Annual Health Report

Fiscal Year 2080/81

Lumbini Province Government
Ministry of Health
Health Directorate

Health Office, Dang

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Lumbini Province Government
Ministry of Health
Rapti Valley, Deukhuri Dang, Nepal
Hon. Khem Bahadur Saru
Minister

MESSAGE FROM THE MINISTER

I am jubilant to learn that the Health Office Dang is releasing its annual report for the fiscal year 2080/81. This report offers a comprehensive overview of the district's healthcare performance, showcasing progress and challenges across all components of the healthcare delivery system. In collaboration with local government, it serves as a vital resource for assessing the impact of health initiatives and will guide future efforts to enhance healthcare services in Dang.

The health ministry is dedicated to delivering high-quality healthcare services to everyone within the province. The ministry is resolute in attaining universal health coverage (UHC) in collaboration with all stakeholders, including the public, private, and non-governmental sectors.

Several outstanding achievements have been made in health sector in past decades now. Nepal's average life expectancy has improved steadily, reaching 71.74 years, Maternal Mortality Rate (MMR) is 151 per 100,000 live births. Infant Mortality Rate (IMR) 25 per 1,000 live births. Nepal has reduced childhood stunting from 57% in 2001 to around 36% in 2023. The percentage of institutional deliveries has increased from 9% to around 57% now.

However, there remain challenges that we must continue to address. Limited infrastructure, human resource shortages, out of pocket expenditure are persistent barriers to healthcare access in this region. We are committed to overcome these obstacles by investing in infrastructure development, training more healthcare professionals, and expanding health services to the most underserved populations.

Let us move ahead with renewed determination in the coming years, recognizing that the physical, mental, and social well-being of our citizens is central to our nation's progress.

(Khem Bahadur Saru)
Minister

Lumbini Province Government

Ministry of Health

Ref.No:

Message

It is a matter of great pleasure for me to have Annual Health Report of Dang District. It is a comprehensive report covering all the activities and achievements of the district and the local levels within the district. This kind of report not only presents the past performance but also supports for a robust and evidence-based planning. I believe that the information provided in this report will be of an immense use to planners, researchers, managers, service providers and relevant stakeholders.

This comprehensive report covers all the major health sector activities of district and below including the contribution from non-governmental sectors. I am confident that a competent and efficient health care delivery system is in place and all the relevant data from the community to district level are included in this report.

I also would like to point out that while celebrating the success, we should be aware that sustained efforts are needed to accelerate the effort we have made. Still there are many areas to improve and shape up the health sector achievements in the federal context. It is strongly felt that additional efforts are required to maintain the quality in health service delivery thereby ensuring equity and equality in opportunities

Finally, I highly appreciate the Health Office of Dang for the hard work accompanied by dedication to ensure the quality of health care services. I acknowledge to all Health Service Workforces including Female Community Health Volunteers (FCHVs) and external health partners for achieving these outcomes. They deserve wholehearted thanks for improving health status of the citizens of the entire province.

Dr. Vasudev Upadhyay
Secretary
Ministry of Health

Government of Province
Lumbini Province
Ministry of Health

Health Directorate

Bhalubang, Dang

Ref No: Date:2081/06/07

Message from Director of Health Directorate

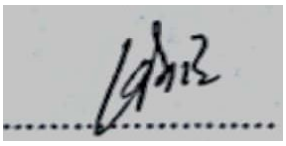
It gives me great pleasure to know that the Health Office, Dang is going to publish a comprehensive Annual Report of FY 2080/81 after conducting an annual performance review workshop at the district level.

This kind of report doesn't only present the past performance but also supports robust and evidence-based planning exercise. I believe that the information provided in this report will be of immense help to planners, policymakers, decision-makers, researchers, managers, health service providers and relevant students as well.

This report is very comprehensive, covering all the major activities conducted by health Facilities within the district in three fiscal years. It also values the contributions from external development partners, non-governmental organizations and private sectors. The data, statistics and analysis presented in this report provide us with a clear picture of the status of our health system in the Dang district.

This report has indicated progress in many areas during the last fiscal year, but additional efforts are needed to maintain the quality of the health service delivery system. I sincerely appreciate the hard work done by the Health Office, Dang and its teams to produce this comprehensive annual health report.

Finally, I hope that this report will help to strengthen the health services in Dang district. I take this opportunity to extend my thanks to our partners, national and international non-governmental organizations, multilateral and bilateral development partners and all the supporting hands for their valuable service rendered in preparing and publishing this report.



Dr. Binod Kumar Giri

Director

Lumbini Province
Health Ministry
Health Directorate
Health Office, Dang

Ref.No:

Acknowledgement

It is a great pleasure for me to present this year's annual report, highlighting our collective achievements, progress and challenges in improving the health and well-being of our citizens. This report reflects annual performance of all components of health care delivery system along with the reviews conducted at the district level as well as the local levels of health service delivery. It summarizes the dedication, hard work, and resilience of our health workers, government partners, program managers, external development partners, private sector, female community health volunteers and the community at large. The data presented here in this report is mainly based on the information reported each month by the health institutions to the Health Management Information System (HMIS/DHIS2) and the other reliable government sources.

This report is a compilation of the background information about health programs, all the major health activities, their results, innovations, the best practices and lessons learnt including the opportunities for improving the delivery of health service at the district and local levels. It encompasses the information that highlights the trend, the patterns in service-coverage and the continuum of care. Furthermore, this report also guides the monitoring and the evaluation task of the programs and activities routinely throughout the running fiscal year. We have also made a concerted effort to ensure that this report meets an expected standard and allows it to serve as a valuable reference for health researchers and academicians.

I extend my sincere gratitude to the Honorable Minister Mr. Khem Bahadur Saru, Ministry of Health, Lumbini Province, for his inspiring leadership and guidance. I would also like to express my gratitude to Dr. Vasudev Upadhyay, the Secretary of Ministry of health, for his invaluable leadership and support in strengthening the healthcare delivery system across the province. Special thanks to Dr. Binod Giri, Director, Health Directorate, for his instrumental leadership in providing necessary direction to support health care management in this province. I extend my heartfelt thanks to all the health workers, program managers, the policy makers, and all the esteemed personalities of Lumbini Province, for their guidance and contribution in preparing and publishing of this report. I am also grateful to our health workers of all the municipalities and health facilities of the district who have been working sincerely throughout the year to provide quality health services. My appreciation also goes to Female Community Health Volunteers for their efforts in promoting health activities and raising public awareness in community levels. Furthermore, I take this opportunity to thank various external development partners, non-government organizations, and the private sector for their valuable contributions in advancing the health sector performance of Dang district.

Finally, I would like to extend my gratitude to all my colleagues involved in preparing this report, the statistical section, the program focal persons, and the entire Health Office family.

Thanks to all for their continued support, dedication, and collaboration.

Mr. Kishor Kumar Acharya
Act. Chief
Health Office, Dang

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Abbreviations and Acronyms

Abbreviations	Full Forms
AHR	Annual Health Report
AIDS	Acquired Immuno Deficiency Syndrom
ALOS	Average Length of Hospital Stay
AMR	Antimicrobial Resistance
ASRH	Adolescent Sexual and Reproductive Health
AWPB	Annual Work Planning and Budgeting
BCC	Behavioural Change Communication
BEmONC	Basic Emergency Obstetric and Newborn care
BHS	Basic Health Services
BHSCs	Basic Health Service Centers
CAPP	Consolidation of Annual Procurement Plan
CBIMNCI	Community Based Integrated Management of Newborn and Childhood Illness
CEmONC	Comprehensive Emergency Obstetric and Newborn care
CNSI	Comprehensive Nutrition Specific Interventions
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
DOHS	Department of Health Services
DRTB eGP	Drug-resistant TuberculosisElectronic Government Procurement
EHCS	Essential Health Care Services
eLMIS	Electronic Logistic Management Information System
EmOC	Emergency Obstetric Care
EWARS	Early Warning and Reporting System
FCHVs	Female Community Health Volunteers
FP	Family Planning
FY	Fiscal Year
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HCWM	Health Care Waste Management
HIV	Human Immunodeficiency Virus
HDPs	Health Development Partners
HMIS	Health Management Information System
HRH	Human Resources in Health
ICD I/NGOs	International Classification of DiseasesInternational/ Non-Governmental Organizations
IEC	Information, Education and Communication

IFA	Iron Folic Acid
IHIMS	Integrated Health Information Management Section
IHR	International Health Regulation
IVM	Integrated Vector management
JEE	Joint External Evaluation
LBW	Low Birth Weight
LF	Lymphatic Filariasis
LLGs	Local Level Governments
MAM	Moderate Acute Malnutrition
MDGs	Millennium Development Goals
MDR	Multi Drug Resistance
MoHP	Ministry of Health and Population
MSS	Minimum Service Standards
MUAC	Mid Upper Arm Circumference
NBBD	Newborn Birth Defect
NCDs	Non-Communicable Diseases
NDHS	Nepal Demographic and Health Survey
NEQAS NHS-SP	National External Quality Assessment SchemeNepal Health Sector- Strategic
NJAR	PlanNational Joint Annual Review
NMICS	Nepal Multiple Indicator Cluster Survey
NTDs	Neglected Tropical Diseases
OCMC O & M OPD	One Stop Crisis Management CenterOrganization and managementOutpatient
PEN	Package of Essential Non-Communicable Disease
PHC	Primary Health Care
PHCCs	Primary Health Care Centers
PHD	Provincial Health Directorate
PPP	Public Private Partnership
RCCE	Risk Communication and Community Engagement
RDQA R & R SAM	Routine Data Quality AssessmentRecording and ReportingSevere Acute Malnutrition
SARCs	Short-acting Reversible Contraceptives
SARI	Severe Acute Respiratory Infection
SARS	Severe Acute Respiratory Syndrome
SAM	Severe Acute Malnutrition
SCM	Supply Chain Management
SDGs	Sustainable Development Goals
SDPs	Service Delivery Points
SOPs	Standard Operating Procedures
SSU	Social Service Unit
STIs	Sexually Transmitted Infections

SWAp	Sector Wide Approach
SWOT	Strength Weakness Opportunity Threat
TAS	Transmission Assessment Surveys
TB	Tuberculosis
TIMS	Training Information Management System
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UHC	Universal Health Coverage
VBDs	Vector Borne Diseases
VPDs	Vaccine Preventable Diseases
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Health Office, Dang

Health Service Coverage Fact Sheet

Fiscal Year 2078/79 -2080/81 (2019/20 - 2023/24)

Program indicators	DANG District			FY 2080/81									
	FY 2078/2079	FY 2079/2080	FY 2080/2081	Bangalachuli RM	Ghorahi SM	Tulsipur SM	Shantinagar RM	Babai RM	Dangisharan RM	Lamahi Municipality	Rapti RM	Gadhawa RM	Rajpur RM
Reporting Status													
Reporting Status Dataset (NEW) Reporting rate		99.9	100	100	100	100	100	100	100	100	100	100	100
Reporting Status Dataset (NEW) Reporting rate on time		96.5	96.8	98.1	97	94.9	99	78.1	100	100	99.1	100	98.6
Immunization Program													
Percentage of children under one year immunized with BCG	99.5	102.6	99	69	101.2	123.3	74.3	74.2	82.8	98.6	93	83	74.6
% of children under one year immunized with DPT-HepB-Hib3	100.5	101.5	104.8	76.3	107.3	113.9	96.5	92.9	103.5	114	110	95.9	78.5
% of children aged 12-23 months immunized with measles/rubella 2	102.9	91.1	117.4	86.1	114.9	133	113.2	103.2	115	126.2	116	113.3	100
% of children fully immunized as per NIP schedule	102.9	81.1	117.2	86.1	114.9	133	110	103.2	114.7	126.2	116	113.3	99.4
% of pregnant women who received completed dose of TD (TD2 and TD2+)	67.7	70.1	74.3	60.2	70.4	80.6	60.6	60.7	69.9	84.3	104	67.6	57.3
DPT-HepB-Hib dropuout rate (DPT-HepB-Hib 1 vs 3)	-2.2	1.1	-3.4	2	-8.8	-0.16	-5.1	-7.2	-1.4	-0.74	-2.7	-4.1	4.8
Drop out Penta 1st Vs MR2	-3.7	11	-12.8	-8.3	-15.5	-7.1	-22.5	-17.9	-13.7	-11.2	-8.2	-23.4	-20.1
Nutrition Program													
Percentage of children aged 0-23 months registered for growth monitoring	99	75.1	69.1	46.9	71.4	62.6	71.8	62.2	121.7	89.6	84	45.7	59.1

% of children aged 0-23 months registered for Growth Monitoring (New) who were Underweight	4	3.7	2.1	0.9	1.3	4.1	1.9	2	4.8	0.3	0.7	1.9	1.8
Average number of visits among children aged 0-23 months registered for growth monitoring	NA	6	8	15	7	6	6	5	9	14	17	8	8
% of newborns with low birth weight (<2.5KG)	8.5	10.3	11	5.4	14.8	9.2	5.5	2.8	8.6	5.9	7.3	11.3	8.8
Percentage of women who received a 180 day supply of Iron Folic Acid during pregnancy	63	68.6	71.9	52	72.8	74.4	69.1	52.2	68.7	78.4	87.1	71.4	66.7
% of postpartum mother who received vitamin A suppliment		80.6	100.7	98.8	101.6	99.2	100	101.3	103.2	100	100	100	110.3
IMNCI Program													
Incidence of pneumonia among children under five years (per 1000)	27.8	28	25.9	61.6	14.5	21.2	30.5	38	40.6	7	61.3	21.1	41.9
% of children U5 years with Pneumonia treated with antibiotics (Amoxicillin)	98.8	100.4	100	100	100	100	100	100	100	100	100	100	100
Diarrhoea incidence rate among children under five years	72.4	87.5	104.2	141.5	57.1	62	139.4	97.8	137	96.1	157	187.4	359.9
% of children under five years with diarrhea treated with zinc and ORS	100	99.7	100	100	100	100	100	100	100	100	100	100	100
Safe motherhood Program													
% of pregnant women who had at least one ANC checkup	103	127.9	148.8	84.5	250.2	112.1	85.6	87.6	97.7	106.6	139	95.8	96.1
Percentage of pregnant women who had four ANC checkups as per protocol (4th, 6th, 8th and 9th month/16, 20-24, 32 and 36 Weeks)	65.5	79.2	86	56	109.4	74.4	68.8	71.8	64.9	87	99.6	71.4	76.8
% of institutional deliveries	65.3	84.3	76.3	42.2	107.7	89.9	12	24.7	27	67.5	83.8	42.7	37.4
% of births attended by a skilled birth attendant (SBA trained ANMs)	0	83	71.4	37.2	107.6	74.6	12	19.4	27	67.5	83.8	40.2	32.5
Percentage of women who had 3 PNC check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery)	49.5	47.5	49	55.3	31.6	39.8	65.8	41	73.3	75.7	101	59.1	43.5
Family Planning Program													

Contraceptive prevalence rate (unadjusted) among women of reproductive age (WRA)	23.1	22.1	23.6	22.6	26.7	16	18.5	11.4	30.3	20	43.5	25.7	31.2
% of modern contraceptives new acceptors among WRA	6.8	6.4	6	6	4.9	4.2	6.6	4.7	5.6	6.6	15.8	4.5	9.4
% of postpartum mothers using a modern contraceptive method	0.37	2.6	6.1	2	1.8	5.1	74.5	4	33.3	14.5	6.8	10.6	35.9
FCHV Program													
% of Mother groups meeting held	95.3	98.7	98.9	97.8	99.1	100	99.5	96.3	99.5	97.7	98.3	99.6	98.3
Total FCHVs within Catchment Area	910	912	866	55	191	197	48	51	51	72	64	82	55
Malaria and kala-azar Program													
Malaria annual parasite incidence (per 1000 population in high risk districts)	0.01	0	0.01	0	0.01	0	0	0	0.04	0.05	0.02	0	0
Annual blood examination rate (ABER) of malaria in high risk districts	0.65	0	1.5	0.03	0.32	1.1	1.4	1.2	2	3.2	5.5	3.4	0.25
Total Malaria Indigenous Cases	0	0	4	0	1	0	0	0	0	3	0	0	0
Number of kala-azar cases in at risk districts	0	0	0	0	0	0	0	0	0	0	0	0	0
Tuberculosis Program													
Case notification rate (All forms of TB cases - New and Relapse)	213.9	186.5	206	277.8	247.6	200.6	204.1	174.8	262.7	152.5	169	140.8	156.3
Treatment Success Rate	92.9	96.1	94.3	100	95.2	95.1	93.2	94	94.5	88.9	94.9	84.7	92.9
TB Case Fatality Rate (%)	4.6	2.6	2.8	0	3.2	3.3	1.7	1.5	1.8	6.9	0	3.4	3.6
Loss to follow up rate (%)	1.3	0.73	1.5	0	0.68	0.27	1.7	4.5	1.8	2.8	3.1	8.5	0
Leprosy Program													
New case detection rate of leprosy	3.2	3.8	2.1	0	1.9	2.7	0	0	0	1.7	1.9	4.4	3.6
Prevalence of leprosy per 10,000 population	0.32	0.38	0.21	0	0.19	0.27	0	0	0	0.17	0.19	0.44	0.36
HIV/AIDS Program													
Number of people newly infected with HIV in the reporting period per 1000 uninfected population	0.06	0.09	0.05	0	0.11	0.07	0	0	0	0	0	0	0
New HIV positive cases	47	59	34	0	22	12	0	0	0	0	0	0	0
Currently on ART	612	394	429	0	278	151	0	0	0	0	0	0	0

Curative Services													
% of New OPD Visits	80.9	59.3	62.95	52.33	43.69	67.96	74.6	49.1	66.87	69.88	92.1	91.58	64.39
Bed occupancy rate	26	24.7	34.6	NA	40.9	27.9	NA	NA	NA	18.8	NA	NA	NA
Average length of stay in hospital	2.2	2.2	2.9	NA	3.5	2.2	NA	NA	NA	1.9	NA	NA	NA
Hospital Deaths	127	96	64	0	43	21	0	0	0	0	0	0	0
% of population utilising emergency services at hospitals (Number at facility level and % at national level)	4.3	7.5	9	0	14.6	12.5	0	0	0	13.8	0	0	0
% population utilizing inpatient services at hospitals	2.4	4.4	4.4	0	7.5	7.5	0	0	0	1.1	0	0	0

Executive Summary

Introduction

Each year, the Health Office in Dang compiles an annual health progress report to evaluate the success of health programs, track changes in key health metrics, and identify emerging health concerns. This report offers a thorough overview of the district including all local level's health conditions, accomplishments, and challenges over the past year. It presents detailed information on healthcare delivery, program execution, disease control initiatives, and health outcomes. Additionally, the report identifies service delivery gaps, assesses the impact of health interventions, and provides recommendations for future improvements. This document is an essential tool for evaluating program effectiveness, informing policy decisions, and guiding resource allocation to meet the health needs of the Dang district.

The main institutions that delivered basic health services in 2080/81 were the 6 public hospitals, the 10 non-public health facilities, the 2 Primary Health Care Centers (PHCCs) and the 39 Health Posts (HPs) primary health care services were also provided by Primary Health Care Outreach Clinic (PHC-ORC) sites. A total of 122 Expanded Program of Immunization (EPI) clinics provided immunization services. These services were supported by 869 Female Community Health Volunteers (FCHV). The information on the achievements of the public health system, NGOs, INGOs and private health facilities were collected by HO's Health Management Information System (HMIS).

National Immunization Program (NIP)

The coverage for BCG vaccination has decreased slightly, from 103% in FY 2079/80 to 99% in FY 2080/81. However, coverage rates for other vaccines have improved compared to the previous fiscal year. This includes DPT/Hep-B/Hib3 (105%), Td2 and Td2+ (74%), Rota2 (102%), FIPV2 (118%), PCV3 (118%), MR2 (117%), and JE (114%). The overall coverage for fully immunized children at the district level stands at 102%. Regarding dropout rates, the DPT-HepB-Hib1 vs. DPT-HepB-Hib3 rate has improved, decreasing from 1.1% to -3.4%. Similarly, the dropout rate for DPT-HepB-Hib1 vs. MR2 has also improved, reducing from 3.8% to 2.8%. In terms of accessibility and use of immunization services, 7 out of the 10 local levels fall into Category I, while the remaining 3 local levels are in Category III. During FY 2080/81, both the Measles-Rubella and IPV campaigns were successfully conducted, with nearly all targeted children receiving vaccinations.

IMNCI Program:

The incidence of diarrhea among children under five in Dang increased over three years, from 72 per 1,000 in FY 2078/79 to 104 per 1,000 in FY 2080/81, with Rajpur Rural Municipality having the highest rate (360) and Ghorahi Sub-Metropolitan the lowest (57). Severe dehydration in diarrhea cases was low at 0.17% in Dang. All the dehydration cases with 100% treated using ORS and Zinc. The percentage of infants with Possible Severe Bacterial Infection (PSBI) dropped to 13.3% in FY 2080/81 from 23.5% in FY 2079/80, with all receiving their first dose of Gentamycin. Local Bacterial Infection (LBI), slightly rising to 27.8% in FY 2080/81. There were 52 cases of low weight or feeding problems within 28 days post-birth, mostly in Tulsipur SMC (37 cases). Acute Respiratory Infection (ARI) cases increased from 239 per 1,000 in FY 2078/79 to 263 in FY 2080/81, while pneumonia cases remained stable at around 10-12%, with nearly all treated with Amoxicillin.

Nutrition Program:

The percentage of new growth monitoring for children aged 0-23 months slightly decreased to 69% in FY 2080/81, with an average of 8 visits. The percentage of pregnant women receiving 180 iron tablets increased to 72%. Vitamin A and Albendazole coverage for children under five exceeded 100%, and the rate of exclusive breastfeeding was 78%. The malnutrition screening program identified and treated 125 SAM cases and 424 MAM cases. Anemia testing among 2,015 adolescent girls in 9 schools found 432 to be anemic. In Dang District, 72.7% of teenage girls received Iron Folic Acid for 13 weeks, while 49% received it for 26 weeks. Percentage of low birth weight child in the past three years is increasing from 9% in 2078/79 to 11% in FY 2080/081.

Safe Motherhood program:

In Dang District, the proportion of pregnant women receiving their first antenatal care (ANC) at any time increased from 128% in FY 2079/80 to 149% in FY 2080/81. The percentage of women receiving their first ANC checkup according to protocol rose by 7%, from 65% in FY 2079/80 to 72% in FY 2080/81. Similarly, the percentage of women receiving four ANC checkups as per protocol increased by 7%, from 79% to 86%. In FY 2080/81, 60% of pregnant women completed eight antenatal visits according to protocol. The percentage of institutional deliveries reached 76% in 2080/81. In terms of birthing center's service utilization, highest number of delivery was conducted in Lalmatiya HP with 413 deliveries and lowest in Khandra Naka basic health center with only 6 deliveries. Among total institutional deliveries, 16% involved mothers under 20 years of age. In terms of postnatal care (PNC), 49% of mothers attended three PNC visits as per protocol, with the highest coverage in Rapti Rural Municipality (101%) and the lowest in Ghorahi Sub-Metropolitan (32%). The Maternal and Perinatal Death Surveillance and Response (MPDSR) system recorded 8 maternal deaths in Dang during FY 2080/81.

Family Planning:

A total of 41 health facilities provided family planning services, providing 5 modern contraceptives. The contraceptive prevalence rate for modern methods in Dang District has shown an upward trend over the past three years, reaching 24% in FY 2080/81. The highest rate was in Rapti (44%), while Babai recorded the lowest (11%). In FY 2080/81, 6% of women of reproductive age (WRA) in Dang District were new acceptors of modern contraceptives. Postpartum family planning usage also increased, rising to 6% in FY 2080/81, compared to 3% in FY 2079/80.

Safe Abortion:

In the Dang district, 29 health facilities offered safe abortion services. A total of 1,340 women received medical abortion services. While 1,070 opted for surgical abortions, including 70 women under 20 years. Additionally, 1,651 women utilized family planning services after abortions.

Tuberculosis Control program:

The Case Notification Rate (CNR) for all forms of tuberculosis (TB) rose to 208 per lakh population in FY 2080/81, up from 188 in FY 2079/80. Similarly, the CNR for new pulmonary and relapse TB cases increased compared to the previous two years. The treatment success rate for Drug-Susceptible (DS) TB is 94%, surpassing the national target for treatment success rate (TSR) of at least 90%. In FY 2080/81, there were 37 deaths attributed to TB. Additionally, the number of Drug-Resistant TB (DR-TB) cases increased to 13 in FY 2080/81, compared to 7 cases in FY 2079/80. The overall treatment success rate for DR-TB is 68%.

Leprosy Program:

In the Dang district, the new case detection rates for leprosy were 3.2, 3.8, and 2.1 in fiscal years 2078/79, 2079/80, and 2080/81, respectively. The prevalence of leprosy decreased to 0.38 in FY 2080/81 compared to the previous year which was 0.52. There were 7 new cases reported in FY 2080/81, with females constituting 57% of these cases. Additionally, nearly all new cases (93%) were classified as Multi-bacillary.

HIV/AIDs Control Program:

In Dang, two ART sites are available for HIV testing and provide ART services, one is in Rapti Swasthya Bigyan Pratisthan Ghorahi, and another is one in Rapti provincial Hospital, Tulsipur Dang. Through these 2 ART sites, a total of 14,830 individuals were tested for HIV during the fiscal year 2080/81, which is almost half the number tested in the previous year. Additionally, 42 new HIV cases were diagnosed in FY 2080/81, reaching 430 cases. Of these 430 cases, 429 individuals were enrolled in ART treatment, aiming to the suppression of HIV virus load. Total of 16,425 pregnant mothers tested for HIV in FY 2080/81, representing 112% of the estimated

pregnancies in the district. One mother tested positive in FY 2080/81 and all positive mothers have been receiving ART treatment. A total of 168 STI cases were diagnosed among PHLIV and high-risk population, with 84% (138 cases) receiving treatment at service sites.

Malaria Control Program:

Over recent fiscal years, there has been an upward trend in malaria blood slide collection, with a total of 10,390 slides collected in FY 2080/81. Confirmed malaria cases rose from 5 in FY 2079/80 to 7 in FY 2080/81, with over half (4) being indigenous cases. Notably, there were no cases of *P. falciparum* infection in FY 2080/81. The annual blood examination rate (ABER) increased from 1.3% in the previous year to 1.5% in FY 2080/81. The slide positivity rate also showed a slight rise, from 0.05 in 2079/80 to 0.07 in 2080/81, and the parasite incidence rate stood at 0.01 per thousand population. The malaria screening among OPD visit was 1.8% in Dang district.

Kala-azar Program:

According to the EWARS report, one case of Kala-azar was reported in Dang district in 2024. The case was treated, and case-based surveillance was carried out among nearby contacts.

Dengue Control Program:

Total of 831 new dengue cases were identified in 2080/81 which was in increasing trend than previous year. Highest number of dengue cases were seen in Gadhawa Rural Municipality (241) and lowest in Shantinagar Rural Municipality (1) and Babai Rural Municipality (1).

Non-Communicable Disease and Mental Health

In the fiscal year 2080/81, a total of 16,368 non-communicable diseases were reported in Dang district, with 9,193 male patients and 7,175 female patients. The most prevalent condition was hypertension, accounting for 6,847 cases, followed by diabetes with 4,188 cases. During this period, 30 deaths were reported due to diabetes. In terms of follow-ups, there were 7,308 hypertension cases and 1,643 diabetes cases. Additionally, 1,034 new mental illness cases were identified, with depression being the most common (546 cases). In dang 7,852 new injury cases were seen with 2 resulting in fatalities. As part of a screening program for diabetes, blood pressure, and kidney disease among people over 40 years of age, 847 cases of diabetes, 488 cases of hypertension & 85 cases of kidney problems were detected from a total population of 41,233.

HMIS and eLMIS Status:

Regarding the HMIS status, a 100% reporting rate was achieved in the reporting status dataset, though other datasets experienced fluctuations, with some reporting rates falling below 100%. Many health facilities did not submit their reports to the DHIS2 software on time. In terms of the ELMIS status, all local levels and health facilities reported their logistic status in the software, but timely reporting was not consistent across all areas. Some municipalities, such as Tulsipur, had only a 35% on-time reporting rate, while Rajpur had 86%, Lamahi 89.4% & Dangisharan 93%.

Nepal Health Service Delivery System

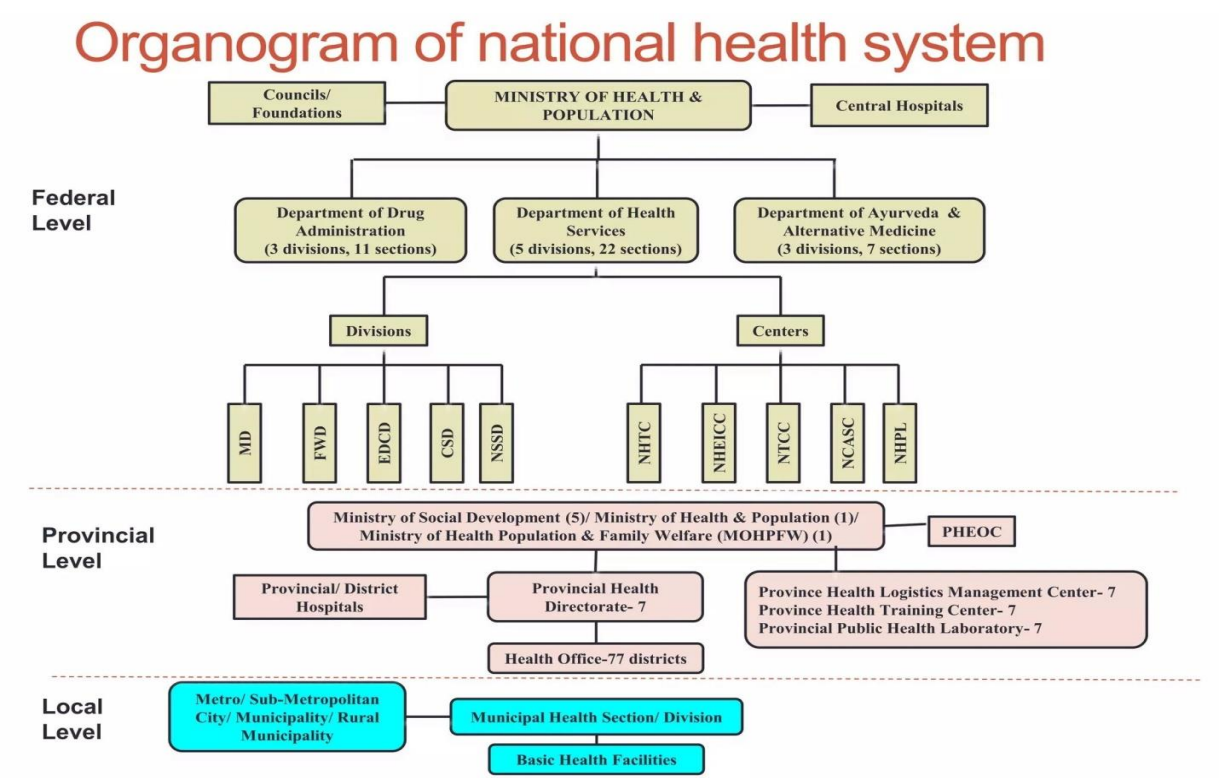
Nepal's health system is distinguished by a comprehensive and inclusive approach that incorporates accessibility, quality assurance, and responsiveness to emerging health challenges. The ongoing commitment to UHC and alignment with global development goals positions Nepal's healthcare system on a trajectory of continuous improvement and resilience.

Health service delivery systems in Nepal encompasses Allopathic, Ayurvedic, Homeopathic, Unani, Naturopathy, Amchi, Acupuncture/Acupressure, Yoga and other indigenous practices, with a mix of both public and private sectors. The health system underwent and is in continuous restructuring at the federal, provincial, and LLGs, levels adapting to exercise authority and fulfil constitutional mandates at each level of government. At the federal level, five divisions (Policy, Planning and Monitoring division, Health Coordination Division, Quality Standards and Regulation Division, Population Management Division) and HEOC unit operating under the MoHP, are responsible for managing the policy framework, planning, setting standards, coordination, monitoring, and supervision. Immediate implementation and further planning are conducted through departments- DoHS, Department of Ayurveda and Alternative Medicine (DoAA), and Department of Drug Administration (DDA). These departments, through their respective de-concentrated entities viz divisions, centers, and laboratories, provide guidance to their provincial counterparts under the provincial ministries, which in turn support health offices at the district and health coordination units at the LLGs. Public institutions, including BHS units/centers and hospitals at the LLGs, primary and secondary hospitals at the provincial level, and tertiary, super-specialized, and academia/teaching hospitals at the federal level, are mandated to deliver health services. The structure encompasses both allopathic, Ayurvedic and alternative medicine health service provisions, extending beyond curative aspects to include promotive, preventive, rehabilitative and palliative dimensions. Furthermore, private health facilities operate at all levels, complementing public institutions. Each institution is mandated to allocate 10% of free beds for poor and impoverished citizens to access health facilities as needed. Additionally, HDPs either collaborate with these public institutions or work through local nongovernment organizations to strengthen the health system using the SWAp approach to management.

The service provision extends further into communities through FCHVs, school health nurses, and ongoing pilot programs for community health nurses. Moreover, there is an expansion of the health insurance program to cover services beyond BHS, aiming to reduce out-of-pocket (OOP) expenses and protect against catastrophic health expenditure. This comprehensive network, inclusive of academia/teaching hospitals and super-specialized hospitals at the federal level, contributes to the holistic and community-centric nature of Nepal's health service delivery. In addition to the institutional structures of service delivery, regulatory bodies and professional councils are in place to ensure the quality of service provision and safeguard the rights of health professionals and citizens. These entities play an indirect yet crucial role in the health service delivery system. All these structures work together guided by the framework of the plans,

policies and commitments of the country and sector specific policies and strategic plans. Furthermore, all health facilities/programs bear the responsibility of documenting and reporting program/ service statistics through standardized platforms for Management Information Systems (MIS). These platforms include Health Management Information System (HMIS), Logistics Management Information System (LMIS/electronic LMIS (eLMIS), Financial Management Information System (FMIS), Health Infrastructure Information System (HIIS), Planning and Management of Assets in Health Care System (PLAMAHS), Human Resource Information System (HuRIS), Training Information Management System (TIMS), Ayurveda Health Management Information System (AHMIS), Early warning and Reporting System(EWARS), Malaria Disease Information System (MDIS) and the Drug Information Network (DIN). Additionally, these facilities contribute data to various health surveillance systems, such as disease surveillance, vital registration, censuses, sentinel reporting, surveys, rapid assessments, and research initiatives. DoHS takes the lead in managing information system except for DIN and AHMIS, which are overseen by the DDA and DoAA respectively.

The figure below outlines the organizational structure of Nepal's health system from the central to local levels. At the central level, the Ministry of Health and Population (MOHP) leads the health sector and has various divisions, departments, and facilities. The MOHP oversees the Department of Health Services (DOHS) which contains 5 divisions and 22 sections. Provincially, health directorates manage provincial health training centers and hospitals. District health offices oversee health facilities. Municipally, health sections in rural municipalities and cities manage urban health clinics and centers.



National Plan and policies

National Health Policy 2076 (2019)

1. Background

The constitution of Nepal has established basic health care as a fundamental right of its citizens. As the country has moved to a federal governance system, it is the responsibility of the state to ensure the access to quality health services for all citizens based on contextual norms of the federal system. This National Health Policy, 2019 has been formulated based on the lists of exclusive and concurrent powers and functions of federal, state and local levels as per the constitution. Also amalgamated with reference to the policies and programmes of the Government of Nepal; the international commitments made by Nepal at different times; and the problems, challenges, available resources and evidence in the health sector.

2. Review

With the establishment of Singhadarbar Vaidyakhana in the seventeenth century, the Ayurveda treatment system began in Nepal. Institutional development of the modern medical system started in Nepal with the establishment of Bir Hospital in 1889. The planned development in the health sector began with the inception of periodic planning in 1956. The first 15- year long-term health plan was introduced in 1975 and the second 20-year long-term health plan, in 1997. After the political change in 1990, National Health Policy 1991 was introduced to address the aspirations of people. Under this policy, sub-health posts in all erstwhile village development committees, health posts in all areas (the then Ilakas - administrative unit) and one primary health center in each electoral constituency were established in order to expand primary health services to the village level. The policy also promoted structural development and expansion, and involvement of private sectors to invest in the health sector. Similarly, the National Health Policy, 2014 stressed on participatory free basic health services in line with the spirit of the interim constitution of Nepal, 2007. Begun with the International Conference on Primary Health Care Alma-Ata in 1978, the global campaign on primary health services has been reinforced by the Millennium Development Goals and the Sustainable Development Goals. These international commitments have contributed to the development and expansion of Nepal's health system. Similarly, Nepal expressed its commitment to the global campaign of expanding people's access to quality primary health care in the Global Conference on Primary Health Care that took place in Astana, Kazakhstan in October 2018 to review the achievements of Alma-Ata Conference.

3. Current Situation

Local and state governments have also started delivering social services including health services after the implementation of federalism in Nepal. Although the central government has expanded a network of primary health care throughout the country so far, there is a need to enhance the quality of services, classify services, distribute skilled technical human resources, and add new

service centers to improve the quality as per the expectations of people. Most of the private sector hospitals are concentrated in urban areas and there is a need for collaboration in monitoring and regulating them. Human resources required for almost all levels of health care are being produced within the country with the investment of public and private sectors. However, there again is a need for quality assessment and regulation in the production of human resources since they are the foundation of quality health services. Around 40 percent of drugs required for the county are being supplied internally. Since there is no difference between the prices of domestically produced and imported drugs, it is necessary to technically regulate and scientifically monitor the production, distribution and management of drugs. Similarly, numerous super-specialized treatment facilities relating to eye, heart, kidney, neurology, orthopedic, organ transplant, plastic surgery and cancer have been established in Nepal. International partnership is essential for development and expansion of modern technology in diagnostic and laboratory services for those treatments.

Owing to effective continuation of public health activities, maternal and newborn tetanus, leprosy and trachoma have been eradicated. Similarly, the major health problems seen in the past such as kalaajar, filariasis, malaria, tuberculosis, HIV, measles, whooping cough, diphtheria, Japanese encephalitis, diarrhea, respiratory infections, and typhoid are being controlled and the morbidity is decreasing. Public health activities need to be made more effective and sustained to improve maternal health, child and newborn health.

Several regulatory bodies (Medical Council, Nursing Council, Pharmacy Council, Health Professional Council, Ayurvedic Medical Council and National Health Research Council) are active in ensuring quality of and regulating production of human resources, health services, and health research. It is essential to develop such regulatory bodies and make them more effective.

With the increase in public awareness and expectations about health and treatment services, it is essential to make such services accountable to the people and develop and expand health institutions, hospitals and health science academies in a contemporary manner. For this, it is necessary to make partnerships with supporting countries, donor agencies and international organizations. Such partnership should be transparent and responsive to people.

Similarly, it is essential to collaborate and coordinate with concerned agencies to control and regulate environmental pollution (air, sound, food, and water) which have been directly or indirectly affecting public health and causing chronic diseases like cancer. It is imperative to develop quality control methods to test, monitor and regulate the effects of agricultural products, food grains and consumable goods on human health.

4. Problems, Challenges and Opportunities

4.1. Problems

Main problems in promoting and availing quality health services at all levels include: inability to ensure consistent access to quality health services as expected by the people; inability to develop

services and human resources accountable to public health and services; no proportionate return from investment in the health services; unavailability of necessary modern equipment and specialized doctors in public health institutions; prevalence of health problems related to communicable and non-communicable diseases, malnutrition, accidents and disasters; and increase in the burden of non-communicable diseases and mental health problems generated from globalization and changes in food habits and lifestyles.

The other problems include imbalance between the production and use of human resources in health services; humanitarian health problems stemmed from increased food insecurity and natural disasters; increase in the incidences of antimicrobial resistance due to inappropriate use of antibiotics; slow pace of decrease in maternal mortality ratio; absence of adequate nutrition in more than one-third of children of 0-5 age and women of reproductive age; and absence of reasonable partnership with and effective regulation of the private sector in community level health services.

4.2. Challenges

The challenges in health sector include ensuring equal access of all citizens to all health sectors; providing free, quality basic health services through all local levels; providing health services with priority to ultra-poor and vulnerable citizens; reducing the existing high level of out of pocket expenditure for health care; ensuring required financial resources; establishing and operating health institutions in line with the federal system; effectively implementing health insurance policy; making the health sector responsible towards human health by transforming it from profit-orientation to serviceorientation; managing skilled human resources with a blend of skills in health services and social responsibility in the health sector; becoming self-reliant on drugs production; solving health problems associated with climate change, urbanization and changes in lifestyles; managing and regulating medicines and medical products effectively; increasing the use of data in monitoring, evaluation, review, policy making and decision making processes by making the health management information system more effective, integrated and technology-friendly to address the needs of all levels; developing a system to record the causes of deaths and continually conducting researches on them; and to maintain good governance in overall health and nutrition sectors by means of conforming quality health services and regulation.

4.3. Opportunities

The existing opportunities in health sector include sharing of responsibilities in health services among the federal, state and local levels as per the constitution; implementation of health insurance through policies and laws; operation of health programmes funded by state and local governments; increase in the availability of new information technologies, drugs and equipment; development of infrastructure and continuous increase in public awareness; expansion of health network up to the community level; stress of current health policies and programmes on

management and quality; use of statistics in policy making and decision making processes and prioritization of health services by all levels of the government.

5. Relevance, Guiding Principles, Vision, Mission, Goal and Objectives

5.1. Relevance

In order to address existing problems and challenges and to ensure the constitutional rights of citizens to quality health services, it is relevant to amend existing health policy, strategies and programmes and formulate a National Health Policy in accordance with the federal context. It is indispensable to continue existing health services and to sustain their achievements as well as to guide the development and expansion of health service infrastructure as per the federal context, given mandates and responsibilities. This policy is also imperative to address the national and international commitments made by Nepal and to achieve the Sustainable Development Goals while safeguarding the achievements of Millennium Development Goals.

5.2. Guiding Principles

In order to ensure constitutional rights of citizens to health services through a federal health system and to ensure universal access to quality health services, this policy has been formulated on the basis of the following guiding principles:

a. Universal access to, continuous availability of, transparency and comprehensiveness in quality health services.
b. Multi-sectoral involvement, collaboration and partnership in health system in accordance with the federal structure.
c. Special health services targeted to ultra marginalized, Dalit and indigenous communities;
d. Good health governance and assurance of adequate financial investments;
e. Diversification of equitable health insurance;
f. Restructuring in the health services;
g. Health and multi-sectoral coordination and collaboration in all policies;
h. Professionalism, honesty and occupational ethics in health service delivery.

Vision: -Healthy, alert and conscious citizens oriented to happy life.

Mission: To ensure the fundamental health rights of citizens through optimum and effective use of resources, collaboration and partnerships.

Goal: - To develop and expand a health system for all citizens in the federal structures based on social justice and good governance and ensure access to and utilization of quality health services

Objectives

1) To create opportunities for all citizens to use their constitutional rights to health;

2) To develop, expand and improve all types of health systems as per the federal structure;
3) To improve the quality of health services delivered by health institutions of all levels and to ensure easy access to those services;
4) To strengthen social health protection system by integrating the most marginalized sections;
5) To promote multi-sectoral partnership and collaboration between governmental, non-governmental and private sectors and to promote community involvement; and
6) To transform the health sector from profit-orientation to service-orientation.

Policies

1. Free basic health services shall be ensured from health institutions of all levels as specified;
2. Specialized services shall be made easily accessible through health insurance;
3. Access to basic emergency health services shall be ensured for all citizens;
4. Health system shall be restructured, improved, developed and expanded at federal, state and local levels as per the federal structure;
5. In accordance with the concept of universal health coverage, promotional, preventive, curative, rehabilitative and palliative services shall be developed and expanded in an integrated manner;
6. Collaboration and partnerships among governmental, non-governmental and private sectors shall be promoted, managed and regulated in the health sector and private, internal and external investments in health education, services and researches shall be encouraged and protected;
7. Ayurveda, naturopathy, Yoga and homeopathy shall be developed and expanded in an integrated way;
8. In order to make health services accessible, effective and qualitative, skilled health human resources shall be developed and expanded according to the size of population, topography and federal structure, hence managing health services;
9. Structures of Health Professional Councils shall be developed, expanded and improved to make health services provided by individuals and institutions effective, accountable and qualitative;
10. Domestic production of quality drugs and technological health materials shall be promoted and their access and proper utilization shall be ensured through regulation and management of efficient production, supply, storage and distribution;
11. Integrated preparedness and response measures shall be adopted to combat communicable diseases, insect borne and animal-borne diseases, problems related with climate change, other diseases, epidemics and disasters;

12. Individuals, families, societies and concerned agencies shall be made responsible for prevention and control of non-communicable diseases and integrated health system shall be developed and expanded;
13. In order to improve nutritional situation, adulterated and harmful foods shall be discouraged and promotion, production, use and access to qualitative and healthy foods shall be expanded;
14. Health researches shall be made of international standards and the findings and facts of such reports shall be effectively used in policy formulation, planning and health system development;
15. The health management information system shall be made modern, qualitative and technology-friendly and integrated health information system shall be developed;
16. Right to information related to health and right of a beneficiary to know about the treatment shall be ensured;
17. Mental health, oral, eye, ENT (ear, nose and throat) health services shall be developed and expanded;
18. Quality of health services provided by all health institutions including hospitals shall be ensured;
19. Good governance and improvement shall be ensured in policy-related, institutional and managerial structures in the health sector through timely amendments;
20. In accordance with the concept of health across the lifecycle, health services around safe motherhood, child health, adolescence and reproductive health, adult and senior citizen shall be developed and expanded;
21. Necessary financial resources and special fund shall be arranged for sustainable development of the health sector;
22. Urbanization, internal and external migration shall be managed and public health problems associated with such phenomena shall be resolved;
23. Demographic statistics shall be managed, researched and analyzed to link them with the policy decisions and programme designing;
24. Antimicrobial resistance shall be reduced, one-door health policy shall be developed and expanded for the control and management of communicable diseases, environmental pollution such as air pollution, sound pollution and water pollution shall be scientifically regulated and controlled;
25. Necessary arrangements shall be made to reduce the risks of immigration process on public health and to provide health protection to Nepalese staying abroad.

Fifteenth Plan- Health and Nutrition FY 2019/20-2023/24

Background

The Constitution of Nepal has the provision of the right to get free basic health services from the state as a fundamental right of the citizens of Nepal. Considering the importance of healthy and productive citizens in the nation's development, the state has an obligation to ensure equitable access to quality and easily accessible health services by increasing investment in this sector. In this context, as per the concept of federal state, it is necessary to gradually transform the health sector from being profit-oriented to service-oriented. As per the list of exclusive and concurrent powers enumerated by the Constitution, the functions of formulating health policy and standards, ensuring quality and monitoring, traditional treatment services and infectious disease control have been assigned to the federal government whereas the responsibility of health services have been assigned to the federal, provincial, and local levels. For its effective implementation, inter-ministry coordination and collaboration is a must.

As a result of various programmes implemented in the health service, the infant mortality rate per thousand live births has decreased to 32, the neonatal mortality rate has decreased to 21, the child mortality rate (under five years) has decreased to 39 and the maternal mortality rate has decreased to 239 (per one hundred thousand live births) and total fertility rate is 2.3 per woman. Similarly, the rate of stunting in children below five years has decreased to 36 percent. In this context, the national agenda is to achieve Sustainable Development Goals in keeping with the international commitments Nepal has made time to time, existing policy of the government as well as the major problems, challenges, and opportunities of the health and nutrition sector. To make citizens healthy, there is a need to increase investment in modern medicine as well as the medicines pertaining to ayurvedic, naturopathic and homeopathic treatment, and good governance and research in the health sector. According to this Plan, the state must play the lead role whereas the private and cooperative sectors have to play complementary roles in bringing health services to the doorsteps of the people.

Main Problems

- Lack of fulfillment of people's expectation of access to quality and uniform health services
- Inadequate development of service oriented and public health responsible health services and human resources
- The return of investment in health sector was poor
- Lack of adequate modern equipment and specialist doctors in public sector health facilities
- Communicable and Non-communicable diseases
- Malnutrition
- Accident and disaster related health consequences
- Changes in lifestyle and food behavior due to globalization leading to increase in Non-communicable diseases

- Increase in mental health problems
- Inconsistency in health workforce product and utilization
- Climate change
- Increasing food insecurity
- Natural disasters leading to humanitarian problems
- Anti-microbial resistance (AMR)
- Low decline rate of MMR
- Under-nutrition among more than one-third of under-five children and reproductive aged women
- Ineffective regulation and coordination for private sector's participation in community-based health services

Opportunities and Challenges:

Opportunities

- Sharing responsibility on health service related constitutional rights among federal, provincial and local level governments.
- Implementation of health insurance based on policy and legal provision.
- Increasing investment in health sector from provincial and local level governments through their own funding source
- Increasing civic sense on health as well as development of infrastructure
- Expansion of health networks to community level
- Focus of existing health policy and programs on management and quality of health services
- Evidence being prioritized by all levels of government in policy formulation and decision-making process.

Challenges:

- Establishing equitable access to all sectors of health
- Delivery of free and quality basic health services in all local level governments with universal access
- Provision of health services with focus on ultra-poor and vulnerable population
- Decreasing out of pocket expenditure
- Ensuring availability and adequate source of health financing
- Management of health facilities in federal system
- Effective implementation of health insurance
- Gradual transformation of profit-oriented health sector to service oriented sector.
- Management of socially responsible and qualified skill mix health workforce
- Self-reliance in production of drugs
- Addressing health problems resulting from climate change, rampant urbanization and unhealthy lifestyle
- Effective management and regulation of drugs and medical equipments

- Management of integrated and technology friendly health information system to fulfill the health information needs of all levels and increased use of data in monitoring, evaluation, review, policy formation and decision-making process.
- Development of mechanism to record cause of deaths
- Regular research
- Maintaining governance in health and nutrition sector through quality assurance and regulation of health services.

Vision, Goal, Objectives, Strategies, and Working Policies

Vision: - Healthy, productive, responsible, and happy citizens.

Goal: -To ensure access to quality health services at the people's level by developing and expanding a strong health system at all levels.

Objectives

1. To achieve balanced development and expansion of all sorts of health services at the federal, provincial, and local levels.
2. To transform the profit-oriented health sector gradually into a service-oriented sector by increasing government responsibilities and effective regulation for easily accessible and quality health service.
3. To promote a healthy lifestyle by making health service providers and service seekers more responsible for increasing the citizens' access to health service through multi-sectoral coordination and partnership.

Strategies and Action Plan:

Strategy	Action Plan
1. Ensuring access to quality basic and specialized health services	Necessary package and protocol will be developed and implemented for universal access to free basic health services. Utilize telemedicine and modern technology in health sector; develop and implement guideline for mobile health program in coordination with private and development sector to expand access of health services to rural population. Community based rehabilitation centers will be established in all levels. Based on disease burden and effectiveness, immunization services will be provided and immunization fund will be strengthened for making immunization services sustainable.

	Promotional programs will be conducted for improving relation between service providers and service users. Adequate budget will be ensured for effective implementation of Nepal Health Infrastructure Development Protocol and Minimum Service Protocol for improving quality of health services at all levels of health facility.
2. Develop and expand Ayurvedic, natural medicine and other complementary medicines in a planned way.	Institutional mechanism will be developed for identification, collection, preservation and promotion of locally available medicinal herbs and minerals. Health tourism will be promoted by establishing service center for Ayurveda & other complementary medicine at national level.
3. Address health needs of population of all age groups based on life cycle approach with more focus on maternal and child health, adolescent health and family management services.	Services related to maternal and neonatal health; child health and adolescent health; and family management services will be further strengthened and expanded. Health services will be made gender, elderly and disabled friendly. Provision will be made for free screening and diagnosis of diseases like breast cancer and cervical cancer. Evidence based midwifery education and services as well as special programs will be developed and implemented for reduction of maternal mortality.
4. Develop and expand health facilities based on population distribution and geography; and build technically sound and socially responsible health workforce	At least one basic health service center in each ward; primary hospital in each municipality; secondary level hospital, specialized hospital and one health science academy in province level & super-specialty hospitals in central level will be establish. Expanded health services will be implemented in public sector hospitals with additional services to increase access to services & implement 'One doctor/health worker-One health facility' approach. A master plan will be developed for effective management of health workforce and health institutions. Scholarship will be provided for study in different health science disciplines based on country's health needs.
5. Increase government financing in health and build sustainable health financing system.	Integrated national health financing strategy will be developed and implemented. Basic health services will be provided free of cost; health insurance will be implemented for covering treatment of specialized and other health services.

6. Management and regulation of cooperation and collaboration between public-private and non-government sector.	One school-one health worker' policy will be implemented in coordination with education sector. Umbrella structure of health-related professional councils will be developed by strengthening its workforce, organogram and working area. Integrated act will be developed for management of health science academies. Guideline will be developed for coordination with private, community and non-government health institutions. Clinical governance will be maintained by incorporating public, private, community and cooperative sector. Regulation of health care cost will be done by developing specific guideline. Regulatory mechanism will be developed and province and local government will be made responsible for management of health care waste.
7. Regulation of production, import, storage, distribution and utilization of medical equipments, drugs and supplies.	Self-reliance in production of drugs will be built. Promotion of farming of medical herbs and development of medical industries will be done along with effective production, storage and distribution of medical goods. Regulatory mechanism will be developed to address antibiotic resistance; implement generic prescribing, set price of drugs and quality control measures and for drug research.
8. Implement integrated measures for control of communicable and non-communicable diseases as well as for disaster preparedness and response.	Integrated institutional mechanism will be developed for prevention, control, elimination, monitoring, surveillance and research of communicable and non-communicable diseases. Long term plan will be developed through multi-sectoral coordination for effective implementation of prevention, control and treatment services of non-communicable and chronic diseases. Control and treatment programs will be developed based on research for addressing sickle cell anemia, Thalassemia and other genetic diseases. Access to mental health services will be expanded at all levels. Health care services related to eye, ear, nose, throat and oral health will be gradually developed and implemented in central, province and local level. Guideline for rapid response to disaster, improvement of ambulance services and mobilization of skilled health workers will be developed and implemented.

9. Increase use of evidence-based decision making by strengthening health information system.	Use of evidence in decision making at all levels will be promoted through quality and user-friendly data management approach. Data management will be made technology friendly at health facility level for electronic reporting and electronic health record will be gradually expanded in all health facilities. A system for integrating locally generated health data with national portal will be developed. Survey, research and studies will be done based on national health needs and priorities and the evidence generated will be used in policy making and designing programs.
10. Expand working area of Nepal health Research Council to province level.	Institutional arrangement of NHRC will be established in province level in coordination with academic sectors.
11. Develop measures to prevent and manage the public health threats of imported cases.	Management information system will be developed for responding threat of imported infectious cases; and policy and institutional measures will be formulated for providing screening and health care services.
12. Effective implementation of multi-sectoral nutrition plan through coordination and collaboration.	Nutrition related mechanisms and nutrition sensitive and nutrition focused programs will be implemented from all health facility levels. Access to and utilization of quality and healthy foods will be improved and promotion of healthy food behaviors for reducing malnutrition will be done.
13. Incorporate health in all policies through multi-sectoral coordination.	One Health Approach' will be implemented by incorporating health in all policies through multi-sectoral approach. Control and regulation of tobacco and alcohol use, chemicals and unhealthy foods will be done; scientific and effective health messages will be developed to reduce the use of health harming processed foods. Advocacy and coordination will be done with stakeholders to promote healthy food behavior, physical activity and clean environment. Mechanism will be developed in central, province and local level for public health impact assessment before the approval of industries, project or any other services.

Expected outcomes

- At the end of the five-year plan, **life expectancy of Nepalese population will increase to 72 years.**
- Maternal mortality will be reduced from 239 to **99 per 100,000 live births**; neonatal mortality will be reduced from **21 to 14 per 1000 live births** and under-five mortality will be reduced from **39 to 24 per 1000 births.**
- Prevalence of under-weight among under-five children will be reduced from current 27% to **15 % while stunting will be reduced from 36% to 20%.**
- Nepalese population will receive basic health services free of cost.
- Population coverage in **health insurance will increase to 60%**; Out of pocket payment will be reduced from 55% to 40% and government investment in health sector will increase from 4% to 8%
- Proportion of population residing **within 30 minutes of distance to health facility will be 80%.**
- The proportion of women attending at least four Antenatal check-ups will increase from 69% to **81%,** delivery attended by skilled birth attendant will increase from 58% to 79% and children receiving full immunization services will increase from 78% to 95%.
- Malaria, Kala Azar and Lymphatic filariasis will be **eliminated** from Nepal.

Nepal Health Sector Strategy and Sustainable Development Goals (SDGs)

Introduction:

Between 2047 and 2071 (1990 and 2014), Nepal witnessed significant strides in healthcare, characterized by remarkable reductions in under-five and infant mortality rates, along with notable progress in maternal mortality. Achievements in disease control initiatives, such as advancements toward polio eradication and leprosy elimination, were evident. However, persistent health challenges, including stagnated neonatal mortality, malnutrition, and gender inequality, necessitated a nuanced approach to address financial, socio-cultural, geographical, and institutional barriers to healthcare access and utilization. Furthermore, in 2072 (2015), Nepal adopted its new constitution for institutionalizing federalism. It guarantees inclusive socio-political and economic development, along with a broad range of basic and fundamental rights. The Constitution also sparked to institutionalize significant political, social, and economic changes in the country and sectoral mandate of providing free BHS. This is further guided by Public Health Service Act 2075 and Public Health Service Regulation 2077 that defined the detail BHS package. Nepal's equity-based approach and aspirations for rapid and sustainable development resonate strongly with the SDGs.

Nepal Health Sector Strategy (NHSS) 2071/72-2077/78 (2015-2020) was endorsed under the National Health Policy 2071 (2014), alongside insights from the 2072 (2015) earthquake and alignment with the newly promulgated constitution of Nepal in 2015, marked a pivotal milestone in healthcare development. This strategy focused on ensuring UHC through equitable access,

quality health services, health systems reform, and multi-sectoral approaches. It established the framework for outcomes aimed at enhancing health systems, promoting evidence-based decision-making, and realizing an accountable and equitable health service delivery system. In advancing UHC, NHSS delineated service delivery arrangements, accentuating BHS and social health protection. The initiation of the social health insurance program in Chaitra 2072 (April 2016) by the GoN further streamlined this process to offer social protection beyond BHS needs. The strategy aligned with the government's commitment to progressively fund BHS internally. Concurrently, the restructuring of MoHP and legislative measures like the Public Health Service Act 2075 (2018) set the stage for progressive realization of UHC by creating the avenues for ensuring the aspirations (BHS, Emergency Health Services) of the Constitution. Additionally, the 14th Plan 2073/74-2075/76 (2016/17–2018/19) was the first periodic plan to mainstream and internalize the SDG 2030 Agenda. The 15th Plan 2075/76-2080/81 (2019/20- 2023/24) continued to align and mainstream the SDGs.

The resilience of Nepal's health sector was rigorously tested during the COVID-19 pandemic. The response, characterized by the rapid activation of the HEOC and an efficient vaccine rollout, demonstrated the adaptability and commitment of the healthcare system. Despite initial challenges, Nepal succeeded in swift resumption of the health services and vaccinating a significant proportion of the population to halt the spread of the disease.
Under the leadership of MoHP, a comprehensive National Action Plan on SDG3-Global Action Plan 2076/77- 2078/79 (2020-2022) was formulated and presented at the United Nations in September 2019. Focused on enhancing the quality of basic health care services, evidence-based decision-making, response to social determinants of health, and capacity building across government levels, this plan sought to institutionalize the quality of care and a national health care quality framework (endorsed in 2079). Additionally, there were initiatives taken amidst pandemic, from the government to establish basic hospitals in each LLGs to ensure access and availability of basic health services in the LLGs. However, effectively managing the necessary resources for operations and securing an adequate workforce to provide services pose significant and thoughtful challenges. In these difficult times, MoHP developed National Health Financing Strategy (NHFS) 2080-2090 (2023/24-2033/34) guiding the health sector investments in two major areas ensuring equitable access to quality health services and reducing financial hardship of the population and managing financial resources for health.

Amid the backdrop of the COVID-19 pandemic, the timeline for NHSS was extended until Paush 2080 (December 2023). During this extension, the Nepal Health Sector Strategic Plan (NHS-SP) for the period 2079/80-2087/88 (2023-2030) was meticulously crafted in accordance with the strategic direction of the National Health Policy 2076 (2019). The strategy was endorsed by the cabinet in the fiscal year 2079/80. The articulated objectives and targets within this strategic plan are envisaged to delineate the trajectory of the nation's efforts in attaining the SDGs. Notably, the SDG index score for the year 2078/79 has been registered at 64.47,

indicative of the nation's commendable progress in aligning healthcare strategies with broader sustainable development imperatives. The NHS-SP is underpinned by five overarching strategic objectives:

- ✓ Enhancement of efficiency and responsiveness within the health system.
- ✓ Comprehensive addressing of determinants influencing health.
- ✓ Promotion of sustainable financing and social protection in health.
- ✓ Ensuring equitable access to quality health services, and
- ✓ Adapt management of population dynamics and migration.

As the nation embarks on the journey towards graduation from its least developed status, the NHSSP is poised not only to sustain but also to advance the progress achieved in the health sector while proactively addressing pertinent health issues. The progress of the SDGs in Nepal is reported through report of National Planning Commission (NPC).

Provincial Plan and Policies

Provincial Health Policy 2077:

The province government has endorsed a Provincial Health Policy 2077 (cabinet decision: 2077/02/02 BS) to ensure the fundamental right to health as stipulated in the constitution of Nepal. The health policy envisions to achieve "Healthy and Happy Citizens for a Prosperous Province". The provincial health policy consists of six guiding principles, 24 policy statements and 126 strategies.

Guiding principles

- Universal access to quality healthcare,
- Intergovernmental and multi-sectoral participation, coordination, and cooperation,
- Equitable health service based on social justice,
- Ensure sufficient investment and adequate utilization,
- Commitment to good governance, accountability, and professional conduct,
- Innovation and creativity in health service.

Vision: - Healthy and happy citizens for a prosperous province

Mission: - Ensure the fundamental right of the citizens to stay healthy.

Goal: - Improve the health status of citizen by increasing access to quality health service through strengthened health system.

Objectives of provincial health policy:

- Ensure an efficient and effective health care system.
- Enhance access to services to all citizens of the province, who can get easy, accessible, simple, and quality health services from all levels.
- Create an enabling environment to promote healthy lifestyles, change behavior and upset the factors that adversely affect health.
- Provide effective and uninterrupted health service delivery in case of emergencies and disasters.
- Inter-governmental, community and multilateral coordination, partnership, and cooperation in health service management, as well as cooperation with the private and non-governmental sector as needed.
- Make health services responsive to the people by promoting good governance, accountability, and responsibility.
- Increase investment in the health sector and reduce the proportion of personal expenses due to health problems.

Policy statements

1. Ensure basic and emergency health services, free of cost from all levels of health institutions in the province (6 strategies)
2. Increase equitable access through strengthening specialists and specialized health services (10 strategies)
3. Provide necessary infrastructure, medicines, medicinal materials, tools, equipment, and diagnostic services for the quality health service delivery (10 strategies)
4. Produce, distribute, mobilize, and manage the skilled health manpower to strengthen health service delivery (9 strategies)
5. Effectively provide basic, specialist and specialized health services relating to the Ayurveda and other traditional, natural medicine, yoga, and other alternative medicine existing in the province (6 strategies)
6. Develop provincial standard based on minimum service standards and national medical standards to deliver the delivery of quality health services (3 strategies)
7. Increase the access and utilization of quality health services for socially, economically, geographically, gender, religiously and culturally backward community (6 strategies)
8. Ensure the safe maternal and reproductive health rights of adolescents and women (8 strategies)
9. Provide promotive, preventive, curative, rehabilitative and palliative health services for the prevention and management of non-communicable diseases (5 strategies)
10. Ensure the favorable environment by providing health education and information for healthy positive behavior change (6 strategies)
11. Formulate and implement urban health promotion plan to manage health problems arising from increasing urbanization (3 strategies)
12. Promotion and consumption of healthy foods to improve nutritional status and perform necessary coordination to increase production and access (6 strategies)
13. Perform multilateral cooperation to minimize and respond to possible health effects and epidemics during disasters or disasters (5 strategies)
14. Minimize and manage the adverse effects of environment on health (6 strategies)
15. Institutionalizing the progress and achievements made in health sector, emphasize on necessary coordination and cooperation to achieve more achievements (2 strategies)
16. Ensure the occupational health and safety of workers working in various workplaces (4 strategies)
17. Collaborate with public, community and private sectors to increase access and utilization of health services (4 strategies)
18. Promote study and research works and use the acquired findings to develop and implement the health programs and strategies (3 strategies)
19. Develop the more robust and technology-friendly integrated health information system for developing fact-based plans and effective management of health services (5 strategies) šš‹‹‹

20. Made health sector a people-oriented and result-oriented through maintaining good governance (6 strategies)
21. Effective prevention, control and management of communicable diseases, insect-borne diseases, animal-borne diseases and sickle cell anemia, thalassemia in selected places and communities and diseases that can enter through open borders (4 strategies)
22. Strengthen the social security scheme and reduce the personal expenditure in health care through increasing investment in the health sector (4 strategies)
23. Promote health tourism within the province by emphasizing the health protection of people coming to and from the province (2 strategies)
24. Formulate and implement health service program based on demographic situation and analysis (4 strategies)

First Five-Year Plan (2076/77 – 2080/81)

The First Five-Year Plan of Provincial Planning Commission is developed based on the Constitution of Nepal, National Long-term Vision 2100, 15th Plan, Sustainable Development Goals and policies and program of province government and set to achieve "prosperous province: Happy citizen". In the health sector, the plan envisions to develop healthy and strong citizen by providing access to quality healthcare for all. The goal, objectives, strategies and expected outcomes set by the plan in health sector mentioned hereunder:

Goal: - Provide quality health services to all citizens easily.

Objectives:

- Ensure equitable access to basic health services.
- Make easy access of people to quality promotive, preventive, and curative services.
- Minimize risk factors in the field of public health promotion.

Strategies:

- Expand access to basic health services and improve qualitatively.
- Increase the capacity of hospitals, including quality curative services, and provide specialized health services at province.
- Adopt and promote alternative methods of health treatment.
- Conduct public awareness campaign related to health.
- Arrange for the availability of quality and nutritious food in the market.

Expected outcomes:

- Achieved health-related sustainable development goals through increasing easy access to health services.
- Established Trauma center.
- Provided specialized health services through provincial hospital.

Introduction

Background

Dang District is located in western region of Lumbini province, Nepal characterized by its diverse geography. There are 10 local governments within the dang district, including both hilly and Terai (plains) regions. This diversity presents unique challenges for healthcare delivery, making the role of the Health Office crucial in addressing the health needs of a varied population.

The Health Office in Dang, Nepal, is a key governmental body responsible for technical support, coordination and overseeing public health services within the district. Initially this organization was established as 'District Health Office (DHO)' in 2028 BS based on the decentralization act. With the implementation of federalism in Nepal, where the country is divided into seven provinces each with its provincial health offices in each district. These offices are responsible for planning, coordinating and implementation of health programs and policies within their respective provinces. The establishment of Health Offices in Nepal is closely linked to the country's transition from centralized government system to a federal system. Prior to the implementation of federalism, the healthcare services were primarily managed by the central government through Ministry of Health and Population.

In 2015, Nepal promulgated a new constitution that paved the way for federalism, decentralizing power and authority to the province and local levels. The constitution mandated the establishment of Health Offices to ensure effective healthcare service delivery and management within the provinces. Since then Health Office Dang has been established within the Lumbini province with the primary objective of providing accessible and quality health services to the population with the close coordination among higher authorities, local level, stakeholders and health facilities.

The Health Office is tasked with the coordination, commodity distribution, disease surveillance and monitoring, capacity building and training and administration of primary health care, disease prevention, health education, and the monitoring of health trends within the district. It works in close collaboration with local government and health facilities, including primary healthcare centers, health posts, basic health service centers, and community health units, to ensure that basic health services are accessible to everyone, particularly those in remote and underserved areas. In addition to service delivery, the Health Office is responsible for the implementation of various public health programs, such as immunization drives, maternal and child health initiatives, prevention and control of various communicable and non-communicable diseases and different nutrition interventions. It also provides a critical statistical support in recording and reporting of data, which helps in tracking the progress of health interventions and planning future activities.

Each year, we prepare an annual health progress report to assess the effectiveness of health programs, monitor changes in key health indicators and identify emerging health issues. This annual progress report of the Health Office, Dang, typically provides a comprehensive overview of the district's health status, achievements, and challenges over the year. It includes detailed data

on health service delivery, program implementation, disease control efforts, and health outcomes. The report also highlights the gaps in service delivery, the impact of health interventions, and recommendations for future improvements. The report serves as a critical tool for evaluating the effectiveness of health programs, guiding policy decisions, and allocating resources to address the health needs of the population in Dang district.

Organizational Structure of Health Office, Dang

The provincial health office in Nepal is the key governmental organization responsible for overseeing and managing healthcare services at the provincial level. Operating under the Ministry of Health and Population of Lumbini province, the office plays a vital role in implementing national health policies and ensuring that essential healthcare services reach all corners of Dang. Organogram of Health Office dang has shown in table below.

Table 1: Organigram Health Office:

S.N.	Post	Level	Service	Group	Number of staffs
1.	Sr./PHA	9/10	Health Service	Health inspection	1
2.	PHO	7/8	Health Service	Health inspection	1
3.	Statistical Officer	5/6	Aa. Yo.Ta.	Statistics	1
4.	HA/PHI	5/6/7	Health Service	Health inspection	3
5.	PHN	5/6/7	Health Service	Community Nursing	1
6.	Lab Technician	5/6/7	Health Service	MLT	1
7.	Cold Chain	4/5/6	Health Service	Health inspection	1
8.	Section Officer	6	Administration	General Admin.	1
9.	Account Officer	6	Administration	Account	1
10.	Office Assistant	-	Administration	General Admin.	2
11.	Ha.sa.cha	-	Administration	MI	1
Total staffs					14

Major roles and responsibilities of Health Office

1. As a subordinate office of the Health Directorate under the province, coordination, facilitation, cooperation with the province and local levels and implementation as per the instructions of the province specified.
2. Implement the storage and distribution plan (monthly, quarterly, semi-annually and annually) of vaccines, essential and sensitive medicines and health commodities required by the local level and heath institutions within the area of district.

3. Coordinate and facilitate to run public health programs, vector surveillance, disaster and epidemic management.
4. Conducting and supporting, coordinating and facilitating public health campaigns.
5. Support to build coordination between local level and private organizations.
6. Analyze and evaluate the integrated health information, verify the data and support to make plan accordingly.
7. Plan, coordinate and facilitate to ensure the access and utilization of healthcare services.
8. Perform supervision, monitoring and quality related activities for the improvement of government, private and cooperative agencies.
9. Increase the technical capacity of institutions and health professionals.
10. Conduct, coordinate and facilitate the regular provincial health programs (TB/leprosy control program, family planning, maternal and child health, social security, health insurance, Lymphatic filariasis, nutrition, measles/rubella and other special health campaigns.
11. Health promotion and management on environmental health, nutrition, water and sanitation and occupational health related aspects.
12. Population management related activities.
13. Carry out the activities as per the instruction of provincial government.
14. Facilitate multi-sector coordination
15. Carry out the functions related to internal administration (finance, administration and management).

Health Service Delivery Outlets:

In the dang district, there are 1 federal hospital, 1 provincial hospital, 4 local level hospital. There are 1 PHCC, 39 Health Post, 29 Basic Health Service Centers, 33 Urban Health Centers, 13 Community Health Unit, 12 ayurved health service sites provides basic health care services to the communities, 43 which are birthing centers. To improve the access and utilization of health care services 122 EPI clinics, 129 PHC/ORCs are conducted every month within the district. Likewise, 867 FCHVs are being mobilized to advocate healthy behaviors of mothers and community people to promote safe motherhood, child health, family planning, and other community-based health promotion and service delivery.

Table 2: Service Delivery Outlest

Organization unit	Bangalachuli RM	Ghorahi SMC	Tulsipur SMC	Babai RM	Shantinagar RM	Dangisharan RM	Lamahi Mun	Rapti RM	Gadhawa RM	Rajpur RM	Total
Government hospital	1	1	1	1	0	0	1	1	0	0	**6**
Primary health care centers	1	0	0	0	0	1	0	0	0	0	**2**
Health posts	3	8	8	2	5	3	2	2	4	2	**39**
Basic health service centers	4	0	0	5	3	4	0	4	4	5	**29**
Urban health centers	0	14	11	0	0	0	8	0	0	0	**33**
Community health unit	1	0	2	0	0	0	0	3	2	5	**13**
Birthing centers	5	9	9	3	3	2	2	2	4	4	**43**
BEONC sites	1	0	0	0	0	1	0	0	0	0	**2**
CEONC sites	0	1	1	0	0	0	1	0	0	0	**3**
Outreach clinic	14	21	38	1	8	6	3	19	7	13	**130**
EPI Clinic	19	46	61	11	14	15	16	15	16	14	**227**
FCHCs	55	191	195	55	48	51	72	64	82	54	**867**
TB DOTS Center	5	11	13	4	3	3	3	2	4	2	**50**
OTCs	3	2	9	2	2	1	2	1	2	2	**26**
Safe abortion service center	3	3	8	1	3	3	2	2	2	2	**29**
Health facility with IUCD service	2	11	10	2	3	2	3	2	4	2	**41**
Health facility with Implant service	9	22	14	3	3	7	9	6	9	5	**87**
Health facility with 5 temporary family planning devices	2	11	10	2	3	2	3	2	4	2	**41**
Adolescent friendly health facilities	5	9	9	3	3	2	3	2	4	4	**44**
Nutrition Rehabilitation center	0	1	0	0	0	0	0	0	0	0	**1**
Snake bite treatment center	0	0	0	0	0	0	0	0	1	0	**1**
OST site	0	1	1	0	0	0	0	0	0	0	**2**

Sources of Information in the Report

The main source of data for this progress report is the Health Management Information System (HMIS). Majority of the data used in this report is obtained from the DHIS2 platform. These data were retrieved from DHIS2, following the completion of the district annual health review meeting, and were summarized to analyze progress of various health programs and activities. Other information systems used in the report include the Logistic Management Information System (eLMIS), disease surveillance systems, sentinel reporting, and the IMU. The report also included information obtained from the municipal and district counterparts during the annual health review meeting undertaken at various levels (local levels, and health facilities). The Annual Health Report Preparation Committee collated, compiled, and examined all relevant data and then organized them into various sections and chapters in the annual health report.

Child Health and Immunization Program

National Immunization Program (NIP)

Introduction:

Child Health and Immunization Service Section is one of the four sections of Family Welfare Division, which plans, executes and monitors several activities of child health and immunization services. The NIP is highly Priority Program (P1). NIP is one of the most **cost-effective** Health Interventions.The National Immunization Program (NIP) of Nepal (Expanded Program on Immunization) was started in 2034 BS and is a priority program of the Government of Nepal. It is one of the successful public health programs of the Ministry of Health and Population and has achieved several milestones contributing to reduction in morbidity, mortality and disability associated with vaccine preventable diseases.

National Immunization Program has introduced several new and underutilized vaccines contributing towards achievement of Global Vaccine Action Plan targets of introducing new and underutilized vaccines in routine immunization. As per comprehensive Multi-year Plan for Immunization (cMYPI) 2017 - 2021, several other vaccines, including Typhoid Conjugate Vaccine (TCV) and Human Papillomavirus Vaccine (HPV) were planned for introduction in Nepal. Typhoid Conjugate Vaccine (TCV) was introduced in the National Immunization Program through a nationwide. For measles elimination, high coverage of both MR 1 and 2 are required (≥ 95%). Therefore, coverage of both MR 1 and MR 2 is near the elimination level.

Comprehensive Multi-Year Plan for Immunization (cMYPI)

The comprehensive Multi-year Plan for Immunization (cMYP) 2017-21 ended in 2021 and national immunization strategy development has been initiated in 2022. Furthermore, this plan addresses new challenges and expands the previous plan by providing guidelines for introduction of new vaccines, eradication, elimination, and control of targeted VPDs and strengthening of routine immunization.

New Comprehensive Multi-Year Plan for Immunization (cMYP) 2017 - 2021 provide a plan for 5 years to achieve immunization related goal of the country.

Vision: -Nepal: a country free of vaccine-preventable diseases.

Mission: - To provide every child and mother high-quality, safe and affordable vaccines and immunizationservices from the National Immunization Program in an equitable manner.

Goal: - Reduction of morbidity, mortality and disability associated with vaccine preventable diseases.

Strategic Objectives

Objective 1: Reach every child for full immunization;

Objective 2: Accelerate, achieve and sustain vaccine preventable diseases control, elimination anderadication.

Objective 3: Strengthen immunization supply chain and vaccine management system for qualityimmunization services;

Objective 4: Ensure financial sustainability for immunization program;

Objective 5: Promote innovation, research and social mobilization activities to enhance best practices.

Target Population of NIP: -

1. All infants (<1 year) for BCG, DPT, Hep-B, Hib, OPV, PCV, FIPV, Rota and MR 1st dose.
2. All pregnant women for TD vaccines. and All grade 1 student for school TT Immunization program.
3. All child age 12-23 month for JE & MR2.

Table 3: National Immunization Schedule

S. N.	Type of Vaccine	Doses	Recommended age
1	BCG	1	At birth or on first contact with HFs
2	Oral Polio Vaccine (OPV)	3	6, 10 and 14 weeks of age
3	Rota	2	6, 10 weeks of age
4	DPT-Hep B-Hib	3	6, 10 and 14 weeks of age
5	FIPV	2	14 weeks and 9 months of age
6	PCV	3	6 and 10 weeks and 9 months of age
7	Measles-Rubella (MR)	2	9 months (MR1) and 15 months (MR2)
8	Japanese Encephalitis	1	12 months of age
9	TCV (Typhoid)	1	15 months of age
10	TD	2	Pregnant women: 2 doses of TD one month apart in first pregnancy, and 1 dose in each subsequent pregnancy

Table 4: Immunization Schedule for Missed Children

Vaccine	Up to 12 months if missed in routine schedule	>12 months to 23 months if missed	24 months to 5 years if missed
BCG	1 dose The standard dose of reconstituted vaccine is 0.05 mL for infants aged <1 year and 0.1 mL for children aged ≥1 year. TST (Tuberculin Skin Test) not required before vaccination.		
Rota virus	2 doses with 1-month interval		Rotavirus vaccine should not be given to children above 2 years of age
bOPV	3 doses with interval of 1 month between doses		
fIPV	2 doses with interval of 4 months between doses		
PCV	3 doses with 1-month interval between doses	2 doses with 2 months interval between doses	
DPT-HepB-Hib (Pentavalent)	3 doses with interval of 1 month between doses		3 doses interval of 1 month between 1st & 2nd dose, and 6 months between 2nd & 3rd dose
MR	> 9 months to < 15 months of age 1st dose at first contact, and 2nd dose at 15 months of age. There should be at least 1month interval between doses.		≥ 15 months to 5 years of age 2 doses with 1-month interval between doses
JE		1 dose	
TCV (Typhoid)			≥ 15 months to 5 years of age 1 dose

Full Immunization

Full immunization program aims to assure immunization services for all children specially focusing hard to reach population through local ownership, participation and local resource mobilization. It was initiated from the Bhageswor VDC of Achham, Farwest region. Full immunization refers to a state when a under one-year age child receives complete doses of vaccine as per national immunization schedule which include BCG- 1 dose, DPT-HepB-Hib -3 doses, OPV - 3 doses and Measles-Rubella-1 dose. A VDC is declared as fully immunized VDC if all the children of 12-23 aged are immunized with all the mentioned vaccines within one year during survey.

History

- Initiated in 2012 form selected districts. CHD developed and endorsed Full Immunization Guideline. First review meeting held in 2014.

- Bhageswor of Achham district is the first VDC declared as fully immunized VDC.
- Palpa is the first district declared as first fully immunized district.
- The fully immunized district declaration program targeted to declare the country as fully immunized by 2074/75. But it was not achieved.
- By 2078/79, 70 districts have been declared fully immunized.
- Gandaki province has declared their province as fully immunized province. Wide range of collaboration at local level.
- More than 80% of total Palikas declared fully immunized.

Goal:

- To reduce child mortality, morbidity and disability associated with vaccine preventable diseases and prepare healthy children by recognizing local resources and ensuring the local government and stakeholder's participation, ownership and support for strengthening immunization and providing complete vaccination to children under 1 year.

Objectives

- To provide complete doses of vaccine children under 1 year.
- To provide continued, sustained and assured quality vaccination service.
- To Encourage local ownership, participation and support.

Strategies

- Enhance human resources for the activities like line listing, survey and reporting Included Full Immunizationprogram in annual development development plan by local government,
- Organize activities to increase public awareness,
- Prepare and update micro planning to continue and sustain full immunization,
- Integrate full immunization program with other public health programmes.

Status of Polio Myelitis and its path to eradication

- Nepal is polio free since August 2010 but officially SEAR (Southeast Asian Region) member countries were declared polio free in 2014 after 3 years of continuation of polio free in all member countries.
- On March 27, 2014; WHO declared the 11 countries of Southeast Asia including Nepal as polio free nation.
- Other ten countries are Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor- Leste.
- Nepal has adopted End game strategy (2014- 2018) for Polio eradication by 2018. It includes four strategies:
    - Detection of polio virus and prevention of its transmission.

- Improvement in Immunization program and introduction of IPV.
- Declaration of eradication of polio from world with limitation of polio virus in laboratory
- Conduction of public health activities related to polio for continuation of eradication status.

VPD Surveillance Syatem:

1. Acute Flaccid Paralysis (AFP) Surveillance.
2. Measles-rubella surveillance FY 2079/80.
3. Acute encephalitis syndrome (AES) surveillanc.
4. Neonatal tetanus surveillance.
5. Environmental Surveillance.

Immunization Act and Regulation:

Nepal is the first country in SEAR to have Immunization Act, thus supporting and strengthening the NIP. Immunization Act 2072 was published in Official Gazette on 26 January 2016. Based on the immunization Act, Nepal has Immunization Regulation 2074, which was published in Official Gazette on 06 August 2018. The Immunization Act of Nepal has recognized immunization as right of all children. In line with these one of the 7 provinces of Nepal Gandaki Province also has it'sProvonce Immunization Act.

Major Activities Carried Out in FY 2080/81

- Ensured quality assured operation of Routine Immunization services across the district through Health Facilities and outreach immunization sessions incorporating the recommendations of microplanning.
- Commemorated the national immunization month in Baisakh.
- Periodic Onsite coaching for vaccinators at immunization sessions.
- Routine distribution of vaccines to Municipalities according to microplanning.
- Ensured the fully immunization district declaration for sustainability.

Key Achievement of National Immunization Program FY 2080/81

Three Years Trend of Vaccine Coverage:

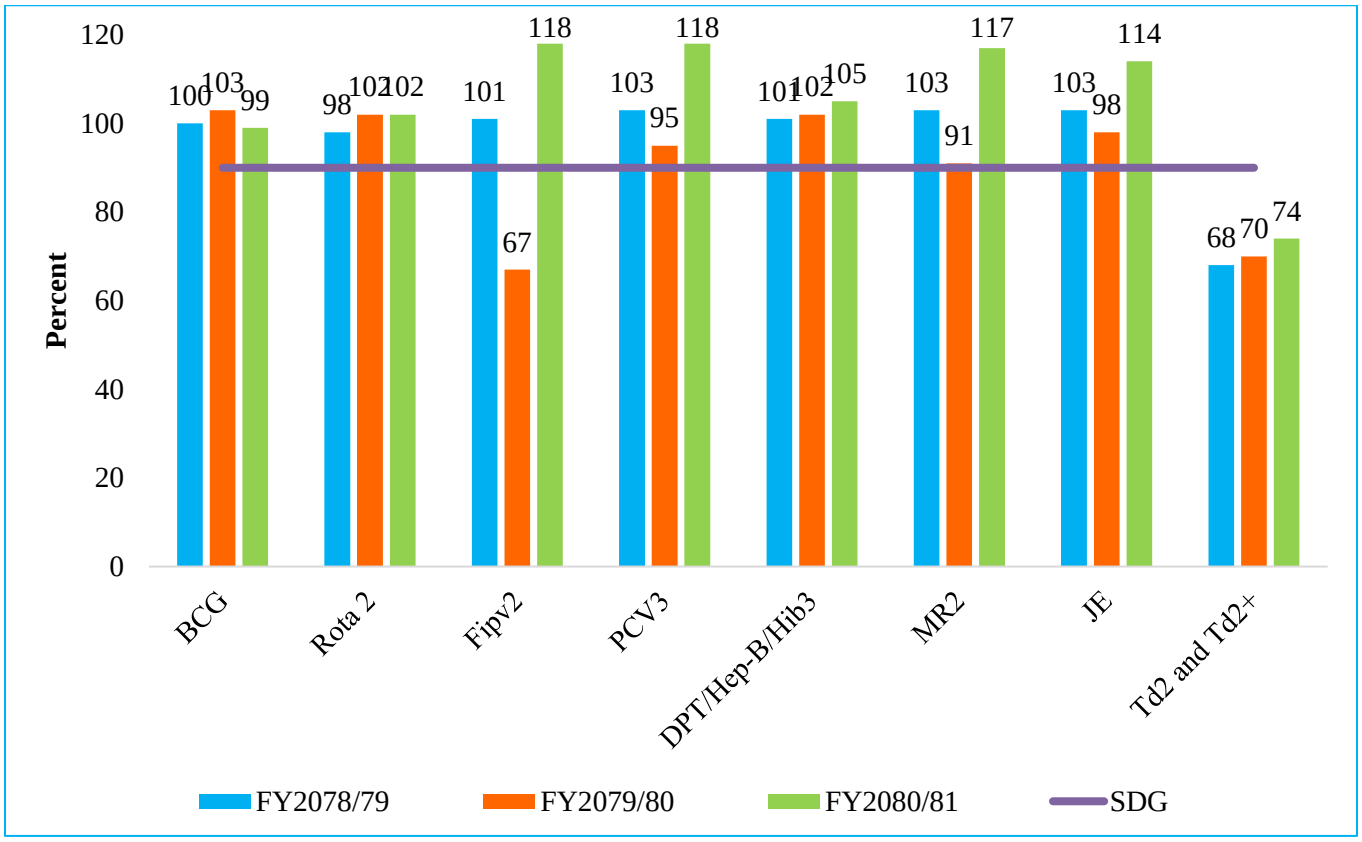


Figure 1: Inter-Vaccine Coverage Trend:

The above figure illustrates the comparative administrative coverage of BCG, Rota2 Fipv2, PCV3, DPT/HepB-Hib, MR2, JE and Td2 and Td2+ vaccine antigens last 3 sequential fiscal years. BCG coverage decreased than previous fiscal year which is 99 percent but DPT/Hep-B/Hib3 Td2and Td2+ coverage increased than previous fical year. It has maintained the national recommended target of achieving >90% vaccination coverage except Td and Td2+ Which is 74%.

Palika Wise Three Years Trend of Vaccine Coverage:

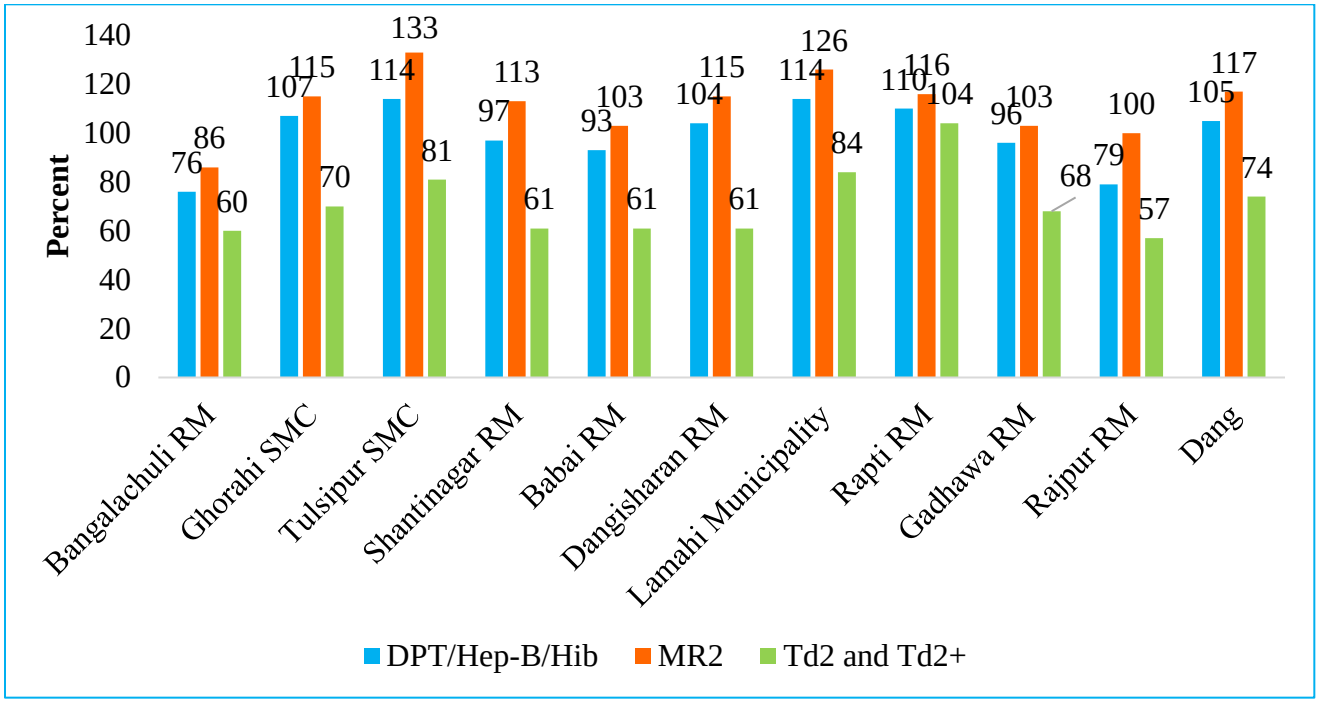


Figure 2: Palika wise coverage of major three vaccines.

The above graph shows municipalities wise coverage of DPT/Hep-B/Hib, MR2, Td2 and Td2+ vaccine. DPT/Hep-B/Hib coverage highest in Tulsipur followed by Lamahi which is 114% and lowest in Bangalachuli which is 76% MR2 Coverage highest in Tulsipur which is 133% and lowest in bangalachuli which is 86%. Td2 and Td2+ coverage highest in Lamahi which is 84% and lowest in Rajpur which is 57%.

Three-Year Drop-out Trend of Vaccine:

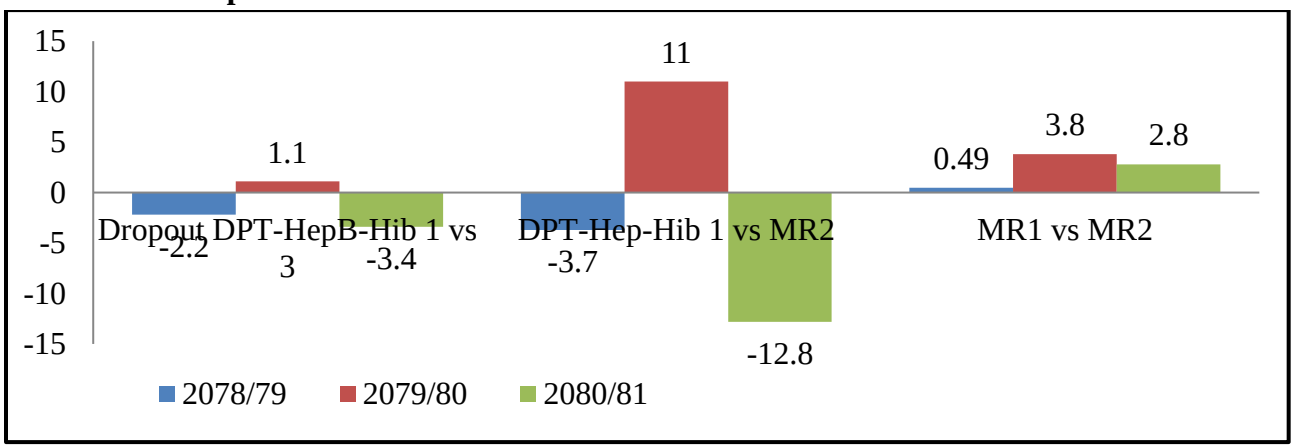


Figure 3: Drop-Out Trend Vaccine:

In the above figure, DPT-HepB-Hib1Vs DPT-HepB-Hib2, DPT-HepB-Hib1vs MR2 and MR1 Vs MR2 drop-out rate has decreased than previous fiscal year.

Palika Wise drop out rate in FY 2080/81

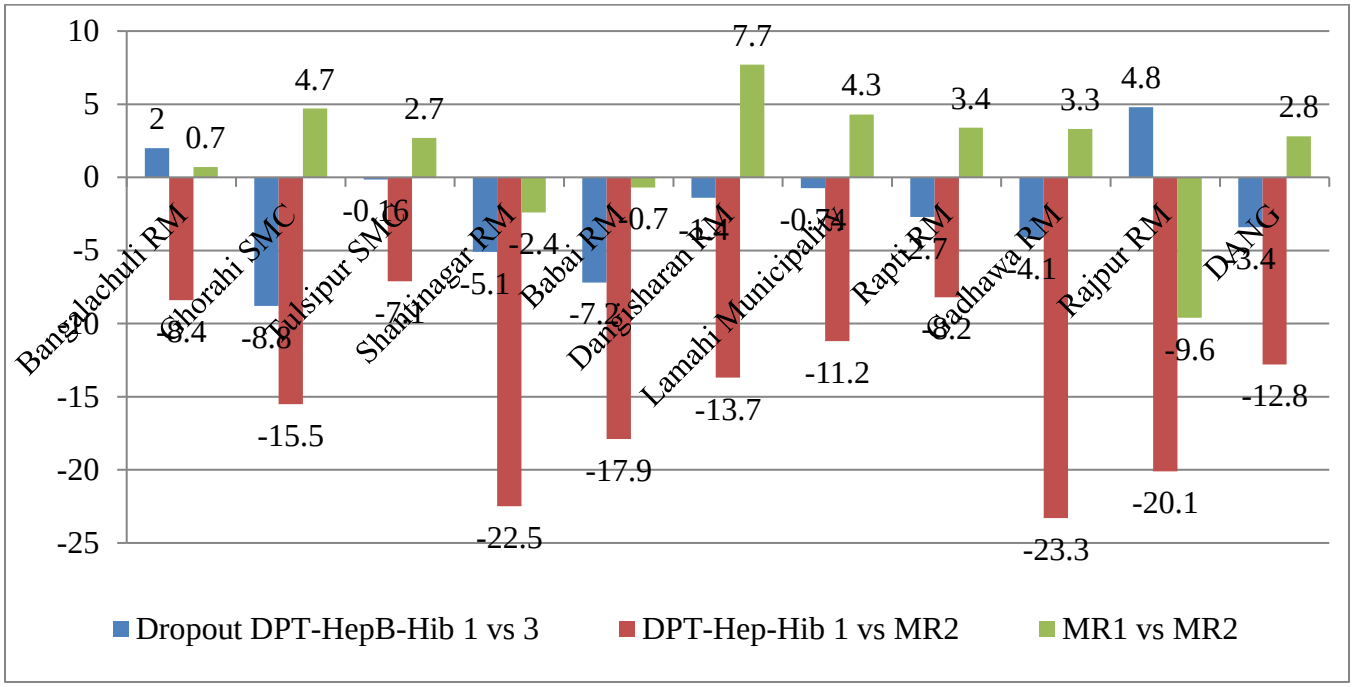


Figure 4: Palika Wise drop out rate

In the above figure, DPT-HepB-Hib1Vs DPT-HepB-Hib3 drop-out rate has decreased in all local levels Which is Recorded in minus except bangalachuli and rajpur. DPT-HepB-Hib1Vs MR2 drop-out rate has decreased in all local levels which .is recorded in minus. MR1Vs MR2 dropped out rate hihest in Lamahi municipality (7.7) and lowest in rajpur municipality which is recorded in minus (-9.6)

Categorization of Palika based on access and Utilization of Immunization in FY 2080/81

- The NIP monitors the status of the districts by accessibility and utilization of immunization services. Districts are categorized in category 1 to 4 on the basis of **DPT-HepB-Hib1 coverage** and **dropout rate of DPTHepB-Hib1 vs MR2** to know the accessibility and utilization of immunization services respectively.

CategoryI: -High coverage ≥90% & Low drop-out <10%: Good access & Good Utilization
CategoryII: -High coverage ≥90% & High drop-out ≥10%: Good access & Poor Utilization
CategoryIII: -Low coverage <90% & Low drop-out <10%: Poor access & Good Utilization
CategoryIV: -Low coverage <90% & High drop out≥ 10%: Poor access & Poor Utilization.

Table 5: Categorization of Palika

CATEGORY-I High coverage (≥90%) Low drop-out (<10%)	CATEGORY-II High coverage (≥90%) High drop-out (≥10%)	CATEGORY- III Low coverage (<90%) Low drop-out (<10%)	CATEGORY-IV Low coverage (<90%) High drop-out (≥10%)
1. **Ghorahi SMC** 2. **Tulsipur SMC** 3. **Dangisharan RM** 4. **Rapti RM** 5. **Gadhawa RM** 6. **Lamahi Municipality** 7. **Shantinagar RM** **(7)**	0	1. **Bangalachuli RM** 2. **Rajpur RM** 3. **Babai RM** **(3)**	**0**

The above Table clearly highlights that 7 out of 10 Local level are in Category-I (good access and good utilization) Bangalachuli, rajpur and Babai Rm are in Category-III (poor access and utilization where as there is no local level in category-II and category-IV in dang disrict.

SWOT Analysis NIP

Strength	Opportunity
• Conducted regular monitoring for Vaccine distribution centres, immunization sessions, full immunization declaration process (72 dropped out children were searched and mainstraimed into routine immunization services across the district). • Managed Outbreak-Response Immunization against measles outbreak. • Repaired cold chain equipment by doing regular follow up. • Added a new Deep freezer and installed temperature monitoring software(U-Cool) in all ILR and Deep freezer of district cold store. • Conducted basic and refresher training on immunization for Vaccinators, • Successfuly Conducted vaccination campaigns against Measles-Rubella (MR) and Poliomyelits**.**	• Sustainability of District Full immunization decleration. • Quite Coordination with all level of government. • Children from marginalized community were covered with routine immunization by regular update of routine immunization microplanning. • Hygiene promotion sessions are conducting along with EPI sessions.
Weakness	**Threat**
• Time to time out break of Vaccine Preventable Diseases (VPDs). • Inconsistency in data quality of immunization programme. • High vaccine wastage rate. • Not provided cold chain dedicated trainings, • Problems in regular reporting on e-LMIS and others real consumption. • Partially released budget which were insufficient to conduct programmes successfully.	• Lack of cold chain storage equipments on Rajpur and Bangalachuli RM vaccine distribution center. • Inappropriate immunization induced waste management.

CB-IMNCI Program and New Born Care Program

Introduction:

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

In CB-IMNCI program, FCHVs carry out health promotional activities for maternal, new-born and child health and provideessential commodities like distribution of iron, zinc, ORS, chlorhexidine which do not require assessment and diagnostic skills, and immediate referral in case of any danger signs that appear among sick new-borns and children. Health service providers counsel and provide health services like management of non-breathing cases, low birth weight babies, common childhood illnesses, and management of neonatal sepsis. Also, the program has provisioned for the post-natal visits by trained health service providers through primary health care outreach clinics.

IMNCI is an integration of CB-IMCI and CB-NCP Programs as per the decision of MoHP on 2071/ 6/ 28 (October 14, 2015). This integrated package of child-survival intervention addresses the major problems of sick newborn such as birth asphyxia, bacterial infection, jaundice, hypothermia, low birth-weight, counseling of breastfeeding. It also maintains its aim to address major childhood illnesses like Pneumonia, Diarrhea, Malaria, Measles and Malnutrition among under 5 year's children in a holistic way.

In Nepal, child survival intervention began when the Control of Diarrhoeal Disease (CDD) Program was initiated in 1983 and the Acute Respiratory Infection (ARI) Control Program initiated in 1987. For the management of ARI Cases from household level and to maximize ARI related services, referral model and treatment model at the community level were piloted. An evaluation of this intervention in 1997 revealed that the treatment model was more effective and popular in the community than the referral model. In 1997/98, ARI intervention was combined with CDD and named the CB-AC program. One year later two more components, nutrition and immunization, were also incorporated in the CBAC program. The IMCI program was piloted in Mahottari district and was extended to the community level as well.

Community-Based Integrated Management of Newborn and Childhood Illnesses (CB-IMNCI) maintains its aim to address major childhood illnesses like Pneumonia, Diarrhoea, Malaria, Measles and Malnutrition among under 5 year's children in a holistic way. CB-IMNCI program addressed killer disease diseases like Pnemonia, Diarrhoea, Malaria, Measles and Malnutrition with assesment of TB & HIV/AIDS, it is holistic Way in 2 months to 5yrs children. Where asless than 2-month children assesment and management of Possible Severe Bacterial

Infection (PSBI)/Very Severe Disease, Pneumonia, Local Bacterial Infection (LBI), NBI (No Bacterial Infection), Jaundice (Severe, Mild\Moderate NoJaundice) LBW, hypothermia and Breastf eeding Problem.

Chronological development of Community Based-Integrated Management of Neonate and Childhood Illness (CB-IMNCI)

Integrated Management of Childhood Illness **(IMCI) in 1997AD**

↓

Community Based Integrated Management of Childhood Illness **(CB-IMCI) in 1999.**

↓

Community Based Newborn Care Program **(CB-NCP) in 2065/66** wth 10 districts.

↓

Integration of CB-IMCI and CB-NCP programs and formed **CB-IMNCI program in 2071/6/28 (14 Oct. 2014)**

↓

CB-IMNCI program has been started from FY **2071/72 (14 Oct.2014 AD).**

Vision: 90 by 30: - CB-IMNCI program has a vision to provide targeted services to 90% of the estimated population by 2030 asshown in the diagram.

Vision: - "Contribute to survial, healthy growth and development of under five children of Nepal."

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

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

Table 6: Targets of NENAP

Indicators (Per 1000 live births)	Nepal Health Sector Strategy III (2015-2020)	NENAP, by 2035	SDGs (3.2)
Neonatal Mortality Rate	17.5	11	At least as low as 12
Stillbirths		13	
Under-five Mortality Rate (U5MR)	28	21	At least as low as 20

Facility-Based Integrated Management of Neonatal and Childhood Illnesses (FB-IMNCI):

- The Facility-Based Integrated Management of Neonatal and Childhood Illnesses (FB-IMNCI) was initiated in **2016 with a package** designed specially to address and bridge existing gap in the management of Neonataland Childhood cases referred from peripheral level health institutions to higher institutions.

Nepal Every New-born Action Plan (NENAP)

- MoHP initiated NENAP in line with ENAP (Every New-born Action Plan).

Vision:

- A Nepal in which 'there is no preventable deaths of New-born or stillbirths, where every pregnancy is wanted, every birth celebrated and women, babies and children survive, thrive and reach their full potential'.

Goal:

- NENAP aims to achieve NMR of less than 11 deaths per 1000 live births and a stillbirth rate of less than 13 stillbirths per 1000 total births in every province by the year 2035.

Table 7: Target of NENAP (Nepal Every Newborn Action Plan)- 2035

Indicators	Target NENAP- 2035
MMR	98
NMR	11
Still Birth Rate	13
Small for gestational age	38
U5MR	21

Preterm Birth Rate	14
4 ANC visit	95%

Kangaroo Mother Care Program

- Kangaroo mother care (KMC) is a proven, cost-effective intervention to care for stable preterm/LBW babies that is being implemented by Government of Nepal as a special care for small and/or sick new-born.
- Skin to skin contact has been part of different programs/ training packages such as CB-IMNCI, FB-IMNCI, SBA Training, Comprehensive level-II new-born care etc. a full-fledged KMC program from 2021. The goal of KMC Program is to end preventable new-born deaths due to prematurity & low birth weight through skin-to-skin contact, breast feeding and early discharge from health center.

Revision of CB-IMNCI Treatment Chart booklet: 2078

1. Management of sick children 0-59 days (below 2 months) of age

- The treatment chart booklet has been developed as per revised treatment chart booklet 2020 published by WHO. It includes Pneumonia classification for 0-2 month's new-born,.
    1. Possible severe bacterial infection (PSBI)\Very Severe Disease .
    2. Pneumonia
    3. Local bacterial infection (LBI)
    4. Jaundice
    5. Low weight or feeding problem.
    6. Hypothermia and
    7. Management of Birth asphaxia.

2. Management of sick children 2 months to 59 months of age:

All cases of ARI accessed by health workers should be classified into one of the following categories

1. Very Severe Disease: - Any Danger sign present
2. Severe Pneumonia: - Cough and cold with Danger sign, chest indrawing, cynosis.
3. Pneumonia: - Cough and cold with RR increase.
4. No Pneumonia/Common Cough: - Simple cough and cold.
5. Diarrhoea (Severe dehydration, some dehydration and No dehydration)
6. Severe Chronic Diarrhoea
7. Chronic diarrhoea (Prolong diarrhoea)
8. Dysentry: - diarrhea with blood.
9. Assessment of Malaria (Severe Complicated malaria, P. Falcifarum, Non Falcifarum)
10. Assessment of Measles.
11. Ear Infection (Mastatis, Acute Ear Infection, Chronic Ear Infection)

12. Assessment of Malnutrition (SAM, MAM & Normal)
13. Assessment of Anemia (Severe Anemia, Anemia & No anemia).
14. Assessment of Childhood Tuberculosis as per National TB Program.
15. Assessment of HIV/AIDS infection as per National of HIV/AIDS Program guideline.

Key Achievement of CB-IMNCI Program FY 2080/81

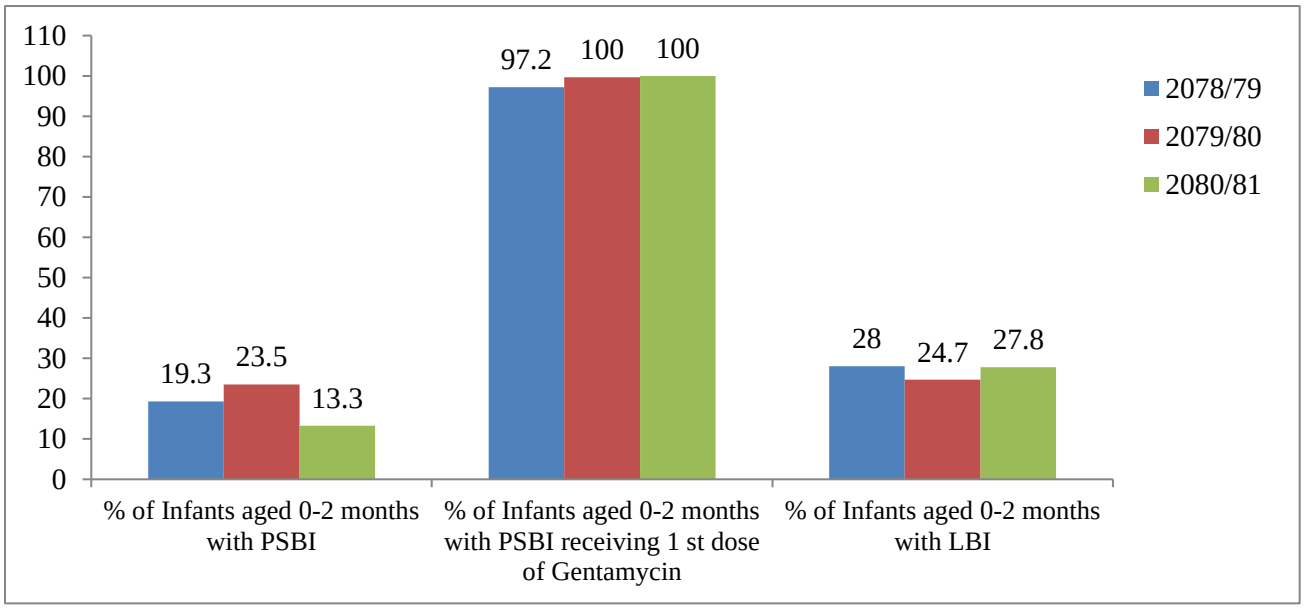


Figure 5: Three Year Trend of infection of < 2 months newborn.

The three-year trend data on infections in infants aged 0-2 months shows a mixed picture of progress within the CB-IMNCI program. In FY 2080/81, the percentage of infants with Possible Severe Bacterial Infection (PSBI) decreased to 13.3% compared to 23.5% in FY 2079/80 and 19.3% in FY 2078/79. 100% of infants with PSBI received their first dose of Gentamycin and maintained the trend of complete coverage since FY 2079/80. It shows an improvement from 97.2% in FY 2078/79. For Local Bacterial Infection (LBI), the trend remains fairly consistent across the three fiscal years. In FY 2080/81, 27.8% of infants were diagnosed with LBI which is a slight increase from 24.7% in FY 2079/80 and close to the 28% seen in FY 2078/79.

Table 8: Management of < 2 months Newborn:

	510 DANG										
Indicators	FY 2080/81	Bangalachuli RM	Ghorahi SMC	Tulsipur SMC	Shantinagar RM	Babai RM	Dangisharan RM	Lamahi Municipality	Rapti RM	Gadhawa RM	Rajpur RM
<2Months-Classification-PSBI Cases	193	3	5	116	7	4	5	2	25	17	9
<2Months-Classification-Jaundice Cases	91	1	14	66	2		0	2	6	0	0
<2Months-Treatment-Gentamycin 1st Dose	193	3	5	116	7	4	5	2	25	17	9
Pneumonia Cases 0-59 days	51	2	17	8	1	2	0	0	20	1	0
<2Months-Classification-LBI Cases	404	16	68	55	13	6	7	56	133	41	9
<2Months-Treatment-Amoxicillin Paediatrics	387	8	30	63	10	8	7	56	150	46	9
<2Months-Low Weight/Feeding Problem ≤28 days Facility	52	0	7	37	0	0	0	2	6	0	0
<2Months Low Weight/Feeding Problem 29-59 days Facility	22	1	13	0	0	0	0	0	8	0	0
<2Months-Refer Cases	130	0	25	46	7	4	4	3	15	14	12
<2 Month-Death-0 to 7 days	5	0	0	5	0	0	0	0	0	0	0
<2 Month-Death-8 to 28 days	0	0	0	0	0	0	0	0	0	0	0

In FY 2080/81 in Dang district, a total of 193 cases of PSBI were reported with the highest number recorded in Tulsipur SMC (116 cases) and the lowest in Lamahi Municipality (2 cases). For Jaundice, 91 cases were identified, most of which occurred in Tulsipur SMC (66 cases) while Ghorahi SMC reported only 1 case. All PSBI cases across all areas received Gentamycin

treatment as a first dose. The district reported 51 cases of pneumonia in infants aged 0-59 days, with the highest occurrence in Rapti SMC (20 cases). For LBI, 404 cases were reported with the largest numbers in Rapti RM (133 cases) and Ghorahi SMC (68 cases). Amoxicillin treatment was administered to 387 infants, most notably in Rapti RM (150 cases).

There were 52 cases of low weight or feeding problems within the first 28 days post-birth, predominantly in Tulsipur SMC with 37 cases. An additional 22 cases were noted for infants aged between 29 to 59 days with Ghorahi SMC accounting for the majority with 13 cases. The district also had 130 referral cases with Tulsipur SMC having highest number 46. Mortality rates were concentrated in Tulsipur SMC, where five deaths were recorded within the first week of life. No deaths were reported in the age range of 8 to 28 days across all regions assessed.

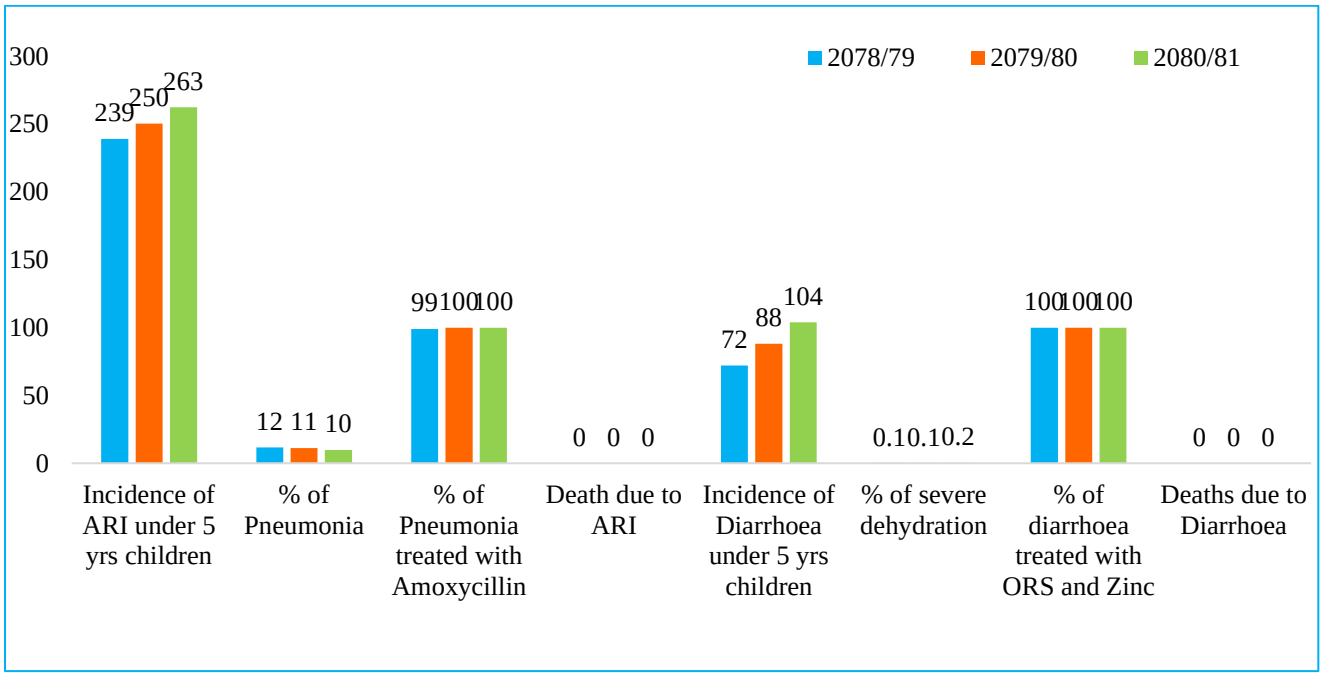


Figure 6: Three Year Trend of Pneumonia and Diarrhoea under 5 Year Children.

The data illustrates trends in health indicators for children under five years old over the past three fiscal years (2078/79 to 2080/81). The incidence of ARI increased over the years, from 239 cases per 1000 children in 2078/79 to 250 in 2079/80 and 263 in 2080/81. The percentage of pneumonia cases remained steady, with 12% in 2078/79, 11% in 2079/80 and 10% in 2080/81. All pneumonia cases were treated with Amoxicillin over the three years consistently at 99% to 100%. No deaths due to ARI were recorded during this period. The incidence of diarrhoea in under 5 children rose from 72 cases in 2078/79 to 104 cases in 2080/81. The percentage of severe dehydration from diarrhoea was low across the years at 0.1% to 0.2%. All diarrhoeal cases were treated with ORS and Zinc and maintained a 100% treatment rate. No deaths due to diarrhoea were recorded in the three years.

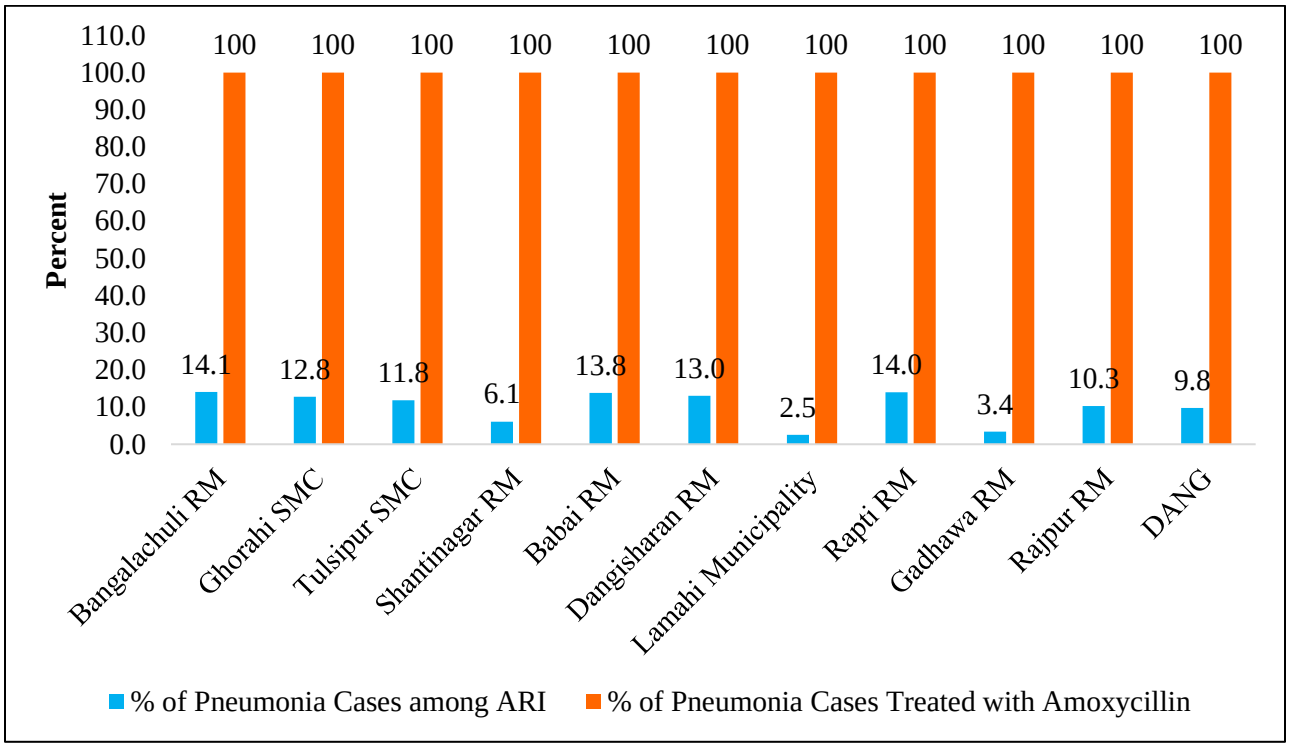


Figure 7: Percentage of Pneumonia Cases among ARI & % of Pneumonia Cases treated with Amoxycillin

The bar graph presents the percentage of pneumonia cases among ARI cases and the percentage of pneumonia cases treated with Amoxycillin across different regions in Dang District. The percentage of pneumonia cases among ARI cases varies across regions. Bangalachuli RM has the highest percentage at 14.1% followed by Rapti RM at 14%. Other regions, such as Ghorahi SMC (12.8%), Tulsipur SMC (11.8%), and Rajpur RM (10.3%) report slightly lower percentages. Lamahi Municipality has the lowest percentage of pneumonia cases among ARI, with only 2.5%. All regions have a 100% treatment rate of pneumonia cases with Amoxycillin. Dang district as a whole reported 9.8% of pneumonia cases among ARI and 100% of them were treated with Amoxycillin.

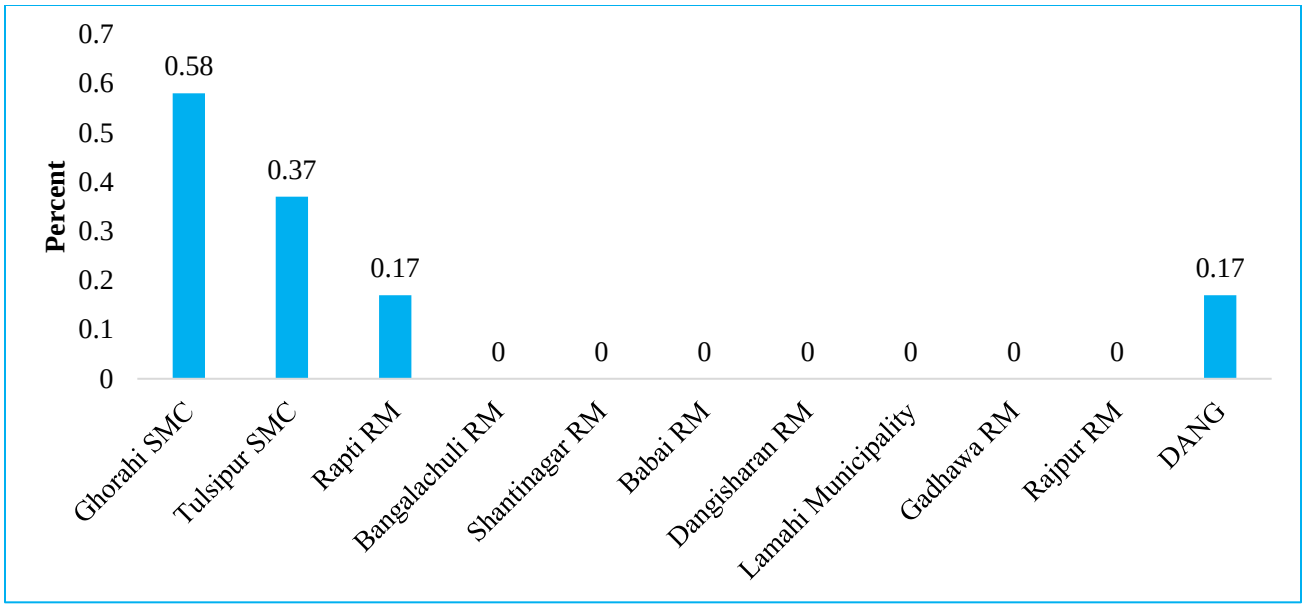


Figure 8: Percentage of severe dehydration among Diarrhea Cases:

The data presents the percentage of severe dehydration among diarrhoea cases in different municipalities and rural municipalities of Dang District. Ghorahi SMC reported the highest percentage with 0.58% of diarrhoea cases experiencing severe dehydration. Tulsipur SMC followed with 0.37% while Rapti RM recorded 0.17%. Bangalachuli RM also reported 0.17%. At the district level, Dang as a whole had a 0.17% rate of severe dehydration among diarrhoea cases.

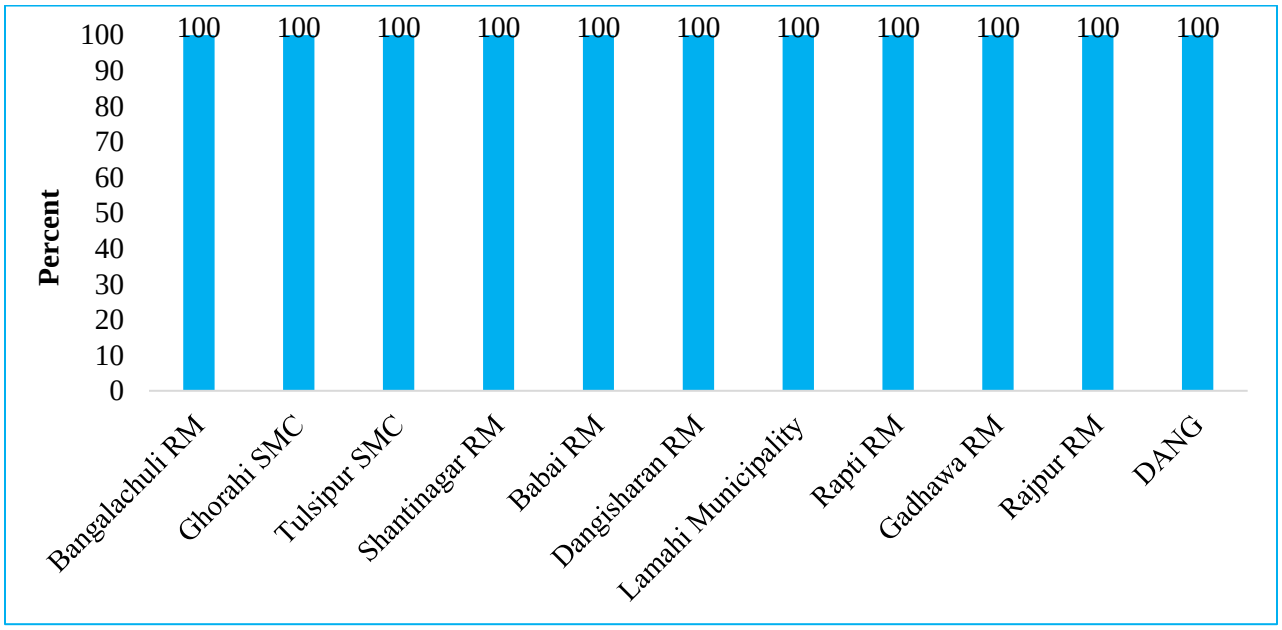


Figure 9: Percentage of Diarrhea Cases treated with ORS & Zinc:

The bar graph shows that 100% of diarrhoea cases in all municipalities and rural municipalities of Dang District were treated with ORS and Zinc. Across the entire district, every diarrhoea case received the same treatment.

Table 9: Morbidity Status and Management by Palika 2-59 months children FY 2080/81

	510 DANG										
Indicators	FY 2080/81	Bangalachuli RM	Ghorahi SMC	Tulsipur SMC	Shantinagar RM	Babai RM	Dangisharan RM	Lamahi Municipality	Rapti RM	Gadhawa RM	Rajpur RM
Total ARI Cases 2-59 Months	13456	1072	1703	2349	1075	758	539	1153	1631	2207	969
2-59Months - Pneumonia	1260	145	201	264	64	103	70	29	211	73	100
PneumoniaTreatment-Amoxicillin	1260	145	201	264	64	103	70	29	211	73	100
(2-59Months)-ARI-Severe Pneu/Very Severe Disease	14	4	2	7	1		0	0	0	0	0
Total Diarrhoea Cases 2-59 Months	5343	347	865	817	302	270	236	400	592	656	858
Diarrhoea Cases 2-59 MonthsTreatment-ORS & Zinc	5343	347	865	817	302	270	236	400	592	656	858
2-59Months Severe Dehydration	9	0	5	3	0		0	0	1	0	0
2-59Month Prolonged Diarrhoea	4	0	0	0	0		0	0	4	0	0
2-59Months-Dysentery	292	24	31	37	5	23	20	9	55	87	1
2-59Months)-Malaria-Falciparum Facility	1	0	1	0	0		0	0	0	0	0
Malaria-Non-Falciparum Facility	0	0	0	0	0		0	0	0	0	0
2-59Months Classification-Measles	0	0	0	0	0		0	0	0	0	0
2-59Months -Severe Malnutrition	170	2	33	47	6	8	31	11	27	3	2
2 to 59 Months-Mild Malnutrition	290	5	56	115	15	15	27	10	33	13	1
2-59 Months-Treatment-Vit A	126	0	16	26	2		31	11	37	1	2
2-59MonthsAnaemia	33	0	0	23	1		1	0	7	1	0
2-59Months Treatment Antehelminthes	350	1	98	78	2	32	33	44	43	17	2
2-59Months Refer-ARI	125	3	4	35	1	4	3	4	36	35	0
2-59Months -Refer-Diarrhoea	4	0	1	3	0		0	0	0	0	0
2-59Months Death-ARI	0	0	0	0	0		0	0	0	0	0
2-59Months Death-Diarrhoea	0	0	0	0	0		0	0	0	0	0
2-59 Mon.Death-Others	1	0	0	1	0		0	0	0	0	0

The table presents the morbidity status and management of children aged 2-59 months across different municipalities and rural municipalities for fiscal year 2080/81 in Dang District. A total of 13,456 ARI cases were reported in this age group. Tulsipur SMC had the highest number of cases (2,349), while Lamahi Municipality had the lowest (539). Pneumonia was recorded in 1,260 of these cases, with Tulsipur SMC having 264 cases, followed by Rapti RM with 211. All pneumonia cases were treated with Amoxicillin across all areas. Severe or very severe disease due to ARI was recorded in 14 cases across the district. Tulsipur SMC had the highest number of severe cases (7). Several municipalities, such as Babai RM, Dangisharan RM, and others, had no reported severe ARI cases.

There were 5,343 diarrhoea cases reported in the same age group. Ghorahi SMC had the highest number of diarrhoea cases (865), while Dangisharan RM had the lowest (236). All diarrhoea cases were treated with ORS and Zinc in every municipality and rural municipality in the district. There were 9 cases of severe dehydration, with 5 cases reported in Ghorahi SMC, 3 in Tulsipur SMC, and 1 in Rapti RM. Four cases of prolonged diarrhoea were reported, all in Rapti RM. Dysentery cases totaled 292, with the highest number in Gadhawa RM (87 cases) and Rapti RM (55 cases). Tulsipur SMC reported 37 cases.

One case of Malaria (Falciparum) was recorded in Ghorahi SMC, and no cases of non-Falciparum malaria were reported in any region.

There were 170 cases of severe malnutrition, with Tulsipur SMC reporting the highest number (47 cases). Mild malnutrition affected 290 children, with the highest number again in Tulsipur SMC (115 cases), while Rajpur RM reported the lowest (1 case). A total of 126 children received Vitamin A treatment, with Rapti RM reporting the highest number (37 cases), while Ghorahi SMC did not report any. Anaemia was recorded in 33 children, with Tulsipur SMC having the highest number of cases (23).

Anthelmintic treatment was given to 350 children, with Ghorahi SMC leading in this category (98 cases), followed by Tulsipur SMC (78 cases). In terms of referrals for ARI, there were 125 cases, with Rapti RM reporting the most (36 cases). There were 4 diarrhoea-related referrals, with Tulsipur SMC reporting 3 case. Referrals for other conditions amounted to 164 cases, with the majority in Tulsipur SMC (42 cases).

No deaths related to ARI or diarrhoea were recorded across the municipalities. There was 1 death from other causes reported in Tulsipur SMC.

SWOT Analysis of CB-IMNCI

Strength	Opportunity
• Local level health facilities capable for assessment and management of under 5 years children. • Trained HR at local level H.F. • Covers both community and facility based managementof the common newborn and childhood illnesses.	• Owership of local government. • Engagement of the private sector. • Mobilization of FCHV at comminity level.
Weakness	**Threat**
• No dedicated human resource at National, Province and distric level. • Lack of dedicated human resource in Hospital for SNCU/NICU/KMCU. • Inadequate IEC and BCC activities • Lack of equipment to deliver new-born and child health services at service delivery points.	• No provision of CB-IMNCI dedicated officer atprovince & municipalities. • Difficulties to implement free new-born care guideline as expected. • Frequently stock-outs of essential commodities indistricts, municipality and community level. • Inappropriate referral mechanism

National Nutrional Program

Introduction:

The National Nutrition Programme is priority programme of the government. It aims to achieve the nutrition well-being of all people so that they can maintain a healthy life and contribute to the country's socioeconomic development. There is a high-level commitment to improve the nutritional status especially of Adolescence, Pregnant and Lactating mother, and Children under five. Nutrition is the intake of food, considered in relation to the body's dietary needs and its appropriate utilization. Good nutrition is essential for sound health and the prevention of diseases. It involves consuming a varied and balanced diet that includes all essential nutrients, such as carbohydrates, proteins, fats, vitamins, and minerals. Deviance from the recommended dietary needs, i.e. insufficiency (undernutrition) or the excess (over nutrition) of macro or micronutrients in our daily diet results in different manifestations of malnutrition.

The usual outcomes of undernutrition are stunting, underweight, wasting and micronutrient deficiencies while the most notable form of overnutrition is obesity. Inadequate nutrition, owing to factors such as the limited of access to nutritious food, poor feeding practices, or certain health conditions that interfere with nutrient absorption, can lead to a variety of health problems in children, adults, and the geriatric population, including growth failure, weakened immune systems, and increased susceptibility to infections and diseases. Over nutrition, on the other hand, resulting from the high intake of unhealthy, calorie-rich foods, a lack of physical activity, or underlying health conditions that exacerbate the body's ability to regulate food intake can lead to weight gain (overweight) and obesity, which multiples the risk of non-communicable diseases such as diabetes, heart disease, and some types of cancer.

Malnutrition is a significant public health problem in Nepal, with malnutrition rates ranking among the highest in the South Asia region. From 1996 to 2022 (NDHS), the national prevalence of stunting among children under five years declined from 57% (severe) to 25% (moderate) while wasting among the same age group dropped from 15% (severe) to 8% (moderate). Despite the gradual reduction in stunting and wasting, the low weight-for-age (underweight) and high prevalence of anemia continues to be a significant impediment to health, social and economic development. With the prevalence of underweight among children under five years at 19% (NDHS 2022), Nepal is faced by a moderate public health problem. Speaking of anemia, over one-third (43%) of children under five years and around one-fourth (23.1%) of women (15-49 years) are anemic in Nepal (NDHS 2022). The situation is even more alarming in the 6-23 months' age group, with over 65% children suffering from anemia.

The Constitution of Nepal 2015 ensure the right to food, health and nutrition to all citizen. Nutrition intervention are cost effective intervention for attaining many of SDGs.**National Nutrition Strategy in 2077 (2020).**

National Nutrition Strategy in 2077 (2020):

National Nutrition Strategy 2077 has been prepared to incorporate the nutrition related strategies included in the NHP 2076, Constitution of Nepal 2072 and fifteenth five year plan 2076/77-2080/81. The duration of this strategy will be from 2077 to 2087 (2020 to 2030).

Basic principles and concepts:

1. Federally structured nutrition plan and activities;
2. Gender equality and social inclusion;
3. Program expansion to underserved groups and communities;
4. Transparency, responsibility, and accountability;
5. Good governance;
6. Evidence-based nutrition service; vii. Private sector engagement;
7. Mobilization of local resources; and ix. Community participation.

Vision: To prepare well-nourished, healthy, happy and capable citizens

Mission: To build a nutrition friendly society.

Goal: To reduce the current problem of malnutrition in line with the Sustainable Development Goals by 2030.

Objectives

- To enhance nutritional well-being, reduce child and maternal mortality and Contribute to equitable human development.

Specific objectives

1. Improve the nutritional status of infant, young children, adolescent girls and women by increasing access to nutrition specific and nutrition sensitive services.
2. Improve the quality of nutrition specific and nutrition sensitive interventions and build capacity of the service providers.
3. Increase the demand of nutrition specific and nutrition sensitive interventions through public awareness promote good nutrition behaviors and inhibit harmful behaviors.
4. Timely expansion of nutrition services.

Key Strategies:

1. **Multi-sectorial nutrition policy and programs including food security will be updated and implemented with high priority.**

   Strategy 1.1: To continue, strengthen and expand the life cycle-based nutrition service.

   Strategy 1.2: To continue coordination and support to improve the quality of nutrition sensitive services.

   Strategy 1.3: To increase the capacity of nutrition service providers to provide nutrition services.

Strategy 1.4: To make institutional arrangements and strengthen in accordance with the federal structure for the implementation of the programs and activities decided by the Multisector Nutrition Plan.
Strategy 1.5: To strengthen multi-sectoral coordination and cooperation
Strategy 1.6: To integrate nutrition services with other health sector programs
Strategy 1.7: To strengthen and promote nutrition related information and communication
Strategy 1.8: To conduct special nutrition programs for the inaccessible classes, communities and regions
Strategy 1.9: To promote nutrition research
Strategy 1.10: To make the monitoring and evaluation of nutrition services effective
Strategy 1.11: To take appropriate initiatives to address the nutritional needs of senior citizens.

2. **Short-term, medium-term, and long-term measures will be adopted at all levels with an emphasis on food diversification and balanced diet to improve the micro-nutrition status of different age groups including women and children.**
   Strategy 2.1: Supplementation to prevent, control and treat micronutrient deficiencies (Short term strategy)
   Strategy 2.2: To fortify various micronutrients in food to prevent micronutrient deficiency in women, adolescents and children (Midterm Strategy).
   Strategy 2.3: To conduct programs for social behaviour change to prevent micronutrient deficiency in women, adolescents and children (Long term strategy).

3. **Programs will be developed and operated by strengthening school health programs and nutrition education.**
   Strategy 3.1: To strengthen and expand the school health and nutrition program**.**

4. **Domestic production will be promoted by encouraging the consumption of various nutritious and healthy foods.**
   Strategy 4.1: To promote domestic food production by encouraging consumption of various nutritious and healthy foods.

Key achievement of National Nutrition Program in FY 2080/81

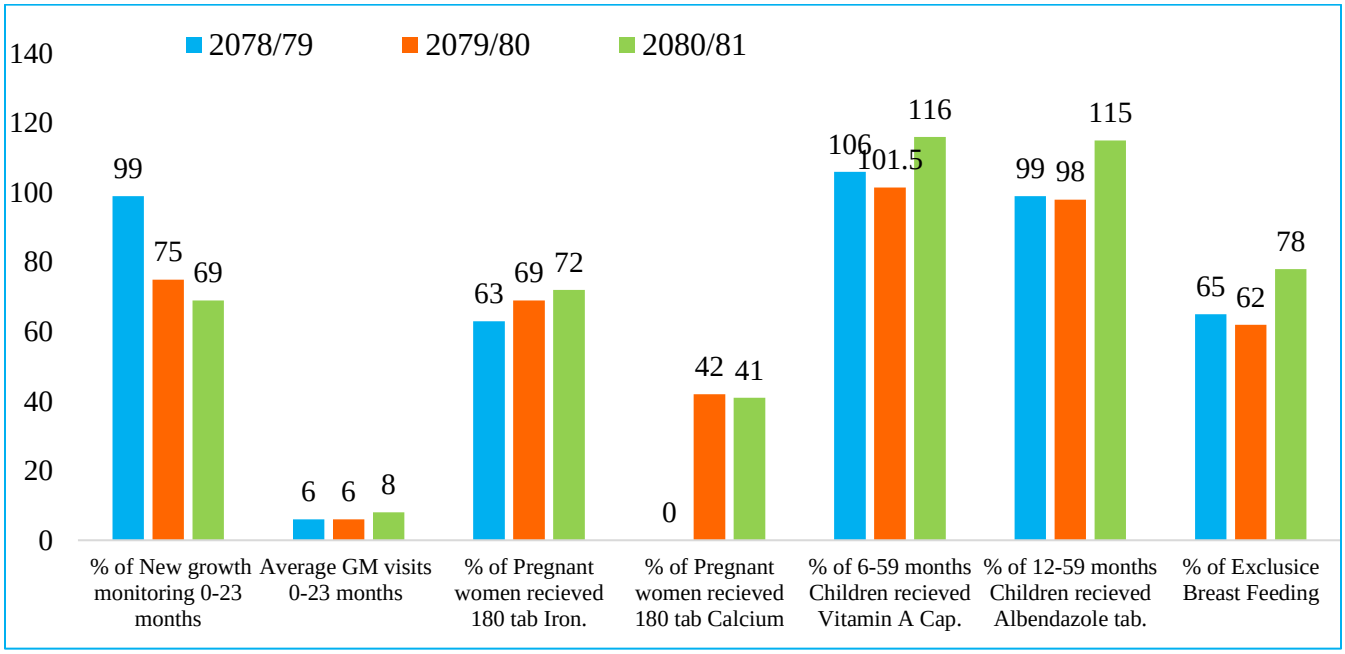


Figure 10: Major indicators of nutrition program

The above figure show percentage of new growth monitoring 0-23 months slightly decresed i.e. 69% in FY 2080/81 and average visits is 8. Percentage of pregnant women received 180 Iron tablets about third fourth (72%) grasually increased by previous year. More than 100% coverage of Vitamin A and Albendazole inUnder 5-year children. And Percentage of Exclusive Breast Feeding is more than third fourth (78%).

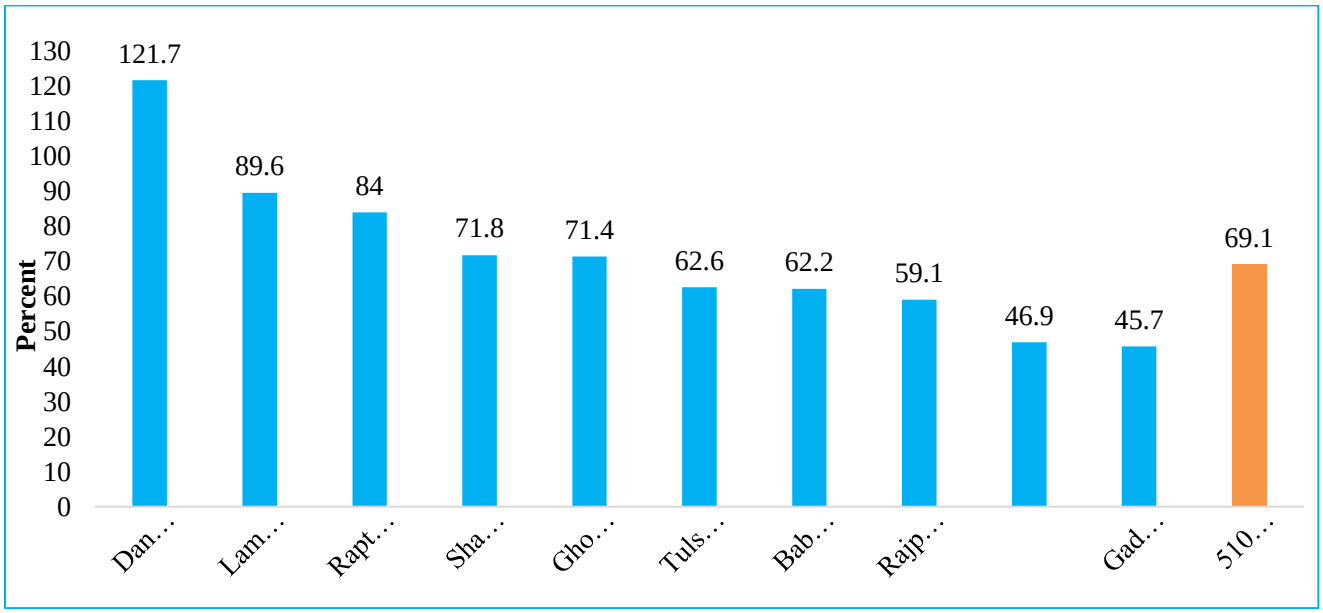


Figure 11: Percentage of growth monitoring 0-23 months age children in FY 2080/81

The data for fiscal year 2080/81 shows the percentage of children aged 0-23 months registered for growth monitoring across various municipalities and rural municipalities in Dang District. Dangisharan RM reported the highest percentage, with 121.7% of children registered for growth monitoring, followed by Lamahi Municipality at 89.6% and Rapti RM at 84%. Shantinagar RM and Ghorahi SMC both reported 71.8% and 71.4% respectively, while Tulsipur SMC and Babai RM each recorded around 62%. Rajpur RM had 59.1%, Banglachuli RM had 46.9% and Gadhawa RM reported the lowest registration percentage at 45.7%. The overall average for Dang District was 69.1%.

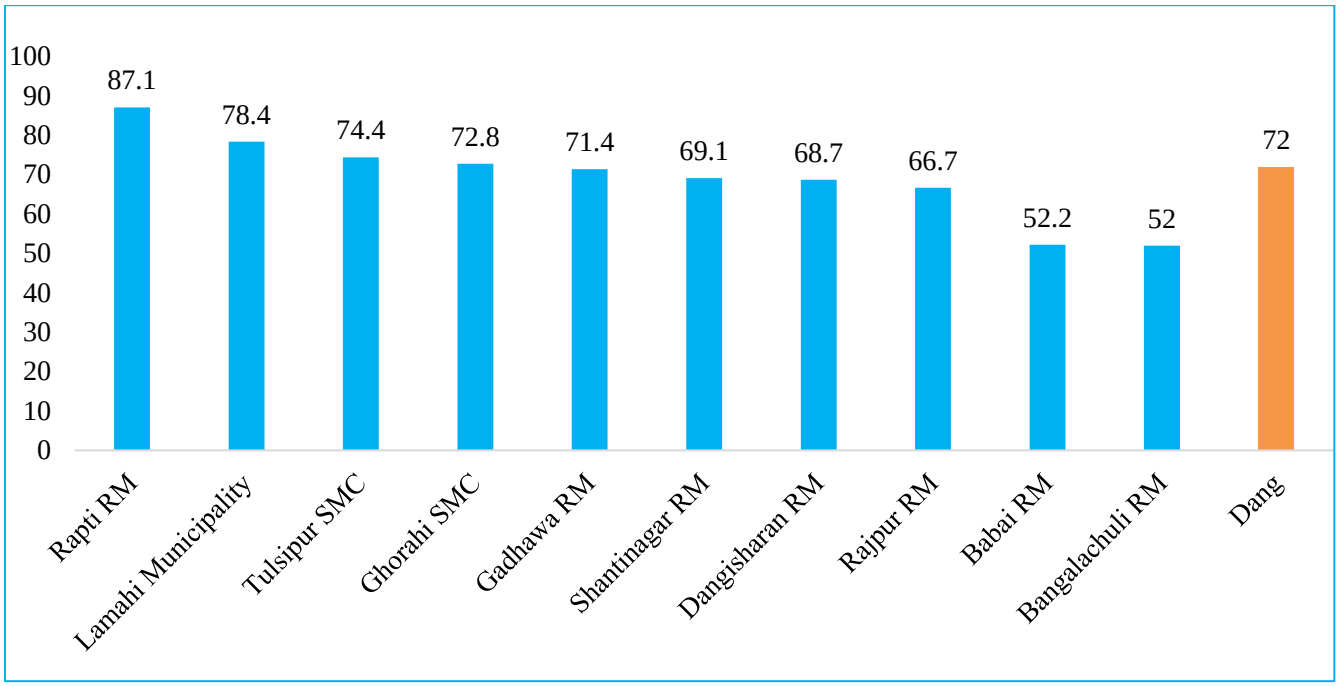


Figure 12: Percentage of 180 180 IFA tablets received by pregnancy women in FY 2080/81

The bar graph for fiscal year 2080/81 presents the percentage of women who received a 180-day supply of Iron Folic Acid during pregnancy across different regions in Dang District. Rapti RM had the highest percentage, with 87.1% of pregnant women receiving the supply, followed by Lamahi Municipality at 78.4%. Tulsipur SMC reported 74.4%, and Ghorahi SMC recorded 72.8%. Other areas such as Gadhawa RM (71.4%) and Shantinagar RM (69.1%) had slightly lower figures.

The percentages continued to decrease in Dangisharan RM (68.7%) and Rajpur RM (66.7%), with the lowest figures reported in Babai RM (52.2%) and Bangalachuli RM (52%). Across the entire district, the overall percentage of women receiving the supply was 72%.

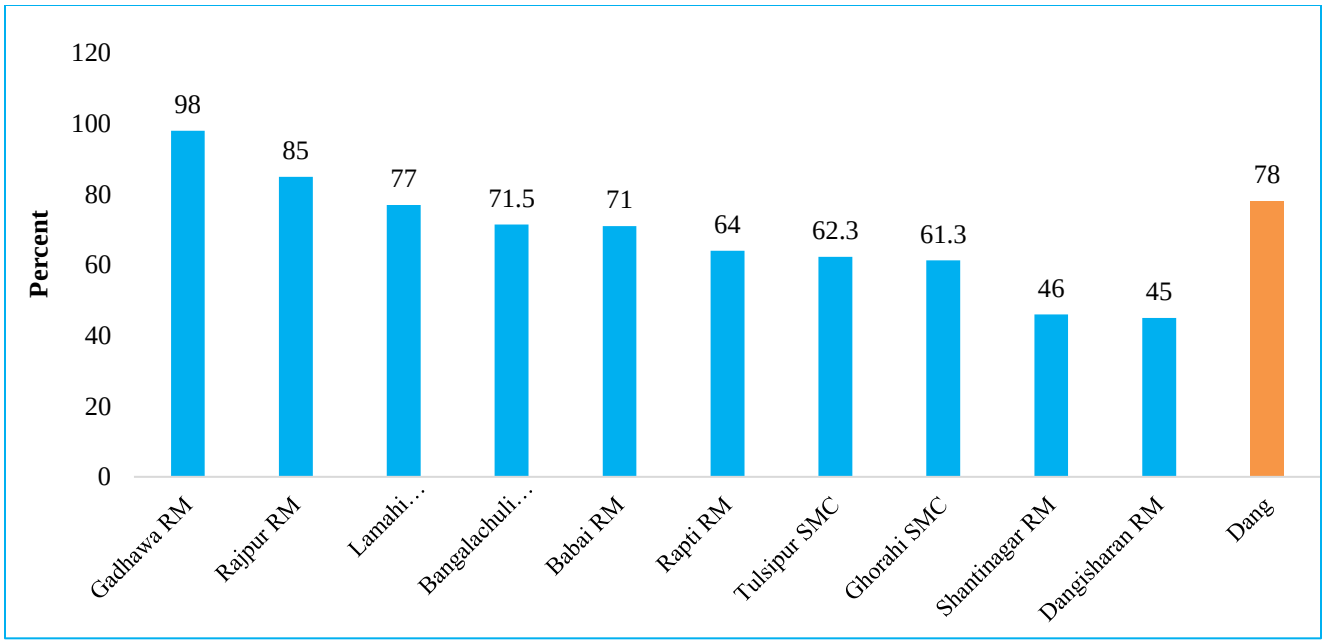


Figure 13: Percentage of exclusively breastfed children in FY 2080/81

The data for fiscal year 2080/81 shows the percentage of children aged 0-6 months registered for growth monitoring who were exclusively breastfed for the first six months. Gadhawa RM reported the highest percentage, with 98% of children exclusively breastfed, followed by Rajpur RM with 85% and Lamahi Municipality with 77%. Banglachuli RM recorded 71.5%, Babai RM recorded 71%, and Rapti RM had 64%. Tulsipur SMC and Ghorahi SMC reported 62.3% and 61.3% respectively, while Shantinagar RM and Dangisharan RM had the lowest percentages at 46% and 45%. Across the entire district, the overall percentage of children exclusively breastfed for the first six months was 78%.

Table 10: Registration and Treatment of SAM Cases in OTC in FY 2080/81

Name of Local level	Total No. of Child in OTC	Cure	Died	Defulter	Not Cure	Reffered to Hospital	No. of Child recieved RUTF
Bangalachuli RM	8	3	0	0	0	0	8
Ghorahi SMC	44	18	0	5	0	5	44
Tulsipur SMC	54	36	0	2	0	2	54
Shantinagar RM	20	4	0	4	0	4	20
Babai RM	19	10	0	2	0	2	19
Dangisharan RM	32	24	0	0	0	1	32
Lamahi Municipality	33	15	1	0	1	1	30
Rapti RM	13	7	0	0	0	0	13
Gadhawa RM	18	13	0	2	0	0	18
Rajpur RM	13	7	0	0	0	0	13
Total	**254**	**137**	**1**	**15**	**1**	**15**	**251**

Table 11: Malnutrition Screening Program

Name of Local level	Total No. of Screened Child	Number of Malnutrition Child			Malnutrition %	Remarks
		SAM	MAM	Total		
Tulsipur SMC	6171	26	140	166	2.7%	
Lamahi Municipality	2335	6	16	22	0.94%	
Rapti RM	1120	75	125	200	17.9%	
Gadhawa RM	172		9	9	5.2%	
Rajpur RM	311	1	6	7	2.3%	
Bangalachuli RM	320	0	2	2	0.63	
Dangisharan RM	1002	0	25	25	2.5	
Shantinagar RM	1503	12	73	85	5.7	
Babai RM	350	5	28	33	9.4	
Total	**13248**	**50**	**495**	**545**	**4.1**	

Malnutrition Screening Program show the highest proportion malnutrition in Rapti RM about 18% and followed by Babai RM 9.4%, Shantinagar RM 5.7%, Gadhawa RM 5.2%, Dangisharan RM 2.5 Rajpur RM 2.3%.

Table 12: Blood Haemoglobin (Anemia) test of school going Adolescent girls.

Name of Local level	Total No. of School	Total Adolescent girls Tested	Anemic Adolescent	% of Anemia	Remarks
Lamahi Municipality	1	281	40	14.23%	
Rapti RM	2	604	160	26.5%	
Gadhawa RM	2	363	124	34.2%	
Rajpur RM	2	448	95	21.2%	
Bangalachuli RM	2	319	13	4%	
Total	**9**	**2015**	**432**	**21.4%**	

Blood Haemoglobin (Anemia) test of school going Adolescent girls program shows the highest anemia of school going Adolescent girls of Gadhawa RM one third portion 34.2% followed by Rapti RM and Rajpur RM.

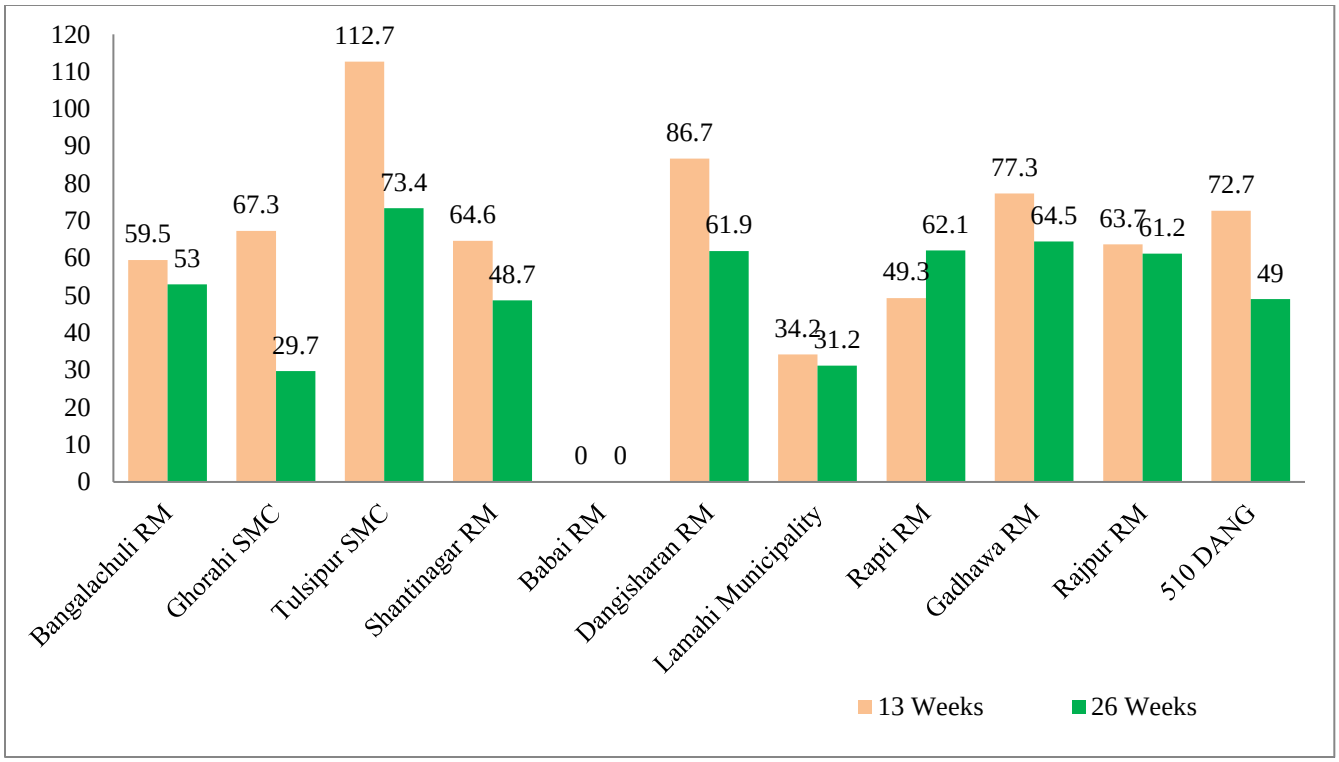


Figure 14: Percentage of adolescent received Iron Folic Acid (IFA)

Fiscal year 2080/81 shows the percentage of girl teenagers who received Iron Folic Acid (IFA) in across different regions of Dang. Tulsipur SMC reported the highest percentage for 13 weeks at 112.7%, followed by Dangisharan RM with 86.7% and Gadhawa RM with 77.3%. Lamahi Municipality recorded lowest percentage at 34.2%. Babai RM reported no data for both categories. For 26 weeks, Tulsipur SMC led again with 73.4%, while Gadhawa RM reported 64.5%. The lowest percentage for 26 weeks was recorded in Ghorahi SMC at 29.7%. Across Dang District, the average percentage of girl teenagers who received Iron Folic Acid for 13 weeks was 72.7%, while 49% of them received it for 26 weeks.

SWOTS Analysis of National Nutrition Program:

Strength	Opportunity
• Regular supply of Nutritional comodities like IFA, Albendazole, Bal-Vita, Vitamin A etc. • Training on comprehensive nutrition specificinterventions (CNSI) package for health workers. • Implementation of IFA supplementation program fora dolescent girls to prevent iron deficiency anemia. • Placement of nutrition volunteers at the local level under MSNP. • 1 NRH functioning in district for management of SAM cases. • Capacity building of local level HR	• Integrating and coordinating with the Education sector for School Health and Nutrition is key to addressing malnutrition in adolescents. • Coverage, compliance, and relevancy of VitaminA supplementation programs can be studied to provide factual support for the continuation of the same approach to control Vitamin A deficiency. • MMS study gives solid conclusion about IFA and MMS. • Advocacy to Malnutrition search. • Need to ensure sustainable financing from the local level.
Weakness	**Threat**
• GMP, IMAM, MNP, and Adolescent IFA interventions have poor coverage, compliance, and service quality. • Early initiation and exclusive breast-feeding trends are weak. • Recording and reporting of nutrition program indicators within HMIS is incomplete and untimely. • Transportation and storage at local levels are unsatisfactory. • Limited allocation of financial resources and delay in disbursement. • There's a lack of a Stadiometer and weight machine in OTC. • No dedicated HR at distric and province level.	• Deep-rooted misconceptions, taboos, and harmful socio-cultural practices related to food and nutrition persist. • Emerging issues of the triple burden of malnutrition (undernutrition, overweight/obesity, and micronutrient deficiencies) are noted. • The trend of bottle feeding is increasing. • Increase consuption of junk and unhealthy foods.

Safe Motherhood and Newborn Health Program:

Introduction:

National Safe Motherhood Programme has been implemented to reduce maternal and neonatal morbidity and mortality; and to improve maternal and neonatal health through preventive and promotive activities and by addressing avoidable factors that cause death during pregnancy, childbirth and the postpartum period.

The fundamental right of citizens to free basic health services from the State is enshrined in the constitution of Nepal, 2015 and Maternal and Newborn Health (MNH) has always been given high priority in Nepal. The Right to safe motherhood and reproductive health act 2018 and its regulation respect, preserve and commit to fulfilling the rights of women to safe motherhood and reproductive health services and to ensure their safety, quality, and accessibility. Nepal is a signatory to the Sustainable Development Goal and has committed to one of the important targets to reduce the Maternal Mortality Ratio to less than 70 per 100,000 live births and reduce the Newborn Mortality Rate to less than 12 per 1000 live births by 2030.

In 1998, the Government's Safe Motherhood Policy adopted two key strategies to improve maternal health: ensur- ing that selected health facilities have emergency obstetric care services that are available 24 hours a day and the presence of health personnel with midwifery skills who can competently provide safe and effective delivery care.

The Family Welfare division (FWD) developed the Safe Motherhood and New-born Health (SMNH) Roadmap (SMNH), 2030 which aims to ensure a healthy life for and the well-being of, all mothers and newborns. Nepal's SMNH Road Map 2030 is developed with a focus on ending preventable maternal and newborn deaths, by building on the successes of the SMNH Programme and addressing the remaining challenges, especially around strengthening community health system platforms and improving institutional quality of care in an equitable manner.

The goal of the **National Safe Motherhood Programme** is to **reduce maternal and neonatal morbidityand mortality and improve maternal and neonatal health** through **preventive and promotive activities**and by addressing avoidable factors that cause death during pregnancy, childbirth and the postpartumperiod.

Evidence suggests that **3 delays are important factor**s for maternal and newborn morbidityand mortality in Nepal. They are**Delay in seeking care**, **Delay in reaching care** and **Delay in receiving care.**

The major 3 strategies have been adopted to reduce risks during pregnancy & childbirth mortality & morbidity:

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

Family Welfare division (FWD) developed Safe Motherhood and New-born Health Roadmap, 2030 which aims to ensure a healthy life for and the well-being of, all mothers and newborns.

Goal: - Ensuring healthy lives and promoting wellbeing for all mothers and newborns.

Five Outcomes

I. Increased the availability of high-quality maternal and new-born health services leaving no one behind.
II. Increased the demand for and utilization of equitable maternal and new-born health services.
III. Improved governance and ensured accountability of maternal and new-born health services.
IV. Improved monitoring and evaluation of maternal and new-born health services.
V. Strengthened emergency preparedness of maternal and new-born health services.

Six Pillars of Safe motherhood: -

- Family Planing,
- Ante Natal Care (ANC)
- Obstretic care,
- Post Natal Care (PNC)
- Safe abortion Services,
- HIV/AIDS & STIs control.

Provisions of the Aama Programme and New born programme

Aama programme provision

a. **For women delivering their babies in health institutions:**
   Transport incentive for institutional delivery: Cash payment to women after institutional delivery **NPR 3,000** in mountains, **NPR 2,000** in hills and **NPR 1000 in** Tarai districts. **Incentive for 4 ANC visits:** A cash payment of **NPR 800 to women on completion of 4 ANC** visits at 4, 6, 8 and 9 months of pregnancy, institutional delivery and postnatal care.

   Free institutional delivery services: A payment to health facilities for providing free delivery care. Health facilities get reimbursement by unit cost**; NPR 2,500 for normal delivery**, NPR **4,000 for complicated delivery,** NPR **10,000 for caesarean section,** NPR 5,000 for Anti-D administration for RH negative and NPR **7,000 for Molar pregnancy.**
   For **complicated deliveries** health facilities receive **NPR 3,000** and for **Cesarian sections (surgery) NPR 7,000**. Anti-D administration for RH negative is reimbursed **NPR 5,000.**

b. **Incentives to health service provider:** For deliveries: A payment of NPR 300 to health workers for attending all types of deliveries **to be arranged from health facility reimbursement amounts**.

Key Achivement of MNH Program in FY 2080/81

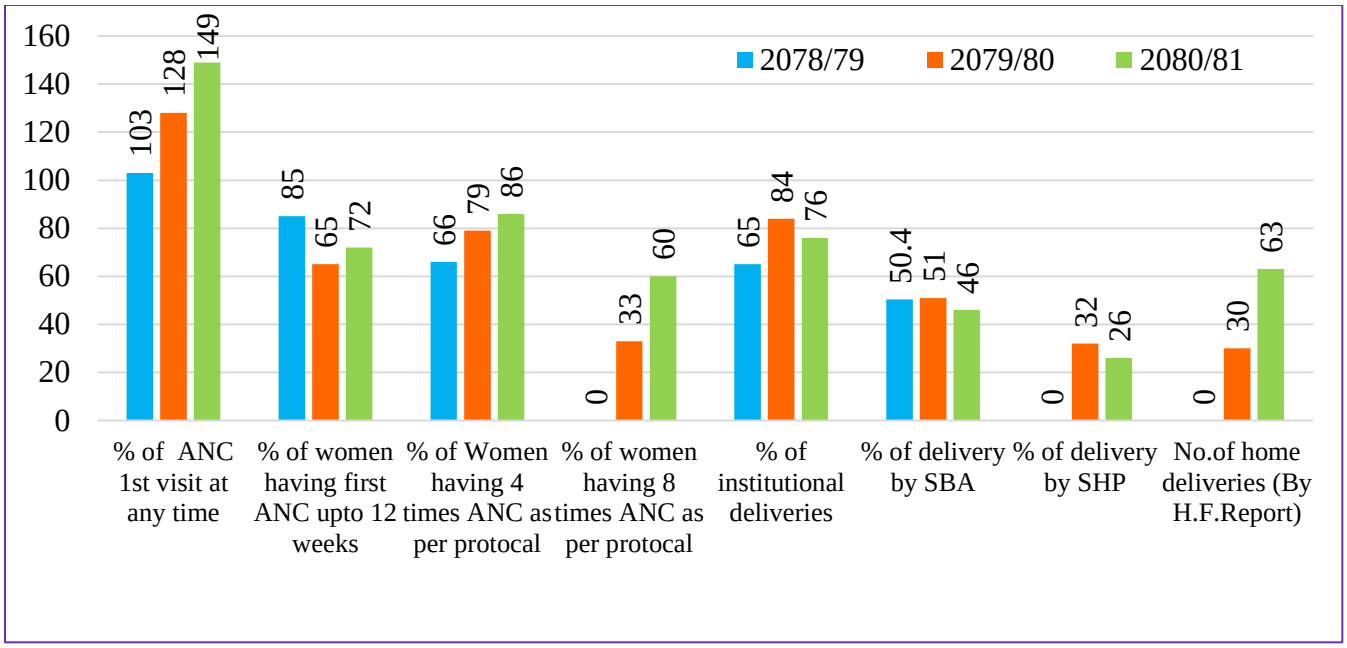


Figure 15: Three-year trend of major indicators of safe motherhood program.

In Dang District, the proportion of pregnant women who received their first antenatal care at any time accordingly to increasing from 128% in Fy 2079/080 to 149% in 2080/081. Percentage of women receiving first ANC checkups as per protocol is increased by 7% from FY 2079/080 (65%) to FY 2080/81 (72%) in Dang District. Similarly, percentage of women receiving four ANC checkups as per protocol is increased by 7% from FY 2079/080 (79%) to FY 2080/81 (86%) in Dang District. The propertion of pergnant women who received their eight antenatal contacts according to protocol in FY 2080/081 is 60%.the percentage of institutional deliveries in

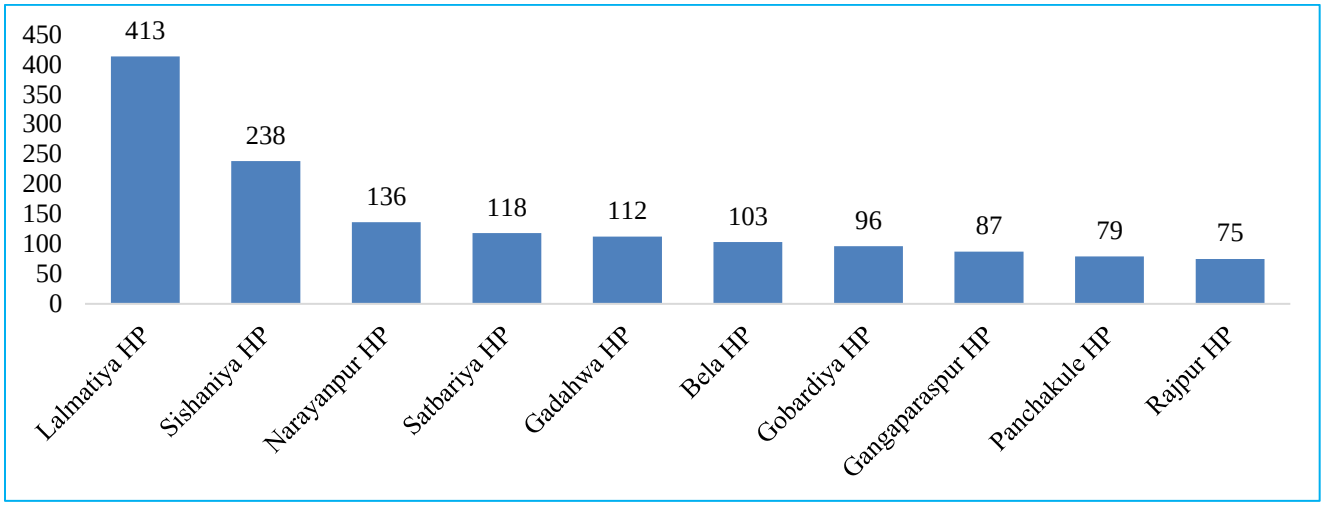


Figure 16: Highest number of Delivery in Birthing Center FY 2080/81

The total number of birthing centre are 43 and the total number of instutional delivery, Highest in Lalmatiya HP (413) followed by Sishaniya HP (238), Narayanpur HP (136) in FY 2080/81.

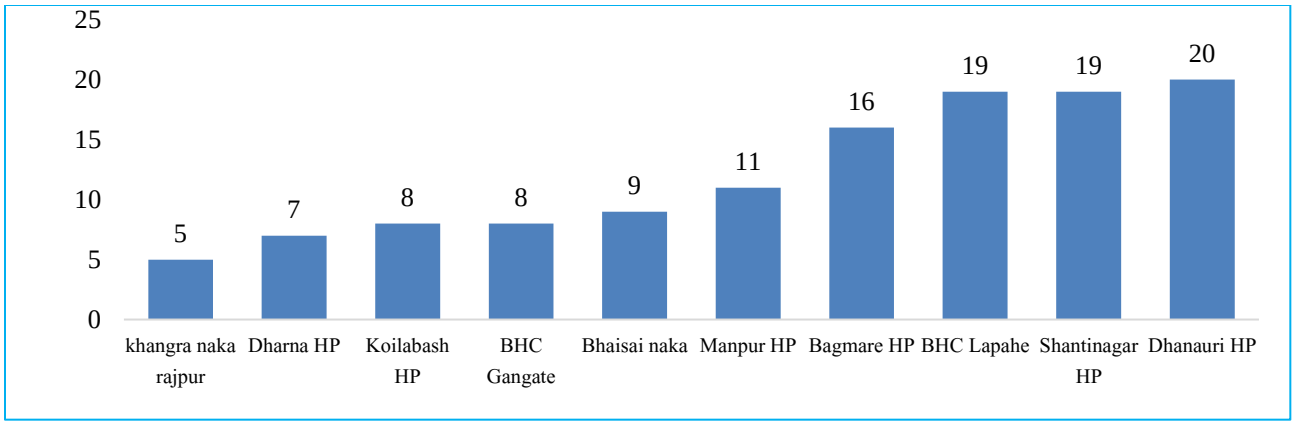


Figure 17: Lowest number of Delivery in Birthing Center: FY 2080/81

In dang District the total number of birthing centre is 43 and instutional delivery in Lowest 10 birthing center is Khangra naka Rajpur (5), Dharna HP (7), Koilabash HP (8), BHC Gangate (8), Bhaisai naka Rajpur (9), Manpur HP (11), Bagmare HP (16), BHC Lahape (19), Shantinagar HP (19), Dhanauri HP (20) in FY 2080/81.

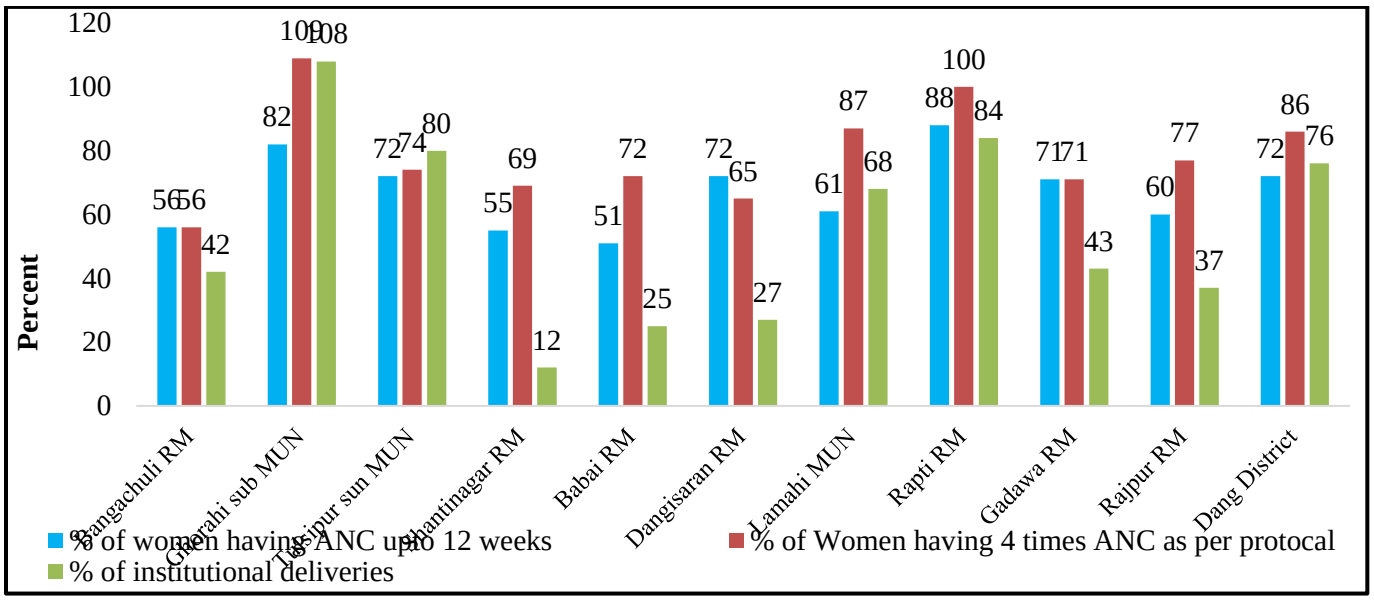


Figure 18: Maternal and neonatal health status of FY 2080/81.

In Dang District, the percentage of women who had four ANC visit is higher (86%) than the percentage of women who have first ANC visit (72%). ANC fourth visit is in increasing trend as compared to first visit in almost palika. Similarly, the percentage of instutional deliveries is in decreasing trend in last two years trend FY 2079/80 (84%) and FY 2080/81(76%).

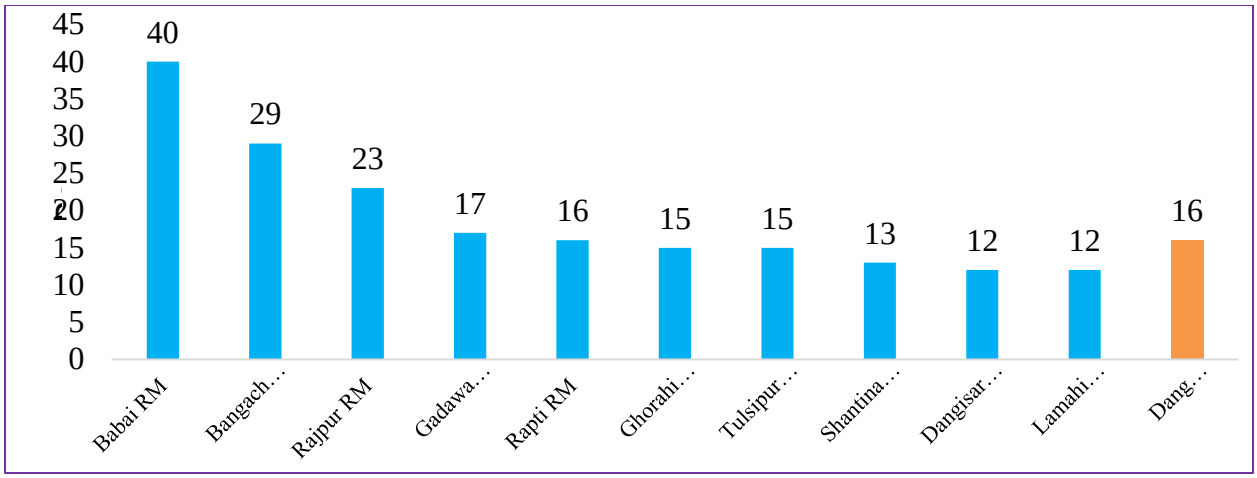


Figure 19: Percentage of Deliveries <20 years of FY 2080/81

In the fiscal year 2080/081, Dang District recorded 16% of deliveries below 20 years of age among total institutional deliveries. Within Dang District, Babai RM has the highest percentage (40%) of deliveries below the age of 20 followed by Bangachuli RM (29%) and Rajpur RM (23%). This data indicates a higher pervalence of childbirth among adolescents which highlights the need for targeted intervention and healthcare strategies.

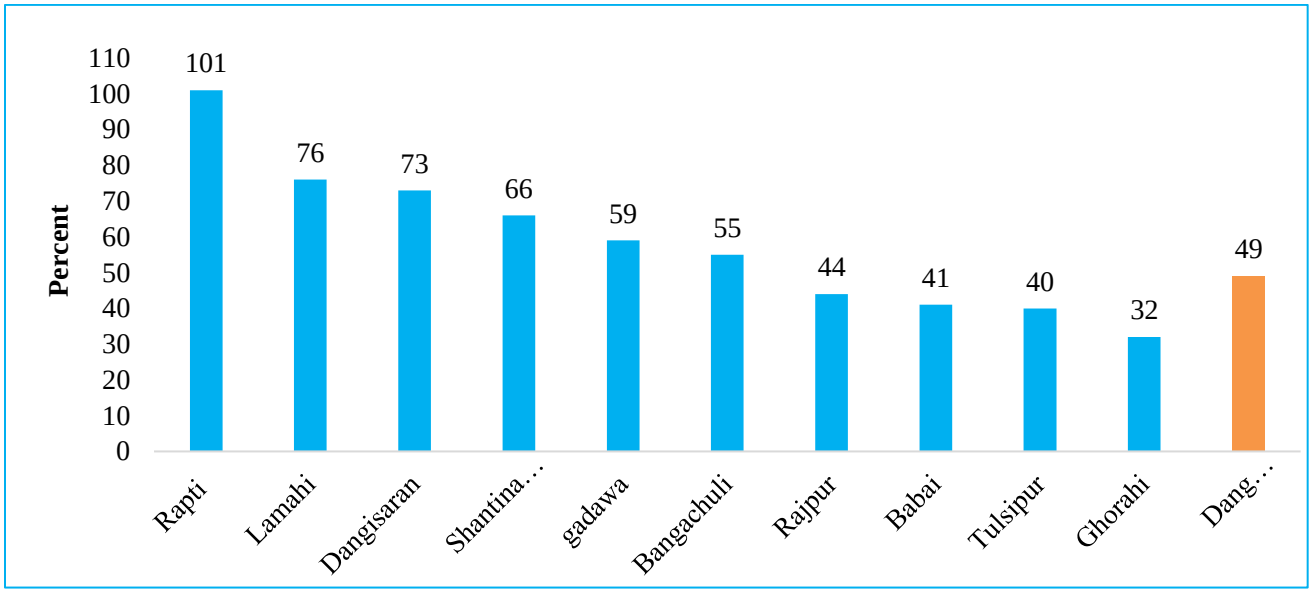


Figure 20: Percentage of PNC Visits 3 times as per protocol: FY 2080/81

The mother attending three PNC visit as per protocol in 2080/081 and service coverage of three PNC visits care is 49% in Dang District. Highest in Rapti ga pa 101% and lowest in Ghorahi 32%.

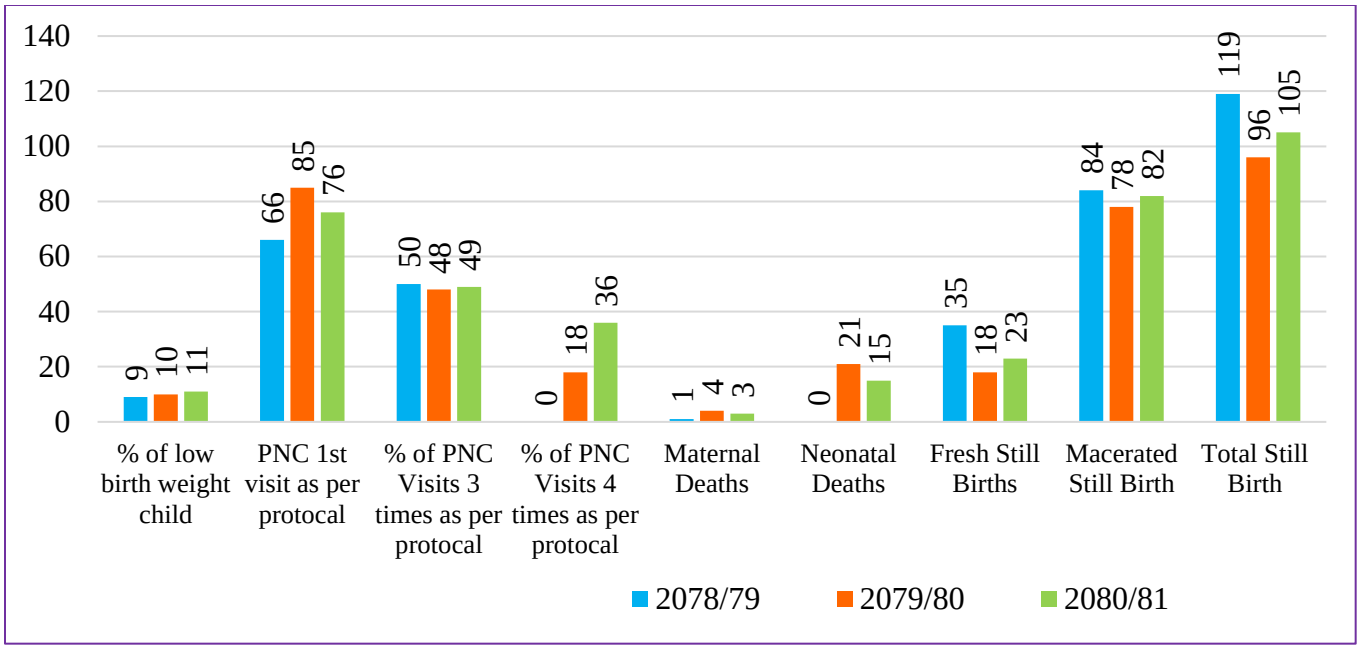


Figure 21: Trend of major indicators of MNH program

Percentage of low birth weight child in the past three years is increasing from 9% to 11% in FY 2080/081. Percentage of postpartum women who received PNC checkup within 24hrs of delivery in the past 2 years is decreasing from 85% to 76% in FY 2080/081.The proportion of mothers attending three PNC visits as per protocol slightly increasing in Dang District from 48 % in 2079/080 to 49 % in FY 2080/081.Government of Nepal endorsed ANC to PNC continuum of care guideline in 2079 B.S. according to revised protocol , four PNC care at 42 days of delivery is started in 2079/80 and service coverage of four PNC visits care is 36% in Dang district. In Dang district, 3 maternal death, 15 neonatal death and 105 stillbirths were reportde in ficial year 2080/081. The number of maternal and neonatal death in FY 2080/081 was significantly lower than in FY 2079/080.

Maternal and Perinatal Death Surveillance and Response (MPDSR)

GoN prioritized and implemented MPDSR in FY 2073/74 MPDSR with further strengthening & expansion. Government of Nepal (GoN) developed MPDSR guidelines 2015. Community-based MPDSR: Community based MPDSR program was implementing in 21 districts 99 hospitals. In addition, there are MPDSR committees formed at PHD, Health Office, health facility level and LLGs. The committee meeting has to commence within 72 hours of every maternal death. The national committee and TWG meet on quarterly bases and as per need.

Table 13: Three Years MPDSR Report

Name of palika	2078/79		2079/80		2080/81	
	Total no. of maternal death	Conducted VA	Total no. of maternal death	Conducted VA	Total no. of maternal death	Conducted VA
Bangachuli RM	0	0	0	0	0	0
Ghorahi SMC	0	0	1	0	1	0
Tulsipur SMC	0	0	7	7	4	4
Shantinagar RM	0	0	1	1	0	0
Dangisaran RM	0	0	0	0	1	1
Babai RM	0	0	1	1	1	1
Rapti RM	0	0	0	0	1	1
Gadhawa RM	0	0	0	0	0	0
Lamahi MUN	0	0	1	0	0	0
Rajpur RM	0	0	0	0	0	0
Total	**0**	**0**	**11**	**9**	**8**	**7**

Table 14: Reproductive Health Morbidity FY 2080/081

VIA	HPV, DNA, VIA and Pap Smear & Others	
	Screened	Positive
Total number of 30-49 years female	**4404**	**191**
Number of 50 years above female	**740**	**36**
Number of Ablative Treatment	0	
Number of Colposcopy	0	

Table 15: Breast Cancer Screening FY 2080/081

Breast Cancer	<40 years	40-70 years	>70 years
Screened	253	238	7
Suspected	2	2	0

Table 16: Uterine Prolapsed Screening FY 2080/081

Uterine prolapse (number of women)		
Screened		3935
Prolapsed Cases	Stage 1&2	**584**
	Stage 3	**128**
	Stage 4	**37**
Ring Pessary insert		**329**
Reffer		**45**
Surgery		**21**

SWOT Analysis of MNH Program:

Strength	Opportunity
• Coaching mentoring program for continuous improvement of quality of care • Regular case auditing through MPDSR program hasbeen expanded. • PNC Visit of CS and Home delivery. • Rural Ultrsound Program running. • Continuous capacity building and HR support.	• Initiation of ownership of local government for Birthing Center establish and HR placement. • Integrating MNH QI tools with other programs/tools for integrated supervision.
Weakness	**Threat**
• Inadequate Budget for MNH program includings upervision and monitoring. • Inefficient implementation of DQSA. • Maternal/newborn deaths at health facilities. • Increase numbers of home delivery and still birth and Maternal death.	• Timely referral from remote areas and execution of emergency referral funds/air lift. • Natural disasters like flooding, landslides, earthquakes etc.

Family Planning Program

Introduction:

Family Planning (FP) program is a long-standing program in Nepal. The aim of the National FP program is to ensure individuals and couples fulfill their reproductive needs and rights by using quality FP methods voluntarily based on informed choices. Government of Nepal (GoN) is committed to equitable and right based access to voluntary, quality FP services based for all individuals with special focus on hard-to-reach communities such as adolescents and youths, migrants, slum dwellers, ethnic minorities, sexual minorities, and other vulnerable groups ensuring no one is left behind.

To achieve this, GoN is committed and striving to strengthen policies and strategies related to FP within the federal context, mobilize resources, improve enabling the environment to engage effectively with supporting partners, promote public-private partnerships, and involve health and non-health sectors. Modern Family planning (FP) refers to female sterilization, male sterilization, intrauterine contraceptive device (IUCD), implants, injectables, pills, condoms (male), lactational amenorrhea method (LAM), emergency contraceptive (EC) and standard days method (SDM).

FP information, education, communication, and services are provided through the government, social marketing, NGOs and the private sector (including commercial sectors). In the public health system, short acting reversible contraceptive methods are provided through all levels of health service centres. FCHVs provide information and education at community and distribute male condoms and resupply OCPs. Access to LARC services in remote areas is provided through satellite clinics, visiting service providers and mobile camps. Sterilization services are provided at static sites or through scheduled seasonal and mobile outreach services. FP services are also provided through private and commercial outlets such as NGO run clinics/centers, private clinics, pharmacies, hospitals, including academic hospitals. FP services and com- modities are made available by some social marketing (and limited social franchising) agencies.

Family Planning (FP) has been enshrined as a fundamental right in the constitution and included in the basic health service package under the Public Health Service Act 20751. In addition, the Safe Motherhood and Reproductive Health Act 20752, Safe Motherhood and Reproductive Health Regulation 20773, 15th National Plan (2076/77-2080/81) as well as Safe Motherhood and Newborn Roadmap (2076-2087) emphasizes the availability and accessibility of right-based FP services.

The strategic focus involves ensuring access and utilization of high-quality, client-centered FP services, particularly targeting underserved populations and achieving SDG targets. Efforts are directed towards reducing contraceptive discontinuation, scaling up successful innovations, generating evidence, and linking FP services with delivery and demand generation interventions.

Modern Family planning (FP) refers to female sterilization, male sterilization, intrauterine contraceptive device (IUCD), implants, injectables, pills, condoms (male), lactational amenorrhea method (LAM), emergency contraceptive (EC) and standard days method (SDM).

Objectives, policies and strategies

- The overall objective of Nepal's FP programme is to improve the health status of all people through informed choice on accessing and utilizing client-centred quality voluntary FP Services.

The specific objectives are as follows:

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

Status of Family Planning Program in FY 2080/81

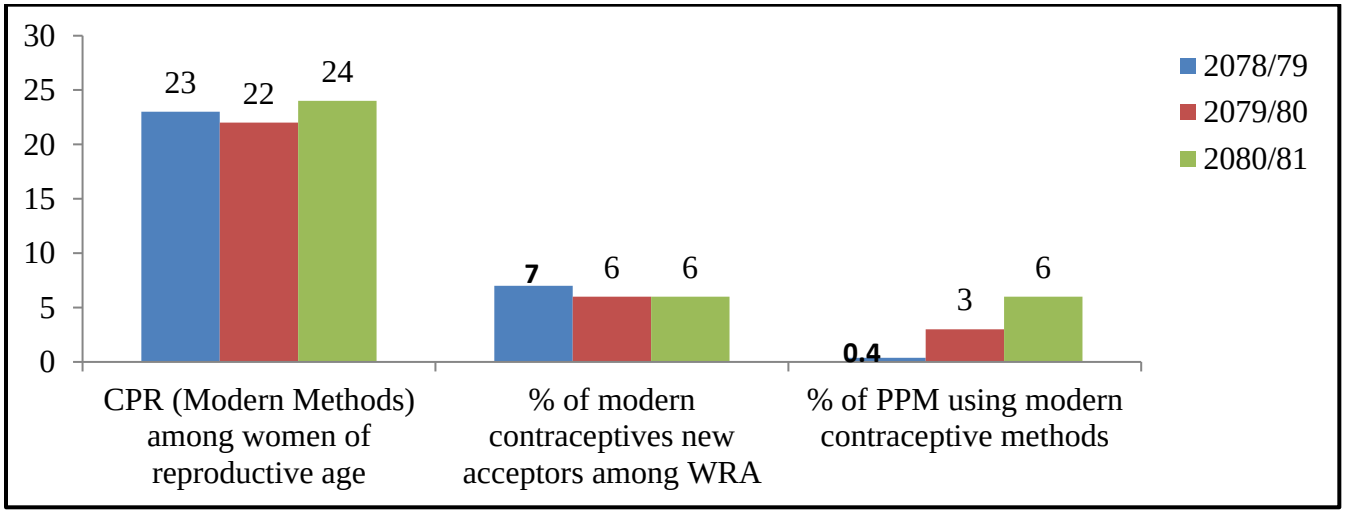


Figure 22: Trend of CPR (Unadjusted)

The status of contraceptive prevalence rate of Dang District has been in increasing trend over the last three years. In the fisical year 2080/081 in Dang District, percentage of modern contraceptive new acceptors among WRA was 6% in ficial year 2080/081, compared to 6% in fiscal year 2079/080. The post- partum family planning user in increasing trend in Dang District 6%, compared to 3% in fiscial year 2079/080.

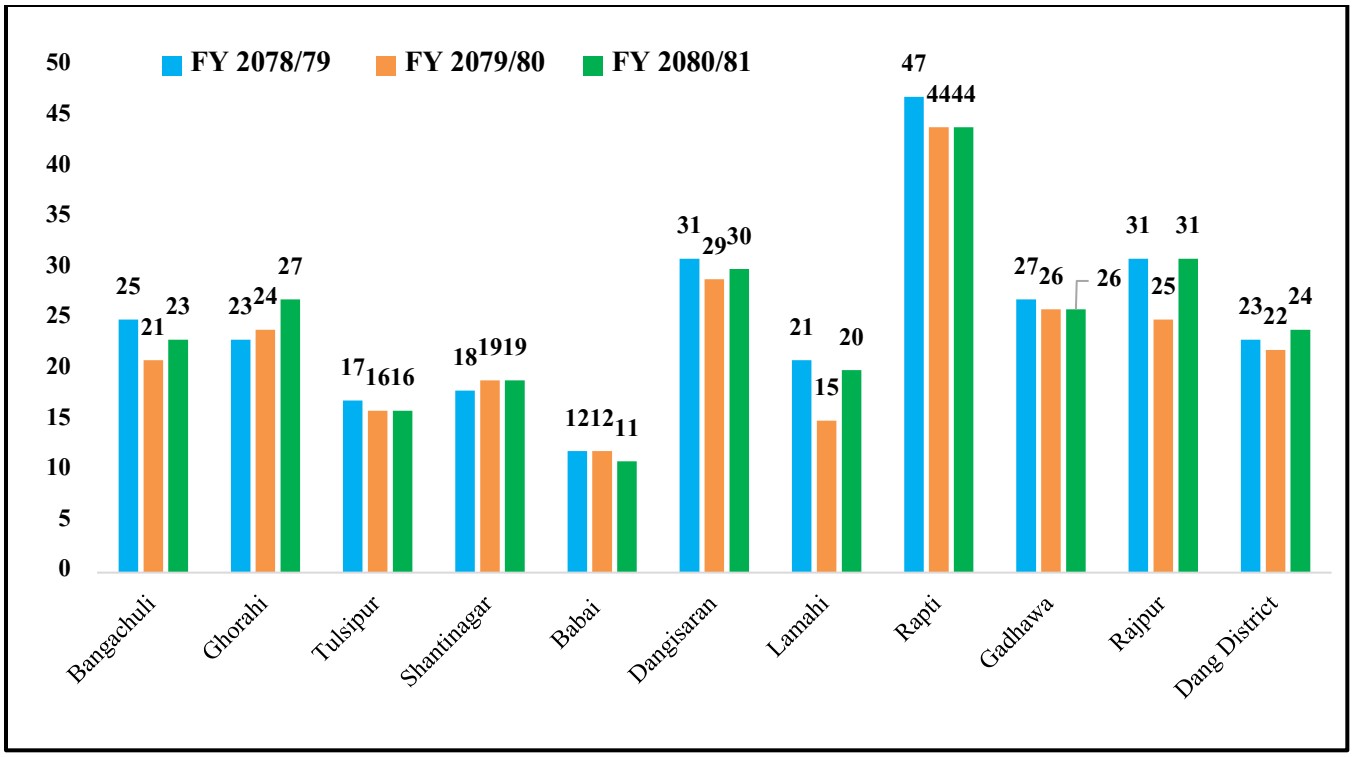


Figure 23: Palika wise 3-year trend of CPR

The status of contraceptive prevalence rate of Dang District has been in increasing trend over the last three years. In Fiscal year 2080/081, the highest percentage of contraceptive prevalence rate was in Rapti 44% and the least in babai 11%.

Table 17: Safe Abortion Services in FY 2080/81:

Safe Abortion Service		Up to 12 Weeks		> 12 weeks	
		Medical	Surgical	Medical	Surgical
Total number of SAS service	<20 years	85	70	16	0
	≥ 20 years	1164	1009	75	2
Post abortion FP User	Short term acting Method	774	478	34	0
	Long Acting Method	109	254	2	0
Post abortion complicaton		**8**	**0**	**1**	**1**

SWOT Analysis of Family Planning Program

Strength	Opportunity
• Adoption of new and innovative approaches. • Strong coordination mechanism through different thematic committees at local level. • Emphasis on evidence generation and practice of evidence-based planning	• Government's commitment on FP programs (FP 2030 commitment). • Integrate FP and RH services with other programs • Private sector engagement and partnership • Supporting partners and donors.
Weakness	**Threat**
• Service disruption due to unavailability of program related commodities. • Low Coordination with federal government. • Inadequate monitoring of quality of services. • Integration of FP service data from private sector yet to be done. • Limited understanding of FP program investment, expenditure and return.	• Program budget for FP and RH is continuously decreasing. • Challenges in coordination with private H.F. or Clinic. • Untimely supply of FP commodities by approved distributors.

National Tuberculosis Control and Management Program

Introduction:

Tuberculosis (TB) is a communicable disease which is a major public health problem in Nepal. It is one of the top 10 causes of death worldwide and in Nepal, and the leading cause of death from a single infectious agent (ranking above HIV/ AIDS). TB is caused by the bacillus Mycobacterium tuberculosis, which is spread when people who are sick with TB expel bacteria into the air; for example, by coughing. The disease typically affects the lungs (pulmonary TB) but can also affect other sites (extrapulmonary TB). About a quarter of the world's population is infected with Mycobacterium tuberculosis, which is similar for Nepal.

Tuberculosis (TB) is a significant public health issue in Nepal, being a leading cause of global mortality. Caused by Mycobacterium tuberculosis, it primarily affects the lungs but can also manifest in other areas. With nearly a quarter of the global population infected, TB is linked to poverty and disproportionately impacts adults, particularly men. Despite being curable and preventable, access to diagnosis and care falls short of UHC, affecting a substantial portion of the population in Nepal. Annually the program assesses the current.

TB epidemic status, progress in response efforts, and the impact of COVID-19, drawing on data from various sources, including NTCC, HMIS, Nepal Tuberculosis Program Management Information System (NTPMIS) and WHO country profiles.

TB can affect anyone anywhere, but most people who develop the disease are adults, there are nearly twice as many cases among men than women, and 30 high TB burden countries account for almost 90% of those who fall sick with TB each year. TB is a disease of poverty, and economic distress, vulnerability, marginalization, stigma and discrimination are often faced by people affected by TB. TB is curable with medicine (nearly 90% cure rates) and preventable.

TB Burden Estimates

Based on the National TB prevalence survey report 2076 (2020), TB prevalence in Nepal is 1.8 times, incidence is 1.6 times and TB mortality is 3.1 times higher than the previous estimates**.**

Table 18: Comparison between the pre-and post-survey TB burden, 2075 (2018)

Year	Incidence (all forms)	Prevalence (all forms)	Mortality (HIV Neg. & Pos.)
2075 (2018) New estimates	69,000 (245 per 100k)	1,17,000 (416 per 100k)	17,003 (9,000-26,000)
2075 (2018) Prior estimates	42,000 (151 per 100k)	60,000 (215 per 100k)	5,500 (3,900 - 7,400)
Revised burden, higher by:	1.6	1.8	3.1

Table 19: Nepal TB burden estimates, 2078 (2022)

	Number	(Rate per 100,000 population)
Total TB incidence	70,000 (43,000-117,000)	229 (141-382)
HIV-positive TB incidence	540 (290-870)	1.8 (0.94-2.8)
MDR/RR-TB incidence**	2,900 (1,200-4,600)	9.5 (4-15)
HIV-negative TB mortality	18,000 (9,100-29,000)	58 (30-94)
HIV-positive TB mortality	220 (110-360)	0.71 (0.37-1.2)
Estimated proportion of TB cases with MDR/RR-TB*, 2078 (2022)		
New cases % (CI)	4% (3.6-4.4)	
Previously treated cases % (CI)	6.3% (0.97-20)	

National Tuberculosis Program:

Vision: - TB Free Nepal by 2050 AD.

By 2050 Eliminate TB as Public Health Problem. (<1 case per million population).

Goal: - To reduce the TB incidence rate by 20% from 2015 to 2021. and identify additional 20,000 new TB cases by next 5 years.

Objectives:

Objective 1:

- To increase case notification through improved health facility-based diagnosis; increase diagnosis among children (from 6% at baseline to 10% of total cases by 2021); examination of household contacts and expanded diagnosis among vulnerable groups within the health service, such as PLHIV (from 179 cases at baseline to over 1,100 cases in 2020/21), and those with diabetes mellitus (DM).

Objective 2:

- To maintain the treatment success rate of 90% for all forms of TB (except drug resistant TB) by 2021.

Objective 3:

- To provide DR TB diagnosis services to 50% of the presumptive MDR TB patients by 2018 and 100% by 2021 and to successfully treat at least 75% of those diagnosed.

Objective 4:

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

Objective 5:

- To gradually scale up the Community System Strengthening Program (CSS) at 60% of the local administrative units by 2018 and to 100% of the administrative units by 2021. It will help in creating a patient-friendly ambiance in the health facilities, advocacy for TB

patients regarding their rights which will, in turn, contribute to the diagnosis and management of TB cases.

Objective 6:

- To contribute to health system strengthening through HR management and capacity development, financial management, infrastructure, procurement, and supply management in TB.

Objective 7: To develop comprehensive Monitoring and Evaluation system

Objective 8:

- To develop plans so that NTP can function even at times of crises like natural disasters or public health emergencies.

The End TB Strategy

VISION: A world free of TB. (Zero deaths, disease and suffering due to TB)

GOAL: - End the Global TB Epidemic**.**

Milestones For 2025:

1. **75**% reduction in TB deaths (compared with 2015).
2. 50% reduction in TB incidence rate (less than 55 TB cases per 100,000 population).
3. No affected families facing catastrophic costs due to TB.

Targets For 2035:

1. 95% reduction in TB deaths (compared with 2015)
2. 90% reduction in TB incidence rate (less than 10 TB cases per 100,000 population)..
3. Families facing catastrophic costs due to TB is Zero.

The strategy's components (three pillars) and related strategies are as follows:

1. Integrated, patient- entered care and prevention:

- Early diagnosis of TB including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups. Treatment of all people with TB including drug-resistant TB.

2. Bold policies and supportive systems:

- Political commitment with adequate resources for TB care and prevention. The engagement of communities, civil society organizations, and public and private care providers.

3. Intensified research and innovation:

- The discovery, development and rapid uptake of new tools, interventions and strategies.

National Strategic Plan (NSP) 2079/80- 2083/84 (2021/22-2025/26) for TB

Goal:

- Nepal has set a goal to decrease incidence rate from 238 in 2078/79 (2020/21) to 181 per 100,000 populations by 2083/84 (2025/26); decrease mortality rate from 58 in 2078/79 (2020/21) to 23 per 100,000 by 2025/26; end TB epidemic by 2091/92 (2035); eliminate TB by 2107 (2050); and reduce the catastrophic cost to zero

Objectives:

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

Strategies

- Improve the quality of TB services and strengthen the health system for universal access to TB services; effectuate the TB services and support by increasing the community engagement in TB management, and strengthen the digitalized case-based surveillance system in health care
- Strengthen laboratory services to further improve the management of TB diagnosis and treatment.
- Quality Improvement of the services for TB prevention, identification and treatment.

Table 20: Target of National Strategic Plan (NSP) 2079/80- 2083/84

Indicators	Milestones		Targets	
	2076/77 (2020)	2081/82 (2025)	SDG 2087/88 (2030)	END TB 2091/92 (2035)
Reduction in number of TB deaths compared with 2015 (%)	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	20% (<85/100,000)	50% (<55/100,000)	80% (<20/100,000)	90% (<10/100,000)
TB Affected Families facing catastrophic costs due to TB (%)	Zero	Zero	Zero	Zero

TB preventive treatment (TPT)

- The National Strategic Plan (NSP) of TB for the period 2021/22-2025/26 emphasizes the initiation of TB Preventive Treatment (TPT) among children under 5 years old. As part of this strategy, NTP aims to expand TPT services not only among this specific age group but also to other identified risk groups across all 77 districts by the conclusion of the NSP period.

TB free Nepal initiative

- The TB Free Nepal Initiative represents a comprehensive government-led approach aimed at enhancing the ownership and accountability of local-level governance in the response to TB. In the fiscal year 2078/79, the initiative was introduced in 25 LLGs out of the total

753, backed by an additional federal budget of NRs 150 million. This initiative encompasses various interventions, including intensified TB case finding, expanded access to TB prevention therapy improved quality treatment, increased care and social protection schemes/support, and effective community engagement.

- The implementation of the initiative requires structural improvements, including the allocation of additional designated human resources at the local level/ municipality. Various committees have been formed at different levels to strengthen the TB support system. Tools such as TB microplanning and social audit are being applied to ensure meaningful community engagement and the sustainability of the initiative.

Status of NTP FY 2080/81:

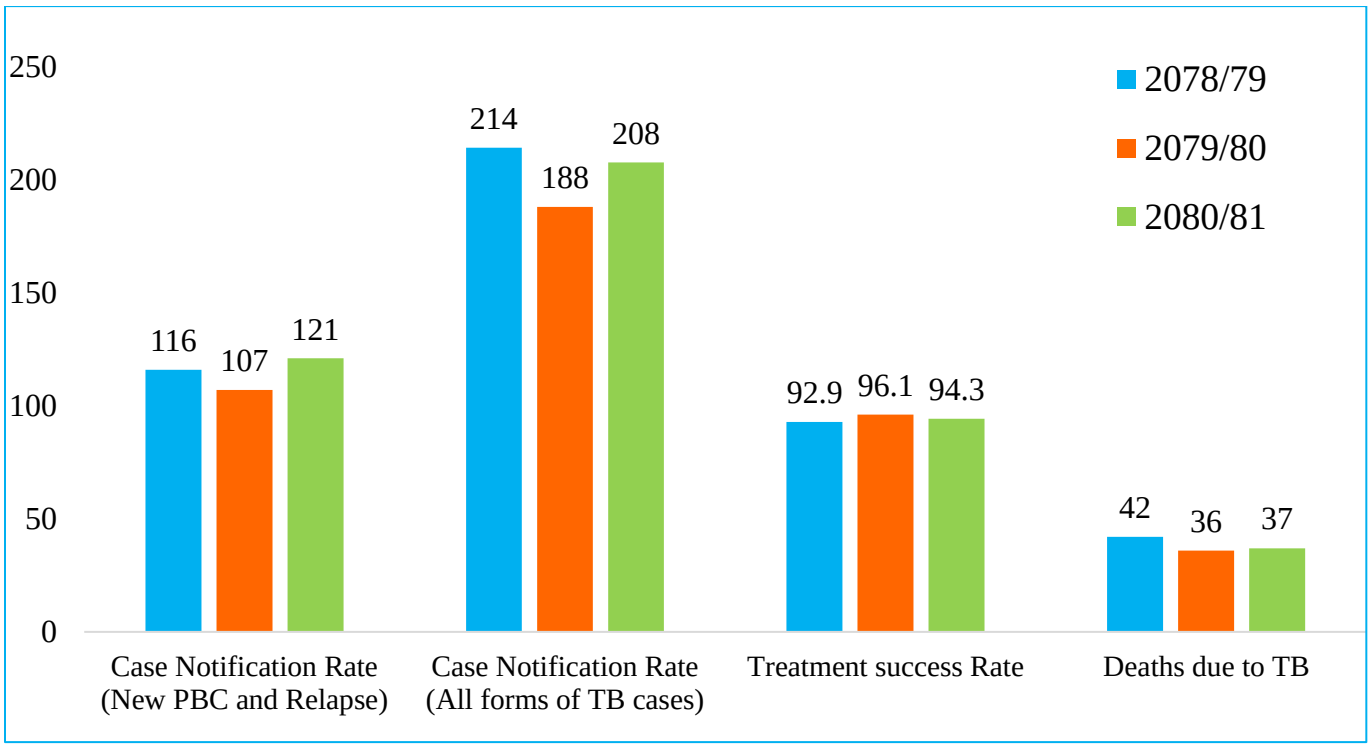


Figure 24: Trend of major TB Indicator

The above figure shows the 3-year trend of CNR of All form of TB cases is increase in FY 2080/81, 208 per lakh population and CNR of New PBC and Relapse TB cases also increased as compare to previous two year. DS TB treatment success rate is 94% i.e. meet national target of TSR. And Death due to TB 37 in FY 2080/81.

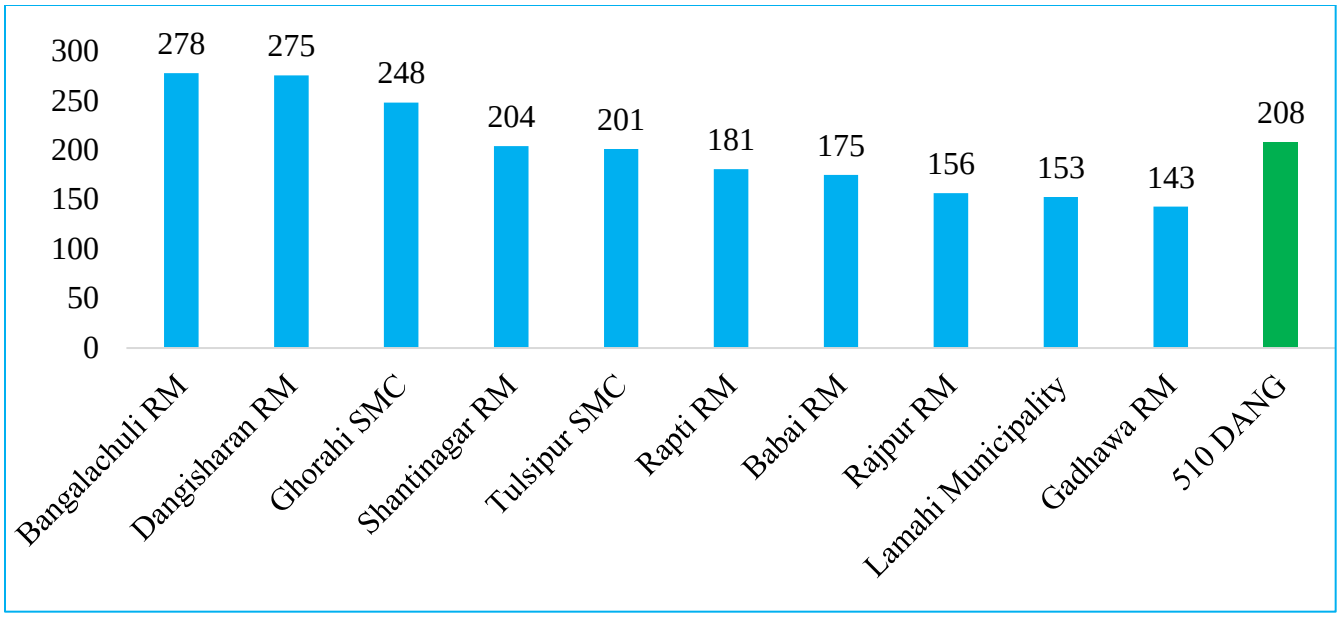


Figure 25: Palika Wise Case Notification Rate All FormTB in FY 2080/81

The above figure shows the Palika wise CNR of All form of TB cases in FY 2080/81, the highest CNR is 278 in Bangalachuli RM, followed by Dangisharan RM 275, Ghorahi SMC 248, Shantinagar RM 204 and lowest in Gadhawa RM 143 per lakh population.

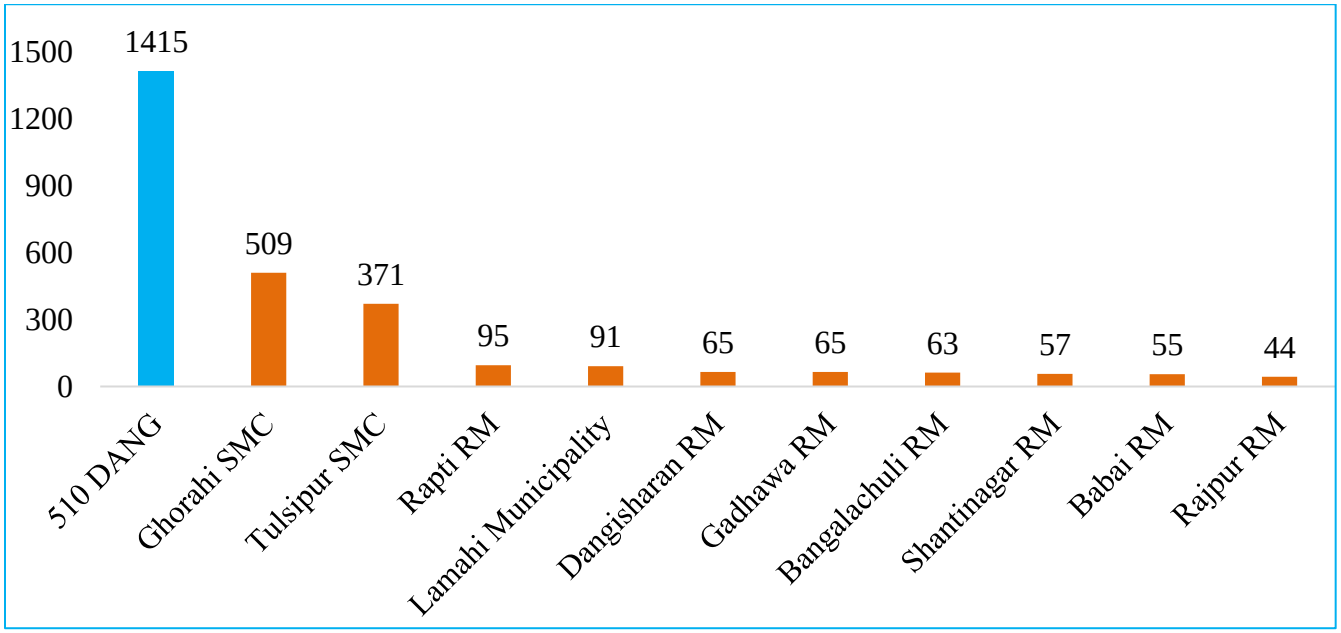


Figure 26: Palika Wise total number of TB Case (All Form) FY 2080/81

The above figure shows the Palika wise total 1415 TB cases in FY 2080/81, the highest number of TB cases 509 in Ghorahi SMC, followed by Tulshipur SMC 371, Rapti RM 95 and lowest in Rajpur RM 44 TB cases.

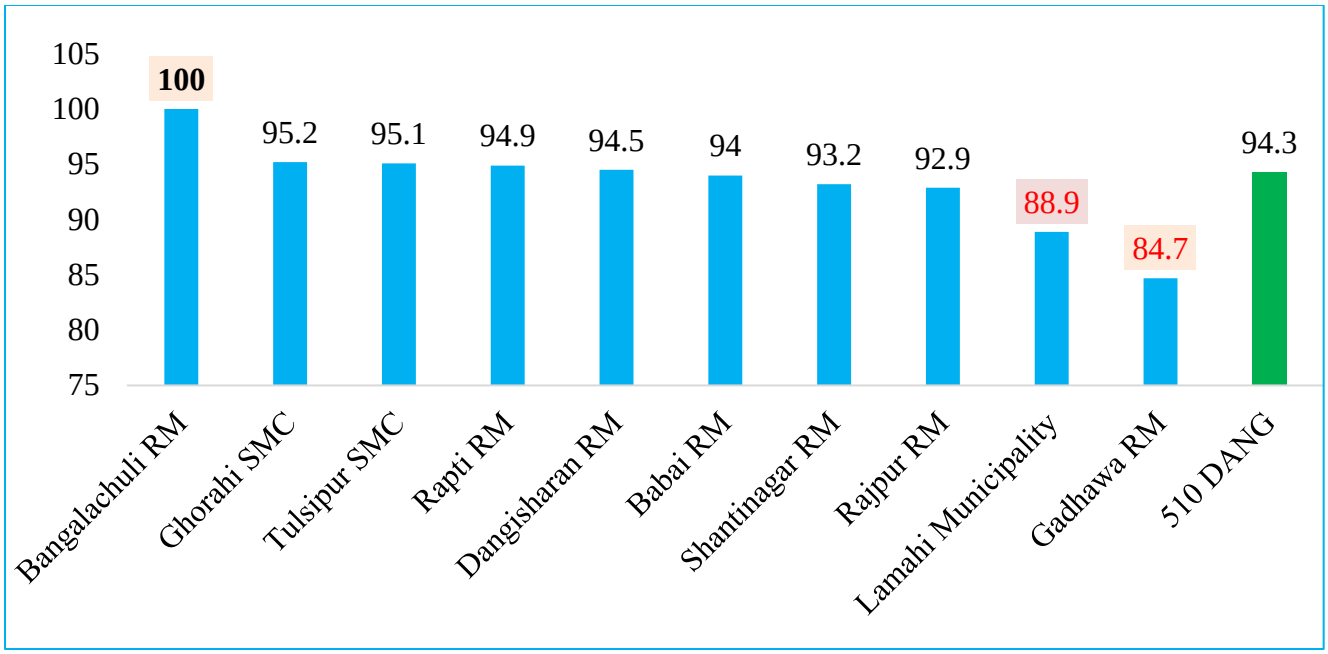


Figure 27: Palik wise DS-TB Treatment Success Rate (TSR) FY 2080/81

The above figure shows the DS TB treatment success rate (TSR) is 94% in FY 2080/81, the highest TSR is 100% in Bangalachuli followed by Ghorahi SMC 95%, Tulshipur SMC 95, Rapti RM 94.9% and low TSR is 88.9% in Lamahi Municipality and Lowest in Gadhawa RM 84.7%.

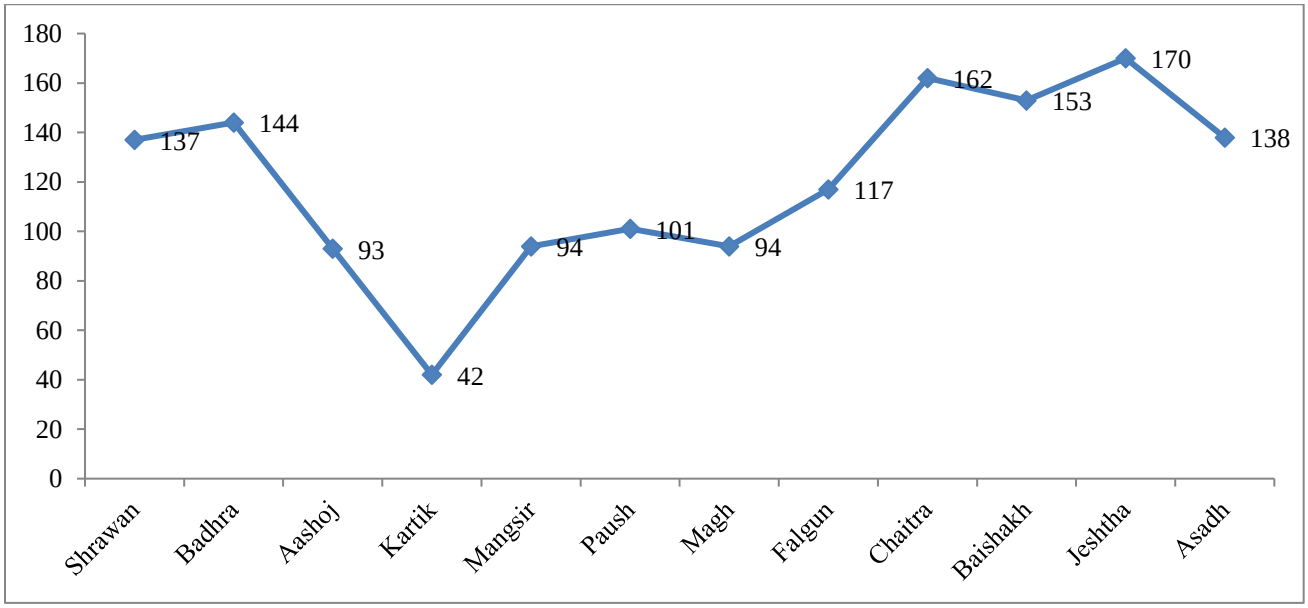


Figure 28: DS-TB Cases distribution by month in FY 2080/81

The above figure shows the highest number of TB cases diagnosed in Jeshtha 170, followed by Chaitra 162, Baishakh 153, Badhra 144 and lowest in Kartik 42 due festival like Dashain, Tihar and Chhath puja in FY 2080/8.

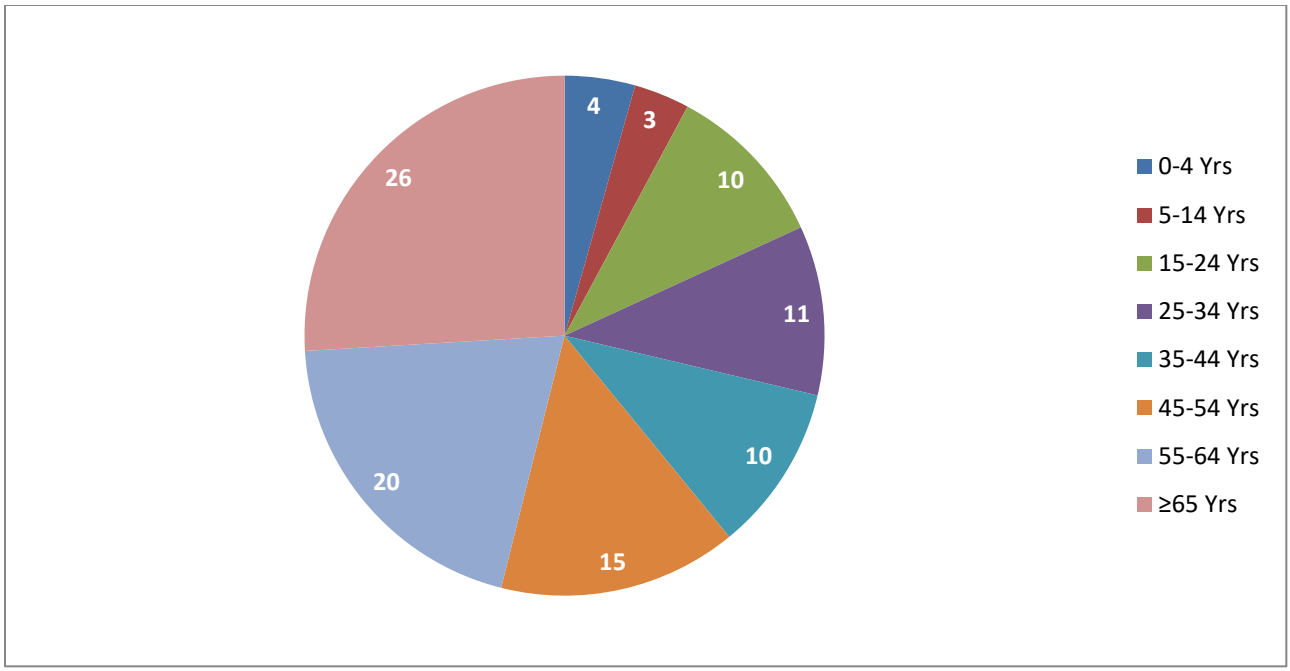


Figure 29: Age wise distribution DS-TB Cases in FY 2080/81

The above figure shows the highest number of TB cases 26 % in age group ≥ 65 yrs, followed by 20% in age group 55-64 yrs, 15% in age group 45-54 yrs and low in age group 5-14 yrs.

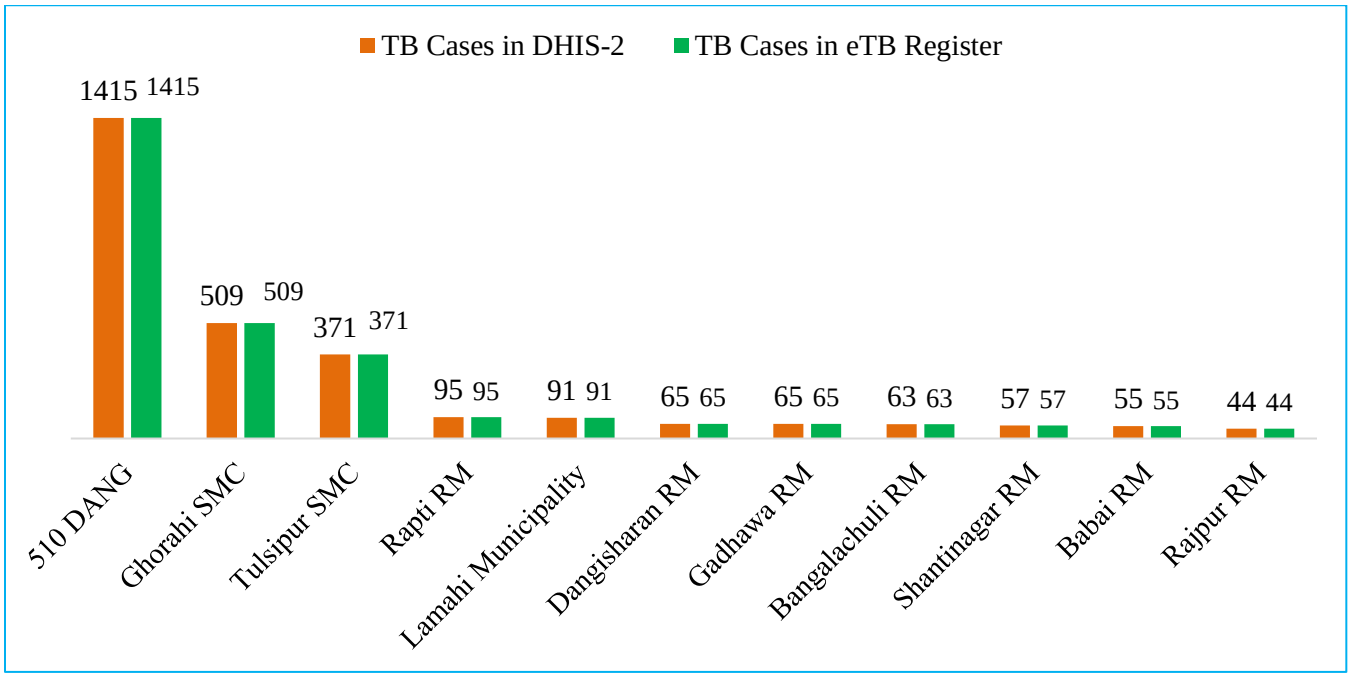


Figure 30: DS-TB Cases in DHIS-2 Vs eTB Register in FY 2080/81

The above figure shows that the all TB cases entry in DHIS-2 and eTB Register in FY 2080/81.

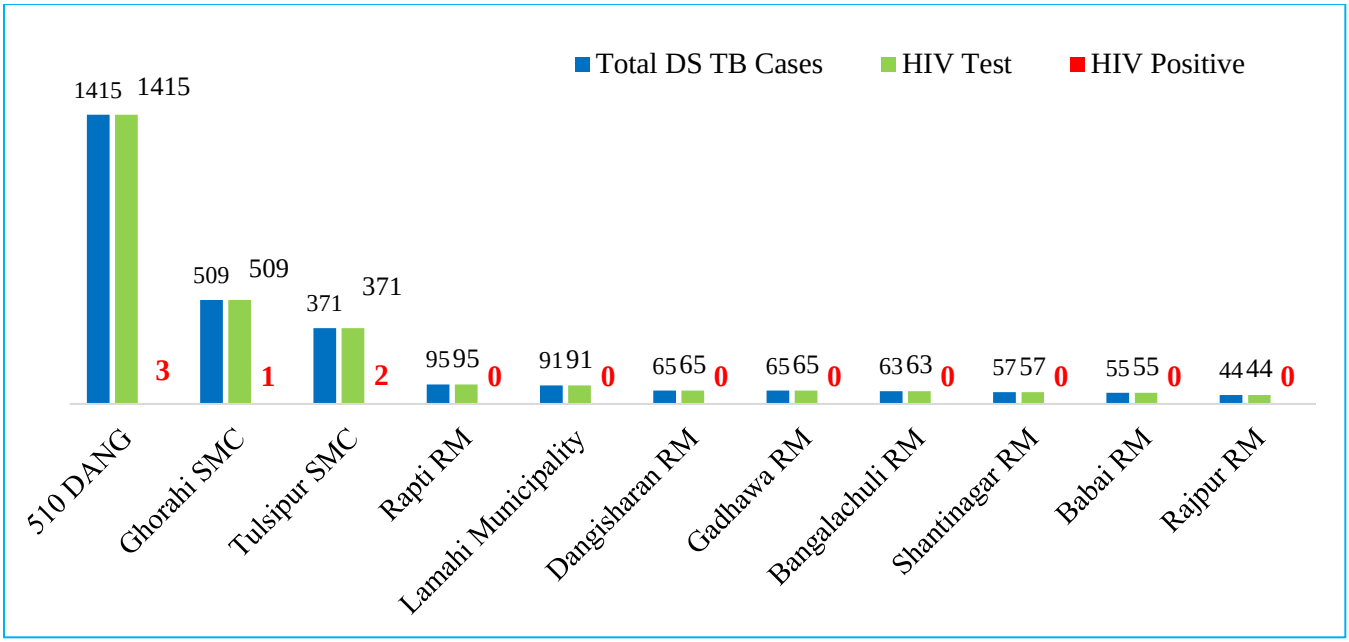


Figure 31: Total DS-TB Cases and HIV test in FY 2080/81

The above figure shows the all TB cases tested HIV, among among them 3 cases are TB-HIV co-infection in FY 2080/81.

Drug Resistant Tuberculosis (DR-TB):

Drug Resistant Tuberculosis (DR-TB) is a critical public health challenge in Nepal, necessitating innovative approaches and increased funding for national programmatic management. The focus is on detecting and enrolling more patients in MDR TB treatment to enhance outcomes.

Types of DR-TB

1. **Rifampicin resistant TB (RR-TB)** is resistant to rifampicin (detected using rapid diagnostic tests), with or without resistance to other anti-TB drugs. It includes RR/MDR (SSTR) and includes RR/MDR (LTR).
2. **MDR- TB (Multi-Drug Resistant TB)** is the resistant of Both Rifampicin and Isoniazide TB drugs**.**
3. **Pre-extensively drug resistant TB (Pre-XDR TB)** is a multi-drug resistant strain of TB that is also resistant to either one of the fluoroquinolones and all the second line injectable drugs.
4. **Extensively drug resistant TB (XDR TB)** is a severe form of MDR-TB that is multidrug-resistant (MDR-TB) to all the fluoroquinolones and second line injectable drugs.

Achievemnt of DR-TB Cases in FY 2080/81

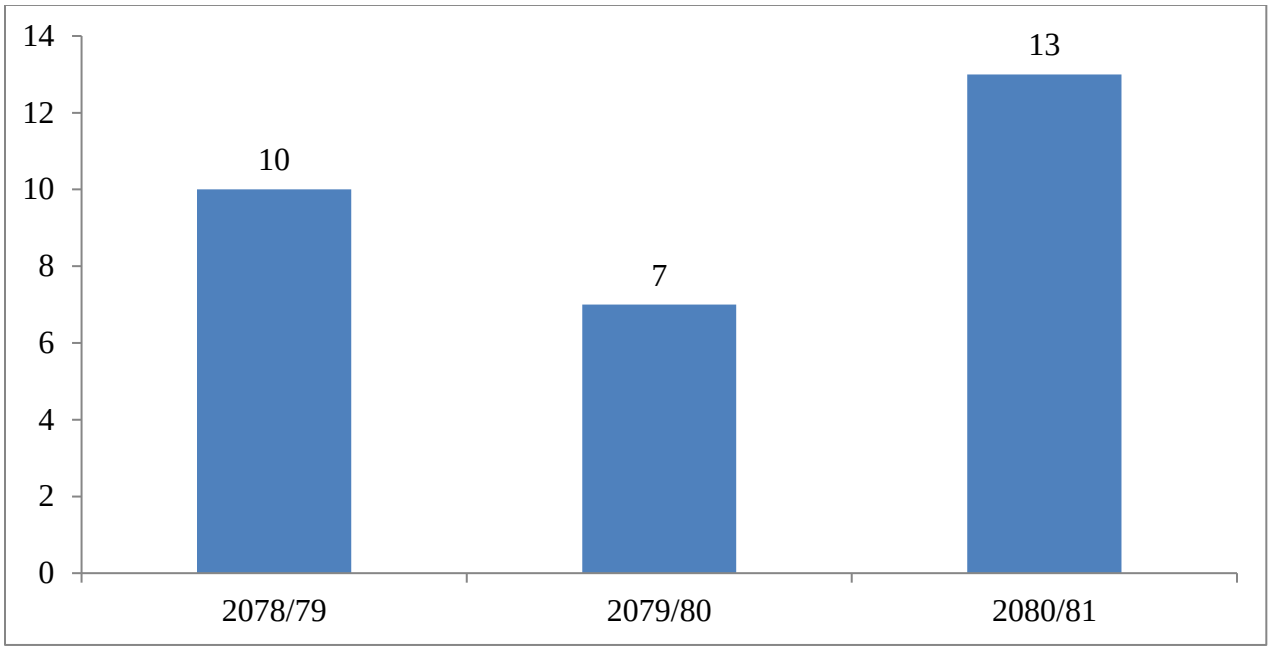


Figure 32: Three-year trend of DR-TB cases:

The above figure shows the increase number of DR-TB cases 13 in FY 2080/81, and 7 DR-TB cases in FY 2079/80.

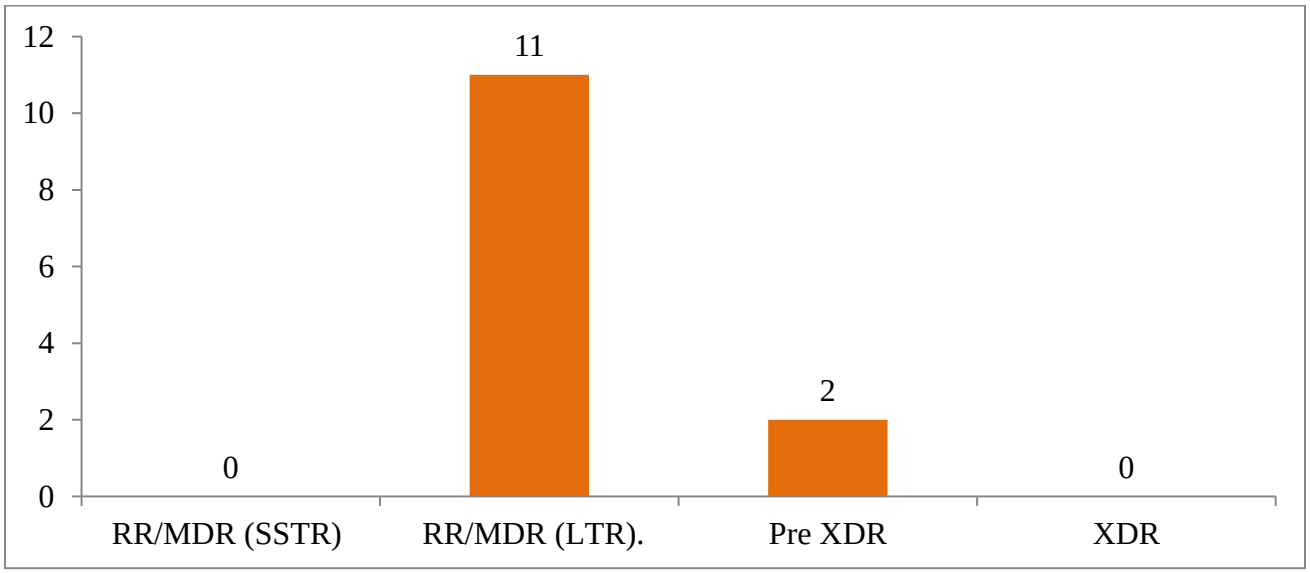


Figure 33: DR TB Cases in FY 2080/81

The above figure shows the category of DR-TB cases, 11 RR/MDR (LTR) cases and 2 Pre-XDR cases in FY 2080/81.

SWOT Analysis of NTP:

Strength	Opportunity
• Utilization of electronic database systems (NTPMIS and HMIS) for TB, with ownership of the systems. • Regular reviews of data quality conducted at health facility levels. • TB control and prevention activities allocation by federal government. • Registration of TB Cases in eTB Register and interoperability between HMIS and NTP MIS.	• Roll-out of interoperability between HMIS and NT PMIS, GX and DR sites. • Full coverage of electronic TB registers and update of Geographic Information System (GIS) systems. • Mobilization of NGOs/INGOs. • Mobilization of available human resources (logistics officers).
Weakness	**Threat**
• No of dedicated TB focal person at province, district and local level. • Inadequate engagement of private sectors and community in TB diagnosis and management. • No research activities in NTP. • Inadequate supply of TB medicine and Gene xpert Cartige. • Significant gap in treatment coverage (TB case notification vs. estimated incident TB cases). • Interrupted TB logistics supply over the year.	• Insufficient resources for TB, including both human resources and budget. • Inadequate expansion, maintenance, and utilization of rapid molecular diagnostic tests, specifically Gene Xpert.

National Leprosy Elimination Program (NLEP)

Introduction:

Leprosy also known as Hanssen's disease is an infectious disease caused by Mycobacterium leprae, an acid-fast, rodshaped bacillus. Leprosy is an age-old disease, described in the literature of ancient civilizations. It is likely transmitted by droplets from the nose and mouth during prolonged and close contact with untreated leprosy patients. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract, and the eyes. Leprosy is curable and early diagnosis and treatment in the early stages can prevent disability.

The establishment of the Khokana Leprosarium in the nineteenth century was the beginning of organized leprosy preventive services in Nepal. The Government of Nepal in collaboration with WHO conducted a leprosy survey in 1960. With an estimated number of 100,000 Leprosy cases, Dapsone monotherapy was started as a pilot project in 1966 in Nepal. This project gradually expanded as a vertical program and remained so till 1987 when it was integrated into general health services. Multi drug therapy (MDT) was introduced for the first time in Nepal in the year 1982/83 in selected few areas and hospitals. By that time the number of registered cases had come down to 31,537 (PR of 21 per 10,000). Number of districts then with a prevalence rate (PR) of over 5 was 62 and in only three districts the PR was less than 1 per 10,000.

Vision: Leprosy free Nepal

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

Objectives

1. To eliminate leprosy at the sub-national level (province, district, local level).
2. To strengthen clinical case management at district and municipal levels and improve referral system.
3. To enhance capacity building through training of health staff particularly at the peripheral health facilities.
4. To enhance prevention of leprosy.
5. Reduction of stigma and discrimination.
6. To strengthen leprosy surveillance system and regular monitoring, supervision, and periodic evaluation at all level.
7. To strengthen partnerships among different stakeholders.
8. To strengthen management of leprosy complications like reactions and disability prevention and rehabilitation.

9. To coordinate with neighbouring states of India in management, reporting and referral of cases from border areas.
10. To promote research and innovations.

Targets of National Leprosy Strategy

S.N.	Targets	2025
Target 1	Mapping of districts/municipalities including human resources	updated
Target 2	Number of municipalities with zero new child autochthonous cases over consecutive 5 years period	700/753
Target 3	Number of municipalities with zero leprosy cases	377
Target 4	Number of annual new leprosy cases reduced to	2462 (25 % reduction from baseline)
Target 5	Rate of new leprosy cases with G2D (per million population)	< 1
Target 6	New child leprosy case detection rate (per million child population)	< 6
Target 7	Number of child cases among new leprosy cases reduced to	50 (2% child case proportion among new leprosy cases)
Target 8	Number of children G2D among new child leprosy cases	0
Target 9	Discriminatory laws	Zero discrimination as a result of no discriminatory laws and complaints reporting system in place
Target 10	Roll out of preventive chemoprophylaxis	50 % coverage among eligible contacts
Target 11	Household contact examination of an index case within 3 months of case detection	75 % of index case

Strategic Pillars

Pillar 1: Implement the national leprosy roadmap for zero leprosy across all level national, provincial and local level.

Pillar 2: Scale up leprosy prevention alongside integrated active case detection

Pillar 3: Manage leprosy and its complications and prevent new disability

Pillar 4: Combat stigma and ensure human rights are respected.

The Status of NLEP FY 2080/81:

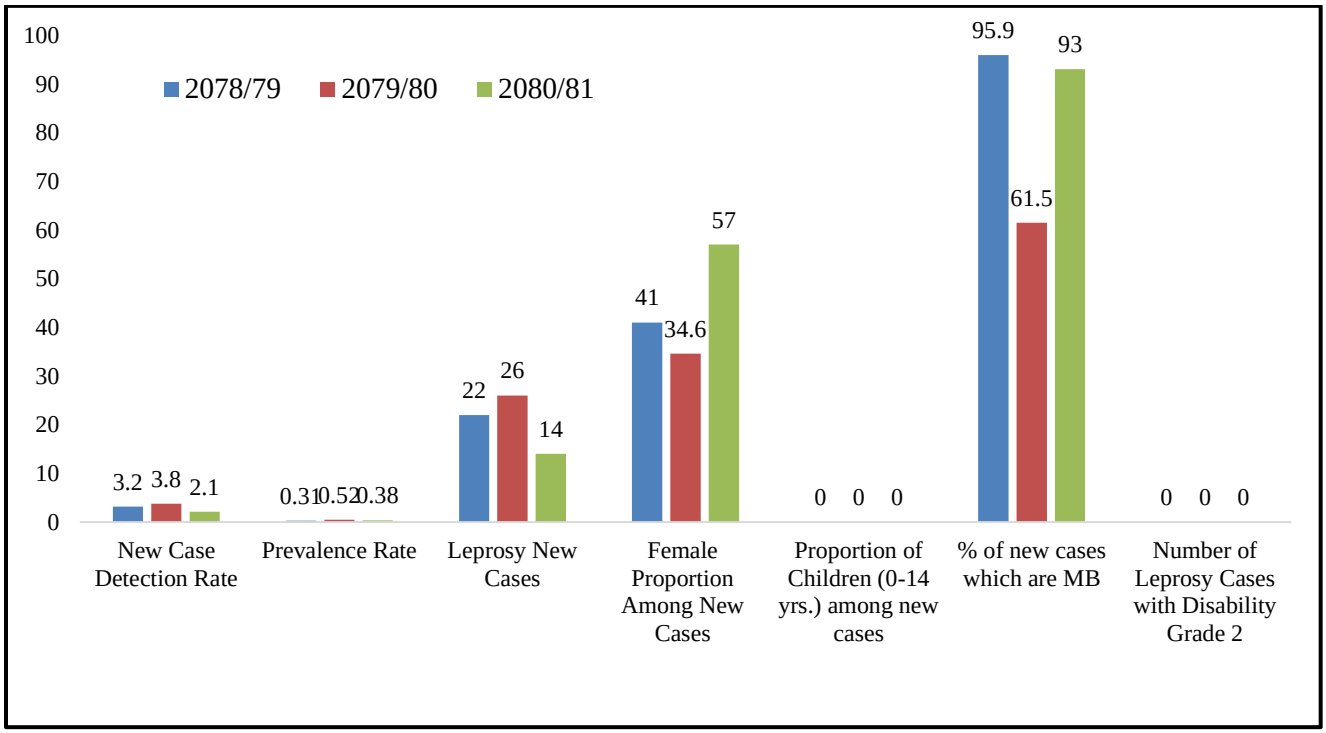


Figure 34: Trend of major indicators NLEP:

The above bardiagram show the three-year trend of NCDR 3.2, 3.8 and 2.1 in FY 2078/79, 2079/80 and 2080/81 respectively. The prevalence of Leprosy is 0.38 in FY 2080/81 decresed as compare to previous year. The number of New cases also decresed in FY 2080/81. The female proportion in leprosy cases is more than half (57%).

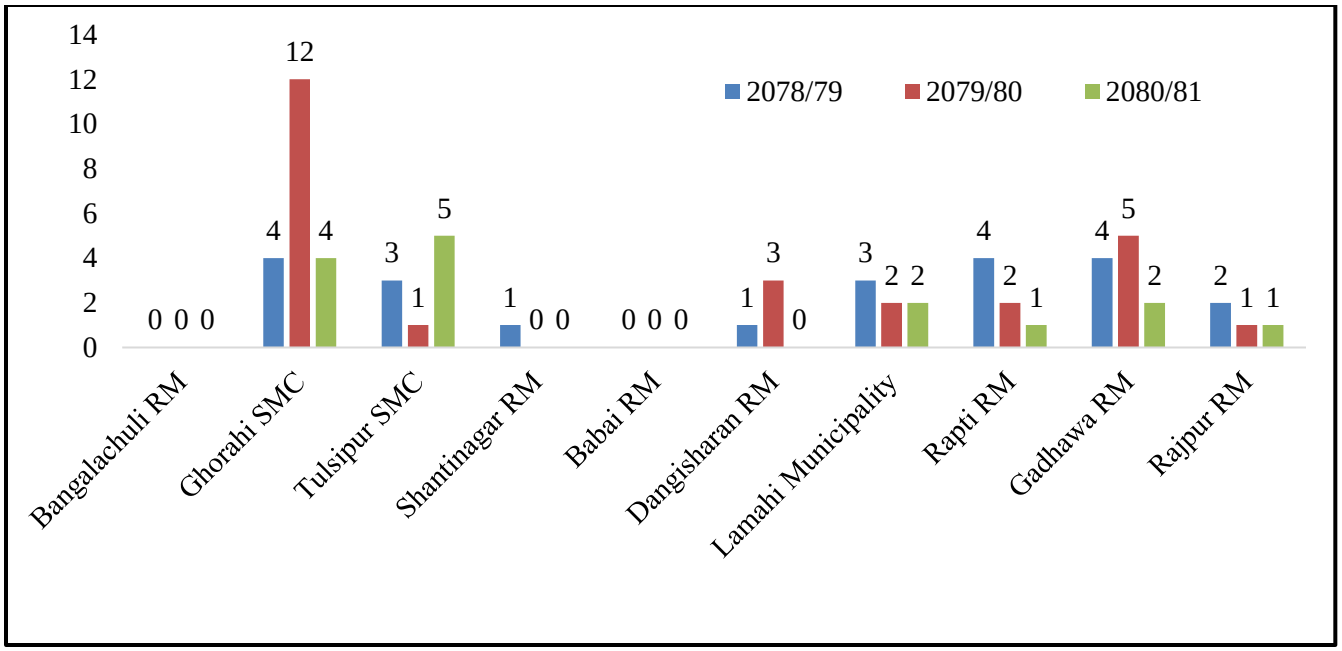


Figure 35: Palika-wise trend of New leprosy case

The above bardiagram show the palika wise 3-year trend of leprosy cases, highest in Tulsipur SMC 5 cases, followed by Ghorahi SMC 4 cases, Lamahi municipality and Gadhawa RM have 2 cases and Rapti RM and Rajpur RM have 1 case.

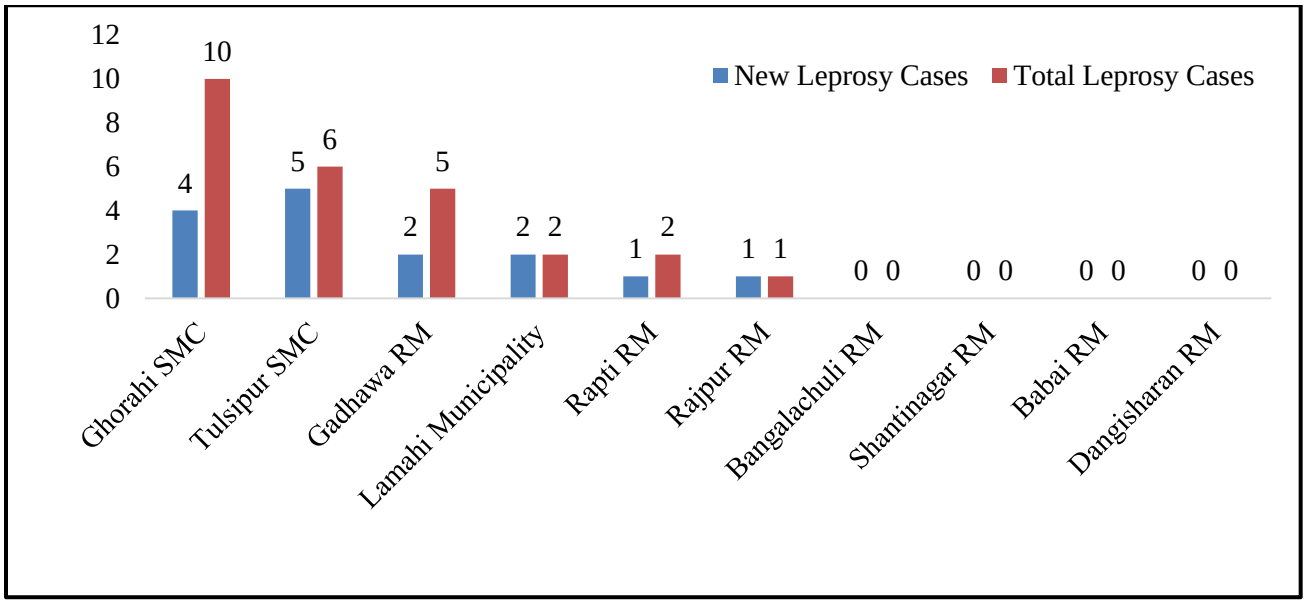


Figure 36: Palika- wise New and total leprosy cases in FY 2080/81

The above bardiagram show the palika wise new and total leprosy cases, new leprosy case 5 highest in Tulsipur SMC, followed by Ghorahi SMC 4 cases, Lamahi municipality and Gadhawa RM have 2 cases and Rapti RM and Rajpur RM have 1 case.

HIV/AIDS and STIs Control Program

Introduction:

Nepal first identified a case of Human Immunodeficiency Virus (HIV) in 2044/45 (1988), prompting the development of National Policy on Acquired Immunodeficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs) Control in 2052 (1995) The National Centre for AIDS & STD Control (NCASC) was established in 2050 B.S. to formalize the response against HIV and STIs control in Nepal. Recognizing the dynamic nature of the HIV epidemic, Nepal revised its initial policy and endorsed an updated version in 2067/68 (2011): The National Policy on HIV and Sexually Transmitted Infections (STIs).

The epidemic in Nepal is predominantly driven by sexual transmission and is characterized as a concentrated HIV epidemic among key populations, including men who have sex with men, male sex workers, transgender individuals, people who inject drugs, female sex workers and their clients, migrants, and prisoners. The national response primarily focuses on accelerating and expanding comprehensive HIV prevention programs, as well as enhancing access to equitable, quality, and gender-sensitive HIV diagnosis, treatment, care, and support services through strengthened health and community systems.

The National HIV Strategic Plan (NHSP) 2077/78- 2082/83 has been launched to achieve the ambitious global 95-95-95 targets by Ashad 2083. As per the targets, by July 2026, 95% of all people living with HIV (PLHIV) should know their HIV status, 95% of those diagnosed should receive sustained antiretroviral therapy (ART), and 95% of those on ART should achieve viral suppression. Nepal is also committed to the global 'UNAIDS Strategy 2021-2026' and the SDGs which include commitments to Fast-Tracking the end of the AIDS epidemic as a public health threat by 2087/88 (2030). The estimated PLHIV in Nepal was 30,000 in 2078/79 (2022). The vision of NHSP 2077/78-2082/83 (2021-2026) is to end the AIDS epidemic as a public health threat in Nepal by 2087/88 (2030).

Sexually Transmitted Infection (STI) have direct effect on maternal and child health. The adverse effects may range from infertility, maternal morbidity, and adverse pregnancy outcomes. Motherto child transmission of STI may also result in stillbirth, neonatal death, low-birth weight, prematurity, sepsis, pneumonia, neonatal conjunctivitis, and congenital deformities. STI increase the risk of sexual transmission and acquisition of HIV.

Concurrent HIV in an STI patient may increase the infectivity and complicate treatment, which may further increase in mental health comorbidities like anxiety, depression, and dementia. Connection with this the Global Health Sector Strategy (GHSS) recommends the provision of high-quality STI prevention and care integrated into the primary health care centers, sexual and reproductive health services, and HIV preventive and care services.

Strengthening Strategic Information of National HIV Programs

HIV testing services

HIV testing services (HTS) has been a strategic focus in national response to HIV control. Previously, HTS was referred to as voluntary HIV counseling and testing (VCT) or HIV counseling and testing (HTC) services. The first-ever HTS program was initiated in 2051/52 (1995), employing the Client-Initiated Testing and Counseling (CITC) approach. GoN is actively promoting HIV testing uptake among key populations (KPs) through targeted communications and establishing connections between community outreach and HTS. Additionally, ProviderInitiated Testing and Counseling (PITC) services have been extended to STI clinics, antenatal Clinics, childbirth facilities, malnutrition clinics, postpartum care, Family Planning centers, and TB services to address TB/HIV co-infection management. HTS are available in all 77 districts of Nepal.

Sexually transmitted infections (STIs) management

Standardizing the quality of STI diagnosis and treatment up to the health post level as part of primary healthcare services has been a key strategy in the national response to HIV. One of the key actions in addressing the concentrated HIV epidemic in Nepal has been the strengthening of documented linkages, including the referral and follow-up mechanisms between BCC services and HIV testing and counseling. This effort also includes enhancing the linkage between HTS and STI services. STI management services targeted at key populations are provided through ART centers.

Prevention of mother to child transmission of HIV for elimination of vertical transmission (eVT)

In 2061 (2005), Nepal initiated the Prevention of Mother-to-Child Transmission (PMTCT) program, also known as eVT. Later, in 2065/66 (2009), Communitybased PMTCT (CB-PMTCT) programs was introduced and now covers all 77 districts where HIV screening and counseling are provided to women during their ANC visits at health facilities.

Similarly, the National Guidelines on PMTCT have been developed and integrated into the National HIV Testing and Treatment Guidelines 2078/79 (2022). Furthermore, HIV testing has been incorporated into maternal and child healthcare through PMTCT. Counseling and information regarding infant feeding have been adapted to meet the needs of HIV-infected infants and HIV-exposed babies. In addition to the CB-PMTCT program, the country is scaling up PMTCT services, aligning them with planned ART, HTC, and STIs services. This ensures access to a continuum of care and ART for pregnant women living with HIV. Furthermore, 130 linkages have been established between PMTCT sites and interventions targeting key populations, Family Planning, sexual and reproductive health services, and counseling services.

Pursuant to its commitment to eliminate vertical transmission of HIV among children by 2082/83 (2026), Nepal adheres to test and treat strategy and promotes rapid ART initiation for all identified pregnant women and breastfeeding mothers with HIV, regardless of CD4 along with prophylaxis treatment for their infants as well. Nepal has scaled up its PMTCT services in recent years which led to an increased testing and detection over years.

HIV treatment services

Since 2060/61 (2004), the government began providing free anti-retroviral (ARVs) from ART centers with the aim of improving the survival of PLHIV. The NCASC adopted the WHO "Treat All" policy following the revision of the national HIV testing and treatment guidelines in 2073/74 (2017). Infrastructure necessary for diagnosis and treatment, including CD4 machines and viral load machines, has been established in various parts of the country, and human resources have been trained in treatment, care and support.

Opioid substitution therapy (OST) services

Harm Reduction encompasses methods, programs, and practices designed for individuals in the stages of continued drug use before they establish motivation for enrollment in treatment or during periods of slips/ relapses. Harm Reduction is a goal-oriented approach aimed at reducing the specific health risks and damages associated with substance use. OST is one of the harm reduction initiatives designed to facilitate recovery from substance use disorders, particularly those dependent on opioids. OST is an effective treatment that also plays a critical role in the prevention of HIV and Hepatitis C virus. Currently, there are 12 OST sites (eight government sites and four NGO-managed sites) providing services across 10 districts in Nepal.

Strengthening strategic information of national HIV program

To address the challenges of aggregated data reported to the national system, the NCASC developed and introduced the HIV Care and ART Tracking System (also known as DHIS2 Tracker). This system generates realtime data for an informed HIV response in the country. The previous recording and reporting (R&R) system was solely paper-based, lacking individual-level data at the national level. The HIV Care and ART Tracking System comprises three interconnected systems: a) DHIS2 Tracker; b) mHealth; and c) Biometrics.

Currently, the DHIS2 tracker is implemented at all HIVrelated service delivery points across the nation for recording HIV prevention, testing, treatment, care and support details of clients.

DHIS2 tracker

The DHIS2 Tracker maintains records of all personal information of clients for HIV prevention, testing, treatment, care and support services including PMTCT, Early Infant Diagnosis (EID), and discontinuation of follow-up services across all service delivery points (EID diagnosis is done by NPHL). Once a client is registered, all related information is entered and is retrievable at any time. The system's primary goal is to record client information in real time, ensuring accessibility for treatment and effective implementation of HIVrelated programs. It also facilitates client information transfer and referral to other sites. The system is linked with the Biometric System for scanning client fingerprints, streamlining duplication checks and transfer processes. However, some sites face challenges with internet speed, impacting the full functionality of the DHIS2 Tracker system.

mHealth (Mobile Health)

mHealth aims to support HIV treatment and improve retention. The system includes automated and manual push SMS methods for sending appointment reminders and general awareness messages to clients. It has significantly contributed to increased adherence to services and retention in HIV care and treatment through targeted messages to mothers and their babies, among others. However, health workers must frequently update the mobile numbers of PLHIV in the system, as some groups frequently change their numbers.

Biometrics

The biometric system is employed for clients confirmed as HIV positive or enrolled in HIV care. It registers new clients in the HIV Care and ART Tracking System with a unique alphanumeric identification code. This helps identify if a client is registered at another ART center in Nepal, addressing the issue of client duplication. The unique identification code facilitates the search and review of clients' past records and aids in treatment planning. The system also simplifies tracking clients transferred between sites and districts.

Lessons learned from this system are being applied by various partners to integrate individual-level data HIV AND STIS CONTROL AND MANAGEMENT PROGRAM 131 recording and reporting for HIV prevention, care, and support components into the national HIV program. NCASC and HIMS have developed recording registers and reporting forms for HIV prevention, testing, care, and support services managed by different implementing agencies or partners (INGOs, NGOs). These are being integrated into the existing information system and will be incorporated into the national HMIS/ DHIS2 from FY 2080/081. This integration aims to ensure real-time data generation.

Progress and Achievement in FY 2080/81

HIV Testing Services:

Table 21: HIV testing services and positive cases:

Indicator	Time period		
	2078/79	2079/80	2080/81
Total Tested for HIV	NA	25351	14830
Total Positive reported	47	36	42

The table above presents data on HIV testing services and positive cases in Dang District over the past three years. In Dang, two ART sites are available for HIV testing and provide ART services, one is in Rapti Swasthya Bigyan Pratisthan Ghorahi, and another is one in Rapti provincial Hospital, Tulsipur Dang. Through these 2 ART sites, a total of 14,830 individuals were tested for HIV during the fiscal year 2080/81, which is almost half the number tested in the previous year. Additionally, 42 new HIV cases were diagnosed in FY 2080/81.

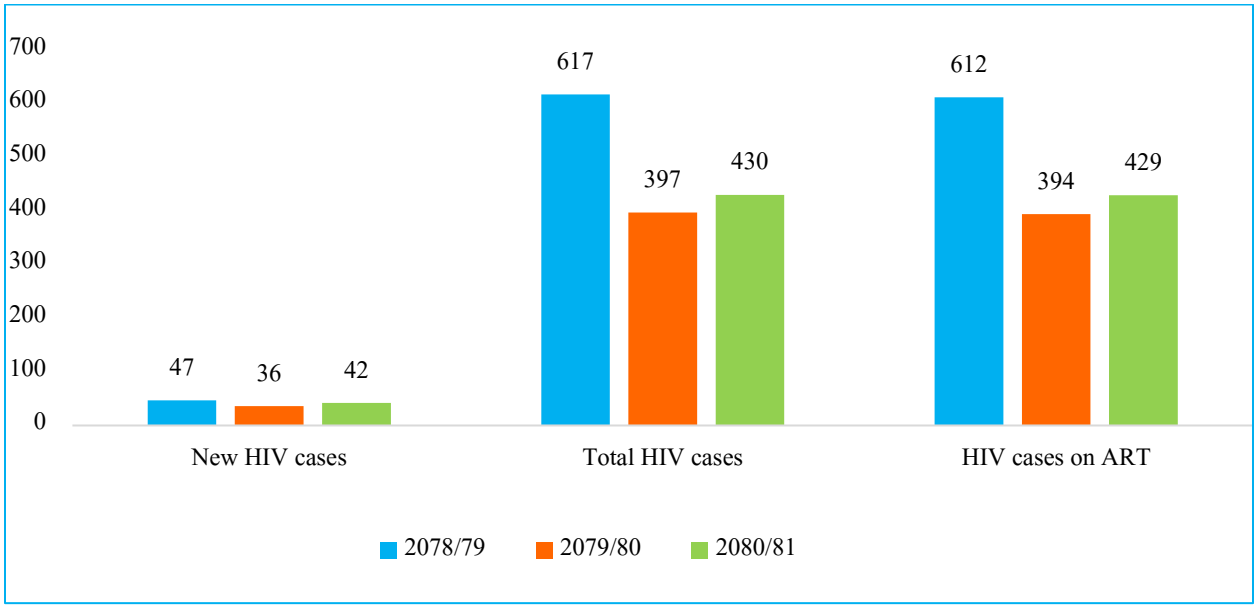


Figure 37: HIV status and ART enrollment

The graph above illustrates HIV status and ART enrollment in Dang District. In FY 2080/81, 42 new HIV cases were identified, an increase compared to the previous year, 2079/80. The total number of HIV cases fluctuated over the past three years, reaching 430 cases in FY 2080/81. Of these 430 cases, 429 individuals were enrolled in ART treatment, aiming to the suppression of HIV virus load.

Prevention of Mother to Child Transmission (PMTCT) services:

Aiming to the elimination of mother to child transmission, Ministry of Health and Population, Nepal taking a major transformative measure this fiscal year, providing lifelong ART for all identified pregnant women and breastfeeding mothers with HIV, regardless of CD4, along with prophylaxis treatment for their infants. The rollout of the lifelong treatment adds to the benefits of the triple reinforcing effectiveness of the HIV response: (a) help improve maternal health (b) prevent vertical transmission, and (c) reduce sexual transmission of HIV to sexual partners.

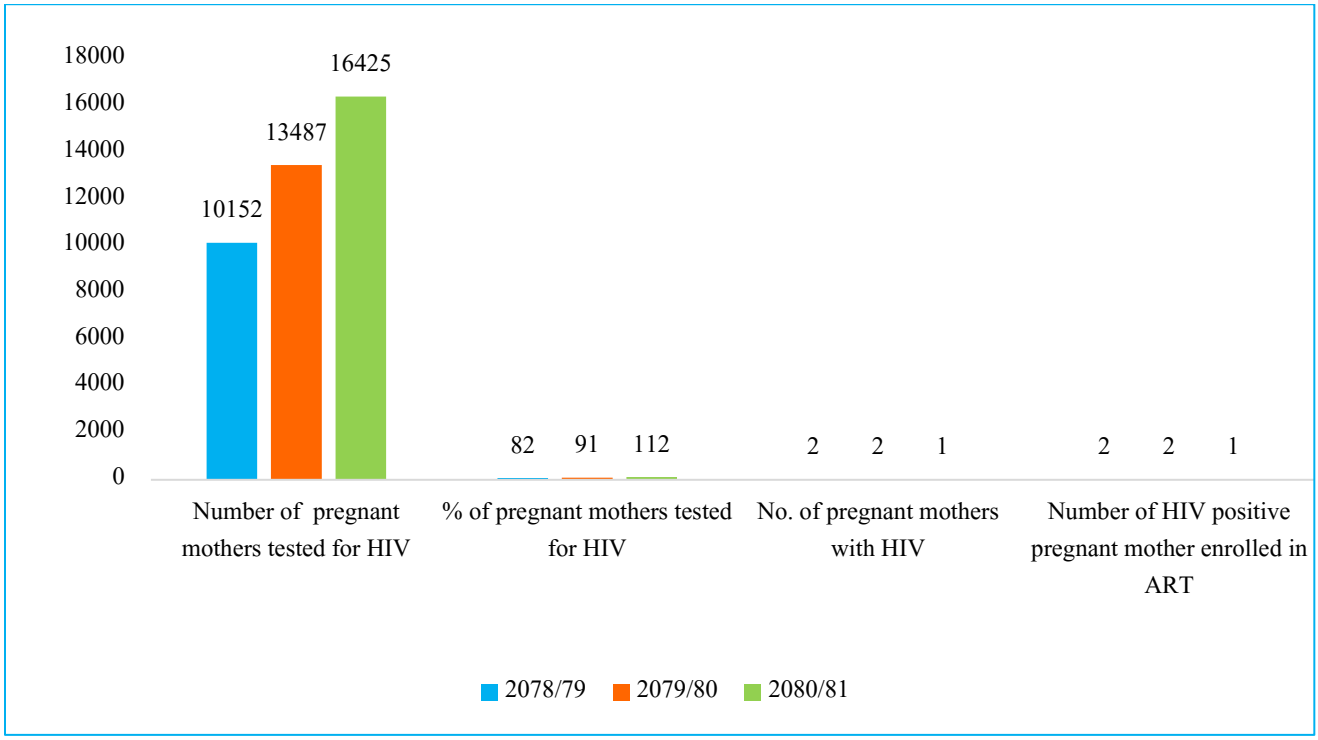


Figure 38: Trend of PMTCT and Enrollement in ART.

The graph provides details on the PMTCT service status in Dang District. The number of pregnant women tested for HIV has been on an upward trend over the past three years, with a total of 16,425 tested in FY 2080/81, representing 112% of the estimated pregnancies in the district. In both FY 2078/79 and 2079/80, two mothers were diagnosed with HIV, while one mother tested positive in FY 2080/81. All mothers diagnosed with HIV have been receiving ART treatment over the past three years.

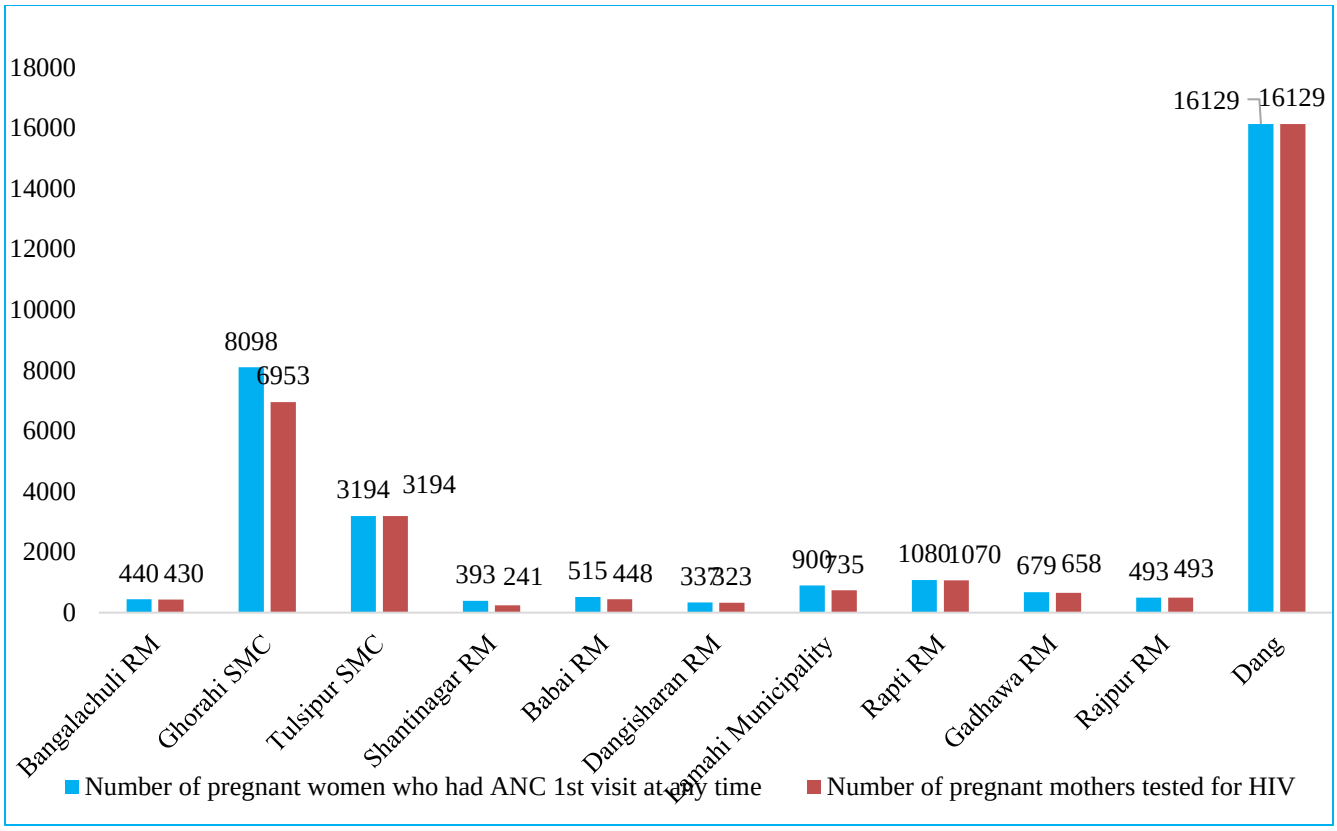


Figure 39: First ANC any time and and HIV Test.

The graph shows the ANC 1st visit any time and HIV test of pregnant mother, highest of HIV test in Ghorahi SMC Followed by Tulsipur SMC, Rapti RM and Gadhawa RM in FY 2080/82.

Sexually Transmitted Infection (STIs)

National HIV Strategic Plan (2012-2026) aims to achieve case rate of congenital syphilis of ≤50 per 100 000 live births by promoting the treatment, obtaining cure, reducing infectivity and the risk of developing complications of STI. It is also guided from National STI management guideline 2022 that; to take correct medical and sexual history, establish a correct diagnosis and provide effective treatment, provide health education and counseling on infection, risk reduction and on compliance with treatment and promotion and/or provision of condoms.

Data was taken from ART centers or NGO based services providing syndromic or aetiologic services for sexually transmitted diseases (STDs) to groups at risk of HIV or individuals infected with HIV.

Table 22: STI Service status for the period 2080/81

Vulnerable population	STI Diagnosed	STI treated	% of treatment
Sex workers	48	32	66.6
PWIDs	3	3	100
MSM and TG	8	1	12.5
Client of FSWs	10	6	60
Migrants	3	2	66.6
Spouse/Partner of migrants)	2	1	50
PLHIV	9	9	100
Others	85	84	98.8
Dang district	**168**	**138**	**82.1**

The table presents the status of STI services in the district. A total of 168 STI cases were diagnosed, with 84% (138 cases) receiving treatment at service sites. According to the data, the highest number of STI cases were diagnosed in the "others" group, followed by sex workers and clients of FSW. Additionally, 9 PLHIV were diagnosed with STIs, and all of them (100%) received treatment.

SWOT analysis of HIV/AIDS and STIs Control Program:

Strength	Weakness
• Availability of free HIV testing, treatment, and care services at ART centers. • Extensive awareness and educational campaigns to reduce stigma and promote prevention. • Integration of HIV services with other health services like TB, PMTCT, maternal health, and sexual health programs. • Adoption of Pre-exposure Prophylaxis (PrEP) for high-risk populations. • National systems for tracking HIV prevalence, new infections, and treatment outcomes help target interventions.	• Supply chain issues leading to inconsistent availability of essential medicines, testing kits, and other resources. • Rural and marginalized populations may have less access to healthcare services due to geographic, social stigma, or economic barriers. • Rising rates of new infections, particularly among high-risk groups due to inadequate preventive measures. • Unavailability of viral load testing service in the district, PHLIV are unable to know their VL status in time.
Opportunity	**Threat**
• Backing from national governments, international organizations (UNAIDS, WHO), and local NGOs (Dang Plus, Manaw Swasthya Samaj, Change Team, Nagarjun Development Committee) in HIV testing, Treatment, funding and resources. • The local government plans to introduce new interventions next year to support people living with HIV (PLHIV) and high-risk populations. • Expansion of educational programs, particularly targeting young people, high-risk populations, and rural areas through developmental organizations coordinating with local governments.	• Due to privacy issue PLHIV do not want receive any services from local authorities and other agencies**.** • High risk populations are not ready to undergo testing, diagnosis and enroll in ART due to fear of social stigma. • Potential reduction in international aid and allocation of domestic resources to other health priorities could undermine program sustainability.

Vector Borne Diseases (VBDs) and Neglected Tropical Disease (NTDs) control Programme

Malaria Elimination Program

Background

Malria is vector born disease caused Plasmodium parasites and transmitted by female anopheles' mosquitos. Malaria control project in Nepal was first initiated in 1954 with the support from USAID (the then USOM), with the objective of controlling malaria, mainly in plain region (Terai belt) of central Nepal. In 1958, national malaria eradication program was launched with the objective of eradicating malaria from the country. Due to various reasons the eradication concept reverted to control program in 1978. Following the call of WHO to revamp the malaria control programs in 1998, Roll Back Malaria (RBM) initiative was launched to control malaria transmission in hard-core forests, foot-hills, inner-Terai and hill river valleys, which accounted for more than 70 % of the total malaria cases in the country. The high risk of acquiring the disease is attributed to the abundance of vector mosquitoes, mobile and vulnerable population, relative inaccessibility of the area, suitable temperature, environmental and socio-economic factors.

To better understand and combat malaria, Nepal has adopted a micro-stratification approach. Nepal's "malaria micro-stratification process" began at the district level in 2066/67 (2010). To enhance communitylevel risk stratification and accurately define the total population at risk, micro-stratification was performed at the ward level within LLGs.

The methodology used recent malaria burden data supplemented by information on the spatial distribution of key determinants of transmission risk including climate, ecology, and the presence or abundance of key vector species and vulnerability in terms of human population movement. The method was based on 2012 and 2016 micro-stratification study, and it was recommended by Epidemiology and Disease Control Division (EDCD) and Malaria Technical Working Group (TWG). EDCD provided the overall oversight of the study. The methodology used for malaria risk stratification is based on the malaria burden, information on the spatial distribution of key determinants of transmission risk including climate, ecology, and the presence or abundance of key vector species and vulnerability in terms of human population movement. The method is explained in the 2018 microstratification study report and it was recommended by Epidemiology and Disease Control Division (EDCD) and Malaria Technical Working Group (TWG).

Key Highlights of the National Malaria Strategic Plan (2014–2025 updated)

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

Vision: Malaria Elimination in Nepal by 2025.

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

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

Objectives: To ensure proportional and equitable access to quality assured diagnosis and treatment in health facilities as per federal structure and implement effective preventive measures to achieve malaria elimination.

The updated NMSP (2014-2025) will attain the elimination goals through the implementation of following five strategies:

- Strengthen surveillance and information system on malaria for effective decision making.
- Ensure effective coverage of vector control interventions in malaria risk areas to reduce transmission.
- Ensure universal access to quality assured diagnosis and effective treatment for malaria.
- Ensure government committed leadership and engage community for malaria elimination. 143 Epidemiology and Disease Control DoHS, Annual Report 2078/79 (2021/22)
- Strengthen technical and managerial capacities towards malaria elimination.

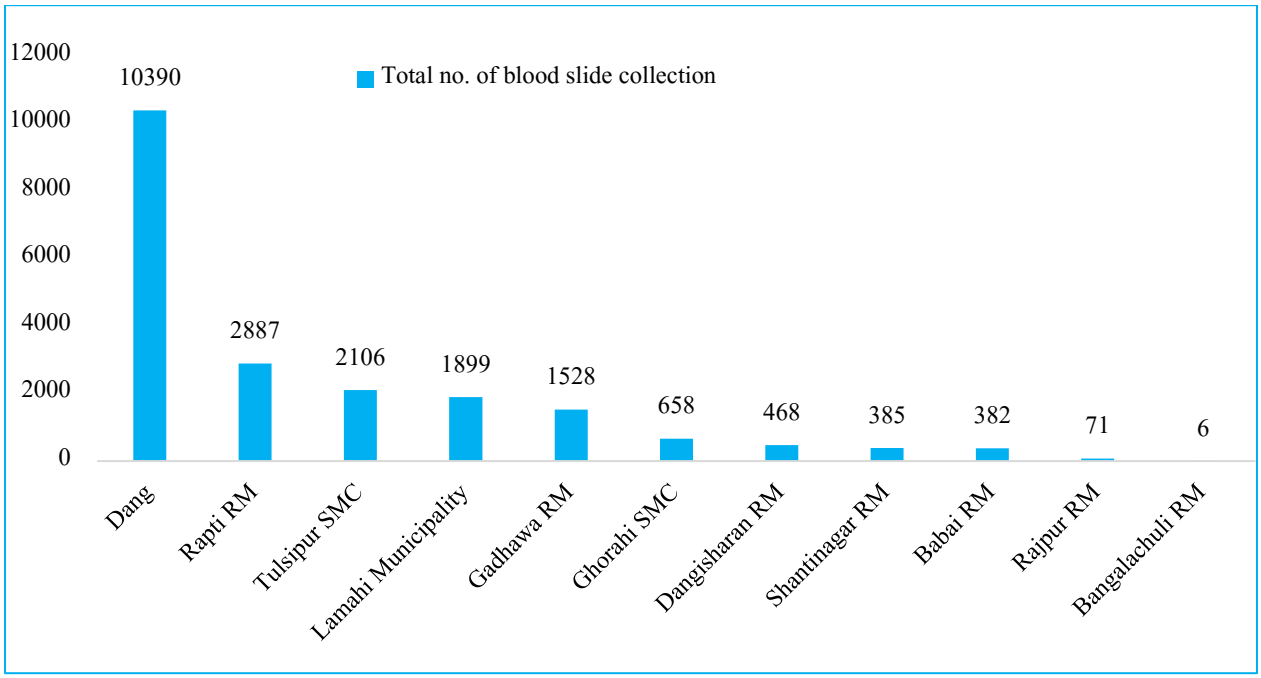
Status of Malaria Program in FY 2080/81

Table 23: Malaria Epidemiological Information (FY2078/79-2080/81)

Data Indicator	Period		
	2078/2079	2079/2080	2080/2081
Total risk population	677963	687776	681175
Total Malaria Blood Slide Collection	4113	9361	10390
Total Malaria positive cases	6	5	7
Total Malaria Indigenous cases	0	0	4
Total Malaria PF cases	2	1	0
% of PF cases	33.3	20	0
Annual blood examination rate (ABER) of malaria	0.65	1.3	1.5
Malaria test positivity rate /slide positivity rate	0.15	0.05	0.07
Malaria annual parasite incidence (per 1000 population)	0.008	0.007	0.01
Death due to malaria	0	0	0

*Data source: DHIS2

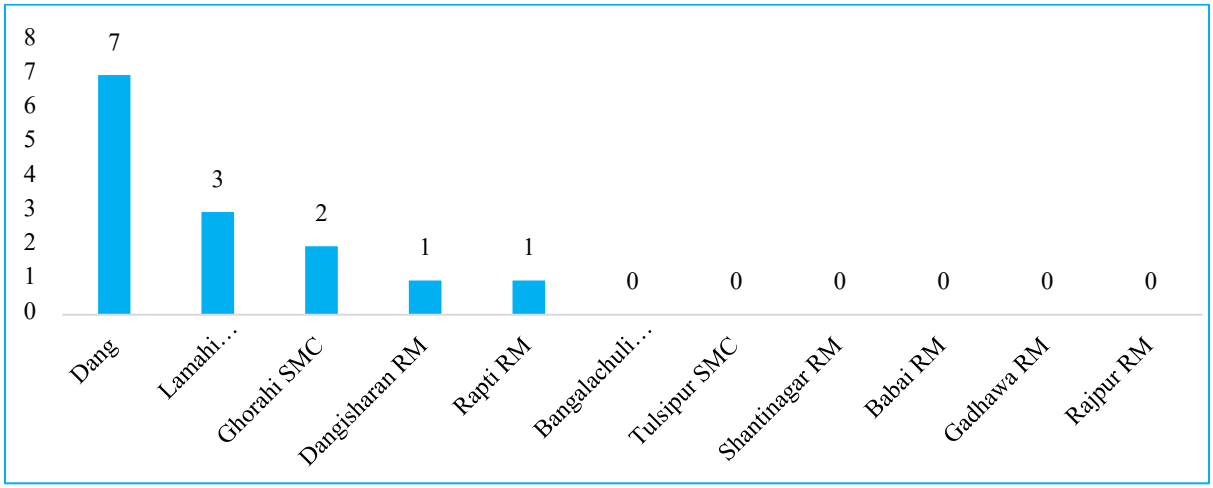
The table highlights the malaria epidemiological situation in Dang district. Over recent fiscal years, there has been an upward trend in malaria blood slide collection, with a total of 10,390 slides collected in FY 2080/81. Confirmed malaria cases rose from 5 in FY 2079/80 to 7 in FY 2080/81, with over half (4) being indigenous cases. Notably, there were no cases of *P. falciparum* infection in FY 2080/81. The annual blood examination rate (ABER) increased from 1.3% in the previous year to 1.5% in FY 2080/81. The slide positivity rate also showed a slight rise, from 0.05 to 0.07, and the parasite incidence rate stood at 0.01 per thousand population.



*Data source: DHIS2

Figure 40: Malaria blood slide collection status:

The figure above illustrates the total malaria blood slide collection across all local levels in Dang district. According to the graph, Rapti Rural Municipality collected the highest number of malaria blood slides, totaling 2,887. In contrast, Bangalachuli Rural Municipality collected the fewest slides, with only 6. All the municipalities tested the collected slides.



*Data source: DHIS2

Figure 41: Malaria positive status:

The figure above presents the malaria positivity status across local levels in Dang district. Out of the total 7 malaria cases, 3 were detected in Lamahi Municipality, 2 in Ghorahi Sub-metropolitan, 1 in Dangisharan Rural Municipality, and 1 in Rapti Rural Municipality. No malaria cases were found in the remaining local levels.

Table 24: Malaria screening among OPD visits FY 2080/81

Local level	Total OPD Visit	Malaria Screening	% of Malaria screening among OPD visit
Dang District	575602	10390	1.8
Bangalachuli Rural Municipality	18096	6	0.03
Ghorahi Sub Metropolitan	119236	658	0.6
Tulsipur Sub Metropolitan	156324	2106	1.3
Shantinagar Rural Municipality	26562	385	1.4
Babai Rural Municipality	21423	382	1.8
Dangishran Rural Municipality	21239	468	2.2
Lamahi Municipality	56394	1899	3.4
Rapti Rural Municipality	73209	2887	4.0
Gadhawa Rural Municipality	57374	1528	2.7
Rajpur Rural Municipality	25745	71	0.3

*Data source: DHIS2

The table above displays the malaria screening rates among total OPD visits. Rapti Rural Municipality had the highest screening rate, with 4% of OPD cases screened for malaria,

followed by Lamahi Municipality at 3.4%. The lowest screening rate was observed in Bangalachuli Rural Municipality, with only 0.03% of OPD cases screened.

SWOT analysis of Malaria Program:

Strength	Weakness
▪ All health institutions are providing malaria testing and treatment free of charge. ▪ Case Base investigation done all positive case. ▪ Having RAHS, RPH Hospital for the treatment of severe malaria patients. ▪ Micro-stratification from time to time and decreasing area of indimicity. ▪ Increasing trained of slide collection rate.	▪ Shortage in medicine and RDT supply from time to time ▪ All private sector reports could not be included. ▪ Failed to give malaria basic and refresher training to all the laboratory person. ▪ Malaria fever should not be a priority for clinician.
Opportunity	Threat
▪ Safe the Children supported for Case Base Investigation and Foci Investigation. ▪ Increasing the microscopic center. ▪ Coordinated with Nagarjuna Development Committee to conduct HIV and Malaria screening.	▪ Drug resistant. ▪ Vector dispersal. ▪ Climate change Support to the vector Bionomics. ▪ Increasing trained of Indigenous Case.

2. Kala-Azar Elimination Program:

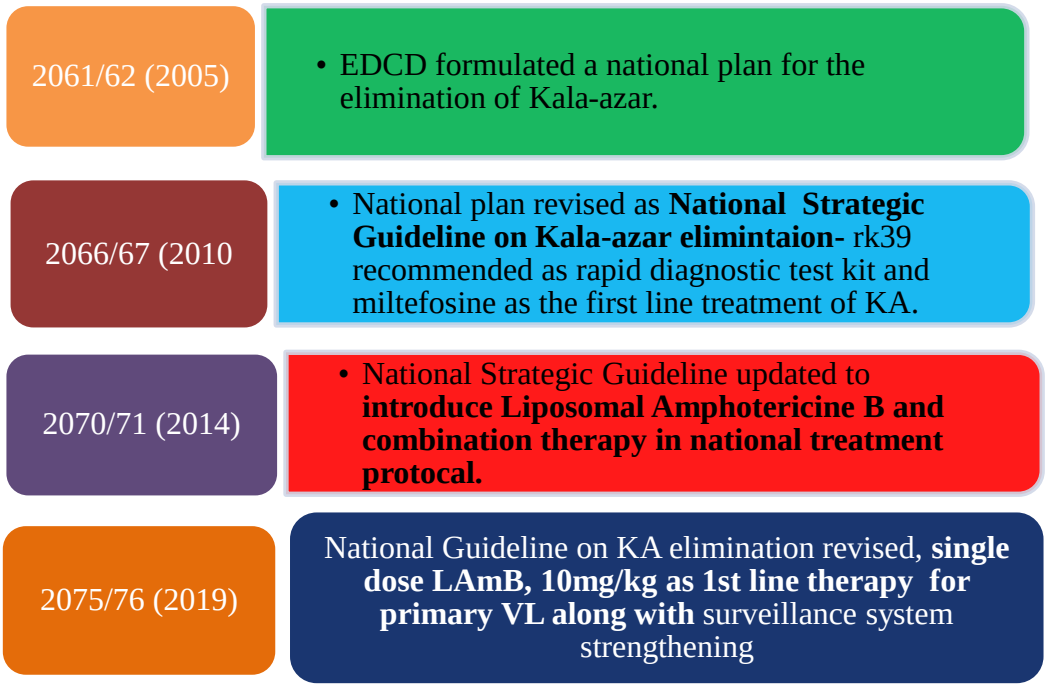
Introduction:

Kala-azar (Leishmaniasis) is caused by an intracellular protozoan parasite, of which 20 Leishmania species can cause human disease. Leishmania parasites are transmitted through the bites of infected female phlebotomine sandflies, which feed on blood to produce eggs. The disease occurs in 3 main clinical forms:

(i) Life-threatening visceral leishmaniasis (VL) or kala-azar with its dermal sequel – PostKala-azar Dermal Leishmaniasis (PKDL);
(ii) Self-healing or chronic cutaneous leishmaniasis (CL); and
(iii) Mutilating mucosal or mucocutaneous leishmaniasis.

Kala-azar is characterized by prolonged fever, weight loss, weakness, anemia, and hepato-splenomegaly. If untreated, the patient usually dies in about 2 years due to inter- current infections.

Nepal aims to eliminate Kala-azar by maintaining an annual incidence rate of less than 1 case per 10,000 people at the district level, with a case fatality rate below 1%. The government is aligned with the WHO regional strategy and has signed a memorandum of understanding with Bangladesh and India to strengthen collaborative regional elimination efforts. The activities are guided by Kala-azar elimination program



In the last decade, Nepal has made significant progress in Kala-azar diagnosis and treatment. The rK39 dipstick test kit is now available at PHCC level in affected districts, offering a rapid serological test. Essential drugs like liposomal amphotericin B, miltefosine, and paromomycin are accessible at all treatment centers. EDCD provides free diagnostics and drugs to the patients. Additionally, treatment centers receive an incentive of NPR 5,000 per case, and patients are reimbursed NPR 2,000 to cover transportation costs.

Kala-azar Elimination Program:

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

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

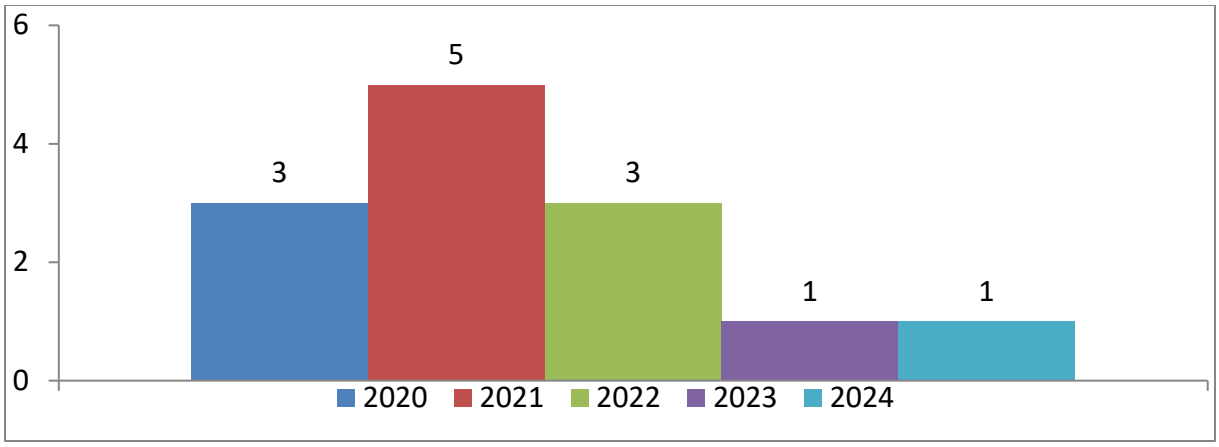
Objectives:

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

Strategies:

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

Status of Kala-azar Elimination Program:



***Data source: EWARS**

Figure 42: Reported cases of Kala-azar in Dang district

In 2024, only one Kala-azar case was reported in Dang district, same status compared with the previous year.

SWOT analysis of kala-azar Elimination Program:

Strength	**Weakness**
▪ There is a budget allocation for examination, treatment, case base investigation and transport expenses of the patient. ▪ Case base surveillance of all Kala-azar patients. ▪ Trashing of positive patients in coordination with all private institutions ▪	▪ Rk 39 was not available for kala-azar test hospital and PHC. ▪ Necessity to send the patients of Kala-azar to Bheri Hospital Nepalgunj or Lumbini Provincial Hospital Butwal for treatment. ▪ There is no provision of training for doctors to treat kalazar patients. ▪ Difficulty to distribute transportation expenses to Kala-ajar patients.
Opportunity	**Threat**
▪ Kala-azar can be treated free of cost in RAHS & RPH where doctors are trained. ▪ Having technical support from WHO for Case base surveillance. ▪ Kala-azar is checked by private health institutions also.	▪ The number of Kala-ajar patients is increasing. ▪ Recurrence of the disease after complete treatment. ▪ Increasing trained of Indigenous case. ▪ Parasite increase the chance of drug resistant**.**

Lymphatic filariasis (LF) Elimination Program:

Introduction:

Lymphatic filariasis (LF), commonly known as elephantiasis, is one of the mosquitoes borne parasitic diseases. It's a painful and highly disfiguring neglected tropical disease often associated with areas that have poor sanitation and housing quality. The infection may be acquired during childhood whereas its visible manifestations may occur later in life, causing temporary or permanent disability, pain and social stigma. The infection transmitted by different species of mosquitoes (Culex, Anopheles & Aedes) is caused by a thread like filarial worms (nematodes). In the majority of the cases (90%), the infection is caused by Wuchereria Bancrofti and the remainder by Brugia Species (Brugia Malayi & Brugia Timori).

Adult worms reside in the lymphatic vessels interrupting the normal function of the lymphatic system. The worms have a life span of about 6–8 years and produce millions of microfilariae (immature larvae) that circulate in the blood. Mosquitoes are infected with microfilariae by consuming blood when biting an infected person. Microfilariae mature into infective larvae within the mosquito. When infected mosquitoes bite people, mature parasite larvae are deposited on the skin from where they can enter the body. The larvae then migrate to the lymphatic vessels where they develop into adult worms, thus continuing the cycle of transmission

Table 25: EMS Survey in FY 2080/81

Evaluation Unit	
A	**B**
Ghorahi SMC, Tulsipur SMC and Bangalachuli RM	Lamahi Municipality, Shantinagar RM, Dangisharan RM, Babai RM, Rapti RM, Gadhawa RM and Rajpur RM.

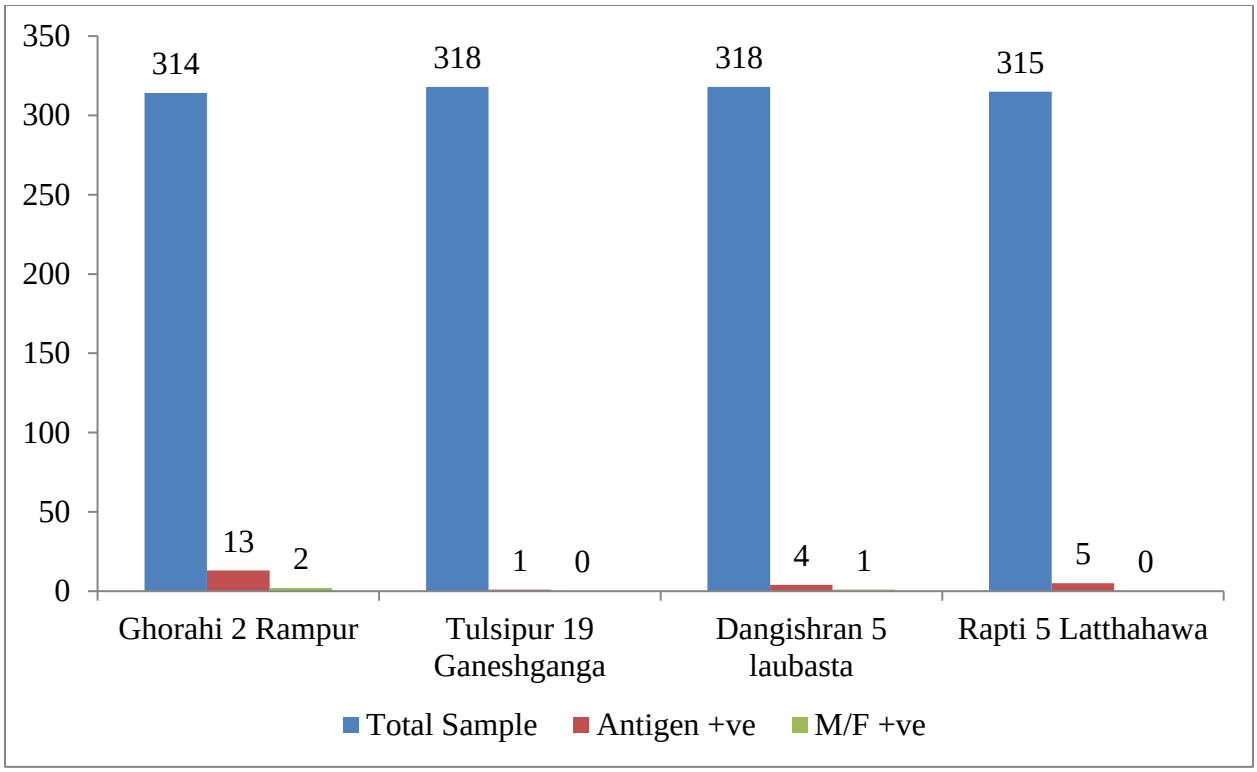


Figure 43: **EMS Survey in FY 2080/81**

Dengue Control program

Introduction:

Dengue, a mosquito-borne disease transmitted by Aedes aegypti and Aedes albopictus, is endemic in most of the provinces in Nepal. First reported in the country in 2060/61 (2004), cases have steadily risen, particularly in tropical lowlands and subtropical hilly regions, including Kathmandu. Multiple outbreaks occurred between 2062/63 (2006) and 2078/79 (2022), with notable instances in 2062/63 (2006) and 2066/67 (2010), signaling the disease's persistence and expansion in various districts. The A. aegypti was identified in five peri-urban areas of the Terai (Kailali, Dang, Chitwan, Parsa and Jhapa) during entomological surveillance conducted by EDCD from 2062/63 - 2066/67 (2006–2010), suggesting the local transmission of dengue. From 2068/69 to 2071/72 (2012 to 2015), cases continued variably. Subsequent years saw annual outbreaks in different districts, notably in 2075/76 (2019) when 68 out of 77 districts were affected with 17,992 reported cases. The COVID-19 pandemic 2076/77-2077/78 (2020-2021) resulted in fewer cases, but the 2079 (2022) outbreak was larger, with 56,338 cases and 88 deaths, marking it as the largest outbreak in Nepal to date. Dengue has emerged as a significant concern nationwide, with cases reported in all 77 districts throughout the year. The implementation of the program is guided with the goal to reduced dengue related mortality.

Recent study by Vector Borne Disease Research and Training Center (VBDRTC) has shown that both A. aegypti and A. albopictus mosquitoes are transmitting the disease in Nepal. Entomological surveillance conducted in three cities (Kathmandu, Lalitpur and Ghorahi) in 2079 (2022) also showed the presence of both species in Lalitpur and Ghorahi. In 2062/63 (2006), a collaborative study by EDCD and NPHL with the Walter Reed/AFRIMS Research Unit Nepal identified the circulation of all four Dengue virus sub-types (DEN-1, DEN-2, DEN-3, and DEN-4) in Nepal. Contrastingly, the 2079 (2022) dengue virus serotyping conducted by EDCD and NPHL revealed the prevalence of DENV1, followed by DENV3 and DENV2, with no positive samples for DENV4.

Nepal's Dengue Control Program

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

Objectives:

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

Strategies:

- Early case detection, diagnosis, management and reporting of dengue fever
- Regular monitoring of dengue fever surveillance through the EWARS

- Mosquito vector surveillance in municipalities
- The integrated vector control approach where a combination of several approaches are directed towards containment and source reduction

Major activities in 2080/81

- Conducted orientation to multi-stakeholders at local levels for advocacy on dengue prevention and control including support for search and destroy activities.
- Conducted 'search and destroy' activities at local levels to search for the potential breeding sites of Aedes mosquitoes and destroy them.
- Community awareness activities at local level.
- Routine surveillance of Dengue through EWARS (sentinel sites).
- Supplied rapid diagnostic test kits (IgM).
- Dengue test and individual counseling.
- Dengue case monitoring and vector surveillance.
- Developed IEC materials and disseminated health education messages engaging various stakeholders including the media and youth.
- Distribution of nets.

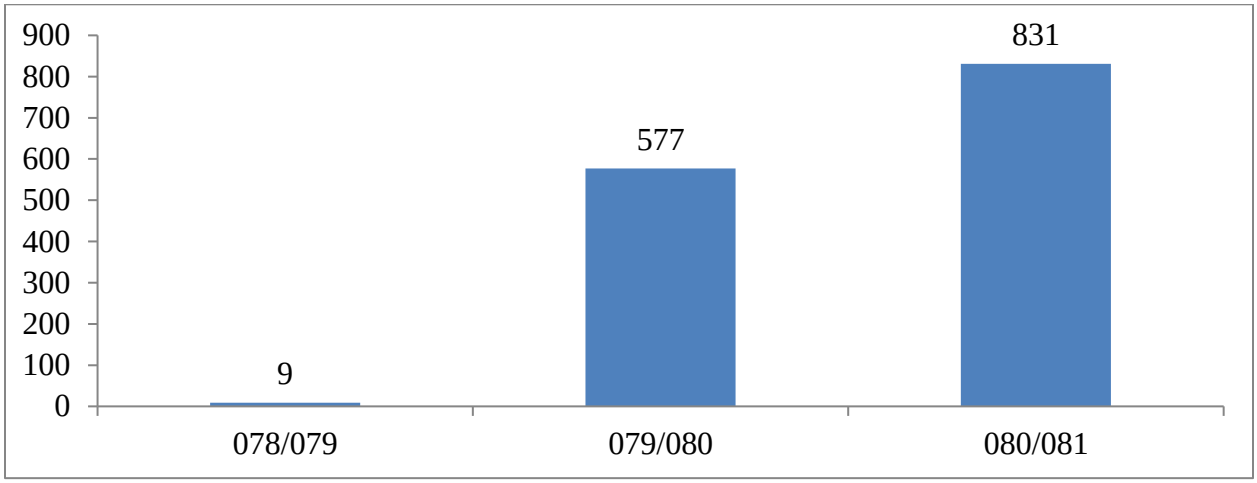


Figure 44: Status of Dengue in Dang.

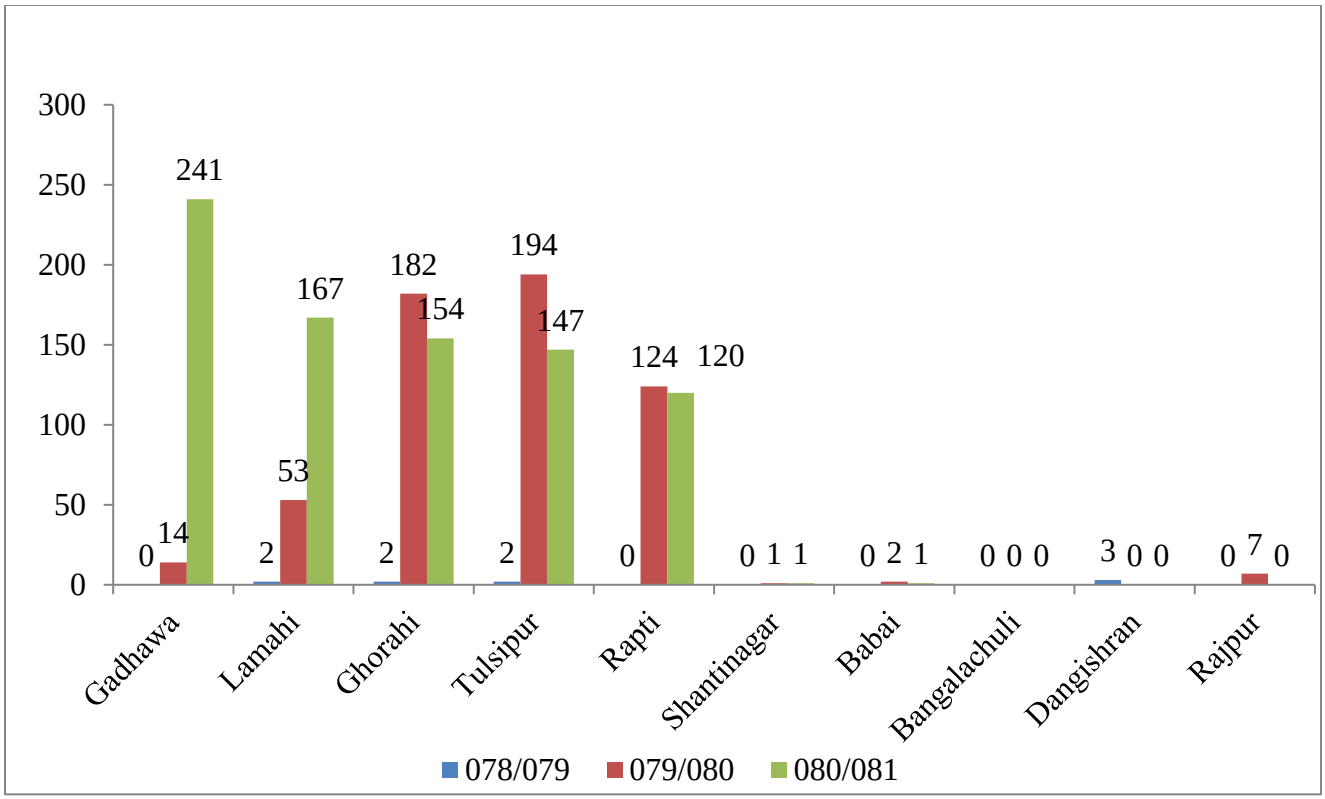


Figure 45: Palikawise distribution of Dengue Case:

SWOT Analysis of Dengue Program

Strength	Weakness
▪ Allocated the Budget for search and destroyed in health office & Municipality. ▪ Conducting search and destroy program in coordination with municipality and various stakeholders ▪ Compiled and analyzed the reports of government and private health institutions ▪ IVM guideline 2020 issued by the Centre	▪ Giving priority to pesticide spraying and fogging by public representatives for control the dengue. ▪ Inadequate supply of RDT kits from the center for Dengue testing ▪ Taking expensive fees for dengue testing from private health institutions. ▪ Fees for dengue testing have not been determined at the central and local levels. ▪ No initiative for serotype identification. ▪ Adopting traditional treatment methods for patients.
Opportunity	**Threat**
▪ In case of infection with one of the four serotypes of dengue, getting immunity against it for life long. ▪ Signs and symptoms of dengue disease do not appear in most patients. ▪ All private health institutions and government hospitals have arrangements to check for dengue disease even if they charge a fee. ▪ Vector identification by conducting entomological surveillance program from time to time. ▪ Complication rate after dengue disease is low.	▪ If infected with the Aedes mosquito from dengue virus that transmits all its eggs are infected. ▪ Aedes mosquito eggs can survive without water for long periods of time and will hatch if exposed to water again. ▪ Aedes mosquito bites during the day time. It likes to suck human blood. ▪ Aedes mosquito bites many people at the same time, which can transmit the disease to many people at the same time

Non-communicable diseases (NCDs), Mental Health and Injury Program:

Non-communicable diseases (NCDs):

Introduction:

Non-communicable diseases (NCDs) are emerging as the leading cause of death globally and also nationally due to changes in many social determinants like unhealthy lifestyles, globalization, trade and marketing, demographic and economic transitions. The deaths due to NCDs (Cardio-Vascular Disease, diabetes, cancer and respiratory disease) haveincreased from 60% of all deaths in 2014 to 66% in 2018 (WHO Nepal Country profile 2018). Globally, 15 million people die prematurely due to NCDs annually and over 85% of these deaths occur in low and middle-income countries.

The World Health Organization has identified NCDs as a major public health problem. NCDs pose a challenge in achieving the Sustainable Development Goals 2030 of reducing the premature NCD related mortality by one third by 2030. The premature mortality due to NCDs in Nepal has risen from 51% in 2010 to 71% in 2019. The proportional mortality of NCDs is ever increasing. CVD is responsible for 30% deaths, cancer 9%, diabetes 4%, chronic respiratory disease 10% and other NCDs 13%.

Key strategies for the prevention and control of NCDs include:

- Reducing exposure to risk factors through health promotion and primary prevention,
- Early diagnosis and management of people with NCDs, and
- Surveillance to monitor trends in risk factors and diseases.

Package of essential non-communicable disease (PEN) Implementation Plan (2016–2020) has been developed in line with the **Multi-Sectoral Action Plan (MSAP)** for prevention and control of NCDs **(2014-2020).** Recently Multisectoral Action Plan for NCDs (2021-2025) endorsed by the cabinet of ministry.

Multi-Sectoral Action Plan (MSAP) II for NCD: - 2021-2025 AD.

Strategic Approach for MSAP II

Vision: - All people of Nepal enjoy the highest attainable status of health, well-being and quality of lifeat every age, free of preventable NCDs, avoidable disability and premature death.

Goal: - Reduce the burden of NCDs in Nepal through "whole of government" and "whole of society" approach.

Specific objectives

- To raise priority accorded to the prevention and control of non-communicable diseases in the national agenda, policies and programs.

- To strengthen national capacity and governance to lead multisectoral action and partnership across sectors for the prevention and control of noncommunicable diseases.
- To reduce risk factors for noncommunicable diseases and address underlying social determinants across sectors.
- To strengthen health systems through provision of people-centric, comprehensive, integrated, and equitable care for improved prevention and control of NCDs.
- To establish NCD surveillance, monitoring and evaluation system for evidence-based policies and programmes.

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

Mental Health Programs:

History of mental health services in Nepal roots back to 2018 (1961) as an out-patient service from Bir Hospital. Mental health problems constitute of 18% of the total NCDs and is the fourth leading cause of disability. National Mental Health Survey 2077 (2020) showed that 10% of the adult population had some mental disorder in their lifetime and 4.3% currently had some mental disorder.

The prevalence of suicidality was 7.2%, current suicidality was 6.5%, lifetime suicidal attempts were 1.1% and risk of future suicidal attempts was 0.3%. There is increased risk among the vulnerable like- poor, hard to reach population, homeless, conflict affected, survivors of violence, minority groups, non-binary gender, prisoners, people in humanitarian setting are more prone to mental health problems. Nepal has endorsed its National Mental Health Strategy and Action Plan (NMHSAP) 2077 as an umbrella strategy to guide the overall mental health program planning and service delivery.

Five strategies of National Mental Health Strategy and Action Plan 2077

- Ensure easy availability, affordability and equitable access in mental health services
- Manage resources, human resources and institutionalize mental health and psychosocial services.
- Promote mental health and increase awareness to eliminate superstitions, myths related to mental health.
- Protect human right of people with mental health problem and psychosocial disability
- Integrate mental health services information with existing integrated health information system and promote research.

Table 26: Status of Non-Communicable Diseases in FY 2080/81

NCD cases on Treatment (OPD/Emergency)	Number of new cases		Number of Death	Remarks
	Male	Female		
Cardiovascular Disease	**6**	**7**		
Cancer	**4**	**2**		
COPD	**2280**	**1908**		
Diabetes	**1040**	**905**	**30**	
Asthma	**1102**	**701**		
Hypertension	**3845**	**3002**		
Stroke	**51**	**39**		
Heart attack	**11**	**7**		
CKD	**3**	**1**		
RHD	**35**	**8**		
Congenital heart disease	**0**	**0**		
Thyroid Disease	**61**	**70**		
Obesity	**4**	**5**		
Other NCDs	**751**	**520**		
Total	**9193**	**7175**	**30**	

* Source DHIS-2

Table 27: Control and Follow Up Cases of Hypertension and Diabetes

Types of Cases	Hypertension	Diabetes:
Follow Up cases	**7308**	**1643**
Control Cases	**5646**	**1334**

* Source DHIS-2

Table 28: Status of Mental Heath peoblems in FY 2080/81

Mental Health Cases on Treatment (OPD/Emergency)	Number of new cases		Remarks
	Male	Female	
Depression	212	334	
Suicide Attempt	52	56	
Epilepsy	2	2	
Psychosis	3	4	
Anxiety	86	76	
Alcohol Use Disorder	9	2	
Dementia	19	22	
Emotional and Behavioral Disorder of Children and Adolescents	30	47	
Conversion Disorder	10	41	
Bipolar Disorder	2	12	
Other Substance Use Disorder	7	5	
Other Mental Disorder	1	0	
Total	**433**	**601**	

* Source DHIS-2

Table 29: Status of injuries in FY 2080/81

Types of Injuries	Number of new cases		Number of Death	Remarks
	Male	Female		
Road Traffic Injuries	2005	541	2	
Fall	1231	902		
Burn	320	160		
Drowning	6	4		
Bites	570	301		
Violence	124	152		
Self harm	1	3		
Occupational Injury	1121	411		
Total	**5378**	**2474**	**2**	

* Source DHIS-2

Table 30: Screening of Diabetes, Blood Pressure and Kidney Disease above 40 years age population.

Name of Local level	Diabetes			Blood Pressure (BP)			Kidney Disease		
	Total Popln.	Problems	%	Total Popln.	Problems	%	Total Popln.	Problems	%
Rapti RM	9610	161	1.7	9610	51	0.5	9610	19	0.2
Gadhawa RM	8035	133	1.7	8035	51	0.63	8035	13	0.2
Rajpur RM	4287	105	2.4	4287	44	1	4287	15	0.3
Bangalachuli RM	3833	76	1.9	3833	59	1.5	3833	6	0.2
Dangisharan RM	4679	101	2.2	4679	95	2	4679	6	0.12
Shantinagar RM	5367	131	2.4	5367	125	2.3	5367	14	0.3
Baba RM	5422	140	2.6	5422	63	1.2	5422	12	0.2
Total	**41233**	**847**	**2.1**	**41233**	**488**	**1.2**	**41233**	**85**	**0.2**

Health Management Information System (HMIS)

Introduction:

Health Management Information System (HMIS) operating on DHIS2, an ICT friendly platform with highly scalable features, manages health sector information in an integrated and comprehensive manner through a one door system. HMIS is collection, storing, processing (analysis), reporting of health information to support the operation management and decision. HMIS is integrated effort to collect, process, report and use health information and knowledge to influence policy making, Programme and research. Health Management Information System (HMIS) operating on DHIS2, an ICT friendly platform with highly scalable features, manages health sector information in an integrated and comprehensive manner through a one door system. HMIS is P_1 Programme under management division. **HMIS** was started in **2051/52 (1995 A.D.)** Revised HMIS form- formates were intrpduced all over the country since **FY 2071/72. With total 58 tools,** 53 Recording tools and 5 Reporting tools. Latest Revision of the HMIS tool in FY 2078/79 was the massive effort in history of tool revision by IHIMS. With **total 73 Tools, 68 Recording tools and 5 Reporting tools**.

Objectives of HMIS: -

- To monitor the achievement, coverage, continuity and quality of health services.
- To access progress towards districts health Programme.
- To provide information that can be used to improve the quality of care.
- To health senior manager develop appropriate health policy guidelines.
- To link data/information to all department, division and center for quick application of data.
- To support PEM (Planning, Evaluation and Management) of all health Programme.

Grouping of HMIS Tools: -

Table 31: Latest Revised in 2078/79, HMIS have 9 section and 73 forms

Number	Sub-number	Groups	Number	Sub-number	Groups
1	1.1-1.8	Common Forms	6	6.1-6.10	Tuberculosis.
2	2.1-2.8	Infant & Child Haelth.	7	7.1-7.6	HIV/AIDS & STIs.
3	3.1-3.8	Family Welfare.	8	8.1-8.6	Hospital.
4	4.1- 4.4	Community Services.	9	9.1-9.5	Reporting Form.
5	5.1-5.10	Vector Borne, NCDs & senior Citizens Health Servises			

HMIS Reporting Tools

HMIS 9.5: FCHV monthly reporting form.

HMIS 9.5: PHC/ORC monthly reporting form.

HMIS 9.3: HP/PHCC/BHSC/UHC monthly reporting form.

HMIS 9.4: Public Hospital monthly reporting form.

HMIS 9.5: Non- Public Hospital Monthly Reporting form.

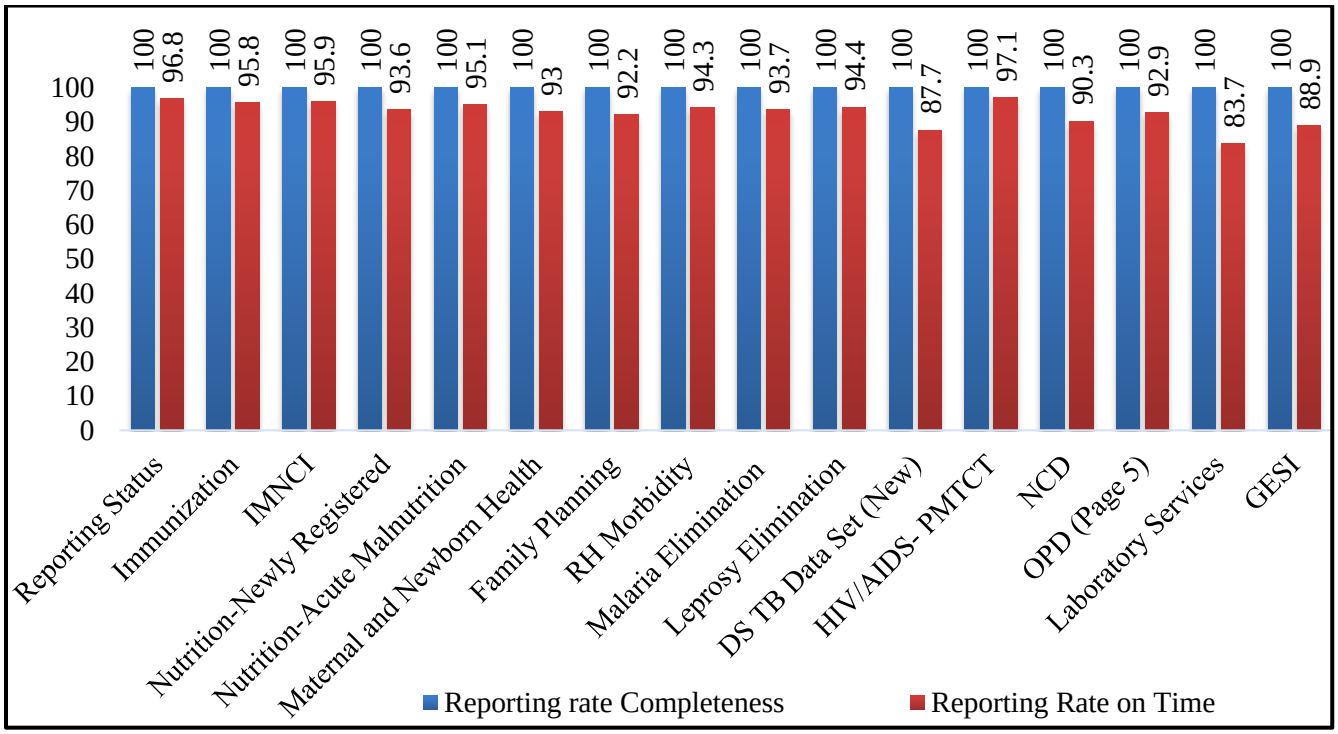


Figure 46: Reporting Status of different Program in FY 2080/81

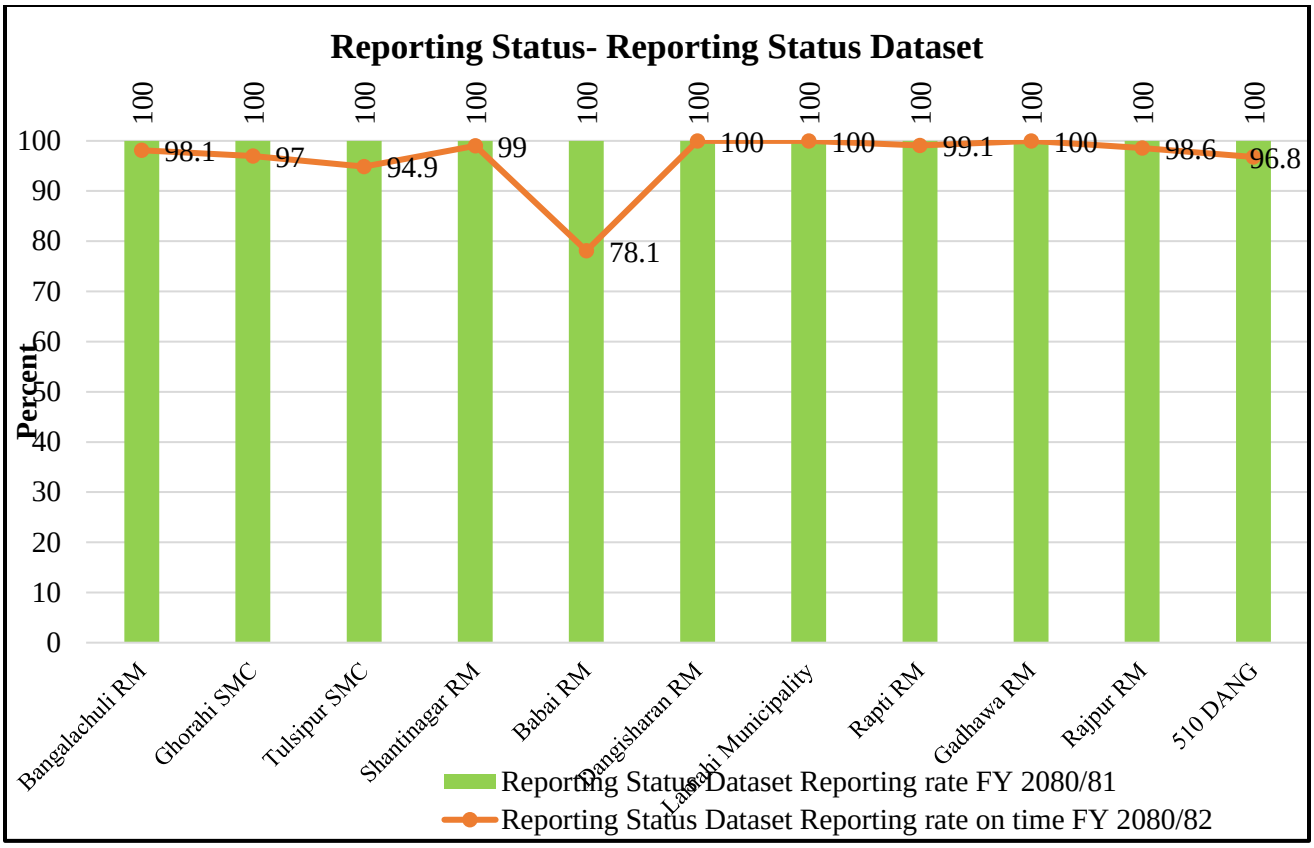


Figure 47: Palika-wise Reporting Status in FY 2080/81

Logistic Management Information System Program

It is defined as the systemic and scientific process of planning, implementing and controlling the efficient and effective flow and storage of resources from the point of origin to the consumption in order to meet the customer's requirements. In health care set up logistic management refers to medicine, equipment and materials management. To streamline logistics management, LMIS unit was established within the Logistic Management Division (LMD) in fiscal year 2050/51 (1994), now under MD. The LMIS unit introduced a web-based LMIS in fiscal year 2065/66 and later implemented an online Inventory Management System (IMS) in fiscal year 2073/74 for store management and to strengthen supply chain management. Store management should be done according to FEFO (First Expiry First Out).

Goal: - Quality health commodities available at health facilities and community level round the year.

Overall Objective:

To plan and carry out the logistics activities for the uninterrupted supply of essential medicines, vaccines, contraceptives, equipment, HMIS/LMIS forms and allied commodities (including repair and maintenance of bio-medical equipment) for the efficient delivery of healthcare services from the health institutions of government of Nepal in the country.

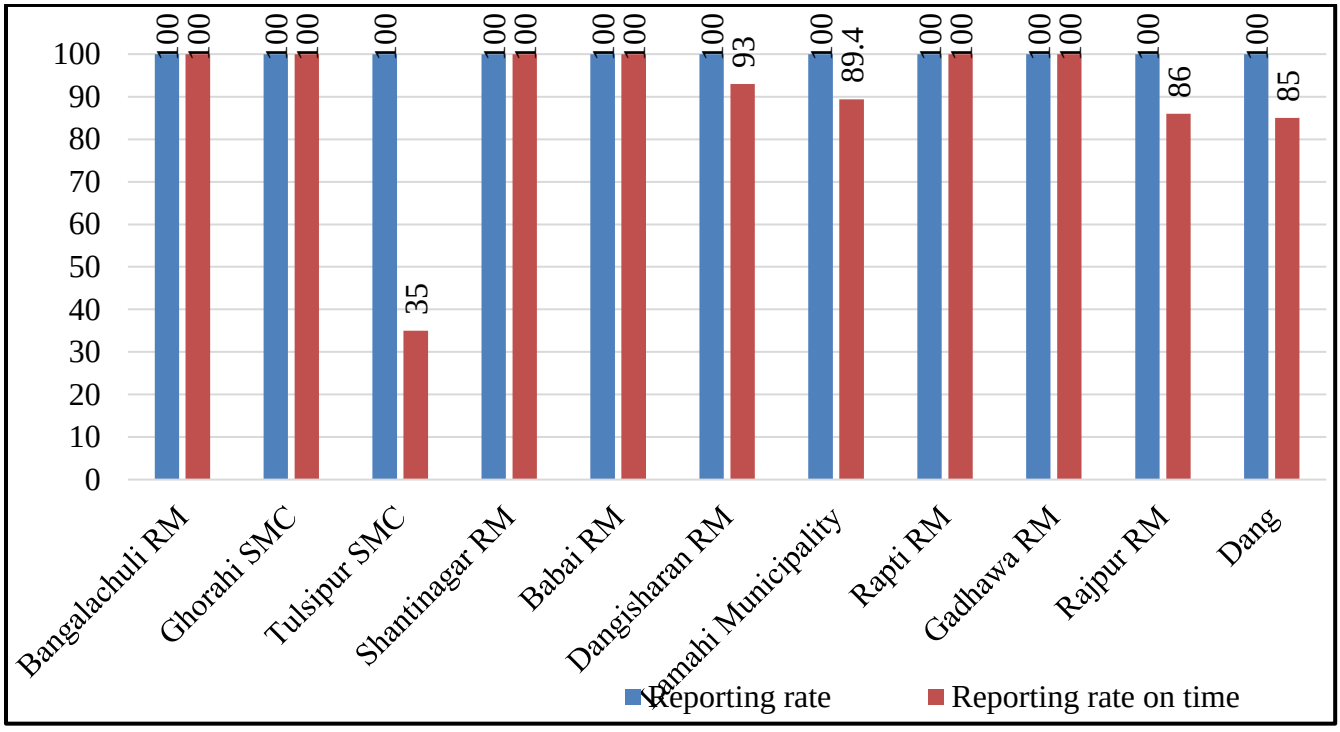


Figure 48: eLMIS reportiong status in FY 2080/81

Female Community Health Volunteer (FCHV) Program

Introduction:

The Government of Nepal initiated the FCHV program in 2045/46 (1988/1989) in 27 districts and expanded it to all 77 districts thereafter. Initially one FCHV was appointed per ward and followed by a population-based approach that was introduced in 28 districts in 2050 (1993/94). Out of the total of 51,423 FCHVs recruited a total of 49,481 (as reported in HMIS) FCHVs are actively working in Nepal. The goal and objectives of the programme.

The major role of FCHV is to promote health and healthy behavior of mothers and community people for the promotion of safe motherhood, child health, family planning and other community health services with support of health personnel from HP, and PHCC.The FCHV program strategy has been revised in 2067 (2010) and document provides strategic directions and critical approaches for support of each FCHVs. FCHV strategy was firstly revised in 1990, second in 1992 and third in 2003, fourth time in 2008. It was rewritten in in 2067/68. The first revision of FCHV strategy 2067 was done in 2076. This is revised in the context of federalism.

FCHV Strategy 2067 (First revision 2076)

Key points:

- This strategy has 6 strategies, and 6 strategic objectives.
- There should be at least 15 members in mother group for health. the priority will be given to marginalized and hard to reach women.
- The member secretary of mother group for health (MGH) is FCHV.
- The meeting of the MGH should be conducted at least once a month. Usually it can be conducted on the day when PHC/ORC clinic is conducted in that community.
- Every year, MGH meeting should review the work of FCHV and inform local health facility.

Criteria of FCHV selection

- Permanent resident of that community.
- Interested to work as FCHV for at least five years.
- Age of 25-45 years
- Married women should be prioritized.
- Interested to do social work
- Should complete 10th grade, but in case of mountain or remote place, she can have fundamental education.
- Marginalized, and hard to reach women.
- Not involved in formal job.
- Not a member of political party, or not an elected local representative.
- Married or single (priority to be given to women having up to 1-2 children in case of married woman.

- Priority will be given to women from Dalit, Janajati and who can read and write

Goal of FCHV program

Goal: - Improve the health of local communities by promoting public health. This includes imparting knowledge and skills for empowering women, increasing awareness on health-related issues and involving local institutions in promoting health care.

Objectives: -

i) Mobilise a pool of motivated volunteers to connect health programmes with communities and to provide community-based health services.
ii) Activate women to tackle common health problems by imparting relevant knowledge & skills.
iii) Increase community participation in improving health,
iv) Develop FCHVs as health motivators and
v) Increase the use of health care services.

Table 32: Number of FCHV Palika Wise in FY 2080/81

Name of Local level	Total no. of FCHV	FCHV took Basic Trained	FCHV took Refreshor Trained	Complete 60 yrs age in FY 2080/81	Entry of FCHV in DHIS-2
Bangalachuli RM	**55**	**50**	**27**	**0**	**0**
Ghorahi SMC	**191**	**183**	**157**	**9**	**191**
Tulsipur SMC	**195**	**183**	**157**	**2**	**67**
Shantinagar RM	**48**	**40**	**40**	**0**	**48**
Babai RM	**55**	**50**	**50**	**1**	**55**
Dangisharan RM	**51**	**51**	**21**	**0**	**51**
Lamahi Municipality	**72**	**65**	**0**	**1**	**0**
Rapti RM	**64**	**64**	**62**	**0**	**0**
Gadhawa RM	**82**	**19**	**63**	**1**	**54**
Rajpur RM	**54**	**40**	**40**	**2**	**0**
Total	**867**	**752**	**617**	**16**	**466**

National Health Education, Information and Communication Program

Introduction:

National Health Education Information and Communication Centre (NHEICC)is responsible for health promotion activities and delivery of health information and messages using multimedia, methods and channels up to individual level for the demand creation and increased use of available health services under ministry of health and population.

Modern digital media as well as print, audio-visual and social media are used in promoting health behaviours in the areas of communicable and non-communicable diseases, reproductive and child health, mental health, birth defect, organ donation and environmental sanitation. Social behaviour change communication approaches are applied with social mobilization through health volunteers and communication channels at the door step of target audiences. The health promotion activities are currently more focused on capturing hard to reach areas and marginalized populations through new technology and programmes.

Vision: - Healthy, alert and conscious citizens concerned with happy life.

Goal: - The goal of health education, information and communication program is to promote healthy behavior, prevention and control of diseases and increase use of health services.

Objectives:

The objective of the health promotion, health education, information and communication are to raise health awareness, motivate and guided into action to the people as a means to promote improved health status and to prevent disease through the efforts of the people themselves and full utilization of available resources.

Table 33: Health Education and communcation in FY 2080/81:

	School	Community	Others
No. of Session	225	409	107
Total no. of Participants	18812	10644	3379

Bipanna Nagarik Aaushadi Upachar Programme

Introduction:

The provisions for free medication and treatment of severe type of diseases namely Cancer, Heart Disease, Kidney Disease, Traumatic Head Injury, Traumatic Spinal Injury, Alzheimer's diseases, Parkinson's and Sickle Cell Anemia.

"Bipanna Nagrik Aaushadi Programme"

Goal: - Managed the provision of free treatment to impoverished citizens.

Objectives:

- Notified the different types of hospitals for free medication and treatment.
- Develop, revise and update the policy, standard, guideline and protocol for **"Bipanna Nagrik Aaushadi Programme"**

Major Ongoing Activities

Social Health Security Section provides the following funding for impoverished Nepalese citizens to treat serious health conditions:

- Up to NPR 100,000 per patient via notified hospitals for free medication and treatment of severe some diseases including **cancer, heart disease, head injury, spinal injuries, kidney failure, Alzheimer's, Parkinson's and sickle cell anaemia diseases.**

Table 34: Recommendation for Free health service to Bipanna Nagarik Aaushadi Upachar Programme in FY 2080/81

Name of Local level	Types of Disease							
	Kidney	Heart	Cancer	Head Injury	Spinal Injury	Sickel Cell Anemia	Paekinson's Disease	Alzimer Disease
Bangalachuli RM	5	7	17	0	0	0	0	0
Ghorahi SMC	0	20	78	0	0	3	0	28
Tulsipur SMC	39	43	90	0	7	2	0	0
Shantinagar RM	4	3	15	0	1	2	1	0
Babai RM	13	12	22	0	2	0	2	3
Dangisharan RM	10	9	17	0	0	8	0	0
Lamahi Municipality	15	12	26	0	2	6	0	0
Rapti RM	22	14	38	0	1	13	0	0
Gadhawa RM	4	13	20	0	1	9	0	0
Rajpur RM	2	3	4	0	0	2	0	0
Total	**114**	**136**	**327**	**0**	**14**	**45**	**3**	**31**

Table 35: Number of Chronic Disease Treatment Patients from Federal Government (NRP5000) in FY 2080/81

Name of Local level	Spinal Paralysis	Kidney Disease	Cancer Disease
Bangalachuli RM	0	1	4
Ghorahi SMC	0	2	9
Tulsipur SMC	0	0	0
Shantinagar RM	0	0	0
Babai RM	2	16	22
Dangisharan RM	0	0	0
Lamahi Municipality	2	21	53
Rapti RM	1	7	40
Gadhawa RM	1	7	14
Rajpur RM	0	7	0
Total	**6**	**61**	**142**

Table 36: Special economic support 3 chronic diseases from Province Government (NRP 2,00,000)

Name of Local level	Kidney Transplantation	Cancer Disease	Heart Vulve Replacement	Total
Bangalachuli RM	0	2	0	2
Ghorahi SMC	6	46	3	55
Tulsipur SMC	5	101	9	115
Shantinagar RM	3	9	0	12
Babai RM	0	12	1	13
Dangisharan RM	1	13	2	16
Lamahi Municipality	3	17	4	24
Rapti RM	1	25	0	26
Gadhawa RM	0	8	0	8
Rajpur RM	3	3	0	6
Total	**22**	**236**	**19**	**277**

Table 37: Treatment of total number of Senior citizens >80 Years; FY 2080/81

Name of Local level	Treatment of total no. of senior citizens 80 Yrs old.			Major Diseases
	Female	Male	Total	
Bangalachuli RM	**30**	**31**	**61**	Hypertension, Diabetes Mellitus, COPDs, Asthma, Stroke, Arthritis, Anxiety etc.
Ghorahi SMC	**423**	**288**	**711**	
Tulsipur SMC	**398**	**343**	**741**	
Shantinagar RM	**296**	**344**	**640**	
Babai RM	**84**	**84**	**168**	
Dangisharan RM	**126**	**86**	**212**	
Lamahi Municipality	**390**	**341**	**731**	
Rapti RM	**253**	**272**	**525**	
Gadhawa RM	**188**	**222**	**410**	
Rajpur RM	**42**	**27**	**69**	
Total	**2230**	**2038**	**4268**	Per Person Expenditure 332.68

Table 38: Status of Water Quality test in FY 2080/81

Name of Palika	Water Test			E. Coli Positive Sample	E. Coli Negative Sample	% of E. Coli Positive Sample
	Private	Public	Total Sample Collectin			
Ghorahi SMC	**0**	**1**	**3**	**0**	**3**	**0**
Lamahi Municipality	0	1	5	0	5	0
Rapti RM	0	2	16	0	16	0
Gadhawa RM	0	3	19	0	19	0
Shantinagar RM	0	2	10	9	1	**90%**
Babai RM	0	3	15	13	2	**87%**
Total		**12**	**68**	**22**	**46**	**32.4%**

Table 39: Top Ten Disease of FY 2080/81

S.N.	Disease Name	Number of Cases
1	Gastritis (APD)	32944
2	Upper Respiratory Tract Infection (URTI) Cases	29191
3	Conjunctivitis Cases	29000
4	Hypertension	19395
5	Water/Food Borne-Presumed Non-Infectious Diarrhoea Cases	17350
6	Skin Diseases-Fungal Infection (Lichen Planus) Cases	16574
7	Rhinitis Cases	13839
8	Lower Respiratory Tract Infection (LRTI) Cases	13013
9	Dermatitis/Eczema Cases	10437
10	Dental Caries Cases	9628

Performance Evaluation

The Health Office Dang has formed a five-member evaluation committee in leadership of Health Office chief to evaluate performance and examine different aspects of health system functionality and ranking of local levels of Dang based on the annual service delivery and management status. For the fiscal year 2080/81, the evaluation was conducted using specific indicators provided by the Ministry of Health of Lumbini Province.

The detail criteria undertaken for evaluation, their weight was described in table below.

Table 40: Detail criteria for local level performance evaluation

Indicator	Numerator	Multiplier	weight	Evaluation Criteria
National Immunization Program (14)				
Dropout Rate of DPT1 vs DPT3	Number of children under one year who have received Penta Ist-MR II vaccine	100	3	Below 10% dropout rate equals 3, otherwise decreases proportionately
Penta3 Coverage	Number of children under one year immunized with 3rd dose of Penta	100	3	100% coverage equals 3, otherwise decreases proportionately
%measles/rubella 2	Number of children under one year immunized with II dose of measles/ rubella	100	5	100% coverage equals5, otherwise decreases proportionately
% of TD 2 & 2+	Number of Pregnant Women immunized with TD2 & TD2+	100	3	100% coverage equals 3, otherwise decreases proportionately
Nutrition Program (6)				
Average visit Growth	Total Visit Time of growth	100	3	100% coverage equals 3, otherwise

monitoring (U2)	monitoring Children who Completed 23 months			decreases proportionately
% of exclusive Breast feeding	Total Number of children completed 6 month who exclusive Breast Feeding	100	3	100% coverage equals 3, otherwise decreases proportionately
Community Based Integrated Management of Neonatal & Childhood Illness (CBIMNCI, 6)				
% of diarrheal cases treated with zinc plus ORS	Number of children under five years with Diarrhea treated with ORS and zinc (facility, outreach and community	100	3	100% coverage equals 3, otherwise decreases proportionately
% of severe pneumonia among new cases	Number of new cases of children under five years with ARI Suffering very/severe pneumonia (facility, outreach & community)	100	3	3 for coverage ≤1%, otherwise decreases proportionately
Family Planning Program (6)				
New Acceptors rate as percentage of women of reproductive age of modern temporary method	Total number of WRA New using modern methods of family planning	100	3	3 for New users rate ≥10%, otherwise decreases proportionately
CPR	Total number of WRA Current User all methods of family planning end of Ashadh	100	3	100% coverage equals 3, otherwise decreases proportionately

Safe Motherhood program (21)				
% of pregnant women who had first ANC Checkups among expected pregnancy	Number of pregnant women aged 15-49 years who had first ANC Checkup	100	3	3 for coverage ≥80%, otherwise decreases proportionately
% of pregnant women who had eight ANC Checkups as per protocol	Number of pregnant women aged 15-49 years who had eight ANC Checkups as per protocol	100	5	5 for coverage ≥80%, otherwise decreases proportionately
% of Institutional delivery	Number of deliveries conducted in health facilities	100	3	3 for coverage ≥65%, otherwise decreases proportionately.
% of 4 PNC Visit	Number of 4 PNC	100	5	5 for coverage ≥65%, otherwise decreases proportionately
Number of Home delivery reported	Number of Home delivery Reported by HF	100	5	0 for 100 cases and 5 for o cases
Reproductive Health Morbidity (3)				
% of screening of Uterine Prolepses	Number of Uterine Prolepses Female	100	3	100% equals 3, otherwise decreases proportionately
Primary Health Care Out Reach Clinics (PHCORC), (3)				
% of planned primary health care (PHC) Outreach clinics (ORC) conducted	Number of primary health care outreach clinics conducted	100	3	100% equals 3, otherwise decreases proportionately

Female Community Health Volunteers (FCHV) program (3)				
% of mothers group meetings held	Number of mothers group meetings held	100	3	100% equals 3, otherwise decreases proportionately
Malaria Control Program (3)				
% of blood slide collected and examined	Total Number of blood slides examined (microscopic, RDT, both)	100	3	100% coverage equals 3, otherwise decreases proportionately
Tuberculosis Control Program (8)				
Case Notification Rate (All forms of TB) (%)	All forms of TB cases registered in NTP in defined time and area	100	3	100% equals 3, otherwise decreases proportionatly
Treatment Success Rate (%)	[(Number of new positive cases (bacteriologically confirmed who smear Negative in the last month of treatment and On at least one previous occasion) + (Number Of new positive cases registered who Completed treatment but did not meet the Criteria for cure or failure)]	100	5	5 for coverage ≥90%, otherwise decreases proportionately
Reporting Status of HMIS, Physical and Financial Progress (13)				
Reporting rate of Health Management Information System	Number of health facilities reported their HMIS report ontime completely	100	5	5 for cent percent Reporting, otherwise decreases proportionately

Data error Checking false	Number of data error false reported in 12 months	100	3	3 for cent percent Reporting, otherwise decreases proportionately
Annual Report Fact sheet	NA	100	5	5 for Annual report fact sheet otherwise 0
Achievement Status (3)				
Senior citizens Home Visit Service	NA	NA	3	3 for Service provide Otherwise 0 proportionately
Local level annual health report (5)				
Local level Evaluation	NA	NA	5	Evaluation of Local Level team 5 for excellent, otherwise decreases accordingly
Remoteness (5)				
Remoteness	NA	NA	3	Remote area out of High way Wards-3 High way touch Wards-2 Palika capital Wards-1
Budget expenditure (3)				
Budget expenditure	NA	NA	3	3 For 100% expenditure Otherwise Decreasing proportionately

Table 41: Ranking of Local level performance evaluation

Annual Performance Evaluation 080/81			
Name of Local level	**Obtained Marks (%)**	**Obtained Rank 2080/81**	**Last Year Rank**
Bangalachuli Rural Municipality	60.33	9th	5th
Ghorahi Sub-metropolitan City	67.38	2nd	2nd
Tulsipur Sub-metropolitan City	65.11	5th	7th
Shantingar Rural Municipality	62.49	7th	3rd
Babai Rural Municipality	55.90	10th	9th
Dangisharan Rural Municipality	66.19	3rd	8th
Lamahi Municipality	64.72	6th	6th
Rapti Rural Municipality	68.35	1st	1st
Gadhawa Rural Municipality	66.13	4th	4th
Rajpur Rural Municipality	61.04	8th	10th

External Developmental partners

Name of Organization/Program	Major thematic areas	Geographic Coverage	Major Achievements in FY 2080/081	Contact Person/s (Name, Designation, Email, Phone number	Working in Fiscal Year 81/082 in district (Yes / No)
Dang Plus Implemented program: Care and support program	HIV testing and counseling	Dang district (All 10 local level)	• From January to August 2024, a total of 180 people living with HIV (PLHIV) received services through Community Care Centers (CCC. • Total 220 PLHIV accessed services at external facilities under the Community and Home-Based Care (CHBC) program. • During HIV testing activities, 331 individuals were tested, with two confirmed HIV-positive cases. The organization supported these individuals in enrolling in antiretroviral therapy (ART). • The organization majorly support to enrolled PLHIV in health insurance program. • Provided education, distributing condoms and lubricants, offering pre-exposure prophylaxis, conducting index testing, promoting HIV self-testing, engaging in enhanced peer outreach, facilitating online	Gopal Nepali Program/ Finance officer Email: gopalnepali46@gmail.com Contact no: 9844929346	Yes

			appointments, counseling and referral services.		
Change Team	Harm Reduction program among PWID	Dang district (All 10-local level)	Under the Global Fund's comprehensive HIV/AIDS program for people who inject drugs (PWIDs) in Dang district, the harm reduction initiative focuses on several key components: 1. **Prevention of Blood-Borne Infections**: Implementing strategies to protect drug users from HIV, AIDS, sexually transmitted infections, and hepatitis. This includes providing access to clean needles and syringes, as well as education on safe injection practices. Since January to August 2024, 54949 syringes and 23453 condoms were distributed to the risk group and PWIPs. 2. **Education and Outreach**: Conducting awareness campaigns to inform PWIDs about the risks of blood-borne infections and the importance of safe practices. Total 751 BCC interventions were conducted in this fiscal year. 3. **Testing and Treatment Services**: Offering regular testing for HIV and other infections, along with access to treatment and care services. Individuals suspected of substance use disorders were referred to	Hari Paudel, Program officer Email:changeteam.program@gmail.com Contact no:9848072411	Yes

			ART (Antiretroviral Therapy) services for comprehensive diagnosis and treatment. 4. **Supportive Services**: Providing psychological support and counseling to help PWIDs cope with the challenges of addiction and improve their overall well-being. Implemented methadone oral substitution therapy to enhance both the physical and mental health of PWIDs, supporting their recovery and reducing harm.		
Manav Swasthya Samaj (MSS)	HIV prevention, Treatment C are and Supp ort for MSM, MSW and TG people in Dang District.	Dang District (Including 10 local level)	**1. HIV prevention education, referral and follow-up:** • Online (www.merosathi.net and social media), and offline • 41,475 condoms and 17,044 lubricants were distributed to the risk population. • 67 individual received Pre-exposure prophylaxis (PrEP) through this program. **2. HIV testing and counseling services from city clinic and community outreach**: • 180 self test-kit were distributed and total 245 individual tested for HIV and received their result. Among them 23 were confirmed as HIV positive and MSS helps to enroll them on ART. • 152 individuals were screened for sexually transmitted infection and 37 were	Junu Chaudhary, Project coordinator Email: bdsdang21@gmail.com Contact no: 9865203828	Yes

			diagnosed and enrolled in treatment. **3. HIV case management:** • Support to treatment service for HIV positive diagnosed case. • Peer navigation, community care and support. • Implement 180 days package for addressing lost to follow up and retention. • Promote Undetectable = Untransmittable(U=U), Treatment literacy. • Facilitate support group/adherence club meeting . • 105 health care workers and other stakeholders were participated in stigma and discrimination reduction and gender-transformative trainings.		
Nagarjun Development  Community	HIV prevention program for migrants and their couples (Funded by The Global Fund and Save the Children)	Dang district (Including 10 local level)	1. **Behavior Change Education Program** **Participants Served:** A total of 14,318 individuals received education and resources aimed at promoting healthy behaviors. 2. **HIV Screening Initiatives** **Screening Conducted:** Home visits and campaigns led to HIV screenings for 11,301 individuals. **Positive Results:** 8 individuals were	Dilendra Malla, District Program officer Email:ndcdang078@gmail.com Contact no: 9847854053	

			confirmed as HIV positive. 3. **Tuberculosis Screening** **Screening Conducted:** Tuberculosis screenings were performed on 14,318 individuals. **Positive Results:** 3 individuals were confirmed as TB positive. **4.Condom and Testing Kit Distribution** **Condoms Distributed:** A total of 69,334 condoms and essential travel test kits were provided to immigrant workers to promote safe practices. **5.Stakeholder Engagement** **Joint Meetings Conducted:** Collaborative meetings were held with stakeholders, health workers, and monitoring teams to enhance support for HIV referral services.		
Family Planning association of Nepal (FPAN)	Family Planning		▪ 6811 CYP achieved. ▪ 201779 SRH services provided to the clints. ▪ 16 batch Implant training provided to government health facility service providers. ▪ 10 mobile camp completed to marginalized	Basanta Khanal, Branch Manager Email:fpandang@fpan.org.np Contact no:	Yes

			people. ▪ MISP (Minimum Initial Service Package) provided for Sexual and Reproductive Health (SRH), along with other SRH and non-SRH services to 7,300 individuals, comprising 944 males, 6,355 (Jajarkot 4430, Rukum West 2869) females, and 1 other gender, through 46 integrated SRH camps. ▪ Out of 4109 women screened for VIA: 106 women were found with different stages of uterine prolapsed. 20 women were suspected with VIA positive. ▪ 107 individuals with disabilities accessed SRH services successfully. ▪ Distribution of contraceptive methods: ✓ Implant: Out of the total benefitted women, 545 opted for the implant method, 10 women chose IUCD. ✓ Conducted 170 SRH sessions, Engaged 7797 participants in SRH sessions. ▪ A comprehensive emergency contraceptive session for school students and out of school students.	9857832208	
MOMENTUM Private Healthcare Delivery Nepal	Reproductive Health, Family planning	Dang district (Ghorahi sub-	1. Enhanced strong technical capacity to enable adolescents (15-19 years) and young people (20-29 years) to access family planning advice, methods of using	Resham DC, Senior Program Officer	Yes

(Funded by USAID) 	(Coordination with private health facilities)	metropolitan, Lamahi municipality and Rapti rural municipality)	contraceptives, delivery services and quality, beneficiary-centred family planning services. 2. Improved managerial and institutional capacity to provide family planning services in an equitable, profitable and sustainable manner. 3. Major activities conducted: ✓ Identification and selection of private clinics, orientation at palika and health facility level, ASRH training to service providers, Depo training to service providers, HMIS and DHIS2 training, Running client feedback mechanism, VCAT orientation, orientation to adolescents at community level, monitoring activities.	Email:resham.dc@crs.org.np Contact no: 9857843891	
Nepal Anti-Tuberculosis Associattion 	Tuberculosis Control and Management	Dang district	•**TB Prevention and Control**: NATA collaborates with the government's National Tuberculosis Program (NTP) to control the spread of TB through preventive measures like awareness campaigns and mass education programs. •**Diagnosis and Treatment**: The organization runs TB diagnosis centers and treatment facilities, offering Directly Observed Treatment, Short-course (DOTS)		Yes

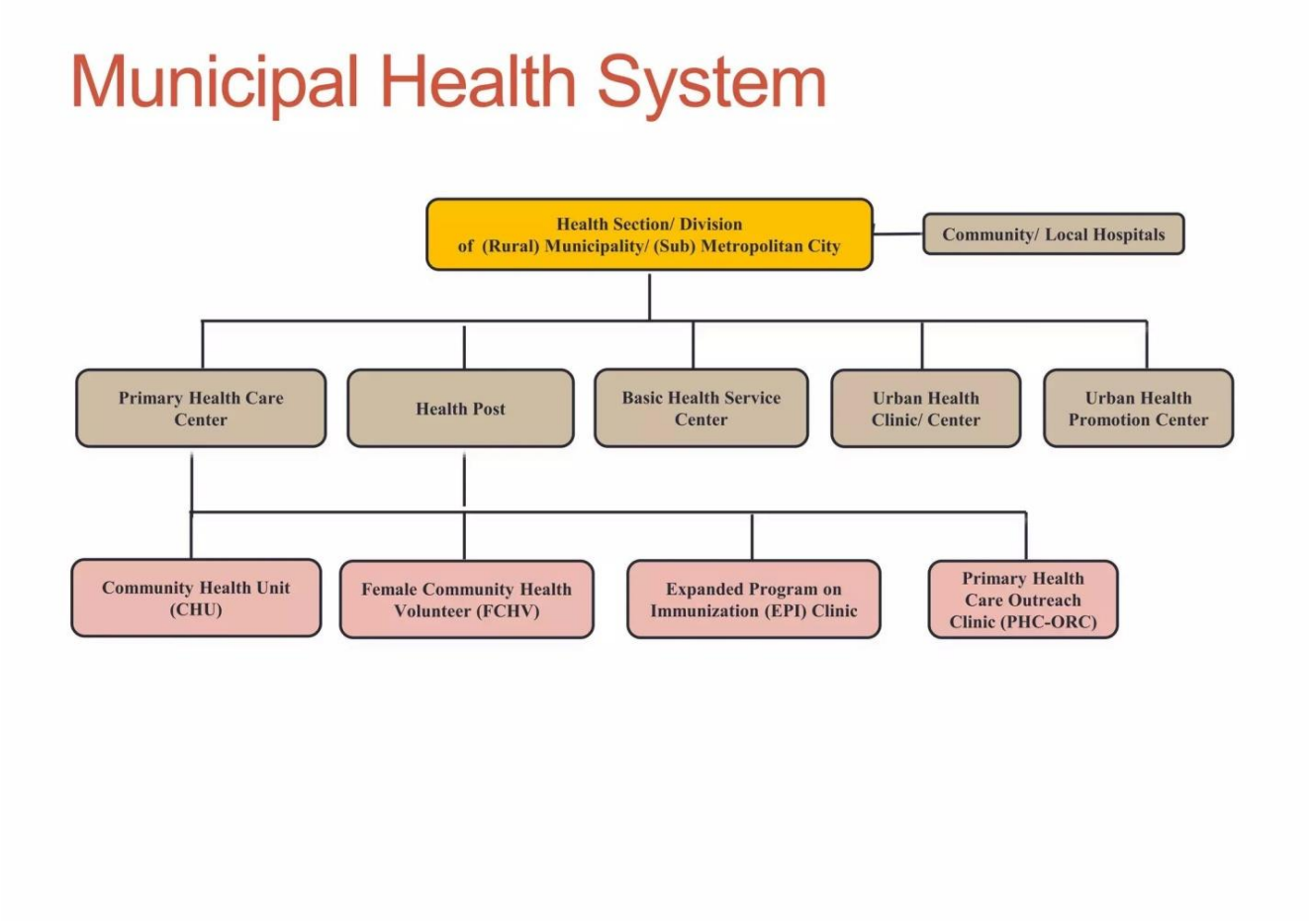
			services to patients across the country. •**Advocacy and Awareness**: NATA organizes community outreach programs, health camps, and workshops to raise public awareness about TB, its symptoms, and the importance of early detection and treatment. •**Training and Capacity Building**: NATA provides training for healthcare professionals and volunteers, strengthening their capacity to manage TB cases and implement TB control strategies. •**Research and Monitoring**: •**Collaboration with International Partners**:		
KIDS Nepal	Tuberculosis control and Management	Dang district (Including 10 local level)	• Sputum collection and transportation for TB diagnosis. • Contact tracing of TB patient family members including children under 15 years of age. • Identification and testing for DR TB among possible DRTB patient. • Contact tracing of DRTB patient's family members. • Support in testing and diagnosis of TB	Aastha Sharma, District Program Coordinator Email: aasthashrama.kids @gmail.com Contact no:9847018040	Yes

			among the children of malnutrition and ARI. • Continuity of Tuberculosis Preventive Therapy (TPT). • Implementation of FAST program to control and diagnosis the Tuberculosis among OPD patients. • TB screening and diagnosis among migrants and seasonal workers. • Coordinating with private health facilities for TB diagnosis, screening and case notification. • Interaction program among private health facilities, government organizations and other stakeholders. • Integrated monitoring and evaluation of TB program. • Review and planning program at local level. • Logistics support (3 layer packaging material)		

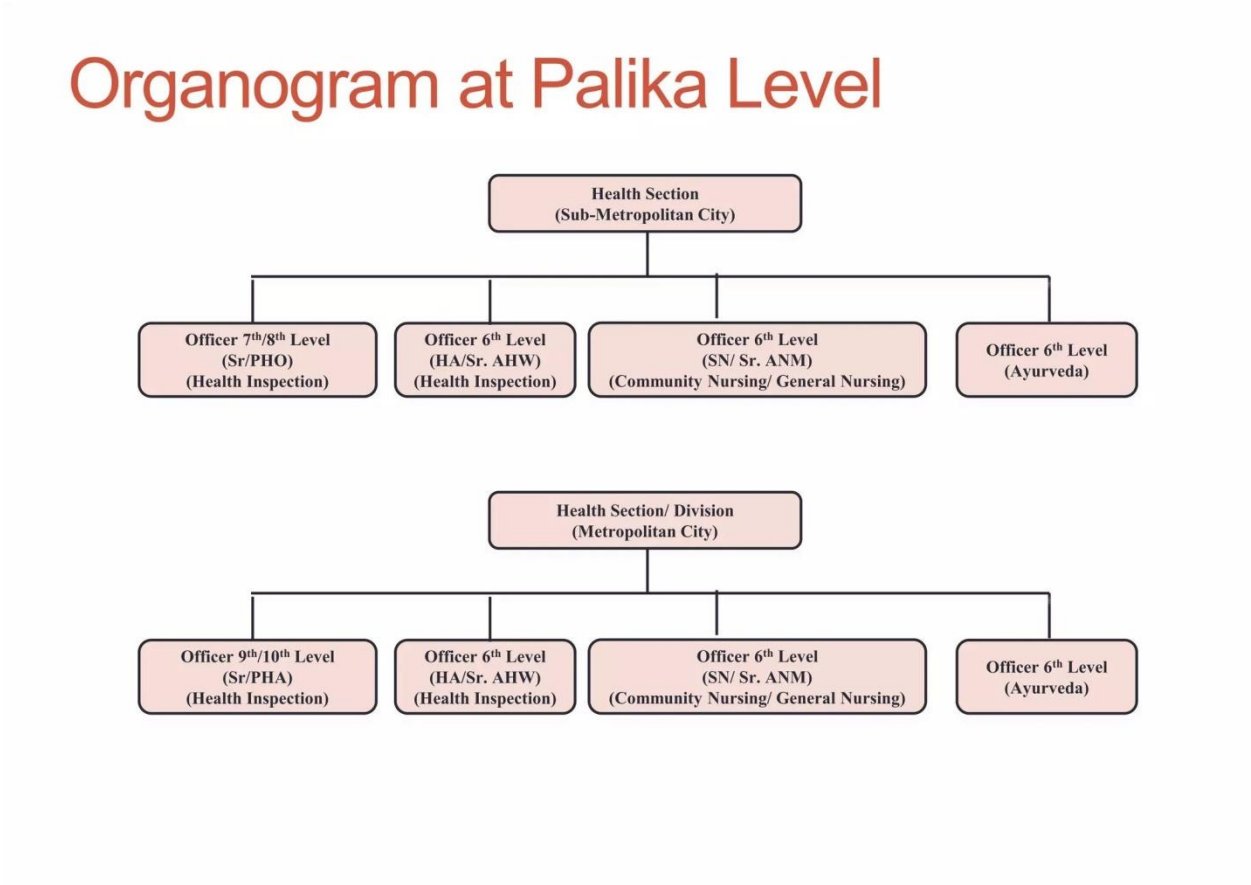
Annex:

Organogram of Local Level:

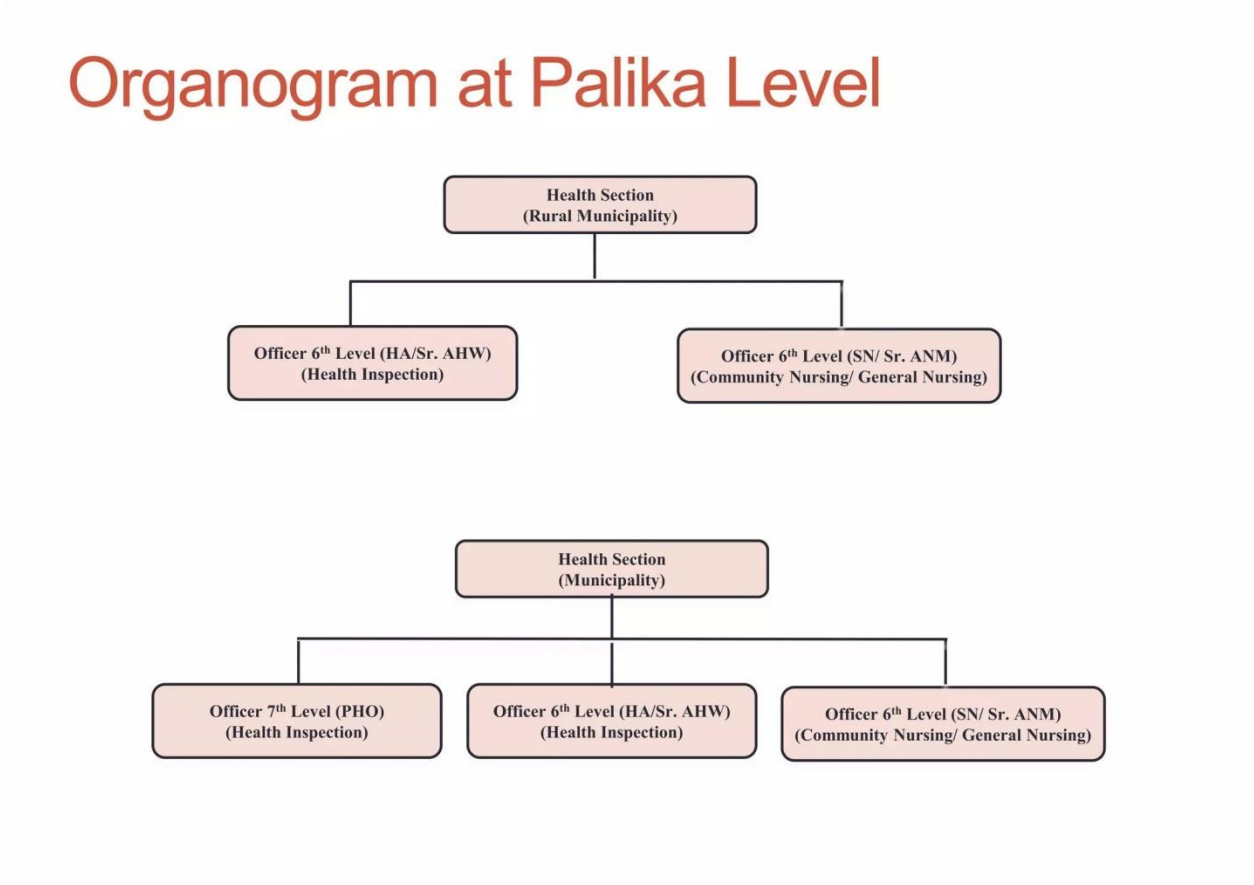
Structure of Municipal Health System



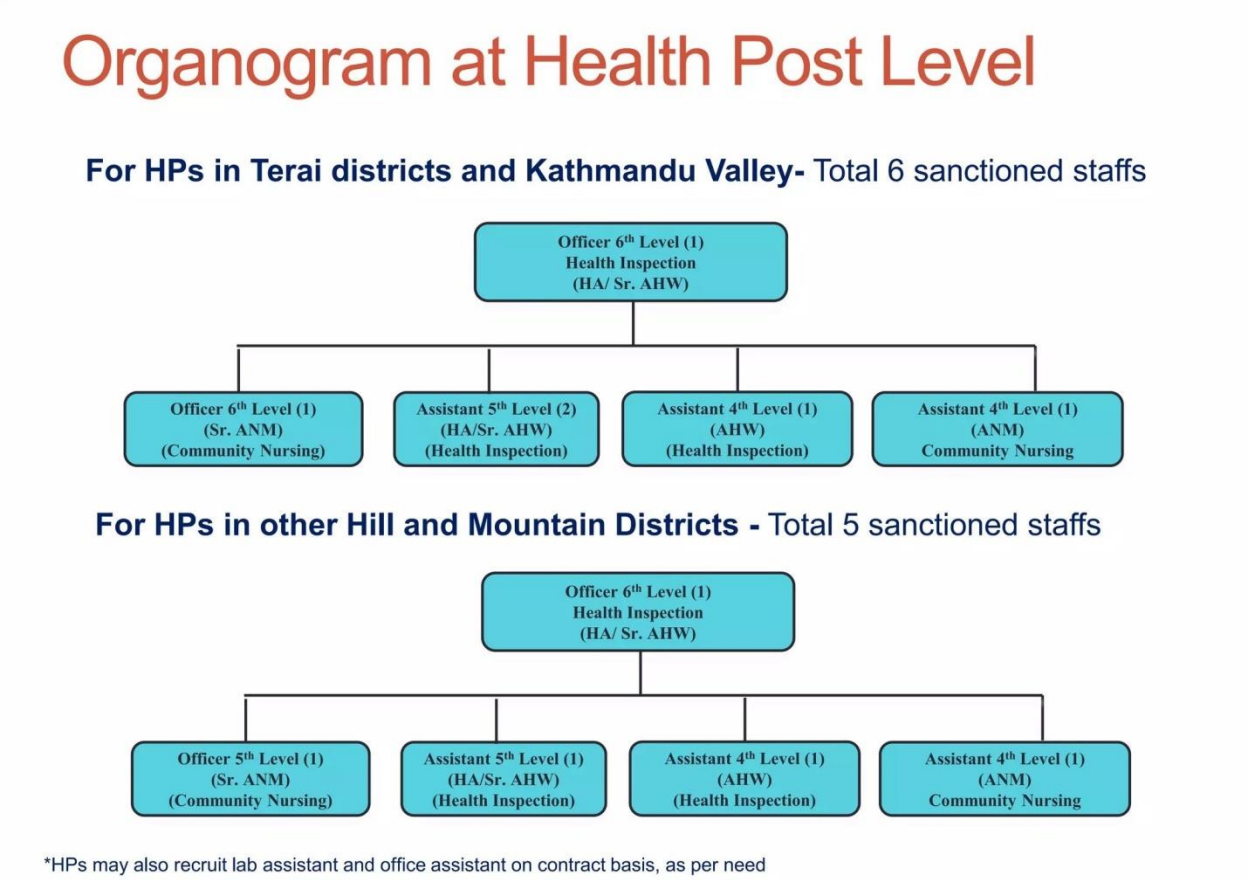
Organogram of Metropolitan City and Sub-Metropolitan City:



Organogram of Municipality and Rural Municipality:



Organogram of Health Post



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