Ministry of Health & Population
BUSINESS PLAN - 2012/2013

Ministry of Health & Population
Ram Shah Path, Kathmandu, Nepal
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MoHP is committed to continuing its efforts to strengthen financial management practices, particularly to facilitate the timely disbursement of grants to health offices and facilities, improvements in financial recording and reporting systems at all levels, and to strengthen procurement systems at central and district levels. We believe that this business plan provides pertinent information on this year's budget to assist with the preparation of future budgets. Once again we offer our special thanks to all who have contributed to preparing this important document.

Dr Padam Bahadur Chand
Chief
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LIST OF ACRONYMS

AA	anaesthesia assistant
ACSM	Advocacy, communication and social mobilisation
AD	auto-disable (syringes)
AHWs	auxiliary health workers
ANM	auxiliary nurse midwives
ART	anti-retroviral treatment
ARV	anti-rabies vaccine or antiretroviral
AWPB	annual work planning and budget
BCC	behaviour change communication
BEONC	basic emergency obstetric and neonatal care
CABA	children affected by AIDS
CAC	comprehensive abortion care
CB-IMCI	Community-Based Integrated Management of Childhood Illness programme
CB-NCP	Community-Based Newborn Care Programme
CEONC	comprehensive emergency obstetric and neonatal care
CHD	Child Health Division
CMAM	community-based management of acute malnutrition
COPE/PLA	client oriented providers / efficient participatory learning action
CPR	contraceptive prevalence ratio
DACC	district AIDS coordinating committees
DDA	Department of Drug Administration
DEC	Diethylcarbamazine citrate
DFID	Department for International Development
DHO	district health office/officer
DoHS	Department of Health Services
DOTS	Directly Observed Treatment Short Course
DPHO	district public health office
DUDBC	Department of Urban Development and Building Construction
e-AWPB	electronic annual planning and budgeting
EDCD	Epidemiology and Disease Control Division
EDP	external development partner
EOC	emergency obstetric care
EPI	Expanded Programme of Immunisation
FCHV	female community health volunteer
FHD	Family Health Division
FSW	female sex workers
FY	fiscal year

GAAP	Governance and Accountability Action Plan
GAVI	Global Alliance for Vaccines and Immunisation
GBV	gender based violence
GESI	gender equality and social inclusion
GIS	geographical information systems
GoN	Government of Nepal
HFMC	health facility operation management committee
HIIS	Health Infrastructure Information system
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency virus
HMIS	Health Management Information System
HSIS	Health Sector Information System
ICB	international competitive bidding
IEC	information, education and communication
IUCD	intrauterine contraceptive devices
IYCF	infant and young child feeding
KfW	Kreditanstalt für Wiederaufbau (German development bank)
LCD	Leprosy Control Division
LMD	Logistics Management Division
MCHC	maternal and child health care
MCHW	mother and child health worker
MD	Management Division
MDG	Millennium Development Goal
MLM	male labour migrants
MoHP	Ministry of Health and Population
MSM	men who have sex with men
NCASC	National Centre for AIDS and STD Control
NCB	national competitive bidding
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NNJS	Nepal Netra Jyoti Sangh
NNP	National Nutrition Programme
NPHL	National Public Health Laboratory
NPR	Nepali rupees
NSV	no-scalpel vasectomy
NTC	National Tuberculosis Centre
PAL	Practical Approach to Lung Health
PF	pooled funds
PHC	primary health care

PHC/ORC	primary health care outreach clinics
PHCC	primary health care centre
PHC-RD	Primary Health Care Revitalisation Division
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
SBA	skilled birth attendants/attendance
SN	staff nurses
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
VA	visual acuity
VDC	village development committee
VHW	village health worker
WHO	World Health Organisation

Exchange rate used in this report: US$ 1: NPR 75

CONTENTS

PART 1
INTRODUCTION

1 OBJECTIVES AND METHODOLOGY

1.1 Background

The Interim Constitution of Nepal, 2007 recognises health as a fundamental right of the people. To meet this obligation the Government of Nepal has committed to boosting spending in the health sector. The second Nepal Health Sector Programme (NHSP-2) 2010–2015 calls for the share of health spending in the total government budget to rise from around 7% in 2010/11 to 9.6% in 2014/15.

The Nepal Health Sector Programme (NHSP-2) and the Gender Equality and Social Inclusion (GESI) Strategy for the health sector require an improved annual work planning and budgeting process and the provision of equitable health services with respect to geographical area, gender, caste and economic condition. An enhanced annual work plan and budget for the health sector with a structured business plan is an essential foundation for more effective and efficient health service delivery.

1.2 Objective

The purpose of this business plan is to inform and involve policy makers and external development partners in the preparation and finalisation of the Ministry of Health and Population's (MoHP) budget, programme and strategies for fiscal year 2012/2013 (B.S. 2069/70, mid-July 2012 to mid-July 2013). This plan is a compilation of the policy and resource allocation decisions that determine the activities, programmes and services that will be delivered in fiscal year 2012/2013.

1.3 Methodology

Thirteen entities of MoHP (see Box 1.1) prepared initial drafts of their business plans and then developed and finalized them in consultation with:

- planning and finance officials of MoHP, departments, divisions and centres;
- representatives of external development partners and experts at joint consultative meetings (JCM).

This exercise was coordinated by MoHP's Policy, Planning and International Cooperation Division (PPICD). This document contains the separate business plans of the 13 MoHP entities: one department, seven divisions, four centres and Nepal Netra Jyoti Sangh.

Box 1.1: MoHP entities with business plans

1 Child Health Division (CHD)	8 National Centre for AIDS and STD Control (NCASC)
2 Family Health Division (FHD)	9 National Tuberculosis Centre (NTC)
3 Management Division (MD)	10 National Health Training Centre (NHTC)
4 Logistics Management Division (LMD)	11 National Health Education, Information and Communication Centre (NHEICC)
5 Primary Health Care Revitalisation Division (PHC-RD)	12 Department of Drug Administration (DDA)
6 Epidemiology and Disease Control Division (EDCD)	13 Nepal Netra Jyoti Sangh (NNJS).
7 Leprosy Control Division (LCD)	

The business plans provides information on the following subjects for each of the 13 entities for fiscal year 2012/2013:

- Annual budget
- Major activities
- Procurement
- Programme implementation strategies
- Targets
- Governance related activities
- Gender equality and social inclusion activities
- Requirements for technical assistance
- Constraints.

The above information was available for most of the entities although some of the information is not available for the Logistics Management Division as its work is all on behalf of other entities. Note that this is the first time that this exercise has been carried out and a number of lessons have been learned that should enable the collection of more comprehensive information in the next business plan.

This plan also includes the status of the implementation of NHSP-2's Governance and Accountability Action Plan (GAAP) (see Annex 1). This is included as budgetary information is not available separately for the implementation of the GAAP.

2 MOHP'S BUDGET 2012/2013

2.1 MoHP budget

Budget — MoHP has a budget of NPR 27.3 billion (US$ 369.9 million at $1: NPR 75) for fiscal year 2012/2013. Of this amount 16.9% is for capital expenditure and 83.1% for recurrent expenditure (see Table 2.1) while NPR 7 billion is for administrative costs (26%) and NPR 20.3 billion for development costs (74%).

Table 2.1: Budget allocation by capital and recurrent budgets (NPR '000)

Category	Budget	Percentage
Capital	4,602,040	16.86
Recurrent	22,687,241	83.14
TOTAL	**27,289,281**	**100**

Source: e-AWPB, MoHP

Budget allocation by level — The main budget authorities within MoHP are the Ministry of Health and Population itself, the Department of Health Services (DoHS), the Department of Drug Administration, health centres and hospitals, the Department of Ayurveda and alternative medicine facilities. These organisations have the authority to commit and disburse funds to implementing agencies such as district public health offices, district health offices (DPHO/DHOs) and hospitals. Table 2.2 shows that the majority of MoHP's funds are channelled through the Department of Health Services (69.1%).

Table 2.2: Budget allocation by level for 2012/2013 (NPR '000)

SN	Level	Amount	Percentage
1	Department of Health Services	18,865,667	69.1
2	Hospitals (central, regional, zonal, district and other)	2,960,653	10.8
3	Centres (NHTC, NTC, NCASC, NHEICC, NHLC)	2,651,045	9.7
4	Ministry of Health and Population	2,094,196	7.7
5	Department of Ayurveda	653,406	2.4
6	Department of Drug Administration	53,619	0.2
7	Alternative medicine facilities (Pashupati Homeopathic Hospital and Unani clinics)	10,695	0.04
	TOTAL	**27,289,281**	**100**

Total central and district budget — Sixty percent of funds are allocated to the district level with the balance of 40% allocated to the central level (Table 2.3). District level allocations include programme activities planned at the central level.

The district allocations have direct and indirect components. The indirect allocations are funds that are first allocated to the central level and then transferred on to the district level. The central level authorises DPHOs, DHOs and hospitals to procure drugs, family planning commodities and medical equipment using funds received from the central level.

Table 2.3: Budget allocation by central and district level (NPR '000)

Category	Amount	Percentage
Central level	10,870,515	39.8
District level	16,418,766	60.2
TOTAL	27,289,281	100

Budget sources — The health budget from domestic sources has steadily increased over the years. This illustrates the political commitment, support and state ownership of the health budget. The government plans to provide 56.5% and external development partners 43.5% of MoHP's budget in 2012/2013 (Table 2.4). Note that under NHSP-2 a number of external development partners (World Bank, DFID, AusAID, KfW and Global Alliance for Vaccines and Immunisation [GAVI]) are pooling their funds to provide budgetary support through the red book for MoHP to spend. These are the pooled funds (PF) referred to in subsequent tables are included under external development partner funding in Table 2.4).

Table 2.4: Health budget provision by Government of Nepal and external development partners (NPR '000)

Source	Budget	Percentage
Government of Nepal (GoN)	15,431,912	56.6
External development partners (EDP)	11,857,369	43.4
TOTAL	**27,289,281**	**100**

Budget for GAAP and GESI — MoHP is committed to fund the Governance and Accountability Action Plan (GAAP) and gender equality and social inclusion (GESI) activities. A number of central and district level activities are directed at advancing the GAAP and GESI strategies. However, MoHP is unable to provide an exact amount allocated for these important areas. MoHP is upgrading its electronic annual planning and budgeting system (e-AWPB), which will enable the description of budget allocation by NHSP-2 results framework, GAAP and GESI categories. The status of the implementation of the GAAP is presented at Annex 1.

2.2 Budgets of entities

Among the 13 entities the Management Division has the largest budget for 2012/2013 (Table 2.5).

Table 2.5: Budgets for 2012/2013 of the 13 MoHP entities with business plans

SN	Entity	NPR
1	Child Health Division	3,077,864,000
2	Family Health Division	3,000,280,000
3	Management Division	3,688,880,000
4	Logistics Management Division	1,053,510,000
5	Primary Health Care Revitalisation Division	1,550,925,000
6	Epidemiology and Disease Control Division	918,474,000
7	Leprosy Control Division	55,296,000
8	National Centre for AIDS and STD Control	689,194,500
9	National Tuberculosis Centre	1,262,818,000
10	National Health Training Centre	251,873,000
11	National Health Education, Information and Communication Centre	262,340,000
12	Department of Drug Administration	53,619.000
13	Nepal Netra Jyoti Sangh	61,610,000
	TOTAL	**15,878,464,500**

PART 2
INDIVIDUAL BUSINESS PLANS

3 CHILD HEALTH DIVISION

3.1 Background

The major objective of MoHP's Child Health Division (CHD) is to reduce under-five mortality, morbidity and disability and to improve the nutritional status of children and mothers among all social groups including the economically poor and socially excluded, and in all geographical locations. In order to achieve this goal, the division is implementing the following programmes:

- National Immunisation Programme (Expanded Programme of Immunisation — EPI)
- Community-Based Integrated Management of Childhood Illness and Newborn Care Programme (CB-IMCI and CB-NCP)
- National Nutrition Programme (NNP).

More detailed information on these programmes is available in the annual report of Department of Health Services and at www.dohs.gov.np.

3.2 Annual budget

The Child Health Division has a budget of NPR 3.1 billion (US$ 41 million at NPR 75:$1) for 2012/2013 (Table 3.1).

Table 3.1: Child Health Division budget for fiscal year (FY) 2012/2013 (NPR '000)

Programmes	Central Level			District Level			Central + district		
	GoN/PF	EDPs	Total	GoN/PF	EDPs	Total	GoN/ PF	EDPs	Total
EPI	332,939	630,694	963,633	165,050	251,983	417,033	497,989	882,677	1,380,666
NNP	298,332	516,028	814,360	198,400	23495	221,895	814,360	221,895	1,036,255
CB-IMCI and CB-NCP	106,083	232,500	338,583	280,160	42,200	322,360	386,243	274,700	660,943
TOTAL	**737,354**	**1,379,222**	**2,116,576**	**643,610**	**317,678**	**961,288**	**1,698,592**	**1,379,272**	**3,077,864**

3.3 Major activities

National Immunisation Programme

- Intensification of routine immunisation
- Polio immunisation campaign
- Measles-rubella immunisation campaign
- Strengthening cold chain and vaccine management
- Vaccine and logistic procurement
- Strengthening adverse events following immunisation (AEFI) surveillance
- Updating the micro-planning guidelines using evidence from the GESI perspective to help reach the unreached
- Running targeted immunisation campaigns to address the barriers to taking and completing the immunisation cycle.

Community-based Integrated Management of Childhood Illnesses (CB-IMCI)

- Maintenance of CB-IMCI and scale-up of community based newborn care (CB-NCP) activities
- Pilot reaching the unreached in the CB-IMCI programme using tools like vulnerability mapping and micro-planning.

National Nutrition Programme

- Scaling-up infant and young child feeding (IYCF), the community management of acute malnutrition, running nutrition rehabilitation homes, and distributing multiple micronutrient powders linked with infant and young child feeding prioritising districts with a high prevalence of nutrition-related problems
- Maintain and sustain micronutrient deficiency prevention and control, and run behaviour change communication and dietary diversification programmes to improve maternal nutrition.

3.4 Procurement

Table 3.2: Child Health Division planned procurement for FY 2012/2013 (NPR '000)

SN	Activities	Budget in '000 (NPR)
A. National Immunisation Programme		
1	Procurement of DPT, HEP B, Hib 10 doses & AD syringe & safety boxes	431,787
2	Procurement of vaccines (BCG, OPV, MR, Td, JE vaccines)	248,827
3	Procurement of vaccine carriers, cold boxes & safety boxes	81,692
4	Procurement of cold chain spare parts & refrigerators	35,735
5	Procurement of DPT, HEP B, Hib vaccines, AD syringes and safety boxes (GAVI co-financing)	33,215
6	Procurement of AD syringes & reconstitution syringes (BCG, MR & JE vaccines)	11,228
B. CB-IMCI and CB-NCP		
1	CB-IMCI/NCP equipment	130,323
2	CB-IMCI/NCP drugs	79,483
3	Consultancy services for CB-NCP programme	18,657
4	Printing of CB-IMCI/NCP materials	6,000
C. National Nutrition Programme		
1	Procurement of micronutrient powder	91,500
2	Procurement of drugs (vitamin A, albendazole, iron)	72,800
3	Consultancy services: (IYCF, school health & nutrition [SHN], and maternal & child health care [MCHC] programme coordinator)	30,580
4	Printing of nutrition training materials	6,000
5	Procurement of salter scales	1,565
TOTAL		**1,279,392**

The Child Health Division plans NPR 1.3 billion of procurement in 2012/2013 (Table 3.2) The largest planned expenditure is for the procuring of diphtheria (DPT), hepatitis B and Hib 10 vaccines and auto-disable (AD) syringes and safety boxes, accounting for 34% of all the division's procurement.

3.5 Programme implementation strategies

- Working in partnership.
- Selecting evidence-based interventions and operational strategies using the life-cycle approach.
- Using community-level approaches for social mobilisation and demand creation by revitalizing mothers' groups and female community health volunteers (FCHVs).
- Building the capacity of health providers to deliver child health services through on-site coaching, and on-the-job, in-service and pre-service training.
- Strengthening regional health directorates and identifying focal points for the child health programme at regional level for effective monitoring and supervision.
- Implementing effective supportive supervision and monitoring performance-based monitoring.
- Developing a 'national standards document' for child health to maintain uniformity of, and consistency in, the quality of services provided.
- Working with non-state actors to strengthen women's empowerment and enhance men's support for improving the health and nutritional status of children and mothers.

3.6 Targets

The achievements and targets for child health in Nepal are given in Tables 3.3, 3.4 and 3.5.

Table 3.3: Achievements and targets for child health (1996 to 2015)

SN	Indicator	1996	2001	2006	2011	2013	2015 (Target)
1	Under five mortality rate (per 1,000)	118	91	61	54	47	38
2	Infant mortality rate (per 1,000)	79	64	48	46	38	32
3	New born mortality rate (per 1,000)	50	43	33	33	23	16
4	One year old children fully immunized (%)	43	66	83	87	90	90
5	% of children under five years of age, who are stunted		57	49	41	35	28
6	% of children under five years of age who are underweight	49	43	39	29	34	29
7	% of children under five years of age who are wasted		11	13	11	7	5

Table 3.4: Achievements and targets for outcome indicators of child health

SN	Indicator	Baseline		2011	2013	2015 (Target)
		Year	%			
1	% children under 12 months of age immunized against DPT3 (Penta) and measles (or fully immunized as per HMIS scale up) disaggregated by wealth quintiles and caste/ethnicity	2006	83%	87%	85% (90%)	85% (90%)
2	% children under 5 with diarrhoea treated with zinc and oral rehydration salts	2009	7%	7%	25%	40%
3	% children under 5 with pneumonia, who received antibiotics	2009	29.2%	30%	40%	50%
4	% women of reproductive age (15 – 49) having under two years children aware of at least three danger signs of new-born	-	-	-	60%	70%

Table 3.5: Child health output targets for 2012/2013

SN	Output	Coverage
1	Achieve and sustain > 90% coverage of full immunisation of children ensuring equitable coverage	Nationwide
2	Implement measles-rubella (MR) campaign with > 95% evaluated coverage	60 districts
3	Complete National Immunisation Day (NID) with > 95% evaluated coverage	75 districts
4	Strengthen adverse events following immunisation (AEFI) surveillance and strengthen the management of this programme	75 districts
5	Develop a cold chain replacement plan and make available	
6	Expand CB-NCP	From current 35 to 41 districts
7	Run CB-NCP community level training and post-training follow up	5 districts
8	Run CB-IMCI/CB-NCP training for newly recruited health workers	100 persons
9	Carry out CB-IMCI/CB-NCP focal person reviews	75 districts
10	Run CB-IMCI referral training for doctors and health workers	80 persons
11	Scale up community-based management of acute malnutrition (CMAM)	from 5 to 13 districts
12	Scale up infant and young child feeding (IYCF)	from 19 districts to 36 districts (additional 17 districts)
13	Review and provide refresher training on the Iron Intensification Programme	5 regions and 75 districts
14	Collect evidence from the pilot programme on approaches that ensure access to IMCI services by vulnerable children	National

3.7 Governance-related activities

The governance related activities of the Child Health Division are as follows:

- Regular programme monitoring in collaboration with health facility management committees (HFMCs).
- The development of annual work plans with time-lines and outputs by each district.
- Develop community health worker review monitoring guidelines.
- Increase government and non-government interaction for joint planning and effective implementation and monitoring, supervision and evaluation of programmes.

3.8 Gender equality and social inclusion activities

The GESI activities of the Child Health Division are as follows:

- Select districts for programme implementation based on the existing health status of communities, and to reach the unreached.
- Intensively monitor and supervise selected districts according to their performance including providing services to the unreached.
- Run a vulnerability mapping and micro-planning pilot programme.
- Run a pilot programme to increase Vitamin A coverage among 6-11 months infants in three low coverage districts including urban areas.
- Distribute multiple micronutrient powders for children under 5 years of age.
- Treat global acute malnutrition (GAM) and severe acute malnutrition (SAM) through the gradual scaling up of community-based management of acute malnutrition (CMAM) and nutrition rehabilitation homes (NRH) in areas where GAM and SAM rates are high.
- Run social marketing and mobilisation campaigns in two low coverage districts (Doti and Achham) to promote the consumption of the 2 child logo iodized salt.
- Implement MCHC programme in 47 VDCs of 9 food insecure districts.
- Pilot the weekly supplementation of iron-folic acid (IFA) tablets for female adolescents for preventing and controlling anaemia.

3.9 Technical assistance requirements

The Child Health Division needs technical assistance to:

- improve the quality of training in IYCF and CB-NCP;
- integrate CB-IMCI and CB-NCP based on findings of the CB-NCP assessment; and
- intensify routine immunisation especially to increase demand for vaccination.

3.10 Constraints

The main constraints facing the Child Health Division are as follows:

- The funding gap to conduct the national polio campaign. Though the Government's financial commitment is still upheld, World Health Organisation/UNICEF financial support to conduct the National Immunisation Day (NID) is decreasing. The budget proposed for National Immunisation Day from WHO/UNICEF source has yet to be secured.

- The upgrading of many community health workers to auxiliary health workers (AHWs) has seen many of them becoming reluctant to continue the work they did as community health workers.
- The questionable quality of training on IYCF and CB-NCP in the existing contracting-out system. Need to evaluate training and act to improve it.
- The slow scale-up of nutrition interventions especially for IYCF, CMAM, micro-nutrient programme (MNP) and CB-NCP due to limited resource and capacity of the Child Health Division.
- Weak monitoring and supervision at all levels with poor use of available data.
- Fragmented packages designed and implemented for a continuum of care by different divisions with poor coordination.
- Inadequate resources to reach the unreached, especially the most excluded, both in terms of funding and staff time.
- Skills, competencies and health worker motivation constraints to address GESI.

4 FAMILY HEALTH DIVISION

4.1 Background

The core objective of the Family Health Division (FHD) is to reduce maternal and neonatal mortalities and morbidities and improve the health status and overall quality of life of families, including poor and excluded families.

The major areas of work of the Family Health Division are as follows:

- **Safe motherhood and newborn health** — Reducing maternal and neonatal mortalities by addressing complications of pregnancy and childbirth for all women, including poor and excluded women, which lead to morbidity, death and disability.
- **Safe abortion services** — Making available comprehensive abortion care (CAC) to terminate unwanted pregnancies through safe techniques with effective pain management and post-procedure family planning information and services to avoid further unwanted pregnancies.
- **Family planning** — As delivered through the National Family Planning Programme to improve the health status of mothers and children and the quality of life of families by fulfilling the family planning needs of individuals and couples, including those who are poor and excluded.
- **Adolescent and sexual reproductive health** — As delivered through the National Adolescent and Sexual Reproductive Health (ASRH) Programme to create a conducive environment in public health facilities for adolescents to access adolescent reproductive health services.
- **Female community health volunteers** (FCHV) — Supporting the achievement of national health goals through community involvement in public health activities that includes imparting knowledge and skills for women's empowerment, increasing awareness on health related issues and the involvement of local institutions in promoting health care.
- **The primary health care outreach clinics** — These PHC/ORC improve access to basic health services, including family planning and safe motherhood, for rural households.

4.2 Annual budget

Table 4.1: Family Health Division budget FY 2012/2013 (NPR '000)

SN	Major programmes	Central Level			District			Central and district		
		GoN/PF	EDPs	Total	GoN/PF	EDPs	Total	GoN/PF	EDPs	Total
1	Safe motherhood	26,900	29,600	56,500	1,451,360	25,100	1,476,460	1,478,260	54,700	1,532,960
2	Family planning	379,636	8,320	387,956	83,863	30,480	114,343	463,499	38,800	502,299
3	FCHV & PHC outreach clinics (ORCs)	2,900	0	2,900	427,601	19,331	446,932	430,501	19,331	449,832
4	Uterine prolapse	175,000	0	175,000	43,200	0	43,200	218,200	0	218,200
5	Capital expenditure*	65,049	10,290	75,339	96,500	1,450	97,950	161,549	11,740	173,289
6	Prog. orientation, training, M&E, research, printing	42,960	33,535	76,495	29,985	6,080	36,065	72,945	39,615	112,560
7	Adolescent reproductive health	1,200	0	1,200	9,940	0	9,940	11,140	0	11,140
	TOTAL	**693,645**	**81,745**	**775,390**	**2,142,449**	**82,441**	**2,224,890**	**2,836,094**	**164,186**	**3,000,280**

Note*: Capital budget includes equipment, computers and physical improvements.

The Family Health Division has a budget of NPR 3 billion (US$ 40 million) for 2012/2013 (Table 4.1). Over a half of the 2012/13 budget is allocated for safe motherhood.

4.3 Major activities

The following are the planned major activities for 2012/2013 of the Family Health Division.

Family planning

- Carry on implementing the voluntary surgical contraception (VSC) programme in 75 districts, including mobile clinics in underserved areas.
- Promote the spacing method of family planning through health institutions and satellite clinics in 3-5 facilities per district in all 75 districts including unreached areas.
- Provide post-partum family planning counselling and services in 10 districts at community level.
- Build safe birth attendance capacity through on-site coaching on intrauterine contraceptive devices (IUCD).
- Increase access to family planning information and services for rural and marginalised communities in 10 low contraceptive prevalence ratio (CPR) districts, covering women and men.
- Carry out micro-planning in 3 low CPR districts and implement specific interventions to address identified issues.
- Pilot the integration of family planning services into Expanded Programme of Immunisation (EPI) clinics.

Safe motherhood

- Strengthen comprehensive emergency obstetric and neonatal care (CEONC) funds to provide the human resource needs at 26 CEONC sites.
- Contract 1,200 auxiliary nurse midwives (ANM) and 60 staff nurses to provide delivery services in birthing centres, with a special effort to reach unreached areas.
- Train 1,000 skilled birth attendants (SBA) through the National Health Training Centre (NHTC).
- Prevent post-partum haemorrhages in home births using misoprostol in 28 districts (two new districts in 2012/13).
- Expand comprehensive abortion care (CAC) services (manual vacuum aspiration [MVA] and medical abortions) to primary health care centres (PHCC) and expand medical abortion to selected birthing centres in health posts in 21 districts (expanding from 16 districts).
- Provide free blood transfusion for maternal complications.
- Continue the Aama programme in all 75 districts, including in 54 private institutions, with revised implementation guidelines.
- Strengthen referral funds for emergency obstetric care (EOC) in 14 districts where CEONC services are not available.

Adolescent sexual and reproductive health

This programme is being scaled up under the National ASRH Programme Implementation Guide (2011) at the rate of at least 13 health facilities per district so as to meet the NHSP-2 national target of 4,000 such health facilities by 2015.

Activities planned In 2012/2013 include:

- Expand ASRH activities in 16 new districts (in addition to the existing 35 districts).
- Orientate stakeholders on the programme at different levels.
- Provide logistical support to make health facilities more adolescent-friendly (equivalent to at least NPR 10,000 per facility).

Female community health volunteers

- Continue biannual FCHV review meetings.
- Continue providing NPR 10,000 to the FCHV fund in each village development committee.
- Reactivate mothers' health groups, especially in the mid-west and far west regions.
- Update computerised FCHV profiles in all 75 districts.
- Continue celebrating FCHV Day.
- Continue to provide an annual uniform allowance of NPR 4,000 to FCHVs.
- Provide NPR 10,000 to 60 years and older FCHVs who choose to withdraw voluntarily.

Primary health care outreach clinics

- Supply PHC/ORC kits to 1,305 clinics.
- Provide orientations to communities for re-activating PHC/ORCs in 1,305 clinics.

Uterine prolapse and cervical cancer screening

- Continue to screen women for prolapsed uterus nationwide.
- Carry out the surgical management of prolapsed uterus in regional and zonal hospitals, selected districts and private hospitals and at camps.
- Provide counselling and orientation for men and family decision-makers (of different social groups) on the causes of uterine prolapse.
- Build the capacity of four zonal and regional hospitals for screening and managing cervical cancer cases (with technical assistance from WHO/UNFPA).
- Provide training, coaching and mentoring to strengthen staff capacity to address gender equality and social inclusion (GESI) issues in all activities.

Demography and research

- Conduct further analysis of data from the national census 2011 on maternal mortality with disaggregation.
- Carry out a study of safe abortion and medical abortion in four districts.
- Carry out a study on the effects of gender based violence on the reproductive health of women.

4.4 Procurement

The Family Health Division has planned for NPR 384 million worth of procurement in 2012/13 (Table 4.2) for safe motherhood, safe abortion and family planning. The procurement of implant contraceptives is the single largest category. Note that the Logistics Management Division (LMD) procures and distributes these commodities and equipment as per programme need. Almost all of the procurement is funded by the Government of Nepal (GoN)/pooled fund (PF).

Table 4.2: FHD planned procurement for fiscal year 2012/2013 (in '000)

SN	Activities	Central Level			District			Total (central and district)		
		GoN/PF	EDPs	Total	GoN/PF	EDPs	Total	GoN/PF	EDPs	Total
A. Safe motherhood										
1	Equipment for birthing centres	41,900	0	41,900	75,000	1.450	76,450	11,6900	1,450	118,350
2	Equipment for CEOC	10,000	0	10,000	12,000	0	12.000	22,000	0	22,000
3	Misoprostol	7,500	0	7,500	0	0	0	7,500	0	7,500
4	Medical abortion drugs	5,100	0	5,100	0	0	0	5,100	0	5,100
5	Manual vacuum aspiration kits	4,000	0	4,000	0	0	0	4,000	0	4,000
6	2nd trimester equipment for comprehensive abortion care (CAC)	720	0	720	0	0	0	720	0	720
7	Equipment for BEOC	0	0	0	0	0	0	0	0	0
B. Family planning										
1	Implant	151,200	0	151,200	0	0	0	151,200	0	151,200
2	Depo Provera	94,400	0	94,400	0	0	0	94,400	0	94,400
3	Condoms	89,000	0	89,000	0	0	0	89,000	0	89,000
4	Contraceptive pills	36,800	0	36,800	0	0	0	36,800	0	36,800
5	Equipment for vasectomies (VSC)	3,000	0	3,000	0	0	0	3,000	0	3,000
6	IUD kits	0	0	0	2,250	0	2250	2,250	0	2,250
7	Implant kits	0	0	0	2,250	0	2250	2,250	0	2,250
8	Minilap kits	2,000	0	2,000	0	0	0	2,000	0	2,000
9	IUCDs	1,866	0	1,866	0	0	0	1,866	0	1,866
10	No-scalpel vasectomy (NSV) kits	1,500	0	1,500	0	0	0	1,500	0	1,500
11	Virex	220	0	220	0	0	0	220	0	220
Total budget		**379,986**	**0**	**379,986**	**91,500**	**1,450**	**4,500**	**384,486**	**1,450**	**384,486**

4.5 Programme implementation strategies

FHD's strategies for implementing its programmes are as follows:

- Targeted approaches to address low CPR and inadequate institutional delivery, focusing on underserved areas and unreached population
- Expanding and strengthening institutional services and outreach services to increase access to services.
- Increasing demand though mass media and mobilisation of FCHVs and mothers health groups.
- Running satellite clinics and mobile camps in remote and underserved areas.
- Selecting sites for birthing centres and other facilities in underserved areas.
- Working with non-state partners at central and local levels.
- Promoting women's empowerment and working with men on reproductive health issues of women and adolescents.
- Monitoring and research to collect evidence to inform programming.

4.6 Targets

The findings of the National Demographic Health Surveys (NDHS) show very good progress on family-health indicators between 1996 and 2011 (Table 4.3). However, considerable work still needs doing to meet the MDG targets by 2015.

Table 4.3: Family health achievements and targets (1996 to 2015)

SN	MDG Indicator	Achievements				Target	MDG target
		1996 NDHS	2001 NDHS	2006 NDHS	2011 NDHS	2013	2015
1	Maternal mortality ratio (per 100,000)	539	415	281	170 (WHO 2010)	192	134
2	Total fertility rate (per women of child bearing age)	4.6	4.1	3.1	2.6	2.8	2.5
3	Adolescent fertility rate (per per 1,000 women aged 15-19)	127	110	98	81	85	70
4	Neonatal mortality rate (per 1,000)	50	43	33	33	23	16
5	CPR (modern methods) %	29	39	48	43	52	67
6	% of pregnant women attending at least 4 antenatal clinic (ANC) visits					65	80
7	Postnatal care (PNC) coverage (3 visits during postnatal period as % of expected live births)					43	50
8	% of deliveries by SBAs	9	11	19	36	40	60
9	Institutional deliveries (%)	8	9	18	35	35	40
10	Caesarean section rate (%)	-	1	3	4.6	4.3	4.5
11	Met need of EOC service (%)					43	49
12	% women who received post-abortion contraceptives				55	60	60

The projected outputs of the Family Health Division for 2013 and 2015 are given in Table 4.4. It will be a major challenge to achieve many of the outputs needed for achieving the 2015 MDG targets.

Table 4.4: Family health outputs for 2012/2013

SN	NHSP-2 Output Indicators	Achieved 2011	Target 2013	MDG target 2015
1	Number of health facilities providing adolescent-friendly health services	455 FHD	500	1,000
2	Number of production and deployment of SBA through NHTC	3,500	6,000	7,000
3	Number of additional FCHVs in mountain regions and remote districts		52,000	53,513
4	% of districts with at least one facility providing all CEONC signal functions	57.3	68	76
5	% of PHCCs providing all basic emergency obstetric and neonatal care (BEONC) signal functions	53.6	50	60
6	% of health posts with a birthing centre 24/7	79	>80	>80
7	% of safe abortion (surgical and medical) sites with long acting family planning services		>90	>90
8	% of health posts with at least five family planning methods	13	35	60
9	% of budget allocated to district and below facilities (including flexible health grants)		65	70

4.7 Governance-related activities

FHD's governance related activities for 2012/2013 are as follows:

- Carrying out micro-planning with key stakeholders.
- Revising and disseminating the Aama guidelines.
- Disseminating programme guidelines to establish standard operating procedures.
- Promoting health facilities to carry out social audits through the Primary Health Care Revitalisation Division (PHC-RD).
- Promoting health facilities to maintain citizen's charters.
- Strengthening the capacity of health facility management committees (HFMCs).

4.8 Gender equality and social inclusion activities

FHD's GESI-related activities for 2012/2013 are as follows:

- Continuing the Aama programme.
- Identifying unreached groups and underserved areas and supporting their use of contraceptives and institutional delivery.
- Micro-planning in low contraceptive prevalence districts.

- Counselling and orientation of men and family decision makers (of different social groups) on the causes of uterine prolapse (technical assistance).
- Activities with adolescents, uterine prolapse cases and on cervical cancer.
- Training, coaching and mentoring to build the capacity of health facility staff to address GESI issues in all activities (with the National Health Training Centre).

4.9 Technical assistance requirements

FHD's needs for technical assistance in 2012/2013 are as follows:

- For monitoring the Aama programme.
- For micro-planning in underserved areas.
- For research on overcrowding in hospitals and further analysis of demographic and health survey 2011 data on reproductive health.
- To carry out a study on the effects of gender based violence on women's reproductive health.
- For building the capacity among health personnel for screening and managing cervical cancer.
- To carry out social mobilisation work with men, communities and families, especially in underserved areas and unreached groups for improved reproductive health.

4.10 Constraints

The many constraints of the Family Health Division are as follows:

Service provision

- Inadequate capacity to strengthen referral systems.
- The inadequate and often untimely supply of equipment and commodities.
- The inappropriate location of some health facilities.
- Inequality in the use of family planning and delivery services: urban/rural, rich/poor, Tarai/mountainous, and between ethnic and caste groups.
- Fulfilling the family planning needs of adolescents, post-partum women, post abortion women, migrants, rural people, poor people and disadvantaged ethnic groups.
- The integration of family planning into maternal and child health (MCH), HIV/AIDS and other health services.
- The NDHS 2011 finding of the increased use of traditional contraceptive methods.
- Inadequate intensive demand creation/community mobilisation activities to bridge the demand–supply gap.
- Health service recording and reporting is yet to be fully incorporated in the Health Management Information System (HMIS).

Health facility staffing

- Inadequate key service providers at CEONC sites.

- Yearly contracts of medical doctors-general practitioners (MDGP), staff nurses (SN), anaesthesia assistants (AA), auxiliary nurse midwives (ANM) limit round year services and increase transaction costs.
- The attitude and behaviour of some health workers.
- The frequent staff transfers that hamper the smooth running of programmes.
- Limited staff skills and motivation to address specific issues of marginalised groups of people.

FCHVs

- The increasing demands of FCHVs and their affiliation with the FCHV trade union. As more community-based programmes are being carried out through FCHVs, the expectations of FCHVs have increased, which could adversely affect the voluntary nature of their services.
- The effective utilisation of FCHV funds is a challenge. With more money being channelled in this way, its effective utilisation as per government guidelines is a major challenge as it requires large resources to train volunteers and effective and supportive monitoring by local health facilities.
- The FCHV programme is a cross-cutting programme used by many health and non-health programmes. However, there is a lack of coordination which challenges the maintenance of the voluntary FCHV spirit.

5 MANAGEMENT DIVISION

5.1 Background

The Management Division (MD) is one of the major wings of the Department of Health Services. It is responsible for planning, information management, coordination, supervision, monitoring and evaluation of health programmes and the quality assurance of health services. The division is also responsible for monitoring the delivery of quality health services through non-governmental health institutions and for monitoring building construction and the maintenance of public health institutions. The division also supports the maintenance of medical equipment.

The major programme areas of the Management Division are:

- programming, budgeting, building construction and maintenance;
- programme monitoring and evaluation;
- running the Health Management Information System (HMIS);
- the quality assurance of health services; and
- other programmes (oral health, mental health, and nursing leadership programmes).

More information on these programmes is available in the annual report of the Department of Health Services and at www.dohs.gov.np.

5.2 Annual budget

The Management Division has a budget of NPR 3.6 billion (US$ 49 million) for 2012/2013 (Table 5.1), the large majority of which is provided by the Government of Nepal/pooled funding (PF).

Table 5.1: Management Division budget for 2012/2013 (NPR '000)

	Central Level			District Level			Central + District		
	GoN/PF	EDPs	Total	GoN/ PF	EDPs	Total	GoN/ PF	EDPs	Total
2012/2013	123,080	67,250	190,330	3,498,550	0	3,498,550	3,621,630	67,250	3,688,880

5.3 Major activities

HMIS and M&E

The major planned activities for 2012/2013 for improving and strengthening the Health Management Information System (HMIS) and monitoring and evaluation are as follows:

- Regular monitoring and reviews at national, regional, district and below district level, and the production of annual reports.
- Printing and distributing recording and reporting forms and monitoring profiles for all types of health facilities through the Logistics Management Division (LMD).
- Further improvements to, and the integration of, HMIS with other information systems and the continued piloting of the Health Sector Information System (HSIS).
- Carrying out the health facility mapping survey (health GIS) and promoting its use in programme monitoring and evaluation.

- Training and orientation on HMIS for health staff.
- Upgrading facilities for networking and communications using the internet.
- Data verification and validation at below district level and data verification at the regional level.
- Continuing to run the Performance Based Management System (PBMS) of health personnel.
- The reporting of health service data disaggregated by age, gender, caste, ethnicity and religious minority is being initiated in core programme areas in 17 districts.

Physical infrastructure

The major planned activities for expanding the coverage of health facility physical infrastructure more equitably to meet the needs of all citizens are as follows:

- Strengthen, institutionalise and decentralise the existing Health Infrastructure Information System (HIIS).
- Implement standard designs and guidelines that help to increase the quality, accountability and transparency of health facilities.
- Build suitable health infrastructure in, and for, deprived geographical locations, communities, ethnic groups and for women.
- Support the repair and maintenance of health facility equipment in the Mid and Far Western regions through the KfW-supported Physical Assets Management (PAM) unit.
- Support the repair and maintenance of existing facilities through more rational budgeting using HIIS. Develop and implement repair and maintenance guidelines for the rational implementation of repair and maintenance budgets to support timely repair and maintenance and prioritise the optimal use of resources.
- Promote community participation and enhance local ownership of public facilities.
- Develop and institutionalise a more rationale planning cycle for infrastructure development.
- Improve site selection and land development processes when developing new health facilities. Previous practices sometimes resulted in high development costs and sites with poor accessibility for clients.

Waste management

Address health facility waste management through the following activities in 2012/2013:

- Develop and publish a health facility waste management training manual.
- Support the construction of waste management facilities in health facilities that use appropriate technologies.
- Support the provision of logistics for better waste management.
- Run awareness, orientation and training courses including training of trainers programmes on waste management for staff at all levels of health facilities, and for users and communities.
- Develop awareness materials and provide orientation on the dangers of mercury.
- Hire consultants to design waste management systems in hospitals.
- Provide training and follow-up on community based mental health for health facility staff in 19 districts.

- Run appreciative enquiry based service orientation for nurses.
- Provide training to health directors and managers.
- Train health workers on oral health in 10 districts.

5.4 Procurement

The total procurement budget of the Management Division for 2012/2013 is NPR 3.7 billion. The largest item of expenditure in is on-going works through the Department of Urban Development and Building Construction (DUDBC), which accounts for 80% of all procurement expenditure. By programme area 91% of the budget is for physical infrastructure development, repair and maintenance (Table 5.3).

Table 5.2: Management Division planned procurement for 2012/2013 (NPR in '000)

SN	Types of expenditure	NPR in '000
1	Procurement of works through Department of Urban Development & Building Construction (DUDBC)	
	On-going	2,934,000
	New	180,000
2	Monitoring, review and reporting	173,500
3	Capacity building (orientation, workshop, training)	121,280
4	Building repair and maintenance	90,000
5	Hospital instrument equipment maintenance support programme	41,600
6	Procurement of works to district directly by Management Division	36,000
7	Procurement of furniture and logistics for office administration	25,150
8	Printing and publishing	19,050
9	Operation and maintenance	16,000
10	Procurement of services	14,000
11	Procurement of works directly by the Management Division	3,500
12	Construction of support services at health facilities	3,500
	TOTAL	**3,688,880**

Table 5.3: Management Division budget by programme areas (NPR '000)

SN	Programmes	District level Implementation	Central Level Implementation	Total
1	Physical infrastructure development, repair and maintenance	3,288,500	56,600	3,345,100
2	HMIS	112,050	81,380	193,430
3	Monitoring and evaluation	67,000	23,800	90,800
4	Operation and maintenance of health facilities		16,000	16,000
5	Oral health		12,000	12,000
6	Quality assurance	15,000	3,800	18,800
7	Mental health		7,850	7,850
8	Nursing		4,900	4,900
	TOTALS	**3,482,550**	**206,330**	**3,688,880**

5.5 Programme implementation strategies

The main programme implementation strategies of the Management Division for 2012/2013 are:

- monitoring reviews and planning at local, district, regional and national levels;
- carrying out need-based and evidence-based planning and implementation;
- private sector participation in delivering health services;
- community partnership in health service delivery including reaching the unreached;
- gender equality and social inclusion in health service delivery; and
- quality assurance of health services.

5.6 Targets

Table 5.4: Impact and outcome achievements and targets of the Management Division

SN	Indicator	Baseline		2011	2013	2015
		year		achieved	(target)	(target)
1	Utilisation of essential health care services (outpatient, inpatient, especially deliveries and emergency) by targeted groups, and disadvantaged castes and ethnicities at least proportionate to their populations by 2015			90%	90%	90%
2	% of clients satisfied with their health care at district facilities among targeted groups, and disadvantaged castes and ethnicities by 2015	2008	68.4%	68%	74%	80%
3	% of PHCCs that provide BEOC, including safe abortion care (SAC) and at least 5 family planning methods	2007/08	1 BEOC site, 46 under construction, 15 planned	23%	50%	70%
4	% of health posts that operate 24/7, including delivery services and at least 5 family planning methods			45%	60%	70%

The achievements and targets for the main impact and outcome indicators related to the work of the Management Division are presented in Table 5.4.

The main planned outputs of the Management Division for 2012/2013 are as follows:

Building construction

- Complete all on-going civil works (561) from last fiscal year being implemented through DUDBC.
- Complete tendering for all international competitive bidding (ICB) for civil works above the threshold of US$ 1 million and initiate all ICB civil works.
- Complete bidding process and contract signing for building 50 health posts, 25 birthing centres, 2 district stores, 5 primary health care centres, 25 quarters and 10 BEOC centres proposed for 2012/2013.
- Complete and call ICB tenders for all district hospitals proposed for fiscal year 2012/2013.
- Endorse standard designs that suit different ecological zones for health posts, PHCCs and district hospitals.
- Update and upgrade the Health Infrastructure Information System (HIIS) and make it GIS- and web-based. Link physical and financial progress in the HIIS system.
- Publish standard bidding documents for ICB and national competitive bidding (NCB) works and provide orientations on them to DUDBC staff and officials.
- Identify and expand health services focused on underserved locations, with more attention to identifying optimal locations for serving poor and excluded people in 20 districts.
- Upgrade 500 sub-health posts to health posts based on need assessments.

Information management

- Support all DPHOs/DHOs to prepare, publish and disseminate annual reports with district health profiles.
- Contract out 70 computer operators for DHO/DPHOs.
- Facilitate the production of disaggregated data and reporting on social inclusion and backward communities in 17 districts.
- Update the health GIS system at central level.
- Carry out micro level HMIS data analysis for planning, monitoring and evaluation in 45 districts.
- Expand computer networking in 25 DPHOs/DHOs and install internet services in 33 hospitals.
- Update HMIS records and publish annual and trimester reports.
- Complete health facility and service mapping surveys in 18 districts.

Other

- Facilitate and carry out planning, monitoring and evaluation and integrated monitoring in all 75 districts.
- Train primary health care workers (PHCWs) on basic oral health care, including extraction and simple fillings in 10 districts.

5.7 Governance related activities

The following governance related activities will be carried out by the Managements Division in 2012/2013:

- Preparing the DoHS annual report in a participatory way and widely distributing it and making it available on the DoHS website.
- Producing periodic reports of HMIS data and distributing hard and soft copies to stakeholders in and providing access to databases for divisions, centres, regions and districts.
- Web-based reporting by health facilities.
- Evidence based planning and monitoring at district level using HMIS, other information systems and GIS.
- Expanding the performance based evaluation system.
- Continuing support for e-bidding for procurement and construction contracts for better competition and transparency.
- Supporting the formation of local bodies and HFMCs responsible for the construction and maintenance of infrastructure at the local level for community participation and ownership.

5.8 Gender equality and social inclusion activities

The planned GESI activities of the Management Division for 2012/2013 are as follows:

- Train and orientate health care providers on GESI.
- Build health facilities at locations most likely to increase access by poor, vulnerable and marginalised people to health services.
- Identify and expand health services focused on underserved locations, with increased attention to the optimal locations for serving the catchment areas of poor and excluded people in 20 districts.
- Incorporate gender equality social inclusion dimensions in the standard designs of health facility buildings.
- Manage disaggregated data and reporting on social inclusion and backward communities in 19 districts.
- Revise and update integrated supervision guidelines and tools from the GESI perspective.
- Revise and update tools for district, regional level planning, monitoring and review from the GESI perspective.
- Conduct integrated programme supervision from the GESI perspective.

5.9 Technical assistance requirements

The main technical assistance requirements of the Management Division for 2012/2013 are for:

- strengthening, institutionlising and decentralising the Health Infrastructure Information System (HIIS).
- developing standard designs and associated guidelines for health facility buildings.
- developing tools and mechanisms for ensuring sufficient number of and appropriately located health facilities.

- implementing a predictable and timely financing budgeting and resource allocation mechanism.
- ensuring the repair and maintenance of health facilities through more rational budgeting and the preparation of repair and maintenance implementation, monitoring and reporting guidelines.
- promoting community participation and enhancing the local ownership of public facilities.
- scaling-up and strengthening the Health Sector Information System (HSIS).
- building capacity for health information management at all levels.
- GIS-based planning, monitoring and evaluation at all levels.
- health facility mapping (GIS) and institutionalization.
- preparing procurement plans and progress reports and standard bidding documents; and
- improving the e-bidding system.

5.10 Constraints

The main constraints for further improving and strengthening the HMIS are as follows:

- The HMIS is not directly linked to financial, human resource, or logistic management information and other systems.
- How to cover non-public health facilities.
- Building the capacity of information managers at all levels to cope with new technologies and methods.
- The implementation of HSIS for comprehensive information on the health system.

Other constraints:

- Lack of appropriate technicians at the Management Division hinders the monitoring and evaluation of health infrastructure. Also, the fragile political situation causes construction works to often be delayed and DUDBC to be frequently approached for contract extensions.
- Many existing sites for the construction of health facilities are not suitably located or are too small in area. Also, in many cases ownership lies with a different entity.
- The policy to develop health facilities only on donated lands, which in many instances makes building construction more costly and time consuming.
- Inadequate data on health human resources seriously limits the planning, monitoring and improving the quality of health care.
- The responsibility for mental health has been handed over to the Management Division (MD) without any additional logistics and human resources support being provided to the division for this major health care issue.

6 LOGISTICS MANAGEMENT DIVISION

6.1 Background

The Logistics Management Division (LMD) is not itself responsible for any major programmes. It procures goods and services on behalf of all the programme divisions of the Department of Health Services. LMD is assisted by a Procurement Assistance Component with two senior international procurement advisers funded by DFID and a national procurement consultant funded by KfW.

LMD carries out its work in accordance with the official procurement guidelines as per the Public Procurement Act article 67.1 (b) which states:

> *"Procurement is required to be made in accordance with the procurement guidelines of a donor agency pursuant to an agreement entered into between the Government of Nepal and the donor agency."*

This is the case as pooled donor funds are provided directly to the government budget. The government and the external development partners (EDPs) of the pooled fund agree that all procurement will happen under the World Bank's Procurement Guidelines 2004 (revised 2006) in accordance with the Financing Agreement dated 18 August 2010 between the Government of Nepal and the International Development Association (IDA).

6.2 Annual plan and budget

The Logistic Management Division has a budget of just over NPR 1 billion (NPR 1,053,510,000) (US$ 14 million) for 2012/2013.

6.3 Major activities

The major activities of the Logistics Management Division in 2012/2013 are as follows:

Procurement

- Procure bio-medical equipment and instruments for districts including for the many new service centres including birthing centres.
- Procure essential drugs and programme health commodities.

Procurement procedures

- Improve office management practices within LMD's web-based Logistics Management Information System (LMIS), (including Inventory Management System, and Internal Mailing System) to all 75 districts and 5 regions for more effective and timely decisions (new activity for 2012/2013).
- Increase the number of multi-annual procurements (new for 2012/2013).
- Contract out the supply of drugs and equipment to the private sector in five districts (one per region) (new in 2012/2013).
- Introduce the concept of pre-qualifying bidders to reduce the workload (new for 2012/2013).

- Take further steps to bundle similar goods in single contracts to increase the chance that international bidders will be interested in bidding and to take advantage of economies of scale (new for 2012/2013).
- Tighten bidding procedures to minimise the risk of carteling and other dubious practices (new for 2012/2013).
- Strengthen the repair and maintenance of bio-medical equipment by contracting it out to bio-medical engineers to facilitate uninterrupted service provision (new for 2012/2013).

Storage and distribution

- Build state-of-the-art central warehouses in Teku (Kathmandu) and Pathalaiya (Parsa) to implement the 'Pull' system of drug supply at all levels (new for 2012/2013). There is an acute need to improve storage facilities at central and regional levels to meet the growing demand for health commodities since the introduction of the free essential drugs for all policy.
- Establish web-based assistance to provide advice to district storekeepers nationwide and for the routine functioning of the web-based LMIS, Inventory Management System, and Internal Mailing System. Through web-based LMIS, LMD can monitor district stocks of health commodities from the centre and effectively and efficiently manage supply chain management.
- Review the drug stock out situation in one district.
- Procure vehicles for distributing health commodities across all 75 districts to take advantage of the improving road network.

6.4 Targets

Outcome targets — The Logistics Management Division will work towards the following NHSP-2 outcome indicators in 2012/2013:

- Develop a bank of standards and qualities of commodities and instruments to be procured for each tier of the health facility, and regularly carry out market surveys on products and prices to keep the databank up-to-date.
- Require MoHP divisions to prepare procurement plans as part of their annual budget planning.
- Prepare a consolidated national annual procurement plan.
- Revise the procurement policy and guidelines for MoHP.
- Provide orientations to bidders and staff and introduce e-bidding for procurement including mechanisms for pre-bid consultation and for managing complaints.
- Develop a system for the quality assurance of all types of goods and commodities procured at central and district levels.
- Introduce quality control mechanisms, including the use of World Health Organisation (WHO) good manufacturing practice-certified producers, and the laboratory testing of the quality of drugs and commodities. Do this by establishing partnerships with private laboratories.
- Improve efficiency through multi-year contracts, and further develop the practice of central bidding and local purchasing for essential drugs.
- Enhance the storage and distributive capacity of central, regional and district medical stores.

- Adopt a multi-year framework for contracting out the procurement of essential drugs, health commodities and equipment.

LMD's main outcome indicator is the year-round availability of health commodities at service delivery sites of the country by 2015 with the following targets:

- Keep the stock-out rate of family planning commodities at health facilities below 5%.
- Keep the stock-out rate of maternal and child health (MCH) commodities at the health facilities below 7%.
- Bring down the stock-out rate of selected essential drugs from the existing 21% to below 15%.

Output target — The key output of LMD is the timely procurement of goods and services as planned in its budgets and work plans.

6.5 Technical assistance requirements

The following technical assistance is needed in 2012/2013 by LMD:

- To recruit additional human resources including biomedical engineers.
- To prepare documents for international competitive bidding.
- To prepare a consolidated procurement plan.

6.6 Constraints

The main constraints currently experienced by LMD are as follows:

- Sensitising all parts of MoHP on the procurement guidelines to be followed for international competitive bidding (ICB) for health commodities and services which are those of the World Bank and **not** the Government of Nepal's Public Procurement Act and Regulations. This is rather complicated for civil servants to grasp. Note that the World Bank guidelines allow for the use of the project performance assessment report (PPA/R) for national competitive bidding procedures for procurements of less than US$ 500,000 equivalent.
- Sensitising all contract bidders on the use of World Bank guidelines for international competitive bidding (see above point). Failures to comply among bidders has resulted in much wasted time and effort as more and more unsuccessful bidders resort to the complaints procedure.
- The timely procurement of essential drugs and other commodities for family planning, maternal, neonatal and child health, and vaccination programmes.
- Inadequate human resources at all levels to manage the supply chain.
- Inadequate storage facilities at central and regional levels.
- Inadequate trained human resources for the district level storage of health commodities as district storekeepers are mostly from the administrative sector and often get transferred to other ministries.

7 PRIMARY HEALTH CARE REVITALISATION DIVISION

7.1 Background

Article 16.2 of the Interim Constitution of Nepal 2063 (2007) specifies free basic health care as a fundamental right of every Nepalese citizen resident in the country. To safeguard citizen's rights to basic health care, the Ministry of Health and Population (MoHP) has introduced free health care in a phased manner from fiscal year 2063/64 (2006/07). The Primary Health Care Revitalisation Division (PHC-RD) was established under the Department of Health Services in 2007 to strengthen and monitor primary health care services. Similarly, MoHP added different targeted interventions to ensure equitable access to primary health care services for poor and excluded people and people in remote villages.

The objectives of the programmes conducted by PHC-RD are to:

- reduce out-of-pocket spending on health care particularly by poor, marginalised and vulnerable people.
- reduce disability, and address morbidity especially of poor, marginalised and vulnerable people by securing the right of citizens to basic health care services.
- ensure the constitutional right of citizen to basic health care services; and
- increase access to, and the utilisation of, essential health care services, especially by poor marginalised groups.

To achieve these objectives PHC-RD runs the programmes listed in Box 7.1.

Box 7.1: Major programmes run by PHC-RD

On-going programmes:

- National Free Health Care Programme
- Social Health Protection
- Urban Health Programme.

New Initiatives:

- Integrated Public Health Campaign
- Model Healthy Village
- Community Health Unit
- Social Audit (third party mobilisation)
- Gender Equality and Social Inclusion including Equity and Access Programme.

7.2 Annual budget

The Primary Health Care Revitalisation Division has a budget of NPR 1.5 billion (US$ 20.7 million) for 2012/2013 (Table 7.1).

Table 7.1: Annual budget of PHC-RD for FY 2012/2013 (NPR '000)

SN	Major programmes	Central level	District level	Total (central and district)
1	National Free Health Care Programme	541,050	616,500	1,157,550
2	Social Health Protection	50,725	188,500	239,225
3	Urban and Environmental Health Programme	5,100	149,050	154,150
	TOTAL			**1,550,925**

7.3 Major activities

The major activities under by PHC-RD's three programmes and their status in 2012/2013 are as follows:

National Free Health Care Programme

- Drug procurement – continued
- Monitoring of free health programme – continued
- Programme review and reflection – continued
- Recruitment of human resources on contract basis – continued

Social Health Protection

- Integrated Public Health Campaign – continued
- Model Healthy Villages – continued
- Community health units – continued
- Community health insurance – continued
- Social audit (3rd party mobilisation) – continued
- Equity and Access Programme (through NGOs) – continued
- Targeted comprehensive camps – new
- Gender equality and social inclusion – new

Urban Health Programme:

- Urban female community health volunteers (FCHVs) programme – continued
- Urban health clinics – continued
- Construction of urban health clinics – continued/scaled-up.

7.4 Procurement

In 2012/2013 PHC-RD plans to carry out NPR 649 million of procurement (Table 7.2) with the procurement of drugs accounting for a large part of this expenditure.

Table 7.2: PHC-RD planned procurement for FY 2012/2013 (NPR in '000)

SN	Activities	Amount-NPR	Remarks
1	Drug procurement (multi-year)	520,000	Centre
2	Integrated Public Health Campaign, ear nose and throat (ENT) camps,	66,000	District/centre
3	Recruitment of human resources on contract basis – district level procurement	30,000	District/centre
4	Equity and Access Programme – district level procurement	22,500	District
5	Social audit – district level procurement	6,000	District
6	Printing of programme guidelines	3,700	Centre
7	Purchasing of audiometers	400	Centre
8	Office furniture and related equipment and accessories	300	Centre
9	Computer purchasing	300	Centre
	TOTAL	**649,200**	

7.5 Programmes implementation strategies

The main programme implementation strategies of PHC-RD are to:

- use public-private partnerships to conduct health camps (including with NGOs).
- mobilise civil society organisations to carry out social audits and equity and access programmes, and
- facilitate the networking and coordination of with different stakeholders including local government and the private sector.

7.6 Targets

Table 7.3: Primary health care achievements and targets (2010–2016)

	Achievements		Targets			
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Health outcomes:						
Under 5 mortality rate (per 1,000)	54	50.8	47.6	44.4	41.2	38
% of people with a disability	3.6%	3.5%	3.4%	3.3%	3.2%	3%
% of out of pocket spending (by clients)		56%	54%	52%	51%	50%
Coverage:						
% of households aware about free care	60%	66%	72%	78%	84%	90%
Total new outpatient visits as % of total population (source: HMIS)	75.98%	78%	81%	84%	87%	90%
% of people who received free health care at district level and below	29%	45%	60%	70%	80%	90%
% health facilities with no stock-outs of tracer drugs/commodities for more than one or two weeks per year	70%	75%	80%	85%	90%	90%

Table 7.3 gives the achievements and targets for the main primary health care indicators.

The planned PHC-RD outputs for 2012/2013 are as follows:

- Equity and access programme run in 20 districts.
- Health facility social audit programmes run in 20 districts.
- 300 paramedics recruited and mobilised on a contract basis.
- Integrated public health campaigns run in 33 districts.
- Model Healthy Village programmes run in 30 places.
- Comprehensive health camps run in 5 places (one per region).
- Targeted health camps run in two districts (to respond to epidemics).
- Community health units operational in 30 places.
- Community health insurance operated in 6 health institutions.
- GESI training through appreciative enquiry in 10 places.
- Development of a health insurance policy/strategy.
- Development of a health cooperative policy/strategy.
- Printing of 1,000 copies of the comprehensive social audit guidelines.
- Review of the free health care programme to identify strengths and gaps to improve services in and to unreached areas and populations.

7.7 Governance-related activities

The main governance related activities of PHC-RD are:

- promoting the carrying out of social audits at health facilities.
- publishing and disseminating programme related information.
- programme monitoring, periodic review and reflection by PHC-RD; and
- DoHS annual reporting.

7.8 Gender equality and social inclusion activities

The GESI activities of PHC-RD for 2012/2013 are as follows:

- Deliver essential health care in selected vulnerable communities.
- Continue the Equity and Access Programme in 20 districts.
- Review the free health care programme to identify strengths and gaps and improve services to unreached areas and populations.
- Train health managers and workers on GESI in 10 districts.
- Organise special health care programmes for poor people, Dalits and people with disabilities.
- Provide financial support to poor and excluded people and Dalits for referrals.
- Organise integrated public health camps in remote rural areas with weak health service delivery.
- Establish community health units in additional remote rural communities of selected VDCs.
- Study the existing mental health situation (including the effects of alcoholism) and access to mental health care services.

7.9 Technical assistance requirements

PHC-RD has the following technical assistance requirements:

- To roll out social audit guidelines in planned districts (including training for district teams and selected NGO social auditors).
- To refine the Equity and Access Programme (EAP) package and its implementation.
- To rollout the GESI concept for health workers and officials at least up to district level.
- To review the success of the free health programme on reaching the unreached.
- To develop and finalise the urban health policy and strategy.
- To review existing urban health programming – its function, management, role of Ministry of Federal Affairs and Local Government and MoHP.
- To update the strategy paper related to the Integrated Public Health Campaign, the Model Healthy Village Programme and community health units.
- To develop a health insurance policy/strategy.
- To develop a health cooperative policy/strategy.

7.10 Constraints

The main constraints faced by PHC-RD are:

- inadequate monitoring and supervision at all levels and poor use of available data.
- the challenge of completing all policy and strategy development processes within 2012/2013. This calls for focussing on priority policies and strategies.
- delays in approval of priority health programmes, and the finalisation of implementation guidelines; and
- the unavailability of policy documents on urban health, health insurance and health cooperatives.

8 EPIDEMIOLOGY AND DISEASE CONTROL DIVISION

8.1 Background

The Epidemiology and Disease Control Division (EDCD) works to prevent and control communicable diseases, particularly epidemic-prone diseases such as vector-borne diseases and zoonoses. It is also responsible for post-disaster and natural calamity-related public health issues and is the focal point for international health regulation in Nepal.

The major objectives of EDCD are as follows:

- The surveillance of communicable diseases, and epidemic preparedness and response for the prevention and control of immunisation-preventable vector-borne diseases.
- Achieving by 2015 the Millennium Development Goal of halting the spread and reversing the trend of malaria.
- Reducing Kala-azar incidence at district level to 1 per 10,000 at-risk population by 2015.
- Reducing the microfilaria incidence rate to 1% at district level by 2018.
- Implementing immediate, intermediate and long-term dengue prevention and control plans.
- Enhancing access to post exposure treatment (PET) for rabies exposure in humans and the management of snakebites to prevent mortality.
- Enhancing the capacities of the health sector in emergency preparedness and disaster response by focusing on disaster prevention, mitigation and response; and providing emergency and humanitarian assistance and medical support during disasters and natural calamities.

8.2 Annual budget

Table 8.1: EDCD annual budget FY 2012/2013 ('000 NPR)

SN	Major programmes	Central Level			District Level			Central + district		
		GoN/PF	EDPs	Total	GoN/PF	EDPs	Total	GoN/PF	EDPs	Total
1	Lymphatic Filariasis elimination	39,462	25,300	64,762	185,488	114,196	299,684	224,950	139,496	364,446
2	Malaria control	40,550	199,881	240,431	54,080	17,200	71,280	94,630	217,081	311,711
3	Zoonosis control	101,800	2,100	103,900	1,000	0	1,000	102,800	2,100	104,900
4	Epidemic control	29,600	22,467	52,067	27,400	0	27,400	57,000	22,467	79,467
5	Kala-azar control	11,600	1,500	13,100	15,150	0	15,150	26,750	1,500	28,250
6	Natural disaster management	3,600	8,500	12,100	7,500	0	7,500	11,100	8,500	19,600
7	Dengue control	6,100	4,000	10,100	0	0	0	6,100	4,000	10,100
	TOTAL							**523,330**	**395,144**	**918,474**

The Epidemiology and Disease Control Division has a budget of NPR 920 million (US$ 12.2 million) for 2012/2013 (Table 8.1). The highest proportion (40%) is for the elimination of lymphatic filariasis. Note that Population Services International (PSI) budget of NPR 115 million for long-lasting insecticidal nets (LLIN) is also included in EDCD's budget. This amounts to 23% of the proposed budget for FY 2012/2013.

8.3 Major activities

The major activities of EDCD's seven programmes in 2012/2013 are as follows:

Lymphatic filariasis elimination:

- Procure Diethylcarbamazine citrate tablets for mass drug administration (MDA).
- Manage post-mass drug administration complications, treat filariasis cases and organize treatment camps.

Malaria control:

- Procure insecticides for indoor residual spraying (IRS).
- Distribute long lasting insecticide treated nets.
- Procure medicines, equipment and diagnostic kits.

Zoonosis control:

- Procure cell culture anti-rabies vaccine for post-exposure treatment of rabies in human.
- Procure anti-snake venom serum to prevent mortality due to poisonous snakebites.

Epidemic disease control:

- Procure drugs and equipment to control epidemic diseases.
- Train district and community rapid response team members and health workers on epidemic investigation, control and management.

Kala-azar control:

- Procure insecticides for indoor residual spraying.
- Distribute long lasting insecticide treated nets.
- Procure medicines, equipment and diagnostic kits.

Natural disaster management:

- Orientate rapid response teams on emergencies and natural disasters and promote district level contingency planning.
- Run emergency planning workshops for hospitals and primary health care centres.

Dengue control:

- Procure dengue and chickungunya diagnostic test kits.
- Search and destroy disease vectors.

8.4 Procurement

Of the NPR 32.2 million total procurement for 2012/2013 the largest amount (36%) is for procuring insecticide nets for malaria prevention (Table 8.2).

Table 8.2: EDCD planned procurement for FY 2012/2013

SN	Activities	Amount (NPR)
1	Insecticide nets received though Population Services International (PSI) for malaria high risk districts	115,200,000
2	Anti-rabies vaccines (ARV cell culture) for approx. 65,000 persons	82,500,000
2	Insecticides for malaria and kala-azar control	28,000,000
3	Diethylcarbamazine citrate (DEC) tablets	25,000,000
5	Anti snake venom serum for districts	13,000,000
6	Medicines, diagnosis kits and logistics for malaria control through WHO	12,500,000
7	Machinery and equipment for malaria control through WHO	12,500,000
8	Medicines and medical goods for kala-azar control	11,000,000
9	Drugs and equipment for controlling epidemic diseases	10,000,000
10	Medicines and diagnostic materials for malaria control	5,000,000
11	Pre-fabricated cold rooms for storing vaccines and medicines	4,000,000
12	Dengue and chickungunya diagnostic test kits	3,000,000
	TOTAL	**321,700,000**

8.5 Programmes implementation strategies

The main EDCD programme implementation strategies are:

- the early detection of epidemic outbreaks and the timely mobilisation of rapid response teams.
- carrying out indoor residual spraying in high risk districts to prevent malaria and kala-azar.
- mass drug administration with albendazole and DEC to eliminate lymphatic filariasis.
- the post exposure treatment of rabies in humans to prevent mortality.
- administering anti-snake venom serum to prevent mortality due to poisonous snakebites; and
- supporting district authorities to carry out contingency planning to address disaster situations.

8.6 Targets

The outcome indicator for EDCD in NHSP-2 is Millennium Development Goal 6 of halting the spread and reversing the trend of malaria by 2015 (annual malaria parasite incidence). The outcome target for 2012/2013 remains the same.

EDCD's planned outputs for FY 2012/2013 are as follows:

- Mobilise rapid response teams for epidemic outbreaks and emergency preparedness, prevention, control and management (12 times).
- Procure insecticides for indoor residual spraying to control malaria and kala-azar.
- Procure and distribute long lasting insecticide treated nets for 25,000 families.
- Carry out mass drug administration (MDA) for lymphatic filariasis elimination in 55 districts.
- Follow up the microfilaria survey in 10 mass drug administration districts and conduct a post-MDA survey in 20 districts.
- Treat 65,000 suspected rabies exposures with tissue culture anti-rabies vaccine.

- Treat 1,600 poisonous snakebite victims with anti-snake venom serum.
- Orientate medical officers, paramedical staff and stakeholders on dengue and chickungunya 3 times for a total of about 120 participants.
- Orientate rapid response teams on reproductive health promotion in emergency and natural disaster situations (6 times), and support the preparation of district contingency plans.

8.7 Governance-related activities

EDCD's main governance related activities for 2012/2013 are as follows:

- Conduct orientation trainings for district/community rapid response teams and health workers on epidemic control and management.
- Procure and develop materials and manuals for malaria control.
- Train lab. technicians and assistants on basic malaria microscopy.
- Train EDCD and programme management unit (PMU) staff on Global Fund guidelines and policies.
- Train service providers on the rational use of artemisinin-based combination therapy (ACT) and rapid diagnostic tests (RDTs).
- Provide capacity building training programmes for EDCD and PMU staff through the World Health Organisation.
- Provide orientation training for health workers on malaria.
- Provide orientation training for health workers on Kala-azar case management and control.
- Orientate rapid response teams on emergency and natural disaster and prepare district level contingency plans.
- Orientate rapid response teams on the continuity of health care provision in emergencies and natural disasters and prepare district level contingency plans.
- Produce revised information education and communication (IEC) materials, checklists, reporting, recording, and guidelines for mass drug administration campaigns.
- Collaborate with the Nepal Medical Association and the Federation of Nepali Journalists for publicising mass drug administration campaigns.
- Orientate medical officers and paramedical staff on the rational use of anti-rabies vaccine drugs and poisonous snakebite case management.
- Orientate medical officers and paramedical staff and journalists on dengue and chickungunya.
- Hold orientations and interactions with stakeholders on dengue disease control.

8.8 Gender equality and social inclusion activities

EDCD's GESI activities for 2012/2013 are as follows:

- Neutral budgets.
- Indirect contribution to poverty elimination.
- No gender discrimination.

8.9 Technical assistance requirements

The technical assistance requirements of EDCD in 2012/2013 are:

- logistics and human resource support for emergency outbreak management (EOM).
- additional technical assistance to eliminate malaria, kala-azar, lymphatic filariasis especially for formulating effective strategies.
- to study vector bionomics and carry out surveys related to malaria, kala-azar and lymphatic filariasis.
- capacity building training on epidemiology and outbreak investigation; and
- an international expert to support the indigenous production of cell culture anti-rabies vaccine (ARV), its quality assurance, and zoonosis control.

8.10 Constraints

The main constraints facing EDCD are as follows:

- the delayed disbursement of The Global Fund and pooled fund budgets.
- lack of budget for district level programme management.
- incomplete, inconsistent and late programme reporting from districts.
- lack of medicine, diagnostic kits and equipment due to delays and complex procurement processes.
- lack of supportive supervision at the district level to correct programmatic errors; and
- difficulties related to media management during epidemics.

9 LEPROSY CONTROL DIVISION

9.1 Background

Nepal officially eliminated leprosy as a public health problem in December 2009. The Department of Health Services acknowledged this as one of the major successes of Nepal's health sector. Although the disease burden has been reduced, sustaining the achievement and further reducing the burden through quality leprosy services remains a challenge. The Leprosy Control Division (LCD) is the concerned government entity.

After meeting the elimination target, the national strategy was revised to "Sustain Quality Leprosy Services and Further Reduce the Disease Burden due to Leprosy in Nepal: 2011-2015". This was based on the Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy: 2011-2015 and the updated Operational Guideline of WHO.

The main principles of leprosy control are based on the early detection of new cases and their timely and complete treatment with multi-drug therapy (MDT) through integrated health services. The emphasis is on sustaining provisions for quality patient care that are equitably distributed, affordable and accessible. However, there is a need to bring about some changes in the working arrangements among all partners to improve coordination in providing care to persons affected by leprosy and their families and enhance knowledge levels and attitudes of the general public towards leprosy.

9.2 Annual budget

The Leprosy Control Division has a budget of NPR 55.3 million (US$ 0.7 million) for 2012/2013 (Table 9.1).

Table 9.1: Annual budget of the Leprosy Control Division for FY 2012/2013 (NPR '000)

Budget	Government	EDPs	Total
Central level	13,710	5,810	19,520
District level	32,620	3,156	35,776
TOTAL	**46,330**	**8,966**	**55,296**

9.3 Major activities

The following LCD-run programmes are planned for 2012/2013:

- Provide and sustain quality leprosy services in an integrated way including for referrals.
- Run leprosy referral clinics in 17 strategically located districts to access other districts.
- Carry out leprosy surveillance in high and low endemic districts, detect new cases and then provide timely and complete management of cases.
- Provide leprosy-related training programmes and orientations to health workers, civil society, volunteers, managers including on medical and community based rehabilitation.
- Provide incentives to relieved from treatment (RFT) cases and referrals – NPR 1,000 for each case.

- Orientate and train stakeholders to reduce leprosy associated disabilities, stigma and discrimination.
- Provide medical and community-based rehabilitation of leprosy-affected persons.
- Monitor and evaluate the leprosy control programme including by on-site coaching, studies and research programmes.
- Mobilise networks of leprosy affected people and forming self-help/self-care groups of people affected by leprosy and mobilizing them.

9.4 Procurement

Not applicable.

9.5 Programmes implementation strategies

The main programme implementation strategies of LCD are as follows:

- The early detection of new cases and their timely and complete management in endemic and non-endemic areas, slums, and among excluded, marginalised and underserved people and in urban populations through public-private partnerships and integrated health services and the uninterrupted supply of logistics and drugs.
- Build the capacity of health care workers and providers for quality leprosy service provision.
- Prevent leprosy-associated impairment and disability.
- Rehabilitate people affected by leprosy, including medical and community based rehabilitation.
- Reduce stigma and discrimination through advocacy, social mobilisation and IEC activities and address gender equality and social inclusion.
- Strengthen referral centres to treat and manage leprosy-related complications.
- Promote the meaningful involvement of people affected by leprosy in leprosy services, and address human right issues.
- Promote and conduct operational research studies.
- Monitoring, supportive supervision, surveillance and evaluation to ensure and strengthen quality leprosy services.
- Strengthen partnerships, co-operation and coordination among government and non-government, local government and private organisations.

9.6 Targets

The leprosy-related outcome targets for 2012/2013 are to:

- reduce by 5% disability Grade 2 among leprosy patients per 100,000 population in comparison to 2010; and
- further reduce the leprosy disease burden in Nepal with intensified initiatives (to achieve a targeted prevalence rate of 7%).

The leprosy-related outcome targets for 2015 are to:

- reduce by 35% disability Grade 2 among leprosy patients per 100,000 population in comparison to 2010; and

- further reduce the leprosy disease burden in Nepal with intensified initiatives (new case detection rate [NCDR] 25%, prevalence rate 35%, in comparison to 2010).

The leprosy-related output targets for 2012/2013 are as follows:

- Sustain the national level prevalence of leprosy at < 1 case per 10,000 population.
- Increase the access of underserved populations to leprosy services.
- Expand public-private partnerships for leprosy treatment.
- The improved coverage of leprosy services in urban areas.
- Surveillance of leprosy cases.
- Improve logistic and drug supply and information systems related to leprosy control.
- Provide job oriented capacity-building for general health workers.
- Carry out operational research for leprosy control.
- Strengthen the secondary and tertiary levels of leprosy services at district hospitals, sub-regional, zonal and regional hospitals.
- Strengthen regional health training centres for building the capacity of service providers including private practitioners in leprosy control and treatment.
- Provide a sustained quality of leprosy services in an integrated setup.
- Improve referral systems for people affected by leprosy.
- Sustain leprosy care expertise among service providers.
- Strengthen and establish prevention of impairment and disability (POID) services and referral centres to reduce the rates of disability.

9.7 Governance-related activities

LCD's main governance activities are:

- implementing the National Strategy (2011-2015) to further reduce leprosy disease burden.
- publishing the quarterly bulletin *Hamro Sawal.*
- publishing a pocket book on leprosy for health workers.
- publishing a brochure in English and Nepali; and
- producing a television documentary to improve understanding about leprosy.

9.8 Gender equality and social inclusion activities

LMD promote GESI by involving people affected by leprosy in leprosy-related awareness activities.

9.9 Technical assistance requirements

The following technical assistance is needed:

- a consultant dermatologist;
- a health worker for medical and community based rehabilitation; and
- a planning, documentation, resource and coordination officer to assist in planning and programming work at the centre in the Leprosy Control Division and to coordinate with partners.

9.10 Constraints

The main constraints facing LCD in rolling out its programme are:

- inadequate trained human resources (experts, experience health worker).
- the low priority given for rehabilitating people affected by leprosy.
- lack of mainstreaming of social inclusion in leprosy programmes.
- sustaining effective surveillance, monitoring and supervision; and
- inadequate community based rehabilitation and medical rehabilitation.

10 NATIONAL CENTRE FOR AIDS AND STD CONTROL

10.1 Background

About 50,200 people were living with the human immunodeficiency virus (HIV) in Nepal in 2011[1]. The country's HIV epidemic is concentrated among key populations at higher risk such as people who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers (FSW). More than 80% of cases have acquired the infection through sexual transmission. The current National HIV/AIDS Strategy, 2011–2016[2] prioritises a national response that aims to:

- reduce new HIV infections by 50% and reduce new HIV infections among children by 90%; and
- reduce HIV related deaths by 25% by 2016 compared with the 2010 baseline.

These goals are designed to help achieve universal access to HIV prevention among key populations at higher risk and general populations, and treatment, care and support for HIV infected and affected populations. Work is on-going to:

- optimise HIV prevention.
- provide treatment, care and support; and to:
- strengthen health and community systems, strengthen strategic information for evidence-based planning and programming, provide legal support, and for human rights and social protection.

The National Centre for AIDS and STD Control (NCASC) is the government body responsible for Nepal's response to HIV/AIDS.

10.2 Annual budget

The National Centre for AIDS and STD Control has a budget of NPR 689 million (US$ 9.2 million) for 2012/2013 (Table 10.1). The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the largest funder providing 57% of all planned funds.

Table 10.1: NCASC budget for 2012/13 (NPR)

SN	Funding source	FY 2012/2013
1	The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	390,523,000
2	Pooled Fund	222,269,000
3	Government of Nepal	63,000,500
4	UNICEF	9,869,000
5	World Health Organisation (WHO)	3,533,000
6	United Nation Population Fund (UNFPA)	-
	TOTAL	**689,194,500**

[1] NCASC (2012) National Estimates of HIV Infections, 2011, March 2012.

[2] NCASC (2011) National HIV/AIDS Strategy, 2011-2016, Kathmandu Nepal, December 2011.

10.3 Major activities

The major programmes planned for fiscal year 2012/2013 by NCASC are as follows:

- Targeted interventions among key populations at higher risk to HIV: people who inject drugs (PWID), men who have sex with men (MSM), labour migrants and their spouses, and prison inmates. These interventions will be provided through contracted non-government organisations in selected districts. The interventions include HIV testing and counselling, behaviour change communication (BCC), and sexually transmitted infection (STI) diagnosis, treatment and referral services. PWIDs are provided with opioid substitution therapy (methadone maintenance) (six sites) and needle and syringe exchange.
- STI diagnosis, treatment and referral at HIV testing and counselling sites, hospitals and a few NGO-run sites to key populations and the general population.
- Scaling-up prevention of mother-to-child transmission (PMTCT) services to districts hospitals and primary health care centres (PHCCs) in selected districts to reach 100 sites by 2012/2013 (47 institution-based and 53 community-based sties). Provide WHO-recommended Option B ART to all HIV infected pregnant women and girls.
- Implement a blood safety programme through the Nepal Red Cross Society for 100% quality assured screening of HIV in blood supplies.
- Scale up ART services to 8,335 PLHIV with improved coverage and quality. Manage opportunistic infections among PLHIV and provide PLHIV with nutritional support when taking antiretrovirals for the first time. Provide TB-HIV co-infected PLHIV with treatment for TB and HIV. Provide PLHIV with community and home based care and community care services.
- Provide 600 children affected by AIDS (CABA) with monthly cash payment in selected districts.
- Strengthen the health system by training public and private health care providers, strengthening strategic information systems (HIV surveillance, M&E and research); procuring HIV related commodities (ARVs, test kits, and STI drugs) and ensuring their regular supply, and strengthening the national and local response to HIV by NCASC and district AIDS coordinating committees (DACCs).
- Run community system strengthening activities through NGOs to create demand for services, reduce stigma and discrimination and ensure rights of affected people to quality services.

10.4 Procurement

In 2012/2013 NCASC plans to carry out NPR 98 million of procurement with ARV drugs accounting for the most expenditure (39%) (Table 10.2).

Table 10.2: NCASC's planned procurement for FY 2012/2013 (NPR)

SN	Activities	Amount (NPR)
1	Antiretroviral drugs	38,766,764
2	Nutritional support to PLHIV	20,000,000
3	HIV test kits	9,597,356
4	CD4 reagents for HIV monitoring machines	8,708,612
5	Condom and lubricants	5,631,812
6	Equipment	4,618,520
7	Methadone	4,481,188
8	STI and opportunistic infection drugs	4,110,612
9	Harm reduction commodities (needle-syringes)	2,545,068
TOTAL		**98,459,932**

10.5 Programme implementation strategies

NCASC has the following programme intervention strategies for 2012/2013:

- Provide comprehensive packages of services through the continuum from prevention to care among key populations at higher risk to HIV and PLHIV.
- Ensure the universal coverage of essential and impact producing HIV interventions.
- Ensure equity in service provision, social protection and human rights.
- Provide services as follows with:
  - government and non-government organisations providing HIV testing and counselling, STI management, and PMTCT.
  - Government health facilities providing ART and TB-HIV co-infection management.
  - NGOs providing behaviour change communication, community outreach, HIV testing and counselling and STI management.
- Primary health care approaches to delivering HIV services.
- Engaging a wide range of stakeholders in planning, programming and reviewing the response to HIV including government agencies, INGOs, community based organisations [CBOs], donors, infected and affected communities, civil society organisations and by implementing some activities through public-private partnerships.
- The regular monitoring and evaluation of interventions in thematic areas such as HIV testing and counselling, PMTCT, ART, STI management, community home-based care (CHBC) jointly by key stakeholders, and regular capacity building and the sharing of results and knowledge.
- Regular surveillance and research activities to enable evidence-based programming ('know your epidemic, know your response').
- Strengthen the health system and community systems to respond to HIV.
- The meaningful engagement of infected and affected communities in all levels of the response's structure and programmes through the National AIDS council, DACCs and technical groups and committees.

- Following the overarching principle of the 'Three Ones' with one national strategic plan, one national co-ordinating authority and one national M&E systems and tools.

10.6 Targets

The main HIV/AIDS outcome indicators and targets are given in Table 10.3 and the main output targets in Table 10.4.

Table 10.3: HIV/AIDS related targets in Nepal for FY 2012/2013 and 2015

SN	Indicators	Baseline		Target	
		Data	Year	2013	2015
1	HIV prevalence among men and women aged 15-24 years	0.12 % (total) M = 0.20%, F = 0.05%	2010	0.08%	0.06%
2	Percentage of adults and children with HIV known to be on treatment 12, 24 and 36 months after initiation of antiretroviral therapy	89% - 12 months 84% - 24 months 70% - 36 months	2010	90% - 12 months 86% - 24 months 80% - 36 months	93% - 12 months 90% - 24 months 85% - 36 months
3	Percentage of eligible adults and children currently receiving antiretroviral therapy	24%	2011	55%	80%
4	Percentage of key populations at higher risk (people who inject drugs, sex workers, men who have sex with men, male labour migrants) reached with HIV prevention programmes	PWIDs = 71.4% FSWs = 60.0% MSWs = 93.3% MSM = 77.3% MLM = 22.9%	PWIDs (2011) FSWs (2011) MSWs (2009) MSM (2009) MLM (2010)	PWIDs = 75% MSWs = ≥93% MSM = 80% MLM = 50%	PWIDs = 80% FSWs = 80% MSWs = ≥95% MSM = ≥80% MLM = 80%
5	Percentage of key populations at higher risk (sex workers, men who have sex with men, people who inject drugs, male labour migrants) reporting the use of condom at last sex	FSWs = 82.6% MSWs = 37.8% MSM = 75.3% PWIDs = 46.5% MLM = 53%	FSWs (2011) MSWs (2009) MSM (2009) PWIDs (2011) MLM (2010)	FSWs = 83% MSWs = 50% MSM = 75% PWIDs = 60% MLM = 65%	FSWs = 85% MSWs = 80% MSM = 80% PWIDs = 80% MLM = 80%
6	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	95.3%	2011	≥95%	≥95%

Note: PWIDs = people who inject drugs; FSWs = female sex workers; MSWs = male sex workers; MSM = men who have sex with men; MLM = male labour migrants (to India)

The achievement of the high risk groups reached with HIV prevention activities indicator (indicator 5 in Table 10.3) is measured as follows:

- For sex workers (female and male): The percentage of sex workers reached with HIV prevention programmes (know where to go for HIV testing services, wish to receive an HIV test and received condoms in the last 12 months).
- For MSM: The percentage of men who have sex with men reached with HIV prevention programmes.
- For PWIDs: The number of syringes distributed per person who injects drugs per year by needle and syringe programmes.

- For male labour migrants (MLM): The percentage of male labour migrants reached with HIV prevention programmes (know where to go for HIV testing services, wish to receive an HIV test and received condoms in the last 12 months).

Table 10.4: HIV/AIDS related output targets for Nepal for 2012/2013

SN	Output indicators	Baseline	Baseline year	Target (2012/2013)
1	Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS by sex	M = 33.9% F = 25.8%	2011	M = 40% F = 33%
2	Number of IDUs newly enrolled in oral substitution therapy (OST) services	450	2010	950
3	Number of adults who received HIV testing and counselling including test results	140,362	2010	279,114
4	Percentage of donated blood units screened for HIV in a quality assured manner	38.9%	2009	75%
5	Number of HIV-infected pregnant women receiving a complete course of antiretroviral therapy to reduce the risk of mother-to-child transmission of HIV	96	2010	235
6	Number of eligible adults and children with HIV infection currently receiving antiretroviral therapy	4,867	2010	9,002
7	Number and percentage of adults and children enrolled in HIV care who had their TB status assessed and recorded during last visit (among all adults and children enrolled in HIV care in the reporting period)	0	2010	15,000 (50%)
8	Percentage of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug in last 12 months	0%	2010	0%
9	Number of health workers trained in clinical management	NA	2010	120

10.7 Governance-related activities

The main planned activities involving NCASC for the governance of the response to HIV/AIDS are as follows:

- Annual review of national response to HIV and STIs at district, region and national levels.
- Strengthening DACCs by supporting their human resources (DACC coordinators), programme management training, DACC review meetings, monitoring support from DHO/DPHOs.
- Developing multiplier training packages and conducting training for district health managers and DACC coordinators.
- One-month international management training for five core trainers.
- Strengthening strategic information provision by producing annual reports, epidemiology and programme fact sheets, surveillance reports, annual strategic information reviews/reports, HIV & STI related journal papers (as a supplementary edition of peer reviewed indexed journal) and updating the NCASC website (www.ncasc.gov.np).
- Capacity building activities for health care providers on M&E, surveillance, PMTCT, ART/opportunistic infections, logistics, financial management, and HIV programme management.

- Conducting and participating in HIV and STI related seminars, workshops and conferences.

10.8 Gender equality and social inclusion activities

The main NCASC planned initiatives for gender equality and social inclusion in 2012/2013 are as follows:

- Providing HIV and STI prevention services for female drug users by creating an enabling environment.
- Providing nutritional support for PLHIV who start ART.
- Providing comprehensive HIV and STI prevention interventions among key populations at high risk including male, female and third gender sex workers, PWID, MSM, prison inmates, and male labour migrants and their spouses.
- Preventing mother to child transmission of HIV, with an emphasis on providing the poorest and excluded women with PMTCT services via incentives such as nutritional packages.
- Monthly direct cash transfer to about 600 children affected by AIDS (CABA).
- Providing care and support, including social protection among PLHIV through community and home based care, community care services and by reducing stigma and discrimination.

10.9 Technical assistance requirements

The main technical assistance requirements in NCASC's programme for 2012/2013 are as follows:

- For implementing PMTCT, including formative research on generating evidence for improving PMTCT coverage and access for needy people.
- HIV and STI surveillance including the surveillance of HIV drugs resistance and monitoring indicators of drugs resistance. Related activities include updating HIV surveillance systems and tools, developing a training package, training health care providers, epidemic analysis and modelling, size estimation of populations at higher risk, HIV drug resistance strategy and surveys.
- For carrying out integrated biological and behavioural surveillance (IBBS) among populations at higher risk of contracting HIV.
- For designing assessment tools of HIV related stigma and discrimination at national, health facility and community level.
- For training operators and other stakeholders on the operation, maintenance and repair of HIV-related biomedical equipment.
- On-site coaching of health personnel at ART sites.
- For developing HIV-related GIS systems and the national HIV database.
- For developing the National HIV research agenda.

10.10 Constraints

The following are the main constraints for carrying out the above programmes:

- Scaling up care and support service for PLHIV and affected populations.
- Managing the quality of care, including community and home base care and community care services for PLHIV.
- Strengthening HIV and STI surveillance and monitoring and evaluation systems.

- The expansion of comprehensive PMTCT services to reach more women, girls, men and children.
- The unpredictability of funding for HIV/AIDS.
- The uneven distribution of care and support programmes between districts.
- The difficulty of retaining trained and qualified staff at NCASC and DACCs.

11 NATIONAL TUBERCULOSIS CENTRE

11.1 Background

Tuberculosis (TB) is a major public health problem in Nepal. About 45% of the population is infected with TB, of which 60% are adults. Every year, 40,000 people develop active TB, of whom 20,000 have infectious pulmonary disease. These 20,000 are able to spread the disease to others. Treatment by Directly Observed Treatment Short course (DOTS) has reduced the number of deaths; however 5,000-7,000 people still die each year from TB in Nepal. DOTS has been successfully implemented throughout Nepal since April 2001. The treatment success rate is 90% with a case finding rate of 73.3%. The National TB Programme (NTP) adopted Gene Xpert for TB case diagnosis in nine districts as pilot programme.

The National Tuberculosis Centre (NTC) is the government agency responsible for the response to TB in Nepal.

11.2 Annual budget

The National Tuberculosis Centre has a NPR 1.3 billion budget (US$ 16.8 million) for 2012/2013 (Table 11.1).

Table 11.1: Budget of NTC for FY 2012/2013 (NPR '000)

SN	Major programmes	Central level			District level			Total (central+ districts)		
		GoN	EDPs	Total	GoN	EDPs	Total	GoN	EDPs	Total
1	TB detection and treatment	72,835	313,249	386,084	16,909	72,200	89,109	89,744	385,449	475,193
2	Drug resistant (DR) TB management	2,160	277,846	280,006		135	135	2,160	277,981	280,141
3	Operational research	500	160,308	160,808	15,000	53,375	68,375	15,500	213,683	229,183
4	Health system strengthening (PAL programme)	0	90,111	90,111	0	718	718	0	90,829	90,829
5	Advocacy, communication and social mobilisation (ACSM)	250	54,503	54,753	11,780	21,305	33,085	12,030	75,808	87,838
6	TB/HIV collaboration	0	62,789	62,789		654	654	0	63,443	63,443
7	Programme planning and management (PPM)	0	35,952	35,952		239	239	0	36,191	36,191
	TOTAL	**75,745**	**994,758**	**1,070,503**	**43,689**	**148,626**	**192,315**	**119,434**	**1,143,384**	**1,262,818**

11.3 Major activities

The major activities of the National TB Centre in 2012/2013 are to continue the following initiatives.

DOTS and laboratory network — The National TB Programme has rapidly expanded the DOTS strategy initiated from 4 pilot centres in 1996 to 1,118 DOTS centres and 3,103 sub centres by mid July 2011. This network of centres is integrated into general health services throughout Nepal. By mid-July 2011, the no. of microscopy centres had reached 505 (Government of Nepal 407 and partners/INGOs 98.)

Sputum culture and drug susceptibility testing — The National Reference Laboratory and the German Nepal Tuberculosis Project (GENETUP) provide culture and drug susceptibility testing (DST). Germany supports external quality assurance for these laboratories.

Research — The National TB Programme carries out research to improve the quality of care for people with TB and to assist in planning and implementing the TB control programme. Research is being carried out on the surveillance of multi-drug resistant TB, assessing HIV among sputum smear pulmonary TB patients and other research topics within the National TB Programme in collaboration with sub-recipients.

TB-HIV collaborative activities — On-going.

Drug resistant-TB management — The drug-resistant TB (DR-TB) management programme was initiated in 2005 with approval of the Green Light Committee of the World Health Organisation (WHO). WHO agreed to treat 300 multi-drug resistant TB cases per year. There are 12 treatment centres and 62 sub-treatment centres. As per Green Light Committee recommendations, The National TB Programme Nepal started an XDR programme in 2008.

Advocacy, communication and social mobilisation — The ACSM intervention approach focuses on improving case detection and treatment adherence, combating stigma and discrimination, empowering people affected by TB and mobilizing political commitment and resources for TB.

Practical approach to lung health — The main objectives of the Practical Approach to Lung Health (PAL) programme are:

- managing respiratory illness of over 5 year old people;
- increasing TB case findings;
- the rationale use of antibiotics and others medication to respiratory symptomatic; and
- building the capacity of health workers.

Public-private mix — The Public Private Mix (PPM) programme aims to engage public and private health care providers to ensure the provision of quality TB services in line with National TB Programme policy and international standards of TB care (ISTC).

Logistic supply system — The National TB Control Programme provides all TB drugs and other logistic supplies. To avoid shortages and stock-outs the programme has developed a drug ordering system that uses the trimesterly reporting meetings for clinic staff to calculate their requirements based on utilisation and buffer stock requirements.

11.4 Procurement

The NTC's planned procurement budget for 2012/2013 is NPR 449 million with the most expenditure planned for TB drugs (65%) (Table 11.2).

Table 11.2: NTC's planned procurement for FY 2012/2013 (NPR '000)

SN	Activities	Amount (NPR)
1	First line and drug resistant TB drugs	291,269
2	Equipment and medicines for Practical Approach to Lung Health (PAL) programme	41,721
3	Digital X-ray and printer	34,450
4	Strengthening national laboratory	22,150
5	Hepa filter, UV light, N95 masks etc. for infection control	12,579
6	Microscopes for treatment centres	11,187
7	Equipment and other commodities procured last year	11,125
8	Equipment for culture labs in regions	9,092
9	Reagents and consumables for culture labs	8,962
10	Computers, LCDs and projectors for districts and NTC	1,844
11	Generators	1,400
12	Motorcycles for programme supervision for districts and NTC	1,070
13	Furniture for DOTS centres, sub-centres and NTC	886
14	Cupboards and filters for DOTs centres	700
15	Equipment for new multi-drug resistance (MDR) centres	516
16	Water filtration for laboratories	500
	TOTAL	**449,451**

11.5 Targets

Tables 11.3 and 11.4 present the main achievements and targets for TB indicators in Nepal.

Table 11.3: Tuberculosis programme achievements and targets for Nepal

SN	Indicator (per 100,000)	Base year (1990)	2009/2010	Target (2015)	Remarks
1	TB incidence rate	243	163	121.5	Nearly Achieved
2	TB prevalence rate	621	241	310.5	Achieved
3	TB mortality rate	51	21	25.5	Achieved

Table 11.4: National TB Programme outcome indicators from NHSP-2 results framework

Indicators		Baseline	2010/11	2013	2015
Case finding rate (%)	Estimated		75	80	85
	Achieved	75	73.2		
Treatment success rate (%)	Estimated		89	90	90
	Achieved	89	90		

The major planned outputs for FY 2012/2013 are:

- the sputum testing of 186,100 chest symptomatic patients;
- 641,123 new sputum smear examinations carried out and follow up slides produced; and
- the diagnosis of 18,610 new smear sputum positive cases, 11,166 new smear sputum negative cases, 7,445 extra pulmonary cases and 2,794 retreatment cases.

11.6 Constraints

Table 11.5 presents the three major constraints facing the National TB Programme.

Table 11.5: Constraints for National TB Programme

SN	Problems/Constraints	Actions to be taken	Responsibility
1	No sanctioned post of chest physician at national, regional and zonal level hospitals	Create chest physician post at national and regional level hospitals.	MoHP/DoHS
2	No post for quality control assessors at regional level	Sanction at least one post for quality control assessor at regional level	MoHP, DoHS, NTC, National Public Health Laboratory (NPHL), regional health directorates (RHD)
3	No national level chest hospital	Establish national level TB hospital	MoHP/DoHS

12 NATIONAL HEALTH TRAINING CENTRE

12.1 Background

The National Health Training Centre (NHTC) is the apex body for the development of human resources for the health sector. It caters for the training needs of all departments, divisions and centres of the Ministry of Health and Population. NHTC aims to train health service providers to deliver quality health care services. To achieve this objective the division delivers the training programmes in Table 12.1. More information on the centre is available in the annual report of the Department of Health Services and at www.dohs.gov.np

Table 12.1: Major training areas for Nepal's health system

SN	Type of training	Participants/course
1	Pre-service	Bio medical equipment technician (BMET), female community health volunteer (FCHV)
2	Basic	Village health worker (VHW), mother and child health worker (MCHW), auxiliary nurse-midwife (ANM)
3	Refresher	VHW, MCHW, mid-level providers (MLP), health assistant/staff nurse (HA/SN)
4	Specialized	Anaesthesia, family planning, safe birth attendance (SBA), caesarean section, ultrasonagraphy (USG), anaesthesia assistant training (AAT)
5	Up-grading	ANM to senior ANM, AHW to senior AHW
6	In service:	VHW, MCHW, senior ANM, senior AHW, health assistant, PHN/SN, medical officer, district supervisors
7	Orientations	Community leaders

12.2 Annual budget

The National Health Training Centre has a budget of NPR 252 million (US$ 3.4 million) for 2012/2013 (Table 12.2). Almost all of this amount comes from the government and its pooled donor funds.

Table 12.2: NHTC annual budget FY 2012/2013 (`000 NPR)

Source	Centre	District	Total
GoN/Pooled Fund	184,100	55,080	239,180
Donor funds	12,693	0	12,693
TOTAL	**196,793**	**55,080**	**251,873**

12.3 Major activities

The major NHTC activities for 2012/2013 are running the following types of training programmes:

- Upgrading AHW to senior AHW, ANMs to senior ANMs and MCHWs to ANMs.
- Training programmes on ultrasonagraphy for anaesthesia assistants.
- Family planning training programmes on no-scalpel vasectomies (NSV), minilaps, intrauterine contraceptive devices (IUCDs) and implants.

- In-service training programmes on medico-legal issues, safe birth attendance (SBA), safe abortion services (SAS), clinical training skills (CTS) and other subjects.
- The development of GESI modules for SBA, senior AHW, senior ANM, health facility management committee, behaviour change communication and FCHV training courses.

12.4 Procurement

No major procurement planned in 2012/2013.

12.5 Programme implementation strategies

NHTC's major programme implementation strategies are:

- develop and strengthen training sites.
- develop and revise training packages.
- publish training packages.
- prepare trainers.
- select training participants.
- conduct advanced training programmes.
- conduct training of trainer courses.
- train service providers.
- conduct post-training follow-up.
- provide on-site coaching.
- report on training activities.

12.6 Targets

Table 12.3: NHTC targets for FY 2012/2013

SN	Training	Target (persons)	Remarks
1	Number of SBAs trained up to 2012/13 (cumulative target)	6,000	
2	Reproductive health training: USG, AAT, medical abortion, A/SBA, comprehensive abortion care (CAC) & CAC on the job training	1,631	Central and regional training sites
3	Family planning: operation theatre , minilap, NSV, IUCD and implant, family planning and counselling (COFP)/counselling	481	
4	Up-grading training: AHW to Sr AHW, ANM to Sr ANM, MCHW to ANM and MLP	270	
5	CTS and training methodology	116	
6	Nursing/medical service management training	115	
7	Bio medical equipment technician training	32	
8	General trainings: Gender-based violence, behaviour change communication, implant, COPE/PLA, logistics	688	
9	FCHV basic training	4,200	District

COPE/PLA = client oriented providers efficient participatory learning action

Tables 12.3 and 12.4 give the main targets for NHTC for 2012/2013. The main impact and outcome indicator for NHTC for 2012/2013 relate to the training of safe birth attendants (Table 12.4).

The main NHTC planned outputs for 2012/2013 are:

- USG, AAT, MA, A/SBA, CAC and CAC OJT training 1,631 persons
- Family planning (op. theatre, minilap, NSV, IUCD, implant, COFP/counselling) 481 persons
- AHW to Sr AHW, ANM to Sr ANM, MCHW to ANM & MLP 350 persons
- CTS and training methodology 116 persons
- Nursing and medical service management training 115 persons
- General training (GBV, BCC, IP, COPE/PLA, logistics) 688 persons
- FCHV basic training 4,200 persons, 75 districts
- Integration of GESI module in selected curricula.

12.7 Governance-related activities

The NHTC's governance related activities for 2012/2013 relate to running training courses:

- on 'Client-oriented providers efficient participatory learning action' (COPE/PLA) for health workers;
- for health facility operation management committee (HFMC) members; and
- on gender based violence (GBV) training for health workers.

12.8 Gender equality and social inclusion activities

In 2012/2013 gender equality and social inclusion modules will be included in SBA, HFMC, BCC and FCHV training courses.

12.9 Technical assistance requirements

Technical assistance is needed in 2012/2013 for:

- integrating GESI issues into the curricula of upgrading trainings;
- integrating GESI issues into the curriculum of SBA, HFMC, BCC, and FCHV training courses; and
- revising the behaviour change communication BCC training package to include GESI.

12.10 Constraints

The four main constraints faced by NHTC are:

- inadequate human resources;
- difficulty of retaining human resources;
- the human resource plan not addressing emerging training needs; and
- the non-internalisation of the training policy and strategy by stakeholders.

13 NATIONAL HEALTH EDUCATION, INFORMATION AND COMMUNICATION CENTRE

13.1 Background

The core objective of the National Health Education, Information and Communication Centre (NHEICC) is to raise the health awareness of the people to enable them to improve their health status and prevent diseases through their own efforts and through the full utilisation of available resources.

The specific objectives of NHEICC's programmes are to:

- increase awareness and knowledge of the people on health issues.
- increase positive attitudes towards health care.
- increase healthy behaviour.
- increase the participation of people in health intervention programmes at all health service levels.
- increase access to new information and technology in health programmes for the people.
- promote environmental health and hygiene.
- control the use of tobacco and non-communicable diseases (NCDs).

More detailed information on NHEICC is available in the annual report of the Department of Health Services and at www.dohs.gov.np.

13.2 Annual budget

The National Health Education, Information and Communication Centre has a budget of NPR 262 million (US$ 3.5 million) for 2012/2013 (Table 13.1). Fifty-four percent is allocated to the central level and 46% to district level programming.

Table 13.1: NHEICC budget for FY 2012/2013 ('000 NPR)

SN	Programmes	Central Level			District Level	Central + district		
		GoN/PF	EDPs	Total	Total	GoN/PF	EDPs	Total
A. Health promotion and disease prevention								
1	Community mobilisation	8,640	0	8,640		8,640	0	8,640
2	Message dissemination through print media	6,915	1,350	8,265		6,915	1,350	8,265
3	Message development and airing on Radio Nepal	6,530	600	7,130		6,500	600	7,130
4	Message development and broadcast on Nepal TV	7,030	0	7,030		7,070	0	7,030
5	Message development and airing on FM Radio	5,600	1,200	6,800		5,600	1,200	6,800
6	Message development and broadcast on private TV channels	6,380	0	6,380		6,380	0	6,380

B. Environmental health and hygiene promotion								
7	Community mobilisation	1,400	3,940	5,340		1,400	3940	5,340
8	Print media	1,900	0	1,900		1,900	0	1,900
9	Message development and airing on Radio Nepal	900		900		900	0	900
10	Message development and broadcast on Nepal TV	900		900		900	0	900
11	Message development and broadcast on private TV channels	800		800		800		800
12	Message development and airing on FM radio	400		400		400		400
C. Health communication through different media								
13	Message development and airing on FM radio	400	0	400	25,000	25,400	0	25,400
14	Print media	8,400	0	8,400	12,750	21,150	0	21,150
15	TV programme production & broadcast	15,450	0	15,450	0	15,450	0	15,450
16	Community mobilisation	4,600	7,760	12,360		4,600	7,760	12,360
17	Radio programme production and airing	8,000	575	8,575		8,000	575	8,575
18	Message development and airing on private TV channels	660	0	660		660	0	660
D. Non-communicable diseases (NCD) and tobacco control programme								
19	Community mobilisation	450	10,320	10,770		450	10,320	10,770
20	Message development and airing on FM radio	500		500		500		500
21	TV programme production and broadcast	450		450		450		450
22	Radio programme production and airing	300		300		300		300
23	Message development and airing on private TV channels	300		300		300		300
24	Print media	250		250		250		250
E. Capacity building								
25	Advocacy and social mobilisation	5,100		5,100	72,250	77,350		77,350
26	Capacity building and resource centre strengthening	2,190	5,700	7,890	2,800	4,990	5,700	10,690
27	Research and studies	1,100		1,100		1,100		1,100
F. Community Health Education Programme								
28	Supervision and monitoring	3,050		3,050	1,875	4,925		4,925
29	School health programme				5,250	5,250		5,250
30	FCHV motivational programme				1,500	1,500		1,500
31	Office management costs	10,875				10,875		10,875
	TOTAL	**109,470**	**31,445**	**140,915**	**121,425**	**230,895**	**31,445**	**262,340**

13.3 Major activities

The following activities are planned under NHEICC for 2012/2013:

- Design, produce and distribute IEC/BCC materials on reproductive health issues, child health, communicable and non-communicable diseases, environmental health and hygiene, tobacco use, gender equality and social inclusion, neglected tropical diseases and other public health issues.
- Produce and broadcast radio programmes, spots and jingles at national, regional, and district level.
- Design, produce and broadcast audiovisual programmes, film spots, jingles, and drama serials on local and national television channels.
- Publish promotional, preventive, and rehabilitative health messages in the print media.
- Conduct campaigns by using mass media, multimedia and community mobilisation on specific events and days for preventing and controlling epidemics and communicable diseases.
- Conduct health education programmes in schools.
- Celebrate special days via advocacy on the health themes.
- Disseminate messages through high-level bureaucrats and politicians.
- Conduct interaction activities among marginalised and socially disadvantaged groups on different health issues at the community level.

Other activities include producing audio visual programmes and IEC/BCC materials on tobacco control and non-communicable diseases, the environment, hygiene and sanitation and alcohol control.

13.4 Procurement

NHEICC has a procurement budget of NPR 17.7 million for 2012/2013 (Table 13.2)

Table 13.2: NHEICC planned procurement for 2012/2013 (NPR in '000)

SN	Activities	Amount (NPR)
1	Printing wall flipcharts	5,500
2	Airing messages on immunisation on Nepal TV	1,800
3	Printing materials on immunisation	1,500
4	Message airing on immunisation on Radio Nepal	1,350
5	Message dissemination on FM radio on safe abortions	1,200
6	Community level orientations on safe abortions	1,200
7	Publishing IEC materials on nutrition	1,100
8	Printing a flip chart on safe abortion for use by FCHVs	1,050
9	Developing and printing IEC materials on environmental health, hygiene and sanitation	1,000
10	Broadcasting messages on malaria and other communicable diseases on FM radio	1,000
11	Broadcasting messages on malaria and other communicable diseases on private TV channels	1,000
	TOTAL	**17,700**

13.5 Programmes implementation strategies

NHEICC's main programme implementations strategies are as follows:

- Implementing IEC interventions at national, regional, district and community levels.
- Ensuring adequate supplies of IEC/BCC materials to service outlets by using private and government distribution systems.
- Ensuring and mobilizing the participation of communities, INGOs, NGOs, local bodies, social workers and individuals in disseminating health messages.
- Building institutional capacity at various levels through training, orientations and workshops.
- Developing, producing and disseminating uniform, accurate, appropriate and adequate messages on health, based on local needs and audiences.
- Using multimedia approaches to disseminate health information at the community level.
- Emphasising interpersonal communication in community level interventions.
- Establishing and strengthening coordination and cooperation with related governmental, non-governmental and international organisations at all levels.
- Strengthening monitoring and supervision at different levels of intervention.
- Conducting research on different disciplines of IEC/BCC to determine gaps in knowledge, attitudes and practices among target audiences and service providers.
- Segmenting audiences and developing specific messages for specific audience group based on research.
- Support a functioning national IEC/BCC Co-ordination Committee and central level technical committees consisting of the representatives from government organisations, NGOs and INGOs for providing approval and guidance on disseminating uniform, accurate, appropriate and adequate health messages to the people.
- Conducting health advocacy activities through national and international health related events.
- Emphasising social inclusion and gender equity at all levels.

13.6 Targets

Health education, information and communication programmes play an important role in improving health and other MDG indicators such as education as these programmes provide knowledge and information to targeted audiences for behaviour change. The achievement and targets of the main indicators related to the work of NHEICC are shown in Table 13.3.

Table 13.3: NHEICC related impact indicator achievements and targets (1996–2015)

SN	Indicator	1996	2001	2006	2011	2013	2015 (target)
1	Under five mortality rate (per 1,000)	118	91	61	54	47	38
2	Infant mortality rate (per 1,000)	79	64	48	46	38	32
3	New born mortality rate (per 1,000)	50	43	33	33	23	16
4	One year old children fully immunized (%)	43	66	83	87	90	90
5	Underweight children under five (%)		43	39	29	34	29

The main outcome indicators related to the work of NHEICC are as follows:

- % increase in knowledge on key health issues among intended audiences.
- % increase in health service utilisation (such as maternal health, family planning, newborn, and the expanded programme of immunisation [EPI]).
- % people practicing key health behaviours to prevent diseases and for child and maternal survival.
- % increase in funds for key health issues and communication programmes.
- Increase in number of qualified dedicated human resources for health communication.
- % households with soap and water at a hand washing station inside or within 10 paces of latrines.

The main outputs related to the work of NHEICC in 2012/2013 are as follows:

- Demand created for quality essential health services.
- Increased knowledge of targeted people by getting information on health.
- Attitudinal changes towards positive health.
- Desired behaviour changes of targeted populations.
- Increased utilisation of available health services.

13.7 Governance-related activities

The main governance related activities of NHEICC are as follows:

- BCC training on environmental health, hygiene and sanitation, and hand washing.
- Trainer's training on BCC on environment health and sanitation and hand washing.
- Message dissemination through NHEICC website.

13.8 Gender equality and social inclusion activities

- Message dissemination on public and private TV and radio channels.
- Designing, developing and distributing gender equality and social inclusion-related materials to targeted audiences; and
- Running interaction programmes on gender equality and social inclusion.

13.9 Technical assistance requirements

The technical assistance requirements of NHEICC are a BCC officer to support the Family Health Programme and an IEC coordinator.

13.10 Constraints

The main constraints faced by NHEICC are as follows:

- Inadequate budget for health education, information and communication.
- The position of health education technician no longer exists at district level.
- The inadequate implementation of the one-door system (through NHEICC) for communicating health messages.

14 DEPARTMENT OF DRUG ADMINISTRATION

14.1 Background

The main objective of the Department of Drug Administration (DDA) is to regulate all functions relating to modern, veterinary and traditional medicines. These include preventing the misuse and abuse of medicines and raw materials, stopping false and misleading advertisements and making available safe, efficacious and quality drugs to the general public by controlling the production, marketing, distribution, sale, export-import, storage and use of medicines as per the Drug Act, 1978 and its regulations. More information is available on the department at www.dda.gov.np

14.2 Annual budget

The Department of Drug Administration has a budget of NPR 53,619,000 (US$ 0.7 million) for 2012/2013.

14.3 Major activities

The major activities of the department for 2012/2013 are:

- providing drug information to the general public.
- publishing the Drug Bulletin of Nepal (DBN).
- inspecting domestic pharmaceutical industries.
- inspecting drug wholesalers and retail outlets.
- inspecting foreign pharmaceutical industries based in Nepal.
- drug analysis.
- auditing pharmaceutical analytical laboratories.

14.4 Procurement

The Department of Drug Administration plans to carry out NPR 7.8 million of procurement in 2012/2013 (Table 14.1)

Table 14.1: DDA planned procurement for 2012/2013 (NPR)

SN	Activities	Amount
1	Furniture and fixtures	250,000
2	Machinery and equipment	6,100,000
3	Construction and maintenance	1,500,000
	TOTAL	7,850,000

14.5 Programmes implementation strategies

The main DDA programme implementation strategy is the inspection and audit of drug production and sale.

14.6 Targets

Table 14.2 gives the seven output targets for DDA in 2012/2013.

Table 14.2: Department of Drug Administration targets for 2012/2013

SN	Activities	Unit	Target
1	Drug information to the public through different media	Times	70
2	Publication of the Drug Bulletin	Times	3 (15,000 copies per time)
3	Inspection of pharmaceutical industries	No.	100
4	Inspection of drug retailers and wholesalers	No.	1,700
5	Inspection of foreign pharmaceutical industries	Times	3
6	Drug analysis	No.	700
7	Audit of pharmaceutical analytical laboratories	No.	28

14.7 Governance-related activities

- Publication of the Drug Bulletin of Nepal.
- Website of DDA: ww.dda.gov.np.
- Additional human resources for organisation and management.

14.8 Technical assistance requirements

The main technical assistance requirements of DDA are for strengthening national medicine laboratories and for strengthening DDA's capacity in general.

14.9 Constraints

- Inadequate human resources.
- Inadequate branch offices and too few staff. There are only branch offices in Biratnagar, Birgunj and Nepalgunj.

15 NEPAL NETRA JYOTI SANGH

15.1 Background

Nepal Netra Jyoti Sangh (NNJS) is a society for comprehensive eye care services in Nepal. It is a non-profit organisation that was established in 1978. The society runs 14 eye hospitals and 52 eye care centres. The main programmes run by the organisation are the community outreach, eye health education, ophthalmic assistant training, research and monitoring, National Trachoma Programme, National Eye Sight Programme, and the National Low Vision Programme.

The main objective of the society is to reduce the prevalence of avoidable blindness through a comprehensive eye care service network and community outreach programme. To achieve this objective the Ministry of Health and Population supports NNJS to:

- run the National Trachoma Programme.
- establish and run district-level primary eye care centres.
- distribute spectacles to correct near vision impairment in rural areas.
- cataract surgery.
- human resource development.

15.2 Annual budget

Nepal Netra Jyoti Sangh has a budget of 61 million (US$ 0.8 million) for 2012/2013 (Table 15.1). The highest proportion of this budget is for running the primary eye care centres (36%).

Table 15.1: Annual budget of Nepal Netra Jyoti Sangh for FY 2012/2013 (NPR '000)

SN	Major programmes	Total (central + district
1	Primary eye care centres	21,960
2	Cataract surgery	21,000
3	Trachoma programme	10,150
4	Spectacles distribution	5,000
5	Human resource development	3,500
	TOTAL	**61,610**

15.3 Major activities

Trachoma programme

- Increase public awareness in Rukum and Rautahat districts about trachoma diseases through local FM radio and newspapers.
- Run training courses/orientation programmes on managing and distributing trachoma drugs for DHO/DPHO, primary health care centre, health post and sub-health post staff of Rukum and Rautahat districts.
- Distribute Zithromax, a drug of choice to treat trachoma, free of cost to people in need in Rukum and Rautahat.

- Run an information programme on trachoma disease (face washing and environmental cleanliness) in 20 districts in coordination with the Department of Health Services.
- Carry out monitoring and supervision visits in Rukum and Rautahat districts to review trachoma programme activities.
- Carry out an impact survey in districts where the trachoma programme was carried out previously (Achham, Doti, Rolpa and Dailekh).

Other activities

- Support the running costs of 35 primary eye care centres.
- Carry out 8,000 cataract surgeries free of cost in remote districts.
- Carry out monitoring and supervision visits to eye hospitals and 52 primary eye care centres.
- Distribute 5,000 spectacles to people aged 50 years and over in the Karnali, Far Western, Mid-Western and Western regions of Nepal.
- Provide scholarships for 10 ophthalmic assistants to study.

15.4 Procurement

Not applicable.

15.5 Programmes implementation strategies

The main programme implementation strategies of NNJS are:

- establishing and running primary eye care centres.
- conducting mobile eye screening and surgical camps.
- running awareness programmes on eye health; and
- population based surveys of eye health.

15.6 Target

Nepal Netra Jyoti Sangh has made a large contribution to the good progress made in Nepal on improving eye health and extending eye health service provision (Table 15.2).

Table 15.2: Eye health indicator achievements and targets, 1981–2015

SN	Indicator	1981	1997	2010	2013	2015 (Target)
1	Prevalence of blindness, visual acuity (VA) <6/60	1.28%	1.1%	0.82	0.8	<0.6
2	Prevalence of blindness VA <3/60	0.84	0.7	0.4	0.3	<0.2
3	Cataract surgical coverage in blind eyes	30%	45%	60%	65%	>90%
4	Trachoma prevalence	5%	2%	0.4%	0.3%	<0.2%
5	Service coverage districts	<10%	50%	80%	90%	100%
6	Prevalence of uncorrected presbyopia			60%	50%	<40%

Nepal Netra Jyoti Sangh's planned outputs for 2012/2013 are to:

- perform 8,000 cataract operations with Government of Nepal support in rural and remote areas.

- run primary eye care centres in 72 district with GoN support in 35 districts.
- distribute 5,000 presbyopic glasses in rural and remote area of the country.
- run trachoma orientation programmes in 15 districts.
- distribute Zithromax in two districts.
- train DHO/DPHO, health post and sub-health post staff in 2 districts; and
- carry out a trachoma impact assessment in 4 districts.

15.7 Constraints

The main constraints faced by NNJS are lack of sufficient human resource for eye care services and the unstable political situation that hinders the smooth implementation of eye care programme at the district level.

ANNEX 1: GAAP RELATED ACTIVITIES AND FUNDING (FY 2012/2013)

The activities in the left hand column of Table 16 are some of the key activities of NHSP-2's Governance and Accountability Action Plan (GAAP) that may have budget implications for the business plans featured in this report. Comparing the GAAP activities with the status in MoHP's annual work plan and budget shows the extent to which governance related issues have been taken into consideration in the AWPB for 2012/2013. The source of reference for the following information is MoHP's Electronic Annual Work Plan and Budget for 2012/2013.

Table 16: Status of GAAP activities in MoHP annual work plan and budget (AWPB) for 2012/2013.

SN	Activities listed in GAAP (FY 2012/2013)	Status in AWPB (FY 2012/2013)
A.	**Sector Governance/Enabling Environment**	
1	Output-based budgeting	Incorporated in e-AWPB
2	Transparency and disclosure measures	AWPB for FY 2011/12 uploaded on MoHP website. Plan to upgrade www.mohp.gov.np website this year
B.	**Stakeholder information**	
3	Performance audits of programmes	Audits done by Office of The Auditor General (OAG) and published in its annual report and available at www.nep.gov.np
C.	**Implementation capacity/Institutional capacity**	
4	Capacity development initiatives for different levels of health staff	Initiatives mainly included in National Health Training Centre's (NHTC) AWPB
5	AWPB to incorporate institutional development programme	Programme included in the Management Division's (MD) AWPB
6	Implementation of phase 1 health facility block grants	Provision of grants included in MoHP's AWPB with a plan to prepare a regulation
7	Implementation of remote area allowances for health workers	Since 2011/12 remote allowances have gone to health workers in remote areas. Human resource related issues are planned to be addressed in MoHP's AWPB as per draft human resources for health (HRH) strategy.
8	Conduct an organisation and management survey of human resources for health	Survey conducted in 2011/12 by MoHP, Management Division and DoHS administration section
9	Implementation of deployment and retention plan	Not clearly documented in AWPB.
10	Implement strategies for recruiting local staff in health facilities	Local staff recruited through local contracts since 2010/11.
11	Establish a system for reviewing quality health services	Service Tracking Survey (facility survey) conducted in 2011
12	Improve and expand health physical infrastructure	Health Infrastructure Information System (HMIS) prepared and is being disseminated to stakeholders.
13	Link other sectors in HMIS	On-going discussion going on under Health Sector Information System (HSIS)
14	Quarterly publication of health statistics and analysis	Planned under Management Division
15	Update and prepare new guidelines and protocols for primary health care system	Included under Primary Health Care Revitalisation Division (PHC-RD) in 2011/12
16	Carry out annual facility survey	Service Tracking Survey conducted in 2011/12 and

		planned for 2012/2013
D.	**Financial Management**	
17	Computerised system for accounting and reporting at MoHP and DPHOs/DHOs with networking	Concept paper prepared and consulting firm is designing the system (Transaction Accounting and Budget Control System — TABUCS)
18	Fund flow tracking system developed in software	System included under TABUCS
19	Regular updating of inventory of all assets	Updating included in LMD's AWPB
20	Improve inventory software for non-consumable fixed assets and strengthen Logistics Management Information System (LMIS)	Improvements included in LMD's AWPB
21	Build district level capacity to comply with quality assurance (QA) of health care services	Capacity building included in Logistic Management Division's (LMD) AWPB
22	Adequate funds for maintenance in AWPB	Funds included in Management Division's AWPB
23	Update financial regulations for hospitals and management committees	Development of a policy on public-private partnerships in health is underway and included in MoHP's AWPB
24	Prepare acts and regulations for non-state partners	Included in MoHP's AWPB
25	At least 2% of budget for operation and maintenance of medical equipment and hospital buildings	A proportion has been included in the AWPB of the Management Division
E.	**Procurement**	
26	The timely preparation of the Consolidated Annual Procurement Plan (CAPP)	LMD is preparing this plan
27	Revise procurement policy and guidelines for MoHP	Included in MoHP's AWPB
28	Revise logistics management policy and guidelines	Included in LMD's AWPB
29	A quality assurance (QA) system including pre and post-shipment inspections at central and district levels	LMD is practising this QA system
30	Local capacity at district level to comply with QA	LMD is practising this
31	Training for strengthening procurement capacity at central and district levels	LMD is practising this
32	Introduce e-procurement	LMD is currently practising this (For national competitive bidding, LMD can do e-procurement, but for international competitive bidding (ICB), LMD requires approval from World Bank)
F	**Environment**	
33	Annual contingency plans and budgets for districts incorporating reproductive health (RH) and gender-based violence (GBV) issues	Included in MoHP's and FHD's AWPB
34	Ensure that all health facilities have and implement a waste management plan	Included in MD's AWPB
35	Replace the use of kerosene energy with solar energy in health facilities	Included in LMD's AWPB
G	**GESI**	
36	Updating social audit guidelines	MoHP has endorsed provisional guidelines, which are being piloted in 2012
37	Provision of training and budget for undertaking social audits	Included in PHC-RD's AWPB
38	Capacity building of local HFMCs on GESI	Included in PHC-RD's AWPB

39	Capacity building on GESI at all levels	Included in MoHP's AWPB (Population Division)
40	Ensuring HFMCs are formed for all health facilities at local level and are properly orientated	Not clearly mentioned
41	Recruitment of local health personnel through HFMCs	Included in different divisions including Family Health Division, PHC-RD and Child Health Division