Health Sector Strategy:

An Agenda for Reform

His Majesty's Government
Ministry of Health
Nepal

Kathmandu
October 2004

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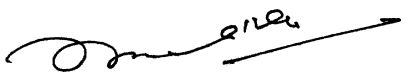
Preface

Provision of equitable access to health to attain an acceptable level of health and better quality of life by creating more equitable distribution of resources is the dominant concern of Nepal, today. In accordance with this, at the policy level efforts are underway to reform the national health system. Several analytical works were undertaken in the health sector during the last several years, for example: Operational Issues and Prioritization of Resources in the Health Sector; Public Expenditure Review; Strategic Analysis to Operationalize the Second Long Term (Twenty years) Health Plan; Medium Term Strategic Plan; Medium Term Expenditure Framework and exercise for the health component of the Tenth Five Year Development Plan: the first PRSP of Nepal. Most of these and other similar reports have concluded that the MoH should focus on and deal with those health problems which are disproportionately and maximally contributing to the highest level of mortality and burden of diseases. All these reviews and studies indicated for development of a coherent strategy on the health sector where all interested can assist to contribute to better health outcomes.

Against the above backdrop that this strategy document named as "Health Sector Strategy "An agenda for Change" is produced. During its development policy–makers, law–makers, external development partners, non–governmental organisations, academicians, private sector and other relevant stakeholders were deeply involved through series of workshops, meetings, seminars, group works, contribution of international and national consultants was availed.

So, Ministry is satisfied with the wider involvement of stakeholders in the health sector strategy development process and likes to thank all of those who have contributed to this task specially to the parliament members, NPC members and officials, officials from MoF and MoLD, MoH and DoHS, all involved from international, bilateral, multilateral and donors agencies and their representatives. Ministry also likes to acknowledge the efforts of the Core Group members and all the members of the Working Groups. We greatly appreciate the support of the International Consultants who contributed in drafting and preparing the strategy and also the hard work of the local consultants, consultanting organisations and co-ordinator for making this effort possible. We are very much thankful to District Health Strengthening Project (DHSP) for assisting in its publication

Ministry of Health approved this document in 2002 and later it was endorsed by Council of Ministers in December 2003.



Dr. Mahabir Krishna Malla
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Ministry of Health
June 2004

Abbreviations

BCC	Behaviour, Change and Communication
CDD	Control of Diarrhoeal Diseases
CG	Core Group
CPR	Contraceptive Prevalence Rate
DALYs	Disability Adjusted Live Years
DDC	District Development Committee
EDPs	External Development Partners
EHCS	Essential Health Care Service
EHSP	Essential Health Services Package
EPI	Expanded Programme for Immunisation
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
HSRC	Health Sector Reform Committee
ICMR	Indian Council of Medical Research
ICSSR	Indian Council of Social Science Research
IEC	Information, Education and Communication
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoLD	Ministry of Local Development
MTEF	Medium Term Expenditure Framework
MTEP	Medium Term Expenditure Plan
NDHS	Nepal Demographic and Health Survey
NHSP-IP	Nepal Health Sector Programme – Implementation Plan
NPC	National Planning Commission
PERC	Public Expenditure Review Commission
PPNP	Public – Private - NGO Partnership
PPT	Programme Preparation Team
SLTHP	Second Long Term Health Plan
VDC	Village Development Committee

Executive Summary

This health sector strategy is the outcome of the considerable work that has been carried out by His Majesty's Government of Nepal (HMGN), the NGO and private sectors and External Development Partners (EDPs) over the last three years. It draws on several key HMGN health sector documents including the 1991 National Health Policy and the Second Long Term Health plan 1997-2017.

There is considerable commitment by HMGN and its EDPs to poverty reduction and delivering the Millennium Development Goals (MDGs) as set out in HMGNs Poverty Reduction Strategy Paper. While this strategy is for the health sector as a whole it focuses in particular on how the health sector will make its contribution to poverty reduction and to improving health outcomes for the poor and those living in remote areas.

Nepal is one of the poorest countries in the world with an annual per capita income of approx $235 per year. Population growth is high at 2.3 percent per year. Over the next 20 years the current population of approximately 23 million people is projected to increase by about 60 percent. The number of women of reproductive age is expected to increase by 71 percent. Life expectancy is low at 59 years but there are considerable regional disparities. It is reported to be 74.4 years in the Kathmandu valley and the elderly population in urban areas is expected to rise more than threefold increasing demand for treatment of non-communicable diseases. In addition tobacco and alcohol related diseases will be a major problem. It is estimated that 60-85 percent of the population over 19 years smoke with the highest incidence in the mountain areas. More than 50 percent of the population drink alcohol.

The overall pattern of morbidity in Nepal is dominated by infectious disease, nutritional disorders, and maternal and perinatal diseases (Group l). Half of all deaths and two thirds of all DALYs are caused by them. However non-communicable diseases are beginning to increase in relative importance, though not to the same extent yet as they have in many low-income countries.

The highest risk groups are children under five, particularly females, who account for 52.5 percent of all female deaths, and women of reproductive age. Although children under 5 years old represent only 16 percent of the population, they account for over 50 percent of the total DALYs lost from all causes, and 80 percent of the under-five deaths are due to Group I causes. Women 15–44 years old experience a 26 percent higher loss of DALYs than men in the same age group. Much of this excess loss is related to problems related to pregnancy.

The issue of equity of access to the health services compounds the impact of these

diseases. Transport costs are a significant deterrent to the poor accessing health care in remote areas and the largest equity discrepancies relate to area of residence.

Health Expenditure is very low in Nepal in spite of some real increases over recent years. Currently total expenditure is about $10.50 percapita with $7.40 being private – the majority of which is out of pocket expenditure. Of the latter it is estimated that approximately 70 percent is spent on pharmaceuticals either through cost sharing at public facilities or in the private sector

The challenges faced by the health sector in Nepal are similar to those facing other low income countries – namely an under resourced public health sector and a rapidly expanding and unregulated private sector. While the government needs to focus on ensuring access by the poor and vulnerable to an essential health care service (EHCS), this will only succeed if it ensures that systems – both financial and regulatory - are in place to meet the expectations of the population who wish to access services outside the EHCS. Key issues to be addressed in the strategy include:

- How will HMGN and partners leverage better value for the out of pocket expenditure that constitutes 70-75 percent of health care expenditure?
- How will HMGN and partners ensure access by the poor and vulnerable to an EHCS?
- How will HMGN ensure that public health services are run in the most efficient manner?
- How will HMGN ensure access to services outside the EHCS?
- How will sector performance be monitored?

The emphasis of the strategy will be on outputs and health outcomes. Although the strategy could cover the fifteen-year period to the end of the long-term health plan, HMGN recognises that the outputs for the first five years have to be realistic and achievable. This means making choices and setting priorities. They will give priority to interventions that will help achieve the MDGs. HMGN have set three programme outputs and five sector management outputs which will be the core of the reform programme over the next five years. They are:

Programme Outputs:

1. The priority elements of an Essential Health Care Service – safe motherhood and family planning, child health, control of communicable disease, strengthened out patient care – will be costed, allocated the necessary resources and implemented. Clear systems will be in place to ensure that the poor and vulnerable have priority for access.
2. Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.
3. The role of the private sector and NGOs in the delivery of health services will be

recognised and developed with participative representation at all levels. Clear systems will be in place to ensure consumers get access to cost effective high quality services that offer value for money.

Sector Management Outputs:

1. There will be coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH to support decentralised service delivery with the involvement of the NGO and private sectors.
2. Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes will be in place.
3. A structure and systems will be established and resources allocated within the MoH for the effective management of physical assets and procurement and distribution of drugs, supplies and equipment.
4. Clear and effective Human Resource Development policies, planning systems and programmes will be in place.
5. A comprehensive and integrated management information system for the whole health sector will be designed and implemented at all levels.

Other activities will of course continue included in the second five years of the long term plan but the above will be the core of the sector reform programme for the first five years (2002/03 to 2006/07), the first year of Tenth Plan, 2002/03, is taken as a preparatory period.

A costed sector plan will be drawn up to deliver this strategy (by December 2002). This will cover the period of the HMGNs 10th five year plan (2002-7) and take into account its MTEF. It will identify the additional financial and technical support needed for its implementation. Negotiations will then take place with EDPs as to how that support can be made available. Work on delivering the strategy will be led by the Health Sector Reform Committee (HSRC) and its core group. They will be supported by the programme preparation team which has been set up in the Policy, Planning and International Cooperation Division in the MOH

Although the HSRC and its core group will be the key forum for ensuring involvement of key stakeholders in the delivery of the strategy it is recommended that this relationship is formalised with a memorandum of understanding setting out ways of working together including the annual planning cycle and annual reviews of progress and health outcomes.

Nepal, August 2002

Introduction

This health sector strategy is the outcome of the considerable work that has been carried out by His Majesty's Government of Nepal (HMGN), the NGO and private sectors and External Development Partners (EDPs) over the last three years. This work started with a joint review of the sector in autumn 1999 and has continued through a series of workshops and consultations led by the Health Sector Reform Committee (HSRC) chaired by the Health Minister and a core group of that committee. The strategy draws on several key HMGN health sector documents. They include: The 1991 National health policy; the second Long Term Health Plan 1997-2017; the strategic analysis to support that plan (May 2000); the medium term strategic plan to operationalise that plan approved in 2001; the draft medium term expenditure framework (MTEF) for the first three years of that plan and the policy documents for specific programme areas developed by the Department of Health Services, including the 10th plan concept paper or Health Approach paper - a Poverty Reduction Strategy Paper (PRSP) of the Government of Nepal.

There is considerable commitment by HMGN and its EDPs to poverty reduction and delivering the millennium development goals (MDGs). This is set out in HMGNs Poverty Reduction Strategy Paper and its fiscal framework, the MTEF. The health sector strategy set out in this document, while setting a strategy for the health sector as a whole, focuses in particular on how the health sector will make its contribution to poverty reduction and to improving health outcomes for the poor and those living in remote areas. Its outputs focus on the first five years of the Long Term Health plan but its strategic aims are those of the plan as a whole.

Situation Analysis

Two detailed situation analyses have recently been carried out in Nepal and are summarised briefly here. They are the Joint Health Sector Review (autumn 1999) and the World Bank Report 'Operational issues and prioritisation of resources in the health sector (June 2000)'. Nepal is one of the poorest countries in the world with an annual percapita income of approximately $235 per year. Population growth is high at 2.3 percent per year. Over the next 20 years the current population of approximately 23 million people is projected to increase by about 60 percent. The number of women of reproductive age is expected to increase by 71 percent with a resulting increase in demand for reproductive health services. Life expectancy is at 59 years but there are considerable regional disparities. It is 74.4 years in the Kathmandu valley and the elderly population in urban areas is expected to rise more than threefold increasing demand for treatment of non-communicable diseases. In addition tobacco and alcohol related diseases will be a major problem. It is estimated that 60-85 percent of the population over 19 years smoke with the highest incidence in the mountain areas and more than 50 percent of the population drink alcohol.

The population is diverse comprising of as more than 75 ethnic, caste and linguistic groups. Although officially a Hindu kingdom, Nepal has a rich religious diversity, with substantial Buddhist and a small Muslim minorities. The mountainous terrain and geographic conditions isolate the primarily rural population, many living at or below poverty level. Such conditions provide a particular challenge to providing health care. This is currently not being met. As in many countries it is difficult to persuade health staff to work in the rural and remote areas and this is reflected in staffing of HMGN health facilities. In addition most of the country's NGOs and private health providers are concentrated in the better off regions of the country.

Infectious diseases, nutritional disorders, and maternal and perinatal diseases dominate the overall pattern of morbidity in Nepal. The main causes of death and disability are infectious and parasitic diseases and perinatal and reproductive ill health. Table 1 sets out the burden of disease in terms of overall mortality and in terms of Disability Adjusted Life Years (DALYs). This shows that, while half of all deaths are caused by the Group I category of diseases, and half are caused by the remaining combination of Group II and III categories, over two thirds of all lost DALYs are caused by Group I causes. Non-communicable diseases are beginning to increase in relative importance, though not to the same extent yet as they have in many low-income countries.

TABLE 1 **Comparison of "Deaths by Cause" and DALYs Lost by Cause**

Causes of Death	Cause? Specific Deaths as % of All Deaths	DALYs Lost as % of All DALYs Lost
Group I: Infectious diseases and maternal, perinatal and nutritional problems.	49.7%	68.5%
Group II: Non-communicable and congenital problems.	42.1%	22.8%
Group III: Injuries and accidents.	6.9%	8.7%
Unclassified.	1.0%	0.0%

Source: Health Sector Strategy - Agenda For Change, 2002

The highest risk groups are children under five, particularly females, who account for 52.5 percent of all female deaths, and women of reproductive age. Although children under 5 years old represent only 16 percent of the population, they account for over 50 percent of the total DALYs lost from all causes, and 80 percent of the under-five deaths are due to Group I causes. Women 15–44 years old experience a 26 percent higher loss of DALYs than men in the same age group. Much of this excess loss is related to problems related to pregnancy.

TABLE 2 **Mortality by Area of Residence**

Area of Residence	Infant Mortality Rate	Under 5 Mortality Rate
Urban	60.4	93.6
Rural	100.2	147.0
Mountains	132.3	201.0
Hills	85.5	131.3
Terai (Plains)	104.3	147.3

Source: NDHS, 2001

The issue of equity of access to the health services compounds the impact of these diseases. In Nepal the major equity issues relate to gender, age, caste, ethnic group, income and area of residence (Table 2). Transport costs are a significant deterrent to the poor accessing health care in remote areas and the largest equity discrepancies relate to area of residence.

Health Expenditure is very low in Nepal in spite of some real increases over recent years. Total expenditure is about $10.50 percapita with $7.40 being private - the majority if which is out of pocket expenditure. HMGN expenditure is about $1.80 percapita and EDP expenditure $1.30 per capita (as of 1995/96 expenditure). However the true level may be higher as there may be significant under reporting in both HMGN and EDP expenditure. Of the out of pocket expenditure it is estimated that approximately 70 percent is spent on pharmaceuticals either through cost sharing at public facilities or in the private sector.

There are considerable concerns about access to services by the poor. Access to both public and private inpatient facilities varies considerably by income group with the wealthier having higher utilisation of both public and private facilities. In spite of a continuing commitment to primary care this has not been reflected in resource allocation in the public health sector. There has been a shift in resources to urban secondary and tertiary care facilities with a reduction in spending on primary care. MoH expenditure on secondary and tertiary hospitals increased from 14.6 percent of the health budget in 1991/92 to 37.5 percent in 1997/98. While the share of spending on primary care decreased from 76.8 percent to 57.25 percent over the same period. However the share of spending on primary care has increased in recent years.

There are a number of institutional issues, which again are well documented in the two situation analyses *(Health Sector Review – 1999 and Nepal Operational Issues and Prioritization of Resources in the Health Sector June 2000 – WB)*. They include a lack of planning and co-ordination capacity within the Ministry of Health; lack of clarity of roles and responsibilities between the MoH and the Directorate of Health Services (DoHS); weak intersectoral collaboration; resources and responsibility insufficiently decentralised for delivering health care; and lack of integration of disease based programmes. A particular issue is collaboration between HMGN and EDPs. This has improved considerably over recent years but there is still considerable work to be done to increase co-ordination of donor resources within a national strategy. In particular, not all EDP expenditure is notified to the Government.

The Health Sector and the MDGs

The Millenium Declaration set out eight Millenium Development Goals (MDGs) and eighteen targets to create an environment – at national and global levels – conducive to development and the elimination of poverty. The health sector is particularly involved in five of the targets. These are:

1 Target

Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day. Currently about 38 percent of the population live on less than $1 a day. The target is 17 percent. Poverty is most severe in rural areas. The health sector makes a major contribution to the overall goal of reducing poverty. Not only do the poor spend a significant proportion of household income on accessing health care of dubious standard but also ill health can stop individuals from working. The poor suffer disproportionately from ill health and poverty is a major cause of ill health. Poverty can reduce access to good quality health care, the poor are more likely to become ill and catastrophic illness in a health care system without a safety net can cause families to fall into poverty. The sector strategy must be to develop pro poor health policies, which will focus public health resources on primary care with special emphasis on remote areas. In addition it must set out how HMGN will work with private and NGO providers to ensure that the poor get value for money for their out of pocket expenditure on their services.

5 Target

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Child mortality has reduced over the past decade from 162/1000 live births in 1990 to 91 per 1000 in 2001. The target is 30 per thousand. Progress so far has been due to successful control of communicable diseases. Mortality is highest in rural areas and the mountain region in particular. In addition to the pro poor health policies mentioned above, key interventions will be locally sensitive nutrition and health programmes and specifically targeting those areas with high rates of malnutrition.

6 Target

Reduce by three quarters, between 1990 and 2015, the maternal mortality rate. MMR is currently high at about 539 per 100,000 live births. The target is 134. The key intervention will be to implement the national plan for safer motherhood which aims to significantly increase the number of births attended by skilled health workers, increase access to emergency obstetric care and improve maternal nutrition.

Target 7

Have halted, by 2015, and begun to reverse, the spread of HIV/AIDS. Data is scarce but the infection rate is rising. Estimated prevalence is 0.29 percent but it is much higher in at risk groups. To meet the target, there will have to be much more high-level political commitment, and a considerable scaling up of current interventions with special focus on prevention.

Target 8

Have halted, by 2015, and begun to reverse, the incidence of malaria and other major diseases. Malaria rates have declined dramatically – from 92 per 100,000 in 1992 to 37 in 2000 *(Annual Report DoHS)*. However it is still a problem and adequate control programmes will have to continue. TB is a major challenge. Though the rate has increased from 92 to 106 cases per 100,000 from 1995 to 1998 this is due to better reporting systems. Effective programmes are in place but the strategy will need to reach the 15 percent not yet covered by the DOTs programme.

Key Issues in the Health Sector

The challenges faced by the health sector in Nepal are similar to those facing other low income countries – namely an under resourced public health sector and a rapidly expanding and unregulated private sector. While the government needs to focus on ensuring access by the poor and vulnerable to an essential health care service (EHCS), this will only succeed if it ensures that systems – both financial and regulatory are in place to meet the expectations of the population who wish to access services outside the EHCS. Key issues and their strategic implications include:

How does the government and partners leverage better value for the out of pocket expenditure that constitutes 70-75 percent of health care expenditure?

Strategic implications This implies a major change of role and focus for the MoH/DoS and the decentralised services. New skills will be needed. One output would be to develop alternative financing mechanism such as social and community insurance schemes whereby out of pocket expenditure is channelled through schemes that will act as an 'informed purchaser' on the clients' behalf to get better value. Regulation of providers including the development of self-regulation schemes will also be needed. However, much of the out of pocket expenditure is on drugs in the informal sector. There is a need to improve central regulation and quality assurance of pharmaceuticals but the key task will be to scale up proven successful interventions such as consumer and provider education, pre-packaged drugs, franchising of providers, vouchers etc. Regular data on trends in out of pocket expenditure must be routinely collected through National Health Accounts.

How does the government and partners ensure access by the poor and vulnerable to an EHCS?

Strategic implications The first is to ensure that public finance is directed to the EHCS and the poor and vulnerable. This will mean reversing current trends in expenditure towards secondary and tertiary care. This will only be achieved if alternative financing schemes for these services are developed along side resource allocation policies for public finance which target the EHCS and the poor and vulnerable. If cost sharing takes place in public facilities, schemes must have workable pro poor exemption policies. Out of pocket expenditure by the poor must be channelled towards the elements of the EHCS using the interventions outlined above. Not all the elements of the EHCS can be delivered immediately. Priorities will have to be set and the elements introduced in a gradual manner as the various components of the overall strategy succeed. Regular data from benefit incidence

studies as to which socio-economic groups are accessing health care at all levels will be needed to monitor progress.

How does the government ensure that public health services are run in the most efficient manner?

Strategic implications Decentralisation of both power (financial, administrative and legal) and responsibility for service delivery to local bodies combined with a performance management system that allows the centre to set targets and monitor compliance is the key. This will involve integrating the separate disease based programmes which currently have their own financing and performance management systems. This must be done gradually to ensure that the effectiveness of these programmes - which their separate management systems give - adds to the system as a whole and is not lost. In addition the public sector must move from being a provider of services to an enabling role using public finance to contract with private and NGO providers to provide services where it is more cost effective for them to do so. Both decentralisation and contracting with other providers will involve developing new roles, responsibilities and skills for the MoH/DoHS and local bodies. An appropriate capacity building programme as well as an effective monitoring system must be in place to ensure this happens.

How does the government ensure access to services outside the EHCS?

Strategic implications In most countries pro poor health strategies are failing because not enough attention is placed on ensuring that the population as a whole and particularly those who are not poor, have access to affordable good quality health care outside the EHCS. Increasingly even relatively well off individuals will not be able to finance secondary and tertiary care from out of pocket expenditure. Private providers are ensuring that patients are aware of what modern medicine can do for them. Unless alternative strategies for ensuring access to these services are in place then government money will end up financing them rather than the EHCS. The government needs to be explicit about its role in this area. It will be one of enabler rather than financier. It will ensure that appropriate insurance schemes are developed, that individuals and households are covered and that the market including the insurance market is regulated. It is unlikely that government spending in this area will totally cease but it will be reduced significantly and will take the form of subsidies that can be targeted to the poor and vulnerable. The Government needs to develop a positive discrimination approach beyond the EHCS. The Government will be responsible for developing sound policy on how the private and NGO sector can assist MOH in establishing effective services beyond the EHCS. The private sector also needs to develop safety-net criteria for the poor and unreached populations.

How do you monitor and track sector performance?

Strategic implications Key system and program indicators need to be identified for effective monitoring and the government will have to ensure that appropriate information systems are in place both to monitor the performance of the decentralised public sector and the sector as a whole. The latter, as well as mortality and morbidity data, must include details of health expenditure through Health Resource Accounts and who is benefiting from that expenditure through Benefit Incidence studies. Both can draw on key household based studies such as the Demographic Health Survey (DHS) and Living Standard Measurement (LSM). There must be a move away from ad hoc studies to institutionalising key studies and building local capacity to carry them out.

How do you ensure that the strategy is delivered?

Strategic implications The strategy implies new roles and responsibilities for organisations and individuals in the sector. A capacity appraisal needs to identify these and set out what capacity building is necessary through restructuring and training. In addition where capacity is limited it must be strengthened using technical assistance on a temporary basis until it is in place locally. Above all the agreed outputs and time table for their implementation must be realistic and deliverable.

Key Elements of the Strategy

The emphasis of the strategy will be on outputs and health outcomes. Although the strategy covers the fifteen-year period to the end of the Long-term health plan, HMGN recognises that the outputs for the first five years have to be realistic and achievable. This means making choices and setting priorities. They will give priority to interventions which will help achieve the MDGs. HMGN have set three programme outputs and five sector management outputs which will be the core of the reform programme over the next five years. They are:

Programme Outputs:

1. The priority elements of an Essential Health Care Service – safe motherhood and family planning, child health, control of communicable disease, strengthened out patient care – will be costed, allocated the necessary resources and implemented. Clear systems will be in place to ensure that the poor and vulnerable have priority for access.

2. Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.

3. The role of the private sector and NGOs in the delivery of health services will be recognised and developed with participative representation at all levels. Clear systems are in place to ensure consumers get access to cost effective high quality services which offer value for money.

Sector Management Outputs:

1. There will be co-ordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH to support decentralised service delivery with the involvement of the NGO and private sectors.
2. Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes will be in place.
3. A structure and systems will be established and resources allocated within the MoH for the effective management of physical assets and procurement and distribution of drugs, supplies and equipment.
4. Clear and effective Human Resource Development policies, planning systems and programmes will be in place.
5. A comprehensive and integrated management information system for the whole health sector will be designed and implemented at all levels

Other activities will of course continue including planning for the second five years of the long term plan but the above will be the core of the sector reform programme for the first five years (2002/03 to 2006/07), the first year of Tenth Plan, 2002/03, is taken as preparatory period.

Programme output 1: Essential Health Care Services

In September 1999 the Cabinet approved the Essential Health Services Package (EHSP) as part of the second Long Term Health Plan. Twenty broad areas of intervention have been identified. However, the whole of the package of essential health care services is not immediately affordable. Initially, therefore, the first programme output will deliver four main areas of essential care: safe motherhood and family planning, child health, control of communicable disease, and strengthened out patient care. The first task will be to identify and cost the resources necessary to deliver the package across all districts. Prioritising these services at VDC/sub heath post level will require a major transfer of resources. The staff and skills mix at that level will need revision, regular and timely provision of drugs and equipment will be required and service protocols and quality standards will need to be established to build confidence and awareness. This will draw on the work already done in these priority areas by the DoHS. The role of the district hospital in supporting the EHCS needs to be further developed, particularly their role in providing essential obstetric care and emergency simple life saving measures. Clear policies for financing and providing care outside the priority programmes will have to be in place with exemption mechanisms for the very poor.

Fifteen districts will be targeted initially to achieve full coverage of the essential services at all levels within three years. They will be selected to ensure maximum coverage of the poor and vulnerable. Over years four and five extension across all 75 districts will be targeted. This output will be led by the Director General of DoHS. A key feature will be integrating programmes in these areas being supported by EDPs. Where appropriate, NGOs and private providers will be contracted to provide the services. Indicators of progress will include the rate of increased coverage, the MDGs, the increase in budget - both real and proportionate - given to the EHCS, community perception of services available and accessed, and direct health impact.

The delivery of the EHCS will mainly focus on personal preventive and curative services. It will, however, be supported by a national Behaviour Change and Communication (BCC) programme which will increase consumer knowledge about common illnesses and cost-effective interventions particularly in the four priority areas. This programme will also focus on raising the knowledge about key interventions of providers in the informal sector e.g. rural shopkeepers and pharmacists. Although the EHCS will not initially give priority to non-communicable diseases, it is essential that the BCC programme in the first five years includes programmes aimed at reducing tobacco and alcohol abuse. HMGN will also consider what legislative and taxation policies could be effective in this latter area.

Programme output 2: Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners

Establishing local bodies capable of managing health services and facilities moves beyond decentralisation. It implies transfer not only of budgets but also of responsibilities for planning and implementation of health service development within the districts and has implications for a new relationship between the Ministry, DDCs and VDCs. The process will be developed gradually in phases with all districts being covered by decentralisation after five years. Five districts will be selected in the first year. To promote innovation, districts could be invited to submit proposals on how they would develop the various tools and mechanisms needed to regulate the links between the different organisations involved in the decentralised health sector. These proposals would be assessed against set criteria. The process will be carefully evaluated and changed as necessary before developing nationwide. It may be better to concentrate during the first phase on districts that are relatively easily accessible and are situated close to each other. This would allow experience to be readily shared. In remote districts the NGO/private sector will be invited to submit proposals.

Responsibility will rest with a Decentralisation Group chaired by the Secretary and involving all the Regional Directors. Dialogue on the relationship and co-ordination with the Ministry of Local Development will be essential. Increased resources at regional level to support the districts and at district level to implement the new responsibilities will need to be provided. The role of the centre will change allowing staff to concentrate on policy development, planning, human and finance resource mobilisation and allocation, and performance management including quality assurance of both the public and private sector. The Regions will have a key role to play in performance management. These new roles and the capacity building necessary to develop them will be identified in a capacity appraisal exercise. Support from EDPs will be important financially and at a technical level. Existing projects supporting the strengthening of district level health systems will be brought together as a co-ordinated programme of support to the initial group of districts and subsequently to the whole programme.

Indicators of progress will be:

- Increased expenditure on health at district level
- The achievement of performance targets by health facilities
- Improvement in health outcomes at district level
- The meeting of financial and performance targets identified in district health plans and the quality of those plans
- The outcome of management audits in the decentralised districts.

Programme Output 3: The role of the private sector and NGOs in the delivery of health services is recognised and developed with participative representation at all levels.

The public sector is currently the lesser partner both in the financing and provision of health services and this will not change. The strategy is therefore based on a commitment to a mixed economy of health provision. The public health sector will develop a major new role in working with the private/NGO sector. This will fall into four separate areas. The first covers sustainable finance and is dealt with below (sector management output 3). The second will be to avoid duplication of services and develop an integrated approach to providing the priority elements of the EHCS. Where appropriate the private/ NGO sector will be contracted to provide these. This will be developed as part of the development of the EHCS as set out in Programme output 1. It will mean the public sector developing the skills needed for contracting. The third area will be assuring the quality of the services provided by the NGO/private sectors. Common standards will be developed for both public and private providers and facilities. They will be assured in the private sector through a mixture of regulation including self-regulation and the contracting process. Particular programmes will be developed for the informal sector where out of pocket expenditure will continue. Internationally this is recognised as a particular challenge with the task being to scale up lessons from successful pilot projects. This will follow the timetable for programme output 1. The fourth area will be working with the private sector on the supply side both in pharmaceuticals and other consumables and new technology. This will involve drawing up agreements on quality assurance, availability and cost. This work will take place in the first five years. The key in all four areas will be to work collaboratively rather than relying on regulation and control.

All levels and areas of the Ministry will be involved in delivering this output and it should be seen as an essential part of the role of all managers, integrated into all planning and implementation. However, there will have to be individuals with specific responsibility particularly at MoH and DoHS levels. It is an area where international experience can be usefully drawn upon. EDPs, NGOs, INGOs and the private sector can provide support and will all be involved from the outset.

Sector Management Output 1: There will be co-ordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH to support decentralised service delivery and the involvement of the NGO and private sectors.

The remaining five priority outputs all relate to the management of the sector. This increased emphasis on sector management is an acknowledgement of the support needed to make sure the programme outputs are delivered. There will be new roles and responsibilities at all levels. The ability of the centre to lead the process of reform and respond to the challenges of managing differently will be critical. A capacity appraisal of the sector to identify the new roles and the structures, skills

and the capacity building to deliver them will be carried out at an early stage. Whilst the Policy, Planning and International Co-operation Division has recently been restructured, it should still be included. In particular the inclusion of health financing policy and planning capacity amongst its functions should be considered. This would allow policy, planning, programming, budgeting and financing for the sector to be co-ordinated effectively. The strengthening of the division should also be considered. This Division is seen as the appropriate location for the essential support to the Minster and Secretary in leading the development and reform of the sector. The capacity to provide that support and leadership will be essential to ensuring that the sector strategy is implemented.

Sector Management Output 2: Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes will be in place

Delivering improved health care that is poverty focused requires the mobilisation of increased resources and the efficient and transparent allocation and expenditure procedures. Understanding the macro economic context of health financing requires access to intelligent information and research. A health economics group will be established to fulfil this function located within the strengthened Policy, Planning, and International Co-operation Division. National health accounts will be produced on a regular basis. These will include regular household surveys to track out of pocket expenditure and all EDP expenditure. They will be supplemented by benefit incidence studies to track who is benefiting from health expenditure. A resource allocation formula will be developed to support the implementation of programme outputs 1 and 2. This should be agreed by year two. The Central Bureau of Statistics could also be used to provide relevant information.

Policy development on health sector finance will have to involve other government departments as well as politicians and civil society. A mechanism will be developed to ensure this involvement takes place. One option to be considered will be a local macroeconomic commission for health.

A programme of work will start in year 1 to produce proposals for alternative financing schemes including social insurance, employment based insurance and community insurance. They will draw on existing experience both locally and regionally. Alternative financing schemes will be in place by year five. In addition a regulatory framework for the private health insurance sector will be agreed and implemented by year five.

Sector Management Output 3: Structure and systems will be established and resourced within MoH for the effective management of physical assets and procurement and distribution of drugs, supplies and equipment.

The Health Care Technology Policy developed by MoH will be finalised and approved by the cabinet. A programme for establishing the necessary structure and systems

will be identified as part of the capacity appraisal. It will be implemented at an early stage and will link with programme outputs 1 and 2 both of which will require the timely and effective provision of drugs, supplies and equipment. Structures and systems need to be established and resourced within MoH for the delivery of its responsibilities but in line with the programme output related to the role of the private sector and NGOs, out sourcing /contracting could play a complementary role in both areas.

Sector Management Output 4: Clear and effective Human Resource Development policies and systems and programmes will be in place.

The immediate task will be to support decentralisation and the delivery of the EHCS package both of which have substantial human resource implications. Transferring employment responsibilities and increasing the accountability of staff at lower levels will need careful preparation and monitoring. The capacity appraisal will ensure that the lead responsibility for human resource development is clear within the present structure and that capacity for developing HRD policy, planning and programming are in place. Policies on skill mix, training and capacity building, rewards and retention as well as ensuring that all areas of the country are served will be developed. Again the private /NGO sector will be involved in training and capacity building. MoH will play an effective role in co-ordinating with academic institutions to ensure that the required volume and quality of human resources are produced and trained.

Sector Management Output 5: A comprehensive and integrated management information system for the whole health sector is designed and implemented at all levels

Setting clear targets and putting in place a performance management system to help ensure they are met is seen as the key to deliver the strategy. A comprehensive and integrated management information system for the health sector (HMIS) will be developed in a phased manner over the first five years. This will include financial, personnel, logistics, facilities, maintenance, performance, and impact data and will be able to be accessed at all levels. This will be a major task. Again the process will start with redefining service indicators and mapping the information needs required to deliver the priority programme. At all stages the key principle will be to ensure that managers at all levels can have accurate information to make decision available to them in a timely manner. The adoption of the Human Resource Development Information System (HuRDIS) in the MoH/DoHS can be part of this process and the information generated by it will be useful for decision-making.

Other Activities

Delivering the above eight outputs will be the main focus of the sector over the next five years. However it is unrealistic to think that other activities will not take place and other priorities not brought to the attention of HMGN. They must be placed within the context of the strategy. Where possible they should be considered within the context of remainder of the period of the long-term plan i.e. from 2007 onwards. In this latter period it is envisaged that there will be complete coverage of the key elements of the EHCS and inclusion of additional elements of the EHCS. This will include non-communicable diseases. Meeting the MDGs requires the support of other sectors and the MOH will ensure that appropriate intersectoral co-ordination takes place. It will be particularly important to ensure that programmes to improve coverage of access to clean water, improve environmental sanitation and support income generation initiatives at the local level by mothers' groups continue to take place and that school health programmes with appropriate health education programmes take place in schools.

Implementing the Strategy

A costed sector plan will be drawn up to deliver this strategy by December 2002. This will cover the period of the HMGNs 10th five year plan (2002-7) and take into account its MTEF. It will identify the additional financial and technical support needed for its implementation. Negotiations can then take place with EDPs as to how that support can be made available. Work on this will be led by the Health Sector Reform Committee (HSRC) and its core group. They will be supported by the programme preparation team which has been set up in the Policy, Planning and International Co-operation Division in the MOH. Some further work will be needed to support the development of the sector plan. A work programme has been prepared for this and EDPs have been approached to support it. This will include starting work on delivering key elements of the strategy such as the health resource accounts and the sector programme preparation.

It is expected that the HSRC and its core group will be the key forum for ensuring involvement of key stakeholders in the delivery of the strategy. It is, therefore, recommended that this relationship be formalised with a memorandum of understanding setting out ways of working together including annual reviews of progress.

Annex 1:
Key References in date order

These are the significant documents that reflect the progress towards health sector reform and the development of a health sector strategy since 1997. More detailed bibliographies are contained in the 'Second Long Term Health Plan' and 'Nepal: Operational Issues and Prioritisation of Resources in the Health Sector'.

1 ***Second Long Term Health Plan 1997 – 2017***
HMGN Ministry of Health (1999) Kathmandu

2 ***Strategic Analysis to Operationalise Second Long Term Health Plan,* (1999)**
HMGN Ministry of Health, Kathmandu, October 1999

3 ***Health Systems Review in Nepal, Draft Report 1999***
Ken Grant and Mark Pearson, Institute for Health Sector Development (1999) London, June 1999

4 ***Nepal Public Expenditure Review Volume I, PER Overview –The Main Report***
World Bank, HNPU South Asia Region, April 2000

5 ***Operational Issues and Prioritization of Resources in the Health Sector***
(2000) Nepal, World Bank, Washington, June 2000

6 ***Tenth Five Year Plan (Draft) 2002 – 2007***
HMGN Ministry of Health (2001) Kathmandu, 2001

7 ***Medium Term Strategic Plan based on Strategic Analysis to Operationalise SLTHP***
HMGN Ministry of Health/Department of Health Services (2001), Kathmandu, February 2001

8 ***Annual Report 2057/58 (2000/01)***
HMGN Ministry of Health/Department of Health Services (2000/01) Kathmandu, 2001

9 ***Health Information Bulletin 2001***
HMGN Ministry of Health, Kathmandu, 2001

10 ***Nepal Demographic Health Survey 2001***
HMGN Ministry of Health, Family Health Division, Kathmandu, 2001

11 **Medium Term Expenditure Program (MTEP)** ***Operationalise 1st Three Years of 10th Five years Plan's Health Programmes***
HMGN Ministry of Health, Kathmandu, January 2002

12 ***Health Sector Reform Towards a Sector Strategy – Synthesis Report 2002***
HMGN Ministry of Health, Kathmandu May 2002

13 ***Nepal Health Sector Strategy Development: Consolidated Report 2002***
HMGN Ministry of Health, Kathmandu May 2002

14 ***Elements of Essential Health Care Services by Main Interventions or Program Components***
HMGN Ministry of Health, Kathmandu May 2000

Annex 2:
List of contributers:

Dr. B. D. Chataut	MoH, Chair, working group on EHCS Delivery and all other group members
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Dr. Angelika Schrettenbrunner	GTZ, Co-chair, HRD and QA
Dr. Yashobardhan Pradhan	DoHS, Chair, Logistic Management sub-working group
Mr. T. M. Sharma	Finance Controller, MoH, Chair, Health Financing sub-working group
Mr. Ramesh Neupane	Chair IEC/BCC Sub-working group
Dr. Hernando Agudelo	UNFPA, Co-chair, IEC/HMIS sub-working group
Mr. Sundar Man Shrestha	Under Secretary, Ministry of Finance
Ms. Padma Mathema	Under Secretary, National Planning Commission
Mr. Mahesh Raj Sharma	Under Secretary, Ministry of Local Development
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Dr. B R Pandey	Chairman, NHEA
Dr. Bharat Pradhan	President, PHECT Nepal
Mr. Pradeep Vaidhya	General Secretary, APPON
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Mr. Narendra Bahadur Bam	Hon. Member, House of Representative
Mr. Ganga Prasad Nepal	Hon. Member, House of Representative
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Mr. Kapil Ghimire	workshop facilitator
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Dr. Charles Collins	International Consultant
Dr. Ken grant	International Consultant
Dr. Enamul Karim	International Consultant
Mr. Krishna P. Bista	National Co-ordinator

All News and media representatives (during the workshops)

Annex 3:
Cabinet Approval of HSR Document (in Nepali)

प्रस्ताव नं. : १९

श्री ५ को सरकार
स्वास्थ्य मन्त्रालय

विषय : स्वास्थ्य क्षेत्र सुधार रणनीतिलाई कार्यान्वयनमा ल्याउने ।

विभागीय मन्त्रीको स्वीकृति मितिः २०६०।९।४

१. **विषयको संक्षिप्त बेहोराः**

दोश्रो दीर्घकालीन स्वास्थ्य योजना, (सन् १९९७-२०१७), सहस्राब्दि विकास लक्ष्य, चालु दशौं योजना र मध्यकालीन खर्च संरचनाले अवलम्बन गरेका अवधारणा, नीति, उद्देश्य अनुरुप स्वास्थ्य क्षेत्रमा आवश्यक सुधार ल्याई स्वास्थ्य सेवा प्रदान गर्ने कार्यक्रमहरुलाई प्रभावकारी रुपमा संचालन गर्न मा. स्वास्थ्य मन्त्रीज्यूको अध्यक्षतामा गठित स्वास्थ्य क्षेत्र सुधार समितिले श्री ५ को सरकार, दातृ संस्था र निजी क्षेत्रको सहभागितामा तयार गरेको यसैसाथ संलग्न स्वास्थ्य क्षेत्र सुधार रणनीतिलाई स्वीकृत गरी कार्यान्वयनमा ल्याउनुपरेको छ ।

नेपालमा स्वास्थ्य सम्बन्धी योजनाबद्ध विकासको थालनी सन् १९५० को दशकदेखि भएको हो । त्यस बेलासम्म नेपालमा स्वास्थ्य सेवा प्रदान गर्नका लागि एक दुई वटा अस्पताल र तराई क्षेत्रमा ५/७ वटा डिस्पेन्सरी मात्र थिए । स्वास्थ्य सेवा दिने न कुनै स्तरीय जनशक्ति थियो, न त्यस्तो जनशक्ति उत्पादन गर्ने निकायहरु नै थिए । त्यस्तो अवस्थाबाट माथि उठी अहिले ठूलो संख्यामा उपस्वास्थ्य चौकी, स्वास्थ्य चौकी, प्राथमिक स्वास्थ्य केन्द्रहरुको स्थापना हुनु, ६९ जिल्लामा जिल्ला अस्पताल स्थापना हुनु, अञ्चल र केन्द्रीय स्तरका अस्पतालहरु स्थापना भइसक्नु, स्वास्थ्य सम्बन्धी उच्च र मध्यम स्तरीय जनशक्ति उपलब्ध हुनु र त्यस्तो जनशक्ति तयार गर्ने निकायहरु नेपालभित्रै विकास भईसक्नु, स्वास्थ्य सेवा दिन निजी र गैह्रसरकारी क्षेत्रको अग्रसरता देखिनु, स्वास्थ्य सेवाका लागि दातृ संस्थाहरुको सहयोग जुट्न सक्नुलाई एउटा महत्वपूर्ण उपलब्धिको रुपमा लिनु पर्दछ । यो स्थितिसम्म आइपुग्नमा पञ्चबर्षीय योजनाहरु मार्फत निर्दिष्ट नीति र रणनीतिको कार्यान्वयनका साथै २०३३ देखि २०४७ सम्मका लागि तयार पारिएको पन्ध्र वर्षे प्रथम स्वास्थ्य सम्बन्धी दीर्घकालीन योजनाको योगदान उल्लेखनीय रहेको छ ।

तथापि, स्वास्थ्य सम्बन्धी शिशु मृत्यु दर, मातृ मृत्यु दर, औसत आयु, प्रजनन दर, जनसंख्या वृद्धिदर आदि जस्ता समस्त सूचकाङ्कहरु हेर्दा स्वास्थ्य स्थितिमा वाञ्छनीय सुधार ल्याउन स्वास्थ्य कार्यक्रमहरुलाई अरु योजनाबद्ध रुपले कार्यान्वयन गर्नु पर्ने महसूस गरी सन् १९९७ देखि २०१७ सम्मका लागि २० वर्षे दोश्रो दीर्घकालीन योजना तर्जुमा गरी १९९९ मा श्री ५ को सरकार मं.प. बाट स्वीकृत गरिएको छ । श्री ५ को सरकारका सम्बन्धित निकायहरु, दातृ संस्थाहरु र अन्य सरोकारवाला (stakeholder) को सहभागिताबाट तयार पारिएको उक्त दीर्घकालीन योजनामा खोप, प्रजनन स्वास्थ्य, वाल स्वास्थ्य, पोषण, क्षयरोग नियन्त्रण, कुष्ठरोग नियन्त्रण जस्ता २० वटा कार्यक्रमहरु अत्यावश्यक स्वास्थ्य सेवा (Essential Health Care Services-EHCS) को रुपमा संचालन गर्न इंगित गरिएको छ । तर स्वास्थ्यका लागि वर्तमान परिप्रेक्ष्यमा प्राप्त हुँदै आएको र हुन सक्ने श्रोतलाई हेरी ती बीसवटै कार्यक्रमहरुलाई नै प्राथमिकता दिई संचालन गर्न नसकिने महसूस गरी दशौं पञ्चबर्षीय योजना अवधिभरका लागि कार्यान्वयन गर्ने गरी प्राथमिकता दिनु पर्ने कार्यक्रमहरुको छनौट गरी कार्यान्वयन गर्न रणनीतिको तर्जुमा गरिएको छ । छनौटमा परेका कार्यक्रमहरुमा सुरक्षित मातृत्व

तथा परिवार नियोजन, बाल स्वास्थ्य, संक्रामक रोग नियन्त्रण र स्वास्थ्य संस्थाहरुवाट दिइने वहिरंग सेवा (Out patient services) रहेका छन् । मूलतः यसैलाई आधार मानी तयार पारिएको रणनीति संलग्न छ र प्रकृयागत रुपमा मा. स्वास्थ्य मन्त्रीज्यूको अध्यक्षतामा गठित स्वास्थ्य क्षेत्र सुधार समिति (Health Sector Reform Committee) वाट समय समयमा प्राप्त निर्देशनानुसार दातृ संस्थाहरु समेत रहेको मुख्य कार्यदल (Core Group) ले दशौं पंचवर्षीय योजना र मध्यमकालीन खर्च संरचना (Medium Term Expenditure Framework) मा रहेका स्वास्थ्य क्षेत्र सम्वन्धी अवधारणा एवं सहस्राव्दि विकास लक्ष्य (Millennium Development Goal-MDG) संग तादात्म्य राख्दै रणनीतिको तर्जुमा गरिएको छ । साथै, युगाण्डा, मलावी, हैटी आदि मुलुकमा गरिएको स्वास्थ्य क्षेत्र सुधार अन्तर्गत प्राप्त सफल अनुभवलाई पनि मध्यनजर राखी रणनीतिमा समायोजित गर्ने प्रयास गरिएको छ ।

क. यस रणनीतिको मुख्य विशेषता निम्नानुसार रहेको छ :-

१. स्वास्थ्य क्षेत्रका कार्यक्रमहरुको प्राथमिकता निर्धारण गरी गरीवी मूलक कार्यक्रम कार्यान्वयन गर्ने ।
२. यसको कार्यान्वयनको लागि सबै संलग्न सरोकारवालाहरुको सहभागिता सुनिश्चित गरी आवश्यक सहयोग, आर्थिक सहयोग संकलन तथा परिचालन गर्ने । यसका लागि दातृ संस्था र स्वास्थ्य मन्त्रालय बीच समझदारी पत्र (Memorandum of Understanding) मा हस्ताक्षर गर्ने ।
३. वार्षिक रुपमा सोच तालिका (Logical Fremework) अनुरुप कार्यक्रम कार्यान्वयनको अनुगमन गर्ने ।

ख. मुख्य मुख्य कार्यहरु :-

१. प्रस्तावित रणनीतिको आधारमा श्री ५ को सरकार तथा सबै सरोकारवाला स्वदेशी तथा विदेशी दातृ संस्थाहरु वीच हुने सहमतिको दस्तावेज (Memorundum of Understanding) अनुरुप कार्य गर्ने ।
२. नेपाल स्वास्थ्य कार्यक्रम कार्ययोजना (Nepal Health Sector Programme - Implementation Plan NHSP-IP) कार्यान्वयन गर्ने ।
३. संयुक्त रुपमा तयार गरिएको सोच तालिका (Logical Framework) अनुसार अनुगमन गर्ने प्रकृया बसाल्ने
४. क्रमिक रुपमा सम्पूर्ण कार्यक्रमहरुलाई राष्ट्रिय स्वास्थ्य कार्यक्रमको गुरु योजना (Master Plan) को खाका भित्र ल्याउने ।

ग. राष्ट्रिय स्वास्थ्य कार्यक्रमको प्रतिफलहरू (Programme Outputs) :-

१. ५ वर्ष मुनिका वाल वालिकाको मृत्यूदर सन् २००१ मा भएको ९१ प्रतिहजार जीवित जन्म (live birth) लाई घटाई ३० प्रतिहजार जीवित जन्ममा घटाउने लक्ष्य निर्धारण गरिएको छ ।
२. सन् १९९६ को डेमोग्राफिक हेल्थ सर्भे अनुसार मातृ मृत्यूदर प्रति एक लाखमा ५३९ रहेकोमा सहस्राव्दिको लक्ष्य अनुसार सन् २०१५ सम्ममा प्रति एक लाख १३४ मा झार्न सुरक्षित मातृत्व कार्यक्रमलाई प्रभावकारी रुपले संचालन गरिनेछ ।
३. हाल १५ देखि ४९ वर्षका व्यक्तिहरुमा HIV/AIDS को Prevalence Rate ०.५ प्रतिशत अनुमान गरिएको छ । यसरी वढदै गएको HIV/AIDS को Trend सन् २०१५ सम्ममा वढने क्रम रोकी विस्तारै घटने क्रममा लगिने छ ।
४. स्वास्थ्य सेवा विभागको सन् २००० को वार्षिक प्रतिवेदन अनुसार औलोको प्रभावित दर ३७ प्रति १,००,००० रहेकोमा यसको वढने क्रमलाई सन् २०१५ सम्ममा रोकी क्रमशः घटने क्रममा लगिनेछ । साथै क्षय रोगको उपचारको लागि हाल प्रत्यक्ष निगरानीमा दिइने उपचार सेवा पुग्न नसकेका बाँकी १५% जनसमुदायलाई सेवा पुऱ्याइने छ ।
५. संयुक्त राष्ट्र संघद्धारा प्रतिदिन यु.एस डलर १ भन्दा कम आय हुने गरीवको संख्या आधा घटाउने सहस्राव्दिको लक्ष्य निर्धारण गरिएको छ । तदनुरुप नेपालले पनि यो संख्या हालको ३८% वाट १७% मा झार्न स्वास्थ्य क्षेत्रबाट सहयोग पुऱ्याउने लक्ष्य रहेको छ ।

घ. क्षेत्रगत व्यवस्थापनका प्रतिफलहरू (Sector Management Output) :-

१. विकेन्द्रीकरणको सिद्धान्त वमोजिम प्राथमिक स्वास्थ्य सेवालाई स्थानीय तहमा क्रमशः निक्षेपण गर्दै लगिने छ । स्वास्थ्य सेवाका कर्मचारीहरुलाई स्थानीय निकाय प्रति उत्तरदायी वनाइनुको साथै योजना तर्जुमा, अनुगमन तथा मूल्यांकन, वित्तीय व्यवस्थापन तथा अन्य स्थानीयस्तरका निर्णय प्रक्रियामा गैरसरकारी संस्था र निजी क्षेत्र तथा स्थानीय समुदायको सहभागिता अभिवृद्धि गरिनेछ ।

२. समस्त स्वास्थ्य क्षेत्रमा स्वास्थ्य लगानी, स्रोत निर्धारण तथा सामुदायिक स्वास्थ्य बीमा कार्यक्रम जस्ता न्यायोचित वैकल्पिक लगानीको दिगो विकासका लागि उपयुक्त व्यवस्था गरिनेछ ।

३. स्वास्थ्य मन्त्रालय अन्तर्गत भौतिक सम्पत्ति/साधन, औषधि, उपकरण र अन्य स्वास्थ्य सामग्रीको खरीद, वितरण र आपूर्तिका लागि प्रभावकारी प्रणालीको स्थापना गरी आवश्यक श्रोत विनियोजित गरिनेछ ।

४. स्वास्थ्य क्षेत्रमा दक्ष जनशक्तिको विकास सम्बन्धि नीतिहरू, योजना व्यवस्थापन तथा कार्यक्रमहरूको व्यवस्था स्पष्ट एवं पार दर्शी रुपले संचालन गर्ने संयन्त्रको विकास गरिनेछ ।

५. विस्तृत तथा एकीकृत व्यवस्थापन सूचना प्रणालीको ढाँचा (Design) तयार गरी प्रत्येक तहमा प्रभावकारी रुपले कार्यान्वयन गरिनेछ ।

यी पाँच वटा प्रतिफलहरुलाई दर्शौं योजनाको मुख्य कार्यक्रमको रुपमा लिइएको छ र आधारभूत स्वास्थ्य कार्यक्रम बाहेक अन्य प्राथमिकता प्राप्त कार्यक्रम र स्वास्थ्य सेवाका अन्य सम्पूर्ण कार्यक्रमहरु यथावत् रुपमा संचालन गरिने छन् ।

हाल यो रणनीति कार्यान्वयनको निम्ति नेपाल स्वास्थ्य क्षेत्रको कार्यक्रम कार्य योजना (NHSP-IP) को तर्जुमा गरिएको छ । यसमा कार्यक्रम कार्यान्वयन गर्न वित्तीय र प्राविधिक सहायता पहिचान गरिएको छ । यसबाट स्वास्थ्य क्षेत्रका सम्पूर्ण सरोकारवालाहरु (Stakeholders) को सहभागितामा प्रस्तावित कार्ययोजना अनुसार समझदारी पत्रमा हस्ताक्षर गरी वैधानिकता दिइने छ र सोही अनुसार वार्षिक रुपमा प्रगतिको अनुगमन गरिनेछ ।

२. प्रस्ताव पेश गर्नुपरेको कारण :
प्रकरण १ मा उल्लेख भए बमोजिम यसैसाथ संलग्न रणनीतिलाई स्वीकृत गरी कार्यान्वयनमा ल्याउनुपर्ने भएको छ ।

३. प्राप्त परामर्श र अन्य प्रासंगिक कुरा :
श्री ५ को सरकार, स्वास्थ्य मन्त्रालयले गठन गरेको स्वास्थ्य क्षेत्र सुधार समितिले दातृ संस्था, निजी क्षेत्र तथा अर्थ मन्त्रालय र र ाष्ट्रिय योजना आयोग समेतको राय परामर्शमा स्वास्थ्य क्षेत्र सुधार रणनीति तयार गरेको हो ।

४. मन्त्रालयको सिफारिश :
प्रकरण १ मा उल्लेख भए बमोजिम यसैसाथ संलग्न स्वास्थ्य क्षेत्र सुधार रणनीतिलाई कार्यान्वयनमा ल्याउन स्वीकृतिको लागि मं.प. मा प्रस्ताव पेश गर्न मा. मन्त्रीज्यूबाट अनुमति प्राप्त भएकोले श्री ५ को सरकार (कार्य सम्पादन) नियमावली, २०४७ को अनुसूची १(क) बमोजिम यो प्रस्ताव पेश गरेको छु ।

५. निर्णय हुनुपर्ने बेहोरा :
स्वास्थ्य क्षेत्र सुधार रणनीतिलाई स्वीकृत गर्ने ।

मिति : २०६०।९।७

(बिजयराज भट्टराई)
सचिव

श्री सचिव,
स्वास्थ्य मन्त्रालय

स्वास्थ्य क्षेत्र सुधार रणनीतिलाई कार्यान्वयनमा ल्याउने विषयको स्वास्थ्य मन्त्रालयको नं. २३ क १/६२-०६०/९/८ को प्रस्ताव मं.प.बैं.सं. ६५/०६० मिति २०६०/९/१० को मन्त्रिपरिषद्को बैठकमा पेश हुँदा श्री ५ को सरकारले (कार्य सम्पादन) नियामावली, २०४७ को नियम २६ (अनुसूची १ खण्ड क) अनुसार यसमा श्री ५ को सरकारले देहायमा लेखिएबमोजिम गर्ने निर्णय गरेकोले सो बमोजिम कार्यान्वयन हुन अनुरोध गरेको छु -

श्री ५ को सरकारको निर्णयः-
"प्रस्तावमा लेखिएबमोजिम गर्ने"

(विमल प्रसाद कोइराला)
मुख्य सचिव

मिति : २०६०/९/१०