | % of postpartum women who received Vitamin A supplementation | Number of postpartum women who received Vitamin A supplementation | Estimated number of live births | 100 | |
| **D** | **MATERNAL COMPLICATIONS** | | | | |
| 1.18 | Met need for emergency obstetric care [% of women with a direct obstetric complication who was treated at a EONC (basic or comprehensive) site] | Number of women with a direct obstetric complication who were treated in a EONC (basic or comprehensive) site | Estimated number of women with a direct obstetric complication (15% of estimated number of live birth) | 100 | **Level of facility:** Higher level hospitals, district hospitals, PHCC, HP **Type of facility:** CEOC, BEOC, BC |
| 1.19 | Number of women treated for haemorrhage | | | | **Type:** APH, PPH **Blood:** With and without blood transfusion **Level of facility:** Higher level hospitals, district hospitals, PHCC, HP |
| 1.20 | Number of women treated for ectopic pregnancy | | | | |
| 1.21 | Number of women treated for prolonged/obstructed labor | | | | |
| 1.22 | Number of women treated for ruptured uterus | | | | |
| 1.23 | Number of women treated for pre-eclampsia | | | | |
| 1.24 | Number of women treated for eclampsia | | | | |
| 1.25 | Number of women treated for retained placenta | | | | **Method:** MRP |
| 1.26 | Number of women treated for puerperal sepsis | | | | |
| 1.27 | Number of women treated for abortion complications | | | | **Type:** Surgical, medical **Blood:** With and without blood transfusion |
| 1.28 | % of women treated for an obstetric complication who received a blood transfusion | Number of women treated for an obstetric complication who received a blood transfusion | Number of women treated for an obstetric complication | 100 | |
| 1.29 | Number of blood units used for treating obstetric complications | | | | |
| 1.30 | Met need of cesarean section (CS) | Number of CS done | 5% of the estimated live birth | 100 | |
| E | **MATERNAL MORTALITY** | | | | |
| 1.31 | Maternal mortality ratio | Number of maternal | Estimated | 100,000 | **Place:** Facility, |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | per 100,000 live births | deaths in the community and facilities | number of live births | | Community |
| 1.32 | Facility maternal mortality ratio per 100,000 live births | Number of maternal deaths in facilities | Number of live births at facilities | 100,000 | |
| 1.33 | Direct obstetric case fatality rate | Number of maternal deaths due to direct obstetric complications in health facilities | Number of women treated for direct obstetric complications in health facilities | 100 | |
| **F** | **NEONATAL** | | | | |
| 1.34 | % of infants who received a check-up within 24 hours of birth | Number of infants who received a checkup within 24 hours of birth | Estimated number of live births | 100 | |
| 1.35 | % of infants who received three check-ups as per PNC protocol (within 24 hours, on 3rd day and 7th day) | Number of infants who received three checkups as per PNC protocol (within 24 hours, on 3rd day and 7th day) | Estimated number of live births | 100 | |
| **G** | **ABORTION** | | | | |
| 1.36 | % of pregnancies terminated by induced procedure at health facility | Number of pregnancies terminated by induced procedure at health facility | Estimated number of pregnancies | 100 | **Age:**<20 yrs, ≥20 years **Method:** Surgical/Medical |
| 1.37 | % of women who received contraceptives after Induced abortion (surgical or medical) | Number of women who received contraceptives after abortion care at health facility | Number of women who received abortion care at health facility | 100 | **Timing:** Induced, PAC **FP method:** short-acting methods, long-acting methods **Age:**<20 yrs,≥20 years |
| 1.38 | % of women of reproductive age (15-49) with complications from induced abortion (surgical and medical) | Number of women with complications after receiving induced abortioncare athealth facility | Number of women of receiving induced abortion care at health facility | 100 | **Age:**<20 yrs,≥20 years |

## 2. Family Planning

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 2.1 | Contraceptive prevalence rate (CPR) (modern methods) among women of reproductive age (WRA) | Number of WRA currently using a modern method of family planning | Estimated number of WRA | 100 | **Age:** 15-19 yrs, 20-49 yrs **Area:** Urban, rural **Method:** Condom, pill, injectable, Implant, IUCD, Sterilization |
| 2.2 | % of postpartum mothers using a modern family planning method (implant, IUCD) | Number of postpartum mothers (who delivered within last one year) using a family planning method | Total number of delivery (Home + Institutional) | 100 | |

## 3. Female Community Health Volunteers (FCHV)

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **A** | **FCHV** | | | | |
| 3.1 | Number of Female Community Health Volunteers (FCHVs) | | | | **Age:**<60,≥60 years **Area:** Urban, rural |
| 3.2 | Number of FCHVs who received basic training[a] | | | | **Area:** Urban, rural |
| 3.3 | % of FCHVs attending both biannual review meetings[a] | Number of FCHVs attending both biannual | Number of FCHVs | | 1st and 2nd biannual review meeting |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | | review meeting | | | **Area:** Urban, rural |
| 3.4 | Number of mothers group meetings held | | | | **Area:** Urban, rural |
| 3.5 | % of FCHVs utilising FCHV fund (new users) | Number of FCHVs utilising FCHV fund (new users) | Number of FCHVs | 100 | **Area:** Urban, rural |
| 3.6 | % of women of reproductive age utilizing FCHV fund [a] | Number of women of reproductive age utilizing FCHV fund | Estimated number of women of reproductive age | 100 | **Area:** Urban, rural |
| 3.7 | Amount of money invested from the FCHV fund | | | | **Area:** Urban, rural |
| **B** | **Program specific indicators** | | | | |
| 3.8 | % of pregnant women visited by FCHVs | Number of pregnant women visited by a FCHV | Estimated number of pregnancies | 100 | **Area:** Urban, rural |
| 3.9 | % of postpartum women visited by FCHVs | Number of postpartum women visited by a FCHV | Estimated number of live births | 100 | **Area:** Urban, rural |
| 3.10 | Number of oral contraceptive pill cycles distributed by FCHVs | | | | **Area:** Urban, rural |
| 3.11 | Number of condoms distributed by FCHVs | | | | **Area:** Urban, rural |
| 3.12 | % of FCHVs who participated in PHC outreach clinics | Number of FCHVs who participated in PHC outreach clinics | Number of FCHVs | 100 | **Area:** Urban, rural |
| 3.13 | Average number of times FCHVs participated in PHC outreach clinics | Total number of times FCHVs participated in PHC ORC | Number of FCHVs | | **Area:** Urban, rural |

## 4. Primary Health Care Outreach Services

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 4.1 | % of planned primary health care (PHC) outreach clinics conducted | Number of PHC outreach clinics conducted | Number of PHC outreach clinics planned | 100 | |
| 4.2 | Average number of clients served per PHC outreach clinic | Number of clients served at PHC outreach clinics | Number of outreach clinics conducted | 100 | |
| 4.3 | % of women who received a contraceptive injectable at a PHC outreach clinic | Number of women who received a contraceptive injectable at a PHC outreach clinic | Number of women who received a contraceptive injectable | 100 | |
| 4.4 | Number of women who received at least one ANC check-up at a PHC outreach clinic | | | | |

## 5. Immunization

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| A | CHILDREN | | | | |
| 5.1 | % of children under one year immunized with BCG | Number of children under one year immunized with BCG | Number of children under one year | 100 | |
| 5.2 | % of children under one year immunized with DPT-HepB-Hib1 | Number of children under one year immunized with DPT-HepB-Hib1 | Number of children under one year | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 5.3 | % of children under one year immunized with DPT-HepB -Hib2 | Number of children under one year immunized with DPT-HepB-Hib2 | Number of children under one year | 100 | |
| 5.4 | % of children under one year immunized with DPT-HepB -Hib3 | Number of children under one year immunized with DPT-HepB-Hib3 | Number of children under one year | 100 | |
| 5.5 | % of children under one year immunized with Polio 1 | Number of children under one year immunized with Polio 1 | Number of children under one year | 100 | |
| 5.6 | % of children under one year immunized with Polio 2 | Number of children under one year immunized with Polio 2 | Number of children under one year | 100 | |
| 5.7 | % of children under one year immunized with Polio 3 | Number of children under one year immunized with Polio 3 | Number of children under one year | 100 | |
| 5.8 | % of children under one year immunized with PCV 1 | Number of children under one year immunized with PCV 1 | Number of children under one year | 100 | |
| 5.9 | % of children under one year immunized with PCV 2 | Number of children under one year immunized with PCV 2 | Number of children under one year | 100 | |
| 5.10 | % of children under one year immunized with PCV 3 | Number of children under one year immunized with PCV 3 | Number of children under one year | 100 | |
| 5.11 | % of children under one year immunized with IPV | Number of children under one year immunized with IPV | Number of children under one year | 100 | |
| 5.12 | % of one-year-old children immunized against measles/rubella | Number of children under one year immunized with measles/rubella | Number of children under one year | 100 | **Age:** 9-11 months, 12-23 months<br>**Area:** Rural, urban<br>**Caste/Ethnicity** |
| 5.13 | % of children aged 12-23 months immunized with measles/rubella 1 | Number of children aged 12-23 months immunized with measles/rubella 1 | Number of children aged 12-23 months | 100 | |
| 5.14 | % of children aged 12-23 months immunized with measles/rubella 2 | Number of children aged 12-23 months immunized with measles/rubella 2 | Number of children aged 12-23 months | 100 | |
| 5.15 | % of children aged 12-23 months immunized with JE | Number of children aged 12-23 months immunized with JE | Number of children aged 12-23 months | 100 | |
| 5.16 | % of children under one year fully immunized as per NIP schedule (BCG, DPT-Hep B-Hib-3, OPV-3, Measles/Rubella and PCV3) | Number of children under one year fully immunized as per NIP schedule (BCG, DPT-Hep B-Hib-3, OPV-3 and Measles/Rubella, PCV3) | Number of children under one year | 100 | |
| 5.17 | % of children under one year not immunized against DPT-HepB-Hib3 | Number of children under one year *minus* number of children immunized against DPT-HepB-Hib3 | Number of children under one year | 100 | |
| 5.18 | DPT-HepB-Hib 1 vs 3 drop-out rate | Number of children immunized with DPT-HepB-Hib1 *minus* number of children immunized with DPT-HepB-Hib3 | Number of children immunized with DPT-HepB-Hib1 | 100 | |
| 5.19 | DPT-HepB-Hib1 vs measles/rubella 1 dropout rate | Number of children immunized with DPT-HepB-Hib1 *minus* number of children immunized with Measles/Rubella 1 | Number of children immunized with DPT-HepB-Hib1 | 100 | |
| 5.20 | Measles/rubella 1 vs 2 | Number of children | Number of | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | dropout rate | immunized with Measles/Rubella 1*minus* number of children immunized with Measles/Rubella 2 | children immunized with Measles/Rubella 1 | | |
| 5.21 | BCG vs Measles dropout rate | Number of children immunized with BCG*minus* number of children immunized with Measles | Number of children immunized with BCG | 100 | |
| 5.22 | % of VDCs/districts in each immunization category | Number of VDCs/districts in each category of immunization | Number of VDCs/districts | 100 | **Category**: 1, 2, 3 and 4<br>I: (>90% DPT 1 coverage and DPT 1 vs 3 drop out < 10%)<br>2: (> = 90% DPT 1 coverage and drop out DPT 1 vs 3 = > 10%)<br>3: (<90% DPT 1 coverage and drop out DPT 1vs3 < 10%)<br>4: (<90% DPT 1 coverage and drop out DPT 1vs3 > = 10%) |
| 5.23 | % of children aged 4-7 years receiving Td vaccine | Number of children aged 4-7 years receiving Td vaccine | Number of children aged 4-7 years | 100 | |
| B | WASTAGE RATE | | | | |
| 5.24 | Vaccine wastage rate for of BCG, Measles, DPT-HepB-Hib, Td, JE, Polio | Number of doses expended*minus* number of doses used for BCG, Measles, DPT-HepB-Hib, Td, JE, Polio | Number of doses expended for BCG, Measles, DPT-HepB-Hib, Td, JE, Polio | 100 | **Antigen:** BCG, Measles, DPT-HepB-Hib, Td, JE, Polio |
| C | IMMUNIZATION CLINICS | | | | |
| 5.25 | % of planned immunization clinics (site) conducted | Number of immunization clinics (site) conducted | Number of immunization clinics (site) planned | 100 | |
| 5.26 | % of planned immunization sessions conducted (health facility, outreach and mobile clinic) | Number of immunization sessions conducted | Number of immunization sessions planned | 100 | **Type of facility:** Health facility, outreach and EPI clinic |
| D | ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI) | | | | |
| 5.27 | % of adverse events following immunization (AEFI) cases reported, by antigen | Number of AEFI cases reported, by antigen | Number of children immunized by antigen | 100 | **By antigen:** BCG, DPT-HepB-Hib3, OPV-3 and Measles<br>**By type**: Serious and minor |
| 5.28 | Acute flaccid paralysis (AFP) rate per 100,000 children under 15 years | Number of children under 15 years with AFP | Number of children under 15 years | 100,000 | |
| 5.29 | Neonatal tetanus rate per 1000 live births | Number of neonatal tetanus cases | Estimated number of live birth | 1,000 | |
| 5.30 | Acute encephalitis syndrome (AES) rate per 1000 population in high risk districts | Number of acute encephalitis syndrome cases in high risk districts | Total population of high risk districts | 1,000 | |
| 5.31 | Measles like illness rate per 1000 population | Number of measles like illness cases | Total population | 1,000 | |

## 6. Integrated Management of Childhood Illnesses (IMCI)

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **A** | CHILDREN UNDER FIVE YEARS: DIARRHOEA | | | | |
| 6.1 | Diarrhoea incidence rate among children under five years | Number of children under five years with a new case of diarrhoea | Estimated number of children under five years | 100 | |
| 6.2 | % of children under five years with diarrhea suffering from dehydration (facility, outreach and community) | Number of children under five years with diarrhea suffering from dehydration (facility, outreach and community) | Number of children under five years with diarrhoea (facility, outreach and community) | 100 | **Severity of dehydration:**some, severe |
| 6.3 | % of children under five years with diarrhea suffering from dysentery (blood in stool) | Number of children under five years with diarrhea suffering from dysentery (blood in stool) | Number of children under five years with diarrhoea | 100 | |
| 6.4 | % of children under five years with diarrhea treated with ORS only (facility, outreach and community) | Number of children under five years with diarrhea treated with ORS only (facility, outreach and community) | Number of children under five years with diarrhoea (facility, outreach and community) | 100 | |
| 6.5 | % of children under five years with diarrhea treated with zinc and ORS | Number of children under five years with diarrhea treated with ORS and zinc (facility, outreach and community) | Number of children under five years with diarrhoea(facility, outreach and community) | 100 | Health facility, CHW, FCHV |
| 6.6 | % of children under five years with diarrhoea treated with IV fluid | Number of children under five years with diarrhoea treated with IV fluid | Number of children under five years with diarrhoea | 100 | |
| 6.7 | Diarrhoea mortality rate among children under five years (per 1,000) | Number of deaths due to diarrhoea among children under five years (facility and community) | Estimated number of children under five years | 1,000 | |
| 6.8 | Diarrhoea case fatality rate among children under five years (per 1,000) | Number of deaths due to diarrhoea among children under five years occurring at health facilities | Number of children under five years with diarrhoea treated at a health facility | 1,000 | |
| **B** | CHILDREN UNDER FIVE YEARS: ARI | | | | |
| 6.9 | ARI incidence rate among children under five years (per 1,000) | Number of children under five years with a new case of ARI | Estimated number of children under five years | 1,000 | |
| 6.10 | Incidence of pneumonia among children under five years (per 1,000) | Number of new cases of pneumonia (pneumonia or severe pneumonia, or very severe pneumonia) among children under five years | Estimated number of children under five years | 1,000 | |
| 6.11 | % of children under five years with ARI suffering pneumonia | Number of children under five years with ARI suffering pneumonia | Number of children under five years with ARI | 100 | **Severity:** Severe pneumonia, very severe pneumonia |
| 6.12 | % of children under five years with pneumonia, | Number of children under five years with pneumonia, | Number of children under | 100 | **Antibiotic type**: Paediatric cotrim, |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | who received antibiotics | who received antibiotics | five years with pneumonia | | Other antibiotics<br>**Place**: Health facility, community (FCHV - Cotrim) |
| 6.13 | % of children under five years with pneumonia counselled for home care management (facility, outreach and community) | Number of children under five years with pneumonia counselled for home care management (facility, outreach and community) | Number of children under five years with ARI (facility, outreach and community) | 100 | |
| 6.14 | % of children under five years with ARI managed at a health facility | Number of children under five years with ARI managed at a health facility | Number of children under five years with ARI (facility, outreach and community) | 100 | Health facility, CHW, FCHV |
| 6.15 | ARI mortality rate among children under five years (per 1,000) | Number of deaths due to ARI among children under five years | Estimated number of children under five years | 1,000 | |
| 6.16 | ARI case fatality rate among children under five years (per 1,000) | Number of deaths due to ARI at a health facility among children under five years | Number of children under five years treated for ARI at a health facility | 1,000 | |
| **D** | CHILDREN UNDER FIVE YEARS: VITAMIN A | | | | |
| 6.17 | % of children 6-59 months treated with Vitamin A | Number of children 6-59 months treated with Vitamin A | Number of children 6-59 months reported in CB-IMCI | 100 | |
| **E** | CHILDREN UNDER FIVE YEARS: MULTIPLE CLASSIFICATION | | | | |
| 6.18 | % of multiple illness classification cases reported in CB-IMCI | Number of multiple illness classification cases reported in CB-IMCI | Number of cases reported in CB-IMCI | 100 | |
| **F** | COMMUNITY BASED NEONATAL CARE PROGRAM (CB-NCP) | | | | |
| 6.19 | % of newborns who had skin-to-skin contact immediately after birth | Number of newborns who had skin-to-skin contact immediately after birth | Number of reported live births | 100 | **Place:** Facility, Community |
| 6.20 | % of newborns who had chlorhexidine ointment applied immediately after birth | Number of newborns who had chlorhexidine ointment applied immediately after birth | Number of reported live births | 100 | **Place:** Facility, Community |
| 6.21 | % of newborns with low birth weight kept in KMC | Number of newborns with low birth weight kept in KMC | Number of newborns recorded with low birth weight | 100 | |
| 6.22 | % of newborns who initiated breastfeeding within an hour of birth | Number of newborns who initiated breastfeeding within an hour of birth | Number of reported live births | 100 | **Place:** Facility, Community |
| 6.23 | % of infants aged 0-2 months with possible severe bacterial infection (PSBI) | Number of infants aged 0-2 months with possible severe bacterial infection (PSBI) | Number of infants aged 0-2 months reported in CB-IMCI | 100 | **Age**:≤28 days, 29-59 days |
| 6.24 | % of infants aged 0-2 months with PSBI receiving a first dose of Gentamycin | Number of infants aged 0-2 months with PSBI receiving a first dose of Gentamycin | Number of infants aged 0-2 months reported with PSBI | 100 | |
| 6.25 | % of infants aged 0-2 months with PSBI receiving a complete dose of Gentamycin | Number of infants aged of 0-2 months with PSBI receiving a complete dose of Gentamycin | Number of infants aged 0-2 months reported with PSBI | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 6.26 | PSBI case fatality rate among infants under one month old (per 1000) | Number of newborn deaths due to PSBI at a health facilities | Number of infants aged 0-2 months reported with PSBI | 1000 | |
| 6.27 | % of infants aged 0-2 months with localized bacterial infection (LBI) | Number of infants aged 0-2 months with localized bacterial infection (LBI) | Number of infants aged 0-2 months reported in IMCI | 100 | **Age**:≤28 days, 29-59 days |
| 6.28 | % of infants aged 0-2 months with hypothermia | Number of infants aged 0-2 months with hypothermia | Number of infants aged 0-2 months reported in IMCI | 100 | **Age**:≤28 days, 29-59 days |
| 6.29 | % of infants aged 0-2 months with low weight for age | Number of infants aged 0-2 months with low weight for their age | Number of infants aged 0-2 months reported in IMCI | 100 | **Age**:≤28 days, 29-59 days |
| 6.30 | % of infants aged 0-2 months who had feeding problems | Number of infants aged 0-2 months who had feeding problems | Number of infants aged 0-2 months reported in IMCI | 100 | **Age**:≤28 days, 29-59 days |
| **G** | **Others** | | | | |
| 6.31 | % of children under five years enrolled in CBIMCI program | Number of children under five years enrolled in CBIMCI program | Number of children under five years | 100 | **Caste/ethnicity** |

## 7. Nutrition

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **A** | GROWTH MONITORING | | | | |
| 7.1 | % of newborns with low birth weight (<2.5kg) | Number of newborns who were weighed less than 2.5 kg | Number of live births at health facilities and home who were weighed | 100 | **Place of birth:** Health facility, Home |
| 7.2 | % of children aged 0-12 months registered for growth monitoring | Number of aged 0-12 months registered for growth monitoring | Estimated number of children age 0-12 months | 100 | |
| 7.3 | Average number of visits among children aged 0-24 months registered for growth monitoring[a] | Sum of number of visits among children aged 0-24 months registered for growth monitoring | Number of registered visits for children age 0-24 months registered for growth monitoring | 100 | **Age:** 0-11 months, 12-23 months, Annual |
| 7.4 | % of children aged 0-24 months registered for growth monitoring who were underweight | Number of children aged 0-24 months registered for growth monitoring who were underweight | Number of children age 0-24 months registered for growth monitoring | 100 | **Severity:** Moderate, Severe **Age:** 0-11 months, 12-23 months **Caste/Ethnicity** |
| **B** | INFANT AND YOUNG CHILD FEEDING | | | | |
| 7.5 | % of newborns who initiated breastfeeding within 1 hour of birth | Number newborns who initiated breastfeeding within 1 hour of birth | Number of recorded live births | 100 | |
| 7.6 | % of children aged 0- 6 months registered for growth monitoring, who were exclusively breastfed for the first six months | Number of children aged 0-6 monthsand registered for growth monitoring who were exclusively breastfed for first 6 months | Number of children age 6-11 months | 100 | |
| 7.7 | % of children aged 6–8 | Number of children aged 6- | Number of | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | months registered for growth monitoring who received solid, semi-solid or soft foods | 8 months registered for growth monitoring who received solid, semi-solid or soft foods | children age 6-11 months | | |
| C | MICRO-NUTRIENTS AND ANTIHELMINTHICS | | | | |
| 7.8 | % of children aged 6-59 months, who received Vitamin A supplements | Number of children aged 6-59 months who received Vitamin A supplementation | Estimated number of children aged 6-59 months | 100 | **Age:** 6-11 months,12-59 months |
| 7.9 | % of children aged 12-59 months who received antihelminthics | Number of children aged 12-59 months who received antihelminthics | Estimated number of children aged 12-59 months | 100 | |
| 7.10 | % of children aged 6-23 months, who received Baal Vita (MNP) | Number of children aged 6-23 months, who received Baal Vita (MNP) | Estimated number of children age 6-23 months | 100 | **Age:** 6-11 months, 12-17 months, 18-23 months |
| 7.11 | % of children aged 6-23 months, who received all 3 cycles of Baal Vita (MNP) | Number of children aged 6-23 months, who received all 3 cycles of Baal Vita (MNP) | Estimated number of children age 6-23 months | 100 | |
| 7.12 | % of adolescents girls aged 10-19 years who received iron supplementation for 13 weeks | Number of adolescents girls aged 10-19 years who received iron supplementation for 13 weeks | Estimated number of adolescent girls aged 10-19 years | 100 | **Age:** 10-14 and, 15-19 years |
| D | MANAGEMENT OF ACUTE MALNUTRION (MAM) | | | | |
| 7.13 | Number of cases admitted at outpatient therapeutic centers (OTPs) | | | | |
| 7.14 | % of cases admitted at OTPs with moderate acute malnutrition (MAM) | Number of cases admitted at OTPs with MAM | Number of cases admitted at OTPs | 100 | |
| 7.15 | % of cases admitted at OTPs with MAM who recovered | Number of cases admitted at OTPs with MAM who recovered | Number of cases admitted at OTPs with MAM | 100 | |
| 7.16 | % of cases admitted at OTPs with MAM who died | Number of cases admitted at OTPs with MAM who died | Number of cases admitted at OTPs with MAM | 100 | |
| 7.17 | % of cases admitted at OTPs with severe acute malnutrition (SAM) | Number of cases admitted at OTPs with SAM | Number of cases admitted at OTPs | 100 | |
| 7.18 | % of cases admitted at OTPs with SAM who recovered | Number of cases admitted at OTPs with SAM who recovered | Number of cases admitted at OTPs with SAM | 100 | |
| 7.19 | % of cases admitted at OTPs with SAM who died | Number of cases admitted at OTPs with SAM who died | Number of cases admitted at OTPs with SAM | 100 | |
| 7.20 | Number of SAM cases admitted at nutrition rehabilitation homes (NRHs) | | | | |
| 7.21 | % of cases admitted at NRHs with SAM who recovered | Number cases admitted at NRHs with SAM who recovered | Number of cases admitted at NRHs with SAM | 100 | |
| 7.22 | % of SAM cases at NRHs who died | Number of cases admitted at NRHs with SAM who died | Number of cases admitted at NRHs with SAM | 100 | |
| E | SCHOOL HEALTH AND NUTRITION | | | | |
| 7.23 | % of public schools that received a first aid kit box | Number of public schools that received a first aid kit | Number of public schools | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | | box | | | |
| 7.24 | % of students in grade 1-10 who received anthelminthic | Number of students in grade 1-10 who received anthelminthic | Number of students in grade 1-10 | 100 | **Sex:** Male, Female |
| F | FOOD SUPPLEMENT | | | | |
| 7.25 | % of children aged 6-23 months who received monthly food supplements | Number of children aged 6-23 months who received monthly food supplements | Estimated number of children age 6-23 months | 100 | |

## 8. HIV/AIDS

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| A | HIGH RISK GROUPS | | | | |
| 8.1 | % of high risk groups who received an HIV test (e.g. through an outreach service, drop-in centre or sexual health clinic) | Number of high risk groups who received an HIV test (e.g. through an outreach service, drop-in centre or sexual health clinic) | Target population | 100 | **High risk group:** Sex workers, men who have sex with men, male labor migrants, PWIDs |
| 8.2 | % of high risk groups who received an HIV test and know their results | Number of high risk groups who received an HIV test and know their results | Number of high risk groups who received an HIV test | 100 | **High risk group:** Sex workers, men who have sex with men, male labor migrants, PWIDs |
| 8.3 | % of people who inject drugs (PWIDs) currently on opioid substitution therapy (OST) | Number of people who inject drugs (PWIDs) currently on opioid substitution therapy | Estimated number of PWIDs | 100 | |
| 8.4 | % of diagnosed sexually transmitted infections (STIs) treated | Number of STIs diagnosed that are treated | Number of STIs diagnosed | 100 | **High risk group:** MSM, IDUs, Sex Workers, Male labor migrants<br>**Age:** 0-14, >14 years<br>**Sex:** Female, male |
| 8.5 | % of active syphilis among high risk population diagnosed and treated for syphilis | Number of active syphilis among high risk population diagnosed and treated for syphilis | Number of high risk population diagnosed and treated for syphilis | 100 | |
| 8.6 | % of people who inject drugs (PWIDs) who have been on Opoid Substitution Therapy (OST) | Number of people who inject drugs (PWIDs) who have been on OST | Estimated number of PWIDs | 100 | |
| B | MOTHER TO CHILD TRANSMISSION | | | | |
| 8.7 | % of women screened for syphilis at an antenatal care (ANC) check-up | Number of women who were screened for syphilis at an ANC check-up | Estimated number of pregnancies | 100 | |
| 8.8 | % of women screened for syphilis at an ANC check-up and tested positive | Number of women who were screened for syphilis at an ANC check-up and tested positive | Number of women who were screened for syphilis at an ANC check-up | 100 | |
| 8.9 | % of women who tested positive for syphilis at an ANC check-up and were treated | Number of women who tested positive for syphilis at an ANC check-up and were treated | Number of women who tested positive for syphilis at an ANC check-up | 100 | |
| 8.10 | % of HIV positive pregnant women enrolled in PMTCT service | Number of HIV positive pregnant women enrolled in PMTCT service | Estimated number of HIV-positive pregnant women | 100 | |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 8.11 | % of infants born to HIV positive women who received an HIV test within two months of birth | Number of infants born to HIV-positive women who received an HIV test within two months of birth | Number of infants born to HIV positive women | 100 | |
| 8.12 | % of infants born to HIV positive mothers who were exclusively breastfed for first six months | Number of infants born to HIV infected women who were exclusively breastfed for first 6 months | Number of infants aged 6 months born to HIV positive mothers | 100 | |
| 8.13 | % of infants born to HIV positive mothers who had received replacement feeding for first six months | Number of infants born to HIV infected women who had received replacement feeding for first six months | Number of infants aged 6 months born to HIV positive mothers | 100 | |
| 8.14 | % of infants born to HIV positive mothers who had received mixed feeding for first six months | Number of infants born to HIV infected women who had received mixed feeding for first six months | Number of infants aged 6 months born to HIV positive mothers | 100 | |
| **C** | TREATMENT: ANTIRETROVIRAL THERAPY | | | | |
| 8.15 | % of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 12 months[a] | Number of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 12 months | Number of people who initiated antiretroviral therapy | 100 | **Age:** 0-14 years, >14 years |
| 8.16 | % of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 24 months | Number of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 24 months | Number of people who initiated antiretroviral therapy | 100 | |
| 8.17 | % of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 36 months | Number of people with HIV who initiated antiretroviral therapy and are known to have been on it continuously for at least 36 months | Number of people who initiated antiretroviral therapy | 100 | |
| **E** | TREATMENT AND CARE | | | | |
| 8.18 | % of people enrolled in HIV care/ treatment who received cotrimoxazole prophylaxis | Number of people enrolled in HIV care/ treatment who received cotrimoxazole prophylaxis | Number of people enrolled in HIV care / treatment | 100 | **Age:** 0-14 years, >14 years |
| 8.19 | % of people living with HIV currently enrolled in HIV care, who received opportunistic infection (OI) services | Number of people living with HIV currently enrolled in HIV care, who received opportunistic infection (OI) services | Estimated number of people living with HIV infection | 100 | **Age:** 0-14 years, >14 years |
| 8.20 | % of people living with HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol | Number of people living with advanced HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol | Estimated number of people with advanced HIV infection | 100 | **Age:** 0-14 years, >14 years |
| 8.21 | % of people who started antiretroviral therapy and picked up all prescribed antiretroviral drugs on time for two consecutive drug pick-ups | Number of people that started antiretroviral therapy and picked up all prescribed antiretroviral drugs on time for two consecutive drug pick-ups | Number of people who started antiretroviral therapy | 100 | |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **F** | HIV - TB TREATMENT | | | | |
| 8.22 | % of people enrolled in HIV care who had their TB status assessed and recorded during their last visit) | Number of people enrolled in HIV care who had their TB status assessed and recorded during their last visit | Number of people enrolled in HIV care | 100 | **Age:** 0-14 years, >14 years |
| 8.23 | % of PLHIV positive TB cases who received treatment for both TB and HIV (antiretroviral combination therapy) | Number of people with HIV positive TB cases who received treatment for both TB and HIV (antiretroviral combination therapy) | Estimated number of HIV positive TB cases | 100 | **Age:** 0-14 years, >14 years |
| 8.24 | % of people newly enrolled in HIV care who started treatment for latent TB infection (isoniazid preventive therapy) | Number of people newly enrolled in HIV care who started (given at least one dose) treatment of latent TB infection | Number of people newly enrolled in HIV care | 100 | |

## 9. Tuberculosis

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 9.1 | Number of TB cases registered | | | | |
| 9.2 | Sex ratio of new positive smear cases | Number of new positive smear cases among males | Number of new positive smear cases among females | | **Caste/Ethnicity** |
| 9.3 | % of children aged 0-14 years with a new positive smear | Number of children aged 0-14 years with a new positive smear | Number of children aged 0-14 years | 100 | **Sex:** Female, male |
| 9.4 | Number of relapse cases | | | | **Age:** 15-24, 25-34, 35-44, 45-54, 55-64, 65+ |
| 9.5 | Number of failure cases | | | | **Sex:** Female, male |
| 9.6 | Number of TAD cases | | | | **Sex:** Female, male |
| 9.7 | Number of pulmonary negative cases | | | | **Sex:** Female, male |
| 9.8 | Number of extra pulmonary cases | | | | **Sex:** Female, male |
| 9.9 | Number of cases classified as 'other' | | | | **Sex:** Female, male |
| 9.10 | Ratio of new smear-positive cases to new smear-negative and extra-pulmonary cases | Number of new smear positive cases | Number of smear negative and extra-pulmonary cases | | |
| 9.11 | Positivity rate among suspected cases | Number of sputum positive cases examined by microscopy | Number of suspected cases | 100 | |
| 9.12 | Tuberculosis case detection rate per 100,000 population | Number of new smear positive cases registered | Population | 100,000 | |
| 9.13 | Cure rates among new smear positive cases | Number of new smear positive male cases cured | Number of new smear positive male cases registered in that period | 100 | **Sex:** Female, male |
| 9.14 | Treatment completion rates for EP and pulmonary positive cases | Number of new smear positive cases who completed full course of treatment | Number of new smear positive cases registered | 100 | **Sex:** Female, male |
| 9.15 | Number of defaulted cases | | | | **Sex:** Female, male |
| 9.16 | Number of treatment | | | | **Sex:** Female, male |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | failure cases | | | | |
| 9.17 | Death rate per 100,000 population[a] | Number of deaths attributable to TB | Total population | 100,000 | **Sex:** Female, male |
| 9.18 | Number of cases transferred out | | | | **Sex:** Female, male |
| 9.19 | Number of cases referred from private to public facilities | | | | |
| 9.20 | Number of cases referred from other countries | | | | |
| 9.21 | Tuberculosis treatment success rate | Number of registered smear-positive cases (New, Relapse, Default, TAD) that were cured or in which a full course of treatment was completed. | Number of smear positivecases registered in the same period | 100 | **Cases:** New, Relapse, Default, TAD |
| 9.22 | Smear conversion rate at 2 months of treatment | Number of smear positive cases (new, relapse or failure cases) which are smear-negative at 2(3) months of treatment | Number of smear positivecases (new, relapse, or failure cases) registered during the same period | 100 | **Sex:** Female, male |
| 9.23 | TB case finding rate | Number of new smear positive cases registered | Estimated number of new smear positive cases | 100 | |
| 9.24 | Quality assurance of smear examination: percentage agreement | Number of smears read the same by the sending laboratory and the reference laboratory | Number of slides sent by the sending laboratory to the reference laboratory for quality assurance | 100 | |
| 9.25 | % of TB cases with HIV infection | Number of TB cases with HIV infection | Number of TB cases | 100 | **Sex:** Female, male |
| 9.26 | MDR TB cases per 10,000 population | MDR TB cases | Total population | 10,000 | **Cases:** New, relapse, TAD, TAF Cat-I, TAF Cat-II<br>**Transfer:** In, out<br>**Age:** 0-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65+<br>**Sex :** Female, male |
| 9.27 | X-DR TB cases per 10,000 population | X-DR TB cases | Total population | 10,000 | |
| 9.28 | % of drug resistant TB patients who completed full course of treatment | Number of drug resistant TB patients who completed full course of treatment | Number of drug resistant TB patients | 100 | **Cases:** New, relapse, TAD, TAF Cat-I, TAF Cat-II<br>**Transfer:** In, out<br>**Outcome**: Cured, treatment completed, failure, defaulted, died<br>**Sex :** Female, male |
| 9.29 | Chronic respiratory disease (CRD) cases per 10,000 population | Chronic respiratory disease | Total population | 10,000 | |
| 9.30 | % of CRD cases who underwent a sputum examination | Number of CRD cases who underwent a sputum examination | Number of CRD cases | 100 | |
| 9.31 | % of examined CRD cases | Number of sputum | Number of | 100 | |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | who were sputum positive | positive cases among examined CRD cases | examined CRD cases | | |
| 9.32 | % of pulmonary TB cases identified as smokers | Number of smokers identified among pulmonary TB cases | Number of pulmonary TB cases | 100 | |
| 9.33 | % of pulmonary TB smokers who quit smoking after counselling | Number of pulmonary TB smokers who quit smoking after counselling | Number of smokers identified among pulmonary TB cases | 100 | |

## 10. Epidemiology and Disease Control

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| A | MALARIA | | | | |
| 10.1 | Annual blood examination rate (ABER) of malaria in high risk districts[a] | Number of slides examined in high risk districts | Population in high risk districts | 100 | |
| 10.2 | Slide positivity rate (SPR) of malaria in high risk districts | Number of positive slides in high risk districts | Number of slides examined | 100 | **Level of facility:** District Hospital, PHC, HP |
| 10.3 | Malaria annual parasite incidence (per 1,000 population in high risk districts) [a] | Number of positive cases in high risk districts | Population in high risk districts (*1000 population) | 1,000 | |
| 10.4 | Clinical malaria incidence (CMI) in high risk districts | Number of new cases of clinical malaria in high risk districts | Population in high risk districts | 1,000 | |
| 10.5 | % of P. Falciparum (PF) cases in high risk districts | Number of PF cases in high risk districts | Number of positive cases in high risk districts | 100 | |
| 10.6 | % of imported cases among positive cases of malaria | Number of imported cases | Number of positive cases (suspected + confirmed) | 100 | |
| 10.7 | % of malaria cases by target group | Number of malaria cases by target group | Number of positive cases (suspected + confirmed) | 100 | **Age:** Children <5<br>**Sex:** Girls, Boys<br>**Client:** Pregnant women |
| 10.8 | Case fatality rate of malaria | Number of deaths due to malaria (suspected and confirmed) | Number of positive cases (suspected + confirmed) | 100 | **Cases:** Suspected, confirmed |
| 10.9 | % of pregnant women receiving a LLIN from an ANC clinic | Number of pregnant women receiving a LLIN from an ANC clinic | Number of pregnant women | 100 | |
| 10.10 | % of confirmed cases ofuncomplicated malaria treated with antimalarials as per national guidelines | Number of confirmed cases of uncomplicated malaria treated with antimalarials as per national guidelines | Number of confirmed cases of uncomplicated malaria | 100 | |
| 10.11 | % of confirmed cases of severe malaria treated with antimalarials as per national guidelines | Number of confirmed cases of severe malaria treated with antimalarials as per national guidelines | Number of confirmed cases of severe malaria | 100 | |
| 10.12 | % of blood slide collected that were examined and tested positive | Number of blood slides examined + slide positive | Target for malaria slide collection | 100 | |
| 10.13 | Number of health facilities designated at sentinel surveillance sites that are functioning as sentinel surveillance sites[a] | Number of health facilities designated assentinel surveillance sites that are functioning as sentinel surveillance sites | Number of health facilities designated as sentinel surveillance sites | | |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| B | KALA-AZAR | | | | |
| 10.14 | Number of kala-azar cases in at risk districts | | | | |
| 10.15 | Incidence of kala-azar (KA) per 10,000 population in at risk districts | Number of new KA cases in at risk districts | Population in at risk districts (*10,000) | 10,000 | |
| 10.16 | % of kala-azar cases that were treated by Sodium Astivo Gluconate (SAG) in at risk districts | Number of kala-azar cases treated by SAG in at risk districts | Number of kala-azar cases in at risk districts | 100 | |
| 10.17 | % of kala-azar cases that were treated by Fungizone in at risk districts | Number of kala-azar cases treated by Fungizone in at risk districts | Number of kala-azar cases in at risk districts | 100 | |
| 10.18 | Kala-azar case fatality rate in at risk districts | Number of deaths due to kala-azar in at risk districts | Number of kala-azar cases in at risk districts | 100 | |
| 10.19 | Kala-azar treatment failure rate (KATFR) in at risk districts | Number of kala-azar cases not responding to miltefosin/ fungizone in at risk districts | Number of kala-azar cases in at risk districts | 100 | |
| 10.20 | Prevalence of Kala-azar in at risk districtsper 10,000 population | Number of kala-azar cases in at risk districts | Population in at risk districts (*10,000) | 10,000 | |
| C | LYMPHATIC FILARIASIS | | | | |
| 10.21 | Prevalence of lymphatic filariasis in at risk districts per 10,000 population | Number of cases of lymphatic filariasis in at risk districts | Population in at risk districts | 10,000 | |

## 11. Leprosy

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 11.1 | New case detection rate of leprosy[Pausi Besilli (PB) and Multi Besilli (MB)] | Number of new leprosy cases (PB and MB) | Total population | 100,000 | |
| 11.2 | Prevalence of leprosy per 10,000 population | Number of leprosy cases (PB and MB) | Total population | 10,000 | |
| 11.3 | Incidence of leprosy per 10,000 population | Number of new leprosy cases (PB and MB) | Total population | 10,000 | **Age:** <15 years,≥15 years<br>**Sex:** Female, male |
| 11.4 | % of new leprosy cases presenting with a grade-2 disability | Number of new leprosy cases (PB and MB) presenting with a grade-2 disability | Number of new leprosy cases (PB and MB) | 100 | |
| 11.5 | % of new leprosy cases that are MB | Number of new leprosy cases that are MB | Number of new leprosy cases (PB and MB) | 100 | |
| 11.6 | Treatment compliance rate for PB cases | Number of new PB cases who completed the treatment on time | Number of PB cases who started treatment in the same batch/year | | |
| 11.7 | Treatment compliance rate for MB cases | Number of new MB cases who completed the treatment on time | Number of MB cases who started treatment in the same batch/year | | |
| 11.8 | % of PB and MB cases who started treatment but defaulted | Number of PB and MB cases who started treatment but defaulted | Number of leprosy cases (PB and MB) | 100 | |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 11.9 | % of leprosy cases released from treatment (RFT) | Number of leprosy cases (PB and MB) released from treatment | Number of leprosy cases (PB and MB) | 100 | |
| 11.10 | % of multi-drug resistant (MDR) leprosy cases | Number of MDR leprosy cases | Number of leprosy cases (PB and MB) | 100 | |
| 11.11 | % of relapse cases of leprosy | Number of relapse cases of leprosy | Number of leprosy cases (PB and MB) | 100 | |
| 11.12 | % of leprosy cases under rehabilitation | Number of leprosy cases under rehabilitation | Number of leprosy cases (PB and MB) | 100 | |

## 12. Curative Services

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| **A** | **OUTPATIENTS** | | | | |
| 12.1 | Number of outpatients | | | | **Type:** New, old<br>**Target group:** Ultra poor, Poor, FCHV, disabled, senior citizen |
| 12.2 | % of population utilizing outpatient services | Number of new outpatients | Total population | 100 | **Sector:** Govt., non Govt.<br>**Level of facility:** Higher level, district hospitals, PHCC, HP<br>**Type of facility:** AFHS facility, other HF<br>**Sex:** Female, male<br>**Caste/ethnicity**<br>**Target group:** Ultra poor, Poor, FCHV, disabled, senior citizen<br>**Age**: 0-9, 10-14 Yrs, 15-19 Yrs, >= 20 Yrs |
| 12.3 | Outpatient sex ratio | Number of new male outpatients | Number of new female outpatients | | **Level of facility:** Hospitals, PHCC, HP<br>**Target group:** Ultra poor, Poor, FCHV, disabled, senior citizen |
| 12.4 | % of outpatients who were referred in | Number of new outpatients who were referred in | Number of new outpatients | 100 | **Sex:** Female, male |
| 12.5 | % of outpatients who were referred out | Number of new outpatients who were referred out | Number of new outpatients | 100 | **Sex:** Female, male |
| 12.6 | % of top ten diseases among outpatients | Number of outpatients by top ten diseases | Number of new outpatients | 100 | **Ecological zone:** Mountain, Hill, Terai |
| **B** | **INPATIENTS** | | | | |
| 12.7 | % population utilising inpatient services at hospitals | Number of inpatient cases | Total population | 100 | **Sector:** Govt., non Govt.<br>**Level of facility:** Higher level hospitals, district hospitals<br>**Sex:** Female, male<br>**Target group:** Ultra poor, Poor, FCHV, disabled, senior citizen<br>**Age**: 0-9, 10-14 Yrs, 15-19 Yrs, >= 20 Yrs |
| 12.8 | Inpatient sex ratio | Number of male inpatients | Number of female inpatients | | **Sex:** Female, male |

| Code | Indicators | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| 12.9 | % of inpatients who were referred in | Number of inpatients who were referred in | Number of inpatients | 100 | **Sex:** Female, male |
| 12.10 | % of inpatients who were referred out | Number of inpatients who were referred out | Number of inpatients | 100 | |
| 12.11 | % of top ten diseases among inpatients | Number of inpatients by top ten diseases | Number of inpatients | 100 | |
| 12.12 | % of top ten diseases among population | Number of outpatients by top ten disease | Total population | 100 | |
| 12.13 | Average length of stay in hospital | Number of inpatient days stay | Number of inpatients who have been discharged | | **Level of hospital:** Higher level government hospital, district hospital |
| **C** | **EMERGENCY SERVICES** | | | | |
| 12.14 | % of population utilising emergency services at hospitals (Number at facility level and % at national level) | Number of people utilizing emergency services at hospitals | Total population | 100 | **Level of hospital:** Higher level government hospital, district hospital<br>**Sex:** Female, male |
| **D** | **HOSPITAL BEDS** | | | | |
| 12.15 | Number of hospital beds per 5,000 population | Number of hospital beds | Population | 5,000 | **Level of hospital:** Higher level government hospital, district hospital |
| 12.16 | Bed occupancy rate | Number of inpatient days | Number of inpatient beds available in hospitals x 365 days | 100 | **Level of facility:** District, zonal, sub-regional, regional, central |
| 12.17 | Number of maternity beds | | | | Annual |
| 12.18 | Maternity bed occupancy rate | Number of inpatient days in maternity ward | Number of inpatient beds available in maternity wards x 365 days | 100 | **Level of facility:** Higher level hospitals, district hospitals |
| 12.19 | Throughput of inpatients | Number of inpatient admissions | Number of inpatient beds available | 100 | **Level of facility:** Higher level hospitals, district hospitals |
| 12.20 | Hospital bed turnover rate | 365 – average length of stay | Throughput | 100 | **Level of facility:** Higher level hospitals, district hospitals |
| **E** | **MORTALITY** | | | | |
| 12.21 | Disease specific case fatality rate | Number of deaths, by disease | Number of cases of disease registered in the same year | 100 | |
| 12.22 | Hospital death rate, by duration of admission | Number of deaths in the hospital, by duration of admission | Number of inpatients | 100 | **Duration:** Within 48 hours, after 48 hours of admission |
| **F** | **SURGERY** | | | | |
| 12.23 | Infection rate among surgical cases | Number of infected surgical cases | Number of surgical cases | 100 | |
| 12.24 | Surgery related death rate | Number of deaths among surgical cases | Number of surgical cases | 100 | |
| 12.25 | Ratio of surgeons: surgeries | Number of surgeries | Number of surgeons | | |
| **H** | **DIAGNOSTIC SERVICES** | | | | |
| 12.26 | Average number of radiographic images per day | Number of radiographic images/x-rays | Number of days | | **Type:** X-ray, ultrasound, USG, MRI, CT Scan |
| 12.27 | Average number of laboratory tests per day | Number of laboratory tests | Number of days | | |

## 13. Health Facilities

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| A | CEONC | | | | |
| 13.1 | % of hospitals that are certified CEONC sites[a] | Number of hospitals that are certified CEONC sites | Number of hospitals | 100 | **Sector:** Govt., non Govt. **Level of facility:** Higher level hospitals, district hospitals |
| 13.2 | % of CEONC facilities providing all CEONC signal functions 24/7[a] | Number of CEONC facilities providing all CEONC signal functions 24/7 | Number of CEONC facilities | 100 | **Sector:** Govt., non Govt. **Level of facility:** Higher level hospitals, district hospitals |
| 13.3 | Number of CEONC facilities per 500,000 population[a] | Number of CEONC facilities | Total population | 500,000 | **Ecological zone:** Mountain, Hills, Terai |
| 13.4 | % of districts with at least one CEONC public facility [a] | Number of districts with at least one CEONC public facility | Number of districts | 100 | |
| 13.5 | % of districts with at least one public facility providing all CEONC signal functions[a] | Number of districts with at least one public facility providing all CEONC signal functions | Number of districts | 100 | |
| B | BEONC | | | | |
| 13.6 | % of district/district level hospitals and PHCCs that are certified BEONC sites[a] | Number of district/district level hospitals that are BEONC | Number of District and district level hospitals and PHCCs | 100 | **Level of facility:** District/district level hospitals, PHCCs |
| 13.7 | Number of BEONC facilities per 100,000 population[a] | Number of BEONC facilities | Total population (*100,000) | 100,000 | **Ecological zone:** Mountain, Hills, Terai |
| 13.8 | % of PHCCs providing all BEONC signal functions 24/7[a] | Number of PHCCs providing all BEONC signal functions | Number of PHCCs | 100 | **Availability:** 24/7, not 24/7 |
| C | BIRTHING CENTRES | | | | |
| 13.9 | % of PHCCs, health posts and sub-health posts that are certified birthing centers[a] | Number of PHCCs, health posts and sub-health posts that are certified birthing centers | Number of PHCCs, health posts and sub-health posts | 100 | **Level of facility:** PHCCs, HP **Availability:** 24/7, not 24/7 |
| D | SAFE ABORTION SITES | | | | |
| 13.10 | % of government health facilities that are certified safe abortion sites[a] | Number of government health facilities that are certified safe abortion sites | Number of government health facilities | 100 | **Level of facility:** Higher level hospitals, district hospitals, PHCCs, HPs **Method:** Surgical, medical |
| 13.11 | % of safe abortion (surgical and medical) sites with long acting family planning services[a] | Number of safe abortion (surgical and medical) sites with long acting family planning services | Number of safe abortion (surgical and medical) sites | 100 | **Level of facility:** Higher level hospitals, district hospitals, PHCCs, HPs **Method:** Surgical, medical |
| E | PHCCs | | | | |
| 13.12 | Number of PHCCs per 50,000 population[a] | Number of PHCCs | Population (* 50,000) | 50,000 | |
| 13.13 | % of PHCCs with long acting family planning services[a] | Number of PHCCs with long acting family planning services | Number of PHCCs | 100 | |
| F | HEALTH POSTS | | | | |
| 13.14 | Number of HPs per 5,000 population[a] | Number of HPs | Population (*5000) | 5,000 | |
| 13.15 | % of health posts with at least five family planning | Number of health posts with at least five family | Number of health posts | 100 | |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | methods[a] | planning methods | | | |
| 13.16 | % of health posts with long acting family planning services[a] | Number of health posts with long acting family planning services | Number of health posts | 100 | |
| G | HEALTH CLINICS | | | | |
| 13.17 | Number of urban health clinics | | | | |
| 13.18 | Number of community health clinics | | | | |
| G | REPORTING TO HMIS | | | | |
| 13.19 | % of health facilities (public and private) reporting to HMIS (by type or level) | Number of health facilities (public and private) reporting to HMIS | Number of health facilities (public and private) | 100 | **Sector:** Govt., non Govt. **Level of facility:** Higher level, district hospitals, PHCCs, HPs |
| 13.20 | % of tertiary and secondary hospitals (public and private) implementing ICD 10 and reporting coded information to HMIS | Number of tertiary and secondary hospitals implementing ICD 10 and reporting coded information to HMIS | Number of tertiary and secondary hospitals | 100 | **Level of facility:** Tertiary, secondary |
| 13.21 | % of health information systems implementing (using) uniform standard codes | Number of health information systems implementing (using) uniform standard codes | Number of health information systems | 100 | |
| **H** | **LABORATORY** | | | | |
| 13.22 | % of health facilities with a laboratory[a] | Number of health facilities with a laboratory | Number of health facilities, by level | 100 | **Availability:** 24/7, not 24/7 **Level of facility:** District Hospital, PHCC |
| **I** | **FAMILY PLANNING SERVICES** | | | | |
| 13.23 | % of health facilities providing IUCD services, by type of facility | Number of health facilities providing IUCD services | Number of health facilities | 100 | **Type of facility:** HPs, PHCCs and district clinics |
| 13.24 | % of health facilities providing Implant services, by type of facility | Number of health facilities providing Implant services | Number of health facilities | 100 | **Type of facility:** HPs, PHCCs and district clinics |
| **J** | **HIV/AIDS** | | | | |
| 13.25 | % of health facilities that provide HIV testing and counseling services[a] | Number of health facilities that provide HIV testing and counseling services | Number of health facilities | 100 | **Service:** Testing and counseling **Level of facilities:** Higher level, district hospitals, PHCC, HP |
| 13.26 | % of health facilities that provide PMTCT services[a] | Number of health facilities that provide PMTCT services | Number of health facilities | 100 | **Level of facilities:** Higher level, district hospitals, PHCC, HP |
| 13.27 | % of health facilities that provide ART services[a] | Number of health facilities that provide ART services | Number of health facilities | 100 | **Level of facilities:** Higher level, district hospitals, PHCC, HP |
| 13.28 | % of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug | Number of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug | Number of health facilities dispensing antiretroviral therapy | 100 | **Level of facilities:** Higher level, district hospitals, PHCC, HP |
| **K** | **Adolescence sexual and reproductive health services** | | | | |
| 13.29 | % of health facilities with adolescent friendly services[a] | Number of health facilities with adolescent friendly services | Number of health facilities | 100 | **Sector:** Govt., non govt. **Level of facility:** Higher level govt. hospitals, district hospitals, |

| Code | Indicator | Numerator | Denominator | Multiplier | Disaggregation by: |
|---|---|---|---|---|---|
| | | | | | PHCCs, HPs |

Note: a = Indicators to be reported annually.