ANNUAL HEALTH REPORT

FY 2080/81

Government of Bagmati Province

Ministry of Health

Health Directorate

Public Health Office, Rasuwa

Dhunce, Nepal

Message from the Chief

I am pleased to present the Annual Health Report for Rasuwa District, which provides a comprehensive overview of the district's public health achievements, challenges, progress, and recommendations for various health programs.

Aligned with Nepal's Constitution, National Health Policy, and Health Sector Strategy, the Public Health Office of Rasuwa is committed to achieving universal health coverage. Our efforts have yielded positive results, contributing to progress towards Sustainable Development Goals and other national health targets.

The data and indicators presented in this report are based on information gathered through an integrated health management information system (HMIS) and annual review meetings conducted at different levels within the district. This comprehensive report identifies key areas for improvement and offers insights for strengthening existing health programs.

I recommend that policymakers, managers, and planners utilize the information contained in this report to inform decision-making at all levels. I extend my sincere gratitude to Ms Neelam Suwal, Public Health Officer, Health Section Chief, and the dedicated teams from all rural municipalities and the Public Health Office for their invaluable contributions to the development of this comprehensive document.

In conclusion, this report serves as a valuable resource for all stakeholders, supporting evidence-based program design, implementation, and monitoring.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
BC	Birthing Center
BCC	Behaviour Change Communication
BEONC	Basic Emergency Obstetric Newborn Care
CB-NCP	Community Based Newborn Care Package
CEONC	Comprehensive Emergency Obstetric Newborn Care
CHU	Community Health Unit
CLT	Comprehensive Leprosy Training
cMYP	Comprehensive Multi-Year Plan for Immunization
DOTS	Directly Observed Treatment Short Course
FB-IMNCI	Facility-Based Integrated Management of Neonatal and Childhood Illnesses
FCHV	Female Community Health Volunteer
FIPV	Fractional Inactivated Polio Vaccine
FP	Family planning
FWD	Family Welfare Division
GBV	Gender Based Violence
HMIS	Health Management Information System
PHO	Public Health Office
HP	Health Post
HR	Human Resources
HTC	HIV Testing and Counseling
HWs	Health Workers
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illness
IUCD	Intrauterine Contraceptive Device
IVM	Integrated Vector Management
LAM	Lactation Amenorrhea Method
LAPM	Long Acting Family Planning Method
MDT	Multi-Drug Treatment
MoH	Ministry of Health
NIP	National Immunization Program
NGO	Non-Government Organization
NHEICC	National Health Education Information and Communication Center
NMSP	National Malaria Strategic Plan

NPHL	National Public Health Laboratory
NTP	National Tuberculosis Program
OPV	Poliomyelitis
PHCC	Primary Health Care Center
PHD	Provincial Health Directorate
PHLMD	Provincial Health Logistic Management Division
PKDL	Post-Kala-Azar Dermal Leishmaniasis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PSBI	Possible Severe Bacterial Infection
RM	Rural Municipality
SARC	Short Acting Reversible Contraceptive Method
SBA	Skill Birth Attendant
SDC	Sustainable Development Goal
SMC	Sub Metropolitan City
SNCU	Special Newborn Care Unit
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
Td	Tetanus and diphtheria
TCV	Typhoid Conjugate Vaccine
UHC	Urban Health Care
VDC	Village Development Committee
VPD	Vaccine-Preventable Disease
WHA	World Health Assembly
WHO	World Health Organization

राष्ट्रिय स्वास्थ्य निति २०७६

१. पृष्ठभुमि

नेपालको सविधानले आधारभुत स्वास्थ्य सेवालाई प्रत्येक नागरिकको मौलिक हकको रूपमा स्थापित गरेको छ। देश संघीय शासन प्रणालीमा गइसकेकोले संघीय संरचनाको वस्तुगत धरातलमा आधारित रही गणुस्तरीय स्वास्थ्य सेवालाई सबै नागरिकको सर्वसुलभ पहुँचमा पुर्याउनु राज्यको दायित्व हो। सविधान बमोजिम राज्यका संघ, प्रदेश र स्थानीय तह ले सम्पादन गर्ने कार्यहरूको एकल तथा साझा अधिकार सूची, नेपाल सरकारका नीति तथा कार्यक्रमहरू, नेपालले विभिन्न समयमा गरेका अन्तराष्ट्रिय प्रतिबद्धताहरु एवं स्वास्थ्य क्षेत्र भित्रका समस्या र चनुौतीहरू, उपलब्ध स्रोत साधन तथा प्रमाणलाई समेत आधार बनाई राष्ट्रिय स्वास्थ्य नीति २०७६ तर्जुमा गरी जारी गरिएको छ।

२. औचित्य, सिद्धान्त,भावी सोच, ध्येय, लक्ष्य तथा उद्देश्य

२.१. औचित्य

विद्यमान समस्या तथा चुनौतीहरुको सम्बोधन गरी गुणस्तरीय स्वास्थ्य सेवामा नागरिकको संविधान प्रदत्त हक सुनिश्चित गर्न एवम संघीय संरचना अनुरुप विद्यमान स्वास्थ्य नीति, रणनीति तथा कार्यक्रमहरूलाई परिमार्जन गरी संघीयतामा आधारित राष्ट्रिय स्वास्थ्य नीति प्रतिपादन गर्न आवश्यक छ। विद्यमान स्वास्थ्य सेवालाई निरन्तरता दिदै यसका उपलब्धिहरूलाई समेत दिगो राख्दै राज्यको संघीय संरचना, अधिकार क्षेत्र तथा दायित्व अनुरुप स्वास्थ्य सेवाको संरचना विकास तथा विस्तारका लागि मार्गदर्शन गर्नु अपरिहार्य छ। नेपालले गरेका राष्ट्रिय तथा अन्तराष्ट्रिय प्रतिबद्धताहरू लाई सम्बोधन गर्नका लागि एवं नेपालले सहस्राब्दी विकास लक्ष्यहरूमा प्राप्त सफलतालाई कायम राख्दै दिगो विकासको लक्ष्य हासिल गर्नका लागि समेत यो नीति अनिर्वाय छ।

२.२. निर्देशक सिद्धान्त

संघीय संरचना अनसुारको स्वास्थ्य प्रणाली मार्फत सविधान प्रदत्त नागरिकको स्वास्थ्य सम्बन्धी मौलिक हक र गुणस्तरीय स्वास्थ्य सेवामा सर्वव्यापी पहुँच सुनिश्चित गर्न देहाय बमोजिमका निर्देशक सिद्धान्तहरुका आधारमा यो नीति प्रतिपादन गरिएको छ।

क) गुणस्तरीय स्वास्थ्य सेवामा सर्वव्यापी पहुँचमा अविच्छिन्न पर्याप्तता, पारदर्शिता र व्यापकता ।

ख) संघीय संरचना अनुरुप स्वास्थ्य प्रणालीमा बहुक्षेत्रीय सहभागिता, सहकार्य र साझेदारी।

ग) अति सिमान्तकृत दलित र आदिवासी समुदायलाई लक्षित विषेश स्वास्थ्य सेवा।

घ) स्वास्थ्य सुशासन र पर्याप्त आर्थिक लगानीको सुनिश्चितता।

ङ) समतामुलक स्वास्थ्य बिमाको विविधीकरण।

च) स्वास्थ्य सेवामा पुन संरचना।

छ) सबै नीतिमा स्वास्थ्य तथा बहुक्षेत्रीय समन्वय र सहकार्य ।

ज) स्वास्थ्य सेवा प्रवाहमा व्यवसायिकता, इमानदारी, पेसागत नैतिकता ।

२.३. भावी सोच

स्वास्थ्य तथा सुखी जीवन लक्षित सजग र सचेत नागरिक

२.४.ध्येय

साधन स्रोतको अधिकतम एव प्रभावकारी प्रयोग गरी सहकार्य र साझदारी मार्फत नागरिकको स्वास्थय सम्बन्धी मौलिक हक सुनिश्चित गर्ने।

२.५. लक्ष्य

सघीय सरचनामा सबै वर्गका नागरिकका लागि सामाजिक न्याय र सुशासनमा आधारित स्वास्थ्य प्रणालीको विकास र विस्तार गर्दै गुणस्तरीय स्वास्थ्य सेवाको पहुँच र उपभोग सुनिश्चित गर्ने।

२.६. उद्देश्यहरू

२.६.१. संविधान प्रदत्त स्वास्थ्य सम्बन्धी हक सबै नागरिकले उपभोग गर्न पाउने अवसर सिर्जना गर्न।

२.६.२. सघीय सरचना अनुरूप सबै किसिमका स्वास्थ्य प्रणालीलाई विकास , विस्तार र सुधार गर्नु।

२.६.३. सबै तहका स्वास्थ्य सस्थाहरूबाट प्रदान गरिने सेवाको गुणस्तरीय सुधार गर्दै पहुँच सुनिश्चित गर्ने ।

२.६.४ अति सिमान्तकृत वर्गलाई समेट्दै सामाजिक स्वास्थ्य सुरक्षा पद्धतिलाई सुदृढ गर्ने।

२.६.५. सरकारी, गैर-सरकारी तथा निजी क्षेत्र संग बहुक्षेत्रीय साझेदारी, सहकार्य तथा सामुदायिक सहभातगिालाई प्रबर्धन गर्ने।

२.६.६. नाफामुलक स्वास्थ्य क्षेत्रलाई सेवामुलक स्वास्थ्य सेवामा रूपान्तरण गर्दै लाने।

३. नितिहरु

३.१. सबै तहका स्वास्थ्य सस्थाहरूबाट तोकिए बमोजिम निःशुल्क आधारभुत स्वास्थ्य सेवा सुनिश्चित गरिनेछ।

३.२. स्वास्थ्य बिमा मार्फत विशेषज्ञ सेवाको सुलभ पहुच सुनुश्चित गरिनेछ।

३.३. सबै नागरिकलाई आधारभूत आकस्मिक स्वास्थ्य सेवाको पहुँच सुनिश्चित गरिनेछ।

३.४. स्वास्थ्य प्रणालीलाई संघीय संरचना अनुरुप संघ, प्रदेश र स्थानीय तहमा पुनर्संरचना, सुधार एवं विकास तथा विस्तार गरिनेछ।

३.५. स्वास्थमा सर्वव्यापनी पहुँच (Universal Health Coverage) को अवधारणा अनुरुप प्रवर्धनात्मक, प्रतिकारात्मक, उपचारात्मक, पुनर्स्थापनात्मक तथा प्रशामक सेवालाई एकीकृत रुपमा विकास तथा विस्तार गरिनेछ।

३.६. स्वास्थ्य क्षेत्रमा सरकारी, निजी तथा गैर-सरकारी क्षेत्र बिचको सहकार्य तथा साझेदारीलाई प्रबर्द्धन, व्यवस्थापन तथा नियमन गर्नुका साथै स्वास्थ्य शिक्षा, सेवा र अनुसन्धानका क्षेत्रमा निजी, आन्तरिक तथा बाह्य लगानीलाई प्रोत्साहन एवं सरक्षण गरिनेछ।

३.७. आयुर्वेद, प्राकृति चिकित्सा, योग तथा होमियोप्याथिक लगायतका चिकित्सा प्रणाली लाई एकिकृत रुपमा विकास र विस्तार गरिनेछ।

३.८. स्वास्थ्य सेवालाई सर्वसुलभ, प्रभावकारी तथा गुणस्तरीय बनाउन जनसंख्या, भुगोल र संघीय संरचना अनुरुप सीप मिश्रित तथा दक्ष स्वास्थ्य जनशक्तिको विकास तथा विस्तार गर्दै स्वास्थ्य सेवालाई व्यवस्थित गरिनेछ।

३.९. सेवा प्रदायक व्यक्ति तथा संस्थाबाट प्रदान गरिने स्वास्थ्य सेवालाई प्रभावकारी, जवाफदेही र गुणस्तरीय बनाउन स्वास्थ्य व्यवसायी परिषद्हरुको संरचनाको विकास, विस्तार तथा सुधार गरिनेछ।

३.१०. गुणस्तरीय औषधी तथा प्रविधिजन्य स्वास्थ्य सामाग्रीको आन्तरिक उत्पादनलाई प्रोत्साहन गर्दै, कुशल उत्पादन, आपूर्ति, भण्डारण, वितरणलाई नियमन तथा प्रभावकारी व्यवस्थापन मार्फत पहुँच एवं समुचित प्रयोग सुनिश्चित गरिनेछ।

३.११. सरुवा रोग, किटजन्य रोग, पशुपन्छी रोग, जलवायु परिवर्तन र अन्य रोग तथा महामारी नियन्त्रण लगायत विपद् व्यवस्थापन पूर्व तयारी तथा प्रतिकार्यको एकीकृत उपाएहरु अवलम्बन गरिनेछ ।

३.१२. नसर्ने रोगहरु रोकथाम तथा नियन्त्रणका लागि व्यक्ति , परिवार समाज तथा सम्बन्धित निकायलाई जिम्मेवार वनाउदै एकीकृत स्वास्थ्य प्रणालीको विकास तथा विस्तार गरिनेछ ।

३.१३. पोषणको अवस्थालाई सुधार गर्न, मिसावट युक्त तथा हानिकारक खानालाई निरुत्साहित गर्दै गुणस्तरीय एवं स्वास्थ्यवर्धक खाद्यपदार्थको प्रवर्द्धन, उत्पादन, प्रयोग र पहुँचलाई विस्तार गरिनेछ ।

३.१४. स्वास्थ्य अनुसन्धानलाई अन्तर्राष्ट्रिय मापदण्ड अनुरुप गुणस्तरीय बनाउँदै अनुसन्धानबाट प्राप्त प्रमाण र तथ्यहरुलाई नीति निर्माण, योजना तर्जुमा तथा स्वास्थ्य पद्धतिको विकासमा प्रभावकारी उपयोग गरिनेछ ।

३.१५. स्वास्थ्य व्यवस्थापन सूचना प्रणालीलाई आधुनिकिरण, गुणस्तरीय तथा प्रविधिमैत्री बनाई एकिकृत स्वास्थ्य सूचना प्रणालीको विकास गरिनेछ।

३.१६. स्वास्थ्यसम्बन्धी सूचनाको हक तथा सेवाग्राहीले उपचारसम्बन्धी जानकारी पाउने हकको प्रत्याभूति गरिनेछ ।

३.१७. मानसिक स्वास्थ्य, मुख, आँखा, नाक कान घाँटी स्वास्थ्य लगायतका उपचार सेवालाई विकास र विस्तार गरिनेछ ।

३.१८. अस्पताल लगायत सबै प्रकारका स्वास्थ्य संस्थाबाट प्रदान गरिने सेवाको गुणस्तर सुनिश्चित गरिनेछ ।

३.१९. स्वास्थ्य क्षेत्रमा नीतिगत, संगठनात्मक तथा व्यवस्थापकीय संरचनामा समायनुकूल परिमार्जन तथा सुधार गर्दै सुशासन कायम गरिनेछ।

३.२०. सुरक्षित मातृत्व, बाल स्वास्थ्य, किशोर-किशोरी तथा प्रजनन स्वास्थ्य, प्रौढ तथा जेष्ठ नागरिक लगायतका सेवाको विकास तथा विस्तार गरिनेछ ।

३.२१. स्वास्थ्य क्षेत्रको दिगो विकासका लागि आवश्यक वित्तिय स्रोत तथा विशेष कोषको व्यवस्था गरिनेछ।

३.२२. बढ्दो सहरीकरण, आन्तरिक तथा बाह्य बसाइसराइ जस्ता विषयहरुको समायनुकूल व्यवस्थापन गर्दै यसबाट हुने जनस्वास्थ्य सम्बन्धी समस्याहरुलाई समाधान गरिनेछ

३.२३. जनसांख्यिक तथ्यांक व्यवस्थापन, अनुसन्धान तथा विष्लेषण गरी निर्णय प्रक्रिया तथा कार्यक्रम तर्जुमासँग आवद्ध गरिनेछ ।

३.२४. प्रति-जैविक प्रतिरोधलाई न्यूनिकरण गर्दै संक्रामक रोग नियन्त्रण तथा व्यवस्थापनका लागि एकद्धार स्वास्थ्य प्रद्धतिको विकास तथा विस्तार गरिनुका साथै वायु प्रदुषण, ध्वनी प्रदुषण, जल प्रदुषण लगायतका वातावरणीय प्रदुषणका साथै खाद्यन्न प्रदुषणलाई वैज्ञानिक ढंगले नियमन तथा नियन्त्रण गरिनेछ ।

३.२५. आप्रवासन प्रक्रियाबाट जनस्वास्थ्यमा उत्पन्न हुन सक्ने जोखिमलाई न्यूनिकरण गर्न तथा विदेशमा रहेका नेपाली नागरिकहरुको स्वास्थ्य सुरक्षाका लागि समुचित व्यवस्थापन गरिनेछ ।

CHAPTER 1: INTRODUCTION

१.१ जिल्लाको सामान्य जानकारी

रसुवा जिल्ला, बागमती प्रदेश अन्तर्गत पर्ने उत्तरी भाग चीनको स्वशासित क्षेत्र तिब्बतसँग सिमाना जोडिएको राजधानीबाट नजिकको विकट हिमाली जिल्ला हो। भौगोलिक बनौट, हावापानी, वनजंगलको विविधता, नदीनाला र जलकुण्ड विभिन्न जातजातिहरूको बसोबास, रहनसहन, भेषभूषाका साथै जैविक विविधताको धनी यस जिल्लाको आफ्नै पृथक ऐतिहासिक महत्व रहेको छ। यो छिमेकी मित्रराष्ट्र चीनको स्वशासित क्षेत्र तिव्वतसँग मितेरी गाँसेर बसेको पर्यटकीय जिल्ला हो। देशकै तेस्रो पदयात्रा गन्तव्यको रुपमा रहेको लामटाङ राष्ट्रिय निकुञ्ज, सिमसार क्षेत्रमा सूचीकृत गोसाईंकुण्ड सिमसार क्षेत्र रहेको यस जिल्ला भौगोलिक, जैविक, साँस्कृतिक, धार्मिक र पर्यावरणीय हिसावले धेरै धनी छ।

यस जिल्लाको नामाकरण सम्बन्धमा स्थानीय तामाङ भाषामा "र" को अर्थ "भेडाच्याङग्रा" र "सोवा" को अर्थ "चराउने वा राख्ने ठाउँ" भन्ने हुन्छ अर्थात प्रशस्त चरन क्षेत्र र भेडाच्याङग्रा पाइने ठाउँ भएकोले "रसोवा" भन्ने गरेको र स्थानीय बोलचालको भाषामा अप्रभंश भएर पछि रसुवा भनिन थालिएको विश्वास गरिन्छ।

प्रवर्द्धनात्मक, प्रतिकारात्मक र उपचारात्मक सेवाहरू सहित स्वास्थ्य सेवाको विभिन्न दायरा प्रदान गर्न जनस्वास्थ्य कार्यालय ले विभिन्न पालिकासंग समन्वय गर्न महत्वपूर्ण भूमिका खेलेको छ। जनस्वास्थ्य कार्यालय ले विभिन्न सरकारी र गैर-सरकारी संघ संस्थासँग समन्वय गरि समस्त स्वास्थ्य सुधारमा महत्वपूर्ण भुमिका खेलेको छ।

भौगोलिक अवस्थिति:

अक्षांश : २८ डिग्री ० मिनेट उत्तरी अक्षांश देखि २८ डिग्री १५ मिनेट उत्तर
देशान्तर : ८५ डिग्री १५ मिनेटदेखि ८५ डिग्री ५० मिनेटपूर्व
क्षेत्रफल : १,५१९.३१ वर्ग कि.मि.
सिमाना : पूर्वमा सिन्धुपाल्चोक, पश्चिममा धादिङ, उत्तरमा चीनको स्वशासित क्षेत्र तिव्वत र दक्षिणमा नुवाकोट जिल्लासँग सिमाना जोडिएको छ।
सबभन्दा होचोस्थान : ६१४ मिटर
सबभन्दा अग्लोस्थान : लाङटाङ हिमाल ७,२२७ मिटर
सदरमुकाम : धुन्चे (१९५० मि.)
भौगोलिक बनावटको हिसावले उच्च हिमशिखर, नाङ्गा पहाड, भीर, पाखापखेरा, केही पहाडी एवम् बेंसी भू–भाग रहेको यस जिल्लालाई मुख्यतया तीन भाग/क्षेत्रमा विभाजन गर्न सकिन्छ।

- **हिमाली क्षेत्र**

समुन्द्री सतहबाट ५००० मिटरभन्दा माथि बाह्रै महिना हिउँले ढाकिने क्षेत्र यस अन्तर्गत पर्दछ। पर्वतारोहण र ट्रेकिङको लागि महत्त्वपूर्ण मानिने यस क्षेत्रमा बर्षैभरि तापक्रम ऋणात्मक हुनेगर्छ। यस क्षेत्रमा गणेश हिमाल, लाङटाङ हिमाल, लाङटाङ लिरूङ,

यलापिक, लाङसिसा खर्क, साङजेन खर्क लगायतका ५,००० मिटर भन्दा अग्ला भाग तथा सधै हिउँ ढाकिरहने पर्वत श्रृखलाहरू पर्दछन् ।

- **लेकाली क्षेत्र**

समुन्द्री सतहबाट २५०० मिटरदेखि ५००० मिटरसम्मको उचाईमा रहेको सधै हिउँदको मौसममा हिमपात हुने उच्च पहाडी भाग यस प्रदेशमा पर्दछ । विशेषगरी लाङटाङ उपत्यका, क्यान्जिङ उपत्यका, घोडातबेला, गोसाईकुण्ड, लौरीबिनायक, चन्दनवारी, माङचेत, सोमदाङ, नागथली, गञ्जला भञ्ज्याङ आदि यस अन्तर्गत पर्ने मुख्य स्थानहरू हुन । यस भेगका मानिसहरू मौसम अनुसार बसोबास गर्ने र गोठ तल माथि सार्ने गर्दछन् । यहाँका मानिसहरू न्यानोको लागि बख्खु र ऊनीका बाक्लो लुगा लगाउने गर्दछन् भने भेडाबाख्रा, चौरी आदि पालन गर्ने गर्दछन् । तुलनात्मक रुपमा यहाँको जनजीवन कठिन रहेको छ ।

- **पहाडी/वेंसी क्षेत्र**

समुन्द्री सतहदेखि २,५०० मिटरभन्दा तल ४५७ मिटरसम्मको भू-भाग यस अन्तर्गत पर्दछ । वेत्रावती, पैरेवेंसी, स्याफ्रुवेंसी, फलाखु खोलाको किनार आदि नगन्य मात्रामा बेंसी परेका स्थानहरू भएतापनि मुख्य-मुख्य स्थानहरू पहाडी भू-भाग भएकोले स्थानीय जनजीवनमा पहाडी प्रभाव अत्यधिक रहेको छ । धुन्चे, गोल्जुङ, यार्सा, सरमथली, कालिकास्थान, लहरेपौवा, ठूलोगाउँ आदि यस क्षेत्रका प्रमुख स्थानहरू हुन । यहाँको जनजीवन अन्यत्र भन्दा सामान्य भएतापनि उत्पादनको न्यूनता र उद्योग व्यापारको कमीले गर्दा जनताहरूको जीवनस्तर माथि उठ्न सकेको छैन । अझैपनि खेतीपाती र पशुपालन यस जिल्लाका बासिन्दाहरूको मुख्य पेशा रही आएको छ ।

हावापानी

समुन्द्री सतहदेखि १,९०० मिटर माथिको उचाईमा लेकाली, ५,००० मिटरमाथिको उचाईमा टुन्ड्रा हावापानी पाईन्छ । उच्च हिमाली भेगमा धरातलीय विषमताको कारण हावापानी पनि विषम रहेको छ । बेंसीमा प्रायःउष्णदेखि समशीतोष्ण किसिमको हावापानी रहेको छ । मनसुनी वर्षा र लेकाली हिमाली वर्षा हुने भएकोले जेष्ठ महिनादेखि आश्विन महिनासम्म प्रशस्त वर्षा हुने, मौसम प्रायःबदली रहने गर्दछ । विश्वव्यापी उष्णता, जलवायु परिवर्तनको कारणले हिमरेखामाथि सर्दै गईरहेको र परिवर्तित जलवायुअनुसार अनुकुलित हुन मानिस, जीवजनावर, वनस्पतिहरूलाई कठिन भई जैविक विविधतामा समेत ह्रास आउन थालेको छ ।

नदीनाला, ताल तथा पोखरी

यस जिल्लाबाट बाहिर बगेर निस्कने नदीहरूमा त्रिशुली र फलाखु मुख्य छन् । त्रिशुलीको उद्गमस्थल प्रशिद्ध तीर्थस्थल गोसाँईकुण्ड हो । भोटेकोशी चीनको स्वशासित क्षेत्र तिब्बतबाट नेपाल प्रवेश गरी साविक गा.वि.स. टिमुरे, गोल्जुङ, स्याफ्रु, धुन्चे, हाकु, गत्लाङ, राम्चे, डाडाँगाउँ, ठूलोगाउँ, लहरेपौवाहुँदै बेत्रावतीबाट नुवाकोट जिल्ला प्रवेश गर्छ । भोटबाट आएको भोटेकोशी स्याफ्रुवेंसीमा लामटाङ खोलालाई आफूमा लीन गराउँदै धुन्चे गा.वि.स.को सिमाना त्रिशुली नदीको सँगमस्थलमा समाहित भएपश्चात त्रिशुली नदीको नामले प्रवाहित हुन्छ । यस्तै अन्य खोलाहरूमा चिलिमे खोला, मैलुङ खोला, नेसिङ खोला, घट्टे खोला र अन्य स–साना खोलाहरू पनि असंख्य मात्रामा रहेका छन् ।

जैविक विविधता

टुन्ड्रा, शितोष्ण, समशीतोष्ण हावापानी र थोरै दूरीमा उचाईको धेरै फरकपनले गर्दा यस जिल्लामा उष्णदेखि हिमाली भेगमा पाईने विभिन्न किसिमका जीव तथा वनस्पतिहरू पाईन्छन् । हावापानी र भू-बनोटको विविधताको कारण १००० भन्दा बढी प्रजातिको वनस्पती जसमध्ये २१ प्रजातिको रैथाने, ८०० भन्दा बढी प्रजातिको झ्याउ, ४६ भन्दा बढी प्रजातिको स्तनधारी जनावर, २५० भन्दा बढी प्रजातिको चरा, करिब ११ प्रजातिको सरिसृप तथा उभयचर लामटाङ राष्ट्रिय निकुञ्ज र यस जिल्ला वरिपरी पाईन्छ । साल, खोटे सल्ला, चिलाउने, लालिगुराँस, उतीस जिल्लाको पहाडी तथा बेंसीहरूमा पाईन्छ भने खसु, तालिसपत्र, भोजपत्र, गोब्रे सल्ला, ठिङ्ग्रे सल्ला, धुपी सल्ला, लाङटाङ लार्क, चिमाललगायत गुराँसका अन्य विभिन्न प्रजातिहरू, सुनाखरीका प्रजातिहरू लेकाली तथा हिमाली क्षेत्रहरूमा पाईन्छ । जैविक विविधताको धनी यस जिल्लाको अर्को चिनारी रेडपाण्डा (हाब्रे) हो । यस क्षेत्रमा तिलहरी चरा, चाकाचुसक, वनचाहा, सुन गिद्ध, राज गिद्ध, जिवाहार महाचील, रणमत्त महाचील, नेपाल डिकुरे भ्याकुर लगायत विश्वमै संकटापन्न तथा लोपोन्मुख अवस्थामा रहेको १२ प्रजातिका चराहरू पनि पाईन्छ ।

हाडखोर, हिमाली गिद्ध, खैरो गिद्ध, लरवान, मधुहा, खोया हाँस, चखेवा, विजुला गैरौ, कालिजुरे हाँस, मणितुण्डक, कोङमा हिउँकुखुरा, हिमाली हिउँकुखुरा, हिमाली पिउराजस्ता चराका प्रजातिका कारण यस जिल्ला चरा अध्यायन अनुसन्धान तथा चरा पर्यटनको लागि पनि उत्तिकै महत्त्वपूर्ण रहेको छ ।

धार्मिक, सांस्कृतिक एवम् ऐतिहासिक स्थलहरू

विभिन्न जातजाति, भाषाभाषी, सम्प्रदाय र धर्मावलम्बीहरूको बसोबास रहेको यस जिल्लामा विभिन्न धार्मिक एवम् साँस्कृतिक रूपले महत्वपूर्ण मानिने तालतलैया, मठमन्दिर, गुम्बा, गढी, धामहरू रहेका छन । साविक स्याफ्रु गा.वि.स.स्थित गोसाईकुण्ड, भैरवकुण्ड, सरस्वतीकुण्ड, सूर्यकुण्ड तथा गल्लाङ गा.वि.स.स्थित पार्वतीकुण्ड, नुवाकोट र रसुवाको सीमावर्ती साविक गा.वि.स. लहरेपौवामा पर्ने उत्तरगयाधाम, नेपाल र चीनको स्वशासित क्षेत्र तिव्वतको सिमानामा पर्ने टिमुरे गा.वि.स.मा अवस्थित ऐतिहासिकस्थल रसुवागढी र गुप्तेश्वर महादेव, धैबुङ गा.वि.स.स्थित कालिकास्थान मन्दिर, लामटाङस्थित क्यान्जिङ गुम्बालगायतका अनेकौं धार्मिक, सांस्कृतिक एवम् ऐतिहासिक स्थलहरू यस जिल्लामा रहेका छन ।

भू-उपयोग

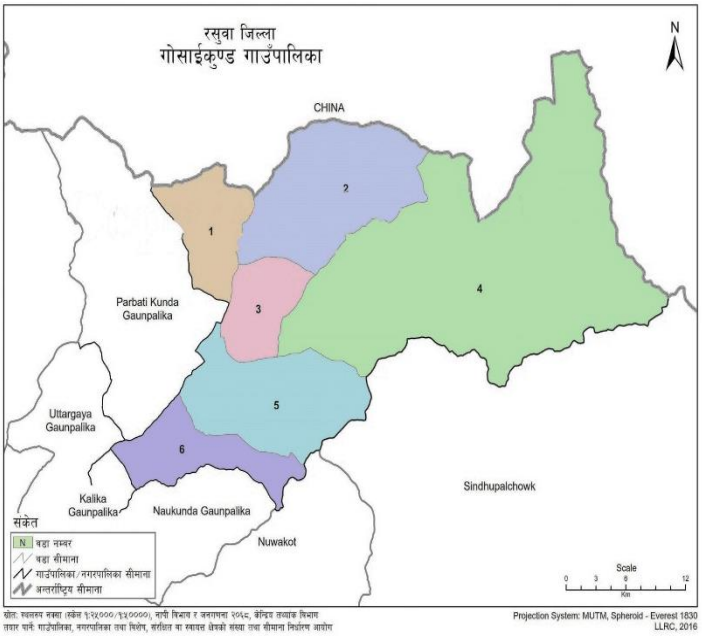
टोपोग्राफिक नक्सा १९९४/९८ का अनुसार यस जिल्लाको कुल क्षेत्रफल १,५१९.३१ वर्ग कि.मि. र राष्ट्रिय जनगणना २०७८ को प्रतिवेदन अनुसार १५४४ वर्ग कि.मि.रहेको छ । जसमध्ये झाडी क्षेत्र ६३.११ वर्ग कि.मि., १,५१२ वर्ग कि.मि., खेतीयोग्य जमिनको क्षेत्रफल ११९.१४ वर्ग कि.मि., जंगल ३८४.८८ वर्ग कि.मि., हिमनदी ९०.६८ वर्ग कि.मि., घाँसे जमिन १७५.४० वर्ग कि.मि., बरफ–चट्टान ०.५३ वर्ग कि.मि., बलौटे क्षेत्र ७.७५ वर्ग कि.मि., खेर गएको जमिन ६३५.५४ वर्ग कि.मि. र जल क्षेत्र ४२.२४ वर्ग कि.मि., हवाई मैदान ०.०४ वर्ग कि.मि. रहेको छ ।

प्रशासनिक विभाजन

जिल्ला	–	रसुवा
प्रदेश	–	बागमती
प्रतिनिधि निर्वाचन क्षेत्र	–	१
प्रदेश सभा निर्वाचन क्षेत्र	–	२
स्थानीय तह(गाउँपालिका)	–	५ (गोसाईकुण्ड गाउँपालिका, आमाछोदिङमो गाउँपालिका, नौकुण्ड गाउँपालिका, कालिका गाउँपालिका, उत्तरगया गाउँपालिका)

१.२ रसुवा जिल्ला अन्तर्गतका स्थानिय तहहरुको आधारभूत जानकारी

१। गोसाईकुण्ड गाँउपालिका



रसुवा जिल्लाको गोसाईकुण्ड गाउँपालिका ऐतिहासिक र पर्यटकीय महत्व बोकेको गाउँपालिका हो। राज्य पुन: संरचना पश्चात् रसुवा जिल्लाका विभिन्न गाविसहरूहलाई एकीकृत गरी गठन गरिएको गोसाईकुण्ड गाउँपालिका रसुवा जिल्लाको करिब ५१ प्रतिशत भूभागमा फैलिएको छ।

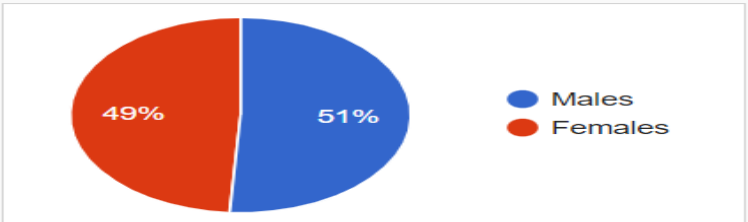
यस गाउँपालिका प्रसिद्ध धार्मिक स्थल गोसाईकुण्ड ताल, रमणीय लाङटाङ हिमाल, एतिहासिक रसुवागढी नाका, विभिन्न कुण्डहरू, लाङटाङ राष्ट्रिय निकुञ्ज र दुर्लभ रेडपाण्डा जस्ता प्राकृतिक तथा सांस्कृतिक सम्पादाको भण्डार हो। रसुवा जिल्लाको सदरमुकाम धुन्चे, गाउँकार्यपालिकाको केन्द्र स्याफ्रवेशी, र ऐतिहासिक रसुवागढी नजिकको टिमुरे यहाँका प्रमुख बजार क्षेत्रहरू हुन्।

जनसंख्या:

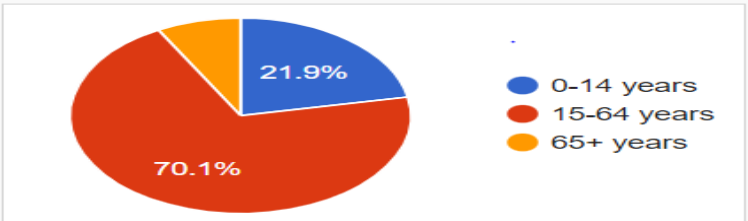
Name	Status	Transcription	Native	Population Census 2001-05-28	Population Census 2011-06-22	Population Census 2021-11-25
Gosaikunda	Rural Municipality	Gōsāīkuṇḍa	गोसाईकुण्ड गाउँपालिका	...	8,134	7,788

Gosaikunda

- **7,788** Population [2021] – *Census*
- **977.3 km²** Area
- **7.969/km²** Population Density [2021]
- **-0.42%** Annual Population Change [2011 → 2021]



Gender (C 2021)	
Males	3,973
Females	3,815

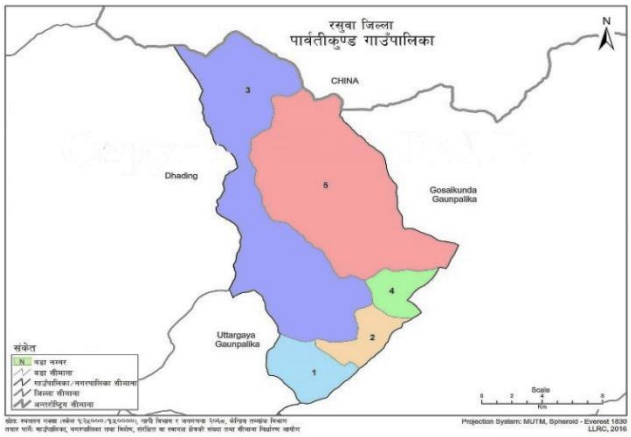


Age Groups (C 2021)	
0-14 years	1,709
15-64 years	5,456
65+ years	623

स्वास्थ्य अवस्था:

- यस गाउँपालिका अन्तरगत १ प्रदेशिक अस्पताल, स्वास्थ्य चौकी ६ वटा र ३ सामुदायिक स्वास्थ्य ईकाइ मार्फत स्वास्थ्य सेवा निरन्तर रुपमा प्रदान भैईरहेको छ।
- यस गाउँपालिका अन्तर्गत स्वास्थ्य सेवा प्रदान गर्ने संरचनाहरूमा ४ वर्थिङ्ग सेन्टर, १ BEONC १ CEONC Site, २ Safe Abortion Site, २ OTC, ३ किशोरकिशोरी मैत्री सेवा साइट,९ DOTS Site, २ Microscopy Site, १६ खोप क्लिनिक, १० गाउँघरक्लिनिक,५४ महिला सामुदायिक स्वास्थ्य स्वंयमसेविका, ९ PMTCT Site, र २ वटा संस्थामा प्रयोगशाला सेवा समेत संचालनमा रहेको छ।
- यस गाउँपालिकाको श्री भिमसेन आधारभुत विद्यालय र रसुवा मा.वि मा १/१ बिद्यालय नर्स कार्यरत छन्।
- विपद् व्यवस्थापन समिति गठन भएको, फोकल पर्सन तोकिएको र छुट्टै कोषको नामाकरण दिई बजेट छुटयाइएको छ।

२। आमाछोदिङमो गाउँपालिका



रसुवा जिल्लाको उत्तरी भेगमा अवस्थित पार्बतीकुण्ड (आमाछोदिङमो) गाउँपालिकाको नाम पार्बतीकुण्डको धार्मिक महत्वबाट प्रेरित छ। यस गाउँपालिकाको क्षेत्रफल ६८३ वर्ग किलोमिटर र जनसंख्या ६६७३ रहेको छ। जलस्रोतमा अत्यन्त सम्पन्न यस गाउँपालिकामा चिलिमे, सानजेन र त्रिशुली जलविद्युत आयोजनाहरू सञ्चालित छन्।

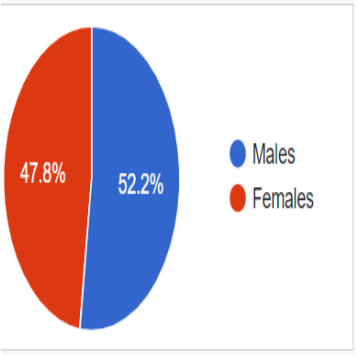
हजारौं नेपाली तथा विदेशी पर्यटकहरू प्रत्येक वर्ष यस क्षेत्र भ्रमणमा आउँछन्। गाउँपालिकामा हाकु, ग्रेय, गत्लाङ, गोल्जुङ र चिलिमे गरी पाँच वटा वडा छन्। गाउँपालिकाको कार्यालय हाल वडा नं ४ गोल्जुङमा अवस्थित छ।

जनसंख्या:

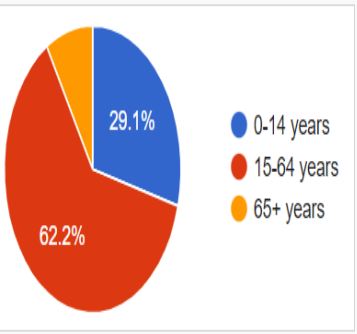
Name	Status	Transcription	Native	Population Census 2001-05-28	Population Census 2011-06-22	Population Census 2021-11-25
Aamachhodingmo [Parbatikunda]	Rural Municipality	Āmāchōdiṅmō	आमाछोदिङ्मो गाउँपालिका	...	5,533	6,673

Aamachhodingmo [Parbatikunda]

- **6,673** Population [2021] – *Census*
- **246.6 km²** Area
- **27.06/km²** Population Density [2021]
- **1.8%** Annual Population Change [2011 → 2021]



Gender (C 2021)	
Males	3,480
Females	3,193

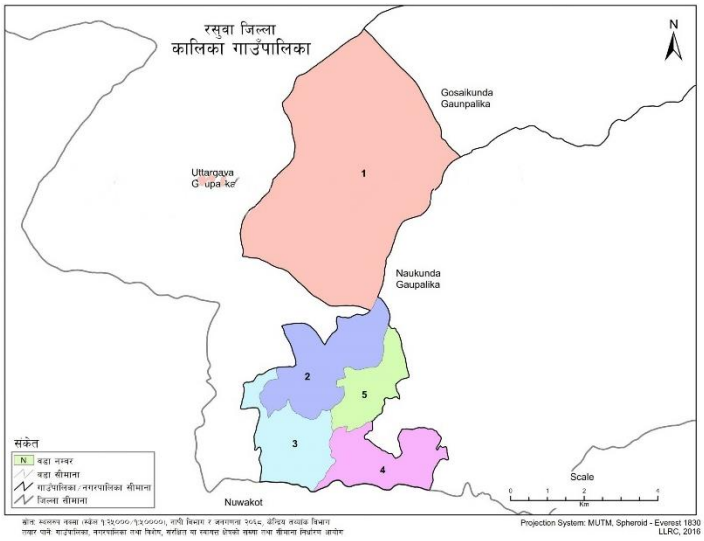


Age Groups (C 2021)	
0-14 years	1,941
15-64 years	4,151
65+ years	581

स्वास्थ्य अवस्था:

- यस गाउँपालिका अन्तरगत स्वास्थ्य चौकी ४ वटा र २ सामुदायिक स्वास्थ्य ईकाइ मार्फत स्वास्थ्य सेवा निरन्तर रुपमा प्रदान भैईरहेको छ।
- यस गाउँपालिका अन्तर्गत स्वास्थ्य सेवा प्रदान गर्ने संरचनाहरूमा ४ वर्थिङ्ग सेन्टर, ० BEONC Site, ० CEONC, ० Safe Abortion Site, १ OTC, ४ किशोरकिशोरी मैत्री सेवा साइट, ४ DOTS Site, १ Microscopy Site, १० खोप क्लिनिक, ९ गाउँघरक्लिनिक, ३४ महिला सामुदायिक स्वास्थ्य स्वंयमसेविका, ४ PMTCT Site, र १ वटा संस्थामा प्रयोगशाला सेवा समेत संचालनमा रहेको छ।
- विपद् व्यवस्थापन समिति गठन भएको, फोकल पर्सन तोकिएको र छुट्टै कोषको नामाकरण दिई बजेट छुटयाइएको छ।

३। कालिका गाउँपालिका



कालिका गाउँपालिका रसुवा जिल्लाको दक्षिणी सिमानामा अवस्थित, रमणीय प्राकृतिक सौन्दर्यले भरिपूर्ण एक गाउँपालिका हो। रसुवाको सदरमुकाम धुन्चेबाट २४ किलोमिटर दक्षिणपूर्वमा अवस्थित यस गाउँपालिकाको भूगोल लाम्चो र चेप्टो छ। साविकका धैबुङ, लहरेपौवा र राम्चे गाविसहरूलाई मिलाएर यो गाउँपालिका निर्माण गरिएको हो।

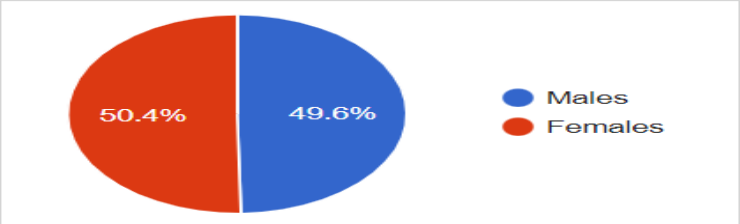
फलाँखुखोला देखि सुरु भई इटपारे, बेतीनी, कटुन्जे, कालिकास्थान, गोम्बोडाँडा हुँदै राम्चे सम्म पश्चिम उत्तरतर्फ र फलाँखुखोला, आम्बास, रुप्सेपानी, जिबजिबे, ज्याङलाङदेखि लोकिलसम्म पूर्व उत्तरतर्फ फैलिएको यस गाउँपालिकाको कुल क्षेत्रफल १२९.५४ वर्ग किलोमिटर रहेको छ। साविकको धैबुङ गाविसको कार्यालयलाई यस गाउँपालिकाको केन्द्र बनाइएको छ।

जनसंख्या:

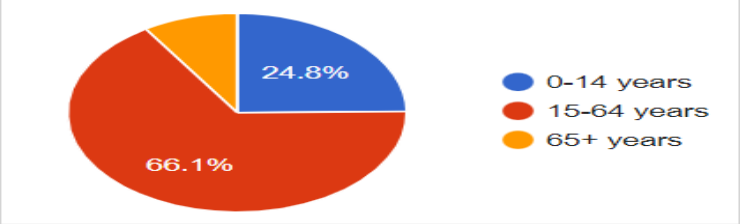
Name	Status	Transcription	Native	Population Census 2001-05-28	Population Census 2011-06-22	Population Census 2021-11-25
Kalika	Rural Municipality	Kālikā	कालिका गाउँपालिका	…	9,502	10,115

Kalika

10,115 Population [2021] – *Census*
42.50 km² Area
238.0/km² Population Density [2021]
0.60% Annual Population Change [2011 → 2021]



Gender (C 2021)	
Males	5,021
Females	5,094

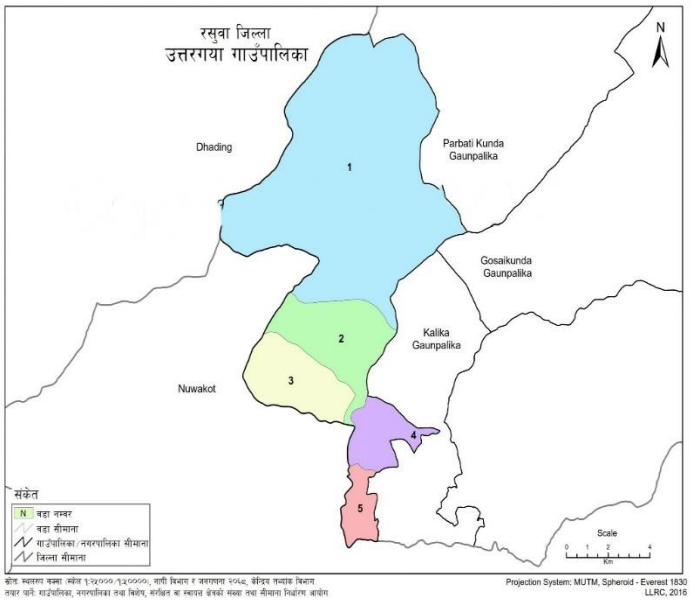


Age Groups (C 2021)	
0-14 years	2,507
15-64 years	6,690
65+ years	918

स्वास्थ्य अवस्था

- यस गाउँपालिका अन्तरगत १ प्रथमिक स्वास्थ्य सेवा केन्द्र (ग्रामिण अस्पताल), स्वास्थ्य चौकी १ वटा र ३ आधारभुत स्वास्थ्य सेवा केन्द्र मार्फत स्वास्थ्य सेवा निरन्तर रुपमा प्रदान भैईरहेको छ।
- यस गाउँपालिका अन्तर्गत स्वास्थ्य सेवा प्रदान गर्ने संरचनाहरूमा ३ वर्थिङ्ग सेन्टर, १ BEONC ० CEONC Site, १ Safe Abortion Site, ५ OTC, ३ किशोरकिशोरी मैत्री सेवा साइट, ५ DOTS Site, २ Microscopy Site, ८ खोप क्लिनिक, ३ गाउँघरक्लिनिक, ५३ महिला सामुदायिक स्वास्थ्य, ५ PMTCT Site, र २ वटा संस्थामा प्रयोगशाला सेवा समेत संचालनमा रहेको छ।
- यस गाउँपालिकाको श्री कालिका हिमालय मा.वि, श्री सेतिभुमे मा.वि र श्री निलकण्ठ नमुना मा.वि, श्री सेतिदेवि मा वि र सुन्धरा मा वि मा ५ बिद्यालय नर्स कार्यरत छ।
- विपद् व्यवस्थापन समिति गठन भएको, फोकल पर्सन तोकिएको र छुट्टै कोषको नामाकरण दिई बजेट छुटयाइएको छ।

४। उत्तरगया गाउँपालिका



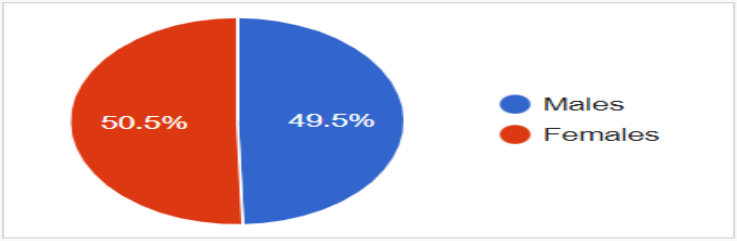
उत्तरगया गाउँपालिकाको नाम नेपालको प्रसिद्ध धार्मिक स्थल उत्तरगया धामबाट प्रेरित छ। रसुवा जिल्लामा अवस्थित यस गाउँपालिका प्राकृतिक, धार्मिक र सांस्कृतिक रूपले अत्यन्तै सम्पन्न छ। यो गाउँपालिका साबिकका लहरेपौवा, ठुलोगाउँ, डाडागाउँ र हाकुगाउँ गाविसहरूका केही वडाहरूलाई मिलाएर गठन गरिएको हो। यसको कुल क्षेत्रफल १०४.५१ वर्ग किलोमिटर रहेको छ भने वि.सं. २०७८ को जनगणना अनुसार कुल जनसंख्या ८५५५ छ। हाल, गाउँपालिकाको कार्यालय वडा नं ५ खाल्टे बगरमा सञ्चालित छ।

जनसंख्या:

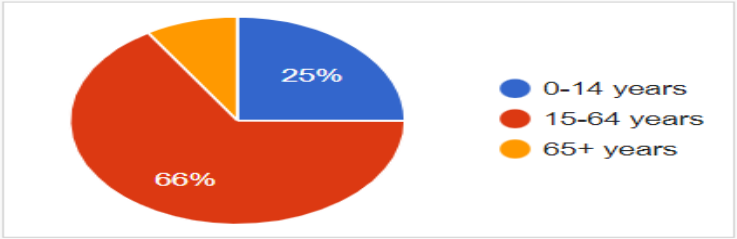
Name	Status	Transcription	Native	Population Census 2001-05-28	Population Census 2011-06-22	Population Census 2021-11-25
Uttargaya	Rural Municipality	Uttaragayā	उत्तरगया गाउँपालिका	…	8,298	8,555

Uttargaya

- **8,555** Population [2021] – *Census*
- **118.5 km²** Area
- **72.22/km²** Population Density [2021]
- **0.29%** Annual Population Change [2011 → 2021]



Gender (C 2021)	
Males	4,235
Females	4,320

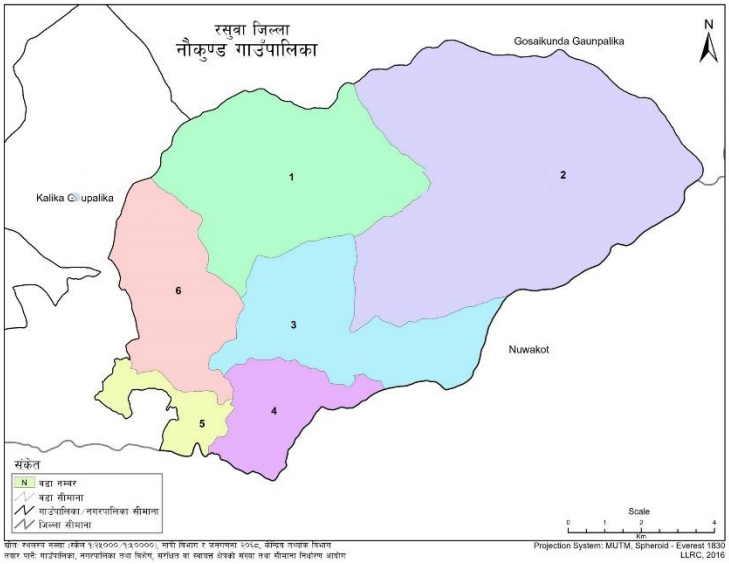


Age Groups (C 2021)	
0-14 years	2,143
15-64 years	5,646
65+ years	766

स्वास्थ्य अवस्था:

- यस गाउँपालिका अन्तरगत स्वास्थ्य चौकी ३ वटा र ३ सामुदायिक स्वास्थ्य ईकाइ मार्फत स्वास्थ्य सेवा निरन्तर रुपमा प्रदान भैईरहेको छ।
- यस गाउँपालिका अन्तर्गत स्वास्थ्य सेवा प्रदान गर्ने संरचनाहरूमा ३ वर्थिङ्ग सेन्टर, ०/० BEONC/CEONC Site, ० Safe Abortion Site, ४ OTC, ४ किशोरकिशोरी मैत्री सेवा साइट, ४ DOTS Site, ३ Microscopy Site, ९ खोप क्लिनिक, ६ गाउँघरक्लिनिक, ४४ महिला सामुदायिक स्वास्थ्य स्वंयमसेविका, ६ PMTCT Site, र ३ वटा संस्थामा प्रयोगशाला सेवा समेत संचालनमा रहेको छ।
- यस गाउँपालिकाको श्री निलकण्ठ मा.वि, नवविजयि महेन्द्र मा.वि, र डाडाँगाउँ मा.वि. मा १/१ बिद्यालय नर्स कार्यरत छन्।
- विपद् व्यवस्थापन समिति गठन भएको, फोकल पर्सन तोकिएको र छुट्टै कोषको नामाकरण दिई बजेट छुटयाइएको छ।

नौकुण्ड गाँउपालिका



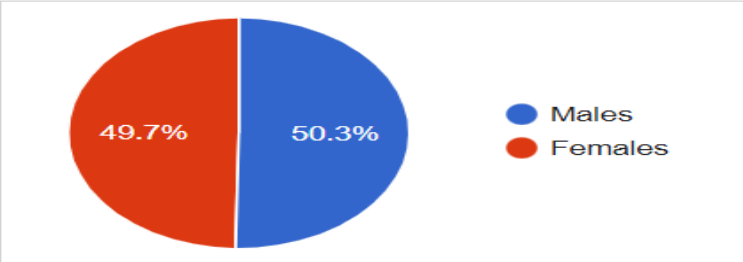
साविकका गाविसहरू भोर्ले, यार्सा, सरमथलीमा फैलिएको यस नौकुण्ड गाँउपालिकाको नामाकरण साविक यार्सा गाविसमा अवस्थित पर्यटकिय रूपमा निकै नै प्रख्यात नौ वटा कुण्डहरू चिनाउन यस पालिकालाई नौकुण्ड गाँउपालिका भनी नामाकरण गरिएको हो। यहा अबस्थित नौ वटा कुण्डहरू प्राकृतिक, प्रर्यटकिय र साँस्कृतिक रूपमा धेरै पर्यटकहरूको आकर्षणको केन्द्र रहेको छ ।पूर्वमा गोसाईकुण्ड गा.पा र नुवाकोट जिल्ला, पश्चिममा कालिका गा.पा., उत्तरमा गोसाईकुण्ड गा.पा. तथा दक्षिणमा नुवाकोट जिल्लाको सिमानासंग जोडिएको यो गा.पा. १२७.७८ किलोमिटर क्षेत्रफलमा फैलिएको छ।

जनसंख्या:

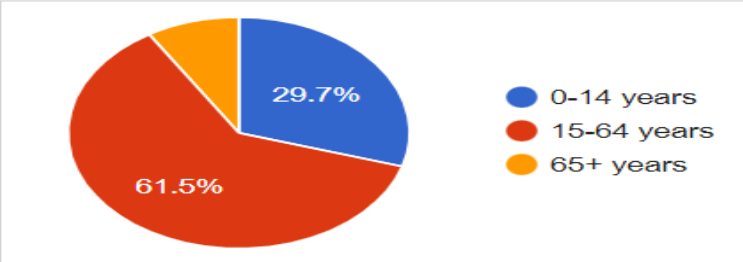
Name	Status	Transcription	Native	Population Census 2001-05-28	Population Census 2011-06-22	Population Census 2021-11-25
Naukunda	Rural Municipality	Naukuṇḍa	नौकुण्ड गाउँपालिका	…	11,833	12,344

Naukunda

- **12,344** Population [2021] – *Census*
- **116.4 km²** Area
- **106.1/km²** Population Density [2021]
- **0.41%** Annual Population Change [2011 → 2021]



Gender (C 2021)	
Males	6,209
Females	6,135



Age Groups (C 2021)	
0-14 years	3,666
15-64 years	7,592
65+ years	1,086

स्वास्थ्य अवस्था:

- यस गाउँपालिका अन्तरगत स्वास्थ्य चौकी ३ वटा र ५ सामुदायिक स्वास्थ्य ईकाइ मार्फत स्वास्थ्य सेवा निरन्तर रुपमा प्रदान भैईरहेको छ।
- यस गाउँपालिका अन्तर्गत स्वास्थ्य सेवा प्रदान गर्ने संरचनाहरूमा ३ वर्थिङ्ग सेन्टर, ०/० BEONC/CEONC Site, ० Safe Abortion Site, १ OTC, ३ किशोरकिशोरी मैत्री सेवा साइट, ६ DOTS Site, २ Microscopy Site, ११ खोप क्लिनिक, ४ गाउँघरक्लिनिक, ६० महिला सामुदायिक स्वास्थ्य स्वंयमसेविका, ६ PMTCT Site, र २ वटा संस्थामा प्रयोगशाला सेवा समेत संचालनमा रहेको छ।
- यस गाउँपालिकाको श्री गोसाईकुण्ड मा.वि, श्री निरकुभुमि मा.वि र श्री नारायण मा.वि मा १/१ बिद्यालय नर्स कार्यरत छन्।
- विपद् व्यवस्थापन समिति गठन भएको, फोकल पर्सन तोकिएको र छुट्टै कोषको नामाकरण दिई बजेट छुटयाइएको छ।

१.३ जनस्वास्थ्य कार्यालय, रसुवा

परिचय:

नेपाल एकात्मक राज्य प्रणालीमा हुदा जिल्लास्तरको स्वास्थ्यसंग सम्बन्धित कार्यक्रमको कार्यन्वयनको जिम्मेवारी जिल्ला जनस्वास्थ्य कार्यालय ले गरेको थियो l नेपालको संविधान २०७२ अनुसार नेपाल एकात्मक राज्य प्रणालीबाट संघ, प्रदेश र स्थानिय तह गरी तीन तहको संघीय प्रणालीमा गएको छ । स्वास्थ्य सम्बन्धि अधिकार तिनै तहको सरकारमा राखिएको छ । जस अन्तर्गत संघ सरकारले प्रदेश तथा स्थानिय तहको लागि विभिन्न स्वास्थ्य सेवा प्रवाह गर्न मार्गनिर्देशकको भूमिकामा निर्भाह गर्दछ । त्यसै गरि प्रदेश तहमा प्रदेशको स्वास्थ्य मन्त्रालय मातहतको स्वास्थ्य निर्देशनालयले सम्बन्धित प्रदेश अन्तर्गतका जिल्लाहरुमा स्वास्थ्य कार्यक्रमको अनुगमन तथा प्राविधिक सहयोग गर्दछ । आधारभूत स्वास्थ्य सेवाको जिम्मेवारी स्थानिय तहलाई दिएको छ । यधपी सो जिम्मेवारी विभिन्न व्यवस्थापकीय दक्षतापूर्ण जनशक्तिको अभावका कारणले स्थानिय तहले अपेक्षित कार्यन्वयन गर्न सकेन । यही कुरालाई मध्यनजर गर्दै नेपाल सरकारको मन्त्रिपरिषद्ले स्वास्थ्य निर्देशनालयको मातहतमा रहने गरि प्रत्येक प्रदेशका सबै जिल्लामा स्थापना भएका जनस्वास्थ्य कार्यालयहरू मध्येको एक जनस्वास्थ्य कार्यालय रसुवा हो।

जनस्वास्थ्य कार्यालय रसुवा, रसुवा जिल्लामा प्रमुख प्राविधिक र प्रशासनिक स्वास्थ्य निकाय हो जसले विशेषता स्वास्थ्य निर्देशनालय मातहातको कार्यालयको रूपमा रही, प्रदेश र स्थानीय तहसँग समन्वय, सहजीकरण, सहयोग, र तोकिए बमोजिम प्रदेशको निर्देशानुसार कार्य सम्पादन गर्दैछ। विशेष गरि कोभिड १९ विश्व ब्यापी महामारीको नियन्त्रण तथा व्यवस्थापनमा जनस्वास्थ्य कार्यालय , रसुवाले खेलेको महत्वपूर्ण भूमिकाले जनस्वास्थ्य कार्यालय को आबस्यकता अझै बढेको छ । जनस्वास्थ्य कार्यालय रसुवाले नेपाल सरकारको स्वास्थ्य नीति अनुसार प्रतिकारात्मक, प्रवृद्धानात्मक स्वास्थ्य सेवा प्रदान गर्ने लक्ष्य राखेको छ र यसका साथै, राष्ट्रिय लक्ष्यहरू, दीर्घकालिन लक्ष्यहरू, सहश्राव्दी विकास लक्ष्य, र दिगो विकास लक्ष्यका पूर्ति गर्नका लागि केन्द्र एवं क्षेत्रबाट आएका कार्यक्रम, निर्देशनहरूलाई कार्यान्वयन गरी, विभिन्न क्षेत्रमा स्थानीय स्वास्थ्य सेवा प्रदान गरी राष्ट्रिय स्वास्थ्य अभियानहरूमा सहभागी बनाइरहेको छ।

जनस्वास्थ्य कार्यालय रसुवाले आफ्नो स्वास्थ्य संग संवन्धित कार्यालयहरूको सुपरिवेक्षण, अनुगमन, मूल्यांकन, र महामारी नियन्त्रण सहितको कर्मचारी व्यवस्थापन गरेको छ। जनस्वास्थ्य कार्यक्रमहरूको योजना तर्जुमा, संचालन समन्वय, तालिम, वजेट व्यवस्था, औषधि औजारको आपूर्ति, र अन्य नियमित कार्यक्रमहरूको संचालन गरिरहेको छ।

जनस्वास्थ्य कार्यालय , रसुवाको विष्तृत कार्य विवरण तल उल्लेख गरिए बमोजिम रहेको छ ।

कार्य विवरण:

१. प्रदेश अन्तर्गत स्वास्थ्य निर्देशनालय मातहत कार्यालयको रुपमा रही प्रदेश र स्थानिय तह संग समन्वय, सहजीकरण, सहयोग एवम तोकिए बमोजिम प्रदेशको निर्देशन भए अनुसार कार्यन्वयन गर्ने l
२. कार्यक्षेत्र भित्रका जिल्लाहरु तथा स्थानिय स्वास्थ्य संस्थाहरुलाई आबस्यक पर्ने खोप, अत्यावश्यक तथा गुणस्तर र संबेदनशील औषधि तथा स्वास्थ्य सामग्रीहरु भण्डारण तथा वितरण योजना (मासिक, त्रैमासिक/चौमासिक, अर्ध वार्षिक, वार्षिक) गरि कार्यन्वयन गर्ने ।
३. जनस्वास्थ्य तथा भेक्टर सर्भिलेन्स र विपद/महामारी व्यवस्थापन, सहजीकरण र समन्वय गर्ने ।
४. जनस्वास्थ्य अभियान संचालन तथा सहयोग, समन्वय र सहजीकरण गर्ने ।

५. स्थानिय सरकार र स्वास्थ्य निकायहरु बीच समन्वय गर्ने l

६. एकीकृत स्वास्थ्य सूचना विश्लेषण र अध्ययन गरि सो अनुसार योजना बनाउने एवम स्थानिय तहमा सहजीकरण तथा पृष्ठपोषण गर्ने।

७. स्वास्थ्य सेवाको पहुच, उपयोग बृधि गर्न आबस्यक योजना बनाउने, समन्वय तथा सहजीकरण गर्ने।

८. सरकारी, निजि, सहकारी द्वारा संचालित स्वास्थ्य संस्थाहरु, कर्मचारीहरुको सुपरिवेक्षण, अनुगमन, नियमन तथा गुणस्तर सम्बन्धि कार्य गर्ने।

९. संस्थागत तथा जनशक्तिको प्राविधिक क्षमता अभिवृद्धि गर्ने।

१०. प्रादेशिक विशेष स्वास्थ्य एवम नियमित कार्यक्रमहरु (क्षयरोग तथा कुष्ठरोग नियन्त्रण, परिवार नियोजन, मातृ शिशु स्वास्थ्य, सामाजिक सुरक्षा, बिमा विशेषज्ञ स्वास्थ्य शिविर लगायत हात्तीपाइले, पोषण, दादुरा खोप, लगायत अन्य विशेष कार्यक्रमहरु) को संचालन, समन्वय र सहजीकरण गर्ने।

११. वातावरणीय स्वास्थ्य, खानेपानी, सरसफाई तथा पेशागत स्वास्थ्य प्रबर्द्धन एवम व्यवस्थापनका कार्य गर्ने।

१२. जनसंख्या व्यवस्थापन सम्बन्धि कार्य गर्ने।

१३. प्रदेश सरकारबाट तोकिएका कार्यहरु गर्ने।

१४. बहुक्षेत्रीय समन्वय सहजिकरण सम्बन्धी कार्य।

१५. आन्तरिक प्रशासन (आर्थिक, प्रशासनिक, व्यवस्थापन) सम्बन्धी कार्य गर्ने l

सांगठनिक संरचना

सि. न.	पद	श्रेणी/तह	सेवा	समुह	दरबन्दी		कैफियत
					स्थायी	अस्थायी	
१.	जनस्वास्थ्य अधिकृत	७/८	स्वास्थ्य	हे.इ	१	२	अस्थायी रिक्त
२.	स्वास्थ्य शिक्षा अधिकृत	७/८	स्वास्थ्य	हे.ए	१		रिक्त
३.	सहायक/अधिकृत	५/६	आयोत	तथ्याङ्क	१		रिक्त
४	सहायक/अधिकृत	५/६	प्रशासन	सा.प्र			रिक्त
५	सहायक/अधिकृत	५/६/७	प्रशासन	लेखा			पद्पूरति
६	हे.अ वा सो सरह	५/६/७	स्वास्थ्य	हे.इ			रिक्त
७	प.हे.न	५/६/७	स्वास्थ्य	क.न	१		रिक्त
८	ल्याव टेक्निसियन	५/६/७	स्वास्थ्य	मे.ल्या.टे	१		रिक्त
९	कोल्ड चेन असिस्टेन्ट/ हे.अ वा सो सरह	४/५/६	स्वास्थ्य	हे.इ.	१		पद्पूर्ति
१०	सहायक कम्पुटर अपरेटर	४	प्रशासन	विविध		१	पद्पूर्ति
११	ह.स.चा	श्रैणि विहिन	ई.	मे.ई.	२		पद्पूर्ति
१२	का.स	श्रेणी विहिन	प्रशासन	सा.प्र.	१		पद्पूर्ति
	जम्मा				**१४**		

१.४ जनस्वास्थ्य कार्यालय, रसुवामा कार्यरत कर्मचारीहरूको विवरणहरू

सि.न.	नाम थर	पद	सर्म्पक नम्बर	इमेल
स्थाई				
१.	झम प्रसाद आचार्य	जनस्वास्थ्य अधिकृत	९८५५०६८८५८	*achryajp301@gmail.com*
३.	चाल्स जंग शाहि	लेखापाल	९८६४९५०१२६	*charlesjungshahithakuri@gmail.com*
४.	राम सागर यादव	कोल्ड चेन असिस्टेन्ट	९८६१६४९७०५	*ramsagaryadav3737@gmail.com*
५.	अर्जुन प्रसाद सुवेदी	कार्यालय सहयोगी	९८४३५०७५३५	
करार सेवा				
१.	निलम सुवाल	जनस्वास्थ्य अधिकृत (छात्रवृति करार)	९८४१६०४१७१	*ssuwalneelam@gmail.com*
३.	सरस्वति न्यौपाने	कम्प्यूटर अपरेटर	९८६६३३०१०७	*saraswoti2074neupane@gmail.com*
४.	दिलिप आचार्य	ह.स.चा.	९८६६३११७९८	
५.	ईश्वरी पौडेल	कार्यालय सहयोगी	९८६०९१८८८०	

1.3 Health Management Information System Reporting Rates in the District

Table 1 below presents the completeness of HMIS reporting for five local levels within the district from the fiscal year 2078/79 to 2080/81. The data reveals a significant improvement in overall reporting completeness, increasing from 0% in FY 2078/79 to 88.4% in FY 2079/80 and 88.9% in FY 2080/81. However, there remains a notable disparity among the local levels, with some achieving 100% completeness while others lag.

Table 1: HMIS Reporting Completeness, FY 2078/79 to FY 2080/81

Local Level	2078/79	2079/80	2080/81
Gosaikunda	0	100	100
Aamachhodingmo	0	83.3	83.3
Kalika	0	96.7	100
Uttargaya	0	83.3	83.3
Naukunda	0	80	80
District Total	**0**	**88.4**	**88.9**

Table 2 below presents the HMIS reporting status on time for different local levels in Rasuwa district from the fiscal year 2078/79 to 2080/81. The data shows the percentage of timely reporting for each local level, with Gosaikunda, Aamachhodingmo, Kalika, Uttargava, and Naukunda having varying levels of compliance. The district total indicates an overall improvement in timely reporting from 55.8% in 2079/80 to 64.4% in 2080/81, indicating better adherence to HMIS reporting guidelines.

Table 2: HMIS Reporting Status on time, FY 2078/79 to FY 2080/81

Local Level	2078/79	2079/80	2080/81
Gosaikunda	0	57.4	68.5
Aamachhodingmo	0	65.3	33.3
Kalika	0	58.3	86.7
Uttargaya	0	54.2	54.2
Naukunda	0	48.3	74.2
District Total	0	**55.8**	**64.4**

CHAPTER:2 FAMILY WELFARE

2.1 CHILD HEALTH AND IMMUNIZATION

2.1.1 Background

The National Immunization Program (NIP), formerly the Expanded Program on Immunization (EPI), was established in 2034 and is a cornerstone of Nepal's public health initiatives. A priority program under the Ministry of Health and Population, the NIP has significantly contributed to Nepal's achievements in reducing child and maternal mortality from vaccine-preventable diseases, aligning with the Millennium Development Goals 4 and 5.

Immunization is crucial in achieving the Sustainable Development Goals (SDGs), particularly SDG3, which aims to ensure healthy lives and promote well-being for all. With its wide reach, immunization serves as a foundation for primary healthcare and a catalyst for universal health coverage. Nepal's constitution recognizes access to basic healthcare services as a fundamental right, and the Immunization Act further strengthens this commitment by ensuring every child's right to quality vaccines.

NIP currently provides free immunization services to children under 2 years of age and pregnant women. Children receive protection against 13 antigens, including tuberculosis, rotavirus diarrhoea, diphtheria, pertussis, tetanus, hepatitis B, Haemophilus influenzae type B, polio, pneumococcal disease, measles, rubella, Japanese encephalitis, and typhoid. Pregnant women are administered the Td vaccine to protect against tetanus and diphtheria. The Comprehensive Multi-Year Plan for Immunization (cMYP) for 2011-2016 and 2017-2021 has outlined plans to expand the NIP by introducing additional vaccines, further strengthening Nepal's efforts to protect its population from preventable diseases.

In alignment with the National Immunization Program (NIP), the Public Health Office of Rasuwa has taken a leading role in all immunization-related activities. Working in close collaboration with provincial health directorates and local authorities, the office has developed a comprehensive functional EPI session plan and vaccine movement plan. Currently, Rasuwa district operates 49 EPI posts, comprising health facilities, outreach sessions, and mobile clinics. These posts conduct 49 immunization sessions per month, typically scheduled for the 4th-8th and 20th-24th days of each month.

To ensure the safe and effective storage and distribution of vaccines, the district maintains a cold chain infrastructure consisting of:

- 1 cold chain room with 1 deep freezer and 4 ice-lined refrigerators (3 lines & 1 solar)
- 5 cold chain sub-centres/cold chain distribution centres, each equipped with 1 ice-lined refrigerator

National Immunization Schedule

Table 3: National Immunization Schedule

S.N.	Type of vaccine	No. of Doses	Schedule
1.	BCG	1	At birth or on first contact with a health institution
2.	Rota	2	6 weeks, 10 weeks
3.	OPV	3	6,10, and 14 weeks of age
4.	DPT-Hep b-Hib	3	6,10, and 14 weeks of age
5.	FIPV	2	6, and 14 weeks of age
6.	PCV	3	6,10, weeks and 9 months of age
7.	MR	2	First dose at 9 months and second dose at 15 months of age
8.	JE	1	12 months age
9.	Td	2	Pregnant women: 2 doses of Td one month apart in the first pregnancy, and 1 dose in each subsequent pregnancy
10.	TCV	1	15 months of age

2.1.2 Major Activities Conducted in FY 2080/81

The major activities carried out during FY 2080/81 and their achievement status are presented below:

- A micro-planning seminar was conducted to enhance the quality and accessibility of vaccination services and minimize vaccine wastage.
- A four-day basic training program was implemented for health workers to enhance their knowledge and skills in vaccination services and hygiene promotion.
- A one-day capacity-building session was conducted to enhance the skills of health staff responsible for maintaining the cold chain and ensuring the integrity of vaccines.
- Joint supervision and monitoring activities were conducted to ensure consistent adherence to immunization guidelines and identify areas for improvement.
- A one-day review of the full vaccination program was conducted to assess its effectiveness and develop plans for ensuring its sustainability in the long term.
- Through rigorous line-listing procedures, the local-level government successfully verified the immunization status of all children across all wards of the palika, thereby ensuring that the Palika meets the criteria for full immunization status.
- A measles and rubella (MR) campaign was conducted, targeting children aged 9 months to 5 years. With a coverage rate of 117.5%, the campaign significantly accelerated the country's progress towards MR elimination by 2026. Additionally, children who missed regular vaccinations were provided with DPT-HepB-Hib and PCV vaccines.
- An IPV campaign was implemented to protect children born between Baishak 2073 and Ashoj 2075 from polio. The campaign achieved an 83% coverage rate, demonstrating progress towards polio eradication.

2.1.3 Immunization Status of Rasuwa

Vaccination Coverage (%) for selected antigens for three years, from FY 2078/79 to 2080/81

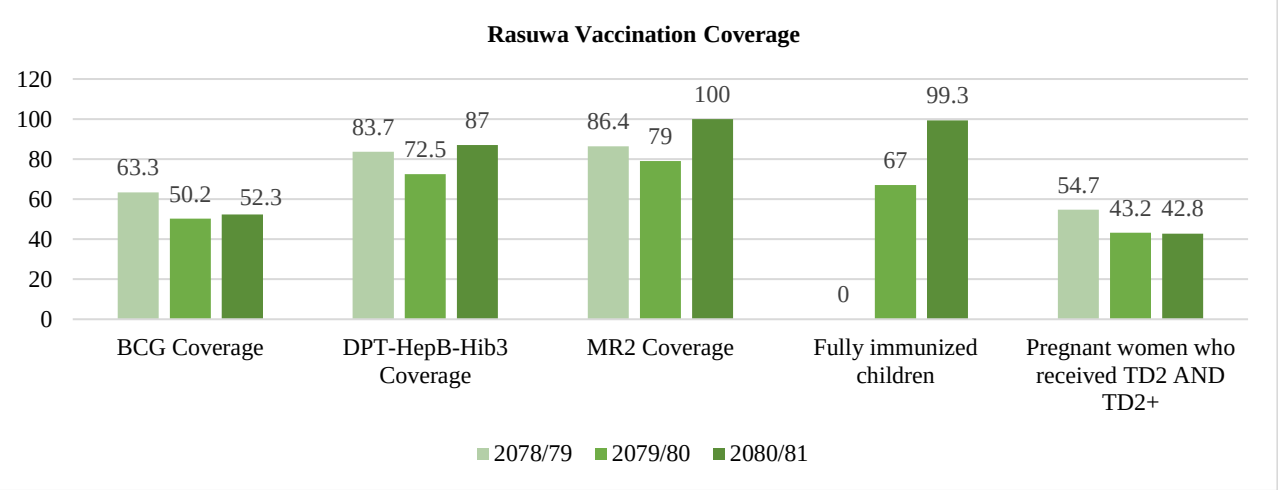


Figure 1:Vaccination Coverage (%) for selected antigens for three years, from FY 2078/79 to 2080/81

Figure 1 presents the vaccination coverage for selected antigens in Rasuwa district over three fiscal years, from 2078/79 to 2080/81. Notably, there has been a significant increase in coverage for DPT-HepB-Hib3, MR2, and fully immunized children. While BCG coverage has shown a modest improvement, it remains below the desired levels. The coverage for pregnant women receiving TD has remained relatively consistent.

Local level-wise three-year trends of BCG coverage (%), FY 2078/79 to 2080/81

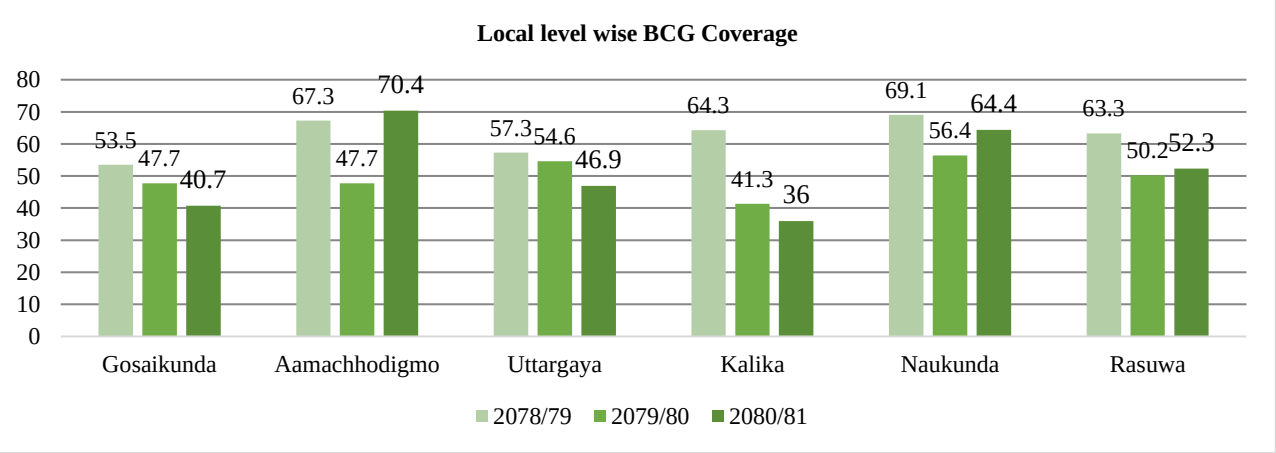


Figure 2: Local level-wise three-year trends of BCG coverage, FY 2078/79 to 2080/81

Figure 2 illustrates the trend in BCG coverage for different local levels in Rasuwa district from FY 2078/79 to 2080/81. The trend shows fluctuations in coverage, with some years showing improvements and others showing declines. Overall, there has been a general increase in BCG coverage in the district. However, significant disparities persist at the local level.

Local level-wise three-year trends of Rota coverage (%), FY 2078/79 to 2080/81

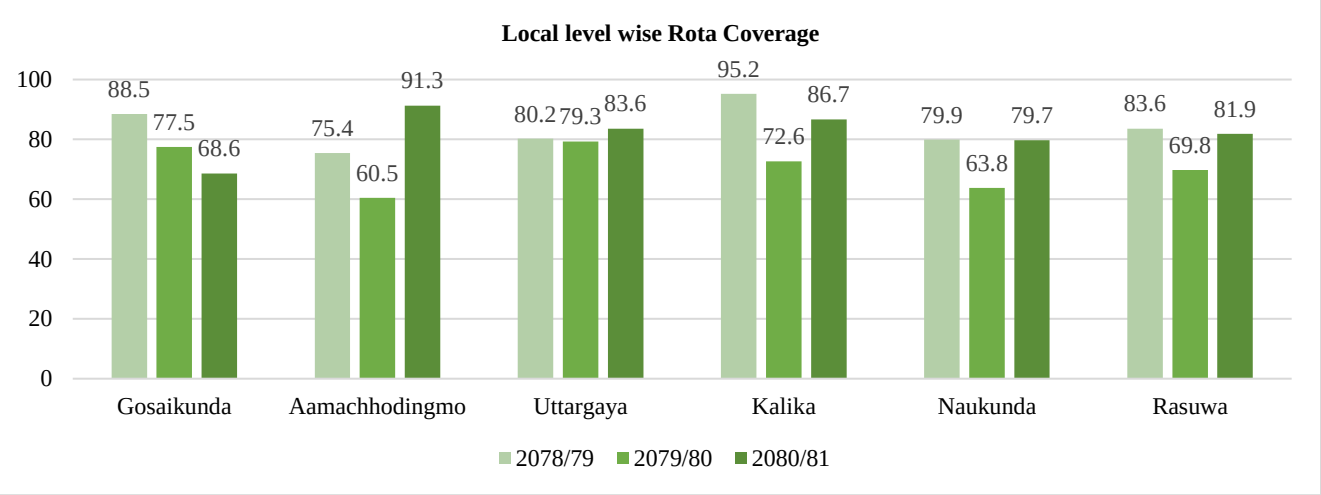


Figure 3: Local level-wise three-year trends of Rota coverage, FY 2078/79 to 2080/81

Figure 3 presents the rotavirus vaccine coverage trends for different local levels in Rasuwa district from FY 2078/79 to 2080/81. The trend shows fluctuations in coverage, with some years showing improvements and others showing declines. Overall, the rotavirus vaccine coverage in the district has generally increased. However, significant disparities persist at the local level.

Local level-wise three-year trends of DPT-HepB-Hib1 coverage (%), FY 2078/79 to 2080/81

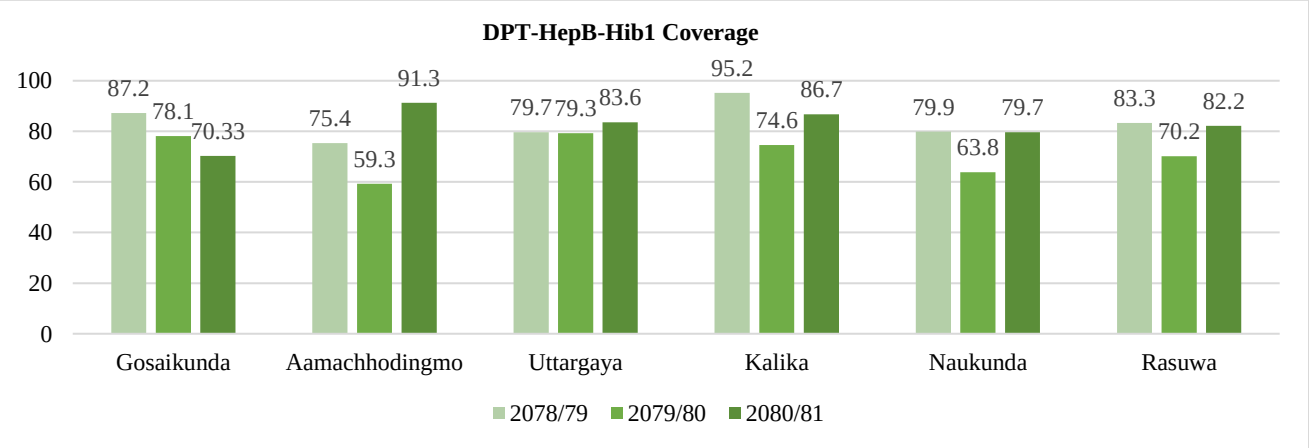


Figure 4: Local level-wise three-year trends of DPT-HepB-Hib1 coverage, FY 2078/79 to 2080/81

Figure 4 presents the DPT-HepB-Hib1 vaccine coverage trends for different local levels in Rasuwa district from FY 2078/79 to 2080/81. The trend shows fluctuations in coverage, with some years showing improvements and others showing declines. Overall, there has been a general increase in DPT-HepB-Hib1 vaccine coverage in the district. However, significant disparities persist at the local

level with the highest coverage of 91.3% in Aamachhodingmo RM and the lowest of 70.33% in Gosaikunda RM.

Local level-wise three-year trends of DPT-HepB-Hib3 coverage (%), FY 2078/79 to 2080/81

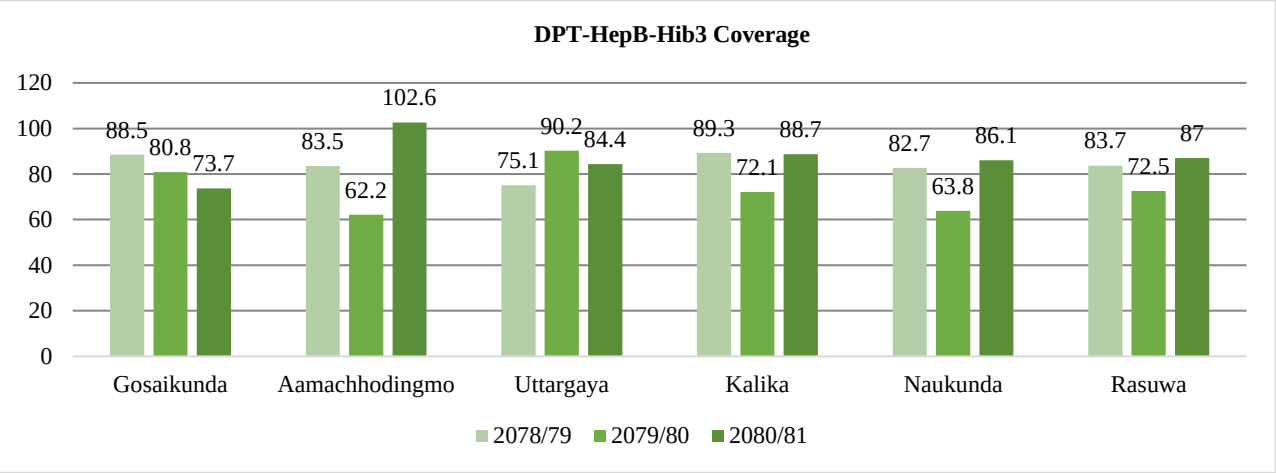


Figure 5: Local level-wise three-year trends of DPT-HepB-Hib3 coverage, FY 2078/79 to 2080/81

Figure 5 illustrates a significant increase in DPT-HepB-Hib3 vaccine coverage across Rasuwa district over the past three fiscal years, from 2078/79 to 2080/81. The district achieved a peak coverage rate of 87% during this period. Notably, a majority of the local level experienced substantial improvements in vaccine coverage, indicating effective immunization efforts at the grassroots level.

Local level-wise three-year trends of the measles-rubella first dose coverage (%), FY 2078/79 to 2080/81

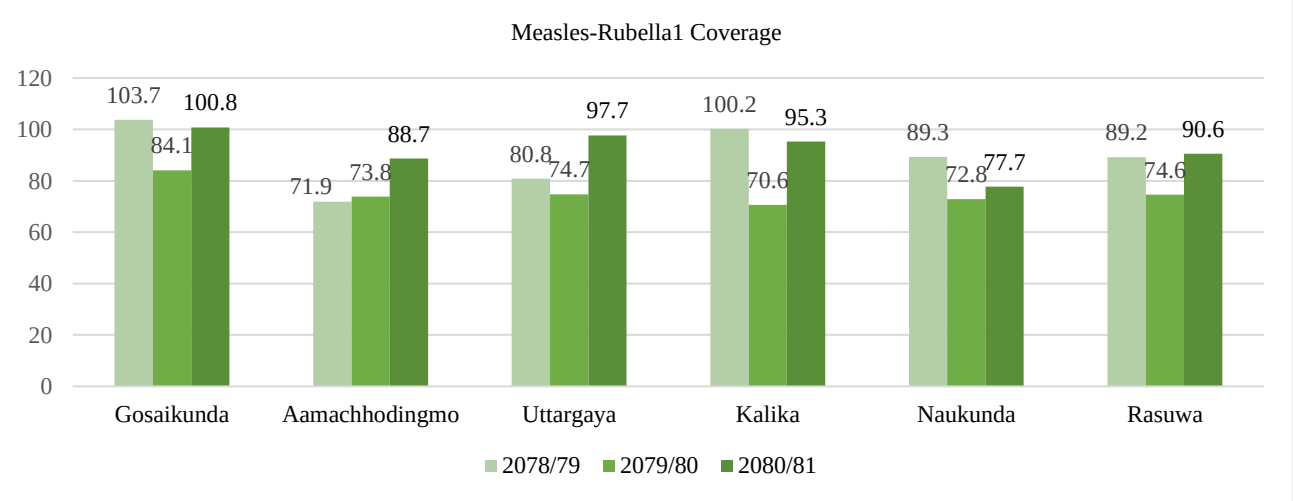


Figure 6: Local level-wise three-year trends of the measles-rubella first dose coverage, FY 2078/79 to 2080/81

Figure 6 demonstrates a substantial increase in MR1 vaccine coverage across Rasuwa district between fiscal years 2078/79 and 2080/81. The district reached a peak coverage rate of 90.6% during this time. Notably, most local levels experienced significant improvements, with Gosaikunda RM achieving the highest coverage at 100.8% and Naukunda RM recording the lowest at 77.7%.

Local level-wise three-year trends of the measles-rubella second dose coverage (%), FY 2078/79 to 2080/81

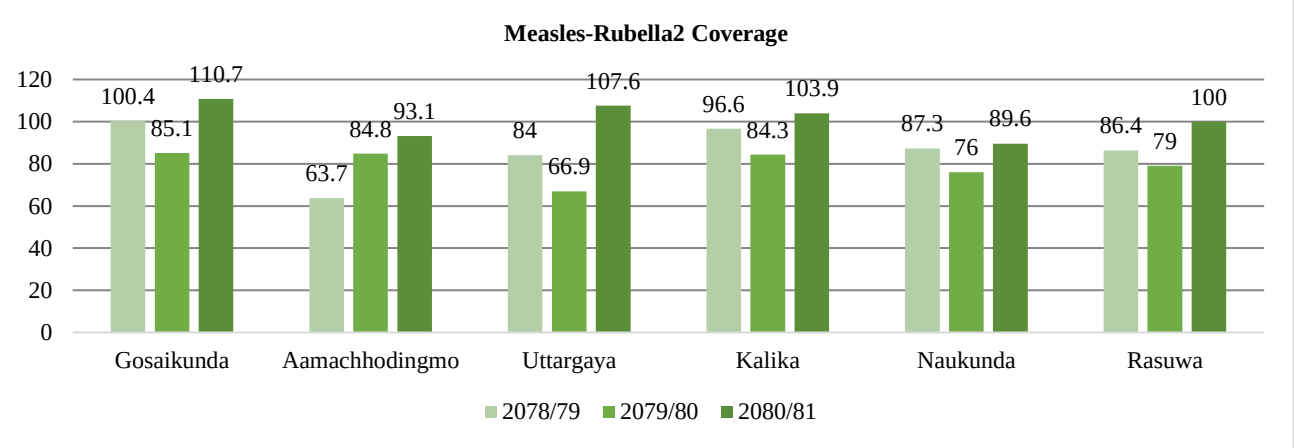


Figure 7: Local level-wise three-year trends of the measles-rubella second dose coverage, FY 2078/79 to 2080/81

Figure 7 highlights a significant improvement in MR2 vaccine coverage across Rasuwa district between fiscal years 2078/79 and 2080/81. The district achieved a remarkable 100% coverage, indicating that all eligible children received the vaccine dose. Notably, all local levels witnessed substantial increases in coverage, with Gosaikunda RM reporting the highest rate at 110.7%, while Naukunda RM recorded the lowest at 89.6%.

Local level-wise three-year trends of Td2 and TD2+ coverage (%), FY 2078/79 to 2080/81

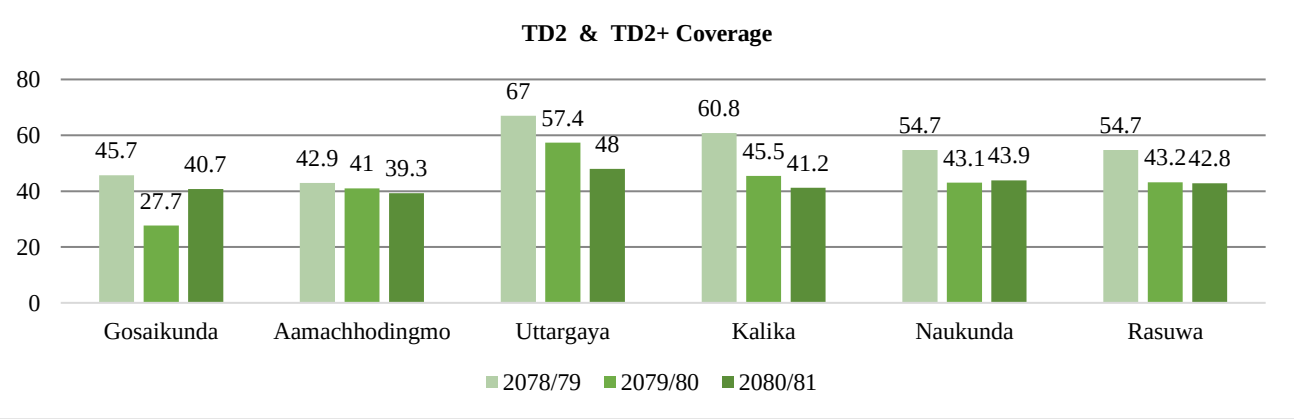


Figure 8: Local level-wise three-year trends of TD2 and TD2+ coverage, FY 2078/79 to 2080/81

Figure 8 indicates a slight decline in the district-wide coverage of pregnant women who received a complete dose of the TD vaccine. However, it's noteworthy that Gosaikunda RM demonstrated a significant increase in TD vaccine coverage among pregnant women.

Dropout rates (%) for selected antigens for three years, from FY 2078/79 to 2080/81

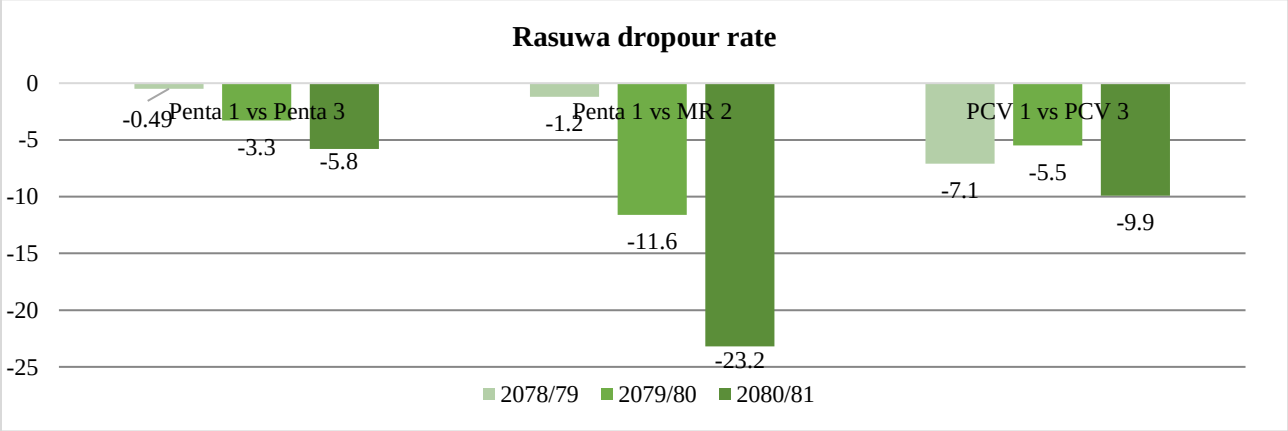


Figure 9: Dropout rates (%) for selected antigens for three years, from FY 2078/79 to 2080/81

Figure 9 illustrates the dropout rates for selected antigens in Rasuwa district from FY 2078/79 to 2080/81. The data reveals a consistent decline in dropout rates for all antigens over the three years. The most significant reduction between Penta 1 and MR2 was observed, with a dropout rate of -23.2% in FY 2080/81. Overall, these positive trends indicate an improvement in vaccine completion rates within the district, suggesting enhanced access to and uptake of immunization services.

Vaccine wastage rates (%) for selected antigens for three years, from FY 2078/79 to 2080/81

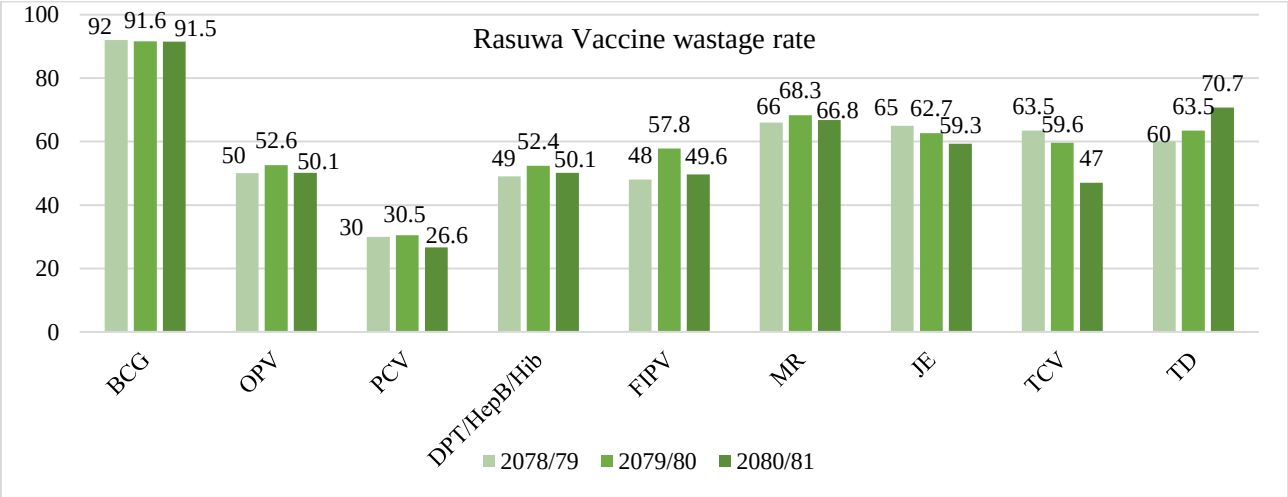


Figure 10: Vaccine wastage rates (%) for selected antigens for three years, from FY 2078/79 to 2080/81

For all re-constituted vaccines (BCG, MR and JE) that need to be discarded within 6 hours (1 hour only for JE) or at the end of the immunization session whichever comes first, wastages are expected to be higher. Figure 10 illustrates the vaccine wastage rates for various antigens in Rasuwa district from fiscal year 2078/79 to 2080/81. The data reveals that wastage rates for reconstitute vaccines, such as BCG, MR, and JE, are generally higher due to their short shelf life and the "one vial per person" policy adopted in Nepal. Additionally, the sparse population in the district's hilly and mountainous terrain often necessitates smaller session sizes, leading to higher rates of opened vial wastage to ensure that no child misses' immunization.

Despite these challenges, the district has made notable progress in reducing vaccine wastage. However, further efforts are required to minimize losses and optimize resource utilization.

2.1.4 Access and utilization of immunization service

A comprehensive analysis of rural municipalities in the Rasuwa district revealed that only Aamachhodingmo demonstrated a high level of access and utilization for immunization services, falling into Category 1. This category is characterized by both high coverage of DPT-HepB-Hib1 and low dropout rates for DPT-HepB-Hib1 versus MR2.In contrast, the remaining four rural municipalities were categorized under Category 3, indicating low coverage and low dropout rates.

Based on this analysis, Rasuwa district is classified under Category 3, suggesting a district-wide challenge in achieving adequate immunization coverage. To address this issue, it is imperative to identify the underlying factors hindering access and utilization of immunization services in the district and implement targeted interventions to improve access and uptake in the district's rural municipalities.

Table 4: Local level categorization based on access (DPT-Hep B-Hib 1 coverage) and utilization (DPT-Hep B-Hib 1 vs MR 2 dropout), FY 2078/79

Category 1 (No Problem) High Coverage (≥90%) Low Dropout (<10%)	Category 2 (Problem) High Coverage (≥90%) High Dropout (≥10%)	Category 3 (Problem) Low Coverage (<90%) Low Dropout (<10%)	Category 4 (Problem) Low Coverage (<90%) High Dropout (≥10%)
Aamachhodingmo Rural M.		**Naukunda Rural M.** **Gosaikunda Rural M.** **Uttargaya Rural M.** **Kalika Rural M.**	

2.1.5 Immunization Coverage

One of the strategies of the comprehensive multi-year plan of action under the first strategic objective is to increase immunization coverage to reach 100% of children. Table 5 shows the progress made toward this strategy and the objective of the cMYP.

Table 5: Immunization Coverage by Antigen Doses FY 2080/81

S. N	Antigen	Target Population	Target	Achievement	Per cent Achieved
1.	BCG	Under 1 year	719	373	52.3
2.	Rota1	Under 1 year	719	584	81.9
3.	Rota2	Under 1 year	719	600	84.2
4.	DPT-Hep B HIB1	Under 1 year	719	586	82.2
5.	DPT-Hep B HIB2	Under 1 year	719	601	84.3
6.	DPT-Hep B HIB3	Under 1 year	719	620	87
7.	OPV 1	Under 1 year	719	584	82
8.	OPV 2	Under 1 year	719	603	84.2
9.	OPV 3	Under 1 year	719	620	87
10.	PCV1	Under 1 year	719	584	81.9
11.	PCV2	Under 1 year	719	604	84.7
12.	PCV3	Under 1 year	719	642	90
13.	fIPV1	Under 1 year	719	619	86.8
14.	fIPV2	Under 1 year	719	642	90
15.	Measles/Rubella 1st Dose	Under 1 year	719	646	90.6
16.	Measles/Rubella 2nd Dose	12-23 months	728	722	100
17.	Japanese Encephalitis	12-23 months	728	659	91.3
18	TCV	12-23 months	728	732	101.4
19.	Td2 and 2+	Expected live birth	722	183	42.8

Source: DHIS-2

2.1.6 Status of the Hygiene Promotion Session in EPI Clinics

In fiscal year 2080/81, 557 immunization and hygiene promotion sessions were planned, of which 450 were successfully conducted. These sessions benefited a total of 3816 mothers/guardians.

2.1.7 Issues, recommendations and responsibilities

Table 6: **Prevailing problems and recommended action**

Issues	Recommended action	Responsibilities
A congested warehouse building for storage at the district and Palika level	• Establish or construct dedicated vaccine storage facilities that adhere to the Essential Vaccine Management (EVM) standards.	Provincial government, Public Health Office
Infrastructure for routine immunization and hygiene promotion sessions	• Identify specific infrastructure gaps at the local level • Infrastructure development and improvement	Provincial government, Public Health Office, Health Section, Palika
Sustaining full immunization in low-coverage Palika	• Conduct regular checks to confirm the immunization status of fully immunized children and ensure the accuracy of immunization records. • Establish a robust coverage monitoring system	Public Health Office, Health Section, Palika
Replacement of CC equipment	• Upgrade and modernize aging cold-chain equipment.	Public Health Office
Lack of mechanism to revert the excess vaccine after immunization session to the cold-chain distribution sub-centre	• Develop standardized procedures with clear guidelines and protocols for the return of unused vaccines to designated cold-chain facilities.	Provincial government, Public Health Office, Health Section, Palika
Inadequate vaccinators in the district	• Vaccinator recruitment and training programs	Provincial government, Public Health Office,

2.2 NUTRITION PROGRAM

2.2.1 Background

Nutrition plays a pivotal role in human development and societal progress. It is a fundamental prerequisite for achieving the Sustainable Development Goals (SDGs), fostering economic growth, and enhancing individual productivity. Malnutrition, however, poses a significant obstacle to health, social, and economic development. The Government of Nepal recognizes the importance of nutrition and is committed to ensuring the nutritional well-being of all its citizens. This commitment is aligned with international and national declarations, including the National Health Policies and the International Conference on Nutrition. Nepal's Constitution also guarantees all its citizens the right to food, health, and nutrition.

The National Nutrition Program seeks to achieve nutritional well-being for all individuals, reduce child and maternal mortality, and contribute to equitable human development. To accomplish these objectives, the program will prioritize food-based approaches, food fortification, supplementation, and public health measures.

The National Nutrition Program focuses on a comprehensive approach to promoting child and maternal nutrition**.** Key interventions include:

- **Growth monitoring and counselling:** Regular monitoring of child growth and providing nutritional counselling for parents.
- **Exclusive breastfeeding:** Promoting exclusive breastfeeding for the first six months of life.
- **Complementary feeding:** Guiding parents on appropriate complementary feeding practices.
- **Micronutrient supplementation:** Providing bi-annual vitamin A supplementation and deworming tablets to children under five years of age.
- **Maternal nutrition:** Distributing iron-folic acid and deworming tablets to pregnant women and iron-folic acid and vitamin A to postpartum mothers, along with nutritional counselling.

The Public Health Office of Rasuwa plays a pivotal role in coordinating and providing technical assistance for the implementation of the nutrition program across all rural municipalities. The program prioritizes exclusive breastfeeding, growth monitoring, addressing protein-energy malnutrition and vitamin A deficiency, combating iron deficiency anaemia, and promoting the consumption of locally grown foods to meet the nutritional needs of mothers and children. These efforts aim to reduce mortality and morbidity associated with nutritional deficiencies.

2.2.2 Major Activities Conducted in FY 2080/81

- Growth monitoring services were integrated into immunization sessions at EPI clinics.
- Vitamin A supplementation was to children aged 6 months to 5 years while deworming tablets were distributed to children aged 1 to 5 years through the mobilization of Female Community Health Volunteers.
- Continued distribution of iron-folic acid supplementation to pregnant and postpartum women, along with vitamin A supplementation for postpartum mothers.

- School-based iron-folic acid supplementation programs were implemented for girls aged 10 to 19 years, facilitated by school nurses.
- World Breastfeeding Week and Iodine Month were commemorated to raise awareness about nutritional well-being.
- Efforts were made to enhance the capacity and effectiveness of Outreach Centers (OTCs) within the district.

2.2.3 Nutrition program performance status by key indicators

Local level-wise three-year trends of children aged 0-23 months registered for growth monitoring (%), FY 2078/79 to 2080/81

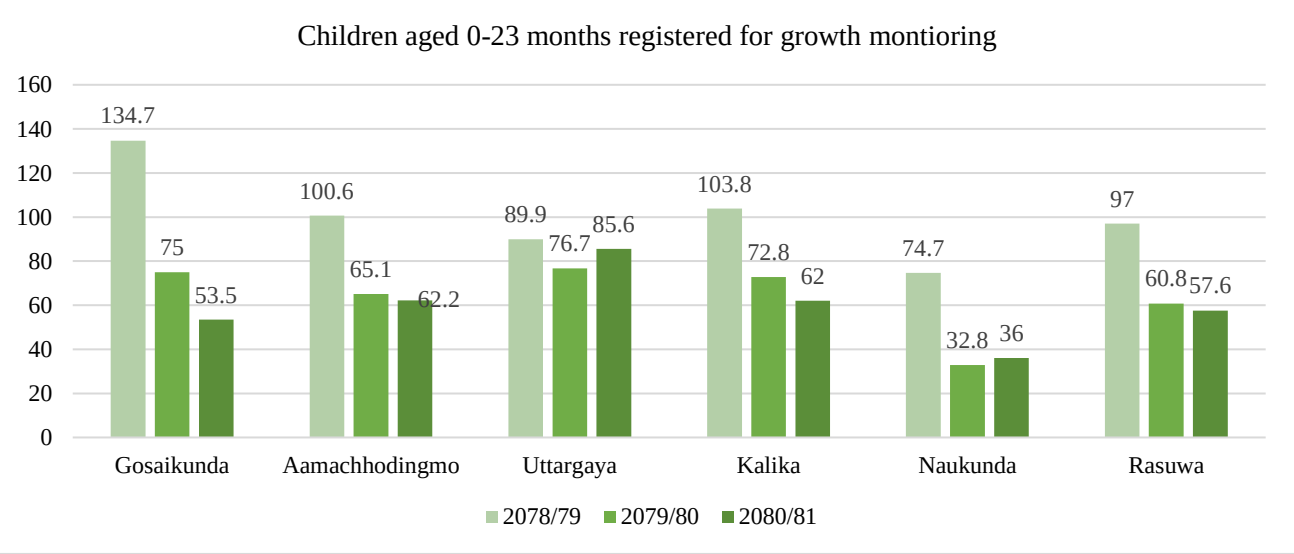


Figure 11: Local level-wise three-year trends of children aged 0-23 months registered for growth monitoring, FY 2078/79 to 2080/81

Figure 11 presents the three-year trends of children aged 0-23 months registered for growth monitoring in the district. The data reveals fluctuations in registration rates across different local levels and over time indicating varying levels of service utilization. Uttargaya and Naukunda showed a substantial increase in registration rates, indicating the successful implementation of the growth monitoring program. Rasuwa can further improve the GM registering rate by implementing targeted intervention and strengthening health systems.

Local level-wise three-year trends of the average number of growth monitoring visits per child (0-23 months), FY 2078/79 to 2080/81

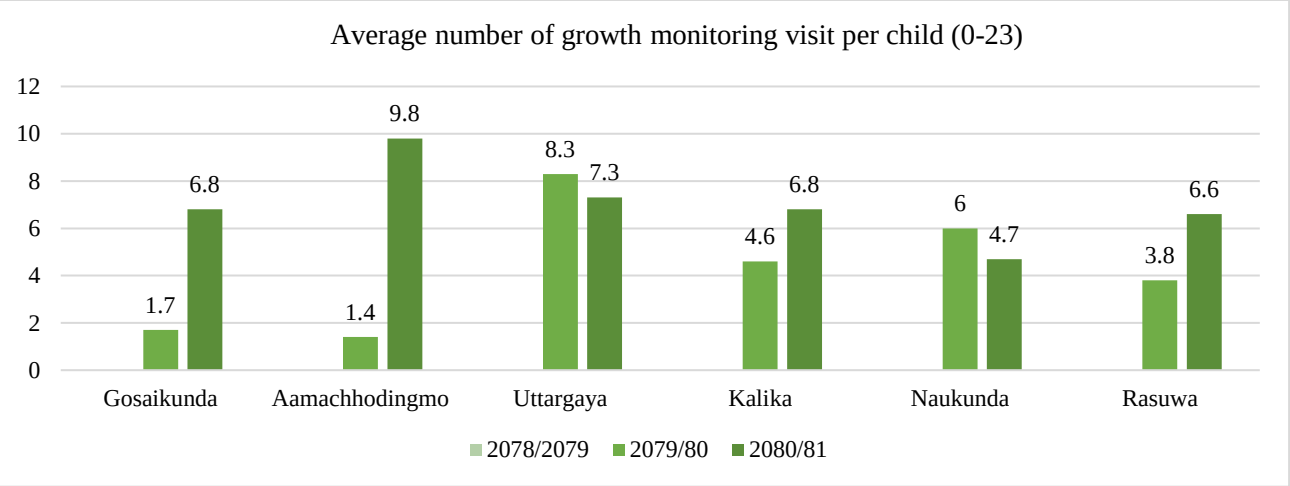


Figure 12: Local level-wise three-year trends of the average number of growth monitoring visits per child (0-23 months), FY 2078/79 to 2080/81

Figure 12 depicts the trends in the average number of growth monitoring visits per child aged 0-23 months across different local levels in the district. The data reveals a generally positive trend, with most local levels showing an increase in visits over the three years indicating improved access to and utilization of growth monitoring services. However, the average remains below the recommended minimum visits of 7 per child, highlighting the need for targeted intervention and adjusting strategies to ensure ongoing improvements.

Local level-wise three-year trends of the children aged 0-23 months registered who were Underweight (%), FY 2078/79 to 2080/81

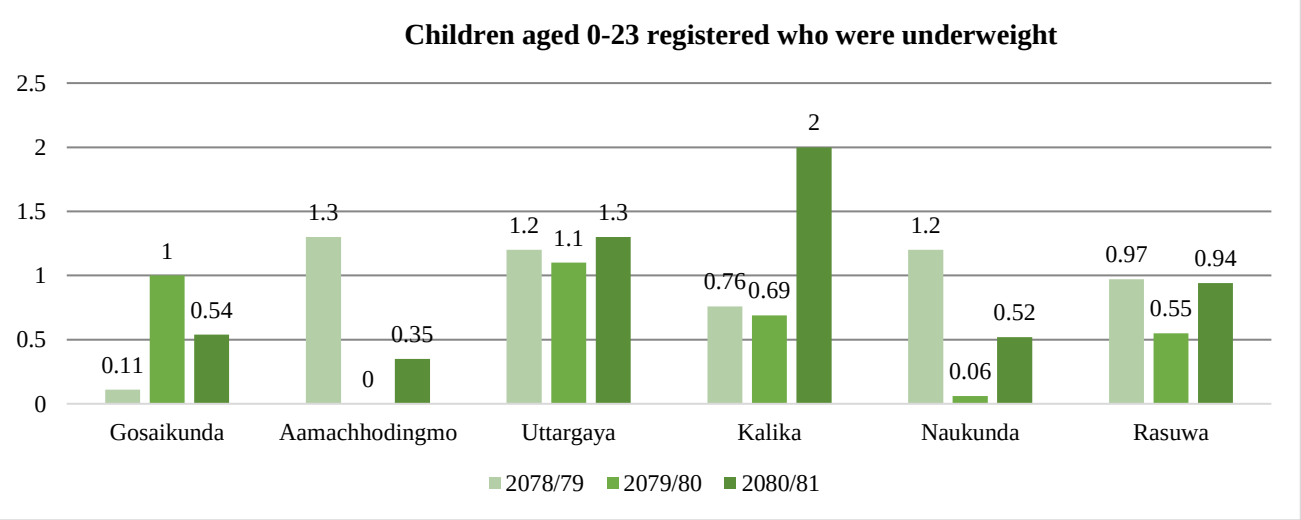


Figure 13: Local level-wise three-year trends of the children aged 0-23 months registered who were Underweight, FY 2078/79 to 2080/81

Figure 13 depicts the trend in the percentage of underweight children aged 0-23 registered for growth monitoring in the district. The data reveals fluctuations among the local levels, with some showing improvements and others experiencing an increase in underweight rates.

Infant and Young Child Feeding (IYCF)

The infant and young child feeding (IYCF) practices include early initiation of breastfeeding within an hour of childbirth, exclusive breastfeeding for six months and providing nutritionally adequate and appropriate complementary feeding starting from six months with continued breastfeeding up to two years of age or beyond.

Local level-wise three-year trends of the children aged (0-6 months) who were exclusively breastfed (%), FY 2078/79 to 2080/81

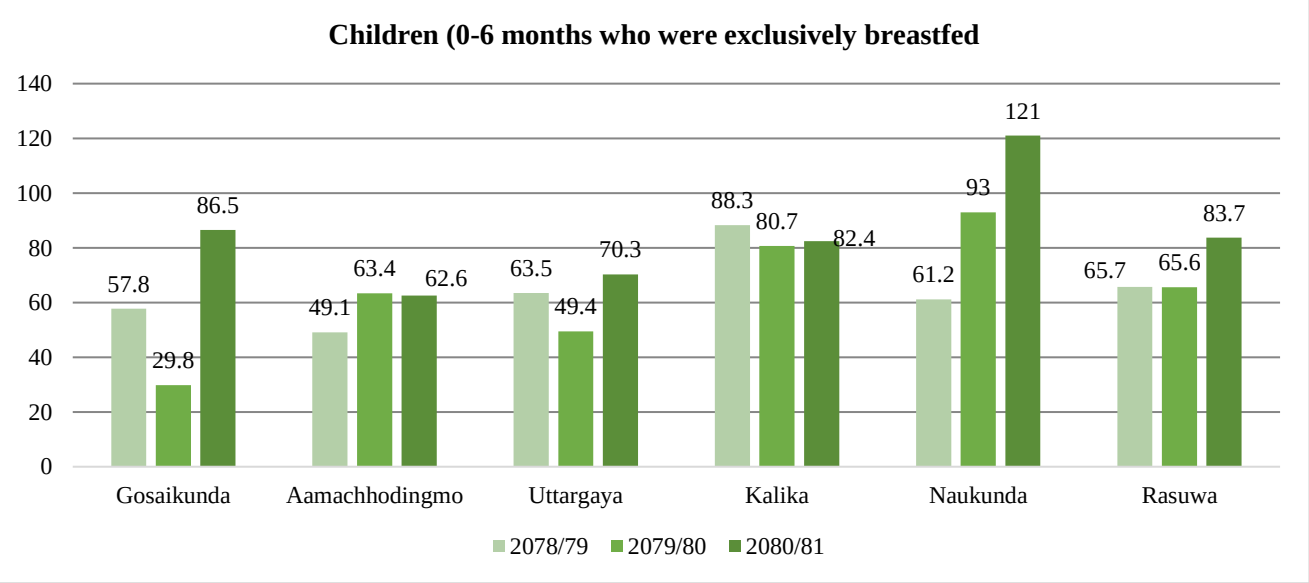


Figure 14: Local level-wise three-year trends of the children aged (0-6 months) who were exclusively breastfed, FY 2078/79 to 2080/81

Figure 14 depicts the trends in the percentage of exclusively breastfed children aged 0-6 months in the district. Notably, the district has demonstrated a significant improvement in this indicator over the year. Additionally, it underscores the importance of ongoing monitoring and evaluation to track progress and identify areas requiring further support.

Prevention and control of iron deficiency Anaemia (IDA)

To improve access and utilization of IFA supplements, the Intensification of Maternal and Neonatal Micronutrient Program (IMNMP) started IFA supplementation through Female Community Health Volunteers (FCHVs) in 2003. The protocol is to provide 60 mg of elemental iron and 400 micrograms of folic acid to pregnant women for 225 days from their second trimester.

Local level-wise three-year trends of pregnant women receiving 180 IFA tablets (%), FY 2078/79 to 2080/81

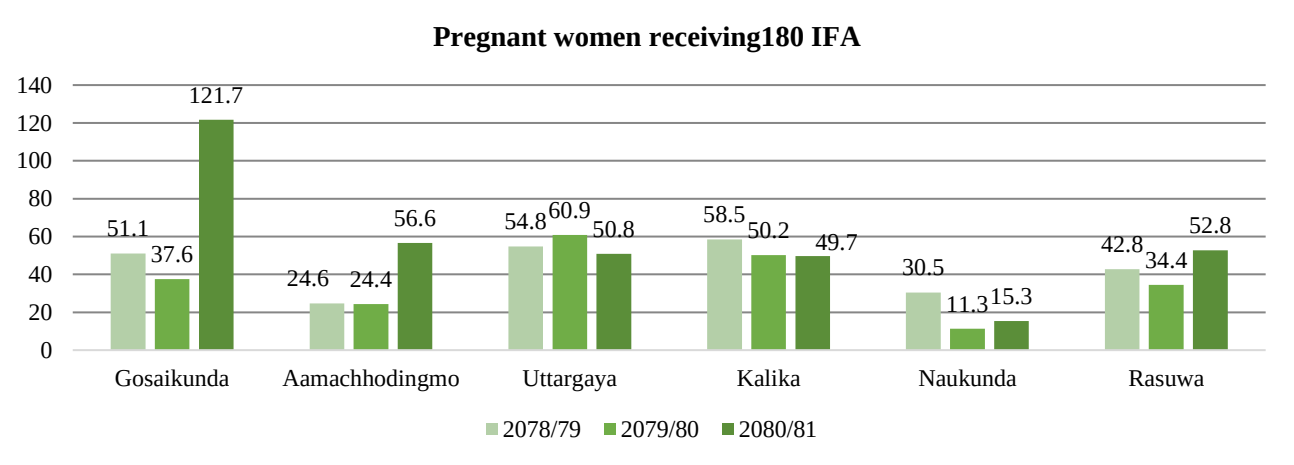


Figure 15: Local level-wise three-year trends of pregnant women receiving 180 IFA tablets, FY 2078/79 to 2080/81

Figure 15 illustrates the three-year trend of pregnant women receiving 180 IFA tablets at various local levels within the district. Goasikunda and Aamachhodingmo reported the highest percentages of pregnant women receiving the full course of IFA in comparison. While there are fluctuations within individual local levels, overall, there seems to be a general trend of increasing IFA tablet distribution over the three years. Notably, the percentage of pregnant women receiving IFA tablets in Goasikunda exceeds 100%, which might indicate data entry or calculation errors. Further investigation is necessary to clarify this anomaly.

Local level-wise three-year trends of post-partum women receiving 45 IFA tablets (%), FY 2078/79 to 2080/81

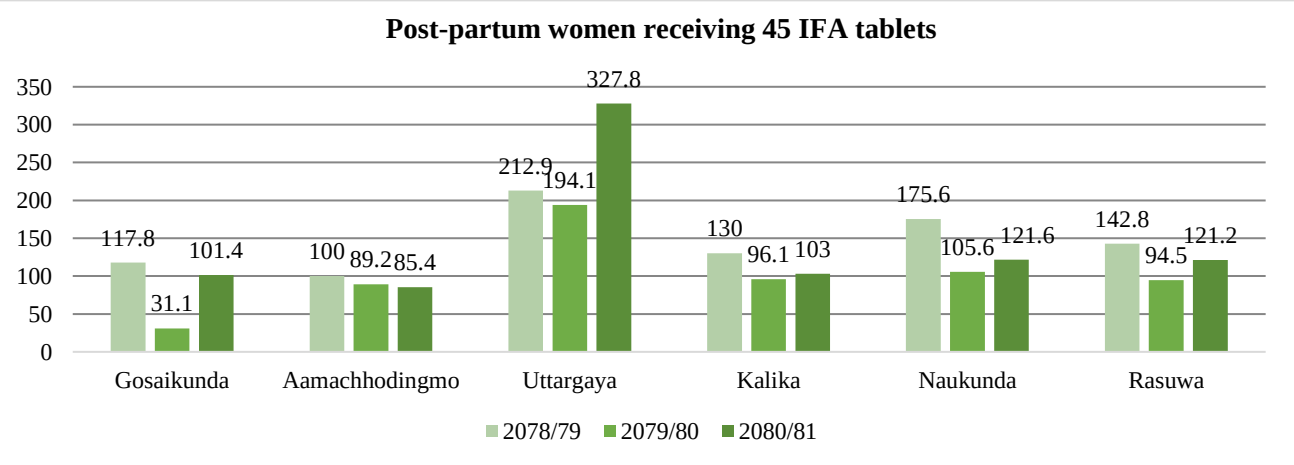


Figure 16: Local level-wise three-year trends of post-partum women receiving 45 IFA tablets, FY 2078/79 to 2080/81

Figure 16 illustrates the three-year trend of post-partum women receiving 45 IFA tablets at various local levels within the district. The graph shows a significant disparity in IFA tablet distribution among different local levels. While the overall trend is positive, there are still instances of inconsistent data. The percentage exceeds 100% which might indicate data entry errors, so further investigation is necessary to clarify this anomaly.

Local level-wise three-year trends of post-partum women receiving Vitamin A supplementation (%), FY 2078/79 to 2080/81

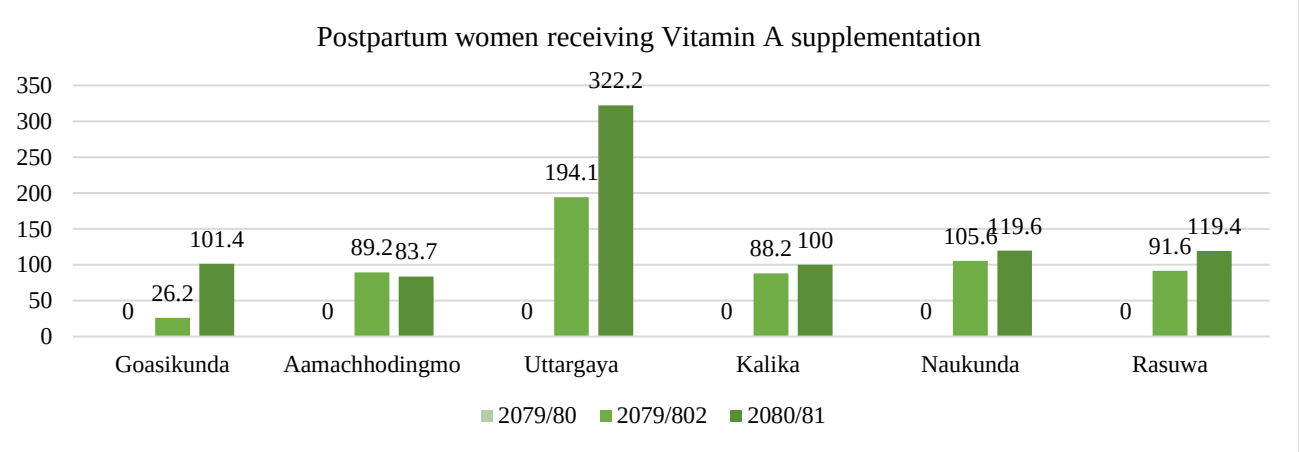


Figure 17: Local level-wise three-year trends of post-partum women receiving Vitamin A supplementation, FY 2078/79 to 2080/81

Figure 17 illustrates the local-level, three-year trends of post-partum women receiving Vitamin A supplementation from fiscal years 2078/79 to 2080/81. In the fiscal year 2080/81, the proportion of women receiving Vitamin A supplementation peaked at 322.2% in Uttargaya, dramatically increasing from 194.1% in 2079/80. Gosaikunda saw a sharp rise from 26.2% in 2078/79 to 101.4% by 2080/81. Other areas like Naukunda displayed relatively stable trends, with percentages consistently above 90% across the two latter fiscal years. In contrast, Kalika and Aamachodingmo saw minor fluctuations, though they remained between 80-100%. These variations indicate disparities in Vitamin A supplementation coverage across different regions of the district.

Control of vitamin A deficiency disorders (VAD)

The Government of Nepal launched the National Vitamin A Program in 1993 with the primary objectives of enhancing child health, mitigating Vitamin A deficiency-related disorders, and significantly reducing child mortality. This program has garnered global recognition as a public health success story.

The program entails the distribution of Vitamin A capsules to children aged 6-59 months twice annually, typically during the months of Kartik (October) and Baisakh (April). This distribution is facilitated by Female Community Health Volunteers (FCHVs) in collaboration with health facilities, local governments, and volunteers.

The bi-annual deworming tablet distribution initiative for children aged 12-59 months is an integral component of the program. This initiative addresses childhood anaemia with control of parasitic infestations through municipal-level interventions.

Table 7: Coverage of National Vitamin A supplementation and deworming tablet distribution program

Local Levels	Children receiving Vitamin A- 6-11 Months			Children receiving Vitamin A- 12-59 Months			Children receiving the deworming tablet		
	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81
Gosaikunda	132	100	95	980	922	883	980	925	618
Aamachho dingmo	154	132	94	995	884	832	995	884	752
Uttargaya	148	123	98	1412	1138	1117	1406	1138	930
Kalika	203	157	122	1536	1383	1347	1590	1400	1129
Naukunda	240	200	129	1815	1331	1368	1819	1247	1108
Rasuwa	**877**	**712**	**538**	**6738**	**5658**	**5547**	**6790**	**5594**	**4537**

2.2.4 Integrated management of acute malnutrition (IMAM)

The Integrated Management of Acute Malnutrition (IMAM) Program provides comprehensive treatment for children aged 0-59 months with Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) through inpatient and outpatient services at health facilities and community levels. In the IMAM districts, prevention and treatment of acute malnutrition are ongoing through outpatient therapeutic centres (OTCs) located at local health facilities. Female community health volunteers (FCHVs) conduct community-based screenings of 6-59-month-old children using colour-coded mid-upper arm circumference (MUAC) tape, referring identified SAM and MAM children to the OTCs for treatment.

Table 8: Number of OTC centres at the local level

Local Level	Number of OTC
Gosaikunda Rural Municipality	2
Aamachodigmo Rural Municipality	1

Uttargaya Rural Municipality	4
Kalika Rural Municipality	5
Naukunda Rural Municipality	1
Total	**13**

Local level-wise three-year trends of SAM and MAM cases (6-59 months) admitted at outpatient therapeutic centres, FY 2078/79 to 2080/81

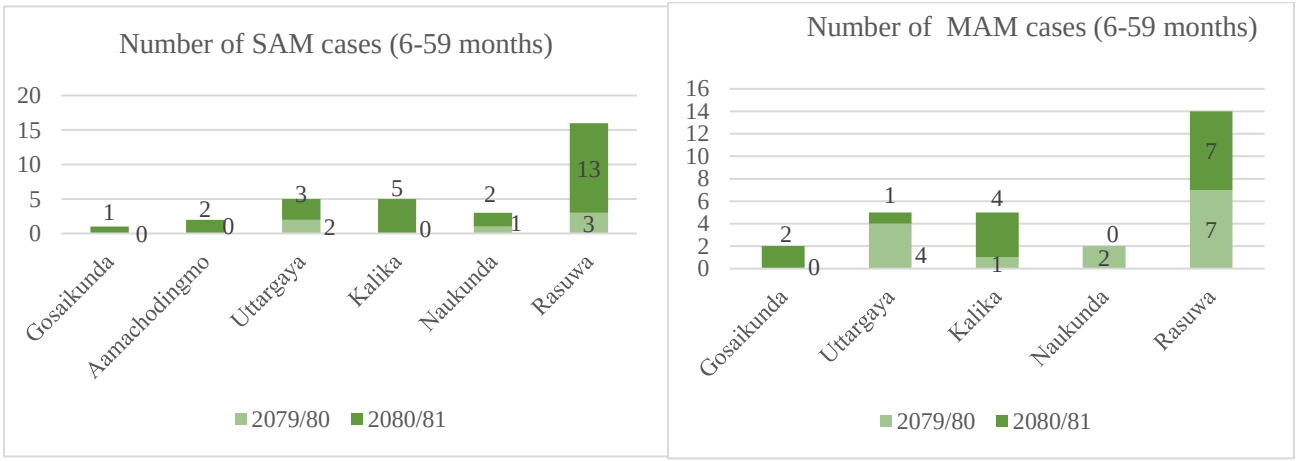


Figure 18: Local level-wise three-year trends of SAM and MAM cases (6-59 months) admitted at outpatient therapeutic centres, FY 2078/79 to 2080/81

Figure 18 illustrates the three-year trends of SAM and MAM cases in children aged 6-59 months admitted at OTCs within the district. In 2079/80, the number of SAM cases was relatively low across all local levels, with most areas recording between zero to two cases. However, a significant increase is observed in 2080/81, where the number of SAM cases surged to thirteen, compared to just three cases in the previous year throughout the district.

Meanwhile, the MAM trend presents a more varied distribution across the local level and year. Gosaikunda and Kalika experienced an increase in admitted cases while in contrast Uttargaya and Naukunda witnessed a decrease in the admitted case.

Overall, the trend indicates a notable increase in both SAM and MAM cases over the analyzed period, indicating a growing malnutrition burden in the district.

2.2.5 Issues, recommendations and responsibilities

Table 9: Prevailing issues and recommended action

Issues	Recommendation	Responsibilities
The effectiveness of growth monitoring and promotion programs has been limited due to a lack of awareness among mothers and caregivers about the availability of growth monitoring and promotion sessions.	• Comprehensive training and Hands-on practice for health workers and FCHVs to practice growth monitoring techniques and counselling skills in a simulated setting.	Health Section, Palika
Data errors due to problems with recording and reporting	• Appoint dedicated nutritional focal persons at the provincial and municipal levels to oversee data management and ensure accuracy. • Data Verification and training	PHD, Public Health Office, Health Section, Palika
Inadequate provision of Salter scales and other necessary equipment in healthcare facilities.	• Prioritize the provision of essential equipment, such as MUAC tape, Salter scale, height board, weighing scale, and measuring tape, to all healthcare facilities.	Provincial Health Logistic Centre, Public Health Office, Health Section, Palika
Increase in SAM & MAM Cases	• Mobilization of FCHVs for the MUAC screening campaign • Proper Care for SAM and MAM Cases • Ensuring that SAM cases are brought under curative/therapeutic centre services	PHD, Public Health Office, Health Section, Palika

2.3 Integrated Management of Neonatal and Childhood Illnesses (IMNCI)

2.3.1 Background

The Integrated Management of Neonatal and Childhood Illness (CB-IMNCI) program is a comprehensive approach to improving child health in Nepal. It combines the Integrated Management of Childhood Illness (CB-IMCI) and Newborn Care Package (CBNCP) to address the major causes of neonatal and child mortality.

Implemented nationwide since 2071/6/28 (October 14, 2015), CB-IMNCI focuses on reducing mortality and morbidity among children under five years of age. The program addresses key health issues such as birth asphyxia, bacterial infection, jaundice, hypothermia, low birth weight, and breastfeeding counselling for newborns. For children aged 2 months to 59 months, CB-IMNCI addresses major childhood illnesses like pneumonia, diarrhoea, malaria, measles, and malnutrition through a holistic approach.

Major Interventions

- **New-born Specific Interventions:** Promotion of birth preparedness plan, promotion of essential new-born care practices and postnatal care to mothers and new-born; identification and management of non-breathing babies at birth; identification and management of preterm and low birth weight babies); and management of sepsis among young infants (0-59 days) including diarrhoea.

- **Child Specific Interventions:** Case management of children aged between 2-59 months for 5 major childhood killer diseases (Pneumonia, Diarrhea, Malnutrition, Measles and Malaria).

- **Cross-cutting Interventions:** Behavior Change Communication for healthy pregnancy, safe delivery and promotion of personal hygiene and sanitation; improve knowledge related to immunization, nutrition, and care of sick children; and improve interpersonal communication skills of HWs and FCHVs)

2.3.2 Major Activities of the program conducted by the district in FY 2079/2080

- A six-day CB-IMNCI training program was conducted, benefiting 20 new health workers.
- Equipment and medicines necessary for the IMNCI program were procured and distributed.
- Free newborn care services were implemented to improve neonatal health.
- The IMNCI program was supervised and monitored through municipalities to ensure effective implementation.
- Children aged 2-59 months were provided with case management services for the five major childhood killer diseases (pneumonia, diarrhoea, malnutrition, measles, and malaria) at all health facilities.

2.3.3 IMNCI Program Performance by Key Indicators

Local level-wise three-year trends of the percentage of institutional delivery, FY 2078/79 to 2080/81

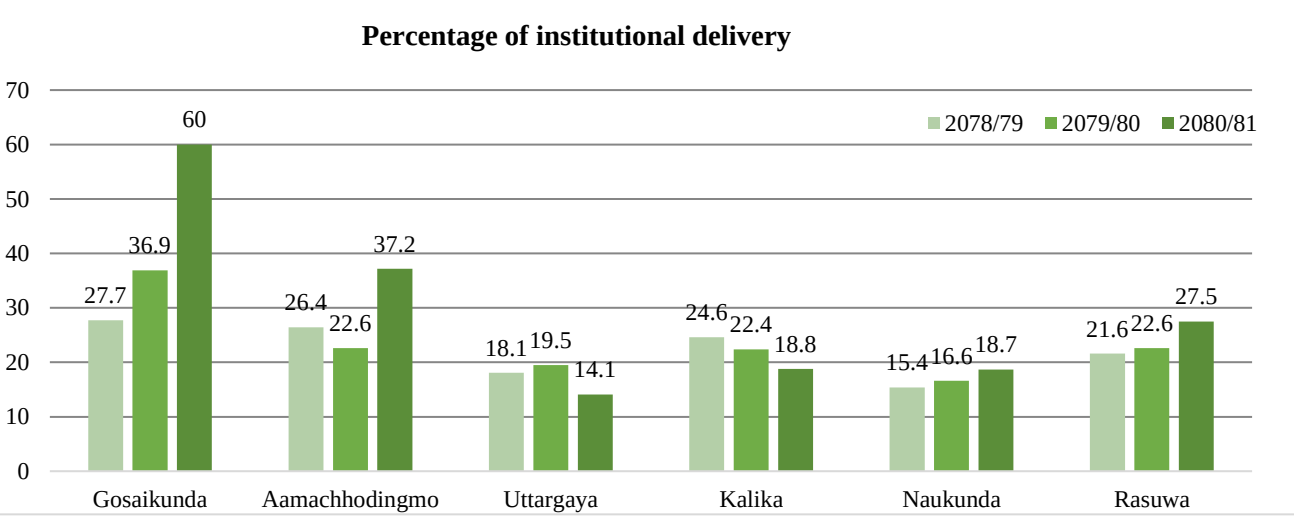


Figure 19: Local level-wise three-year trends of the percentage of institutional delivery, FY 2078/79 to 2080/81

Figure 19 highlights the three-year trends in institutional deliveries within Rasuwa district from FY 2078/79 to 2080/81. Goasikunda shows the most significant improvement, rising sharply from 27.7% to 60%, while Aamachhodimgmo also improved, increasing from 22.6% to 37.2%. Conversely, Uttargaya, Kalika, and Naukunda experienced either stagnation or decline, with Uttargaya dropping to 14.1% and both Kalika and Naukunda showing slight decreases. Rasuwa district overall saw modest growth, with rates increasing from 21.6% to 27.5% suggesting an increasing preference for healthcare facilities for childbirth, which is a positive indicator for maternal and child health outcomes.

Local level-wise three-year trends of the percentage of new-born applied with CHX Gel, FY 2078/79 to 2080/81

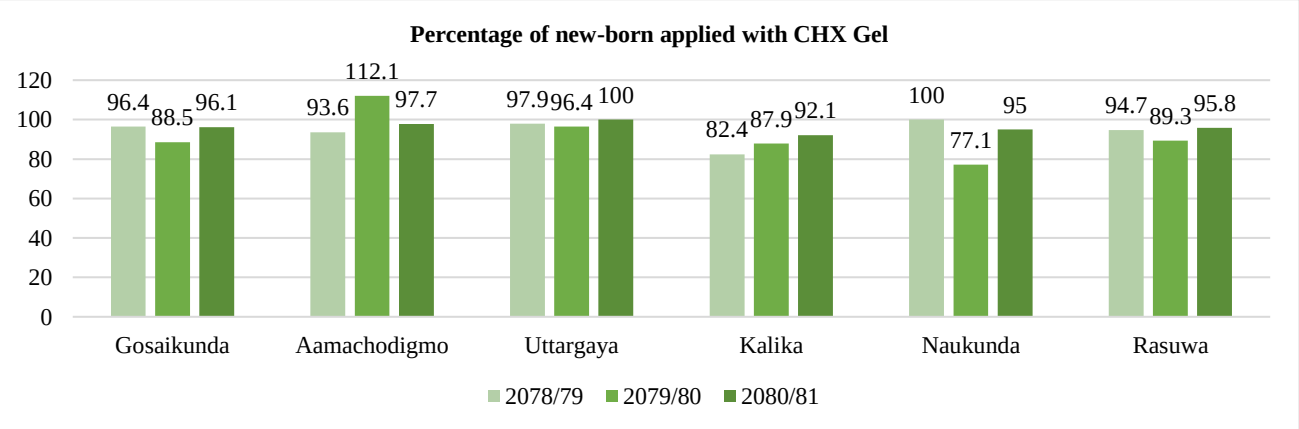


Figure 20: Local level-wise three-year trends of the percentage of new-born applied with CHX Gel, FY 2078/79 to 2080/81

Figure 20 presents a three-year trend of newborns receiving Chlorhexidine (CHX) gel application across local levels in Rasuwa district from FY 2078/79 to 2080/81. Overall, the district shows consistently high rates of CHX application, indicating strong adherence to neonatal health interventions aimed at preventing infections.

Local level-wise three-year trends of the percentage of infants (0-2 months) with PSBI receiving a complete dose of Gentamycin, FY 2078/79 to 2080/81

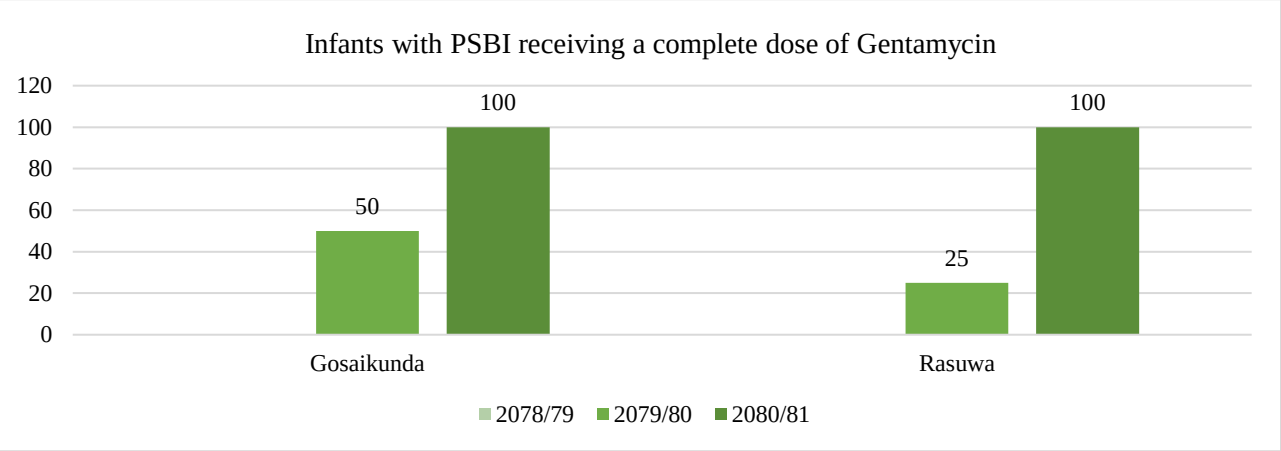


Figure 21: Local level-wise three-year trends of the percentage of infants (0-2 months) with PSBI receiving a complete dose of Gentamycin, FY 2078/79 to 2080/81

Figure 21 illustrates the three-year trends of infants (0-2 months) with Possible Severe Bacterial Infection (PSBI) receiving a complete dose of Gentamycin. Goasikunda saw a substantial increase in the percentage of infants receiving a full course of Gentamycin, rising from 50% in FY 2079/80 to 100% in FY 2080/81. This 100% coverage was sustained through FY 2080/81, reflecting strong intervention efforts in addressing PSBI, ensuring that affected infants receive complete and timely treatment.

Local level-wise three-year trends of the percentage of children under 5 years with pneumonia treated with antibiotics, FY 2078/79 to 2080/81

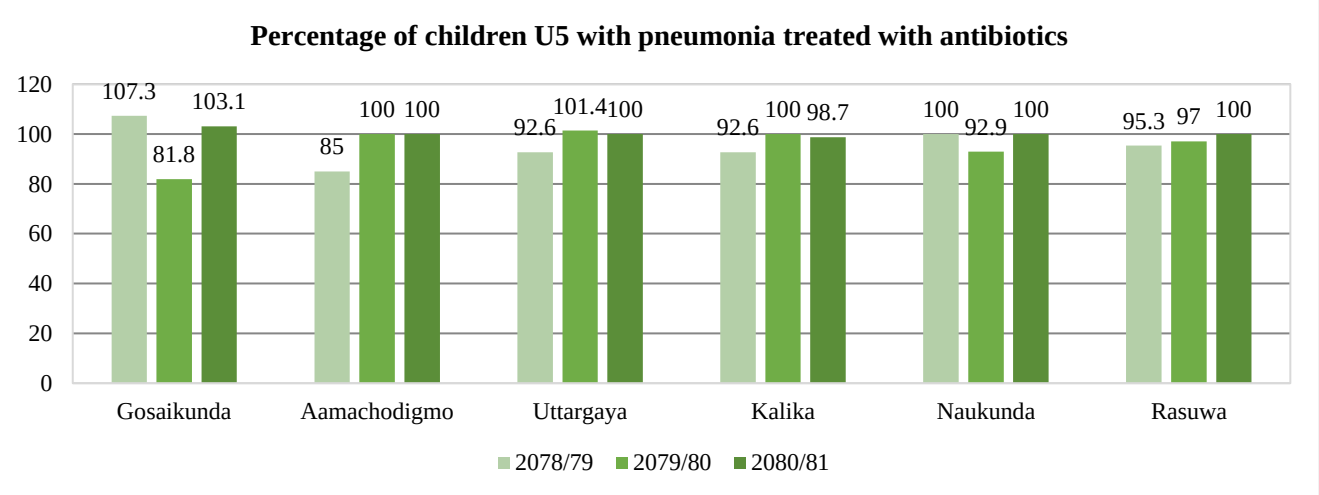


Figure 22: Local level-wise three-year trends of the percentage of children under 5 years with pneumonia treated with antibiotics, FY 2078/79 to 2080/81

Figure 22 illustrates the three-year trends of the percentage of children under 5 years with pneumonia treated with antibiotics. The data generally reflects high coverage of antibiotic treatment for pneumonia, with most areas maintaining or improving their performance over the three years. This suggests strong health intervention efforts in pneumonia management across the district., a significant cause of child mortality.

Local level-wise three-year trends of the percentage of children under 5 years with diarrhoea treated with Zinc + ORS, FY 2078/79 to 2080/81

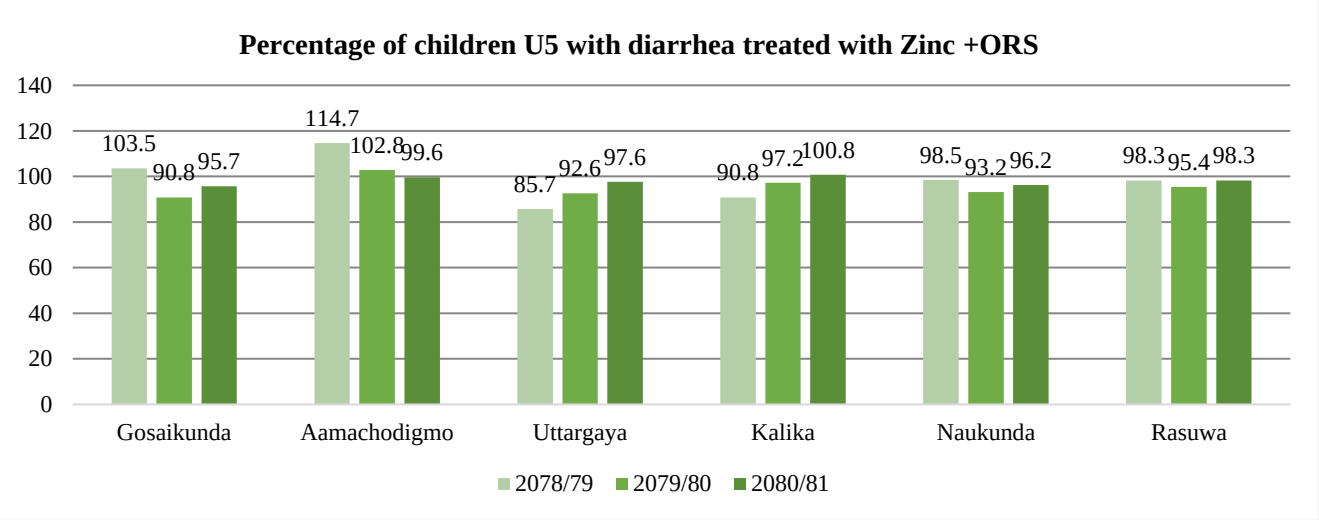


Figure 23: Local level-wise three-year trends of the percentage of children under 5 years with diarrhoea treated with Zinc + ORS, FY 2078/79 to 2080/81

Figure 23 shows the local level-wise three-year trends of the percentage of children under 5 years old (U5) with diarrhoea treated with Zinc + ORS in the district from FY 2078/79 to 2080/81. The data reflects high coverage of diarrhoea treatment across most areas, with the majority achieving consistent or improved performance over the three years. This reflects a positive sign for child health and an effective public health intervention and successful program implementation across the district.

Acute Respiratory Infections

ARI management is one of the components of the IMNCI program. As per IMNCI protocol, every ARI case should be correctly assessed and classified as no pneumonia, pneumonia or severe pneumonia; and given home therapy, treated with appropriate antibiotics, or referred to a higher-level health facility as per the indications.

Table 10: Classification of ARI cases by local level

Local Levels	ARI incidence rate among children under 5 years (per 1000)			Incidence of children under 5 years with ARI suffering pneumonia			Incidence of pneumonia among children under 5 years (per 1000)		
	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81
Gosaikunda	607.5	360.2	381.9	97.5	138.6	144.7	59.2	50.5	55.3
Aamachho dingmo	322.5	334.5	480.3	81.2	56.5	29.5	26.2	19	14.2
Uttargaya	715.1	609	746.6	158.9	142.9	161.2	113.6	87.2	120.6
Kalika	555.6	491.8	669.8	104.4	142.6	154.5	58	70.1	103.4
Naukunda	303.4	237.4	298.1	59.2	41.9	83.6	18	10	25
Rasuwa	**476.4**	**390.3**	**496.9**	**106.2**	**111.2**	**122.1**	**50.6**	**43.5**	**60.8**

Diarrhoea

IMNCI program has created an enabling environment for health workers for better identification, classification and treatment of diarrheal diseases. As per IMNCI national protocol, diarrhea has been classified into three categories: 'No Dehydration', 'Some Dehydration', and 'Severe Dehydration'.

Table 11: Classification of diarrehoeal cases by local level

Local Levels	Diarrhoea incidence rate among children under 5 years			% of children under 5 years with diarrhoea suffering from dehydration			% of children under five years with diarrhoea suffering from Some dehydration		
	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81
Gosaikunda	268.6	204.6	167.5	2.6	9.3	3	2.6	9.3	3
Aamachho dingmo	267.8	234.9	281.2	4	1	3.4	4	1	3.4

Uttargaya	147.1	172	180.2	4.9	2.7	1.7	4.9	2.7	1.7
Kalika	73.8	112.4	119.4	7.1	0.92	0	7.1	0	0
Naukunda	148.8	135.7	113.9	2.4	0.52	8.9	2.4	0.52	8.9
Rasuwa	**172.9**	**165.3**	**163.8**	**3.7**	**2.8**	**3.6**	**3.7**	**2.6**	**3.6**

2.3.4 Issue, Recommendations and Responsibilities

Table 12: Prevailing issues and recommended action

Issue	Recommendation	Responsibilities
Lack of dedicated program focal persons to monitor the program and related data	• Appoint a designated program focal person at each health facility to oversee the implementation and monitoring of CB-IMNCI activities.	Health Section, Palika
Inability to implement free newborn care guidelines as expected.	• Enhance coordination and collaboration between hospitals and municipalities to ensure effective implementation of newborn care guidelines.	Provincial Health Directorate, Public Health Office and Health Section, Palika
Lack of equipment to deliver newborn and child health services at service delivery points	• Conduct a comprehensive needs assessment and develop a detailed procurement plan.	Health Section, Palika, Public Health Office
Poor service data quality	• Carry out routine data quality assessments • Strengthen regular feedback mechanisms	Health Section, Palika Public Health Office
Inadequate Budget Allocation for CB-IMNCI Programs at the Local Level	• Advocacy for increased resource allocation • Performance based funding	Provincial Health Directorate, Public Health Office and Health Section, Palika

2.4 Safe Motherhood and Newborn Health

2.4.1 Background

The goal of the National Safe Motherhood Program is to reduce maternal and neonatal morbidity and 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 postpartum period. Evidence suggests that three delays are important factors for maternal and newborn morbidity and mortality in Nepal (delays in seeking care, reaching care, and receiving care).

The following major strategies have been adopted to reduce risks during pregnancy and childbirth and address factors associated with mortality and morbidity:

• Promoting birth preparedness and complication readiness including awareness raising and improving preparedness for funds, transport, and blood transfusion.

• Expansion of 24-hour birthing facilities alongside the Aama Suraksha 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

2.4.2 Major Activities Conducted in FY 2080/81

Maternal Health Services

- Maintained uninterrupted 24-hour birthing services at 17 birthing centers within the district.
- Provided continuous antenatal care (ANC) and postnatal care (PNC) services through health facilities and primary healthcare-outreach clinics (PHC-ORCs)
- Implemented Birth Preparedness Packages and promoted maternal and newborn health (MNH) activities at the community level.
- Expanded the Rural Ultrasound Program to improve prenatal diagnosis and care.
- Implemented the Aama and the Newborn program to support maternal and child health.
- Conducted cervical cancer screening using visual inspection with acetic acid (VIA) and Pap smear tests.
- Provided comprehensive care for women with obstetric fistula.

Newborn Health Services

- Continued implementation of the Nayno Jhola program, a comprehensive package of newborn care interventions.
- Distributed one carat of eggs to pregnant women during their first and eighth ANC visits to improve maternal nutrition.
- Implemented PMTCT services to prevent the transmission of HIV from mother to child.
- Conducted MNH clinical updates for healthcare workers at birthing centres and health institutions to enhance their skills and knowledge.

2.4.3 Safe Motherhood and Newborn Health Program Performance by Key Indicator

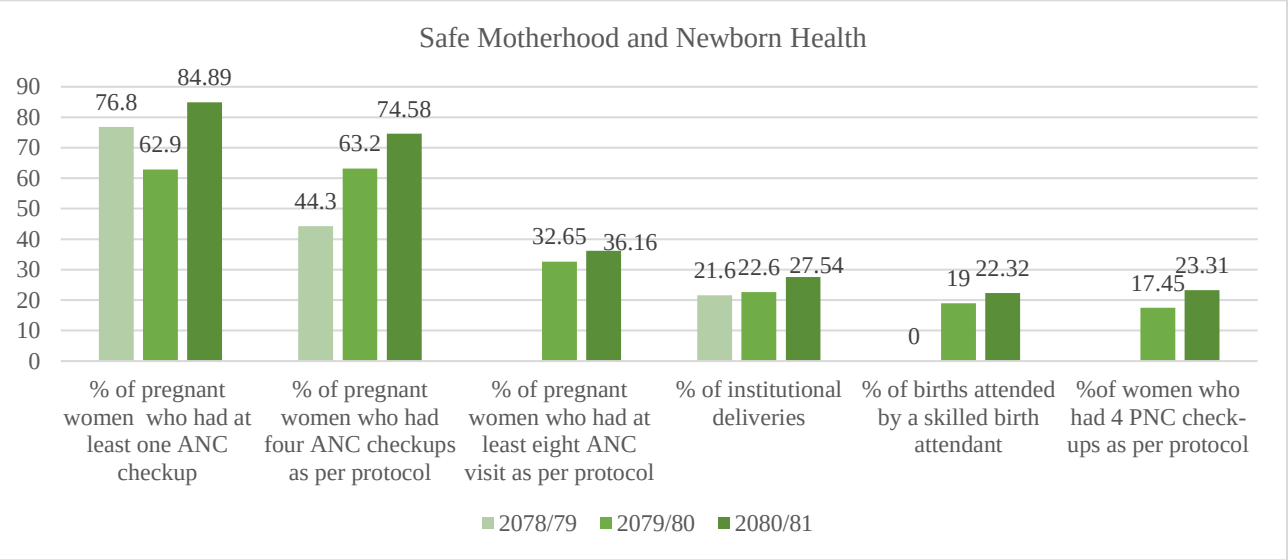


Figure 24: Safe Motherhood and Newborn Health

Figure 24 presents the district status of safe motherhood and newborn health indicators from 2078/79 to 2080/81 in the last three fiscal years. The data show notable increments of all indicators, reflecting maternal and child health service improvement. The increasing access to antenatal and postnatal care, rise in institutional deliveries, and skilled birth attendance are promising signs. However, there is still room for improvement, particularly in ensuring that a higher percentage of women receive all recommended ANC and PNC checkups.

Antenatal Care

Antenatal care is a crucial component of maternal and child health services, providing essential care for pregnant women throughout their pregnancy. The GoN recommends at least four high-quality ANC visits for pregnant women at a health facility. However, recent guidelines, aligned with the WHO recommendations, suggest increasing the number of ANC contacts to eight or more. This change is particularly important for countries like Nepal, where pre-eclampsia/eclampsia remains a leading cause of maternal mortality.

The increased frequency of ANC visits enables more comprehensive monitoring of pregnant women's health, early detection of potential risks, and timely interventions. It also provides opportunities for health workers to offer essential services such as:

- Blood pressure, weight and fetal heart rate monitoring.
- IEC and BCC on pregnancy, childbirth and early newborn care and family planning.
- Information on danger signs during pregnancy, childbirth and the postpartum period and timely referral to appropriate health facilities.
- Early detection and management of complications during pregnancy.

- Provision of Tetanus and diphtheria (Td) immunization, iron-folic acid tablets and deworming tablets to all pregnant women, and malaria prophylaxis where necessary.

Local level-wise three-year trends of the percentage of pregnant women with eight ANC visits as per protocol, FY 2078/79 to 2080/81

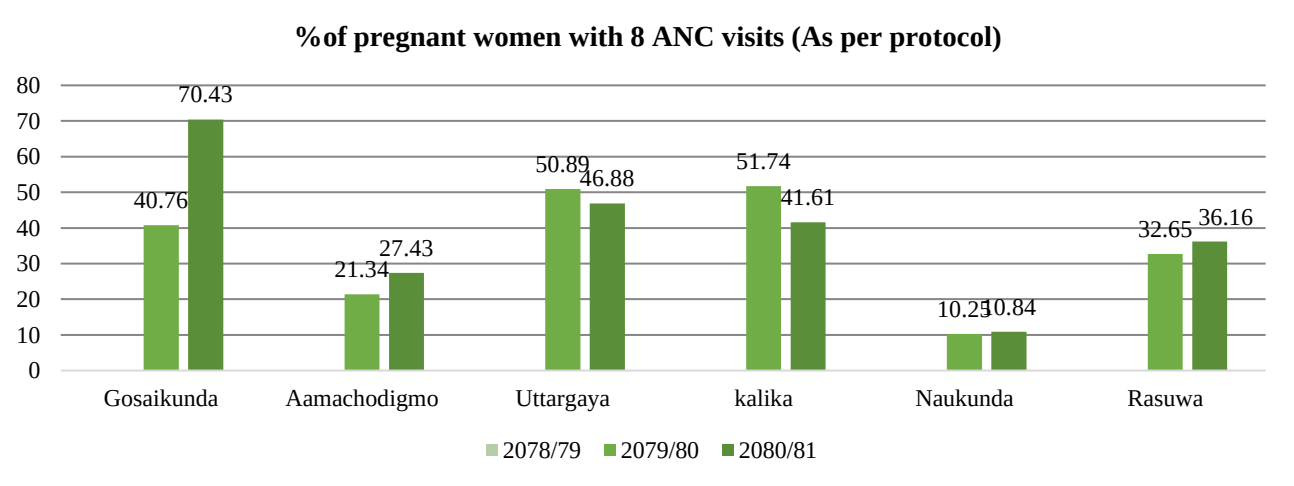


Figure 25: Local level-wise three-year trends of the percentage of pregnant women with eight ANC visits as per protocol, FY 2078/79 to 2080/81

Figure 25 illustrates the trend of the percentage of pregnant women who completed eight ANC visits as per protocol. The data shows notable variation across the year and local levels with Gosaikunda RM exhibiting a strong upward trend in eight ANC visit compliance, while in contrast, Naukunda reflecting a consistent but low compliance rate. At the district level, Rasuwa demonstrates growth, moving from 32.65% in FY 2079/80 to 36.16% in FY 2080/81. However, there are challenges in maintaining or improving the proportion of women adhering to the eight-visit ANC protocol, signalling the need for targeted intervention to enhance maternal health outcomes.

Comparison between the percentage of pregnant women who had first ANC, four ANC, and at least eight ANC check-ups as per protocol

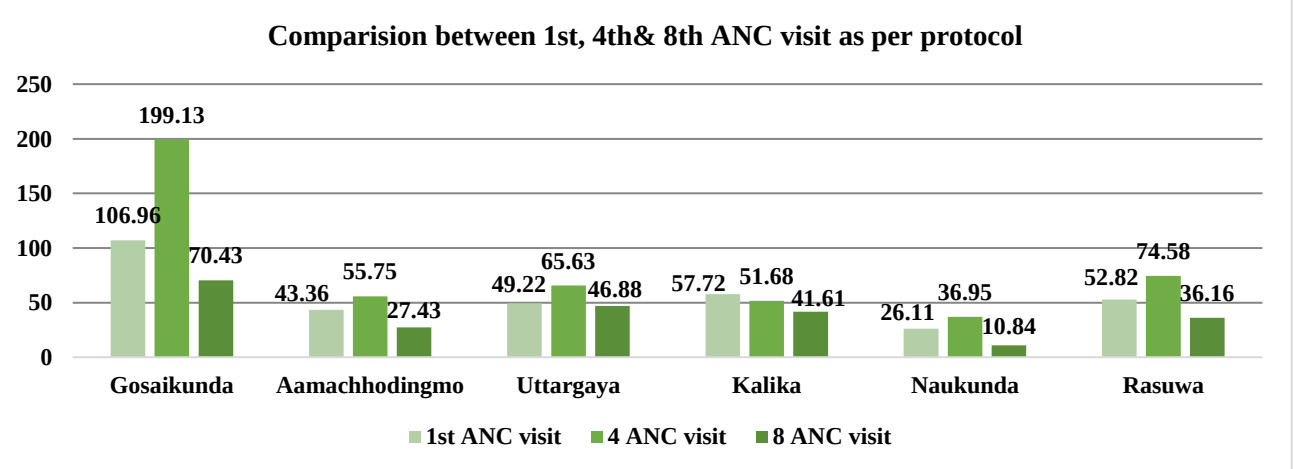


Figure 26: Comparison between the percentage of pregnant women who had first ANC, four ANC, and at least eight ANC check-ups as per protocol

Figure 26 compares the percentage of pregnant women who had at least their first ANC visit, four ANC visits, and eight ANC visits as per protocol across different local levels within the district in FY 2080/81. It highlights the disparity in adherence to different stages of ANC visits, which are critical for ensuring the well-being of both the mother and the newborn.

This comparison highlights a trend where ANC attendance decreases progressively as pregnancy advances. Although some localities, like Gosainkunda, maintain relatively higher percentages throughout, most areas show a sharp decline in the number of women completing the 8th ANC visit, signalling potential challenges in sustained antenatal care utilization, which could impact maternal and newborn health outcomes.

Safe Delivery

Safe delivery care includes skilled birth attendance at home and institutional deliveries; early detection of complicated cases and management or referral (after providing obstetric first aid) to an appropriate health facility with 24-hour emergency obstetric services, and registration of births and maternal and neonatal deaths. Although women are encouraged to give birth in a facility, home delivery with clean delivery kits, misoprostol to prevent post-partum haemorrhage, and early detection of danger signs and complications are important components of delivery care in settings where institutional delivery services are not available or are not used by the women.

Local level-wise three-year trends of the percentage of births attended by a skilled birth attendant (SBA) among expected live births, FY 2078/79 to 2080/81

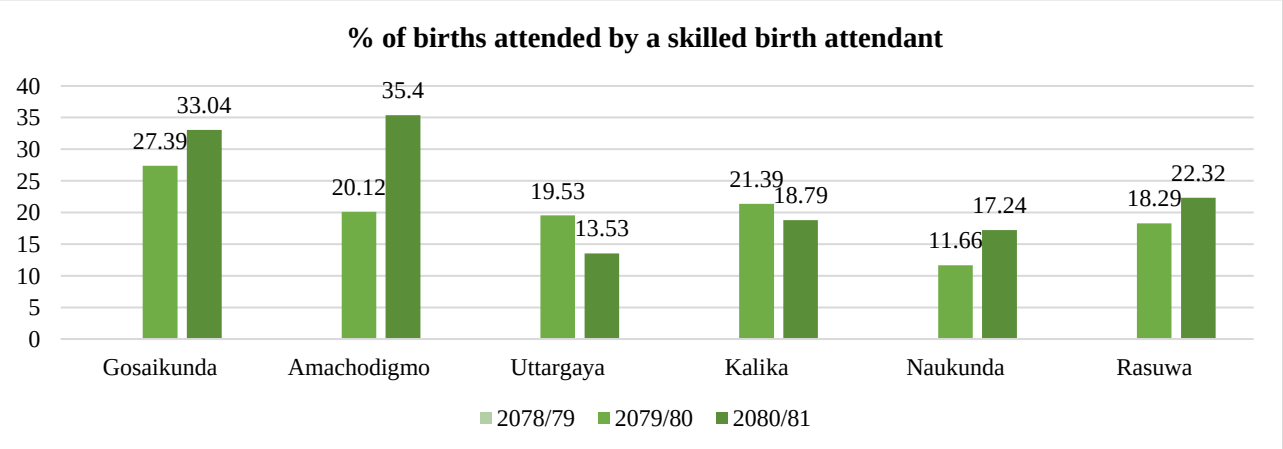


Figure 27: Local level-wise three-year trends of the percentage of births attended by a skilled birth attendant (SBA) among expected live births

Figure 27 displays the three-year trends of the percentage of births attended by a skilled birth attendant among the expected live births across various local levels within the district. The bar chart illustrates a general upward trend in the percentage of births attended by an SBA suggesting an increasing

preference for skilled healthcare providers during childbirth, which is a positive indicator for maternal and child health outcomes.

Local level-wise three-year trends of the percentage of institutional deliveries among expected live births, FY 2078/79 to 2080/81

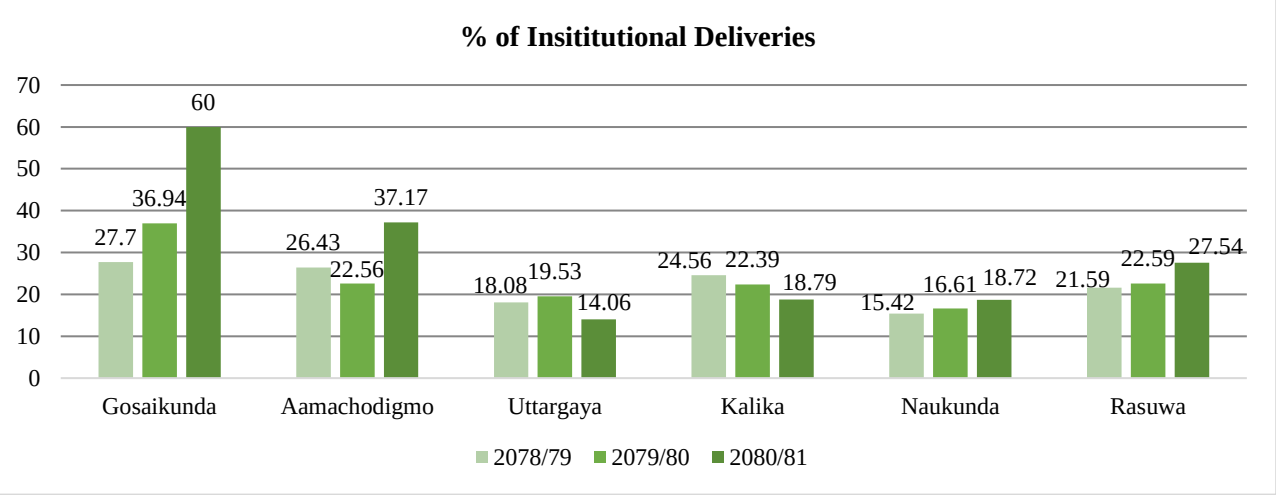


Figure 28: Local level-wise three-year trends of the percentage of institutional deliveries among expected live births

Figure 28 shows the three rends of the percentage of institutional deliveries among the expected live births across various local levels within the district. The chart illustrates the increasing trend of institutional deliveries, however, the data reveals significant disparities across the local levels, highlighting the need for targeted interventions to further enhance maternal and child health outcomes in the district.

Local level-wise three-year trends of the percentage deliveries by caesarean section, FY 2078/79 to 2080/81

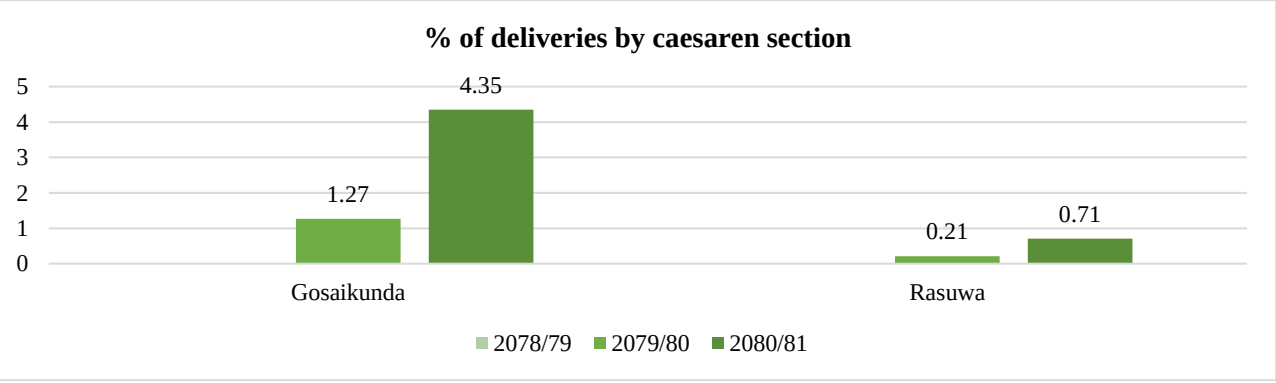


Figure 29: Local level-wise three-year trends of the percentage of deliveries by caesarean section

Figure 29 depicts the three-year trends of the percentage of deliveries by Cs across various local levels within the district. Gosaikunda RM is the only local level with CEONC services, and therefore, the deliveries by Cs are reported from Gosaikunda. While the data is limited to only one local level, the increasing trend of Cs rates suggests a growing reliance on surgical intervention during childbirth.

Postnatal Care

The postnatal period is a critical time in the lives of both mothers and their newborn children. This period is important for the initial bonding of the mother and newborn, for early initiation of breastfeeding and for promoting good nutrition and hygienic practices. But unfortunately, it is also the most critical time for maternal mortality, when the majority of deaths occur, primarily due to preventable causes. Yet, this is the most neglected period for providing quality care. The national protocol which is in line with the WHO guidance in 2015 recommend four postnatal checkups care recommended for all mothers and newborns: first as early as possible within 24 hours of birth, second on the third day, third between the seventh-fourteen days after delivery and fourth at the six weeks after birth.

The postnatal care services include the following:

- Identifying and managing complications in mothers and newborns, as well as referring them to appropriate health facilities
- Promotion of exclusive breastfeeding
- Postnatal vitamin A and iron supplementation for mothers, as well as personal hygiene and nutrition education
- Immunization of newborns
- Counseling and services for postnatal family planning

Local level-wise three-year trends of the percentage of women who had four post-natal check-ups, FY 2078/79 to 2080/81

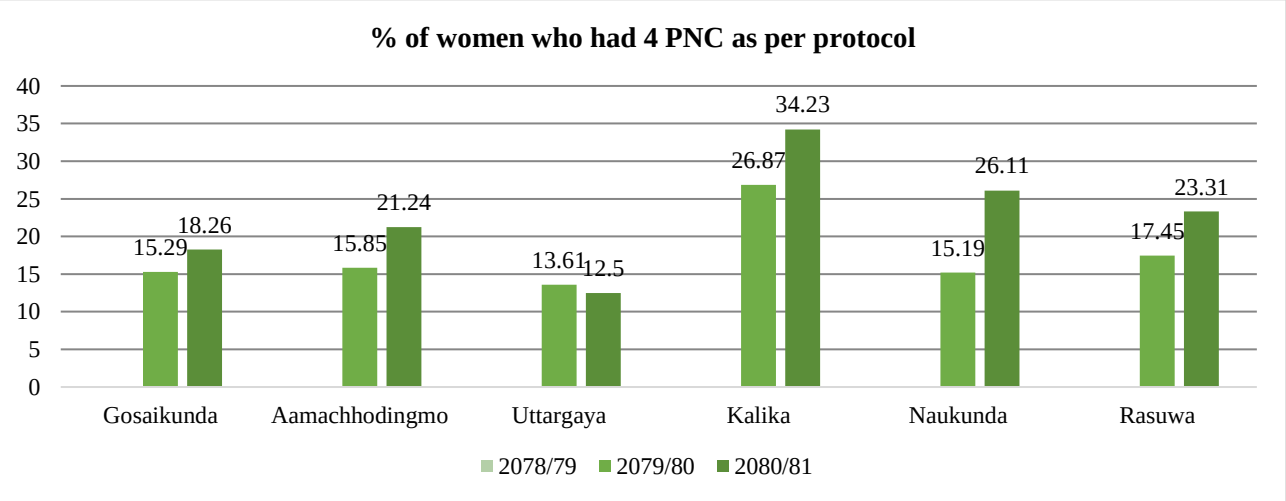


Figure 30: Local level-wise three-year trends of the percentage of women who had four post-natal check-ups

Figure 30 depicts the percentage of women who had four postnatal check-ups as per protocol across all local levels within the districts from FY 2078/79 to 2080/81. Kalika and Naukunda have shown significant improvement in comparison. The district has shown a relatively lower increase in the PNC check-up rate suggesting a need for further efforts to improve healthcare access and quality in the district.

Comparison between the percentage of pregnant women who had PNC within 24 hours, 3 PNC, and at least four PNC check-ups as per protocol

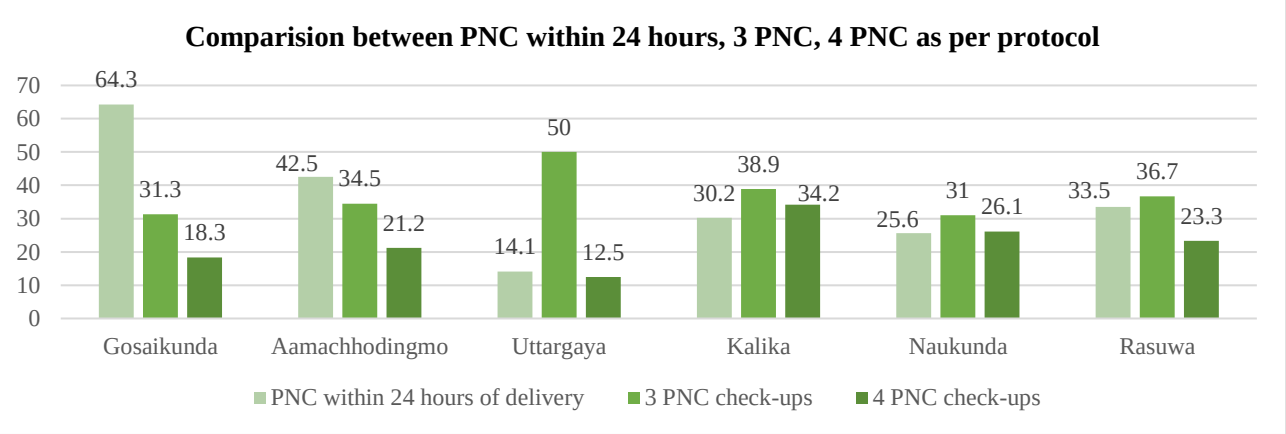


Figure 31: Comparison between the percentage of pregnant women who had PNC within 24 hours, 3 PNC, and at least four PNC check-ups as per protocol

Figure 31 compares the percentage of pregnant women who received postnatal care (PNC) within 24 hours of delivery, attended 3 PNC check-ups, and completed at least 4 PNC check-ups as per protocol across different local levels within the district in FY 2080/81. The chart reflects a trend where most localities see a sharp decline in PNC follow-up after 24 hours, with significantly fewer women completing the 4 recommended PNC check-ups. This indicates a need for improved outreach and education to encourage women to complete the full PNC protocol, ensuring better maternal and newborn health outcomes.

Maternal, Neonatal Deaths and Stillbirths

Table 13: Palika wise Maternal, Neonatal Deaths and Stillbirths

Palika	Maternal deaths			Neonatal deaths			Stillbirth		
	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81	2078/79	2079/80	2080/81
Gosaikunda	-	-	-	-	$1^{\$}$	$1^{\#}$, $1^{\$}$ (H reported)	-	1^{F},1^{M} (H reported)	1^{F} H reported)
Aamachhodingmo	-	-	-	-	-	-	1^{M}		-
Uttargaya	-	-	-	-	-	-	-	1^{F}	-
Kalika	-	-	-	-	-	-	-	-	-
Naukunda	-	-	-	-					1^{F}
Rasuwa	0			0	1	2	1	3	2

$1^{\#}$ denotes Neonatal deaths at the facility

1$ denotes Neonatal deaths other than a facility
**F denotes fresh stillbirth, M denotes Macerated stillbirth*

2.4.4 Issue, Recommendations and Responsibilities

Table 14: Prevailing issues and recommended action

S. N	Issues	Recommendations	Responsibility
1.	Decreased 8 ANC visits, gaps between the 1st ANC, 4 ANC and 8ANC visits as well as shallow PNC coverage	• Improve the quality of ANC counselling services by emphasizing the continuum of care • Introduce m-health technologies, where possible to register and track all pregnant women in communities • Continue/initiate PNC home visitation in hard-to-reach communities	PHD, Health Section, Palika, Public Health Office
2.	Limited availability of CEONC sites	• Prioritize the establishment of additional CEONC sites, strategically located to ensure equitable access across the district.	MoH and PHD Public Health Office
3.	Inadequate no of Trained SBA in the birthing centres	Provision of SBA training to the eligible candidate.	PHTC, Public Health Office

2.5 Family Planning and Reproductive Health

2.5.1. Background

Family Planning is one of the priority programs of the Government of Nepal. It is also considered as a component of the reproductive health package and essential health care services of Nepal Health Sector Program II (2010-2015), National Family Planning Costed Implementation Plan2015-2021, Nepal Health Sector Strategy 2015-2020 (NHSS) and the Government of Nepal's commitments to FP2020. The Right to Safe Motherhood and Reproductive Health Act of 2018 and its Regulations of 2020 have articulated quality Family Planning (FP) information and services with a broader method mix, including emergency contraception, as a women's right. The 15th National Periodic Plan as well as Safe Motherhood and Newborn Health Roadmap 2030 also emphasizes the availability and accessibility of right-based FP services. Male condoms, oral contraceptive pills, injectables, implants, and IUCD are the five modern temporary family methods that have been an important component of the Basic Health Service.

The main aim of the National Family Planning Program is to ensure that individuals and couples can fulfil their reproductive needs by using appropriate FP methods voluntarily based on informed choices. To achieve this, the Government of Nepal (GoN) is committed to equitable and right based access to voluntary, quality FP services based on informed choice for all individuals and couples, including adolescents and youth, those living in rural areas, migrants and other vulnerable or marginalized groups ensuring no one is left behind.

In the district, family planning information, education and services are provided through the government, social marketing, NGOs and the private sector (including commercial sectors). In the government health system, short-acting reversible contraceptive methods (SARCs: male condoms, oral pills and injectables) are provided through Hospitals, PHCCs, Health Posts, BHSC, CHU, and PHC-ORCs. FCHVs provide information and education to community people and distribute male condoms and resupply oral contraceptive pills. Long-acting reversible contraceptive (LARC) services such as intrauterine contraceptive devices (IUCDs) and implants are only available in hospitals, PHCCs and health posts that have trained and skilled providers. Male and female sterilization services (e.g. voluntary surgical contraception (VSC) are provided at static sites or through scheduled seasonal and mobile outreach services.

2.5.2 Major Activities Conducted in FY 2080/81

- Provided regular and comprehensive FP service from health facilities and PHC/ORC clinic
- Offered personalized counselling services to clients to ensure informed decision-making regarding the most appropriate family planning methods.
- Ensured a consistent and reliable supply of family planning commodities and logistics to meet the needs of service users.
- Conducted regular program supervision and monitoring to assess service delivery, identify challenges, and implement necessary improvements.

2.5.3. Family Planning and Reproductive Health Program Performance by Key Indicator

Local level-wise three-year trends of modern contraceptive prevalence rate (unadjusted) among women of reproductive age (WRA), FY 2078/79 to 2080/81

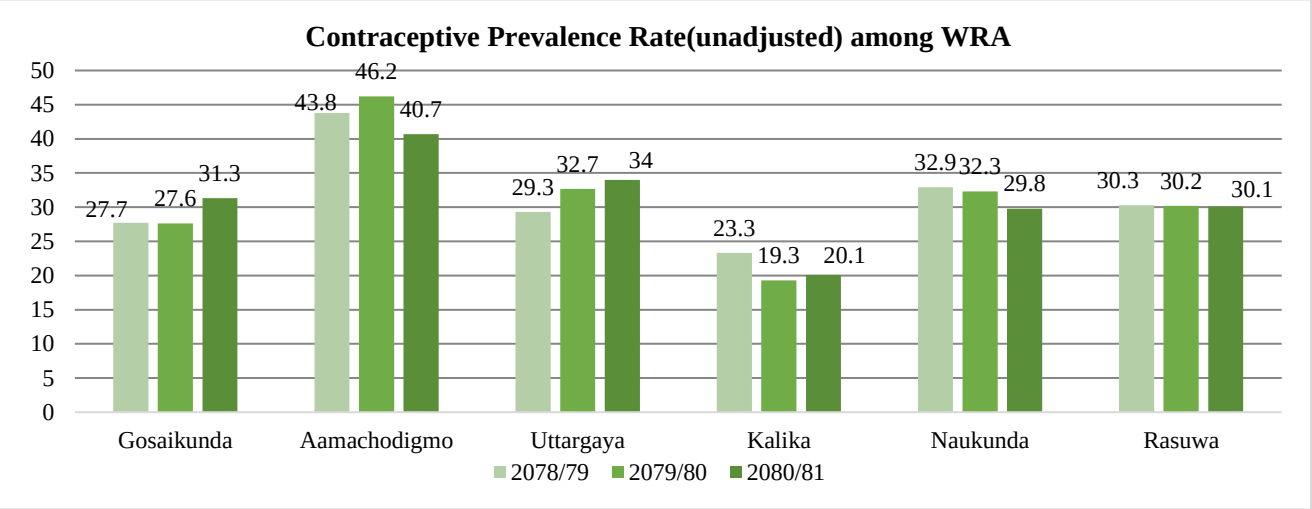


Figure 32: Local level-wise three-year trends of modern contraceptive prevalence rate (unadjusted) among women of reproductive age (WRA)

Figure 32 illustrates the three-year trends of modern contraceptive prevalence rates (unadjusted) among women of reproductive age (WRA) across various local levels within Rasuwa District for fiscal years 2078/79 to 2080/81. Local levels such as Gosaikunda, Uttargaya, and Kalika demonstrate promising increases in modern contraceptive use, while others, particularly Aamachhodingmo, Naukunda shows a decline, suggesting potential barriers to access or acceptance of modern contraceptive methods. Rasuwa district-wide figrures are stable, with a prevalence of 30.47% in FY 2078/79, slightly fluctuating to 30.59% in FY 2079/80 and 30.64% in FY 2080/81.

Local level-wise three-year trends of FP methods new acceptor among as % of MWRA, FY 2078/79 to 2080/81

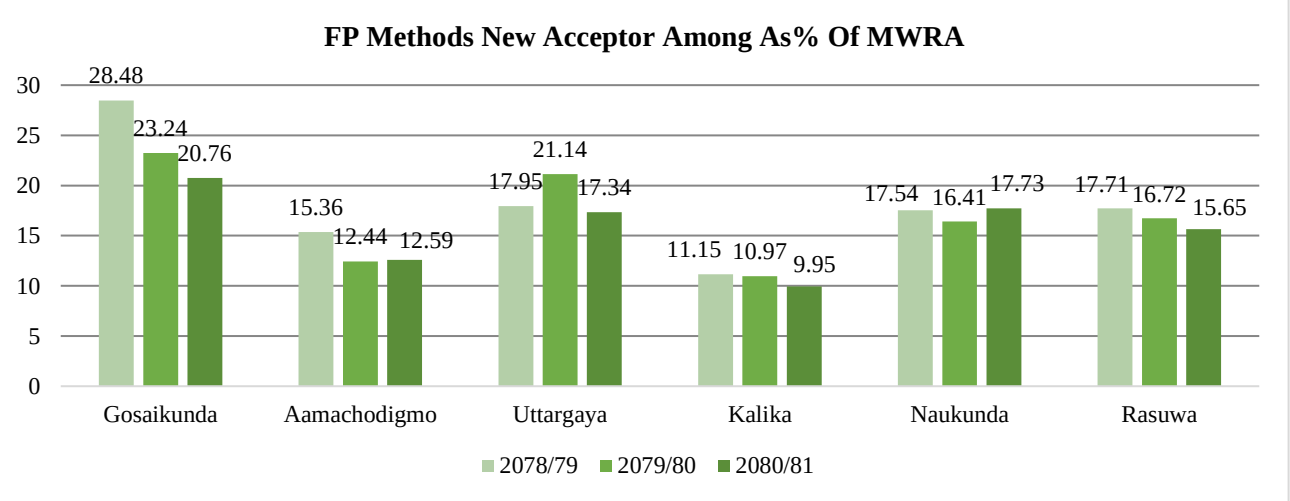


Figure 33: Local level-wise three-year trends of FP methods new acceptor among as % of MWRA

Figure 33 illustrates the local-level three-year trends of modern contraceptive prevalence rates (unadjusted) among women of reproductive age (WRA) in terms of the percentage of new acceptors of family planning (FP) methods as a proportion of the married women of reproductive age (MWRA) from FY 2078/79 to FY 2080/81. The chart reveals a declining trend in the proportion of new acceptors of modern contraceptive methods in most localities, with Goasikunda and Uttargaya experiencing the most significant reductions. This suggests a potential need for renewed family planning education and service delivery efforts to boost acceptance rates, particularly in areas showing a sharp decline.

2.5.4 Issue, Recommendations and Responsibilities

Table 15:Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Fewer long-acting services centres/Only seasonal centres in case of VSC	• Expansion of long-acting service centres and the need for trained service providers/Skilled doctors should be available in governmental hospitals throughout the year for VSC services	Provincial Training Center, Public Health Office
Insufficient and irregular supply of FP commodities	• Strengthened Supply Chain Management • Data Tracking and Monitoring on Consumption Pattern	PHLMC, Public Health Office, Health Section, Palika

2.6 Safe Abortions Services

2.6.1 Background

Global and national evidence unequivocally demonstrates that a significant number of women encounter unintended pregnancies, often due to limited access to comprehensive family planning information and services. When these women are unable to obtain safe and legal abortion services on time, they are at a heightened risk of experiencing severe complications arising from unsafe abortions or, in the most tragic cases, succumbing to suicide as a result of social pressures.

To mitigate these risks and safeguard the health and well-being of women, there is a compelling imperative to ensure that safe abortion services are available, accessible, and affordable to all women facing unwanted pregnancies. WHO has defined the four key components of comprehensive abortion care as:

- Pre- and post-counselling on safe abortion methods and post-abortion contraceptive methods

- Termination of pregnancies as per the national law and protocol
- Diagnosis and treatment of existing reproductive tract infections; and
- Provide contraceptive methods as per informed choice and follow-up for post-abortion complication management

Nepal legalized abortion in 2002 to reduce maternal morbidity and mortality through unsafe abortion. According to the Safe Motherhood and Reproductive Health Right Act 2075, the law permits abortion with the consent of pregnant women for any indication up to 12 weeks gestation and up to 28 weeks of gestation in special conditions like Rape, insist, fetus abnormalities, mental condition, immune suppression disease. Similarly, this Act has adopted that only licensed health workers who have fulfilled the prescribed standards and qualifications and are listed as safe abortion service providers shall have to provide the pregnant woman with safe abortion service under Section 15 in the licensed health institution which should also be listed as safe abortion service site.

Table 16: Number of listed and functional safe abortion sites in the district

Local Level	2078/79	2079/80	2080/81
Gosaikunda	-	1	2
Aamachhodingmo	-	-	-
Uttargaya	-	-	-
Kalika	-	1	1
Naukunda	-	-	-
Rasuwa	**0**	**2**	**3**

2.6.2 Utilization of Safe Abortion Services in the District

The table 15 displays the three-year trends in safe abortion services received by pregnant women of twenty years below and above either Medical or Surgical within the district.

Table 17: Safe abortion services at the local level in the last 3 fiscal years

Local Level	2078/79		2079/80		2080/81	
	<20 yrs	≥20 yrs	<20 yrs	≥20 yrs	<20 yrs	≥20 yrs
Rasuwa	**3**	**20**	**-**	**19**	**-**	**15**
Total	**23**		**19**		**15**	

Local level-wise three-year trends of the Percentage of clients who received post-abortion contraceptives, FY 2078/79 to 2080/81

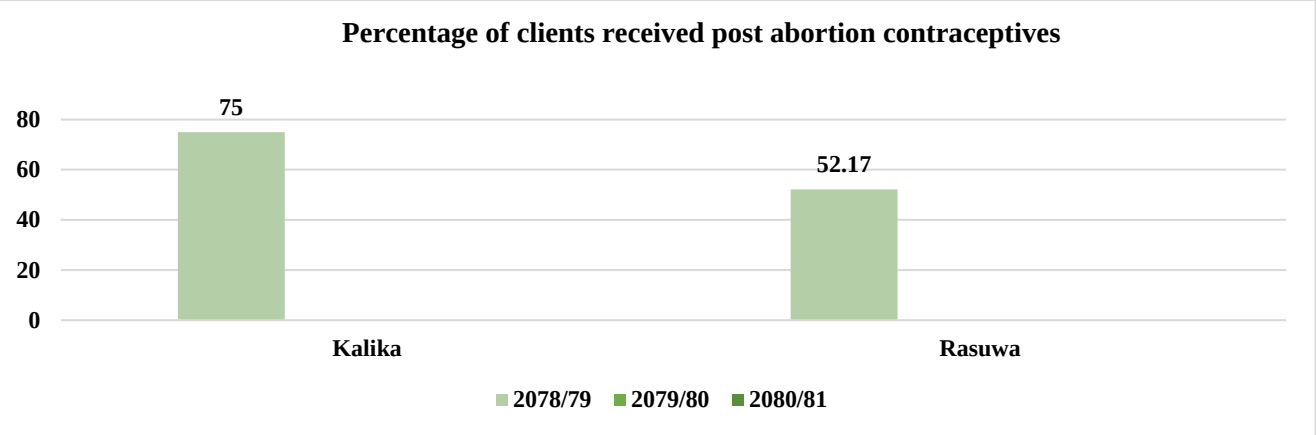


Figure 34: Local level-wise three-year trends of the Percentage of clients who received post-abortion contraceptives

Figure 34 illustrates the three-year trends (FY 2078/79 to 2080/81) in the percentage of clients receiving post-abortion contraceptives in Kalika and Rasuwa districts. Notably, Kalika showed a high uptake rate of 75% in FY 2078/79, but data was missing for subsequent years, hindering the identification of a clear trend.

Overall district data for FY 2078/79 indicates that 52.17% of clients who underwent abortions received post-abortion contraceptives. While this suggests a potentially high uptake rate, the lack of data for other years limits the ability to assess whether this represents a sustained outcome or an isolated event.

Local level-wise three-year trends of the Proportion of LARC among post-abortion contraception used, FY 2078/79 to 2080/81

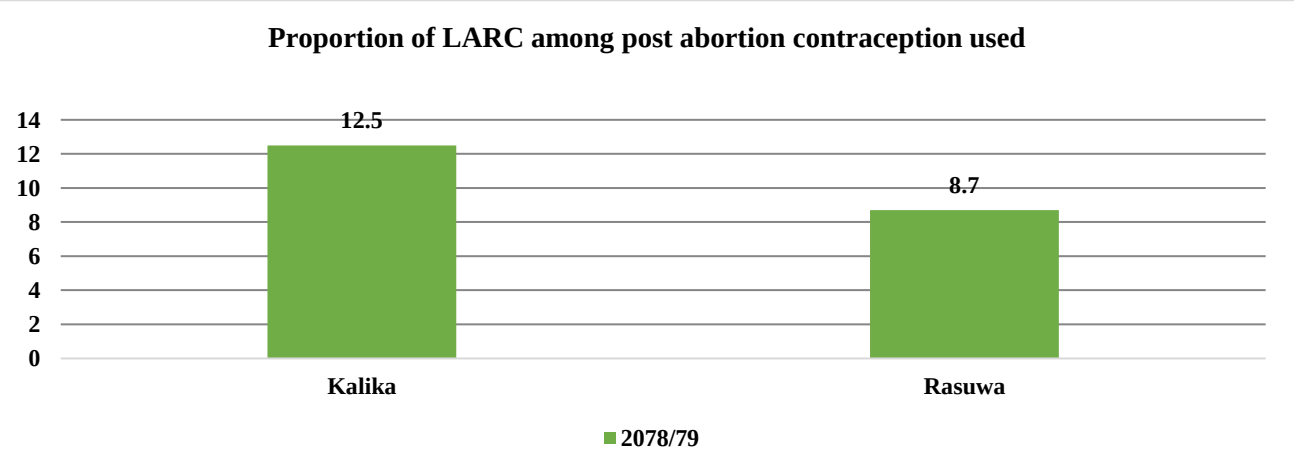


Figure 35: Local level-wise three-year trends of the Proportion of LARC among post-abortion contraception used

Figure 35 presents the proportion of post-abortion clients in Kalika district who utilized long-acting reversible contraceptives (LARCs) in FY 2078/79. The data reveals a moderate uptake of LARCs, with 12.5% of post-abortion contraception users opting for this method.

At the district level, 8.7% of post-abortion contraception users in FY 2078/79 chose LARCs. However, as the data is limited to a single fiscal year, it does not allow for the identification of trends over time. Nonetheless, this information could be useful for assessing the promotion and availability of long-term contraceptive options post-abortion, which can be crucial for preventing unintended pregnancies and improving reproductive health outcomes.

2.6.3 Issues, Recommendations and Responsibilities

Table 18: Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Inadequate Designation of Safe Abortion Sites Despite Trained Human Resources	• Streamlined Designation Process	Health Section, Palika, Public Health Office

2.7 Adolescent Sexual and Reproductive Health

2.7.1 Background

Nepal's National Adolescent Health and Development (NAHD) Strategy was endorsed in 2000, followed by the development of an implementation guideline for Adolescent Sexual and Reproductive Health (ASRH) in 2007. With the support of GIZ, a draft national ASRH program was formulated in 2008 and successfully piloted in 26 public health facilities in 2009.

Building upon the lessons learned from the pilot, a comprehensive National ASRH Program was designed in 2011, encompassing orientation manuals for district health managers, stakeholders, healthcare providers, and Health Facility Operation and Management Committees (HFOMCs).

The program has been progressively scaled up, achieving the target of establishing 1,000 adolescent-friendly health facilities by 2015, as outlined in the National Health Strategy II. These facilities meet specific criteria, including trained staff, information materials on ASRH, confidential service delivery, adolescent-friendly opening hours, the AFS logo, and adolescent representation in HFOMCs. The overall goal of the National ASRH Program is to promote the sexual and reproductive health status of adolescents.

Table 19: Number of listed and functional Adolescent Friendly Health Service sites in the district

Local Level	2078/79	2079/80	2080/81
Gosaikunda	-	2	3
Aamachhodingmo	-	1	4
Uttargaya	1	2	4
Kalika	-	3	3
Naukunda	-	1	3
Rasuwa	**1**	**9**	**14**

Table 20: Percentage of adolescent girls aged 10-19 years who received IFA supplement for 13 and 26 weeks in FY 2080/81

Local Levels	Adolescent girls who received IFA supplement for 13 weeks	Adolescent girls who received IFA supplement for 26 weeks
Gosaikunda	43.7	2.3
Aamachhodingmo	21.4	6.8
Uttargaya	89.5	14.5
Kalika	72.7	63.1
Naukunda	72.5	23.1
Rasuwa	**64.2**	**25**

2.8 FCHV program

2.8.1 Background

Recognizing the importance of women's participation in promoting the health of the people, GoN initiated the Female Community Health Volunteer (FCHV) Program in FY 2045/46 (1988/1989) initially, the approach was to select one FCHV per ward regardless of the population size. Later in 1993 population-based approach was introduced in selected districts but in Rasuwa, a population-based approach was not implemented. At present, there are 245 FCHVs actively working in Rasuwa district.

PHO Rasuwa is committed to increasing the high morale of FCHVs & participation in community health development. In FY 2064/65 MoHP established FCHVs fund by providing Rs. 50,000 to each VDC. The mobilization of this fund for income-generating activities is expected to benefit the FCHVs and the community at large.

2.8.2. Major activities conducted under the FCHV Program in 2080/81

- Provided basic training to newly recruited Community Health Volunteers (FCHVs) to equip them with essential skills and knowledge for their role in primary healthcare.
- Implemented a farewell program for FCHVs who had reached the age of 60, by recommendations from health mothers' groups.
- Conducted training and orientation programs for FCHVs to prepare them for their role in national health programs.
- Organized monthly reporting meetings at all health facilities to facilitate information sharing and coordination among FCHVs and healthcare providers.
- Celebrated FCHV Day on December 5th to recognize and appreciate the valuable contributions of FCHVs to primary healthcare.

2.8.3. FCHV program performance by selected indicators

Table 21: Three-year trends of FCHV program performance by selected indicators

Indicators	2078/79	2079/80	2080/81
% of mothers' group meetings held	73.6	78.7	92.5
% of pregnant women visited by FCHVs	222.3	206.8	209
FP-Pills Cycles Distribution	501	310	410
FP-No. of Condom Piece Distribution	5002	5789	5468
FP- Pregnant women given Iron Tablets	644	573	476
CBIMNCI (2-59 Months)-Treated with ORS & Zinc	2126	1741	1478

Support provided by FCHVs for home deliveries

Even though the government of Nepal has a policy of mandatory institutional deliveries because of various reasons women cannot reach the health centre for delivery, so in case of any home deliveries in their locality FCHVs provide support and care to the postpartum women and newborns.

In 2080/81 they initiated baby-to-mother skin-to-skin contact after delivery in 56 cases, and applied chlorhexidine to the umbilicus after delivery for 74 (Table 26).

Table 22: Support provided by FCHVs for home deliveries, 2078/79- 2080/81

Indicators	2078/79	2079/80	2080/81
Initiating skin-to-skin contact after birth	177	82	56
Chlorhexidine applied to the umbilicus	123	73	74
Ensured misoprostol tablets taken	5	3	0

Postnatal visits and support to postpartum mothers

FCHVs provide care to postpartum mothers and encourage them for postpartum visits to institutions as per the national protocol. In 2080/81 (Table 27), FCHVs visit to support 39 newborn & Postpartum Mothers within 24 hours of Birth at home, 36 new-born and postpartum mothers on the 3rd day of birth at home and 35 newborn and postpartum mothers on the 7th day of birth at home. During their visit they provide counselling on breastfeeding, danger signs of mother and newborn, care of newborn and mother.

Table 23: Support provided by FCHVs for postpartum mothers and neonates

Indicators	2078/79	2079/80	2080/81
Home Delivery visit-new born& PP Mothers- ≤24 hours of Birth	93	46	39
Home Delivery visit - born& PP Mothers- 3rd day of Birth	73	44	36
Home Delivery visit - new born& PP Mothers-7th day of Birth	82	40	35
Home Delivery-Breast Feeding <1hour of birth	125	82	67
Distribution of Vitamin A capsule to Postpartum mother	141	112	103

IMAM services provided by FCHVs at the Household level

Along with these services, FCHVs also assess children under 5 years of age for acute malnutrition and then refer them for further management as per their severity by measuring the Mid-Upper Arm Circumference (MUAC) of the children. FCHVs provided the screening service of acute malnutrition and IMAM services provided by FCHVs in 2080/81 are as seen in Table 28. Screening of children

through MUAC and categorising their nutritional status as follows: 6 are SAM, 32 are MAM whereas 12455 are normal.

Table 24: IMAM Service provided by FCHVs at the Household level

Indicators	2078/79	2079/80	2080/81
MUAC Screening Red-SAM	4	2	6
MUAC Screening Yellow-MAM	24	46	32
MUAC Screening Green-Normal	9156	11067	12455

Table 25: Municipalities-wise number of FCHV working in the district

S.N.	Municipalities	No. of Wards	Total no. of FCHV
1	**Gosaikunda**	6	54
2	**Aamachhodingmo**	5	34
3	**Uttargaya**	5	44
4	**Kalika**	5	53
5	**Naukunda**	6	60
	Total		**245**

CHAPTER 3: EPIDEMIOLOGY AND DISEASE CONTROL

3.1 Malaria Control Program

3.1.1 Background

Malaria control has been the Government of Nepal's priority program for decades. The first insect-borne disease control program was started in 1954 under the financial support of the USAID (then known as USOM).

Since then, the program has undergone a series of changes in structure and scope. Building on these decades of targeted intervention for malaria control, Nepal is committed to eliminating malaria and has introduced the Nepal Malaria Strategic Plan (2014-2025) with the target of achieving malaria-free status by 2025. The strategic plan points out several interventions for malaria control, including Malaria disease surveillance, integrated vector management and mass campaigns in high and moderate-risk areas and improved early diagnosis and treatment of all suspected cases.

National Malaria Strategies Plan (2014-2025)

The current National Malaria Strategic Plan (NMSP) 2014-2025 was developed based on the epidemiology of malaria derived from the 2012 micro-stratification, the 2013 mid-term Malaria Program Review and the updated WHO guidelines, particularly for elimination in a low endemic country. Nepal government seeks appraisal of external development partners, including the Global Fund, for possible external funding and technical assistance. NMSP aims to attain a “Malaria Free Nepal by 2025”

The strategic plan was divided into two phases: achieve Malaria pre-elimination by 2018 and attain Malaria Elimination by 2025. Malaria pre-elimination targets were set to achieve and sustain zero deaths due to malaria by 2015, reduce the incidence of indigenous malaria cases by 90%, and reduce the number of VDCs having indigenous malaria cases by 70% of current levels by 2018. The baseline year was taken as 2012.

3.1.2. Major Activities of Malaria Program in FY 2080/81

- Conducted routine slide collection and microscopic examination to diagnose malaria cases.
- Implemented a case-based surveillance system, including a fully operational web-based recording and reporting system (MDIS), to enhance data management and analysis.
- Commemorated World Malaria Day on April 25th by organizing an orientation session for healthcare workers. The session covered topics such as the life cycle of malarial parasites, diagnosis and treatment methods, prevention strategies, the Malaria Control Program, communication and advocacy, and emerging technical practices. A question-and-answer session was also held to address queries and facilitate knowledge sharing.

3.1.3. Three-Year Assessment of Malaria Control Efforts in the District

Table 26: Three-year trends of malaria indicators

S.N	Indicators	Fiscal Year Wise		
		2078/79	2079/80	2080/81
1	Total malaria slide collection	0	51	30
2	The target for malaria slide collection	0	-	491
3	Total malaria slide examination	0	51	30
4	Malaria Blood slide collection-ACD	0	0	3
5	Malaria Blood slide collection-PCD	0	51	27
6	Total malaria-positive cases	0	0	0
7	Malaria test positivity rate/slide positivity rate	-	0	0
8	Annual blood examination rate (ABER) of malaria in high-risk	0	-	0.07
9	Malaria annual parasite incidence per 1000 population at risk	0	-	0

3.1.4. Issues, Recommendations and Responsibilities

Table 27: Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Below target blood slide examination rates	• Strengthen the surveillance system • Improved Accessibility • Incentivization and Motivation • Community Engagement	Health Section, Palika, Public Health Office

3.2 Kala-azar elimination program

3.2.1 Background

Kala-azar, a vector-borne disease transmitted by the sandfly *Phlebotomus argentipes*, is caused by the *Leishmania donovani* parasite. Characterized by prolonged fever, splenomegaly, anemia, progressive weight loss, and occasionally skin pigmentation changes, kala-azar is a chronic disease affecting the reticuloendothelial system, including the bone marrow, spleen, and liver primarily. In endemic regions, children and young adults are disproportionately impacted. Untreated kala-azar can be fatal. In recent years, the coexistence of kala-azar with HIV/TB infections has become a concerning public health issue.

Rasuwa district is classified as non-endemic for kala-azar. Over the past three fiscal years (2078/79 to 2080/81), no kala-azar cases have been reported within the district, resulting in a zero incidence and prevalence rate per 10,000 population.

3.3 Lymphatic Filariasis

3.3.1 Background

Lymphatic filariasis (LF), or elephantiasis, is a neglected tropical disease transmitted to humans through the bite of infected mosquitoes. In Nepal, LF is a public health concern, with the country committed to its elimination by 2030 in alignment with the Sustainable Development Goals (SDGs) and the World Health Organization's (WHO) Neglected Tropical Diseases (NTDs) roadmap.

To inform targeted interventions, Nepal conducted multiple rounds of mapping to identify endemic areas. The most recent confirmatory mapping in 2021 revealed the Rasuwa district as endemic, increasing the total number of endemic districts to 64. Among these, 49 districts are currently under post-MDA surveillance, while 15 districts remain in the MDA phase.

The primary strategy for LF elimination in Nepal is mass drug administration (MDA), which involves providing at-risk populations with a preventive chemotherapy regimen consisting of three drugs: ivermectin, diethylcarbamazine, and albendazole. Following a successful first round of MDA in FY 2079/80, the second round was initiated on April 28, 2024, in four provinces encompassing seven districts. Prior to the second round, a three-day national workshop on LF MDA review and strategic planning was conducted to capacitate and facilitate participating districts.

Table 18 presents the epidemiological coverage for the second round of IDA-MDA in the district, providing insights into the reach and effectiveness of the program.

Table 28: Epidemiological coverage for the second of IDA-MDA in the district

Local Levels	Total Population	Target Population for the Campaign	No. of designated fixed booth	Coverage (%)
Gosaikunda	8120	7689	41	86.03
Naukunda	11958	11231	49	74.39
Aamachhodingmo	6512	6098	28	93.30
Kalika	9844	9302	34	97.33
Uttargaya	8368	7900	48	87.76
Rasuwa	**44802**	**42220**	**200**	**86.79**

3.3.2 Programmatic Approaches for Lymphatic Filariasis Elimination in Rasuwa District

1. **District-Level Planning and Coordination:**

   IDA Planning Meetings: Conducted district-level meetings to orient municipal representatives on the triple-drug regimen for LF elimination, support microplanning for the IDA campaign, address programmatic challenges and mitigation measures, and discuss effective implementation strategies, including severe adverse event (SAE) management plans.

Multi-Sectoral Coordination: Convened municipality-level meetings to develop micro-plans for the campaign, review lessons learned from previous rounds, orient participants on program activities, and seek support from various sectors for successful implementation, including SAE management.

2. **Human Resource Capacity Building:**

   Refresher Training: Organized one-day refresher training sessions for all health workers involved in the MDA program to cover drug dosage, directly observed drug administration, SAE management, counselling, coverage, and compliance.

   Community Health Volunteer (FCHV) Training: Provided orientation and training to FCHVs on their role in social mobilization for IDA and their support to health workers during drug administration.

3. **Communication and Outreach:**

   Media Orientation: Conducted media orientation programs to ensure effective dissemination of information about the LF program and its activities.

   Hospital Interaction: Organized programs to enhance collaboration with hospitals for the management of SAE cases.

3.3.3 Strategies Employed for Lymphatic Filariasis Elimination in Rasuwa District

- Social mapping techniques were integrated into the campaign planning phase to gather vital data on the target population and better understand community dynamics.
- To ensure comprehensive coverage of LF MDA among a mobile resident population, the district health team adopted a targeted intervention approach. This involved deploying health workers to key locations frequented by residents, ensuring that individuals received the MDA medication regardless of their transient residency status.
- A community mobilization team was established to raise public awareness about the campaign. This team utilized social media platforms to share information through short video clips, social media posts detailing the locations of fixed booth sites, and promotional photo frames encouraging MDA participation. Additionally, rallies and a locality-wide miking program were conducted to further engage the community.
- A strategic printing plan was developed for the distribution of informative materials to support the campaign's objectives.
- The Supervisory Coverage tool was employed more extensively to enhance monitoring efforts and support mop-up activities.
- Social mapping techniques were integrated into the campaign planning phase to gather vital data on the target population and better understand community dynamics.
- A door-to-door drug distribution method was implemented to ensure that every member of the target population was reached.

3.4 Dengue

3.4.1 Background

Dengue is a vector-borne disease that is transmitted by mosquitoes (Aedes aegypti and Aedes albopictus) and occurs in most of the districts of Nepal in the form of Dengue Fever (DF), Dengue Hemorrhagic Fever (DHF) and Dengue Shock Syndrome (DSS). In Nepal, dengue is a rapidly emerging disease. Endemic across most provinces, dengue incidence has increased in recent years largely due to the expansion of the vector Aedes aegypti and Aedes albopictus, as well as the movement of people and the introduction of imported cases. All 4 dengue serotypes exist in Nepal, with DENV-1 historically contributing the highest burden. It has been identified as one of the youngest emerging infectious diseases in Nepal.

3.4.2. Major Activities of Dengue Control Program in FY 2080/81

- Supplied rapid diagnostic test kits (IgM).
- Continued monitoring of dengue fever through EWARS

3.4.3. Three-Year Assessment of Malaria Control Efforts in the District

A glance at the data of Table 19 shows a rising trend in dengue incidence and cases over three years, with the incidence per 10,000 population increasing from 1.3 in 2078/79 to 7 in 2079/80, before slightly dropping to 5.2 in 2080/81. The number of dengue cases followed a similar pattern, peaking at 33 cases in 2079/80 and reducing to 24 in 2080/81. Dengue testing expanded significantly, with tests increasing from 38 to 359 over the same period, while 17 dengue-positive cases were confirmed in 2080/81.

This data reflects a growing public health challenge concerning dengue. The rise in incidence and number of cases is accompanied by a notable increase in diagnostic testing, indicating an improved surveillance and response effort. However, despite these efforts, the incidence remains high, underscoring the need for sustained interventions to reduce the burden of dengue in the population.

Table 29: Three-year trends of dengue indicators

S.N	Indicators	Fiscal Year Wise		
		2078/79	2079/80	2080/81
1	Incidence of Dengue cases per 10,000 population	1.3	7	5.2
2	Number of dengue cases	6	33	24
3	Immunology-Dengue positive	-	-	17
4	Immunology-Dengue test conducted	38	176	359
5	Outpatient Morbidity-Dengue Fever Cases	6	33	24

3.4.4. Issues, Recommendations and Responsibilities

Table 30: Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Despite its mountainous location, the district has experienced a concerning rise in dengue cases.	• Implement targeted vector control measures, including larval surveillance and vector control operations, in high-risk local levels such as Gosaikunda and Kalika. • Health Promotion and Education • Early diagnosis and treatment • Surveillance and Monitoring	Health Section, Palika, Public Health Office

3.5 Leprosy

3.5.1 Background

The establishment of the Khokana Leprosarium in the nineteenth century was the beginning of organized leprosy services in Nepal.

In Rasuwa, MDT service is being delivered through all the public health facilities. Healthcare providers serving at community-based health facilities have undergone Comprehensive Leprosy Training (CLT) and are effectively providing MDT service.

3.5.2. Three-Year Assessment of Leprosy Control Efforts in the District

Table 20 summarizes leprosy indicators for Rasuwa district during fiscal years 2078/79 to 2080/81. In FY 2079/80, the new case detection rate was 2.1 per 10,000 population, with an overall prevalence and incidence of 0.21 per 10,000 population. The sole case reported in that year was classified as multibacillary (MB) leprosy, a more severe form of the disease, detected in Kalika RM. Unfortunately, data for FY 2078/79 and 2080/81 is unavailable.

Table 31: Three-year trends of leprosy indicators

S.N	Indicators	Fiscal Year Wise		
		2078/79	2079/80	2080/81
1	New case detection rate of leprosy	-	2.1	-
2	Prevalence of leprosy per 10,000 population	-	0.21	-
3	Incidence of leprosy per 10,000 population	-	0.21	-
4	Total no. of leprosy cases	-	1	-
5	Total leprosy new cases	-	1	-
6	Percentage of new leprosy cases that are MB	-	100	-

3.6 Tuberculosis

3.6.1. Background

Tuberculosis (TB) remains a public health problem in Nepal, as it is responsible for ill health among thousands of people each year. Worldwide, TB ranks as the second leading infectious killer, surpassing HIV and AIDS and following COVID-19. Nepal has been grappling with a high burden of tuberculosis (TB) for many years. Despite progress, challenges persist, including the rise of drug-resistant TB and the impact of HIV/AIDS co-infection. Nepal ranks among the top 30 countries with a high burden of drug-resistant TB.

Nepal's TB program has achieved a consistent treatment success rate of over 90% and expanded TB diagnosis through GeneXpert technology. Drug-sensitive TB is now included in basic health services, and community support is available. The NTPMIS system facilitates data collection and analysis, while surveys provide valuable insights for decision-making.

Nepal aims to end the tuberculosis epidemic by 2050 with the intermediate target of reducing TB incidence by 20% by the year 2021 compared to 2015 and increasing case notifications by a cumulative total of 20,000 from July 2016 to July 2021.

3.6.2. Major Activities of Tuberculosis Control Program in FY 2080/81

A. Early Diagnosis and Case Management:

- Promoted early diagnosis of infectious pulmonary TB through sputum smear examinations.
- Ensured a consistent and reliable supply of anti-TB medications to all treatment centres.
- Maintained a standardized system for recording and reporting TB cases.

B. Capacity Building:

- Provided TB modular and basic training to healthcare workers to enhance their knowledge and skills in TB diagnosis, treatment, and management.

C. Program Monitoring and Evaluation:

- Conducted half-yearly cohort reviews among all local-level TB focal persons to assess program progress and identify areas for improvement.
- Commemorated World TB Day to raise awareness about the disease and its prevention.
- Implemented active surveillance programs, including microscopic camps, to detect and diagnose TB cases.
- Conducted regular program performance monitoring and supervision to ensure effective implementation and identify challenges.

3.6.3 Tuberculosis Program Performance by Key Indicator

Institutional Coverage of TB

Table 32: Institutional Coverage of TB

	FY 2080/81 by Local level

Name of centres/Institutes	District	Gosaikunda	Aamachhodingmo	Kalika	Uttargaya	Naukunda
DOTS sites	**28**	9	4	5	4	6
MDR Treatment Centers	**0**	-	-	-	-	-
MDR Treatment Sub-Centers	**0**	-	-	-	-	-
DR Homes	**0**	-	-	-	-	-
Microscopy sites	**10**	2	1	2	3	2
GeneXpert Facility	**0**	-	-	-	-	-

Case notification (all forms of TB/1000,000 Population)

Local level-wise three-year trends of the case notification rate of all forms of TB-New and Relapse) per 100,000 population, FY 2078/79 to 2080/81

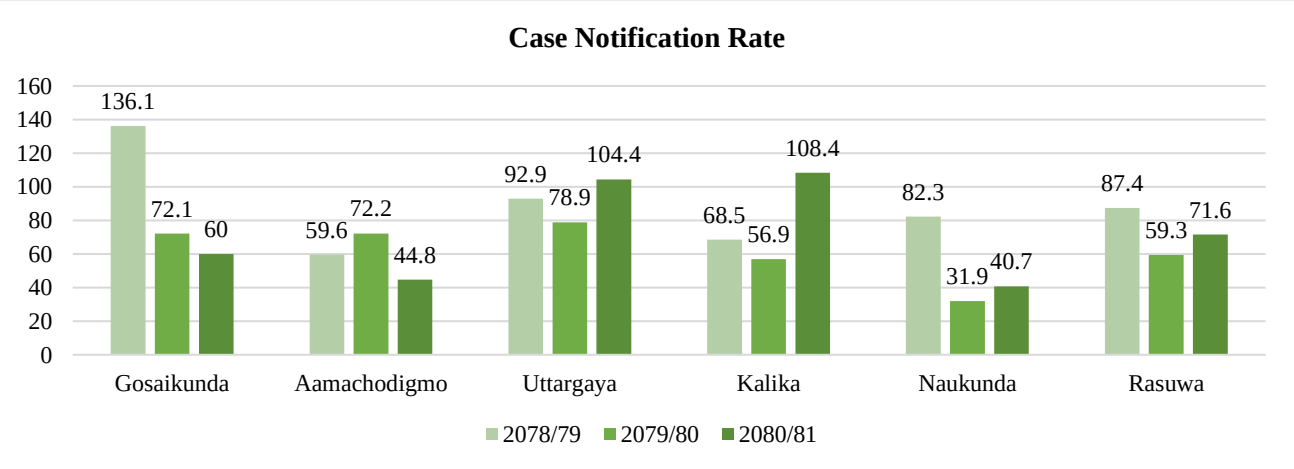


Figure 36: Local level-wise three-year trends of the case notification rate of all forms of TB-New and Relapse per 100,000 population

Figure 36 presents the local-level, three-year trends of the case notification rate of all forms of tuberculosis (TB)—both new cases and relapses—per 100,000 population, spanning fiscal years 2078/79 to 2080/81. Gosaikunda showed the highest notification rate in 2078/79 (136.1 per 100,000) but saw a sharp decline over the years to 60 per 100,000 in 2080/81. Aamachhodingmo also experienced a significant decline from 72.2 in 2078/79 to 44.8 in 2080/81. Uttargaya and Kalika showed more stable notification rates over the years, with moderate declines from 92.9 and 104.4 in

2080/81 to 56.9 and 108.4 in 2080/81, respectively. Naukunda had the lowest notification rate in 2079/80 (31.9), followed by a slight increase in the following years.
Overall the district showed a relatively steady trend, starting at 87.4 in 2078/79 and ending at 71.6 in 2080/81. This data suggests variations in TB notification rates across the different local levels, with many showing declines in recent years.

Three-year trends of the case notification rate of all forms versus case notification rate of new and relapse cases per 100,000 population, FY 2078/79 to 2080/81

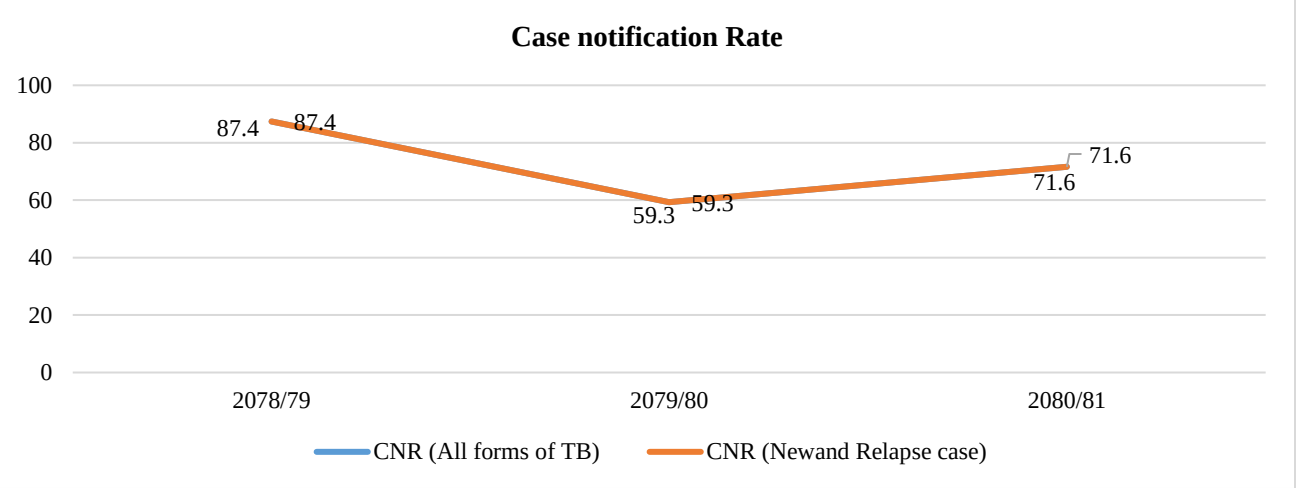


Figure 37: Three-year trends of the case notification rate of all forms versus case notification rate of new and relapse cases per 100,000 population

Figure 37 represents the line chart that presents the three-year trends of the case notification rate (CNR) for all forms of tuberculosis (TB) and new/relapse TB cases per 100,000 population from fiscal year (FY) 2078/79 to 2080/81. Both metrics show a decline from 87.4 in 2078/79 to 59.3 in 2079/80, after which there is a moderate recovery to 71.6 in 2080/81. The alignment of these two lines indicates that the CNR for all forms of TB closely mirrors that for new and relapse cases, suggesting that the overall TB notification trend is largely driven by new and relapse case patterns during these fiscal years.

Three-year trends of the success rate of all forms of TB versus a Success rate of new plus relapse cases per 100,000 population, FY 2078/79 to 2080/81

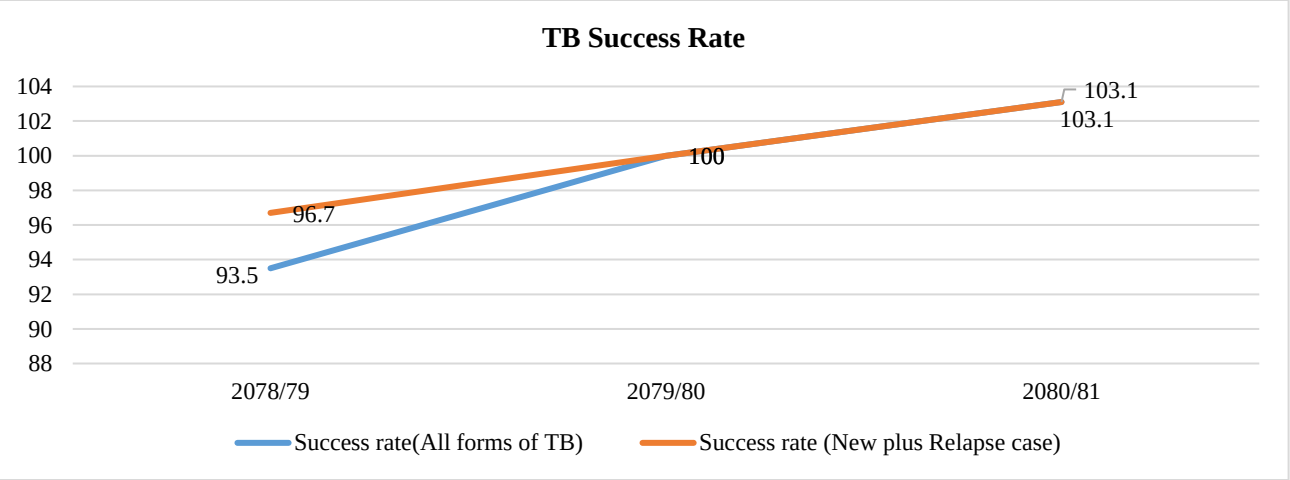


Figure 38: Three-year trends of the success rate of all forms of TB versus a Success rate of new plus relapse cases per 100,000 population

Figure 38 shows the three-year trends of the success rate for all forms of tuberculosis (TB) versus the success rate for new plus relapse TB cases per 100,000 population from FY 2078/79 to 2080/81. Both success rates for all forms of TB and new plus relapse cases show consistent improvement over the three years. The TB treatment success rates have not only improved but have surpassed 100% by FY 2080/81, indicating highly effective TB treatment programs. The nearly identical trends in the final year suggest that the management of all TB cases and the specific management of new plus relapse cases are performing at similar, highly successful levels.

Local -level-wise data on TB case

Table 33: Local -level-wise data on TB case

S. N	Local-Levels	Total notified TB Cases						TB-Total number of child cases (0-14 years)		
		2078/79		2079/80		2080/81		2078/79	2079/80	2080/81
		New	Relapse	New	Relapse	New	Relapse			
1	Gosaikunda	11	-	5	1	5	-	-	-	-
2	Naukunda	10	-	4	-	5	-	-	-	-
3	Aamachhodingmo	4	-	3	2	2	1	-	**1**	-
4	Kalika	6	1	6	-	10	1	**2**	**1**	-
5	Uttargaya	7	1	5	2	8	1	-	-	-
6	**Rasuwa**	**40**		**28**		**33**		**2**	**2**	**0**

3.6.4. Issues, Recommendations and Responsibilities

Table 34: Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Inadequate Laboratory Infrastructure and Limited Access to GeneXpert Technology in Tuberculosis Control	• Upgradation of Existing Laboratories and lab staff • Procurement and Deployment of GeneXpert Machines	PHD, Health Section, Palika, Public Health Office
Insufficient microscopic center	• Expansion of Microscopic Centers and/or Upgradation of Existing Centers:	PHD, Health Section, Palika, Public Health Office
Insufficient Active Case-Finding Initiatives	• Strengthened Active Case-Finding Programs	Health Section, Palika, Public Health Office
Lack of Dedicated Focal Persons for Tuberculosis (TB) Control at District and Local Levels	• Designation of Focal Persons and capacity building	Health Section, Palika, Public Health Office

3.7 HIV/AIDS and STI Program

3.7.1. Background

The history of Nepal's response against HIV/AIDS began with the launching of the first National AIDS Prevention and Control Program in 1988. In 1995, a National HIV/AIDS Policy with 12 key policy statements and supportive structures like the National AIDS Coordination Committee (NACC) and District AIDS Coordination Committee to guide and coordinate the response at the central and district levels was endorsed. Taking the dynamic nature of the epidemic of HIV into consideration, Nepal revisited its first national policy in 1995. It endorsed the latest version: National Policy on Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs), 2011. A new National HIV Strategic Plan 2016-2021 is recently launched with the vision of ending the AIDS epidemic in Nepal by 2030.

HIV in Nepal is characterized as a concentrated epidemic, where the majority of infections are transmitted through sexual transmission. Prevention of HIV among Most At Risk Populations (MARPs) is the key programmatic strategy adopted by the district in line with the national strategies. The district provides ART services through Rasuwa Hospital.

3.7.2. Prevention of Mother to Child Transmission (PMTCT)

The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission. In the absence of any interventions, transmission rates range from 15-45%. Table 23 rovides an overview of local-level service statistics

for the Prevention of Mother-To-Child Transmission (PMTCT) of HIV in the district for the fiscal year 2080/81. Despite the significant number of women counselled and tested, no HIV-positive cases were reported at any of the local levels.

Table 35: Local level-wise service Statistics on PMTCT in the district 2080/81

S.N	Local Levels	HIV-PMTCT-Pregnant/Intrapartum/ postpartum Counselled	HIV-PMTCT-Pregnant/Intrapartum/ postpartum Tested	HIV-PMTCT-Pregnant/Intrapartum/ postpartum Positive
1	Gosaikunda	46	21	-
2	Naukunda	108	38	-
3	Aamachhodingmo	51	41	-
4	Kalika	41	23	-
5	Uttargaya	102	50	-
6	**Rasuwa**	**348**	**173**	**0**

3.7.3. Issues, Recommendations and Responsibilities

Table 36: Prevailing issues and recommended action

Issues	Recommendations	Responsibilities
Disparity Between HIV-PMTCT Counseling and Testing Rates	• Provide comprehensive training to healthcare providers on HIV-PMTCT counselling, testing, and prevention strategies.	PHTC, PHD, Health Section, Palika, Public Health Office
PMTCT kit supply issue	• Strengthened Supply Chain Management • Diversified Sources of Supply	FWD, PHLMC, PHD, Public Health Office, Health Section, Palika

CHAPTER 4: NON-COMMUNICABLE DISEASE

4.1. Non-Communicable Disease

4.1.1 Background

Non-communicable diseases (NCDs) have emerged as a significant global health challenge, contributing to premature deaths, exacerbating poverty, and straining national economies. While communicable diseases were once the primary causes of mortality, the rise of NCDs is attributed to factors such as urbanization, increased incomes, lifestyle changes, and rising life expectancy.

Cardiovascular diseases (CVDs), cancer, diabetes, chronic pulmonary diseases, and mental health conditions have become a substantial burden on healthcare systems worldwide, including Nepal. The increasing incidence of NCDs in the country is driven by factors such as rising life expectancy, demographic shifts, urbanization, and the adoption of unhealthy lifestyles.

Tackling NCDs called for a paradigm shift: from addressing each NCD separately to collectively addressing a cluster of diseases in an integrated manner, and from using a biomedical approach to a public health approach guided by the principles of universal access and social justice. High levels of commitment and multisectoral approaches were needed to reverse the growing burden of NCDs in Nepal. The costly and prolonged treatment of NCDs raises the equity problem between and within countries.

4.1.2 PEN Program

The WHO Package of Essential Non-communicable Disease Interventions (WHO PEN) for primary care in low-resource settings is an innovative and action-oriented response that prioritised a set of cost-effective interventions that can be delivered to an acceptable quality of care, even in resource-poor settings. WHO PEN is the minimum standard for NCDs to strengthen national capacity to integrate and scale up care of heart disease, stroke, cardiovascular risk, diabetes, cancer, asthma and chronic obstructive pulmonary disease in primary health care in low-resource settings.

Table 37: Outpatient morbidity of major non-communicable diseases in the district

Disease	Period		
	2078/79	2079/80	2080/81
COPD	433	479	1111
Hypertension	948	1261	2130
Diabetes Mellitus	167	216	588
Bronchial Asthma	401	401	387
Bronchitis (Acute) & Chronic	68	89	104

4.1.3 मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रम

नेपालमा नसर्ने रोग खासगरी मुटु तथा रक्तनली, दम, मधुमेह, क्यान्सर र सोबाट हुने मुत्युदर दुई तिहा भन्दा नै बढि रहेको, बागमती प्रदेशका स्वास्थ्य व्यक्तिमा नसर्ने रोगहरु र तिनका जोखिमहरु समयमा नै पहिचान गरि उचित परामर्श, स्वास्थ्य व्यवहार, परिक्षण, निदान र उपचार गरी नसर्ने रोग जटिलता हुननदिन तथा हर्दयघात, मस्तिष्क घात, फिस्टुला लगायत नसर्ने रोगको रोकथाम, नियन्त्रण, न्यूनीकरण, निदान र उपचारमा आर्थिक सहायता तथा सहुलियत दिने र सहजिकरण गर्ने कार्यलाई व्यवस्थित गर्ने सो कार्यक्रम बागमती प्रदेश सरकारले सञ्चालनमा ल्याएका छन्।

4.1.3.1 आ. व २०८०/८१ मा सचालित क्रियाकलापहरु:

- मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रम (परिक्षण, निदाण, परामर्श र उपचार) व्यवस्थापन कार्यविधि २०७९ अनुसार सन्चालन गर्नका लागि बाहिरंग रोग विभाग मा कार्यरत हे.अ, अ.हे. ब वा अ.न.मी हरुलाई अभिमुखिकरण गरिएको र हरेक महिनाको अन्तिम बिहिबारको दिन सो कार्यक्रम सम्बन्धि सेवा/सुविधा उपलब्ध गराउने निर्णय गरिएको।
- मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रम सम्बन्धि आवश्यक फर्म फर्मेट छपाई तथा वितरण गरिएको।
- मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रम सम्बन्धि औषधी जन्यव सामाग्री, रिएजेन्ट, टेष्ट किट आदि खरिद तथा वितरण गरिएको।
- मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रमको अनुगमन गरिएको।

***Table 38:* मुख्यमन्त्रि जनता स्वास्थ्य कार्यक्रम अनुसार विभिन्न स्थानमा परिक्षण गरिएको विवरण**

स्क्रिनिङ्ग गरिएको जम्मा सेवा ग्राहीहरुको संख्या				स्क्रिनिङ्ग गरिएका नसर्ने रोगहरुको अवस्था							
उमेर समुह	लिङ्ग			उच्च रक्तचाप	उच्च रक्तचापको लागि औषधि सेवन गर्ने	सम्भावित मधुमेह भएका	मधुमेहको औषिधि सेवन गरेका	महिलाको पाठेघरको मुखको भि.आई. ए. गरेको		महिलाको मूत्र नलीबाट पिसाब वा दिसा वा दुबै चुहिने समस्या	
	महिला	पुरुष	अन्य					सामान्य	असामान्य	भएको	नभएको
३०-३९ वर्ष	५५७	४७३		९०	१४४	८१	३२	१२०	२	०	०
४०-४९ वर्ष	४१६	२८७		१६८	११६	६४	४०	६१	०	०	०
५०-५९ वर्ष	४१५	२९०		११०	३३०	४५	२६	४६	०	०	०
६० वर्ष वा सो भन्दा माथि	४९५	४८८		१४७	४२७	१६	१०	०	०	०	०
जम्मा	१८८०	१५३८		५१५	१०१७	२०६	१०८	२२७	२	०	०

CHAPTER 5: ONE SCHOOL ONE NURSE PROGRAM

5.1 Background

Health and education are inextricably linked, and schools offer a strategic platform to enhance the health and educational outcomes of school-age children. To capitalize on this opportunity, the Government of Nepal launched the "One School, One Nurse" program in 2075 B.S. to provide emergency medical services and promote health awareness among students at the local level. This initiative represents a valuable approach to integrating health services into educational settings.

At present, the "One School, One Nurse" program is being implemented in all local levels of the district, with a total of nine nurses recruited to participate in the program.

Table 39: List of schools with One School One Nurse Program (2080/81)

स्थानिय तह	विद्यालयको नाम	विद्यालय नर्स	सम्पर्क नं	ईमेल
गोसाईकुण्ड गा.पा	श्री भिमसेन आधारभुत वि	सुजिता घले	९८४१०८४४००	Sujugrg288@gmail.com
कालिका गा.पा	श्री कालिका हिमालय मा वि	दीपा ठाकुर	९८४३७०६३१८	Deepathakur637@gmail.com
	श्री निलकण्ठ नमुना मा वि	रजनी मगर	९८४५२८०३६४	Rajanimagar27@gmail.com
	श्री सेति भुमे मा वि	अस्मिता पौडेल	९८६२६८४७५३	Arzeemac1@gmail.com
नौकुण्ड गा.पा	श्री गोसाईकुण्ड मा वि	अनु लुईटेल	९८४०३८७३५३	Anu.789lu@gmail.com
	श्री नारायण मा वि	आशिका तामाङ	९८६११७१९४८	tamangashika@gmail.com
उत्तरगया गा.पा	श्री डाँडागाउँ मा वि	सोनि गुरूङ	९८४९८२२२२२	Sonigurung433@gmail.com
	श्री निलकण्ठ मा वि	ममता श्रेष्ठ	९८६७४०७३९४	Mamatasth8@gmail.com
	श्री नव विजय महेन्द्र मा वि	अस्मिता योनजन	९८४५६२७८२७	ayoanjan@gmail.com

5.2 Major activities conducted in FY 2080/81 by the School Nurse

- Health Screening at the primary level, and referral which includes: height and weight measurement, dental screening and hygiene, and vision
- Biannual supplementation of de-worming tablets to school children of grades 1-10
- Iron-folate supplementation to adolescent school children of grades 6-10

- Midday meal program
- Ensuring safe drinking water taps and toilets, child-friendly furniture, classroom and school buildings
- First aid, Hygiene, health education and counselling
- Child club mobilization o raise awareness about health issues and promote healthy behaviors among students.

CHAPTER 6: CURATIVE SERVICES

6.1 Background

The Bagmati Provincial Government has introduced various programs aimed at enhancing the health standards of all citizens residing in both rural and urban areas within the province by providing quality healthcare services. To achieve this objective, the government has strengthened the diagnosis, treatment, and referral systems at various levels, including community health units, urban health centres, primary health centres, health posts, and hospitals, to ensure the provision of accessible services to patients. The primary objective of therapeutic services is to identify diseases accurately and timely, and to provide quality and comprehensive treatment services, thereby reducing morbidity and mortality rates.

Nepal's Constitution of 2072 also stipulates the provision of free basic and emergency services to all citizens. In line with this, provincial-level hospitals have been established in all districts to provide therapeutic services such as diagnosis, treatment, and referrals.

6.1.2 Major activities conducted under curative services in FY2080/81

- Provided 2-day training to healthcare workers on standardized treatment protocols to ensure consistent and effective care delivery.
- Conducted training programs to enhance the skills and knowledge of healthcare providers in ear, nose, and throat (ENT) services.

Table 40: Top 10 disease

S.N	Disease	Total cases %
1	Upper Respiratory Tract Infection (URTI)	38.11
2	Gastritis (APD)	32.40
3	Headache	28.21
4	Fever	22.58
5	Cut Injuries	18.65
6	Cough	17.89
7	Musculoskeletal Pain	17.24
8	Water/Food borne-presumed Non-infectious diarrheal cases	14.23
9	Acute Tonsilitis	13.05
10	Hypertension	12.82

CHAPTER 7: HOSPITAL SERVICES

7.1 रसुवा अस्पताल

यो रसुवा अस्पताल रसुवा जिल्लाको गोसाईकुण्ड गा .पा बडा नं ६ मा धुन्चे बजारमा अवस्थित रहेको छ। यो अस्पताल विकाशक्रममा विकशित हुदै आएको छ। यो अस्पताल सुरुमा २०५५ सालमा १५ बेड बाट शुरु भै जिल्ला अस्पतालको रुपमा ५५ सालमा स्थापना भएको हो।

सेवाहरु

- दैनिक तथा नियामित बहिरङ्ग/अन्तरङग/ आकास्मिक सेवाहरु
- सामाजिक सेवा इकाइ तथा जेष्ट नागरिक सेवा
- स्वास्थ्य बिमा
- गर्भवाति तथा सुत्केरी परामर्श तथा उपचार सेवा
- शल्यक्रिया सेवा
- दन्त रोग सम्बन्धी सेवा
- मानसिक स्वास्थ्य सम्बन्धी बिशेस्ज्ञ सेवा
- प्रयोगशाला x-ray, USG(video x-ray)सेवा
- वजातशिशु नि: शुल्क भर्ना सेवा
- नि: शुल्क परिवारनियोजन सेवा
- सुरक्षित गर्भपतन सेवा
- अस्पताल फार्मेसी सेवा
- एक द्वार सङ्कट व्यव्सथापन केन्द्र (OCMC)सेवा
- पुलिस केस प्रतिबेदन सेवा
- पोस्टमार्टम सेवा

ओपिडि खुल्ने समय -

आईतबार बिहीबार-:- ९ बजेदेखि ५ बजेसम्म

शुक्रबार :- ९ बजेदेखि ३ बजेसम्म

बिरामी पुर्जा लिने समय

आईतबार बिहीबार-:- ९ बजेदेखि ५ बजेसम्म

शुक्रबार :- ९ बजेदेखि ३ बजेसम्म

नि:शुल्क सेवा पाउने लक्षित वर्गहरु

CHAPTER 8: SUPPORTING PROGRAMS

8.1 Public Health Laboratory Services

8.1.1. Introduction

Public health laboratories focus on diseases and the health status of population groups. They perform limited diagnostic testing, reference testing, and disease surveillance. They also provide emergency response support, perform applied research, and provide training for laboratory personnel. The Public Health Laboratory works in collaboration with the National public health system. The National Public Health Laboratory (NPHL) is a central specialised national referral public health laboratory for the country. The provincial public health laboratory has a provincial referral and regulatory body to license public and private labs.

The core function of the Provincial Public Health Laboratory

- Disease prevention, control, and surveillance
- Integrated data management
- Reference specialized testing and quality control.
- Environmental health and protection.
- Laboratory improvement and regulation
- Public health preparedness and response
- Training and education.

Table 41: Number, Types and Function of Laboratories in Rasuwa District

SN	Rural Municipality	Types	No.	Function
1.	Gosaikunda	Health Post Based	3 (Syafru HP Rasuwa Hospital) (Rasuwa HP)	• Provide diagnosis, prevention and control of vector-borne diseases and TB. • Provide general routine tests (Haematology, biochemistry Urine stool, HIV tests) and sputum microscopy.
2.	Aamachhodingmo	BHSC Based	1 (Goljung HP)	

3.	Kalika	Hospital &BHSC Based	2 (PHC & Kalika BHSC)	• Provide diagnosis, prevention and control of vector-borne diseases and TB. • Provide general routine tests (Haematology, Urine stool, HIV tests) and sputum microscopy
4.	Uttargaya	BHSC Based	3 (Dadagaun, Laharepauwa and Thulogaun HP)	
5.	Naukunda	BHSC Based	3 (Parchyang, Yarsa and Bhorle HP)	

8.2 Infrastructure Development

रसुवा जिल्ला भित्र रहेको स्वास्थ्य संस्थाहरुको जग्गाको विवरण र भवनको अवस्था

Table 42: Details of Health Facility of Rasuwa district

सि.न.	स्वास्थ्य संस्थाको नाम	वडा नं	जग्गा को विवरण	भवनको विवरण			Facility Type
				पक्की	कच्ची	भुकम्प प्रतिरोधी	
गोसाईकुण्ड गाउँपालिका							
१.	दाहालफेदी सामुदाईक स्वास्थ्य ईकाई	१	आफ्नै	निमार्णधीन	-	√	
२.	थुमन स्वास्थ्य चौकी	१	वडा कार्यालय	-	√	√	Health Post
३.	टिमुरे स्वास्थ्य चौकी	२	आफ्नै	√	-	√	Health Post
४.	वृद्धिम स्वास्थ्य चौकी	३	आफ्नै	√	-	√	Health Post
५.	खाम्जिङ सामुदाईक स्वास्थ्य ईकाई	३	आफ्नै	निमार्णधीन	भाडामा		
६.	लाङटाङ स्वास्थ्य चौकी	४	ऐलानी	-	√	-	Health Post

७.	स्याफ्रुबेशी स्वास्थ्य चौकी	५	आफ्नै	√	√	√	Health Post
८.	ठुलो स्याफ्रु सामुदाईक स्वास्थ्य ईकाई	५	ऐलानी	√	-	-	Community Health Unit
९.	रसुवा स्वास्थ्य चौकी	६	आफ्नै	√	√	√	Health Post
आमाछोदिङमो गाउँपालिका							
१.	हाकु स्वास्थ्य चौकी	१	आफ्नै		√		आधारभूत स्वास्थ्य सेवा केन्द्र
२.	पाङलिङ सामुदाईक स्वास्थ्य ईकाई	१	आफ्नै		√		आधारभूत स्वास्थ्य सेवा केन्द्र
३.	ग्रे सामुदाईक स्वास्थ्य ईकाई	२	आफ्नै		√		आधारभूत स्वास्थ्य सेवा केन्द्र
४.	नेसिङ सामुदायिक स्वास्थ्य ईकाई	२	आफ्नै		√		आधारभूत स्वास्थ्य सेवा केन्द्र
५.	गत्लाङ स्वास्थ्य चौकी	३	आफ्नै	√			आधारभूत स्वास्थ्य सेवा केन्द्र
६.	दोबो तेम्बा पुर्पु आधारभुत अस्पताल	४	आफ्नै	√			आधारभूत आयुर्वेद स्वास्थ्य सेवा केन्द्र
७.	थाम्बुचेत स्वास्थ्य चौकी	५	आफ्नै	√			आधारभूत स्वास्थ्य सेवा केन्द्र
कालिका गाउँपालिका							
१.	राम्चे स्वास्थ्य चौकी	१	आफ्नै	√ निमार्णधीन			आधारभूत स्वास्थ्य सेवा केन्द्र
२.	कालिका आधारभुत स्वास्थ्य सेवा केन्द्र	२	आफ्नै	√			आधारभूत स्वास्थ्य सेवा केन्द्र
३.	बेतिनी आधारभुत स्वास्थ्य सेवा केन्द्र	३	आफ्नै	√			आधारभूत स्वास्थ्य सेवा केन्द्र
४.	धुसेनी आधारभुत स्वास्थ्य सेवा केन्द्र	४	आफ्नै	√			आधारभूत स्वास्थ्य सेवा केन्द्र
५	जिवजिवे ग्रामिण प्राथमिक स्वास्थ्य केन्द्र	५	आफ्नै	√ निमार्णधीन			आधारभूत अस्पताल (५ देखि १५ शैयासम्म)
उत्तरगया गाँउपालिका							
१	तिरु सामुदायिक स्वास्थ्य इकाई	१	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
२	मैलुङ सामुदायिक स्वास्थ्य केन्द्र	१	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
३	डाडाँगाउँ स्वास्थ्य चौँकी	२	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र

४	ठुलोगाउँ स्वास्थ्य चौँकी	३	आफ्नै	√ निमार्णधीन		√	आधारभूत स्वास्थ्य सेवा केन्द्र
५	लहरेपौवा स्वास्थ्य चौँकी	४	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
३.	बोगटिटार सामुदायिक स्वास्थ्य इकाई	५	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
नौकुण्ड गाँउपालिका							
१.	आरूखर्क सामुदायिक स्वास्थ्य इकाई	१	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
२.	लाङबु सामुदायिक स्वास्थ्य इकाई	१	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
३.	सिम्बन्दी सामुदायिक स्वास्थ्य इकाई	१	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
४.	यार्सा स्वास्थ्य चौँकी	२	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
५.	पार्च्याङ स्वास्थ्य चौँकी	३	आफ्नै	निमार्णधीन			आधारभूत स्वास्थ्य सेवा केन्द्र
६.	सरमथली सामुदायिक स्वास्थ्य इकाई	४	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
७.	ठुलो भोर्ले सामुदायिक स्वास्थ्य इकाई	५	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
८.	भोर्ले स्वास्थ्य चौँकी	५	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
९.	वेताङ सामुदायिक स्वास्थ्य इकाई	५	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र
१०.	सर्स्यू सामुदायिक स्वास्थ्य इकाई	६	आफ्नै	√		√	आधारभूत स्वास्थ्य सेवा केन्द्र

8.3 Development Partner Support

8.3.1 District Community Eye Centre

- Established in 2006 A.D
- **Location :** Gosainkunda -6, Dhunche
- In Collaboration with Nepal Eye Program Tilganga Institute of Ophthalmology and Nepal Red Cross Society District Chapter Rasuwa

Service Outlet in the district

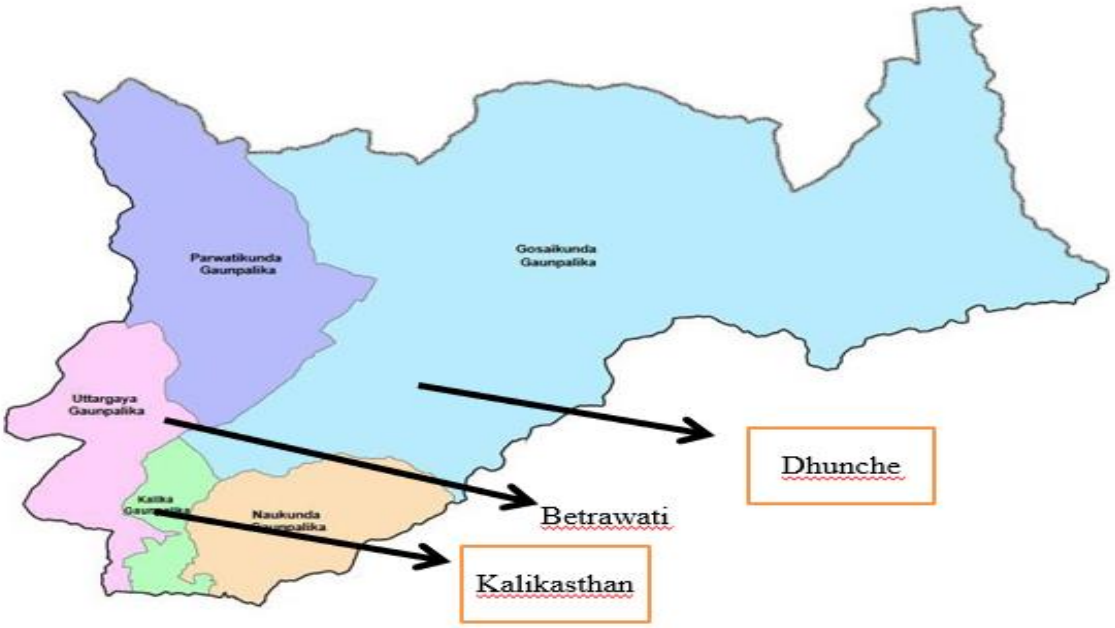


Figure Service outlets of CEC

Table 43: Available service at the district eye center

Available Service at Eye Centre	
Clinical Service	**Outreach Service**
➢ Vision & Refraction	➢ Community Screening eye camps
➢ Slit lamp examination	➢ Free Cataract Surgery Camp
➢ Investigations (IOP/BP/Schirmer test, syringing,colour vision test etc)	➢ Rural Eye Centres (Kalika, Uttargaya)
➢ Minor surgery (Chalazion/ lid abcess/Corneal FB removal)	➢School Screening eye camps
➢ Medicine & spectacle dispensing ➢Telemedicine/Fundus Photo	➢Eye health orientation Programs/Trainings

Major Activities conducted in FY 2080/81

- Centre OPD
- Minor Surgery
- Community Screening camp and free cataract surgery
- Health Workers, FCHVs, Teachers'/School Nurse training
- Spectacle subsidy for school students

ANNEXES 1

Annexe 1.1: Estimated Target Population 2080/81

Rural Municipality	Total population	Total expected live birth	0-23 Months	6-23 months	0-59 months	6-59 months	0-14 yrs	10-19 years	Total expected pregnancies
Gosaikunda	8120	119	241	181	587	527	1694	535	190
Aamachhodingmo	6512	115	232	174	619	562	1906	544	182
Uttargaya	8368	130	261	196	644	580	2066	672	207
Kalika	9844	150	303	228	747	672	2344	824	239
Naukunda	11958	205	405	304	1051	949	3404	1206	322
District Total	**45974**	**755**	**1447**	**1088**	**3657**	**3297**	**11463**	**3824**	**1145**

Annexe 1.2: पालिकाका स्वास्थ्य शाखा प्रमुखहरुको विवरण

क्र स	गाउँपालिका नाम	स्वास्थ्य शाखा प्रमुख	सम्पर्क नं	ईमेल
१	गोसाईकुण्ड	श्री विमल घिमिरे	९८४९०९३२९५	*cool.bimal48@gmail.com*
२	आमाछोदिङमो	श्री निमा नुर्पू तामाङ	९८६९२२३८३२	*nimatamang196@gmail.com*
३	कालिका	श्री नवराज न्यौपाने	९८५११८६५७०	*nawarajneupane340@gmail.com* *kalikagaupalikaswasthyashakha@gmail.com*
४	उत्तरगया	श्री बलराम न्यौपाने	९८४१५३९७९०	*balaram.neupn@gmail.com*
५	नौकुण्ड	श्री अण प्रसाद पौडेल	९८४१४१८०२९ ९८१८१६२०६०	*anapaudel72@gmail.com*

Annexe 1.3 कार्यक्रम सँग सम्बन्धित तस्विरहरु

क्षयरोग आधारभुत तालिम

स्वास्थ्यकर्मिहरुलाई खोप सेवा तथा सरसफाई प्रवर्द्धन कार्यक्रम

जिल्ला अन्तर्गत पूर्ण खोप सुनिश्चितता, सुक्ष्म योजना अध्यावधिक सम्बन्धि समिक्षा/गोष्ठि

पोषण प्रवर्द्धन तथा विषादि न्यूनिकरण तथा रोकथाम अभिमुखिकरण कार्यक्रम

मुख्यमन्त्री जनता स्वास्थ्य परिक्षण कार्यक्रम सम्बन्धि अभिमुखिकरण

मुख्यमन्त्री जनता स्वास्थ्य परिक्षण कार्यक्रम समिक्षा

संघिय उपचारात्मक सेवा कार्यक्रम: आधारभुत स्वास्थ्य सेवाको स्तरिय उपचार पद्धति (BHS-STP) तालिम

क्षयरोग पहिचानको लागि माइक्रोस्कोपी शिविर

कृष्ठ रोग पहिचानको लागि छाला रोग शिविर संचालन - स्वास्थ्य परिक्षण तथा परामर्श सेवा

महिलाहरूको लागि एकिकृत प्रजनन् स्वास्थ्य रूग्णता शिविर

प्रजनन् स्वास्थ्य रूग्णताको एकिकृत स्कृनिङ्ग तथा व्यवस्थापन शिविर

पारस्परिक स्वास्थ्य संस्था अवलोकन भ्रमण

संघिय बाल रोग कार्यक्रम: CB-IMNCI तालिम कार्यक्रम

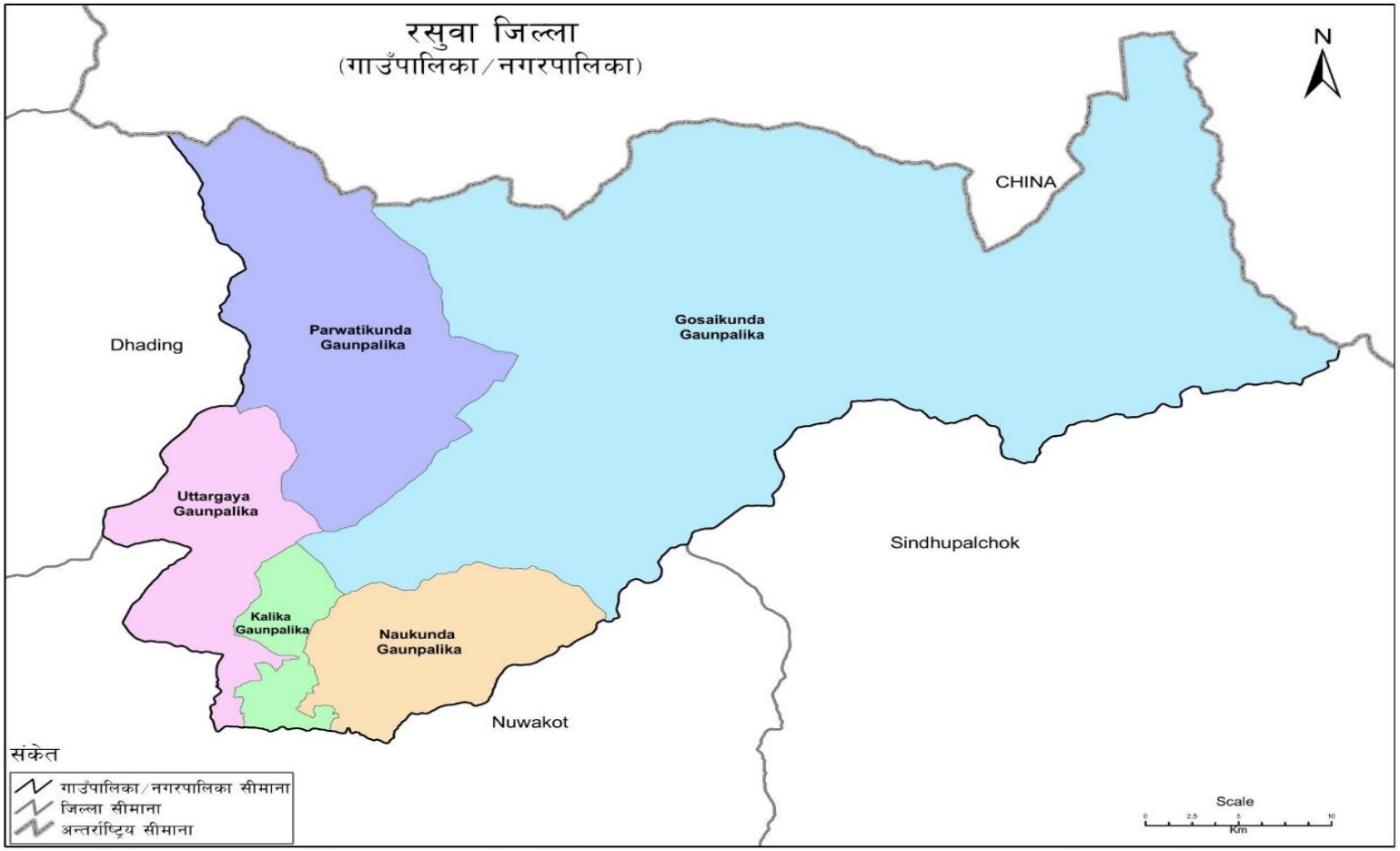
राष्ट्रिय हात्तीपाईले रोग निवारण कार्यक्रम अन्तर्गत आम औषधी सेवन अभियान२०८१/८१ -शुभारम्भ कार्यक्रम

दादुरा-रूबेला खोप अभियान २०८१/८१ शुभारम्भ कार्यक्रम

आई.पि.भि/ IPV खोप अभियान २०८०/८१ सम्बन्धि जिल्ला स्तरिय अभिमुखिकरण तथा योजना तर्जुमा गोष्ठी

लागु औषध दुरुपयोग तथा अवैध ओसारपसार विरूद्धको अन्तराष्ट्रिय दिवसमा धुन्चे बजारमा प्ले कार्ड सहित सचेतनामूलक रयाली

आ.व २०८०/८१ को स्वास्थ्य कार्यक्रमहरुको वार्षिक प्रगति समिक्षा तथा कदर-पत्र वितरण



स्रोत: स्थलरुप नक्सा (स्केल १:२५०००/१:५००००), नापी विभाग र जनगणना २०६८, केन्द्रिय तथ्यांक विभाग
तयार पार्ने: गाउँपालिका, नगरपालिका तथा विशेष, संरक्षित वा स्वायत्त क्षेत्रको संख्या तथा सीमाना निर्धारण आयोग

Projection System: MUTM, Spheroid - Everest 1830
LLRC,2016

Map of Rasuwa Distirct

ANNEXES 2

अनुसुचि-३

(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशिर्षक नं.-३७०००११ रकम रु हजारमा

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको भौतीक प्रगती			यस अबधि सम्माको खर्च		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	विद्यालयमा सूचना संचार सामाग्रो(एल सी डी, ल्यापटप खरिद)	०	१	१२	८.५	१	१२	८.५	१	१२	१००	८.५	१००	
४	स्वास्थ्यकर्मीहरुलाई MCH, NIS तथा पोषण सम्बन्धी तालिम प्रदान गर्ने	०	१	७.०६	५	१	७.०६	५	१	७.०६	०	०	०	
५	स्थानीय तहका तालिमप्राप्त आमा समूह तथा समुदायका सदस्यहरूबाट प्रदर्शनी तथा पोषणको अवस्था पहिचान (प्रत्येक आमा समूहबाट प्रत्येक महिना खाद्य प्रदशर्नी)	०	१	५.३	३.७५	१	५.३	३.७५	१	५.३	३२	१.१८	३२	
६	स्वास्थ्य आमा समूहलाई स्वास्थ्य प्रवर्द्धन प्रविधिको अनुशरणका लागि साना अनुदान	०	१	२८.९५	२०	१	२८.९५	२०	०	०	०	०	०	
७	स्वास्थ्य कार्यालय तथा स्थानीय तहबाट प्राविधिक सहयोग तथा मेन्टोरिङ्ग	०	१	१.४१	१	१	१.४१	१	१	१.४१	६१.	१	६१.	
८	स्वास्थ्य संस्थाहरुमा वृद्धि अनुगमनका लागि आवश्यक सामाग्रीहरु खरिद तथा विवरण	०	१	९.१८	६.५	१	९.१८	६.५	१	९.१८	९९.	६.४	९९	
९	स्थानीय तहका पदाधिकारीहरु तथा सरोकारवालाहरुसँग कार्यक्रमको समीक्षा तथा भावी योजना तर्जुमा गोष्ठी	०	१	१.१३	०.८	१	१.१३	०.८	०	०	०	०	०	
१०	व्यवहार परिवर्तन सञ्चार	०	१	३.५३	२.५	१	३.५३	२.५	१	३.५३	१००.	२.४९	१००.	
११	सुरक्षित मातृत्व तथा वाल स्वास्थ्य सेवाको प्रतिवेदन तथा अभिलेखिकरणलाई चुस्त दुरूस्त बनाइ HMIS (DHIS-II) सदृढीकरण गर्ने	०	१	०.७१	०.५	१	०.७१	०.५	०	०	०	०	०	
१२	विद्यालय साथी शिक्षकहरुका लागि २ दिने क्षमता अभिवृद्धि तालिम	०	१	१.४१	१	१	१.४१	१	१	१.४१	१००	१	१००	
१३	स्थानीय सरकारसंग छात्र छात्रा (स्थानीय तहका प्रमुख, उपप्रमुख तथा कार्यपालिका सदस्यसंग प्रजनन तथा यौन स्वास्थ्य सम्बन्धी अन्तरक्रिया)	०	१	२.१२	१.५	१	२.१२	१.५	०	०	०	०	०	
१४	विद्यालयमा आधारित लैगिक हिंसा, बाल विवाह, सामाजिक संजालको दुरुपयोग रोकथाम सम्बन्धी प्रहरी प्रशासनसंगको अन्तरक्रिया	०	१	२.१२	१.५	१	२.१२	१.५	१	२.१२	९०.	१.४	९०	
१५	छात्रामैत्रि शौचालयको व्यवस्थापन तथा सरसफाई		५	३.५३	२.५	५	३.५३	२.५	५	३.५३	९५.	२.३७	९५	

१६	विद्यालय छाडेका किशोर किशोरीलाई यौन तथा प्रजनन स्वास्थ्य सम्बन्धी गोष्ठी	०	५	३.५३	२.५	५	३.५३	२.५	५	३.५३	४०.	१.०१	४०.	
१७	किशोरकिशोरीहरुको लागि यौन तथा प्रजनन स्वास्थ्य सम्बन्धी गोष्ठी	०	५	७.०६	५	५	७.०६	५	५	७.०६	६५	३.२५	६५.	
१८	किशोरकिशोरीहरुको अभिभावकहरुको लागि विद्यालयमा आधारित यौन तथा प्रजनन स्वास्थ्य सम्बन्धी गोष्ठी	०	५	२.१२	१.५	५	२.१२	१.५	५	२.१२	९१.	१.३६	९१.	
१९	विद्यालयमा सुचना कक्ष स्थापना	०	५	८.१२	५.७५	५	८.१२	५.७५	५	८.१२	१००.	५.७४	१००.	
२०	कार्यक्रमको व्यवस्थापन, अनुगमन, मुल्यांकन मेन्टोरिङ्ग तथा प्रभावकारिता अध्ययन गर्ने		१	०.७१	०.५	१	०.७१	०.५	१	०.७१	८९.	०.४९	८९.	
	कुल 'जम्मा		३८	१००	७०.३	३८	१००	७०.३	३४	६७	५०	३५.८	५०	

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(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२१३

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको भौतीक			यस अबधि सम्माको		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	उपचारात्मक सेवा सम्वन्धि स्वास्थ्य कार्यालयबाट संचालन हुने कार्यक्रम (१. आधारभूत स्वास्थ्य सेवाको स्तरीय उपचार पद्धती (BHS STP) सम्वन्धि स्वास्थ्यकर्मीलाइ अभिमुखीकरण २. स्वास्थ्यकर्मीहरुका लागि आँखा, नाक, कान, घाटी तथा मुख स्वास्थ्य सम्वन्धि प्राथमिक उपचार बारे अभिमुखीकरण ३. स्वास्थ्य चौकी (आधारभूत स्वास्थ्य सेवा केन्द्र) को न्युनतम सेवा मापदण्ड सम्वन्धि समिक्षा , अनुगमन. पारस्परिक अवलोकन भ्रमण तथा सुद्रिधिकरण)		१	९२.३१	१२	१	९२.३१	१२	१	९२.३१	७६.	९.२१२	७६.	
२	सामाजिक परिक्षण सम्वन्धि तालिम		१	७.६९	१	१	७.६९	१	१	७.६९	०	०	०	
	कुल जम्मा		२	१००.	१३	२	१००.	१३	२	१००.	७६.	९.२१२	७६.	

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(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

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जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२२३

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको			यस अवधिसम्मको			यस अबधि सम्माको खर्च		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	राष्ट्रिय महिला स्वास्थ्य स्वयंसेविका कार्यक्रम (स-सम्मान विदाई, आधारभूत तथा पुनर्ताजगी तालिम तथा स्वयंसेविकाको लागि सामग्री समेत)		१	१००	७.७८	१	१००	७.७८	१	१००	९७.	७.६०७	९७.	
	कुल जम्मा		१	१००.	८	१	१००.	८	१	१००.	९७.	७.६०७	९७.	

अनुसुचि-३

(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२३

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको			यस अबधि सम्माको		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	स्वास्थ्य कार्यालय मार्फत स्थानीय तहहरूको डाटा भेरिफिकेशन एवं गुणस्तर सुधार, मासिक बैठक, अर्धबार्षिक एवं बार्षिक समिक्षा साथै बार्षिक प्रतिवेदन तयारी एवं छपाई समेत		1	44.22	3.25	1	44.22	3.25	1	44.22	87	2.851	87	
२	स्वास्थ्य कार्यालय मार्फत स्थानीय तहहरू साथै स्वास्थ्य संस्थामा डाटा इन्ट्रि गर्ने कर्मचारीहरुलाई परिमार्जित एल एम आइ एस, एच एम आई एस अभिलेख, प्रतिवेदन तथा मासिक अनुगमन पुस्तिका र आइ एम यू समेतको ओरियण्टेशन		1	50.34	3.7	1	50.34	3.7	1	50.34	98	3.643	98	
३	तथ्यांक व्यवस्थापन समिति निर्माण तथा तथ्यांक बिष्लेषण गरी नियमित प्रस्तुतिकरण		1	5.44	0.4	1	5.44	0.4	1	5.44	0	0	0	
	कुल जम्मा		3	100	7.35	3	100	7.35	3	100	88	6.494	88	

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(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२७

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको भौतीक			यस अबधि सम्माको		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
	विद्यालय स्वास्थ्य शिक्षा कार्यक्रम		1	100	0.5	1	100	0.5	1	100	76	0.383	76	
	कुल जम्मा		1	100	0.5	1	100	0.5	1	100	76	0.383	76	

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(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२४

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको			यस अबधि सम्माको		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
	पालिकास्तरको कुष्ठरोग नियंत्रण तथा अपांगता व्यवस्थापन कार्यक्रमको प्राविधिक अन्तरक्रिया, समिक्षा एवं		1	95.24	1	1	95.24	1	1	95.2	0	0	0	
	कुष्ठरोगको नियमित उपचार पूरा गर्ने बिरामीको लागि यातायात खर्च		1	4.76	0.05	1	4.76	0.05	1	4.76	0	0	0	
	कुल जम्मा		2	100	1.05	2	100	1.05	2	100	0	0	0	

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जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२६

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको भौतीक			यस अवधि सम्माको खर्च		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	कालाजार, डेंगू, चिकनगुनिया, स्क्रब टाइफस, जीका, अन्य ईमर्जिड रोगहरू साथै किटजन्य रोग नियन्त्रणबारे स्वास्थ्यकर्मी, म.स्वा.से. तथा अन्य सरोकारवालाहरूलाई अभिमूखिकरण/अन्तरक्रिया		1	8	1.5	1	8	1.5	1	8	99	1.496	99	
२	डेङ्गु सार्ने लामखुट्टेको बासस्थान खोजी गरि लार्भा नष्ट गर्ने तथा स्थानीय तहहरुसँगको पैरवी		1	10.7	2	1	10.7	2	1	10.67	0	0	0	
३	हात्तीपाइले रोग बिरुद्धको औषधि खुवाउने अभियानको योजना तर्जुमा गोष्ठी , जिल्लाबाट पालिकासम्म औषधि तथा IEC ढुवानी, जिल्ला समन्वय समितिको मिटिङ, पत्रकार अन्तर्कृया, बिज्ञापन, छपाई, हात्तीपाइले रोग बिरुद्धको औषधि सेवन पश्चात असर देखिएका बिरामीहरूको उपचारका लागि अस्पतालहरूमा हुने खर्चको सोधभर्ना तथा अनुगमन र मुल्याङ्कन		1	35.3	6.62	1	35.3	6.62	1	35.33	95	6.328	95	
४	विश्व औलो/ उपेक्षित उष्णप्रदेशीय रोग (NTD) दिवस मनाउने, किटजन्य रोगहरूको परिमार्जित निर्देशिका बमोजिम प्राबिधिकहरूबाट अनुगमन तथा अनसाईट कोचिङ, किटजन्य रोगहरू सम्बन्धि सरोकारवालाहरूसंगको समन्वय बैठक		1	5.34	1	1	5.34	1	1	5.34	0	0	0	
५	हात्तीपाइले इन्डेमिक जिल्लाहरूमा मोर्बीडिटी म्यापिंग, बिरामी व्यवस्थापन तथा अपाँगता रोकथाम सम्बन्धि कार्यक्रम सञ्चालन गर्ने।		1	35.3	6.62	1	35.3	6.62	1	35.33	0	0	0	
६	Water Safety Plan and Water Quality Surveillance program		1	5.34	1	1	5.34	1	1	5.34	0	0	0	
	कुल जम्मा		6	100	18.74	6	100	18.74	6	100.01	41	7.824	41	

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(नियम २१ को उपनियम (२) र नियम २६ सँग सम्बन्धित)

प्रदेश सरकार

जनस्वास्थ्य कार्यालय, रसुवा

आ.ब. २०८०/०८१ को अवधिसम्मको लक्ष्य प्रगती विवरण

बजेट उपशीर्षक नं :३७०९११२८

क्र.स	कार्यक्रम क्रियाकलाप	ईकाई	बार्षिक लक्ष्य			यस अवधिसम्मको लक्ष्य			यस अवधिसम्मको भौतीक			यस अबधि सम्माको खर्च		कैफियत
			सुचक	भार	बजेट	सुचक	भार	बजेट	सुचक	भार	प्रतिशत	रकम रु	प्रतिशत	
१	प्रसूति पश्चातको रक्तश्रावको अवस्थामा प्रयोग गरिने Anti-Shock Garment खरीद		1	2.4	3	0	2.4	3	0	2.4	97	2.938	97	
२	जिल्ला खोप समन्वय समिति, जिल्ला कोभिड खोप अभियान संचालन तथा अनुगमन समितिको समन्वयमा पालिका, वडा स्तरको खोप कार्यक्रम, कोभिड खोप अभियानको प्रगति , पूर्णखोप सुनिश्चितता , सुक्ष्म योजना अध्यावधिक अवस्थाको समिक्षा र स्थानीय तहहरु बाट गरिएका क्रियाकलाप , बजेट आदि बारे सार्बजनिक सुनुवाई, उत्कृष्ट कार्य गर्ने प्रत्यक जिल्लाको २ वटा पालिका र ५- १० वटा स्वास्थ्य संस्था हरुलाई सम्मान गर्ने साथै एवं भावी कार्य योजना तयारि १ दिने गोष्ठी		1	2.24	2.81	1	2.24	2.81	1	2.24	99	2.975	99	
३	खोप बाट बचाउन सकिने रोगहरुको सर्भिलेन्स, नमुना संकलन र ढुवानी, महामारी व्यवस्थापन, महामारी नियन्त्रणको लागि खोप कार्यक्रम (Out Break Response Immunization- ORI) संचालन ब्यबस्थापन खर्च जिल्लामा बजेट उपलब्ध गराउने)		1	0.8	1	1	0.8	1	1	0.8	0	0	0	
४	खोप तथा पूर्ण खोपको बारेमा जनचेतना बढाई खोप उपयोग बृद्धिको लागि स्थानिय भाषामा शैक्षिक सामाग्रि (खोप सम्बन्धि सन्देश मुलक ब्रोसर, पम्प्लेट, खोप तालिका, खोप मौज्दात नियन्त्रण रजिष्टर, सुक्ष्म योजना फारम तथा खोप अनुगमन चार्ट र खोपसँग सम्बन्धित अन्य सामाग्री आदि) छपाई तथा वितरण ७७ जिल्ला		1	0.5	0.63	1	0.5	0.63	1	0.5	99	0.621	99	
५	जिल्लाबाट पालिका तथा स्वास्थ्य संस्थास्तरमा खोप, सरसफाई प्रवद्र्धन कार्यक्रम तथा पूर्ण खोप भेरिफिकेसन र दिगोपनाको लागी सहजीकरण, महामारी नियन्त्रण , सर्भिलेन्स एवं सुपरिवेक्षण ब्यबस्थापन खर्च		1	2.4	3	1	2.4	3	1	2.4	99	2.99	99	
६	गुणस्तरीय खोप सेवा संचालन तथा सरसफाई प्रवर्द्धनमा संलग्न स्वास्थ्यकर्मीको दक्षता बृद्धि, ज्ञानसीप अद्यावधिक गर्न नयाँ तथा खोप तालिम नलिएका स्वास्थ्यकर्मीहरुलाई पूर्ण खोप सुनिश्चितता एवं सुक्ष्म योजना तयारी प्रक्रिया, शुन्य खोप र ड्रप आउट बच्चाको पहिचान ,कोल्डचेन व्यवस्थापन, ए.ई.एफ.आई, सर्भिलेन्स, र सरसफाई प्रवर्द्धन सम्बन्धि आधारभुत ४ दिने तालिम (७०० जना)		1	3.99	5	1	3.99	5	1	3.99	61	3.03	61	
७	खोपको पहुंच बढाई छुट वच्चालाई खोप दिलाई पूर्ण खोप सुनिश्चित गर्न मंशिर र बैशाख महिनामा खोप छुट (सुन्य मात्रा र ड्रप आउट बच्चा) निर्देशिकामा उल्लेख भय अनुसार खोप केन्द्रमा ल्याई खोप दिलाए बापत मा. स्व.सेविका हरुलाई यातायात खर्च , वैशाख महिनालाइ खोप महिनाको रूपमा संचालन गर्न (बिशेष समुदायहरुमा अभिमुखीरण र सामाजिक परिचालन, छुट बच्चाको line listing, अतिरिक्त खोप सेवा संचालन आदि को योजना र पालिका/ वडा स्तरमा कार्यक्रम संचालन ब्यबस्थापन खर्च		1	1.6	2	1	1.6	2	1	1.6	13	0.26	13	

८	दादुरा रुबेला खोप अभियान संचालन तथा नियमित खोप सुदृढीकरणको लागि जिल्ला तहमा अभियान संचालन निर्देशिका बमोजिम कार्यक्रम संचालन तथा व्यवस्थापन (बैठक, अभिमुखिकरण, योजना गोष्ठी,जनशक्ति परिचालन, ए.ई.एफ.आई व्यवस्थापन र टिम परिचालन, प्रचार प्रसार तथा सामाजिक परिचालन,अभियानको launching, सुपरिवेक्षण अनुगमन, खोप तथा कोल्डचेन सामाग्री वितरण तथा ढुवानी, कार्यक्रम व्यवस्थापन खर्च ,सामाग्री छपाई आदी) (जिल्ला हरुमा बजेट उपलब्ध गराउने)		1	18.86	23.61	1	18.86	23.61	1	18.86	38	9.09	38	
९	आई.पी.भी. खोप अभियान संचालन व्यवस्थापन खर्च (अभिमुखीकरण , योजना गोष्ठी, जनशक्ति परिचालन , सुपरिबेक्षण,खोप तथा खोप सामाग्री वितरण खर्च (प्रदेश र जिल्ला हरुमा बजेट उपलब्ध गराउने)		1	3.43	4.3	1	3.43	4.3	1	3.43	94	4.07	94	
१०	प्रजनन स्वास्थ्य रूणता सेवा		1	6.39	8	1	6.39	8	1	6.39	64	5.166	64	
११	खोप कोल्ड चेन ढुवानी कर्ता (स्थानीय तह, स्वास्थ्य संस्था का कर्मचारी / ढुवानी कर्ता) लाई खोप ढुवानी र कोल्ड चेन व्यवस्थापन सम्बन्धि १ दिने अभिमुखीकरण (जिल्ला तहमा)		1	1.28	1.6	1	1.28	1.6	1	1.28	0	0	0	
१२	कोभिड१९ खोप बुस्टर मात्रा समेतको अभियान संचालन, आई. पी.भी. खोप अभियान संचालन तथा व्यवस्थापन खर्च (ए.ई.एफ.आई व्यवस्थापन र टिम परिचालन, बैठक, अभिमुखिकरण, जनशक्ति परिचालन, प्रचार प्रसार तथा सामाजिक परिचालन, सुपरिवेक्षण अनुगमन, खोप तथा कोल्डचेन सामाग्री वितरण तथा ढुवानी, सामाग्री छपाई आदी) जिल्ला तथा प्रदेशमा बजेट उपलब्ध गराउने)		1	19.32	24.19	1	19.32	24.19	1	19.32	65	15.815	65	

१२	कोभिड१९ खोप बुस्टर मात्रा समेतको अभियान संचालन, आई. पी.भी. खोप अभियान संचालन तथा व्यवस्थापन खर्च		1	19.32	24.19	1	19.32	24.19	1	19.32	65	15.815	65	
१३	खोप छुट बच्चा (शुन्य डोज तथा ड्रप आउट) को पहिचान र छुट खोप पूरा गरी पूर्ण खोप सुनिश्चितता तथा नियमित खोप र सरसफाई प्रबद्धन कार्यक्रम सुदृढीकरणको लागि समिक्षा, अभिमिखिकरण तथा सुक्ष्म योजना अद्यायवधिक र महामारी रोकथाम तथा नियन्त्रण, सर्भिलेन्सको लागि स्थानीय तहको योजना तयारी समेत २ दिन गोष्ठि जिल्लामा बजेट उपलब्ध गराउने		1	3.2	4	1	3.2	4	1	3.2	84	3.38	84	
१४	पोषण बिशेष कार्यक्रम		1	4.19	5.25	1	4.19	5.25	1	4.19	34	1.79	34	
१५	IMNCI कार्यक्रम		1	5.78	7.23	1	5.78	7.23	1	5.78	78	5.666	78	
१६	नेपाल सरकार बाहेक अन्य दाता को श्रोत बाट कार्यक्रम संचालन गर्दा विभिन्न कर हरु		1	0.13	0.16	1	0.13	0.16	1	0.13	0	0	0	
१७	खोपकोल्डचेन व्यवस्थापनको लागि ईन्धन तथा विधुत महशुल भुक्तानि (प्रदेश स्वास्थ्य आपूर्ती व्यवस्थापन केन्द्र र स्वास्थ्य कार्यालयहरुको लागि)		1	0.35	0.44	1	0.35	0.44	1	0.35	0	0	0	
१८	नियमित खोप सेवा र आकस्मिक अवस्थामा प्रदेश तथा जिल्लाबाट भ्याक्सिन, खोप सामग्री र खोप तथा सरसफाई प्रवर्द्धनसँग सम्बन्धित अन्य सामाग्रीको व्यवस्थापन, वितरण तथा ढुवानी खर्च (प्रदेश स्वास्थ्य आपूर्ती व्यवस्थापन केन्द्र र स्वास्थ्य कार्यालयहरुको लागि))		1	5.19	6.5	1	5.19	6.5	1	5.19	82	5.33	82	
१९	खोपकोल्डचेन सामाग्रिको नियमित मर्मत, आकष्मिक मर्मत व्यवस्थापन, नवलपरासी पूर्व स्वास्थ्य कार्यालय अन्तर्गत जिल्ला कोल्डरुम सञ्चालन व्यवस्थापन समेत (प्रदेश स्वास्थ्य आपूर्ती व्यवस्थापन केन्द्र र स्वास्थ्य कार्यालयहरुको लागि बजेट उपलब्ध गराउने)		1	0.8	1	1	0.8	1	1	0.8	89	0.89	89	
२०	किशोरकिशोरी स्वास्थ्य सेवा		1	2.14	2.68	1	2.14	2.68	1	2.14	0	0	0	

२१	नियमित खोपको सुदृढीकरण, खोप छुट बच्चा लाई खोप पूरा गराउन को लागि स्थानिय एफ रेडियोहरुबाट सूचना प्रसारण (माघ देखि वैशाख सम्म) जिल्लामा बजेट उपलब्ध गराउने		1	0.52	0.65	1	0.52	0.65	1	0.52	0	0	0	
२२	स्वास्थ्य कार्यालय मार्फत MNH कार्यक्रम		1	9.98	12.5	1	9.98	12.5	1	9.98	0	0	0	
२३	परिवार योजना सेवा		1	4.51	5.64	1	4.51	5.64	1	4.51	0	0	0	
	कुल जम्मा		23	100	125.2	0	100	125.19	0	100	51	64.011	51	