WHO Country Cooperation Strategy Nepal, 2013–2017

Country Office for Nepal

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Message from the Ministry of Health and Population, Nepal

This Country Cooperation Strategy (CCS) represents a comprehensive and coherent medium-term vision for WHO's technical cooperation and defines its strategic framework for working in and with Nepal between 2013 and 2017.

The new CCS is aligned with national health priorities as outlined in the National Health Sector Programme Implementation – Plan II (NHSP-IP II) and those of WHO, as expressed in its General Programme of Work and based on its regional orientation and priorities. This document has been developed through intensive consultation with the Government of Nepal (GoN), the United Nations Country Team, national stakeholders and other external development partners working in the country's health sector. Six strategic priority areas has been identified for WHO cooperation: (1) achieving communicable diseases control targets; (2) controlling and reversing the growing burden of noncommunicable disease; (3) promoting health over the life-cycle focusing on interventions for underprivileged and vulnerable populations; (4) strengthening health systems within the revitalized primary health care approach and supporting policy dialogue on health policies, strategies and plans for universal coverage; (5) reducing the health consequences of natural and human induced disasters; and (6) addressing environmental determinants of health. It also takes into stride WHO's normative functions, monitoring progress towards achievement of all health-related Millennium Development Goals (MDGs) and other emerging and re-emerging public health challenges.

In the present context, when Nepal is in the process of drafting a new constitution, which is expected to have a significant influence on the structure and operation of health sector, this CCS envisages WHO performing the role of a technical adviser and convener who engages with the GoN and other partners, facilitating multisectoral collaboration and harmonization for sustainable and significant improvement in health outcomes.

In this regard, the Ministry of Health and Population welcomes this strategy as a guiding document for WHO collaboration with Government of Nepal and other relevant stakeholders; thus contributing towards national and global health development efforts.

Dr Praveen Mishra
Secretary
Ministry of Health and Population

Preface

The Country cooperation strategy (CCS) is a key instrument of the World Health Organization and a medium-term vision for technical cooperation in support of Nepal's National health plan, policies and strategies.

The World Health Organization has been working closely with the Member States of the South-East Asia Region to improve the health of its peoples. In fact, the Region was the first to promote the development of country cooperation strategies, which guide WHO in how to support national health development according to the challenges, strengths, strategic objectives and priorities of the country. In the case of Nepal, WHO began working with the Government of Nepal in 1954, when Nepal became a Member State of WHO.

The previous CCS Nepal covered the period when the country moved fast towards achieving different health-related Millennium Development Goals (MDGs). I am pleased to recall Nepal's achievements and awards in several important areas of public health. For example, the 2012 Resolve Award for *Innovative financing in improving maternal health, the 2010 MDG 5 award for Reduction (by half) in maternal mortality between 1990 and 2010 and the 2009 GAVI Alliance award for Outstanding performance in improving child health and immunization*. Welcome and deserved though they are, we cannot rest content with awards alone. Nepal continues to experience economic, social, epidemiological and demographic transitions, in addition to the vision of federalism in its interim constitution, which may impact the health system in the long run.

The process of development of the current CCS took over a year. It involved a series of consultations with multisectoral stakeholders in health and a Joint Annual Review with the Government. A range of different stakeholders played, and continue to play, an active part in complementing the efforts of the Ministry of Health and Population to address emerging health needs and priorities of the country. Comprehensive consultation helped ensure that WHO's inputs would supplement and support these health development efforts effectively, as spearheaded by the Ministry of Health and Population of Nepal.

I would like to take this opportunity to thank all those who have been involved in the development of this CCS, which has the full support of the Regional Office. Over the next 5 years, we shall work together to achieve its objectives in order to provide maximum health benefits to the people of Nepal. I am confident that with our joint efforts, we shall be able to move forwards together and support implementation of the Government's vision to build a healthier nation, achieving and sustaining health-related MDGs and towards universal coverage of health for all its citizens.

Dr Samlee Plianbangchang
Regional Director

Foreword

The World Health Organization and the Government of Nepal have been working closely to improve the health of the people of Nepal for many years. The Country Cooperation Strategy (CCS) provides a basis for all possible collaborations, including in-depth analysis of the strengths, opportunities, gaps and challenges, taking into account the strategic objectives of the Nepal Health Sector Strategic Plan 2010–2015 of the Ministry of Health and Population, while detailing how WHO will support the implementation of national health development strategies.

In recent years, Nepal has been able to improve the health condition of the people. During the past CCS period, the country was able to receive at least three international recognitions through the 2012 Resolve Award, the 2010 MDG 5 award, and the 2009 GAVI Alliance award. There are noticeable improvements in terms of capacities of health institutions, Government strategies and capacities by private sector health-care providers in specialized services through medical college hospitals. Nepal is, however, prone to emerging infectious diseases (for example influenza, or dengue and other vector-borne diseases) and the increasing burden of noncommunicable diseases (NCD) are gradually becoming an added challenge to the health-care system of the country.

This CCS for Nepal is the third generation WHO Country Cooperation Strategy. It articulates WHO strategies for cooperation with the Member State at country level for the period 2013–2017. The Strategic Agenda reflects and envisages the health development agenda of the Federal Democratic Republic of Nepal and is aligned with the mandate for collaboration in health with WHO.

This CCS is a based on a series of concerted, multisectoral meetings and consultations with a range of different stakeholders in the Nepalese health sector, including sister United Nations agencies, bilateral and multilateral development partners, civil society, academia, nongovernmental organizations. In order to maximize mutual benefit and WHO support to national health development, the CCS attempts to maintain a balance between evidence-based country priorities and WHO strategic priorities.

It gives me immense pleasure to present the WHO Nepal CCS, a comprehensive strategic document, useful for national and international development partners in the health sector. I hope it will help ensure better cooperation, collaboration and investment in the areas of need and priority in the country to implement collaborative activities so that the health and well-being of the people of Nepal may be improved.

Dr Lin Aung
WHO Representative to Nepal

Abbreviations and acronyms

ACT	artemisinin-combination therapy
AES	acute encephalitis syndrome
ARI	Acute acute respiratory infections
ART	antiretroviral therapy
AusAID	Australian Agency for International Development
BCG	Bacille Calmette Guerin [tuberculosis vaccine]
BCP	business continuity plan
CBO	community-based organization
CCA	Common Country Assessment
CCF	country coordination and facilitation
CCS	country cooperation strategy
CFR	case–fatality rate
COPD	chronic obstructive pulmonary disease
CP	country programme
CPD	continued professional development
CSO	civil society organizations
CTEVT	Council for Technical Education and Vocational Training
DALY	disability-adjusted life years
DDA	Department of Drug Administration
DFID	Department for International Development (United Kingdom)
DoHS	Department of Health Services (Nepal)
DOTS	directly observed therapy – short course
DTC	Drug and Therapeutic Committees
DPT3	diphtheria-tetanus-pertussis [vaccine]
EDP	external development partners
EDCD	Epidemiology & Disease Control Division (Nepal)
EHCS	essential health-care services
EWARS	Early Warning and Alert Response Surveillance
GAAP	governance and accountability action plan
GAVI	GAVI Alliance (formerly Global Alliance for Vaccines and Immunisation)
GAVI HSS	GAVI Health Systems Strengthening funding

GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* (German Agency for international development cooperation)
GoN	Government of Nepal
GPW	General programme of work (of WHO)
HMIS	health management information systems
HR	human resources
HRH	human resources for health
HuRIS	human resource information system
IASC	Inter Agency Standing Committee
ICIMOD	International Centre for Integrated Mountain Development (based in Kathmandu, Nepal, founded in 1983)
IGO	intergovernmental organization
IHP+	International Health Partnership
ILO	International Labour Organization
IPD	in-patient department
JAR	Joint Annual Review
JE	Japanese encephalitis
JFA	joint financing arrangement
JICA	Japanese International Cooperation Agency
JMP	WHO–UNICEF Joint Monitoring Programme on Water Supply and Sanitation
JTAA	joint technical assistance arrangement
KfW	*Kreditanstalt fuer Wiederaufbau* (financial assistance by the Federal Republic of Germany)
LF	lymphatic filariasis
LLIN	long-lasting insecticide-treated net
LMD	Logistics Management Division
M&E	monitoring and evaluation
MCH	maternal and child health
MDA	mass drug administration
MDG	Millennium Development Goals
MDGP	medical doctor and general practitioner
MDR	multidrug resistance

MDR/XDR	multidrug- resistant and extremely drug-resistant tuberculosis
MMI	Modified Mercalli Intensity scale
MMR	maternal mortality rate
MoHP	Ministry of Health and Population, Nepal
MSM	men having sex with men
MSNP	multisectoral nutrition plan
MSW	male sex workers
MTSP	medium-term strategic plan
NCD	noncommunicable diseases
NDHS	Nepal Demographic and Health Survey
NEML	National Essential Medicines List
NEPHEN	Nepal Public Health Education Network
NGO	nongovernmental organization
NHSP-II	Nepal Health Sector Programme – II
NHSP IP-II	National Health Sector Programme Implementation Plan – II
NIDs/SNIDs	national immunization days and subnational immunization days
NPC	National Planning Commission, Nepal
NTP	Nepal Tuberculosis Programme
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OOPE	out-of-pocket expenditure
OPD	out-patient department
OPV	oral polio vaccine
PBA	programme-based approaches
PCL	proficiency certificate level [nursing]
PMTCT	preventing mother-to-child transmission [of HIV/AIDS]
RTA	road-traffic accident
SBA	skilled birth attendant
SDC	Swiss Development Corporation
STI	sexually transmitted infections
SWAp	Sector-Wide Approach
SWC	Social Welfare Council
TA	technical assistance
TB	tuberculosis

TFR	total fertility rate
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene
WB	World Bank
WHO	World Health Organization

Executive summary

The WHO Country Cooperation Strategy (CCS) 2013–2017 for Nepal provides a coherent medium-term vision for WHO's technical cooperation and defines its strategic framework for working in and with Nepal.

The CCS is aligned with the national health objectives in the National Health Sector Programme–II (NHSP-II); it focuses on selected country priorities, as analysed by WHO in consultation with the Government, national stakeholders, the United Nations (UN) Country Team, the United Nations Development Assistance Framework (UNDAF) and other external development partners (EDPs). This CCS also encompasses social determinants of health.

The CCS has been designed to represent a balance between the country's priorities and those of WHO as expressed in WHO's General Programme of Work and regional orientations and priorities. The CCS development process coincides with the development of the new UNDAF for Nepal and the EDP technical assistance matrix for support of the NHSP-II, enabling a close coordination and harmonization across these frameworks.

Nepal has been passing through a period of political unrest, insurgency, and violence. During the period 1996 and 2006 the country experienced Maoist insurgency which resulted in a significant number of deaths and internally displaced persons. The new constitution is expected to have a significant effect on the structure and operation of the health sector.

Over the period of the previous CCS, Nepal has made progress in raising health status. Currently, Nepal is on track to meet MDGs 4 and 5, for which Nepal received a "Child Survival Award" from GAVI Alliance (GAVI) for its progress in MDG 4; and a UN MDG 5 award for its progress in maternal health. Tuberculosis (TB) control has been achieved and the country is on track to achieve the TB-related MDGs. Leprosy elimination targets have also been met. The MDG goal for malaria has been achieved and Nepal is moving towards pre-elimination with a target of elimination by 2026. A kala-azar (leishmaniasis) elimination programme is in progress, with less than 900 cases and a case–fatality rate (CFR) of 0.11 by 2010; elimination of lymphatic filariasis and soil-transmitted helminths is considered on track.

Epidemic prone diseases, such as cholera and acute gastroenteritis, are endemic in all regions of the country with a constant threat to the public health system. Compounding the situation are emerging threats, for example dengue, novel influenza and leptospirosis, which have the potential to cause widespread morbidity and mortality. Despite the continuing improvement in nutritional status, Nepal will have difficulty in achieving nutrition-related MDG targets.

The current situation warrants strengthening of surveillance, response and preparedness capacities to minimize damage to human lives and containment of infection at source or as near as possible to the source. The country is stepping towards implementation of integrated disease surveillance and adopting integrated vector management system.

Although there is paucity of information on the burden of noncommunicable diseases (NCDs), the behavioural and intermediate risk factors for NCDs are increasing due to changing lifestyles in the cities. The major NCD burdens are cardiovascular disease, chronic obstructive pulmonary disease, diabetes, cancer, blindness, hearing impairment and mental disorders.

The environmental determinants for better health, such as safe water, sanitation, hygiene and health-care waste management, require continued attention. Water, sanitation and hygeine associated diseases including skin diseases, acute respiratory infections (ARI) and diarrheal diseases are the three leading preventable diseases with the latter two being among leading causes of child deaths. Health care waste management remains a huge challenge. Nepal is also prone to many natural disasters, particularly earthquakes, floods and landslides. Effort and investment are needed to prepare for and mitigate the impact of natural disasters and climate change.

The Government's Nepal Health Sector Programme – II 2010–2015 (NHSP–II) builds upon the progress made towards improved health outcomes in the preceding 5 years to: increase access to and utilization of a set of defined, quality essential health-care services; reduce cultural and economic barriers to accessing health-care services particularly by those who are poor, vulnerable and marginalized and reduce harmful cultural practices, in partnership with non–state actors; and to improve the health system to achieve universal coverage of essential health services. The CCS is also aligned towards achieving universal health coverage and social health protection.

In support of the NHSP-II, six strategic priority areas for WHO cooperation have been identified for the period 2013–2017. The order in which the strategic priorities are listed does not indicate a relative weighting, level of effort or the importance attributed to each.

Six strategic priorities have been identified for WHO cooperation:

(1) Achieving communicable diseases control targets.

(2) Controlling and reversing the growing burden of noncommunicable disease.

(3) Promoting health over the life-cycle focusing on interventions for underprivileged and vulnerable populations.

(4) Strengthening health systems within the revitalized primary health care approach and support policy dialogue on health policies, strategies and plans for universal health coverage.

(5) Reducing the health consequences of disasters.

(6) Addressing environmental determinants of health.

Beyond the six strategic priorities WHO will continue to address other important public health challenges in Nepal that do not fall within the priority areas as part of WHO's collaboration. Collaborative work in these areas will be planned in a biennium-to-biennium mode through negotiation between WHO, national authorities and relevant stakeholders.

1 — Introduction

The WHO Country Cooperation Strategy (CCS) 2013–2017 for Nepal provides a coherent medium-term vision for WHO's technical cooperation and defines its strategic framework for working in and with Nepal.

The criteria for WHO's cooperation with Nepal – on which the CCS is based – are:

- *Ownership* of the development process by the country.
- *Alignment* with national health objectives and strengthening national systems in support of the National Health Sector Programme – II (NHSP-II).
- *Harmonization* with the work of sister UN agencies and other national and external development partners for better aid effectiveness.
- *Cooperation* as a two-way process that fosters contribution of Member States to the global health agenda.
- *Potential for impact*, focusing on areas where WHO's inputs will have substantial impact on country capacity in health policy and systems, public health services and management capacity at all levels.
- *Comparative advantage,* focusing on areas within WHO's core functions and competencies where WHO has a comparative advantage vis-à-vis other national and external development partners.

The CCS is aligned with the national health objectives outlined in the NHSP-II, which will facilitate WHO to better synchronize its technical cooperation in priority areas set by the Government. In addition, the document builds on the WHO reform process and responds to the priority-setting practices in WHO, their strengths and weakness and the formulation of the Twelfth General Programme of Work.

The CCS focuses on selected country priorities, as analysed by WHO in consultation with the government, national stakeholders, the UN country team and other external development partners (EDPs). As such it identifies priority areas for WHO's technical support and serves as the key WHO instrument for alignment with national plans and strategies, harmonization with national and external development partners in country.

Moreover, by highlighting "what WHO will do, and how and with whom it will do it" the CCS provides strategic guidance and a coherent framework for formulating the biennial WHO operational plan (country workplans) for Nepal and serves as a platform for resource mobilization at national, regional and global levels.

The CCS development process coincides with the development of the new UNDAF 2013–2017 for Nepal and the EDP technical assistance matrix for support of the NHSP-II, enabling a close coordination and harmonization across these frameworks.

2 — Health and development achievements, opportunities and challenges

2.1 Macroeconomics, political and social context

2.1.1 Demographic profile

Nepal's population was 26.6 million in 2011 with the population growing at a projected rate of 1.4%. Nepal is predominantly rural despite an increasingly rapid rate of urbanization from 14% in 2001 to 17% in 2011 *(1)*. Life expectancy at birth continues to increase for both males and females; increasing from 55.0 years for males and 53.5 years for females in 1991 to 67 years and 68 years for males and females, respectively, in 2011 *(2)*. As per the 2011 census 37.2% of population was below 15 years, 54.4% between 15 and 59 years, and 8.4% was 60 years and above.

2.1.2 Socioeconomic situation

The population living below the national poverty line has declined from 42% in 1996 to 25% in 2010. Poverty remains predominantly a rural phenomenon with 96% of the poor living in rural areas; 29% of the rural population fall below the poverty line versus 8% of the urban population. The Human Development Index continues to improve increasing from 0.398 in 2000 to 0.458 in 2011 *(3)* although wide disparities persist across districts. Nepal ranks 113th in the Gender Inequality Index with a value of 0.558 *(4)* revealing the low status of women in the country.

Although the overwhelming majority of the population depends on agriculture for their livelihoods, the contribution of agriculture to the national economy has been steadily decreasing, accounting for 33% of the gross domestic product (GDP) in 2009. Remittances, which accounted for 18% of national income, remain one of the principle contributors to poverty reduction with 30% of households having received remittances in 2008.

2.1.3 Political and governance structure

Nepal has been passing through a period of political unrest, insurgency, and violence. During the period 1996 and 2006 the country experienced Maoist insurgency which resulted in a significant number of deaths, internally displaced people, the destruction of infrastructure, and a significant disruption in the economy. In 2008 the Maoists joined with the other major political parties in establishing a federal republican structure. The political parties are striving to develop an inclusive constitution which may affect different aspect of the health sector.

2.2 Other major determinants of health

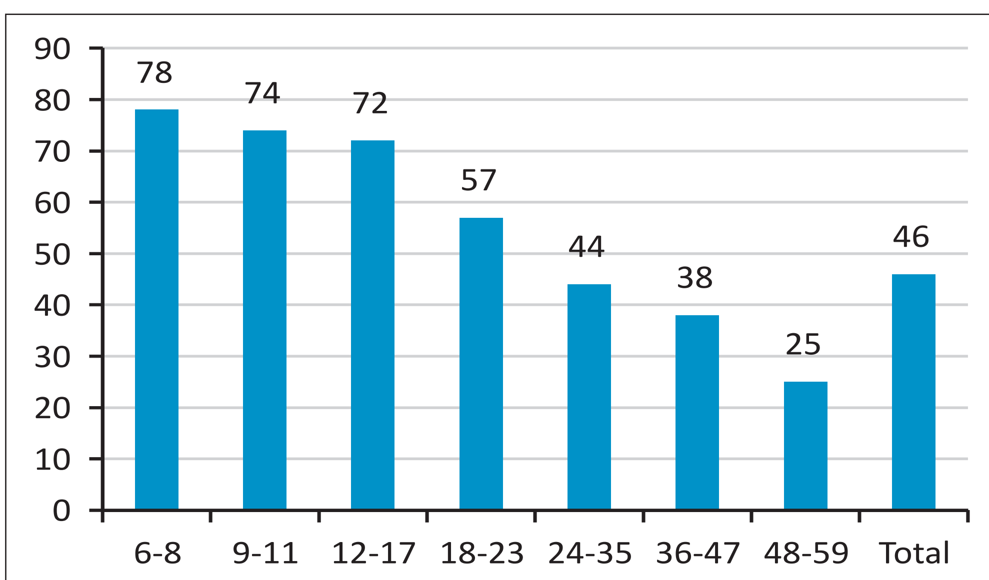
2.2.1 Education

The youth literacy rate (age 15–44), an MDG indicator, has increased over the decade (2000–2010) from 70% to 87%. The literacy rates for women and men in this age group were 76% and 91%, respectively, in 2008. There remains however a disparity in literacy rates for urban and rural youths particularly in terms of women. In urban areas 92% of women and 96% of men are literate compared with 73% and 90%, respectively, in rural areas.

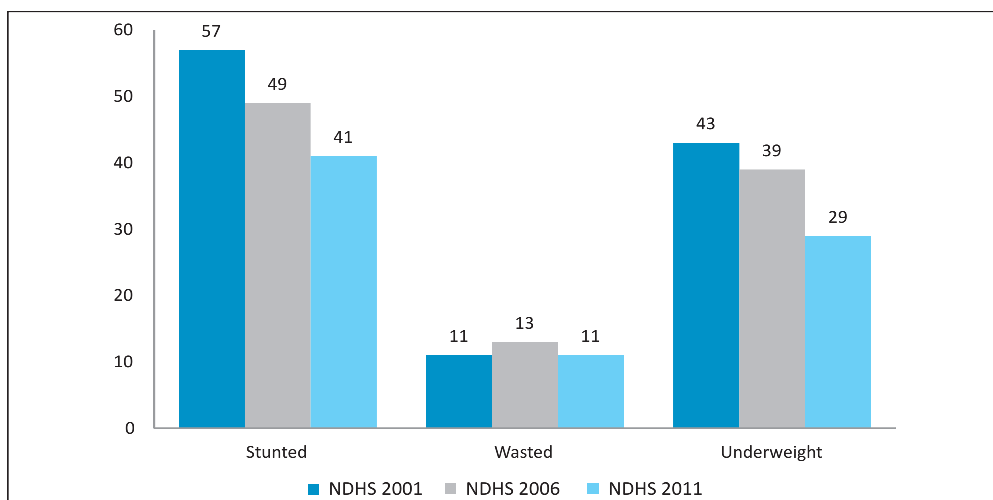
2.2.2 Nutrition, food security and food safety

The trends in nutritional status continued to improve during the period 2000–2011. The coverage of supplementation activities has steadily increased with more than 90% of children receiving bi-annual vitamin A capsules consistently over the past decade, a rise in consumption of iodized salt from 55% in 1998 to 80% in 2011, and increasing coverage of iron tablets among women from 20% in 2001 to 56% in 2011. However, anaemia continues to be very high and in 2011 was at 46% among children aged 6–59 months and at 35% among women aged 15–49 years *(5)*.

While there has been an overall reduction in undernutrition, there is a growing disparity across economic and geographic strata. Rural children are more likely to be underweight (30%) than urban children (17%). Children living in the *mountain* zone are more likely to be underweight (36%) than those living in the *Terai* zone (30%) and the *hilly* zone (27%) *(5)*.



Prevalence of anaemia among children aged 6–59 months.



Trend in nutritional status of children <5 years of age based on WHO child growth standards.

Since 1990, Nepal has been food-deficient requiring food-grain imports to meet its requirements; food insecurity remains a major problem.

Coordinated efforts from all relevant sectors addressing the social and economic determinants of malnutrition are necessary for sustained improvement in the nutritional status along all stages of the life-cycle.

In September 2012, GoN launched a 5-year multisectoral nutrition plan (MSNP 2013–2017). The plan was developed by the GoN in collaboration with the stakeholders. Declaration of commitments for an accelerated improvement in maternal and child nutrition in Nepal was made.

2.2.3 Health and environment

According to the WHO–UNICEF Joint Monitoring Programme on Water Supply and Sanitation (JMP) the percentage of households with access to improved water sources (piped water into a dwelling, yard or plot, public tap or standpipe, tube-well or borehole, protected dug well or protected spring, or rainwater) has increased from 83% to 89% over the period between 2000 and 2010, the latest year for which JMP estimates are available. The percentage in urban and rural areas is 93% and 88%, respectively (JMP 2010) . Only 18% of households nationwide have access to piped systems, with 71% to other improved water sources. Among urban households the percentage of population having access to piped water rises to 53% but water supply is often inadequate with water being available for only a few hours a day. In addition, surveillance of drinking-water quality is, generally speaking, weak. This raises doubt on the safety of drinking-water for human consumption.

The JMP also estimates that the percentage of households with access to improved sanitation facilities (flush or pour-flush toilets draining to a sewer system, septic tank or pit latrine, ventilated improved pit latrines, pit latrines with slabs, or composting toilets) increased from 20% to 31% over the period 2000–2010. There is, however, wide disparity between rural and urban areas with 27% of rural households and 48% of urban households having access to toilets.

It may be noted that official Government estimates of access to drinking-water and sanitation differ considerably from the WHO–UNICEF JMP estimates. Differences are mainly due to differences in defining access and in statistical methods used for analysis of data.

Outdoor air pollution in Nepal, although not well documented, is becoming an increasingly serious problem in urban areas due to vehicular traffic, industrial pollution and natural sources of particulates (i.e. dust, soot). Indoor air pollution due to use of solid fuels for cooking without adequate ventilation is a serious health concern. Of Nepali households, 83% use solid fuel, 93% of which without chimney. In Nepal, approximately 50% of DALYs due to ARI and pneumonia have been attributed to indoor household smoke.

With regard to waste management, health-care waste poses a particular concern to the health sector. In 2003, the Ministry of Health estimated that public and private hospitals, health centres, and other health-care facilities in Nepal generate approximately 10 519 tons per year of solid waste of which approximately 3094 tons per year are hazardous due to its infectious or toxic properties (MoH, 2003). No doubt the annual volume has since increased with the growing population. Regulations governing handling, treatment and disposal of health-care waste are largely unenforced. Used syringes and personal care products made of used gauze material are easily found for sale in public markets. Immunization waste, comprising sharps, used syringes, used glass vials, is typically disposed of onsite and subject to resale in the black market even if buried in pits. It is not uncommon for construction works to unearth sharp burial pits when breaking ground for new, or expanding, buildings. Model health-care waste management programmes have been implemented in Bir Hospital, in the Western Regional Hospital, and in other locations, but a major challenge remains to scale up safe health-care waste management nationwide.

Health worker at Bir Hospital segregating waste in different colour buckets, making for easy health-care waste management.

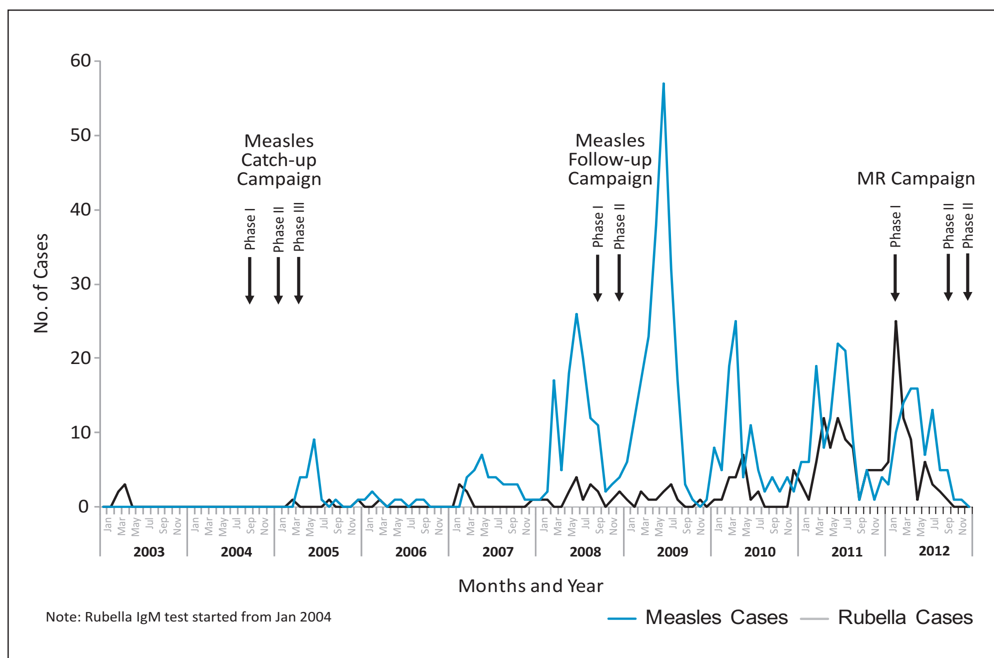
2.2.4 Disasters

Nepal is exposed to multiple hazards, and the country continues to face numerous development challenges. The health sector is particularly prone to the effects of disasters because of the country's geographic and population size, which translate into a limited margin of human, material and financial resources. Disasters tend to have a twofold impact on health systems: directly, through damage to the infrastructure and health facilities and the consequent interruption of services at a time when they are most needed, and indirectly, by potentially causing an unexpected number of casualties, injuries and illnesses in affected communities.

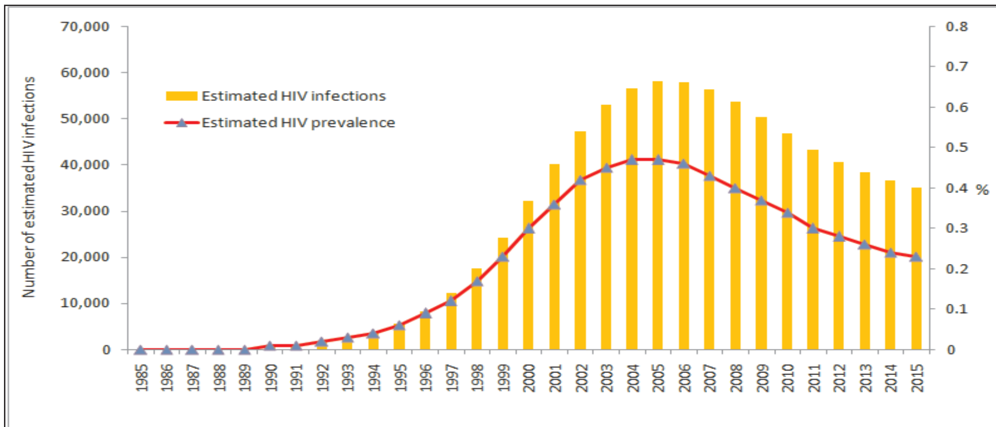
2.3 Health status of population

2.3.1 Burden of communicable disease

Vaccine preventable diseases: Nepal is actively supporting the global polio eradication initiative conducting active surveillance for acute flaccid paralysis throughout the country. In 2010, six cases of wild poliovirus type 1 were confirmed related to two separate importations. In response, a total of 10 rounds of national and subnational immunization days (NIDs/SNIDs) were conducted. Nepal was polio free in 2011. Case-based surveillance for measles is functional throughout the country. Nepal has targeted measles elimination by 2016. The country achieved the maternal/neonatal tetanus elimination status in 2005.



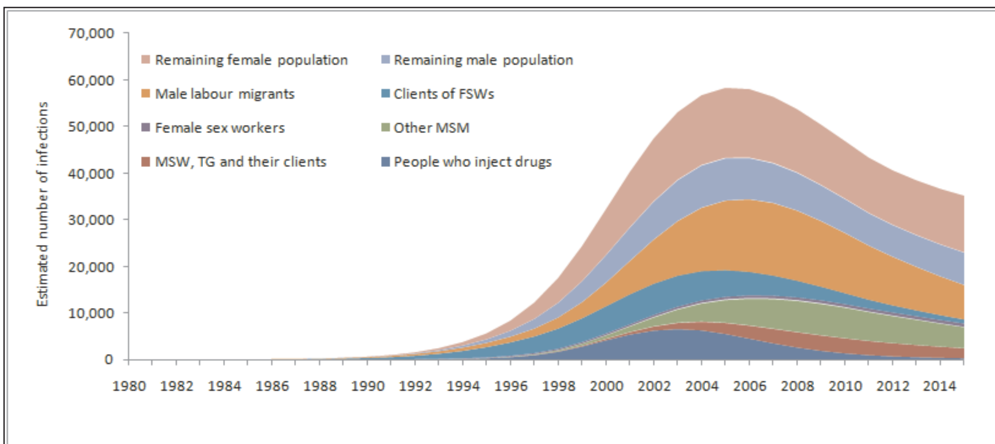
Measles and rubella cases from case-based and routine sites, Nepal, 2003–2012.



HIV prevalence among the adult (15–49) population group in Nepal, 1985–2015; National Centre for AIDS and STD Control (NCASC), Department of Health Services, Nepal.

HIV/AIDS: The HIV epidemic in the country has gradually evolved from being a "low-prevalence" to a "concentrated" epidemic. Adult HIV prevalence is estimated at 0.3%, corresponding to approximately a total of 50 288 people living with HIV in the country, of whom women account for 28%. Out of the total estimated number of HIV infections, 4716 were found in the 0–14 year age group. Interventions targeting key populations have had good impact on overall HIV prevalence among adults (aged 15–49 years), which is declining gradually.

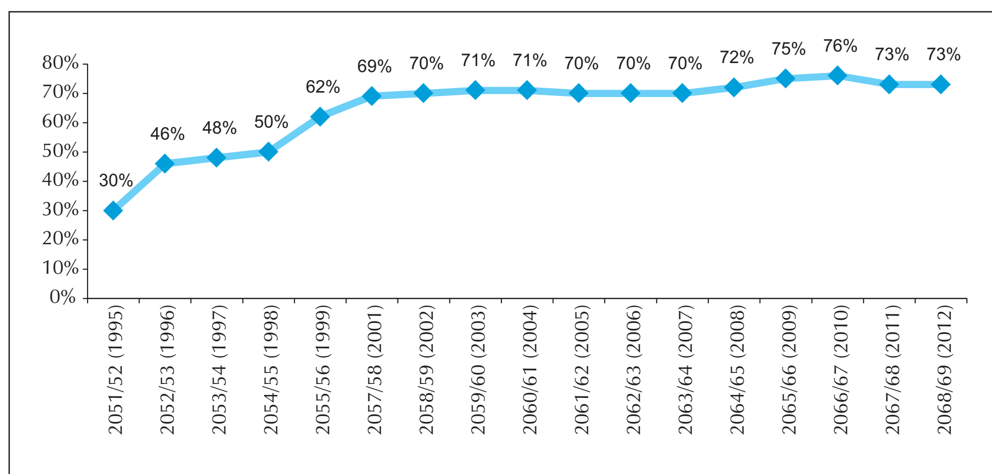
The distribution of total estimated HIV infections (15+ years) in the country among key and high-risk populations is: male sex workers (MSW) transgender and clients (7.2%); other men having sex with men (MSM) who do not buy or sell sex (14.4%); clients of females sex workers (4.4%); people who inject drugs (2.2%); female sex workers (1.5%) and male labour migrants (27%). Remaining male and female populations, who are classified as low-risk populations, accounted for 16% and 27.3%, respectively. The



Estimated HIV infections among at-risk population groups, 1980–2015; National Centre for AIDS and STD Control (NCASC), Department of Health Services, Nepal.

total number of HIV-positive pregnant women requiring preventing mother-to-child transmission (PMTCT) service is 933. The estimated total ART need is 27 288 persons (CD4+ below 350) in 2011 and the coverage for is ART is 24% *(6)*.

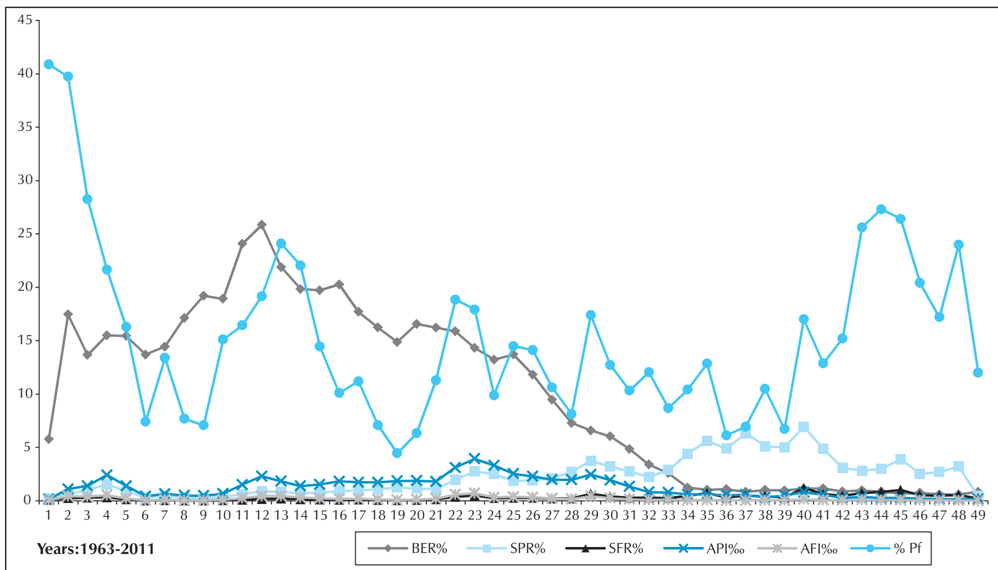
Tuberculosis: Nepal has achieved both global targets for TB control constantly over the past several years and is on track to achieve the TB-related MDG by 2015. WHO estimates prevalence for all types of tuberculosis cases for Nepal at 74 000 (243 per 100 000 population) while the numbers of all forms of cases is estimated at 50 000 (163 per 100 000 population). After the implementation of DOTS in 1995 and its progressive countrywide extension, the percentage of new cases detected increased dramatically from 30% in 1995 up to 70% in 2002 and then stabilized around 71–73% in recent years (as shown in the graph below). Although this value is in line Stop TB Partnership target for 2015, yet the detection of many more cases, particularly in the private sector and among the vulnerable groups, is a top-priority for the National TB Programme, given the large expansion of the investment in TB control in the past 10 years.



Case finding trend in tuberculosis. *Source:* National Tuberculosis Centre, Nepal. The graph depicts percentage of new cases over the years 1995–2012 (including Nepali year).

Among the 35 443 TB cases (all forms) registered during 2010–2011, 15 000 (42.3%) were new smear-positive cases, achieving a case detection rate of 71%. The treatment success rate in this cohort is 90.1%. A Drug Resistance Survey conducted in 2011 showed multidrug resistance (MDR) at 2.2% among new TB cases and 15.4% among previously treated cases.

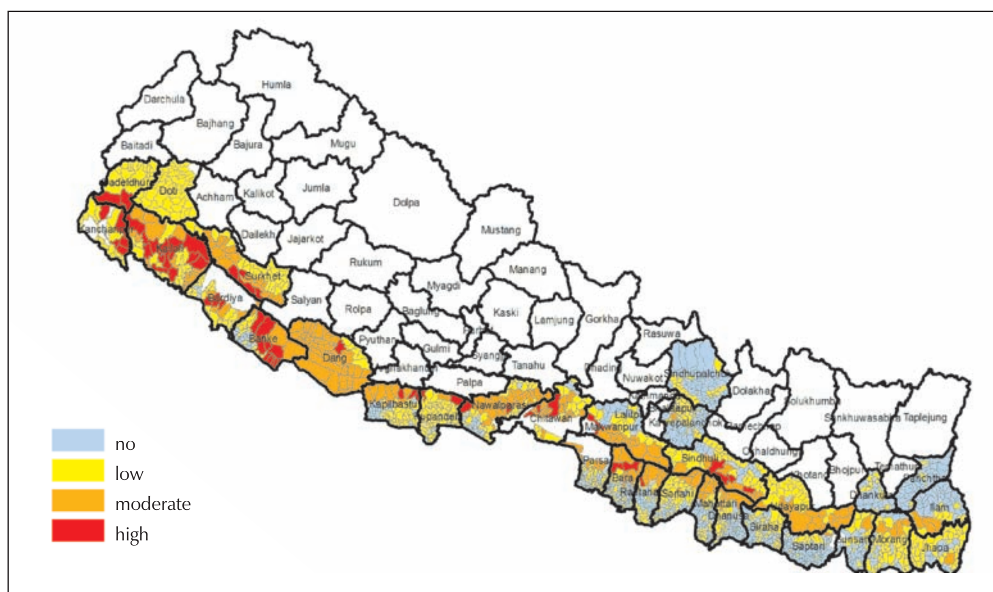
Leprosy and intestinal helminths: During the year 2008–2009, 4565 new cases of leprosy were detected and put under multidrug therapy. In 2010, Nepal was successful in eliminating leprosy as a public health problem. Soil-transmitted intestinal helminths (hookworm, *ascaris* and *trichuris)* are estimated to infect roughly 50% of children and adolescents nationwide. The prevalence of trachoma is 6.9% with 43 000 people suffering from advanced stages of the disease.



Trends of malaria 1963–2011, Nepal. *Source:* Epidemiology and Disease Control Division, Department of Health Services, Ministry of Health and Population, Nepal.

Malaria and vector-borne diseases: Malaria is a major public health problem in Nepal. In 2008–2009, there were 113 872 cases diagnosed as probable malaria (clinical cases), but only 3577 were laboratory-confirmed cases. Among the laboratory-examined cases, 588 were identified as *Plasmodium falciparum*. The proportion of *P. falciparum* cases increased from 19.7% to 22.2% in 2008–2009. Sixty-five districts are at risk for malaria, 13 of which are highly endemic where more than 70% of malaria cases originate. All *Terai* and inner *Terai* districts are endemic for acute encephalitis syndrome (AES). In 2008–2009 a total of 1355 cases of AES were reported from 60 districts, of which 119 were confirmed cases of Japanese encephalitis (JE).

Nepal has arrived at a critical junction in its fight against malaria. It has achieved the malaria-related MDG, and the country is progressing towards pre-elimination. The MoHP's strong malaria programme is steadily increasing access to rapid diagnosis, introduction of new effective medicine artemisinin-combination therapy (ACT) and improving the coverage of long-lasting insecticide-treated nets (LLINs). Nepal has been able to reduce malaria cases from ~50 000 cases in the early 1980s to ~3000 by the year 2010 with the available resources through the Government, WHO and GFATM. Malaria cases are being reported from 65 out of the 75 districts of Nepal; out of which 13 are classified as high, 18 moderate and 34 low priority and 10 malaria-free districts in terms of reporting of cases and possible response. An external review held in 2010 commended the country for its achievements and recommended to move forward for pre-elimination consolidating the gains achieved so far, sustaining the downward trend in malaria morbidity/mortality and maintaining the outbreak free status. MoHP has set



Distribution of malaria risk areas in Nepal. *Source:* Epidemiology and Disease Control Division, Department of Health Services, Ministry of Health and Population, Nepal.

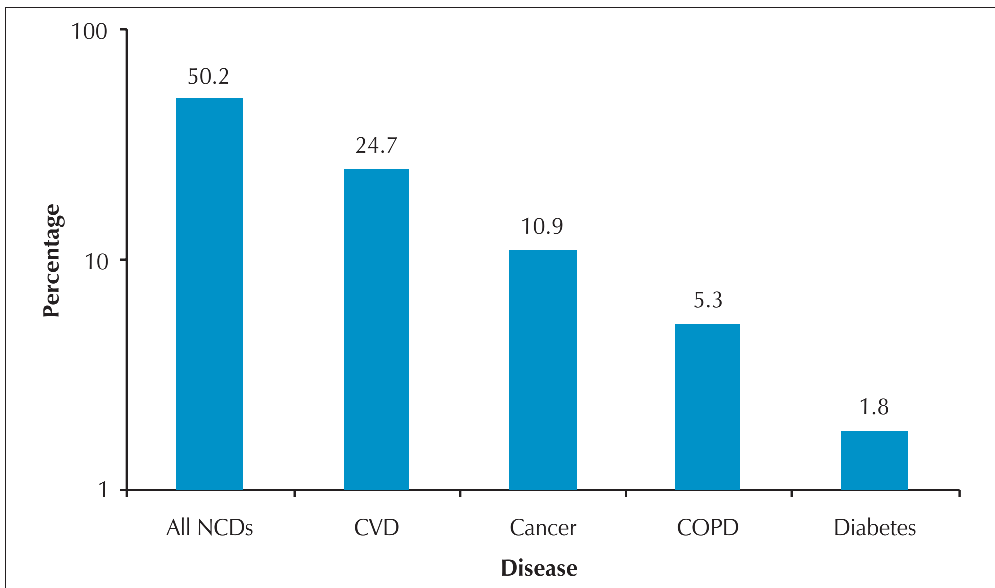
an ambitious vision of malaria-free Nepal by 2026. Current interventions are focused on early diagnosis and prompt treatment, prevention of transmission through selective vector control utilizing LLIN/IRS and training of programme staff in case diagnosis, management and outbreak response, by collaboration among Government, WHO, GFATM and NGO partners. In view of progress made and to consolidate gains, it is key to sustain such interventions with the support of all stakeholders, including GFATM, WHO and external development partners.

Lymphatic filariasis (LF), although endemic in 60 out of 75 districts with 25 million people at risk by early 2000, elimination by 2020 is on track, with the use of mass drug administration (MDA). Eleven districts are endemic for Kala Azar. The incidence of Kala Azar is 1.33/10 000 with a case–fatality rate (CFR) of 0.59%.

Apart from endemic communicable diseases, incidence of emerging diseases such as dengue, chikungunya, and leptospirosis, has increased in recent years.

2.3.2 Burden of noncommunicable diseases, injuries, and mental illness

Demographic transition and urbanization in Nepal is slowly shifting the national disease burden from communicable towards a noncommunicable disease pattern. This trend is particularly visible in metropolitan areas, where unhealthy lifestyles such as inadequate physical activity, tobacco use, alcohol consumption, indoor smoke pollution, and intake of unhealthy and adulterated foods take place.



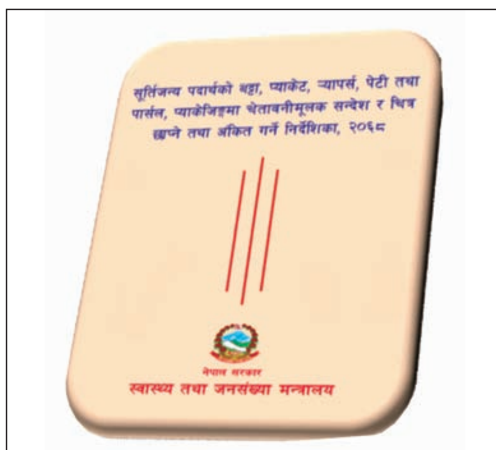
Noncommunicable diseases and mortality. *Source:* National Health Education, Information and Communication Centre, Department of Health Services, Ministry of Health and Population, Nepal.

The third NCDs risk factor survey 2007–2008 showed a high prevalence in the general population of behavioural (tobacco use, alcohol consumption, low intake of fruits and vegetables, and physical activity) and intermediate (obesity, high blood pressure) for major NCDs. With the increasing use of processed food and drinks, coupled with diminishing physical activities, there has been a steady rise in obesity and related chronic diseases. About 14% of women aged 15–45 years are overweight or obese. Overweight and obesity are higher in urban areas 26% compared with rural areas 11% *(5)*. Likewise, the risk of NCDs attributable to pesticides exposure is also substantial among agricultural farmers as well as consumers. Implementation of regulatory mechanisms to enhancing food safety can protect the population from such risks.

Epidemiological information on NCD prevalence is limited to tertiary-care hospital records as the existing health information system fails to record and report the NCDs appropriately. Moreover, population-based studies on incidence and prevalence of noncommunicable diseases have not been carried out in Nepal. Available data indicate that NCDs accounted for 44 % of hospital deaths, 80% of hospital out-patient department (OPD) contacts and 86% of hospital in-patient department (IPD) admissions in 2008–2009. The major NCD burdens are cardiovascular disease, chronic obstructive pulmonary disease, diabetes and cancer, blindness, hearing impairment and mental disorders.

Prevalence of mental illnesses ranges, according to a few subnational studies, from 4 to 20% of the total population. While the mental health policy and the essential free health care propose community-based mental health programmes, such services are currently available only in a few pilot sites which are managed by NGOs and the Mental Hospital. A mental health act has been under preparation for nearly 10 years.

The *Tobacco product control and regulatory act 2011* has been passed by parliament and is in process of implementation. Major features of this bill are: (i) pictorial health warnings on cigarette and other tobacco-product packets; (ii) a ban on smoking and other use of tobacco products in public places and on public transportation; (iii) a complete ban of sales to children under 18 years old and to pregnant women; and (iv) the institutionalization of an earmarked tobacco-product health tax fund.



Tobacco Act Nepal 2011.

The *Decade of Action for Road Safety 2011–2020* was launched by the Government of Nepal on 11 May 2011. A *National Road Safety Action Plan 2011–2012* by the Departments of Roads and a Strategic Plan of Action for Violence, Injury and Disability including Road Safety by MoHP had already been disseminated. The focus is on the prevention of road-traffic accidents and injuries through improved road engineering, better traffic rule education and law enforcement. In particular, legislation will be enforced on the use of helmets for motorcyclists and pillion riders, the use of seat belts and driving under the influence of alcohol.

Blindness in Nepal is a major public health problem with 92% of the blind residing in rural areas. Thanks mostly to NGOs and philanthropic support through eye camps, the prevalence of blindness has been reduced from 0.84% (1981) to 0.39% (2010). A collaborative Strategic National Plan of Action for Eye Care Services in Nepal for 2002–2019 has been initiated in support of GoN's commitment towards the "Vision 2020: The Right to Sight", and the WHO Action Plan 2009–2013 for the Prevention of Avoidable Blindness and Visual Impairment.

The national response to this emerging NCD trend has been mostly in the private and NGO sector. While the NHSP-II emphasize the need to address NCDs, NCDs currently are not part of the essential health-care service package nor are they represented in the MDGs. WHO has agreed with MoHP on a dedicated intersectoral NCD prevention programme.

National consultation on road safety and trauma care, Kathmandu, Nepal. *Source:* Epidemiology and Disease Control Division, Department of Health Services, Nepal.

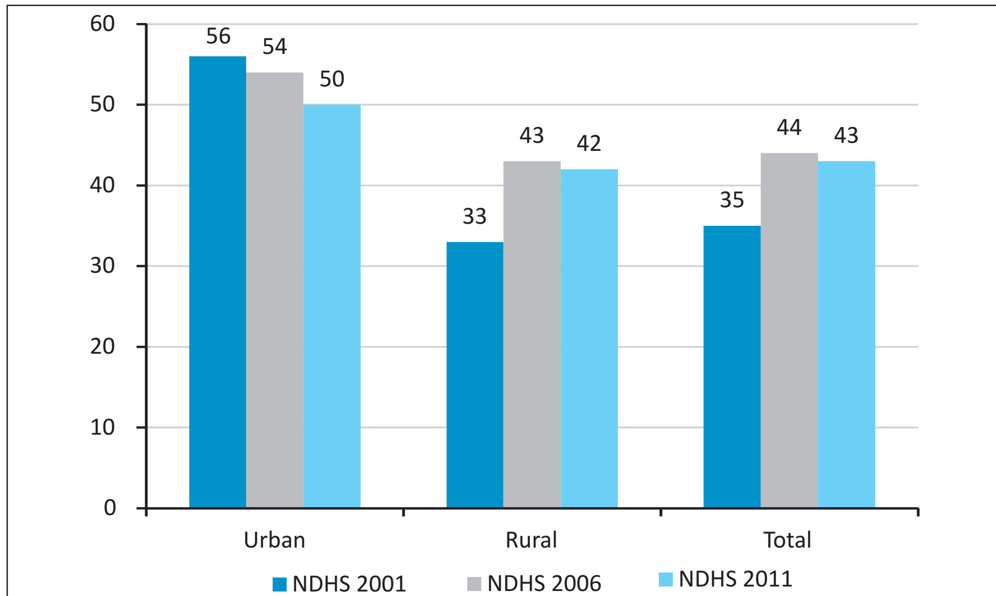
2.3.3 Environment health including water, sanitation, waste management and air quality

Environmental determinants for better health such as safe water, sanitation, and hygiene (WASH) remain critical aspects to be addressed in Nepal. WASH-associated diseases including skin diseases, ARI and diarrheal diseases are the three leading preventable diseases with the latter two being among leading causes of child deaths. Indoor and urban air pollution alike are likely contributors to respiratory illnesses such as ARI, COPD, bronchitis, asthma and tuberculosis. Unsafe handling and disposal of sharps and other health-care wastes are likely contributing to transmission of infectious diseases such as HIV/AIDS, and hepatitis B and C. While national data are lacking, in 2000 it was estimated *globally* that injections with contaminated syringes caused 21 million hepatitis B infections, 2 million hepatitis C infections and 260 000 HIV infections. In addition, health-care workers, patients and the general public are exposed to significant amounts or toxic substances in health-care waste, such as mercury and expired pharmaceuticals.

2.3.4 Health over the life-cycle: sexual and reproductive health, child and adolescent health, and the health of the elderly

Family planning is one of the key components of reproductive health-care services. The contraceptive prevalence rate has decreased from 44.2% in 2006 to 43.2% in 2011 although the knowledge of family planning methods is more than 99% in women aged 15–49 years *(5)*.

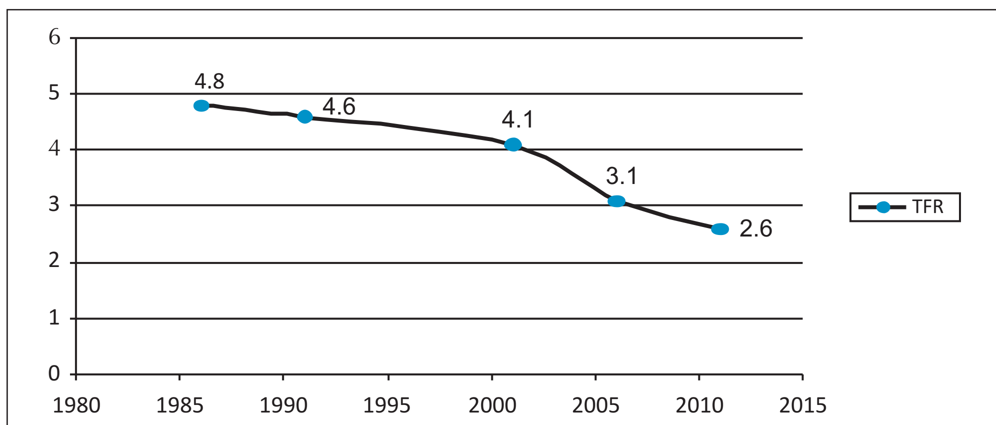
Springtime in Nepal: mother carrying her baby and performing routine household activity.



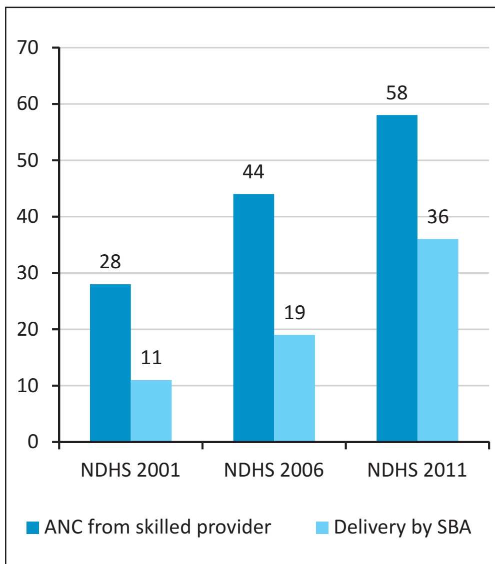
Trends in use of modern contraceptive methods among married women, Nepal. *Source:* NDHS 2011.

The most commonly known methods are female sterilization (99%), injectables (98%) and male condoms (98%). A significant disparity exists in terms of the use of modern contraceptive methods with only 42% of women in the rural areas using a modern method compared with 50% in the urban area *(5)*.

Contrary to the contraceptive prevalence rate, the total fertility rate (TFR) has reduced over the years as shown in the figure below. Urban–rural differentials in Nepal are obvious with rural women having a TFR of 2.8 compared with urban women with a TFR of 1.6 as per NDHS 2011. The unmet need of family planning among married women is 27% as per NDHS 2011.



Trend in total fertility rate, Nepal.



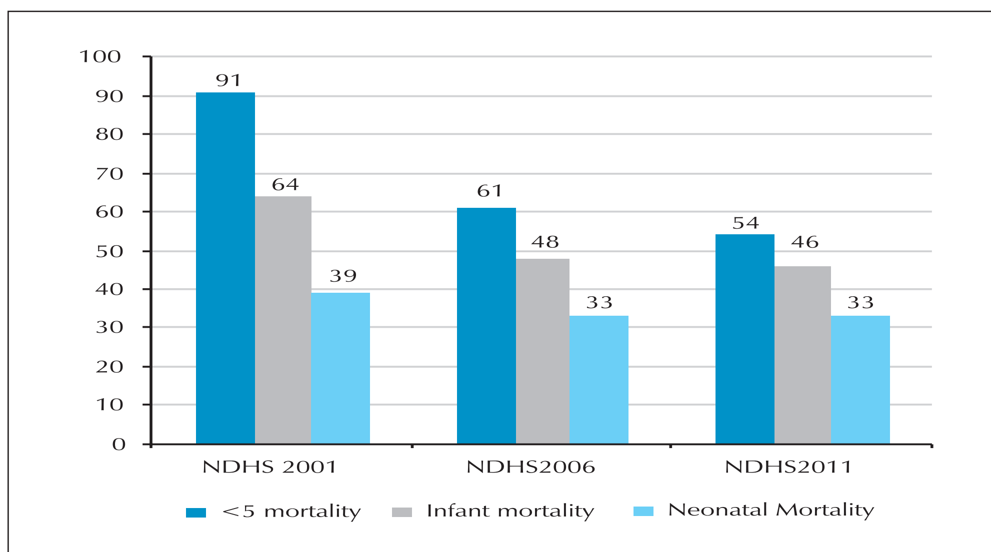
Trends in using maternal health-care services, Nepal.

Nepal has made significant progress in reducing the maternal mortality ratio from 539 to 281 per 100 000 in 2006. The rate of progress makes it likely that Nepal will achieve the MDG for MMR (maternal mortality rate) by 2015. The decline in the MMR has been attributed in part to: the promotion of institutional delivery; delivery by skilled birth attendants; the expansion of birthing units and basic and comprehensive emergency obstetrical care sites; the safe delivery incentive programme; the Aama Program which is a free maternity programme; birth preparedness; and expansion of safe abortion services since its legalization in 2002.

Almost 60% of the women receive antenatal care from a skilled provider. This shows improvement from 44% in 2006. NDHS 2011 also shows that about 35% of the deliveries occur at health institutions making the missed opportunities obvious. The most common reason given for not delivering at health institutions is the belief that it is not necessary (62%).

The health of the adolescents is profoundly linked to their development since their physical, psychological and social abilities help to determine their behaviour. In Nepal, the percentage of adolescent girls aged 15–19 years that are already mothers or are pregnant is 19%. NDHS 2011 shows that median age of first marriage is 17.5 years and 21.6 years for women and men age 25–49, respectively which rises with level of education. Besides early marriage, young people have their sexual debut at an early age making them vulnerable to HIV/STIs, unwanted pregnancies, unsafe abortion etc. The adolescent fertility rate for ages 15–19 years is 81 per 1000 women in 2011, while the contraceptive prevalence rate for any method is 17.6%.

Nepal has had remarkable success in improving under-five and infant mortality as shown in the adjacent figure. However, neonatal mortality has been stagnant at 33/1000 live births since 2006. Neonatal mortality contributes to 54% of under-five mortality, making its reduction a key to achieving MDG 4. Major causes of neonatal mortality are infection, birth asphyxia, preterm birth and hypothermia. Diarrhoea still remains a leading cause of death among children under five years of age due to many factors starting from poor hygiene and sanitation to lack of timely management and referral.



Trends in childhood mortality, Nepal.

According to NDHS 2011, 87% of children aged 12–23 months received all recommended vaccines.[1] Vaccination coverage was only slightly higher in urban areas (90%) than rural areas (87%). The overall immunization coverage for BCG is 97%, DPT3 92%, OPV3 93% and measles 88% *(5)*. It is also interesting to note that with increase in the education level of mothers, vaccination coverage increases. Hence, it is key to educate and empower women. Nepal has a patriarchical society. Women tend to have lower status in society compared with men. NDHS 2011 showed that 22% women had suffered from some form of physical violence since the age of 15. Spousal violence was reported by 32% of ever-married women. MoHP has developed a Gender Equality and Social Inclusion Strategy in 2009 to guide the achievement of health goals with equality.

Despite continuing improvement in nutritional status (see Section 2.2.2) malnutrition remains a significant challenge to child survival and overall growth and development. Protein energy malnutrition is the commonest form of malnutrition followed by iodine, iron, and vitamin A deficiency. According to NDHS 2011 stunting among under-fives is 41%, wasting among under-fives is 11% and 29% of under-fives are underweight.

Maternal undernutrition is another chronic problem. A recent review conducted by the Child Health Division and a team of experts suggests that interventions should aim at integration within the health sector, intersectoral collaboration, addressing social determinants, knowledge generation, promoting use of local food, and community-to-community exchanges.

[1] One dose BCG and measles, three doses each of DPT and polio.

Nepal witnessed an increase in elderly population, from 6.5% in 2001 to 8.4% in 2011. Health problems affecting the elderly include chronic diseases, NCDs and disabilities, but also they may be subject to victimization, maltreatment and increasing dependency. The life expectancy of people has been increasing. However, the problem is a negative relationship between life expectancy and per capita income as well as a high dependency ratio. MoHP has been undertaking promotional programmes for the elderly, for example distribution of health-related essential materials (walking sticks, ear phones , umbrellas) in coordination with district eye treatment centres, conducting health check-ups and providing treatment support to heart patients aged 75 and over through a social security programme. However, much needs to be done to create an age-friendly environment, and to foster the health and participation of old people in society.

2.3.5 Health systems and services

Health service delivery. Over the past decade, the scope and coverage of Government health-care services has expanded. Nevertheless, availability and access remain issues especially in rural and remote areas. In *mountain* and *hilly* regions, approximately 40% and 30% of individuals, respectively, have to travel 1–4 hours to reach the nearest health or subhealth post. In *urban* areas, there are insufficient health-care facilities providing public health programmes such as immunization and antenatal care. In the past, there were efforts to develop urban maternal and child health (MCH) services. An urban MCH health policy has been developed. Several municipalities increased access to immunization services in urban areas, but a need for strong urban MCH health services remains. Hence, it is considered urgent to initiate and implement municipal health programmes.

A policy for provision of free health-care services at MoHP facilities below district hospitals was progressively introduced, reducing financial barriers to access and increasing utilization by poor and marginalized groups. However, disparities remain as the non-poor benefited more than the poor from such programmes.

Honourable State Minister of Health and Secretary, Ministry of Health and Population, Nepal, open the measles vaccination campaign, 2012 (left picture) and a child receiving measles vaccination (right picture)

Nepal has a vibrant private sector, with significant presence in terms of hospital and laboratory services. The private sector accounted for two thirds of Nepal's approximately 20 000 hospital beds in 2006, and operated three times the number of health laboratories than the public sector. Despite its significant role in service delivery, regulation of the private health sector has been minimal.

Quality of services is significant issue in both the public and private sectors. MoHP developed a policy on quality assurance and initiated a hospital accreditation system. Nonetheless, an urgent need remains to fully implement hospital accreditation in public and private sectors and develop a broad range of effective mechanisms to improve health outcomes for the individual service user and the community.

There is concern about environmental health conditions within hospitals and health posts. This applies especially to the adequacy of water supply for hand washing, safety of drinking-water, availability of toilets or latrines for staff, patients and visitors alike, and provisions for disposal of both liquid and solid waste, including infectious waste. The findings of an ongoing study will illustrate environmental health conditions in health-care settings across the country. It can be expected to show the need to significantly upgrade conditions in many facilities.

Stewardship and governance. Nepal's new constitution is expected to provide a decentralized federal structure. This will require restructuring and redefining roles, responsibilities, and authorities of the MoHP at all levels to support a decentralized health system. The current managerial, administrative, and technical capacity at district level (local level) needs to be increased, focusing health systems strengthening.

Health financing. Analysis of health outcomes data (NDHS) suggests increasing inequities between socioeconomic groups and geographical regions. Furthermore, out-of-pocket expenditure (OOPE) remains very high (55% of total health expenditures). Estimates attribute a 2.5% point increase in poverty to these high OOPE level.

The GDP share of general Government health expenditure is projected to increase from 2.1% in 2009 to 2.2% in 2015. External assistance to Nepal is already one of the highest in the Region and, in the current financing climate, is unlikely to increase significantly. The share of health in Government spending is also relatively high (10.5% as per WHO estimate) as compared with other countries in the Region (3.7–10.3%) except Bhutan (13.5%) and other low-income countries in the world (10.1%).

Consultative meeting on health financing, universal health coverage and social protection, May 2011.

Given limited fiscal space, reducing systems inefficiencies could be a viable way of effectively raising funds for health. Grants to nongovernment facilities account for 10% of the health budget; further gains in the level of care are possible out of these grants. The other area that requires attention in terms of efficiency improvement is medicines as a major part of public as well as OOPE goes to the purchase of medicines.

Within this context and to address the overarching goal of universal coverage, emergence of NCDs, rural and urban social protection, strategic purchasing and provider payment mechanisms, the Government is in the process of developing a health financing strategy and a national health insurance policy in close coordination with an HR strategy and plan.

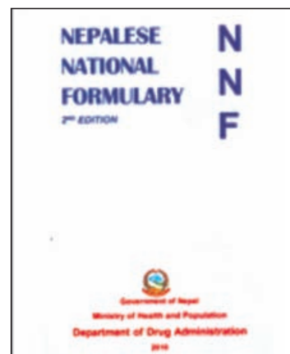
Health workforce. The major issues that arise in the health workforce of Nepal include retention, inadequate skill mix, maldistribution, inadequate finance, and few opportunities for pre- and in-service training. GoN recognized these issues and put in place a number of constitutional, legal and policy provisions: the National Health Policy (NHP) 1991, the Second Long Term Health Plan (SLTHP) 1997–2017, the Nepal Health Service Act and regulation, the National Drug Policy 1996, the health institution operation guideline 2061 BS, the National Ayurvedic Health Policy 1996, NHSP-I, NHSP-II 2010–2015, and finally the Nepal Human Resource for Health Strategy 2003–2017. Building on this platform, with WHO support, the Nepal country coordination facilitation (CCF) was founded in 2010 to formulate a new HRH Strategy and Plan.

About 19 medical colleges and many institutes are producing the medical professional workforce (MBBS, BDS, BAMS, MD/MS/MDS, DM/MCH), more than 100 paramedical institutions are producing nurses (PCL nursing, BN, BSc N, MN), *Bachelor in Pharmacy* in higher course (M Pharm, Pharm D, PhD) are conducted by 14 educational institutes, and a diploma in pharmacy by 24 institutes (CTEVT). About three dozen institutes affiliated to the Council for Technical Education and Vocational Training (CTEVT) produce allied health professionals, for example radiographers, ayurvedic health assistants, auxiliary ayurvedic workers, auxiliary nurse midwives and health assistants.

However, the impact of this enormous training capacity on workforce availability at public health facilities needs to be strengthened through a number of approaches: (i) improving coordination of human resources among planners, producers and users (academia, MoE, MoHP, professional councils, MoGA, PSC) in both public and private sectors; (ii) strengthening the monitoring and evaluation (M&E) framework and human resources information systems (HuRIS) to monitor effectively both qualitative and quantitative benefits of a retention scheme; (iii) enhancing recruitment, retention and utilization of Government health workers at all levels, especially in remote part of the country; and (iv) assisting in development of a deployment and retention strategy for mitigating distribution problems, which has resulted in urban concentration, shortage of selected categories of health worker and a lack of quality of all categories of HRH.

The human resources scenario can also be improved by establishing a system for coordination, and collaboration with various stakeholders (Government, multilateral agencies, private sector, bilateral partners, civil society, academia, professional associations, regulatory bodies, trade unions) for human resources development. A comprehensive human resource development plan, including incentives and retention provision, and an M&E framework/HuRIS, could guide pre- and in-service training and continuous professional development with focus on selected categories, e.g. MDGP, anesthesia, anesthetic assistants, epidemiologists, hospital administrators, and microbiologists.

Drugs, medical products, and laboratories. The Department of Drug Administration (DDA) manages a pharmaceutical sector of 10 316 registered products, 15 000 registered drug retail shops and about 100 manufacturers. The DDA is managing an active pharmacovigilance programme but is unable to monitor pharmaceutical drug promotion due to resource constraints. The DDA has its own drug testing laboratory and tests more than 1000 samples per year but does not have the capacity to do all the testing that it feels is necessary.



Medicines are supplied by the Logistics Management Division (LMD), MoHP, to all public facilities in the districts. A 'push' system is used from the central level down to the district and, a 'pull' system from the primary health-care facility (SHP/HP/PHC) to the district is currently being piloted.

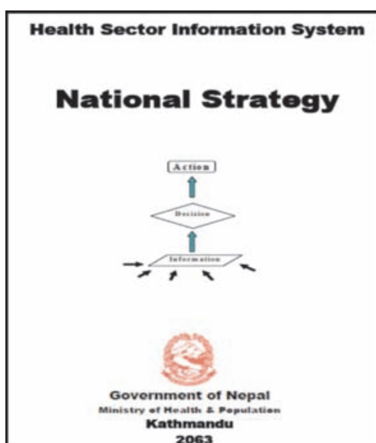
There is a National Essential Medicines List (NEML) 2002, that was updated in 2011, and is available on the web.

High use of antibiotics for upper respiratory tract infection is still the norm in district level facilities. National standard treatment guidelines for primary health care are outdated and none exists for hospitals.

Many functions are not undertaken by any MoHP department, such as monitoring of medicines use, coordinating continued professional development (CPD), supporting Drug and Therapeutic Committees (DTC), ensuring adherence to the NEML, updating guidelines and ensuring their distribution and incorporation into CPD and undergraduate curricula, public education on medicines use. The National Drug Policy document, while comprehensive, is not implemented in many aspects and is currently being updated.

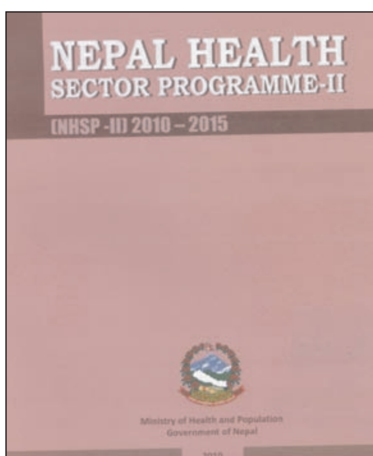
Traditional medicines, especially in the form of *ayurvedic* and *amchi* formulations are widely used and Ayurveda is a recognized component of the Government's public health system. However, evidence-based information on the quality, safety, and efficacy of traditional medicine is still required for further improvement.

Public health laboratories require further strengthening particularly the capacity for: quality assurance of blood transfusion services; establishing and strengthening of regional level laboratories; and diagnosing and tracking the emergence or re-emergence of new species and antimicrobial resistance.



Health information. The Ministry of Health and Population relies on a broad array of disparate information systems to capture data to report on: service delivery, utilization and coverage, logistics, human resources and financial management. These systems are supplemented by regular surveys, the periodic Demographic Health Survey, and disease specific surveillance systems. The systems and surveys, while producing an extensive range of detailed and generally accurate information are not well coordinated for effective use by managers and policy-makers (the administrative data are of variable quality). Capacity for data analysis is considered inadequate, and therefore use of data for effective and efficient policy-making is limited, which represents a lost opportunity.

A health sector information strategy was formulated in 2007 with the aim to: improve data quality; better integrate administrative and facility reporting systems; strengthen analytical capacity to meet policy and planning needs; and establish an M&E framework in which data from all vertical information systems are brought together in publicly accessible databanks and synthesized to monitor the country's health progress and performance. The proposed M&E framework follows a conceptual approach of the joint work on health systems strengthening and the International Health Partnership (IHP+) common evaluation framework.



The registration of birth, deaths and other vital events are captured by local bodies (village development committees and municipalities) under the authority of the Ministry of Federal Affairs and Local Development. The annual vital registration report and the periodic census show significant discrepancies indicating that the accuracy of the vital

registration system is suboptimal. By default, MoHP is not involved in the registration or verification of such events. This has the effect that MoHP official mortality statistics do not capture road-traffic accident deaths if victims are not brought into contact with the health system.

National response to overcoming health challenges. The Nepal National Health Policy (1991) is the foundation of the current national health policy framework. The framework envisions to: "upgrade the health standards of the majority of the rural population by strengthening the primary health care system and making effective health-care services readily available at the local level." Similarly, the Second Long Term Health Plan 1997–2017, focuses on improving the health status of the people of Nepal, especially targeting the most vulnerable groups, women and children, the rural population, the poor, and the underprivileged and the marginalized.

Building upon that foundation, a "Health Sector Strategy: An Agenda for Reform", the first Nepal Health Sector Programme 2004–2009 (NHSP) and accompanying implementation plan (NHSP-IP) were introduced in 2004 with the goal of achieving the health-sector-related MDGs with improved health outcomes for the poor and those living in remote areas. Recognizing the extensive role of external development partners in financing public health expenditure, the NHSP-IP adopted a sector-wide approach (SWAp) to increase development assistance effectiveness through harmonization, alignment and coordination of EDPs in support of the Government's health policies and plans.

The Nepal Health Sector Programme – II (NHSP-II) 2010–2015 builds upon on the progress made towards improved health outcomes in the preceding five years, and the lessons learnt in implementing NHSP-I to: increase access to and utilization of a set of defined, quality essential health-care services; reduce cultural and economic barriers to accessing health-care services particularly by those who are poor, vulnerable and marginalized, and reduce harmful cultural practices, in partnership with non-state actors; and improve the health system to achieve universal coverage of essential health services.

NHSP-II is underpinned by a strong policy, the focus of which is to upgrade health standards by strengthening the health-care system and to provide equitable access to all citizens.

In achieving the objectives of the NHSP-II, the Government and stakeholders are committed to pursuing the following strategic directions in a cohesive and coordinated manner, as outlined in the NHSP-II document: 1. increase access and utilization of quality essential health-care services; 2. reduce cultural and economic barriers in accessing health-care services and harmful cultural practices in partnership with non-state actors; 3. to improve the health system to achieve universal services of essential health-care services.

2.3.6 Reducing the health consequences of disasters; and environmental determinants of health

Disaster risk reduction. Nepal is highly vulnerable to various types of disasters, e.g. floods, landslides, earthquake, fire, epidemics as well as the effects of climate change. In addition, the country encountered new types of challenges, e.g. avian influenza, industrial accidents, explosions of improvised explosive devices, road accidents, poisoning-related cases. Nepal is thus facing different types of natural and non-natural disasters. Based on facts and statistics, Nepal is placed 20th in the global hazard map, while the country is ranked 30th in terms of water-induced hazards, such as landslides and floods. In seismic vulnerability ranking, Kathmandu valley is placed top. The whole country is vulnerable to earthquakes as it lies high in the Modified Mercalli Intensity (MMI) IX and XI vulnerability scale, with especially the middle belt of the country sitting on a high earthquake intensity zone. According to the *Disaster vulnerability and risk assessment study report* (UNDP/BCP 2004), Nepal ranks 11th globally among countries most vulnerable to earthquakes. Similarly, as per the joint ICIMOD UNEP prepared details, out of 2315 glacial lakes in Nepal, 22 are in imminent danger of bursting (ICIMOD/UNEP, 2000) . Fire breakouts in rural *Terai* remain a major problem during summer season when temperatures soar to 45 °C. Forest fires have been increasing, too, representing additional disaster risks in recent years *(7)*.

WHO technical support provided during Koshi flood.

Culling chicken in Jhapa District, for prevention of transmission of avian influenza (H5N1).
Source: National Strategy for Disaster Risk Management, 2009, Kathmandu, Ministry of Home Affairs (MoHA)

Epidemic prone diseases. Cholera and gastroenteritis are endemic in all areas of the country. In 2010, the EWARS sentinel surveillance system captured 13 600 acute gastroenteritis cases from 40 sentinel sites. This is just the tip of the iceberg. Cases from communities not visiting hospitals are not reflected in the surveillance data. Similarly, incidence of diarrhoea per 1000 children increased from 378 in 2007–2008 to 598 in 2009–2010, although case–fatality rates in children decreased from 0.15 in 2007–2008 to 0.00 in 2009–2010. Although no human cases of avian influenza (H5N1) were detected in humans in Nepal to date, with a recent chain of outbreaks in poultry in eastern Nepal and in Kathmandu valley, an increased risk of human transmission has surfaced.

2.4 Contribution of Nepal to the global health agenda

Nepal has made major contributions to the global health development agenda, most notably in the area of managing drug-resistant tuberculosis. Experience of operating successful DOTS services through all health institutions within the health-care system – as well as an array of public and private sector partners – prompted Nepal to be one of the first countries in the South-East Asia Region, in 2011, to plan for universal access to drug-resistant TB diagnosis and treatment as recommended by WHO. Nepal provides an effective model of fully ambulatory and supervised multidrug resistance TB services that can be replicated in other countries. Using standard treatment regimens, Nepal achieves cure rates at par with international standards. This enables Nepal to achieve country-wide programme coverage for multidrug-resistant and extensively drug-resistant TB (MDR/XDR) while minimizing hospitalization. A further element of NTP's approach, which greatly contributes to the success of the ambulatory treatment policy, is its socioeconomic support to drug-resistant TB patients. Such support enables MDR/XDR patients to remain with their family while benefiting from daily contact with health staff observing treatment, managing adverse drug effects, providing health education, infection control instructions, and moral support.

The Nepal Drug Resistant TB Management Programme is a unique example of public–private partnership. Nearly half of treatment centres operate through partners which include public and private hospitals, INGO and NGO clinics, with national reference laboratory services provided by an NGO partner. The public–private partnership approach makes it possible for the programme to benefit from a much wider range of expertise, infrastructure, and human resources than would otherwise be case.

Experiences of the Nepal drug-resistant TB programme were shared internationally through scientific publications and presentations, with national TB programmes serving as a learning centre for South-East Asia Region Member countries such as by hosting field visits as well as regional training regularly.

2.5 Summary

Key health achievements, opportunities and challenges

Achievements

- Achievement of global targets for TB control; on track to achieve TB and maternal mortality rate (MMR) related MDGs; achievement of maternal/neonatal tetanus elimination; achieved measles mortality reduction goal; achieved zero polio cases since 2010; significantly reduced mortality and morbidity from Japanese encephalitis.
- Significant achievement towards reaching the targets of MDGs 4 & 5.
- Increase in access to improved water sources and sanitation facilities.

Opportunities

- Expertise in Government, academia, nongovernmental institutions.
- GoN's strong commitment to improving the health status of the population particularly the poor, vulnerable and marginalized and to achieve universal coverage of essential health services.
- EDPs strong commitment to implementing the GoN's national priorities and plans in a cohesive fashion within the Government's aid coordination and effectiveness mechanisms (IHP +).
- New UNDAF 2013–2017.

Challenges

- Sustaining the achievement made in communicable diseases including HIV/AIDS, TB, malaria, vaccine preventable and neglected tropical diseases.
- Addressing the growing burden of noncommunicable diseases, linking disability/rehabilitation services as well as mental health into the primary health-care system.
- Mitigating potential health consequences of natural and human induced disasters.
- Identifying and addressing environmental health challenges.
- Meeting national and MDG targets for access to safe water and sanitation.
- Identifying and mitigating the public health impact of climate change.
- Improving access to and adapting quality of health services including essential medicines and medical devices particularly in remote and rural areas.
- Providing universal health coverage and social protection.
- Strengthening the health policy dialogue process and the underlying institutional base for performance review, information use and accountability.

WHO Representative handing over World No Tobacco Day Award to Secretary, Ministry of Health and Population, in the presence of Honourable Minister of Health, Director-General of Health Services and Director, National Health Education & Communication Centre, Nepal.

Inauguration ceremony for World Health Day 2012 'Ageing and Health'; Kathmandu, Nepal.

3 — Development cooperation and partnerships

3.1 The aid environment in Nepal

Nepal became an aid-recipient country in 1956 with the launch of the First Five-year Plan (1956–1961). Ever since then, foreign aid has continued to flow and has influenced the overall socioeconomic development of the country. Nepal has been party to many international foreign-aid instruments, including the Paris Declaration on Aid Effectiveness. The Ministry of Finance drafted a new foreign-aid policy in 2008 but it is yet to be formally endorsed.

Official Development Assistance (ODA) plays a significant role in Nepal's health sector. ODA accounted for 21% of total health expenditure in 2006 (with out-of-pocket and Government expenditure accounting for 55% and 24%, respectively) and is estimated to have comprised between 40% and 50% of the Government's health budget during the period 2005/6–2011/12.

The principal mechanisms through which ODA is provided include:

- *sector budget support,* amounting for 50% of ODA (2009) as the Government's preferred modality;
- *project aid*, i.e. funds managed through Government systems;
- *technical assistance* and cooperation, with resources managed by external development partners' systems, or managed jointly with MoHP, Nepal.

Pooled funding *(sector budget support)* was initially provided under the framework of NHSP-IP by DFID and the World Bank. Over the years, the number of external development partners providing pooled funding increased, as has the amount of total pooled funds. Currently there are five pool partners (World Bank, DFID, AusAID, GAVI HSS, KfW). In the 20010–2011 financial year, the total contribution of pooled funds was 63% of the total external development partners' contribution to the health sector. However, many external developmental partners operate outside the purview of pooled funding. NGOs also play a significant role in the aid environment, channeling substantial funding to the health sector at the community level.

3.2 Stakeholder analysis

Key health development partners in Nepal, known as Health Sector External Development Partners (EDPs), include: AusAID, DFID, KfW, GAVI, GFATM, GIZ, ILO, JICA, UNICEF, UNFPA, UNAIDS, USAID, WB, and WHO. EDPs are committed to support implementation of the NHSP-II. AusAID, DFID, KfW, and WB are supporting through the pool fund mechanism. India and China remain significant donors to the health sector and they are yet to be fully integrated within the Sector-Wide Approach (SWAp) arrangements. From 2012, the *Busan High Level Forum on Aid Effectiveness,* provided impetus to encompass non-OECD countries, e.g. India and China, to the aid-effectiveness agenda. This could present an opportunity to better integrate them into the SWAp framework.

I/NGOs remain important partners in the health sector, specifically in supporting the Government in health service delivery. In Nepal, all I/NGOs are placed under the purview of the Social Welfare Council (SWC) which means that I/NGOs working in the health sector are not legally bound to MoHP. Among other things, this creates a challenge for harmonizing I/NGO support within the health sector.

Following the First People's Movement of 1990, which restored constitutional democracy in the country, many civil society organizations (CSOs) emerged in different social sectors. The engagement of CSOs in the health sector has been improving over the years, specifically after the advent of the SWAp arrangement in 2004. Both MoHP and external development partners make an earnest effort to ensure CSOs' participation in annual reviews, strategic, and technical meetings. At the same time, engagement of CSOs in health sector development needs to be enhanced further.

The commercial sector is ever growing and a vital part of the health sector in Nepal. Partnership with *not-for-profit* private health institutions has much improved in recent years. Many examples of good partnership exist, e.g. the Ama programme, provision of uterine prolapse surgical services, eye care, and waste management. However, unclear legal provisions and scattering roles for regulating the private sector between different line agencies, impedes monitoring and streamlining activities of these institutions by MoHP.

3.3 Coordination and aid effectiveness in Nepal

In 2004, MoHP made a strategic shift with the implementation of the *"Health sector reform strategy: an agenda for change"* and introduction of NHSP. Among other things, the strategy envisioned a Government-led sector with better harmonization and alignment with partners and strong stewardship over the health sector. This led to the initiation of the the Sector-Wide Approach (SWAp) under the auspices of the Paris Declaration on Aid Effectiveness in 2005, to which Nepal is signatory. SWAp is formally endorsed and supported by 12 donors working in Nepal's health sector.

Joint Annual Review, by Government and external development partners in health, 2011.

Since 2004, an increasing number of external development partners adopted programme-based approaches (PBA) and forsook independent projects. This significantly improved aid effectiveness, including harmonization and alignment. Among other things, improved aid effectiveness resulted in reduced overall transaction cost for the MoHP, which subsequently contributed to a steady improvement in MoHP's budget absorptive capacity, from 69% in 2004–2005 to 89% in 2009–2010.

Since 2005, there has been good progress in formulation and implementation of clear result oriented strategies in the health sector. Both NHSP-I and NHSP-II were developed with joint participation of EDP and other state and non-state actors, indicating greater focus on partnership in the health sector. MoHP, EDPs and increasingly non-state actors (I/NGOs, civil society) discuss and review national strategies and programmes in a formal Joint Annual Review (JAR).

Based on the results, a mutually agreed upon *aide memoire* is developed to guide coordinated work for the following 6 months. Government endeavours to bring different actors into the JAR has increased and diversified participation. The efficacy of JAR as a platform for reviewing progress against results and instruments, such as the Governance and Accountability Action Plan (GAAP) and IHP+ has improved over the years. Since 2004, external development partners in health have been meeting regularly as a formal group, with annual rotation of the chair and co-chair. This certainly contributed to improved harmonization among these partners and resulted in a more coordinated approach to Government interactions. WHO is an active participant in the aid platforms and in the aid-effectiveness network within the IHP+ country compact and joint financing arrangement (JFA). The IHP+ country compact, signed by the Nepal Health Development Partnership sin February 2009, reinforced earlier commitments

to partnerships and aid effectiveness, contributing to continuing improvements in this area. This was helpful in the design of NHSP-II, on which Government and external partners worked together. The country compact has also contributed to an increase in the role of civil society in the health sector, as during development phase of the country compact discussions of the IHP+ draft were led by civil society in all five regions. In 2009, JFA was signed between MoHP and all pool partners (DFID, AusAID, World Bank, KfW, GAVI HSS) *plus* four non-pool partners (USAID, UNFPA, UNICEF, WHO). This clearly set out harmonized procedures for performance reviews, financial management, coordinating planning, monitoring and review.

Effective coordination and implementation of technical assistance has been a subject of much discourse in health. Under the auspices of SWAp, both Government and partners made earnest efforts to improve utilization, but gaps remain. Technical assistance issues include alignment with national priorities, and cost–effectiveness, proper utilization, duplication, and underutilization of national knowledge and resources. To address these shortcomings and improve efficacy, the Government and partners are working together to draft and endorse a Joint Technical Assistance Arrangement (JTAA).

Within the spirit of the above arrangements, MoHP, with support and participation of major stakeholders, conducts a Joint Annual Review (JAR) focusing on planning and budgeting (June) and programme review (November), to provide ongoing assessment of the performance of the health sector.

3.4 United Nations reform and the status of CCA-UNDAF process

Recent UN reform initiatives have, at country level, focused on enhancing the work of the UN country team, strengthen the Resident Coordinator's Office, and emphasized UNDAF as the strategic programme framework for collective country work of resident and nonresident UN agencies in response to national priorities.

The *UNDAF 2007–2012,* developed in the aftermath of a 10-year civil conflict, emphasized peace, and development of social inclusion. It did not, however, highlight health as a programmatic priority. The *UNDAF 2013–2017* does so. It is informed by a common country analysis with people at its core, which targets vulnerability through 10 distinct *outcome* areas within a shared framework of human rights, gender equality, environmental sustainability, and results based management. WHO will, in its 2-year collaborative country programmes, address 3 out of these 10 *outcome* areas. UNDAF *outcome 1* details how health impact is to be achieved at policy, systems and community levels; UNDAF *outcome 6* addresses health issues related to climate change, disaster risk mitigation and management; and UNDAF *outcome 8* deals with how Nepal's institutions and economy can be more effectively integrated into intergovernmental economic and normative dialogues, and policy and legal regimes. Within this UNDAF

framework, WHO will address – either as a single agency, or in collaboration with other UN partners – those social determinants of health that prevent access by disadvantaged populations to health services: safe drinking-water, improved sanitation, nutrition, environmental health and waste management. The main implementation strategy for WHO will be capacity-building for health systems analysis and development of healthy public policies. Other strategies focus on developing effective intersectoral actions, and promoting partnership between Government and academia.

Implementation of the UNDAF framework will be monitored by the UN country team through *outcome* specific theme groups, who in turn will serve as the main platform for joint programming, interagency collaboration and progress monitoring. WHO's biennial collaborative proragmmes and the Country Cooperation Strategy are aligned with WHO's General Programme of Work globally, with UNDAF, with NHSP-II as well as other relevant national development plans.

3.5 Key challenges and opportunities in aid effectiveness

Key opportunities and challenges in aid coordination and effectiveness

Achievements:

- Commitment and participation of the principal EDPs in well-defined and accepted aid coordination and effectiveness mechanisms through SWAp.
- Markedly improved national ownership – all EDPs operate within the framework of MoHP led NHSP-II and aid flows are increasingly aligned to national priorities.
- Aid fragmentation and duplication have reduced due to increased emphasis on harmonization and alignment from both the Government and EDPs.
- Increased orientation on the part of EDPs to pool resources (financial and technical) – as is evident by commitments exhibited in JFA and forthcoming JTAA. GAVI HSS has joined as a pooled partner.
- To harmonize and facilitate the program specific monitoring requirement for NHSP-II implementation, unified monitoring and evaluation framework has been developed.

Opportunities

- MoHP aspires to improve its sector stewardship role.
- Civil society participation in policy dialogue forums has increased and become more meaningful over the years – IHP+ has made a contribution to this regard.
- UNDAF 2013-17 has given greater prominence to health than current UNDAF.

Challenges

- Despite improved alignment of the EDPs at the policy and strategic levels, alignment with the Government institutional system needs to be further improved. At times the donor requirement imposes stringent procurement and financial management requirements.
- Integrating INGOs, NGOs and civil society organizations into the aid coordination and effectiveness mechanism.
- Further strengthening alignment, harmonization, coordination and management of EDP support for aligning the technical assistance.
- Reduce the number of EDP specific monitoring and evaluation activities.
- Further strengthening governance & accountability to ensure resources in the health sector are utilized efficiently and transparently.

4 — Review of the WHO cooperation over the past CCS cycle

4.1 Review of WHO cooperation with stakeholders

4.1.1 Key aspects of WHO's contribution to the national ownership in national priority-setting and plan formulation processes

WHO supported effective aid coordination and national ownership in priority-setting and formulation processes, as signatory and active participant in the aid coordination and effectiveness mechanisms outlined in Section 3. In doing so, WHO has:

- contributed extensively to the development of the NHSP- II, actively participating in all eight thematic groups;
- lead the thematic group on strengthening the health system to enhance capacity in policy planning and strategic management championing a focus on: effectively reducing health inequities through cost-effective interventions, multisectoral coordination and fair financing; systematically involving private and NGO sectors; promoting decentralization of health services aiming at community empowerment; and enhancing the health system's responsiveness in respect of quality of care, and managerial accountability;
- supported MoHP in organizing the Joint Annual Review (JAR) meetings to help harmonize the work of EDPs with that of MoHP in support of the NHSP-II; and
- supported the development and use of the EDP Technical Assistance (TA) matrix in: clearly outlining the proposed areas of work of partners over the period of the NHSP IP-II; helping to identify gaps in technical support; preventing programmatic duplication of work and strengthening collaboration and coordination with the GoN.

4.1.2 WHO's comparative advantage

The role of WHO as the lead technical support agency in health is well recognized within the United Nations country team as well as among external development partners. WHO is acknowledged as having a comparative advantage in terms of policy dialogue on health policy, strategies, and plans; development of norms and standards; and relevant expertise across a broad range of technical areas such as communicable and

noncommunicable diseases. Within the country team agencies, UNICEF and UNFPA work particularly closely with WHO, seeking technical advice and actively engaging in partnerships on health-related programmes. WHO similarly engages in active partnership arrangements among the broader community of external development partners in health.

4.2 Internal review

4.2.1 Implementation of strategic agenda of the previous CCS 2006–2011

The *WHO Country Cooperation Strategy, Nepal, 2006–2011* embraced an approach which acknowledged the country's economic constraints, epidemiological situation, difficulties posed by geographic factors and frequent political change. The CCS exhibited a high level of complementarity with the Government of Nepal and external partners' health programmes.

The Country Cooperation Strategy 2006–2011 focused on six priority areas of intervention:

(1) Strengthening the health system

(2) Control and prevention of disease and disability

(3) Human resource development

(4) Child, adolescent and reproductive health

(5) Healthier environment

(6) Emergency preparedness and response.

As noted in Annex 3, the CCS strategic priorities were consistent with the NHSP-IP 2004 – 10 strategic objectives and outputs; the Rural Water Supply and Sanitation Sector Plan, 2004; the NHSP-II's strategic directions and key objectives in the NHSP–II Governance and Accountability Action Plan key objectives 2010–2015 as well as the UNDAF 2008–2012.[1]

The six priorities were implemented through three biennial collaborative workplans (2006–2007; 2008–2009 and 2010–2011). Programme budget performance assessments were undertaken during *each* of the three programming cycles (bienniums) covered by the CCS. These helped ensure that CCS priorities and strategic approaches provided a sound basis for strategic and operational planning, and are reflected in WHO collaborative programmes of the following cycle. In addition, a formal assessment at the midpoint of each cycle is carried out to see whether implementation is on track and whether corrective action is required.

[1] Formally, there was no UNDAF to cover 2007.

In addition, an internal review and technical assessment carried during the past CCS cycle found that the strategic agenda and objectives have been addressed in the biennial collaborative programmes. However, constraints were observed regarding coordination and availability of funding in some areas, and high turnover of programme managers in others.

4.2.2 Allocation of resources

Over the period of the CCS, the WHO country budget has increased significantly from approximately US$ 13.8 million for the 2004–2005 biennium to approximately US$ 30.4 million for the 2010–2011 biennium. Although a significant increase in resources has been observed, there has been no significant increase in the number of professional staff at the WHO Nepal Country Office. Consistency between CCS priorities and allocation of financial resources are noted in Table 1.

Table 1: Percentage of financial resources by CCS 2006–2011 priority areas

CCS priority areas	Assessed contributions (%) by priority area	Voluntary contributions (%) by priority area
Strengthening the health system	18	8
Control and prevention of disease and disability	37	70
Human resource development	18	3
Child, adolescent and reproductive health	11	6
Healthier environment	8	3
Emergency preparedness and response	5	11

In assessing consistency between resource allocation and CCS strategic priorities it should be recognized that WHO continued to provide the normative core functions as a core area of support and addressed other important public health challenges that arose in Nepal that did not fall within the priority areas.

4.3 Summary of findings

WHO has sharpened its programmatic focus in the current WHO Country Cooperation Strategy 2013–2017 as a result of reviewing the previous cycle, which contained a wider range of collaborative areas and broader strategic priorities. In addition, there

is greater emphasis on *health beyond health* factors and on intersectoral collaboration than previously. Furthermore, universal coverage for health, a likely overarching development goal beyond 2015, features in the new Strategic Agenda. Regarding staffing skills and competencies, the skill mix of WHO Country Office in the past CCS cycle was influenced by resource availability as well as programmatic demand. The new Country Cooperation Strategy will attempt to improve this balance by having defined more closely the programmatic direction for resource mobilization (rather than the other way round). The Country Office will assess the competency and skill mix required to respond effectively to these expectations. Unpredictability of resources, especially voluntary contributions coming to the Country Office sometimes late in the biennium, were found to adversely affect the Country Office's capacity to respond effectively to country needs and priorities. This should be redressed.

Strengthening partnership in health.

Consultation for CCS Nepal 2013–2017.

5 — Strategic agenda for WHO cooperation

5.1 Introduction

A strategic agenda for WHO cooperation with Nepal has been developed for the period 2013–2017 in line with the National Health Sector Plan II. This takes into account:

- key health and development challenges confronting the country as analysed by WHO in consultation with the Government, nongovernmental organizations, and external development partners in health, including the need to mainstream gender and social inclusion into collaborative programmes;
- contributions to health development by other external development partners and identified challenges and gaps in health sector cooperation;
- lessons learnt from a review of WHO's cooperation over the last CCS cycle;
- WHO's comparative advantage; and
- WHO's General Programme of Work, its strategic objectives and priorities, as well as regional orientations and priorities.

Six strategic priorities for WHO cooperation have been identified for the period 2013–2017. The order in which the strategic priorities are listed does *not* indicate a relative weighting, level of effort, or the importance attributed to each.

(1) *Achieving communicable diseases control targets*.

(2) *Controlling and reversing the growing burden of noncommunicable disease*.

(3) *Promoting health over the life-cycle, focusing on interventions for under privileged and vulnerable population*.

(4) *Strengthening health systems within the revitalized primary health care approach and support policy dialogue on health policies, strategies, and plans for universal coverage*.

(5) *Reducing the health consequences of disasters*.

(6) *Addressing environmental determinants of health*.

For each of the strategic priorities, a set of *"main foci"* and *"strategic approaches"* have been formulated. The main foci clarify the role of WHO in addressing the priorities and reflect WHO's comparative advantage. They are areas where potential for impact

exists, and emphasize both the convening and policy advisory roles of WHO (rather than confining its contribution to support implementation of public health activities in the country).

The strategic approaches reflect the ways and means WHO will adopt in undertaking collaborative actions identified under the main foci, based on WHO's core functions. Given the cross-cutting nature and interrelationships among strategic approaches, a strategic approach under one main focus may impact positively on other main foci and priorities.

As part of its core functions, WHO will continue to move towards and share norms, standards and guidelines. Expertise will be provided to support application of those standards and guidelines. With health at the heart of the Millennium Development Goals, *WHO will continue to monitor progress in the achievement of all health-related MDGs* and particularly 4 (reduce child mortality), 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria and other diseases). For the international development agenda beyond 2015, universal health coverage has been proposed as an overarching development goal.

Capacity to develop evidence in response to current and emerging issues, ability to contribute to capacity-building, capacity to respond to changing needs based on ongoing assessment of performance, potentials to work with other sectors, organizations and stakeholders to have a significant impact on health are some priority-setting programmes for WHO in forthcoming years. There are *other important public health challenges in Nepal that do not fall within the priority areas, but which will continue to be part of WHO's collaboration*. The work in these areas will be planned in a biennium-to-biennium mode through negotiation between WHO, national authorities and relevant stakeholders.

Nepal's Ministry of Health and Population remains WHO's principal partner: in recognizing the increasingly complex health landscape, WHO will broaden its focus to work more closely with nongovernmental organizations, civil society and the private sector in collaborative implementation of the Strategic Agenda 2013–2017.

5.2 Strategic agenda 2013–2017

Strategic priority 1: Achieving communicable diseases control targets.

Main focus 1.1: Reduce mortality and morbidity from communicable diseases including vaccine preventable diseases, and to achieve disease eradication, elimination and control targets of communicable diseases.

Strategic approaches

1.1.1: Provide technical support to achieve and maintain high coverage levels for all targeted antigens in the routine immunization programme; the

year 2012–2013 has been designated as the year of intensification of routine immunization.

1.1.2: Conduct supplementary immunization activities supported by surveillance for eradication of poliomyelitis, to achieve measles elimination target by 2016; to use the measles elimination platform to achieve accelerated control of rubella/CRS and control of mortality from Japanese encephalitis.

1.1.3: Support introduction of new and underused vaccines in the country based on disease burden and financial sustainability on priority basis.

1.1.4: Strengthen epidemiological capacity for epidemic preparedness and response for: emerging, re-emerging, ARI and diarrhoeal disease, zoonotic and outbreak-prone diseases with particular emphasis on an integrated disease surveillance system; and integrated vector management.

1.1.5: Strengthen laboratory capacity for quality assurance of blood transfusion services and diagnosis and tracking the emergence or re-emergence of new antimicrobial species and antimicrobial resistance.

1.1.6: Strengthen national core capacities required by the International Health Regulations (2005).

Main focus 1.2: Eliminate and further reduce the disease burden due to neglected tropical diseases (leprosy, kala-azar, lymphatic filariasis, trachoma, intestinal helminths).

Strategic approaches

1.2.1: Provide technical support to sustain leprosy elimination status (new case detection and completion of treatment) and rehabilitation.

1.2.2: Strengthen tools, skills and support systems for active case search, early diagnosis and complete treatment to achieve kala-azar elimination.

1.2.3: Support integrated elimination strategies and activities for lymphatic filariasis, soil-transmitted intestinal helminths and trachoma.

Main focus 1.3: Further reduce the disease burden due to HIV/AIDS , tuberculosis, malaria and vector-borne diseases.

Strategic approaches

1.3.1: Provide technical support to achieve universal access to HIV prevention, treatment and care, and second generation surveillance including ART drug resistance.

1.3.2: Provide technical support to the national tuberculosis control programme to ensure implementation of the six components of the *Stop TB Strategy*.

1.3.3: Provide technical support for revision and implementation of the national strategy for prevention and control/elimination of malaria and vector-borne diseases.

Strategic priority 2: Controlling and reversing the growing burden of noncommunicable diseases

Main focus 2.1: Support prevention and control of major NCDs through the primary health care approach.

Strategic approaches

2.1.1: Provide technical support for the development and introduction of a package of low-cost and cost-effective interventions for prevention and control of NCDs at the primary health care level.

2.1.2: Provide technical support for the development and implementation of a surveillance system for priority NCDs including their risk factors and mechanisms to monitor and evaluate the impact of interventions in an ongoing and systemic manner.

2.1.3: Provide technical support to prevent and tackle chronic noncommunicable conditions, violence, injuries and disabilities together with visual impairment, including blindness, deafness, mental and behavioural disorders.

Main focus 2.2: Promote healthy lifestyles.

Strategic approaches

2.2.1: Provide technical support for the development and implementation of policies and strategies that make use of health promotion and evidenced based legislation, regulations and fiscal measures to reduce the consumption of tobacco and alcohol; promote the consumption of healthy food, promote physical activities and oral health.

Main focus 2.3: Support integration of mental health within a revitalized primary health care system.

Strategic approaches

2.3.1: Provide technical and policy support to review and revise mental health policy and legislative frameworks.

2.3.2: Strengthen tools, skills, and support systems for development and implementation of community mental health package.

Main focus 2.4: **Support development of community-based disability and rehabilitation services linked to revitalized primary health system.**

Strategic approaches

2.4.1: Provide technical support to the Ministry of Health and Population to effectively coordinate Government, nongovernmental and civil society organizations in the development and promotion of a comprehensive strategy and plan of action for the provision of community-based disability and rehabilitation services.

2.4.2: Support the Ministry of Health and Population in advocating for vocational training initiatives and apprenticeships for community-based production of assistive devices and mechanisms to ensure access to assistive devices by the poor and marginalized.

Strategic priority 3: Health over the life-cycle focusing on interventions for under privileged and vulnerable populations.

Main focus 3.1: **Promote evidence-based interventions to improve quality of neonatal, child, adolescent, maternal and reproductive health including family planning.**

Strategic approaches

3.1.1: Provide technical support for intensified action to ensure skilled care, based on *continuum of care* model from adolescents through to pregnancy, delivery and postnatal period and from community to facility.

3.1.2: Support to strengthen evidence-based norms, standards, guidelines, protocols and capacity to improve maternal, newborn, child, adolescent and reproductive health-care services, including family planning.

3.1.3: Support sustainable multisectoral approaches to improve nutrition throughout the life-cycle by addressing social and economic determinants of all forms of malnutrition.

Main focus 3.2: Improving access and utilization of maternal, neonatal, child, adolescent health and reproductive health including family planning, focusing on interventions in underprivileged areas.

Strategic approaches

3.2.1: Strengthening partnerships and resource mobilization efforts to scale up implementation of the package of essential maternal, neonatal, child and adolescent health services.

3.2.2: Scale-up adolescent sexual and reproductive health-care services including family planning.

3.2.3: Enhance demand creation of maternal, newborn, child, adolescent and reproductive health-care services.

3.2.4: Capacity-building to address reproductive health morbidities and key reproductive health issues of the elderly.

Strategic priority 4: Strengthening health systems within the revitalized primary health care approach and support policy dialogue on health policies, strategies, and plans for universal health coverage.

Main focus 4.1: **Improve access and quality.**

Strategic approaches

4.1.1: Engage with the Ministry of Health and Population, external development partners, civil society organizations and the private sector to generate strategies and policy options to improve provision of health services in rural and urban areas within the revitalizing primary health care framework under the decentralized federal structure.

4.1.2: Provide technical support for design and implementation of effective interventions to promote quality and improved health outcomes for the individual service user as well as the community.

Main focus 4.2: **Develop a national health financing system to achieve universal health coverage and social protection.**

Strategic approaches

4.2.1: Provide technical support for the development of policy, related legislation, and regulation, and monitoring of an integrated health-care financing strategy towards universal health coverage.

4.2.2: Strengthen the tools, skills, and support systems to enable the focal unit for health financing to track resource flows into and within the health sector and track performance of financing sources.

Main focus 4.3: **Strengthen the health workforce particularly for improved district health system performance.**

Strategic approaches

4.3.1: Provide technical support for the development of policy, related legislation, and regulation for implementing the Human Resources for Health Strategy.

4.3.2: Strengthen the National Health Training Centre for capacity-building of community-based health workforce.

4.3.3: Strengthen the quality of pre-service nursing and midwifery education.

4.3.4: Strengthen the Nepal Health Professional Council for accreditation of vocational education.

4.3.5: Strengthen coordination of the role of academia in health system strengthening.

4.3.6: Support coordination of the Nepal Public Health Education Network (NEPHEN).

Main focus 4.4: **Improve availability, access, quality and safety of essential medicines, medical devices, blood for transfusion and traditional medicine.**

Strategic approaches

4.4.1: Provide technical support to the Ministry of Health and Population to strengthen policies and strategies for ensuring the availability of, and equitable access to, essential medicines, medical devices, and pharmaceutical care and services that meet quality, safety, and efficacy standards.

4.4.2: Strengthen the tools, skills, and support systems to enable MoHP to implement the 12 core interventions for promoting the rational use of medicine and to more effectively discharge its drug regulatory function and ensure quality of medical devices.

4.4.3: Provide technical support for the development of evidence-based information on the quality, safety, efficacy, and use of traditional medicines.

4.4.4: Strengthen national capacity for availability of quality assured blood and blood products for transfusion services.

Main focus 4.5: Strengthen quality, sharing, analysis and utilization of health data.

Strategic approaches

4.5.1: Provide technical support for design and implementation of a system for monitoring and evaluation of data quality at all levels.

4.5.2: Advocate and provide technical support for the establishment of a national “data warehouses” and district databanking.

4.5.3: Strengthen skills for data analysis, utilization, and the application of methodologies to address data problems.

Main focus 4.6: Strengthen the institutional base for progress and performance review, information use and accountability.

Strategic approaches

4.6.1: Engage with Ministry of Health and Population and external development partners in supporting the road map to implement the national framework for monitoring and evaluation of the National Health Systems Plan II and beyond.

Main focus 4.7: Support management of the health policy dialogue process.

Strategic approaches

4.7.1: Strengthen the tools and skills to enable the Ministry of Health and Population to conduct meaningful policy dialogue.

4.7.2: Engage with the Ministry of Health and Population and external development partners to broaden health policy dialogue to include social determinants of health and interaction between health and other sectors of society; and advocate the inclusion of health in policy deliberations of other sectors.

4.7.3: Engage with the Ministry of Health and Population to bring together external development partners, nongovernmental organizations, civil society organizations and the private sector around priority health issues ensuring strategic advice is based on complete and valid information, and that action is informed by a common, cohesive strategy applied by all partners.

4.7.4: Provide technical support to policy observatories to identify problems of national concern, gather intelligence, and generate policy options for debate.

4.7.5: Promote and support intercountry experience-exchange in managing specific policy challenges and support documentation, assessment and sharing of health policy innovations.

4.7.6: Participate actively in making health and monitoring and achievement of health-related MDGs more prominent in the components of UNDAF 2013–2017.

Strategic priority 5: Reducing the health consequences of disasters.

Main focus 5.1: Strengthen national capacity and coordination in health sector emergency risk management.

Strategic approaches

5.1.1: Advocate for adequate human resources in the area of health sector emergency preparedness at all levels.

5.1.2: Strengthen the tools, skills and support systems to enable district health systems to undertake initiatives in emergency risk management.

5.1.3: Provide technical support to programmes for reducing the vulnerability of health facilities to the effects of disasters in accordance with the National Disaster Risk Reduction Strategy and hospital safety initiatives.

Main focus 5.2: Promote and support a coherent intersectoral approach to health emergency preparedness and response including recovery.

Strategic approaches

5.2.1: Provide technical and policy support for the development and implementation of an intersectoral mass casualty management strategy.

5.2.2: Strengthen partnerships with Government, nongovernmental and civil society organizations for more effective planning, coordination, and response linking with the existing Inter Agency Standing Committee (IASC).

Strategic priority 6: Addressing environmental determinants of health.

Main focus 6.1: Strengthen programmes for achieving national and MDG targets for access to safe water supply and sanitation.

Strategic approaches

6.1.1: Engage with the Department of Water Supply and Sewage to strengthen the tools, skills and support systems required to accelerate roll out of water safety plans in rural and urban water supply projects.

6.1.2: Provide technical and policy support to establish viable water quality monitoring units at central and regional levels within Department of Water Supply and Sewage.

6.1.3: Strengthen tools, skills and support systems to enable the Ministry of Health and Population to undertake water quality surveillance in accordance with national drinking-water quality standards and directives and scale-up the Total Sanitation Programme.

Main focus 6.2: Support implementation of the national environmental health programme.

Strategic approaches

6.2.1: Provide technical and policy support for undertaking environmental health impact studies and developing mitigation strategies and scaling-up health-care waste management programmes for public, private and community-based health-care facilities.

6.2.2: Partner with Government, nongovernmental and civil society organizations, and the community to advocate for a multisectoral response to indoor and outdoor air pollution, including environmental prevention of childhood pneumonia.

6.2.3: Engage with the Ministry of Health and Population, the Ministry of Urban Development and relevant stakeholders to develop and promote pilot projects for demonstrating the application of healthy setting concepts in schools, health facilities, public offices and urban and rural settings.

Main focus 6.3: Support efforts to identify and mitigate the public health impact of climate change.

Strategic approaches

6.3.1: Support research to close the knowledge gap on the public health impact of climate change on water resources, agricultural production, and vector-borne diseases.

6.3.2: Advocate and provide technical support for development of consistent and comprehensive strategies for the health, agriculture and water sectors to mitigate the current and potential public health impact of climate change.

WHO staff association-organized blood donation commemorating World Blood Donors Day 2012.

Participants in the Regional workshop to accelerate the implementation of TB–HIV collaborative activities in the South-East Asia Region (9–11 July 2012).

5.3 Validation of the strategic agenda with NHSP-II

Strategic directions and Governance and Accountability Action Plan (GAAP) key objectives, strategic agenda with the MTSP strategic objectives, UNDAF outputs and new categories in the 12th General Programme of Work of WHO.

Validation of the strategic agenda

CCS Strategic Priority *	Related NHSP–II Strategic Directions and GAAP key objectives	Related MTSP Strategic Objective and Organization-wide Expected Results (from the 11th GPW of WHO)	Related UNDAF 2008–2012 outputs	Related UNDAF 2013–2017 Outputs
Strategic priority 1: Achieving communicable diseases control targets. *Relates to category 1: communicable diseases and to category 5: preparedness, surveillance and response.*	SD[1] – Eradication, elimination and control of selected vaccine preventable diseases SD – Disaster management and disease outbreak control.	SO[3] 1 To reduce the health, social and economic burden of communicable diseases. ⦿ OWER[4] 1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies. ⦿ OWER 1.2 Effective coordination and support provided in order to achieve certification of poliomyelitis eradication. ⦿ OWER 1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases. ⦿ OWER 1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance. ⦿ OWER 1.6 Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005). SO 2 To combat HIV/AIDS, tuberculosis and malaria. ⦿ OWER 2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria. ⦿ OWER 2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria.	CP Output B.2.3 – Basic package of HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable groups is included in district AIDS plans, and resources allocated and services provided in selected districts.	Outcome 1: Vulnerable and disadvantaged groups increasingly demand, utilize and access equitable and quality essential social services and programmes. Output 1.3- The performance of district health systems in the delivery of primary health care is significantly improved. Output 1.4- Prevention and care seeking behaviours of communities improved based on informed choices.

** and related categories in the 12th GPW of WHO*

CCS Strategic Priority *	Related NHSP–II Strategic Directions and GAAP key objectives	Related MTSP Strategic Objective and Organization-wide Expected Results (from the 11th GPW of WHO)	Related UNDAF 2008–2012 outputs	Related UNDAF 2013–2017 Outputs
Strategic priority 2: Controlling and reversing the growing burden of noncommunicable diseases. *Relates to category 2: noncommunicable diseases.*	SD – Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure SD – Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure.	SO 3 To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment ◉ OWER 3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of mental disorders and disabilities. ◉ OWER 3.3 Improvements made in Member States' capacity to collect, analyse, disseminate, and use data. on the magnitude, causes, and consequences of chronic noncommunicable diseases. ◉ OWER 3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health. ◉ OWER 3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities. SO 6 To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, unhealthy diets, physical inactivity. ◉ OWER 6.1 Advice and support provided to Member States to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.	CP Output B.1.3 – Selected communities, particularly socially excluded and economically marginalized groups will have enhanced knowledge, skills and resources for improved, nutrition, home-based health-care and health-seeking behaviour.	Outcome 1: Vulnerable and disadvantaged groups increasingly demand, utilize and access equitable and quality essential social services and programmes.

** and related categories in the 12th GPW of WHO*

CCS Strategic Priority *	Related NHSP–II Strategic Directions and GAAP key objectives	Related MTSP Strategic Objective and Organization-wide Expected Results (from the 11th GPW of WHO)	Related UNDAF 2008–2012 outputs	Related UNDAF 2013–2017 Outputs
Strategic priority 3: Health over the life-cycle focusing on interventions for under privileged and vulnerable populations. *Relates to category 3: promoting health through the life course.*	SD – Gender equality and social inclusion SD – Modern Contraception and safe abortion GAAP[2] 3.3 – Redeployment of health workforce GAAP 3.4 – Improving quality of health services.	SO 4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps. ◉ OWER 4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling-up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector. ◉ OWER 4.1 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.	CP Output B.2.1 – Existing human resources in education and health facilities and community health workers and volunteers are trained to provide basic services in selected districts. CP Output B.2.2 – District public health and educations offices are provided with increased skills and resources to plan, implement, supervise, monitor and ensure quality health and education interventions.	Output 1.5 – Government (NPC, MOAC, MoLD and MoHP) has strengthened information management system to monitor improved food security and nutrition situation which enables a better and informed policy-making and interventions. Output 1.6 – Adolescent girls, mothers, infant and young children, vulnerable groups have increased access and utilization of essential micronutrients. (Vitamin A, iron folic acid, MNP, Iodized salt). Output 1.7 – Families, especially the vulnerable groups, practice optimal maternal, infant and young child feeding and care practices and manage acute malnutrition Output 1.11 – Children at risk or victims of violence, abuse or exploitation benefit from quality social welfare services in selected districts and municipalities Output 1.12 – Government institutions promoting children and adolescents' rights at national and subnational levels are more able to generate evidence including child poverty analysis for policy.

** and related categories in the 12th GPW of WHO*

CCS Strategic Priority *	Related NHSP–II Strategic Directions and GAAP key objectives	Related MTSP Strategic Objective and Organization-wide Expected Results (from the 11th GPW of WHO)	Related UNDAF 2008–2012 outputs	Related UNDAF 2013–2017 Outputs
Strategic priority 4: Strengthening health systems within the revitalized primary health care approach and support policy dialogue on health policies, strategies and plans for universal coverage. *Relates to category 4: health systems.*	SD – Health systems strengthening SD – Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure. SD – Access to facilities and removal of barriers to access and use. SD – Institutionalizing health sector reform. SD – Sector-Wide Approach. SD – EDP harmonization and International Health Partnership. SD – Intersectoral coordination. GAAP 3.1 – Ensuring adequate capacity development of institutions and human resources strengthening to effectively NHSP IP-II implementation plan GAAP 3.2 – Ensuring adequate number and diversity of health work force as per norms set by MoHP. GAAP 3.4 – Improving quality of health services. GAAP 3.5 – Strengthening quality assurance and M&E. GAAP 5.1 – Procurements at central and district level. GAAP 5.2 – Timely availability of drugs, equipment and supplies.	SO 10 To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research. ◉ OWER 10.1 Management and organization of integrated, population-based health-service delivery….improved, reflecting the primary health-care strategy, scaling-up coverage, equity, quality and safety of personal and population-based health services. ◉ OWER 10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity building for policy analysis and development, strategy-based health system performance assessment. ◉ OWER 10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health system development and global health goals improved. ◉ OWER 10.4 Country health information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals. SO 11 To ensure improved access, quality and use of medical products and technologies ◉ OWER 11.1 Formulation and monitoring of comprehensive national policies on access, quality, and use of essential medical products and technologies advocated and supported. ◉ OWER 11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.	CP Output B.2.1 – Existing human resources in education and health facilities and community health workers and volunteers are trained to provide basic services in selected districts. CP OutputB.2.2 – District public health and educations offices are provided with increased skills and resources to plan, implement, supervise, monitor and ensure quality health and education interventions. CP Output B.3.2 – Policy changes and restructuring to support decentralization, programme coordination and sector-wide approaches are recommended and endorsed. CP Output B.3.4 – Government's management information systems are providing disaggregated data by age, sex, ethnicity, caste and economic status for evidence-based planning and monitoring and equitable resource allocation. CP Output B.3.5 – Local bodies have the knowledge and skills and increased resources for participatory and inclusive planning, implementation, transparent budgeting, public financial management and effective monitoring.	Output 1.2– Health policies, strategies and programmes of the GoN increasingly address social inclusion, equity, and social and financial risk protection. Output 1.3 – The performance of District Health Systems in the delivery of Primary Health Care is significantly improved. Output 1.4 – Prevention and care seeking behaviours of communities improved based on informed choices. Output 1.5 – Government (NPC, MOAC, MoLD and MoHP) has strengthened information management system to monitor improved food security and nutrition situation which enables a better and informed policy-making and interventions. Output 1.12 – Government institutions promoting children and adolescents' rights at national and subnational levels are more able to generate evidence including child poverty analysis for policy-making and to monitor performance of programmes for the situation of vulnerable children and adolescents. Output 1.13 – Institutional frameworks for volunteering for delivery and development services established by GoN/NPC and the capacity of local actors including local government, CBOs and volunteer organizations to mobilize volunteers for delivery of basic services strengthened.

** and related categories in the 12th GPW of WHO*

CCS Strategic Priority *	Related NHSP–II Strategic Directions and GAAP key objectives	Related MTSP Strategic Objective and Organization-wide Expected Results (from the 11th GPW of WHO)	Related UNDAF 2008–2012 outputs	Related UNDAF 2013–2017 Outputs
Strategic priority 5: Reducing the health consequences of disasters. *Relates to category 5: preparedness, surveillance and response.*	SD – Disaster management and disease outbreak control. GAAP[2] 6.1 Ensuring continued access to EHCS for all people in the face of emergencies, crisis and conflict situations.	SO 5 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact. ◉ OWER 5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes. ◉ OWER 5.2 Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.	CP Output C.4.1 – Planning capacities of selected Government institutions, DDC's and municipalities, enhanced to integrate disaster risk management into their development plans. CP Output C.4.2 – Implementation capacities of national and local government, civil society and CBOs enhanced for disaster mitigation, preparedness, emergency response and early recovery.	Outcome 6: People living in areas vulnerable to climate change and disasters benefit from improved risk management and are more resilient to hazard-related shocks. Output 6.1 Government officials at all levels have the capacity to lead and implement systems and policies to effectively manage risks and adapt to climate change.
Strategic priority 6: Addressing environmental determinants for health. *Relates to category 3: promoting health through the life course.*		SO 8 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address root causes of environmental threats to health. ◉ OWER 8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings. ◉ OWER 8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment. ◉ OWER 8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change.	CP Output B.1.2 - Socially excluded and economically marginalized households in selected districts will have increased awareness, knowledge, skills and resources to access education, build proper sanitation facilities and practice proper hygiene and environmental sanitation.	Output 1.9- Socially excluded and economically marginalized communities (including schools) increasingly utilize and participate in the management of safe and sustainable drinking-water and sanitation facilities and improved hygiene practices in selected diarrhoea and low sanitation coverage districts. Output 1.10- Municipalities adopt and implement effective urban sector policies related to water, sanitation, and shelter.

** and related categories in the 12th GPW of WHO*

[1] SD-NHSP-II Strategic direction (pages 49-53)

[2] GAAP–NHSP-II Governance and Accountability Action Plan key objective (pages 51-53)

[3] MTSP Strategic Objective (pages 49-53)

[4] MTSP Organization-wide Expected Result (pages 49-53)

6 — Implementing the strategic agenda: implications for the entire secretariat

6.1 The role and presence of WHO according to the strategic agenda

The role of WHO as broadly envisaged in the CCS strategic agenda is that of a technical adviser, trusted broker, and convener that engages with Government and facilitates partner's contribution towards national health policies, strategies, and plans.

In effectively performing this role, the CCS strategic agenda requires refocusing and prioritizing the work at the country level around six areas:

- communicable diseases;
- noncommunicable disease;
- health over the life-cycle focusing on interventions for under privileged and vulnerable population;
- health systems and policy dialogue;
- emergency preparedness, and response;
- environmental determinants of health.

While recognizing that WHO will continue to: maintain its normative functions as a core area of support; monitor progress towards the achievement of all health-related MDGs; and provide some level of support to other important public health challenges in Nepal that do not fall within the priority areas.

The six strategic priorities in the CCS cover a broad range of technical expertise. Within this content, the WHO Country Office will critically review the current composition, capacity, and competencies available in the Country Office in view of the requirements for most effectively achieving the CCS strategic agenda.

Continued technical support from the Regional Office and WHO headquarters will be important in supplementing the technical expertise available in the Country Office. Towards that end, close working relationships between the Country Office and the relevant technical units in the Regional Office and headquarters will be strengthened and maintained.

6.2 Using the Country Cooperation Strategy

WHO Country Office

The WHO Nepal Country Office will:

- widely disseminate the CCS document to the Government, national and external development partners, nongovernmental organizations, civil society organizations, and other stakeholders working in and with the country;
- use the CCS strategic priorities, main focuses and strategic priorities to guide current and future work plan development;
- use the content of the CCS to help define and shape the health-related components of the UNDAF and other partnership platforms while recognizing the partners contributions; and
- use the CCS for advocacy and resource mobilization for WHO's work in Nepal.

WHO Regional Office for South-East Asia and WHO headquarters

The technical interactions of the Regional Office and headquarters with the Nepal Country Office (the provision of timely technical support and high level expertise) and through the Country Office with the Government of Nepal, the UN country team, external development partners and other principle stakeholders will be informed and guided by the strategic priorities, main focuses, and strategic approaches of the CCS.

Moreover, the Regional Office and headquarters will:

- widely disseminate the CCS document and CCS Brief to all WHO departments and divisions, and to other relevant partners and stakeholders, including through the use of innovate approaches such as "country days", the "official launch" of the CCS, lunchtime seminars and the use of intranet and Internet sites;
- ensure the CCS priorities are used as the basis for the preparation of strategic and operations plans including budgets and resource allocation; and
- use the CCS for advocacy and resource mobilization for WHO's work in Nepal.

6.3 Monitoring and evaluation of the Country Cooperation Strategy

WHO Nepal Country Office in collaboration with the Ministry of Health and Population, national and external development partners and other stakeholders will undertake a review of the CCS towards the end of the CCS cycle. The focus of the review will be to assess WHO's contribution to the NHSP-II through implementation of CCS Strategic Agenda.

As the strategic agenda laid out in this Country Cooperation Strategy is implemented through operational programmes (detailed biennial workplans), the WHO Nepal Country Office shall assess the degree of implementation of the CCS strategic agenda and consistency between its strategic priorities, main foci and strategic approaches with the collaborative detailed workplans for the bienniums 2012–2013, 2014–2015 and 2016–2017.

The findings and lessons learnt from these dual reviews will be used as an input into the development of the next WHO Country Cooperation Strategy for Nepal and shared with other countries and partners.

Annex 1: Key health indicators

Key mortality indicators

Indicators	2001	2006	2011	Source
Neonatal mortality rate per 1000 live births	39	33	33	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Infant mortality rate per 1000 live births	64	48	46	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Under-five mortality rate (probability of dying by the age of 5 years per 1000 live births)	91	61	54	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Maternal mortality ratio per 100 000 live births	415	281	229	2001: NDHS (2001) 2006: NDHS (2006) 2009: MMM Study

Key morbidity indicators

Indicators	2001	2006	2007	2009	2011	Source
Prevalence of tuberculosis per 100 000 population	242 (2000)	237 (2005)		241	243	Global TB Control Report 2012
Incidence of tuberculosis per 100 000 per year	163 (2000)	163 (2005)		163	163	Global TB Control Report 2012
Prevalence of HIV among adults (15 – 49 years) – percentage			0.49	0.39	0.33	2009: National Estimates HIV infection in Nepal(2010) 2011: National Estimates of HIV infection in Nepal(2012)
Malaria: Annual parasite incidence (API)	0.5	0.26	0.19	0.16	0.164	Annual report , DoHS
Number of confirmed cases of poliomyelitis	4	5	5	0	4 (2010)	WHO IPD

Health services coverage

Indicators	2001	2006	2007	2009	2011	Source
Coverage of antenatal care (percentage)	50	72			87.4 (1st visit)	2001: NDHS (2001) 2006: NDHS (2006) (2011)Annual report 2009/10
Births attended by skilled health personnel (percentage)	11	19			36	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Immunization coverage for DPT 3 among 1-year-olds (percentage)			84.1	81.6	91.4	2007:Annual report 2007/8 2009:Annual report 2009/10 2011: NDHS (2011)
Immunization coverage for measles 1-year-olds (percentage)			79	86.4	82.3	2007:Annual report 2007/8 2009:Annual report 2009/10 2011: NDHS (2011)
Children aged 6–59 months who received vitamin A supplementation (percentage)	81	87.5			90.4	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Children aged less than 5 years with acute respiratory illness symptoms taken to health facility (percentage)		43			50	2006: NDHS (2006) 2009: DHS/MoHP Annual report 2008/9 2011:NDHS (2011)
Children aged less than 5 years with diarrhoea receiving oral rehydration therapy (percentage)		29	60	53.21	39	2006: NDHS (2006) 2011: NDHS (2011) 2007: Annual report 2008/9, 2009:Annual report 2009/10
Prevalence of contraceptive use (by sex) (percentage)	35	M-42 F- 53.3			43	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)
Eligible adults and children currently receiving antiretroviral therapy (percentage)				19.03%	23.7 (2012)	2012: GAR Report Nepal 2012
Tuberculosis detection rate under DOTS (percentage)	74 (2000)	75 (2005)		73	71	Global TB Control Report 2012
Tuberculosis treatment success under DOTS (percentage)		88 (2005)		90	90 (2010)	Global TB Control Report 2012

Other major determinants of health

Indicators	2001	2006	2007	2011	Source
Literacy rate of 15–24-year-olds (percentage)	70.1 (2000)	79.4 (2005)		86.5 (2010)	MDG report 2010
Net enrolment in primary education (percentage)	81 (2000)	86.8 (2005)		93.7 (2010)	MDG report 2010
Proportion of pupils that start Grade 1 and reach Grade 5 (percentage)	63 (2000)	79.1 (2005)		77.9 (2010)	MDG report 2010
Proportion of population using an improved drinking water (percentage)	83.0 (2000)	86.0 (2005)		89.0 (2010)	WHO / UNICEF (JMP) for Water Supply and Sanitation
Percentage of children aged 0–5 years with height-for-age less than – 2 standard deviations of the WHO Child Growth Standards median	57	49		41	2001: NDHS (2001) 2006: NDHS (2006) 2011: NDHS (2011)

Notes: Indicators have been selected for their relevance to public health in the context of possible sustainable development goals. Furthermore, data are reflected as reported in different sources. For some indicators, trends cannot be generated as different sources are used for different years.

Annex 2: Consistency between CCS 2006–2011 priorities and NHSP-IP/rural water supply and sanitation sector plan 2004/NHSP-II/UNDAF

CCS 2006–011 priorities	NHSP-IP strategic objectives & outputs and Rural water supply and sanitation sector plan 2004 (RWSS)	Related NHSP – II Strategic directions and GAAP key objectives	UNDAF 2008-2012 health-related
Strengthening the health system	NHSP Output 2 Decentralized management of health facilities: Sub-output 1: Strategic plan for devolution of health service NHSP Output 3: Private sector and NGOs: Sub-output 1: Coordinating body; Sub-output2: Strategic plan NHSP Output 4: Coordinated sector management: Sub-output 1: Cross-cutting sector Management NHSP Output 5: Health Financing and resource allocation: Sub-output 5: Alternative financing and safety net arrangements; Sub-outputs 6 & 7: User fees and social and community health insurance NHSP Output 6: Physical assets, procurement, distribution and rational use of drugs: Sub-output 4: National drug policy; Sub-output 6: A responsive and effective logistics and management system NHSP Output 8: Comprehensive and integrated management information system: Sub-output 1: Strengthened HMIS and related IT	SD - Institutionalizing health sector reform SD - Health systems strengthening SD - Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure SD - Access to facilities and removal of barriers to access and use GAAP 3.1 – Ensuring adequate capacity development of institutions and human resources strengthening to effectively NHSP IP-II implementation plan GAAP 3.4 - Improving quality of health services GAAP 3.5 - Strengthening quality assurance and M&E GAAP 5.1 – Procurements at central and district level GAAP 5.2 – Timely availability of drugs, equipment and supplies	CP Output B.1.3 – Selected communities, particularly socially excluded and economically marginalized groups will have enhanced knowledge, skills and resources for improved, nutrition, home-based health-care and health seeking behaviour CP Output B.2.1 – Existing human resources in education and health facilities and community health workers and volunteers are trained to provide basic services in selected districts CP Output B.2.2 – District public health and educations offices are provided with increased skills and resources to plan, implement, supervise, monitor and ensure quality health and education interventions CP Output B.3.2 – Policy changes and restructuring to support decentralization, programme coordination and sector-wide approaches are recommended and endorsed CP Output B.3.4 – Government's management information systems are providing disaggregated data by age, sex, ethnicity, caste and economic status for evidence-based planning and monitoring and equitable resource allocation CP Output B.3.5 – Local bodies have the knowledge and skills and increased resources for participatory and inclusive planning, implementation, transparent budgeting, public financial management and effective monitoring

CCS 2006–011 priorities	NHSP-IP strategic objectives & outputs and Rural water supply and sanitation sector plan 2004 (RWSS)	Related NHSP – II Strategic directions and GAAP key objectives	UNDAF 2008-2012 health-related
Control and prevention of disease and disability	NHSP Output 1: EHCS: Sub-output 4 Vaccine preventable diseases; Sub-output 6 TB; Sub-output 7 Leprosy; Sub-output 8 HIV/AIDS; Sub-output 9: Emerging and re-emerging diseases; Sub-output 11: Vector-Borne Diseases; Sub-output13: Promoting healthy behaviour	SD- Eradication, elimination and control of selected vaccine preventable diseases SD - Disaster management and disease outbreak control	CP OutputB.2.3 – Basic package of HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable groups is included in district AIDS plans, and resources allocated and services provided in selected districts.
Human resource development	NHSP Output 7: Human resource development: Sub-output2: HR plan and systems; Sub-output 6: Training, coordination and Quality; Sub-output 7: Integrated network for appraisal and accreditation	GAAP 3.1 – Ensuring adequate capacity development of institutions and human resources strengthening to effectively NHSP IP-II implementation plan GAAP 3.2 – Ensuring adequate number and diversity of health work force as per norms set by MoHP	CP Output B.2.1 – Existing human resources in education and health facilities and community health workers and volunteers are trained to provide basic services in selected districts CP Output B.2.2 – District public health and educations offices are provided with increased skills and resources to plan, implement, supervise, monitor and ensure quality health and education interventions CP Output B.3.5 – Local bodies have the knowledge and skills and increased resources for participatory and inclusive planning, implementation, transparent budgeting, public financial management and effective monitoring.
Healthier environment	Suitable and cost-effective technological options Changes in health, hygiene and sanitation behaviour	SD – Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure	CP Output B.1.2 – Socially excluded and economically marginalized households in selected districts will have increased awareness, knowledge, skills and resources to access education, build proper sanitation facilities and practice proper hygiene and environmental sanitation.
Child, adolescent and reproductive health	NHSP Output 1: EHCS Sub-output2: Reduce maternal and newborn mortality; Sub-output 3: Infant and child mortality; Sub-output 5 Nutritional deficiencies	SD – Essential health-care services free to patients/clients and protection of families against catastrophic health-care expenditure	CP Output B.3.1 – Community-based health-care strategies and packages for children including neonates, nutrition, antenatal, delivery and postnatal care, most-at-risk adolescents and vulnerable children are developed, piloted, and expanded to selected districts.
Emergency preparedness and response	NHSP Output 1 EHCS: Sub-output: 10: Health sector capacity to mitigate health effects of disasters	SD – Disaster management and disease outbreak control GAAP 6.1 Ensuring continued access to EHCS for all people in the face of emergencies, crisis & conflict situations	CP Output C.4.1 – Planning capacities of selected Government institutions, DDC's and municipalities , enhanced to integrate disaster risk management into their development plans CP Output C.4.2 – Implementation capacities of national and local government, civil society and CBOs enhanced for disaster mitigation, preparedness, emergency response and early recovery.

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This *WHO country cooperation strategy Nepal 2013–2017* is a comprehensive strategic document in support of national health development and plans. It articulates the World Health Organization's strategy for cooperation in, and with, Nepal, covering the period 2013–2017. The strategy is based on in-depth analysis of health challenges facing Nepal and contributes to the United Nations Development Assistance Framework in the country. It represents the fruit of multisectoral consultations with key stakeholders in the Nepal health sector.

At the heart of the country cooperation strategy is its strategic agenda. This was developed by WHO in close collaboration with the Ministry of Health and Population and other partners. Six areas of work have been identified as strategic priorities for the coming six years of cooperation:

- achieving communicable diseases control targets;
- controlling and reversing the growing burden of noncommunicable diseases;
- health over the life-cycle focusing on interventions for underpriviledged and vulnerable populations;
- strengthening health systems within the revitalized primary health care approach and supporting policy dialogue on health policies, strategies and plans for universal health coverage;
- reducing the health consequences of disasters;
- addressing environmental determinants of health.

The strategic agenda for WHO cooperation is outlined in Chapter 5 of this document. It defines not only the strategic priorities, but also the main focus areas and strategic approaches for their implementation.

Nepal needs a healthy and productive population to sustain its continuing development. In implementing this country cooperation strategy and in accordance with its mandate, WHO will work closely with the Ministry of Health and Population and a range of partners and stakeholders for sustainable development of health.

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